Meaningful Use (MU) Stage 3 and 2015 certification rules

Highlights

- The Stage 3 rule provides a 60-day public comment period to continue to consider program changes and align requirements with the Medicare Access and CHIP Reauthorization Act (MACRA).
- Stage 3 is the last stage of MU.
- Stage 3 requirements are optional in 2017 and mandatory for all participants 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 Program Structure

- All Stage 3 MU participants (both physicians and hospitals) must meet 8 objectives listed below. Each objective, however, may include multiple measures. A more detailed list of the objectives and associated measures are included in a separate chart.

Stage 3 Program Objectives
Protect Electronic Health Information
Electronic Prescribing (eRx)
Clinical Decision Support (CDS)
Computerized Provider Order Entry (CPOE)
Patient Electronic Access
Coordination of Care through Patient Engagement
Health Information Exchange (HIE)
Public Health and Clinical Data Registry Reporting

- Participants would be required to *attest* to the numerators and denominators of *all* measures associated with an objective. However, to allow for some flexibility, participants would only need to meet the *thresholds* for a subset of the measures within an objective as outlined below:
    - Coordination of Care through Patient Engagement – providers must meet the thresholds for two out of the three measures;
    - Health Information Exchange – providers must meet the thresholds for two out of the three measures; and
    - Public Health and Clinical Data Registry Reporting – eligible professionals (EPs) must report on three measures and hospitals must report on four measures.
- The Centers for Medicare & Medicaid Services (CMS) will remove redundant, duplicative, or ''topped out" measures, or measures CMS feels are no longer useful in gauging performance (e.g., recording certain demographics).
- Paper-based workflows, chart abstraction, or other manual actions will not be allowed for the objectives and measures for Stage 3.

Medicaid

- States would still be allowed to change the public health and clinical data registry reporting objective as long as they do not require functionality greater than what is required in Stage 3.
- All other Stage 3 objectives would be the same for Medicaid participants.

Reporting Period

- Stage 3 generally requires a full calendar year reporting period
    - There is an optional 90-day reporting period for providers electing to demonstrate Stage 3 early in 2017
    - Beginning in 2018, the EHR reporting period is a full calendar year with an exception for new Medicaid participants.
- Physicians would have two months following the close of their full EHR reporting period to attest.
- For 2017, physicians may either repeat a year in Modified Stage 2 or move up to Stage 3.
- For 2018, physicians, regardless of their prior participation or the stage level chosen in 2017, would be required to attest to Stage 3 objectives and measures.

First Year Demonstrating Meaningful Use	Stage of Meaningful Use		
	2017	2018	2019 and future years
2011	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2012	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2013	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2014	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2015	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2016	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2017	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2018	- NA -	Stage 3	Stage 3
2019 and future years	- NA -	- NA -	Stage 3

Payment Adjustments and Hardships

The same MU penalties previously designated and hardship categories are retained in Stage 3. These hardships categories are:
- 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 and technological problems;
- Lack of face-to-face or telemedicine interaction with patient or lack of follow-up need with patients; and
- 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).

In 2019, physicians not participating in qualifying alternative payment models will move into the Merit-Based Incentive Payment System (MIPS) which replaces/consolidates the MU program penalties with other quality reporting programs.

Quality

- CMS' long-term vision is to have hospitals, clinicians, and other health care providers report through a single, aligned mechanism for multiple CMS programs.
- EHRs will 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; 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.
- For 2017, CMS expects to continue encouraging electronic submission of CQM data for all physicians where feasible and in 2018 *require* the electronic submission of CQMs.
- The reporting period for CQMs 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.
- CMS is continuing its policy where the only measures that may be reported through a Qualified Clinical Data Registry (QCDR) that count towards satisfying MU quality requirements are those finalized in the Stage 2 final rule, which does not include the non-Physician Quality Reporting System (PQRS) measures submitted via QCDR.

Registries

- Stage 3 includes a stand-alone public health and clinical registry objective that includes multiple parts, but includes credit for specialty developed clinical data registries. To satisfy the objective, an EP must report on two out of five measures, which include: immunization registry reporting; syndromic surveillance reporting; case reporting; public health registry reporting and/or clinical data registry reporting.
- To assist with satisfying the objective and provide support, CMS plans to create a centralized repository by the start of CY 2017, where a public health agency could post readiness updates regarding their ability to accept electronic data using specifications prescribed by ONC for the public health objective
- To satisfy the registry measures, CMS proposed that an EP must be in "active engagement" with the registry—defined as an EP is in the process of moving towards sending "production data" with a registry and provided several options for satisfying active engagement.
- CMS includes several exclusions for this objective, including: (1) does not diagnose or directly treat any disease or condition associated with a registry in their jurisdiction during the EHR reporting period; (2) operates in a jurisdiction for which no registry is capable of accepting electronic registry transitions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) operates in a jurisdiction where no registry for which the EP is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the EHR reporting period.

Telehealth

- CMS will consider a patient seen through telehealth or remote communication to count in the numerator for certain Stage 3 measures.
- Telehealth may include commonly known telemedicine as well as telepsychiatry, telenursing, and other diverse forms of technology-assisted health care.

Patient-Authorized Representatives

- For the objectives on "Coordination of Care through Patient Engagement" and the "Patient Electronic Access," CMS will include not only patients but patient-authorized representatives in the numerators.

Certification

- For those moving to Stage 3 early in 2017, physicians are required to use EHR technology certified to the 2015 Edition.
- All physicians are required to use EHR technology certified to the 2015 Edition for Stage 3 beginning in 2018.
- ONC has increased the focus of EHR certification on improving how data is exchanged, including patient matching, testing conformance to health information technology standards, and an *application programming interface (*API) concept, which is expected to improve interoperability as well as access to data in an actionable format.
- ONC has expanded the requirements EHR vendors must follow to improve the safety and usability of their products, including post-market surveillance, public disclosures for product costs, and an improvement in the Certified Health IT Product List (CHPL).
- ONC has also increased the transparency requirements vendors must follow regarding the functionalities and design limitations of their products.