SUMMARY

Centers for Medicare and Medicaid Services
Medicare and Medicaid
Electronic Health Record Incentive Programs—Stage 2
Final Rule CMS-0044-F

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Introduction

Division B-Title IV of The American Recovery and Reinvestment Act (ARRA) of 2009 establishes incentive payments to eligible professionals (EPs), eligible hospitals (EHs), Critical Access Hospitals (CAHs), and Medicare Advantage Organizations to promote the adoption and "meaningful use" of interoperable health information technology (HIT) and qualified electronic health records (EHRs). Beginning October 1, 2014 for inpatient services and January 1, 2015 for covered professional services, Medicare payment reductions will be taken if eligible providers have not adopted and become meaningful users of HIT and EHRs. These provisions, together with Division A- Title XIII of ARRA, are considered the "Health Information Technology for Economic and Clinical Health Act" (HITECH). The incentive program and potential payment reductions are part of a broader effort under HITECH to accelerate the adoption of HIT and utilization of EHRs.

On July 28, 2010, the Department of Health and Human Services (HHS) released two regulations required to implement provisions of HITECH: the Office of the National Coordinator for HIT (ONC) released the final rule for the *Initial Set of Standards, Implementation Specifications, and Certification Criteria for EHR Technology* and the Centers for Medicare and Medicaid Services (CMS) released the final rule for implementation of the Medicare and Medicaid EHR Incentive Program or what is colloquially referred to as *Stage 1 meaningful use*.

To receive incentive payments and avoid future Medicare payment penalties, an eligible provider must: 1) utilize CEHRT; 2) demonstrate "meaningful use" of CEHRT; and 3) report Clinical Quality Measures (CQMs) defined for the EHR Incentive Program. The ONC final rule of 2010 provides the initial set of specifications for CEHRT to ensure it is capable of supporting the achievement of Stage 1 meaningful use as defined under the CMS EHR Incentive Program final rule. CMS stated in the final rule its intention to evolve the definition of meaningful use (by raising measurement thresholds and introducing new requirements) through a Stage 2 final rule expected in mid-2012 and a subsequent Stage 3 final rule expected in 2014. ONC stated that specifications for CEHRT would also evolve to support the achievement of Stage 2 and Stage 3 meaningful use.

On September 4, 2012, the *Federal Register* posted the CMS *Medicare and Medicaid EHR Incentive Program–Stage 2* final rule and the ONC *HIT Standards, Implementation Specifications, and Certification Criteria for EHR Technology, 2014 Edition; Revisions to the Permanent Certification Program*. The ONC final rule outlines the capabilities required of CEHRT to support the demonstration of meaningful use beginning with the 2014 EHR reporting periods for all eligible providers (regardless of their Stage of meaningful use). This summary of the Medicare and Medicaid EHR Incentive Program—Stage 2 final rule generally follows the outline of the final rule.

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I. Executive Summary

A. Purpose of the Regulatory Action

The final rule issued by the Secretary of the Department of Health and Human Services (HHS), through CMS, specifies the Stage 2 criteria for EPs, eligible hospitals, and CAHs participating in the EHR Incentive Program. The rule introduces changes to the program timeline and details Medicare payment penalties for those eligible providers who do not demonstrate "meaningful use" of certified EHR technology (CERHT) (there are no payment penalties under Medicaid). ONC released a companion proposed rule that outlines the "2014 Edition" of standards and certification criteria required of EHR technology to support the attainment of meaningful use beginning with the 2014 EHR reporting periods.

B. Summary of the Major Provisions

1) Stage 2 Meaningful Use Objectives and Measures

CMS maintains the same core-menu structure for objectives that was introduced in Stage 1 meaningful use. Stage 2 requires EPs to meet 17 core objectives and three of six menu objectives and EHs/CAHs to meet 16 core objectives and three of six menu objectives (or qualify for exclusion). Nearly all Stage 1 core and menu objectives are retained for Stage 2 but some objectives have been combined. All Stage 1 menu objectives that are not combined with other objectives become part of the core set in Stage 2 with two exceptions. CMS finalized six new EP objectives (one core/five menu) and seven new eligible hospital/CAH objectives (two core/five menu). Two of the new menu set objectives that were finalized, were not included in the Stage 2 proposed rule: "provide structured electronic laboratory results to ambulatory providers (EH/CAH)" and "record electronic notes in patient records (EH/ CAH/ EP)." In total, EPs must attest to 20 objectives and EHs/CAHs attest to 19 objectives for Stage 2 (this marks an increase of one objective for EHs/CAHs over what had been outlined in the proposed rule).

CMS signals its intent that all Stage 2 menu objectives will be proposed as core objectives for Stage 3.

2) Reporting Clinical Quality Measures

CMS finalized a policy to include clinical quality measure reporting as part of the definition of" meaningful EHR user." Under the Stage 1 regulation, clinical quality measure reporting is an objective with an associated measure for a specific stage of meaningful use. In these latest regulations, CMS finalized CQMs for both EPs and EHs/CAHs outlined in section II.B. that will be reported by all eligible providers beginning in 2014 **regardless** of the eligible provider's stage of meaningful use.

CMS will require EPs to report nine CQMs from at least three of the National Quality Strategy domains out of a potential list of 64 CQMs across six domains (32 of the 44 CQMs finalized as part of the Stage 1 rule are included in the list of 64 CQMs)EHs/CAHs will be required to report 16 CQMs from at least three of the National Quality Strategy domains out of a potential list of 29 CQMs across six domains (all of the EH/CAH CQMs finalized as part of the Stage 1 rule are included in the list of 29 CQMs). CMS finalized fewer CQMs than proposed (12 CQMS from a menu of 125 for EPs and 24 from a menu of 49 for EHs).

Eligible providers in their first year of demonstrating meaningful use must submit their CQM data via attestation and those beyond their first year must submit their CQM data electronically via a CMS-designated transmission method beginning with the 2014 EHR reporting periods. See section II.B.5.c. (EPs) and section II.B.6.c. (EHs/CAHs) for electronic submission methods finalized in the Stage 2 rule.

3) Medicare Payment Penalties and Exceptions

Medicare payment penalties are required by statute to take effect in 2015 for EHs and EPs that fail to become meaningful users. For EPs, applicable payment penalties will be effective for the calendar year (CY) and for EHs and CAHs, applicable payment penalties will be effective for the federal fiscal year (FFY).

CMS finalized a process by which payment penalties will be determined by a prior EHR reporting period for EPs and EHs. For example, an EP/EH that demonstrates meaningful use in 2013 would avoid the payment penalty in 2015 as would any EP/EH that meets meaningful use, for the first time, in 2014 **if** they demonstrate meaningful use at least three months prior to the end of the CY (EP) or FFY (EH) and meet the registration and attestation requirement by October 1, 2014 (EP) or July 1, 2014 (EH). For CAHs and Medicare Advantage (MA) organizations the EHR reporting period for the penalty would be aligned with the penalty applicability year or what CMS refers to as the "payment adjustment year."

CMS finalized three hardship exception categories for EHs and CAHs based on: 1) insufficient Internet access; 2) a time-limited exception for new EHs/CAHs that would not otherwise be able to avoid payment penalties; and 3) extreme circumstances beyond the control of the EH/CAH.

CMS finalized five hardship exception categories for EPs based on: 1) insufficient Internet access; 2) a time-limited exception for newly practicing EPs who would not otherwise be able to avoid payment penalties; 4) lack of face-to-face or telemedicine interaction with patients and the lack of need for follow-up care; and 5) lack of control over availability of CEHRT for an EP practicing in multiple locations.

4) Modifications to the Medicaid EHR Incentive Program

CMS is expanding the definition of what constitutes a Medicaid patient encounter by including encounters for individuals enrolled in a Medicaid program, including Title XXI-funded Medicaid expansion encounters, but not separate Children's Health Insurance Programs (CHIP). Also finalized is flexibility in the look-back period for determining the Medicaid patient volume eligibility thresholds to be over the 12 months preceding attestation **in addition to** using the prior year. Medicaid encounter data are used to determine if an eligible provider meets certain Medicaid volume thresholds to participate in the Medicaid EHR Incentive Program.

CMS finalized the proposal to make eligible approximately 12 additional children's hospitals that have not been able to participate to date, despite meeting all other eligibility criteria, because they do not have a CMS Certification Number. Also finalized are clarifications regarding the Medicaid Hospital Incentive Payment Calculation.

5) Stage 2 Timeline Delay

In the Stage 1 final rule, CMS established that any provider that first attested to Stage 1 criteria for Medicare in 2011 would begin using Stage 2 criteria for purposes of demonstrating meaningful use in the 2013 EHR reporting periods—CY 2013 for EPs and FFY 2013 for EHs/CAHs). CMS finalized their proposal to delay the onset of Stage 2 criteria until 2014 for Medicare eligible providers who first attested in 2011. CMS is also introducing **a special three-month EHR reporting period, rather than a full year of reporting, for providers attesting to either Stage 1 or Stage 2 in 2014 to allow time for providers to implement the 2014 Edition of CEHRT**. CMS states in the preamble its commitment to ensure that Stage 3 occurs on schedule (implemented by 2016).

6) Changes to Stage 1 Meaningful Use Criteria

CMS finalizes changes to Stage 1 that would impact 11 Stage 1 objectives. Some changes are effective at the beginning of the Stage 1 reporting periods in 2013, others are optional for 2013. **All changes are required beginning in 2014 for providers demonstrating Stage 1 meaningful use**.

7) Cost and Benefits

The final rule is anticipated to have an annual effect on the economy of $100 million or more, making it an economically significant rule under the Executive Order and a major rule under the Congressional Review Act. Section V provides a summary of the CMS Regulatory Impact Analysis of the Stage 2 final rule.

8) Hospital-based Eligible Professionals

CMS finalized a new policy to allow hospital-based EPs to participate in the EHR Incentive Programs **if** they can demonstrate that the EP funds the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an EH or CAH and uses such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital/CAH's CEHRT). See section II.C.3.

II. Provisions of the Final Regulations

A. Definitions Across the Medicare and Medicaid Programs

1) Uniform Definitions

In the Stage 1 final rule, CMS finalized many uniform definitions for the Medicare and Medicaid EHR Incentive Programs and CMS is maintaining most of those definitions for concepts such as "Certified EHR Technology," "Qualified EHR," and "Payment Year." CMS notes that to the extent that ONC revises the definitions of "Certified EHR Technology" and "Qualified EHR," CMS will also incorporate those revisions.

CMS revises the definition of the "EHR reporting period (see section II.A.3.a.)," defines the "applicable EHR reporting period" for purposes for determining the payment adjustments (see section II.D.), and the definition of a "payment adjustment year (see section II.D.)."

2) Meaningful EHR User

CMS finalized the policy of including clinical quality measure reporting as part of the definition of "meaningful EHR user" instead of categorizing clinical quality measure reporting as a separate meaningful use objective for eligible providers. Under the Stage 1 regulation, clinical quality measure reporting is an objective that has an associated measure for a specific stage of meaningful use. CMS finalized that the clinical quality measures outlined in section II.B.5.b. for eligible providers and in section II.B.6.b. for EHs/CAHs will be reported by all eligible providers beginning in 2014 **regardless** of the eligible provider's stage of meaningful use.

CMS also finalizes a change to one part of the definition of "meaningful EHR user" for EPs. Under the Stage 1 final rule, one of the requirements for an EP to be considered a "meaningful EHR user" is that "at least 50 percent of an EP's patient encounters during the EHR reporting period during the payment year must occur at a practice/location or practices/locations equipped with certified EHR technology." CMS has modified the language of this requirement to read, "To be considered a meaningful EHR user, at least 50 percent of an EP's patient encounters during an EHR reporting period for a payment year (or during an applicable EHR reporting period for a payment penalty year) must occur at a practice/location or practices/locations equipped with Certified EHR Technology." The change is intended to include the payment penalty in the definition.

CMS also offers clarification about what it means for a practice/location to be equipped with CEHRT. CMS says this may be accomplished in three ways: 1) CEHRT could be permanently installed at the practice/location; or 2) the EP could bring CEHRT to the practice/location on a portable computing device; or 3) the EP could access CEHRT remotely using computing devices at the practice location. Under the current regulation, CMS allows an EP to create a record in a location not equipped with CEHRT as long as the EP later inputs that information into CEHRT at another location. CMS will not allow this practice beginning in 2013.

3) Definition of Meaningful Use

a. Considerations in Defining Meaningful Use and Changes to the Staging Timeline

In Stage 1 rulemaking, CMS laid out a phased approach to meaningful use whereby CMS updates the meaningful use criteria through staggered rulemaking. The following table outlines the goals CMS stated for meaningful use staging and the proposed rulemaking timeline for future stages. CMS has not precluded the potential for subsequent stages to be defined following Stage 3 rulemaking (e.g., Stage 4).

CMS' Stated Goals for Each Stage of Meaningful Use

Stage	Rulemaking Timeline	Focus of Meaningful Use Objectives
Stage 1	July 28, 2010	Focused on electronically capturing health information in a structured format; using that information to track key clinical conditions and communicating that information for care coordination purposes; implementing clinical decision support tools to facilitate disease and medication management; using EHRs to engage patients and families and reporting clinical quality measures and public health information.
Stage 2	September 4, 2012	Expand upon the Stage 1 criteria with a focus on ensuring that the meaningful use of EHRs supports the aims and priorities of the National Quality Strategy. Specifically, Stage 2 meaningful use criteria encourage the use of HIT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible. Rigorous expectations for health information exchange including: more demanding requirements for e-prescribing; incorporating structured laboratory results; and the expectation that providers will electronically transmit patient care summaries with each other and with the patient to support transitions in care. Increasingly robust expectations for health information exchange in Stage 2 and Stage 3 will support the goal that information follows the patient.
Stage 3	NPRM early 2014 Final Rule expected mid-2014	Criteria will focus on: promoting improvements in quality, safety, and efficiency leading to improved health outcomes; focusing on decision support for national high-priority conditions; patient access to self-management tools; access to comprehensive patient data through robust, secure, patient-centered health information exchange; and improving population health. CMS intends to propose that every objective in the menu set for Stage 2 be included in Stage 3 as part of the core set. As the capabilities of HIT infrastructure increase, CMS may raise the thresholds for these objectives in both Stage 2 and Stage 3.

CMS finalized a change in the timeline for when an eligible provider progresses through the stages of meaningful use. In the Stage 1 final rule, CMS published the following table, which illustrates the timeline for eligible providers and hospitals to move to the next stage of meaningful use criteria based on their first payment year:

Stage of Meaningful Use Criteria by Payment Year (finalized in 2010 Stage 1 rule)					
First Payment Year	Payment Year (FFY for EHs and CAHs/CY for EPs)				
	2011	2012	2013	2014	2015
2011	*Stage 1*	*Stage 1*	*Stage 2*	*Stage 2*	*TBD*
2012		*Stage 1*	*Stage 1*	*Stage 2*	*TBD*
2013			*Stage 1*	*Stage 1*	*TBD*
2014				*Stage 1*	*TBD*

In the Stage 2 final rule, CMS outlines a revised timeline for when an eligible provider would be expected to move to the next stage of meaningful use criteria determined by the provider's first payment year. Providers who first demonstrated meaningful use in 2011 will now have a one-year delay before being required to move to the Stage 2 meaningful use requirements in 2014. CMS has also finalized a three-month quarter EHR reporting period for Medicare and a continuous 90-day EHR reporting period for Medicaid EPs for 2014 for those providers in their first year of Stage 2 or their second year of Stage 1. Medicare eligible providers in their first year of demonstrating meaningful use may use any continuous 90-day EHR reporting period. The following table reflects the final policy:

Stage of Meaningful Use Criteria By First Payment Year (finalized in 2012 Stage 2 rule)											
First Payment Year	Payment Year (FFY for EHs and CAHs/CY for EPs)										
	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
2011	Stage 1	Stage 1	Stage 1	Stage 2*	Stage 2	Stage 3	Stage 3	TBD	TBD	TBD	TBD
2012		Stage 1	Stage 1	Stage 2*	Stage 2	Stage 3	Stage 3	TBD	TBD	TBD	TBD
2013			Stage 1	Stage 1*	Stage 2	Stage 2	Stage 3	Stage 3	TBD	TBD	TBD
2014				Stage 1*	Stage 1	Stage 2	Stage 2	Stage 3	Stage 3	TBD	TBD
2015					Stage 1	Stage 1	Stage 2	Stage 2	Stage 3	Stage 3	TBD
2016						Stage 1	Stage 1	Stage 2	Stage 2	Stage 3	Stage 3
2017							Stage 1	Stage 1	Stage 2	Stage 2	Stage 3

*Three-month quarter EHR reporting period for Medicare and continuous 90 day EHR reporting period (or three months at state option) for Medicaid EPs. All providers in their first year in 2014 use any continuous 90-day EHR reporting period.

CMS observes that the Medicare EHR incentive program and the Medicaid EHR incentive program have different rules regarding the number of payment years available, the last year for which incentives may be received, and the last payment year for initiating the program. Medicaid EPs, EHs, and CAHs can receive a Medicaid EHR incentive payment for "adopting, implementing, and upgrading" (AIU) to CEHRT in their first payment year, which is not reflected in the above table. For example, a Medicaid EP who earns an incentive payment for AIU in 2013 would have to meet Stage 1 of meaningful use in his or her next two payment years

(2014 and 2015). The applicable payment years and the incentive payments available for each program are discussed in the Stage 1 final rule.

See section II.D, which outlines the payment penalties for Medicare eligible hospitals, CAHs and EPs that do not demonstrate meaningful use during the applicable EHR reporting period for purposes of the payment penalty. Medicaid will not assess payment penalties for eligible providers who do not demonstrate meaningful use of CEHRT.

b. Changes to Stage 1 Criteria for Meaningful Use

In addition to finalizing criteria for Stage 2 meaningful use, **CMS finalized changes to the existing Stage 1 meaningful use criteria.** Some of the changes are effective beginning with the 2013 Stage 1 EHR reporting periods, but most are optional for Stage 1 in 2013 and then become required for Stage 1 in 2014 and subsequent years. Note: EHs and CAHs follow the FFY for reporting and EPs follow the CY and those demonstrating meaningful use for the first time would need to do so for only 90 continuous days during the FFY/CY.

Stage 1 Changes		
Stage 1 Objective	**Finalized Changes**	**Effective Year (CY/FFY)**
Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines.	*Change: Addition of an alternative measure* More than 30% of medication orders created by the EP or authorized providers of the EH's or CAH's inpatient or emergency department—place of service (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	2013 – Onward (Optional)
Generate and transmit permissible prescriptions electronically (eRx)	*Change: Addition of an additional exclusion* Any EP who: does not have a pharmacy within his/her organization and there are no pharmacies that accept electronic prescriptions within ten miles of the EP's practice location at the start of his/her EHR reporting period.	2013 – Onward (Required)
Record and chart changes in vital signs	*Change: Addition of alternative age limitations* More than 50% of all unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age three and over only) and height and weight (for all ages) recorded as structured data.	2013 - Only (Optional)

Stage 1 Changes		
Stage 1 Objective	**Finalized Changes**	**Effective Year (CY/FFY)**
Record and chart changes in vital signs	*Change: Addition of alternative exclusions* Any EP who (1) sees no patients three years or older is excluded from recording blood pressure; (2) believes that all three vital signs of height, weight, and blood pressure have no relevance to his/her scope of practice is excluded from recording them; (3) believes that height and weight are relevant to his/her scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (4) believes that blood pressure is relevant to his/her scope of practice, but height and weight are not, is excluded from recording height and weight.	2013 – Only (Optional)
Record and chart changes in vital signs	*Change: Age limitations on growth charts and blood pressure* More than 50% of all unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age three and over only) and height and weight (for all ages) recorded as structured data.	2014 – Onward (Required)
Record and chart changes in vital signs	*Change: Changing the age and splitting the EP exclusion* Any EP who (1) sees no patients three years or older is excluded from recording blood pressure; (2) believes that all three vital signs of height, weight, and blood pressure have no relevance to his/her scope of practice is excluded from recording them; (3) believes that height and weight are relevant to his/her scope of practice, but blood pressure is not, is excluded from recording blood pressure; or (4) believes that blood pressure is relevant to his/her scope of practice, but height and weight are not, is excluded from recording height and weight.	2014 – Onward (Required)
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	*Change: Objective is no longer required, from 2013 forward.*	2013 – Onward (No Longer Required)
Report ambulatory (hospital) clinical quality measures to CMS or the states.	*Change: Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective under 42 CFR 495.6.*	2013 – Onward (Required)

Stage 1 Changes		
Stage 1 Objective	**Finalized Changes**	**Effective Year (CY/FFY)**
EP & Hospital Objectives: Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request. Hospital Objective: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request. EP Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within four business days of the information being available to the EP.	*Change: Replace these four objectives with the Stage 2 objective and one of the two Stage 2 measures* EP Objective: Provide patients the ability to view online, download, and transmit their health information within four business days of the information being available to the EP. EP Measure: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within four 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. Hospital Objective: Provide patients the ability to view online, download, and transmit information about a hospital admission. Hospital Measure: 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.	2014 – Onward (Required)
Public Health Objectives:	Change: Addition of "except where prohibited" to the objective regulation text for the public health objectives under 42 CFR 495.6.	2013 – Onward (Required)
Stage 1 Policy Change		
Meeting an exclusion for a menu set objective counts towards the number of menu set objectives that must be satisfied to meet meaningful use.	Meeting an exclusion for a menu set objective does not count toward the number of menu set objectives that must be satisfied to meet meaningful use.	2014- Onward (Required)

c. State Flexibility for Stage 2 of Meaningful Use (e.g., Public Health Reporting)

Under the Medicaid EHR Incentive Program, CMS will continue its policy of offering states flexibility for certain meaningful use objectives subject to the same conditions and standards as outlined in the July 2010 final rule (e.g., states currently have the option to make Stage 1 public health objectives "core" under the Medicaid EHR Incentive Program). This applies to the public health measures as well as the measure to "generate lists of specific conditions to use for quality improvement, reduction of disparities, research or outreach."

CMS will also allow states to specify the means of transmission of the data or otherwise change the public health measure, as long as it does not require EHR functionality above and beyond that which is included in the ONC "2014 Edition" of CEHRT final rule.

d. Stage 2 Criteria for Meaningful Use (Core Set and Menu Set)

CMS finalized the same core-menu structure for objectives that was introduced in Stage 1 meaningful use. Stage 2 requires EPs to meet 17 core objectives and three of six menu objectives and EHs/CAHs to meet 16 core objectives and three of six menu objectives (or qualify for exclusion). Two of the new menu set objectives that were finalized were not included in the Stage 2 proposed rule: "provide structured electronic laboratory results to ambulatory providers (EH/CAH)" and "record electronic notes in patient records (EH/CAH/EP)." In total, EPs must attest to 20 objectives and EHs/CAHs attest to 19 objectives for Stage 2 (this marks an increase of one objective for EHs/CAHs over what had been outlined in the proposed rule).

Nearly all Stage 1 core and menu objectives are retained for Stage 2 but some objectives have been combined. For example, the "exchange of key clinical information" core objective from Stage 1 has been re-evaluated and incorporated into the "transitions of care" core objective in Stage 2, and the "provide patients with an electronic copy of their health information" objective is replaced by an "electronic/online access" core objective (see section II.A.3.b. which outlines changes to these objectives that are effective for eligible providers demonstrating Stage 1 meaningful use beginning in 2013/ 2014).

The Stage 1 recording objectives, "maintain problem list," "maintain active medication list," and "maintain active medication allergy list" have all been incorporated into the "provide summary care record" objective (as they are required fields in the summary care document).

All Stage 1 menu objectives become part of the core set in Stage 2 with two exceptions. For EPs, CMS has retained "capability to submit electronic syndrome surveillance data to public health agencies" in the menu set for Stage 2 due to readiness of states to receive this information and for EHs/CAHs, CMS has kept "record advance directive" in the menu set due to potential conflicts between storing advance directives and existing state laws.

CMS finalized six new EP objectives (1 core/5 menu):

- use secure messaging to communicate with patients on relevant health information (core);
- imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT (menu);
- record patient family health history as structured data (menu);
- capability to identify and report cancer cases to a public health central cancer registry (menu);
- capability to identify and report specific cases to a specialized registry (menu); and
- record electronic notes in patient records (menu).

CMS finalized seven new EH/CAH objectives (2 core/5 menu):

- provide patients the ability to view online, download, and transmit information about a hospital admission (core);

- automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (core);
- imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT (menu);
- record patient family health history as structured data (menu);
- generate and transmit permissible discharge prescriptions electronically (menu);
- provide structured electronic laboratory results to ambulatory providers (menu); and
- record electronic notes in patient records (menu).

CMS signals in the final rule that it intends to make all menu objectives finalized in Stage 2 core objectives for Stage 3.

Stage 2 Measurement Approach for the percentage based measures: CMS finalized a policy to limit the number of denominator "populations" on which EPs and EHs/CAHs must report.

For EPs the denominators are: 1) unique patients seen by the EP during the EHR reporting period (stratified by age or previous office visit); 2) number of orders (medication, laboratory, radiology); 3) office visits; and 4) transitions of care/referrals.

For EHs/CAHs, the denominators are: 1) unique patients admitted to the EHs/CAHs inpatient or emergency department during the EHR reporting period (stratified by age); 2) number of orders (medication, laboratory, radiology); 3) electronic laboratory orders received by the hospital from ambulatory providers; and 4) transitions of care.

Under the current Stage 1 regulation, CMS allows eligible providers to limit the denominators of certain measures (e.g., "record smoking status") to only those patients whose records **are maintained using CEHRT**. For Stage 2, CMS will maintain the distinction between measures that include only those patients whose records are maintained using CEHRT and measures that include all unique patients. Providers may limit the denominator to those patients whose records are maintained using CEHRT for measures **with a denominator other than** "unique patients seen by the EP during the EHR reporting period" or "unique patients admitted to the EH's or CAHs inpatient or emergency department during the EHR reporting period."

CMS defines "unique patient" for purposes of calculating the meaningful use measures: The term "unique patient" means that if a patient is seen or admitted more than once during the EHR reporting period, the patient only counts once in the denominator. Patients seen or admitted only once during the EHR reporting period will count once in the denominator. A patient is "seen by the EP" when the EP has an actual physical or telemedicine encounter with the patient in which they render any service to the patient. In cases where the EP and the patient do not have an actual physical or telemedicine encounter, but the EP renders a minimal consultative service for the patient (like reading an EKG), the EP may choose whether to include the patient in the denominator as "seen by the EP" provided the choice is consistent for the entire EHR reporting period and for all relevant meaningful use measures.

For example, a cardiologist may choose to exclude patients for whom they provide a one-time reading of an EKG sent to them from another provider, but include more involved consultative services as long as the policy is consistent for the entire EHR reporting period and for all meaningful use measures that include

patients ”seen by the EP.” EPs who never have a physical or telemedicine interaction with patients must adopt a policy that classifies at least some of the services they render for patients as ”seen by the EP,” and this policy must be consistent for the entire EHR reporting period and across meaningful use measures that involve patients ”seen by the EP.”

In cases where the patient is seen by a member of the EP's clinical staff the EP can include or not include those patients in the denominator at his/her discretion as long as the decision applies universally to all patients for the entire EHR reporting period and the EP is consistent across meaningful use measures. In cases where a member of the EP's clinical staff is eligible for the Medicaid EHR incentive in his/her own right (e.g., nurse practitioners[NP,]), patients seen by NPs under the EP's supervision can be counted by both the NP and the supervising EP as long as the policy is consistent for the entire EHR reporting period.

CMS also finalized a policy that will give EPs who practice at multiple locations and eligible providers (EPs/EHs/CAHs) who switch CEHRT during the EHR reporting period some flexibility as to the method for counting unique patients in the denominators. For EPs who practice in multiple locations, the EP may count a unique patient across all locations equipped with different CEHRT (e.g., one patient seen at three locations with different CEHRT counts once) or at each location equipped with CEHRT (e.g., one patient seen at three locations would count thrice). In cases where an eligible provider switches certified EHR technology products at a single location during the EHR reporting period, the provider will have the flexibility to count a patient as unique on each side of the conversion and not across it (e.g., one patient seen before the conversion and after the conversion to new CEHRT could be counted once or twice). Eligible providers in these scenarios must choose one of these methods for counting unique patients and apply it consistently throughout the entire EHR reporting period.

CMS defines “office visit” for purposes of calculating the meaningful use measures: Office visit is defined as any billable visit that includes: 1) concurrent care or transfer of care visits; 2) consultant visits; or 3) prolonged physician service without direct, face-to-face patient contact (e.g., telehealth). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider. The visit does not have to be individually billable in instances where multiple visits occur under one global fee.

CMS defines “transitions of care” for purposes of calculating the meaningful use measures: For an EP who is on the receiving end of a transition of care or referral, the denominator includes first encounters with a new patient and encounters with existing patients where a summary of care record (of any type) is provided to the receiving provider. The summary of care record may be provided either by the patient or by the referring/transitioning provider or institution. For an EP who is initiating a patient transfer to another setting and/or referring a patient to another provider, the initiating/referring EP would count the transitions and/or referrals that were ordered by the EP in the measure denominator. If another provider also sees the same patient, only the EP who orders the transition/referral would need to account for this transition for the purpose of this measure. EPs are not responsible for including patient-initiated transitions and referrals that were not ordered by the EP.

An EH/CAH that is on the receiving end of a transition/referral of care, should include all admissions to the inpatient and emergency departments. For transitions of care when the hospital is transitioning the patient,

all discharges from the inpatient department and after admissions to the emergency department when follow-up care is ordered by an authorized provider of the hospital should be included.

CMS emphasizes that the transition of care and referral events described in the final rule definition are the minimum requirements: an eligible provider may include in the denominator transitions of care and referrals that fit the broader descriptions of these terms, but are not one of the specific events described in the minimum definition.

CMS defines "electronic laboratory orders received by the hospital from ambulatory providers" for purposes of calculating the meaningful use measures: For the order to be considered "received electronically", it must be received by the hospital utilizing an electronic transmission method and not through methods such as physical electronic media, electronic fax, paper document or telephone call.

4) Relationship of Meaningful Use to Certified EHR Technology

In Stage 2, CMS has continued the policy of linking each meaningful use objective to certification criteria as defined by ONC in the *HIT Standards, Implementation Specifications, and Certification Criteria for EHR Technology, 2014 Edition; Revisions to the Permanent Certification Program* final rule. As with Stage 1, EPs, EHs, and CAHs must use the capabilities and standards that are certified to meet the objectives and associated measures for Stage 2 meaningful use.

5) Relationship Between Stage 2 Meaningful Use Objective and its Associated Measure

CMS carries forward the Stage 1 policy that "regardless of any actual or perceived gaps between the measure of an objective and full compliance with the objective…meeting the criteria of the measure means that the provider has met the objective for Stage 2."

6) Stage 2 Meaningful Use Objectives and Measures

The following tables, titled, "**Stage 2 Meaningful Use Criteria for Eligible Professionals**," and "**Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals**" list the core and menu objectives, measures, and exclusions finalized by CMS.

Comparison of Stage 1 and Stage 2 Criteria: See Appendix A for a "Comparison of Stage 1 and Stage 2 Meaningful Use Criteria—Eligible Professionals," and Appendix B for a "Comparison of Stage 1 and Stage 2 Meaningful Use Criteria—Eligible Hospitals and Critical Access Hospitals."

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p53985-53989)	**Use CPOE for medication, laboratory, and radiology orders** directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines. (An EP through a combination of meeting the thresholds and/or exclusions must satisfy all three measures for this objective.)	**> 60%** of medication orders created by the EP during the EHR reporting period are recorded using CPOE.	**Numerator:** number of orders in the denominator recorded using CPOE. **Denominator:** number of medication, orders created by the EP during the EHR reporting period.[1]	An EP who writes fewer than 100 medication orders during the EHR reporting period.
		> 30% of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE.	**Numerator:** number of orders in the denominator recorded using CPOE. **Denominator:** number of laboratory orders created by the EP during the EHR reporting period.[1]	An EP who writes fewer than 100 laboratory orders during the EHR reporting period.
		>30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	**Numerator:** number of orders in the denominator recorded using CPOE. **Denominator:** number of radiology orders created by the EP during the EHR reporting period.[1]	An EP who writes fewer than 100 radiology orders during the EHR reporting period.
CORE (p53989-53990)	**Generate and transmit permissible prescriptions electronically** (eRx)	**> 50%** of all permissible prescriptions, or all prescriptions written by the EP and queried for a drug formulary and transmitted electronically using CEHRT.	**Numerator:** number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT. **Denominator:** number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.	An EP who 1) writes fewer than 100 prescriptions during the EHR reporting period; or 2) does not have a pharmacy within his/her organization and there are no pharmacies that accept electronic prescriptions within ten miles of the EP's practice location at the start of the EHR reporting period.

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p53991-53993)	**Record all of the following demographics:** (A) preferred language, (B) sex, (C) race, (D) ethnicity, (E) date of birth.	**> 80%** of all unique patients seen by the EP during the EHR reporting period have demographics recorded as structured data.	**Numerator:** number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data. **Denominator:** number of unique patients seen by the EP during the EHR reporting period.	If a patient declines to provide one or more demographic elements this can be noted in the CEHRT and the EP may still count the patient in the numerator for this measure. The required elements and standards for recording demographics and noting omissions because of state law restrictions or patients declining to provide information will be discussed in the ONC standards and certification rule.
CORE (p53993-53994)	**Record and Chart Changes in the following Vital Signs:** (A) height/length, (B) weight, (C) blood pressure (ages 3+), (D) calculate and display BMI, (E) plot and display growth charts for patients 0 - 20 years, including BMI.	**> 80%** of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age three and over only) and height/length and weight (for all ages) recorded as structured data.	**Numerator:** number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and blood pressure (ages three and over) recorded as structure data. **Denominator:** number of unique patients seen by the EP during the EHR reporting period.	An EP who 1) sees no patients three years or older is excluded from recording blood pressure; or 2) believes that all three vital signs of height/length, weight, and blood pressure have no relevance to his/her scope of practice; or 3) believes that height/length and weight are relevant to his/her scope of practice, but blood pressure is not, is excluded from recording blood pressure; or 4) believes blood pressure is relevant to his/her scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.
CORE (p53994-53995)	**Record smoking status** for patients 13 years or older.	**> 80%** of all unique patients 13 years old or older seen by the EP during the EHR reporting period have smoking status recorded as structured data.	**Numerator:** number of patients in the denominator with smoking status recorded as structured data. **Denominator:** number of unique patients age 13 or older seen by the EP during the EHR reporting period.	An EP who sees no patients 13 years or older.

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p53995-53998)	Use **clinical decision support** to improve performance on high-priority health conditions. (An EP must satisfy both measures for this objective.)	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 CQMs related to an EP'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 health care efficiency.	Yes/no attestation measure.	For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.
		The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.		
CORE (p54003-54004)	Incorporate **Clinical Lab-Test Results** into CEHRT as structured data.	**> 55%** of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in CEHRT as structured data.	**Numerator:** number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated into CEHRT as structured data.	An EP who orders no lab tests whose results are either in a positive/negative affirmation or numeric format during the EHR reporting period.
			Denominator: number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.	
CORE (p54004-54005)	**Generate Lists of Patients by Specific Conditions** to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition.	Yes/no attestation measure.	None

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54007-54011)	Enable patients to **view online, download, and transmit their health information** within four business days of the information being available to the EP. (EP must satisfy both measures in order to meet the objective.)	**> 50%** of all unique patients seen by the EP during the EHR reporting period are provided timely (within four 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.	**Numerator:** number of patients in the denominator who have timely (within four business days after the information is available to the EP) online access to their health information. **Denominator:** number of unique patients seen by the EP during the EHR reporting period.	1) An EP who neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and "Provider's name and office contact information," may exclude both measures. 2) An EP that conducts 50% or greater of his or her patient encounters in a county that does not have 50% or greater of its housing units with 3Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period **may exclude only the second measure.**
		> 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.	**Numerator:** number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information. **Denominator:** number of unique patients seen by the EP during the EHR reporting period.	
CORE (p54005-54007)	Use clinically relevant information to **identify patients who should receive reminders** for preventive/ follow-up care and send these patients the reminder, per patient preference.	**> 10%** of all unique patients who have had two or more office visits with the EP within the 24 months prior to the beginning of the EHR reporting period were sent a reminder, per patient preference when available.	**Numerator:** number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period. **Denominator:** number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR reporting period.	An EP who has had no office visits in the 24 months before the EHR reporting period.
CORE (p53998-54002)	Provide **clinical summaries** for patients for each office visit.	Clinical summaries provided to patients within one business day for **> 50%** of office visits.	**Numerator:** number of office visits in the denominator where the patient or a patient-authorized representative is provided a clinical summary of their visit within one business day. **Denominator:** number of office visits conducted by the EP during the EHR reporting period	An EP who has no office visits during the EHR reporting period.

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54011-54012)	Use clinically relevant information from CEHRT to **identify Patient-Specific Education Resources** and provide those resources to the patient.	Patient-specific education resources identified by CEHRT are provided to patients for **> 10%** of all unique patients with office visits seen by the EP during the EHR reporting period.	**Numerator:** number of patients in the denominator who were provided patient-specific education resources identified by CEHRT. **Denominator:** number of unique patients with office visits seen by the EP during the EHR reporting period.	An EP who had no office visits during the EHR reporting period.
CORE (p54031-54033)	Use **secure electronic messaging** to communicate with patients on relevant health information.	A secure message was sent using the electronic messaging function of CEHRT by **> 5%** of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.	**Numerator**: number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period. **Denominator:** number of unique patients seen by the EP during the EHR reporting period.	An EP who has no office visits during the EHR reporting period or any EP who conducts 50% or more of his/her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the latest information available from FCC on the first day of the EHR reporting period.
CORE (p54012-54013)	EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should **perform medication reconciliation.**	The EP performs medication reconciliation for **> 50%** of transitions of care in which the patient is transitioned into the care of the EP.	**Numerator:** number of transitions of care in the denominator where medication reconciliation was performed. **Denominator:** number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.	An EP who was not the recipient of any transitions of care during the EHR reporting period.

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54013-54021)	EP who transitions his/her patient to another setting of care or provider of care or refers his/her patient to another provider of care provides a summary care record for each transition of care or referral. (EP must satisfy all three measures in order to meet the objective.)	EP who transitions or refers patient to another setting of care or provider of care provides a summary of care record for **> 50%** of transitions of care and referrals.	**Numerator:** number of transitions of care and referrals in the denominator where a summary of care record was provided.	An EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures
			Denominator: number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.	
		EP that transitions or refers patient to another setting of care or provider of care provides a summary of care record for **>10%** of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a Nationwide Health Information Network Exchange (NwHIN) participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.	**Numerator:** number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third party or the sender's own organization.	
			Denominator: number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.	
		An EP must satisfy one of the two following criteria: (A) Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at 495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.31(b)(2); or (B) Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.	Yes/ no attestation measure.	

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54022-54023)	Capability to **Submit Electronic Data to Immunization Registries or Immunization Information Systems** except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.	Yes/no attestation measure.	An EP who meets one or more of the following criteria: 1) the EP does not administer any of the immunizations to any of the populations for which data are collected by his/her jurisdiction's immunization registry or immunization information system during the EHR reporting period; or 2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of the EHR reporting period; or 3) EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or 4) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of his/her EHR reporting can enroll additional EPs. The second exclusion will not apply if an entity designated by the immunization registry or immunization information system can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by CEHRT, but it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54002-54003)	**Protect electronic health information** created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	EP must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 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 provider's risk management process	Yes/no attestation measure.	None
MENU (p54026-54028)	**Imaging results** consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	**> 10%** of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.	**Numerator:** number of results in the denominator that are accessible through CEHRT. **Denominator:** number of tests whose result is one or more images ordered by the EP during the EHR reporting period.	Any EP who orders less than 100 tests whose result is an image during the EHR technology period or An EP who has no access to electronic imaging results at the start of the EHR reporting period.
MENU (p54028-54029)	**Record patient family history** as structured data.	**> 20%** of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.	**Numerator:** number of patients in the denominator with a structured data entry for one or more first-degree relatives. **Denominator:** number of unique patients seen by the EP during the EHR reporting period.	An EP who has no office visits during the EHR reporting period.
MENU (p54043-54044)	Record electronic notes in patient records.	Enter at least one electronic progress note created, edited, and signed by an EP for **>30%** of unique patients with at least one office visit during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with searchable text notes under this measure.	**Numerator:** The number of unique patients in the denominator who have at least one electronic progress note from an EP recorded as text-searchable data. **Denominator:** Number of unique patients with at least one office visit during the EHR reporting period.	None

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
MENU (p54024-54026)	Capability to **Submit Electronic Syndromic Surveillance Data to Public Health Agencies**, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.	Yes/no attestation measure.	An EP that meets one or more of the following criteria: 1) the EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patient during the EHR reporting period; or 2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required for CEHRT at the start of their EHR reporting period; or 3) the EP operates in a jurisdiction where no public health agency provides information timely on the capability to receive syndromic surveillance data or 4) the EP operates in a jurisdiction for which no public health agency is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period. Note: exclusions 2 and 3 do not apply if the public health agency has designated a health information exchange (HIE) or other intermediary to collect this information on its behalf and that the HIE can do so in the specific Stage 2 standards.
MENU (p54029-54030)	Capability to **identify and report cancer cases to a public health central cancer registry**, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of cancer case information from CEHRT to a cancer registry for the entire EHR reporting period.	Yes/no attestation measure.	An EP that meets at least one of the following criteria: 1) the EP does not diagnose or directly treat cancer; or 2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required under Stage 2 at the beginning on the EHR reporting period; or 3) the EP operates in a jurisdiction where no public health agency (PHA) provides information timely on capability to receive electronic cancer case information; 4) the EP operates in a jurisdiction for which no PHA that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period can enroll additional EPs.

Stage 2 Meaningful Use Criteria for Eligible Professionals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
MENU (p54030-54031)	Capability to **identify and report specific cases to a specialized registry** (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.	Yes/no attestation measure.	An EP that meets at least one of the following criteria: 1) the EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction; or 2) the EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of the EHR reporting period; 3) the EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their specialized registries; or 4) the EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional EPs.

Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p53985-53989)	**Use CPOE for medication, laboratory, and radiology orders** directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines. (An eligible hospital/CAH must satisfy all three measures for this objective.)	**> than 60%** of medication orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	**Numerator:** number of orders in the denominator recorded using CPOE. **Denominator:** number of medication orders created by authorized providers in the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.[1]	None
		> than 30% of laboratory orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	**Numerator:** number of orders in the denominator recorded using CPOE. **Denominator:** number of laboratory orders created by authorized providers in the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.[1]	None
		> than 30% of radiology orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	**Numerator:** number of orders in the denominator recorded using CPOE. **Denominator:** number of radiology orders created by authorized providers in the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.[1]	None
CORE (p53991-53993)	**Record all of the following demographics:** (A) preferred language, (B) sex, (C) race, (D) ethnicity, (E) date of birth (F) date and preliminary cause of death in the event of mortality in the EH or CAH.	**> 80%** of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.	**Numerator:** number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data. **Denominator:** number of unique patients admitted to an EH's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	Note: If a patient declines to provide one or more demographic elements this can be noted in the CEHRT and the EP may still count the patient in the numerator for this measure. The required elements and standards for recording demographics and noting omissions because of state law restrictions or patients declining to provide information will be discussed in the ONC standards and certification rule.

Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p53993-53994)	**Record and chart changes in the following vital signs:** (A) height/length, (B) weight, (C) blood pressure (ages 3+), (D) calculate and display BMI, (E) plot and display growth charts for patients 0 - 20 years, including BMI.	**> 80%** of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age three and over only) and height/length and weight (for all ages) recorded as structured data.	**Numerator:** number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and blood pressure (ages three and over) recorded as structure data. **Denominator:** number of unique patients admitted to EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	none
CORE (p53994-53995)	**Record smoking status** for patients age 13 years or older.	**> 80%** of all unique patients 13 years old or older admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data.	**Numerator:** number of patients in the denominator with smoking status recorded as structured data. **Denominator:** number of unique patients age 13 or older admitted to EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	An EH or CAH that admits no patients age 13 years or Older.
CORE (p53995-53998)	Use **clinical decision support** to improve performance on high-priority health conditions. (EH or CAH must satisfy both measures to meet the objective.)	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 CQMs related to an EH 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 health care efficiency. Enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	Yes/no attestation measure.	None

Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54003-54004)	Incorporate **clinical lab test results** into CEHRT as structured data.	**> 55%** of all clinical lab test results ordered by authorized providers of the EH or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in CEHRT as structured data.	**Numerator:** number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated into CEHRT as structured data. **Denominator:** number of lab tests ordered during the EHR reporting period by authorized providers of EH's or CAH's for patients admitted to its inpatient or emergency department (POS 21 or 23) whose results are expressed in a positive or negative affirmation or as a number.	None
CORE (p54004-54005)	**Generate lists of patients by specific conditions** to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EH or CAH with a specific condition.	Yes/no attestation measure.	None
CORE (p54033-54035)	Automatically track medications from order to administration using assistive technologies in conjunction with an **electronic medication administration record** (eMAR).	**> 10%** of medication orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are tracked using eMAR.	**Numerator:** number of orders in the denominator for which all doses are tracked using eMAR. **Denominator:** number of medication orders created by authorized providers in the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	Any hospital with an average daily inpatient census of fewer than ten patients.

Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54036-54040)	Provide patients the ability to **view online, download, and transmit information about a hospital admission.** (EH or CAH must satisfy both measures in order to meet the objective.)	**> 50%** of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH have their information available online within 36 hours of discharge.	**Numerator:** number of patients in the denominator whose information is available online within 36 hours of discharge. **Denominator**: number of unique patients discharged from an EH's or CAH's inpatient or emergency department (POS 21 or23) during the EHR reporting period.	An EH or CAH will be excluded from the second measure if it is located in a county that does not have 50% or more of their housing units with 3Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period.
		> 5% of all patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH view, download or transmit to a third party their information during the EHR reporting period.	**Numerator:** number of patients (or their authorized representatives) in the denominator who view, download, or transmit to a third party the information provided by the EH or CAH online during the EHR reporting period. **Denominator:** number of unique patients discharged from an EH's or CAH's inpatient or emergency department (POS 21 or23) during the EHR reporting period.	
CORE (p54011-54012)	Use CEHRT to **identify patient-specific education resources** and provide those resources to the patient.	**> 10%** of all unique patients admitted to the EH's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources identified by CEHRT.	**Numerator:** number of patients in the denominator who are subsequently provided patient-specific education resources identified by CEHRT. **Denominator:** number of unique patients admitted to the EH's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	None
CORE (p54012-54013)	EH or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should **perform medication reconciliation.**	Medication reconciliation is performed for >**50%** of transitions of care in which the patient is admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23).	**Numerator:** number of transitions of care in the denominator where medication reconciliation was performed. **Denominator:** number of transitions of care during the EHR reporting period for which an EH's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.	None

Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54013-54021)	EH or CAH who transitions a patient to another setting of care or provider of care or refers a patient to another provider of care **provides a summary care record for each transition of care or referral.** (EH or CAH must satisfy all three measures in order to meet the objective.)	EH or CAH that transitions or refers a patient to another setting of care or provider of care provides a summary of care record for **> 50%** of transitions of care and referrals.	**Numerator:** number of transitions of care and referrals in the denominator where a summary of care record was provided. **Denominator:** number of transitions of care and referrals during the EHR reporting period for which the EH's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.	None
		EH or CAH that transitions or refers a patient to another setting of care or provider of care provides a summary of care record for **>10%** of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.	**Numerator:** number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization. **Denominator:** number of transitions of care and referrals during the EHR reporting period for which the EH's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.	
		An EH or CAH must satisfy one of the two following criteria: (A) Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EH and CAHs the measure at 495.6(1)(11(ii)(B) with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or (B) Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.	Yes/ no attestation measure.	

Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54022-54023)	Capability to **submit electronic data to immunization registries or immunization information systems** except where prohibited, and in according to applicable law and practice.	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.	Yes/no attestation measure	An EH or CAH that meets one or more of the following criteria: 1) the EH or CAH does not administer any of the immunizations to any of the populations for which data are collected by the jurisdiction's immunization registry or immunization information system during the EHR reporting period; or 2) the EH or CAH operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of the EHR reporting period; or 3) EH or CAH operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or 4) the EH or CAH operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required by CEHRT at the start of the EHR reporting period can enroll additional EHs or CAHs. The second exclusion will not apply if an entity designated by the immunization registry or immunization information system can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by CEHRT, but if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
CORE (p54023-54024)	Capability to **submit electronic reportable laboratory results to public health agencies**, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic reportable lab results from CEHRT to public health agencies for the entire EHR reporting period.	Yes/no attestation measure.	The EH or CAH that meets one or more of the following criteria: 1) operates in a jurisdiction for which no public health agency is capable of receiving electronic reportable laboratory results in the specific standards required for CEHRT at the start of the EHR reporting period; 2) operates in a jurisdiction where no public health agency provides information timely on capability to receive electronic laboratory results; or 3) the EH or CAH operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EHs or CAHs.

Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
CORE (p54024-54026)	Capability to **submit electronic syndromic surveillance data to public health agencies**, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.	Yes/no attestation measure.	An EH or CAH that meets one or more of the following criteria: 1) the EH or CAH does not have an emergency or urgent care department; or 2) the EH or CAH operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required for CEHRT at the start of their EHR reporting period; or 3) the EH or CAH operates in a jurisdiction where no public health agency provides information timely on the capability to receive syndromic surveillance data or 4) the EH or CAH operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period. Note: exclusions 2 and 3 do not apply if the public health agency has designated a health information exchange (HIE) or other intermediary to collect this information on its behalf and that the intermediary can do so in the specific Stage 2 standards and/or the same standard as the provider's CEHRT. An urgent care department delivers ambulatory care, usually on an unscheduled, walk-in basis, in a facility dedicated to the delivery of medical care, but not classified as a hospital emergency department. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency department, which will be open at all times.
CORE (p54002-54003)	**Protect electronic health information** created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	EH or CAH must conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 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 provider's risk management process.	Yes/no attestation measure.	None

Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
MENU (p54040-54041)	Record whether a patient age 65 years or older has an **advance directive.**	**> 50%** of all unique patients 65 or older admitted to the EH's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.	**Numerator:** the number of patients in the denominator who have an indication of an advance directive status entered using structured data. **Denominator:** the number of unique patients age 65 or older admitted to an EHs or CAH's inpatient department (POS 21) during the EHR reporting period.	An EH or CAH that admits no patients age 65 years old or older during the EHR reporting period.
MENU (p54026-54028)	**Imaging results** consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT	**> 10%** of all tests whose result is one or more images ordered by an authorized provider of the EH or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period are accessible through CEHRT	**Numerator:** the number of results in the denominator that are accessible through CEHRT. **Denominator:** number of tests whose result is one or more images ordered by an authorized provider on behalf of the EH or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	None
MENU (p54028-54029)	**Record patient family history** as structured data.	**> 20%** of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives.	**Numerator:** number of patients in the denominator with a structured data entry for one or more first-degree relatives. **Denominator:** number of unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	None

Stage 2 Meaningful Use Criteria for Eligible Hospitals and Critical Access Hospitals (Pages noted under core/menu refer to the final rule discussion of the objective.)				
Type	**Stage 2 Objective**	**Stage 2 Measure(s)**	**Measurement Approach**	**Objective Exclusion(s)**
MENU (p54035-54036)	**Generate and transmit permissible discharge prescriptions electronically** (eRx).	**> 10%** of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.	**Numerator:** the number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically. **Denominator:** the number of new, changed or refilled prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances for patients discharged during the EHR reporting period.	Any EH or CAH that does not have an internal pharmacy that can accept electronic prescriptions and is not located within ten miles of any pharmacy that accepts electronic prescriptions at the start of its EHR reporting period.
MENU (p54043-54044)	Record **electronic notes** in patient records.	Enter at least one electronic progress note created, edited and signed by an authorized provider of the EH's or CAH's inpatient or emergency department (POS 21 or 23) for **>30%** of unique patients admitted to the EH or CAH's inpatient or emergency department during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with searchable text notes under this measure.	**Numerator:** The number of unique patients in the denominator who have at least one electronic progress note from an authorized provider of the EH or CAH inpatient or emergency department (POS 21 or 23) recorded as text-searchable data. **Denominator:** Number of unique patients admitted to an EH or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	None
MENU (p54041-54043	Provide structured electronic lab results to ambulatory providers.	Hospital labs send structured electronic clinical lab results to the ordering provider for **>20%** of electronic lab orders received.	**Numerator:** the number of structured clinical lab results sent to the ordering provider. **Denominator:** the number of electronic lab orders received.	None

B. Reporting Clinical Quality Measures Using Certified EHR Technology

1) Time Periods for Reporting CQMs

Generally, EPs will report CQMs for the calendar year or January 1 - December 31 and EHs and CAHs will report CQMs for the FFY or October 1 - September 30. For EPs, EHs, and CAHs in their first year of meaningful use Stage 1 only, the EHR reporting period would be any continuous 90-day period within the calendar year (CY) or the federal fiscal year (FFY). CMS has also finalized optional "quarter" reporting periods for CY/ FFY 2014.

The following table outlines reporting periods for EPs in their first year of Stage 1 meaningful use:

CQM Reporting and Submission Periods Eligible Providers Demonstrating their First Year of Meaningful Use – Stage 1			
Provider Type	**Reporting Period**	**Submission Period[1]**	**Submission Method**
EP	90 consecutive days	Anytime immediately following the end of the 90-day reporting period, but no later than February 28 of the following calendar year.[1]	CQMs submitted via attestation.
EH/ CAH	90 consecutive days	Anytime immediately following the end of the 90-day reporting period, but no later than November 30 of the following FFY.[1]	CQMs submitted via attestation.

Table Note

[1] For purposes of avoiding a payment adjustment, Medicare EPs and EHs that are in their first year of demonstrating meaningful use in the year **immediately preceding a payment adjustment year** must submit their CQM data by October 1 (EPs) or July 1 (EHs/ CAHs) of such preceding year.

As stated in the table note above, to avoid a payment penalty, Medicare EPs and eligible hospitals that are in their first year of demonstrating meaningful use **in the year immediately preceding a payment penalty year** would have to ensure that the 90-day EHR reporting period ends at least three months before the end of the CY (EPs) or FFY (EHs), and that all submission is completed by October 1 (EPs) or July 1 (EHs).

CMS provides two examples: For an EP the EHR reporting period for calendar year 2014 is January 1, 2014 through December 31, 2014. If the EP is in his or her first year of Stage 1, the EHR reporting period could be at the earliest from January 1, 2014 through March 31, 2014 and at the latest from October 3, 2014 through December 31, 2014. If the EP is demonstrating meaningful use for the first time in CY 2014, for

purposes of avoiding the payment penalty in CY 2015, the EHR reporting period must end by September 30, 2014 and submission of CQM information must be completed by October 1, 2014.

For an EH or CAH the EHR reporting period for FFY 2014 is October 1, 2013 through September 30, 2014. If the eligible hospital or CAH is in its first year of meaningful use for Stage 1, the EHR reporting period could be at the earliest from October 1, 2013 through December 29, 2013 and at the latest from July 3, 2014 through September 30, 2014. If an eligible hospital is demonstrating meaningful use for the first time in FFY 2014, for purposes of avoiding the payment penalty in FFY 2015, the EHR reporting period must end by June 30, 2014 and submission of CQM information must be completed by July 1, 2014.

The following table outlines reporting periods for EPs beyond their first year of Stage 1 meaningful use:

CQM Reporting and Submission Periods Eligible Providers Beyond their First Year of Meaningful Use beginning with CY/FFY 2014				
Provider Type	**Reporting Period**	**Optional Reporting Periods for 2014 Only**	**Submission Period[1]**	**Submission Method**
EP	Calendar year (January 1 - December 31)	(1) Calendar year quarter: Jan. 1 - March 31; or April 1 - June 30; or July 1 - Sept. 30; or Oct. 1 - Dec. 31	Two months following the end of the EHR reporting period (January 1 - February 28)	CQMs submitted electronically.
EH/ CAH	Federal fiscal year (October 1 - September 30)	Federal fiscal year quarter: Oct. 1 - Dec. 31; or Jan. 1 - March 31; or April 1 - June 30; or July 1 -Sept. 30	Two months following the end of the EHR reporting period (October 1 - November 30)	CQMs submitted electronically.

Table Note

[1] The optional 2014 quarter reporting periods have the same submission period as a full year reporting period.

See section II.D. for an overview of Medicare payment penalties that take effect in FFY 2015 for EHs and CAHs and in CY 2015 for EPs.

2) EHR Certification Requirements for CQMs

Certified EHR technology must be used to meet the CQM reporting requirements finalized in the Stage 2 rule. CMS finalized the following policy regarding CEHRT and CQM reporting:

- Data reported to CMS for CQMs must originate from an EP's, EH's, or CAH's CEHRT that has been certified to "capture and export" in accordance with 45 CFR 170.314(c)(1) and "electronic submission" in accordance with 45 CFR 170.314(c)(3).
- For attestation and the aggregate electronic reporting methods, the only CQMs that can be reported are those for which an EP's, EH's, or CAH's CEHRT has been certified to "import and calculate" in accordance with 45 CFR 170.314(c)(2).
- In FFY/CY 2013, if an EP, EH, or CAH seeks to use EHR technology certified only to the 2014 Edition EHR certification criteria for reporting CQMs, they can only report those CQMs that are included in both the Stage 1 and Stage 2 final rules. For EPs, this would exclude the option of reporting NQF 0013, 0027, 0084 from the CQMs in the Stage 1 final rule. Since NQF 0013 is a core CQM in the Stage 1 final rule, EPs would select one of the alternate core CQMs to replace it. All 15 CQMs for eligible hospitals and CAHs in the Stage 1 final rule are included in the Stage 2 final rule.

For a discussion of certification requirements finalized to support clinical quality measure reporting see the ONC "2014 Edition" final rule pages 54226-54232.

3) Criteria Used by CMS to Select CQMs

CMS states a commitment to aligning quality measurement and reporting among programs such as Inpatient Quality Reporting (IQR), Physician Quality Reporting System (PQRS), Children's Health Insurance Program Reauthorization Act (CHIPRA), and Accountable Care Organization (ACO) programs. Alignment efforts focus on: 1) choosing the same measures for different program measure sets; 2) standardizing measure development and specification processes across CMS programs; 3) coordinating quality measurement stakeholder involvement efforts and opportunities for public input; and 4) identifying ways to minimize multiple submission requirements and mechanisms. CMS states a long-term vision of allowing hospitals and clinicians to report through a single, aligned mechanism for multiple CMS programs.

CMS categorizes all measures into six domains based on the National Quality Strategy's six priorities:

- Clinical Process/Effectiveness
- Patient Safety
- Care Coordination
- Efficient Use of Health Care Resources
- Patient and Family Engagement
- Population and Public Health

In the final rule CMS does not require eligible providers to choose at least one CQM from each of the six domains as proposed. See section II.B.5.b. (EPs) and II.B.6.b. (EHs/ CAHs) for finalized CQMs and selection criteria.

4) CQM Measure Specifications

CMS does not intend to use notice and rulemaking as a means to update or modify clinical quality measure specifications. Changes to specifications would be described in full through supplemental updates to the electronic specifications for EHR submission provided by CMS. Electronic specifications for measures finalized as part of this rule will be available on the CMS Web site at or around the time of the final rule.

CMS finalized the following policies regarding CQM specifications:

- Updates to CQM specifications may be provided annually approximately six months in advance of the FFY/CY for hospitals and EPs, respectively.
- Providers will not be required to use the updated specifications for purposes of submitting the CQMs for the EHR Incentive Program unless specified in future rulemaking. EPs choosing to submit CQMs through another quality reporting program (for example, PQRS) would need to use the updated specifications if required by the other program.
- In the event that one or more CQMs are removed between rulemakings, the number of CQMs that an EP, EH, or CAH must report would be reduced by the number of CQMs removed. For example, if one EP CQM was removed from the set of CQMs finalized for EPs in Table 8, EPs would only be required to submit eight CQMs instead of nine. Likewise, if a hospital CQM is removed from the set of CQMs finalized in Table 10, EHs and CAHs would only be required to submit 15 CQMs instead of 16. The requirement that the CQMs submitted cover at least three domains will remain the same unless all CQMs for a particular domain have been eliminated. EPs that are not affected by such a removal of a CQM between rulemakings and could report on other CQMs are expected to continue reporting on nine CQMs. Likewise, EHs and CAHs that are not affected and could report on other CQMs are expected to continue reporting on 16 CQMs.

5) CQMs and Reporting Options for Eligible Professionals

a. Alignment with other Quality Reporting Programs

EP CQMs will be the same for both the Medicare and the Medicaid EHR Incentive Programs. See section II.B.3. for a discussion of alignment with other programs.

b. Clinical Quality Measures for EPs

CQMs for Eligible Professionals for CY 2013: For the EHR reporting periods in CY 2013, EPs must submit data for the clinical quality measures that were finalized in the Stage 1 final rule for CYs 2011 and 2012. CMS has posted updated CQM specifications on the EHR Incentive Program Web site but providers are not required to use the updated specifications for CY 2013 CQM reporting.

Clinical Quality Measures for Eligible Professionals beginning in CY 2014: CMS finalized 64 clinical quality measures, which are listed in Table 8 of the final rule, which apply to all EPs for the EHR reporting periods in CYs 2014 and 2015 (and potentially subsequent years), **regardless of whether an EP is in Stage 1 or Stage 2 of meaningful use.** Appendix C provides a reference copy of Table 8 from the Stage 2 final rule.

For Medicaid EPs, the reporting method for clinical quality measures may vary by state; however, the set of clinical quality measures from which to select (Table 8) would be the same for both Medicaid EPs and Medicare EPs. CMS expects that by CY 2016, it will have engaged in another round of rulemaking for the EHR Incentive Programs. However, if such rulemaking does not occur, the clinical quality measures proposed for CYs 2014 and 2015 would continue to apply for the EHR reporting periods in CY 2016 and subsequent years.

CMS finalized two reporting options (Option 1 and Option 2) that would begin in CY 2014 for Medicare and Medicaid EPs and are described below.

1) Report 9 clinical quality measures: EPs choose nine measures from a menu of 46 and the nine measures that are chosen must cover at least three of the following six domains:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Health Care Resources
- Clinical Process/Effectiveness

Under this option EPs are expected to select the CQMs that best apply to their scope of practice and/or unique patient population. CQMs will be submitted on an aggregate basis reflective of all patients without regard to payer. CMS is not requiring the submission of a core set of CQMs (as in Stage 1) but does identify two ***recommended core sets***, one for adults (see Appendix D) and one for children (see Appendix E) and EPs are encouraged to report to the extent those CQMs are applicable to an EP's scope of practice and patient population. Appendix C provides a reference copy of all EP CQMs finalized as part of the Stage 2 rule that is sorted by "Domain," "New Measure," and then "NQF #."

If an EP's certified EHR technology does contain patient data for at least nine CQMs covering at least three domains, then the EP must report the CQMs for which there are patient data and report the remaining required CQMs as "zero denominators" as displayed by the EP's CEHRT. If there are no CQMs applicable to the EP's scope of practice and patient population, EPs must still report nine CQMs even if zero is the result in either the numerator or the denominator of the measure. If all applicable CQMs have a value of zero from their CEHRT, then EPs must report any nine CQMs from Table 8.

2) Successfully report clinical quality measure under PQRS using certified EHR technology: Medicare EPs who submit and satisfactorily report PQRS clinical quality measures under the PQRS EHR reporting option **using CEHRT** would satisfy their clinical quality measures reporting requirement under the Medicare EHR Incentive Program. EPs that choose this option to satisfy their clinical quality measures reporting obligation under the Medicare EHR Incentive Program would be required to comply with any changes to the requirements of the PQRS that may apply in future years. Important Note: EPs who are in their first year of demonstrating meaningful use in the year immediately preceding a payment penalty

year cannot choose Option 2 for reporting CQMs for the EHR Incentive Program because of the timing of the PQRS reporting program. For purposes of avoiding a payment penalty, they must submit their CQM data by attestation by October 1 of such preceding year.

CQMs finalized in Stage 1 that are eliminated beginning in CY 2014: CMS eliminated the following 12 CQMs, finalized as part of the Stage 1 rule making process, beginning in CY 2014:

EP CQMs Finalized in the 2010 Stage 1 Final Rule that Have Been Eliminated Beginning in CY 2014		
NQF #	**Title**	**Description**
0001	Asthma Assessment	Percentage of patients age five through 40 years with a diagnosis of asthma and who have been seen for at least two office visits, which were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.
0012	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.
0013	Hypertension: Blood Pressure Measurement	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least two office visits, with blood pressure (BP) recorded.
0014	Prenatal Care: Anti-D Immune Globulin	Percentage of D(Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.
0027	Smoking and Tobacco Use Cessation, Medical assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies	Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.
0047	Asthma Pharmacologic Therapy	Percentage of patients age five through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
0061	Diabetes: Blood Pressure Management	Percentage of patients 18 to 75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.

EP CQMs Finalized in the 2010 Stage 1 Final Rule that Have Been Eliminated Beginning in CY 2014		
NQF #	**Title**	**Description**
0067	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	Percentage of patients age 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
0073	Ischemic Vascular Disease (IVD): Blood Pressure Management	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1 to November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).
0074	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	Percentage of patients aged 18 years and older with a diagnosis of CAD who was prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
0575	Diabetes: HbA1c Control (<8%)	The percentage of patients 18 to 75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.

CMS is replacing NQF# 0084 with the following CQM:

ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range: Average percentage of time in which individuals with atrial fibrillation who are on chronic anticoagulation have International Normalized Ratio (INR) test results within the therapeutic range during the measurement period (NQF# 1525).

c. Reporting Methods for CQMs for EPs

Reporting Methods for Medicaid EPs: For Medicaid EPs, the states are responsible for determining whether and how electronic reporting would occur, or whether they wish to allow reporting through attestation. If a state does require such electronic reporting, the state is responsible for communicating the process to the provider community. CMS anticipates that whatever means states have deployed for capturing Stage 1 clinical quality measures would be similar for reporting in CY 2013. However, CMS notes that this is within the states' purview (subject to CMS approval). Beginning in CY 2014, the states will establish the method and requirements for electronically reporting CQMs (subject to CMS approval).

Reporting for Medicare EPs CY 2013: For CQM reporting beginning in 2013 CMS lists two options:

1) Attestation Reporting: EPs may use the current Medicare attestation process.

2) Physician Quality Reporting System—Medicare EHR Incentive Pilot Reporting Option: In the CY 2012 Medicare Physician Fee Schedule (PFS) final rule, CMS established a pilot program intended to test and demonstrate CMS's capacity to accept electronic reporting of Stage 1 clinical quality measure data. In the PFS 2013 proposed rule, CMS proposes to include this as a reporting option for CY 2013. CMS states in the EHR Incentive Stage 2 final rule that it intends to finalize this as a reporting option *as part of the PFS 2013 final rule*.

Reporting Methods for Medicare EPs Beginning CY 2014

EPs in their first year of Stage 1 meaningful use: Medicare EPs who are in their first year of Stage 1 meaningful use will report the nine clinical quality measures chosen from Table 8 through attestation for a continuous 90-day EHR reporting period.

EPs who choose to report 9 CQMs under Option 1: Medicare EPs who are beyond their first year of meaningful use will be required to submit aggregate level data through a CMS-designated electronic transmission method using CEHRT. The format required for aggregate reporting will be the QRDA-III, which is an XML-based format.

EPs Who Choose PQRS Reporting Under Option 2: Medicare EPs who are beyond their first year of Stage 1 and who choose the Physician Quality Reporting System EHR reporting option as described in Option 2 above, must report in the form and manner specified for PQRS.

EP Group Reporting Options: For Stage 1, EPs are required to report the clinical quality measures on an individual basis and do not have an option to report the CQMs as part of a group practice. Beginning with CY 2014, CMS finalized two group reporting options to allow EPs within a single group practice to report clinical quality measure data on a group level. Both methods would be available for Medicare EPs. The group reporting options would only be available for reporting clinical quality measures for purposes of the EHR Incentive Program: EPs who choose group reporting options for clinical quality measures must still individually satisfy the objectives and associated measures for their respective stage of meaningful use.

1) Medicare Shared Savings Program Reporting Option: Medicare EPs participating in the Medicare Shared Savings Program and the testing of the Pioneer Accountable Care Organization (ACO) model who **use CEHRT to submit ACO measures** in accordance with the requirements of the Medicare Shared Savings Program would be considered to have satisfied their clinical quality measures reporting requirement as a group for the Medicare EHR Incentive Program. The Medicare Shared Savings Program does not require the use of CEHRT; however, all clinical quality measure data must be extracted from CEHRT in order for the EP to qualify for the Medicare EHR Incentive Program if an EP intends to use this group reporting option.

2) PQRS Group Option: Medicare EPs who satisfactorily report Physician Quality Reporting System clinical quality measures **using certified EHR technology** under the PQRS Group Practice Reporting Option (GPRO) would be considered to have satisfied their CQM reporting requirement as a group for

the Medicare EHR Incentive Program. Under the CY 2013 Medicare PFS proposed rule, additional group reporting options are proposed. CMS notes in the final rule that the proposed claims and registry options for GPRO, which do not involve the use of CEHRT, would not satisfy the CQM reporting requirement for the EHR Incentive Program. However, the options for GPRO involving the use of CEHRT, which include submissions from CEHRT directly to CMS or through a data intermediary to CMS, could satisfy the CQM reporting requirement for the EHR Incentive Program. Under PQRS GPRO, CQM submission is at the group level, not at the level of any individual EP that is part of the group. Each individual EP who is a member of the group would meet the CQM reporting requirement for the EHR Incentive Program if the group meets the requirements for PQRS, with the exception of the EPs in the group who are in their first year of demonstrating meaningful use.

Although a group may include EPs who are demonstrating meaningful use for the first time, EPs cannot use either of these group reporting options for reporting CQMs for the EHR Incentive Program. CQM data collected by EPs that are part of a group and are in their first year of demonstrating meaningful use could still be part of the group's collective data submission. However, for purposes of avoiding a payment adjustment, EPs who are in their first year of demonstrating meaningful use in the year immediately preceding a payment adjustment year must individually submit their CQM data by attestation by October 1 of such preceding year.

For the Medicaid EHR Incentive Program, the states will have the option to allow group reporting of CQMs through an update to their state Medicaid HIT plan, which must describe how they would address the issue of EPs who switch group practices during an EHR reporting period.

6) CQMs and Reporting Options for Eligible Hospitals and Critical Access Hospitals

a. Alignment with Other Quality Reporting Programs

The HITECH Act requires the HHS Secretary to give preference to clinical quality measures that have been selected for the Hospital Inpatient Quality Reporting (IQR) Program or that have been endorsed by the entity with a contract with the Secretary, currently NQF. CMS finalized clinical quality measures for EHs and CAHs for 2013, 2014, and 2015 (and potentially subsequent years) that reflect this preference (CQMs listed in the final rule that do not have an NQF identifying number are not NQF-endorsed). The clinical quality measures finalized apply for both the Medicare and Medicaid EHR Incentive Programs. In finalizing CQMs, CMS also sought alignment with other CMS and national hospital quality measurement programs (see section II.B.3.).

CMS states in the final rule the following goals for alignment of the Hospital IQR and the Medicare and Medicaid EHR Incentive Program:

- provide a single set of CQMs for hospital reporting;
- to the extent possible, avoid duplicate reporting by hospitals by using a single submission for multiple purposes as appropriate; and
- transition from manual chart abstraction to automated extraction and electronic reporting based on the use of EHR technology.

CMS noted in the final rule that the 2015 target date for using EHR-based reporting of as a mechanism for Hospital IQR Program data collection will depend on whether EHR-based reporting is accurate and reliable, CMS stated, "We must assess any data collection mode difference between EHR-based reporting and chart abstracted measures using a diverse and robust sample of hospitals before proposing in rulemaking to use EHR data collection in the Hospital IQR program (pg. 54079)."

b. CQMs for Eligible Hospitals and Critical Access Hospitals

CQM Reporting for FFY 2013 (October 1, 2012 - September 30, 2013):
For the EHR reporting periods in FFY 2013, EHs and CAHs are required to submit information on each of the 15 clinical quality measures that were finalized for FFYs 2011 and 2012 in the Stage 1 final rule.

CQM Reporting Beginning FFY 2014 (October 1, 2013 - September 30, 2014)

Beginning with FFY 2014, EHs and CAHs must report 16 clinical quality measures from a menu of 29 clinical quality measures, covering at least three of the six domains:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Health Care Resources
- Clinical Process/Effectiveness

All of the EH/CAH CQMs finalized as part of the Stage 1 rule have been carried forward as part of the menu of 29 CQMs. Appendix E provides a reference copy of Table 10 from the Stage 2 final rule. The clinical quality measures in Table 10 apply for all EHs and CAHs beginning with FFY 2014, **regardless of whether an eligible hospital or CAH is in Stage 1 or Stage 2 of meaningful use**.

If an EH's or CAH's certified EHR technology does not contain patient data for at least 16 measures, covering at least three domains, then the EH or CAH must report the measures for which there are patient data and report the remaining required measures as "zero denominators" as displayed by their CEHRT. In the unlikely event that there are no measures applicable to the EH's or CAH's patient mix, EHs or CAHs must still report 16 measures, even if zero is the result in either the numerator or the denominator of the measure (e.g., if all measures have a value of zero from their CEHRT, then EHs or CAHs must report any 16 of the measures).

CMS finalized a new policy on case threshold exemptions for eligible hospitals and CAHs in all stages of meaningful use beginning in FFY 2014. Eligible hospitals and CAHs, beyond their first year of meaningful use, that have five or fewer discharges per quarter in the same quarter as their reporting period in FFY 2014, or 20 or fewer discharges per full FFY reporting period beginning in FFY 2015, for which data are being electronically submitted (Medicare and non-Medicare combined) as defined by the CQM's denominator population are exempted from reporting the CQM. Eligible hospitals and CAHs that are demonstrating meaningful use for the first time must submit their CQMs through attestation and will not be able to qualify for this exemption.

For example, if the CQM's denominator population is ischemic stroke patients greater than or equal to 18 years of age, then the threshold would be five or fewer ischemic stroke patients aged 18 years or older discharged from the hospital in the quarter for which data are being submitted (the hospital's FFY 2014 three-month quarter reporting period). To be eligible for the exemption, hospitals must submit their aggregate population and sample size counts for Medicare and non-Medicare discharges for the CQM for the reporting period no later than the two-month submission period of October 1 through November 30 immediately following the reporting period (please see section II.B.1. of this final rule for a description of reporting and submission periods). Hospitals will report this information in the same manner as for the Hospital IQR Program. Hospitals that do not seek an exemption under the EHR Incentive Program do not have to submit aggregate population and sample size counts for any CQMs for the purposes of the EHR Incentive Program.

c. Reporting Methods for CQMs for Eligible Hospitals and Critical Access Hospitals

Reporting Methods for Medicaid EHs/CAHs: CMS anticipates that whatever means states have deployed for capturing Stage 1 clinical quality measures would be similar for reporting in FFY 2013. CMS points out that states that have launched their Medicaid EHR Incentive Programs plan to collect CQMs electronically from CEHRT beginning in FFY 2014. Each state is responsible for sharing the details on the process for electronic reporting with its provider community. **Dually eligible hospitals** may submit their CQMs via the methods outlined below for the Medicare EHR Incentive Program.

Reporting Method FFY 2013: For CQM reporting beginning in 2013 CMS lists two options:

1) Attestation Reporting: Eligible hospitals and CAHs may use the current Medicare attestation process.

2) Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs: For CQM reporting beginning in 2013 CMS anticipates that EHs and CAHs may use a reporting process similar to the one currently being piloted under the Medicare EHR Incentive Program Electronic Reporting Pilot for EHs and CAHs. In the 2012 Hospital Outpatient Prospective Payment System (OPPS) final rule, CMS implemented a pilot program intended to test and demonstrate CMS' capacity to accept electronic reporting of clinical quality measure information. CMS *expects to finalize* this as a reporting option for FFY 2013, as part of the OPPS final rule.

Reporting Methods Beginning FFY 2014

Eligible hospitals/CAHs in their first year of Stage 1 meaningful use: Medicare eligible hospitals and CAHs that are in their first year of Stage 1 meaningful use will report the 16 clinical quality measures chosen from Table 10 through attestation for a continuous 90-day EHR reporting period.

Eligible hospitals/CAHs beyond their first year of meaningful use will have two reporting options:

1) Submit the selected 16 clinical quality measures on an aggregate basis through a CMS-designated transmission method using CEHRT: The CQM data will be submitted in the QRDA-III format reflective of all patients without regard to payer. This method will require transmitting the data via a CMS-designated transmission method.

2) Submit the selected 16 clinical quality measures on a patient-level basis in a manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot for EHs and CAHs using CEHRT: The electronically reported patient-level CQM data must use the QRDA category I (release 2) based on the Quality Data Model (QDM), which will include only patients that meet the denominator criteria of each reported CQM without regard to payer. As long as the CQM data originate from CEHRT, it may be submitted directly from the hospital's CEHRT or through a data intermediary to CMS. CMS finalized the "sampling-all payer" option for patient-level data. This submission characteristic will only include patients who meet the denominator criteria of the CQMs that the EH or CAH selects to report to CMS.

C. Demonstration of Meaningful Use and Other Issues

1) Demonstration of Meaningful Use

a. Common Methods of Demonstration in Medicare and Medicaid

CMS finalized the continued use of a common method for demonstrating meaningful use in both the Medicare and Medicaid EHR Incentive Programs. Eligible providers will demonstrate meaningful use by reporting clinical quality measures and meeting meaningful use criteria (e.g., objective measures). The demonstration methods CMS adopts for the Medicare program will automatically be available to the states for use in their Medicaid programs.

b. Methods for Demonstration of the Stage 2 Criteria for Meaningful Use

CMS did make changes to the attestation process for Stage 2 meaningful use objectives and measures with the exception of the batch reporting option outlined in II.C.1.c. An EP, EH or CAH must successfully attest to the Stage 2 meaningful use objectives and successfully submit clinical quality measures to be a meaningful EHR user.

c. Group Reporting Option of Meaningful Use Core and Menu Objectives and Associated Measures for Medicare and Medicaid EPs Beginning with CY 2014

In the Stage 1 rule, CMS required EPs to attest and report on core and menu objectives on an individual basis and did not have an option to report collectively with other EPs in the same group practice. In lieu of EP-by-EP attestation, CMS has finalized a batch file process for attestation that would be available no later than January 1, 2014. The batch process would continue to require that meaningful use measures be assessed at the individual EP level: batch reporting would allow large group practices to submit a large number of attestations at once, while maintaining individual EP assessments of meaningful use. **Each EP would still need to meet the required meaningful use thresholds independently**; the batch reporting option does not allow the use of group averages or any other method of group demonstration.

CMS will establish a file format and develop a process to allow for the batch submission of core and menu objective information for individual Medicare EPs (including the stage of meaningful use the individual EP is in, numerator, denominator, exclusion, and yes/no information for each core and menu objective). States would have the option of offering batch reporting of meaningful use data for Medicaid EPs.

CMS finalized the following policies that will apply to EP objective and measure batch attestation reporting:

- A **Medicare EHR Incentive Group** will be defined as two or more EPs, each identified with a unique National Provider Identifier (NPI) associated with a group practice identified under one Tax Identification Number (TIN) through the Provider Enrollment, Chain, and Ownership System (PECOS). None of the EPs in either a Medicare or Medicaid EHR Incentive Group could be hospital-based according to the definition for these programs.

- States choosing to exercise this option will have to clearly define a Medicaid EHR Incentive Group via their state Medicaid HIT Plan.

- None of the EPs in either a Medicare or Medicaid EHR Incentive Group could be hospital-based.

- Any EP that successfully attests are part of one Medicare EHR Incentive Group will not be permitted to also attest individually or attest as part of a batch report for another Medicare EHR Incentive Group.

- Because EPs can only participate in either the Medicare or the Medicaid Incentive Programs in the same year, an EP that is part of a Medicare EHR Incentive Group will not be able to receive a Medicaid EHR incentive payment or be included as part of a batch report for a Medicaid EHR Incentive Group or vice versa.

- The group reporting option for meaningful use objective and measure attestation is limited to data for the core and menu objectives and does not include the reporting of clinical quality measures. Clinical quality measures must be reported separately through other submission options (see section II.B.5.c. above for an outline of CQM reporting options beginning in CY 2014).

- Given that CMS finalized multiple group reporting options for clinical quality measures, EPs will not have to report core and menu objective data in the same EHR Incentive Group as they report clinical quality measures (e.g., an EP will be able to submit the core and menu objectives as part of a group and the clinical quality measures as an individual and vice versa).

- CMS does not require batch reporting. EPs may still attest individually through the CMS attestation Web site.

- Batch reporting would not change the policy that payment adjustments will be applied to individual EPs and not to Medicare EHR Incentive Groups.

- Batch reporting would not change incentive payment assignment (e.g., an EPs incentive payment will not automatically be assigned to the Medicare EHR Incentive Group—the EP will still have to select the payee TIN during the registration process).

- An EP who chooses the group reporting option will be required to include in such reporting core and menu objective information on all outpatient encounters where CEHRT is available even if some encounters occurred at locations not associated with the EP's Medicare EHR Incentive Group.

- There would not be a minimum participation threshold for reporting as part of an EHR Incentive Group. An EP who is able to meet the 50% threshold of patient encounters in locations equipped with CEHRT could report all of his or her core and menu objective data as part of an EHR Incentive Group in which they had only 5% of their encounters, provided they report all of the data from the other locations through the same batch reporting process with the EHR Incentive Group.

2) Data Collection and Online Posting, Program Coordination, and Accurate Payments

In addition to the information already collected by CMS under the Stage 1 final rule, CMS will begin collecting the business e-mail address of EPs, EHs, and CAHs to facilitate communication with providers. CMS will not post e-mail addresses online.

3) Hospital-Based Eligible Professionals

Hospital-based EPs are not eligible to participate in the EHR Incentive Programs and are not subject to the Medicare payment penalties. A hospital-based EP was defined in the 2010 Stage 1 final rule as "an EP who furnishes 90 percent or more of his or her covered professional services in a hospital setting in the Federal fiscal year preceding the payment year. A setting is considered a hospital setting if it is a site of service that would be identified by the codes used in the HIPAA standard transactions as an inpatient hospital (POS 21), or emergency room setting (POS 23)." See section 11.D.2.d. below which discusses a modification to the timeframe for determining hospital-based status.

In the Stage 2 final rule, CMS finalized a new policy to allow hospital-based EPs to participate in the EHR Incentive Programs if they can demonstrate that the EP funds the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an EH or CAH and uses such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital/CAH's CEHRT).

Upon registration for a given year, an EP will know whether he or she is hospital-based. An EP who is designated hospital-based, but wishes to be determined non hospital-based due to his or her funding of CEHRT (as outlined above) will utilize an administrative process throughout the incentive payment year (and extending two months after the end of the incentive payment year) to provide documentation and seek a non-hospital based status. In subsequent years, the EP must attest that he or she will continue to be in the same situation of funding the CEHRT. The EP would then need to meet the meaningful use requirements in order to draw down an incentive payment and avoid applicability of the Medicare payment adjustment. **The EP would include in his or her attestation to meaningful use all encounters at all locations, including those in the inpatient and emergency departments of the hospital.**

D. Medicare Payment Penalties and Hardship Exceptions

1) General Background and Statutory Basis

The HITECH Act provides for Medicare payment penalties effective in 2015 and subsequent years for EPs, EHs, and CAHs **that are not meaningful users of CEHRT for an applicable EHR reporting Period.** For EPs, applicable payment penalties will be effective for the calendar year and for eligible hospitals and CAHs, applicable payment penalties will be effective for the FFY.

In the Stage 2 final rule, CMS outlines applicable EHR reporting period(s) for the purpose of determining payment penalties and proposes hardship exception categories for EPs, EHs, and CAHs.

2) Payment Penalties Effective in CY 2015 and Subsequent Years for Eligible Professionals Who are Not Meaningful Users of Certified EHR Technology for an Applicable EHR Reporting Period

The HITECH Act outlines Medicare payment penalties beginning in calendar year 2015 for EPs who are not meaningful users of CEHRT during the applicable EHR reporting period(s) for the adjustment year under either the Medicare or the Medicaid EHR Incentive Programs. The adjustments apply to the following Medicare EPs: doctors of medicine or osteopathy, doctors of dental surgery or medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. If an EP is not a meaningful EHR user for an applicable EHR reporting period, the Medicare Physician Fee Schedule amount for covered professional services furnished by the EP during the year is adjusted to equal the ”applicable percent“ of the fee schedule amount that would otherwise apply. This will also apply to any payments based on the fee schedule amount. Medicare payment penalties generally do not apply to hospital-based EPs (see section II.D.2.d. for a definition of hospital-based EP and section II.C.3. which discusses a special circumstance where the payment penalty may apply to a hospital-based EP).

Important note for EPs who are dually eligible for Medicare and Medicaid: EPs who are dually eligible for the Medicare and Medicaid EHR Incentive programs must choose to participate in one program or the other in any given CY. There are no Medicaid payment penalties; however, an EP who chooses to participate in the Medicaid EHR Incentive Program who is also eligible for the Medicare EHR Incentive Program, will need to be in compliance with meaningful use under Medicaid by 2013 or 2014 (if first year) to avoid the Medicare penalty in 2015 (and meet future meaningful use requirements to avoid subsequent year payment penalties).

a. Applicable Payment Penalty Amounts for EPs Beginning in Calendar Year 2015

HITECH provides that if, for 2018 and subsequent years, the proportion of EPs who are meaningful EHR users is less than 75%, the applicable percent shall be decreased by 1% in the preceding year, but in no case shall the applicable percent be less than 95%. The following table provides a schedule of the Medicare EP “applicable percent” adjustments payment penalty for CY 2015 and subsequent years:

Applicable Percent Adjustments for EPs Beginning in 2015 (applied to the Medicare physician fee schedule amount)						
EP EHR Adoption Situation	**2015**	**2016**	**2017**	**2018**	**2019**	**2020+**
If less than 75% of EPs are meaningful users for CY 2018 and subsequent years	99%	98%	97%	96%	95%	95%
If at least 75% of EPs are meaningful users for CY 2018 and subsequent years	99%	98%	97%	97%	97%	97%

b. Applicable EHR Reporting Periods for Determining whether an EP is Subject to the Adjustment 2015+

CMS finalized the following applicable EHR reporting periods for purposes of avoiding the payment penalty and finalized five hardship exceptions that are described in section II.D.2.c below. Therefore, to avoid the Medicare payment penalty, an EP must do one of the following:

1) demonstrate meaningful use during the EHR reporting period two years prior to the payment penalty year; or
2) demonstrate meaningful use for the first time in the year prior to the payment penalty year, begin the continuous 90-day reporting period no later than July 3, and successfully attest by October 1; or
3) apply for a hardship exception by the submission deadline and qualify for the exception (e.g., CMS approves the exception request).

The following table outlines the applicable EHR reporting periods for purposes of avoiding the EP Medicare payment penalty for calendar years 2015 through 2019:

EP payment penalty year (CY)	**Applicable EHR Reporting Periods for EPs (non hospital-based) for Purposes of Avoiding the Medicare Payment Penalty**	
	Demonstrate meaningful use during the EHR reporting period two years prior to the payment penalty year:	**Demonstrate meaningful use for the first time in the year prior to the payment penalty year and begin the continuous 90-day meaningful use reporting period no later than:**
2015	CY 2013 (with attestation submission no later than February 28, 2014)	July 3, 2014 (with attestation submission no later than October 1, 2014)
2016	CY 2014 (with attestation submission no later than February 28, 2015)	July 3, 2015 (with attestation submission no later than October 1, 2015)
2017	CY 2015 (with attestation submission no later than February 29, 2016)	July 3, 2016 (with attestation submission no later than October 1, 2016)

2018	CY 2016 (with attestation submission no later than February 28, 2017)	July 3, 2017 (with attestation submission no later than October 1, 2017)
2019	CY 2017 (with attestation submission no later than February 28, 2018)	July 3, 2018 (with attestation submission no later than October 1, 2018)

Table Notes

- The timelines for CY 2020 and subsequent calendar years will follow the same pattern.
- When demonstrating meaningful use for the calendar year two years prior to the payment penalty year, EPs in their first year of demonstrating meaningful use would have a continuous 90-day reporting period during the calendar year.

Medicare Payment Penalties and EPs Participating in the Medicaid EHR Incentive Program: An EP who is eligible to participate in both the Medicare and Medicaid EHR Incentive Programs may opt to demonstrate meaningful use under the Medicaid EHR Incentive program (EPs may only participate and receive an incentive from one program in any given year). In the first participation year of the Medicaid EHR incentive program, the EP may be eligible for an incentive payment for having adopted, implemented, or upgraded (AIU) to CEHRT; however, AIU does not constitute meaningful use of CEHRT. Therefore, an EP who receives an incentive payment for AIU would not be considered a meaningful EHR user for purposes of determining applicability of the Medicare payment penalty.

For example, an EP who meets the first year requirements by AIU under the Medicaid EHR Incentive program in 2013 but fails to demonstrate meaningful use for 90 continuous days in 2014 (beginning no later than July 3, 2014) will still be subject to the payment penalty in 2015 because they he or she not demonstrate meaningful use in an applicable EHR reporting period for purposes of the Medicare payment penalty.

c. Hardship Exceptions for EPs to Avoid the Payment Penalty

On a case-by-case basis, CMS may grant an exception to the payment penalty for an EP who is not a meaningful EHR user for the applicable EHR reporting period, if the EP can demonstrate that compliance with the meaningful use requirements would result in a significant hardship. CMS finalized five hardship exception categories. Exceptions are subject to annual renewal and in no case may an EP be granted an exception for more than five years. The following table outlines hardship exceptions and submission deadlines for EPs (CMS states it will provide additional guidance, subsequent to the publication of the final rule, regarding the ”New EP” hardship exception application process and deadline):

Hardship Exceptions for EPs			
Exception Category	**Key Information**	**Period of Consideration for Exception**	**Submission Deadline for CY 2015**

Hardship Exceptions for EPs			
Exception Category	**Key Information**	**Period of Consideration for Exception**	**Submission Deadline for CY 2015**
Insufficient internet access	Applications will be required to demonstrate insufficient Internet connectivity to comply with the meaningful use objectives requiring Internet connectivity (e.g., summary of care documents, electronic prescribing, making health information available online, and submission of public health information) and insurmountable barriers to obtaining such internet connectivity (e.g., high cost to build out internet to EP's facility).	Demonstrate insufficient Internet access for any continuous 90-day period from the start of the calendar year two years prior to the payment adjustment year to July 1 of the year prior to the payment adjustment year (e.g., for CY 2015: January 1, 2013 - July 1, 2014).	July 1, 2014
New EP	Newly practicing EPs will not be able to demonstrate that they are meaningful users for a reporting period that occurs prior to the payment adjustment year and therefore may apply for a hardship exception under this category. An EP who switches specialties and begins practicing under a new specialty will not be considered newly practicing for purposes of this hardship exception category.	New EP granted an exception for the year he or she becomes an EP and the following year (e.g., for CY 2015: the EP would have to be new in either CY 2014 or CY 2015).	Guidance to be issued following publication of the final rule.

Hardship Exceptions for EPs			
Exception Category	**Key Information**	**Period of Consideration for Exception**	**Submission Deadline for CY 2015**
Extreme circumstances outside of the EP's control.	An extreme circumstance that creates a hardship for the EP to become a meaningful user during the applicable EHR reporting period for purposes of the payment penalty. Circumstances might include: a practice being closed down; a hospital is closed; a natural disaster in which an EHR system is destroyed; EHR vendor going out of business; an EP whose CEHRT (complete or modular) loses its certification either through revocation or because the vendor did not upgrade its CEHRT to the latest requirements; and a EP suffering severe financial distress resulting in a bankruptcy or restructuring of debt. CMS also notes in the preamble that the above list is not exhaustive and other circumstances *may qualify* for a hardship exception (e.g., EP unable to meet meaningful use because of failure(s) on the part of the EHR vendor). But CMS states clearly that **the EP would need to demonstrate that it meets the extreme circumstance, that the circumstance was outside of the EP's control, and the circumstance directly impacted the EP's ability to demonstrate meaningful use.**	For an EP who has previously demonstrated meaningful use, the EP must demonstrate extreme circumstances that affect the calendar year two years prior to the payment adjustment year (e.g., to avoid the CY 2015 payment adjustment under this exception category the extreme circumstance would need to take place during CY 2013). For an EP who has never demonstrated meaningful use, the EP must demonstrate extreme circumstances that affect the calendar year prior to the payment adjustment year (e.g., in order to avoid the CY 2015 payment adjustment under this exception category the extreme circumstance would need to take place during CY 2014 **and** the EP would need to apply for the exception by July 1, 2014).	July 1, 2014

Hardship Exceptions for EPs			
Exception Category	**Key Information**	**Period of Consideration for Exception**	**Submission Deadline for CY 2015**
Lack of face-face/ telemedicine patient interactions and lack of need for follow-up care.	Lack of face-to-face or telemedicine interaction with patients and the lack of need for follow-up care, thereby making compliance with meaningful use criteria more difficult. An EP may apply for this exception only on the grounds that he or she meets both of these criteria (lack of face-to-face interactions **and** lack of follow-up with patients). The EP would need to demonstrate either a complete lack of face-to-face interactions and follow-up or that cases of face-to-face interaction and follow-up are extremely rare and not part of normal scope of practice for the EP.	The calendar year two years prior to the payment adjustment year through the application deadline (e.g., for CY 2015: January 1, 2014 - July 1, 2014)	Note: If an EP is registered in PECOS with a primary specialty of anesthesiology, pathology, or radiology six months prior to first day of the payment adjustment year he or she **will be deemed to automatically qualify for this exception**. All other EPs must submit an exception application by July 1, 2014
Lack of control over availability of CEHRT for an EP practicing in multiple locations.	An EP who practices at multiple locations and has little or no control over whether CEHRT is available at their locations. CMS provides the examples of surgeons using ambulatory surgery centers or physicians treating patients in a nursing home. In these cases, the surgeon or physician likely would bear the entire impact of any payment adjustment and such adjustment would not affect the earnings of the ambulatory surgery center or nursing home. In addition, because the surgeon or physician typically does not have any other interest in the facility, he or she may exert little to no influence over whether the nursing home, center, or other similar outpatient site adopts and implements CEHRT. This exception would apply only in the case of EPs practicing in multiple locations where the lack of control exists for a majority (50% or more) of their outpatient encounters at such locations.	The calendar year two years prior to the payment adjustment year through the application deadline.	July 1, 2014

d. Modification to the Timeframe for Determining Hospital-based Status (for purposes of payment penalty applicability)

The Medicare payment penalty is generally not applicable to hospital-based EPs (see section II.C.3., which discusses a special circumstance where the payment penalty may apply to a hospital-based EP). A hospital-based EP was defined in the 2010 Stage 1 final rule as "an EP who furnishes 90 percent or more of his or her covered professional services in a hospital setting **in the Federal fiscal year preceding the payment year**. A setting is considered a hospital setting if it is a site of service that would be identified by the codes used in the HIPAA standard transactions as an inpatient hospital (POS 21), or emergency room setting (POS 23)."

In the Stage 2 final rule, CMS has modified the timeframe for determining hospital-based status for purposes of determining the payment penalty applicability. Hospital-based status, for purposes of determining applicability of the payment penalty, will be determined using either of the following fiscal year's data: 1) the fiscal year before the year that is one year prior to the payment adjustment year (e.g., FFY 2013 data for payment adjustment year 2015); or 2) the fiscal year before the year that is two years prior to the payment adjustment year (e.g., FFY 2012 data for payment adjustment year 2015).

CMS finalized this change to ensure that an EP is aware of his or her hospital-based status in time to purchase EHR technology and meaningfully use it during the applicable EHR reporting period for the payment adjustment year.

3) Payment Penalties Effective in FFY 2015 and Subsequent Years for Eligible Hospitals that are Not Meaningful Users of Certified EHR Technology for an Applicable EHR Reporting Period

a. Medicare Marketbasket Adjustments for EHs Beginning in 2015

HITECH outlines adjustments to the marketbasket update to the IPPS standardized amount beginning in FFY 2015 for EHs that do not demonstrate meaningful use of CEHRT during the applicable EHR reporting period(s) for the adjustment year. The following table provides a schedule of the Medicare-eligible hospital payment penalties for FFY 2015 and subsequent years:

Applicable Percent Adjustments for EHs beginning in 2015 (applied to the Medicare marketbasket update to the IPPS standardized amount)		
2015	**2016**	**2017+**
25%	50%	75%

b. Applicable EHR Reporting Periods for Determining Whether an Eligible Hospital is Subject to the Marketbasket Adjustment 2015+

CMS finalized the following applicable EHR reporting periods for purposes of avoiding the payment penalty and three hardship exceptions that are described in section II.D.3.c below. Therefore, to avoid the Medicare payment penalty, an eligible hospital must do one of the following:

1) demonstrate meaningful use during the EHR reporting period two years prior to the payment penalty year; or
2) demonstrate meaningful use for the first time in the year prior to the payment penalty year, begin the continuous 90-day reporting period no later than April 2, and successfully attest by July 1; or
3) apply for a hardship exception by the submission deadline and qualify for the exception (e.g., CMS approves the exception request).

The following table outlines the applicable EHR reporting periods for purposes of avoiding the Medicare marketbasket adjustments for FFYs 2015 through 2019:

Hospital payment penalty year (FFY)	Applicable EHR Reporting Periods for Purposes of Avoiding the Medicare Adjustment for EHs	
	Demonstrate meaningful use during the EHR reporting period two years prior to the payment penalty year:	**Demonstrate meaningful use for the first time in the year prior to the payment penalty year and begin the continuous 90-day meaningful use reporting period no later than:**
2015	FFY 2013 (with attestation submission no later than November 30, 2013)	April 2, 2014 (with attestation submission no later than July 1, 2014)
2016	FFY 2014 (with attestation submission no later than November 30, 2014)	April 2, 2015 (with attestation submission no later than July 1, 2015)
2017	FFY 2015 (with attestation submission no later than November 30, 2015)	April 2, 2016 (with attestation submission no later than July 1, 2016)
2018	FFY 2016 (with attestation submission no later than November 30, 2016)	April 2, 2017 (with attestation submission no later than July 1, 2017)

Hospital payment penalty year (FFY)	Applicable EHR Reporting Periods for Purposes of Avoiding the Medicare Adjustment for EHs	
	Demonstrate meaningful use during the EHR reporting period two years prior to the payment penalty year:	**Demonstrate meaningful use for the first time in the year prior to the payment penalty year and begin the continuous 90-day meaningful use reporting period no later than:**
2019	FFY 2017 (with attestation submission no later than November 30, 2017)	April 2, 2018 (with attestation submission no later than July 1, 2018)

Table Notes:

- The timelines for FFY 2020 and subsequent fiscal years follow the same pattern.
- When demonstrating meaningful use for the FFY two years prior to the payment penalty year, EHs in their first year of demonstrating meaningful use would have a continuous 90-day reporting period during the FFY.

Medicare Payment Penalty Considerations for Hospitals Undergoing Reorganization or Changes in Ownership: CMS observes in the final rule an important consideration for hospitals undergoing reorganization or changes in ownership. Under the current regulation, for purposes of determining whether hospitals are eligible for receiving EHR incentive payments CMS uses the CMS Certification Number (CCN) to identify a hospital's status as a meaningful user of CEHRT. CCNs will also be used to identify hospitals for purposes of determining marketbasket payment penalties beginning in FFY 2015. In other words, a hospital's status as a meaningful user of CEHRT for an applicable EHR reporting period (to determine the payment penalty) is tracked by the hospital's CCN.

The association of meaningful use status with the hospital CCN impacts hospitals that are changing ownership, merging or otherwise reorganizing. For example, when a single hospital changes ownership, CMS determines whether to retain the existing CCN or to assign a new CCN depending upon whether the new owner accepts assignment of the provider's prior Medicare participation agreement. Where a change of ownership has occurred and a new CCN is assigned due to the new owner's decision not to accept assignment of the prior provider agreement, **CMS would not recognize a meaningful use determination that was established under the prior CCN for purposes of determining whether the payment penalty applies**. In cases where the new owner accepts the prior provider agreement and maintains the same CCN, CMS would continue to recognize the demonstration of meaningful use under that CCN.

The same policy would apply to merging hospitals that use a single CCN. For example, if hospital A is not a meaningful EHR user (for the applicable EHR reporting period) and it absorbs hospital B, which was a meaningful EHR user, then the entire hospital will be subject to a payment penalty if hospital A's CCN is the surviving identifier. The converse is true as well—if it were hospital B's CCN that survived, the entire merged hospital would not be subject to a payment penalty for the applicable payment penalty year (the hospital would then need to demonstrate ongoing meaningful use to avoid future payment penalties). The guidelines for determining CCN assignment in the case of merged hospitals are described in the *State*

Operations Manual, sections 2779A ff. CMS advises hospitals that are changing ownership, merging, or otherwise reorganizing to take this policy into account.

c. Hardship Exceptions for EHs to Avoid the Payment Penalty

On a case-by-case basis, CMS may grant an exception to the payment penalty for an EH that does not demonstrate meaningful use for the applicable EHR reporting period, if the EH can demonstrate that compliance with the meaningful use requirements would result in a significant hardship. CMS finalized three hardship exception categories for EHs. Exceptions are subject to annual renewal and in no case may an EH be granted an exception for more than five years. The following table outlines hardship exceptions and submission deadlines for EHs (CMS states it will provide additional guidance, subsequent to the publication of the final rule, regarding the 'New Hospital' hardship exception application process and submission deadline):

Hardship Exceptions for Eligible Hospitals			
Exception Category	**Key Information**	**Period of Consideration for Exception**	**Submission Deadline for FFY 2015**
Insufficient Internet Access	Applications will be required to demonstrate insufficient Internet connectivity to comply with the meaningful use objectives requiring Internet connectivity (e.g., summary of care documents, electronic prescribing, making health information available on-line, and submission of public health information) and insurmountable barriers to obtaining such internet connectivity (e.g., high cost to build out Internet to facility).	Demonstrate insufficient Internet access for any 90 days from the start of the FFY two years prior to the payment adjustment year to April 1 of the year prior to the payment adjustment year (e.g., for FFY 2015: October 1, 2012 - April 1, 2014).	April 1, 2014

Hardship Exceptions for Eligible Hospitals			
Exception Category	**Key Information**	**Period of Consideration for Exception**	**Submission Deadline for FFY 2015**
New Hospital	A hospital that changes its status from a hospital (other than a CAH) that is excluded from the Medicare hospital Inpatient Prospective Payment System (IPPS) to a hospital that is subject to the IPPS would be considered a new hospital for purposes of this exception category (e.g., a long-term care hospital, a psychiatric hospital, inpatient rehabilitation facility). For purposes of this exception category the following would not be considered a new hospital: (1) a hospital that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement; (2) a hospital that closes and subsequently reopens; and (3) a hospital that changes its status from a CAH to a hospital that is subject to the Medicare hospital inpatient prospective payment system.	New hospital granted an exception for one full cost reporting period after they admit their first Medicare patient.	Guidance to be issued following publication of the final rule.
Extreme circumstances outside of the hospital's control	An extreme circumstance that creates a hardship for the hospital to become a meaningful user during the applicable EHR reporting period for purposes of the payment penalty. Circumstances might include: hospital is closed; a natural disaster in which an EHR system is destroyed; EHR vendor going out of business; hospital whose CEHRT (complete or modular) loses its certification either through revocation or because the vendor did not upgrade their CEHRT to the latest requirements; and a hospital suffering severe financial distress resulting in a bankruptcy or restructuring of debt. CMS also notes in the preamble that the above list is not exhaustive and other circumstances *may qualify* for a hardship exception (e.g., hospital unable to meet meaningful use because of failure(s) on the part of the EHR vendor). But CMS states clearly that **the hospital would need to demonstrate that it meets the extreme circumstance, that the circumstance was outside of the hospital's control, and the circumstance directly impacted the hospital's ability to demonstrate meaningful use.**	For a hospital that has previously demonstrated meaningful use, the hospital must demonstrate extreme circumstances that affect the FFY two years prior to the payment adjustment year (e.g., for FFY 2015: hardship would be experienced in FFY 2013). For a hospital that has never demonstrated meaningful use, the hospital must demonstrate extreme circumstances that affect the FFY prior to the payment adjustment year (e.g., for FFY 2015: hardship would be experienced in FFY 2014).	April 1, 2014

d. Application of the Marketbasket Adjustment in FFY 2015 and Subsequent FFYs to a State Operating Under a Payment Waiver Provided by Section 1814(B)(3) of the Act

CMS notes that a state operating under a payment waiver under section 1814(b)(3) of the Act must provide to the Secretary, by January 1, 2013, a report on the method that it proposes to employ to make the requisite payment penalty. CMS finalized that an aggregate reduction in payments would mean the same dollar amount in reduced Medicare payments that would have occurred if payments had been reduced to each EH in the state in a manner comparable to the reduction outlined above for EHs.

4) Payment Penalties Effective in FFY 2015 and Subsequent Years for Critical Access Hospitals that are Not Meaningful Users of Certified EHR Technology for an Applicable EHR Reporting Period

a. Reduction of Reasonable Cost Reimbursement for CAHs Beginning in 2015

HITECH outlines adjustments to a CAH's reimbursement at 101% of its reasonable costs beginning in FFY 2015 for CAHs that do not demonstrate meaningful use during the applicable EHR reporting period for the adjustment year. The following table provides a schedule of the Medicare payment penalties in the form of reduced reasonable cost reimbursement for CAHs in FFY 2015 and subsequent years:

Reduced Reasonable Cost Reimbursement for CAHs Beginning in 2015 (unadjusted reasonable costs are reimbursed at 101%)		
2015	**2016**	**2017+**
100.66%	100.33%	100%

b. Applicable EHR Reporting Periods for Determining whether a CAH is Subject to the Reduction of Reasonable Cost Payment 2015+

CMS finalized the alignment of the applicable EHR reporting period, for purposes of determining the payment penalty, with the adjustment applicability year (e.g., if a CAH demonstrated meaningful use in FFY 2015 the CAH avoids the 2015 payment penalty). CMS also finalized three hardship exceptions that are described in section II.D.4.c below. Therefore, to avoid the Medicare payment penalty in the form of the reduced reasonable cost reimbursement, a CAH must do one of the following:

1) demonstrate meaningful use during the payment penalty year and successfully attest by November 30 of the following FFY; or
2) demonstrate meaningful use for the first time in the payment penalty year, with a continuous 90-day reporting period ending no later than September 30, and successfully attest by November 30 of the following FFY; or
3) apply for a hardship exception by the submission deadline and qualify for the exception (e.g., CMS approves the exception request).

The following table outlines the applicable EHR reporting periods for purposes of avoiding the Medicare payment penalty for FFYs 2015 through 2019:

CAH with Cost Reporting Period Beginning During Payment Penalty Year:	Applicable EHR Reporting Periods For Purposes of Avoiding the Medicare Adjustment for CAHs	
	Demonstrate meaningful use for the EHR reporting period:	Demonstrate meaningful use for the first time for a continuous 90-day reporting period ending no later than:
FFY 2015	FFY 2015 (with attestation submission no later than November 30, 2015)	September 30, 2015 (with attestation submission no later than November 30, 2015)
FFY 2016	FFY 2016 (with attestation submission no later than November 30, 2016)	September 30, 2016 (with attestation submission no later than November 30, 2016)
FFY 2017	FFY 2017 (with attestation submission no later than November 30, 2017)	September 30, 2017 (with attestation submission no later than November 30, 2017)
FFY 2018	FFY 2018 (with attestation submission no later than November 30, 2018)	September 30, 2018 (with attestation submission no later than November 30, 2018)
FFY 2019	FFY 2019 (with attestation submission no later than November 30, 2019)	September 30, 2019 (with attestation submission no later than November 30, 2019)

Table Note:

- The timelines for FFY 2020 and subsequent fiscal years follow the same pattern.

For CAHs, CMS finalized an applicable EHR reporting period that is aligned with the payment penalty year. For example, if a CAH is not a meaningful EHR user in FFY 2015, then its Medicare reimbursement will be reduced to 100.66 for its cost reporting period that begins in FFY 2015. This differs from what has been finalized for EHs where the applicable EHR reporting period will be prior to the marketbasket adjustment year. CMS states that the Medicare cost report process allows CMS to make the CAH reduction for the cost reporting period that begins in the payment penalty year, with minimal disruptions to the CAH's cash flow and minimal administrative burden on the Medicare contractors.

The adjustment would then apply based upon the cost reporting period that begins in the payment penalty year (that is, FFY 2015 and thereafter). Thus, if a CAH is not a meaningful user for FFY 2015 and thereafter, the adjustment would be applied to the CAH's reasonable costs incurred in a cost reporting period that begins in that affected FFY.

For example, if a CAH is attesting that it was a meaningful EHR user for FFY 2015, the attestation must be submitted by November 30, 2015. Such an attestation (or lack thereof) would then affect interim payments to the CAH made after December 1 of the applicable FFY. If the cost reporting period ends prior to December 1 of the applicable FFY, then any applicable payment penalty will be made through the cost report settlement process.

c. Hardship Exceptions for CAHs to Avoid the Reasonable Cost Payment Reduction

On a case-by-case basis, CMS may grant an exception to the payment penalty for a CAH that does not demonstrate meaningful use for the applicable EHR reporting period, if the CAH can demonstrate that compliance with the meaningful use requirements would result in a significant hardship. CMS finalized three hardship exception categories for CAHs. Exceptions are subject to annual renewal and in no case may a CAH be granted an exception for more than five years. The following table outlines hardship exceptions and submission deadlines for CAHs (CMS states it will provide additional guidance, subsequent to the publication of the final rule, regarding the "New CAH" hardship exception application process and submission deadline):

Hardship Exceptions for Critical Access Hospitals			
Exception Category	**Key Information**	**Period of Consideration for Exception**	**Submission Deadline for FFY 2015**
Insufficient Internet access	Applications will be required to demonstrate insufficient Internet connectivity to comply with the meaningful use objectives requiring Internet connectivity (e.g., summary of care documents, electronic prescribing, making health information available online, and submission of public health information) and insurmountable barriers to obtaining such Internet connectivity (e.g., high cost to build out Internet to facility).	Demonstrate insufficient Internet access for any 90-day period within the cost reporting period that begins prior to or during the payment adjustment year.	November 20, 2015

Hardship Exceptions for Critical Access Hospitals			
Exception Category	**Key Information**	**Period of Consideration for Exception**	**Submission Deadline for FFY 2015**
New CAH	A hospital that changes its status to a CAH from a hospital that is excluded from the Medicare hospital IPPS would be considered a new hospital for purposes of this exception category (e.g., a long-term care hospital, a psychiatric hospital, inpatient rehabilitation facility). For purposes of this exception category the following would not be considered a new CAH: (1) a CAH that builds new or replacement facilities at the same or another location even if coincidental with a change of ownership, a change in management, or a lease arrangement; (2) a CAH that closes and subsequently reopens; and (3) a CAH that has been converted from an eligible hospital subsection (d) hospital	New CAH granted an exception for one full cost reporting period after it admits its first Medicare patient.	Guidance to be issued following publication of the final rule.
Extreme circumstances outside of the CAH's control.	An extreme circumstance that creates a hardship for the CAH to become a meaningful user during the applicable EHR reporting period for purposes of the payment penalty. Circumstances might include: CAH is closed; a natural disaster in which an EHR system is destroyed; EHR vendor going out of business; CAH whose CEHRT (complete or modular) loses its certification either through revocation or because the vendor did not upgrade their CEHRT to the latest requirements; and a CAH suffering severe financial distress resulting in a bankruptcy or restructuring of debt. CMS also notes in the preamble that the above list is not exhaustive and other circumstances *may qualify* for a hardship exception (e.g., CAH is unable to meet meaningful use because of failure(s) on the part of the EHR vendor). But CMS states clearly that **the CAH would need to demonstrate that it meets this extreme circumstance, that the circumstance was outside of the CAH's control, and the circumstance directly impacted the CAH's ability to demonstrate meaningful use.**	October 1 through September 30 of the payment adjustment year.	November 30, 2015

5) Administrative Review Process (e.g., appeals) for Certain EHR Incentive Program Determinations

The Stage 1 final rule established requirements for states to create appeals processes under the Medicaid EHR Incentive Program, but did not establish an appeal process for the Medicare EHR Incentive Program. In the CMS Stage 2 proposed rule, CMS proposed an administrative appeals process that would apply to both Stage 1 and Stage 2 of meaningful use and proposed to limit permissible appeals to three types of appeals 1) eligibility appeals; 2) meaningful use appeals; and 3) incentive payment appeals.

In the Stage 2 final rule CMS states on page 54112, "we believe the administrative review process is primarily procedural and does not need to be specified in regulation…. Therefore, our administrative appeals process will be included on our Website at www.cms.gov/EHRIncentivePrograms." CMS also notes on page 54112 that it is reluctant to finalize only three categories of appeals stating, "Based on the comments we received and the information we have regarding appeals that have already been filed, we are concerned that finalizing the categories we proposed for appeals could negatively impact providers."

While CMS does not finalize regulations on appeals in the Stage 2 final rule, it does provide the following important commentary in the preamble:

- In the event of an audit, at a minimum, providers should have available electronic or paper documentation that supports providers' completion of the Attestation Module responses, including the specific information that supports each measure. In addition, providers should have documentation to support the submission of CQMs, including the specific information that supports each measure. Providers (e.g., hospitals and CAHs) should also maintain documentation to support their incentive payment calculations; for example, data to support amounts included on their cost report, which are used in the calculation. All documentation should be kept for at least six years.

- There will not be appeal reconsiderations of hardship exception or payment adjustment determinations. The granting of hardship exception will be through an application process, and CMS expects providers to make a full declaration of all relevant information at the time of filing a hardship application. The HITECH Act prohibits both administrative and judicial review of the standards and methods used to determine payment adjustments, including hardship exceptions to those payment adjustments.

E. Medicare Advantage Organization Incentive Payments

1) Definitions

CMS finalized definitions of the following terms regarding Medicare Advantage Organizations: "MA payment penalty year," "Potentially qualifying MA-EP," and "Potentially qualifying MA-affiliated eligible hospitals" to cross-reference the definition from the Stage 1 rule.

CMS declined to finalize the proposed definitions of the terms "Adverse eligibility determination" and "Adverse payment determination," stating that formal regulatory definitions are not required for an informal reconsideration procedural rule.

CMS clarifies the application of "hospital-based EP" as that term is used regarding the definition of "qualifying MA EP": the calculation is not based on fee-for-service (FFS) covered professional services, but rather on MA plan enrollees. Otherwise, qualifying MA EPs who provide at least 80% of their covered professional services to MA plan enrollees of qualifying MA organizations might be considered "hospital based" solely on the basis of the fact that 90% of their FFS-covered professional services were provided in a hospital setting. CMS is clarifying in the definition of "qualifying MA EP" that for purposes of the MA EHR Incentive Program, a hospital-based MA EP provides 90% or more of his or her covered professional services in a hospital setting to MA plan enrollees of the qualifying MA organization.

2) Identification of Qualifying MA Organizations, MA-EPs and MA-affiliated Eligible Hospitals

CMS finalized a technical change to indicate that a qualifying MA organization must identify those MA EPs and MA-affiliated eligible hospitals that the qualifying MA organization believes will be meaningful users of CEHRT during the reporting period, if a qualifying MA organization intends to claim an incentive payment for a given qualifying MA EP or MA-affiliated eligible hospital. MA organizations must identify both "qualifying" and "potentially qualifying" MA EPs and MA-affiliated eligible hospitals as part of this process.

Prior to the Stage 2 final rule, MA organizations were required to identify qualifying MA EPs or MA-affiliated eligible hospitals **within 60 days** of the close of the payment year. CMS changed the "within 60 days" requirement to "within two-months" to be consistent with the Medicare FFS EHR Incentive Program. CMS also clarifies that MA organizations must report the CMS Certification Number (CCN) for qualifying MA-affiliated eligible hospitals.

CMS finalized a new reporting requirement to ensure that CMS can identify which qualifying MA EPs a given qualifying MA organization believes have furnished more than 50% of their covered Medicare professional services to MA enrollees of the qualifying MA organization in a designated geographic Health Professional Shortage Area (HPSA) during the reporting period.

3) Incentive Payments to Qualifying MA Organization for Qualifying MA EPs and Qualifying MA-Affiliated Eligible Hospitals

CMS clarifies that methods relating to overhead costs may be submitted for MA EPs regardless of whether the MA EP is salaried or paid in another fashion, such as on a capitated basis. MA organizations must

submit revenue amounts relating to qualifying MA EPs within two months of the close of the calendar year, as opposed to 60 days.

CMS clarifies that an MA organization does not automatically receive a HPSA bonus because its qualifying MA EPs predominantly serve a geographic HPSA. In order for the MA organization to receive the 10% increase, the MA EP would need to provide at least 10% or more of Medicare Part B covered professional services to MA plan enrollees of the qualifying MA organization.

CMS included language in the final rule to clarify that if 1) a qualifying MA EP; 2) an entity that employs a qualifying MA EP; 3) an MA-affiliated eligible hospital; or 4) another party contracting with the qualifying MA organization fails to comply with an audit request for documentation needed to audit the validity of an EHR incentive payment, CMS will recoup the EHR incentive payment.

CMS clarifies that duplicative incentives are prohibited. If a qualifying MA organization is paid for a qualifying MA EP and it is later determined that the MA EP is entitled to a full incentive under the Medicare FFS EHR Incentive Program or has received payment under the Medicare EHR Incentive Program, CMS will recover fund paid to the qualifying MA organization. If it is determined that an MA organization has received an incentive payment for an MA-affiliated EH that also received a payment under the Medicare FFS EHR Incentive Program, CMS will recover the funds paid to the qualifying MA organization.

4) Avoiding Duplicate Payments

Qualifying MA EPs are eligible for the Medicare FFS EHR incentive payment if they meet certain requirements under that program. However, an EHR incentive payment is only allowed under one program. In order to avoid the duplicate payment situations, CMS finalized a requirement that each qualifying MA organization must attest (as part of the existing attestation process) that it has notified MA EPs of its intent to claim the MA EP under the EHR Incentive Program.

5) Payment Penalties Effective for 2015 and Subsequent MA Payment Penalty Years

Beginning in 2015, if a qualifying MA organization's potentially qualifying MA EPs or MA-affiliated EHs (or both) are not meaningful users of CEHRT, adjustments will be made to monthly MA payments. In order to have its Part C payment adjusted during the payment penalty phase of the program an MA organization: 1) must have at least initiated participation in the incentive payment phase of the program from 2011 through 2014 for MA EPs or through 2015 for MA-affiliated EHs; and 2) must continue to qualify for participation in the program as a "qualifying MA organization." The payment penalty is also conditioned on the qualifying MA organization having potentially qualifying MA EPs and MA-affiliated EHs for the respective payment penalty years. Further, the payment penalties for not demonstrating meaningful use will only apply to qualifying MA organizations for the category (or categories) of MA provider (either MA-EP, MA-affiliated hospital, or both) for which it claimed and received MA EHR incentive payments.

CMS notes that organizations that do not meet the Public Health Service (PHS) definition of "Health Maintenance Organization" cannot receive an incentive payment and would likewise not be eligible to have its Part C payment adjusted for having potentially qualifying MA EPs or MA-affiliated EHs that do not

successfully demonstrate meaningful use (see 2010 Medicare and Medicaid EHR Incentive Program final rule) for this and other current requirements.

Under the current regulation, qualifying MA organizations that have potentially qualifying MA EPs or MA-affiliated EHs that are not meaningful users are required to initially report that fact to CMS beginning in June of MA plan year 2015. This reporting requirement would include only qualifying MA organizations that participated in and received MA EHR incentive payments. CMS will adjust payments beginning for payment penalty year 2015 only for qualifying MA organizations that received MA EHR payments and that have potentially qualifying MA EPs or MA-affiliated EHs that are not meaningful users. CMS states that it would rely on the existing self-reporting requirements and subsequent audits to ensure compliance.

For MA organizations, final attestation of meaningful use would occur after the end of the EHR reporting period, which for MA EPs will run concurrent with the payment penalty year. For MA-affiliated EHs, attestation of meaningful use would occur by the end of November after the EHR reporting period. CMS will collect payment penalties after meaningful use attestations have been made. CMS intends to adjust one or more of the qualifying MA organization's monthly MA payments after the qualifying MA organization attests to the percent of hospitals and professionals that either are or are not meaningful users of CEHRT.

MA EP payment penalties: Beginning in 2015, if a qualifying MA EP is not a meaningful EHR user during the payment penalty year, CMS will determine a payment penalty based on data from the payment penalty year and will collect the payment penalty owed by adjusting a subsequent year's prospective payment or payments, or by otherwise collecting the payment penalty, if, in the year of collection, the MA organization does not have an MA contract with CMS.

Beginning in 2015, a qualifying MA organization that previously received incentive payments must, for each payment penalty year, report to CMS the following: [total number of potentially qualifying MA EPs] divided by the [(total number of potentially qualifying MA EPs) + (the total number of qualifying MA EPs)]. CMS will adjust the monthly prospective payment amount for the payment penalty year by taking the resulting percentage above and multiplying it by the Medicare Physician Expenditure Proportion percent and then take the applicable percent (Medicare payment penalty percent) as follows: 1% for 2015, 2% for 2016, 3% for 2017, and 3% for 2018, 3% for 2019 and subsequent years.

If the resulting percentage of [total number of potentially qualifying MA EPs] divided by the [(total number of potentially qualifying MA EPs) + (the total number of qualifying MA EPs)] is greater than 25% beginning in 2018, then the applicable percent (Medicare payment penalty) will be increased by 1%. In no case will the applicable percent (Medicare payment penalty) be higher than 5%.

MA-affiliated eligible hospital payment penalties: Beginning in 2015, the Medicare payment penalty applies if a qualifying MA organization that previously received an incentive payment (or a potentially qualifying MA-affiliated EH on behalf of its qualifying MA organization) attests that a qualifying MA-affiliated EH is not a meaningful EHR user for a payment penalty year. The payment penalty is calculated by multiplying the qualifying MA organization's monthly prospective payment for the payment penalty year by the product of:

> [payment penalty reduction to the applicable percentage increase in the marketbasket or 25% in 2015, 50% in 2016, and 75% in 2017 and subsequent years] x

[Medicare Hospital Expenditure Proportion percent] x

[[number of potentially qualifying MA-affiliated eligible hospitals]/ [(the total number of potentially qualifying MA-affiliated eligible hospitals) + (the total number of qualifying MA affiliated eligible hospitals)]

= payment penalty (penalty) amount for the year.

Note: The Medicare Hospital Expenditure Proportion for a year is the estimate of expenditures under Part A and B that are not attributable to Part C, that are attributable to expenditures for inpatient hospital services, adjusted for the proportion of expenditures that are provided by hospitals that are neither qualifying nor potentially qualifying MA-affiliated EHs with respect to a qualifying MA organization.

6) Reconsideration Process for MA Organizations

CMS proposed an appeals process for MA organizations to seek reconsideration of adverse eligibility or payment determination regarding the EHR Incentive Program in the March 2012 Stage 2 proposed rule.

In the Stage 2 final rule CMS states on page 54112, "we believe the administrative review process is primarily procedural and does not need to be specified in regulation . . . . Therefore, our administrative appeals process will be included on our website at www.cms.gov/EHRIncentivePrograms."

7) MA Organizations and Submission of Quality Measure Reporting

CMS confirms in the Stage 2 final rule that during Stage 2 and subsequent stages of the MA EHR Incentive Program implementation, CMS will continue to require qualifying MA organizations (MA-EPs and MA-affiliated EHs) to successfully report Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcomes Survey (HOS), and CAHPS (Consumer Assessment of Healthcare Providers and Systems) measures **in lieu of** the CQMs defined under the Medicare and Medicaid EHR Incentive Programs.

F. Medicaid Revisions and Clarifications to Take Effect with Finalization of Stage 2 Rule

The revisions and clarifications discussed in this section took effect upon publication of the Stage 2 final rule in the *Federal Register* on September 4, 2012.

1) Net Average Allowable Costs EPs

CMS formalizes through rulemaking that EPs are not required to provide documentation of certain costs related to acquiring and implementing CEHRT (e.g., "net average allowable costs"). The Medicare and Medicaid Extenders Act of 2010 amended the relevant statue by allowing for providers to simply document and attest that they have adopted, implemented, upgraded, or are meaningfully using CEHRT.

2) Definition of Adopt, Implement, Upgrade

CMS clarifies in the final rule that to qualify for a Medicaid "adopt, implement, or upgrade" payment in year one of the Medicaid EHR Incentive Program, a provider must adopt, implement or upgrade to CEHRT **that would allow that provider to qualify as a meaningful user**.

3) Eligibility Requirements for Children's Hospitals

The definition of a children's hospital was revised to also include any separately certified hospital, either freestanding or hospital within hospital that predominately treats individuals under 21 years of age, and that does not have a CCN because it does not serve any Medicare beneficiaries but has been provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program. CMS will provide future guidance to these hospitals and the states on enumeration and determining eligibility.

4) Medicaid Program Eligibility

CMS finalized a policy that at least one of the clinical locations used for the calculation of an EP's Medicaid patient volume have CEHRT during the payment year for which the EP is attesting to adopt, implement or upgrade in its first participation year, or to meaningful use in subsequent years. CMS intends to ensure that an EP receives Medicaid funding for CEHRT that is used on behalf of the EP's Medicaid patients.

a. Calculating Patient Volume Requirements

CMS finalized a policy to allow states the option for their providers to calculate total Medicaid or total needy individual patient encounters in any representative, continuous 90-day period in the 12 months preceding the EP or EH's attestation. This option would be in addition to the current regulatory language basing patient volume on the prior calendar or fiscal year. **This is an option for states to implement at their discretion: states must seek prior approval from CMS via an amendment to their state Medicaid HIT Plan before implementing this change.**

CMS finalized a policy to allow states the option for their providers to calculate total Medicaid patients assigned to the EP's panel in any representative, continuous 90-day period in either the preceding calendar

year, as is currently permitted, or in the 12 months preceding the EP's attestation when at least one Medicaid encounter took place with the Medicaid patient in the 24 months prior to the beginning of the 90-day period. **This is an option for states to implement at their discretion: states must seek prior approval from CMS via an amendment to their state Medicaid HIT Plan before implementing this change.**

CMS finalized a policy to expand the current definition of "encounter" to include any service rendered on any one day to an individual "enrolled" in a Medicaid program. Such a definition would ensure that patients enrolled in a Medicaid program are counted, **even if the Medicaid program did not pay for the service** (e.g., a third-party payer paid for the service or the service is not covered under Medicaid). CMS also finalized a policy to include encounters for patients who are Title XIX eligible and who meet the definition of "optional targeted low income children" under section 1905(u)(2) of the Act. Thus, individuals in Title XXI-funded Medicaid expansions (but not separate CHIP programs) could be counted in providers' patient volume calculations. As of 2010, 33 states have Title XXI Medicaid expansions via approved State Plan Amendments and providers in those states would be able to include encounters with individuals in such expansions in their patient volume calculation for purposes of this program. **States are directed to implement this new definition of "Medicaid encounter" no later than six months after publication of the Stage 2 final rule and only for providers attesting for the 2013 program year and subsequent program years. The expanded definition of "Medicaid encounter" will not apply to 2012 attestations or be applied retroactively to attestations already filed with CMS for 2011 or 2012.**

CMS finalized a clarification for calculating Medicaid patient volume when Medicaid patients are seen by multiple providers. Multiple providers may submit an encounter for the same patient on the same day. For example, it may be common for a physician assistant (PA) or nurse practitioner (NP) to provide care to a patient, then a physician to also see, or invoice for services to that patient. CMS clarifies that it is acceptable in these and similar circumstances to count the same encounter for multiple providers for purposes of calculating each provider's patient volume when the encounters take place within the scope of practice.

b. Practices Predominantly in a Federally Qualified Health Center or Rural Health Clinic

CMS finalized a policy to allow states the option for their EPs to use either: 1) the most recent calendar year; or 2) the most recent 12 months prior to attestation for determining their status as "practicing predominantly" in a Federally Qualified Health Center or Rural Health Clinic. **This is an option for states to implement at their discretion: states must seek prior approval from CMS via an amendment to their state Medicaid HIT Plan before implementing this change.**

5) Medicaid Hospital Incentive Payment Calculation

a. Discharge Related Amount

To ensure that Medicaid regulations are consistent with Medicare, CMS proposed that the Medicaid calculation should be consistent with the Medicare calculation, which requires the use of the "12-month period selected by the state, but ending in the federal fiscal year before the hospital's fiscal year that

serves as the first payment year." CMS goes on to note that some hospitals may not have a full 12 months of data ending with the FFY immediately preceding the first payment year, or they may have a slightly older 12-month period that could be used.

Therefore, CMS is revising its policy to allow states to use, for the purpose of calculating the discharge related amount, and other determinations (e.g., such as inpatient bed days), the most recent continuous 12-month period for which data are available prior to the payment year. If such 12-month period is a cost report, it should be one, single 12-month cost reporting period (and not a consolidation of two separate cost reporting periods). If it is an alternative source different from the cost report, CMS would rely on the state to ensure that the source is an appropriate source, that the period is a continuous 12 months, and that the state is using the most recent data that are available.

b. Acute Care Inpatient Bed Days and Discharges for the Medicare Share and Discharge Related Amount

CMS clarifies that only discharges from the acute care part of the hospital are allowable to be counted in both the discharge-related amount and the Medicaid share. For example, in FAQ 10361, CMS explained that nursery days and nursery discharges (for newborns) could not be counted in both the Medicare and Medicaid EHR Incentive Programs. CMS amended the hospital payment regulations to recognize that only acute care discharges and bed days are included in the calculations. CMS clarifies that such regulatory amendments do not represent a change in policy but rather a clarification of existing policy. The Medicaid share would count only those days that would count as inpatient bed days for Medicare purposes.

c. Hospitals Switching States

There could arise a situation where a hospital changes participation from one State Medicaid EHR incentive program to participate in another State Medicaid EHR Incentive Program. CMS clarifies that in no case will a hospital receive more than the aggregate incentive amount calculated by the state from which the hospital initiated participation in the program. Hospitals are required under the current regulation to choose only one state per payment year from which to receive an incentive payment. Under this scenario, both states would be required to work together to determine the remaining payments due to the hospital based on the aggregate incentive amount and incentive amounts already paid. The hospital would then assume the second state's payment cycle less the money that was paid from the first state. CMS requests that states should consult with CMS before addressing this specific scenario.

6) Hospital Demonstrations of Meaningful Use—Auditing and Appeals

CMS finalized a policy under which states would have the option for CMS to conduct audits and handle any subsequent appeals of whether EHs are meaningful EHR users on the state's behalf, including those that are eligible for only the Medicaid EHR Incentive Program. Under this option, hospitals would be subject to the CMS appeals process for any disputes regarding audit findings related to meaningful use, and states would be bound by CMS determinations regarding meaningful use findings. Appeals of adverse CMS audits would be subject to the CMS administrative appeals process and not the state administrative process. Because the regulation text made the CMS audits and appeals a state option, no state would be required to delegate the responsibility to CMS.

Under these regulations, states that opt for CMS to conduct meaningful use audits and appeals will remain responsible for auditing all other aspects of eligibility for both EPs and EHS for incentive payments,

including, but not limited to: (1) adoption, implementation or upgrade; (2) patient volume; (3) average stay length; and (4) calculation of payment amounts. States would also remain responsible for auditing Medicaid EPs for compliance with meaningful use of CEHRT.

7) State Flexibility for Stage 2 of Meaningful Use

States may propose a revised definition for Stage 2 of meaningful use of CEHRT, subject to CMS prior approval, but only with respect to the following objectives: 1) generate list of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach; 2) Capability to submit electronic data to immunization registries or immunization information systems; 3) Capability to submit electronic reportable laboratory results to public health agencies; 4) capability to provide electronic syndromic surveillance data to public health agencies; 5) capability to identify and report cancer cases to a public health central cancer registry; and 6) capability to identify and report specific cases to a specialized registry.

A state may have the discretion to move a menu objective to a core objective, specify the means of transmission of the data, or otherwise change the public health measures, as long as it does not require EHR functionality above and beyond that which is included in the ONC "2014 Edition" certification final rule.

III. Waiver of Delayed Effective Date

CMS notes in the final rule that it ordinarily provides a 60-day delay in the effective date of the provisions of a major rule. However, the Secretary finds that good cause exists to make certain regulatory provisions effective upon publication in the *Federal Register*.

CMS states in the final rule that the 60-day delay in effective date will be waived and the following regulatory provisions will be effective upon publication in the *Federal Register*:

- Changes to the criteria for Stage 1 Meaningful Use beginning in with the 2013 EHR Reporting Periods (see section II.A.3.b.)
- A technical correction to S495.102(c) that states "In the case of a qualifying EP who furnishes more than 50 percent of his or her covered professional services during the payment year in a geographic HPSA that is designated as of December 31 of the prior year, the incentive payment limit determined under paragraph (b) of this section is to be increased by 10 percent."
- Medicaid EHR Incentive Program revisions and clarifications (see section II.F.)

IV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, CMS is required to provide 60-day notice in the *Federal Register* and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. CMS is soliciting comments on the following issues:

- the need for the information collection and its usefulness in carrying out the proper functions of CMS;
- the accuracy of CMS' estimate of the information collection burden;
- the quality, utility, and clarity of the information to be collected; and
- recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

CMS outlines new information collection requirements for eligible providers based on the Stage 2 final rule. CMS contends that the actual burden would remain constant for all of Stage 2 as eligible providers will only need to attest that they have successfully demonstrated meaningful use one time per program participation year. The only variable from year to year in Stage 2 would be the number of respondents, as noted in the *Impact Analysis Assumptions*.

CMS states that to successfully demonstrate meaningful use of CEHRT for Stage 2, an EP, EH or CAH (collectively referred to as "provider" in this section) must attest, through a secure mechanism in a specified manner, to the following during the EHR reporting period: 1) the provider used CEHRT and specified the technology that was used; and 2) the provider satisfied each of the applicable objectives and associated measures for Stage 2; and 3) providers must also successfully report the clinical quality measures selected by CMS to CMS or the states, as applicable. CMS estimates that the CEHRT adopted by the provider will capture many of the objectives and associated measures and generate automated numerator and denominator information where required, or generate automated summary reports.

For Stage 2 meaningful use EPs would be required to report on a total of 13 core objectives and associated measures, three menu set objectives and associated measures, and nine ambulatory clinical quality measures. Eligible hospitals and CAHs would be required to report on a total of 16 core objectives and associated measures, two of four menu set objectives and associated measures, and 16 clinical quality measures.

There are 13 core objectives and up to three menu set objectives that would require an EP to enter numerators and denominators during attestation. Eligible hospitals and CAHs would have to attest they have met ten core objectives and three menu set objectives that require numerators and denominators. For objectives and associated measures requiring a numerator and denominator, CMS limits estimates to actions taken in the presence of CEHRT. CMS makes the assumption that a provider would not maintain two recordkeeping systems when CEHRT is present and therefore, all patient records that would be counted in the denominator would be kept using CEHRT. CMS estimates that it would take an individual provider or its designee approximately ten minutes to attest to each meaningful use objective and

associated measure that requires a numerator and denominator to be generated, as well as each CQM for providers attesting in their first year of the program.

Additionally, providers will be required to report they have completed objectives and associated measures that require a ”yes“ or ”no“ response during attestation. For EPs, there are three core objectives and up to three menu set objectives that would require a ”yes“ or ”no“ response during attestation. For EHs and CAHs, there are five core objectives and that would require a ”yes“ or ”no“ response during attestation and no such menu set objectives. It is expected that it would take a provider or its designee one minute to attest to each objective that requires a ”yes“ or ”no“ response.

Providers would also be required to attest that they are protecting electronic health information. CMS estimates completion of the analysis required to successfully meet the associated measure for this objective will take approximately six hours, which is identical to our estimate for the Stage 1 requirement. This burden estimate assumes that covered entities are already conducting and reviewing these risk analyses under current HIPAA regulations. Therefore, CMS has not accounted for the additional burden associated with the conduct or review of such analyses.

Table 20 in the final rule lists those objectives and associated measures for EPs, EHs, and CAHs and CMS estimates that the core set of objectives and associated measures will take an EP eight hours and 13 minutes to complete, and will take an EH or CAH seven hours and 45 minutes to complete. For EPs, CMS estimates the completion of three menu set objectives and associated measures will take between three and 30 minutes to complete, depending on the combination of objectives they choose to attest to. For EPs, CMS estimates the selection, preparation, and electronic submission of the nine ambulatory clinical quality measures would take one hour and 30 minutes; for EHs and CAHs, 30 minutes to attest to the three menu set objectives they choose. For EHs and CAHs, CMS estimates the selection, preparation, and electronic submission of 16 required clinical quality measures would take two hours and 40 minutes.

V. Regulatory Impact Analysis

CMS states that it expects the Stage 2 final rule to have an annual effect on the economy of $100 million or more, making it an economically significant rule under the Executive Order and a major rule under the Congressional Review Act. Accordingly, CMS prepared a Regulatory Impact Analysis that presents the costs and benefits of the final rule. The total federal cost of the Medicare and Medicaid EHR Incentive Programs is estimated to be $15.4 billion for transfer payments to Medicare and Medicaid providers between 2014 and 2019 (these estimates include payment adjustments for Medicare providers who do not achieve meaningful use and are subject to payment penalties in 2015 and subsequent years in the amount of $2.1 billion).

In the final rule, CMS does not quantify the overall benefits to the industry, nor to EHs or EPs in the Medicare and Medicaid EHR Incentive Programs. That said, CMS believes there to be substantial benefits that can be obtained by EHs and EPs, including: reductions in medical recordkeeping costs, reductions in repeat tests, decreases in length of stay, and reduced errors. When used effectively, EHRs can enable providers to deliver health care more efficiently.

APPENDIX A: Comparison of Stage 1 and Stage 2 Meaningful Use Criteria—Eligible Professionals

Meaningful Use Objectives EPs	Core/Menu		Meaningful Use Measures—EPs	
	Stage 1	Stage 2	Stage 1	Stage 2
Drug-drug/drug-allergy interaction checks.[1]	CORE		Functionality enabled	These objectives have been incorporated into other Stage 2 objectives (see table endnotes).
Maintain an up-to-date problem list.[2]	CORE		> 80%	
Maintain active medication list.[3]	CORE		> 80%	
Maintain active medication allergy list.[4]	CORE		> 80%	
Report clinical quality measures (CQMs).[5]	CORE		Report CQMs	
Provide patients with an electronic copy of their health information upon request.[6]	CORE		> 50%	
Capability to electronically exchange key clinical information.[7]	CORE		Conduct a test	
Implement drug-formulary checks.[8]	MENU		Functionality enabled and access to at least one internal or external formulary.	
Use CPOE.	CORE	CORE	> 30% for medication orders	> 60% of medication orders >30% of laboratory orders >30% of radiology orders
Electronic prescribing (eRx).	CORE	CORE	> 40%	> 50%
Record key demographics.	CORE	CORE	> 50%	> 80%
Record and chart changes in vital signs.	CORE	CORE	> 50%	> 80%
Record smoking status for patients 13 years or older.	CORE	CORE	> 50%	> 80%
Clinical decision support.	CORE	CORE	Implement one clinical decision support intervention	1) Implement five clinical decision support interventions; and 2) enable drug-drug and drug-allergy interaction checks
Provide clinical summaries for patients for each office visit.	CORE	CORE	>50%	>50%

Meaningful Use Objectives EPs	Core/Menu		Meaningful Use Measures—EPs	
	Stage 1	Stage 2	Stage 1	Stage 2
Protect electronic health information.	CORE	CORE	Conduct or review a security risk analysis and implement security updates.	Conduct or review a security risk analysis, including addressing the encryption/security of data at rest requirements, and implement security updates as necessary.
Incorporate clinical lab test results into EHR as structured data.	MENU	CORE	> 40%	> 55%
Generate lists of patients by specific conditions.	MENU	CORE	Generate at least one report.	Generate at least one report.
Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care.	MENU	CORE	> 20%	> 10%
Use CEHRT identify patient-specific education resources and provide to patient.	MENU	CORE	> 10%	> 10%
Perform medication reconciliation for transitions of care by receiving provider.	MENU	CORE	> 50%	> 50%
Provide summary care record for each transition of care or referral.	MENU	CORE	> 50% (sent via paper or electronically)	1) > 50% of patients provided with a summary of care record; and 2) for > 10% of transitions of care or referrals the EP electronically transmits a summary of care record to a recipient with no organizational affiliation and using a different CEHRT vendor than the sender.
Capability to submit electronic data to immunization registries or immunization information systems.	MENU	CORE	Performed at least one test.	Successful ongoing submission of electronic immunization data.
Capability to submit electronic syndromic surveillance data to public health agencies.	MENU	MENU	Performed at least one test.	Successful ongoing submission.

Meaningful Use Objectives EPs	Core/Menu		Meaningful Use Measures—EPs	
	Stage 1	Stage 2	Stage 1	Stage 2
Stage 1: provide online access and in Stage 2: expand online capability to include the ability for patients to download, and transmit their health information.	MENU	CORE	> 10%	1) > 50% of patients are provided online access to their health information; and 2) > 5% of all unique patients view, download, or transmit their health information.
Use secure messaging to communicate with patients on relevant health information.		CORE		> 5%
Imaging results and information are accessible through CEHRT.		MENU		>10%
Record patient family health history as structured data.		MENU		> 20%
Capability to identify and report cancer cases to a state cancer registry.		MENU		Successful ongoing submission.
Capability to identify and report specific cases to a specialized registry (other than a cancer registry).		MENU		Successful ongoing submission.
Record electronic notes in patient records.		MENU		At least 1 note for >30% of patients with at least one office visit.

[1] For Stage 2 included in decision support objective; [2,3,4] Objectives have been incorporated into the provide summary care record objective; [5] For Stage 2 report clinical quality measures is being incorporated into the definition of meaningful use and will no longer be tracked as an objective tied to a specific Stage of meaningful us; [6] For Stage 2 included in provide patients ability to view online, download, and transmit health information objective; [7] For Stage 2 included with summary care record objective; [8] For Stage 2 included in eRx objective as prescriptions must be compared to at least one drug formulary prior to eRx.

APPENDIX B: Comparison of Stage 1 and Stage 2 Meaningful Use Criteria—Eligible Hospitals and Critical Access Hospitals

Meaningful Use Objectives EHs and CAHs	Core/Menu		Meaningful Use Measures—EHs and CAHs	
	Stage 1	Stage 2	Stage 1	Stage 2
Drug-drug/drug-allergy interaction checks.[1]	CORE		Functionality enabled.	These objectives have been incorporated into other Stage 2 objectives (see table endnotes).
Maintain an up-to-date problem list.[2]	CORE		> 80%	
Maintain active medication list.[3]	CORE		> 80%	
Maintain active medication allergy list.[4]	CORE		> 80%	
Report clinical quality measures (CQMs).[5]	CORE		Report CQMs.	
Provide patients with an electronic copy of their health information upon request.[6]	CORE		> 50%	
Capability to electronically exchange key clinical information. [7]	CORE		Conduct a test.	
Provide patients with an electronic copy of their discharge instructions upon request.[9]	CORE		> 50%	
Implement drug-formulary checks.[8]	MENU		Functionality enabled with access to at least one internal or external formulary.	
Use CPOE.	CORE	CORE	> 30% for medication orders	> 60% of medication orders > 30% of laboratory orders >30% of radiology orders
Record key demographics.	CORE	CORE	> 50%	> 80%
Record and chart changes in vital signs.	CORE	CORE	> 50%	> 80%
Record smoking status for patients 13 years or older.	CORE	CORE	> 50%	> 80%
Clinical decision support.	CORE	CORE	Implement one clinical decision support intervention.	1) Implement five clinical decision support interventions; and 2) enable drug-drug and drug-allergy interaction checks.
Protect electronic health information.	CORE	CORE	Conduct or review a security risk analysis and implement security updates.	Conduct or review a security risk analysis, including addressing the encryption/security of data at rest requirements, and implement security updates as necessary.

Meaningful Use Objectives EHs and CAHs	Core/Menu		Meaningful Use Measures—EHs and CAHs	
	Stage 1	Stage 2	Stage 1	Stage 2
Incorporate clinical lab test results into EHR as structured data.	MENU	CORE	> 40%	> 55%
Generate lists of patients by specific conditions.	MENU	CORE	Generate at least one report.	Generate at least one report.
Use CEHRT to identify patient-specific education resources and provide to patient.	MENU	CORE	> 10%	> 10%
Perform medication reconciliation for transitions of care by receiving provider.	MENU	CORE	> 50%	> 50%
Provide summary care record for each transition of care or referral.	MENU	CORE	> 50% (sent via paper or electronically).	1) >50% of patients provided with a summary of care record; and 2) for > 10% of transitions of care or referrals the EP electronically transmits a summary of care record to a recipient with no organizational affiliation and using a different CEHRT vendor than the sender.
Capability to submit electronic data to immunization registries or immunization information systems.	MENU	CORE	Performed at least one test.	Successful ongoing submission.
Submit electronic reportable laboratory results to public health agencies.	MENU	CORE	Performed at least one test.	Successful ongoing submission.
Capability to submit electronic syndromic surveillance data to public health agencies.	MENU	CORE	Performed at least one test.	Successful ongoing submission.
Record whether a patient age 65 years or older has an advance directive.	MENU	MENU	> 50%	> 50%

Meaningful Use Objectives EHs and CAHs	Core/Menu		Meaningful Use Measures—EHs and CAHs	
	Stage 1	Stage 2	Stage 1	Stage 2
Provide patients the ability to view online, download, and transmit their health information.		CORE		1) > 50% of all unique patients are provided online access to health information; and 2) > 5% of all unique patients view, download, or transmit their health information.
Track medications using assistive technologies in conjunction with an eMAR.		CORE		> 10%
Imaging results and information are accessible through CEHRT.		MENU		> 10%
Record patient family health history as structured data.		MENU		> 20%
Generate and transmit permissible discharge prescriptions electronically (eRx).		MENU		> 10%
Record electronic notes in patient records.		MENU		At least one note for > 30% of patients.
Provide structured electronic lab results to ambulatory providers.		MENU		>20%

[1] For Stage 2 included in decision support objective; [2,3,4] Objectives have been incorporated into the provide summary care record objective; [5] For Stage 2 report clinical quality measures is being incorporated into the definition of meaningful use and will no longer be tracked as an objective tied to a specific stage of meaningful use; [6,9] For Stage 2 included in provide patients ability to view online, download, and transmit health information objective; [7] For Stage 2 included with summary care record objective; [8] For Stage 2 included in eRx measure as prescriptions must be compared to at least one drug formulary prior to eRx.

APPENDIX C: Table 8—CQMs Finalized for Medicare and Medicaid Eligible Professionals Beginning with CY 2014

Table Notes: 1) this reference table has been sorted by "Domain," "New Measure," and then "NQF #;"
2) CQMs that are part of the "recommended core CQMs for adults" are denoted with an * and CQMs that are part of the "recommended core set of CQMs for children" are denoted with an **.

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014

Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
TBD *	Title: Closing the referral loop: receipt of specialist report Description: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	CMS (888) 734-6433 or https://questions.cms.hhs.gov/app/ask/p/21,26,1139		New	Care Coordination
NQF 0060	Title: Hemoglobin A1c Test for Pediatric Patients Description: Percentage of patients five to 17 years of age with diabetes with an HbA1c during the measurement period.	National Committee for Quality Assurance (NCQA) www.ncqa.org		New	Clinical Process/ Effectiveness
NQF 0104	Title: Major Depressive Disorder (MDD): Suicide Risk Assessment Description: Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.	AMA- Physician Consortium for Performance Improvement (PCPI) cpe@ama-assn.org	PQRS	New	Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0108 **	Title: ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication Description: Percentage of children six to 12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.	NCQA www.ncqa.org		New	Clinical Process/ Effectiveness
NQF 0110	Title: Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use Description: Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Center for Quality Assessment and Improvement in Mental Health (CQAIMH) www.cqaimh.org; cqaimh@cqaimh.org	NCQA-Patient-Centered Medical Home (PCMH) Recognition	New	Clinical Process/ Effectiveness
NQF 0403	Title: HIV/AIDS: Medical Visit Description: Percentage of patients regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 60 days between each visit.	AMA-PCPI cpe@ama-assn.org; NCQA www.ncqa.org		New	Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0405	Title: HIV/AIDS: Pneumocystitis jiroveci pneumonia (PCP) Prophylaxis Description: Percentage of patients aged six weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.	AMA-PCPI cpe@ama-assn.org; NCQA www.ncqa.org	PQRS, NCQA-PCMH Recognition	New	Clinical Process/ Effectiveness
TBD (proposed as NQF 0407)	Title: HIV/AIDS: RNA control for patients with HIV Description: Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS with at least two visits during the measurement year, with at least 60 days between each visit, whose most recent HIV RNA level is <200 copies/mL.	NCQA www.ncqa.org	PQRS	New	Clinical Process/ Effectiveness
NQF 0565	Title: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery Description: Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.	AMA-PCPI cpe@ama-assn.org; NCQA www.ncqa.org	PQRS	New	Clinical Process/ Effectiveness
NQF 0608	Title: Pregnant women that had HBsAg testing Description: This measure identifies pregnant women who had an HBsAg (hepatitis B) test during their pregnancy.	Ingenix www.ingenix.com		New	Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0710	Title: Depression Remission at Twelve Months Description: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at 12 months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	Minnesota Community Measurement (MNCM) www.mncm.org; info@mncm.org		New	Clinical Process/ Effectiveness
NQF 0712	Title: Depression Utilization of the PHQ-9 Tool Description: Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a four-month period in which there was a qualifying visit.	MNCM www.mncm.org; info@mncm.org		New	Clinical Process/ Effectiveness
TBD **	Title: Children who have dental decay or cavities Description: Percentage of children ages 0-20, who have had tooth decay or cavities during the measurement period.	Maternal and Child Health Bureau, Health Resources and Services Administration http://mchb.hrsa.gov		New	Clinical Process/ Effectiveness
TBD	Title: Primary Caries Prevention Intervention as Offered by Primary Care Medical Providers including dentists Description: Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	University of Minnesota www.umn.edu		New	Clinical Process/ Effectiveness
TBD	Title: Preventive Care and Screening: Cholesterol—Fasting Low Density Lipoprotein (LDL-C) Test Performed Description: Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; QIP www.usqualitymeasures.org	EHR PQRS	New	Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
TBD	Title: Preventive Care and Screening: Risk-Stratified Cholesterol-Fasting Low Density Lipoprotein (LDL-C) Description: Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below recommended LDL-C goal.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; QIP www.usqualitymeasures.org	EHR PQRS	New	Clinical Process/ Effectiveness
TBD	Title: Dementia: Cognitive Assessment Description: Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.	AMA-PCPI cpe@ama-assn.org	PQRS	New	Clinical Process/ Effectiveness
TBD	Title: Hypertension: Improvement in blood pressure Description: Percentage of patients 18 to 85 years of age with a diagnosis hypertension whose blood pressure improved during the measurement period.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139		New	Clinical Process/ Effectiveness
NQF 0004	Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Description: The percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	NCQA www.ncqa.org	EHR PQRS, HEDIS, state use, ACA 2701, NCQA-PCMH Recognition		Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0018 *	Title: Controlling High Blood Pressure Description: Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	NCQA www.ncqa.org	EHR PQRS, ACO, Group Reporting PQRS, UDS		Clinical Process/ Effectiveness
NQF 0031	Title: Breast Cancer Screening Description: Percentage of women 40 to 69 years of age who had a mammogram to screen for breast cancer.	NCQA www.ncqa.org	EHR PQRS, ACO, Group Reporting PQRS, ACA 2701, HEDIS, state use, NCQA-PCMH Recognition		Clinical Process/ Effectiveness
NQF 0032	Title: Cervical Cancer Screening Description: Percentage of women 21 to 64 years of age, who received one or more Pap tests to screen for cervical cancer.	NCQA www.ncqa.org	EHR PQRS, ACA 2701, HEDIS, state use, NCQA-PCMH Recognition, UDS		Clinical Process/ Effectiveness
NQF 0034	Title: Colorectal Cancer Screening Description: Percentage of adults 50 to 75 years of age who had appropriate screening for colorectal cancer.	NCQA www.ncqa.org	EHR PQRS, ACO, Group Reporting PQRS, NCQA-PCMH Recognition		Clinical Process/ Effectiveness
NQF 0036 **	Title: Use of Appropriate Medications for Asthma Description: Percentage of patients five to 64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year.	NCQA www.ncqa.org	EHR PQRS		Clinical Process/ Effectiveness
NQF 0043	Title: Pneumonia Vaccination Status for Older Adults Description: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	NCQA www.ncqa.org	EHR PQRS, ACO, Group Reporting PQRS, NCQA-PCMH Recognition		Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0055	Title: Diabetes: Eye Exam Description: Percentage of patients 18 to 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	NCQA www.ncqa.org	EHR PQRS, Group Reporting PQRS		Clinical Process/ Effectiveness
NQF 0056	Title: Diabetes: Foot Exam Description: The percentage of patients aged 18 to 75 years with diabetes who had a foot exam during the measurement period.	NCQA www.ncqa.org	EHR PQRS, Group Reporting PQRS		Clinical Process/ Effectiveness
NQF 0059	Title: Diabetes: Hemoglobin A1c Poor Control Description: Percentage of patients 18 to 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	NCQA www.ncqa.org	EHR PQRS, ACO, Group Reporting PQRS, UDS		Clinical Process/ Effectiveness
NQF 0062	Title: Diabetes: Urine Protein Screening Description: Percentage of patients 18 to 75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	NCQA www.ncqa.org	EHR PQRS, Group Reporting PQRS		Clinical Process/ Effectiveness
NQF 0064	Title: Diabetes: Low Density Lipoprotein (LDL) Management and Control Description: Percentage of patients 18 to75 years of age with diabetes whose LDL-Cwas adequately controlled (< 100 mg/dL) during the measurement period.	NCQA www.ncqa.org	PQRS, Group Reporting PQRS		Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0068	Title: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period and who had documentation of use of aspirin or another antithrombotic during the measurement period.	NCQA www.ncqa.org	EHR PQRS, ACO, Group Reporting PQRS		Clinical Process/ Effectiveness
NQF 0070	Title: Coronary Artery Disease (CAD): Beta- Blocker Therapy– Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) Description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.	AMA-PCPI cpe@ama-assn.org	EHR PQRS, NCQA-PCMH Recognition		Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0075	Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Description: Percentage of patients 18 years of age and older who were discharged alive for AMI, CABG or PCI in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (<100 mg/dL).	NCQA www.ncqa.org	EHR PQRS, ACO, Group Reporting PQRS		Clinical Process/ Effectiveness
NQF 0081	Title: Heart Failure (HF): Angiotensin- Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge	AMA-PCPI cpe@ama-assn.org	EHR PQRS, Group Reporting PQRS, NCQA-PCMH Recognition		Clinical Process/ Effectiveness
NQF 0083	Title: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	AMA-PCPI cpe@ama-assn.org	EHR PQRS, ACO, Group Reporting PQRS		Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0086	Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation Description: Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months.	AMA-PCPI cpe@ama-assn.org	EHR PQRS		Clinical Process/ Effectiveness
NQF 0088	Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	AMA-PCPI cpe@ama-assn.org	EHR PQRS		Clinical Process/ Effectiveness
NQF 0089	Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	AMA-PCPI cpe@ama-assn.org	EHR PQRS		Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0105	Title: Anti-depressant Medication Management: Description: The percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (six months).	NCQA www.ncqa.org	EHR PQRS, HEDIS, state use, ACA 2701		Clinical Process/ Effectiveness
NQF 0385	Title: Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients Description: Percentage of patients aged 18 through 80 years with Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.	AMA-PCPI cpe@ama-assn.org; American Society of Clinical Oncology (ASCO) www.asco.org; National Comprehensive Cancer Network (NCCN) www.nccn.org	EHR PQRS		Clinical Process/ Effectiveness
NQF 0387	Title: Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.	AMA-PCPI cpe@ama-assn.org; ASCO www.asco.org; NCCN www.nccn.org	EHR PQRS		Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0069 **	Title: Appropriate Treatment for Children with Upper Respiratory Infection (URI) Description: Percentage of children three months to 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	NCQA www.ncqa.org	PQRS, NCQA-PCMH Recognition	New	Efficient Use of Health Care Resources
NQF 0002 **	Title: Appropriate Testing for Children with Pharyngitis Description: Percentage of children two o 18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A *streptococcus* (strep) test for the episode.	NCQA www.ncqa.org	EHR PQRS, CHIPRA		Efficient Use of Health Care Resources
NQF 0052 *	Title: Use of Imaging Studies for Low Back Pain Description: Percentage of patients 18 to 50 years of age with a diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.	NCQA www.ncqa.org	EHR PQRS		Efficient Use of Health Care Resources
NQF 0389	Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	AMA-PCPI cpe@ama-assn.org	EHR PQRS		Efficient Use of Health Care Resources

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0384	Title: Oncology: Medical and Radiation– Pain Intensity Quantified Description: Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	AMA-PCPI cpe@ama-assn.org	PQRS	New	Patient and Family Engagement
TBD	Title: Functional Status Assessment for Knee Replacement Description: Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139		New	Patient and Family Engagement
TBD	Title: Functional Status Assessment for Hip Replacement Description: Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139		New	Patient and Family Engagement
TBD *	Title: Functional Status Assessment for Complex Chronic Conditions Description: Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up (patient-reported) functional status assessments.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139		New	Patient and Family Engagement

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0022 *	Title: Use of High-Risk Medications in the Elderly Description: Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	NCQA www.ncqa.org	PQRS	New	Patient Safety
NQF 0101	Title: Falls: Screening for Future Fall Risk Description: Percentage of patients aged 65 years and older who were screened for future fall risk during the measurement period	AMA-PCPI cpe@ama-assn.org; NCQA www.ncqa.org	PQRS, ACO, Group Reporting PQRS	New	Patient Safety
NQF 0419 *	Title: Documentation of Current Medications in the Medical Record Description: Percentage of specified visits for patients aged 18 years and older for which the EP attests to documenting a list of current medications to the best of his/her knowledge and ability. This list ***must*** include ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency, and route of administration.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; QIP www.usqualitymeasures.org	PQRS, EHR PQRS	New	Patient Safety

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0564	Title: Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures Description: Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.	AMA-PCPI cpe@ama-assn.org; NCQA www.ncqa.org	PQRS	New	Patient Safety
NQF 1365	Title: Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment Description: Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	AMA-PCPI cpe@ama-assn.org		New	Patient Safety
TBD	Title: ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range: Description: Average percentage of time in which individuals with atrial fibrillation who are on chronic anticoagulation have International Normalized Ratio (INR) test results within the therapeutic range during the measurement period.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139		New	Patient Safety

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
TBD	Title: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented Description: Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; QIP www.usqualitymeasures.org	PQRS, EHR PQRS, Group Reporting PQRS, ACO	New	Population/ Public Health
NQF 0418 * **	Title: Preventive Care and Screening: Screening for Clinical Depression and follow-up Plan Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow –up plan is documented on the date of the positive screen.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; Quality Insights of Pennsylvania (QIP) www.usqualitymeasures.org	EHR PQRS, ACO, Group Reporting PQRS	New	Population/ Public Health
NQF 1401	Title: Maternal Depression Screening Description: The percentage of children who turned six months of age during the measurement year who a face-to-face visit between the clinician and the child during child's first six months, and who had a maternal depression screening for the mother at least once between birth and six months of life.	NCQA www.ncqa.org		New	Population/ Public Health

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0024 **	Title: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents Description: Percentage of patients three to 17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist(OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. • Percentage of patients with height, weight, and body mass index (BMI) percentile documentation. • Percentage of patients with counseling for nutrition. • c. Percentage of patients with counseling for physical activity.	NCQA www.ncqa.org	EHR PQRS, UDS		Population/ Public Health
NQF 0028 *	Title: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	AMA-PCPI cpe@ama-assn.org	EHR PQRS, ACO, Group Reporting PQRS, UDS		Population/ Public Health
NQF 0033 **	Title: Chlamydia Screening in Women Description: Percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	NCQA www.ncqa.org	EHR PQRS, CHIPRA, ACA 2701, HEDIS, state use, NCQA-PCMH Recognition		Population/ Public Health

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0038 **	Title: Childhood Immunization Status Description: Percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	NCQA www.ncqa.org	EHR PQRS, UDS		Population/ Public Health
NQF 0041	Title: Preventive Care and Screening: Influenza Immunization Description: Percentage of patients aged six months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	AMA-PCPI cpe@ama-assn.org	EHR PQRS, ACO, Group Reporting PQRS		Population/ Public Health

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0421 *	Title: Preventive Care and Screening: Body Mass Index (BMI) Adult Weight Screening and Follow-Up Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current reporting period documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current reporting period. Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30. Age 18 to 64 years BMI ≥ 18.5 and < 25.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; QIP http://www.usqualitymeasures.org I	EHR PQRS, ACO, Group Reporting PQRS, UDS		Population/ Public Health

APPENDIX D: CQMs Finalized as "Recommended Core Measures for Adults" for Medicare and Medicaid Eligible Professionals Beginning with CY 2014

Table Note: This reference table has been sorted by "Domain," "New Measure," and then "NQF #"

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014

Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
TBD	Title: Closing the referral loop: receipt of specialist report Description: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	CMS (888) 734-6433 or https://questions.cms.hhs.gov/app/ask/p/21,26,1139		New	Care Coordination
NQF 0018	Title: Controlling High Blood Pressure Description: Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	NCQA www.ncqa.org	EHR PQRS, ACO, Group Reporting PQRS, UDS		Clinical Process/ Effectiveness
NQF 0052	Title: Use of Imaging Studies for Low Back Pain Description: Percentage of patients 18 to 50 years of age with a diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.	NCQA www.ncqa.org	EHR PQRS		Efficient Use of Health Care Resources
TBD	Title: Functional Status Assessment for Complex Chronic Conditions Description: Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up (patient-reported) functional status assessments.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139		New	Patient and Family Engagement

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0022	Title: Use of High-Risk Medications in the Elderly Description: Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	NCQA www.ncqa.org	PQRS	New	Patient Safety
NQF 0419	Title: Documentation of Current Medications in the Medical Record Description: Percentage of specified visits for patients aged 18 years and older for which the EP attests to documenting a list of current medications to the best of his/her knowledge and ability. This list ***must*** include ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency, and route of administration.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; QIP Contact Information: www.usqualitymeasures.org	PQRS, EHR PQRS	New	Patient Safety
NQF 0418	Title: Preventive Care and Screening: Screening for Clinical Depression and follow-up Plan Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; Quality Insights of Pennsylvania (QIP) Contact Information: www.usqualitymeasures.org	EHR PQRS, ACO, Group Reporting PQRS	New	Population/ Public Health

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0028	Title: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	AMA-PCPI cpe@ama-assn.org	EHR PQRS, ACO, Group Reporting PQRS, UDS		Population/ Public Health
NQF 0421	Title: Preventive Care and Screening: Body Mass Index (BMI) Adult Weight Screening and Follow-Up Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current reporting period documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current reporting period. Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30. Age 18 to 64 years BMI ≥ 18.5 and < 25.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; QIP Contact Information: http://www.usqualitymeasures.org I	EHR PQRS, ACO, Group Reporting PQRS, UDS		Population/ Public Health

APPENDIX E: CQMs Finalized as "Recommended Core Measures for Children" for Medicare and Medicaid Eligible Professionals Beginning with CY 2014

Table Note: This reference table has been sorted by "Domain," "New Measure," and then "NQF #"

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014

Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
TBD	Title: Children Who Have Dental Decay or Cavities Description: Percentage of children ages 0 to 20 who have had tooth decay or cavities during the measurement period.	Maternal and Child Health Bureau, Health Resources and Services Administration http://mchb.hrsa.gov		New	Clinical Process/ Effectiveness
NQF 0108	Title: ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication Description: Percentage of children six to 12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.	NCQA www.ncqa.org		New	Clinical Process/ Effectiveness

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0036	Title: Use of Appropriate Medications for Asthma Description: Percentage of patients five to 64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year.	NCQA www.ncqa.org	EHR PQRS		Clinical Process/ Effectiveness
NQF 0069	Title: Appropriate Treatment for Children with Upper Respiratory Infection (URI) Description: Percentage of children three months to 18 years of age who were diagnosed with UR) and were not dispensed an antibiotic prescription on or three days after the episode.	NCQA www.ncqa.org	PQRS, NCQA-PCMH Recognition	New	Efficient Use of Health Care Resources
NQF 0002	Title: Appropriate Testing for Children with Pharyngitis Description: Percentage of children two to 18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A *streptococcus* (strep) test for the episode.	NCQA www.ncqa.org	EHR PQRS, CHIPRA		Efficient Use of Health Care Resources
NQF 0418	Title: Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	CMS (888) 734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139; Quality Insights of Pennsylvania (QIP) Contact Information: www.usqualitymeasures.org	EHR PQRS, ACO, Group Reporting PQRS	New	Population/ Public Health

TABLE 8: CLINICAL QUALITY MEASURES FINALIZED FOR MEDICARE AND MEDICAID ELIGIBLE PROFESSIONALS BEGINNING WITH CY 2014					
Measure Number	Clinical Quality Measure Title and Description	Clinical Quality Measure Steward and Contact Information	Other Quality Measure Programs that use the Same Measure	New Measure	Domain
NQF 0024	Title: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents Description: Percentage of patients three to 17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist(OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. • Percentage of patients with height, weight, and body mass index (BMI) percentile. documentation • Percentage of patients with counseling for nutrition. • c. Percentage of patients with counseling for physical activity.	NCQA www.ncqa.org	EHR PQRS, UDS		Population/ Public Health
NQF 0033	Title: Chlamydia Screening in Women Description: Percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period	NCQA www.ncqa.org	EHR PQRS, CHIPRA, ACA 2701, HEDIS, state use, NCQA-PCMH Recognition		Population/ Public Health
NQF 0038	Title: Childhood Immunization Status Description: Percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	NCQA www.ncqa.org	EHR PQRS, UDS		Population/ Public Health

APPENDIX F: Table 10—CQMs Finalized for Eligible Hospitals and Critical Access Hospitals Beginning with FFY 2014

Table Note: This reference table has been sorted by "Domain," "New Measure," and then "NQF #"

Table 10—Clinical Quality Measures Finalized for Eligible Hospitals and Critical Access Hospitals Beginning with FFY 2014					
NQF #	**Title**	**Measure Steward and Contact Information**	**Other Quality Measure Programs that use the same Measure**	**New Measure**	**Domain**
0496	Title: ED-3-Median Time from ED Arrival to ED Departure for Discharged ED Patients Description: Median time from emergency department arrival to time of departure from the emergency room for patients discharged from the emergency department.	CMS/OFMQ www.qualitynet.org and click on "Questions & Answers"	OQR	**New**	Care Coordination
0441	Title: Stroke-10 Ischemic or Hemorrhagic Stroke—Assessed for Rehabilitation Description: Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Care Coordination
0142	Title: AMI-2-Aspirin Prescribed at Discharge for AMI Description: AMI patients who are prescribed aspirin at hospital discharge.	CMS/OFQM www.qualitynet.org and click on "Questions & Answers"	IQR	**New**	Clinical Process/ Effectiveness
0163	Title: AMI-8a- Primary PCI Received Within 90 Minutes of Hospital Arrival Description: AMI patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving primary PCI during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.	CMS/OFMQ www.jqualitynet.org and click on "Questions & Answers"	IQR, HVBP	**New**	Clinical Process/ Effectiveness
0164	Title: AMI-7a- Fibrinolytic Therapy Received within 30 minutes of Hospital Arrival Description: Acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay with a time from hospital arrival to fibrinolysis of 30 minutes or less.	CMS/OFMQ www.jqualitynet.org and click on "Questions & Answers"	IQR, HVBP	**New**	Clinical Process/ Effectiveness

Table 10—Clinical Quality Measures Finalized for Eligible Hospitals and Critical Access Hospitals Beginning with FFY 2014					
NQF #	**Title**	**Measure Steward and Contact Information**	**Other Quality Measure Programs that use the same Measure**	**New Measure**	**Domain**
0469	Title: PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation Description: Patients with elective vaginal deliveries or elective cesarean sections >=37 and <39 weeks of gestation completed.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	TJC	**New**	Clinical Process/ Effectiveness
0480	Title: Exclusive Breast Milk Feeding Description: Exclusive Breastfeeding during the newborn's entire hospitalization.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	State use	**New**	Clinical Process/ Effectiveness
0639	Title: AMI-10 Statin Prescribed at Discharge Description: AM) patients who are prescribed a statin medication at hospital discharge.	CMS/OFMQ www.qualitynet.org and click on "Questions & Answers"	IQR	**New**	Clinical Process/ Effectiveness
1354	Title: EHDI-1a- Hearing Screening Prior to Hospital Discharge Description: This measure assesses the proportion of births that have been screened for hearing loss before hospital discharge.	CDC www.cdc.gov and click on "Contact CDC"	State use	**New**	Clinical Process/ Effectiveness
0373	Title: VTE-3 VTE Patients with Anticoagulation Overlap Therapy Description: This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications or have a reason for discontinuation of overlap therapy. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) greater than or equal to 2 prior to discontinuation of the parenteral anticoagulation therapy, discharged on both medications or have a reason for discontinuation of overlap therapy.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Clinical Process/ Effectiveness

Table 10—Clinical Quality Measures Finalized for Eligible Hospitals and Critical Access Hospitals Beginning with FFY 2014					
NQF #	**Title**	**Measure Steward and Contact Information**	**Other Quality Measure Programs that use the same Measure**	**New Measure**	**Domain**
0374	Title: VTE-4 VTE Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram) Description: This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Clinical Process/ Effectiveness
0435	Title: Stroke-2 Ischemic Stroke—Discharged on Anti-thrombotic Therapy Description: Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Clinical Process/ Effectiveness
0436	Title: Stroke-3 Ischemic stroke – Anticoagulation Therapy for Atrial Fibrillation/Flutter Description: Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Clinical Process/ Effectiveness
0437	Title: Stroke-4 Ischemic stroke—Thrombolytic Therapy Description: Acute ischemic stroke patients who arrive at this hospital within 2 hours (120 minutes) of time last known well and for whom IV t-PA was initiated at this hospital within three hours (180 minutes) of time last known well.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Clinical Process/ Effectiveness
0438	Title: Stroke-5 Ischemic Stroke—Antithrombotic Therapy by End of Hospital Day Two Description: Ischemic stroke patients administered antithrombotic therapy by the end of hospital day two.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Clinical Process/ Effectiveness
0439	Title: Stroke-6 Ischemic Stroke—Discharged on Statin Medication Description: Ischemic stroke patients with LDL greater than or equal to 100 mg/dL, or LDL not measured, or, who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Clinical Process/ Effectiveness

Table 10—Clinical Quality Measures Finalized for Eligible Hospitals and Critical Access Hospitals Beginning with FFY 2014					
NQF #	**Title**	**Measure Steward and Contact Information**	**Other Quality Measure Programs that use the same Measure**	**New Measure**	**Domain**
0147	Title: PN-6- Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients Description: Immunocompetent patients with Community-Acquired Pneumonia who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines.	CMS/OFMQ www.qualitynet.org and click on "Questions & Answers"	IQR, HVBP	**New**	Efficient Use of Health Care Resources
0528	Title: SCIP-INF-2-Prophylactic Antibiotic Selection for Surgical Patients Description: Surgical patients who received prophylactic antibiotics consistent with current guidelines (specific to each type of surgical procedure).	CMS/OFMQ www.qualitynet.org and click on "Questions & Answers"	IQR, HVBP	**New**	Efficient Use of Health Care Resources
0338	Title: Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver Description: An assessment that there is documentation in the medical record that a Home Management Plan of Care (HMPC) document was given to the pediatric asthma patient/caregiver.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	State use	**New**	Patient and Family Engagement
0375	Title: VTE-5 VTE discharge instructions Description: This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, home care, court/law enforcement, or home on hospice care on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Patient and Family Engagement
0440	Title: Stroke-8 Ischemic or hemorrhagic stroke—Stroke education Description: Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Patient and Family Engagement

Table 10—Clinical Quality Measures Finalized for Eligible Hospitals and Critical Access Hospitals Beginning with FFY 2014					
NQF #	**Title**	**Measure Steward and Contact Information**	**Other Quality Measure Programs that use the same Measure**	**New Measure**	**Domain**
0495	Title: Emergency Department (ED)-1 Emergency Department Throughput—Median Time from ED Arrival to ED Departure for Admitted ED Patients Description: Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.	CMS/Oklahoma Foundation for Medical Quality (OFMQ) www.qualitynet.org and click on "Questions & Answers"	IQR		Patient and Family Engagement
0497	Title: ED-2 Emergency Department Throughput—Admitted Patients—Admit Decision Time to ED Departure Time for Admitted Patients Description: Median time (in minutes) from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.	CMS/Oklahoma Foundation for Medical Quality (OFMQ) www.qualitynet.org and click on "Questions & Answers"	IQR		Patient and Family Engagement
0453	Title: SCIP-INF-9- Urinary Catheter Removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with Day of Surgery Being Day Zero Description: Surgical patients with urinary catheter removed on Postoperative Day 1 or Postoperative Day 2 with day of surgery being day zero.	CMS/OFMQ www.qualitynet.org and click on "Questions & Answers"	IQR, TJC	**New**	Patient Safety
0527	Title: SCIP-INF-1 Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision Description: Surgical patients with prophylactic antibiotics initiated within one hour prior to surgical incision. Patients who received Vancomycin or a Fluoroquinolone for prophylactic antibiotics should have the antibiotics initiated within two hours prior to surgical incision. Due to the longer infusion time required for Vancomycin or a Fluoroquinolone, it is acceptable to start these antibiotics within two hours prior to incision time.	CMS/OFMQ www.qualitynet.org and click on "Questions & Answers"	IQR, HVBP	**New**	Patient Safety

Table 10—Clinical Quality Measures Finalized for Eligible Hospitals and Critical Access Hospitals Beginning with FFY 2014					
NQF #	**Title**	**Measure Steward and Contact Information**	**Other Quality Measure Programs that use the same Measure**	**New Measure**	**Domain**
0716	Title: Healthy Term Newborn Description: Percent of term singleton live births (excluding those with diagnoses originating in the fetal period) who DO NOT have significant complications during birth or the nursery care.	California Maternal Quality Care Collaborative www.cmqcc.org and click on "Contact Us"	State use	**New**	Patient Safety
0371	Title: Venous Thromboembolism (VTE)-1 VTE prophylaxis Description: This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Patient Safety
0372	Title: VTE-2 Intensive Care Unit (ICU) VTE prophylaxis Description: This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Patient Safety
0376	Title: VTE-6 Incidence of potentially preventable VTE Description: This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	The Joint Commission http://www.jointcommission.org and click on "Contact Us"	IQR		Patient Safety