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Practice Group:
Health Care

Stage 2 of Meaningful Use: Ten Points of Interest

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On September 4, 2012, the Department of Health and Human Services, Centers for Medicare and Medicaid Services (“CMS”), published final regulations for Stage 2 criteria for the Medicare and Medicaid Electronic Health Record Incentive Program (the “EHR Incentive Program”).¹ Under the EHR Incentive Program, eligible professionals (EPs), eligible hospitals, and critical access hospitals (“CAHs”) (referred to collectively in this Alert as “providers”) that adopt and meaningfully use certified electronic health record technology (“CEHRT”) are eligible for incentive payments. CMS is implementing the program in stages.

Stage 1, in which some providers began participating as early as 2011, established 15 required core objectives for EPs and 14 core objectives for eligible hospitals and CAHs. In addition, Stage 1 required providers to meet five additional objectives from a list of 10 menu set objectives. Collectively, the objectives were designed to establish certain basic functionalities for EHR usage, including recording certain information electronically, providing patients with electronic copies of their information, and reporting on specified quality measures.

Stage 2 builds upon Stage 1 by increasing the requirements for providers to exchange information electronically.² Stage 2 also encourages patients to access their health information online and to generally become more involved in their own care and health. For the most part CMS adopted the Stage 2 proposed rule as final. However, and as explained in more detail below, CMS modified the timeframe for certifying Stage 2 meaningful use because providers expressed concern that the proposed implementation schedule was too aggressive.

The final Stage 2 regulations and the commentary surrounding them are extensive. This Alert highlights ten aspects of the regulations that are likely to be of most interest, impact, and concern for providers. In addition, attached hereto as Tables 1 and 2 is a complete summary of the core objectives and associated reporting measures for EPs and for eligible hospitals. Attached hereto as Tables 3 and 4 is a complete summary of the menu objectives and associated measures for EPs and for eligible hospitals and CAHs.

1. Stage 2 implementation will begin in 2014, but CMS has eased reporting requirements.

CMS anticipated at the time of the Stage 1 final rule that providers attesting to Stage 1 in 2011 would begin using Stage 2 in 2013.³ Nevertheless, CMS noted in commentary that the timeline associated with the implementation of the stages to meaningful use constituted the “significant majority of all comments received” to the proposed regulations.⁴ The concern was straightforward: Providers that

¹ See 77 Fed. Reg. 53968 (Sept. 4, 2012).

² CMS anticipates that the final Stage 3 requirements will further build upon the objectives outlined in Stage 2 with a goal of improving outcomes. CMS plans to announce the requirements for Stage 3 through rulemaking in early 2014 to begin in 2016. See *id.* at 53973.

³ *Id.*

⁴ *Id.* at 53974.

Stage 2 of Meaningful Use: Ten Points of Interest

first attested to Stage 1 in 2011 and 2012 believed they would not have enough time to adopt technology and workflow changes that Stage 2 meaningful use would require between the publication of the final Stage 2 regulations and implementation.⁵ In response, CMS modified the definition of “EHR reporting period” applicable for the 2014 EHR reporting period, providers that are in the first year of Stage 2 or the second year of Stage 1 will only need to report for a 3-month period.

Accordingly, for EPs seeking to demonstrate meaningful EHR use for the Medicare EHR Incentive Program, the reporting period will be one of January 1, 2014 through March 31, 2014; April 1, 2014 through June 30, 2014; July 1, 2014 through September 30, 2014; or October 1, 2014 through December 31, 2014. For EPs seeking to demonstrate meaningful EHR use for the Medicaid EHR Incentive Program, the reporting period will be any continuous 90-day period between January 1, 2014 and December 31, 2014 or a 3-month calendar quarter, depending on the applicable state’s election. For eligible hospitals and CAHs seeking to demonstrate meaningful use under either the Medicare or Medicaid EHR Incentive Programs, the reporting period will be October 1, 2013 through December 31, 2013; January 1, 2014 through March 31, 2014; April 1, 2014 through June 30, 2014; or July 1, 2014 through September 30, 2014.

This modification to the reporting period only applies to providers attesting to meaningful use in 2014 for their first year of Stage 2 or their second year of Stage 1. CMS plans to require the full year of reporting requirements for all other years.

2. Stage 3 implementation remains as scheduled for 2016.

Providers must satisfy each stage of meaningful use for a full year before they can progress to the next stage. In this regard, if a provider has not yet attested to meaningful use for Stage 1, a provider may not be able to take full advantage of the availability of the incentive payments. For example, EPs had to begin participating in the program no later than 2012 in order to obtain the maximum incentive payments available to them -- \$44,000 to \$63,750 depending on whether the EP participates in the Medicare or Medicaid incentive programs, respectively. Likewise, eligible hospitals and CAHs were able to begin receiving incentive payments beginning in 2011; however, the payment amount begins decreasing in 2014. So the longer a provider waits to attest to meaningful use, the less incentive payments will be available. In 2015 the statutorily-mandated downward payment adjustments also begin. Providers who have not yet attested to meaningful use should do so to avoid these negative outcomes.

3. The longer providers wait to demonstrate meaningful use, the sooner they will see downward payment adjustments.

CMS has determined that the reporting period on which the determination of a downward payment adjustment is made will be based, with some exceptions, on the reporting period two years prior to the effective date of such downward adjust.⁶ As such, if a provider cannot demonstrate meaningful use in 2013 (under any stage), a payment reduction will occur (unless an exception applies) in 2015 regardless of whether the provider is demonstrating meaningful use in 2015. In this regard, planning ahead is important because CMS will be looking backwards.

Importantly, however, notwithstanding the general rule that a provider must demonstrate meaningful use of some type in 2013 to avoid the 2015 downward adjustments, providers that first meet meaningful use standards in 2014 will be able to avoid the 2015 downward payment adjustment if

⁵ *Id.* at 53974 – 75. Providers also noted that CMS had previously stated that providers would be required to meet the Stage 2 requirements and report on them for two full years. Given that CMS also anticipates beginning Stage 3 in 2016, providers did not believe they would be able to satisfy these timeframes.

⁶ *Id.* (to be codified at 42 CFR § 495.4) (adding definition for “EHR reporting period for a payment adjustment year”).

Stage 2 of Meaningful Use: Ten Points of Interest

they can demonstrate meaningful use at least 3 months prior to the end of the 2014 calendar or fiscal year, for EPs and eligible hospitals, respectively.⁷

4. CMS specified the core and menu set objectives for Stage 2 meaningful EHR use.

The core and menu set objectives and measures framework that CMS established in Stage 1 will continue for Stage 2, and presumably into Stage 3. “Core” objectives and measures are those that EPs and eligible hospitals and CAHs must meet to establish meaningful use under the applicable stage. “Menu” set objectives and measures are an array of additional measures from which the EPs and eligible hospitals and CAHs must meet a specified number of those menu measures. CMS initially indicated that it anticipated reclassifying the menu set objectives and measures from Stage 1 into core measures and objectives for Stage 2, and this continues to be the plan although CMS is making a few modifications.⁸

For EPs receiving incentive payments, the final rule specifies 17 core objectives and corresponding measures for Stage 2 meaningful use. Eligible hospitals have 16. Both EPs and eligible hospitals/CAHs must meet 3 of 6 menu objectives and measures. As discussed in more detail below, in most cases, there are specified criteria for being excluded from an objective that, if satisfied, would allow the provider to still meet the definition of meaningful user.

See Tables 1-4 attached hereto for a complete listing of the EP and eligible hospital core and menu criteria.

5. Exclusions will not be deductible from Stage 1 meaningful use objectives and measures.

As noted above, the majority of the core objectives have corresponding exclusion criteria. Under Stage 1, an exclusion can be reduced (by the number of exclusions received) the number of objectives that would otherwise apply.⁹ Significantly, under the revised rule, beginning in 2014, this policy will change. At that time, for EPs an exclusion will not be reduced by the number of objectives that would otherwise apply unless five or more objectives can be excluded.¹⁰ However, the EP must still meet five of the combined core and menu objectives and associated measures, one of which must be either (i) the capability to submit, and actual submission of, electronic data to immunization registries or immunization systems and actual submission, unless prohibited by law, or (ii) the capability to submit, and the actual submission of, electronic syndromic surveillance data to public health agencies, unless prohibited by law.¹¹

Eligible hospitals and CAHs that meet criteria for exclusions likewise will no longer be able to reduce (by the number of exclusions applicable) the number of objectives that would otherwise apply.¹² Eligible hospitals and CAHs must also meet at least five of the core and menu objectives and associated measures, one of which must be (i) the capability to submit, and actual submission of, electronic data to immunization registries or immunization systems and actual submission, unless prohibited by law, (ii) capability to submit, and actual submission of, electronic data on reportable lab results to public health agencies, unless prohibited by law, and (iii) the capability to submit, and the

⁷ *Id.*

⁸ *Id.* at 54026. The “capability to submit electronic syndromic surveillance data to public health agencies” and the “record advance directives” will continue to be menu objectives and measures for EPs and eligible hospitals/CAHs, respectively.

⁹ See 42 CFR § 495.6(a)(2)(ii) (applicable to EPs); § 495.6(b)(2)(ii) (applicable to eligible hospitals and CAHs).

¹⁰ See 77 Fed. Reg. at 54150 (to be codified at 42 CFR § 495.6(a)(2)(ii)(B)).

¹¹ *Id.*

¹² *Id.* (to be codified at 42 CFR § 495.6(b)(ii)(B)).

Stage 2 of Meaningful Use: Ten Points of Interest

actual submission of, electronic syndromic surveillance data to public health agencies, unless prohibited by law.¹³

6. CMS modified Stage 1 meaningful use objectives and measures.

CMS finalized a number of changes to Stage 1 objectives and associated measures:

(1) A core objective under both Stage 1 and Stage 2 requires a specified percentage (by order type) be made by computerized provider order entry (CPOE). Under the new rule, CMS significantly increased the difficulty of meeting this standard by implementing an alternative denominator – namely, the number of medication orders created by the EP or in the eligible hospital’s or CAH’s inpatient or emergency department – rather than limit this number as under the original rule to only orders for patients whose records are maintained using certified EHR technology.¹⁴

(2) Beginning in 2013, CMS will permit EPs to split the exclusion associated with the objective of “record and chart changes in vital signs” and to exclude blood pressure only or height/weight only.¹⁵ This change recognizes that these measures do not always have relevance to the scope of a particular EP’s practice. The change gives an EP more discretion in making that good faith determination.¹⁶ CMS has also modified the age limitations on vital signs for Stage 1 (from 2 years of age and over to 3 years of age and over) for all providers.¹⁷ These changes will be an alternative for providers in 2013 but will be standard for all providers beginning in 2014.¹⁸

(3) CMS removed the Stage 1 objective and associated measurement for the “exchange of key clinical information” beginning in 2013 because providers were finding it extremely difficult to understand and achieve.¹⁹ CMS replaced the objective with the “more robust, actual use case of electronic exchange through a summary of care record following each transition of care or referral.”²⁰ CMS believes that the summary of care record will result in better coordination of care for patients and thus better outcomes.

(4) Beginning in 2014, CMS will replace the Stage 1 core objectives of (i) “providing patients with electronic copies of health information”; (ii) “providing patients with electronic copies of their discharge instructions (if requested)”; and (iii) “providing patients with timely electronic access to their health information” with a new core objective: provide patients with the ability to “view online, download and transmit” their health information.²¹ Providers demonstrating Stage 1 meaningful use will only be required to make information available online to view online, download, and transmit for more than 50 percent of all unique patients during the EHR reporting period to satisfy this measure, regardless of whether the patients take advantage of this capability.²² In Stage 2, providers will be

¹³ *Id.*

¹⁴ *Id.* (to be codified at 42 CFR § 495.6(d)(1)(ii)(B) (for EPs); § 495.6(f)(1)(ii)(B) (for eligible hospitals and CAHs)). CMS will permit providers in any year in Stage 1 to use the original denominator or the alternative to calculate the CPOE measure, however. *Id.*

¹⁵ *Id.* (to be codified at 42 CFR § 495.6(d)(8)(iii)).

¹⁶ See *id.* at 53994.

¹⁷ *Id.* at 54150 (to be codified at 42 CFR § 495.6(d)(8)(ii)(B)).

¹⁸ *Id.* (to be codified at 42 CFR § 495.6(d)(8)(ii)(c)).

¹⁹ *Id.* (to be codified at 42 CFR § 495.6(d)(14)(i)(B), (ii)(B) (for EPs); § 495.6(f)(13)(i)(B), (ii)(B) (for eligible hospitals and CAHs)); see also *id.* at 54002.

²⁰ *Id.* at 54002.

²¹ *Id.* at 54150 (to be codified at 42 CFR § 495.6(d)(12)(i)(B) (for EPs); § 495.6(f)(12)(i)(B) (for eligible hospitals and CAHs)).

²² *Id.* (to be codified at 42 CFR § 495.6(d)(12)(ii)(B) (for EPs); and § 495.6(f)(12)(ii)(B) (for eligible hospitals and CAHs)).

Stage 2 of Meaningful Use: Ten Points of Interest

measured on the second half of this objective – namely, that more than 5 percent of patients do in fact view, download, or transmit to a third party their health information.²³

(5) Beginning in 2013, the existing “public health” core objectives are modified to include the phrase “except where prohibited” to account for some instances where providers are prohibited by law from transmitting this sensitive patient information.²⁴

(6) Beginning in 2013, a new exclusion criteria to the e-prescribing core objective included with the Stage 2 criteria will also be available to EPs in Stage 1.²⁵ This exclusion applies to any EP who does not have a pharmacy available within 10 miles of the EP’s practice location at the start of the EHR reporting period.

7. CMS revised the definition of “meaningful EHR user” to include clinical quality measures reporting.

Under Stage 1, CMS required providers to report specified control quality measures (CQMs) as a separate core objective of meaningful use.²⁶ However, providers will now be required to electronically report CQM data. CMS believed that this electronic reporting requirement would cause confusion when embedded with the remainder of the core and menu objectives that are reported through attestation. Accordingly, CMS has deleted CQM reporting as a core objective and has transferred it to the definition of “meaningful EHR user.”²⁷ CQM therefore remains a requirement for being a meaningful EHR user although the method by which the data will be reported will be different.

8. CMS has specified the “manner and form” in which providers must report CQMs.

Under the original Stage 1 rule, providers were required to successfully report CQMs to CMS or a state Medicaid agency, as applicable, in the form and manner specified by CMS or the state.²⁸ However, CMS had not yet provided any guidance on the form and manner of these reports.

Beginning in 2014, CMS has specified the “form and manner” for submissions to be electronic through the use of CEHRT as defined by the Office of the National Coordinator (“ONC”) for providers who are beyond their first year of meaningful use demonstration.²⁹ Accordingly, EPs must submit an aggregate electronic submission or a patient-level submission through the method specified by the Physician Quality Reporting System.³⁰ For eligible hospitals and CAHs, this includes aggregate electronic submission or patient-level data submission through the method similar to the Medicare EHR Reporting Pilot.³¹

²³ *Id.* at 54153 (to be codified at 42 CFR § 495.6(j)(10)(ii)(B) (for EPs); and § 495.6(l)(8)((ii)(B) (for eligible hospitals and CAHs)).

²⁴ *Id.* at 54151 (to be codified at 42 CFR § 495.6(e)(9)(i)(B), (10)(i)(B) (for EPs); and § 495.6(g)(8)(i)(B), (9)(i)(B), and (10)(i)(B) (for eligible hospitals and CAHs)).

²⁵ *Id.* at 54150 (to be codified at 42 CFR § 495.6(d)(4)(iii)(B)).

²⁶ See 42 CFR § 495.6(d)(10) (applicable to EPs) and § 495.6(f)(9) (applicable to eligible hospitals and CAHs).

²⁷ See 77 Fed. Reg. at 54149 (to be codified at 42 CFR § 495.4) (modifying the definition of “meaningful EHR user”).

²⁸ *Id.* at 54157 (to be codified at 42 CFR § 495.8(a)(2)(ii) and § 495.8(b)(2)(ii)).

²⁹ *Id.* at 54050.

³⁰ *Id.* at 54051.

³¹ *Id.*

Stage 2 of Meaningful Use: Ten Points of Interest

In 2013, providers' CQM reporting period will be the same as their EHR reporting period.³² Providers must submit the data no later than the two months immediately following the end of the calendar year (for EPs) or the fiscal year (for eligible hospitals and CAHs).³³ In 2014, the reporting periods for CQMs will be the same as the modified EHR reporting periods—namely, the 3-month quarters previously discussed.³⁴ Providers in their first year of meaningful use may submit the CQM data after the end of their initial 90-day EHR reporting period until the end of the calendar or fiscal year, as applicable.³⁵

9. CMS added an option for group reporting of meaningful use core and menu set objectives and measures for EPs.

Beginning in 2014, CMS will permit groups with two or more EPs to submit core and menu set objective information for individual Medicare EPs using a batch file reporting process. The batch file reporting process will not apply to CQM reporting, and the individual EPs in the group must each satisfy the objectives (unless an exception applies).

10. CMS has changed standards applicable to the Medicaid EHR Incentive Program.

The Medicaid patient encounter serves as an eligibility threshold for the Medicaid EHR Incentive Program insofar as the regulations require providers to achieve a specified minimum volume of Medicaid patients to qualify for incentive payments.³⁶ CMS has expanded the definition of a Medicaid patient encounter to include individuals enrolled in a Medicaid program, including Title XXI-funded Medicaid expansion encounters (i.e., SCHIP).³⁷ Additionally, CMS expanded the definition of “encounter” to include any service rendered to a Medicaid beneficiary regardless of whether the Medicaid program paid for the service as long as on the date of such service the patient was enrolled in the Medicaid program. CMS is also expanding the look-back period for patient volume to be over the 12 months preceding attestation and not tied to the calendar year.³⁸ CMS' rationale for expanding the look-back period for calculating patient volumes is to give providers greater flexibility.³⁹ Combined with the expanded definition of “encounter,” providers may find it easier to meet the patient volume requirements. States will be required to amend their Medicaid HIT Plan and obtain CMS' approval of the amendment in order to adopt these changes.

³² Beginning in calendar year 2013, EPs will submit 9 CQMs from at least 3 of the National Quality Strategy domains out of a potential list of 64 CQMs across 6 domains. Depending on the nature of the EP's practice, CMS recommends a core set of 9 CQMs (i) that focus on adult populations and emphasize controlling blood pressure, and (ii) for pediatric populations. Eligible hospitals and CAHs will submit 16 CQMs from at least 3 of the National Quality Strategy domains out of a potential list of 29 CQMs across 6 domains. See generally *id.* at 53970.

³³ *Id.* at 54050.

³⁴ *Id.*

³⁵ *Id.*

³⁶ See 42 CFR § 495.304(c) and (e) (specifying required patient volumes for EPs and eligible hospitals, respectively).

³⁷ See 77 Fed. Reg. at 54161 (to be codified at 42 CFR § 495.306(e)).

³⁸ *Id.* (to be codified at 42 CFR § 495.306(b)(2)(ii)).

³⁹ See *id.* at 54121.

Stage 2 of Meaningful Use: Ten Points of Interest

Table 1

“EPs: Core Objectives and Associated Measures”⁴⁰

| Summary of Objective | Measure |
|---|--|
| 1. Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by licensed health care professional | More than 60% of all medication orders; more than 30% of laboratory orders; and more than 30% of radiology orders during the reporting period |
| 2. Generate and transmit prescriptions electronically | Place more than 50% of prescriptions electronically |
| 3. Record demographics: preferred language, sex, race, ethnicity, and date of birth | More than 80% of all unique patients the EP sees during the reporting period recorded as structured data |
| 4. Record chart changes in vital signs: height/length, weight, blood pressure, body mass index, growth charts for patients below age 20 | More than 80% of all unique patients the EP sees during the reporting period have blood pressure, height/length recorded as structured data |
| 5. Record smoking status for patients 13 or older | More than 80% of all unique patients the EP sees during the reporting period |
| 6. Use clinical decision support to improve performance on high priority health conditions | Implement 5 clinical support interventions related to 4 or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period ⁴¹ ; and enable and implement drug-drug and drug-allergy interaction checks for the entire reporting period |
| 7. Incorporate clinical lab test results into CEHRT as structured data | Incorporate more than 55% of all clinical lab test results ordered during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format into the CEHRT as structured data |
| 8. Generate patient lists by specific condition to use for quality improvement, reduction of disparities, research or outreach | Generate at least one report listing patients with a specific condition |
| 9. Use clinically relevant data to identify persons who should receive reminders for preventive/follow-up care, and send per patient preference | Send the reminders to at least 10% of unique patients who have had at least 2 office visits within 24 months before the beginning of the EHR reporting period |
| 10. Provide patients with the ability to view online, download, and transmit their health information | More than 50% of patients must be able to view online, download, and transmit their health information within 4 days of that information being available to the EP, and more than 5% of such patients do so |
| 11. Provide clinical summaries | More than 50% of office visits within 1 business day |
| 12. Provide patient-specific education resources identified by CEHRT | More than 10% of all unique patients with office visits |
| 13. Perform medication reconciliation | More than 50% of patients transitioned from another setting of care |
| 14. Provide a summary of care record | More than 50% of patients transitioned or referred to another setting |

⁴⁰ See *id.* at 54151 – 54 (to be codified at 42 CFR § 495.6(h), (i)).

⁴¹ Absent 4 clinical quality measures related to the EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Stage 2 of Meaningful Use: Ten Points of Interest

| Summary of Objective | Measure |
|---|--|
| | of care |
| 15. Capability to submit electronic data to immunization registries or immunization systems | Successful ongoing submission from CEHRT for entire reporting period |
| 16. Protect electronic health information | Implement appropriate technologies identified while performing the risk assessment mandated by the HIPAA Security Rule |
| 17. Use secure electronic messaging to communicate with patients on relevant health information | More than 5% of patients used the secured electronic messaging function to send a message to the EP |

Table 2

“Eligible Hospitals and CAHs: Core Objectives and Associated Measures”⁴²

| Summary of Objective | Measure |
|---|--|
| 1. Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by licensed health care professional | More than 60% of all medication orders; more than 30% of laboratory orders; and more than 30% of radiology orders during the reporting period for patients in the inpatient or emergency department (POS 21 or 23) |
| 2. Record demographics: preferred language, sex, race, ethnicity, date of birth, and preliminary cause of death, if applicable | More than 80% of patients during the reporting period recorded as structured data based on the inpatient or emergency department (POS 21 or 23) |
| 3. Record chart changes in vital signs: height/length, weight, blood pressure, body mass index, growth charts for patients below age 20 | More than 80% of patients during the reporting period have blood pressure, height/length recorded as structured data based on the inpatient or emergency department (POS 21 or 23) |
| 4. Record smoking status for patients 13 or older | More than 80% of patients based on the inpatient or emergency department (POS 21 or 23) |
| 5. Use clinical decision support to improve performance on high priority health conditions | Implement 5 clinical support interventions related to 4 or more clinical quality measures at a relevant point in patient care for the reporting period ⁴³ ; and enable and implement drug-drug and drug-allergy interaction checks for the entire reporting period. Based on the inpatient or emergency department (POS 21 or 23) |
| 6. Incorporate clinical lab test results into CEHRT as structured data | Incorporate more than 55% of all clinical lab test results ordered during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format into the CEHRT as structured data based on the inpatient or emergency department (POS 21 or 23) |
| 7. Generate patient lists by specific condition to use for quality improvement, reduction of disparities, research or outreach | Generate at least one report listing patients with a specific condition, based on the inpatient or emergency department (POS 21 or 23) |
| 8. Provide patients with the ability to view online, download, and transmit | More than 50% of patients must be able to view online, download, and transmit their health information within 36 hours of discharge, |

⁴² See 77 Fed. Reg. at 54155 – 56 (to be codified at 42 CFR § 495.6(l)).

⁴³ Absent 4 clinical quality measures related to the EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Stage 2 of Meaningful Use: Ten Points of Interest

| Summary of Objective | Measure |
|---|---|
| their health information | and more than 5% of such patients do so. Based on the inpatient or emergency department (POS 21 or 23) |
| 9. Provide patient-specific education resources identified by CEHRT | More than 10% of all unique patients, based on the inpatient or emergency department (POS 21 or 23) |
| 10. Perform medication reconciliation | More than 50% of patients transition from another setting of care to the inpatient or emergency department (POS 21 or 23) |
| 11. Provide a summary of care record | More than 50% of patients in either the inpatient or emergency department (POS 21 or 23) transferred to another setting of care |
| 12. Capability to submit electronic data to immunization registries or immunization systems | Successful ongoing submission from CEHRT for entire reporting period |
| 13. Capability to submit electronic reportable laboratory results to public health agencies | Successful ongoing submission from CEHRT for entire reporting period |
| 14. Capability to submit syndromic surveillance data for CEHRT to a public health agency | Successful ongoing submission from CEHRT for entire reporting period |
| 15. Protect electronic health information | Implement appropriate technologies identified while performing the risk assessment mandated by the HIPAA Security Rule |
| 16. Use assistive technologies to automatically track medications from order to administration in conjunction with an electronic medication administration record | More than 10% of such medication orders for patients admitted to the inpatient or emergency departments |

Table 3

“EPs: Menu Objectives and Associated Measures”⁴⁴

| Summary of Objective | Measure |
|---|---|
| 1. Imaging results consisting of the image and any explanation or other accompanying information are accessible through CEHRT | More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT |
| 2. Record patient family history as structured data | More than 20% of all unique patients seen by the EP during the reporting period have a structured data entry for one or more first-degree relatives |
| 3. Capability to submit electronic reportable laboratory results to public health agencies | Successful ongoing submission from CEHRT for entire reporting period |
| 4. Capability to identify and report cancer cases to a public health central cancer registry | Successful ongoing submission from CEHRT for entire reporting period |
| 5. Capability to identify and report specific cases to a specialized registry (other than a cancer registry) | Successful ongoing submission from CEHRT for entire reporting period |

⁴⁴ See 77 Fed. Reg. at 54154 – 55 (to be codified at 42 CFR § 495.6(k)).

Stage 2 of Meaningful Use: Ten Points of Interest

| Summary of Objective | Measure |
|--|--|
| 6. Record electronic progress notes in patient records | Enter at least one electronic progress note created, edited, and signed by an EP for more than 30% of unique patients with at least one office visit during the reporting period |

Table 4

“Eligible Hospitals & CAHs: Menu Objectives and Associated Measures”⁴⁵

| Summary of Objective | Measure |
|---|--|
| 1. Record whether a patient 65 years or older has an advance directive | More than 50% of all unique patients 65 years or older admitted to inpatient department (POS 21) during the reporting period have an indication of an advance directive status recorded as structured data |
| 2. Imaging results consisting of the image and any explanation or other accompanying information are accessible through CEHRT | More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT |
| 3. Record patient family history as structured data | More than 20% of all unique patients admitted to inpatient or emergency department during the reporting period have a structured data entry for one or more first-degree relatives |
| 4. Generate and transmit permissible discharge prescriptions electronically | More than 10% of hospital discharge medication orders for permissible prescriptions are queried for a drug formulary and transmitted electronically using CEHRT |
| 5. Record electronic notes in patient records | Enter at least one electronic progress note created, edited, and signed by an authorized provider of the inpatient or emergency department for more than 30% of unique patients admitted to the eligible hospital or during the reporting period |
| 6. Provide structured electronic lab results to ambulatory providers | Hospital labs send electronic clinical lab results to the ordering provider for more than 20% of electronic lab orders received |

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⁴⁵ See *id.* at 54156 – 57 (to be codified at 42 CFR § 495.6(m)).

Stage 2 of Meaningful Use: Ten Points of Interest

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