

PA MA EHR Incentive Program								
Measure	Objective	Description	Exclusion	Supporting Doc.		Supporting Doc.		Supporting Doc.
Drug Formulary Checks	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	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	OR	Screenshots of the enabled drug formulary, either internal or external, that was functional during the entire EHR reporting period. 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	AND	Process or methodology of how the Drug Formulary Checks operate
Clinical Lab Test Results	Incorporate clinical lab test results into EHR as structured data	More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology 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	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT	OR	Proof of Exclusion: Report demonstrating that Exclusion was met		
Patient Lists	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one report listing patients of the eligible provider with a specific condition	N/A	A copy of the generated report listing patients of the eligible provider with a specific condition	OR	Generated report showing the functionality within the EHR for all providers attesting to this measure. A single report submitted for Group of applying providers can be used, however, report needs to be broken down by provider name and NPI		
Patient Reminders	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	An EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT	OR	Proof of Exclusion: Report demonstrating that Exclusion was met		
Patient Electronic Access	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP	At least 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	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	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT	OR	Proof of Exclusion: Report demonstrating that Exclusion was met		

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Patient-Specific Education Resources	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 during the EHR reporting period are provided patient-specific education resources	N/A	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT				
Medication Reconciliation	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	An EP who was not the recipient of any transitions of care during the EHR reporting period.	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT	OR	Proof of Exclusion: Report demonstrating that Exclusion was met		
Transition of Care Summary	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 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.	An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period	Meaningful Use Reports documenting the attestations that were generated from the provider's CEHRT	OR	Proof of exclusion: Report from the certified EHR system that shows a zero denominator for the measure or otherwise documents that the provider qualifies for the exclusion		
Immunization Registries Data Submission	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to 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 CMS Sensitive Audit Information For internal use only Page 110 (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)	An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically	A copy of the email received from the immunization registry, showing that the test was successful				
Syndromic Surveillance Data Submission	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to 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)	An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically	A copy of the email received from the public health agency, showing that the test was successful				