



**Federal EHR Incentives –  
The HITECH Act**

Jeff Grant, President  
HCMA, Inc

## **IMPORTANT NOTICE:**

- **What is your motivation for implementing EHR?**



# **IMPORTANT NOTICE:**

- **There are two Federal EHR incentives available to non-hospital based physicians – Medicare and Medicaid.**
- **The Medicaid incentive “could” pay much more than the Medicare incentive (\$64,000 vs. \$44,000), depending on the amount of your investment in EHR.**
- **There are many similarities between the two programs, but also some important differences.**



# **IMPORTANT NOTICE:**

- **One of the requirements to qualify for the Medicaid incentive is that you must have 30% of your patient volume come from Medicaid patients (Title XIX).**
- **Therefore, since so few EPs will be able to meet the threshold and qualifications for the Medicaid incentive, this presentation focuses on the Medicare incentive option and requirements.**



# Federal EHR Incentive

- Will the EHR Incentives actually be paid out?
  - The State Health Information Exchange (State HIE) Cooperative Agreement Program awards cooperative agreements to states, eligible territories, and qualified State Designated Entities (SDEs) to develop and advance mechanisms for information sharing across the health care system, including establishing health information exchange (HIE) capacity among health care providers and hospitals in their jurisdiction, ultimately enabling exchange across states. (\$548 Million – March, 2010)
  - 15 communities across the country to serve as pilot communities for eventual wide-scale use of health information technology through the Beacon Community program. \$220 million in Recovery Act awards will not only help achieve meaningful and measurable improvements in health care quality, safety and efficiency in the selected communities, but also help lay the groundwork for an emerging health IT industry that is expected to support tens of thousands of jobs.



# Federal EHR Incentive

- **Will the EHR Incentives actually be paid out?**
  - Under HITECH, \$677 million is allocated to support a nationwide system of RECs that cover every geographic region of the United States to ensure plenty of support to health care providers in communities across the country.  
Awards made:
    - February 2010: \$375 million awarded to establish 32 RECs
    - April 2010: \$267 million awarded to establish an additional 28 RECs
    - September 10, 2010: nearly \$20 million in additional funding awarded to 46 existing RECs to support critical access and rural hospitals in their efforts to adopt certified EHR technology
    - September 28, 2010: \$10 million additional funding awarded to establish two new RECs and expand coverage areas with two existing Florida RECs.
  - \$77.5 Million for Community College, Curriculum Development, & University-based Training programs
  - **TOTAL = \$1.522 BILLION**



# Federal EHR Incentive

- **Definitions:**

- **Certification Criteria** - Criteria: 1) to establish that health information technology meets applicable standards and implementation specifications adopted by the Secretary; or 2) that are used to test and certify that health information technology includes required capabilities.
- **EHR Module** - Any service, component, or combination thereof that can meet the requirements of at least one certification criterion adopted by the Secretary.
- **Complete EHR** - EHR technology that has been developed to meet, at a minimum, all applicable certification criteria adopted by the Secretary.



# Federal EHR Incentive

- **Definitions:**

- **Certified EHR Technology** - A Complete EHR that meets the requirements included in the definition of a Qualified EHR and has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary; or A combination of EHR Modules in which each constituent EHR Module of the combination has been tested and certified in accordance with the certification program established by the National Coordinator as having met all applicable certification criteria adopted by the Secretary, and the resultant combination also meets the requirements included in the definition of a Qualified EHR.
- **Payment Year** – For EP's, any CY beginning with 2011; for Hospitals, any FY beginning with 2011 (10/1/10).
- **EHR Reporting Period** – Any continuous 90-day period within the first payment year and the entire payment year for all subsequent payment years.



# Medicare EHR Incentive Amounts

## 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



# Medicare EHR Incentive Amounts

	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



# Federal EHR Incentive Payments

- EHR Reporting Period / Dates to Keep in Mind:

- Jan. 1, 2011 to Mar. 31, 2011

- First possible EHR Reporting Period

- Oct. 3, 2012 to Dec. 31, 2012

- Last possible EHR Reporting Period to get full amount

- Oct. 4, 2012

- Lose \$5,000



# “Specialty-oriented” variations?

- There were comments about “specialty-oriented” variations of a Certified EHR Technology.
- ONC Response: At the present time, we believe that the definition of Certified EHR Technology already includes some of the flexibility these commenters request. We permit, for example, a Complete EHR designed for an ambulatory setting and a Complete EHR designed for an inpatient setting both to meet the definition of Certified EHR Technology, even though each is compliant with a slightly different set of applicable certification criteria. In that regard, we believe we have integrated a balanced and appropriate amount of flexibility into the definition of Certified EHR Technology, which will also allow us to make additional refinements over time. We believe that it is possible based on industry need for us to specify in a future rulemaking sets of applicable certification criteria for Complete EHRs and EHR Modules designed for particular clinical settings.



# Meaningful Use Finalized

- 15 “Core Set” Measures – All must be met.
- 10 “Menu Set” Measures – 5 must be met.
- At least one of the Menu Set Measures must be Public Health Related\*\*
- Thresholds have been reduced
- Administrative requirements removed
- Reduced Clinical Quality Metrics
- Additional Quality Options
- Exclusions have been acknowledged and detailed
- “Unique Patient” defined



# Meaningful Use Finalized

- **Meaningful Use Exclusions:**
  - An EP will be able to report if an objective/measure is inapplicable to them, because they have no patients or insufficient number of actions that would allow calculation of the meaningful use measure. This will allow an EP to qualify as a meaningful EHR user without being required to meet objectives we have specified as potentially inapplicable.
  - For example, for one objective included in the menu set an EP attests that he or she did not have any patients or insufficient actions during the EHR reporting period on which to base a measurement of a meaningful use objective, rather than satisfy 5 of the 10 meaningful use objectives included in the menu set for EPs, the EP need only satisfy 4 of the 9 remaining meaningful use objectives included in the menu set for EPs.



## Meaningful Use – “Unique Patient”

- **“Unique Patient”** - To further describe the concept of “unique patient” we mean that if a patient is seen by an EP more than once during the EHR reporting period then for purposes of measurement they only count once in the denominator for the measure.
- **Your EHR vendor is required to do these calculations for you.**



# Meaningful Use – Core Set

## 1. CPOE

- **Objective:** Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
- **Measure:** More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period have at least medication one order entered using CPOE.
- **Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period.



# Meaningful Use – Core Set

## 2. Drug-Drug, Drug-Allergy Interaction Checks

- **Objective:** Implement drug-drug and drug-allergy checks.
- **Measure:** Implement drug-drug and drug-allergy checks for the entire EHR reporting period



# Meaningful Use – Core Set

## 3. E-Prescribing

- **Objective:** Generate and transmit permissible prescriptions electronically (eRx).
- **Measure:** More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. Does not apply to any EP who writes fewer than 100 prescriptions during the EHR reporting period.
- **Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period.



# Meaningful Use – Core Set

## 4. Maintain a Problem List

- **Objective:** Maintain up-to-date problem list of current and active diagnoses.
- **Measure:** “More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data”.



# Meaningful Use – Core Set

## 5. Active Medication List

- **Objective:** Maintain active medication list.
- **Measure:** More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.



# Meaningful Use – Core Set

## 6. Active Medication Allergy List

- **Objective:** Maintain active medication allergy list.
- **Measure:** More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data”.



# Meaningful Use – Core Set

## 7. Record Demographics

- **Objective:** Record the following demographics: preferred language, gender, race and ethnicity, and date of birth
- **Measure:** More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data



# Meaningful Use – Core Set

## 8. Record Vital Signs:

- **Objective:** Record and chart changes in the following vital signs: height, weight and blood pressure and calculate and display body mass index (BMI) for ages 2 and over; plot and display growth charts for children 2 - 20 years, including BMI.
- **Measure:** For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data. The Certified EHR Technology will calculate BMI and the Growth Chart if applicable to patient based on age.
- **Exclusion:** Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.



# Meaningful Use – Core Set

## 9. Smoking Status

- **Objective:** Record smoking status for patients 13 years old or older
- **Measure:** More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
- **Exclusion:** Any EP who sees no patients 13 years or older.
- **NOTES:** The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community. The information could be collected by any member of the medical staff.



# Meaningful Use – Core Set

## 10. Report Clinical Quality Measures

- **Objective:** Report ambulatory clinical quality measures to CMS (or, for EPs seeking the Medicaid incentive payment, the States)
- **Measure:** Report CQM to CMS or states. For 2011, provide aggregate numerator and denominator through attestation. For 2012, electronically submit measures.



# Meaningful Use – Core Set

## 11. Clinical Decision Support

- **Objective:** Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
- **Measure:** Implement one clinical decision support rule.
- **Exclusion:** None allowed.



# Meaningful Use – Core Set

## 12. Clinical Summaries

- **Objective:** Provide clinical summaries for patients for each office visit.
- **Measure:** Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
- **Exclusion:** Any EP who has no office visits during the EHR reporting period.



# Meaningful Use – Core Set

## 13. Electronically Exchange Clinical Information

- **Objective:** Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
- **Measure:** Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
- **NOTE:** The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. No standards of exchange are specified. What “key clinical information” is sent is left up to the EP.



# Meaningful Use – Core Set

## 14. Electronic Copy of Health Information

- **Objective:** Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.
- **Measure:** More than 50 percent of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days.
- **Exclusion:** Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.



# Meaningful Use – Core Set

## 15. Privacy & Security (HIPAA)

- **Objective:** Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
- **Measure:** Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) of the certified EHR technology, and implement security updates and correct identified security deficiencies as part of its risk management process.
- **NOTE:** As we state in the proposed rule compliance with HIPAA privacy and security rules is required for all covered entities, regardless of whether or not they participate in the EHR incentive programs. Furthermore, compliance with the HIPAA Privacy and Security Rules constitutes a wide range of activities, procedures and infrastructure.



# Meaningful Use – Menu Set

## 1. Lab Results

- **Objective:** Incorporate clinical lab-test results into EHR as structured data.
- **Measure:** More than 40 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
- **Exclusion:** An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the HER reporting period.



# Meaningful Use – Menu Set

## 2. Patient Lists

- **Objective:** Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
- **Measure:** Generate at least one report listing patients of the EP or eligible hospital with a specific condition.



# Meaningful Use – Menu Set

## 3. Patient Reminders

- **Objective:** Send reminders to patients per patient preference for preventive/follow-up care.
- **Measure:** More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
- **Exclusion:** An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.



# Meaningful Use – Menu Set

## 4. Timely Electronic Access to Health Information

- **Objective:** Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP.
- **Measure:** At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.
- **Exclusion:** Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period.
- **NOTE:** "There may be situations where a provider may decide that electronic access of a portal or Personal Health Record is not the best forum to communicate results. Within the confines of laws governing patient access to their medical records, we would defer to EP's, eligible hospital or CAH's judgment as to whether to hold information back in anticipation of an actual encounter between the provider and the patient."



# Meaningful Use – Menu Set

## 5. Medication Reconciliation

- **Objective:** The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
- **Measure:** The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
- **Exclusion:** An EP who was not the recipient of any transitions of care during the EHR reporting period.



# Meaningful Use – Menu Set

## 6. \*\*Submission of electronic immunization data

- **Objective:** Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with to applicable law and practice.
- **Measure:** Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, submits such information have the capacity to receive the information electronically).
- **Exclusion:** An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.
- **NOTES:** 1) We clarify that this objective and its associated measure apply only to EPs that administer one or more immunizations during the EHR reporting period. 2) A failed attempt meets the measure. 3) This measure is related to Public Health.



# Meaningful Use – Menu Set

## 7. \*\*Submission of electronic syndromic surveillance data

- **Objective:** Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice
- **Measure:** Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital, or CAH submits such information have the capacity to receive the information electronically)
- **Exclusion:** An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically
- **NOTES:** 1) The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. 2) A failed attempt would meet the measure. 3) This measure is related to Public Health.



# Meaningful Use – Menu Set

## 8. Drug Formulary Checks

- **Objective:** Implement Drug Formulary Checks.
- **Measure:** The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
- **Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period should be excluded from this objective and associated measure.



# Meaningful Use – Menu Set

## 9. Education Resources

- **Objective:** Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate
- **Measure:** More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources”.



# Meaningful Use – Menu Set

## 10. Summary of Care Record

- **Objective:** The EP transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
- **Measure:** The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
- **Exclusion:** An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.



# Clinical Quality Measure (CQM) Reporting

- 3 Core Measures – All 3 must be reported.
- 3 Alternate Core Measures – If the denominator for one or more of the Core Measures is zero, you will be required to report results for up to three Alternate Core Measures.
- 38 Additional Measures – Must report on 3 Measures from this list.
- In sum, EPs must report on 6 total measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures.



# CQM Reporting – Core Set

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 Reporting – Alternate Core Set

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 Reporting – Additional Set

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 Reporting – Additional Set

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 Reporting - Attestation

## Requirements for EPs reporting clinical quality measures:

- You must report the Core Measures even if the denominator is zero.
- The information submitted with respect to clinical quality measures was generated as output of an identified certified electronic health record.
- The information submitted is accurate to the best of the knowledge and belief of the EP.
- The information submitted includes information on all patients to whom the clinical quality measure applies for all patients included in the certified EHR technology.
- The NPI and TIN of the EP submitting the information.
- The numerators, denominators, and exclusions for each clinical quality measure result reported, providing separate information for each clinical quality measure including the numerators, denominators, and exclusions for all applicable patients contained in the certified EHR technology irrespective of third party payer or lack thereof.
- The beginning and end dates for which the numerators, denominators, and exclusions apply (the Medicare EHR reporting period in payment year 1 is 90 days and for payment year 2 is the beginning and end date of the reporting period as stated).



# Meaningful Use Demonstration

- For CY 2011 through attestation.
- For payment years beginning in CY 2012 and subsequent years, EPs demonstrate that they satisfy each of the proposed meaningful use objectives other than “Submitting quality measures to CMS or the States” through attestation, and demonstrate that they satisfy the objective “Submitting quality measure to CMS or the States” through electronic reporting of clinical quality measures to CMS or the States.
- Specifically, we propose that EPs provide attestation through a secure mechanism, such as through claims based reporting or an online portal.



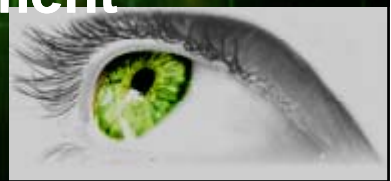
# Meaningful Use Demonstration

- **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 to demonstrate Meaningful Use
  - Must be enrolled in PECOS



# Meaningful Use Demonstration

- An EP must submit in a manner specified by CMS the following information in the first payment year:
  - Name of the EP, eligible hospital or CAH.
  - National Provider Identifier (NPI).
  - Business address and phone number.
  - The Taxpayer Identification Number (TIN) which may be the EP's Social Security Number (SSN) to which the EP's incentive payment should be made.
  - Identify the certified EHR technology they are utilizing
  - Medicare or Medicaid program selection (may only switch once after receiving an incentive payment before 2015) for EPs



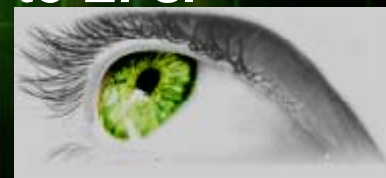
# Incentive Payments

- **Who gets paid?**
  - **“Except as otherwise indicated, each objective must be satisfied by an individual EP as determined by unique National Provider Identifiers(NPIs).”**
  - **“We do not propose to post information on group practices because we do not propose to base incentive payments at the group practice level.”**



# Incentive Payments

- **How / When will payments be made?**
  - To facilitate funds control, payments will be made by the single payment contractor. Additionally, the Integrated Data Repository (IDR), rather than the carriers/MACs will be accumulating the allowed charges for each qualified EP's NPI.
  - Payments would be made on a rolling basis.
  - We anticipate that it will take anywhere from 15 to 46 days from the time an EP successfully attests to being a meaningful user to the time an incentive payment is made, and that for FY 2011, incentive payments will be made to EPs who successfully demonstrate that they were meaningful EHR users for the EHR reporting period as early as May 2011.
  - A single, consolidated, annual incentive payment to EPs.



# Incentive Payments - Reassignment

- Assigning payments to an employer or other entity:
  - “EPs are allowed to reassign their incentive payment to their employer or an entity which they have a valid employment agreement or contract providing for such reassignment, consistent with all rules governing reassignments.”
  - “We are proposing to preclude an EP from reassigning the incentive payment to more than one employer or entity.”



# Incentive Payments – More than one practice

- For an EP furnishing covered professional services in more than one practice:
  - “We propose to use the EP's Medicare enrollment information to determine whether an EP belongs to more than one practice (that is, whether the EP's National Provider Identifier (NPI) is associated with more than one practice). In cases where the EP is associated with more than one practice, we propose that EPs select one tax identification number to receive any applicable EHR incentive payment.



# Incentive Payments – HPSA

- There is a 10% bonus on Incentive Payments for EP's practicing "predominantly" in a Health Care Shortage Area.
- For an EP to be considered as "predominantly" furnishing covered professional services in a geographic HPSA, more than 50 percent of the EP's covered professional services must be furnished in a geographic HPSA.
- This would be an additional lump sum payment made no earlier than 2 months after the end of the year.



# Incentive Payments – Reviews

- We will conduct selected compliance reviews of EPs who register for the incentive programs and of recipients of incentive payments for the meaningful use of certified EHR technology. The reviews will validate provider eligibility through their meaningful use attestations including verification of meaningful use and would also review components of the payment formulas.
- We will identify and recoup overpayments made under the incentive payment programs that result from incorrect or fraudulent attestations, quality measures, cost data, patient data, or any other submission required to establish eligibility or to qualify for a payment. The overpayment will be recouped by CMS or its agents from the EP or other entities to whom the right to payment has been assigned/reassigned.
- Medicare FFS EPs will need to maintain evidence of qualification to receive incentive payments for 10 years after the date they register for the incentive program.



# No E-Rx Incentive with EHR Incentive

- **No E-Rx Incentive Payment if you accept Medicare EHR Incentive Payment:**

**“We will exclude those EPs who accept a Medicare EHR incentive payment for a given year from being eligible for the E-Prescribing Incentive Program payment for that same year. EPs receiving a Medicaid EHR incentive payment would remain eligible for the Medicare MIPAA E-Prescribing Incentive Program payment.”**



# Certification Programs for HIT

- ***On August 30th the ONC announced the first two Authorized Testing & Certification Bodies (ONC-ATCB):***
  - ***Certification Commission for Health Information Technology (CCHIT), Chicago, IL***
  - ***Drummond Group, Inc., Austin, TX***
- ***On September 17th the ONC announced a third Authorized Testing & Certification Body (ONC-ATCB):***
  - ***The Office of the National Coordinator for Health Information Technology (ONC) named InfoGard Laboratories, Inc., San Luis Obispo, Calif. as an ONC-Authorized Testing and Certification Body (ONC-ATCB).***



# Certification Programs for HIT

- Other certified products, either Complete or Modular EHRs and inpatient or outpatient, are listed on a government Web page at:

<http://onc-hpl.force.com/ehrcert>





**Thank you!**

Jeff Grant, President  
HCMA, Inc

[jeff@hcma-consulting.com](mailto:jeff@hcma-consulting.com)  
[www.hcma-consulting.com](http://www.hcma-consulting.com)