STATEMENT OF

KAREN TRUDEL

ACTING DIRECTOR,
OFFICE OF E-HEALTH STANDARDS AND SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON
MEDICARE AND MEDICAID ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAMS

BEFORE THE

U.S. HOUSE COMMITTEE ON SMALL BUSINESS
SUBCOMMITTEE ON HEALTHCARE AND TECHNOLOGY

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

JUNE 2, 2011

CMS TESTIMONY

Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs

U.S. House Committee on Small Business

Subcommittee on Healthcare and Technology

June 2, 2011

Chairwoman Ellmers, Ranking Member Richmond, and Members of the Subcommittee, thank you for the invitation to discuss the impact of the implementation of Health Information Technology (HIT) on small and solo providers, especially the implementation of the Centers for Medicare & Medicaid Services' (CMS) new incentive program for electronic health records (EHRs). My testimony will focus on explaining the different components of the Medicare and Medicaid EHR Incentive Programs and how these programs encourage the widespread adoption of EHRs, as well as CMS' progress in helping providers implement and meaningfully use EHRs. CMS and States are now providing incentive payments to 1139 eligible professionals and 110 eligible hospitals that have successfully adopted, implemented, upgraded, or demonstrated meaningful use of EHRs under the Medicare and Medicaid EHR Incentive Programs.

Background

Through the Health Information Technology for Economic and Clinical Health (HITECH) provisions within the American Recovery and Reinvestment Act of 2009 (ARRA) (P.L. 111-5), Congress established the Medicare and Medicaid EHR Incentive Programs to provide incentive payments to eligible professionals and eligible hospitals (including critical access hospitals (CAHs)) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. Since enactment, CMS and HHS' Office of the National Coordinator for Health Information Technology (ONC) have been laying the groundwork to support this national investment in EHRs. Both CMS and ONC published regulations providing a roadmap to eligible professionals and eligible hospitals about what they would need to do to qualify for the EHR incentive payments and ONC's Regional Extension Centers provide direct assistance to providers seeking to select and implement EHR technology.

Widespread adoption and meaningful use of EHRs and health information exchange are expected to improve health care quality for patients by increasing the information available to individual providers, enhancing provider coordination, and reducing unnecessary health care costs that come from items such as duplicated tests or preventable drug errors. While early in implementation, the EHR Incentive Programs are already helping to bring our health care system into the 21st Century. By promoting the adoption of EHR and health information exchange, health care providers will have powerful tools to improve health care. EHRs have the potential to:

- Increase patient safety by identifying preventable safety concerns such as alerts that warn providers when a new prescription will interact with another medication the patient is taking.
- Further care coordination by making a patient's complete current health information more easily available and eliminate the need to duplicate diagnostic tests;
- Advance care by delivering outputs that paper records cannot;
- Enhance patient and provider convenience by providing more informational resources and follow-up instructions for patients, allowing physicians to e-prescribe, and reducing paperwork time for providers;
- Improve patient privacy and security over paper records – rules based access can limit who has access to specific information based on their job, and robust audit trails can track and provide information for patients on who accessed or changed a particular record.

With improvements that reduce administrative burden, enhance patient safety, reduce duplicative tests, and progress toward high quality effective care, we are confident that the meaningful use of EHRs will be a powerful tool to help providers deliver better care more efficiently– one of CMS' main goals in transforming the health care delivery system.

However, I want to be clear that EHRs do not achieve their many benefits merely by transferring information from paper files into digital form. EHRs can only deliver their maximum benefits when the information is standardized and structured so that it can be used to provide an

additional knowledge base to providers at the point of care, and also allow multiple health care providers to exchange health information, known as interoperability. Therefore, CMS and ONC require providers to meet specific objectives and to use EHRs that are certified specifically for this program in order to receive incentive payments. The HITECH provisions define which health care professionals and hospitals may be eligible for the EHR Incentive Programs and the differences between the Medicare and Medicaid EHR Incentive Programs. The HITECH Act also grants HHS the authority to determine the standardized criteria for how EHRs should function and how professionals and hospitals should use EHRs in a meaningful way. ONC defines the standards and certification criteria for EHR technology and information exchange. CMS defines the criteria for what a meaningful user of EHR technology is and how providers must demonstrate their meaningful use to CMS and to States. By coordinating our respective regulations, CMS and ONC are ensuring that the incentive payments are received for adoption and use of EHR systems that actually improve care and will lower unnecessary health care costs.

The Medicare and Medicaid EHR Incentive Programs

The following section provides an overview of the key components and differences between the Medicare and Medicaid EHR Incentive Programs. Eligible professionals, including small practitioners, who meet the eligibility requirements for both the Medicare and Medicaid EHR Incentive Programs may participate in only one program and must designate which program they choose to participate in. Eligible hospitals meeting all requirements for the Medicare and Medicaid EHR Incentive Programs can receive payments under both programs. Because the programs are so closely related, we established the same rules, requirements, and procedures for both Medicare and Medicaid wherever possible.

Medicare EHR Incentive Program

The Medicare EHR Incentive Program provides incentive payments to eligible professionals and eligible hospitals that demonstrate meaningful use of certified EHR technology for a defined reporting period (90 days in the first payment year, a full year in subsequent years).

- Eligible professionals, including small and solo providers, can receive up to $44,000 over five consecutive years under the Medicare EHR Incentive Program. There is an additional incentive payment for eligible professionals who provide more than fifty percent of their covered services in a designated Health Professional Shortage Area (HPSA).
- To qualify for the maximum incentive payment, Medicare eligible professionals must begin participation by 2012, as the first year payment amount diminishes starting in 2013.
- Incentive payments for eligible hospitals are based on a base payment of $2 million combined with an additional computation based on the number of acute care inpatient discharges a hospital has that year which is then multiplied by a "Medicare share," which is calculated using the percentage of the hospital's acute care inpatient bed days paid by Medicare with an allowance for charity care. To qualify for the maximum incentive payment, hospitals must begin participating by 2013; hospitals may begin receiving payments in 2014 or 2015 but they will receive a lesser total payment.
- In 2015 and later years, the law includes a negative payment adjustment in Medicare reimbursement for Medicare eligible professionals and eligible hospitals that do not successfully demonstrate meaningful use.

The HITECH Act defines a Medicare eligible professional as a doctor of medicine or osteopathy, dental surgery or dental medicine, podiatric medicine, optometry, or a chiropractor, who is legally authorized to practice under State law. However, eligible professionals who are hospital-based (as defined in regulation as, those who furnish 90 percent or more of covered professional services in the inpatient hospital or emergency department settings) do not qualify for the incentive payments, and therefore, are not subject to the payment adjustment. Certain professionals who are employed or subcontracted by a Medicare Advantage (MA) organization and who provide an average of at least 20 hours of patient care services per week to enrollees of the MA organization may also be eligible for incentive payments.

The HITECH Act states that an eligible hospital for Medicare EHR incentives is a "subsection (d) hospital" that is paid under the hospital inpatient prospective payment system and located in

one of the 50 States or the District of Columbia. CAHs are also eligible for Medicare incentive payments.

Medicaid EHR Incentive Program

The Medicaid EHR Incentive Program will enable states to provide incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use for up to five remaining participation years. Under the law:

- Individual States and Territories voluntarily offer the Medicaid EHR Incentive Program. All states have indicated that they plan to do so. Eligible professionals, including small and solo practitioners, can receive up to $63,750 over the six years that they choose to participate in the program, with initial payments beginning no later than 2016. They can receive $21,250 in the first year.
- The last year a Medicaid eligible hospital may begin the program is 2016. Hospital payments are based on an estimation of the total amount that would be available under a similar formula as that used in Medicare, except using a "Medicaid" rather than Medicare share, which is based on acute-care inpatient bed days paid by Medicaid. The States can then determine how quickly the total amount is disbursed as long as this timeframe is at least 3 years and no more than 6 years.
- There are no payment adjustments mandated under the Medicaid EHR Incentive Program for providers that do not demonstrate meaningful use.

While the State expenditures for incentives are eligible for 100 percent Federal matching payments, States are required to plan for and administer the program with a 90 percent Federal match for approved costs. To qualify to receive 90 percent Federal matching funds for State costs associated with administering the Medicaid EHR Incentive Program, States must develop:

- Health Information Technology Planning Advance Planning Document (HIT PAPD) – A plan of action requesting Federal matching funds and approval to accomplish the

planning necessary for a State Medicaid agency to implement and oversee the EHR Incentives.

- State Medicaid Health Information Technology Plan (SMHP) – A landscape assessment describing the State's current and future HIT activities, as well as the activities in support of the Medicaid EHR Incentive Program.
- Health Information Technology Implementation Advance Planning Document (HIT IAPD) – A plan of action requesting Federal matching funds and approval to implement and oversee the EHR incentive payments.

Under the terms of the HITECH Act, Medicaid has a more expansive definition of eligible professionals and allows not only physicians, but also nurse practitioners, dentists, certified nurse-midwives, and certain physician assistants (when the physician assistant is practicing at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) led by a physician assistant), to qualify for incentive payments. Medicaid incentives are also available for acute care hospitals, which include cancer hospitals, general short-term stay hospitals and CAHs, as well as, children's hospitals. Eligible professionals and most eligible hospitals are subject to a requirement that some portion of their patient volume is derived from treating vulnerable populations. In general, Medicaid eligible professionals may participate in the program when they: 1) have at least 30 percent of their patient volume derived from Medicaid (20 percent for pediatricians); or 2) practice predominantly in an FQHC or RHC and have 30 percent of their patient volume derived from needy individuals. Acute care hospitals must have 10 percent of their patient volume derived from Medicaid patients. Only children's hospitals have no patient volume requirement.

EHR Incentive Program "Meaningful Use" Final Rule

As explained earlier, the HITECH Act defined certain aspects of the Medicare and Medicaid EHR Incentive Programs, but granted HHS the authority to define other standardizing criteria. CMS defined, through a notice-and-comment rulemaking process, what it means to "meaningfully use" certified EHR technology and how professionals, including small and rural

providers, and hospitals can demonstrate their meaningful use; the final rule was published on July 28, 2010 (CMS-0033-F). The following sections summarize the meaningful use provisions of this rule.

Meaningful Use Criteria and Clinical Quality Measures

EHRs cannot achieve their full potential if providers do not fully utilize the capabilities they bring. Therefore, the "meaningful use" approach requires providers to meet specified objectives and measures in order to qualify for incentive payments. In order to maximize the potential of EHRs, we adopted an "escalator" approach to meaningful use, in that we envision three Stages, each requiring more rigorous requirements. The first stage focuses on using EHRs to collect clinical data, begin implementation of Computerized Provider Order Entry (CPOE) and electronic prescribing, and taking initial steps to move toward patient engagement and secure electronic exchange of clinical data. The remaining stages, which will be defined through rulemaking, plan to incorporate robust clinical decision support, widespread secure electronic data exchange, care coordination and full patient engagement. Privacy and security requirements are required in all stages of the program.

The announcement of final "meaningful use" regulations provided a critical component in our efforts to speed EHR adoption and use. ONC simultaneously issued a closely related final rule that defines an initial set of standards, implementation specifications, and certification criteria for EHRs. ONC issued the final rule setting up a temporary certification program for health IT on June 24, 2010, (75 FR 36158), and the final rule setting up a permanent certification program for health IT on January 7, 2011, (76 FR 1262).

Stage 1 Criteria for Meaningful Use and Clinical Quality Measures

The Stage 1 criteria for meaningful use focus on electronically capturing health information in a standardized format, using that information to track key clinical conditions, securely communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information. The criteria for meaningful use are

based on a series of specific objectives, each of which is tied to a measure that allows eligible professionals and eligible hospitals to demonstrate that they are meaningful users of certified EHR technology.

For Stage 1, there are 25 objectives for eligible professionals and 24 objectives for eligible hospitals. The objectives have been divided into a "core" set and a "menu" set. Eligible professionals and hospitals must meet all objectives in the "core" set (15 for eligible professionals and 14 for eligible hospitals). They can choose to defer up to five remaining objectives (other than certain required public health measures) in the "menu" set. CMS evaluated each objective for its potential applicability to all eligible professionals and hospitals. In instances where it is impossible for an eligible professional or hospital to meet a specific measure, the regulation allows for exclusion, in which case the professional or hospital does not have to meet that objective in order to be determined a meaningful EHR user. For example, if an eligible professional has two exceptions (one for a core objective and one for a menu objective); the professional would need to meet the remaining 14 objectives in the core set and four of the remaining nine objectives in the menu set. We added this flexibility in response to public comment that strongly recommended that we accommodate the various levels of EHR implementation in order to facilitate participation by providers who did not have robust EHR implementations. This flexibility should be especially important for small providers that are just embarking on the process of selecting and implementing EHR technology.

One of the core meaningful use objectives is to report clinical quality data to CMS or the States. CMS promulgated final clinical quality measures in its July 28 final rule. For eligible professionals, there are core and menu set clinical quality measures. Eligible hospitals must report on a core set of clinical quality measures. In 2011, eligible professionals and eligible hospitals will submit aggregate numerator, denominator, and exclusion data for each such clinical quality measure to CMS or the States. In the future, eligible professionals, eligible hospitals, and CAHs seeking to prove meaningful use will be required to electronically submit clinical quality measures selected by CMS directly to CMS (or the States for Medicaid) through certified EHR technology. CMS recognizes that for clinical quality reporting to become routine,

CMS must reduce the administrative burden of reporting. The burden will be reduced when registrants use certified EHR technology to securely report information on clinical quality measures electronically to a health information network, a State, CMS, or a registry. CMS expects that by their second implementation year, States will have the capacity to accept direct submission of Medicaid providers' clinical quality measures from certified EHR technology.

EHR Incentive Program Status

Less than a year after publishing the final rule, CMS is now providing incentive payments to eligible professionals and hospitals that have successfully adopted, implemented, upgraded or demonstrated meaningful use of EHRs under the Medicare and Medicaid EHR Incentive Programs. As of May 2011, more than 42,600 eligible professionals and hospitals registered for either the Medicare or Medicaid EHR Incentive Program and more than 9,100 people have subscribed to the EHR listserv, which updates subscribers about new materials and resources for the EHR Incentive Programs. We have developed a web-based application for providers to register for both the Medicare and Medicaid incentive programs. The web-based application also helps CMS keep track of which providers have selected and received incentive payments from which program. The same application is used for Medicare providers to attest to their meaningful use of EHRs. States will develop their own attestation mechanisms, and data is exchanged bi-directionally between CMS' central database and the States.

Medicare Status

On January 3, 2011, registrations both for the Medicare and Medicaid EHR Incentive Program began and 42,393 professionals and 221 hospitals have registered for the program through April 30. Attestation for the Medicare EHR Program successfully opened on April 18, 2011; already, 485 providers and hospitals have successfully attested during this first month, and CMS expects this number to continue to grow over the duration of the program. To attest for the Medicare Program, professionals, hospitals, and CAHs must have registered for the program, and must have reported on their meaningful use of certified EHR technology for the 90-day reporting period. The first EHR incentive payments went out to meaningful users on May 19, 2011, and

CMS paid $5,094,000 in incentive payments to eligible professionals that attested to meaningful use and $70,762,912 in incentive payments to eligible hospitals that attested to meaningful use. Eligible hospitals and CAHs may begin their attestation period as late as July 3, 2011, and eligible professionals may begin as late as October 1, 2011.

Medicaid Status

CMS is encouraged that States across the country have already shown strong enthusiasm for the EHR incentive program. States began launching their Medicaid EHR Incentive Payments Programs in January 2011. Eleven States – Alaska, Iowa, Kentucky, Louisiana, Michigan, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, and Texas – began their programs on day one. Since then, Alabama, Missouri, Indiana, and Ohio have begun EHR registration for Medicaid providers, bringing the total number of states participating in the program to 15. The majority of states have indicated to CMS that they will launch by the end of calendar year 2011. Of the States that have launched programs since January, many have already started making payments. Kentucky, Iowa, Oklahoma, and Louisiana launched their program in January and started making payments within days. Louisiana made the first EHR incentive payment in the country to eligible professionals, who are safety net providers at Winn Community Health Center. Kentucky paid the first hospitals in the country, Central Baptist Hospital and University of Kentucky Hospital, which is a teaching hospital. Oklahoma paid the first eligible professionals at the Gastorf Family Clinic, a small, independently-owned primary care clinic in Durant, Oklahoma. As of May 4, CMS and the States have paid out over $83 million in Federal matching for incentives through the Medicaid EHR incentive program.

Outreach

CMS strives to increase awareness and participation in the Medicare and Medicaid EHR Incentive Programs, as well as increase stakeholder support for the programs. CMS uses a variety of tools to engage eligible providers, including small and solo providers, hospitals, and States in the programs, including social media, print and web advertisements, articles in trade magazines and blogs including WebMD's Medscape, and professional conferences. This

strategy focuses on making high quality information easily accessible to busy providers. CMS has established a website at www.CMS.gov/EHRIncentivePrograms where providers can access frequently asked questions, and other materials that make registering for the programs and attesting to meaningful use easier, such as step-by-step guides, factsheets in English and Spanish, and web tools like the Meaningful User Calculator.

CMS has held webinars and conference calls to teach and inform potential and current registrants about the EHR Incentive Programs. For example, three webinars in August 2010 that provided an overview of the program had over 9,000 participants. A registration webinar on February 18, 2011, attracted 2,556 participants. On April 1 and April 6, CMS sponsored two national provider sessions on registering for the programs which had 2,998 and 1,701 participants, respectively. On May 3 and May 5, CMS also sponsored two national provider sessions on attestation which had 1,116 and 3,132 participants, respectively. CMS also conducted several educational sessions at the Healthcare Information and Management Systems Society, one of the largest annual healthcare information technology conferences in the country. Through those sessions, CMS was able to reach thousands of eligible professionals and representatives from eligible hospitals. CMS continues to conduct educational sessions as national association meetings around the country.

CMS also focuses its outreach efforts regionally. On April 6 to April 8, Dallas team members, from the CMS regional office, participated as exhibitors at the annual conference of the Texas Organization of Rural & Community Hospitals. They provided information about the EHR Incentive Programs to the region's small and rural providers. On April 12 and 13, San Francisco team members conducted five State-specific webinars for eligible professionals in California, Nevada, Arizona, Nevada, Hawaii, American Samoa, and Guam, to discuss the EHR Incentive Programs. Each webinar or call featured speakers from the Regional Extension Centers and State Medicaid Offices.

Throughout the implementation of the program, CMS is engaging in frequent outreach activities to educate the States on the Medicaid EHR Incentive Program, and to gather feedback from the States about the program. Every two weeks, CMS hosts an All-States Call that addresses a particular set of requirements or activities that the States must undertake to successfully participate in the incentive program.

Finally, it is also worth noting that States are engaged in a number of outreach activities to reach their providers directly. Many states are pre-determining eligibility for the program through data matches in their systems to target outreach directly at providers with high Medicaid patient volume and those working in FQHCs and RHCs. States are leveraging the communication tools and resources already in use (e.g. Twitter, websites, newsletters, town hall meetings, etc.) to conduct outreach for this program.

Beyond the Stage 1 Criteria for Meaningful Use

CMS plans to build on our experience and achievements to meet our policy goals for EHR implementation. CMS intends to pursue future rulemaking that would outline two additional stages of criteria for meaningful use. In planning for future stages of meaningful use, CMS is seeking input from a variety of sources, including the Health Information Technology Policy Committee, State Medicaid agencies, and provider feedback from the Stage 1 implementation. CMS will carefully evaluate this input as we work towards our goal of meeting our policy priorities and supporting the health care community's ability to meaningfully use certified EHR technology through flexible and feasible regulations. The Stage 2 proposed rule is expected to be released in early 2012.

Looking Ahead

I am happy to present CMS' progress and accomplishments in implementing the EHR Incentive Programs at such an exciting time for developing and implementing the programs. Just one year ago, we were still working with professionals, including small and solo providers, hospitals, and other stakeholders, to define what it means to meaningfully use EHRs and how we can measure

that without undue provider burden. Now, we have thousands of professionals and hospitals registered to participate in the EHR programs, reporting their use, and receiving payments to help them continue to move toward a fully implemented EHR system. Together, we are advancing toward using EHRs to improve patient care and coordination while improving the efficiency of health care.

CMS plans to continue to reach out and inform eligible professionals and hospitals about the benefits of participating in this program. CMS will continue to participate in calls, webinars, and conferences explaining how eligible professionals and hospitals can receive incentive payments. CMS will also publish articles and disseminate information about the EHR Incentive Programs, so that as many professionals and hospitals as possible are aware of the program and the resources available to help them make the switch from paper to electronic records. Over the last 30 years, we have watched information technology transform industry after industry, dramatically improving the customer experience and driving down costs. Now that government and stakeholders are coming together, we are finally poised to make the same transformation in health care.