EHR Federal Mandates, Incentives and Your Practice

A Guide to Understanding the New Landscape of Electronic Health Records

About This Document

The intention of this guide is to provide physicians and practice administrators with *highlights* of nearly 1500 pages of federal legislation (the ARRA/HITECH Act and subsequent proposed and finalized rules from HHS) that provides financial incentives for EHR implementation & usage. The reader is encouraged to fully investigate the legislation and rules themselves before making any assumptions or decisions based on the contents of this guide.

For more details and updates regarding ARRA, HITECH and EHR incentives, please contact

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What's All This About?

In February 2009, the medical practice landscape changed dramatically with the signing of the **American Recovery and Reinvestment Act (ARRA)**. Included in this large piece of legislation was the **HITECH Act**, which seeks to improve the nation's healthcare IT infrastructure through a collection of mandates, incentives, and penalties. Primary among HITECH's goals is the widespread introduction and interoperability of electronic health/medical records (EHR or EMR).

Between February and the end of 2009, offices and workgroups within the Department of Health and Human Services (HHS) held myriad hearings and public sessions to formulate the proposed regulations that provide meat to HITECH's bone. After releasing preliminary rules in December 2009, final rules and regulations were adopted and released in July 2010. These rules were published in the Federal Register and will become law in September 2010.

On July 13th, 2010, CMS released a final rule entitled "**Medicare and Medicaid Programs; Electronic Health Record Incentive Program**." This rule codified the participation requirements the incentive programs, including eligibility guidelines, objectives and measures that must be met for a health provider to receive incentive dollars from either the Medicare or Medicaid versions of the program. (Note: This rule is referred to as the "MU Rule" throughout this guide.)

Also released in July by the Office of the National Coordinator for Health Information Technology (ONC) was the "**Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology**". This rule sets initial standards, implementation specifications, and certification criteria for EHR technology. This is the initial set of capabilities that EHR technology will need to provide in order to support Stage 1 Meaningful Use requirements, as explained later in this document. (Note: This rule is referred to as the "Certification Rule" throughout this guide.)

Another rule entitled "**Establishment of the Temporary Certification Program for Health Information Technology**" was released in June 2010. This rule defined the programs that will provide officially-sanctioned certifications for EHR solutions. (Note: This rule is referred to as the "Certifying Body Rule" throughout this guide.)

The purpose of this guide is to *highlight* the most salient highlights of the rules for Medicare FFS providers in the specialized ambulatory community. Altogether, these three rules constitute nearly 1,500 pages of federal regulations. Therefore, it is not possible to include all details in this guide. Those intending to participate in the program are encouraged to review the official documentation at www.cms.gov/EHRIncentivePrograms.

NOTES: This document focuses on HITECH as applied in the ambulatory setting, rather than hospitals. The proposed regulations and definitions apply very different standards to physicians and other eligible professionals in each setting.

HITECH: Quick Facts

Given the enormity of the legislation and the lightening-like pace at which it's been rolled out, it's not surprising that many of those it impacts are unsure of even its most basic points. What's below is a collection of quick facts to provide a 30,000-foot view of HITECH and the EHR incentive programs it creates.

- The American Reinvestment and Recovery Act (ARRA) of 2009 provides significant financial incentives for EHR implementations over a five year period, starting in 2011. Incentives can total up to $44,000 per physician or $63,750 for Medicaid providers. (Incentives can only be recognized with Medicare/Medicaid billing and volume thresholds. See the sections below for more details regarding both programs.)
- The incentives are "front-loaded" in a manner meant to encourage early adoption (75% paid out in the first two years). Essentially, the later physicians wait to install EHRs, the fewer incentive dollars they'll see.
- To receive ARRA incentives, physicians must demonstrate "meaningful use" (MU) of a "certified EHR".
- To make the transition process more manageable, MU requirements have been broken into three stages, which will be phased in over the next five years.
- Requirements for hospitals and independent physicians are not identical. Likewise, requirements for Medicare and Medicaid providers are different. This guide specifically discusses the incentive program for ambulatory-based physicians. See the sections below for details regarding the Medicare and Medicaid programs.
- A dual set of certification programs, one temporary and the other permanent has been created. The former is intended to "fast-track" the identification of an initial and temporary EHR certification process, so that providers can identify and purchase HHS-acceptable EHR solutions in time for 2011 incentives. The second, permanent certification process would be in place by early 2012 and replace the temporary process.
- HHS expects 90% of all EHRs with CCHIT® 2008 or later certification to "be prepared for certification" to the new Complete EHR criteria.
- What should you do to participate in the programs?
    - If your practice hasn't already implemented an EHR, you need to start the EHR evaluation/buying process as soon as possible.
    - If your practice is currently using an EHR:
        - Check with your vendor to make sure they intend to provide a solution that will be certified for ARRA incentives. Keep in mind that the certification process is only now getting underway. So, right now, both you and your vendor are in a "hurry up and wait" mode. In other words, there's only so much either you or your vendor can do at this point in time.
        - Ask your vendor how they intend to deploy the ARRA-certified version to customers. Will there be an additional cost to you? Will it require on-site activity on their part? Are there any activities you should be doing to prepare

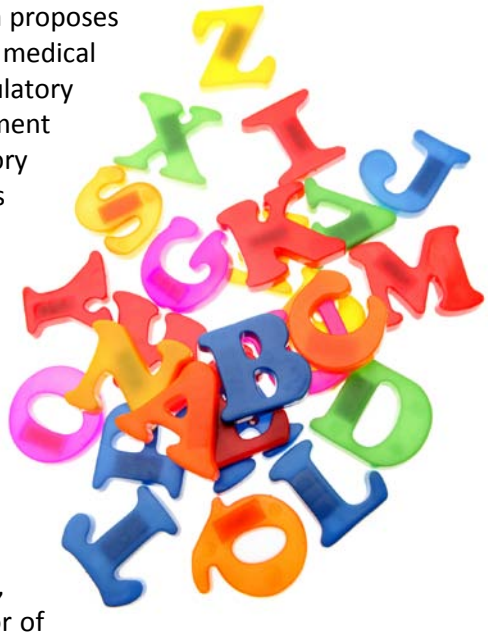
either your system or your staff for the update? Do you need to go ahead and put your name on a list?

- Keep in regular contact with your EHR vendor to determine their schedule/readiness for ARRA certification.

What follows is a more detailed explanation of how we arrived where we are now, the implications for US medical practices, and timeline details that will help you recognize the earliest and largest federal incentive payments for EHR usage.

Acronyms Abound: Basic Definitions

Before we continue any further, let's put some quick definitions to acronyms and titles you'll find sprinkled throughout this material. Many of them will be more fully explained in due time, but it's important that a basic understanding is established now, so that early references don't leave you scrambling for Google or Wikipedia.

ARRA	The American Recovery and Reinvestment Act of 2009. (Also known as the "stimulus package.") Major federal omnibus spending bill passed in February 2009 with the intention of "jump starting" the faltering economy. Of interest here because of the portion known as *HITECH*
EP	Eligible Professional. The regulation proposes different requirements for medical professionals who practice in ambulatory and hospital settings. This document covers those within ambulatory settings only. Further distinctions are made between those participating in the Medicare and Medicaid programs. General identifying remarks are presented here; more detail and requirements are detailed later in this document.  Medicare EP: Doctor of Medicine or Osteopathy, Doctor of Dental Surgery or of Dental Medicine, Doctor of Podiatric Medicine, Doctor of Optometry, Chiropractor. Medicaid EP: a physician, dentist, certified nurse midwife, nurse practitioner, and physician assistant practicing in a Federally Qualified Health Center or Rural Health Clinic that is led by a PA.

CCHIT®	The Certification Commission for Health Information Technology (www.cchit.org). An independent, non-profit organization that was initially started by the nation's major health IT organizations and a subsequent grant from the US government. This group has provided certification programs for EMRs/EHRs since 2006 and has recently been approved by CMS to be a temporary certifying body for the EHR Incentive Program. Note: The Drummond Group (www.drummondgroup.com) has also been approved by CMS as a temporary certifying body for the EHR Incentive Program and others may follow.
HITECH	The Health Information Technology for Economic and Clinical Health Act. Section of ARRA that provides for substantial investments in the nation's health information technology system, including the widespread use of electronic health records.
MU	Meaningful Use. Usage and reporting standards required for EHR incentives. Discussed in detail below.
ONCHIT/ONC	Office of the National Coordinator of Health Information Technology (aka "ONCHIT" or "ONC"), a section within the Department of Health & Human Services. Established via executive order by President Bush in 2004 and charged with improving the nation's health IT infrastructure. The National Coordinator's position is currently held by David Blumenthal, MD, a practicing physician and former professor at Harvard Medical School and director of the Institute for Health Policy at Partners Healthcare System in Massachusetts.
ONC-AA	ONC-Approved Accreditor. An organization recognized by the ONC that will accredit EHR certification bodies. These groups are only recognized in the *permanent* certification program. Probably created/recognized in 2012.
ONC-ACB	ONC-Authorized Certification Body. An organization recognized by an ONC-AA that will certify EHR solutions. These groups are only recognized in the *permanent* certification program. Probably created/recognized in 2012.
ONC-ATCB	ONC-Authorized Testing and Certification Body. An organization authorized by ONC to perform both EHR testing and certification functions. These dual-natured entities were created to serve EPs who wish to participate in the incentive program in 2011. These groups are only recognized in the *temporary* certification program and are essentially displaced by ONC-ACBs in the permanent program, once they are created.

Medical Record Solutions: What's in a Name?

Currently, the market is congested with many different brands of electronic records (at last count, there were over 300 vendors). Generally, however, only a few functional-models exist among the throngs, each providing very different solutions for their users. Given recent events on the federal level, it's worth a few minutes to review the major product-types and discuss the mechanisms that are likely to influence the outcome of the evolutionary struggle.

Scanning Solutions (aka Document Management Systems)

Also referred to as "hybrid EMRs," these systems primarily collect data by scanning hardcopy documents into electronically-formatted images, which are then collected into individual patient "records". These solutions offer benefits such as simplified implementations and oftentimes claim to lessen the impact on the physician's workflow. However, hybrid EMRs also present potential liabilities, such as the general inability to capture and, thus, report on discrete data points. When such a weakness is viewed in light of today's federal standards and incentive requirements, scanning systems usually fall short of what many physicians see as solutions with much stake in the future of healthcare data management. Indeed, an August 2009 survey performed by Health Data Management Journal found that fully 75% of respondents felt that "electronic health records systems that rely extensively on document imaging and management technology will find it difficult to meet the stimulus law's forthcoming meaningful use requirements." (More about the "stimulus law" and "meaningful use" later.)

EMRs (aka Electronic Medical Records)

Unlike their scanning-based cousins, EMRs are highly interactive solutions that allow physicians to enter data directly into the solution as well as import data from disparate systems into a single patient record. An EMR's interoperability means that information may originate from nearly any source, including data gathered during encounters themselves, templates, patient web portals, interfaces with peripheral equipment (imaging systems, diagnostic instruments, etc.), scanned documents, etc. Traditionally, EMRs provide *enterprise-wide solutions* that are used within a *single* facility or healthcare entity.

One often-overlooked differentiator is the manner in which information is stored in the system's database. Many solutions do not promote database uniformity, as random customizations at one site necessarily mean its structure differs from that of all the others. Such differences have made it very difficult for vendors to offer effective reporting functions. Furthermore, these structural variations cause issues for vendors during troubleshooting or upgrade activities. However, vendors that feature consistent database structures, find it much easier to support their systems and supply

fully-fledged reporting tools that can dive deeply into the data being collected. This situation becomes important as the nation moves toward EHRs…

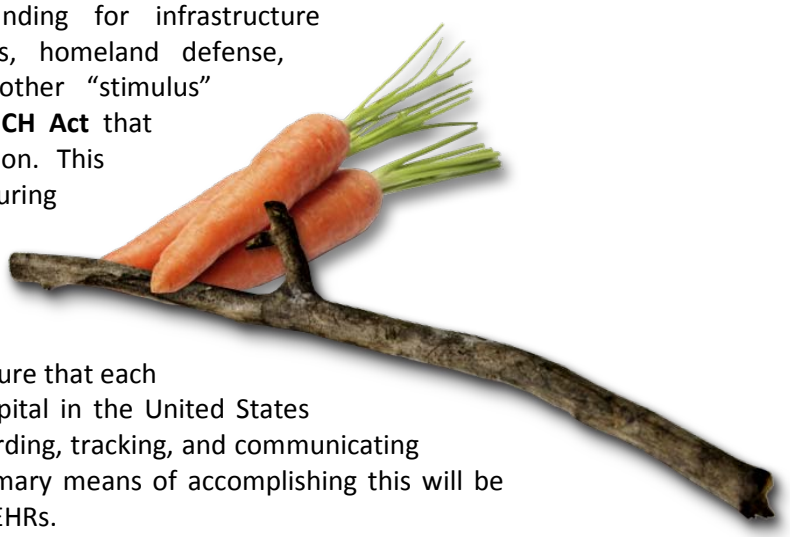
EHRs (aka Electronic Health Records)

The term "electronic health record" was once the catch-all phrase used to describe every sort of electronic records system created over the last 50 years. However, in the last few years, both the Bush and Obama administrations have adopted the term and refined its meaning. Today, EHRs are viewed as systems of *longitudinal* patient health information that exist across a *community* of care-givers. Herein is the primary difference between EMRs and EHRs: the sharing of data with other healthcare records systems. Generally, a patient's electronic health record is not "owned" by any one physician or practice (as is the case with EMRs). Rather, EHRs allow multiple entities to compile and access data in a manner that creates a more *unified patient record*.

Take note, however, that the industry is in a "label-transition," with many vendors moving their marketing terminology from "EMR" to "EHR". There are certainly differences between the two models. EMRs typically exist within *individual* facilities, while EHRs' more conceptual nature serves to *unify* the data gathered among many EMRs (and other sources). However, the marketplace and other certifying and federal bodies are clearly moving toward labeling both individual and unified electronic record solutions as "EHRs".

ARRA & HITECH: Carrots and Sticks

ARRA includes measures and funding for infrastructure improvements, education programs, homeland defense, alternative energy projects, and other "stimulus" initiatives. Of course, it's the **HITECH Act** that draws most of this audience's attention. This section of ARRA is dedicated to ensuring significant improvements in the nation's health IT system.



One of HITECH's major goals is to ensure that each physician, medical practice, and hospital in the United States move to an electronic means of recording, tracking, and communicating patient health information. The primary means of accomplishing this will be through the widespread adoption of EHRs.

Removing Obstacles

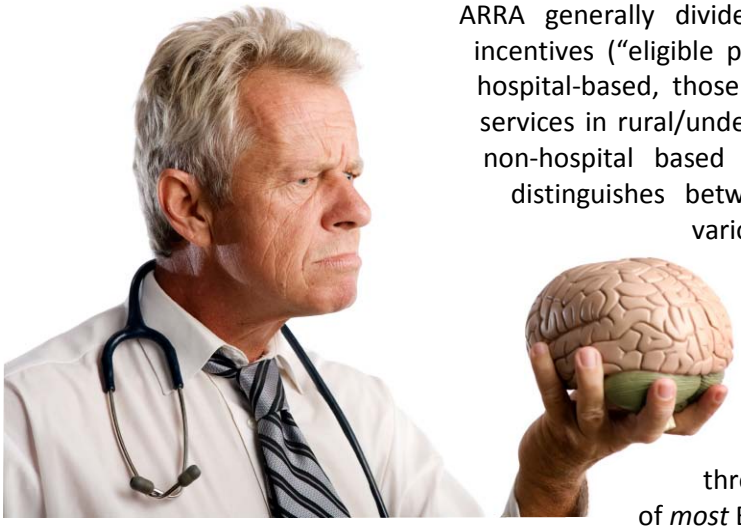
What HITECH attempts to accomplish is the removal of the three primary, historic obstacles to EMR/EHR adoption. HITECH attempts to remedy these issues through a collection of mandates, certifications, and incentives.

- **Cost**
  HITECH recognized cost as a major impediment to widespread implementation and has structured financial incentives (aka the "carrot") to make the digital jump more palatable. Many physicians can recognize a positive return on their investment when incentives alone are taken into account.

- **Inertia / Reluctance to "Jump in the Pool"**
  Simply put, the payment and penalty structure serves as a mandate of sorts to encourage much greater adoption rates, sooner rather than later. To encourage more immediate implementations, the incentives are front-loaded, meaning that the longer a practice waits to begin using an EHR, the smaller the potential overall incentive. After 2014, incentives will no longer be paid at all. Finally, the government's "stick" shows itself, as penalties begin to be assessed in the form of reduced Medicare payments, beginning in 2015 and escalating in the years afterward.

- **Doubts about Capabilities**
  Criteria used by CCHIT in its earlier certification programs have evolved over the years through the input of health IT associations, medical professionals, vendors, and public policy groups. The result has been standards forged through experience that reflect the actual needs of the healthcare community. Upon passage of HITECH into law, the ONC's Meaningful Use Committee worked with CCHIT to build a new list of criteria from its finished 2008 and preliminary 2009/11 certification standards as well as additional requirements added by various members and groups (see the "Objectives and Measures" section below). The finalized rules integrate much of this input and the certification process makes it much more likely that certified EHRs provide the capabilities needed by physicians and their staffs.

EP or Not EP… *that* is the Question.



ARRA generally divides those who are eligible for the incentives ("eligible providers" or EP) into those who are hospital-based, those who aren't and those who provide services in rural/underserved areas. (This guide highlights non-hospital based EPs only.) Furthermore, the law distinguishes between those who participate in the various Medicare and Medicaid/needy-individual programs. The table below details those providers who may qualify for EHR incentive payments. Keep in mind, however, that the concept of Meaningful Use (discussed in the next section) runs throughout the programs and is required of *most* EPs to qualify for payments.

Medicare	• Doctor of Medicine or Osteopathy (MD, DO) • Doctor of Dental Surgery of Dental Medicine (DDS, DMD) • Doctor of Podiatric Medicine (DPM) • Doctor of Optometry (OD) • Chiropractor (DC)
Medicaid	• Physicians (MD, DO, DPM) • Dentists (DDS, DMD) • Certified Nurse-Midwives (CNMW) • Nurse Practitioners (NP) • Physician Assistants* (PA)

** To be eligible for Medicaid-based incentives, PAs must practice predominantly in a federally-qualified health center (FQHC) or rural health clinic (RHC) that is lead by a PA.*

Hospital-Based and the Rule of 90

While this guide highlights ARRA regulations for the non-hospital EP only, just what makes a provider hospital-based needs to be addressed. According to the rule, a hospital-based EP is an eligible provider "such as a **pathologist, anesthesiologist, or emergency physician**, who furnishes *substantially all* of his or her Medicare-covered professional services during the relevant EHR reporting period *in a hospital setting* through the use of the facilities and equipment of the hospital, including the hospital's qualified EHRs" [emphasis added].

There are two phrases in this section that deserve extra attention, "substantially all" and "in a hospital setting." ARRA defines "hospitals" as institutions that are "…primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons.''

Based on this definition and language used elsewhere in the Act, the rule posits that EPs who provide a substantial amount of their services in hospital-owned inpatient or emergency room settings (POS codes 21 and 23) are to be considered "hospital-based EPs" for ARRA purposes (and, therefore, not eligible for the EHR incentive programs). The rule goes on to establish 90% as the overall volume threshold that defines the phrase "substantially all." Therefore, if less than 10% of an EP's services are provided in hospital-based inpatient or emergency room settings as described above, he/she is not eligible for EHR incentives.

Specifically, though, the final rule identifies EPs who provide services in hospital-based *outpatient* settings (POS code 22) are eligible for incentive program.

Those providers who meet the EP definition still must achieve other usage, billing and volume thresholds to receive the payments. These are discussed in the Medicare and Medicaid sections below.

No Groups…for Now

The rule and, therefore, the incentive program does not generally recognize medical groups, at least as far as performance requirements and payment recipients are concerned. (The exception here is for EPs participating in the *Medicaid* incentive program. Please see "Medicaid Patient Volumes"

below for details.) The reasoning here is the measures and objectives were designed on an individual-level, which the ONC does not feel would provide an accurate measure of meaningful use if provided in consolidated group-measurements. This situation is also a matter of law, as the ARRA legislation itself provided incentives only to "eligible professionals;" to make payments at the group-level, it's likely the law would have to be amended. See the section below entitled "The Ol' Switcheroo" for discussion regarding how ONC suggests handling payment transfers from EPs to groups.

It's All about "Meaningful Use"

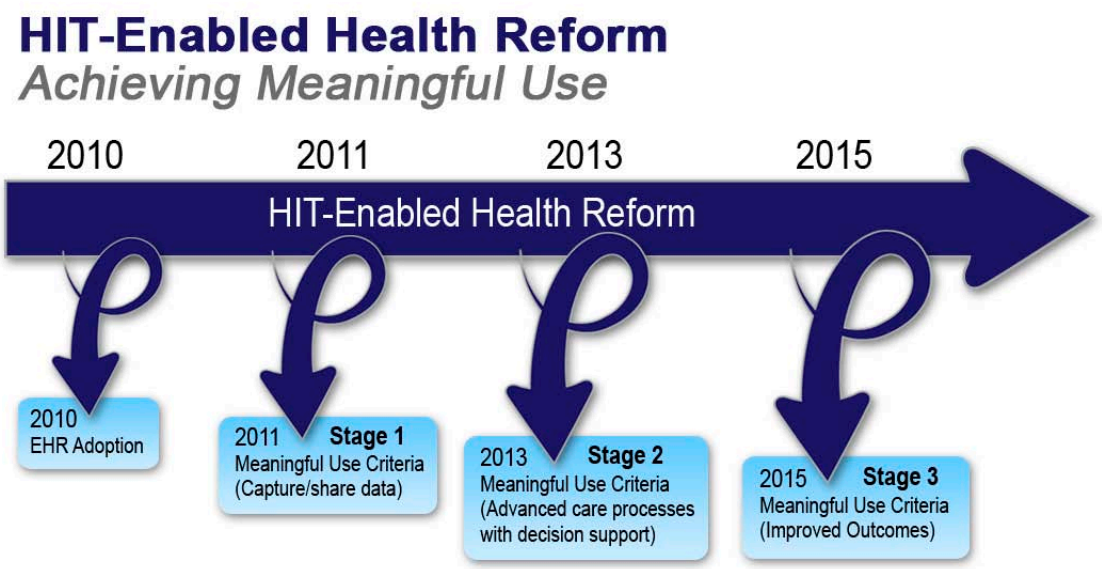
If you've been paying even the mildest amount of attention to the debate regarding HITECH and EHRs since February 2009, you've undoubtedly come across the phrase "Meaningful Use" (MU). MU is a concept and term that's going to be heard quite often in the coming years, whether EPs opt in or out of the EHR incentive programs. Meaningful Use is the "central thread" that runs through all 800+ pages of regulations. MU is the level of proficiency and functionality that EPs must achieve in order to qualify for Medicare or Medicaid EHR incentives. It is also the level above which those who accept Medicare payments must rise in order to avoid cuts in reimbursement amounts in 2015 and beyond.

The basic definition of meaningful use is fairly pedestrian, yet also far-reaching: "…to enable significant and measurable improvements in population health through a transformed health care delivery system. The ultimate vision is one in which all patients are fully engaged in their healthcare, providers have real-time access to all medical information and tools to help ensure the quality and safety of the care provided while also affording improved access and elimination of health care disparities" (from "'Meaningful Use: A Definition.' Recommendations from the Meaningful Use Workgroup to the Health IT Policy Committee," 6/16/2009).

ARRA broke Meaningful Use into three types of requirements:

1. Using certified EHRs in a meaningful manner,
2. Using certified EHRs to submit data to HHS/CMS that details clinical quality measures as identified by the Secretary (of HHS), and
3. Employing the exchange of electronic data in a way that improves the quality of care.

Thankfully, HHS recognized the EHR and healthcare industries simply couldn't move from A to Z in one fell-swoop. Instead, ONC decided to phase in the full vision of "meaningful use" in three, graduated stages between 2011 and 2015. Furthermore, the rules relax the manner in which stages will be rolled in, so as not to discourage later implementation. This staging approach also gives EHR vendors time to more thoughtfully add functionality that's currently not offered in their products and also gives EPs a better chance to ramp up toward the lofty (but worthy) goals set by the committee. However, it should be noted that the rule's lack of clarity regarding stage 2 and 3 specifics and timings does not necessarily mean an easier track for later adopters. Indeed, the final rules only promise "additional review" regarding what is not yet known and indicate that "policies for 2015 and subsequent years will be determined through future rulemaking."



In a nutshell, the rule puts forward the following general goals for each stage:

Stage 1	• Electronically capturing health information in a coded format, • Using that information to track key clinical conditions and communicating that information for care coordination purposes, • Implementing clinical decision support tools to facilitate disease and medication management, • Using EHRs to engage patients, and • Reporting clinical quality measures and public health information.
Stage 2	Stage 2 goals and requirements have not yet been finalized, but are expected to: • Expand on Stage 1 criteria to encourage the use of health IT for continuous quality improvement at the point of care, and • Furthering capabilities to exchange information in the most structured format possible
Stage 3	Stage 3 goals and requirements have not yet been finalized, but are expected to: • Promoting improvements in quality, safety and efficiency, • Focusing on decision support for national high priority condition, • Patient access to self management tools, • Access to comprehensive patient data, and • Improving population health.

The rules provide a stair-step calendar that is intended to encourage early-adoption while also ensuring that late-comers are not entirely discouraged by performance requirements that build too rapidly. Medicare EPs who implement EHRs in 2015 or later will, of course, not recognize any Medicare incentives. The table below details the schedule meaningful users can expect to follow throughout the program.

Year Entering Program	Payment Year				
	2011	2012	2013	2014	2015+
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD
2015+					TBD

NOTE: While ONC reserves the ability to redefine the current rules, the schedule above appears to apply to both the Medicare and Medicaid EPs, even though the latter provides payment options up through 2021.

State Additions to MU

Many of the comments received during the feedback period regarded the States' ability to require additional objectives and measures of Medicaid participants. The overwhelming consensus was apparently that allowing States to add requirements, especially for Stage 1, could add a significant amount of difficulty and confusion to early adoption periods. Therefore, ONC announced it would only entertain requests from States to tailor Stage 1's definition of Meaningful Use "as it pertains to public health objective and data registries" and specifically to the list below. (Note: These items are also found among MU's Stage 1 "Core" items, as detailed later in this document.)

Keep in mind that any alteration/addition to MU requirements must be approved by CMS and ONC. However, this dynamic also underscores the idea that Medicaid EPs will need to determine what their specific State's requirements and processes are for the incentive program.

Possible State-based additions to Stage 1 MU requirements include:

- The generation of at least one report listing patients of the EP with a specific condition.
- Perform 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.
- Perform at least one test of certified EHR technology's capacity to submit electronic data on reportable lab results to public health agencies and follow-up submission if the test is successful.
- Perform at least one test of certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful.

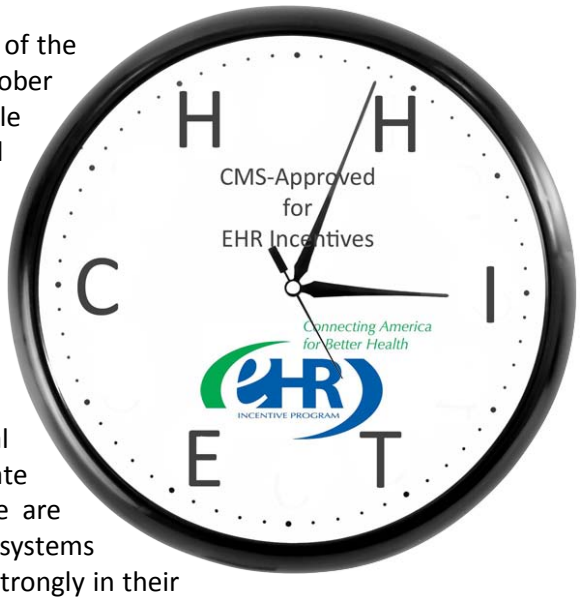
AN IMPORTANT POINT ABOUT MU

Purchasing and even using an EHR that's been certified for the EHR Incentive Programs does not automatically equate to "meaningful use" and incentive eligibility. A complete certified EHR will provide all the tools and reporting mechanisms necessary to provide sufficient evidence of usage levels. However, it's ultimately up to the EP (*not the EHR*) to prove "meaningful use" standards have been met to qualify for federal incentives.

The Government Defines… *Time?*

In just a few paragraphs, we're going to provide details regarding *when* EPs can implement an EHR, *when* EPs need to meet usage requirements, *when* incentives are paid, *when* penalties take effect. Obviously, time is going to be an issue. So, it's worth a few more paragraphs explaining that aspect of the incentive programs.

CY vs. FY



Many public institutions match its workings to that of the federal government's "fiscal year" (aka "FY," October 1st through September 30th of the next year), while many private groups operate in the traditional "calendar year" (CY, January 1st through December 31st). A program that involves players as varied as hospitals, individual physicians, and group practices needs to clearly define the periods within which its mechanisms function.

The proposed rule works diligently to establish common definitions for its diverse audiences. Below, you'll see it works to keep functional requirements as universal as possible in both private practices and large multi-facility hospitals. There are times, though, that it's best to allow two separate systems to exist, simply because currents already flow too strongly in their own directions to attempt reconciliation. That's how the rule approaches the methods of time-keeping, although it does herd similar actors into the same corral. It all boils down to hospitals and non-hospitals…

For purposes of the EHR incentive programs, non-hospital, eligible providers (EPs) will function within *calendar years*. Thus, any time an EP reads "payment year" or "year of payment" or any similar term within the proposal he/she should think of the time period from January through December. This is the case for those who participate in <u>any</u> Medicare or Medicaid program, as described by the rule. On the other hand, any eligible hospital that participates in the Medicare FFS, MA or Medicaid EHR incentive programs will understand those same phrases in terms of the federal government's fiscal year. These definitions and interpretations will determine the manner in which each eligible provider and hospital will function within the incentive programs.

Reporting Period

Readers will find the term "reporting period" peppered throughout the rules. Perhaps the most important occurrences are found in relation to the achievement of Meaningful Use and Payment Years, such as "a provider is not a meaningful EHR user unless it has 'for an EHR reporting period for a payment year and 'reporting period for a payment year' demonstrated meaningful use." As "payment years" and "meaningful use" figure prominently in the workings for the incentive program, it makes sense to discuss what, exactly, is meant (and not meant) by the phrase "reporting period."

Within the context of HITECH, "reporting period" indicates the time in which meaningful use performance must be achieved and sufficient data collected to qualify for incentive payments. "Reporting period" is not simply a window during which performance measures may be turned in to CMS to qualify for incentives, but rather the 90-day (Payment Year 1) or 12-month periods (Payment Years 2-5 or 2-6) during which the required EHR usage actually takes place. Confusion of this issue has led some EPs to assume usage may begin during 2010, since the reporting period begins on January 1, 2011. To be sure, Medicare EPs may only start reporting on MU-caliber usage that begins on 1/1/2011. Any usage prior to this date is superfluous to the incentive program.

Medicare participants may recognize payments over a five year period, between 2011 and 2016 (see "Medicare Incentives" section below for more details) as long as they successfully demonstrate meaningful use of their EHR and correctly report that usage over the required time/reporting period. These reporting periods differ from the first year to subsequent years and between Medicare and Medicaid participants.

Medicare Participants: The only twist thrown at those who take part in the Medicare incentive program takes place during the *first* payment year. During the first year in which the EP is participating, he/she must show meaningful use of the EHR over any continuous 90-day period within that payment year. For example, MU could be achieved and reported from January 1, 2011 to March 31, 2011. Or, an acceptable MU period during the first year would be May 16th, 2012 to August 13th, 2012. The 90-day period cannot lapse into the next calendar year, such as November 1st through January 31st. Therefore, the last day during the year on which the reporting period could *start* is October 1st. (The *first* acceptable day for reporting is January 1, 2011.) For all subsequent years during which the EP participates in the program, the reporting period will be an entire year (i.e. from January 1st through December 31st.)

Medicaid Participants: The Medicaid program possesses the same 90-day requirement for its first payment year. However, as described below, Medicaid participants may actually receive payment in the first year without achieving MU, if that first year is spent adopting, implementing or upgrading (AIU) certified EHR technology. The rule does not require a reporting period for AIU (e.g. an EP doesn't have to prove that she's been installing an EHR for 90 days). However, the rule is clear to state that the reporting period is 90 continuous days for the first year an EP participates in the program by demonstrating meaningful use (this would likely be Payment Year 2 for EPs who receive the AIU payment in Payment Year 1). Payment years subsequent to the first in which the EP demonstrates meaningful use (Payment Years 3-6, if AIU was used for Year 1; Payment Years 2-6 if MU was achieved in Year 1) will require a full year of MU performance to qualify for incentives.

Objectives and Measures

Stage 1 Objectives and Measures

The rule includes detailed objectives and measures for stage 1, as 2011 Medicare EPs will be expected to meet them to qualify for incentives. HHS acknowledged they are creating somewhat of a "moving target" for these later stages, but indicated they will be dictated by the progress that is realized from one stage to the next as well as technological and infrastructure developments.

After holding hearings and accepting public comment regarding the proposed rules, ONC heard one very clear message: "You're moving too fast and too inflexibly." So, the rules transformed from a proposed set of 25 objectives that required an "all or nothing" performance to a final set of 25 objectives, broken down into "Core" and "Menu" items. To achieve Stage 1 MU requirements, EPs will need to meet 15 Core items and 5 of 10 Menu items.

NOTE: There's one catch with the flexibility that ONC provided: one of five Menu Items chosen must be from among the "Population and Public Health" measures. For the EP, this grouping includes only two items: submitting data to immunization registries and submitting electronic syndromic surveillance data to public health agencies. These are noted in the Menu Set table below.

Exclusions

The ONC recognized the possibility that some EPs would be unable to meet some of the objective measurements as specified above. The objectives and measures were modified in the final rule to indicate if/when there is an option for an EP to determine that one or more are inapplicable to them (for details, please see pages 44,331 – 44,380 in the National Registry release of the final rule, which may be found at http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf). In such cases, EPs would be required to attest that the objective is inapplicable or their practice does not provide sufficient data to make measurements possible.

The impact of claiming an exclusion(s) would be to reduce the total number of measurements needed to qualify for MU and EHR incentives. According to the final rule, "For objectives in the Core set, such an attestation would remove the objective from consideration when determining whether an EP…is a meaningful EHR user. In other words, the EP…could satisfy the core set objectives by satisfying all remaining objectives included in the core set." Similarly, by attesting that a Menu set measurement is inapplicable, it would be removed from consideration and "rather than satisfy 5 of the 10 meaningful use objectives…the EP need only satisfy 4 of the remaining 9…"

An exhaustive discussion of Stage 1 objectives and measures (O&M) are provided in detail on pages 44,331 – 44,380 in the National Registry release of the final rule (found at http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf). Exclusions to objectives and measures may also be found in this section of the final rule. The table below (adapted from table 2 in the rule as well as data provided by the AMA) provides *summary* information for each O&M at the non-hospital, EP level; please see the official rule for more detailed explanations.

Unique Patients

The final rules use the term "unique patients" quite often, generally in a manner that relaxes requirements originally set forth by the proposed rules. This term affects measurements of CPOE,

recording of demographics, vital signs, and smoking status, maintenance of up-to-date problem, medication and allergy lists, the sending of patient reminders, and the provision of electronic access to health information and patient education materials.

According to the rule "a unique patient [generally] means that even if an [established] patient is seen multiple times during the EHR reporting period, they are only counted once." This would not be case if the patient comes in multiple times for different reasons/services/diagnoses. It should be pointed out that since the reporting requirements and incentives are geared toward *individual* providers, a patient that is seen more than once by different members of a group/practice would be present in multiple denominator counts.

As mentioned, ONC inserted this phrase to relax the proposed rules: "Measuring by every patient encounter places an undue burden on EPs and may have unintended consequences of affecting the provision of care to patients merely to comply with meaningful use." Such reasoning can be seen, for example, in the case of maintaining active medication lists. If required for each patient encounter, rather than each unique patient, the EP would have to update the list every time the patient was seen during the reporting period. Such a requirement would be overly-burdensome and inefficient, especially during Payment Year 1's 90 day reporting period.

CORE SET **EPs Must Meet <u>All</u> Core Objectives**		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**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 have at least one medication order entered using CPOE. ➔ <u>Exclusion</u>: If EP writes fewer than 100 prescriptions during the reporting period. ➔ <u>Reporting Method</u>: Through the EHR. Counts are limited to patients whose data is maintained in/by the EHR.
	Implement drug-to-drug & drug-allergy checks.	The EP has **enabled** this functionality for the entire EHR reporting period. ➔ <u>Exclusion</u>: If EP writes fewer than 100 prescriptions during the reporting period.

CORE SET EPs Must Meet <u>All</u> Core Objectives		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
		➔ <u>Reporting Method</u>: Attestation.
	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. ➔ <u>Exclusion</u>: If EP writes fewer than 100 prescriptions during the reporting period. ➔ <u>Reporting Method</u>: Through the EHR. Counts are limited to patients whose data is maintained in/by the EHR.
	Record demographics: • Preferred language • Gender • Race • Ethnicity • Date of Birth	More than **50%** of all unique patients seen by the EP have demographics recorded as structured data. ➔ <u>Exclusion</u>: None. ➔ <u>Reporting Method</u>: As long as thresholds are met, through the EHR. If thresholds not met for patient data maintained in the EHR, EP must manually count paper records to meet the threshold.

CORE SET EPs Must Meet <u>All</u> Core Objectives		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
	Maintain an up-to-date problem list (ICDs) of current and active diagnoses.	More than **80%** 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. ➔ <u>Exclusion</u>: None. ➔ <u>Reporting Method</u>: As long as thresholds are met, through the EHR. If thresholds not met for patient data maintained in the EHR, EP must manually count paper records to meet the threshold.
	Maintain active medication list.	More than **80%** 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. ➔ <u>Exclusion</u>: None. ➔ <u>Reporting Method</u>: As long as thresholds are met, through the EHR. If thresholds not met for patient data maintained in the EHR, EP must manually count paper records to meet the threshold.

CORE SET EPs Must Meet <u>All</u> Core Objectives		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
	Maintain active medication allergy list.	More than **80%** 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. ➔ <u>Exclusion</u>: None ➔ <u>Reporting Method</u>: As long as thresholds are met, through the EHR. If thresholds not met for patient data maintained in the EHR, EP must manually count paper records to meet the threshold.
	Record and chart changes in vital signs: • 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 height, weight and blood pressure are recorded as structured data. ➔ <u>Exclusion</u>: EPs who only see patients younger than 2 years of age and those who believe that all three vital signs have no relevance "to their scope of practice to so attest and be excluded." ➔ <u>Reporting Method</u>: Through the EHR. Counts are limited to patients whose data is maintained in/by the EHR.
	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 have smoking status recorded as structured data. ➔ <u>Exclusion</u>: EPs who see no

CORE SET EPs Must Meet <u>All</u> Core Objectives		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
		patients 13 years or older. ➔ <u>Reporting Method</u>: Through the EHR. Counts are limited to patients whose data is maintained in/by the EHR.
	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	**Implement one** clinical decision support rule. ➔ <u>Exclusion</u>: None. ➔ <u>Reporting Method</u>: Attestation.
	Report ambulatory clinical quality measures to CMS or the States.	**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. ➔ <u>Exclusion</u>: None. ➔ <u>Reporting Method</u>: As long as thresholds are met, through the EHR. If thresholds not met for patient data maintained in the EHR, EP must manually count paper records to meet the threshold.

CORE SET EPs Must Meet <u>All</u> Core Objectives		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**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.	More than **50%** of all patients of the EP *who request* an electronic copy of their health information are provided it within 3 business days. ➔ <u>Exclusion</u>: If the EP has no requests for electronic copies of medical records from patients or "their agents," he/she would be excluded. ➔ <u>Reporting Method</u>: Through the EHR. Counts are limited to patients whose data is maintained in/by the EHR.
	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than **50%** of all office visits within 3 business days. ➔ <u>Exclusion</u>: An EP who sees no patients during the reporting period would be excluded. ➔ <u>Reporting Method</u>: Attestation.
Improve care coordination.	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.	Performed **at least one test** of certified EHR technology's capacity to electronically exchange key clinical information. ➔ <u>Exclusion</u>: None. ➔ <u>Reporting Method</u>: Attestation.

CORE SET EPs Must Meet <u>All</u> Core Objectives		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
Ensure adequate privacy and security protections for personal health information.	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	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. ➔ <u>Exclusion</u>: None. ➔ <u>Reporting Method</u>: Attestation.

MENU SET (Choose 5 of 10)		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
Improving quality, safety, efficiency, and reducing health disparities.	Implement drug-formulary checks.	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. ➔ <u>Exclusion</u>: None. ➔ <u>Reporting Method</u>: Attestation.
	Incorporate clinical lab test results into certified EHR technology as structured data.	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. ➔ <u>Exclusion</u>: If an EP orders no labs during the reporting period he/she would be excluded.

MENU SET (Choose 5 of 10)		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
		➔ Reporting Method: Through the EHR. Counts are limited to patients whose data is maintained in/by the EHR.
	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least **one report** listing patients of the EP with a specific condition. ➔ Exclusion: None. ➔ Reporting Method: Attestation.
	Send reminders to patients per patient preference for preventive/ follow up care.	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. ➔ Exclusion: If the EP sees no patients 5 years or younger or 65 years and older, he/should would be excluded. ➔ Reporting Method: Through the EHR. Counts are limited to patients whose data is maintained in/by the EHR.
Engage patients and families in their health care.	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.	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. ➔ Exclusion: Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) (e.g., lab test results,

MENU SET (Choose 5 of 10)		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
		problem list, medication list, medication allergy list, immunizations, and procedures) during the EHR reporting period qualifies for an exclusion from this objective/measure ➔ Reporting Method: As long as thresholds are met, through the EHR. If thresholds not met for patient data maintained in the EHR, EP must manually count paper records to meet the threshold.
	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than **10%** of all unique patients seen by the EP are provided patient-specific education resources. ➔ Exclusion: None. ➔ Reporting Method: As long as thresholds are met, through the EHR. If thresholds not met for patient data maintained in the EHR, EP must manually count paper records to meet the threshold.
Improve care coordination.	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.	The EP performs medication reconciliation for more than **50%** of transitions of care in which the patient is transitioned into the care of the EP. ➔ Exclusion: If the EP is not "on the receiving end of any transition of care" during the reporting period, he/she would be excluded. ➔ Reporting Method: Through the EHR. Counts are limited to patients whose data is

MENU SET (Choose 5 of 10)		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
		maintained in/by the EHR.
	The EP 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.	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%** of transitions of care and referrals. ➔ Exclusion: EPs who do not transfer/refer a patient to another provider during the reporting period are excluded. ➔ Reporting Method: Through the EHR. Counts are limited to patients whose data is maintained in/by the EHR
Improve population and public health. **IMPORTANT NOTE:** *At least ONE Menu measurement must come from this outcome grouping.*	Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.	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: EPs who do not administer immunizations during the reporting period are excluded. ➔ Reporting Method: Attestation.
	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and	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

MENU SET (Choose 5 of 10)		
Health Outcomes Policy Priority	**Stage 1 Objectives**	**Stage 1 Measures**
	practice.	the test is successful (unless none of the public health agencies to which an EP). ➔ Exclusion: EPs who do not collect any "reportable syndromic information on their patients" during the reporting period are excluded. ➔ Reporting Method: Attestation.

States' Influence on Medicaid Standards

Finally, the rule poses an important difference between Meaningful Use as defined for Medicare and Medicaid program participants, the criteria proposed and adopted at the federal level are potentially the *minimum* standards for Medicaid participants:

> Therefore, we propose to create a common definition of meaningful use that would serve as the definition for EPs, eligible hospitals and CAHs participating in the Medicare FFS and MA EHR incentive program, and the minimum standard for EPs and eligible hospitals participating in the Medicaid EHR incentive program. We clarified that under Medicaid this proposed common definition would be the minimum standard. We proposed to allow States to add additional objectives to the definition of meaningful use or modify how the existing objectives are measured; the Secretary would not accept any State alternative that does not further promote the use of EHRs and healthcare quality or that would require additional functionality beyond that of certified EHR technology.

As stated earlier, Medicaid incentives will be paid through the states, while Medicare payments will come directly from CMS. This arrangement is intended to give states the ability to customize their programs, including reporting mechanisms and, *if approved by HHS*, additional measures and objectives.

However, for Stage 1, ONC places significant limitations on States' abilities to apply additional requirements for the Medicaid program. Specifically, ONC will only consider requests to add criteria relating to public health objectives and data registries. These criteria are currently among the MU Objectives Menu items, meaning states might be permitted to add them to the Cores as detailed above.

- Generate at least one report listing patients of the EP with a specific condition.

- Perform 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.
- Perform 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.
- Perform at least one test of certified EHR technology's capacity to submit electronic data on reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital submits such information have the capacity to receive the information electronically).

  Note: This last objective only appears in the final rule's list of Core items for *hospitals*, not EPs. Furthermore, the parenthetical language above (as well as that found elsewhere) seems to indicate that even in the current context, the objective applies to hospitals, rather than EPs. However, States' abilities to apply the objective to EPs is not specifically discussed in the final rule and, therefore, its applicability remains questionable. Clarification has been requested, but is not known at this time.

The possibility of state-altered objectives underscores one very important point: EPs participating in the Medicaid incentive program should be in close contact with the appropriate state agencies to ensure he/she is fully aware of differences (reporting methods, additional criteria, etc.) that are required for successful participation.

The final rule closes discussion on States' abilities to alter requirements for their Medicaid participants: "As part of Stage 2 of meaningful use, CMS might consider States requests to tailor meaningful use as it pertains to health information exchange, for example. Further details about the policy option will be included in future rulemaking and subject to public comment."

Clinical Quality Measures

CQMs: Core, Alternate, and Menu Items

The other type of Meaningful Use requirement identified in ARRA is *clinical quality measures* (CQM). The reason for including such measures is to help define standards and "best practices" that will allow EPs to compare their own outcomes with those of their peers and, in turn, identify areas for overall healthcare improvements.

The quality measures adopted by the ONC were largely pulled from those previously endorsed by the National Quality Forum (NQF), including those already included in the Physicians Quality Reporting Initiative (PQRI) program. Therefore, physicians who are already participating in the PQRI incentive program will be familiar with many of the measures in the final rule.

As it did with the meaningful use objectives, the final rule significantly reduced the total number of measures which must be reported. The rule also provided similar flexibility by breaking the CQMs into Core, Alternate and

Menu groupings. And, as they did largely with the objectives, ONC limited required CQMs to only those whose data can be obtained electronically via the EHR. However, unlike the objectives, the ONC did not establish any thresholds for Stage 1 CQMs. Instead, EPs are simply to report the data to CMS (and attest to its accuracy) in numerator/denominator format.

Noticeably missing from the proposed rule are specialty measures, which ONC indicates will return for Stage 2 at either the same level of development or, more likely, even higher. Furthermore, ONC indicates that all 90 of the proposed rule's CQMs (along with others meant to "fill gaps") will likely be required for Stage 2 MU performance levels.

As mentioned above, Stage 1 CQMs have been split into Core, Alternate and Menu groupings (see the appendix for a full listing). To qualify as meaningful users, EPs must submit at least 6 total clinical quality measures from among the groups. ONC intends for all participating EPs to provide numerator and denominator data for the three Core measures even if the measurement is zero (more on this below):

CORE MEASURES	
Title: Adult Weight Screening & Follow Up **Description:** Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.	NQF 0421 PQRI 128
Title: Hypertension: Blood Pressure Measurement **Description:** Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.	NQF 0013
Title: Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention **Description:** Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.	NQF 0028

The second set is called "Alternates," as they are to be used if/when one of the Core measures is zero and/or does not apply to the EP's area of practice. The 3 Alternate measures are:

ALTERNATE MEASURES	
Title: Weight Assessment & Counseling for Children and Adolescents **Description:** Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	NQF 0024
Title: Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old **Description:** Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	NQF 0041 / PQRI 110
Title: Childhood Immunization Status **Description:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio(IPV), one measles, ,mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.	NQF 0038

The "Menu" set provides the CQM requirements with their flexibility, just as they do the objectives. There are 38 total Menu items, from among which EPs must select 3 to report. Please see the appendix for a full listing of all Menu measures.

Numerators & Denominators

All measurements are to be reported in numerator/denominator format, which generally requires the denominator number to contain all patients whose records are maintained in the EHR, who have been seen during the reporting period and who meet the measure's description. The numerator includes all patients whose records are maintained in the EHR, who have been seen during the reporting period and who have been provided with the service or measurement described.

For example, the data required for the first Core measure regarding Hypertension: BP Measurement (NQF 0013) will consist of the following for ambulatory EPs:

Measurement	Criteria
Initial Patient Population	Patients 18 years or older who are seen by the EP during the reporting period and have an active diagnosis of hypertension.
Denominator	All patients in the initial patient population (see cell above).
Numerator	Patients for whom both systolic and diastolic blood pressure readings were taken.

Obviously, any objective and measure may have its own unique twist, so the reader is encouraged to consult the regulations for a full understanding.

If what's above seems like a lot to keep track of, it is. That's why the final rule requires that all certified EHRs provide functionality that will automatically calculate each measure and provide it to the user in a way that it may be used for reporting. Full breakdowns for each CQM may be downloaded directly at:

www.cms.gov/QualityMeasures/Downloads/EP_MeasureSpecificiations.zip.

Downloading this zip file provides "human readable" explanations of each CQM, along with the criteria required for each numerator and denominator.

The final rule provides specific guidance for cases in which patients do not meet the measure's description: "We would expect that the patient for whom a clinical quality measure does not apply will not be included in the denominator of the clinical quality measure. If not appropriate for a particular EP we would expect that either patients would not appear in the denominator of the measure (a zero value) or an exclusion would apply. Therefore reporting "N/A" is not necessary."

Measuring Zero

As mentioned above, EPs are still required to report all Core measures, even if their measurement is zero. As explained in the final rule:

> We note that to qualify as a meaningful EHR user, EPs need only report the required clinical quality measures; they need not satisfy a minimum value for any of the numerator, denominator, or exclusions fields for clinical quality measures. The value for any or all of those fields, as reported to CMS or the States, may be zero if these are the results as displayed by the certified EHR technology. Thus, the clinical quality measure requirement for 2011 and beginning in 2012 is a reporting requirement and not a requirement to meet any particular performance standard for the clinical quality measure, or to in all cases have patients that fall within the denominator of the measure. [Emphasis added.]
>
> Insofar as the denominator for one or more of the core measures is zero, EPs will be required to report results for up to three alternate core measures… The EP will *not* be excluded from reporting any core or alternate clinical quality measure because the measure does not apply to the EPs scope of practice or patient population… If all six of the clinical quality measures…have zeros for the denominators (this would imply that

> the EPs patient population is not addressed by these measures), then the EP is still required to report on three additional clinical measures of their choosing from [among the Menu measures] in this final rule. In regard to the three additional clinical quality measures, if the EP reports zero values, then for the remaining clinical quality measures…(other than the core and alternate core measures) the EP will have to attest that all of the other clinical quality measures calculated by the certified EHR technology have a value of zero in the denominator, if the EP is to be exempt from reporting any of the additional clinical quality measures (other than the core and alternate core measures)... Thus, EPs are not penalized in the Stage 1 reporting years as long as they have adopted a certified EHR and that EHR calculates and the EP submits the required information on the required clinical quality measures, and other meaningful use requirements as defined in this final rule in section II.A.2.d.1 of this final rule. [Emphasis added.]

To summarize, ANY value is acceptable for Stage 1 measurements, including zero. Further, no thresholds exist, for either the numerators or denominators. Stage 1 is primarily about reporting, but Stage 2 is expected to impose more measures and, most likely, actual thresholds for EPs to meet. EPs are to always report all three Core measures, even if they are zero, in which case Alternatives are to be reported, even if they are zero, as well. Finally, 3 additional measures must be chosen from the Menu items and reported. In the unlikely case that all of the measures (Core, Alternate, or Menu items) have values of zero, the EP must attest to that fact in order to be exempt from reporting any Menu items.

To put it even more succinctly, the final rule provides this basic guideline: "In sum, EPs must report on six total measures, three core measures (substituting alternate core measures where necessary) and three additional measures (other than the core and alternate core measures) selected from the [Menu items]."

A NOTE ABOUT THE PRQI AND E-PRESCRIBING INCENTIVE PROGRAMS

E-Prescribing: EPs who participate in the Medicare EHR Incentive Program cannot double-dip by earning incentives for both the ePrescribing and HITECH/EHR programs; rather, it's one or the other. EPs participating in the Medicaid EHR Incentive Program, however, may collect incentives from both the EHR and e-Prescribing incentive programs. For more information regarding the e-prescribing incentive program, please see www.cms.hhs.gov/ERXIncentive.

PQRI: EPs participating in either the Medicare or Medicaid EHR Incentive Program may also collect incentives from the PQRI incentive program. For more information regarding the PQRI program, please see www.cms.hhs.gov/pqri.

Stages 2 & 3: Rising Thresholds

In the final rule, HHS indicates that it kept Stage 1 criteria to lower levels that some had originally expected. For example, the rule excludes the electronic exchange of structured data in many of the Stage 1 objectives and requires "relatively low" performance thresholds for measures that rely on

electronic data exchange. This was done in recognition of the fact that many parts of the country do not yet feature the infrastructure needed to support such functionality.

However, HHS clearly indicates that it intends to impose graduated, rising thresholds for such objectives in future criteria in an overall effort to achieve greater collection and sharing of clinical data across multiple systems and locations. Indeed, according to the final rule "the number of clinical quality measures for which EPs…would be able to electronically submit information would rapidly
expand in 2013 and beyond." The end result will be "…patient-centric, interoperable health information exchange across provider organizations regardless of provider's business affiliation or EHR platform."

Stage 2 requirements are expected to be released by late 2011 and Stage 3 details should be out by late 2013, both through "future rulemaking." However, due to concerns regarding the comingling of the Medicare and Medicaid timelines as well as whether or not Stage 3 requirements would be appropriate or reasonable for an EP's first payment year, ONC has declared it needs "additional review and discussion before [laying] out a clear path forward for 2015 and beyond."

The rule does offer hints of what stages 2 and 3 might hold for EPs. Essentially, each stage is expected to build on its predecessor, making the optional measures requirements, as well as adding additional criteria "that are necessary to maximize the potential of EHR technology, but were not ready for Stage 1."

The final rule mentions objectives and measures that were suggested for future inclusion during the public comment period and indicates they will be considered for later stages. However, the rule also cautions that any suggestions published in the final rule should not be considered comprehensive or "sure bets," as any new objectives or measures must be available for public comment before they can be added to any new rules. As well, ONC continues to solicit feedback and suggestions. Suggestions included in the final rule include the following:

- Ear, Nose, and Throat measures
- Pain and injection-related measures
- Cardiovascular measures
- Group practice measures
- Use of evidence-based order sets
- Electronic medication administration record
- Record physician notes in EHR
- Multimedia/Imaging integration
- Contribute data to a PHR
- Asking patients about their experience of care
- Additional pediatric measures
- Long-term care measures
- Additional obstetrics measures
- Dental care/oral health measures
- Additional behavioral/mental health and substance abuse measures

Medicare Incentives: Title IV, Subtitle A, Section 4001

How could a heading like "Title IV, Subtitle A, Section 4001" be guaranteed to get attention? By putting $20,819,000,000 behind it, that's how. And, there it is, on page 354 of the American Recovery and Reinvestment Act of 2009, just 53 pages from the very end:

> "…the applicable amount specified in this subparagraph for an eligible professional is as follows [for EPs participating in the Medicare incentive program]:
> (I) For the first payment year for such professional, $15,000 (or, if the first payment year for such eligible professional is 2011 or 2012, $18,000).
> (II) For the second payment year for such professional, $12,000.
> (III) For the third payment year for such professional, $8,000.
> (IV) For the fourth payment year for such professional, $4,000.
> (V) For the fifth payment year for such professional, $2,000.
> (VI) For any succeeding payment year for such professional, $0…"
>
> Excerpted from the American Recovery and Reinvestment Act of 2009, available at *www.thomas.gov/home/approp/app09.html#hl*.

Summed up by the Healthcare Information and Management Systems Society (HIMSS), the bottom line is that "eligible professionals who adopt [certified] EHRs as early as 2011 or 2012 [and demonstrate meaningful use of the technology] could be eligible for **up to $44,000/physician** in Medicare incentive payments (over five years)."

The incentive payments are equal to 75% of the annual, allowable Medicare charges per physician as capped by the figures above. Still, maximum payments can be met by submitting from $24,000 to $2700 of allowable Medicare charges (depending on the payment year) over a five year span of the program. Such thresholds should pose little problem for most practices that already serve Medicare populations.

The law goes on to phase down incentive payments for "late adopters" such that those waiting until 2013 will see less than those who adopt in 2011 or 2012. Physicians who first achieve meaningful use in 2014 will recognize less and those who wait later will see nothing at all. The table below provides greater clarity regarding incentive amounts and aligns them with the stages that must be met for each payment year.

Note: As the payment amounts are specified in the HITECH Act itself, the ONC does not have the authority to alter them. Therefore, incentive payments awarded each year are all-or-nothing; there are no partial or prorated payments.

Medicare EHR Incentives							
First Year to Achieve MU	Maximum Potential Incentive Received						
	2011	2012	2013	2014	2015	2016	TOTAL
2011	$18,000 / Stage 1	$12,000 / Stage 1	$8,000 / Stage 2	$4,000 / Stage 2	$2,000 / TBD	$0 / TBD	**$44,000**
2012		$18,000 / Stage 1	$12,000 / Stage1	$8,000 / Stage 2	$4,000 / TBD	$2,000 / TBD	**$44,000**
2013			$15,000 / Stage 1	$12,000 / Stage 2	$8,000 / TBD	$4,000 / TBD	**$39,000**
2014				$12,000 / Stage 1	$8,000 / TBD	$4,000 / TBD	**$24,000**
2015 +					$0 / TBD	$0 / TBD	**Penalties**

In other words, those who adopt EHRs and achieve meaningful use in 2011 or 2012 can receive up to $44,000 in total Medicare EHR incentives. On the other hand, those who wait until 2014 to adopt will see substantially less.

That's the carrot. Now, here's the stick:

"If eligible professionals have not become meaningful users of EHRs by 2015, they will not receive full Medicare payments beginning in 2015. The reduction in the fee schedule is as follows:

- 2015: -1%
- 2016: -2%
- 2017: -3%
- Subsequent years: between -3 to -5%... "

Furthermore, ARRA gives HHS the authority to increase these penalty amounts after 2017, if EHR adoption and/or meaningful use of EHR technology has not become sufficiently widespread throughout the healthcare community.

Finally, there's the question of continuity. According to the rule, "every payment year subsequent to the first payment is a payment year regardless of whether an incentive payment is received by an EP." In other words, meeting MU standards and receiving the first incentive payment kicks off a five-year timer, during which payment years may not be skipped. For instance, if an EP receives an incentive payment of $18,000 in 2012 and then fails to meet MU requirements in 2013, that year and its associated payment amount ($12,000) is simply missed (it cannot be skipped and picked up again the following year). In this case, the EP would, at most, be able to receive 4 years of incentive payments, assuming MU is reached in the final 3 Payment Years. As you will notice below, this facet of the rule differs for Medicaid participants.

Medicaid Incentives

Medicaid providers are also eligible for incentive payments, based on the percentage of needy patients they serve. EPs who serve Medicaid populations can recognize **up to $63,750/physician** in EHR incentive payments. This full amount is tied to meaningful use, whether an EHR has already been implemented, and if the EP receives "payments from other, non-State/local sources."

These incentives will be *provided to physicians via the states*, which will be permitted to proposed alternative timeframes for measuring the required patient volumes. This is intended to allow individual states to use "alternatives that synchronize with existing data sources," if they provide fewer administrative burdens. Therefore, if an EP intends to participate in the Medicaid program, it will be necessary to check with the appropriate state agency for specific guidance.

There are a few significant differences between the Medicare and Medicaid programs. Obviously, the maximum incentive amount is 30% higher than that of the Medicare program. But, there are other details in the Medicaid plan that are substantially different from those of the Medicare program, including:

Net Average Allowable Costs

The rule goes to great lengths to describe how the panel determined the appropriate maximum incentive amount for the Medicaid program. The group used four recent comprehensive studies on which to base its figure, which was determined to be between $25,000 and $54,000 for first-year costs and $3,000 to $20,610 for subsequent-year costs (maintenance, etc.). Assuming that costs for certified EHRs will be on the high end, the rules sets $54,000 as the first-year "average allowable cost" and $20,610 as the subsequent year "average allowable cost." So, what does all that mean?

HITECH explicitly restricts Medicaid incentive amounts to what it calls "net average allowable costs," as it assumes that EPs may secure funds from other sources (state or local government funds are not included) for their EHR costs. Specifically, the bill mandates that EPs may be paid no more than "85% of a maximum net average allowable cost" of $25,000 (or $21,250) in the first year and of $10,000 (or $8500) in subsequent years.

Therefore, EPs can receive up to $29,000 in "alternative funds" and still receive the first-year maximum incentive payment of $21,250. Similarly, EPs can receive up to $10,610 in "alternative funds" and still receive maximum incentive payments of $8500 in years 2-6. Section II.D.4.(5).ii indicates receiving alternative funds (other than those from state or local governments) that rise beyond the figures above, will result in lower HITECH incentive payments.

NOTE: The rule goes into much more detail than this guide can provide regarding sources and types of funds and how they might affect Medicaid incentive payments. Therefore, please see Section II.D.4.a in the Federal Register version of the final rule (beginning on page 44,492) for full details before making any decisions or assumption regarding this topic.

Medicaid Patient Volumes

Non-hospital-based professionals and those in rural health clinics are eligible if at least 30% of their total patient volume receives care under Medicaid provisions (for pediatricians, that requirement is lowered to 20%). This volume must be established over a representative, continuous 90-day period

in the preceding year and the EP will need to re-attest to such volumes each year of the program. (The key word here is "representative," as language in the rule stipulates that the period used must reach the "reasonable person" standard to be considered acceptable as representative of the practice's normal volumes.)

Regarding calculating the Medicaid volume in a group setting, the final rule amended what ONC had originally proposed. The final rule states that ONC "will allow clinics and group practices to use the practice or clinic Medicaid patient volume (or needy individual patient volume, insofar as it applies) and apply it to all EPs in their practice under three conditions:"

- The group's volume is "appropriate as a patient volume methodology calculation for the EP." For example, it would be inappropriate to apply a group volume measure to an EP who does not see Medicaid patients;
- The volume calculations must be supported by an auditable source; and
- Only one method of volume calculation can be used for all EPs in the group for the year to which it is being applied. In other words, some EPs can't use individual levels, while others use the group levels.

The rule provides two other stipulations regarding the use of group-level measurements. First, the group must use the *entire practice's patient volume* and cannot limit it in any way. And, secondly, if an EP provides services both within and outside a group, then only Medicaid encounters provided for the group may be included in the group-level volume calculation.

Payment Period

The Medicaid program provides payments over six years (as opposed to the Medicare program's five years) and EPs can wait until CY 2016 to begin participating while still receiving the maximum incentive amount. Yes, the Medicaid version of the incentive program could last until 2021.

Another contrast to Medicare's payment period: Medicaid EPs may "skip" a payment year without losing it. Medicaid participants may receive incentives for up to 6 years between 2011 and 2021; importantly, these years do not have to be continuous. For example, if a Medicaid EP receives incentive payments in 2012 ($21,250) and 2013 ($8500) and fails to meet MU standards in 2014, he/she may continue the program in 2015 without "losing" a payment year or its associated incentive amount, thus still preserving the ability to receive 6 total years of incentive payments (assuming MU is met within those subsequent years).

AIU: Adopting, Implementing and Upgrading

The first year of payment under the Medicaid program is set at $21,250 and issued for "adopting, implementing or upgrading" (AIU) certified EHR solutions. You'll notice nothing is mentioned about achieving meaningful use, as doing so is not a requirement during the first year of Medicaid incentive payments. A brief explanation of the terms Adoption, Implementation and Upgrading is important at this time:

Adoption requires that the EP provide evidence that actual *installation* of the EHR occurred prior to the incentive, as opposed to merely showing that "efforts to install" have been taken. The purpose of this language was to differentiate between activities that don't result in installation, such as

researching EHRs or vendors, and the purchase/acquisition or installation of a certified EHR solution. The rule indicates that "a proof of purchase or signed contract would likely be an acceptable indicator of EHR adoption per the States."

Implementation will be recognized if the EP "has installed certified EHR technology and has started using the EHR in his or her clinical practice." Staff training, workflow redesign, data entry of demographic and administrative data, and even the establishment of data exchange agreements/relationships (labs, pharmacies, HIEs, etc.) are recognized as legitimate components of implementation activities. The development or submission of an implementation plan for the adoption of an EHR is specifically prohibited as proof of implementation.

Upgrading is defined as "the expansion of the functionality of the certified EHR technology, such as the addition of clinical decision support, e-prescribing functionality, CPOE or other enhancements that facilitate the meaningful use of certified EHR technology." Inferred in this description is also upgrading from an existing EHR to one that is certified for the incentive program. This could be an upgrade from one vendor's product to that of another or a version upgrade from your current EHR provider.

AIU, Even When You're Not!

The rule rationalizes a great many of its requirements by stating that its goal is to promote the widespread use of EHRs and participation in the program. Therefore, it avoids placing any obstacles or disincentives for EPs *not* to begin participating as early as possible. So, perhaps oddly, the rule actually permits the AIU-level payment ($21,750 for Year 1) to be paid even to those who already have a certified EHR. There's one catch: such EPs will have to demonstrate meaningful use performance levels over a 90-day period in Payment Year 1 (again, those who are truly adopting, implementing or upgrading don't have to meet MU requirements that year). Still, it's a great opportunity for those EPs who see enough Medicaid/Needy Patients to qualify for the program.

The table below details how Medicaid EPs can begin EHR implementation between 2011 and 2016 and receive full incentive amounts. As explained above, ALL Medicaid-participating EPs are eligible for the adopting, implementing, and upgrading payment amount for Year 1, even if they already have a fully-functional EHR by January 1, 2011. Therefore, you'll notice the chart indicates that the first year always pays $21,750 via the AIU provision.

Medicaid EHR Incentives						
Payment Year	Year EHR Adoption Begun					
	2011	2012	2013	2014	2015	2016
2011	$21,250 / AIU					
2012	$8,500 / Stage 1	$21,250 / AIU				
2013	$8,500 / Stage 2	$8,500 / Stage 1	$21,250 / AIU			
2014	$8,500 / Stage 2	$8,500 / Stage 1	$8,500 / Stage 1	$21,250 / AIU		
2015	$8,500 / TBD	$8,500 / TBD	$8,500 / TBD	$8,500 / TBD	$21,250 / AIU	
2016	$8,500 / TBD	$8,500 / TBD	$8,500 / TBD	$8,500 / TBD	$8,500 / TBD	$21,250 / AIU
2017		$8,500 / TBD	$8,500 / TBD	$8,500 / TBD	$8,500 / TBD	$8,500 / TBD
2018			$8,500 / TBD	$8,500 / TBD	$8,500 / TBD	$8,500 / TBD
2019				$8,500 / TBD	$8,500 / TBD	$8,500 / TBD
2020					$8,500 / TBD	$8,500 / TBD
2021						$8,500 / TBD
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

No Penalties

One final difference between the Medicare and Medicaid programs: those who participate in the latter will not be subject to the same penalties as Medicare EPs: "… No reductions in Medicaid payments are to be made if a provider does not adopt certified EHR technology" (from *HIMSS Summary of Key Health Information Technology Provisions*, July 1, 2009).

Reporting Methods

Medicaid

As with much of the proposal, the methods for reporting required data vary between the Medicare and Medicaid programs. As stated earlier, HHS has proposed leaving much of the logistics of the Medicaid program to the states, as long as they dovetail with the intent of the law and do not act to lower the criteria set by the federal body. The same is true with reporting: Medicaid EPs will report their data directly to their state's appropriate body. All states must first have their plans to accept the data reviewed and approved by CMS. Therefore, Medicaid EPs will need to keep abreast of their own state's plans, requirements and mechanisms regarding the EHR incentive program.

Medicare 2011

The rule provides greater specifics regarding Medicare reporting, as this program is wholly administered by CMS. The writers express their desire to "reward" early adopters by making the reporting process as simple as possible. The rule also acknowledges that some infrastructure components needed to facilitate electronic reporting may not be ready by the earliest reporting date, which is March 31st, 2011. Therefore, the rule identifies attestation as the methodology to be used for reporting throughout the 2011 payment year. Specifically, the proposal suggests that Medicare EPs "attest that certified EHR technology was used to capture the data elements and calculate the results for the applicable quality measures." Attestation will also be required to confirm the "accuracy and completeness" of the data components submitted.

The rule requires that Medicare EPs log onto **www.cms.gov/EHRIncentivePrograms** and submit/attest to the following:

- Business information of the EP who is submitting the information:
  - EP's name
  - National Provider Identifier (NPI)
  - Taxpayer Identification Number (TIN)
  - Business address
  - Business phone number
  - Election to participate in either the Medicare or Medicaid EHR Incentive program.
- 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 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.

Medicare 2012

As the HIT environment matures, the rule provides three methods to report summary information via electronic means to CMS:

- The rules identify the "primary method" of reporting as logging into a CMS-designated portal, through which the EP will submit via upload "data payload based on specified structures such as Clinical Data Architecture (CDA), and accompanying templates produced as output from their certified EHR technology."
- The second method – contingent on feasibility – will be to submit required data with certified EHRs through a Health Information Exchange (HIE) or Health Information Organization (HIO). Using such data networks will require that CMS is capable of collecting it from the source as well as the EP being a member of the HIE/HIO.

- Finally, CMS will also accept "submission through registries dependent upon the development of the necessary capacity and infrastructure to do so using certified EHRs."

Clearly, each of these methods assumes or relies upon the availability of technology that is not necessarily available at this time, to either EPs or even CMS itself. However, as these methods are intended for 2012 reporting and not 2011, both the industry and federal government have some time to prepare. Therefore, EPs should continue to monitor **http://healthit.hhs.gov** and **www.cms.gov/EHRIncentivePrograms** for updates to the rule.

Medicare 2013 and beyond…

No details are provided for reporting requirement beyond 2012. The reader is encouraged to stay abreast of all new developments by regularly checking the group's website at *http://healthit.hhs.gov*.

The Ol' Switcheroo(s)

Medicare ↔ Medicaid

The regulations make it very clear that EPs may participate in either the Medicaid or Medicare programs, but not both. Specifically, EPs cannot *simultaneously* participate in both incentive programs. However, the proposed rule allows EPs the ability to switch from one program to the other a single time, as long as the change occurs prior to 2015. For instance, if an EP meets the Medicaid volumes required for participation and elects to collect the first-year "adoption payment" of $21,250, he/she may then switch to the Medicare program as long as the change takes place before January 1, 2015.

NOTES: The regulations prohibit "gaming" the system to recognize total incentives larger than Medicaid's $63,750, which is the larger of the two programs.

EPs switching to the Medicare program are subject to its requirements, which might be higher than they are/were in the Medicaid program. Payment timelines and deadlines in the Medicare program are also assumed, meaning the EP could recognize fewer payment years (depending upon when the EP starts the Medicaid or Medicare program).

OK, So When Do I Get Paid…?

Medicare Participants

Regarding the timing of payments for Medicare FFS participants, section II.B.1.b indicates they will be made on a rolling basis, as soon as CMS ascertains that an EP has demonstrated meaningful use for the applicable reporting period (90 days for the first year; a calendar year for subsequent years), and reached the threshold for maximum payment. EPs should expect a single consolidated incentive payment each year from the Federal Supplementary Medical Insurance Trust Fund.

The rule states that it is CMS' intention to make payment within 4-6 weeks of receiving MU data from the EP. As January 1, 2011 is the first day EPs can begin collecting MU data, the earliest Year 1 data can be submitted is April 1, 2011. Therefore, the first incentive payments from CMS should be received sometime in May 2011.

Medicaid Participants

For Medicaid participants, of course, the payment will come from either the State Medicaid agency or their designated intermediary, such as a Medicaid HMO. The rule indicates that states' payments should be made within the same calendar year for that which is being reported.

Transferring the Payments

By default, all incentives are to be paid directly to the eligible provider (via CMS for Medicare EPs and the states for Medicaid participants). However, the proposal allows EPs to reassign incentives "…to an employer or entity with which the physician has a valid contractual arrangement allowing the entity to bill for the physician's services." The reassignment may only be made to a single employer, even if the EP has a contractual relationship with more than one entity. The proposal does not identify the mechanism through which reassignment is to be accomplished; we assume it will be made available in time for 2011 payments.

HHS will not wade into any EP/employer disputes over assignment of incentives. Any questions regarding the need of an EP to reassign his/her incentive payments "are a matter of contract interpretation that should be resolved by the parties themselves." Furthermore, the writers advise both EPs and employers/entities to "review their existing contract to determine whether it currently provides for reassignment of the incentive payment to the employer/entity or needs to be revised."

Multiple-Location EPs

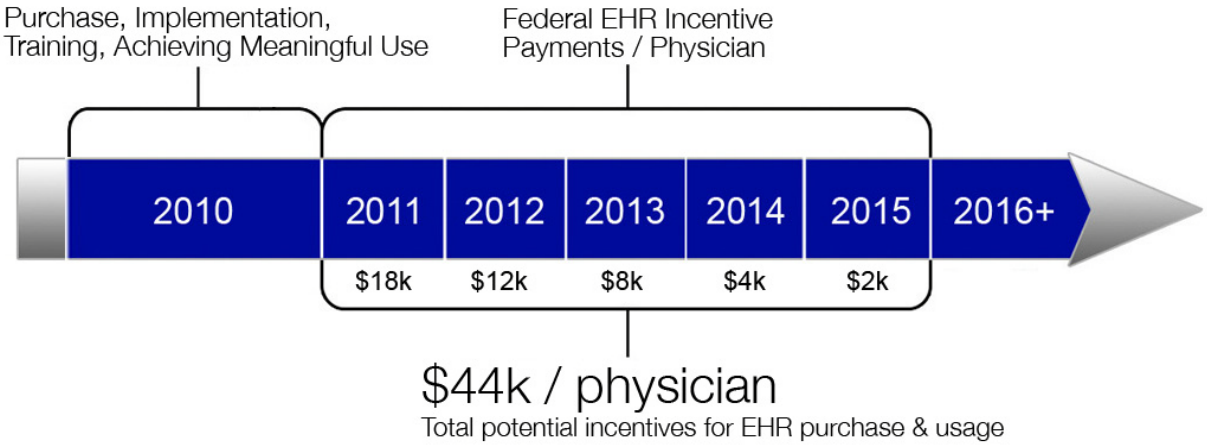
ONC recognized that many EPs provide services at more than a single location, such as a physician who practices at both an FQHC and his/her own practice. In these situations, the rule requires that to be considered a meaningful user, at least 50% of the EP's total patient encounters during the reporting period must be conducted at a location(s) that's equipped with a certified EHR. If an EP does not conduct 50% of his/her encounters at a single location, the threshold may be met by combining encounters from multiple locations which are each equipped with certified EHRs.

The Early Bird Gets the (Most) Cash

If you take a look at the "schedule" outlined above, you'll notice that the incentives have been front-loaded into the program. What this means is that those who implement certified EHRs sooner, rather than later, will see greater total incentive payments. That's partially where the "up to $44,000" comes from. Physicians can begin participating through 2014 and that's where it ends, whether you've enjoyed a full five years of payments or only three. Physicians who have not achieved MU by 2015 will be subject to the Medicare reductions discussed earlier.

Because of the manner in which the payments are structured, experts expect a crush of practices to begin their EHR implementations this year. Of significant concern is whether or not this might overwhelm the industry's ability to install EHRs in time for all groups to be eligible for the earliest and largest incentive payments. Therefore, it literally could pay more to be near the front of the line.

The timeline below illustrates how a practice that begins their EHR decision immediately can gain the earliest and largest federal EHR incentives. Many practices will overlook the lengthy pre-incentive phases, which must be completed to qualify in this scenario. Generally, the evaluation, purchasing, implementation, and training phases of an EHR process can take between 3 to 12 months (especially when the buying crush begins). Beyond that, practices will require time to meet the standards defined by the federal government under the "meaningful EHR user" definition. As the illustration makes clear, there is very little time to wait!



Modern Medicine (5/1/2009) summed up the time-sensitive nature of the incentives in a recent article:
"The industry will not be capable of handling the mass entrance of EHR adopters in the next 2 years. My advice is to select and deploy an established, reputable EHR vendor within the next few months; one that you think is most likely to be… ARRA certified in sufficient time. Waiting longer may result in delays, frustration, and **reduced incentive payments**."

Essentially, the sooner you're prepared to implement and start using your EMR/EHR, the better position you'll be in to reap the earliest and largest incentive payments. At the very least, it's high time to begin your EMR/EHR search.

Certifiably Certified

At the same time it released the final rule that defined Meaningful Use and detailed payment schedules for the EHR incentive programs, CMS released another final rule called "**Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology."** This rule describes (primarily for EHR vendors) the capabilities and standards that will

be required of a certified EHR. According the CMS announcement, the Certification Rule "describes standard formats for clinical summaries and prescriptions; standard terms to describe clinical problems, procedures, lab tests, medication and allergies; and standards for the secure transportation of this information using the Internet." In short, the rule defines the standards in which healthcare information is to be formatted and moved from one clinical setting to another.

This certification rule aligns its requirements and language with that of the MU rule discussed throughout the earlier section of this guide. The authors (the HIT Policy and the HIT Standards committees) are sure to label the standards, implementation specifications and certification criteria it puts forth as an "initial set." The groups propose that the current guidelines are merely the first step in "an *iterative* approach to enhancing the interoperability, functionality, utility and security of HIT."

Complete EHRs and *Modular* EHRs

Most of the standards and definitions were expected by the EHR community, but the committees included one curveball that was surprising: the idea of "EHR Modules" and a "Complete EHR." In an effort to assist groups and large institutions that already use technology which doesn't provide complete MU functionality, the committees put forth the definition of the EHR *Module*: "Any service, component, or combination thereof that can meet the requirements of at least one certification criterion adopted by the Secretary." Such components include interfaces, web portals, a clinical decision support rules engine, etc. Allowing the certification of modules permits best-of-breed approaches as well as the ability to simply keep using tools that are working.

However, the rule clearly states that <u>it is the responsibility of the EP</u> to ensure that certified modules function together to support the overall achievement of meaningful use. In other words, EHR incentives are paid for attaining *all* MU criteria, not simply a sub-set(s). Therefore, the use of certified modules will be permitted, but the EP must make sure that the collection of modules assembled provides <u>all</u> the functionality needed to achieve meaningful use.

A "Complete EHR" is just what it sounds like (especially in light of the discussion above): "Technology that has been developed to meet all applicable certification criteria."

Finally, the rule defines the term "Certified EHR Technology" for *Complete* EHRs as:

- 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" [emphasis added].

Certifying the Certifiers

In June 2010, the ONC released a rule entitled "**Establishment of the Temporary Certification Program for Health Information Technology,"** which established the process by which organizations may become HHS-recognized certifiers of EHR solutions. ONC created of two certification programs, one temporary (and immediate) and one permanent (and requiring more rigorous standards and, therefore, more time to establish).

The temporary program allows the ONC to authorize organizations that will test and certify Complete EHRs and/or EHR modules. At the time, the ONC indicated that such groups should be identified and functional in summer of 2010 and, as one might expect, it took until very late summer for that to be accomplished. On the very last day of August 2010, CMS announced that CCHIT and The Drummond Group had been awarded the status of temporary certifiers ("ONC-ATCB"). CCHIT indicated it will begin accepting applications from EHR vendors on September 20th and Drummond did not provide immediate indication of when it would be able to schedule testing.

The temporary program will end once the permanent program has been fully established and the ONC has authorized at least one permanent EHR certification body. The rule suggests this will be accomplished in Q1 of 2012. The permanent program separates the testing and certification functions, although a single organization, if authorized, could perform both roles. The essential difference is that the permanent program would move the accrediting function from ONC to an outside, private agency(ies) and it requires EHRs to renew their certification every 2 years.

The bottom line for providers is that fully certified EHRs are anticipated sometime in the fall of 2010, just in time to meet HITECH's timeline for its earliest and largest incentive payments. In the meantime, providers can follow the suggestions in the "What Do You Do Now?" section below to quick-start their EHR selection process and better guarantee their eligibility for HITECH's coming incentives.

Hurry Up…*and Wait*

Obviously, given the January 1, 2011 start date for EPs to begin collecting MU data, there's a keen interest for both EPs and EHR providers to have EHRs certified as quickly as possible. CMS and ONC have accomplished much since the signing of the American Reinvestment and Recovery Act in February 2009, which called for the creation of EHR incentive programs. However, with finalized requirements released in late summer and certification only available late in the year, it will likely take industry leaders some time to get their seal of approval. Again, though, the process by put forth by CMS/ONC provide flexibilities that make things more realistic.

In webinars conducted shortly after the release of the final rules, ONC officials explained that EPs could use EHRs that were not yet officially certified to collect MU data, assuming they provide proper functionality to do so. As long as the EP performs to MU requirements and the EHR obtains certification prior to the EP's attestation/submission of data to CMS, incentives will be recognized. This flexible approach acknowledges the development, testing and certification that EHRs must accomplish since finalization of the rules and possible waiting periods that may form during the certification process.

The bottom line: As long as an EHR properly measures meaningful use and is certified by April 1, 2011, EPs can begin participating in the EHR Incentive Program on January 1, 2011.

How Do I Participate?

Medicare or Medicaid?

Requirements for participating in the programs vary, depending upon whether the EP elects to take part in the Medicare or Medicaid versions. Remember, the law puts handling of the Medicaid program squarely in the hands of the States. ONC will audit each State's program, ensuring that all federal requirements are met, as well as determining whether or not a State is allowed to add more requirements. However, registering, reporting, and receiving payments will be concentrated at the state-level. As each state must develop their own infrastructure and resources, readiness may vary across the country. Therefore, each EP should identify their state's controlling agency(ies) and determine when their program are prepared to begin.

As the Medicare program is fully controlled at the federal-level, it's much easier to provide details regarding what is necessary to participate. As indicated above, obtaining and using an HHS-certified EHR is the first step toward preparing for the program. Once an appropriate EHR has been implemented, the EP may register for the program any time after January 1, 2011 by going to

www.cms.gov/EHRIncentivePrograms.

This site will collect several pieces of information, including the following:

- The EP's name,
- The EP's National Provider Identifier (NPI),
- The EP's business address and business phone number,
- The EP's taxpayer ID number (TIN) (for incentive payment),
- Selection of either the Medicare or Medicaid program (may switch once), and
- Selection of the state in which the EP will be participating (if the EP is taking part in the Medicaid program).

Once the EP has finished the reporting period (90 continuous days for Payment Year 1 and 12 months for Payment Years 2-5), data will be collected at the same site detailed above. For 2011, data submission will be a fully-manual process, meaning the CMS site will provide fields into which the EP will enter his/her performance calculations. In 2012, ONC anticipates it will be able to electronically accept some MU data, but will still require manual entry of some data points. The end-goal, of course, is for the EHR itself to submit data directly to CMS. Lump-sum payments are anticipated to be paid within 3-4 weeks after the EP's data has been submitted.

What Do You Do *Now*?

What's the Hurry?

As stated throughout this guide, the federal government's timelines are very aggressive and the process of buying an EHR is generally not a quick one. In many cases, practices can take 3-12 months to begin their search, do their due diligence, make their purchase, implement the product, and train their staff. Some observers are suggesting that Q4 2010 / Q1 2011 should be used to bring staffs to "meaningful use" levels and start collecting data to prove they've met it.

Finally, don't overlook the "natural" advantages that EHRs can provide your practice in the meantime. A fully-implemented EHR should allow most practices to eliminate most, if not all, transcription service costs, potentially saving $4000-$10,000/physician. If the physician is not spending time dictating notes for transcription, that time could be spent seeing additional patients. The cost of chart pulling – the cost of staffing, physician time spent waiting for lost charts, etc. – could be reduced by as much as 50%. The exercise of entering the charges for services performed by providers can be eliminated with point-of-care entry. This not only reduces labor costs, but also can increase revenue from each visit, as services are not forgotten and encounters may be filed at higher levels. Even quality of life issues (longer hours at work, chart work at home, access to charts) can be addressed by the use of an EHR.

What Do I Look For?

But, how can EPs know which EHR will meet their needs with certification beginning only months before the program starts? It would be nice if you could simply look for a foil sticker that says "HHS Certified for HITECH Incentives" and, indeed, that may be coming. But, for those looking to better guarantee access to the earliest and largest incentives, there are some characteristics that may help to identify the right solution now:

- **HITECH Certification.** The bottom-line guide to EHR selection must be whether or not it will be certified for the federal incentives programs. As mentioned above, the certification process – including even applying for the test itself – is one that's only now getting off the ground. CCHIT, the group which has providing certifications since 2006, has announced it will only start accepting applications on September 20, 2010. Once applications have been accepted, a 3-4 week process should be expected before vendors receive their "gold seal." Therefore, a large group of certified EHRs aren't expected until late September or October. Still, a valid question, even at the *earliest* of points is, "Will your EHR be certified for federal incentive programs in 2011?"

- **CCHIT® Certification**. The Certification Rule used CCHIT certification as a gauge to help determine the industry's capability to meet MU criteria within the timelines established by HHS. The rule notes that "previously CCHIT-certified-EHRs are similar to our definition of a Complete EHR." Since approximately 85% of HHS requirements were required for CCHIT 2008 certification, the rule further states that of those already possessing such certification, "…we expect that 90% will be prepared for certification to the certification criteria adopted by the Secretary [of HHS]." Clearly, CCHIT 2008 (or later) certification is a sign that the vendor has stayed current with the latest requirements and has proactively achieved certification before it was required by the federal government. And, as mentioned earlier, CCHIT and The Drummond Group will begin offering official certification in late 2010. Finding an EHR with any of these certifications should provide you with a greater sense that "meaningful use" can be accomplished.

- **References & Return on Investment**. Can the vendor demonstrate the financial benefits your practice should realize when its product is implemented? Can they provide the names of at least 10 similar practices to call? Don't take their word for it; call customers who have been using the product and ask what they've experienced. Of course, full HITECH incentives should more than pay for the solution, but wouldn't it be nice for the EMR to pay for itself and to enjoy the incentives, too?

- **Specialty Experience**. Many of the largest EHR vendors began by providing systems in primary care environments. There's not necessarily anything wrong with this, but, if you're a specialty physician, you should question whether or not the vendor truly provides a solution that works in your environment. Or, will you end up with a blank slate of sorts and spend the first 6 months after go-live building templates and customizing it to work in your office? Do they understand your unique needs and workflows? Do they provide the deep clinical content that will allow you to quickly document just about anything that presents itself in the exam room? How well developed is their specialty-based library of templates, protocols and algorithms, PIFs and correspondence, and Rx hotlists unique to your specialty? If the EHR you select does not provide you with the clinical content to get up and running almost immediately, you'll likely find yourself struggling to meet meaningful use requirements in time for 2011 incentives.

- **Length of Time in Business & Lifetime Retention Rate**. There are generally a few reasons a vendor might have been around for 10 years, especially in such a dynamic and competitive industry. Vendors with experience typically provide a more user-friendly and complete solution because they've evolved to satisfy their customer base. And, finally, companies with lifetime retention rates over 90% are simply doing something right. In an industry in which the failure rate is nearly 50%, it pays to find one who's done it the right way from the very beginning.

Conclusion

The changes brought forth by HITECH will have significant impact on many in the healthcare marketplace. EHR vendors are working to ensure their products meet goals and standards within very short timeframes. Vendors must also wrestle with the significant financial requirements that certification will entail. Physicians must also deal with the timelines and changes imposed on their practices in order to successfully meet incentive standards and, later, to avoid increasing Medicare penalties. The goals and timelines imposed on the entire healthcare community are daunting.

However, given the compelling evidence of improved healthcare and lower costs from other EHR-equipped countries, it is clear that America's 21st Century healthcare system must embrace the electronic record revolution. After years of recommendations and mandates that carried no weight, HITECH, at least, has put money where its mouth is. Have no doubt, EHRs are coming.

But, the reactions to HITECH's impositions shouldn't obscure the cost and revenue benefits that EHRs can also bring to practices. At a time when Medicare and other insurance reimbursements are falling, many physicians and practices are finding it more and more difficult to make ends meet. EHRs can provide many avenues for increasing revenue and also decreasing costs.

Finally, it must be noted that the administration's EHR goals are not only targeted at the financial bottom line. They are also meant to improve care and ensure higher levels of patient safety. The

increased role of specialists, while greatly increasing the well-being of American patients, has also made continuity of care more difficult. With the current amalgam of paper and EMR systems, this oftentimes leads to a disjointed patient health record. Interoperability standards and functions are meant to provide the smooth and accurate transmission of data from one office to another.

Added together, HITECH incentives and the "natural" benefits provided by EHRs – greater continuity of care and patient safety, reduced costs, increased revenue, and even improved physician/staff lifestyles – can make for a winning opportunity for the nation's physicians.

IMPORTANT NOTICES

NOTE: The information presented here is believed to be accurate at the time it was written in September 2010. As ONC itself has labeled the current guidelines as "iterative" of a continually-developing process, details regarding the EHR incentive programs could change since this document was assembled. EPs are urged to keep abreast of changes by monitoring www.cms.gov/EHRIncentivePrograms.

NOTE: "CCHIT®", "CCHIT Certified®" and "Drummond Group Inc." are registered marks of their respective owners. Drummond Group Inc. and CCHIT are independent bodies and neither has reviewed or endorsed this material.

APPENDIX: Clinical Quality Measures – Menu Items

(From CMS' "Medicare and Medicaid Programs; Electronic Health Record Incentive Program," July 13, 2010.)

CQM MENU ITEMS	
Measure Title/Description	**NQF/PQRI Attribution**
Title: Diabetes: Hemoglobin A 1 c Poor Control **Description**: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%	NQF 0059 PQRI 1
Title: Diabetes: Low Density Lipoprotein (LDL) Management and Control **Description**: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL.	NQF 0064 PQRI 2
Title: Diabetes: Blood Pressure Management **Description**: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.	NQF 0061 PQRI 3
Title: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) **Description**: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	NQF 0081 PQRI 5
Title: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) **Description**: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.	NQF 0070 PQRI 7
Title: Pneumonia Vaccination Status for Older Adults **Description**: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	NQF 0043 PQRI 111

CQM MENU ITEMS	
Measure Title/Description	**NQF/PQRI Attribution**
Title: Breast Cancer Screening **Description**: Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	NQF 0031 PQRI 112
Title: Colorectal Cancer Screening **Description**: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	NQF 0034 PQRI 113
Title: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD **Description**: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.	NQF 0067 PQRI 6
Title: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) **Description**: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed betablocker therapy.	NQF 0083 PQRI 8
Title: Anti-depressant medication management: (a) Effective Acute Phase Treatment,(b) Effective Continuation Phase Treatment **Description**: The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NQF 0105 PQRI 9
Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation **Description**: Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.	NQF 0086 PQRI 12
Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	NQF 0088 PQRI 18

CQM MENU ITEMS	
Measure Title/Description	**NQF/PQRI Attribution**
Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	
Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care **Description**: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	NQF 0089 PQRI 19
Title: Asthma Pharmacologic Therapy **Description**: Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.	NQF 0047 PQRI 53
Title: Asthma Assessment **Description**: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.	NQF 0001 PQRI 64
Title: Appropriate Testing for Children with Pharyngitis **Description**: Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	NQF 0002 PQRI 66
Title: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer **Description**: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting	NQF 0387 PQRI 71

CQM MENU ITEMS	
Measure Title/Description	**NQF/PQRI Attribution**
period.	
Title: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients **Description**: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.	NQF 0385 PQRI 72
Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients **Description**: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	NQF 0389 PQRI 102
Title: 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 **Description**: Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.	NQF 0027 PQRI 115
Title: Diabetes: Eye Exam **Description**: Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.	NQF 0055 PQRI 117
Title: Diabetes: Urine Screening **Description**: Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.	NQF 0062 PQRI 119

CQM MENU ITEMS	
Measure Title/Description	**NQF/PQRI Attribution**
Title: Diabetes: Foot Exam **Description**: The percentage of patients aged 18 – 75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).	NQF 0056 PQRI 163
Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol **Description**: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).	NQF 0074 PQRI 197
Title: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation **Description**: Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.	NQF 0084 PQRI 200
Title: Ischemic Vascular Disease (IVD): Blood Pressure Management **Description**: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1- November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).	NQF 0073 PQRI 201
Title: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic **Description**: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.	NQF 0068 PQRI 204

CQM MENU ITEMS	
Measure Title/Description	**NQF/PQRI Attribution**
Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement **Description**: The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	NQF 0004
Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) **Description**: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.	NQF 0012
Title: Prenatal Care: Anti-D Immune Globulin **Description**: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.	NQF 0014
Title: Controlling High Blood Pressure **Description**: The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.	NQF 0018
Title: Cervical Cancer Screening **Description**: Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer	NQF 0032
Title: Chlamydia Screening for Women **Description**: Percentage of women 15- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.	NQF 0033

CQM MENU ITEMS	
Measure Title/Description	**NQF/PQRI Attribution**
Title: Use of Appropriate Medications for Asthma **Description**: Percentage of patients 5 - 50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).	NQF 0036
Title: Low Back Pain: Use of Imaging Studies **Description**: Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.	NQF 0052
Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control **Description**: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100 mg/dL.	NQF 0075
Title: Diabetes: Hemoglobin A1c Control (<8.0%) **Description**: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c <8.0%.	NQF 0575