Overview

On October 6, 2015, the Centers for Medicare and Medicaid Services (CMS) released its final rule, Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017. The rule specifies the requirements that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to qualify for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program. It includes a 90-day EHR reporting period in 2015 for all providers and removes reporting requirements on measures that have become redundant, duplicative, or topped out. In addition, the rule establishes the requirements for Stage 3 of the program as optional in 2017 and required for all participants beginning in 2018. CMS also continues to encourage the electronic submission of clinical quality measure (CQM) data, establishes requirements to transition the program to a single stage, and aligns reporting for providers in the Medicare and Medicaid EHR Incentive Programs.

While not clearly explained in the rule, providers who are unable to meet the requirements of meaningful use for an EHR reporting period in 2015 for reasons related to the timing of the publication of the final rule may apply for a hardship exception under the "extreme and uncontrollable" circumstances category. Each hardship exception application will be reviewed on a case-by-case basis. CMS is expected to remind providers about this hardship exception and its application to these unique circumstances as part of a frequently asked questions (FAQ) document in the coming days.

The rule will be published in the *Federal Register* on October 16, 2015, and includes a 60-day comment period, through which CMS hopes to gain additional feedback on the Stage 3 criteria. Note that page numbers below link to the display version of the final rule.

Provisions of the Proposed Regulations and Analysis of and Responses to Public Comments

Introduction (pg. 34)

In 2015, CMS published two notices of proposed rulemaking relating to the EHR Incentive programs to address near term goals in 2015 through 2017 and long-term goals for Stage 3 in 2017 and subsequent years.

CMS' March 2015 Stage 3 proposed rule (80 FR 16734) proposed the requirements for the Medicare and Medicaid EHR Incentive Programs for 2017 and subsequent years to build a long-term sustainable program focused on the advanced use of CEHRT to support clinical effectiveness, health information exchange, and quality improvement. CMS proposed a total of eight objectives that focus on supporting advanced clinical processes, promoting interoperability and health information exchange, continuing progress in electronic public health reporting, and expanding the scope and methods for provider and patient engagement.

CMS' April 2015 EHR Incentive Programs in 2015 through 2017 rule (80 FR 20347) proposed modifications to Stage 1 and Stage 2 to reflect this long-term vision and to be responsive to the changing environment and stakeholder concern over program complexity and redundant reporting requirements. The proposed rule included a reduced set of objectives and measures based on previously finalized Stage 2 requirements that better aligned with the policies for Stage 3. The proposed rule also proposed removing measures that had

become topped out, redundant or duplicative, and easing requirements around measures requiring providers to be accountable for patient action.

Despite commenter concerns, CMS continues to believe its policies outlined in both rules reduce provide burden and promote interoperability, and that the costs associated with the program are outweighed by the benefits healthcare providers will realize in the long-term.

Meaningful Use Requirements, Objectives, and Measures (pg. 45)

Definitions across the Medicare Fee-for-Service, Medicare Advantage, and Medicaid Programs (pg. 45)

Stages of Meaningful Use. CMS finalized its approach to the timing of the stages of meaningful use as proposed through the two proposed rules. Specifically, CMS finalized that all EPs, eligible hospitals, and CAHs must attest to the Modified version of Stage 2 beginning with an EHR reporting period in 2015, with alternate exclusions and specifications for certain providers, as discussed further in the rule. CMS finalized as proposed the option for all EPs, eligible hospitals, and CAHs to attest to Stage 3 for an EHR reporting period in 2017 and the requirement for all providers to attest to Stage 3 beginning with an EHR reporting period in 2018. The table below shows the finalized stages of meaningful use criteria according to first year of demonstrating meaningful use.

First Year Demonstrating Meaningful Use	Stage of Meaningful Use				
	2015	2016	2017	2018	2019 and future years
2011	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2012	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2013	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2014	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2015	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2016	NA	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2017	NA	NA	Modified Stage 2 or Stage 3	Stage 3	Stage 3
2018	NA	NA	NA	Stage 3	Stage 3
2019 and future years	NA	NA	NA	NA	Stage 3

EHR Reporting Period: Calendar Year Reporting. CMS finalized its proposal to align the EHR reporting period for eligible hospitals and CAHs with the calendar year beginning in 2015. For 2015 only, eligible hospitals and CAHs may begin an EHR reporting period as early as October 1, 2014 and must end by December 31, 2015. Beginning with 2016, the EHR reporting period must be completed within January 1 and December 31 of the calendar year.

EHR Reporting Period: EHR Reporting Period in 2015 through 2017. CMS finalized a 90-day EHR reporting period in 2015 for all providers as proposed. Eligible professionals may select an EHR reporting period of any

continuous 90-day period from January 1, 2015 through December 31, 2015; eligible hospitals and CAHs may select an EHR reporting period of any continuous 90-day period from October 1, 2014 through December 31, 2015. CMS also finalized a 90-day EHR reporting period in CY 2016 for EPs, eligible hospitals, and CAHs that have not successfully demonstrated meaningful use in a prior year. For all providers who have successfully demonstrated meaningful use in a prior year, CMS finalized an EHR reporting period of the full CY 2016.

EHR Reporting Period: EHR Reporting Period in 2017 and Subsequent Years. CMS finalized its proposal to require full CY reporting for all providers (with a limited exception for new meaningful EHR users under Medicaid) beginning in CY 2017, with a modification for providers attesting to Stage 3 of meaningful use in 2017. For EPs, eligible hospitals, and CAHs that choose to meet Stage 3 in 2017, the EHR reporting period is any continuous 90-day period within CY 2017. Beginning in CY 2018, for all EPs, eligible hospitals, and CAHs (including those attesting to Stage 3 for the first time), the EHR reporting period is the full CY.

Considerations in Review and Analysis of the Objectives and Measures for Meaningful Use, Topped out Measures and Objectives. CMS finalized as proposed its approach for evaluating whether objectives and measures are "topped out," and if so, whether a particular objective or measure should be considered for removal from the EHR Incentive Programs.

Considerations in Review and Analysis of the Objectives and Measures for Meaningful Use: Electronic Versus Paper-Based Objectives and Measures. CMS finalized its proposal that paper-based formats will not be required or allowed for the purposes of the objectives and measures for Stage 3 of meaningful use.

The table below outlines current objectives and measures identified by provider type that CMS has finalized as redundant, duplicative, or topped out, and that CMS will no longer require for meaningful use beginning with an EHR reporting period in 2015. However, CMS explains that the removal of these measures does not implicate a withdrawal of an endorsement for these best practices and is not meant to discourage providers from conducting and tracking these activities for their own quality improvement goals.

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

Provider Type	Objectives and Measures	
	eMAR	42 CFR 495.6 (l)(16) (i) and (ii)
	Advanced Directives	42 CFR 495.6 (m)(1) (i) and (ii)
	Electronic Notes	42 CFR 495.6 (j)(9) (i) and (ii)
	Imaging Results	42 CFR 495.6 (k)(6) (i) and (ii)
	Family Health History	42 CFR 495.6 (k)(2) (i) and (ii)
	Structured Labs to Ambulatory Providers	42 CFR 495.6 (m)(6) (i) and (ii)

Considerations in Defining the Objectives and Measures of Meaningful Use for 2015 through 2017, Changes to Objectives and Measures for 2015 through 2017 and Structural Requirements of Meaningful Use in 2015 through 2017. CMS finalized its proposed structure, which is outlined in the table below.

	Current Stage 1 Structure	Retained Objectives	Proposed/Finalized Structure
EP	13 core objectives 5 of 9 menu objectives including 1 public health objective	6 core objectives 3 menu objectives 2 public health objectives	9 core objectives 1 public health objective
EH/CAH	11 core objectives 5 of 10 menu objectives including 1 public health objective	5 core objectives 3 menu objectives 3 public health objectives	8 core objectives 1 public health objective
	Current Stage 2 Structure	**Retained Objectives**	**Proposed/Finalized Structure**
EP	17 core objectives including public health objectives 3 of 6 menu objectives	9 core objectives 0 menu objectives 4 public health objectives	9 core objectives 1 public health objective
EH/CAH	16 core objectives including public health objectives 3 of 6 menu objectives	7 core objectives 1 menu objective 3 public health objectives	8 core objectives 1 public health objective

Considerations in Defining the Objectives and Measures of Meaningful Use for 2015 through 2017, Alternate Exclusions and Specifications for Stage 1 Providers for Meaningful Use. CMS finalized as proposed the proposal for alternate exclusions and specifications for certain providers in 2015. Specifically, CMS finalized that providers who were scheduled to demonstrate Stage 1 in 2015 or 2016 (for certain exclusions only) may choose the alternate exclusions and specifications where applicable or may attest to the modified Stage 2 objectives and measures. CMS finalized that EPs, eligible hospitals and CAHs that were scheduled to be in Stage 1 in 2016 may claim an alternate exclusion for 2016 for the Computerized Provider Order Entry Objective Measures 2 and 3 (lab and radiology orders). CMS also finalized that eligible hospitals and CAHs that were scheduled to be in Stage 1 in 2016 may claim an alternate exclusion for an EHR reporting period in 2016 for the Electronic Prescribing Objective.

Considerations in Defining the Objectives and Measures of Meaningful Use Stage 3. CMS finalized its approach for setting the eight key policy areas for Stage 3 as proposed, which are outlined in the table below. Individual objectives and measures are addressed later in the rule.

Program Goal/Objective	Delivery System Reform Goal Alignment
Protect Patient Health Information	Foundational to the EHR Incentive Program and Certified EHR Technology* Recommended by HIT Policy Committee
Electronic Prescribing (eRx)	Foundational to the EHR Incentive Program National Quality Strategy Alignment
Clinical Decision Support (CDS)	Foundational to Certified EHR Technology Recommended by HIT Policy Committee National Quality Strategy Alignment
Computerized Provider Order Entry (CPOE)	Foundational to Certified EHR Technology National Quality Strategy Alignment
Patient Electronic Access to Health Information	Recommended by HIT Policy Committee National Quality Strategy Alignment
Coordination of Care through Patient Engagement	Recommended by HIT Policy Committee National Quality Strategy Alignment
Health Information Exchange (HIE)	Foundational to the EHR Incentive Program and Certified EHR Technology Recommended by HIT Policy Committee National Quality Strategy Alignment
Public Health and Clinical Data Registry Reporting	Recommended by HIT Policy Committee National Quality Strategy Alignment
**See, for example, sections 1848(o)(2) and (4) of the Act*	

Considerations in Defining Meaningful Use: Flexibility within Meaningful Use Objectives and Measures. CMS finalized its proposal to provide flexibility within certain measures. The Stage 3 objectives including flexible measure options are as follows:

- **Coordination of Care through Patient Engagement** – Providers must attest to the numerators and denominators of all three measures, but must only meet the thresholds for two of three measures.
- **Health Information Exchange** – Providers must attest to the numerators and denominators of all three measures, but must only meet the thresholds for two of three measures.
- **Public Health Reporting** – EPs must report on two measures and eligible hospitals and CAHs must report on four measures.

Considerations in Defining Meaningful Use: EPs Practicing in Multiple Practices Locations. For Stage 3, CMS finalized its proposal to maintain the policy from the Stage 2 final rule (77 FR 53981) that states that to be a meaningful user, an EP must have 50% or more of his or her outpatient encounters during the EHR reporting period at a practice/location or practices/locations equipped with CEHRT. Therefore, an EP who does not conduct at least 50% of their patient encounters in any one practice/location would have to meet the 50% threshold through a combination of practices/locations equipped with CEHRT. In the Stage 2 final rule, CMS defined patient encounter as any encounter where a medical treatment is provided or evaluation and management services are provided, and defined a practice/location as equipped with CEHRT if the record of the patient encounter that occurs at that practice/location is created and maintained in CEHRT. CMS stated that this could be accomplished in the following three ways:

- CEHRT could be permanently installed at the practice/location.
- The EP could bring CEHRT to the practice/location on a portable computing device.
- The EP could access CEHRT remotely using computing devices at the practice/location.

Considerations in Defining Meaningful Use: Denominators. CMS finalized its proposed denominators and the related explanations of terms. The complete discussion can be found in the rule beginning on page 125.

Considerations in Defining Meaningful Use: Patient Authorized Representatives. CMS finalized its proposed inclusion of patient-authorized representatives in the numerators of the Coordination of Care through Patient Engagement objective and the Patient Electronic Access objective as equivalent to the inclusion of the patient. CMS stated that it would expect that patient-authorized representatives with access to such health information will always act on the patient's behalf and in the patient's best interests and will remain free from any potential or actual conflict of interest with the patient.

Considerations in Defining Meaningful Use: Discussion of the Relationship of the Requirements of the EHR Incentive Programs to CEHRT. CMS finalized its proposal to continue its policy of linking each objective to the CEHRT definition and to ONC-established certification criteria. As with Stage 1 and Stage 2, EPs, eligible hospitals, and CAHs must use technology certified to the certification criteria in the ONC HIT Certification Program to meet the objectives and associated measures for Stage 3.

Considerations in Defining Meaningful Use: Discussion of the Relationship between a Stage 3 Objective and the Associated Measure. CMS finalized its proposal to continue its Stage 1 and Stage 2 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 in Stage 3.

Meaningful Use Objectives and Measures

Meaningful Use Objectives and Measures for 2015, 2016, and 2017 (pg. 134)

For 2015-2017, CMS finalized 10 objectives for EPs and 10 objectives for eligible hospitals and CAHs. These objectives would be mandatory for all providers. However, as mentioned earlier, CMS finalized alternate exclusions and specifications for some providers for 2015 and 2016 depending on their prior participation. CMS' decision to extend alternate exclusions to 2016 was limited to situations where a provider may not have the appropriate CEHRT functions in place for a measure and where rushed implementation of the function could present a risk to patient safety. Other exclusions are offered for providers who were scheduled for Stage 1 but "did not intend to select a specific Stage 1 objective." CMS acknowledges concerns that this is vague and could lead to audit problems and therefore, will not require a provider to actually document such intent.

The **Meaningful Use Objectives and Measures for EPs for 2015 through 2017** are listed in the table below. The table also includes a brief explanation of instances where the finalized policy differs from what was originally proposed, as well as additional clarifications regarding each measure.

A list of the **Meaningful Use Objectives and Measures for Eligible Hospitals and CAHs for 2015 through 2017** can be found in Table 8 on pgs. 276-280 of the rule.

ELIGIBLE PROFESSIONAL (EP) OBJECTIVES AND MEASURES FOR 2015 THROUGH 2017

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
Objective 1: Protect Patient Health Information ***For more information, see pgs. 134- 140***	Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI	None	Proposed vs. Final Rule: Measure finalized as proposed. Clarifications: Note that the security risk assessment is not an "episodic" item related only to a snapshot in time, but should cover the entirety of the year for which the analysis or review is

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
	created or maintained by CEHRT 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's risk management process.		conducted. Thus, it is acceptable for the security risk analysis to be conducted outside the EHR reporting period if the reporting period is less than one full year, but it must be conducted within the same calendar year as the EHR reporting period, and if the provider attests prior to the end of the calendar year, it must be conducted prior to the date of attestation. An organization may conduct one security risk analysis/review, which is applicable to all EPs within the organization, provided it is within the same calendar year and prior to any EP attestation for that calendar year. However, each EP is individually responsible for their own attestation and for independently meeting the objective. Also note that the scope of the security risk analysis for purposes of this meaningful use measure applies to ePHI created or maintained in CEHRT. However, other ePHI may be subject to the HIPAA rules, and providers are referred to those rules for additional security requirements. The HHS Office for Civil Rights (OCR) has issued guidance on conducting a security risk analysis in accordance with HIPAA: http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/rafinalguidancepdf.pdf Other free tools and resources available to assist providers include a Security Risk Assessment (SRA) Tool developed by ONC and OCR: http://www.healthit.gov/providers-professionals/securityrisk-assessment-tool.
Objective 2: Clinical Decision Support ***For more information, see pgs. 140- 148***	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 EPs scope of practice or patient population, the	If for 2015, the EP is scheduled to demonstrate Stage 1: Alternate Objective and Measure 1: Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to	Proposed vs. Final Rule: Measures finalized as proposed. Clarifications: For Measure 1, CMS notes its intent to provide flexibility for providers to identify high-priority health conditions that are most appropriate for CDS and by allowing CDS implementation at a relevant point in patient care when the intervention can influence clinical decision making before diagnostic or treatment action is taken in response to the

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
	clinical decision support interventions must be related to high-priority health conditions 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 2 Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period*.	track compliance with that rule. Measure 1: Implement one clinical decision support rule.	intervention. CMS expects providers will implement many CDS interventions, and providers are free to choose interventions in any domain that is a priority to the EP. For the Measure 2 Exclusion, CMS clarifies that the policy is fewer than 100 orders during the EHR reporting period. There is no distinction based on the length of the EHR reporting period and no option to pro-rate if using a shorter reporting period (i.e., the order threshold won't be less for those using a 90-day reporting period).
Objective 3: Computerized Provider Order Entry (CPOE) ***For more information, see pgs. 148-164***	Measure 1: More than 60% of medication orders created by the EP during the EHR reporting period are recorded using CPOE. *Measure 1 Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period*. Measure 2: More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE. *Measure 2 Exclusion: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.* Measure 3: More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE. *Measure 3 Exclusion: Any EP who writes fewer than*	Alternate Measure 1: For Stage 1 providers in 2015 only, more than 30% of all unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period have at least one medication order entered using CPOE; or more than 30% of medication orders created by the EP during the EHR reporting period during the EHR reporting period, are recorded using CPOE. Alternate Exclusion for Measure 2: Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 2 (laboratory orders). Providers scheduled to be in Stage 1 in 2016 may also claim an exclusion for measure 2.	Proposed vs. Final Rule: CMS expanded the alternate exclusions for measures 2 and 3 so that they also apply to providers scheduled to be in Stage 1 in 2016, which was not proposed in the original rule. Clarifications: An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective. In regards to the exclusions for less than 100 orders, CMS clarifies that there is no distinction based on the length of the EHR reporting period (i.e., the order threshold won't be less for those using a 90-day reporting period). CMS also clarifies that a licensed health care provider or a medical staff person who is a credentialed medical assistant or is credentialed to and performs the duties equivalent to a credentialed medical assistant may enter orders. However, CMS defers to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines proscribed. CMS believes that interns who have completed their medical training and are working toward appropriate licensure would fit within this definition. In general, scribes are not included

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
	100 radiology orders during the EHR reporting period.	Alternate Exclusion for Measure 3: Providers scheduled to be in Stage 1 in 2015 may claim an exclusion for measure 3 (radiology orders). Providers scheduled to be in Stage 1 in 2016 may also claim an exclusion for measure 3.	as medical staff that may enter orders for purposes of the CPOE objective. Nevertheless, this policy is not specific to a job title but to the appropriate medical training, knowledge, and experience. In terms of what constitutes an "order" under this objective, CMS clarifies that each order that is associated with a specific code would count as one order. Multiple tests ordered at the same time count individually if they fall under a different order code. For example, a laboratory panel, which consists of one order code but multiple tests, would only count as one order for the purposes of CPOE. Under this objective, EPs could exclude "protocol" or "standing orders;" i.e., EPs could exclude orders that are predetermined for a given set of patient characteristics or for a given procedure from the calculation of CPOE numerators/denominators. Note this does not *require* EPs to exclude this category of orders from their numerator/denominator. CMS also clarifies that a circumstance involving tele-health or remote communication may be included in the numerator as long as the order entry otherwise meets the requirements of the objective and measures.
Objective 4: Electronic Prescribing ***For more information, see pgs. 164-171***	Measure: More than 50% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. *Measure Exclusion: No pharmacies that accept e-prescriptions within 10 miles of EP's practice at the start of the EHR reporting period.* *Measure Exclusion: EPs who write fewer than 100 permissible prescriptions during the EHR reporting period*.	Alternate Measure: For Stage 1 providers in 2015 only, more than 40% of all permissible prescriptions written by the EP are transmitted electronically using CEHRT.	Proposed vs. Final Rule: Same as proposed, accept for the clarification below. Clarifications: CMS will no longer distinguish between prescriptions for controlled substances and all other prescriptions, and instead will refer only to permissible prescriptions in the denominator. Prescriptions for controlled substances *may* be included in the denominator's definition of permissible prescriptions at the EP's discretion and where allowable by law. However, this will remain an option for providers and is not required. Additionally, in order to balance the potential benefit of e-prescribing with the current

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
			burden on providers, CMS clarifies how EPs may count the query of a formulary. EPs may count a patient in the numerator where no formulary exists to conduct a query. EPs may also limit their effort to query a formulary to simply using the function available to them in their CEHRT with no further action required. This means that if a query using the function of their CEHRT is not possible or shows no result, a provider is not required to conduct any further manual or paper-based action in order to complete the query, and the provider may count the prescription in the numerator.
Objective 5: Health Information Exchange ***For more information, see pgs. 179-193***	Measure: The EP that transitions or refers their patient to another setting of care or provider of care (1) uses CEHRT to create a summary of care record; and (2) electronically transmits such summary to a receiving provider for more than 10% of transitions of care and referrals. *Measure Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.*	Alternate Exclusion: Provider may claim an exclusion for this measure if for 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.	Proposed vs. Final Rule: Same as proposed, although this objective was originally referred to as "Summary Care." Clarifications: CMS will maintain the previously finalized Stage 2 requirements for the data elements that need to be included in the summary of care document. All summary of care documents used to meet this objective must include the following information if the provider knows it: • Patient name • Referring or transitioning provider's name and office contact information • Procedures • Encounter diagnosis • Immunizations • Laboratory test results • Vital signs (height, weight, blood pressure, BMI). • Smoking status • Functional status, including activities of daily living, cognitive and disability status • Demographic information (preferred language, sex, race, ethnicity, date of birth) • Care plan field, including goals and instructions • Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider • Reason for referral

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
			In circumstances where there is no information available to populate one or more of the fields listed, either because the provider can be excluded from recording such information (e.g., vital signs) or because there is no information to record (e.g., laboratory tests), the provider may leave the field(s) blank and still meet the objective and its associated measure. In addition, all summary of care documents used to meet this objective must include the following: • Current problem list (providers may also include historical problems at their discretion); • Current medication list; and • Current medication allergy list. A provider *must* verify these three fields are not blank and include the most recent information known by the provider as of the time of generating the summary of care document. Understanding provider concern over the ability to exercise some discretion over the amount of data transmitted, CMS provides flexibility specifically for the lab results portion of the summary of care document. A provider must have the ability to send all lab test results in the summary of care document, but a provider may work with their system developer to establish clinically relevant parameters based on their specialty, patient population, or for certain transitions and referrals to determine the most appropriate results for given transition or referral. Also, a provider who limits the results in a summary of care document must send the full results upon the request of the receiving provider or upon the request by the patient. Furthermore, CMS clarifies that in cases where providers share access to an EHR, a transition or referral may still count toward the measure if the referring providers create the summary of care document using CEHRT and send the summary of care document electronically. Note that if a provider chooses

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
			to include such transitions to providers where access to the EHR is shared, they must do so universally for all patient and all transitions or referrals. Finally, CMS clarifies that to count in the numerator the sending provider must have reasonable certainty of receipt of the summary of care document. This means that a "push" to an HIE, which might be queried by the recipient, is insufficient. Instead, the referring provider must receive confirmation that a query was made to count the action toward the measure.
Objective 6: Patient-Specific Education ***For more information, see pgs. 193-204***	Measure: Patient-specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period. *Measure Exclusion: EPs who have no office visits during the EHR reporting period*.	Alternate Exclusion: Provider may claim an exclusion for the measure if they were scheduled to demonstrate Stage 1 in 2015, but did not intend to select the Stage 1 Patient-Specific Education menu objective.	Proposed vs. Final Rule: Same as proposed. Clarifications: While CEHRT must be used to identify/suggest patient-specific education resources, these resources or materials do not have to be maintained within or generated by the CEHRT. Similarly, the provider can then provide these educational resources to patients in a useful format for the patient (e.g., electronic copy, printed copy, electronic link to source materials, through a patient portal or PHR). Furthermore, while patient-specific education resources may be provided outside of the EHR reporting period, this action must occur no earlier than the start of the same year as the EHR reporting period if the EHR reporting period is less than one full calendar year and no later than the date of attestation. CMS also clarifies that if the education resources are provided electronically and attribution is impossible, it may be counted in the numerator for any provider within a group sharing the CEHRT who has contributed information to the patient's record, if that provider also has the patient in their denominator for the EHR reporting period (versus if a provider gives a patient a paper-based educational resource during their office visit, which is only attributable to that provider and should not be counted in the numerator for other providers within the group practice).

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
Objective 7: Medication Reconciliation ***For more information, see pgs. 204-214***	Measure: The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP. *Measure Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period.*	Alternate Exclusion: Provider may claim an exclusion for the measure of the Stage 2 Medication Reconciliation objective if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, but did not intend to select the Stage 1 Medication Reconciliation menu objective	Proposed vs. Final Rule: Same as proposed. Clarifications: This objective does not dictate what information must be included in medication reconciliation. However, "medication reconciliation" is defined as the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider. This measure is *not* limited to only those patients for whom a record is received electronically. While health information exchange is of great assistance to medication reconciliation, an electronic summary of care document is not required for medication reconciliation. Nor is electronic HIE the only way EHRs can assist with medication reconciliation. Medication reconciliation may take many forms, from automated inclusion of ePHI to review of paper records, to discussion with the patient upon intake or during consultation with the provider. While medication reconciliation may become more automated as technology progresses, CMS recognizes it may never reach a point of full automation as these other methods continue to offer value. To clarify, the denominator includes when the provider is the recipient of the transition or referral, 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 definition of a transition of care is the movement of a patient from one setting of care (e.g., a hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. CMS makes no distinction between settings nor does it reference any POS code for the party transitioning the patient.

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
			Referrals are cases where one provider refers a patient to another, but the referring provider maintains his or her care of the patient as well. "New patient" is defined as someone who has never before been seen by the provider, although a provider may use an expanded definition to capture a wider range of patients for whom medication reconciliation would be relevant and beneficial (e.g., "new" if they have not been seen in 2 years). CMS clarifies that the action of reviewing the medication list in a summary of care document to determine if there are changes or confirm that there are no changes would meet the requirements of the objective.
Objective 8: Patient Electronic Access (VDT) ***For more information, see pgs. 214-234***	Measure 1: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely access (within 4 business days after information is available to EP) to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. Measure 2: For 2015 and 2016: At least 1 patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period. For 2017: More than 5% of unique patients seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits	Alternate Exclusion for Measure 2: Providers may claim an exclusion for this measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.	Proposed Vs. Final Rule: For measure 2, the original proposal would have only required that 1 patient view, download, or transmit his health information to a third party during the reporting period in each year from 2015-2017. It did not include the "more than 5%" requirement for 2017. CMS believes this modification aligns with its policy to build from basic to advanced use, to increase measure thresholds over time, and to maintain an incentive to focus on approaches that increase patient engagement over time. Clarifications: In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP: • Patient name • Provider's name and office contact information • Current and past problem list • Procedures • Laboratory test results • Current medication list and medication history • Current medication allergy list and medication allergy history • Vital signs (height, weight, blood pressure, BMI, growth charts)

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
	their health information to a third party during the EHR reporting period. *Measure Exclusions: Any EP who--* *(a) Neither orders nor creates any of the information listed for inclusion as part of the measures; or* *(b) Conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period*.		• Smoking status • Demographic information (preferred language, sex, race, ethnicity, date of birth) • Care plan field(s), including goals and instructions • Any known care team members including the primary care provider (PCP) of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider. CMS clarifies that Measure 1 is already required for all providers in Stage 1 and Stage 2. The specifications for this measure allow the provision of access to take many forms and do not require a provider to obtain an email address from the patient (in response to concerns about attaining this measure's threshold when a patient population is elderly, ill, low-income, and/or located in remote, rural areas). In addition, the provider must continue to update the information accessible to the patient each time new information is available. So if the provider fails to provide access to a patient upon an initial visit during the EHR reporting period, but provides access on a subsequent visit (or vice versa), the patient cannot be counted in the numerator because the patient did not have timely online access to health information related to the first visit. For measure 2 (which measures the patient's action, not the provider), the only change that CMS originally proposed was to modify the existing threshold of 5% to at least one patient for 2015-2017. As noted above, CMS ultimately decided to require at least one patient for 2015 and 2016, but to revert back to the 5% threshold for 2017. This patient action must be taken no earlier than the start of the same year as the EHR reporting period and no later than the date of attestation. CMS also clarifies that providers who are covered by civil rights laws, including the Americans with Disabilities Act, Section 504 of

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
			the Rehabilitation Act of 1973, or Section 1577 of the Affordable Care Act, must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
Objective 9: Secure Messaging ***For more information, see pgs. 234-243***	Measure: For 2015: The capability for patients to send and receive a secure electronic message with the EP was fully enabled. For 2016: For at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative) during the EHR reporting period. For 2017: For more than 5% of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period. *Measure Exclusion: Any EP who: (a) has no office visits during the EHR reporting period; or (b) conducts*	Alternate Exclusion: An EP may claim an exclusion for this measure if for an EHR reporting period in 2015 they were scheduled to demonstrate Stage 1, which does not have an equivalent measure.	Proposed vs. Final Rule In proposed rule, CMS only proposed that for 2015-2017, the capability for patients to send and receive a secure electronic message with the provider be fully enabled. CMS finalized a more phased approach to encourage providers to work incrementally toward a higher goal. Clarifications: The current Stage 2 secure messaging objective, as finalized in the 2012 Stage 2 final rule, does not include this flexibility of form, method and participation. It includes only patient-initiated communication rather than provider driven engagement, and it does not promote a wide range of use cases. CMS is modifying the current objective to include provider initiated communications and communications with a patient-authorized representative in the numerator. This change also means that a patient-initiated message would only count toward the numerator if the provider responded to the patient as that is part of measuring the provider action rather than the patient action for this measure. This measure allows for a single action by a patient to count in the numerator for multiple providers under certain circumstances if each of the providers has the patient in their denominator for that EHR reporting period. The calculation of this measure may include actions taken before, during, or after the EHR reporting period if the period is less than one full year. However, these actions must be taken no earlier than the start of the same year as the EHR reporting period and no later than the date of attestation.

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
	50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability		
Objective 10: Public Health ***For more information, see pgs. 243-272***	EPs must meet at least 2 of the following measures: Measure 1 – Immunization Registry Reporting: The EP is in active engagement with a public health agency to submit immunization data. *Measure Exclusion: If the EP* • *Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period;* • *Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or* • *Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP.* Measure 2 – Syndromic Surveillance Reporting:	For 2015, Stage 1 EPs must meet at least 1 measure. Stage 2 EPs must meet at least 2 measures. For 2016 and 2017, all EPs must meet at least 2 measures.	Proposed vs. Final Rule: CMS originally proposed that for 2015-2017, EPs would have to report on any 2 out of 5 measures from the public health reporting objective. For 2015 only, EPs in Stage 1 would be allowed to report on only 1 of the 5 available measures options (similar to what was finalized). In the final rule, CMS did *not finalize* the following measure options under this objective, which results in total of 3 measures, rather than 5 for 2015-2017 (Public Health Registry Reporting and Clinical Data Registry Reporting were combined into a single "Specialized Registry Reporting" measure): 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. The 3 final measures were finalized with the following modifications: • For Measure 1, CMS removed the requirement for bi-directional data exchange. Providers will not be required to receive a full immunization history and will not be required to display an immunization forecast from an Immunization Information System (IIS) to meet the measure. Providers will only need to electronically submit immunization data to the appropriate public health

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
	The EP is in active engagement with a public health agency to submit syndromic surveillance data. *Measure Exclusion:* *An EP is* • *Not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;* • *Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or* • *Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.* Measure 3 – Specialized Registry Reporting: The EP is in active engagement to submit data to a specialized registry. *Measure Exclusion:* *Any EP that* • *Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during*		jurisdiction's IIS. • For Measure 2, CMS will allow all EPs to submit syndromic surveillance data and to modify the exclusions to reflect that different categories of providers may or may not be able to report based on the requirements of the registry. Clarifications: The definition of "active engagement" can be found on pgs. 244-245. This definition replaces and is much more flexible than the current "ongoing submission" requirement and allows EPs who register their intent to submit data to successfully meet a measure under this objective. Providers could register before the reporting period begins. Also, previous registrations that occurred in a previous stage of meaningful use would count towards "active engagement." CMS clarifies that for providers who have already planned for and/or acted toward meeting any of the Stage 1 or Stage 2 public health reporting objectives (i.e., "ongoing submission), those actions would count toward meeting the active engagement options. CMS also clarifies that providers can demonstrate meaningful use by using communications and information provided by a PHA or CDR to the provider directly *or* by using communications and information provided by a PHA or CDR to the practice or organization of the provider (as long as the provider shares the same CEHRT as the practice or organization). Furthermore, CMS clarifies that exclusions for a measure do not count toward the total of two measures. But, if the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting the one remaining measure available (or claim exclusions for all measures). A provider also may report to more than one specialized registry and may count specialized

Objectives for 2015, 2016 and 2017	Measures for Providers in 2015, 2016 and 2017	Alternate Exclusions and/or Specifications for Certain Providers	Notes
	the EHR reporting period; • *Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or* • *Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.*		registry reporting more than once to meet the required number of measures for the objective (but may not count the other two measures twice for this purpose). CMS notes that it supports the inclusion of a variety of registries under the specialized registry measure, including Prescription Drug Monitoring Program reporting and electronic case reporting. CMS believes that a variety of registries may be considered specialized registries to give providers the flexibility to report using a registry that is most helpful to their patients. Also, EPs who were previously planning to attest to the cancer case reporting objective may count that action toward the Specialized Registry Reporting measure. However, EPs who did not intend to attest to the cancer case reporting menu objective are not required to engage in or exclude from cancer case reporting in order to meet the specialized registry reporting measure.

Objectives and Measures for Stage 3 of the EHR Incentive Programs (pgs. 280-460)

OBJECTIVES, MEASURES, AND CERTIFICATION CRITERIA FOR STAGE 3

**Note: this table includes criteria for both EPs and Eligible Hospitals/CAHs*

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
Objective 1: Protect Patient Health Information ***For more information, see pgs. 280- 291***	Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained in CEHRT 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's risk management process	Same	Proposed vs. Final Rule: Same
Objective 2: Electronic Prescribing ***For more information, see pgs. 291-303***	Measure: More than 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT. *Measure Exclusion: Any EP who:* • *Writes fewer than 100 permissible prescriptions during the EHR reporting period; or* • *Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.*	Measure: More than 25% of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT. *Exclusion: Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and there are no pharmacies that accept electronic prescriptions within 10 miles at the start of their EHR reporting period.*	Proposed vs. Final Rule: Same Clarifications: CMS will continue to allow providers the option to include or exclude controlled substances in the denominator where such medications can be electronically prescribed. Eligible prescriptions also includes authorization for refills of previously authorized drugs.

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
Objective 3: Clinical Decision Support ***For more information, see pgs. 304-317***	Measure 1: The EP must 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. 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 2 Exclusion: For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.*	Same, except Measure 2 exclusion only applies to EPs.	Proposed vs. Final Rule: Same
Objective 4: Computerized Provider Order Entry (CPOE) ***For more information, see pgs. 317-331***	Measure 1: More than 60% of medication orders created by the EP during the EHR reporting period are recorded using CPOE. *Measure 1 Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period.* Measure 2: More than 60% of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE. *Measure 2 Exclusion: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.*	Same, except exclusions only apply to EPs. All measures under this objective also apply to emergency department (POS 21 or 23).	Proposed vs. Final Rule: Measure 1 threshold was originally proposed at 80%

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
	Measure 3: More than 60% of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using CPOE. *Measure 3 Exclusion: Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.*		
Objective 5: Patient Electronic Access ***For more information, see pgs. 331-355***	Measure 1: For more than 80% of all unique patients seen by the EP: (1) The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The EP ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT. Measure 2: The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35% of unique patients seen by the EP. *Exclusions: If one of the following apply:* • *An EP has no office visits during the EHR reporting period.* • *Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more*	Same measures apply to hospitals, CAHs, and the emergency department (POS 21 or 23) *Exclusion for hospitals: If eligible hospital or CAH is located in a county that does not have 50% or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period.*	Proposed v. Final Rule: For Measure 1, CMS finalized Alternate A, which includes the requirement that providers offer all four functionalities (view, download, transmit, and access through API) to their patients. A discussion of alternate proposals considered can be found on pgs. 348-352. Also for Measure 1, due to concerns expressed about the original 24-hour timeframe for availability, CMS instead finalized that information must be included for access within 48 hours for EPs and retained the 36 hours for eligible hospitals and CAHs. Measure 2 was finalized as proposed for the method of delivery, but with a modification to specify that for the numerator for each year, the action must occur within the same calendar year as the EHR reporting period, but may occur before, during, or after the EHR reporting period if it is less than a full calendar year. The action also must occur prior to the provider submitting their attestation if they attest prior to the end of the calendar year.

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
	of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.		
Objective 6: Coordination of Care through Patient Engagement ***For more information, see pgs. 355-378***	Providers must attest to all three of the following measures and must meet the thresholds for at least two measures to meet the objective. Measure 1: For 2017, during the EHR reporting period, more than 5% of all unique patients (or patient-authorized representative) seen by the EP actively engage with the EHR made accessible by the provider by (1) viewing, downloading or transmitting to a third party their health information; or (2) accessing their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2). For 2018 and subsequent years, the threshold is more than 10%. Measure 2: For 2017, more than 5% of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-	Same measures apply to hospitals, CAHs, and the emergency department (POS 21 or 23) *Exclusion for hospitals is:* • *If eligible hospital or CAH is located in a county that does not have 50% or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period.*	Proposed vs. Final Rule: Measure 1: The threshold was originally 25%, but CMS lowered it for 2017 due to public concern and to be consistent with the rule finalized for 2015-2017. CMS also believes that 10% is a reasonable threshold for providers participating in 2018, as compared to the proposed 25% threshold. Measure 2: The original threshold for this measure was 35%, but was lowered for 2017 due to concern and to align with the 2015-2017 requirements. However, CMS believes a 25% threshold is reasonable for 2018 because the measure focuses on provider-initiated action and offers multiple paths for success, while the reduction from 35% reduces the risk of failure for those who may require additional time to implement the functions and workflows within their practice. Measure 3: Original threshold was 15%. Clarifications: Measure 1: CMS clarifies that it would count any and all actions listed (view, download, transmit, or accessing through an API) toward a numerator, rather than establishing separate thresholds for each. Measure 3: A discussion of how CMS defines "non-clinical setting" starts on pg. 370. CMS also clarifies that it does not specify the manner in which providers are required to incorporate the data. Providers may work with their EHR developers to establish the methods and processes which work

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
	authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative. For 2018 and subsequent years, the threshold is 25% Measure 3: Patient-generated health data or data from a non-clinical setting is incorporated into the CEHRT for more than 5% of all unique patients seen by the EP during the EHR reporting period. *Exclusions: A provider may exclude the measures if one of the following apply:* • *An EP has no office visits during the EHR reporting period.* • *Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.*		best for their practice and needs.
Objective 7: Health Information Exchange ***For more information, see pgs. 378-423***	Providers must attest to the numerator and denominator for all three measures, but would only be required to successfully meet the threshold for two of the three measures. Measure 1: For more than 50% of transitions of care and referrals, the EP that transitions or refers their patient to another setting	Same measures apply to hospitals, CAHs, although only Measures 1 and 2 appear to apply to the emergency department (POS 21 or 23) *Measure 1 Exclusion for hospitals:* • *If eligible hospital or CAH is located in*	Proposed vs. Final Rule: CMS modified its initial proposal so that patient self-referrals may be included under Measure 1, but are not required. The provider should determine in what cases they would/would not include such cases and apply that policy across all such referrals for the duration of the reporting period. Clarifications:

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
	of care or provider of care-- (1) creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record. *Measure 1 Exclusion:* *A provider may exclude from the measure if any of the following apply:* • *Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.* • *Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measures.* Measure 2: For more than 40% of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, the EP receives or retrieves and incorporates into the patient's record an electronic summary of care document. *Measure 2 Exclusion:* • *Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the*	*a county that does not have 50% or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period.* *Measure 2 Exclusion for hospitals:* • *Any eligible hospital or CAH for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure.* • *If eligible hospital or CAH is located in a county that does not have 50% or more of their housing units with 4Mbps broadband availability according to the latest information available from the FCC at the start of the EHR reporting period.* *Measure 3 Exclusion:* *Same as for EPs*	Transitions of care and referrals may include situations where the recipient provider may already have access to the medical record maintained in the referring provider's CEHRT, as long as the providers have different billing identities within the EHR Incentive Program (e.g., such as different NPIs or hospital CMS CCNs). A provider may count these transitions with providers who share CEHRT if they do so universally across all settings and for all such transitions. However, for any action to count in the numerator, the provider may not simply deem the shared access to the record sufficient, they would instead need to complete the required action associated with each measure. For Measure 1, summary of care document requirements are discussed starting on pg. 383. For Measure 3, the provider must implement clinical information reconciliation for the following three clinical information sets: • Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. • Medication allergy. Review of the patient's known medication allergies. • Current Problem list. Review of the patient's current and active diagnoses.

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
	patient, is fewer than 100 during the EHR reporting period is excluded from this measure. • *Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measures.* Measure 3: For more than 80% of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, the EP performs clinical information reconciliation. *Measure 3 Exclusion: Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure.*		
Objective 8: Public Health and Clinical Data Registry Reporting ***For more information, see pgs. 423-460***	EPs would be required to successfully attest to any combination of 2 out of 5 measures. Measure 1: Immunization Registry Reporting The EP is in active engagement with a public health agency to submit immunization data and	Hospitals/CAHs would be required to successfully attest to any combination of 4 out of 6 measures. Measure 1: Immunization Registry Reporting Measure and exclusions the same as	Proposed vs. Final Rule CMS originally proposed that EPs attest to any combination of 3 measures, rather than 2. For all 6 measures, CMS broadened the exclusions so they include a 6 month lead time for the declaration of readiness rather than requiring that public health agency and clinical data registries declare readiness

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
	receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS). *Measure 1 Exclusion:* *If the EP:* • *Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;* • *Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or* • *Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the EHR reporting period.* Measure 2: Syndromic Surveillance Reporting The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.	for EPs Measure 2: Syndromic Surveillance Reporting Same measure, but different exclusion *Measure 2 Exclusion for eligible hospitals or CAHs:* • *Does not have an emergency or urgent care department;* • *Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from eligible hospitals or CAHs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period;* • *or operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from eligible hospitals or CAHs as of 6 months prior to the start of the EHR reporting period* Measure 3: Electronic Case Reporting Same measure and exclusion as applies to EPs Measure 4: Public Health Registry	on the first day of the EHR reporting period (i.e., if they have not declared 6 months before the start of the EHR reporting period whether their registry will be ready on January 1 of the upcoming year for use by providers seeking to meet EHR reporting, a provider can claim an exclusion). CMS also clarified the setting specificity for syndromic surveillance reporting and specified electronic case reporting. Clarifications: A discussion of what would qualify as "active engagement" starts on pg. 424 An exclusion to a measure does not count toward the total, but an EP and hospital can claim applicable exclusions for all the measures and still meet the objective. Table 10 on pg. 460 lists the maximum times each measure may count toward the objective.

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
	Measure 2 Exclusion: *Any EP that:* • *Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;* • *Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or* • *Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs as of 6 months prior to the start of the EHR reporting period.* Measure 3: Electronic Case Reporting The EP is in active engagement with a public health agency to submit case reporting of reportable conditions. *Measure 3 Exclusion:* • *Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period;* • *Operates in a jurisdiction for which no public health agency is capable of receiving electronic*	Reporting Same measure and exclusion as applies to EPs Measure 5: Clinical Data Registry Reporting Same measure and exclusion as applies to EPs Measure 6: Electronic Reportable Laboratory Results The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results. *Measure 6 Exclusion:* *Any hospital or CAH that:* • *Does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period;* • *Operates in a jurisdiction for which no public health agency is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or* • *Operates in a jurisdiction where no public health agency has declared readiness to receive electronic reportable laboratory results*	

Objective	EP Measures	Eligible Hospital/CAH Measures	Notes (please also refer to 2015-2017 notes)
	case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or • *Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the EHR reporting period.* Measure 4: Public Health Registry Reporting The EP is in active engagement with a public health agency to submit data to public health registries. *Measure 4 Exclusion: Same as above* Measure 5: Clinical Data Registry Reporting The EP is in active engagement to submit data to a clinical data registry. *Measure 5 Exclusion: Same as above*	*from an eligible hospital or CAH as of 6 months prior to the start of the EHR reporting period.*	

Certified EHR Technology (CEHRT) Requirements (pg. 460)

CEHRT Definition for the EHR Incentive Programs (pg. 460)

CMS finalized its proposal to move the full EHR Incentive Programs specific definition of CEHRT from the ONC certification criteria rules to the EHR Incentive Programs rule. This change is designed to simplify the overall regulatory relationship between ONC and CMS rules for stakeholders and to ensure that relevant CMS policy for the Medicare and Medicaid EHR Incentive Programs is clearly defined in CMS regulations.

CMS also clarifies here that providers must use EHR technology certified at least to the 2014 Edition in 2016 and 2017. Providers may adopt EHR technology certified to the 2015 Edition prior to the beginning of Stage 3 in 2017 or 2018.

Defining CEHRT for 2015 through 2017 (pg. 465)

For EHR reporting periods in 2017:

- A provider who has technology certified to the 2015 Edition may attest to Stage 3 or to the modified Stage 2 requirements identified elsewhere in this rule.

- A provider who has technology certified to a combination of 2015 Edition and 2014 Edition may attest to: (1) the modified Stage 2 requirements; or (2) potentially to the Stage 3 requirements if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures.
- A provider who has technology certified to the 2014 Edition only may attest to the modified Stage 2 requirements and may not attest to Stage 3.

For EHR reporting periods in 2018:

- All providers must use technology certified to the 2015 Edition to meet Stage 3 requirements.

CMS also clarifies that technology that is certified only to the Base EHR definition would not be adequate for purposes of attesting to meaningful use in any EHR reporting period. The Base EHR definition is not designed solely for the use of the EHR Incentive Programs.

CMS encourages providers to work closely with their developers to determine what compilation of technology certified under the ONC Health IT Certification Program would allow the provider to successfully attest to meaningful use in an EHR reporting period covered under this rule.

CMS also encourages providers to review the website of the ONC Health IT Certification Program and the Certified Health IT Products List (CHPL), which include real time information on what products are certified for what functionalities (see www.healthit.gov)

Defining CEHRT for 2018 and Subsequent Years (pg. 472)

CMS finalized the following policies, as proposed:

Starting with 2018, all EPs, eligible hospitals, and CAHs would be required to use technology certified to the 2015 Edition to meet the CEHRT definition and to demonstrate meaningful use. The CEHRT definition would include meeting the 2015 Edition Base EHR definition and having other important capabilities that include the capabilities to:

- Record or create and incorporate family health history;
- Capture patient health information such as advance directives;
- Record numerators and denominators for meaningful use objectives with percentage-based measures and calculate the percentages;
- Calculate and report clinical quality measures; and
- Any other capabilities needed to be a Meaningful EHR User.

CMS clarifies that 2017 provides a flex year by allowing providers options in the edition of CEHRT used and the stage of meaningful use to which the provider attests. This flexibility is in place in recognition of the implementation needed for technology. However, by 2018, all providers will be required to attest to Stage 3 using 2015 Edition technology.

In response to concerns that technology certified to the 2015 Edition would not be ready in 2018, CMS noted that with the finalization of this rule, developers and providers will have more than 24 months to develop and implement 2015 Edition technology required by this rule. CMS also notes that many of the requirements of Stage 3 are similar to those of Stage 2 and would use the same certification criteria with slight updates to vocabulary standards.

CMS urges providers to carefully make determinations regarding the technology they will need to attest to meaningful use and to work closely with their developers to ensure that the technology they possess will meet their attestation needs. Tables 11 through 16, listed below, were developed in conjunction with ONC and reflect the technology requirements that support the CEHRT definition and each measure in this final rule.

Final Definition of CEHRT (p. 477)

To facilitate readers identifying the requirements of CEHRT for each objective and measure finalized in this rule, ONC and CMS present a set of tables providing the appropriate certification criteria reference under the 2014 Edition and 2015 Edition certification criteria for the objectives and measures of meaningful use. These tables are listed below.

TABLE 11 - EP OBJECTIVES, MEASURES AND CERTIFICATION CRITERIA FOR 2015-2017 (pgs. 477-483)

TABLE 12: ELIGIBLE HOSPITAL AND CAH OBJECTIVES, MEASURES, AND CERTIFICATION CRITERIA FOR 2015-2017 (pgs. 483-488)

TABLE 13 - EP OBJECTIVES, MEASURES, AND CERTIFICATION CRITERIA FOR STAGE 3 IN 2017 (pgs. 488-494)

TABLE 14 - ELIGIBLE HOSPITAL/CAH OBJECTIVES, MEASURES, AND CERTIFICATION CRITERIA FOR STAGE 3 IN 2017 (pgs. 494-501)

TABLE 15 - EP OBJECTIVES, MEASURES, AND CERTIFICATION CRITERIA FOR STAGE 3 IN 2018 AND SUBSEQUENT YEARS (pg. 501-504)

TABLE 16 - ELIGIBLE HOSPITAL/CAH OBJECTIVES, MEASURES, AND CERTIFICATION CRITERIA FOR STAGE 3 IN 2018 AND SUBSEQUENT YEARS (pgs. 504-509)

Clinical Quality Measurement (pg. 510)

Clinical Quality Measure (CQM) Requirements for Meaningful Use in 2015 and 2016 (pg. 510)

CMS finalized its proposal to maintain the existing requirements established in earlier rulemaking for the reporting of CQMs, which are summarized below:

EP Options for Medicare EHR Incentive Program Participation (single program Participation – EHR Incentive Program only)	++Option 1: Attest to CQMs through the EHR Registration & Attestation System ++ Option 2: Electronically report CQMs through Physician Quality Reporting System (PQRS) Portal
EP Options for Electronic Reporting for Multiple Programs (for example: EHR Incentive Program plus PQRS participation)	++ Option 1: Report individual EP's CQMs through PQRS Portal ++ Option 2: Report group's CQMs through PQRS Portal *CMS notes that under option 2, this may include an EP reporting using the group reporting option, either electronically using QRDA, or via the GPRO Web Interface.*
Eligible hospital and CAH Options for Medicare EHR Incentive Program Participation (single program participation - EHR Incentive Program only)	++ Option 1: Attest to CQMs through the EHR Registration & Attestation System ++ Option 2: Electronically report CQMs through QualityNet Portal
Eligible hospital and CAH Options for Electronic Reporting for Multiple Programs (for example: EHR Incentive Program plus IQR participation)	++ Electronically report through QualityNet Portal

CMS finalized its proposal to maintain the existing CQM reporting requirements of nine CQMs covering at least three NQS domains for EPs and 16 CQMs covering at least three NQS domains for eligible hospitals and CAHs.

CMS finalized its proposal to change the definition of "EHR reporting period" in §495.4 for eligible hospitals and CAHs such that the EHR reporting period would begin and end in relation to a calendar year. In connection with this proposal, CMS also proposed that in 2015 and for all methods of reporting, eligible hospitals and CAHs would be required to complete a reporting period for CQMs aligned with the calendar year in order to demonstrate meaningful use.

CMS finalized its proposal to change the EHR reporting period for all EPs, eligible hospitals, and CAHs to any continuous 90-day period within the calendar year, as well a 90-day reporting period in 2015 for clinical quality measures for all EPs, eligible hospitals, and CAHs that report clinical quality measures by attestation. CMS finalized its proposal that EPs may select any continuous 90-day period from January 1, 2015 through December 31, 2015, while eligible hospitals and CAHs may select any continuous 90-day period from October 1, 2014 through December 31, 2015, to report CQMs via attestation using the EHR Incentive Program registration and attestation system. In addition, CMS finalized its proposal that a provider may choose to attest to a CQM reporting period of greater than 90 days up to and including 1 full calendar year of data.

CMS also finalized its proposal to continue its existing policy that providers in any year of participation for the EHR Incentive Programs for 2015 through 2017 may instead electronically report CQM data using the options previously outlined for electronic reporting either for single program participation in the Medicare EHR Incentive Programs, or for participation in multiple programs if the requirements of the aligned quality program are also met. CMS noted that EPs seeking to participate in multiple programs with a single electronic submission would be required to submit a full calendar year of CQM data using the 2014 electronic specifications for the CQMs (which are also known as eCQMs) for a reporting period in 2015. CMS also noted that eligible hospitals and CAHs seeking to participate in multiple programs with a single electronic submission for a reporting period in 2015 would be required to submit one calendar quarter of data for 2015 from either Q1 (January 1, 2015–March 31, 2015), Q2 (April 1, 2015 June 30, 2015), or Q3 (July 1, 2015–September 30, 2015) and would require of the use of the April 2014 release of the eCQMs.

CMS noted that an EHR certified for CQMs under the 2014 Edition certification criteria does not need to be recertified each time it is updated to a more recent version of the eCQMs.

Clinical Quality Measure (CQM) Requirements for Meaningful Use in 2017 and Subsequent Years (pg. 516)

Clinical Quality Measure Reporting Requirements for EPs. CMS finalized that it intends to continue its policy of establishing certain CQM requirements that apply for both the Medicare and Medicaid EHR Incentive Programs, including a common set of CQMs and the reporting periods for CQMs. CMS intends to address CQM reporting requirements for the Medicare and Medicaid EHR Incentive Programs for EPs in subsequent Medicare Physician Fee Schedule rulemaking. CMS further intends to continue to allow the states to determine the form and manner of reporting CQMs for their respective state Medicaid EHR Incentive Programs subject to CMS approval.

CQM Reporting Requirements for Eligible Hospitals and Critical Access Hospitals. CMS finalized that it intends to continue its policy of establishing certain CQM requirements that apply for both the Medicare and Medicaid EHR Incentive Programs, including a common set of CQMs and the reporting periods for CQMs. CMS intends to address CQM reporting requirements for the Medicare and Medicaid EHR Incentive Programs for eligible hospitals and CAHs in the Inpatient Prospective Payment System rulemaking. CMS further intends to continue to allow the states to determine form and manner of reporting CQMs for their respective state Medicaid EHR Incentive Programs subject to CMS approval.

Quality Reporting Data Architecture Category III (QRDA-III) Option for Eligible Hospitals and CAHs. CMS finalized in its FY 2016 IPPS/LTCH PPS final rule its proposal to remove the QRDA–III as an option for reporting under the Medicare EHR Incentive Program. CMS stated that for 2016 and future years, CMS will be requiring QRDA-I for CQM electronic submissions for the Medicare EHR Incentive Program. CMS also noted that states would continue to have the option, subject to CMS' prior approval, to allow or require QRDA-III for CQM reporting. For more information, refer to the discussion in the FY 2016 IPPS/LTCH PPS final rule (80 FR 49759 through 49760).

CQM Reporting Period Beginning in 2017 (pg. 523)

CQM Reporting Period for EPs. CMS finalized its proposal to require a CQM reporting period of one full calendar year for EPs participating in the Medicare and Medicaid EHR Incentive Programs starting in 2017. CMS finalized with modification its proposal of a limited exception for EPs demonstrating meaningful use for the first time under the Medicaid EHR Incentive Program. For these EPs, the reporting period for CQMs would be any continuous 90-day period within the CY, with the modification that it could be a different 90-day period than their EHR reporting period for the incentive payment under Medicaid.

CQM Reporting Period for Eligible Hospitals and CAHs. CMS finalized its proposal to require a reporting period of one full calendar year, which consists of 4 quarterly data reporting periods starting in 2017 for eligible hospitals and CAHs participating in the Medicare and Medicaid EHR Incentive Program. CMS finalized with modification its proposal of a limited exception for eligible hospitals and CAHs demonstrating meaningful use for the first time under the Medicaid EHR Incentive Program. For these eligible hospitals and CAHs, the reporting period for CQMs would be any continuous 90-day period within the CY, with the modification that it could be a different 90-day period than their EHR reporting period for the incentive payment under Medicaid. More details of the form and manner will be provided in the IPPS rulemaking cycle.

Reporting Flexibility EPs, Eligible Hospitals, CAHs 2017. CMS finalized its proposal that EPs, eligible hospitals, and CAHs would be able to have more flexibility to report CQMs in one of two ways in 2017 – via electronic reporting or attestation (80 FR 16770). First EPs, eligible hospitals, and CAHs may choose to report eCQMs electronically using the CQMs finalized for use in 2017 using the most recent version of the eCQMs (electronic specifications), which would be the electronic specifications of the CQMs published by CMS in 2016. Alternately, a provider may choose to continue to attest also using the most recent (2016 version) eCQM electronic specifications.

Reporting Methods for CQMs in 2017 (pg. 530)

CMS finalized its policy as proposed, that in 2017 all providers have two options to report CQM data, either through attestation or through use of established methods for electronic reporting where feasible. Starting in 2018, providers participating in the Medicare EHR Incentive Program must electronically report where feasible and that attestation to CQMs would no longer be an option except in certain circumstances where electronic reporting is not feasible. CMS also finalized its proposal that for the Medicaid EHR Incentive Program states would continue to be responsible for determining whether and how electronic reporting of CQMs would occur, or whether they wish to continue to allow reporting through attestation. CMS noted that if a state does require such electronic reporting, the state is responsible for sharing the details of the process with its provider community. CMS also noted that the states would establish the method and requirements, subject to our prior approval, for the electronic capture and reporting of CQMs from CEHRT.

CQM Specification and Changes to the Annual Update (pg. 535)

CMS received many comments in response to its request for comments. However, CMS did not make any specific proposals in regard to the annual update process for CQMs.

Certified EHR Technology Requirements for CQMs (pg. 537)

CMS received many comments in response to its request for comments. However, CMS did not make any specific proposals to implement alternate plans that would require EHRs to be certified to more than the minimum number of CQMs required for reporting, and CMS will not be finalizing any policy regarding a requirement to have EHRs certify to a certain number of CQMs. CMS agreed with the majority of commenters that EHRs should be required to certify to more than the minimum number of CQMs for reporting, but are still determining what that number should be, and will take these comments into consideration as its continues to develop that policy.

Electronic Reporting of CQMs (pg. 540)

CMS did not make any proposals on this subject in the Stage 3 proposed rule, but noted that it did not consider the manual abstraction of data from the EHR to be capturing the data using certified EHR technology (80 FR 16772). An explanation of CMS' goal to transition from manual abstraction of data to electronic reporting for hospital reporting can be found in the Medicare and Medicaid EHR Incentive Programs Stage 2 final rule (77 FR 54078 through 54079).

Demonstration of Meaningful Use and Other Issues (pg. 542)

Demonstration of Meaningful Use (pg. 542)

Common Methods of Demonstration in Medicare and Medicaid and Methods for Demonstration of the Criteria for Meaningful Use in 2015 through 2017. CMS finalized its proposal to maintain attestation as the demonstration method for EHR reporting periods in 2015 through 2017 and the corresponding regulation text at § 495.40.

Attestation Deadlines for the EHR Incentive Programs in 2015 through 2017. CMS finalized its proposal to maintain the attestation deadlines for meaningful use in 2015 and 2016 as proposed. CMS noted that any EP, eligible hospital or CAH that attested to meaningful use for the first time under Medicare or Medicaid for an EHR reporting period in 2015 prior to the effective date of the final rule will not be required to submit a new attestation.

New Participant Attestation Deadlines for Meaningful Use in 2015 and 2016 to Avoid a Payment Adjustment. CMS addressed its proposals and responded to the comments received on this section in the section dedicated to payment adjustments and hardship exceptions, which is later in the rule.

Methods for Demonstration of the Stage 3 Criteria of Meaningful Use for 2017 and Subsequent Years. CMS finalized its proposal to maintain attestation as the method of demonstration of meaningful use for the EHR Incentive Programs for 2017 and subsequent years.

Meaningful Use Objectives and Measures in 2017 and CEHRT Flexibility in 2017. CMS finalized its proposal with modifications to allow providers to attest to the Stage 3 objectives and measures for an EHR reporting period in 2017 instead of the objectives and measures for 2015 through 2017 if they so choose.

Stage and CEHRT Flexibility in 2017. CMS finalized a modification to its proposal to allow providers using EHR technology certified to the 2015 Edition, in whole or in part, the option to attest to Stage 3 objectives and measures if they have the relevant CEHRT modules certified to the 2015 Edition certification criteria necessary to support Stage 3. *CMS further noted that it would not be accepting attestations for an EHR reporting period in 2015 and subsequent years for any objective or measure that have been removed in the final rule*. CMS reiterated that *certification to the 2011 Edition is no longer valid for use in the EHR Incentive Programs and a provider may not attest to a system with that certification in any year after 2014*. Finally, CMS noted that providers using only EHR technology certified to the 2014 Edition may not attest to the Stage 3 objectives and

measures for an EHR reporting period in 2017. CMS reiterated the following options for providers for Stage and CEHRT flexibility for an EHR reporting period in 2017:

- Providers using only EHR technology certified in whole or in relevant part to the 2014 Edition certification criteria may attest to the objectives and measures of meaningful use finalized for 2015-2017.

- Providers using EHR technology certified in relevant parts to the 2014 Edition certification criteria and EHR technology certified in relevant parts to the 2015 Edition certification criteria may elect to:
  - Attest to the objectives and measures for 2015-2017
  - Attest to the Stage 3 objectives and measures if they have the 2015 Edition functionality required to meet the Stage 3 objectives and measures.

- Providers using only EHR technology certified in whole or in relevant parts to the 2015 Edition certification criteria may elect to:
  - Attest to the objectives and measures for 2015-2017.
  - Attest to the Stage 3 objectives and measures.

CQM Flexibility in 2017. CMS finalized as proposed the policy to allow providers the flexibility to electronically report CQMs or to attest to CQMs using either EHR technology certified to the 2014 Edition or EHR technology certified to the 2015 Edition, independently of the Edition they use for their objectives and measures for an EHR reporting period in 2017. For further discussion of this final policy, readers are directed to the section on Clinical Quality Measurement (pg. 510).

Alternate Method of Demonstration for Certain Medicaid Providers Beginning in 2015 (pg. 558)

CMS finalized the proposal for the alternate method of demonstrating meaningful use for certain Medicaid EPs to avoid the Medicare payment adjustment with a modification allowing the alternate attestation for new participants in 2015 as described previously.

Data Collection for Online Posting, Program Coordination, and Accurate Payments (pg. 562)

CMS finalized its proposals. Specifically, CMS will continue posting Stage 1 and Stage 2 aggregate and individual performance and participation data resulting from the EHR Incentive Programs online regularly for public use. CMS will potentially publish the performance and participation data on Stage 3 objectives and measures of meaningful use in alignment with quality programs, which utilize publicly available performance data such as Physician Compare.

In addition to the data already being collected under CMS' regulations, as outlined in the Stage 3 proposed rule, CMS finalized its proposal to collect the following information from providers to ensure providers keep their information up-to-date through the system of record for their NPI in the NPPES:

- Primary Practice Address (address, city, state zip, country code, etc.).
- Primary Business/Billing Address (address, city, state, zip, country code, etc.).
- Primary License information (for example, provide medical license in at least one state (or territory)).
- Contact Information (phone number, fax number, and contact email address).
- Health Information Exchange Information:
  ++ Such as DIRECT address required (if available).
  ++ If DIRECT address is not available, Electronic Service Information is required.
  ++ If DIRECT address is available, Electronic Service Information is optional in addition to DIRECT address.

Hospital-Based Eligible Professionals (pg. 565)

Given significant concerns raised by commenters, CMS did not finalize changes to the definition of hospital-based EP at this time. CMS stated that it would continue to consider this issue in the future as the agency explores program requirements for the MIPS.

Interaction with Other Programs (pg. 570)

CMS proposed no changes to the ability of providers to participate in the Medicare and Medicaid EHR Incentive Programs and other CMS programs. CMS stated it would continue to work on aligning the data collection and reporting of the various CMS programs, especially in the area of clinical quality measurement.

Payment Adjustments and Hardship Exceptions (pg. 571)

EHR Reporting Period for a Payment Adjustment Year (pg. 575)

Changes to the EHR Reporting Period for a Payment Adjustment Year for EPs. CMS finalized the following changes to the EHR reporting period for a payment adjustment year for EPs as proposed, with a modification for 2017.

2015			
	EHR reporting period for a payment adjustment year	**Applies to avoid a payment adjustment in CY 2016**	**Applies to avoid a payment adjustment in CY 2017**
EPs who have not successfully demonstrated meaningful use in a prior year (new participants)	Any continuous 90-day period in CY 2015	Yes, if EP successfully attests by February 29, 2016	Yes, if EP successfully attests by February 29, 2016
EPs who have successfully demonstrated meaningful use in a prior year (returning participants)	Any continuous 90-day period in CY 2015	No	Yes, if EP successfully attests by February 29, 2016
2016			
	EHR reporting period for a payment adjustment year	**Applies to avoid a payment adjustment in CY 2017**	**Applies to avoid a payment adjustment in CY 2018**
EP new participants	Any continuous 90-day period in CY 2016	Yes, if EP successfully attests by October 1, 2016	Yes, if EP successfully attests by February 28, 2017
EP returning participants	CY 2016	No	Yes, if EP successfully attests by February 28, 2017
2017			
	EHR reporting period for a payment adjustment year	**Applies to avoid a payment adjustment in CY 2018**	**Applies to avoid a payment adjustment in CY 2019**
EP new participants	Any continuous 90-day period in CY 2017	Yes, if EP successfully attests by October 1, 2017	N/A
EP returning participants	N/A	N/A	N/A
Medicaid EP returning participants demonstrating Stage 3	Any continuous 90-day period in CY 2017	No	Yes, if EP successfully attests by February 28, 2018

Changes to the EHR Reporting Period for a Payment Adjustment Year for Eligible Hospitals. CMS finalized the following changes to the EHR reporting period for a payment adjustment year for eligible hospitals as proposed, with a modification for 2017.

2015			
	EHR reporting period for a payment adjustment year	**Applies to avoid a payment adjustment in CY 2016**	**Applies to avoid a payment adjustment in CY 2017**
Eligible hospitals that have not successfully demonstrated meaningful use in a prior year (new participants)	Any continuous 90-day period October 1, 2014 through December 31, 2015	Yes, if eligible hospital successfully attests by February 29, 2016	Yes, if eligible hospital successfully attests by February 29, 2016
Eligible Hospital who have successfully demonstrated meaningful use in a prior year (returning participants)	Any continuous 90-day period from October 1, 2014 through December 31, 2015	No	Yes, if EP successfully attests by February 29, 2016
2016			
	EHR reporting period for a payment adjustment year	**Applies to avoid a payment adjustment in CY 2017**	**Applies to avoid a payment adjustment in CY 2018**
Eligible Hospital new participants	Any continuous 90-day period in CY 2016	Yes, if eligible hospital successfully attests by October 1, 2016	Yes, if eligible hospital successfully attests by February 28, 2017
Eligible Hospital returning participants	CY 2016	No	Yes, if eligible hospital successfully attests by February 28, 2017
2017			
	EHR reporting period for a payment adjustment year	**Applies to avoid a payment adjustment in CY 2018**	**Applies to avoid a payment adjustment in CY 2019**
Eligible Hospital new participants	Any continuous 90-day period in CY 2017	Yes, if eligible hospital successfully attests by October 1, 2017	N/A
Eligible Hospital returning participants	N/A	N/A	N/A
Medicaid Eligible Hospital returning participants demonstrating Stage 3	Any continuous 90-day period in CY 2017	No	Yes, if eligible hospital successfully attests by February 28, 2018
2018			
	EHR reporting period for a payment adjustment year	**Applies to avoid a payment adjustment in CY 2019**	**Applies to avoid a payment adjustment in CY 2020**
Eligible Hospital new participants	CY 2018	No	Yes, if eligible hospital successfully attests by February 28, 2019
Eligible Hospital returning participants	The continuous 90-day EHR reporting period for the Medicaid incentive payment in CY 2018	No	Yes, if eligible hospital successfully attests by February 28, 2019
Medicaid Eligible Hospital returning participants demonstrating Stage 3	CY 2018	No	Yes, if eligible hospital successfully attests by February 28, 2019

Hardship Exceptions (pg. 595)

CMS finalized no changes to the types of hardship exceptions already available to EPs, eligible hospitals, and CAHs, nor did CMS finalize any new types of hardship exceptions. CMS finalized one procedural change to the hardship exception application deadline for eligible hospitals to July 1 of the year preceding the payment adjustment year to align the application period with EPs. This change was finalized in light of the change to align hospitals with the calendar year and the changed attestation deadlines.

However, providers who are unable to meet the requirements of meaningful use for an EHR reporting period in 2015 for reasons related to the timing of the publication of the final rule may apply for a hardship exception under the "extreme and uncontrollable" circumstances category. Each hardship exception application will be reviewed on a case-by-case basis, as required by law. As noted earlier, CMS is expected to remind providers about this hardship exemption and its application to these unique circumstances as part of a frequently asked questions (FAQ) document in the coming days.

Administrative Review Process of Certain Electronic Health Record Incentive Program Determinations (pg. 600)

CMS finalized its proposal to maintain its policy as previously adopted. Specifically, in the Stage 2 final rule, CMS discussed an administrative appeals process for both Stages 1 and 2 of meaningful use. CMS continues to believe this appeals process is primarily procedural and does not need to be specified in regulation. CMS developed guidance on the appeals process, which is available on its website at www.cms.gov/EHRIncentivePrograms. CMS proposed no changes to this process and intends to continue to specify the appeals process in guidance available on its website.

Medicare Advantage Organization Incentive Payments (pg. 602)

CMS did not propose any changes to the existing policies and regulations for MA organizations. CMS' existing policies and regulations include provisions concerning the EHR incentive payments to qualifying MA organizations and the payment adjustments for 2015 and subsequent MA payment adjustment years. (For more information on MA organization incentive payments, readers should refer to the final rules for Stages 1 and 2 (75 FR 44468 through 44482 and 77 FR 54113 through 54119).) CMS also confirmed that it would continue to allow MA organizations to report HEDIS measures in lieu of CQMs for purposes of meaningful use for qualifying MA-EPs and MA-affiliated eligible hospitals.

Collection of Information Requirements, Burden Estimates and the Regulatory Impact of the Final Rule can be found beginning on page 619.