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CMS Issues Meaningful Use Stage 3 Proposed Rule

The Centers for Medicare and Medicaid Services (CMS) recently published a proposed rule (Proposed Rule) implementing Stage 3 of the Medicare and Medicaid electronic health record (EHR) Incentive Programs (Meaningful Use Programs). Under the Proposed Rule, CMS aims to streamline and simplify the Meaningful Use Programs for providers. CMS proposes that, beginning in 2018, Stage 3 will be the final (and only) stage in the Meaningful Use Programs. Providers are required to attest to a single set of eight objectives, and the reporting period for all providers is a full calendar year, with limited exceptions described below. CMS also proposes changes to give providers flexibility in transitioning to Stage 3.

CMS is seeking public comments regarding the Proposed Rule, which are due by May 29, 2015.

STAGE 3 OVERVIEW

All providers that receive payments from Medicare or Medicaid must satisfy the applicable requirements of the Meaningful Use Programs or be subject to reduced Medicare or Medicaid reimbursements. Providers are currently able to participate in Stage 1 or Stage 2 of the Meaningful Use Programs. The Proposed Rule eliminates Stages 1 and 2 in 2018, and all providers will be required to participate in Stage 3 in 2018 and all subsequent years of the Meaningful Use Programs. Even providers demonstrating meaningful use for the first time in 2018 (or later) must meet the requirements, objectives, and measures of Stage 3. Providers will have the choice of participating in Stage 3 in 2017 but will not be required to do so until 2018.

Though Stage 3 becomes the final stage in the Meaningful Use Programs, CMS will still, from time to time, update technological and clinical objectives and measures applicable to the Meaningful Use Programs through additional rulemaking.

EHR REPORTING PERIOD

Providers participating in the Meaningful Use Programs must meet certain objectives and measures during their respective "EHR reporting periods." Currently, the EHR reporting period for eligible hospitals and critical access hospitals (CAHs) is based on the federal fiscal year. The EHR reporting period for eligible professionals (EPs) is based on the calendar year. There is also a continuous 90-day EHR reporting period for providers satisfying meaningful use for the first time. Under the Proposed Rule, beginning with calendar year 2017, all EPs, eligible hospitals, and CAHs (collectively, Providers) are required to use an EHR reporting period of one full calendar year; however, EPs and eligible hospitals participating in the Medicaid Meaningful Use Program for the first time are still able to use the 90-day EHR reporting period.

The Proposed Rule similarly revises the EHR reporting period for purposes of determining a Provider's downward payment adjustment for failing to become a meaningful user of certified EHR technology (CEHRT) within the required time. Therefore, the EHR reporting period for an EP's or eligible hospital's payment adjustment year is the full calendar year that is two years before the payment adjustment year. The Proposed Rule allows Medicaid EPs or eligible hospitals that are first-time meaningful users to use an EHR reporting period of 90 continuous days. A CAH's payment adjustment reporting period is the

calendar year that overlaps the last three quarters of the federal fiscal year that is the payment adjustment year.

OBJECTIVES AND MEASURES

Under the Meaningful Use Programs, Providers must use CEHRT to satisfy certain objectives and measures and successfully demonstrate meaningful use. Stages 1 and 2 require Providers to meet as many as 20 objectives, with a number of objectives requiring additional measures. In the Proposed Rule, CMS attempts to ease Providers' reporting obligations by removing objectives that are redundant or have a reporting burden that outweighs the value of information provided. After reviewing current Stage 1 and 2 objectives, Provider performance in Stages 1 and 2, and the Health Information Technology Policy Committee's recommendations, CMS proposes the following eight Stage 3 objectives and associated measures, which, as in Stages 1 and 2, must be met during the Provider's EHR reporting period.

- **Objective 1: Protect Patient Health Information**
  Stage 3 maintains the Stage 2 objective requiring Providers to protect electronic protected health information (ePHI) by implementing appropriate technical, administrative, and physical safeguards. To meet this objective, as in Stage 2, Providers are required to conduct or review a security risk analysis that assesses the risks associated with ePHI created or maintained in CEHRT. Providers are required to perform the risk analysis upon the installation of or the upgrade to a CEHRT and at least once during each EHR reporting period.

- **Objective 2: Electronic Prescribing**
  Under the Proposed Rule, Stage 3 also maintains the Stage 2 requirement that EPs generate and transmit prescriptions electronically, and eligible hospitals and CAHs generate and transmit discharge prescriptions electronically. To satisfy this objective, more than 80 percent of an EP's, or 25 percent of an eligible hospital's or CAH's, prescriptions must be queried for a drug formulary and transmitted electronically using CEHRT. The Proposed Rule also retains the Stage 2 exceptions to this measure for Providers that infrequently write prescriptions.

- **Objective 3: Clinical Decision Support**
  The Proposed Rule retains the Stage 2 objective requiring Providers to implement clinical decision support interventions in CEHRT to improve their performance on high-priority health conditions. According to CMS, examples of well-designed clinical decision support tools include computerized alerts and reminders, clinical guidelines, patient-data reports, and diagnostic support.

  The Proposed Rule requires Providers to meet two measures to satisfy this objective. The first is implementing, at a relevant point in patient care, five clinical decision support interventions related to four clinical quality measures (CQMs), discussed further below. If fewer than four CQMs are relevant to a Provider's practice, the clinical decision support interventions must be related to high-priority health conditions. Second, Providers are required to enable drug-drug and drug-allergy interaction checks in the CEHRT for the entire EHR reporting period.

- **Objective 4: Computerized Provider Order Entry (CPOE)**
  Providers in Stage 2 must use CPOE to enter a minimum threshold of medication, laboratory, and radiology orders. The Proposed Rule expands the types of orders that may be entered using CPOE by replacing radiology orders with the broader category of diagnostic imaging, which includes radiology, ultrasound, magnetic resonance, and computed tomography orders. CMS also makes the measures more stringent. To satisfy this objective, Providers are required to enter more than 80 percent of medication orders and 60 percent of laboratory orders and to enter 60 percent of diagnostic imaging orders using CPOE. The Proposed Rule retains the Stage 2 exceptions to this measure for Providers that infrequently issue the relevant types of orders.

- **Objective 5: Patient Electronic Access to Health Information**
  Under the Proposed Rule, Providers must give patients access to view online, download, and transmit their health information or retrieve their health information through an application program interface (API) within 24 hours of availability. This objective combines into a single objective two Stage 2 objectives: to "provide patients the ability to view online, download and transmit" health or hospital admission information and to "provide patient-specific education resources to patients." Notably, the Proposed Rule adds the option for Providers to satisfy this

objective using APIs, which, according to CMS, are available at little or no cost. Providers are no longer required to purchase and install a separate patient portal or similar mechanism to provide patients access to health-related information.

CMS proposes that Providers meet two measures to satisfy this objective. The first measure requires that more than 80 percent of unique patients seen by an EP or discharged from an eligible hospital or CAH inpatient or emergency department (Unique Patients) are either (1) provided access to view online, download, and transmit their health information within 24 hours of its availability to the Provider or (2) provided access to an API that can be used by third-party applications or devices to access to their health information within 24 hours of availability to the Provider. A Provider who chooses the API option must use an API certified by the Office of the National Coordinator for Health Information Technology (ONC). CMS also specifically seeks comment on three alternatives to this measure that either (1) requires the use of an API and a separate "view online, download and transmit" function, (2) allows an option to use either an API only or a combination of an API and a separate "view online, download and transmit" function, or (3) only permits use of an API.

The second measure requires Providers to use clinically relevant information from their CEHRT to provide 35 percent of their respective Unique Patients electronic access to patient-specific educational resources.

- **Objective 6: Coordination of Care through Patient Engagement**
  CMS proposes that Providers use communication functions of their CEHRT to engage patients about their care. Similar to Objective 5 above, this objective merges several Stage 2 objectives related to secure messaging, patient reminders, and patient engagement. Providers are required to attest to each of the following three measures, but are only required to meet the threshold for two of the three measures.

  The first measure is dependent upon patient action and requires 25 percent of Unique Patients to "actively engage" with their EHR made available by the Provider. Patients may actively engage with the EHR by either (1) viewing, downloading, or transmitting to a third party their health information or (2) accessing their health information through an ONC-certified API that can be used by third-party applications or devices.

  The second measure requires Providers to respond to a patient's secure message using an electronic messaging function in their CEHRT to more than 35 percent of Unique Patients. Messages sent between Providers using CEHRT count toward fulfillment of this measure as long as the patient has the ability to actively participate in the conversation between Providers.

  The third proposed measure requires Providers to incorporate into their CEHRT data from a nonclinical setting or patient-generated health data for more than 15 percent of Unique Patients. Nonclinical-setting data includes data from physical therapists, nutritionists, psychologists, home health care providers, and care providers in other settings where the care provider does not have shared access to the Provider's CEHRT. Patient-generated health data is data resulting from patient self-monitoring. CMS is seeking comment on how such nonclinical and patient-generated data should be captured, standardized, and incorporated into a patient's EHR.

- **Objective 7: Health Information Exchange**
  Under the Proposed Rule, Stage 3 expands Stage 2's "summary care record" requirement. Providers are required to supply a summary of care record when transitioning or referring patients to another setting of care, to retrieve a summary of care record upon the first encounter with a new patient, and to incorporate summary of care information from other providers into a patient's EHR using CEHRT. Transitions or referrals must be between Providers with different Meaningful Use Program billing identities to count toward this objective. Under the Proposed Rule, transitions or referrals count toward the objective even if the recipient Provider already has access to the patient's medical record maintained in the referring provider's CEHRT. Providers are required to attest to each of the following three measures but are only required to meet the threshold for two measures.

  The first proposed measure requires that the Provider create a summary of care record using CEHRT and electronically exchange such record for more than 50 percent of the Provider's transitions of care or referrals. In a separate proposed rule issued at the same time as the

Proposed Rule, the ONC proposed, among other things, the elements required for a summary of care document.

The second measure CMS proposes requires the Provider to incorporate into a patient's EHR an electronic summary of care document from a source other than the Provider's own EHR system for more than 40 percent of transitions or referrals received and for new patient encounters.

The third measure requires the Provider to perform a clinical information reconciliation for more than 80 percent of transitions or referrals received and for new patient encounters. The Provider is required to reconcile a patient's medication, medication allergies, and current problem list.

- **Objective 8: Public Health and Clinical Data Registry Reporting**
  Stage 2 requires that Providers have the capability to submit electronic data to immunization registries. The Proposed Rule builds upon this objective to require Providers to be in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data to such agency or registry using CEHRT. A Provider may demonstrate "active engagement" in one of three ways: (1) within 60 days after the start of the EHR reporting period, register to submit data with a PHA or CDR, (2) test and validate the electronic submission of data to a PHA or CDR and respond within 30 days of a request from a PHA or CDR, or (3) electronically submit production data to a PHA or CDR.

  CMS proposed the following six measures for the PHA and CDR reporting objective: (1) immunization registry reporting, (2) syndromic surveillance reporting, (3) case reporting, (4) public health registry reporting, (5) CDR reporting, and (6) electronic reportable laboratory results. EPs must successfully attest to any combination of three of the measures one through five, and eligible hospitals and CAHs must successfully attest to any combination of four of the six measures. Public health registry and CDR reporting may be counted as more than one measure if the Provider reports to more than one public health registry or CDR.

  CMS also proposes several exclusions to the measures for Providers. If the Provider qualifies for an exclusion, it does not count as a successfully attested measure; however, if there are two or fewer measures (in the case of an EP) or three or fewer measures (for an eligible hospital or CAH) available after qualification for exclusions, the Provider may satisfy the objective by attesting to the remaining number of measures.

DEFINING CEHRT FOR 2015 THROUGH 2017, AND 2018 AND BEYOND

Currently, ONC is responsible for defining CEHRT, which Providers are required to use in meeting the Meaningful Use Programs' objectives. Under the Proposed Rule, CMS assumes responsibility for defining CEHRT for years 2015 and beyond. CMS requires Providers to use 2014 Edition CEHRT for EHR reporting periods 2015 through 2017 but permits upgrades to 2015 Edition CEHRT at any time during that period. Providers can also use a combination of 2014 and 2015 Edition CEHRT if they have modules from both editions that meet the requirements for applicable objectives and measures. Beginning in 2018, CMS will require all Providers to use 2015 Edition CEHRT.

REPORTING CQMS

In Stage 3, CMS maintains its requirement that Providers report certain CQMs. As noted above, Stage 3 requires a uniform EHR reporting period of one calendar year for all Providers beginning in 2017. Similarly, the Proposed Rule requires that Providers report CQMs based on a full calendar year, starting with calendar year 2017; however, the CQM reporting period for a Medicaid provider demonstrating meaningful use for the first time is the 90-day period the provider uses as the EHR reporting period. CMS also proposes that, beginning in 2018, all Providers participating in the Medicare Meaningful Use Program be required to submit CQMs electronically unless electronic reporting is not feasible. Each state may continue to determine the appropriate method for submission of CQMs for Providers participating in the Medicaid Meaningful Use Program.

MEANINGFUL USE IN 2017

In the Proposed Rule, CMS regards 2017 as a transition year and allows Providers flexibility in meeting the Meaningful Use Programs' requirements. Providers are permitted to repeat a year at their current

Meaningful Use Program stage or move up to the next stage. Providers are not permitted to revert to a prior stage. As mentioned above, Providers are also permitted to use 2014 Edition CEHRT in 2017 and can attest to either Stage 1 or Stage 2 objectives and measures, depending on when the Provider first demonstrates meaningful use. A Provider that uses 2014 Edition CEHRT, however, is not able to attest to the Stage 3 objectives and measures. Providers that upgrade to 2015 Edition CEHRT for the 2017 EHR reporting period are not able to attest to Stage 1, 2, or 3 if the Provider first demonstrates meaningful use in 2015 or 2016, or Stage 2 or 3 if the Provider first demonstrates meaningful use before 2015.

Beginning in 2017, CMS also decouples the use of CEHRT for CQM reporting from the use of CEHRT for satisfying the Meaningful Use Programs' objectives and measures. This allows a Provider to report CQMs using either 2014 or 2015 Edition CEHRT, regardless of which edition the Provider uses to attest to the applicable objectives and measures.

CONCLUSION

CMS proposes a variety of changes to the Meaningful Use Programs to ease the burden on Providers and to encourage widespread adoption and use of EHRs. If finalized in its current form, the Proposed Rule eliminates separate Meaningful Use Program stages, aligns Providers on a full calendar year EHR reporting period, and reduces to eight the total number of objectives that Providers must meet. Under Stage 3, Providers are still required to report CQMs, and Providers that fail to successfully attest to meaningful use continue to face reduced Medicare reimbursement rates.

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