CIO Cheat Sheet

Overview of Meaningful Use Changes in the OPPS Proposed Rule

Listening to repeated cries from hospitals and CIOs, the Centers for Medicare and Medicaid Services (CMS) has proposed sweeping changes to the Meaningful Use program for both 2016, 2017 and 2018. CHIME has advocated tirelessly for changes calling on CMS and Congress to make the program more flexible. Below is a recap of the changes CMS has proposed. CHIME recently spear-headed a letter signed by 30 plus organizations requesting CMS shorten the reporting period in 2016 to 90 days. We are grateful CMS listened to providers and proposed this change.

Highlights include:

- **90-day reporting period for 2016**
- **Reduction of numerous thresholds in Stage 3 to Modified Stage 2 levels for 2017 and 2018**
- **CDS and CPOE removed for Modified Stage 2 and Stage 3**
- **VDT measure threshold reduction for Modified Stage 2 and Stage 3 to one patient**

1. Shorter Reporting Period:

CMS has proposed any continuous 90-day reporting period for those returning to the program for the 2016 reporting year.

2. More Flexibility under Modified Stage 2 and Stage 3:

CMS has proposed several changes to the Meaningful Use objectives and measures for both Modified Stage 2 and Stage 3 for the 2017 and 2018 reporting periods.

A. **CDS and CPOE Removed:** Under both Modified Stage 2 in 2017 and Modified Stage 2 and Stage 3 in 2017 and 2018, CMS has proposed for eligible hospitals (EHs) and Critical Access Hospitals (CAHs) attesting under the Medicare EHR Incentive Program, to eliminate the Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE) objectives and measures. CMS is removing these measures because they have determined they are "topped out." The proposed changes would not apply to EHs and CAHs that attest to Meaningful Use under their State's Medicaid EHR Incentive Program. However, CMS has proposed that the certified electronic health record technology (CEHRT) capabilities a hospital has still must include CDS and CPOE.

B. **Lowered Thresholds:** They have also called for lowering the reporting thresholds for a subset of the remaining objectives and measures, generally to the Modified Stage 2 thresholds. This proposal would not apply to EHs and CAHs attesting under a State's Medicaid EHR Incentive Program. CMS does note they plan on increasing thresholds in the future years of the program.

What it means for EPs vs EHs/CAHs: CMS has proposed that the current Modified Stage 2 Meaningful Use objectives and measures apply for EPs for 2015 through 2017, for EHs / CAHs attesting under a State's Medicaid

EHR Incentive Program for 2015 through 2017, and for EHs and CAHs attesting under the Medicare EHR Incentive Program for 2015 and 2016.

3. Details on Reduced Measures / Objectives:

Modified Stage 2 – 2017 (EHs / CAHs)

A. VDT Measure: CMS has proposed reducing the threshold from 5% to one patient.

B. ePrescribing: CMS has proposed reducing the threshold from 50% to 10%

Stage 3 – 2017 and 2018 (EHs / CAHs) (NOTE – only those objectives with measures where CMS proposed changes are discussed below).

A. **Patient Electronic Access to Health Information Objective:** The EH or CAH provides patients (or their representative) with timely electronic access to their health information and patient specific education.
   a. **Patient Education Measure:** CMS has proposed reducing the threshold from 35% to more than 10% for 2018 for EHs and CAHs which aligns with Modified Stage 2. EHs / CAHs would need to provide electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the EHR reporting period. Broadband exclusion applies.
   b. **Patient Electronic Access to Health Information Measure:** CMS has proposed reducing the threshold from 80% to more than 50% of unique patients who are discharged are: 1) given timely access to view, download or transmit (VDT) their info; and 2) the provider ensures patient's information is available for access using any application of their choice that is configured to meet the technical specifications of the application programming interfaces (APIs) in the provider's CEHRT. Broadband exclusion applies.

B. **ePrescribing Objective:** CMS has proposed reducing the threshold from 60% to 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. Exclusion for local pharmacies accepting electronic scripts applies.

C. **Coordination of Care Through Patient Engagement Objective**: Under the Stage 3 rules that were finalized CMS called for providers to attest to three numerators / denominators for three measures but only had to meet thresholds for two measures. This requirement remains intact.
   a. **VDT Measure**: CMS has proposed reducing the threshold from 5% to at least one patient who is discharged actively engages with CEHRT via: 1) VDT their information thru a third party; 2) access info using an API of patient's choice; or 3) combo of 1 and 2. Broadband exclusion applies.
   b. **Secure Messaging:** CMS is proposing reducing the threshold from 25% to more than 5% of all unique patients discharged a secure message was sent using CEHRT to the patient (or their representative) or in response to a message sent by the patient (or their representative). Broadband exclusion applies.
   c. **Patient-Generated Data:** Patient-generated health data or data from a non-clinical setting is incorporated into the CEHRT for more than 5% of unique patients discharged from an EH / CAH. (No change)

D. **Health Information Exchange Objective:** EH/CAH provides a summary of care (SoC) when transitioning or referring a patient to another care setting, receives or retrieves a SoC upon receipt of the transition or referral or first encounter with the patient, and incorporates the SoC into their CEHRT. Providers must attest to the numerators/denominators for all three measures but only have to meet the thresholds for two. This requirement remains intact.
   a. **Patient Care Record Exchange Measure:** CMS has proposed reducing the threshold from 50% to more than 10% of transitions / referrals of patients to another care setting the EH/CAH: 1) creates

a SoC using CEHRT; and 2) electronically exchanges the summary of care record. Broadband exclusion applies.

b. **Request/Accept Patient Care Record Measure:** CMS has proposed reducing the threshold from 40% to more than 10% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the eligible hospital or CAH incorporates into the patient's EHR an electronic summary of care document. Patient transfer / referral volume and broadband exclusions apply.

c. **Clinical Information Reconciliation Measure:** CMS has proposed reducing the threshold from 80% to more than 50% transitions / referrals received and patient encounters in which the provider has never before encountered the patient, the EH / CAH performs a clinical information reconciliation. The provider must implement clinical information reconciliation for three clinical information sets: 1) Medication; 2) Medication allergy; and 3) Current Problem list. Patient transfer / referral volume exclusion applies.

4. **Public Health and Clinical Data Registry Reporting Objective:** The EH / CAH is actively engaged with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using CEHRT. CMS has proposed reducing the reporting requirements to what was finalized in the Modified Stage 2 rule. Thus, a EH / CAH could select any combination of three measures from any combination of measures finalized for Modified Stage 2. Exclusions apply.
    - Immunization Registry Reporting Measure
    - Syndromic Surveillance Reporting Measure
    - Electronic Case Reporting Measure
    - Public Health Registry Reporting Measure
    - Clinical Data Registry Reporting Measure
    - Electronic Reportable Laboratory Result Reporting Measure
5. **Clinical Quality Measurement:** CMS has proposed any continuous 90 days for any provider who reports via attestation for 2016. Does not need to be the same 90 days as the EHR reporting for measure and objectives.
6. **Participants new to MU in 2017:** CMS proposes these providers would have to meet Modified Stage 2 measures and objectives in 2017 to avoid a penalty in 2018 and that these providers would need to attest by October 1, 2017 to avoid the 2018 penalty
7. **Hardship for EPs:** CMS is proposing a one-time significant hardship exception for EPs who are new to the MU program and transitioning to the Merit-Based Incentive Payment System (MIPS) in 2017. There is an application process EPs would need to follow. This is intended to help them avoid a penalty in 2018.
8. **Measure calculations outside of Reporting Period:** For all MU measures, unless specifically noted, CMS is proposing that actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs. For example, if the EHR reporting period is any continuous 90-day period within CY 2017, the action must occur between January 1 and December 31, 2017, but does not have to occur within the 90-day EHR reporting period timeframe.
9. **Those new to MU in 2017:** CMS has determined that is not technically feasible for a new MU participant to meet MU to attest to Stage 3 in the attestation system. They must meet Modified Stage 2 instead.