American Hospital Association

Special Bulletin

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CMS PROPOSES MODIFYING EHR REPORTING PERIOD IN 2015 TO 90 DAYS

The Centers for Medicare & Medicaid Services (CMS) April 10 released a proposed rule modifying the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program for 2015 through 2017. Among other changes, CMS proposes shortening the meaningful use reporting period for 2015 to a 90-day period aligned with the calendar year and provide additional flexibilities, including reducing the share of patients that must use the patient portal from 5 percent to at least one patient. The rule also would remove some measures that CMS believes have become "redundant, duplicative, or topped out." In addition, it would make a significant number of other changes to the program in the middle of the program year to better align it with the proposed Stage 3 rule that is currently out for public comment.

The AHA greatly appreciates the shorter reporting period and many of the other flexibilities proposed in this rule. We are concerned, however, that the volume of change proposed in the middle of the program year could cause confusion and burden for hospitals.

CMS will accept comments on the proposed rule for 60 days after publication in the April 15 Federal Register. Watch for an AHA Regulatory Advisory with more details on the rule.

For more information on the current regulatory requirements for the meaningful use program, see the AHA Regulatory Advisory on Stage 2 Meaningful Use. Additional AHA resources on meaningful use are available at http://www.aha.org/.

HIGHLIGHTS OF THE PROPOSED RULE

Reporting period. CMS proposes a 90-day reporting period for all providers in 2015, rather than the full-year reporting currently required. **The AHA has long advocated for this shorter reporting period and appreciates this proposed change, which will keep providers on track to meet Stage 2.**

CMS also proposes to change the reporting period for eligible hospitals (EHs) and critical access hospitals (CAHs) from the fiscal year to the calendar year, aligning it with

the reporting period for physicians and other eligible professionals (EPs). For 2015 only, EHs would report on any continuous 90-day period between Oct. 1, 2014 and Dec. 31, 2015. EPs would report on any continuous 90-day period between Jan. 1 and Dec. 31, 2015. The reporting period would be a full calendar year in later years for those continuing their participation in the program. For new Medicare participants, CMS proposes a 90-day reporting period in 2016 and a full-year reporting period in 2017 and beyond. New Medicaid participants would continue to have a 90-day reporting period for each and every year.

Attestation deadlines. As a consequence of the move to a calendar year reporting period for hospitals, CMS proposes to move the attestation deadline for 2015 to Feb. 29, 2016 from Dec. 31, 2015. Further, to accommodate the significant changes proposed for 2015, CMS proposes to delay any attestations for 2015 until Jan. 1, 2016 or later. Thus, even hospitals that choose Oct. 1 to Dec. 31, 2015 as their reporting period would not be able to attest until Jan. 1, 2016 at the earliest. **The AHA is concerned that this change would delay incentive payments for hospitals, possibly causing financial challenges.**

Meaningful use requirements. CMS proposes numerous changes to the meaningful use requirements for 2015 to 2017. Under the proposed rule, CMS would:

- Remove the core and menu approach and require providers to meet all objectives. This would include requiring EHs and CAHs to use e-prescribing at discharge, which is currently a menu item.
- Remove 11 objectives and two measures from Stage 2 for EHs and CAHs that CMS believes are redundant, duplicative or topped out. This includes all but one of the six menu items. For EPs, CMS proposes to remove 10 objectives and two measures.
- Change the requirement for the share of patients that must access the patient portal from 5 percent to at least one patient.
- Remove the requirement that a summary of care document be sent for at least 50 percent of discharges and referrals (which could include fax and paper copies), but retain the requirement that a summary of care document be sent electronically for at least 10 percent of discharges or referrals.
- Change the public health reporting requirements to include new clinical and public health registry reporting measures.
- Require all providers to meet Stage 2 requirements in 2015, with certain exceptions for those meant to be at Stage 1 in 2015. Specifically these providers would be given “alternate exclusions and specifications for certain objectives and measures” in 2015, but these exceptions would not be available in 2016 or later (see below).

Clinical Quality Measures. CMS proposes no changes to the quality reporting requirements for meaningful use, which would remain as laid out in the Stage 2 rule and relevant hospital and physician payment rules.

Modified Stage 2 for 2015 to 2017. Table 1 below lists the nine objectives and 18 measures that would apply to all EHs and CAHs under the proposed rule. The requirements for EPs are similar to those for EHs and CAHs, but list e-prescribing separately from other types of computerized provider order entry (CPOE). EPs also must have enabled secure messaging capabilities. The proposed rule also details specific exclusions (see table 6 of the proposed rule). For example, for 2015 only, CMS proposes to allow providers to claim an exclusion for any objective they had not planned to pursue as a menu item. This includes EHs and CAHs that had not planned to pursue e-prescribing of discharge medications as a Stage 2 menu item.

Table 1. Meaningful Use Objectives and Measures for 2015 to 2017

Objective	Measures
Computerized Provider Order Entry (CPOE)	Measure 1: More than 60 percent of medication orders created by the EP or by authorized providers of the EH's or CAH's inpatient or emergency department place of service ((POS) 21 or 23) during the EHR reporting period are recorded using CPOE. Measure 2: More than 30 percent of laboratory orders created by the EP or by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE. Measure 3: More than 30 percent of radiology orders created by the EP or by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.
Clinical decision support	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's, EH's or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving health care efficiency. Measure 2: The EP, EH or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
Patient electronic access (view, download and transmit)	EH/CAH Measure 1: More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH have their information available online within 36 hours of discharge. EH/CAH Measure 2: At least one patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH (or his or her authorized representative) views, downloads or transmits to a third party his or her information during the EHR reporting period.
Protect electronic health information	Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of electronic protected health information data stored in Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP, EH or CAH risk management process.
Patient-specific education	EH/CAH Measure: More than 10 percent of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology.
Medication	Measure: The EP, EH or CAH performs medication reconciliation for more than 50

Objective	Measures
reconciliation	percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23).
Transitions of care	Measure: The EP, EH or CAH that transitions or refers their patient to another setting of care or provider of care (1) uses Certified EHR Technology to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals.
e-Prescribing	EH/CAH Measure: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology.
Public health*	Measure Option 1 – Immunization Registry Reporting: The EP, EH or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system. Measure Option 2 – Syndromic Surveillance Reporting: The EP, EH or CAH is in active engagement with a public health agency to submit syndromic surveillance data from a nonurgent care ambulatory setting for EPs, or an emergency or urgent care department for EHs and CAHs (POS 23). Measure Option 3 – Case Reporting: The EP, EH or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. Measure Option 4 – Public Health Registry Reporting: The EP, EH or CAH is in active engagement with a public health agency to submit data to public health registries. Measure Option 5 – Clinical Data Registry Reporting: The EP, EH or CAH is in active engagement to submit data to a clinical data registry. Measure Option 6 – Electronic Reportable Laboratory Result Reporting: The EH or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.

*EHs and CAHs would need to report on three of the six measure options.

Treatment of Stage 1 providers. For 2015 only, CMS proposes to afford providers meant to be at Stage 1 the option to attest to the Stage 1 objective and measure specifications for all of the objectives of meaningful use that it has retained. For example, these providers would implement only one clinical decision support tool (Stage 1 requirement), rather than five (Stage 2 requirement). For objectives that did not exist in Stage 1, these providers would have an exclusion in 2015. For example, these providers would have an exclusion for the transitions of care objective because Stage 1 does not have a similar objective. In 2016 and later, however, CMS would require all providers to meet the same requirements, regardless of when they first enter the program. **The AHA is concerned that these changes would be confusing and possibly burdensome for providers new to the program.**

Patient engagement. In response to the concerns of hospitals and physicians, CMS proposes to change the requirements on patient engagement for 2015 to 2017. Under the proposed rule, the current requirement to provide patients online access to their health information would remain. However, the current requirement that 5 percent of patients use the patient portal would be modified to at least one patient. CMS states that this change would ensure the capability is enabled while giving providers and patients

more time to implement these tools. **The AHA strongly advocated for this change and greatly appreciates this proposal.**

Transitions of care. CMS proposes to modify the specifications for the transitions of care objective. First, as noted above, CMS proposes to remove the current Stage 2 requirement that a summary of care document be sent for 50 percent of transitions and referrals (which could include fax and paper copies). Second, the agency would keep the requirement that the EH, CAH or EP send the summary of care electronically for 10 percent of transitions and referrals. Third, CMS proposes to remove any requirements on the specific methods used to electronically send the summary of care document, such as specifically using Certified EHR Technology to do so.

Public health reporting. CMS proposes to modify the public health objective, consistent with the Stage 3 proposed rule that is currently out for public comment. The changes include the addition of new measures for reporting to clinical or public health registries, and introducing the concept of "active engagement" with public health, which could include registering to submit data, conducting testing or submitting production data. EHs and CAHs would need to report on three of the six measures, giving some flexibility to providers.

NEXT STEPS

CMS will accept comments on the proposed rule for 60 days after publication in the April 15 Federal Register. Watch for an AHA Regulatory Advisory with more details on the rules.

The AHA also will hold a member call on April 29 at 2 p.m. ET, where AHA staff will discuss this rule and the Stage 3 proposed rule. You can register for the call at http://www.aha.org/.