


**Meaningful Use Defined:  
Now What?**



**Wide River**  
Technology Extension Center

**Nebraska's Regional Extension Center**  
July 23, 2010

This document was developed by CIMRO of Nebraska through funding from the United States Office of the National Coordinator, Department of Health and Human Services, grant number 9060203401, Form No. 0016-0710

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**Introductions**

**Wide River Technology Extension Center**

- Renee' Rowell, Meaningful Use Specialist
- Jennifer Rathman, Communications Manager
- Dr. Bob Rauner, Principal Clinical Coordinator
- Todd Searls, Director

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**Agenda**

- Introduction
- HITECH Act- Incentives and Timelines
- Meaningful Use Summary
- How can Wide River TEC help Priority Primary Care Providers in Nebraska meet Meaningful Use?
- Q&As
- Closing Comments

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**Regional Extension Centers:  
Introduction**

Todd Searls  
Director



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**What is a Regional Extension Center (REC)?**

RECs were created by the Office of the National Coordinator for Health Information Technology (ONC) to assist Priority Primary Care Providers (PPCP) with their selection, implementation and meaningful use of certified EHR technology.

- 60 REC grants were awarded
- Goal to assist 100,000 providers over two years meet Meaningful Use

**Wide River Technology Extension Center (TEC)** was awarded the Regional Extension Center contract for the state of Nebraska in February 2010.

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**Network of Support**

- Regional Extension Centers are supported by:
  - **Health Information Technology Research Centers (HITRC)**
    - Designed by the ONC to quickly disseminate information to all RECs
    - Facilitate regional collaboration
    - Leverage the power of the 60 RECs to engage vendors on behalf of all REC clients
  - **Each of the other RECs**
    - Community of Practices exist to share best practices, vendor information and solve problems facing all RECs
  - **Vendors**
    - Some vendors have offered non-branded, de-identified and unbiased technical and workflow training to REC staff and their clients
    - Other vendors have offered discounted services to REC clients, covering everything from hardware and network installation to HIPAA auditing and staffing services

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### Primary Care Priority

**REC priority will be given to sites which have Primary Care Providers in any of the following settings:**

- Individual and small group practices (10 or fewer professionals with prescriptive privileges) primarily focused on primary care
- Public and Critical Access Hospitals
- Community Health Centers and Rural Health Clinics
- Other settings that predominantly serve uninsured, underinsured and medically underserved populations

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### HITECH Act – Incentives and Timelines

Dr. Bob Rauner  
Principal Clinical Coordinator




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### Who is a Medicare Eligible Provider?

Eligible Providers in Medicare FFS	
<b>Eligible Professionals (EPs)</b>	
Doctor of Medicine or Osteopathy	
Doctor of Dental Surgery or Dental Medicine	
Doctor of Podiatric Medicine	
Doctor of Optometry	
Chiropractor	
<b>Eligible Hospitals</b>	
Acute Care Hospitals *	
Critical Access Hospitals (CAHs)	

\* Subsection (d) hospitals that are paid under the PPS and are located in the 50 states or Washington, DC (including Maryland)

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### Who is a Medicaid Eligible Provider?

Eligible Providers in Medicaid/Pt. Volume Thresholds
<b>Eligible Professionals (EPs)</b>
Physicians (30% patient volume threshold)
Nurse Practitioners (NPs) (30% patient volume)
Certified Nurse-Midwives (CNMs) (30% patient volume)
Dentists (30% pt. volume)
Physician Assistants (PAs) working in a FQHC or RHC that is so led by a PA (30% pt. volume)
<b>Eligible Hospitals</b>
Acute Care Hospitals (now including CAHs) (10% pt. volume)
Children's Hospitals (no requirement of volume/threshold)

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### Medicaid Eligibility: “Practices Predominantly” and “Needy Individuals”

- Eligible Professionals (EP) are eligible when *practicing predominantly* in FQHC/RHC providing care to *needy individuals*
- *Practicing predominantly* is when FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year
- *Needy Individuals* include:
  - Medicaid or CHIP enrollees
  - Patients furnished uncompensated care
  - Patients furnished services at either no or a sliding fee basis

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### Medicaid Only: Adopt/Implement/Upgrade (A/I/U)

- First participation year only for Medicaid providers
- Adopted –Acquired and Installed  
*Example: Evidence of installation prior to incentive*
- Implemented –Commenced Utilization of  
*Example: Staff training, data entry of patient demographic information into EHR*
- Upgraded –Expanded  
*Example: Upgraded to certified EHR technology or added new functionality to meet the definition of certified EHR technology*
- Must use certified EHR technology
- No EHR reporting period

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**Incentive Payments for Medicare EPs –**  
First CY in which the EP receives an incentive payment

Calendar YR	2011	2012	2013	2014	2015 and after
2011	\$18,000				
2012	\$12,000	\$18,000			
2013	\$ 8,000	\$12,000	\$15,000		
2014	\$ 4,000	\$ 8,000	\$12,000	\$12,000	
2015	\$ 2,000	\$ 4,000	\$ 8,000	\$ 8,000	\$0
2016		\$ 2,000	\$ 4,000	\$ 4,000	\$0
TOTAL	\$44,000	\$44,000	\$39,000	\$24,000	\$0

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**Incentive Payments for Medicaid EPs**  
First CY in which the EP receives an incentive payment

CY	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

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**Timeline for 2011**

**Medicare:**

- Requires that you are a “meaningful user” for 90 consecutive days in 2011
- You need your certified EHR installed and fully implemented by September 30, 2011 and then “meaningfully use” for 90 days

**Medicaid:**

- Your need to Adopt/Implement/Upgrade to a certified EHR in 2011
- You need your certified EHR installed by Dec. 31, 2011

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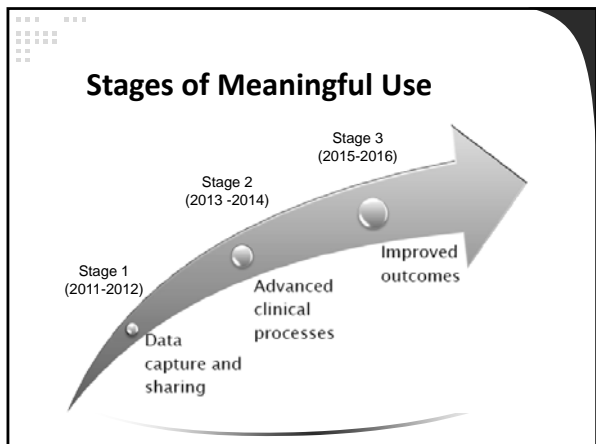
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### Meaningful Use Summary

Renee' Rowell  
Meaningful Use Clinical Specialist

*Wide River*  
Technology Extension Center

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- ### What the Final Rule Does
- Harmonizes MU criteria across CMS programs
  - Closely links with the ONC Certification and Standards final rules
  - Builds on the recommendations of the HIT Policy Committee and Public Commenters
  - Coordinates with existing CMS quality initiatives
  - Provides a platform that allows for a staged implementation of EHRs over time

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### Meaningful Use: HITECH Act Description

The Recovery Act specifies the following three components of Meaningful Use:

1. Use of certified EHR in a **meaningful manner** (e.g., e-prescribing)
2. Use of certified EHR technology for **electronic exchange** of health information to improve quality of healthcare
3. Use of certified EHR technology to submit **clinical quality measures** (CQM) and other such measures selected by the Secretary

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### Meaningful Use: Basic Overview of Final Rule

Stage 1 (2011 and 2012)

- To meet certain objectives/measures, 80% of patients must have records in the certified EHR technology
- EPs have to report on 20 of 25 MU objectives
- Eligible hospitals have to report on 19 of 24 MU objectives
- Reporting period –90 days for first year; one year subsequently

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### Meaningful Use: Changes from the NPRM to the Final Rule

NPRM	Final Rule
Meet all MU reporting objectives ("all or nothing")	Must meet "core set"/can defer 5 from optional "menu set" (flexibility)
25 measures for EPs/23 measures for eligible hospitals	25 measures for EPs/24 for eligible hospitals
Measure thresholds range from 10% to 80% of patients or orders (most a higher range)	Measure thresholds range from 10% to 80% of patients or orders (most at lower to middle range)
Denominators – To calculate the threshold, some measures required manual chart review	Denominators – No measures require manual chart review to calculate threshold
Administrative transactions (claims and eligibility) included	Administrative transaction removed
Measures for Patient-Specific Education Resources and Advanced Directives discussed but not proposed	Measures for Patient-Specific Education Resources and Advanced Directives (for hospitals) included

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### Meaningful Use: Changes from the NPRM to the Final Rule (Cont'd)

NPRM	Final Rule
States could propose requirements above/beyond MU floor, but not with additional EHR functionality	States' flexibility with Stage 1 MU is limited to seeking CMS approval to require 4 public health-related objectives to be core instead of menu
Core clinical quality measures (CQM) and specialty measure groups for EPs	Modified Core CQM and removed specialty measure groups for EPs
90 CQM total for EPs	44 CQM total for EPs – must report total of 6
CQM not all electronically specified at time of NPRM	All final CQM have electronic specifications at time of final rule publication
35 CQM total for eligible hospitals and 8 alternate Medicaid CQM	15 CQM total for eligible hospitals
5 CQM overlap with CHIPRA initial core	4 CQM overlap with CHIPRA initial core set

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- ### Clinical Quality Measures (CQM) Overview
- 2011 - EPs, eligible hospitals and CAHs seeking to demonstrate MU are required to **SUBMIT** aggregate CQM (num/den and exclusion data) to CMS or state **BY ATTESTATION**
  - 2012 - EPs, eligible hospitals and CAHs seeking to demonstrate MU are required to **electronically submit** aggregate CQM (num/den and exclusion data) to CMS or the individual state

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### Notable Differences between the Medicare & Medicaid Programs

Medicare	Medicaid
Federal Government will implement (will be an option nationally)	Voluntary for States to implement (may not be an option in every state)
Payment reductions begin in 2015 for providers that do not demonstrate Meaningful Use	No Medicaid payment reductions
Must demonstrate MU in Year 1	A/I/U option for 1 <sup>st</sup> Participation year
Maximum incentive is \$44,000 for EPs (bonus for EPs in HPSAs)	Maximum incentive is \$63,750 for EPs
Last year a provider may initiate program is 2014; Last year to register is 2016; Payment adjustments begin in 2015	Last year a provider may initiate program is 2016; Last year to register is 2016 (Last year to receive Incentive 2021)
Only physicians, subsection (d) hospitals and CAHs	5 types of EPs, acute care hospitals (including CAHs) and children's hospitals

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**Registration Overview**

All providers must:

- Register via the EHR Incentive Program Web site
  - 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 Medicaid providers may adopt, implement, or upgrade in their first year
- All Medicare providers and Medicaid eligible hospitals must be enrolled in PECOS

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**EHR Incentive Program Timeline**

- January 2011 –Registration for the EHR Incentive Programs begins
- January 2011 –For Medicaid providers, States may launch their programs if they so choose
- April 2011 –Attestation for the Medicare EHR Incentive Program begins
- May 2011 –EHR incentive payments begin
- November 30, 2011 –Last day for eligible hospitals and CAHs to register and attest to receive an incentive payment for FFY 2011

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**EHR Incentive Program Timeline**

- February 29, 2012 –Last day for EPs to register and attest to receive an incentive payment for CY 2011
- 2015 –Medicare payment adjustments begin for EPs and eligible hospitals that are not meaningful users of EHR technology
- 2016 –Last year to receive a Medicare EHR incentive payment; Last year to initiate participation in Medicaid EHR Incentive Program
- 2021 –Last year to receive Medicaid EHR incentive payment

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**Wide River TEC and PPCPs:  
Partnering to Achieve Meaningful Use**

Todd Searls  
Director



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**Our Approach**

- **100% Vendor Agnostic**
  - Wide River TEC will not publish a “Selected / Preferred” vendor list
    - Request for information (RFI) provided to interested vendors
      - ~35 initial vendor responses , totaling 40+ EHR solutions
      - No vendor rejected unless they failed to follow the RFI requirements
    - Organized responses into a “vendor matrix”
      - Any data not marked “confidential” by the vendor can be tabulated for client reference
      - Confidential data is treated as a null answer, which means the vendor will miss being selected because they will not allow us to share their data with our clients directly
  - Vendor lists and questions are continually updated based on new information provided by the vendors, requested by our clients, and/or as directed by the ONC/CMS with respect to Meaningful Use standards

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**It Is All About You!**

- **Client Focused**
  - Partnering with you throughout the entire process, providing end-to-end project management and consulting services
    - Wide River TEC will work closely with you to identify and document your EHR goals and vendor selection criteria based on your sites unique circumstances, workflows and technological abilities
    - Deliver complete workflow, site and technology assessments to help you understand any and all pain points that will occur as you change from paper to electronic documentation

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**It Is All About You!**

- Help you identify onsite project team members and super users who will continue to assist your staff long after “go-live” has come and gone
- Facilitate site-to-site and peer-to-peer discussions to educate and inform you about particular vendors and/or EHR concerns prior to contract signing
- Provide detailed Meaningful Use education to accelerate incentive attestation for every PPCP in your practice

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- Total PCP: 2,532
- Priority PCP Goal: 1,200
- Population: 1.8 million
- Projected Patients Served: 570,600

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**Direct Assistance Segments & Fees**

**Priority PCP (Years 1 and 2)**

- Providers will be asked to pay a very small portion of the cost
- Providers can utilize direct incentive dollars to cover their match

**Priority PCP (Years 3 and 4) and Non-Priority PCP (Years 1-4)**

- Providers will be asked to pay a TBD fee based on a number of factors, including current EHR adoption state and gap analysis
- Providers can still utilize direct incentive dollars to cover their match

**Promotional Pricing Coming Soon!**  
Look for Promotional Pricing to be announced for qualified clients (TBD) in early August

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**Wide River TEC Overview**

Grant Recipient: *CIMRO of Nebraska*  
Structure: *Wide River TEC is a business unit of CIMRO of Nebraska*  
Funding Amount: *\$6.6 million*  
Funding Structure: *Years 1 & 2, 90%/10%; Years 3 & 4, 10%/90%*  
Service Area: *State of Nebraska*  
Website: [www.widerivertec.org](http://www.widerivertec.org)  
Vision: *Our vision is to make healthcare in Nebraska the nation's best.*  
Mission: *Our mission is to create a respected, reputable, and sustainable entity that will promote the use of HIT to improve healthcare quality and efficiency through the authorized and secure use and electronic exchange of health information.*

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**Q & As**

**How to ask a question -**

- Webinar Attendees – Click on the raise your hand button and your line will be unmuted
- Teleconference Attendees – You can submit questions via email to [contact@widerivertec.org](mailto:contact@widerivertec.org). We will answer questions as they come in

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**Interested in Wide River TEC Events?**

View our calendar for upcoming events at <http://www.widerivertec.org/home/events.aspx>

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Contact Information

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E: [contact@widerivertec.org](mailto:contact@widerivertec.org)



The logo for Wide River Technology Extension Center features the words "Wide River" in a stylized, cursive font, with "Technology Extension Center" in a smaller, sans-serif font below it. The logo is set against a light, curved background element.

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