A Lawyer’s Take on Meaningful Use

By Steven J. Fox & Vadim Schick
Overview

• American Reinvestment & Recovery Act (ARRA) – February 2009
  ▪ HITECH Act provides incentives for EHR adoption
• EHR Incentive NPRM issued December 30, 2009; published in Federal Register January 13, 2010
• NPRM Comment Period Closes – March 15, 2010
Key Acronyms/Definitions

- CAH = Critical Access Hospital
- EP = Eligible Professional
- EH = Eligible Hospital
- EHR = electronic health record
- FQHC = Federally Qualified Health Center
- HPSA = Health Professional Shortage Area
- MU = Meaningful Use
- NPRM = Notice of Proposed Rule Making
- RHC = Rural Health Center
Roadmap

- Eligibility
- Stages
- Objectives and measures
- Incentives
  - Medicare EPs and EHs
  - Medicaid EPs and EHs
- Next Steps
Eligibility
Eligible Professionals

- **Medicare**: MDs, Doctor of Osteopathy, Dental surgeon, Doctor of Dental Medicine, Podiatrist, Optometrist, Chiropractor

- **Medicaid**: Physicians, Pediatricians, Dentists, Certified Nurse Midwives, Nurse Practitioners, Physician Assistants, et al.

- May not be “hospital-based” (e.g., pathologists, anesthesiologists, ER physicians)
  - Certain exceptions under Medicaid
Hospital-based Professionals

- EP is hospital-based if one furnishes “substantially all” professional services in a hospital setting (whether inpatient or outpatient) through the use of the facilities and equipment of the hospital, including the hospital’s qualified EHRs
- “Substantially all” means at least 90% of services furnished in a hospital setting, either inpatient, outpatient or ER
- CMS will consider the use of place of service (POS) codes on physician claims to determine whether substantially all of EP’s services performed in a hospital setting
- Exception: Medicaid EPs practicing predominantly in an FQHC or RHC are *not* subject to the hospital-based exclusion
Eligibility— Medicaid EPs

- 30% **patient volume** attributable to those who are receiving Medicaid
  
  - Minimum of 30% of all patient encounters attributable to Medicaid over any continuous 90 day period within the most recent calendar year prior to reporting
  
  - Two exceptions
    - Pediatrician must have 20%
    - Medicaid EPs in an FQHC or RHC
Eligibility – Medicaid

**Table 26—Qualifying Patient Volume Threshold for Medicaid EHR Incentive Program**

<table>
<thead>
<tr>
<th>Entity</th>
<th>Minimum 90-day Medicaid patient volume threshold (percent)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Pediatricians</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Certified nurse midwives</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Physician Assistants when practicing at an FQHC/RHC, led by a physician assistant</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Acute care hospital</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Children’s hospital</td>
<td></td>
<td>Or the Medicaid EP practices predominantly in an FQHC or RHC—30% “needy individual” patient volume threshold.</td>
</tr>
</tbody>
</table>
Eligible Hospitals

- **Medicare:** Subsection (d) hospitals that are paid under the hospital inpatient prospective payment system, CAHs
  - **Note:** Maryland Hospitals *are* eligible for ARRA incentives (see NPRM, p. 1911)

- **Medicaid:**
  - Acute Care Hospitals (10% min. volume requirement)
  - Children’s Hospitals
Stages
Conceptual Approach to Meaningful Use

- Data capture and sharing
- Advanced clinical processes
- Improved outcomes
Meaningful Use Criteria Timeline

2011 – Stage 1: capture/share data

2013 – Stage 2: advanced clinical processes with decision support

2015 – Stage 3: improved outcomes
Medicare and Medicaid EHR Incentive Programs

Design -- Three-stage effort (pp. 1852-1854 of the NPRM):

- **Stage 1** – Electronic capture of health information in a coded format; tracking key clinical conditions and communicating outcomes for care coordinating; implementing clinical decision support tools to facilitate disease and medication management; and reporting outcomes for public health purposes.

- **Stage 2** – Expands on Stage 1. Encourages the use of health IT to enhance computerized provider order entry; transitions in care; electronic transmission of diagnostic test results; and, research.

- **Stage 3** – Expands on Stage 2. Promotes improvements to quality and safety; focuses on clinical decision support at a national level by encouraging patient access and involvement; and, improved population health data.
# Stages of Meaningful Use Timeline

<table>
<thead>
<tr>
<th>First payment year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015+**</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 2</td>
<td>Stage 2</td>
<td>Stage 3</td>
</tr>
<tr>
<td>2012</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 2</td>
<td>Stage 3</td>
</tr>
<tr>
<td>2013</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 2</td>
<td>Stage 3</td>
</tr>
<tr>
<td>2014</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 2</td>
<td>Stage 3</td>
</tr>
<tr>
<td>2015+*</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 1</td>
<td>Stage 3</td>
</tr>
</tbody>
</table>

* Avoids payment adjustments only for EPs in the Medicare EHR Incentive Program.

** Stage 3 criteria of meaningful use or a subsequent update to the criteria if one is established through rulemaking.
Objectives and Measures
Meaningful Use Defined

• An EP and an EH shall be considered a meaningful EHR user for an EHR reporting period for a payment year, if they meet the following three requirements:
  ▪ Use certified EHR in a meaningful manner (e.g., E-Prescribing)
  ▪ Utilize certified EHR technology that is connected in a manner that provides for the electronic exchange of health information to improve the quality of healthcare such as promoting care coordination
  ▪ Submit information on clinical quality measures and other measures in a form and manner specified by the Secretary
NPRM on Meaningful Use

• Five Policy Goals for MU*:
  ▪ Improve quality, safety, efficiency, and reduce health disparities
  ▪ Engage Patients and Families
  ▪ Improve Care Coordination
  ▪ Ensure adequate privacy and security protections for personal health information
  ▪ Improve Population and Public Health

* Same five goals were presented by the HIT Policy Committee in August 2009. See also pp. 1867-1870 of NPRM.
Meaningful Use Summary

• EPs
  ▪ 25 Objectives and Measures
  ▪ 8 Measures require ‘Yes’ or ‘No’ as structured data
  ▪ 17 Measures require numerator and denominator

• Eligible Hospitals and CAHs
  ▪ 23 Objectives and Measures
  ▪ 10 Measures require ‘Yes’ or ‘No’ as structured data
  ▪ 13 Measures require numerator and denominator

• Reporting Period – 90 days for first year; one year subsequently
Stage 1 – Highlights

- **Insurance** - Check insurance eligibility electronically & file at least 80% of all claims electronically.
- **EHR** - Provide patients with an electronic copy of their health information & implement 5 clinical decision support rules.
- **CPOE** - in the areas of medications, laboratories, radiology/imaging, and provider referrals.
- **E-Prescribing** - Requires electronic generation and transmission of permissible prescriptions.
- **Privacy/Security** - Protect electronic health information created or maintained by the certified EHR.
Clinical Quality Measures (CQMs)

- 2011 – providers required to submit summary quality measure data to CMS or States by attestation
- 2012 – providers required to electronically submit summary quality measure data to CMS or States
- EPs to submit clinical data on the 2 measure groups
  - Core measures
  - Subset of clinical measure by specialty (see next slide)
- EHs to report summary quality measure for applicable cases
  - report on 35 CQM to CMS or States
  - Certain exceptions for Medicaid EHs
Clinical Quality Measures (cont’d)

• Core measures for EPs
  ▪ For Preventive Care and screening: Inquiry re: tobacco use
  ▪ Blood pressure management
  ▪ Drugs to be avoided by seniors
    ➢ Patients receiving at least 1 or 2 drugs to be avoided

• 15 Specialties include: Cardiology, pulmonology, endocrinology, oncology, surgery, primary care, pediatrics, nephrology, et al.
Incentives
Eligible Professionals – Medicare Incentives

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>First CY in which the EP receives an incentive payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
</tr>
<tr>
<td>2011</td>
<td>$18,000</td>
</tr>
<tr>
<td>2012</td>
<td>12,000</td>
</tr>
<tr>
<td>2013</td>
<td>8,000</td>
</tr>
<tr>
<td>2014</td>
<td>4,000</td>
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<tr>
<td>2015</td>
<td>2,000</td>
</tr>
<tr>
<td>2016</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>44,000</td>
</tr>
</tbody>
</table>
Eligible Hospitals – Medicare Incentives

Initial Amount
($2 million plus additional amounts calculated in accordance with each hospital’s Medicare discharges)

×

Medicare Share
(roughly, a hospital’s share of Medicare discharges over total discharges)

×

Transition Factor

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Fiscal year that eligible hospital first receives the incentive payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
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<tr>
<td>2011</td>
<td>1.00</td>
</tr>
<tr>
<td>2012</td>
<td>0.75</td>
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<tr>
<td>2013</td>
<td>0.50</td>
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<tr>
<td>2014</td>
<td>0.25</td>
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<tr>
<td>2015</td>
<td></td>
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<tr>
<td>2016</td>
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</tbody>
</table>
Medicaid Incentive Program

• EPs and EHs have the option to earn their incentive for the first payment year through the adoption, implementation or upgrade (AIU) of certified EHR technology
  ▪ Do not have to demonstrate meaningful use in first year
  ▪ 2nd Year – Meaningful Use
• CMS sets “floor” on MU, but state may add criteria subject to CMS’s approval
  ▪ CMS will not allow state to alter specs for EHRs
AIU

- **Adopt:** acquired and installed
  - Evidence of acquisition, installation (not just shopping for an EMR)
- **Implement:** Commence utilization
  - Staff training, data entry of patient demographic info into EMR, data use agreements
- **Upgrade:** To certified EMR; expanded functionality
  - Once certification regulation is out, upgrades may be necessary
Medicaid Incentives - EPs

- Must begin receiving payments no later than CY 2016; for up to max of 6 years, ending in 2021.
  - First year AIU; Second year MU payment linked to Stages
    - Ex: If AIU claimed in 2015, EP will have to demonstrate Stage 3 MU in 2016 to receive second year Medicaid incentive payments.
- 85% of “net average allowable cost”
- Medicaid EPs can flow in and out of program ONCE
# Medicaid Incentives – EPs

## Table 27—Maximum Incentive Payment Amount for Medicaid Professionals

<table>
<thead>
<tr>
<th>Cap on net average allowable costs, per the HITECH Act</th>
<th>85 percent allowed for eligible professionals</th>
<th>Maximum cumulative incentive over 6-year period</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25,000 in Year 1 for most professionals</td>
<td>$21,250</td>
<td>$63,750</td>
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<tr>
<td>$10,000 in Years 2–6 for most professionals</td>
<td>8,500</td>
<td></td>
</tr>
<tr>
<td>$16,667 in Year 1 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients</td>
<td>14,167</td>
<td></td>
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<tr>
<td>$6,667 in Years 2–6 for pediatricians with a minimum 20 percent patient volume, but less than 30 percent patient volume, Medicaid patients</td>
<td>5,667</td>
<td>42,500</td>
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## Table 29—Maximum Incentive Payments for Medicaid EPs Who Are Meaningful Users in the First Payment Year

<table>
<thead>
<tr>
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<td>2017</td>
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<td>2018</td>
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<td>2019</td>
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<td>2021</td>
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<td>Total</td>
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<tr>
<td></td>
<td></td>
<td>63,750</td>
<td>63,750</td>
<td>63,750</td>
<td>63,750</td>
<td>63,750</td>
<td>63,750</td>
</tr>
</tbody>
</table>
Medicaid Incentives (Cont’d)

• Unlike Medicare, Medicaid has no statutory implementation date for making EHR incentive payments.
  ▪ some states might be prepared to implement their program and make payments in 2010 for adopting, implementing, or upgrading certified EHR technology.
  ▪ states can initiate payments after the final rule; CMS – late fall of 2010
  ▪ Payments made directly to EP
• States will disperse payments in a calendar year
Medicaid Incentives – EHs

• Children’s Hospitals
  ▪ Medicare issued CCNs – numbers whose last four digits are in the 3300 to 3399 series are assigned to Children’s hospitals; and

• Acute care must meet patient volume threshold
  ▪ Health care facility where length of stay (LOS) is 25 days or fewer.
  ▪ Includes some specialty hospitals where the average LOS is 25 days or fewer

• Children’s hospitals do not have patient volume requirements

• CCN that has the last four digits in the series 0001 through 0879

• Federal Fiscal Year
Medicaid Incentives – EHs

- **Overall EHR Amount x Medicaid Share**
  - Overall amount = Sum of 4 years of Base Amount ($2M) + Discharge Related Amount Applicable for each year * x transition factor applicable for each year
  - Medicaid Share = Medicaid inpatient days plus Medicaid managed care inpatient days divided by total inpatient bed days x estimated total charges minus charity care charges divided by estimated total charges
Medicaid Incentives – EHs

*The discharge related amount defined as $200 for the 1,150th through 23,000th discharge for the first payment year

- For subsequent payment years, States must assume discharges increase by the provider’s average annual rate of growth for the most recent 3 years for which data are available per year.

- Medicaid incentive payments can be paid out over 3 to 6 years
  - Not more than 50% in one year
  - Not more than 90% in two years
Medicaid Incentives – EHs

- Hospital cost reporting periods can begin with any month of a calendar year and end on the last day of the 12th subsequent month in the next calendar year.
- Participants in first year may qualify for an incentive payment by demonstrating AIU of certified EHR.
- Hospitals meeting Medicare MU requirements may be deemed qualified for Medicaid, even if the State has an expanded approved definition of MU:
  - Administrative simplification.
## Notable Differences Between the Medicare & Medicaid EHR Programs

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feds will implement (will be an option nationally)</td>
<td>Voluntary for States to implement (may not be an option in every State)</td>
</tr>
<tr>
<td>Fee schedule reductions begin in 2015 for providers that are not Meaningful Users</td>
<td>No Medicaid fee schedule reductions</td>
</tr>
<tr>
<td>Must be a meaningful user in Year 1</td>
<td>Adopt/Implement/Upgrade option for 1(^{st}) participation year</td>
</tr>
<tr>
<td>Maximum incentive is $44,000 for EPs</td>
<td>Maximum incentive is $63,750 for EPs</td>
</tr>
<tr>
<td>MU definition will be common for Medicare</td>
<td>States can adopt a more rigorous definition (based on common definition)</td>
</tr>
<tr>
<td>Medicare Advantage EPs have special eligibility accommodations</td>
<td>Medicaid managed care providers must meet regular eligibility requirements</td>
</tr>
<tr>
<td>Last year an EP may initiate program is 2014; Last payment in program is 2016. Payment adjustments begin in 2015</td>
<td>Last year an EP may initiate program is 2016; Last payment in program is 2021</td>
</tr>
<tr>
<td>Only physicians, subsection (d) hospitals and CAHs</td>
<td>5 types of EPs, 3 types of hospitals</td>
</tr>
</tbody>
</table>
## NPRM changes from HITPC Recommendations

<table>
<thead>
<tr>
<th>Deletions</th>
<th>Additions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record advance directives</td>
<td>Provide summary care record for each transition of care and referral</td>
</tr>
<tr>
<td>Document a progress note for each encounter</td>
<td></td>
</tr>
<tr>
<td>Provide access to patient-specific education resources</td>
<td></td>
</tr>
</tbody>
</table>

## Changes

- Adding DOB to record demographics and cause and date of death for hospitals
- Adding growth charts to record vital signs
- Limiting smoking status to age 13+
- Increasing CDS rules from 1 to 5
- Removed “where possible” from insurance eligibility checks
- Changed the provision of clinical summaries from “each encounter” to “each office visit”
- Changed compliance with HIPAA to Protect electronic health information maintained by certified EHR technology
Get Started Now!
Provider Gap Analysis

- Undertake compliance assessment re gap between existing practices & Meaningful Use
- Restructure existing contractual relationships
- Begin RFP/contract process to add needed software applications and/or hardware
Facts of Life

• “Meaningful Use” is an evolving concept – it will change over time
• Incentives insufficient to cover all real costs of achieving Meaningful Use
• Risk shifting will be attempted
Licensing and Negotiations Webinar

• How does the HITECH Act affect provider-vendor relationships?
  ▪ How to structure the relationship with an HIT vendor
  ▪ Special attention paid to vendor-financed agreements; privacy and security concerns

• Thursday, March 18, 2010 – 1PM-2PM
• Same format
• Registration link coming soon
• More on www.healthitlawblog.com
Questions?
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  (202) 661-6945 in Washington, D.C.

Steven J. Fox is a partner with Post & Schell, PC, a national law firm serving clients throughout the United States. He chairs the firm’s Information Technology Group and is co-chair of the Data Protection Group. Since 1990, Steve’s practice has been primarily devoted to healthcare information technology issues. He is experienced in the development, acquisition and negotiation of complex information systems contracts, RHIOs (Regional Health Information Organizations); HIEs (Health Information Exchanges); EHRs (Electronic Health Records), privacy and security policies, outsourcing contracts; HIPAA (Health Insurance Portability and Accounting Act of 1996); Internet and Technology-use policies; and related HIT matters. Most recently he has been working with and advising clients on the legal implications of establishing and maintaining RHIOs and HIEs, including the impact of privacy and security issues and Stark and Anti-Kickback regulations on the donation, adoption and sharing of electronic health record systems (EHRs).

Steve is co-author of "Guide to Medical Privacy and HIPAA," published by Thompson Publishing Group. He is also a co-author of "Guide to Establishing a Regional Health Information Organization," which was published in February 2007 by the Healthcare Information and Management Systems Society (HIMSS). Mr. Fox is a frequent national speaker and author on issues involving technology and healthcare information. For five years beginning in 2000 he authored a regular "Q&A" column about compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at www.HIPAAAdvisory.com.
Vadim Schick is an associate in Post & Schell’s Washington, DC office. He is a member of the firm’s Information Technology and Data Protection Groups, where his practice focuses on advising clients regarding legal issues and strategic counseling involving technology, e-commerce and healthcare information systems. Vadim has experience in preparation and negotiation of licensing, outsourcing, consulting, and marketing agreements, including electronic health record systems licensing and related physician participation agreements; advising clients regarding Stark and Anti-Kickback Statute compliance issues; and advising clients regarding data privacy protection matters, including compliance with international, federal and state regulations, privacy policies and data breach protection and response procedures. Vadim received his B.A. in History and Russian Literature from Johns Hopkins University and his J.D. from Berkeley Law School.