

# UPDATE ON MEANINGFUL USE



## Overview of Proposed Changes and Clarifications to Meaningful Use

A proposed rule for meaningful use incentives was released on December 30, 2009. The basic shape of the meaningful use incentives is unchanged, but there are some new details and clarifications:

- In the first qualifying year, only three months of meaningful use is required to qualify for incentive payments.
- Except for 2015, in the first qualifying year the incentives will be based on meeting Stage 1 criteria
- There will be criteria to measure use of all the capabilities for meaningful use (not just selected measures or quality reporting).
- In 2011, all meaningful use will be by attestation; in 2012 in addition to attestation, quality data will be required to be submitted electronically.
- Hospital-based physicians will be determined by place of service (POS) codes; individual hospitals will be distinguished by CCN codes.

## Introduction

The HITECH provisions of the American Recovery and Reinvestment Act of 2009 provide billions of dollars in incentives for the adoption and use of Health Information Technology (HIT) by Medicare and Medicaid providers over the next ten years.

To receive the financial incentives, eligible professionals and hospitals must achieve “Meaningful Use” of an electronic health record (EHR). On December 30, 2009 the Centers for Medicare & Medicaid Services (CMS) released an advanced copy of a notice of proposed rulemaking defining the requirements for meaningful use, the measures and the details of how eligible providers and hospitals will be paid the incentive dollars. The requirements are substantially the same as those approved by the Office of the National Coordinator (ONC) policy committee in July of 2009. Meaningful use requirements are still grouped into three stages but the designations are no longer tied to dates (2011, 2013 and 2015): In Stage 1, the focus is on capturing data, in Stage 2 on reporting health information and tracking key clinical conditions, and in Stage 3 on improving performance and health outcomes. The notice of proposed rulemaking released on December 30 details only Stage 1 requirements, but provides some commentary on what will be included in Stage 2. The rules are available at <http://healthit.hhs.gov/portal/server.pt>

One major change in the recently released proposed rules is that hospitals and providers would be able to qualify for their first payment using Stage 1 criteria up until 2014. In the first payment year only 3 months of meaningful use needs to be demonstrated to receive incentive payments, while in future years meaningful must be demonstrated for the entire year. To get the maximum Medicare payments, eligible providers need to qualify by CY 2012 and hospitals by FY 2013. Both physicians and hospitals also need to meet Stage 3 criteria by 2015 to avoid Medicare penalties. Physicians who provide more than 90 percent of their care in a hospital inpatient, hospital outpatient or ED (point of service codes 21, 22, and 23) are not eligible for incentives. Eligible hospitals are defined by their unique CMS Certification Number (CCN or OSCAR codes). More details related to qualification and payments are provided in the companion white paper [Update on Incentives](#).

## Industry Impact

The financial incentives in the stimulus bill provide a landmark opportunity for eligible organizations and professionals who desire a fully integrated EHR but struggle with funding and with barriers to sharing information effectively. We believe that there are four key requirements to achieve the right outcomes from an EHR:

1. Setting the right EHR goals
2. Purchasing the right EHR product
3. The right implementation of the EHR
4. The right use of the EHR by caregivers

## The Right Goals

The goal in implementing an EHR is to improve patient care. This is a major undertaking involving massive changes that will touch everyone in the organization. Busy providers will rally around the cause of safer, more efficient care. At best, they are willing to “go along with” a change that provides an extra payment to the hospital. This is especially true of community physicians who need to take time away from their practice (and their income) to lead the change, receive training and optimize use.

## The Right Product

Purchasing the right EHR product is an essential requirement for achieving meaningful use. First, the product must be certified as providing the capabilities and complying with the standards for meaningful use. The product must also provide the applications and features to meet the quality and efficiency goals (including but not limited to the proposed Stage 1 requirements), and it must be designed to be useable by physicians. For example, even though not required in Stage 1, if an EHR does not provide the capability to check orders for the right dose based on renal function, then use of computerized physician order entry (CPOE) will not address one of the top ten causes of preventable adverse drug events. If drug-drug alerts are turned off because they “over-alert”, you will not qualify as a meaningful user; and obviously, if the system is not used because it creates inefficiencies, no benefits will accrue. Note that certification ensures that the capabilities will be available, but the user must still evaluate if they are integrated and can be used efficiently. Certification can be either for a complete EHR or modules of an EHR acquired from different vendors, and certification will be available for products developed by the hospital as well as those purchased from vendors.

## The Essential Capabilities

The table below summarizes the essential capabilities and the measures of use that need to be demonstrated in Stage 1 to receive incentive payments. Each requirement has an associated measure. The percentages indicated apply to all patients—not just Medicare and Medicaid patients. In 2011, all meaningful use will be demonstrated by attestation; in 2012, in addition to attestation, quality data will be required to be submitted electronically. Also note that in many cases data must be coded according to standards released by the ONC.

Requirement	Eligible Professionals	Hospitals	Notes
CPOE	80 percent of all orders	10 percent of all orders	In Stage 1, electronic <b>communication</b> of orders is only required for e- prescribing; will expand in Stage 2
Drug-drug, drug allergy, drug formulary checking	All capabilities enabled	All capabilities enabled	The capability needs to be enabled and information displayed at the point of care
Maintain up-to-date problem list	80 percent of patients have at least one entry or indication of no problems	80 percent of patients have at least one entry or indication of no problems	Structured data required; measure is of unique patients not visits or admissions
Generate and transmit e-Rx	At least 75 percent permissible Rx transmitted electronically	N/A	Excludes controlled substances
Maintain active medication and allergy list	80 percent of patients seen have at least one entry or indication of “none”	80 percent of admitted patients have at least one entry or indication of “none”	Requires structured data; applies to unique patients, not visits/admissions

*Table continues*

Table continued from previous page

Requirement	Eligible Professionals	Hospitals	Notes
Record demographics	80 percent of patients seen have gender, race, DOB, ethnicity, preferred language, insurance recorded	80 percent of patients admitted have gender, race, DOB, ethnicity, preferred language, insurance and cause of death recorded	
Record vital signs	80 percent of patients 2 years and older have BP and BMI; growth chart for ages 2 – 20	80 percent of patients 2 years and older have BP and BMI; growth chart for ages 2 – 20	
Record smoking status	80 percent of patients over 13 seen	80 percent of patients over 13 admitted	
Incorporate test results into EHR	50 percent of results expressed as a number or positive/negative	50 percent of results expressed as a number or positive/negative	Changed to apply only to lab results; will be expanded in Stage 2
Generate list of patients with specific conditions	Generate at least one report	Generate at least one report	
Report quality measures to CMS and the States	For 2011 capture required data electronically and provide aggregate numerator and denominator by attestation, for 2012 and beyond submit electronically	For 2011 capture required data electronically and provide aggregate numerator and denominator by attestation, for 2012 and beyond submit electronically	List of required measures included in II (A)(3), Tables 3 through 21 of the NPRM
Send reminders for preventive/follow up care	Send reminders (per patient preference) for preventive/follow up care to 50 percent of patients age 50+		
Implement clinical decision support rules related to clinical priority, track compliance	Implement five rules and track compliance	Implement five rules and track compliance	
Check insurance eligibility	Check eligibility electronically for 80 percent of patients seen	Check eligibility electronically for 80 percent of patients admitted	
Submit claims electronically	File 80 percent of claims electronically	File 80 percent of claims electronically	Includes public and private payers
Provide patients with their health information on request	80 percent of patients who make the request receive it within 48 hours: test results, problem list, med list, allergies	80 percent of patients who make the request receive it within 48 hours: test results, problem list, med list, allergies, discharge summary, procedures	
Provide Patients with discharge information	N/A	80 percent of patients who request receive electronic copy of discharge instructions	
Provide access to clinical summaries	Clinical summaries provided for 80 percent of office visits	N/A	

Table continues

Table continued from previous page

Requirement	Eligible Professionals	Hospitals	Notes
Provide timely access to new results	10 percent of all patients seen receive access to lab results, problem list, medication and allergy lists within 96 hours of provider's receipt	N/A	
Exchange meaningful clinical information with care team	One test of capability to exchange key clinical information (see list above)	One test of capability to exchange key clinical information	Exchange must be between different clinical entities using different certified EHRs – cannot share EHR
Perform medication reconciliation	Provide at 80 percent of encounters and care transitions	Provide at 80 percent of encounters and care transitions	
Provide summary record at transitions in care and referrals	Provide summary care record at 80 percent of transitions in care and referral	Provide summary care record at 80 percent of transitions in care and referral	
Information to immunization registries submitted electronically	Capability to submit data to immunization registries and submission where required and accepted	Capability to submit data to immunization registries and submission where required and accepted	Must be at least one test of the capability to submit, submission will be required in Stage 2
Reportable lab results submitted electronically	N/A	Capability to electronically submit reportable lab results to public health agencies, submission where it can be received	Must be at least one test of the capability to submit if public health agencies are capable of accepting, submission will be required in Stage 2
Electronic reporting of syndromic surveillance data	Capability to submit electronic syndromic surveillance data, actual submission where possible	Capability to submit electronic syndromic surveillance data, actual submission where possible	One test of capability to submit if public health agencies are capable of accepting, submission will be required in Stage 2
Protect security and confidentiality	Conduct review of security risk per 45 164.308; implement updates as necessary	Conduct review of security risk per 45 164.308; implement updates as necessary	Must be done at least once during the qualifying period

There were many minor changes to the description of capabilities that must be in practice to demonstrate meaningful use but the overall requirements are similar to those proposed last summer. Some of the clarifications and changes are:

- For eligible providers and hospitals, CPOE requires that the provider directly enter all medical orders (e.g., medications, consultations, laboratory services, imaging services) but only requires electronic transmission for permissible pharmacy prescriptions in the ambulatory environment.
- The requirement to record body mass index was clarified to only apply for ages 2 and over, for patients aged 2 – 20 the requirement for growth charts was added.
- The requirement to record smoking status was clarified to be required for ages 13 and older.
- Reporting quality measures was expanded to include reporting to the States.
- The requirement for implementing clinical decision support rules relevant to high clinical priorities was increased from one rule to five rules in Stage 1 and the requirement to track compliance with the rule was added.
- The requirement to document a progress note for each ambulatory encounter was dropped since this is already a medical-legal requirement.

- The requirement to check insurance eligibility was strengthened to require electronic checking and eliminating the caveat “where possible”.
- All requirements for electronic access or delivery of information to patients now state that the disclosure could be through a personal health record (PHR), a patient portal, a CD or a USB drive.
- The requirement to provide access to patient-specific educational resources was eliminated.
- An objective was added to require exchange of a summary care record at each transition in care **or referral**.

## Right Implementation

Organizations satisfying meaningful use requirements must implement qualified EHRs in such a way that the staff can make full use of its capabilities.

The right implementation involves setting goals for benefits and adjusting processes and organizational governance to achieve those goals. It is essential to recognize that achieving meaningful use of an EHR system is a large-scale clinical change project involving significant changes in care delivery that must be clinician-led.

## Right Use

To meet the meaningful use requirements, all organizations must implement an EHR so that it is incorporated into the routine care process. This key area speaks to the effective use by clinical professionals for the purpose of delivering quality care and service.

We recommend that the “right use” of a qualified EHR is demonstrated by the following levels of adoption:

- Equal to or greater than 90 percent of care-related electronic tasks are completed by clinical professionals utilizing the EHR (e.g., entering medication orders and/or documenting problems and allergies).
- Direct evidence of role-based use by clinicians (e.g., physician order entry, e-prescribing, registered nurses documenting medication administration, pharmacist electronically sending pharmacy alerts to physician team, respiratory therapist electronically entering and reporting ventilator bundle checks each shift, etc.).
- Direct evidence of quality reporting fed by electronic clinical documentation.
- Integration with the revenue cycle process (e.g., appropriate interfaces must be established and documentation should feed charge capture rather than requiring a separate electronic step in the charging process).
- Monitoring evidence of benefit (e.g., the number of alerts that result in a change in orders, the number of nursing hours spent in compiling quality data, the number of chronic care patients that meet the criteria for appropriate care).

## Recommendations

- Plan to start working on meaningful use immediately. There have already been opportunities to comment on the requirements (public comments on the proposed rule are due by March 13, 2010). There were few substantive changes in the requirements for meaningful between the recommendations from the ONC policy committee in July and the CMS notice of proposed rulemaking in December. We do not expect that major changes will be made based on comments on the proposed rule.
- Don't be lulled into thinking you can slow the pace of achieving meaningful use because of the more generous schedule. If you qualify using Stage 1 criteria in 2013, you then have to meet Stage 2 in 2014 and Stage 3 in 2015. Being a meaningful user in 2015 is essential to avoid Medicare penalties.

- Start now to fill gaps based on the proposed requirements. If you have not yet implemented CPOE, start now. This is a large-scale change project that has to be done right and will take time.
- Independent of the meaningful use requirements, implement CPOE with evidence-based order sets and meaningful decision support at the point of care from the start. Order sets greatly reduce the time for ordering and reinforce evidence-based practice. Without meaningful decision support, the physician will be acting as transcriber and not perceive any added value from CPOE.
- The basis for meaningful use is a certified system, interim certification is available now, and the standards for systems have already been published as an interim final rule. Individual modules can be certified as well as full EHRs. Make sure the vendors you plan to use to meet meaningful use have defined plans to be certified and that their schedule meets your needs.

### **About CSC's Healthcare Group**

*We help our customers realize superior performance by enhancing the quality of care delivery and clinical outcomes through interoperable, standards-based information systems and optimized management processes.*

### **About CSC**

*The mission of CSC is to be a global leader in providing technology-enabled business solutions and services.*

*With the broadest range of capabilities, CSC offers clients the solutions they need to manage complexity, focus on core businesses, collaborate with partners and clients, and improve operations.*

*CSC makes a special point of understanding its clients and provides experts with real-world experience to work with them. CSC is vendor-independent, delivering solutions that best meet each client's unique requirements.*

*For 50 years, clients in industries and governments worldwide have trusted CSC with their business process and information systems outsourcing, systems integration and consulting needs.*

*The company trades on the New York Stock Exchange under the symbol "CSC."*

### **Healthcare Group**

1160 West Swedesford Road  
 Building One, Suite 200  
 Berwyn, Pennsylvania 19312  
 +1.800.345.7672  
[www.csc.com](http://www.csc.com)

Copyright © 2010 Computer Sciences Corporation. All rights reserved.

WA10\_0004  
 January 2010

### **About the Authors**

David Classen, M.D., M.S., is a Senior Partner at CSC and an Associate Professor of Medicine at the University of Utah. Erica Drazen is Managing Director of CSC's Emerging Practices group. Emerging Practices is the applied research arm of CSC's Healthcare Group.

For more information on the definition of meaningful use, please contact [dclassen@csc.com](mailto:dclassen@csc.com), [edrazen@csc.com](mailto:edrazen@csc.com) or [healthcaresector@csc.com](mailto:healthcaresector@csc.com).

### **Transforming Healthcare with Better Information for Better Decisions**