**Meaningful Use Stage 2 Requirements**

**Source:** cms.gov

CMS recently published a final rule that specifies the Stage 2 requirements that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

In the Stage 1 Meaningful Use regulations, CMS had established a timeline that required providers to progress to Stage 2 criteria after two program years under the Stage 1 criteria. This original timeline would have required Medicare providers who first demonstrated Meaningful Use in 2011 to meet the Stage 2 criteria in 2013.

However, CMS delayed the onset of Stage 2 criteria. The earliest that the Stage 2 criteria will be effective is in fiscal year 2014 for eligible hospitals and CAHs, or calendar year 2014 for EPs. The table below illustrates the progression of Meaningful Use stages from when a Medicare provider begins participation in the program.

### Stage 2 Timeline

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Note that providers who were early demonstrators of Meaningful Use in 2011 will meet three consecutive years of Meaningful Use under the Stage 1 criteria before advancing to the Stage 2 criteria in 2014. All other providers would meet two years of Meaningful Use under the Stage 1 requirements before moving to the Stage 2 requirements in their third year.

In the first year of participation, providers must demonstrate Meaningful Use for a 90-day reporting period; in subsequent years, providers would need to demonstrate Meaningful Use for a full year, either an entire fiscal year for hospitals or an entire calendar year for EPs except in 2014. Providers who participate in the Medicaid EHR Incentive Programs are not required to demonstrate Meaningful Use in consecutive years as described by the table above, but their progression through the stages of Meaningful Use would follow the same overall structure of two years meeting the criteria of each stage. The first year of Meaningful Use participation consists of a 90-day EHR reporting period.

Furthermore, CMS will permit hospital-based EPs who were not eligible for incentives to request a waiver from that non-eligibility if the EP can demonstrate that he/she helped fund (without reimbursement from the hospital) the acquisition, implementation or
maintenance of a stand-alone ambulatory certified EHR that the EP uses in the hospital inpatient or emergency department.

For purposes of satisfying the Medicaid patient volume thresholds to qualify for Medicaid EHR incentives, EPs may count all encounters with Medicaid-enrolled patients during which the EP furnishes any service to the patient regardless of whether the state Medicaid agency makes payment for the service. Previously, CMS only permitted EPs to count those encounters in which a Medicaid covered service was furnished. This change is not retroactive to encounters from 2011 or 2012. States are required to adopt this change in their State Medicaid HIT Plans within six months after the Final Rule is published.

For 2014 only

All providers, regardless of their stage of Meaningful Use, are only required to demonstrate Meaningful Use for a three-month EHR reporting period.

For Medicare providers, this three-month reporting period is fixed to the quarter of either the fiscal (for eligible hospitals and CAHs) or calendar (for EPs) year in order to align with existing CMS quality measurement programs, such as the Physician Quality Reporting System (PQRS) and Hospital Inpatient Quality Reporting (IQR).

For Medicaid providers only eligible to receive Medicaid EHR incentives, the three-month reporting period is not fixed, where providers do not have the same alignment needs.

CMS is permitting this one-time, three-month reporting period in 2014 only so that all providers who must upgrade to 2014 certified EHR technology will have adequate time to implement their new certified EHR systems.

Furthermore, hardship exemptions could be given to certain physicians, primarily radiologists, pathologists and anesthesiologists. Many times, these specialists do not interact with patients and may not be in a position to comply with Meaningful Use requirements. Consequently, they can apply for an exemption to participating in the program without facing Medicare reimbursement penalties for failure to achieve Meaningful Use.

Core and Menu Objectives

Stage 1 established a core and menu structure for objectives that providers had to achieve in order to demonstrate Meaningful Use. Core objectives are objectives that all providers must meet. There are also a predetermined number of menu objectives that providers must select from a list and meet in order to demonstrate Meaningful Use.

For many of the core and menu objectives, exclusions were provided that would allow providers to achieve Meaningful Use without having to meet those objectives that were outside of their normal scope of clinical practice. Under the Stage 1 criteria, EPs had to meet 15 core objectives and five menu objectives that they selected from a total list of ten. Eligible hospitals and CAHs had to meet 14 core objectives and five menu objectives that they selected from a total list of ten.

Stage 2 retains this core and menu structure for Meaningful Use objectives. Although some Stage 1 objectives were either combined or eliminated, most of the Stage 1 objectives are now core objectives under the Stage 2 criteria. For many of these Stage 2 objectives, the threshold that providers must meet for the objective has been raised. CMS expects that providers who reach Stage 2 in the EHR incentive programs will be
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able to demonstrate Meaningful Use of their certified EHR technology for an even larger portion of their patient populations.

Under Stage 2, most of the new objectives were introduced as menu objectives. CMS states that as with Stage 1, many of the Stage 2 objectives include exclusions that would allow providers to achieve Meaningful Use without having to meet objectives outside their normal scope of clinical practice.

To demonstrate Meaningful Use for Stage 2 requirements:

- EPs must meet 17 core objectives and three menu objectives that they select from a total list of six, or a total of 20 core objectives
- Eligible hospitals and CAHs must meet 16 core objectives and three menu objectives that they select from a total list of six, or a total of 19 core objectives

Though most of the new objectives introduced for Stage 2 are menu objectives, EPs and eligible hospitals each have a new core objective that they must achieve. CMS believes that both of these objectives will have a positive impact on patient care and safety and are therefore requiring all providers to meet the objectives in Stage 2. These are:

- For EPs: use secure electronic messaging to communicate with patients on relevant health information
- For EHs/CAHs: automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)

Stage 2 also replaces previous Stage 1 objectives to provide e-copies of health information or discharge instructions and provide timely access to health information with objectives that allow patients to access their health information online. These are:

- For EPs: provide patients the ability to view their health information online, download it and transmit it within four business days of the information being available to the EP
- For EHs/CAHs: provide patients the ability to view(online), download and transmit their health information within 36 hours after discharge from the hospital

In addition, the Stage 2 criteria place an emphasis on health information exchange between providers to improve care coordination for patients. One of the core objectives for EPs, eligible hospitals and CAHs requires providers who transition or refer a patient to another setting or provider to provide a summary of care record for more than 50% of those transitions-of-care and referrals. Additionally, there are new requirements for the electronic exchange of summary of care documents:

- For more than 10% of transitions and referrals, EPs, eligible hospitals and CAHs that transition or refer their patient to another setting-of-care or provider-of-care must provide a summary-of-care record electronically
- The EP, eligible hospital or CAH that transitions or refers their patient to another setting-of-care or provider-of-care must either: a) conduct one or more successful electronic exchanges of a summary-of-care record with a recipient using technology that was designed by a different EHR developer than the sender’s, or b) conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period

Finally, there are new Stage 2 measures for several objectives that require patients to use health information technology in order for providers to achieve Meaningful Use.
CMS believes that EPs, eligible hospitals and CAHs are in the best position to encourage the use of health IT by patients to further their own health care.

Here are two examples that engage patients under the Stage 2 core objectives:

- To provide patients the ability to view, download and transmit their health information in Stage 2, more than five percent of patients seen by the EP or admitted to an inpatient (Place of Service 21) or emergency department (Place of Service 23) of an eligible hospital or CAH view, download, or transmit to a third party their health information.
- To use secure electronic messaging to communicate with patients on relevant health information, a secure message must be sent using the electronic messaging function of certified EHR technology by more than five percent of unique patients seen by an EP during the EHR reporting period.

Even though clinical quality measure (CQM) reporting has been removed as a core objective for EPs, EHs and CAHs, all providers are required to report on CQMs in order to demonstrate Meaningful Use. Beginning in 2014, all providers, regardless of their stage of Meaningful Use, will need to report on CQMS in the same way.

- EPs must report on nine out of 64 total CQMs
- Eligible hospitals and CAHs must report on 16 out of 29 total CQMs

In addition, all providers must select CQMs from at least three of the six key healthcare policy domains recommended by the Department of Health and Human Services’ National Quality Strategy:

- Patient and family engagement
- Patient safety
- Care coordination
- Population and public health
- Efficient use of healthcare resources
- Clinical processes/effectiveness

A complete list of 2014 CQMs and their associated National Quality Strategy domains will be posted on the CMS EHR Incentive Programs website (www.cms.gov/EHRIncentivePrograms) in the future. CMS will also post a recommended core set of CQMs for EP.

**Payment Adjustments**

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare eligible hospitals, and critical access hospitals (CAHs) that are not Meaningful Users of certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Programs.

These payment adjustments will be applied beginning on October 1, 2014, for Medicare eligible hospitals. Payment adjustments for CAHs will be applied beginning with the 2015 fiscal year cost-reporting period. Medicaid-eligible hospitals that can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

Eligible hospitals and CAHs that can participate in either the Medicare or Medicaid EHR Incentive Programs will be subject to the payment adjustments unless they are
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Meaningful Users under one of the EHR Incentive Programs in the periods specified below.

For more information on payment adjustments, visit the following website:

Hardship Exceptions for Medicare EHs and CAHs

Eligible hospitals and CAHs may apply for hardship exceptions to avoid the payment adjustments described above. Hardship exceptions will be granted only under specific circumstances, and only if CMS determines that providers have demonstrated that those circumstances pose a significant barrier to their achieving Meaningful Use. Information on how to apply for a hardship exception will be posted on the CMS EHR Incentive Programs' website (www.cms.gov/EHRIncentivePrograms) in the future.

Also, Medicare Subsection (d) eligible hospitals can apply for hardship exceptions in the following categories:

- **Infrastructure** — Eligible hospitals must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband)
- **New eligible hospitals** — Eligible hospitals with new CMS Certification Numbers (CCNs) that would not have had time to become Meaningful Users can apply for a limited exception to payment adjustments. The hardship exception is limited to one full-year cost reporting period.
- **Unforeseen circumstances** — Examples may include a natural disaster or other unforeseeable barrier

Critical Access Hospitals (CAHs) can apply for hardship exceptions in the following categories:

- **Infrastructure** — CAHs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband)
- **New CAHs** — CAHs with new CMS Certification Numbers (CCNs) that would not have had time to become Meaningful Users can apply for a limited exception to payment adjustments. The hardship exception is limited to one full year after the CAH accepts its first patient.
- **Unforeseen Circumstances** — Examples may include a natural disaster or other unforeseeable barrier

Objectives for Stage 2

Listed below are the objectives for Stage 2:

**Eligible Providers (EPs)**

Report on all 17 Core Objectives:

1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders
2. Generate and transmit permissible prescriptions electronically (eRx)
3. Record demographic information
4. Record and chart changes in vital signs
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5. Record smoking status for patients 13 years old or older
6. Use clinical decision support to improve performance on high-priority health conditions
7. Provide patients the ability to view online, download and transmit their health information
8. Provide clinical summaries for patients for each office visit
9. Protect electronic health information created or maintained by the certified EHR technology
10. Incorporate clinical lab-test results into certified EHR technology
11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
12. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care
13. Use certified EHR technology to identify patient-specific education resources
14. Perform medication reconciliation
15. Provide a summary-of-care record for each transition-of-care or referral
16. Submit electronic data to immunization registries
17. Use secure electronic messaging to communicate with patients on relevant health information

Report on three of six menu objectives:

1. Submit electronic syndromic surveillance data to public health agencies
2. Record electronic notes in patient records
3. Imaging results accessible through CEHRT
4. Record patient-family health history
5. Identify and report cancer cases to a state cancer registry
6. Identify and report specific cases to a specialized registry (other than a cancer registry)

Eligible Hospitals and CAHs

Report on all 16 core objectives:

1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders
2. Record demographic information
3. Record and chart changes in vital signs
4. Record smoking status for patients 13 years old or older
5. Use clinical decision support to improve performance on high-priority health conditions
6. Provide patients the ability to view online, download and transmit their health information within 36 hours after discharge
7. Protect electronic health information created or maintained by the certified EHR technology
8. Incorporate clinical lab-test results into certified EHR technology
9. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
10. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate
11. Perform medication reconciliation
12. Provide summary-of-care record for each transition-of-care or referral
13. Submit electronic data to immunization registries
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14. Submit electronic data on reportable lab results to public health agencies
15. Submit electronic syndromic surveillance data to public health agencies
16. Automatically track medications with an electronic medication administration record (eMAR)

Report on three of six menu objectives:

1. Record whether a patient 65 years or older has an advance directive
2. Record electronic notes in patient records
3. Imaging results accessible through CEHRT
4. Record patient-family health history
5. Generate and transmit permissible discharge prescriptions electronically (eRx)
6. Provide structured electronic lab results to ambulatory providers

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Hayes consultants are subject-matter experts in IT strategic planning, revenue cycle improvement, system implementation, interoperability and business and clinical operational efficiency. Hayes also offers software solutions to improve efficiency and productivity. To learn more about Hayes’ services, visit www.HayesManagement.com or call us at 617-559-0404.

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