Feds Release Final Meaningful Use Standards

BY MARY ELLEN SCHNEIDER

The federal government on July 13 released the much-anticipated requirements for how physicians and hospitals can qualify for tens of thousands of dollars in incentive payments to adopt and use electronic health records.

The final rule on the meaningful use of electronic health records (EHRs) eases many of the requirements that officials in the Health and Human Services department had outlined in a proposal published in January. Physician organizations had objected to the initial proposal, saying that it asked doctors, especially those in small practices, to do too much too quickly. Physicians were also critical of the all or nothing framework of the proposal, which required them to meet all 25 objectives for meaningful use or lose out on incentive payments.

Federal officials aimed to address those concerns in the final rule by requiring physicians to first meet a core set of 15 requirements and then meet any 5 of 10 additional requirements. The core set includes requirements such as recording patient demographics and vital signs in the EHR, maintaining an up-to-date problem list and an active list of medications and allergies, and transmitting permissible prescriptions electronically.

HHS officials also relaxed some of the thresholds related to the requirements. For example, under the proposed rule, physicians would have had to generate and transmit 75% of their permissible prescriptions electronically to meet the e-prescribing requirement. Under the final rule, the threshold has been lowered to more than 40% of permissible prescriptions, Dr. David Blumenthal, National Coordinator for Health Information Technology at HHS, said during a press briefing to announce the final rule.

The final rule also creates an easier path for physicians to meet meaningful use requirements on electronic reporting of quality data. Under the final rule, physicians will need to report data on blood pressure, tobacco status, and adult weight screening, and follow-up in 2011 and 2012, in order to qualify. Alternatives are available if those measures do not apply to their practices. Physicians will also have to choose three other quality measures to report on through their EHRs.

The final rule outlines the steps physicians must take in 2011 and 2012 to quality for the maximum incentive payments through the Medicare and Medicaid programs. The incentives were mandated by the Health Information Technology for Economic and Clinical Health Act (HITECH).

Starting in 2011, physicians who demonstrate meaningful use of certified EHRs can receive payments of up to $18,000 from Medicare. Those bonuses continue for 5 years, with physicians eligible to earn up to $44,000 in total incentives. Physicians can still receive bonuses if they begin their meaningful use of the technology later, but they must start before 2013 to get all the available incentives. A similar program is in place under the Medicaid program, with physicians eligible to receive up to $64,000 over 6 years for the adoption and use of certified EHRs. ■

Total Maximum EHR Incentive Payment Amounts

Calendar year	First calendar year for which an eligible professional receives incentive payment				2015 and subsequent years
	2011	2012	2013	2014	
2011	$18,000	—	—	—	—
2012	$12,000	$18,000	—	—	—
2013	$8,000	$12,000	$15,000	—	—
2014	$4,000	$8,000	$12,000	$12,000	—
2015	$2,000	$4,000	$8,000	$8,000	$0
2016	—	$2,000	$4,000	$4,000	$0
Total	$44,000	$44,000	$39,000	$24,000	$0

Note: Incentives were mandated in 2009 by the HITECH Act.
Source: Centers for Medicare and Medicaid Services

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COMMENTARY

Meaningful Use Criteria: What's Missing

BY CHRISTOPHER NOTTE, M.D., AND NEIL SKOLNIK, M.D.

Since the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act in February 2009, there has been a tremendous amount of discussion about the idea of "meaningful use." Associated with the meaningful use criteria, are financial incentives for those who adopt an electronic health record and care for Medicare and Medicaid patients. Such incentives may total more than $40k-$60k per provider. Those who fail to meet the criteria will find their reimbursements reduced beginning in 2016.

The term meaningful use has been defined only recently. And now that the full set of rules for meaningful use is available, it might surprise some to know what has actually been excluded.

Any aspects of electronic health record (EHR) implementation that do not meet U.S. Department of Health and Human Services' goals of improving the quality, safety, efficiency, and accessibility of care have been specifically left out of the criteria. The intent is to challenge health care providers to move forward toward the goal of EHR implementation, while acknowledging the limitations of current technology.

The first and most fascinating exclusion is any requirement for encounter note generation. The criteria specifically state that it will not be necessary for providers to document their encounter notes using the EHR, commenting that proper documentation is "a medical-legal requirement and a component of basic EHR functionality, [but] is not directly related to advanced processes of care or improvements in quality, safety, or efficiency," according to the report (Federal Register 2010;75:1,843-2,010).

In other words, while most EHR products emphasize electronic note generation, the authors feel this does not provide a significant benefit over handwritten charting in meeting the goals of HITECH.

Providers with limited computer skills may rest assured, knowing that—for now—holding onto pen and paper for documenting patient encounters will not preclude them from the financial incentives under the HITECH act. Still, it might be difficult to implement an EHR without this piece, as once an office becomes dependent on the technology, workflow can be significantly hindered by searching for documentation that is not in the electronic record.

To address this, some practices have chosen to scan in handwritten notes. Unfortunately, this might preclude critical data points from being captured by the system, and make it impossible to meet some of the quality reporting goals laid out in elsewhere in HITECH.

A second intentional omission in the criteria is the requirement that providers make educational resources available to patients. In spite of a clear objective to involve patients more in their care, the authors are reluctant to make this a necessity. They admit that proper information and education are "a critical component of patient engagement and empowerment," but acknowledge that "there is currently a paucity of knowledge resources that are integrated within EHRs, that are widely available, and that meet [our] criteria, particularly in multiple languages."

Many EHR products do include integrated patient education resources, but these often are limited in quality and come at an additional fee. As an alternative, online resources available through Web sites such as familydoctor.org and emedicine.com provide numerous educational tools that are free and peer reviewed. Once an EHR is implemented in the office, it can be very easy for physicians to access and print these on demand.

Another anticipated requirement that's been excluded from the criteria is the necessity for orders to be transmitted electronically from care provider to testing, diagnostic imaging, or treatment facilities. It should be noted that Computerized Physician Order Entry (CPOE) is greatly emphasized under HITECH, with the objective that 80% of orders be entered through the EHR. CPOE is defined as "the provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device." But in the criteria released so far, the requirements "will not include the electronic transmittal of [those orders] to the pharmacy, laboratory, or diagnostic imaging center." Seemingly contrary to this, the guidelines do require e-prescribing to meet criteria, so further clarification is needed to determine which orders must be sent electronically and which do not.

In reviewing these exclusions, it becomes apparent that no one is completely sure how the meaningful use criteria will affect the day-to-day practice of medicine. Many physicians will remain skeptical of any government intervention in health care but can at least now be assured that the financial incentives are attached to a fairly practical set of requirements. ■

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