The following provides a brief summary of the Meaningful Use (MU) Stage 3 and 2015 Edition certification proposed rules. Comments on the rules are due on May 29, 2015.

**Overview**

- Stage 3 would be the last stage of MU.
- The Centers for Medicare & Medicaid Services (CMS) proposes to remove the 90-day reporting period for Medicare newly eligible professionals (EPs), requiring a full calendar year reporting period after 2015.
- Stage 3 requirements would be optional in 2017 and mandatory for all EPs in 2018, no matter when they started the MU program.
- The pass/fail approach would remain; however, the concept of core vs. menu measures would be removed.
- Stage 3 requirements would be divided into 8 objectives listed below (though each objective would have several measures):

<table>
<thead>
<tr>
<th>Program Goal/Objective</th>
<th>Delivery System Reform Goal Alignment</th>
</tr>
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<tbody>
<tr>
<td>Protect Patient Health Information</td>
<td>Foundational to Meaningful Use and Certified EHR Technology Recommended by HIT Policy Committee</td>
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<tr>
<td>Electronic Prescribing (eRx)</td>
<td>Foundational to Meaningful Use National Quality Strategy Alignment</td>
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<tr>
<td>Clinical Decision Support (CDS)</td>
<td>Foundational to Certified EHR Technology Recommended by HIT Policy Committee National Quality Strategy Alignment</td>
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<tr>
<td>Computerized Provider Order Entry (CPOE)</td>
<td>Foundational to Certified EHR Technology Recommended by HIT Policy Committee National Quality Strategy Alignment</td>
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<tr>
<td>Patient Electronic Access to Health Information</td>
<td>Recommended by HIT Policy Committee National Quality Strategy Alignment</td>
</tr>
<tr>
<td>Coordination of Care through Patient Engagement</td>
<td>Recommended by HIT Policy Committee National Quality Strategy Alignment</td>
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<tr>
<td>Health Information Exchange (HIE)</td>
<td>Foundational to Meaningful Use and Certified EHR Technology Recommended by HIT Policy Committee National Quality Strategy Alignment</td>
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<tr>
<td>Public Health and Clinical Data Registry Reporting</td>
<td>Recommended by HIT Policy Committee National Quality Strategy Alignment</td>
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A more detailed list of the objectives and associated measures are included in a separate chart.

- 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:
  - Coordination of Care through Patient Engagement;
  - Health Information Exchange; and
  - Public Health Reporting.
- CMS also proposes to remove redundant, duplicative, or “topped out” measures, or measures CMS feels are no longer useful in gauging performance (e.g., recording certain demographics).
- The Office of the National Coordinator (ONC) proposes that all physicians use EHR technology certified to the 2015 Edition for the 2018 reporting period.
• Measures in the Stage 1 and Stage 2 final rules that included paper-based workflows, chart abstraction, or other manual actions would be removed or transitioned to an electronic format utilizing EHR functionality for Stage 3.

• To better align quality reporting programs, CMS proposes to address clinical quality measure reporting requirements for 2017 and subsequent years in the Medicare Physician Fee Schedule.

• Given the multiple technological and clinical care standard changes associated with EHR technology, CMS states that they may need to consider other changes to the objectives and measures of MU and, if warranted, will address such needed changes in future rulemaking.

**Key provisions in detail**

**Reporting Period**

• Stage 3 would require a full calendar year reporting period; the 90-day reporting period for the first year of Medicare EPs would be removed.
  o There would be an exception for Medicaid EPs and eligible hospitals (EHs) demonstrating meaningful use for the first time—these entities would continue to use a 90-day reporting period.

• Physicians would have two months following the close of their full EHR reporting period to attest.

• 2017:
  o CMS proposes physicians may either repeat a year at their current stage or move up stage levels.
  o A physician may not move backward in their progression.
  o For example, a physician who participated in Stage 1 in 2016 would be able to attest to Stage 1 or they could move to Stage 2 or Stage 3 in 2017.
  o For example, a physician who participated in Stage 2 in 2016 could attest to the Stage 2 objectives and measures or move on to Stage 3 in 2017; however, the EP would not be permitted to return to Stage 1.

• 2018:
  o Physicians, regardless of their prior participation or the stage level chosen in 2017, would be required to attest to Stage 3 objectives and measures for 2018.

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<td>2018 and future years</td>
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*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.

**Payment Adjustments and Hardships**

CMS does not propose to change the MU penalties and maintains the previously designated four hardship categories:
- 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 due to a combination of clinical features limiting physician’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. This is for EPs only (not EHs).

**Quality**

- CMS proposed long-term vision is to have hospitals, clinicians, and other health care providers report through a single, aligned mechanism for multiple CMS programs.
- CMS has proposed EHRs be certified to more than the minimum number of clinical quality measures (CQM) 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.
- CMS expects to continue encouraging electronic submission of CQM data for all physicians where feasible in 2017. They propose to require the electronic submission of CQMs where feasible in 2018. Starting in 2018, attestation would no longer be accepted when electronic submission is possible.
- The reporting period will be a year starting in 2017 (with the exception of Medicaid).
- It is CMS’ intent to move to yearly quality measure updates and better align the MU quality measures with the Physician Quality Reporting System (PQRS). CQM requirements would be published as part of the annual Physician Fee Schedule rule moving forward.

<table>
<thead>
<tr>
<th>Proposed eCQM Reporting Timelines for Medicare &amp; Medicaid EHR Incentive Program</th>
<th>2017 only</th>
<th>2017 only</th>
<th>2018 and subsequent years</th>
<th>2018 and subsequent years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reporting Method Available</strong></td>
<td>Attestation</td>
<td>Electronic Reporting</td>
<td>Attestation</td>
<td>Electronic Reporting</td>
</tr>
<tr>
<td><strong>Provider Type who May Use Method</strong></td>
<td>All Medicare providers</td>
<td>All Medicare Providers</td>
<td>Medicare Providers with circumstances rendering them unable to eReport</td>
<td>All Medicare Providers</td>
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<td>Medicaid providers must refer to state requirements for reporting</td>
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<td><strong>(CQM electronic specifications update)</strong></td>
<td>2016 Annual Update</td>
<td>2016 Annual Update</td>
<td>2016 Annual Update or more recent version</td>
<td>2017 Annual Update</td>
</tr>
</tbody>
</table>
Registries

- CMS has proposed to create a stand-alone registry objective that includes multiple parts, but includes credit for specialty developed clinical data registries.

EPs Practicing in Multiple Practices/Locations

- To be a meaningful user, CMS would maintain its policy that an EP have 50 percent or more of his or her outpatient encounters during the EHR reporting period at a practice/location or practices/locations equipped with CEHRT.
  - An EP who does not conduct at least 50 percent of their patient encounters in any one practice/location would have to meet the 50 percent threshold through a combination of practices/locations equipped with CEHRT.

Denominators

- The denominators of the measures that reference "office visits" would be limited to only those patients whose records are maintained using CEHRT. An office visit would be defined as any billable visit that includes the following:
  - Concurrent care or transfer of care visits;
  - Consultant visits; or
  - Prolonged physician service without direct, face-to-face patient contact (for example, telehealth).
- As proposed, CMS would count in the denominator medication, laboratory, and diagnostic imaging orders created during the reporting period.
- Transitions of care and referrals would include at least:
  - When the EP is the recipient of the transition or referral, the first encounter with a new patient and encounters with existing patients where a summary of care record (of any type) is provided to the receiving EP; and
  - When the EP is the initiator of the transition or referral, transitions and referrals ordered by the EP.
- CMS would define transitions of care as the movement of a patient from one setting of care to another.
  - CMS proposes that for the purposes of distinguishing settings of care in determining the movement of a patient, that a transition or referral may take place when a patient is transitioned or referred between providers with different billing identities, such as a different National Provider Identifier (NPI) or hospital CMS Certification Number (CCN).
  - CMS also proposes that in the cases where a provider has a patient who seeks out and receives care from another provider without a prior referral, the first provider may include that transition as a referral if the patient subsequently identifies the other provider of care.

Telehealth

- CMS would consider a patient seen through telehealth as a patient "seen by the EP" to count for MU. Telehealth 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."
Patient-Authorized Representatives

- As part of the objectives concerning “Coordination of Care through Patient Engagement” and the “Patient Electronic Access,” CMS proposes the inclusion of patient-authorized representatives in the numerators and encourages providers to provide access to health information in accordance with all applicable laws.

Audit Logs

- The Stage 3 rule notes that audit logs can be a valuable resource in ensuring the protection of electronic health information. While CMS recognizes legitimate instances where the function must be disabled for a short time, they strongly recommend physicians ensure this function is enabled at all times when the CEHRT is in use.

Medicaid

- Medicaid physicians demonstrating MU for the first time in 2017 would still use a 90-day reporting period.
- CMS proposes to continue to allow states to set up a CQM submission process that physicians may use to report on CQMs for 2017 and subsequent years.
- The rule also proposes amendments to state reporting on Medicaid EPs as well as implementation and oversight activities.

Certification

- CMS has proposed that all physicians would be required to use EHR technology certified to the 2015 Edition for the EHR reporting period in 2018.
- ONC also proposes more focus on improving how data is exchanged, including provider directories, patient matching, and the application programming interface (API) concept, which is expected to improve interoperability as well as access to data in an actionable format.
- The certification rule also proposes vendor product post-market surveillance, public disclosures for product costs, such as implementation and use, and an improvement in the Certified Health IT Product List (CHPL).