Hospitals Have an Extra Year to Meet Stage 2 Meaningful Use Standards

American Hospital Association Wants New Concessions

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The U.S. Department of Health and Human Services (DHHS) gave hospitals a little bit of breathing room when it extended the deadline for complying with stage 2 meaningful use standards by a year—from October 2015 to October 2016. The American Hospital Association (AHA) had been pressing for this extension, arguing that the stage 2 “menu” and “core” standards were overly complex. Enhancements from stage 1 to stage 2 include several new medication and pharmacy measures.

Hospitals must meet meaningful use standards for integrating electronic health records (EHRs) in order to qualify for DHHS incentive payments, which are substantial. Failure to meet those standards by certain deadlines means that the DHHS will dock hospitals a percentage of Medicare reimbursements. A significant number of hospitals will fail to meet the stage 1 deadline, which is July 1, 2014. For example, 20 of 87 hospitals in the Catholic Health Initiative (CHI) will not make this deadline, which will result in millions of dollars in penalties. It is therefore particularly important for late-complying stage 1 hospitals that the DHHS extended the stage 2 deadline by 1 year.

“The extension of the stage 2 deadline for us is great,” said Ann D. Shepard, RN-BC, MSN, Vice President and Chief Nursing Informatics Officer at CHI.

She pointed out that the extra time is doubly important, because CHI hospitals, as well as every other hospital in the country, must switch over to the International Classification of Diseases, 10th revision (ICD-10) coding system by October 1, 2014. Hospitals may now be able to reallocate stage 2 “dollars” to ICD-10 efforts.

Last July, the AHA related the results of a 900-hospital survey to the Senate Finance Committee. The survey found that the majority of hospitals were on track for the transition to ICD-10 but saw meaningful use as the single most challenging competing priority. The survey asked those providers who had already achieved stage 1 to rate the difficulty of achieving each stage 2 objective. Most of the responding hospitals considered half of the core measures in stage 2 to be “difficult” or “not possible” to achieve.

Hospitals that met stage 1 standards in 2011 (the incentive program’s first year) were eligible to enter stage 2 on October 1, 2013. Stage 1 established a core and menu structure for objectives that health care providers had to achieve in order to demonstrate meaningful use.1,2 Under stage 1 criteria, eligible hospitals and critical-access hospitals had to meet 14 core objectives and five menu objectives that they selected from a total list of 10. For stage 2, that increases to 16 core objectives and three menu objectives from a list of six.

The stage 2 rules are tremendously complex and include entirely new requirements—such as sending Summary of Care documents—and expand on requirements that were a significant challenge in stage 1. Many of the objectives make provider performance contingent on the actions of other people and entities, such as health information exchanges, patients, and public health departments; the objectives also assume a level of interoperability and information exchange infrastructure that is still in its infancy. Moreover, stage 2 requires the adoption and use of many new and unfamiliar data standards, such as the codes for entering patient problems.

Medication procedures play a prominent role in many of the core and menu objectives. In fact, stage 2 requirements increase the importance of medication administration considerably. That is because the DHHS has added one new core and one new menu objective relating to pharmacy.

The final stage 2 objectives also toughen some of the stage 1 core objectives involving medications. For example, in stage 1, more than 30% of “unique patients,” with at least one drug in their medication list who are admitted to the eligible hospital’s inpatient or emergency department, must have at least one medication order created by computerized prescriber order entry (CPOE). (A unique patient is counted only once even if he or she is seen more than once during the EHR reporting period.) For stage 2, more than 60% of medication orders, 30% of laboratory orders, and 30% of radiology orders must be created via CPOE.

Although the AHA was happy to be given the extra year to reach stage 3, it is still pushing the DHHS to make additional changes in stage 2. In a December 2013 letter to the administrator of the Centers for Medicare and Medicaid Services (CMS) and the acting National Coordinator for Health Information Technology, the AHA pleaded for extra time for hospitals to purchase 2014 Edition Certified EHR software and to be able to comply with some of the more complicated aspects of stage 2. One part of the letter, signed by Rick Pollack, AHA Executive Vice President, stated:

The meaningful use program has provided a common direction for adoption of EHRs, and the incentives have been helpful to those who have received them. However, the pace and scope of change have outstripped the ability of vendors to support hospitals and for hospitals to manage the transition to the 2014 Edition Certified EHR in a safe and orderly manner.

There is no telling whether the DHHS will respond with additional latitude, but given that software vendors have gotten few 2014 editions certified, and given the glitches that have shown up with some of those, some leeway for hospitals seems justified.

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REFERENCES

