Merit-Based Incentive Payment System (MIPS) Promoting Interoperability Performance Category Measure 2018 Performance Period

Objective:	**Coordination of Care Through Patient Engagement**
Measure:	**View, Download, or Transmit (VDT)** During the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician by either—(1) viewing, downloading or transmitting to a third party their health information; or (2) accessing their health information through the use of an Application Programming Interface (API) that can be used by applications chosen by the patient and configured to the API in the MIPS eligible clinician's certified electronic health record technology (CEHRT); or (3) a combination of (1) and (2).
Measure ID:	**PI_CCTPE_1**

Definition of Terms

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

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

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.

Unique Patient – If a patient is seen by a MIPS eligible clinician more than once during the MIPS performance period, then for purposes of measurement, that patient is only counted once in the denominator for the measure. All the measures relying on the term ''unique patient'' relate

to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same MIPS performance period.

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 and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the 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 Base Score: **No**
- Percentage of Performance Score: **Up to 10%**
- Eligible for Bonus Score: **One-time bonus of 10% for MIPS eligible clinicians and groups who report using 2015 Edition CEHRT exclusively for the 2018 performance period and submit only Promoting Interoperability measures**

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 Promoting Interoperability performance category. In addition to the base score, MIPS eligible clinicians have the opportunity to earn additional credit through the submission of performance measures and a bonus measure and/or activity.

Additional Information

- MIPS eligible clinicians can report the Promoting Interoperability objectives and measures if they have technology certified to the 2015 Edition, or a combination of technologies from the 2014 and 2015 Editions that support these measures.
- Actions included in the numerator must occur within the performance period.

- This measure is worth up to 10 percentage points towards the Promoting Interoperability performance category score. More information about Promoting Interoperability scoring is available on the QPP website.
- There are four actions a patient might take as part of the measure:
  - View their information,
  - Download their information,
  - Transmit their information to a third party, and
  - Access their information through an API.

  These actions may overlap, but a MIPS eligible clinician is able to count any and all actions in the single numerator. Therefore, a MIPS eligible clinician may meet a combined threshold for VDT and API actions, or if their technology functions overlap, then any view, download, transmit, or API actions taken by the patient using CEHRT would count toward the threshold.
- In order to meet the objective, the following information must be available:
  - Patient name
  - MIPS eligible clinician'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
- 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 Promoting Interoperability performance category. If these MIPS eligible clinicians choose to report as part of a group practice, they will be scored on the Promoting Interoperability 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 77228.
- In order to meet this objective and measure, MIPS eligible clinicians must use the capabilities and standards of CEHRT as defined at § at 45 CFR 170.315(e)(1)(2) and (3) and (g)(7) (g)(8) and (g)(9).

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

summary or inpatient summary must include, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set):

(i) Ambulatory setting only. All of the data specified in paragraph (e)(1)(i)(A)(1), (2), (4), and (5) of this section.
(ii) Inpatient setting only. All of the data specified in paragraphs (e)(1)(i)(A)(1), and (3) through (5) of this section.

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

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

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

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

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

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

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

	(ii) Activity history log. (A) When any of the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section are used, the following information must be recorded and made accessible to the patient (or his/her authorized representative): (1) The action(s) (i.e., view, download, transmission) that occurred; (2) The date and time each action occurred in accordance with the standard specified in §170.210(g); (3) The user who took the action; and (4) Where applicable, the addressee to whom an ambulatory summary or inpatient summary was transmitted. (B) Technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section if it is also certified to the certification criterion specified in §170.315(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) of this section is accessible by the patient (or his/her authorized representative).

** 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, (incorporated by reference in §170.299). The use of the “unstructured document” document-level template is prohibited.
§ 170.202(a)	ONC Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).

§ 170.210(g)	The date and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, (incorporated by reference in §170.299) or (RFC 5905) Network Time Protocol Version 4, (incorporated by reference in §170.299).

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