OVERVIEW

The Centers for Medicare and Medicaid Services (CMS) on March 20 released its proposed rule for Stage 3 of the Electronic Health Record (EHR) Incentive Program, also called Meaningful Use (MU) Stage 3 (also referred to throughout this summary as Stage 3). The rule contains the proposed criteria that eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) would need to meet in order to qualify for electronic health record (EHR) incentive payments and avoid penalties for non-participation. CMS' stated objectives for the proposed rule are to increase simplicity and flexibility in the program while driving interoperability and increasing focus on patient outcomes in the meaningful use program. CMS also makes it clear in the rule that it intends for its proposal to apply beyond EHRs to other categories of health information technology (IT). Public comments on the proposed rule are due to CMS by 5 p.m. on Friday, May 29, 2015. The ACC is working with members to develop a response and intends to submit comments by the deadline. The ACC has online resources available for Stage 1 and Stage 2.

EXECUTIVE SUMMARY

Stage 3 is *expected* to be the final stage of MU and builds on the groundwork established in Stages 1 and 2. Given the continued effort to improve care and expand health IT functionality, there may be future changes to the objectives and measures of MU which *could* result in future rulemaking. The rule proposes that providers would have the option in 2017 of either participating in the previously prescribed stage, based on the year they entered the program, or participating in Stage 3, regardless of their first year of program participation. Beginning in 2018, all providers would report at the Stage 3 level regardless of prior participation.

TABLE 1: STAGE OF MEANINGFUL USE CRITERIA BY FIRST PAYMENT YEAR

First Payment Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2012		1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2013			1	1*	2	2	3	3	TBD	TBD	TBD
2014				1*	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

*3-month quarter EHR reporting period for Medicare and continuous 90-day EHR reporting period (or 3 months at Stage option) for Medicaid EPs. All providers in the first year in 2014 use any continuous 90-day EHR reporting period.

TABLE 2: STAGE OF MEANINGFUL USE CRITERIA BY FIRST YEAR (PROPOSED)

First Year as a Meaningful EHR User	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021 and future years
2011	1	1	1	2*	2	2	2 or 3	3	3	3	3
2012		1	1	2*	2	2	2 or 3	3	3	3	3
2013			1	1	2	2	2 or 3	3	3	3	3
2014				1	1	2	2 or 3	3	3	3	3
2015					1	1	1, 2 or 3	3	3	3	3
2016						1	1, 2 or 3	3	3	3	3
2017							1, 2 or 3	3	3	3	3
2018 and future years								3	3	3	3

*Please note, a provider scheduled to participate in Stage 2 in 2014, who instead elected to demonstrate stage 1 because of delays in availability of EHR technology certified to the 2014 Edition, is still considered a stage 2 provider in 2014 despite the alternate demonstration of meaningful use. In 2015, all such providers are considered to be participating in their second year of Stage 2 of meaningful use.

Therefore, come January 1, 2018, the rule proposes that all providers would need to begin reporting to the proposed single set of 8 Stage 3 MU objectives and their respective measures and do so for a full year. This means they are proposing to eliminate the current 90 day EHR reporting period for EPs, EHs, and CAHs demonstrating MU for the first time, thus creating a single reporting period for all providers aligned to the calendar year, which would provide better alignment with other CMS quality reporting programs such as Hospital Inpatient Quality Reporting (IQR) and Physician Quality Reporting System (PQRS). A single reporting period based on the calendar year would also allow for a single attestation period, which CMS believes would enable the Health and Human Services (HHS) systems to better capture data, conduct enhanced stress testing and issue resolution, and improve quality assurance of systems before each deployment. However, this streamlining may hinder those implementing EHRs or demonstrating MU for the first time since they are not provided much of a window to allow for adjustments. For attestation, physicians would have two months following the close of their full EHR reporting period. As it is proposed, the attestation and batch reporting process that is available for group practices would remain as methods of demonstrating MU.

By requiring that all providers meet all 8 objectives, the proposal appears to continue to focus on 'checking the box' or providing a pass/fail approach to the program rather than changing care delivery to achieve the goal of improved patient care. In order to simplify the number of objectives from 17 or 16 to 8, CMS has proposed removing objectives and measures that the Agency believes are redundant, duplicative, or “topped out.” "Topped out" is the term used to describe 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. An example of a current Stage 1 objective that would be considered "topped out" is the objective to record demographics. Redundant objectives and measures include those where a viable health IT-based solution may replace paper-based actions, such as the Stage 2 Clinical Summary Objective. Duplicative objectives and measures included those where some aspect is also captured in the course of meeting another objective or measure, such as recording vital signs which is also required as part of the summary of care document.

TABLE 3: CURRENT STAGE 1 & 2 STRUCTURE AND PROPOSED STAGE 3 STRUCTURE

	Current Stage 1 Structure
EP	13 core objectives 5 of 9 menu objectives including 1 public health objective
EH/ CAH	11 core objectives 5 of 10 menu objectives including 1 public health objective
	Current Stage 2 Structure
EP	17 core objectives including public health objectives 3 of 6 menu objectives
EH/ CAH	16 core objectives including public health objectives 3 of 6 menu objectives
	Proposed Stage 3 Structure
EP/ EH/ CAH	8 core objectives 1 public health objective (EPs: 3 measure options of 5) (EHs/CAHs: 4 measure options of 6)

The rule proposes a set of 8 objectives with associated measures designed to:

- Align with national health care quality improvement efforts;
- Promote interoperability and health information exchange;
- Focus on the 3-part aim of reducing cost, improving access, and improving quality.

The 8 objectives and their associated measures are highlighted below along with a thorough overview of each.

CLINICAL QUALITY MEASUREMENT:

In the proposed rule, CMS intends to support alignment between the EHR Incentive Programs and CMS quality reporting programs, such as PQRS and Hospital IQR by including the reporting requirements for clinical quality measures (CQMs) for providers as part of the Medicare physician fee schedule and Inpatient Prospective Payment System (IPPS) rulemaking processes going forward. The proposed CQM reporting period for EPs, EHs and CAHs, starting in 2017, would be the calendar year, rather than the federal fiscal year. Medicaid eCQM reporting requirements would continue to be determined by the states, and subject to CMS approval.

CMS has also proposed EHRs be certified to more than the minimum number of CQMs required by MU, phasing in the number of quality measures vendors would need to be certified to handle. Manual abstraction of data from an EHR would not be considered acceptable for the purposes of meeting data capture using a certified EHR. However, electronic information that is interfaced or electronically transmitted from a non-certified EHR (e.g., automated blood pressure cuff) would satisfy the "capture" requirement, as long as data is visible to the physician in the EHR.

Providers are encouraged to attest CQM data through electronic means in 2017, and CMS proposes to require electronic submission where feasible beginning in 2018, unless providers are able to demonstrate circumstances that prevent them from eReporting. EPs and EHs that chose to eReport would be required to use the most recent version of the electronic measure specifications.

TABLE 4: Proposed eCQM Reporting Timelines for Medicare & Medicaid EHR Incentive Program				
Year	2017 only	2017 only	2018 and subsequent years	2018 and subsequent years
Reporting Method Available	Attestation	Electronic Reporting	Attestation	Electronic Reporting
Provider Type who May Use Method	All Medicare providers Medicaid providers must refer to state requirements for reporting	All Medicare providers Medicaid providers must refer to state requirements for reporting	Medicare Providers with circumstances rendering them unable to eReport Medicaid providers must refer to state requirements for reporting	All Medicare providers Medicaid providers must refer to state requirements for reporting
CQM Reporting Period	1 CY for Medicare 1 CY for returning Medicaid 90 days for first time meaningful	1 CY for Medicare 1 CY for returning Medicaid 90 days for first time meaningful	1 CY for Medicare 1 CY for returning Medicaid 90 days for first time meaningful	1 CY for Medicare 1 CY for returning Medicaid 90 days for first time meaningful

	user Medicaid	user Medicaid	user Medicaid	user Medicaid
eCQM Version Required **(CQM electronic specifications update)**	2016 Annual Update	2016 Annual Update	2016 Annual Update or more recent version	2017 Annual Update
CEHRT* Edition Required	2014 Edition Or 2015 Edition	2014 Edition Or 2015 Edition	2015 Edition	2015 Edition

*certified electronic health record technology (CEHRT)

PAYMENT ADJUSTMENTS AND HARDSHIP EXCEPTIONS:
CMS does not propose any changes to the payment adjustment provisions, with one exception. The change to the EHR reporting period for CAHs described above also applies to the attestation and hardship exception deadlines as they relate to the payment adjustment year, allowing for a transition to EHR reporting on a calendar instead of fiscal year. This means that for EPs and EHs, the reporting period for a payment adjustment year would be the full calendar year that is 2 years before the payment adjustment year.

The original statute required reductions in payments to EPs, EHs, and CAHs that are not meaningful users of certified EHR technology, beginning in calendar year (CY) 2015 for EPs, fiscal year (FY) 2015 for EHs, and in cost reporting periods beginning in FY 2015 for CAHs. On April 16, 2015, the President signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA combines CMS quality reporting initiatives and their associated penalties into one program, the Merit-based Incentive Payment System (MIPS), which will affect the regulations regarding penalties for failure to meaningfully use EHRs beginning in 2019. The College will work closely with CMS as the Agency engages in extensive rulemaking to implement this important law in the coming years.

The proposal includes 4 main categories of hardship exceptions:
–Lack of internet availability or barriers to obtain IT infrastructure;
–A time-limited exception for newly practicing EPs or new hospitals;
–Unforeseen circumstances such as natural disasters (handled on a case-by-case basis);
–(For EPs only) – EP practicing at multiple locations with lack of control over the availability of CEHRT at practice locations constituting 50% or more of their encounters.

DEFINITIONS
The rule proposes to consider a patient seen through telehealth as a patient "seen by the EP," which would count for purposes of MU. Telehealth, as proposed, may include commonly known telemedicine as well as telepsychiatry, telenursing, and other diverse forms of technology-assisted health care. In cases where the EP and the patient do not have a real time physical or telehealth encounter, but the EP renders a consultative service for the patient, such as reading an EKG, virtual visits, or asynchronous telehealth, the EP may choose whether to include the patient in the denominator as "seen by the EP."

PROPOSED OBJECTIVES AND MEASURES:
The Stage 3 proposed rule adopts a reporting structure that features eight objectives and associated measures that would replace all criteria under Stages 1 and 2. As of 2018, all providers would be reporting at Stage 3 using these criteria (or meet the exclusion criteria).

CMS identified key policy areas representing advanced use of EHR technology that align with the foundational goals such as those in the CMS National Quality Strategy. The eight objectives are

1. Protect Patient Health Information
2. Electronic Prescribing (eRx)
3. Clinical Decision Support (CDS)
4. Computerized Provider Order Entry (CPOE)
5. Patient Electronic Access to Health Information
6. Coordination of Care through Patient Engagement
7. Health Information Exchange (HIE)
8. Public Health and Clinical Data Registry Reporting

In the above list, EPs would be required to attest to the numerators and denominators of all measures associated with an objective; however, for certain objectives physicians would only need to meet the thresholds for some of the measures. These objectives include:

- Objective 6 - Coordination of Care through Patient Engagement;
- Objective 7 - Health Information Exchange; and
- Objective 8 - Public Health Reporting.

For the optional year 2017, providers may use EHR technology certified to either the 2014 Edition or new 2015 Edition being proposed by the Office of the National Coordinator for Health IT. All providers would be required to use EHR technology certified to the 2015 Edition for a full calendar year for the reporting period in 2018. More information on the 2015 Edition and ONC's rule is at the end of this document.

COMPANION NPRM:
At the same time that CMS' Stage 3 rule was released, the Office of the National Coordinator (ONC) introduced a new edition of EHR certification criteria in the notice of proposed rulemaking titled "2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications."

The ONC proposed rule focuses on enabling interoperability, as well as a more flexible certification program that supports developer innovation and provides access to data in an actionable format. The rule also intends to facilitate the accessibility and exchange of electronic health information by including enhanced data portability, provider directories, transitions of care, and API capabilities as part of the 2015 Edition Base EHR definition. ONC's proposed rule also suggests new and updated vocabulary and content standards for the structured recording and exchange of electronic health information.

Patient safety is also emphasized in the rule by applying enhanced user-center design principles to health IT, enhancing patient matching, requiring relevant electronic health information to be exchanged (e.g., unique device identifiers), improving the surveillance of certified health IT, public disclosures for product costs, such as implementation and use, and making more information about certified products publicly available and accessible. In addition, the rule would make the privacy and security of data and PHI a priority, by ensuring relevant privacy and security capabilities and by addressing the exchange of electronic sensitive health information through the Data Segmentation for Privacy standard.

The rule proposes that, at a minimum, EPs, EHs, and CAHs would be required to use EHR technology certified to the 2014 Edition certification for their respective reporting periods in 2015 through 2017. A provider may also upgrade to the 2015 Edition prior to 2018 to meet the EHR reporting periods in 2015, 2016 and 2017 or use of combination of 2014 and 2015 Editions prior to 2018. Based on experience with delays in the availability of CEHRT, CMS proposes to include a longer period of time for providers to use technology certified to 2014 Edition to give providers more time in updating their technology to the 2015 Edition before the EHR reporting period in 2018, when it is proposed that use of the 2015 Edition becomes required.