CPCA

California Primary Care Association

Health Care Access for All

Meaningful Use Registration

TOOLKIT

CONTENTS

December 2013

Meaningful Use Registration Toolkit

The following material is meant to assist health centers when preparing and registering for Medi-Cal meaningful use incentive payments on behalf of their providers. CPCA recommends that at least one person at the health center review all the material in the Tool Kit, and then determine the key staff at the organization to handle the various aspects of meaningful use. CPCA encourages the user of the Tool Kit to adapt the resources as is appropriate for his/her health center.

The goal of the California Primary Care Association (CPCA) is to assist our members by providing technical assistance and helping to navigate the licensing and certification process.

About the Sections

FAST FACTS ON MEDI-CAL MEANINGFUL USE INCENTIVES (PAGE 5)

This section is intended for a CEO / CIO / CMO or other management that is overseeing the meaningful use incentives program at the health center. It contains the most relevant information related to meaningful use and applying for a payment for stage 1.

PHYSICIAN ASSISTANT-LED (PAGE 12)

We address Physician Assistant-Led (PA-Led) qualifications in the meaningful use incentive program. It contains the most relevant information related to criteria that must be met in order to attest as a PA-Led site and how to qualify all the PA's at an organization. A sample PA-Led attestation form is also included for reference.

READINESS CHECK LIST (PAGE 13)

Intended for a CEO / CIO / CMO or other management that is overseeing meaningful use incentives program at the health center. The checklist is an attempt at an exhaustive list of items and data necessary for applying and receiving meaningful use incentive payments. It is likely that more than one management level position at the health center will need to review this document and coordinate an appropriate process.

CEO SCRIPT (PAGE 20)

This section contains a suggested framework of talking points and elements to include when a CEO or a CMO approaches their providers about the incentive payments and reassigning the payment to the health center. CPCA created the elements in the script to be tailored to a conversation or a letter. Each CEO/CMO should determine which elements make the most sense to include in their conversations with providers. Key provisions of the meaningful use rule that would be applicable for providers can be found in the The Basics: Medicaid Meaningful Use for Providers. (see page 21).

THE BASICS: MEDICAID MEANINGFUL USE FOR PROVIDERS (PAGE 21)

This section is meant to accompany communication the CEO or CMO has with providers about meaningful use. It is an attempt to distill the meaningful use information down to what a provider would be interested in and what is relevant to him/her.

REGISTRATION ORGANIZER (PAGE 24)

The Registration Organizer outlines all the information a health center will need in order to register for the meaningful use incentives, either as a group or assisting their providers individually.

CONTRACT TEMPLATE (PAGE 38)

The contract template was created by CPCA legal counsel, Lawrence B. Garcia with Gordon and Rees LLP, and is meant to serve as a template for health centers looking to revise contracts with their providers. This contract template is not a substitute for the guidance, counsel or advice of legal counsel on any matters particular to a specific primary care clinic.

DENTISTS AND MEANINGFUL USE (PAGE 40)

This section is a tool for dentists at health centers to use in understanding meaningful use and how they can participate. At one time meaningful use was a challenge for dentists, but now that a limited number of certified EDRs have been developed the transition for dentists have been easier. Further there were no oral health measures in Stage 1 clinical quality measures originally, but in 2014 there are an additional two dental measures that a dentist could report. An MU for Dentists Tip sheet is included as a helpful tool.

STAGE 1 CLINICAL QUALITY MEASURES AND FUNCTIONAL OBJECTIVES AND MEASURES (PAGE 54)

The measures for Stage 1 meaningful use are included as a reference.

2014 CLINICAL QUALITY MEASURES FOR STAGE 1 AND STAGE 2 (PAGE 69)

Beginning 2014 Clinical Quality Measures will have changed due to Stage 2 final rule. This section will give more insight into the changes to CQMs and include the 2014 CQMs as a reference.

STAGE 2 OBJECTIVES AND MEASURES (PAGE 98)

We give a brief introduction to Stage 2 final rule, objectives and measures. A link is provided to the stage 2 objectives and measures as a reference.

Fast Facts on Medi-Cal Meaningful Use Incentives

Overview

- Providers must qualify for the meaningful use program every year. Likewise, they must also decide every year if they want to reassign the payment.
- In order to be eligible to receive incentive payments the eligible professional must use certified EHR technology.
- The ONC has a website listing all certified EHR technologies.
  The website address is: http://onc-chpl.force.com/ehrcert.

Qualifying Medicaid Eligible Professionals (EPs)

CLASSES OF ELIGIBLE PROFESSIONAL IN THE MEDI-CAL PROGRAM

- Non-hospital based[1]
  - Physicians – a doctor of medicine (MD) or osteopathy (DO), and optometrists[2]
  - Dentists (DDS or DMD)
  - Certified nurse-midwives,
  - Nurse practitioners, and
  - Physician assistants (PA) who are practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) led by a physician assistant.[3]

ENCOUNTER THRESHOLDS

- EPs must have 30% of their encounters attributable to Medi-Cal over any continuous 90-day period within the most recent calendar year prior to reporting.
- Or, if an EP **practices predominantly** at a FQHC or RHC, then the EP must have 30% of his/her encounters attributable to "needy individuals"
  - **Needy individuals.** Medi-Cal, Healthy Families, 1115 Waiver individuals, sliding fee scale, and uncompensated care.[4]
  - **Practices predominantly.** Clinical location for over 50 percent of his/her patient encounters over a period of 6 months in the calendar year prior to reporting occurs at a FQHC or RHC or in the 12 month period prior to attestation.
- **Pediatricians** are eligible if 20% of their encounters are attributable to Medi-Cal or for an EP that practices predominantly at a FQHC or RHC, 20% of their encounters to needy individuals; however, they are only eligible for 2/3 of the incentive amount if they can only reach 20%. If the pediatrician can reach the 30% threshold (s)he is eligible for the full incentive amount.

The meaningful use incentive payments are directed at eligible professionals (EPs), not the health center. EPs can reassign their incentive payments to their employer if they choose to.

1. A hospital-based eligible professional (EP) is defined as an EP who furnishes 90% or more of their covered professional services in either the inpatient (Place of Service 21) or emergency department (Place of Service 23) of a hospital.
2. Optometrists are technically eligible for program year 2013, but at the time of publication cannot yet register in the SLR. Please refer to http://medi-cal.ehr.ca.gov for the latest updates on optometrists ability to participate in the Medi-Cal Meaningful Use program.
3. In California a FQHC is PA-led when either a PA is currently the primary provider in the clinic (i.e. the PA has more encounters or hours relative to the other eligible providers) months or when a PA is a clinical director at the clinical site of practice. For more detail refer to section III.PA-led FQHCs.
4. Healthy Families is transitioning to Medi-Cal. Patients who transitioned already encounters will count towards Medi-Cal encounters

DEFINITION OF ENCOUNTER (30% MEDICAID)

- Services rendered to an individual on any one day where Medi-Cal (or a Medicaid demonstration project under section 1115 of the Act) paid for part or all of the service, and effective January 1, 2013 providers may count "billable" services provided to Medi-Cal-enrolled patients as Medicaid encounters regardless of whether Medicaid paid for any portion of the services; or
- Medi-Cal (or a Medicaid demonstration project under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, and cost-sharing.

DEFINITION OF ENCOUNTER (30% NEEDY)

- Services rendered to an individual on any one day where Medi-Cal or Healthy Families (or a Medicaid or CHIP demonstration project under section 1115 of the Act) paid for part or all of the service.
- Medi-Cal or Healthy Families (or a Medicaid or CHIP demonstration project under section 1115 of the Act) paid all or part of the individual's premiums, co-payments, or cost-sharing.
- The services were furnished at no cost.
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

For FQHCs, if there are EPs that want to use the group proxy to prove eligibility, the only ones that can use the 30% needy threshold are those that practice predominantly. However, EPs at FQHCs can use the 30% Medi-Cal threshold as a proxy as long as the EP provided at least one Medi-Cal encounter at the FQHC during the year eligibility is being determined.

QUALIFYING USING GROUP PRACTICE

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

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (i.e. 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 or group practice's patient volume determination (i.e. OSHPD annual data).
- All EPs in the group practice or clinic must 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 group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way. If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.
- All providers that contribute to group volumes during the representative period must be listed as group members, even if the provider is not eligible or applying for MU
- Providers that are apart of groups must still have their own individual account on the SLR for reporting purposes.

PREQUALIFICATION

- The state has created a methodology for providers in California called prequalification. For 1204(a) clinics prequalification will involve the state analyzing the OSHPD data submitted from the year prior and determining if the site achieved the 30% Medi-Cal and/or 30% Needy threshold.
  - If the site achieves one or both of the thresholds the state will send a letter to the FQHC that they are prequalified. It is then up to the FQHC to choose which providers can use the prequalification threshold as a proxy for their own.
  - The benefit to prequalification is that it uses 1 year of data rather than just 90 days so any provider that contributed at least one Medi-Cal encounter during that year would be eligible if the FQHC were prequalified at 30% Medi-Cal. And any provider that practices predominantly and provided at least one needy encounter would be eligible if the site were prequalified at 30% Needy.

- Even if an EP uses the clinic or group practice's patient volume as a proxy for his/her own, (s)he is not required to reassign the incentive payment to the FQHC.
- An EP can choose the practices (s)he wants to use in proving eligibility, and is not required to use encounter data from all practice locations. The only requirement is that one of the locations be where the certified EHR technology is located.

> For example, if an EP was hired to the FQHC this year, the EP could not use the FQHCs group encounter rate as a proxy since (s)he didn't contribute to the encounter rate last year. (S)he would need to use the encounter data from practice locations last year and at least one of those would need to have a certified EHR now or be in the process of adopting / implementing / upgrading.

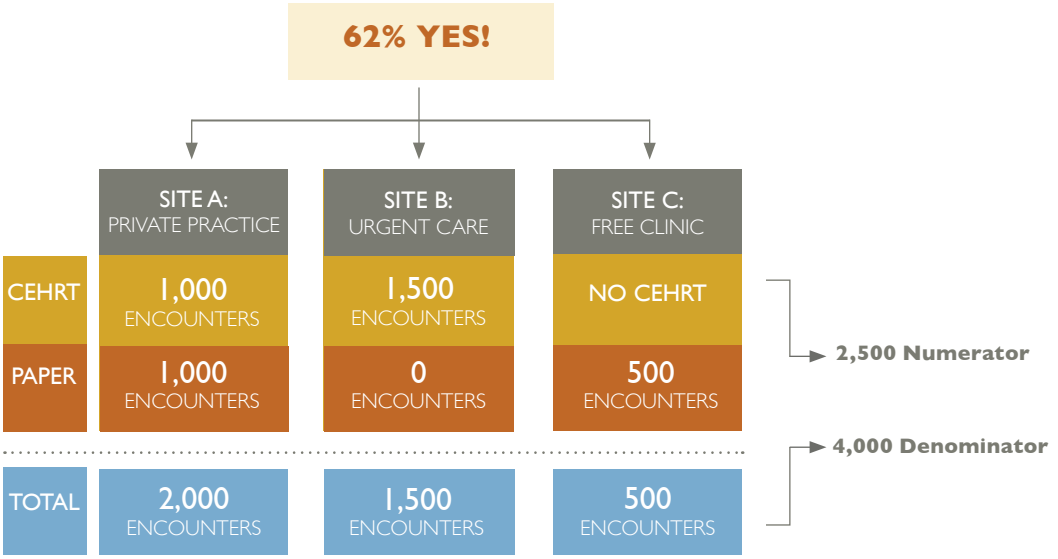
- Full or part-time status is of no consequence to the EHR incentive program. Both a full time and a part time provider could receive the full incentive amount. Eligibility is based on encounters, not work hours.

50% MU provision

- In order for an EP to be considered a meaningful EHR user, at least 50% of the EP's patient encounters during the EHR reporting period must occur at a practice/location or practices/locations equipped with CEHRT.
- A location is considered equipped with CEHRT if CEHRT is available at the start of the reporting period.
- EPs who do not conduct 50% of their patient encounters in any one practice/location would have to meet the 50% threshold through a combination of practices/locations equipped with CEHRT.
- EPs who do not meet this criteria are not eligible to participate in the EHR Incentive Program.

CALCULATING 50% MU PROVISION

During the EHR reporting period, does the eligible professional have **50%** or more of all of their **patient encounters** at a practice location or locations equipped with a CEHRT?



Medicaid Incentive Payments

- Funds the health center received for HIT or an EHR do not count against the incentive payments an EP can receive.
- The meaningful use incentive payments are directed at EPs, not the health center. EPs can reassign their incentives to their employer if they choose to.
- There are no rules or requirements on what must be done with the incentive payments once received.

Reassignment of incentive payment:

- EPs are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services.
- EPs can only reassign if the contract is current.
- EPs can receive or assign payment to only one location, even if they work at multiple locations.

The 1a terminology is a reference used by CPCA, but not endorsed by CMS. 1a signifies the changes CMS made to Stage 1 in the Stage 2 final rule.

Reporting and Payment Years for the Medicaid Program

- MU is comprised of three stages. Each stage has its own payment years and program years. Each stage takes two years to complete, except AIU.

Receiving Payments

FIRST YEAR

In the first year of payment in the Medicaid EHR incentive program an EP may choose to attest to adopting, implementing or upgrading certified (A/I/U) EHR technology.

- **Adopting.** Acquire, purchase or secure access to certified EHR technology (signed contract counts).
- **Implementing.** Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements.
- **Upgrading.** Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.
- **A/I/U** payments to EPs will be within 60 days of application/submission. If payment is not received by this window send an email, including Group or Individual NPI, to Medi-Cal.EHR@dhcs.ca.gov.

SECOND YEAR

In the second year of payment an EP must achieve the first year of meaningful use Stage 1 measures for a 90 day consecutive period.

THIRD AND FOLLOWING YEARS

In the third and following years of payment an EP must achieve meaningful use for 365 days

- **Stage 1**. Providers 365 days in the second year of reporting.
- **Stage 2**. Providers will have to achieve and report meaningful use for 365 days each year.
- **Stage 3**. Providers in the Medicaid MU program will only have to report 365 days of MU data for one year.

Incentive Payments for A/I/U and Meaningful Use of Certified EHR

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
2011	$21,250 AIU	$8,500 Stage 1	$8,500 Stage 1a*	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$0	$0	$0	$0	$63,750
2012		$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$0	$0	$0	$63,750
2013			$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$0	$0	$63,750
2014				$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$0	$63,750
2015					$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$63,750
2016						$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 2	$63,750 Stage 3

**Eligibility is required (30% Medi-cal or Needy) but there is NO reporting period.*

The 1a terminology is a reference used by CPCA, but not endorsed by CMS. 1a signifies the changes CMS made to Stage 1 in the Stage 2 final rule.

The last year that an eligible professional can begin participation in the Medicaid EHR Incentive Program is 2016.

EXCEPTION: Any provider participating in MU in 2014, no matter the stage, will only have to report for 90 days. Due to EHR upgrading to a new certification level in 2014 and the federal government is trying to afford providers with an opportunity to adapt.

- The Medicaid EHR Incentive Program will continue to pay incentives through 2021. Eligible professionals can participate for 6 years, and participation years do not have to be consecutive.

MU Program Year Break Down

Each stage takes two years to complete, therefore, program years are used to aid in deciphering what stage year of attestation/reporting participants may be in. It is important to understand that MU eligibility is based on prior year data, reporting is based on the current year, and payment is either made in the program year or the following year, depending on timing of submission.

PROGRAM YEAR 1 = STAGE AIU

- $21,250 is paid
- Must meet 30% Medi-Cal or Needy for the year prior
- Must be an eligible provider
- Attest that you have a certified EHR

PROGRAM YEAR 2 = STAGE 1 MEANINGFUL USE (FIRST YEAR)

- $8,500/year
- Must meet 30% Medi-Cal or Needy for the year PRIOR and 50% meaningful user provision for reporting year
- Attest to achieving MU over 90 days for program year
  - i.e. Attesting/Reporting 90 days of data has to be in current program year

PROGRAM YEAR 3 = STAGE 1 MEANINGFUL USE (SECOND YEAR)

- $8,500/year
- Must meet 30% Medi-Cal or Needy for the year PRIOR and 50% meaningful user provision for reporting year
- Attest to achieving MU over 365 days for program year
  - If program year is 2014, 90 days of data has to be reported[5]

PROGRAM YEAR 4 = STAGE 2 MEANINGFUL USE (FIRST YEAR)

- $8,500/year
- Must meet 30% Medi-Cal or Needy for the year PRIOR and 50% meaningful user provision for reporting year
- Attest to achieving MU over 365 days for program year
  - Reporting 365 days of data has to be in current program year

5. For 2014 ONLY, reporting regardless of stage is 90 days. Every other year is 365 days of reporting.

PROGRAM YEAR 5 = STAGE 2 MEANINGFUL USE (SECOND YEAR)

- $8,500/year
- Must meet 30% Medi-Cal or Needy for the year PRIOR and 50% meaningful user provision for reporting year
- Attest to achieving MU over 365 days for program year
  - Reporting 365 days of data has to be in current program year

PROGRAM YEAR 6 = STAGE 3 MEANINGFUL USE (FIRST YEAR)

- $8,500/year
- Must meet 30% Medi-Cal or Needy for the year PRIOR and 50% meaningful user provision for reporting year
- Attest to achieving MU over 365 days for program year
  - Reporting 365 days of data has to be in current program year

Meaningful Use Objectives and Clinical Quality Measures

Stages of Meaningful Use

FIRST PAYMENT YEAR	PAYMENT YEAR				
	2011	2012	2013	2014	2015
2011	Stage 1	Stage 1	Stage 2	Stage 2	Stage 3
2012		Stage 1	Stage 1	Stage 2	Stage 2
2013			Stage 1a	Stage 1a	Stage 2
2014				Stage 1a	Stage 1

- While an EP may reassign payment to an entity and may use the entity's encounter rate to qualify, meaningful use objectives and measures must be tracked and reported by the individual EP, as determined by unique National Provider Identifier (NPI).
- CMS has clarified that it does not necessarily have to be the EP him/herself that reports the data, but rather there will be a manner for a third party to do so on behalf of the provider. The third party will only be able to report by provider, however, and cannot report on behalf of a group.
- Meaningful Use Stage Measures and Objectives can be found in Section Stage 1 Clinical Quality Measures and Functional Objectives and Measures.

CMS has issued a final rule for Stage 1 and Stage 2 meaningful use. Due to Stage 2 final rule being implemented Stage 1 now has a Stage 1a to implement the changes generated from Stage 2.

Eligibility is based on the program year the PA is applying for and eligibility must be re-established every year.

Physician Assistant-Led

PA-Led Eligibility

Physician Assistants (PA) who are practicing at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or FQHC Look-Alike are considered Eligible Professionals if the FQHC is led by a PA.

Eligibility is established when at least one PA acts as:

- Clinical Director, or
- Dominant provider, as compared to other providers
  - PA was assigned the most patients
  - PA had the most patient encounters
  - PA had the most practice hours

HOW IS ELIGIBILITY ESTABLISHED

- If one PA at a site of a multi-site organization is determined eligible, all the other PA's across the organization (under one Tax ID), even those not at that site, are then considered eligible.
- The lead PA must sign and date the attestation form on the day he/she led the FQHC.
  - All other PA's must sign and date their forms with the date that the lead PA was leading the FQHC.

IMPORTANT NOTES ON HOW TO COMPLETE THE ATTESTATION FORM

PA-led Attestation Form is located on Department of Health Care Services website at: www.dhcs.ca.gov/provgovpart/Documents/OHIT/PA-led attestation3.docx.

- Every PA who intends to participate in the Meaningful Use program must fill out and sign a PA-led form. The lead PA must also fill out and sign a form, even if he/she does not intend to participate.
- The PA led form must be submitted with registration for the program.
- When filling out the form, the section for clinic information is relevant to the site where the lead PA is the dominant provider or clinical director.
- The lead PA's name and NPI is for the section: Name of PA who presently leads the clinic.
- The eligible PA's name and signature is necessary at the very bottom of the form.
  - Only in the case of the Lead PA does the middle section and bottom name/signature match.
- The date on the PA led forms should be the same for all the PA's at the organization if the organization is using the PA led dominant provider option and is choosing one day which the PA led the FQHC/RHC.

Readiness Check List

Getting Started

RESEARCH EHR PRODUCTS

- If you enroll with a REC, the REC or its LEC will assist you in researching products and negotiating with vendors. If you choose to not enroll with a REC, make sure you go through a thorough vendor vetting process.

To see a list of which EHR products clinics and health centers are using in California, visit: www.cpca.org/cpca/assets/File/2010-11-03-EMR-Products-List.pdf.

- When researching EHR products keep in mind your practice workflow, gaps that the EHR technology can fill, process that it can improve and your future goals for usage.

EHR PRODUCT CERTIFICATION TIMELINE

- Talk to your vendor(s) about their timeline for getting the product(s) certified.
- Certified EDRs and modules for dentists have been developed in addition to the certified EHR products available. Dentists that are not using a certified EDR or an EDR module must use a certified EHR in conjunction with their products in order to participate in the incentive program.

Check to see if your EHR is certified: http://onc-chpl.force.com/ehrcert#.

IDENTIFY YOUR ELIGIBLE PROFESSIONALS (EP)

- Create a spreadsheet of all the providers who are in the category of EPs. Refer to the Registration Organizer on page 24.
- Document your EPs encounters at your organization and outside (if possible).
  - The spreadsheet of encounters aids in determining which providers can/should use your health center's patient volume as a proxy and which providers may reassign their incentive to the health center, you need to understand where your providers practice and what patients they serve.
- Determine if you have any Physician Assistant (PA)-led sites. The California Medi-Cal Department will require that when PA's register they attest to being the lead PA at a FQHC or RHC or are practicing at a FQHC or RHC site that is PA led.

"PA-Led" means:

- PA is the clinical director of the site or
- PA is the dominant provider at the site determined by the following:

Compared to the other providers at the site (check one):

- PA had the most patients assigned
- PA had the most patient encounters
- PA had the most practice hours

NOTE: Refer to Physician Assistant-Led on page 12 for more information.

- Determine if you have dentists that will participate in the meaningful use program. In the first year, dentists can attest to adopting / implementing / upgrading (AIU) with a certified EHR.

ASSUMPTION: FQHC wants to work with their EPs to participate in the Medi-Cal EHR Incentive Program to receive payment year 1 ($21,250 per Eligible Professional).

REFERENCED MATERIALS

- Fast Facts on Medi-Cal Meaningful Use Incentives (page 5)
- CEO Script (page 20)
- Registration Organizer (page 24)

There are three ways for EPs to be eligible. Your EPs can: (1) individually be eligible, (2) eligible via group practice proxy, or (3) through prequalification.

UNDERSTANDING ELIGIBILITY

1. Individually

If the EP practices predominantly at a FQHC (50% or more of his/her encounters during the EHR reporting period over a 6 month period in calendar year (CY) prior to reporting occurs or in the 12 month period prior to attestation) then (s)he can use 30% needy at the organization.

[needy encounters at FQHC over 90 day period in previous CY/ total encounters at FQHC over 90 day period in previous CY] ***or***

[needy encounters at FQHC + Medi-Cal managed care panel members seen over 90 day period in previous CY / total encounters at FQHC + Medi-Cal managed care panel members assigned over 90 day period in previous CY]

If the EP does not practice predominantly at a FQHC the EP must meet the 30% Medi-Cal encounter rate or 20% for Pediatrics.

[Medi-Cal encounters over 90 day period in previous CY / total encounters over 90 day period in previous CY] ***or***

[Medi-Cal encounters + Medi-Cal managed care panel members seen over 90 day period in previous CY / total encounters + Medi-Cal managed care panel members assigned over 90 day period in previous CY]

2. Group

The FQHC can choose to use group practice eligibility with the 30% needy criteria or for only the EPs that practice predominantly (50% or more of their encounters over a 6 month period in CY prior to reporting or in the 12 month period prior to attestation).

[needy encounters at FQHC over 90 day period in previous CY / total encounters at FQHC over 90 day period in previous CY] ***or***

[needy encounters at FQHC + Medi-Cal managed care panel members seen over 90 day period in previous CY / total encounters at FQHC + Medi-Cal managed care panel members assigned over 90 day period in previous CY]

The FQHC can choose to use group practice eligibility with 30% Medi-Cal eligibility, and could include any EP that provided at least 1 Medi-Cal encounter in the 90 day period chosen.

[Medi-Cal encounters over 90 day period in previous CY / total encounters over 90 day period in previous CY] ***or***

[Medi-Cal encounters + Medi-Cal managed care panel members seen over 90 day period in previous CY / total encounters + Medi-Cal managed care panel members assigned over 90 day period in previous CY]

3. Prequalification

- The state will be prequalifying individual providers, providers in managed care counties, and 1204(a) licensed clinics.
- 1204(a) licensed clinics will be prequalified by the state using the 2010 OSHPD data submitted. The state will look at the FQHC site's patient encounters over the full year and determine whether the site achieves the 30% needy threshold and/or the 30% Medi-Cal threshold.
- If the site achieves the 30% needy threshold, the state will send the FQHC a letter indicating the site is prequalified and next steps for registering the providers using group proxy eligibility. The site is then responsible for choosing which providers to register as a group. Only the providers that practice predominantly can go with the prequalification for 30% needy.
- If the site achieves the 30% Medi-Cal threshold, the state will send the FQHC a letter indicating the site is prequalified and the next steps for registering their providers using group proxy eligibility. The site is then responsible for choosing which providers to register as a group. Any provider that provided at least 1 Medi-Cal encounter during the OSHPD reporting year is eligible to be in the group.
- If the site achieves both the Medi-Cal and needy rate the site can choose which rate to go with.

Questions Regarding Prequalification criteria should be sent to DHCS at Medi-Cal.EHR@dhcs.ca.gov.

METHOD OF ELIGIBILITY

Determine if you are going to be prequalified (look at the OSHPD data submitted for last year) and which providers would be eligible to be included in the prequalification method. If you are not going to be prequalified or you will choose not to register your group with the prequalification method, determine if you will use a group practice encounter calculation (30% needy or 30% Medi-Cal) or if it's better for your EPs to prove eligibility with their own panel data.

- If your EPs do use the group encounter rate, then ALL of the EPs that are eligible for group must use the group encounter rate. You cannot have some EPs use the group data and others try and use their own panel data from the site. If an EP wants to go with another group or register independently using encounter data from another practice, this would not impact the FQHC using group proxy for the rest of their EPs. Refer to the Fast Facts on Medi-Cal Meaningful Use Incentives on page 6 for more information on group eligibility.

OSHPD Medi-Cal and Needy Encounters

MEDI-CAL AND NEEDY	NEEDY ONLY	DOESN'T COUNT FOR MEDI-CAL OR NEEDY
Medi-Cal	Healthy Families (through 2013)	Private Insurance
Medi-Cal Managed Care	Self-Pay/ Sliding Fee	Medicare
LIHP	Free	Medicare Managed Care
Breast Cancer Program	Alameda Alliance for Health	Other County
Family – PACT		All Other Payers
PACE		
CHDP		
LA County Public Private		

If a FQHC site is prequalified they do not have to have their providers use the prequalification data to register. Some FQHCs might determine they would prefer to wait until the state allows providers at FQHCs to use their individual encounter data to register or the FQHC site may prefer to use the 90 day period in the previous CY.

Working with Your Providers

VALUE PROPOSITION

Craft your value proposition to the EPs about why they should reassign their incentive payments to your health center.

Elements to include:

- **Encounter Rate Determination.** The easiest way for your EPs to be able to include encounters provided at your organization is if they go with group proxy. Using group proxy doesn't mean they have to reassign, but they currently do not have a way to use encounters at your organization unless they participate with the group.
  - If possible, determine what percentage of encounters your EPs perform at your organization. This will be useful to you when you negotiate. Many EPs who practice only a small portion of their time at your organization may only be able to reach the 30% Needy/ Medi-Cal rate because of their service at your organization. See the Registration Organizer on page 24 for all the information you will need to collect.
- **Applying for and Reporting on Meaningful Use.** It would be difficult for individual EPs to manage this task without your organization.
- **Attesting to A/I/U.** The provider will need to supply a signed contract with the certified EHR vendor or a work plan for implementing the certified EHR or something that proves the provider is adopting/ implementing/or upgrading to a certified EHR. This documentation is most likely held by the FQHC leadership.
- **Taking Over the Liability (Fraud/Abuse, Tax, etc.).** Once an EP reassigns payment, the health center absorbs the fiduciary duty of the contract for the incentive payments. If the EP were to take the incentive him/herself, (s)he would have to pay the taxes on the payment.

COORDINATING WITH OTHER ORGANIZATIONS

If you share or contract with another organization for your providers, have a conversation with those entities, about which entity the EPs should reassign to if they choose to reassign the incentive payment, and if they reassign determine if just one organization will take the incentive payment or if it will be shared.

TALK TO YOUR PROVIDERS

Have a conversation with your EPs, either individually or as a group, about the incentives. Refer to CPCA's CEO Script on page 20.

- Discuss the advantages of using the group practice eligibility calculation and the possible ease of the prequalification method.
- Discuss what it takes to qualify for the incentives and to achieve meaningful use.

CONTRACTS

Update your provider contracts to reflect the meaningful use incentive payments and to account for the reassignment.

- CPCA has created a template contract to be revised to fit your FQHC's needs. Refer to the Contract Template on page 38.

- You may want to review the brief on reassignment of incentive payments the National Association of Community Health Centers (NACHC) has created to reevaluate your provider contracts. Click here to see the language. You will want your own legal counsel to ensure your updated contracts are sound.

START NEGOTIATIONS

Identify which EPs want to share the incentive across multiple organizations, and negotiate with those entities and develop appropriate contracts post the EP choosing which entity he/she reassigns to.

Registering for the Incentives

GATHER THE APPROPRIATE MATERIAL TO REGISTER

There is a lot of information required when a provider and/or group registers, both at the federal and state level. See the Registration Organizer page 24 for all the information you will need to collect.

FQHC REPRESENTATIVE

- Users working on behalf of an Eligible Professional(s) must have an Identity and Access Management system (I&A) web user account (User ID/Password) and be associated to the Eligible Professional's NPI. If you are working on behalf of an Eligible Professional(s) and do not have an I&A web user account click here to create a login in the I&A system.

FEDERAL REGISTRATION

The national registration website: https://ehrincentives.cms.gov/hitech/login.action.

- If the EP registers him/herself the EP will need to have a NPPES username and password to log on to the system. CMS will allow a third party to register the provider.

To create a NPPES account visit: http:nppes.cms.hhs.gov/NPPES/createloginforexistingNPIpage.do

STATE REGISTRATION

The state's registration portal can be found at: http://Medi-Cal.ehr.ca.gov/.

Important elements FQHC needs to be aware of in preparing for the meaningful use incentives:

- An FQHC representative will be able to register on behalf of the EPs they employ or contract with.
- All EPs must have a separate registration from the FQHC group regardless of whether or not their organization is applying on their behalf. This is because the EP must sign and attach the attestation page at the very end.
- A FQHC representative can register an EP even if the EP does not reassign the payment to the FQHC.
- When the FQHC enrolls the EPs in their group, the FQHC's information will be auto-populated into the EP's individual registration. For example, when the FQHC submits information about the EHR used, it will auto-populate into the EP's registration.
- A FQHC can use the group eligibility formula for the EPs it enrolls, but it's possible for an individual EP to eliminate the health center's ability to do so. This could happen if the FQHC enrolls the EP in their group practice eligibility, but then the EP applies for the incentives on his/her own. If the EP were to do this, it would send a WARNING to the EP and the FQHC that there is a conflict of information. The other EPs would not be able to use the group practice calculation if the EP did this, but there will be time for the EP and the FQHC to discuss before the system wipes out the FQHC's group eligibility allowance.

Designate an individual at your organization to register on behalf of the EPs that have agreed to reassign the payment.

There is no timeline in place for adopt. An organization could have adopted in late 2010 when the product they purchased was certified and be in the middle of an implementation and still choose this option.

CALCULATE WHAT YOUR ORGANIZATION WILL RECEIVE

- Number of EP's that reassigned x $21,250 = Total. (Example: 10 x $21,250 = $212,500)
- CMS issued a letter to the state Medicaid departments indicating that as long as an EP meets all the requirements, (s)he would be eligible for the full incentive amount.

FIRST YEAR OF PAYMENT

Determine how the organization will receive the first year of payment, either adopting/implementing/upgrading (a/i/u).

- **Adopting.** Have a signed contract by the vendor and the organization. California Department of Health Care Services will want to see a scanned version with both signatures. There will also be a free text field that asks the respondent to explain why he/she or the organization meets the requirements for this option.
- **Implementing.** The state will require an action plan for implementation. There will be a choice to fill out a template or upload the health center's action plan. There will also be a free text field that asks the respondent to explain why he/she or the organization meets the requirements for this option.
- **Upgrading.** Have a signed contract of the certified EHR product by the vendor and the organization. There will also be a free text field that asks the respondent to explain why he/she or the organization meets the requirements for this option.

DUE DILIGENCE

Once the FQHC and the EPs register, make sure DHCS has all the information necessary.

- The state has 60 days after all information is approved and verified to release the incentive payment to the tax identification number (TIN) supplied for the EP.
- The state anticipates this process being much faster if the FQHC goes through the prequalification method.

DOCUMENT PAYMENT YEAR

Once payment is received, document First Year of Payment amount next to each EP in the Registration Organizer on page 24.

- Remember each EP can only receive up to 6 years of incentive payments, or $63,750. Tracking this will be very important if you have EPs at various payment years and stages of meaningful use. (May be helpful to track on Registration Organizer)

PRACTICE REPORTING MEANINGFUL USE DATA

Begin practicing or doing test runs of meaningful use. Refer to the Stage 1 Clinical Quality Measures and Functional Objectives and Measures on page 53.

- To receive the second year of payment, the EP must report on meaningful use over a 90 day period by submitting electronic reports (not attest) and must reach all the required percentages in order to be successful.

Last Step

SCOPE OF SERVICE CHANGE

Assess if the adoption and implementation of your EHR system can qualify as a triggering event for a scope of service change for an adjustment in your health center's reimbursement rate.

- Triggering events must directly impact the intensity, duration or amount of services provided, or any combination thereof.
- Following a CPCA case study in 2008 that documented how the implementation of an EHR impacted the services at one health center in a manner sufficient to qualify for an adjustment to the rate, a number of health centers have since successfully used this event to trigger a scope of service change request.

ASSUMPTION:
The eligible professional being approached meets the eligibility criteria.

CEO Script

Sample Script for Speaking to Providers

In 2009, as part of the Stimulus Package, Congress appropriated $36 billion for the adoption and meaningful use of electronic health records. The meaningful use incentive payments were created to accelerate the use of health information technology in America's health care delivery system. Congress fashioned the incentives to be paid to providers, and included a process for providers to reassign the incentive payment to his/her employer. Reassignment recognizes that it's usually the group practice or employer that purchases and maintains the EHR, not the provider. The incentive payments are structured to help mitigate the high upfront and ongoing costs of an EHR.

[Clinic/health center] has made a considerable investment in an EHR system in order to provide high quality health care to our patients. This system will provide us with instant access to charts, standardization, population and disease management, as well as access to medical databases. In the future it will allow **[Clinic/health center]** to communicate with other medical facilities, both locally and nationally which will enable us to better serve our patients. The system we purchased is capable of achieving the meaningful use measures and objectives, and as new components of meaningful use are developed by the government our EHR vendor will help ensure our EHR can keep achieving meaningful use criteria.

While the incentive payments are considerable they are not intended, nor do they, cover the cost of purchasing and maintaining an EHR.

[Clinic/health center] intends to participate in the meaningful use incentive program and we'd like you to participate with us in that endeavor. That partnership begins with your reassigning the incentive payment to the [clinic/health center].

There are many reasons I think you would want to reassign the payment to the **[Clinic/health center]**.

First, taxes. If you reassign the payment to the [clinic/health center] you do not absorb the taxes associated with the incentives. While we do have to input your name and information into the system to receive the incentive, we would put the **[Clinic/health center]** tax ID number, and that is the entity that is responsible for the taxes.

In line with taxes and the IRS, by reassigning you are putting the [clinic/ health center] in charge of managing the fraud and abuse implications with accepting the incentives, and the investigations that could occur. Our state Medicaid department has told our state association, the California Primary Care Association that they are going to be extra vigilant about fraud and abuse and make sure there is no abuse or illegitimate requests for incentive payments.

Lastly, registering and reporting all the measures required to achieve meaningful use of an EHR will be onerous and time intensive. By reassigning the payment we are taking over this responsibility from you. Of course there will be some limited time involved in the registration process, where we will need some of your information and a signature, but it will be minimal. And for the reporting, we will have to report by your NPI, not the clinics aggregate measures, so we will expect that you work to achieve the measures individually, however the reporting won't be necessary until next year. We will work as a team to make sure everyone can do this.

The Basics: Medicaid Meaningful Use for Providers

Qualifying for Medi-Cal Meaningful Use

WHAT TYPES OF PROVIDERS ARE ELIGIBLE?

- Physicians – a doctor of medicine (MD) or osteopathy (DO), and optometrists[6]
- Dentists (DDS or DMD)
- Certified nurse-midwives,
- Nurse practitioners, and
- Physician assistants who are practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) led by a physician assistant.[7]

WHAT TYPES OF PATIENTS DO ELIGIBLE PROVIDERS HAVE TO SERVE?

- Providers must have 30% of their encounters attributable to Medi-Cal over any continuous 90-day period within the most recent calendar year prior to reporting.
- If a provider provides, practices predominantly, more than 50% of his/her encounters over a 6 month period at a FQHC or RHC, then the provider must have 30% of his/her encounters attributable to "needy individuals" or patients who have Medi-Cal or Healthy Families coverage, 1115 Waiver Individuals, sliding fee scale, or who are provided uncompensated care.
- Pediatricians are eligible if 20% of his/her encounters are attributable to Medi-Cal, or for an EP who practices predominantly at a FQHC or RHC, 20% of their encounters to needy individuals. If the pediatrician practices predominantly at a FQHC/RHC; however, (s)he is only eligible for 2/3 of the incentive amount if only the 20% threshold can be achieved. If the pediatrician can reach the 30% threshold (s)he is eligible for the full incentive amount.
- Providers can also be eligible using group practice eligibility, which means the provider can use the health center's Medi-Cal (or needy if he/she practices predominantly) rate as a proxy for his/her own.
  - Group proxy would be over a 90 day period or if the clinic or health center is prequalified by the state of California using the OSHPD data from the year prior the group proxy would be over a full year.
  - In order to use the group proxy for the 30% Medi-Cal rate a provider must have contributed at least one Medi-Cal encounter during the respective time period. In order to use the group proxy for the 30% Needy rate a provider must practice predominantly and have contributed at least one needy encounter in the respective time period.

Providers must have 30% of their encounters attributable to Medi-Cal over any continuous 90-day period within the most recent calendar year prior to reporting.

6. The state must pass legislation to make Optometrists eligible in California. This has not happened yet.
7. In California a FQHC is PA-led when either a PA is currently the primary provider in the clinic (i.e. the PA has more encounters or hours relative to the other eligible providers) months or when a PA is a clinical director at the clinical site of practice. For more detail refer to section III.PA-led FQHCs.

Incentive Payments for A/I/U and Meaningful Use of Certified EHR

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
2011	$21,250 AIU	$8,500 Stage 1	$8,500 Stage 1a*	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$0	$0	$0	$0	$63,750
2012		$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$0	$0	$0	$63,750
2013			$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$0	$0	$63,750
2014				$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$0	$63,750
2015					$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 3	$0	$63,750
2016						$21,250 AIU	$8,500 Stage 1a	$8,500 Stage 1a	$8,500 Stage 2	$8,500 Stage 2	$8,500 Stage 2	$63,750 Stage 3

**Eligibility is required (30% Medi-cal or Needy) but there is NO reporting period.*

The 1a terminology is a reference used by CPCA, but not endorsed by CMS. 1a signifies the changes CMS made to Stage 1 in the Stage 2 final rule.

Medi-Cal Incentive Payments

- A provider that meets the qualifications is eligible for up to $63,750. Please see the chart on page 22 for a breakdown of payments.
- The incentive payments are intended to promote implementation and meaningful use of electronic health record (EHR) and, in turn, improve health outcomes.
- Providers, can receive and pay taxes on the incentive payments themselves, or reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the provider's covered professional services. Reassignment puts the tax responsibility on the provider's employer.
- Providers can receive or reassign payment to only one location, even if they work at multiple locations.
- While an EP may reassign payment to an entity and may use the entity's encounter rate to qualify, meaningful use objectives and measures must be tracked and reported by the individual EP, as determined by unique National Provider Identifier (NPI).
- CMS has clarified that it does not necessarily have to be the EP him/herself that reports the data, but rather there will be a manner for a third party to do so on behalf of the provider. The third party will only be able to report by provider and cannot report on behalf of a group.

Reporting and Payment Years for the Medi-Cal Program

- In the first year of payment in the Medi-Cal EHR incentive program a provider may attest to adopting, implementing or upgrading (A/I/U) certified EHR technology
  - **Adopting:** acquire, purchase or secure access to certified EHR technology (signed contract counts)
  - **Implementing:** install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
  - **Upgrading:** expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology.

Meaningful Use Stages

- The measures and objectives (see Stage 1 Clinical Quality Measures and Functional Objectives and Measures on page 54) outlined are for the first Stage of the Meaningful Use Incentive Program. Stage 2 measures and objectives have been finalized.

Each stage aims to get providers to use an EHR in more sophisticated manners and capture and report on a wider range of clinical measures.

Included in this section are an:

- Registration Organizer Template
- Registration Organizer Example
- List of important definitions

Registration Organizer

The Registration Organizer outlines all the information a health center will need in order to register for the meaningful use incentives, either as a group or assisting their providers register individually.

CMS is allowing third party registration on the national level registry, however they do not allow for providers to register as a group. An eligible professional may elect a third party to register on his/her behalf.

On the state side in California, there will be third party registration capabilities and group registration, though even with group registration there will still be elements where a third party must fill out information for each provider in the group individually.

Registration Organizer – TEMPLATE

ORGANIZATION SITE INFO	EXPLANATION OF CATEGORY
Name	Of the organization/site or business
Address	Of the organization/site or business
Phone	Main line
Email Address	Organization email
Medicaid / NPI Number	Site's NPI
Tax Identification Number	TIN
Organization Type	FQHC, Community clinic, IPA, etc.
Organization Contact	Users working on behalf of an Eligible Professional(s) must have an Identity and Access Management system (I&A) web user account (User ID/Password) and be associated to the Eligible Professional's NPI. If you are working on behalf of an Eligible Professional(s) and do not have an I&A web user account, Create a Login in the I&A System.*
Phone	Of contact person
Email	Of contact person
ELECTRONIC HEALTH RECORD VENDOR	
ElecHR Name	Name of the certified electronic health record
Certification number	See: http://onc-chpl.force.com/ehrcert
ElecHR Version Number	See: http://onc-chpl.force.com/ehrcert
Supporting documentation	This is an option to attach documentation if something has been received. For example, if a vendor sends a letter to the provider stating that the version they are using has been certified and provides the number, the provider could choose to attach the letter as supporting documentation. **The field is not required.**
ATTESTATION OF ElecHR	
Text description of why provider/group meets this critiera	You will choose Adopt, Implement, or Upgrade. For whichever choice, you need to explain quickly why you meet that criteria. Use the definitions of Adopt, Implement, or Upgrade on the definitions tab as a basis.
Supporting documentation	You will need to upload supporting material to enforce whichever option you are attesting to.
GROUP PRACTISE ELIGIBILITY	
FQHCs Needy Encounter Rate – Prequalification	Insert percentage as reported to OSHPD for 2010
Year OSHPD data	Full year 2010
FQHCs Medi-Cal Encounter Rate – Prequalification	Insert percentage as reported to OSHPD for 2010
Year OSHPD data	Full year 2010
FQHCs Needy Encounter Rate	Insert percentage as reported to OSHPD in 2010. If OSHPD data not available determine appropriate auditable method to prove this rate. See "Definitions" tab to determine what constitutes Needy Encounters for OSHPD. Remember, only EP's that practice predominantly can use a group needy encounter rate.
90 day period previous CY	Enter specific dates

**https://ehrincentives.cms.gov/hitech/redirection.action?transferReason=CreateLogi*

Registration Organizer – TEMPLATE

ORGANIZATION SITE INFO	EXPLANATION OF CATEGORY
GROUP PRACTISE ELIGIBILITY *continued*	
FQHCs Medi-Cal Encounter Rate	Insert percentage as reported to OSHPD in 2010. If OSHPD data not available determine appropriate auditable method to prove this rate. See "Definitions" tab to determine what constitutes Medi-Cal Encounters for OSHPD. Remember, any EP that provided at least one Medi-Cal encounter last year can use the Medi-Cal group encounter rate.
90 day period previous CY	Enter specifc dates
ELIGIBILITY PROFESSIONAL	
General	
First Name Middle Name Last Name Legal Name Suffix	
Federal Exclusion Federal Exclusion Description	Exclusions are codes/reasons from either the federal or state level that would indicate that the provider has some sort of federal or state level sanction. Any provider that is federally excluded will not have their data sent to the SLR because they are not eligible to receive federal funding. There is a defined list of exclusions.
IDs	
Personal National Provider Identifier (NPI)	EP's NPI
Personal Taxpayer Identification Number (TIN)	Necessary for verification and will be requested on CMS side, but if they reassign to the clinic or health center the EP won't be taxed.
Personal TIN Type	There will be a drop down of choices
Payee NPI	If the EP is reassigning to the clinic or health center this is where the health center's NPI goes*
Payee TIN	If the EP is reassigning to the clinic or health center this is where the health center's TIN goes*
Payee TIN Type	What type of entity is the payee*

**Where the reassignment information goes.*

Registration Organizer – TEMPLATE

ORGANIZATION SITE INFO	EXPLANATION OF CATEGORY
ELIGIBILITY PROFESSIONAL *continued*	
Program	
Participation Year	An EP has 6 years to participate, select which year out of the 6 this is
Program Option	Medicare/Medicaid
State	California (EP's can only apply in one state)
State ID	Pick the CA ID
Provider Type	A choice of physician, dentist, nurse practitioner, cert. nurse midwife, or PA at PA-led FQHC or RHC
PA-led	Determined by a PA being the clinical director at the site, or that PA has more hours, encounters, or patients assigned relative to the other providers at the site.
If yes, which PA is deemed as leading	Name of PA
License Information	
Professional License Number	EP's license number
Licensing Board Name	
(Medicaid) Managed Care Organization	
Other state license number (if provider practices in another state	
Other license state	

Registration Organizer – TEMPLATE

ORGANIZATION SITE INFO	EXPLANATION OF CATEGORY
ELIGIBILITY PROFESSIONAL *continued*	
Eligibility*	
All Encounters at your Health Center Chosen continuous 90 day period in previous CY • Total Encounters at your organization (over continuous 90 day period in previous CY) • Total Encounters across all organizations (over continuous 90 day period in previous CY) % encounters at your organization	The EP will not be asked for this question, but the health center may want it to understand their EP and how many encounters are done with the health center as compared to other locations. A67/A68
Practice Predominantly Chosen continuous 6 month period in previous CY • Total Encounters at your organization (over 6 months in previous CY) • Total Encounters across all organizations (over 6 months in previous CY) % encounters at your organization	This calculation is to help you determine if the EP does practice predominantly at your FQHC. A72/A73…If over 50% of encounters are at your FQHC then the EP does practice predominantly and proceed to 30% Needy calculation (A75).
Needy Encounters Chosen continuous 90 day period in previous CY • Total Needy Encounters (only include Healthy Families, uncompensated care, sliding fee) at your organization (over continuous 90 day period in previous CY) *The CA registration will ask you to break out Needy and Medi-Cal but both Needy and Medi-cal count for the Needy determination.* • Total Encounters at your organization (over continuous 90 day period in previous CY) % Needy encounters	 A77/A78

**At the time of this publication, eligibility methods are still being crafted. The state will be doing prequalification by group site using 2010 OSHPD data. The state is considering whether they will allow groups to use to aggregate all sites to register as an organizational group or if it will be by site only. Understanding what your providers are doing at your sites and in aggregate, as well as outside the organization will assist you in strategizing how to approach the incentive program. To be kept apprised of the latest information on registration and eligibility be included on the HIT Newsletter listserve. Contact Andie Patterson at apatterson@cpca.org to be put on the list.*

Registration Organizer – TEMPLATE

ORGANIZATION SITE INFO	EXPLANATION OF CATEGORY
ELIGIBILITY PROFESSIONAL *continued*	
Medi-Cal Encounters Chosen continuous 90 day period in previous CY • Total Medi-Cal Encounters at your organization % Medi-Cal at your organization	 A82/ A67
• Total Medi-Cal Encounters across all organizations % Medi-Cal across all organizations	You will not be asked for this, but you might want to know it if you are trying to convince a provider to reassign theirn incentive payment to your FQHC. A84/ A68
Needy and Medi-Cal Encounters at your health center % Needy and % Medi-Cal at FQHC	Only if the provider practices predominantly, as determined in A74 Add A77 and A82, and divide against A67.
If your organization is in a managed care county you may choose to use the panel information as well as the straight Medi-cal figures: Panel Members • Total Panel Members Seen (that are specific to Medicaid Managed Care) at your organization • Total Assigned Panel Members (that are specific to Medicaid Managed Care) at your organization % Medi-Cal panel members served at your organization	 A92 / A93
• Total Panel Members Seen (that are specific to Medicaid Managed Care) across all organizations • Total Assigned Panel Members (that are specific to Medicaid Managed Care) across all organizations % Medi-Cal panel members served across all organizations	 A95/A96
% Needy, Medi-Cal and Panel members seen at organization	(A77 + A82 + A92) and divide by (A67 + A93)
% Medi-Cal and Panel members seen at organization	(A82 + A92) and divide by (A67 + A92)
% Medi-Cal and Panel members across all organizations	(A84 + A95) and divide by (A68 + A96)

Registration Organizer – TEMPLATE

ORGANIZATION SITE INFO	EXPLANATION OF CATEGORY
ELIGIBILITY PROFESSIONAL *continued*	
Practice Location(s) Name	Name of organization(s) where eligible encounters took place. Make sure that this location(s) has a certified ElecHR or is attesting to A/I/U if the provider wants to use encounters from this(these) locations. At least one location where eligible encounters are being used must have or plan to adopt a certified ElecHR.
Encounters in previous CY not at your health center Chosen continuous 90 day period in previous CY • Total Encounters at chosen organization(s) (over continuous 90 day period in previous CY) • Total Encounters across chosen organizations (over continuous 90 day period in previous CY) % encounters at your organization	
METHOD OF ELIGIBILITY	**Choose:** Prequalification Needy, Prequalification Medi-Cal, Group Needy, Group Medi-Cal, Individual Needy, Individual Medi-Cal
REASSIGNING PAYMENT	
Contract Updated?	Use this space to document whether the provider has agreed to reassign payment to the FQHC and whether or not the contract agreement between the FQHC and provider has been updated.
MEANINGFUL USE INCENTIVE	
Payment Year	Once payment received, document date of receipt next to appropriate payment year.
1 – $21,250 2 – $8,500 3 – $8,500 4 – $8,500 5 – $8,500 6 – $8,500	

Registration Organizer – EXAMPLE

ORGANIZATION INFORMATION				
Name	Happy Lake Clinic (Parent: Happy Place Health Center)			
Address	1414 California Blvd, Los Angeles, CA 99831			
Phone	781-999-0000			
Email Address	clinic@happylake.org			
Medicaid / NPI Number	XXXX-3435353			
Tax Identification Number	45-921-99007832			
Organization Type	FQHC			
Organization Contact	Jane Doe			
Phone	871-999-0000 ext 34			
Email	jdoe@happylake.org			
ELECTRONIC HEALTH RECORD VENDOR	NextGen Healthcare			AdvantaChart Inc
ElecHR Name	NextGen Ambulatory ElecHR			AdvantaChart
Certification number	CC-1112-345777-1			04142011-7347-1
ElecHR Version Number	5.6 SP1			7.0
Supporting documention				
ATTESTATION OF ELECHR	Adopt			
Text description of why provider/group meets this critiera				
Supporting documentation	Attachement (portions of signed vendor contract)			
GROUP PRACTICE ELIGIBILITY				
FQHCs Needy Prequalification	53%			
Year OSHPD data	2010			
FQHC Medi-Cal Encounter Rate	37%			
Year OSHPD data	2010			
FQHCs Needy Encounter Rate (over continuous 90 day period in previous CY)	50%			
90 time period	May 1 2010- July 29, 2010			
FQHCs Medi-Cal Encounter Rate (over continuous 90 day period in previous CY)	36%			
90 day time period	May 1 2010- July 29, 2010			

Registration Organizer – EXAMPLE

ORGANIZATION INFORMATION				
ELIGIBILITY PROFESSIONAL				
General				
First Name	John	Gloria	Lucinda	Robert
Middle Name	David	Lucia	Bell	Victor
Last Name	Peterson	Hernandez	Roberts	Pacheco
Legal Name	Johnathon David Peterson	Gloria Lucia Hernandez	Lucinda Bell Roberts	Robert Victor Pacheco
Exclusions				
Federal Exclusion	N/A	N/A	N/A	N/A
Description				
IDs				
National Plan and Provider Enumeration System (NPPES) user ID	jdavid444	glucia686	lbell25	rpacheco4591
National Plan and Provider Enumeration System (NPPES) password	clinics4l1fe	t0m0rr0w	1976May	56_kk_irt
Personal National Provider Identifier (NPI)	78999888	4572444	78779078	68992381
Personal Taxpayer Identification Number (TIN)	32-3434389	23-423566234	34-2466634	42-3614387
Personal TIN Type	Personal	Personal	Personal	Personal
Payee NPI	XXXX-3435353	XXXX-3435353	XXXX-3435353	XXXX-3435353
Payee TIN	24515353	24515353	24515353	24515353
Payee TIN Type	501c3	501c3	501c3	501c3
Program				
Participation Year	2011	2011	2011	2011
Program Option	Medicaid	Medicaid	Medicaid	Medicaid
State	California	California	California	California
State ID	CA	CA	CA	CA
Provider Type	Physician (MD)	Dentist (DDS)	Physician Assistant (PA)	Physician (MD)
PA-led Clinic?	Yes	Yes	Yes, PA is primary provider at Happy Lake Clinic (site of Happy Place Health Center) by most hours	Yes
If yes, supporting documentation			Time report over a 12 month period	

Registration Organizer – EXAMPLE

ORGANIZATION INFORMATION				
ELIGIBILITY PROFESSIONAL continued				
License Information				
Professional License Number	4728888	567346	676763432	4728888
Licensing Board Name	California Medical Board	Dental Board of California	California Medical Board, Physician Assistant Committee	California Medical Board
(Medicaid) Managed Care Organization	Blue Cross, Health Net…	Blue Cross, Health Net…	Blue Cross, Health Net…	Blue Cross, Health Net…
Other state license number (if provider practices in another state)	N/A	N/A	N/A	N/A
Other license state	N/A	N/A	N/A	N/A
Eligibility				
All Encounters at Your Health Center				
Chosen continuous 90 day period in previous CY	May 15, 2010 – July1 4, 2010	January 1 2010 – April 30, 2010	March 1 2010 – May 31, 2010	N/A start date with Happy Place 1-2-2011
• Total Encounters at your organization (over continuous 90 day period in previous CY)	245	150	275	
• Total Encounters across all organizations (over continuous 90 day period in previous CY)	450	400	275	
% encounters at your organization	54.44%	37.50%	100.00%	
Practice Predominantly				
Chosen continuous 6 month period in previous CY	March 1 2010 – August 31, 2010	January 1 2010 – June 30, 2010	March 1 2010 – August 31, 2010	N/A start date with Happy Place 1-2-2011
• Total Encounters at your organization (over 6 months in previous CY)	600	300	500	
• Total Encounters across all organizations (over 6 months in previous CY)	900	800	500	
% encounters at your organization	66.7%	37.50%	100.00%	
Needy Encounters				
Chosen continuous 90 day period in previous CY	May 1, 2010 – July 1, 2010			
• Total Needy Encounters (only include Healthy Families, uncompensated care, sliding fee) at your organization (over continuous 90 day period in previous CY)	100	N/A	100	
• Total Encounters at your organization (over continuous 90 day period in previous CY)	245		275	
% Needy encounters	40.82%	N/A	36.36%	

Registration Organizer – EXAMPLE

ORGANIZATION INFORMATION				
ELIGIBILITY PROFESSIONAL continued				
Medi-Cal Encounters				
Chosen continuous 90 day period in previous CY	May 1, 2010 – July 1, 2010	May 1, 2010 – July 1, 2010	June 1, 2010 – August 1, 2010	
• Total Medi-Cal Encounters at your organization	100	100	100	
% Medi-Cal at your organization	40.82%	66.67%	36.36%	
• Total Medi-Cal Encounters across all organizations	100	110	N/A	
% Medi-Cal across all organizations	22.22%	13.75%		
Needy and Medi-Cal Encounters				
% Needy and % Medi-Cal at FQHC	81.63%	N/A	72.73%	
If your organization is in a managed care county you may choose to use the panel information as well as the straight Medi-cal figures: • Total Panel Members Seen (that are specific to Medicaid Managed Care) at your organization	70	70	70	
• Total Assigned Panel Members (that are specific to Medicaid Managed Care) at your organization	600	600	600	
% Medi-Cal panel members served at your organization	11.67%	11.67%	11.67%	
• Total Panel Members Seen (that are specific to Medicaid Managed Care) across all organizations	100	100	100	
• Total Assigned Panel Members (that are specific to Medicaid Managed Care) across all organizations	600	600	600	
% Medi-Cal panel members served across all organizations	16.67%	16.67%	16.67%	
% Needy, Medi-Cal and Panel members seen at organization	31.95%	N/A	30.86%	
% Medi-Cal and Panel members seen at organization	20.12%	22.76%	19.43%	
% Medi-Cal and Panel members across all organizations	19.05%	21.00%	22.86%	
Practice Location(s) Name				John Muir Private Practice
Encounters in previous CY not at your health center				
Chosen continuous 90 day period in previous CY				September 23, 2010 – December 23, 2010
• Total Encounters at chosen organization(s) (over continuous 90 day period in previous CY)				
• Total Encounters across chosen organizations (over continuous 90 day period in previous CY)				
% encounters at your organization				

Registration Organizer – EXAMPLE

ORGANIZATION INFORMATION				
METHOD OF ELIGIBILITY	Prequalification Medi-Cal	Prequalification Medi-Cal	Prequalification Medi-Cal	Individual Medi-Cal
REASSIGNING PAYMENT	Yes	Yes	Yes	
Contract Updated?	Yes	Yes	Yes	
MEANINGFUL USE INCENTIVE				
Payment Year	Information submitted September 15, 2011	Information submitted September 15, 2011	Information submitted September 15, 2011	Information submitted September 15, 2011
1 – $21,250	Received December 14, 2011	Received December 14, 2011	Received December 14, 2011	Pending
2 – $8,500				
3 – $8,500				
4 – $8,500				
5 – $8,500				
6 – $8,500				

Registration Organizer – DEFINITIONS

TOPIC	DEFINITION	NOTES
1115 Waiver services or encounters 15% Match Expenses	See list of eligible services for the 1115 Waiver in 2010: www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MediCal_and_HCCI_Covered_Srvcs_Mar_2010.pdf. **Categories include:** hardware, software, training, bandwidth, design services, workflow, loss of productivity, other	Encounters must be over a consecutive 90-day period in the Calendar Year prior to reporting
Adopt Eligible Professional	Acquire, purchase, or secure access to certified EHR technology; • Physician (MD or DO) • Optometrist • Dentist (DDS or DMD) • Certified Nurse Midwife • Nurse Practitioner • PA at P A-led FQHC or RHC	**NOTE:** Optometrist not yet eligible.
Group Practice Eligiblity	Clinics and group practices may use the practice or clinic Medicaid patient volume (or needy individual patient volume, insofar as it applies) and apply it to all EPs in their practice under the following conditions: 1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (i.e. if an EP only sees Medicare, commercial or self-pay patients this is not an appropriate calculation). 2. There is an auditable data source to support the clinic's or group practice's patient volume determination. 3. All EPs in the group practice or clinic must 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 group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way. If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters. **Additional clarifications:** For FQHCs, only the EP's that practice predominantly may be included in the group practice eligibility for the 30% Needy Encounter Rate.	Encounters must be over a consecutive 90-day period in the Calendar Year prior to reporting

Registration Organizer – DEFINITIONS

TOPIC	DEFINITION	NOTES
Implement	Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements;	Encounters must be over a consecutive 90-day period in the Calendar Year prior to reporting
Medicaid encounter Needy Encounter	1. Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid for part or all of the service; or 2. Services rendered on any one day to an individual for where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing. Needy encounters are to those individuals that meet any of the following three criteria: 1. They are receiving medical assistance from Medicaid (Medi-Cal) or the Children's Health Insurance Program (CHIP) (Healthy Families in CA); 2. They are furnished uncompensated care by the provider; or 3. They are furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.	Encounters must be over a consecutive 90-day period in the Calendar Year prior to reporting
OSHPD Data	**Medi-Cal:** Medi-Cal, Medi-Cal Managed Care,Family PACT, CHDP; BCCT **Needy:** Medi-Cal, Medi-Cal Managed Care, EAPC, Family PACT, CHDP, BCCT, Healthy Families, LA County Public Private, Self Pay /Sliding Fee, Free, Alameda Alliance for Health	
PA-led	When a PA is the primary provider in the clinic 25% or more of the time in the last 12 months (PA has more hours or encounters or patients assisgned as compared to other eligible providers at the site) When a PA is a clinical director at the clinical site of practice 25% or more of the time in the last 12 months	
Practice Predominantly Upgrade	Clinical location for over 50 percent of eligible professional's patient encounters over a period of 6 months in the calendar year prior to reporting occurs at a FQHC or RHC. Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.	

Contract Template

ADDENDUM TO EMPLOYMENT AGREEMENT

THIS ADDENDUM is entered into and made effective as of _____, 2011 (the "Effective Date") by and between _____, a California nonprofit public benefit corporation ("Health Center"), and _____, [a California professional corporation][an individual] ("Provider"), and hereby modifies and supplements that certain Employment Agreement entered into between Health Center and Provider on [INSERT DATE] (the "Agreement").

RECITALS

A. Whereas, the Medicare and Medicaid Electronic Health Record Incentive Programs (the "Program") under the American Recovery and Reinvestment Act of 2009 ("ARRA") provide incentives to Eligible Professionals (as defined under ARRA) for the adoption, implementation, upgrading, and meaningful use of certified electronic health records.

B. Whereas, providers at federally qualified health centers who are Eligible Professionals are eligible for incentive payments (the "Incentive Payments") under the Program, provided that they meet the requirements set forth under ARRA.

C. Whereas, Eligible Professionals participating in the Program may reassign the Incentive Payments to state-designated entities that promote the adoption of Electronic Health Record ("EHR") technology (individually, a "Designee").

D. Whereas, Provider is an Eligible Professional under the Program and Health Center is a Designee for purposes of the Program.

E. Whereas, Provider and Health Center have agreed to this Addendum to modify and supplement the Agreement in order to allow Provider to reassign Provider's Incentive Payments to Health Center.

AGREEMENT

NOW THEREFORE, in consideration of the mutual covenants and promises herein contained, the parties agree as follows:

1. **Agreement.** Under and pursuant to the Agreement, Provider agreed that Health Center would be the exclusive entity to bill and collect, under its own tax identification number and provider number, for all professional services rendered by the Provider.

2. **EHR Program.** Provider understands that Health Center is adopting, implementing, and/or upgrading its health information technology systems to comply with the Program. Provider agrees to assist Health Center in meeting the obligations and objectives set forth in 42 CFR Part 495 and to take such steps as necessary to allow Health Center to realize the benefits of the Program, including but not limited to participating in the Program as an Eligible Professional, using Certified EHR Technology, and providing attestations of adoption, implementation, upgrading and meaningful use of such technology as requested or required by Health Center or other federal or state authority.

3. **Reassignment of Incentive Payments.** Provider reassigns to Health Center the right to receive the Incentive Payment and any other payments made in connection to Provider's participation as an Eligible Professional (as that term is defined in 42 C.F.R. § 495.4) in the Program. Provider understands and agrees that Health Center will collect and retain any payments made for the implementation, adoption, upgrade, and/or meaningful use of health information technology systems, including but not limited to certified EHR technology, by its employees or independent contractors.

4. **Term and Termination.** This Addendum shall be effective from the Effective Date and as long as the Agreement remains effective. This Addendum shall terminate automatically upon the failure by Provider to maintain eligibility to participate in or to receive payment under the Program. Notwithstanding any termination of this Addendum, any and all claims for Incentive Payments prior to the date of termination shall remain reassigned to Health Center and shall remain the property of Health Center.

5. **Whole Agreement.** This Addendum and the Agreement together form the entire agreement between the parties hereto relating to the subject matter of the Agreement and this Addendum. Unless otherwise provided for in this Addendum, all terms and conditions of the Agreement continue to apply. Where any of the terms of conditions of this Addendum and the Agreement conflict, the terms and conditions of this Addendum shall prevail. This Addendum may be modified in writing only.

IN WITNESS WHEREOF, the parties hereto have executed this Addendum through their duly authorized officers in duplicate on the day, month and year first written above. B

HEALTH CENTER

_____

By: _____

Its: _____

IF CORPORATION/ PARTNERSHIP [Provider]

_____

By: _____

Its: _____

IF INDIVIDUAL [Provider]

_____

[Name of Provider]

The final rule on meaningful use requires that an Eligible Professional (EP) report on both clinical quality measures and functional objectives and measures

Dentists and Meaningful Use

Overview

The final rule on meaningful use requires that an Eligible Professional (EP) report on both clinical quality measures and functional objectives and measures. While dentists (refers to a DDS or DMD) are a provider type in the EP category, there are a couple of limitations that could impede their robust participation in the meaningful use incentive program. For one, there are no oral health measures for dentists in the clinical measure group for reporting in years 2012 and 2013. The list of clinical measures will change though in 2014, regardless of what stage a provider is at, and the clinical measures in 2014 include a few oral health measures. Additionally, dentists must use certified EHR technology in order to participate. At the time of this publication, there are only a few certified EDR modules but the module alone will not allow a dentist to achieve all of the meaningful use requirements. Dentists may want to work with their IT departments to determine the certification status of their EHR product.

PAYMENT YEAR 1

Dentists at locations where there is a certified EHR can easily register and attest to adoption / implementation / upgrade for the first payment year of meaningful use ($21,250).

PAYMENT YEAR 2

All payment years after the first require reporting, and the dentist must consider whether it makes sense and is appropriate to use a certified EHR to report meaningful use measures and objectives. CMS clarified that it is possible that none of the core clinical quality measures, none of the alternative core clinical quality measures, AND none of the additional clinical quality measures will fall within a provider's scope of practice and still the provider is able meet the meaningful use requirements by reporting 0. This clarification makes it easier for dentists to participate.

The Office of the National Coordinator has confirmed that you can use an uncertified product to feed information into a certified EHR product, as long as the meaningful use information is being captured by the certified EHR product this will count towards achieving meaningful use. The only measures that must be pulled directly from the certified EHR are the clinical quality measures.

Functional Objectives and Measures

FROM THE CMS FINAL RULE

- Dentists (like all EPs) must report on 15 core functional meaningful use criteria and 5 additional measures from the menu set of 10 measures. (see Table 2 page 61)
- One of the five additional measures must be a public health measure; however in the case of dentists both public health measures have exclusions that are applicable to dentists.
- If multiple EPs are using the same certified EHR technology in a shared physical setting, certain measures could be met for all the EPs if the organization completed the measure. Measures where this is allowed are noted in the table.

Clinical Measures

FROM THE CMS FINAL RULE

- Dentists (like all EPs) must report on 6 clinical measures; 3 core measures (see Table 7 page 54) and 3 additional measures (see Table 6 page 55).
- If any of the core measures have a 0 as the denominator because it is not within the dentist's scope of practice to capture that information then (s)he must choose from the alternates list. If the alternates don't apply he/she must attest and explain why the alternates are not applicable to his/her scope of practice. It is possible that the EP because of his/her specialty will not report on 3 of the core / alternate measures.
- If a dentist cannot find three measures within the menu set of 38 quality measures on which to report because it falls outside of his/her scope of practice, the dentist has the option of providing a statement attesting to that fact. **It is possible that the dentist will not report on 3 menu clinical measures.**

Eligible Professional Core Objectives Overview

1. Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
2. Implement drug-drug and drug-allergy interaction checks.
3. Maintain an up-to-date problem list of current and active diagnoses.
4. Generate and transmit permissible prescriptions electronically (eRx).
5. Maintain active medication list.
6. Maintain active medication allergy list.
7. Record all of the following demographics
   - **A.** Preferred language
   - **B.** Gender
   - **C.** Race
   - **D.** Ethnicity
   - **E.** Date of birth
8. Record and chart changes in the following vital signs
   - **A.** Height
   - **B.** Weight
   - **C.** Blood pressure
   - **D.** Calculate and display body mass index (BMI)
   - **E.** Plot and display growth charts for children 2–20 years, including BMI
9. Record smoking status for patients 13 years old or older.
10. Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the States.
11. Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
12. Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request.
13. Provide clinical summaries for patients for each office visit.

Please refere to the table on the following pages for more details.

MU-Dentist-Crosswalk Functional-Clinical Measures

Required Objectives (Report On All 13)

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 1				
Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	**Denominator:** Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator that have at least one medication order entered using CPOE.	If an EP writes fewer than one hundred prescriptions during the EHR reporting period they would be excluded from this requirement	Unique Patients refers to all patients seen during the EHR reporting period
Number 2				
Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.	YES/NO	NO EXCLUSION	At a minimum, an EP must have at least one formulary that can be queried. This may be an internally developed formulary or an external formulary.
Number 3				
Maintain up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.	**Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.	NO EXCLUSION	**Unique Patients** refers to all patients seen during the EHR reporting period. The term "up-to-date" means the list is populated with the most recent diagnosis known by the EP. This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the EP, or querying the patient. **Problem List** – A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient. • EPs will need to maintain an up-to-date problem list of current and active diagnoses using ICD-9 or SNOMED-CT® as a basis for the entry of structured data into certified EHR technology in order to meet the measure for this objective. For patients with no current or active diagnoses, an entry must still be made to the problem list indicating that no problems are known. An EP is not required to update the problem list at every contact with the patient.

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 4				
Generate and transmit permissible prescriptions electronically.	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	**Denominator:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed, other than controlled substances, during the EHR reporting period. **Numerator:** The number of prescriptions in the denominator generated and transmitted electronically.	1. If an EP writes fewer than one hundred prescriptions during the EHR reporting period they would be excluded from this requirement. 2. 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/her EHR reporting period.	The term "permissible prescriptions" refers to the restrictions that were established by the Department of Justice (DOJ) on electronic prescribing (eRx) for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf). Any prescription not subject to these restrictions would be a permissible prescription. • Providers can use intermediary networks that convert information from the certified EHR into a computer-based fax in order to meet this measure as long as the EP generates an electronic prescription and transmits it electronically using the standards of certified EHR technology to the intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner. • Prescriptions transmitted electronically within an organization (the same legal entity) do not need to use the NCPDP standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be Certified EHR Technology
Number 5				
Maintain active medication list	More than 80% of all unique patients seen by EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	**Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of unique patients in the denominator who have at medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	NO EXCLUSION	**Active medication list** is a list of medications that a given patient is currently taking. • For patients with no active medications, an entry must still be made to the active medication list indicating that there are no active medications. • An EP is not required to update this list at every contact with the patient. The EP can then use his or her clinical judgment to decide when additional updating is required.

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 6				
Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	**Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.	NO EXCLUSION	**Active Medication Allergy List** – A list of medications to which a given patient has known allergies. **Allergy** – An exaggerated immune response or reaction to substances that are generally not harmful. • For patients with no active medication allergies, an entry must still be made to the active medication allergy list indicating that there are no active medication allergies. • An EP is not required to update this list at every contact with the patient.
Number 7				
Record demographics: preferred language, gender, race, ethnicity, and date of birth.	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.	**Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.	NO EXCLUSION	• Use the race and ethnicity codes that follow current federal standards published by the Office of Management and Budget. • If a patient declines to provide all or part of the demographic information, or if capturing a patient's ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure. In regards to patients who do not know their ethnicity, EPs should treat these patients the same way as patients who decline to provide race or ethnicity – identify in the patient record that the patient declined to provide this information.

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 8				
Record and chart changes in the following vital signs: height, weight, and blood pressure and calculate and display body mass index; plot and display growth charts for children 2-20 years, including BMI.	**Measure for 2013 ONLY:** For more than 50% of all unique patients age 2 and over seen by EP record height, weight, and blood pressure are recorded as structured data. **New Measure (Optional 2013; Required 2014 and beyond):** For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data	**For 2013 ONLY:** **Denominator:** Number of unique patients age 2 or over seen by the EP during the EHR reporting period. Numerator: The number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structure data. **New Numerator/ Denominator** ***(Optional 2013; Required in 2014 and beyond)*** **Denominator:** Number of unique patients (age 3 or over for blood pressure) seen by the EP during the EHR reporting period. **Numerator:** Number of patients in the denominator who have at least one entry of their height, weight and blood pressure (ages 3 and over) recorded as structured data.	**Exclusion for 2013 ONLY:** EPs who do not see patients 2 years and older. EPs who believe that measuring and recording height, weight and blood pressure of their patients has no relevance to their scope of practice. ***New Exclusion (Optional 2013; Replaces exclusion above in 2014):*** **Any EP who** 1. Sees no patients 3 years or older is excluded from recording blood pressure; 2. Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; 3. Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; or 4. Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	• The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology. • The only information required to be inputted by the provider is the height, weight, and blood pressure of the patient. The certified EHR technology will calculate BMI and the growth chart if applicable to patient based on age. • Height, weight, and blood pressure do not have to be updated by the EP at every patient encounter. The EP can make the determination based on the patient's individual circumstances as to whether height, weight, and blood pressure need to be updated. • Height, weight, and blood pressure can get into the patient's medical record as structured data in a number of ways. Some examples include entry by the EP, entry by someone on the EP's staff, transfer of the information electronically or otherwise from another provider or entered directly by the patient through a portal or other means.

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 9				
Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years and old and older seen by EP have smoking status recorded as structured data.	**Denominator:** Number of unique patients age 13 or older seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator with smoking status recorded as structured data.	EPs who see no patients 13 years or older would be excluded from this requirement.	• The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology. • This is a check of the medical record for patients 13 years old or older. If this information is already in the medical record available through certified EHR technology, an inquiry does not need to be made every time a provider sees a patient 13 years old or older. The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community.
Number 10				
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.	Implement one clinical decision support rule.	YES/NO	NO EXCLUSION	**Clinical Decision Support** – HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care. • Drug-drug and drug-allergy interaction alerts cannot be used to meet the meaningful use objective for implementing one clinical decision support rule. EPs must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks.
Number 11				
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days.	**Denominator:** The number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period. **Numerator:** The number of patients in the denominator who receive an electronic copy of their health information within three business days.	Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.	**Diagnostic Test Results** – All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests • Limited to information that exists electronically in or accessible from the certified EHR technology and is maintained by or on behalf of the EP.

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 12				
Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.	**Denominator:** Number of unique patients seen by the EP for an office during the EHR reporting period **Numerator:** Number of patients in the denominator who are provided a clinical summary of their visit within three business days.	An EP who has no office visits during the EHR reporting period would be excluded from this requirement.	**Clinical summary** – After-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the patient name, providers office contact information, date and location of visit, an updated medication list and summary of current medications, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during the visit, summary of topics covered/considered during visit, time and location of next appointment/ testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and testing patient needs to schedule with contact information, recommendation patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms. **Definition of an office visit** – Any billable visit that includes: (1) concurrent care or transfer of care visits, (2) consultant visits, (3) prolonged physician service without direct (face-to-face) patient contact (tele-health).
Number 13				
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary and correct indentified security deficiencies as part of its risk management process.	YES/NO	NO EXCLUSION	**Appropriate Technical Capabilities** – A technical capability would be appropriate if it protected the electronic health information created or maintained by the certified EHR technology. All of these capabilities could be part of the certified HER technology or outside systems and programs that support the privacy and security of certified EHR technology. * If multiple EPs are using the same certified EHR technology in a shared physical setting, the testing would only have to occur once for a given certified EHR technology.

Menu Objectives

(Choose five, one must be related to public health)

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 1				
Implement drug-formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	**YES/NO**	An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this objective and associated measure. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.	If multiple EPs are using the same certified EHR technology in a shared physical setting, the testing would only have to occur once for a given certified EHR technology. • At a minimum an EP must have at least one formulary that can be queried. This may be an internally developed formulary or an external formulary. The formularies should be relevant for patient care during the prescribing process.
Number 2				
Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	**Denominator:** Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number. **Numerator:** The number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.	An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.	Structured data does not need to be electronically exchanged in order to qualify for the measure of this objective. The EP is not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.
Number 3				
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and research and outreach.	Generate at least one report listing patients of the EP with a specific condition.	YES/NO	NO EXCLUSION	**Specific Conditions** – Those conditions listed in the active patient problem list. • This objective does not dictate the report(s) which must be generated. An EP is best positioned to determine which reports are most useful to their care efforts. • The report generated could cover every patient whose records are maintained using certified EHR technology or a subset of those patients at the discretion of the EP. • The report generated is required to include only patients whose records are maintained using certified EHR technology.

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 4				
Send reminders to patients per patient preference for preventive/follow up care.	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.	**Denominator:** Number of unique patients 65 years old or older or 5 years old or younger. **Numerator:** The number of patients in the denominator who were sent the appropriate reminder.	If the EP does not have patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology that EP is excluded from this requirement.	EP has the discretion to determine the frequency, means of transmission, and form of the reminder limited only by the requirements the HIPAA Privacy Rule
Number 5				
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the EP.	More than10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.	**Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR) electronic access to their health information online.	Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period.	Online electronic access through either a patient portal or personal health record (PHR) will satisfy the measure of this objective.
Number 6				
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than10% of all unique patients seen by the EP are provided patient-specific education resources.	**Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** Number of patients in the denominator who are provided patient education specific resources.	NO EXCLUSION	**Patient-Specific Education Resources** – Resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient. • Education resources or materials do not have to be stored within or generated by the certified EHR. However, the provider should utilize certified EHR technology in a manner where the technology suggests patient-specific educational resources based on the information stored in the certified EHR technology. The provider can make a final decision on whether the education resource is useful and relevant to a specific patient.

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 7				
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	**Denominator:** Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition. **Numerator:** The number of patients in the denominator who were sent the appropriate reminder.	An EP who was not the recipient of any transitions of care during the EHR reporting period.	**Medication Reconciliation** – The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. **Relevant Encounter** – An encounter during which the EP performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the EP. Essentially an encounter is relevant if the EP judges it to be so. (Note: Relevant encounters are not included in the numerator and denominator of the measure for this objective.) **Transition of Care** – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) toanother.
Number 8				
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	**Denominator:** Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider. **Numerator:** The number of transitions of care and referrals in the denominator where a summary of care record was provided.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.	**Transition of Care** – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 9				
Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice..	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).	YES/NO	An EP who administers no immunizations during the EHR reporting period, where no immunization registry has the capacity to receive the information electronically, or where it is prohibited.	• The test to meet the measure of this objective must involve the actual submission of information to a registry or immunization information system, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective. • The transmission of actual patient information is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. • If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology. • An unsuccessful test to submit electronic data to immunization registries or immunization information systems will be considered valid and would satisfy this objective. • If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. There is not a measurement associated with this reporting.

OBJECTIVE	MEASURE		EXCLUSION	NOTES
Number 10				
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).	YES/NO	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period, does not submit such information to any public health agency that has the capacity to receive the information electronically, or if it is prohibited.	• The test to meet the measure of this objective must involve the actual submission of electronic syndromic surveillance data to public health agencies, if one exists that will accept the information. Simulated transfers of information are not acceptable to satisfy this objective. • The transmission of electronic syndromic surveillance data is not required for the purposes of a test. The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. • An unsuccessful test to submit electronic syndromic surveillance data to public health agencies will be considered valid and would satisfy this objective. • If the test is successful, then the EP should institute regular reporting with the entity with whom the successful test was conducted, in accordance with applicable law and practice. • There is not a measurement associated with this reportingEPs must test their ability to submit electronic syndromic surveillance data to public health agencies at least once prior to the end of the EHR reporting period. Testing may also occur prior to the beginning of the EHR reporting period. Each payment year requires it own unique test. • If multiple EPs are using the same certified EHR technology in a shared physical setting, testing would only have to occur once for a given certified EHR technology.

It is possible that the EP because of his/her specialty will not report on 3 of the core/alternate measures.

Stage 1 Clinical Quality Measures and Functional Objectives and Measures

Clinical Measures

- Eligible Professionals (EPs) must report on 6 clinical measures; 3 core measures (see table 7 below) and 3 additional measures.
- If any of the core measures have a 0 as the denominator because it is not within the EP's scope of practice to capture that information then the EP must choose from the alternates list. If the alternates do not apply to that particular EP he/she must verify that the alternates are not applicable to his/her scope of practice.
- CMS acknowledged there is a lack of relevant measures for various specialties, like behavioral and oral health. They expect to have measures in stage 2 for the specialties that were not included in stage 1.

Table 7 from Final Rule

Clinical Quality Measure Group: Core for all EPs, Medicare or Medicaid

MEASURE NO	CLINICAL QUALITY MEASURE TITLE
NQF 0013	Hypertension: Blood Pressure Management
NQF 0028	Preventive Care and Screening Measure Pair: a. tobacco use assessment; b. tobacco cessation intervention
NQF 0421 PQRI 128	Adult Weight Screening and Follow up

Alternate Core for all EPs, Medicare or Medicaid

MEASURE NO.	CLINICAL QUALITY MEASURE TITLE
NQF 0024	Weight Assessment and Counseling for Children and Adolescents
NQF 0041 PQRI 1110	Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old
NQF 0038	Childhood Immunization Status

Table 6 from Final Rule

Clinical Quality Measures – Menu Set (choose 3)

MEASURE & PQRI IMPLEMENTATION NO.	CLINICAL QUALITY MEASURE TITLE
NQF 0059 **PQRI 1**	**Title:** Diabetes: Hemoglobin A1c Poor Control **Description:** Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.
NQF 0064 **PQRI 2**	**Title:** Diabetes: Low Density Lipoprotein (LDL) Management and Control **Description:** Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL).
NQF 0061 **PQRI 3**	**Title:** Diabetes: Blood Pressure Management **Description:** Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.
NQF 0081 **PQRI 5**	**Title:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) **Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.
NQF 0070 **PQRI 7**	**Title:** Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) **Description**: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.
NQF 0041 **PQRI 110** *Alternate Core Measure*	**Title:** Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old **Description:** Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
NQF 0043 **PQRI 111**	**Title:** Pneumonia Vaccination Status for Older Adults **Description:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
NQF 0031 **PQRI 112**	**Title:** Breast Cancer Screening **Description:** Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.
NQF 0034 **PQRI 113**	**Title:** Colorectal Cancer Screening **Description:** Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
NQF 0067 **PQRI 6**	**Title:** Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD **Description:** Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.

Table 6 from Final Rule continued

MEASURE & PQRI IMPLEMENTATION NO.	CLINICAL QUALITY MEASURE TITLE
NQF 0083 PQRI 8	**Title:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) **Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed betablocker therapy.
NQF 0105 PQRI 9	**Title:** Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment **Description:** The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.
NQF 0086 PQRI 12	**Title:** Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation **Description:** Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.
NQF 0088 PQRI 18	**Title:** Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy **Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.
NQF 0089 PQRI 19	**Title:** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care **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.
NQF 0047 PQRI 53	**Title:** Asthma Pharmacologic Therapy **Description:** Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
NQF 0001 PQRI 64	**Title:** Asthma Assessment **Description:** Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.
NQF 0002 PQRI 66	**Title:** Appropriate Testing for Children with Pharyngitis **Description:** Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Table 6 from Final Rule continued

MEASURE & PQRI IMPLEMENTATION NO.	CLINICAL QUALITY MEASURE TITLE
NQF 0387 **PQRI 71**	**Title:** Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer **Description:** Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.
NQF 0385 **PQRI 72**	**Title:** Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients **Description:** Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemo therapy within the 12-month reporting period.
NQF 0389 **PQRI 102**	**Title:** Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients **Description:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at 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.
NQF 0027 **PQRI 115**	**Title:** Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies **Description:** Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.
NQF 0055 **PQRI 117**	**Title:** Diabetes: Eye Exam **Description:** Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.
NQF 0062 **PQRI 119**	**Title:** Diabetes: Urine Screening **Description:** Percentage of patients 18 -75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
NQF 0421 **PQRI 128** *Core Measure*	**Title**: Adult Weight Screening and Follow-Up **Description:** Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
NQF 0056 **PQRI 163**	**Title:** Diabetes: Foot Exam **Description:** The percentage of patients aged 18 –75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with mono filament, or pulse exam).

Table 6 from Final Rule continued

MEASURE & PQRI IMPLEMENTATION NO.	CLINICAL QUALITY MEASURE TITLE
NQF 0074 **PQRI 197**	**Title:** Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol **Description:** Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
NQF 0084 **PQRI 200**	**Title:** Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation **Description:** Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were pre scribed warfarin therapy.
NQF 0073 **PQRI 201**	**Title:** Ischemic Vascular Disease (IVD): Blood Pressure Management **Description:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).
NQF 0068 **PQRI 204**	**Title:** Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic **Description**: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.
NQF 0004	**Title:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement **Description:** The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
NQF 0012	**Title:** Prenatal Care: Screening for Human Immunodeficiency Virus (HIV) **Description:** Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.
NQF 0013 *Core Measure*	**Title:** Hypertension: Blood Pressure Measurement **Description:** Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who has been seen for at least 2 office visits, with blood pressure (BP) recorded.

Table 6 from Final Rule continued

MEASURE & PQRI IMPLEMENTATION NO.	CLINICAL QUALITY MEASURE TITLE
NQF 0014	**Title:** Prenatal Care: Anti-D Immune Globulin **Description**: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.
NQF 0018	**Title:** Controlling High Blood Pressure **Description:** The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year
NQF 0024 *Alternate Core Measure*	**Title:** Weight Assessment and Counseling for Children and Adolescents **Description:** Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
NQF 0028 **Core Measure*	**Title:** Preventive Care and Screening Measure Pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention **Description:** Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
NQF 0032	**Title:** Cervical Cancer Screening **Description:** Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer
NQF 0033	**Title:** Chlamydia Screening for Women **Description:** Percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.
NQF 0036	**Title:** Use of Appropriate Medications for Asthma **Description:** Percentage of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).
NQF 0038 *Alternate Core Measure*	**Title:** Childhood Immunization Status **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); two H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.

Table 6 from Final Rule continued

MEASURE & PQRI IMPLEMENTATION NO.	CLINICAL QUALITY MEASURE TITLE
NQF 0052	**Title:** Low Back Pain: Use of Imaging Studies **Description:** Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.
NQF 0075	**Title:** Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control **Description:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100 mg/dL.
NQF 0575	**Title:** Diabetes: Hemoglobin A1c Control (<8.0%) **Description:** The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c <8.0%.

Functional Measures

- Eligible Professionals (EPs) must report on 15 core functional meaningful use criteria and 5 additional measures from the menu set of 10 measures. One of the five additional must be a public health measure.
- CMS has identified objectives and measures that may have exclusions. Providers wishing to claim that an objective/measure is inapplicable to them would need to meet the criteria of such an exception.
- CMS expects that the menu set of 10 measures in stage 1 will be core criteria in Stage 2 meaningful use. The thresholds will likely increase as well.

Table 2 from Final Rule

FUNCTIONAL CORE OBJECTIVES (REQUIRED)

Improving Quality, Safety, Efficiency and Reducing Health Disparities

OBJECTIVE	MEASURE
Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. **NOTE:** Unique Patients refers to all patients seen during the EHR reporting period	More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE. **Denominator:** Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator that have at least one medication order entered using CPOE. **Exclusion:** If an EP writes fewer than one hundred prescriptions during the EHR reporting period they would be excluded from this requirement.
Implement drug-drug and drug-allergy interaction checks. **NOTE:** At a minimum, an EP must have at least one formulary that can be queried. This may be an internally developed formulary or an external formulary.	The EP has enabled this functionality for the entire EHR reporting period. **Exclusion:** If an EP writes fewer than one hundred prescriptions during the EHR reporting period they would be excluded from this requirement.
Generate and transmit permissible prescriptions electronically. **NOTE:** Permissible prescriptions refers to the current restrictions established by the Department of Justice on electronic prescribing for controlled substances in Schedule II. *A prescription is the authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization. This does not include authorizations for items such as durable medical equipment or other items and services that may require EP authorization before the patient could receive them. These are excluded from the numerator and the denominator of the measure.*	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.* **Denominator:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed, other than controlled substances, during the EHR reporting period. **Numerator:** The number of prescriptions in the denominator generated and transmitted electronically. **Exclusion:** If an EP writes fewer than one hundred prescriptions during the EHR reporting period they would be excluded from this requirement.
Record demographics: preferred language, gender, race, ethnicity, and date of birth. **NOTE:** Use the race and ethnicity codes that follow current federal standards published by the Office of Management and Budget. *If a patient declines to provide the information or if capturing a patient's ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure.*	More than 50% of all unique patients seen by the EP have demographics recorded as structured data. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

Table 2 from Final Rule Core Objectives continued

OBJECTIVE	MEASURE
Maintain up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.
Maintain active medication list. **NOTE:** Active medication list is a list of medications that a given patient is currently taking.	More than 80% of all unique patients seen by EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of unique patients in the denominator who have at medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.
Record and chart changes in the following vital signs: height, weight, and blood pressure and calculate and display body mass index; plot and display growth charts for children 2-20 years, including BMI.	For more than 50% of all unique patients age 2 and over seen by EP record height, weight, and blood pressure are recorded as structured data. **Denominator:** Number of unique patients age 2 or over seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structure data. **Exclusion:** EPs who do not see patients 2 years and older. EPs who believe that measuring and recording height, weight and blood pressure of their patients has no relevance to their scope of practice.

Table 2 from Final Rule Core Objectives continued

OBJECTIVE	MEASURE
Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years and old and older seen by EP have smoking status recorded as structured data. **Denominator:** Number of unique patients age 13 or older seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator with smoking status recorded as structured data. **Exclusion:** EPs who see no patients 13 years or older would be excluded from this requirement.
Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.	Implement one clinical decision support rule.
Report ambulatory quality measures to CMS or the States.	For 2011, provide aggregate numerator, denominator, and exclusions through attestation. For 2012, electronically submit the clinical quality measures.

Table 2 from Final Rule Core Objectives continued

Engage Patients and Families in their Health Care

OBJECTIVE	MEASURE
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request. NOTE: Limited to information that exists electronically in or accessible from the certified EHR technology and is maintained by or on behalf of the EP.	More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days. **Denominator:** The number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period. **Numerator:** The number of patients in the denominator who receive an electronic copy of their health information within three business days.
Provide clinical summaries for patients for each office visit. NOTE: Definition of an office visit- Any billable visit that includes: (1) concurrent care or transfer of care visits, (2) consultant visits, (3) prolonged physician service without direct (face-to-face) patient contact (tele-health). ***Clinical summary:*** *After-visit summary that provides a patient with relevant and actionable information and instructions containing, but not limited to, the patient name, providers office contact information, date and location of visit, an updated medication list and summary of current medications, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during the visit, summary of topics covered/considered during visit, time and location of next appointment/ testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and testing patient needs to schedule with contact information, recommendation patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms.*	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days. **Denominator:** Number of unique patients seen by the EP for an office during the EHR reporting period **Numerator:** Number of patients in the denominator who are provided a clinical summary of their visit within three business days. **Exclusion:** An EP who has no office visits during the EHR reporting period would be excluded from this requirement.

Table 2 from Final Rule Core Objectives continued

Improve Care Coordination

OBJECTIVE

Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically.

NOTE: Definition of diagnostic test results-

All data needed to diagnose and treat disease,such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

MEASURE

Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

NOTE: Exchange can be of structured (i.e. drug and clinical lab data) or unstructured data (i.e. free text and scanned images).

The use of information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective.

The test must include the transfer of actual or "dummy" data to the chosen other entity. The testing could occur prior to the beginning of the EHR reporting period, but must occur prior to the end of the EHR reporting period and every payment year would require its own, unique test.

If multiple EPs are using the same certified EHR technology in a shared physical setting, the testing would only have to occur once for a given certified EHR technology.

To be considered an exchange, the clinical information must be sent between different legal entities with distinct certified EHR technology or other system that can accept the information and not

Ensure Adequate Privacy and Security Protections for Personal Health Information

Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary and correct indentified security deficiencies as part of its risk management process.

Table 2 from Final Rule

FUNCTIONAL MENU OBJECTIVES (choose five, one must be related to public health)

Improving Quality, Safety, Efficiency and Reducing Health Disparities	
OBJECTIVE	**MEASURE**
Implement drug-formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data. **Denominator:** Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number. **Numerator:** The number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and research and outreach.	Generate at least one report listing patients of the EP with a specific condition.
Send reminders to patients per patient preference for preventive/follow up care.	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period. **Denominator:** Number of unique patients 65 years old or older or 5 years old or younger. **Numerator:** The number of patients in the denominator who were sent the appropriate reminder. **Exclusion:** If the EP does not have patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology that EP is excluded from this requirement.

Table 2 from Final Rule Menu Objectives continued

Engage Patients and Families in their Health Care

OBJECTIVE	MEASURE
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within 4 business days of the information being available to the EP.	More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** The number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR) electronic access to their health information online.
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP are provided patient-specific education resources. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** Number of patients in the denominator who are provided patient education specific resources.

Improve Care Coordination

The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP. **Denominator:** Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition. **Numerator:** The number of transitions of care in the denominator where medication reconciliation was performed.
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals. **Denominator:** Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider. **Numerator:** The number of transitions of care and referrals in the denominator where a summary of care record was provided.

Table 2 from Final Rule Menu Objectives continued

Improve Population and Public Health

OBJECTIVE	MEASURE
Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically). **NOTE:** The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. CMS only requires a single test and follow up submission if that test is successful. If the attempt fails, the EP still meets this objective but no submission of data is required. The testing could occur prior to the beginning of the EHR reporting period, but must occur prior to the end of the EHR reporting period. EPs in a group setting using identical certified EHR technology would only need to conduct a single test, not one test per EP. If the test is successful, then the EP, eligible hospital, or CAH should institute regular reporting to that entity in accordance with applicable law and practice. CMS will accept a yes/no attestation to verify all of the above for EPs have administered immunizations during the EHR reporting period. **Exclusion:** CMS requires that an EP determine if he/she has given any immunizations during the EHR reporting period. Those that have not given any immunizations during the EHR reporting period are excluded from this measure.
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically). **NOTE:** The use of test information about a fictional patient that would be identical in form to what would be sent about an actual patient would satisfy this objective. ***A failed attempt would meet the measure.*** This test must include the transfer of either actual or "dummy" data to the chosen public health agency. The testing could occur prior to the beginning of the EHR reporting period, but must occur prior to the end of the EHR reporting period. If the test is successful, then the EP should institute regular reporting to that entity according to applicable law and practice. **Exclusion:** If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period, then they are excluded from this measure.

2014 Clinical Quality Measures for Stage 1 and 2 Clinical Measures

Eligible professionals (EPs) will be required to report using the new 2014 criteria regardless of whether they are participating in Stage 1 or Stage 2. For 2014 only, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period. Medicare providers can either report their CQMs for the entire year or select an optional three-month reporting period for CQMs that is identical to their three-month reporting period for meaningful use. In 2014 CQMs will no longer be a core objective of the EHR Incentive Program. However, all providers are required to report on CQMs in order to demonstrate meaningful use.

- EPs must report on 9 out of 64 clinical quality measures

Selected CQMs must cover at least 3 of the 6 NQS Domains:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness

CMS has posted a recommended core set of CQMs for eligible professionals that focus on high-priority health conditions and best – practices for care delivery on the site:

- 9 for adult populations
- 9 for pediatric populations
- NQF 0018 strongly encouraged since controlling blood pressure is a high priority goal in many national health initiatives, including the Million Hearts campaign

For more information on Recommended Core Measures visit: www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Recommended_Core_Set.html

EP Clinical Quality Measures for 2014 EHR Incentive Programs: www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MeasuresTable_Posting_CQMs.pdf

All Medicare EHR Incentive Program EPs beyond their first year of meaningful use will be required to submit CQMs electronically.

Medi-Cal is not accepting CQMs electronically in 2014, but by way of attestation through the State Level Registry regardless of their stage of MU.

ADDITIONAL INFORMATION REGARDING EP CLINICAL QUALITY MEASURES FOR 2014 EHR INCENTIVE PROGRAMS

The following table entitled "Clinical Quality Measures for 2014 CMS EHR Incentive Programs for Eligible Professionals" contains additional up-to-date information for the EP clinical quality measures finalized in the Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule. Because measure specifications may need to be updated more frequently than our expected rulemaking cycle will allow for, this table provides updates to the specifications. Subsequent updates will be provided in a new version of this table at least 6 months prior to the beginning of the calendar year for which the measure will be required, and CMS will maintain and publish an archive of each update.

Please note the titles and descriptions for the clinical quality measures included in this table were updated by the measure stewards and therefore may not match the information provided on NQF's website. Measures that do not have an NQF number are measures that are not currently endorsed.

In an effort to align the clinical quality measures used within the EHR Incentive Program with the goals of CMS and the Department of Health and Human Services, the National Quality Strategy (NQS), and recommendations from the Health Information Technology Policy Committee, each clinical quality measure has been assessed against six domains based on the NQS's six priorities.

The six domains have been integrated into the CQMs and they are:

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population/Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Process/Effectiveness

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS146v1	0002	Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis	Children age 2-18 years who had an outpatient or emergency department (ED) visit with a diagnosis of pharyngitis during the measurement period and an antibiotic ordered on or three days after the visit	National Committee for Quality Assurance	Efficient Use of Healthcare Resources.
CMS137v1	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	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.	Numerator 1: Patients who initiated treatment within 14 days of the diagnosis Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS165v1	0018	Controlling High Blood Pressure	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.	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS156v1	0022	Use of High-Risk Medications in the Elderly	Percentage of patients 66 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 different high-risk medications.	Numerator 1: Patients with an order for at least one high-risk medication during the measurement period. Numerator 2: Patients with an order for at least two different high-risk medications during the measurement period.	Patients 66 years and older who had a visit during the measurement period	National Committee for Quality Assurance	Patient Safety.
CMS155v1	0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	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	Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period Numerator 2: Patients who had counseling for nutrition during the measurement period Numerator 3: Patients who had counseling for physical activity during the measurement period	Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/ gynecologist (OB/GYN) during the measurement period	National Committee for Quality Assurance	Population/Public Health.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS138v1	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user	All patients aged 18 years and older	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Population/Public Health.
CMS125v1	0031	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	Women with one or more mammograms during the measurement period or the year prior to the measurement period	Women 42-69 years of age with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS124v1	0032	Cervical Cancer Screening	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	Women with one or more Pap tests during the measurement period or the two years prior to the measurement period	Women 24–64 years of age with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS153v1	0033	Chlamydia Screening for Women	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.	Women with at least one chlamydia test during the measurement period	Women 16-24 years of age who are sexually active and who had a visit in the measurement period	National Committee for Quality Assurance	Population/Public Health.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS130v1	0034	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria below: - Fecal occult blood test (FOBT) during the measurement period - Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period - Colonoscopy during the measurement period or the nine years prior to the measurement period	Patients 51-75 years of age with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS126v1	0036	Use of Appropriate Medications for Asthma	Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.	Patients who were dispensed at least one prescription for a preferred therapy during the measurement period	Patients 5-64 years of age with persistent asthma and a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS117v1	0038	Childhood Immunization Status	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.	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday	Children who turn 2 years of age during the measurement period and who have a visit during the measurement period	National Committee for Quality Assurance	Population/Public Health.
CMS147v1	0041	Preventive Care and Screening: Influenza Immunization	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	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization	All patients aged 6 months and older and seen for a visit between October 1 and March 31	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Population/Public Health.
CMS127v1	0043	Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	Patients who have ever received a pneumococcal vaccination	Patients 65 years of age and older with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS166v2	0052	Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	Patients with an imaging study conducted on the date of the outpatient or emergency department visit or in the 28 days following the outpatient or emergency department visit	Patients 18-50 years of age with a diagnosis of low back pain during an outpatient or emergency department visit	National Committee for Quality Assurance	Efficient Use of Healthcare Resources.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS131v1	0055	Diabetes: Eye Exam	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	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS123v1	0056	Diabetes: Foot Exam	Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.	Patients who received a foot exam (visual inspection with either a sensory exam or pulse exam) during the measurement period	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS122v1	0059	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS148v1	0060	Hemoglobin A1c Test for Pediatric Patients	Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period	Patients with documentation of date and result for a HbA1c test during the measurement period	Patients 5 to17 years of age with a diagnosis of diabetes and a face-to-face visit for diabetes care between the physician and the patient that predates the most recent visit by at least 12 months	National Committee for Quality Assurance	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS134v1	0062	Diabetes: Urine Protein Screening	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.	Patients with a screening for nephropathy or evidence of nephropathy during the measurement period	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS163v1	0064	Diabetes: Low Density Lipoprotein (LDL) Management	Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.	Patients whose most recent LDL-C level performed during the measurement period is < 100 mg/dL	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS164v1	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.	Patients who have documentation of use of aspirin or another antithrombotic during the measurement period	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS154v1	0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	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.	Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory infection	Children age 3 months to 18 years who had an outpatient or emergency department (ED) visit with a diagnosis of upper respiratory infection (URI) during the measurement period	National Committee for Quality Assurance	Efficient Use of Healthcare Resources.
CMS145v1	0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy	Patients who were prescribed beta blocker therapy	All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF <40%	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.
CMS182v1	0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).	Numerator 1: Patients with a complete lipid profile performed during the measurement period Numerator 2: Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary intervensions (PCI) in the 12 months prior to the measurement period	National Committee Quality Assurance	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS135v1	0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	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	Patients who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.
CMS144v1	0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	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	Patients who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.
CMS143v1	0086	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months	Patients who have an optic nerve head evaluation during one or more office visits within 12 months	All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS167v1	0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months	Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months	All patients aged 18 years and older with a diagnosis of diabetic retinopathy	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.
CMS142v1	0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	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	Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care	All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.
CMS139v1	0101	Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	Patients who were screened for future fall risk at least once within the measurement period	Patients aged 65 years and older with a visit during the measurement period	National Committee for Quality Assurance	Patient Safety.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS161v1	0104	Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.	Patients who had suicide risk assessment completed at each visit	All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.
CMS128v1	0105	Anti-depressant Medication Management	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on 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).	Numerator 1: Patients who have received antidepressant medication for at least 84 days (12 weeks) of continuous treatment during the 114-day period following the Index Prescription Start Date Numerator 2: Patients who have received antidepressant medications for at least 180 days (6 months) of continuous treatment during the 231-day period following the Index Prescription Start Date	Patients 18 years of age and older with a diagnosis of major depression in the 180 days (6 months) prior to the measurement period or the first 180 days (6 months) of the measurement period, who were treated with antidepressant medication, and with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS136v2	0108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	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.	Numerator 1: Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSD Numerator 2: Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation Phase, and at least two follow-up visits during the Continuation and Maintenance Phase. One of the two visits during the Continuation and Maintenance Phase may be a telephone visit with a practitioner.	Denominator 1: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period Denominator 2: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who remained on the medication for at least 210 days out of the 300 days following the IPSD, and who had a visit during the measurement period.	National Committee for Quality Assurance	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS169v1	0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Patients in the denominator with evidence of an assessment for alcohol or other substance use following or concurrent with the new diagnosis, and prior to or concurrent with the initiation of treatment for that diagnosis. (Note: the endorsed measure calls for the assessment to be performed prior to discussion of the treatment plan with the patient, but the current approach was considered more feasible in an EHR setting. The "Assessment for Alcohol or Other Drug Use" required in the numerator is meant to capture a provider's assessment of the patient's symptoms of substance use. The essence of the measure is to avoid treating the patient for unipolar depression or bipolar disorder without an assessment of their use of alcohol or other drugs.) The intent of the measure is that the appraisal be performed at each and every initial assessment. It is possible for there to be one or two initial assessments during the measurement period. Due to limitations in the current measurement frameworks, the numerator in the current	Patients 18 years of age or older at the start of the measurement period with a new diagnosis of unipolar depression or bipolar disorder during the first 323 days of the measurement period, and evidence of treatment for unipolar depression or bipolar disorder within 42 days of diagnosis. The existence of a 'new diagnosis' is established by the absence of diagnoses and treatments of unipolar depression or bipolar disorder during the 180 days prior to the diagnosis.	Center for Quality Assessment & Improvement in Mental Health (CQAIMH)	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
				measure definition can be satisfied if the appraisal is performed at ANY single initial assessment. Future versions, implemented with ever improving measurement logic frameworks, should close this loophole.			
CMS157v1	0384	Oncology: Medical and Radiation – Pain Intensity Quantified	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	Patient visits in which pain intensity is quantified	All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Patient and Family Engagement.
CMS141v2	0385	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period	Patients who are referred for chemotherapy, prescribed chemotherapy, or who have previously received adjuvant chemotherapy within the 12- month reporting period	All patients aged 18 through 80 years with AJCC Stage III colon cancer	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.
CMS140v1	0387	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period	Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period	All female patients aged 18 years and older with a diagnosis of stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS129v2	0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at 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	Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer	All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Efficient Use of Healthcare Resources.
CMS62v1	0403	HIV/AIDS: Medical Visit	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.	Patients with at least two medical visits during the measurement year with a minimum of 90 days between each visit	All patients, regardless of age, with a diagnosis of HIV/AIDS seen within a 12 month period	National Committee for Quality Assurance	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS52v1	0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	Numerator 1: Patients who were prescribed pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm^3 Numerator 2: Patients who were prescribed pneumocystic jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/ mm^3 or a CD4 percentage below 15% Numerator 3: Patients who were prescribed Pneumocystic jiroveci pneumonia (PCP) prophylaxis at the time of diagnosis of HIV	Denominator 1: All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm3 who had at least two visits during the measurement year, with at least 90 days in between each visit Denominator 2: All patients aged 1-5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm3 or a CD4 percentage below 15% who had at least two visits during the measurement year, with at least 90 days in between each visit Denominator 3: All patients aged 6 weeks to 12 months with a diagnosis of HIV who had at least two visits during the measurement year, with at least 90 days in between each visit	National Committee for Quality Assurance	Clinical Process/ Effectiveness.
CMS77v1	TBD (proposed as NQF 0407)	HIV/AIDS: RNA control for Patients with HIV	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL.	Patients whose most recent HIV RNA level is <200 copies/mL.	All patients aged 13 years and older with a diagnosis of HIV/AIDS with at least two visits during the measurement year, with at least 90 days between each visit.	National Committee for Quality Assurance	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS2v2	0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical 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.	Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Population/Public Health.
CMS68v2	0419	Documentation of Current Medications in the Medical Record	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list *must* include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND *must* contain the medications' name, dosage, frequency and route of administration.	Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration.	All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Patient Safety.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS69v1	0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with an encounter during the reporting period with a documented calculated BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, follow-up plan is documented during the encounter or during the previous 6 months of the encounter with the BMI outside of normal parameters. Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 Age 18-64 years BMI ≥ 18.5 and < 25	Patients with a documented calculated BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters	Initial Patient Population 1: All patients 65 years of age and older before the beginning of the measurement period with at least one eligible encounter during the measurement period NOT INCLUDING encounters where the patient is receiving palliative care, refuses BMI measurement, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate. Initial Patient Population 2: All patients 18 through 64 years before the beginning of the measurement period with at least one eligible encounter during the measurement period NOT INCLUDING encounters where the patient is receiving palliative care, refuses BMI measurement, the	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Population/Public Health.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
					the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.		
CMS132v1	0564	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	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.	Patients who had one or more specified operative procedures for any of the following major complications within 30 days following cataract surgery: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence	All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the surgical complication rate	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Patient Safety.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS133v1	0565	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	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.	Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery	All patients aged 18 years and older who had cataract surgery	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.
CMS158v1	0608	Pregnant women that had HBsAg testing	This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.	Patients who were tested for Hepatitis B surface antigen (HBsAg) during pregnancy within 280 days prior to delivery.	All female patients aged 12 and older who had a full term delivery during the measurement period.	OptumInsight	Clinical Process/ Effectiveness.
CMS159v1	0710	Depression Remission at Twelve Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter.	MN Community Measurement	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS160v1	0712	Depression Utilization of the PHQ-9 Tool	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit.	Adult patients who have a PHQ-9 tool administered at least once during the four-month period.	Adult patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during each four month period	MN Community Measurement	Clinical Process/ Effectiveness.
CMS75v1	TBD	Children who have dental decay or cavities	Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period.	Children who had cavities or decayed teeth.	Children, age 0-20 years, with a visit during the measurement period.	Maternal and Child Health Bureau, Health Resources & Services Administration	Clinical Process/ Effectiveness.
CMS177v1	1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	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.	Patient visits with an assessment for suicide risk	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder	American Medical Association-Physician Consortium for Performance Improvement (AMA-PCPI)	Patient Safety.
CMS82v1	1401	Maternal depression screening	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.	Children with documentation of maternal screening or treatment for postpartum depression for the mother.	Children with a visit who turned 6 months of age in the measurement period.	National Committee for Quality Assurance	Population/Public Health.
CMS74v2	TBD	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	Children who receive a fluoride varnish application	Children, age 0-20 years, with a visit during the measurement period.	University of Minnesota	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS61v2	TBD	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed	Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.	Numerator 1: (High Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period Numerator 2: (Moderate Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period Numerator 3: (Low Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period or up to four (4) years prior to the current measurement period	Denominator 1: (High Risk) All patients aged 20 through 79 years who have CHD or CHD Risk Equivalent Denominator 2: (Moderate Risk) All patients aged 20 through 79 years who have Multiple Risk Factors (2+) of the following: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL-C)**, Family History of Premature CHD, or Age (men >= 45; women >= 55) Denominator 3: (Low Risk) All patients aged 20 through 79 years who have risk factors 0 or 1 of the following risk factors: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL-C)**, Family History of Premature CHD, or Age (men >= 45; women >= 55) **For Denominator 2 and Denominator 3, HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS64v2	TBD	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)	Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.	Numerator 1: Patients whose most recent fasting LDL-C test is <100 mg/dL Numerator 2: Patients whose most recent fasting LDL-C test is <130 mg/dL Numerator 3: Patients whose most recent fasting LDL-C test is <160 mg/dL	Denominator 1: (High Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have CHD or CHD Risk Equivalent OR Have Multiple Risk Factors (2+) of the following: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL-C)**, Family History of Premature CHD, or Age (men >= 45; women >= 55) AND a 10-year Framingham risk >20% Denominator 2: (Moderate Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have Multiple Risk	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Clinical Process/ Effectiveness.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
					Factors (2+) of the following: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL-C)**, Family History of Premature CHD, or Age (men >= 45; women >= 55) and AND 10-year Framingham risk <=20% Denominator 3: (Low Risk) All patients aged 20 through 79 years who have had a fasting LDL-C or a calculated LDL-C test performed up to 4 years prior to the current measurement period and have 0 or 1 of the following risk factors: Cigarette Smoking, Hypertension, Low High Density Lipoprotein (HDL-C)**, Family History of Premature CHD, or Age (men >= 45; women >= 55) **HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor)		

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS149v1	TBD	Dementia: Cognitive Assessment	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.	Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period	All patients, regardless of age, with a diagnosis of dementia.	American Medical Association-convened Physician Consortium for Performance Improvement ® (AMA-PCPI)	Clinical Process/ Effectiveness.
CMS65v2	TBD	Hypertension: Improvement in blood pressure	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Patients whose follow-up blood pressure is at least 10 mmHg less than their baseline blood pressure or is adequately controlled. If a follow-up blood pressure reading is not recorded during the measurement year, the patient's blood pressure is assumed "not improved."	All patients aged 18-85 years of age, who had at least one outpatient visit in the first six months of the measurement year, who have a diagnosis of hypertension documented during that outpatient visit, and who have uncontrolled baseline blood pressure at the time of that visit	Centers for Medicare & Medicaid Services	Clinical Process/ Effectiveness.
CMS50v1	TBD	Closing the referral loop: receipt of specialist report	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.	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.	Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.	Centers for Medicare & Medicaid Services	Care Coordination.
CMS66v1	TBD	Functional status assessment for knee replacement	Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10 Global Health; PROMIS-29, KOOS) not more than 180 days prior to the primary TKA procedure, and at least 60 days and not more than 180 days after TKA procedure	Adults, aged 18 and older, with a primary total knee arthroplasty (TKA) and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after TKA procedure.	Centers for Medicare & Medicaid Services	Patient and Family Engagement.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS56v1	TBD	Functional status assessment for hip replacement	Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10-Global Health, PROMIS-29, HOOS) not more than 180 days prior to the primary THA procedure, and at least 60 days and not more than 180 days after THA procedure.	Adults aged 18 and older with a primary total hip arthroplasty (THA) and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after THA procedure.	Centers for Medicare & Medicaid Services	Patient and Family Engagement.
CMS90v2	TBD	Functional status assessment for complex chronic conditions	Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments	Patients with patient reported functional status assessment results (e.g., VR-12; VR-36; MLHF-Q; KCCQ; PROMIS-10 Global Health, PROMIS-29) present in the EHR at least two weeks before or during the initial encounter and the follow-up encounter during the measurement year.	Adults aged 65 years and older who had two outpatient encounters during the measurement year and an active diagnosis of heart failure.	Centers for Medicare & Medicaid Services	Patient and Family Engagement.

CMS eMeasure ID	NQF #	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS179v1	TBD	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.	Average percentage of time that patients in the measure population have INR results within the therapeutic range (i.e., TTR)	Initial Patient Population statement: Patients aged 18 and older with atrial fibrillation without valvular heart disease who had been on chronic warfarin therapy for at least 180 days before the start of and during the measurement period. Patient should have at least one outpatient visit during the measurement period Equals All in Initial Patient Population with sufficient international normalized ratio (INR) results to calculate a warfarin time in therapeutic range (TTR)	National Committee for Quality Assurance	Patient Safety.
CMS22v1	TBD	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	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	Patients who were screened for high blood pressure AND a recommended follow-up plan is documented as indicated if the blood pressure is pre-hypertensive or hypertensive	Percentage of patients aged 18 years and older before the start of the measurement period	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Population/Public Health.

Stage 2 retains the same basic structure as Stage 1 of meaningful use, except EPs must now report on 20 objectives in Stage 2.

Stage 2 Objectives and Measures

After completing two program years of Stage 1 EPs will begin their first program year of Stage 2.

Building upon Stage 1 data capture and sharing requirements, Stage 2 focuses on advanced clinical procedures, including:

- Measures focused on more rigorous health information exchange (HIE)
- Additional requirements for e-prescribing and incorporating lab results
- Electronic transmission of patient care summaries across multiple settings
- Increased patient and family engagement

In order to participate in Stage 2 Certified EHR criteria must meet ONC's 2014 standards and certification criteria. *Go to:* www.healthit.gov/policy-researchers-implementers/certificationprograms-policy. Due to upgrade or adoption of CERHT to 2014 standards and certification criteria, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a 90 day reporting period.

Stage 2 Functional Objectives and Measures

Stage 2 retains the same basic structure as Stage 1 of meaningful use, except EPs must now report on 20 objectives in Stage 2. Like in Stage 1 the measures are split into core and menu objectives. Eligible professionals must now report on 17 core objectives and 3 out of a possible 6 menu objectives and 2014 Clinical Quality Measures (CQMs).

STAGE 2 AND STAGE 1 OBJECTIVES

May look similar, but there have been some changes, such as:

- Some objectives in the menu set of Stage 1 are now core for Stage 2 and are required for all EPs
- Some objectives in the core set of Stage 1 have higher thresholds in Stage 2
- Some new core and menu objectives in Stage 2

Stage 1	Stage 2
Eligible Professionals	Eligible Professionals
13 core objectives	17 core objectives
5 of 10 menu objectives	3 of 6 menu objectives
18 total objectives	20 total objectives

For further information on Stage 2 Meaningful Use CMS Stage 2 Meaningful Use Specification Sheets provide more in-depth information on each objectives requirements, thresholds and exclusions. The sheet also provides more information how to calculate numerators, denominators, definitions of important terms and achieving objectives. *Go to:* www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf

For more information on 2014 CQMs referred to 2014 Clinical Quality Measures or CMS 2014 Clinical Quality Measures at: www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_MeasuresTable_Posting_CQMs.pdf

NOTICES AND DISCLAIMER

The information in this tool kit is intended only to provide a general overview of the topics addressed. This tool kit is not intended to provide legal advice or to substitute for the guidance, counsel or advice of legal counsel on any matters particular to a specific primary care clinic.

DO NOT COPY OR DISTRIBUTE the contents of the Registration Tool Kit to anyone outside of your clinic or health center.

CPCA
California Primary
Care Association

www.cpca.org
1231 I Street, Suite 400
Sacramento, California 95814