What's New in 2: Top Changes in the Stage 2 Rule

By Kevin Heubusch

There are few surprises in CMS's proposed rule on stage 2 of the meaningful use program. The provisions generally reflect the recommendations of the Health IT Policy Committee made last year, and in the case of the intended change to the timeline, an announcement was made last December.

Nonetheless, the Centers for Medicare and Medicaid Services has proposed some notable changes, several of particular interest to HIM professionals.

Deadline Changes

CMS is sure to find support for its proposal to give providers who demonstrated meaningful use in 2011 a one-year extension on advancing to stage 2. Under the modification, stage 2 would have a uniform start date of 2014. All participants would be in stage 1 through 2013, no matter what year they join the program.

Shuffled Objectives

The rule proposes new objectives for stage 2, eliminates some, and combines others.

With two exceptions, the objectives from the "menu" set in stage 1-the list of 10 items from which providers were required to choose five-would be required in stage 2. There are new objectives with greater applicability to specialty practices.

Stage 2 would retain the core-menu approach. Eligible professionals (EPs) would have 17 core items and choose three of five menu items. Eligible hospitals (EHs) would have 16 core items and choose two of four menu items.

Nearly all stage 1 core and menu objectives would be retained in stage 2. However, some stage 1 objectives would be combined into more unified stage 2 objectives.

Reporting quality measures would be removed as an objective and instead incoporated directly into the definition of meaningful use.

Also proposed are exclusions for the stage 2 menu objectives intended to accommodate EPs who are unable to meet certain objectives due to the scope of their practices.

CMS summarizes the changes to stage 1 in a table on page 13705 in the published rule. The complete set of proposed stage 2 objectives and measures begins on page 13734.

A Shift from Electronic Copies to Online Access

Some of the most significant changes to objectives focus on patient engagement, an area that CMS had identified as a priority for stage 2.

Beginning in 2014, the patient engagement objectives would shift from providing copies of information to providing online access.

For EPs, a new measure would require that more than half of patients receive online access to their information within four business days of the information becoming available to the EP. More than 10 percent of patients must view, download, or transmit their information. EPs could withhold information at their discretion.

Hospitals would be required to offer more than half of their inpatient and emergency department patients online access to information about their admission within 36 hours of discharge. More than 10 percent of patients must view, download, or transmit the information.

The objective would replace three stage 1 requirements related to providing patients with electronic copies of their information (EPs and EHs) or online access (EHs only).

Those requirements have proven to be a common challenge to date in stage 1, because few providers had processes or IT systems that provide patients with copies of their information promptly, especially in electronic format.

Under other stage 2 objectives EPs would have to provide more than half of their patients with clinical summaries within 24 hours of each office visit, and EPs and EHs would have to use EHR technology to identify and provide patient-specific education resources to more than 10 percent of their patients.

Finally, more than 10 percent of an EP's patients must use the secure messaging function in the provider's EHR.

Easing Quality Measures Reporting

Acknowledging the challenges the industry faces in reporting quality measures, CMS proposes better alignment of stage 2 measures with existing programs, such as the Physician Quality Reporting System, the Medicare Shared Savings Program, and Joint Commission accreditation.

Beginning in 2014, EPs would report 12 clinical quality measures, and EHs would report 24.

CMS proposes two reporting options for Medicare and Medicaid EPs, but it intends to select a single method in the final rule. In one option, EPs would report 12 clinical quality measures, including at least one measure from each of six domains. In the other, EPs would report 11 core clinical quality measures plus one menu measure.

In the Medicaid program, states would continue to determine how reporting occurs. However, reporting under the Medicare program would change dramatically.

Beginning with 2014, EPs would have three options that allow professionals within a single group practice to report on a group level. All three methods would be available for Medicare EPs, while only the first one would be possible for Medicaid EPs, at the state's discretion.

The first option would allow EPs in a group practice to report their measures in aggregate as an EHR incentive group.

The other two options would allow EPs to satisfy their meaningful use quality measures requirement if they successfully meet the quality measures reporting requirements of either the Medicare Shared Savings Program or the Physician Quality Reporting System. However, the measures would have to be reported through EHR technology certified for the meaningful use program.

Beginning with FY 2014 EHs would report 24 clinical quality measures from a menu of 49 clinical quality measures, including at least one clinical quality measure from each of the six domains.

For the remaining clinical quality measures, EHs would select the measures from table 9 (page 13760) that best apply to their patient mix.

The 49 clinical quality measures would include the current set of 15 clinical quality measures that were finalized for FYs 2011 and 2012 in the stage 1 final rule as well as additional pediatric measures, an obstetric measure, and cardiac measures.

Medicare EHs would submit the measures through a CMS-designated portal or through their EHRs similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot.

Medicaid-only eligible hospitals would report as determined by their states.

Comments on the rule are due May 7. CMS intends to publish a final rule this summer.

Reference

Centers for Medicare and Medicaid Services. "Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 2." March 7, 2012. www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4443.pdf.

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