

## Meaningful Use of Health Information Technology

### What It Is and Why It Matters to Patients and Purchasers

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#### INTRODUCTION

To stimulate investment and use of health information technology (IT) to improve health care, the federal government has established a combination of voluntary financial incentives and eventual penalties to encourage the “*meaningful use*” of electronic health records (EHRs). If implemented effectively (e.g., “meaningfully”) EHRs can dramatically improve how care is delivered. The Centers for Medicare & Medicaid Services (CMS) released for public comment in December its proposal for implementing the initial years of the meaningful use incentive program, with a March 15, 2010 deadline for submitting comments.

The CMS proposal represents many of the elements that those who receive and pay for care have advocated for to ensure that meaningful use maximizes the role of health IT in improving patient care. This Issue Brief provides a summary of how meaningful use came into being, an overview of CMS’ proposal for meaningful use and its implications for providers, patients, consumers and purchasers in the coming years.

#### BACKGROUND

Health IT has tremendous potential to transform how health care is delivered. Congress sought to realize this potential in the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), a part of the American Recovery and Reinvestment Act of 2009 (ARRA), by including \$34 billion in financial incentives for Medicare and Medicaid providers (e.g., hospitals and health care professionals) for their *meaningful use* of certified electronic health records (EHRs). For providers, the financial implications will extend far beyond the \$34 billion in incentives, with Medicare providers facing what will become substantial payment reductions if they are not meaningful users of health IT after 2015.

The congressional intent is that providers, to receive these incentives and avoid future payment reductions, will have to do more than simply install EHRs in their practices; they will have to meaningfully use them to improve patient care. The concept of meaningful use is strongly supported by consumers and purchasers because it supports critical goals, which include:

- Increasing care coordination and fostering better doctor-patient communication
- Reducing medical errors and improving patient safety
- Supporting delivery of evidence-based care
- Reducing disparities by recording demographic information
- Improving quality of care, while fostering more cost-effective delivery
- Advancing payment reform (by supplying needed data on provider performance)
- Providing patients with their own, portable health information

In the HITECH legislation, Congress provided a broad framework of what meaningful use will encompass, leaving the details to be worked out through the regulatory process. Congress provided three general requirements for providers to be considered meaningful users of EHRs:

1. Use EHR certified technology in a meaningful manner, including e-prescribing
2. Demonstrate capability of exchanging electronic health information to improve quality
3. Submit information on clinical quality measures

CMS, building on Congress’s framework for meaningful use, developed a staged approach for implementing meaningful use in 2011 and 2012, signaling some of the 2013-2015 requirements, but appropriately leaving details of future rule-making to be determined based on how meaningful use plays out in the field. CMS’ proposals draw heavily from the recommendations made by the [Health IT Policy Committee](#), a multi-stakeholder federal advisory body created by ARRA to help develop a policy framework for the development and adoption of a nationwide health information infrastructure.

On a parallel track, the federal government is developing standards to be incorporated in EHR technology that will help providers achieve meaningful use and ensure that data can be shared across the country, among providers, and with patients and families in a private and secure manner. Although this brief does not explore this issue in further detail, more information is available at <http://healthit.hhs.gov./portal/server.pt>.

## WORKING OUT THE DETAILS

In its proposed rules, CMS delineates two major areas for public comment: its broad strategy of phasing in meaningful use by stages; and the specific criteria that will be used for the first stage of meaningful use.

### Proposed Timeline for Phasing-in Meaningful Use

For federal investment in meaningful use to be a success, it must recognize the wide range of capacities of different providers when it comes to implementing EHRs. CMS' plan accordingly provides a phased approach to meaningful use that consists of three stages over 2011 to 2015; with each stage reflecting increasing expectations and rigor. The staged approach acknowledges the need for the health IT infrastructure to mature to support increasingly ambitious goals. The three stages are:

- **Stage 1:** Centers on *health information collection* and using it to track key clinical conditions, communicate about care needs (including provider-provider and provider-patient communication), facilitate disease and medication management, and report key quality and public health information.
- **Stage 2:** Focuses on *exchanging and using information* to improve the care of individual patients.
- **Stage 3:** Concentrates on *promoting systematic improvements* through promoting improvements in quality, safety and efficiency, advancing decision support for national high priority conditions, providing patient access to self-management tools, facilitating access to comprehensive patient data, and improving population health.

Linked to each stage is a set of criteria for meaningful use of EHRs that providers must satisfy to fulfill the stage and receive an incentive payment (or avoid payment reductions after 2015). CMS' current proposed rule details the criteria for Stage 1 that will take effect in 2011. Criteria for Stage 2 are expected by the end of 2011 and Stage 3 criteria by the end of 2013.

To receive Stage 1 incentive payments, CMS requires that providers fulfill approximately two dozen measures of provider use of health IT functionality and report measures of clinical quality. The criteria vary appropriately by provider type (e.g., the criteria for doctors differ from those for hospitals) and whether providers receive their meaningful use incentives through Medicare or Medicaid. ***From the consumer and purchaser perspective, the timeline and criteria proposed by CMS are achievable and appropriate. A slower process would continue to allow patients to suffer needless harm, perpetuate system inefficiencies, and fail to satisfy the intent of Congress.***

CMS seeks to align the Medicare and Medicaid meaningful use programs. CMS proposes that Medicaid meaningful use programs use the Medicare definition of meaningful use, but states may request CMS approval to implement meaningful use measures above the minimum. However, some appropriate differences remain. Medicaid providers are eligible to receive larger total payments over a longer time period, they can receive more "up-front" support to help pay for initial costs, and they face less stringent performance criteria in the first stage.

### The Timeline for Implementing the Three Stages of Meaningful Use

CMS proposes a timeline for implementing the three stages of meaningful use. Based on the requirements set forth in HITECH, this timeline rewards early adopters, but also encourages broad adoption by being sensitive to the fact that providers are in different places when it comes to their ability to implement EHRs. Whether Stage 1, Stage 2, or Stage 3 criteria are used to determine meaningful use payments will depend on the first year for which a provider receives a payment. While providers can determine the first year in which they will seek a meaningful use incentive payment, the longer a provider waits, the faster the provider will need to progress through the stages to continue receiving the incentive payments.

Congress set forth the basic meaningful use payment structures in HITECH. Below is an illustration of how these incentives and payment reductions are applied to encourage meaningful use of EHRs by Medicare health care professionals (more details on meaningful use payment formulas are available on the CMS website at <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3466>):

- **Incentives:** Medicare health care professionals can receive an incentive payment as high as \$18,000 if their first payment year is 2011 or 2012, otherwise the incentive payment limits in the first, second, third,

fourth, and fifth years are \$15,000, \$12,000, \$8,000, \$4000, and \$2,000 respectively. Similarly, a hospital could have incentives from \$2 to \$5 million in the first four years of meaningful use, decreasing over the next few years.

- **Payment reductions:** For every year beginning in 2015 where covered Medicare health care facilities and professionals do not achieve meaningful use, their payments will be reduced (i.e., for professionals, their fee-for-service payments would be reduced 1 percent in 2015, 2 percent in 2016, 3 percent in 2017, and 3 to 5 percent in subsequent years).

**Meaningful Use Stage 1 Criteria: Measures of Provider Use of Health IT Functionality**

Electronic health records can include a number of functions to improve the safety and quality of care, and the meaningful use criteria are meant to assess whether the providers are making use of the most important features. The Stage 1 proposed criteria require providers to demonstrate whether they adequately use EHR capabilities. The measures focus more on the ability to exchange data rather than actual exchange of data because the information exchange infrastructure is not sufficiently established at this time. The specific areas of measurement are in Table 1. *From the perspective of consumers and purchasers, the initial measures proposed by CMS provide a reasonable first step towards meeting the safety, quality, and patient-centered goals of the HITECH legislation. All of the proposed measures should be adopted, although minor additions could be made to improve the criteria.*

**Table 1: Stage 1 Criteria for Measures of Provider Use of Health IT Functionality<sup>1</sup>**

<b>Capturing patient health information</b>
<ul style="list-style-type: none"> <li>• Using computerized physician order entry systems (i.e., provider use of computer assistance to directly enter medical orders)</li> <li>• Maintaining an up-to-date problem list of patients' current and active diagnoses</li> <li>• Recording demographic information (e.g., preferred language, insurance type, gender, race, ethnicity, date of birth, death and cause of death in the event of mortality)</li> <li>• Recording vital signs (i.e., blood pressures and BMI) and plotting growth charts for children</li> <li>• Capturing smoking status</li> <li>• Incorporating data on clinical lab results</li> </ul>
<b>Using EHR tools for provider decision-making, patient reminders and insurance activities</b>
<ul style="list-style-type: none"> <li>• Enabling drug-drug, drug-allergy, drug-formulary safety checks</li> <li>• Generating at least one report listing patients with a specific condition</li> <li>• Sending prevention and follow-up reminders to patients</li> <li>• Implementing five clinical decision support rules</li> <li>• Checking insurance eligibility electronically and filing claims electronically</li> </ul>
<b>Giving patients access to their health information</b>
<ul style="list-style-type: none"> <li>• Providing patients with an electronic copy of their health information, their discharge instructions, electronic access to their health information, and clinical summaries</li> </ul>
<b>Exchanging information and facilitating care coordination</b>
<ul style="list-style-type: none"> <li>• Transmitting prescriptions electronically</li> <li>• Demonstrating capacity to electronically exchange key clinical information</li> <li>• Demonstrating capacity to submit electronic data to immunization registries</li> <li>• Demonstrating capacity to provide electronic submission of reportable lab results to public health agencies</li> <li>• Demonstrating capacity to provide electronic syndromic surveillance data to public health agencies</li> <li>• Performing medication reconciliation at relevant encounters and transitions of care</li> <li>• Providing a summary of care record for transitions of care and referrals</li> </ul>
<b>Security and privacy</b>
<ul style="list-style-type: none"> <li>• Conducting or reviewing a security risk analysis and implementing security updates as necessary</li> </ul>

While consumers and purchasers strongly support the proposed elements, many believe that some elements can and should be improved in Stage 1 and some additions should be considered for future years:

- **Advance patient engagement** by requiring providers to record patients' advance directives and ensuring patients receive education materials in Stage 1.
- **Reduce Health Disparities** by creating the building blocks in 2011 (i.e., requiring providers to stratify quality data by race, ethnicity, language, and gender and requiring providers when generating lists of patients by specific conditions to stratify these lists by these categories) so that CMS can promulgate rules in 2013 that requires providers to use data on race, ethnicity, language and gender in quality reporting to improve care and reduce disparities.
- **Encourage care coordination** by incorporating the National Quality Forum's recently endorsed series of care coordination measures in 2013.

## Meaningful Use Stage 1 Criteria: Measures of Clinical Quality

To receive an incentive under the proposed rule, providers will be required to report clinical quality measures relevant to their practice. For hospitals, CMS has asked for public comments on a list of 43 clinical quality measures, in order to select an appropriate subset on which hospitals would report. Ambulatory health care professionals would report on a core group of four clinical quality measures and a small set of 3-5 specialty measures based on their area of practice.<sup>2</sup> ***From the perspective of consumers and purchasers, the proposed measures of clinical quality represent a practical first step and should be adopted, although some minor improvements could be helpful in Stage 1 and substantial improvements will be needed in future stages.*** Areas for potential improvement include:

- ***Ensure that future measures reflect meaningful enhancements in quality of care.*** The meaningful use program is not a substitute for other programs that evaluate quality of care or provide for quality-based payment. This program provides direction for the evolution of health IT in ambulatory and inpatient settings and should ensure that increasingly sophisticated capabilities to access and report clinical data are being implemented.
- ***Delay implementation of “core measures” until Stage 2:*** The core measure set should be implemented in Stage 2, which will allow CMS the time needed to revise the proposed core measure set. The currently proposed core measures are not robust enough to produce the type of information that consumers and purchasers need and want to know across all specialties.
- ***Increase the focus on measures of appropriateness, efficiency and functional status.*** Many of the measures proposed for Stage 1 reflect discrete health care processes which only capture a snapshot of the care a person received rather than the effect of that care on the patient. As a result, there needs to be a greater emphasis on collecting measures of appropriateness (including capturing the indications for treatment such as patient functional limitations or symptom burden) and efficiency of care beginning in 2011 and continuing into future years. In Stage 1, CMS should require a measure of efficiency that relates to the use of generic medications, and that at least one of the five clinical decision support rules should address efficient diagnostic test ordering. Measures of functional status (i.e., how well a patient is able to function as an end result of the care he or she received) should also be adopted for future stages.
- ***Require real verification.*** For 2011, Medicare providers will only need to attest via survey to CMS (and Medicaid providers to states) the accuracy and completeness of their overall performance on a clinical quality measure. CMS plans to use attestation for 2011 because it does not expect to have the capacity to electronically accept data on clinical quality measures from EHRs at that time. Attestation could overestimate the actual use of EHR functions in daily practice, so there must be an urgent effort to ensure that CMS can receive the measures electronically by 2012.

## MAKING SURE THAT IT'S MAKING A DIFFERENCE

Going forward, ***consumers and purchasers believe that CMS should set forth clear measures that would represent the extent to which electronic health records and information sharing is making a difference in the lives of patients.*** Medical error rates and measures of patient experience of care are two examples of measures that could be used to assess the impact of health IT uptake.

***Consumers and purchasers have been active supporters of the HITECH legislation and believe that CMS should follow the legislative intent by setting a high bar for the measures that would be tied to the incentives for meaningful use of EHRs.*** If providers fail to make meaningful use of electronic health records, the nation's large investment will be squandered. Providers remain free to invest their own funds in technology as they wish, but if public funds are to be used, public goals must be met.

***Beyond working to assure that CMS effectively implements meaningful use incentives, consumers and purchasers are promoting alignment between the public and private sectors,*** so that providers receive common payment signals from the public and private sector and so all Americans, not just those under Medicare and Medicaid, can reap the benefits that health IT can bring to patient care.

*The Consumer-Purchaser Disclosure Project is an initiative that is improving health care quality and affordability by advancing public reporting of provider performance information so it can be used for improvement, consumer choice, and as part of payment reform. The Project is a collaboration of leading national and local employer, consumer, and labor organizations whose shared vision is for Americans to be able to select hospitals, physicians, and treatments based on nationally standardized measures for clinical quality, consumer experience, equity, and efficiency. The Disclosure Project is funded by the Robert Wood Johnson Foundation along with support from participating organizations. For more information contact questions@healthcaaredisclosure.org or visit our website at <http://healthcaaredisclosure.org/>.*

<sup>1</sup> CMS assigns specific thresholds or percentages to most of these criteria

<sup>2</sup> These areas of practice include: cardiology, pulmonology, endocrinology, oncology, proceduralist/surgery, primary care physicians, pediatrics, obstetrics and gynecology, neurology, psychiatry, ophthalmology, podiatry, radiology, gastroenterology, and nephrology)