EDUCATIONAL COMMENTARY – MEANINGFUL USE: WHEN WILL WE GET TO STAGE 3?

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Learning Objectives

On completion of this exercise, the participant should be able to
- provide a brief review of the stages of meaningful use (MU);
- identify the legal authority for the regulatory action required by MU; and
- identify modifications to MU Stage 2 included in the MU Stage 3 Federal Rule.

What Is Meaningful Use?

“Health care reform” describes a broad spectrum of intertwined guidelines, rules, and regulations designed to improve overall health in the United States and at the same time to reduce the burden of cost. Meaningful use (MU), in broadest terms, is defined as using electronic health record (EHR) technology to achieve those goals.

The Medicare and Medicaid EHR Incentive Programs provide financial incentives to meet specific goals in the adoption of certified electronic health record technology (CEHRT).

- MU provides the “what” and “when” to report.
- CEHRT guidelines define “how” those reports must be delivered.

The idea of meaningful use was initially generated by the National Quality Forum (NQF) and revolved around the broad goal of improving population health, patient safety, patient engagement, and the coordination of care.

Tracing the History of Meaningful Use

The American Recovery and Reinvestment Act of 2009 (ARRA) included a number of measures to modernize the US health care infrastructure while reducing overall costs and improving outcomes. ARRA
providing the legal authority for regulatory action by amending the Social Security Act (the Act) to authorize incentive payments to eligible professionals (EPs), eligible hospitals (EHs), critical access hospitals (CAHs), and Medicare Advantage Organizations (MAOs) based on how and when they report data and which data they report. This was designed to promote the adoption and meaningful use of CEHRT by requiring that it be used to submit the data. The Act also established downward payment adjustments, beginning in 2015, for those EPs, MAOs, EHs, and CAHs that do not meet the deadlines for reporting. The Medicare and Medicaid EHR Incentive Programs were designed to be implemented in stages, each requiring the use of certified EHR technology in ways that could be measured significantly in both quality and in quantity.

The Centers for Medicare & Medicaid Services (CMS) administers the EHR Incentive Program defined by the MU rules. Reimbursement levels for Medicare and Medicaid patients are determined by the ability of the provider to report the required data to CMS using a certified EHR. CMS defines and specifies the objectives for meeting MU of EHR technology.

The CEHRT component of the ARRA is defined in the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act outlines the technical requirements for the adoption of CEHRT to maintain and transmit electronic health records. Incentive payments for implementations that meet specific parameters are part of a broader effort under the HITECH Act to accelerate the adoption of health information technology (HIT) and use of qualified EHRs to submit required data to the Secretary of Health & Human Services (HHS). The incentive payments began in 2012 and phase out over time.

The Office of the National Coordinator for Health Information Technology (ONC) manages the CEHRT requirements defined by the HITECH Act. ONC defines the functionality needed for an EHR to be certified.

The guidelines for MU are broken into categories for EPs, EHs, and CAHs. This review will focus primarily on the guidelines for eligible hospitals (EHs), because their relationship to laboratories has led to an earlier and higher level of adoption of MU than among EPs. Details of all categories can be found using the links to CMS documents and federal rules listed at the end of this article.

**Meaningful Use Stage 1:** Promotes the adoption of basic EHRs for the capture and sharing of data, with reporting beginning in 2012.

Stage 1 became final in the fall of 2010. It set the foundation for the Medicare and Medicaid EHR Incentive Programs by establishing requirements for
the electronic capture of clinical data, including providing patients with electronic copies of health information. It contained 15 core set objectives and an option to select five of the ten menu set objectives. During Stage 1, labs verified that their EHRs were capable of receiving a message using Logical Observations, Identifiers, Names and Codes (LOINC) from the lab system to identify the test run, and that the Systematized Nomenclature of Medicine (SNOMED) could be used to identify the result that was transmitted and enhance the use of clinical decision support tools. Public health departments and EHSs explored the requirements for electronic laboratory records (ELRs) of all reportable test results, but were not required to report electronically.

**Meaningful Use Stage 2:** Emphasizes care coordination and the exchange of patient information to advance clinical processes, with reporting beginning in 2014.

In August 2012, the CMS and ONC released the final requirements to qualify for Stage 2 incentives and for EHRs to qualify for certification. The Stage 2 final rule expanded on the Stage 1 criteria with a focus on ensuring that the meaningful use of EHRs supported the aims and priorities of the National Quality Forum. Stage 2 criteria encouraged the use of HIT for continuous quality improvement at the point of care as well as the exchange of information in the most structured format possible. The requirements were focused on health information exchange between providers. Patient engagement was also encouraged by giving patients secure online access to their health information. In Stage 2, EPs were required to meet (or qualify for an exclusion from) 17 core set objectives and three of six menu set objectives. EHSs and CAHs were required to meet (or qualify for an exclusion from) 16 core set objectives and three of six menu set objectives. The final rule delayed the requirement to use this set of criteria until 2014, with a new start date for EHSs of October 1, 2013, and for EPs January 1, 2014.

As part of the public health objectives, it became a requirement for EHSs to submit electronic laboratory records for reportable diseases to the public health department. Computerized Provider Order Entry (CPOE) needed to account for 55% of all the lab orders (up from 40% in Stage 1) and 40% of all the clinical lab results needed to be incorporated into the EHR.

**Meaningful Use Stage 3:** Improved Outcomes

CMS and ONC released notices of proposed rulemaking (NPRMs) for the EHR Incentive Programs and the EHR Certification Program in March and April
Notices of Proposed Rulemaking, Spring 2015:

1. *Medicare and Medicaid Programs: Electronic Health Record Incentive* - Specifies the Stage 3 requirements for eligible professionals, eligible hospitals, and critical access hospitals in the EHR Incentive Programs (https://federalregister.gov/a/2015-06685)

2. *EHR Technology Certified to the 2015 Edition* - Outlines the certification and standards to help providers meet the proposed Stage 3 requirements with EHR technology certified to the 2015 Edition (https://federalregister.gov/a/2015-06612)


Final Rule Released Oct. 6, 2015

CMS combined the EHR Incentive Program and the Modifications to MU in 2015 to 2017 (Notices 1 and 3 above) into a single final rule, which was released on October 6 and published in the Federal Register on October 16, 2015. This rule modifies the 2015 to 2017 provisions (Modified Stage 2) as well as defining Stage 3 for 2018 forward. It is intended that Stage 3 will be the final stage, providing a single set of criteria for all providers. The final rule included a 60-day comment period for the Stage 3 portion of the rule. Any changes that result from those comments will be proposed through notice and comment rulemaking in future regulations. The final rule can be found at http://federalregister.gov/a/2015-25595.

**What Does “Modified Stage 2” Mean?**

The required reporting for the EHR Incentive Programs for 2015 through 2017 (Modified Stage 2) will reflect changes to Stages 1 and 2 to better align with Stage 3. Modified Stage 2 will simplify some requirements and provide a single set of objectives and measures, replacing the core and menu structure of previous stages. Some of the key changes include:

- Redundant or topped-out measures have been eliminated, allowing for a more direct transition to Stage 3.
- A single set of sustainable objectives that promote best practices for patients:
  - For EHs and CAHs, there are nine objectives, including one public health reporting objective.
  - EPs have ten objectives, including one public health reporting objective.
• No changes to the Clinical Quality Measures (CQMs) reporting established in Stage 2.
• Starting in 2015, the EHR reporting period aligns with the calendar year for all providers, making both recording and reporting easier.
• Because of the changes this rule brings:
  o The reporting period for 2015 will be 90 days.
  o EHs and CAHs may choose any continuous 90-day period from October 1, 2014, to December 31, 2015 (15-month data reporting window). EPs will use January 1, 2015, to December 31, 2015.
  o Providers who were previously scheduled to be in a Stage 1 EHR reporting period for 2015 may use a lower threshold for certain measures.
  o It will allow providers to exclude Stage 2 measures in 2015 for which there is no Stage 1 equivalent.

Changes for EHs and CAHs

<table>
<thead>
<tr>
<th>Previous Stage 1</th>
<th>Previous Stage 2</th>
<th>Modified Stage 2</th>
<th>Stage 3</th>
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<tbody>
<tr>
<td>• 11 Core Objectives</td>
<td>• 16 Core objectives, including public health objectives</td>
<td>• 9 Objectives</td>
<td>• 8 Objectives</td>
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<tr>
<td>• 5 of 10 menu objectives, including one public health objective</td>
<td>• 3 of 6 Menu objectives</td>
<td>• Include one consolidated public health objective with 4 measure options</td>
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EHR Certification: CEHRT Requirements

In 2015 all providers must attest to objectives and measures using EHR technology certified to the 2014 Edition. There are alternate exclusions and specifications within individual measures for providers who were previously scheduled to certify in Stage 1 in 2015. Providers may continue to use the 2014 Edition until 2017. In 2018, all providers will be required to report using the 2015 Edition, but may choose to begin using it sooner.

Overview of Timeline and Attestation Requirements

2015
- Attest to modified criteria for 2015-2017 (Modified Stage 2) using CEHRT Edition 2014 with accommodations for Stage 1 providers
- All providers report for any continuous 90-day period using the calendar year (EHS have a 15-month period)

2016
- Attest to 2015-2017 (Modified Stage 2) using CEHRT Edition 2014 or Edition 2015 (some alternate exclusions remain for Stage 1 providers)
- First-time providers may use any continuous 90-day period for the calendar year, but all returning providers must use the full calendar year

2017
- Attest to either 2015-2017 (Modified Stage 2) or the full version of Stage 3 (requires the Edition 2015 CEHRT)
- First-time providers and those attesting to Stage 3 may use any continuous 90-day reporting period for the calendar year. Returning providers attesting to Modified Stage 2 will report for the entire calendar year

2018
- Attest to full version of Stage 3 using the CEHRT Edition 2015
- First-time providers may use the 90-day reporting period, but all other providers must report for the entire calendar year
Where Does the Lab Fit Into This Picture?

In the table below, the measures most directly related to the laboratory are highlighted. Persons who work in a lab can likely add a number of tactics or actions related to those below.

### Modified Stage 2 Objectives and Measures

<table>
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<tr>
<th>Objectives for 2015-2017</th>
<th>Measures for Eligible Hospitals and CAHs in 2015 through 2017</th>
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<tr>
<td><strong>Objective 1: Protect Patient Health Information</strong></td>
<td><strong>Measure</strong>: Conduct or review a security risk analysis, including the security (to include encryption) of ePHI created or maintained in CEHRT and implement updates and correct deficiencies as needed.</td>
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| **Objective 2: Clinical Decision Support** | **Measure 1**: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Must be related to high-priority health conditions.  
**Measure 2**: The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period. |
| **Objective 3: Computerized Provider Order Entry** | **Measure 1**: More than 60% of medication orders are recorded using computerized provider order entry.  
**Measure 2**: More than 30% of laboratory orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.  
**Measure 3**: More than 30% of radiology orders are recorded using computerized provider order entry. |
| **Objective 4: Electronic Prescribing** | **Measure**: More than 10% of hospital discharge medication orders for permissible prescriptions are queried for a drug formulary and transmitted electronically using CEHRT. |
| **Objective 5: Health Information Exchange** | **Measure**: The hospital or CAH that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals. |
| **Objective 6: Patient Specific Education** | **Measure**: More than 10% of patients admitted to the eligible hospital's or CAH's inpatient or emergency department are provided patient specific education resources identified by CEHRT. |
| **Objective 7: Medication Reconciliation** | **Measure**: The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital’s or CAH’s inpatient or emergency department (POS 21 or 23). |
| **Objective 8: Patient Electronic Access (VDT)** | **Measure 1**: More than 50% of all unique patients who are discharged from the inpatient or emergency department are provided timely access to view online, download and transmit to a third party their health information.  
**Measure 2**: For an EHR reporting period in 2015, at least one patient who is discharged from the inpatient or emergency department views, downloads or transmits to a third party his or her health information during the EHR reporting period.  
**Measure 2 Exclusion**: Any eligible hospital or CAH that is located in a county that does not have 50% or more of its housing units with 4 Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. |
| **Objective 9: Public Health Reporting** | **Measure Option 1 – Immunization Registry**  
**Measure Option 2 – Syndromic Surveillance Reporting**  
**Measure Option 3 – Specialized Registry Reporting**  
**Measure Option 4 – Electronic Reportable Laboratory Result Reporting** |

American Proficiency Institute – 2015 3rd Test Event
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Health Insurance Portability and Accountability Act (HIPAA): Security and risk audits, as well as concrete guidelines around encryption and what can be transmitted through email.

Clinical decision support interventions: Test utilization, critical value notification, infection control notification, partnering with pharmacy to better manage drug levels or bring in companion tests for specific drugs, stroke protocols, and cardiac algorithms are ways that the lab currently affects clinical decision making.

Computerized provider order entry (CPOE): The requirement for internal (inpatient and emergency department) CPOE is commonly satisfied through a hospital or system application (e.g., Cerner, Epic). Those with an outpatient business may have a combination of paper requisitions and interfaced offices that use CPOE. Although the outpatient locations are not included in the MU reporting, the patient access to results, patient ability to transmit records to a third party, and transition or referral of care documentation all include lab results, making the impact broader than just inpatient and ED.

Public Health Reporting: The lab has a direct role in the interfaced delivery of reportable test results to public health, and cancer registries depend on anatomic pathology results that can be delivered electronically.

Resources


5. 42 CFR Parts 412 and 495 (CMS-3310-FC and CMS-3311-FC). This is the final rule released October 6: [http://federalregister.gov/a/2015-25595](http://federalregister.gov/a/2015-25595).


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