Electronic Health Records: Updates on Registration, Meaningful Use, and Incentive Payments

Presented to the HCCA Mid Central Regional Annual Conference by Kathie McDonald-McClure & Kristen Holt

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The information in the following slides is a summary, and is not intended to cover all the finer points of the HITECH Act, which is a multifaceted law, that is continuously evolving through the issuance of regulations, rules and governmental guidance. The requirements of the HITECH Act and its implementing regulations can vary according to the specific factual situation presented. This presentation is not intended to be legal advice, which should always be obtained through direct consultation with an attorney.
The HITECH Act’s EHR Objectives

The HITECH Act was signed into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009.

HITECH’s Electronic Health Record (EHR) objectives include:

- Reforming the health care system.
- Improving health care quality.
- Increasing patient safety.
- Containing costs in government healthcare programs.
- Ensuring privacy and security.
HHS Office of National Coordinator for Health Information Technology (ONC)

ONC is responsible for managing the public-private collaboration to develop EHR certification standards & meaningful use standards.

The ONC National Coordinator
Farzad Mostashari, MD, ScM
The Broader Picture: Health Information Exchanges

The Broader Picture: Relevance of Meaningful Use and Certified EHRs to Other Programs

- Medicare Shared Savings Program: Accountable Care Organizations (ACOs) are not required to be Meaningful Users to qualify for the cost savings, but EHR adoption is rewarded.
  - CMS expanded the EHR quality measure to include any primary care providers (PCPs) who qualifies for an EHR incentive program rather than only including those deemed “meaningful users.”
  - Use of certified EHRs will be the highest-weighted quality measure for an ACO under the new Medicare Shared Savings Program.
- The Physician Quality Reporting Incentives Program (PQRI) and Hospital Inpatient Value Based Purchase Program (VBP) also incorporate MU requirements.*

*For more information about meaningful use and the ACO PQRI, and VBP, see articles on the HITECH Law Blog: [www.healthitlaw.wordpress.com](http://www.healthitlaw.wordpress.com).
Available Incentives

Two EHR incentive payment plans are available to Eligible Hospitals (EHs) and Eligible Physicians (EPs):

- Medicare Incentive Plan.
- Medicaid Incentive Plan.

Hospitals can participate in both Medicare & Medicaid Incentive Plans. Physicians can only participate in one.

Eligible Physicians can receive eRx Medicare EHR and Medicaid EHR incentive payments in the same year, but cannot receive eRx Medicare EHR and Medicare EHR incentives payments.

Medicare Advantage physicians can also choose the Medicare Advantage Incentive Plan.

Incentives are available to EHs and EPs who demonstrate a meaningful use of a certified EHR.
Eligible Hospitals – Subsection D & CAHs

Subsection D hospitals include hospitals located in one of the 50 States or in D.C.

Subsection D hospitals do not include:

- Hospitals located in US territories or Puerto Rico.
- Hospitals excluded from IPPS, i.e., psychiatric, rehab, children’s and cancer and Critical Access Hospitals (CAHs) however . . .

CAHs are eligible under a separate provision of the law.
Eligible Professionals

- **Medicare incentive plan**: Physicians in medicine, osteopathy, dental surgery or dental medicine; podiatric medicine; optometry; or chiropractic.

- **Medicaid incentive plan**: All of the above* plus certified nurse mid-wives; nurse practitioners; or physician assistants working in a rural health clinic (RHC) or federally qualified health center (FQHC) that are led by PAs.

*Except optometrists; however, per Sandeep Kapoor, KY CHFS, Kentucky Medicaid has filed an amended state plan with CMS to include optometrist as “physician” so they are eligible as well (4-21-11)
EHs May Qualify for Both Medicare Incentive Payments and Medicaid Incentive Payments

- Subsection D hospitals and CAHs can qualify if Medicaid acute care hospitals.

- A potentially easy route to get both incentives:
  - Report on meaningful use to CMS for Medicare EHR Incentive Program.
  - Automatically deemed meaningful users for Medicaid, even if State has increased core objective requirements.
How Much Money Can an EH Receive?

The incentive payment for Eligible Hospitals is determined based on a formula and data from the hospital’s cost report. The incentive payment for each Eligible Hospital would be calculated based on the product of:

- Base amount of $2M plus per-discharge amount ($200 for every discharge between 1,150 and 23,000) multiplied by
- Medicare Share and
- Transition Factor.
How Much Money Can an EH Receive?

➤ Medicare Share:

➤ Numerator is total of Part A and Part C inpatient days

➤ Denominator is total inpatient days, multiplied by a fraction of non-charity care charges over total charges

➤ Transition Factor (see chart on next slide).
# How Much Money Can an EH Receive?

Transition Factor Depends on Year of Adoption

<table>
<thead>
<tr>
<th>Year EH Adopts Below</th>
<th>Payment Year 2011</th>
<th>Payment Year 2012</th>
<th>Payment Year 2013</th>
<th>Payment Year 2014</th>
<th>Payment Year 2015</th>
<th>Payment Year 2016</th>
<th>Payment Year 2017</th>
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</thead>
<tbody>
<tr>
<td>2011 Adoption</td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2012 Adoption</td>
<td></td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
<td></td>
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<tr>
<td>2013 Adoption</td>
<td></td>
<td></td>
<td>100%</td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
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<tr>
<td>2014 Adoption</td>
<td></td>
<td></td>
<td></td>
<td>75%</td>
<td>50%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>2015 Adoption</td>
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<td></td>
<td></td>
<td></td>
<td>50%</td>
<td>25%</td>
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<tr>
<td>Penalty For No Adoption</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25% of APU</td>
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How Much Medicare Money Can an EP Receive?

<table>
<thead>
<tr>
<th>Payment Year Below</th>
<th>Adopt by 12/31/2011:</th>
<th>Adopt by 12/31/2012:</th>
<th>Adopt by 12/31/2013:</th>
<th>Adopt by 12/31/2014</th>
<th>Adopt in 2015 or after</th>
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<tr>
<td>2011</td>
<td>$18,000 cap</td>
<td>$0</td>
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<td>2012</td>
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<td>2013</td>
<td>$8,000 cap</td>
<td>$12,000 cap</td>
<td>$15,000 cap</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>2014</td>
<td>$4,000 cap</td>
<td>$8,000 cap</td>
<td>$12,000 cap</td>
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<td>2015</td>
<td>$2,000 cap</td>
<td>$4,000 cap</td>
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<td>2016</td>
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<td>$2,000 cap</td>
<td>$4,000 cap</td>
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<td>2017</td>
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<tr>
<td>Totals</td>
<td>$44,000</td>
<td>$44,000</td>
<td>$39,000</td>
<td>$24,000</td>
<td>$0</td>
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</tbody>
</table>
How Much Medicaid Money Can an EP Receive?

➢ Up to $63,750 available for adopting, implementing, upgrading ("AIU") a "certified EHR"

➢ 85% of "net average allowable costs"

➢ Up to 6 years of incentive payments:
  ▪ 1st year payment: 85% of $25,000 (85% of $16,667 for pediatricians)
  ▪ 2nd year & after: 85% of $10,000 per year (85% of $6,667 for pediatricians)
  ▪ Must incur EHR costs by 2016.
  ▪ No payment after 2021.
What EHRs Have Been “Certified”?

http://onc-chpl.force.com/ehrcert
What is “Meaningful Use?”

The HITECH Act specifies **three components** of “meaningful use”:

1. Use of a certified EHR in a meaningful manner.
   - Providers must use the functions that deliver the most benefits (rational for requiring minimum Core Objectives).

2. Use of certified EHR technology for electronic exchange of health information to improve quality of health care.
   - Must standardize the data to enable effective exchange.

3. Use of certified EHR technology to submit clinical quality measures (CQMs) and other measures selected by the Secretary.
Meaningful Use Objectives and Measures Are Implemented in Three Stages

- **Stage 1** is intended to establish functionalities in certified EHR technology that will allow for continuous quality improvement and ease of information exchange.

- **Stage 2** will encourage the use of health IT for continuous quality improvement at the point of care and the exchange of information in a structured format.

- **Stage 3** will focus on improvements in quality, safety and efficiency leading to improved health outcomes, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data through robust, patient-centered health information exchange and improving population health.
Meaningful Use Objectives and Their Related Measures Are Intended to Balance a Number of Competing Considerations:

- Improving health care quality.
- Encouraging widespread EHR adoption.
- Promoting innovation.
- Avoiding imposing excessive or unnecessary burdens on health care providers.
- Working within the timeframes required by the HITECH Act.
Meaningful Use – Stage 1 Overview

- Stage 1 MU is the only stage being measured right now. Stages 2 and 3 are yet to be finalized and will be measured in later years.
- Must electronically capture health information in a coded format. Electronically scanned paper records do NOT qualify.
- Track key clinical conditions.
- Communicate clinical information for care coordination purposes.
- Report Clinical Quality Measures to CMS.
Meaningful Use – Eligible Hospitals
Stage 1 Objectives

24 Total EH Objectives

14 Core Objectives → Must Comply with all 14

10 Menu Objectives → Must Comply with 5 of 10

+ 1 Public Health Objective
Meaningful Use – Eligible Professionals
Stage 1 Objectives

- 25 Total EP Objectives
  - 15 Core Objectives: Must Comply with all 15
  - 10 Menu Objectives: Must Comply with 5 of 10
    + 1 Public Health Objective
Meaningful Use Example

▶ **Objective:** Record smoking for patients 13 years and older.

▶ **Measure:** More than 50% of all unique patients 13 years or older who are admitted to the EH inpatient or emergency department have smoking status recorded in the EHR as structured data.

▶ **Exclusion:** Any EH that admits no patients who are 13 years or older to their inpatient or emergency department meet the exclusion for this objective.
Meaningful Use Objective Requires Compliance with HIPAA Security Rule

- EHs and EPs must conduct or review a security risk analysis, as defined by HIPAA (45 CFR 164.308(a)(1)), of a certified EHR, implement security updates, and correct any deficiencies in order to meet their core objectives to demonstrate a meaningful use.

- A HIPAA Security Risk analysis is an individual assessment and evaluation of security risks with a number of detailed considerations, not a boilerplate document.

- EHs and EPs must ensure there are administrative, physical and technical safeguards for electronic protected health information (ePHI).

- Must not only conduct the risk assessment, but correct any identified deficiencies to qualify for the incentive payment.
Meaningful Use Objective Requires Compliance with HIPAA Security Rule (con’t)

- A recent OIG audit of ONC’s health IT standards provides insight into areas that should be addressed in a security analysis, including:
  - Encrypting data stored on portable media/mobile devices (e.g., thumb drives).
  - Requiring two-factor authentication.
  - Failure to download patches on computer systems that process and store EHRs.
- Security Rule safeguards should include, among other things, a policy on your plan of operation in case of emergency. Is there a back-up of the data in your EHR?
Meaningful Use Objective Requires Compliance with HIPAA Security Rule (con’t)

Use of **cloud computing** may decrease your risk of noncompliance because of enhanced encryption and security capabilities and familiarity with privacy and security issues and legal requirements.

Ensure your Business Associate Agreement with the cloud computer service provider or vendor requires HIPAA Security Rule Compliance and that you are provided documentation of compliance.

**Compliance Tip:** Be careful not to certify that a HIPAA security analysis is completed without proper documentation. Failure to do so can be considered a false certification subject to penalties under the False Claims Act.
Medicaid Incentive – States May Increase the Core Objective Requirements on Limited Basis

- States may seek CMS approval to categorize 4 public health-related objectives as “core objectives” instead of menu objectives. These are:
  - Generate lists of patients by specific conditions.
  - Capability to submit electronic data to immunization registries.
  - Capability to submit electronic data on reportable lab results to public health agencies.
  - Capability to submit electronic syndromic surveillance data to public health agencies.
EHs and EPs Must Also Meet MU **Measures** Associated with Each Objective

- Compliance with MU “Measures” is determined by either:
  - a “yes/no” question, or
  - calculating data on a percentage basis.

- Many percentage-based measures are likely to increase in Stages 2 & 3.
Two types of percentage-based measures:

1. Denominator = all patients seen or admitted during EHR reporting period, regardless of whether records kept using certified EHR technology.

2. Denominator = actions or subsets of patients seen or admitted during EHR reporting period, but only patients or actions taken on behalf of patients whose records are kept using certified EHR technology.
Relationship between Stage 1 Objectives and their Associated Measures

Derived from recommendations of the ONC’s HIT Policy Committee, which identified improving quality, safety, efficiency and reducing health disparities as its policy priorities.

HIT Policy Committee Goals:

- Provide access to comprehensive patient health data for patient’s healthcare team.
- Use evidence-based order sets and CPOE.
- Apply clinical decision support at the point of care.
- Generate lists of patients who need care and use them to reach out to those patients.
- Report information for quality improvement and public reporting.
Clinical Quality Measures (CQMs) Are Included in Medicare’s Meaningful Use Criteria

 EHs must comply with 15 CQMs that fall into 3 major categories:

- Emergency Department throughput processes.
- Stroke patient management.
- Venous thromboembolism patient management.


*A link to the MU Final Rule is available under HIT Links on the side-bar of the HITECH Law Blog, www.healthitlawblog.wordpress.org.
Clinical Quality Measures (CQMs) Are Included in Medicare’s Meaningful Use Criteria (con’t)

EPs must report **6 CQMs** to CMS or the State:

- **3 “core” or “alternative core” measures.**
  - Core Measures:
    - blood pressure for patients with hypertension
    - tobacco use and cessation counseling, and
    - BMI screening and weight management counseling.
  - Alternative Core Measures:
    - weight measurement and counseling for children and adolescents
    - influenza vaccinations for patients over 50, and
    - childhood immunization status.

Meaningful Use – Stage 2

Stage 2 will focus on:

- Improving quality, safety, efficiency, and reducing health disparities.
- Engaging patients and families in their care.
- Improving care coordination.
- Improving population and public health.
Approved Delay for Stage 2

On June 8, 2011, HITPC approved postponing implementation of Stage 2 until 2014, a one-year delay. As a result:

- Stage 1 demonstration and attestation will continue through 2013;
- Stage 2 will start in 2014; and
- Stage 3 will start in 2015.

Providers will receive the same payments as originally planned. Instead of 2013, however, early entrants will have to wait until 2014 to attest and receive payments for Stage 2.
Meaningful Use – Stage 3: Criteria To Be Determined Through Future Rulemaking

Stage 3 will focus on:

- improvements in quality, safety and efficiency.
- decision support for national high priority conditions.
- patient access to self management tools.
- access to comprehensive patient data.
- improving population health outcomes.
Meaningful Use – Overview of Measuring Compliance with Stages 1, 2 & 3

- Stage 1 results are being measured now and will be the only stage measured through 2013.
- Stage 2 results will first be measured in 2014 and beyond.
- Stage 3 results will first be measured in 2015 & beyond.
- EHs and EPs who have not adopted EHRs before the end of 2013 can still adopt. However, such EHs and EPs will have to meet ALL applicable stages in that first year of adoption to qualify for an incentive payment.
When Should EHs and EPs Register for Incentive Payments?

EHs and EPs can register now, even though they may not be ready to attest to a meaningful use of certified EHR until a later year.

To receive incentive payments for the 2011 Payment Year:

- EHs must register no later than November 30, 2011.
How Should EHs and EPs Register for Incentive Payments?

Register for Medicare and/or Medicaid incentive payments online at the CMS EHR Incentive Program webpage:
https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp

Registration instructions also are available on the CMS HER Incentive Program webpage at:


CMS EHR Incentives FAQs available at:
http://questions.cms.hhs.gov/app/answers/list/p/21,26,1139
Kentucky Medicaid Incentive Payment Registration

- Medicaid incentive pay outs are determined by each state. Kentucky was the first state to make incentive payments available.

- To register go to: http://chfs.ky.gov/dms/ehr.htm


- For the Kentucky EHR Tips sheet, go to: http://chfs.ky.gov/NR/rdonlyres/B0C6926E-775F-41A6-991D-1B6F5BB19ABA/0/ProviderTips.pdf
EHR Incentive Payments for Meaningful Use Are Tied to the “Payment Year”

“Payment Year” is a fiscal year for Hospitals (10/1 to 9/30) and a calendar year for EPs (1/1 to 12/31).

The first “Payment Year” is 2011, referred to as the 2011 Payment Year.
How Do I *Report* Meaningful Use for Each Payment Year?

2011 Payment Year: Use the on-line attestation to report the results for all objectives or measures, including aggregate CQMs, numerator, denominator, and exclusion data, for both Medicare and Medicaid incentive payments.

*Retain support for your attestation for at least 6 years.*

2012 Payment Year and after: Use your certified EHR technology to directly submit CQMs to CMS (Medicare) or to the State (Medicaid), as applicable.
How Do I *Demonstrate* Meaningful Use for Each Payment Year?

- Meaningful Use is demonstrated during a “Reporting Period.”
- 1st year Reporting Period: Demonstrate meaningful use during a 90-day period anytime after October 1, 2010 (EHs and EPs).
- Reporting Period start date for Payment Year 2011: The last day for EHs to begin the reporting period was July 3, 2011, and for EPs was October 3, 2011.
- Reporting Period for subsequent years: Demonstrate meaningful use for the full fiscal year (EHs) or full calendar year (EPs).
Meaningful Use Compliance – Proper Attestation Essential to Avoid a Fraud Claim

- Focus on accuracy is critical for 2011 attestation. CMS must rely on honesty of the provider making the attestation.
- After 2011, the certified EHR must have the capability to transmit all MU measures electronically to CMS, including data that could not be transmitted during 2011, the first year of attesting.
- CMS will be checking the veracity of 2011 attestations through certified EHRs in 2012.
GE Healthcare recently reported that its EHR product inaccurately reports three MU measures.

GE has recommended that clients not attest for MU until the reports are corrected.

For those that have already attested, GE recommends running the reports again after the errors are corrected.

- May create problems with 90-day attestation period.

- Do not rely on EHR vendors for absolute compliance with MU measures!
Meaningful Use Compliance – Potential EHR Fraud and Abuse Risks

- Entry of false information.
- Individual responsibility and accountability.
- Logging individual use of EHR.
- Correcting and amending records.
- Personal responsibility for accuracy (cut and paste function), protecting information, and notifying others if problems are discovered.
- Preventing unauthorized access.
- Conflict identification.
- Duplication of information.
EHR Compliance Considerations – Converting Paper Records to EHRs

➢ Is the “coded format” the same as the original record?
  ➢ Need quality control to verify images are captured correctly.

➢ Retention of paper records for sufficient time periods is the best practice.
  ➢ Review your liability insurance requirements.
  ➢ Check healthcare malpractice statute of limitations for your state and any exceptions for minors, the disabled, or the deceased.
  ➢ State licensing authorities may require retention (check Medicaid regulations).
  ➢ False Claims Act actions may be brought up to 10 years after the date of the violation.
  ➢ Medicare conditions of participation for hospitals require retention for 5 years.

➢ Be sure to comply with any existing, internal written policy.
EHR Compliance Considerations

- Providing EHRs to physicians on the medical staff (versus employed physicians) may create issues with the Stark Law, CLIA, and HIPAA if not carefully structured.

- Hospitals should contract with employed physicians to ensure that payments are properly assigned.

- Regulatory compliance issues may exist involving the design, use, and interoperability of the EHR.

- Barriers to complete interoperability remain (e.g., e-prescribing and CLIA).
What is the Impact of the Failure to Adopt and Make a Meaningful Use of a Certified EHR?

- EHs face 25 - 75% payment adjustment beginning in 2015 if they are not meaningful users by that time.
- Plus, consequences of failure to adopt also will be felt if hospital unable to transmit data through its certified EHR in order to comply with Medicare’s new Hospital Inpatient Value-Based Purchase (VBP) Program.
- EPs must be meaningful users before 2015 to avoid 1-5% decrease in EP Medicare Fee Schedule (possible exception for rural EPs).
- No Medicaid Penalty for EHs or EPs who fail to adopt.
How Do I Keep the Payments Coming Year After Year?

- Must continue to make “meaningful use” in EACH “reporting period” for the applicable “payment year” and

- Use of the EHR must be in compliance with the reporting period’s then applicable Stage 1, 2, or 3 standards for “meaningful use.”
Miscellaneous Incentive Payment Details

- All EP payments are single lump sum payments paid to the EP or to the taxpayer identification number (TIN) that has been reassigned by the EP.
- EPs can allow another person to register and attest for them.
- If the EP wants to reassign incentive payments, the TIN number must be associated with that EP in the PECOS system.
- EPs can reassign payments to only one employer or entity.
- CMS issues the EHR incentive payment approximately 4-8 weeks after an EP or EH attests. The form of payment will be the same as claims payments (EFT or check). However:
  - EP must first meet the maximum allowed charges threshold of $24,000. If EP does not reach the threshold, payment will be made the following year.
  - CMS payments to EHs are “interim”; a “final” payment determination will be made after cost report settlement for the applicable Payment Year.
EHR Legislation Introduced in Congress Last Month Would Protect Medicare and Medicaid Providers Using EHRs

- H.R. 3239 intended to provide certain legal safe harbors to Medicare and Medicaid providers who participate in the EHR meaningful use program or otherwise demonstrate use of certified health information technology.

- Would permit users to submit information to a PSO and to receive the same protections as other PSWP under the Patient Safety Act.

- Would implement limitations on liability through electronic discovery rules, statutes of limitations, and eligible damages.
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