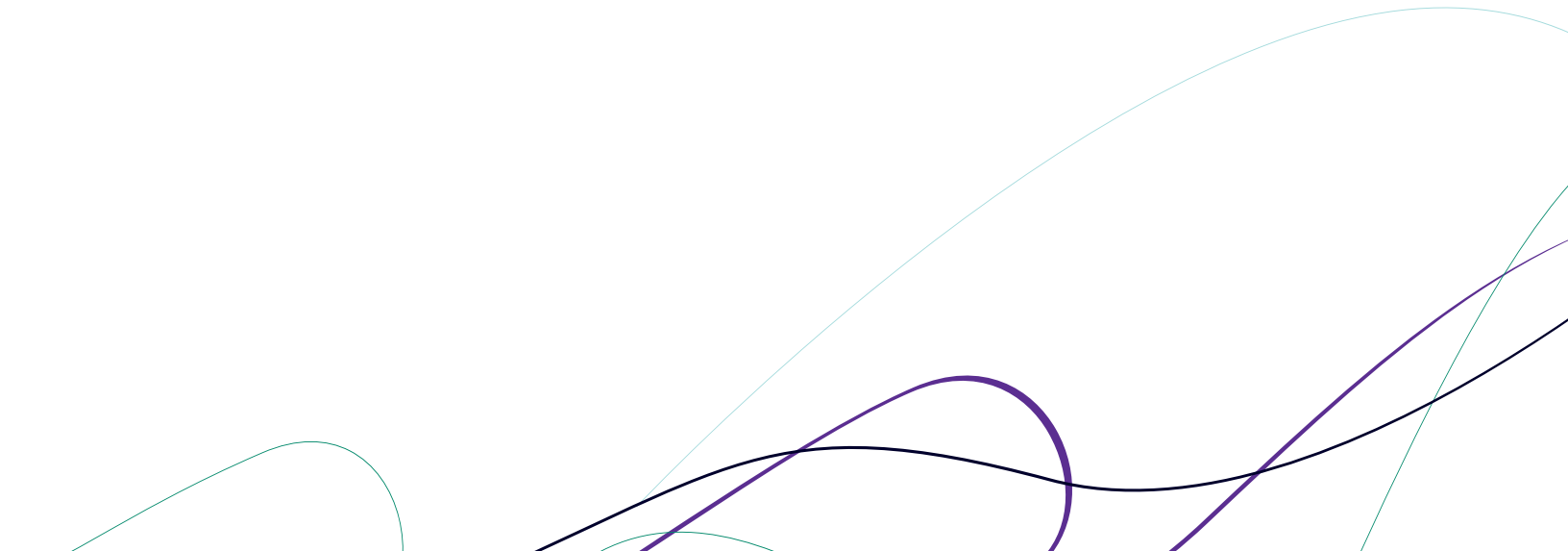
Understanding the “Meaningful Use” Regulations

By Elizabeth W. Woodcock,
MBA, FACMPE, CPC



Understanding the "Meaningful Use" Regulations

By Elizabeth W. Woodcock, MBA, FACMPE, CPC

This white paper informs the reader about the federal government's final proposed criteria for "meaningful use" of electronic health records (EHR) systems in order to qualify for Medicare and Medicaid reimbursement bonuses starting in 2011. Focusing exclusively on how the proposed criteria apply to eligible professionals, including physicians, this paper also provides physicians and practice executives with a framework for understanding the goals of the EHR bonus program and preparing to meet its objectives.

In February 2009, Congress passed, and President Obama signed into law, landmark legislation to encourage the adoption of electronic health records (EHRs). Part of the multi-billion dollar package known as the American Recovery and Reinvestment Act (ARRA), the Health Information Technology for Economic and Clinical Health (HITECH Act) allocates $19 billion to encourage the health care industry to adopt information technology. The funds — aimed at improving the quality, efficiency and safety of the nation's health — are available in the form of bonus payments to qualifying physicians and hospitals.

Although the government has attempted to encourage the use of EHRs for nearly two decades, implementation has been limited at best. Research studies vary greatly on the percent of physicians who use EHRs. As many studies have been based on small samples, a large, representative national sample of U.S. physicians in 2008 may provide the most reliable finding: just four percent of private practice-based physicians reported having a fully functional EHR system and 13 percent reported having a "basic system."[1]

The HITECH Act intends to put an end to the industry's resistance to embrace information technology. It authorizes incentive payments of up to $64,000 to physicians who implement an EHR system.

Like any government program where the "prize" is a payment, there's a catch. The government requires physicians to actually adopt technology; that is, they must move beyond purchasing and even implementing an EHR. Physicians must prove that they have put the system to "meaningful use" in their practices. Of course, such "meaningful use" is indeed defined by the government. Those who fail to comply within the projected timeframe face penalties in the form of reduced Medicare payments.

Since the passage of the stimulus legislation, the health care industry has anxiously anticipated the government's definition of "meaningful use." On December 30, 2009, the Centers for Medicare and Medicaid Services (CMS) released a Notice of Proposed Rulemaking (NPRM), which outlines the standards, specifications for implementation and criteria for EHR "meaningful use".[2]

On the same day, the Office of the National Coordinator for Healthcare Information Technology (ONC) issued an Interim Final Rule on the initial set of standards, implementation specifications, and certification criteria for EHR systems.[3] Published in conjunction with CMS, the certification standards support the proposed meaningful use criteria.

Examining the CMS proposal in detail reveals the essential objectives and criteria for the regulation's goal of "meaningful use" and how physicians must demonstrate that use in order to participate in the EHR incentive program. The CMS rules also describe the processes by which physicians are expected to demonstrate meaningful use, the timing of the implementation and phase-out of the incentive bonus programs, and other requirements that were broadly outlined in the HITECH Act.

While the proposed rules won't be finalized until spring 2010 and changes may be made based on comments received, physicians now have more insight into the government's direction for those who wish obtain the "prize" promised for successful participation in the EHR incentive program — and avoid the payment penalties imposed on those who choose not to.

An Overview of the HITECH Act

The HITECH Act outlines the federal government's financial support for health care industry efforts to improve the use of information technology. Of particular interest to physicians are the bonuses for "using certified EHR technology in a meaningful manner…."[4]

Eligible Professionals

Available through Medicare and Medicaid, the HITECH Act established two incentive payment programs for the healthcare industry. Eligible professionals, the focus of this white paper, and eligible hospitals can participate in either program.

For the Medicare program, "eligible professionals" — or "EPs" — are defined as doctors of medicine or osteopathy; doctors of dental surgery or medicine; doctors of podiatric medicine; doctors of optometry; and doctors of chiropractic medicine.

Eligible professionals for the Medicaid program include physicians, dentists, certified nurse midwives, nurse practitioners and physician assistants who are practicing in federally qualified health centers (FQHCs) or rural health clinics (RHCs) led by a physician assistant.

In this white paper, the term "physician" is used interchangeably with eligible professional unless a specific exception or requirement of one type of professional is to be described.

Incentive Bonuses

Physicians receiving payment for treating Medicare patients can receive up to $44,000 payable over a five-year period *(See Exhibit One: Medicare EHR Bonus Schedule).* The payments are linked to 75 percent of the physician's annual allowed charges from Medicare, up to the maximum annual bonus. A physician seeking to qualify for the maximum $18,000 bonus in 2011, for example, must bill $24,000 in allowed charges for services to Medicare beneficiaries during that year. Eligible professionals treating Medicaid patients would receive up to $63,750, capped at 85 percent of the government's evaluation of current market cost for the implemented (and meaningfully used) EHR system, and payable over a six-year period. Physicians and other eligible professionals may select to participate in only one of the bonus programs.

Physicians who choose not to participate will receive a one percent reduction in their Medicare allowed charges, beginning in 2015. This reduction will increase by one percent each subsequent year, up to a maximum of five percent, after which the penalty will become permanent subject to the discretion of the Secretary of Health and Human Services. *(See Exhibit Two: Medicare Reimbursement Penalties for Non-Participation)*.

Exhibit Two: Medicare Reimbursement Penalties for Non-Participation

Year	Penalty
2015	1%
2016	2%
2017	3%
Beyond	<5%

Objectives

The HITECH Act lists three broad objectives:

- Physicians use certified EHR technology in a meaningful manner;
- Systems they use must have the capability to provide electronic exchange of health information to improve the quality of care; and
- Providers must submit information clinical quality and other measures as defined by the Secretary of HHS.

The HITECH Act assigned responsibility for developing details of these objectives to CMS. Throughout 2009, ONCHIT and its HIT Policy and HIT Standards Committees, serving as advisers to CMS, released preliminary criteria for meaningful use.

Exhibit One: Medicare EHR Bonus Schedule

Year	2011	2012	2013	2014	2015	2016	Total
2011	$18,000	$12,000	$8,000	$4,000	$2,000	$ -	$44,000
2012	$ -	$18,000	$12,000	$8,000	$4,000	$2,000	$44,000
2013	$ -	$ -	$15,000	$12,000	$8,000	$4,000	$39,000
2014	$ -	$ -	$ -	$12,000	$8,000	$4,000	$24,000
2015	$ -	$ -	$ -	$ -	$ -	$ -	$ -

The Stages of Meaningful Use

CMS proposes a three-stage process for the meaningful use criteria. *(See Exhibit Three: Stages of Meaningful Use Criteria by Payment Year).* In the Notice of Proposed Rulemaking, details are provided about the initial stage, which covers the first two years of the program (2011 and 2012). Important to those wishing to ensure they meet the goals of this first set of regulations are the objectives of **Stage One,** which CMS clarifies as:

- 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; and
- Reporting clinical quality measures and public health information.

Stage Two is intended to migrate users from Stage One's less rigorous actions of capturing and sharing data to executing advanced care processes with decision support. The requirements to meet this higher level of use will be proposed by the end of 2011 and commence in time for the 2013 payment year. CMS anticipates that its Stage Three definitions will be proposed by the end of 2013 in time for the 2015 payment year.

These timeframes are expected to allow physicians to anticipate the additional actions they must take to continue receiving incentive payments.

Many months will pass before Stage Two criteria are officially released for public comment. For a smoother and more informed route to EHR purchase, and implementation adoption, it is worth considering the hints CMS has already given about Stage Two requirements — those requirements which must eventually be adopted to remain a meaningful user and receive subsequent incentive payments.

Stage Two would expand upon the Stage One criteria in the areas of disease management, support, medication management, support for patient access to their health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies *(See Exhibit Four: Stage Two Expands on Stage One).*

Stage Three would focus on achieving improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data, and improving population health outcomes.

Exhibit Three: Stages of Meaningful Use Criteria by Payment Year

	Payment Year				
First Payment Year	**2011**	**2012**	**2013**	**2014**	**2015****
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 3
2013			Stage 1	Stage 2	Stage 3
2014				Stage 1	Stage 3
2015*					Stage 3

*Avoids payment adjustments only for EPs in the Medicare EHR Incentive program.
**Stage Three criteria of MU or a subsequent update to the criteria if one is established through rulemaking.

Exhibit Four: Stage Two Expands on Stage One

Meaningful Use Criteria	Stage One	Stage Two*
Computerized physician order entry (CPOE)	Report the percentage of orders entered directly through CPOE	Electronic transmission of CPOE
Structured lab data in EHR	Clinical lab test results	Full array of diagnostic test data (including blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, etc.)
Electronic syndromic surveillance data to public health agencies	Show EHR has capacity to send data	Demonstrate actual transmission of data
Clinical care summaries	Allowed on paper	Must be structured and exchanged electronically

* Based on CMS 2009 statements, not actual proposed regulation.

Exhibit Five: Stage One Criteria for Meaningful Use

1	Use CPOE
2	Implement drug-drug, drug-allergy, drug-formulary checks
3	Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®
4	Generate and transmit permissible prescriptions electronically (eRx)
5	Maintain active medication list
6	Maintain active allergy list
7	Record demographics: preferred language, insurance type, gender, race, ethnicity and date of birth
8	Record and chart changes in vital signs: height, weight, blood pressure, calculate and display: BMI, and plot and display growth charts for children 2-20 years, including BMI
9	Record smoking status for patients 13 years old or other
10	Incorporate clinical lab-test results into EHR as structured data
11	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities and outreach
12	Report ambulatory quality measures to CMS or the States
13	Send reminders to patients per patient preference for preventive/follow up care
14	Implement five clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules
15	Check insurance eligibility electronically from public and private payers
16	Submit claims electronically to public and private payers
17	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request
18	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP
19	Provide clinical summaries for patients for each office visit
20	Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically
21	Perform medication reconciliation at relevant encounters and each transition of care
22	Provide summary care record for each transition of care and referral
23	Capability to submit electronic data to immunization registries and actual submission where required and accepted
24	Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice
25	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities

Source: Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule. January 13, 2010. Accessed January 15, 2010, at http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf

measures

1	CPOE is used for at least 80% of all orders
2	EP has enabled this functionality
3	At least 80% of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data
4	At least 75% of all permissable prescriptions written by the EP are transmitted electronically using certified EHR technology
5	At least 80% of all unique patients seen by the EP have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data
6	At least 80% of all unique patients seen by the EP have at least one entry (or an indication of none if the patient has no medication allergies) recorded as structured data
7	At least 80% of all unique patients seen by the EP have demographics recorded as structured data
8	For at least 80% of all unique patients age 2 and over seen by the EP, record blood pressure and BMI additionally plot growth chart for children age 2-20
9	At least 80% of all unique patients 13 years or older seen by the EP have "smoking status" recorded
10	At least 50% of all clinical lab tests ordered whose results are in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
11	Generate at least one report listing patients of the EP with a specific condition
12	For 2011, provide aggregate numerator and denominator through attestation as discussed in section II(A)(3) of this proposed rule for 2012, electronically submit the measures as discussed in section II(A)(3) of this proposed rule
13	Reminder sent to at least 50% of all unique patients seen by the EP that are age 50 or over
14	Implement 5 clinical decision support rules relevant to the clinical quality metrics the EP is responsible for as de scribed further in section II(A)(3)
15	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP
16	At least 80% of all claims filed electronically by the EP
17	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours
18	At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information
19	Clinical summaries are provided for at least 80% of all office visits
20	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
21	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
22	Provide summary of care record for at least 80% of transitions of care and referrals
23	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries
24	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)
25	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary

Stage One: The Proposed Criteria

Understanding the policy priorities behind the CMS proposed regulations will help physicians in selecting and adopting EHRs into their practices. To that end, the proposed regulations outline five priorities for health outcomes policy:

1. Improve quality, safety, efficiency, and reducing health disparities;
2. Engage patients and families in their health care;
3. Improve care coordination;
4. Improve population and public health; and
5. Ensure adequate privacy and security protections for personal health information.

Each priority comes with several specific care goals and, in turn, objectives and measures are aligned with each of those goals.

CMS presents 25 objectives, representing actions that meaningful users should take. For each objective, a Stage One measure is outlined to indicate how the physician should plan to report on the use of those capabilities. For example, consider the following selected objectives and measures:

> ***Objective:*** *Use computerized physician order entry (CPOE)*
>
> ***Measure:*** *CPOE is used for at least 80 percent of all orders*
>
> ***Objective:*** *Send reminders to patients per patient preference for preventive/ follow up care*
>
> ***Measure:*** *Preventive/follow up care reminders sent to at least 50 percent of all unique patients age 50 or over*
>
> ***Objective:*** *Provide patients with an electronic copy of their health information on request*
>
> ***Measure:*** *Provide electronic copy of patient health information to at least 80 percent of patients who request it within 48 hours of the request*

The CMS proposal includes a nod to administrative simplification, with a set of objectives for users to check insurance eligibility for and submit claims electronically to all payers. *(See Exhibit Five: Stage One Criteria for Meaningful Use).*

While the HITECH Act outlined a general requirement for meaningful users to report clinical quality measures, the description of the measures is contained in CMS' proposal. Many of the measures CMS proposes are the same as found in its Physician Quality Reporting Initiative but CMS adds several additional quality measures it believes will address other important aspects of clinical quality for the EHR incentive program. For example, all physicians will be required to report on what CMS defines as "core" measures, to include tobacco use, blood pressure and medications to be avoided in the elderly, as well as one specialty group measure. Only 15 medical specialties are outlined in the interim rule, leaving out important ones such as Pathology, Dermatology and Allergy. (See Exhibit Six: Specialty Measure Groups). The rule indicates that physicians can attest that none of the defined specialty groups apply to their scope of practice, which is what physicians to whom the criteria does not pertain may be forced to do.

Exhibit Six: Specialty Measure Groups

- Cardiology
- Pulmonology
- Endocrinology
- Oncology
- Proceduralist/Surgery
- Primary Care Physicians
- Pediatrics
- Obstetrics & Gynecology
- Neurology
- Psychiatry
- Ophthalmology
- Podiatry
- Radiology
- Gastroenterology
- Nephrology

What's important to understand is that physicians cannot pick and choose among the meaningful use criteria and expect to receive incentive payments. Nor is there a plan to award lower incentive payments to those who partially meet the criteria.

There are 25 objectives with measures for physicians in Stage One, which begins in 2011, and all must be met to be considered a meaningful EHR user.

Proving Meaningful Use

In the NPRM, CMS reveals its inability to electronically accept data from EHRs in time for the 2011 payment year, announcing its intention to allow "attestation" rather than electronic submission of data to prove compliance with the program in its inaugural year. Although the exact form for making these attestations has yet to be determined, it is important to prepare to document the required measures. Physicians will be asked to identify the certified technology they are using and to report the results of their performance on all of the meaningful use measures required, for all patients.

The proposal leaves the door open for states to require different eligibility reporting for the Medicaid incentive program if they choose to establish the same or more stringent requirements. Understanding the criteria for the state in which a physician practices, in the case of participating in the Medicaid incentive program, will be essential.

CMS acknowledges that the attestation forms are not yet ready, but will be available on the agency's website in the future.

Getting Paid

In the announced regulations, CMS asserts that during the initial year of the program, it will release the incentive funds — $18,000 for Medicare, for example — after a physician has proven to have met the meaningful use criteria over a consecutive 90-day period during that calendar year. The physician will still have to wait until allowed charges of $24,000 have been billed to Medicare to obtain the maximum of $18,000 ($24,000, multiplied by the required 75 percent threshold). But the good news is that some physicians may qualify to receive their first incentive checks soon after the conclusion of the first quarter of 2011, and the even better news for many is that physicians can wait until October 1, 2011 to report and still qualify for that year's bonus payment.

The incentives will be paid in single, consolidated annual payments. They will be made to physicians on a rolling basis as soon as they demonstrate meaningful use for the reporting period (after 90 consecutive days in the first year, and after the calendar year in subsequent years). Depending on the incentive program in which the physician participates, the incentive payments will come via a Medicare carrier or state Medicaid program.

It is important to note that physicians can only obtain incentives from one of the programs, even if they qualify for both. Fortunately, CMS confirmed that physicians can transfer — once, and only once — from the Medicaid to the Medicare incentive program — or vice versa.

For physicians seeking incentives through Medicaid, CMS will allow states to make incentive payments as early as 2010 to those qualifying. The provision applies to states with programs that CMS deems capable. Physicians who treat Medicaid patients, and seek the higher EHR incentive payments for doing so, must have a minimum of 30 percent of their patient encounters attributable to Medicaid over any representative, continuous 90-day period in the most recent calendar year prior to reporting.[5] Medicaid physicians can qualify for these early payments by adopting, implementing or upgrading certified EHR technology. In following years they, too, will need to demonstrate meaningful use in order to qualify.

With more than a quarter of Medicare physicians now receiving bonus payments through the program's Physician Quality Reporting Initiative (PQRI), it is logical to ask if one could continue to participate in that program while also gaining an EHR incentive bonus. Fortunately, the answer from CMS is "yes." In fact, it is likely that participation with PQRI has better prepared those physicians for the coming regime of EHR use and reporting. As for another Medicare incentive program, ePrescribing, physicians who are eligible for the Medicare program will not be able to access the bonuses from ePrescribing in addition to EHR incentive bonuses, however, CMS will allow participants in the Medicaid program to remain eligible.

Hospital-based Physicians

The HITECH Act provides a separate program of EHR incentive bonuses to hospitals. Because the technology deployed by hospitals is made available to physicians who perform most of their work there, argues CMS, the incentive program for eligible professionals excludes these "hospital-based" physicians as a way to prevent potential "double-dipping" of the incentives.

For the purposes of these regulations, CMS defines hospital-based physicians as those who furnish "substantially all" — defined in the proposed regulations as at least 90 percent — of their services in a hospital setting (inpatient and outpatient). CMS proposes to use the place-of-service codes on physician claims — 21 (inpatient hospital), 22 (outpatient hospital), and 23 (emergency room; hospital) — to determine whether physicians furnish substantially all of their professional services in a hospital setting and are, therefore, hospital-based. Based on this definition, CMS estimates that approximately 27 of percent of physicians will be excluded from the EHR incentive program.

Take Action

With less than 12 months before the initial year of the EHR incentive program, physicians have little time to begin a thoughtful and thorough process of reviewing their options. The time to begin the process is now.

Those who have not yet purchased an EHR should develop a plan to complete the following actions:

- Assemble a team of staff and physicians to develop purchase goals;
- Define useful qualities;
- Select a list of vendors to approach;
- Write and disseminate a request for proposal (RFP); and
- Commit to reviewing prospective EHR systems by assessing RFP responses, product demonstrations and references from practices similar to theirs.

(See Exhibit Seven: Time to Implement an EHR).

Those who already own an EHR should look carefully at the objectives and measures CMS will require for qualifying as a meaningful user. *(See Exhibit Eight: Eight Steps to Become a Meaningful User).*

Although the government has defined meaningful use for the industry, it's up to each of you to make it meaningful for you — and your patients.

Exhibit Seven: Timeline to Implement an EHR

Day 0 to 30:

Gather a Team and Develop Criteria for Selection

Day 30 to 60:

Develop and Send a RFP to Vendors

Day 60 to 90:

Await Responses; Hold Discussions about Impact on Billing, Workflow and other aspects of the Practice

Day 90 to 120:

Receive RFPs, Compile Results

Day 120 to 150:

Choose Top 3 to 5 Vendors; Develop Specific Selection Criteria

Day 150:

Contact Vendors to Schedule Demonstration

Day 150 to 210:

Watch Demonstration; Grade each Vendor based on Selection Criteria; Check References; Hold Internal Discussions

Day 210 to 240:

Decide; Gather Information about Financing Options

Day 240 to 270:

Purchase; Discuss Conversion Logistics; Decide on Implementation Date

Day 270 to 330:

Implement; Comply with MU Criteria

Exhibit Eight: Eight Steps to Become a Meaningful User

1. Form EHR payment program committee.
2. Assemble resources and educational material about the HITECH Act for committee members' background reading and review.
3. Carefully read and evaluate published tables, focusing on the 25 objectives and measures presented in Exhibit Four.6
4. Divide criteria into (1) implemented; (b) system capable, but not implemented and (c) system not capable.
5. Based on current capabilities and employed processes, establish a timeframe and goals for meaningful use compliance.
6. One-by-one, with involvement of key stake-holders, begin steps to implement "system capable, but not implemented."
7. Assign responsibility to commence internal and external discussions, with vendors and stakeholders, regarding the expansion of system capability(ies).
8. Establish, in writing, specific timeframes, action steps and responsible party(ies); meet, review and update monthly to identify progress based on goal of compliance.

1 DesRoches CM, Campbell EG, Rao SR. “Electronic Health Records in Ambulatory Care — A National Survey of Physicians” NEJM Vol. 359:50-60. July 3, 2008. Accessed January 13, 2009, at http://content.nejm.org/cgi/content/full/NEJMsa0802005.

2 Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule. January 13, 2010. Accessed January 15, 2010, at http://edocket.access.gpo.gov/2010/pdf/E9-31217.pdf

3 Health Information Technology: Initial Set of Standards, Implementation, Specifications, and Certification Criteria for EHR Technology. January 13, 2010. Accessed January 15, 2010, at http://edocket.access.gpo.gov/2010/pdf/E9-31216.pdf

4 H.R. 1., 111th Cong., 1st sess., Title IV — Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions. Section 4101, “Incentives for Eligible Professionals”, p. 356, Paragraph (i) “Meaningful Use of Certified EHR Technology.” Accessed January 13, 2010, at http://frwebgate.access.gpo.gov/cgibin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf

5 Pediatricians may qualify with 20 percent Medicaid volume; Rural Health Clinics and Federally Qualified Health Centers may qualify with 30 percent “needy individuals”.

6 Effort should also be made to ensure certification criteria associated with each objective are established during the process. See pages 13 through 16 of Health Information Technology: Initial Set of Standards, Implementation, Specifications, and Certification Criteria for EHR Technology. January 13, 2010. http://edocket.access.gpo.gov/2010/pdf/E9-31216.pdf

4301 West Boy Scout Blvd., Suite 800
Tampa, FL 33607
877-932-6301
www.sagehealth.com