American Hospital Association

Special Bulletin

Monday, March 23, 2015

CMS RELEASES PROPOSED RULE FOR STAGE 3 OF 'MEANINGFUL USE' OF EHRs

The Centers for Medicare & Medicaid Services (CMS) March 20 released a proposed rule defining "meaningful use" of electronic health records (EHRs) for Stage 3 of the Medicare and Medicaid EHR Incentive Programs. At the same time, the Office of the National Coordinator (ONC) for Health Information Technology (IT) released a proposed rule that sets certification criteria, standards and implementation specifications for EHR technology beginning in 2017.

CMS proposes an optional start date for Stage 3 in 2017. Beginning in 2018, however, all eligible hospitals, critical access hospitals (CAHs) and eligible professionals (EPs) would be required to report on the same eight objectives of meaningful use that incorporate 21 specific measures, many with higher thresholds than in Stage 2. All providers, even those new to the program, would have to meet Stage 3 beginning in 2018.

The proposed rule does not include any of the flexibility provisions CMS has indicated it will provide for 2015, such as shortening the meaningful use reporting period from 365 to 90 days. In a statement, AHA said the proposed rules demonstrate that CMS "continues to create policy for the future without fixing the problems the program faces today," and urged CMS to release rules immediately to provide much-needed flexibility for the 2015 reporting year.

Comments on the proposed rules are due May 29. Watch for an AHA Regulatory Advisory with more details, as well as information on member calls to provide feedback to AHA on the rules.

HIGHLIGHTS OF THE CMS PROPOSED RULE

Meaningful Use Objectives and Measures for Stage 3: In an attempt to simplify the program, CMS proposes that all eligible hospitals, CAHs and EPs report on the same eight objectives of meaningful use. However, Stage 3 would include 21 specific measures, with very limited variation and flexibility in reporting for eligible hospitals, CAHs and EPs.

The eight proposed objectives support meaningful use statutory requirements, the National Quality Strategy or recommendations from the Health IT Policy Committee. They include:

- Protect Patient Health Information
- Electronic Prescribing (eRx)
- Clinical Decision Support (CDS)
- Computerized Provider Order Entry (CPOE)
- Patient Electronic Access to Health Information
- Coordination of Care through Patient Engagement
- Health Information Exchange
- Public Health and Clinical Data Registry Reporting

The proposed Stage 3 objectives and measure are available in Table 1 (attached).

Comparison to Stage 2: In Stage 2, eligible hospitals and CAHs were required to meet 16 core objectives and three of six menu objectives. In Stage 3, CMS proposes eight objectives and 21 measures. Other changes from Stage 2 include:

- Eliminating core and menu objectives. All objectives included in Stage 3 are required;
- Increasing certain performance thresholds for current measures (such as increasing the e-prescribing threshold from 10 to 25 percent of all hospital discharge medication orders for permissible prescriptions; and the CPOE requirement from 30 to 60 percent for laboratory and radiology and from 60 to 80 percent of medications);
- Combining multiple Stage 2 objectives into a new Patient Electronic Access objective, including patient access to patient-specific education resources and patient access to their health information within 24 hours through either view online, download and transmit (VDT) or an ONC-certified application program interface (API) that can be used by third party applications or devices;
- Combining multiple Stage 2 objectives into a new Coordination of Care through Patient Engagement objective, including secure messaging, patient-generated data and patient reminders, as well as increasing the percent of patients engaged using VDT or an API; and
- Revising the summary of care record in support of transitions of care to require the inclusion of the common clinical data set (CCDS) specified by ONC for certification to the newly proposed 2015 Edition certified electronic health record technology (CEHRT), including new information such as the unique device identifier (UDI) for medical devices and increasing the share of summary of care documents sent electronically from 10 percent to 50 percent.

CMS proposes to adopt a “topped out” approach to evaluate whether measures from prior stages of meaningful use are retained and increased. CMS defines “topped out" as describing measures that have achieved widespread adoption at a high rate of performance and no longer represent a basis upon which provider performance may be

differentiated. CMS also notes in the proposed rule where thresholds were raised from Stage 2 to Stage 3. **The AHA is concerned that the proposed large number of measures and higher thresholds would raise the bar too high and is not grounded in evidence from Stage 1 and Stage 2 experience.**

Reporting Clinical Quality Measures (CQMs): The proposed rule encourages eligible hospitals, CAHs and EPs to submit CQM data electronically when feasible in 2017 and mandates the electronic submission of such data in 2018. **The AHA is concerned with the required electronic reporting of CQMs in 2018, especially given the continued challenges hospitals face implementing CQMs for meaningful use.**

To further the alignment across quality reporting programs, CMS intends to address CQM reporting requirements, including reporting periods and submission requirements, for eligible hospitals and CAHs in the EHR Incentive Program for 2016 and beyond in the hospital inpatient prospective payment system rulemaking. Similarly, CMS intends to address CQM reporting requirements for EPs for 2017 and beyond in the physician fee schedule rulemaking.

Changes to Meaningful Use Attestation: CMS proposes, beginning in 2018, all providers would report on the same definition of meaningful use at the Stage 3 level regardless of their prior stage in the program. All providers would have the option to attest to Stage 3 in 2017. (See the chart on page 31 of the proposed rule for more information on the revised timeline of meaningful use stages.) In contrast to the 2014 EHR Incentive Program rules, both the 2014 CEHRT and the 2015 Edition CEHRT would support attestations for Stage 1 or Stage 2 in 2017.

Changes to the Meaningful Use Reporting Period: CMS proposes that the reporting period for eligible hospitals, CAHs and EPs would be a calendar year, with the exception of Medicaid EPs and eligible hospitals demonstrating meaningful use for the first time. Beginning in 2017, eligible hospitals and EPs demonstrating meaningful use for the first time in the Medicaid EHR Incentive Program would be required to attest for an EHR reporting period of any continuous 90-day period in the calendar year for purposes of receiving an incentive, as well as avoiding the payment adjustment under the Medicare Program. CMS states that this proposal to move all providers to a full calendar year reporting period aligns the EHR reporting period with reporting periods for other quality reporting programs identified in the meaningful use Stage 2 final rule and allows for a single attestation period. This proposal would mean that eligible hospitals and CAHs would have a reporting gap for the objectives and measures of meaningful use for the three-month quarter from Oct. 1, 2016 through Dec. 31, 2016.

Medicare Payment Adjustments: CMS proposes to maintain for all eligible hospitals, CAHs and EPs the payment adjustment provisions finalized in the Stage 2 final rule with the exception of a change to the relationship between the EHR reporting period year and the payment adjustment year for CAHs.

Hardship Exceptions: CMS proposes to retain the following four categories for hardship exceptions finalized in Stage 2 rulemaking:

- The lack of availability of Internet access or barriers to obtain IT infrastructure;
- A time-limited exception for newly practicing EPs or new hospitals that would not otherwise be able to avoid payment adjustments;
- Unforeseen circumstances such as natural disasters that would be handled on a case-by-case basis; and
- Exceptions (for EPs only) due to a combination of clinical features limiting a provider's interaction with patients or, if the EP practices at multiple locations, lack of control over the availability of CEHRT at practice locations constituting 50 percent or more of their encounters.

Privacy and Security: The proposed rule continues the Stage 2 requirement to conduct or review annually a security risk analysis (as required by the Health Insurance Portability and Accountability Act); but, it includes language clarifying that “appropriate technical, administrative, and physical safeguards” are included within the scope of the security risk analysis review requirements.

NEXT STEPS

Comments on the proposed rules are due May 29. Watch for an AHA Regulatory Advisory with more details on the rules, as well as information on member calls to provide feedback to AHA on the rules.

Table 1: Stage 3 Meaningful Use Objectives and Measures

Objective	Measures	Optionality
1. Protect patient health information: Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.	1. Conduct or review a security risk analysis per HIPAA (assessing the security of data stored in CEHRT), implementing security updates as necessary, and correcting identified security deficiencies as part of the provider's risk management process.	None
2. Electronic prescribing. EPs must generate and transmit permissible prescriptions electronically, and eligible hospitals and CAHs must generate and transmit permissible discharge prescriptions electronically (eRx).	2. More than 25 percent of hospital discharge medication orders for permissible prescriptions (new and changed) are queried for a drug formulary and transmitted electronically using CEHRT. More than 80 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. Menu objective in Stage 2 with threshold of 10 percent.	None
3. Clinical decision support	3. Implement five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period.	None
	4. Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	
4. CPOE	5. CPOE for medication - 80 percent of orders. Stage 2 was 60 percent.	None
	6. CPOE for labs - 60 percent of orders. Stage 2 was 30 percent.	
	7. CPOE for diagnostic imaging - 60 percent of orders. Stage 2 was 30 percent.	

5. Patient electronic access to health information	8. For more than 80 percent of unique patients, either: (i) the patient (or patient-authorized representative) is provided access to view online, download, and transmit their health information within 24 hours of its availability of the provider - or (ii)the patient (or patient-authorized representative) is provided access to an ONC-certified API that can be used by 3rd-party applications or devices. Stage 2 threshold was 50 percent.	None
	9. Use CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients. Stage 2 threshold was 10 percent.	
6. Coordination of care through patient engagement	10. More than 25 percent of all unique patients actively engage with the EHR made accessible by the provider. Measure may be met by (i) more than 25 percent of patients view, download, or transmit to a third parity their health information, or (ii) more than 25 percent of unique patients access health information using an API. Stage 2 threshold was 5 percent.	Attest/Report the numerators/denominators for all three measures. Must meet threshold on 2 of 3 measures.
	11. For more than 35 percent of all unique patients (or patient's authorized representative) a secure message was sent by the provider.	
	12. Patient generated data or data from a non-clinical setting for more than 15% of all unique patients.	
7. Health information exchange	13. For more than 50 percent of transitions of care and referrals, a summary of care record is created and sent electronically. Stage 2 threshold was 50 percent for creation of summary of care record and 10 percent for electronic exchange.	Attest/Report the numerators/denominators for all three measures. Must meet threshold on 2 of 3 measures.

	14. For more than 40 percent of transitions and referrals received and patient encounters in which the provider has never before encountered the patient, incorporate into the patient's EHR an electronic summary of care document from a source other than the provider's EHR system.	
	15. For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP, eligible hospital, or CAH performs a clinical information reconciliation that includes medications, medication allergy, and current problem list.	
8. Public health and clinical data registry reporting	16. Immunization registry reporting	EPs must attest/report to on 3 measures. EHs/CAHs must attest/report on 4 measures. The registry measures may be counted more than once if multiple registries are supported.
	17. Syndromic surveillance reporting	
	18. Case reporting	
	19. Public health registry reporting	
	20. Clinical data registry reporting	
	21. Electronic reportable lab results	