Highlights of the Centers for Medicare and Medicaid Services' (CMS) Medicare and Medicaid Electronic Health Record (EHR) Meaningful Use Stage 2 Requirements[1]

The Stage 2 requirements of the meaningful use EHR program build on Stage 1 program requirements. Stage 2 starts in 2014.

Please keep in mind that this summary will be difficult to understand if you have not been through Stage 1 of the meaningful use program. You have to start in Stage 1 before you progress to Stage 2. Stage 2 builds on the Stage 1 requirements. Details on the Stage 1 requirements can be found at: http://www.ama-assn.org/ama/pub/physician-resources/health-information-technology/incentive-programs/medicare-medicaid-incentive-programs.page

Effective Date for Stage 2 of Meaningful Use is 2014: Stage 2 does not start until 2014.

First Payment Year	Stages of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2*	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2*	2	3	3	TBD	TBD	TBD	TBD
2013			1	1*	2	2	3	3	TBD	TBD	TBD
2014				1*	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

***For 2014 only: all eligible professionals (EPs) including physicians regardless of their stage of meaningful use are only required to demonstrate meaningful use for a 3-month EHR reporting period for the meaningful use incentive program.** Medicare eligible physicians have to meet meaningful use requirements within a 3-month quarter EHR reporting period and Medicaid physicians only eligible to receive Medicaid EHR incentives can use any continuous 90-day EHR reporting period (or 3 months at the discretion of their State).

Changes to Stage 1 Requirements: CMS has made several changes to existing Stage 1 meaningful use requirements. Some of these changes are optional while others will be required for use by physicians starting in 2013 or 2014. See the attached chart on Stage 1 and Stage 2 meaningful use measures for details. The changes include:

- Changes to the computerized provider order entry (CPOE)[2] measure;
- Additional exclusion category for the e-prescribing measure;
- Changes to the exclusions and age limitations for the vital signs measure;
- Elimination of the "exchange of key clinical information" core measure and replaced with a "transitions of care" core measure that requires electronic exchange of summary of care documents; and
- Replacing "provide patients with an electronic copy of their health information" measure with a "view online, download and transmit" core measure.

[1] Complete details on Stage 2 of the meaningful use program are located at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

[2] Computerized provider order entry (CPOE) entails the physician's use of computer assistance to directly enter medical orders (e.g., medications, consultations with other providers, laboratory services, imaging studies, etc.) from a computer or mobile device. The order is then documented or captured in a digital, structured, and computable format for use in improving safety and efficiency of the ordering process.

Stage 2 Meaningful Use Requirements (other than clinical quality measure reporting): For Stage 1, physicians must meet 15 core (required) measures and an additional 5 measures of their choice from a menu set of ten measures. For Stage 2, physicians are required to meet 17 core measures and an additional 3 measures of their choice from a menu set of six measures. Nearly all of the Stage 1 core and menu measures are included in Stage 2. There are also multiple Stage 1 measures that are combined under Stage 2, and many percentages have been increased for measures that have been retained from Stage 1 in Stage 2. For example, the Stage 1 CPOE measure, which requires use of CPOE for more than 30 percent of medication orders, has significantly changed for Stage 2. In Stage 2, CMS requires CPOE use for medication, laboratory, and radiology orders, and the Stage 2 percentage requirements are: more than 60 percent for medications, more than 30 percent for laboratory, and more than 30 percent for radiology orders. For details, see the attached chart on all of the Stage 1 and 2 meaningful use measures.

Stage 2 Clinical Quality Measure (CQM) Reporting Requirements: Through 2013, eligible physicians must report on 3 core CQMs. Insofar as the denominator for one or more of the core measures is zero, physicians must report results for up to 3 alternate core measures. If all 6 of the core/alternate core CQMs have zeros for the denominators (this would imply that the physician's patient population is not addressed by these measures) then the eligible physician is still required to report on 3 additional clinical measures. And if three additional measures are not applicable (as evidenced by a zero on the summary report), the physician will need to further demonstrate that no additional measures apply.

Starting in 2014, eligible physicians must report on a total of 9 CQMs from at least 3 of the National Quality Strategy domains out of a potential list of 64 CQMs across 6 domains. Unlike Stage 1 meaningful use, CMS is not requiring the submission of a core set of CQMs, but rather identifies a core set of 9 CQMs focusing on adult populations with a particular focus on controlling blood pressure and is also recommending a core set of 9 CQMs for pediatric populations. Physicians should report on these recommended CQMs if they are representative of their clinical practice and patient population. Alternatively, physicians can satisfy the CQM reporting component of meaningful use if they submit and satisfactorily report CQMs under the Physician Quality Reporting System's (PQRS) EHR Reporting Option. CMS modified the reporting period for CQMs in 2014. Specifically, CMS will allow 3-month quarters (e.g., January-March) as the reporting period in 2014 for eligible physicians who are beyond their first year of demonstrating meaningful use. This is only applicable for year 2014. For 2015 and beyond, CMS will require one year of reporting CQMs. Note that eligible physicians choosing to report CQMs through the PQRS EHR option for Stage 2 would be subject to the reporting periods established under the PQRS program, which is one calendar year (January 1 – December 31). For the Medicare EHR meaningful use incentive program, eligible physicians in their first year of demonstrating meaningful use must submit their CQM data via attestation, and those beyond their first year must submit their CQM data electronically via a CMS-designated transmission method. Starting in 2014, all CQMs must be submitted electronically to CMS (if technically feasible).

Medicare Meaningful Use EHR Penalty Phase: The meaningful use EHR program has a penalty phase that starts on January 1, 2015.

Penalty program for physicians who are meaningful users starting in 2011 or 2012
Physicians who first demonstrated meaningful use in 2011 or 2012 must successfully meet the meaningful use requirements for a full year in 2013 to avoid a penalty in 2015. These physicians must also continue to successfully meet the meaningful use requirements every year (full calendar years) to avoid penalties in subsequent years.

Penalty program for physicians who are meaningful users starting in 2013
Physicians who first demonstrate meaningful use in 2013 must successfully meet the meaningful use requirements for a 90-day reporting period in 2013 to avoid a penalty in 2015. These physicians must also continue to successfully meet the meaningful use requirements every year (full calendar years) to avoid penalties in subsequent years.

Penalty program for physicians who are meaningful users starting in 2014
Physicians who first demonstrate meaningful use in 2014 must successfully meet the meaningful use requirements for a 90-day reporting period in 2014 to avoid penalties in 2015. This reporting period must occur in the first 9

months of calendar year 2014, and physicians must attest to meaningful use no later than October 1, 2014, in order to avoid the 2015 penalty. These physicians must continue to successfully meet the meaningful use requirements every year to avoid penalties in subsequent years.

Hardship Exceptions for Medicare Physicians: CMS has finalized the following penalty exception categories:

- Infrastructure exception: Lack of availability of internet access or barriers to obtaining IT infrastructure (e.g., lack of broadband);
- New practicing physician exception: Newly practicing physicians who would not have had time to become meaningful users can apply for a 2-year limited exception from penalties. These physicians who begin practice in calendar year 2015 would receive an exception to the penalties in 2015 and 2016, but would have to begin successfully meeting the meaningful use requirements in calendar year 2016 to avoid penalties in 2017;
- Unforeseen circumstances exception: Examples may include a natural disaster or other unforeseeable barrier;
- Specialist/Provider type exception: Eligible physicians must demonstrate that they meet all three of the following criteria: (1) lack of face-to-face or telemedicine interaction with patients; (2) lack of follow-up need with patients; and (3) lack of control over the availability of Certified EHR Technology at their practice location (eligible physicians who practice at multiple locations may be granted a hardship exception solely for lack of control over the availability of Certified EHR Technology).

Exceptions are subject to an application process, application deadlines (that pre-date the penalty year), and annual review. CMS will be posting information on its webpage detailing the exception request categories and process and deadlines for applying for an exception from meaningful use penalties at: www.cms.gov/EHRIncentivePrograms.

Exemption for Hospital-Based Medicare Eligible Professionals/Physicians: If a physician performs 90 percent or more of his/her covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital, then the physician is considered hospital-based and is not eligible to receive an EHR meaningful use incentive and will not be subject to meaningful use penalties. However, a physician's hospital-based status can change from year to year. For example, a physician who is determined to be hospital-based for the 2015 program year would not be subject to the penalty in 2017. But if that same physician is determined not to be hospital-based for the 2016 and the 2017 program year, then s/he could be subject to a penalty in 2018 if s/he does not demonstrate meaningful use. For the penalty program, CMS will be reviewing a physician's hospital-based status up to two years prior to the penalty year. Therefore, it is important for physicians to check their hospital-based status at the beginning of each year. Physicians can check their hospital-based status by visiting the Medicare EHR Incentive Programs Registration System at: https://ehrincentives.cms.gov/.

Appeals Process: CMS has established an appeals process which would apply to both Stages 1 and 2 of the meaningful use incentive program. CMS has determined that the administrative review process is primarily procedural and therefore does not need to be specified in regulation. CMS recommends that physicians maintain documentation to support their incentive payment calculations, for example data to support amounts included on their cost report, which are used in the calculation. In addition, physicians should keep documentation for at least six years following the date of attestation. Details on the administrative appeals process will be posted on CMS' website at: www.cms.gov/EHRIncentivePrograms.

Revised Definition for a Medicaid Patient Encounter: In order for physicians to be eligible for Medicaid EHR incentives, physicians have to meet certain eligibility and patient volume requirements. The Stage 2 rule now states that the Medicaid encounter can be counted towards patient volume if the patient is enrolled in the state's Medicaid program (either through the state's fee-for-service programs or the state's Medicaid managed care programs). CMS has also revised the look-back period for calculating Medicaid patient volumes to be more flexible to also cover the 12 months preceding the eligible physician's/EP's attestation, and not tying it to the prior calendar year. For more details, go to: https://questions.cms.gov/faq.php?id=5005&faqId=7535.

Medicare Meaningful Use Incentive and Penalty Chart (2011-2019)

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015+
CY 2011	$18,000				
CY 2012	$12,000	$18,000			
CY 2013	$8,000	$12,000	$15,000		
CY 2014	$4,000	$8,000	$12,000	$12,000	
CY 2015	$2,000	$4,000	$8,000	$8,000	$0 (-1% penalty)
CY 2016	$0	$2,000	$4,000	$4,000	$0 (-2 % penalty)
CY 2017	$0	$0	$0	$0	$0 (-3 % penalty)
CY 2018	$0	$0	$0	$0	$0 (-3 or -4% penalty)
CY 2019+	$0	$0	$0	$0	$0 (-3 to -5% max. penalty capped at -5%)
TOTAL	$44,000	$44,000	$39,000	$24,000	$0

Medicaid Meaningful Use Incentive Chart (2011-2021)

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$21,250					
CY 2012	$8,500	$21,250				
CY 2013	$8,500	$8,500	$21,250			
CY 2014	$8,500	$8,500	$8,500	$21,250		
CY 2015	$8,500	$8,500	$8,500	$8,500	$21,250	
CY 2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
CY 2017		$8,500	$8,500	$8,500	$8,500	$8,500
CY 2018			$8,500	$8,500	$8,500	$8,500
CY 2019				$8,500	$8,500	$8,500
CY 2020					$8,500	$8,500
CY 2021						$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750