To make your job easier, we’ve narrowed down the Stage 1 and recently released Stage 2 rules of the Medicare and Medicaid EHR Incentive Programs to determine how they differ.

**Core and Menu Set Requirements**

In Stage 2 of CMS' EHR Incentive Programs, scheduled to begin in 2014, eligible providers (EPs) must meet 17 core objectives and three of six menu objectives. In Stage 1, EPs must meet 15 core objectives and satisfy five of 10 menu objectives.

While the total number of measures EPs must satisfy remains the same in Stage 2, the requirements become more complicated. Nearly all of the Stage 1 core and menu objectives are retained in Stage 2, and nearly every Stage 1 menu set objective is required in Stage 2. In addition, the thresholds (percentages) that providers must to satisfy the requirements increase and many of the Stage 1 measures combine to make up Stage 2 measures.

Stage 2 also broadens the focus of meaningful use to include more rigorous patient engagement and information exchange related requirements.

**Clinical Quality Measures**

EPs will submit 9 CQMs from at least 3 of the National Quality Strategy domains out of a potential list of 64 CQMs across 6 domains under the Stage 2 rules.

In Stage 1, EPs must report three core CQMs (or if the denominator of one or more of those core measures is zero, then eligible professionals may report up to three alternate core measures). In the first stage, EPs must also report an additional three of 38 measures.

Stage 2 CQMs align more closely with preexisting national quality programs, such as measures used for PQRS, accountable care organizations, and Patient-Centered Medical Homes.

**Measure-by-Measure Comparison**

(For in-depth details on Stage 1 requirements, see our [Meaningful Use Stage 1 Cribsheet](#).)

**Core Measures**

**Computerized provider order entry (CPOE) for medication orders**

**Stage 2:** Record using CPOE more than 60 percent of medication, 30 percent of laboratory, and 30 percent radiology orders created by the EP.

**Stage 1:** Record using CPOE more than 30 percent of unique patients with at least one medication in their medication list (also only applied to medication orders).

**Generate and transmit permissible prescriptions electronically (e-Rx)**

**Stage 2:** More than 50 percent of all permissible prescriptions, or all prescriptions written by the EP, are queried for a drug formulary and transmitted electronically using CEHRT.

**Stage 1:** More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology (comparison to drug formulary is not included)

**Record demographics**

**Stage 2:** More than 80 percent of all unique patients seen by the EP during the EHR reporting period have demographics recorded as structured data.

**Stage 1:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period have demographics recorded as structured data.

**Record vital signs**

**Stage 2:** More than 80 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data.

**Stage 1:** More than 50 percent of all unique patients age 2 and over seen by the EP have height, weight, and blood pressure recorded as structured data.

**Record smoking status**

**Stage 2:** The EP records, for more than 80 percent of all unique patients age 13 or older, smoking status recorded as structured data.

**Stage 1:** The EP records, for more than 50 percent of all unique patients age 13 or older, smoking
status as structured data.

**Report ambulatory clinical quality measures**

**Stage 2:** The EP implements five clinical decision support interventions related to five or more clinical quality measures; and the EP enables and implements the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

**Stage 1:** The EP successfully reports ambulatory clinical quality measures selected by CMS in the manner specified (or in the case of Medicaid, the States) and implements one clinical decision support rule; and the EP implements the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

**Incorporate clinical lab results**

**Stage 2:** More than 55 percent of all clinical lab tests results ordered by the EP are incorporated in Certified EHR Technology as structured data.

**Stage 1:** More than 40 percent of all clinical lab tests results ordered by the EP are incorporated in certified EHR technology as structured data. This is optional and appears in the menu set for Stage 1.

**Detail specific patient conditions**

**Stage 2:** Generate at least one report listing patients of the EP with a specific condition.

**Stage 1:** This is optional and appears in the menu set.

**Patient reminders**

**Stage 2:** More than 10 percent of all unique patients who have had an office visit with the EP within 24 months prior to the beginning of the EHR reporting period are sent a reminder, per patient preference.

**Stage 1:** More than 20 percent of patients older than 75 or younger than 5 are sent reminders for preventive follow-up care. This is optional and appears in the menu set.

**Patient access to health information**

**Stage 2:** More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided online access to their health information within four business days after the information is available to the EP, subject to the EP’s discretion to withhold certain information. And, more than 5 percent of all unique patients seen by the EP (or their authorized representatives) view, download, or transmit to a third party their health information within four business days.

**Stage 1:** This objective replaces the Stage 1 core objective for EPs of “Provide patients with an electronic copy of their health information upon request” and the Stage 1 menu objective of “Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within four business days of the information being available to the EP.”

**Provide clinical summaries to patients**

**Stage 2:** The EP provides clinical summaries to patients within 1 business day for more than 50 percent of office visits.

**Stage 1:** The EP provides, for more than 50 percent of all patients who request it, an electronic copy of their clinical summaries within three business days.

**Provide patient-specific educational resources**

**Stage 2:** The EP provides, for more than 10 percent of all office visits, patient-specific education resources identified by EHR.

**Stage 1:** More than 10 percent of all unique patients seen by the EP receive patient-specific resources. This is optional and appears in the menu set.

**Transitions of care**

**Stage 2:** 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.

**Stage 1:** The EP performs medication reconciliation for more than 50 percent of all transitions of care in which the patient is transitioned into the care of the EP. This is optional and appears in the menu set.

**Provide summary of care records**

**Stage 2:** The EP provides a summary of care record for more than 50 percent of transitions of care and referrals. And the EP provides a summary of care record for more than 10 percent transitions and referrals either electronically transmitted using CEHRT to a recipient or where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. And, an EP, must satisfy one of the two
following criteria: 1. Conduct one or more successful electronic exchanges of a summary of care
document with a recipient who has EHR technology that was developed designed by a different EHR
technology developer than the sender's EHR; 2. Conduct one or more successful tests with the CMS
designated test EHR during the EHR reporting period.

**Stage 1:** The EP provides a summary of care record for more than 50 percent of transitions of care
and referrals. This is optional and not required. The second aspect of the Stage 2 requirement,
transmit a summary of care record electronically to a recipient using a different EHR, is new.

**Provide immunization data**

**Stage 2:** The EP successfully submits electronic immunization data from the EHR to an
immunization registry or immunization information system for the entire EHR reporting period.

**Stage 1:** The EP submits electronic immunization data from the EHR to an immunization registry or
immunization information system; does not require successful submission. This is optional and
appears in the menu set.

**Protect electronic health information**

**Stage 2:** The EP conducts or reviews a security risk analysis in accordance with the requirements
under 45 CFR 164.308(a)(1), including addressing the encryption/security of data in accordance with
requirements under 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 provider’s risk
management process.

**Stage 1:** The above Stage 2 measure is the same as in Stage 1.

**Secure messaging to patients**

**Stage 2:** More than 5 percent of unique patients seen during the reporting period send a secure
message using the electronic messaging function of the EHR.

**Stage 1:** Does not appear.

**Menu Set Measures**

(*Measure does not appear in Stage 1)

**Scans and tests**

**Stage 2:** More than 10 percent of all scans and tests ordered by the EP that result in an image are
accessible through the EHR.

**Family history**

**Stage 2:** More than 20 percent of all unique patients seen by the EP have a structured data entry for
one or more first-degree relatives (a family member who shares about 50 percent of their genes with
a particular patient including the patient’s parents, siblings, and children).

**Electronic syndromic surveillance data**

**Stage 2:** Successful ongoing submission of electronic syndromic surveillance data from the EHR to a
public health agency for the entire EHR reporting period. (In Stage 1, this is a single test and does
not require successful ongoing submission.)

**Cancer case information**

**Stage 2:** Successful ongoing submission of cancer case information from a certified EHR to a cancer
registry for the entire EHR reporting period.

**Specific case information**

**Stage 2:** Successful ongoing submission of specific case information from a certified EHR to a
specialized registry for the entire EHR reporting period.

**Electronic notes**

**Stage 2:** Enter at least one electronic progress note created, edited, and signed by an EP for more
than 30 percent of unique patients with at least one office visit during the EHR reporting period.

**Stage 1 Objectives Eliminated from Stage 2**

**Exchange of clinical information**

The “exchange of key clinical information” core objective from Stage 1 is replaced by a “transitions
of care” core objective in Stage 2.

**Electronic copies**

The “provide patients with an electronic copy of their health information” objective is replaced by an
“electronic/online access” core objective.