The passage of the American Recovery and Reinvestment Act of 2009 (ARRA, Public Law 111-5) activated the provisions of the Health Information Technology Economic and Clinical Health Act, or HITECH Act. The HITECH Act codified into law the position of National Coordinator for Health Information Technology as part of the Office of the National Coordinator (ONC). The National Coordinator now, by law, reports directly to the HHS Secretary.

The provisions of HITECH also gave rise to two new powerful committees: The Health Information Technology (HIT) Policy Committee and the HIT Standards Committees. Both of these committees directly advise the ONC concerning how best to significantly increase the adoption of electronic health records (EHRs) and to use them to improve the quality, safety and efficiency of healthcare delivery.

Federal stimulus funds for hospitals and physicians
To stimulate the widespread use of EHRs, ARRA has authorized federal incentive payments in the total amount of $34 billion to roughly 5700 nonfederal hospitals and 700,000 practicing physicians who qualify. This money is the total outlay of federal funds authorized for incentive payments for physicians and hospitals to implement electronic records (since the final figure in ARRA assumed that approximately half of that $34 billion amount would result in savings for a net cost to the federal government for this investment of $17 billion).

These federal funds in the total amount of $34 billion will be distributed to physicians and hospitals qualifying for them over a five-year period, which will begin for hospitals on October 1, 2010 and for physicians on January 1, 2011.

Physicians may qualify for up to $44,000 over five years (2011 - 2015) through additional Medicare payments. Physicians not qualifying for these Medicare payments depending on the number of their qualifying Medicaid patients, may receive up to a total payment of $63,750, also over a five-year period from 2011 - 2015.

Physicians may only qualify for these payments from either the Medicare or Medicaid programs, not both. If physicians only see Medicaid patients (not Medicare patients which would be the case with pediatricians) they may only qualify for the extra payments under the Medicaid program. If they see both Medicare and Medicaid patients, however, (as most physicians do),
they would still only be able to qualify for extra incentive payments under the Medicare program.

Qualifying under either program (Medicare or Medicaid), these payments are front-loaded so that it literally does pay physicians more to have qualified EHRs in place as soon as possible and to be able to demonstrate that they are using them in a “meaningful way.”

The largest single annual payment (approximately 41% of the total possible) will be distributed to physicians in either calendar year 2011 or 2012 who are able to demonstrate “meaningful use” of a “qualified EHR” some time during either 2011 or 2012. This 2011 or 2012 payment will amount to $18,000 for those qualifying for additional Medicare payments and $26,080 for those qualifying for increased (maximum possible) Medicaid payments. Accomplishing this in 2011 or 2012 will qualify physicians for the total amount of possible incentive payments ($44,000 in extra Medicare payments and up to $63,750 in extra Medicaid payments for those otherwise meeting requirements for maximum payments) as authorized by ARRA over the course of a five-year period.

If physicians do not qualify for federal incentive payments during the 2011 and 2012 time periods, they may still qualify for incentive payments by meeting the 2011 requirements for meaningful use of qualified EHRs during 2013 or 2014. Qualifying under these 2011 definitions of “meaningful use of a qualified EHR” in 2013 will get physicians approximately 38.5% ($15,000 for Medicare and up to $21,733 from Medicaid) of a total five-year award which has been reduced by 11.4% ($39,000 for Medicare and a maximum of $56,506 in extra Medicaid payments) during calendar year 2013, with the rest payable in 2014 and 2015. Qualifying under 2011 definitions some time in 2014 will get physicians half ($12,000 in extra Medicare payments and up to $17,386 in extra Medicaid payments) of a total award that has been reduced by 45.5% ($24,000 total extra Medicare payments and $34,773 in total extra Medicaid payments) payable in 2014, with the remainder payable in 2015.

After qualifying for payments in the first two years under 2011 definitions of “meaningful use of an EHR” to obtain the third and fourth year payments, physicians must meet more advanced 2013 definitions of these terms. The physicians first qualifying for incentive payments in the 2011-12 window who may be eligible for the final fifth year payment, must meet the 2015 definitions. Those physicians not initially qualifying for federal incentive payments until the 2011-12 time period will not be eligible for this final fifth annual payment under 2015 definitions.

Physicians not meaningfully using qualified EHRs by 2015 (by any definition) will begin to see decreases in their base (market basket) Medicare and Medicaid payments by 1% in that year and by 2% in 2016. The decrease to such non-qualifying physicians will increase to 3% by 2017. In subsequent years, this decrease will remain at 3%, but could go up to as much as a 5% decrease if certain overall EHR adoption percentage thresholds are not met.

Qualifying for federal stimulus funds

Not since legislation in 1983 launched diagnosis-related groups (DRGs), has so much emphasis been put on the importance of how a particular term is defined. Title XIII of ARRA is dedicated to health information technology. There are eight specific national priorities for the meaningful use of qualified electronic health records to meet under subsection 3002(b)(2)(B) of ARRA. A discussion of these eight specific national priorities is beyond the scope of this article. However, these eight priorities have been nicely grouped into five overarching policy goals by the National Priorities Partnership (NPP, which was convened by the National Quality Forum or NQF):

- Improving the quality, safety and efficiency of care
- Engaging patients and their families
- Improving the coordination of care
- Improving population and public health, while reducing disparities in treating different racial, ethnic and socioeconomic groups of patients
- Ensuring privacy and security protections

All 2011, 2013 and 2015 definitions have been categorized under these five goals set forth by the NPP.

The Role of the Federal Health IT Policy and Standards Committees

ARRA gave rise to two new federal bodies whose roles include defining what is meant by the statutory language concerning the meaningful use of qualified electronic health records. Accomplishing this will help HHS determine which physicians and hospitals may qualify for the federal incentive payments according to the schedule discussed above for years 2011 through 2015. These two new bodies are the Health IT Policy Committee and the Health IT Standards Committee. To date, it has been the so-called ‘higher body’ - the Health IT Policy Committee - which has taken the lead in defining meaningful use of qualified electronic health records.

Led by National Coordinator for Health Information Technology, David Blumenthal, M.D., M.P.P. on July 16, 2009, the Health IT Policy Committee adopted an extensive list of care goals, objectives and measures falling under the five NPP categories listed above which constitute the meaningful use of qualified electronic health records. These goals, measures and objectives were adopted for 2011, 2013 and 2015 definitions for the purposes of determining which physicians and hospitals would qualify for the payments in particular amounts and at specific times between 2011 and 2015. In general, the following summary holds:

- Meeting the 2011 standards for meaningful use of a qualified electronic health record requires that physicians can demonstrate that they capture and share electronic data (which includes prescribing electronically, sharing electronic patient data with other providers to facilitate better diagnosis and treatment, and reporting on certain quality performance measures)
- Meeting the 2013 standards requires that they meet the 2011 standards, plus incorporate specific advanced care processes such as clinical decision support at the point of care
- Meeting the 2015 standards requires that they begin to demonstrate actual improvements in yet to be determined clinical outcome, safety and efficiency measures, as a result of their meaningful use of qualified electronic health records.

A detailed list of even the 2011 objectives and measures adopted by the Health IT Policy Committee on July 16, 2009 as constituting meaningful use of qualified electronic health records is beyond the scope of this article. However, it is available by performing the following functions:
For purposes of this article, there are five high level care goals to improve the quality, safety and efficiency of care (the first and arguably most important of the NPP policy goals) which physicians must be prepared to demonstrate that their meaningful use of qualified electronic health records are meeting:

- Providing access to comprehensive patient health data for the patient’s healthcare team
- Using evidence-based order sets and computerized physician order entry (CPOE)
- Applying clinical decision support at the point of care (now a 2013 meaningful use objective)
- Generating a list of patients who need care and using them to reach out to patients (reminders of care, instructions, etc.)
- Reporting to patient registries for purposes of quality improvement, public reporting, etc.

What constitutes a qualified electronic health record?

Finally, according to the Health IT Policy Committee, a qualified electronic health record is one capable of being meaningfully used by physicians to achieve these five care goals (and others falling under the four additional NPP categories according to the “Meaningful Use Matrix” approved at its July 16, 2009 meeting). Henceforth, it will be the federal government (through the granting of “HHS Certification”) which will determine whether EHRs which physicians and hospitals use are qualified and capable of being meaningfully used according to ARRA definitions.

The National Institute of Standards and Technology (NIST, which is actually part of the U.S. Department of Commerce and administers the Malcolm Baldrige National Quality Award) will oversee the accreditation of health IT certifying bodies (e.g., the Certification Commission for Health Information Technology or CCHIT). Although the private, not-for-profit CCHIT is currently the only federally qualified body to certify EHRs, it may be possible for other groups to become accredited to do so under this new HHS certification process, including the accreditation of health IT certification bodies by NIST.

To expedite the process, all ambulatory EHRs used by physicians and certified by the CCHIT under its 2007 or 2008 criteria will only need to meet additional new criteria, intended to permit its physician-users to demonstrate their meaningful use. The CCHIT will be developing and launching this new certification program for 2011 by January 31, 2010.

All EHRs previously certified by the CCHIT as meeting either 2007 or 2008 standards as well as those additional criteria developed and launched by the CCHIT by the end of January 2010 will be deemed to be qualified EHRs through December 31, 2012. Physicians demonstrated to be meaningfully using these 2011 HHS Certified EHRs through 2012 will qualify for maximum federal incentive payments (either through Medicare or Medicaid).

Risk management benefits

Achieving the five NPP policy priorities used to categorize the care goals, objectives and measures sought to be achieved through the meaningful use of qualified EHRs should result in risk management benefits for physicians. The first three, which are intended to improve quality, safety and efficiency of care; engage patients and their families; and improve care coordination, are closely related to three of the four areas most responsible for medical liability actions (communication gaps, ineffective office practices and clinical systems, and the clinical judgment and outcomes that these shortcomings may impact).

These areas were determined to be the most associated with liability claims from an analysis of thousands of claims from past years performed at Princeton Insurance and reported in: Electronic Medical Records Patient Safety and Risk Management Guide—An Addition to the Physician Office Practice Toolkit; Princeton Insurance Company; Princeton, NJ (2008).

In addition, the meaningful use of EHRs may also address the fourth major cause of liability as determined by this analysis of past medical liability claims— the content and sufficiency of medical records. According to the Princeton Insurance Electronic Medical Records Patient Safety and Risk Management Guide: “Standardized collection and evaluation of complete information on patients promotes content and clarity, the availability of which assists the physician in better decision-making, enhancing patient safety, and helping substantiate a physician’s diagnostic and therapeutic decision-making process. Depending on the level of interoperability, the patient safety benefits and efficiencies can be exponential” (p 17).

Looking ahead

Specific physician guidance on how to demonstrate meaningful use of qualified EHRs is still a work in progress. There must yet be put into place enabling regulations by the U.S. Department of Health and Human Services. These will determine more specifically the precise steps which physicians and hospitals must follow and all the various things that they must be able to demonstrate by way of meaningful use of qualified EHRs. This article was intended to provide an up-to-date and accurate roadmap of where everything is headed to give physicians a head start.

Given the amount of time that it takes to evaluate, select, implement and begin to meaningfully use qualified EHRs according to the measures discussed and references cited above (perhaps 18 to 24 months), it behooves all physicians who have not already begun this process to begin now. Not only will doing so put them in a position to reap maximum federal incentive money benefits, but done properly, early adoption and appropriate use of electronic records will result in significant risk management benefits for them and their practices through significant improvements in the quality and safety of care delivered to their patients.

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