



Initial Commentary on Meaningful Use Final Rule

November 1, 2010

Prologue

The [American Recovery and Reinvestment Act of 2009](#) (ARRA) includes billions of dollars in Medicare and Medicaid incentive payments for the "Meaningful Use" of certified Electronic Health Record (EHR) technology. Specifically, the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions within ARRA required the Secretary of Health and Human Services (HHS) to develop a program for incentive payments for eligible professionals (EPs), eligible hospitals (EHs), and Critical Access Hospitals (CAHs) that demonstrate the "meaningful use of certified EHR technology."

Following a Notice of Proposed Rule Making (NPRM) period with more than 2,000 responses, the Centers for Medicare and Medicaid Services (CMS) completed and released a [Medicare and Medicaid EHR Incentive Program Final Rule](#) based on input received that identifies the criteria for becoming a meaningful user of certified EHR technology. The CMS Final Rule on Meaningful Use became effective on September 27, 2010, 60 days after publication in the *Federal Register*. Registration for EP and EH programs will begin on January 1, 2011.

Background

Providing impactful financial incentives for providers to transform healthcare through the best use of IT products has long been a core principle of HIMSS as detailed in our [Principles on Government Initiatives](#). The final rule on Meaningful Use (MU) identifies 15 criteria that must be met by EPs and 14 for EHs. In addition, there are 10 "menu" criteria. From these 10 criteria, EPs and EHs can defer up to five criteria to Stage 2. Both must include one public health criterion for Stage 1.

For their first year of eligibility under Medicare, EPs and EHs will have to attest to having used certified EHR technology for 90 consecutive days in their applicable reporting year, with CMS readiness for first attestations to begin in April 2011. EPs will have to report on the specific meaningful use measures met as well as summary data on applicable quality measures. For those seeking Medicaid incentives, it will only be necessary to demonstrate adoption, implementation or upgrade of certified EHR technology in the first year of incentive payments. Future years will require meaningful use for 365 days and likely electronic reporting of quality measures from the EHR.

HIMSS Initial Commentary

Based on extensive and detailed comments received in response to the NPRM, HHS reduced the meaningful use achievement levels in the Final Rule while maintaining a robust and forward-looking set of requirements. HIMSS notes several changes within the Final Rule that were of interest to our members during review of the NPRM, including:

- **Elimination of the “all or nothing” approach to meaningful use**, allowing some flexibility for providers with core and menu objectives and measures.
- **Computerized Provider Order Entry (CPOE) for EPs:** Reduced from 80% to 30% and otherwise refined – Anticipated to be 60% in Stage 2.
- **CPOE for EEs and CAHs:** Threshold changed from 10% to 30% and now includes only Medication Orders – Anticipated to be 60% in Stage 2.
- **E-Prescribing:** EPs were required to electronically prescribe 75% of their prescriptions in the NPRM. The final rule for Stage 1 calls for 40%. The percentage is expected to increase in Stage 2.
- **Clinical Decision Support:** Reduced the number of rules from five to one.
- **Provide patients with an e-copy of their health information:** Changed from 48 hours to 72 hours and reduced threshold from 80% to 50% of patients *who request an electronic copy*.
- **Provide patients with an e-copy of their discharge summaries:** Changed from 80% to 50% of all patients who are discharged from an EE or CAH *who request an electronic copy*.
- **Enhanced definition of hospital-based professionals** that greatly increased the number of EPs.

Several items were maintained at proposed rule levels – with clarifications on the definitions – including problem lists, medication lists, medication allergy lists, and quality reporting requirements.

Of all the federal health IT rules, MU has received by far the most attention by both government and the private sector. Overall, HIMSS was pleased that HHS responded to input submitted on the NPRM, including elimination of the “all or nothing” approach to meaningful use, with requirements made more flexible with both core and menu measures. **Based on the requirements clarified in the Final Rule, initial hospital data findings from HIMSS Analytics indicate that the majority of EEs should have the technical capability to achieve Stage 1 MU prior to the enactment of Stage 2.**

HIMSS Concerns

As is always the case with new regulations, there has been a need to issue clarifications, corrections, and FAQs. Though CMS has moved quickly, recognizing the need for providers to make critical decisions on acquiring and implementing certified EHR technology, the time constraints have proven to be very tight. **HIMSS encourages CMS and ONC to continue issuing timely clarifications.** For example, providers need sufficient time to make critical decisions on acquiring and implementing EHRs based on applicable incentive timelines and the associated implications of non-compliance. Vendors need sufficient time to make decisions on product development in response to new information.

Although generally positive on the MU Final Rule, HIMSS does have some continuing concerns and suggestions:

1. **Providers need a simple, consolidated communication tool spanning both ONC and CMS rules, and other communication tools that show all key information in a simpler format.** HIMSS encourages ONC and CMS to collaborate on providing one chart/tool that shows the meaningful use criteria, objectives, certification criteria, associated standards, NIST test scripts as well as any key information (e.g. who can enter orders, patient list needs to show the following data, etc). This is needed for all stakeholders to be able to more quickly assess the scope and details and feel confident that they have the full picture. This tool should be updated based on content that is provided in advisory documents and FAQs. Today, a provider needs to read all three rules, the CMS advisories, and all of the FAQs to have a complete picture. In addition, the CMS and ONC FAQs are updated regularly so providers need to continually check back for any new information. When multiplied by thousands of hospitals and EPs across the country, time would be well spent to make the communication of this complex topic as accessible and comprehensible as possible. The tool will provide consolidated information in one location so that providers understand what they need to do to achieve MU.
2. **There is insufficient lead time between the publishing of the final rules and the dates when providers need to become meaningful users.**
3. **We urge HHS to utilize long-standing non-profit societies with health IT knowledge and content expertise to augment the work of the Regional Extension Centers (RECs) and the Health Information Technology Resource Center (HITRC) to help provide the needed education to assist its targeted providers in meeting meaningful use within its funding timeline.**
4. **HIMSS believes that more clarity is needed on how a provider could be exempt from a public health reporting requirement** if applicable public health organizations cannot receive submissions electronically.
5. **Providers need more education on applicable incentive timelines and the associated implications for non-compliance.**
6. **HIMSS recommends that HHS issue guidance and funding to the states to begin implementing the state loan program for EHRs as required by HITECH.** At this time, HIMSS has concerns that state governments have not received guidance on implementation of these financing mechanisms (loans) for EHRs.

HIMSS Recommendations

Looking toward MU Stages 2 and 3, **HIMSS recommends that HHS publish definitional criteria for each new Stage of Meaningful Use at least 18 months before implementing the next stage.** Fundamentally, providers and vendors need far more time than has been publicly forecast by ONC and CMS between when MU Stage 2 and certification criteria are finalized and when the next stage

begins. Given some likely challenges with meeting this timing, we urge CMS to consider several approaches that can help mitigate this issue, such as:

- Allowing the early adopters (providers that achieved MU in FY11) to remain at Stage 1 for FY13;
- Looking to possible Congressional action to remove the Medicare program requirement that meaningful use years must be consecutive (there is no such requirement in the Medicaid program);
- Shifting from three stages to two stages in the timeframe between now and 2015;
- Accelerating the regulatory process; and
- In Stage 2 criteria, granting providers an opportunity to increase the use of functionality introduced in Stage 1, rather than focus on increasing functionality.

HIMSS notes that, as the largest health profession in the United States, nurses represent the greatest number of potential users of certified EHR technologies. For example, in most hospitals, nurses provide 90% of patient care. Consequently, a large portion of the patient care documented in the EHR is completed by nurses. Therefore, **HIMSS recommends including patient-centered nursing care objectives and measures in MU Stage 2.**

In addition, **more transparency would be helpful in the area of quality measures.** There are indications that there will be a significant increase in the number of quality measures for Meaningful Use Stage 2. Transparency around the process to develop new measures, identify existing measures, development of e-measure specifications and the discussions on which measures to include in Stage 2 would be helpful. This transparency would allow stakeholders to engage early in the processes. In addition, new quality measures must be finalized and released in the same 18-month timeframe as is needed for meaningful use and certification criteria given the fact that such measures often require substantial revision in: EHR data models, user interfaces and other elements; integration with non-EHR systems; and provider workflow changes.

HIMSS would also like to point out a number of gaps in the HITECH legislation and in the MU Final Rule. We recognize that some of the legislative gaps reflect budgetary realities. We also recognize that some of these items are currently being considered by the U.S. Congress in proposed legislation, and other items should be considered soon. The major gaps include the facts that:

- (Legislative Gap) Under the ARRA legislation, the main focus is on physicians, hospitals and ambulatory practices; however, there are many healthcare professionals and settings that are not eligible for the incentive programs. **Congress may want to revisit the eligible settings and professionals;**
- (Legislative Gap) **Congress needs to address the fact that, in some cases, multiple hospitals share a single CMS Certification Number (CCN), thereby reducing the incentives available for each individual hospital;** this reality constrains Congressional intent;

- (Legislative Gap) The Secretary of HHS, under the direction of the U.S. Congress, **needs to establish an informed patient identity solution**. As part of this solution, steps need to include: a) Congressional lifting of the prohibition against HHS studying Unique Identifier (UI) solutions; b) HHS conducting a study of the cost/benefit and practicality of implementing a UI solution; and, c) HHS establishing pilot implementations of unique identifiers to document the challenges and benefits;
- (Regulatory Gap) To ensure that measures have been adequately specified and tested before requiring them for MU, **CMS and ONC need to implement an aggressive quality measures testing program**; and,
- (Regulatory Gap) There is a need to **move aggressively with CMS's stated intention to align EHR incentive program quality reporting requirements with other Federal reporting/incentive programs**.

Closing Remarks

HIMSS was a supporter of the ARRA HITECH legislation and continues to be optimistic about its potential to enhance the U.S. healthcare system through increased adoption and meaningful use of certified EHRs and other health IT. We offer our concerns and recommendations as constructive contributions to the always-necessary process to enhance implementation of legislation and associated regulations. HIMSS stands ready to help this process in any way we can.

HIMSS is a cause-based not-for-profit organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare. Founded 50 years ago, HIMSS and its related organizations have offices in Chicago, Washington, DC, Brussels, Singapore, Leipzig, and other locations across the United States. HIMSS represents more than 30,000 individual members, of which more than two-thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes over 470 corporate members and more than 85 not-for-profit organizations that share our mission of transforming healthcare through the effective use of information technology and management systems. HIMSS frames and leads healthcare practices and public policy through its content expertise, professional development, and research initiatives designed to promote information and management systems' contributions to improving the quality, safety, access, and cost-effectiveness of patient care.

The Society is now updating its Public Policy Principles and Call for Action documents to share our members' most impactful recommendations with the 112th Congress starting in January 2011. We will continue to evolve our commentary and positions, and to communicate our members' opinions for consideration in all federal and state policy discussions.

HIMSS believes that by linking health IT principles based on our members' needs and experiences, we will help our nation successfully transform healthcare through the best use of IT. Questions on this Initial Commentary document should be addressed to Dave Roberts, MPA, FHIMSS, HIMSS Vice President for Government Relations, at 703-562-8811 or via email at droberts@himss.org.