

Meaningful Use Rules Proposed for Electronic Health Record Incentives Under HITECH Act

By:

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Introduction

On December 30, 2009, The Centers for Medicare & Medicaid Services (CMS) released its notice of proposed rules implementing the American Recovery and Reinvestment Act of 2009 (ARRA) provisions providing incentive payments for the meaningful use of certified Electronic Health Records (EHR) technology, also known as the HITECH Act. Providers and hospitals will be able to receive payments if they implement EHRs and follow meaningful use criteria, which have been defined by the rule. The U.S. Department of Health and Human Services was charged through the American Recovery and Reinvestment Act of 2009 (ARRA) to develop a program through which medical professionals would implement health IT.

HITECH Act Background

Two separate sections of the Recovery Act comprised what is referred to collectively as the "HITECH Act" (Health Information Technology for Economic and Clinical Health Act). The purpose of this HITECH Act is to promote the use of health information technology with a goal of utilization of an electronic health record for each person in the United States by 2014. The HITECH Act authorizes an investment in health care IT that is expected to top \$20 billion. The bulk of this funding is allocated to direct financial incentives intended to encourage hospitals and other health care providers to invest in IT infrastructure, training, and electronic health records.

As I have previously written in past columns, the HITECH Act, most notably, provides financial incentives to physicians and hospitals to adopt and use certified electronic health records (or EHR) technology. Providers that participate in the Medicare and Medicaid program stand to receive between \$43,000 and \$64,000 (for individuals) and up to \$11 million (for hospitals) in cash incentives over four to six years. These incentives come with attached conditions – the provider must be considered a “meaningful EHR user.”

Meaningful Use Defined

The long-awaited, 556-page meaningful use rule document details the functions of electronic records that are deemed “meaningful” by the CMS. Meaningful use of EHR is demonstrated through the use of certified EHR technology consistent with the objectives and measures presented in the proposed rule. This includes the use of certified EHR technology in a manner that improves the quality, safety, and efficiency of health care delivery, reduces health care disparities, engages patients and their families in patient care, improves care coordination, and ensures adequate privacy and security protections for personal health information.

CMS proposes to phase-in criteria for meaningful use in three stages. Stage 1 will govern Medicare incentive payments for 2011 and 2012. The proposed Stage 1 criteria for meaningful use focus on electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information.

The proposed criteria for meaningful use are based on a series of specific objectives, each of which is tied to a proposed measure that all eligible professionals and hospitals must meet in order to demonstrate that they are meaningful users of certified EHR technology. For Stage 1, CMS proposes 25 objectives/measures for eligible professionals and 23 objectives/measures for eligible hospitals that must be met to be deemed a meaningful EHR user.

The following list of 25 Stage 1 Meaningful Use criteria for **eligible providers** [EP] was taken from the proposed rule: "Medicare and Medicaid Programs; Electronic Health Record Incentive Program."

1. Use CPOE
2. Implement drug-drug, drug-allergy, drug- formulary checks
3. Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT®
4. Generate and transmit permissible prescriptions electronically (eRx).
5. Maintain active medication list.
6. Maintain active medication allergy list.
7. Record demographics.
8. Record and chart changes in vital signs.
9. Record smoking status for patients 13 years old or older
10. Incorporate clinical lab-test results into EHR as structured data.
11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach.
12. Report ambulatory quality measures to CMS or the States.
13. Send reminders to patients per patient preference for preventive/ follow-up care
14. Implement five clinical decision support rules relevant to specialty or high clinical priority, including for diagnostic test ordering, along with the ability to track compliance with those rules
15. Check insurance eligibility electronically from public and private payers
16. Submit claims electronically to public and private payers.
17. Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, and allergies) upon request

18. Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, allergies)
19. Provide clinical summaries to patients for each office visit.
20. Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
21. Perform medication reconciliation at relevant encounters and each transition of care.
22. Provide summary care record for each transition of care and referral.
23. Capability to submit electronic data to immunization registries and actual submission where required and accepted.
24. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice.
25. Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities.

There is a slightly different list of meaningful use criteria for hospitals. In 2011, all of the results for all objectives/measures, including clinical quality measures would be reported by EPs and hospitals to CMS, or for Medicaid EPs and hospitals to the states, through attestation.

In 2012, CMS proposes requiring the direct submission of clinical quality measures to CMS (or to the states for Medicaid EPs and hospitals) through certified EHR technology. CMS recognizes that for clinical quality reporting to become routine, the administrative burden of reporting must be reduced. By using certified EHR technology to report information on clinical quality measures electronically to a health information network, a state, CMS, or a registry, the burden on providers that are gathering the data and transmitting them will be greatly reduced. The burden of generating the necessary information for the provider to then use the information to improve health care quality, efficiency, and patient safety will also be reduced.

Beyond the Stage 1 Criteria for Meaningful Use

The policy goals of meaningful use will be most fully realized by building on findings from Stage 1 and by making full use of the greater proliferation of certified EHR technology and supporting HIT infrastructure that will take place under Stage 1. CMS intends to propose through future rulemaking two additional stages of the criteria for meaningful use.

Stage 2 would expand upon the Stage 1 criteria in the areas of disease management, clinical decision support, medication management, support for patient access to their health information, transitions in care, quality measurement and research, and bi-directional communication with public health agencies. CMS may consider applying the criteria more broadly to both the inpatient and outpatient hospital settings.

Consistent with other provisions of Medicare and Medicaid, Stage 3 would focus on achieving improvements in quality, safety and efficiency, focusing on decision support for national high priority conditions, patient access to self management tools, access to comprehensive patient data, and improving population health outcomes.

Notably, the definition of meaningful use is the same for the Medicare and Medicaid incentive programs, except that States may request CMS approval of meaningful use measures above the minimum requirements, but may not request approval of meaningful use measures below the minimum requirements.

Outcome Priorities and Goals from Meaningful Use Policy

1. Improving quality, safety, efficiency, and reducing health disparities

- Provide access to comprehensive patient health data for patient's health care team
- Use evidence-based order sets and CPOE
- Apply clinical decision support at the point of care
- Generate lists of patients who need care and use them to reach out to patients
- Report information for quality improvement and public reporting

2. Engage patients and their families in their health care

- Provide patients and families with timely access to data, knowledge, and tools to make informed decisions and to manage their health

3. Improve care coordination

- Exchange meaningful clinical information among professional health care team

4. Improve population and public health

- Communicate with public health agencies

5. Ensure adequate privacy and security protections for personal health information

- Ensure privacy and security protections for confidential information through operating policies, procedures, and technologies and compliance with applicable law
- Provide transparency of data sharing to patient

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Early Feedback

Industry experts have expressed concern that physicians and hospitals may not be ready to qualify for the criteria proposed in the meaningful use rules. Officials from the American Hospital Association have expressed concern that the rules impose a needlessly fast timeline for EHR adoption, include too many requirements for EHR functionality, and require health care providers to develop new systems to measure their compliance with the criteria.

In addition, the proposed rule excludes “hospital-based EPs” from Medicare incentive payments, which includes any hospital based provider that furnishes 90% or more of his/her allowed services in a hospital, including inpatient, outpatient, emergency department, and provider-based settings. While it makes sense that physicians should not receive incentives for EHR that is provided in a hospital setting, there are strong concerns from health systems across the country that investment in unifying electronic record systems for inpatient and outpatient care will be near impossible.

CMS has admitted concerns that hospital investment in outpatient primary care sites is likely to lag behind their investment in their inpatient EHR systems. As such and to address these concerns, CMS has indicated that, as part of future rulemaking, they plan to consider ways to realign the meaningful use objectives and criteria to include a broader definition of hospital care to include outpatient services. CMS believes this could provide an important incentive for hospital investment in EHRs for their outpatient primary care sites.

Conclusion

Until the final rule is issued late this spring, doctors and hospitals should not shy away from submitting comments on these issues including other ways that CMS could meet its objective to increase the meaningful use of EHR technology by 2014. For more information on these issues or for assistance in navigating through the meaningful use rules as applied to your organization, please do not hesitate to contact our offices for assistance.

About the Author:

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