Meaningful Use: Participating in the Federal Incentive Program

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Meaningful use legislation was first introduced in the American Recovery and Reinvestment Act of 2009 as a multistaged program to incentivize adoption of electronic health record technology. Since that time, numerous eligible providers and eligible hospitals have captured incentive payments by installing certified electronic health record technology and capturing and reporting on key elements for patients whose health records are stored in an electronic format. Although the question of whether radiologists should participate in the program was initially debated, the evidence is now clear that lack of participation leaves a significant amount of money at risk. This article provides an overview of how the program is structured, what technology needs to be installed, the necessary data elements to capture in an electronic format, and how radiologists can effectively participate in the program to capture their maximum incentive payment.

Key Words: Meaningful use, electronic health record, eligible provider, stage 1


INTRODUCTION

Industries such as finance and air travel have been able to leverage IT tools to cut costs and improve customer service, but the health care field has lagged behind. Purchasing tickets online for a trip around the world is easy, yet securing an appointment for an imaging exam still requires a phone call during regular business hours, in most instances. The latest music and movies can be streamed to mobile devices effortlessly, but obtaining lab results or radiology reports is still an arduous task. Online banking tools allow for the secure electronic transfer of funds to pay a majority of bills, except for the ones mailed out from the doctor’s office or hospital.

To accelerate the adoption of IT in health care, the government has instituted an incentive program focused on “meaningful use” (MU). To be eligible to receive the incentive payments, simply purchasing an electronic health record (EHR) is not enough; that EHR must be certified to meet certain standards, termed certified EHR technology (CEHRT). The purchaser of the EHR must also use it in a “meaningful way,” hence the term “meaningful use.”

The government’s MU program is staggered over multiple years (it began in 2011) and currently includes 3 stages. Each stage of the program is intended to gradually phase in more-stringent measures that are designed to lead, when adopted, to a nationwide interoperable health information exchange network and improved patient care. Stage 1 focuses on the capturing and sharing of data. Stage 2 focuses on information exchange in a structured format and continuous quality improvement. Stage 3 attempts to achieve the ultimate goal of improved outcomes by building on the infrastructure established by stages 1 and 2. Additional goals include clinical decision support, patient health portals, and population health improvement. All physicians enter the program at stage 1, regardless of the calendar year in which they enroll in the program; they remain in each stage for a period of 2 years.

Both CMS and the Office of the National Coordinator for Health IT (ONC) oversee the MU program. CMS handles the program as it relates to physicians, who are to follow measures and meet objectives to receive incentive payments. The ONC develops corresponding criteria and software standards for manufacturers to follow. The ONC has approved a number of private authorized certification and testing bodies (ATCB) to certify that EHR software meets these standards. If any ATCB certifies that a product meets the ONC standards, that software is deemed CEHRT.

The MU program is divided into a separate program for physicians, who are designated as eligible professionals (EPs), and a separate program for hospitals, which are designated as eligible hospitals (EHs) [1]. Each program has different but overlapping requirements, along with different incentive payments for both the Medicare and...
Medicaid versions. Most radiologists qualify for the Medicare EP program, the focus of this article.

Within the radiology community, the question of whether radiologists should participate in the government’s MU program is a subject of debate. Arguments have been made that the measures within the program do not seem relevant to a radiologist’s daily workflow. Although the stage 1 measures may seem to be more relevant to primary care providers, the main goals of stage 1 relate to simply capturing common data elements, not improving workflow or efficiency for any specialty. Moreover, the MU program will likely become a cornerstone of health care IT adoption in the United States, providing an opportunity for radiology groups to better integrate imaging services with existing hospital EHRs with little out-of-pocket cost. Professional radiology associations such as the ACR are addressing relevant concerns in an ongoing manner by providing comments to CMS and ONC upon release of proposed rules, and advocating on behalf of radiologists to ensure that future rulemaking better reflects ways in which radiologists can provide higher quality care by leveraging data contained in the EHR.

Prior to more recent rulemaking, radiologists were subject to penalties (1-3% of total Medicare reimbursement) for not participating in the program. In September of 2012, a significant hardship exemption was extended to all radiologists, meaning that they would not be subject to penalties as long as radiology was listed as their primary specialty. However, CMS maintains that this could change in subsequent rulemaking, and the significant hardship exemption will apply for only 5 years but is subject to annual renewal. CMS has noted that physicians should not expect this exemption to continue indefinitely.

LEGISLATION

MU legislation is included in the American Recovery and Reinvestment Act of 2009, better known as the “stimulus bill.” Specifically, Title XIII of the bill outlines the Health IT for Economic and Clinical Health (HITECH) Act that describes the incentive program (totaling up to $20 billion) for the MU of CEHRT. MU legislation is not part of the Patient Protection and Affordable Care Act of 2010 (“the health care reform bill”) and will not be affected directly by amendments or potential future repeal of the Affordable Care Act.

As EPs, radiologists are eligible to receive incentive payments (up to $1.5 billion in aggregate) and will not face penalties for the near future. More recently, CMS and the ONC have created new rules that allow for radiologists to be exempt from MU requirements, provided they are listed in the “provider enrollment, chain, and ownership” system. However, future penalties for lack of participation in the MU program will likely be on the horizon, as the significant hardship exemption automatically expires in 2020. Thus, understanding the rules of MU and keeping up to date with the evolving incentive/penalty payment structure issued by CMS is imperative for radiologists.

How and Why MU Legislation Affects Radiologists

The ways that MU legislation affects radiologists are best illuminated by examining the basic structure of the program. The MU program is divided into 2 parts, one for EPs and one for EHs. Each program has different but overlapping requirements, along with different incentive payments. CMS uses place-of-service (POS) codes to determine whether a particular physician falls under the EH or EP part of the program. POS codes refer to where an imaging exam was done (see Eligibility Requirements section). When the interim final rule for stage 1 was released in 2010, POS code 22 (outpatient services rendered in the hospital) was part of the EH program [2]. This particular code generated fear that primary care physicians who saw outpatients in the hospital would lose out on incentive payments, jeopardizing the entire program. To correct this potential problem, POS code 22 was shifted from the EH to the EP part of the MU program (Continuing Extension Act of 2010, H.R. 4851). Because a large amount of the imaging done in the United States also falls under this POS code (outpatient hospital), most radiologists were inadvertently converted to EPs as well.

Eligibility Requirements

For a radiologist to be eligible for incentive payments, >10% of a radiologist’s total CMS yearly billing must be outside of POS code 21 (for an inpatient hospital) and POS code 23 (for an emergency room [ER] hospital). A radiologist who reads exclusively ER or inpatient studies would not be eligible for the program. However, a radiologist who reads <90% of their studies from either ER- or inpatient-derived studies would be eligible. This broad inclusion allows the majority of radiologists to be eligible for the program. Eligibility is determined per physician and is not based on group size or group expertise. Although attestation can be made for an entire group by an authorized employee, each MU metric is measured on an individual physician basis.

CMS will not issue any feedback, or accept or reject applications. The only enforcement of an EP’s attestation comes from the risk of a future audit (42 CFR 495.8(c). Available at http://www.ecfr.gov/cgi-bin/text-display?SID=35d21010cfd786652c3571e02c9a37e0&node=42:5.0.1.11.1.32.5&rgn=div8). In addition, an attestation record for each EP must be maintained for 6 years. Therefore, a full understanding of what one is attesting to is imperative to avoid penalties during a potential audit.
Table 1. Medicare meaningful use incentive program payment values for eligible providers by year of entry (original graphic courtesy of K. Dreyer, personal communication, October 11)

<table>
<thead>
<tr>
<th>Meaningful User</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>Total Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>18,000</td>
<td>12,000</td>
<td>8,000</td>
<td>4,000</td>
<td>2,000</td>
<td>44,000</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td>18,000</td>
<td>12,000</td>
<td>8,000</td>
<td>4,000</td>
<td>44,000</td>
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</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td>12,000</td>
<td>8,000</td>
<td>4,000</td>
<td>39,000</td>
<td></td>
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<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td>12,000</td>
<td>8,000</td>
<td>2,000</td>
<td>24,000</td>
</tr>
<tr>
<td>2015+</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1%-5% penalties</td>
</tr>
</tbody>
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Note: Values are $, unless otherwise indicated.

Incentives and Penalties

EPs needs to be compliant with the MU requirements for only the first 90 days in the initial reporting period to receive payment for the first year they participate in the program. A reporting period comprises the number of days a radiologist would have to comply with or meet the exclusion criteria of the objectives to successfully achieve MU. Subsequent years require compliance on all 365 days. An additional caveat is the way CMS calculates EP reimbursement. An annual threshold of $24,000 in CMS billing must be met for EPs to receive the maximum incentive payment. If a particular EP’s CMS billing falls below $24,000, the EP receives a percentage of the full incentive payment, calculated separately for each year. For example, the maximum incentive payment in 2011 was 75% of an EP’s total CMS billing up to $24,000; hence, the maximum incentive an EP could have received in 2012 was $18,000 (Table 1).

October 2012 was the last time at which an EP could apply for and still receive the maximum incentive over 5 payment years under the Medicare portion of the program. After 2012, the total sum of incentive payments was reduced (Table 1). Payment is annual, lump sum, and per EP. Depending on the group structure, incentive payments may go directly to individual radiologists, be reassigned to the group, or be reassigned to the hospital.

In addition, the prospect of running into penalties in 2015 and beyond poses a danger. These penalties will likely be further detailed in the stage-3 regulations and, as noted earlier, may not occur if radiologists take advantage of the significant hardship exemption. Potential penalties would result in a 1-3% reduction of an EP’s total Medicare physician fee schedule payments starting in 2015, implemented in 1% yearly increments (ie, 1% in 2015, 2% in 2016, 3% in 2017). Although not implemented in the stage-1 regulations, the legislative language in the American Recovery and Reinvestment Act mandates that the penalties will be increased to 5% if <75% of all EPs are successful meaningful users in the future. Radiologists will not be liable for penalties as long as radiology is their main specialty listed with CMS. However, if a radiologist chooses exempt status, no incentives will be paid to that provider.

A $63,750 per physician maximum incentive payment can be obtained through Medicaid, provided that 30% of volume is through Medicaid, and the Medicare requirements are met. This incentive should be examined closely if an EP has a high volume of Medicaid patients. Although CMS does give EPs an opportunity to switch from Medicare to Medicaid once, this high-volume threshold is the main reason that most radiologists will not be eligible for Medicaid incentives. Medicaid pays the full $63,750 incentive payment as late as 2016, so close examination of Medicaid volume may be worthwhile for radiologists.

MEASURES

Attainment of MU goals is achieved through use of certified software built with core functionality. Possession of software that can capture relevant data points is not enough to qualify for the incentive payment. In addition, end-users must demonstrate that they are using the certified technology to capture and record the data in a manner that can be reported to CMS at the time of attestation. CMS refers to these metrics as “measures” and “objectives.” A schema on how EPs and health IT vendors interact with their respective governing bodies is illustrated in Figure 1.

The MU measures that need to be met are divided into 2 categories: a mandatory core group that must be met, and a menu set of items from which EPs may choose. The core group of items includes those patient data elements and EHR functionalities that are considered essential for all EPs. Based on predefined conditions as stipulated by CMS, some of the core measures may be excluded by radiologists. The menu set of items may eventually evolve into core items in future stages of the MU program, but for now, applicants are given latitude to specify the subset of items to which they wish to attest.

As of 2014, the total number of meaningful use objectives is 22; core requirements number 13, and 9 is the number of menu set items (a total of 18 objectives must be met). Many of the core measures are eligible for exclusion. Of the 9 menu set measures, EPs must pick 5, with the remaining being deferred. Starting in 2014, EPs will not be able to count an excluded menu set item
as one of their 5; they must select a different menu set item to achieve until no other measures can be selected.

CEHRT, either modular or full, is required for each of these measures. Modular certified technologies allow EPs to fulfill one or a series of measures but do not encompass a completely certified EHR. If a specific software program can perform all of the tasks but is not certified, it does not count. Each certified module needs to meet specific privacy and security rules. Certification cannot be obtained for older technologies; no manufacturers are seeking certification for older versions of their technology. Check with product manufacturers to learn their MU strategy.

The 2014 and 2011 edition EHRs are independent of stage. "Edition" is the most current term applied to the EHR software certification requirements. For EHR software to meet the criteria to be deemed a complete EHR, the software must meet all the nonoptional criteria. A new, key term to be aware of is "Base her," which refers to a basic list of criteria that have to be met by one or a group of products to meet the definition of CEHRT. Please refer to the ACR Meaningful Use Resource Center for up-to-date information regarding MU measures from a radiologist’s perspective. The ACR Summary of Meaningful Use Rules [3] and the ACR Pocket Guide to Meaningful Use are resources that contain measure-specific information regarding the MU program [4].

MU criteria for a radiology group are easiest to implement if the group is affiliated with a hospital that has purchased CEHRT [5]. The main hurdle in this case is integrating the radiology group’s EPs with the hospital EHR. Implementation is more challenging for groups that have recently spent a large amount of time and capital in recent non-MU-certified upgrades and for standalone imaging centers that would be required to integrate with multiple, disparate hospital systems.

On January 3, 2011, the CMS website started accepting registrations of EPs for stage 1 of the MU program. All participants must initially register through the website and then perform the attestation via the same website after the reporting period. Even if a department with multiple EPs has no plans to meet the incentives, completing the process is crucial. As criteria are made more stringent, the department or group practice will in this way have at minimum an understanding of the process.

Another key facet of implementation is that a practice put in place a methodology to measure what they have implemented. Even in stage 1, attestation requires automated measure calculation by an EHR for percentage-based measures. Examples are as follows: (1) What percentage of patients who request a CD of their images (or clinical summary) actually receive a CD within 3 business days; and (2) How will a group record smoking status for patients? Favoring MU-certified products that capture such measures in current purchasing decisions will make the future transition to stage 3 and beyond much easier.

A 10-step strategic approach to complying with the MU incentive program has been proposed by Dreyer and Dreyer in their book, The Radiologist’s Guide to Meaningful Use: A Step by Step Approach to the Stage 1 CMS EHR Incentive Program [6]. The abbreviated list that follows is adapted from this book, with permission:

1. Understand the fundamentals of MU: In addition to the overview of the MU program, a comprehensive
A key component is to determine how to blend existing IT infrastructure with any new technology that must be purchased to achieve MU;

5. Meet with radiology IT vendors: Many existing Radiology Information Systems and PACSs are not currently MU certified; working with existing vendors or considering alternatives to achieve MU, with add-on products if necessary, is important.

6. Plan your MU technological and operational strategies: Consider enlisting the help of consultants who specialize in MU;

7. Acquire and implement CEHRT: Once certified technology has been implemented, measuring the status of EPs using dashboards is important to assess compliance. A sample dashboard system implemented at a hospital-based practice is shown in Figure 2;

8. Register online with CMS: Once certified technology has been acquired and implemented, EP registration via the CMS website is critical;

9. Monitor MU compliance regularly: Use dashboards as noted to keep track of the status of all EPs in a practice;

10. Attest online with CMS: To collect the incentive payments, the final step will be attesting that all MU criteria have been met [7].

**HOW MU AFFECTS RADIOLOGISTS**

The ACR has been advocating on behalf of radiologists to the relevant government bodies to address radiologists’ concerns as well as integrate imaging-based measures into the MU program. Please refer to the ACR Meaningful Use Resource Center for further advocacy information. The ACR has consistently maintained that more attention needs to be paid to radiologists’ concerns, such as how images are handled in an EHR. Additional example of measures that the ACR hopes will be included in future stages of the MU program include: electronic order entry for radiology studies linked to decision-support engines based on ACR Appropriateness Criteria, and EHR tracking of radiation dose data.

One particular source of frustration in stage 1 is that EPs are required to “possess” certified products, even for measures they have chosen to exclude, although the new definition of a base EHR helps mitigate this hardship to a certain extent. An additional frustration is that the measures required by EPs and those required by EHs differ slightly, leading many vendors to offer EP and EH versions of software. This situation has led to friction between EPs who want to be certified and hospitals that are willing to purchase only EH versions of software. The frequency of such hurdles seems to have significantly
Failure to participate in the MU program puts a significant amount of money at risk for radiologists during the incentive period. Moreover, future stages of the program will likely institute financial penalties for lack of participation.
REFERENCES


