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CMS releases final rule on meaningful use and HIT incentive payments

The final rule on meaningful use and EHR incentive program which CMS released on July 13, 2010 made several key changes to the proposed rule for hospitals and eligible professionals (EPs) to qualify for HIT incentive payments in 2011 and 2012 , including

- Reducing the requirement from having to meet all standards to having to meet a smaller "core" set and several standards from a "menu" set,
- Re-defining hospital-based EPs to allow more EPs to qualify for their own incentives,
- Adding critical access hospitals to the Medicaid HIT incentive program as IPPS hospitals, and
- Allowing Medicaid incentive programs to start in 2011.

Registration for the incentive program will open in **January 2011**. Stage one requires hospitals and EPs to demonstrate 90 days of meaningful use; so attestations can begin in April 2011**.** Initial incentive payments are expected to be made starting in the middle of May 2011.

In order to register and qualify for the EHR meaningful use program, providers will need a national provider number and be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS). Most providers are also expected to have an active user account in the National Plan and Provider Enumeration System (NPPES).

CMS has granted a bit of flexibility when it comes to using a certified EHR system: the system must be certified at the time the attestation is made. Some or all of the 90-day demonstration period could occur before the system receives certification, according to a CMS official at the July 28 meeting of the Health IT Standards Committee.

The outstanding issue with multi-campus hospitals under a single provider number was not addressed. Under the law, the discharge-related amount of incentive payments is capped at 23,000 discharges: discharges above that number do not increase the amount of the bonus a hospital can earn. CMS will apply the discharge-related limit to the **entire** multi-campus provider rather than allowing each hospital to reach that amount. House Ways and Means Committee, Health subcommittee chairman Pete Stark (D-CA) said he intends to “study future steps to address this issue” and has scheduled a July 30th hearing on the EHR requirements.

"Core" and "Menu" Standards

In order to qualify as a meaningful EHR user under the final rule, an EP, eligible hospital, or CAH must successfully meet each objective in the core set and all but 5 of the objectives in the menu set. With one limitation, they may select any 5 objectives from the menu set to be removed from consideration for the determination of qualifying as a meaningful EHR user.

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

In addition to the core objectives, hospitals must meet five of the menu set objectives. Choices among the menu set must include at least one of the public health objectives. The menu set objectives for hospitals are

- 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
- Public health objectives
    - 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

In addition to developing "core" and "menu" sets, the agency also changed several objectives and measures, including:

- No measures require manual chart review to calculate threshold (50%, 40% etc.)
- "Generate and transmit permissible prescriptions electronically": Modified from 75% to 40% are transmitted electronically using certified EHR technology
- "Record vital signs and chart changes (height, weight, blood pressure, BMI, growth charts for children": Modified from 80% to 50% of patients 2 years of age or older have height, weight, and blood pressure as recorded data
- "Record smoking status for patients 13 years or older": Modified from 80% to 50% of patients 13 years of age or older have smoking status recorded as structured data
- Both "provide patients with an electronic copy of their health information" and "provide a patient with and electronic copy of their discharge instructions: Modified from an 80% to 50% threshold
- Administrative simplification has been postponed to stage 2
- EPs and hospitals will be required to implement one instead of 5 clinical decision support rules.
- CMS dropped the demographic "insurance type" from the list to be recorded for both the EP, eligible hospitals, and CAHs objective
- EPs and hospitals must provide access to patient specific education resources upon request

Many are pleased with CMS's decision to limit CPOE to medication orders and to include the use of CPOE's in the emergency department. The CPOE measure will be calculated by the number of patients with at least one medication order entered using CPOE out of the number of patients with at least one medication in their medication list by the EP or admitted to an eligible hospital/CAH's inpatient OR emergency department. However, concern has been raised over the decision to include emergency departments in all hospital quality measures. While it was expected and recommended for measures such as CPOE, many were surprised to see ED's included in the measures for problem lists, medication lists, and drug allergies as these were not requested.

The proposed rule did not include the recording of advanced directives or a provision for providing patients with educational materials; with the final rule including these as discretionary meaningful use requirements.

EPs will be required to attest to the clinical measures, but only need to submit the information that is automatically calculated by their certified EHR technology. This method of attestation has been implemented to relieve some of the administrative burden to both providers and CMS in these early stages of meaningful use adoption.

Hospital-based EPs Defined

Hospital-based EP will be defined as such if 90% of their services are provided for in the inpatient hospital or emergency room setting. CMS also granted flexibility to EPs who wish to switch between Medicare and Medicaid payment schemes. If an EP switches during the course a reporting year, she will

be paid under the scheme she switched to for that year. However, she may only switch once after she has begun receiving EHR payments.

CAHs in the Medicaid Incentive Program

CAHs were also included in CMS' updated definition of "acute care hospitals" with regards to Medicaid payments. The updated definition ensures that CAHs will be applicable for Medicaid payments at acute care hospital rates.

Medicaid HIT Incentive Program Can Start in 2011

States may choose to launch their Medicaid programs as early as 2011. Colorado, Utah, Wyoming, Nevada, Mississippi, and North Carolina were among the earliest states to qualify for federal funding to implement Medicaid HIT bonus systems. Other states continue to apply for and receive implementation funding which could help them set up Medicaid incentive programs.

For a full summary of the measures found in the proposed rule, please visit www.strategichealthcare.net. For any other questions or information, please contact Marian Lowe or Sharon Cheng at 202-266-2600.