

# Meaningful Use: *Moving Closer to Clarity*



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# Caveats

This document is based upon the Final Rule published 28 July 2010; some of the information presented herein may change as the regulatory process continues

- > In order to make this material comprehensible, the information presented here is, in some cases, oversimplified to give a sense of the situation.
- > This presentation is not intended as specific guidance as to how to structure an arrangement that complies with the statutory or regulatory requirements.
- > Medicare Advantage Organizations and Critical Access Hospitals are not discussed in this presentation.

This is not legal advice. Legal advice can only be rendered by a qualified individual with full knowledge of the specific plans and situation in question.

# Meaningful Use Final Regulation

The American Recovery and Reinvestment Act of 2009 (ARRA) established incentives for the adoption by providers of electronic health record (EHR) solutions.<sup>1</sup>

- > ARRA delegated to the Secretary of Health and Human Services (HHS) the responsibility for issuing implementing regulations, including the specifics of Meaningful Use – a key requirement for a provider to qualify for the EHR incentive payments.
- > CMS issued proposed regulations regarding meaningful use and the approach for payment of the EHR incentives in January 2010 and solicited comments.
  - Over 2,000 comments were received through the end of the comment period (14 March 2010)
- > At the end of July 2010, CMS issued the Final Rule, setting forth the requirements for Meaningful Use and the associated incentive payments.
- > Companion Regulations have also been issued by ONC:
  - EHR certification requirements (July 2010)
  - Establishment of a Temporary Authorized Testing Body to perform the certification of EHR Technology (June 2010)

The Final Rule generally represents an attempt to reduce the initial burden on providers in meeting the requirements for Meaningful Use.

- > CMS has indicated that it will impose additional requirements in subsequent rulemaking, as required by ARRA.
- > Where relevant, this document discusses noteworthy changes between the January 2010 Proposed Rule and the July 2010 Final Rule regarding Meaningful Use.

# The Meaningful User

In order to be eligible for the EHR incentive payments, the provider must be a meaningful EHR user:

- > Meaningful EHR user
  - An eligible provider (hospital or professional),
  - Who uses a certified EHR,
  - During the relevant period, and
  - Submits the required metrics, information, and attestations.
  - First year: meaningful use must be shown for 90 consecutive days.
  
- > There will be three stages of meaningful use:
  - So long as meaningful use begins before 2015, the first year is always Stage 1
  - Stage 1 requirements are defined in the Final Rule: Stages 2 and 3 will be defined later (See Future Development section, *infra*)
  - CMS has declined, at present, to provide information on the Stage level requirements in 2015, and beyond

First Payment Year	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

\* In the Final Rule, CMS indicated that it would defer to a future rulemaking the requirements for 2015

# Objectives and Measurements<sup>2</sup>

## Objectives

- > The objectives that must be achieved and reported focus on keeping records, using discrete data, health improvement actions, providing information to patients and other care givers, and reporting data.
- > Eligible Professionals (EPs) must meet 20 objectives (all 15 from Core Set, plus 5 from Menu Set).
- > Eligible hospitals must meet met 20 objectives (all 15 from Core Set, plus 5 from Menu Set).
- > Broader exclusions from objectives if practice inappropriate.

## Measurements

- > Objectives related to a patient (or each patient for whom it is relevant) the measurement is usually that it must be performed for a minimum percentage of the patients. Again, these are on a base of ALL patients with records in the EHR, not just those for whom Medicare or Medicaid is being billed.
- > Objectives related to providing electronic data to patients, the measure usually relates to a percentage of requesting patients (such as providing an electronic copy of the patient's record)
  - In some cases, information that is to be supplied to all patients, providers may supply it via hard copy (such as discharge instructions)
- > Electronic exchange, the usual requirement is that the provider perform at least one test during the EHR reporting period.
- > Successfully report practice-specific clinical quality measures.

# Hospital Providers

The focus is on inpatient; there are no EHR incentive payments for emergency department use, or other hospital-based uses:

- > Hospital-based physicians are not eligible to receive EHR incentive payments.
  - Primary place of work is in a hospital facility
  - Includes anesthesiologist, pathologists, emergency medicine providers
    - The key is the Place of Service (POS) Code utilized in billing for the services (POS Codes 21 – Inpatient Hospital and 23 – Hospital Emergency Room)
    - Employment status is not the issue
- > However, physicians working in a hospital clinic may be eligible based upon a statutory revisions signed into law on 15 April 2010.
- > CPOE usage in the emergency department does not count toward meeting the CPOE usage requirement.
  - Only POS Code 21 – Inpatient Hospital, counts

The EHR incentives are part of the Medicare/Medicaid regulations, so much of the foundation is based upon payment-related concepts.

# Eligible Professional Payments

An Eligible Professional (EP) who meets both Medicare and Medicaid requirements may:

- > Draw from either program, but not both
- > Make a one-time switch between the Medicare and Medicaid EHR incentive program; total payment limited to \$63,500

## Medicare Payments

Up to \$44,000 over five years

- > Payments are also limited to 75% of Medicare billings in any year

FIRST CY ELIGIBLE PPOVIDER RECEIVES INCENTIVE PAYMENT				
Calendar Year	2011	2012	2013	2014
2011	\$18,000			
2012	12,000	\$18,000		
2013	8,000	12,000	\$15,000	
2014	4,000	8,000	12,000	\$12,000
2015	2,000	4,000	8,000	8,000
2016		2,000	4,000	4,000
<b>TOTAL</b>	<b>\$44,000</b>	<b>\$44,000</b>	<b>\$39,000</b>	<b>\$24,000</b>

# Eligible Professional Payments

## Medicaid Payments

\$63,750 over six years

- > First year, may qualify for payments for adopting, implementing, or upgrading to an EHR
- > Prior to 2016, the years for Medicaid EP do not need to be consecutive
- > Minimum 30% Medicaid patient volume
  - Pediatricians with minimum 20% Medicaid volume qualify for two-thirds payment; full if over 30%

MEDICAID ELIGIBLE PROVIDER WHO BEGIN ADOPTION IN:							
Calendar Year	2011	2012	2013	2014	2015	2016	
2011	\$21,250						
2012	8,500	\$21,250					
2013	8,500	8,500	\$21,250				
2014	8,500	8,500	8,500	\$21,250			
2015	8,500	8,500	8,500	8,500	\$21,250		
2016	8,500	8,500	8,500	8,500	8,500	\$21,250	
2017		8,500	8,500	8,500	8,500	8,500	8,500
2018			8,500	8,500	8,500	8,500	8,500
2019				8,500	8,500	8,500	8,500
2020					8,500	8,500	8,500
2021							8,500
<b>TOTAL</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>

# Eligible Hospital Payments

Hospitals may simultaneously receive incentive payments under both Medicare and Medicaid incentive programs.

- > Medicare incentive payment is a function of:

$$\begin{aligned}
 \text{Medicare Incentive Payment} &= \left[ \text{Initial Amount} \right] * \left[ \text{Medicare Share} \right] * \left[ \text{Transition Factor} \right] = \\
 &\left[ \$2,000,000 + \$200 * \sum_{1,150}^{23,000} \text{Discharge} \right] * \left[ \frac{\text{Medicare Inpatient Days}}{\left( \frac{\text{Total Inpatient Days}}{1 - \left( \frac{\text{Gross Revenue} - \text{Charity Revenue Foregone}}{\text{Gross Revenue}} \right)} \right)} \right] * \left[ \text{Transition Factor}_n \right]
 \end{aligned}$$

First Year Meaningful Use Achieved	2011	2012	2013	2014	2015	2016
2011	100%	75%	50%	25%		
2012		100%	75%	50%	25%	
2013			100%	75%	50%	25%
2014				75%	50%	25%
2015					50%	25%

# Penalties Start in 2015

Providers who do not achieve meaningful use by 2015 will be penalized.

## Eligible Professionals

- > Will lose one percent of their Medicare reimbursement per year (up to three percent by 2017)<sup>3</sup>
  - Hospital-based physicians will not be penalized (they also are ineligible for an EHR incentive payment)
  - Note, this is in addition to the penalty of one percent in 2015 for failing to use electronic prescribing

## Eligible Hospitals

- > Will lose one-quarter of their Medicare market basket adjustment for each year, up to three-quarters<sup>4</sup>
  - This is in addition for any penalties associated with non-reporting under RHQDAPU

There is no penalty under Medicaid for failing to reaching meaningful use.

<sup>3</sup> ARRA provides that the penalties may reach 5%, but CMS has not chosen to include further reductions in this rule.

<sup>4</sup> This reduction is only discussed in the Preamble and is not mentioned in the rule (p 1915), but is stated in HITECH (§4102(b)(1)).

# Future Developments

The Final Rule defines the requirements of Stage 1 – the requirements a provider must meet in the first year of meaningful use.

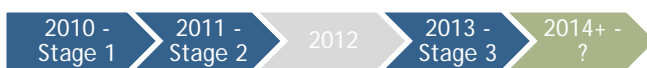
- > The requirements will increase over time – a provider will need to keep up or risk no longer meeting Meaningful Use.
- > CMS plans to issue revisions to the Meaningful Use requirements over time.

Anticipated requirements in future stages will continue to drive towards the goal of utilizing EHR Technology promote patient centered, health data following the patient, evidence-based, prevention-oriented, and efficient and equitable health care.

## Broad objectives and requirements of the Stages

### Stage 1:

- > Electronically capture health information in a structured format;
- > Track key clinical conditions and
- > Communicate information for care coordination;
- > Implement clinical decision support tools to facilitate disease and medication management;
- > Engage patients and families and
- > Report clinical quality measures and public health information.
- > Build familiarity with EHR Technology to create a strong foundation to build on in later years.



Expected Stage definition dates

First Payment Year	PAYMENT YEAR			
	2011	2012	2013	2014
2011	Stage 1	Stage 1	Stage 2	Stage 2
2012		Stage 1	Stage 1	Stage 2
2013			Stage 1	Stage 1
2014				Stage 1

# Future Developments

## Stage 2:

- > Stage 1 optional items will be required and higher achievement levels mandated.
- > Higher requirements for structured data.
- > Exchange of information in the most structured format (e.g., electronic transmission of orders, diagnostic test, prescriptions (e-Rx)).
- > Health information exchange so information travels with patient.
- > Electronically transmit patient care summaries to support transitions in care across unaffiliated providers, settings and EHR systems.

## Stage 3:

- > Decision support for national high priority conditions.
- > Patient access to self management tools.
- > Access to comprehensive patient data through robust, patient-centered health information exchange.
- > Population health exchange and reporting.

# Noteworthy Changes Between Proposed and Final Rule

## Previous requirements now divided into

- > Core Set (15)
- > Menu Set
  - Pick 5 of 10
  - Must include one population/public health measure) requirements

## Measures refined

- > Thresholds for use reduced
- > Calculations requires less manual data collection

## Broader exclusion criteria – to allow avoiding a requirement

## Decision Support requirements reduced

## Reduced Quality Metrics

## Additional Quality options

# Core Set

## Patient Demographics

- > Record patient demographics.
- > Gender, race, ethnicity, date of birth, preferred language.
- > Hospitals only (added): date and preliminary cause of death in the event of mortality).
- > More than 50% of patients' demographic data must be recorded as structured data.

## Vital Signs

- > Record vital signs and chart changes.
- > Height, weight, blood pressure, body mass index, growth charts for children.
- > More than 50% of patients 2 years of age or older must have height, weight and blood pressure recorded as structured data.

## Problem List

- > Maintain up-to-date problem list of current and active diagnoses.
- > More than 80% of patients must have at least one entry recorded as structured data.

# Core Set

## Medication List

- > Maintain an active medication list.
- > More than 80% of patients have at least one entry recorded as structured data.

## Medication Allergy List

- > Maintain an active medication allergy list.
- > More than 80% of patients have at least one entry recorded as structured data.

## Smoking Status

- > Record smoking status for patients 13 and older.
- > More than 50% if patients age 13 or older have smoking status recorded as structured data.

# Core Set

## Clinical Summaries – EP only

- > Provide patients with clinical summaries for each office visit.
- > Clinical summaries provided to patients for more than 50% of all visits within 3 business days.

## Discharge Instructions – Hospital only

- > Provide patients an electronic copy of hospital discharge instructions upon request.
- > More than 50% of all patients who are discharged from an inpatient or ED of a hospital who request an electronic copy of their discharge instructions must be provided with it.

# Core Set

## Electronic Copy of Health Information

- > Upon request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication list, medication allergies).
- > Hospitals only (added): discharge summary and procedures).
- > More than 50% of requesting patients must receive an electronic copy within 3 business days.

## Electronic Prescribing – EP only

- > Generate and transmit permissible prescriptions electronically.
- > More than 40% must be transmitted electronically using certified EHR technology.

## CPOE - Medication Orders – Hospital only

- > More than 30% of patients with at least one medication in their medication list must have at least one medication ordered through CPOE.

# Core Set

## Drug-drug / Drug Allergy Checks

- > Implement drug-drug and drug-allergy interaction checks.
- > Functionality must be enabled for these checks for the entire reporting period.

## Electronic Exchange

- > Implement capability to electronically exchange key clinical information among providers and patient-authorized entities.
- > Must perform at least one test of the EHR's capacity to electronically exchange information.

## Clinical Decision Support Rule

- > Implement one clinical decision support rule.
- > Track compliance with that rule.
- > One rule must be implemented.
- > Implement systems to protect privacy and security of patient data in the EHR. Must conduct or review a security risk analysis, implement security updates as necessary and correct identified security deficiencies.

# Core Set

## Privacy and Security

- > Implement systems to protect privacy and security of patient data in the EHR.
- > Must conduct or review a security risk analysis
  - Must implement security updates as necessary
  - Correct identified security deficiencies.

## Clinical Quality Reporting

- > Report clinical quality measures to CMS or states.
  - For 2011, provide aggregate numerator and denominator through attestation.
  - For 2012 and subsequent, electronically submit measures.

## Menu Set – Pick At Least Five

### Formulary Checks

- > Implement drug formulary checks.
- > Drug formulary check system must be implemented and access at least one internal or external drug formulary during the reporting period.

### Clinical Lab Results

- > Incorporate clinical laboratory test results into EHRs as structured data.
- > More than 40% of clinical laboratory test results that are positive/negative or in numerical format and are incorporated into EHRs as structured data.

### Patient Lists

- > Generate lists of patients by specific conditions for use for quality improvement, reduction of disparities, research or outreach.
- > Must generate one listing of patients with a specific condition.

## Menu Set – Pick At Least Five

### Patient Education

- > Use EHR technology to identify patient-specific education resources.
- > Provide those to the patient as appropriate.
- > More than 10% of patients are provided patient specific education resources.

### Medication Reconciliation

- > Perform Medication reconciliation between care settings.
- > Medication reconciliation must be performed for more than 50% of transitions of care.

### Summary of Care Record

- > Provide summary of care record for patients referred or transitioned to another provider or setting.
- > Summary of care record must be provided for more than 50% of patient transitions or referrals.

## Menu Set – Pick At Least Five

### Immunization Registries

- > Submission of electronic immunization data to immunization registries or immunization information systems.
- > Must perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions).

### Syndromic Surveillance Data

- > Submission of electronic syndromic surveillance data to public health agencies.
- > Must perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data).

### Advanced Directives – Hospital only

- > For hospitals - record advanced directives for patients 65 years or older.
- > More than 50% of patients aged 65 or older must have an indication of an advanced directive status recorded.

## Menu Set – Pick At Least Five

### Advanced Directives – Hospital only

- > For hospitals - record advanced directives for patients 65 years or older.
- > More than 50% of patients aged 65 or older must have an indication of an advanced directive status recorded.

### Public Health Reportable Lab Results – Hospital only

- > Submission of electronic data on reportable laboratory results to public health agencies.
- > Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data).

## Menu Set – Pick At Least Five

### Patient Reminders – EP only

- > Send reminders to patients (per patient preference) for preventative and follow-up care.
- > More than 20% of patients aged 65 or older or age 5 or younger must be sent appropriate reminders.

### Patient Electronic Access – EP only

- > Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication list, medication allergies).
- > More than 10% of patients must be provided with electronic access to information within 4 days of its being updated in the EHR.

# References

- > Act – The Social Security Act [the statutory basis underlying the Medicare and Medicaid program] – Congress amended the Act to effectuate the EHR Incentive Program.
- > ARRA – American Recovery and Reinvestment Act of 2009, Public Law 111-5
- > Certification Interim Rule – Health Information Technology: Initial Set of Standards, Implementation, Specifications, And Certification Criteria for Electronic Health Record Technology; Interim Final Rule, 45 CFR 170, 75 Fed. Reg. 2014 (13 January 2010).
- > Certification Final Rule – Health Information Technology: Initial Set of Standards, Implementation, Specifications, And Certification Criteria for Electronic Health Record Technology; Final Rule, 45 CFR 170, 75 Fed. Reg. 44590 (28 July 2010).
- > Certification Authority -- Establishment of the Temporary Certification Program for Health Information Technology; Final Rule, 45 CFR Part 170, 75 Fed. Reg. 36158 (24 June 2010).
- > CMS – Centers for Medicare & Medicaid Services, Department Health and Human Services
- > HITECH – Health Information Technology for Economic and Clinical Health Act -- the portion of ARRA pertaining to EHRs and related matters: Title XIII of Division A and Title IV of Division B of ARRA
- > HHS – Department of Health and Human Services

## References

- > Hospital-based Physicians in Clinics – clarification allowing physicians in hospital-based ambulatory clinics to qualify for the EHR incentives: Section 5 of the Continuing Extension Act of 2010 (Public Law 111-157, 15 April 2010).
- > Meaningful Use Proposed Rule – Medicare and Medicaid Programs; Electronic Health Records Incentive Program; Proposed Rule, 42 CFR Parts 412, et al., 75 Fed. Reg. 1844 (13 January 2010).
- > Meaningful Use Final Rule -- Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule, 42 CFR Parts 412, 413, 422, and 495, et al.. 75 Fed. Reg. 44314 (28 July 2010).
- > ONC – Office of the National Coordinator for Health Information Technology.
- > RHQDAPU – Reporting Hospital Quality Data for Annual Payment Update.
- > Secretary – Kathleen Sebelius, Secretary, Department Health and Human Services.

## About the People and Firm Behind This Update

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