

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

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On January 13, 2010, the Centers for Medicare and Medicaid Services (CMS) published a much-anticipated Proposed Rule (the “Rule”) establishing requirements for eligible professionals and hospitals to demonstrate “meaningful use” of electronic health record (EHR) technology so as to be entitled to receive incentive payments.¹ On the same date, the Office of the National Coordinator of Health Information Technology (ONC) issued a coordinated Interim Final Rule containing the standards, specifications and certification criteria for Certified EHR Technology.² CMS and ONC have invited comments as to both sets of regulations; the comment period for both expired on March 15, 2010.

These regulations were mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act generally establishes incentive payments for eligible professionals and hospitals who demonstrate that they are “meaningful users” of “certified EHR technology.” Eligible professionals who so demonstrate will be entitled to receive up to \$44,000 in incentive payments over the course of several years, and those who fail to do so will be subject to a penalty beginning in 2015.

This payment structure initially caused much consternation among providers as to what exactly this would require in practice. These regulations represent an attempt to help providers navigate the EHR incentive waters. The following presents a summary of the key aspects of the Rule that non-hospital based eligible professionals will need to demonstrate in order to be eligible for HITECH’s incentive payments. However, it is important to keep in mind that there may be additional changes to the proposed criteria in response to public comments received.

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;

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

² 75 Fed. Reg. 2014-2047 (Jan. 13, 2010).

- 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;
- 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

In order to demonstrate compliance with the meaningful use objectives and functional measures and to report required clinical quality measures, the Rule suggests that eligible professionals utilize attestation methodology. This choice reflects the reality that providers and CMS do not yet have the appropriate technological infrastructure in place to transmit and accept reports through direct electronic transmission, largely because vendors have not yet had time to adjust their technologies to comply with the Interim Final Rule's mandates for certified EHR technology. Until this has been done, CMS will rely upon attestation.

The Rule provides significant guidance as to what eligible professionals will need to do to demonstrate meaningful use of EHR technology and ensure that they will receive incentive payments under the HITECH Act. Providers who wish to take advantage of these incentives must remain cognizant of the

requirements of the Rule, as well as any changes that may be made in response to public commentary. Providers 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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