

HITECH Act and Measuring Meaningful Use

Hearing on “Meaningful Use” of Health Information Technology
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Panel 10: Measuring Meaningful Use

1. A. What are the strengths and limitations of the various methodologies provided in the statute for demonstrating meaningful use (attestation, submission of claims with appropriate coding, survey, reporting of quality measures, or other means)?

B. What are the most feasible and reliable measurement methods to ascertain compliance with these requirements for meaningful EHR use and associated incentives?

Statutory Options

- Attestation
- Submission of claims with appropriate coding
- Survey
- Reporting of quality measures
- Other means

Statutory Requirements

- Demonstration of being a “meaningful user”
 - Basic requirements:
 - Electronic prescribing for physicians
 - Being connected in a manner that provides... for the exchange of health information to improve the quality of health care, such as promoting care coordination
 - Quality measures submission when Secretary can accept
 - Additional requirements: Policy question as to what additional uses required to be considered “meaningful” for a particular year
- Mechanism for determination: Attestation, Survey, Claim, or other could serve to document “meaningful use” for individual or group representative

Incentive

- Incentive payment tied to PFS charges
 - 75 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the payment year) of the allowed charges under this part for all such covered professional services furnished by the eligible professional during such year
- Requires reviewing claims for individual professional with respect to a practice to which benefits are reassigned
- Attestation, Survey or Other would need to identify the practice to which the individual's attestation, survey or other applies (in order to make incentive payment)

Statutory Payment Limitations

- Statutory Maximum
 - \$18,000 Year One
 - A 10% increase to an eligible professional who predominantly furnishes services under this part in an area that is designated by the Secretary ... as a health professional shortage area
- Coordination of incentive limitations among practices
 - Secretary shall establish rules for cases where an eligible professional furnishes covered professional services in more than one practice ...including the application of the limitation on [maximum] amounts of such incentive payments among such practices
- No incentive for hospital based eligible professional
 - an eligible professional, such as a pathologist, anesthesiologist, or emergency physician, who furnishes substantially all of such services in a hospital setting (whether inpatient or outpatient) and through the use of the facilities and equipment, including qualified electronic health records, of the hospital

Options for Meaningful Use Determination at NPI-TIN level

- Claims data can be used to determine meaningful use based on submitting additional codes on claims for specific individual NPI as submitted on the claim, related to a particular practice (TIN).
- Claims data also quantifies amount of PFS charges for individual NPI as submitted on the claims related to a particular practice (TIN)
- Business process models for use of claims to make determination for eligibility for incentive at NPI-TIN developed and implemented for PQRI
- Existing structural measures in use for PQRI for HIT Adoption and E-Prescribing
- Use of Attestation, Survey, or other would need to address making determination at NPI-TIN level.

Statutory Incentive Payment Limitations

- Adds additional requirements to arrive at amount of incentive payment for an individual professional connected with a particular practice after determination of “meaningful user” at NPI-TIN level
- Goes beyond what exists for PQRI
 - No maximum incentive under existing PQRI or E-Prescribing incentive programs
 - 2% of PFS allowed charges
 - No maximum
 - No need to coordinate among practices
 - No limitation for hospital based eligible professionals
 - No additional payment for professional shortage area

Structural Measures to determine Meaningful Use

- Mechanism to identify, quantify, and track by professional/provider (meaningful) use

Elements of Claims Reported HIT Structural Measure

- Definition of qualified/certified HIT system [functionalities or other requirements]
- Specification of “uses” of HIT system functionalities to be reported
- Claims Codes to report uses for particular patients
- Denominator billing codes identifying on whom to report
- Program requirements for satisfactory reporting
 - Examples
 - Certain number or percentage of patients
 - Required instances of particular (meaningful) use

Panel 10: Measuring Meaningful Use

2. The third criterion for a provider to be determined to be a meaningful user is the reporting of quality measures using EHR's. What, if any, additional standards are needed to enable providers to report and CMS/States to successfully accept quality measures from EHR's? Are the needs different for measures applied to different settings (e.g. hospital or physician office)?

Multiple current data sources for Quality Measures

- Claims
 - Physician, Hospitals
- Augmented Claims
 - Quality Data Codes included on Claims
 - Physician Quality Reporting Initiative
 - ESRD requirement
- Chart Abstracted Measures
 - Hospital Pay for Reporting
- Patient Assessment Instruments
 - MDS
 - Nursing homes
 - OASIS
 - Home Health Agencies
- Clinical Registries
 - 31 Registries in PQRI

Advantages of EHR for quality measures

- Primary Source Data
- Data not segmented by payer (contrast claims)
- Standardized data elements
- Availability of much more timely data
- Audit output files
- Improved Relationship of Population and Accountability Measures
- Potential to aggregate clinical and claims information to assess value
- Potential to use data as an element to consider in payment

Clinical Quality Measures

- HITECH requires for meaningful use submission from EHR's of clinical quality measures only if Secretary has capability of accepting information, which may be on a pilot basis

EHR Standards Requirements for Clinical Quality Measures

- Numerator and Denominators for the Quality Measure
- Electronic specification standards for capturing the data elements specifications of the quality measures
- Requirements for certified systems to capture the data element
- Transmission of Data

Reporting Quality Data from EHR's

- Various options for receiving quality measures
 - In either case, quality Measures could be accompanied by audit files providing information on other EHR “ meaningful uses”
 - Data elements in EHR – file output
 - Various forms of transmission of file
 - Output files of calculated measures
 - Data elements exported to file and transmitted
 - Data elements in EHR – data element transmission
 - Direct transmission from EHR to CMS
 - Submission through health information exchange
 - Pushed or queried data elements from which measures calculated

CMS: Status of EHR reporting of clinical quality measures

Physicians

- PQRI – 2007 PFS Rule announced plan to test EHR submission
- PQRI – 2008 Posted electronic specifications 10 physician clinical quality measures
 - Preparation for testing of submission
 - Seeks alignment with standards adoption processes for EHR's
- PQRI - 2009 PQRI testing of EHR submission; attention to transmission using Health Exchange Standards and NHIN
- PQRI - 2010 Potential receipt of EHR submission based on testing results
- CMS - EHR Demonstration – may provide means to expand physician measures set pending broader EHR standards development, January 2011

CMS: Status of EHR reporting clinical quality measures for Hospitals

- Stated interest in moving to EHR reporting in IPPS rules for Hospital Reporting Incentive Program
- Standards identification by HITSP for three Measures Sets
 - Hospital Emergency Department Throughput
 - Stroke
 - Venous Thromboembolism
 - Submission to CCHIT for inclusion in certification requirements

Challenges for expanding use of EHR's for clinical quality measure data

- Clinical data frequently unstructured
 - Structured data elements desired for clinical quality measures
- Quality Measurement Development dynamic
 - Limited experience with physician measures other than primary care, prevention, chronic conditions
 - Additional or changed data elements will be regularly needed
- Standardized Quality Data Sets for Physicians and Inpatient EHR's
 - Support quality measure capture using selected standards in certified EHR products
 - Physician Quality Data Set
 - Initial Measures Set
 - Inpatient Hospital Quality Data Set
 - Initial measures set
 - CARE Data Set
- Process needed for regular update of EHR certification requirements

CMS EHR Testing Using Health Information Exchange Standards

- Anticipate testing submission using template standards for quality measures that can be transported using standards for communication within and between health information exchanges.
- Other aspects of testing involving portal based testing
- Goal is to have information pulled from the health information exchanges through the NHIN based on vendors utilizing the NHIN standard

Quality Measurement: Relationship to interoperability

- Coordination of Care High Priority Quality Goal
 - Supported by sharing of information
- Optimal Quality Measurement depends on data from multiple EHR sources
 - Supported by interoperability standards and sharing of information
 - Allows population/provider analysis

Conclusions

- Quality Measurement can support measurement of meaningful use progressing from structural measures to clinical quality measurement.
- Structural measures based on claims submission can identify, quantify and track meaningful use; Alternative mechanisms not utilizing claims code submission must nevertheless address determination at individual professional-practice unit.
- Clinical Quality Measures require mechanism for Secretary to receive data. Such mechanism could also identify, quantify and track meaningful use.
- Clinical Quality Measurement using EHR's as data source has multiple advantages.
 - can provide primary source clinical data and documentation of EHR uses
 - Clinical quality data from multiple EHR's can be combined to support population level measurement and measurement for professional and provider accountability
 - Potential for broad measurement perspective not payer specific
 - Potential to support payment system at least in part based on clinical data and clinical quality

Conclusions

- Standards for EHR submission relate to what and how data is captured in EHR; and standards for transmission of data. Standards for capture of data and placing in a standard template requires an ongoing process based upon new and modified clinical quality measures. Standards for transmission of data are closely connected with the broader application of EHR's for exchange of clinical data.
- CMS existing mechanisms for structural measures and preparations for EHR submission provide foundation for promotion and measurement of meaningful EHR use.