"Meaningful Use" – An Update on Meeting Criteria for Federal Incentive Payments

Overview

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was signed into law on February 17, 2009 as part of the American Recovery and Reinvestment Act (ARRA) of 2009. The ARRA is a $787 billion stimulus package with heavy investments in science, energy, healthcare, and technology. Of the $787 billion, more than $180 billion has been set aside for healthcare-related spending, with the intent of creating compelling financial incentives for physicians and hospitals to adopt Electronic Health Records (EHR) during the next five years.

The funding for the EHR implementation will be administered through Medicare and Medicaid via incentive payments for hospitals and healthcare professionals that implement compliant EHR systems. Hospitals are eligible to receive up to four years of financial incentive payments under Medicare and up to six years of incentive payments under Medicaid beginning on October 1, 2010. Eligible physicians can receive up to $44,000 over five years under Medicare or $63,750 over six years under Medicaid, beginning on January 1, 2011.

What does it mean?

These steps to "meaningful use" may seem like a heavy lift. However, you can leverage numerous projects already in process including Health Information Exchange (HIE) initiatives, Regional Extension Center (REC) grants, and Beacon Community grants to help you or your organization meet the goal of achieving 'meaningful use."

Along with considerable health IT funding, "meaningful use" will be phased in over the next several years, in three stages. Stage 1 will primarily be collecting electronic health data in coded formats; Stage 2 will implement structured data exchange and continuous quality improvement; and Stage 3 focuses on advanced decision support and population health.

An important consideration for both providers and hospitals is the payment schedule developed under the ARRA program. The incentive is clearly to engage the healthcare community sooner rather than later in adopting "meaningful use" and to promote a nationwide acceleration in the use of HIT.

Furthermore, the payment incentive program is intended to take providers and hospitals through all three of the stages of adoption. The three stages will use the following general criteria:

- **Stage 1: Data Capture and Sharing —** Goal is to electronically capture data in coded format as well as report health information usable for tracking key clinical conditions.
- **Stage 2: Advanced Clinical Processes —** Goal is to guide and support care processes and care coordination and the exchange of information in the most structured format

possible, such as the electronic transmission of orders entered using CPOE and the electronic transmission of diagnostic test results (such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, pulmonary function tests, and other such data needed to diagnose and treat disease).

- **Stage 3: Improved Outcomes** — Goal is to achieve improved performance through the effective adoption and use of care processes as well as advance key health system outcomes. In addition, at this stage, the goal is to promote further improvements in quality, safety, and efficiency by focusing on decision support for national high priority conditions, patient access to self management tools, improving access to comprehensive patient data, and improving population health.

"Meaningful Use"

For hospitals and physicians to qualify for the ARRA incentive payments, they must demonstrate they are certified "meaningful users" of EHR technology. There has been much speculation and many predictions throughout 2009 about exactly what "meaningful use" includes, and the federal government recently released information to define the scope and criteria of this all-important term.

In December 2009, the Office of the National Coordinator for Health IT (ONCHIT), an office within Health and Human Services (HHS) that provides recommendations, announced a notice for proposed rulemaking (NPRM) to define "meaningful use," which is a key element in providing incentive payments for EHR technology. This NPRM will be published January 13th with the initial set of standards, certification criteria, and implementation specifications for Stage 1 of the EHR incentive program. (http://www.federalregister.gov/OFRUpload/OFRData/2009-31217_PI.pdf). A 60 day public comment period will commence at that time to allow for input from all interested constituencies on the meaningful use criteria. Below are the final recommendations released by ONCHIT for defining "meaningful use"—

Hospital - Stage 1 Criteria

- Use computerized physician order entry (CPOE) for all order types. (10 percent minimal use for hospitals)
- Implement drug-drug, drug-allergy, drug-formulary checks (hospital has enabled functionality)
- Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT. (80 percent of all unique patients admitted to the eligible hospital have at least one entry or an indication of "none" recorded as structured data)
- Maintain active medication list. (80 percent requirement)
- Maintain active medication allergy list. (80 percent requirement)
- Record demographics. (80 percent requirement)
- Record and chart changes in vital signs. (80 percent of all unique patients age 2 and older admitted to the eligible hospital, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20)

- Record smoking status for patients 13 years old or older. (80 percent requirement)
- Incorporate clinical lab-test results into EHR as structured data. (50 percent requirement)
- Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach. (Generate at least one report)
- Report hospital quality measures to CMS or the States.
- 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.
- Submit claims electronically to public and private payers. (80 percent requirement)
- Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request.
- Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, allergies, diagnostic test results) among providers of care and patient authorized entities electronically. (Perform at least one test of certified EHR technology's capacity to electronically exchange key clinical information)
- Perform medication reconciliation at relevant encounters and each transition of care. (80 percent requirement)
- Provide summary care record for each transition of care and referral. (80 percent requirement)
- Capability to submit electronic data to immunization registries and actual submission where required and accepted. (Perform at least one test)
- Capability to provide electronic submission of reportable lab results to public health agencies and actual submission where it can be received. (Perform at least one test)
- Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission according to applicable law and practice. (Perform at least one test)
- Protect electronic health information maintained using certified EHR technology through the implementation of appropriate technical capabilities. (Conduct or review a security risk analysis in accordance with the requirements and implement security updates as necessary)

Provider - Stage 1 Criteria

- Use CPOE for all order types. (80 percent for eligible provider)
- Implement drug-drug, drug-allergy, drug-formulary checks (eligible provider has enabled functionality)
- Maintain an up-to-date problem list of current and active diagnoses based on ICD-9-CM or SNOMED CT. (80 percent of all unique patients admitted to the eligible provider have at least one entry or an indication of none recorded as structured data)
- Generate and transmit permissible prescriptions electronically (eRx). (75 percent requirement)

- Maintain active medication list. (80 percent of all unique patients seen by the eligible provider have at least one entry or an indication of "none" if the patient is not currently prescribed any medication)
- Maintain active medication allergy list. (80 percent requirement)
- Record demographics. (80 percent requirement)
- Record and chart changes in vital signs. (80 percent of all unique patients age 2 and older seen by the eligible provider, record blood pressure and BMI; additionally, plot growth chart for children age 2 to 20)
- Record smoking status for patients 13 years old or older (80 percent requirement)
- Incorporate clinical lab-test results into EHR as structured data. (50 percent requirement)
- Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, and outreach. (Generate at least one report listing patients of the eligible provider with a specific condition)

Certification/Adoption Interim Rule

The standards adopted in the ONCHIT interim final rule relied heavily on existing standards for the interoperability of HIT, including those established and/or promoted by Health Level 7, Inc. (HL7), the National Institute of Standards and Technology (NIST), and Integrating the Healthcare Enterprise (IHE). This interim final rule will take effect 30 days after publication in the Federal Register which is scheduled for January 13, 2010 with a 60 day comment period. (**http://www.federalregister.gov/OFRUpload/OFRData/2009-31216_PI.pdf**)

The standards also rely on existing classification and nomenclature systems including SNOMED CT, ICD-9 and 10, X12, LOINC, NCPDP, and RxNorm. These standards were chosen in an attempt to provide a minimum set of transport, content, and vocabulary standards required to drive or enhance the predictability of data exchange when used in EHR technologies, thus driving adoption.

ONCHIT established the following goals to guide its approach to adopting the standards, implementation specifications, and certification criteria within the interim final rule:

- Promote interoperability through the use of standards and, where necessary, be specific about certain content exchange and vocabulary standards to establish a path forward toward semantic interoperability;
- Support the evolution and timely maintenance of adopted standards;
- Promote technical innovation using adopted standards;
- Encourage participation and adoption by all vendors, including small businesses;
- Keep implementation costs as low as reasonably possible;
- Consider best practices, experiences, policies, frameworks, and the input of the HIT Policy Committee and HIT Standards Committee in current and future standards; and,

- Enable mechanisms such as the Nationwide Health Information Network (NHIN) to serve as a test-bed for innovation and as an open-source reference for implementation of best practices.

Conclusion

Taking advantage of Medicare and Medicaid incentive payment to implement EHRs is intended to foster improved prevention and management of chronic diseases, reduction of medication errors, and manage other healthcare disparities which, will transform healthcare delivery and lower healthcare cost. The implementation of these systems will also serve as a foundation for efforts to amplify the effectiveness of healthcare services by supporting a host of new reimbursement models. While considerable discussion is underway on the exact focus of these new models of care delivery, it is anticipated that the modification of reimbursement methodologies will reward more organized, coordinated, and efficient care.

The "meaningful use" NPRM will be published in the Federal Register on January 13, 2010 and at that time will be open for a **60-day public comment period, with comments due by March 12.** As with all proposed rules, the agency may offer additional modifications after the comment period expires, however we do expect this regulation to be finalized in the Spring of 2010.

The Certification and Adoption interim final rule will take effect 30 days after publication in the Federal Register which is scheduled for 60 day comment period beginning on January 13, 2010.

Instructions on how to submit public comment can be found at http://healthit.hhs.gov/.