

# Meaningful Use Stage 1 Requirements for Medicaid Incentive Program

## Inpatient Checklist

### **Provided By:**

The National Learning Consortium (NLC)

### **Developed By:**

Health Information Technology Research Center (HITRC)  
American Academy of Pediatrics

*The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.*



## NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and resources designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource can be used in support of the [EHR Implementation Lifecycle](#). It is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

### EHR Implementation Lifecycle



## DESCRIPTION & INSTRUCTIONS

The Meaningful Use Stage 1 Requirements for Medicaid Incentive Program inpatient checklist is intended to aid providers and health IT implementers with achieving meaningful use during stage 1. It can be used to assist pediatricians in understanding what is required to receive incentive payments from the US Centers for Medicare and Medicaid Services (CMS). Providers are not required to begin participating in the program in 2011; however, providers must begin receiving payments no later than 2016<sup>1</sup>.

### Background

On July 13, 2010, the US Centers for Medicare and Medicaid Services (CMS) released a Final Rule establishing the criteria with which eligible pediatricians, other health providers and hospitals must comply in order qualify for the incentive payments that are available to clinicians through the American Recovery

<sup>1</sup> To access the rest of the American Academy of Pediatrics resource series, go to <http://www.aap.org/informatics/AAPOverview.html>. The entire Meaningful Use Final Rule may be viewed at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.



and Reinvestment Act. Acute care hospitals and stand-alone children's hospitals are eligible to receive Medicaid incentives for the meaningful use of electronic health record technology. Hospitals may participate in both the Medicare and Medicaid incentive programs, and payment rates should be similar between the two programs.

*Note: The formula for calculating incentive payments under the Medicaid program is as follows:*

*[\$2,000,000 + (\$200 for the first 1,150-23,000 discharges\*)] x (1 in Year 1, ¾ in Year 2, ½ in Year 3, ¼ in Year 4) x % of total inpatient bed-days charges attributable to Medicaid*

*\*The number of applicable discharges will increase for each payment year.*



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# 1 Getting Ready to Participate in the Medicaid Incentive Program

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You have your hospital name, National Provider Identifier (NPI), Taxpayer Identification Number (TIN), business address, business phone, and CMS Certification Number (CCN) ready. (You'll need them to enroll in the program using a secure Web portal that will be set up and managed by the US Centers for Medicare and Medicaid Services (CMS)).

If you participate in more than 1 state's Medicaid program, you've chosen in which state you will participate. You will still qualify based on your entire Medicaid patient population.

If you currently use electronic health record technology, you've contacted your vendor to make sure they are certified for the incentive program.

For each of the functional requirements and quality measures listed below, you will be ready to report the following:

- Reporting period beginning and end dates
- Numerators and denominators for each functional and quality measure

# 2 Qualifying for Meaningful Use – Core Functional Requirements

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If you are using a certified EHR (or a combination of certified EHR technology components), your vendor(s) is (are) required to meet a set of requirements that ensure your EHR can provide the functions you need to qualify for meaningful use. Hospitals are then required to implement those functions in order to receive the incentive payments.

The authorizing provider must directly enter into an electronic ordering system (CPOE) at least 30% of medication orders.

Enable drug-drug and drug-allergy checking within your CPOE program.

Using structured data (i.e., not free text), maintain an up-to-date problem list of current and active problems for at least 80% of admitted patients.

Using structured data, maintain an active medication list for at least 80% of admitted patients. If a patient is not currently on any medications (including over-the-counter medications), indicate, "none."

Using structured data, maintain an active medication allergy list for at least 80% of admitted patients. If a patient does not have any medication allergies, indicate "none."

Using structured data, record the following demographic information in your EHR for at least 50% of your patients:

- Preferred language
- Gender
- Race



- Ethnicity
  - Date of birth
  - Date and preliminary cause of death in the event of mortality in the eligible hospital.
- For at least 50% of admitted patients age 2 years and older, record height, weight, and blood pressure in your EHR as structured data.
- For at least 50% of admitted patients age 13 years and older, record smoking status.
- Identify 1 high-priority hospital condition, and use your EHR to implement a clinical decision support rule; then track your hospital's compliance with those rules.
- Provide at least 50% of patients with an electronic copy of the health information within 3 business days, upon request.
- Provide at least 50% of discharged patients with an electronic copy of their discharge instructions, upon request.
- Perform at least 1 test of the EHR's ability to exchange key clinical information (egg, using the Continuity of Care Document [CCD] or Continuity of Care Record [CCR]).
- Conduct a risk analysis to ensure your hospital is compliant with the HIPAA Security Rule. If your hospital has already conducted a risk analysis, review it. Update your hospital's security measures and correct deficiencies if necessary.

### 3 Qualifying for Meaningful Use – Menu Functional Requirements

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Hospitals may defer up to 5 of these requirements:

- Enable access to at least 1 internal or external formulary and implement drug-formulary checks.
- For at least 50% of admitted patients age 65 years and older, include in the EHR (in structured data) an indication of whether or not the patient has an advance directive. (Hospitals that do not accept patients age 65 years and older are excluded from this measure.)
- For at least 40% of clinical lab test results that are received electronically in positive/negative or numerical format, incorporate the results as structured data (i.e., not just an image of the report) into your EHR.
- Identify at least 1 clinical condition that is a priority for your hospital and use your EHR to generate a report of admitted patients with that condition for the purpose of quality improvement, reduction of disparities, research, or outreach.
- For more than 10% of unique patients admitted, use the EHR to provide patient-specific education resources.
- For at least 50% of admitted patients who have transitioned from another care setting, perform medication reconciliation.



- Provide a summary of care record (CCD or CCR) for at least 50% of patients whose care transitions to another care setting.
- Perform at least 1 test of your EHR's ability to send electronic immunization information to your state or local registry. If the test is successful, continue to submit. (You are excluded from this measure if you do not provide immunizations or if the registry does not allow for standardized electronic transmissions.)
- Perform at least 1 test of your EHR's ability to send reportable lab results to a public health agency. If the test is successful, continue to submit. (You are excluded from this measure if the public health agency does not allow for standardized electronic transmissions.)
- Perform at least 1 test of your EHR's ability to send electronic syndromic surveillance data to your state or local public health agency. If the test is successful, continue to submit. (You are excluded from this measure if you do not collect any reporting surveillance information during the reporting period or if the public health agency does not allow for standardized electronic transmissions.)

## 4 Qualifying for Meaningful Use – Quality Measures

All hospitals must report on the following set of quality measures: *(NOTE: The National Quality Forum number for each measure is included for your reference.)*

- Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department. (NQF 0495)
- Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status. (NQF 0497)
- Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge. (NQF 0435)
- Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge. (NQF 0436)
- Acute ischemic stroke patients who arrive at this hospital within 2 hours of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours of time last known well. (NQF 0437)
- Ischemic stroke patients administered antithrombotic therapy by the end of hospital day 2. (NQF 0438)
- Ischemic stroke patients with LDL  $\geq$  100 mg/dL, or LDL not measured, or, who were on a lipid lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge. (NQF 0439)
- Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke. (NQF 0440)
- Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services. (NQF 0441)
- The number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission. (NQF 0371)



- The number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer). (NQF 0372)
- The number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR)  $\geq 2$  prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications. (NQF 0373)
- The number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol. (NQF 0374)
- The number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health, home hospice or discharged/transferred to court/law enforcement on warfarin with written discharge instructions that address all 4 criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions. (NQF 0375)
- The number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date. (NQF 3076)
- If any of the above measures do not apply for your hospital's patient population, report a 0 denominator.

In 2011, all quality measure reporting will take place by attestation. Beginning in 2012, it is expected that CMS and/or your state will have a secure electronic portal in place for the submission of electronic reporting directly from an EHR.