

CMS Proposed Rule: Meaningful Use of Certified EHR Technology
Summary of the Proposed Medicare EHR Incentives Program for Eligible Professionals

The Centers for Medicare and Medicaid Services' (CMS) proposed rule implements the provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) that provide incentive payments to eligible professionals (EPs) and eligible hospitals participating in Medicare and Medicaid programs that meaningfully use certified electronic health record (EHR) technology. The following summary focuses exclusively on the Medicare version of the incentives program for EPs.

CMS notice of proposed rulemaking is expected to be published in the January 13, 2010 *Federal Register*. Following publication, a comment period will be open for 60 days. CMS will then consider the public comments, make modifications to the rule, and publish a final rule in late Spring or Summer 2010.

Three Stages of Meaningful Use Updates

CMS proposes three stages updated on a biennial basis through future rulemakings. This particular proposed rule only describes specific criteria for Stage 1 of the program.

- Stage 1: Focuses on electronically capturing health information in a coded format; using that information to track key clinical conditions and communicating that information for care coordination purposes (whether that information is structured or unstructured, but in structured format whenever feasible); implementing clinical decision support tools to facilitate disease and medication management; and reporting clinical quality measures and public health information.
- Stage 2: Expand upon the Stage 1 criteria to encourage the use of HIT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders entered using CPOE and the electronic transmission of diagnostic test results (such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, pulmonary function tests and other such data needed to diagnose and treat disease).
- Stage 3: Focuses on promoting improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data and improving population health.

The three stages are intended to correspond with EPs' payment years as follows:

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015+**
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012	----	Stage 1	Stage 1	Stage 2	Stage 3
2013	----	----	Stage 1	Stage 2	Stage 3
2014	----	----	----	Stage 1	Stage 3
2015+*	----	----	----	----	Stage 3

* Avoids payment adjustments only for EPs in the Medicare EHR Incentive Program.
** Stage 3 criteria of meaningful use or subsequent update if one is established via rulemaking.

Radiologists' Eligibility

All physicians are eligible to participate in the Medicare incentives program for EPs if they are not "hospital-based," whereas "hospitals" are defined by existing CMS regulations (42 CFR 413.65) and determined by the 21 (inpatient hospitals), 22, and 23 (outpatient hospitals) Place of Service (POS) codes. EPs would be considered "hospital-based" if they provided >90% of services within a POS 21, 22, or 23 location.

Certified EHR Technology

The definition and certification of EHR technology is under the regulatory authority of the HHS Office of the National Coordinator for HIT (ONC), not CMS. ONC released an Interim Final Rule on criteria, implementation specifications, and standards for certified EHR technology at the same time CMS released its proposed rule on meaningful use. ACR will summarize the ONC's Interim Final Rule separately.

Stage 1 Meaningful Use Criteria: Radiologist EPs

EPs would be required to demonstrate all applicable measures described in the below table in order to receive incentive payments. CMS proposes two types of measures: 1) health IT functionality measures; and, 2) clinical quality measures (see blue table cell). The clinical quality measures are divided into “core” and “specialty” groupings. For the purposes of this ACR summary, the only specialty set of clinical quality measures we list below is the Radiology subset.

Stage 1 Objectives for EPs	Stage 1 Measures and Descriptions for EPs
Use CPOE	CPOE is used for at least 80% of all orders. NOTE: For multi-practice physicians, only those locations with certified EHR technology will count toward a clinician's 80%. However, in order to participate in the MU program, at least 50% of locations must have certified EHR technology.
Implement drug-drug, drug-allergy, drug-formulary checks	The EP has enabled this functionality. NOTE: Checks would be automated, so all the EP needs to do is consider the information
Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®	At least 80% of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data. NOTE: Every unique patient - not every patient encounter.
Generate and transmit permissible prescriptions electronically (eRx)	At least 75% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Maintain active medication list	At least 80% 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.
Maintain active medication allergy list	At least 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. The capability to maintain an active medication allergy list using structured data.
Record demographics: preferred language; insurance type; gender; race; ethnicity; date of birth	At least 80% of all unique patients seen by the EP have demographics recorded as structured data.
Record and chart changes in vital signs: height; weight; blood pressure; Calculate and display: BMI; Plot and display growth charts for children 2-20 years, including BMI.	For at least 80% of all unique patients ages 2 and older seen by the EP.
Record smoking status for patients 13 years old or older	At least 80% of all unique patients 13 years old or older seen by the EP have “smoking status” recorded.
Incorporate clinical lab-test results into EHR as structured data	At least 50% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. NOTE: Radiology reports are excluded from this measure, but may be incorporated in Stage 2 or 3 rulemakings.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach	Generate at least one report listing patients of the EP with a specific condition. NOTE: CMS states that an EP is best positioned to determine which reports are most useful to their care efforts. So, they do not propose to direct certain reports be created, but rather require EPs attest to their ability to do so and to attest that they have actually done so at least once.
Report ambulatory quality measures to CMS or the States	All EPs will be required to report on two ambulatory/clinical quality measure groups: 1) core measures; and, 2) one of the specialty subsets of measures.

	<p>Core Measures</p> <ol style="list-style-type: none"> 1. PQRI 114 / NQF 0028 - Title: Preventive Care and Screening: Inquiry Regarding Tobacco Use 2. NQF 0013 - Title: Blood pressure measurement 3. NQF 0022 -Title: Drugs to be avoided in the elderly: a. Patients who receive at least one drug to be avoided; b. Patients who receive at least two different drugs to be avoided <p>Radiology Clinical Quality Measures</p> <ol style="list-style-type: none"> 1. PQRI 10 / NQF 0246 - Title: Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports 2. PQRI 195 / NQF 0507 - Title: Stenosis Measurement in Carotid Imaging Studies 3. PQRI 145 / NQF 0510 - Title: Radiology: Exposure Time Reported for Procedures Using Fluoroscopy 4. PQRI 146 / NQF 0508 - Title: Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening 5. PQRI 147 / NQF 0511 - Title: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy 6. NQF 0052 - Title: Low back pain: use of imaging studies 7. NQF 0513 - Title: Use of Contrast: Thorax CT
Send reminders to patients per patient preference for preventive/ follow up care	Reminder sent to at least 50% of all unique patients seen by the EP that are 50 and over. NOTE: CMS proposes to limit the patient population for this measure to patients age 50 or over because they are more likely to require additional preventive or follow-up care.
Implement 5 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	Implement 5 clinical decision support rules relevant to the clinical quality metrics (see blue cell) the EP is responsible for.
Check insurance Eligibility electronically from public and private payers	Insurance eligibility checked electronically for at least 80% of all unique patients seen by the EP.
Submit claims electronically to public and private payers.	At least 80% of all claims filed electronically by the EP.
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, allergies), upon request	At least 80% of all patients who request an electronic copy of their health information are provided it within 48 hours.
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies) within 96 hours of the information being available to the EP	At least 10% of all unique patients seen by the EP are provided timely electronic access to their health information.
Provide clinical summaries for patients for each office	Clinical summaries provided to patients for at least 80% of all office visits. NOTE: The clinical summary can be provided through a PHR, patient

visit	portal on the web site, secure email, electronic media such as CD or USB fob, or printed copy. The after-visit clinical summary contains an updated medication list, laboratory and other diagnostic test orders, procedures and other instructions based on clinical discussions that took place during the office visit. The denominator for this objective is the number of unique patients seen in the office during the EHR reporting period.
Capability to exchange key clinical information (for example, problem list, medication list, allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least 1 test of certified EHR technology's capacity to electronically exchange key clinical information. NOTE: To be considered an "exchange" (for this measure alone) the clinical information must be sent between different clinical entities with distinct certified EHR technology and not between organizations that share a certified EHR (same product).
Perform medication reconciliation at relevant encounters and each transition of care	Perform medication reconciliation for at least 80% of relevant encounters and transitions of care.
Provide summary care record for each transition of care and referral	Provide summary of care record for at least 80% of transitions of care and referrals. NOTE: The summary of care record can be provided through an electronic exchange, accessed through a secure portal, secure email, electronic media such as CD or USB fob, or printed copy. The denominator for this objective is the number of transitions of care for which the EP was a transferring or referring provider during the EHR reporting period.
Capability to submit electronic data to immunization registries and actual submission where required and accepted	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries. NOTE: EPs in a group setting using identical certified EHR technology would only need to conduct a single test, not one test per EP.
Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to 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 (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).
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 in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary.

Reporting/Demonstrating Meaningful Use to CMS

In Stage 1, CMS is proposing an attestation methodology for demonstrating compliance for all measures *except* for the clinical quality measures (the blue cell in the previous table). For the clinical quality measures, attestation is acceptable for 2011, but will likely move to electronic reporting starting in 2012, unless CMS does not have the technical capability in place by 2012.

The **attestation** statement requires the following:

- The information submitted with respect to clinical quality measures was generated as output of an identified certified electronic health record.
- The information submitted is accurate to the best of the knowledge and belief of the EP.

- The information submitted includes information on all patients to whom the clinical quality measure applies.
- The NPI and TIN of the EP submitting the information, and the specialty group (radiology) of clinical quality measures that are being submitted.
- For an EP who is exempt from reporting each of the core measures, an attestation that one or more of the core measures do not apply to the scope of practice of the EP.
- For an EP who is exempt from reporting on a specialty group, an attestation that none of the specialty groups applies to the scope of practice of the EP.
- For an EP who does report on a specialty group, but is exempt from reporting on each of the clinical quality measures in the group, an attestation that the clinical quality measures not reported do not apply to any patients treated by the EP.
- The numerators, denominators, and exclusions for each clinical quality measure result reported, providing separate information for each clinical quality measure including the numerators, denominators, and exclusions for all patients irrespective third party payer or lack thereof; for Medicare FFS patients; for Medicare Advantage patients; and for Medicaid patients.
- The beginning and end dates for which the numerators, denominators, and exclusions apply.

For the proposed **electronic reporting** of clinical quality measures starting in 2012, CMS is proposing that EPs choose from the following three methods:

- Medicare EPs to log into a CMS-designated portal. Once the EP has logged into the portal, they would be required to submit, through an upload process, data payload based on specified structures, such as Clinical Data Architecture (CDA), and accompanying templates produced as output from their certified EHR technology.
- Medicare EPs to submit the required clinical quality measures data using certified EHR technology through Health Information Exchange (HIE)/Health Information Organization (HIO). This alternative data submission method would be dependent on the Secretary's ability to collect data through a HIE/HIO network and would require the EP who chooses to submit data via an HIE/HIO network to be a participating member of the HIE/HIO network. Medicare EPs would be required to submit their data payload based on specified structures or profiles, such as Clinical Data Architecture (CDA), and accompanying templates. The EP's data payload should be an output from their respective certified EHR products, in the form and manner specified from their HIE/HIO adopted architecture into the CMS HIE/HIO adopted architecture.
- Submission through registries dependent upon the development of the necessary capacity and infrastructure to do so using certified EHRs.

Reporting Periods and Payment Years

To qualify for an incentive payment under the Medicare incentive payment program for a payment year, an EP must meaningfully use for the duration of the EHR reporting period of the relevant payment year (calendar year). The EHR reporting period may be any continuous 90-day period within the first payment year (regardless of which year the EP begins the program) and the entire payment year for all subsequent payment years. This 90-day/first year concept means that EPs would be able to begin their reporting period late in the first payment year and still be eligible for payment that year, thus giving a large buffer for implementation during that first year.

Incentive Payments

Incentive payments are capped at 75% of total Medicare fee schedule compensation. There are also hard caps based on calendar/payment years, which are shown below. For eligible professionals in a HPSA (health professional shortage area), incentive amounts are increased by 10%. The following table

illustrates the maximum possible incentives, assuming an EP's total allowed Medicare charges for covered professional services is estimated to be >\$24,000 during a calendar year.

Calendar Year	First Payment Year in Which an EP Receives an Incentive Payment				
	2011	2012	2013	2014	2015
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

Payment Reductions

There will be reimbursement reductions for EPs who do not demonstrate meaningful use by 2015. CMS intends to further hash out this regulatory language in the Stage 2 or 3 rulemakings, such as future regulatory language regarding "significant hardship exemptions." The payment reductions will be as follows:

Calendar Year	Payment Reductions
2015	Minus 1% total Medicare payments
2016	Minus 2% total Medicare payments
2017	Minus 3% total Medicare payments
2018	Minus 4% total Medicare payments if >75% of EPs are not meaningful users
2019+	Minus 5% total Medicare payments if >75% of EPs are not meaningful users

Comments and Questions

The American College of Radiology will continue to review CMS' proposed rule and will develop formal comments in accordance with the Notice of Proposed Rulemaking in the January 13, 2010 *Federal Register*. ACR is interested in gathering input from our members, particularly those members who are Eligible Professionals (EPs). All feedback will be used to inform the ACR IT & Informatics Commission (ITIC) leaders and ACR staff as we work to develop draft comments over the next couple of months.

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