BIPARTISAN POLICY CENTER

Assessment of Proposed Rules for Stage 2 of "Meaningful Use" in Light of Bipartisan Policy Center's Report "Transforming Health Care: The Role of Health IT"

May 7, 2012

Overview

With an unprecedented investment of nearly $30 billion in health information technology (IT) brought about by the Health Information Technology for Economic and Clinical Health (HITECH) Act and the advancement of new delivery system and payment models, the U.S. has the opportunity to make significant progress toward health care's triple aim of improving health, improving the experience of care, and reducing costs.

At the three-year anniversary of HITECH, it is clear that the health care landscape is changing. Spurred by rising costs, inconsistent quality and eroding coverage, coordinated, accountable and patient-centered models of care delivery – previously implemented by only a handful of organizations – are now poised for more widespread adoption. Initiatives launched by the federal government, numerous states and communities, and private sector providers and health plans designed to test new methods of payment and delivery are driving significant change to promote much-needed improvements in the quality and cost-effectiveness of health care.

The Bipartisan Policy Center (BPC) commends the Department of Health and Human Services (HHS) for continuing to advance—through two Notices of Proposed Rulemaking (NPRM) for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs—informally referred to as "Meaningful Use"—the health information foundation needed for new models of care.

On January 27, 2012, the Bipartisan Policy Center released a report entitled "Transforming Health Care: The Role of Health IT," (BPC Report) outlining a set of recommendations for the most effective use of health IT to improve health, improve health care and reduce costs. The BPC Report was developed under the leadership of the BPC Task Force on Delivery System Reform and Health IT (Task Force), led by BPC Health Project co-leaders and former Senate Majority Leaders Tom Daschle and Bill Frist, and including a broad range of nationally recognized experts and leaders from many sectors of health care. Grounded in research, including interviews with forty high-performing organizations and input from health care leaders, the Task Force identified the common attributes of high-performing health care organizations and the health IT capabilities required to support them. The Task Force also developed a set of recommendations for addressing the gaps in health IT capabilities in the U.S. today—many of which were related to stage 2 of Meaningful Use. See http://www.bipartisanpolicy.org/sites/default/files/Transforming%20Health%20Care.pdf for a copy of the BPC Report, "Transforming Health Care: The Role of Health IT".

This statement highlights the health IT capabilities needed for high-performance in health care and assesses the proposed rules in light of such capabilities.

Common Attributes of High Performance in Health Care and the Health IT Capabilities Needed to Support Them

Our nation's highest performing health care organizations share many attributes that enable them to achieve higher quality care, lower cost and greater access.

1. Organization-wide focus on the needs of the patient
2. Strong organizational and clinical leadership
3. Access to information to support efficient, coordinated care
4. Timely access to care
5. Emphasis on prevention, wellness and healthy behaviors
6. Accountability, alignment of incentives and payment reform

The health IT capabilities needed to support these common attributes that are relevant to the proposed rules fall into three primary categories:

1. **Access to health information** from across the range of settings in which care and services are delivered—while effectively managing privacy and security—combined with clinical decision support, to help clinicians and care teams provide coordinated, patient-centered, evidence-based care both at the point of care and between visits.
2. **Engagement of consumers through the use of electronic tools** to support access to their health information, better communication with their clinicians and care teams between visits, and education and awareness of important information relevant to their health and health care.
3. **Ability to analyze health information** from across patient populations—while effectively managing privacy and security—to support clinicians and other health care providers set goals, track performance, and identify opportunities for clinical improvement.

As noted in the BPC Report, Meaningful Use alone is not expected to address all of the health IT capabilities needed for new coordinated, accountable, patient-centered models of care. Getting to the "data-rich" environments necessary for delivery system and payment reforms will require innovative tools that appropriately fall beyond the current and anticipated requirements for Meaningful Use. It is also important to note that many providers are not eligible for Meaningful Use, including nursing homes, rehabilitation centers, and other long-term care facilities. Steps must be taken to support transition of these practices and organizations to the meaningful use of health IT to support higher quality, more cost-effective care.

As noted above, new payment and delivery models that are now being evaluated will provide the biggest boost to health IT and health information exchange efforts. Given the size of its investment, Meaningful Use—if well implemented—can also provide much-needed incentives and support for a flexible foundation that enables clinician and care teams, as well as patients and their caregivers, to access the right information at the right time, from across the multiple settings in which care and services are delivered. This is a key component of higher quality, cost-effective, coordinated, accountable, and patient-centered care.

EHR adoption rates among providers continue to be fairly low. Currently only 35 percent of office-based physicians and 27 percent of non-federal hospitals have adopted a "basic" EHR.[1,2] According to the results of research published last month, only 11 percent of physicians eligible for Medicare or Medicaid Meaningful Use incentives both intend to apply for the incentives and have EHR systems with the capabilities to support two-thirds of the stage 1 core objectives required for Meaningful Use.[3] As of March 31, 2012, either Medicare or Medicaid EHR incentive payments had been made to approximately 74,000 of the 521,600 eligible practicing clinicians and 2,667 of the approximately 5,000 eligible hospitals.[4]

Meaningful Use must strike a careful balance, setting the bar high enough to lay a solid foundation for new models of care, but also low enough to encourage broad participation, especially among those still using paper records.

Assessment of Proposed Rules for Stage 2 Meaningful Use in Light of BPC Report

The proposed rules make many positive strides in building the health information foundation needed for higher quality, cost-effective care. At the same time, there are some areas where adjustments are needed to further align Stage 2 requirements with the health IT capabilities needed for coordinated, accountable, patient-centered care, while also encouraging flexibility and innovation and enabling broad participation across the multiple settings in which care is delivered. An assessment of key elements of the proposed rules against the relevant findings and recommendations of the recently-released BPC Report is provided below.

Promote and Support Progress on the Electronic Exchange of Health Information

High-performing organizations that demonstrate higher quality, more cost-effective care, work hard to coordinate care across providers, settings, conditions and time. Multi-disciplinary teams communicate effectively and deliver integrated, collaborative care. Enabled by health IT, they provide access to patient records from across a range of settings, along with clinical decision support tools that help clinicians and care teams provide integrated, patient-centered and evidence-based care both at the point of care and between visits. Health IT and health information exchange enable all providers who care for the patient, as well as patients and family caregivers, to access the right information at the right time—regardless of the system in which it resides. The information is drawn from patient records in hospitals, physician practices, laboratories, pharmacies, and health plans, as well as from the patients themselves. Information management tools help health care organizations manage the health of their population of patients. Privacy and security are carefully managed.

Without interoperability across disparate systems and robust health information exchange, it will be difficult, if not impossible, to achieve on a wide scale, several common attributes of high performance. These attributes include those related to care coordination, clinical decision support, shared decision-making among the patient and the care team, and measurement of outcomes to support accountability and improvement.

While access to and the exchange of information across multiple settings are central and necessary components of coordinated, accountable and patient-centered models of care--and a

primary priority articulated within HITECH—at HITECH's three-year anniversary, the level of electronic health information exchange in the U.S. remains extremely low.

Recommendations Drawn from BPC Report:

To lay the foundation for coordinated, accountable, patient-centered care, stage 2 of Meaningful Use should expand the requirements associated with health information exchange for both eligible professionals (EPs) and hospitals. A summary of recommendations—drawn from the recently released BPC Report—is provided below.

1. Promote the Electronic Transmission of Summary of Care Records for Transitions of Care and Referrals

The proposed rule for the EHR Incentive Programs calls for making it required rather than optional to provide summary of care records for transitions of care and referrals (though these records need not be electronic). The proposed rule also calls for the summary of care records for a percentage of transitions of care and referrals to be transmitted electronically to a recipient with no organizational affiliation that uses a different certified EHR vendor.

As noted in the BPC Report, the electronic transfer of information plays a critical role in improving quality and cost-effectiveness and promoting coordinated, accountable, patient-centered care, and should be promoted. Clinicians and the teams of professionals who care for patients should have access to the right information at the right time to inform clinical decision-making—regardless of the system in which it resides. Due to the nature of the U.S. health care system, this information currently resides in a wide variety of settings including the offices of primary care physicians and specialists, hospitals, laboratories, pharmacies, and health plans.

Approximately three-quarters of all physician visits in the U.S. take place in physician practices with five or fewer health professionals and the nearly 34 percent of all physicians who have adopted a basic EHR use a variety of systems.[5,6] Research indicates that the average Medicare beneficiary has just over 15 visits annually and sees 6.4 unique physicians in a year.[7] And, as of this writing, there were 2,066 certified EHR products listed on the Office of the National Coordinator for Health IT's (ONC's) Certified Health IT Product List.[8] Enabling clinician and care team access to a patient's health information—drawn from the multiple settings in which care and services are delivered—will necessitate the movement of information across different organizations and different vendor products.

The use of standards for the information that is transmitted will help clinicians, hospitals and other health care providers use health IT to analyze and present the information in useful formats to support better clinical decisions and improvements in the overall health and health care of their patients.

Promoting--in some fashion--the electronic transmission of a feasible number of summary of care records that cross organizational lines will lay the groundwork for the more robust health information exchange that must occur in the future to support high quality, cost-effective, coordinated, patient-centered care. Also, hospitals, clinicians and other providers who have chosen to participate in more advanced levels of information exchange—including

"push and pull" methods supported by a wide range of electronic health information exchange networks—should be able to demonstrate compliance with the stage 2 Meaningful Use objective through their participation in such networks.

Stage 2 certified EHR technology should demonstrate the ability to electronically receive, display, and transmit information included in the summary of care record. Information included in the summary of care record should use standards to promote interoperability and use of this information for clinical decision support and other quality improvement interventions. Data transport standards should support both the "push and pull" of health information.

2. Replace the Current "Test" of Exchange Capability With Requirements for Electronic Transmission

The proposed rules for the EHR Incentive Programs call for the removal from both stage 1 and 2 the current core objective related to the test of the "capability to exchange key clinical information." Proposed rules for stage 2 replace this with requirements associated with the electronic transmission of a summary of care record for a percentage of transitions of care and referrals.

The BPC Report recommends transition of the current requirement for a "test" to the "operational standards-based exchange of real patient information for a real, but achievable, number of patients" in stage 2. Requiring the electronic transmission of the summary of care record, as outlined in #1 above, accomplishes this goal.

If HHS chooses to retain the test of the "capability to exchange key clinical information" in stage 1, hospitals and EPs could be invited to voluntarily report the results of that test (with no identification of the patient) to HHS or some other HHS-designated entity, including the purpose of the exchange, the results of that test (success or failure), the method used to facilitate exchange, the type of information exchanged, the standards utilized, and the name of the provider or electronic health information network with which the exchange was attempted. Based on BPC's research to date, there is very little data regarding the level and nature of exchange being conducted by individual practices, hospitals or other provider organizations. This information would play an important role in assessing the current practical and technical barriers to health information exchange and informing the development and execution of a set of policies and strategies for accelerating interoperability and the robust health information exchange needed for rapidly emerging new models of care.

3. Incorporate Clinical Lab Test Results into the EHR as Structured Data

The proposed rule for the EHR Incentive Programs calls for transitioning from the current "menu" objective that calls for both EPs and hospitals to incorporate the results of clinical lab tests into the EHR as structured data, to the "core" or required set in stage 2 of Meaningful Use.

As noted in the BPC Report, access to lab tests results—in a structured format and using standards, and both during and in between visits—is critical to clinical decision-making and

plays a key role in improving both the quality and cost-effectiveness of care. Access to the results of tests previously performed reduces the potential for redundant testing, which causes both inconvenience to the patient and unnecessary cost in the system. While not addressable in Meaningful Use, HHS should continue to explore methods to incentivize laboratories to also electronically transmit data using the standards included in the proposed rules.

4. Enable Access to Imaging Results

The proposed rule for the EHR Incentive Programs includes a new "menu" objective that calls for a percentage of imaging results to be accessible through certified EHR technology. Access to imaging test results (e.g. through a "link" or otherwise) both during and in between visits is critical to clinical decision-making and improving both the quality and cost-effectiveness of care. Access to the results of imaging tests previously performed enables clinicians to review trends, reduces the potential for and cost of redundant tests, and reduces inconvenience and, in some cases, unnecessary radiation exposure for the patient.

5. Support Both "Push and Pull" of Electronic Standards-Based Information to Support the Needs of Coordinated, Accountable, Patient-Centered Care

According to the BPC Report, one of the most important attributes of high-performance in health care is access to information to support efficient, coordinated care. Access to patient records from across a range of settings, along with clinical decision support tools, helps clinicians and care teams provide integrated, patient-centered and evidence-based care both at the point of care and between visits. As a result, clinicians and care teams must be able to "pull" discrete data from across the settings in which a patient's care and services are delivered, while effectively managing privacy and security, and organize that information within their systems to provide a longitudinal view of a patient's health information. Furthermore, the appropriate use of such data supports both measurement and improvement of outcomes across the clinician's patient population.

The Office of the National Coordinator for Health Information Technology (ONC) has launched several efforts to support health information exchange, including the State Health Information Exchange Cooperative Agreement Program, the Nationwide Health Information Network (Nw-HIN) Exchange initiative and the Direct Project. ONC launched the Direct Project in 2010 to help providers begin to electronically transmit information to meet the limited health information exchange requirements of stage 1 Meaningful Use. Direct is often described as a "push" model—somewhat like secure email—in which a message can be sent so long as the receiving person's email address is known. Direct is perceived by many to be easier to implement, and has been described by ONC as a useful "on ramp" to more robust two-way data exchange--which will be required for new models of care.

The proposed rule on EHR Standards and Certification requires the use of transport standards developed under the Direct Project (e.g. SMTP and SMIME secure messaging standards) for both the electronic transmission of the summary of care record (outlined in #1 above) and the ability to transmit information downloaded by the patient to a third party. One of the transport standards that facilitates "push and pull" (e.g. SOAP-Based

Secure Transport RTM version 1.0 standard) is presented as an option for the transmission of the summary of care record, but is not required.

The BPC Report recognizes the value of "push" models such as Direct, particularly as it relates to providing an easy "on-ramp" for EPs, hospitals and other providers who are just beginning to transition to the use of health IT. At the same time, increasing numbers of clinicians, hospitals and health systems are rapidly moving toward new coordinated, accountable, patient-centered models of care supported by new methods of payment. These models will require more robust methods of health information exchange--including not only transmission of, but also access to, discrete standards-based health information from across settings. Significant investments in infrastructure are now being made to support the mobility of such information while effectively protecting patient privacy. Clinicians, hospitals and other providers that are rapidly moving toward these new models of care must have the flexibility to utilize health information exchange approaches that meet their needs.

HHS should continue to promote and expand—through Meaningful Use and its other programs—its support for both "push and pull" methods of exchange and the ability to exchange discrete, standards-based data, given the needs of delivery system and payment reforms, and coordinated, accountable, patient-centered care.

Promote the Use of Electronic Tools to Support Consumer Engagement

Patients are at the center of high-performing organizations and new models of care. Health IT supports patient engagement in all aspects of their health and health care by offering individuals access to the information they need to manage their health and navigate care.

In high-performing organizations, patients benefit from secure access to information contained in their health records, effective communication with their clinicians and care teams during and between visits, access to educational resources, and availability of user-friendly self-monitoring and tracking aids.

Health IT plays a critical role in supporting patient-centered care, yet use of electronic tools to coordinate care, drive provider-patient communication, and empower patients to manage their health and health care is not widespread.

Recommendations Drawn from BPC Report:

To lay the foundation for coordinated, accountable, patient-centered care, stage 2 of Meaningful Use should expand the requirements associated with consumer engagement. A summary of recommendations—drawn from the recently released BPC Report—is provided below.

1. Enable Consumers to Have Electronic Access to Their Health Information

The proposed rule for the EHR Incentive Programs expands on the current requirement that EPs and hospitals provide an electronic copy of a patient's health information upon request and the optional objective to make available to at least ten percent of patients, timely electronic access to their health information. Specifically, the proposed rule requires that

EPs and hospitals provide to more than 50 percent of their patients, timely, online access to their health information. In addition, the proposed rule requires EPs and hospitals to assure that their patients either view, download, or transmit to a third party, their health information.

The BPC Report emphasizes the value and need for patients to have electronic access to their health information. A recent survey indicates that a majority of personal health record (PHR) users believe that either looking at their test results or prescriptions online would be somewhat or very useful.[9] Providing consumers with online access to targeted and useful health information—in formats that are understandable and easy to read--will enable patients and their caregivers to review their diagnostic test results, review their prescriptions and remember any follow-up needed, including appointments. Having access to this information is especially important upon discharge from the hospital. Such access will also enable patients to input this information into their PHRs or share such information with their other clinicians—this is particularly important given the current low levels of health information exchange among clinicians, hospitals and other providers in the U.S.

Clinicians also have a lot to gain from providing online access to information for their patients, including reducing the number of calls to the office and reducing the number of missed appointments—both of which have impact on the business of the busy physician practice. Clinicians play a critical role in supporting activation among patients. Research indicates that consumers have a high degree of trust in their doctors.[10] As a result, clinicians can play a key role in making their patients aware of the availability of online services and encouraging their patients to use them.

Certified EHR technology should demonstrate capabilities that enable patients to view, download and transmit to a third party their health information. It should also support transport standards that encompass both the "push and pull" of health information.

In assessing the number or percentage of patients for which this requirement is applicable, HHS should consider a number of factors, including research on the ability of both EPs and hospitals to have impact on patient behavior as well as factors that might prohibit patients from taking advantage of these services. Such factors could include lack of access to the internet or a computer, low levels of health literacy among disadvantaged populations, and in some cases, cultural norms. As noted in the BPC Report, HHS should also take steps to raise awareness of the benefits of electronic tools among both consumers and clinicians, and collaborate with the private sector on the development and dissemination of education and training materials to help health care providers make the transition.

2. Provide Timely Clinical Summaries to Patients to Support Actions Needed After Visits

The proposed rule for the EHR Incentive Programs shortens the amount of time under which EPs should provide clinical summaries to patients for each office visit.

As noted in the BPC Report, timely access to health information—either on paper or in electronic form—is critical to high quality, cost-effective care. As noted in #1 above, providing such information can help patients and their caregivers (which is particularly

important for parents and adult children of elderly patients) remember their diagnoses, prescriptions needed, their next appointment, and any follow-up instructions.

3. **Enable Secure Messaging Between Clinicians and Patients**

   The proposed rule for the EHR Incentive Programs introduces a new "core" objective that requires EPs to use secure messaging to communicate with a percentage of their unique patients.

   As noted in the BPC Report, secure messaging enables communication between clinicians and their patients between visits. Evidence shows that secure messaging between patients and their providers enhances quality of care and outcomes and that about half of PHR users believe that emailing their providers would be somewhat or very useful.[11,12,13,14] Secure messaging offers an easy way for clinicians or care teams to remind patients to schedule their appointments for follow-up or routine preventive measures and answer questions that don't require a face to face visit.

Other Issues Requiring Consideration

There are other challenges and barriers that must be addressed in order to continue laying the foundation for higher quality, more cost-effective care.

As outlined in the recently released BPC Report, attention must also be paid to the following key issues:

1. **Misaligned Incentives**
   New models of care, supported by the health IT capabilities required for their success, will not become the norm without transforming the nation's primarily volume-based payment model to one that promotes higher quality, more cost-effective care. Federal, state and private sector programs should align incentives and payment with higher quality, more cost-effective health care.

2. **Limited Levels of EHR Adoption**
   While EHRs are a necessary foundational component for new models of care, the level of EHR adoption and Meaningful Use among physicians, hospitals and other provider organizations remains low. Several steps are needed, including the rapid development and implementation of mechanisms for sharing best practices and strategies for addressing challenging areas and expanding implementation assistance programs.

3. **Privacy and Security Concerns**
   Solidifying public trust in health IT and electronic health information exchange initiatives will require assurance about the processes used to protect the privacy and security of health information. The administration should consistently issue comprehensive and clear guidance on compliance with federal privacy and security laws covering personal health information.

4. **Multiple Federal Priorities Require Focus and Attention**
   Health care organizations are faced with numerous requirements associated not only with health IT, but also with delivery system and payment reforms, health care coverage and access, administrative improvements, and program integrity. The federal government, working closely with states and the private sector, should align policies, programs and requirements associated with the use of IT for multiple federal health care programs.

   In particular, the federal government should coordinate and align its work on clinical quality measures. Specifications for such measures should be unambiguous, field-tested and align with data standards adopted by the HHS secretary. Specifications should also be consistent across federal programs, including Meaningful Use, Physician Quality Reporting System (PQRS), the CMS Shared Savings Program, and the Inpatient Quality Reporting program. The proposed rules for the EHR Incentive Programs appropriately reference this issue.

Summary

Given the level of federal (and therefore, public) investment being made in health IT today, it is imperative that such investments lay the foundation for rapidly emerging delivery system and payment reforms that will address the unsustainable growth in health care costs in the U.S.

Meaningful Use incentives and related health IT programs are a critical first step toward establishing the health IT capabilities needed for new coordinated, accountable, patient-centered models that have demonstrated improvements in quality and cost-effectiveness of care. Meaningful Use must increasingly support interoperability and health information exchange, patient access to information, and robust clinical decision support, all of which are required for these new models of care. In addition, federal policy should be developed with an eye towards promoting innovation and flexibility and supporting broad participation.

By continuing to couple federal investments with the baseline capabilities needed to share information electronically across settings and further engage patients in their health and health care, HHS can help assure that the extraordinary and unprecedented investment of nearly $30 billion — which is being equaled and exceeded by similar investments by the private sector — lays the necessary foundation for a coordinated, accountable, patient-centered health care system that provides all Americans with the affordable, accessible, high-quality care they need and deserve.

[1] Hsiao, C-J., Decker, S.L., Hing, E., and Sisk, J. (2012). Most physicians were eligible for federal incentives in 2011, but few had EHR systems that met meaningful use criteria. *Health Affairs*, 31, no.5.
[2] DesRoches, C.M., Worzala, C., Joshi, M.S., Kralovec, P.D., and Jha, A.K. (2012) Small, nonteaching, and rural hospitals continue to be slow in adopting electronic health record systems. *Health Affairs*, 31, no.5.
[3] Hsiao, C-J., Decker, S.L., Hing, E., and Sisk, J. (2012). Most physicians were eligible for federal incentives in 2011, but few had EHR systems that met meaningful use criteria. *Health Affairs*, 31, no.5.
[4] Centers for Medicare and Medicaid Services. (2012). *March 2012 EHR Incentive Program*. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Monthly_Payment_Registration_Report_Updated.pdf Accessed May 3, 2012.
[5] Hsiao, C., Cherry, D., Beatty, P.C. and Rechtsteiner, E.A. (2010). National ambulatory Medicare care survey: 2007 Summary. *National Health Statistics Reports*. No. 27. Hyattsville, MD. National Center for Health Statistics. November 2010.
[6] Calculated based on Centers for Medicare and Medicaid Services. (2012). *March 2012 EHR Incentive Program*. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Monthly_Payment_Registration_Report_Updated.pdf Accessed May 3, 2012.
[7] Berenson, R.A., and Horvath, J. (2002). The clinical characteristics of Medicare beneficiaries and implications for Medicare reform. Prepared for the Center for Medicare Advocacy, Inc.
[8] Office of the National Coordinator for Health Information Technology. Certified Health IT Product List. http://oncchpl.force.com/ehrcert?q=chpl Accessed May 3, 2012.
[9] California HealthCare Foundation. (2010). *Consumers and Health Information Technology: a National Survey*.
[10] Gallup. (2011). Honesty/ethics in professions: seventy percent of consumers polled rate doctors high or very high in honesty and ethical standards. http://www.gallup.com/poll/1654/honesty-ethics-professions.aspx Accessed May 4, 2012.
[11] Jimison, H. P. Gorman, SS. Woods et al. *Barriers and drivers of health information technology use for the elderly, chronically ill, and underserved*. (2008). Rockville, MD: Agency for Healthcare Research and Quality.
[12] Zhou, Y.Y., Kanter, M., Wang, J.J., and Garrido, T. (2010) Improved quality at Kaiser Permanente through email between patients and physicians. *Health Affairs*, *29,* no.7 ,1370-1375.
[13] Ralston, J.D., Carrell, D., and Reid, R. *Patient web services integrated with a shared medical record: patient use and satisfaction*. (2007). *J Am Med Inform Assoc* ,*14*(6),798-806.
[14] California HealthCare Foundation. (2010). *Consumers and Health Information Technology: a National Survey*.