Overview of AHIMA's Comments on Meaningful Use

Save to myBoK

posted by Kevin Heubusch

Mar 03, 2010 03:59 pm

AHIMA Meaningful Use White Paper Series Paper no. 8

Preceding papers in this series have reviewed the requirements in the notice of proposed rulemaking on meaningful use, published by the Centers for Medicare and Medicaid Services in January 2010. This paper highlights AHIMA's comments on the NPRM and links to the full document.

The Centers for Medicare and Medicaid Services (CMS) released its proposal for the meaningful use program as a notice of proposed rulemaking (NPRM) in part to solicit comment on the details of this complex initiative prior to proceeding with the rulemaking process. Comments are due March 15.

CMS intends to post the final rule in late spring or early summer. The number and variety of comments it receives will affect the final rule's timeliness as well as its content.

AHIMA's comments on the NPRM were prepared by its members and staff, who reviewed and analyzed not only the NPRM itself, but all related activity beginning with initial testimony taken at the National Committee on Vital and Health Statistics hearings in April 2009 through the recommendations of the Health IT Policy and Standards Committees and CMS's own comments within the NPRM.

AHIMA has focused its comments on subjects that affect the health information management profession directly and on which it has direct expertise.

The Association's intention in posting a draft preview of its comments is to offer perspectives that individual members or state associations might want to consider as they write their own comments. It is not AHIMA's intention that members or state association resubmit this same set of comments under their own names.

Meaningful Use

[Note: Page numbers refer to AHIMA's draft comments.]

AHIMA supports the payment year concept proposed by CMS. AHIMA also supports the concept of beginning year 1 with a 90-day eligibility period and using the fiscal or calendar year of eligible hospitals (EHs) or eligible providers (EPs) (p. 2).

AHIMA also indicates its support for the proposal that Medicare and Medicaid programs employ the same definitions and objectives in the interest of making the incentive programs as uniform and simple as possible.

While the Association also agrees with the three-stage concept proposed by CMS, it raises its concern about the time available for vendors and providers to gear up for the program. AHIMA also underscores its concern that there must be significant integration of clinical workflow, data quality processes, and technology (pp. 2–3).

AHIMA points out that the NPRM uses the term "evidence-based order set" but does not define it. The Association therefore proposes the following definition:

"Evidence-based orders sets are sets of orders for services and/or medications that are considered the most effective for a given condition and are listed in the sequence that provides the most efficacies for treating the findings and/or obtaining the best results. They are based on best practices that have been published and often are more efficient and cost-effective than

less structured traditional approaches. These sets are incorporated into EHR's CPOE and will prompt the physician when an order is entered to consider other tests and/or medications in addition to or in lieu of the original order entered."

Criteria and Functionality Measures

AHIMA turns considerable attention to the criteria for meaningful use and the health IT functionality measures, discussing the level of requirements and reporting flexibility (p. 3). It further comments on the need for feedback in the reporting process, parallel reporting requirements from other CMS programs, and the attestation program that CMS has proposed (pp. 3–4).

The Association raises concern with the testing of the measurements or metrics used in the measurement process as well as the manual data collection that will be required. Throughout its comments AHIMA expresses concern that the manual requirements caused by the current lack of integrated systems could deter providers from electing to participate in the program (p. 5).

AHIMA also raises concerns on the testing required of providers to demonstrate meaningful use. Most of the NPRM requirements call for one test to demonstrate the abilities of the EHR system. AHIMA suggests that attempting such a test might require considerable effort from providers given the lack of infrastructure and networking at this time and in the near future (pp. 5–6). This difficulty also could deter providers from taking part in the program.

Within its comments the Association offers feedback on the functionality measures for eligible professionals (pp. 6–14) and eligible hospitals (pp. 14–21). These comments are presented with their measures in a table to aid readability.

Among the comments related to EPs, the Association recommends that:

- CPOE requirement be held until stage 2
- The drug check requirements be merged with those of e-prescribing
- The problem list not be generated from coded data and that eventually SNOMED-CT be used
- CMS clarify the rules on medications lists
- Laboratories be required to use standards-based reporting
- Eligibility and claims requirements should not be required because they are not available in many EHRs that EPs use
- CMS clarify requirements for consumer access to electronic information
- Progress notes be required in stage 1

Many of AHIMA's comments with regard to EHs mirror those made regarding EPs, but the Association also comments on:

- The need to clarify the use of SNOMED-CT and ICD classifications (noting that AHIMA has long advocated that the US should adopt SNOMED-CT)
- The collection of race and ethnicity data (which AHIMA supports) and body mass index in age groups 2–20 (which AHIMA does not support for EHs at this time)

Quality Measures

Given its extensive work on quality measures, AHIMA comments in depth on the proposed submission of clinical quality measures (pp. 23–26).

The Association calls for consideration of the measures themselves as they apply to different provider groups and different methods of submission. AHIMA's comments are consistent with its previous calls for uniform reporting of clinical quality measure across all health plans and providers and its advocacy for an agreed-upon set of data to be captured in EHRs that will enable quality reports to be generated uniformly and allow providers to collect data once and report them for many subsequent uses.

Finally, AHIMA notes its understanding of CMS's proposal to recognize only hospital inpatient services initially; however, the Association states its concern for the impact this could have on hospital-based outpatient clinics.

AHIMA also comments that if EHRs are meant to support patient-centered healthcare, then the meaningful use programs should include outpatient clinics and long-term care facilities. Doing so enables the continuity of a person's care through the

use of EHRs across the care continuum and health information exchange (p. 27.)

This is the last paper in the series to address the meaningful use NPRM. The next and final paper will offer an overview of AHIMA's comments on the certification standard interim final rule from the Office of the National Coordinator for Health IT, which is closely related to the meaningful use NPRM.

Original source:
AHIMA. "Overview of AHIMA's Comments on Meaningful Use" (Journal of AHIMA website), March 2010.
