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Compliance 101: Why Meaningful Use is still meaningful

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Is Meaningful Use still relevant today? Since its inception in 2010, the program has evolved to reflect industry-wide uptake in electronic health record (EHR) adoption, technology advances, and close alignment with alternative payment models such as the Quality Payment Program, including the Merit-based Incentive Payment System (MIPS) established under the Medicare Access and CHIP Reauthorization Act (MACRA).

Although no longer officially called “Meaningful Use,” the program is still an essential component of any healthcare organization’s pursuit of high-quality, standardized care and the secure dissemination of patient information.

What was the original intent of Meaningful Use?

Meaningful Use was written into the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the 2009 American Reinvestment and Recovery Act, to underscore and promote the need for use of interoperable EHRs. The program, originally known as the Medicare and Medicaid EHR Incentive Program, was based on five pillars of health outcomes policy priorities:

1. Improve quality, safety, and efficiency, and reduce health disparities
2. Engage patients and families in their health
3. Improve care coordination
4. Improve population and public health
5. Ensure adequate privacy and security protection for personal health information^[1]

At the time, many smaller healthcare organizations—small facilities, systems, and physician practices—were still using paper records and charts. And although larger healthcare organizations may have been using EHR platforms, those platforms were not standardized. Legacy systems in place almost ten years ago lacked the ability to capture information in a standardized way and could not transmit that information easily. With disparate data, the healthcare industry was not set up to advance the five pillars set forth by the Centers for Medicare & Medicaid Services (CMS).

Standardized, electronic data capture in certified EHR technology (CEHRT) was a means towards advancing and

better managing population health, recognizing trends, and improving the quality of care for patients in a fragmented delivery model. Achieving those objectives was not possible with paper-based records.

Meaningful Use adoption was originally broken into three stages, aimed at progressively advancing adoption of EHRs and the standardization needed to achieve the five pillars. To encourage participation, CMS offered incentive payments to providers who could demonstrate that they were participating in each stage and using CEHRT. ^[2]

Stage 1: Data capture and sharing

The purpose of the first stage was to create standardization, and increase habitual input and sharing of data electronically. For example, physicians typically were not users of an EHR system. Rather, nurses would enter information into the EHR, after it was dictated, ordered, or handwritten by a physician. One of the goals of Stage 1 was for physicians and other clinicians to enter that data directly into the EHR using a computerized provider order entry (CPOE) system.

Stage 2: Advanced clinical processes

The criteria here encouraged the use of the EHR for continuous quality improvement at the point of care and the exchange of information in the most structured format possible. ^[3] For example, thresholds increased for several measures (e.g., from one clinical decision support intervention to five), and measures that were optional in Stage 1 become mandatory in Stage 2, such as the provision of summaries of care for patient transitions/referrals and medication reconciliation.

Stage 3: Improved outcomes

Stage 3 aimed to focus on improved outcomes through interoperability and better coordination of care and delivery, and it also required adoption of a more advanced CEHRT that was subject to different certification requirements. However, because of significant concerns from the provider and CEHRT communities in meeting CMS's goals for Stage 3, a "Modified Stage 2" was implemented by CMS for 2015 through 2017 to better position providers to transition to Stage 3. Topped-out and redundant measures were removed, reporting burdens were reduced, and measures and objectives were redesigned by CMS. Although more advanced Stage 3 measures were adopted by CMS, these were subsequently amended again by CMS in April of 2018 as a result of its rebrand of the Meaningful Use program.

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