For 2016, what alternate exclusions are available for the public health reporting objective? What are the alternate exclusions available to accommodate the changes to how the measures are counted?

We do not intend to retroactively penalize providers for changes to their systems or reporting made necessary by the provisions of the 2015 HIRA Incentive Programs Final Rule. This includes alternate exclusions for providers for certain measures in 2016 which might require the acquisition of additional technologies they did not previously have or did not previously intend to include in their activities for meaningful use (BFIR-52606). For 2016, EPs scheduled to be in Stage 1 or Stage 2 must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3 and eligible hospitals or CAHs scheduled to be in Stage 1 or Stage 2 must attest to at least 2 public health measures from the Public Health Reporting Objective Measures 1-4. We will allow providers to claim an alternate exclusion for the Public Health Reporting measure(s) which might require the acquisition of additional technologies providers did not previously have or did not previously intend to include in their activities for meaningful use. We will allow Alternate Exclusions for the Public Health Reporting Objective in 2016 so providers scheduled to be in Stage 1 or Stage 2: Must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3. May claim an Alternate Exclusion for Measure 2 and Measure 3 (Synthetic Surveillance and Specialized Registry Reporting). An Alternate Exclusion may only be claimed for up to two measures, then the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22(e)(10)(ii)(C). Eligible hospitals/CAHs scheduled to be in Stages 1 and 2: Must attest to at least 3 measures from the Public Health Reporting Objective Measures 1-4. May claim an Alternate Exclusion for Measure 3 (Specialized Registry Reporting). An Alternate Exclusion may only be claimed for one measure, then the provider must either attest to or meet the exclusion requirements for the remaining measures described in 495.22(e)(10)(ii)(C).

Who can enter medication orders in order to meet the measure for the computerized provider order entry (CPOE) meaningful use objective under the Medicare and Medicaid Promoting Interoperability Programs?

We refer to 45 CFR 160.202, a medical staff person who is a board-certified medical assistant or is certificated to and performs the duties equivalent to a board-certified medical assistant may enter orders. We maintain our position that medical staff must have at least a certain level of medical training in order to execute the related CDS for a CPOE order entry. We refer to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines we have prescribed. We believe that intern who have completed their medical training and are working toward appropriate licensure would fit within this definition. We maintain our position that, in general, nurses are not included as medical staff that may enter orders for purposes of the CPOE objective. However, we note that the policy is not specific to a job title but to the appropriate medical training, knowledge, and experience.

If a provider does not administer immunizations, they should not attest to the measure; they must claim the exclusion. If a provider does administer immunizations, but did not have immunization data, they may claim the exclusion as long as they did not successfully submit data to meet the measure. If the provider fails to submit data to meet the measure in subsequent years, they must either attest to the measure or meet the exclusion requirements for the remaining measure described in 495.22(e)(10)(ii). We refer to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines we have prescribed. We believe that intern who have completed their medical training and are working toward appropriate licensure would fit within this definition. We maintain our position that, in general, nurses are not included as medical staff that may enter orders for purposes of the CPOE objective. However, we note that the policy is not specific to a job title but to the appropriate medical training, knowledge, and experience.

If the EP or hospital qualifies for and attests to an exclusion for a public health measure, they would not need to have CEHRT that meets the certification criteria related to that public health objective. For example, if an EP does not give any immunizations during their EHR reporting period, they would not need to have CEHRT that meets the certification criteria related to the immunization reporting objective in order to attest to the exclusion. If the EP or hospital qualifies for an exclusion, but elects to try to meet objective, they would need to have and use CEHRT that meets the certification criteria for the objective.

For the Stage 2 objectives of the Medicare and Medicaid Promoting Interoperability Programs, when does the provider need to register with PHA or other body to whom the information is being submitted, to meet the measure?

We refer to 45 CFR 160.010, providers must own and have CEHRT installed by the first day of their EHR reporting period. There are certain core functions that must be fully functional on the first day and in use by the providers for their entire EHR reporting period. There is other functionality, including for the public health objectives, where the CEHRT may not be fully functional at the start of the provider's EHR reporting period and that is acceptable. Completing the implementation and making it fully functional would be part of the onboarding process with the public health agency.

For the reporting objective in 2016 as follows: EPs scheduled to be in Stage 1 and Stage 2: Must attest to at least 2 measures from the Public Health Reporting Objective Measures 1-3. May claim an Alternate Exclusion for Measure 2 and Measure 3 (Synthetic Surveillance and Specialized Registry Reporting). An Alternate Exclusion may only be claimed for up to two measures, then the provider must either attest to or meet the exclusion requirements for the remaining measure described in 495.22(e)(10)(ii)(C). Eligible hospitals/CAHs scheduled to be in Stages 1 and 2: Must attest to at least 3 measures from the Public Health Reporting Objective Measures 1-4. May claim an Alternate Exclusion for Measure 3 (Specialized Registry Reporting). An Alternate Exclusion may only be claimed for one measure, then the provider must either attest to or meet the exclusion requirements for the remaining measures described in 495.22(e)(10)(ii)(C).
For the meaningful use objective of "generate and transmit prescriptions electronically (CPDE)" for the Medicare and Medicaid Promoting Interoperability Programs, should electronic prescriptions fulfilled by an internal pharmacy be included in the numerator?

We define a permissible prescription as all drugs meeting the definition of prescription not listed as a controlled substance in Schedules II–V. Removal of the prohibition to electronic prescribing of controlled substances, some challenges remain including more restrictive state laws and the widespread availability of products both for providers and pharmacies that include the functionality required by the Core IGs. We continue to exclude the counter (OTC) medications from the definition of a prescription (77 FR 63998). We continue to allow providers the option to include or exclude controlled substances in the denominator in which such medications can be electronically prescribed. These prescriptions may be included in the definition of "permissible prescriptions" at the provider discretion where allowable by law (80 FR 62685). The denominator for this measure written in the regulations is "an eligible provider that sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP." Yes; therefore, for the purposes of this objective, that prescriptions for controlled substances qualify as "permissible prescriptions" for the Medicare and Medicaid Promoting Interoperability Programs.

Can a public health agency use a Health Information Exchange (HIE) to interface with providers who are submitting public health data to meet the public health objectives of meaningful use (such as submitting information to an immunization registry, reporting lab results to a public health agency or reporting syndromic surveillance information)?

There are a variety of methods for the exchange of public health information, and CMS does not limit or define the meaning of public health entities. Among other requirements as specified in the regulations, a provider must submit data for the public health objectives of meaningful use as a follow-up. The information required by a public health meaningful use objective must originate from the provider's Certified Electronic Health Records Technology (CEHRT) and be transmitted to the HIE. The information sent from the provider's CEHRT to the HIE must be formatted according to the standards and implementation specifications associated with the public health meaningful use objective included in the measure. This will clarify that use of an HIE to meet public health objectives is acceptable, as long as the information transferred meets the requirements as specified in the regulations.

When meeting the meaningful use measure for computerized provider order entry (CPOE) in the Promoting Interoperability Programs, does an individual need to have the job title of medical assistant in order to use the CPOE function of Certified EHR Technology (CCHIT) for the entry to count toward the measure, or can they have other titles as long as their job functions are those of medical assistants?

Yes. A staff member of the eligible provider is appropriately credentialed and performs similar assistive services as a medical assistant but carries a more specific title due to other specialization of their duties or to the specialty of the medical professional they assist, or he or she can use the CPOE function of CCHIT and have it count towards the measure. This will clarify that medical assistants in roles outside of the patient care environment can use the CPOE function of a certified EHR technology to meet the meaningful use CPOE measure. It will also clarify that a medical assistant who assists with patient care in the hospital setting should use the CPOE function of the certified EHR technology to meet the measure.

How can a provider meet the "Protect Electronic Health Information" measure objective in the Promoting Interoperability Programs?

To meet the "Protect Electronic Health Information" measure objective for Stage 1, eligible providers must conduct a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1)(ii) and implement security safeguards as necessary and correct identified deficiencies as part of the provider's risk management process. In Stage 2, in addition to meeting the same security risk analysis requirements as Stage 1, EPs and hospitals will also need to address the description and security of data stored in the certified CEHRT technology. These steps may be completed outside the EHR reporting period timeframe but must take place no later than the EHR reporting year. For example, a provider that is conducting a security risk analysis for the second year of the EHR reporting period may conduct the analysis outside the EHR reporting year timeframe but must take place no later than the EHR reporting period. The revised definition of permissible prescriptions allows providers the option of including or excluding prescriptions in the numerator for controlled substances in the denominator in which such medications can be electronically prescribed. These prescriptions may be included in the definition of "permissible prescriptions" at the provider discretion where allowable by law (80 FR 62685). The denominator for this measure written in the regulations is "an eligible provider that sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP." Yes; therefore, for the purposes of this objective, that prescriptions for controlled substances qualify as "permissible prescriptions" for the Medicare and Medicaid Promoting Interoperability Programs.

For the Medicare and Medicaid Promoting Interoperability Programs, should an eligible professional (EP) who orders medication re-calculated for the measure for the "computerized provider order entry (CPOE)" objective if the EP sees patients whose medications are maintained in the medication list by the EP but were not ordered or prescribed by the EP?

Stage 1 providers may have this issue if they choose the alternate specification. Yes; however, these providers may simply use the total number of orders for the denominator. If they prescribe fewer than 200 medications, they may qualify for the exclusion.

For the Medicare and Medicaid Promoting Interoperability Programs, are controlled substances qualified as "permissible prescriptions" for the meaningful use objective of implementing one clinical decision support rule for the Medicare and Medicaid Promoting Interoperability Programs?

The inclusion of controlled substances in the permissible prescriptions for the purposes of the EP's meaningful use objective is an option for providers, but not required. As discussed in the Stage 3 Final Rule, EPs may choose different schedules regarding controlled substances, may vary in their clinical decision support rule across different specialty sections and may choose to interpret the exclusion differently. Given these developments with states easing some of the prior restrictions on electronically prescribing controlled substances, we believe it is no longer necessary to categorically exclude controlled substances from the term "permissible prescriptions" (80 FR 62685). Yes; therefore, for the purposes of this objective, that prescriptions for controlled substances may be included in the definition of permissible prescriptions where the electronic prescription of a specific medication or schedule of medications is permissible under state law and federal law.
In order to satisfy the Meaningful Use objective for electronic prescribing (pS) in the Medicare and Medicaid Promoting Interoperability Programs, can providers use intermediary networks that contain information from the certified EHR in a computer readable format for sending to the pharmacy and include this transaction in the numerator for the measure of this objective?  

The threshold for a prescribing for an EHR reporting period in 2015 through 2017 is more than 30 percent for EPs and more than 10 percent for eligible hospitals and CNs. If the EP generates an electronic prescription and transmits it electronically using the standards of certified EHR technology to either a pharmacy or an intermediary network, and this result or prescription being filled without the need for the provider to communicate the prescription in an alternative manner, then the prescription would be included in the numerator.

If a certified electronic health record (EHR) technology is capable of submitting batch files to an immunization registry using the standards adopted by the Office of the National Coordinator of Health Information Technology, is sufficient to meet the Meaningful Use objective “submit electronic data to immunization registries” for the Medicare and Medicaid Promoting Interoperability Programs?  

Transmitting batch files to an immunization registry, provided that they are formatted according to the standards adopted by the Office of the National Coordinator of Health Information Technology, is sufficient to meet the Public Health Reporting objective measure 1, Immunization Registry Reporting. However, if a provider in the group does not automatically immunizations, they did not notify any for a particular EHR reporting period, they are not required to claim the exclusion as long as they have not done any necessary registration and bonding and are reporting when they have the data to report.  

Does the exclusion of certified Medical Assistant in the list of professionals who can enter orders into the EHR using pS and have them count in the numerator?  

The licensed healthcare professional can enter orders into the electronic health record for purposes of recording the order in the numerator for the measure of the pS objective if they can enter the order on the state, local, and professional guidelines. The order must be entered by someone who could exercise clinical judgment in the care that the orders generate and any alerts about possible interactions or other clinical decision support alerts. This necessitates that pS occurs when the first order begins part of the patient’s medical record and before any action can be taken on the order. Each provider will have to evaluate on a case-by-case basis whether a given situation is entered according to state, local, and professional guidelines, allow for clinical judgment before the medication is given, and is the first time the order begins part of the patient’s medical record.

Can a provider register their intent after the first 60 days of the EHR reporting period?  

If an eligible hospital (EH) or critical access hospital (CAH) does not access the information on the portal or PHR?  

The EH or CAH should indicate the following exclusion for attesting yes; Does not perform or order laboratory tests that are reportable in their jurisdiction during the EHR reporting period.  

In calculating the numerator for measures requiring patient action, at least one patient who can be counted in the numerator for the measure of this objective?  

If a provider sees a patient during the EHR reporting period and no later than the date of attestation (80 FR 62814). For more information about actions taken outside of the EHR reporting period and numerator calculations, please see FAQ 821I.

Can a hospital count a patient toward the measure of the “Patient Electronic Access” objective in the Medicare and Medicaid Promoting Interoperability Programs if the patient accessed his/her information after they were discharged?  

This measure of Objective B: Patient Electronic Access for eligible hospitals and CAHs states, “For EHR reporting period in 2015, at least 1 patient who is discharged from the inpatient or emergency department (FIS 21 or 23) of an eligible hospital or CAH (or patient authorized representatives) views, downloads or transmits to a third party his or her health information during the EHR reporting period. By 2017, the threshold increases to more than 5% of unique patients. The denominator for measure 2 includes the number of unique patients discharged from the inpatient or emergency department (FIS 21 or 23) of the eligible hospital or CAH during the EHR reporting period (SR R36281). Patients may choose to access their information prior to leaving the hospital, where guidance and support in using the online patient portal is still available to them. To this end, the hospital may include patients found in the denominator who access their information or before or before the hospital discharge date, but must take place no later than the date of attestation in order to be counted in the numerator. The calculation may include actions taken before, during, or after the EHR reporting period if the less than one full year; however, consistent with FAQ 821I, these actions must be taken no earlier than the start of the same full EHR reporting period and no later than the date of attainment (SR R36281). For more information about actions taken outside of the EHR reporting period and numerator calculations, please see FAQ 821I.

When do eligible hospitals and Critical Access Hospitals need to take to meet the specialized registry objective? is it different from the first 60 days of the EHR reporting period?  

For an eligible hospital or Critical Access Hospitals (CAHs), the process is the same as for any pS data. The eligible hospital or CAH should check their state’s and any such organization or specialty society with which they are affiliated to determine if they entity maintains a specialized registry and for which they may have a public declaration of readiness to receive data for meaningful use not later than the first day of the provider’s EHR reporting period. However, we note that eligible hospitals or CAHs do not need to explore every specialty society with which their hospital-based specialists may be affiliated. The hospital may simply check with their state’s and any such organization with which it is affiliated, and if no registries exist, they may simply exclude from the measure. For further information please see FAQ “K4363” with “K4367” for patients maintained by one or more specialized societies and for which they have made a public declaration of readiness to receive data for meaningful use not later than the first day of the provider’s EHR reporting period. Two registries maintained by a public health agency and one or two registries maintained by a specialty society and one or two registries maintained by a public health agency and one registry maintained by a specialty society. Two registries maintained by a public health agency and one exclusion registry maintained by a specialty society and one exclusion. One registry maintained by a public health agency and two exclusions. These registries must be maintained by a specialty society and one exclusion.

Can a provider register their intent after the first 60 days of the EHR reporting period?  

If the provider is able to use the EHR for these shared portal or PHR services, the provider must include the state’s certification number as part of their attestation.
Are Computerized Provider Order Entry (CPOE) and Clinical Decision Support (CDS) required objectives under the Medicare and Medicaid EHR Incentive Programs?

In the 2017 OPPS rule, we finalized the elimination of the CPOE and CDS objectives and associated measures for eligible hospitals and Critical Access Hospitals (CAHs). The elimination of the CPOE and CDS objectives and associated measures also applies to dual-eligible hospitals that are attesting to CMS for both the Medicare and Medicaid EHR Incentive Programs. However, the CPOE and CDS objectives and measures are still required for the Medicaid EHR Incentive Program to successfully attest to meaningful use.

Please also note we did not include CPOE and CDS objectives and associated measures as part of the advancing care information performance category, thus, they are not required for reporting by MIPS eligible clinicians.