CMS Rule

Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 and 2017

- Align all three stages of Meaningful Use into single program/rule
  - All providers would meet Stage 3 requirements starting in 2018
  - Phased-in timelines that allows some providers to continue to meet Stage1 and Stage 2 requirements in 2017
- Aligns reporting periods – calendar year reporting for eligible professionals, eligible hospitals and critical access hospitals
  - Full year reporting periods
  - Allows 90 day reporting periods for first time attesters in 2017 only
- Provides simplified objectives and measures –
  - Modification: Objective 10: Public Health and Clinical Data Registry Reporting
  - Stage 3:Objective 8: Public Health and Clinical Data Registry Reporting

ONC Rule

2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications

- New 2015 Base EHR Definition
- No optional/required criteria – developers should choose the criteria relevant to their purpose
- Can be used beyond CMS EHR Incentive Program

Mod Rule: Objective 10: Public Health and Clinical Data Registry Reporting

- NPRM Proposed Objective: The EP, eligible hospital, or CAH is in active engagement with a PHA or CDR to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.
  - Six possible measures to meet the objective
    - Eligible professionals must meet three measures
    - Eligible Hospitals and Critical Access Hospitals must meet four measures
- Final Rule Objective: Unchanged
  - Six possible measures to meet the objective
    - Eligible professionals must meet TWO measures
    - Eligible Hospitals and Critical Access Hospitals must meet THREE measures

Mod Rule: Measures for Objective 10

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PUBLIC HEALTH AND CLINICAL DATA REGISTRY REPORTING OBJECTIVE		
Measure	Maximum times measure can count towards objective for EP	Maximum times measure can count towards objective for eligible hospital or CAH
Measure 1 – Immunization Registry Reporting	1	1
Measure 2 – Syndromic Surveillance Reporting	1	1
Measure 3 – Case Reporting (Dropped)		
Measure 4 - Public Health Registry Reporting Measure 5 - Clinical Data Registry Reporting (Now Specialized Registries Includes Cancer for EP)	2	3
Measure 6 - Electronic Reportable Laboratory Results	n/a	1

Stage 3 Rule: Objective 8: Public Health and Clinical Data Registry Reporting

- NPRM Proposed Objective: The EP, eligible hospital, or CAH is in active engagement with a PHA or CDR to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.
  - Six possible measures to meet the objective
    - Eligible professionals must meet three measures
    - Eligible Hospitals and Critical Access Hospitals must meet four measures

- Final Rule Objective: Unchanged

Stage 3: Measures for Objective 8

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PUBLIC HEALTH AND CLINICAL DATA REGISTRY REPORTING OBJECTIVE		
Measure	Maximum times measure can count towards objective for EP	Maximum times measure can count towards objective for eligible hospital or CAH
Measure 1 – Immunization Registry Reporting	1	1
Measure 2 – Syndromic Surveillance Reporting	1	1
Measure 3 – Case Reporting	1	1
Measure 4 - Public Health Registry Reporting	3	4
Measure 5 - Clinical Data Registry Reporting	3	4
Measure 6 - Electronic Reportable Laboratory Results	n/a	1

State Flexibility for Stage 3 of Meaningful Use

- Consistent with our approach under both Stage 1 and 2, we propose to continue to offer states flexibility under the Medicaid EHR Incentive Program in Stage 3 by adding a new provision at § 495.316(d)(2)(iii) subject to the same conditions and standards as the Stage 2 flexibility policy. Under Stage 3, state flexibility would apply only with respect to the public health and clinical data registry reporting objective outlined under section II.A.1.c.(1).(b).(i). of this proposed rule.
- For Stage 3 of meaningful use, we would continue to allow states to specify the means of transmission of the data and otherwise change the public health agency reporting objective as long as it does not require functionality greater than what is required for Stage 3 and included in the 2015 Edition proposed rule elsewhere in this issue of the Federal Register.

State Flexibility for Stage 3 of Meaningful Use

- Potential to make Immunization Registry reporting required
- May only to apply to Medicaid providers

Mod Rule: Exclusions/Total number of measures required for EP

- For EPs, we proposed that an exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective an EP would need to meet two of the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting the one remaining measure available to them and claiming the applicable exclusions. If no measures remain available, the EP can meet the objective by claiming applicable exclusions for all measures. An EP who is scheduled to be in Stage 1 in 2015 must report at least one measure unless they can exclude from all available measures. Available measures include ones for which the EP does not qualify for an exclusion.

- Adopted as proposed.

Alternate Exclusions

- Alternate exclusions extended to 2017
- Immunization Registry reporting not included as a measure for which providers can take an alternate exclusion

Active Engagement (page 425)

- Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.
- We noted that the term "production data" refers to data generated through clinical processes involving patient care and it is used to distinguish between this data and "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers.
- We proposed that "active engagement" may be demonstrated by any of the following options:
  - Option 1 – Completed Registration to Submit Data:
  - Option 2 - Testing and Validation
  - Option 3 – Production

NPRM: Measure 1 – Immunization Registry Reporting:

- The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

NPRM: Exclusions for Measure 1 – Immunization Registry Reporting:

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Any EP, eligible hospital, or CAH meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP, eligible hospital, or CAH: (1) Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period; (2) operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting 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 immunization registry or immunization information system has declared readiness to receive immunization data at the start of the EHR reporting period.

Mod Rule: Immunization Registry Reporting:

- We appreciate commenters' concerns regarding the addition of a bi-directionality requirement for the EHR reporting periods covered by the modified Stage 2 requirements. We agree with commenters that additional time may be needed for both public health agencies and providers to adopt the necessary technology to support bi-directional functionality. **Therefore, we are not finalizing the bi-directionality proposal in the EHR Incentive Programs for 2015 through 2017**.

Stage 3 Rule:– Immunization Registry Reporting:

- For clarification, we note that the provider's technology certified in accordance with the ONC Health IT Certification Program may layer additional information and recommendations on top of the forecast received from the immunization registry. The requirements of CEHRT serve only as a baseline upon which additional capabilities may be built.

- …we are finalizing this measure, with the modification that a **provider's health IT system may layer additional information on the immunization history, forecast, and still successfully meet this measure**

NPRM: § 170.315(f)(1) (Transmission to immunization registries)

- HL7 Version 2.5.1: Implementation Guide for Immunization Messaging, Release 1.5 (October 2014)
- Require NDC Codes for recording administered vaccines, require CVX codes for historical vaccines
- Require a Health IT Module presented for certification to this criterion to be able to request, access and display an immunization history and forecast from an immunization registry

2015 Edition Final Rule: § 170.315(f)(1) (Transmission to immunization registries)

HL7 Version 2.5.1: Implementation Guide for Immunization Messaging, Release 1.5 (October 2014)

- …have adopted **HL7 Version 2.5.1: Implementation Guide for Immunization Messaging, Release 1.5 (October 1, 2014) and HL7 Version 2.5.1: Implementation Guide for Immunization Messaging, Release 1.5, Addendum (July 2015)** for the transmission to immunization requirement. We clarify that to meet this criterion, health IT must comply with all mandatory requirements of Release 1.5 and its addendum, which would include the coding for race and ethnicity. The 2015 Edition "demographics" criterion and Common Clinical Data Set requirements related to race and ethnicity are not implicated by this criterion.

2015 Edition Final Rule: § 170.315(f)(1) (Transmission to immunization registries)

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Require NDC Codes for recording administered vaccines, require CVX codes for historical vaccines

- we finalize a criterion that supports one set of codes to be used for administered vaccines at all times and another set of codes to be used for historical vaccines at other times.
- …we have adopted the **August 17, 2015 version of the CVX code set as the minimum standards code set for historical vaccines.**
- For purposes of **administered vaccines, we have adopted the National Drug Codes (NDC) –Vaccine NDC Linker**, updates through August 17, 2015 as the minimum standards code set.

2015 Edition Final Rule: § 170.315(f)(1) (Transmission to immunization registries)

Require a Health IT Module presented for certification to this criterion to be able to request, access and display an immunization history and forecast from an immunization registry

- We have adopted the requirement for a Health IT Module to enable a user to request, access, and display a patient's immunization history and forecast from an immunization registry in accordance with the Release 1.5 IG.
- However, we note that this criterion **does not prescribe a particular workflow or reconciliation requirements**. Providers and health IT developers may reconcile forecast and history information in a manner that best meets their needs for workflow and patient safety.

CEHRT – Immunization Registries

- CEHRT under Mod Rule Years, 2015-2017:
  - HL7 2.5.1 Implementation Guide for Immunization Messaging Release 1.4 (August 2012)
- CEHRT under Stage 3 Option Year 2017:
  - HL7 Version 2.5.1: Implementation Guide for Immunization Messaging, Release 1.5 (October 2014) and HL7 Version 2.5.1: Implementation Guide for Immunization Messaging, Release 1.5, Addendum (July 2015)
- CEHRT under MU Stage 3 2018 and beyond:
  - HL7 Version 2.5.1: Implementation Guide for Immunization Messaging, Release 1.5 (October 2014) and HL7 Version 2.5.1: Implementation Guide for Immunization Messaging, Release 1.5, Addendum (July 2015)

Bridging the Healthcare Digital Divide: Improving Connectivity Among Medicaid Providers

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Connecting All Parts of the Health System

That's why today, we are announcing an initiative to bring interoperable technology to a broader universe of health care providers, including long-term care, behavioral health providers, substance abuse treatment centers, and other providers that have been slower to adopt technology. This announcement will help to bridge an information sharing gap in Medicaid by permitting states to request the 90 percent enhanced matching funds from CMS to connect a broader variety of Medicaid providers to a health information exchange than those providers who are eligible for such connections today. This additional funding will enhance the sustainability of health information exchanges and lead to increased connectivity among Medicaid providers.

Doctors and other clinicians need access to the right information at the right time in a manner they can use to make decisions that impact their patient's health. The free flow of information is hampered when not all doctors, facilities or other practice areas are able to make a complete circuit. Adding long-term care providers, behavioral health providers, and substance abuse treatment providers, for example, to statewide health information exchange systems will enable seamless sharing of a patients' health information between doctors or other clinicians when it's needed. This sharing helps create a more complete care team to collaborate on the best treatment plans and goals for Medicaid patients.

Andy Slavitt, Centers for Medicare & Medicaid Services (CMS) Acting Administrator, **Karen DeSalvo**, National Coordinator for Health Information Technology (ONC) and Acting Assistant Secretary for Health

https://blog.cms.gov/2016/03/02/bridging-the-healthcare-digital-divide-improving-connectivity-among-medicaid-providers/

How it works:

- This funding goes directly to the state Medicaid agency in the same way existing Medicaid HITECH administrative funds are distributed
  - State completes IAPD (Implementation Advanced Planning Document) to be reviewed by CMS
  - States complete Appendix D (HIE information) for IAPD as appropriate
- This funding is in place until 2021 and is a 90/10 Federal State match. The state is still responsible for providing the 10%.
- The funding is for HIE and interoperability **only**, not to provide EHRs.
- The funding is for implementation **only**, it is not for operational costs.
- The funding still must be cost allocated if other entities than the state Medicaid agency benefit
- **All providers or systems supported by this funding must connect to Medicaid EPs.**

HIE Architecture

Several HIE modules and use cases are specifically called out for support:

- **Provider Directories**: with an emphasis on dynamic provider directories that allow for bidirectional connections to public health and that might be web-based, allowing for easy use by other Medicaid providers with low EHR adoption rates
- **Secure Messaging**: with an emphasis on partnering with DirectTrust
- **Encounter Alerting**
- **Care Plan Exchange**
- **Health Information Services Providers** (HISP) Services
- **Query Exchange**
- **Public Health Systems**

Any requested system must support Meaningful Use for a Medicaid EP in some manner. So, for example, the content in the Alerting feed or Care Plan must potentially help an EP meet an MU measure.

Public Health Systems

- The public health systems that support
- Eligible Providers in achieving Meaningful
- Use may now be supported:
- Immunization Registries
- Syndromic Surveillance Registries
- Specialty Registries
  - Prescription Drug Monitoring Programs (non-MMIS)
  - Other diseases/conditions that are state priorities (homelessness, lead exposure, etc.)
- Architecture for the registries can now be supported, not just connections

CMS Oversight

- Cost allocation requirements from SMD 11-004* remain in place:

CMS will work with States on an individual basis to determine the most appropriate cost allocation methodology.

- HITECH cost allocation formulas should be based on the direct benefit to the Medicaid EHR incentive program, taking into account State projections of eligible Medicaid provider participation in the incentive program
- Cost allocation must account for other available Federal funding sources, the division of resources and activities across relevant payers, and the relative benefit to the State Medicaid program, among other factors
- Cost allocations should involve the timely and ensured financial participation of all parties so that Medicaid funds are neither the sole contributor at the onset nor the primary source of funding. Other payers who stand to benefit must contribute their share from the beginning. The absence of other payers is not sufficient cause for Medicaid to be the primary payer.

Sample Cost Allocation Plan

Federal/State Program	Medicaid Share (%/$)	Federal Share ($/%)	State Share ($/%)	TBD Share (duplicate this column as many times as necessary) ($/%)	Total Program Cost ($)
Medicaid EHR Incentive Program					

*https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/medicaid_hit_iapd_template.pdf

CMS Oversight

- New funding must connect Medicaid providers to EPs and map to specific MU measures (to be described by the state)
- Implementation benchmarks to be defined by the state
- States should assume data will be requested regarding MU implications of new systems and newly on-boarded providers
- For new systems without defined data standards (Encounter Alerting, Care Plan Exchange), the systems must still support some MU measure to be defined by the state.

Foundation for Delivery System Reform

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