Overview of the Meaningful Use Stage 3 Proposed Rules

On March 20, 2015, the Department of Health and Human Services’ (HHS) Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for Stage 3 of the Medicare and Medicaid EHR Incentive (meaningful use) Programs. Separately, the Office of the National Coordinator for Health Information Technology (ONC) issued an additional proposed rule seeking to improve the way electronic health information is shared and ultimately improve the care delivery experience. According to HHS, these proposed rules focus on making meaningful use “more flexible, simplifying and reducing burden of providers participating in the program, driving the interoperability of health IT across systems and between providers, and improving patient outcomes.”

Please note: This analysis is based on the contents of the CMS and ONC proposed rules and are subject to change once they are released in their final regulatory language.

Key Provisions

The CMS Stage 3 meaningful use proposed rule includes the following provisions:

- Establishes a single reporting period for all providers based on the calendar year;
- Allows eligible professionals (EPs) the option to start Stage 3 of meaningful use in either 2017 or 2018;
- Requires all EPs (with a limited exception under the Medicaid EHR Incentive Program for providers demonstrating meaningful use for the first time) to be on Stage 3 in 2018, regardless of which stage they were at previously;
- Eliminates a number of duplicative, redundant or “topped out” Stage 2 measures;
- Adds application-program interfaces (APIs) as an additional functionality through which EPs may engage with patients. According to the NPRM “if the provider elects to implement an API, the provider would only need to fully enable the API functionality, provide patients with detailed instructions on how to authenticate, and provide supplemental information on available applications which leverage the API.”
- Establishes API criteria that would “allow patients, through a third-party application, to pull certain components of their unique health data directly from the provider’s CEHRT, and potentially could—on demand—pull such information from multiple providers caring for a patient.”
- Continues to encourage electronic submission of clinical quality measure (CQM) data for all providers where feasible in 2017;
- Proposes to require the electronic submission of CQMs where feasible in 2018;
- Attempts to better align CQM reporting with other CMS programs; and
- Reduces the overall number of objectives to eight (incorporating 21 measures).
Stage 3 EP meaningful use objectives and measures

(1) Protect patient health information

- **Objective.** Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical, administrative and physical safeguards.

- **Measure.** Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) that includes:
  
  1. Addressing the security (including encryption) of data stored in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3);
  2. Implementing security updates as necessary; and
  3. Correcting identified security deficiencies as part of the EP’s risk management process.

(2) Electronic prescribing

- **Objective.** Generate and transmit permissible prescriptions electronically (eRx).

- **Measure.** Subject to paragraph (c) of this section, more than 80% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

(3) Clinical decision support

- **Objective.** Implement clinical decision support interventions focused on improving performance on high-priority health conditions.

- **Measures.** (1) Implement five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions; and
  
  2. Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

(4) Computerized provider order entry (CPOE)

- **Objective.** Use computerized provider order entry (CPOE) for medication, laboratory and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant or medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant who can enter orders into the medical record per state, local and professional guidelines.

- **Measures.** (1) More than 80% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry;
(2) More than 60% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry; and

(3) More than 60% of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

(5) Patient electronic access to health information

- **Objective.** The EP provides access for patients to view online, download and transmit their health information, or retrieve their health information through an application-program interface (API) within 24 hours of its availability.

- **Measures.** EPs must meet the following two measures:

  1. For more than 80% of all unique patients seen by the EP---(i) The patient (or patient authorized representatives) is provided access to view online, download and transmit their health information within 24 hours of its availability to the provider; or (ii) The patient (or patient authorized representatives) is provided access to an ONC-certified API that can be used by third-party applications or devices to provide patients (or patient authorized representatives) access to their health information within 24 hours of its availability to the provider.

  2. The EP must use clinically relevant information from CEHRT to identify patient specific educational resources and provide electronic access to those materials to more than 35% of unique patients seen by the EP during the EHR reporting period.

(6) Coordination of care through patient engagement

- **Objective.** Use communications functions of CEHRT to engage with patients or their authorized representatives about the patient's care.

- **Measures.** EPs must satisfy two out of the three following measures, excepting those measures for which an EP qualifies for an exclusion under paragraph (a)(3) of this section.

  1. During the EHR reporting period, more than 25% of all unique patients seen by the EP actively engage with the EHR made accessible by the provider. An EP meets the measure specified in paragraph (d)(5)(i)(B)(1) of this paragraph if either (i) More than 25% of all unique patients (or patient-authorized representatives) seen by the EP during the EHR reporting period view, download or transmit to a third party their health information; or (ii) More than 25% of all unique patients (or patient-authorized representatives) seen by the EP during the EHR reporting period access their health information through the use of an ONC-certified API that can be used by third-party applications or devices.

  2. For more than 35% of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or their authorized representatives), or in response to a secure message sent by the patient.

  3. Patient-generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 15% of all unique patients seen by the EP during the reporting period.
(7) Health information exchange

- **Objective.** The EP provides a summary of care record when transitioning or referring their patient to another setting of care, retrieves a summary of care record upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

- **Measures.** An EP must attest to all three of the following measures and meet the threshold for two of the three measures.

  1. For more than 50% of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care (i) Creates a summary of care record using CEHRT and (ii) Electronically exchanges the summary of care record.

  2. For more than 40% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document from a source other than the provider's own EHR system.

  3. For more than 80% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets:

     (i) **Medication:** Review patient medications including the name, dosage, frequency and route.

     (ii) **Medication allergy:** Review the patient's known allergic medications.

     (iii) **Current problem list:** Review the patient's current and active diagnoses.

(8) Public Health and Clinical Data Registry Reporting

- **Objective.** The EP is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.

- **Measures.** In order to meet the preceding objective, an EP must successfully attest to any combination of three measures from the following list (which can include meeting measures four or five multiple times) in accordance with applicable law and practice.

  1. **Immunization registry reporting:** The EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

  2. **Syndromic surveillance reporting:** The EP is in active engagement with a PHA to submit syndromic surveillance data from a non-urgent care ambulatory setting.

  3. **Case reporting:** The EP is in active engagement with a PHA to submit case reporting of reportable conditions.

  4. **Public health registry reporting:** The EP is in active engagement with a PHA to submit data to public health registries.

  5. **Clinical data registry reporting:** The EP is actively engaged with a clinical data registry for the purposes of submitting data.