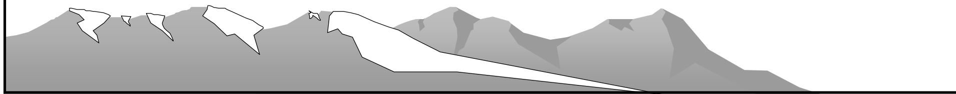
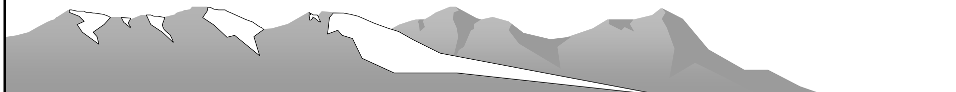
Meaningful Use

October 15, 2010



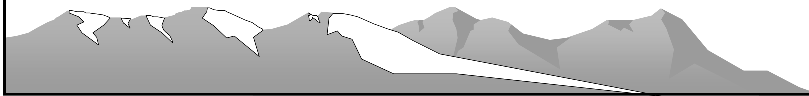
Goals/Objectives

- Meaningful Use Overview
- Timelines
- Incentives/penalties
- Potential barriers & challenges
- Scott & White journey



What is Meaningful Use?

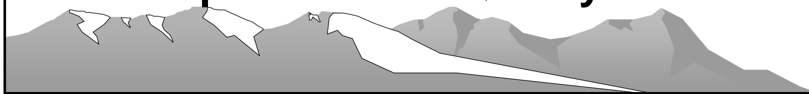
- Set of required objectives with specific timelines which are part of ARRA stimulus package
- Applies to hospitals and individual providers (EPs)
- Divided into Stages 1, 2, & 3



Meaningful Use Requirements

Central Components

- **1. Adopt Certified EHR Technology-renewal every two years**
- **2. Use EHRs in Care Delivery in meaningful way per CMS definitions**
- **3. Report Clinical Quality Measures**



Timeline for MU Reporting

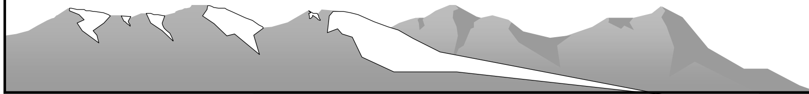
- Hospital payment years coincide with the Federal FY; hospitals are eligible for up to four years of payments
- FY 11 is first potential payment year; EPs are on a calendar year.
- The first year of reporting starts the clock; each subsequent counts even if no reporting occurs the next year (different for Medicaid)
- Stage 2 requirements are added for 2013 incentives
- If MU is not in place by 2015, penalties begin

Eligible Professionals-definition

- Hospital-based EPs who furnish substantially all their services in a “hospital setting” are not eligible for incentive payments.
- The Continuing Extension Act of 2010 modified the definition of a hospital-based EP.
- Hospital-based EPs are now defined as EPs who furnish 90 percent or more of their allowed services in a hospital inpatient setting, or hospital emergency department

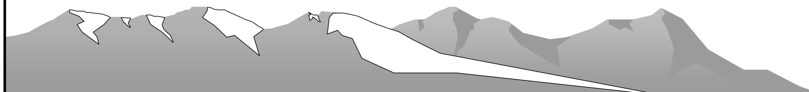
Eligible Professionals-definition

- Medicare EP includes physician as defined in SSA Act (MD, DO, DDS, podiatry, optometry, or chiropractor)
- Medicaid EP definition includes certified nurse-midwife, nurse practitioner,
- and PA if in FQHC or RHC
- EPs are enrolled by TIN's; elect to participate
- CMS does not include PA, NP, psychologists



Eligible Hospitals

- An eligible hospital for Medicare incentive payments is a "subsection (d) hospital" that is paid under the hospital inpatient prospective payment system (IPPS).
- Eligible hospitals may qualify from both the Medicare and Medicaid EHR Incentive Programs. Children's hospitals qualify for Medicaid.
- A qualifying hospital is an eligible hospital that successfully demonstrates meaningful use for the EHR reporting period during a payment year.
- A Payment Year is a Federal Fiscal Year (FFY).



Incentives for Hospitals

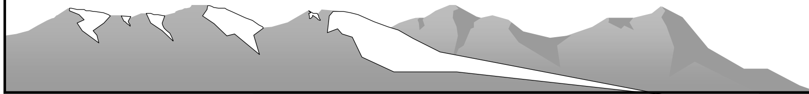
- Year 1, the EHR Reporting Period equals any 90 continuous days beginning and ending within the year. Thereafter, reporting period is the entire year.
- The incentive for each eligible hospital hospital based on
  – 1. initial amount which is the sum of a $2 million base amount and the product of a per discharge amount (of $200) and the number of discharges (for discharges between 1150 and 23,000)
  – 2. the Medicare share which has as its numerator Medicare FFS and managed care acute-care inpatient bed-days and as denominator the product of total acute care inpatient days and % of hospital's total charges not attributed to charity care; and
  – 3. a transition factor which phases down the incentive payments over the four year period.
- POS Code 21 defines inpatient, POS 23 for the ED
- Payments are calculated based upon CMS cert #'s

Incentives for Providers

- EPs (ambulatory providers)
  – CMS Maximum $44K total over 5 years, ($18K year 1)
  – Medicaid max $63,750 ($21,250 yr 1)
  – Qualify for Medicaid if >30% payor mix (20% for pediatrics)
  – EP can choose Medicare or Medicaid program- not both, but may make one-time switch
  – An EP who predominantly furnishes services in a geographic Health Professional Shortage Area (HPSA) is eligible for a 10% increase in the maximum incentive payment.

Penalties

- Invoked for not achieving MU by 2015
- Hospitals
  - Hospital market basket decreases: 25%, 50%, 75% per year after 2015 if MU not met
  - Additionally, 25% of market basket is tied to reporting against all CMS quality metrics
- Providers
  - 1% per year penalty assessed for pro fee CMS payments



Stage I Objectives for Hospitals

Core Measure Set- MUST DO ALL 14

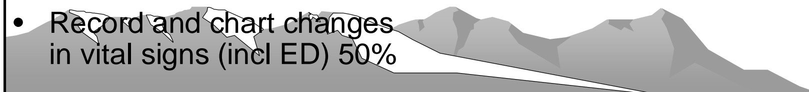
- Achieve CPOE utilization for medication orders (30%)
- Implement drug-drug, drug-allergy checks
- Record demographics
- Maintain active problem list using ICD-9 or SNOMED
- Maintain active medication and allergy lists (incl ED) 80%
- Record and chart changes in vital signs (incl ED) 50%

•Record smoking status
•Implement one clinical decision support rule

•Report quality measures to CMS
•Providepatients with electronic copy of health information within3 business days

•Provide electronic discharge instructions upon request (incl ED) 50%

•HIE test
•Security risk analysis



Stage I Objectives for Hospitals

Menu Objectives- must do AT LEAST 5 (incl 2 with *)

- **Implement drug-formulary checks**
- **Record advance directive status**

- **Incorporate lab results into EHR as structured data**
- **Generate patient lists by condition**

- **Use certified EHR to identify and provide patient-specific education**
- **Provide summary of care record at transitions in care**
- **Perform medication reconciliation at relevant transitions**

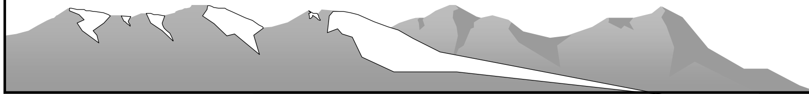
- **Test ability to electronically submit immunization data ***
- **Test ability to electronically submit syndrome surveillance data and reportable results ***

EPs must do slightly different Core set: (underline indicates EP specific)

- use CPOE for med orders
- drug/drug, drug/allergy interaction checks
- Formularies, **eRx,** demographics, structured problem list
- **Send appt reminders (20% select pop)**
- Active med and allergy list, entry of Vitals, smoking status
- Implement one clinical decision support rule
- Report Quality measures as specified by CMS
- Provide patients electronic copy of records within 4 days (10%)
- **clinical summary for each visit (electronic)**
- Electronically exchange key clinical info

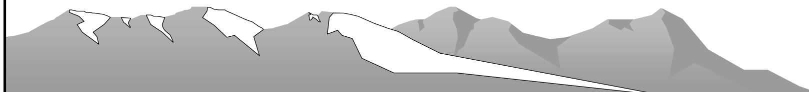
Hospital Reporting Clinical Quality Measures

- Must report on 15 clinical quality measures in these three categories:
  - Venous thromboembolism
  - Emergency Department
  - Stroke
- attestation allowed in first year of reporting- from certified EHR, (need numerator and denominator from EHR even for attestation).
- reporting electronically from EHR in subsequent years



CQM for EPs-3 Core Measures
(must do 3 core plus 3 others)

- NQF 0013 Blood Pressure Measurement
- NQF 0028 Tobacco Use Assessment and Cessation Intervention
- NQF 0421 Adult Weight Screening and Follow-up



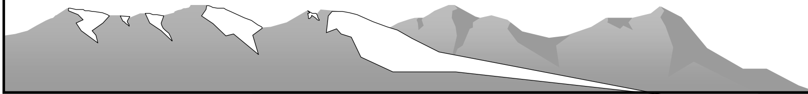
What MU means to S&W HC

2012 first year adoption assumed

- Incentives for Eligible EP's- estimated 610; 90 M'caid eligible:

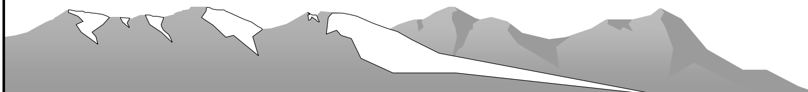
  Year 1: **$12,892,500** 5 yr total: **$32,577,500**
- Hospitals (5) (Memorial, Hillcrest, Llano, Round Rock, Brenham) approx $25 M 5 year total
- Total 5 yr. Approx $58 M

  IF we are able to achieve all stages of MU for ALL hospitals and providers in estimate



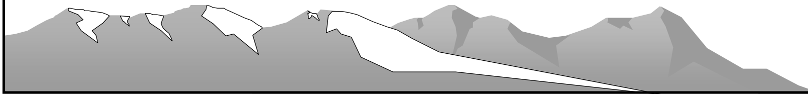
Meaningful Use for Scott & White Healthcare System

- Certification of existing EHR systems:
  - Awaiting certification of 7 vendor systems
  - With certification, each system expected to have components necessary to achieve MU
- Our home grown EMR will not be certified and cannot be used for reporting of MU data; (becomes historical data repository only)
- Need to establish health information exchange
- Upgrades required for 2 of enterprise systems



SW MU Achievement Status Overview

- Implement CPOE in hospitals
- Complete goal to implement ambulatory EHR in all clinics in FY 2011 (presently 325 full time providers enrolled, approx 40% completed0
- Implement other necessary components to meet documentation of MU quality for all specialties, providers and hospitals
- Establish data analytics and reporting
- Perform HITECH security audit



Challenges and Barriers to MU Success

- Engagement
- Process Change
- Technology
- Resources
  - $$$$
  - Skilled staff
  - Administrative support