

Getting Meaningful Use Right

THE ISSUE

The American Recovery and Reinvestment Act (ARRA) of 2009 incentivized the adoption and meaningful use of certified electronic health records (EHRs) by providing the possibility of short-term positive incentives for hospitals, physicians and other eligible professionals (EPs), followed by long-term financial penalties that began in 2015 and do not sunset. The program has led to greater adoption of EHRs over the past six years, particularly among hospitals. However, the administration's implementation of the Medicare and Medicaid EHR Incentive Programs has proved challenging and unwieldy – particularly its creation and implementation of a three stage system with tiered

requirements designed to trigger incentives or penalties for providers. The timeline for the program has been overly aggressive, moving too quickly from Stage 1 of “meaningful use,” to Stage 2, and soon to Stage 3. The requirements for the current Modified Stage 2 are, in some cases, too prescriptive and hold providers accountable for events outside their control.

Furthermore, providers have been mandated to purchase costly certified EHRs that do not always support them in meeting the federal requirements or achieving their larger goals for improving patient care. Due to these regulatory choices, the current program is overly complex and burdensome, which means patients will not realize the benefits of a wired health care system.

AHA POSITION

America's hospitals are strongly committed to the adoption of EHRs. The transition to an EHR-enabled health system is well underway, but we need to fix the meaningful use program to realize the benefit for patients. That is why the AHA supports the EHR Regulatory Relief Act (S. 3173), which would provide much needed flexibility to hospitals and providers participating in the Medicare and Medicaid EHR Incentive Programs. The AHA urges the Department of Health and Human Services (HHS) to finalize Stage 3 no sooner than 2019 and provide more flexibility in the Stage 3 meaningful use requirements.

WHY?

- **The AHA has long advocated for the elimination of the “all-or-nothing approach” to meaningful use of EHRs.** The legislation would allow participants in the Medicare and Medicaid EHR Incentive Programs to be deemed meaningful users if they meet 70 percent of the measures as determined by HHS. The EHR Regulatory Relief Act also allows hospitals a 90-day EHR reporting period in 2016 and beyond and extends flexibility in applying hardship exceptions for meaningful use.
- **The meaningful use program started in 2011 and most hospitals have attested to meaningful use although critical access hospitals (CAHs) have faced greater challenges and are less likely to have met the federal requirements.** Hospitals are committed to EHR adoption and want the meaningful use program to work. Hospitals face tremendous challenges meeting program requirements for a number of reasons:
 - **The certification process is broken.** Vendor delays and implementation issues have limited hospitals' ability to meet Modified Stage 2 requirements. Hospitals are finding that 2014 Edition Certified EHRs do not work as expected and require significant and expensive patches or work-arounds. The biggest problems have been with the “transitions of care” and “patient portal” requirements.
 - **2014 Edition Certified EHRs do not share data easily, either within the hospital or across care settings.** They are not, generally speaking, interoperable. In addition, many areas of the country do not have efficient and affordable information exchange networks in place.
 - **The program holds hospitals accountable for events outside their control.** For example, to meet the transitions of care requirement, a hospital must find other providers ready to receive information in the manner

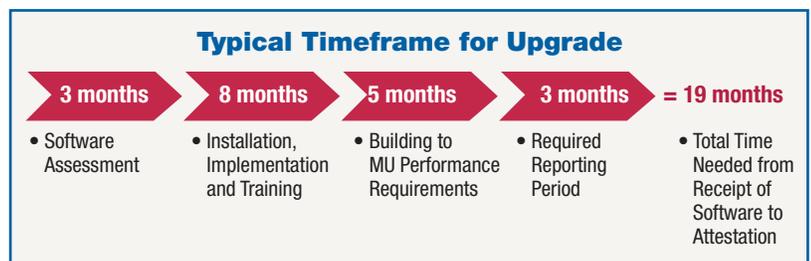
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required by the government. However, post-acute care providers are not part of the meaningful use program, and many physicians have yet to implement their 2014 Edition Certified EHRs.

- **The 2015 Edition Certified EHRs will be expected to include functionality that is premature**, such as requiring that providers use Application Programming Interfaces (APIs) in the EHR to make health information accessible by any application (app) that requests access to the information.
- **The Centers for Medicare & Medicaid Services (CMS) has yet to finalize a proposal that would address some stakeholder concerns by shortening the reporting period in 2016 and offer limited flexibilities in the Modified Stage 2 requirements.** Hospitals greatly appreciated the proposed flexibilities, but need the certainty of a final rule now since that it will affect the program's current reporting period.
- **Despite the limited experience with Modified Stage 2, CMS states that Stage 3 requirements will begin in 2018.** CMS should wait until a sufficient number of hospitals have met Modified Stage 2 before setting the start date or requirements for Stage 3, and it should begin no sooner than 2019. HHS has had to fix both the Stage 1 and Stage 2 rules after they were first finalized because experience on the ground proved some of the requirements unworkable. Stage 3 should not follow that same pattern.
- **The move to Stage 3 will require costly upgrades to a new version of certified EHRs.** Hospitals estimate that it takes 19 months, on average, to properly and safely implement an upgrade to their EHR system. Changing a system disrupts both clinical care and operations, consumes capital and delays other important initiatives, such as building out new models of care. CMS should have solid proof that the benefits of Stage 3 will outweigh the costs before imposing this mandate.

KEY FACTS:

- **The meaningful use program has spurred remarkable growth in EHR adoption by hospitals.** The most recent AHA survey data show by 2015, 84 percent of hospitals had at least a basic EHR in place – more than five times the share in 2010. However, having a basic EHR does not mean it meets requirements for meaningful use.



- **CMS has paid about \$18 billion in incentives to hospitals, and \$12 billion to physicians.** Hospitals greatly appreciate this federal assistance.
- **However, the AHA estimates that, collectively, America's hospitals spent \$47.5 billion on information technology each and every year between 2010 and 2014.**
- **Medicare penalties began in 2015.** CMS has reported one of every two EPs received a 1 percent Medicare payment penalty in 2015 because they could not meet meaningful use in a prior year. About 200 hospitals paid under the inpatient prospective payment system also received payment penalties in 2016. The share of CAHs receiving penalties is not yet known.
- **Meaningful use is an all-or-nothing program.** If a hospital fails to meet a meaningful use objective, such as use of computerized provider order entry, by a single percentage point, the hospital will fail to meet meaningful use and be exposed to significant payment penalties. CMS should increase flexibility in the program requirements so that a small mistake does not have a large impact. The current "all-or-nothing" approach of having to meet each and every metric, or fail altogether, is solely a regulatory design and is unfair.
- **The rules of the program expose hospitals to financial penalties if they choose to switch vendors and cannot meet meaningful use while they are changing systems.** While Congress gave CMS the authority to grant hardship exceptions from the penalties, the agency has refused to grant an exemption for providers that are switching vendors. This policy is unfair to providers and reduces competition among EHR vendors.
- **Certified EHRs cannot easily generate accurate electronic clinical quality measures (eCQMs).** We strongly support the long-term goal of using EHRs to streamline and reduce the burden of quality reporting, but eCQMs and EHRs require additional improvements before they can feasibly and reliably generate valid performance data. Additional time is needed for development, independent testing and rigorous review.