Meaningful Use—Final at Last: Final Rule Adds Flexibility to Objectives, Eases Measures

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The final rule on the EHR incentive plan offers more "flexibility and choice" than the daunting proposed rule, adjusting the objectives and scaling back some of the measures. Now interested providers just need to figure out how to get with the program.

After perhaps the longest six months in healthcare history, the industry has an actionable rule on meaningful use. The Department of Health and Human Services published a final rule on the EHR incentive program July 28, effective September 26.

HHS published the final rule on standards and certification criteria, which supports the meaningful use program on the same day. It becomes effective August 27. (The final rule on the temporary certification program supporting the program was published in June and became effective immediately.)

The rule's release was announced at an event in Washington, DC, featuring HHS secretary Kathleen Sebelius and other HHS officials, including David Blumenthal, head of the Office of the National Coordinator for Health IT.

The event was short on details, but when asked, Blumenthal confirmed that the rule eases the requirements put forth in the notice of proposed rulemaking published in January. HHS received more than 2,000 comments on the proposed rule, Blumenthal said, and heard consistently that it was too inflexible.

In response, he said, the final rule adds "flexibility and choice," allowing program participants to "take different pathways to meaningful use." The objectives, he said, are intended to be both "ambitious" and "achievable," so that "if you try, you can get there."

Overall, the rule lowers the bar on many of the measures associated with the objectives and adds flexibility by allowing participants to choose some of the objectives they will pursue.

Core and Menu Objectives

The proposed rule established 27 objectives participants would meet to qualify for meaningful use in stage 1 of the program. The final rule largely maintains these objectives, but divides them into "core" and "menu" sets.

Participants must achieve each objective in the core set. There are 15 objectives for eligible professionals (EPs) and 14 for eligible hospitals and critical access hospitals.

The menu set, which Blumenthal described as the "a la carte part," offers choice. It includes 10 additional objectives, of which eligible professionals and hospitals will choose five. The items not chosen will be deferred to stage 2. (There are 12 objectives in total, with 10 applying to EPs and 10 to hospitals.)

Participants may select any five objectives from the menu set, with one limitation. They must choose at least one population and public health measure, a requirement that HHS made to ensure these goals received sufficient attention.

HHS expects to update the meaningful use criteria every two years, with the stage 2 criteria to be finalized by the end of 2011 and stage 3 criteria by the end of 2013.

Easing up on the Requirements

In many instances the final rule adds to or alters the NPRM descriptions of objectives and measures, adding clarification or detail and often addressing challenges to data collection raised in the comments.

The majority of notable changes are reductions in the measure thresholds, recognition that HHS set its sights too high in the proposed rule. Many of the measures that required performance levels of 80 percent have been reduced to 50 percent or lower, for example.

In all, two objectives were **added**-both to the menu set:

- Record advance directives for patients 65 years old or older (hospitals only; measure: indication of an advance directive status recorded for more than 50 percent of all unique patients 65 years old or older admitted)
- Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate (both EPs and hospitals; measure: resources provided to more than 10 percent of all unique patients)

Two objectives were **removed**, deferred to later stages:

- Check insurance eligibility electronically from public and private payers (at least 80 percent of all unique patients)
- Submit claims electronically to public and private payers (at least 80 percent of all claims filed electronically)

Among the relaxed measures are the following:

- Use CPOE-more than 30 percent of unique patients (proposed: 80 percent of all orders for EPs and 10 percent of all orders for hospitals)
- Record and chart changes in vital signs-for more than 50 percent of all unique patients age 2 and older (proposed: more than 80 percent)
- Provide patients with an electronic copy of their health information…upon request-for more than 50 percent of requests within 3 business days (proposed: more than 80 percent, within 48 hours)
- Implement 1 clinical decision support rule (proposed: implement 5 rules)

For a full list of objectives, including the changes, visit http://journal.ahima.org.

On the Menu

Ten objectives were moved to the "menu" set, and two were added. EPs and hospitals must choose five, with one being a population and public health objective. Objectives not chosen will be deferred to stage 2.

Stage 1 Objectives
Implement drug-formulary checks (Moved from the core objective "use evidence-based order sets and CPOE")
Record advance directives for patients 65 years old or older **(new, hospitals only)**
Incorporate clinical lab test results into certified EHR technology as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach
Send reminders to patients per patient preference for preventive/follow-up care **(EPs only)**

Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP **(EPs only**)
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate **(new)**
The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation
The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral
Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice
Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice **(hospitals only)**
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice

For a full list of the final rule's objectives and measures, including how they changed from the proposed rule, visit http://journal.ahima.org.

Stages Remain

The final rule retains the phased approach to meaningful use that HHS introduced in the proposed rule. There remain three stages.

HHS had originally proposed that all participants be at stage 3 in 2015 regardless of when they joined the program. However, enough concerns and questions remain on how to achieve this that HHS chose to remove all language discussing possible directions beyond 2014. It will address those years in later rulemaking.

HHS also notes that nothing restricts it from requiring additional stages later.

Otherwise, there was one change in the staging-providers joining the program in 2013 will be required to be at stage 1 in 2014, not stage 2 as originally proposed.

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