

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

Objective:

Coordination of Care Through Patient Engagement

Measure:

View, Download, or Transmit (VDT)

During the performance period, at least one unique patient (or patient-authorized representatives) seen by the MIPS eligible clinician actively engages with the EHR made accessible by the MIPS eligible clinician. A MIPS eligible clinician may meet the measure by either—(1) view, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the MIPS eligible clinician's CEHRT; or (3) a combination of (1) and (2).

Reporting Requirements

NUMERATOR/DENOMINATOR

- **NUMERATOR:** The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the performance period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the performance period.
- **DENOMINATOR:** 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 (50%): **No**
- Percentage of Performance Score (up to 90%): **Up to 10%**
- Eligible for bonus score: **No**

Note: Eligible clinicians must earn the full base score in order to earn any score in the advancing care information performance category. In addition to the base score, eligible clinicians have the opportunity to earn additional credit through a performance score and the bonus score.

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 clinician must use the capabilities and standards of CEHRT as defined at § at 45 CFR 170.315(e)(1)(2) and (3).

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) Patient Engagement

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

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

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

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

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

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

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

(ii) The information related to reference intervals or normal values as specified in 42 CFR 493.1291(d); and (iii) The information for corrected reports as specified in 42 CFR 493.1291(k)(2).

(5) Diagnostic image report(s).

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

(i) Human readable format; and

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

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

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

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

(3) Inpatient setting only. Patients (and their authorized representatives) must be able to download transition of care/referral summaries that were created as a result of a transition of care

(pursuant to the capability expressed in the certification criterion specified in paragraph (b)(1) of this section).

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

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

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

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

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

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

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

- (1) The action(s) (i.e., view, download, transmission) that occurred;
- (2) The date and time each action occurred in accordance with the standard specified in §170.210(g);

- (3) The user who took the action; and
- (4) Where applicable, the addressee to whom an ambulatory summary or inpatient summary was transmitted.

(B) Technology presented for certification may demonstrate compliance with paragraph (e)(1)(ii)(A) of this section if it is also certified to the certification criterion specified in §170.315(d)(2) and the information required to be recorded in paragraph (e)(1)(ii)(A) of this section is accessible by the patient (or his/her authorized representative).

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

Standards Criteria	
§ 170.204(a)	Web Content Accessibility Guidelines (WCAG) 2.0, Level A Conformance (incorporated by reference in § 170.299).
§ 170.210(f)	Any encryption and hashing algorithm identified by the National Institute of Standards and Technology (NIST) as an approved security function in Annex A of the FIPS Publication 140-2 (incorporated by reference in § 170.299).
§ 170.205(a)(3)	HL7 Implementation Guide for CDA® Release 2: IHE Health Story Consolidation, (incorporated by reference in §170.299). The use of the “unstructured document” document-level template is prohibited.
§ 170.202(a)	ONC Applicability Statement for Secure Health Transport, Version 1.0 (incorporated by reference in §170.299).
§ 170.210(g)	The date and time recorded utilize a system clock that has been synchronized following (RFC 1305) Network Time Protocol, (incorporated by reference in §170.299) or (RFC 5905) Network Time Protocol Version 4, (incorporated by reference in §170.299).

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