Quality Payment PROGRAM

Merit-Based Incentive Payment System (MIPS) Advancing Care Information Performance Category Transition Measure 2017 Performance Period

Objective:	**Patient Electronic Access**
Measure:	**View, Download or Transmit (VDT)** At least one patient seen by the MIPS eligible clinician during the performance period (or patient-authorized representative) views, downloads or transmits their health information to a third party during the performance period.
Measure ID:	**ACI_TRANS_PEA_2**

Definition of Terms

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

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

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

Reporting Requirements

NUMERATOR/DENOMINATOR

- **NUMERATOR**: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the performance period.

- **DENOMINATOR**: The number of unique patients seen by the MIPS eligible clinician during the performance period.

Scoring Information

BASE SCORE/PERFORMANCE SCORE/BONUS SCORE

- Required for the Base Score: **No**
- Percentage of Performance Score: **Up to 10%**
- Eligible for Bonus Score: **No**

Note: MIPS eligible clinicians must fulfill the requirements of base score measures to earn a base score in order to earn any score in the advancing care information performance category. In addition to the base score, eligible clinicians have the opportunity to earn additional credit through the submission of performance measures and a bonus measure and/or activity.

Additional Information

- In 2017, MIPS eligible clinicians can report the 2017 Advancing Care Information transition objectives and measures if they have technology certified to the 2015 Edition, or technology certified to the 2014 Edition, or a combination of technologies certified to the 2014 and 2015 Editions.
- This measure is worth up to 10 percentage points towards the Advancing Care Information performance category score. More information about Advancing Care Information scoring is available in the Advancing Care Information fact sheet.
- In order to meet this measure, the following information must be made available to patients electronically:
    - Patient name
    - Provider's name and office contact information
    - Current and past problem list
    - Procedures
    - Laboratory test results
    - Current medication list and medication history
    - Current medication allergy list and medication allergy history
    - Vital signs (height, weight, blood pressure, BMI, growth charts)
    - Smoking status
    - Demographic information (preferred language, sex, race, ethnicity, date of birth)
    - Care plan field(s), including goals and instructions
    - Any known care team members including the primary care provider (PCP) of record
- The patient must be able to access this information on demand, such as through a patient portal or personal health record (PHR) or by other online electronic means. We note that while a covered entity may be able to fully satisfy a patient's request for information through VDT, the measure does not replace the covered entity's responsibilities to meet the broader

requirements under HIPAA to provide an individual, upon request, with access to PHI in a designated record set.

- MIPS eligible clinicians should also be aware that while the measure is limited to the capabilities of certified electronic health record technology (CEHRT) to provide online access, there may be patients who cannot access their EHRs electronically because of a disability. MIPS eligible clinicians who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- A patient who has multiple encounters during the MIPS performance period, or even in subsequent MIPS performance periods in future years, needs to be provided access for each encounter where they are seen by the MIPS eligible clinician.
- When MIPS eligible clinicians choose to report as a group, data should be aggregated for all MIPS eligible clinicians under one Taxpayer Identification Number (TIN). This includes those MIPS eligible clinicians who may qualify for reweighting such as a significant hardship exception, hospital or ASC-based status, or in a specialty which is not required to report data to the Advancing Care Information performance category. If these MIPS eligible clinicians choose to report as part of a group practice, they will be scored on the Advancing Care Information performance category like all other MIPS eligible clinicians.

Regulatory References

- For further discussion, please see the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) final rule: 81 FR 77230
- In order to meet this objective and measure, MIPS eligible clinicians must use the capabilities and standards of CEHRT at 45 CFR 170.314 (e)(1).

Certification and Standards Criteria

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

Certification Criteria*	
§170.314(e)(1) View, download, and transmit to third party	(i) EHR technology must provide patients (and their authorized representatives) with an online means to view, download, and transmit to a 3rd party the data specified below. Access to these capabilities must be through a secure channel that ensures all content is encrypted and integrity-protected in accordance with the standard for encryption and hashing algorithms specified at § 170.210(f). (A) View. Electronically view in accordance with the standard adopted at § 170.204(a), at a minimum, the following data: (1) The Common MU Data Set** (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set). (2) Ambulatory setting only. Provider's name and office contact information. (3) Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization. (B) Download. (1) Electronically download an ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) in human readable format or formatted according to the standard adopted at § 170.205(a)(3) that includes, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set): (i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1) and (e)(1)(i)(A)(2) of this section. (ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1) and (e)(1)(i)(A)(3) of this section. (2) Inpatient setting only. Electronically download transition of care/referral summaries that were created as a result of a transition of care (pursuant to the capability expressed in the certification criterion adopted at paragraph (b)(2) of this section). (C) Transmit to third party. (1) Electronically transmit the ambulatory summary or inpatient summary (as applicable to the EHR technology setting for which certification is requested) created in paragraph (e)(1)(i)(B)(1) of this section in accordance with the standard specified in § 170.202(a).

	(2) Inpatient setting only. Electronically transmit transition of care/referral summaries (as a result of a transition of care/referral) selected by the patient (or their authorized representative) in accordance with the standard specified in § 170.202(a). (ii) Activity history log. (A) When electronic health information is viewed, downloaded, or transmitted to a third-party using the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section, the following information must be recorded and made accessible to the patient: (1) The action(s) (i.e., view, download, transmission) that occurred; (2) The date and time each action occurred in accordance with the standard specified at § 170.210(g); and (3) The user who took the action. (B) EHR technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section if it is also certified to the certification criterion adopted at § 170.314(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) is accessible by the patient.

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

Standards Criteria	
§ 170.204(a)	Web Content Accessibility Guidelines (WCAG) 2.0, Level A Conformance (incorporated by reference in § 170.299).
§ 170.210(f)	Any encryption and hashing algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the FIPS Publication 140-2 (incorporated by reference in § 170.299).
§ 170.205(a)(3)	HL7 Implementation Guide for CDA Release 2: IHE Health Story Consolidation. The use of the “unstructured document” document-level template is prohibited.
§ 170.202(a)	Applicability Statement for Secure Health Transport.

§ 170.210(g)	The data and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, or (RFC 5905) Network Time Protocol Version 4.

Additional certification and standards criteria may apply. Review the ONC 2015 Edition Final Rule for more information.