

Merit-Based Incentive Payment System (MIPS) Advancing Care Information Performance Category Measure 2018 Performance Period


Objective:	Patient Electronic Access
Measure:	<p>Provide Patient Access</p> <p>For at least one unique patient seen by the MIPS eligible clinician: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the MIPS eligible clinician's certified electronic health record technology (CEHRT).</p>
Measure ID:	ACI_PEA_1

Definition of Terms

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

Provide Access – When a patient possesses all of the necessary information needed to view, download, or transmit their information. This could include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information.

Timely Access – We define “timely” as within 4 business days of the information being available to the MIPS eligible clinician.



Unique Patient – If a patient is seen by a MIPS eligible clinician more than once during the performance period, then for purposes of measurement, that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the MIPS eligible clinician at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same MIPS eligible clinician multiple times in the same performance period.

Reporting Requirements

NUMERATOR/DENOMINATOR

- **NUMERATOR:** The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured meet the technical specifications of the API in the MIPS eligible clinician's CEHRT.
- **DENOMINATOR:** The number of unique patients seen by the MIPS eligible clinician during the performance period.

Scoring Information

BASE SCORE/PERFORMANCE SCORE/BONUS SCORE


- Required for Base Score: **Yes**
- Percentage of Performance: **Up to 10%**
- Bonus Score: **One-time bonus of 10% for MIPS eligible clinicians and groups who report using 2015 Edition CEHRT exclusively for the 2018 performance period and submit only Advancing Care Information measures.**

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

Additional Information

- MIPS eligible clinicians can report the Advancing Care Information objectives and measures if they have technology certified to the 2015 Edition, or a combination of technologies from the 2014 and 2015 Editions that support these measures.

- In 2018, a one-time bonus will be earned by MIPS eligible clinicians and groups who report using 2015 Edition CEHRT exclusively.
- Actions included in the numerator must occur within the performance period.
- This measure contributes to the 50% base score for the Advancing Care Information performance category. MIPS eligible clinicians must submit a “yes” for the security risk analysis measure, and at least a 1 in the numerator for the numerator/denominator of the remaining measures. The measure is also worth up to 10 percentage points towards the performance category score. More information about Advancing Care Information scoring is available on the [QPP website](#).
- To implement an API, the MIPS eligible clinician would need to fully enable the API functionality such that any application chosen by a patient would enable the patient to gain access to their individual health information provided that the application is configured to meet the technical specifications of the API. MIPS eligible clinicians may not prohibit patients from using any application, including third-party applications, which meet the technical specifications of the API, including the security requirements of the API. MIPS eligible clinicians are expected to provide patients with detailed instructions on how to authenticate their access through the API and provide the patient with supplemental information on available applications that leverage the API.
- Similar to how MIPS eligible clinicians support patient access to view, download and transmit (VDT) capabilities, MIPS eligible clinicians should continue to have identity verification processes to ensure that a patient using an application, which is leveraging the API, is provided access to their health information.
- In circumstances where there is no information available to populate one or more of the fields previously listed, either because the MIPS eligible clinicians can be excluded from recording such information or because there is no information to record (for example, no medication allergies or laboratory tests), the MIPS eligible clinician may have an indication that the information is not available and still meet the objective and its associated measure.
- The patient must be able to access this information on demand, such as through a patient portal or personal health record (PHR) or by other online electronic means. We note that while a covered entity may be able to fully satisfy a patient's request for information through VDT, the measure does not replace the covered entity's responsibilities to meet the broader requirements under HIPAA to provide an individual, upon request, with access to PHI in a designated record set.
- MIPS eligible clinicians should also be aware that while the measure is limited to the capabilities of CEHRT to provide online access, there may be patients who cannot access their EHRs electronically because of a disability. MIPS eligible clinicians who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- For the measure, MIPS eligible clinicians must offer all four functionalities (view, download, transmit, and access through API) to their patients. And, patient health information needs to be made available to each patient for view, download, and transmit within 4 business days of the information being available to the clinician for each and every time that information is



generated whether the patient has been "enrolled" for three months or for three years. A patient who has multiple encounters during the performance period, or even in subsequent performance periods in future years, needs to be provided access for each encounter where they are seen by the MIPS eligible clinician. The patient cannot be counted in the numerator if the MIPS eligible clinician does not continue to update the information accessible to the patient each time new information is available.

- If a patient elects to "opt out" of participation, that patient must still be included in the denominator.
- If a patient elects to "opt out" of participation, the MIPS eligible clinician may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access their information, obtain access through a patient-authorized representative, or otherwise opt-back-in without further follow up action required by the clinician.
- The Provide Patient Access measure is critical to increasing patient engagement, and to allowing patients access to their personal health data in order to improve health, provide transparency and drive patient engagement. Thus, it is a required measure in the base score.
- When MIPS eligible clinicians choose to report as a group, data should be aggregated for all MIPS eligible clinicians under one Taxpayer Identification Number (TIN). This includes those MIPS eligible clinicians who may qualify for reweighting such as a significant hardship exception, hospital or ASC-based status, or in a specialty which is not required to report data to the Advancing Care Information performance category. If these MIPS eligible clinicians choose to report as a part of a group practice, they will be scored on the Advancing Care Information performance category like all other MIPS eligible clinicians.

Regulatory References

- For further discussion, please see the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) final rule: [81 FR 77228](#).
- In order to meet this objective and measure, MIPS eligible clinicians must use the capabilities and standards of CEHRT at 45 CFR 170.315 (e)(1) (g)(7) (g)(8) and (9).

Certification and Standards Criteria

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

Certification Criteria*

§170.315(e)(1) View Download and Transmit to 3rd party

(e) Patient engagement—(1) View, download, and transmit to 3rd party.

(i) Patients (and their authorized representatives) must be able to use internet-based technology to view, download, and transmit their health information to a 3rd party in the manner specified below. Such access must be consistent and in accordance with the standard adopted in §170.204(a)(1) and may alternatively be demonstrated in accordance with the standard specified in §170.204(a)(2).

(A) View. Patients (and their authorized representatives) must be able to use health IT to view, at a minimum, the following data:

(1) The Common Clinical Data Set (which should be in their English (i.e., non-coded) representation if they associate with a vocabulary/code set).

(2) Ambulatory setting only. Provider's name and office contact information.

(3) Inpatient setting only. Admission and discharge dates and locations; discharge instructions; and reason(s) for hospitalization.

(4) Laboratory test report(s). Laboratory test report(s), including:

(i) The information for a test report as specified all the data specified in 42 CFR 493.1291(c)(1) through (7);

(ii) The information related to reference intervals or normal values as specified in 42 CFR 493.1291(d); and

(iii) The information for corrected reports as specified in 42 CFR 493.1291(k)(2).

(5) Diagnostic image report(s).

(B) Download. (1) Patients (and their authorized representatives) must be able to use technology to download an ambulatory summary or inpatient summary (as applicable to the health IT setting for which certification is requested) in the following formats:

(i) Human readable format; and

(ii) The format specified in accordance to the standard specified in §170.205(a)(4) following the CCD document template.

(2) When downloaded according to the standard specified in §170.205(a)(4) following the CCD document template, the ambulatory summary or inpatient summary must include, at a minimum, the following data (which, for the human readable version, should be in their English representation if they associate with a vocabulary/code set):

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

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

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

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

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

(i) Email transmission to any email address; and

(ii) An encrypted method of electronic transmission.

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

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

(1) Select data associated with a specific date (to be viewed, downloaded, or transmitted); and

(2) Select data within an identified date range (to be viewed, downloaded, or transmitted).

(ii) Activity history log. (A) When any of the capabilities included in paragraphs (e)(1)(i)(A) through (C) of this section are used, the following information must be recorded and made accessible to the patient (or his/her authorized representative):

(1) The action(s) (i.e., view, download, transmission) that occurred;

(2) The date and time each action occurred in accordance with the standard specified in §170.210(g);

(3) The user who took the action; and

(4) Where applicable, the addressee to whom an ambulatory summary or inpatient summary was transmitted.

(B) Technology presented for certification may demonstrate compliance with paragraph

(e)(1)(ii)(A) of this section if it is also certified to the certification criterion specified in §170.315(d)(2) and the information required to be recorded in

paragraph (e)(1)(ii)(A) of this section is accessible by the patient (or his/her authorized representative).

170.315(g)(7)

170.315 (g)(8)
Application
Access

7) *Application access—patient selection.* The following technical outcome and conditions must be met through the demonstration of an application programming interface (API).

(i) *Functional requirement.* The technology must be able to receive a request with sufficient information to uniquely identify a patient and return an ID or other token that can be used by an application to subsequently execute requests for that patient's data.

(ii) *Documentation—(A)* The API must include accompanying documentation that contains, at a minimum:

(1) API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns.

(2) The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s).

(3) *Terms of use.* The terms of use for the API must be provided, including, at a minimum, any associated developer policies and required developer agreements.

(B) The documentation used to meet paragraph (g)(7)(ii)(A) of this section must be available via a publicly accessible hyperlink.

(8) Application Access. Data category request. The following technical outcome and conditions must be met through the demonstration of an application programming interface.

(i) Functional requirements. (A) Respond to requests for patient data (based on an ID or other token) for each of the individual data categories

specified in the Common Clinical Data Set and return the full set of data for that data category (according to the specified standards, where applicable) in a computable format.

(B) Respond to requests for patient data associated with a specific date as well as requests for patient data within a specified date range.

(ii) Documentation—(A) The API must include accompanying documentation that contains, at a minimum:

(1) API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns.

(2) The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s).

(3) Terms of use. The terms of use for the API must be provided, including, at a minimum, any associated developer policies and required developer agreements.

(B) The documentation used to meet paragraph (g)(8)(ii)(A) of this section must be available via a publicly accessible hyperlink.

**170.315(g)(9)
Design
Performance**

(9) All data request. The following technical outcome and conditions must be met through the demonstration of an application programming interface.

(i) Functional requirements. (A) Respond to requests for patient data (based on an ID or other token) for all of the data categories specified in the Common Clinical Data Set at one time and return such data (according to the specified standards, where applicable) in a summary record formatted according to the standard specified in §170.205(a)(4) following the CCD document template.

(B) Respond to requests for patient data associated with a specific date as well as requests for patient data within a specified date range.

(ii) Documentation—(A) The API must include accompanying documentation that contains, at a minimum:

(1) API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns.

(2) The software components and configurations that would be necessary for an application to implement in order to be able to successfully interact with the API and process its response(s).

(3) Terms of use. The terms of use for the API must be provided, including, at a minimum, any associated developer policies and required developer agreements.

(B) The documentation used to meet paragraph (g)(9)(ii)(A) of this section must be available via a publicly accessible hyperlink.

(h) Transport methods and other protocols—(1) Direct Project—(i) Applicability Statement for Secure Health Transport. Able to send and receive health information in accordance with the standard specified in §170.202(a)(2), including formatted only as a “wrapped” message.

(ii) Delivery Notification in Direct. Able to send and receive health information in accordance with the standard specified in §170.202(e)(1).

(2) Direct Project, Edge Protocol, and XDR/XDM—(i) Able to send and receive health information in accordance with:



	<p>(A) The standard specified in §170.202(a)(2), including formatted only as a “wrapped” message;</p> <p>(B) The standard specified in §170.202(b), including support for both limited and full XDS metadata profiles; and</p> <p>(C) Both edge protocol methods specified by the standard in §170.202(d). (ii) Delivery Notification in Direct. Able to send and receive health information in accordance with the standard specified in §170.202(e)(1).</p>
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**Depending on the type of certification issued to the EHR technology, it will also have been certified to the certification criterion adopted at 45 CFR 170.314 (g)(1), (g)(2), or both, in order to assist in the calculation of this meaningful use measure.*

Standards Criteria	
§ 170.204(a)	Web Content Accessibility Guidelines (WCAG) 2.0, Level A Conformance (incorporated by reference in § 170.299).
§ 170.210(f)	Any encryption and hashing algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the FIPS Publication 140-2 (incorporated by reference in § 170.299).
§ 170.205(a)(3)	HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, (incorporated by reference in §170.299). The use of the “unstructured document” document-level template is prohibited.
§ 170.202(a)	ONC Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).



§ 170.210(g)

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

Additional certification and standards criteria may apply. Review the [ONC 2015 Edition Final Rule](#) for more information.