



Illinois Health Information Technology Regional Extension Center



www.ilhitrec.org

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 hospitals.

Under the law, the Centers for Medicare and Medicaid in concert with the Office of the National Coordinator for Health Information Technology have created a new program and released final rules for demonstrating “meaningful use” and applying for incentive payments. Provided below are responses to common questions on Stage 1 meaningful use and EHR incentive payments. Responses are based on the CMS rule. However, this is not intended to be official guidance. We encourage you to work with IL-HITREC to make sure you, your practice or hospital qualifies for incentives.

1. Who is eligible to apply?

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

For Medicaid, there are also patient volume requirements to qualify:

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

2. What is “meaningful use” exactly?

Meaningful use is defined as:

- Use of a **certified EHR** in a meaningful manner (ex: clinical documentation, e-prescribing, etc.)
- 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?

Requirements vary based on whether the applicant is an “eligible professional” or eligible hospital.” Tables summarizing the requirements are provided at the end of this document.

Eligible Professionals (EPs)

- Must meet 15 core requirements + 5 menu requirements
- Quality measures required for reporting for EPs – 3 core + 3 menu
- If EP unable to report on normal core measures, three (3) alternative core measures are specified as well as a process for determining reporting requirements for the EP.

Eligible Hospitals and Critical Access Hospitals

- Must meet 14 core requirements + 5 menu requirements
- Quality measures required for reporting - 15 measures for hospitals

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 quality measure data to CMS or States

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.

5. How much money can I receive in incentives?

Eligible professionals (EPs) Timeline

- 2011-2016 (Medicare) –Up to \$44,000 over 5 years if “meaningful user”
- 2011-2021 (Medicaid) –Up to \$63,750 over 6 years –Adopt/Implement/Upgrade systems or meaningful use in Year 1, meet MU requirements in 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.



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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

6. When can I apply?

Medicare	Medicaid
<ul style="list-style-type: none"> Fall 2010 - Certification of EHR vendors will start 2011-2012 - Clinicians can begin using a certified EHR in a meaningful manner (must use for 90 days) Jan. 2011 - Registration with CMS can begin April 2011 - Attestation of meaningful use begins May 2011 - CMS payments will begin 	<p>Medicaid EHR incentives will be managed by states. The State of Illinois is expecting registration to be available by spring or summer of 2011.</p>



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7. 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
<ul style="list-style-type: none"> Feds will implement (will be an option nationally) Fee schedule reductions begin in 2015 for providers that are not Meaningful Users Must be a meaningful user in Year 1 Maximum incentive is \$44,000 for EPs MU definition will be common for Medicare Medicare Advantage EPs have special eligibility accommodations Last year an EP may initiate program is 2014; Last payment in program is 2016; Payment adjustments begin in 2015 Only physicians, subsection (d) hospitals and CAHs 	<ul style="list-style-type: none"> Voluntary for States to implement (may not be an option in every State) No Medicaid fee schedule reductions A/I/U option for 1st participation year Maximum incentive is \$63,750 for EPs States can adopt a more rigorous definition (based on common definition) Medicaid managed care providers must meet regular eligibility requirements Last year an EP may initiate program is 2016; Last payment in program is 2021 5 types of EPs, 3 types of hospitals

8. 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 $\$24,000 \times .75 = \$18,000$), 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, $\$10,000 \times .75 = \$7,500$, 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.

9. I am a health care professional who... What do I need to know?

Is an eligible provider under 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



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Practices primarily in a hospital inpatient setting. Am I eligible for incentives?

- 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)

Practices 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.

Practices in a Health Professional Shortage Area (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/>.

10. 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

Additional Meaningful Use Resources:

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CMS EHR Incentive Program Home Page

<http://www.cms.gov/EHRIncentivePrograms/>

Office of National Coordinator for Health IT

<http://healthit.hhs.gov/>



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Stage 1 Meaningful Use Criteria For Eligible Professionals (EP)

Source: CMS EHR Incentive Program Final Rule

Core Set

Objective	Measure
1. Use CPOE	More than 30 percent of unique patients with at least one medication have at least one medication order entered using CPOE
2. Implement drug-drug and drug-allergy, checks	The EP has enabled this functionality
3. Generate and transmit permissible prescriptions electronically	More than 40 percent of all prescriptions written are transmitted electronically using certified EHR technology
4. Record demographics <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth 	More than 50 percent of all unique patients seen have demographics recorded as structured data
5. Maintain an up-to-date problem list of current and active diagnoses	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data.
6. Maintain active medication list	More than 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.
7. Maintain active medication allergy list	More than 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.
8. Record and chart changes in vital signs <ul style="list-style-type: none"> • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20, including BMI 	Record height, weight and blood pressure as structured data for more than 50 percent of all unique patients age 2 and over seen by the EP
9. Record smoking status for patients 13 years old or older	More than 50 percent of all unique patients 13 years old or older seen by the EP have "smoking status" recorded as structured data.
10. Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance with those rules	Implement one clinical decision support rule
11. Report ambulatory quality measures to CMS or the States	For 2011, provide aggregate numerator and denominator and exclusions through attestation, as discussed in section II(A)(3) of this final rule For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of this final rule.



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Objective	Measure
12. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days
13. Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days
14. Capability to exchange key clinical information (for example, problem list, medication list, medication 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
15. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security a deficiencies as part of its risk management process

Menu Set

Objective	Measure
1. Implement drug-formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary
2. Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the EP with a specific condition
4. Send reminders to patients per patient preference for preventative/follow up care	More than 20 percent of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period
5. Provide patients with timely access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP	More than 10 percent of all unique patients are provided with electronic access to their health information within 4 business days of being updated in the certified EHR technology



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Objective 6. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate	Measure More than 10 percent of all unique patients seen during the EHR reporting period are provided patient-specific education resources
7. Perform medication reconciliation	Perform medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP
8. Provide summary of care record for each transition of care or referral	EP provides a summary of care record for more than 50 percent of transitions of care and referrals
9. Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful
10. Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with 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 and follow-up submission if the test is successful

Stage 1 Meaningful Use Criteria For Eligible Hospitals (EH)

Source: CMS EHR Incentive Program Final Rule

Core Set

Objective 1. Use CPOE	Measure More than 30 percent of unique patients with at least one medication have at least one medication order entered using CPOE
2. Implement drug-drug and drug-allergy checks	The eligible hospital/CAH has enabled this functionality
3. Generate and transmit permissible prescriptions electronically	More than 40 percent of all prescriptions written are transmitted electronically using certified EHR technology
4. Record demographics <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth • Date and preliminary cause of death in the event of mortality 	More than 50 percent of all unique patients seen have demographics recorded as structured data



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Objective	Measure
5. Maintain an up-to-date problem list of current and active diagnoses	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department have at least one entry or an indication of none recorded as structured data.
6. Maintain active medication list	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department have at least one entry (or an indication of "none" if the patient is not currently prescribed any medication) recorded as structured data.
7. Maintain active medication allergy list	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department have at least one entry (or an indication of "none" if the patient has no medication allergies) recorded as structured data.
8. Record and chart changes in vital signs <ul style="list-style-type: none"> • Height • Weight • Blood pressure • Calculate and display BMI • Plot and display growth charts for children 2-20, including BMI 	Record height, weight and blood pressure as structured data for more than 50 percent of all unique patients age 2 and over admitted to the eligible hospital's or CAH's inpatient or emergency department.
9. Record smoking status for patients 13 years old or older	Have "smoking status" recorded as structured data for more than 50 percent of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department.
10. Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance with those rules	Implement one clinical decision support rule
11. Report ambulatory quality measures to CMS or the States	<p>For 2011, provide aggregate numerator and denominator and exclusions through attestation, as discussed in section II(A)(3) of the final rule</p> <p>For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of the final rule</p>
12. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days
13. Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	More than 50 percent of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department and who request an electronic copy of their discharge instructions are provided it at discharge



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<p>Objective</p> <p>14. Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically</p>	<p>Measure</p> <p>Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information</p>
<p>15. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</p>	<p>Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process</p>

Menu Set

Objective	Measure
<p>1. Implement drug-formulary checks</p>	<p>The eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary</p>
<p>2. Record advance directives for patients 65 years old or older</p>	<p>More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department have an indication of an advance directive status recorded</p>
<p>3. Incorporate clinical lab-test results into certified EHR technology as structured data</p>	<p>More than 40 percent of all clinical lab test results ordered by an authorized provider of the eligible hospital or CAH during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data</p>
<p>4. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach</p>	<p>Generate at least one report listing patients of the eligible hospital or CAH with a specific condition</p>
<p>5. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate</p>	<p>More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department during the EHR reporting period are provided patient-specific education resources</p>
<p>6. Perform medication reconciliation</p>	<p>Perform medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department</p>
<p>7. Provide summary of care record for each transition of care or referral</p>	<p>The eligible hospital or CAH provides a summary of care record for more than 50 percent of transitions of care and referrals</p>



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Menu Set

Objective	Measure
<p>8. Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice</p>	<p>Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful</p>
<p>9. Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice</p>	<p>Performed at least one test of certified EHR technology capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful</p>
<p>10. Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice</p>	<p>Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful</p>



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