Meaningful Use of Electronic Health Records (EHR)

A Summary of CMS's Final Rule on Meaningful Use

This document provides a summary of the 'meaningful use' objectives, as defined by CMS, for physicians seeking to receive Medicare or Medicaid incentives related to their electronic health record (EHR). These rules, which are now final, define what a physician must do to be considered 'meaningful users' in 2011 and 2012, and thus qualify for incentive payments.

CMS's Health Care Goals and Meaningful Use

The MU objectives, as defined by CMS and the basis for eligible providers (EP) to receive HITECH incentive payments, are based on five stated goals.

1. To improve the quality, safety, and efficiency of care while reducing disparities
2. To engage patients and families in their care
3. To promote public and population health
4. To improve care coordination
5. To promote the privacy and security of EHRs

HITECH's goal is not EHR adoption alone but "meaningful use" — that is, their use by providers to achieve significant improvements in care. The legislation ties payments specifically to the achievement of advances in healthcare processes and outcomes.

These rules are the final regulation for the first two years (2011 and 2012) of this multiyear incentive program. Subsequent rules will govern later phases.

Concerns about the pace and scope of implementation that gets to 'meaningful use' led CMS to adopt a two-track approach regarding the MU objectives. Of the 25 MU objectives required of physicians, CMS has now divided these elements into two groups.

• **Core Set:** These 15 objectives are required to demonstrate MU and constitute an essential starting point for meaningful use of EHRs. These include tasks essential to creating any medical record, including the entry of basic data: patients' vital signs and demographics, active medications and allergies, up-to-date problem lists of current and active diagnoses, and smoking status.

Other Core objectives include several features that begin to realize the true potential of EHRs to improve the safety, quality, efficiency of care -- and avoid preventable errors: clinical decision support tools, using records to enter clinical orders and medication prescriptions, and providing patients with electronic versions of their health information.

• **Menu Set:** Of these additional 10 objectives, physicians must choose at least 5 that they meet during the 2011 and 2012 time frame. These objectives provide physicians latitude to pick their own path toward full EHR implementation and MU. For example, the Menu Set includes: drug-formulary checks, incorporating laboratory results into EHRs, providing reminders to patients for needed care, identifying and providing patient-specific health education resources, and employing EHRs to support the patient's transitions between care settings or personnel.

For most objectives, the regulation specifies the rates at which providers will have to use particular functions to be considered 'meaningful users.'

Meaningful Use Incentive Payouts

The final rule also includes the calculation for incentive payments. The payments will begin in 2011 and continue throughout 2016. Payments are based on meaningful use reporting, which is on an annual schedule beginning with 90 days of reporting in 2011. As the chart illustrates below, no payments will be made after 2016 so the sooner EP's begin meaningfully using EHRs, the more incentive money they will receive.

Year that Medicare EP Qualifies to Receive First Payment

Payment Amount	2011	2012	2013	2014	2015 and later	Non Adoption Penalty
2011	$18,000					
2012	$12,000	$18,000				
2013	$8,000	$12,000	$15,000			
2014	$4,000	$8,000	$12,000	$12,000		
2015	$2,000	$4,000	$8,000	$8,000	$0	1%
2016		$2,000	$4,000	$4,000	$0	2%
2017 and later						3-5%
TOTAL	$44,000	$44,000	$39,000	$24,000	$0	

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CMS's Final Rule on Meaningful Use

Core Set and Menu Set Objectives

Meaningful Use Objectives- Core Set		
	Objective	Measure
1	Record patient demographics (sex, race, ethnicity, date of birth, preferred language, and in the case of hospitals, date and preliminary cause of death in the event of mortality)	More than 50% of patients' demographic data recorded as structured data
2	Record vital signs and chart changes (height, weight, blood pressure, body-mass index, growth charts for children)	More than 50% of patients 2 years of age or older have height, weight, and blood pressure recorded as structured data
3	Maintain up-to-date problem list of current and active diagnoses	More than 80% of patients have at least one entry recorded as structured data
4	Maintain active medication list	More than 80% of patients have at least one entry recorded as structured data
5	Maintain active medication allergy list	More than 80% of patients have at least one entry recorded as structured data
6	Record smoking status for patients 13 years of age or older	More than 50% of patients 13 years of age or older have smoking status recorded as structured data
7	For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days; more than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital or critical access hospital and who request an electronic copy of their discharge instructions are provided with it
8	On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures)	More than 50% of requesting patients receive electronic copy within 3 business days
9	Generate and transmit permissible prescriptions electronically (does not apply to hospitals)	More than 40% are transmitted electronically using certified EHR technology
10	Computer provider order entry (CPOE) for medication orders	More than 30% of patients with at least one medication in their medication list have at least one medication ordered through CPOE
11	Implement drug–drug and drug–allergy interaction checks	Functionality is enabled for these checks for the entire reporting period
12	Implement capability to electronically exchange key clinical information among providers and patient-authorized entities	Perform at least one test of EHR's capacity to electronically exchange information
13	Implement one clinical decision support rule and ability to track compliance with the rule	One clinical decision support rule implemented
14	Implement systems to protect privacy and security of patient data in the EHR	Conduct or review a security risk analysis, implement security updates as necessary, and correct identified security deficiencies
15	Report clinical quality measures to CMS or states	For 2011, provide aggregate numerator and denominator through attestation; for 2012, electronically submit measures

Meaningful Use Objectives- Menu Set		
	Objective	Measure
1	Implement drug formulary checks	Drug formulary check system is implemented and has access to at least one internal or external drug formulary for the entire reporting period
2	Incorporate clinical laboratory test results into EHRs as structured data	More than 40% of clinical laboratory test results whose results are in positive/negative or numerical format are incorporated into EHRs as structured data
3	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one listing of patients with a specific condition
4	Use EHR technology to identify patient-specific education resources and provide those to the patient as appropriate	More than 10% of patients are provided patient-specific education resources
5	Perform medication reconciliation between care settings	Medication reconciliation is performed for more than 50% of transitions of care
6	Provide summary of care record for patients referred or transitioned to another provider or setting	Summary of care record is provided for more than 50% of patient transitions or referrals
7	Submit electronic immunization data to immunization registries or immunization information systems	Perform at least one test of data submission and follow-up submission (where registries can accept electronic submissions)
8	Submit electronic syndromic surveillance data to public health agencies	Perform at least one test of data submission and follow-up submission (where public health agencies can accept electronic data)
9	Send reminders to patients (per patient preference) for preventive and follow-up care	More than 20% or patients 65 years of age or older or 5 years of age or younger are sent appropriate reminders
10	Provide patients with timely electronic access to their health information(including laboratory results, problem list, medication lists, medication allergies)	More than 10% of patients are provided electronic access to information within 4 days of its being updated in the EHR