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MEMORANDUM

To: PPSV Clients and Friends

From: Powers, Pyles, Sutter & Verville, P.C.

Date: July 21, 2010

Re: Final Rules on HITECH Act Incentive Payments

The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) each issued rulemakings on July 13 to implement the electronic health record (EHR) incentive program established under the HITECH Act. CMS's rule provides details on how hospitals and eligible professionals (EPs) can qualify for the Medicare and Medicaid incentive payments under the "meaningful use" criteria. The ONC rule establishes standards and certification criteria for EHR technology for hospitals and EPs. Both rules will be published in the Federal Register on July 28, 2010.

Generally, the final rule reduces and relaxes the meaningful use criteria that CMS had proposed. However, some industry representatives have stated that the meaningful use measures are still unattainable for many providers.

Links to the final rules are at http://www.cms.gov/EHRIncentivePrograms/ (CMS) and http://healthit.hhs.gov/portal/server.pt?open=512&objID=1195&parentname=CommunityPage&parentid=97&mode=2&in_hi_userid=11673&cached=true (ONC).

I. BACKGROUND ON HITECH ACT

The HITECH Act provides for Medicare and Medicaid incentive payments to certain hospitals and EPs that demonstrate "meaningful use" of "certified EHR technology." (One exception to the "meaningful use" requirement is that hospitals and EPs can receive a Medicaid incentive payment for the first payment year if they adopt, implement or upgrade certified EHR.) Hospitals and EPs that do not demonstrate meaningful use of EHR by 2015 (federal fiscal year for hospitals and calendar year for EPs) are subject to Medicare payment reductions. There are

no Medicaid penalties. Neither the incentives nor the penalties are applicable to hospital-based EPs. Qualifying hospitals may receive both Medicare and Medicaid incentive payments; EPs must choose one program, but may make a one-time switch before 2015.

II. CMS'S FINAL RULE

A. Meaningful Use Criteria

1) Phase-In

CMS had proposed a three-stage phase-in of the meaningful use criteria for both the Medicare and Medicaid programs, which required all hospitals and EPs to meet Stage 3 by 2015. In the final rule, CMS stated that it has decided to address meaningful use criteria for years after 2014 at a later date. CMS will propose complete Stage 2 criteria in a later rulemaking, although it indicated in this final rule some of the Stage 2 criteria that it plans to adopt. The stages will be implemented in accordance with the following schedule, depending on when a hospital or EP becomes a meaningful user.

First Payment Year	Payment Year				
	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	TBD
2012		Stage 1	Stage 1	Stage 2	TBD
2013			Stage 1	Stage 1	TBD
2014				Stage 1	TBD
2015					TBD

2) Stage One Meaningful Use Criteria

CMS has reduced the number of criteria that hospitals and EPs have to meet to demonstrate meaningful use and given them some discretion as to which measures to meet. Hospitals have to meet 14 core measures, most of which are applicable to inpatients and ER patients. EPs have to meet 15 core measures.

Hospitals and EPs also have to select 5 other "menu" measures (from a list of 10 applicable to each). One of the selected measures, however, has to be one of the population and public health measures.

Some of the measures have a related exclusion and if the exclusion applies to a hospital or EP, the hospital or EP does not have to respond to that measure. In addition, the number of measures that a hospital or EP has to comply with is reduced by the number of exclusions that apply to the hospital or EP.

Attached are lists of the measures as follows:

Hospital Core Measures and Exclusions – Attachment 1
EP Core Measures and Exclusions – Attachment 2
Hospital Menu Measures and Exclusions – Attachment 3

EP Menu Measures and Exclusions – Attachment 4

For many of the criteria, CMS also relaxed the thresholds for compliance. As one example, CMS had proposed that EPs use computerized provider order entry (CPOE) for 80% of all orders. (CPOE is defined as the use of computer assistance, but not the transmittal of the order.) The final rule requires that the EP enter at least one medication order using CPOE for 30% or more of all unique patients that are prescribed medications. The same CPOE criteria will apply to hospitals.

Many of the criteria apply only to "unique" patients. CMS clarified that, if a patient is seen by an EP, admitted to the hospital, or seen in the ER more than once during a reporting period, the patient is not unique.

CMS has also limited many of the measures to patients for which an EP or hospital maintains an electronic record. The EHR should be able to calculate these measures automatically.

For the Medicaid incentive, States have the opportunity to change certain meaningful use criteria, but hospitals that meet requirements for both Medicare and Medicaid incentives only have to meet the Medicare meaningful use criteria. The meaningful use criteria that States may change are listed at pp. 47 – 49 of the electronic rule.

3) Clinical Quality Measures

One of the meaningful use criterions is that hospitals and EPs report on clinical quality data. CMS had originally proposed that EPs report on a core set of clinical quality measures and clinical specialty measures. CMS decided not to require reporting of specialty measures, although it stated that it will reintroduce that concept in Stage 2. Instead, EPs must report on six total measures: three core measures (or three alternate measures if the denominator for any of the core measures is 0) and three additional measures selected from a list of 38. The core and alternate clinical quality measures are:

NQF Measure Number & PQRI Implementation Number	EP Core Clinical Quality Measure
NQF 0013	**Title:** Hypertension: Blood Pressure Measurement
NQF 0028	**Title:** Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment b. Tobacco Cessation Intervention
NQF 0421 PQRI 128	**Title:** Adult Weight Screening and Follow-up
	EP Alternate Core Clinical Quality Measures
NQF 0024	**Title:** Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 110	**Title:** Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
NQF 0038	**Title:** Childhood Immunization Status

The 38 measures from which an EP must select 3 are listed in Table 6 (pp. 272 – 282 of the electronic rule).

CMS also reduced the number of clinical quality measures for hospitals to 15. These measures are listed in Table 10 (pp. 303-305 of the electronic rule).

CMS limited the clinical quality measures to certain measures endorsed by NQF with current electronic specifications. Although the measures can be automatically obtained from EHR, hospitals and EPs will report the measures through attestation in federal fiscal year 2011. The electronic specifications are on display at http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage.

CMS stated that if any clinical quality measure is not applicable to a hospital or EP, the hospital or EP should report a value of 0 in the denominator. CMS also noted that hospitals and EPs are required to report the clinical quality data under the meaningful use criteria, not meet particular quality standards.

Hospitals and EPs must report on clinical quality measures for all patients, regardless of payer.

B. Demonstrating Meaningful Use

For 2011, hospitals and EPs report meaningful use through an attestation for both Medicare and Medicaid, which includes an attestation regarding clinical quality measures. The reporting period is any continuous 90-day period during the first payment year and the entire year for subsequent years. Hospitals and EPs that are eligible for the Medicaid incentive because they adopt, implement or upgrade EHR in the first year do not have a first year reporting period, and will have a 90-day period in the second year (their first meaningful use year).

CMS will identify which hospitals meet the meaningful use criteria by their CMS certification numbers and which EPs meet the criteria by their NPIs. EPs have to designate the TIN (which may be the EP's social security number), to which the incentive payments should be made. EPs may reassign their payment, consistent with Medicare rules on reassignment, but the reassignment must be for the entire incentive payment and may be made to only one entity.

For EPs that practice at more than one location, the meaningful use measures apply only to those locations equipped with certified EHR technology. In addition, an EP must have 50% or more of his or her patient encounters at one or more of these locations to be a meaningful user.

CMS plans to conduct selected compliance reviews to validate eligibility for the incentive payments. Hospitals and EPs must maintain documentation supporting their demonstration of meaningful use for 6 years.

CMS will post online the names of EPs and hospitals who are meaningful users.

C. Eligible Hospitals and Professionals

As stated above, hospitals that meet the Medicare and Medicaid criteria may participate in both programs. EPs must pick one program, but can make a one-time switch before 2015. Total payments to an EP who switches will not be more than the total incentive available under Medicaid.

1) Medicare

Medicare incentives are available to acute care PPS hospitals, including Maryland hospitals (but not Puerto Rico hospitals) and critical access hospitals (CAHs). Medicare incentives are also available to the following professionals, unless they are hospital-based: MDs and DOs, dentists, podiatrists, optometrists and chiropractors.

2) Medicaid

Medicaid incentives are available to acute care PPS hospitals and CAHs, as well as the 11 U.S. cancer hospitals, provided the hospitals meet certain Medicaid patient volume requirements (discussed below). Children's hospitals are also eligible for Medicaid incentive payments, but do not have to meet Medicaid patient volume requirements.

Medicaid incentives are available to the following professionals that meet certain patient volume requirements, unless they are hospital-based: physicians, dentists, certified nurse-mid-wives, nurse practitioners and physician assistants (PAs) practicing in an FQHC or RHC led by a PA. [1] In States whose State Plan includes optometrist's services as physician services, optometrists are also eligible.

3) Patient Volume Requirements for Medicaid Incentive

Most hospitals and EPs must meet patient volume requirements to qualify for a Medicaid incentive. The Medicaid patient volume requirements are:

Acute care hospitals, including CAHs – 10%
EPs – 30%
Pediatricians – 20% (but allowed only 2/3 of incentive payment) [2]
EPs practicing in a FQHC or RHC – 30% "needy patients"[3]
Children's Hospitals – Not Applicable

CMS is giving States three options to determine Medicaid and needy individual patient volume and stated that it expects that the determination will be based on estimates. States may review data on: 1) patient encounters in any representative, continuous 90-day period in the preceding fiscal year; 2) for EPs, patients assigned to the EP's panel (by a Medicaid managed plan or medical home, for example) with at least one encounter with the patient during the prior

[1] Medicare and Medicaid incentive payments are also available to Medicare Advantage organizations on behalf of affiliated hospitals and physicians. This memo focuses on the hospitals and EPs listed in the text above.
[2] A pediatrician who has a 30% Medicaid patient volume receives the full payment.
[3] A needy patient is a Medicaid, CHIP, uncompensated care or sliding scale payment patient.

year plus the EP's unduplicated Medicaid encounters for the same period; or 3) a methodology proposed by the Medicaid State agency and approved by CMS, provided it does not result in fewer providers meeting the patient volume requirements under 1) or 2). CMS is also giving States the option whether to count out-of-state Medicaid patients in any of these tests.

For a hospital, a Medicaid encounter is defined as an inpatient discharge, or emergency room visit for which Medicaid (including § 1115) paid for all or part of the patients services or coinsurance. For an EP, a Medicaid encounter is defined as services provided to an individual on any one day for which Medicaid (including § 1115) paid for all or part of the services or coinsurance. A needy individual encounter is defined similarly, but with respect to Medicaid, SCHIP and uncompensated care or sliding scale patients. Group practices may calculate patient volume at the group level, provided all of the EPs use the same method for the payment year, auditable data is available to verify the volume determination, and related requirements are met.

4) Hospital-based Professionals

Hospital-based professionals are not eligible for Medicare or Medicaid incentive payments.[4] The HITECH Act originally defined a hospital-based professional as one who furnishes "substantially all" of his or her professional services in a hospital inpatient or outpatient setting. The Continuing Extension Act of 2010 (Pub. L. 111-157), however, amended the definition of hospital-based professional to state that only inpatient and emergency room services (not outpatient) are hospital-based services for purposes of this definition. Therefore, the final rule states that an EP is considered to be hospital-based, and therefore ineligible to receive a Medicare or Medicaid EHR incentive payment, if 90 percent or more of the EP's covered Medicare (or Medicaid) services are provided in place of service (POS) codes 21 (inpatient) and/or 23 (emergency room). The determination is based on the number of the EP's services, not on the amount of the EP's charges. The hospital-based determination is not affected by whether the EP is an employee of the hospital, is under a contractual relationship with the hospital, or has made a reassignment to the hospital for billing.

For purposes of the Medicare incentive payment, CMS will make the hospital-based determination for each payment year based on claims from the prior federal fiscal year. CMS stated that it plans to make the determination early in the calendar year. For purposes of the Medicaid incentive payment, State Medicaid agencies may make the determination based on either the prior calendar year or federal fiscal year.

D. Medicare Payments

1) Acute Care Hospitals

Hospitals are eligible for Medicare incentive payments beginning October 1, 2010. The HITECH Act provides that the Medicare incentive payment to hospitals is: ($2,000,000 +

[4] The only exception is that hospital-based professionals that practice in a FQHC or RHC are eligible for a Medicaid incentive payment.

Discharge Amount)(Medicare Share)(Transition Percentage). CMS's rule defines some terms used in that formula and specifies how it will collect the required data.

The "discharge amount" is $200 per discharge (any payer) beginning with the 1,150th discharge through the 23,000th discharge. CMS will count discharges from the acute care area of the hospital only, except nursery. The Medicare share is a fraction defined as:

$$\frac{\text{Inpatient Medicare Part A + Part C Days}}{\text{Total Inpatient Days}\left[\dfrac{\text{Total Charges Less Charity}}{\text{Total Charges}}\right]}$$

The transition percentage is 100% for the first payment year, decreasing by 25% in each subsequent year, except that hospitals that begin in 2014 receive a first year transition percentage of 75%, decreasing by 25% in each subsequent year, and hospitals that begin in 2015 receive a first year transition percentage of 50%, decreasing by 25% in each subsequent year.

Data for discharges, Medicare inpatient days and charity care charges will be taken from the hospital's cost report. CMS is including a new Worksheet E-1, Part II, "Calculation of Reimbursement for Settlement for HIT" in the revised cost report form (2552-10). CMS will make preliminary incentive payments to hospitals based on their most recently submitted cost report after the hospital qualifies as a meaningful user. Final payments will be based on the settled cost report for the period that begins after the start of the payment year and will be paid at the time of settlement.

If a hospital meets the meaningful use criteria in one year, but does not meet the criteria in the subsequent year, the hospital is still eligible for a payment in the third year (provided it meets the applicable criteria), but it is not able to regain the second year payment and its overall payments will therefore be reduced.

2) CAHs

The Medicare incentive payment to CAHs is the reasonable costs of the EHR multiplied by the Medicare share, as computed for acute-care hospitals, plus 20%. The Medicare share for CAHs cannot be more than 100%.

3) EPs

EPs are eligible for Medicare incentive payments beginning January 1, 2011. The HITECH Act provides that Medicare incentive payments to EPs are 75% of Medicare allowed charges, subject to caps. The cap is $44,000 for EPs who demonstrate meaningful use in 2011 or 2012, and decreases thereafter as shown in the following chart:

	2011	2012	2013	2014	2015	2016	Total
Start in 2011	18,000	12,000	8,000	4,000	2,000	0	44,000
Start in 2012		18,000	12,000	8,000	4,000	2,000	44,000
Start in 2013			18,000	12,000	8,000	4,000	39,000
Start in 2014				12,000	8,000	4,000	24,000
Start in 2015					0	0	0

An EP who provides more than 50% of his or her Medicare services in a designated health professional shortage area (HPSA) in the year prior to the payment year receives a 10% add-on.

The amount of an EP's allowed charges is based on claims submitted no later than two months after the end of the payment year. If an EP meets the meaningful use criteria in one year, but does not meet the criteria in the subsequent year, the EP is still eligible for a payment in the third year (provided the EP meets the applicable criteria), but the EP is not able to regain the second year payment and the EP's overall payments will therefore be reduced. CMS proposes to make a single, annual Medicare incentive payment to EPs as soon as the EP demonstrates meaningful use and reaches the threshold for maximum payment.

E. Medicaid Payments

Hospitals and EPs will receive Medicaid payments if they "adopt, implement, or upgrade" certified EHR in the first year and demonstrate meaningful use in subsequent years, or are meaningful users in the first and subsequent years. Hospitals and EPs may receive a Medicaid incentive from one State only per year, but may make an annual switch.

The definition of "adopt, implement, or upgrade" is:

(1) Acquire, purchase, or secure access to certified EHR technology;
(2) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or
(3) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

The preamble makes clear that providers and EPs are eligible for the Medicaid incentive if they only purchase certified EHR in the first year.

The Medicaid incentive payment to hospitals, including CAHs, is generally calculated using the same formula as the Medicare incentive payment, except that Medicaid paid (not

eligible) inpatient days, not including dual eligibles, are substituted for Medicare inpatient days. Also, for the Medicaid calculation, the Medicaid share is calculated in the base year and applied to all subsequent years. Medicaid payments may begin as late as 2016 and continue through 2021. Unlike Medicare payments, the hospital can skip a payment year and still be eligible for the full Medicaid payment until 2016. Starting in federal fiscal year 2016, incentive payments must be made in every year to continue participation in the program.

The payments schedule for Medicaid EPs is:

	Medicaid Incentive Payments for EPs who begin adoption in					
Calendar Year	2011	2012	2013	2014	2015	2016
2011	$21,250	----------	----------	----------	---------	---------
2012	$8,500	$21,250	----------	----------	----------	----------
2013	$8,500	$8,500	$21,250	----------	----------	----------
2014	$8,500	$8,500	$8,500	$21,250	----------	----------
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	----------	$8,500	$8,500	$8,500	$8,500	$8,500
2018	----------	----------	$8,500	$8,500	$8,500	$8,500
2019	----------	----------	----------	$8,500	$8,500	$8,500
2020	----------	----------	----------	----------	$8,500	$8,500
2021	----------	----------	----------	----------	----------	$8,500
TOTAL	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

If the EP has already adopted EHR and is a meaningful user, he or she is eligible for the same incentive payments. Medicaid EPs may skip a payment year and still be eligible for the full Medicaid incentive of $63,750.

EPs may only participate in either the Medicare or Medicaid incentive program and may make a one-time switch between programs before 2015.

F. Payment Reductions

Hospitals and EPs that are not meaningful users will be subject to Medicare payment reductions beginning in 2015 (federal fiscal year for hospitals and calendar year for EPs), unless they qualify for a hardship exception. There are no Medicaid penalties. The penalty for acute-care hospitals is a reduction to the annual Medicare update of 33 1/3% in 2015, 66 2/3% in 2016 and no update beginning in 2017. The penalty for EPs is a reduction to the fee schedule amount of 1% in 2015, 2% in 2016 and 3% in 2017 and later years. HHS may make an adjustment of up to 5% if the percentage of EP meaningful users is less than 75%. For CAHs, the penalty is a reduction of their cost-based reimbursement percentage to 100.66% in 2015, 100.33% in 2016 and 100% in 2017 and thereafter.

III. ONC's FINAL RULE

As stated above, the HITECH Act requires the meaningful use of "certified" EHR technology. ONC's final rule complements the CMS final rule by establishing the required capabilities and related standards and implementation specifications that EHR has to include to support the achievement of Stage 1 meaningful use and be certified by an ONC certifying body. EHR that is designed and certified in accordance with the final rule may be adopted by eligible health care providers who seek to achieve Stage 1 meaningful use.

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For additional information, please contact Barbara Straub Williams at (202) 466-6550 or barbara.williams@ppsv.com.

Attachment 1 - Hospital Core Criteria

	Objective	Measure	Exclusion
1	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per State, local, and professional guidelines.	More than 30 percent of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE. Measure may be calculated only for patients whose records are maintained electronically.	N/A
2	Implement drug-drug and drug-allergy interaction checks.	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.	N/A
3	Maintain an up-to-date problem list of current and active diagnoses.	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A
4	Maintain active medication list.	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A
5	Maintain active medication allergy list.	More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A

Attachment 1 - Hospital Core Criteria

	Objective	Measure	Exclusion
6	Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth (F) Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	More than 50 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A
7	Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI	For more than 50 percent of all unique patients age 2 and over admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight, and blood pressure are recorded as structured data. Measure may be calculated only for patients whose records are maintained electronically.	N/A
8	Record smoking for patients 13 years old or older.	More than 50 percent of all unique patients 13 years old or older or admitted to the eligible hospital's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data. Measure may be calculated only for patients whose records are maintained electronically.	Any eligible hospital or CAH that admits no patients 13 years or older to their inpatient or emergency department (POS 21 or 23).
9	Report hospital clinical quality measures to CMS or, in the case of Medicaid eligible hospitals, the States.	Successfully report to CMS (or, in the case of Medicaid eligible hospitals or CAHs, the States) hospital clinical quality measures selected by CMS in the manner specified by CMS (or, in the case of Medicaid eligible hospitals or CAHs, the States). Measure may be calculated only for patients whose records are maintained electronically.	N/A

Attachment 1 - Hospital Core Criteria

	Objective	Measure	Exclusion
10	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule.	Implement one clinical decision support rule.	N/A
11	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request.	More than 50 percent of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days. Measure may be calculated only for patients whose records are maintained	Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
12	Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.	More than 50 percent of all patients who are discharged from an eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it. Measure may be calculated only for patients whose records are maintained electronically.	Any eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of the discharge instructions during the EHR reporting period.
13	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	N/A
14	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	N/A

Attachment 2 - EP Core Criteria

	Objective	Measure	Exclusion
1	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. Measure may be calculated only for patients whose records are maintained electronically.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
2	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.	N/A
3	Maintain an up-to-date problem list of current and active diagnoses.	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A
4	Generate and transmit permissible prescriptions electronically (eRx).	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology. Measure may be calculated only for patients whose records are maintained electronically.	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
5	Maintain active medication list.	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A
6	Maintain active medication allergy list.	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A

Attachment 2 - EP Core Criteria

	Objective	Measure	Exclusion
7	Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth	More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A
8	Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI	More than 50 percent of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structured data. Measure may be calculated only for patients whose records are maintained electronically.	Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.
9	Record smoking status for patients 13 years old or older.	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data. Measure may be calculated only for patients whose records are maintained electronically.	Any EP who sees no patients 13 years or older.
10	Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States.	Successfully report to CMS (or, in the case of Medicaid EPs, the States) ambulatory clinical quality measures selected by CMS in the manner specified by CMS (or in the case of Medicaid EPs, the States). Measure may be calculated only for patients whose records are maintained electronically.	N/A
11	Implement one clinical decision support rules relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	Implement one clinical decision support rule.	N/A

Attachment 2 - EP Core Criteria

	Objective	Measure	Exclusion
12	Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days. Measure may be calculated only for patients whose records are maintained electronically.	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
13	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days. Measure may be calculated only for patients whose records are maintained	Any EP who has no office visits during the EHR reporting period.
14	Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	N/A
15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	N/A

Attachment 3 - Hospital Menu Criteria

Hospital must choose 5 (unless exclusion applies) and at least one must be 8, 9 or 10

	Objective	Measure	Exclusion
1	Implement drug-formulary checks.	The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	N/A
2	Record advance directives for patient 65 years old or older.	More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient (POS 21) have an indication of an advance directive status recorded as structured data. Measure may be calculated only for patients whose records are maintained electronically.	An eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period.
3	Incorporate clinical lab-test results into EHR as structured data.	More than 40 percent of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. Measure may be calculated only for patients whose records are maintained electronically.	N/A
4	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition. Measure may be calculated only for patients whose records are maintained electronically.	N/A

Attachment 3 - Hospital Menu Criteria

Hospital must choose 5 (unless exclusion applies) and at least one must be 8, 9 or 10

	Objective	Measure	Exclusion
5	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient specific education resources. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A
6	The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23). Measure may be calculated only for patients whose records are maintained electronically.	N/A
7	The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. Measure may be calculated only for patients whose records are maintained electronically.	N/A
8	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).	An eligible hospital or CAH that administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

Attachment 3 - Hospital Menu Criteria

Hospital must choose 5 (unless exclusion applies) and at least one must be 8, 9 or 10

	Objective	Measure	Exclusion
9	Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology’s capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information has the capacity to receive the information electronically).	No public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically.
10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits information has the capacity to receive the information electronically).	No public health agency to which the eligible hospital or CAH submits information has the capacity to receive the information electronically.

Attachment 4 - EP Menu Criteria

EP must choose 5 (unless exclusion applies) and at least one must be 9 or 10

	Objective	Measure	Exclusion
1	Implement drug-formulary checks.	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	N/A
2	Incorporate clinical lab-test results into EHR as structured data.	More than 40 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. Measure may be calculated only for patients whose records are maintained electronically.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
3	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition. Measure may be calculated only for patients whose records are maintained electronically.	N/A
4	Send reminders to patients per patient preference for preventive/followup care.	More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. Measure may be calculated only for patients whose records are maintained electronically.	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.
5	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.	At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	Any EP that neither orders nor creates any of the information listed at 45 CFR 170.304(g) during the EHR reporting period.

Attachment 4 - EP Menu Criteria

EP must choose 5 (unless exclusion applies) and at least one must be 9 or 10

	Objective	Measure	Exclusion
6	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources. Measure must be calculated for all patients whether or not the patient's record is maintained electronically.	N/A
7	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP. Measure may be calculated only for patients whose records are maintained electronically.	An EP who was not the recipient of any transitions of care during the EHR reporting period.
8	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. Measure may be calculated only for patients whose records are maintained electronically.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.
9	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.
10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.