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Meaningful Use: An Update on the Electronic Health Record Incentive Program for Urologists

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Abstract

Introduction: Meaningful use is a federal incentive program designed to stimulate the adoption of health information technology and improve the quality of care delivery in the United States. This article provides a specialty specific perspective to clarify program details and review participation for the specialty of urology.
Methods: Publicly available documents from CMS (Centers for Medicare & Medicaid Services), including program materials, participation and payment data, were reviewed to construct this narrative as well as statistics on adoption in urology.
Results: Details of eligibility, participation, certification, attestation and payment are presented. Since program inception, 4,700 unique urologists have received payments totaling $95,864,021 or 2.4% of program payments. Of urologists who received payment for program year 2011, 14.8% did not receive a payment for program year 2012. Of eligible urologists 47.2% successfully attested for meaningful use in 2012.
Conclusions: Meaningful use has stimulated the adoption of health information technology and about half of all eligible urologists have participated. There was a significant dropout rate in program year 2012 compared to 2011.

Key Words: urology, meaningful use, electronic health records, federal government, American Recovery and Reinvestment Act

Abbreviations and Acronyms

CMS = Center for Medicare and Medicaid Services

CQM = Clinical Quality Metrics

EHR = electronic health record

EP = eligible professional

HIT = health information technology

HITECH = HIT for Economic and Clinical Health Act

MU = meaningful use

ONC = Office of the National Coordinator

NAMCS = National Ambulatory Medical Care Survey

On February 17, 2009 President Obama signed the American Recovery and Reinvestment Act of 2009, a stimulus bill that included HITECH.[1] HITECH created billions of dollars in incentives for eligible hospitals and providers to adopt and "meaningfully use" certified EHR technology. While MU has been part of the health care lexicon since 2010 and by some accounts has successfully stimulated the adoption of health information technology in the United States, it remains a complex and shifting set of objectives, measures, rules, payments and penalties for providers and hospitals. This article reviews the MU program with an emphasis on clarifying program details and the status of adoption in urology.

Methods

MU resources available on the CMS website[2] were reviewed to prepare this narrative summary of the EHR Incentive Program. In addition, publicly available data from CMS on payments made under the program and payments made under part B were analyzed to estimate participation and dropout rates among urologists.

Results

The Basics of Participation for Providers

The EHR Incentive Program, also known as MU, is founded in legislation, clarified and modified by policy makers (including the ONC) through rule making and administered by a government agency (CMS). Payments under MU can be made to eligible hospitals or eligible physicians and they are treated as

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separate and distinct in the EHR Incentive Program. To qualify for payments providers must determine their eligibility to participate through the Medicare, Medicare Advantage or Medicaid incentive program and they cannot participate in more than one.[3] There are important differences between the Medicare and Medicaid programs (Appendix 1),[3] including eligibility requirements and payment adjustments. For example, there is no penalty for failing to meet MU under the Medicaid program. In each program incentive payments are made to individual providers who successfully attest to MU, not to group practices. Because most urologists would typically qualify for eligibility under Medicare, this article focuses on that incentive program.

After a provider has determined eligibility for the EHR Incentive Program there is a process for enrollment, registration, attestation and eventual payment. Medicare providers must be enrolled in the federal PECOS (Provider Enrollment, Chain and Ownership System) before they can register separately for MU. CMS has excellent resources to guide providers through the registration process and, once successfully registered, the attestation.[4] The final year to begin participation in the Medicare EHR Incentive Program is 2014. All Medicare providers will be subject to potential payment adjustments in 2015.

Certified EHR Technology

To qualify for incentive payments providers must meaningfully use an EHR that is "certified" to meet program requirements determined by ONC and CMS. EHR vendors must design their systems to meet these criteria and obtain the certification from ONC authorized testing entities. The first edition of certification criteria was published in 2011 and the second edition was published in 2014. CMS stated that all eligible providers must upgrade or adopt EHRs to meet the 2014 criteria to successfully attest to MU in 2014 and beyond. While the technical burden for meeting these certification requirements rests with software vendors, eligible providers must understand whether their version is current and obtain the certification identification number directly from CMS.[5] Recognizing that not all vendors will have met the 2014 certification criteria by early 2014, CMS requires only 90 days of participation regardless of stage for program year 2014.

The Basics of Incentive Payments and Adjustments

Providers who successfully attest in the Medicare EHR incentive program are eligible for a maximum of $44,000 according to a straightforward schedule based on the first year of successful participation. Beginning in 2015 providers who are not meaningful users will be subject to a cumulative payment adjustment of 1% per year for each year the provider is not a meaningful user. The maximum adjustment will be determined by the total number of eligible providers who successfully attest by 2018 but it could be as high as 5% by 2019 if fewer than 75% of eligible providers are meaningful users.[6] Hardship exceptions are offered to new eligible providers and those whose EHR vendor was unable to obtain 2014 certification for select reasons.

Providers who receive incentive payments are subject to postpayment audits and beginning in 2013 those who attest are subject to prepayment audits. CMS advises eligible providers to retain any documentation related to the attestation process and lists on its website the documentation that it would expect to see in an audit.[7]

The Basics of MU Requirements

MU means using a certified EHR 1) in a meaningful manner, 2) to exchange health care information to improve health and 3) to submit clinical quality measures.[8] MU is achieved with a set of required and optional (chosen from a menu) objectives and associated measures. Each objective is aligned with 1 of 5 broad goals, including improving quality, safety and efficiency, engaging patients and their families, improving care coordination, improving population health, and ensuring the security and privacy of health care information. MU has been divided into 3 stages and each stage brings increasing requirements for the number of measures and the measure thresholds for successful attestation.

Almost all MU objectives are met with process measures defined by denominators, numerators and possible exclusion criteria. For example, for the core objective "Generate and transmit permissible prescriptions electronically (eRx)" the measure denominator is "Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period" and the numerator is "Number of prescriptions in the denominator generated and transmitted electronically." EPs who write fewer than 100 prescriptions or do not have a pharmacy within 10 miles of their practice are excluded from meeting the required measure. The numerator/denominator must exceed 40% to successfully meet the measure for stage 1. Some objectives have more than 1 measure.

Stage 1 MU focuses on incentivizing the capture and appropriate sharing of structured health care information. There are currently 13 required core objectives in this stage with corresponding measures. Eligible providers must also choose 5 objectives from a menu set of 10, of which 1 must be a public health objective (Appendix 2). Finally, providers must separately report clinical quality measures to CMS (see below). Providers attesting in their first year of stage 1 MU must do so for a 90-day period ending before October 1 of the reporting year. In year 2 of participation providers attest for 12 months and then must progress to stage 2 of MU.

Stage 2 is designed to encourage the advancement of clinical processes, including health information exchanges, incorporation of laboratory results into EHRs, transmission of clinical summaries across care settings, and increased patient and family engagement.[9] There are 17 required core objectives in stage 2 and for some objectives that were also in stage 1 the measure threshold is increased in stage 2. For example, the stage 2 electronic prescribing measure threshold has increased to 50%