Step by Step Directions for Getting the EHR Incentive Money: My Notes From Last Week's CMS Call

First the facts on what has taken place so far in the 2011 EHR Incentive Programs.

- As of June 30th, the total of ***Medicare*** EHR Incentive Program payments is over $94 million.
- As of June 30th, over $166 million has been paid in ***Medicaid*** EHR incentives since the program began in January. In May and June, four states launched Medicaid EHR Incentive Programs – Indiana, Ohio, Pennsylvania, and Washington, bringing the total states with Medicaid EHR Incentive Programs to 21. More states will launch in July.
- There are 68,001 active registrations of eligible professionals and eligible hospitals for the Medicare and Medicaid EHR Incentive Programs.

If your group hasn't received a check and hasn't registered for the Medicare or Medicaid Incentive Program, then this blog post is for you! For anyone who is really just beginning their EHR journey, today's presentation clarified previous information given by CMS, as well as giving listeners new information about the programs.

The two primary steps to obtaining incentive payments are:

1. **Register** for the EHR Incentive Program
2. **Attest** to meeting all the incentive payment eligibility criteria

Let's start with information on the two different incentive

programs. Remember that an eligible professional (EP) is defined differently for Medicare than it is for Medicaid.

Step One: Are You Eligible for the EHR Incentive Programs?

Medicare Eligible Professionals:

- Must be a physician (defined as MD, DO, DDM/DDS, optometrist, podiatrist, or chiropractor) – mid-levels do not qualify
- Must have Pa rt B Medicare allowed charges
- Must not be hospital-based which is defined as having 90% or more of their covered
  professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital
- Must be enrolled in PECOS
- Must be living (Social Security records are examined)

Medicaid Eligible Professionals:

- Must be a MD, DO, DDM/DDS or a Nurse Practitioner, a Certified Nurse Midwife, **OR** a Physician Assistant who is the lead provider for a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
- Must either have 30% or more Medicaid patient volume (pediatricians must have 20% or more Medicaid patient volume) **OR** must practice predominantly in a FQHC or RHC with 30% or more needy individual patient volume. Needy is defined as patients who are Medicaid, Medicare, uninsured, under-insured, charity care and indigent care.
- Must be licensed and credentialed
- Must have no OIG exclusions
- Must be living (Social Security records are examined)

- Must not be hospital-based, which is defined as having 90% or more of their covered
  professional services in either an inpatient (POS 21) or emergency room (POS 23) of a hospital

Step Two: How much EHR Incentive Money is Available From the Two Programs?

Medicare Incentive Payments:

- First eligible year for the program is 2011.
- Incentive amounts are based on the EP's Medicare Fee-for-Service allowable charges.
- Maximum incentives are $44,000 over 5 years.
- Incentives decrease if the EP does not start until after 2012.
- EPs must begin using an EHR by 2014 to receive incentive payments.
- Last payment year is 2016.
- An extra 10% bonus amount based on actual payments from Medicare, not allowables, is available for EPs practicing predominantly in a Health Professional Shortage Area (HPSA). **Go here to see if you practice in a HPSA.**
- EPs will receive only 1 incentive payment per year.

Medicaid Incentive Payments:

- First eligible year for the program is 2011.
- Maximum incentives are $63,750 over 6 years.
- Incentives are the same regardless of the year started.
- The first year's payment is $21,250.
- Must begin by 2016 to receive incentive payments.
- No extra bonus for health professional shortage areas.

- Incentives are available through 2021.
- EPs will receive only 1 incentive payment per year.

How Do You Choose Which Program to Qualify For?

1. First, determine which programs you can qualify for based on the **type of eligible professional** you are.
2. Then, determine which programs you can qualify for based on **your patient population**.
3. Next, review the **requirements and potential payments and/or reductions** for each program – get your calculator out!
    - Once an eligible professional has demonstrated meaningful use in the first participation year, they may receive an incentive payment equal to 75% of Medicare allowable charges for covered professional services furnished by the eligible professional in a payment year **VERSUS** Once an eligible professional has demonstrated adoption, implementation, upgrading, or meaningful use of certified EHR technology in the first participation year, they may receive an incentive payment of $21,250 from Medicaid. Remember the payments are for each provider. Don’t forget the 10% HPSA bonus if you participate in the Medicare program.
    - Medicare requires EPs to escalate meaningful use participation and reporting and ultimately plans to impose payment reductions for EPs not engaged in using a certified EHR and implementing meaningful use. For Medicaid, each state has some leeway is defining the criteria for eligibility for incentives and there are no plans for payment

reductions as a part of the program.

4. If you not up to speed on meaningful use and want to collect incentive money for 2011, it will be easier to you to meet the requirements of the Medicaid program than the Medicare program, if you are eligible for the Medicaid program and there is one offered in your state.
5. Remember that EPs can switch programs once after their first year in either program.

Getting Ready for the Registration Process

1. Make sure you have your provider's **National Plan and Provider Enumeration System (NPPES)** User ID and Password. If the provider does not know this information, s/he will have to call and get the information. **The NPI, NPPES User ID and password are the basis for everything else.** While you're in that record, make sure all the provider's information is correct and completely up-to-date. You'll have an opportunity to update this information during the registration process, but it will not backfill the NPPES record.
2. Make sure your provider's enrollment record in the **Provider Enrollment, Chain and Ownership System (PECOS).** You can see if s/he has a record in PECOS here – scroll down this page to "OrderingReferringReport". This is a 16,000+ page pdf file and as of this post it was updated June 27, 2011. (Note: Eligible professionals who are only participating in the **Medicaid** EHR Incentive Program are not required to be enrolled in PECOS.)
3. If you do not have an active User ID and Password for NPPES or PECOS, request them via **Identity & Access Management**. You will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS

Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.

4. Payee Tax Identification Number (if you are reassigning your benefits to a group or a hospital).
5. Payee National Provider Identifier (NPI) if you are reassigning your benefits. Note that many independent physicians are reassigning their benefits to their practice and almost all hospital-sponsored physicians are reassigning their benefits to the hospital.

Step by Step Directions to Register for the Medicare/Medicaid EHR Incentive Programs

NOTE! You can register before you have a certified EHR. Register even if you do not have an enrollment record in PECOS which is required for all Medicare eligible professionals. If you plan to register for the Medicaid program, your state's Medicaid program must be up and running. Check to see if your state has launched a Medicaid EHR Incentive Program here.

1. Go to the **registration site here**. The Login page instructs the user on what is required for a valid User ID and Password combination. EPs are required to have an active NPI and must have a National Plan and Provider Enumeration System (NPPES) user account to login. For users who do not have either of these requirements, click on the link provided to you in the program.
2. A link to the Identity and Access Management System, I&A, is also provided. The I&A system allows EP users use to reset their passwords and edit their account information. Any additional login issues can be resolved by contacting the help desk (see info at the bottom of this post.) At the bottom of the page the user enters

their User ID and Password combination. Please keep in mind that both of the fields are case-sensitive.

3. Once the user has logged into the system, the links and tabs displayed in the top right hand corner are shown on every page.
    - The **Home** hyperlink navigates the user to the Welcome page.
    - The **Help** hyperlink opens a PDF User Manual that assists the user throughout the Registration process.
    - If at anytime you wish to logout of the system, click the **Log Out** link and select yes in the pop-up window.
    - The **Instructions** section on the Welcome page describes the actions that can be performed under each of the tabs. The EP submits and maintains their registration under the Registration tab and completes their Attestation under the Attestation tab.
    - The **Status Tab** provides a snapshot of the user's current standing in the EHR Incentive Program. This includes the status of their registration and any attestations and payments associated with their account.
    - The **Account Management** tab allows the user to proceed to the I&A system in order to change their account information.
    - Clicking the **Registration** tab will reveal a set of instructions about the actions that can be performed. These options will differ depending on the status of the registration.
4. The EP's name, social security number, and NPI are retrieved from their NPPES account. If they have not started their registration, the status will be blank and **Register** will be the only available action.
5. Select the **Register** link to begin.
6. The Registration ID is displayed on the "Topics for this

Registration" page. **Write this number down** for tracking purposes.

7. There are three topics that an Eligible Professional must complete before submitting their Registration. They are EHR Incentive Program, Personal Information, and Business Address and Phone. The "Begin Submission" button cannot be selected until all of the topics are complete. Select the **"Start Registration"** button to navigate to the first topic.
8. On the EHR Incentive Program page, EPs are given the option to receive either a **Medicare or Medicaid EHR Incentive Payment**. For additional information about the two EHR Incentive Programs select the link that is provided. By selecting the Medicare option and clicking the "Apply" button, the EP type field page cursor moves across screen to highlight information. Provider Types that are eligible in the Medicare EHR Incentive Program are displayed in the dropdown. Selecting the Medicaid option and then the "Apply" button refreshes the page with two fields, Medicaid State/Territory and Eligible Professional Type. Only those states and territories participating in the Medicaid EHR Incentive Program are displayed in the Medicaid State/Territory dropdown. Provider types that are eligible for the Medicaid EHR Incentive Program are displayed in the dropdown.
9. Two additional links on the EHR Incentive Program page provide the user with information on certified EHRs and the EHR Certification Number. The Eligible Professional is required to indicate whether they are currently using a certified EHR.
   A provider's EHR system is not required to be certified prior to registration; however, an EHR Certification Number will be required at the time of attestation. See the **Certified Health IT Product List (CHPL)** for a listing of "certified" EHR products and to identify a product's corresponding certification number.Select the "Save and Continue"

button to navigate to the next topic.

10. The Name and Identifiers displayed on the Personal Information page are retrieved from the user's NPI record on the NPPES system. These fields cannot be modified in the EHR Incentive Program System. The Payee TIN Type field provides the user with two options in terms of who receives the EHR Incentive Payments. If the payments should be sent directly to the Eligible Professional, the SSN tab should be selected in the Payee TIN Type field. If the payments should be sent to a group associated with the Eligible Professional, the user should select E-I-N in the Payee TIN Type field and then select the "Apply" button. After the page is refreshed, three additional fields are displayed.
11. The next step is to select the Group that should receive the payments. A Group Name will only appear in the dropdown if the EP's Medicare enrollment in the Provider Enrollment, Chain, and Ownership System, or PECOS, has reassigned benefits to the Group. After the Group Name is selected, the Group's TIN is retrieved from PECOS and displayed in the Payee TIN field. It is also required that the user enters the NPI associated with the Group in the Payee NPI field. If the user had selected to register for the Medicaid EHR Incentive Program, the system requires the user to manually enter the Group Name, Payee TIN, and Payee NPI. A dropdown list of Group Names would not be provided. Select the "Save and Continue" button to navigate to the next topic.
12. The address and phone number displayed on the Business Address and Phone page is consistent with the Practice Location on the Eligible Professional's NPI record. Unlike the Personal Information page, the address and phone number fields can be modified here. However, if changes are made to the address and phone number in the EHR Incentive Program System, the changes will not be reflected on the Eligible Professional's NPI record. E-mail Address is also a required field and must be

entered with the correct email address format. Select the “Save and Continue” button to complete the last topic.

13. Once the user has entered the required registration information, all three of the topics are marked as completed. To initiate the submission process, select the “Begin Submission” button.
14. The Verify Registration page displays a summary of the registration information. It displays Personal Information, Business Address, as well as the Incentive Program that was chosen for this registration. The “Reason for Submission” section describes the action that the user is currently performing on the registration. If any of the information on this page is incorrect, the user should select the “Previous Page” button and make the appropriate modification.
15. After verifying that all of the information is correct, please select the “Submit” button to proceed. Before the registration can be submitted, the user must review and agree to the Registration Disclaimer. Agreeing to the legal notice means that the EP is certifying that the information provided in the registration is true and accurate. Please take the time to review each line of the disclaimer. Select the “Agree” button to proceed.
16. If the registration passes all validations, the submission will be successful. Please keep in mind that things like a non-approved Medicare enrollment in PECOS or OIG Exclusions can result in registration failure. Contact the help desk
    to resolve any of these issues.
17. The Submission Receipt page reminds users that they will not receive an e-mail confirmation and that attestation information must be submitted in order to qualify for an incentive payment. **Print the Submission Receipt page** by selecting the “Print” button at the bottom of the page. Select the “Return to Home” button to proceed.
18. A registration must be Active in order to proceed with

Attestation and Payment. If any changes need to be made to the registration, the user would select the Modify link and navigate back to the topics page. The registration can also be cancelled, which would end the Eligible Professional's participation in the EHR Incentive Program.

19. Selecting the Status tab navigates the user to the Status Summary page. The Select link navigates to the Status Detail page which displays all of the registration information in one location. The Additional Information link expands to display more registration information and the status of validations that are performed during submission.

Q & A from the listeners (always the best part!)

Q: Do you have to have paid for an EHR to receive the money? Can you use a Free EHR and still receive the incentive money?

A: Yes, you can use a free EHR and still receive the incentive money. The incentive money is to assist EPs implement EHRs and is not intended to be used only to purchase the software. Remember that the EHR must be certified by one of the certifying bodies and must be certified for ambulatory care.

Q: Is there a certain amount of time after registering that an EP must attest for Medicaid?

A: Once an EP registers, there is no deadline for attesting. Once an EP has attested, payment will be received in 45 days or less.

Q: Is the denominator for the meaningful use measures all patients that an EP sees, or just all Medicare or Medicaid

patients seen during a specific period?

A: The denominator is all patients that the EP sees during the applicable period.

Q: Are radiologists eligible?

A: Yes. The radiologist must use a certified ambulatory care EHR. There is no guideline as to where the information going into the EMR comes from, with the exception of the CPOE measure. Many radiologists have expressed concerns as they do not actually "see" patients – CMS will be addressing this in the future.

Q: Where does the certification number needed for the EHR Incentive Program registration come from?

A: The certification number comes from the **CHPL website.** Get the EHR Vendor's certification number, enter that number into the CHPL site and a registration/attestation number will be provided from the CHPL program to enter into the registration/certification program.

nursing home visits

Q: Is attestation the last step after completing the 90-day reporting period and collecting the data for the Medicare meaningful use program?

A: Yes.

Q: Do visits count if an EP sees patients in nursing homes?

A. Nursing home visits can count if a certified ambulatory EHR is being used, for instance if the EP carries a laptop with him, or if the visit information is later entered into the EP's EHR.

Q: Can an administrator or other third party complete the registration and attestation?

A: Yes, if the third party goes through the Identity and Authority Management system, they can register and attest. The system will ask for the third party's social security number as they will be legally attesting to the information entered.

Q: What is the latest 90-day period an EP can use a certified EHR to receive an incentive payment for 2011?

A: October 1, 2011 – December 31, 2011 is the latest 90-day period. EPs must start using a certified EHR by October 1, 2011 and must demonstrate meaningful use by providing data via the attestation process before 60 days after the close of the 2011 calendar year.

Q: What if due to the EP's specialty none of the meaningful use measures can be met?

A: The EP must exhaust all core, alternate and menu measures by answering "0", exhausting all 38 of the measures by attesting "0" to all 38.

Q: If state does not accept any electronic submission of public health information, is the EP excluded from having to meet this requirement?

A: Yes.

Resources:

EHR Information Center

Hours of Operation: 7:30 a.m. – 6:30 p.m. (Central Time)
Monday through Friday, except federal holidays.
1-888-734-6433 (primary number) or 888-734-6563 (TTY number)

My Notes from the CMS Open Door Forum on May 19, 2010: PECOS, DMEPOS and Blue Ink on Paper Forms

CMS held a two-hour Open Door Forum today and there was so much good information shared that I thought I'd pass my notes from the call along to you.

New EFT Form

The revised EFT (Electronic Funds Transfer) authorization form 588 is available **here** (pdf.) The old form will still work for a few months longer before it becomes invalid.

Changes to the Medicare Program Integrity Manual

The Program Integrity Manual (publication 100-08) will have revisions related to the changes in provider enrollment. The online-only manual **here** will have content moved from Chapter 10 to Chapter 15 and the provider enrollment information will be easier to understand.

The Question on Everyone's Lips

How do I know if I'm listed in PECOS (Provider Enrollment and Chain/Ownership System) and how do I know if others are listed in PECOS? A new downloadable file is now available **here** (12,000 pages!) and everyone listed in this Ordering/Referring file has approved enrollment status. Anyone not appearing on this list is not in approved status, or has opted completely out of the Medicare program.

Advanced Diagnostic Imaging

Beginning in January 2012, all diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET) must be performed in a facility accredited by the American College of Radiology (ACR), The Joint Commission (TJC) or the Intersocietal Accreditation Commission (IAC) for the technical component of the test to be reimbursed by Medicare. This rule does not apply to x-rays, ultrasound, fluoroscopy, mammography or DEXA scans and does not apply to any professional component.

Hospital Revalidations

Hospitals not enrolled in PECOS or not receiving EFT (Electronic Funds Transfer) will be contacted by CMS in an attempt to get all hospitals revalidated.

PECOS (pronounced "pay-cose")

CMS recommends that anyone with questions or just getting started in PECOS read the "Getting Started Guide", of which there are two versions, both available **here** in pdf form. One is for providers and one is for suppliers of DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.) You need to know your corporate structure before getting started because the business must enroll before the providers can assign benefits to the business. The 855I is for individual/solos providers and the 855B is for non-individuals (multiple owners) billing Medicare Part B and assigning benefits to a legal entity/corporation. Dentists and pediatricians who order or refer services for Medicare patients are required to have an enrollment record in the PECOS. Residents and interns are exempt from the enrollment requirement, but an attending physician needs to be identified on the claim when a service is ordered or referred. The main page for enrollment is

https://www.cms.gov/MedicareProviderSupEnroll/

Two Ways to Get Into PECOS

One is to complete the paper form **in BLUE INK (and if time is of the essence CMS suggests that you use the paper form)** and let the MAC enter it into PECOS for you. The other is to use the internet-PECOS system directly, and sign, date and mail the certification statement to complete the process. Submit the participation form or EFT form if required. The certification form for the paper process is NOT the same as the certification from for the internet-PECOS process.

What is the 30-day rule?

The 30-day rule states that you can bill for services provided to Medicare patients up to 30 days prior to your filing date. The filing date is the date your enrollment is accepted, not the date you mailed it. Online it will say "Status Approved", and you will receive an email, and then a letter confirming it. You will appear on the Ordering/Referring file on the CMS website.

What happens to payments for patients that were referred by a provider not enrolled on PECOS?

Even though you are enrolled, if the referring physician is not enrolled, you will not be paid for that patient's services. However, if that referrer becomes enrolled, you can resubmit the claim and it will be paid.

~~**What happens on July 6, 2010? When does this happen?**~~

~~July 6, 2010~~ The compliance date for Part A providers (hospitals, skilled nursing homes and home health agencies) and Part B providers (physicians, ambulance) must be enrolled in PECOS as ordering/referring physicians for payments to be made **has been delayed indefinitely!**

~~**What happens on July 13, 2010?**~~

~~DMEPOS (pronounced "demmy-pos") providers must be enrolled in PECOS to receive Medicare payments.~~

What should be done if a provider leaves a group?

The provider or his Authorized Official (CEO, CFO, Manager) should file a 855R or make the change in PECOS as soon as possible.

Why do provider offices still request UPINs from our office?

Unclear. UPINs were no longer required as of May 23, 2008. The NPI is the only number accepted on Medicare claims.

Should the information submitted on a 855 be the same information in PECOS?

Yes, if it isn't, contact the Help Desk. Their toll-free number is 1-866-484-8049 and their e-mail address is eussupport@cgi.com.

For more information on the nuts and bolts of PECOS, see my post **here.**

FAQ on HITECH, Meaningful Use, Eligible Providers, and the Stimulus Money

NOTE: Read my latest post on how to register and attest for the EHR Incentive Programs **here.**

Where Did the Idea of Meaningful Use of Electronic Medical Records Come From?

The American Recovery and Reinvestment Act of 2009 was signed by President Obama on February 17, 2009. The Law includes the Health Information Technology for Economic and Clinical Health Act or the HITECH Act. The HITECH Act establishes programs under Medicare and Medicaid to provide incentive payments for the Meaningful Use of Certified Electronic Health Records technology.

The goal of the HITECH legislation is to improve healthcare outcomes, to facilitate access to care and to simplify care. It is believed that the installation of electronic health records in medical practices is only the beginning. The goals of HITECH will be met when the EHR is used in a meaningful way.

What is Meaningful Use (MU)?

There are three identified components of Stage I Meaningful Use. They are:

1. Use of a certified EHR in a meaningful manner such as e-prescribing.
2. Use of Certified EHR Technology for the exchange of health information (exchange data with other providers of care or business partners such labs or pharmacies)
3. Use of Certified EHR Technology to submit clinical quality and other measures.

The first stage of Meaningful Use is capturing and sharing the data. Meaningful Use Stage II is advanced clinical processes and Stage III is starting to look Meaningful Use of an EHR in the context of improved healthcare outcomes.

There are 25 specific criteria for MU Stage I listed in this article in **Healthcare IT News:**

[1] Objective: Use CPOE (Computerized Physician Order Entry)
Measure: CPOE is used for at least 80 percent of all orders

[2] Objective: Implement drug-drug, drug-allergy, drug-formulary checks
Measure: The EP (Eligible Provider) has enabled this functionality

[3] Objective: Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®
Measure: At least 80 percent of all unique patients seen by the EP have at least one entry or an indication of none recorded as structured data.

[4] Objective: Generate and transmit permissible prescriptions electronically (eRx).
Measure: At least 75 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.

[5] Objective: Maintain active medication list.
Measure: 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 is not currently prescribed any medication) recorded as structured data.

[6] Objective: Maintain active medication allergy list.
Measure: 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.

[7] Objective: Record demographics.
Measure: At least 80 percent of all unique patients seen by the EP or admitted to the eligible hospital have demographics recorded as structured data

[8] Objective: Record and chart changes in vital signs.
Measure: For at least 80 percent of all unique patients age 2 and over seen by the EP, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20.

[9] Objective: Record smoking status for patients 13 years old or older
Measure: At least 80 percent of all unique patients 13 years old or older seen by the EP "smoking status" recorded

[10] Objective: Incorporate clinical lab-test results into EHR as structured data.
Measure: At least 50 percent of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital 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.

[11] Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.
Measure: Generate at least one report listing patients of the EP with a specific condition.

[12] Objective: Report ambulatory quality measures to CMS or the States.
Measure: For 2011, an EP would provide the aggregate numerator and denominator through attestation as discussed in section II.A.3 of this proposed rule. For 2012, an EP would electronically submit the measures are discussed in section II.A.3. of this proposed rule.

[13] Objective: Send reminders to patients per patient preference for preventive/ follow-up care
Measure: Reminder sent to at least 50 percent of all unique patients seen by the EP that are 50 and over

[14] Objective: Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering, along with the ability to track compliance with those rules
Measure: Implement five clinical decision support rules relevant to the clinical quality metrics the EP is responsible

for as described further in section II.A.3.

[15] Objective: Check insurance eligibility electronically from public and private payers
Measure: Insurance eligibility checked electronically for at least 80 percent of all unique patients seen by the EP

[16] Objective: Submit claims electronically to public and private payers.
Measure: At least 80 percent of all claims filed electronically by the EP.

[17] Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request
Measure: At least 80 percent of all patients who request an electronic copy of their health information are provided it within 48 hours.

[18] Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies)
Measure: At least 10 percent of all unique patients seen by the EP are provided timely electronic access to their health information

[19] Objective: Provide clinical summaries to patients for each office visit.
Measure: Clinical summaries provided to patients for at least 80 percent of all office visits.

[20] Objective: Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure: Performed at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.

[21] Objective: Perform medication reconciliation at relevant encounters and each transition of care.
Measure: Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care.

[22] Objective: Provide summary care record for each transition of care and referral.
Measure: Provide summary of care record for at least 80 percent of transitions of care and referrals.

[23] Objective: Capability to submit electronic data to immunization registries and actual submission where required and accepted.
Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries.

[24] Objective: Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.
Measure: 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 or eligible hospital submits such information have the capacity to receive the information electronically).

[25] Objective: Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities.
Measure: 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.

Have the Details of MU been finalized?

The comment period for the NPRM (Notice of Proposed Rule Making) for Meaningful Use is currently open but will close on March 15, 2010. You can read the NPRM **here**. Many individuals

and organizations have expressed concern that the timeline for implementing EHR and meeting MU criteria is too short for the majority of providers. The American Academy of Family Physicians (AAFP) recently sent a 7-page letter to acting CMS Administrator Charlene Frizzerathat included the following concerns:

1. The administrative burden of reporting computerized physician order entry measures "is excessive to the point of being unachievable for most eligible providers."
2. The rule could require manually entering results from laboratories that don't have an interoperable interface with the physician's electronic health record.
3. The term "health information" is used throughout the proposed rule, but is never defined.
4. A requirement that a patient's health information be shared with that patient within 48 hours doesn't take in account that physicians or their staff may not be able to process the information if that 48-hour period includes weekend days.
5. There is no incentive for physicians who meet less than 100% of the proposed requirements, so it is an all-or-nothing approach.

The Medical Group Management Association recently surveyed **(see Modern Healthcare story here)** 445 physician practice administrators in February 2010 with the following feedback:

1. Nearly all are aware of the upcoming incentive programs for meaningful use of electronic health records, but fear the programs will reduce physician productivity.
2. 68% of respondents expect physician productivity will decrease if all 25 proposed meaningful use criteria are implemented.
3. Nearly one-third believe the decrease in productivity will be greater than 10 percent.
4. Almost 25% of practices without an EHR doubt some of

their providers will ever attempt to qualify for incentives.

5. Among practices with an EHR, nearly 84 percent believe some of their physicians will attempt to qualify for Medicare or Medicaid incentives by the end of 2011.

How Do I Comment on the MU Standard?

You can submit your comments on the NPRM on MU **here**.

You can read comments already submitted **here**.

How Do I Know if My EHR is Certified?

No EHRs have been certified for the CMS Incentive Program and the certifying bodies have not yet been announced. It seems reasonable that **CCHIT will be one certifying body**, but there are expected to be others. If your vendor tells you that his EHR is certified before the rule has been finalized and the certifying bodies have been announced, ask him "For what?"

What Does it Mean to Be Eligible? (description courtesy of Everything HITECH)

This term encompasses three general types of payers to establish eligibility: 1) Medicare Fee For Services (FFS), 2) Medicare Advantage (MA) and 3) Medicaid.

For hospitals to be eligible, they can be acute care (excluding long term care facilities), critical access hospitals, children's hospitals.

For providers, these include non-hospital-based physicians who receive reimbursement through Medicare FFS program or a contractual relationship with a qualifying MA organization. The Act defines the term "hospital based" eligible professional to mean an EP such as a pathologist, anesthesiologist,or emergency physician, who furnishes substantially all of his or her Medicare covered professional services during the relevant EHR reporting period in a

hospital setting (whether inpatient or outpatient) through the use of the facilities and equipment of the hospital, including the hospital's qualified EHR's (Fed Reg p. 1905). The determining factor is the site of service as to whether the service is hospital based or not. If the EP provides at least 90 % of their services in a hospital inpatient, hospital outpatient or hospital emergency room setting (Point of Service codes 21, 22, 23), then they are considered a hospital based EP and not eligible for EHR incentive payments (i.e. providing substantially all of his or her Medicare covered professional services).

There is a difference between Medicare and Medicaid when it comes to defining an eligible professional for EHR incentive payment purposes. Medicare defines an eligible professional as (Fed Reg p. 1996):

1. doctor of medicine or doctor of osteopathy
2. doctor of dental surgery or dental medicine
3. doctor of podiatric medicine
4. doctor of optometry
5. chiropractor

Medicaid, on on the other hand, defines an eligible professional as (Fed Reg p. 2001):

1. physician
2. dentist
3. certified nurse-midwife
4. nurse practitioner
5. physician assistant practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic, led by a physician assistant.

What are the Guidelines for Providing Patients With Their Medical Records Electronically?

Under HIPAA, patients currently have the ability to access their medical records. Meaningful Use does not change HIPAA in that regard. You may charge patients for the expense related to providing paper or electronic medical records. Each state has its own schedule for charging for medical records (**state-by-state schedule here**.)

Do Eligible Providers Have to be Participating With Medicare to Receive the Incentive Money?

No, the eligibility requirements only relate to the benchmarks for the percentage of Medicaid patients you have, or amount of allowed Medicare charges you have.

Can Eligible Providers Work at Locations Other Than Hospitals and Private Practices and Receive the Incentive Money?

The location where the provider works is not the issue. The issue is whether or not the provider meets the requirements, either for Medicare or Medicaid, to be considered eligible for the program.

It doesn't matter where the provider accesses the certified EHR. If they meet the eligibility criteria, and they are using a certified EHR, they can collect on the stimulus money.

What Are Health Provider Shortage Areas?

Physicians practicing in determined "health provider shortage" (**detailed info here**) areas will be eligible for a 10% bonus payment.

How Does This Incentive Relate to ePrescribing or PQRI?

If the PQRI Program is extended in its current form, practices can participate in both PQRI and an EHR Incentive Plan.

If the EP chooses to participate in the Medicare EHR Incentive Program, they cannot participate in the Medicare eRx Incentive Program simultaneously. If the EP chooses to participate in

the Medicaid EHR Incentive Program, they can participate in the Medicare eRx Incentive Program simultaneously.

Also, e-prescribing penalties sunset after 2014, so that no physician will be subject to penalties for failing to both e-prescribe and use an EHR!

How Do EPs Get Paid For Meaningful Use of a Certified EHR?

For the first payment year only, all an EP or hospital has to do is to be a "meaningful user" for a continuous 90-day period during the payment year. Hospitals' payment year is October 1 to September 30 and EPs' payment year is the calendar year. You must start and complete the 90-day period within the payment year with no overlapping.

Also, if you can qualify as a Medicaid Eligible Provider (or Hospital), are in the process of adopting, implementing or upgrading your EHR and your Medicaid patient volume is at least 30% (Pediatricians only need 20% minimum and Hospitals need 10% minimum), you can collect your incentive money without meeting Meaningful Use criteria.

Attestation forms and forms of other types are most likely the way that EPs will provide information to apply for the incentive funds, although the details have not yet been released.

What Does it Mean to Transition From One Program (Medicaid or Medicare) to Another?

EPs who meet the eligibility requirements for both the Medicare and Medicaid incentive programs will be able to participate in only one program, and will have to designate which one they would like to participate in. After their initial designation, EPs are allowed to change their program selection only once during payment years 2012 through 2014.

To Recap:

How Do I Get My EHR Stimulus Money?

1. Decide whether you are an eligible provider for any of the programs.
2. If you are, buy a certified EMR (once certification has been defined.)
3. Use your EMR in a way that demonstrates your meaningful use of the product.
4. Pass “GO” and collect your money.

ARRA (Stimulus Bill) Acronyms

”¢ A/I/U ”“Adopt, implement or upgrade
”¢ CAH ”“Critical Access Hospital
”¢ CCN ”“CMS Certification Number
”¢ CDS ”“Clinical Decision Support
”¢ CMS ”“Centers for Medicare & Medicaid Services
”¢ CY ”“Calendar Year
”¢ EHR ”“Electronic Health Record
”¢ EP ”“Eligible Professional
”¢ eRx ”“E-Prescribing
”¢ FFS ”“Fee-for-service
”¢ FY ”“Federal Fiscal Year
”¢ HHS ”“U.S. Department of Health and Human Services
”¢ HIT ”“Health Information Technology
”¢ HITECH Act ”“Health Information Technology for Electronic and Clinical Health Act
”¢ HITPC ”“Health Information Technology Policy Committee
”¢ HIPAA ”“Health Insurance Portability and Accountability Act of 1996
”¢ HPSA ”“Health Professional Shortage Area
”¢ IFR ”“Interim Final Rule
”¢ MA ”“Medicare Advantage
”¢ MCMP ”“Medicare Care Management Performance Demonstration
”¢ MITA-Medicaid Information Technology Architecture
”¢ MU ”“Meaningful Use

”¢ NPI ”“National Provider Identifier
”¢ NPRM ”“Notice of Proposed Rulemaking
”¢ OMB ”“Office of Management and Budget
”¢ ONC ”“Office of the National Coordinator of Health Information Technology
”¢ PQRI ”“Medicare Physician Quality Reporting Initiative
”¢ Recovery Act ”“American Reinvestment & Recovery Act of 2009
”¢ TIN ”“Taxpayer Identification Number

For more information who is eligible and for how much, read my post **“ARRA Eligible Providers: Who Is Eligible to Receive Stimulus Money and How Much is Available Per Provider?”**