Meaningful Use and Anesthesiologists

Anesthesiologists Eligible for Meaningful Use Incentives or Avoidance of Penalties: Take Action Now

In 2009, Congress passed and the President signed into law the American Recovery and Reinvestment Act (ARRA). Included in the law is the HITECH Act, which details the terms of the EHR Incentive Program. CMS is implementing the EHR Incentive Program known as “Meaningful Use” in multiple stages with the goal of making clinicians meaningful users of electronic health technology to improve care processes and outcomes and to create a national medical record system that integrates care delivery.

Meeting Meaningful Use Stage 1 (MU Stage 1) requirements must be accomplished before moving to meeting MU Stage 2 (and later stage) requirements. Under the program, eligible professionals (EP), including many anesthesiologists, who can adopt and agree to meaningfully use (according to government guidelines) electronic health record (EHR) technology can receive incentives payments.

Originally, anesthesiologists, like other EPs who did not successfully attest to meaningful use were to be subject to penalties; however, the American Society of Anesthesiologists (ASA) advocated for—and CMS granted—a specific hardship exception from non-adoption penalties for anesthesiologists (along with radiologists and pathologists) for up to five years (CMS cautions not to assume that all five years will be granted). Anesthesiologists who apply for non-adoption penalties exceptions must do so annually. Importantly, anesthesiologists who apply for a penalty exception can still apply for the incentive program.

Incentives for each EP anesthesiologist who achieves MU starting in 2013 can be $39,000 to $63,750 (Medicaid) over the life of the program. In 2012, 1,615 anesthesiologists successfully attested to Medicare Meaningful Use.

With regard to MU, EP anesthesiologists have two decisions to make: 1) Decide whether or not to pursue MU incentives or 2) Claim an exemption to forgo penalties.
Health Information Technology for Economic and Clinical Health (HITECH)
The 2009 HITECH Act focused on health information technology and adoption, allotted an estimated $30+ billion specifically to accelerate EHR adoption and meaningful use of certified EHR technology. The HITECH Act seeks to improve quality, safety, and efficiency of care while reducing health disparities among different populations; engage patients and families in care; promote public health; improve care coordination; and promote privacy and security.

The EHR Meaningful Use Incentive Program incentivizes providers to meaningfully use certified EHR technology. HITECH also provided the basis for CMS to require that EPs use certified EHR technology, which must include a range of specified functionality, in meeting Meaningful Use. The office of the National Coordinator for Health IT (ONC) establishes and oversees the application of criteria used to certify EHR technology, which can include both Complete EHRs, which meet all applicable criteria, and Modular EHRs that meet some criteria and can be combined with other Complete and Modular EHRs by EPs.

Meaningful Use has three defined stages so far:

Stage 1: (Data capture and sharing) First available in 2011. The focus is on the capture and sharing of data to inform care coordination, implement clinical decision support, and report quality and public health information.

Stage 2: (Advance clinical processes) Scheduled to be first available in 2014. The focus is on expanding Stage 1 criteria, which includes more robust exchange of information with providers and patients in increasingly structured formats (e.g., CPOE, transmission of diagnostic test result values).

Stage 3: (Improved outcomes) Scheduled to begin in 2016 (more likely in 2017). Although regulations have not yet been issued, the stated goals are to improve outcomes promoting improvements in quality, safety and efficiency; decision support for national high-priority conditions and patient personal health data access and tools; and improve population health.

Which Anesthesiologists are eligible?
The HITECH Act’s incentives are designed to encourage adoption and meaningful use of EHR technology for eligible providers, eligible hospitals and eligible Critical Access Hospitals (CAH). Eligible professionals cannot be hospital-based physicians (defined as those who perform 90% or more of covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital).

Scenario 1 (Inpatient): You are an intensivist who specializes in caring for critically ill ICU patients. You use the hospital’s EHR technology ... to input patient notes, view patient vitals and laboratory results, and order medications. Because you see only inpatients, 100% of your patients are billed as POS code 21, so you are considered to be hospital-based; consequently, you are ineligible for any of the CMS incentive payments but are also exempt from any of the penalties. All of the equipment, medications, and EHR technology that you use were purchased by the hospital anyway.

Scenario 2 (Outpatient Office): You are a chronic pain specialist who performs facet and medial branch blocks in your own outpatient clinic. You have been thinking about going paperless for some time now; after the HITECH Act passed, you think it is the perfect time to purchase and implement a certified, anesthesia information management system (AIMS). You selected one that enables you to meet all of the meaningful use criteria and begin using it in 2012. Because you have adopted and then meaningfully used your certified EHR technology year after year, by the end of 2016, you will have received up to $44,000 in Medicare incentive payments from CMS (minus a small adjustment due to “budget sequestration”).

Scenario 3 (Outpatient Hospital/ASC): You are an anesthesiologist who works wherever your anesthesia group assigns you each day. Today, for instance, you will be working in the OR of a private hospital. Tomorrow, you will be based in an ASC. Approximately 30% of the POS codes you submit to Medicare are 21 or 23; consequently, you are not considered hospital-based because you do not meet the 90% threshold. As a non–hospital based EP, you may qualify for the CMS incentive payments for using the anesthesia information management systems (AIMS) at the hospitals, outpatient clinics, and ASCs where you work so long as these systems, in conjunction with other certified EP or hospital EHRs, meet the requirements for the certified EHR capabilities that apply to you. Moreover, when you review the MU criteria list, you realize that you meet the exclusion criteria for several of these criteria; the others, you believe, you will be able to meet using the AIMS and other certified EHR technology.

Scenario 4 (Outpatient Medicaid): You are an anesthesiologist in an outpatient setting, and more than 30% of your patient encounters are with Medicaid beneficiaries. This means that you are eligible for the Medicaid EHR Incentive Program. Qualifying for an initial year of adoption, implementation, or upgrade (AIU) and then 5 years of MU from any of the penalties. All of the equipment, medications, and EHR technology that you use were purchased by the hospital anyway.

Stage 3: (Improved outcomes) Scheduled to begin in 2016 (more likely in 2017). Although regulations have not yet been issued, the stated goals are to improve outcomes promoting improvements in quality, safety and efficiency; decision support for national high-priority conditions and patient personal health data access and tools; and improve population health.
Hospital-based EPs
Under the HITECH Act, a hospital-based professional (defined above) is not an EP. The definition of a hospital-based EP includes anesthesiologists, pathologists, and others who furnish substantially all of their services in a hospital setting using the hospital’s equipment and facilities. Under MU, an anesthesiologist who performs more than 90% of cases in a hospital inpatient or emergency department setting is not eligible. If an anesthesiologist performs 89% or fewer of his or her cases in a hospital or Emergency Department OR, then the physician is not considered hospital-based and falls into the EP category which qualifies for the MU Incentive Program. Note that qualifying as an EP entails the EP with the need to apply for hardship exceptions to the penalties that start in 2015 if the EP does not wish to attest to Meaningful Use to gain incentive payments and also avoid the penalties.

Which criteria are needed and how do you meet them?
Eligible Professionals (EP) and Hospitals (EH) must demonstrate “Meaningful Use” of a Certified EHR (according to ONC criteria) to receive Medicare or Medicaid EHR incentives. After meeting MU Stage 1 requirements, EPs can seek to meet the criteria for MU Stage 2.

To meet MU requirements for Stage 1, the EP selects specific measures. CMS outlines several sets of measures that have to be met including core measures (15 and 14 starting in 2013); menu set measures (5 of 10) and clinical quality measures (6). To meet MU requirements for Stage 2, providers extend and add to Stage 1 measures. They collect and report data on the measures for Stage 2 which include core measures (17), menu set measures (3), and clinical quality or PQRS measures (9).

Because not all meaningful use measures are applicable for all EPs, CMS has created exemptions for specific measures based on specific criteria; several of these exemptions may be applicable to all or most anesthesiologists. Anesthesiologists have been able to claim exemptions from certain MU Stage 1 measures and should be able to do so for several Stage 2 measures as well. Examples of Stage 1 measures from which anesthesiologists have been excluded include core measure 4, e-prescribing if the EP writes fewer than 100 prescriptions in a year and core measure 13 providing clinical information summaries. Similar exceptions will be available for Stage 2 measures.

Financial Incentives and Penalties
Although physicians can qualify for MU through Medicare or Medicaid, each program has different qualifications, requirements, and incentive payments (with some state variation for Medicaid incentive programs). Most anesthesiologists who are EPs will qualify for MU under Medicare, so most anesthesiologists will want to understand the Medicare incentive payment schedule.

For Medicare EPs: EPs who first attest by the end of February 2014 for 90 consecutive days in 2013 will qualify for up to $39,000 over four years if they successfully attest for 4 years (Those first attesting in 2011 or 2012 were eligible for up to $44,000). Payments are by EP, so if a group has two EPs, then the two could receive a total of $78,000 over the life of the program if they first attest in 2013.

For Medicaid EPs: If an EP begins the Medicaid program in 2013 (or as late as 2016), then the EP can collect up to $63,750 over six years. If two EPs attest in 2013, then the two can collect up to $127,500 over the life of the program.

Exceptions for penalties: Anesthesiologists who are not considered hospital-based (thus an EP) must apply for an exception each year. Exceptions for the 2015 penalties must be applied for by July 1, 2014. CMS intends to allow exceptions for up to five years but cautions EPs not to expect approval of five years of exceptions.

### Medicare Incentive Payments

<table>
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<th>Calendar year</th>
<th>First calendar year in which the Eligible Professional receives an incentive payment</th>
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<tr>
<td>TOTAL</td>
<td>$44,000 $44,000 $39,000 $24,000 $0</td>
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8Biggs, D. and Lai, M. “Meaningful Use for Anesthesiologists.”
9Biggs, D. and Lai, M. “Meaningful Use for Anesthesiologists.”
12Clavo, J. “Electronic Health Record Versus.”
13GE Healthcare, “Framework for Understanding MU.”
14Clavo, J. “Electronic Health Record Versus.”
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