



## Health Information Technology (HIT)

### Background

Congress established the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs in the American Recovery and Reinvestment Act (ARRA) to provide much-needed funds to support the rapid and widespread adoption of electronic health records. Under ARRA, these funds are to be made available to hospitals and physicians demonstrating “meaningful use” of a “certified” EHR system.

Wisconsin’s hospitals are appreciative of the opportunity presented under ARRA and share the Administration and Congress’ vision of a health care system where widespread use of interoperable EHRs supports improved clinical care, better coordination of care, fully informed and engaged patients, and improved public health. **However, WHA has concerns that DHHS’s implementation of the EHR Incentive Programs will fall short of Congress’s goal of supporting rapid, widespread electronic health record adoption.**

Under ARRA, hospitals and health care providers eligible for the EHR incentive payments must meet two criteria: (1) Have *certified* EHR technology and (2) *meaningfully use* that certified EHR technology. On July 13, HHS released its final rules defining certified EHR technology and meaningful use. WHA and Wisconsin hospitals are currently reviewing both of these new rules.

### Proposed Meaningful Use

In WHA’s comments on the proposed meaningful use rule released in January, WHA expressed several critical concerns to CMS, including:

- CMS’s timeline and requirements were unrealistic and would have negative consequences on patient safety and quality. According to a survey of Wisconsin hospitals, ***only half of responding Wisconsin hospitals expected to be capable of performing all 23 of the Stage 1 meaningful use functions in the proposed rule by 2015.***
- CMS excluded many physicians from eligibility for the incentive payments due to an overly broad definition of “hospital-based physician.”
- CMS defined an eligible hospital in a way that resulted in some Wisconsin multi-hospital systems being treated as a single hospital, and therefore significantly reducing the amount of incentive payments to each hospital in the system
- CMS proposed to exclude Wisconsin’s smallest hospitals, Critical Access Hospitals (CAHs), from eligibility for Medicaid EHR incentive payments, thereby potentially increasing the digital divide between Wisconsin’s smaller, rural hospitals and their counterparts.

### Final Meaningful Use Rule and Other Implementation Issues

As WHA and Wisconsin hospitals continue to review the just released final rule on meaningful use, we are pleased to see **some positive changes** in the final rule:

- **Modified “all-or-nothing”** - CMS somewhat modified its strict “all-or-nothing” approach where a hospital would be required to meet 23 separate requirements to meet meaningful use. Instead, a hospital must now meet 14 requirements plus choose from 5 of 10 additional functionality requirements in order to meet meaningful use. However, as discussed below, it is not clear that this modest change will ensure the goal of this stimulus program to have widespread adoption and use of EHR technology.
- **CAHs now eligible for Medicaid EHR incentives** –Wisconsin CAHs that meet the 10% Medicaid volume threshold are now eligible for Medicaid EHR incentives. This change will provide some Wisconsin CAHs additional money to more fully develop their EHR functionalities.

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- **Exclusion for “hospital-based physician” narrowed** – Early this spring, Congress passed legislation correcting overly narrow language that excluded many physicians who work in hospital-owned clinics from receiving EHR incentives. Given Wisconsin’s highly integrated health care system, many Wisconsin physicians would not have been eligible for the EHR incentives without this change. WHA thanks Congress for making this important change.
- **Reduction in reporting burden** – CMS appears to have made changes that will make it easier for hospitals to show that they have met the meaningful use requirements. Under the proposed rule, many of the required meaningful use measures would have required hospitals to conduct time consuming manual reviews of patient records. It appears that CMS has made modifications eliminating many, if not all, of the measures requiring manual review.

While there are positive changes in the final meaningful use rule, **WHA remains concerned that CMS’s implementation of the EHR Incentive Programs will not ensure widespread success of this stimulus program.**

In particular:

- **Only modest flexibility** – After a preliminary review of the final meaningful use rule, we remain concerned that the path to meeting the meaningful use requirements remains too steep, especially for hospitals that are at low levels of adoption of EHR functionality. Given the difficulty and timelines needed to implement EHR technology in hospitals, the implementation of the EHR stimulus program needs to be flexible enough to aid all hospitals whether they are just beginning EHR implementation or further along the path to implementing robust EHR systems.
- **Multi-Campus Hospital Definition** – CMS declined to define an eligible hospital in a way that would allow multi-campus hospitals/systems from each receiving incentive payments. Unfortunately, many Wisconsin multi-hospital systems will therefore be treated as a single hospital, which will significantly reduce the amount of incentive payments to each hospital in the system. WHA strongly opposes this definition and urges Congress to address legislatively.
- **Regulatory uncertainty will hinder hospitals’ ability to meet timelines** - We are especially concerned that delay of critical aspects of HHS’s implementation plan for the incentive program will make it especially difficult for hospitals to meet the timelines set forth by Congress and HHS. For example, ONC is not expected to identify the entities that will test and certify EHR products before the end of summer. Yet, the hospital incentive program begins October 1, 2010. Further, many of the meaningful use provisions in the final rule contain significant ambiguity. CMS indicates that additional guidance and explanation of the meaningful use rule will be forthcoming. Until the regulatory uncertainty of the EHR incentive programs are resolved, hospitals and vendors will be faced with the choice of making million dollar commitments with uncertain regulatory requirements in order to meet a tight regulatory timeline, or foregoing stimulus funding until those requirements become more certain.
- **No long term plan** – Hospital EHR projects are complex, time consuming and require careful advance planning. For this reason, WHA, AHA, and hospitals throughout the country recommended that CMS immediately promulgate a set of defined but expanding meaningful use requirements through 2017, so that hospitals and vendors can appropriately plan and implement compliant EHR systems. Unfortunately, CMS has chosen to reserve rulemaking on future stages of meaningful use until a later date. We believe this is a mistake which will force rushed EHR planning in future years that will be more costly and potentially reduce quality.
- **Non-EHR related policy** – New meaningful use requirements have been added to the final rule which appear to have little relation to EHRs. For example one measure would require hospitals to show that “more than 10 percent of all unique patients admitted to [the hospital] are provided patient-specific education resources.” Without debating the merits of such requirements, it seems inappropriate for measures loosely related or unrelated to EHR adoption to have an impact on receiving stimulus funding for EHR adoption.