Promoting Interoperability Program for Medicaid

Illinois Toolkit

Version 11.0

August 10, 2021

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1 INTRODUCTION

The Promoting Interoperability Program (PIP) – Medicaid (formerly the EHR Incentive Payment Program) will provide incentive payments to eligible professionals (EP), eligible hospitals (EH) and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. This toolkit will help guide participants complete the Illinois PIP attestation process.

1.1 Resources

1.1.1 Websites

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule and other legislation:
  - **2010 Stage 1 Final Rule**
  - **2012 Stage 2 Final Rule**
  - **2014 Modifications (Flexibility Rule)**
  - **2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule**
  - **2017 IPPS Final Rule**
  - **2017 OPPS Final Rule**
  - **2015 ONC CEHRT**
  - **2018 IPPS Final Rule**
  - **2019 Physician Fee Schedule Final Rule**
  - **2019 IPPS Final Rule**
  - **2020 Physician Fee Schedule Final Rule**
  - **2020 IPPS Final Rule**
  - **2021 Physician Fee Schedule Final Rule**
  - **2021 IPPS Final Rule**
  - **MACRA/MIPS Final Rule**
- Promoting Interoperability Program – Medicaid/Illinois system (eMIPP) Portal located at: **https://IMPACT.illinois.gov**
- Medicare and Medicaid Promoting Interoperability Program national website located at **http://www.cms.gov/EHRIncentivePrograms/**
- Office of the National Coordinator for Health Information Technology located at **http://www.healthit.gov/providers-professionals**
- eCQI Resource Center located at **https://ecqi.healthit.gov/**

1.1.2 Regional Extension Centers

The U.S. Department of Health and Human Services (DHHS), Office of the National Coordinator for Health Information Technology (ONC), has awarded two Illinois applicants with Regional Extension Center (REC) grants. The federal REC program (officially known as the Health Information Technology Extension Program) was developed to assist health professionals in implementing and becoming "meaningful users" of electronic health records.

The two REC awardees are: ILHITREC, a consortium led by Northern Illinois University, serving all areas of Illinois outside the 606 Zip codes; and CHITREC, a consortium led by Northwestern University, serving the city of Chicago. The two Illinois RECs provide outreach and support services to thousands of primary

care providers and hospitals, throughout the state. The RECs provide a full range of assistance related to EHR selection, EHR training, and the attestation process while providing guidance with meaningful use issues. The RECs also administer a Promoting Interoperability Incentive help desk.

The Illinois Department of Healthcare and Family Services (HFS) is working cooperatively with these RECs to coordinate resources and achieve the state's goals for health information technology. The REC websites are listed below:

IL-HITREC (Statewide Consortium)
www.ilhitrec.org
P.O. Box 755, Sycamore, IL 60178
Phone: 815-753-1136
Fax: 815-753-2460
Email: info@ILHITREC.org

CHITREC (Chicago Consortium)
http://chitrec.org/
750 N. Lake Shore Drive, 9th Floor
Chicago, Illinois 60611
Phone: 312.503.2986
Fax: 312.503.6743
Email: info@chitrec.org

1.1.3 Promoting Interoperability Program Workgroup

A bi-weekly meeting is held with representatives from HFS and numerous provider groups to discuss Promoting Interoperability Program activities. To request joining the meeting's distribution list, please email **HFS.EHRINCENTIVE@illinois.gov**.

2 BACKGROUND

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

Use of certified EHR systems is required to qualify for incentive payments. The ONC has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at **https://www.healthit.gov/providers-professionals/ehr-incentives-certification**.

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

HFS will work closely with federal and state partners to ensure that the Illinois Medicaid PIP fits into the overall strategic plan for the HIE, thereby advancing national and Illinois goals.

Both EPs and EHs are required to begin by registering at the national level with the CMS Medicare and

Medicaid Registration and Attestation System (RAS) at **CMS' official Web site for the Medicare and Medicaid Promoting Interoperability Programs**. The site provides general and detailed information on the programs, including tabs on meaningful use, clinical quality measures, certified EHR technology, payment adjustments and hardship exceptions, Stage information and frequently asked questions.

3 ELIGIBILITY

EPs and EHs must begin the program no later than program year 2016. The first tier of provider eligibility for the Promoting Interoperability Program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the IL MMIS provider data base does not correspond to the provider types and specialties approved for participation in the PIP, the provider will be notified of disqualification.

The following providers and hospitals are potentially eligible to enroll in the IL Medicaid PIP:

EP Type and Specialty	EH Type and Specialty

• Physician
• Physician Assistant (practicing in a FQHC or RHC led by a Physician Assistant): An FQHC or RHC is considered to be PA led in the following instances:
  ○ The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
  ○ The PA is the clinical or medical director at a clinical site of the practice
  ○ The PA is the owner of the RHC
• Pediatrician: Any provider who is Board Certified as a Pediatrician or has at least 90% of Medicaid Recipients Under the Age of 21.
• Nurse Practitioner
• Certified Nurse Midwife
• Dentist
• Optometrist
	• Acute Care Hospital
	• Children's Hospital
	• Critical Access Hospital

Note: Some provider types who are eligible for the Medicare program, such as podiatrists and chiropractors, are not currently eligible for the IL Medicaid PIP.

3.1 Additional requirements for the EP

To qualify each year for an Promoting Interoperability incentive payment , the EP must:

1. Meet one of the following patient volume criteria in any 90 consecutive days during the preceding calendar year or twelve months prior to the attestation date:
   a. Have a minimum of 30 percent patient volume attributable to individuals receiving Medicaid funded services; or
   b. Have a minimum 20 percent patient volume attributable to individuals receiving Medicaid funded services, **and** be a pediatrician (for the purposes of the Illinois Medicaid PIP, a pediatrician is defined as a Medicaid enrolled provider who serves 90% of patients under the age of 21 based on the age of the patient at the time the service is rendered or a Medicaid enrolled provider with a valid, unrestricted medical license and board certification in Pediatrics

through either the American Board of Pediatrics or American Osteopathic Board of Pediatrics); or

   c. Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals (For this program, practicing predominantly in an FQHC/RHC means 50% or more of the total patient volume for the EP over a six-month period is at an FQHC/RHC).

2. Have no sanctions and/or exclusions.
3. Not be deceased.
4. Not have 90% or more of the patient encounters take place in a hospital setting.
5. Be enrolled and in good standing with Illinois Medicaid.

An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he/she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment ("payee") is required when registering with CMS Registration and Attestation System (RAS) and must match a TIN associated to the individual provider in the HFS IMPACT provider enrollment system. The system will check for the following:

- Provider is enrolled with HFS
- Provider status is active and in good standing
- Provider/Payee combination is valid
- Provider is enrolled with HFS in an eligible Provider Type
- Provider is not sanctioned
- Provider is not deceased

If any of the checks performed above fail, the provider will not be able to attest. For contact information please see **Section 10 HELP DESK INFORMATION**.

3.2 Additional requirements for the EH

To qualify each year for an Promoting Interoperability incentive payment, the EH must be:

1. An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume in the previous calendar year for each year the hospital seeks an Promoting Interoperability incentive payment; or
2. A children's hospital (exempt from meeting a patient volume threshold).

Hospital-based providers (90% or more of their patient encounters take place in a hospital setting) are not eligible for the Promoting Interoperability program.

3.3 Qualifying Providers by Type and Patient Volume

Providers by Type	Minimum Percent Patient Volume (90-day period)	
Physicians	30%	Or the Medicaid EP practices predominantly in a FQHC or RHC with 30% "needy individual" patient volume threshold
Pediatricians	20%	
Dentists	30%	
Optometrist	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	
Children's Hospital	No minimum	

3.4 Out-of-State Providers

The IL Medicaid PIP welcomes any out-of-state provider to participate in this program as long as they are enrolled in IL Medicaid. Illinois must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records and claims data considered to be pertinent to an audit. Records must be maintained as applicable by law in the state of practice or Illinois, whichever is deemed longer.

4 ESTABLISHING PATIENT VOLUME

An Illinois Medicaid provider must meet patient volume requirements annually. The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP (Children's Health Insurance Program).

There are several items to be considered when calculating Medicaid patient volume, including:

- Methodology for determining patient volume
- Individual volume vs. group proxy
- Out-of-state encounters

4.1 Methodology for Determining Eligible Professional Patient Volume

All EPs (except EPs predominantly practicing in an FQHC/RHC) will calculate patient volume based on encounters with Medicaid and out-of-state Medicaid patients. The EHR statute allows for an EP practicing predominantly in a FQHC or RHC to consider CHIP patients under the needy individual patient volume requirements.

4.1.1 Definition of an Eligible Professional Medicaid Encounter

For purposes of calculating EP patient volume, a Medicaid encounter is defined as services rendered on any one day to an individual where the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the billable service was provided.

It also includes Managed Care Organization (MCO) encounters and Dual Eligible (Medicare/Medicaid) encounters.

4.1.2 Definition of an Eligible Professional Needy Individual Encounter

For purposes of calculating patient volume for an EP practicing predominantly in a FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Billed to HFS;
- Furnished by the provider as uncompensated care (charity care); or
- Furnished at either no cost or reduced cost based on a sliding fee scale determined by the individual's ability to pay.

4.1.3 Calculating Eligible Professional Patient Volume

To calculate patient volume, providers must include a ratio where the numerator is the total number of Medicaid (billed to HFS) patient encounters (or needy individuals for FQHCs and RHCs) treated in any 90-day period in the previous year or the twelve months prior to the attestation date , and the denominator is all patient encounters over the same period. The numerator must consist of all encounters billed to HFS during the 90-day period; the denominator must consist of all encounters billed to any entity during the 90-day period.

To calculate Medicaid patient volume, EPs (except those practicing predominantly in a FQHC/RHC) must divide:

- The total Medicaid encounters , Medicaid Managed Care encounters or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
- The total patient encounters by all payers in the same 90-day period.

$$\frac{\text{Total Medicaid Member Encounters in any 90-day period in the preceding calendar year or twelve months prior to the attestation date}}{\text{Total Patient Encounters in that same 90-day period}} * 100 = \textit{\%Medicaid patient volume}$$

To calculate needy individual patient volume, EPs practicing predominantly in a FQHC/RHC must divide:

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

4.1.4 Individual vs. Group Patient Volume

Medicaid patient volume thresholds may be met at the individual level (by provider NPI) or at the group practice level (by organizational NPI/TIN). EPs may attest to patient volume under the individual calculation or the group/clinic calculation in any participation year.

4.1.5 EPs Using Individual Patient Volume

For EPs calculating individual patient volume, the numerator must consist of all encounters billed to HFS. Following is an example of how the EP will calculate the Medicaid patient volume:

> *Dr. Smith reviews the encounters in his practice management system and determines that, for a 90-day period from October 1, 2015 – December 29, 2015, he has 500 encounters for HFS recipients and his total volume of encounters for this period is 1,000.*

$$\frac{\text{500 Medicaid encounters}}{\text{1,000 total encounters}} * 100 = \text{50\% Medicaid Patient Volume}$$

4.1.6 EPs Using Group Patient Volume Method

EPs may use a clinic or group practice's patient volume as a proxy for their own under these conditions:

- 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).
- There is an auditable data source to support the clinic's patient volume determination.
- All the EPs in the group practice use the same methodology for the payment 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 group's patient volume and not limit it in any way.
- 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 and not the EP's outside encounters.

The following is an example of how an EP would use the group patient volume method:

> ***Example #1*** *Dr. Sue, a physician practicing in pediatrics, works for ZZ Clinic, YY Clinic and individually. She alone has 19% patient volume therefore does not qualify for the program.*

Professional	*Provider Type*	*Medicaid Encounters*	*All Encounters*	*Patient Volume %*
Ms. Leigh	***Dietician***	*50*	*100*	*50*
Dr. Tom	*Physician*	*34*	*100*	*34*
Dr. Sue	*Pediatrician*	*19*	*100*	*19*
Dr. Bob	*Pediatrician*	*20*	*100*	*20*
Total		*123*	*400*	***31***

In the example above the pediatricians are part of a group and if you aggregate all of the Medicaid encounters and divide by the number of members you can arrive at the group volume of 123/400 = 31% Medicaid Patient Volume.

In this example, the group maximized their benefits. Each member of the group would attest to 123 Medicaid encounters and 400 for all encounters allowing all providers in the group to attest to 30% Medicaid volume. Notice in the example above, it is appropriate when using group encounter methodology to include all licensed professionals regardless of eligibility for the program. Dieticians are excluded from participation; however their encounters can be used in calculating group volume.

The practice maximized their benefits:

a. *The practice was allowed to use all the providers encounters*
b. *Ms. Leigh is not eligible for the program, but her encounters are able to be used in the group methodology*
c. *Dr. Tom could have attested as an individual and received the same year 1 incentive of $21,250 because he has more than 30% Medicaid Patient Volume.*
d. *Dr. Sue would have not been eligible, but based on the calculation can attest and receive the full incentive of $21, 250 in her first year of participation.*
e. *If Dr. Bob would have attested individually he would have received $14,167 in their first year of the program. By utilizing the group methodology he can receive $21,250.*

Example #2

Dr. Pete is part of a large group practice with multiple locations consisting of providers that serve some Medicaid and providers that are enrolled but see no Medicaid patients. If the practice calculates the patient volume individually they have wildly varying results from 100% to 10% and would only be eligible for 70% of the clinics professionals. The practice includes professionals that are eligible for the program and some that are not. If the practice calculates the combined total of the group's patient volume based on Payee Tax ID and reaches 30% or more Medicaid utilization, then it is acceptable to use the entire practices patient volume when attesting. This is the easiest method for HFS to validate.

4.1.7 Groups – Additional Considerations

- When state adjudicators review the **first** group member for eligible encounters and find that the eligible encounter data does not meet the required threshold:
  - All members of the group are rejected or denied
  - Each member receives an email notifying them of the state action
  - If "Registration Rejected" or "Registration Denied":
    - The eligible encounter data becomes editable for all members of the group, including start date and encounters, both total and eligible.
    - The first member of the group to edit and save the data to correct it forces all other members' eligible encounter data to be read-only.
- When a group member is approved then no member of the group can be denied or rejected for patient volume eligibility.
- When patient volume reporting period "Start Date" is updated by the first provider, all existing

members receive an email asking them to revalidate their membership in the group during the new reporting period.

- When "Medicaid Encounters" or "total encounters" is updated the System will send an email to all members of the group asking them to revalidate the update.
- If the first provider updates the "Include Organizational Encounters" button = YES to NO, then the group ceases to exist and the System:
  - Disenrolls all members of the group for group eligibility
  - Removes all group eCQM data that exists for each disenrolled member
  - Sends an email to each ex-member that notifies them of the following:
    - The group no longer exists
    - All eligibility information for the group has been removed.
    - All eCQM information for the group has been removed.
    - The group may be recreated by another provider
    - Each provider will have to rejoin the recreated group.
    - All group eCQM data will have to be resubmitted if the group is recreated.
    - Each provider should validate whether the MU reporting period, if created, still applies and the MU reporting period start date is now editable.
- If the group is an FQHC, then the provider who first saves the group must select "Render Care in FQHC/RHC?=YES.
  - FQHC will default to FQHC=YES for all group members and no longer be modifiable.
  - If the first (FQHC) provider later changes FQHC=NO, then the system will identify all Physician Assistants ("Practice as a Physician Assistant"=YES) and do the following:
    - Remove the group eligibility information.
    - Make the MU reporting period dates editable for this provider.
    - Send an email to the Physician Assistants that they can no longer participate as a group member for purposes of eligibility or eCQM reporting. The PA may still attest as an individual provider in an FQHC setting but not for this group.
- If a provider loses group membership because of a change in eligible encounter reporting period, or chooses to drop group membership then the system will:
  - Remove any group eCQM data that has been submitted for that provider.
  - Make the MU reporting period dates editable for this provider.
  - Wipe the org eligible encounters. The provider may use the same eligible encounter reporting period or another but must use a single practitioner's practice encounters.
- If a member of a group is rejected for MU Core or Menu objective compliance, then only that member of the group is rejected and must re-attest.
- When the first member of a group uploads documentation for Public Health Registries or a UDS, those documents will automatically be uploaded to anyone else in the group that attests after that.

4.1.8 No-Cost Encounters

Providers have the option to include zero-pay claims in their patient volume calculation. If the provider chooses to include zero-pay claims in the calculation, they should be included in the total Medicaid encounters number and must also be separately identified during attestation.

4.1.9 Out-of-State Encounters

If you serve Medicaid patients from bordering states or if your practice location is in a border state, you may include the Medicaid patient volume from the state or location(s) only if that additional encounter volume is needed to meet the Medicaid patient volume threshold. If an EP aggregates Medicaid patient volume across states, HFS may audit any out-of-state encounter data before making the incentive payment. The EP must maintain auditable records for the duration of the HFS Medicaid PIP.

5 PAYMENT METHODOLOGY FOR ELIGIBLE PROFESSIONALS

The maximum incentive payment an EP could receive from Illinois Medicaid equals $63,750, over a period of six years, or $42,500 for pediatricians with a 20-29 percent Medicaid patient volume as shown below.

Provider	EP	EP-Pediatrician
Patient Volume	30 Percent	20-29 Percent
Year 1	$21,250	$14,166.67
Year 2	8,500	5,666.67
Year 3	8,500	5,666.67
Year 4	8,500	5.666.67
Year 5	8,500	5,666.67
Year 6	8,500	5,666.65
Total Incentive Payment	$63,750	$42,500

Since pediatricians are qualified to participate in the Promoting Interoperability Program as physicians, and therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirement.

5.1 Payments for Eligible Professionals

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation System (RAS). The TIN must be associated to the provider in the Illinois MMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated.

The timeline for receiving incentive payments is illustrated below:

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

Note: Pediatricians receive 2/3 of the incentive payments above. For any given year that a pediatrician attests to 30% or more Medicaid encounters, the pediatrician shall receive the full incentive amount.

6 MEANINGFUL USE

Second year providers will receive an e-mail when they become eligible to register for the second year of the incentive program. When registering for year two, providers will still need to review their federal information and enter their CMS assigned registration ID.

Providers and hospitals must ensure that their Medicaid registration and certification and/or license are up to date as well. Providers will be unable to complete their registration until this information is up to date within MMIS system.

Information required for attestation for MU varies based on the measure. It is highly recommended that providers familiarize themselves with the required objectives prior to beginning data entry. The information on MU Objectives/Measures can be found at the following CMS websites:

- **2020 and 2021 Stage 3 EP Objectives** – Provides additional detailed data to assist the provider in understanding how to meet 2021 Stage 3 MU requirements. Provides specific objective definitions.

Note: All providers must attest according to Stage 3 requirements in 2021.

6.1 MU Objectives for 2021

- **Eligible Professionals** using **Stage 3** must attest to **8 objectives**, including **2** public health reporting measures (out of 5 measure options).

MU-Eligibility screen (EP)

Eligibility Information

Identifying Information

Confirmation Number: 1000123123 Program Year: 2021

NPI: 1055011051 Payment Year: 6

EHR Certification Information

EHR Status ? MU

EHR Certification Number ? 0015ETT27UTH8XT

CQM Certification Number ? 0015ETT27UTH8XT

Email ? ehrmipp@cns-inc.com

Organization Encounters

Include Organization Encounters ? Yes No

Reporting Period

Patient volume reporting option ? Prior Calendar Year Prior Twelve Months

Start Date: ?

End Date: ?

Eligible Patient Volume

Practice as a Pediatrician ? Yes No

Practice as a Physician Assistant ? Yes No

Hospital Based Provider ? Yes No

Render care in FQHC/RHC ? Yes No

Did you include no-cost encounters? ? Yes No

Include encounters outside IL ? Yes No

MU-Objective screen (EP Stage 3)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

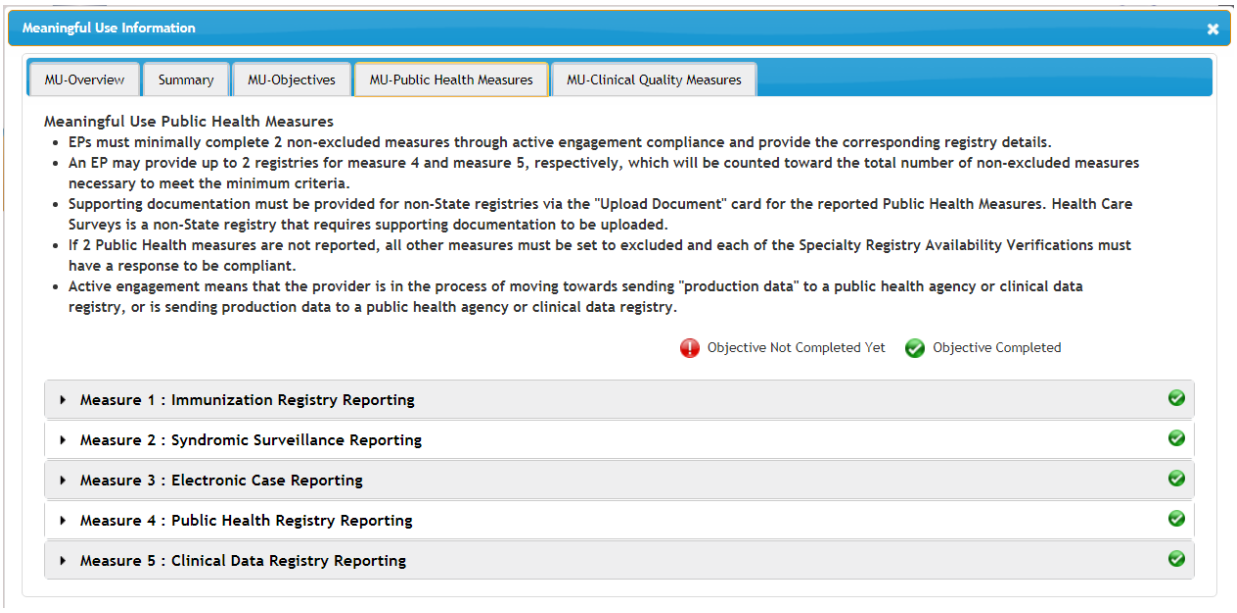
Meaningful Use Objectives

- EPs must complete all 7 Meaningful Use Objectives.

Objective Not Completed Yet Objective Completed

- Objective 1 : Protect Patient Health Information
- Objective 2 : Electronic Prescribing
- Objective 3 : Clinical Decision Support
- Objective 4 : Computerized Provider Order Entry (CPOE)
- Objective 5 : Patient Electronic Access to Health Information
- Objective 6 : Coordination of Care Through Patient Engagement
- Objective 7 : Health Information Exchange

MU-Public Health Measures screen (EP Stage 3)



6.1.1.1 Changes to EP Objectives in 2021

The **Stage 3 Final Rule** documented several changes to the MU objectives. There were also modifications to reporting periods. This section highlights these changes.

6.1.2 Stage 3

EP Stage 3 Objective

1 – Protect Patient Health Information

Objective Description
Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.

In 2021, providers are allowed to attest prior to completion of their Security Risk Analysis. However, they must upload the SRA in the eMIPP applications prior to the end of the 2021 calendar year.

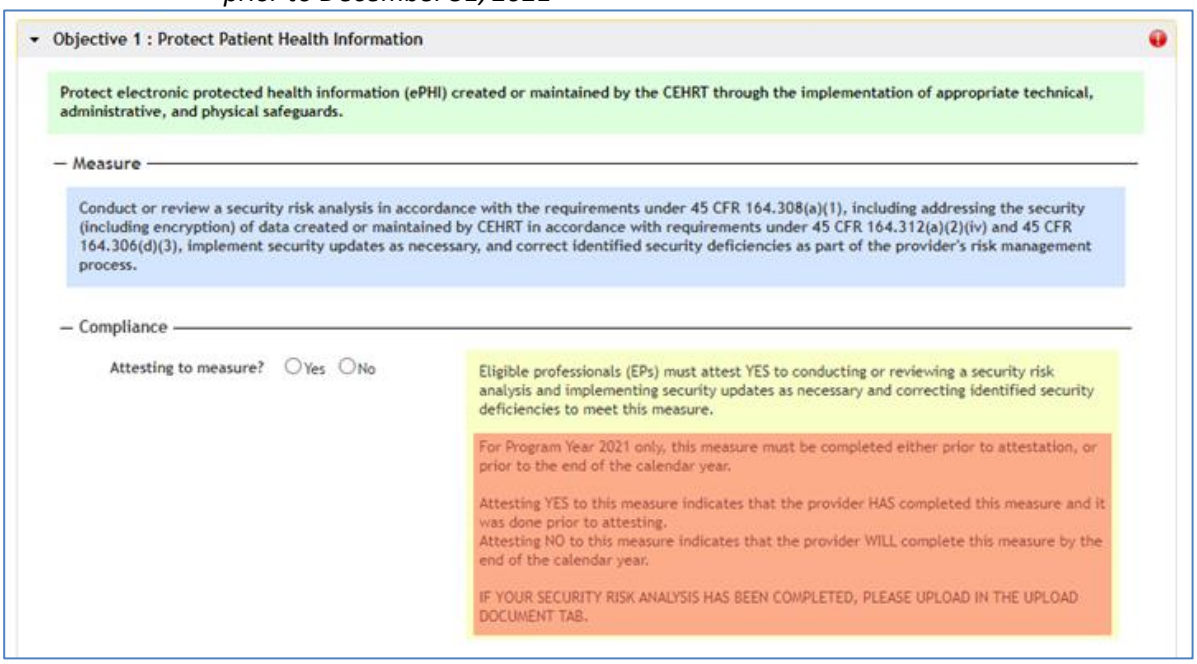
2021 Program Year Objective 1 – **Protect Patient Health Information**

- It is acceptable for the security risk analysis to be conducted outside the EHR reporting period; however, the analysis must be unique for each EHR reporting period, the scope must include the full EHR reporting period, and it must be conducted within the calendar year of the EHR reporting period.

- State Medicaid Agencies have the flexibility to require EPs to submit evidence that the security risk analysis has been completed after the incentive payment has been issued in program year 2021.
- An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each EHR reporting period. Any security updates and deficiencies that are identified should be included in the EP's risk management process and implemented or corrected as dictated by that process.
- At minimum, EPs should be able to show a plan for correcting or mitigating deficiencies and that steps are being taken to implement that plan.

2021 SRA information - Illinois attestation in eMIPP

- SRA should be uploaded using the SRA document type
- eMIPP screen was revised slightly (see below):
  - *Select YES if you completed the SRA prior to attestation*
  - *Select NO if you have not completed the SRA prior to attestation.*
  - *Selecting NO assumes that you will complete the SRA (and upload to eMIPP) prior to December 31, 2021*


Objective 1 : Protect Patient Health Information

Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.

— Measure

Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.

— Compliance

Attesting to measure? ○Yes ○No

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

For Program Year 2021 only, this measure must be completed either prior to attestation, or prior to the end of the calendar year.

Attesting YES to this measure indicates that the provider HAS completed this measure and it was done prior to attesting.
Attesting NO to this measure indicates that the provider WILL complete this measure by the end of the calendar year.

IF YOUR SECURITY RISK ANALYSIS HAS BEEN COMPLETED, PLEASE UPLOAD IN THE UPLOAD DOCUMENT TAB.

Key SRA FAQs:

For Program Year 2021, does the Security Risk Analysis need to be completed, prior to the attestation date:

No, due to the December 31, 2021 statutory deadline for making incentive payments, CMS changed the SRA measure to allow an EP to conduct a security risk assessment at any time during CY 2021, even if that EP attests will be required to attest that they will complete one by December 31, 2021. States will have the flexibility to require EPs to submit evidence that the security risk assessment has been completed, even after the incentive payment has been issued. Additional information regarding this can be found in the **PFS Final Rule** *released Nov. 1, 2019.*

For State 3, does the Security Risk Analysis cover the period up to when the analysis was completed or the period after the analysis was completed:

We reiterate that the security risk analysis and review should not be an episodic "snap-shot" in time, but rather include an analysis and review of the protection of ePHI for the full year no matter at what point in time that analysis or review are conducted within the year. In short, the analysis should cover retrospectively from the beginning of the year to the point of the analysis and prospectively from the point of the analysis to the end of the year.

2 – Electronic Prescribing

Objective Description
Generate and transmit permissible prescriptions electronically.

3 – Clinical Decision Support

Objective Description
Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

4 – Computerized Provider Order Entry (CPOE)

- An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions.

Objective Description
Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant; who can enter orders into the medical record per state, local, and professional guidelines.

Measure 1 Description
More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Measure 2 Description
More than 60 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Measure 3 Description
More than 60 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

5 – Patient Electronic Access to Health Information

Objective 5 Description
The eligible professional (EP) provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

6 – Coordination of Care Through Patient Engagement

- An EP must attest to all 3 of the following measures and meet the thresholds for at least 2 measures to meet the objective except those measures for which an EP qualifies for an exclusion.

Objective 6 Description
Use CEHRT to engage with patients or their authorized representatives about the patient's care.

Measure 1 Description
More than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) Access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) A combination of (1) and (2).

Measure 2 Description
For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative.

Measure 3 Description
Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.

7 – Health Information Exchange

- An EP must attest to all three measures, and must meet the threshold for at least two measures to meet the objective.

Objective Description
The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record

upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

Measure 1 Description
For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) Electronically exchanges the summary of care record.

Measure 2 Description
For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she incorporates into the patient's EHR an electronic summary of care document .

Measure 3 Description
For more than 80 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she performs a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies.

MU Public Health Measures

- EPs must minimally complete 2 non-excluded measures through active engagement compliance and provide the corresponding registry details.
- An EP may provide up to 2 registries for measure 4 and measure 5, respectively, which will be counted toward the total number of non-excluded measures necessary to meet the minimum criteria.
- Supporting documentation must be provided for non-State registries via the "Upload Document" card for the reported Public Health Measures. Health Care Surveys is a non-State registry that requires supporting documentation to be uploaded.
- If 2 Public Health measures are not reported, all other measures must be set to excluded and each of the Specialty Registry Availability Verifications must have a response to be compliant.
- Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.

1. Immunization Registry Reporting

Measure 1 Description
Immunization Registry Reporting: The EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories

from the public health immunization registry/immunization information system (IIS).

2. Syndromic Surveillance Reporting

Measure 2 Description
Syndromic Surveillance Reporting: The EP is in active engagement with a PHA to submit syndromic surveillance data.

3. Electronic Case Reporting

Measure 3 Description
The EP is in active engagement with a PHA to submit case reporting of reportable conditions.

4. Public Health Registry Reporting

Measure 4 Description
The EP is in active engagement with a PHA to submit data to public health registries.

5. Public Health Registry Reporting

Measure 5 Description
The EP is in active engagement to submit data to a CDR.

Measure Number	Measure Name	Measure Specification	Maximum Times Measure Can Count Towards The Objective
1	Immunization Registry Reporting	The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).	1
2	Syndromic Surveillance Reporting	The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.	1
3	Electronic Case Reporting	The EP is in active engagement with a public health agency to submit case	1

		reporting of reportable conditions.	
4	Public Health Registry Reporting	The EP is in active engagement with a public health agency to submit data to public health registries.	2
5	Clinical Data Registry Reporting	The EP is in active engagement to submit data to a clinical data registry.	2

2021 Clinical Quality Measures

- Providers must report at least 6 measures, one of which must be an Outcome or High-Priority Measure. If no Outcome or High-Priority measure is relevant to the provider's scope of practice, report on any six measures that are relevant.
- Outcome Measures are indicated with an asterisk (*). High-Priority Measures are indicated with a double asterisk (**).
- After utilizing a QRDA III file, you will not be able to enter CQM information via online entry. Only MU Objectives and Public Health data can be updated via online entry. To update the CQM information, please upload a new QRDA III file via eMIPP.

1. Domain: Person and Caregiver-Centered Experience and Outcomes

These CQMs reflect the potential to improve patient-centered care and the quality of care delivered to patients. They emphasize the importance of collecting patient reported data and the ability to impact care at the individual patient level as well as the population level through greater involvement of patients and families in decision making, self care, activation, and understanding of their health condition and its effective management.

a. CMS56 **: Functional Status Assussment for Total Hip Replacement

Measure Description
Percentage of patients 18 years of age and older who received an elective primary total hip arthroplasty (THA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery

b. CMS66 **: Functional Status for Total Knee Replacement

Measure Description
Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery

c. **CMS90 **: Functional Status Assessments for Congestive Heart Failure**

Measure Description
Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments

d. **CMS157 / NQF0384 **: Oncology: Medical and Radiation – Pain Intensity Quantified**

Measure Description
Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

e. **CMS771 *: Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia**

Measure Description
Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points

2. **Domain: Patient Safety**

These CQMs reflect the safe delivery of clinical services in both hospital and ambulatory settings and include processes that would reduce harm to patients and reduce burden of illness. These measures should enable longitudinal assessment of condition specific, patient-focused episodes of care.

a. **CMS68 / NQF0419 **: Documentation of Current Medication in the Medical Record**

Measure Description
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

b. **CMS139 / NQF0101 **: Falls: Screening for Future Fall Risk**

Measure Description

Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period

c. CMS156 / NQF0022 **: Use of High-Risk Medications in the Elderly

Measure Description
Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two of the same high-risk medications.

d. CMS177 / NQF1365 **: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Measure Description
Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk

3. Domain: Communication and Care Coordination

These CQMs demonstrate appropriate and timely sharing of information and coordination of clinical and preventive services among health professionals in the care team and with patients, caregivers, and families in order to improve appropriate and timely patient and care team communication.

a. CMS50 **: Closing the Referral Loop: Receipt of Specialist Report

Measure Description
Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred

b. CMS142 / NQF0089 **: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

4. Domain: Community/Population Health

These CQMs reflect the use of clinical and preventive services and achieve improvements in the health of the population served and are especially focused on the leading causes of mortality. These are outcome-focused and have the ability to achieve

longitudinal measurement that will demonstrate improvement or lack of improvement in the health of the US population.

a. CMS2 / NQF0418 **: Preventaive Care and Screening: Screening for Depression and Follow-Up Plan

Measure Description
Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

b. CMS22 *: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Measure Description
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

c. CMS69 / NQF0421 : Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Measure Description
Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2

d. CMS75 *: Children Who Have Dental Decay or Cavities

Measure Description
Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period

e. CMS117 / NQF0038: Childhood Immunization Status

Measure Description
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

f. CMS127 / NQF0043: Pneumococcal Vaccination Status for Older Adults

Measure Description
Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine

g. CMS138 / NQF0028: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure Description
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

h. CMS147 / NQF0041: Preventative Care and Screening: Influenza Immunization

Measure Description
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

i. CMS153 / NQF0033 **: Chlamydia Screenign for Women

Measure Description
Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period

j. CMS155 / NQF0024 **: Weigh Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Measure Description
Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period.Three rates are reported: - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity

k. CMS349: HIV Screening

Measure Description
Percentage of patients 15-65 years of age who have been tested for HIV within that age range

5. **Domain: Efficiency and Cost Reduction**

These CQMs reflect efforts to significantly improve outcomes and reduce errors. These CQMs also impact and benefit a large number of patients and emphasize the use of evidence to best manage high priority conditions and determine appropriate use of healthcare resources.

a. **CMS129 / NQF0389 **: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients**

Measure Description
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer

b. **CMS146 / NQF0002 **: Appropriate Testing for Children with Pharyngitis**

Measure Description
Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.

c. **CMS154 / NQF0069 **: Appropriate Treatment for Children with Upper Respiratory Infection (URI)**

Measure Description
Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode

d. **CMS249 **: Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture**

Measure Description
Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.

6. **Domain: Effective Clinical Care**

These CQMs reflect clinical care processes closely linked to outcomes based on evidence and practice guidelines.

a. CMS74: Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists

Measure Description
Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period

b. CMS122 / NQF0059 *: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)

Measure Description
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

c. CMS124 / NQF0032: Cervical Cancer Screening

Measure Description
Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21-64 who had cervical cytology performed every 3 years - Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

d. CMS125 / NQF2372 **: Breast Cancer Screening

Measure Description
Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer

e. CMS128 / NQF0105 **: Anti-Depressant Medication Management

Measure Description
Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported: a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks) b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)

f. CMS130 / NQF0034: Coloroectal Cancer Screening

Measure Description

Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer

g. CMS131 / NQF0055: Diabetes: Eye Exam

Measure Description
Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period

h. CMS133 / NQF0565 *: Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery

i. CMS134 / NQF0062: Diabetes: Medical Attention for Nephropathy

Measure Description
The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period

j. CMS135 / NQF2907: Hearth Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge

k. CMS136 / NQF0108 **: Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Measure Description
Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported: a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two

additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended

l. CMS137 / NQF0004 **: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Description
Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported: a. Percentage of patients who initiated treatment within 14 days of the diagnosis b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit

m. CMS143 / NQF0086: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

n. CMS144 / NQF2908: Heart Failure (HF): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventriculare Systolic Dysfunction (LVEF <40%)

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge

o. CMS145 / NQF0070: Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventriculare Systolic Dysfunction (LVEF <40%)

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen with in a 12 month period who also have a prior MI or a current or prior LVEF<40% who were prescribed beta-blocker therapy.

p. CMS149: Dementia: Cognitive Assessment

Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

q. CMS159 / NQF0710 *: Depression Remission at Twelve Months

Measure Description
The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.

r. CMS161 / NQF0104: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

s. CMS165 / NQF0018 *: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Measure Description
Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

t. CMS347: Controlling High Blood Pressure

Measure Description
Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: * Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR * Adults aged >= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR * Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL

u. CMS645: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Measure Description
Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater (indicated by HCPCS code) and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.

6.1.3 Active Engagement

The **Stage 3 Final Rule** removed the prior ongoing submission requirement and replaced it with an "active engagement" requirement.

"*Active engagement*" may be demonstrated by meeting any of the following 3 options:

- **Option 1 – Completed Registration to Submit Data:** The EP, EH or CAH registered to submit data with Public Health or, where applicable, the Clinical Data Registry to which the data is being submitted. Public health registration may be made via IDPH's **Meaningful Use Reporting System (MURS) web site**. Registration must be completed within 60 days after the start of the EHR reporting period. Failure to complete registration by the deadline would result in that provider not meeting the measure.
- **Option 2 – Testing and Validation:** The EP, EH or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from Public Health or, where applicable, the Clinical Data Registry within 30 days. Failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.
- **Option 3 – Production:** The EP, EH or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to Public Health (or the Clinical Data Registry).

In order to implement active engagement with the Public Health Reporting Objective, 2 new fields have been added to each Public Health Measure. These fields can only be accessed if "Other" or "Health Care Surveys" is selected as a registry.

1) Active Engagement Status

Select from the following drop list:

- *Completed Registration, Awaiting Invitation*
- *Production*
- *Testing and Validation*

2) Active Engagement Date

Enter the start date that the Active Engagement Status was achieved.

6.1.4 Supporting Providers with the Performance of CEHRT (SPPC) and Information Blocking Language

The MACRA MIPS Rule requires three attestation statements regarding information blocking, two required statements on SPPC/direct review and two optional statements on SPPC/surveillance. The SPPC requirements are documented on pages 77019-77028 of the legislation, while the information blocking requirements are documented on pages 77028-77030.

For an EHR reporting period in CY 2017 and subsequent years, the health care provider must attest to the statements below.

STATEMENT 1: A health care provider must attest that it did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.

STATEMENT 2: A health care provider must attest that it implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times:

(1) Connected in accordance with applicable law;
(2) compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;
(3) implemented in a manner that allowed for timely access by patients to their electronic health information (including the ability to view, download, and transmit this information); and
(4) implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated health care providers, and with disparate certified EHR technology and vendors.

STATEMENT 3: A health care provider must attest that it responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

To engage in activities related to supporting providers with the performance of CEHRT, the health care provider —

STATEMENT 4: A health care provider must attest that it acknowledges the requirement to cooperate in good faith with ONC direct review of its' health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and

STATEMENT 5: A health care provider must attest that if requested, it cooperated in good faith with ONC direct review of its' health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the health care provider in the field.

Optionally:

STATEMENT 6: A health care provider must attest that it acknowledges the option to cooperate in good faith with ONC-ACB surveillance of its' health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received; and

STATEMENT 7: A health care provider must attest that if requested, it cooperated in good faith with ONC-ACB surveillance of its' health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating capabilities as implemented and used by

the health care provider in the field.

Should you choose to opt out of Statements 6 & 7, please contact your state's Medicaid EHR Incentive team.

6.1.5 Additional Public Health Information

- Providers only need to register intent once (registration each year is not required) with IDPH (or a Clinical Data Registry) and could register prior to the start of the EHR reporting period.
- Registration **is** required where a provider seeks to meet meanful use using a measure they have not successfully attested to in a previous EHR reporting period.

For more information about public health reporting for meaningful use, visit:
2020/2021 Stage 3 EP Public Health Information

6.1.6 EHR and CQM Reporting periods

- For 2021 Stage 3, the EHR reporting period for all first year Meaningful Use participants is a minimum of any continuous 90-days between January 1, 2021 and August 30, 2021.

- For a CQM reporting period in 2021, the CQM reporting period is a minimum of any continuous 90-day period between January 1, 2021 and August 30, 2021 for EPs who have previously demonstrated meaningful use.

6.1.7 Program year 2021 CEHRT requirements

For the 2021 program year, all participants must use 2015 Edition CEHRT.

6.2 MU Reporting Data

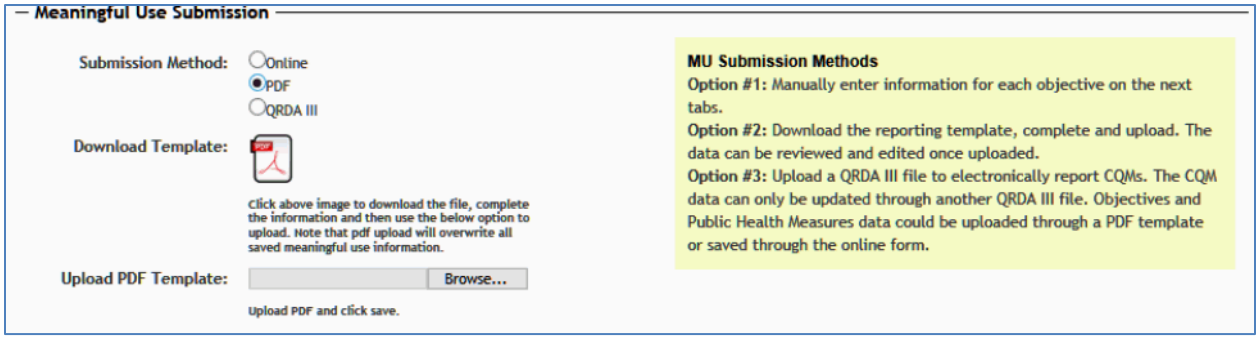
There are three methods by which to enter MU data. Select eMIPP's Meaningful Use tab and click on the MU document for the appropriate submission year. On the MU Overview tab, a heading called "Meaningful Use Submission" lists three options; Online, PDF and QRDA III.

6.2.1 Online submission

The first method is to enter and submit the data online, through the website. Select "Online" as the submission method and enter data for objectives on the following screens.

6.2.2 PDF submission

The second method (shown below) allows the user download a .pdf template to your computer to complete and upload. This method allows entry of MU data off-line and at the user's convenience. Providers can simply upload the document on the MU Overview Tab when finished.

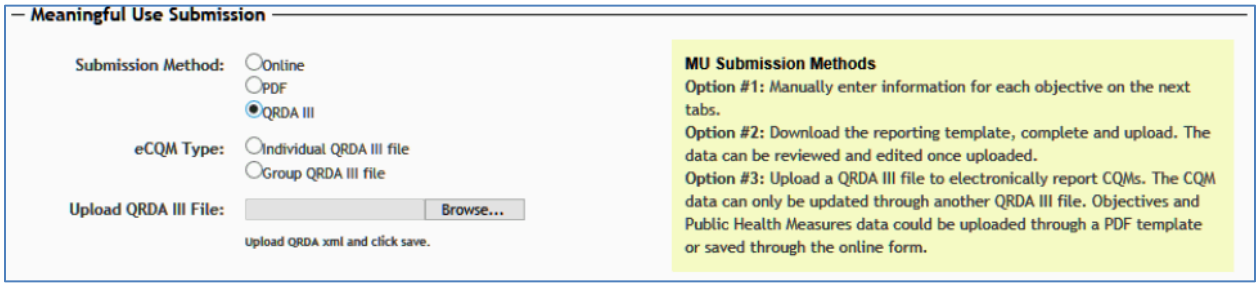


The system will automatically populate the online version with all of the data entered in the PDF. You will now be able to review and make any changes to your data from the online form.

6.2.3 QRDA III submission

A third submission method became available in late March 2014, QRDA III. If a provider's EHR system is capable of exporting MU CQM data to a QRDA III format, the QRDA III file may be uploaded directly into eMIPP (see below). Core and Menu data must be entered "online" or via a PDF file.

Please note that the item 'eCQM Type: Individual QDRA III file/Group QDRA III file' was added after the 'Submission Method' in late September 2018.



6.2.3.1 Meaningful Use Attestation Using Group NPI Data

With the December 2017 changes to the Use Organization Encounters data, nearly every provider that has a valid payee can make use of using a group NPI to populate both the Eligibility and eCQM data from the group NPI and associated group TIN QRDA III file. With the change in late September 2018, the choice of how to enter the eCQM data was moved from the Eligibility Information screen to the Meaningful Use Information screen as 'eCQM Type: Individual QDRA III file/Group QDRA III file'.

This allows a Group Provider the choice to use the Eligibility information of the Group Administrator and use their own QDRA III file for their eCQM data by choosing eCQM Type of Individual QDRA III file. Or they can use the eCQM data of the Group Administrator by choosing eCQM Type of Group QDRA III file. If this option is selected, a box appears to select the Group NPI from a drop down box. If the Group Administrator's NPI is selected, another box appears saying that the eCQM data from the Group

Administrator is already available and to click 'OK' to use this data. The Group Provider also has the option of choosing a different group NPI and use a QDRA III file to load that group's eCQM data.

A provider that does not belong to a group can choose eCQM Type of Individual QDRA III file to load their own eCQM data or can choose eCQM type of Group QDRA III file to load the eCQM data of any Group NPI associated with the provider.

6.2.3.2 Group Administrator

When the first provider in a group begins to enter data in the Eligibility screen in eMIPP, They have a choice to select "Use Organization Encounters". If they select Yes, a dropdown box appears containing all the groups the provider belongs to. Once a group is selected, a popup box appears saying you are the first in the group to select to use it and asks if you will accept to enter the Eligibility information for the group and to become the Group Administrator. If the provider accepts they are informed that they are now the Group Administrator and only they can change any encounter data on the Eligibility screen.

In the Meaningful Use MU-Overview screen the Group Administrator fills in the MU Objectives and Public Health Reporting Period, the MU CQM Reporting Period, and the Location Information. At this point the Group Administrator should select QRDA III under Selection Method, Group QDRA III file under eCQM Type, and upload the eCOM QRDA III file for the group. Then save the screen. This will load all the CQM data from the uploaded file and when you back out to the main Meaningful Use screen the CQM column should now say "Complete" for the current Program Year. The Core / Objectives and Menu / PH data must be filled out manually or by a PDF template. If the PDF template contains CQM data of its own, it will be ignored. The Group Administrator will now finish up the attestation and submit it for approval.

Please note that the line 'Use Group eCQM Data Yes/No' was removed from the 'Organization Encounters' section of the Eligibility Information screen in late September 2018.

Example of Group Administrator Eligibility Screen

Eligibility Information

Confirmation Number: 1000414568 Program Year: 2018

NPI: 1316097355 Payment Year: 6

Bold fields are required.

You are the administrator for this group. Only you can make the changes to the group-level data.

EHR Certification Information

EHR Status ? MU

EHR Certification Number ? 0015HEQ86VKN4B5

CQM Certification Number ? 0015HEQ86VKN4B5

MU Reporting Choice ? Modified Stage 2

Email ? ehrmipp@cms-inc.com

Organization Encounters

Include Organization Encounters ? Yes No

Organization NPI

Organization:

1234567890 - Acme Institute

Reporting Period

Patient volume reporting option ? Prior Calendar Year Prior Twelve Months

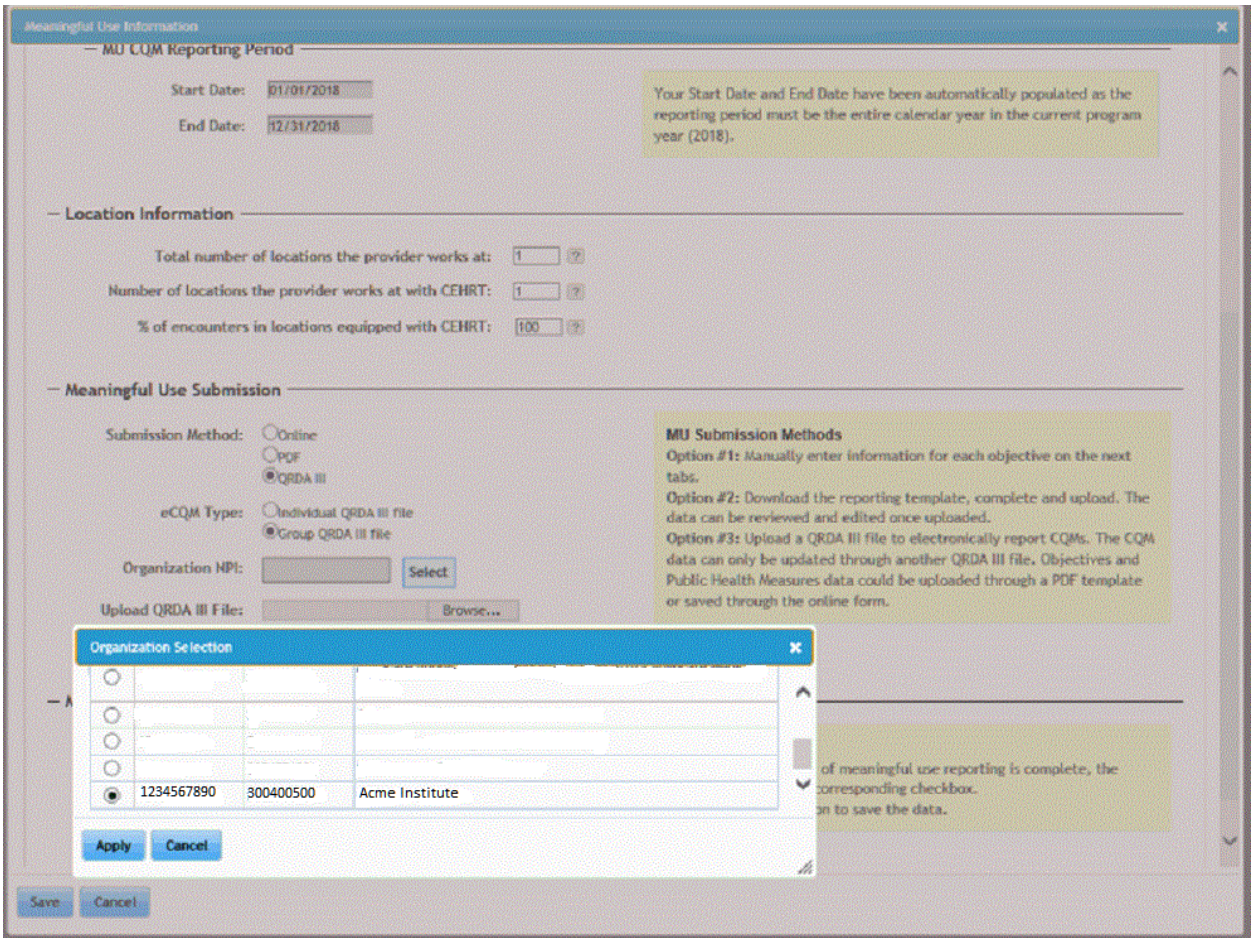
Start Date ? 07/01/2017

End Date: ? 09/28/2017

Save Cancel

Please note that the item 'eCQM Type: Individual QDRA III file/Group QDRA III file' was added after the 'Submission Method' in late September 2018.

Example of Group Administrator Meaningful Use Screen



6.2.3.3 Group Provider

When a Provider that wants to be part of the group selects "Use Organization Encounters" Yes and selects the same group NPI as the Group Administrator, a popup box appears saying "Group Eligibility details have already been created by:" and lists the Provider Name, Payment Year and Reporting Period of the Group Administrator. An instruction says to click Ok to copy the details from the group eligibility. This action will fill in the Eligibility data to look the same as the Group Administrator.

In the Meaningful Use MU-Overview screen the Group Provider will use the eCQM Type of Group QDRA III file to choose to use the Group Administrator's eCQM data or choose to use other options detailed in section 6.2.3.1.

As with the Group Administrator, the Core / Objectives and Menu / PH data must be filled out manually or by a PDF template. If the PDF template contains CQM data of its own, it will be ignored. The Provider will now finish up the attestation and submit it for approval.

Please note that the line 'Use Group eCQM Data Yes/No' was removed from the 'Organization Encounters' section of the Eligibility Information screen in late September 2018.

<u>Example of Group Provider Eligibility Screen</u>

Eligibility Information

Confirmation Number: 1000416718 Program Year: 2018

NPI: 1194990705 Payment Year: 5

Bold fields are required.

Group level eligibility details are read-only for non-administrators. Only the group administrator can edit the group details. The administrator for this group is : JOHN SMITH

EHR Certification Information

EHR Status ? MU

EHR Certification Number ? 0015HEQ86VKN4B5

CQM Certification Number ? 0015HEQ86VKN4B5

MU Reporting Choice ? Modified Stage 2

Email ? ehrmipp@cns-inc.com

Organization Encounters

Include Organization Encounters ? Yes No

Organization NPI

Organization:

1234567890 - Acme Institute

Reporting Period

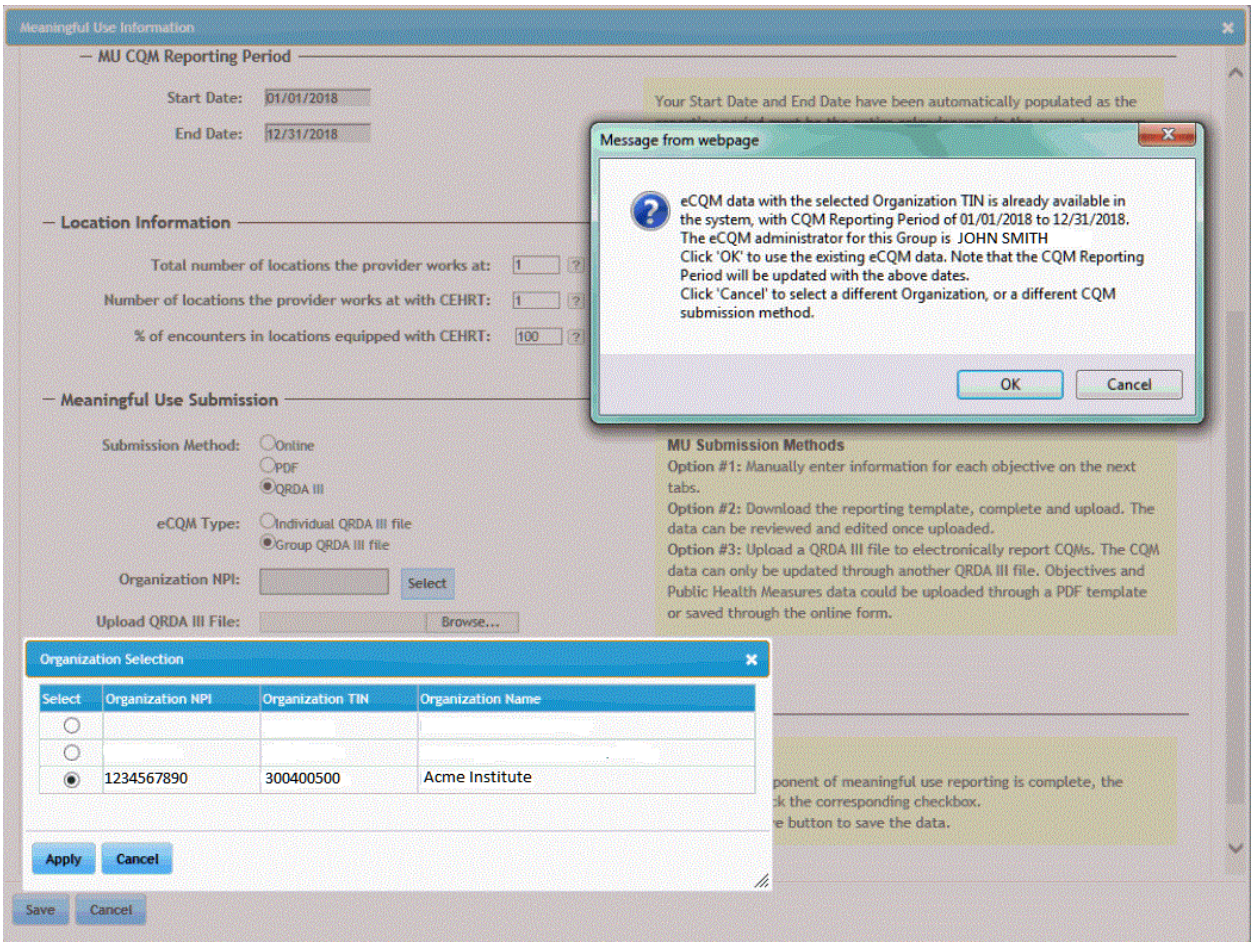
Patient volume reporting option ? Prior Calendar Year Prior Twelve Months

Start Date ? 07/01/2017

Save Cancel

Please note that the item 'eCQM Type: Individual QDRA III file/Group QDRA III file' was added after the 'Submission Method' in late September 2018.

Example of Group Provider Meaningful Use Screen



For additional information see:

- [eCQI Resource Center page]

6.3 Clinical Quality Measures

6.3.1 CQMs

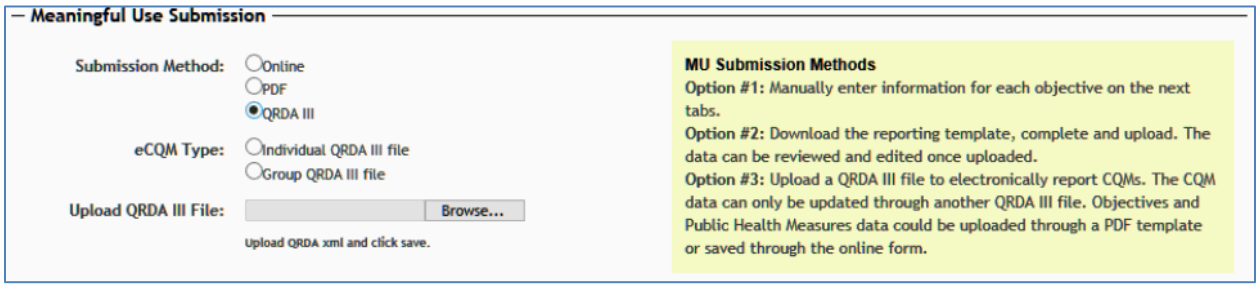
- **For the 2021 program year, Eps must report on 6 out of 50 total CQMs.**

For more information on 2021 Clinical Quality Measures, please visit:
[eCQI Resource Center page]
[2021 Eligible Professional/Eligible Clinician eCQMs]

6.3.2 Medicaid eCQM reporting

Although States are not required to implement eCQM reporting for Medicaid Promoting Interoperability programs, it is allowed for the States to invoke this option. Illinois has chosen to allow Medicaid Promoting Interoperability program eCQM reporting.

The provider has two options available for eCQM reporting; **Group** eCQM (QRDA III) reporting or **Individual** eCQM (QRDA III)reporting. When completing the Meaningful Use Information tab, in the Meaningful Use Submission area, when the Submission Method of QDRA III is selected , the eCQM Type selection appears as shown below. If you select Group QDRA III file, you have chosen Group eCQM reporting. If you select Individual QDRA III file, you have chosen Individual eCQM reporting. There are other options available as detailed in section 8.2.3.1.



6.3.3 Group eCQM Reporting – Additional Considerations

- Providers must have reported Stage 1 MU for at least one year before using group eCQM reporting.
- For the submitting provider, the MU Core and Menu data is saved from the web form, and the CQM data is saved from the QRDA III file.
- For other providers in the group, only CQM data is saved from the QRDA III file. The existing MU Core and Menu data is maintained.
- The group QRDA III file upload:
  - Is not saved if there is existing CQM data loaded via an Individual QRDA III upload
  - Updates existing CQM data if it was loaded via a group QRDA III file
  - Clears all existing CQM data loaded via web forms or PDF upload, and saves only the CQMs on the QRDA III group file.
- If providers choose to upload a PDF after the group QRDA IIII file is uploaded:
  - The data for Core and Menu categories will be uploaded/overwritten from the PDF
  - CQM data will not be updated from the PDF
- If providers choose to update the MU data from the web form after the group QRDA III file is uploaded:
  - Core and Menu categories can be edited from the web form.
  - CQM data will be read-only and will not be editable from the web form.
  - On saving the MU form, only the Core and Menu will be updated.
- If providers choose to upload another group QRDA III file after the first group QRDA III file is uploaded:
  - Only the submitter of the first group QRDA III file is allowed to upload another group QRDA III file.
  - The new group QRDA III file is not a replacement file. It will update existing CQMs and save new CQMs.
- If providers choose to upload an individual QRDA III file after the group QRDA III file is uploaded:
  - All the CQMs loaded from the group QRDA III file are discarded.
  - Fresh CQMs are loaded from the individual QRDA III file
- Group CQM data are read-only on the screens.
- Groups may submit eCQM data multiple times until the first individual provider has attested.
  - Only the original NPI identified on the first eCQM upload is allowed to upload updates.
  - Updates of eCQM data is NOT a replacement file
  - All previously uploaded data will be kept unless changed.

- If a group wants to delete a specific CQM already uploaded then the CQM should be sent in another group QRDA III file with zeroes in the denominator.
- CQMs may be reported by a group with a single or multiple reports received by eMIPP, from one provider then applied to all members of the group.
- To qualify for group reporting a provider must be a member of the group on the attestion date.
- The group's "Organization NPI" must be "active" in MMIS on the attestation date.
- The first verified member of a group to submit a group QRDA III report must have entered and saved the group's eligible encounter information BEFORE sending the QRDA III CQM data set to assure that the group NPI is valid for this provider.
- The first verified member of a group that submits the group QRDA III report sets the CQM MU reporting period for the group in calendar/program year 2014.
- If a provider joins a group the provider is not eligible for "Group" MU reporting the first year of membership; except for calendar/Program year 2014 and the provider joined before the 90 day MU reporting window.
- Individual providers must report their first year of MU using their individual provider MU data, not group data.
- When State adjudicators find eCQM data to be non-compliant, then all members of the group are denied or rejected.
- If a group is rejected then each member of the group must re-attest to assure that all MU information is correct for the "fixed" registration.
- If eCQMs are accepted at the time of the first provider's attestation then the other members will never be rejected based on eCQM compliance because of CQM edits at time of submission. If the provider attempts to attest and submit prior to eCQMs being compliant for the group, the system will not accept the submission and the provider will receive an error message.

6.3.4 Individual eCQM Reporting – Additional Considerations

- Providers must have reported Stage 1 MU for at least one year before using eCQM reporting.
- Individual providers may submit eCQMs multiple times until the individual provider has attested:
  - Updates of eCQM data are NOT replacement files. All previously uploaded data will be kept unless modified.
  - Providers have to enter a start and end date of their MU reporting period from the screen upon clicking on the save button. The start and end date from the QRDA file is ignored.
- An individual QRDA III upload:
  - Removes all prior CQM data uploaded via web form, PDF or Group QRDA III and loads fresh CQM data.
  - Only updates the existing CQM data loaded from an earlier individual QRDA III file.
  - Has no Core or Menu data. Core and Menu measures are loaded from the web form.
- If providers upload a group QRDA III file after an individual QRDA III file is uploaded:
  - No CQM data is saved from the group QRDA III file.
- If providers upload a PDF file after an individual QRDA III file is uploaded:
  - No CQM data is saved from the PDF file.
  - Core and MU data is saved from the PDF file.
- If providers edit data from the web form after an individual QRDA III file is uploaded:
  - All the data from the web form is saved, over-writing any existing data.
  - All the CQM data is now marked as 'Saved from web form'.

7 PROVIDER REGISTRATION AND ATTESTATION

7.1 Minimum System Requirements

For best results, the computer used for registration and attestation should meet the minimum system requirements stated below.

1. The recommended windows resolution is 1024 x 768.
2. The computer must have a Java Run Time Addition (JRE)
3. The eMIPP system is designed to run on Internet Explorer 8.0 and above.
4. If you are using Internet Explorer 10.0, you can adjust the browser settings In order to maximize the eMIPP module. Open the "Tools" Menu and select the "Compatibility View" Settings option and enter the eMIPP Module URL in the 'Add this website' option.
5. The eMIPP module uses pop-up menus that need to be displayed. In order for the module to display these correctly, the user will need to ensure that the Pop-up Blocker is turned off. To turn Pop-up Blocker on or off, follow these steps:
    - Open Internet Explorer, and then click on the "Tools" menu located at the far right hand side of your browser's Tab Bar.
    - When the drop-down menu appears, select the *Pop-up Blocker* option.
    - A sub-menu will now appear. Click on the option labeled *Turn Off Pop-up Blocker*.

7.2 Registration and Attestation Checklist

☐ Medicaid enrollment is up-to-date (IMPACT)
☐ EP must be attached to correct group NPI and TIN
☐ CMS assigned Registration ID (assigned when registering at the CMS site)
☐ CMS EHR Certification ID (see the CMS Certified EHR Technology web page)
☐ Eligible Professional Patient Volume Calculation worksheet completed; patient volume requirement met. Complete below and email to **HFS.EHRINCENTIVE@ILLINOIS.GOV**

Requested Information	Provider Response
TIN	
Group or individual numbers	
Provider type (*physician, hospital, dentist, etc.)*	
Date Range • 90 days from 2018	
Encounters: Straight Medicaid (*only traditional Medicaid & All Kids*)	
Encounters: Medicaid Managed Care	
Encounters: Total for all payees	

☐ If attesting for meaningful use, MU Reporting Data template completed
☐ Uploaded all appropriate documentation, including:
- *Registry verification emails from Illinois Department of Public Health (includes status: registered with MURS, testing, production).*
- *Registry verification emails from registry vendors (Genesis, Dartnet, Cerner, etc.)*
- *(optional) Patient Volume worksheets (will be needed in case of audit)*
- *(optional) All other information necessary to assist with audit*

7.3 CMS Registration

Both EPs and EHs are required to begin by registering at the CMS EHR Registration and Attestation System.

CMS' official Web site for the Medicare and Medicaid Promoting Interoperability Programs can be found at **http://www.cms.gov/EHRIncentivePrograms/**.

The guides below will help you register and attest for Promoting Interoperability Programs. These official guides provide easy instructions for using the Federal CMS Medicare and Medicaid Registration & Attestation System (RAS), helpful tips and screenshots to walk you through the process, and important information that you will need in order to successfully register and attest. Please download the guide that best fits your needs:

- **Registration User Guide for Medicaid Eligible Professionals**
- **Registration User Guide for All Eligible Hospitals**

Additional User guides may be found on CMS' Registration and Attestation web page.

What is needed to register?

1. **National Plan and Provider Enumeration System (NPPES)** web user account, user ID and password
2. NPI of the individual provider
3. Payee Tax Identification Number (SSN or FEIN)
    - If payee is a Group (Group NPI, Name, TIN)
4. Email address
5. Business Name, Address, Phone, Zip + 4
6. Answer to which program you wish to attest to? Medicare or Medicaid
7. **ONC Certified Electronic Health Record Technology Certification ID**

EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong.

EPs must select the Medicare or Medicaid incentive program (a provider may switch from one to the other once during the incentive program prior to 2015).

If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the RAS to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment.

After the initial registration, the provider does not need to return to the RAS before seeking annual payments unless information needs to be updated. EHs seeking payment from both Medicare and Medicaid will be required to visit the RAS annually to attest to MU before returning to the Illinois PIP system to attest.

The RAS will assign the provider a CMS Registration Number and electronically notify HFS of a provider's choice to access Illinois' Medicaid PIP for payment.

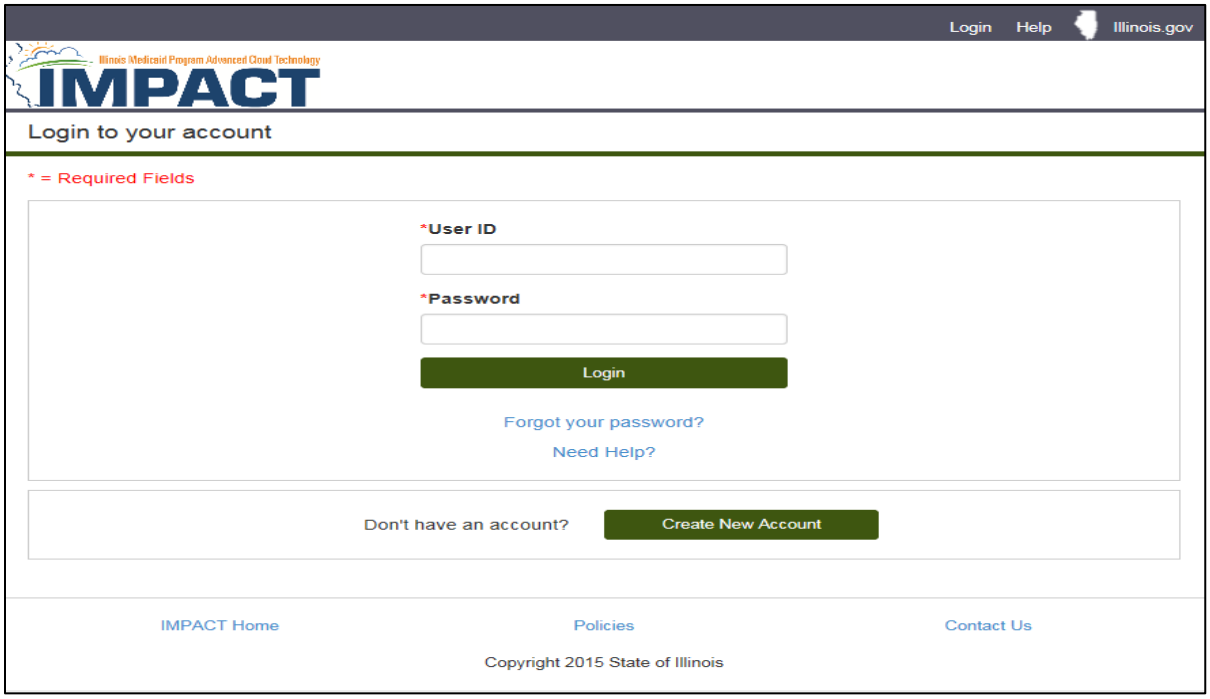
7.4 Attestation – Registration with eMIPP

After registering with the CMS EHR Registration and Attestation System, providers must register at the HFS Medicaid Login portal **https://IMPACT.illinois.gov** to access the eMIPP system. The provider must be enrolled and active in Illinois Medicaid system to complete the attestation process.

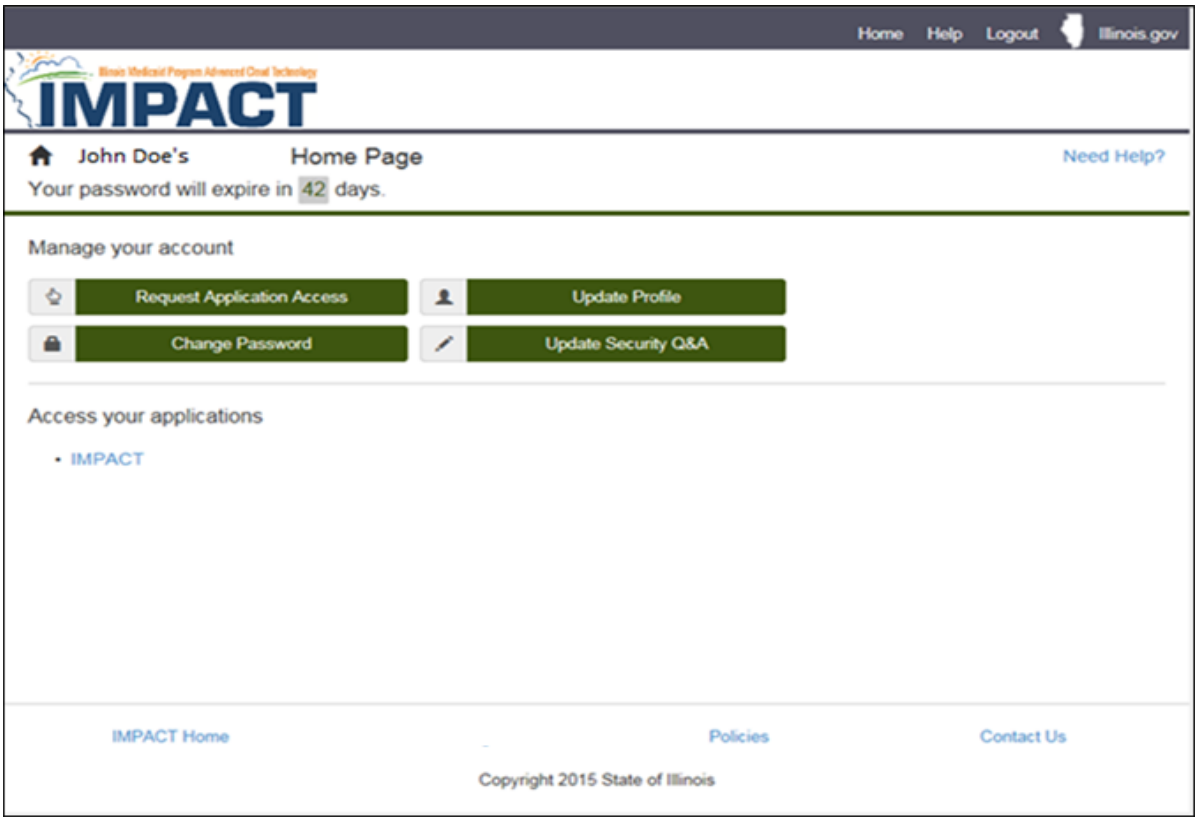
7.4.1 IMPACT/eMIPP Login Instructions

Access the IMPACT Login Screen at **https://IMPACT.illinois.gov**.

Login with your IMPACT userid and password. *As of the 2016 program year, Medi access is no longer associated with Illinois Medicaid Promoting Interoperability Program attestations.* If you don't have an IMPACT userid, click Create New Account and follow the **instructions for Single Sign-on** on the IMPACT Presentations and Materials web page.



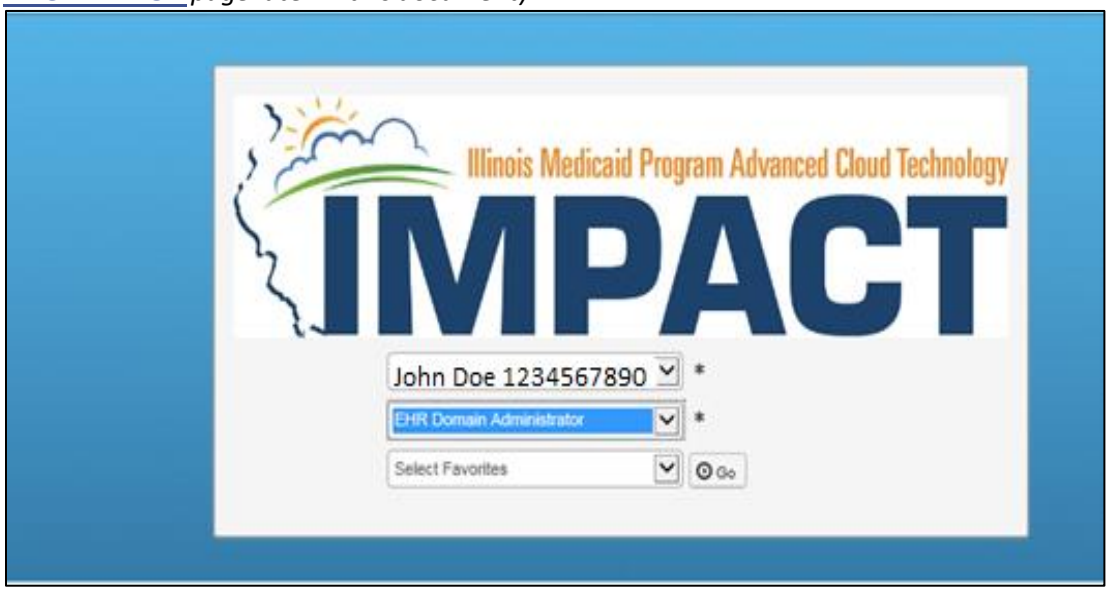
The screen below appears.



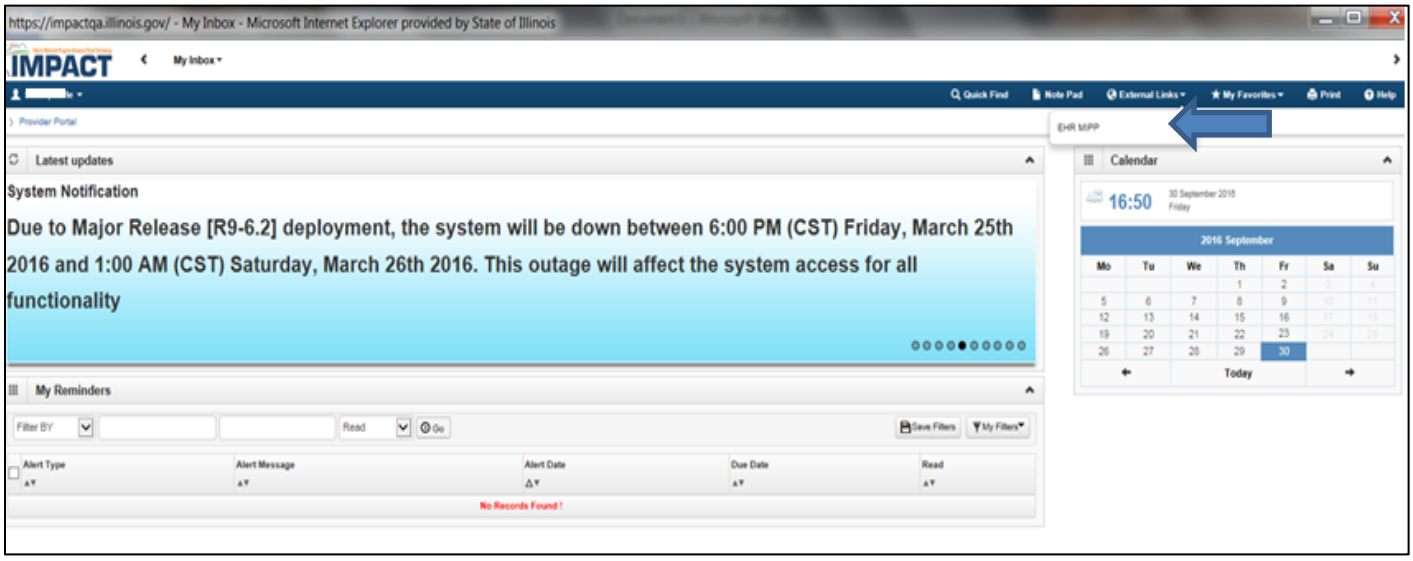
Select the IMPACT application.

The screen below appears. Select your Domain (i.e., name/NPI) and select EHR Domain Administrator.

If EHR Domain Administrator does not appear as a selection, contact your Domain Administrator. If you are unsure who your Domain Administrator is, contact the IMPACT team (see ***HELP DESK INFORMATION*** *page later in this document).*



The IMPACT "My Inbox" screen appears. Select EHR MIPP from the External Links drop list.



The main eMIPP page is displayed. Start your registration or view your existing registration.

7.4.2 Additional Login information

What you will need to login:

- User name and Password for the HFS Medicaid IMPACT Login Portal
- CMS Registration ID for the provider you are attesting for.

If the provider entry does not match with what IL Medicaid has on file, an error message with instructions will be returned.

1. After successful log in to the eMIPP system, the provider will be asked to view the Federal Information that will be displayed with pre-populated data received from the CMS EHR Registration and Attestation System. To make corrections to the information, providers must visit the CMS EHR Registration and Attestation System website to make these changes and submit. Providers will need to wait for at least one business day before these changes are received in the eMIPP system.

2. The provider will then be asked to attest to the patient volume characteristics and EHR details including their EHR Status and EHR Certification number. Multiple practice locations can be typed and uploaded as a document. Organization NPI is needed to include organizational encounters. For FQHC/RHC, Charity Care and Sliding Fee Scale encounters are needed in addition to the Medicaid encounters.

3. Before submitting the attestation for state review, provider will be asked to upload required documentation and electronically sign the HFS disclaimer page. See Appendix A for the Attestation Disclaimer Language for EPs and Appendix B for the Attestation Disclaimer Language for EHs.

4. Upon submission of the electronic attestation and receipt of the required documentation, HFS will validate the attestation and adjudicate for payment. The payment will be issued by the Office of the Illinois State Comptroller.

5. Once the payment is disbursed to the eligible TIN, Federal CMS EHR Registration and Attestation System will be notified by Illinois Medicaid that a payment has been made.

Note: HFS will be conducting regular reviews of attestations and incentive payments as part of the audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers should keep their supporting documentation on file for at least six years to support the audit requirement.

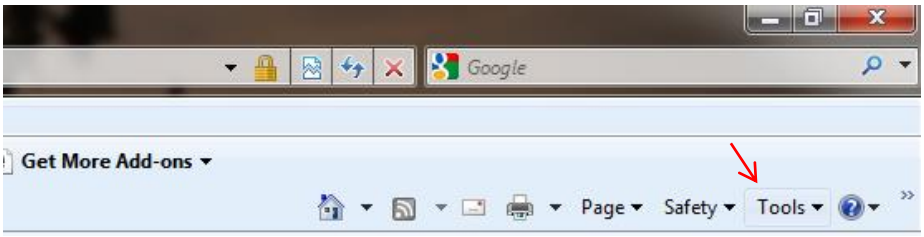
7.4.3 Web Browser Troubleshooting:

It is recommended that you use Microsoft Internet Explorer (IE) 8 or 9 to access the EHR registration system. If you have trouble using the EHR registration system, review these settings in IE 8.

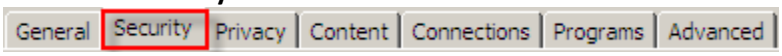
From the desktop icon for IE 8:
Right Click on Internet Explorer Icon

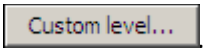
and click on **Properties.**
OR from inside IE 8:

Click on the **Tools** menu and go to **Internet Options**.



1) Select the **Security** tab.



2) Next click on 

3) Verify that the following settings have either been **Enabled** or **Prompted**:

In the "ActiveX controls and plug-ins" section:

Binary and script behaviors
- ○ Administrator approved
- ○ Disable
- ◉ Enable

Download signed ActiveX controls
- ○ Disable
- ○ Enable (not secure)
- ◉ Prompt (recommended)

Only allow approved domains to use ActiveX without prompt
- ○ Disable
- ◉ Enable

Run ActiveX controls and plug-ins
- ○ Administrator approved
- ○ Disable
- ◉ Enable
- ○ Prompt

Script ActiveX controls marked safe for scripting*
- ○ Disable
- ◉ Enable
- ○ Prompt

In the "**Downloads**" section:

Font download
- ○ Disable
- ◉ Enable
- ○ Prompt

7.5 Attestation Deadlines

Remaining attestation deadlines for the Illinois Medicaid PIP include:

2021 PROGRAM YEAR (FINAL YEAR)

- Eligible Professionals (EP) – August 31, 2021

8 HELP DESK INFORMATION

If you need additional support, please use the contact information below.

Issue	Contact
Providers with general questions about IMPACT or provider enrollment	**Email:** IMPACT.Help@Illinois.gov **Phone:** 1-877-782-5565 (select option #1)
Providers that are *having trouble logging in* to the IMPACT system	**Email:** IMPACT.Login@Illinois.gov **Phone:** 1-888-618-8078
eMIPP questions or Promoting Interoperability Program policy questions: EHR Help Desk	**Email:** hfs.ehrincentive@illinois.gov **Phone:** 217-524-7322
CHITREC (within Chicago)	**Phone:** 1-855-MUHELP1 or 855-684-3571 **Email:** info@CHITREC.org
IL HITREC (outside Chicago)	**Email:** info@ILHITREC.org

For all other issues, please email HFS at: hfs.ehrincentive@illinois.gov

Website: IL Medicaid Promoting Interoperability Program (eMIPP) website

9 AUDIT INFORMATION

9.1 Medicaid Audits

PIP Medicaid Audits for the State of Illinois will be conducted by the Department of Healthcare and Family Services, Office of the Inspector General, Bureau of Medicaid Integrity.

Any eligible professional (EP), eligible hospital (EH) or critical access hospital (CAH) attesting to and receiving an Promoting Interoperability incentive payment through the Illinois Medicaid PIP may be subject to a Medicaid audit.

It is the provider's responsibility to maintain the proper documentation that supports the MU claims and the clinical quality measures submitted during attestation. Documentation supporting provider eligibility and Medicaid volume calculations also must be retained. It is recommended that EPs, EHs, and CAHs should retain all supporting attestation documentation in both electronic and paper format. If retaining screenshots, make sure all protected health information has been blackened out. To demonstrate that electronic documents have not been manipulated, save in a version that is not able to be manipulated such as PDF. Documentation supporting attestation should be kept for six years post-attestation.

9.1.1 Documentation to save:

- Office of the National Coordinator (ONC)-certified EHR software
  - Screenshot or other applicable document of certified health IT product list certification ID number for the version of software referenced during attestation
  - Documentation to prove acquisition/purchase/lease of ONC-certified EHR software. Examples include:
    - Contract documents

        - Documents supporting Invoice
        - Documents supporting Purchase Order
        - Lease documents
        - License documents
    - Practicing Locations – A list of all locations in which EP encounters occurred
    - Other Supporting Documents
- Hospital payment calculation
    - Documents supporting Cost Reports
    - Hospital calculation worksheet
- Eligibility requirements
    - Reports that support calculations of Medicaid and total patient encounter volumes, explanations of how and when they were generated
    - Documentation to support the number of unique patients seen by the EP
    - Group definitions, including a listing of the individual members of a group, patient volume reporting periods used, and the locations used to accumulate the group encounters
    - Documentation showing an FQHC or RHC is led by a Physician Assistant, if a Physician Assistant is requesting eligibility in the program
- MU achievement: *The provider must keep enough supporting documentation for each objective/measure to verify the numeric and other information supplied in the attestation. Examples of supporting documents that may be appropriate are listed below:*
    - MU dashboard reports showing provider achievement of core and selected menu measures, and screenshots or other applicable documents used to verify the date the reports were run
    - Documentation to support any exclusions taken for any MU measure
    - Screenshot or other applicable document that verifies the EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period
    - Screenshot or other applicable document that shows the clinical decision support (CDS) rule was enabled (Stage 1) or that five clinical decision supports rules were enabled (Stage 2), dated prior to the beginning of the EHR reporting period
    - Clinical summary for a patient
    - Description of how/when (timeframe after visit) a clinical summary is given to the patient
    - Documentation to support exchange of key clinical information: what documentation was sent, name of the entity to whom the test was sent, the software and version of the EHR used by the receiving entity and a response from the receiving entity if the test was successful (effective for meaningful use attestations for 2010-2012 only as revised per Stage 2 legislation, effective 2013)
    - HIPAA Security risk analysis, including:
        - Physical inspection report
        - List of security deficiencies and how they were mitigated
        - Standards followed when conducting security risk analysis
        - How is encryption/security of data at rest addressed? (Stage 2)
    - Screenshot or other applicable document that verifies that drug formulary was enabled, dated prior to the beginning of the EHR reporting period (Stage 1)
    - Name of the formulary vendor (for example: Surescripts)
    - List of the types of clinical lab tests incorporated into CEHRT

    - Screenshot or other applicable document of lab order, dated during the EHR reporting period
    - Patient list, description of how the patient list was generated and for what purpose
    - Email sent to Illinois Department of Public Health (IDPH) with test file for submission of electronic data
    - IDPH letter verifying test of electronic data was submitted or that ongoing transmission is occurring in a production mode
- List of top five recipients of eRx and a Screenshot or other applicable document of the top five from the e-prescribing vendor (for example: Surescripts)
- For program year 2014, if claiming a lesser certification (less than 2014 CEHRT) per the 2014 Flexibility rule, provide proof of vendor delays or other documentation supporting the selection of the lesser certification.
- Health Care Survey (if selected) see page 18 for reference.

Utilization of the information above does not guarantee that the EP will pass a CMS or State of Illinois audit. For more information on audits: **http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Attestation.html**

APPENDIX A – EP ATTESTATION DISCLAIMER LANGUAGE

Providers will need to accept the following disclaimer language in order to submit their attestation.

Eligible Professionals:

You are about to submit your attestation for Eligible Health Records (EHR). Please make sure if you have uploaded one of the following files:

1. Proof of Certified Electronic Health Record Adoption, Implementation or Upgrade or Meaningful Use (Submit one from list below)
    - Contract
    - Software license
    - Receipt or proof of acquisition
    - Purchase order or invoice
    - Lease
    - Receipt for Training – evidence of cost or contract
2. Required only if you are attesting to Meaningful Use: Proof of compliance with the EHR submission measure, which states that "[c]apability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice"
    - The Illinois Comprehensive Automated Immunization Registry Exchange (iCare) registry email stating that the provider has attempted a test of the EHR capabilities.

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre-payment or post payment audit. All documentation supporting the information attested to by the Provider or Facility should be kept for 6 years.

I certify that the information submitted for Clinical Quality Measures was generated as output from an identified certified EHR technology. The information submitted is based on the knowledge and

information provided by me, the Eligible Professional or is submitted on behalf of the Eligible Professional and the Eligible Professional has affirmed that the information provided is true, accurate and complete to the best of my knowledge. The information submitted is accurate and complete for numerators, denominators and exclusions for functional measures that are applicable to the EP. The information submitted includes information on all patients to whom the measure applies. As a meaningful EHR user, at least 50% of the Eligible Professional's patient encounters during the EHR reporting period occurred at the practice/location given in the Eligible Professional's Attestation information and is equipped with certified EHR technology.

I understand that I, the Eligible Professional must have, and retain, documentation to support my eligibility for incentive payments and that the Illinois Department of Healthcare and Family Services may ask for this documentation. I further understand that the Illinois Department of Healthcare and Family Services will pursue repayment in all instances of improper payment. I certify that I, the Eligible Professional have not received Medicaid Promoting Interoperability incentive funds from any other state or commonwealth and have not received a payment from the Illinois Medicaid Program for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid Promoting Interoperability incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

APPENDIX B – EH ATTESTATION AND DISCLAIMER LANGUAGE

Eligible Hospitals and Critical Access Hospitals:

You are about to submit your attestation for Eligible Health Records (EHR). Please make sure if you have uploaded one of the following files:

1. Proof of Certified Electronic Health Record Adoption, Implementation or Upgrade or Meaningful Use (Submit one from list below)
    - Contract
    - Software license
    - Receipt or proof of acquisition
    - Purchase order or invoice
    - Lease
    - Receipt for Training – evidence of cost or contract
    - Hospital Calculation Worksheet
2. Required only if you are attesting to Meaningful Use: Proof of compliance with the EHR submission measure, which states that "[c]apability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice"
    - The Illinois Comprehensive Automated Immunization Registry Exchange (iCare) registry email stating that the provider has attempted a test of the EHR capabilities.

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre-payment or post payment audit. All documentation supporting the information attested to by the Provider or Facility should be kept for 6 years.

I certify that the information submitted for Clinical Quality Measures was generated as output from an identified certified EHR technology. The information submitted is accurate to the knowledge of

and on behalf of the Eligible hospital or CAH. The information submitted is based on the knowledge and information provided by the Eligible Hospital or CAH, is submitted on behalf of the Eligible Hospital or CAH, and the Eligible Hospital or CAH has affirmed that the information provided is true, accurate and complete to the best of my knowledge. The information submitted is accurate and complete for numerators, denominators and exclusions for functional measures that are applicable to the Eligible Hospital or CAH. The information submitted includes information on all patients to whom the measure applies. For Clinical Quality Measures, a zero was reported in the denominator of a measure when an Eligible Hospital or CAH did not care for any patients in the denominator population during the EHR reporting period.

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Illinois Department of Healthcare and Family Services may ask for this documentation. I further understand that the Illinois Department of Healthcare and Family Services will pursue repayment in all instances of improper payment. I certify that I (the Eligible Hospital) am not receiving Medicaid Promoting Interoperability incentive funds from any other state or commonwealth and have not received a payment from the Illinois Medicaid Program for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid Promoting Interoperability incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

APPENDIX C – HISTORICAL MEANINGFUL USE INFORMATION

1 PREVIOUS PROGRAM YEARS

Information on Core and Menu MU Measures for previous program years can be found at the following CMS websites:

- **General Stage 1 Information** – Provides general information about Stage 1 MU.
  - **2013 or 2014 Stage 1 meaningful use**

- **Stage 1 EP Core and Menu Meaningful Use Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet Stage 1 MU measure per measure. Provides definitions.
  - **2013 EP Stage 1 meaningful use specifications**
  - **2014 EP Stage 1 meaningful use specifications**

- **Stage 1 EH/CAH Core and Menu MU Measure Specifications** – Provides additional detailed data to assist the EH/CAH in understanding how to meet MU measure per measure. Provides Definitions.
  - **2013 EH Stage 1 meaningful use specifications**
  - **2014 EH Stage 1 meaningful use specifications**

- **General Stage 2 Information** – Provides general information about Stage 2 MU.
- **2015 Program Requirements** - Provides general info about attesting for the 2015 program year. In 2015, the Core/Menu Set objective format was replaced by a combined Objective/Public Health format. EP's must attest to 10 objectives, including one consolidated public health objective while EH's must attest to 9 objectives, including one consolidated public health objective.

- **2015 EP Objective/Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet 2015 MU requirements. Provides specific objective definitions.

- **2015 EH/CAH Objective/Measure Specifications** – Provides additional detailed data to assist the EH/CAH in understanding how to meet 2015 MU requirements. Provides specific objective definitions.

Starting in program year 2015, the Stage 2 Core and Menu Set objective breakdown has been retired. In eMIPP the MU tabs for Core and Menu Set will now be replaced with "MU-Objectives" and "MU-Public Health Measures"

The **2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule** removed several redundant, duplicative, topped out measures (see below):

Removed Objectives	EP	EH
Record Demographics	●	●
Record Vital Signs	●	●
Record Smoking Status	●	●
Clinical Summaries	●	
Structured Lab Results	●	●
Patient List	●	●
Patient Reminders	●	●
Summary of Care: • Measure 1 - Any Method • Measure 3 - Test	●	●
Electronic Notes	●	●
Imaging Results	●	●
Family Health History	●	●
eMAR		●
Advanced Directives		●
Structure Labs to Ambulatory Providers		●

In the **Stage 1 meaningful use regulations**, CMS had established a timeline that required providers to progress to Stage 2 criteria after two program years under the Stage 1 criteria. This original timeline would have required Medicare providers who first demonstrated MU in 2011 to meet the Stage 2 criteria in 2013.

This criteria was modified with **Stage 2 legislation** and again in the **Flexibility Rule**, effective October 1, 2014. The table below illustrates the progression of MU stages from when a Medicaid provider begins participation in the program as it existed in 2014.

2014 MU Stage Progression

1st Pymt Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021

2011	1	1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2012		1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2013			1	1*	2	2	3	3	TBD	TBD	TBD
2014				1*	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

- *3-month EHR reporting period for Medicare and continuous 90-day EHR reporting period (or 3 months at State option) for Medicaid EPs. All providers in their first year in 2014 use any continuous 90-day EHR reporting period.*

Note: Stage 3 can not occur until program year 2017 at the earliest. In 2014, providers who received their first payment in 2011 or 2012 could have again attested for Stage 1, provided they could not fully implement 2014 Edition CEHRT for the EHR reporting period due to delays in 2014 Edition CEHRT availability. All other providers would have needed to meet two years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in their third year.

In the first year of participation, providers must demonstrate MU for a 90-day EHR reporting period; in subsequent years, providers will demonstrate MU for a full year EHR reporting period (an entire fiscal year for hospitals or an entire calendar year for EPs) except in 2014 or 2015. The 2014 scenario is described below.

In 2014, providers who participated in the Medicaid PIP were not required to demonstrate MU in consecutive years as described by the table above, but their progression through the stages of MU followed the same overall structure of two years meeting the criteria of each stage, with the first year of MU participation consisting of a 90-day EHR reporting period. Providers who did not demonstrate MU by October 1, 2014 (and each subsequent year) were subject subject to Medicare payment adjustments.

2 2014 SPECIFIC

In 2014, all providers regardless of their stage of MU use were only required to demonstrate MU for a three-month EHR reporting period.

For Medicare providers, this 3-month reporting period was fixed to the quarter of either the fiscal (for eligible hospitals and CAHs) or calendar (for EPs) year in order to align with existing CMS quality measurement programs, such as the Physician Quality Reporting System (PQRS) and Hospital Inpatient Quality Reporting (IQR).

For Medicaid providers only eligible to receive Medicaid Promoting Interoperability incentives, the 3-month reporting period was not fixed, as providers did not have the same alignment needs.

CMS permitted this one-time three-month reporting period in 2014 so that all providers upgrading to 2014 Certified EHR Technology would have adequate time to implement their new Certified EHR systems. Later in 2014, the Flexibility Rule allowed additional options for 2014 attestations.

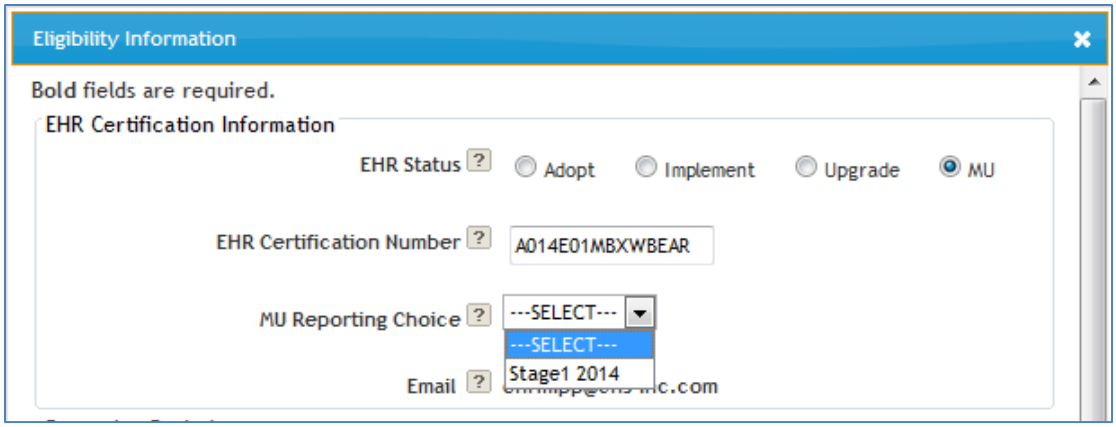
As shown in Table 3 below, if providers could not fully implement 2014 Edition CEHRTs for the EHR Reporting period in 2014 due to delays in 2014 Edition CEHRT availability, they could attest using a 2011 Edition CEHRT or a combined 2011 & 2014 Edition CEHRT. Providers who attested using the 2011 Edition CEHRT would be attesting to 2013 Stage 1 objectives and measures, regardless of Stage. Providers who attested using the combined 2011 & 2014 Edition CEHRT could attest using several different reporting options dependent on Stage.

Table 3—Proposed CEHRT Systems Available for Use in 2014			
If you were scheduled to demonstrate:	You would be able to attest for Meaningful Use:		
	Using 2011 Edition CEHRT to do:	Using 2011 & 2014 Edition CEHRT to do:	Using 2014 Edition CEHRT to do:
Stage 1 in 2014	2013 Stage 1 objectives and measures*	2013 Stage 1 objectives and measures* —OR— 2014 Stage 1 objectives and measures*	2014 Stage 1 objectives and measures.
Stage 2 in 2014	2013 Stage 1 objectives and measures*	2013 Stage 1 objectives and measures* —OR— 2014 Stage 1 objectives and measures* —OR— Stage 2 objectives and measures*	2014 Stage 1 objectives and measures* —OR— Stage 2 objectives and measures.

* Only providers that could not fully implement 2014 Edition CEHRT for the EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability.

Providers attesting for Medicaid in 2014 saw a new section, EHR Certification Information, on the Eligibility Information screen in the eMIPP application. First participation year providers selected the appropriate EHR status (MU will be the only option in all other years) and entered their EHR Certification Number. The eMIPP application identified the CEHRT Edition and provided the appropriate MU Reporting Choices in a droplist. The appropriate MU Upload PDF files were made available in the MU tab.

In the example shown below, the EHR Certification Information section of a first-year participation year screen was shown with MU selected and a 2014 Edition CEHRT entered. Since the provider attested for the first time, they were attesting for Stage 1. As a result, Stage 1 2014 is the only MU Reporting Choice provided (see Table 3).



3 2015 SPECIFIC

3.1 Meaningful Use

In the first year of participation, providers must demonstrate MU for a 90-day EHR reporting period; in subsequent years (except for the 2015 program year), providers will demonstrate MU for a full year EHR reporting period. For the 2015 program year, all providers may demonstrate MU for a 90-day (or greater) reporting period.

3.1.1 Meaningful Use Objectives

- **Eligible Professionals** must attest to **10 objectives**, including one consolidated public health reporting objective with measure options.
- **Eligible Hospitals and Critical Access Hospitals** must attest to **9 objectives**, including one consolidated public health reporting objectivie with measure options.

The Stage 2 Core and Menu Set objective breakdown has been retired. In eMIPP the MU tabs for Core and Menu Set will now be replaced with "MU-Objectives" and "MU-Public Health Measures" (see screenshots below).

For program year 2015, providers attesting after February 13, 2016 are attesting to "Modified Stage 2". Providers who previously would have been scheduled to attest for Stage 1 will view additional alternative objectives\measures\exclusions on their attestation screens. If providers can attest to the normal "Modified Stage 2" objective, they should do so. If they need to attest to the alternative objective to remain MU compliant, then they should attest only to those measures they must to remain MU compliant.

3.1.2 Changes to Objectives in 2015

The **2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule** documented several changes to the MU objectives. Some measures were removed completely, others were modified. There were also modifications to reporting periods This section highlights these changes.

3.1.3 Removed objectives

The 2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule removed several redundant, duplicative, topped out measures (see below):

Removed Objectives	EP	EH
Record Demographics	●	●
Record Vital Signs	●	●
Record Smoking Status	●	●
Clinical Summaries	●	
Structured Lab Results	●	●
Patient List	●	●
Patient Reminders	●	●
Summary of Care: • Measure 1 - Any Method • Measure 3 - Test	●	●
Electronic Notes	●	●
Imaging Results	●	●
Family Health History	●	●
eMAR		●
Advanced Directives		●
Structure Labs to Ambulatory Providers		●

3.1.4 Additional Public Health Information

2015 EP Public Health Reporting information

2015 EH/CAH Public Health Reporting information

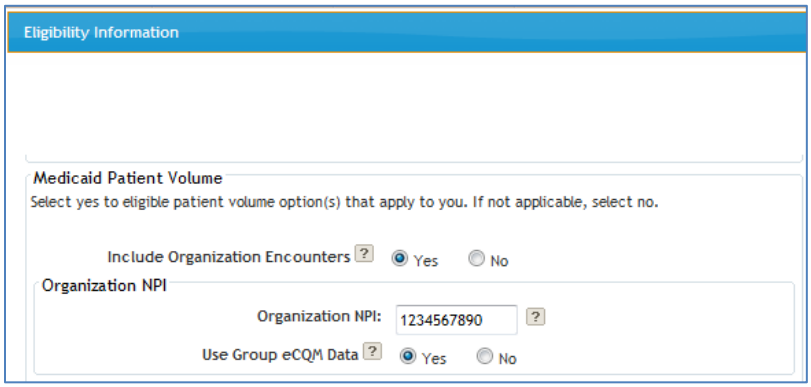
2017-2018 Modified Stage 2 EP Public Health Information

2017-2018 Stage 3 EP Public Health Information

2017-2018 Modified Stage 2 EH/CAH Public Health Information

2017-2018 Stage 3 EH/CAH Public Health Information

3.1.5 Medicaid eCQM reporting



3.2 Clinical Quality Measures

3.2.1 CQMs 2014 and Beyond

Although clinical quality measure (CQM) reporting has been removed as a core objective for both EPs and eligible hospitals and CAHs, all providers are required to report on CQMs in order to demonstrate meaningful use. Beginning in 2014, all providers regardless of their stage of meaningful use will report on CQMs in the same way.

- **EPs must report on 9 out of 64 total CQMs.**
- **Eligible hospitals and CAHs must report on 16 out of 29 total CQMs.**

For more information on 2014 Clinical Quality Measures, please visit:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html

4 2016 SPECIFIC

- **2016 Program Requirements** - Provides general info about attesting for the 2016 program year. EP's must attest to 10 objectives, including two consolidated public health measures while EH's must attest to 9 objectives, including three consolidated public health measures.

- **2016 EP Objective/Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet 2016 Meaningful Use requirements. Provides specific objective definitions.
- **2016 EH/CAH Objective/Measure Specifications** – Provides additional detailed data to assist the EH/CAH in understanding how to meet 2016 Meaningful Use requirements. Provides specific objective definitions.

4.1 Meaningful Use Objectives for 2016

The **2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule** restructured objectives to align with Stage 3:

- **Eligible Professionals** must attest to **10 objectives**, including two consolidated public health reporting measure options.
- **Eligible Hospitals and Critical Access Hospitals** must attest to **9 objectives**, including three consolidated public health reporting measure options.

For program year 2016, providers who previously would have been scheduled to attest for Stage 1 will view additional alternative objectives\measures\exclusions on their attestation screens. If providers can attest to the normal "Modified Stage 2" objective, they should do so. If they need to attest to the alternative objective to remain MU compliant, then they should attest only to those alternative measures needed to remain MU compliant.

MU-Objective screen (EP)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

Meaningful Use Objectives

- EPs must complete all 9 Meaningful Use Objectives.

Objective Not Completed Yet Objective Completed

- Objective 1 : Protect Patient Health Information
- Objective 2 : Clinical Decision Support
- Objective 3 : Computerized Provider Order Entry (CPOE)
- Objective 4 : Electronic Prescribing
- Objective 5 : Health Information Exchange
- Objective 6 : Patient-Specific Education
- Objective 7 : Medication Reconciliation
- Objective 8 : Patient Electronic Access
- Objective 9 : Secure Electronic Messaging

MU-Public Health Measures screen (EP)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

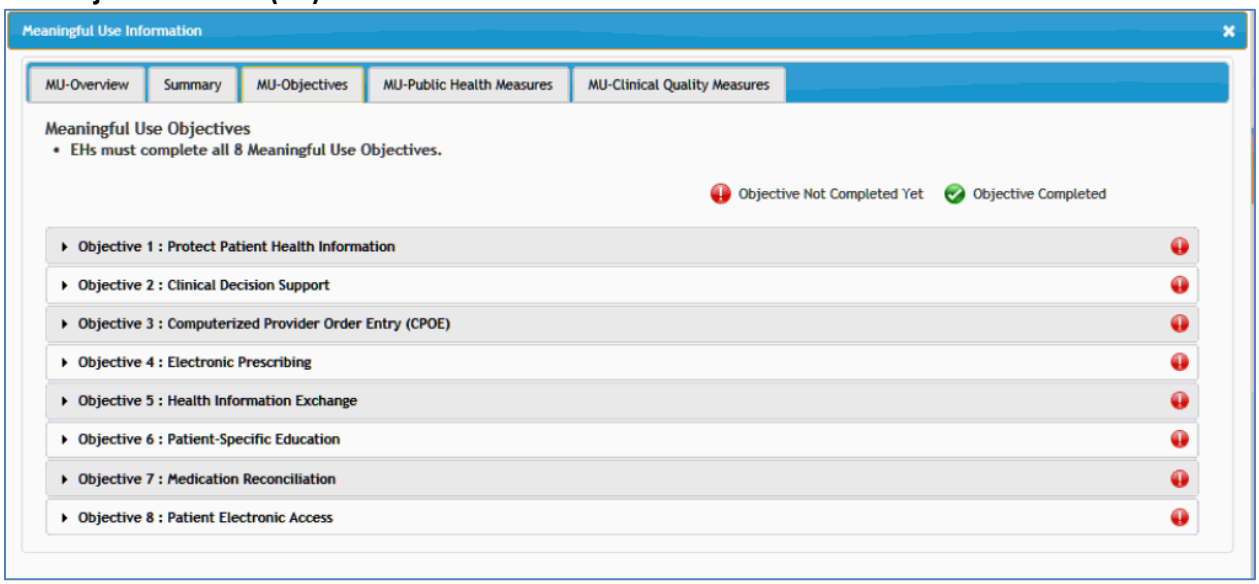
Meaningful Use Public Health Measures

- EPs must minimally complete 2 non-excluded measures through active engagement compliance and provide the corresponding registry details.
- An EP may provide up to 2 registries for measure 3, which will be counted toward the total number of non-excluded measures necessary to meet the minimum criteria.
- Supporting documentation must be provided for non-State registries via the 'Upload Document' card for the reported Public Health Measures.
- If 2 Public Health measures are not reported, all other measures must be set to excluded to be compliant.
- Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.
- Alternate exclusions are available for an EP to use, with a maximum of 2 alternate exclusions within the measures.
- An EP must either attest to or meet the exclusion for the remaining measure.

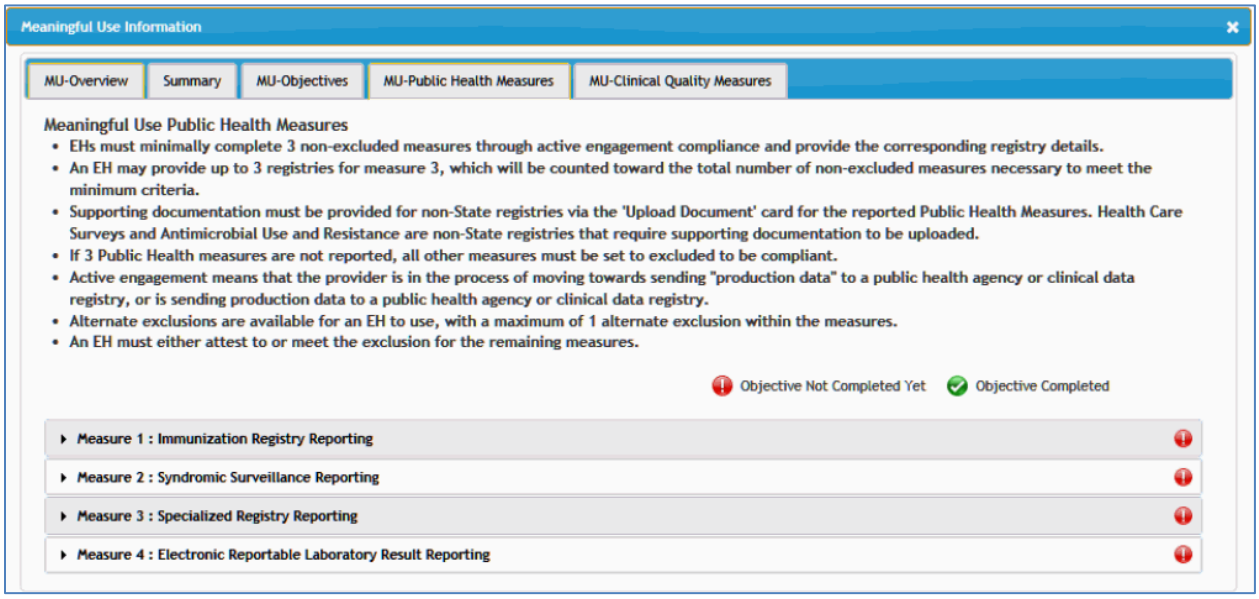
Objective Not Completed Yet Objective Completed

- Measure 1 : Immunization Registry Reporting
- Measure 2 : Syndromic Surveillance Reporting
- Measure 3 : Specialized Registry Reporting

MU-Objective screen (EH)



MU-Public Health Measures screen (EH)



4.1.1 For additional information see:

- **2017 QRDA Implementation Guide (EP)**
- 2017 CMS QRDA Implementation Guide for Hospital Quality Reporting
- **2018 QRDA Implementation Guide (EP)**
- **2018 CMS QRDA I Implementation Guide for Hospital Quality Reporting**

4.1.2 Changes to Objectives in 2016 (EP)

The **2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule** documented several changes to the MU objectives. There were also modifications to reporting periods. This section highlights these changes.

4.1.2.1 Stage 2

Objective 2 – Clinical Decision Support:

Measure 1: Alternate Measure 1 allowing the implementation of one clinical decision support rule in 2015 is eliminated in 2016.

Objective 3 – Computerized Provider Order Entry:

Measure 1: The two Alternate Measures allowed in 2015 are eliminated in 2016.

Measure 2: The 2015 Exclusion 2 (Alternate): "*any EP scheduled to demonstrate Stage 1 in 2015 which does not have an equivalent measure*" is replaced with the 2016 Exclusion 2 (Alternate): "*Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for Measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016*."

Measure 3: The 2015 Exclusion 3 (Alternate): "*any EP scheduled to demonstrate Stage 1 in 2015 which does not have an equivalent measure*" is replaced with the 2016 Exclusion 2 (Alternate): "*Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for Measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.*"

Objective 4 – Electronic Prescribing:

The Alternate Measure allowing a 40 percent threshold in 2015 has been eliminated for 2016.

Objective 5 – Health Information Exchange:

Alternate Exclusion 2 allowed in 2015 has been eliminated for 2016.

Objective 6– Patient-Specific Education:

Alternate Exclusion 2 allowed in 2015 has been eliminated for 2016.

Objective 8– Patient Electronic Access:

Measure 1: For 2016 a new exclusion was added: "*Any EP who neither orders nor creates any of the information listed for inclusion as part of the measure except for ''Patient name'' and ''Provider's name and office contact information*''.

Measure 2: Alternate Exclusion 3 allowed in 2015 was eliminated for 2016.

Objective 9– Secure Electronic Messaging:

2015 Measure description: "*The capability for patients to send and receive a secure electronic message with the EP was fully enabled duiring the EHR reporting period*" was changed in 2016 to: "f*or at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period*".

Alternate Exclusion 3 allowed in 2015 has been eliminated for 2016.

The 2015 compliance statement: "*EPs must attest Yes to the capability for patients to send and receive a secure electronic message with the EP was fully enabled duiring the EHR reporting period*" was replaced in 2016 with:

Numerator: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).

Denominator: Number of unique patients seen by the EP during the EHR reporting period.

Meaningful Use Public Health Measures:

In 2015, EPs had to minimally complete 1 non-excluded measure to meet the minimum criteria. In 2016, EPs must minimally complete 2 non-excluded measures to meet the minimum criteria. In 2016, an EP may provide up to 2 registries for measure 3, which will be counted toward the total number of non-excluded measures necessary to meet the minimum criteria. An EH may select up to 3 registries for measure 3.

Measure 1: Alternate Exclusion 2 allowed in 2015 has been eliminated in 2016.

Objective 1: Protect Patient Health Information:

In 2016, the objective description was changed from: "*Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities"* to: "*Protect electronic protected health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities*".

Objective 8: Patient Electronic Access:

Measure 1: In 2016, an Exclusion was added:

Exclusion: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."

Measure2:

In 2016, the Measure 2 description changed from: "*at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period"* to: "*for an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits to a third party his or her health information during the EHR reporting period*".

In 2016, the Exclusion 1 description changed from: "*any EP who neither orders nor creates any of the information listed for inclusion as part of the measures*" to: "*any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information*."

Objective 9: Secure Electronic Messaging:

Measure:

In 2016, the Measure description changed from: "*the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period*" to: "*for an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting*

period, a secure message was sent using the electronic messaging function of CHERT to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative) during the EHR reporting period".

In 2016, the compliance information changed from:

Compliance: EPs must attest YES to the capability for patients to send and receive a secure electronic message with the EP was fully enabled during the EHR reporting period.

to:

Numerator: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).

Denominator: Number of unique patients seen by the EP during the EHR reporting period.

4.1.2.2 Public Health Reporting Objective

For the 2016 program year, Eligible Professionals must answer 2 of the first 3 measures listed below. Eligible Hospitals must answer 3 of the 4 measures below.

PUBLIC HEALTH MEASURES (2015-16)

Measure Number	Measure Name	Measure Specification	Maximum Times Measure Can Count Towards The Objective
1	Immunization Registry Reporting	The EP, EH, or CAH is in active engagement with a public health agency to submit immunization data	1
2	Syndromic Surveillance Reporting	The EP, EH, or CAH is in active engagement with a public health agency to submit syndromic surveillance data	1
3	Specialized Registry Reporting	The EP, EH, or CAH is in active engagement with a public health agency to submit data to a specialized registry	2 for EP - 3 for EH/CAH
4	Electronic Reportable Laboratory (ELR) Results Reporting	The EH, or CAH is in active engagement to submit ELR results	1 for EH/CAH only

4.1.2.2.1 Active Engagement

The **2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule** removed the prior ongoing submission requirement and replaced it with an "active engagement" requirement.

"*Active engagement*" may be demonstrated by meeting any of the following 3 options:

- **Option 1 – Completed Registration to Submit Data:** The EP, EH or CAH registered to submit data with Public Health or, where applicable, the Clinical Data Registry to which the data is being submitted. Public health registration may be made via IDPH's **Meaningful Use Reporting System (MURS) web site**. Registration must be completed within 60 days after the start of the EHR reporting period. Failure to complete registration by the deadline would result in that provider not meeting the measure.
- **Option 2 – Testing and Validation:** The EP, EH or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from Public Health or, where applicable, the Clinical Data Registry within 30 days. Failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.
- **Option 3 – Production:** The EP, EH or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to Public Health (or the Clinical Data Registry).

In order to implement active engagement with the Public Health Reporting Objective, 2 new fields have been added to each Public Health Measure. These fields can only be accessed if "Other" or "Health Care Surveys" is selected as a registry.

1) Active Engagement Status

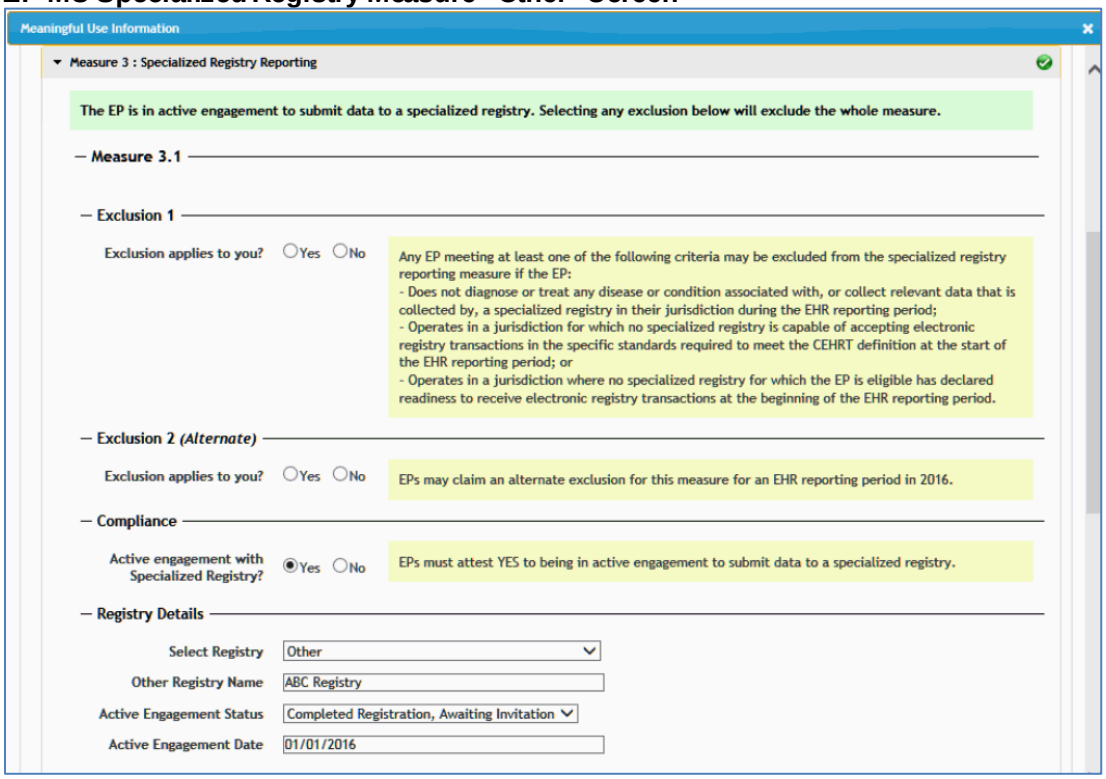
   Select from the following drop list:

   - *Completed Registration, Awaiting Invitation*
   - *Production*
   - *Testing and Validation*

2) Active Engagement Date

   Enter the start date that the Active Engagement Status was achieved.

EP MU Specialized Registry Measure "Other" Screen



4.1.2.2.2 Additional Public Health Information`

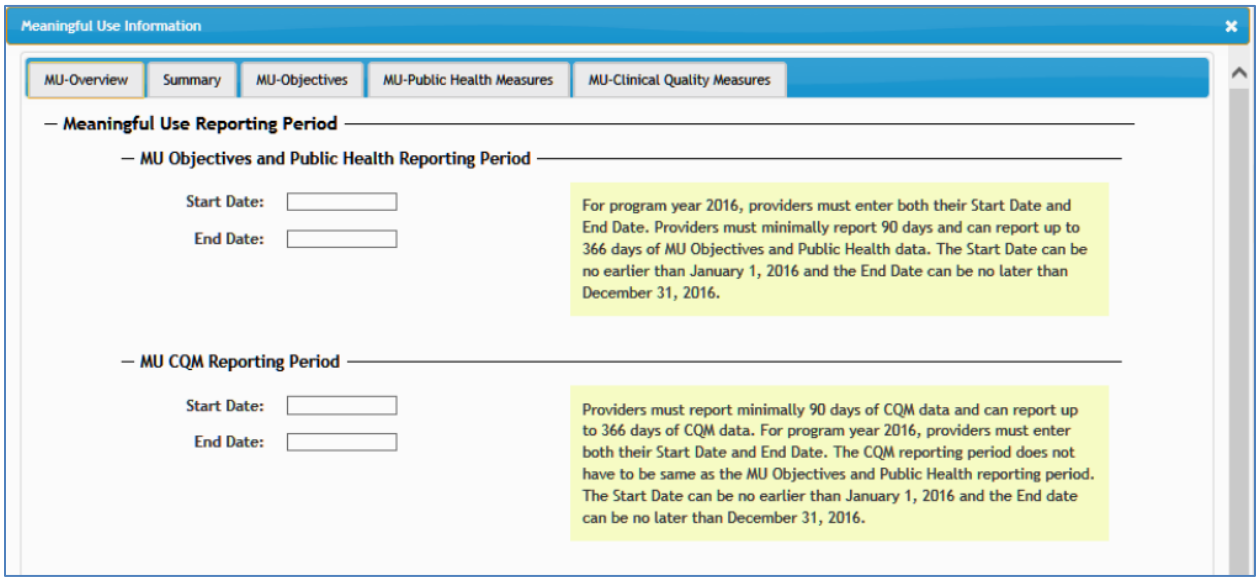
- Providers only need to register intent once (registration each year is not required) with IDPH (or a Clinical Data Registry) and could register prior to the start of the EHR reporting period.
- Registration **is** required where a provider seeks to meet MU using a measure they have not successfully attested to in a previous EHR reporting period.

For more information about public health reporting for MU, visit:
[2016 EP Public Health Information]
[2016 EH/CAH Public Health Information]

4.1.3 2016 Reporting period requirements

Additional program year changes required by the [2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule] include several new reporting period requirements.

EP MU Overview Screen



4.1.3.1 EHR Reporting period

- For program year 2015 onward, EHR reporting aligns with the calendar year for all providers. Previously, the EH reporting year aligned with the federal fiscal year.

- For program year 2016 for all providers, the EHR reporting period is minimally 90 days and can be up to 366 days.

4.1.3.2 CQM Reporting period

For an EHR reporting period in 2016, providers may:

- Attest to any continuous 90-366 day period of CQM data during the calendar year through the Medicare Promoting Interoperability Program registration and attestation site

- For program year 2016, EPs may select any continuous 90-366 day period from January 1, 2016 through December 31, 2016 to report CQMs via attestation.
- For program year 2016, EHs may select any continuous 90-366 day period from January 1, 2016 through December 31, 2016, to report CQMs via attestation.
- For program year 2016, a provider may choose to attest to a CQM reporting period of greater than 90 days upto and including 1 full calendar year of data.
- For program year 2016, the reporting period for CQMs does not have to be the same 90-366 day period as the EHR Reporting period.

OR

• Electronically report CQM data using the established methods for electronic reporting.

4.1.4 Program year CEHRT requirements

For the 2016 program year, Stage 2 providers can choose to use technology certified to the 2014 Edition, the 2015 Edition, or a hybrid combination of the 2014/2015 editions.

- **2017 Program Requirements** - Provides general info about attesting for the 2017 program year. EP's in Modified Stage 2 must attest to 10 objectives, including two consolidated public health measures while EH's in Modified Stage 2 must attest to 9 objectives, including three consolidated public health measures.
  EP's in Stage 3 must attest to 8 objectives, including two consolidated public health objective while EH's in Stage 3 must also attest to 8 objectives, including four consolidated public health measures.

- **2017 EP Modified Stage 2 Objective/Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet 2017 Modified Stage 2 MU requirements. Provides specific objective definitions.

- **2017 EH/CAH Modified Stage 2 Objective/Measure Specifications** – Provides additional detailed data to assist the EH/CAH in understanding how to meet 2017 Modified Stage 2 MU requirements. Provides specific objective definitions.

- **2017 EP Stage 3 Objective/Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet 2017 Stage 3 MU requirements. Provides specific objective definitions.

- **2017 EH/CAH Stage 3 Objective/Measure Specifications** – Provides additional detailed data to assist the EH/CAH in understanding how to meet 2017 Stage 3 MU requirements. Provides specific objective definitions.

The **2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule** restructured objectives to align with Stage 3:

- **Eligible Professionals** using **Modified Stage 2** must attest to **10 objectives**, including **two** consolidated public health reporting measure options.
- **Eligible Hospitals and Critical Access Hospitals** using **Modified Stage 2** must attest to **9 objectives**, including **three** consolidated public health reporting measure options.
- **Eligible Professionals** using **Stage 3** must attest to **8 objectives**, including **two** consolidated public

health reporting measure options.

- **Eligible Hospitals and Critical Access Hospitals** using **Stage 3** must attest to **8 objectives**, including **four** consolidated public health reporting measure options.

For program year 2017 and 2018, providers may attest to the normal "Modified Stage 2" objectives. If the provider has a system using 2014-2015 Hybrid CEHRT or 2015 CEHRT technology, they may opt to attest to the "Stage 3" objectives.
In 2017, the Eligibility screen was changed:

1) A second box had been added to allow the use of a separate CEHRT for CQM submission.
2) A dropdown box was added to choose between "Modified Stage 2" or "Stage 3".
   The "Stage 3" option will only appear if a valid 2014-2015 Hybrid EHR CEHRT or a 2015 EHR CEHRT is used.

- **2018 Program Requirements** - Provides general info about attesting for the 2018 program year. EP's in Modified Stage 2 must attest to 10 objectives, including two consolidated public health measures while EH's in Modified Stage 2 must attest to 9 objectives, including three consolidated public health measures.
  EP's in Stage 3 must attest to 8 objectives, including two consolidated public health objective while EH's in Stage 3 must also attest to 8 objectives, including four consolidated public health measures.

- **2018 EP Modified Stage 2 Objective/Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet 2018 Modified Stage 2 MU requirements. Provides specific objective definitions.

- **2018 EH/CAH Modified Stage 2 Objective/Measure Specifications** – Provides additional detailed data to assist the EH/CAH in understanding how to meet 2018 Modified Stage 2 MU requirements. Provides specific objective definitions.

- **2018 EP Stage 3 Objective/Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet 2018 Stage 3 MU requirements. Provides specific objective definitions.

- **2018 EH/CAH Stage 3 Objective/Measure Specifications** – Provides additional detailed data to assist the EH/CAH in understanding how to meet 2018 Stage 3 MU requirements. Provides specific objective definitions.

MU-Objective screen (EP Modified Stage 2)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

Meaningful Use Objectives

- EPs must complete all 9 Meaningful Use Objectives.

Objective Not Completed Yet Objective Completed

- Objective 1 : Protect Patient Health Information
- Objective 2 : Clinical Decision Support
- Objective 3 : Computerized Provider Order Entry (CPOE)
- Objective 4 : Electronic Prescribing
- Objective 5 : Health Information Exchange
- Objective 6 : Patient-Specific Education
- Objective 7 : Medication Reconciliation
- Objective 8 : Patient Electronic Access
- Objective 9 : Secure Electronic Messaging

MU-Public Health Measures screen (EP Modified Stage 2)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

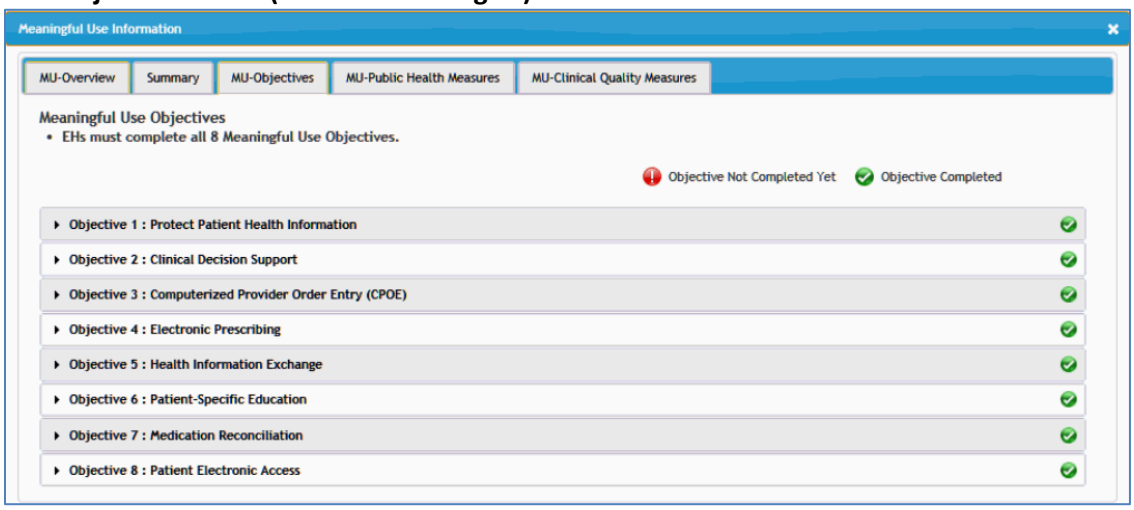
Meaningful Use Public Health Measures

- EPs must minimally complete 2 non-excluded measures through active engagement compliance and provide the corresponding registry details.
- An EP may provide up to 2 registries for measure 3, which will be counted toward the total number of non-excluded measures necessary to meet the minimum criteria.
- Supporting documentation must be provided for non-State registries via the 'Upload Document' card for the reported Public Health Measures.
- If 2 Public Health measures are not reported, all other measures must be set to excluded to be compliant.
- Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.
- Alternate exclusions are available for an EP to use, with a maximum of 2 alternate exclusions within the measures.
- An EP must either attest to or meet the exclusion for the remaining measure.

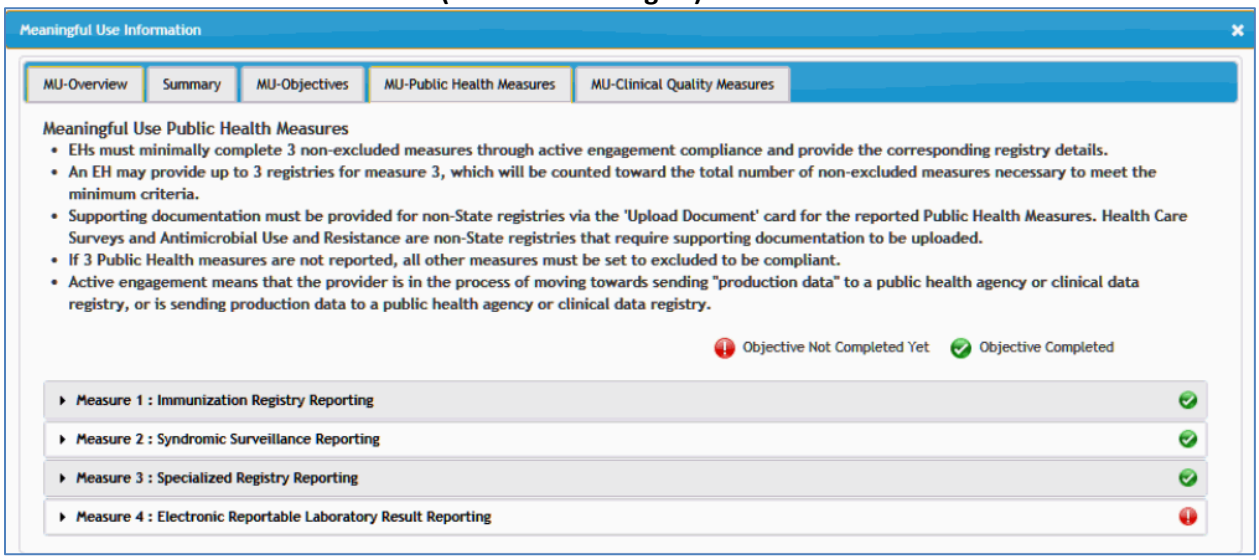
Objective Not Completed Yet Objective Completed

- Measure 1 : Immunization Registry Reporting
- Measure 2 : Syndromic Surveillance Reporting
- Measure 3 : Specialized Registry Reporting

MU-Objective screen (EH Modified Stage 2)



MU-Public Health Measures screen (EH Modified Stage 2)



MU-Objective screen (EP Stage 3)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

Meaningful Use Objectives

- EPs must complete all 7 Meaningful Use Objectives.

Objective Not Completed Yet Objective Completed

- Objective 1 : Protect Patient Health Information
- Objective 2 : Electronic Prescribing
- Objective 3 : Clinical Decision Support
- Objective 4 : Computerized Provider Order Entry (CPOE)
- Objective 5 : Patient Electronic Access to Health Information
- Objective 6 : Coordination of Care Through Patient Engagement
- Objective 7 : Health Information Exchange

MU-Public Health Measures screen (EP Stage 3)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

Meaningful Use Public Health Measures

- EPs must minimally complete 2 non-excluded measures through active engagement compliance and provide the corresponding registry details.
- An EP may provide up to 2 registries for measure 4 and measure 5, respectively, which will be counted toward the total number of non-excluded measures necessary to meet the minimum criteria.
- Supporting documentation must be provided for non-State registries via the "Upload Document" card for the reported Public Health Measures. Health Care Surveys is a non-State registry that requires supporting documentation to be uploaded.
- If 2 Public Health measures are not reported, all other measures must be set to excluded to be compliant.
- Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.
- Electronic Case Reporting will not be available until Program Year 2018.

Objective Not Completed Yet Objective Completed

- Measure 1 : Immunization Registry Reporting
- Measure 2 : Syndromic Surveillance Reporting
- Measure 3 : Electronic Case Reporting
- Measure 4 : Public Health Registry Reporting
- Measure 5 : Clinical Data Registry Reporting

MU-Public Health Measures screen (EP Stage 3)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

Meaningful Use Public Health Measures

- EPs must minimally complete 2 non-excluded measures through active engagement compliance and provide the corresponding registry details.
- An EP may provide up to 2 registries for measure 4 and measure 5, respectively, which will be counted toward the total number of non-excluded measures necessary to meet the minimum criteria.
- Supporting documentation must be provided for non-State registries via the "Upload Document" card for the reported Public Health Measures. Health Care Surveys is a non-State registry that requires supporting documentation to be uploaded.
- If 2 Public Health measures are not reported, all other measures must be set to excluded to be compliant.
- Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.
- Electronic Case Reporting will not be available until Program Year 2018.

Objective Not Completed Yet Objective Completed

- Measure 1 : Immunization Registry Reporting
- Measure 2 : Syndromic Surveillance Reporting
- Measure 3 : Electronic Case Reporting
- Measure 4 : Public Health Registry Reporting
- Measure 5 : Clinical Data Registry Reporting

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

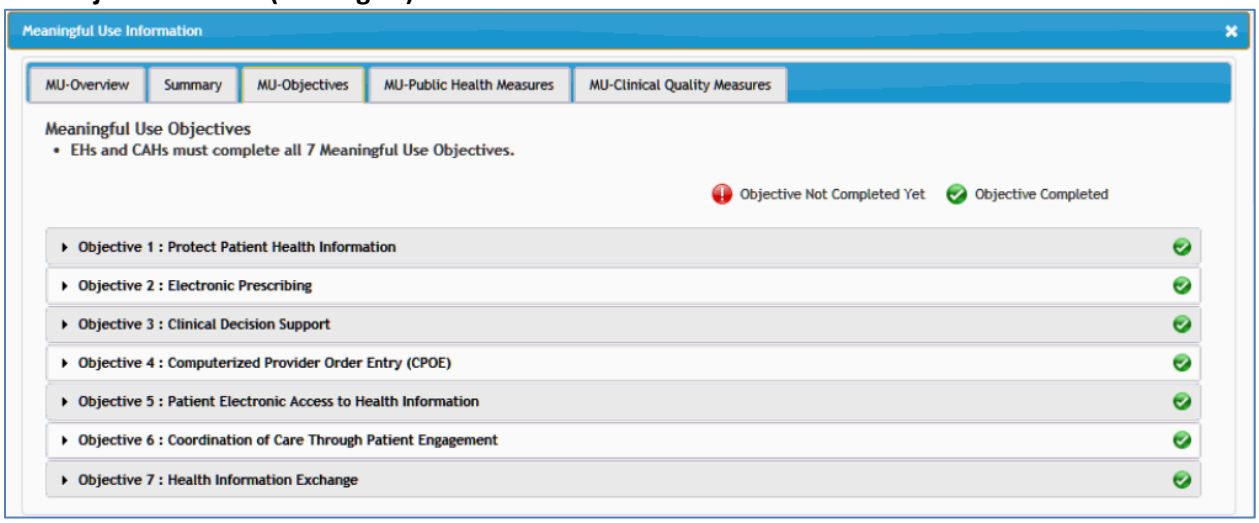
Meaningful Use Public Health Measures

- EPs must minimally complete 2 non-excluded measures through active engagement compliance and provide the corresponding registry details.
- An EP may provide up to 2 registries for measure 4 and measure 5, respectively, which will be counted toward the total number of non-excluded measures necessary to meet the minimum criteria.
- Supporting documentation must be provided for non-State registries via the "Upload Document" card for the reported Public Health Measures. Health Care Surveys is a non-State registry that requires supporting documentation to be uploaded.
- If 2 Public Health measures are not reported, all other measures must be set to excluded and each of the Specialty Registry Availability Verifications must have a response to be compliant.
- Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.

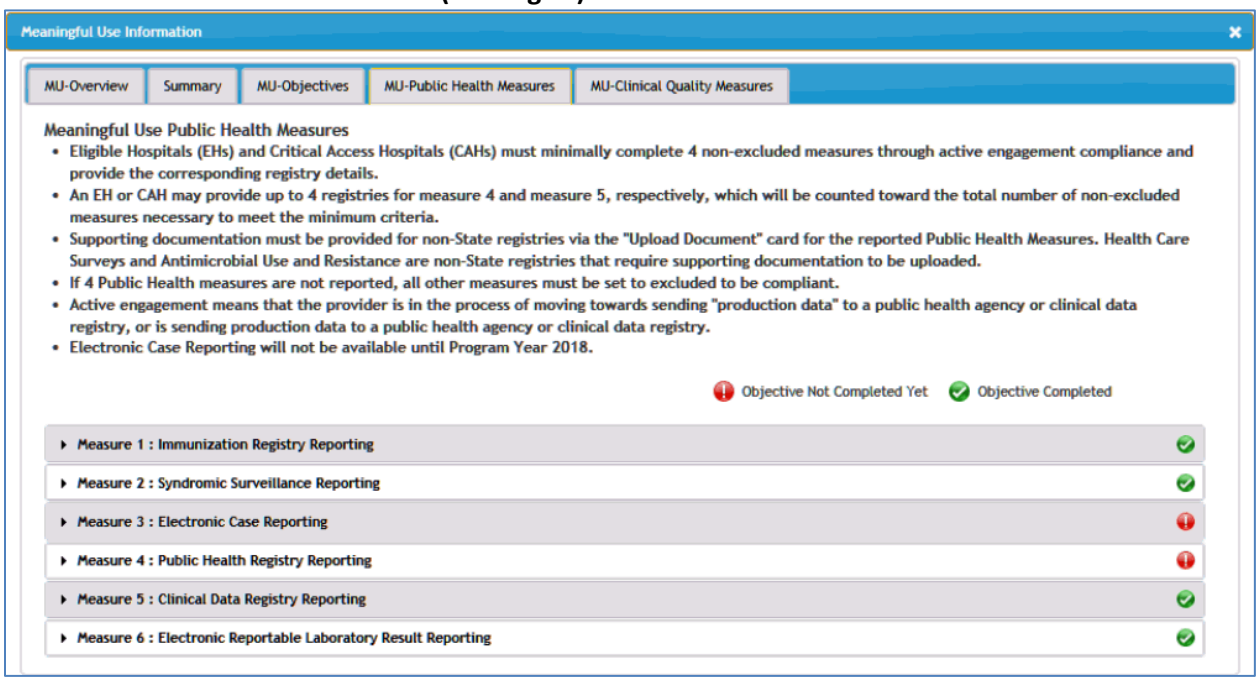
Objective Not Completed Yet Objective Completed

- Measure 1 : Immunization Registry Reporting
- Measure 2 : Syndromic Surveillance Reporting
- Measure 3 : Electronic Case Reporting
- Measure 4 : Public Health Registry Reporting
- Measure 5 : Clinical Data Registry Reporting

MU-Objective screen (EH Stage 3)



MU-Public Health Measures screen (EH Stage 3)



Note: *Electronic Case Reporting is listed as an option for 2017, but is actually unavailable until 2018. All options are grayed out.*

5 CHANGES TO OBJECTIVES IN 2017 AND 2018 (EP)

The 2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule documented several changes to the MU objectives. There were also modifications to reporting periods. This section highlights these changes.

5.1 Stage 2

All objectives for 2017 and 2018 Stage 2 are the same as 2016 Stage 2 with the exception of the MU public health measures, where all alternate exclusions have been eliminated.

Eps that are returning MU attesters in CY2017 or CY2018 will submit attestations using the 2017 Modified Stage 2 or Stage 3 requirements as finalized in the 2015 PIP Final Rule.

5.2 Stage 3

5.2.1 Changes to Eligible Professional Stage 2 Objectives and Measures:

EP Stage 3 Objective

1 – Protect Patient Health Information

Old Objective Description	New Objective Description
Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, *administrative, and physical safeguards.*

2 – Electronic Prescribing

- Stage 2 Objective 4 now Stage 3 Objective 2.
- Measure percentage increased from 50% to 60%.

Old Denominator	New Denominator
Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed.	*Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period;* or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.

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

3 – Clinical Decision Support

- Stage 2 Objective 2 now Stage 3 Objective 3.

Old Objective Description	New Objective Description
Use clinical decision support to improve performance on high-priority health conditions.	*Implement clinical decision support (CDS) interventions focused on improving* performance on high-priority health conditions.

4 – Computerized Provider Order Entry (CPOE)

- Stage 2 Objective 3 now Stage 3 Objective 4.

Old Objective Description	New Objective Description
Use computerized provider order entry for medication, laboratory, and *radiology* orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	Use computerized provider order entry (CPOE) for medication, laboratory, and *diagnostic imaging* orders directly entered by any licensed healthcare professional, *credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant;* who can enter orders into the medical record per state, local, and professional guidelines.

Old Measure 2 Description	New Measure 2 Description
More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	More than *60* percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Old Measure 3 Description	New Measure 3 Description
More than *30* percent of *radiology* orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	More than *60* percent of *diagnostic imaging* orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Old Measure 3 Exclusion	New Measure 3 Exclusion
Any EP who writes fewer than 100 *radiology* orders during the EHR reporting period.	Any EP who writes fewer than 100 *diagnostic imaging* orders during the EHR reporting period.

5 – Patient Electronic Access to Health Information

- Stage 2 Objective 6 – Patient Specific Education and measure 1 of Objective 8 – Patient Electronic Access were combined into Stage 3 Objective 5.
- Measure 1 percentage increased from 50% to 80%.
- Measure 2 percentage increased from 5% to 35%

6 – Coordination of Care Through Patient Engagement

- Stage 2 Objective 9 – Secure Electronic Messaging is now measure 2 of Stage 3 Objective 6.
- Providers are required to attest for the numerators and denominators of all three measures and must meet the thresholds for at least two measures to meet the objective.

7 – Health Information Exchange

- Stage 2 Objective 5 – Health Informational Exchange is now measure 1 of Stage 3 Objective 7.
- Stage 3 Measure 2 and Measure 3 are new.
- Providers are required to attest for the numerators and denominators of all measures associated with this objective.

Old Objective Description	New Objective Description
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.	*The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT. Providers must attest to all three measures, and must meet the threshold for at least two measures to meet the objective.*

Old Measure 1 Description	New Measure 1 Description
The EP that transitions or refers their patient to another setting of care or provider of care *must* – (1) *Use CEHRT to create a summary of care record: and* *(2)* Electronically *transmit such* summary *to a receiving provider for more than 10 percent of transitions of care and referrals.*	*For more than 50 percent of transitions of care and referrals,* the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and *(2) Electronically exchanges the summary of care record.*

MU Public Health Measures

- EP providers must complete at least 2 of 5 non-excluded measures to satisfy the Public Health objective's measure requirements.
- EP providers may select multiple Public Health registries up to 2 times to satisfy the Public Health objective's measure requirements.
- EP Providers may select multiple Clinical Data registries up to 2 times to satisfy the Public Health objective's measure requirements.

- Stage 3 measure 3 is new.
- Stage 2 measure 3.1 and 3.2 - Specialized Data Reporting are now in either Stage 3 measure 4.1 and 4.2 - Public Health Registry Reporting or measure 5.1 and 5.2 - Clinical Data Registry Reporting.
- Exclusion C on all measures changed to:
  Operates in a jurisdiction where no ---------- has declared readiness to receive ---------- *as of 6 months prior to* the start of the EHR reporting period.
- For Stage 3 measures 1, 2, 4, and 5; if 'Other" registry is selected, providers must enter the Other Registry Name, Active Engagement Status, and Active Engagement Date.
- Active Engagement options: see section 8.1.4
- For Stage 3 measures 4 and 5, the providers must respond to Specialty Registry Availability Verification Yes/No:
  - By selecting Yes, you indicate that you have performed due diligence of specialty registry availibility verification with State and speciality society
  - By selecting No, you indicate that you did not perform due diligence of specialty registry availibility verification with State and speciality society

Old Measure 1 Description	New Measure 1 Description
The EP is in active engagement with a public health agency to submit immunization data.	The EP is in active engagement with a public health agency to submit immunization data *and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).*

Old Measure 2 Description	New Measure 2 Description
The EP is in active engagement with a public health agency to submit syndromic surveillance data.	The EP is in active engagement with a public health agency to submit syndromic surveillance data *from an urgent care setting.*

Old Measure 3 Description	New Measure 4 Description
The EP is in active engagement to submit data to a specialized registry.	*The EP is in active engagement with a public health agency to submit data to public health registries.*

Old Measure 3 Description	New Measure 5 Description
The EP is in active engagement to submit data to a specialized registry.	*The EP is in active engagement to submit data to a climical data registry.*

Clinical Quality Measures

- CMS 122 switched domains in 2017 to Population/Public Health.
- CMS 142 switched domains in 2018 to Care Coordination.
- CMS 75 switched domains in 2018 to Population/Public Health.
- CMS 122 switched domains in 2018 to Population/Public Health.
- Requirements for a specific number of CQMs per domain were removed in 2017. Selected CQMs may come from any domain.
- Providers must respond to at least 6 Clinical Quality Measures in 2017 and 2018 instead of 9.
- The requirement of using CQMs in at least 3 domains was removed in 2017.
- When reporting as a group practice, EPs must report all available CQMs.

5.3 Changes to EHs Stage 2 Objectives and Measures:

EH Stage 3 Objective

1 – Protect Patient Health Information

Old Objective Description	New Objective Description
Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical *capabilities*.	Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical*, administrative, and physical safeguards.*

2 – Electronic Prescribing

- Stage 2 Objective 4 is now Stage 3 Objective 2.

Old Measure Description	New Measure Description
More than *10* percent of hospital discharge medication orders for permissible prescriptions *(for new and changed prescriptions)* are queried for a drug formulary and transmitted electronically using CEHRT.	More than *25* percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using CEHRT.

Old Denominator	New Denominator
The number of new or changed *permissable* prescriptions written for drugs requiring a prescription in order to be dispensed for patients discharged during the EHR *R*eporting *P*eriod.	The number of new or changed prescriptions written for drugs requiring a prescription in order to be dispensed *other than controlled substances* for patients discharged during the EHR reporting period.

Old Exclusion	New Exclusion

Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and *is not located* within 10 miles *of any pharmacy that accepts electronic prescriptions* at the start of their EHR reporting period.	Any eligible hospital or CAH that does not have an internal pharmacy that can accept electronic prescriptions and *there are no pharmacies that accept electronic prescriptions* within 10 miles at the start of their EHR reporting period.

3 – Clinical Decision Support

- Stage 2 Objective 2 is now Stage 3 Objective 3.

Old Objective Description	New Objective Description
Use clinical decision support to improve performance on high-priority health conditions.	*Implement clinical decision support (CDS) interventions focused on improving* performance on high-priority health conditions.

4 – Computerized Provider Order Entry (CPOE)

- Stage 2 Objective 3 is now Stage 3 Objective 4.

Old Objective Description	New Objective Description
Use computerized provider order entry for medication, laboratory, and *radiology* orders directly entered by any licensed healthcare professional, who can enter orders into the medical record per state, local, and professional guidelines.	Use computerized provider order entry *(CPOE)* for medication, laboratory, and *diagnostic imaging* orders directly entered by any licensed healthcare professional, *credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant;* who can enter orders into the medical record per state, local, and professional guidelines.

Old Measure 1 Description	New Measure 1 Description
More than *60* percent of medication orders created by the authorized providers of the eligible hospital*'s* or CAH*'s* inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.	More than *60* percent of laboratory orders created by the authorized providers of the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

Old Measure 2 Description	New Measure 2 Description

More than *30* percent of laboratory orders created by the authorized providers of the eligible hospital*'s* or CAH*'s* inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.	More than *60* percent of laboratory orders created by the authorized providers of the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

Old Measure 3 Description	New Measure 3 Description
More than *30* percent of *radiology* orders created by *the* authorized providers of the eligible hospital*'s* or CAH*'s* inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.	More than *60* percent of *diagnostic imaging* orders created by authorized providers of the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.

Old Measure 3 Denominator	New Measure 3 Denominator
Number of *radiology* orders created by the authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	Number of *diagnostic imaging* orders created by the authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

5 – <u>Patient Electronic Access to Health Information</u>

- Stage 2 Objective 6 – Patient Specific Education and Measure 1 of Objective 8 – Patient Electronic Access were combined into Stage 3 Objective 5.

Old Measure 1 Description	New Measure 1 Description
More than 50 percent of all uniqure patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligibile hospital or CAH are provided timely access to view onliine, download and transmit to a third party their health information.	*For more than 80 percent of all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23):* ○ *The patient (or the patient authorized representative) is provided timely access to view online, download, and transmit his or her health information; and* ○ *The provider ensures that the patient's health information is availible for the patient (or the patient authorized representative) to access using any application of their choice that is configured to meet the*

	technical specifications of the API in the provider's CEHRT.

Old Measure Description	New Measure 2 Description
More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are provided patient-specific education resources identified by CEHRT.	*The eligible Hospital or CAH must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by th EP or discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period*

6 – Coordination of Care Through Patient Engagement

- Stage 2 Measure 2 of Objective 8 – Patient Electronic Access was changed to Stage 3 Measure 1 of Objective 6.

Old Measure 2 Description	New Measure 1 Description
For an EHR reporting period in 2017, more than 5 percent of uniqure patients discharged from the inpatient or emergency department (POS 21 or 23) of an eligibile hospital or CAH (or patient authorized representative) view, download or transmit to a third party their health information during the EHR reporting period.	*For an EHR Reporting perod in 2017 and 2018, more than 5 percent of all unique patients (or their patient authorized representatives) discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23) activly engage with the electronic health record made accessible by the provider and either –* *1. View, download or transmit to a third party their health information; or* *2. Access their health information through The use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or* *3. A combination of (1) and (2)*

7 – Health Information Exchange

- Stage 2 Objective 5 – Health Informational Exchange is now Measure 1 of Stage 3 Objective 7.
- Stage 3 Measure 2 and Measure 3 are new.
- Providers are required to attest for the numerators and denominators of all measures associated with this objective.

Old Objective Description	New Objective Description
The eligible hospital or CAH who transitions their patient to another setting of care or provider of care	*The eligible hospital or CAH provides a summary of care record when transitioning or referring their patient to another setting*

or refers a patient to another provider of care provides a summary care record for each transition of care or referral.	*of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.* *Providers must attest to all 3 measures and must meet the thresholds for at least 2 measures in order to meet the objective.*

Old Measure 1 Description	New Measure 1 Description
The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.	*For more than 50% of transitions of care and referrals,* the eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care: *(1) Creates a summary of care record using CEHRT; and* *(2) Electronically exchanges the summary of care record.*

<u>MU Public Health Measures</u>

- EH providers must complete at least 4 of 6 non-excluded measues to satisfy the Public Health objective's measure requirements.
- EH providers may select multiple Public Health registries up to 4 times to satisfy the Public Health objective's measure requirements.
- EH Providers may select multiple Clinical Data registries up to 4 times to satisfy the Public Health objective's measure requirements.
- Stage 3 Measure 3 is new.
- Stage 2 Measure 3.1 thru 3.4 - Specialized Data Reporting are now in either Stage 3 Measure 4.1 thru 4.4 - Public Health Registry Reporting or Measure 5.1 thru 5.4 - Clinical Data Registry Reporting
- Stage 3 Exclusion C on all Measues was changed to:
    - C: Operates in a jurisdiction where no ---------- has declared readiness to receive ---------- from an eligible hospital or CAH *as of 6 months prior to* the start of the EHR reporting period.

Old Measure 1 Description	New Measure 1 Description
The eligible hospital or CAH is in active engagement with a public health agency to submit immunization data.	The eligible hospital or CAH is in active engagement with a public health agency to submit immunization data *and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).*

Old Measure 2 Description	New Measure 2 Description
The eligible hospital or CAH is in active engagement with a public health agency to submit syndromic surveillance data.	The EP is in active engagement with a public health agency to submit syndromic surveillance data *from an urgent care setting.*

Old Measure 3 Description	New Measure 4 Description
The eligible hospital or CAH is in active engagement to submit data to *a specialized registry.*	The eligible hospital or CAH is in active engagement to submit data to *public health registries.*
Old Measure 3 Description	**New Measure 5 Description**
The eligible hospital or CAH is in active engagement to submit data to a *specialized registry.*	The eligible hospital or CAH is in active engagement to submit data to a *clinical data* registry.

Old Measure 4 Description	New Measure 6 Descrition
The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory *(ELR)* results.	The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results.

Clinical Quality Measures

Per the **Hospital Inpatient Prospective Payment Systems (IPPS) 2017** rule, 13 CQMs were removed for program year 2017.

EH CQMs Removed for program year 2017

Name	CMS #	NQF #
STK-4 Thrombolytic Therapy	91	0437
VTE-5 Venous Thromboembolism Discharge Instructions	110	N/A
AMI-7a Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival	60	N/A
HTN Healthy Term Newborn	185	0716
PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients	188	0147
SCIP-Inf-9 Urinary Catheter Removed on Postoperative Day 2 (POD2) With Day of Surgery Being Day Zero	178	N/A
VTE-3 Venous Thromboembolism Patients with Anticoagulation Overlap Therapy	73	373
VTE-4 Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)	109	N/A
VTE-6 Incidence of Potentially Preventable Venous Thromboembolism	114	N/A
AMI-2 Aspirin Prescribed at Discharge for AMI	100	0142
AMI-10 Statin Prescribed at Discharge	30	N/A
SCIP-Inf-1a Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	171	0527
SCIP-Inf-2a Prophylactic Antibiotic Selection for Surgical Patients	172	0528

Eligible Hospitals will be required to attest to all 16 remaining CQMs for program year

2017 and 2018.Eligible Hospitals attesting CQMs electronically (eCQMs) can attest to a lowered threshold of 8 CQMs (covering 3 domains) for program year 2017 and 2018.

5.4 Public Health Reporting Objective

For the 2017 and 2018 program year, Eligible Professionals must using Modified Stage 2 must answer 2 of the first 3 measures listed below. Eligible Hospitals using Modified Stage 2 must answer 3 of the 4 measures below.

PUBLIC HEALTH MEASURES (2017-2018 Stage 1 & Stage 2)

Measure Number	Measure Name	Measure Specification	Maximum Times Measure Can Count Towards The Objective
1	Immunization Registry Reporting	The EP, EH, or CAH is in active engagement with a public health agency to submit immunization data	1
2	Syndromic Surveillance Reporting	The EP, EH, or CAH is in active engagement with a public health agency to submit syndromic surveillance data	1
3	Specialized Registry Reporting	The EP, EH, or CAH is in active engagement with a public health agency to submit data to a specialized registry	2 for EP - 3 for EH/CAH
4	Electronic Reportable Laboratory (ELR) Results Reporting	The EH, or CAH is in active engagement to submit ELR results	1 for EH/CAH only

For the 2017 and 2018 program year, Eligible Professionals must using Stage 3 must answer 2 of the first 5 measures listed below. Eligible Hospitals using Stage 3 must answer 4 of the 6 measures below.

PUBLIC HEALTH MEASURES (2017-2018 Stage 3)

Measure Number	Measure Name	Measure Specification	Maximum Times Measure Can Count Towards The Objective
1	Immunization Registry Reporting	The EP, EH, or CAH is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS)	1
2	Syndromic Surveillance Reporting	The EP, EH, or CAH is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting	1
3	Electronic Case Reporting *This measure is not required until 2018.*	The EP, EH, or CAH is in active engagement with a public health agency to submit case reporting of reportable conditions	1

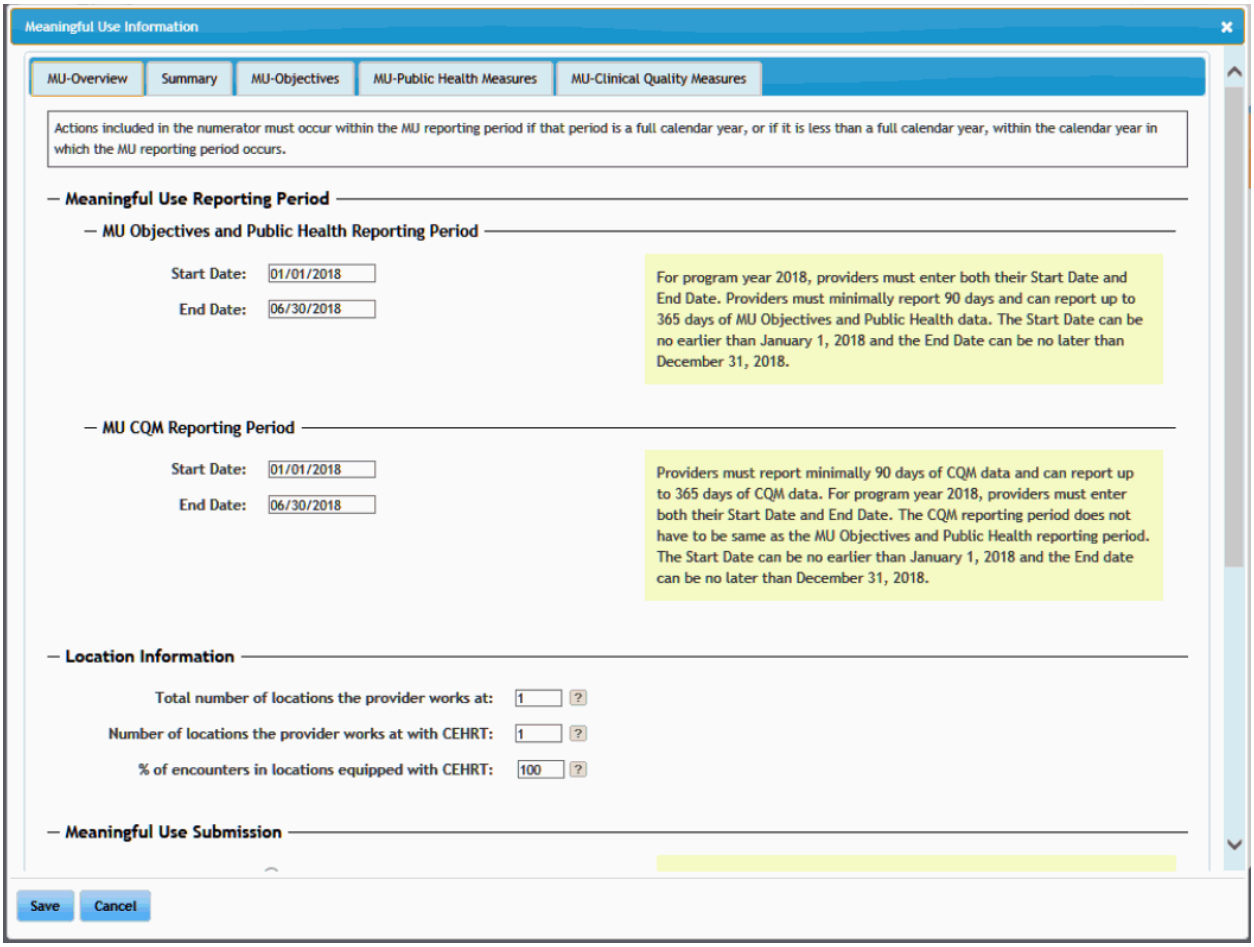
4	Public Health Registry Reporting	The EP, EH, or CAH is in active engagement with a public health agency to submit data to public health registries	2 for EP - 4 for EH/CAH
5	Clinical Data Registry Reporting	The EP, EH, or CAH is in active engagement to submit data to a clinical data registry	2 for EP - 4 for EH/CAH
6	Electronic Reportable Laboratory Result Reporting	The EH or CAH is in active engagement with a public health agency to submit electronic reportable laboratory results	1 for EH/CAH only

5.5 2017 and 2018 Reporting Period Requirements

Additional 2017-2018 program year changes required by the [2015 (Modifications to Stage 1 & Stage 2 for 2015-2017) & Stage 3 Final Rule] include several new reporting period requirements.

Please note that the line for '% of locations equipped with CEHRT:' under Location Information has been removed beginning in 2017.

EP MU 2017-2018 Overview Screen



5.5.1 EHR and CQM Reporting periods

- For 2017 Modified Stage 2, the EHR reporting period for all returning participants and all new

participants is a minimum of any continuous 90-days between January 1 and December 31, 2017.

- For 2017 Stage 3, the EHR reporting period for all returning participants and all new participants is a minimum of any continuous 90-days between January 1 and December 31, 2017.
- For a CQM reporting period in 2017, the reporting period must a minimum of any continuous 90-days between January 1 and December 31, 2017.
- For 2018 Modified Stage 2, the EHR reporting period for all returning participants and all new participants is a minimum of any continuous 90-days between January 1 and December 31, 2018.
- For 2018 Stage 3, the EHR reporting period for all returning participants and all new participants is a minimum of any continuous 90-days between January 1 and December 31, 2018.
- For a CQM reporting period in 2018, the CQM reporting period is one full year for EPs who have previously demonstrated meaningful use.
- For a CQM reporting period in 2018, under the Medicaid Promoting Interoperability Program, all EPs in their first year of meaningful use have a CQM reporting period of any continuous 90 days between January 1 and December 31, 2018.

5.6 Program year 2017 and 2018 CEHRT requirements

For the 2017-2018 program year, Stage 2 providers can choose to use technology certified to the 2014 Edition, the 2015 Edition, or a hybrid combination of the 2014/2015 editions.

For the 2017-2018 program year, Stage 3 providers can choose to use technology certified to the 2015 Edition, or a hybrid combination of the 2014/2015 editions.

6 2019 MEANINGFUL USE

Second year providers will receive an e-mail when they become eligible to register for the second year of the incentive program. When registering for year two, providers will still need to review their federal information and enter their CMS assigned registration ID.

Providers and hospitals must ensure that their Medicaid registration and certification and/or license are up to date as well. Providers will be unable to complete their registration until this information is up to date within MMIS system.

Information required for attestation for MU varies based on the measure. It is highly recommended that providers familiarize themselves with the required objectives prior to beginning data entry. The information on MU Objectives/Measures can be found at the following CMS websites:

- **2020 and 2021 Stage 3 EP Objectives** – Provides additional detailed data to assist the provider in understanding how to meet 2021 Stage 3 MU requirements. Provides specific objective definitions.

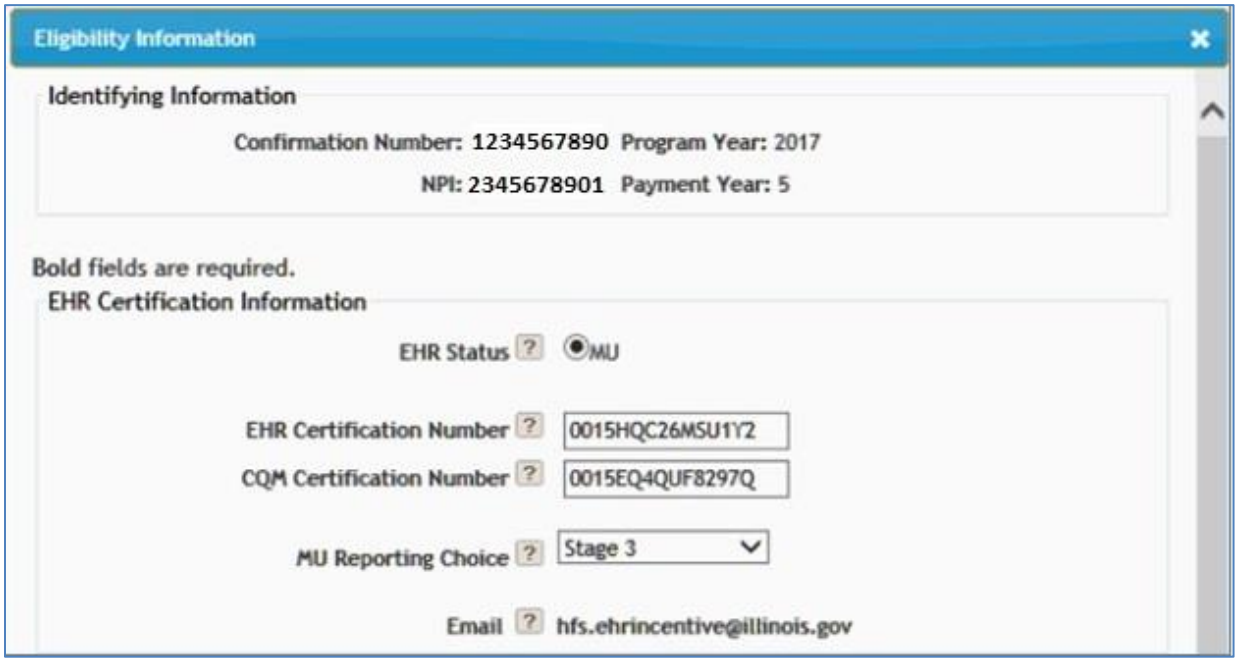
- **2019 Stage 3 EP Objectives** – Provides additional detailed data to assist the provider in understanding how to meet 2019 Stage 3 MU requirements. Provides specific objective definitions.

Note: All providers must attest according to Stage 3 requirements in 2021.

6.1 MU Objectives for 2019

- **Eligible Professionals** using **Stage 3** must attest to **8 objectives**, including **2** public health reporting measures (out of 5 measure options).

MU-Eligibility screen (EP)



MU-Objective screen (EP Stage 3)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

Meaningful Use Objectives

- EPs must complete all 7 Meaningful Use Objectives.

Objective Not Completed Yet Objective Completed

- Objective 1 : Protect Patient Health Information
- Objective 2 : Electronic Prescribing
- Objective 3 : Clinical Decision Support
- Objective 4 : Computerized Provider Order Entry (CPOE)
- Objective 5 : Patient Electronic Access to Health Information
- Objective 6 : Coordination of Care Through Patient Engagement
- Objective 7 : Health Information Exchange

MU-Public Health Measures screen (EP Stage 3)

Meaningful Use Information

MU-Overview | Summary | MU-Objectives | MU-Public Health Measures | MU-Clinical Quality Measures

Meaningful Use Public Health Measures

- EPs must minimally complete 2 non-excluded measures through active engagement compliance and provide the corresponding registry details.
- An EP may provide up to 2 registries for measure 4 and measure 5, respectively, which will be counted toward the total number of non-excluded measures necessary to meet the minimum criteria.
- Supporting documentation must be provided for non-State registries via the "Upload Document" card for the reported Public Health Measures. Health Care Surveys is a non-State registry that requires supporting documentation to be uploaded.
- If 2 Public Health measures are not reported, all other measures must be set to excluded and each of the Specialty Registry Availability Verifications must have a response to be compliant.
- Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.

Objective Not Completed Yet Objective Completed

- Measure 1 : Immunization Registry Reporting
- Measure 2 : Syndromic Surveillance Reporting
- Measure 3 : Electronic Case Reporting
- Measure 4 : Public Health Registry Reporting
- Measure 5 : Clinical Data Registry Reporting

6.1.1 Changes to EP Objectives in 2019

The Stage 3 Final Rule documented several changes to the MU objectives. There were also modifications to reporting periods. This section highlights these changes.

6.1.2 Stage 3

EP Stage 3 Objective

1 – Protect Patient Health Information

Objective Description
Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.

2 – Electronic Prescribing

Objective Description
Generate and transmit permissible prescriptions electronically.

3 – Clinical Decision Support

Objective Description
Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

4 – Computerized Provider Order Entry (CPOE)

- An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions.

Objective Description
Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant; who can enter orders into the medical record per state, local, and professional guidelines.

Measure 1 Description
More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Measure 2 Description
More than 60 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

Measure 3 Description
More than 60 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

5 – Patient Electronic Access to Health Information

Objective 5 Description
The eligible professional (EP) provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

6 – Coordination of Care Through Patient Engagement

- An EP must attest to all 3 of the following measures and meet the thresholds for at least 2 measures to meet the objective except those measures for which an EP qualifies for an exclusion.

Objective 6 Description
Use CEHRT to engage with patients or their authorized representatives about the patient's care.

Measure 1 Description
More than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) Access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) A combination of (1) and (2).

Measure 2 Description
For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative.

Measure 3 Description
Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.

7 – Health Information Exchange

- An EP must attest to all three measures, and must meet the threshold for at least two measures to meet the objective.

Objective Description
The EP provides a summary of care record when transitioning or referring their

patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

Measure 1 Description
For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) Electronically exchanges the summary of care record.

Measure 2 Description
For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she incorporates into the patient's EHR an electronic summary of care document .

Measure 3 Description
For more than 80 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she performs a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies.

MU Public Health Measures

- EPs must minimally complete 2 non-excluded measures through active engagement compliance and provide the corresponding registry details.
- An EP may provide up to 2 registries for measure 4 and measure 5, respectively, which will be counted toward the total number of non-excluded measures necessary to meet the minimum criteria.
- Supporting documentation must be provided for non-State registries via the "Upload Document" card for the reported Public Health Measures. Health Care Surveys is a non-State registry that requires supporting documentation to be uploaded.
- If 2 Public Health measures are not reported, all other measures must be set to excluded and each of the Specialty Registry Availability Verifications must have a response to be compliant.
- Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.

1. Immunization Registry Reporting

Measure 1 Description
Immunization Registry Reporting: The EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories

from the public health immunization registry/immunization information system (IIS).

2. Syndromic Surveillance Reporting

Measure 2 Description
Syndromic Surveillance Reporting: The EP is in active engagement with a PHA to submit syndromic surveillance data.

3. Electronic Case Reporting

Measure 3 Description
The EP is in active engagement with a PHA to submit case reporting of reportable conditions.

4. Public Health Registry Reporting

Measure 4 Description
The EP is in active engagement with a PHA to submit data to public health registries.

5. Public Health Registry Reporting

Measure 5 Description
The EP is in active engagement to submit data to a CDR.

Measure Number	Measure Name	Measure Specification	Maximum Times Measure Can Count Towards The Objective
1	Immunization Registry Reporting	The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).	1
2	Syndromic Surveillance Reporting	The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.	1
3	Electronic Case Reporting	The EP is in active engagement with a public health agency to submit case	1

		reporting of reportable conditions.	
4	Public Health Registry Reporting	The EP is in active engagement with a public health agency to submit data to public health registries.	2
5	Clinical Data Registry Reporting	The EP is in active engagement to submit data to a clinical data registry.	2

Clinical Quality Measures

- Providers must report at least 6 measures, one of which must be an Outcome or High-Priority Measure. If no Outcome or High-Priority measure is relevant to the provider's scope of practice, report on any six measures that are relevant.
- Outcome Measures are indicated with an asterisk (*). High-Priority Measures are indicated with a double asterisk (**).
- After utilizing a QRDA III file, you will not be able to enter CQM information via online entry. Only MU Objectives and Public Health data can be updated via online entry. To update the CQM information, please upload a new QRDA III file via eMIPP.

7. Domain: Person and Caregiver-Centered Experience and Outcomes

These CQMs reflect the potential to improve patient-centered care and the quality of care delivered to patients. They emphasize the importance of collecting patient reported data and the ability to impact care at the individual patient level as well as the population level through greater involvement of patients and families in decision making, self care, activation, and understanding of their health condition and its effective management.

a. CMS56 **: Functional Status Assussment for Total Hip Replacement

Measure Description
Percentage of patients 18 years of age and older who received an elective primary total hip arthroplasty (THA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery

b. CMS66 **: Functional Status for Total Knee Replacement

Measure Description
Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery

c. **CMS90 **: Functional Status Assessments for Congestive Heart Failure**

Measure Description
Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments

8. **CMS157 / NQF0384 **: Oncology: Medical and Radiation – Pain Intensity Quantified**

Measure Description
Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

9. **Domain: Patient Safety**

These CQMs reflect the safe delivery of clinical services in both hospital and ambulatory settings and include processes that would reduce harm to patients and reduce burden of illness. These measures should enable longitudinal assessment of condition specific, patient-focused episodes of care.

a. **CMS68 / NQF0419 **: Documentation of Current Medication in the Medical Record**

Measure Description
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

b. **CMS132 / NQF0564 *: Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures**

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence

c. **CMS139 / NQF0101 **: Falls: Screening for Future Fall Risk**

Measure Description
Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period

d. **CMS156 / NQF0022 **: Use of High-Risk Medications in the Elderly**

Measure Description
Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two of the same high-risk medications.

e. **CMS177 / NQF1365 **: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment**

Measure Description
Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk

10. Domain: Communication and Care Coordination

These CQMs demonstrate appropriate and timely sharing of information and coordination of clinical and preventive services among health professionals in the care team and with patients, caregivers, and families in order to improve appropriate and timely patient and care team communication.

a. **CMS50 **: Closing the Referral Loop: Receipt of Specialist Report**

Measure Description
Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred

11. CMS142 / NQF0089 **: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

12. Domain: Community/Population Health

These CQMs reflect the use of clinical and preventive services and achieve improvements in the health of the population served and are especially focused on the leading causes of mortality. These are outcome-focused and have the ability to achieve longitudinal measurement that will demonstrate improvement or lack of improvement in the health of the US population.

a. CMS2 / NQF0418 **: Preventaive Care and Screening: Screening for Depression and Follow-Up Plan

Measure Description
Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

13. CMS22 *: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Measure Description
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

a. CMS69 / NQF0421 : Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Measure Description
Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2

b. CMS75 *: Children Who Have Dental Decay or Cavities

Measure Description
Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period

c. CMS82 / NQF1401: Maternal Depression Screening

Measure Description
The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during

child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life

d. CMS117 / NQF0038: Childhood Immunization Status

Measure Description
Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday

e. CMS127 / NQF0043: Pneumococcal Vaccination Status for Older Adults

Measure Description
Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine

f. CMS138 / NQF0028: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure Description
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

g. CMS147 / NQF0041: Preventative Care and Screening: Influenza Immunization

Measure Description
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

h. CMS153 / NQF0033 **: Chlamydia Screenign for Women

Measure Description

Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period

i. CMS155 / NQF0024 **: Weigh Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Measure Description
Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported: - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity

j. CMS349: HIV Screening

Measure Description
Percentage of patients 15-65 years of age who have been tested for HIV within that age range

14. Domain: Efficiency and Cost Reduction

These CQMs reflect efforts to significantly improve outcomes and reduce errors. These CQMs also impact and benefit a large number of patients and emphasize the use of evidence to best manage high priority conditions and determine appropriate use of healthcare resources.

a. CMS129 / NQF0389 **: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

Measure Description
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer

b. CMS146 / NQF0002 **: Appropriate Testing for Children with Pharyngitis

Measure Description

Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.

c. **CMS154 / NQF0069 **: Appropriate Treatment for Children with Upper Respiratory Infection (URI)**

Measure Description
Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode

15. **CMS249 **: Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture**

Measure Description
Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.

16. **Domain: Effective Clinical Care**

These CQMs reflect clinical care processes closely linked to outcomes based on evidence and practice guidelines.

a. **CMS52 / NQF0405: HIV/AIDS: Pheumocystic jiroveci pneumonia (PCP prophylaxis**

Measure Description
Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis

b. **CMS74: Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists**

Measure Description
Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period

c. **CMS122 / NQF0059 *: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)**

Measure Description
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

d. **CMS124 / NQF0032: Cervical Cancer Screening**

Measure Description
Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: - Women age 21-64 who had cervical cytology performed every 3 years - Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years

e. CMS125 / NQF2372 **: Breast Cancer Screening

Measure Description
Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer

f. CMS128 / NQF0105 **: Anti-Depressant Medication Management

Measure Description
Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported: a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks) b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)

g. CMS130 / NQF0034: Coloroectal Cancer Screening

Measure Description
Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer

h. CMS131 / NQF0055: Diabetes: Eye Exam

Measure Description
Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period

i. CMS133 / NQF0565 *: Cataracts: 20/40 or Better Visual Acuity within 90

Days Following Cataract Surgery

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery

j. CMS134 / NQF0062: Diabetes: Medical Attention for Nephropathy

Measure Description
The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period

k. CMS135 / NQF2907: Hearth Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge

l. CMS136 / NQF0108 **: Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Measure Description
Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported: a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended

m. CMS137 / NQF0004 **: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Description
Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported: a. Percentage of patients who initiated treatment within 14 days of the diagnosis b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit

n. CMS143 / NQF0086: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

o. CMS144 / NQF2908: Heart Failure (HF): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventriculare Systolic Dysfunction (LVEF <40%)

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge

p. CMS145 / NQF0070: Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventriculare Systolic Dysfunction (LVEF <40%)

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen with in a 12 month period who also have a prior MI or a current or prior LVEF<40% who were prescribed beta-blocker therapy.

q. CMS149: Dementia: Cognitive Assessment

Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

r. CMS159 / NQF0710 *: Depression Remission at Twelve Months

Measure Description
The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/- 60 days) after an index event.

s. CMS160 / NQF0712: Depression Untilization of the PHQ-9 Tool

Measure Description
The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter

t. CMS161 / NQF0104: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Measure Description
Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

u. CMS165 / NQF0018 *: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Measure Description
Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period

v. CMS347: Controlling High Blood Pressure

Measure Description
Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: * Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR * Adults aged >= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR * Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL

w. CMS645: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Measure Description
Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater (indicated by HCPCS code) and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.

APPENDIX D – TOOLKIT REVISION HISTORY

Topic/Subtopic	Page	Revisions	Revision Date
Table of Contents	2	Updated topics and page numbers	*11/19/2014*
1.1.1 Websites	3	Added and updated links	*11/19/2014*
1.1.3 Regional Extension Centers	4	Moved CHITREC info next to IL-HITREC (formatting)	*11/19/2014*
2 Background	4	Updated links; modified tabs examples listed in last paragraph	*11/19/2014*
3.3 Qualifying Providers by Type and Patient Volume	7	Minor formatting (table color)	*11/19/2014*
4.1.1.1 Definition of an Eligible Professional Medicaid Encounter	8	Revised definition to Stage 2 language, which includes zero-pay encounters (the services no longer must be paid by Medicaid).	*11/19/2014*
4.1.2.1 Groups - Additional Considerations	9	Added subtopic to document how eMIPP handles various scenarios regarding groups and patient volume (encounters).	*11/19/2014*
4.1.5.1 Definition of an Eligible Hospital Medicaid Encounter	8	Revised definition to Stage 2 language, which includes zero-pay encounters (the services no longer must be paid by Medicaid).	*11/19/2014*
8 Meaningful Use	19	Updated links; added links to cover 2013/2014 meaningful use options	*11/19/2014*
8 Meaningful Use	20	Modified text to include Flexibility rule information	*11/19/2014*
8 Meaningful Use	20	Updated "Stage of Meaningful Use" table to match Flexibility Rule	*11/19/2014*
8.1 For 2014 Only	21	Added text detailing the CEHRT options provided by the Flexibility Rule. Added Table 3.	*11/19/2014*
8.1 For 2014 Only	22	Added example of "Eligibility Information" section of the Eligibility tab revised by new coding for the Flexibility rule.	*11/19/2014*
8.2 Public Health Reporting	22	Created new subtopic (8.2 Public Health Reporting) to more specifically address Stage 1 testing vs. Stage 2 testing requirements for public health objectives.	*11/19/2014*
8.4 New Objectives & New Measures	24	Added link to Patient Access Tipsheet	*11/19/2014*
8.5 Meaningful Use Reporting Data	25-26	Adding subtopics to define the 3 submission options (Online, PDF, QRDA III eCQM). Added screenprints to demonstrate.	*11/19/2014*
8.6 Clinical Quality Measures	27	Added and updated links	*11/19/2014*
8.6.3 Medicaid eCQM reporting	27	Added subtopic (8.6.3 eCQM reporting) to detail Group vs. Individual eCQM reporting options. Included screen print for example.	*11/19/2014*
8.6.3.1 Group eCQM Reporting - Additional Considerations	28-29	Added subtopic (8.6.3.1) to list how eMIPP handles numerous new scenarios created with Group eCQM reporting	*11/19/2014*
8.6.3.2 Individual eCQM Reporting - Additional Considerations	29	Added subtopic (8.6.3.2) to list how eMIPP handles numerous new scenarios created with Individual eCQM reporting	*11/19/2014*

Topic/Subtopic	Page	Revisions	Revision Date
9.3 CMS Registration	31	Added link for Additional User Guides	*11/19/2014*
9.4 Attestation - Registration with eMIPP	32	Removed 2013 from section header	*11/19/2014*
10 Help Desk Information	35	Reformatted information; added email address for Medi/security issues	*11/19/2014*
11 Audit Information	36-37	Added section on Medicaid Audit information, including examples of documents to save.	*11/19/2014*
Table of Contents	2	Updated topics and page numbers	*3/10/2015*
8.2.1 Public Health Stage 1	22	Added information regarding selection exclusions of PH measures	*3/10/2015*
8.2.2 Public Health Stage 2	22	Added information regarding registration of intent	*3/10/2015*
9.5 Attestation Deadlines	34	Added complete section	*3/10/2015*
10 - Help Desk Information	34	Added Entrust information to contact list	*3/10/2015*
11 Audit Information	36	Added information regarding documentation needed for choosing lesser CEHRTS per flexibility rule options	*3/10/2015*
Appendix C - Toolkit Revision History	39	Added complete section	*3/10/2015*
1.1.1 Websites	3	Added 2015 final rule link	*2/1/2016*
2 Background	4	Updated link (www.healthit.gov)	*2/1/2016*
3.2 Additional requirements for the EH	6	Change "previous fiscal year" to "previous calendar year"	*2/1/2016*
4.2 Methodology for Determining Eligible Hospital Patient Volume	12	Added 2015 paragraph for encounters	*2/1/2016*
8 Meaningful Use	19	Moved 2014 references to Appendix C. Added 2015 program requirements and objective spec information.	*2/1/2016*
8 Meaningful Use	19	Added new Meaningful Use stage table	*2/1/2016*
8.1 Meaningful Use Reporting Periods	20	Removed topic; added to later section	*2/1/2016*
8.2 Meaningful Use Objectives	20-25	Revamped section to explain 2015 Meaningful Use changes	*2/1/2016*
8 Meaningful Use	19	Moved 2015 references to Appendix C. Added 2016 program requirements and objective spec information.	*1/1/2017*
8.1 Meaningful Use Objectives	20	Moved 2015 references to Appendix C. Added 2016 objective spec differences for Stage 1 & Stage 2	*1/1/2017*
8.1.2 Public Health Report Objectives	25	Moved 2015 references to Appendix C Added 2016 program requirements and Public Health objective spec information.	*1/1/2017*
8.1.2.2 Additional Public Health Information	25	Moved 2015 hyperlinks to Appendix C Added 2016 program hyperlinks.	*1/1/2017*
8.3.2 Medicaid eCOM Repoerting	30	Moved 2015 screen sample to Appendix C. Added 2016 screen sample.	*1/1/2017*

Topic/Subtopic	Page	Revisions	Revision Date
9.5 Attestation Deadlines	34	Corrected the 2015 deadline, removed the 2014 deadlines; added the 2016 deadlines	*1/1/2017*
Appendix C – Historical Meaningful Use Information	39	Created historical appendix as previous year information becomes obsolete.	*1/1/2017*
1.1.1 Websites	3	Modified eMIPP portal link (IMPACT)	*2/24/2017*
8 Meaningful Use	19	Modified for 2016 requirements	*2/24/2017*
9.4.1 IMPACT/eMIPP Login instructions	36	Added section for logging in to IMPACT	*2/24/2017*
8 Meaningful Use	19-20	Added links and descriptions for2017 Program Requirements, 2017 EP Modified Stage 2 Objectives/Measure Specifications, 2017 EH/CAH Modified Stage 2 Objectives/Measure Specifications, 2017 EP Stage 3 Objectives/Measure Specifications, and 2017 EH/CAH Modified Stage 2 Objectives/Measure Specifications	*3/27/2017*
8.2 Meaningful Use Objectives for 2017	30-39	Added complete section	*3/27/2017*
1.1.1 Websites	3	Added portal Links for 2017 IPPS Final Rule and 2017 OPPS Final Rule	*3/19/2018*
8 Meaningful Use	19-20	Added links and descriptions for 2018 Program Requirements, 2018 EP Modified Stage 2 Objectives/Measure Specifications, 2018 EH/CAH Modified Stage 2 Objectives/Measure Specifications, 2018 EP Stage 3 Objectives/Measure Specifications, and 2018 EH/CAH Modified Stage 2 Objectives/Measure Specifications. Also added new Stage of Meaningful Use table	*3/19/2018*
8.1 Meaningful Use Objectives for 2016	21-29	Moved to Appendix C – Historical Meaningful Use Information	*3/19/2018*
8.2 Meaningful Use Objectives for 2017	30-49	Changed to 8.1 Meaningful Use Objectives for 2017 and 2018. Modified logic for 2018 attestation.	*3/19/2018*
Table of Contents	2	Updated topics and page numbers	*3/19/2017*
9.1 Whole document		Renamed program to Promoting Interoperability	*9/19/2018*
8.2 MU Reporting Data		Changed screens to match new format. Changed instructions for QDRA III submission to match changes done in September 2018.	*10/22/2018*
1.1.1 Websites	3	Added portal links for 2019 Final Rule and 2020 Final Rule	*10/18/2019*
6 Payment Methodology for Eligible Hospitals	14-17	Moved to Appedix C – Historical Meaningful Use Information	*10/18/2019*
8 Meaningful Use	18-52	Moved 2015-2018 data to Appendix C – Historical Meaningful Use Information	*10/18/2019*
1.1.1 Websites	3	Inserted links for 2020 legislation	*1/08/2020*
6.1.2 Stage 3	15-30	Updated Core Objectives and CQMs for 2019	*1/08/2020*
9.1.1 Documentation to save	50	Added Health Care Surveys	*1/08/2020*
Appendix C – Historical Meaningful Use Information	52	Relocated outdated information (2018, Stage 2, etc.) to this section	*1/08/2020*