The Proposed Meaningful Use Regulations: A Guide to EHR Incentive Payments

On January 13, 2010, the Centers for Medicare and Medicaid Services ("CMS") published a Proposed Rule ("the Rule") clarifying the definition of "meaningful use."[1] The HITECH Act generally establishes incentive payments for certain "eligible" providers who demonstrate that they are "meaningful users" of "certified EHR technology." Providers who do not achieve "meaningful use" will be subjected to penalties beginning in 2015. Thus, the "meaningful use" definition is very important for all providers, including those who are interested in qualifying for incentive payments as well as those who wish to avoid future penalties.

Meaningful Use Criteria

The Rule envisions a phased approach to demonstrating meaningful use. This approach recognizes that existing technological limitations make full adoption of EHR difficult to achieve immediately, and allows providers to incrementally expand and improve their technologies while continuing to receive incentive payments. This approach would entail a total of 3 stages of criteria, and dictates a specific timeline by which providers must complete each stage depending upon when the EHR technology was first implemented. The Rule only discusses the stage 1 meaningful use criteria.

The Rule establishes a total of 25 objectives that non-hospital based eligible professionals must satisfy in order to demonstrate meaningful use of EHR technology. The objectives are as follows:

- Use Computer Physician Order Entry (CPOE) technology;
- Implement drug-drug, drug-allergy, and drug-formulary checks;
- Maintain an up to date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT;
- Generate and transmit permissible prescriptions electronically;
- Maintain an active medication list;
- Maintain an active medication allergy list;
- Record demographic information, including preferred language, insurance type, gender, race and ethnicity, and date of birth;
- Record and chart changes in vital signs, including height, weight, blood pressure, body mass index (children age 2 and over), and growth charts (children age 2-20);
- Record smoking status for patients 13 years of age or older;
- Incorporate clinical lab test results as structured data;
- Generate lists of patients by specific conditions for purposes of quality improvement, reducing disparities, research and outreach;

[1] 75 Fed. Reg. 1844-2011 (Jan. 13, 2010).

- Report ambulatory quality measures to CMS;
- Send reminders to patients for preventative or follow-up care;
- Implement five clinical decision support rules relevant to specialty or high clinical priority, and develop the ability to track compliance therewith;
- Check insurance eligibility electronically from public and private payers;
- Submit claims electronically to public and private payers;
- Provide patients with an electronic copy of their health information;
- Provide patients with timely electronic access to their health information within 96 hours of the information becoming available;
- Provide clinical summaries for each office visit;
- Capability to exchange key clinical information among providers and other patient authorized entities electronically;
- Perform medication reconciliation at relevant encounters and at each transition of patient care;
- Provide summary care record for each transition of care and referral;
- Capability to submit electronic data to immunization registries and actual submission where required and accepted;
- Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice; and
- Protect electronic health information created or maintained through the implementation of appropriate technical capabilities.

Each of these objectives is associated with a specific functional measure that will be necessary to ensure compliance. For the most part, these measures are calculated on a percentage basis, i.e. the objective must be met in a defined percentage of patients. A percentage-based calculation is designed to ensure that differences in patient volume do not affect the provider's ability to satisfy the objectives and receive incentive payments. The Rule provides detailed instructions on how to calculate the majority of these functional measures.

Clinical Quality Measures

The Rule also establishes clinical quality measures that non-hospital based eligible professionals must report to CMS in order to be entitled to incentive payments. The clinical quality measures fall into two categories: core clinical quality measures and specialty clinical quality measures. All eligible professionals must submit data relevant to the core clinical measures, and each professional must also

select and submit data relevant to one specialty subset that is most appropriate to the provider's practice. For example, if the provider is a cardiologist, she will be required to submit core clinical quality measures as well as cardiology specialty clinical quality measures.

For the most part, these clinical quality measures focus on preventative care, patient screening and disease management. The core clinical quality measures include inquiries regarding tobacco use, blood pressure measurement, and evaluation of drugs to be avoided in the elderly. The specialty clinical quality measures vary greatly depending upon the particular specialty area chosen, but generally reflect similar themes of disease management and preventative care.

Demonstrating Meaningful Use Criteria and Reporting Clinical Quality Measures

The Rule recognizes that providers and CMS do not yet have the appropriate technology in place to transmit or accept reports demonstrating compliance electronically. Thus, providers will initially be permitted to report compliance with the meaningful use requirements through attestation.

Although a "certified" EHR as defined by additional rulemaking is required, compliance with the Rule cannot be satisfied merely by relying on an EHR vendor. The "meaningful use" regulations require eligible professionals to actually use the EHR technology to improve the quality of health care, according to the requirements set forth above. Providers should also be aware that the Rule may change in response to public comments, which were required to be submitted by March 15, 2010. Providers seeking financial incentives should also remain informed of additional rulemaking regarding future stages of meaningful use criteria in subsequent years. For additional information or for assistance in ensuring compliance and obtaining incentive payments, contact a Wachler & Associates attorney at (248) 544-0888.

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