



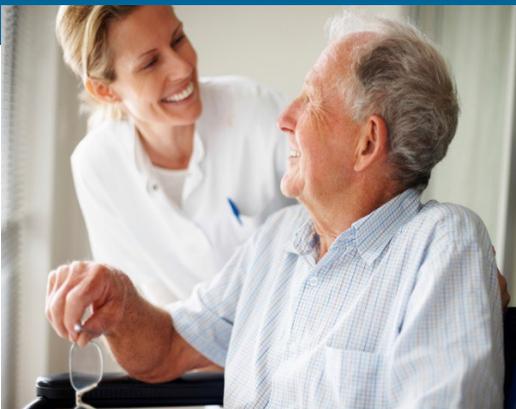
Medicare providers can continue to participate in the Medicaid Promoting Interoperability Program and avoid a payment adjustment by demonstrating meaningful use .

2018

Participation Year
(PY) Meaningful
Use

Updated: September 28, 2018

S.C. Medicaid Promoting Interoperability Program State Level Repository User Guide for Eligible Professionals



6 ANNUAL PAYMENTS AVAILABLE FOR EACH PROVIDER - ONLY 4 MORE YEARS REMAINING

LINKS TO ON-LINE HELPFUL RESOURCES

NEW [QUICK GUIDE TO ASSIST RETURNING APPLICANTS](#)
COMPLETE INFORMATION FOR NEW APPLICANTS

[QUICK REFERENCE LIST](#) OF EXCLUSIONS AVAILABLE

CMS MU STAGE 2 AND STAGE 3 CRITERIA SPECIFICATIONS INCLUDED AND [COMPARE HERE](#)

South Carolina Department of Health &
Human Services
Health Information Technology
Division
Phone: 803-898-2996
Web Site: <http://www.scdhhs.gov/hit>
Email: HITSC@scdhhs.gov

UPDATED 9/28/18 When using links in this document, return to your previous location by pressing Alt and left arrow keys at same time.

Registering to Submit Attestations

[Click here to Register or Update Registration Information for the Medicaid Promoting Interoperability Program](#)

Please ensure that South Carolina is listed as your “Medicaid state/ Territory”.

Are you registering or attesting on behalf of an Eligible Professional?

CMS allows an eligible professional to designate a third party to register and attest on his or her behalf. To do so, users working on behalf of an eligible professional must have an Identity and Access Management System (I&A) web user account (User ID/Password), and be associated to the eligible professional's National Provider Identifier (NPI). If you are working on behalf of one or more eligible professionals and do not have an I&A web user account, please visit [I&A Security Check](#) to create one. (Note: States will not necessarily offer the same functionality for registration and attestation in the Medicaid Promoting Interoperability Program.

Official CMS Registration User Guides

Below are step-by-step guides to help you register and attest for EHR Incentive Programs. These official guides provide easy instructions for using the CMS Registration & Attestation system, helpful tips and screenshots to walk you through the process, and important information that you will need in order to successfully register and attest. Please download the guide that best fits your needs:

- [Identify & Access System Quick Reference Guide](#)
- [Registration User Guide for Medicaid Eligible Professionals](#)
- [Registration User Guide for Medicaid Hospitals](#)

The CMS Electronic Health Record (EHR) Information Center is open to assist you with all of your registration and attestation system inquiries. **EHR Information Center Hours of Operation:**

9:00 a.m. – 5:00 p.m. (Central Time) Monday through Friday, except federal holidays.

1-888-734-6433* (primary number) *(press option 1) or 888-734-6563 (TTY number)

LINKS TO HELPFUL RESOURCES

<https://chpl.healthit.gov/#/resources/overview>

This Web site is the single authority to obtain the Certified Health IT Product List (CHPL)/Office of National Coordinator (ONC) Product Number(s) and the 15-character alphanumeric Centers for Medicare & Medicaid Services (CMS) Electronic Health Record (EHR) Certification ID for the certified EHR technology products(s). These are required for your attestation.

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2018ProgramRequirementsMedicaid.html>

CMS website for the Medicare and Medicaid EHR Incentive Programs with links to general program requirements as well as detailed meaningful use criteria specifications.

https://www.healthit.gov/sites/default/files/clinicaldecisionsupport_tipsheet.pdf

For helpful information regarding Clinical Decision Support (CDS) interventions: More than Just Alerts.

<https://www.federalregister.gov/documents/2017/08/14/2017-16434/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the>

On August 14, 2017, CMS published the Fiscal Year (FY) 2018 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) prospective Payment System Final Rule. Effective October 1, 2017, the rule contains several changes that directly affect the Medicare and Medicaid EHR Incentive Programs.

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2018ProgramRequirementsMedicaid.html>

CMS provides tip sheets, fact sheets on public health reporting, and additional resources on this website specific to Program Year 2018

The Meaningful Use Specification Sheets for Program Year 2018 are located in appendices included with this document or at the following CMS links:

Modified Stage 2

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_ModifiedStage2_2018.pdf

Stage 3

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_Stage3_2018.pdf

Available Exclusions

MEASURE	OBJECTIVE	AVAILABLE EXCLUSION FOR PY2018	
		Modified Stage 2 (MS2)	Stage 3 (S3)
EP reviewed the security risk analysis	Protect Patient Information	NONE	
EP implemented clinical decision support interventions	Clinical Decision Support	NONE	
CEHRT checked for drug-drug and drug-allergy interaction	Clinical Decision Support	wrote < 100 medication orders during the EHR reporting period	
CEHRT used for medication orders	Computerized Provider Order Entry	wrote < 100 medication orders during the EHR reporting period	
CEHRT used for lab orders	Computerized Provider Order Entry	wrote < 100 lab orders during the EHR reporting period	
CEHRT used for radiology /diagnostic imaging orders	Computerized Provider Order Entry	wrote < 100 radiology/diagnostic imaging orders during the EHR reporting period	
CEHRT queried for a drug formulary and permissible prescriptions transmitted electronically	Electronic Prescribing (eRx)	wrote < 100 permissible prescriptions during the EHR reporting period, OR does not have a pharmacy within the organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the practice location at the start of his or her EHR reporting period	
CEHRT used to create a summary of care record and to transmit it electronically to receiving provider when EP transitions or refers patient	Health Information Exchange	transfers a patient to another setting or refers a patient to another provider < 100 times during the EHR reporting period	
(S3) EP incorporated into the patient's EHR an electronic summary of care document when EP saw new patient by transition or referral	Health Information Exchange	transitions or referrals of new patients to the EP total < 100 times during the EHR reporting period	
(S3) EP performed clinical information reconciliation when EP saw new patient by transition or referral	Health Information Exchange		
(MS2) med rec performed when the patient is transitioned into the care of the EP	Medication Reconciliation	EP was not the recipient of any transitions of care during the EHR reporting period	not applicable
secure message was sent using the electronic messaging function of CEHRT to the patient	(MS2) Secure Electronic Messaging/(S3) Coordination of Care	EP had no office visits during the EHR reporting period	
CEHRT used to identify clinically-relevant education resources provided to patients with office visits	(MS2) Patient-Specific Education/ (S3) Patient Electronic Access to Health Information	EP had no office visits during the EHR reporting period	
patient was provided timely access to view online, download, and transmit to a third party their health information	(MS2) Patient Electronic Access/ (S3) Patient Electronic Access to Health Information	neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information"	no office visits during the EHR reporting period
(S3) patient's health information was available for the patient to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT	(S3) Patient Electronic Access to Health Information	not applicable	

MEASURE	OBJECTIVE	AVAILABLE EXCLUSION FOR PY2018	
		Modified Stage 2 (MS2)	Stage 3 (S3)
(MS2) patients viewed, downloaded or transmitted to a third party their health information	Patient Electronic Access	neither ordered nor created any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information"	not applicable
(S3): patient viewed, downloaded or transmitted their health information made available by the provider and/or access it through applications chosen by the patient and configured to the API in the provider's CEHRT	Coordination of Care	not applicable	EP had no office visits during the EHR reporting period
(S3) patient-generated health or nonclinical data was incorporated into CEHRT	Coordination of Care	not applicable	
immunization data reported	Public Health Reporting	EP did not administer any immunizations during the EHR reporting period	
syndromic surveillance data reported		EP not in a category of providers from which ambulatory syndromic surveillance data is collected by jurisdiction's system	
(MS2) Specialized Registry Reporting		EP did not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in jurisdiction during the EHR reporting period	not applicable
(S3) Electronic Case Reporting		not applicable	EP did not diagnose or treat any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period; OR Operated in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; OR
(S3) Public Health Registry Reporting		not applicable	Operated in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the EHR reporting period
(S3) Clinical Data Registry Reporting		not applicable	

Eligible Provider Decisions

- STEP 1: Confirm provider is an [eligible licensed type](#) to participate
- STEP 2: Confirm provider was not [hospital-based](#) in previous calendar year
- STEP 3: Confirm provider is [enrolled in S. C. Medicaid](#) and address as maintained by the Provider Enrollment Office to receive payments of claims for patient care (also where incentive check will be credited) is correct.
- STEP 4: Update [provider registration information](#) only if it has changed at Centers for Medicaid and Medicare Services (CMS) Registration & Attestation website.

Patient Volume Decisions

- STEP 5: Decide to use [Medicaid patient volume or needy patient volume](#) for this provider
- STEP 6: Confirm > 50% of patient volume encounters occurred at [location where certified EHR technology was used](#).
- STEP 7: Decide to use [group practice patient volume or individual provider patient volume](#) [must be group or individual for each and every provider practicing at location(s) with the same Tax ID Number (TIN)]
- STEP 8: Select [start date](#) of 90-Day patient volume period
- STEP 9: Based on Decisions Above, Print Patient Volume Report (and retain for use while entering data in to SLR and in the event of an [audit](#))

MU Criteria Quick Scan

STEP 10: Considering the following required practices and performance thresholds for meaningful use of your electronic health record system, select an EHR review period (90-days) to document that attestation can show all measures are met or allowable exclusions of the measure apply.

Scheduled Stage 2 Providers

- Conducted or reviewed a [Security Risk Analysis](#) within most recent calendar year
- 5 [Clinical Decision Support Rules](#) in use with CEHRT
- >60% of all [medication orders](#) are recorded using CPOE
- >30% of all [laboratory orders](#) are recorded using CPOE
- >30% of all [radiology orders](#) are recorded using CPOE
- >50% of permissible [prescriptions](#) written by the EP are transmitted electronically using CEHRT

Scheduled Stage 3 Providers

- Conducted or reviewed a [Security Risk Analysis](#) within most recent calendar year (same as Stage 2)
- 5 [Clinical Decision Support Rules](#) in use with CEHRT (same as Stage 2)
- >60% of all [medication orders](#) are recorded using CPOE (same as Stage 2)
- >60% of all [laboratory orders](#) are recorded using CPOE
- >60% of all [radiology orders](#) are recorded using CPOE
- >60% of permissible [prescriptions](#) written by the EP are transmitted electronically using CEHRT

Scheduled Stage 2 (continued)

- CEHRT used to create [summary of care record](#) upon referral of patient or care transition and >10% of such transitions or referrals include electronic transmittal of summary of care via CEHRT
- >10% of unique patients with office visits by EP are provided [patient-specific education resources](#)
- [Medication reconciliation](#) on >50% of transitions of care patients during the EHR reporting period for which the EP was the receiving party of the transition.
- Timely access after EP's receipt, >50% of unique patients seen by EP have [access to view their health information](#).
- >5% of unique patients seen by EP have [viewed their health information](#).
- >5% of unique patients seen by EP were [sent a secure message](#) using the electronic messaging function of CEHRT.
- EP must actively engage with a public health agency to submit [immunization data](#).
- EP must actively engage with a public health agency to submit [syndromic surveillance data](#).
- EP must actively engage with a public health agency to submit [specialized registry data](#).

Scheduled Stage 3 (continue)

- CEHRT used to create [summary of care record](#) upon referral of patient or care transition and >50% of such transitions or referrals include electronic transmittal of summary of care via CEHRT
- >40% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic [summary of care document](#)
- >80% of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a [clinical information reconciliation for medication, medication allergy, current problem list](#).
- >35% of unique patients with office visits by EP are provided [patient-specific education resources](#)
- Timely access after EP's receipt, >80% of unique patients seen by EP have [access to view their health information](#).
- >5% of unique patients seen by EP have [viewed their health information](#). (same as Stage 2)
- >5% of unique patients seen by EP were [sent a secure message](#) using the electronic messaging function of CEHRT.(same as Stage 2)
- Patient generated health data or [data from a nonclinical setting](#) is incorporated into the CEHRT for >5% of all unique patients seen by the EP
- EP must actively engage with a public health agency to submit [immunization data](#) and receive information
- EP must actively engage with a public health agency to submit [syndromic surveillance data](#) from an urgent care setting
- EP must actively engage with a public health agency to submit [electronic case reporting; public health registry data; clinical registry data](#)



Prepare To Log In To
the SLR

STEP 11: Have on hand the provider's NPI and CMS Registration ID

STEP 12: Confirm the provider has received payment of an approved attestation from their previous PY before attempting to attest for a new year.

CONTACT THE HIT DIVISION WITH ANY
QUESTIONS hitc@scdhhs.gov
803-898-2996

Login to the SLR to begin your attestation at: www.scdhhs.gov/slr.

**IMPORTANT: YOUR REGISTRATION AT CMS ESTABLISHED AN
EMAIL ADDRESS FOR USE BY THE S.C. MEDICAID
INCENTIVE PAYMENT HIT DIVISION**

NOT HAVING A VALID EMAIL ADDRESS INCLUDED ON THE REGISTRATION
CAN RESULT IN PROVIDERS NOT RECEIVING INCENTIVE PAYMENTS.

WHEN THE EMAIL CONTACT INFORMATION ON THE EP'S REGISTRATION IS
NO LONGER VALID, CORRESPONDENCE IS NOT DELIVERABLE.
OFTEN THE CONTACT PERSON HAS LEFT THE ORGANIZATION OR CHANGED
EMAIL ADDRESSES DUE TO AN ORGANIZATION'S NAME CHANGE.

UPDATE THE EMAIL CONTACT INFORMATION PROMPTLY
WHEN A CHANGE OCCURS.

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The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Record (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EP and EHs to adopt, implement, or upgrade (AIU) to certified EHR technology and use it in a progressively more advanced meaningful manner in patient care.

CMS published a final rule in October 2015, the Electronic Health Record Incentive Program – Stage 3 and Modifications to MU in 2015 through 2017, that addresses criteria for Stage 3 and Modifications to Meaningful Use (MU) in 2015-2017 for the Electronic Health Records (EHR) Incentive Programs. Additionally, in October of 2016 CMS finalized the Medicare Quality Payment Program and in November of 2016, CMS finalized updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2017 which included modifications to the EHR Medicaid Incentive program that impacted the reporting periods for PY 2017 eligible providers. The last year to begin participation in the Medicaid EHR incentive programs was PY 2016.

The intent of this user guide is to describe changes in effect now for PY 2018 Meaningful Use attestations in response to this final rule, S.C. Medicaid program changes and S.C. State Level Repository (SLR) attestation screen changes for PY 2018.

The CMS official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.



Eligible Professional Types

There are 5 types of providers who are considered Eligible Professionals (EP) for the Medicaid Promoting Interoperability Program:

1. Physician*
*In South Carolina, this includes Medical Doctors, Doctors of Osteopathy, and Optometrists.
2. Dentist (DDS or DMD)
3. Advanced Practice Nurse
4. Certified Nurse Midwife
5. Physician Assistant (PA) practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a PA which means:
 - a. The PA is the primary provider in a clinic (e.g., a clinic with a part-time physician and full-time PA); or
 - b. The PA is a clinical or medical director at a clinical site of practice; or
 - c. The PA is the owner of an FQHC or RHC.

If the EP has any state or federal exclusions that would prevent the EP from receiving federal funding, the EP is not eligible to participate in the S.C. Medicaid Promoting Interoperability Program.

For PY2018 EPs must not furnish 90% or more of their covered Medicaid professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital in CY2016. Covered professional services are physician fee schedule (PFS) services paid under Section 1848 of the Social Security Act.

Providers have the opportunity to appeal the program's determination of hospital-based status.

Additional HIT Division Participation Requirements

Once an EP meets the basic eligibility requirements for the S.C. Medicaid Promoting Interoperability Program, there are program participation requirements to meet in order to qualify for an incentive payment. An EP must:

- Meet applicable patient volume threshold;
and
- Demonstrate meaningful use for this PY and advance in further years to more advanced scheduled stages of meaningful use.

Incentive Payments

The payment year for an EP is based on the calendar year. EP may receive Medicaid EHR incentive payments over 6 payment years up to a maximum of \$63,750. Medicaid EHR incentive payments do not need to be consecutive until 2016. No EP may initiate the program after 2016, and no EP will receive a payment after the 2021 PY.

- Payment Year 1: \$21,250 (\$14,167 for Pediatricians qualifying with reduced Medicaid volume)
- Payment Years 2-6: \$8,500 per year (\$5,667 for Pediatricians qualifying with reduced Medicaid volume)

Incentive Payments will be made to the designated entity as established by the EP/EP assignee through the CMS Registration Website

EPs have the option of reassigning their incentive payment to an entity with which there is a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services.

The South Carolina Department of Health and Human Services' State Medicaid Health Information Technology Plan (SMHP) is available at www.scdhhs.gov/hit to provide detailed information about the S.C. Medicaid Promoting Interoperability Program.

Overview of Attesting to the S.C. Medicaid Promoting Interoperability Program

NOTE: DO NOT RETURN TO THE CMS REGISTRATION UNLESS A CHANGE IS NEEDED TO THE CMS REGISTRATION INFORMATION.

The S.C. Medicaid Promoting Interoperability Program is administered by S.C.'s Medicaid agency, the South Carolina Department Health & Human Services (SCDHHS), Division of Health Information Technology (HIT). The EP may access the S.C. Medicaid State Level Repository (SLR) to complete the attestation. The SLR is available at www.scdhhs.gov/slr.

To login, the EP must provide his or her NPI and **CMS Registration ID** (that was generated after initially registering or updating a registration with the CMS Registration and Attestation System). If the CMS Registration ID is not known, the EP must return to his or her CMS registration to retrieve that ID. The CMS EHR Information Center is available to assist with questions about the CMS registration: (888) 734-6433.

During attestation, the EP will first have the opportunity to review basic registration information provided at the CMS Registration and Attestation System (displayed in the SLR's "CMS Registration/SC Medicaid Data" screen). Then, the EP will progress through attestation screens to enter data to attest to meeting meaningful use requirements. Attestations for meaningful use require that providers attest to meeting measures for the meaningful use objectives, and enter information pertaining to selected Clinical Quality Measures that have been generated by the certified EHR technology (CEHRT) used by the provider and identified in the attestation.

A final attestation screen will provide the EP the opportunity to review a summary of their attestation data, and will require the EP (or the EP's authorized designee) to agree to a series of attestation statements and that their attestation is true, accurate and complete prior to submitting the attestation for review by SCDHHS.

SLR Log In Screen

Helpful Links

- Update Registration Information
- Register to Attest on Behalf of an EP or EH
- SLR Attestation User Guide
- Security/Risk Assessment Information
- Eligible Provider Stage 2 MU Clarification
- Eligible Provider Stage 3 MU Clarification
- Eligible Hospital Stage 2 MU Clarification
- Eligible Hospital Stage 3 MU Clarification
- Send E-mail to HIT Division

WELCOME TO THE SOUTH CAROLINA MEDICAID STATE LEVEL REPOSITORY (SLR)

The SLR is not yet accepting Program Year 2018 attestations. Please stand by for announcements.

The South Carolina Medicaid State Level Repository (SLR) is designed for eligible professionals (EP) and eligible hospitals (EH) to attest to meeting the requirements for the S.C. Medicaid Promoting Interoperability (PI) Program, formerly named the "EHR Incentive Program", and receive incentive payments by submitting an attestation via the SLR. The Program is administered by S.C.'s Medicaid agency, the South Carolina Department of Health & Human Services (SCDHHS), Division of Health Information Technology (HIT).

Incentive payments are not a reimbursement but are intended to encourage EPs and EHs to use **Certified EHR Technology (CEHRT)** in meaningful ways. Eligibility and Meaningful Use requirements can be found [here](#).

How to Begin an Attestation to Receive an Incentive Payment:

Step #1 Register with the Centers for Medicare and Medicaid Services (CMS) to obtain your CMS Registration ID. EPs, EHs, or representatives who wish to attest on their behalf, must first register with CMS (if they have not already done so) by clicking the following link: [CMS Registration System](#). Once registration is completed, you will receive your CMS Registration ID which you need to login to the SLR below.

Step #2 Login to the SLR here:

Please enter your NPI (EPs enter their personal NPI)

Please enter your CMS Registration ID

Already registered with CMS? You need your CMS Registration ID to login to the SLR to begin your attestation. If you do not know your CMS Registration ID, please login to the [CMS Registration System](#) by clicking this link to retrieve it.

For help, contact hitsc@scdhhs.gov or call 803-898-2996.

You are accessing a South Carolina government information system, which includes: (1) this computer, (2) this computer network, (3) all computers connected to this network, and (4) all devices and storage media attached to this network or to a computer on this network. This information system is provided for State-authorized use only. Access or attempted access is "STRICTLY PROHIBITED" unless authorized. If you are not authorized disconnect immediately. Authorized users may only perform authorized activities and may not exceed the limits of such authorization. Disclosure of information found in this system for any unauthorized use is STRICTLY PROHIBITED. Unauthorized or improper use of this system may result in disciplinary action, as well as civil and criminal penalties, including but not limited to the civil and criminal penalty sections of Title 26 Sections 7213, 7213A and 7431. (Pub 1075, Sec 9.2, Exhibit 13) and Title 18, US Code, Section 1030. By using this information system, you understand and consent to the following: (1) You have no reasonable expectation of privacy regarding any communication or data transiting or stored on this information system. At any time, and for any lawful purpose, the State may monitor, intercept, and search and seize any communication or data transiting or stored on this information system. (2) Any communication or data transiting or stored on this information system may be disclosed or used for any lawful purpose. (3) All activities on this information system are subject to monitoring, logging, and auditing in accordance with the Minimum Acceptable Risk Standards for Exchanges, IRS-1075, the Health Insurance Portability and Accountability Act and State Acceptable Use Policies. By continuing to access this system you affirm that you are an authorized user and that you have read, understand and agree to comply with the restrictions stated above.*

Upon successful registration with the CMS Registration and Attestation System, CMS will provide a unique CMS Registration ID to the provider and will transmit registration data to the S.C. Medicaid SLR. Please allow two (2) business days for the SLR to process your registration. The provider, or their authorized representative, must then use their CMS Registration ID along with their personal NPI (if they are an eligible professional) to login to the SLR. The SCDHHS Division of HIT will verify the provider's eligibility to participate (generally within 24-48 hours) and will email confirmation of eligibility to the provider along with information about how to proceed with attestation. After the initial registration, the provider will not need to return to the CMS Registration and Attestation System unless registration information needs to be corrected or updated.

Users working on behalf of an eligible provider for registration and/or attestation must have a CMS Identity and Access Management System (I&A) Web user account (User ID/Password). In absence of a CMS I&A account, an individual may not act as a surrogate user on behalf of the provider for registration or attestation.

If an EP enters an incorrect NPI and CMS Registration ID combination 5 consecutive times for the same NPI, the SLR will display the following error message:

- “Your log-in screen to the SLR has been locked due to too many failed login attempts. Please contact (803) 898-2996, or email HITSC@scdhhs.gov, to request this screen be unlocked. If you do not know your CMS Registration ID, please contact the CMS EHR Information Center at (888) 734-6433.”

Red Asterisks

Required fields are denoted with a red asterisk.

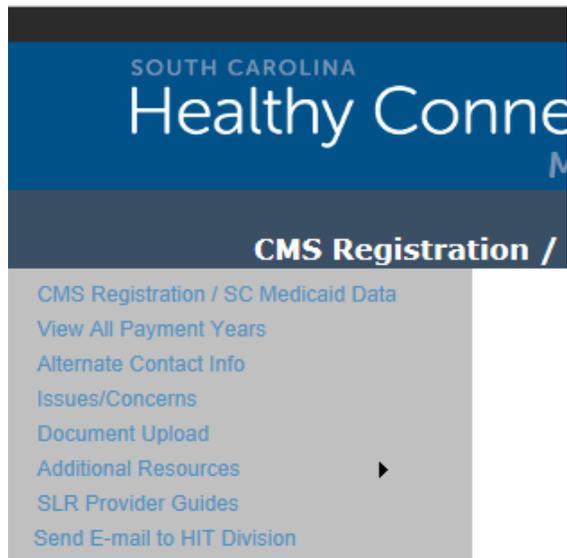
Error Messages

Error messages are designed to alert the EP to an issue with the attestation so that the EP may submit a complete attestation. If the screen has errors (for example, a required field has not been completed), it will display an error message when the EP attempts to save the screen. In many screens, the EP will not be able to save the information (or progress to the next attestation screen) until the error has been corrected. Some screens will allow progression to the next attestation screen even after an error message has displayed; however, when the EP attempts to complete the final Attestation screen to submit the attestation, the SLR will not allow submission unless errors have been addressed and resolved.

Save, Next, and Previous Buttons

Upon completion of any screen, select the **Save** button to save the data; then, upon logout, the SLR will retain the information. When ready to proceed to the next screen of the attestation, select the **Next** button at the bottom of the screen. (Selecting “**Next**” will also result in saving the information on the screen.) The EP may always return to a previous screen by selecting the **Previous** button at the bottom of the screen.

Left Navigation Links



CMS Registration/SC Medicaid Data: Returns the EP to the CMS Registration/SC Medicaid Data Screen (beginning of the attestation).

View All Payment Years: Displays a view of payments received by payment year.

Alternate Contact Info: Allows the EP to designate alternate contacts for the SCDHHS HIT Division should there be questions related to the attestation. The Alternate Contact link is functional even if the attestation is in a submitted status.

Issues/Concerns: Allows submission of an issue or question within the attestation to the SCDHHS HIT Division.

Document Upload: Navigates the EP to a screen to browse and upload files essential to the attestation or its review by the SCDHHS.

Additional Resources: Expands to provide links to the S.C. Medicaid HIT site, the CMS EHR site, and the ONC CHPL site.

SLR Provider Guides: Navigates to SLR Guides specific to Eligible Professionals and to Eligible Hospitals.

Send e-mail to HIT Division: Allows the EP to send an email to the HITSC@scdhhs.gov e-mail box.

SLR "Home" Screen

The SLR Home screen provides a "home page" for the EP to view messages from the SCDHHS HIT Division, payment information, and current status. It also displays a grid for the EP to access a view of past Paid attestations or to begin/modify a new attestation. The name of the EP will display in the screen header.

SLR Home:
Provider Name
(Year 5 Attestation)

Messages and Announcements

EHR Incentive Payment Details

Payment Year	Program Year	Payee Name	Payee NPI	Payment Amount	Payment Date	Payment Type
1	2011	Payee Name	Payee NPI	21250.00	04/01/2011	Initial
2	2013	Payee Name	Payee NPI	8500.00	09/06/2013	Initial
3	2014	Payee Name	Payee NPI	8500.00	10/17/2014	Initial
4	2015	Payee Name	Payee NPI	8500.00	09/23/2016	Initial

Provider Information

You are currently enrolled in the SC Medicaid EHR Incentive Program

The current status of your application for the fifth year payment is 'AWAITING PROVIDER ATTESTATION'

The program year(s) currently available for attestation: 2017

Select one of the following Actions:

****If you are beginning a new attestation you will also need to select a program year.**

Program Year	Payment_Year	Status	Action
2011	1	Paid	View
2013	2	Paid	View
2014	3	Paid	View
2015	4	Paid	View
2017	5	Attest_inProcess	Begin/Modify Attestation

To view a paid attestation, select the view link.

To begin or modify an attestation from a PY available.

Messages and Announcements

Information from the SCDHHS HIT Division will display. This time-limited information may be general (for example, applicable to all EP), or may be specific to the EP.

Provider Information

In the information displayed under Provider Information, the provider's current status will display with one of the following messages:

Attest_inProcess	Provider has begun the attestation, but has not yet submitted
Attest_Completed	Provider has submitted the attestation to the SLR
DHHSCheck_inProcess	SCDHHS is checking the provider attestation against requirements
DHHSCheck_Completed	SCDHHS has completed the requirements check
NLRDupCheck_inProcess	SCDHHS has sent CMS their intent to pay the incentives
NLRDupCheck_Completed	CMS has responded to SCDHHS' request

MMISPayment_inProcess	SCDHHS is processing payment
Paid	SCDHHS has disbursed the incentive
Ineligible	SCDHHS has found the provider to be ineligible for the incentive
Ineligible-CMS	CMS has found the provider to be ineligible for the incentive

EHR Incentive Payment Details

The SLR Home screen displays information about all attestation payments or adjustments in one summary table.

PY Selection Table

The PY Selection Table provides a view of past paid attestations, and also the means to begin or modify a new attestation.

The PY Selection table will not display a PY for selection for attestation until the date scheduled by SCDHHS allowing that selection.

- The EP may attest during the current PY; or for a two-month period following the PY (the “attestation tail period”). So, although the PY year for an EP is the calendar year (January-December), the attestation tail period extends the attestation submission period through the February that follows the PY. There are situations where CMS approves an extended tail period. This information is available on the HIT website, www.scdhhs.gov.
- The SLR does not allow the EP to begin a PY for which the deadline to submit an initial attestation has expired. Should the EP attempt to select a PY after the attestation submission deadline, the following message will display: “This PY is not available for attestation.” Note: Should the attestation be submitted by the PY deadline, and later be re-opened by SCDHHS for provider correction, the SLR will allow the EP to re-submit the attestation even after the PY deadline.
- The SLR does not allow the EP to begin a PY attestation when a prior year attestation is in progress, under review, or pending payment.

The CMS Registration/SC Medicaid Data screen allows the EP to review information sent to SCDHHS from the CMS registration, and to verify the Payee information for the incentive payments. EP have the option of reassigning their incentive payments to their employer or an entity with which the EP has a contractual arrangement. EP must designate their Payee NPI and Payee TIN when registering with the CMS Registration and Attestation System. **The S.C. Medicaid Promoting Interoperability Program requires the Payee to be actively enrolled as a S.C. Medicaid provider.** Once a payment is disbursed, the SCDHHS will notify CMS of the payment.

CMS Registration Data Review

The top portion of the CMS Registration/SC Medicaid Data screen displays information about the provider from the CMS Registration and Attestation System. Corrections to this information may only be made by the provider by returning to the CMS system to modify registration data.

NOTE: DO NOT RETURN TO THE CMS REGISTRATION UNLESS A CHANGE IS NEEDED TO THE CMS REGISTRATION INFORMATION.

If the EP does return to the CMS account, the EP must be sure to re-submit the registration at the CMS Registration and Attestation System, even if no changes are made. If the registration is not re-submitted, the account status with CMS will change to **In Progress** or **Registration Started/Modified** and will remain so until it is re-submitted. If the CMS account status shows **In Progress** or **Registration Started/Modified**, SCDHHS will not be able to exchange the transactions with CMS that are necessary to work the attestation. A status of **Pending State Validation** or **Registration Sent to State** in the CMS registration will indicate a successful submission.

CMS Registration Data			
Applicant National Provider Identifier (NPI):	1239874560	Name:	Jane Doe
Applicant TIN:	987654321	Address 1:	123 Circle Lane Doe
Payee National Provider Identifier (NPI):	222222222	Address 2:	
Payee TIN:	555555555	City/State:	Small Town, SC
Program Option:	MEDICAID	Zip Code:	99999
Medicaid State:	SC	Phone Number:	987-654-3210
Provider Type:	Physician	Email:	import@contact.net
Participation Year:	5	Specialty:	<input type="text"/>
Federal Exclusions:	<input type="checkbox"/>	State Rejection Reason:	<input type="text" value="None"/>
Rejection Reason State:	<input type="text" value="None"/>	Rejection Reason Date:	<input type="text" value="None"/>

*** If any of the above information is incorrect, please return to the CMS Registration and Attestation System to correct it.

Review the information on this screen that the HIT Division has received based on information the EP entered at the CMS Registration & Attestation System.

Note: Communications from the SCDHHS HIT Division related to the provider attestation will be emailed to the email address associated with the CMS registration. Please ensure that this information is kept current.

S.C. Medicaid Data Review

The State Level Repository (SLR) system searches a download of provider data from the S.C. Medicaid Management Information System (MMIS) to display the Medicaid Provider ID(s) associated with the Payee NPI and Payee TIN provided by the EP during the CMS registration. Only actively enrolled Medicaid ID will display.

SC Medicaid Data	
The Payee NPI and Payee TIN you provide at CMS drives the SLR to pre-populate the Payee Medicaid ID field with all associated active S.C. Medicaid IDs. If there are multiple active Medicaid IDs, they are displayed in the drop-down from which you must select the Medicaid ID to which you are reassigning your incentive.	
*** If no information is pre-populated in the Payee Medicaid ID field, either the Payee TIN/Payee NPI is not associated in the Medicaid Management Information System with an active S.C. Medicaid ID, or there is an issue with the SLR search of the MMIS data. Please contact the SCDHHS HIT Division at 803-898-2996, or by email at HITSC@scdhhs.gov, for assistance.	
Payee Medicaid ID:	GP000
Payee Name:	Specialty Services
Mailing Address	
Address 1:	
Address 2:	123 Circle Lane Doe
City/State:	Small Town, SC
Zip Code:	99999

Where there is only one active Payee Medicaid ID associated with the Payee information, it will display in the field for Payee Medicaid ID; the Mailing Address for the Payee will display also. (**Note: Any changes noted for the Mailing Address must be made by the provider by contacting the S.C. Medicaid Provider Service Center: 888-289-0709.**)

Where there are multiple active Medicaid IDs associated with the Payee information, the Payee Medicaid ID field will display **Search**. Clicking **Search** will display the active Medicaid IDs; select the one to which the incentive payment will be made. Once the selection is made, the Mailing Address will display also. (**Note: Any changes noted for the Mailing Address must be made by the provider by contacting the S.C. Medicaid Provider Service Center: 888-289-0709.**) If the EP does not select a Payee Medicaid ID, the SLR will display an error message: **This is a required field. Please select the Payee Medicaid ID from the list.**

If no information is displayed in the Payee Medicaid ID field, either the Payee TIN/Payee NPI is not associated in the MMIS with an active S.C. Medicaid ID, or there is an issue with the SLR search of the MMIS data. Please contact the SCDHHS HIT Division at 803-898- 2996, or by email at HITSC@scdhhs.gov, for assistance.

After reviewing information on the CMS Registration/S.C. Medicaid Data Screen, select the **Save** button to save your work; or, to proceed to the next screen, select the **Next** button.

Provider Eligibility Details Screen

Patient volume reflects encounters from any representative continuous 90-day period from the calendar year preceding the PY; or from any representative continuous 90-day period from the 12-month period prior to the date of attestation submission. The table below identifies **3 decision points** for determining the patient volume calculation methodology.

I. Medicaid Encounters? Or Needy Individual Encounters?	II. Individual EP's Data? Or Group/Clinic Data?	III. Encounter Methodology? Or Panel Methodology?
<p>Medicaid Patient Volume: An EP must have a minimum 30% patient volume attributable to Medicaid patients.</p> <p>*Pediatricians with reduced Medicaid patient volume may qualify for a reduced incentive with a minimum 20% patient volume.</p> <p>A Medicaid encounter includes services rendered to an individual on any one day where the individual was enrolled in Medicaid at the time of service.</p> <p>OR</p> <p>“Needy Individual” Patient Volume: An EP who practices predominantly in an FQHC or RHC may meet a minimum 30% patient volume attributable to needy individuals.</p> <p>Practicing predominantly: More than 50% of the EP’s encounters over 6 months in the calendar year prior to the PY occurred at FQHC or RHC including a 90-day period where 30% of encounters were with needy patients.</p> <p>A Needy Individual encounter means services rendered to an individual on any one day where the individual was enrolled in Medicaid at the time of service; or the services were furnished at no cost, and calculated consistent with S495.310; or the services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.</p>	<p>An EP may qualify based on patient volume calculated on the individual EP’s patient encounters;</p> <p>OR</p> <p>Clinics and group practices may calculate the clinic/group practice Medicaid patient volume (or Needy Individual patient volume, as applicable), and its EP may attest to the volume as a proxy for their own.</p> <p>For purposes of the S.C. Medicaid Promoting Interoperability Program, a group/clinic is defined as a group of healthcare practitioners organized as one legal entity under one Tax Identification Number (TIN).</p> <p>There are conditions for group/clinic proxy: (1) The clinic or practice’s patient volume is appropriate as a patient volume calculation for the EP; (2) There is an auditable data source to support the clinic or practice’s patient volume determination; (3) The clinic or practice and EP decide to use one methodology in each year, and (4) The group or clinic uses the entire group or clinic’s patient volume and does not limit it in any way.</p> <p>If an EP works inside and outside of the clinic or practice, the group/clinic proxy patient volume calculation includes only those encounters associated with the clinic or group practice. (The EP’s outside encounters are not included.)</p> <p>In order for an EP to utilize group patient volume as a proxy, it must be appropriate as a patient volume methodology calculation for the EP; i.e., the EP must be able and available to see Medicaid patients.</p>	<p>The S.C. Medicaid Promoting Interoperability Program offers the EP two options from which to choose to calculate patient volume:</p> <p>(1) The Encounter methodology</p> $\frac{\text{Total Medicaid patient encounters in any representative continuous 90-day period *in the preceding year}}{\text{Total patient encounters in that same 90-day period}} \times 100$ <p>OR</p> <p>(2) The Panel methodology: Note: An EP must not count an assigned patient who was also an encounter more than once.</p> $\frac{[\text{Total Medicaid patients assigned to the provider in any representative continuous 90-day period *in the preceding calendar year with at least one encounter in the 24 months preceding the start of the 90-day period}] + [\text{Unduplicated Medicaid encounters in that same 90-day period}]}{[\text{Total patients assigned to the provider in the same 90-day period with at least one encounter in the 24 months preceding the start of the 90-day period}] + [\text{All unduplicated encounters in that same 90-day period}]} \times 100$ <p>*or, the EP may opt to select the 90-day patient volume period from the 12-month period that precedes attestation submission.</p>

When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site.

For eligible professionals (EP) choosing individual patient volume, they may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an eligible professional's sites of practice. However, at least one of the locations where the eligible professional is adopting or meaningfully using certified EHR technology should be included in the patient volume. In other words, if an EP practices in two locations, one with certified EHR technology and one without, the eligible professional should include the patient volume at least at the site that includes the certified EHR technology. [CMS FAQ3015](#)

Acceptable Encounters for EPs Using Medicaid Patient Volume:

- Services rendered on any one day to a Medicaid enrolled individual, regardless of payment liability, including zero-pay and some denied claims
- Such services can be included in provider's Medicaid patient volume calculation if the services were provided to a beneficiary who is enrolled in Medicaid at the time the service was rendered, regardless of whether Medicaid paid anything on the bill.
- Zero-pay claims can include but are not limited to:
 - Claim denied because the Medicaid beneficiary has maxed out the service limit;
 - Claim denied because the service wasn't covered under the State's Medicaid program;
 - Claim paid at \$0 because another payer's payment exceeded the Medicaid payment;
 - Claim denied because claim wasn't submitted timely (late filing).This can be for any type of service (lab work, immunization, office visit, nursing home visit, ER visit, etc.).

Only one service rendered per day per patient per provider can be counted. For example, if a patient came in for an office visit and was also given a flu shot that same day by the same physician, this is considered one encounter for that EP. If the patient came in for an office visit and then returned the next day for an allergy shot, this is considered two encounters. Services rendered to the same patient by **different providers** on the same day may be claimed discretely by each provider.

Both Medicaid as primary and secondary insurer can be counted toward the encounters. If Medicaid is secondary and the primary insurance paid more than the Medicaid allowable share (so Medicaid paid zero), then it would still be counted as an encounter.

A claim that was denied because the patient was not enrolled in Medicaid at the time of service would not count toward the provider's Medicaid volume.

SCDHHS allows EPs to include encounters from out-of-state Medicaid recipients when calculating patient volume. To calculate patient volume using this option, the EP would add out-of-state Medicaid encounters to in-state Medicaid encounters for the numerator, and add out-of-state total patient encounters to in-state total patient encounters for the denominator. As with all other data to which EPs attest, EPs must be able to supply an auditable data source that supports their calculations.

Patient Panel Methodology Calculation

Patient panel assignment is an **alternative** volume calculation available only to EPs that are primary care providers (PCP) that have Medicaid managed care patients assigned to them. These providers have the option to include encounters by patient panel assignment in their eligible patient volume calculation. Please contact DHHS before using this method.

SCDHHS opted to use the two options listed in the final rule. SCDHHS has a fee for service Medicaid and managed care model, so SCDHHS aims to support providers in the most flexible way for determining patient volume by making both patient volume calculations available. The first option uses all patient encounters attributable to Medicaid during a 90 day period in the most recent calendar year prior to the year of reporting or within the twelve (12) months prior to the date the provider submits their attestation. The second option (managed care option or Patient Panel) uses the total Medicaid patients assigned to the EP, with at least one encounter taking place during the calendar year preceding the start of the 90day period, plus unduplicated Medicaid encounters in the same 90day period.

Option One Formula:

$$\frac{\text{Total Medicaid encounters in any representative continuous 90 day period in preceding calendar year}}{\text{Total patient encounters in the same 90 day period}} \times 100$$

Option Two Formula:

$$\frac{\left(\begin{array}{l} \text{Total Medicaid patients assigned to the provider in any representative continuous 90 day period in the preceding calendar year, with at least one encounter taking place during the calendar year preceding the start of the 90 day period} \end{array} \right) + \left(\begin{array}{l} \text{Unduplicated Medicaid encounters in the same 90 day period} \end{array} \right)}{\left(\begin{array}{l} \text{Total patients assigned to the provider in the same 90 day period, with at least one encounter taking place during the calendar year preceding the start of the 90 day period} \end{array} \right) + \left(\begin{array}{l} \text{All unduplicated encounters in the same 90 day period} \end{array} \right)} \times 100$$

A reminder that the patient volume thresholds for program year 2017 and forward have been lowered:

- **29.5%** for Medicaid Patient Volume
- **19.5%** for Pediatricians

Needy Patient Volume is an additional option only available to EPs who have practiced predominantly in an FQHC or RHC in either the calendar year preceding the payment year or within the twelve (12) months prior to attestation.

A needy patient encounter means services rendered to an individual on any 1 day if any of the following occur:

- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid for part or all of the service.
- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, or cost-sharing.
- The individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.
- The services were furnished at no cost; and calculated consistent with Title 42 of the Code of Federal Regulations, Section 495.310
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

Note: a newly hired EP may utilize a TIN groups needy patient volume if the EP meets the requirement of having practiced predominantly in an FQHC or RHC. The EP is not required to have practiced predominantly at the location being used for their patient volume.

To have practiced predominantly, means that over 50 percent of the EP's total patient encounters over a period of 6 months (either within the most recent calendar year OR within the 12-month period preceding their attestation submission) occurred at a federally qualified health center (FQHC) or rural health clinic (RHC).

The EP will provide information in these fields on the Provider Eligibility Details Screen:

Patient Volume

Enter data into the following fields, as applicable:

- **Line 1: Please indicate if you are using a clinic or group's patient volume as a proxy for your own.**

For purposes of the S.C. Medicaid Promoting Interoperability Program, a group/clinic is defined as "A group of healthcare practitioners organized as one legal entity under one TIN." All encounters for that TIN (even across multiple sites) must be used in the calculation of the group/clinic patient volume. If the EP is using group patient volume as a proxy for the EP's own, answer Yes to Line 1 and also complete 2.A. and 2.B. If the answer is No to Line 1, Line 2.A and 2.B are not required (they do not allow data entry).

- **Line 2.A. If using clinic/group patient volume, indicate the TIN of the one legal entity.**

- **Line 2.B. So that the TIN may be verified, the EP is asked to indicate one NPI that is associated with the TIN.**

If the NPI that is entered is not a valid NPI for the TIN, an error message will display as an alert that the TIN entered is not correct. ("The NPI and TIN does not match in MMIS. Please verify your info.")

- **Line 3. (If attesting to Needy Individual patient volume) Do you practice predominantly in an FQHC or RHC?**

In order to base an attestation on Needy Individual patient encounters, the EP must individually meet the requirement of practicing predominantly in an FQHC or RHC. "Practices predominantly" is based on the EP's activity over 6 months in the most recent calendar year (e.g., 2017 for a 2018PY attestation). If attesting to Medicaid patient volume, and not Needy Individual patient volume, do not check the box for Line 3.

- **Line 4. Select the option that indicates the time period from which the 90-day patient volume period is derived:**

Select one of the options that displays in the drop-down: prior calendar year; or, 12 months prior to attestation.

- **Line 5: Enter the starting date of the 90-day period used to calculate patient volume percentage.**

Patient volume reflects encounters from any continuous 90-day period in the preceding calendar year; or, from any continuous 90-day period within the 12 months preceding the attestation submission date. If the starting date entered does not allow for a full 90-day period in the time period selected from the drop-down on Line 4, an error message will display.

- **Line 6. Medicaid (or Needy Individual, as applicable) patient encounters during this period.**
- **Line 7. Total patient encounters during this period.**

If the EP confuses data entry for the patient volume, and enters the Medicaid encounters in the total encounters field, and vice versa, an error message will display.

- **Line 8. (If using the Panel Methodology) Total number of Medicaid (or Needy Individual) patients assigned to your panel with whom you did not have an encounter in the 90-day patient volume period but you did have an encounter in the 24 months prior. (If n/a, enter “0”).**

If the EP has not used the Panel methodology to calculate patient volume, please enter a “0” in line 8. For more information on Panel methodology, please see the Final Rule, or the SCDHHS State Medicaid HIT Plan.

- **Line 9. (If using the Panel Methodology) Total number of patients assigned to your panel from any Plan with whom you did not have an encounter in this 90-day period but you did have an encounter in the 24 months prior. (If n/a, enter “0”).**

If the EP has not used the Panel methodology to calculate patient volume, please enter a “0” in line 9. For more information on Panel methodology, please see the Final Rule, or the SCDHHS State Medicaid HIT Plan.

Enter data into fields 1-9; then, **select the Calculate** button.

Line 10 will display the Medicaid or Needy Individual patient volume percentage calculated from the attestation.

EHR Details

- **Line 11: Confirm the status of your EHR as Meaningful Use**

Upon completion of the Provider Eligibility Details Screen, select the **Save** button to save the data. The SLR will retain the information on the page.

To proceed to the next screen of the attestation, please select the **Next** button. To return to the previous screen, please select the **Previous** button.

Patient Volume:	1. Please indicate if you are using a clinic or group's patient volume as a proxy for your own (A group of healthcare practitioners organized as one legal entity under one TIN):	No
	2A. If yes, enter the TIN (FEIN) of the one legal entity:	0
	2B. To ensure this is a valid TIN, enter an NPI associated with the entity's TIN:	0
	3. If attesting to Needy Individual patient volume please click on the box to the right.	<input checked="" type="checkbox"/>
	4. Select the option that indicates the time period from which the 90-day patient volume period is derived:	* Prior calendar year
	5. Select the starting date of the 90-day period used to calculate patient volume percentage:	* 10/01/2016 (mm/dd/yyyy)
	6. Medicaid (or Needy Individual, as applicable) patient encounters during this period:	* 1000
	7. Total patient encounters during this period:	* 3000
	8. (If using the Panel methodology) Total number of Medicaid (or Needy Individual, as applicable) patients assigned to your panel with whom you did not have an encounter in this 90-day period but you did have an encounter in the 24 months prior: (If n/a, enter "0")	* 0
	9. (If using the Panel methodology) Total number of patients assigned to your panel from any Plan with whom you did not have an encounter in this 90-day period but you did have an encounter in the 24 months prior: (If n/a enter "0")	* 0
10. Medicaid or Needy Individual patient volume percentage:	33% <input type="button" value="Calculate"/>	
EHR Details:	11. Indicate the status of your EHR:	* <input checked="" type="radio"/> Meaningful User

Line 3: Only select the checkbox for Line 3 if attesting to Needy Individual patient volume.

Line 5: Providers attesting in consecutive years will not be allowed to select a start date that results in use of any part of the patient volume period from a previous attestation.

Lines 8 & 9: If the EP is NOT attesting to using the Panel methodology to calculate patient volume, enter "0" in Fields 8 & 9.

Provider Eligibility Details - 'Needy Individual' Patient Volume Additional Screen (EP attesting to Needy Individual Patient Volume)

If the EP is attesting to Needy Individual patient volume (selected the checkbox to line 3 to attest to “practicing predominantly”), the next screen that will display is the Needy Individual Patient Volume screen. In order to attest to meeting patient volume requirements based on Needy Individual patient volume, an EP must individually meet the definition of “**practicing predominantly**” in an FQHC or RHC. The Final Rule defines an EP who “practices predominantly” as “an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of six months **in the most recent calendar year** occurs at an FQHC or RHC.” In other words, the six-month period used for this determination must be from the calendar year preceding the PY.

In this screen, the EP will identify the FQHC/RHC location(s) for the attestation of practicing predominantly by completing an FQHC/RHC table. Note: If the EP has not selected the checkbox in line 3 to attest to “practicing predominantly,” and is attesting to Medicaid patient volume, this screen will not display. Instead, the next screen that will display will be the Provider Locations screen.

When the screen first displays, the FQHC/RHC table is empty awaiting attestation. Select the FQHC/RHC(s) from the options; the choices will populate the table. Once the FQHC/RHC table is complete, select **Next** to proceed to the next attestation screen.

FQHC/RHC

Practicing Predominantly:
As an EP who does not meet Medicaid patient volume thresholds, you can meet needy individual patient volume thresholds by attesting that you practiced predominantly (**over 50% of your patient encounters**) at an FQHC or RHC **over a six-month period in the most recent calendar year**.

To search, enter part of the FQHC/RHC name in the field provided and click Find. Select the location(s) from the FQHC/RHC listing. Your selection(s) will appear in the FQHC/RHC table displayed below. Delete options display at the left side of your listed choices should you wish to delete one or all of your selections, click the Delete link(s).

REMEMBER: Do not select the FQHC(s)/RHC(s) based on where you are working now. Your selected FQHC(s)/RHC(s) for this list are those at which you were working during the Previous Calendar Year. For example, if this attestation is for Program Year 2016, select FQH(s)/RHC(s) at which you were working during Calendar Year 2015.

You should upload employment statements from each of the selected FQHC/RHC. Each statement should be on that organization’s letterhead and include:

The statement of employment must include the following:

- 1) Date of hire,
- 2) Full-time/part-time, and
- 3) If part-time, the number of hours per week.

The letter should be addressed to the S.C. Medicaid EHR Incentive Program and signed by the appropriate Human Resources authority within the employing organization. Scan the signed letter from your employer, and upload the information to your attestation using the Document Upload screen

Provider Name	Address	City	State	Zip
No record found.				

Filter:

Enter part of the name in the search field, and select Find

Provider Name	Address	City	State
No record found.			
Filters: <input type="text" value="Provider Name"/> <input type="text" value="Little"/>	<input type="button" value="Find"/>	<input type="button" value="Reset"/>	
Provider Name	Address	City	State
<input type="button" value="Select"/> ROBESON HEALTH CARE CORP	402 NORTH PINE STREET STEA		
<input type="button" value="Select"/> FRANKLIN C FETTER FAMILY H	51 NASSAU STREET		
<input type="button" value="Select"/> BEAUFORT JASPER CHS INC	721 OKATIE HIGHWAY		
<input type="button" value="Select"/> ALLENDALE CO RURAL HEALTH	PO BOX 990		
<input type="button" value="Select"/> HEALTH CARE PARTNERS OF SC	PO BOX 2100		
<input type="button" value="Select"/> PALMETTO FAMILY PRIMARY	POST OFFICE BOX 326		
<input type="button" value="Select"/> CAROLINA HEALTH CTRS INC	535 JACKSON STREET	CALHOUN FALLS	SC
<input type="button" value="Select"/> CAROLINA HEALTH CTRS INC	219 GREENWOOD HWY	SALUDA	SC

REMEMBER: Do not select the FQHC(s)/RHC(s) based on where you are working now. Your selected FQHC(s)/RHC(s) for this list are those at which you were working during the **Previous Calendar Year**. For example, if this attestation is for PY 2018, select FQH(s)/RHC(s) at which you were working during Calendar Year 2017.

Provider Locations Screen

To be considered a meaningful user, at least 50% of an EP's outpatient encounters during an EHR reporting period (the period selected for reporting meaningful use measure data) must occur at practice(s) location(s) equipped with CEHRT. The Provider Locations screen collects information from the EP regarding all outpatient locations at which the EP renders services. The screenshot below provides an example of how the screen will display prior to information being entered.

Provider Locations

Provider Patient Volume Requirement: Beginning with program year 2013 a new requirement was established with 42 CFR 495.304 which states at least one clinical location used in the calculation of patient volume must have Certified Electronic Health Record Technology (CEHRT) during the program year for which the eligible professional (EP) attests to having adopted, implemented or upgraded to CEHRT, or attests they are a meaningful EHR user.

Provider Encounter Requirement During their EHR Reporting Period: During the EP's selected EHR Reporting Period (the minimum 90-day consecutive period selected for reporting meaningful use data) at least 50% of the EP's patient encounters must have occurred at a location or locations that were equipped with Certified EHR Technology* to be considered a meaningful user.

***Equipped with Certified EHR Technology would include:**

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

Please provide additional information regarding practice locations below:

Enter the number of locations where you provided services during the program year.

Use the text fields below to enter the details for all the locations where you provided services during the program year and all locations used in your patient volume calculations.

Check the CEHRT box if the location entered was equipped with CEHRT that had all the capabilities necessary for an EP to satisfy the meaningful use objectives and measures for the Stage of Meaningful Use and Program Year for which the provider is seeking an incentive payment.

Check the Patient Volume box if the location entered was utilized to meet the patient volume requirement.

Note: Meaningful Use Measure data will need to be calculated across all locations which had CEHRT during the EP's EHR Reporting Period. If the EP is not able to access data from a location, the EP cannot include those patients in the numerator but must include them in the denominator.

Edit	Address Line 1	Address Line 2	City	State	Zip Code	Zip Code Ext	CEHRT	Patient Volume	Delete
Modify	123 Circle Lane		Small Town	SC	99999		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Delete
	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	Add					

Ensure you click the "Add" button to add each location to the table above the text boxes. You will then be able to add additional locations. You can determine if you have successfully added a location when you see a "modify" link on the left; this link will allow you to edit the record if needed.

Once the EP enters information for the first provider location, and selects **Add**, the display will change to a more linear display. Information about additional locations must be typed into the fields under the column headings; then, select the **Add** button.

The EP must enter data for each practice location; for example, where the EP has indicated 2 locations, there must be 2 rows completed in the provider locations table. Should information be entered that is inconsistent (for example, only 1 description where the provider has indicated multiple locations), the SLR will display the following error message when the provider attempts to select **Next** to progress:

"The number of locations in which you provide services must equal the number of location descriptions entered below."

Enter the number of locations at which the EP provides outpatient services; then complete the provider locations table, indicating for each location if the location was used for patient volume data, and if the location currently has certified EHR technology.

Upon completion of the Provider Locations screen, select the **Save** button to save the data. The SLR will retain the information on the page.

To proceed to the next screen of the attestation, please select the **Next** button. To return to the previous screen, please select the **Previous** button.

Certified EHR Technology is technology certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to the Office of the National Coordinator (ONC). Learn more about the Standards and Certification Criteria for Electronic Health Record Technology 2014 Edition Final Rule at: <https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25595.pdf>.

In PY 2018 you must attest using technology certified to the 2014 Edition or the 2015 Edition. To meet Stage 3 requirements, all providers must use technology certified to the 2015 Edition. A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures.

On the CEHRT details screen, the EP will enter information to provide the EP’s attestation to the certified EHR technology (CEHRT). You are attesting to Meaningful Use, so the EP will attest to the CEHRT(s) that was used for the Meaningful Use EHR Reporting period.

The ONC Certified Health IT Product List (CHPL) serves as the official listing of certified products: <https://chpl.healthit.gov/#/resources/download>. This Web site is the single authority to obtain the CHPL/ONC Product Number(s) and the 15-character alphanumeric CMS EHR Certification ID for the certified EHR technology products(s). Please note: the left navigation link, “Additional Resources,” will expand when clicked to display a link to the ONC CHPL Website page to lookup products and obtain the related CEHRT ID.

Step 1: Complete the My Certified Health IT Product List.

Certified EHR technology must be a complete product, or combination of multiple products, that offers 100% of the criteria required by the Medicare and Medicaid EHR Incentive Programs.

Enter information into the tables listed for the certified EHR technology product(s) by completing the fields for **Product Name and Version #, Developer, and CHPL ID**. Select **Click Here to Add Product to My CHPL** to populate the information into the CHPL product table.

My Certified Health IT Product List

Using the data fields below, enter the Product Name, Version Number, Developer Name, and CHPL Product Number for **each and every** product that you used during your EHR Reporting Period.

After you enter all four fields, select the button “Click Here to Add Product to My CHPL” to add it. You will then be able to add additional products. Check below to ensure your products have been entered correctly.

Payment Year	Sequence Number	Product Name	Version #	Developer	CHPL Product Number
No uploaded product found.					

Product Name *

Version # (enter "0" if not applicable) *

Developer *

CHPL Product Number *

Click the button above to add your product to the My Certification Health IT Product List.

Failure to select “Click Here to Add Product,” will result in the following error message:
“There cannot be any empty Certified Health IT Product List field. Please complete the Certified Health IT Product table.”

Step 2: Enter the CMS EHR Certification ID of your certified EHR Technology.

The CMS EHR Certification ID is a 15-character alphanumeric ID. Clicking the **What Is This** link located next to the field will enable the EP to view the ONC CHPL Web site. For more information on steps to take to determine the CMS EHR Certification ID for the certified EHR technology, click the link under the ‘Using the CHPL Application’ to **Learn More**.

- If the EP provided the CMS Certification ID of the certified EHR technology during the registration with the CMS Registration and Attestation System (optional), this field will pre-populate that information. **If the field is pre-populated, please review the information to be sure that it still accurately reflects the CEHRT used during the MU EHR reporting period.**
- If there is no information displayed in the CMS Certification ID field, please enter information into this field.

CMS EHR Certification ID

If your EHR vendor has already supplied you with a CMS EHR Certification ID for this program year’s attestation, you do not need to create another one. If you do not have a CMS EHR Certification ID, [use the link here](#) to create one using the products and version numbers you entered in the “My Certified Health IT Product List”.

You **MUST** enter your CMS EHR Certification ID in the [reverse lookup here](#) first to confirm that all of the products and version numbers exactly match the ones you entered in the “My Certified Health IT Product List” above. Once you have verified this, enter your CMS EHR Certification ID in the text box below. This is an alphanumeric ID, with letters in ALL CAPS.

* [What is this?](#)

Step 3: Complete the Certified EHR Technology Description.

EHR Details Screen: Meaningful Use Attestation

The CMS EHR Certification ID and the CHPL table should reflect information for the certified EHR technology relative to the attestation to meaningful use (the CEHRT(s) used in the EHR reporting period). If the EHR details have changed from the previous year’s attestation, please enter details of the certified EHR technology that was in place during the EHR/Meaningful Use reporting period.

Certified EHR Technology Description

In the text box, you must describe any changes made to the CEHRT relative to this program year's MU attestation. Include for each product listed in the My CHPL table a description of the commitment to the CEHRT, including product name and version, evidence retained, and how it is being retained to support your attestation and meaningful use data [invoice(s) and receipt(s) for payment/purchase agreement/license agreement, or binding contract, EHR reports, document retention schedules (note: documents MUST be retained for a minimum of 6 years from the date of attestation), archival procedures for related documentation, who will be in charge of storing and locating these documents, etc.] with applicable date(s).

Example (provider returning to the S.C. Medicaid EHR Incentive Program to attest to MU):

Since my last attestation to the S.C. Medicaid EHR Incentive Program, [Organization/Provider] has changed CEHRT vendors. We are attesting with 2014 Edition certified EHR technology, [myBestCEHRT, version 123], implemented XX/XX/XXXX, and have retained evidence of commitment to this technology through an invoice and payment receipt dated XX/XX/XXXX. I have generated reports with help from my EHR vendor(s), which provide evidence of my usage of CEHRT and the data I attested to for meaningful use. I have archived both written and digital copies of these documents and have also uploaded them to my attestation for retrieval in case they are requested, or in the event of a post-payment audit. I have sought input from my vendor on how I can continue to successfully attest to meaningful use in the future and how I can retain evidence to support my attestation if requested. John Public is responsible for archiving and storing this evidence and is knowledgeable about how to retrieve it. In his absence, Jane Public can access these documents, or her successor. I have also discussed and have planned with my EHR vendor how I can archive this data in the event I change EHR vendors or practice/ location.

*

Previous

Next

Save

Cancel

Step 4: Save Your Information

Select the **Save** button before leaving this screen.

The SLR will run a check against the ONC CHPL site to validate that the CMS Certification ID that was entered is a valid CMS Certification ID. There may be slight delay as the system runs this check. If the CMS Certification ID supplied is not valid, the following error message will display: **“Not a valid CMS certification ID.”**

To continue to the next attestation screen, select the **Next** button at the bottom of the screen.

[Meaningful Use Questionnaire](#)

For Program Year 2017 Only, Eligible Professionals have the option to report to the Stage 3 Meaningful Use Objectives early. This option should only be taken if the Eligible Professional has a 2015 Edition Certified EHR Technology (CEHRT) or has a 2014 Edition CEHRT in combination with 2015 Edition modules that can produce the responses for the objectives required for a Stage 3 attestation. In addition any Eligible Professional that selects to report Stage 3 early may also utilize a 90 day EHR Reporting Period for this attestation only.

* Would you like to attest using the Stage 3 Objectives for Program Year 2017?

Yes No

The "EHR reporting period" is the timeframe for which meaningful use measure data was collected and reported for your attestation. Please provide the continuous EHR Reporting period associated with this attestation (this period must be a minimum of 90 consecutive days within the dates of January 1 and December 31, 2017):

* EHR Reporting Period Start Date: (mm/dd/yy)

* EHR Reporting Period End Date: (mm/dd/yy)

* Is the reporting period for your CQM submission the same period as your EHR reporting period listed above?

Yes No

Please enter the start and end date for your CQM submission:

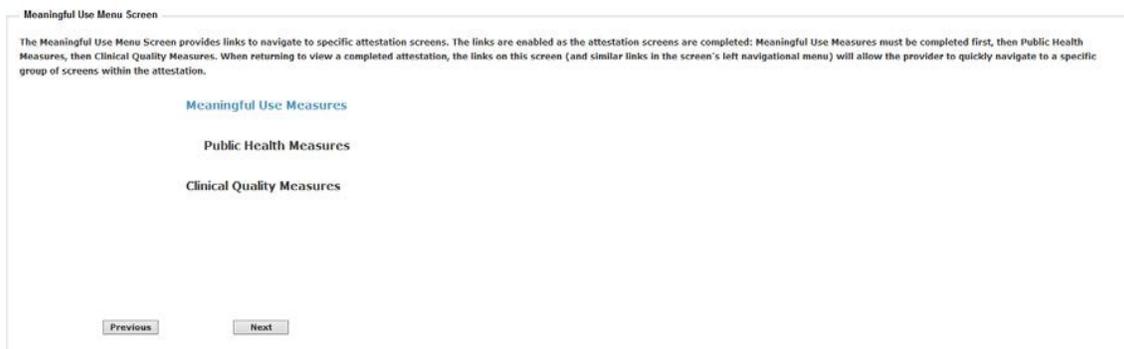
* CQM Reporting Start Date: (mm/dd/yy)

* CQM Reporting End Date: (mm/dd/yy)

Indicate if you plan to attest using Stage 3 Objectives. Then enter the EHR Reporting Period Start and End Dates and the CQM entries.

Save your information then continue to the next attestation screen by selecting **Next**

The Meaningful Use Menu Screen allows the EP to navigate directly to 1 of the 3 attestation data entry sections: Meaningful Use Measures except Public Health Measures, Public Health Measures and Clinical Quality Measures.



Meaningful Use Measures Screens

A screen or series of screens will be displayed in numerical order of each MU Objective / Measure for PY 2018. The screens will be displayed to the EP according to the EP's previous selection of Modified Stage 2 or Stage 3 MU in PY 2018.

The EP must attest to each MU Objective in order by selecting answers and/or entering data for multiple screens prior to progressing to the next MU Objective. Questions deal with meeting the measure's required threshold or eligible exclusions. After answering these questions and when clicking Save or Next, the following errors or warning messages may appear to assist the EP.

- Error statements may include the following.
 - “Measure response is required.”
 - “Your data entries indicate you have not met the measure for this objective. Please review your entries.”

- Warning statements may include the following.
 - “Your data entries indicate you have not met the measure for this objective; please review. If your data entries are not correct, please select “Cancel” and correct your data entries as applicable.”

Meaningful Use Objective 4 of 10

This is an example of the screens for each meaningful use objective.

(* Red asterisk indicates a required field.)

Electronic Prescribing

Objective: Generate and transmit permissible prescriptions electronically (eRx).

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

Complete the following:

* Patient Records: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

- This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- This data was extracted only from patient records maintained using certified EHR technology.

Exclusion 1: Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period.

* I have determined that I am eligible for the exclusion and I wish to claim it.

- Yes No

Exclusion 2: Any EP who does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.

* I have determined that I am eligible for the exclusion and I wish to claim it.

- Yes No

Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.

Denominator: Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed.

* Numerator: * Denominator:

* Which eRx service is used?

* Name a pharmacy that you transmit to.

The Meaningful Use Specification Sheets for PY2018 are located in appendices included with this document or at CMS links:

Modified Stage 2

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_ModifiedStage2_2018.pdf

Stage 3

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_Stage3_2018.pdf

Also, CMS provides tip sheets, fact sheets on public health reporting, and additional resources found on this website:

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2018ProgramRequirementsMedicaid.html>

Clinical Quality Measure Screens

EPs attesting for any MU stage are required to report 6 of 53 CQMs using EHR technology that is certified to the 2014 standards and certification criteria. EPs no longer have to choose the CQMs from 3 National Quality Strategy (NQS) domains. EPs are expected to select the CQMs that best apply to their scope of practice and/or unique patient population

All fields must be entered to continue to the next measure screen. The responses entered must be reported from the certified EHR reporting for the EHR reporting period even if the report states zero.

The following details other requirements of most of these screens:

- Please enter a Numerator. 0 is acceptable if that was reported by the EHR technology.
- Numerator must be a whole number.
- Please enter a Denominator. 0 is acceptable if there is no measure population.
- Denominator must be a whole number.
- Please enter Performance Rate. 0 is acceptable if that was reported by the EHR technology.
- Please enter an Exclusion. 0 is acceptable if that was reported by the EHR technology.
- The Numerator should be less than or equal to the Denominator.

Please note that selecting **Previous** prior to saving will result in the data on the current screen not being saved. Selecting **Next** or **Save** will save data entered on the screen.

Summary of Measures Screens

The Meaningful Use Summary of Measures Selection Screen allows the EP to return to the various MU attestation sections prior to submitting the final attestation. Please note that the EP may return to this screen from within the attestation by selecting the “Pre-Attestation Measure Summary” left navigation link located at the top left of the screen.

Summary of Measures (Year 5 Attestation / Program Year 2017)

[Summary of Measures](#)

Please select the desired measure link below to review the details of your attestation. This is your last chance to view/edit the information you have entered before you attest. Please review your information as you will be unable to edit your information after you attest.

[Meaningful Use Measures Summary](#)

[Public Health Measures Summary](#)

[Clinical Quality Measures Summary](#)

Providers attesting to meaningful use must upload documentation to support the attestation for selected public health menu objective(s) measures and/or exclusions. The SCDHHS Division of Health Information Technology (Division of HIT) may also contact a provider to request documentation to support or clarify an attestation. The Document Upload screen provides the means for providers to attach PDF, Word, or Excel files to the provider attestation.

To upload a document, select the **Browse** button and locate the desired information. Then, select the **Upload** button.

If the upload is successful, the SLR will display a message:

'You have successfully uploaded: [File Name].'

The Document Upload screen allows you to upload required documentation (PDF, Word, or Excel files) to support your attestation. Should you have difficulty attaching a file, please e-mail the SCDHHS Division of Health Information Technology (HIT) staff for assistance. (There is a link for Send E-mail to HIT Division located in the left navigation links on this page.)

Required Documentation Uploads:

- 1) Eligible Hospitals: Hospitals are required to complete and upload documentation required for SCDHHS to validate the attestation of Medicaid patient volume: the HIT Hospital Worksheet, the HIT Volume Calculation Worksheet, and other documentation to respond to questions in the EH Checklist. Links to these templates are available for download on the Hospital Eligibility Details screen.
- 2) Providers attesting to the Meaningful Use Measures: You are required to upload documentation to support your attestation related to Public Health Measures. Please note: If you are an Eligible Hospital that has successfully attested to meaningful use with the Medicare EHR Incentive Program for this participation year, you are "deemed" a meaningful user for purposes of the Medicaid EHR Incentive program and are not required to re-attest to meaningful use or upload this documentation.

For Meaningful Use Public Health Reporting

If you attested to **Active Engagement** with a public health or specialized registry, upload "written communication" from the registry that is specific to the attested program year. For example, if the EP has submitted an attestation for **PY2015 MU**, the EP must upload documentation from the public health registry or specialized registry that supports **active engagement in 2015**.

Other Documentation Uploads:

The SCDHHS may contact you after your attestation submission to request other documentation to support your attestation. Documentation uploaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre-payment review or post-payment audit. The provider must retain all documentation supporting the attestation for a minimum of 6 years from the provider's last participation year in the Program.

Payment Year	File Name	Description	Document Uploaded Date
No uploaded document found.			

Upload a new document: (Word, Excel, or PDF) Please select the documentation type:

The EP may review the uploaded document by selecting the **View** button. To delete the file, select the **Delete** button. Once the attestation is submitted, uploaded documents may not be deleted.

Public Health Registries

To contact public health registries in the State of South Carolina please use the following contact information, or contact HITSC@SCDHHS.GOV with questions. Please contact DHEC for the latest and most comprehensive list of public health registries available at the time of attestation.

Public Health Agency (S.C. DHEC): <http://www.scdhec.gov/Health/FHPPF/MeaningfulUse/EligibleProviders/>

- S.C. DHEC Immunization Registry: sciregistry@dhec.sc.gov
- S.C. DHEC Cancer Registry: CancerRegistryMU@dhec.sc.gov
- S.C. DHEC Electronic Reportable Labs and Syndromic Surveillance Registries: muhelpdesk@dhec.sc.gov

Attestation Statements

The EP must attest to statements 1-8 for their demonstration of meaningful use. Please indicate your attestation of each statement by checking the box to the left. Statements 9 and 10 are optional and are not required for meaningful use. You will not be able to submit your attestation unless you attest to statements 1-8.

Attestations for the Demonstration of Meaningful Use

In order to comply with 42 CFR 495.40 the provider must attest to the following statements for their demonstration of meaningful use criteria.

Please indicate your attestation of the following statements by checking the box below each statement for which you wish to attest.

1. Acknowledges the requirement to cooperate in good faith with ONC direct review of your health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received.
 I attest to statement 1
2. If requested, you will or have cooperated in good faith with ONC direct review of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the EP in the field.
 I attest to statement 2
3. Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.
 I attest to statement 3
4. Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times, connected in accordance with applicable law.
 I attest to statement 4
5. Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times, compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170.
 I attest to statement 5
6. Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times, implemented in a manner that allowed for timely access by patients to their electronic health information.
 I attest to statement 6
7. Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times, implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300j(3)), including unaffiliated providers, and with disparate certified EHR technology and vendors.
 I attest to statement 7
8. Will or have responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300j(3)), and other persons, regardless of the requestor's affiliation or technology vendor.
 I attest to statement 8

The attestations questions and statements below are optional and will not impact the outcome of your attestation.

9. Acknowledges the option to cooperate in good faith with ONC-ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received.
 I attest to statement 9
10. If requested, will or have cooperated in good faith with ONC-ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating capabilities as implemented and used by the EP in the field.
 I attest to statement 10

Attestation Screen

The Attestation screen displays a summary of information from the provider attestation. To also view the information from the provider attestation for the meaningful use objectives, the provider may select the **Pre-Attestation Measure Summary** navigation link located at the top left of the screen. If, while reviewing the information, the provider decides to revise information he or she may return to the data entry field to modify information before submitting the attestation. Please note, however, that once the **Submit** button is selected, the attestation will be locked. In the screenshot that follows, a partial display of the Attestation Screen provides an example of the summary of information. Note that the link to the Pre-Attestation Measure Summary is also shown.

Before submitting the attestation, read the Attestation Statement that is included on the Attestation Screen. To submit the attestation, enter the initials, the NPI, and select Submit.

Note: If the attestation to the meaningful use objectives has met the requirements, the Submit button will be displayed as active and will allow selection. If the attestation to the meaningful use objectives has not met the requirements, the Submit button will be grayed out, and the following error message will display: “Your MU attestation cannot be accepted. One or more of the measures did not meet MU requirements. Please select the navigation link to the Pre-Attestation Measure Summary to view all measures and the corresponding attestation data.”

Once an attestation is successfully submitted for meaningful use, the EP may select the **Post-Attestation Measure Summary** to view all measures and the corresponding calculations.

The screenshot shows the 'Attestation (Year 2 Attestation)' screen. The left navigation menu includes links such as 'CMS/NLR', 'Meaningful Use Questionnaire', and 'Pre-Attestation Measure Summary'. A yellow arrow points to the 'Pre-Attestation Measure Summary' link. The main content area displays a form for provider information and a table for Certified Health IT Product List (CHPL).

Please verify the following information:			
CMS/NLR:			
Applicant National Provider Identifier (NPI):	1111111111	Name:	Clopher Wired
Applicant TIN:	999999999	Address 1:	323 Elm CT
Payee National Provider	222222222	Address 2:	
		City/State:	Bowling Green / SC
		Zip Code:	43472 - 1447
		Phone Number:	8595774692
		Email:	G@a.com
		Specialty:	
Payment Year:	2	Payee Name:	Me Myself and Irene
Provider Type:	Nurse_Practitioner		
Payee Medicaid ID:	FQCD24		

Certified Health IT Product List (CHPL):		
Product Name and Version #	Vendor Name	CHPL Product Number
Test Product Y 2	Test Vendor Y 2	Test CHPL Product No Y 2
Test Product	Test Vendor	Test CHPL Product No

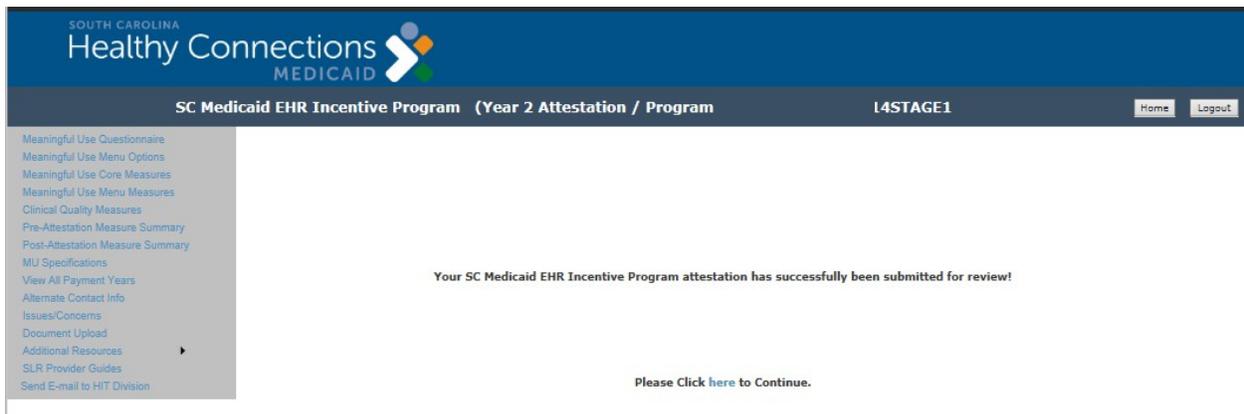
Buttons: Previous, Submit, Print

The following message appears in RED on the attestation screen if MU criteria are not met:

"Your MU attestation cannot be accepted. One or more of the measures did not meet MU requirements. Please select the navigation link to the Pre-Attestation Measure Summary to view all measures and the corresponding attestation data."

When this error appears, the submit button is also greyed out.

Once a provider has successfully submitted an attestation, the following screen will display:



Any provider attesting to receive an EHR incentive payment potentially can be subject to audit. ALL relative supporting documentation (in either paper or electronic format) used in the completion of the attestation responses must be retained and easily retrievable for a minimum of six years from the last year of participation in the Program.

Once the attestation is submitted, the SCDHHS Division of Health Information Technology (HIT) will review it to determine if it meets the requirements of the S.C. Medicaid Promoting Interoperability Program. Should the HIT Division staff have any questions concerning the attestation, they will contact the EP using the e-mail address provided by the EP to CMS during registration and, if necessary, alternate contact information provided by the EP in the SLR.

Approved incentives are incorporated into the SCDHHS' weekly claims payment cycle and paid as **credit** adjustments to the individual or entity designated by the EP as the Payee. If the EP has reassigned the incentive, the EP should forward this important information to the Payee.

Payment Notification

Providers will be notified by e-mail of payments. The payment e-mail will provide information to identify provider-specific information on the remittance advice (RA).

- Payee Name
- Eligible Provider Who Earned the Incentive
- Payment Date
- Incentive Amount
- Provider Own Reference Number

Remittance Advice

Information about each EP's incentive will be displayed as a separate line item in the Adjustments section. The names of the individuals for whom incentives are being issued will not be detailed on the RA; however, each line item will display information in columns labeled Provider Own Reference Number, Claim Reference Number, Action, and Debit/Credit Amount.

An example of a remittance advice with information about 3 separate incentive credits follows.

PROVIDERS OWN REF. NUMBER	CLAIM REFERENCE NUMBER	SERVICE DATE(S)	PROC / DRUG CODE	RECIPIENT ID. NUMBER	RECIPIENT NAME LAST NAME I I	ORIG. F M DATE	ORIGINAL CHECK PAYMENT	ACTION	DEBIT / CREDIT AMOUNT	EXCESS REFUND
EHRRPQH002	11147010540301000	-						INCENTIVE	21250.00	
EHRRPQH003	11147010550301000	-						INCENTIVE	21250.00	
EHRRPQH004	11147010560301000	-						INCENTIVE	21250.00	
PAGE TOTAL:									63750.00	0.00

PROVIDER INCENTIVE CREDIT AMOUNT	DEBIT BALANCE PRIOR TO THIS REMITTANCE	MEDICAID TOTAL	CERTIFIED AMT	TO BE REFUNDED IN THE FUTURE
63750.00	0.00	8991.53	0.00	0.00
		ADJUSTMENTS		
		63750.00	0.00	
	YOUR CURRENT DEBIT BALANCE	* CHECK TOTAL	CHECK NUMBER	PROVIDER NAME AND ADDRESS
	0.00	72741.53	6712051	Provider Name Street Address City, State Zip Code

* FUNDS AUTOMATICALLY DEPOSITED TO:
BANK NAME: SECURITY FEDERAL SAVINGS ACCOUNT #: XXXXXXXXXXXX
NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.



APPENDIX A
Modified Stage 2 Objectives and Measures for 2018

Medicaid Promoting Interoperability Program Modified Stage 2 Eligible Professionals

Objectives and Measures for 2018

Objective 1 of 10 Updated: July 2018

Protect Patient Health Information	
Objective	Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.
Measure	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT 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 eligible professional's (EP) risk management process.

Table of Contents

- Attestation Requirements
- Additional Information
- Regulatory References
- Certification and Standards Criteria

Attestation Requirements

YES/NO

Eligible professionals (EPs) must attest YES to conducting or reviewing a security risk analysis and implementing security updates as necessary and correcting identified security deficiencies to meet this measure.

Additional Information

- EPs must conduct or review a security risk analysis of CEHRT including addressing encryption/security of data, and implement updates as necessary at least once each calendar year and attest to conducting the analysis or review.
- An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each Promoting Interoperability (PI) reporting period. Any security updates and deficiencies that are identified should be included in the provider's risk management process and implemented or corrected as dictated by that process.
- It is acceptable for the security risk analysis to be conducted outside the PI reporting period; however, the analysis must be unique for each PI reporting period, the scope must include the full PI reporting period, and must be conducted within the calendar year of the PI reporting period (January 1st – December 31st).
- The parameters of the security risk analysis are defined 45 CFR 164.308(a)(1), which was created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule. Meaningful use does not impose new or expanded requirements on the HIPAA Security



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Rule nor does it require specific use of every certification and standard that is included in certification of EHR technology. More information on the HIPAA Security Rule can be found at: <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/>.

- HHS Office for Civil Rights (OCR) has issued guidance on conducting a security risk analysis in accordance with the HIPAA Security Rule: <http://www.hhs.gov/hipaa/for-professionals/security/guidance/guidance-risk-analysis/index.html>.
- Additional free tools and resources available to assist providers include a Security Risk Assessment (SRA) Tool developed by Office of the National Coordinator for Health Information Technology (ONC) and OCR: <http://www.healthit.gov/providers-professionals/security-risk-assessment-tool>

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i) and (ii)(A). For further discussion please see [80 FR 62793](http://www.federalregister.gov).
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.314(d)(4), (d)(2), (d)(3), (d)(7), (d)(1), (d)(5), (d)(6), (d)(8), and optionally (d)(9).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
<p>§ 170.314(d)(1) Authentication, access control, and authorization</p>	<p>(i) Verify against a unique identifier(s) (e.g., username or number) that a person seeking access to electronic health information is the one claimed; and</p> <p>(ii) Establish the type of access to electronic health information a user is permitted based on the unique identifier(s) provided in paragraph (d)(1)(i) of this section, and the actions the user is permitted to perform with the EHR technology.</p>
<p>§ 170.314(d)(2) Auditable events and tamper-resistance</p>	<p>(i) Record actions. EHR technology must be able to:</p> <p>(A) Record actions related to electronic health information in accordance with the standard specified in § 170.210(e)(1);</p> <p>(B) Record the audit log status (enabled or disabled) in accordance with the standard specified in § 170.210(e)(2) unless it cannot be disabled by any user; and</p> <p>(C) Record the encryption status (enabled or disabled) of electronic health information locally stored on end-user devices by EHR technology in accordance with the standard specified in § 170.210(e)(3) unless the EHR technology prevents electronic</p>



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	<p>health information from being locally stored on end-user devices (see 170.314(d)(7) of this section).</p> <p>(ii) Default setting. EHR technology must be set by default to perform the capabilities specified in paragraph (d)(2)(i)(A) of this section and, where applicable, paragraphs (d)(2)(i)(B) or (C), or both paragraphs (d)(2)(i)(B) and (C).</p> <p>(iii) When disabling the audit log is permitted. For each capability specified in paragraphs (d)(2)(i)(A) through (C) of this section that EHR technology permits to be disabled, the ability to do so must be restricted to a limited set of identified users.</p> <p>(iv) Audit log protection. Actions and statuses recorded in accordance with paragraph (d)(2)(i) of this section must not be capable of being changed, overwritten, or deleted by the EHR technology.</p> <p>(v) Detection. EHR technology must be able to detect whether the audit log has been altered.</p>
<p>§ 170.314(d)(3) Audit report(s)</p>	<p>Enable a user to create an audit report for a specific time period and to sort entries in the audit log according to each of the data specified in the standards at § 170.210(e).</p>
<p>§170.314(d)(4) Amendments</p>	<p>Enable a user to electronically select the record affected by a patient's request for amendment and perform the capabilities specified in paragraphs (d)(4)(i) or (ii) of this section.</p> <p>(i) Accepted amendment -For an accepted amendment, append the amendment to the affected record or include a link that indicates the amendment's location.</p> <p>(ii) Denied amendment -For a denied amendment, at a minimum, append the request and denial of the request to the affected record or include a link that indicates this information's location.</p>
<p>§ 170.314(d)(5) Automatic log-off</p>	<p>Prevent a user from gaining further access to an electronic session after a predetermined time of inactivity.</p>
<p>§ 170.314(d)(6) Emergency access</p>	<p>Permit an identified set of users to access electronic health information during an emergency.</p>
<p>§ 170.314(d)(7) End-user device encryption</p>	<p>Paragraph (d)(7)(i) or (ii) of this section must be met to satisfy this certification criterion.</p> <p>(i) EHR technology that is designed to locally store electronic health information on end-user devices must encrypt the electronic health information stored on such devices after use of EHR technology on those devices stops.</p> <p>(A) Electronic health information that is stored must be encrypted in accordance with the standard specified in § 170.210(a)(1).</p>



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	<p>(B) Default setting. EHR technology must be set by default to perform this capability and, unless this configuration cannot be disabled by any user, the ability to change the configuration must be restricted to a limited set of identified users.</p> <p>(ii) EHR technology is designed to prevent electronic health information from being locally stored on end-user devices after use of EHR technology on those devices stops.</p>
§ 170.314(d)(8) Integrity	<p>(i) Create a message digest in accordance with the standard specified in §170.210(c).</p> <p>(ii) Verify in accordance with the standard specified in § 170.210(c) upon receipt of electronically exchanged health information that such information has not been altered.</p>
§ 170.314(d)(9) Optional-Accounting of disclosures	Record disclosures made for treatment, payment, and health care operations in accordance with the standard specified in § 170.210(d).

Standards Criteria	
<p>§ 170.210(e)(1), § 170.210(e)(2) and § 170.210(e)(3) Record actions related to electronic health information, audit log status, and encryption status</p>	<p>(i) The audit log must record the information specified in sections 7.2 through 7.4, 7.6, and 7.7 of the standard specified at § 170.210(h) when EHR technology is in use.</p> <p>(ii) The date and time must be recorded in accordance with the standard specified at § 170.210(g).</p> <p>The audit log must record the information specified in sections 7.2 and 7.4 of the standard specified at § 170.210(h) when the encryption status of electronic health information locally stored by EHR technology on end-user devices is changed. The date and time each action occurs in accordance with the standard specified at § 170.210(g).</p>
§ 170.210(a)(1) Encryption and decryption of electronic health information	Any encryption algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the Federal Information Processing Standards (FIPS) Publication 140-2 (incorporated by reference in §170.299).
§ 170.210(c) Create message digest	A hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm) as specified by the National Institute of Standards and Technology (NIST) in FIPS PUB 180-4 (March, 2012) must be used to verify that electronic health information has not been altered.



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§ 170.210(d) Record treatment, payment, and health care operations disclosures

The date, time, patient identification, user identification, and a description of the disclosure must be recorded for disclosures for treatment, payment, and health care operations, as these terms are defined at 45 CFR 164.501.



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Objectives and Measures for 2018

Objective 2 of 10
Updated: July 2018

Clinical Decision Support	
Objective	Use clinical decision support (CDS) to improve performance on high-priority health conditions.
Measure	<p>Eligible professionals (Eps) must satisfy both of the following measures in order to meet the objective:</p> <p>Measure 1 – Implement 5 CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire Promoting Interoperability (PI) reporting period. Absent 4 CQMs related to an EP’s scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.</p> <p>Measure 2 – The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period.</p>
Exclusion	For the second measure, any EP who writes fewer than 100 medication orders during the PI reporting period.

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Definition of Terms

Clinical Decision Support – Health information technology (HIT) functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.



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Attestation Requirements

YES/NO/EXCLUSION

MEASURE 1:

- EPs must attest YES to implementing 5 CDS interventions related to 4 or more CQMs at a relevant point in patient care for the entire PI reporting period.

MEASURE 2:

- EPs must attest YES to enabling and implementing the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period.

EXCLUSION:

- For the second measure, any EP who writes fewer than 100 medication orders during the PI reporting period.

Additional Information

- If there are limited CQMs applicable to an EP's scope of practice, the EP should implement CDS interventions that he or she believes will drive improvements in the delivery of care for the high-priority health conditions relevant to their specialty and patient population.
- Drug-drug and drug-allergy interaction alerts are separate from the 5 CDS interventions and do not count toward the 5 required for this first measure.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(2)(i) and (ii). For further discussion please see [80 FR 62795](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(8) and (a)(2).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.



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Certification Criteria

§170.314(a)(8) Clinical decision support

(i) Evidence-based decision support interventions. Enable a limited set of identified users to select (i.e., activate) one or more electronic CDS interventions (in addition to drug-drug and drug-allergy contraindication checking) based on each one and at least one combination of the following data:

- (A) Problem list;
- (B) Medication list;
- (C) Medication allergy list;
- (D) Demographics;
- (E) Laboratory tests and values/results; and
- (F) Vital signs.

(ii) Linked referential CDS.

(A) EHR technology must be able to:

- (a) Electronically identify for a user diagnostic and therapeutic reference information; or
- (b) Electronically identify for a user diagnostic and therapeutic reference information in accordance with the standard specified at § 170.204(b) and the implementation specifications at § 170.204 (b)(1) or (2).

(B) For paragraph (a)(8)(ii)(A) of this section, EHR technology must be able to electronically identify for a user diagnostic or therapeutic reference information based on each one and at least one combination of the following data referenced in paragraphs (a)(8)(i)(A) through (F) of this section:

(iii) CDS configuration.

(A) Enable interventions and reference resources specified in paragraphs (a)(8)(i) and (ii) of this section to be configured by a limited set of identified users (e.g., system administrator) based on a user's role.

(B) EHR technology must enable interventions to be electronically triggered:

(a) Based on the data referenced in paragraphs (a)(8)(i)(A) through (F) of this section.

(b) When a patient's medications, medication allergies, and problems are incorporated from a transition of care/referral summary received pursuant to paragraph (b)(1)(iii) of this section.

(c) Ambulatory setting only. When a patient's laboratory tests and values/results are incorporated pursuant to paragraph (b)(5)(i)(A)(1) of this section.



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	<p>(iv) Automatically and electronically interact. Interventions triggered in accordance with paragraphs (a)(8)(i) through (iii) of this section must automatically and electronically occur when a user is interacting with EHR technology.</p> <p>(v) Source attributes. Enable a user to review the attributes as indicated for all CDS resources:</p> <p>(A) For evidence-based decision support interventions under paragraph (a)(8)(i) of this section:</p> <p>(a) Bibliographic citation of the intervention (clinical research/guideline);</p> <p>(b) Developer of the intervention (translation from clinical research/guideline);</p> <p>(c) Funding source of the intervention development technical implementation; and</p> <p>(d) Release and, if applicable, revision date(s) of the intervention or reference source.</p> <p>For linked referential CDS in paragraph (a)(8)(ii) of this section and drug-drug, drug-allergy interaction checks in paragraph(a)(2) of this section, the developer of the intervention, and where clinically indicated, the bibliographic citation of the intervention (clinical research/guideline).</p>
<p>170.314 (a)(2) Drug-drug, drug-allergy interaction checks</p>	<p>(i) Interventions. Before a medication order is completed and acted upon during computerized provider order entry (CPOE), interventions must automatically and electronically indicate to a user drug-drug and drug-allergy contraindications based on a patient's medication list and medication allergy list.</p> <p>(ii) Adjustments.</p> <p>(A) Enable the severity level of interventions provided for drug-drug interaction checks to be adjusted.</p> <p>Limit the ability to adjust severity levels to an identified set of users or available as a system administrative function.</p>

Standards Criteria	
<p>§ 170.204(b) Reference source</p>	<p>HL7 Version 3 Standard: Context-Aware Retrieval Application (Infobutton) (incorporated by reference in § 170.299).</p>
<p>§ 170.204 (b)(1) or (2). Implementation specifications</p>	<p>HL7 Version 3 Standard: Context-Aware Retrieval Application (Infobutton) (incorporated by reference in § 170.299).</p> <p>(1) Implementation specifications. HL7 Version 3 Implementation Guide: URL-Based Implementations of</p>



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- the Context-Aware Information Retrieval (Infobutton) Domain, (incorporated by reference in § 170.299).
- (2) Implementation specifications. HL7 Version 3 Implementation Guide: Context-Aware Knowledge Retrieval (Infobutton) Service-Oriented Architecture Implementation Guide, (incorporated by reference in § 170.299).



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Computerized Provider Order Entry	
Objective	Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.
Measure	<p>An eligible professional (EP), through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective:</p> <p>Measure 1 – More than 60 percent of medication orders created by the EP during the Promoting Interoperability (PI) reporting period are recorded using CPOE.</p> <p>Measure 2 – More than 30 percent of laboratory orders created by the EP during the PI reporting period are recorded using CPOE.</p> <p>Measure 3 – More than 30 percent of radiology orders created by the EP during the PI reporting period are recorded using CPOE.</p>
Exclusion	<p>Measure 1 – Any EP who writes fewer than 100 medication orders during the PI reporting period.</p> <p>Measure 2 – Any EP who writes fewer than 100 laboratory orders during the PI reporting period.</p> <p>Measure 3 – Any EP who writes fewer than 100 radiology orders during the PI reporting period.</p>

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Definition of Terms

Computerized Provider Order Entry (CPOE) – A provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.



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Laboratory Order – An order for any service provided by a laboratory that could not be provided by a non-laboratory.

Laboratory – A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Radiology Order – An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long as the policy is consistent across all patients and for the entire PI reporting period.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

MEASURE 1:

- DENOMINATOR: Number of medication orders created by the EP during the PI reporting period.
- NUMERATOR: The number of orders in the denominator recorded using CPOE.
- THRESHOLD: The resulting percentage must be more than 60 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who writes fewer than 100 medication orders during the PI reporting period.

MEASURE 2:

- DENOMINATOR: Number of laboratory orders created by the EP during the PI reporting period.
- NUMERATOR: The number of orders in the denominator recorded using CPOE.
- THRESHOLD: The resulting percentage must be more than 30 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who writes fewer than 100 laboratory orders during the PI reporting period.

MEASURE 3:

- DENOMINATOR: Number of radiology orders created by the EP during the PI reporting period.
- NUMERATOR: The number of orders in the denominator recorded using CPOE.



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- **THRESHOLD:** The resulting percentage must be more than 30 percent in order for an EP to meet this measure.
- **EXCLUSION:** Any EP who writes fewer than 100 radiology orders during the PI reporting period.

Additional Information

- The EP is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- The CPOE function must be used to create the first record of the order that becomes part of the patient's medical record and before any action can be taken on the order to count in the numerator.
- In some situations, it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under his/her direct supervision. Therefore, in these situations, so long as the order is entered using CPOE by a licensed healthcare professional or certified medical assistant to create the first record of that order as it becomes part of the patient's medical record, these orders would count in the numerator of the CPOE measure.
- Any licensed healthcare professionals and clinical staff credentialed to and with the duties equivalent of a medical assistant, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. It is up to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines prescribed. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.
- An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions (or both).
- Orders involving tele-health or remote communication (such as phone orders) may be included in the numerator as long as the order entry otherwise meets the requirements of the objective and measures.
- Providers may exclude orders that are predetermined for a given set of patient characteristics or for a given procedure (also known as "protocol" or "standing orders") from the calculation of CPOE numerators and denominators. Note this does not require providers to exclude this category of orders from their numerator and denominator ([77 FR 53986](#)).
- CPOE is the entry of the order into the patient's EHR that uses a specific function of CEHRT. CPOE does not otherwise specify how the order is filled or otherwise carried out.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(3)(i) and (ii). For further discussion please see [80 FR 20359](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(1).



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Certification Standards and Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§ 170.314(a)(1) Computerized provider order entry	Enable a user to electronically record, change, and access the following order types, at a minimum: <ul style="list-style-type: none">• Medications;• Laboratory; and• Radiology/imaging.
<i>*Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.</i>	
Standards Criteria	
N/A	



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Electronic Prescribing (eRx)	
Objective	Generate and transmit permissible prescriptions electronically (eRx).
Measure	More than 50 percent of permissible prescriptions written by the eligible professional (EP) are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).
Exclusion	Any EP who: <ul style="list-style-type: none"> • Writes fewer than 100 permissible prescriptions during the Promoting Interoperability (PI) reporting period; or • Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her PI reporting period.

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Definition of Terms

Prescription – The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.

Permissible Prescriptions – “Permissible prescriptions” may include or not include controlled substances based on provider selection and where allowable by state and local law.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSIONS

- **DENOMINATOR:** Number of permissible prescriptions written during the PI reporting period for drugs requiring a prescription in order to be dispensed.
- **NUMERATOR:** The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.
- **THRESHOLD:** The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- **EXCLUSIONS:** Any EP who:
 - Writes fewer than 100 permissible prescriptions during the PI reporting period; or



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- Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her PI reporting period.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using CEHRT.
- Authorizations for items such as durable medical equipment, or other items and services that may require EP authorization before the patient could receive them, are not included in the definition of prescriptions. These are excluded from the numerator and the denominator of the measure.
- Instances where patients specifically request a paper prescription may not be excluded from the denominator of this measure. The denominator includes all prescriptions written by the EP during the PI reporting period.
- As electronic prescribing of controlled substances is now possible, providers may choose to include these prescriptions in their permissible prescriptions where feasible and allowable by state and local law.
- An EP needs to use CEHRT as the sole means of creating the prescription, and when transmitting to an external pharmacy that is independent of the EP's organization such transmission must use standards adopted for EHR technology certification.
- EPs should include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective.
- For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur concurrently if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.
- Providers can use intermediary networks that convert information from the certified EHR into a computer-based fax in order to meet this measure as long as the EP generates an electronic prescription and transmits it electronically using the standards of CEHRT to the intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner.
- Prescriptions transmitted electronically within an organization (the same legal entity) do not need to use the National Council for Prescription Drug Programs (NCPDP) standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be CEHRT. For more information, refer to ONC's FAQ at <https://www.healthit.gov/topic/certification-ehrs/frequently-asked-questions>.
- Providers may limit their effort to query a formulary to simply using the function available to them in their CEHRT with no further action required. If a query using the function of their CEHRT is not possible or shows no result, a provider is not required to conduct any further manual or paper-based action in order to complete the query, and the provider may count the prescription in the numerator.



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- EPs practicing at multiple locations are eligible for the exclusion if any of their practice locations that are equipped with CEHRT meet the exclusion criteria.
- EPs who are part of an organization that owns or operates its own pharmacy within the 10-mile radius are not eligible for the exclusion regardless of whether that pharmacy can accept electronic prescriptions from EPs outside of the organization.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(4)(i) and (ii). For further discussion please see [80 FR 62800](#).
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.314(b)(3) and (a)(10).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§ 170.314(b)(3) Electronic prescribing	Enable a user to electronically create prescriptions and prescription related information for electronic transmission in accordance with: <ul style="list-style-type: none"> • The standard specified in § 170.205(b)(2); and • At a minimum, the version of the standard specified in § 170.207(d)(2).
§ 170.314(a)(10) Drug formulary checks	EHR technology must automatically and electronically check whether a drug formulary (or preferred drug list) exists for a given patient and medication.

** Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.*

Standards Criteria	
§170.205(b)(2) Electronic Prescribing	NCPDP SCRIPT Version 10.6.
§170.207(d)(2) Medications	RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine, August 6, 2012 Release (incorporated by reference in § 170.299)



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Health Information Exchange	
Objective	The eligible professional (EP) who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
Measure	The EP that transitions or refers their patient to another setting of care or provider of care must—(1) use certified electronic health record technology (CEHRT) to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.
Exclusion	Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the Promoting Interoperability (PI) reporting period.

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Definition of Terms

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

Summary of Care Record – All summary of care documents used to meet this objective must include the following information if the provider knows it:

- Patient name
- Referring or transitioning provider's name and office contact information (EP only)
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions



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- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral (EP only)
- Current problem list (Providers may also include historical problems at their discretion)*
- Current medication list*
- Current medication allergy list*

**Note: An EP must verify that the fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies.*

Current problem lists – At a minimum a list of current and active diagnoses.

Active/current medication list – A list of medications that a given patient is currently taking.

Active/current medication allergy list – A list of medications to which a given patient has known allergies.

Allergy – An exaggerated immune response or reaction to substances that are generally not harmful.

Care Plan – The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

- **DENOMINATOR:** Number of transitions of care and referrals during the PI reporting period for which the EP was the transferring or referring provider.
- **NUMERATOR:** The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
- **THRESHOLD:** The percentage must be more than 10 percent in order for an EP to meet this measure.
- **EXCLUSION:** Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the PI reporting period.



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Additional Information

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- This exchange may occur before, during, or after the PI reporting period. However, it must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs in order to count in the numerator.
- Apart from the three fields noted as required (i.e., current problem list, current medication list, and current medication allergy list), in circumstances where there is no information available to populate one or more of the fields listed (because the EP does not record such information or because there is no information to record), the EP may leave the field(s) blank and still meet the objective and its associated measure.
- A provider must have the ability to transmit all data pertaining to laboratory test results in the summary of care document, but may work with their system developer to establish clinically relevant parameters for the most appropriate results for the given transition or referral. This policy is limited to laboratory test results.
- A provider who limits the transmission of laboratory test result data in a summary of care document must send the full results upon request (i.e., all lab results as opposed to a subset).
- The referring provider must have reasonable certainty of receipt by the receiving provider to count the action toward the measure.
- The exchange must comply with the privacy and security protocols for ePHI under HIPAA.
- In cases where the providers share access to an EHR, a transition or referral may still count toward the measure if the referring provider creates the summary of care document using CEHRT and sends the summary of care document electronically. If a provider chooses to include such transitions to providers where access to the EHR is shared, they must do so universally for all patient and all transitions or referrals.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(5)(i) and (ii). For further discussion please see [80 FR 62806](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(1), (b)(2), (a)(5), (a)(6) and (a)(7).



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Certification Standards and Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§ 170.314 (b) (1) Transitions of care – receive, display, and incorporate transition of care/referral summaries	<p>(i) Receive. EHR technology must be able to electronically receive transition of care/referral summaries in accordance with:</p> <ul style="list-style-type: none">(A) The standard specified in § 170.202(a).(B) Optional. The standards specified in § 170.202(a) and (b).(C) Optional. The standards specified in § 170.202(b) and (c). <p>(ii) Display. EHR technology must be able to electronically display in human readable format the data included in transition of care/referral summaries received and formatted according to any of the following standards (and applicable implementation specifications) specified in: § 170.205(a)(1), § 170.205(a)(2), and § 170.205(a)(3).</p> <p>(iii) Incorporate. Upon receipt of a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3), EHR technology must be able to:</p> <ul style="list-style-type: none">(A) Correct patient. Demonstrate that the transition of care/referral summary received is or can be properly matched to the correct patient.(B) Data incorporation. Electronically incorporate the following data expressed according to the specified standard(s):<ul style="list-style-type: none">(a) Medications. At a minimum, the version of the standard specified in § 170.207(d)(2);(b) Problems. At a minimum, the version of the standard specified in § 170.207(a)(3);(c) Medication allergies. At a minimum, the version of the standard specified in § 170.207(d)(2).(C) Section views. Extract and allow for individual display each additional section or sections (and the accompanying document header information) that were included in a transition of care/referral summary received and formatted in accordance with the standard adopted at § 170.205(a)(3).



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§ 170.314(b)(2) Transitions of care – create and transmit transition of care/referral summaries	<p>(i) Create. Enable a user to electronically create a transition of care/referral summary formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the Common MU Data Set and the following data expressed, where applicable, according to the specified standard(s):</p> <p>(A) Encounter diagnoses. The standard specified in § 170.207(i) or, at a minimum, the version of the standard specified § 170.207(a)(3);</p> <p>(B) Immunizations. The standard specified in § 170.207(e)(2);</p> <p>(C) Cognitive status;</p> <p>(D) Functional status; and</p> <p>(E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information.</p> <p>(F) Inpatient setting only. Discharge instructions.</p> <p>(ii) Transmit. Enable a user to electronically transmit the transition of care/referral summary created in paragraph (b)(2)(i) of this section in accordance with:</p> <p>(A) The standard specified in § 170.202(a).</p> <p>(B) Optional. The standards specified in § 170.202(a) and (b).</p> <p>(C) Optional. The standards specified in § 170.202(b) and (c).</p>
§ 170.314(a)(5) Problem list	<p>Enable a user to electronically record, change, and access a patient's problem list:</p> <p>(i) Ambulatory setting. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3); or</p> <p>(ii) Inpatient setting. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in § 170.207(a)(3).</p>
§ 170.314(a)(6) Medication list	<p>Enable a user to electronically record, change, and access a patient's active medication list as well as medication history.</p>
§ 170.314(a)(7) Medication Allergy List	<p>Enable a user to electronically record, change, and access a patient's active medication allergy list as well as medication allergy history:</p> <p>(i) Ambulatory setting. Over multiple encounters; or</p> <p>(ii) Inpatient setting. For the duration of an entire hospitalization.</p>

* Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.

Additional certification criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.



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Standards Criteria	
§ 170.202(a) Transport standards	ONC Applicability Statement for Secure Health Transport (incorporated by reference in § 170.299).
§ 170.202(b) Transport standards	ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in § 170.299).
§ 170.202(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in § 170.299).
§ 170.205(a)(1)	HL7 Implementation Guide for CDA® Release 2, CCD. Implementation specifications: HITSP Summary Documents Using HL7 CCD Component HITSP/C32.



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Patient-Specific Education	
Objective	Use clinically relevant information from certified electronic health record technology (CEHRT) to identify patient-specific education resources and provide those resources to the patient.
Measure	Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the eligible professional (EP) during the Promoting Interoperability (PI) reporting period.
Exclusion	Any EP who has no office visits during the PI reporting period.

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Definition of Terms

Patient-Specific Education Resources Identified by CEHRT – Resources or a topic area of resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.

Unique Patient – If a patient is seen by an EP more than once during the PI reporting period, then for purposes of measurement, that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same PI reporting period.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

- **DENOMINATOR:** Number of unique patients with office visits seen by the EP during the PI reporting period.
- **NUMERATOR:** Number of patients in the denominator who were provided patient-specific education resources identified by the CEHRT.
- **THRESHOLD:** The resulting percentage must be more than 10 percent in order for an EP to meet this measure.



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Updated: July 2018

- **EXCLUSION:** Any EP who has no office visits during the PI reporting period.

Additional Information

- Unique patients with office visits means that to count in the denominator a patient must be seen by the EP for one or more office visits during the PI reporting period, but if a patient seen by the EP more than once during the PI reporting period, the patient only counts once in the denominator.
- The EP must use elements within CEHRT to identify educational resources specific to patients' needs. CEHRT is certified to use the patient's problem list, medication list, or laboratory test results to identify the patient-specific educational resources. The EP may use these elements or may use additional elements within CEHRT to identify educational resources specific to patients' needs. The EP can then provide these educational resources to patients in a useful format for the patient (such as, electronic copy, printed copy, electronic link to source materials, through a patient portal or PHR).
- The education resources or materials do not have to be stored within or generated by the CEHRT.
- There is no universal "transitive effect" policy in place for this objective and measure. It may vary based on the resources and materials provided and the timing of that provision. If an action is clearly attributable to a single provider, it may only count in the numerator for that provider. However, if the action is not attributable to a single provider, it may be counted in the numerator for all providers sharing the CEHRT who have the patient in their denominator for the PI reporting period.
- This exchange may occur before, during, or after the PI reporting period. However, in order to count in the numerator, it must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs.

Regulatory References

This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(6)(i) and (ii). For further discussion please see [80 FR 62807](#).

In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (a)(15).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.



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Certification Criteria	
§ 170.314(a)(15) Patient-specific education resources	EHR technology must be able to electronically identify for a user patient-specific education resources based on data included in the patient's problem list, medication (i) In accordance with the standard specified at § 170.204(b) and the implementation specifications at § 170.204(b)(1) or (2); and (ii) By any means other than the method specified in paragraph (a)(15)(i) of this section.

**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.*

Standards Criteria	
§ 170.204(b) Reference source	Version 3 Standard: Context-Aware Retrieval Application (Infobutton) (incorporated by reference in § 170.299).
§ 170.204(b)(1) or (2) Implementation Specifications	Version 3 Standard: Context-Aware Retrieval Application (Infobutton) (incorporated by reference in § 170.299). (1) Implementation specifications. HL7 Version 3 Implementation Guide: URL-Based Implementations of the Context-Aware Information Retrieval (Infobutton) Domain, (incorporated by reference in § 170.299) (2) Implementation specifications. HL7 Version 3 Implementation Guide: Context-Aware Knowledge Retrieval (Infobutton) Service-Oriented Architecture Implementation Guide, (incorporated by reference in § 170.299).



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Medication Reconciliation	
Objective	The eligible professional (EP) who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.
Measure	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.
Exclusion	Any EP who was not the recipient of any transitions of care during the Promoting Interoperability (PI) reporting period.

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Definition of Terms

Medication Reconciliation – The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.

Transition of Care – The movement of a patient from one setting of care (for example, a hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Referral – Cases where one provider refers a patient to another, but the referring provider maintains his or her care of the patient as well.

Denominator for Transitions of Care and Referrals – The denominator includes transitions of care and referrals (as finalized in the Stage 2 rule where the definition of transitions of care includes: "When the EP is the recipient of the transition or referral, first encounters with a new patient and encounters with existing patients where a summary of care record (of any type) is provided to the receiving EP" ([77 FR 53984](#))).

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION



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- DENOMINATOR: Number of transitions of care during the PI reporting period for which the EP was the receiving party of the transition.
- NUMERATOR: The number of transitions of care in the denominator where medication reconciliation was performed.
- THRESHOLD: The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who was not the recipient of any transitions of care during the PI reporting period.

Additional Information

- Only patients whose records are maintained using certified electronic health record technology (CEHRT) must be included in the denominator for transitions of care.
- In the case of reconciliation following transition of care, the receiving EP should conduct the medication reconciliation.
- The electronic exchange of information is not a requirement for medication reconciliation.
- The measure of this objective does not dictate what information must be included in medication reconciliation. Information included in the process of medication reconciliation is appropriately determined by the provider and patient.
- We define “new patient” as a patient never before seen by the provider. A provider may use an expanded definition of “new patient” for the denominator that includes a greater number of patients for whom the action may be relevant within their practice, such as inclusion of patients not seen in 2 years.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(7)(i) and (ii). For further discussion please see [80 FR 62811](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (b)(4).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.314 (b)(4) Clinical Information Reconciliation	Enable a user to electronically reconcile the data that represent a patient’s active medication, problem, and medication allergy list as follows. For each list type: (i) Electronically and simultaneously display (i.e., in a single view) the data from at least two list sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date.



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	<p>(ii) Enable a user to create a single reconciled list of medications, medication allergies, or problems.</p> <p>(iii) Enable a user to review and validate the accuracy of a final set of data and, upon a user's confirmation, automatically update the list.</p>
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**Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.*

Standards Criteria

N/A



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Patient Electronic Access	
Objective	Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the eligible professional (EP).
Measure	<p>EPs must satisfy both measures in order to meet this objective:</p> <p>Measure 1 – More than 50 percent of all unique patients seen by the EP during the Promoting Interoperability (PI) reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.</p> <p>Measure 2 – For the PI reporting periods in 2017 and 2018, more than 5 percent of unique patients seen by the EP during the PI reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the PI reporting period.</p>
Exclusion	<p>Measure 1: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."</p> <p>Measure 2: Any EP who: (1) Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information;" or (2) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the PI reporting period.</p>

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Definition of Terms

Provide Access – When a patient possesses all of the necessary information needed to view, download, or transmit their information. This could include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information.

View – The patient (or authorized representative) accessing their health information online.

Download – The movement of information from online to physical electronic media.

Transmission – This may be any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.

Business Days – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

Diagnostic Test Results – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

MEASURE 1:

- DENOMINATOR: Number of unique patients seen by the EP during the PI reporting period.
- NUMERATOR: The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.
- THRESHOLD: The resulting percentage must be more than 50 percent in order for an EP to meet this measure.
- EXCLUSION: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for “Patient Name” and “Provider’s name and office contact information.”

MEASURE 2:

- DENOMINATOR: Number of unique patients seen by the EP during the PI reporting period.
- NUMERATOR: The number of patients in the denominator who view, download, or transmit to a third party their health information.
- THRESHOLD: The resulting percentage must be greater than 5 percent.

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- **EXCLUSIONS:** Any EP who— (a) Neither orders nor creates any of the information listed for inclusion as part of the measures except for “Patient Name” and “Provider’s name and office contact information;” or (b) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period.

Additional Information

- In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:
 - Patient name
 - Provider's name and office contact information
 - Current and past problem list
 - Procedures
 - Laboratory test results
 - Current medication list and medication history
 - Current medication allergy list and medication allergy history
 - Vital signs (height, weight, blood pressure, BMI, growth charts)
 - Smoking status
 - Demographic information (preferred language, sex, race, ethnicity, date of birth)
 - Care plan field(s), including goals and instructions
 - Any known care team members including the primary care provider (PCP) of record
- An EP can make available additional information and still align with the objective.
- In circumstances where there is no information available to populate one or more of the fields previously listed, either because the EP can be excluded from recording such information or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have an indication that the information is not available and still meet the objective and its associated measure.
- The patient must be able to access this information on demand, such as through a patient portal or personal health record (PHR) or by other online electronic means. We note that while a covered entity may be able to fully satisfy a patient's request for information through view, download, and transmit the measure does not replace the covered entity's responsibilities to meet the broader requirements under Health Information Protectability and Accountability Act (HIPAA) to provide an individual, upon request, with access to patient health information (PHI) in a designated record set.
- Providers should also be aware that while meaningful use is limited to the capabilities of CEHRT to provide online access there may be patients who cannot access their EHRs electronically because of a disability. Providers who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- For Measure 1, PHI needs to be made available to each patient for view, download, and transmit within 4 business days of the information being available to the provider for each and every time that information is generated whether the patient has been "enrolled" for three months or for three years.



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- A patient who has multiple encounters during the PI reporting period, or even in subsequent PI reporting periods in future years, needs to be provided access for each encounter where they are seen by the EP.
- If a patient elects to "opt out" of participation, that patient must still be included in the denominator.
- If a patient elects to "opt out" of participation, the provider may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access their information, obtain access through a patient authorized representative, or otherwise opt-back-in without further follow up action required by the provider.
- For Measure 2, the patient action may occur before, during, or after the PI reporting period. However, in order to count in the numerator, it must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(8)(i)(A). For further discussion please see [80 FR 62815](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (e)(1).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria *

§170.314(e)(1) View, download, and transmit to third party

(i) EHR technology must provide patients (and their authorized representatives) with an online means to view, download, and transmit to a 3rd party the data specified below. Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f).

(A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data:

- (1) The Common MU Data Set** (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set.
- (2) Provider's name and office contact information.
- (3) Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization.



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(B) Download.

(1) Electronically download an ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) in human readable format or formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set):

(i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2) of this section.

(ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(3) of this section.

(2) Inpatient setting only. Electronically download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion adopted at paragraph (b)(2) of this section).

(C) Transmit to third party.

(1) Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) created in paragraph (e)(1)(i)(B)(1) of this section in accordance with the standard specified in § 170.202(a).

(2) Inpatient setting only. Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in accordance with the standard specified in § 170.202(a).

(ii) Activity history log.

(A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section, the following information must be recorded and made accessible to the patient:

(1) The action(s) (i.e., view, download, transmission) that occurred;

(2) The date and time each action occurred in accordance with the standard specified at § 170.210(g); and

(3) The user who took the action.

(B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient.



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**Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.*

Additional certification criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.

Standards Criteria*	
§ 170.204(a)	Web Content Accessibility Guidelines (WCAG) 2.0, Level A Conformance (incorporated by reference in § 170.299).
§ 170.210(f)	Any encryption and hashing algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the FIPS Publication 140-2 (incorporated by reference in § 170.299).
§ 170.205(a)(3)	HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation. The use of the “unstructured document” document-level template is prohibited.
§ 170.202(a)	Applicability Statement for Secure Health Transport.
§ 170.210(g)	The data and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, or (RFC 5905) Network Time Protocol Version 4.

**Note: Additional standards criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.*



Medicaid Promoting Interoperability Program Modified Stage 2 Eligible Professionals

Objectives and Measures for 2018

Objective 9 of 10 Updated: July 2018

Secure Electronic Messaging	
Objective	Use secure electronic messaging to communicate with patients on relevant health information.
Measure	For a Promoting Interoperability (PI) reporting period in 2018, for more than 5 percent of unique patients seen by the eligible professional (EP) during the PI reporting period, a secure message was sent using the electronic messaging function of certified electronic health record technology (CEHRT) to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the PI reporting period.
Exclusion	Any EP who has no office visits during the PI reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the PI reporting period.

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Definition of Terms

Secure Message – Any electronic communication between a provider and patient that ensures only those parties can access the communication. This electronic message could be email or the electronic messaging function of a public health record, an online patient portal, or any other electronic means.

Fully Enabled – The function is fully installed, any security measures are fully enabled, and the function is readily available for patient use.

Attestation Requirements

YES/NO/EXCLUSION

- DENOMINATOR: Number of unique patients seen by the EP during the PI reporting period.
- NUMERATOR: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).



Medicaid Promoting Interoperability Program Modified Stage 2 Eligible Professionals

Objectives and Measures for 2018

Objective 9 of 10

Updated: July 2018

- **THRESHOLD:** The resulting percentage must be more than 5 percent in order for an EP to meet this measure.
- **EXCLUSIONS:** Any EP who has no office visits during the PI reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period.

Additional Information

- The thresholds for this measure have increased over time to allow providers to work incrementally toward a high goal. This is consistent with our past policy in the program to establish incremental change from basic to advanced use and increased thresholds over time. The measure threshold for this objective was “fully enabled” for 2015, was at least one patient for 2016, and is 5 percent for 2017 and 2018 to build toward the Stage 3 threshold.
- This measure includes provider-initiated communications (when a provider sends a message to a patient or the patient’s authorized representatives), and provider-to-provider communications if the patient is included. A provider can only count messages in the numerator when the provider participates in the communication (e.g. any patient-initiated communication only if the provider responds to the patient.) Note: Providers are not required to respond to every message received if no response is necessary.
- The EP action may occur before, during, or after the PI reporting period. However, in order to count in the numerator, it must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(9)(i) and (ii). For further discussion please see [80 FR 62816](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(e)(3).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.314(e)(3) Secure messaging	Enable a user to electronically send messages to, and receive messages from, a patient in a manner that ensures: (i) Both the patient (or authorized representative) and EHR technology user are authenticated; and (ii) The message content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f).



**Medicaid Promoting Interoperability Program Modified Stage 2
Eligible Professionals
Objectives and Measures for 2018**

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Updated: July 2018**

**Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.*

Standards Criteria	
§ 170.210(f) Encryption and hashing of electronic health information	Any encryption and hashing algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the FIPS Publication 140-2 (incorporated by reference in § 170.299.)



Medicaid Promoting Interoperability Program Modified Stage 2 Eligible Professionals

Objectives and Measures for 2018

Objective 10 of 10
Updated: July 2018

Public Health Reporting	
Objective	The eligible professional (EP) is in active engagement with a public health agency (PHA) to submit electronic public health data from certified electronic health record technology (CEHRT) except where prohibited and in accordance with applicable law and practice.
Measure	<p>Measure 1: Immunization Registry Reporting – The EP is in active engagement with a PHA to submit immunization data.</p> <p>Measure 2: Syndromic Surveillance Reporting – The EP is in active engagement with a PHA to submit syndromic surveillance data.</p> <p>Measure 3: Specialized Registry Reporting – The EP is in active engagement to submit data to a specialized registry.</p>
Exclusion	<p>Measure 1 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP—</p> <ul style="list-style-type: none"> (1) Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system (IIS) during the Promoting Interoperability (PI) reporting period; (2) Operates in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or (3) Operates in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data from the EP at the start of the PI reporting period. <p>Measure 2 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP—</p> <ul style="list-style-type: none"> (1) Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; (2) Operates in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or (3) Operates in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs at the start of the PI reporting period.



Medicaid Promoting Interoperability Program Modified Stage 2 Eligible Professionals

Objectives and Measures for 2018

Objective 10 of 10 Updated: July 2018

Measure 3 Exclusions: Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP—

- (1) Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the PI reporting period;
- (2) Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
- (3) Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the PI reporting period.

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- Definition of Terms
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Definition of Terms

Active Engagement – The provider is in the process of moving towards sending "production data" to a PHA or clinical data registry (CDR), or is sending production data to a PHA or CDR.

Active Engagement Option 1: Completed Registration to Submit Data –The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the PI reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each PI reporting period.

Active Engagement Option 2: Testing and Validation – The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an PI reporting period would result in that provider not meeting the measure.



Medicaid Promoting Interoperability Program Modified Stage 2 Eligible Professionals Objectives and Measures for 2018

Objective 10 of 10 Updated: July 2018

Active Engagement Option 3: Production – The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

Production data – Refers to data generated through clinical processes involving patient care, and it is used to distinguish between data and “test data” which may be submitted for the purposes of enrolling in and testing electronic data transfers.

Attestation Requirements

YES/NO/EXCLUSIONS

MEASURE 1:

- YES/NO: The EP must attest YES to being in active engagement with a PHA to submit immunization data.
- EXCLUSIONS: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP—
 - Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or IIS during the PI reporting period;
 - Operates in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the PI reporting period.

MEASURE 2:

- YES/NO: THE EP must attest YES to being in active engagement with a PHA to submit syndromic surveillance data.
- EXCLUSIONS: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP—
 - Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
 - Operates in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs at the start of the PI reporting period.

MEASURE 3:

- YES/NO: The EP must attest YES to being in active engagement to submit data to a specialized registry.
- EXCLUSIONS: Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP—
 - Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the PI reporting period;



Medicaid Promoting Interoperability Program Modified Stage 2 Eligible Professionals

Objectives and Measures for 2018

Objective 10 of 10

Updated: July 2018

- Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
- Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the PI reporting period.

Additional Information

- EPs must attest to at least two measures from the Public Health Reporting Objective measures 1 through 3.
- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP would need to meet two of the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting the one remaining measure available to them and claiming the applicable exclusions. If no measures remain available, the EP can meet the objective by claiming applicable exclusions for all three measures.
- For Measure 1, an exclusion does not apply if an entity designated by the immunization registry or immunization information system can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by CEHRT, but if it has designated a Health Information Exchange (HIE) to do so on their behalf and the HIE is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 2, an exclusion does not apply if an entity designated by PHA can receive electronic syndromic surveillance data submissions. For example, if the PHA cannot accept the data directly or in the standards required by CEHRT, but if it has designated a HIE to do so on their behalf and the HIE is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 3, a provider may report to more than one specialized registry and may count specialized registry reporting more than twice to meet the required number of measures for the objective.
- Providers who have previously registered, tested, or begun ongoing submission of data to registry do not need to “restart” the process beginning at active engagement option 1. The provider may simply attest to the active engagement option which most closely reflects their current status.
- In determining whether an EP meets the first exclusion, the registries in question are those sponsored by the PHAs with jurisdiction over the area where the EP practices and national medical societies covering the EPs scope of practice. Therefore, an EP must complete two actions in order to determine available registries or claim an exclusion:
 - Determine if the jurisdiction (state, territory, etc.) endorses or sponsors a registry; and,
 - Determine if a National Specialty Society or other specialty society with which the provider is affiliated endorses or sponsors a registry.



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Objectives and Measures for 2018

Objective 10 of 10
Updated: July 2018

Public Health Reporting	
Objective	The eligible professional (EP) is in active engagement with a public health agency (PHA) to submit electronic public health data from certified electronic health record technology (CEHRT) except where prohibited and in accordance with applicable law and practice.
Measure	<p>Measure 1: Immunization Registry Reporting – The EP is in active engagement with a PHA to submit immunization data.</p> <p>Measure 2: Syndromic Surveillance Reporting – The EP is in active engagement with a PHA to submit syndromic surveillance data.</p> <p>Measure 3: Specialized Registry Reporting – The EP is in active engagement to submit data to a specialized registry.</p>
Exclusion	<p>Measure 1 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP—</p> <ul style="list-style-type: none"> (1) Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system (IIS) during the Promoting Interoperability (PI) reporting period; (2) Operates in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or (3) Operates in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data from the EP at the start of the PI reporting period. <p>Measure 2 Exclusions: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP—</p> <ul style="list-style-type: none"> (1) Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; (2) Operates in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or (3) Operates in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs at the start of the PI reporting period.



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Objectives and Measures for 2018

Objective 10 of 10 Updated: July 2018

Measure 3 Exclusions: Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP—

- (1) Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the PI reporting period;
- (2) Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
- (3) Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the PI reporting period.

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Definition of Terms

Active Engagement – The provider is in the process of moving towards sending "production data" to a PHA or clinical data registry (CDR), or is sending production data to a PHA or CDR.

Active Engagement Option 1: Completed Registration to Submit Data –The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the PI reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each PI reporting period.

Active Engagement Option 2: Testing and Validation – The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an PI reporting period would result in that provider not meeting the measure.





APPENDIX B
Stage 3 Objectives and Measures for 2018

Medicaid Promoting Interoperability Program Stage 3

Eligible Professionals

Objectives and Measures for 2018

Objective 1 of 8

Updated: July 2018

Protect Patient Health Information	
Objective	Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.
Measure	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.

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Attestation Requirements

YES/NO

Eligible professionals (EPs) must attest YES to conducting or reviewing a security risk analysis and implementing security updates as necessary and correcting identified security deficiencies to meet this measure.

Additional Information

- To meet Stage 3 requirements for an Promoting Interoperability (PI) reporting period in 2018, all providers must use technology certified to the [2015 Edition](#). A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. A provider who has technology certified to the 2014 Edition may not attest to Stage 3.
- EPs must conduct or review a security risk analysis of CEHRT including addressing encryption/security of data, and implement updates as necessary at least once each calendar year and attest to conducting the analysis or review.
- It is acceptable for the security risk analysis to be conducted outside the PI reporting period; however, the analysis must be unique for each PI reporting period, the scope must include the full PI reporting period and it must be conducted within the calendar year of the PI reporting period (January 1st – December 31st).
- An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each PI reporting period. Any security updates and deficiencies that



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Objective 1 of 8

Updated: July 2018

- are identified should be included in the provider's risk management process and implemented or corrected as dictated by that process.
- The security risk analysis requirement under 45 CFR 164.308(a)(1) must assess the potential risks and vulnerabilities to the confidentiality, availability, and integrity of all ePHI that an organization creates, receives, maintains, or transmits. This includes ePHI in all forms of electronic media, such as hard drives, floppy disks, CDs, DVDs, smart cards or other storage devices, personal digital assistants, transmission media, or portable electronic media.
 - At minimum, providers should be able to show a plan for correcting or mitigating deficiencies and that steps are being taken to implement that plan.
 - The parameters of the security risk analysis are defined 45 CFR 164.308(a)(1), which was created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule. The PI Program does not impose new or expanded requirements on the HIPAA Security Rule nor does it require specific use of every certification and standard that is included in certification of EHR technology. More information on the HIPAA Security Rule can be found at <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/>.
 - HHS Office for Civil Rights (OCR) has issued guidance on conducting a security risk analysis in accordance with the HIPAA Security Rule: <http://www.hhs.gov/hipaa/for-professionals/security/guidance/guidance-risk-analysis/index.html>.
 - Additional free tools and resources available to assist providers include a Security Risk Assessment (SRA) Tool developed by Office of the National Coordinator on Health Information Technology (ONC) and OCR: <http://www.healthit.gov/providers-professionals/security-risk-assessment-tool>.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(1)(i)(A) and (B). For further discussion please see [80 FR 62832](#).
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.315 (d)(1) through (d)(9).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§ 170.315(d)(1) Authentication, access control, and authorization	(i) Verify against a unique identifier(s) (e.g., username or number) that a user seeking access to electronic health information is the one claimed; and (ii) Establish the type of access to electronic health information a user is permitted based on the unique identifier(s) provided in paragraph (d)(1)(i) of this section, and the actions the user is permitted to perform with the EHR technology.



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Objective 1 of 8

Updated: July 2018

<p>§ 170.315(d)(2) Auditable events and tamper- resistance</p>	<p>(i) Record actions. EHR technology must be able to:</p> <p>(A) Record actions related to electronic health information in accordance with the standard specified in § 170.210(e)(1);</p> <p>(B) Record the audit log status (enabled or disabled) in accordance with the standard specified in § 170.210(e)(2) unless it cannot be disabled by any user; and</p> <p>(C) Record the encryption status (enabled or disabled) of electronic health information locally stored on end-user devices by EHR technology in accordance with the standard specified in § 170.210(e)(3) unless the EHR technology prevents electronic health information from being locally stored on end-user devices (see paragraph (d)(7) of this section).</p> <p>(ii) Default setting. Technology must be set by default to perform the capabilities specified in paragraph (d)(2)(i)(A) of this section and, where applicable, paragraphs (d)(2)(i)(B) and (d)(2)(i)(C), of this section.</p> <p>(iii) When disabling the audit log is permitted. For each capability specified in paragraphs (d)(2)(i)(A) through (C) of this section that technology permits to be disabled, the ability to do so must be restricted to a limited set of users.</p> <p>(iv) Audit log protection. Actions and statuses recorded in accordance with paragraph (d)(2)(i) of this section must not be capable of being changed, overwritten, or deleted by the EHR technology.</p> <p>(v) Detection. Technology must be able to detect whether the audit log has been altered.</p>
<p>§ 170.315(d)(3) Audit report(s)</p>	<p>Enable a user to create an audit report for a specific time period and to sort entries in the audit log according to each of the data specified in the standards at § 170.210(e).</p>
<p>§170.315(d)(4) Amendments</p>	<p>Enable a user to electronically select the record affected by a patient's request for amendment and perform the capabilities specified in paragraphs (d)(4)(i) or (ii) of this section.</p> <p>(i) Accepted amendment - For an accepted amendment, append the amendment to the affected record or include a link that indicates the amendment's location.</p> <p>(ii) Denied amendment - For a denied amendment, at a minimum, append the request and denial of the request in at least one of the following ways:</p> <p>(A) To the affected record.</p> <p>(B) Include a link that indicates this information's location.</p>

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Objectives and Measures for 2018

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Updated: July 2018

§ 170.315(d)(5) Automatic access time-out	<p>(i) Automatically stop user access to health information after a predetermined period of inactivity.</p> <p>(ii) Require user authentication in order to resume or regain the access that was stopped.</p>
§ 170.315(d)(6) Emergency access	Permit an identified set of users to access electronic health information during an emergency.
§ 170.315(d)(7) End-user device encryption	<p>The requirements specified in one of the following paragraphs (that is, paragraphs (d)(7)(i) and (d)(7)(ii) of this section) must be met to satisfy this certification criterion.</p> <p>(i) Technology that is designed to locally store electronic health information on end-user devices must encrypt the electronic health information stored on such devices after use of the technology on those devices stops.</p> <p>(A) Electronic health information that is stored must be encrypted in accordance with the standard specified in § 170.210(a)(2).</p> <p>(B) Default setting. Technology must be set by default to perform this capability and, unless this configuration cannot be disabled by any user, the ability to change the configuration must be restricted to a limited set of identified users.</p> <p>(ii) Technology is designed to prevent electronic health information from being locally stored on end-user devices after use of the technology on those devices stops.</p>
§ 170.315(d)(8) Integrity	<p>(i) Create a message digest in accordance with the standard specified in §170.210(c)(2).</p> <p>(ii) Verify in accordance with the standard specified in § 170.210(c)(2) upon receipt of electronically exchanged health information that such information has not been altered.</p>
§ 170.315(d)(9) Trusted Connection	<p>Establish a trusted connection using one of the following methods:</p> <p>(i) Message-level. Encrypt and integrity protect message contents in accordance with the standards specified in §170.210(a)(2) and (c)(2).</p> <p>(ii) Transport-level. Use a trusted connection in accordance with the standards specified in §170.210(a)(2) and (c)(2).</p>



Medicaid Promoting Interoperability Program Stage 3 Eligible Professionals

Objectives and Measures for 2018

Objective 1 of 8 *Updated: July 2018*

Standards Criteria	
§ 170.210(e)(1) Record actions related to electronic health information, audit log status, and encryption status	(1)(i) The audit log must record the information specified in sections 7.2 through 7.4, 7.6, and 7.7 of the standard specified in §170.210(h) and changes to user privileges when health IT is in use. (ii) The date and time must be recorded in accordance with the standard specified at §170.210(g).
§ 170.210(e)(2) Record actions related to electronic health information, audit log status, and encryption status	(2)(i) The audit log must record the information specified in sections 7.2 and 7.4 of the standard specified at §170.210(h) when the audit log status is changed. (ii) The date and time each action occurs in accordance with the standard specified at §170.210(g).
§ 170.210(e)(3) Record actions related to electronic health information, audit log status, and encryption status	(3) The audit log must record the information specified in sections 7.2 and 7.4 of the standard specified at §170.210(h) when the encryption status of electronic health information locally stored by health IT on end-user devices is changed. The date and time each action occurs in accordance with the standard specified at §170.210(g).
§ 170.210(a)(1) Encryption and decryption of electronic health information	Any encryption algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the Federal Information Processing Standards (FIPS) Publication 140-2, (January 27, 2010) (incorporated by reference in §170.299).
§ 170.210(c) Hashing of electronic health information	A hashing algorithm with a security strength equal to or greater than SHA-1 (Secure Hash Algorithm (SHA-1)) as specified by NIST in FIPS PUB 180-4 (March 2012)).
§ 170.210(d) Record treatment, payment, and health care operations disclosures	The date, time, patient identification, user identification, and a description of the disclosure must be recorded for disclosures for treatment, payment, and health care operations, as these terms are defined at 45 CFR 164.501.

* Note: Additional certification criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.



Medicaid Promoting Interoperability Program Stage 3

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Objectives and Measures for 2018

Objective 2 of 8

Updated: July 2018

Electronic Prescribing (eRx)	
Objective	Generate and transmit permissible prescriptions electronically.
Measure	More than 60 percent of all permissible prescriptions written by the eligible professional (EP) are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).
Exclusion	Any EP who: (1) Writes fewer than 100 permissible prescriptions during the Promoting Interoperability (PI) reporting period; or (2) Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her PI reporting period.

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Definition of Terms

Prescription – The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.

Permissible Prescriptions – “Permissible prescriptions” may include or not include controlled substances based on provider selection where creation of an electronic prescription for the medication is feasible using CEHRT and allowable by state and local law.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSIONS

- **DENOMINATOR:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the PI reporting period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the PI reporting period.¹

¹ In the Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; final rule at 81 FR 28227, we stated that the 2015 EHR Incentive Program final rule included a discussion of controlled substances in the context of the Stage 3 objective and measure ([80 FR 62834](#)), which we understand from stakeholders has caused confusion. Therefore, for both MIPS and for the EHR Incentive Programs, health care providers continue to have the option to include or not include controlled substances that can be electronically prescribed in the denominator.



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- **NUMERATOR:** The number of prescriptions in the denominator that are generated, queried for a drug formulary, and transmitted electronically using CEHRT.
- **THRESHOLD:** The resulting percentage must be more than 60 percent in order for an EP to meet this measure.
- **EXCLUSIONS:** Any EP who:
 - Writes fewer than 100 permissible prescriptions during the PI reporting period; or
 - Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her PI reporting period.

Additional Information

- To meet Stage 3 requirements, all providers must use technology certified to the [2015 Edition](#). A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. A provider who has technology certified to the 2014 Edition **may not** attest to Stage 3.
- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using (CEHRT).
- Authorizations for items such as durable medical equipment, or other items and services that may require EP authorization before the patient could receive them, are not included in the definition of prescriptions. These are excluded from the numerator and the denominator of the measure.
- Instances where patients specifically request a paper prescription may not be excluded from the denominator of this measure. The denominator includes all prescriptions written by the EP during the PI reporting period.
- As electronic prescribing of controlled substances is now possible, providers may choose to include these prescriptions in their permissible prescriptions where feasible and allowable by state and local law. If a provider chooses to include such prescriptions, he or she must do so uniformly across all patients and across all allowable schedules for the duration of the PI reporting period.
- Over the counter (OTC) medications are excluded from the definition of prescription.
- An EP needs to use CEHRT as the sole means of creating the prescription, and when transmitting to an external pharmacy that is independent of the EP's organization such transmission must use standards adopted for EHR technology certification.
- EPs should include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective.
- For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur concurrently if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.
- Providers can use intermediary networks that convert information from the certified EHR into a computer-based fax in order to meet this measure as long as the EP generates an electronic prescription and transmits it electronically using the standards of CEHRT to the intermediary



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network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner.

- Prescriptions transmitted electronically within an organization (the same legal entity) do not need to use the National Council for Prescription Drug Programs standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of § 170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be CEHRT. For more information, refer to Office of the National Coordinator (ONC) on Health Information Technology's FAQ at <https://www.healthit.gov/topic/certification-ehrs/frequently-asked-questions>.
- Providers may limit their effort to query a formulary to simply using the function available to them in their CEHRT with no further action required. If a query using the function of their CEHRT is not possible or shows no result, a provider is not required to conduct any further manual or paper-based action in order to complete the query, and the provider may count the prescription in the numerator.
- EPs practicing at multiple locations are eligible for the exclusion if any of their practice locations that are equipped with CEHRT meet the exclusion criteria.
- EPs who are part of an organization that owns or operates its own pharmacy within the 10-mile radius are not eligible for the exclusion regardless of whether that pharmacy can accept electronic prescriptions from EPs outside of the organization.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(2)(i)(A) and (B). For further discussion please see [80 FR 62834](#).
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.315(b)(3) and (a)(10)(ii).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.315(b)(3) Electronic prescribing	(i) Enable a user to perform all of the following prescription-related electronic transactions in accordance with the standard specified in §170.205(b)(2) and, at a minimum, the version of the standard specified in §170.207(d)(3) as follows: (A) Create new prescriptions (NEWRX). (B) Change prescriptions (RXCHG, CHGRES). (C) Cancel prescriptions (CANRX, CANRES). (D) Refill prescriptions (REFREQ, REFRES). (E) Receive fill status notifications (RXFILL).



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	<p>(F) Request and receive medication history information (RXHREQ, RXHRES)</p> <p>(ii) For each transaction listed in paragraph (b)(3)(i) of this section, the technology must be able to receive and transmit the reason for the prescription using the diagnosis elements in DRU Segment.</p> <p>(iii) Optional. For each transaction listed in paragraph (b)(3)(i) of this section, the technology must be able to receive and transmit the reason for the prescription using the indication elements in the SIG Segment.</p> <p>(iv) Limit a user's ability to prescribe all oral liquid medications in only metric standard units of mL (i.e., not cc).</p> <p>(v) Always insert leading zeroes before the decimal point for amounts less than one and must not allow trailing zeroes after a decimal point when a user prescribes medications.</p>
§ 170.315(a)(10)(ii)	Automatically check whether a drug formulary exists for a given patient and medication.

**Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.315 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.*

Standards Criteria*	
§170.205(b)(2) Electronic Prescribing	NCPDP SCRIPT Standard, Implementation Guide, Version 10.6 (incorporated by reference in §170.299)
§170.207(d)(2) Medications	(2) RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine, August 6, 2012 Release (incorporated by reference in §170.299).
§170.207(d)(3) Medications	(3) RxNorm, a standardized nomenclature for clinical drugs produced by the United States National Library of Medicine, September 8, 2015 Release (incorporated by reference in §170.299).

**Note: Additional standards criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.*



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Clinical Decision Support	
Objective	Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.
Measure	<p>Eligible Professionals (EPs) must satisfy both of the following measures in order to meet the objective:</p> <p>Measure 1 – Implement five CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire Promoting Interoperability (PI) reporting period. Absent four CQMs related to an EPs scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.</p> <p>Measure 2 – The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period.</p>
Exclusion	Measure 2 – Any EP who writes fewer than 100 medication orders during the PI reporting period.

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Definition of Terms

CDS – Health information technology functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.

Attestation Requirements

YES/NO/EXCLUSION

MEASURE 1:

- EPs must attest YES to implementing five CDS interventions related to four or more CQMs at a relevant point in patient care for the entire PI reporting period.

MEASURE 2:

- EPs must attest YES to enabling and implementing the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period.



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EXCLUSION:

- For the second measure, any EP who writes fewer than 100 medication orders during the PI reporting period.

Additional Information

- To meet Stage 3 requirements for a PI reporting period in 2018, all providers must use technology certified to the [2015 Edition](#). A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. A provider who has technology certified to the 2014 Edition **may not** attest to Stage 3.
- Providers should implement the CDS intervention at a relevant point in clinical workflows when the intervention can influence clinical decision making before diagnostic or treatment action is taken in response to the intervention.
- Well-designed CDS encompasses a variety of workflow optimized information tools, which can be presented to providers, clinical and support staff, patients, and other caregivers at various points in time. These may include but are not limited to: computerized alerts and reminders for providers and patients; information displays or links; context-aware knowledge retrieval specifications which provide a standard mechanism to incorporate information from online resources (commonly referred to as InfoButtons); clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates; diagnostic support; and contextually relevant reference information. These functionalities may be deployed on a variety of platforms (that is, mobile, cloud-based, installed).
- The same interventions do not have to be implemented for the entire PI reporting period as long as the threshold of five is maintained for the duration of the PI reporting period.
- While the Office of National Coordinator on Health Information Technology 2015 Edition final rule specifies that the “CDS module” that is certified to the CDS standard must have certain capabilities to provide or enable CDS for provider use, it does not certify the supports or resources themselves.
- If there are limited CQMs applicable to an EP's scope of practice, the EP should implement CDS interventions that he or she believes will drive improvements in the delivery of care for the high-priority health conditions relevant to their specialty and patient population. These high priority conditions must be determined prior to the start of the PI reporting period in order to implement the appropriate CDS to allow for improved performance.
- Drug-drug and drug-allergy interaction alerts are separate from the five CDS interventions and do not count toward the five required for this first measure.



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Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(3)(i)(A) and (B). For further discussion please see [80 FR 62838](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315(a)(9) and (a)(4).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria	
§170.315(a)(9) Clinical decision support	<p>(i) CDS intervention interaction. Interventions provided to a user must occur when a user is interacting with technology.</p> <p>(ii) CDS configuration.</p> <p>(A) Enable interventions and reference resources specified in paragraphs (a)(9)(iii) and (iv) of this section to be configured by a limited set of identified users (e.g., system administrator) based on a user's role.</p> <p>(B) Enable interventions:</p> <p>(1) Based on the following data:</p> <p>(i) Problem list;</p> <p>(ii) Medication list;</p> <p>(iii) Medication allergy list;</p> <p>(iv) At least one demographic specified in paragraph (a)(5)(i) of this section;</p> <p>(v) Laboratory tests; and</p> <p>(vi) Vital signs.</p> <p>(2) When a patient's medications, medication allergies, and problems are incorporated from a transition of care/referral summary received and pursuant to paragraph (b)(2)(iii)(D) of this section.</p> <p>(iii) Evidence-based decision support interventions. Enable a limited set of identified users to select (i.e., activate) electronic CDS interventions (in addition to drug-drug and drug-allergy contraindication checking) based on each one and at least one combination of the data referenced in paragraphs (a)(9)(ii)(B)(1)(i) through (vi) of this section.</p>



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170.315(a)(4) Drug-drug, drug-allergy interaction checks

(iv) Linked referential CDS. (A) Identify for a user diagnostic and therapeutic reference information in accordance at least one of the following standards and implementation specifications:

(1) The standard and implementation specifications specified in §170.204(b)(3).

(2) The standard and implementation specifications specified in §170.204(b)(4).

(B) For paragraph (a)(9)(iv)(A) of this section, technology must be able to identify for a user diagnostic or therapeutic reference information based on each one and at least one combination of the data referenced in paragraphs (a)(9)(ii)(B)(1)(i), (ii), and (iv) of this section.

(v) Source attributes. Enable a user to review the attributes as indicated for all CDS resources:

(A) For evidence-based decision support interventions under paragraph (a)(9)(iii) of this section:

(1) Bibliographic citation of the intervention (clinical research/guideline);

(2) Developer of the intervention (translation from clinical research/guideline);

(3) Funding source of the intervention development technical implementation; and

(4) Release and, if applicable, revision date(s) of the intervention or reference source.

(B) For linked referential CDS in paragraph (a)(9)(iv) of this section and drug-drug, drug-allergy interaction checks in paragraph (a)(4) of this section, the developer of the intervention, and where clinically indicated, the bibliographic citation of the intervention (clinical research/guideline).

(i) Interventions. Before a medication order is completed and acted upon during computerized provider order entry, interventions must automatically indicate to a user drug-drug and drug-allergy contraindications based on a patient's medication list and medication allergy list.

(ii) Adjustments. (A) Enable the severity level of interventions provided for drug-drug interaction checks to be adjusted.



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	(B) Limit the ability to adjust severity levels in at least one of these two ways: (1) To a specific set of identified users. (2) As a system administrative function.
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Standards Criteria*	
§ 170.204(b) Reference source	Standard. HL7 Version 3 Standard: Context-Aware Retrieval Application (Infobutton) (incorporated by reference in §170.299). (1) Implementation specifications. HL7 Version 3 Implementation Guide: URL-Based Implementations of the Context-Aware Information Retrieval (Infobutton) Domain, (incorporated by reference in §170.299)
§ 170.204(b)(2) Implementation specifications	(2) HL7 Implementation Guide: Service-Oriented Architecture Implementations of the Context-aware Knowledge Retrieval (Infobutton) Domain, Draft Standard for Trial Use, Release 1 (incorporated by reference in §170.299).
§ 170.204(b)(3) Implementation specifications	(3) Standard. HL7 Version 3 Standard: Context Aware Knowledge Retrieval Application. (“Infobutton”), Knowledge Request, Release 2 (incorporated by reference in §170.299). Implementation specifications. HL7 Implementation Guide: Service-Oriented Architecture Implementations of the Context-aware Knowledge Retrieval (Infobutton) Domain, Release 1 (incorporated by reference in §170.299).
§ 170.204(b)(4) Implementation specifications	(4) Standard. HL7 Version 3 Standard: Context Aware Knowledge Retrieval Application (“Infobutton”), Knowledge Request, Release 2 (incorporated by reference in §170.299). Implementation specifications. HL7 Version 3 Implementation Guide: Context-Aware Knowledge Retrieval (Infobutton), Release 4 (incorporated by reference in §170.299).

* Note: Additional standards criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.



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Computerized Provider Order Entry (CPOE)	
Objective	Use CPOE for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.
Measure	<p>An eligible professional (EP), through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective:</p> <p>Measure 1 – More than 60 percent of medication orders created by the EP during the Promoting Interoperability (PI) reporting period are recorded using computerized provider order entry.</p> <p>Measure 2 – More than 60 percent of laboratory orders created by the EP during the PI reporting period are recorded using computerized provider order entry.</p> <p>Measure 3 – More than 60 percent of diagnostic imaging orders created by the EP during the PI reporting period are recorded using computerized provider order entry.</p>
Exclusion	<p>Measure 1 – Any EP who writes fewer than 100 medication orders during the PI reporting period.</p> <p>Measure 2 – Any EP who writes fewer than 100 laboratory orders during the PI reporting period.</p> <p>Measure 3 – Any EP who writes fewer than 100 diagnostic imaging orders during the PI reporting period.</p>

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Definition of Terms

CPOE – A provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.

Diagnostic Imaging – Includes other imaging tests such as ultrasound, magnetic resonance and computed tomography in addition to traditional radiology.

Laboratory Order – An order for any service provided by a laboratory that could not be provided by a non-laboratory.

Laboratory – A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Radiology Order – An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long as the policy is consistent across all patients and for the entire PI reporting period.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

MEASURE 1:

- **DENOMINATOR:** Number of medication orders created by the EP during the PI reporting period.
- **NUMERATOR:** The number of orders in the denominator recorded using CPOE.
- **THRESHOLD:** The resulting percentage must be more than 60 percent in order for an EP to meet this measure.
- **EXCLUSION:** Any EP who writes fewer than 100 medication orders during the PI reporting period.

MEASURE 2:

- **DENOMINATOR:** Number of laboratory orders created by the EP during the PI reporting period.
- **NUMERATOR:** The number of orders in the denominator recorded using CPOE.
- **THRESHOLD:** The resulting percentage must be more than 60 percent in order for an EP to meet this measure.

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- **EXCLUSION:** Any EP who writes fewer than 100 laboratory orders during the PI reporting period.

MEASURE 3:

- **DENOMINATOR:** Number of diagnostic imaging orders created by the EP during the PI reporting period.
- **NUMERATOR:** The number of orders in the denominator recorded using CPOE.
- **THRESHOLD:** The resulting percentage must be more than 60 percent in order for an EP to meet this measure.
- **EXCLUSION:** Any EP who writes fewer than 100 diagnostic imaging orders during the PI reporting period.

Additional Information

- To meet Stage 3 requirements for a PI reporting period in 2018, all providers must use technology certified to the [2015 Edition](#). A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. A provider who has technology certified to the 2014 Edition **may not** attest to Stage 3.
- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- The CPOE function must be used to create the first record of the order that becomes part of the patient's medical record and before any action can be taken on the order to count in the numerator.
- In some situations, it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under his/her direct supervision. Therefore, in these situations, so long as the order is entered using CPOE by a licensed healthcare professional, certified medical assistant or other appropriately credentialed staff member to create the first record of that order as it becomes part of the patient's medical record, these orders would count in the numerator of the CPOE measure.
- Any licensed health care professionals and clinical staff credentialed to and with the duties equivalent of a medical assistant or is appropriately credentialed and performs assistive services similar to a medical assistant, but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. It is up to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines prescribed. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.
- An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions (or both).



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- Orders involving tele-health or remote communication (such as phone orders) may be included in the numerator as long as the order entry otherwise meets the requirements of the objective and measures.
- Providers may exclude orders that are predetermined for a given set of patient characteristics or for a given procedure (also known as “protocol” or “standing orders”) from the calculation of CPOE numerators and denominators. Note this does not require providers to exclude this category of orders from their numerator and denominator ([77 FR 53986](#)).
- CPOE is the entry of the order into the patient's EHR that uses a specific function of CEHRT. CPOE does not otherwise specify how the order is filled or otherwise carried out.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(4)(i)(A) and (B). For further discussion please see [80 FR 62840](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315(a)(1) through (3).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.315(a)(1) Computerized provider order entry	(1) CPOE—medications (i) Enable a user to record, change, and access medication orders. (ii) Optional. Include a “reason for order” field.
§ 170.315(a)(2) Computerized provider order entry	(2) CPOE—laboratory. (i) Enable a user to record, change, and access laboratory orders. (ii) Optional. Include a “reason for order” field.
§ 170.315(a)(3) Computerized provider order entry	(3) CPOE—diagnostic imaging. (i) Enable a user to record, change, and access diagnostic imaging orders. (ii) Optional. Include a “reason for order” field.

* Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.315 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.



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Standards Criteria

N/A



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Patient Electronic Access to Health Information	
Objective	The eligible professional (EP) provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.
Measure	<p>EPs must satisfy both measures in order to meet this objective:</p> <p>Measure 1 – For more than 80 percent of all unique patients seen by the EP: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The provider ensures the patient’s health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider’s certified electronic health record technology (CEHRT).</p> <p>Measure 2 – The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the Promoting Interoperability (PI) reporting period.</p>
Exclusion	<p>Measure 1 and Measure 2: A provider may exclude the measures if one of the following applies:</p> <p>(i) An EP may exclude from the measure if they have no office visits during the PI reporting period.</p> <p>(ii) Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the PI reporting period may exclude the measure.</p>

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Definition of Terms

API – A set of programming protocols established for multiple purposes. APIs may be enabled by a provider or provider organization to provide the patient with access to their health information through a third-party application with more flexibility than is often found in many current “patient portals.”

Provide Access – When a patient possesses all of the necessary information needed to view, download, or transmit their information. This could include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information.

View – The patient (or authorized representative) accessing their health information online.

Download – The movement of information from online to physical electronic media.

Transmission – This may be any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.

Business Days – Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

Diagnostic Test Results – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

MEASURE 1:

- **DENOMINATOR:** The number of unique patients seen by the EP during the PI reporting period.
- **NUMERATOR:** The number of patients in the denominator (or patient-authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the provider’s CEHRT.
- **THRESHOLD:** The resulting percentage must be more than 80 percent in order for a provider to meet this measure.
- **EXCLUSIONS:** A provider may exclude this measure if one of the following applies:
 - An EP may exclude from the measure if they have no office visits during the PI reporting period.



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- Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measure.

MEASURE 2:

- DENOMINATOR: The number of unique patients seen by the EP during the PI reporting period.
- NUMERATOR: The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the PI reporting period.
- THRESHOLD: The resulting percentage must be more than 35 percent in order for a provider to meet this measure.
- EXCLUSIONS: A provider may exclude this measure if one of the following applies:
 - An EP may exclude from the measure if they have no office visits during the PI reporting period.
 - Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measure.

Additional Information

- To meet Stage 3 requirements for a PI reporting period in 2018, all providers must use technology certified to the [2015 Edition](#). A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. A provider who has technology certified to the 2014 Edition **may not** attest to Stage 3.
- To implement an API, the provider would need to fully enable the API functionality such that any application chosen by a patient would enable the patient to gain access to their individual health information provided that the application is configured to meet the technical specifications of the API. Providers may not prohibit patients from using any application, including third-party applications, which meet the technical specifications of the API, including the security requirements of the API. Providers are expected to provide patients with detailed instructions on how to authenticate their access through the API and provide the patient with supplemental information on available applications that leverage the API.
- Similar to how providers support patient access to view, download, and transmit capabilities, providers should continue to have identity verification processes to ensure that a patient using an application, which is leveraging the API, is provided access to their health information.
- In circumstances where there is no information available to populate one or more of the fields previously listed, either because the EP can be excluded from recording such information or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have an indication that the information is not available and still meet the objective and its associated measure.



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- The patient must be able to access this information on demand, such as through a patient portal or personal health record (PHR) or by other online electronic means. We note that while a covered entity may be able to fully satisfy a patient's request for information through view, download, and transmit, the measure does not replace the covered entity's responsibilities to meet the broader requirements under Health Insurance Portability and Accountability Act (HIPAA) to provide an individual, upon request, with access to patient health information (PHI) in a designated record set.
- Providers should also be aware that while meaningful use is limited to the capabilities of CEHRT to provide online access there may be patients who cannot access their EHRs electronically because of a disability. Providers who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- For Measure 1, providers must offer all four functionalities (view, download, transmit, and access through API) to their patients. And, PHI needs to be made available to each patient for view, download, and transmit within 48 hours of the information being available to the provider for each and every time that information is generated whether the patient has been "enrolled" for three months or for three years.
- A patient who has multiple encounters during the PI reporting period, or even in subsequent PI reporting periods in future years, needs to be provided access for each encounter where they are seen by the EP.
- If a patient elects to "opt out" of participation, that patient must still be included in the denominator.
- If a patient elects to "opt out" of participation, the provider may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access their information, obtain access through a patient-authorized representative, or otherwise opt-back-in without further follow up action required by the provider.
- For Measure 2, beginning in 2017, actions included in the numerator must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs (between January 1st and December 31st).
- Paper-based actions are no longer allowed or required to be counted for measure 2 calculations. Providers may still provide paper based educational materials for their patients, we are just no longer allowing them to be included in measure calculations.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(5)(i)(A) and (B). For further discussion please see [80 FR 62846](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (a)(13) and (g)(8) and (9).



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Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.315(a)(13) Patient Specific Education	<p>(i) Identify patient-specific education resources based on data included in the patient's problem list and medication list in accordance with at least one of the following standards and implementation specifications:</p> <p>(A) The standard and implementation specifications specified in §170.204(b)(3).</p> <p>(B) The standard and implementation specifications specified in §170.204(b)(4).</p> <p>(ii) Optional. Request that patient-specific education resources be identified in accordance with the standard in §170.207(g)(2).</p>
§ 170.315(g)(8) Design Performance	<p>(8) Application Access. Data category request. The following technical outcome and conditions must be met through the demonstration of an application programming interface.</p> <p>(i) Functional requirements. (A) Respond to requests for patient data (based on an ID or other token) for each of the individual data categories specified in the Common Clinical Data Set and return the full set of data for that data category (according to the specified standards, where applicable) in a computable format.</p> <p>(B) Respond to requests for patient data associated with a specific date as well as requests for patient data within a specified date range.</p> <p>(ii) Documentation—(A) The API must include accompanying documentation that contains, at a minimum:</p> <p>(1) API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns.</p> <p>(2) The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s).</p> <p>(3) Terms of use. The terms of use for the API must be provided, including, at a minimum, any associated developer policies and required developer agreements.</p>



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	<p>(B) The documentation used to meet paragraph (g)(8)(ii)(A) of this section must be available via a publicly accessible hyperlink.</p>
<p>§ 170.315(g)(9) Design Performance</p>	<p>(9) All data request. The following technical outcome and conditions must be met through the demonstration of an API.</p> <p>(i) Functional requirements. (A) Respond to requests for patient data (based on an ID or other token) for all of the data categories specified in the Common Clinical Data Set at one time and return such data (according to the specified standards, where applicable) in a summary record formatted according to the standard specified in §170.205(a)(4) following the CCD document template.</p> <p>(B) Respond to requests for patient data associated with a specific date as well as requests for patient data within a specified date range.</p> <p>(ii) Documentation—(A) The API must include accompanying documentation that contains, at a minimum:</p> <p>(1) API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns.</p> <p>(2) The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s).</p> <p>(3) Terms of use. The terms of use for the API must be provided, including, at a minimum, any associated developer policies and required developer agreements.</p> <p>(B) The documentation used to meet paragraph (g)(9)(ii)(A) of this section must be available via a publicly accessible hyperlink.</p> <p>(h) Transport methods and other protocols — (1) Direct Project—</p> <p>(i) Applicability Statement for Secure Health Transport. Able to send and receive health information in accordance with the standard specified in §170.202(a)(2), including formatted only as a “wrapped” message.</p> <p>(ii) Delivery Notification in Direct. Able to send and receive health information in accordance with the standard specified in §170.202(e)(1).</p>



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	<p>(2) Direct Project, Edge Protocol, and XDR/XDM—(i) Able to send and receive health information in accordance with:</p> <p>(A) The standard specified in §170.202(a)(2), including formatted only as a “wrapped” message;</p> <p>(B) The standard specified in §170.202(b), including support for both limited and full XDS metadata profiles; and</p> <p>(C) Both edge protocol methods specified by the standard in §170.202(d).</p> <p>(ii) Delivery Notification in Direct. Able to send and receive health information in accordance with the standard specified in §170.202(e)(1).</p>
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**Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.*

Standards Criteria*	
§ 170.204(a)	Web Content Accessibility Guidelines (WCAG) 2.0, Level A Conformance (incorporated by reference in § 170.299).
§ 170.210(f)	Any encryption and hashing algorithm identified by the National Institute of Standards and Technology as an approved security function in Annex A of the FIPS Publication 140-2 (incorporated by reference in § 170.299).
§ 170.205(a)(3)	HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, (incorporated by reference in §170.299). The use of the “unstructured document” document-level template is prohibited.
§ 170.202(a)	ONC Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).
§ 170.210(g)	The date and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, (incorporated by reference in §170.299) or (RFC 5905) Network Time Protocol Version 4, (incorporated by reference in §170.299).

**Note: Additional standards criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.*



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Coordination of Care through Patient Engagement	
Objective	Use certified electronic health record technology (CEHRT) to engage with patients or their authorized representatives about the patient's care.
Measure	<p>Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective:</p> <p>Measure 1 – For a Promoting Interoperability (PI) reporting period in 2018, more than 5 percent of all unique patients (or their authorized representatives) seen by the eligible professional (EP) actively engage with the EHR made accessible by the provider and either—</p> <ul style="list-style-type: none">(1) View, download or transmit to a third party their health information; or(2) Access their health information through the use of an Application Programming Interface (API) that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or(3) A combination of (1) and (2) <p>Threshold for 2019 and Subsequent Years: The resulting percentage must be more than 10 percent.</p> <p>Measure 2 – For a PI reporting period in 2018, more than 5 percent of all unique patients seen by the EP during the PI reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative.</p> <p>Threshold in 2019 and Subsequent Years: The resulting percentage must be more than 25 percent in order for an EP to meet this measure.</p> <p>Measure 3 – Patient generated health data or data from a non-clinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the PI reporting period.</p>



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Exclusion

Measure 1, 2 and 3 Exclusion: A provider may exclude the measures if one of the following apply:

- (i) An EP may exclude from the measure if they have no office visits during the PI reporting period, or;
- (ii) Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the PI reporting period may exclude the measure.

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Definition of Terms

API – A set of programming protocols established for multiple purposes. APIs may be enabled by a provider or provider organization to provide the patient with access to their health information through a third-party application with more flexibility than is often found in many current “patient portals.”

View – The patient (or authorized representative) accessing their health information online.

Download – The movement of information from online to physical electronic media.

Transmission – This may be any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.

Patient Generated Health Data – Data generated by a patient or a patient's authorized representative.

Data from a Non-Clinical Setting – This includes, but is not limited to, social service data, data generated by a patient or a patient's authorized representative, advance directives, medical device data, home health monitoring data, and fitness monitor data.

Secure Message – Any electronic communication between a provider and patient that ensures only those parties can access the communication. This electronic message could be email or the electronic messaging function of a personal health record (PHR), an online patient portal, or any other electronic means.



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Unique Patient – If a patient is seen by an EP more than once during the PI reporting period, then for purposes of measurement, that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same PI reporting period.

Attestation Requirements

Denominator/Numerator/Threshold/EXCLUSIONS

Measure 1:

- **DENOMINATOR:** Number of unique patients seen by the EP during the PI reporting period.
- **NUMERATOR:** The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient’s health information during the PI reporting period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the PI reporting period.
- **THRESHOLD FOR 2018:** The resulting percentage must be more than 5 percent.
- **THRESHOLD FOR 2019 AND SUBSEQUENT YEARS:** The resulting percentage must be more than 10 percent.
- **EXCLUSIONS:** An EP may exclude from the measure if he or she has no office visits during the PI reporting period, or:
 - Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measure.

Measure 2:

- **DENOMINATOR:** Number of unique patients seen by the EP during the PI reporting period.
- **NUMERATOR:** The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the PI reporting period.
- **THRESHOLD FOR 2018:** The resulting percentage must be more than 5 percent.
- **THRESHOLD FOR 2019 AND SUBSEQUENT YEARS:** The resulting percentage must be more than 25 percent.
- **EXCLUSIONS:** An EP may exclude from the measure if they have no office visits during the PI reporting period, or:
 - Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measure.



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Measure 3:

- DENOMINATOR: Number of unique patients seen by the EP during the PI reporting period.
- NUMERATOR: The number of patients in the denominator for whom data from non-clinical settings, which may include patient generated health data, is captured through the CEHRT into the patient record during the PI reporting period.
- THRESHOLD: The resulting percentage must be more than 5 percent.
- EXCLUSIONS: An EP may exclude from the measure if they have no office visits during the PI reporting period, or;
- Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measure.

Additional Information

- To meet Stage 3 requirements, all providers must use technology certified to the 2015 Edition. A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. A provider who has technology certified to the 2014 Edition **may not** attest to Stage 3.
- For the numerator for measures 1 and 2, beginning in 2017, the action must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs (between January 1st and December 31st).
- Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- There are four actions a patient might take as part of Measure 1: 1. View their information, 2. Download their information, 3. Transmit their information to a third party, and 4. Access their information through an API. These actions may overlap, but a provider is able to count any and all actions in the single numerator. Therefore, for the first measure, a provider may meet a combined threshold for view, download, and transmit and API actions, or if their technology functions overlap, then any view, download, transmit, or API actions taken by the patient using CEHRT would count toward the threshold.
- In order to meet the objective, the following information must be available within 4 business days of the information being made available to the EP:
 - Patient name
 - Provider's name and office contact information
 - Current and past problem list
 - Procedures
 - Laboratory test results
 - Current medication list and medication history
 - Current medication allergy list and medication allergy history
 - Vital signs (height, weight, blood pressure, BMI, growth charts)
 - Smoking status



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- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field(s), including goals and instructions
- Any known care team members including the primary care provider of record
- An EP can make available additional information and still align with the objective.
- Measure 2 includes provider-initiated communications (when a provider sends a message to a patient or the patient's authorized representatives), and provider-to-provider communications if the patient is included. A provider can only count messages in the numerator when the provider participates in the communication (e.g any patient-initiated communication only if the provider responds to the patient. *Note: Providers are not required to respond to every message received if no response is necessary.*
- For Measure 3, the types of data that would satisfy the measure are broad. It may include, but is not limited to, social service data, data generated by a patient or a patient's authorized representative, advance directives, medical device data, home health monitoring data, and fitness monitor data. In addition, the sources of data vary and may include mobile applications for tracking health and nutrition, home health devices with tracking capabilities such as scales and blood pressure monitors, wearable devices such as activity trackers or heart monitors, patient-reported outcome data, and other methods of input for patient and non-clinical setting generated health data. Telehealth platform, personal health records, social determinant of health screening modules, long term care/post-acute care coordination platforms might also be considered. (*Note: Data related to billing, payment, or other insurance information would not satisfy this measure.*)
- For measure 3, providers in non-clinical settings may include, but are not limited to, care providers such as nutritionists, physical therapists, occupational therapists, psychologists, and home health care providers. Other key providers in the care team such as behavioral health care providers, may also be included, and we encourage providers to consider ways in which this measure can incorporate this essential information from the broader care team.
- For the Patient Generated Health Data measure, the data may not be information the patient provides to the EP on location during the office visit as such data does not meet the intent of the measure to support care coordination and patient engagement in a wide range of settings outside the provider's immediate scope of practice.
- For measure 3, we do not specify the manner in which providers are required to incorporate the data. Providers may work with their EHR developers to establish the methods and processes that work best for their practice and needs. For example, if data provided can be easily incorporated in a structured format or into an existing field within the EHR (such as a C-CDA or care team member reported vital signs or patient reported family health history and demographic information) the provider may elect to do so. Alternately, a provider may maintain an isolation between the data and the patient record and instead include the data by other means such as attachments, links, and text references again as best meets their needs.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(6)(i)(A) and (B). For further discussion please see [80 FR 62851](#).
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT as defined at § at 45 CFR 170.315(e)(1)(2) and (3).



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Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§170.315(e)(1) Patient engagement	<p>(1) View, download, and transmit to 3rd party. (i) Patients (and their authorized representatives) must be able to use internet-based technology to view, download, and transmit their health information to a 3rd party in the manner specified below. Such access must be consistent and in accordance with the standard adopted in §170.204(a)(1) and may alternatively be demonstrated in accordance with the standard specified in §170.204(a)(2).</p> <p>(A) View. Patients (and their authorized representatives) must be able to use health information technology (HIT) to view, at a minimum, the following data:</p> <p>(1) The Common Clinical Data Set (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set).</p> <p>(2) Ambulatory setting only. Provider's name and office contact information.</p> <p>(3) Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization.</p> <p>(4) Laboratory test report(s). Laboratory test report(s), including:</p> <p>(i) The information for a test report as specified all the data specified in 42 CFR 493.1291(c)(1) through (7);</p> <p>(ii) The information related to reference intervals or normal values as specified in 42 CFR 493.1291(d); and</p> <p>(iii) The information for corrected reports as specified in 42 CFR 493.1291(k)(2).</p> <p>(5) Diagnostic image report(s).</p> <p>(B) Download. (1) Patients (and their authorized representatives) must be able to use technology to download an ambulatory summary or inpatient summary (as applicable to the HIT setting for which certification is requested) in the following formats:</p> <p>(i) Human readable format; and</p> <p>(ii) The format specified in accordance to the standard specified in §170.205(a)(4) following the CCD document template.</p>



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§170.315(e)(2)
Patient engagement

(2) When downloaded according to the standard specified in §170.205(a)(4) following the CCD document template, the ambulatory summary or inpatient summary must include, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set):

(i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1), (2), (4), and (5) of this section.

(ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1), and (3) through (5) of this section.

(3) Inpatient setting only. Patients (and their authorized representatives) must be able to download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion specified in paragraph (b)(1) of this section).

(C) Transmit to third party. Patients (and their authorized representatives) must be able to:

(1) Transmit the ambulatory summary or inpatient summary (as applicable to the HIT setting for which certification is requested) created in paragraph (e)(1)(i)(B)(2) of this section in accordance with both of the following ways:

- (i) Email transmission to any email address; and
- (ii) An encrypted method of electronic transmission.

(2) Inpatient setting only. Transmit transition of care/referral summaries (as a result of a transition of care/referral as referenced by (e)(1)(i)(B)(3)) of this section selected by the patient (or their authorized representative) in both of the ways referenced (e)(1)(i)(C)(1)(i) and (ii) of this section).

(D) Timeframe selection. With respect to the data available to view, download, and transmit as referenced paragraphs (e)(1)(i)(A), (B), and (C) of this section, patients (and their authorized representatives) must be able to:

- (1) Select data associated with a specific date (to be viewed, downloaded, or transmitted); and
- (2) Select data within an identified date range (to be viewed, downloaded, or transmitted).



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	<p>(ii) Activity history log. (A) When any of the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section are used, the following information must be recorded and made accessible to the patient (or his/her authorized representative):</p> <ol style="list-style-type: none"> (1) The action(s) (i.e., view, download, transmission) that occurred; (2) The date and time each action occurred in accordance with the standard specified in §170.210(g); (3) The user who took the action; and (4) Where applicable, the addressee to whom an ambulatory summary or inpatient summary was transmitted. <p>(B) Technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section if it is also certified to the certification criterion specified in §170.315(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) of this section is accessible by the patient (or his/her authorized representative).</p> <ol style="list-style-type: none"> (2) Secure messaging. Enable a user to send messages to, and receive messages from, a patient in a secure manner. (3) Patient health information capture. Enable a user to:
<p>§170.315(e)(3) Patient engagement</p>	<ol style="list-style-type: none"> (i) Identify, record, and access information directly and electronically shared by a patient (or authorized representative). (ii) Reference and link to patient health information documents.

** Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.*

Standards Criteria	
<p>§ 170.204(a)</p>	<p>Web Content Accessibility Guidelines (WCAG) 2.0, Level A Conformance (incorporated by reference in § 170.299).</p>
<p>§ 170.210(f)</p>	<p>Any encryption and hashing algorithm identified by the National Institute of Standards and Technology as an approved security function in Annex A of the FIPS Publication 140-2 (incorporated by reference in § 170.299).</p>



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§ 170.205(a)(3)	HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, (incorporated by reference in §170.299). The use of the “unstructured document” document-level template is prohibited
§ 170.202(a)	ONC Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).
§ 170.210(g)	The date and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, (incorporated by reference in §170.299) or (RFC 5905) Network Time Protocol Version 4, (incorporated by reference in §170.299).

* Note: Additional standards criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.



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Health Information Exchange (HIE)	
Objective	The eligible professional (EP) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT).
Measure	<p>Providers must attest to all three measures and must meet the threshold for at least two measures to meet the objective.</p> <p>Measure 1 – For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) Electronically exchanges the summary of care record</p> <p>Measure 2 – For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient’s EHR an electronic summary of care document.</p> <p>Measure 3 – For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient’s medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient’s known medication allergies. (3) Current Problem list. Review of the patient’s current and active diagnoses.</p>
Exclusion	<p>Measure 1 – A provider may exclude from the measure if any of the following apply: (1) Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the Promoting Interoperability (PI) reporting period. (2) Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to</p>

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the latest information available from the Federal Communications Commission (FCC) on the first day of the PI reporting period may exclude the measures.

Measure 2 – A provider may exclude from the measure if any of the following apply:

(1) Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.

(2) Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measures.

Measure 3 – Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.

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Definition of Terms

Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

Summary of Care Record – All summary of care documents used to meet this objective must include the following information if the provider knows it:

- Patient name
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Smoking status
- Current problem list (providers may also include historical problems at their discretion)*
- Current medication list*
- Current medication allergy list*

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- Laboratory test(s)
- Laboratory value(s)/result(s)
- Vital signs (height, weight, blood pressure, Body Mass Index (BMI))
- Procedures
- Care team member(s) (including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider)*
- Immunizations
- Unique device identifier(s) for a patient's implantable device(s)
- Care plan, including goals, health concerns, and assessment and plan of treatment
- Referring or transitioning provider's name and office contact information
- Encounter diagnosis
- Functional status, including activities of daily living, cognitive and disability status
- Reason for referral

**Note: An EP must verify that the fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies.*

Current problem lists – At a minimum a list of current and active diagnoses.

Active/current medication list – A list of medications that a given patient is currently taking.

Active/current medication allergy list – A list of medications to which a given patient has known allergies.

Allergy – An exaggerated immune response or reaction to substances that are generally not harmful.

Care Plan – The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: goals, health concerns, assessment, and plan of treatment.

Attestation Requirements

DENOMINATOR/NUMERATOR/THRESHOLD/EXCLUSION

Measure 1:

- DENOMINATOR: Number of transitions of care and referrals during the PI reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: The number of transitions of care and referrals in the denominator where a summary of care record was created using certified EHR technology and exchanged electronically.

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- **THRESHOLD:** The percentage must be more than 50 percent in order for an EP to meet this measure.
- **EXCLUSION:** A provider may exclude from the measure if any of the following apply:
 - Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the PI reporting period.
 - Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measure.

Measure 2:

- **DENOMINATOR:** Number of patient encounters during the PI reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.
- **NUMERATOR:** Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the certified EHR technology.
- **THRESHOLD:** The percentage must be more than 40 percent in order for an EP to meet this measure.
- **EXCLUSION:** A provider may exclude from the measure if any of the following apply:
 - Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.
 - Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measure.

Measure 3:

- **DENOMINATOR:** Number of transitions of care or referrals during the PI reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient.
- **NUMERATOR:** The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.
- **THRESHOLD:** The resulting percentage must be more than 80 percent in order for an EP to meet this measure.
- **EXCLUSION:** Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.

Additional Information

- To meet Stage 3 requirements, all providers must use technology certified to the [2015 Edition for the Health Information Exchange objective](#).

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- For Measure 1 and 3, providers may continue to limit the denominator to those patients whose records are maintained using CEHRT for measures with a denominator other than unique patients seen by the EP during the PI reporting period.
- For Measure 1, beginning in 2017, in order to count in the numerator, the exchange must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs.
- For Measure 1, the referring provider must have reasonable certainty of receipt by the receiving provider to count the action toward the measure a provider must have this may include confirmation of receipt or that a query of the summary of care record has occurred in order to count the action in the numerator.
- Apart from the three fields noted as required for the summary of care record (i.e., current problem list, current medication list, and current medication allergy list), in circumstances where there is no information available to populate one or more of the fields listed (because the EP does not record such information or because there is no information to record), the EP may leave the field(s) blank and still meet the objective and its associated measure.
- A provider must have the ability to transmit all data pertaining to laboratory test results in the summary of care document, but may work with their system developer to establish clinically relevant parameters for the most appropriate results for the given transition or referral.
- A provider who limits the transmission of laboratory test result data in a summary of care document must send the full results upon request (i.e., all lab results as opposed to a subset).
- The exchange must comply with the privacy and security protocols for electronic protected health information (ePHI) under the Health Insurance Portability and Accountability Act (HIPAA).
- In cases where the providers share access to an EHR, a transition or referral may still count toward the measure if the referring provider creates the summary of care document using CEHRT and sends the summary of care document electronically. If a provider chooses to include such transitions to providers where access to the EHR is shared, they must do so universally for all patient and all transitions or referrals.
- For Measure 1, the initiating provider must send a consolidated clinical document architecture (C-CDA) document that the receiving provider would be capable of electronically incorporating as a C-CDA on the receiving end. In other words, if a provider sends a C-CDA and the receiving provider converts the C-CDA into a pdf or a fax or some other format, the sending provider may still count the transition or referral in the numerator. If the sending provider converts the file to a format the receiving provider could not electronically receive and incorporate as a C-CDA, the initiating provider may not count the transition in their numerator.
- For the purposes of defining the cases in the denominator for Measure 2, we stated that what constitutes “unavailable” and, therefore, may be excluded from the denominator, will be that a provider—
 - Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; and
 - The provider either:
 - Queried at least one external source via HIE functionality and did not locate a summary of care for the patient, or the provider does not have access to HIE functionality to support such a query, or

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- Confirmed that HIE functionality supporting query for summary of care documents was not operational in the provider's geographic region and not available within the provider's EHR network as of the start of the PI reporting period.
- For Measure 2, a record cannot be considered to be incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for provider use within the EHR.
- For Measure 3, the process may include both automated and manual reconciliation to allow the receiving provider to work with both the electronic data provided with any necessary review, and to work directly with the patient to reconcile their health information.
- For Measure 3, if no update is necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received on referral and determining that such information is merely duplicative of existing information in the patient record.
- Non-medical staff may conduct reconciliation under the direction of the provider so long as the provider or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant CDS.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(7)(i)(A) and (B). For further discussion please see [80 FR 62861](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (b)(1) through (b)(3) and (a)(6) through (a)(8).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for electronic health record technology that supports achieving the meaningful use of this objective.

Certification Criteria*	
§ 170.315(b)(1) Care Coordination	(1) Transitions of care—(i) Send and receive via edge protocol— (A) Send transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) and that leads to such summaries being processed by a service that has implemented the standard specified in §170.202(a)(2); and (B) Receive transition of care/referral summaries through a method that conforms to the standard specified in §170.202(d) from a service that has implemented the standard specified in §170.202(a)(2). (C) XDM processing. Receive and make available the contents of a XDM package formatted in accordance with the standard

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adopted in §170.205(p)(1) when the technology is also being certified using an SMTP-based edge protocol.

(ii) Validate and display—(A) Validate C-CDA conformance—system performance. Demonstrate the ability to detect valid and invalid transition of care/referral summaries received and formatted in accordance with the standards specified in §170.205(a)(3) and §170.205(a)(4) for the Continuity of Care Document (CCD), Referral Note, and (inpatient setting only) Discharge Summary document templates. This includes the ability to:

- (1) Parse each of the document types.
- (2) Detect errors in corresponding “document-templates,” “section-templates,” and “entry-templates,” including invalid vocabulary standards and codes not specified in the standards adopted in §170.205(a)(3) and §170.205(a)(4).
- (3) Identify valid document-templates and process the data elements required in the corresponding section-templates and entry-templates from the standards adopted in §170.205(a)(3) and §170.205(a)(4).
- (4) Correctly interpret empty sections and null combinations.
- (5) Record errors encountered and allow a user through at least one of the following ways to:

- (i) Be notified of the errors produced.
- (ii) Review the errors produced.

(B) Display. Display in human readable format the data included in transition of care/referral summaries received and formatted according to the standards specified in §170.205(a)(3) and §170.205(a)(4).

(C) Display section views. Allow for the individual display of each section (and the accompanying document header information) that is included in a transition of care/referral summary received and formatted in accordance with the standards adopted in §170.205(a)(3) and §170.205(a)(4) in a manner that enables the user to:

- (1) Directly display only the data within a particular section;
- (2) Set a preference for the display order of specific sections; and
- (3) Set the initial quantity of sections to be displayed.

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(iii) Create. Enable a user to create a transition of care/referral summary formatted in accordance with the standard specified in §170.205(a)(4) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates that includes, at a minimum:

(A) The Common Clinical Data Set.
(B) Encounter diagnoses. Formatted according to at least one of the following standards:

- (1) The standard specified in §170.207(i).
- (2) At a minimum, the version of the standard specified in §170.207(a)(4).
- (C) Cognitive status.
- (D) Functional status.
- (E) Ambulatory setting only. The reason for referral; and referring or transitioning provider's name and office contact information.
- (F) Inpatient setting only. Discharge instructions.
- (G) Patient matching data. First name, last name, previous name, middle name (including middle initial), suffix, date of birth, address, phone number, and sex. The following constraints apply:

(1) Date of birth constraint—(i) The year, month and day of birth must be present for a date of birth. The technology must include a null value when the date of birth is unknown.

(ii) Optional. When the hour, minute, and second are associated with a date of birth the technology must demonstrate that the correct time zone offset is included.

(2) Phone number constraint. Represent phone number (home, business, cell) in accordance with the standards adopted in §170.207(q)(1). All phone numbers must be included when multiple phone numbers are present.

(3) Sex constraint. Represent sex in accordance with the standard adopted in §170.207(n)(1).

§ 170.315(b)(2) Care Coordination

(2) Clinical information reconciliation and incorporation—(i) General requirements. Paragraphs (b)(2)(ii) and (iii) of this section must be completed based on the receipt of a transition of care/referral summary formatted in accordance with the standards adopted in §170.205(a)(3) and §170.205(a)(4) using the Continuity of Care Document, Referral Note, and (inpatient setting only) Discharge Summary document templates.

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	<p>(ii) Correct patient. Upon receipt of a transition of care/referral summary formatted according to the standards adopted §170.205(a)(3) and §170.205(a)(4), technology must be able to demonstrate that the transition of care/referral summary received can be properly matched to the correct patient.</p> <p>(iii) Reconciliation. Enable a user to reconcile the data that represent a patient's active medication list, medication allergy list, and problem list as follows. For each list type:</p> <p>(A) Simultaneously display (i.e., in a single view) the data from at least two sources in a manner that allows a user to view the data and their attributes, which must include, at a minimum, the source and last modification date.</p> <p>(B) Enable a user to create a single reconciled list of each of the following: Medications; medication allergies; and problems.</p> <p>(C) Enable a user to review and validate the accuracy of a final set of data.</p> <p>(D) Upon a user's confirmation, automatically update the list, and incorporate the following data expressed according to the specified standard(s):</p> <p>(1) Medications. At a minimum, the version of the standard specified in §170.207(d)(3);</p> <p>(2) Medication allergies. At a minimum, the version of the standard specified in §170.207(d)(3); and</p> <p>(3) Problems. At a minimum, the version of the standard specified in §170.207(a)(4).</p>
§ 170.315(b)(3) Care Coordination	<p>(iv) System verification. Based on the data reconciled and incorporated, the technology must be able to create a file formatted according to the standard specified in §170.205(a)(4) using the Continuity of Care Document template.</p>
§ 170.315(a)(6) Problem list	<p>Enable a user to record, change, and access a patient's active problem list:</p> <p>(i) Ambulatory setting only. Over multiple encounters in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4).</p> <p>(ii) Inpatient setting only. For the duration of an entire hospitalization in accordance with, at a minimum, the version of the standard specified in §170.207(a)(4)</p>

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§ 170.315(a)(7) Medication list	<p>Enable a user to record, change, and access a patient's active medication list as well as medication history:</p> <p>(i) Ambulatory setting only. Over multiple encounters. (ii) Inpatient setting only. For the duration of an entire hospitalization.</p>
§ 170.315(a)(8) Medication Allergy List	<p>Enable a user to record, change, and access a patient's active medication allergy list as well as medication allergy history:</p> <p>(i) Ambulatory setting only. Over multiple encounters. (ii) Inpatient setting only. For the duration of an entire hospitalization.</p>

**Note: Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this PI measure.*

Standards Criteria	
§ 170.202(a) Transport standards	Office of National Coordinator for Health Information Technology (ONC) Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).
§ 170.202(2)(b) Transport standards	<p>ONC Applicability Statement for Secure Health Transport, Version 1.2 (incorporated by reference in §170.299).</p> <p>(b) Standard. ONC XDR and XDM for Direct Messaging Specification (incorporated by reference in §170.299).</p>
§ 170.202(2)(c) Transport standards	ONC Transport and Security Specification (incorporated by reference in §170.299).
§ 170.205(a)(1) Patient Summary Record	Health Level Seven Clinical Document Architecture (CDA) Release 2, Continuity of Care Document (CCD) (incorporated by reference in §170.299). Implementation specifications. The Healthcare Information Technology Standards Panel (HITSP) Summary Documents Using HL7 CCD Component HITSP/C32 (incorporated by reference in §170.299).

Additional certification criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.

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Public Health and Clinical Data Registry Reporting	
Objective	The eligible professional (EP) is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified electronic health record technology (CEHRT), except where prohibited, and in accordance with applicable law and practice.
Measure Options	<p>Measure 1 – Immunization Registry Reporting: The EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).</p> <p>Measure 2 – Syndromic Surveillance Reporting: The EP is in active engagement with a PHA to submit syndromic surveillance data from an urgent care setting.</p> <p>Measure 3 – Electronic Case Reporting: The EP is in active engagement with a PHA to submit case reporting of reportable conditions.</p> <p>Measure 4 – Public Health Registry Reporting: The EP is in active engagement with a PHA to submit data to public health registries.</p> <p>Measure 5 – CDR Reporting: The EP is in active engagement to submit data to a CDR.</p>
Exclusion	<p>Measure 1 – Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP—</p> <ul style="list-style-type: none"> (1) Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction’s immunization registry or IIS during the Promoting Interoperability (PI) reporting period; (2) Operates in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or (3) Operates in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of 6 months prior to the start of the PI reporting period.



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Measure 2 – Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP—

- (1) Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
- (2) Operates in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
- (3) Operates in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs as of 6 months prior to the start of the PI reporting period.

Measure 3 – Any EP meeting one or more of the following criteria may be excluded from the case reporting measure if the EP—

- (1) Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the PI reporting period;
- (2) Operates in a jurisdiction for which no PHA is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
- (3) Operates in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of six months prior to the start of the PI reporting period.

Measure 4 – Any EP meeting at least one of the following criteria may be excluded from the public health registry reporting measure if the EP—

- (1) Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the PI reporting period;
- (2) Operates in a jurisdiction for which no PHA is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
- (3) Operates in a jurisdiction where no PHA for which the eligible hospital or critical access hospital (CAH) is eligible has declared readiness to receive electronic registry transactions as of six months prior to the start of the PI reporting period.

Measure 5 – Any EP meeting at least one of the following criteria may be excluded from the CDR reporting measure if the EP—



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- (1) Does not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the PI reporting period;
- (2) Operates in a jurisdiction for which no CDR is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
- (3) Operates in a jurisdiction where no CDR for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of six months prior to the start of the PI reporting period.

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Definition of Terms

Active engagement – Means that the provider is in the process of moving towards sending "production data" to a PHA or CDR, or is sending production data to a PHA or CDR.

Active Engagement Option 1 – Completed Registration to Submit Data – The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the PI reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each PI reporting period.

Active Engagement Option 2 – Testing and Validation – The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within a PI reporting period would result in that provider not meeting the measure.

Active Engagement Option 3 – Production – The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

Production data – Refers to data generated through clinical processes involving patient care, and it is used to distinguish between data and "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers.



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Attestation Requirements

YES/NO/EXCLUSIONS

Measure 1:

- YES/NO: The EP must attest YES to being in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/IIS.
- EXCLUSIONS: Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP—
 - Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or IIS during the PI reporting period;
 - Operates in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of six months prior to the start of the PI reporting period.

Measure 2:

- YES/NO: The EP must attest YES to being in active engagement with a PHA to submit syndromic surveillance data from an urgent care setting.
- EXCLUSIONS: Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP—
 - Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
 - Operates in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs as of six months prior to the start of the PI reporting period.

Measure 3:

- YES/NO: The EP must attest YES to being in active engagement with a PHA to submit case reporting of reportable conditions.
- EXCLUSIONS: Any EP meeting one or more of the following criteria may be excluded from the case reporting measure if the EP—
 - Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the PI reporting period;
 - Operates in a jurisdiction for which no PHA is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or



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- Operates in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of six months prior to the start of the PI reporting period.

Measure 4:

- YES/NO: The EP must attest YES to being in active engagement with a PHA to submit data to public health registries.
- EXCLUSIONS: Any EP meeting at least one of the following criteria may be excluded from the public health registry reporting measure if the EP—
 - Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the PI reporting period;
 - Operates in a jurisdiction for which no PHA is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no public health registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of six months prior to the start of the PI reporting period.

Measure 5:

- YES/NO: The EP must attest YES to being in active engagement to submit data to a CDR.
- EXCLUSIONS: Any EP meeting at least one of the following criteria may be excluded from the CDR reporting measure if the EP—
 - Does not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the PI reporting period;
 - Operates in a jurisdiction for which no CDR is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period; or
 - Operates in a jurisdiction where no CDR for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of six months prior to the start of the PI reporting period.

Additional Information

- To meet all the measures within the public health objective, EPs must use CEHRT and the standards included in the [2015 Edition proposed rule](#). CMS anticipates that as new public health registries and CDRs are created, the Office of National Coordinator for Health Information Technology (ONC) and CMS will work with the public health community and clinical specialty societies to develop ONC-certified electronic reporting standards for those registries so providers have the option to count participation in those registries under the measures for this objective.
- EPs must attest to *at least two measures* from the Public Health Reporting Objective, Measures 1 through 5.
- If PHAs have not declared six months before the start of the PI reporting period whether the registry they are offering will be ready on January 1 of the upcoming year for use by providers seeking to meet PI reporting periods in that upcoming year, a provider can claim an exclusion.



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- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP would need to meet two of the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting all of the remaining measures available to them and claiming the applicable exclusions. Available measures include ones for which the EP does not qualify for an exclusion.
- For Measure 1, provider's health information technology (HIT) system may layer additional information on the immunization history, forecast, and still successfully meet this measure.
- Bi-directionality provides that certified HIT must be able to receive and display a consolidated immunization history and forecast in addition to sending the immunization record.
- For Measure 1, an exclusion does not apply if an entity designated by the immunization registry or IIS can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by CEHRT, but if it has designated a Health Information Exchange (HIE) to do so on their behalf and the HIE is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 2, because syndromic surveillance reporting is more appropriate for urgent care settings and eligible hospitals, we removed this measure for EPs for Stage 3 with the exception of providers who are practicing in urgent care settings. Note: some states have chosen to waive the urgent care setting requirement. Please contact your state Medicaid agency for more information.
- For Measure 2, an exclusion does not apply if an entity designated by PHA can receive electronic syndromic surveillance data submissions. For example, if the PHA cannot accept the data directly or in the standards required by CEHRT, but if it has designated a HIE to do so on their behalf and the HIE is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- Measure 3, Electronic Case Reporting is not required until 2019, since we believe that the standards will be mature and that jurisdictions will be able to accept these types of data by that time.
- For Measure 4, EPs may choose to report to more than one public health registry to meet the number of measures required to meet the objective.
- For Measure 4, a provider may count a specialized registry (such as prescription drug monitoring) if the provider achieved the phase of active engagement defined under Active Engagement Option 3: Production, including production data submission with the specialized registry, in a prior year under the applicable requirements of the PI Programs for that year.
- For Measure 5, EPs may choose to report to more than one CDR to meet the number of measures required to meet the objective.
- For Measure 5, the definition of jurisdiction is general, and the scope may be local, state, regional or at the national level. The definition will be dependent on the type of registry to which the provider is reporting. A registry that is "borderless" would be considered a registry at the national level and would be included for purposes of this measure.
- Providers who have previously registered, tested, or begun ongoing submission of data to registry do not need to "restart" the process beginning at active engagement option 1. The



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provider may simply attest to the active engagement option which most closely reflects their current status.

- In determining whether an EP meets the first exclusion, the registries in question are those sponsored by the PHAs with jurisdiction over the area where the EP practices and national medical societies covering the EP's scope of practice. Therefore, an EP must complete two actions in order to determine available registries or claim an exclusion:
 - Determine if the jurisdiction (state, territory, etc.) endorses or sponsors a registry; and,
 - Determine if a National Specialty Society or other specialty society with which the provider is affiliated endorses or sponsors a registry.
- If a provider is part of a group which submits data to a registry, but the provider does not contribute to that data (for example they do not administer immunizations), the provider should not attest to meeting the measure but instead should select the exclusion. The provider may then select a different more relevant measure to meet.
- If a provider does the action that results in a data element for a registry in the normal course of their practice and is in active engagement to submit to a registry, but simply has no cases for the reporting period, the provider is not required to take the exclusion and may attest to meeting the measure.
- CMS has published a centralized repository for PHA and CDR reporting. That centralized registry is available at <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/CentralizedRepository-.html>.

Regulatory References

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(8)(i)(A) and (B). For further discussion please see [80 FR 62870](#).
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (f)(1), (f)(2), (f)(4), (f)(5), (f)(6) and (f)(7).

Certification Standards and Criteria

Below is the corresponding certification and standards criteria for EHR technology that supports achieving the meaningful use of this objective.



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Certification Criteria	
§ 170.314(f)(1) Public Health – Transmission to Immunization Registries	<p>(i) Create immunization information for electronic transmission in accordance with:</p> <p>(A) The standard and applicable implementation specifications specified in §170.205(e)(4). (B) At a minimum, the version of the standard specified in §170.207(e)(3) for historical vaccines. (C) At a minimum, the version of the standard specified in §170.207(e)(4) for administered vaccines.</p> <p>(ii) Enable a user to request, access, and display a patient's evaluated immunization history and the immunization forecast from an immunization registry in accordance with the standard at §170.205(e)(4).</p>
§ 170.315(f)(2) Transmission to public health registries-syndromic surveillance	<p>(i) Create syndrome-based public health surveillance information for electronic transmission in accordance with the standard (and applicable implementation specifications) specified in §170.205(d)(4).</p>
§ 170.315(f)(5) Transmission to public health agencies— electronic case reporting	<p>(i) Consume and maintain a table of trigger codes to determine which encounters may be reportable. (ii) Match a patient visit or encounter to the trigger code based on the parameters of the trigger code table. (iii) Case report creation. Create a case report for electronic transmission:</p> <p>(A) Based on a matched trigger from paragraph (f)(5)(ii). (B) That includes, at a minimum:</p> <p>(1) The Common Clinical Data Set. (2) Encounter diagnoses. Formatted according to at least one of the following standards:</p> <p>(i) The standard specified in §170.207(i). (ii) At a minimum, the version of the standard specified in §170.207(a)(4).</p> <p>(3) The provider's name, office contact information, and reason for visit. (4) An identifier representing the row and version of the trigger table that triggered the case report.</p>



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<p>§ 170.315(f)(6) Transmission to public health agencies—antimicrobial use and resistance reporting.</p>	<p>Create antimicrobial use and resistance reporting information for electronic transmission in accordance with the standard specified in §170.205(r)(1).</p>
<p>§ 170.315(f)(7) Transmission to public health agencies—health care surveys</p>	<p>Create health care survey information for electronic transmission in accordance with the standard specified in §170.205(s)(1).</p>

Standards Criteria	
<p>§ 170.205(e)(3) Electronic submission to immunization registries.</p>	<p>HL7 2.5.1 (incorporated by reference in §170.299). Implementation specifications. HL7 2.5.1 Implementation Guide for Immunization Messaging, Release 1.4, (incorporated by reference in §170.299).</p>
<p>§ 170.207(e)(4) Electronic submission to immunization registries.</p>	<p>HL7 2.5.1 (incorporated by reference in §170.299). Implementation specifications. HL7 2.5.1 Implementation Guide for Immunization Messaging, Release 1.5 (incorporated by reference in §170.299) and HL7 Version 2.5.1 Implementation Guide for Immunization Messaging (Release 1.5)—Addendum, July 2015 (incorporated by reference in §170.299).</p>
<p>§ 170.205(d)(2) Electronic submission to public health agencies for surveillance or reporting</p>	<p>HL7 2.5.1 (incorporated by reference in §170.299).</p>
<p>§ 170.205(d)(3) Electronic submission to public health agencies for surveillance or reporting</p>	<p>Standard. HL7 2.5.1 (incorporated by reference in §170.299). Implementation specifications. PHIN Messaging Guide for Syndromic Surveillance (incorporated by reference in §170.299) and Conformance Clarification for EHR Certification of Electronic Syndromic Surveillance, Addendum to PHIN Messaging Guide for Syndromic Surveillance (incorporated by reference in §170.299).</p>



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**§ 170.205(d)(4)
Electronic submission
to public health
agencies for
surveillance or
reporting**

Standard. HL7 2.5.1 (incorporated by reference in §170.299). Implementation specifications. PHIN Messaging Guide for Syndromic Surveillance: Emergency Department, Urgent Care, Inpatient and Ambulatory Care Settings, Release 2.0, April 21, 2015 (incorporated by reference in §170.299) and Erratum to the CDC PHIN 2.0 Implementation Guide, August 2015; Erratum to the CDC PHIN 2.0 Messaging Guide, April 2015 Release for Syndromic Surveillance: Emergency Department, Urgent Care, Inpatient and Ambulatory Care Settings (incorporated by reference in §170.299).

Additional standards criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.

