The Centers for Medicare & Medicaid Services (CMS) April 15 published a proposed rule modifying the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for 2015 through 2017. Among other changes, CMS proposes to shorten the meaningful use reporting period for 2015 to a 90-day period aligned with the calendar year. The rule also provides additional flexibilities, such as reducing the share of patients that must use the patient portal from 5 percent to at least one patient.

CMS proposes a number of structural changes to the program in the middle of the program year to better align it with the proposed Stage 3 rule that is currently out for public comment. Specifically, the rule proposes to remove some measures of meaningful use the agency believes have become “redundant, duplicative, or topped out,” modify others, and add several new measures related to public health, resulting in a “modified Stage 2” that consists of nine objectives and 18 measures for hospitals. In addition, the rule would increase requirements for providers new to the program by eliminating Stage 1 and requiring full-year reporting of Stage 2 for new participants sooner than current rules require. Because of the scope of the program changes, CMS proposes to delay all attestations for 2015 until Jan. 1, 2016 or later.

Our Take:
The AHA greatly appreciates the shorter reporting period and many of the other flexibilities proposed in this rule. However, we are concerned that the volume of change proposed in the middle of the program year could cause confusion and burden for hospitals. In addition, the changes for first-time participants in the program would inappropriately raise the bar beyond current regulatory requirements.

What You Can Do:
- Share this advisory with your senior management team.
- Ask your chief information officer to consider how the proposed rule would affect your plans to attest for meaningful use in 2015, 2016 and 2017.
- Consider submitting comments to CMS no later than June 15 using the instructions in this advisory.

Further Questions:
If you have questions about the proposed rule, please contact Chantal Worzala, AHA director of policy, at (202) 626-2313 or cworzala@aha.org.
CMS PROPOSES MODIFYING EHR REPORTING PERIOD IN 2015 TO 90 DAYS

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) April 15 published a proposed rule modifying the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs for 2015 through 2017. The agency released the rule in response to concerns from the AHA and other stakeholders about the challenges meeting Stage 2 of meaningful use. Additionally, the agency seeks to better align current requirements with the Stage 3 proposed rule currently out for public comment.

Under current regulations, the majority of eligible hospitals (EHs) and critical access hospitals (CAHs) would need to report on Stage 2 for a full year period of Oct. 1, 2014 through Sept. 30, 2015 to receive payments and avoid future payment penalties. If finalized, the proposed rule would shorten the 2015 reporting period for hospitals to any continuous 90 days between Oct. 1, 2014 and Dec. 31, 2015. EPs and CAHs would generally report on a full calendar year for 2016 and 2017.

This advisory summarizes key elements of the proposed rule for EHs and CAHs (jointly referred to as hospitals, for simplicity) and briefly discusses proposed changes for eligible physicians and other professionals (EPs). We encourage members also to reference our previous advisory on the Stage 2 final rule for detailed information on the current meaningful use requirements. CMS also has issued a proposed rule for Stage 3 of meaningful use. That rule and a companion rule from the Office of the National Coordinator for Health Information Technology on certification of health information technology to support Stage 3 and other purposes are summarized in a recent AHA Regulatory Advisory.

AT ISSUE

CMS proposes to:

- Modify the meaningful use reporting period;
- Change the attestation deadlines;
- Change the timing of stages;
Modify the meaningful use requirements for hospitals;
Modify the meaningful use requirements for EPs; and
Modify the reporting periods used to assess payment penalties.

The rule would not make any changes to the formulas used to calculate incentive payments and penalties.

**Reporting Period**
CMS proposes a 90-day reporting period for all providers in 2015, rather than the full-year reporting currently required. The AHA has long advocated for this shorter reporting period and appreciates this proposed change, which will keep providers on track to meet Stage 2.

CMS also proposes to change the reporting period for hospitals from the fiscal year to the calendar year, aligning it with the reporting period for EPs. For 2015 only, hospitals would report on any continuous 90-day period between Oct. 1, 2014 and Dec. 31, 2015 – a period that spans both the fiscal and calendar years. EPs would report on any continuous 90-day period between Jan. 1, 2015 and Dec. 31, 2015. The reporting period would be a full calendar year in 2016 and later years for those continuing their participation in the program. For new Medicare participants, CMS proposes a 90-day reporting period in 2016 and a full-year reporting period in 2017 and beyond.

**Attestation Deadlines**
As a consequence of the move to a calendar year reporting period for hospitals, CMS proposes to change the attestation window for the 2015 reporting period to be Jan. 1, 2016 to Feb. 29, 2016. Further, to accommodate the significant changes proposed for 2015, CMS proposes to delay any attestations for 2015 until Jan. 1, 2016 or later. Thus, even hospitals that choose Oct. 1, 2015 to Dec. 31, 2015 as their reporting period would not be able to attest until Jan. 1, 2016 at the earliest. The AHA is concerned that this change would delay incentive payments for hospitals, possibly causing financial challenges.

**Timing of Stages**
Under current requirements, all providers enter the meaningful use program at Stage 1, and report on Stage 1 requirements for at least two years before moving on to Stage 2. In this rule, CMS proposes to require all providers to meet Stage 2 requirements in 2015, regardless of their history of previous participation in the program. CMS proposes to give limited flexibility to providers meant to be at Stage 1 in 2015 under current rules. Specifically these providers would be given “alternate exclusions and specifications for certain objectives and measures” in 2015 only. Any provider entering the program in 2016 would be required to meet the full modified Stage 2 requirements (see Table 1). For 2017, CMS proposes that all providers would need to meet either the modified Stage 2 requirements, or the Stage 3 requirements that are the subject of a separate proposed rule. CMS proposes to require all providers to be at Stage 3 in 2018.
First-time Participants in the Program. For 2015 only, CMS proposes to afford providers meant to be at Stage 1 the option to attest to the Stage 1 objective and measure specifications for all of the objectives of meaningful use that it has retained. For example, these providers would implement only one clinical decision support tool (Stage 1 requirement), rather than five (Stage 2 requirement). For objectives that did not exist in Stage 1, these providers would have an exclusion in 2015. For example, these providers would have an exclusion for the summary of care objective because Stage 1 does not have a similar objective. In 2016 and later, however, CMS would require all providers to meet the same requirements, regardless of when they first enter the program. The AHA is concerned that these changes would be confusing and possibly burdensome for providers new to the program.

Table 1. Proposed Stage of Meaningful Use Criteria by First Year of Hospital Program Participation

<table>
<thead>
<tr>
<th>First Year as a meaningful user of certified EHR</th>
<th>Stage of Meaningful Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>1</td>
</tr>
<tr>
<td>2012</td>
<td>1</td>
</tr>
<tr>
<td>2013</td>
<td>1</td>
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<tr>
<td>2014</td>
<td>1</td>
</tr>
<tr>
<td>2015</td>
<td>Modified 2 with exceptions</td>
</tr>
<tr>
<td>2016</td>
<td>Modified 2 with exceptions</td>
</tr>
<tr>
<td>2017</td>
<td>Modified 2</td>
</tr>
<tr>
<td>2018 and thereafter</td>
<td>Modified 2</td>
</tr>
</tbody>
</table>

Note: Items in bold denote places where the rule proposes to accelerate requirements on late entrants to the program. CMS states that a provider scheduled to participate in Stage 2 in the 2014 reporting period, who instead elected to demonstrate Stage 1 because of delays in availability of EHR technology certified to the 2014 Edition, is still considered a Stage 2 provider in 2014, despite the alternate demonstration of meaningful use. In 2015, all such providers are considered to be participating in their second year of Stage 2.

Meaningful Use Requirements for Hospitals
CMS proposes numerous changes to the meaningful use requirements with the intent to streamline the program and better align it with proposals for Stage 3. This section
outlines the proposed changes to the definition of meaningful use for hospitals. Items of particular interest to hospitals, such as the patient portal, summary of care and public health reporting are discussed in more detail. Table 2 lists all of the proposed objectives and measures.

**Modified Stage 2 Objectives.** Under current Stage 2 requirements, hospitals must meet 16 core objectives and three of six menu-set objectives. CMS proposes to remove the core and menu approach and require providers to meet all of the following eight objectives:

- Computerized provider order entry (CPOE)
- Clinical decision support
- Patient electronic access (view, download and transmit)
- Protect electronic health information
- Patient-specific education
- Medication reconciliation
- Summary of care
- E-Prescribing
- Public health

Each objective has one or more measures associated with it. Only one objective – public health – would include flexibility in the measures required. The e-prescribing objective, which had been a menu item, would now be required.

**Removed Objectives.** CMS also proposes to remove 11 objectives and two measures from Stage 2 that CMS believes are “redundant, duplicative or topped out.” Many of these items, however, would still be part of the meaningful use program because they are a fundamental piece of another objective. For example, CMS proposes to remove collection of problem lists as a separate objective, but problem lists would be expected to be available through the patient portal. CMS proposes to remove the following objectives and measures:

- Record Demographics
- Record Vital Signs
- Record Smoking Status
- Structured Lab Results
- Patient List
- Summary of Care
- Measure 1-Any Method
- Measure 3-Test
- Electronic medication administration record
- Advanced Directives (currently menu)
- Electronic Notes (currently menu)
- Imaging Results (currently menu)
- Family Health History (currently menu)
• Structure Labs to Ambulatory Providers (currently menu)

For EPs, CMS proposes to remove 10 objectives and two measures, most of which overlap with the hospital objectives proposed for removal.

**Modified Stage 2 for 2015 to 2017.** Table 2 below lists the nine objectives and 18 measures that would apply to all hospitals under the proposed rule and notes the type of exceptions available. After the table, proposed changes of particular interest to hospitals are discussed.

The proposed rule also details specific exclusions for hospitals that are available in 2015 only, listed in Table 2. For example, for 2015 only, CMS proposes to allow providers to claim an exclusion for any objective they had not planned to pursue as a menu item. This includes hospitals that had not planned to pursue e-prescribing of discharge medications as a Stage 2 menu item. The proposed rule also outlines exclusions to certain measures similar to those previously finalized for specific Stage 2 objectives. For example, a provider in an area with insufficient broadband could be excluded from meeting the patient electronic access objective.

**Table 2. Proposed Hospital Meaningful Use Objectives and Measures for 2015 to 2017**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures</th>
<th>Exclusions and Alternate Specifications for Hospitals Available in 2015 Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computerized Provider Order Entry (CPOE)</td>
<td>Measure 1: More than 60 percent of medication orders created by 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. Measure 2: More than 30 percent 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. Measure 3: More than 30 percent 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.</td>
<td>Measure 1: Hospitals meant to be at Stage 1 in 2015 under current rules meet threshold of 30 percent. They may count either: - 30 percent of all unique patients with at least one medication in their medication list, or - 30 percent of medication orders. Measures 2 and 3. Hospitals meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure.</td>
</tr>
<tr>
<td>Clinical decision support</td>
<td>Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EH’s or CAH’s scope of practice or patient population, the clinical decision</td>
<td>Measure 1: Hospitals meant to be at Stage 1 in 2015 under current rules implement one clinical decision support rule.</td>
</tr>
<tr>
<td><strong>Objective</strong></td>
<td><strong>Measures</strong></td>
<td><strong>Exclusions and Alternate Specifications for Hospitals Available in 2015 Only</strong></td>
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<td><strong>Objective</strong></td>
<td>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. Measure 2: The EH or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</td>
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<tr>
<td><strong>Patient electronic access (view, download and transmit)</strong></td>
<td>Measure 1: More than 50 percent 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. Measure 2: At least one patient who is discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH (or his or her authorized representative) views, downloads or transmits to a third party his or her information during the EHR reporting period. Note: The following information must be available: patient name; admit and discharge date and location; reason for hospitalization; care team, including the attending provider and other providers of care; procedures performed during admission; current and past problem list; vital signs at discharge; laboratory test results available at time of discharge; summary of care record for transitions of care or referrals to another provider; care plan field(s) including goals and instructions; discharge instructions for patient; demographics maintained by hospital (sex, race, ethnicity, date of birth, preferred language); and smoking status.</td>
<td>Measure 2: Hospitals meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure. Note that these hospitals must still meet Measure 1.</td>
</tr>
<tr>
<td><strong>Protect electronic health information</strong></td>
<td>Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of electronic protected health information data stored in Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EH or CAH risk management process.</td>
<td>None</td>
</tr>
<tr>
<td><strong>Patient-specific education</strong></td>
<td>Measure: More than 10 percent of all unique patients admitted to the EH’s or CAH’s inpatient or emergency department (POS 21 or</td>
<td>Hospitals meant to be at Stage 1 in 2015 under current rules can claim an exclusion if they did not intend to</td>
</tr>
<tr>
<td>Objective</td>
<td>Measures</td>
<td>Exclusions and Alternate Specifications for Hospitals Available in 2015 Only</td>
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<td>23) are provided patient-specific education resources identified by Certified EHR Technology.</td>
<td>select the Stage 1 patient-specific education menu objective.</td>
<td>Hospitals meant to be at Stage 1 in 2015 under current rules can claim an exclusion if they did not intend to select the Stage 1 medication reconciliation menu objective.</td>
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<tr>
<td>Medication reconciliation</td>
<td>Measure: The EH or CAH performs medication reconciliation for more than 50 percent 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).</td>
<td>Hospitals meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure.</td>
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<tr>
<td>Summary of care</td>
<td>Measure: The EH or CAH that transitions or refers their patient to another setting of care or provider of care (1) uses Certified EHR Technology to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals.</td>
<td>Hospitals meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure.</td>
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<tr>
<td>e-Prescribing</td>
<td>Measure: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology.</td>
<td>Hospitals meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure.</td>
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<tr>
<td>Public health EHS and CAHs would need to report on three of the six measure options.</td>
<td>Measure Option 1 – Immunization Registry Reporting: The EH or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system. Measure Option 2 – Syndromic Surveillance Reporting: The EH or CAH is in active engagement with a public health agency to submit syndromic surveillance data from an emergency or urgent care department for EHS and CAHs (POS 23). Measure Option 3 – Case Reporting: The EH or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions. Measure Option 4 – Public Health Registry Reporting: The EH or CAH is in active engagement with a public health agency to submit data to public health registries.</td>
<td>None specific to 2015.</td>
</tr>
<tr>
<td>Objective</td>
<td>Measures</td>
<td>Exclusions and Alternate Specifications for Hospitals Available in 2015 Only</td>
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<td>Measure Option 5 – Clinical Data Registry Reporting: The EH or CAH is in active engagement to submit data to a clinical data registry.</td>
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<td></td>
<td>Measure Option 6 – Electronic Reportable Laboratory Result Reporting: The EH or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.</td>
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</table>

**Patient Engagement and View, Download and Transmit.** In response to the concerns of hospitals and physicians, CMS proposes to change the requirements on patient engagement for 2015 to 2017. Under the proposed rule, the current requirement to provide patients online access to their health information would remain. However, the current requirement that 5 percent of patients use the patient portal would be modified to at least one patient. CMS states that this change would ensure the capability is enabled while giving providers and patients more time to implement these tools. **The AHA strongly advocated for this change and greatly appreciates this proposal.** We encourage all hospitals to continue to actively engage patients through all channels that patients prefer, whether in person, by telephone, electronically or via other means.

The list of data CMS proposes to be available in the patient portal is listed in Table 2. CMS proposes to offer an exclusion for this objective if a hospital is located in a county with limited broadband, defined as a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission on the first day of the EHR reporting period.

**Summary of Care.** CMS proposes to rename and modify the specifications for the transitions of care objective. First, CMS proposes to remove the current Stage 2 requirement that a summary of care document be sent for 50 percent of transitions and referrals (which could include fax and paper copies). Second, the agency would keep the requirement that the hospital or EP send the summary of care electronically for 10 percent of transitions and referrals. Third, CMS proposes to remove the requirement to send at least one summary of care record to a provider that uses a different EHR vendor. Finally, CMS would remove any requirements on the specific methods used to electronically send the summary of care document, such as specifying the use of a certified EHR to do so. The proposed rule does not include a discussion of the data that must be included in the summary of care document. **The AHA appreciates the proposed changes to this objective, which has been challenging for hospitals to meet.**
**e-Prescribing.** Under previously finalized rules for Stage 2, e-prescribing of discharge medications was a menu item. In this rule, CMS proposes to make it required for all hospitals, with the same threshold of 10 percent of hospital discharge medication orders for permissible prescriptions being queried against a drug formulary and transmitted electronically using a certified EHR. CMS proposes an exclusion to this measure for any hospital that does not have an internal pharmacy that can accept electronic prescriptions and is not located within 10 miles of any pharmacy that access electronic prescriptions.

**Public Health Reporting.** CMS proposes to modify the public health objective, consistent with the Stage 3 proposed rule that is currently out for public comment. The changes include the addition of new measures for case reporting, reporting to public health registries and reporting to clinical data registries. CMS also would change the immunization measure to involve bidirectional information exchange; that is, both reporting to the registry and receiving forecasts and other information from the registry.

CMS also proposes to introduce the concept of “active engagement” with a public health agency or clinical data registry, which could include:

- Registering to submit data within 60 days after the start of the EHR reporting period;
- Being in the process of testing and validating electronic submission of data; or
- Electronically submitting production data.

Hospitals would need to report on three of the six measures, offering some flexibility. However, CMS also proposes that an exclusion for a measure would not count toward the total of three measures that must be met by a hospital. For example, if a hospital qualifies for an exclusion on one measure, the hospital would still need to meet three of the remaining measures. If a hospital qualifies for four exclusions, however, the hospital could meet the objective by meeting the remaining two measures. The exclusions for public health measures relevant to a given reporting period (whether 2015 or later) include:

- Measure 1 – Immunization registry reporting: The hospital does not administer any immunizations for the populations contained in their jurisdiction’s immunization registry.
- Measure 2 – Syndromic surveillance reporting: The hospital does not have an emergency or urgent care department.
- Measure 3 – Case reporting: The hospital does not treat or diagnose any reportable diseases for which data are collected in their jurisdiction’s reportable disease system.
- Measure 4 – Public health registry reporting: The hospital does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction.
• Measure 5 – Clinical data registry reporting. The hospital does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction.
• Measure 6 – Electronic reportable lab result reporting: The hospital does not perform or order lab tests that are reportable in their jurisdiction.

The AHA is concerned that CMS has introduced new public health reporting requirements in a rule meant to provide much needed flexibility and relief in meeting Stage 2.

Clinical Quality Measures. CMS proposes no changes to the quality reporting requirements for meaningful use, which would remain as laid out in the Stage 2 rule and relevant hospital and physician payment rules.

Use of Certified EHR Technology. CMS proposes no changes to the requirement that hospitals and EPs must use 2014 Edition Certified EHR Technology to meet Stage 2 of meaningful use, including the modified version. In a separate rule, CMS proposes that providers would use a new version of certified EHRs, the 2015 Edition, to meet Stage 3. A proposed rule for that certification is currently open for comment, and is described in the AHA’s Stage 3 Regulatory Advisory.

Meaningful Use Requirements for EPs
CMS proposes similar changes for hospitals and EPs. However, EPs would report on 18 measures across 10 objectives, with some optionality in public health reporting. In addition, EPs have a unique secure messaging objective that does not apply to hospitals. CMS proposes to modify the Stage 2 secure messaging objective to become having the capability for patients to send and receive a secure electronic message with the provider fully enabled. Under current rules, the measure is to have a secure message sent using the secure messaging function of certified EHR technology by more that 5 percent of unique patients seen by the EP (or their authorized representatives) during the reporting period.

Table 3 lists the proposed objectives measures applicable to EPs, as well as the exclusions and alternate specifications proposed to be available in 2015 only. We encourage you to consult the proposed rule for more detail on the EP requirements, including additional exclusions (beyond just those in 2015) for specific objectives and measures available to EPs.

Definition of a Hospital-based EP. Under the meaningful use program, hospital-based EPs are not eligible for incentive payments or subject to payment penalties. The current definition considers EPs to be hospital-based if they furnish 90 percent or more of their covered professional services in sites (places) of service identified as an inpatient hospital (POS 21) or emergency room (POS 23) setting in the year preceding the payment year. CMS seeks comment on whether additional POS codes or settings should be included in the definition of a hospital-based EP, and especially POS 22 for outpatient hospital settings. CMS also seeks comment on whether and how
the inclusion of additional POS codes or settings might affect the eligibility of EPs for the EHR incentive payments under Medicare or Medicaid.

Table 3. Proposed EP Meaningful Use Objectives and Measures for 2015 to 2017

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures</th>
<th>Exclusions and Alternate Specifications for EPs Available in 2015 Only</th>
</tr>
</thead>
</table>
| Computerized Provider Order Entry (CPOE)      | Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE.                                                                                                                                                                                                                                                                 | Measure 1: EPs meant to be at Stage 1 in 2015 under current rules may meet a threshold of 30 percent. They may count either:  
  - 30 percent of all unique patients with at least one medication in their medication list, or  
  - 30 percent of medication orders.  
Measures 2 and 3. EPs meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure.                                                                 |                                                                                                                                                                                                                                                                   |
| e-Prescribing                                 | EP Measure: More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using Certified EHR Technology.                                                                                                                                                                                                 | EPs meant to be at Stage 1 in 2015 under current rules may meet a threshold of 40 percent.                                                                                                                                                                               |                                                                                                                                                                                                 |
| Clinical decision support                     | Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP’s scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving health care efficiency.  
Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.                                                                 | Measure 1: EPs meant to be at Stage 1 in 2015 under current rules implement 1 clinical decision support rule.                                                                                                                                                  |                                                                                                                                                                                                 |
<p>| Patient electronic access (view, download and transmit) | Measure 1: More than 50 percent 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.                                                                 | Measure 2: EPs meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure. Note that these hospitals must still meet Measure 1.                                                                 |</p>
<table>
<thead>
<tr>
<th>Objective</th>
<th>Measures</th>
<th>Exclusions and Alternate Specifications for EPs Available in 2015 Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>Measures 2: At least one patient seen by the EP during the EHR reporting period (or their authorized representatives) views, downloads, or transmits his or her health information to a third party.</td>
<td>None</td>
</tr>
<tr>
<td>Protect electronic health information</td>
<td>Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of electronic protected health information data stored in Certified EHR Technology in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP risk management process.</td>
<td>EPs meant to be at Stage 1 in 2015 under current rules can claim an exclusion if they did not intend to select the Stage 1 patient-specific education menu objective.</td>
</tr>
<tr>
<td>Patient-specific education</td>
<td>EP Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.</td>
<td>EPs meant to be at Stage 1 in 2015 under current rules can claim an exclusion if they did not intend to select the Stage 1 medication reconciliation menu objective.</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>Measure: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.</td>
<td>EPs meant to be at Stage 1 in 2015 under current rules can claim an exclusion if they did not intend to select the Stage 1 medication reconciliation menu objective.</td>
</tr>
<tr>
<td>Summary of care</td>
<td>Measure: The EP that transitions or refers their patient to another setting of care or provider of care (1) uses Certified EHR Technology to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10 percent of transitions of care and referrals.</td>
<td>EPs meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure.</td>
</tr>
<tr>
<td>Secure messaging</td>
<td>EP Measure: During the EHR reporting period, the capability for patients to send and receive a secure electronic message with the provider was fully enabled.</td>
<td>EPs meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure.</td>
</tr>
<tr>
<td>e-Prescribing</td>
<td>EH/CAH Measure: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed and refilled prescriptions) are queried for a drug formulary and transmitted electronically using Certified EHR Technology.</td>
<td>Hospitals meant to be at Stage 1 in 2015 under current rules can claim an exclusion because Stage 1 did not have an equivalent measure. Hospitals meant to be at Stage 2 in 2015 under current rules can claim an exclusion if they did not intend to select the Stage 2 e-prescribing of discharge medications menu objective.</td>
</tr>
<tr>
<td>Objective</td>
<td>Measures</td>
<td>Exclusions and Alternate Specifications for EPs Available in 2015 Only</td>
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<tr>
<td>Public health EPs would need to report on two of the five measure options.</td>
<td>Measure Option 1 – Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system. Measure Option 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a public health agency to submit syndromic surveillance data from a nonurgent care ambulatory setting. Measure Option 3 – Case Reporting: The EP is in active engagement with a public health agency to submit case reporting of reportable conditions. Measure Option 4 – Public Health Registry Reporting: The EP is in active engagement with a public health agency to submit data to public health registries. Measure Option 5 – Clinical Data Registry Reporting: The EP is in active engagement to submit data to a clinical data registry.</td>
<td>None specific to 2015.</td>
</tr>
</tbody>
</table>

**Reporting Periods for Payment Penalties**

The proposed change from fiscal to calendar year reporting by hospitals also would affect the reporting periods used to assess penalties, which would still be applied on a fiscal year basis. In addition, the proposal to delay attestations until Jan. 1, 2016 would impact implementation of penalties on hospitals that first enter the meaningful use program in 2015. Because the penalties for hospitals vary across those paid under the inpatient prospective payment system (PPS) and CAHs, they are treated separately below.

**Inpatient PPS Hospitals.** Generally, CMS proposes to base whether an inpatient PPS hospital receives a penalty in a given fiscal year on its meaningful use performance during the calendar year that is two years earlier. For example, a penalty in FY 2018 would be based on performance in CY 2016. For FY 2017 only, CMS proposes to use the reporting period spanning FY/CY 2015 (Oct. 1, 2014 – Dec. 31, 2015).

Under current rules, a hospital that first participates in meaningful use in FY 2015 must attest by July 1, 2015 to avoid a payment penalty in FY 2016. CMS proposes to change those requirements in the following ways:
For inpatient PPS hospitals that first participate in FY/CY 2015, that performance period would apply to assessment of penalties in both FY 2016 and FY 2017.

For FY/CY 2015, CMS proposes an attestation period for these hospitals of Jan. 1, 2016 to Feb. 29, 2016, which is after the beginning of FY 2016.

Therefore, the agency proposes to apply the FY 2016 penalties to inpatient PPS hospitals that have never before participated in meaningful use beginning Oct 1, 2015, including those that first participate in 2015.

If a hospital successfully attests for 2015 after Jan. 1, 2016, CMS would suspend the penalties and subsequently reprocess claims and reconcile any penalties previously assessed.

The AHA is concerned that this process would unfairly penalize inpatient PPS hospitals that first participate in FY/CY 2015.

Inpatient PPS hospitals that first participate in 2016 must finish their 90-day reporting period within the first three quarters of the calendar year and complete their attestation by Oct. 1, 2016 to avoid a payment adjustment in FY 2017. That reporting period also would be used to assess penalties for FY 2018.

Critical Access Hospitals. For CAHs, the penalties are based on same-year performance. Therefore, penalties in FY 2015 will be based on performance in the FY/CY 2015 reporting period, and any penalties would be assessed through cost report reconciliation. CAHs that first participate in 2016 must finish their 90-day reporting period by the end of the calendar year and attest by Feb. 28, 2017 to avoid a payment penalty.

**NEXT STEPS**

Please share this advisory with your senior management team. Ask your chief information officer to consider how the options in the proposed rule would affect your hospital’s approach to meeting meaningful use for 2015, 2016 and 2017.

The AHA will seek input from members to inform our comments on the proposed rule. We also encourage hospitals to submit their own comments to CMS. While the agency deadline is **June 15**, we encourage members to file comments early to enable CMS and ONC to release a final rule as quickly as possible.

Comments may be filed through [www.regulations.gov](http://www.regulations.gov). Follow the “submit a comment” instructions and refer to file code CMS-3311-P. You also may submit written comments (one original and two copies) to the addresses below:
Via regular mail:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-3311-P
P.O. Box 8013
Baltimore, MD 21244-8013

Via express or overnight mail:
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-3311-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

**FURTHER QUESTIONS**

If you have questions or comments about the proposed rule, please contact Chantal Worzala, AHA director of policy, at (202) 626-2313 or cworzala@aha.org.