New Government Regulations in EHRs: Be Ready

Preparing for what's to come.

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The passing of the Health Information Technology for Economic and Clinical Health (HITECH) Act represents one of many major financial and practice changes affecting physicians as part of the American Recovery and Reinvestment Act of 2009. Under the HITECH Act, physicians' practices and hospitals are required to implement electronic health record (EHR) technology by 2015 or face consequences. According to a survey published by the AAO last year, cost was the biggest reason ophthalmologists had not yet adopted EHR technology.[1]

To promote important health policy goals—and to help overcome cost-associated resistance to adopting EHR—the HITECH Act established Medicare and Medicaid EHR incentive programs, to be administered by the Centers for Medicaid & Medicare Services (CMS). This article describes how to get paid for implementing EHR technology in your practice and what will happen if you choose not to.

WHO HAS TO ADOPT EHRs?

Any doctor of medicine or optometry who is legally authorized to practice under state law is considered an eligible professional under the HITECH Act and is therefore subject to its regulations. The HITECH Act excludes hospital-based physicians, but in a subsequent statutory change, Congress broadened the definition to exclude only those who work in an inpatient setting or emergency room, making hospital-based physicians who work in an ambulatory setting eligible.[2]

THE INCENTIVES

Programs

It is important to note that the Medicare and Medicaid incentive programs are independent of each other and have separate requirements. The Medicare program will provide financial incentives to eligible professionals who are meaningful users of certified EHR technology.[3] In its first year, the Medicaid program will provide financial incentives to eligible professionals for efforts to adopt, implement, or upgrade certified EHR technology or for its meaningful use. In subsequent years, however, eligible professionals under the Medicaid program must demonstrate meaningful use. Even if a physician meets the eligibility requirements for both the Medicare and Medicaid incentive programs, he or she may only participate in one.[2]

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Meaningful Use

Qualifying for the HITECH Act's incentives depends on meeting the requirements of the phrase *meaningful use*. A physician must demonstrate that he or she has adopted certified EHR technology and is making meaningful use of it to receive incentive payments. On January 13, 2010, the CMS published a proposed definition of meaningful use, which was followed by a 60-day public comment period. The CMS plan to release the final rule this summer.[3]

Under the HITECH Act, certified EHR technology is being meaningfully used when it is used to exchange health information, improve the quality of the health care provided, and report on clinical quality measures.

TABLE 1. STAGE 1 OBJECTIVES INCLUDE 25 POINTS OF MEANINGFUL USE

1. Implement drug/drug, drug/allergy, and drug/formulary checks
2. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or Systematized Nomenclature of Medicine—Clinical Term
3. Maintain active medication lists
4. Maintain active medication allergy lists
5. Record demographics:
   - Preferred language
   - Insurance type
   - Gender
   - Race
   - Ethnicity
   - Date of birth
6. Record and chart changes and vital signs:
   - Height
   - Weight
   - Blood pressure
   - Calculate and display body mass index
   - Plot and display growth charts for patients aged 2 to 20 years, including body mass index
7. Record smoking status for patients aged 13 years or older
8. Report ambulatory quality measures to Centers for Medicare & Medicaid Services or the states
9. Send reminders to patients per patients' preference for preventive/follow-up care
10. Implement five clinical decision support rules relevant to specialty or high clinical priority, including diagnostic test ordering, along with the ability to track compliance with those rules
11. Check insurance eligibility electronically from public and private payers
12. Submit claims electronically to public and private payers
13. Provide clinical summaries for patients for each office visit
14. Capability to exchange key clinical information (eg, problem list, medication list, allergies, diagnostic test results) among providers of care and patient-authorized entities electronically
15. Capability to submit electronic data to immunization registries and actual submission where required and accepted
16. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice
17. Protect electronic health information created or maintained by the certified electronic health record technology through the implementation of appropriate technical capabilities
18. Use computerized physician order entry
19. Generate and transmit permissible prescriptions electronically
20. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach
21. Incorporate clinical laboratory test results into electronic health records as structured data
22. Provide patients with an electronic copy of their health information (including diagnostic test results, problem lists, medication lists, allergies) upon request
23. Provide patients with timely electronic access to their health information (including laboratory results, problem list, medication lists, allergies) within 96 hours of the information's being available to the eligible professional
24. Perform medication reconciliation at relevant encounters and each transition of care
25. Provide summary care record for each transition of care and referral

Source: Centers for Medicare & Medicaid Services.

The CMS will continue to advance this definition in three stages, which will be rolled out until 2015. Under the CMS's proposed rule, stage 1 will begin in 2011. Stages 2 and 3 are currently in development and are proposed to begin in 2013 and 2015, respectively.[3]

Criteria for meaningful use under stage 1 are defined as "electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information." Under the CMS's proposed rule, a physician must meet 25 objectives to be deemed a meaningful user of EHR under stage 1 (Table 1). Stage 2 will focus on the areas of disease management, clinical decision support, medication management, support for patients' access to their health information, transitions in care, quality measurement and research, and bidirectional communication with public health agencies. Stage 3 will be geared toward achieving improvements in quality, safety, and efficiency; focusing on decision support for national high-priority conditions; offering patients access to self-management tools; accessing comprehensive patient data; and improving population health outcomes.[3]

Certified EHR Technology

Another major factor in qualifying for the incentives is implementing EHR technology that is certified by the Office of the National Coordinator for Health Information Technology (ONC). On January 13, 2010, the ONC published an interim final rule (IFR)—an initial set of standards, implementation specifications, and certification criteria for certified EHR technology. The IFR stated that certified EHR technology is "secure, can maintain data confidentially, can work with other systems to share information, and can perform a set of well-defined functions."[4]

The IFR establishes the required capabilities and standards that certified EHR technology must have to qualify for meaningful use under stage 1. The final rule will be issued later this summer. To view the IFR, visit http://www.federalregister.gov/inspection.aspx#special.

On March 10, 2010, the ONC published a proposed rule on the establishment of certification programs for health information technology. A final rule is expected this year.

Payments

Physicians who adopt EHRs in 2011 or 2012 may be eligible for the maximum Medicare incentive payments, which can total $44,000 over a 5-year period. In general, a physician can receive an annual incentive payment as high as $18,000 under the Medicare program if his or her first payment is issued in 2011 or 2012. Otherwise, the annual incentive payment limits are $15,000 in the first year, $12,000 in the second, $8,000 in the third, $4,000 in the fourth, and $2,000 in the fifth. The last year a physician may enter the Medicare incentive program is 2014, and the last payment will be issued in 2016.[2] Under the Medicaid incentive program, a physicians can receive up to $63,750 over a 6-year period. The initial Medicaid incentive payment will be $21,250 in the first year and $8,500 in subsequent years. The last year a physician may enter the Medicaid incentive program is 2016, and the last payment will be issued in 2021.[5]

Approval Process

Under the CMS's proposed rule, physicians must demonstrate meaningful use of certified EHR technology for a consecutive 90-day period in the first year of the program to qualify for incentives. In subsequent years, the EHR must be used in a meaningful manner for the entire year to qualify. Under both Medicare and Medicaid, payments to eligible professionals will likely begin in 2011.[2]

THE PENALTIES

Eligible professionals who fail to successfully demonstrate meaningful use of certified EHR technology by 2015 and who do not obtain a hardship exemption will be penalized with a reduction in Medicare reimbursement of 1% in 2015, 2% in 2016, 3% in 2017, and 3% to 5% in subsequent years.[6] There are currently no payment adjustments associated with the Medicaid provisions.

CONCLUSION

Although the final rules have not been published on the definition of meaningful use or the requirements for certified EHR technology, the CMS's proposed definition of meaningful use and the ONC's IFR provide a starting point for moving forward with implementation. One thing is clear: taking measures to implement certified EHR technology now will ensure that you receive the maximum benefit allowed. Make sure you are first in line! ■

1. Lum F. Where are you on the continuum of adoption? YO Info. October 2009. http://www.aao.org/yo/newsletter/200907/article02.cfm. Accessed June 8, 2010.
2. CMS proposes requirements for the electronic health records (EHR) medicare incentive program. Centers for Medicare & Medicaid Services Office of Public Affairs. December 30, 2009. http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3563. Accessed June 9, 2009.
3. CMS proposes definition of meaningful use of certified electronic health records (EHR) technology. Baltimore, MD: Centers for Medicare & Medicaid Services Office of Public Affairs; December 30, 2009. http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3564. Accessed June 3, 2010.
4. US Department of Health & Human Services Health Information Technology. Standards & certification criteria IFR. http://healthit.hhs.gov/portal/server.pt?open=512&objID=1195&parentname=CommunityPage&parentid=65&mode=2&in_hi_userid=11673&cached=true. Accessed June 9, 2009.
5. Medicare & Medicaid EHR Incentive NPRM: Implementing the American Recovery & Reinvestment Act of 2009 [PowerPoint]. Baltimore, MD: Office of E-Health Standards and Services and Centers for Medicare & Medicaid Services; 2010.
6. Medicare and Medicaid health information technology: Title IV of the American Recovery and Reinvestment Act. Baltimore, MD. Centers for Medicare & Medicaid Services Office of Public Affairs; June 16, 2009. https://www.cms.gov/apps/media/press/factsheet.asp?Counter=3466. Accessed June 9, 2009.