Medicare & Medicaid EHR Incentive Programs

Stage 2 Final Rule
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HIT Standards Committee
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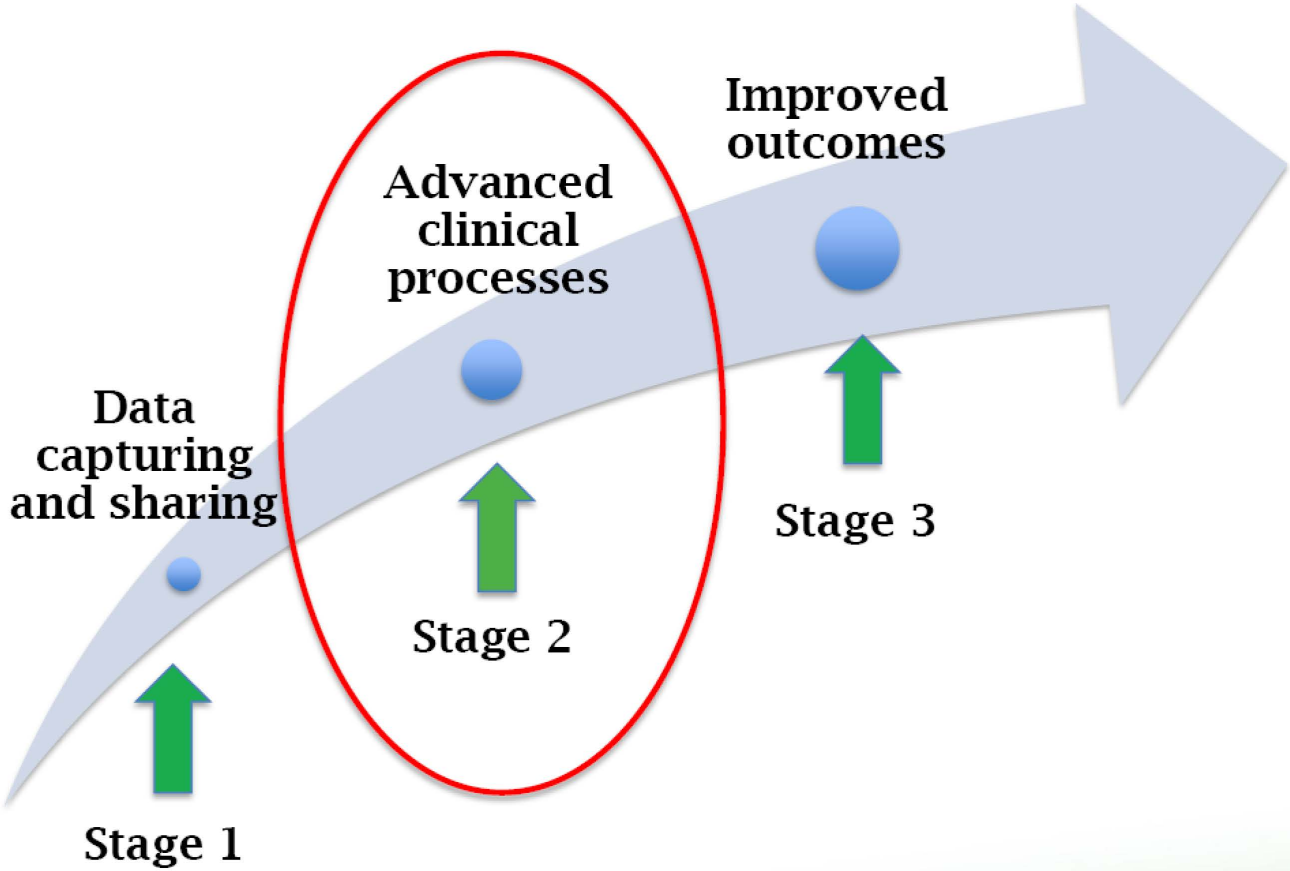
What is in the Rule

- Changes to Stage 1 of meaningful use
- Stage 2 of meaningful use
- New clinical quality measures
- New clinical quality measure reporting mechanisms
- Payment adjustments and hardships
- Medicare Advantage program changes
- Medicaid program changes

Stages of Meaningful Use



AUTHOR'S NOTES:This is the structure to get us where we want to be. It is divided into three stages. The first stage involves collecting health information in a structured way and takes the first steps towards using that data. Structured data is crucial to meaningful use of EHRs. What we mean by structured data is that the system recognizes the data for what it is and knows how that data interacts with other data available in the system. For instance, Microsoft Word knows that aspirin is a seven letter word and even how it should be spelled, but it does not know that it is a drug and one that should be given to patients showing signs of a heart attack or not given to one that is also taking an anticoagulant. This is what we mean by structured data. The second stage involves designing and implementing processes that will use the data collected in a way that we believe will generate improved outcomes. The third stage involves finding out if we were right and determining the effects of meaningful use on outcomes.

What is Your Meaningful Use Path?

For Medicare EPs:

(**Author's Notes:** You start Stage 2 in 2014 or your third year of meaningful use whichever is latter. Please note that not only does giving providers in 2011 a third year of Stage 1 enable the time for Stage 2, but by putting those providers in Stage 2 for two years the breathing room for implementing Stage 3 is also created based on the currently anticipated regulation timeline. Medicaid providers can always do a year of AIU preceding their 2 years of Stages 1, 2 and 3.)

First Year of Participation	Stages of Meaningful Use for Eligible Hospitals (Fiscal Year)					
	2011	**2012**	**2013**	**2014**	**2015**	**2016**
2011	1	1	1	2	2	3
$44,000	$18,000	$12,000	$8,000	$4,000	$2,000	
2012		1	1	2	2	3
$44,000		$18,000	$12,000	$8,000	$4,000	$2,000
2013			1	1	2	2
$39,000			$15,000	$12,000	$8,000	$4,000
2014				1	1	2
$24,000				$12,000	$8,000	$4,000

What is Your Meaningful Use Path?

For Medicare Hospitals:

First Year of Participation	Stages of Meaningful Use for Eligible Hospitals (Fiscal Year)					
	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
2012		1	1	2	2	3
2013			1	1	2	2
2014				1	1	2

*Payments will decrease for hospitals that start receiving payments in 2014 and later

What is Your Meaningful Use Path?

For Medicaid EPs:

Annual Incentive Payment by Stage of Meaningful Use					
YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6
(AIU)	1	1	2	2	3
$21,250	$8,500	$8,500	$8,500	$8,500	$8,500

Maximum incentive amount is $63,750. Payments are made over 6 years and do not have to be consecutive.

*2016 is the last year that Medicaid EPs can begin participation in the program.

Meaningful Use: Changes from Stage 1 to Stage 2

Stage 1	Stage 2
Eligible Professionals 15 core objectives 5 of 10 menu objectives 20 total objectives	**Eligible Professionals** **17** core objectives **3 of 6** menu objectives 20 total objectives
Eligible Hospitals & CAHs 14 core objectives 5 of 10 menu objectives 19 total objectives	**Eligible Hospitals & CAHs** **16** core objectives **3 of 6** menu objectives 19 total objectives

Changes to Meaningful Use

Changes

- **Menu Objective Exclusion**– While you can continue to claim exclusions if applicable for menu objectives, starting in 2014 these exclusions will no longer count towards the number of menu objectives needed.

AUTHOR'S NOTE: This change was made to prevent EPs from selecting and excluding menu objectives when there are other menu objectives they can legitimately meet, thereby making it easier for them to demonstrate meaningful use than EPs who attempt to legitimately meet the full complement of menu objectives. If an EP does meet the exclusion criteria for four or more objectives in the menu set then they would attest to meeting the exclusions for one or more in attestation and would be attesting that they meet the exclusions for the objective not selected as well.

No Changes

- **Half of Outpatient Encounters**– at least 50% of EP outpatient encounters must occur at locations equipped with certified EHR technology.
- **Measure compliance = objective compliance**
- **Denominators based on outpatient locations equipped with CEHRT** and include all such encounters or only those for patients whose records are in CEHRT depending on the measure.

AUTHOR'S NOTE: By the time an EP, eligible hospital, or CAH has reached Stage 2 of meaningful use all or nearly all of their patient population should be included in their Certified EHR Technology, making the distinction between patients whose records are kept in CEHRT and those that are not no longer relevant.

2014 Changes

1. **EHRs Meeting ONC 2014 Standards** – starting in 2014, all EHR Incentive Programs participants will have to adopt certified EHR technology that meets ONC's Standards & Certification Criteria 2014 Final Rule

2. **Reporting Period Reduced to Three Months** – to allow providers time to adopt 2014 certified EHR technology and prepare for Stage 2, all participants will have a three-month reporting period in 2014.

Stage 2: Batch Reporting

Stage 2 rule allows for batch reporting.

What does that mean?

Starting in 2014, **groups** will be allowed to submit attestation information for **all of their individual EPs** in one file for upload to the Attestation System, rather than having each EP individually enter data.

AUTHOR'S NOTE: CMS did not include a group performance option for meaningful use in the Stage 2 final rule, but will plan to signal our intention to implement such an option in future rulemaking once we are able to address operational and system issues.

Stage 2 EP Core Objectives 1 of 2

EPs must meet all 17 core objectives:

Core Objective	Measure
1. CPOE	Use CPOE for more than **60%** of medication, **30%** of laboratory, and **30%** of radiology
2. E-Rx	E-Rx for more than **50%**
3. Demographics	Record demographics for **more than 80%**
4. Vital Signs	Record vital signs for **more than 80%**
5. Smoking Status	Record smoking status for **more than 80%**
6. Interventions	Implement **5** clinical decision support interventions + drug/drug and drug/allergy
7. Labs	Incorporate lab results for **more than 55%**
8. Patient List	Generate patient list **by specific condition**
9. Preventive Reminders	Use EHR to identify and provide reminders for preventive/follow-up care for **more than 10%** of patients with two or more office visits in the last 2 years

Stage 2 EP Core Objectives 2 of 2

EPs must meet all 17 core objectives:

Core Objective	Measure
10. Patient Access	Provide online access to health information for **more than 50%** with **more than 5%** actually accessing
11. Visit Summaries	Provide office visit summaries for **more than 50%** of office visits
12. Education Resources	Use EHR to identify and provide education resources **more than 10%**
13. Secure Messages	**More than 5%** of patients send secure messages to their EP
14. Rx Reconciliation	Medication reconciliation at **more than 50%** of transitions of care
15. Summary of Care	Provide summary of care document for **more than 50%** of transitions of care and referrals **with 10% sent electronically** and **at least one sent to a recipient with a different EHR vendor or successfully testing with CMS test EHR**
16. Immunizations	Successful ongoing transmission of immunization data
17. Security Analysis	Conduct or review security analysis and incorporate in risk management process

Stage 2 EP Menu Objectives

EPs must select 3 out of the 6:

Menu Objective	Measure
1. Imaging Results	More than **10%** of imaging results are accessible through Certified EHR Technology
2. Family History	Record family health history for more than **20%**
3. Syndromic Surveillance	Successful ongoing transmission of syndromic surveillance data
4. Cancer	Successful ongoing transmission of cancer case information
5. Specialized Registry	Successful ongoing transmission of data to a specialized registry
6. Progress Notes	Enter an electronic progress note for **more than 30%** of unique patients

AUTHOR'S NOTE: With the exception of syndromic surveillance data these are all new objectives for Stage 2. An EP must select 3 out of the 6.

Stage 2 Hospital Core Objectives

Eligible hospitals must meet all 16 core objectives:

Core Objective	Measure
1. CPOE	Use CPOE for **more than 60%** of medication, **30%** of laboratory, and **30%** of radiology
2. Demographics	Record demographics for **more than 80%**
3. Vital Signs	Record vital signs for **more than 80%**
4. Smoking Status	Record smoking status for **more than 80%**
5. Interventions	Implement **5** clinical decision support interventions + drug/drug and drug/allergy
6. Labs	Incorporate lab results for **more than 55%**
7. Patient List	Generate patient list by specific condition
8. eMAR	eMAR is implemented and used for more than **10%** of medication orders

Stage 2 Hospital Core Objectives

Eligible hospitals must meet all 16 core objectives:

Core Objective	Measure
9. Patient Access	Provide online access to health information for more than **50%** with more than **5%** actually accessing
10. Education Resources	Use EHR to identify and provide education resources more than **10%**
11. Rx Reconciliation	Medication reconciliation at more than **50%** of transitions of care
12. Summary of Care	Provide summary of care document for **more than 50%** of transitions of care and referrals **with 10% sent electronically** and **at least one sent to a recipient with a different EHR vendor or successfully testing with CMS test EHR**
13. Immunizations	Successful ongoing transmission of immunization data
14. Labs	Successful ongoing submission of reportable laboratory results
15. Syndromic Surveillance	Successful ongoing submission of electronic syndromic surveillance data
16. Security Analysis	Conduct or review security analysis and incorporate in risk management process

Stage 2 Hospital Menu Objectives

Eligible Hospitals must select 3 out of the 6:

Menu Objective	Measure
1. Progress Notes	Enter an electronic progress note for **more than 30%** of unique patients
2. E-Rx	**More than 10%** electronic prescribing (eRx) of discharge medication orders
3. Imaging Results	**More than 10%** of imaging results are accessible through Certified EHR Technology
4. Family History	Record family health history for **more than 20%**
5. Advanced Directives	Record advanced directives for **more than 50%** of patients 65 years or older
6. Labs	Provide structured electronic lab results to EPs for **more than 20%**

AUTHOR'S NOTE: With the exception of syndromic surveillance data these are all new objectives for Stage 2. An EP must select 3 out of the 6.

Closer Look at Stage 2: Patient Engagement

- **Patient engagement** – engagement is an important focus of Stage 2.

Requirements for Patient Action:

- **More than 5% of patients must send secure messages to their EP**
- **More than 5% of patients must access their health information online**

- **EXCLUSIONS** – CMS is introducing exclusions based on broadband availability in the provider's county.

AUTHOR'S NOTES: More than 5% of patients must access their health information online (of the more than 50% of patients who received access).

Requirements for Patient Action:

- More than **5%** of patients must send secure messages to their EP
- More than 5% of patients must access their health information online

Closer Look at Stage 2: Electronic Exchange

Stage 2 focuses on actual use cases of electronic information exchange:

- **Stage 2 requires that a provider send a summary of care record for more than 50% of transitions of care and referrals.**
- **The rule also requires that a provider electronically transmit a summary of care for more than 10% of transitions of care and referrals.**
- **At least one summary of care document sent electronically to recipient with different EHR vendor or to CMS test EHR.**

AUTHOR'S NOTES: Credit given when the receiving providers successfully "pulls" info down from HIE. This is in addition to the "push" methods of electronic HIE that were proposed.

- Stage 2 requires that a provider send a summary of care record for more than **50%** of transitions of care and referrals.
- The rule also requires that a provider electronically transmit a summary of care for more than **10%** of transitions of care and referrals.

Clinical Quality Measures

CQM Reporting in 2013

- CQM reporting will **remain the same** through 2013.
  - 44 EP CQMs
    - 3 core or alternate core (if reporting zeroes in the core) plus 3 additional CQMs
    - Report minimum of 6 CQMs (up to 9 CQMs if any core CQMs were zeroes)
  - 15 Eligible Hospital and CAH CQMs
    - Report all 15 CQMs
- In 2012 and continued in 2013, there are **two reporting methods** available for reporting the Stage 1 measures:
  - Attestation
  - eReporting pilots
    - Physician Quality Reporting System EHR Incentive Program Pilot for EPs
    - eReporting Pilot for eligible hospitals and CAHs
- Medicaid providers submit CQMs according to their **state-based submission requirements**.

CQM Specifications in 2013

- Electronic specifications for the CQMs for reporting in 2013 **will not be updated**.
- Flexibility in implementing CEHRT certified to the 2014 Edition certification criteria in 2013
  - Providers could report via attestation CQMs finalized in both Stage 1 and Stage 2 final rules
  - For EPs, this includes 32of the 44 CQMs finalized in the Stage 1 final rule
    - Excludes: NQF 0013, NQF 0027, NQF 0084
    - Since NQF 0013 is a core CQM in the Stage 1 final rule, an alternate core CQM must be reported instead since it will not be certified based on 2014 Edition certification criteria.
  - For Eligible Hospitals and CAHs, this includes all 15 of the CQMs finalized in the Stage 1 final rule

CQM Selection and HHS Priorities

All providers must select CQMs from **at least 3 of the 6** HHS National Quality Strategy domains:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resource
- Clinical Processes/Effectiveness

AUTHOR'S NOTES:

- Such as measures in which performance rates are currently low or for which there is wide variability in performance, or that address known drivers of high morbidity and/or cost for Medicare and Medicaid.
- For example, Medicare- and Medicaid-eligible physicians, and Medicaid-eligible nurse-practitioners, certified nurse-midwives, dentists, physician assistants)
- Based on the March 2011 report to Congress, "National Strategy for Quality Improvement in Health Care" (National Quality Strategy) (http://www.healthcare.gov/law/resources/reports/nationalqualitystrategy032011.pdf) and the Health Information Technology Policy Committee's (HITPC's) recommendations (http://healthit.hhs.gov/portal/server.pt?open=512&objID=1815&parentname=CommunityPage&parentid=7&mode=2&in_hi_userid=11113&cached=true).

Changes to CQMs Reporting

Prior to 2014		Beginning in 2014	
EPs	Report 6 out of 44 CQMs • 3 core or alt. core • 3 menu	**EPs**	Report 9 out of 64 CQMs Selected CQMs must cover at least 3 of the 6 NQS domains Recommended core CQMs: 9 for adult populations 9 for pediatric populations
Eligible Hospitals and CAHs	Report 15 out of 15 CQMs	**Eligible Hospitals and CAHs**	Report 16 out of 29 CQMs Selected CQMs must cover at least 3 of the 6 NQS domains

EP CQM Reporting Beginning in 2014

Eligible Professionals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
EPs in 1st Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
EPs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
Option 2	Patient	Medicare	Electronic	Satisfy requirements of PQRS EHR Reporting Option using CEHRT
Group Reporting (only EPs Beyond the 1st Year of Demonstrating Meaningful Use)**				
EPs in an ACO (Medicare Shared Savings Program or Pioneer ACOs)	Patient	Medicare	Electronic	Satisfy requirements of Medicare Shared Savings Program of Pioneer ACOs using CEHRT
EPs satisfactorily reporting via PQRS group reporting options	Patient	Medicare	Electronic	Satisfy requirements of PQRS group reporting options using CEHRT

**Attestation is required for EPs in their 1st year of demonstrating MU because it is the only reporting method that would allow them to meet the submission deadline of October 1 to avoid a payment adjustment.*

***Groups with EPs in their 1st year of demonstrating MU can report as a group, however the individual EP(s) who are in their 1st year must attest to their CQM results by October 1 to avoid a payment adjustment.*

Hospital CQM Reporting Beginning in 2014

Eligible Hospitals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
Eligible Hospitals in 1st Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains
Eligible Hospitals/CAHs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains
Option 2	Patient	All payer (sample)	Electronic	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains ➢ Manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot

**Attestation is required for Eligible Hospitals in their 1st year of demonstrating MU because it is the only reporting method that would allow them to meet the submission deadline of July 1 to avoid a payment adjustment.*

CQM – Timing

Time periods for reporting CQMs – **NO CHANGE** from Stage 1 to Stage 2

Author's Note: These time periods apply regardless of Stage of meaningful use.

Provider Type	Reporting Period for 1st year of MU	Submission Period for 1st year of MU	Reporting Period for Subsequent years of MU (2nd year and beyond)	Submission Period for Subsequent years of MU (2nd year and beyond)
EP	90 consecutive days within the calendar year	Anytime immediately following the end of the 90-day reporting period, but no later than February 28 of the following calendar year*	1 calendar year (January 1 – December 31)	2 months following the end of the EHR reporting period (January 1 – February 28)
Eligible Hospital/ CAH	90 consecutive days within the fiscal year	Anytime immediately following the end of the 90-day reporting period, but no later than November 30 of the following fiscal year*	1 fiscal year (October 1 – September 30)	2 months following the end of the EHR reporting period (October 1 – November 30)

**In order to avoid payment adjustments, EPs must submit CQMs no later than October 1 and Eligible Hospitals must submit CQMs no later than July 1.*

2014 CQM Quarterly Reporting

For Medicare providers, the 2014 3-month reporting period is fixed to the quarter of either the fiscal (for eligible hospitals and CAHs) or calendar (for EPs) year in order to align with existing CMS quality reporting programs.

In subsequent years, the reporting period for CQMs would be the entire calendar year (for EPs) or fiscal year (for eligible hospitals and CAHs) for providers beyond the 1st year of MU.

Provider Type	Optional Reporting Period in 2014*	Reporting Period for Subsequent Years of Meaningful Use	Submission Period for Subsequent Years of Meaningful Use
EP	Calendar year quarter: January 1 – March 31 April 1 – June 30 July 1 – September 30 October 1 – December 31	1 calendar year (January 1 - December 31)	2 months following the end of the reporting period (January 1 - February 28)
Eligible Hospital/CAH	Fiscal year quarter: October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30	1 fiscal year (October 1 - September 30)	2 months following the end of the reporting period (October 1 - November 30)

**In order to avoid payment adjustments, EPs must submit CQMs no later than October 1 and Eligible Hospitals must submit CQMs no later than July 1.*

Payment Adjustments & Hardship Exceptions

Medicare Only

EPs, Subsection (d) Hospitals and CAHs

Who, How Much and When?

- The HITECH Act stipulates that for Medicare EP, subsection (d) hospitals and CAHs **a payment adjustment applies if they are not a meaningful EHR user.**
- How much?
  - EPs: 1% of Part B Physician Fee Schedule potentially rising to 5%
  - Subsection (d) hospitals: 1/4 of their annual update rising to 3/4
  - CAHs: 1/3 of a percent rising to a full percent
- Starting in 2015 with annual determinations

EP EHR Reporting Period

Payment adjustments are based on prior years' reporting periods. The length of the reporting period depends upon the first year of participation.

For an EP who has demonstrated meaningful use in **2011** or **2012**:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on Full Year EHR Reporting Period (unless 2013 is your 1st year)	2013	2014*	2015	2016	2017	2018

* Special 3 month EHR reporting period

To Avoid Payment Adjustments:
EPs **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

Author's Notes: As displayed in the charts, for EPs who demonstrated meaningful use in 2011 or 2012, their 2013 reporting period (the full year) will determined their 2015 payment adjustment.

EP EHR Reporting Period

EP who demonstrates meaningful use in **2014** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2014*	2014				
Based on Full Year EHR Reporting Period			2015	2016	2017	2018

In order to avoid the 2015 payment adjustment the EP must attest no later than October 1, 2014, which means they must begin their 90 day EHR reporting period no later than July 1, 2014.

Author's Notes: This continues for EPs who demonstrate meaningful use in 2015 for the first time. Demonstration in 2015 assuming it is no later than Oct 1, 2015 would count for 2016 and 2017.

Subsection (d) Hospital HER Reporting Period

Payment adjustments are based on prior years' reporting periods. The length of the reporting period depends upon the first year of participation.

For a hospital that has demonstrated meaningful use in **2011** or **2012** (fiscal years):

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on Full Year EHR Reporting Period	2013	2014*	2015	2016	2017	2018

For a hospital that demonstrates meaningful use in **2013** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2013					
Based on Full Year EHR Reporting Period		2014*	2015	2016	2017	2018

*Special 3 month EHR reporting period

To Avoid Payment Adjustments:
Eligible hospitals **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

AUTHOR'S NOTES: As displayed in the charts, for hospitals that demonstrated meaningful use in 2011 or 2012, their 2013 reporting period (the full year) will determined their 2015 payment adjustment.
For hospitals that demonstrate meaningful use in 2013 for the first time, their 90-day reporting period determines their 2015 payment adjustment.

Subsection (d) Hospital EHR Reporting Period

For a hospital that demonstrates meaningful use in **2014** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2014*	2014				
Based on Full Year EHR Reporting Period			2015	2016	2017	2018

In order to avoid the 2015 payment adjustment the hospital must attest no later than July 1, 2014 which means they must begin their 90 day EHR reporting period no later than April 1, 2014

AUTHOR'S NOTES: This continues for hospitals that demonstrate meaningful use in 2015 for the first time. Demonstration in 2015 assuming it is no later than July 1, 2015 would count for 2016 and 2017.

CAH EHR Reporting Period

Payment adjustments for CAHs are also based on prior years' reporting periods. The length of the reporting period depends upon the first year of participation.

For a CAH who has demonstrated meaningful use **prior to 2015** (fiscal years):

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on Full Year EHR Reporting Period	2015	2016	2017	2018	2019	2020

For a CAH who demonstrates meaningful use in **2015** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2015					
Based on Full Year EHR Reporting Period		2016	2017	2018	2019	2020

To Avoid Payment Adjustments:

CAHs **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

AUTHOR'S NOTE: Fiscal years. The difference in EHR reporting period is due to the unique cost reimbursement structure of CAHs. Currently, interim payments are made to a CAH based on a prior year cost report and then the report in reconciled at the end of the fiscal year and adjustments to interim payments are made. It is this existing reconciliation structure that allows us to propose to based the EHR reporting period in the same year as the payment adjustment.

EP Hardship Exceptions

EPs can apply for hardship exceptions in the following categories:

1. **Infrastructure**
   EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
2. **New EPs**
   Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments.
3. **Unforeseen Circumstances**
   Examples may include a natural disaster or other unforeseeable barrier.
4. **EPs must demonstrate that they meet the following criteria:**
   - Lack of face-to-face or telemedicine interaction with patients
   - Lack of follow-up need with patients
5. **EPs who practice at multiple locations must demonstrate that they:**
   - Lack of control over availability of CEHRT for more than 50% of patient encounters

AUTHOR'S NOTE: New EPs- Example- those who begin practice in calendar year 2015 would receive an exception to the penalties in 2015 and 2016, but would have to begin demonstrating meaningful use in calendar year 2016 to avoid payment adjustments in 2017.

Eligible Hospital and CAH Hardship Exceptions

Eligible hospitals and CAHs can apply for hardship exceptions in the following categories

1. **Infrastructure**
   Eligible hospitals and CAHs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure
   (e.g., lack of broadband).
2. **New Eligible Hospitals or CAHs**
   New eligible hospitals and CAHs with new CMS Certification Numbers (CCNs) that would not have had time to become meaningful users can apply for a limited exception to payment adjustments.
   - For CAHs the hardship exception is limited to one full year after the CAH accepts its first patient.
   - For eligible hospitals the hardship exception is limited to one full-year cost reporting period.
3. **Unforeseen Circumstances**
   Examples may include a natural disaster or other unforeseeable barrier.

AUTHOR'S NOTE: Payment adjustments for eligible hospitals and CAHs will be applied beginning with the fiscal year 2015 cost reporting period.

Stage 2 Resources

CMS Stage 2 Webpage:

- http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

Links to the Federal Register

Tipsheets:

- Stage 2 Overview
- 2014 Clinical Quality Measures
- Payment Adjustments & Hardship Exceptions (EPs & Hospitals)
- Stage 1 Changes
- Stage 1 vs. Stage 2 Tables (EPs & Hospitals)