Overview

On April 10, 2015, the Centers for Medicare and Medicaid Services (CMS) released its proposed rule on Modifications to Meaningful Use for 2015-2017. In this rule, CMS proposes to make additional changes to the Stage 1 and Stage 2 requirements of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for 2015 and 2016 that better align with recently proposed Stage 3 requirements. This includes the removal of redundant, duplicative, and topped-out measures to streamline reporting and better align with requirements proposed in the Stage 3 rule; modifications to current objectives and measures; and modifications to reporting timelines. Please note that while this rule is separate from the recently published rule, which proposed objectives and measures for Stage 3 of meaningful use for 2017 and beyond, both rules aim to reduce reporting burden and eliminate redundant and duplicative reporting.

CMS clarifies that the changes in this rule are being proposed in response to both environmental changes and requests from the public to reduce the overall complexity of the program and the burden on providers. However, some changes requested by the public were not possible due to certain statutory requirements. For example, electronic prescribing and health information exchange cannot be fully "optional" because they are expressly required under statute. CMS also feels it cannot remove measure thresholds due to the statutory directive that the agency require increasingly more stringent measures of meaningful use.

The proposals included in this rule would also apply to the Medicaid EHR Incentive Program. However, CMS would continue to offer states flexibility under the Medicaid EHR Incentive Program for the public health reporting objective, such as allowing states to specify the means of data transmission or otherwise change the public health measure so long as it does not require EHR functionality above and beyond the 2014 Edition certification criteria.

Also note that CMS does not propose any further changes to the definition of certified electronic health record technology (CEHRT) in this rule. Therefore, providers would continue to use EHR technology certified to the 2014 Edition for EHR reporting periods in 2015, 2016, and 2017. However, CMS does propose in the separate Stage 3 rule to require a transition to the 2015 Edition beginning with the 2018 reporting period.

In a press release related to this rule, CMS noted that as of March 1, 2015, more than 525,000 providers have registered to participate in the Medicare and Medicaid EHR Incentive Programs. In addition, more than 438,000 eligible professionals (EPs), eligible hospitals, and Critical Access Hospitals (CAHs) have received an EHR incentive payment. As of the end of 2014, 95% of eligible hospitals and CAHs, and more than 62% of EPs have successfully demonstrated meaningful use of certified EHR technology.

The following summary provides a high level overview of key sections of this proposed rule**.** Page numbers correlate to the pre-publication display version of the rule found on the *Federal Register* website (linked above). Following publication in the *Federal Register* on **April 15, 2015**, this rule will be **open for public comment for 60 days**.

Meaningful Use Requirements for EHR Reporting Periods in 2015 through 2017

Stages of Meaningful Use (p. 30)

The current progression of stages, as previously finalized, is outlined below and on p. 31.

Previously Finalized Stage of Meaningful Use Criteria By First Year

First Payment Year	Stage of Meaningful Use								
	2011	2012	2013	2014	2015	2016	2017	2018	2019
2011	1	1	1	1 or 2*	2	2	3	3	TBD
2012		1	1	1 or 2*	2	2	3	3	TBD
2013			1	1*	2	2	3	3	TBD
2014				1*	1	2	2	3	3
2015					1	1	2	2	3
2016						1	1	2	2
2017							1	1	2

CMS' proposed revised timeline is outlined below and on p. 33 of the rule.

Newly Proposed Stages of Meaningful Use Criteria By First Year

First Year as a Meaningful EHR User	Stage of Meaningful Use			
	2015	2016	2017	2018
2011	Modified Stage 2	Modified Stage 2	Modified Stage 2 Or Stage 3	Stage 3
2012	Modified Stage 2	Modified Stage 2	Modified Stage 2 Or Stage 3	Stage 3
2013	Modified Stage 2	Modified Stage 2	Modified Stage 2 Or Stage 3	Stage 3
2014	Modified Stage 2*	Modified Stage 2	Modified Stage 2 Or Stage 3	Stage 3
2015	Modified Stage 2*	Modified Stage 2	Modified Stage 2 Or Stage 3	Stage 3
2016	- NA -	Modified Stage 2	Modified Stage 2 Or Stage 3	Stage 3

*The Modifications to Stage 2 proposed in this rule include alternate exclusions and specifications for certain objectives and measures for providers that were scheduled to demonstrate Stage 1 of meaningful use in 2015.

In the Stage 3 proposed rule, CMS proposed that all providers may optionally move to Stage 3 in 2017 and that all providers are required to do so in 2018, regardless of their prior participation or stage of meaningful use. In this proposed rule, in an effort to work toward an overall shift to a single set of objectives and measures in Stage 3 in 2018, CMS proposes to require all providers to attest to a single set of objectives and measures finalized in the Stage 2 final rule (which align with the objectives and measures proposed for Stage 3) beginning with the 2015 reporting period. Because this change may occur after providers have already begun their work toward meeting meaningful use in 2015, CMS proposes accommodations within individual objectives for providers in different stages. These include retaining different specifications between Stage 1 and Stage 2, and allowing

special exclusions for certain objectives or measures for providers previously scheduled to participate in Stage 1 in 2015.

These changes would create a new progression, as outlined in the table above, using the existing objectives and measures where providers attest to:

- A modified version of Stage 2 with accommodations for Stage 1 providers (equivalent to a reduced version of Stage 3) in 2015;
- A modified version of Stage 2 in 2016 (equivalent to a reduced version of Stage 3);
- Either a modified version of Stage 2 (equivalent to a reduced version of Stage 3) or the full version of Stage 3 outlined in the Stage 3 proposed rule in 2017; and
- The full version of Stage 3 outlined in the Stage 3 proposed rule beginning in 2018.

CMS seeks comments on whether to implement only the modifications proposed in this rule from 2015 through 2017 and begin Stage 3 in 2018 without an option year in 2017, or if it should allow providers the option to demonstrate Stage 3 beginning in 2017 as discussed in the Stage 3 proposed rule.

For reader clarity, in this rule, CMS refers to the meaningful use "stage" designations as:

- **Meaningful use objectives and measures for 2015 through 2017**
- **Stage 3 meaningful use objectives and measures for 2017 and subsequent years**

EHR Reporting Periods in 2015 through 2017 (p. 35)

Calendar Year Reporting in 2015 (p. 35)

In the Stage 3 proposed rule, CMS proposes to move eligible hospitals and CAHs to a reporting period based on a calendar year beginning in 2017, rather than the current fiscal year. In this rule, to better align with EHR reporting periods in other CMS quality reporting programs, CMS proposes to change the definition of "EHR reporting period" for *EPs, eligible hospitals, and CAHs* to the calendar year starting in 2015. CMS carves out an exception to accommodate hospitals and CAHs that may have already planned to use the fiscal year as their EHR reporting period for 2015, but would require all hospitals to use the calendar year in 2016.

90-day EHR Reporting Period for all Providers in 2015 (p. 37)

To give providers additional time to address any remaining issues related to the implementation of 2014 Edition certified technology and to accommodate changes to the objectives and measures proposed in this rule, CMS proposes the following changes related to the reporting timeline:

- For 2015 only, allowing all EPs, eligible hospitals and CAHs, regardless of their prior participation in the program, to attest for any continuous 90-day period. EPs may select a 90-day period from January 1, 2015 through December 31, 2015, while eligible hospitals and CAHs may select a period from October 1, 2014 through December 31, 2015.
- For 2015 and 2016, allowing *new* participants to attest to meaningful use for any continuous 90-day period within the calendar year.
- In 2017, the reporting period would be the full calendar year for all providers, as proposed in the Stage 3 proposed rule (with a limited exception for Medicaid providers demonstrating meaningful use for the first time).

Changes to the Definition of Meaningful Use (p. 39)

CMS conducted an analysis of objectives and measures of meaningful use Stages 1 and 2 and identified a number of measures that meet criteria laid out in the Stage 3 proposed rule for being redundant, duplicative, or topped out. The following table, included on p. 41, identifies current objectives and measures that meet these criteria. CMS is proposing to no longer require providers to attest to these objectives and measures beginning in 2015.

Objective and Measures Identified By Provider Type, Which Are Redundant, Duplicative, or Topped Out

Provider Type	Objectives and Measures	
Eligible Professional	Record Demographics	42 CFR §495.6 (j)(3)(i) and (ii)
	Record Vital Signs	42 CFR §495.6 (j)(4) (i) and (ii)
	Record Smoking Status	42 CFR §495.6 (j)(5) (i) and (ii)
	Clinical Summaries	42 CFR §495.6 (j)(11) (i) and (ii)
	Structured Lab Results	42 CFR §495.6 (j)(7) (i) and (ii)
	Patient List	42 CFR §495.6 (j)(8) (i) and (ii)
	Patient Reminders	42 CFR §495.6 (j)(9) (i) and (ii)
	Summary of Care Measure 1 – Any Method Measure 3 – Test	42 CFR §495.6 (j)(14) (i) and (ii)
	Electronic Notes	42 CFR §495.6 (j)(9) (i) and (ii)
	Imaging Results	42 CFR §495.6 (k)(6) (i) and (ii)
	Family Health History	42 CFR §495.6 (k)(2) (i) and (ii)
Eligible Hospital/CAH	Record Demographics	42 CFR §495.6 (l)(2) (i) and (ii)
	Record Vital Signs	42 CFR §495.6 (l)(3) (i) and (ii)
	Record Smoking Status	42 CFR §495.6 (l)(4) (i) and (ii)
	Structured Lab Results	42 CFR §495.6 (l)(6) (i) and (ii)
	Patient List	42 CFR §495.6 (l)(7) (i) and (ii)
	Summary of Care Measure 1 – Any Method Measure 3 – Test	42 CFR §495.6 (l)(11) (i) and (ii)
	eMAR	42 CFR §495.6 (l)(16) (i) and (ii)
	Advanced Directives	42 CFR §495.6 (m)(1) (i) and (ii)
	Electronic Notes	42 CFR §495.6 (m)(2) (i) and (ii)
	Imaging Results	42 CFR §495.6 (m)(2) (i) and (ii)
	Family Health History	42 CFR §495.6 (m)(3) (i) and (ii)
	Structure Labs to Ambulatory Providers	42 CFR §495.6 (m)(6) (i) and (ii)

Structural Requirements of Meaningful Use in 2015 through 2017 (p. 43)

Due to the aforementioned proposed removals of objectives and measures and public concerns about the core vs. menu structure, CMS proposes to eliminate the distinction between core and menu objectives. CMS further proposes that all retained objectives and measures would be *required* for the program.

As such, for EPs, the structure of meaningful use for 2015 through 2017 would be **9 required objectives** using the Stage 2 objectives with alternate exclusions and specifications for Stage 1 providers in 2015. In addition, EPs would be required to report on a total of **2 measures from the public health reporting objective** or meet the criteria for exclusion for up to 5 measures.

For eligible hospitals and CAHs, the structure for 2015 through 2017 would be **8 required objectives** using the Stage 2 objectives with alternate exclusions and specifications for Stage 1 providers and some stage 2 providers in 2015. Hospitals also would be required to report on a total of **3 measures from the public health reporting objective** or meet the criteria for exclusion from up to 6 measures.

These changes are summarized in the table below, found on p. 45 of the rule.

Current Stage Structure, Retained Objectives, and Proposed Structure

	Current Stage 1 Structure	Retained Objectives	Proposed Structure
EP	13 core objectives 5 of 9 menu objectives including 1 public health objective	6 core objectives 3 menu objectives 2 public health objectives	9 core objectives 1 public health objective (2 measure options)
EH/ CAH	11 core objectives 5 of 10 menu objectives including 1 public health objective	5 core objectives 3 menu objectives 3 public health objectives	8 core objectives 1 public health objective (3 measure options)

	Current Stage 2 Structure	Retained Objectives	Proposed Structure
EP	17 core objectives including public health objectives 3 of 6 menu objectives	9 core objectives 10 menu objectives 4 public health objectives	9 core objectives 1 public health objective (2 measure options)
EH/ CAH	16 core objectives including public health objectives 3 of 6 menu objectives	7 core objectives 1 menu objective 3 public health objectives	8 core objectives 1 public health objective (3 measure options)

As a result of these proposed changes, **three current menu objectives would now be required for all Stage 1 providers**:

- Stage 1 Menu: Perform Medication Reconciliation
- Stage 1 Menu: Patient Specific Educational Resources
- Stage 1 Menu: Public Health Reporting Objectives (multiple options)

One current menu objective also would now be a required objective for Stage 2 eligible hospitals and CAHs:

- Stage 2 Menu: Electronic Prescribing

For the **public health reporting objectives and measures,** CMS proposes, as it does in the Stage 3 proposed rule, to consolidate the different Stage 2 core and menu objectives into a single objective with multiple measure options. CMS believes this will provide greater flexibility for providers and supports efforts to engage providers and public health agencies in the essential data capture and information exchange, which supports quality improvement, emergency response, and population health management initiatives. CMS proposes that **EPs must select to report on any combination of 2 of the 5 available options** outlined in this proposed rule and **eligible hospitals and CAHs must select to report on any combination of 3 of the 6 available options** in this proposed rule. CMS proposes to allow **EPs attesting to Stage 1 in 2015 to report on only 1 of the 5 available options** outlined in this proposed rule and **eligible hospitals and CAHs in 2015 to select to report on any combination of 2 of the 6 available options** in this proposed rule.

Alternate Exclusions and Specifications for Stage 1 Providers for Meaningful Use in 2015 (p. 46)

CMS proposes several alternate exclusions and specifications for providers scheduled to demonstrate Stage 1 in 2015, to allow them to continue to demonstrate meaningful use despite the proposals to use only the Stage 2 objectives and measures in 2015 through 2017. These include:

- *Maintaining specifications for objectives and measures, which have a lower threshold or other measure difference between Stage 1 and Stage 2*. For example, in Stage 1, the provider would only have to attest to the objective that more than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology, rather than the Stage 2 objective of more than 50%. However, starting in 2016, all providers, including those scheduled for Stage 1, would be required to meet the Stage 2 specifications with no alternate exclusions.
- *Establishing an exclusion for Stage 2 measures which do not have an equivalent Stage 1 measure associated with any Stage 1 objective or where the provider did not plan to attest to the menu objective which would now be otherwise required*. For example, some objectives, such as the Patient Electronic Access objective, have the same requirements for one measure (more than 50% of patients are provided

access to view, download, and transmit their health information) for both Stage 1 and Stage 2, but also have an additional measure for Stage 2 (more than 5% of patients view, download, or transmit their health information). Other objectives, such as the Summary of Care objective, are designated as a menu objective for Stage 1, but are a core objective for Stage 2 and also may have additional measure requirements in Stage 2 that are not applicable for Stage 1. In this case, Stage 1 providers may exclude from the requirement to send an electronic summary of care record for more than 10% of transitions of care as required in the Stage 2 Summary of Care objective measure 2. Some objectives consist of requirements from multiple objectives from Stage 1 that were consolidated into a single objective for Stage 2 such as drug-drug and drug-allergy decision support interventions. For these consolidated objectives, all providers would be required to attest to the Stage 2 objective and measures.

Changes to Patient Engagement Requirements for 2015 through 2017 (p. 48)

Due to public concerns about these requirements often relying on factors outside of the provider's control, as well as the lack of HIT equipped with the functions to support the transmission of health information by a patient or the delivery of a secure message from a patient to a third party, CMS proposes to modify the current patient engagement objectives:

- Patient Action to View, Download, or Transmit Health Information.
    - CMS proposes to remove the 5% threshold for Measure 2 from the EP Stage 2 Patient Electronic Access (VDT) objective, and instead require that at least 1 patient seen by the provider during the EHR reporting period views, downloads, or transmits his or her health information to a third party.
    - CMS proposes to remove the 5% threshold for Measure 2 from the eligible hospital and CAH Stage 2 Patient Electronic Access (VDT) objective, and instead require that at least 1 patient discharged from the hospital during the EHR reporting period views, downloads, or transmits his or her health information to a third party

  CMS seeks comment on potential alternates such as a percentage threshold less than 5%, or a numerator greater than 10 patients.
- Secure Electronic Messaging Using CEHRT
    - CMS proposes to change the threshold measure for the Stage 2 EP Secure Electronic Messaging objective from the 5% threshold to a yes/no attestation to the statement: "The capability for patients to send and receive a secure electronic message was enabled during the EHR reporting period."

Meaningful Use Objectives and Measures for 2015, 2016, and 2017 (p. 51)

As noted above, there are **9 proposed objectives for EPs plus one consolidated public health reporting objective (for a total of 10**), and **8 proposed objectives for eligible hospitals and CAHs plus one consolidated public health reporting objective (for a total of 9),** which would be required with alternate exclusions for certain providers in 2015 and which would be mandatory for all providers for an EHR reporting period beginning in 2016.

6 of these objectives would require an EP, hospital or CAH to enter numerators and denominators during attestation.

These proposed objectives and measures are outlined in the table below, found on p. 100 of the rule, and explained in more detail on pgs. 51-100.

Meaningful Uses Objectives and Measures Proposed for 2015 Through 2017

Provider Type	Proposed Objectives for 2015, 2016 and 2017	Proposed Measures for Providers in 2015, 2016 and 2017	Proposed Alternate Measures, Exclusions and/or Specifications for Certain Providers in 2015 ONLY
Eligible Professional	CPOE *For more information, see discussion starting on p. 55 of rule.*	Measure 1: More than 60% of medication orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. Measure 2: More than 30% of laboratory orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. Measure 3: More than 30% of radiology orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.	If for an EHR reporting period in 2015, the provider is scheduled to demonstrate Stage 1: Alternate Measure 1: More than 30% of all unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the EP during the EHR reporting period, or created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period, are recorded using computerized provider order entry. Alternate Exclusion for Measure 2: Provider may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015. Alternate Exclusion for Measure 3: Provider may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.
	Electronic Prescribing *For more information, see discussion starting on p. 60 of rule.*	Measure: More than 50% of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using Certified EHR Technology.	If for an EHR reporting period in 2015, the provider is scheduled to demonstrate Stage 1: Alternate EP Measure: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using CEHRT.
	Clinical Decision Support *For more information,*	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four	If for an EHR reporting period in 2015, the provider is scheduled to demonstrate Stage 1: Alternate Objective and Measure 1:

	see discussion starting on p. 53 of rule.	clinical quality measures related to an EP, eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency. Measure 2: The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period. Exclusion: For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.	Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule. Measure: Implement one clinical decision support rule.
	Patient Electronic Access (VDT) *For more information, see discussion starting on p. 75 of rule*.	Measure 1: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information. Measure 2: At least one patient seen by the EP during the EHR reporting period (or their authorized representatives) views, downloads, or transmits his or her health information to a third party	Alternate Exclusion Measure 2: Provider may claim an exclusion for the second measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.
	Protect Electronic Health Information *For more information, see discussion starting on p. 51 of rule*.	Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data stored in Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP, eligible hospital, or CAHs risk management process.	NONE
	Patient Specific Education	Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10% of all	Alternate Exclusion: Provider may claim an exclusion for the measure of the Stage 2 Patient Specific Education objective if for an EHR reporting period in 2015 they were

	For more information, see discussion starting on p. 69 of rule.	unique patients with office visits seen by the EP during the EHR reporting period.	scheduled to demonstrate Stage 1 but did not in d to select the Stage 1 Patient Specific Education menu objective.
	Medication Reconciliation *For more information, see discussion starting on p. 72 of rule*.	Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	Alternate Exclusion: Provider may claim an exclusion for the measure of the Stage 2 Medication Reconciliation objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Medication Reconciliation menu objective.
	Summary of Care *For more information, see discussion starting on p. 66 of rule*.	Measure: The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10% of transitions of care and referrals.	Alternate Exclusion: Provider may claim an exclusion for Measure 2 of the Stage 2 Summary of Care objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.
	Secure Messaging *For more information, see discussion starting on p. 82 of rule*.	Measure: During the EHR reporting period, the capability for patients to send and receive a secure electronic message with the provider was fully enabled.	Alternate Exclusion: An EP may claim an exclusion for the measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.
	Public Health *For more information, see discussion starting on p. 85 of rule*.	Measure Option 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). Measure Option 2 – Syndromic Surveillance Reporting: The EP, eligible hospital/, or CAH is in active engagement with a public health agency to submit syndromic surveillance data from a non- urgent care ambulatory setting for EPs, or an emergency or urgent care department for eligible hospitals and CAHs (POS 23).	NONE

		Measure Option 3 - Case Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. Measure Option 4 - Public Health Registry Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit data to public health registries. Measure Option 5 – Clinical Data Registry Reporting: The EP, eligible hospital, or CAH is in active engagement to submit data to a clinical data registry.	
Eligible Hospital/ CAH	CPOE *For more information, see discussion starting on p. 55 of rule*.	Measure 1: More than 60% of medication orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. Measure 2: More than 30% of laboratory orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. Measure 3: More than 30% of radiology orders created by the EP or by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.	If for an EHR reporting period in 2015, the provider is scheduled to demonstrate Stage 1: Alternate Measure 1: More than 30 % of all unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the EP or created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. Alternate Exclusion for Measure 2: Provider may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015. Alternate Exclusion for Measure 3: Provider may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2015.
	Clinical Decision Support *For more*	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR	If for an EHR reporting period in 2015, the provider is scheduled to demonstrate Stage 1: Alternate Measure 1: Implement one

	information, see discussion starting on p. 53 of rule.	reporting period. Absent four clinical quality measures related to an EP, eligible hospital or CAH's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency. Measure 2: The EP, eligible hospital, or CAH has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period. Exclusion: For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.	clinical decision support rule. CMS proposes that for an EHR reporting period in 2015, an EP, eligible hospital or CAH who is scheduled to participate in Stage 1 in 2015 must also satisfy the Stage 2 measure 2 previously stated because it is the same as an existing Stage 1 measure (77 FR 53998). There are no alternate exclusions for this objective.
	Patient Electronic Access (VDT) *For more information, see discussion starting on p. 75 of rule*.	Measure 1: More than 50% of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge. Measure 2: At least 1 patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or his or her authorized representative) views, downloads, or transmits to a third party his or her information during the EHR reporting period.	Alternate Exclusion Measure 2: Provider may claim an exclusion for the second measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.
	Protect Electronic Health Information *For more information, see discussion starting on p. 51 of rule*.	Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data stored in Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP, eligible hospital, or CAHs risk management process.	NONE
	Patient Specific	Measure: More than 10 % of all unique patients admitted to the eligible hospital's or CAH's	Alternate Exclusion: Provider may claim an exclusion for the measure of the Stage 2

	Education *For more information, see discussion starting on p. 69 of rule.*	inpatient or emergency department (POS 21 or 23) are provided patient specific education resources identified by Certified EHR Technology.	Patient Specific Education objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Patient Specific Education menu objective.
	Medication Reconciliation *For more information, see discussion starting on p. 72 of rule.*	Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	Alternate Exclusion: Provider may claim an exclusion for the measure of the Stage 2 Medication Reconciliation objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1 but did not intend to select the Stage 1 Medication Reconciliation menu objective.
	Summary of Care *For more information, see discussion starting on p. 66 of rule.*	Measure: The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10% of transitions of care and referrals.	Alternate Exclusion: Provider may claim an exclusion for Measure 2 of the Stage 2 Summary of Care objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.
	Electronic Prescribing *For more information, see discussion starting on p. 60 of rule.*	Measure: More than 10% of hospital discharge medication orders for permissible prescriptions (for new, changed and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology.	Alternate Exclusion: Measure Exclusion: Provider may claim an exclusion for the eRx objective and measure if for an EHR reporting period in 2015 they were either scheduled to demonstrate Stage 1 which does not have an equivalent measure, or if they are scheduled to demonstrate Stage 2 but did not intend to select the Stage 2 eRx menu objective for an EHR reporting period in 2015.
	Public Health *For more information, see discussion starting on p. 85 of rule.*	Measure Option 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). Measure Option 2 – Syndromic Surveillance Reporting: The EP, eligible hospital/, or CAH is in active engagement with a public health agency to submit syndromic surveillance data from a non- urgent care ambulatory setting for EPs, or an emergency or urgent care department for eligible hospitals and CAHs (POS 23).	NONE

		Measure Option 3 - Case Reporting: The EP, eligible hospital, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. Measure Option 5 - Clinical Data Registry Reporting: The EP, eligible hospital, or CAH is in active engagement to submit data to a clinical data registry. Measure Option 6 – Electronic Reportable Laboratory Result Reporting: The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.	

Clinical Quality Measurement (p. 109)

For 2015 through 2017, CMS proposes the following in regards to the reporting of clinical quality measures (CQMs) as part of satisfying meaningful use:

- For an EHR reporting period in 2015, and for EPs demonstrating meaningful use for the first time in 2016:
    - Attest to any continuous 90-day period of CQM data during the calendar year through the Medicare EHR Incentive Program registration/attestation site; or
    - Electronically report CQM data using the established methods discussed below (as currently required, provider choosing this method would need to submit a full calendar year of CQM data using 2014 eCQMs).

In accordance with existing policy, it is acceptable for a provider to use a continuous 90-day reporting period for CQMs even if it is different from their continuous 90-day EHR reporting period for the meaningful use objectives and measures if that provider is reporting via attestation. A provider also may choose to attest to a CQM reporting period of greater than 90-days up to and including 1 full calendar year of data. For 2016 and subsequent years, providers beyond their first year of meaningful use may attest to one full calendar year of CQM data or they may electronically report CQM data as discussed below.

CMS also proposes to continue its existing policy that providers in any year of participation for the EHR Incentive Programs for 2015 through 2017 may submit CQM data either through the EHR Registration & Attestation System, or electronically through the PQRS portal. EPs interested in reporting once for multiple programs (e.g., reporting CQMs to qualify for both the EHR Incentive Program + PQRS) have the option of reporting CQM data as individual EPs through the PQRS Portal or reporting a group practice's CQMs through the PQRS Portal (this may include an EP reporting using the group reporting option, either electronically using QRDA, or via the GPRO Web Interface through Pioneer ACO participation).

CMS does not propose any changes to the clinical quality measurements (CQM) selection or reporting scheme (9 or 16 CQMs across at least 3 domains) previously established.

Demonstration of Meaningful Use for 2015 through 2017 (p. 114)

CMS proposes to continue the use of attestation as the method for demonstrating that an EP, eligible hospital, or CAH has met the objectives and measures of meaningful use. In lieu of individual Medicare EP attestation through the CMS registration and attestation system, CMS proposes to continue the existing optional batch file process for attestation.

Attestation Deadlines for Meaningful Use in 2015 and 2016 (p. 114)

CMS also proposes changes to the attestation deadlines to accommodate the proposed change to reporting based on the calendar year for eligible hospitals and CAHs beginning with an EHR reporting period in 2015, as well as the proposed change to a 90-day EHR reporting period for all providers in 2015. For hospitals this would mean:

- Completing an EHR reporting period for 2015 between October 1, 2014 and the end of the calendar year on December 31, 2015 (rather than September 30, 2015) and attest by February 29, 2016 (rather than November 30, 2015), and to complete an EHR reporting period for 2016 between January 1, 2016 and December 31, 2016 and attest by February 28, 2017.

New Participant Attestation Deadlines for Meaningful Use in 2015 and 2016 to Avoid A Payment Adjustment (p. 116)

CMS proposes changes to the attestation deadlines for new meaningful EHR users in 2015 and 2016 to avoid the Medicare payment adjustments in 2016 and 2017.

Current regulations include special deadlines for attestation for EPs and eligible hospitals that are demonstrating meaningful use for the first time in the year immediately preceding a payment adjustment year. In general, a provider must report in the first 3 quarters of the preceding year, and the deadlines for attestation are October 1 for EPs and July 1 for eligible hospitals of the preceding year. For CAHs, the reporting period is within the federal fiscal year that is the payment adjustment year and the deadline for attestation is the same for purposes of the incentive payment and the payment adjustment (November 30, 2015).

After the October 1 or July 1 deadlines, EPs and eligible hospitals may still attest for an EHR reporting period in the fourth quarter of the CY or FY, respectively. However, **if they attest after the respective deadlines, then they would not avoid the Medicare payment adjustment in the subsequent payment adjustment year**.

In this rule, CMS is proposing a later deadline for attestation only for 2015 to allow enough time for all providers to complete a 90-day EHR reporting period after the anticipated effective date of the final rule. As a result of this later deadline, in 2016, providers that are new participants to the program may be subject to a payment adjustment on claims submitted prior to attestation to meaningful use for the 2015 reporting period. After successful attestation, the payment adjustment would be removed and any adjustments previously applied to claims in 2016 would be reprocessed and reconciled for the provider. Recognizing the need to minimize the claims reprocessing burden, CMS points out that this is an exceptional circumstance caused by the need for a later attestation deadline to accommodate a 90-day EHR reporting period in 2015 after the effective date of the final rule, and that this is not an acceptable long-term solution. CMS will revert to the current deadlines for first-time meaningful EHR users (October 1 for EPs and July 1 for eligible hospitals) in 2016 and subsequent years where no extenuating circumstances exist.

Alternate Method of Demonstration for Certain Medicaid Providers Beginning in 2015 (p. 118)

Under current program rules, an EP who qualifies as both a Medicaid EP and a Medicare EP would be subject to the Medicare payment adjustment if the EP fails to demonstrate meaningful use for the applicable EHR reporting period for a payment adjustment year. For purposes of avoiding the Medicare payment adjustment,

CMS proposes to establish an additional attestation option for 2015 and beyond to allow EPs who have received at least one incentive payment under the Medicaid EHR Incentive Program to demonstrate meaningful use by attestation using the EHR Incentive Program Registration and Attestation system. This attestation would not constitute a switch from the Medicaid EHR Incentive Program to the Medicare EHR Incentive Program, and EPs who attest under this option would not earn an incentive payment in either program for the year. This option is only being proposed for purposes of demonstrating meaningful use to avoid the Medicare payment adjustment only. In alignment with other proposals in this rule, Medicaid providers using this alternate attestation option in 2017 or subsequent years would also be required to use an EHR reporting period of one full calendar year even if they are demonstrating meaningful use for the first time.

Hospital-Based Eligible Professionals (p. 121)

Currently, hospital-based EPs are not eligible for the Medicare or Medicaid EHR incentive and exempted from Medicare penalties. This section discusses how the definition of hospital-based EP for purposes of these programs has changed over the years, culminating in the current definition of:

- An EP who furnishes 90% or more of his/her covered professional services in sites of service identified as an inpatient hospital (POS 21) or emergency room (POS 23) setting in either of the 2 years before the year preceding a payment adjustment year.

In response to public concerns that this definition is too narrow and does not adequately capture all settings where services might be furnished by a hospital-based EP (e.g., POS 22, which covers an outpatient hospital place of service), CMS is seeking public comment on additional place of service codes or settings that should be added to the current regulatory definition of hospital-based EP. CMS is especially interested in comments on POS 22 for outpatient hospital settings.

Payment Adjustments and Hardship Exceptions (p. 126)

Changes to the EHR Reporting Period for a Payment Adjustment Year for EPs (p. 134)

2015 Reporting

CMS proposes that for all EPs, including those who have demonstrated meaningful use in a prior year and those who have not, the EHR reporting period in 2015 would be *any* continuous 90-day period and would apply for purposes of the payment adjustments in 2016 for EPs demonstrating meaningful use for the first time in 2015 and for purposes of the payment adjustments in 2017 for both returning and new participant EPs who demonstrate meaningful use in 2015. The deadline for attestation would be February 29, 2016.

2016 Reporting

For 2016 reporting, CMS would maintain its current policy that if an EP is demonstrating meaningful use for the first time, the reporting period would be any continuous 90-day period and applies for purposes of the payment adjustments in 2017 and 2018. To avoid the payment adjustment in 2017, the 90-day period must occur within the first three quarters of 2016 and the EP must attest by October 1, 2016. If an EP has previously demonstrated meaningful use, the EHR reporting period is the full 2016 calendar year and applies for purposes of the payment adjustment in 2018.

2017 Reporting

In the Stage 3 proposed rule, CMS proposed to eliminate the 90-day reporting period for new meaningful users beginning with the 2017 reporting period, with a limited exception for new meaningful EHR users under the Medicaid EHR Incentive Program. For all EPs and eligible hospitals demonstrating meaningful use in 2017, including those who have successfully demonstrated meaningful use in a prior year as well as those who have not, the EHR reporting period would be the full calendar year that is 2 years before the payment adjustment year.

Changes to the EHR Reporting Period for a Payment Adjustment Year for Eligible Hospitals (p. 135)

2015 Reporting

CMS proposes that for all eligible hospitals, including those that have demonstrated meaningful use in a prior year and those that have not, the EHR reporting period would be any continuous 90-day period beginning October 1, 2014 and ending December 31, 2015. This reporting period would apply for purposes of the payment adjustments in 2016 for eligible hospitals demonstrating meaningful use for the first time in 2015 and for purposes of the payment adjustments in 2017 for both returning and new participant eligible hospitals that demonstrate meaningful use in 2015. The deadline for attestation would be February 29, 2016.

2016 Reporting

If an eligible hospital is demonstrating meaningful use for the first time in 2016, CMS proposes that the reporting period would be any continuous 90-day period in 2016 and apply for purposes of the payment adjustments in 2017 and 2018. To avoid the payment adjustment in 2017, the 90-day period must occur within the first three quarters of 2016, and the eligible hospital must attest by October 1, 2016. If an eligible hospital has previously demonstrated meaningful use, the EHR reporting period would be the full 2016 calendar year, the attestation deadline would be February 28, 2017, and this EHR reporting period would apply for purposes of the payment adjustment in 2018.

Hardship Exceptions (p. 136)

CMS proposes no changes to existing hardship exceptions.

Collection of Information Requirement (p. 139)

Table 7 on p. 144 summarizes burden estimates for each meaningful use objective and measure.

CMS estimates that it would take no longer than 6 hours 49 minutes for an EP to attest to each of the applicable objectives and associated measures. The total burden hours for an EP to attest to the meaningful use objectives and measures and to report CQMs would be 8 hours 19 minutes. CMS' estimated reduction in reporting burden is outlined in Table 8 on p. 151.

Regulatory Impact Analysis (p. 156)

The regulatory impact analysis of these proposed modifications to the Medicare and Medicaid EHR Incentive Programs from 2015 through 2017 outlines the reduction in the reporting burden for providers demonstrating meaningful use in 2015 and estimates the total annual cost savings. The low and high estimates for these total savings are $52,547,132 and $68,617,864 respectively. In addition to these reductions, CMs believes there are substantial cost savings accruing to eligible hospitals and EPs related to having additional time to achieve meaningful use.