Tri-State Regional Extension Center

A HealthBridge Regional Collaboration

An Overview of Meaningful Use: FAQs

On Feb. 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) into law. This new law includes provisions (known as the HITECH Act) designed to spur "meaningful use" of health information technology by health care professionals and providers. Under the law, the Centers for Medicare and Medicaid in concert with the Office of the National Coordinator for Health Information Technology are creating a new program that will spell out the requirements for demonstrating "meaningful use" of health information technology and applying for incentive payments.

1. Who is eligible to apply?

Eligible Providers in Medicare	Eligible Providers in Medicaid
Eligible Professionals (EPs)	**Eligible Professionals (EPs)**
Doctor of Medicine or Osteopathy	Physicians (Pediatricians have special eligibility & payment rules)
Doctor of Dental Surgery or Dental Medicine	Nurse Practitioners (NPs)
Doctor of Podiatric Medicine	Certified Nurse-Midwives (CNMs)
Doctor of Optometry	Dentists
Chiropractor	Physician Assistants (PAs) who lead a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is directed by a PA
Eligible Hospitals*	**Eligible Hospitals**
Acute Care Hospitals	Acute Care Hospitals
Critical Access Hospitals (CAHs)	Children's Hospitals

For Medicaid Incentives, there are also patient volume requirements…

Entity	Minimum Medicaid Patient Volume Threshold
For Eligible Professionals (EPs)	
Physicians	30%
-Pediatricians	20%
Dentists	30%
CNMs	30%
PAs when practicing at an FQHC/RHC that is so led by a PA	30%
NPs	30%
**Or the Medicaid EP practices predominantly in an FQHC or RHC—30% needy individual patient volume threshold	
For Eligible Hospitals	
Acute care hospitals	10%
Children's hospitals	No requirement

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2. What is "meaningful use" exactly?

Meaningful use is defined as:

- Use of a **certified EHR** in a meaningful manner (ex: e-prescribing)
- Use of certified EHR technology for **electronic exchange** of health information
- Use of certified EHR technology to **submit clinical quality and other measures**.

3. How do I qualify for incentive payments?

While the rules for meaningful use are still being finalized, certain requirements are defined in the ARRA legislation and in the notice of proposed rule currently available. Requirements vary based on whether the applicant is an "eligible professional" or eligible hospital." A draft summary of requirements is provided at the end of this document.

Eligible Professionals (EPs)

- Meet 25 objectives and report on required measures (see summary at the end)
- 8 Measures require 'Yes' or 'No' as structured data
- 17 Measures require numerator and denominator

Eligible Hospitals and Critical Access Hospitals

- Meet 23 objectives and report on required measures (see summary at the end)
- 10 Measures require 'Yes' or 'No' as structured data
- 13 Measures require numerator and denominator

Reporting Requirements

- **Reporting Period** –for any consecutive 90 days for first year; one year subsequently
- **For 2011** –Providers required to submit summary quality measure data to CMS or States by ***attestation***
- **For 2012** –Providers required to *electronically* submit summary quality measure data to CMS or States
- EPs are required to submit clinical data on 2 measure groups: core measures and a subset of clinical measures most appropriate to the EP's specialty.
- Eligible hospitals are required to report summary quality measures for applicable cases.

4. Where do I begin?

Step 1: Sign up to work with the Tri-State Regional Extension Center's (REC) expert staff.

Step 2: Work with the REC staff to determine which category of incentives best meets your profile:

- Medicare Incentives (Either Fee-For-Service or Medicare Advantage)
- Medicaid Incentives

Step 3: REC staff will assess your practice and help you develop a meaningful use action plan.

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5. How much money can I receive in incentives? When can I apply?

Eligible professionals (EPs) Timeline

- 2011-2016 (Medicare) –Up to $44,000 over 5 years if "meaningful health IT user"
- 2011-2021 (Medicaid) –Up to $63,750 over 6 years –Adopt/Implement/Upgrade or meaningful use in Year 1, MU Years 2-6
- 2015 and later –If not "meaningful user" up to 3% payment adjustment in ***Medicare*** reimbursement
- After the initial designation, EPs will be allowed to change their program selection only once during payment years 2012 through 2014.
- EPs in Health Professional Shortage Areas (HPSAs) get 10% bonus under Medicare Incentive Payments.

MEDICARE EP Incentive Payment - Based on First Calendar Year EP receives					
Calendar Year	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015 and later
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	0
2016		$2,000	$4,000	$4,000	0
TOTAL	$44,000	$44,000	$39,000	$24,000	0

MEDICAID EP Incentive Payment - Based on First Calendar Year EP receives						
Calendar Year	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY2016
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
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

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6. Which incentive program is best for me – Medicare or Medicaid?

This decision will be based on a number of factors, especially patient mix. Medicaid incentives are more generous but also come with different requirements. Some key differences are provided below.

Key Differences in the Two Incentive Programs

Medicare	Medicaid
Feds will implement (will be an option nationally)	Voluntary for States to implement (may not be an option in every State)
Fee schedule reductions begin in 2015 for providers that are not Meaningful Users	No Medicaid fee schedule reductions
Must be a meaningful user in Year 1	A/I/U option for 1stparticipation year
Maximum incentive is$44,000 for EPs	Maximum incentive is $63,750 for EPs
MU definition will be common for Medicare	States can adopt a more rigorous definition(based on common definition)
Medicare Advantage EPs have special eligibility accommodations	Medicaid managed care providers must meet regular eligibility requirements
Last year an EP may initiate program is 2014; Last payment in program is 2016; Payment adjustments begin in 2015	Last year an EP may initiate program is 2016; Last payment in program is 2021
Only physicians, subsection (d) hospitals and CAHs	5 types of EPs, 3 types of hospitals

7. What if I don't see a lot of Medicare patients? What kind of incentive payment should I expect?

Example of how incentive payments will be determined:

• ***Example 1***: *EP receives the maximum payment.*

For payment year 2011, the incentive payment for an EP would be, subject to a payment limit of $18,000, equal to 75 percent of the EP's Medicare physician fee schedule allowed charges for CY 2011 (in this case, the maximum allowed charges recognized for the purposes of the incentive, or $24,000 × .75 = $18,000), estimated based on claims for covered professional services furnished by the EP from January 1, 2011 through December 31, 2011, and submitted to the appropriate Medicare administrative contractor (MAC/carrier) on or before February 29, 2012.

• ***Example 2***: *EP receives less than the maximum payment.*

Assume for this example that the EP's estimated total allowed charges for covered professional services are $10,000 which is less than the $24,000 maximum allowed charges that could be recognized for purposes of this incentive. Therefore, for payment year 2011, the incentive payment in this case would be, $10,000 × .75 = $7,500, based on claims for covered professional services furnished by the EP from January 1, 2011 through December 31, 2011, and submitted to the appropriate Medicare administrative contractor (MAC) or carrier on or before February 29, 2012.

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8. Aren't there OTHER incentive programs – do they overlap?

Other Medicare Incentive Program	Interaction with ARRA/HITECH MU Incentives
Medicare Physician Quality Reporting Initiative (PQRI)	Yes, if the PQRI incentive is extended in its current format beyond 2010, EPs can participate in both if they are eligible
Medicare Electronic Health Records Demonstration(EHR Demo)	Yes, if the EP is eligible
Medicare Care Management Performance Demonstration (MCMP)	Yes, if the practice is eligible. The MCMP demo will end before EHR incentive payments are available
Electronic Prescribing Incentive Program (eRx)	If the EP chooses to participate in the Medicare EHR Incentive Program, they cannot participate in the Medicare eRx Incentive Program simultaneously. If the EP chooses to participate in the Medicaid EHR Incentive Program, they can participate in the Medicare eRx Incentive Program simultaneously

9. What about special eligibility categories? Is anyone not eligible?

- **EPs in Medicare Advantage**

Special Case: Eligible Providers in Medicare Advantage (MA)
MA Eligible Professionals (EPs)
Must furnish, on average, at least 20 hours/week of patient-care services and be employed by the qualifying MA organization
-or-
Must be employed by, or be a partner of, an entity that through contract with the qualifying MA organization furnishes at least 80 percent of the entity's Medicare patient care services to enrollees of the qualifying MA organization
Qualifying MA-Affiliated Eligible Hospitals
Will be paid under the Medicare Fee-for-service EHR incentive program

- **Professionals who practice "Predominantly in FQHC/RHC" or provides care for "Needy Individuals"**
  - EP is also eligible when practicing predominantly in federally qualified health clinic (FQHC) or rural health clinic(RHC) providing care to needy individuals
  - Proposes practicing predominantly is when FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year
  - Needy individuals (specified in statute) include:
    - Medicaid or CHIP enrollees;
    - Patients furnished uncompensated care by the provider; or
    - furnished services at either no cost or on a sliding scale.

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- **Practitioners in Health Professional Shortage Areas (HPSAs)** - Medicare meaningful use incentive payments are increased by 10% for providers located in a "health professional shortage area." For more information on HPSAs, see http://bhpr.hrsa.gov/shortage/.

- **Hospital-based Eligible Professionals – NOT ELIGIBLE**
  - Hospital-based EPs do not qualify for Medicare EHR incentive payments
  - Most hospital-based EPs will not qualify for Medicaid EHR incentive payments
  - Defined as an EP who furnishes 90% or more of their services in a hospital setting (inpatient, outpatient, or emergency room)

Additional Meaningful Use Resources:

Press Release: CMS and ONC Issue Regulations on "Meaningful Use"

Fact Sheet: Proposed Requirements for EHR Medicaid Incentive Program

Fact Sheet: Proposed Requirements for EHR Medicare Incentive Program

Proposed Rule: Electronic Health Record Incentive Program

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Stage 1 Meaningful Use Criteria For Eligible Professionals (EP) *Source: CMS EHR Incentive Program NPRM; Healthcare IT News*	
Objective	Measure
1. Use CPOE	CPOE is used for at least 80 percent of all orders
2. Implement drug-drug, drug-allergy, drug- formulary checks	The EP has enabled this functionality
3. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®	At least 80 percent of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data.
4. Generate and transmit permissible prescriptions electronically	At least 75 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
5. Maintain active medication list.	At least 80 percent 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. Maintain active medication allergy list	At least 80 percent 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. Record demographics.	At least 80 percent of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data
8. Record and chart changes in vital signs.	For at least 80 percent 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 to 20.
9. Record smoking status for patients 13 years old or older	At least 80 percent of all unique patients 13 years old or older seen by the EP "smoking status" recorded
10. Incorporate clinical lab-test results into EHR as structured data.	At least 50 percent of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.	Generate at least one report listing patients of the EP with a specific condition.
12. Report ambulatory quality measures to CMS or the States.	For 2011, an EP would provide the aggregate numerator and denominator through attestation as discussed in section II.A.3 of this proposed rule. For 2012, an EP would electronically submit the measures are discussed in section II.A.3. of this proposed rule.
13. Send reminders to patients per patient preference for preventive/ follow-up care	Reminder sent to at least 50 percent of all unique patients seen by the EP that are 50 and over

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14. Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering, along with the ability to track compliance with those rules	Implement five clinical decision support rules relevant to the clinical quality metrics the EP is responsible for as described further in section II.A.3.
15. Check insurance eligibility electronically from public and private payers	Submit Insurance eligibility checked electronically for at least 80 percent of all unique patients seen by the EP
16. Submit claims electronically to public and private payers.	At least 80 percent of all claims filed electronically by the EP.
17. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request	At least 80 percent of all patients who request an electronic copy of their health information are provided it within 48 hours.
18. Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies)	At least 10 percent of all unique patients seen by the EP are provided timely electronic access to their health information
19. Provide clinical summaries to patients for each office visit.	Clinical summaries provided to patients for at least 80 percent of all office visits.
20. Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
21. Perform medication reconciliation at relevant encounters and each transition of care.	Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care.
22. Provide summary care record for each transition of care and referral.	Provide summary of care record for at least 80 percent of transitions of care and referrals.
23. Capability to submit electronic data to immunization registries and actual submission where required and accepted.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.
24. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.	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 or eligible hospital submits such information have the capacity to receive the information electronically).
25. Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary.

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Stage 1 Meaningful Use Criteria For Eligible Hospitals (EP) ***Source: CMS EHR Incentive Program NPRM; Healthcare IT News***	
Objective	Measure
1. Use of CPOE for orders (any type) directly entered by authorizing provider (for example, MD, DO, RN, PA, NP)	CPOE is used for at least 10 percent of all orders
2. Implement drug-drug, drug-allergy, drug-formulary checks	The eligible hospital has enabled this functionality
3. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT	At least 80 percent of all unique patients admitted to the eligible hospital have at least one entry or an indication of none recorded as structured data.
4. Maintain active medication list.	At least 80 percent of all unique patients admitted by the eligible hospital have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data.
5. Maintain active medication allergy list.	At least 80 percent of all unique patients admitted to the eligible hospital have at least one entry (or an indication of "none" if the patient has no medication allergies) recorded as structured data.
6. Record demographics.	At least 80 percent of all unique patients admitted to the eligible hospital have demographics recorded as structured data
7. Record and chart changes in vital signs.	For at least 80 percent of all unique patients age 2 and over admitted to the eligible hospital, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20.
8. Record smoking status for patients 13 years old or older	At least 80 percent of all unique patients 13 years old or older admitted to the eligible hospital have "smoking status" recorded
9. Incorporate clinical lab-test results into EHR as structured data.	At least 50 percent of all clinical lab tests results ordered by an authorized provider of the eligible hospital during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
10. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach	Generate at least one report listing patients of the eligible hospital with a specific condition.
11. Report hospital quality measures to CMS or the States.	For 2011, an eligible hospital would provide the aggregate numerator and denominator through attestation as discussed in section II.A.3 of this proposed rule. For 2012, an eligible hospital would electronically submit the measures are discussed in section II.A.3. of this proposed rule.
12. Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering, along with the ability to track compliance with those rules	Implement five clinical decision support rules relevant to the clinical quality metrics the Eligible Hospital is responsible for as described further in section II.A.3.

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13. Check insurance eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80 percent of all unique patients admitted to an eligible hospital
14. Submit claims electronically to public and private payers	At least 80 percent of all claims filed electronically by the EP or the eligible hospital.
15. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies, discharge summary, and procedures), upon request.	At least 80 percent of all patients who request an electronic copy of their health information are provided it within 48 hours.
16. Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.	At least 80 percent of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it.
17. Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
18. Perform medication reconciliation at relevant encounters and each transition of care.	Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care.
19. Provide summary care record for each transition of care and referral.	Provide summary of care record for at least 80 percent of transitions of care and referrals.
20. Capability to submit electronic data to immunization registries and actual submission where required and accepted.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.
21. Capability to provide electronic submission of reportable lab results to public health agencies and actual submission where it can be received.	Performed at least one test of certified EHR technology capacity to provide electronic submission of reportable lab results to public health agencies (unless none of the public health agencies to which eligible hospital submits such information have the capacity to receive the information electronically).
22. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.	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 eligible hospital submits such information have the capacity to receive the information electronically).
23. Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary.

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