The Meaning in Stage 2 of Meaningful Use

As physicians continue to adopt electronic health record systems (EHRs) at lightning speed, another set of federal regulations about how to use them was finalized this past August. Spurred largely by government financial incentives and eventual reimbursement penalties, physicians have been putting in place EHRs, trying to meet Stage 1 of "meaningful use". Meaningful use is a set of measures each physician needs to meet to receive as much as $44,000 from Medicare or $63,750 from Medicaid. Maintaining meaningful use also staves off Medicare reimbursement penalties of between one and five percent that begin in 2015. The most recent meaningful use regulations, referred to as "Stage 2", emphasize engaging patients and families in care, patient safety and care coordination. While Stage 2 regulations begin in 2014, there have been some modifications to Stage 1 that take effect in January of 2013.

Most of the rules covering the incentive/penalties established in the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009 will remain in place. There are, however, a few important hardship exceptions that have been added in Stage 2. The criterion to determine whether a physician is considered an eligible provider (EP) in the program is unchanged. If in-patient encounters are less than ninety percent of a physician's total volume, he/she is considered eligible for incentives and penalties. The ninety percent cut off forces large numbers of radiology, pathology and anesthesiology specialists into the EP program. The nature of these specialties is such that reaching meaningful use is more difficult than most other specialties. This was recognized in the Stage 2 ruling and there are now hardship exceptions forestalling Medicare penalties for these specialties for at least two years. However, the incentive payments have not been similarly extended.

Although Stage 2 will be implemented in 2014, all EPs will have two years at the Stage 1 measures prior to having to meet Stage 2 requirements, regardless of when they start in the program. For example, an EP whose first year of meaningful use is 2013 won't start Stage 2 until 2015. The only exception to this is for EPs who have attested in 2011, who will have three years (2011 through 2013) at Stage 1.

There are some aspects of the Stage 2 rule that change Stage 1 measures and which begin in 2013. For example, the requirement to test the exchange of key clinical information will no longer be required. Also, the requirement to state whether a practice will report on clinical quality measures will no longer be a core (required) measure. Another change for 2013 pertains to CPOE. In addition to the current method of calculating the percentage for the measure where the denominator is based on unique patients with a medication in their medication list entered using CPOE, CMS will also allow an optional alternative method of using the number of medications created within a reporting period.

The thrust of Stage 2 meaningful use begins in 2014 when most of the new core measures will be in effect. These include: providing a summary of care record for each transition/referral, the use of

clinical decision support, the use of reminders and patient education (prompted by the EHR), and medication reconciliation. The most challenging new measures will undoubtedly be using secure messaging to communicate with patients as well as the requirement to provide patients the ability to view online, download and transmit their health information. Both of these measures require that at least five percent of patients actually use these features.

CMS recognizes that there will be many practices that need time to upgrade their EHR systems to 2014 certified technology that will support Stage 2 and has provided a one-time accommodation to ease the impact. For 2014 only, all EPs, regardless of their stage of meaningful use, will have a three-month reporting period rather than a full year.

Although conducting a Security Risk Analysis is a core measure in both Stage 1 and Stage 2, this will likely receive much more attention in the coming months. The risk analysis is a formal review of an organization's implementation of the HIPAA Security Rule that went into effect in 2005. This analysis must be conducted and/or reviewed at least annually. In addition, practices must implement any security updates needed to correct security deficiencies identified during the process. The Office of Civil Rights (OCR) is responsible for administering and enforcing the regulations included in the Privacy, Security and Breach Notification rules. The HITECH Act requires compliance audits of HIPAA-covered entities and their business associates. OCR has contracted with the consulting firm KPMG to perform these audits. They have already completed the initial round and the enforcement efforts will continue to escalate.

Also worth noting about the Stage 2 rule is that it has already created political controversy. House republicans recently sent a letter to HHS Secretary Sebelius complaining that the measures are weak, should be made more challenging and focused on different goals.

According to CMS there are additional details about Stage 2 forthcoming. Practices should check the CMS website from time to time to understand how these changes may impact them. Extra time will likely be needed for planning changes to practice operations and for acquiring and/or upgrading to the proper EHR technology. Practices should not linger too far behind the curve since Stage 3 of meaningful use is slated for 2016.

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