10 Arguments You May Have Heard about the Meaningful Use Proposed Rule... And the Consumer Response

Congress provided a rare opportunity in the creation of the Meaningful Use (MU) incentive program to transform our health care system and truly improve the quality and efficiency of care for all Americans. But this can only be achieved if it is accompanied by a robust definition of MU. CMS is on the right track with the proposed rule; and while improvements are needed, the final rule must maintain this ambitious yet achievable direction to ensure that the public truly benefits from this incredible investment of taxpayer dollars.

Argument #1: The proposed meaningful use definition is asking too much, too soon for 2011. It should be scaled back so more providers can focus on simple adoption.

Forward-thinking doctors and hospital administrators have been clear: the proposed criteria for MU in 2011 are achievable. Congress’ intent was not to drive automation, but to drive “meaningful use.” The requirements do not ask for any capabilities that are beyond those of today’s certified EHR technology, and were drafted specifically so they could be met by a broad array of providers. The rule also offers significant flexibility by allowing providers to choose their starting payment year according to the timeline that best suits their needs. Providers who decide not to pursue the incentives in 2011 or 2012 will still have the opportunity for significant payments in succeeding years, while those that have already begun to make progress will be appropriately rewarded. And, it’s important to remember that these incentives are voluntary; they are not an entitlement and there is no requirement to participate. Providers can chose to adopt HIT at their own rate, according to their own criteria, but for those choosing to leverage public dollars we must ensure the investment pays off in the form of better care.

Argument #2: Providers, especially hospitals, need much greater flexibility in the sequencing of the goals and objectives for meaningful use.

In discussions since the publication of the proposed rule, the HIT Policy Committee has recommended additional flexibility by allowing some criteria in some categories to be deferred, while making certain criteria mandatory. We agree with this approach, as long as the criteria in the both Privacy & Security and Patient Engagement are mandatory. Privacy and security criteria are essential for gaining and maintaining trust in the system, and patient engagement criteria require changes that will make the most difference to patients and their families. These changes are not likely to occur without clear incentives for providers. In addition, recently the Policy Committee’s Meaningful Use Work Group recommended some lowering of the highest performance thresholds that providers would have to meet, while still incentivizing measureable progress.

Argument #3: There are too many quality measures proposed, and many criteria require manual recording.

We agree. CMS proposed a number of quality measures for comment that they will streamline based on public input. However, some quality measures must be retained – both because quality measurement is required by the HITECH Act, and because measurably improving quality is the ultimate meaningful use of HIT. To maximize the benefits of electronic systems, we believe it is important to focus on a core set of exemplar measures that demonstrate providers are using key functions of the EHR, can be collected easily as a byproduct normal workflows, and that show progress in improving health outcomes for patients. MU criteria should not include measures that necessitate manual recording.

Argument #4: Small primary care practices have fewer resources to implement meaningful use as defined in the proposed rule. Therefore those intended to benefit most from these incentives, won’t.

Around the country there are many examples of small physician practices that have adopted technology successfully, and it has made their care better and their lives easier. And now, for the first time, federal funds are available to help more small practices cover the cost of such systems. Congress also specified in ARRA that the Regional Extension Centers – entities that will provide help in achieving meaningful use – must prioritize their efforts to support these smaller providers, including those who care for rural and underserved populations. Congress also ensured that eligible Medicaid providers and hospitals can receive funding in their first year for adopting, implementing, or upgrading certified EHR technology so they are able to meaningfully use the technology in their second payment year.
Argument #5: The timeline to meet the proposed measures is too aggressive, given that we don’t have a single national infrastructure or set of national standards.

The requirements for Year 1 of the proposed rule are based on the capabilities and standards of today’s certified EHR technology. The only area of ambiguity is data exchange, and consequently CMS is proposing that providers perform one test of their ability to send data to another authorized provider. Since data exchange is foundational to the goal of better information that will lead to improved quality of care, we believe it is essential to maintain this basic criterion, although we also believe that the data exchange should have to be successful.

Argument #6: Implementing computerized physician order-entry (CPOE) is a tremendous task, and adoption levels are very low. Implementation of CPOE must be paced according to individual provider needs, and it is unreasonable to require criteria related to CPOE before 2015.

CPOE is a foundational tool that allows providers to request and manage orders such as diagnostic tests, clinical procedures, medications, and other services electronically – capabilities necessary to provide the most effective, appropriate care for patients. Without CPOE, providers can’t take advantage of all of the functionalities of an EHR system that will improve the quality of patient care and reduce medical errors, such as reminders for follow up care, clinical alerts, and decision support. Hospitals would only be required to use CPOE for just 10 percent of physician orders in Stage 1.

Argument #7: Many of the criteria require significant workflow and system changes to incorporate services that are not reimbursed.

Simply automating current workflow and processes is not meaningful use of HIT. As part of transforming our health care system, we need to leverage the MU incentives to change processes and incentivize providers to, for example, send reminders to patients for preventive and follow-up care, provide patients access to their health information, and ensure that transitions in care go more smoothly. While these kinds of activities may not be paid for explicitly under fee-for-service, the MU incentives act as a financial reward for this kind of patient-centered care. The activities in the draft rule, and the corresponding incentive payments, will translate to the kind of better provider-patient relationships and more patient-centered care that providers and patients both want. And, we can’t successfully implement further payment reforms without an underlying HIT infrastructure to connect our fragmented system and report on how providers are performing.

Argument #8: Providing patients with access to their health information is too much of an added burden on providers.

In a digital world, if patient health information is available electronically to a provider, it can and should be made available electronically to patients. Many systems today allow patients and family caregivers to have real-time, ongoing access to information that helps them to be active participants in their health and care. This is not a burden when designed well, such as when information is accompanied by education and resource materials that help consumers understand and use their own information effectively. Access to electronic health information will enable consumers and families to better manage their health and coordinate their care.

Argument #9: Collecting structured data on race, ethnicity, preferred language and gender (RELG) is too burdensome for providers.

If we are serious about eliminating health disparities and improving care for vulnerable populations, we need to collect better information about the demographics of patient populations. Congress clearly signaled their interest in collecting and using this information in the HITECH Act, and CMS appropriately followed through by requiring providers to collect RELG data under MU. We hope that in the final rule and succeeding definitions CMS will go further and require the analysis and use of this information to reduce and ultimately eliminate disparities.

Argument #10: Forcing providers to implement HIT too rapidly will ultimately harm patients.

No provider will be forced to implement HIT, since the MU incentive program is voluntary. Countless numbers of patients are already being harmed every day due to the absence of information necessary to provide consistent, high quality care. Providers who are not ready to implement HIT in the first year and are consequently concerned about patient safety can opt not to pursue the incentive money in the first years, while at the same time making the necessary plans to implement these life-saving technologies in future years. Patient safety is a top priority for all stakeholders, and work is underway to monitor HIT-related safety issues as we continue to reap the safety benefits that we know are already resulting from the effective use of HIT, which is critical to the overall advancement of patient safety.

For more information, visit [www.nationalpartnership.org/hit](http://www.nationalpartnership.org/hit) or contact Eva Powell, Director of HIT Programs at 202-986-2600.