Medicaid EHR
INCENTIVE PROGRAM

Eligible Professional's Guide to the Medicaid EHR Incentive Program

Version 1.6, Released 08/29/2011

Michigan Department of Community Health
MDCH

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About This Document

This document is provided as an informational guide for eligible professional (EP) for the Medicaid EHR Incentive Program. Additional information can be found at:

- related Michigan Department of Community Health, Medical Services Administration policy bulletins available at http://www.michigan.gov/mdch/
- Department of Health and Human Services, Centers for Medicare & Medicaid Services 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule available at http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf
- program website available at http://www.michiganhealthit.org/
- CMS's Frequently Asked Questions https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp

Updates to This Document

As the program evolves and as more information is made available, this document will be updated as needed. Providers are encouraged to check the http://www.michiganhealthit.org/ website on a periodically and sign up for the email mailing lists at http://www.michiganhealthit.org/.

Revision History

Version	Release Date	Notes
1	12/21/2010	Original Release
1.1	1/3/2011	Removed EHR investment sections per guidance from CMS, Added public health meaningful use details (page 21), Added Registering for the Medicaid EHR Incentive Program section (page 16)
1.2	4/4/2011	Clarified Meaningful Use reporting period (page 18), updated Certified EHR section with CMS EHR Certification ID information (page 13) updated meaningful Use measures pages with latest from CMS (page 21).
1.3	4/7/2011	Updated Encounters by Patient Panel Assignments section (Page 8) and Eligible Patient Volume by Practice/Organization Proxy section (Page 8-10).
1.4	08/15/2011	Updated Encounters by Patient Panel Assignment section (Page 8) and all references to the National Level Repository (NLR) changed to the CMS registration and attestation system. Eligible patient volume reporting period section added (Page 6). Clarification added regarding MU reporting period (Pages 19-20).
1.5	08/17/2011	Expanded explanation of Eligible Patient Volume by Practice/Organization Proxy (Page 10)
1.6	8/29/2011	Change in Eligible Patient Volume Reporting Period (Page 6)

Professional Eligibility Criteria

In order to be considered an eligible professional (EP) for the Medicaid EHR Incentive Program, professionals must meet several criteria. There are limits on what types of health professionals qualify, eligible patient volume thresholds, care rendered in hospital settings, and practice criteria.

Types of Professionals

Professionals must belong to one of the following eligible professional categories:

- Physicians
  - Medical Doctor (M.D.)
  - Doctor of Osteopathic Medicine (D.O.)
- Doctor of Podiatric Medicine (D.P.M.)
- Dentists
- Nurse Practitioners
- Certified Nurse Midwives
- Physician Assistants (PA) practicing in a PA-led Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC)

Pediatricians

For the purposes of the EHR Incentive Program only, Michigan Medicaid defines pediatrician as:

> Medical doctors who diagnose, treat, examine, and prevent diseases and injuries in children. A pediatrician must hold a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree and hold a current, in good-standing board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP).
>
> **OR**
>
> Medical doctors who diagnose, treat, examine, and prevent diseases and injuries in children. A pediatrician must hold a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree. Also, at least 50% of the EPs total patient population must be 18 years old and under.

Physician Assistant

For a Physician Assistant (PA) to be eligible, he/she must practice in a PA-led Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC). PA-led includes:

- When a PA is the primary provider in a clinic;
- When a PA is a clinical or medical director (or in a similar role with similar responsibilities) at a clinical site of practice; or
- When a PA is an owner of an RHC.

Any PA practicing in a PA-led site is eligible provided that he/she meets all of the other requirements including the eligible patient volume.

Eligible Patient Volume Thresholds

Eligible professionals (EPs) must meet eligible patient volume thresholds. For most professionals, this means a 30% eligible patient volume based on total patient encounters. For most EPs, eligible patient volume only includes Medicaid encounters; however, EPs that "practice predominantly" at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) have different criteria. Pediatricians have special rules and are allowed to participate with a reduced eligible patient volume threshold (20% instead of 30%). If pediatricians have greater than 20% but less than a 30% eligible patient volume their annual incentive cap is reduced to 2/3. Pediatricians who achieve 30% eligible patient volume are eligible to receive the full incentive amount they qualify for. See the Calculation of Eligible Patient Volume section for more details.

Hospital-based

The eligible professional must not be "hospital-based." Hospital-based is currently defined as a medical professional who provides 90% or more of their services in a hospital setting, including inpatient and emergency room settings. This is based on the Place of Service Code (POS Code). Only POS Codes 21 (Inpatient Hospital), and 23 (Emergency Department) are included.

Practice Criteria

EPs participating in Michigan Medicaid EHR Incentive Program must have a practice location physically located within Michigan or have more than 30% of the total Medicaid encounters covered by Michigan Medicaid.

Calculation of Eligible Patient Volume

In order to be eligible for the Medicaid EHR Incentive Program, eligible professionals (EPs) must meet eligible patient volume thresholds. For most professionals, this means a 30% eligible patient volume based on total patient encounters. For most EPs, eligible patient volume only includes Medicaid encounters, however, EPs that "practice predominantly" at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) have different criteria; details below. Pediatricians have special rules and are allowed to participate with a reduced eligible patient volume threshold (20% instead of 30%). If pediatricians have greater than 20% but less than a 30% eligible patient volume, their annual incentive cap is reduced to 2/3. Pediatricians who achieve 30% eligible patient volume are eligible to receive the full incentive amount they qualify for.

Eligible Patient Volume Reporting Period

The eligible patient volume reporting period is a continuous representative 90 days in the previous calendar year where the provider demonstrates that they have maintained adequate patient volume to be eligible for the Medicaid EHR incentive program. This 90 day period can begin any time from January 1st through October 1st.

Note that the eligible patient volume reporting period is different than the reporting period for meaningful use (see page 19).

Encounter Calculation

For purposes of calculating EP eligible patient volume, a Medicaid encounter means services rendered to an individual on any one day where:

- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Social Security Act) paid for part or all of the service; or
- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Social Security Act) paid all or part of the individual's premiums, co-payments, and cost-sharing.

For the purpose of this program, Medicaid is defined as any program administered by the state authorized under Title 19 of the Social Security Act. This includes both fee-for-service and managed care. It does not include any other program or programs authorized under Title 21 for the Social Security Act, including the Children's Health Insurance Program (CHIP, known as MIChild in Michigan).

The chart below lists all of the Title 19 programs in Michigan that can be included in Medicaid portion of the eligible patient volume (see next page).

Benefit Plan ID	Benefit Plan Name
ALMB	Additional Low Income Medicare Beneficiary
BMP	Beneficiary Monitoring Program
CWP	Children's Home and Community Based Services Waiver
SED	Children's Serious Emotional Disturbance Waiver Program

SED-DHS	Children's Serious Emotional Disturbance Waiver-DHS
CMH	Community Mental Health
ESRD	End Stage Renal Disease
Plan First	Family Planning Waiver
MA	Full Fee-for-Service Medicaid
HSW	Habilitation Supports Waiver Program
MI Choice	Home and Community Based Waiver Services
Hospice	Hospice
Hospice-18	Hospice Medicare Benefit Plan
INCAR-ESO	Incarceration - Emergency Services
INCAR-MA	Incarceration - MA
INCAR-MA-E	Incarceration - MA - Emergency Services
INCAR	Incarceration - Other
ICF/MR-DD	Intermediate Care Facility for Mental Retarded - DD
MA-MC	Medicaid Managed Care
MA-ESO	Medical Assistance Emergency Services
Spendown	Medical Spend-down
NH	Nursing Home
PIHP	Prepaid Inpatient Health Plan
PACE	Program All-Inclusive Care for Elderly
QDWI	Qualified Disabled Working Individual
QMB	Qualified Medicare Beneficiary - All Inclusive
SLMB	Special Low Income Medicare Beneficiary
SPF	State Psychiatric Hospital
SA	Substance Abuse

Each EP will have to provide and attest to encounter data in all the different practice settings. It is acceptable to enter 0 in any of these items if they do not apply. They include:

- Ambulatory setting (e.g., private practice, clinic)
    - Medicaid encounter volume
    - Total encounter volume
- Hospital inpatient setting where the EP is the treating or discharging provider
    - Medicaid encounter volume
    - Total encounter volume
- Emergency department/room setting where the EP is the treating or discharging provider
    - Medicaid encounter volume
    - Total encounter volume
- FQHC/RHC setting
    - Medicaid encounter volume
    - Other medical assistance (SCHIP, etc.) encounter volume
    - Uncompensated care encounter volume
    - Sliding scale encounter volume
    - Total encounter volume

By collecting each of these items individually, all the various encounter thresholds will be calculated. EPs will also be asked if they are including any out-of-state encounters, and if so, what state(s). The inclusion of out-of-state encounters is optional and will initiate an eligibility verification audit so Medicaid staff can contact the other state(s) and confirm encounter data. EHR Project staff would contact the Medicaid agency in that/those state(s) and work with the other states on a case-by-case basis. Inclusion of out-of-state encounters is optional and may delay payment.

Encounters by Patient Panel Assignments

Only EPs who are primary care providers (PCP) that have Medicaid managed care or medical home patients assigned to them have the option to include encounters by patient panel assignment in their eligible patient volume threshold calculation. Encounters for patients assigned to your patient panel that occurred during the reporting period should be recorded as encounters, whereas patients that did not have an encounter during the reporting period but within the allowable period may be counted on the panel.

The formula for determining eligible patient volume using patient panel assignments is:

[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 calendar year preceding the start of the 90-day period] -PLUS- [Unduplicated Medicaid encounters* in that same 90-day period]
-DIVIDED BY-
[Total patients assigned to the provider in the same 90-day with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [All unduplicated encounters in that same 90-day period]

**Note that this same equation applies to making a determination for Needy Individual patient volume (for FQHC and RHC, see below), where "Medicaid" is substituted by "Needy Individuals."*

In this calculation, "unduplicated" simply means that an eligible professional may not include the same encounters more than once. There may be multiple encounters with patients (even with patients included on the panel), but these may not be counted in more than one place in the equation. In addition, the "unduplicated encounters" would only be encounters with non-panel Medicaid patients that occurred during the representative 90-day period[1]

Encounter – Special Cases

Not every episode of care in all health care settings results in an easily identified “encounter.” Currently, the special cases that have been identified include:

- Mass charity care by a non-profit health care provider outside an FQHC or RHC where the provider does not charge any payer or track patient insurance coverage. In these cases, Michigan will not count this as an encounter in the Medicaid nor total encounter categories.

- Similarly, not every payer pays for the same care in the same way. An example of this is prenatal care. Some payers pay for the individual prenatal care office visits, while others roll these costs up into the delivery payment. In these cases, Michigan will allow each episode of care (i.e., office visit) that occurs during the eligibility reporting period, even if the resulting “rolled-up” payment happens at a later date. This must be applied uniformly against all payers.

Additional special cases may be identified at a later date and will be updated here.

[1] CMS FAQ # 10476, https://questions.cms.hhs.gov/app/answers/detail/a_id/10476 and preamble of the July 28, 2010 Federal Register (page 44488)

Eligible Patient Volume by Practice/Organization Proxy

EPs are allowed to use the clinic or group practice's eligible patient volume as a proxy to their own eligible patient volume. For purposes of the Michigan Medicaid EHR Incentive Program, a clinic or group is a group of healthcare practitioners organized as one legal entity under one Tax Identification Number (TIN). The organization may be made up of multiple NPI's, but if they are all one legal entity paid under one tax ID then the eligible patient volume may be calculated in aggregate for all NPI's in the organization. EPs that elect this option are required to provide the group NPI of the practice or practices they are using as their proxy. This will facilitate verification and possible audit.

In order to use this proxy option, all of the following criteria must be met:

1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2) there is an auditable data source to support the clinic's patient volume determination; **and**
3) so long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities.

If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from clinic A in calculating his or her individual patient volume.

The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodology for the payment year) was to ensure against EPs within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume EPs from applying using their individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of course be inflated for these lower-volume EPs.

CLINIC A (with a fictional EP and provider type)
EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)
EP# 2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)
Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)
Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)

EP #3 (physician): individually had 10% Medicaid encounters (30/300)
EP #4 (dentist): individually had 5% Medicaid encounters (5/100)
EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.)

The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).

If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other.

Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP # 4 could choose to use the proxy-level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid patient volume. In addition, her Clinic A patient encounters would be included in determining such clinic's overall Medicaid patient volume. [2]

Percent of Patient Encounters in Certified EHR Technology

An EP must have 50% or more of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology. An EP for who does not conduct 50% of their patient encounters in any one practice/location would have to meet the 50% threshold through a combination of practices/locations equipped with certified EHR technology.

Out-of-State Medicaid Encounters

EPs have the option to included encounters from other states in their eligible patient volume thresholds. The inclusion of out-of-state encounters will initiate an eligibility verification audit so Medicaid staff can contact the other state(s) to confirm encounter data; this will likely delay payment. EHR Project staff would contact the Medicaid agency in that/those state(s) and work with the other states on a case by case basis.

[2] CMS FAQ # 10362, https://questions.cms.hhs.gov/app/answers/detail/a_id/10362

Special Criteria for Providers Rendering Care in FQHC and RHC ONLY:

Providers who predominately practice in a FQHC or RHC are allowed to use special criteria when determining eligible patient volume. An EP "practices predominantly" at an FQHC or an RHC when the clinical location for over 50% of his/her total patient encounters over a period of 6 months occur at an FQHC or RHC. Providers who practice in an FQHC or RHC but do not meet the predominately threshold can still include Medicaid encounters, but not needy individual encounters in an FQHC or RHC setting, toward their eligible patient volume.

Needy Individual Encounters Defined

For purposes of calculating needy eligible patient volume, a needy patient encounter means services rendered to an individual on any one day where:

- Medicaid or Children's Health Insurance Program (CHIP, known as MIChild in Michigan) (or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act) paid for part or all of the service;
- Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act) paid all or part of the individual's premiums, co-payments, or cost-sharing;
- The services were furnished at no cost; or
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

For the purpose of this program, Medicaid is defined as any program administered by the state that is authorized under Title 19 of the Social Security Act. This includes both fee-for-service and managed care. Children's Health Insurance Program is defined as the program authorized under Title 21 for the Social Security Act, known as MIChild in Michigan.

Eligible Patient Volume Using Needy Individual Encounters

The formula for determining eligible patient volume using needy individual encounters is:

The total needy individual patient encounters in any representative continuous 90-day period in the preceding calendar year **divided by** the total patient encounters in that same 90-day period.

Eligible Patient Volume by PCP Patient Panel Assignment and Needy Individual

Providers who practice in a FQHC or RHC setting, and who are primary care providers (PCP) that have Medicaid managed care patients assigned to them, have the option of including PCP patient panel assignments in their eligible patient volume calculation. The formula for determining eligible patient volume using needy individual encounters is:

The total Needy Individual patients assigned to the EP's panel in any representative continuous 90-day period in the preceding calendar year when at least one Needy Individual encounter took place with the Medicaid patient in the year prior to the 90-day period **PLUS** Unduplicated Needy Individual encounters in the same 90-day period **divided by** The total patients assigned to the provider in that same 90-day period with at least one encounter taking place with the patient during the year prior to the 90-day period **PLUS** All unduplicated patient encounters in the same 90-day period.

Incentive Payments

Each EP can receive a maximum total incentive of $63,750 over a six year period. The first year's maximum amount is $21,250 and years two thru six are capped at $8,500 per year.

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

EP's may start the program as early as calendar year 2011. EP's may not start the program any later than calendar year 2016. Consecutive years are not required for participation. However, EP's starting in 2016 must participate in consecutive years in order to receive the full incentive amount. No incentive payments will be made after calendar year 2021.

The total for pediatricians who meet the 20 percent patient volume but fall short of the 30 percent patient volume is $14,167 in the first year and $5,667 in subsequent years. This adds up to a maximum Medicaid EHR incentive payment of $42,500 over a six-year period.

Certified EHR

In order to qualify for the Medicaid EHR Incentive Program, eligible providers (EPs) must use certified EHR technology. This is a new certification process through the Office of the National Coordinator for Health IT (ONC) and must be listed on the Certified HIT Product List (CHPL) maintained by ONC. Certified technology must meet or surpass minimum government requirements for security, privacy, and interoperability and will allow the purchaser to attain all of the "meaningful use" measures.

Certified HIT Product List (CHPL)

The Certified HIT Product List (CHPL) is maintained at the federal level by ONC. All certified products appear on this list. Only the product version(s) included on the CHPL are certified. The list can be found at http://onc-chpl.force.com/ehrcert, note this link is subject to change but the CHPL will always be available from the ONC's main page at http://healthit.hhs.gov.

The CHPL will also give you your CMS EHR Certification ID. This is the ID you need to use when registering for the EHR Incentive Programs. See the CHPL guide at http://www.michiganhealthit.org/docs/UsingCHPL.pdf for more details

Types of Certification

There are three types of certification; complete, module and self. EHR products classified as complete EHR have been certified to meet all the meaningful use objectives and measures. This represents one product or solution that meets all the requirements and, if selected and fully implemented, would meet the incentive program's certified EHR technology requirement. EHR modules are those technologies that are certified for at least one of the meaningful use objectives and measures. In order to meet the incentive program's certified EHR technology requirement using modules, a provider must use multiple modules that, together, meet all of the meaningful use objectives and measures. The self certification only applies if the provider does not intend to use a commercial product to meet the incentive program's certified EHR technology requirement. Any provider that intends to use the self certification option should contact ONC at ONC.certification@hhs.gov.

Due to the fact that meaningful use is slightly different between inpatient and ambulatory practice settings, products are identified as Inpatient EHRs or as Ambulatory EHRs. Some products may be certified for both practice settings.

Products are currently only being certified for stage 1 of meaningful use. Later stages of meaningful use will require new certification.

Proof of Certification

Providers should receive a CMS EHR Certification ID from their EHR vendor or the CHPL (see above). The CMS EHR Certification ID will be required for the provider's registration for the Medicaid EHR Incentive Program. Providers may also be asked by Medicaid for additional proof of EHR technology. This may include proof of purchase (invoice, contract, etc.) that indentifies the practice, product(s) being used, and the product version.

Registering for the Medicaid EHR Incentive Program

Providers must register with the CMS registration and attestation system at the federal level to start their registration process. Once registered at the federal level, providers will be invited to complete their registration at the state level.

Federal Level Registration

To register with the CMS registration and attestation system, all providers must have a National Provider Identifier (NPI), and hospitals must be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS). The NLR is available at https://ehrincentives.cms.gov/.

To access the CMS registration and attestation system, providers will need a username and password. Eligible professionals can use the same User ID and Password they use for the National Plan and Provider Enumeration System (NPPES). This is also the same User ID and Password that is used to access PECOS. If you do not have an active User ID and Password for NPPES or PECOS, request them via CMS Identity & Access Management, available at https://ww.cms.gov. When requesting, you will need your type 2 NPI, your Taxpayer Identification Number (TIN), and your address from IRS Form CP-575. You will also need to mail a copy of IRS Form CP-575 as directed.

What information will you need when you register with CMS registration and attestation system?

Providers have to provide basic information at the CMS registration and attestation system.

- Individual (type 1) National Provider Identifier (NPI).
- National Plan and Provider Enumeration System (NPPES) User ID and Password.
- Payee Tax Identification Number (if you are reassigning your benefits).
- Payee National Provider Identifier (NPI) (if you are reassigning your benefits).
- For the Medicaid EHR incentive program, what state they are participating in.

Additional Items

You do not have to provide information on the certified EHR technology you are using or your email address when you register with the CMS registration and attestation system. However, it is strongly recommend that you do so, since it will speed up your registration process at the state level.

The invitation letter for the state level registration (see below) will go to the address provided in the CMS registration and attestation system .

Providers will need to know their federal registration number to access the state level registration. This is provided by the CMS registration and attestation system at the completion of registration. It can also be retrieved by logging back into the CMS registration and attestation system with the same username and password that was originally used during federal registration. NOTE: the state cannot retrieve this information, the provider must do it.

Any changes to the information in the CMS registration and attestation system, must be done by the provider in the CMS registration and attestation system. Any changes may delay your incentive payment.

State Level Registration

Providers have to complete their registration at the state level after the CMS registration and attestation system. Providers will receive a letter inviting them to complete the registration process in the CHAMPS system, if they are not already registered. EPs who are providing services through managed care entities must be individually registered as a Medicaid provider and are required to complete a similar process to verify the provider is in good-standing and is eligible to receive an EHR incentive. Information entered at the CMS registration and attestation system may only be changed at the federal level and must match the information provided in CHAMPS.

- Currently Medicaid-Enrolled Provider - Once Medicaid receives a valid EP request from the CMS registration and attestation system, the Medicaid staff will send a welcome letter to the EP with instructions for logging on to CHAMPS to register for the EHR incentive payment on-line. Once the EP submits the registration information, Medicaid staff will start the review/validation process. In order to ensure that only eligible providers receive EHR incentive payments, a series of verifications will take place at registration, and annually thereafter. These verifications are explained below under Monitoring/Validation.

- Not Currently Medicaid-Enrolled Provider - Once Medicaid receives a valid EP request from the CMS registration and attestation system, the Medicaid staff will send a welcome letter to the EP with instructions on enrolling in CHAMPS to register for the EHR incentive payment on-line. Note that this enrollment is for EHR incentive purposes only. To access the CHAMPS system for enrollment, the EP must follow the directions on the website at www.michigan.gov/medicaidproviders, scroll down the middle of the page to Hot Topics, and click on the CHAMPS link. Once on the CHAMPS page, scroll down the page to Accessing the CHAMPS system portion and there are step by step instructions. There is also a toll free number for help in enrolling in CHAMPS. The number is 800-292-2550, option 2 and they will be able to answer any enrollment questions. Once approved, the EP will receive a letter with instructions on completing the EHR portion of the enrollment.

All participating provider, will have to re-register with CHAMPS every year. This will ensure the providers report on meaningful use and re-attest to program information. They will also be required to complete an annual survey that will address general EHR issues and concerns.

Additionally, if the payee tax ID designated on the CMS registration and attestation system application is not associated to the NPI of the applicant, an association will need to be established with the State of Michigan Treasury department in order to receive an incentive payment. To register as a vendor, go to www.michigan.gov/treasury, in the *How do I find* drop down quick list select *EFT Vendor Payments* and click the green *Go* circle. This will give you the option to register on-line or Form 3636 can be completed and returned via mail or fax.

What information will you need when you register at the state level?

In addition to the items submitted to the CMS registration and attestation system above, providers have to provider several items at the state level. These include:

- What 90 consecutive day period are you using for your eligibly reporting period.
- Type of provider, with additional items for Physician Assistants
- Any encounters in the hospital inpatient or emergency room setting, broken down by Medicaid and total encounters in each setting
- If using the Eligible Patient Volume by Practice/Organization Proxy (see above) option, encounters, broken down by Medicaid and total encounters and the NPI of the organization who's encounters are being used as a proxy [OPTIONAL]
- Any encounters in a Federally Qualified Health Center (FQHC)or Rural Health Clinic (RHC) broken down by Medicaid, MIChild, charity care, sliding fee scale and total patient encounters in the FQHC and/or RHC setting
- Any Medicaid managed care primary care patient panel encounters that are included, broken down by Medicaid patients assigned to PCP panel, unduplicated Medicaid patient encounters (i.e., fee for service encounters), total patients assigned to PCP panel (including any other payers) and total unduplicated patient encounters [OPTIONAL]
- All other encounters in any other setting, broken down by Medicaid and total encounters
- EHR stage information, adopt, implement, upgrade or meaningful use
- CMS EHR Certification ID, available from EHR vendor [if not provided at federal level]. Note the CMS EHR Certification ID is case sensitive and should be entered in all upper case.
- If any reported encounters are from any other state than Michigan, what states.
- Contact email [if not provided at federal level]

Detailed instructions on the state level registration are available at http://www.michiganhealthit.org/ehr/registration.aspx. Providers can start registering with the CMS registration and attestation system as early as January 3, 2011; however, state level registration will not be available until January 21, 2011.

Meaningful Use (MU) Adoption, Implementation, Upgrading (AIU) of EHR

In order to receive and continue to receive incentive payments, providers must achieve and maintain a set of meaningful use measures as defined by CMS. Meaningful use employs a three stage approach, with each stage building on the proceeding stage.

- Stage 1 – 2011: Data capture and sharing
- Stage 2 - 2013: Expand upon the Stage 1 criteria to encourage the use of health information technology for continuous quality improvement
- Stage 3 - 2015: Expand on Stage 3 with a focus on promoting improved outcomes in quality, safety, and efficiency

Only Stage 1 is currently defined. To demonstrate Stage 1 of meaningful use, an EP must comply with "core" requirements and "menu" requirements. Michigan did not modify the meaningful use requirements from the federal requirements. These requirements are explained further in the CMS final rule (http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf) and below.

Adoption, Implementation, Upgrading (AIU)

Medicaid providers do not need to meet meaningful use criteria in the first participation year **IF** the provider is attesting to adopting, implementing, or upgrading EHR. However, meaningful use criteria must be met in subsequent years.

- Adoption – acquired certified EHR technology (e.g., evidence of purchasing or securing access to certified EHR technology)
- Implementation – began using EHR (e.g., staff training, data entry of patient demographic information on EHR)
- Upgrading – expanded EHR (e.g., upgraded to certified EHR technology or added new functionality to meet MU)

All EP's starting the program in calendar year 2011, will be registered under the adopt, implement, or upgrade option. For EP's starting the program in later years, this option is available, but not required.

MU Objectives/Measures

CMS has developed objectives and measures for meaningful use. Meaningful use includes both a core set and a menu set of objectives that are specific for eligible providers. For EPs, in stage 1 there are a total of 20 meaningful use objectives; 15 are core objectives that are required and the remaining 5 objectives may be chosen from the list of 10 menu set objectives.

In summary, the 15 "core" requirements are:

1. Record patient demographics
2. Record vital signs/chart changes
3. Maintain current and active diagnoses
4. Maintain active medication list
5. Maintain active allergy list

6. Record smoking status
7. Provide clinical summaries
8. Provide electronic health info to patients
9. E-prescribe
10. Use CPOE for drug orders
11. Check drug-drug/drug-allergy interaction
12. Exchange electronic clinical info
13. Implement one clinical decision support rule
14. Protect patient data privacy and security
15. Report clinical quality measures

Reporting on clinical quality measures is one of the core meaningful use requirements. Providers are required to report on 3 "core" measures and 3 measures from an additional set of 38 optional measures. In total, providers must report on 6 clinical quality measures. More details on the clinical quality measures are available at http://www.michiganhealthit.org/.

The 10 "menu" requirements (from which five must be chosen for implementation) are:

1. Implement drug formulary checks
2. Incorporate clinical lab test results
3. Generate patient lists by condition
4. Identify patient-specific education resources
5. Perform medication reconciliation between care settings
6. Generate summary of care for transferred patients
7. Submit immunization data to registries
8. Submit epidemiology data to public health
9. Send care reminders to patients
10. Provide patient with timely access to electronic health information

One of the menu measures selected must be one of the two public health measures (#7 or #8).

MU Reporting Period

The MU reporting period is a continuous period where the provider successfully demonstrates all the MU objectives of certified EHR technology.

- Providers who enter the program under AIU must attest to meeting AIU requirements. The subsequent year would then be the first meaningful use reporting period and is a consecutive 90-day period in that calendar year. Meaningful use must be met prior to receiving the second payment.
- For providers who enter the program under MU and not under AIU, the first reporting period is a consecutive 90-day period in that calendar year before receiving the first payment.
- For all subsequent payment years, the reporting period is the full calendar year.

For example, let's say an eligible provider (EP) registers under AIU in 2011 and receives his or her first-year incentive payment. To receive the second-year payment in 2012, the EP would have to wait at least 90 days

after January 1, 2012—in order to demonstrate MU for 90 days (a requirement for the second-year payment)—before re-registering. To receive the third-year payment (nominally, the 2013 payment), the EP would have to demonstrate MU for the entire year (all 12 months in 2013) and then re-register in early 2014. To receive the fourth-year payment (nominally, the 2014 payment), the EP would have to demonstrate MU for the entire year (all 12 months in 2014) and then re-register in early 2015. Of course, the EP can skip years if he or she so desires; this example simply illustrates how an EP could receive incentive payments consecutively.

Meaningful Use Details

The following pages outline each of the Eligible Professional meaningful use measures.

For information on how to connect to the public health systems, including MCIR, in Michigan included in meaningful use, visit http://www.michiganhealthit.org/meaningful_use/publichealth.aspx

Eligible Professional Meaningful Use Core Measures Measure 1 of 15

Stage 1

Date issued: November 7, 2010

CPOE for Medication Orders	
Objective	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
Measure	More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
Exclusion	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

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Definition of Terms

Computerized Provider Order Entry (CPOE) – CPOE entails the provider's use of computer assistance to directly enter medication orders from a computer or mobile device. The order is also documented or captured in a digital, structured, and computable format for use in improving safety and organization.

Unique Patient – If a patient is seen by an EP more than once during the EHR 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 EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator that have at least one medication order entered using CPOE.
- EXCLUSION: EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 30 percent in order for an EP to meet this measure.

Additional Information

- 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.
- Any licensed healthcare professionals can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can enter the order per state, local and professional guidelines.
- The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides. This necessitates that the CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order.
- Electronic transmittal of the medication order to the pharmacy, laboratory, or diagnostic imaging center is not a requirement for meeting the measure of this objective. However, a separate objective (EPCMU 04) addresses the electronic transmittal of prescriptions and is a requirement for EPs to meet Meaningful Use.

Eligible Professional Meaningful Use Core Measures Measure 2 of 15

Stage 1

Date issued: November 7, 2010

Drug Interaction Checks	
Objective	Implement drug-drug and drug-allergy interaction checks.
Measure	The EP has enabled this functionality for the entire EHR reporting period.
Exclusion	No exclusion.

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Definition of Terms

None.

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.

Additional Information

None.

Eligible Professional Meaningful Use Core Measures Measure 3 of 15

Stage 1

Date issued: November 7, 2010

Maintain Problem List	
Objective	Maintain an up-to-date problem list of current and active diagnoses.
Measure	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.
Exclusion	No exclusion.

Table of Contents

Definition of Terms

Problem List – A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient.

Unique Patient – If a patient is seen by an EP more than once during the EHR 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 EHR reporting period.

Up-to-date – The term ‘‘up-to-date’’ means the list is populated with the most recent diagnosis known by the EP. This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the EP, or querying the patient.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

Additional Information

- The Medicare and Medicaid EHR Incentive Programs do not specify the use of ICD-9 or SNOMED-CT® in meeting the measure for this objective. However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted ICD-9 or SNOMED-CT® for the entry of structured data for this measure and made this a requirement for EHR technology to be certified. Therefore, EPs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 or SNOMED-CT® as a basis for the entry of structured data into certified EHR technology in order to meet the measure for this objective.
- For patients with no current or active diagnoses, an entry must still be made to the problem list indicating that no problems are known.
- An EP is not required to update the problem list at every contact with the patient. The measure ensures the EP has a problem list for patients seen during the EHR reporting period, and that at least one piece of information is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances.
- The initial diagnosis can be recorded in lay terms and later converted to standard structured data or can be initially entered using standard structured data.

Eligible Professionals
Meaningful Use Core Measures
Measure 4 of 15

Stage 1

Date issued: December 21, 2010

e-Prescribing (eRx)	
Objective	Generate and transmit permissible prescriptions electronically (eRx).
Measure	More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Exclusion	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

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Definition of Terms

Permissible Prescriptions – The concept of only permissible prescriptions refers to the current restrictions established by the Department of Justice on electronic prescribing for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at *http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf*). Any prescription not subject to these restrictions would be permissible.

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.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.
- NUMERATOR: Number of prescriptions in the denominator generated and transmitted electronically.
- EXCLUSION: EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 40 percent in order for an EP to meet this measure.

Additional Information

- 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.
- 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 EHR reporting period.
- Although the Department of Justice recently published an Interim Final Rule that allows the electronic prescribing of controlled substances, these recent guidelines could not be incorporated into the Medicare and Medicaid EHR Incentive Programs. The determination of whether a prescription is a ''permissible prescription'' for purposes of this measure should be made based on the guidelines for prescribing Schedule II-V controlled substances in effect on or before January 13, 2010.
- EPs cannot receive incentive payments for e-prescribing under both the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Medicare EHR Incentive Program for the same year. However, EPs can receive payments from both the MIPPA E-Prescribing Incentive Program and the Medicaid EHR Incentive Program for the same year.
- 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 certified EHR technology 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 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 Certified EHR Technology. For more information, refer to ONC's FAQ at http://healthit.hhs.gov/portal/server.pt/community/onc_regulations_faqs/3163/faq_22/21286.
- 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 constructively 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.

Eligible Professional Meaningful Use Core Measures Measure 5 of 15

Stage 1

Date issued: November 7, 2010

Active Medication List	
Objective	Maintain active medication list.
Measure	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Exclusion	No exclusion.

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Definition of Terms

Active Medication List – A list of medications that a given patient is currently taking.

Unique Patient – If a patient is seen by an EP more than once during the EHR 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 EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

Additional Information

- For patients with no active medications, an entry must still be made to the active medication list indicating that there are no active medications.
- An EP is not required to update this list at every contact with the patient. The EP can then use his or her clinical judgment to decide when additional updating is required.

Eligible Professional Meaningful Use Core Measures Measure 6 of 15

Stage 1

Date issued: November 7, 2010

Medication Allergy List	
Objective	Maintain active medication allergy list.
Measure	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.
Exclusion	No exclusion.

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Definition of Terms

Active 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.

Unique Patient – If a patient is seen by an EP more than once during the EHR 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 EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

The resulting percentage (Numerator ÷ Denominator) must be more than 80 percent in order for an EP to meet this measure.

Additional Information

- For patients with no active medication allergies, an entry must still be made to the active medication allergy list indicating that there are no active medication allergies.
- An EP is not required to update this list at every contact with the patient. The measure ensures that the EP has not ignored having a medication allergy list for patients seen during the EHR reporting period and that at least one piece of information on medication allergies is presented to the EP. The EP can then use their judgment in deciding what further probing or updating may be required given the clinical circumstances at hand.

Eligible Professional Meaningful Use Core Measures Measure 7 of 15

Stage 1

Date issued: November 7, 2010

Record Demographics	
Objective	Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth
Measure	More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.
Exclusion	No exclusion.

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Definition of Terms

Preferred Language – The language by which the patient prefers to communicate.

Unique Patient – If a patient is seen by an EP more than once during the EHR 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 EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- Race and ethnicity codes should follow current federal standards published by the Office of Management and Budget (http://www.whitehouse.gov/omb/inforeg_statpolicy/#dr).
- If a patient declines to provide all or part of the demographic information, or if capturing a patient's ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure. In regards to patients who do not know their ethnicity, EPs should treat these patients the same way as patients who decline to provide race or ethnicity— identify in the patient record that the patient declined to provide this information.
- EPs are not required to communicate with the patient in his or her preferred language in order to meet the measure of this objective.

Eligible Professional Meaningful Use Core Measures Measure 8 of 15

Stage 1

Date issued: November 7, 2010

Record Vital Signs	
Objective	Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI
Measure	For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.
Exclusion	Any EP who either see no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.

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Definition of Terms

Unique Patient – If a patient is seen by an EP more than once during the EHR 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 EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients age 2 or over seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.
- EXCLUSION: An EP who sees no patients 2 years or older would be excluded from this requirement. Additionally, an EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice would be excluded from this

requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- 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.
- The only information required to be inputted by the provider is the height, weight, and blood pressure of the patient. The certified EHR technology will calculate BMI and the growth chart if applicable to patient based on age.
- Height, weight, and blood pressure do not have to be updated by the EP at every patient encounter. The EP can make the determination based on the patient's individual circumstances as to whether height, weight, and blood pressure need to be updated.
- Height, weight, and blood pressure can get into the patient's medical record as structured data in a number of ways. Some examples include entry by the EP, entry by someone on the EP's staff, transfer of the information electronically or otherwise from another provider or entered directly by the patient through a portal or other means.

Eligible Professional Meaningful Use Core Measures Measure 9 of 15

Stage 1

Date issued: November 7, 2010

Record Smoking Status	
Objective	Record smoking status for patients 13 years old or older.
Measure	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.
Exclusion	Any EP who sees no patients 13 years or older.

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Definition of Terms

Unique Patient – If a patient is seen by an EP more than once during the EHR 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 EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients age 13 or older seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator with smoking status recorded as structured data.
- EXCLUSION: An EP who sees no patients 13 years or older would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- 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.
- This is a check of the medical record for patients 13 years old or older. If this information is already in the medical record available through certified EHR technology, an inquiry does not need to be made every time a provider sees a patient 13 years old or older. The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community.

Eligible Professional Meaningful Use Core Measures Measure 10 of 15

Stage 1

Date issued: November 7, 2010

Clinical Quality Measures (CQMs)	
Objective	Report ambulatory clinical quality measures to CMS.
Measure	Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS.
Exclusion	No exclusion.

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Definition of Terms

None

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to reporting to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS to meet the measure.

Additional Information

- 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.
- Attesting to the measure of this objective indicates that the EP will submit complete ambulatory clinical quality measure information as required during the attestation process. During attestation, EPs will also attest to the numerators, denominators, and exclusions for individual ambulatory clinical quality measures.
- For requirements and electronic specifications related to individual ambulatory clinical quality measures, EPs should refer to: http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage.

Eligible Professional Meaningful Use Core Measures Measure 11 of 15

Stage 1

Date issued: November 7, 2010

Clinical Decision Support Rule	
Objective	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
Measure	Implement one clinical decision support rule.
Exclusion	No exclusion.

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Definition of Terms

Clinical Decision Support – 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.

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet the measure.

Additional Information

- CMS will not issue additional guidance on the selection of appropriate clinical decision support rules for Stage 1 Meaningful Use. This determination is best left to the EP taking into account their workflow, patient population, and quality improvement efforts.
- Drug-drug and drug-allergy interaction alerts cannot be used to meet the meaningful use objective for implementing one clinical decision support rule. EPs must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks.

Eligible Professional Meaningful Use Core Measures Measure 12 of 15

Stage 1

Date issued: November 7, 2010

Electronic Copy of Health Information	
Objective	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.
Measure	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days.
Exclusion	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.

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Definition of Terms

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

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.
- EXCLUSION: An EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- 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.
- When responding to patient requests for information, the EP should accommodate patient requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524, Access of individuals to protected health information. HIPAA contains requirements for providing patients copies of their health information.
- Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology and is maintained by or on behalf of the EP. At a minimum, this would include the elements listed in the ONC final rule at 45 CFR 170.304(f) for EPs and 45 CFR 170.306(d) for eligible hospitals and CAHs as required for EHR technology to become certified.
- An EP may withhold information from the electronic copy of a patient's health information in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524.
- An EP should provide a patient with all of the health information they have available electronically, subject to withholding as described in the HIPAA Privacy Rule, as specified at in 45 CFR 164.524.
- Form and format should be human readable and comply with the HIPAA Privacy Rule, as specified at 45 CFR 164.524(c). The media could be any electronic form such as patient portal, PHR, CD, USB fob, etc. EPs are expected to make reasonable accommodations for patient preference as outlined in 45 CFR 164.522(b).
- The charging of fees for this information is governed by the HIPAA Privacy Rule at 45 CFR 164.524(c)(4) (which only permits HIPAA covered entities to charge an individual a reasonable, cost-based fee for a copy of the individual's health information).
- If provision of the copy involves the mailing of physical electronic media, then it would need to be mailed by at least the third business day following the request of the patient or their agents.
- Third-Party Requests: Only specific third-party requests for information are included in the denominator. Providing the copy to a family member or patient's authorized representative consistent with federal and state law may substitute for a disclosure of the information to the patient and count in the numerator. A request from the same would count in the denominator. All other third-party requests are not included in the numerator or the denominator.

Eligible Professional Meaningful Use Core Measures Measure 13 of 15

Stage 1

Date issued: April 18, 2011

Clinical Summaries	
Objective	Provide clinical summaries for patients for each office visit.
Measure	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.
Exclusion	Any EP who has no office visits during the EHR reporting period.

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Definition of Terms

Clinical Summary – An after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.

Office Visit – Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits, (2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of office visits by the EP during the EHR reporting period.

- NUMERATOR: Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.

- EXCLUSION: EPs who have no office visits during the EHR reporting period would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- 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.
- The provision of the clinical summary is limited to the information contained within certified EHR technology.
- The clinical summary can be provided through a PHR, patient portal on the web site, secure e-mail, electronic media such as CD or USB fob, or printed copy. If the EP chooses an electronic media, they would be required to provide the patient a paper copy upon request.
- If an EP believes that substantial harm may arise from the disclosure of particular information, an EP may choose to withhold that particular information from the clinical summary.
- Providers should not charge patients a fee to provide this information.
- When a patient visit lasts several days and the patient is seen by multiple EPs, a single clinical summary at the end of the visit can be used to meet the meaningful use objective for "provide clinical summaries for patients after each office visit.
- The EP must include all of the items listed under "Clinical Summary" in the above "Definition of Terms" section that can be populated into the clinical summary by certified EHR technology. If the EP's certified EHR technology cannot populate all of these fields, then at a minimum the EP must provide in a clinical summary the data elements for which all EHR technology is certified for the purposes of this program (according to §170.304(h)):
    - Problem List
    - Diagnostic Test Results
    - Medication List
    - Medication Allergy List

Eligible Professional Meaningful Use Core Measures Measure 14 of 15

Stage 1

Date issued: November 7, 2010

Electronic Exchange of Clinical Information	
Objective	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.
Measure	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.
Exclusion	No exclusion.

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Definition of Terms

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.

Different Legal Entities – A separate legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other.

Distinct Certified EHR Technology – Each instance of certified EHR technology must be able to be certified and operate independently from all the others in order to be distinct. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct.

Exchange – Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. The exchange of information requires that the eligible professional must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information.

Patient Authorized Entities – Any individual or organization to which the patient has granted access to their clinical information. Examples would include an insurance company that covers the patient, an entity facilitating health information exchange among providers, or a personal health record vendor identified by the patient. A patient would have to affirmatively grant access to these entities.

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information during the EHR reporting period to meet this measure.

Additional Information

- The test of electronic exchange of key clinical information must involve the transfer of information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. Simulated transfers of information are ***not*** acceptable to satisfy this objective.
- The transmission of actual patient information is ***not*** required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
- When the clinical information is available in a structured format it should be transferred in a structured format. However, if the information is unavailable in a structured format, the transmission of unstructured data is permissible.
- EPs can use their clinical judgment to identify what clinical information is considered key clinical information for purposes of exchanging clinical information about a patient at a particular time with other providers of care. A minimum set of information is identified in the HIT Standards and Criteria rule at 45 CFR 170.304(i), and is generally outlined in this objective as: problem list, medication list, medication allergies, and diagnostic test results. An EP's determination of key clinical information could include some or all of this information, as well as information not included here.
- An EP should test their ability to send the minimum information set in the HIT Standards and Criteria rule at 45 CFR 170.304(i). If the EP continues to exchange information beyond the initial test, then the provider may decide what information should be exchanged on a case-by-case basis.
- EPs must test their ability to electronically exchange key clinical information at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Every payment year requires its own, unique test. If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.
- An unsuccessful test of electronic exchange of key clinical information will be considered valid for meeting the measure of this objective.

Eligible Professional Meaningful Use Core Measures Measure 15 of 15

Stage 1

Date issued: November 7, 2010

Protect Electronic Health Information	
Objective	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
Measure	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.
Exclusion	No exclusion.

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Definition of Terms

Appropriate Technical Capabilities – A technical capability would be appropriate if it protected the electronic health information created or maintained by the certified EHR technology. All of these capabilities could be part of the certified HER technology or outside systems and programs that support the privacy and security of certified EHR technology.

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.

Additional Information

- EPs must conduct or review a security risk analysis of certified EHR technology and implement updates as necessary at least once prior to the end of the EHR reporting period and attest to that conduct or review. The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period.
- A security update would be required if any security deficiencies were identified during the risk analysis. A security update could be updated software for certified EHR technology to be

implemented as soon as available, changes in workflow processes or storage methods, or any other necessary corrective action that needs to take place in order to eliminate the security deficiency or deficiencies identified in the risk analysis.

Eligible Professional Meaningful Use Menu Set Measures Measure 1 of 10

Stage 1

Date issued: November 7, 2010

Drug Formulary Checks	
Objective	Implement drug formulary checks.
Measure	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.
Exclusion	Any EP who writes fewer than 100 prescriptions during the EHR reporting period.

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Definition of Terms

None

Attestation Requirements

YES / NO / EXCLUSION

Eligible professionals (EPs) must attest YES to having enabled this functionality and having had access to at least one internal or external formulary for the entire EHR reporting period to meet this measure.

An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this objective and associated measure. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

Additional Information

- At a minimum an EP must have at least one formulary that can be queried. This may be an internally developed formulary or an external formulary. The formularies should be relevant for patient care during the prescribing process.

Eligible Professional Meaningful Use Menu Set Measures Measure 2 of 10

Stage 1

Date issued: November 7, 2010

Clinical Lab Test Results	
Objective	Incorporate clinical lab test results into EHR as structured data.
Measure	More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
Exclusion	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.

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Definition of Terms

None

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.
- NUMERATOR: Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
- EXCLUSION: If an EP orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 40 percent in order for an EP to meet this measure.

Additional Information

- The provider is permitted, but not required, to limit the measure of this objective to to labs ordered for those patients whose records are maintained using certified EHR technology.
- Structured data does not need to be electronically exchanged in order to qualify for the measure of this objective. The EP is not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.
- Lab results are not limited to any specific type of laboratory or to any specific type of lab test.
- The Medicare and Medicaid EHR Incentive Programs do not specify the use of code set standards in meeting the measure for this objective. However, the Office of the National Coordinator for Health Information Technology (ONC) has adopted Logical Observation Identifiers Names and Codes (LOINC®) version 2.27, when such codes were received within an electronic transaction from a laboratory, for the entry of structured data for this measure and made this a requirement for EHR technology to be certified.

Eligible Professional Meaningful Use Menu Set Measures Measure 3 of 10

Stage 1

Date issued: November 7, 2010

Patient Lists	
Objective	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
Measure	Generate at least one report listing patients of the EP with a specific condition.
Exclusion	No exclusion.

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Definition of Terms

Specific Conditions -- Those conditions listed in the active patient problem list.

Attestation Requirements

YES / NO

Eligible professionals (EPs) must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.

Additional Information

- This objective does not dictate the report(s) which must be generated. An EP is best positioned to determine which reports are most useful to their care efforts.
- The report generated could cover every patient whose records are maintained using certified EHR technology or a subset of those patients at the discretion of the EP.
- The report generated is required to include only patients whose records are maintained using certified EHR technology.

Eligible Professional Meaningful Use Menu Set Measures Measure 4 of 10

Stage 1

Date issued: November 7, 2010

Patient Reminders	
Objective	Send reminders to patients per patient preference for preventive/follow-up care.
Measure	More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
Exclusion	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology.

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Definition of Terms

Unique Patient – If a patient is seen by an EP more than once during the EHR 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 EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients 65 years old or older or 5 years older or younger.
- NUMERATOR: Number of patients in the denominator who were sent the appropriate reminder.
- EXCLUSION: If an EP has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology that EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 20 percent in order for an EP to meet this measure.

Additional Information

- 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.
- EPs meet the aspect of ‘‘per patient preference’’ of this objective if they are accommodating reasonable requests in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), which is the guidance established for accommodating patient requests.
- EP has the discretion to determine the frequency, means of transmission, and form of the reminder limited only by the requirements the HIPAA Privacy Rule, as specified at 45 CFR 164.522(b), and any other applicable federal, state or local regulations that apply to them.

Eligible Professional Meaningful Use Menu Set Measures Measure 5 of 10

Stage 1

Date issued: November 7, 2010

Patient Electronic Access	
Objective	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
Measure	At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.
Exclusion	Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.

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Definition of Terms

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.

Unique Patient – If a patient is seen by an EP more than once during the EHR 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 EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.

- EXCLUSION: If an EP neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period, they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be at least 10 percent in order for an EP to meet this measure.

Additional Information

- Online electronic access through either a patient portal or personal health record (PHR) will satisfy the measure of this objective.
- An EP may decide that electronic access to a portal or PHR is not the best forum to communicate results. Within the confines of laws governing patient access to their medical records, we would defer to EP's judgment as to whether to hold information back in anticipation of an actual encounter between the provider and the patient.
- Information that must be provided electronically is limited to that information that exists electronically in or is accessible from the certified EHR technology and is maintained by or on behalf of the EP. At a minimum, certified EHR technology makes available lab test results, problem list, medication list, and medication allergy list.
- An EP may withhold information from the electronic copy of a patient's health information in accordance with the HIPAA Privacy Rule, as specified at 45 CFR 164.524.
- The objective and measure focus on the availability of access and the timeliness of data, not utilization. The EP is not responsible for ensuring that 10 percent request access or have the means to access, only that 10 percent of all unique patients seen by the EP could access the information if they so desired.

Eligible Professional Meaningful Use Menu Set Measures Measure 6 of 10

Stage 1

Date issued: November 7, 2010

Patient-specific Education Resources	
Objective	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
Measure	More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.
Exclusion	No exclusion.

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Definition of Terms

Patient-Specific Education Resources – 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 EHR 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 EHR reporting period.

Attestation Requirements

NUMERATOR / DENOMINATOR

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: Number of patients in the denominator who are provided patient-specific education resources.

The resulting percentage (Numerator ÷ Denominator) must be more than 10 percent in order for an EP to meet this measure.

Additional Information

- Certified EHR technology is certified to use either the patient's problem list, medication list, or laboratory test results to identify the patient-specific educational resources. These or additional elements can be used in the identification of educational resources that are specific to the patients needs.
- Education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.

Eligible Professional Meaningful Use Menu Set Measures Measure 7 of 10

Stage 1

Date issued: November 7, 2010

Medication Reconciliation	
Objective	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
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	An EP who was not the recipient of any transitions of care during the EHR 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.

Relevant Encounter – An encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP judges it to be so. (Note: Relevant encounters are not included in the numerator and denominator of the measure for this objective.)

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.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
- NUMERATOR: Number of transitions of care in the denominator where medication reconciliation was performed.

- EXCLUSION: If an EP was not on the receiving end of any transition of care during the EHR reporting period they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- Only patients whose records are maintained using certified EHR technology should 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 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.

Eligible Professional Meaningful Use Menu Set Measures Measure 8 of 10

Stage 1

Date issued: November 7, 2010

Transition of Care Summary	
Objective	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
Measure	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
Exclusion	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR 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.

Attestation Requirements

NUMERATOR / DENOMINATOR / EXCLUSION

- DENOMINATOR: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- NUMERATOR: Number of transitions of care and referrals in the denominator where a summary of care record was provided.
- EXCLUSION: If an EP does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period then they would be excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

The resulting percentage (Numerator ÷ Denominator) must be more than 50 percent in order for an EP to meet this measure.

Additional Information

- Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care.
- The transferring party must provide the summary care record to the receiving party.
- The EP can send an electronic or paper copy of the summary care record directly to the next provider or can provide it to the patient to deliver to the next provider, if the patient can reasonably expected to do so.
- If the provider to whom the referral is made or to whom the patient is transitioned to has access to the medical record maintained by the referring provider then the summary of care record would not need to be provided, and that patient should not be included in the denominator for transitions of care.

Eligible Professional Meaningful Use Menu Set Measures Measure 9 of 10

Stage 1

Date issued: November 7, 2010

Immunization Registries Data Submission	
Objective	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.
Measure	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).
Exclusion	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

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Definition of Terms

None.

Attestation Requirements

YES / NO / EXCLUSION

- Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically) to meet this measure.
- EXCLUSION: If an EP does not perform immunizations during the EHR reporting period, or if there is no immunization registry that has the capacity to receive the information electronically, then the EP would be excluded from this requirement. EPs must select NO next to the appropriate exclusion(s), then click the APPLY button in order to attest to the exclusion(s).

Additional Information

- The test to meet the measure of this objective must involve the actual submission of information to a registry or immunization information system, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective.
- The transmission of actual patient information is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
- If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.
- An unsuccessful test to submit electronic data to immunization registries or immunization information systems will be considered valid and would satisfy this objective.
- If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.
- The transmission of immunization information must use the standards at 45 CFR 170.302(k).

Eligible Professional Meaningful Use Menu Set Measures Measure 10 of 10

Stage 1

Date issued: November 7, 2010

Syndromic Surveillance Data Submission	
Objective	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.
Measure	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).
Exclusion	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.

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Definition of Terms

Public Health Agency -- An entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function.

Attestation Requirements

YES / NO / EXCLUSION

- Eligible professionals (EPs) must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic syndromic surveillance data to public health agencies and follow up submission if the test was successful (unless none of the public health agencies to which the EP submits such information has the capacity to receive the information electronically) to meet this measure.
- EXCLUSION: If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period or if no public health agency that has the capacity to receive the information electronically, then the EP is excluded from this requirement. EPs must select NO next to the appropriate exclusion, then click the APPLY button in order to attest to the exclusion.

Additional Information

- The test to meet the measure of this objective must involve the actual submission of electronic syndromic surveillance data to public health agencies, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective.
- The transmission of electronic syndromic surveillance data is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.
- An unsuccessful test to submit electronic syndromic surveillance data to public health agencies will be considered valid and would satisfy this objective.
- If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.
- EPs must test their ability to submit electronic syndromic surveillance data to public health agencies at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Each payment year requires it own unique test.
- If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.
- The transmission of syndromic surveillance information must use the standards at 45 CFR 170.302(l).