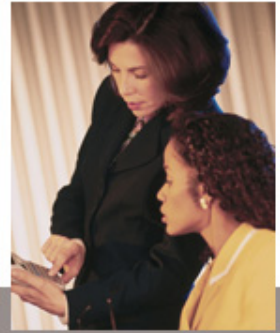




NATIONAL ASSOCIATION OF

Community Health Centers



America's Voice for Community Health Care

Rev 1/19/10



America's Voice for Community Health Care

The NACHC Mission

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved people.



Overview of CMS Final Rule On EHR Adoption for FQHCs

SAAS/NIATx Annual Meeting

Michael R. Lardiere, LCSW
Director HIT; Sr. Advisor Behavioral Health
July 10, 2011



- Copies of the presentation and the Final Rule document referenced in the presentation can be found on the NACHC web site in the HIT section at:



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Health Information Technology (HIT)

Text Size: [A](#) [A](#) [A](#)

This site provides tools and resources to assist health centers in the selection and successful implementation of various health information technologies (HIT). NACHC recognizes that HIT is an important component in a health center's operations, however, HIT is not an end unto itself but rather a tool to assist health care providers to provide quality care that is safe, effective, timely, patient-centered, efficient and equitable.

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Meaningful Use of HIT

"Meaningful Use" of Health Information Technology

Download Overview of CMS Final Rule on EHR Adoption 7/17/10

7/13/10 CMS/ONC announce Final Rules on "Meaningful Use" of EHR

- Secretary Sebelius Press Release
- CMS and ONC Final Regulations Define Meaningful Use And Set Standards for Electronic Health Record Incentive Programs
- Medicare and Medicaid Programs; Electronic Health Record Incentive Programs; FINAL RULE
- Dr. Blumenthal's Views on Use of EHRs
- Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology ONC FINAL RULE

On January 13, 2010 the Centers for Medicare and Medicaid Services (CMS) and the National Coordinator (ONC) published Interim Rules governing the Electronic Health Record (EHR) Incentive Program and the Initial Set of Standards, Implementation Specifications and Certification Criteria for Electronic Health Record Technology. Visit this page for updates and comments provided by NACHC on these Interim Rules. Comments are due by January 15, 2010.

- CMS Interim Rule from Federal Register January 13, 2010 - Electronic Health Record Incentive Program
- ONC Interim Rule from Federal Register January 13, 2010 Initial Set of Standards, Implementation Specifications and Certification Criteria for Electronic Health Record Technology

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- “My presentation today does not include any discussion about a particular commercial product/service and I do not have any significant financial interest/relationship with any organizations that make/provide this product/service”



CMS Interim Rule Authority

American Recovery and Reinvestment Act (ARRA) (Pub. L. 111-5)

- Enacted February 17, 2009

- Modernize nation's infrastructure
- Enhance energy independence
- Expand educational opportunities
- Provide tax relief, and
- Preserve and improve affordable health care

- Title IV of Division B of ARRA
 - Amends Titles XVIII and XIX of the Social Security Act
 - Established incentive payments to eligible professionals (EPs) to promote
 - Adoption and
 - Meaningful Use of Interoperable health information technology

- Together with Title XIII of Division A of ARRA =
 - Health Information Technology for Economic and Clinical Health or the HITECH Act



- **CMS Final Rule Initial Release on July 13, 2010**
 - **Federal Register July 28, 2010**
- **ONC also published a related Rule**
 - **Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology**
 - **Governs the Establishment of Certification Programs for Health Information Technology**
 - <http://www.nachc.com/meaningfuluseofhit.cfm>



- ***HHS Ultimate Goal***
 - ***Reform the health care system***
 - ***Improve***
 - ***Health care quality***
 - ***Efficiency***
 - ***Patient Safety***



➤ Requirements for “Meaningful Use”

- Demonstrates Meaningful Use of Certified EHR technology in a meaningful manner
 - E.g. electronic prescribing

- The certified technology is
 - Connected in a manner that provides for
 - Electronic exchange of health information to
 - Improve quality care

- In using the certified EHR technology
 - Provider submits to the Secretary information on
 - Clinical Quality Measures
 - Other measures selected by the Secretary
 - For Medicaid EPs to the States



➤ Staged Approach

➤ Stage 1 Focus

- Capture information in a structured format
- Using the information to track key clinical conditions
- Communicating the information for Care Coordination Purposes
- Implementing Clinical Decision Support Tools to
 - Facilitate Disease and Medication Management
- Use EHRs to Engage Patients and Families
- Reporting Clinical Quality Measures and Public Health Reporting States



EPs Must Demonstrate “Meaningful Use Of EHR Technology

- **Focuses on functionalities that will allow for**
 - **Continuous Quality Improvement**
 - **Ease of Information Exchange**



➤ Requirements for “Meaningful Use”

- Use of EHR technology in a meaningful manner
 - E.g. electronic prescribing
- The certified technology is
 - Connected in a manner that provides for
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 - Improve quality care
- In using the certified EHR technology
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 - Clinical Quality Measures
 - Other measures selected by the Secretary
 - For Medicaid EPs to the States



➤ Definitions of “Qualified EHR Technology”

- A Qualified EHR must be applicable to the type of practice
 - E.g. ambulatory EHR for office based physicians
- An electronic record of health information on an individual that includes:
 - Patient demographics
 - Clinical health Information
 - Medical History
 - Problem lists
- Has capacity to
 - Provide clinical decision support
 - Support physician order entry
 - Capture and query information relevant to health care quality
 - Exchange electronic health information
 - Integrate such information from other sources



Identification of Qualifying Medicaid EPs

- **EPs that Practice Predominantly in an FQHC**
 - **Physicians**
 - **Certified nurse-midwives**
 - **Nurse practitioners**
 - **Dentists**
 - **Physician assistants practicing in an FQHC or RHC that is so led by a physician assistant**

- **“Practices predominantly “ = is the clinical location for over 50% of his/her total patient encounters over a six (6) month period (pg 280)**

- **Not subject to the “hospital based” exclusion if working predominantly in an FQHC i.e. inpatient or emergency room**



Identification of Qualifying Medicaid EPs

- **Definition of “so led” by a Physician Assistant (pg. 520)**
 - **When a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, CMS would consider the PA as the primary provider);**
 - **Where PA provides the majority of services and the physician provides the minority of services (identified by CMS staff on technical assistance call 7/23/10)**
 - **When a PA is a clinical or medical director at a clinical site of practice; or**
 - **When a PA is an owner of an RHC.**



Identification of Qualifying Medicaid EPs

Definition of Nurse Midwife (pg. 546)

- A registered professional nurse who meets the following requirements:
 - Is currently licensed to practice in the State as a registered professional nurse;
 - Is legally authorized under State law or regulations to practice as a nurse midwife,
 - Has completed a program of study and clinical experience for nurse-midwives as specified in the State, unless the State does not specify such a program
- In the case where the State has not specified a particular program of study and clinical experience, the regulation provides alternative means for demonstrating this training

Generally - so long as an EP qualifies as a practitioner within the State's scope of practice rules for each of the five EP types, they are eligible for this program



Identification of Qualifying Medicaid EPs

- **In order to be a meaningful user the EP must have 50% of their patient encounters in a practice/location where he/she uses a certified EHR**



30% Medicaid Rule and Exceptions

➤ Eligibility

➤ EP must have minimum of 30% of all patient encounters attributable to Medicaid over any continuous 90-day period within the most recent calendar year prior to reporting

➤ Two Exceptions

➤ Pediatricians

➤ 20 % attributable to Medicaid

➤ Medicaid EPs practicing Predominantly in an FQHC



Medicaid EPs practicing Predominantly in FQHC's

- EP must have minimum of 30% of all patient encounters attributable to “Needy Individuals” over any continuous 90-day period within the most recent calendar year prior to reporting



Definition of “Needy” Individuals

➤ They are

- Receiving medical assistance from Medicaid
- including
 - Medicaid MCOs
 - Prepaid Inpatient Health Plans (PIHPs)
 - Prepaid Ambulatory Health Plans (PAHPs)
- The Children's Health Insurance Program (CHIP)
- They are furnished uncompensated care by the provider
- They are furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay



➤ How Calculated:

➤ Numerator:

- EP's total number of Medicaid patient encounters
 - Any representative continuous 90-day period
 - Preceding calendar year

➤ Denominator:

- All patient encounters for the same individual professional
 - Over the same continuous 90-day period
- Must be a "representative period"



➤ **Bad debts are not included**

➤ **Use the Medicare definition of bad debt**

➤ **Should use the Medicare 222-92 Cost Report or most recent version of 222 to determine bad debt numbers**

➤ **All information under attestation is subject to audit**



Formula to Determine 30% "Needy Individuals

[Total (Needy Individuals) patient encounters in any continuous 90-day period in the preceding calendar year

Divided by

Total patient encounters in that same 90-day period] * 100



Flexibility to account for patients on Managed Care and/or Medical Home Panels (pg. 536)

{ [Total (Medicaid) patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year, with at least one encounter taking place during the calendar year preceding the start of the 90-day period] + [Unduplicated (Medicaid) encounters in the same 90-day period]

Divided by

[Total patients assigned to the provider in that same 90-day period, with at least one encounter taking place during the calendar year preceding the start of the 90-day period] + [All unduplicated encounters in that same 90-day period]} * 100



Definition of Encounter for “Needy Individuals” (pg. 538)

- Services rendered on any one day to an individual where Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid for part or all of the service;
- Services rendered on any one day to an individual where Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing; or
- Services rendered to an individual on any one day on a sliding scale or that were uncompensated.

We (CMS) understand that multiple providers may submit an encounter for the same individual. For example, it may be common for a PA or NP to provide care to a patient, then a physician to also see that patient. It is acceptable in circumstances like this to include the same encounter for multiple providers when it is within the scope of practice.

****States will determine their calculation strategy. Use of either²⁷ or both is acceptable to CMS****



Practice or Clinic “Needy Individual” Volume Allowed(pg. 542)

- 1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
 - 2) There is an auditable data source to support the clinic's patient volume determination; and
 - 3) So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data).
- The clinic or practice must use the entire practice's patient volume and Not limit it in any way.
 - EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year.
 - If the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.



Entity	Minimum 90-day Medicaid Patient Volume Threshold	Or the Medicaid EP practices predominantly in an FQHC or RHC - 30% “needy individual” patient volume threshold				
Physicians	30%					
Pediatricians	20%					
Dentists	30%					
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%					
Nurse Practitioner	30%					



- Incentive payments must generally be made directly to the EP
- Permits payment of incentive payments to “entities promoting the adoption of certified EHR technology,”
 - - Designated by the State
 - E.g. State Designated HIE
 - States must publish rules
 - Voluntary participation
- States would disburse reimbursements to EPs in alignment with the calendar year



➤ Payments to Medicaid EPs:

➤ Maximum of 85% of \$75,000 over 6 years

➤ 85% of \$25,000 1st year (\$21,250)

➤ Adopting, Implementing or Upgrading

➤ 85% of \$10,000 years 2 – 6 (\$8,500)

➤ Demonstrating “Meaningful Use”

➤ Total \$63,750

➤ Must begin receiving incentive payments no later than
CY 2016

The Secretary HHS has the authority to determine average
allowable costs (pg. 551)



➤ **Payments to Medicaid EPs: (pg. 553 & 554)**

➤ **Incentive Payments may be reduced due to payments from other non-State/local resources**

➤ **EPs Could Receive**

➤ **Up to \$29,000 from other sources in the 1st year and still be eligible for the full amount of \$21,250**

➤ **Up to \$10,610 in years 2 – 6 and still be eligible for the full amount of \$8,500**

➤ **HRSA Capital Improvement Program Grants do not reduce incentive payments (pg. 557)**

➤ **If EP is an employee of an FQHC it is assumed that the employer contributed the required 15% (pg. 558)**



Calendar Year	Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	\$21,250	-----	-----	-----	-----	-----
2012	\$8,500	\$21,250	-----	-----	-----	-----
2013	\$8,500	\$8,500	\$21,250	-----	-----	-----
2014	\$8,500	\$8,500	\$8,500	\$21,250		
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	-----	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	-----	-----	\$8,500	\$8,500	\$8,500	\$8,500
2019	-----	-----	-----	\$8,500	\$8,500	\$8,500
2020	-----	-----	-----	-----	\$8,500	\$8,500
2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750



Early Adopters: (pg. 566)

- Medicaid EPs who have already adopted, implemented, or upgraded certified EHR technology, and
- Can meaningfully use this technology in the first incentive payment year
- Are eligible to receive the same maximum payments, for the same period of time



- **EPs Must select either Medicare or Medicaid**
- **If working in multiple states must select only one state of participation**
- **Only pay to one TIN**
- **100% State Medicaid FFP will not start until January 1, 2011**



➤ Definitions of Adopting, Implementing or Upgrading EHR Technology

- Medicaid Incentives allow for payments even before an EP begins “meaningful use”
- Adopting, Implementing or Upgrading
 - Installed or commenced utilization of EHR Technology
 - Capable of meeting meaningful use
 - Expanded the available functionality and commenced utilization of the EHR Technology
 - Includes
 - Staffing
 - Maintenance
 - Training



➤ Definitions of Adopting, Implementing or Upgrading EHR Technology

➤ Attest to

- “Adopted” = Having Acquired, Purchased or Secured
- “Implemented” = Install or Commenced utilization
- “Upgraded” = Expanded the available functionality (pg. 814)

➤ Upgraded includes

- Staffing, Maintenance & Training
- Upgrading from an existing system to one that is “certified” (pg. 814)

➤ States must establish a verification process

- Submission of a vendor contract is recommended by CMS as one means of verification



➤ Definitions of Adopting, Implementing or Upgrading EHR Technology

➤ Adoption

- Demonstrate actual implementation prior to the incentive payment
 - “Efforts” to install are not sufficient
 - Researching EHRs or interviewing vendors would not meet the criteria
- Acquire
- Purchase or
- Secure
 - CMS is Seeking actual purchase/acquisition or installation



➤ Definitions of Adopting, Implementing or Upgrading EHR Technology

➤ Implementation

- Has installed certified EHR technology
- Has started using the certified EHR technology

➤ Activities would include

- Staff training on use of the technology

- Data entry of their patients' demographic and administrative data

- Establishing data exchange agreements and relationships between the technology and

➤ Other providers

- Laboratories
- Pharmacies
- HIEs



➤ Definitions of Adopting, Implementing or Upgrading EHR Technology

➤ Upgrade

➤ Expansion of the functionality of the EHR

➤ Addition of

- Clinical decision support

- E-Prescribing functionality

- CPOE

- Other enhancements that facilitate the meaningful use of certified EHR technology

- Moving to a newer version that is now “MU Certified” (pg. 593)



➤ Reporting Period

- Occurs on a rolling basis during the first payment year
 - Any continuous 90-day period
 - March 13, 2011 – June 11, 2011 and
 - January 1, 2011 – April 1, 2011
 - Both are valid
- On an annual basis for subsequent payment years
 - That is for the entire year
 - Must demonstrate meaningful use for any 90 day consecutive period in years 2 through 6**
 - There is no reporting period for the 1st year for adoption, implementation or upgrading (pg. 600)



➤ Objectives for the Core Set of Functional Measures

- Use CPOE (any licensed healthcare professional per state guidelines)
- Implement drug to drug and drug allergy interaction checks
- E-Prescribing (EP only)
- Record demographics
- Maintain an up-to-date problem list
- Maintain active medication list
- Maintain active medication allergy list
- Record and chart changes in vital signs
- Record smoking status
- Implement one clinical decision support rule
- Report CQM as specified by the Secretary
- Electronically exchange key clinical information
- Provide patients with an electronic copy of their health information
- Provide patients with an electronic copy of their discharge instructions (Eligible Hospital/CAH Only)
- Provide clinical summaries for patients for each office visit (EP Only)
- Protect electronic health information created or maintained by certified EHRs

-MUST CHOOSE ONE OF THE POPULATION & PUBLIC HEALTH MEASURES



➤ Objectives for the Core Set of Functional Measures

➤ All EPs Must Demonstrate Meaningful Use by Reporting on 15 Core Measures

And

➤ Reporting on an additional 5 Measures from a Menu of 10 Measures

➤ Medicaid EPs do not need to demonstrate Meaningful Use if they are adopting, implementing or upgrading in their 1st year



CORE SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
Improving quality, safety, efficiency, and reducing health disparities	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	More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE



CORE SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
Improving quality, safety, efficiency, and reducing health disparities	Implement drug-drug and drug-allergy interaction checks <u>Requires Only a Yes/No Attestation</u>	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
	Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology



CORE SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
Improving quality, safety, efficiency, and reducing health disparities	Record demographics > preferred language > gender > race > ethnicity > date of birth	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data



CORE SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
Improving quality, safety, efficiency, and reducing health disparities	Maintain active medication list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
	Maintain active medication allergy list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data



CORE SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
Improving quality, safety, efficiency, and reducing health disparities	Record and chart changes in vital signs: <ul style="list-style-type: none"> ➤ Height ➤ Weight ➤ Blood pressure ➤ Calculate and display BMI ➤ Plot and display growth charts for children 2-20 years, including BMI 	For more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data
	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data



CORE SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
Improving quality, safety, efficiency, and reducing health disparities	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule <u>Requires Only a Yes/No Attestation</u>	Implement one clinical decision support rule
	Report ambulatory clinical quality measures to CMS or the States **Not applicable for most Medicaid eligible providers as they will meet requirements under adoption, implementation or upgrading in 2011**	For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of this final rule ----- For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of this final rule



CORE SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
Engage patients and families in their health care	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon Request <u>Within 3 business days pg. 161</u>	More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days
	Provide clinical summaries for patients for each office visit <u>Within 3 business days pg. 178</u>	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days



CORE SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
Improve care coordination	<p>Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically</p> <p><u>Requires Only a Yes/No Attestation</u></p>	<p>Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information</p> <p><u>From EHR to EHR or through an HIE pg. 186</u></p> <p><u>Must be different legal entities with distinct EHRs pg. 191</u></p>
Ensure adequate privacy and security protections for personal health information	<p>Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</p> <p><u>Requires Only a Yes/No Attestation</u></p>	<p>Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process</p>



MENU SET

Stage 1 Objectives		
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
<p>Improving quality, safety, efficiency, and reducing health disparities</p>	<p>Implement drug formulary checks</p> <p><u>Requires Only a Yes/No Attestation</u></p>	<p>The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period</p>
	<p>Incorporate clinical lab test results into certified EHR technology as structured data</p>	<p>More than 40% of all clinical lab tests results ordered by the EP ...during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data</p>



MENU SET

Stage 1 Objectives		
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
<p>Improving quality, safety, efficiency, and reducing health disparities</p>	<p>Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach</p> <p style="text-align: center;"><u>Requires Only a Yes/No Attestation</u></p>	<p>Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition</p>
	<p>Send reminders to patients per patient preference for preventive/ follow up care</p>	<p>More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period</p>



MENU SET

MENU SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
<p>Engage patients and families in their health care</p>	<p>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</p> <p style="text-align: center;"><u>Within 4 business days pg. 171 & 172 PHR, portal, web site, secure email, USB, CD or paper pg. 179</u></p>	<p>More than 10% 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</p>
	<p>Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate</p>	<p>More than 10% of all unique patients seen by the EP.....are provided patient-specific education resources</p>



MENU SET

MENU SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
<p>Improve care coordination</p>	<p>The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation</p> <p style="text-align: center;"><u>Ability to calculate the measure is incorporated into certified EHRs pg. 196</u></p>	<p>The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to.....</p>
	<p>The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral</p> <p style="text-align: center;"><u>Electronic, via HIE, or paper – must be generated by EHR Pg. 200</u></p>	<p>The EP, eligible hospital or CAH 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% of transitions of care and referrals</p> <p style="text-align: center;"><u>Ability to calculate the measure is incorporated into certified EHRs pg. 201</u> 55</p>



MENU SET

MENU SET		
	Stage 1 Objectives	
Health Outcomes Policy Priority	Eligible Professionals	Stage 1 Measures
<p>Improve population and public health</p> <p><u>(Must Complete 1 of these as part of Menu Set)</u></p>	<p>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice</p> <p style="text-align: center;"><u>Only applies if performed 1 or more immunizations during reporting period pg.203</u></p>	<p>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)</p>
	<p>Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice</p> <p style="text-align: center;"><u>Requires Only a Yes/No Attestation</u></p>	<p>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,submits such information have the capacity to receive the information electronically)</p>



Reporting on Clinical Quality Measures

- States must identify how they will accept Quality Measures in their HIT Plan
 - Directly or
 - Via Attestation

- Describe how they will inform EPs of their timeframe to accept submission of Quality Measures



➤ Quality Measures can be

➤ Process

➤ Experience

➤ Outcomes of Patient Care

➤ Observations or Treatment that relate to other quality aims

➤ Effective

➤ Safe

➤ Efficient

➤ Patient-Centered

➤ Equitable and

➤ Timely Care

➤ Electronic specifications of the clinical quality measures for EPs, eligible hospitals, and CAHs are displayed on the CMS website at

http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage

CMS will seek to align Quality Measures in future rulemaking



Core Measures Required for Reporting
Table 7 pg. 287

NQF Measure Number & PQRI Implementation Number	Clinical Quality Measure Title
NQF 0013	Title: Hypertension: Blood Pressure Measurement
NQF 0028	Title: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment b. Tobacco Cessation Intervention
NQF 0421 PQRI 128	Title: Adult Weight Screening and Follow-up
	<i>Alternate Core Measures</i>
NQF 0024	Title: Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	Title: Preventive Care and Screening: Influenza Immunization for Patients \geq 50 Years Old
NQF 0038	Title: Childhood Immunization Status



➤ Quality Measures

➤ EPs must report on 6 total Quality Measures

➤ 3 from previous slide (Table 7)

➤ Or

➤ the Alternates from previous slide if the first 3 are 0

➤ And

➤ 3 from the list of 38 in Table 6 (pg. 272)

➤ States will determine how attestation will be administered in each state



Reporting on Quality Measures does not start for Medicaid EPs until the 2nd year

FQHCs will still need to report on HRSA Measures

CMS will look to harmonize measures in Stage 2 and Stage 3 with input from Stakeholders



➤ EPs May change programs

➤ Prior to 2014 an EP may elect to switch from Medicare to Medicaid programs or vice versa

➤ When switching to the Medicare program

➤ All years spent in the Medicaid program count towards a payment year

➤ This is not true for Medicaid

➤ There is flexibility – years do not need to be continuous (pg. 352 & 353)

➤ Can never receive more than the Medicaid maximum incentive payment



Information Required from EPs (pg 355 & 356)

- **EPS must provide**
 - **Name of EP**
 - **National Provider Number (NPI)**
 - **Business Address and phone number**
 - **Practice address – cannot be a PO Box**
 - **Taxpayer Identification Number (TIN) to which EPs incentive payment should be made**
 - **Notify CMS if the EP is choosing the Medicaid or Medicare incentive program**
 - **EPs allowed to make a one-time switch from one program to the other**
 - **A medical secretary can register on their behalf (pg. 667 & 672)**
 - **EPs are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement (including part 424, subpart F)**

Must be consistent with §495.10 with Defined in clause (A) of section 1842(b)(6) of the Act and in accordance with regulations at 42 CFR 424.73 and 42 CFR 424.80



How do Payments Occur

- States disburse payments consistent with the calendar year to EPs and must submit their plan to CMS
- States need to verify annually with EPs
- EPs must state: "This is to certify that the foregoing information is true, accurate, and complete. I understand that Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws."



Conditions for States to Receive Federal Financial Incentives

Section 1903(a)(3)(F) of the Act (pg 333 12/30/09)

- States are eligible for 100 percent FFP for direct payment expenditures to certain Medicaid EPs
 - To adopt, implement, upgrade and meaningfully use certified EHR technology
 - 90 percent FFP for reasonable administrative expenses
 - (1) using the funds to administer Medicaid incentive payments for certified EHR technology, including tracking of meaningful use by Medicaid EPs and eligible hospitals;
 - (2) conducting oversight of the Medicaid EHR incentive program, including routine tracking of meaningful use attestations and reporting mechanisms; and
 - (3) pursuing initiatives to encourage the adoption of certified EHR technology for the promotion of health care quality and the exchange of health care information.



Coordinated by the National Association of Community Health Centers

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For more information and to download the document referred to throughout this presentation visit the NACHC web site HIT Section at

<http://www.nachc.com/meaningfuluseofhit.cfm>

Download – [Overview of CMS Final Rule on EHR Adoption](#)

To find certified health information technology go to the “ONC Certified Health Product List” <http://onc-chpl.force.com/ehrcert>

Or Contact

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