Title:
Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 through 2017

Final rules with comment period

Effective Date:
[TBD 60 days after Federal Register Publication]

Key Themes:
Background
This final rule with comment period is a consolidation of two previously-issued NPRMs: Medicare and Medicaid Programs; Electronic Health Record Incentive Program Stage 3 (80 FR 16731 through 16804), known as the “Stage 3 Proposed Rule” and Medicare and Medicaid programs; Electronic Health Record Incentive Program – Modifications to Meaningful Use in 2015 through 2017, known as “EHR Incentive Programs in 2015 through 2017 Proposed Rule.”

However, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed shortly after these two NPRMs were published; it specifies that the Meaningful Use program will become part of the Merit-Based Incentive Payment System (MIPS), which will be established as part of that legislation. A 60-day comment period has been added to this final rule to address provisions related to the creation of and transition of MU into MIPS.
Timelines
Eligible Professional Medicare payment adjustments under the current program become part of MIPS in CY2019. In preparation for that transition, CMS plans to issue a MIPS NPRM by mid-2016. Meanwhile, this Final Rule aligns reporting and intends to further prepare EPs for that transition by eliminating separate MU stages by 2018. Stage 3 will be optional for providers in 2017 and mandatory for all participants in 2018. Objectives and measures for all providers, regardless of prior participation, are finalized for the 2018 reporting period with this rule.

Simplification and alignment
With this rule, CMS has reduced the number of measures as part of moving all participants in both the Medicare and Medicaid incentive programs to uniform requirements for 2018. In finalizing rules while leaving opportunity for comment, it seeks to create regulatory consistency through 2017 while soliciting feedback that will help support MIPS development and ensure a smooth transition to the new program.

MU Modifications 2015-2017
CMS adopted the proposed reporting period changes for both programs in 2015, 2016 and 2017, aligning with the calendar year. All providers in 2015, and all new participants in 2016 or 2017 will have a 90-day reporting period. Some objectives and measures that were deemed redundant or topped-out have been eliminated. CMS will continue to employ its methodology to determine which objectives and measures fall into this category through 2017. Additionally, the menu and core objectives concept has been eliminated, with CMS opting as proposed, for a streamlined objective set for all.

For Stage 2:
- Thresholds have been changed for the Patient Electronic Access and Secure Electronic Messaging measures.
- Public health objectives have been consolidated into a single objective
- For eligible hospitals, the electronic prescribing objective is now required (exclusions apply)
- Numerator and denominator calculations remain the same, as do existing objective and measure definitions
Stage 3 in 2017 and Beyond
For providers opting to demonstrate Stage 3 requirements in 2017, CMS finalized an optional 90-day reporting period. By 2018 however, reporting will be for a full year unless the provider is a first-year Medicaid incentive program participant.

CMS finalized its proposed set of 8 objectives and measures to align with other quality improvement programs, promote interoperability and focus on the triple aim components of cost, access and quality. They are:

- Protect Patient Health Information
- Electronic Prescribing
- Clinical Decision Support
- Computerized Provider Order Entry
- Patient Electronic Access to Health Information
- Coordination of Care through Patient Engagement*
- Health Information Exchange*
- Public Health and Clinical Data Registry Reporting*

Providers must attest to the objectives and measures (unless an exclusion applies) to meet requirements for Stage 3. *There are flexible options within three of these eight objectives:

- **Coordination of Care through Patient Engagement** requires attestation to all three measures but are only required to meet thresholds for two
- **Health Information Exchange** also requires all three measures, but providers are only required to meet thresholds for two
- For the **Public Health Reporting** objective, eligible professionals are required to report on three measures, while hospitals and CAHs must report four

As noted in the proposed rule, *Stage 3 will also be the final MU stage*. Additionally, any Stage 1 or 2 measures dependent on paper-based workflows or abstractions are being eliminated in favor of electronic formats.
Standards and Technology
In 2015 through 2017, providers may still use 2014 Edition CEHRT until 2018 when the 2015 Edition CEHRT is required. Specifically, in 2015, the 2014 Edition may be used; in 2016 and 2017, providers may use either 2014 or 2015 Edition, or a combination; by 2018, the 2015 Edition must be used.

Clinical Quality Measurement
CMS restated its goal of a single quality reporting mechanism for multiple programs. In 2015 and 2016, providers may either:
- Attest to any 90-day continuous period through the registration and attestation site or
- Electronically report through established methods
In 2017, a provider beyond the first year of MU may attest to the full calendar year or electronically report.
In 2018, reports must be filed electronically

Other
Proposals to continue attestation across Medicare and Medicaid, move hospitals and CAHs to calendar year reporting, and a 90-day EHR reporting period starting in 2015 were finalized.

The proposal to change attestation deadlines for new participants in 2015 and 2016, which was designed to help avoid payment adjustments, was finalized.

The alternate attestation method for Medicaid providers facing possible adjustments through Medicare in 2015 through 2017 was also finalized.

Standing payment adjustment policies for EPs, EHs, and CAHs remain as finalized in Stage 2 final rule.

CMS did not finalize changes to the definition of hospital-based eligible professional, and will address that as it builds out requirements for MIPS.

The definitions for reporting periods for a payment adjustment year have been modified for EPs through 2017, eligible hospitals through 2018, and for CAHs through 2018.
**Analysis**

CMS has seized an opportunity to streamline the meaningful use attestation and reporting process. These changes are timely in that they allow providers and states up to 27 months to prepare for Stage 3 if they choose to. The option to proceed with Stage 3 in 2017 provides additional flexibility for organizations ready to do so. An included comment period offers an opportunity for CMS and providers to supply valuable feedback for the creation of and full transition to MIPS.

Contact **Rod Piechowski**, Senior Director, HIS, at rpiechowski@himss.org

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