

# UPDATE ON STAGE 2: CURRENT DIRECTION AND TIMING OF MEANINGFUL USE REQUIREMENTS

CSC

Author: Erica Drazen

## The HIT Policy Committee has released recommendations for Stage 2 of Meaningful Use

### *Changes Proposed:*

- Stage 1 menu items mandatory
- Increased thresholds for many measures
- Some new requirements: Physician documentation, e-MAR, more patient engagement

### *Recommendations from CSC*

- Re-evaluate Stage 1 plans to prevent re-work in Stage 2
- Proceed with all Stage 1 menu requirements
- Pilot challenging areas – inpatient physician documentation, patient engagement

On June 16, 2011, the HIT Policy Committee formally made [recommendations](#) to the Centers for Medicare & Medicaid Services (CMS) on requirements for Stage 2 of meaningful use. These are only recommendations, but provide another important clue as to what is likely to be included when the final rule is published in the summer of 2012.

### **Background**

CMS is expected to publish a Notice of Proposed Rule Making on Stage 2 requirements in late 2011, with the final rule anticipated in mid-2012. This process is informed by recommendations from two Federal Advisory Committees established by the American Recovery and Reinvestment Act of 2009 (ARRA).

- The **HIT Policy Committee** provides Stage 2 recommendations on policy issues such as the schedule and timing of new requirements, criteria associated with new objectives and measures, and changes to the scope and threshold of existing measures
- The **HIT Standards Committee** provides Stage 2 recommendations on standards, implementation specifications, and certification criteria based on the policies developed by the Policy Committee

CMS and the Office of the National Coordinator for Health IT (ONC) are not required to adopt the recommendations made by the two Federal Advisory Committees, but according to National Coordinator for Health IT Farzad Mostashari, “if the past is any indication of the future” the final rule on Stage 2 is “going to look a lot like” what the Policy and Standards Committees recommend.<sup>1</sup>

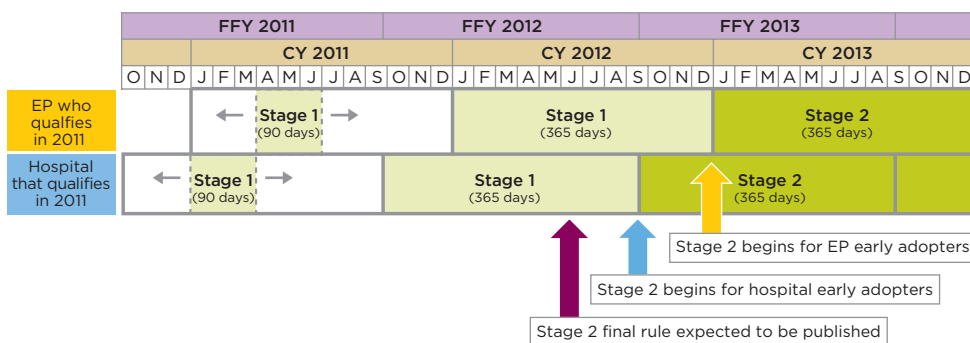
### **HIT Policy Committee Recommendations on the Timing of Stage 2**

The recommendation from the Policy Committee that has generated the most news recently is the proposal to defer Stage 2 by one year for hospitals and Eligible Professionals (EPs) that qualify for meaningful use in the 2011 payment year.

Under the current schedule, providers who attest to meeting 90 days of Stage 1 during 2011 are responsible for a full year of Stage 1 in 2012, followed by a full year of Stage 2 in 2013. For EPs, the 2013 payment year begins in January of 2013. Meaningful use incentives for hospitals are based on the federal fiscal year schedule though (October of previous year through September of current year), so achieving meaningful use in 2011 means a hospital would need to begin meeting Stage 2 requirements in October of 2012.

Since the final rule on Stage 2 is not expected until mid-2012, early adopters (particularly hospitals) would have only a few months between knowing the final Stage 2 requirements and being responsible for actually meeting them. (See Figure 1.)

Figure 1. Current Meaningful Use Schedule for EPs and Hospitals Who Qualify for the 2011 Payment Year



Given this “nearly impossible timing challenge,” the HIT Policy Committee has recommended that Stage 2 be pushed out one year for hospitals and EPs that qualify in 2011. Under this scenario, early adopters would actually have *three* years under Stage 1 instead of only two – which would turn a disincentive for qualifying in 2011 into a clear advantage. ONC leader Farzad Mostashari has indicated that ONC supports this recommendation. The recommended change in timing would only apply to the 2013 payment year and would be limited only to those hospitals and EPs who attest to meaningful use in 2011. (See Table 1.)

Table 1. Recommended Changes to Timing (changes in yellow)

First Payment Year	Requirements for Each Payment Year			
	2011	2012	2013	2014
2011	Stage 1 (90 days)	Stage 1 (365 days)	<b>Stage 1 (365 days)</b>	Stage 2 (365 days)
2012	—	Stage 1 (90 days)	Stage 1 (365 days)	Stage 2 (365 days)
2013	—	—	Stage 1 (90 days)	Stage 1 (365 days)
2014	—	—	—	Stage 1 (90 days)

### HIT Policy Committee Recommendations on Functional Meaningful Use Measures in Stage 2

In the final rule on the electronic health record (EHR) incentive program published in July 2010, CMS outlined the direction of functional meaningful use measures in Stage 2, saying “we will consider every objective that is optional for Stage 1 to be required in Stage 2, as well as reevaluate the thresholds and exclusions of all the measures both percentage based and those currently a yes/no attestation. Additionally, we may consider applying the criteria more broadly to all outpatient hospital settings (not just the emergency department).”<sup>2</sup>

Following the general direction outlined by CMS, the Stage 2 measures recommended by the Policy Committee fall into one of four basic categories:

1. Measures unchanged from Stage 1
2. Measures unchanged from Stage 1, except that in Stage 2 they are no longer optional
3. Measures with higher thresholds or wider scopes in Stage 2 than in Stage 1
4. New measures unique to Stage 2

### Measures unchanged from Stage 1

The Policy Committee is recommending no changes to the Stage 1 “core” measures for problem list, medication list, and medication allergy list, all of which applied to all unique patients, as well as the measure to employ drug-drug and drug-allergy interaction checking.

Unchanged Measures
For Both Hospitals and EPs
Maintain <b>active problem list</b> (more than 80 percent of all unique patients have at least one entry or an indication that no problems are known recorded as structured data)
Maintain <b>active medication list</b> (more than 80 percent of all unique patients have at least one entry or an indication that no medications are currently prescribed recorded as structured data)
Maintain <b>active medication allergy list</b> (more than 80 percent of all unique patients have at least one entry or an indication that no known medication allergies exist recorded as structured data)
Implement <b>drug-drug and drug-allergy</b> interaction checks

### Measures unchanged from Stage 1, except that in Stage 2 they are no longer optional

The Stage 1 “menu set” measures for performing drug formulary checks, storing clinical lab results as structured data, conducting medication reconciliation, and providing a summary of care record would also remain unchanged, except that (just like all the Stage 2 proposed measures) they would no longer be optional.

Unchanged Measures but all required for Stage 2
For Both Hospitals and EPs
Implement <b>drug formulary checks</b> according to local needs (e.g., may use internal or external formularies, which may include generic substitution as a “formulary check”)
More than 40 percent of all <b>clinical lab test results</b> ordered whose results are either in a positive/negative or numerical format are <b>incorporated in certified EHR technology as structured data</b>
<b>Medication reconciliation</b> performed for more than 50 percent of transitions in care when the EP or hospital was the receiving provider
Record and provide (by paper or electronically) a <b>summary of care record</b> for more than 50 percent transitions of care

### Measures with higher thresholds or wider scopes in Stage 2 than in Stage 1

Most of the changes recommended by the Policy Committee for Stage 2 relate to increasing the threshold or expanding the scope of existing Stage 1 core and menu set measures. For example, the percentage of patients with at least one medication order entered using CPOE would be increased from 30 percent in Stage 1 to 60 percent in Stage 2. Hospitals and EPs would also have to record vital signs and smoking status for a higher percentage of patients. The public health reporting measures would be expanded, requiring that actual data be submitted to at least one public health agency. The requirement to conduct a security risk assessment would be retained, but in Stage 2, providers would also have to attest that they have addressed encryption for data at rest (i.e., data in datacenters, data on mobile devices).

A few of the proposed changes would require providers not only to attest to use, but also to attest to *results*. For example, instead of just implementing one clinical decision support rule, in Stage 2 hospitals and EPs would have to use clinical decision support to actually *improve performance* on high-priority health conditions. EPs would have to offer patients access to their electronic health information, and 10 percent of patients would have to actually go online and view it.

<b>Scope and/or threshold changed in Stage 2</b> (All now core; Changes from Stage 1 <u>underlined</u> )
<b>For Both Hospitals and EPs</b>
More than <u>60 percent</u> of unique patients with a medication in their medication list have <b>at least one medication order entered using CPOE</b> [ <i>up from 30 percent</i> ]
More than <u>80 percent</u> of patients have <b>demographics recorded</b> and can use them to produce stratified quality reports [ <i>up from 50 percent and includes more granular categories</i> ]
More than <u>80 percent</u> of patients have <b>vital signs recorded</b> during the reporting year [ <i>up from 50 percent; BP age increased from 2 years to 3 years</i> ]
More than <u>80 percent</u> of unique patients over 13 years old have <b>smoking status recorded</b> as structured data [ <i>up from 50 percent</i> ]
Use <b>clinical decision support</b> to improve performance on high-priority health conditions [ <i>up from implement one rule</i> ]
<b>Generate patient lists</b> for multiple patient-specific parameters [ <i>up from “at least one report listing patients with a specific condition”</i> ]
More than 10 percent of patients are provided with EHR-enabled <b>patient-specific educational resources</b> [ <i>threshold unchanged but “If appropriate” removed</i> ]
Submit actual <b>immunization data</b> to at least one organization in accordance with applicable law and practice [ <i>up from performing just a test; test or “dummy” data not permissible</i> ]
<b>Report clinical quality measures</b> to CMS or the States (note: new measures are still TBD)
Conduct or review a security risk analysis, and implement security updates and correct identified security deficiencies. <u>Attest that encryption/security functionalities for data at rest (which includes data located in data centers and also data in mobile devices) have been addressed.</u>
<b>Hospitals Only</b>
More than 50 percent of patients 65 years and older have an indication of whether an <b>advance directive exists</b> (with date and timestamp of recording) and an electronic copy of the directive itself if it exists (or have direct access to it or instructions for how to access the most recent copy)
Submit actual <b>reportable lab results</b> to at least one organization in accordance with applicable law and practice [ <i>up from performing just a test; test or “dummy” data not permissible</i> ]
Submit <u>actual syndromic surveillance data</u> to at least one organization in accordance with applicable law and practice [ <i>up from performing just a test; test or “dummy” data not permissible</i> ]
<b>EPs Only</b>
More than <u>50 percent</u> of medication orders <b>transmitted as an electronic prescription</b> [ <i>up from 40 percent of medication orders</i> ]
More than <u>10 percent</u> of all “active patients” were sent a <b>clinical reminder</b> (reminders for appointments do not count) [ <i>threshold decreased from 20 percent to 10 percent, but scope expanded from “patients 65 years or older or 5 years or younger” to “all active patients”</i> ]
Patients are provided a <b>clinical summary</b> after more than 50 percent of all visits <u>within 24 hours</u> (pending information, such as lab results, should be available to patients within 4 days of becoming available to EPs) [ <i>up from “more than 50 percent of all visits within 3 business days”</i> ]
More than 10 percent of patients/families <b>view and have ability to download their longitudinal health information</b> ; information available to all patients <u>within 24 hours</u> of an encounter (or within 4 days after available to EPs) [ <i>change from unique patients seen by the EP are provided timely access (available to the patient within 4 business days of being updated in the certified EHR technology) electronic access to their health information</i> ]
The HIT Policy recommends that CMS consider two additional measures for EPs: <ul style="list-style-type: none"> <li>• Submit actual <b>syndromic surveillance data</b> to at least one organization in accordance with applicable law and practice</li> <li>• Submit <b>reportable cancer conditions</b> to at least one organization in accordance with applicable law and practice</li> </ul>

### New measures unique to Stage 2

Many of the entirely new measures being proposed for Stage 2 put greater emphasis on care coordination. For example, care plan goals and instructions would need to be recorded electronically for more than 10 percent of patients, as would a patient’s care team members. For at least 10 percent of hospital discharges, the care summary record would need to be sent electronically to an EP or post-acute care facility. In the outpatient setting, EPs would be responsible for sending a care summary record electronically for at least 25 transactions.

The new measures would also require additional capabilities (and processes) related to patient engagement. For hospitals, Stage 1 measures related to patient engagement were limited to patients who asked for an electronic copy of their health information or discharge instructions. In Stage 2, hospitals would be responsible for an entirely new measure requiring that more than 10 percent of patients actually view information about a hospital admission (similar to the measure for EPs noted earlier). On the EP side, secure online messaging would need to be offered to patients – and at least 25 unique patients would need to use those capabilities during the reporting period.

One of the most challenging new measures recommended for Stage 2 is likely to be the requirement that more than 30 percent of hospital patient days (or EP visits in the outpatient setting) have at least one electronic note by a physician, nurse practitioner or physician assistant. Actual use of electronic physician documentation remains somewhat low (particularly in the inpatient setting) and under the proposed measure, the information would have to be searchable (i.e., scanned notes would not qualify).

<b>New Measures in Stage 2 (all considered “core”)</b>
<b>For Both Hospitals and EPs</b>
More than 60 percent of unique patients with a structured lab result have at least one <b>lab order entered using CPOE</b>
At least one <b>radiology test ordered using CPOE</b> (during the reporting period)
For more than 10 percent of patients, <b>record care plan fields</b> (goals and instructions)
For more than 10 percent of patients, <b>record care team members</b> (including PCP, if available)
<b>Hospitals Only</b>
More than 10 percent of hospital discharge medication orders (for new or changed prescriptions) are <b>transmitted as an electronic prescription</b>
Hospital labs <b>provide structured electronic lab results to outpatient providers</b> for more than 40 percent of electronic orders received and use LOINC where available
More than 30 percent of patient days have at least one <b>electronic note by a physician, NP or PA</b> (scanned notes that are not text-searchable do not qualify)
<b>Medication orders automatically tracked via electronic medication administration record</b> ; eMAR is in-use in at least one hospital ward/unit (with electronic 5 rights checking)
More than 10 percent of patients/families <b>view and are provided the capability to download information about a hospital admission</b> ; information available for all patients within 36 hours of the encounter.
More than 10 percent of all discharges have <b>care summary</b> (including care plan and care team if available) <b>sent electronically to EP or post-acute care facility</b>
<b>EPs Only</b>
More than 25 unique patients have an <b>advance directive</b> (with date and timestamp of recording) and access to a copy of the directive itself if it exists (or have direct access to it or instructions for how to access the most recent copy)
More than 30 percent of EP visits have at least one <b>electronic EP note</b> (scanned notes that are not text-searchable do not qualify)
Patients are offered <b>secure messaging online</b> and at least 25 patients have sent secure messages online
<b>Patient preferences for communication medium</b> recorded for at least 20 percent of patients
<b>Summary of care record sent electronically</b> for at least 25 transactions during the reporting period

### ***Stage 1 measures eliminated in Stage 2***

Due to the fact that some measures in Stage 1 have been superseded, the Policy Committee is recommending that three measures be eliminated. Note that the rationale behind this recommendation was not that these are no longer requirements, only that the Stage 1 measures were deemed redundant or duplicative due to new or expanded measures being recommended for Stage 2.

<b>Stage 1 measures Eliminated or Combined with other Measures in Stage 2</b>
More than 50 percent of patients who request an <b>electronic copy of their health information</b> are provided it within 3 business days.
Perform at least one test of certified EHR technology's <b>capacity to electronically exchange key clinical information</b> .
<b>Hospitals Only</b>
Provide patients with an electronic copy of their <b>discharge instructions</b> at time of discharge, upon request

### **Recommendations for Stage 2 Clinical Quality Measures**

In addition to meeting the functional meaningful use measures in Stage 2, hospitals and EPs will also need to continue to report on clinical quality measures in a “form and manner” specified by CMS. In the final rule on Stage 1 requirements, CMS officials signaled their intention to “expand the clinical quality measures again” in Stage 2. CMS indicated they also intend to include specialty group reporting requirements in Stage 2 “with at least as many clinical quality measures by specialty as we proposed for Stage 1 in the proposed rule.”<sup>3</sup> Formal recommendations from the HIT Policy Committee on clinical quality measures were still pending as of July 13, 2011, but virtually all of the changes being discussed appear to relate to EPs.

Stage 2 clinical quality measures for EPs will come from two sources:

- Sixty-nine measures previously endorsed by NQF that have already been “retooled” for electronic reporting, and
- New — or “de novo” — measures

Thus far, 23 de novo measures have been proposed for Stage 2, a subset from which 8-12 will eventually be selected. Priority was given to de novo measures that were applicable to a broad and diverse group of providers, measures that offer the best opportunity to improve, measures that are already in widespread use, and measures that fill gaps or previously unmet needs. The de novo measures for Stage 2 are expected to be fully defined and released for public comment sometime in mid-to-late 2011.<sup>4</sup>

With a number of new or retooled quality measures expected to be ready for Stage 2, the Policy Committee is also discussing a revised quality reporting framework for EPs. In Stage 1, EPs are responsible for three mandatory “core” or “alternative core” measures as well as three measures from a menu set of 38 additional measures. Under the proposed changes for Stage 2, the core and alternate core measures would be combined (along with a few new measures) into a single set of “core” measures. The optional — or menu set — quality measures would be divided into six domains, which are closely aligned with the six priorities established as part of the National Quality Strategy. (See Figure 2.)

**Figure 2. Proposed Framework for Stage 2 Quality Measures**

*(Source: HIT Policy Committee meeting, June 8, 2011)*



Under the new framework, each EP would have to report on a minimum number of core measures (for example, five out of eight), as well as *at least one* “optional” measure from each of the six domains. The intent is to provide EPs (particularly specialists) with some flexibility, while ensuring each of the six key priority areas is addressed. There has been little discussion to date on quality recommendations for hospitals, but the proposed framework for EPs could conceivably be applied to the inpatient setting as well.

## Update on Certification

In order to successfully meet the requirements for meaningful use, hospitals and EPs must meet Stage 2 objectives and measures using “Certified EHR Technology.” Certified EHR Technology is defined as an EHR (either a Complete EHR or combination of EHR Modules) that has been certified against all applicable certification criteria adopted by ONC for a given payment year.

Currently, EHRs are certified under the [“temporary” certification program](#) — but the temporary program is scheduled to be replaced by the [“permanent” certification program](#) by January 2012. There are a few key differences between the two programs. Currently, both testing and certification organizations (also known as ONC-Authorized Testing and Certification Bodies or “ATCBs”) are accredited by ONC. In the permanent program though, authorized testing organizations (which will be called ONC-ATBs) will be accredited by the National Institute of Standards and Technology and authorized certification organizations (ONC-ACBs) will be accredited by the American National Standards Institute. Certifying organizations will also have the added responsibility of conducting surveillance to ensure systems they have certified are working as expected in the field.

It is important to note that the transition from the temporary program to the permanent program only affects the *process* by which EHRs are certified, not the validity of the actual certification. Regardless of whether a Complete EHR or EHR Module is certified under the temporary program today or the permanent program after January 2012, that certification remains valid as long as ONC has not adopted new certification criteria.

Originally, the plan was for new certification criteria to be adopted for the 2013 payment year to coincide with new or expanded requirements established under Stage 2. If CMS makes the change in the timing of Stage 2 recommended by the Policy Committee, it is possible that new criteria will not be formally adopted until the 2014 payment year. (Additional time for EHR vendors to design, develop and release new functionality was cited as one of the reasons behind the recommended delay.)

## Recommendations for providers

The proposed rule on Stage 2 is not expected to be published until late 2011 and the details of the final rule may not be known until the summer 2012, but there are more and more indications of what to expect — and hospitals and EPs should start preparing today.

- **Focus on achieving meaningful use as soon as possible, *then* decide when to attest.**

The proposed change in schedule would change 2011 attestation from a potential risk to a clear advantage, but CMS has not yet approved the delay. Hospitals have until November 30, 2011 to attest to meaningful use for the 2011 payment year and EPs have until February 29, 2012, so focus first on meeting the requirements and then making a strategic decision based on whether CMS has approved the change in timing.

- **Remember that the challenge in Stage 2 will mainly be meaningful use — not vendor capabilities.**

Despite concerns about vendors meeting a tight schedule, only a few requirements are actually new to the industry. For example, e-MAR and

### The process of “certification” consists of two components:

1. *Testing:* Determining the degree to which a Complete EHR or an EHR Module can meet specific, predefined, measurable, quantifiable requirements, and
2. *Certification:* An assessment that a Complete EHR or an EHR Module meets all of the criteria required for certification; based on the quantitative results from testing, as well as qualitative factors (for example, whether the developer has agreed to the policies and conditions associated with being certified).

physician documentation are available in many commercial products. Work with your vendor to address any gaps in required capabilities, but ensure you have the right foundation in place to actually use those capabilities that are currently available. This is especially true of hospital physician documentation, where pilots now will help prepare for future rollout.

- **Re-evaluate, and if necessary update, your plan for Stage 1**

Most of the workarounds that technically could be used to meet the minimum requirements for some Stage 1 measures may not work in Stage 2. With the threshold and scope of many measures certain to increase, re-evaluate your current plan and ensure you will be able to build off your approach to Stage 1 in later years. Focus planning efforts on satisfying the *objective* of a measure (e.g., “maintain an up-to-date problem list of current and active diagnoses”) rather than just the literal requirements (“more than 80 percent of all unique patients have at least one entry or an indication that no problems are known for the patient recorded as structured data”).

- **As soon as possible begin to implement Stage 1 menu set items you have chosen to defer**

CMS indicated in the final rule on the EHR incentive program that Stage 1 measures in the menu set will be required in Stage 2, and this has been reinforced by the Policy Committee recommendations. Do not wait to tackle the menu set items you are deferring. Unlike many other Stage 2 requirements, the details of these measures are known and EHRs currently need to be certified against all of them. Addressing any issues related to deferred menu set measures over the course of Stage 1 will allow you to focus on meeting the new Stage 2 requirements such as using electronic physician documentation.

- **Implement CPOE the right way from the start**

Although allowed under Stage 1, limiting CPOE to medication orders poses a threat to patient safety and efficiency. Given that Stage 2 recommendations include expanding the measure to include at least lab and radiology orders, it makes sense to implement CPOE for all orders right from the start.

Regardless of what is required in order to receive an incentive payment, CPOE should always be implemented with evidence-based order sets and clinical decision support at the point of care. Order sets include laboratory and radiology orders, as well as medications.

## **About the Author**

Erica Drazen is the Managing Partner of the Global Institute for Emerging Healthcare Practices, the applied research arm of CSC’s Global Healthcare Sector.

## **References**

- 1 “Stage 2 meaningful use to show ‘deference’ to panel proposals”, *Government Health IT*, June 27, 2011.
- 2 “Electronic Health Record Incentive Program; Final Rule”, *Federal Register*, July 28, 2010.
- 3 Ibid
- 4 HIT Policy Committee Meeting, March 2, 2011.



BUSINESS SOLUTIONS  
TECHNOLOGY  
OUTSOURCING

#### **Healthcare Group**

3170 Fairview Park Drive  
Falls Church, Virginia 22042  
+1.800.345.7672  
healthcaresector@csc.com

#### **Worldwide CSC Headquarters**

##### **The Americas**

3170 Fairview Park Drive  
Falls Church, Virginia 22042  
United States  
+1.703.876.1000

##### **Europe, Middle East, Africa**

Royal Pavilion  
Wellesley Road  
Aldershot, Hampshire GU11 1PZ  
United Kingdom  
+44(0)1252.534000

##### **Australia**

26 Talavera Road  
Macquarie Park, NSW 2113  
Australia  
+61(0)29034.3000

##### **Asia**

20 Anson Road #11-01  
Twenty Anson  
Singapore 079912  
Republic of Singapore  
+65.6221.9095

#### **About CSC**

*The mission of CSC is to be a global leader in providing technology-enabled business solutions and services.*

*With the broadest range of capabilities, CSC offers clients the solutions they need to manage complexity, focus on core businesses, collaborate with partners and clients, and improve operations.*

*CSC makes a special point of understanding its clients and provides experts with real-world experience to work with them. CSC is vendor-independent, delivering solutions that best meet each client's unique requirements.*

*For more than 50 years, clients in industries and governments worldwide have trusted CSC with their business process and information systems outsourcing, systems integration and consulting needs.*

*The company trades on the New York Stock Exchange under the symbol "CSC."*

**www.csc.com**