UW-CTRI UNIVERSITY OF WISCONSIN Center for Tobacco Research & Intervention

Meaningful Use and Tobacco Cessation

Q: Why is identifying and treating patients who use tobacco important?

- Every year in the United States, smoking kills over 400,000 people and costs $96 billion in direct medical care.
- Smoking is the leading cause of preventable disease and death in the United States.
- 70% of smokers say they want to quit and 80% visit a primary care clinician each year.
- Only 30% of smokers leave a healthcare visit having received evidence-based tobacco dependence treatment
- The meaningful use of electronic health records (EHRs) is designed to incent and motivate clinicians and healthcare systems to identify patients who use tobacco and to provide them with evidence-based treatment.

Q: What is Meaningful Use?

A: Meaningful Use is an incentive plan that eligible health care professionals and hospitals can qualify for through Medicare and/or Medicaid when they adopt certified Electronic Health Record (EHR) technology and use it to achieve specified objectives. The Recovery and Reinvestment Act of 2009 (ARRA) established the Health Information Technology for Economic and Clinical Health (HITECH) Act. Meaningful Use came out of regulations from the HITECH Act.

Meaningful use is using certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Ultimately, it is hoped that the meaningful use compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

CMS EHR Incentive Programs: http://www.cms.gov/EHRIncentivePrograms
Office of the National Coordinator for Health Information Technology: http://healthit.hhs.gov/

Stage 1: Meaningful use criteria focus on:	Stage 2: Meaningful use criteria focus on:	Stage 3: Meaningful use criteria focus on:
Electronically capturing health information in a standardized format	More rigorous health information exchange (HIE)	Improving quality, safety, and efficiency, leading to improved health outcomes
Using that information to track key clinical conditions	Increased requirements for e-prescribing and incorporating lab results	Decision support for national high-priority conditions
Communicating that information for care coordination processes	Electronic transmission of patient care summaries across multiple settings	Patient access to self-management tools
Initiating the reporting of clinical quality measures and public health information	More patient-controlled data	Access to comprehensive patient data through patient-centered HIE
Using information to engage patients and their families in their care		Improving population health

Q: Why Electronic Health Records (EHRs)?

A: Electronic health records can provide many benefits for providers and patients, including:

- Making a patient's health information available when and where it is needed. EHRs enable clinicians secure access to information needed to support high quality and efficient care.
- Bringing a patient's total health information together to support better health care decisions, and more coordinated care.
- Supporting better follow-up information for patients – for example, after a clinical visit or hospital stay, instructions and information for the patient can be effortlessly provided and reminders for other follow-up care can be sent easily or even automatically to the patient.
- Improving patient and provider convenience – patients can have their prescriptions ordered and ready even before they leave the provider's office, and insurance claims can be filed immediately from the provider's office.

Q: Who is eligible for Meaningful Use Incentives?

A: Two groups are eligible for Meaningful Use Incentives:

- Eligible Providers (EPs) – These are clinicians recognized by either Medicare or Medicaid (defined below). Hospital-based physicians who furnish 90% or more of their services in a hospital setting (e.g., hospitalists) are not eligible. Each qualifying provider is eligible to receive the incentive if he/she demonstrates meaningful use. Each EP is only eligible for one incentive payment each year, regardless of how many practices or locations they provide services.
- Hospitals – Eligible hospitals are those recognized by Medicare or Medicaid, including critical access hospitals.

Q: Which Specific Provider Types Qualify for the Incentives?

A: Under the **Medicare** EHR Incentive Program, EPs must be one of the following:

- Doctors of Medicine or Osteopathy
- Doctors of Dental Surgery or Dental Medicine
- Doctors of Podiatric Medicine
- Doctors of Optometry
- Chiropractors

Under the **Medicaid** EHR incentive program, EPs include the following:

- Physicians (Pediatricians have special eligibility and payment rules)
- Nurse Practitioners (NPs)
- Certified Nurse-Midwives (CNMs)
- Dentists
- Physician Assistants (PAs) who provide services in a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) led by a PA

Medicaid eligible professionals must also meet patient volume criteria, providing services to those attributable to Medicaid or, in some cases, needy individuals.

Q: Is there a difference between Meaningful Use for Medicare and Meaningful Use for Medicaid?
A: Medicare incentives will be measured and paid out on a federal basis, using federally established criteria. Medicaid incentives leverage specific federal criteria, but allow states to tailor criteria. The Medicaid incentive program is voluntarily offered and will be administered at the state level. Providers and hospitals <u>are not</u> eligible to receive both Medicare and Medicaid incentives in the same year. If they qualify for both incentives, they must choose which incentive they plan to accept.

Q: What is the Meaningful Use Incentive?
A: Incentives vary based on Medicare and Medicaid, based on when Eligible Providers (EPs)/Hospitals enroll in the program, and based on where providers/hospitals are located. In general:

- The maximum incentive for EPs under Medicare is $44,000 over five years;
- The maximum incentive for EPs under Medicaid is $63,750 over six years;
- Hospitals can receive $2 million or more annually;
- A 10% bonus exists under Medicare for those enrolling from Health Professional Shortage Areas (HPSAs);
- Maximum incentives are earned by enrolling early and meeting criteria;
- Payment reductions will occur for hospitals who do not demonstrate meaningful use by 2015.

Q: When does the Meaningful Use Incentive Program Start? How Long Does it Last?
A: Start and end dates are slightly different for the Medicare and Medicaid Programs:

- <u>Medicare</u>: The Medicare EHR incentive program for Eligible professionals (EPs) started in 2011 and continues through 2016. Eligible professionals can participate for 5 years throughout the duration of the program. The last year to begin participation is 2014.
- <u>Medicaid</u>: The Medicaid EHR incentive program timeline will vary by state. States started offering their program to eligible professionals (EPs) as early as 2011. The program continues through 2021. Eligible professionals can participate for 6 years throughout the duration of the program. The last year to begin participation is 2016.

CMS Medicare and Medicaid EHR Incentive Programs

Milestone Timeline

Fall 2010	Winter 2011	Spring 2011	Fall 2011	Winter 2012	2014	2015	2016	2021
Certified EHR technology available and listed on ONC website	JANUARY 2011 Registration for the EHR Incentive Programs begins; JANUARY 2011 For Medicaid providers, States may launch their programs if they so choose	APRIL 2011 Attestation for the Medicare EHR Incentive Program begins; MAY 2011 EHR Incentive Payments begin	NOVEMBER 30, 2011 Last day for eligible hospitals and CAHs to register and attest to receive an Incentive Payment for FFY 2011	FEBRUARY 29, 2012 Last day for EPs to register and attest to receive an Incentive Payment for CY 2011	Last year to initiate participation in the Medicare EHR Incentive Program	Medicare payment adjustments begin for EPs and eligible hospitals that are not meaningful users of EHR technology	Last year to receive a Medicare EHR Incentive Payment; Last year to initiate participation in Medicaid EHR Incentive Program	Last year to receive Medicaid EHR Incentive Payment

2011-2012
Stage 1
Data capture and sharing

2014
Stage 2
Advance clinical processes

2016
Stage 3
Improved outcomes

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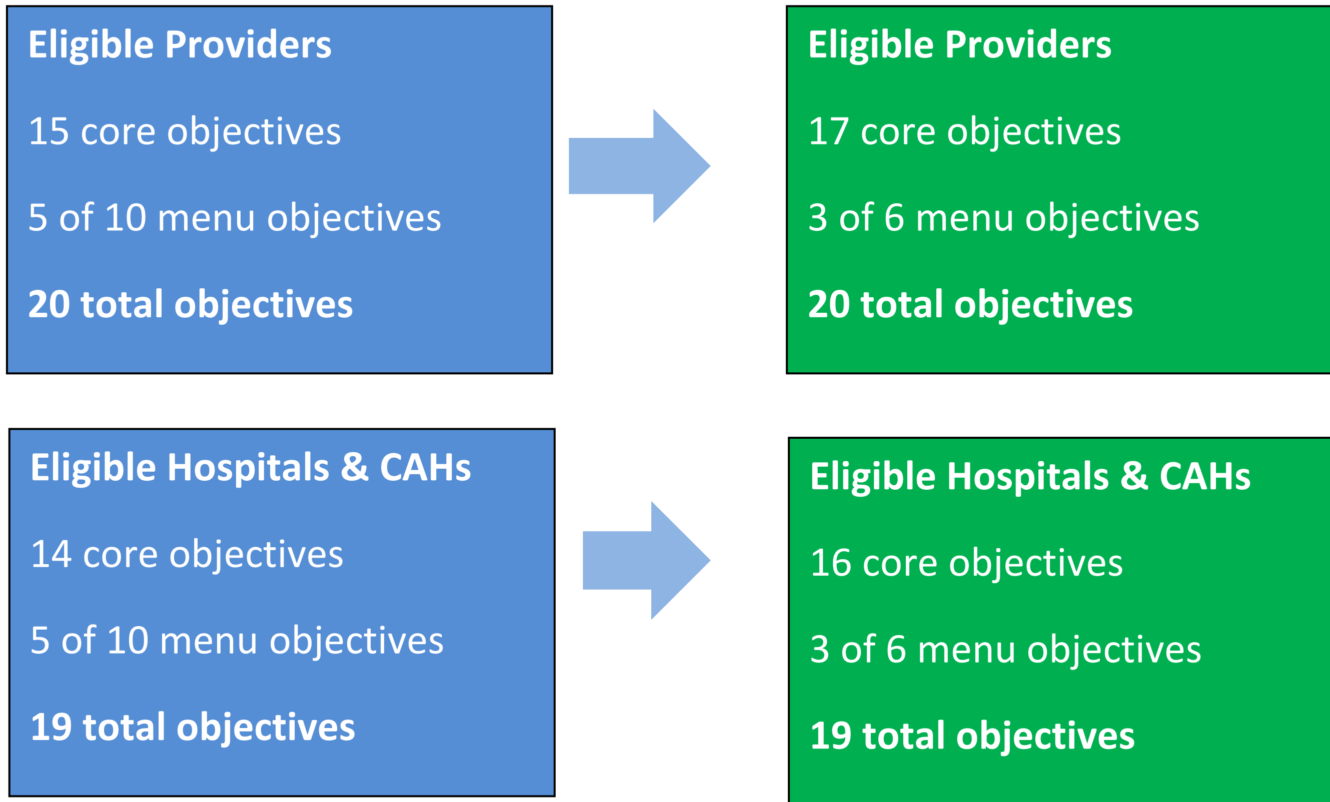
Q: How is Meaningful Use Demonstrated?
A: Meaningful use incentives in Stage 1 will be awarded based on 90 continuous days of aggregate clinical quality measure numerator, denominator, and exclusion data that is submitted to CMS or to the States. Data will come from a combination of "core" and "menu set" objectives and Clinical Quality Measures (CQMs).



Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of these Stage 2 objectives, the threshold that providers must meet for the objective has been raised. Providers who reach Stage 2 in the EHR Incentive Programs will be able to demonstrate meaningful use of their Certified EHR Technology for an even larger portion of their patient populations.

More details about meaningful use core and clinical quality measures can be found here:
http://www.healthit.gov/policy-researchers-implementers/meaningful-use

Q: How Does Tobacco Use Fit into Meaningful Use?
A: Recording smoking status and delivering tobacco cessation is included in Stage 1 and Stage 2.

Meaningful Use Stage 1 and Stage 2 Comparison – Eligible Professionals (EPs)
Outpatient and Inpatient Tobacco Core Objective

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data	Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data

Description	SNOMED CT® ID
Current every day smoker	449868002
Current some day smoker	428041000124106
Former smoker	8517006
Never smoker	266919005
Smoker, current status unknown	77176002
Unknown if ever smoked	266927001
Heavy tobacco smoker	428071000124103
Light tobacco smoker	428061000124105

Outpatient Tobacco Clinical Quality Measure (CQM)

Stage 1 Measure Number (Required)	Stage 1 Measure	Stage 2 Measure Number (Recommended - "EPs should report on these recommended CQMs if they are representative of their clinical practice and patient population.")	Stage 2 Measure
National Quality Forum (NQF) 0028	The percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user	National Quality Forum (NQF) 0028	The percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

All providers are required to report on Clinical Quality Measures (CQMs) in order to demonstrate meaningful use. Beginning in 2014, all providers regardless of their stage of meaningful use will report on CQMs in the same way.

- EPs must report on 9 out of 64 total CQMs
- Eligible hospitals and CAHs must report on 16 out of 29 total CQMs

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Q: What Other Resources Exist to Help Understand Meaningful Use?

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Regional Extension Centers (EHR technology support for providers) state programs/contacts: www.healthit.gov/providers-professionals/regional-extension-centers-recs#listing

Medicaid EHR Incentive Program state contacts and websites: www.cms.gov/apps/files/statecontacts.pdf

The American Academy of Family Physicians: http://www.centerforhit.org

Kaiser Family Foundation Health Care Reform: http://healthreform.kff.org/