Special Meaningful Use Report / July 2016:

CMS' Proposed Meaningful Use Changes Would Substantially Reduce Stage 2 and 3 Burdens on Providers

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Early in July, CMS released a new set of proposed rules to modify Meaningful Use. If all goes well through the comment period and final updates, by fall we will see many Meaningful Use Stage 2 and 3 changes that will significantly reduce the burden on providers struggling to meet MU requirements. Assuming most of you would not relish burning midnight oil to review this 764-page MU modifications document, following is our contribution to the cause: a hopefully readable and worthwhile summary.

Meaningful Use Stage 2

Proposed Changes for Meaningful Use Stage 2

CMS' new proposed rule makes changes to requirements for Meaningful Use Stage 2, which impacts hospitals in 2016 and 2017, and which are the subject of this article. In addition, there are changes proposed for the Meaningful Use Stage 3 goals, which we will cover in a separate post next week. For returning hospital participants in the Medicare incentive program, four substantial changes have been proposed for Stage 2. The proposed rules will:

- For 2016 only, establish a 90-day measurement period.
- For 2017 only, reduce the threshold of the View, Download, and Transmit (VDT) objective to require "at least 1 patient." This is already the established requirement for 2016.
- For 2017 and beyond, eliminate the Clinical Decision Support (CDS) goals. These requirements called for demonstrating 5 ways clinical decision support was used, and required drug-drug interaction and drug-allergy checking.
- For 2017 and beyond, eliminate the Computerized Provider Order Entry (CPOE) requirements, which called for CPOE of lab, radiology, and medication orders.

The Impact of Proposed Changes to Stage 2

A focused set of hospitals will see significant benefits from the proposed changes, but most hospital participants will experience little impact:

- The impact of the 90-day measurement period will be greatest on the small subset of hospitals changing EHRs during 2016. These hospitals will now have the opportunity to use a 90-day period on either side of their transition date for meaningful use purposes instead of having to combine data from the pre- and post-transition systems into one attestation.
- The reduction of the VDT measure to require only a single patient could be substantial for a significant subset of hospitals struggling to meet that goal, and essentially provides another year for these hospitals to reshape their patient portal program.
- The elimination of the CDS and CPOE goals should have minimal impact, as these are being eliminated because they already have widespread acceptance. CMS refers to this condition as "topped-out."

Hospitals should also be aware that the 90-day reporting period change will not allow them to receive their 2016 Medicare incentive program money more quickly. We must wait while the proposed rules remain open for comment for 60 days, and then for the 60 to 90 days CMS will need to process the comments and prepare a final rule for publication. At that point, CMS will generate a task order to modify its portal to accept attestations under the new guidelines — an effort likely to take another 60 to 90 days. Ultimately the rule-making process will push the ability to attest to Meaningful Use well into the first quarter of 2017.

A Major Question Remains

CMS indicates that the proposals to eliminate the CDS and CPOE objectives and reduce the VDT thresholds apply to hospitals participating in the Medicare program, but do not impact the Medicaid program. In many cases, hospitals are still actively participating in both programs. It remains unclear how this disparity of measures would work, particularly in states that rely primarily on federally collected data for their attestations.

Meaningful Use Stage 3

CMS also has proposed significant changes stage 3 requirements for 2017-2018, several of which reduce participation thresholds that have been widely controversial. Many providers are likely to welcome these proposed modifications, which we have summarized as follows:

Patient Access Measure

This measure requires hospitals to provide patients' electronic access to clinically relevant information about their care in a timely fashion. As originally proposed in stage 3, this would require hospitals to make information available for view, download, and transmit, and also to provide access via application programming interface (API). In the proposed rule, CMS would lower the threshold from 80 percent of patients to 50 percent.

Inadequate API technology was cited as a reason that this measure may be difficult for hospitals to meet. This logic doesn't entirely make sense, because the primary barrier to meeting the API measure will be the development of the technology by certified electronic health record technology (CEHRT) vendors. Once the technology is available, hospitals should be able to make the API interface fully available to 50% or 80% of patients with nearly the same effort.

Patient Education Measure

This measure, which requires hospitals to use their CEHRT to identify and provide electronic, patient-specific educational material, is also significantly reduced from 35% to 10%. CMS expressed concern that not all patient users are sufficiently computer savvy to download electronic instructions, rendering them essentially unable to access their instructions.

View, Download, and Transmit (VDT) Measure

CMS has again proposed reducing the measure to only require one unique patient to view, download, or transmit his or her data during the reporting period. CMS has expressed a concern that many healthcare providers have already noted: patient participation is the limiting factor in attaining this goal. The expectation now is that as the technology matures, and hospitals find new ways to engage patients with their patient portals, patient participation will naturally increase.

Secure Messaging Measure

The requirement of providers to use secure messaging to communicate with patients, a new requirement for stage 3, is substantially reduced from 25 % to 5%. Again, CMS cited uncertainties in patient participation and not-fully mature technology as primary reasons.

Transition of Care Measure

This measure's threshold, which was slated to increase substantially to require 50% of patient transitions from one care provider to another to include the exchange of information in stage 3, will remain at 10%. CMS cited hospitals' concerns that there are insufficient receiving providers available to meet the higher numbers.

Request/Accept Patient Care Record Measure

This measure balances the previous measure, by reducing the threshold from 40% to 10% of patients for which hospitals must receive and incorporate an electronic summary of care document accepting them as new patients via transition of care. The threshold originally established at 40% would be substantially reduced to 10%. Ironically, with CMS' reduction of the threshold of sent documents to 10%, meeting this requirement may now become even more difficult than before.

Clinical Information Reconciliation Measure

CMS proposes to reduce the number of patient transitions where a reconciliation of clinical information is performed from more than 80% to 50%, citing interoperability concerns that would impair the easy incorporation of external data into the EHR.

Public Health and Clinical Data Registry Reporting Measure

CMS proposes to reduce the number of required reporting partners from four to three, citing the challenges hospitals have in many states with the lack of availability of qualified registries.

What to Do About Meaningful Use Stage 2 and/or Stage 3 Today

Remember that this discussion is about a *proposed* rule. It doesn't have the force of law until it's been finalized. While it's true that CMS rarely backtracks on proposed changes to make them more difficult, we recommend staying the course until the rule is finalized in the fall. Hospital Meaningful Use teams should, however, review the proposed rule to see how it impacts their attestation efforts and consider submitting comments to CMS, using the procedure outlined in the proposed rule.

If you are in a specific situation that might be impacted by the changed rule, such as implementing a new EHR, by all means devote some time considering how the changes may affect your plans for 2016 — and perhaps positively. For example, we are working with three hospitals that are currently replacing EHRs, for whom a change to an October 2 start date for a 90-day measurement period will make collecting 2016 Meaningful use dollars a possibility.

Another note of caution: while CMS' apparent direction is to lower the bar for meeting Meaningful Use stage 3 in 2017 and 2018, no commitment has been made to continue reductions into 2019 and beyond. Recognize that the proposed lowered thresholds for meeting Meaningful Use has in no way affected the true goal of the program – making us all meaningful users of our EHR technology.

If you'd like to comment on the proposed rules, you may submit electronic comments on this regulation at http://www.regulations.gov**.**

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