Summary and Analysis of the MU Final Rule:

Modifications in 2015-17 and Stage 3 Requirements

A White Paper

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Executive Summary

On October 6, 2015, **CMS *finally* published the highly anticipated** Final Rule on meaningful use requirements. The Final Rule actually covers changes from *two different* proposed rules: the April 2015 proposed rule on modifications to meaningful use in 2015-17 and the March 2015 proposed rule on Stage 3 requirements.

In terms of the changes to meaningful use in 2015-17, CMS largely finalized what it proposed in April 2015. In terms of Stage 3 objectives and measures (which would be required in 2018), CMS appears to have made *some* changes in response to public comments, but overall the Stage 3 requirements still look like they will be very challenging.

Additional highlights from the Final Rule:

- Beginning in 2015, the EHR reporting period for all hospitals and EPs follows *the calendar year.*
- For 2015 *only*, all EPs and hospitals can attest to *90 consecutive days of meaningful use* instead of an entire year.
- A "revised" version of Stage 2 will be required for all hospitals and EPs in 2015 and 2016; providers currently scheduled to demonstrate Stage 1 this year will have a number of exclusions and alternate measures available, though (some extend into next year as well).
- In 2017, hospitals and EPs will have the option of a *full year* of "revised" Stage 2 requirements or *90 consecutive days* of Stage 3.
- A *full year of Stage 3* will be required for all hospitals and EPs starting in 2018, and providers will also need to possess 2015 Edition certified EHRs by that time.

Background

Technically, the Final Rule is a "Final Rule with a 60-day comment period." The reason behind this is **the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – which established the Merit-Based Incentive Payment System (MIPS) – was enacted in April 2015 *after* the proposed MU rules were published**. Under MIPS, existing federal incentive initiatives – including meaningful use and PQRS – will be consolidated under a single umbrella for ambulatory providers in 2019. As a result, CMS is seeking comments as they plan for the transition. (For more information on MIPS, which only applies to EPs, see Impact Advisors' "Week in Review" blog from 4/3/15.)

It is also worth noting that **there is a *tremendous* amount of uncertainly around Stage 3 right now**. Influential provider groups have been calling for a delay for a while, and Congress is increasingly showing interest in getting involved, so there are no guarantees *at all* that Stage 3 will begin in 2018 as planned. (For what it's worth, there are unlikely to be further changes to MU requirements in 2015, 2016 and 2017, though.)

The following summary represents **our initial impressions and takeaways from the Final Rule**.

EHR Reporting Periods in 2015, 2016 and 2017

Beginning in 2015, the EHR reporting period for all hospitals and EPs will follow *the calendar year*. (Note that the reporting period for EPs was already based on the calendar year, but for hospitals the reporting period was previously based on the Federal Fiscal Year.)

For 2015, all EPs and hospitals will be able to attest to an EHR reporting period of *any consecutive 90 days*:

- EPs will be able to choose any consecutive 90-day period between January 1, 2015 and December 31, 2015.
- Hospitals will be able to choose any consecutive 90-day period *between October 1, 2014 and December 31, 2015.*

The 90-day reporting period will *only* be for 2015. **In 2016, a full, 365-day reporting period will again be required** (except for first time MU participants, who will continue to be able to attest to any consecutive 90-day period).

In 2017, Stage 3 will be optional. The reporting period for any hospital or EP that decides to attest to Stage 3 in 2017 will be *any consecutive 90 days*. For all other hospitals and EPs, the 2017 reporting period will be *a full calendar year*. (An exception will again be made for first time MU participants in 2017, who will be able to attest to any consecutive 90-day period.)

In 2018, *a full calendar year of Stage 3* will be required for all hospitals and EPs (including first time MU participants), and all providers will also need to possess **2015 Edition certified EHRs** by that time.

The updated meaningful use timeline is as follows:

Updated MU Timeline

First Payment Year	Required Stage of Meaningful Use and Length of Reporting Period					
	...	2015 *90 days*	2016 *Full year*	2017 *Full year***	2018 *Full year*	2019 + *Full year*
2011		2 (revised)	2 (revised)	2 (rev.) or 3	3	3
2012		2 (revised)	2 (revised)	2 (rev.) or 3	3	3
2013		2 (revised)	2 (revised)	2 (rev.) or 3	3	3
2014		2 (revised)*	2 (revised)	2 (rev.) or 3	3	3
2015		2 (revised)*	2 (revised)**	2 (rev.) or 3	3	3
2016			2 (revised)**	2 (rev.) or 3	3	3
2017				2 (rev.) or 3	3	3
2018+					3	3

*Alternate exclusions and measures available for Stage 1 providers in 2015
**Certain CPOE exclusions available for Stage 1 providers in 2016
***2017 reporting period will be 90 days for providers who choose to attest to the optional Stage 3 requirements in 2017

2015 Edition CEHRT *required*

"Revised" Stage 2 Objectives and Measures (2015, 2016 & 2017)

In the Final Rule, **CMS adopted its proposal to replace the existing Stage 1 and Stage 2 requirements with a "revised" version of Stage 2** beginning in 2015 (and continuing through 2017). The "revised" Stage 2 requirements are essentially a consolidated version of the original Stage 2 objectives and measures. There is no longer a "core" and "menu" set, though. Instead, the "revised" version of Stage 2 consists of **9 objectives (and 16 measures) for hospitals** and **10 objectives (and 16 measures) for EPs**.

In the "revised" version of Stage 2, **many original Stage 1 and Stage 2 measures** – specifically those CMS believes to be redundant, duplicative, or "topped out" – **have been removed.** The finalized list of removed measures is as follows:

Removed HOSPITAL Objectives / Measures	Removed EP Objectives / Measures
▪ Record Demographics ▪ Record Vital Signs ▪ Record Smoking Status ▪ Structured Lab Results ▪ Patient List ▪ Summary of Care – Measure 1 – Any Method – Measure 3 – Test ▪ eMAR ▪ Advanced Directives ▪ Electronic Notes ▪ Imaging Results ▪ Family Health History ▪ Structured Labs to Ambulatory Providers	▪ Record Demographics ▪ Record Vital Signs ▪ Record Smoking Status ▪ Clinical Summaries ▪ Structured Lab Results ▪ Patient List ▪ Patient Reminders ▪ Summary of Care – Measure 1 – Any Method – Measure 3 – Test ▪ Electronic Notes ▪ Imaging Results ▪ Family Health History

Of the original Stage 2 objectives and measures that CMS decided to retain in the "revised" version of Stage 2, **virtually all have the exact same scope and threshold that they always did**. There are a few important exceptions, though, where CMS lowered the scope or the threshold to make it easier for providers to meet the measure:

- In *2015* and *2016*, the second measure of the "Patient Electronic Access" objective only requires that "**at least 1 patient** discharged from the hospital or seen by the EP during the EHR reporting period views, downloads or transmits his or her health information to a third party." In *2017*, this requirement **increases to more than 5% of all unique patients**.
- In *2015*, the EP-only "Secure Messaging" measure **only requires a yes/no attestation** to the statement: "The capability for patients to send and receive a secure electronic message was enabled during the EHR reporting period." In *2016*, a secure message must be sent using CEHRT **to at least one patient seen by the EP** during the reporting period; in *2017*, that threshold will **increase to more than 5% of all unique patients** seen by the EP.
- To meet the revised Summary of Care measure in 2015-17, **providers will still have to *generate* the summary of care record using CEHRT, but will only**

have to *transmit* that summary of care record "electronically." The original version of this Stage 2 measure essentially required that the transmission occur via Direct. CMS does not list any specific transmission mechanisms that will (or will not) be allowed though, other than to say the exchange of the C-CDA "must comply with the privacy and security protocols for ePHI under HIPAA." Although the transmission options have been expanded, the threshold for the measure remains at 10%.

To better align meaningful use requirements in 2015-17 with the planned structure of Stage 3, **CMS also finalized its proposal to group all of the public health measures under a single objective beginning in 2015**. (It is worth noting that CMS scaled back the number of public health measures it *originally* proposed for 2015-17.) Under the Final Rule, **hospitals will now have to meet *3 of the 4* public health measures** to satisfy the public health objective starting in 2015, while **EPs will have to meet *2 of 3*.** As expected, the original Stage 2 requirement to achieve "ongoing submission" has been replaced with **"active engagement."** "Active engagement" is defined by CMS as the process of moving towards sending – or actually sending – production data to a public health agency or specialized registry.

The Final Rule also reiterates that **qualifying for an exclusion for a public health measure does <u>not</u> count towards meeting the number required to satisfy the public health objective** (unless no other measures are available to that provider). In other words, if an EP attests to an exclusion for the Immunization Registry Reporting measure, he or she would need to successfully attest (*or* qualify for an exclusion) for *both* of the other two public health measures (Syndromic Surveillance Reporting and Specialized Registry Reporting) in order to meet the requirements.

Attesting to "Revised" Stage 2 Objectives and Measures in 2015 & 2016

CMS will accept meaningful use attestations for the 2015 reporting period between *January 4, 2016* and *February 29, 2016*.

<u>All</u> hospitals and EPs – regardless of current Stage – will be required to attest to the "revised" version of Stage 2... **but there are a number of exclusions and alternate measures available for providers originally scheduled to be on Stage 1 in 2015.** For example, CMS will allow Stage 1 providers to use a lower threshold for certain Stage 2 measures in 2015. Additionally, there are exclusions available in 2015 for "revised" Stage 2 measures that do not have a Stage 1 equivalent. [See the chart on page 5 for details.]

It is important to note that all of the alternate measures – and virtually all of the alternate exclusions – for Stage 1 providers ***only* apply for the 2015 reporting period.** One important exception is an exclusion for the inpatient e-prescribing measure that will be available to Stage 1 and Stage 2 hospitals in 2015 and 2016.

"Revised" Stage 2 Objectives and Measures (for MU in 2015, 2016 & 2017)

[Note: Measures in red represent changes from original Stage 2 requirements.]

FINALIZED OBJECTIVES AND MEASURES FOR ALL HOSPITALS AND EPs IN 2015, 2016 & 2017		For Providers Scheduled to Be on Stage 1 ONLY	
Objective	**Measure(s)**	Alternate *Measure* Available?	Alternate *Exclusion* Available?
Protect PHI	1. Conduct or review **a security risk analysis**	--	--
CDS	2. Implement **5 clinical decision support rules**	**Yes** (for 2015 only)	--
	3. **Drug-drug and drug-allergy alerts** enabled	--	--
CPOE	1. **Medication orders** (more than 60%)	**Yes** (for 2015 only)	--
	2. **Lab orders** (more than 30%)	--	**Yes** (for 2015 and 2016)
	3. **Radiology orders** (more than 30%)	--	**Yes** (for 2015 and 2016)
e-Rx	EP measure: **Electronic prescribing** (more than 50% of prescriptions)	**Yes** (for 2015 only)	--
	Hospital measure: **Electronic prescribing** (more than 10% of discharge medications)	--	**Yes*** (for 2015 and 2016)
Health Information Exchange	**Create a summary of care document** using CEHRT and transmit summary of care document "electronically" (more than 10% of transitions of care; no specific transport standards required)	--	**Yes** (for 2015 only)
Patient-Specific Education	**Patient-specific education resources** identified by CEHRT are provided to patients (more than 10% of unique patients)	--	**Yes** (for 2015 only)
Med Rec	**Medication reconciliation** performed (more than 50% of transitions of care)	--	**Yes** (for 2015 only)
Patient Electronic Access (V/D/T)	1. **Online access to information** (more than 50% of unique patients)	--	--
	2. **View, Download, Transmit** (at least one patient views, downloads, or transmits his or her health information to a third party) *[Note: increases to 5% of unique patients in 2017]*	--	**Yes** (for 2015 only)

FINALIZED OBJECTIVES AND MEASURES FOR ALL HOSPITALS AND EPs IN 2015, 2016 & 2017		For Providers Scheduled to Be on Stage 1 ONLY	
Objective	**Measure(s)**	Alternate *Measure* Available?	Alternate *Exclusion* Available?
Secure Messaging [EP only]	EP measure: *For 2015:* During the EHR reporting period, the capability for patients to **send and receive a secure electronic message** with the provider was fully enabled *For 2016:* For **at least 1 patient** seen by the EP during the EHR reporting period, a secure message was sent *For 2017:* For **more than 5% of unique patients** seen by the EP during the EHR reporting period, a secure message was sent	--	**Yes** (for 2015 only)
Public Health	*EPs: **2 of 3 measures** must be successfully met* *Hospitals: **3 of 4 measures** must be successfully met* 1. **Immunization Registry Reporting** (active engagement with a public health agency) 2. **Syndromic Surveillance Reporting** (active engagement with a public health agency) 3. **Specialized Registry Reporting** (active engagement to submit data to a specialized registry)** 4. **Electronic Reportable Laboratory Result Reporting** (active engagement with a public health agency) *[Hospital only]*	--	**Yes** (for 2015 only) *In 2015, **Stage 1 EPs** will only need to meet **1 of 3** public health measures* *In 2015, **Stage 1 hospitals** will only need to meet **2 of 4** public health measures*

**Exclusion also applies to Stage 2 hospitals in 2015 and 2016.*

***Measure #3 may be counted more than once if more than one Specialized Registry is available.*

Clinical Quality Measure (CQM) Reporting in 2015 and 2016

CMS finalized its proposal to **maintain the existing requirements for reporting CQMs** in 2015 and 2016. Under the Final Rule, hospitals will still be required to report *16 CQMs covering at least 3 NQS domains*, and EPs will still be required to report *9 CQMs from at least 3 NQS domains*.

The only major change to the previously established CQM reporting requirements is **hospitals and EPs will be able to attest to a continuous 90-day reporting period for clinical quality measures in 2015** instead of a full year. (This change is due to the fact that the reporting period for meaningful use measures will also be 90 days in 2015.)

Final Stage 3 Objectives and Measures *(optional in 2017, required starting in 2018)*

The Final Rule also addresses the Stage 3 objectives and measures proposed by CMS back in March 2015. **The final Stage 3 requirements are fairly similar to what was originally proposed**, although CMS did back off on some (but certainly not *all*) of the more controversial thresholds and provisions.

The final version of Stage 3 includes **a total of 8 objectives for all hospitals and EPs, each of which has one or more associated measures**. Hospitals and EPs will be required to report on all of the measures associated with each objective. However, for 3 of the objectives, hospitals and EPs will only need to *actually meet the thresholds* for a subset of the associated measures. In other words, **providers can fail one of the measures for certain objectives but still successfully achieve meaningful use**.

Overall, many of the final Stage 3 requirements represent measures that have been carried over from Stage 1 or Stage 2, **only with a higher threshold or broader scope in Stage 3.** For example, the threshold for the "Patient Electronic Access" measure will increase from 50% in 2015 to *80%* in Stage 3, and it will include additional provisions related to APIs.

Stage 3 also includes **some entirely new measures that were not part of previous stages**. One of the more notable examples is a measure that will require "patient generated health data or data from a nonclinical setting" to be incorporated into certified EHR technology for more than 5% of unique patients.

A complete list of **the finalized objectives and measures for Stage 3** is as follows:

Final Stage 3 Objective	Final Stage 3 Measure(s)
Protect Patient Health Information	*The measure must be successfully met:* **Conduct or review a security risk analysis** including addressing the security (including encryption) of data created or maintained by CEHRT, implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.
Electronic Prescribing	*The measure must be successfully met:* ▪ EPs: More than **60% of all permissible prescriptions** written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. ▪ Hospitals: More than **25% of hospital discharge medication orders** for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.
Clinical Decision Support	*Both measures must be successfully met:* 1. **Implement 5 clinical decision support interventions related to 4 or more CQMs** at a relevant point in patient care for the entire EHR reporting period. Absent 4 CQMs related to an EP or eligible hospital's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. 2. The EP or eligible hospital **has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks** for the entire EHR reporting period.

Final Stage 3 Objective	Final Stage 3 Measure(s)
CPOE	*All 3 measures must be successfully met:* 1. More than **60% of medication orders** created by the EP or authorized providers of the eligible hospital's inpatient or emergency department during the EHR reporting period are recorded using CPOE. 2. More than **60% of laboratory orders** created by the EP or authorized providers of the eligible hospital's inpatient or emergency department during the EHR reporting period are recorded using CPOE. 3. More than **60% of diagnostic imaging orders** created by the EP or authorized providers of the eligible hospital's inpatient or emergency department during the EHR reporting period are recorded using CPOE.
Patient Electronic Access to Health Information	*Both measures must be successfully met:* 1. For **more than 80% of all unique patients** seen by the EP or discharged from the eligible hospital's inpatient or emergency department: – The patient (or the patient-authorized representative) is provided timely access* to view online, download, and transmit his or her health information; and – 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 CEHRT. 2. The EP or eligible hospital must use clinically relevant information from CEHRT to **identify patient-specific educational resources and provide electronic access to those materials to more than 35% of unique patients** seen by the EP or discharged from the eligible hospital's inpatient or emergency department during the EHR reporting period.
Coordination of Care through Patient Engagement	*Only **2 of 3 measures** must be successfully met (but all 3 must be attested to):* 1. During the EHR reporting period, **more than 10% of all unique patients** (or their authorized representatives) seen by the EP or discharged from the eligible hospital's inpatient or emergency department **actively engage with the electronic health record** made accessible by the provider and either: a. **View, download or transmit** to a third party their health information; or b. **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 CEHRT; or c. A combination of (a) and (b). *[Note: For providers attesting to Stage 3 in 2017, the threshold of the above measure will be 5% instead of 10%.]* 2. For more than **25% of all unique patients** seen by the EP or discharged from the eligible hospital's inpatient or emergency department during the EHR reporting period, **a secure message was sent** using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative. *[Note: For providers attesting to Stage 3 in 2017, the threshold of the above measure will be 5% instead of 25%.]* 3. **Patient generated health data or data from a nonclinical setting** is incorporated into the CEHRT for **more than 5% of all unique patients** seen by the EP or discharged from the eligible hospital's inpatient or emergency department during the EHR reporting period.

Final Stage 3 Objective	Final Stage 3 Measure(s)
Health Information Exchange	*Only **2 of 3 measures** must be successfully met (but all 3 must be attested to):* 1. For more than **50% of transitions of care and referrals**, the EP or eligible hospital that transitions or refers their patient to another setting of care or provider of care: (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record. 2. For more than **40% of transitions or referrals** received and patient encounters in which the provider has never before encountered the patient, the EP or eligible hospital incorporates into the patient's EHR an electronic summary of care document. 3. For more than **80% of transitions or referrals** received and patient encounters in which the provider has never before encountered the patient, the EP or eligible hospital performs a clinical information reconciliation. The provider **must implement clinical information reconciliation for the following 3 clinical information sets**: – *Medication.* Review of the patient's medication, including the name, dosage, frequency, and route of each medication. – *Medication allergy.* Review of the patient's known medication allergies. – *Current Problem list.* Review of the patient's current and active diagnoses.
Public Health and Clinical Data Registry Reporting	*EPs: Only **2 of 5 measures** must be successfully met:* *Hospitals: Only **4 of 6 measures** must be successfully met:* 1. **Immunization Registry Reporting:** The EP or eligible hospital 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 (IIS). 2. **Syndromic Surveillance Reporting:** The EP or eligible hospital is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting. 3. **Electronic Case Reporting:** The EP or eligible hospital is in active engagement with a public health agency to submit case reporting of reportable conditions. 4. **Public Health Registry Reporting:** The EP or eligible hospital is in active engagement with a public health agency to submit data to public health registries.** 5. **Clinical Data Registry Reporting:** The EP or eligible hospital is in active engagement to submit data to a clinical data registry.** 6. **Electronic Reportable Laboratory Result Reporting:** The eligible hospital is in active engagement with a public health agency to submit electronic reportable laboratory results. *[Hospital only]*

**Within 48 hours of its availability to the provider for an EP and 36 hours of its availability to the provider for an eligible hospital.*

***Measures #4 and #5 for Public Health Registry Reporting and Clinical Data Registry Reporting may be counted more than once if more than one Public Health Registry or Clinical Data Registry is available.*

Key Takeaways

- **In terms of the changes to meaningful use in 2015-17, CMS essentially finalized what it originally proposed.** Although relatively minor, the most notable differences between the *proposed* "2015-17 modification rule" and this Final Rule are:
  - A few additional exclusions are now available for certain providers in 2016 (most notably, an exclusion related to the inpatient e-prescribing measure, which will allow some hospitals to delay rollout of e-prescribing until 2017)
  - An *increase* in the scope and threshold of the patient engagement and secure messaging measures in 2017 to provide a more gradual transition to 2018 thresholds
  - A *decrease* in the number of public health measures from which hospitals and EPs can choose in 2015-17 under the "revised" version of Stage 2
- **Now that the changes to the original Stage 2 measures are finally official, attesting to meaningful use requirements should be easier in 2015 and 2016 (at least for most providers).** A number of original Stage 1 and Stage 2 measures are no longer required in 2015-17, and the thresholds and scope for some of the more challenging requirements have been modified to make them more attainable over the next 2-3 years.
- **In 2015-17, the public health reporting measures could very well pose *significant* problems for certain EPs (particularly specialists) though.** The immunization public health measure used to be part of the "core" set of measures. If an EP didn't administer immunizations, he or she would simply attest to an exclusion; that measure did not need to be "replaced" with a different one. Under the new format, there are 3 public health measures for EPs in 2015-17. If an EP does not administer immunizations, he or she will have to claim an exclusion – and by default will have to qualify for an exclusion or successfully attest to *both* of the other two public health measures.
- **The language is also still *extremely* vague around which transport mechanisms can be used to electronically transmit a summary of care record.** Originally, providers were essentially required to send the summary of care record via Direct. CMS changed the measure in the Final Rule though to state that the C-CDA generated by CEHRT must simply be transmitted "electronically." However, there is no explicit language specifying which types of electronic transmission will – or will not – meet this new, broader requirement. **Our initial interpretation is that sending the C-CDA via *secure email* would probably count in 2015-17, but that sending a fax would probably <u>not</u>.** The language in the Final Rule is so vague though that further guidance from CMS will likely be needed in order for most providers to feel comfortable with *any* option other than Direct.
- **Stage 3 requirements still look very challenging.** CMS appears to have backed off on some of the more aggressive requirements it originally proposed, but many of the final Stage 3 measures could still pose significant problems for many providers (especially the measures related to patient engagement and health information exchange). Further complicating matters is the fact that the **entirely new measures that have been finalized for Stage 3 are complete unknowns**. We won't really know just *how* difficult those new requirements will be until vendors try to get their products certified and providers start implementing new capabilities and redesigning workflows.

- **For a "Final" Rule, there is still a *significant* amount of uncertainty.** Although the Final Rule "officially" requires Stage 3 in 2018 (with an option to start in 2017), there is still a reasonable chance it will ultimately be delayed by Congress. We should have a better sense of how (and if) Congress will get involved in meaningful use over the next few months after the dust settles from the publication of the Final Rule. **One potential option for legislative action that bears watching is the 21st Century Cures bill** (which the Senate is expected to take up later this fall or winter), especially given the fact that the version passed by the House in July 2015 included a number of healthcare IT provisions.

About Impact Advisors

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