



NUMEROUS ORGANIZATIONS COMMENT ON STAGE 3 MEANINGFUL USE RECOMMENDATIONS

The Health Information Technology Policy Committee ("HIT Policy Committee") is a federal advisory committee that advises the United States Department of Health and Human Services ("DHHS") on federal health information technology ("HIT") policy issues. One of the pressing issues is how to define the meaningful use of electronic health records ("EHRs") for the purposes of the Medicare and Medicaid EHR incentive programs. The HITECH portion of the American Recovery and Reinvestment Act of 2009 mandated that incentives should be given to Medicare and Medicaid providers for the meaningful use of EHRs. In July 2010 and August 2012, DHHS released final rules defining Stage 1 and Stage 2 meaningful use, respectively.

In November 2012, the HIT Policy Committee, Office of the National Coordinator for Health Information Technology ("ONC"), DHHS released a "Request for Comments" ("RFC"), which was a request for comments regarding the HIT Policy Committee's recommendations for Stage 3 meaningful use.¹ Comments were due by January 14, 2013. Stage 3 requirements are expected to go into effect in 2016. According to the RFC, the Stage 3 meaningful use "vision" includes "a collaborative model of care with shared responsibility and accountability, building upon previous [meaningful use] objectives." Therefore, the HIT Policy Committee recommended that Stage 3 be "the time to begin to transition from a setting-specific focus to a collaborative, patient- and family-centric approach." Further, whereas Stage 1 focused on data sharing and capture and Stage 2 focused on advance clinical processes, Stage 3's focus is on improved outcomes.²

To that end, the HIT Policy Committee developed a preliminary set of recommendations specifically designed to solicit additional public feedback. The recommendations were divided into three broad categories: Meaningful Use Objectives and Measures, Quality Measures, and Privacy and Security.

The Meaningful Use Objectives and Measures was in grid form. The grid compared the Stage 2 final rule with the Stage 3 recommendations. In certain instances, measures were proposed for future stages. These Meaningful Use Objectives and Measures were divided into 6 subsections that included: 1) improving quality, safety, and reducing health disparities; 2) engaging patients and families; 3) improving care coordination; 4) improving population and public health; 5) information exchange; and 6) overarching meaningful use questions. Many subsections contained, among other things, objectives and corresponding measures. For example, one objective for eligible hospitals would be to generate and transmit permissible discharge prescriptions electronically ("eRx"). The measure would be having more than 30 percent of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) compared to at least one drug formulary and transmitted electronically using Certified EHR Technology.

¹ The Request for Comments was published in the Federal Register on Monday, November 26, 2012. 77 Fed. Reg. 70444 (Nov. 26, 2012).

² See HealthIT.gov accessed at <http://www.healthit.gov/providers-professionals/meaningful-use-definition-objectives>



The Meaningful Use Objectives and Measures contained recommendations for new objectives and also included certain Stage 2 goals with recommended higher thresholds. For example, a new objective would require providers to provide 10 percent of patients with the ability to submit patient-generated health information and request an amendment to their health record online. Another recommendation would require that providers implement 15 clinical decision support interventions (Stage 2 required 5 such interventions).

The Quality Measures section was divided into three subsections: patient centeredness, CQM pipeline, and quality improvement support. Both the Quality Measures and Privacy and Security sections contained a series of questions and requests for comments and feedback. For example, in the Quality Measures section, questions included the following: Which, if any, high priority domains should receive prioritized attention in Stage 3? What measure concepts, addressing these domains, should be considered for development? What EHR capabilities should be leveraged to realize these concepts? Privacy and Security questions included: Should ONC permit certification of an EHR as stand-alone and/or an EHR along with a third party authentication service provider? What, if any, security risk issues (or Health Insurance Portability and Accountability Act ("HIPAA") Security Rule provisions) should be subject to Meaningful Use attestation in Stage 3?

Last month, just on or before the due date for comments, a number of organizations provided comments regarding the Stage 3 recommendations contained in the RFC. Organizations included, without limitation, the College of Healthcare Information Management Executives ("CHIME"), the Federation of American Hospitals ("FAH"), the American Hospital Association ("AHA"), the American Medical Association, the American College of Physicians, the American Academy of Family Physicians ("AAFP"), and the Florida Hospital Association ("FHA"). In addition to providing specific comments to the Stage 3 recommendations, many of the organizations' comments set forth broad concerns, criticisms and recommendations with respect to the Stage 3 recommendations.

For example, many of the comments reflected the idea that Stage 1 and Stage 2 meaningful use requirements should be thoroughly evaluated before moving forward with Stage 3. In its letter, dated January 14, 2013, for example, CHIME began by noting the "difficulty of commenting on a number of the proposed objectives and measures for Stage 3 and related issues at a time when there is still limited information regarding Stage 1 and no real experience under Stage 2." The letter continues, "[w]e see no value in setting unrealistic performance thresholds or expectations before current evaluations of what we have accomplished have been undertaken. [] . . . every desirable EHR-related objective cannot feasibly be met by 2016, nor do we see any value in attempting the rushed adoption of various EHR uses by that time. Instead, verifiable and continuous progress should be the goal."

FAH echoed this sentiment in its January 14, 2013 letter and stated: "*We strongly recommend that the ONC institute an initiative to assess the value of current meaningful use requirements and pilot-test proposed future requirements that require significant additional cost for providers before they are added to the program.*" (Original emphasis). Similarly, the FHA noted in its FHA Link Weekly Update, dated January 17, 2013, "that it is much too soon to look at Stage 3. It is vital that HHS first evaluate Stage 1, and even Stage 2, before moving to Stage 3. HHS must evaluate the existing requirements for meaningful use from the perspective of providers, vendors and the government. HHS must identify what components of the existing program are working well and where improvement is needed before adding a new set of measures to the definition of meaningful use."



These and other organizations called on federal policymakers to delay implementation of Stage 3 meaningful use requirements. As noted by the AAFP in its January 10, 2013 letter, ". . . since Stage 2 was delayed until 2014, the AAFP calls on HHS to delay Stage 3 requirements until at least 2017. [] We call for this delay since we remain concerned that HHS is attempting to raise the bar for what constitutes meaningful use before the majority of physicians and hospitals are able to achieve the meaningful use Stage 1 or 2 objectives. The AAFP also calls on HHS to use this time to evaluate the extent of intended and unintended outcomes of existing meaningful use requirements, using these lessons to then appropriately shape stage 3 requirements."

In its January 14, 2013 letter, the AHA recommended that DHHS "fund a comprehensive, external evaluation that highlights progress to date, but also seeks to understand why, more than two years into the program, the large majority of hospitals and physicians have yet to attest to meaningful use." Further, the AHA stated that it ". . . urge[s] the HITPC to refrain from finalizing Stage 3 recommendations until it has reviewed the results of such an evaluation and can develop an implementation plan for Stage 3 that addresses the issues raised in Stage 1."

Many organizations also pointed to the amount of time and money providers have spent trying to comply with meaningful use requirements. For example, the FAH noted that ". . . we are concerned, under the current Meaningful Use timeline, that providers are constantly implementing technology, with no time to work on actually using the data generated by the technology to improve care or support delivery system reforms. We believe the current regulatory construct of 2-years in each stage is a barrier to fully realizing the core goals of the Meaningful Use Program—to improve the quality, safety and efficiency of healthcare provided to patients. [] Providers are almost focused solely on being compliant with requirements, rather than optimizing the technology that has already been implemented. Meaningful Use is not, and cannot be, the sole focus of providers." Accordingly, the FAH recommended that the current two-year meaningful use time-frames for Stage 2, Stage 3 and any future stages be extended by one year.

Further, the FAH stated that ". . . we are concerned that so many of the objectives recommended in this Stage 3 RFC will require significant additional investment by providers. We believe the time has come to assess the value of the requirements providers are already being asked to comply with for Stages 1 and 2 prior to adding substantial new requirements."

CHIME also described its "concerns that with each successive Stage of meaningful use, significant costs are incurred to upgrade and maintain solutions. Each new objective outlined in this RFC translates to more time, money and staffing resources expended by providers to meet meaningful use; meanwhile, EHR Incentive Payments are structured to decline over time. This dynamic makes participation in subsequent Stages less and less palatable for providers, jeopardizing the fundamental aim of bringing the nation's healthcare system into the 21st Century."

CHIME then described the "growing turmoil" facing providers with respect to HER vendors. Specifically, CHIME stated that "it appears that many hospitals and health professionals may have little or no choice but to transition from one vendor's EHR product to another vendor's product, due to vendor business failures, vendor consolidation, vendor decisions not to seek certification for products capable of meeting requirements beyond those adopted for Stage 1, and even vendor performance problems. As you know, such transitions are challenging under the best of circumstances. More



importantly, in the context of EHR payment incentives and payment adjustments, such transitions risk disadvantaging affected hospitals and health professionals."

As noted above, in addition to the broad criticisms and recommendations set forth in the organizations' comments, many organizations provided detailed, specific comments to many of the Stage 3 recommendations. The RFC noted that, following the analysis of the comments received through the comment period, "the HITPC intends to revisit these recommendations in its public meetings in the first quarter of 2013. It is important to note that although the following RFC is being communicated via HHS and the Federal Register, it represents the preliminary thinking of the HITPC, and not necessarily HHS or its various agencies."

For additional information regarding the foregoing, and/or for assistance with any meaningful use issues, please feel free to contact Lynn M. Barrett, Esq. at lbarrett@joneswalker.com.

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