

PA MA EHR Incentive Program								
Measure	Objective	Description	Exclusion	Supporting Doc.		Supporting Doc.		Supporting Doc.
<b>CPOE for Medication Orders</b>	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 or admitted to the eligible provider or CAH have at least one medication entered using CPOE	Any EP who writes fewer than 100 prescriptions during the EHR reporting period	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT	<b>OR</b>	Proof of exclusion: Report demonstrating that Exclusion was met		
<b>Drug Interaction Checks</b>	Implement drug-drug and drug-allergy interaction checks	Drug Interaction Checks	N/A	Report showing when the drug-drug and drug-allergy interaction checks occurred. A single report submitted for Group of applying providers can be used, however, report needs to be broken down by provider name and NPI	<b>OR</b>	Screenshots of the drug-drug and drug-allergy interaction checks in operation. A single screenshot submitted for a Group of applying providers can be used, however, NPIs and provider names who are associated with this measure need to be identified on the screenshot or on a separate submitted list	<b>AND</b>	Process or methodology of how the drug-drug and drug-allergy interaction check operate
<b>Maintain Problems List</b>	Maintain an 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	N/A	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT				
<b>Generate and transmit permissible prescriptions electronically (eRx)</b>	Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	Any EP who writes fewer than 100 prescriptions during the EHR reporting period	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT	<b>OR</b>	Proof of exclusion: Report demonstrating the exclusion was met		
<b>Active Medication List</b>	Maintain active medication list	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	N/A	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT				
<b>Medication Allergy List</b>	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	N/A	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT				
<b>Record Demographics</b>	Record all of the following demographics: (A) Preferred language, (B) Gender, (C) Race, (D) Ethnicity, (E) Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data	N/A	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT				

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<b>Record Vital Signs</b>	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	More than 50% of all unique patients age 2 and over seen by the EP, height, weight and blood pressure are recorded as structure data	Any EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT				
<b>Record Smoking Status</b>	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data	Any EP who sees no patients 13 years or older	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT				
<b>Clinical Quality Measures</b>	Report ambulatory clinical quality measures to CMS	Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by the CMS	N/A	Copy of ambulatory clinical quality measure reported to State				
<b>Clinical Decision Support Rule</b>	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule	N/A	Screenshots of the clinical decision support rule being implemented. A single screenshot submitted for a Group of applying providers can be used, however, NPIs and provider names who are associated with this measure need to be identified on the screenshot or on a separate submitted list	<b>AND</b>	Process or methodology of how the clinical decision support rule was implemented	<b>OR</b>	A report from the CEHRT showing that during the EHR period when a clinical decision support measure was triggered, identifying the provider or providers associated with this measure. NPIs and provider names need to be identified on the report
<b>Electronic Copy of Health Information</b>	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 who request an electronic copy of their health information are provided it within 3 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	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT. A single report submitted for Group of applying providers can be used, however, report needs to be broken down by provider name and NPI	<b>OR</b>	Report of specific MA patients that were provided information	<b>AND</b>	The Process or methodology of how patients are provided electronic copies of their health information within 3 business days of their visit. A single report submitted for Group of applying providers can be used, however, report needs to be broken down by provider name and NPI
<b>Clinical Summaries</b>	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	Any EP who has no office visits during the EHR reporting period	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT. A single report submitted for Group of applying providers can be used, however, report needs to be broken down by provider name and NPI	<b>OR</b>	Report demonstrating they had no office visits and still were able to demonstrate they are meaningful users of EHR without having any office visits (i.e. all by telehealth)	<b>AND</b>	The Process or methodology of how patients are provided clinical summaries within 3 business days. A single report submitted for Group of applying providers can be used, however, report needs to be broken down by provider name and NPI

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<b>Electronic Exchange of Clinical Information</b>	Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of the certified EHR technology's capacity to electronically exchange key clinical information	N/A	Screenshots of at least one test of the certified EHR technology's capacity to electronically exchange key clinical information. A single screenshot submitted for a Group of applying providers can be used, however, NPIs and provider names who are associated with this measure need to be identified on the screenshot or on a separate submitted list	<b>AND</b>	Process or methodology of how the clinical decision support rule was implemented	<b>OR</b>	Identification from the other party that information was exchanged. A single report submitted for Group of applying providers can be used, however, report needs to be broken down by provider name and NPI.
<b>Protect Electronic Health Information</b>	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 identified security deficiencies as part of its risk management process	N/A	A copy of the conducted or reviewed security risk analysis and corrective action plan (if negative findings are identified) that ensures that you are protecting private health information. Report should be dated prior to the end of the reporting period and should include evidence to support that it was generated for that provider's system (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc.) A single report submitted for Group of applying providers can be used, however, report needs to be broken down by provider name and NPI.				