

UPDATE ON MEANINGFUL USE: THE FINAL RULE

The Final Meaningful Use Rule: Overview of Changes and Clarifications to Meaningful Use

The final rule for meaningful use incentives for 2011 and 2012 was released on July 13, 2010. Most of the meaningful use requirements are unchanged from the draft released in January, but some thresholds have been reduced and significant flexibility has been added that will make the transition to EHRs more feasible for many providers.

- CMS received over 2,000 comments on the proposed rule.
- For 2011 and 2012, the requirements for meaningful use incentives are divided into 15 mandatory requirements for eligible providers and 14 mandatory requirements for hospitals plus a menu of ten additional requirements of which five need to be met.
- Two new optional requirements have been added.
- The requirements for electronic eligibility checking and claims submission have been deferred.
- The percentage of patients that are required to qualify as a meaningful user have been lowered for many (but not all) criterion.
- The quality reporting requirements have been scaled back.
- Emergency department patients are included in the hospital requirements.

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 10 years.

To receive the financial incentives, eligible professionals and hospitals must achieve “Meaningful Use” of a certified electronic health record (EHR). On July 13, 2010, the Centers for Medicare & Medicaid Services (CMS) released the final rule defining the requirements for meaningful use in 2011 and 2012. The requirements are substantially the same as those proposed in January, but only 15 core requirements are now mandatory for eligible providers and 14 are mandatory for hospitals. Five additional requirements must be selected from a “menu” of ten additional requirements. At least one of the selected menu requirements must relate to public health. (In the previous version, eligible providers had 25 mandatory requirements and hospitals had 23, so the number of requirements has decreased and the flexibility increased.) Many of the targets for the percentage of patients that must meet the requirements have also been lowered. Two additional “menu” requirements have been added. One significant change is that the hospital requirements now apply to emergency department (ED) patients as well as inpatient admissions. To qualify for incentives, hospitals and eligible providers must be using certified systems—and to be certified the systems must be capable of meeting all the final requirements and to report on all the required measures. Therefore, the requirements for vendor products have increased. The final rule is available at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

The final rule that was released on July 13 only covers Stage 1 requirements for 2011 and 2012. To get the maximum Medicare payments, eligible providers need to qualify by CY 2012 and hospitals by FY 2013. Medicare incentives are still limited subsection “d” hospitals and non-hospital-based physicians. The Medicaid incentives are available to all acute care hospitals and to a broader range of providers. More details related to qualification and payments are provided in our 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 final rule on the certification process was issued in June, and the Office of the National Coordinator expects to have organizations ready to certify products in a few months. (See our [Update on Certification](#) white paper for more details.) The requirements will increase every 2 years, with updates currently scheduled to go into effect in 2013 and 2015. It is important to evaluate the future development plans of each vendor to help ensure that they will remain certified in the future. Every system must meet current certification requirements (in 2013 Stage 2 requirements), independent of the stage of meaningful use for which the user is qualifying.

It is also important to keep in mind that the final rule for meaningful use establishes the minimum requirements, and purchasers may want to go beyond these requirements to maximize the value from their EHR systems. 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. Although use of bar-coded medication administration checking is also not required in Stage 1, it is important to close the loop for medication safety because this is the last chance to catch an error before it reaches the patient, and information on medications administered are required for some quality reporting. Note also that certification ensures that the capabilities will be available, but the user must still evaluate if they are integrated and can be used efficiently. If drug-drug alerts are turned off because they “over-alert,” users will not qualify for incentive payments, and obviously, if the system is not used because it creates inefficiencies, no benefits will accrue.

The Stage 1 Capabilities for 2011 and 2012

The final requirements for qualifying as a meaningful user of an EHR in 2011 and 2012 are summarized in the following table. Major changes from the proposed rule are included under the notes column. Each requirement has an associated measure. Many of the measures have been changed so that they can be reported from the EHR. Most measures are now based on unique patients seen during the reporting period; certified systems will be required to have the capability to report on all the required measures. The percentages indicated apply to all patients—not just Medicare and Medicaid patients. In 2011, all meaningful use requirements will be demonstrated by attestation; in 2012, in addition to attestation, quality data will be required to be submitted electronically. Also note that data must be coded according to final standards released on July 13.

The final rule has 15 core (mandatory) requirements for eligible providers and 14 mandatory requirements for hospitals. There are ten additional “menu” requirements for hospitals and eligible providers; meaningful users must meet at least five of the menu/optional requirements including at least one public health measure.

The biggest expansion in the final rule is that the hospital measures now cover both patients treated in the ED as well as those admitted as inpatients. The only exception is the requirement for recording whether there is an advanced directive. Because of the high volume of patients seen in the ED, this essentially means that the ED must have a certified system with all the capabilities required for meaningful use. Note also that the measures apply to unique patients—patients

seen at least once during the reporting period. This was intended to make reporting from the EHR feasible and to eliminate manual counts of the number of orders, number of smokers, etc. To be certified, systems will need to demonstrate that they can report all the requirements measured from the EHR. Some measures only apply to patients whose records are maintained in the EHR. However, the requirements for maintaining an active problem list, medication list and medication allergy list must be met by 80 percent of all patients. Therefore, at least 80 percent of all patients must have records maintained in the EHR.

The new rules accommodate providers whose scope of service make a requirement not applicable to their practice. For some measures, a provider can petition to be excluded from a requirement if it is not applicable to their practice. They can also report a result of zero if they have no patients who qualify for the measure. Eligible providers are exempt from CPOE and e-prescribing requirements if they write fewer than 100 prescriptions during the reporting period.

Requirement	Eligible Professionals	Hospitals	Notes
Core Requirements			
CPOE for medication orders	More than 30 percent of all patients seen during reporting period with medication orders have at least one order placed using CPOE. Exclusion for EPs who write less than 100 prescriptions.	More than 30 percent of all patients seen during reporting period with medication orders have at least one order placed using CPOE	Changed from 10 percent of all orders for hospitals and 80 percent of all orders for eligible providers. CPOE must be a direct entry by a licensed professional authorized to enter orders in a medical record.
Drug-drug, drug-allergy checking	Capabilities enabled during the entire reporting period.	Capabilities enabled during the entire reporting period	Requirement for drug formulary checking moved to a “menu”/optional requirement
Maintain up-to-date problem/diagnosis list	More than 80 percent of patients have at least one entry as structured data or indication of no problems or diagnosis.	More than 80 percent of unique patients have at least one entry as structured data or indications of no problems or diagnosis	Can be coded by someone other than the provider
Generate and transmit e-Rx	More than 40 percent of permissible Rx transmitted electronically using an EHR.	N/A	Requirement reduced from 75 percent. Exclusion for those who write under 100 prescriptions.
Maintain active medication list	More than 80 percent of patients seen have at least one entry as structured data or indication of no medications.	More than 80 percent of unique patients have at least one entry as structured data or entry of no medications	
Maintain active allergy list	More than 80 percent of patients seen have at least one entry as structured data or indication of no allergies.	More than 80 percent of unique patients have at least one entry as structured data or indication of no allergies	
Record demographics	More than 50 percent of patients seen have gender, race, DOB, ethnicity and preferred language recorded as structured data.	More than 50 percent of patients admitted have gender, race, DOB, ethnicity, preferred language and date and preliminary cause of death recorded as structured data	Requirement reduced from 80 percent; insurance no longer a required demographic

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Requirement	Eligible Professionals	Hospitals	Notes
Core Requirements			
Record vital signs	More than 50 percent of patients 2 years and older have height, weight, BP and BMI; growth chart for children (2-20); recorded as structured data.	More than 50 percent of patients 2 years and older have height, weight BP and BMI; growth chart for children (2-20); recorded as structured data.	Requirement reduced from 80 percent.
Record smoking status	For 50 percent of patients over 13.	For 50 percent of patients over 13.	Requirement reduced from 80 percent.
Report quality measures to CMS and the states	For 2011, capture required data electronically and provide aggregate numerator, denominator and exclusions by attestation. For 2012 and beyond submit electronically.	For 2011, capture required data electronically and provide aggregate numerator, denominator and exclusions by attestation. For 2012 and beyond submit electronically.	Requirement reduced to 15 required measures for hospitals and three required and three selected measures for EPs. State reporting for applicants for Medicaid incentives only.
Implement clinical decision support rules related to clinical priorities and track compliance	Implement one rule.	Implement one rule.	Requirement reduced from five to one; tracking compliance no longer required for Stage 1.
Provide clinical summaries for each office visit	Clinical summaries provided for more than 50 percent of office visits within 3 business days (can be paper copies).		Requirement reduced from 80 percent; visit summary timing requirement changed from 48 hours to 3 business days.
On request, provide discharge electronic instructions for discharged patients		Electronic Instructions provided at discharge for more than 50 percent of ED and hospitalized patients who request it.	Requirement reduced from 80 percent.
On request, provide patients with electronic copies of health information maintained in the EHR	More than 50 percent of patients who make the request receive copies within 3 business days: test results, problem list, medication list, medication allergies.	More than 50 percent of patients who make the request receive copies within 3 business days: test results, problem list, medication list, medication allergies, discharge summary.	Requirement reduced from 80 percent to 50 percent; time extended from 24 hours to 3 business days.
Implement capability to electronically exchange key clinical information among providers and with patient-authorized entities	Perform at least one test of capability to electronically exchange key clinical information.	Perform at least one test of capability to electronically exchange key clinical information.	Exchange must be between different legal entities using distinct EHR systems.
Ensure privacy and security of personal health information	Conduct security risk analysis, implement updates as necessary, correct deficiencies.	Conduct security risk analysis, implement updates as necessary, correct deficiencies.	
“Menu” of Optional Requirements – Five Required for Meaningful Use			
Incorporate test results into EHR as structured data	More than 40 percent of lab results expressed as a number or positive/negative are incorporated into the EHR.	More than 40 percent of results expressed as a number or positive/negative are incorporated into the EHR.	Scope changed from 50 percent of results to 40 percent; applies to tests ordered during the reporting period.

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Requirement	Eligible Professionals	Hospitals	Notes
“Menu” of Optional Requirements – Five Required for Meaningful Use			
Generate list of patients with specific conditions	Generate at least one report.	Generate at least one report.	
Implement drug formulary checks on medication orders	Implemented with access to at least one internal or external formulary for entire reporting period.	Implemented with access to at least one internal or external formulary for entire reporting period.	
Provide timely access to new results	More than 10 percent of all patients seen have access to lab results, problem list, medication and allergy lists within 4 days of availability in the EHR.	N/A	Need to provide access; patients don't need to use that access.
Send reminders for preventive/follow-up care	Send reminders (in patient-preferred format) for preventive/follow-up care to 20 percent of patients age 65+ or less than 5 years of age.	N/A	Scope reduced from 50 percent to 20 percent, age changed from 50+ to 65+ and 5 years of age and younger.
Perform medication reconciliation	Provide at least 50 percent of transitions in care and relevant encounters.	Provide for at least 50 percent of admissions or transitions in care.	Requirement reduced from 80 percent; “transitions in care” means from one setting of care to another.
Provide summary record at transitions in care and referrals	Provide summary care record at 50 percent of transitions in care and referrals.	Provide summary care record at 50 percent of transitions in care and referrals.	Requirement reduced from 80 percent; “transitions in care” means from one setting of care to another.
Information to immunization registries submitted electronically	Perform at least one test of the capability to submit data to immunization registries or immunization information systems and follow-up submission (where agencies can accept electronic submission).	Perform at least one test of the capability to submit data to immunization registries or immunization information systems and follow-up submission (where agencies can accept electronic submission).	Applies only to those who provide immunizations during the reporting period.
Electronic reporting of syndromic surveillance data	Perform at least one test of the capability to submit data and follow-up submission (where public health agencies can accept electronic data).	Perform at least one test of the capability to submit data and follow-up submission (where public health agencies can accept electronic data).	
Submit electronic data on reportable laboratory results to public health agencies	N/A	Perform at least one test of the capability to submit data and follow-up submission (where public health agencies can accept electronic data).	
Record advanced directives for patients 65+	N/A	More than 50 percent of inpatients have indication of advanced directive recorded.	New requirement; applies only to inpatients.
Use EHR technology to identify patient-specific educational resources and provide to patients as appropriate	More than 10 percent of patients are provided patient-specific educational resources using the EHR.	More than 10 percent of patients are provided patient-specific educational resources using the EHR.	New requirement.

Electronic eligibility checking and submitting claims electronically were deferred to Stage 2 of the meaningful use requirements. The health reform law passed earlier this year (The Affordable Care Act of 2010) will require electronic eligibility checking starting on January 2013.

Right Implementation

Organizations satisfying meaningful use requirements must implement qualified EHRs in such a way that the staff can make full use of their capabilities. They also have to be implemented in a manner that promotes safe care.

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. Although the new rules have lower thresholds, some of these lower targets may also create safety issues. For example, the new Stage 1 requirement for CPOE states that patients who have medication orders must have one order entered using CPOE. However, it is our opinion that using CPOE for some but not all medication orders can create confusion and is not a safe practice.

Right Use

To meet the meaningful use requirements, all organizations must implement an EHR so that it is incorporated into the routine care process. 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, appropriate individuals documenting required procedures for quality reporting, etc.).
- All 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

- Most hospitals and some physician practices have developed and started to implement plans to demonstrate meaningful use and qualify for incentive payments. Some were waiting for the final rule to be released. Now is the time to redouble efforts to meet the criteria in 2011 and 2012. There are several benefits for qualifying early. First, hospitals need to qualify by 2013, and physicians need to qualify by 2012 to get the maximum payments. Since about 70 percent of the incentive dollars are paid in the first 2 years, early qualification means earlier availability of money to invest in future requirements. Finally, the Stage 1 requirements have been relaxed and made more flexible for 2011 and 2012; however, there is no guarantee that these same changes will apply if qualifying against Stage 1 criteria at a later date.
- 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.



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- 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. Certification against Stage 1 criteria will be available soon, and the standards for systems have already been published. Make sure the vendors you plan to use to meet meaningful use have definite plans to get their product certified and that their schedule meets your needs.
- Include the ED in your gap analysis. Because of the volume of patients seen in a typical ED, the ED will need to meet meaningful use requirements for a hospital to qualify for incentive payments. Since ED systems have not been certified in the past, make sure that your ED vendor has plans to be certified on an aggressive timetable.
- Review all the requirements for quality reporting to make sure you have captured all the data to report on from a certified EHR system (for more information see our companion paper on [Quality Reporting](#)).

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