EHR and Meaningful Use

Coding on the River
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EHR and Meaningful Use

- Learning Agenda
  - Meaningful Use and why it's here
  - Meaningful Use Rules of Participation
  - Categories, Objectives and Thresholds
  - Impact on coders

EHR and Meaningful Use

- Electronic Health Record = Electronic Medical Record
- In 2009, Congress passed the HITECH Act (Health Information Technology for Economic and Clinical Health) which authorized incentives to clinicians and hospitals.
- The HITECH Act defined objectives for clinicians and hospitals which, if implemented, would result in meaningful use of EHRs and improved health care
- For purposes of the Meaningful Use incentives programs, EHR technology must be tested and certified by the Office of the National Coordinator.

EHR and Meaningful Use

- Meaningful Use is using certified electronic health record technology to:
  - Improve quality, safety, efficiency and reduce health disparities
  - Engage patients and their families in their health care
  - Improve the coordination of care
  - Improve population and public health
  - Maintain privacy and security of health information

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- Meaningful Use rules proposed on December 30,2009; 556 pages published in the Federal register as a proposed rule.
- Public comment responses and further consideration led to the revision of these rules and re-release in the Federal Register in July 28, 2010.
  - The revised rules are less stringent in many areas.
  - Continued feedback from the public, physician groups and professional organizations continue to lead to proposed changes.
- Financial incentives for using certified EHR technology.
- Medicare payment adjustments for not using begin in 2015
- Registration, demonstration of success and payment of incentives will be made at the individual provider level – Eligible Professional (EP)

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Financial Incentives

- For Medicare, up to $44,000 per provider over five year period based on volume.
- For Medicaid, up to $63,750 per provider over six year period if 30% of all patient *encounters* is Medicaid for the most recent calendar year.
  - Pediatrics must reach 20%.
- A 2011 start would be based upon 2010 patient mix for Medicaid
- Must choose one program or the other. Cannot participate in both at the same time.
- Can make one program change for duration of participation.
- Must use EHR technology certified by the Office of the National Coordinator (ONC).
- Incentives are also available for Eligible Hospitals and many objectives are the same.
  - Encourages coordination between EPs and hospitals

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Who is eligible?

- Non Hospital Based

Medicare	Medicaid
MD, DO, Doctor of Dental Surgery, Doctor of Podiatric Medicine, Doctor of Optometry, Chiropractor	Physicians, Dentists, CNM's, Nurse practitioners, PA's only if practicing in an FQHC or RHC led by a PA

- Hospital Based – Not eligible if 90% of claims in the prior year were filed with Place of Service (POS):
  - 21 - Inpatient Hospital
  - 23 – Emergency Department

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When does it start?

- Medicare – 1/1/2011 for EP's
  - Enrollment began 04/11
- Medicaid – 1/1/2011 for those already using an EHR
  - Enrollment in Florida began 09/11

What is the qualifying time?

- 1st Year – Medicare
  - Must be any continuous 90 day period within the payment year in which an organization successfully demonstrates meaningful use.
  - Cannot cross calendar years.
- 2nd – 5th Years – Medicare
  - must be meaningful users for the entire year

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What is the qualifying time?

- 1st Year - Medicaid
  - must be adopting, implementing or upgrading certified EHR technology
- 2nd Year – Medicaid must be any continuous 90 day period within the payment year in which an organization successfully demonstrates meaningful use.
  - Cannot use a time period that crosses into the next calendar year.
- 3rd – 6th years - Medicaid
  - must be meaningful users for the entire year

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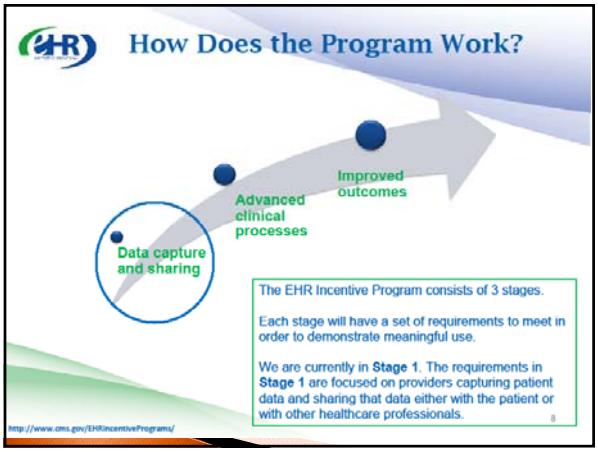
Data be tracked at the individual NPI level.
Stage 1 will be by attestation via a secure website.

A single, annual payment from CMS for Medicare

- Calculated by CMS
- Paid subject to the annual limit which equal to 75% allowed payments
  - 1st year incentive maximum is $18,000 so the allowed payments must be $24,000 to receive the maximum incentive. ($24,000 X 75% = $18,000)
  - If an EP has less than $24,000 in allowed payments, will receive 75% of whatever the allowed payments are during the payment year.

A single, annual payment from AHCA for Medicaid.
Made after attestation of meaningful use.



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- Stage 1 Meaningful Use Criteria
  - 25 objectives and measures (MU) for Eligible Professionals (EP)
  - 15 are required, up to 5 of the remaining 10 (Menu Choice)
  - 8 require attestation; 17 require data submission
  - In 2012, clinical quality metrics will be reported electronically
- Stage 2 Meaningful Use Criteria (Expected to be released as a Proposed Rule in Jan, 2012)
  - 36 objectives and measures (MU) for Eligible Professionals (EP)
  - 4 continued from Stage 1 (no change)
  - 7 new for EPs
  - Stage 1 menu measures moving to Stage 2 required measures
  - Stage 1 thresholds increase
- Stage 3 Meaningful Use Criteria
  - Continued emphasis on Stage 1 & 2 measures
  - Increasing thresholds
  - Emphasis on patient electronic access and self-management

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What are the measures of EHR use?

Three main categories:

Those that improve quality, safety and efficiency

CPOE (medications only in Stage 1)	30%
Drug to Drug/Drug-Allergy interaction checks	Functionality enabled
Problem list in ICD-9-CM or SNOMED-CT	80%
Electronic Prescribing	40%
Active medication list	80%
Active medication allergy list	80%
Record patient demographic data	50%
Record and chart vital signs – over age 2	50%

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Those that improve quality, safety and efficiency – continued

Record smoking status – over age 13	50%
Lab results (numeric) stored as structured data	40%
Medication reconciliation	50%
Generate patient lists by condition	One report
Report quality measures to CMS	3 core (& 3 alternate) + 3 Menu
Send patient reminders – over age 50	20%
Clinical decision support	Five alerts in use now
Drug Formulary checks	Functionality enabled

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Engage Patients and Families

Electronic copy of health record, upon request	50%
Patient access to electronic information (i.e. lab results) within 96 hours of availability.	10%
Clinical summary of each visit to patient.	50%
Provide patient-specific education resources	10%
Protect electronic health information	Ongoing

Improve Care Coordination

Electronic data exchange with provider not in the same organization	1 test
Submission of immunization reports to PHD	1 test
Submission of syndromic surveillance to PHD	1 test
Provide summary care record for each transition of care	50%

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What are the quality measures?

- Similar to the PQRS measures for Stage 1
- Each Eligible Professional (EP) must report on 6 total measures
  - Some of the measures allow exclusions, others do not
- Core measures are the same for all EPs
  - 3 Core with 3 Alternate depending on clinical practice
- 38 menu measures which are applicable across several specialties

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What is the impact on certified coders?

- NO MORE PAPER CHARTS!
- Coders as educators for physicians, non-physician providers and other staff
- Shared EHR technology over specialties and places of service
- Requirement for discrete, structured data elements
  - Problem lists, medications, allergies, orders and results
- Requirements for Quality Measures
- Navigating in at least 1, and potentially several, EHRs

Questions???????

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