



Meaningful Use:

What Health Care Organizations Need to Know

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Agenda

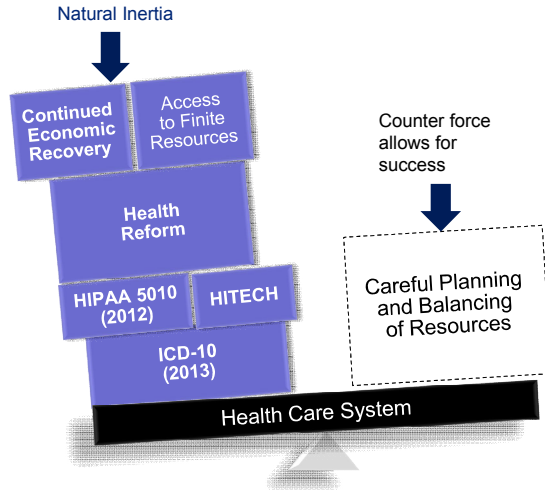
- Meaningful Use Overview
- Timeline for Meeting Meaningful Use
- Medicare and Medicaid Incentives
- Meaningful Use Roadmap
- Thoughts for Providers to Keep in Mind
- Questions

Objectives

- Gain a high-level understanding of Meaningful Use
- Gain a high-level understanding of the Meaningful Use Timeline
- Gain a high-level understanding of the eligibility for Meaningful Use participation and Incentive and Penalty Payments

Meaningful Use Overview

Meaningful Use Sits Among a Myriad of Critical Issues That Must be Absorbed by the Health Care System Over the Next Five years



The ability to manage the volume of change will be dependent upon the balance between available resources and the organization's project portfolio

Meaningful Use Overview: Staged Approach

<p>Stage 1</p>	<p>Focuses on electronically capturing health information in a coded format; using that information to track key clinical conditions and communicating that information for care coordination purposes, implementing clinical decision support tools to facilitate disease and medication management; and reporting clinical quality measures and public health information.</p>
<p>Stage 2 (Criteria to be proposed by end of 2011) - Expands upon Stage 1</p>	<p>Encourage the use of health IT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders entered using computerized provider order entry (CPOE) and the electronic transmission of diagnostic test results. Of particular note, CMS may additionally consider applying the criteria more broadly to both the inpatient and outpatient hospital settings in Stage 2.</p>
<p>Stage 3 (Criteria to be proposed by end of 2013): Expands upon Stage 2</p>	<p>Focus on promoting improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data and improving population health.</p>

Nothing limits further changes to Meaningful Use beyond Stage 3.

Meaningful Use Overview: Stage 1 Priorities

- The goal is to use EHR captured and generated measures to monitor key policy outcomes. Ultimate vision is to enable significant and measurable improvements in population health through a transformed health care delivery system.
- Framework for meaningful use in healthcare is derived from the National Priorities Partnership convened by the National Quality Forum (NQF) in 2008.
 - NQF produced a report entitled "National Priorities and Goals" which identified a set of national priorities to help focus performance improvement efforts.

- Key health outcome goals*:
 - Improving quality, safety, efficiency, and reducing 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 Overview: Eligibility for Medicare & Medicaid Incentives

Eligible Hospitals (EH) — Can receive both incentives simultaneously	
Medicare Incentives	<ul style="list-style-type: none"> • Subsection (d) hospitals — which excludes hospitals and hospital units excluded from Inpatient Prospective Payment System (IPPS) such as psychiatric, rehabilitation, long term care, children's and cancer. • Incentives will be provided to hospitals as they are distinguished by provider number in Hospital Cost Reports (which is the CMS Certification Number (CCN) of the main provider). • Critical Access Hospitals (CAH) will receive incentives based on reasonable cost incurred for purchase of certified EHR technology.
Medicaid Incentives	<p>Only acute care hospitals and children's hospitals are eligible for Medicaid incentives</p> <p>Acute care hospital definition</p> <ul style="list-style-type: none"> • Hospitals with an average patient length of stay of 25 days or fewer, and with a CCN that falls in the range 0001–0879 or 1300–1399 (includes general short-term hospitals, 11 cancer hospitals, and critical access hospitals that meet the Medicaid patient volume criteria). • Acute Care for Medicaid eligibility — must have 10% Medicaid volume — hospitals total number of Medicaid patient encounters in any representative continuous 90 day period in preceding calendar year. <p>Children's hospital definition</p> <ul style="list-style-type: none"> • Certified as a children's hospital, with a CCN in the 3300-3399 series and predominantly treats individuals under the age of 21.

Meaningful Use Overview: Eligibility for Medicare & Medicaid Incentives

Eligible Professional (EP) — can only receive Medicare or Medicaid incentives in any given year	
Medicare Incentives	<ul style="list-style-type: none"> • Doctor of Medicine or Osteopathy • Doctor of Dental Surgery or Dental Medicine • Doctor of Podiatric Medicine • Doctor of Optometry • Doctor of Chiropractor
Medicaid Incentives	<ul style="list-style-type: none"> • Physicians • Dentists • Certified Nurse Midwives • Nurse Practitioners • Physician Assistants (PA) in a Federally Qualified Health Center (FQHC) or Rural Health Clinics (RHC) that is led by a PA <p>* Medicaid has one exception to hospital based exclusion for Medicaid Eligible EPs that > 50% of patient encounters over 6 month period occurs at FQHC or RHC</p> <p>Medicaid eligibility: EPs must have a minimum of 30% patient encounters attributable to Medicaid over any continuous 90-day period within most recent calendar year prior to reporting</p> <p>Pediatricians must have 20% Medicaid (to receive 2/3 payment). If they have 30% — they are eligible for full incentive payment</p> <p>EPs that practice in FQHC or RHC must have 30% of “needy” patients – Needy is defined as: Medicaid or Children’s Health Insurance Program (CHIP), provided uncompensated care, or furnish care at no cost or reduced cost based on patient’s ability to pay</p> <p>The Medicaid volume for group practices/clinics can serve as a proxy for individual EP Patient Medicaid Volume. Therefore, a practice does not need to track for individual EPs.</p>

Note: Special rules apply for Qualifying Medicare Advantage (MA) Organization for their affiliated Eligible Professionals and Eligible Hospitals — which allow them to be eligible for Medicare incentives. For more information please see page 463 of the final rule.



Meaningful Use Overview: Eligibility for Medicare & Medicaid Incentives

Final Rules Related to Hospital-based Professionals

- Hospital-based Professionals are excluded from incentive programs — defined as professionals that provide “substantially all” of Medicare or Medicaid covered professional services in a hospital setting, whether inpatient or emergency room
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- CMS is proposing “substantially all” to mean 90% — so Professionals who have less than 90% would be eligible for Medicare or Medicaid incentives
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- CMS will use place of service code (POS) on physician claims to determine whether an EP furnishes “substantially all” of professional services in hospital setting. There are two POS codes which would be considered a hospital setting:
 - 21 – Inpatient Hospital
 - 23 – Emergency Room, Hospital
 - The Hospital-based status of a professional would get reassessed each year based on the claims data from the year immediately preceding the payment year



Meaningful Use Timeline for Meeting Meaningful Use

Timeline for Meeting Meaningful Use: Overview

The final CMS rules have a more relaxed timeline for achieving Stage 3 of Meaningful Use; in fact it is to be decided. Further, CMS is also prolonging the timeframe required to transition from Stage 1 to Stage 2.

- The HITECH Act uses the term “reporting period” for the time period that an Eligible Professional (EP) or Eligible Hospital (EH) must “meaningfully use” certified EHR Technology in order to receive EHR incentives.
- For the **1st incentive payment year only** (regardless if that year is 2011, 2012, 2013, etc.) - there is a 90 day continuous reporting period anywhere within that payment year that Meaningful Use has to be demonstrated.
- For subsequent payment years – Meaningful Use has to be demonstrated for the entire payment year, except for Medicaid where the reporting period for the second payment years is 90 days.

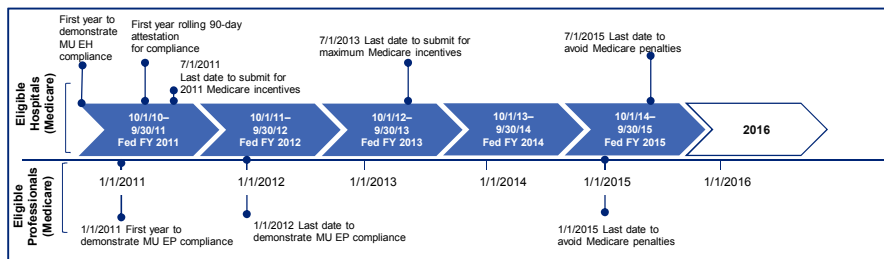
TABLE 1: Stage of Meaningful Use Criteria by Payment Year

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD

Example – Hospital Meets MU in 2012

Timeline for Meeting Meaningful Use: Medicare

Key Medicare Eligible Hospital and Eligible Professional Dates			
Eligible Hospital		Eligible Professionals	
First date that you can begin to demonstrate Meaningful Use (MU) Day #1 of 90	October 1, 2010	First date to demonstrate Meaningful Use (MU)	January 1, 2011
90-day rolling period to attest to compliance	Rolling 90-day attestation period (Fed FY 2010)	Last date to commence MU compliance for Medicare incentives for 2011	October 1, 2011
Subsequent years attestation	Must be able to attest throughout subsequent Federal fiscal years (FFY)	Last date to commence MU compliance for maximum Medicare incentives	October 1, 2012
Last date to commence MU compliance for Medicare incentives for 2011	July 1, 2011	Last date to commence MU to avoid Medicare penalties	October 1, 2015
Last date to commence MU compliance for maximum Medicare incentives	July 1, 2013		
Last date to commence MU compliance to avoid Medicare penalties	July 1, 2015		

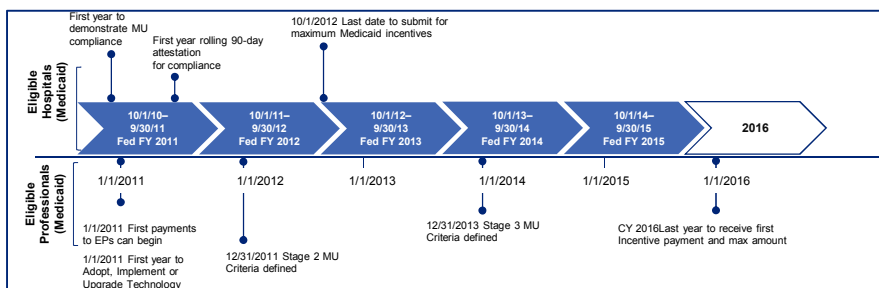


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Timeline for Meeting Meaningful Use: Medicaid

Key Medicaid Eligible Hospital and Eligible Professional Dates			
Eligible Hospital		Eligible Professionals	
First date that you can begin to demonstrate Meaningful Use (MU) ay #1 of 90	October 1, 2010	First year to adopt, implement or upgrade EMR technology	January 1, 2011
90-day rolling period to attest to compliance	Rolling 90-day attestation period (Fed FY 2010)	First date payments to EP can begin	January 1, 2011
Subsequent years attestation	Must be able to attest throughout subsequent Federal fiscal years	Last year to receive first incentive payment and maximum amount	CY 2016
Last date to commence MU compliance for maximum Medicaid incentives	October 1, 2012	Last year to receive an incentive payment	CY 2021



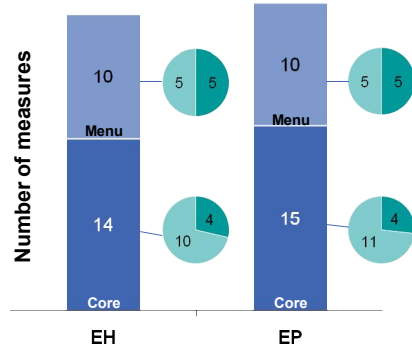
EH compliance is based on Federal fiscal year. EP compliance is based on a calendar year.

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Timeline for Meeting Meaningful Use: Stage 1 Measurement Criteria

Final Meaningful Use rules have been relaxed and allow flexibility rather than define Meaningful Use objectives and measures as strictly “all-or-nothing.” In this manner, the final rules distinguish between a “core set” that must be met and a flexible “menu set” of additional criteria which present choice in implementation.



*See detailed measures chart for exclusions

- Eligible Professionals (EP) have 15 core measures and Eligible Hospitals (EH) have 14.
- The EH and EP can rule out 5 of the 10 menu set measures and are not required to report on those measures not applicable to them.
- EHs and EPs must choose at least one of the population and public health measures to demonstrate as part of the menu set.
- 15 measures contain exclusion criteria for EP, EH, or both*.
- States can impose further criteria to EH and EP only eligible for Medicaid
- Measures must be attested to with either a yes or no response or a discrete data reporting requirement.

Timeline for Meeting Meaningful Use: Stage 1 Measurement Criteria

The criteria below defines both the “core set” and “menu set” of meaningful use objectives outlined in the Final Rules issued by CMS.

“Core set” of meaningful use objectives

- Use CPOE
- Implement drug-drug and drug-allergy interaction checks
- Generate and transmit prescriptions electronically
- Record patient demographics
- Maintain up-to-date problem list
- Maintain active medication list
- Maintain active medication allergy list
- Report vital signs and chart changes
- Record smoking status
- Implement one clinical decision support rule
- Report clinical quality measures to CMS or States
- Electronically exchange key clinical information among providers and authorized entities
- Provide patients with electronic copy of their health information
- Provide patients with clinical summaries and discharge summaries
- Protect electronic health information created or maintained by certified EHR

Must meet all objectives

“Menu set” of meaningful use objectives

- Implement drug-formulary checks
- Incorporate clinical laboratory test results into EHRs
- Generate lists of patients by specific conditions
- Use EHR to identify patient-specific education resources
- Perform medication reconciliation between care settings
- Provide summary of care record for patients referred/transitioned to another provider
- Submit electronic immunization data to registries or information systems
- Submit electronic syndromic surveillance data to public health agencies
- Additional choices EHs (record advance directives for 65 y/o above; electronic data on lab results to public health agencies)
- Additional choices for EPs (reminders to patients for preventive and follow-up care; provide patients with timely electronic access to their health information)

Can opt out of “5” for Stage 1
(ALL of these become Core Set in Stage 2)

Timeline for Meeting Meaningful Use: Attestation

The Department of Health and Human Services (HHS) defines attestation as submitting information through a secure mechanism in a manner specified by the Center for Medicare Services (CMS) for Medicare and in a manner specified by the State for Medicaid. **The regulation indicates that further instructions on the specifics for submitting attestation will be issued in the future.**

Key takeaways for Eligible Hospitals and Eligible Providers

- CMS will determine how Eligible Hospitals (EHs) and Medicare Eligible Providers (EPs) will transmit information for purposes of attestation
- States will determine how Medicaid EHs and Medicaid EPs will transmit information for purposes of attestation
- For 2011, CMS will accept attestations for demonstration of all the meaningful use measures

Key takeaways for Eligible Hospitals

- Eligible hospitals will submit eligibility by provider ID number
- Eligible hospitals can report up to 60 days post federal fiscal year (FFY), which is November 30th
- Eligible hospitals **could attest with a yes/no response to 9 of the 24 measures**. Other reported measures come from discrete data that is contained within the HER

Key takeaways for Eligible Professionals

- Eligible professionals will submit eligibility by Tax Identification Number (TIN) or Social Security Number (SSN)
- Eligible professionals can report up to 60 days post calendar year (CY), which is February 28th
- Eligible professionals could **attest with a yes/no response to 8 of the 25 measures**. Other reported measures come from discrete data that is contained within the EHR

Eligible Hospitals and Eligible Professionals will need to retain attestation records for 6 years

Medicare and Medicaid Incentives

Medicare and Medicaid Incentives: Medicare Eligible Hospitals

The Medicare Hospital incentive will be **paid to Subsection (d) hospitals**. This includes acute care hospitals with an ALOS of greater than or equal to 25 days + CCN (0001-0879; 1300-1399). **It also includes cancer hospitals, critical access hospitals (CAHs) and general short term stay hospitals and children's hospitals (CCN 3300-3399) that are not attached to a larger hospital..**

"Transition Factors" for Hospital Medicare Incentives
(payments decrease in a sliding scale manner)

Fund Year	Adoption Year					
	2011	2012	2013	2014	2015	2016
2011	1	0	0	0	0	0
2012	0.75	1	0	0	0	0
2013	0.5	0.75	1	0	0	0
2014	0.25	0.5	0.75	0.75	0	0
2015	0	0.25	0.5	0.5	0.5	0
2016	0	0	0.25	0.25	0.25	0

- Incentive payments for hospitals FY2011 – FY2016.
- Incentive calculations are the same for FY2011 – FY 2013, however adoption after FY2014 results in lower Medicare aggregate incentive payments.
- **Eligible hospitals receiving incentive payments will use their CMS Certification Number or CCN.**
- A transition factor reduction decreases incentive payment each year of compliance.

Medicare and Medicaid Incentives: Medicare Eligible Hospitals

- Significant penalties exist for NOT demonstrating Meaningful Use by FY2015 - The reporting period (exact date when penalties start) will be defined in future CMS rules.
- **Penalty in the form of an adjustment to the market basket update to the IPPS payment rate for Eligible Hospitals. The adjustment is 25% for FY15; 50% for FY16; and, 75% for FY17 and thereafter.** The DHHS Secretary may choose to sustain the FY17 penalties or increase the penalties in subsequent years.
- In addition, the rules point out that hospitals would remain subject to separate reduction for failure to report quality data under Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU). Hospitals that do not participate in the RHQDAPU initiative will receive a reduction of 2% in their Medicare annual payment update for fiscal year 2011.

Hospital Penalty Factors

Penalty Year	Penalty Factor
2015	0.25
2016	0.50
2017	0.75
2018	0.75
2019	0.75
2020	0.75

Medicare and Medicaid Incentives: Medicaid Eligible Hospitals

Medicaid Incentives

- Medicaid payment incentives align with the Medicare Eligible Hospital (EH) program – using same measurements.
- **Requires states to verify the eligibility of and disburse payments to Medicaid eligible providers.**
- Specifies that states must have a system capable of interfacing with the National Level Repository to verify provider eligibility and identity, and collect data necessary to incentive program administration and coordination.

Medicaid Penalties

- There are NO Medicaid penalties – However, EHs that qualify for both Medicaid and Medicare incentives still would be subject to Medicare penalties if meaningful use is not achieved.

“Transition Factors” for Hospital Medicaid Incentives

Fund Year	Adoption Year					
	2011	2012	2013	2014	2015	2016
2011	0.5	0	0	0	0	0
2012	0.4	0.5	0	0	0	0
2013	0.1	0.4	0.5	0	0	0
2014	0	0.1	0.4	0.5	0	0
2015	0	0	0.1	0.4	0.5	0
2016	0	0	0	0.1	0.4	0.5
2017	0	0	0	0	0.1	0.4
2018	0	0	0	0	0	0.1
2019	0	0	0	0	0	0

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Medicare and Medicaid Incentives: Medicaid Eligible Professionals

Eligible Professionals (EP) who qualify for both the Medicare and Medicaid incentive payments must elect to receive payments from one program or the other in any given payment year

Medicare

Incentives

- Eligible Professionals (**physicians, dentists, podiatrists, optometrists, chiropractors**) may receive the maximum limit of potential incentives, depicted by the following table, depending upon the initial year of EHR adoption and if their Medicare claims exceed the yearly incentive maximum by 33.4%.
- **Physicians furnishing more than 90% of the EPs services in an inpatient or ER setting are excluded** as they would be expected to use the hospital EHR.

Penalties

- Physicians who fail to adopt EHRs will see their **Medicare reimbursement reduced to 99% in 2015, 98% in 2016, and 97% in 2017 and thereafter.**

Maximum Limit of Potential Incentives for EPs - Medicare

Funding Year	Adoption Year				
	2011	2012	2013	2014	2015 +
2011	\$ 18,000				
2012	\$ 12,000	\$ 18,000			
2013	\$ 8,000	\$ 12,000	\$ 15,000		
2014	\$ 4,000	\$ 8,000	\$ 12,000	\$ 12,000	
2015	\$ 2,000	\$ 4,000	\$ 8,000	\$ 8,000	
2016		\$ 2,000	\$ 4,000	\$ 4,000	
Total	\$ 44,000	\$ 44,000	\$ 39,000	\$ 24,000	

Medicaid

- An Eligible Professional provider include **physicians, dentists, nurse practitioners, midwives, and physician assistants practicing predominantly in Federally Qualified Health Centers (FQHC) or Rural Health Clinics (RHC).**
- Eligible Professionals include providers with at least 30% of volume or pediatricians with at least 20% of patient volume on medical assistance (pediatricians receive 2/3 of incentives if volume is between 20–30%).
- The maximum incentive an EP can receive is **\$63,750.**
- If an EP has selected Medicaid, there are no penalties. However, if an EP switches programs to Medicare, they would be subject to penalties. **EPs are allowed to switch programs one time before 2015.**

Maximum Limit of Potential Incentives for EPs - Medicaid

Funding Year	Adoption Year		
	2011	2012	2013 - 2016
2011	\$ 21,250		
2012	\$ 8,500	\$ 21,250	
2013	\$ 8,500	\$ 8,500	
2014	\$ 8,500	\$ 8,500	
2015	\$ 8,500	\$ 8,500	
2016	\$ 8,500	\$ 8,500	
2017		\$ 8,500	
Total	\$ 63,750	\$ 63,750	\$ 63,750

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Medicare and Medicaid Incentives: Incentive Payment Example

	2011	2012	2013
Medicare FFS and MA EHR incentive programs	MU achieved ✓	MU not achieved ✗	MU achieved ✓

- Must be consecutive years
- CY 2012 still counts as one of the EPs five payment years and they would only be able to receive an incentive under the Medicare EHR incentive program for three more years as CY 2013 would be their third payment year.

Medicaid EHR incentive programs	MU achieved ✓	MU achieved ✓	MU not achieved ✗
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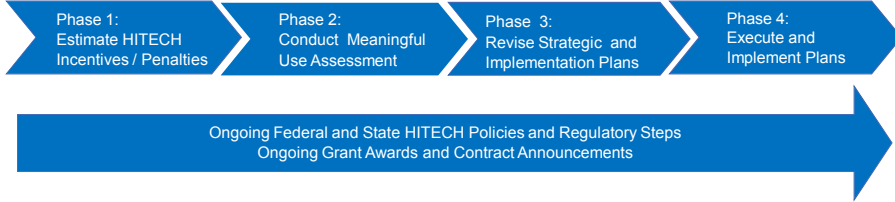
- May be non-consecutive years, meaning if an EP or EH does not receive an incentive payment for a given CY or FFY then that year would not constitute a payment year.
- In this example, they would still be eligible to receive incentives for an additional four payment years.

- For Eligible Hospitals, starting with FY 2017 payments must be consecutive. After 2016, no Medicaid incentive payment may be made to an EH unless the provider has been provided payment for the previous year. Starting in FY 2016, incentive payments must be made every year in order to continue participation in the program. In no case may any Medicaid EP or EH receive an incentive after 2021.
- If an EP, EH, or CAH attains meaningful use in year 1, but does not achieve it the subsequent year, the "skipped" year counts towards the maximum program years permissible.

Meaningful Use Roadmap

Meaningful Use Roadmap?

Sufficient knowledge of "Meaningful Use" of EHRs is available to begin developing and implementing plans with the expectation that mid-course corrections may be required.



Fitting the Regulatory Pieces Together



Thoughts for Providers to Keep in Mind

Thoughts for Providers to Keep in Mind

Timeline

- The timing of meeting stages 1, 2 and 3 requirements has been delayed. (The rules today cover stage 1. The subsequent regulations will be published by the end of 2011 for Stage 2 and end of 2013 for Stage 3.) Specifically, CMS has delayed requirements for Stage 3—still to be decided. CMS is also prolonging the time frame required to go from Stage 1 to Stage 2.

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD

Eligibility

- Eligibility criteria differ between the Medicare and Medicaid EHR incentive programs.** Also, Eligible Professionals can only be eligible for either Medicare or Medicaid Incentives in any given year (they are allowed to switch one time only prior to 2015) while Eligible Hospitals can receive both Medicare and Medicaid incentives simultaneously.
 - Critical access hospitals are now eligible for Medicaid incentives.**
- Hospital Based Professionals that furnish “substantially all” (90%) of their professional services in a hospital setting are not eligible for incentives. Professionals who have less than 90% would be eligible for Medicare or Medicaid incentives. Physicians in ambulatory facilities owned by the hospital are eligible for receiving incentive payments.

Medicare Incentives/Penalties

- All Medicare providers will have payment reduction in 2015 if they are not demonstrating MU regardless of whether they participated in the Medicare/Medicaid incentive programs.**
- Medicare Eligible Hospitals (EH) and Eligible Professionals (EP) must attest to achieving Meaningful Use on a yearly basis in order to be eligible for incentive payments for each compliant year. Eligible Professionals and Hospitals from a Medicare incentive perspective who achieve Meaningful Use compliance in year 1, fail in year 2, but achieve in year 3, will lose the incentive for that failed year. Incentive payment cannot be recouped in subsequent years.

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Thoughts for Providers to Keep in Mind

Medicaid Incentives

- Professionals and Hospitals eligible for the Medicaid Incentive Program can begin incentive payments as late as 2016. There are no decreases in payments for delaying the start date (i.e. there is no aggregate decrease in payments like the Medicare Incentive Program.) Further, achieving Meaningful Use does not require demonstration in consecutive years as in Medicare Incentive Program.
- Medicaid EPs and Hospitals do not need to achieve Meaningful Use in the first payment year – they only need to demonstrate that they are adopting, implementing, or upgrading “certified” EHR technology. Purchase of EHR is within definition of adopting, implementing, and upgrading.**

Meaningful Use Criteria

- The Meaningful Use measures are separated into two main criteria: Core and Menu Set Measures
 - The core set of measures is required;
 - For the menu set of measures, all but 5 are required
 - Overall, Meaningful Use objectives have decreased. However, the number of measures within the objectives increased from 23 to 24 for EH. An EH must achieve 14 core measures and can rule out 5 of the 10 menu set measures.
 - Eligible Professional objectives decreased from 25 to 20. However, the number of core measures remains the same. EPs must achieve 15 core measures and can rule out 5 of the 10 menu set measures.
- EH and EPs will need to demonstrate Meaningful Use for a 90 continuous day “reporting period” for the 1st payment year of incentives.** The 90 day continuous “reporting period” can be anywhere within that payment year for that the EP or EH. Subsequent payment years (after the 1st payment year) require demonstrating Meaningful Use throughout the entire payment year, except for Medicaid where the reporting period for the second payment year is 90 days. There is no reporting period for adopting, upgrading, and implementing EHR.

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Thoughts for Providers to Keep in Mind

Emergency Department

- **Emergency Departments (ED) are now included** in seven of the Meaningful Use core measures. Examples of the core measures with ED include: CPOE, allergy list.

Computerized Provider Order Entry (CPOE)

- CPOE scope was reduced from all orders to include only medication orders. However, the percentage increased for EP's from 10% to 30% and decreased for EH from 80% to 30% of unique patients with at least one medication in their history.
 - The rule specifies that in Stage 2 (2012), CMS will expect a CPOE medication order percentage threshold of 60%.
 - Excluded from the total for medication order calculations is laboratory, pharmacy, or diagnostic imaging originating orders.
 - CPOE measure does not require direct ordering physician, but can be licensed healthcare professional including specifically MD, DO, RN, PA, and NPs.

e-Prescribing

- E-prescribing measures were reduced from 75% to 40% of permissible prescriptions. CMS recognized that some pharmacies may not be able to accept an electronic prescription. Furthermore, patients may prefer a paper prescription over an electronic copy.

Problem Lists

- **The requirement to use standard ICD coding or Snomed for problem lists was removed.** This allows behavioral entities, for example, to use non-standard nomenclature for care management activities.

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Thoughts for Providers to Keep in Mind

Quality Measures

- EH or Critical Access Hospital quality measures were significantly reduced from 41 quality measures to 15 for the reporting period of 2011 and 2012. The 15 measures represent those that can be electronically captured using a certified EHR. However, while quality reporting is relaxed for Stage 1, it will become more prominent in Stages 2 and 3.
- EPs will be required to report on three core quality metrics and three alternative measures that are no longer specialty specific. If the EP is unable to report on any of the three alternative metrics, then the professional must select another metric from the original set of metrics in the proposed rule. The EP is not expected to report against measures of populations they do not serve.
- Reporting by attestation is required for quality measures in 2011; electronic reporting is required in 2012.

Physician Reassignment

- **Reassignment of Incentive Payment from EP to employer is not required. Hospitals may need to renegotiate contracts with providers if the hospital expects to receive the incentive payments.**

Attestation

- States must comply with the Federal requirements. An Eligible Hospital or Eligible Professional participating in Medicaid incentives must attest in writing that the entity is compliant to receive Federal funds. Fraudulent attestation could result in prosecution under Federal and State laws.
- CMS certification numbers (as they are distinguished by provider number in hospital cost reports) will still determine incentive payments to hospitals. Payments to eligible hospitals will be made to each provider of record.
- NPI and Tax Identification Number will still determine incentive payments to eligible professionals.

Privacy and Security

- Modifications to HIPAA Privacy and Security rules under HITECH includes extending applicability to Business Associates, patient access to electronic medical records, updated definitions regarding use and disclosures of protected health information, marketing and fundraising, and further clarity on enforcement and penalties for non-compliance.
- Security breach notification process and response is an active requirement for EPs and EHs.

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Questions

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