Meaningful Use: Frequently Asked Questions and Responses
September 2010

CHIME members asked the following questions during two Webinars conducted in late July. Answers below were derived from the meaningful use regulations issued in mid-July. Several questions asked during the Webinars could not be answered through the regulations, and those and others have been submitted to CMS and ONC for clarification (see posting below on this website).

1. Please clarify that November 30, 2011, is the last day for eligible hospitals and critical access hospitals (CAHs) to register and attest to receive an incentive payment for FY 2011 (Medicare Providers).

Receipt of funds from ARRA depends upon two separate activities. First the eligible provider (EP) or eligible hospital (EH) must meet the eligibility requirements. Second, the EP or EH must register and attest. The dates are not the same. The EP or EH needs to take both actions to receive the incentive payments. Details on attestation forms and the details of how to access the portal by which one will make the attestation are not yet available, but will be announced by CMS. For hospitals, one registers their intent at http://cms.gov/EHRIncentivePrograms .

2. Are rehab and psych discharges excluded from the discharge portion of the incentive calculation?

Yes, rehabilitation and psychiatric discharges are excluded from the discharge portion of the incentive calculation.

3. What is the timing for measuring compliance, and when do payments start?

The earliest that payments will be made for hospitals and CAHs is forecasted to be May 2011. Medicaid payments could begin in January 2011. Please note for EHs and CAHs, skipping years count toward the maximum program years allowable.

4. How do you "enroll" to receive the stimulus incentives?

Please see the answer to question 1 above.

5. What is the definition of "reporting period"?

For EHs and CAHs, the reporting period is the federal fiscal year that runs from October 1 through September 30. For EPs, the reporting period is the calendar year.

6. Several Related Questions:
Are hospital-based physician practices eligible for any type of incentive payments?Are employed physicians in hospital-owned practices excluded from receiving payment? Are hospital-owned physician practices with hospital-employed physicians eligible for incentive payments separate from the hospital payment incentives?

A hospital-based eligible professional (EP) is defined as an EP who furnishes 90 percent or more of their services in either inpatient or emergency department of a hospital and is not eligible for incentive payments; these physicians are listed as a Pathologist, Anesthesiologist, or Emergency Physician.

Section 1861(r) of the Act defines the term "physician" to mean the following five types of professionals, each of which must be legally authorized to practice their profession under state law: 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 chiropractor.

Taking these two terms into consideration, a physician whose ambulatory practice meets these requirements would be eligible for reimbursement under either the Medicare or Medicaid incentive programs.

7. Can reporting be done with Business Intelligence tools that access EHR databases or must reports be generated using the native EHR reporting capability?

Reporting can be accomplished with native EHR capabilities, third party tools or internally developed applications that have been <u>certified</u> to collect the necessary data from the certified EHR and complete the required calculations demonstrating performance. A site certification would be necessary to enable reporting via self-developed tools.

8. How specific must data capture be regarding race/ethnicity/preferred language?

From the regulations, "race and ethnicity codes should follow current federal standards published by the Office of Management and Budget http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr We maintain that proposal for the final rule."

9.What constitutes an electronic copy of the record?

The following statement from the final rule's preamble indicates that: "In the proposed rule, we indicated that electronic copies may be provided through a number of secure electronic methods (for example, personal health record (PHR), patient portal, CD, USB drive). We have changed this description in response to comments to that when responding to patient requests for information, the EP, eligible hospital, or CAH should accommodate patient requests in accordance with 45 C.F.R. 164.524, Access of individuals to protected health information." It appears that you must try to accommodate the individual's request subject to term "readily producible" in the next section. The electronic copy must be available on a portable media. A patient portal is acceptable for providing an electronic copy of the record, only if it has the capability for the patient to download their records.

§ 164.524 45 CFR Subtitle A (10–1–03 Edition)
(2) Form of access requested. (i) The covered entity must provide the individual with access to the protected health information in the form or format requested by the individual, if it is readily producible in such form or format; or, if not, in a readable hard copy form or such other form or format as agreed to by the covered entity and the individual.

10: Do CPOE orders from the ED count in meeting the CPOE requirement?

Yes. CPOE orders from the ED count in meeting the CPOE requirement but only for ED patients admitted or placed in observation units.. A recent clarification from CMS states: "we are clarifying the following specifications for including ED services in the denominator for measures associated with Stage 1 of Meaningful Use objectives for eligible hospitals and critical access hospitals (CAHs):

- *The patient is admitted to the inpatient setting through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider order entry (CPOE) Meaningful Use measure. Similarly, other actions taken within the ED would count for purposes of determining Meaningful Use*
- *The patient initially presented to the ED and is treated in the ED's observation unit or otherwise receives observation services. Details on observation services can be found in the Medicare Benefit Policy Manual, Chapter 6, Section 20.6. "*

11. Regarding the CPOE requirement, why was the term "CPOE" used specifically? Meaning, if any licensed provider can enter the order and meet the criteria, do they have to specifically use the "CPOE" module of an application? With many vendors, the CPOE module is different than the nursing/pharmacy OE module.

The name of the module is less relevant than the function performed. In the future, a list of EHR Modules will be posted on the ONC website. Look for the features and functions supported by the module.

The listing of acronyms at the beginning of the CMS final rule indicates that CPOE stands for Computerized <u>Physician</u> Order Entry although the CMS proposed rule said the acronym stood for Computerized <u>Provider</u> Order Entry. The acronym list at the front of the ONC final rule shows CPOE as standing for Computerized <u>Provider</u> Order Entry and the final rule text for this certification criteria says simply that the EHR technology must "enable a user to electronically record, store, retrieve, and modify, at a minimum, the following order types: (1) Medications; (2) Laboratory; and (3) Radiology/Imaging. In addition, the Web site AcronymFinder.com lists the following as the top four meanings of CPOE: Computerized <u>Physician</u> Order Entry, Computerized <u>Provider</u> Order Entry, Computerized <u>Prescriber</u> Order Entry, and Computerized <u>Practitioner</u> Order Entry (healthcare). In any event, vendors will presumably assure themselves that any EHR technology they plan to submit for certification will meet the CPOE-related certification criterion.

12. The State HIE CAP PIN issued in July prioritizes three capabilities including eRx. Is it your intent that HIEs would directly offer this application duplicating the eRx app that must be part of a certified EHR?

The ONC final rule speaks to the functionalities that Complete EHRs or EHR Modules must meet in order to be certified, and use of certified EHR technology (or adoption, implementation or upgrading of such technology) is an essential step in qualifying for Medicare and Medicaid EHR incentive payments. An e-prescribing module developed by an HIE could be submitted for certification. In fact, ONC has identified the e-prescribing capability as one of seven for which EHR modules will play an increasingly important role. Thus, an eligible professional or hospital could satisfy the requirement to use (or adopt, implement or upgrade) certified EHR technology having an e-prescribing capability in a variety of ways (as long as the Complete EHR or relevant EHR Module was certified).

13. Previously there was certification for In Patient, ER and Ambulatory Services. Will this still be the case and requirement to certify each of these types separately?

The final rule describes Complete EHRs, EHR Modules and bundles of EHR bundles. Testing is based on certification criteria, not the venue of care. The rule does allow the ONC-Authorized Testing and Certification Bodies to focus on only inpatient or only ambulatory EHRs, or both.

14. For those who have multiple applications in the clinical areas, what will be the process for putting a check mark in the certification box? Will it be enough that all the products/applications are certified, therefore, the whole would be deemed to be certified?

The final rule does not require that EHR Modules be certified as a bundle. It does state that each EHR Module must meet the privacy and security requirements unless a particular module performs all the privacy and security functions on behalf of the bundle. This area will require further clarification and understanding.

15. The state's Medicaid incentive payment system has to be approved through the state Medicaid IT plan, which also covers MMIS upgrades, etc. Can states file a plan that only covers the implementation of the incentive program without addressing other items?

No. The CMS final rule specifies detailed requirements that states must meet in order to obtain approval of their Medicaid EHR incentive program. The rule spells out what must be included in a state's health information technology planning advance planning document (HIT PAPD), the State Medicaid health information technology plan (SMHP), and a state's HIT implementation advance planning document (HIT IAPD). For example, the SMHP, the deliverable resulting from the HIT PAPD, must include a description of how intrastate systems, including the Medicaid Management Information System (MMIS) and other automated mechanized claims processing and information retrieval systems have been considered in developing a HIT solution and a plan that incorporates the design, development, and implementation phases for interoperability of such state systems with a description of how any planned systems enhancements support overall state and Medicaid goals. And the HIT IAPD (the last step in the approval process) must, among many other things, contain a statement setting forth the security and interface requirements to be employed for all State HIT systems, and related systems, and the system failure and disaster recovery procedures available. CMS makes no allowance for approving HIT planning and implementation documents that do not include all the required information and has further emphasized that until approval of the SMHP and the HIT IAPD is granted, "States cannot draw down Federal funds."

16: Is there a limit to the number of Medicaid EPs in a dental practice?

No limits to the number of Medicaid EPs in a dental practice are specified.

17. We are a CAH with distinct part inpatient rehab; do we need to peel that out?

Movement of a patient between a rehabilitation facility and inpatient facility using the same EHR (assume same database) does not require medication reconciliation. As it relates to the transition of care, the preamble states, "In the proposed rule we clarified that the term transition of care means a transfer of a patient from one clinical setting (inpatient, outpatient, physician office, home health, rehab, long-term care facility, etc.) to another or from one EP, eligible hospital, or CAH (as defined by CMS Certification Number (CCN) to another. We believe that different settings within a hospital using certified EHR technology would have access to the same information so providing a clinical care summary would not be necessary. We further clarify transition of care as the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another.

18. EMR vs EHR - A couple years ago NAHIT published a paper with the intent of defining standard definitions. It seems that we, as an industry, have used the terms EHR and EMR interchangeably.

Quoting a March 2008 Gartner paper, "In April 2004, a speechwriter for President Bush saved a few words by combining the terms "electronic medical record" (EMR) and "personal health record" (PHR) to create "electronic health record" (EHR). Subsequent U.S. government documents and the U.S. media have adopted EHR as the term describing systems that contain individualized medical information." While hospital-focused products have typically been labeled EMRs and ambulatory-focused products have been called EHRs, the HITECH legislation uses the generic term "EHR."

19. Is the 90-day period of reporting for Year 1 of stimulus funding for just FY2011?

For Medicare EPs, EHs, and CAHs, any 90 day period of use during the first year counts for Stage 1 eligibility until 2014. For Medicaid, the "adopting, implementing, or upgrading the EHR" is enough to quality for eligibility in Stage 1; subsequent to that payment year 2 requires a 90-day period of use.