

## Meaningful Use Frequently Asked Questions

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**1. What is the American Recovery and Reinvestment Act?**

The American Recovery and Reinvestment Act (ARRA) of 2009 is an economic stimulus package enacted by the 111th United States Congress and signed by President Obama in February 2009.

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**2. What is HITECH?**

HITECH is the Health Information Technology for Economic and Clinical Health act that was included in ARRA. HITECH established Electronic Health Records (EHR) incentive programs, which offer Medicare and Medicaid financial incentives for medical providers and hospitals that adopt and engage in Meaningful Use of a certified EHR.

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**3. What is Meaningful Use?**

The primary goal of Meaningful Use is to improve the US healthcare system by improving quality and efficiency of care, and patient safety. To receive the financial incentives established by HITECH, eligible professionals (EP), hospitals (EH), and Critical Access Hospitals (CAH) must demonstrate “Meaningful Use” of a certified electronic health record (EHR).

On July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) released the final rule defining the requirements for Meaningful Use in 2011 and 2012. The requirements are substantially the same as those proposed in January 2010, but only 15 core requirements are now mandatory for eligible providers and 14 are mandatory for hospitals. Five additional requirements must be selected and met, from a “menu” of ten additional requirements. At least one of those selected from the optional menu must relate to public health. To qualify for incentives, hospitals and eligible providers must also be using a certified EHR system—see below for the definition of a Certified EHR.

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**4. The Meaningful Use Rule identifies 15 Core Set required criteria and 10 Menu Set optional criteria from which EPs, EHs and CAHs must choose five to demonstrate. Can they choose any five?**

You cannot choose any five, because the Meaningful Use final rule notes all EPs and hospitals must choose at least one of the population and public health measures to demonstrate as part of the

menu set. This is the only limitation placed on which five objectives can be deferred from the menu set.

This means that eligible professionals (EPs) must submit data to immunization registries or syndromic surveillance registries. Hospitals must submit data to immunization, syndromic surveillance or reportable lab registries. If such registries do not exist in your state/city (i.e. there is no repository to receive the data), CMS will not penalize the EP or Hospital.

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#### **5. Who is eligible under Medicare?**

A Medicare EP is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a legally authorized chiropractor.

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#### **6. Who is eligible under Medicaid?**

Physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants in federal qualified health centers (FQHC) or rural health clinic (RHC) led by a physician assistant are considered an EP.

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#### **7. Who are CMS and ONC?**

Both the Centers for Medicare & Medicaid Services (CMS) and the Office for the National Coordinator (ONC) of Health IT are agencies within the Department of Health & Human Services (HHS). These two agencies are responsible for the bulk of the ARRA funding available to health IT. CMS administers Medicare and works in partnership with states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. ONC, established under Executive Order from President George W. Bush, and codified via ARRA, serves as a resource to the entire US healthcare system to support the adoption of health IT and the promotion of nationwide health information exchange as ways to improve health care.

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#### **8. How much money is allocated to Medicare and Medicaid providers?**

CMS estimates that the Medicare and Medicaid incentive programs will receive between \$14.1 billion and \$27.3 billion (net federal expenditures) in total. However, the level of actual federal

disbursements will hinge upon the number of providers who can achieve Meaningful Use.

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#### 9. What is a "Qualified EHR"?

A Qualified EHR is an electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical history and problem lists. It must have the capacity to provide clinical decision support and assist with physician order entry. Further, it must be designed to capture and query information relevant to healthcare quality.

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#### 10. What is a "Certified EHR"?

ONC defines Certified EHR technology as a complete EHR or a combination of EHR modules that meets the requirements included in the definition of a Qualified EHR. It must also have been tested and certified by an ONC Authorized Testing and Certification Body (ATCB). The new ONC-ATCB certification program was established to ensure EHRs could specifically be used by providers to demonstrate Meaningful Use.

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#### 11. What is a Payment Year?

For EPs, it is any calendar year beginning in 2011. For EOs and CAHs, it is any federal fiscal year beginning in 2011 (after October 1, 2010).

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#### 12. What is an EHR Reporting Period?

As part of demonstrating Meaningful Use, **Medicare** providers must report on 90 consecutive days of data for year one (2011) and a full 12 month period for 2012 and beyond.

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#### 13. What does this mean to my practice?

This is a great opportunity to qualify for federal and state funding to automate your practice with an EHR system, and receive financial incentives for its use.

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**14. When does the “Economic Stimulus” program start?**

Medicare stimulus starts January 1, 2011 for eligible providers and October 1, 2010 for hospitals. Medicaid starts in 2010 on a state-by-state basis once the specific state has its program approved by the federal government.

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**15. For how long do I need to be a “meaningful user” to be eligible for incentive funds?**

In the first payment year, 90 consecutive days of Meaningful Use must be demonstrated to receive incentive payment. In future years, Meaningful Use must be demonstrated for the entire year.

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**16. When is the earliest that I can apply for incentive funds in 2011?**

The earliest date you can apply is April 1, 2011, but only after having collected 90 consecutive days of Meaningful Use data (from January 1, 2011 through March 31, 2011).

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**17. Can I demonstrate Meaningful Use for any three months in 2011?**

Your reporting period must be for 90 consecutive days starting on or after January 1, 2011. The one limitation is that the 90-day continuous period cannot start after October 1, 2011, because that 90-day period would cross into the next year – 2012.

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**18. Will I receive the same amount if I wait until 2012 or 2013?**

To get the maximum Medicare payments, eligible providers need to qualify in CY 2012 and hospitals in FY 2013. Both physicians and hospitals also need to meet Stage 3 criteria by 2015.

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**19. I am not ready! How soon do I have to start?**

Contrary to popular opinion, there is no rush for Medicaid providers. Medicare providers, on the other hand, must act quickly. Their funding stream runs out in 2016 and then they face penalties for non-adoption. The first year Medicaid physicians can be qualified to receive any money is 2011. However, if providers decide to defer this decision, they will *not* be excluded from funding – they simply end up delaying the onset of their payment flows. Remember, payments occur over a six-year

cycle. The first year of that cycle can be anytime between 2011 and 2016. Providers who enroll immediately would receive their final payments in 2016. Those who wait until 2016 would continue to receive payments through 2021. The total amount remains the same, as long as you continue to qualify each year.

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**20. How do I determine if I have selected the right product?**

Purchasing the right EHR product is an essential requirement for achieving Meaningful Use. First, the product must be certified by an Authorized Testing and Certification Body (ONC-ATCB) as providing the right capabilities and complying with the standards for Meaningful Use. The product must also provide the applications and features to meet the quality and efficiency goals (including but not limited to the Stage 1 requirements).

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**21. If I have already implemented an EHR system, can I apply for incentive reimbursement?**

YES! The regulations are not designed to discriminate against early adopters. Providers who already own EHRs and upgrade or continue to maintain them during the qualifying period will be able to claim the same amounts as those who are just adopting for the first time. The most important thing is that your existing EHR must be certified by an ONC-ATCB according to standards defined in the Final Rule. Older software that is not recertified under this program will *not* qualify for incentive payments.

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**22. Must all providers under the same practice tax ID # use the EHR to qualify for the Medicare incentive?**

The Medicare incentive will be paid on a per physician basis, not on a practice basis. Any physician not using the EHR will not qualify as a meaningful user, but this will not affect other physicians in the practice using the EHR. Incentives will be specified per physician using their nation provider indicator (NPI).

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**23. Do I have to use the EHR 100 percent of the time?**

Fifty percent (50%) or more of your patient encounters during the EHR reporting period must be at one or more practices or locations that are equipped with a certified EHR. This allows EPs to participate in the program even if they work at multiple locations with varying levels of Meaningful Use adoption.

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**24. The program seems complicated. Where do I start?**

After determining eligibility, the best place to start would be with the technology. You should verify you have access to “certified EHR technology” where you provide your professional services. For professionals in multiple practices/locations, you must have access to certified EHR technology in a practice/location or combination of practices/locations where you have over 50% of your total patient encounters.

The ONC’s product testing and certification process confirms that the technology is able to facilitate your satisfaction of the measures. Please see the questions above about checking to see if your technology is actually “certified EHR technology.”

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**25. The Meaningful Use Rule identifies 10 Menu Set optional criteria for stage 1 from which eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) must choose five to demonstrate. Can they choose any five?**

You cannot choose any five, because the Meaningful Use final rule notes all EPs and hospitals must choose at least one of the population and public health measures to demonstrate as part of the menu set. This is the only limitation placed on which five objectives can be deferred from the menu set.

This means that EPs must submit data to immunization registries or syndromic surveillance registries. Hospitals must submit data to immunization, syndromic surveillance or reportable lab registries. If such registries do not exist in your state/city (i.e. there is no repository to receive the data), the Centers for Medicare and Medicaid Services (CMS) will not penalize the EP or hospital.

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**26. What money is available for adopting/using EHRs under ARRA?**

ARRA defines “Eligible Professionals” as providers who are not hospital-based. Those who practice adult medicine are eligible for Medicare-based incentives of up to \$18,000 in the first year (\$15,000 if their first year is 2013 or 2014), sliding down to \$12,000, \$8,000, \$4,000 and \$2,000 in the subsequent four years, for a potential total of up to \$44,000 over a five-year cycle. These payments are based on 75% of allowable submitted charges and can be applied to costs associated with software, hardware, networking, training, upgrades, support, and other items related to adoption and use of qualified health information technology.

The following thresholds apply: Participating Medicaid EPs who see a minimum of 30% of their total visits with Medicaid patients qualify for \$21,250 in the first year, and \$8,500 in each of years 2-6, for a potential total of \$63,750 over six years. Pediatricians – who generally rely on Medicaid, rather than Medicare – will face an entirely different set of funding rules, based on what percentage of their encounters occur with Medicaid patients. Participating pediatric Medicaid EPs who see 20% to 30% of their visits with Medicaid patients qualify for up to \$14,167 in the first year, and \$5,667 in each of years (years 2 through 6), for a potential total of \$42,500 over six years. Pediatricians who do not participate in Medicaid, or who participate but don't see at least 20% of their total visits with Medicaid patients, do not qualify for any ARRA funds at all.

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**27. I accept Medicaid patients. How do I calculate which bracket I fall into?**

The rules state that an EP must annually document patient volume thresholds measured by the ratio of the total number of Medicaid patient encounters over any representative continuous 90-day period in the most recent calendar year, to the total number of patient encounters over that same 90-day period. The guidelines state that this calculation should be performed and applied for each individual EP, even those who practice in group settings. However, application of the guidelines, as well as the treatment of mid-level providers, may vary somewhat from state to state. The Department of PA Medicaid has indicated to the PA-AAP that they are committed to having the maximum number of Pennsylvania's pediatricians qualify.

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**28. How do I register for the program and report compliance to CMS?**

Beginning in January 2011, eligible professionals can register for the meaningful use program via an online registration site provided by CMS. Prior to the opening of registration, Medicare and Medicaid participating physicians will be individually notified of their eligibility for the Medicare and/or Medicaid version of the program. If eligible for both versions of the program, the physician will choose one.

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**29. What about inpatient and emergency room hospital settings?**

Hospitals will be able to participate in the version of the meaningful use incentive program for inpatient and emergency room hospitals. This version of the program has different requirements than the version for eligible physicians.

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**30. The meaningful use measures appear to be primary care focused – how am I, as a specialist, going to comply?**

By design, most of CMS' Stage 1 meaningful use measures focus on basic patient data traditionally captured and maintained in primary care settings. For specialists, CMS provides exclusion criteria for many meaningful use measures as well as discretionary "menu set" measures to account for variability in scopes of practice.

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**31. How does a medical provider determine if they are in a health provider shortage area (HPSA) and thus qualify for a larger stimulus amount?**

HPSA regions are determined by the federal government according to a set formula. If you would like to know if your area complies, please visit: <http://hpsafind.hrsa.gov/>

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**32. Can I switch incentive programs once I begin participation?**

Eligible Professionals (EP) may have the opportunity to participate in either the Medicare or Medicaid incentive programs, and once an EP has picked a program, they are permitted to make a one-time switch from one program to the other. Under the proposal, if an EP does decide to switch programs, the EP would continue in the next program at whichever payment year he or she would have attained

had the EP not chosen to switch. For example, if an EP decides to switch after receiving his or her Medicare FFS incentive payment for their second payment year, then the EP would be in its third payment year for purposes of the Medicaid incentive payments. Note – CMS does not believe that the Congress intended for the payment caps to be exceeded under any circumstance, and therefore no EP should receive more than the maximum incentive available to them under Medicaid.

**33. What is the definitive list of race and ethnicity with regard to Meaningful Use?**

The federal standards for classifying data on race or ethnicity include five (5) races and (2) ethnicity categories. The following are the lists of ethnicity and race that the NextGen EHR displays and that meet the federal standards.

**Ethnicity:**

- a) Hispanic or Latino
- b) Not Hispanic or Latino

**Race:**

- a) American Indian or Alaska Native
- b) Asian
- c) Black or African American
- d) Other Race
- e) Native Hawaiian or Other Pacific Islander
- f) American Indian or Alaska Native
- g) White
- h) Unknown

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**34. If I can't install my EHR until March or April 2011, can I still qualify for Meaningful Use?**

To qualify, you only need to report for 90 consecutive days in the first year, and the first year can either be 2011 or 2012. The only limitation is that the 90-day continuous period cannot start after October 1, 2011 or after October 1, 2012, because that 90-day period would cross into the next year – 2012 or 2013 – which is not allowed.

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**35. I am not ready! How soon do I have to start demonstrating Meaningful Use?**

Contrary to popular opinion, there is no rush for Medicaid providers. Medicare providers, on the other hand, must act quickly. Their funding stream runs out in 2016 and then they face penalties for non-adoption. The first year that Medicaid physicians can be qualified to receive any money is 2011.

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**36. May I continue to submit and collect on Pay for Performance programs such as the Physicians Quality Reporting Initiatives (PQRI) and electronic prescribing (ePrescribing or eRx) at the same time I am submitting and receiving funding for meeting Meaningful Use criteria?**

Yes, but as you will see there are limitations.

In 2011 if you apply to receive Meaningful Use incentive funds under Medicare you can also apply to receive PQRI funds, but not ePrescribing. In 2011 if you apply to receive Meaningful Use incentive funds under Medicaid you can also apply to receive both PQRI and ePrescribing.

With the implementation of the Patient Affordable Care Act, CMS is shifting physician payments to those that are tied to quality outcomes, like those of Meaningful Use. CMS, for example have indicated that they plan to integrate PQRI under Meaningful Use and what has up until now been a voluntary program will result in penalties starting in 2015 for those who do not participate.

CMS has similar plans for those who do not participate in ePrescribing. Starting in 2015, they will begin to levy a penalty of 1% each year until 2017 when it reaches its maximum of 3%. At the same time, CMS will decrease the ePrescribing incentive amount to 1 percent in 2011 and 2012, and is finally reduced to 0.5 percent in 2013.

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