

# Meaningful Use as the Stepping Stone for Care Transformation: The View from Washington



**Friday, January 20, 2012 - 2:00 p.m. ET**

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**American Hospital Association**





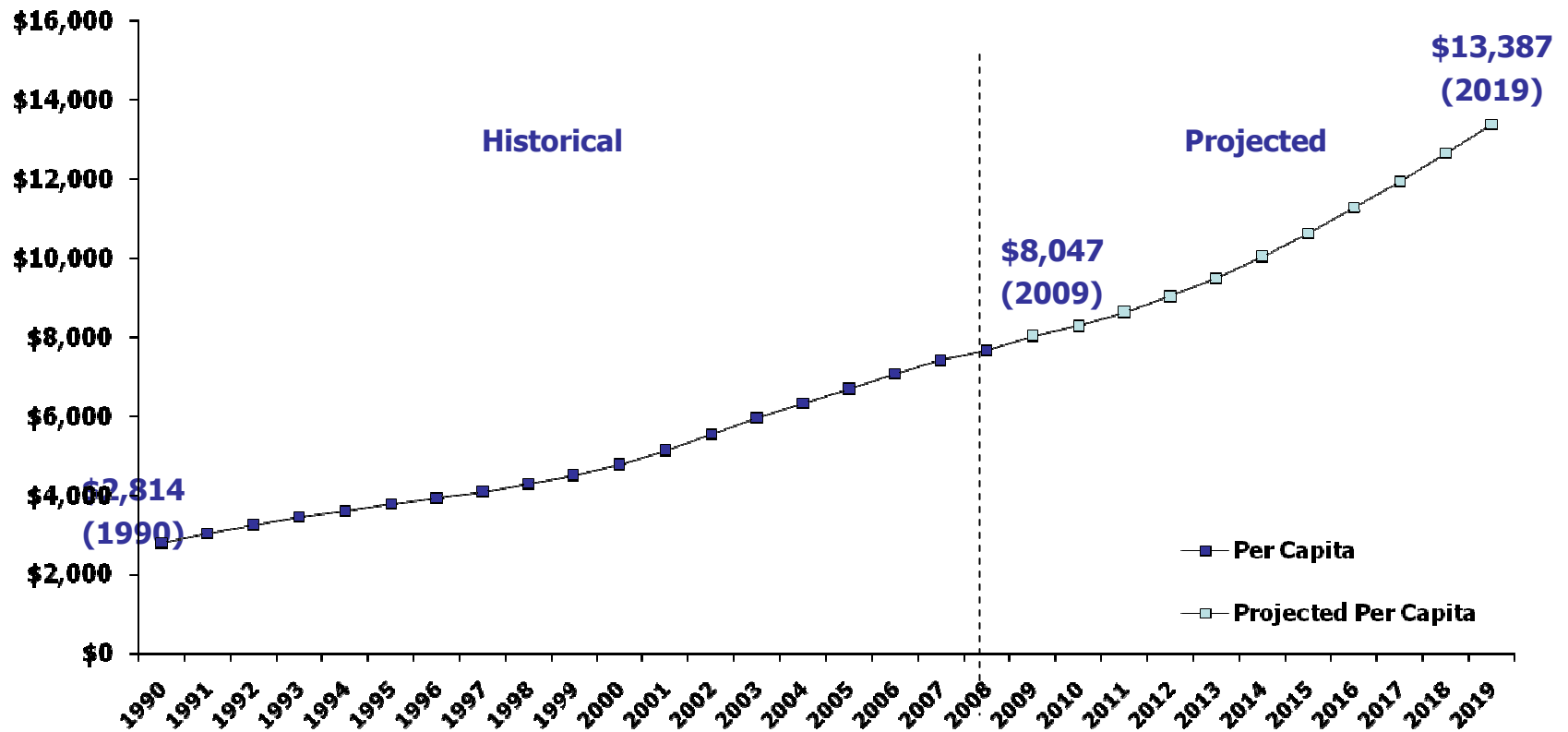
# ***Health Reform as Context***



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# National Health Expenditures Per Capita, 1990-2019

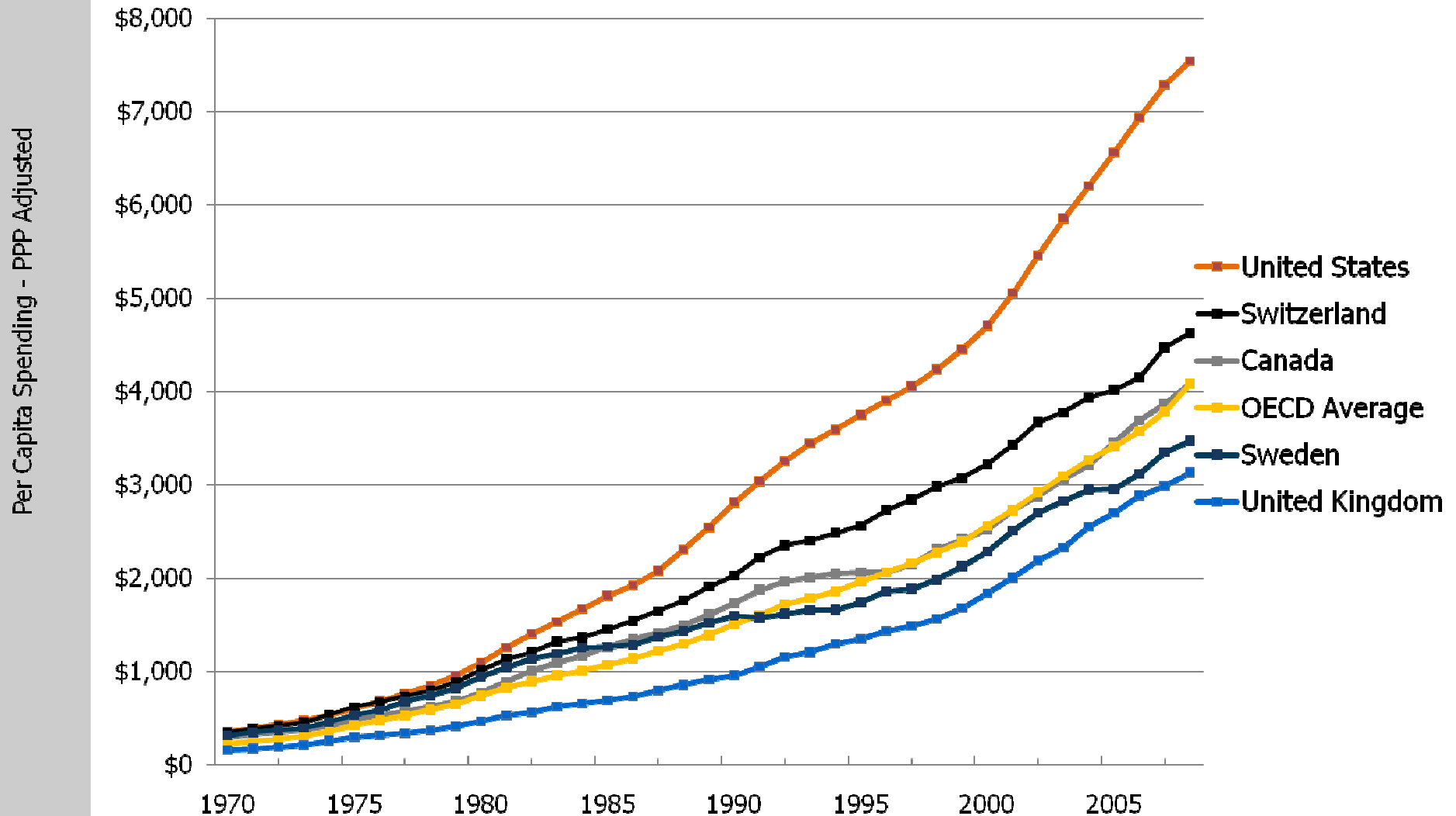
**Update: In 2010, the U.S. spent \$2.6 trillion on health care, or \$8,402 per capita**



Source: Kaiser Family Foundation. Data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (Historical data from NHE summary including share of GDP, CY 1960-2008, file nhegdp08.zip; Projected data from NHE Projections 2009-2019, Forecast summary and selected tables, file proj2009.pdf).



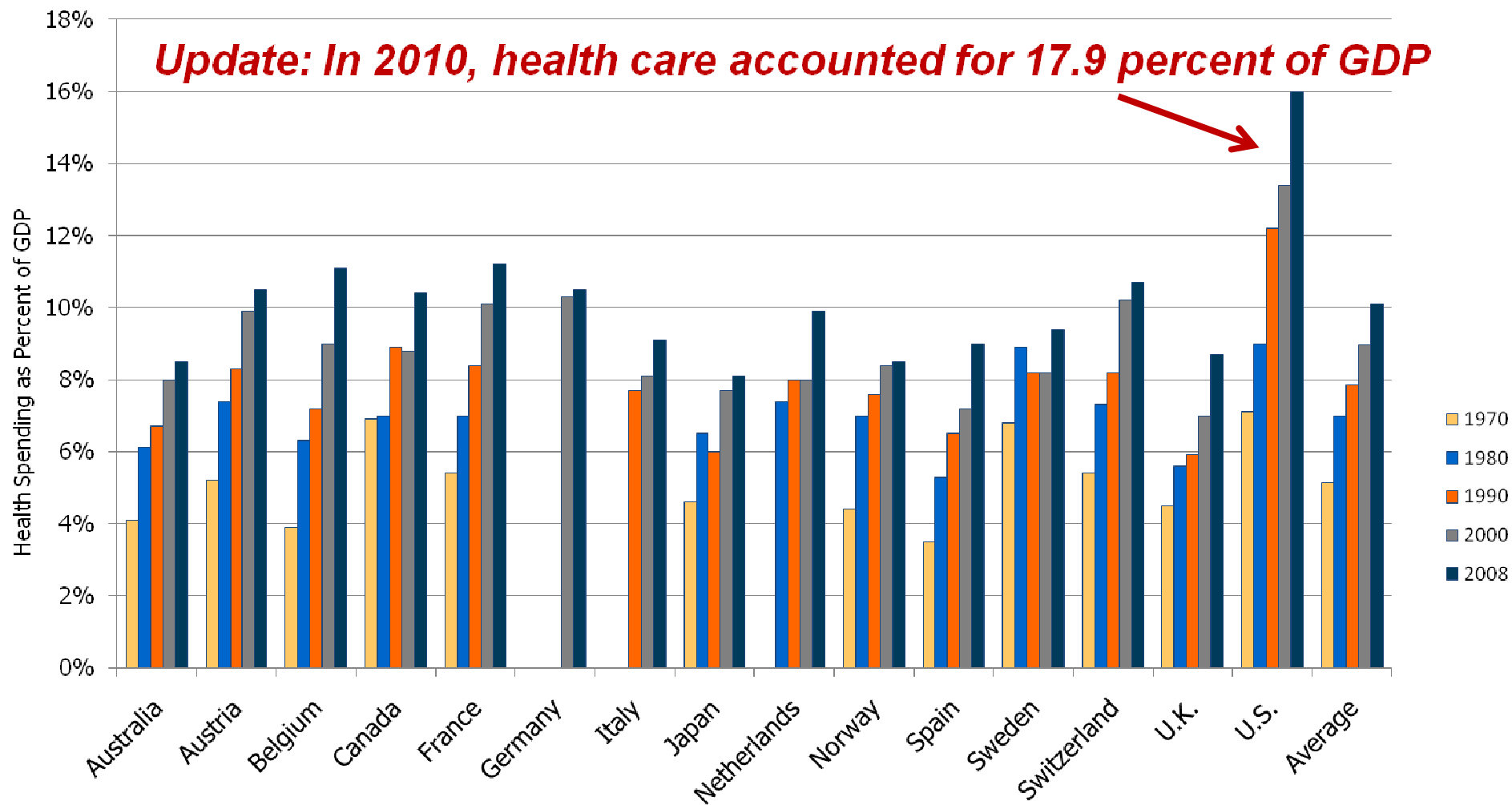
# Growth in Total Health Expenditure Per Capita, U.S. and Selected Countries, 1970-2008



Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: [10.1787/data-00350-en](https://doi.org/10.1787/data-00350-en) (Accessed on 14 February 2011).

Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted. Break in series: CAN(1995); SWE(1993, 2001); SWI(1995); UK(1997). Numbers are PPP adjusted. Estimates for Canada and Switzerland in 2008.

# Total Expenditure on Health as a Share of GDP, U.S. and Selected Countries, 1970, 1980, 1990, 2000, 2008



**Source:** Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). doi: [10.1787/data-00350-en](https://doi.org/10.1787/data-00350-en) (Accessed on 14 February 2011).

**Notes:** Data from Australia and Japan are 2007 data. 2008 figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. 200 figures for Belgium are OECD estimates. Break in Series AUS (1998); AUSTRIA(1990); BEL(2003, 2005); CAN(1995); FRA(1995); GER(1992); JAP(1995); NET(1998, 2003); NOR(1999); SPA(1999, 2003); SWE(1993, 2001); SWI(1995); UK (1997). Starting in 1993 Belgium used a different methodology.

# *American Recovery and Reinvestment Act*

- Signed into law in February 2009
- Also called HITECH or stimulus bill
- \$2 billion to the Office of the National Coordinator of Health Information Technology
- Medicare and Medicaid EHR incentive programs
  - Begin federal fiscal year 2011 for hospitals
  - Begin calendar year 2011 for physicians and other eligible professionals
  - Spending depends on number of providers meeting meaningful use



**RECOVERY.GOV**



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# Meaningful Use Goals

- Supporting best possible clinical care
  - Ensure right information is available at the right time and in the right place to inform care
  - Evidence-based medicine
- Laying groundwork for health reform
  - Care coordination
  - Quality improvement and measurement
  - Improved efficiency
  - Population health

## Triple Aim

1) *Improving the individual experience of care*

2) *Improving the health of populations*

3) *Reducing the per capita costs of care*



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**Patient Protection and Affordable Care Act of 2010**

# Common Goal Across Stakeholders

***“Discontent is the first necessity of progress”***

- Consumers want more
- Payers want less
- Providers want better



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# ***Meaningful Use Stage 1***



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# *Medicare EHR Incentive Program Basics*

- Must use an EHR certified through the new federal process (Certified HIT Products List maintained by ONC)
- Must have 80 percent of patients in the EHR (inpatient and ED)
- Hospitals report on 19 of 24 objectives
- Physicians and other eligible professionals (EPs) report on 20 of 25 objectives
- Includes use of specific standards to record and transmit data
- Must use CPOE, calculate quality measures directly from the EHR, and have capacity to send information to public health



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# Hospital Eligibility for Programs

Hospitals can receive **both** Medicare and Medicaid incentive payments



## • Medicare

- FY 2013 – Last year for PPS hospitals to meet meaningful use and get full four years of consecutive payment (Reduced incentives if start in FY 2014 or 2015)
  - **CAH must start in FY 2012 for full incentives**
- FY 2015 – Penalties begin if not a meaningful user. **Penalties** increase over time, and remain in force.

## • Medicaid (optional - administered by states)

- Includes CAHs
- 3 to 6 years of payment, with first year supporting adoption, implementation, or upgrade
- No penalties



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# Medicare Hospital Payment Formula

Hospital Medicare Incentives in ARRA	
<b>Calculate base dollar amount</b>	$(\$2 \text{ million} + (\text{your discharges from 1150 through and including 23,000}) * 200))$ <p>Example assuming 3,149 discharges (2,000 within eligible range):  <math>\\$2 \text{ million} + \\$400,000 = \\$2,400,000</math></p>
<b>Calculate "Medicare Share"</b>	$\text{Medicare inpatient days} / (\text{total inpatient days} * ((\text{gross revenue} - \text{charity}) / \text{gross revenue}))$
<b>Multiply by Medicare Share</b>	Using an example Medicare Share of .50: $\$2,400,000 \times .50 = \$1,200,000$
<b>Calculate four payments</b>	Payment Year 1: \$1,200,000 (100%) Payment Year 2: \$900,000 (75%) Payment Year 3: \$600,000 (50%) Payment Year 4: \$300,000 (25%)  <b>Total Payments over 4 years: \$3,000,000</b>
<b>Scale down phase</b>	If 2014 is first year of meaningful use, only three payments starting at 75% level, etc.
<b>Penalty phase</b>	If not a meaningful user of EHR by 2015 or after

**Medicaid payments drive off of Medicare payment formula, scaled to Medicaid share**

# Meaningful Use Definition - Hospitals

## 24 Objectives of Meaningful Use

1. CPOE for Medications
2. Drug-drug/drug-allergy checks
3. Record demographics
4. Structured problem list
5. Structured medication list
6. Structured medication allergy list
7. Record and chart changes in vital signs
8. Record smoking status
9. 1 clinical decision support rule
10. Report clinical quality measures
11. Electronic health info to patients
12. Electronic copy of discharge instructions
13. Exchange key clinical information (capability)
14. Protect electronic health information
15. Drug-formulary checks
16. Record advanced directives
17. Incorporate structured clinical-lab data
18. Generate patient lists by condition
19. Identify patient-specific education resources
20. Medication reconciliation
21. Summary care record transitioned or referred patients
22. Submit data to immunization registries
23. Submit lab results to public health
24. Submit syndromic surveillance data

## 19 Objectives Required in Stage 1

1. CPOE for Medications
2. Drug-drug/drug-allergy checks
3. Record demographics
4. Structured problem list
5. Structured medication list
6. Structured medication allergy list
7. Record and chart changes in vital signs
8. Record smoking status
9. 1 clinical decision support rule
10. Report clinical quality measures
11. Electronic health info to patients
12. Electronic copy of discharge instructions
13. Exchange key clinical information (capability)
14. Protect electronic health information
15. Option 1
16. Option 2
17. Option 3
18. Option 4
19. Public Health reporting option

**14 Core Objectives Required of All Hospitals**

**Choose 5 from Menu Set**

**Choose at least 1 Public Health Option**

# Stage 1 Hospital Quality Reporting Measures

Condition	Measure Name
Emergency Department Throughput	Median time from ED arrival to ED departure for admitted patients
	Admission decision time to ED departure time for admitted patients
Stroke	Discharge on anti-thrombotics
	Anticoagulation for A-fib/flutter
	Thrombolytic therapy for patients arriving within 2 hours of symptom onset
	Anti-thrombotic therapy by day 2
	Discharge on statins
	Stroke education
	Rehabilitation assessment
Venous Thromboembolism (VTE)	VTE prophylaxis within 24 hours of arrival
	Intensive care unit VTE prophylaxis
	Anticoagulation overlap therapy
	Platelet monitoring on unfractionated heparin
	VTE discharge instructions
	Incidence of potentially preventable VTE



# *Measures of Meaningful Use*

- A measure for each objective
- Reduced thresholds of compliance from proposed rule for many measures
- Includes both inpatient and emergency departments (POS = 21 or 23) for all percentage measures other than advanced directives (POS = 21)
- Generally refers to entire EHR reporting period
- Generally refers to “unique patients”
- No manual calculations
- Certification will include measure calculation if percentage reporting required



# Three Types of Measures

- Yes/No: Hospital “attests”
  - Have capability enabled (e.g., drug-allergy checks)
  - Tested capability (e.g., public health objectives)
- Percentage Measures with all patients in denominator, whether in EHR or not (demographics, problem list, medication list, medication allergies):
  - Hospital determines denominator
  - EHR determines numerator and calculates value
- Percent of patients with records in the EHR in the denominator
  - EHR determines numerator and denominator and calculates value



# *Three Types of Standards*

- **Content Exchange:** Used to share clinical information such as clinical summaries, prescriptions, structured electronic documents, and quality reporting, accompanied by implementation specifications
- **Vocabulary :** Standardized nomenclatures, terminology, and code sets used to describe clinical problems and procedures, lab test results, medications, immunizations, and race and ethnicity
- **Privacy and Security:** Encryption and decryption, access control, and transmission security standards which relate to and span across all of the other types of standards



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# Examples of Standards Required

- Problem list
  - ICD-9-CM or SNOMED
- Race and ethnicity
  - Incorporate OMB Race and Ethnicity Categories listed in OMB Directive Number 15
  - AHA/HRET Disparities Toolkit available at: [www.hretdisparities.org](http://www.hretdisparities.org)
- Smoking status
  - Incorporate structured values of current every day smoker, current some-day smoker, former smoker, never smoker, smoker with current status unknown, and unknown if ever smoked
- Reporting of lab results to public health:
  - LOINC
  - HL7 2.5.1
- Clinical Care Summary
  - Create either HL7 Continuity of Care Document (CCD) or ASTM Continuity of Care Record (CCR); receive both
  - Use vocabulary standards (such as RxNORM for medications)



# Core Hospital Measures

	OBJECTIVE	MEASURE
C1	CPOE for medications	More than 30% of unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE
C2	Drug-drug/drug-allergy checks	The eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
C3	Record demographics	More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
C4	Structured problem list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data
C5	Structured medication list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
C6	Structured medication allergy list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data
C7	Record and chart changes in vital signs	For more than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structured data

# *EHR Incentive Programs for Eligible Professionals*

Beginning 2011, EPs are eligible for **either** a:

- Medicare incentive payment (up to \$44,000)
  - 75% of Medicare charges for covered professional services subject to an annual cap
  - Up to 5 years of payments
  - **Penalties** for those who are **not** meaningful users beginning in 2015 that increase over time

**Or**

- Medicaid incentive payment (up to \$63,750)
  - Optional and administered by states (12 to date)
  - To qualify, 30%+ encounters are Medicaid
  - No penalties



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# EP Meaningful Use Definition – Eligible Professionals

## 25 Objectives of Meaningful Use

1. CPOE for medications
2. Drug-drug/drug-allergy checks
3. Electronic prescriptions
4. Record demographics
5. Structured problem list
6. Structured medication list
7. Structured medication allergy list
8. Record and chart changes in vital signs
9. Record smoking status
10. 1 clinical decision support rule
11. Report 6 clinical quality measures (3 core)
12. Electronic health info to patients
13. Provide visit summary
14. Exchange key clinical information (capability)
15. Protect electronic health information
16. Drug-formulary checks
17. Incorporate structured clinical-lab data
18. Generate patient lists by condition
19. Generate patient reminders/follow-up
20. Patient access to health information
21. Identify patient-specific education resources
22. Medication reconciliation
23. Summary care record transitioned or referred patients
24. Submit data to immunization registries
25. Submit syndromic surveillance data

## 20 Objectives Required in Stage 1

1. CPOE for Medications
2. Drug-drug/drug-allergy checks
3. Electronic prescriptions
4. Record demographics
5. Structured problem list
6. Structured medication list
7. Structured medication allergy list
8. Record and chart changes in vital signs
9. Record smoking status
10. 1 clinical decision support rule
11. Report clinical quality measures
12. Electronic health info to patients
13. Electronic copy of discharge instructions
14. Exchange key clinical information (capability)
15. Protect electronic health information

15 Core Objectives Required of All EPs

Choose 5 from Menu Set

16. Option 1
17. Option 2
18. Option 3
19. Option 4
20. Public Health Reporting Option 5



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# Clinical Quality Measures for EPs

Key quality measures are the same under the Medicare and Medicaid EHR program

Condition	Measure
Hypertension Prevention	Blood Pressure Management Tobacco use assessment/intervention Adult weight screening & follow-up
Prevention	Weight assessment/counseling for children Influenza immunization age >50yrs Childhood immunization status
Diabetes	Hemoglobin A1c poor control Hemoglobin A1c control (<8.0%) LDL management and control Blood pressure management Diabetic retinopathy – documentation Diabetic retinopathy – communication Eye exam Urine screening Foot exam
Ischemic Vascular Disease	Blood pressure management Use of aspirin or another antithrombotic Lipid panel and LDL control Pneumonia vaccination for older adults ...

3 core measures (must report)

3 alternative core measures (if zero cases)

**Must choose 3 of 38 measures**



# Hospitals and EPs Must Use Certified EHRs

- Vendors may certified either a “Complete EHR” or an “EHR Module” that meets one or more of the certification criteria linked to each meaningful use objective
- Providers must “attest” that they “possess” certified EHR technology for ALL of the objectives
  - Complete EHR or
  - Combination of EHR Modules
  - Either vendor product or “self-developed”
- Providers get their CMS certification identification number from the ONC Certified HIT Products List at:

<http://onc-chpl.force.com/ehrcert>

Certified Health IT Product List  
The Office of the National Coordinator for Health Information Technology



# Providers Must Register and Attest

- Register via the EHR Incentive Program website
- Be enrolled in Medicare FFS, MA, or Medicaid (FFS or managed care)
- Have a National Provider Identifier (NPI)
- Be enrolled in PECOS



## Regulatory Advisory

April 14, 2011

### Registration and Attestation for the Medicare and Medicaid EHR Incentive Programs

#### AT A GLANCE

**The Issue:**

The Centers for Medicare & Medicaid Services (CMS) recently took steps to operationalize the Medicare and Medicaid Electronic Health Record (EHR) incentive programs. The incentive programs provide bonus payments to certain physicians and hospitals for the adoption and "meaningful use" of EHRs beginning in 2011. Beginning in 2015, hospitals and physicians that fail to meet the meaningful use requirements will face payment penalties under Medicare, but not Medicaid.

Registration for the programs began in January 2011, and as of today, six states have made payments under the Medicaid program. Beginning on April 18, hospitals and physicians that meet all of the Medicare program requirements will be able to attest that they have demonstrated meaningful use of EHRs and receive Medicare EHR incentive payments beginning in May.

Providers do not have to register until they are ready to participate in the program. They may, however, register early with no adverse consequences.

**Our Take:**

CMS has been challenged to get the Medicare and Medicaid EHR incentive programs up and running under a very short time frame. The beginning of registration and attestation marks an important milestone in ensuring that needed federal funds are available to support adoption of EHRs. Hospitals interested in pursuing these incentives should familiarize themselves with the operational processes.

While the start of registration and attestation is a positive step, the EHR incentive programs continue to be hampered by regulatory complexity and uncertainty. The AHA will continue to work with CMS and Office of the National Coordinator for Health Information Technology (ONC) to simplify the certification and meaningful use requirements and ensure that the funds Congress intended to support adoption of EHRs are made available to hospitals and physicians.

**What You Can Do:**

- ✓ Share this advisory with your senior management team.
- ✓ Ask your chief information officer about your hospital's strategies to implement EHRs and achieve meaningful use.
- ✓ Involve your compliance officer before you attest to meaningful use.
- ✓ Make sure your quality staff is aware of the new quality reporting requirements for meaningful use.
- ✓ Consult the AHA's *Regulatory Advisories* on the final CMS rule on meaningful use at <http://www.aha.org/aha/advisory/2010/100813-regulatory-adv.pdf> and related certification requirements at <http://www.aha.org/aha/advisory/2010/100720-regulatory-adv.pdf>.
- ✓ Download additional AHA educational materials on meaningful use at <http://www.aha.org/aha/issues/HIT/100226-hit-meaningful.html>.

**Further Questions:**

If you have questions or need more information, please contact Chantal Worzala, director of policy, at [cworzala@aha.org](mailto:cworzala@aha.org) or (202) 626-2313.

AHA's Regulatory Advisories are produced whenever there are significant regulatory developments that affect the job you do in your community. A seven-page, in-depth examination of this issue follows.



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# Compliance

- **AUDITs** will include:
  - whether requirements have been met (including possession of certified EHR)
  - payment formulas
- CMS will audit for Medicare and audit hospitals receiving both Medicare and Medicaid payments
  - States will audit Medicaid-only providers
  - includes proof of certified EHR and documentation to support MU
  - Six-year look-back
- CMS finalizing audit contracts
- Audits will likely begin **fall 2011**
- Appeals process in place

*“A lot of money will be flowing through this program and we are already being looked at by the OIG and Program Integrity Group...”*

*- CMS official*



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## ***Experience to date***



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# Update On EHR Incentive Programs

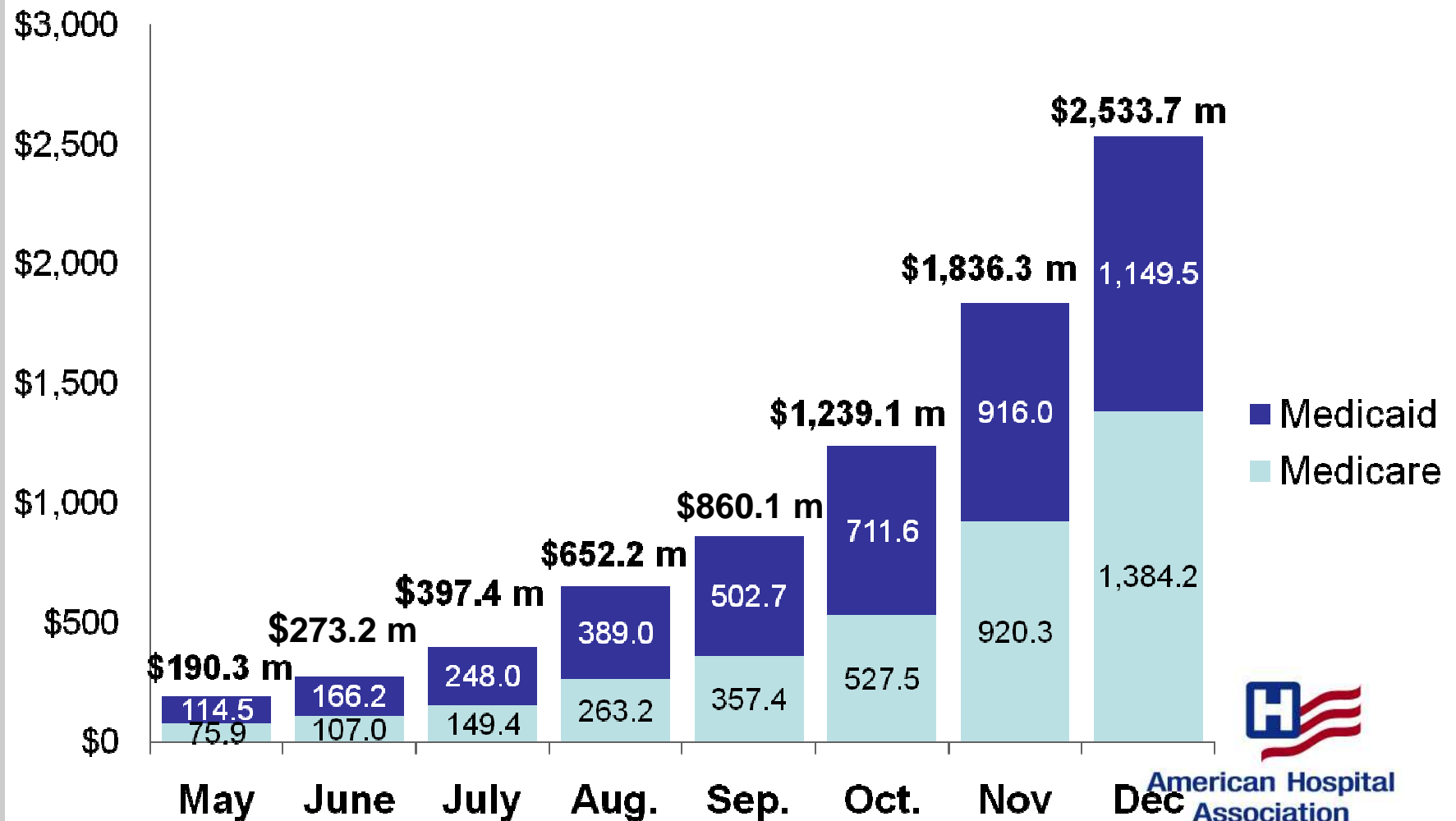
- Medicare and Medicaid EHR incentive program registrations:
  - 3,077 Hospitals
  - About 173,000 Physicians/EPs
- A growing number, but still small share, have been paid for meeting **meaningful use** requirements
  - 604 Hospitals
  - 15,859 Physicians
- 41 states have opened Medicaid programs



*Data from CMS, as of end-December 2011*

# Trends in Year-to-Date Payments, in millions, May through December 2011

Payments to eligible professionals and hospitals under the Medicare and Medicaid EHR incentive programs

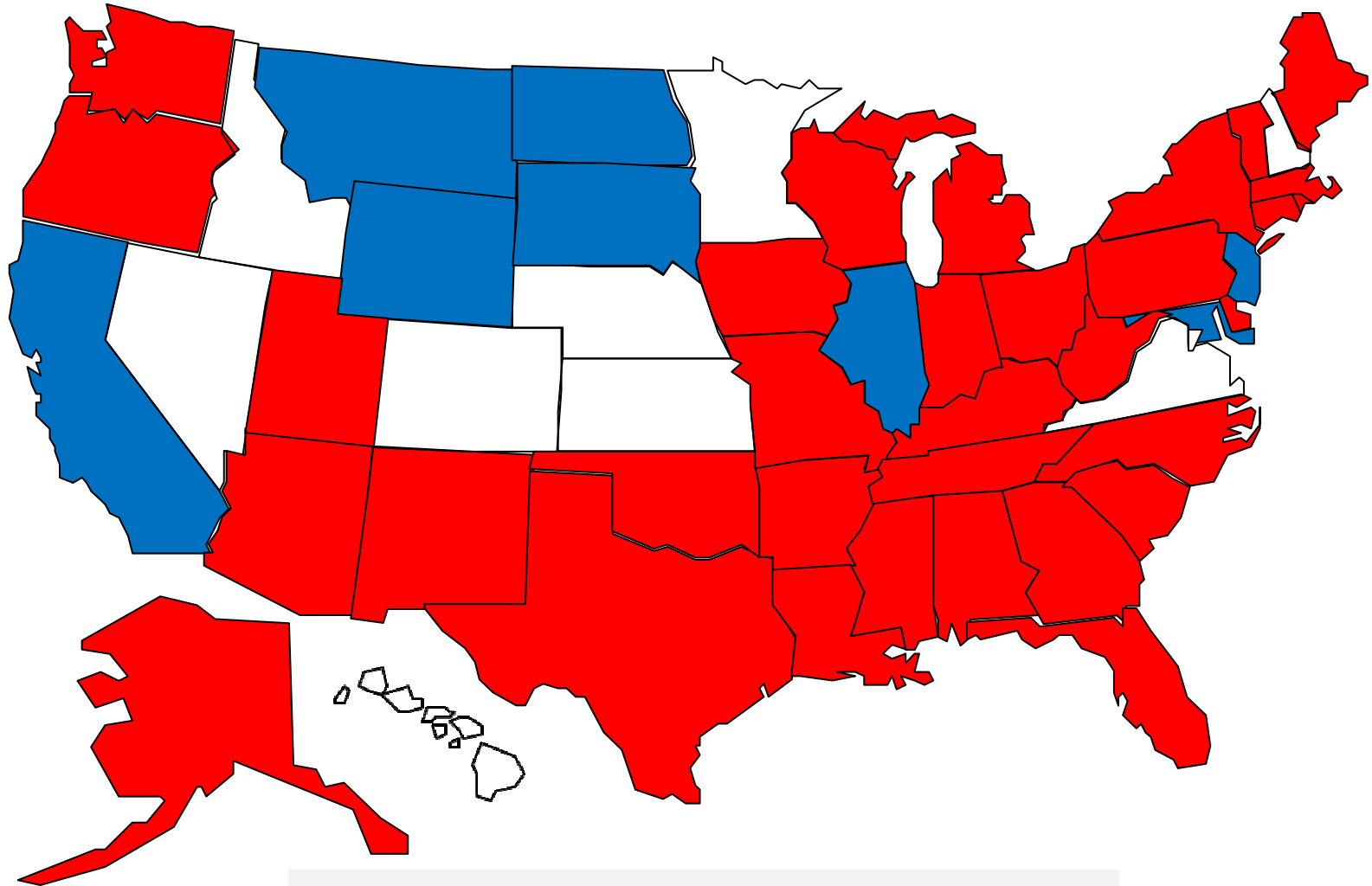


Data from CMS, as of end-December 2011.



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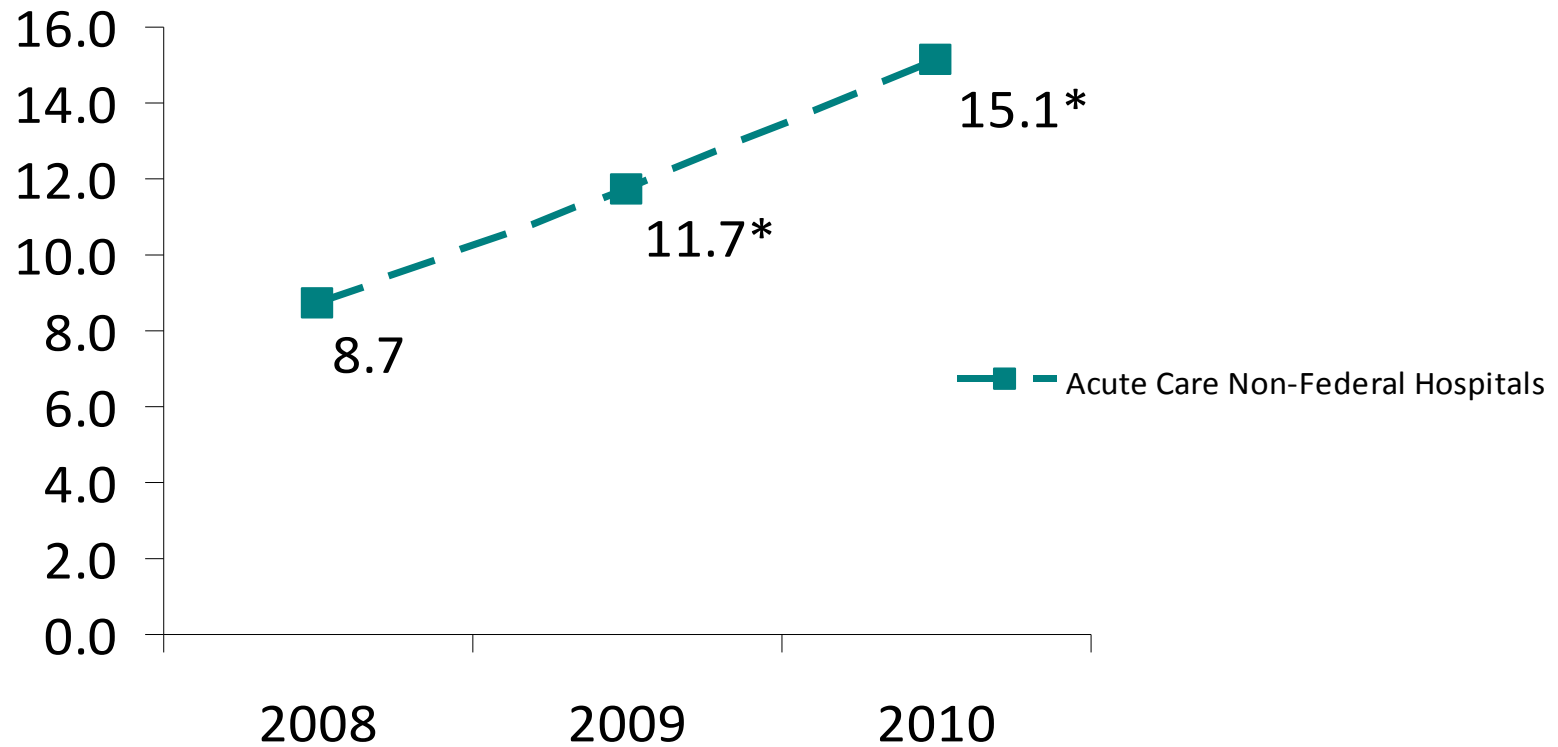
*Most, but not all, states have now established  
Medicaid EHR incentive programs*



**Red** = Made Payments (33);  
**Blue** = Accepting Registrations (8)  
Data from CMS as of December 2011

# AHA Annual Tracking Survey

## Percent of Acute Care Non-Federal Hospitals With at Least a “Basic” EHR (2008 - 2010)



Note: Survey supported by ONC  
Source: ONC analysis of AHA data



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# *Automated Clinical Quality Measurement*

- Has clear benefits
  - Efficiency
  - Real-time results
  - Potential to include whole populations, or specific subsets
- However, to be used it must be:
  - Feasible
  - Result in valid and reliable results
  - Have benefits that outweigh the costs



# Automated Clinical Quality Measurement

## We Are Not There Yet

- Problems with the e-specifications, which were never field tested
- Require data elements and vocabularies that may not be in the EHR
- Certification that explicitly does **not** test the accuracy of CQM calculation
- Adopted transmission standard now rejected by CMS (PQRI XML) as “not feasible to use”
  - CMS has proposed pilot test of new standard in 2012
- No orderly process in place to communicate, facilitate, and test updates to e-specs



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# Recent CMS Clarifications on CQMs

- Statement on attesting to CQM data's validity – October 18
  - Provide data from certified EHRs
  - Can still attest if have questions about accuracy
  - No data validation
  - Report from EHR to be used for audits
- **FAQ 10839**: Does a provider have to record all **clinical** data in their certified EHR technology in order to accurately report complete **clinical quality** measure data for the Medicare and Medicaid EHR Incentive Programs?

... **Although we encourage providers to capture complete clinical data in order to provide the best care possible for their patients, for the purpose of reporting clinical quality measure data, CMS does not require providers to record all clinical data in their certified EHR technology at this time. ...**



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***What's Next?***



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# *Steps to Improve Stage 1*

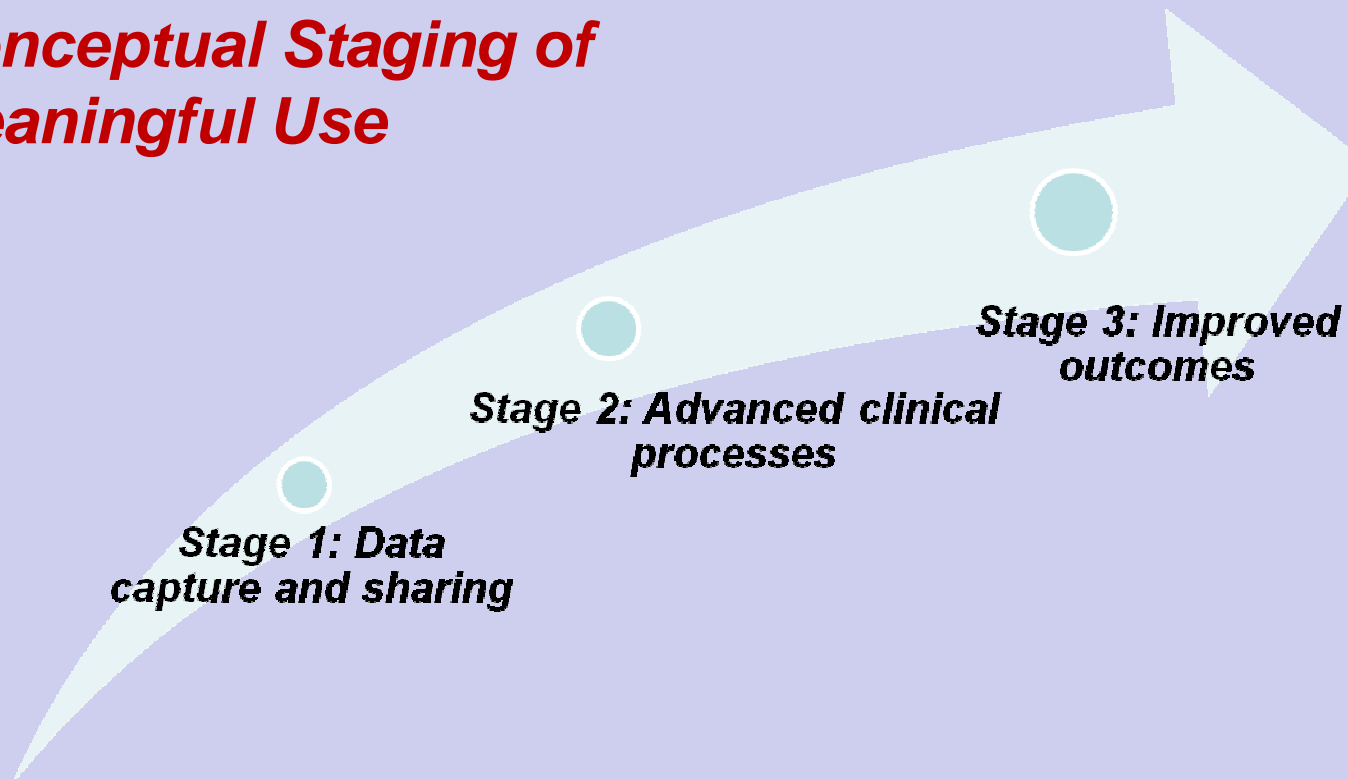
- Collaborative approach to identifying steps that would increase number of successful attestations (hospitals, physicians, HIT professionals, vendors)
- Specific recommendations:
  - Reduce regulatory complexity
  - Clarify certification and site certification processes
  - Address providers' meaningful use resource requirements
  - Clarify and improve registration, attestation, and compliance processes
  - Evaluate regulatory timeline



# Meaningful Use Stage 2

- Stage 2 scheduled to begin FY2014
- CMS to release proposed rule – expected in February 2012

## Conceptual Staging of Meaningful Use



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# *HIT Policy Committee Recommended Changes For Stage 2*

## Changes to existing objectives

- Menu items become core
- Higher levels of use (Ex: CPOE increased from 40% to 60% of medication orders, and expanded to include lab and radiology orders)

## New objectives

- Greater information exchange across settings
- Focus on tools for care coordination
- Website allowing patients and families to view and download information about a hospital stay within 36 hours of discharge
- Structured, coded lab results when hospitals serve as reference labs

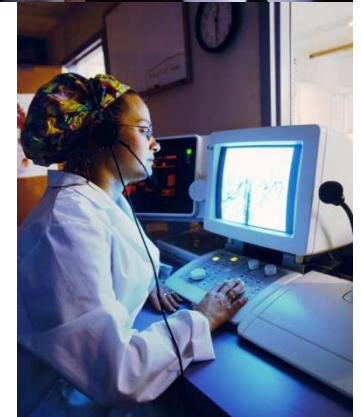
***Results in increase in number of  
required objectives from 19 to over 30***



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# *Multiple Federal Initiatives are Affecting Hospital IT Departments*

- Meaningful use of EHRs
- Transition to new administrative transactions
  - 5010 and related operating rules
  - ICD-10 for coding of diagnoses
- Health reform initiatives that require quality metrics and advanced analytics to support
- Changes to HIPAA requirements to provide new reports to patients
  - Accounting of disclosures
  - Electronic copy of records held in electronic form



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# *Policy Discussions Going Forward*

- Meaningful use stage 2
  - Timing, definition, usability
  - Related standards and certification criteria
- Getting quality measures right
- Approaches to health information exchange
  - State-based HIEs? Direct Project?
  - Nation-wide HIN? Query-based (PCAST approach)?
- Related policies
  - Privacy and security
  - Matching patients to records
- Need for market-based strategic plan
  - Goals, resources, timelines
  - Alignment with other programs and policies



# Hospitals are Pursuing Innovation



*“There is a way to do it better – find it!”*

*“The value of an idea lies in the using of it”*

*“Genius is one percent inspiration, ninety-nine percent perspiration”*

*-- Thomas Edison*



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# Resources

- AHA Member Materials on Meaningful Use  
<http://www.aha.org/meaningfuluse>
- Office of Civil Rights – HIPAA resources  
<http://www.hhs.gov/ocr/privacy>
- Office of the National Coordinator for HIT - Certification program  
<http://healthit.hhs.gov/portal/server.pt?open=512&objID=1153&mode=2>
- Centers for Medicare and Medicaid Services – Medicare and Medicaid EHR Incentive Programs  
<http://www.cms.gov/EHRIncentivePrograms>



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# Contact

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# Questions



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