



**American Hospital  
Association**

## **HIT Incentive Payment Program: Definition of ‘Meaningful Use’**

### **The Issue**

On December 30, 2009, in accordance with the *American Recovery and Reinvestment Act (ARRA)*, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule on Medicare and Medicaid payment incentives for “meaningful users” of electronic health records (EHRs). The rule, which describes how hospitals and physicians can qualify for payments starting in fiscal year (FY) 2011, sets rigid standards and unrealistic time frames for EHR adoption. The AHA believes that the eligibility requirements for hospitals and physicians to receive incentive payments are too restrictive.

In our view, the meaningful use rule should encourage health information technology (HIT) adoption by rewarding those who are ahead of the curve, and support hospitals and health systems by setting forth a realistic, incremental set of benchmarks that are linked to the general progression of EHR implementation. CMS should implement an approach to EHR adoption that includes a flexible and gradual transition to the requirements and clinical measures that are part of being a meaningful user of EHRs.

### **Background**

The CMS rule on qualifying for Medicare and Medicaid payment incentives proposes a staged approach to the definition of “meaningful use.” Stage 1 (2011 and 2012) focuses on electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, implementing some clinical decision support tools, and initiating the reporting of clinical quality measures and public health information. In the first stage, hospitals and critical access hospitals (CAHs) that are “meaningful users” of EHRs can qualify for incentive payments starting in FY 2011 if all 23 different EHR objectives, or requirements, have been adopted. Some examples of objectives include recording of patient demographic information, maintaining medication lists and up-to-date problem lists, providing patients with electronic copies of their health information, providing care instructions upon discharge, performing medication reconciliation at each transition of care, and using computerized provider order entry (CPOE). Specific measures are associated with each objective, and all 23 objectives would need to be adopted in a manner that meets the measures established for the objective. For example, CPOE must be used for at least 10 percent of all orders. Additionally, each of the 23 objectives would have to be certified under a separate and yet-to-be-determined process.

In Stage 2 (2013 and 2014), CMS proposes to expand on the earlier measures to focus on continuous quality improvement at the point of care and the exchange of information in the most structured format possible. Stage 3 (2015 and beyond) will focus on promoting improvements in quality, safety and efficiency, decision support, patient access to self-management tools, access to comprehensive patient data, and improving population health. CMS will specify the requirements for both Stages 2 and 3 in future regulations.

The second (2013) and third (2015) stages require steep increases in the scope and complexity of EHR objectives. Later adopters of EHRs would need to meet the Stage 2 and Stage 3 criteria on the same schedule as early adopters. Specifically, in 2015, all hospitals, including CAHs, would need to meet the Stage 3 criteria to avoid Medicare payment penalties, which are calculated as reductions to the hospital annual market basket update or reductions to reasonable cost reimbursement (in the case of CAHs).

Additionally, the rule proposes to require hospitals to report 35 clinical quality measures through an EHR

in order to be deemed “meaningful users.” While all of the measures have been endorsed by the National Quality Forum, and 25 have been adopted by the Hospital Quality Alliance, only 9 are currently in use in the hospital pay-for-reporting program. Examples of the quality measures include measures for heart failure, pneumonia, stroke, and surgical care improvement. Hospitals would be required to report on all clinical quality measures for which they have any applicable patients, not just for measures applicable to their Medicare patients. For FY 2011, CMS proposes to require hospitals to attest to the use of a certified EHR system to capture the data and calculate the results for the applicable clinical quality measures. Beginning in FY 2012, a hospital using a certified EHR technology would be required to submit information on clinical quality measures electronically to be a meaningful EHR user, regardless of whether FY 2012 is its first or second payment year.

CMS estimates that it will disburse between \$14 and \$28 billion in Medicare HIT payments from 2011 to 2019—lower than the Congressional Budget Office's estimate of \$34 billion. CMS' estimates, which are already lower than Congress intended, rely on optimistic assumptions about the number of providers able to meet the requirements—assumptions that are likely overstated considering the challenging meaningful use definition.

### **AHA View:**

The definition of meaningful use presents many obstacles for hospitals that seek to become meaningful users of EHRs; however, the two key difficulties presented by the rule are the inadequate phase-in period and the “all-or-nothing” approach proposed by CMS.

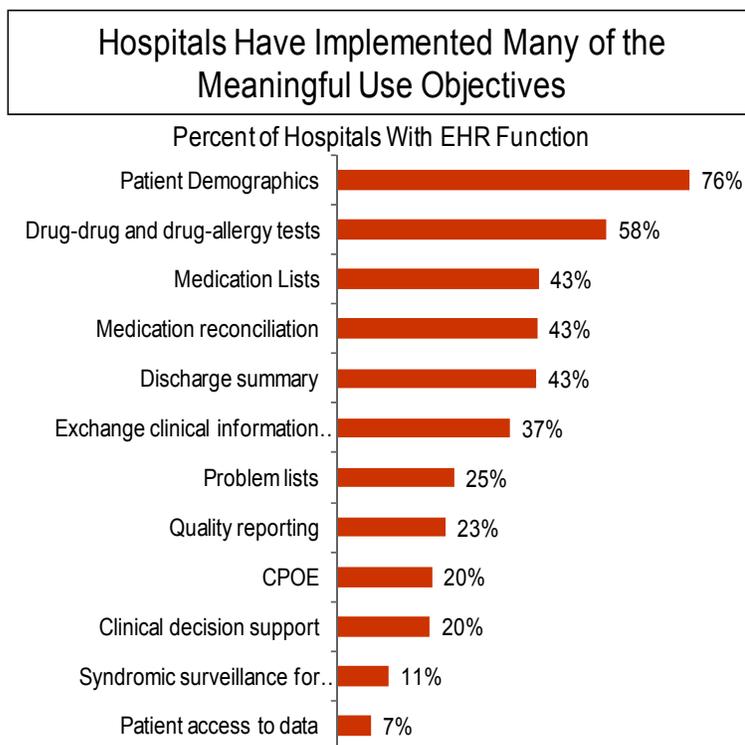
### **Inadequate Phase-in Period (Too Much, Too Soon)**

- CMS' policy should reflect the incremental nature of EHR adoption when setting performance benchmarks. As proposed, the meaningful use objectives and measures are laudable end goals, but are untenable starting points. For small and rural hospitals in particular, the unrealistic timeframes are even more problematic because they have further to go in their implementation of EHRs compared to larger hospitals.
- The meaningful use rule as proposed by CMS adopts an unrealistic timeframe for hospitals to meet an ambitious definition of meaningful use. If finalized, these proposals would likely result in even hospitals with advanced HIT systems not meeting the requirement in 2011.
- The rule fails to acknowledge that hospitals adopt EHR functions incrementally. Included in the 23 measures are advanced functions—such as CPOE, clinical decision support, and electronic medication reconciliation—that generally occur at the end of a multi-year transition to EHRs.
- While the rule proposes a limited transition mechanism, those who would benefit from the transition would still be expected to meet the more comprehensive set of requirements of Stages 2 and 3 in 2015 or face Medicare payment cuts.
- The requirements for achieving meaningful use are ahead of CMS' ability to certify or measure EHR systems. Some elements of meeting the meaningful use definition are outside hospitals' control. For example, given that the HHS Office of the National Coordinator (ONC) has not yet released a rule on the certification process and the time that the rule will take to be finalized, it is unlikely that certified products will be available from vendors until after the beginning of the first deadline in FY 2011.
- CMS should extend the transition and stages of meaningful use through 2017. Congress established a transition as part of the HIT incentive program which includes a transition for the non-meaningful user penalties that extends through 2017. However, CMS proposes to end the meaningful use transition in 2015.

- Hospitals will face a significant challenge in implementing all of the new functional and quality measures. Implementing many of these measures places a significant reporting burden on hospitals because many of them require significant data collection and reporting of non-electronic activity.

### All-or-Nothing Standard

The rule proposes an inflexible approach to HIT adoption. Hospitals already have made great progress in creating and maintaining electronic records to improve patient care and safety. The chart below shows that many hospitals have implemented several of the required functions of meaningful use. For example, 76 percent of hospitals have the ability to collect and utilize patient demographic information; 20 percent of hospitals have implemented CPOE.



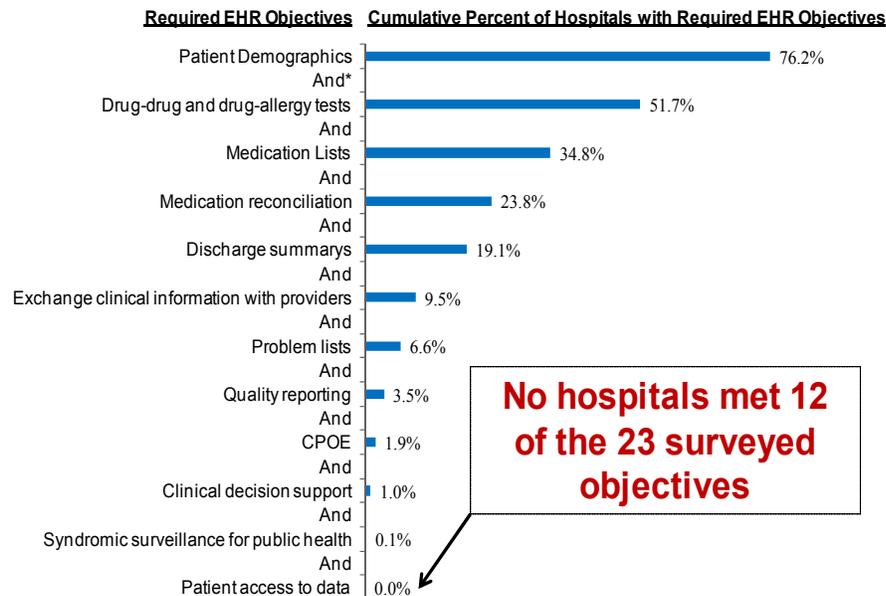
Based on analysis of AHA Annual Survey IT Supplement conducted in mid-2008. Includes data from 3,342 non-federal hospitals (65% of hospitals).

To be eligible for the Medicare incentive payments in all but the first year, hospitals must certify that:

1. They have met *all* 23 EHR objectives and that their EHR system is certified to support them.
2. They have successfully calculated and met required levels for *each of* 23 HIT functionality measures, none of which has been scientifically developed or field-tested.
3. They have used their EHRs to generate the data needed to calculate *each* of 35 new quality measures and attest to the accuracy of these calculations. Most of these measures have not yet been specified for collection from EHRs, tested for validity and reliability when generated from EHRs, or incorporated into EHR products. Few of the measures overlap with existing Medicare quality reporting programs.

Based on survey data from more than 3,300 hospitals, very few hospitals can meet the all-or-nothing approach, even though they have adopted numerous electronic record systems. As seen in the chart below, which lists 12 of the 23 objectives proposed for meaningful use, the percentage of hospitals with required EHR objectives declines as additional objectives are added. The result is that no hospital surveyed had EHRs that met all 12 objectives. Adding the 11 objectives not included in the survey (for a total of 23 required objectives) makes meeting the proposed meaningful use objectives even more difficult.

## “All-or-Nothing” Excludes Most Hospitals



NOTE: Percentages show cumulative effect of adding each additional objective. Based on analysis of AHA Annual Survey IT Supplement conducted in mid-2008. Includes data from 3,342 non-federal hospitals (65% of hospitals).

### AHA Alternative: A Better, More Reasonable Approach

CMS should develop a rule that assists hospitals in charting a course toward the full implementation of the EHR objectives. A more incremental approach must be used for successful transition to the 23 objectives and all functional and clinical measures must be evidence-based and tested for reliability and validity when submitted through an EHR.

CMS should change the requirements and timeframes of its meaningful use rule so that it:

- Requires four to eight objectives in 2011 to qualify as a meaningful user of EHRs and increases the requirements over time until all required objectives are operational by 2017;
- Extends the transition to 2017 so that it mirrors the transition established for Medicare payment penalties for non-meaningful users of EHRs;
- Grandfathers certification requirements for existing systems in use for 24 months to ensure that the delay in ONC’s development of a certification process and time needed to become certified does not prevent hospitals from being considered a meaningful user;
- Includes quality reporting of measures that have been fully tested and validated for EHR reporting and for which CMS has an ability to accept in EHR form; and
- Excludes non-clinical objectives such as electronic insurance verification and claims submission that are unrelated to patient care and rely on voluntary payer participation.