American Hospital Association

Special Bulletin

Wednesday, October 7, 2015

CMS RELEASES FINAL RULE FOR EHR REPORTING PERIOD IN 2015, STAGE 3 'MEANINGFUL USE' OF EHRs

The Centers for Medicare & Medicaid Services (CMS) yesterday released a final rule with comment period modifying the reporting period for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs in 2015 to a 90-day period to align with the calendar year and providing additional flexibilities. The final rule also defines the "meaningful use" of EHRs for Stage 3 of the Medicare and Medicaid EHR Incentive Programs to start in 2018, with the option for providers to begin in 2017.

At the same time, the Office of the National Coordinator for Health Information Technology (ONC) released a final rule that sets new certification criteria, standards and implementation specifications for EHR technology to support Stage 3.

The AHA is pleased that CMS released the long-awaited modifications rule, which provides much-needed relief. Hospitals will have clarity needed to take steps to ensure they meet the revised requirements. However, the Stage 3 final rule raises the bar significantly. The Stage 3 rule is too much too soon.

Highlights follow; watch for an AHA Regulatory Advisory with more details. The AHA will hold a member call on Oct. 29 to review the rules. More information on the call will be sent soon.

CMS will accept comments on the Stage 3 requirements and how they will fit into new Medicare physician payment methods introduced by the Medicare Access and CHIP Reauthorization Act of 2015. Comments are due Dec. 15.

HIGHLIGHTS OF THE MEANINGFUL USE MODIFICATIONS 2015-2017 FINAL RULE

CMS finalized its proposal that all eligible hospitals (EHs) and critical access hospitals (CAHs) report on the same nine objectives of meaningful use:

- Protect Patient Health Information
- Clinical Decision Support (CDS)
- Computerized Provider Order Entry (CPOE)
- Electronic Prescribing (eRx)
- Health Information Exchange
- Patient Specific Education
- Medication Reconciliation
- Patient Electronic Access to Health Information
- Public Health and Clinical Data Registry Reporting

Reporting Period: CMS finalizes a 90-day reporting period for all providers in 2015. **The AHA has long advocated for this shorter reporting period and appreciates this change.** CMS also finalizes a change to the reporting period for EHs and 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, CAHs and 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, 2015 and Dec. 31, 2015. The reporting period will be a full calendar year in later years for those continuing their participation in the program. For new Medicare participants, CMS will allow a 90-day reporting period in 2016 and 2017, as recommended by the AHA. New Medicaid participants would continue to have a 90-day reporting period for each and every year.

Attestation Window: Because of the move to a calendar year reporting period for hospitals, CMS finalizes an attestation window of Jan. 4, 2016 to Feb. 29, 2016. The AHA had recommended that CMS open the attestation window no later than Aug. 1, 2015. We remain concerned that this change will delay incentive payments for hospitals, possibly causing financial challenges.

Overall Structure of the Program: As proposed, CMS removes the core and menu approach and, rather, will require providers to meet all objectives. Also as proposed, the agency removes 12 objectives from Stage 2 for EHs and CAHs that CMS believes are redundant, duplicative or topped out. For EPs, CMS removes 11 objectives.

CMS finalizes its proposal to require all providers to meet Stage 2 requirements beginning 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. CMS adds certain alternate exclusions and specifications in 2016, but not the full set available for 2015 (see section below on alternate exclusions and specifications).

Modified Stage 2 for 2015 to 2017: CMS finalizes many of its proposed changes to the meaningful use requirements for 2015 to 2017, but modifies a few. **On balance, these changes meet many of the concerns expressed by the AHA and increase the likelihood of program success in the near term.**

Table 1 below lists the nine objectives and 18 measures that would apply to all EHs and CAHs under the final rule. The final rule also details specific exclusions, discussed below (see table 8 of the final rule). Requirements of particular interest to hospitals are summarized below.

Patient engagement. In response to the concerns of hospitals and physicians, CMS finalizes changes to the requirements on patient engagement for 2015 to 2017. As proposed, the current requirement to provide patients online access to their health information remains. However, the current requirement that more than 5 percent of patients use the patient portal is modified to at least one patient in 2015 and 2016. The threshold will increase back to more than 5 percent in 2017.

Transitions of care. CMS finalizes its proposal to modify the specifications for the transitions of care objective (now labeled health information exchange). First, CMS removes 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 retains the requirement that a summary of care document be sent electronically for at least 10 percent of discharges or referrals. Third, CMS removes any requirements on the specific methods used to electronically send the summary of care document, such as specifically using the Direct protocol to do so.

e-Prescribing. As proposed, e-prescribing of discharge prescriptions is a required objective beginning in 2015. However, CMS also finalizes its proposed exclusion to this requirement for EHs and CAHs that did not intend to choose e-prescribing as a menu option in 2015 and extended it to 2016. EHs and CAHs meant to be at Stage 1 have a similar exclusion. All EHs and CAHs will be expected to meet the objective in 2017.

Public health reporting. CMS finalizes only one additional measure option for public health reporting – Specialized Registry Reporting – rather than the three proposed. The agency did not finalize a change to the immunization registry reporting measure that would require bidirectional communication. Additionally, CMS finalizes the concept of "active engagement" with public health, which include registering to submit data, conducting testing or submitting production data. EHs and CAHs need to report on three of the four measures.

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.

Alternate exclusions and specifications. For 2015 only, CMS allows 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, EHs and CAHs meant to be at Stage 1 in 2015 would implement only one clinical decision support tool (Stage 1 requirement), rather than five (Stage 2 requirement) and report on only two public health measures, rather than three. For objectives that did not exist in Stage 1, these providers have an exclusion in 2015. For example, these providers have an exclusion for computerized provider order entry (CPOE) for lab and radiology, because Stage 1 does not have similar objectives. In 2016, Stage 1 providers will have exclusion for only those objectives that CMS deems to have a safety risk from rushed implementation, specifically CPOE for lab and radiology orders, and e-prescribing. As noted above, CMS also finalizes exclusions for the e-prescribing objective. Full exclusions are outlined in Table 8 of the final rule.

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

Objective	Measures	Major Changes from Proposed Rule
1. 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 created or maintained 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.	None
2. 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 EH's or CAH's scope of practice or patient	None

Objective	Measures	Major Changes from Proposed Rule
	population, the clinical decision support interventions must be related to high-priority health conditions. Measure 2: The EH or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	
3. 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.	Extended exclusions
4. e-Prescribing	EH/CAH Measure: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology.	Exclude refill prescriptions and extend exclusions
5. Health information exchange	Measure: The 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	None

Objective	Measures	Major Changes from Proposed Rule
	receiving provider for more than 10 percent of transitions of care and referrals.	
6. Patient-specific education	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.	None
7. Medication reconciliation	Measure: The EH or CAH performs medication reconciliation for more than 50 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).	None
8. Patient electronic access (view, download and transmit)	EH/CAH Measure 1: More than 50 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH are provided timely access to view online, download and transmit their health information to a third party their health information. EH/CAH Measure 2: For 2015 and 2016: At least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH (or patient-authorized representative) views, downloads, or transmits to a third party his or her health information during the EHR reporting period. For 2017: More than 5 percent of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH (or patient-authorized representative) view, download, or transmit to a third party their health information during the EHR reporting period.	Threshold increases to more than 5 percent in 2017
9. Public health (EHs and CAHs report on three of	Measure 1 – Immunization Registry Reporting: The EH or CAH is in active engagement with a public health agency to submit immunization data	Fewer measure options than proposed

Objective	Measures	Major Changes from Proposed Rule
four measure options)	Measure 2 – Syndromic Surveillance Reporting: The EH or CAH is in active engagement with a public health agency to submit syndromic surveillance data. Measure 3 – Specialized Registry Reporting: The EH or CAH is in active engagement to submit data to a specialized registry. Measure 4 – Electronic Reportable Laboratory Result Reporting: The EH or CAH is in active engagement with a public health agency to submit ELR results.	Immunization registry does not require bidirectional exchange

Treatment of EPs. The requirements for EPs are similar to those for EHs and CAHs, but e-prescribing is listed separately from other types of CPOE. Additionally, CMS finalizes a slightly different policy for secure messaging than proposed. Specifically, EPs must demonstrate secure messaging capabilities in 2015, send at least one secure message to a patient (or patient-authorized representative) in 2016, and send secure messages to more than 5 percent of patients (or their authorized representative) in 2017.

HIGHLIGHTS OF THE MEANINGFUL USE STAGE 3 FINAL RULE

Meaningful Use Objectives and Measures for Stage 3: CMS finalizes its proposal that all EHs and CAHs must report on the same eight objectives of meaningful use required under the modifications rule. Stage 3 includes 21 specific measures, with very limited variation and flexibility in reporting for eligible hospitals, CAHs and EPs.

The final Stage 3 objectives and measure are listed in Table 2. In general, CMS made few changes from its proposed rule.

Comparison to Modified Stage 2: In Stage 3, CMS will require a full calendar year reporting period in 2018, with a limited exception for Medicaid providers in their first year of demonstrating meaningful use. CMS increases thresholds on measures from the

modified Stage 2 requirements and introduces new requirements. Items of particular note include:

- Raising the threshold for patient engagement from one unique patient to 10 percent of patients and including use of application programming interfaces (APIs) as a mechanism for patients to access their data;
- Requiring providers to incorporate data that is from non-clinical settings or is patient-generated;
- Increasing the thresholds for health information exchange in support of transitions of care (see Table 2); and
- Establishing a total of six measures for public health reporting, including bidirectional exchange with immunization registries.

Reporting Clinical Quality Measures (CQMs): The Stage 3 rule mandates the electronic submission of eCQM data in 2018. **The AHA is concerned with the required electronic reporting of CQMs in 2018, especially given the continued challenges hospitals face implementing them.**

Changes to Meaningful Use Attestation: For 2017, CMS finalizes its proposal that EHs and CAHs have the option to report for Stage 3 for any continuous 90-day period or to report for the modified Stage 2. Beginning in 2018, all providers will report on the Stage 3 definition of meaningful regardless of their prior years of experience in the modified Stage 2. All providers will have the option to attest to Stage 3 in 2017 if they use the 2015 Edition certified EHR. The reporting period in 2017 for Stage 3 is any continuous 90 calendar days.

Table 2. Stage 3 Meaningful Use Objectives and Measures

Objective	Measures	Major Changes from Proposed Rule
1. Protect electronic health information: Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (certified EHR) through the implementation of appropriate technical, administrative, and physical safeguards.	1. Conduct or review a security risk analysis per Health Information Portability and Accountability Act (HIPAA) (assessing the security of data stored in certified EHR), implementing security updates as necessary, and correcting identified security deficiencies as part of the provider's risk management process.	None
2. Electronic prescribing: Eligible hospitals (EHs) and critical access hospitals (CAHs) must generate and	2. More than 25 percent of EH or CAH discharge medication orders for permissible prescriptions (new and changed) are queried	None

Objective	Measures	Major Changes from Proposed Rule
transmit permissible discharge prescriptions electronically (eRx).	for a drug formulary and transmitted electronically using certified EHR.	
3. Clinical decision support (CDS): Implement CDS interventions focused on improving performance on high-priority health conditions.	3. Implement five clinical decision support interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire EHR reporting period. 4. Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	None
4. Computerized Provider Order Entry (CPOE): Use CPOE for medication, laboratory, and diagnostic imaging orders.	5. CPOE for medication - More than 60 percent of medication orders created by authorized providers of the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE. 6. CPOE for labs - More than 60 percent of laboratory orders created by the authorized providers of the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE. 7. CPOE for diagnostic imaging - More than 60 percent of diagnostic imaging orders created by the authorized providers of the EH or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	Proposed rule included an 80 percent threshold for medication orders. Thresholds for laboratory and diagnostic imaging orders are the same as proposed.
5. Patient electronic access to health information: Use the certified EHR functionality to provide patient access health information or patient-specific educational resources.	8. For more than 80 percent of unique patients, either: (i) the patient (or patient-authorized representative) is provided timely access to view online, download, and transmit their health information - and (ii) the provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's certified EHR. 9. Use certified EHR to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients.	First measure: no change to threshold but removed the reference to provision of the timely access within 24 hours of its availability to the provider. Change in the optionality for EH or CAH to select which of the two elements of the first measure to meet.

Objective	Measures	Major Changes from Proposed Rule
		Second measure: no change.
6. Coordination of Care through Patient Engagement: Use certified EHR functionality to engage with patients or their authorized representatives. EH and CAH must attest/report the numerators/denominators for all three measures and must meet thresholds for 2 out of 3 measures.	10. More than 10 percent of all unique patients (or their authorized representatives) discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) actively engage with the electronic health record made accessible by the provider. Measure to be met by patient is one of the following (i) view, download, or transmit to a third parity their health information, (ii) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's certified a combination of (i) and (ii). 11. For more than 25 percent of all unique patients or patient's authorized representative discharged from EH or CAH inpatient or emergency department (POS 21 or 23), certified EHR was used to send a secure message to the patient or used in response to a secure message sent by the patient. 12. Patient generated data or data from a non-clinical setting for more than 5 percent of all unique patients.	First measure: reduction in threshold from 25 percent of all unique patients in 2018 and the option to combine (i) and (ii). Second measure: reduction in the threshold from 35 percent of all unique patients for 2018. Third measure: reduction in the threshold from 15 percent of all unique patients.
7. Health information exchange: provide a summary of care record when transitioning or referring their patient to another setting of care, or retrieve a summary of care record upon the first patient encounter with a new patient. EH/CAH must attest/report the numerators/denominators for all three measures. Must meet threshold on 2 of 3 measures.	13. For more than 50 percent of transitions of care and referrals, a summary of care record is created and sent electronically. 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 EH, CAH or EP performs a clinical information reconciliation	None

Objective	Measures	Major Changes from Proposed Rule
	that includes medications, medication allergy, and current problem list.	
8. Public health and clinical data registry reporting: EH or CAH is in active engagement with a public health agency (PHA) or clinical data repository (CDR) to submit electronic public health data in a meaningful way using certified EHR, except where prohibited and in accordance with applicable law. EHs and CAHs must attest/report on 4 measures. The registry measures may be counted more than once if multiple registries are supported.	16. Immunization registry reporting. The EH or CAH is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). 17. Syndromic surveillance reporting. The EH or CAH is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting. 18. Case reporting. The EH or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. 19. Public health registry reporting. The EH or CAH is in active engagement with a public health agency to submit data to public health registries. 20. Clinical data registry reporting. The EH or CAH is in active engagement to submit data to a clinical data registry. 21. Electronic reportable lab results. The EH or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.	None