

Meaningful Use

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1

Overview

- American Recovery and Reinvestment Act of 2009 contained the Health Information Technology for Economic and Clinical Health (HITECH) Act.
- In addition to changes to HIPAA, HITECH provided significant financial incentives to eligible hospitals and providers to become “meaningful users” of a certified electronic health record (EHR)
- The goal is to accelerate the adoption and implementation of EHR to improve healthcare delivery and outcomes, and to reduce costs.

2

EHR Incentive Regulations

- CMS published the Electronic Health Record (EHR) Incentive Notice of Proposed Rulemaking (NPRM) published January 13, 2010
- Comment period on the CMS NPRM ended March 15, 2010
- Office of the National Coordinator (ONC) Interim Final Rule Health Information Technology (HIT): Initial Set of Standards, Implementation Specifications, and Certification Criteria for EHR Technology, also published January 13, 2010. Rule was effective February 12, 2010. Also provided for a 60-day comment period, which ended on March 15, 2010.
- Office of National Coordinator Proposed Establishment of Certification Programs for Health Information Technology Notice of Proposed Rulemaking (NPRM) published March 10, 2010.

3

Qualifying Technology

- Certified EHR technology
- Complete EHR or combination of EHR Modules:
 - Each of which meet requirements of Qualified EHR and has been tested and certified
 - Complete EHR-all functions/capabilities required
 - Modules- at least one function/capability

4

Qualified EHR

- Qualified EHR means an electronic record of health-related information on an individual that:
 - Includes patient demographic and clinical health information such as medical history and problem lists; and
 - Has the capacity to:
 - Provide clinical decision support;
 - Support physician order entry;
 - Capture and query information relevant to health care quality; and
 - Exchange electronic health information with and integrate such information from other sources

5

Certification

- Rulemaking published March 10, 2010
- Provides for a temporary and a permanent certification program
- Provides for companies to apply for designation as approved company to test and certify EHR technology

6

Eligibility- Who is eligible for payments?

- Medicare Fee for Service (Traditional Medicare):
 - Eligible professionals
 - Eligible hospitals and critical access hospitals

Medicare Advantage (MA):

- MA eligible professionals
- MA-affiliated eligible hospital

Medicaid:

- Eligible professionals
- Eligible hospitals

7

Eligible Providers-Medicare

- Eligible professionals:
 - MD, DO
 - Doctor of dental surgery or dental medicine
 - Doctor of Podiatric Medicine
 - Doctor of Optometry
 - Chiropractor
 - EXCEPT: hospital-based providers
- Eligible hospitals:
 - Hospitals
 - Critical access hospitals

8

Eligible Hospitals-Medicaid

- Hospitals:
 - Qualify for Medicaid payments if an “acute care” hospital with at least 10% Medicaid patient volume threshold; or
 - a children’s hospital
- Acute care hospital is a health care facility where the average length of patient stay is 25 days or fewer AND with a CMS certification number (Medicare provider number) that has the last four digits in the series 0001-0879.
- This definition would not include CAHs

9

Medicaid: Eligible Providers

- Eligible professionals:
 - Physicians (pediatricians have special rules)
 - Nurse practitioners
 - Certified Nurse midwives
 - Dentists
 - Physician Assistants in a Federally Qualified Health Center (FQHC) led by a PA or in a rural health clinic that is directed by a PA

10

Hospital-Based Eligible Professionals

- Hospital-based eligible professionals do not qualify for Medicare EHR incentive payments
- Most will also not qualify for Medicaid EHR incentive payments
- Hospital-based is defined as an eligible professional who furnishes 90% or more of their services in a hospital setting
- Services billed using site of service codes 21, 22 and 23

11

Medicaid Eligibility: Patient Volume Threshold

- Physicians, Dentists, CNMs, PAs (in PA led FQHC, RHC), NPs: 30%
- Pediatricians: 20%
- Acute care hospitals: 10%
- Children's Hospitals- no requirement
- Exception to the above if the EP practices "predominantly" in a FQHC or RHC that has at least 30% needy individuals
- "Predominantly" means FQHC/RHC is clinical location for over 50% of the total encounters over a 6-month period in the most recent calendar year
- Needy individuals means
 - Medicaid or CHIP enrollee,
 - Patients furnished uncompensated care by the provider, or
 - Patients furnished services at either no cost or on a sliding scale.

12

Meaningful Use

- HITECH provides for three components of “meaningful use”:
 - Use of certified EHR in a meaningful manner
 - Use of certified EHR technology for the exchange of health information to improve quality
 - Use of certified EHR technology to submit clinical quality and other measures to HHS
- Regulations provide for a “phased-in” approach to defining meaningful use
- Only Stage 1 is defined in the NPRM

13

Meaningful Use- Stage 1

- Eligible Professionals- 25 objectives and measures
- Eligible hospitals and CAHs-23 objectives and measures
- Some measures are yes/no and others require use of a calculation involving a numerator/denominator
- Reporting period-90 days for the first year; one year for each subsequent year

14

Meaningful Use- Objectives and Measures

- Utilize computerized provider order entry
 - Hospitals- 10% of all orders
 - Eligible professionals- 80% of all orders
- Implement drug-drug, drug-allergy, drug-formulary checks
 - Yes or no
- Maintain up-to-date problem list of current and active diagnoses based on ICD-9 or SNOMED CT
 - At least 80% of all unique patients seen by the EP/admitted to the hospital have at least one entry or an indication of “none” recorded as structured data

15

Meaningful Use- Objectives and Measures

- Maintain an active medication list
 - At least 80% have at least one medication or “none” recorded
- Maintain active medication allergy list
 - At least 80% of patients have an allergy recorded or “none” if the patient states he/she has no allergies
- Record demographics: preferred language, insurance type, gender, race, ethnicity, and date of birth, and for hospitals, date and cause of death in the event of mortality
 - At least 80% of patients have this information recorded as structured data
- Record and chart changes in vital signs: height, weight, blood pressure, calculate and display BMI for patients 2 yrs and older, plot and display growth charts for children 2 to 20 years including BMI
 - At least 80% of patients age 2 and older have blood pressure, and BMI recorded, and 80% of patients age 2-20 have the growth chart plotted

16

Meaningful Use- Objectives and Measures (cont)

- Record smoking status for patients ≥ 13 years
 - At least 80% of the patients have smoking status recorded
- Clinical lab data incorporated into EHR as structured data
 - At least 50% of all clinical lab tests ordered whose results are either positive/negative or a numerical format are incorporated into the certified EHR as structured data
- Generate lists of patients by specific condition to use for QI, reduction of disparities, research, and outreach
 - Generate at least one report listing patients with a specific condition
- Report quality measures to CMS or the States
 - Successfully report to CMS, and if applicable, the State, clinical quality measures in the form and manner specified by CMS.
- Implement 5 clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, and be able to track compliance with the rules

17

Meaningful Use- Objectives and Measures

- Check insurance eligibility electronically from public and private payers
 - At least 80% of patient eligibility checks are performed electronically
- Submit claims electronically to public and private payers
 - At least 80% of all claims are filed electronically
- Perform medication reconciliation at relevant encounters and at each transition of care
 - Perform medication reconciliation for at least 80% of relevant encounters and transitions of care
- Provide summary care record for each transition of care and referral
 - Summary of care record provided for at least 80% of transitions of care and referrals
- Provide patients with an electronic copy of their health information on request
 - Content varies some between EP and hospital: list includes diagnostic testing results, problem list, medication list, allergies, and for hospitals, must also include discharge summary and procedures
 - Measurement- at least 80% of those who request it, receive it within 48 hours

18

Meaningful Use-Objectives and Measures (cont)

- Capability to submit electronic data to immunization registries and actual submission where required and accepted
 - Perform at least one test of certified EHR technology's capability to submit electronic data to immunization registries
- Capability to provide electronic syndromic surveillance data to public health agencies, and actual transmission according to applicable law and practice
 - Perform at least one test of certified EHR technology's capacity to provide this data electronically (unless none have the capacity to receive it)
- Protect electronic health information created or maintained in the certified EHR technology through appropriate technical capabilities
 - Conduct or review a security risk analysis in accordance with the requirements of 45 CFR 164.308(a)(1) and implement security updates if necessary

19

Additional Objectives and Measures- Hospitals Only

- Provide patients with an electronic copy of their discharge instructions and procedures at discharge upon request
 - At least 80% of patients who request the information be provided electronically are provided it electronically
- Capability to provide electronic submission of reportable lab results, as required by state or local law, to public health agencies and actual submission where it can be received
 - Perform at least one test (unless no agencies have the capacity to accept the information electronically)
- Capability to electronically exchange information among providers and other authorized entities
 - Perform at least one test of the certified EHR technology's capacity to exchange key clinical information electronically

20

Additional Objectives and Measures- Eligible Professionals Only

- Generate and transmit permissible scripts electronically
 - At least 75% of permissible prescriptions are submitted electronically
- Send reminders to patients for preventive and follow-up care
 - Reminder sent to at least 50% of patients that are 50 years of age and over
- Provide patients with timely electronic access to their health information within 96 hours of information being available to the EP
 - At least 10% of patients are provided timely electronic access to their health information
- Provide clinical summaries for patients for each office visit
 - Clinical summaries are provided to patients for at least 80% of all office visits

21

Clinical Quality Measures-Overview

- Providers are required to submit summary quality measure data to CMS and/or states
- For 2011- the data will be submitted by attestation
- 2012 and after- electronic submission of summary quality data
- Eligible professionals: core measures and a subset of measures most appropriate to that professional's specialty
- Hospitals- quality measures for applicable cases

22

Quality Measures- Eligible Professionals

- Preventive care and screening: inquiry concerning tobacco use
- Blood pressure management
- Drugs to be avoided by elderly populations:
 - Patients who receive at least one drug to be avoided
 - Patients who receive at least two different drugs to be avoided
- Specialties:
 - Cardiology, pulmonology, endocrinology, oncology, proceduralist/surgery, primary care, pediatrics, nephrology, OB/GYN, neurology, psychiatry, ophthalmology, podiatry, radiology, and gastroenterology

23

Clinical Quality Measures-Hospitals

- Required to report clinical summary data on 35 clinical quality measures
- For Medicaid incentives, hospitals may select 8 alternative measures to meet the requirements of the 35 measures do not apply to their patient population
- Hospital that is only eligible for Medicaid incentives will report directly to the State

24

EHR Incentive Payments Overview

- Eligible Professionals-
 - Calendar year
 - 2011-2016 (Medicare)- up to \$44,000 over 5 years
 - 2011-2021 (Medicaid)- up to \$63,750 over 6 years
 - Recall EPs not eligible for both, BUT may change program designation ONCE during payment years 2012 through 2014
 - 2015 and later-up to 3% payment adjustment in Medicare reimbursement
 - Additional payments for those in HPSAs

25

Incentive Payments Timeline

- Medicare- EPs no sooner than January 2011;
Hospitals and CAHs no sooner than October 2010;
- Medicaid- potentially as early as 2010 for “adopting, implementing or upgrading”

26



Questions?

Thanks!!!