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Meaningful Use Stage 2 Proposed Rule: Detailed Summary

On Thursday, Feb. 23, 2012, the Centers for Medicare & Medicaid Services (CMS) published the proposed Stage 2 Meaningful Use Requirements for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for Hospitals and Eligible Professionals. NAPH provided a high-level summary on Feb. 24, 2012. CMS will accept comments on this proposed rule through May 7, 2012. Key aspects of the proposed rule for hospitals include:

Changes to Meaningful Use Stage 1 Measures for Eligible Hospitals

CMS proposes changes to several Meaningful Use Stage 1 measures for hospitals. These proposed changes are outlined in the text below and in Table 1.

Report Hospital Clinical Quality Measures (CQMs) to CMS or the States

Starting in federal fiscal year (FFY) 2013, this measure would be incorporated into the definition of a meaningful EHR user and eliminated as a separate core set measure for Meaningful Use Stage 1.

Use CPOE for Medication Orders

The new computerized provider order entry (CPOE) measure would allow an "alternative denominator" option for FFY 2013. Starting in FFY 2014, this "alternative denominator" option, which is defined as the number of orders for medications, would be required. Currently, the denominator is defined as unique patients with at least one medication in their medication list. This new option would also apply to the proposed Stage 2 CPOE requirement.

[1] The Meaningful Use Core Set Measures are mandatory measures that hospitals must meet to attest to Meaningful Use.
[2] The Meaningful Use Menu Set Measures are a set of optional measures that hospitals must select a required number of additional measures from.

Public Health Measures (3)

For the three Stage 1 public health measures that involve performing at least one test data submission to immunization registries and public health departments, the regulatory language would be slightly altered to include “except where prohibited.” CMS believes this change would encourage hospitals to submit immunization data, even when not required by state or local law.

Provide Patients with an Electronic Copy of Their Discharge Instructions

Because of changes to certified EHR technology requirements, the measure to “provide patients with an electronic copy of their health information” would be replaced. Instead, hospitals would need to assess the percentage of discharged hospital patients who have access to their information electronically beginning in FFY 2014. Beginning in Stage 2, hospitals would also have to attest to the percentage of patients who have viewed or downloaded this information, or transmitted this information to a third party.

Capability to Exchange Key Clinical Information

Starting in FFY 2013, the core set measure to “perform at least one test of the capability to exchange clinical information among providers electronically” would no longer be required for Stage 1. This test would be replaced with the actual exchange of summary of care documents in Stage 2.

Record and Chart Changes in Vital Signs

The age limitations for the vital signs measure would be changed. Patients ages 3 and older would be included in the denominator for blood pressure, while patients of all ages would be included in the denominator for height/length and weight. Currently, this measure includes blood pressure, height/length, and weight for patients ages 2 and older. The change would be optional for FFY 2013 and mandatory starting in FFY 2014.

Table 1.Proposed Changes to Stage 1 for Eligible Hospitals

Stage 1 Measures	Proposed Changes	Effective Year (FFY)
Report hospital CQMs to CMS or the states.	Measure is incorporated into the definition of a meaningful EHR user and eliminated as a core set measure.	2013-Onward (Required)
Use CPOE for medication orders.	Addition of an “alternative denominator,” using the number of medication orders.	2013(Optional)/ 2014-Onward (Required)
Public Health Measures(3)	Addition of “except where prohibited” to the measures.	2013-Onward (Required)
Provide patients with an electronic copy of their discharge instructions upon request.	Replaced with a measure of patients who have their information available online within 36 hours of discharge.	2014-Onward (Required)
Capability to exchange key clinical information.	No longer required.	2013-Onward (Required)
Record and chart changes in vital signs.	Changes to age limitations.	2013(Optional)/2014 -Onward (Required)

Source: 77 Fed. Reg. 13705 (March 7, 2012).

Meaningful Use Stage 2 Core Measures for Eligible Hospitals

For Meaningful Use Stage 2, CMS proposes a set of 16 core measures for hospitals. Most of these measures are also Stage 1 core or menu set measures. Under the proposed changes, hospitals would need to meet all 16 of these measures. Some of the Stage 1 measures have been combined into more comprehensive measures for Stage 2, and some thresholds have risen for the Stage 1 measures that have been retained for Stage 2.[3] Unlike Stage 1, the denominators for all measures in Stage 2 would not be limited to patients whose records are maintained using a certified EHR technology. Important changes are outlined below.

Core Measures Carried Over and Modified from Stage 1 (7)

1. CPOE for Medication, Laboratory, and Radiology
    - The Stage 2 CPOE measure would be more comprehensive than the Stage 1 measure and would include CPOE for medication, laboratory, and radiology orders. In addition, the threshold would increase to 60 percent, and the denominator would be defined as the number of medication, radiology, and laboratory orders created during the EHR reporting period.

    - CMS welcomes comments on what the appropriate denominator should be for the inpatient and ambulatory environments. CMS is also accepting comments on whether CPOE for laboratory and radiology orders are sufficiently different from CPOE for medication orders to require a different threshold and whether such a threshold should be a lower percentage or a yes/no attestation. The Office of the National Coordinator for Health Information Technology's (ONC's) Health Information Technology (HIT) Policy Committee had recommended that CPOE for laboratory and radiology orders be separate measures, and that CPOE for radiology require only a yes/no attestation. In addition, the HIT Policy Committee recommended that the denominator for each measure only include patients with at least one laboratory/radiology order, instead of the total number of medication/laboratory/radiology orders.

2. Electronic Exchange of Summary of Care Documents
    - The Stage 1 measure to "perform at least one test of the capability to exchange clinical information among providers electronically" would be replaced with a more comprehensive transition of care measure for Stage 2. In addition to previously defined fields, summary of care documents would now require care plan goals and instructions, a list of care team members, and discharge instructions. These documents would also now include an up-to-date problem list, an active medication list, and an active medication allergy list, all of which were included as separate measures for Stage 1.

[3] Thresholds are the required minimum percentage of electronic patient records that must satisfy the measure's requirements for that measure to count toward meeting Meaningful Use.

- Summary of care documents would be required for 65 percent of transitions of care and referrals (by paper or electronically). In addition, summary of care documents for at least 10 percent of transitions and referrals would have to be electronically exchanged between the hospital and a provider that is not affiliated with the hospital and is using a different EHR vendor product.

- CMS proposes that the numerator for the second electronic exchange measure be limited to electronic submissions that conform to ONC-proposed transport standards. CMS may also allow electronic transmissions that follow the Nationwide Health Information Network specifications to count in the numerator for this measure. ONC's HIT Policy Committee had recommended a 50 percent threshold for the first measure and had not recommended the "not affiliated" and "different EHR vendor product" specification in the second measure. CMS seeks comments on any unintended consequences and additional exclusion criteria.

3. Use Clinical Decision Support to Improve Performance on High-Priority Health Conditions
   - The clinical decision support (CDS) measure would be significantly expanded for Stage 2. CMS proposes that a hospital would now be required to implement five CDS interventions that relate to five or more CQMs.

   - CMS also proposes that hospitals must implement "drug-to-drug and drug-to-allergy checks" as a part of this Stage 2 measure. This was a separate core set measure for Stage 1.

4. Record and Chart Changes in Vital Signs
   - CMS proposes that height/length and weight age limits would be eliminated, and the blood pressure limit would be raised to patients ages 3 and older. Because they propose to remove the age restrictions on height/length and weight, CMS also proposes to remove the age restrictions on calculating and displaying body mass index and growth charts.

   - CMS proposes to increase the threshold to 80 percent for Stage 2.

5. Record Patient Demographics
   - CMS proposes to increase the threshold to 80 percent for Stage 2.

   - Although not formally proposed, CMS is seeking comment on the burden associated with including a patient's disability status for this demographic measure. In addition, CMS is seeking comment on the benefits and

feasibility of including gender identity and/or sexual orientation in this measure.

6. Record Smoking Status for Patients Ages 13 and Older
    - The threshold for this measure would increase to 80 percent for Stage 2. Otherwise, this measure would remain unchanged.

7. Conduct or Review a Security Risk Assessment
    - This measure would be the same as the Stage 1 measure, except that it would now be explicitly defined as the encryption/security of data that is stored in a certified EHR (i.e., data at rest).

Menu Measures Carried Over and Modified from Stage 1 (7)

1-3. Public Health Measures (3 measures)
    - The three Stage 1 menu set measures related to the electronic submission of data to immunization registries and public health agencies would become part of the core set for hospitals in Stage 2. Unlike in Stage 1, a failed submission would not meet the measure.

    - CMS is also proposing that the federal Centers for Disease Control and Prevention and public health agencies (PHAs) establish a process where PHAs would provide letters affirming that a hospital was able to submit the relevant public health data to the PHA. A hospital would be excluded if there is no PHA capable of receiving the information in the specific standards required by ONC for EHR certification.

4. Medication Reconciliation for Transitions of Care
    - This Stage 1 menu measure, which would become a core measure for Stage 2, would also have its threshold increased to 65 percent of transitions of care in which the patient is admitted to the hospital's inpatient environment or emergency department (ED). ONC's HIT Policy Committee had recommended that the threshold for this measure remain at 50 percent for Stage 2.

5. Incorporate Clinical Lab Test Results into EHR as Structured Data
    - This Stage 1 menu measure, which would become a core measure for Stage 2, would also have its threshold increased to 55 percent of all clinical lab results ordered. ONC's HIT Policy Committee had recommended that the threshold for this measure remain at 40 percent for Stage 2.

6. Generate Lists of Patients by Specific Condition
    - This Stage 2 core set measure would be identical to its Stage 1 menu set counterpart.

7. Use EHR to Provide Patient-Specific Education Resources
    - This Stage 2 core measure would be the same as the Stage 1 menu set measure, except that CMS is proposing to eliminate the phrase "if appropriate" from the Stage 2 measure. CMS does not believe that hospitals would have difficultly identifying appropriate patient-specific education resources for 10 percent of patients – the threshold required for this measure.

    - CMS is seeking comment on whether hospitals believe that patient-specific resources at appropriate literacy levels and with appropriate cultural competencies can be successfully identified through the use of certified EHR technology.

New Measures for Stage 2 (2)

1. Provide Patients with the Ability to View Online, Download, and Transmit Information
    - The Stage 1 measures directing hospitals to "provide patients with an electronic copy of their health information/discharge information" would be replaced with a measure that assesses the percentage of discharged hospital patients who have access to their information electronically and have viewed or downloaded this information or electronically transmitted this information to a third party.

    - More than 50 percent of all discharged patients would need to have their information available online within 36 hours of discharge from the inpatient environment or ED. In addition, at least 10 percent of patients would need to view or download information about their hospital visit, or electronically transmit their information to a third party during the EHR reporting period.

    - Hospitals could be excluded from attesting to the "view," "download," or "transmit" part of the measure if they are located in a rural county that does not have wide broadband penetration. However, no exclusions are offered for hospitals in urban areas where many patients lack ready access to the internet.

2. Track Medications using Electronic Medication Administration Record (eMAR)
    - CMS proposes that 10 percent of medication orders created by authorized providers in the inpatient environment or ED be automatically tracked from order to administration using assistive technologies in conjunction with an eMAR.

    - CMS proposes to define eMAR as technology that automatically documents the administration of medication into certified EHR technology using electronic tracking censors [e.g., radio frequency identification (RFID)], or electronically readable tagging (e.g., bar coding). ONC's HIT

Policy Committee had recommended that this measure only apply to at least one ward/unit of the hospital for Stage 2.

Meaningful Use Stage 2 Menu Measures for Eligible Hospitals

For Meaningful Use Stage 2, CMS proposes that hospitals meet two of the four menu measures. These measures include recording advanced directives, electronically accessing imaging results and information, recording patient family health history as structured data, and generating and transmitting permissible discharge prescriptions electronically.

Menu Measures Carried Over from Stage 1 (1)

1. Record Advance Directives
    - This measure would remain the same for Stage 2.

New Measures for Stage 2 (3)

1. Imaging Results Accessible through EHR
    - CMS proposes that 40 percent of all scans and tests ordered during the EHR reporting period be accessible through the certified EHR technology. For Stage 2, this information would not need to be structured data. "Accessible" is defined as either the incorporation of the image and accompanying information into the EHR or an indication and direct link to another technology where this information is available. CMS encourages comments on the necessary level of specification and what should constitute a direct link.

    - CMS is also considering, but has not formally proposed, a second measure that encourages the exchange of imaging and results between providers. They are considering a 10 percent threshold for this measure.

2. Record Patient Family History as Structured Data
    - CMS proposes that 20 percent of patients admitted to the inpatient environment or ED during the EHR reporting period have a structured data entry for one or more first-degree relatives. First-degree relatives include parents, offspring, and siblings. ONC's HIT Policy Committee had recommended that this measure be delayed until Stage 3 because of a lack of available standards.

3. Generate and Transmit Permissible Discharge Prescriptions Electronically
    - CMS proposes that 10 percent of hospital discharge medication orders for new or changed prescriptions be compared to at least one drug formulary and transmitted electronically using certified EHR technology. This measure replaces the Stage 1 menu measure "implement drug-formulary checks."

- CMS seeks comments on whether hospitals issue refill prescriptions to discharged patients for medications the patient was taking when he or she arrived at the hospital and, if so, whether distinguishing these prescriptions from new or altered prescriptions would be unnecessarily burdensome for hospitals.

Changes to the Clinical Quality Measure Reporting Requirement

Beginning in FFY 2013, CMS is proposing that clinical quality measure (CQM) reporting become a global requirement for all Stages of Meaningful Use. In other words, CQM reporting would be separated from the Meaningful Use core and menu measures. Beginning with FFY 2014, hospitals attesting to Meaningful Use, regardless of stage, would need to report on 24 CQMs from a menu of 49, including at least one CQM from each of the six care domains. The six domains include clinical process/effectiveness, patient safety, care coordination, efficient use of health care resources, patient and family engagement, and population and public health. A list of the 49 hospital CQMs sorted by domain is available online.

Alignment with Other Quality Reporting Programs

The 49 proposed menu measures for FFY 2014 include the 15 previously finalized hospital CQMs and 34 new CQMs. Of the 34 new measures proposed, 22 are currently included in the Inpatient Quality Reporting (IQR) program, one is included in the Outpatient Quality Reporting Program, and 11 are used in certain states.

Reporting CQMs

Hospitals that are in their first year of meeting Stage 1 requirements may continue to report CQMs through attestation for a continuous 90-day EHR reporting period. During the second year of meeting Meaningful Use requirements, hospitals would need to report CQMs either through a CMS-designated portal or in a manner similar to the method used in the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals (i.e., Medicare, patient-level data for a full fiscal year using Quality Data Reporting Architecture).

For the CMS-designated portal, hospitals would be able to submit CQMs to CMS via an aggregate XML-based format. CMS proposes that all patients would be included in this data submission, regardless of payer, and is requesting comment on four options for patient population-payer data submission through the CMS-designated portal:

1. All patients—Medicare only.
2. All patients—all payer.
3. Sampling—Medicare only, or
4. Sampling—all payer (similar to the IQR program).

Changes to the EHR Incentive Program Timeline

The rule formally proposes to delay Meaningful Use Stage 2 by one year for hospitals that first attested to Meaningful Use Stage 1 requirements in FFY 2011. This change was announced in November 2011 by the U.S. Department of Health and Human Services. Hospitals that met Meaningful Use Stage 1 requirements in FFY 2011 would not have to meet Meaningful Use Stage 2 requirements until FFY 2014. As outlined in Table 2 below, the rule also proposes Stage 2 and Stage 3 timelines for hospitals beginning participation in FFY 2012 and later.

Table 2.Meaningful Use Timeline for Eligible Hospitals

First Year Attesting to Meaningful Use*	**Stage of Meaningful Use**										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013**			1	1	2	2	3	3	TBD	TBD	TBD
2014**				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

Source: Source: 77 Fed. Reg. 13703 (March 7, 2012).

Notes: TBD would be defined in the rule for Stage 3 requirements.

* = Applies to the first year that hospitals attest to Meaningful Use requirements. Hospitals have the option of attesting to the Medicaid "adopt, implement, or upgrade (AIU) option" in the first year of Medicaid program participation. If a hospital chooses this option, the hospital's second year of program participation would be its first year attesting to Meaningful Use.

** = The last years during which hospitals can first attest to Meaningful Use and avoid Medicare payment penalties. (Hospitals that first demonstrate Meaningful Use in FFY 2014 must attest by July 3, 2014.)

Medicare Payment Reduction Process/Timeline

As previously defined in the American Recovery and Reinvestment Act, hospital Medicare market basket reductions (i.e., a reduced update to the IPPS standardized payment amount) will take effect with FFY 2015 Medicare payments. In this proposed rule, despite admitting that there is an existing mechanism to do so, CMS notes its concerns about having to reconcile under or overpayments based on whether a hospital meets Meaningful Use in the actual payment year (i.e., FFY 2015). Therefore, CMS proposes a "look-back period" where hospitals would need to meet Stage 1 of Meaningful Use by FFY 2013 in order to avoid these payment reductions in FFY 2015. In addition, any hospital that first demonstrates Meaningful Use in FFY 2014 would also avoid the penalty if they meet attestation requirements by July 3, 2014. Hospitals that attest to Medicaid Acquire/Implement/Upgrade payments and do not attest to Medicare Meaningful Use by July 3, 2014 would be subject to the Medicare payment reduction.

For each year following FFY 2015, a hospital would continue to need to meet Meaningful Use requirements by the end of the fiscal year two years prior to the payment year (i.e., the two-year "look-back period"). In addition, hospitals attesting to Meaningful Use for the first time would continue to be allowed to attest to Meaningful Use in the fiscal year immediately preceding the payment year subject to the payment reduction. This attestation would need to occur for a 90-day reporting period that ends at least 3 months prior to the end of the preceding fiscal year (i.e., July 1). CMS also proposes several exemptions to these payment reductions, including unforeseen circumstances that would impede reporting, such as natural disasters. Payment adjustment timelines through the FFY 2019 payment year are outlined in Table 3.

Table 3. Timeline for Eligible Hospitals to Avoid Medicare Payment Penalties

Hospital Payment Adjustment Year (FFY)	Demonstrate Meaningful Use 2 Fiscal Year Prior	OR	For a Hospital Demonstrating Meaningful Use for the First Time in the Year Prior to the Payment Adjustment	OR	Apply for an Exception No Later Than
2015	FFY 2013 (with submission period the 2 months following the end of the reporting period)		Continuous 90-day reporting period must begin by April 3, 2014 (with submission no later than July 1, 2014).		April 1, 2014
2016	FFY 2014 (with submission period the 2 months following the end of the reporting period)		Continuous 90-day reporting period must begin by April 3, 2015 (with submission no later than July 1, 2015).		April 1, 2015
2017	FFY 2015 (with submission period the 2 months following the end of the reporting period)		Continuous 90-day reporting period must begin by April 3, 2016(with submission no later than July 1, 2016).		April 1, 2016
2018	FFY 2016 (with submission period the 2 months following the end of the reporting period)		Continuous 90-day reporting period must begin by April 3, 2017 (with submission no later than July 1, 2017).		April 1, 2017
2019	FFY 2017 (with submission period the 2 months following the end of the reporting period)		Continuous 90-day reporting period must begin by April 3, 2018 (with submission no later than July 1, 2018).		April 1, 2018

Source: 77 Fed. Reg. 13776 (March 7, 2012).

Notes: The market basket reduction would equal 25% of update in FFY 2015, 50% of update in FFY 2016, and 75% of update in FFY 2017 and beyond.

Modifications Specific to the Medicaid EHR Incentive Program

Medicaid Patient Encounter

CMS proposes to expand the definition of what constitutes a "Medicaid patient encounter" for determining Medicaid EHR Incentive Program eligibility. The current definition of "encounter" would be expanded to include any service delivered on any one day to a patient "enrolled" in a Medicaid program, even if the Medicaid program did not pay for the service. This definition would also include encounters for patients who are Title XIX eligible and who meet the definition of "optional targeted low-income children." In addition, Medicaid encounters would now include patients enrolled in Title XXI-funded Medicaid expansion programs.

Medicaid Share Calculation/Discharge-Related Amount

For calculating Medicaid program patient volume requirements, the look-back period for patient volume would also be made more flexible, now allowing the use of any 90-day period within 12 months preceding the attestation. Currently, the look-back period may only cover the previous calendar year.

When determining the Medicaid program hospital discharge-related incentive payment amount, states would now be able to use the most recent continuous 12-month period for which data is available prior to the payment year. However, if the source of this data is a cost report, the hospital would not be allowed to consolidate two separate cost-reporting periods. CMS is also proposing not to change its existing policy, which stipulates that only discharges from the acute care part of the hospital can be counted in both the Medicaid share calculation and the discharge-related incentive amount.

Audit and Appeal

Under the CMS proposal, all hospitals participating in the Medicaid EHR Incentive Program would be subject to CMS audit and appeal processes for demonstrations of Meaningful Use. Hospitals would have to follow the CMS appeals process for any disputes regarding audit findings related to Meaningful Use requirements, and states would be bound by CMS' determinations regarding Meaningful Use findings. However, states would continue to be in charge of the remaining audit and appeals processes (i.e., for all other program requirements, excluding Meaningful Use attestation) under the Medicaid EHR Incentive Program.

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If you would like to discuss how the proposed rule would impact your hospital/system or have any questions about the rule, please contact Kevin Van Dyke at kvandyke@naph.org or 202-585-0124.