



**American Hospital  
Association**

# SPECIAL BULLETIN

Wednesday, July 14, 2010

## CMS RELEASES FINAL DEFINITION OF 'MEANINGFUL USE' OF HIT

The Centers for Medicare & Medicaid Services (CMS) yesterday released its final rule defining “meaningful use” of electronic health records (EHRs). At the same time, the Office of the National Coordinator (ONC) for Health Information Technology (IT) issued a final rule that sets certification criteria, standards and implementation specifications for EHR technology. Taken together, these regulations set EHR adoption requirements that hospitals and physicians must meet under the *American Recovery and Reinvestment Act* (ARRA) of 2009 to qualify for additional Medicare and Medicaid incentive payments beginning in 2011 and to avoid significant payment penalties in 2015 and later years. CMS’ final rule can be viewed at [http://www.ofr.gov/OFRUpload/OFRData/2010-17207\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf); it takes effect on September 27. The certification final rule, which will take effect August 27, can be viewed at [http://www.ofr.gov/OFRUpload/OFRData/2010-17210\\_PI.pdf](http://www.ofr.gov/OFRUpload/OFRData/2010-17210_PI.pdf).

CMS made some important improvements in the final rule. However, the AHA remains concerned that the requirements may be out of reach for many of America’s hospitals. CMS provided some flexibility in meeting meaningful use, but a total of 19 objectives will still be required. Hospitals will need to use a certified EHR to meet 14 “core,” or mandatory, objectives and an additional five objectives chosen from a “menu set” of 10 options. Computerized provider order entry (CPOE) for medications is required to be a meaningful user, as is reporting on 15 clinical quality measures generated using a certified EHR. The definition of meaningful use does not include electronic billing or eligibility verification in Stage 1.

In an important change, CMS has made critical access hospitals (CAHs) eligible to receive incentive payments under Medicaid. This change will allow CAHs to access important up-front funds for the adoption, implementation or upgrade of EHRs in the first year that the state Medicaid programs are operational.

Unfortunately, individual hospitals in multi-campus settings will not be eligible for incentive payments if they share a single provider number. The AHA will continue to seek a legislative solution to this problem.

Only hospitals using EHRs certified under a new federal certification process will qualify, as ONC rejected the idea of “grandfathering” currently installed EHRs in an earlier rule (see the AHA’s Special Bulletin on the Temporary Certification Process at

<http://www.aha.org/aha/advocacy-update/2010/100618-bulletin.html>). Therefore, all hospitals and physicians will need to either upgrade to or install new certified EHRs, or undertake a self-developed certification of their installed system at their own expense before they can apply for the incentives. No certified products are yet available.

The AHA will analyze both rules carefully and provide a detailed advisory on the operational details of the new Medicare and Medicaid EHR Incentive Programs. We also will consider next steps to address our remaining concerns, such as the treatment of multi-campus hospitals, alternative approaches for small or rural hospitals, and grandfathering of currently installed EHRs. Watch for a *Regulatory Advisory* with more details in the near future.

Key provisions of both rules are summarized below.

#### CMS' PROPOSED EHR INCENTIVE PROGRAM REGULATION ("MEANINGFUL USE")

**Overall Framework:** CMS finalized an approach to meaningful use that becomes more stringent over time, but provided detailed objectives for only Stage 1, covering 2011 and 2012. The AHA recommended that CMS provide a strategic roadmap by establishing a full definition of meaningful use for 2017, and provide a phased-in approach between 2011 and 2017.

**Meaningful Use Objectives:** The rule requires that hospitals adopt and meaningfully use certified EHRs to meet 14 "core," or mandatory, objectives and an additional five objectives chosen from a "menu set" of 10 options, of which at least one must address public health objectives. The finalized measures draw from those in the proposed rule. In response to comments, including those from the AHA, many of the objectives were narrowed in scope and clarified. In the final rule, CMS:

- Excluded electronic claims submission and eligibility verification from the meaningful use objectives for Stage 1, but stated its intention to include them in later stages.
- Revised the CPOE measure to focus only on medication orders, rather than "all orders" (as proposed), and changed the measure to using CPOE to order at least one medication for more than 30 percent of patients admitted to the inpatient or emergency department.
- Accepted the recommendation of the AHA and others to separate clinical drug alerts (drug-drug and drug-allergy interactions) from the efficiency-oriented drug alerts (drug-formulary checks).
- Added two objectives for hospitals that had been recommended by the HIT Policy Committee: providing patient specific educational resources and recording advanced directives for eligible hospitals.

The "core," or mandatory, objectives for 2011 and 2012 are:

- Use CPOE for medications for more than 30 percent of patients

- Implement drug-drug and drug-allergy interaction checks
- Record demographics (race/ethnicity, gender, date of birth, preferred language, date and preliminary cause of death in the event of mortality)
- Maintain up-to-date problem list
- Maintain active medication list
- Maintain active medication allergy list
- Record and chart changes in vital signs (height, weight, and blood pressure)
- Record smoking status (patients 13 and older)
- Implement one clinical decision support rule
- Report 15 hospital clinical quality measures to CMS
- Provide patients with an electronic copy of their health information on request
- Provide patients with an electronic copy of their discharge instructions on request
- Have the capability to exchange key clinical information among providers of care and patient-authorized entities electronically
- Protect electronic health information through appropriate technical capabilities

A table detailing both the “core” and “menu set” of meaningful use objectives and measures for hospitals is attached (Table 1).

**Health IT Functionality Measures:** Each meaningful use objective has associated functionality measures to ensure that objectives are met (see Table 1). In many cases, CMS has reduced the threshold of compliance for the meaningful use measures. For instance, the threshold for recording demographics was reduced from 80 percent of patients to 50 percent. Most measures are now specified to include both inpatient and emergency departments (POS 21 or 23) and CMS has required use of a certified EHR to achieve the objectives. In addition, CMS has eliminated the need for manual calculation of measures, and ONC has included automated generation of measures requiring a percentage calculation in the certification criteria for EHRs.

**Reporting Clinical Quality Measures:** The ARRA also requires that hospitals submit to the Secretary information on clinical quality measures through EHRs as determined by the Secretary. CMS has finalized 15 clinical quality measures – on stroke care, prevention and treatment of blood clots (venous thromboembolisms), and emergency department throughput – on which hospitals must report to meet the meaningful use criteria. All of the measures have been endorsed by the National Quality Forum and the Hospital Quality Alliance; however, none of the measures is used for the Medicare pay-for-reporting program nor proposed by CMS to be implemented in the coming year.

To report on the quality measures, for FY 2011, hospitals must attest to the use of a certified EHR system to capture and calculate the results for the clinical quality measures. Hospitals also must submit the numerators, denominators and patient exclusions for each clinical quality measure and attest to the accuracy and completeness of the information submitted. Beginning in FY 2012, an eligible hospital using a certified EHR technology would be required to submit information on clinical quality measures electronically in order to be a meaningful EHR user.

In the final rule, CMS clarified that the clinical quality measures adopted for the Medicare EHR Incentive Program also will apply to the Medicaid EHR Incentive Program and did not finalize any separate quality measures for Medicaid.

**Meaningful Use Requirements for Physicians:** The meaningful use requirements for physicians and other eligible professionals (EPs) are similar to hospitals; however, there are differences in some objectives and measures. EPs will need to meet 15 “core,” or mandatory, objectives and an additional five objectives chosen from a “menu set” of 10 options, for a total of 20 objectives. Like hospitals, physicians will need to use CPOE to enter medications for more than 30 percent of patients. In addition, EPs will be required to use e-prescribing for more than 40 percent of all permissible prescriptions. Eligible professionals also will need to report on six clinical quality measures calculated from a certified EHR: three required core measures and three additional measures chosen from a set of 44 measures that have been specified for collection through EHRs.

**Reporting Period:** For FY 2011, CMS will require a shortened reporting period of any continuous 90-day period that falls within the fiscal year. This allows hospitals additional time to implement certified EHR systems and develop the capacity to meet the proposed objectives and calculate the proposed measures. The 90-day reporting period will apply for the first year a hospital attests to being a meaningful user under Medicare. In subsequent years, CMS will use a full-year reporting period.

**Start Date and Registration Process:** CMS has delayed the start of the Medicare EHR Incentive Program for hospitals until January 2011. Hospitals will be able register for the program at that time through the CMS meaningful use webpage. The first opportunity for hospitals to attest that they meet meaningful use objectives will be in April 2011.

**Attestation:** CMS finalized its proposal that hospitals use attestation to report the health IT functionality measures and list the certified EHR technology used. CMS clarified that reporting will occur through a secure CMS website, but did not provide additional operational details on the format attestation will take. CMS has already established a meaningful use webpage at <http://www.cms.gov/EHRIncentivePrograms>, where it will post updated information, including registration information and educational materials.

**Payments:** Hospital payments will be calculated by Medicare’s contractors, with an interim payment finalized upon cost report settlement. However, a single contractor will make the payments. To those who successfully meet the meaningful use criteria, CMS expects payments will be made within 15 to 46 days.

**Transition:** The final rule covers only Stage 1 of the program; therefore, CMS did not finalize its proposed transition, which would apply the Stage 1 criteria to all hospitals in their first year of meaningful use incentive payments, as long as they become eligible before 2015. In the preamble to the rule, CMS notes its intention to update the criteria for meaningful use to Stage 2 in time for the 2013 payment year, but also states that “[f]or this final rule, Stage 1 criteria for meaningful use are valid for all payment years until updated by future rulemaking.”

**Eligible Hospitals:** Subsection (d) (PPS hospitals) and CAHs are subject to the EHR incentive program incentive payments and penalties. A hospital will be identified by its Medicare provider number. Multiple hospital campuses sharing one provider number will not be identified separately for purposes of this program.

**Hospital-based Professionals:** CMS' final rule implements provisions of the AHA-supported *Continuing Extensions Act of 2010*, which made hospital-based physicians providing ambulatory services eligible for incentive payments (and subject to Medicare penalties). A hospital-based physician is defined as a physician with 90 percent or more of his/her services provided in an inpatient hospital or emergency department setting. Hospital is defined broadly (any area that is on campus or any location that meets the "provider-based" definition). CMS estimates that about 15 percent of physicians are hospital-based under the new definition, down from about 30 percent in the proposed rule. Hospital-based professionals will be required to meet the same number of objectives as other eligible professionals.

**Interaction with Medicaid:** States will run the Medicaid EHR incentive programs, which are optional for the states. Each state is responsible for establishing the timeline for its Medicaid EHR incentive program. CMS states in a fact sheet that "states will be initiating their incentive programs on a rolling basis, subject to CMS approval of the State Medicaid HIT plan."

CMS finalized its proposal that states use the Medicare definition of meaningful use as a floor, with the ability to petition CMS for approval of state-specific modifications. For Stage 1, CMS will only allow states' to tailor the definition as it pertains specifically to public health objectives and data registries. However, CMS also finalized its proposal that hospitals that qualify as meaningful users for Medicare will be "deemed" as meaningful users for Medicaid. CMS further clarified that those "deemed" hospitals "need not meet additional criteria imposed by the States."

As required by ARRA, in the first payment year, eligible Medicaid providers will qualify for the incentive payment by adopting, implementing, or upgrading to certified EHR technology. They will not need to attest to meaningful use of EHRs.

**CAHs:** In a change from the proposed rule, CMS has included CAHs as eligible for Medicaid EHR incentive payments, if they meet the volume thresholds and other Medicaid requirements. In general, hospitals must have 10 percent Medicaid patient volume (less for children's hospitals). Medicaid payments to CAHs will follow the same formula as for other acute-care hospitals, which is based on the Medicare payment formula for subsection (d) hospitals.

**Privacy:** In the final rule, CMS reiterates its position that "[w]e do not see meaningful use as an appropriate regulatory tool to impose different, additional, and/or inconsistent privacy and security policy requirements from those policies already required by HIPAA." But the agency retains in the final rule an explicit objective to "protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities" because the agency feels that "it is crucial that EPs, eligible hospitals, and CAHs evaluate the impact

certified EHR technology has on their compliance with HIPAA and the protection of health information in general.” Accordingly, the final regulations also include a related measure for this objective: to conduct or review a security risk analysis (as required by HIPAA), and implement security updates and correct identified security deficiencies.

**Impact Analysis:** CMS estimates that a total of \$9.7 to \$27.4 billion will be paid in incentive payments (net of penalties) to hospitals and physicians from 2011 to 2019. Of that, CMS estimates that hospitals should receive between \$8.4 and \$14.4 billion in Medicare and Medicaid incentives. Given uncertainty over the rate of adoption, CMS provided both a low and high estimate.

#### ONC’S FINAL CERTIFICATION CRITERIA REGULATION

In a separate rule issued yesterday, ONC finalized a definition of certified EHRs and an initial set of certification criteria, standards and implementation specifications for EHRs. The certification criteria follow the Stage 1 meaningful use objectives laid out by CMS and also require specific steps to protect the privacy and security of health information. The certification criteria apply to EHR products, not providers.

Hospitals and physicians, however, must use certified EHRs to qualify for the Medicare and Medicaid payments. ONC provides a multi-stage definition of “certified EHR technology.” In essence, providers must use either a “complete EHR,” which has been developed to meet all of the applicable certification criteria adopted by the Secretary, or a combination of EHR modules, which can be “any service, component, or combination thereof that can meet the requirements of at least one” of the certification criteria adopted by the Secretary. Providers who choose to combine multiple EHR modules are responsible for ensuring that the modules work together and that, together, they meet all of the certification criteria. The actual certification process was described in a recently released final rule from ONC.

**Certification Criteria:** ONC finalized a detailed list of certification criteria for each meaningful use objective. Of note:

- ONC includes certification criteria related to the calculation and submission of all of the clinical quality measures specified by CMS for eligible hospitals and CAHs. Although AHA and others urged ONC to include in the certification criteria that EHRs must show they can **accurately** calculate the quality measures, ONC stated in the final rule that it did not believe this was necessary.
- As recommended by the AHA, ONC clarifies in the rule that the certification criteria include automated measure calculation for each meaningful use objective with a percentage-based measure. This will dramatically lower the burden of reporting by providers and eliminate manual calculations.

**Privacy and Security:** The certification criteria continue to require capabilities related to privacy and security, such as access controls, including emergency access, and audit logs. However, ONC determined that the criterion to account for disclosures will not be a condition of EHR certification at the present time. This change was in response to

comments from the AHA and others about the significant technical and policy challenges that currently remain unresolved.

#### AHA MEMBER CALL SERIES

The AHA has scheduled a series of member calls to offer you a chance to learn more and ask questions about specific provisions of the rules. The schedule is as follows:

- Wednesday, July 28, 1 p.m. ET – Health IT Rules Overview Call
- Thursday, July 29, 3 p.m. ET – Privacy and Security Requirements
- Monday, August 2, 2 p.m. ET – Definition of “Meaningful Use”
- Wednesday, August 4, 1 p.m. ET – Reporting Clinical Quality Measures & Functionality Measures
- Thursday, August 5, 3 p.m. ET – ONC Standards & Certification Regulation
- Friday, August 6, 3 p.m. ET – Rural Considerations
- Monday, August 9, 4 p.m. ET – Physician Considerations

AHA members can register for any of these calls at <http://www.surveymonkey.com/s/ZV26JMH>.

**Table 1: Stage 1 Objectives and Measures for Eligible Hospitals and Critical Access Hospitals**

OBJECTIVES	MEASURES
<b>Core Set:</b> <i>Hospitals must achieve all of the following objectives and meet the required threshold</i>	
<b>C1</b> Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE
<b>C2</b> Implement drug-drug and drug-allergy interaction checks	The eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
<b>C3</b> Record demographics <ul style="list-style-type: none"> <li>• Preferred language</li> <li>• Gender</li> <li>• Race</li> <li>• Ethnicity</li> <li>• Date of birth</li> <li>• Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH</li> </ul>	More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
<b>C4</b> Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data
<b>C5</b> Maintain active medication list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
<b>C6</b> Maintain active medication allergy list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data

<b>OBJECTIVES</b>	<b>MEASURES</b>
<b>C7</b> Record and chart changes in vital signs: <ul style="list-style-type: none"> <li>• Height</li> <li>• Weight</li> <li>• Blood pressure</li> <li>• Calculate and display BMI</li> <li>• Plot and display growth charts for children 2-20 years, including BMI</li> </ul>	For more than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data
<b>C8</b> Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data
<b>C9</b> Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule
<b>C10</b> Report hospital clinical quality measures to CMS or the States	For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of this final rule
	For 2012, electronically submit the clinical quality measures as discussed in section II(A)(3) of this final rule
<b>C11</b> Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	More than 50% of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days
<b>C12</b> Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it
<b>C13</b> Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information
<b>C14</b> Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

OBJECTIVES	MEASURES
<b>Menu Set:</b> Hospitals must achieve 5 of the following objectives and meet the required threshold to include at least one public health reporting measure (M8, M9, M10)	
<b>M1</b> Implement drug-formulary checks	The eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
<b>M2</b> Record advance directives for patients 65 years old or older	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded
<b>M3</b> Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
<b>M4</b> Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition
<b>M5</b> Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources
<b>M6</b> The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)
<b>M7</b> The eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral	The eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals
<b>M8</b> Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information have the capacity to receive the information electronically)

<b>OBJECTIVES</b>	<b>MEASURES</b>
<b>M9</b> Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which the eligible hospital or CAH submits such information have the capacity to receive the information electronically)
<b>M10</b> Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive the information electronically)

**Table 2: List of Stage 1 Meaningful Use Clinical Quality Measures**

<b>Condition</b>	<b>Measure Name</b>
Emergency Department Throughput	Median time from ED arrival to ED departure for admitted patients
	Admission decision time to ED departure time for admitted patients
Stroke	Discharge on anti-thrombotics
	Anticoagulation for A-fib/flutter
	Thrombolytic therapy for patients arriving within 2 hours of symptom onset
	Anti-thrombotic therapy by day 2
	Discharge on statins
	Stroke education
	Rehabilitation assessment
Venous Thromboembolism (VTE)	VTE prophylaxis within 24 hours of arrival
	Intensive care unit VTE prophylaxis
	Anticoagulation overlap therapy
	Platelet monitoring on unfractionated heparin
	VTE discharge instructions
	Incidence of potentially preventable VTE