Developed by the Promoting Interoperability Public Health Task Force

Public Health Agency Readiness for Promoting Interoperability Programs, 2019 Onward

Guidance and Recommendations

Version 3.9 (Updated 07/25/2019)

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2 Overview

2.1 Background

The Medicare and Medicaid Electronic Health Records (EHRs) Incentive Programs were established to provide incentive payments to eligible professionals (EPs) and eligible hospitals (EHs) as they demonstrated adoption, implementation, upgrading, or meaningful use of certified EHR technology. These incentive programs were designed to support providers to transition and instill the use of EHRs in meaningful ways to help improve the quality, safety, and efficiency of patient health care.

Medicare EPs included Doctors of Medicine or Osteopathy, Doctors of Dental Surgery or Dental Medicine, Doctors of Podiatric Medicine, Doctors of Optometry, and Chiropractors. However, hospital-based *EPs, which were defined as any provider who furnished 90% or more of their services in a hospital setting (inpatient or emergency room), were not considered eligible.*

Medicaid EPs included Physicians, Nurse Practitioners, Certified Nurse – Midwife, Dentists, Physicians Assistants who practice in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) led by a Physician Assistant, and Doctors of Optometry. Medicaid Eligible Hospitals included Acute Care Hospitals with at least 10% Medicaid patient volume, including Critical Access Hospitals (CAHs) and cancer hospitals; and children's hospitals.

The Centers for Medicare and Medicaid Services (CMS) published the final rules for Stage 3 Meaningful Use (MU3) and modifications to meaningful use in 2015 through 2017 (Modified Stage 2) in the Federal Register on October 16, 2015. The public health reporting aspects of the rules have continued to push local and state public health agencies (PHAs) to enhance their informatics capabilities and establish new or review existing processes with which to receive meaningful use (MU) public health reporting data from Eligible Professionals (EPs), Eligible Hospitals (EHs), and Critical Access Hospitals (CAHs), collectively referred to as “Providers” in this document.

Key features of Modified Stage 2 and MU3 rules included:

- Aligning all three stages of Meaningful Use into a single program/rule.
- All Providers would meet MU3 requirements starting in 2018.

- Phased-in timelines allowing Providers to continue to meet Stage 2 requirements in 2017.
- Aligning reporting periods – calendar year reporting for EPs, EHs, and CAHs (see Appendix for additional details).
- Full-year reporting periods.
- In 2016, Providers demonstrating MU for the first time would have a 90-day EHR reporting period.
- In 2017, Providers in the Medicaid EHR Incentive Program demonstrating MU for the first time and Providers demonstrating MU3 would have a 90-day EHR reporting period.
- Providing simplified public health objectives and measures (see Appendix A for additional details).
- Modified Stage 2: Objective 10 relates to public health reporting.
- MU3: Objective 8 relates to Public Health and Clinical Data Registry Reporting*
- Describing what constitutes an EP, EH, or CAH being in active engagement with a PHA or CDR to submit electronic public health data.
- The PH objectives under Modified Stage 2 and MU3 regulations have a certain number of measures that Providers need to attest to or claim exclusion from in order to the meet the MU requirements.
- In Modified Stage 2 and MU3 final rules, the prior ongoing submission requirement has been replaced with an ‘‘Active Engagement’’ requirement, which will be more aligned with the process Providers undertake to report to a clinical registry or public health agency. ‘‘Active Engagement’’ means the Provider is in the process of working towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry (see section 4.2 for additional details on Active Engagement)

*https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicareEH_2019_Obj4.pdf

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEH_2019_Obj8.pdf

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEP_2019_Obj8.pdf

In 2018, the Centers for Medicare & Medicaid Services (CMS) renamed the EHR Incentive Programs to *Promoting Interoperability (PI) Programs* with a focus on improving patients’

access to health information and reducing the time and cost required for providers to comply with the programs' requirements, as per details below:

The various programs currently available to providers include

- Hospital Inpatient Prospective Payment System Proposed Rue— (IPPS) Fiscal Year (FY) 2019 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) — Prospective Payment System Proposed Rule, and Request for Information. CMS-1694-P.
- Quality Payment Program (QPP) — Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) with two tracks- A) Merit-based Incentive Payment System (MIPS) B) Advanced Alternative Payment Models (APM).
- Hospital Outpatient Prospective Payment System (OPPS) — Medicare
- Medicaid EHR Incentive Program or State's Medicaid Promoting Interoperability Program*
  *Note: The Medicaid EHR programs are slated to end in September 2021 (9/30/2021).

Even in view of the above changes, PHAs are still strongly encouraged, though not required, to support the public health measures included in the Promoting Interoperability Programs. These measures represent tremendous opportunities for PHAs to improve their data acquisition and surveillance capabilities. Providers whose public health jurisdictions lack the capacity to support any of the public health measures are qualified to take exclusions from meeting those measures.

The Public Health Promoting Interoperability Task Force recommends that the PHAs should continue to perform the four (4) tasks, which include (see Figure 1):

- Publicizing the public health measures for which the PHA will be ready to accept data and sharing this information with Providers through their own websites (*Declaration of Readiness process*).
- Providing a method for Providers to register their intent to submit public health data to a PHA for the MU measures (*Registration of Intent process*/*Active Engagement Option 1*).
- Testing and validating data submissions from health care Providers *(Onboarding process*/ *Active Engagement Option 2).*

- Providing written communication(s) (which may be in electronic format) to health care Providers who are in Active Engagement with public health. (*Acknowledgement of Ongoing Submission process*/ *Active Engagement Option 3*).

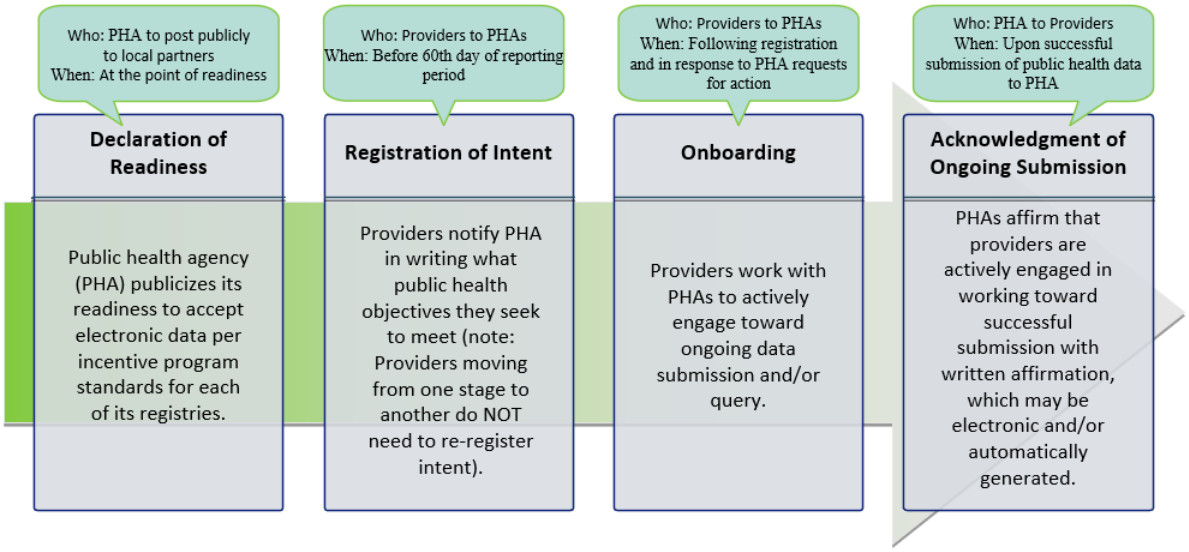

Figure 1: The four tasks for PHAs to support Public Health Reporting measures.

The Centers for Disease Control & Prevention (CDC) facilitated the establishment of the Meaningful Use Public Health Reporting Requirements Task Force (Task Force) in 2015 which has now evolved into the Public Health Promoting Interoperability Task Force. The Task Force has representatives from the public health community including State, Local and Tribal Public Health Departments, National Association of County and City Health Officials (NACCHO), Association of State and Territorial Health Officials (ASTHO), Council of State and Territorial Epidemiologists (CSTE), North American Association of Central Cancer Registries (NAACCR), American Immunization Registry Association (AIRA), Office of the National Coordinator for Health Information Technology (ONC), and others.

2.2 What guidance is available to help PHAs?

The Task Force has created this documentation to identify key concepts, task flows, and guidance for PHAs to support interoperability within public health. The Task Force focuses on objectives and any new business processes that are required for public health measures in the Promoting Interoperability (PI) Programs.

PHAs across the nation will be able to adopt this guidance according to their jurisdictional needs to implement the processes required within the Promoting Interoperability (PI) Programs. The guidance will be made available on the Centers for Disease Control and Prevention (CDC) Public Health Interoperability Task Force web page.

3 Declaration of Readiness

3.1 What does Declaration of Readiness mean?

Providers intending to meet public health measures in the Promoting Interoperability Programs and related federal regulations must register with the PHA to submit data using certified electronic health record technology (CEHRT), except where prohibited, and in accordance with applicable law and practice. Providers who may have registered their intent previously with PHA are not required to register again if moving from one stage to another; however, a Provider engaging with a PHA for a public health measure not previously registered may be required to register separately with the PHA for the new measure.

3.2 What do the regulations say?

A PHA must officially declare for which of its public health registries it has the capacity to receive information electronically using the standards and specifications prescribed by ONC's health IT certification rules. The regulations indicated that CMS anticipated building a centralized repository of PHA readiness information. There is instead an Interoperability Standards Advisory (ISA) website (ISA List of Jurisdictions) that contains links to all the PHA websites that contain this information.

3.3 What does this mean for a Public Health Agency?

It is important to note the term capacity as used in the regulations refers to two aspects of readiness: (1) The PHA has the technical capacity to receive data using the specified standards; and (2) The PHA has the administrative [human resources] capacity to be in one of the steps of active engagement with the providers during the EHR reporting period. Receiving data could mean directly, through a health information exchange, or via a national system such as the BioSense platform, as long as the last system to modify the data is Certified Electronic Health Record Technology. PHAs with the technical capacity to receive data are encouraged to declare their readiness to receive data even if they have limited administrative capacity. PHAs may be able to use *queuing* to prioritize healthcare providers for onboarding and manual processes for tracking and onboarding to effectively manage the administrative workload. For more information on PHA administrative capacity, please refer to the sections on Registration of Intent, Onboarding, and Acknowledgements of Submission of Production Data in this document.

3.4 What actions can a Public Health Agency take now?

In some states, both state and local PHAs are accepting data submissions from healthcare providers. If the PHA has not already done so, consider convening a cross-agency/cross-program task force or work group to coordinate planning, implementation, and communications. State and local agencies should coordinate efforts with Medicaid and state and local HIE and HIT bodies to ensure stakeholders are familiar with PHA expectations. The information in this document and the other resources listed in the Resources section can help PHAs prepare.

Also, PHAs should consider developing or revising the content on the PHA's website to align with the promoting interoperability programs, so that healthcare providers can access general information about the PHA's readiness and be directed to more specific information on measures/public health programs the agency supports. One suggestion could be to create an email group or list that Providers can subscribe to regarding updates from the PHA on recommended provider actions regarding incentive programs, declarations of readiness, changes to program requirements, onboarding, etc.

After communications with a PHA regarding recommended provider actions under previous regulations, providers may not visit the relevant jurisdictional web site again and could potentially assume their actions should remain the same for subsequent program years. Due to changes in the regulations over time, PHA recommendations on provider actions may have changed since the original communication. Providers in that jurisdiction have the potential to be audited, which may result in having their payments recouped.

4 Registration of Intent

4.1 What does Registration of Intent mean?

Providers intending to meet public health measures in the Promoting Interoperability Programs and related federal regulations must register their intent to do so with the PHA to which the Provider intends to submit data. Providers must register their intent with the PHA no later than the 60 days after the start of their EHR reporting period. They may register their intent prior to their reporting period. Providers moving from one stage to another and who have registered intent in previous years do not need to re-register intent.

4.2 What do the regulations say?

Starting January 1, 2019, technology certified to the 2015 Certified Electronic Health Record Technology (CEHRT) Edition is required for Providers to meet program requirements. The EHR reporting period will be 90 days in 2019. The current federal regulations require Active Engagement, meaning the Provider is in the process of working towards sending production data using CEHRT and, as described above, Providers can

contact the PHAs to register their intent to do so. If the PHA has the capacity to accept Providers' data (see Declaration of Readiness section for additional details), a provider can meet public health measure through the Active Engagement steps below:

Active Engagement Option 1—Completed Registration to Submit Data: The EP, EH, or CAH registered to submit data with the public health agency or, where applicable, the clinical data registry to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP, EH, or CAH is awaiting in a queue for an invitation from the public health agency or clinical data registry to begin testing and validation. This option allows Providers to meet the measure when the public health agency or the clinical data registry has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period, unless required by the public health agency.

Active Engagement Option 2—Testing and Validation: The EP, EH, or CAH is in the process of testing and validating the electronic submission of data. Providers must respond to requests from the public health agency or, where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in that Provider not meeting the measure.

Active Engagement Option 3— Production: The EP, EH, or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the public health agency or clinical data registry.

4.3 What does this mean for a Public Health Agency?

In the Promoting Interoperability Programs and related regulations the PHAs are tasked with declaring their readiness to accept data from Providers, registering Providers that intend to submit data, establishing a testing and validation process to onboard Providers, and acknowledging those Providers that successfully submit data. It is not the role of the PHA to determine if Providers meet public health measures or qualify for any financial incentives or payment adjustments.

Outcomes from Providers registering their intent to meet public health measures include:

- PHAs have information on Providers planning to submit data to the PHA for Modified Stage 2, Stage 3 and other federal programs.
- Providers have the information about the PHAs on-boarding process.

To successfully achieve these outcomes, PHAs should develop processes and tools to facilitate registering, onboarding, and acknowledging Providers. A critical success factor will be tracking and documenting communications between a PHA and Providers

reporting within their jurisdiction. The PHA registration process should provide some type of confirmation (e.g., email, webpage confirmation, letter) when the Provider successfully registers. The Providers will need this documentation to support their attestation.

Key Process Communications:

- Providers intending to initiate ongoing submission for public health measures register their intent to submit data to the PHA.
- PHA registration process provides confirmation when the Provider successfully registers their intent.
- PHA should be able to provide appropriate documentation for Providers regarding their current Active Engagement status.

4.4 What actions can a Public Health Agency take now?

At a minimum, PHAs should establish a process to register Providers as they contact PHAs to indicate their intent to submit data to meet public health measures. Some PHAs may implement a simple registration process (like sending an email to a designated mailbox to begin the registration process) while others may use more elaborate electronic registration and tracking processes. This registration process should entail capturing information on the Provider that will later facilitate onboarding. This information could vary depending on the type of Provider (e.g., hospitals, group practices, integrated health care delivery networks). A detailed list of recommended data elements to capture during Provider registration can be found in a functional requirements document developed by the Task Force available at https://www.cdc.gov/ehrmeaningfuluse/Meaningful-Use-MU-Public-Health-PH-Reporting-Requirements-Task-Force.html. The functional requirements document is intended for a technical audience that might be tasked with developing tools or a system to support the Provider registration processes.

As Providers register, PHAs should consider providing them implementation guides and other guidance to prepare them for onboarding (see the sections on Onboarding and Acknowledgements of Submission of Production Data for additional details). The PHA could include an invitation to begin onboarding or information that helps the Provider know when to expect this invitation.

PHAs should consider establishing an Incentive Program Coordinator (see CDC Director's Guidance on MU Coordinator Role) or other dedicated resource(s) to lead and coordinate the PHA's response. It is also recommended that the PHA work with a designated point of contact representing the Provider, which could be an individual professional, hospital, group practice manager, or integrated delivery network coordinator.

3. This document is available on the Task Force's community site on the Center for Disease Control and Prevention's Promoting Interoperability website at https://www.cdc.gov/ehrmeaningfuluse/Meaningful-Use-MU-Public-Health-PH-Reporting-Requirements-Task-Force.html

5 Onboarding

5.1 What is Onboarding?

Onboarding refers to the testing and validation process in which Providers and PHAs collaboratively engage to implement electronic data exchange between the Provider and public health surveillance systems and registries. Providers participate in a PHA's onboarding process by first registering with a PHA (see Registration of Intent section for additional details) and then responding to a PHA's written (email) request for action to test connectivity and the ability to exchange messages in the required format. These actions can include sending data to a PHA for validation and correcting data in response to a PHA's validation feedback.

Since there are multiple Promoting Interoperability Program public health measures, Providers may be concurrently engaged with a PHA in multiple onboarding processes. Each onboarding process ends when the Provider is routinely submitting production data that passes the PHA's validation. Production data refers to data generated through clinical processes involving patient care, and it is used to distinguish between this data and test data which may be submitted for the purposes of enrolling in and testing electronic data exchange.

5.2 What do the regulations say?

The original Stage 2 MU regulations discussed the requirement to submit information to a PHA in accordance with applicable law and practice:

We believe that the requirement to submit information would be under applicable law, the agreements between the Provider and PHA, except where prohibited.

The public health objectives for the original incentive programs included the phrases "except where prohibited" and "in accordance with applicable law and practice." Per information provided in the original MU Stage 2 rule, the phrase "except where prohibited" was meant to encourage reporting to a PHA by a Provider even when there is no explicit reporting requirement in that jurisdiction. For example, voluntary participation in a registry does not require authorization to do so. The phrase "in accordance with applicable law and practice" allowed PHAs to use their existing laws, regulations, and business practices in structuring the data reported from Providers to the PHA. In addition, this phrase also ensured not preempting the applicable state or local laws that govern reporting to the PHA.

A PHA may designate or authorize a third party such as a Health Information Exchange (HIE) to serve as an ongoing destination or conduit for a Provider's data reporting. If, however, this intermediary transforms the Provider's data or message format to meet Incentive Program requirements, then the third party is not functioning merely as a conduit but rather as an extension of the Provider's EHR. In such cases, the HIE must use CEHRT to transform the data, and Providers must attest to the public health measure using that certified module. Providers must ensure their submissions reach the PHA, except in cases where the PHA has explicitly stated submission to the HIE satisfies reporting requirements.

5.3 What does this mean for Public Health Agencies?

PHAs will need to track the status of Providers throughout the onboarding processes. This tracking process should begin when the Provider registers their intent to meet public health measures. After registering, a Provider's status could be described as a series of engagement steps. As examples, these engagement steps could include "waiting for onboarding invitation," "invited to onboard," "currently onboarding," or "in production." The tracking of the onboarding process by a PHA should, at minimum, record when written requests to take action are sent to the Provider and when a Provider responds to these written requests. These written requests should include invitations to begin onboarding and requests for corrective actions the Provider may need to take during testing and validation. A Provider's engagement in the testing and validation process can be demonstrated by the Provider's responses to written requests for action from the PHA, or by any other evidence of compliance with the PHA's request. Upon completion of the onboarding process, the PHA should send or publish communication(s) to the Provider confirming the Provider was able to submit the relevant public health data (see Acknowledgements of Submission of Production Data section for additional details). A Provider that can only submit reportable data in a test environment has not achieved Active Engagement Option 3 - Production.

Providers must still follow applicable state or local laws for reporting to a PHA. Promoting Interoperability Programs do not preempt applicable state or local laws that govern reporting to the PHA. In some jurisdictions, existing public health reporting rules and regulations may reflect more stringent requirements than the Active Engagement requirements outlined in the Promoting Interoperability Program regulations. In those jurisdictions, achieving active engagement with a PHA to satisfy Promoting Interoperability Program requirements could enable a Provider to fulfill some of the reporting requirements to the PHA mandated by applicable state or local laws.

PHAs should consider establishing an Incentive Program Coordinator (see CDC Director's Guidance on Promoting Interoperability Coordinator Role) or other dedicated resource(s) to lead and coordinate the PHA's response to reporting requirements. It is recommended that the PHA works with a designated point of contact representing the Provider, or in the case of group practices and integrated delivery networks, collections

of Providers. The Provider's point(s) of contact would be the recipient of documentation that is needed for attestation and audit for the EHR Incentive Program. During the on-boarding process, Providers' points of contact may work directly with PHA subject matter experts (SME) more familiar with the data and standards for a particular measure.

PHAs are not responsible for verifying if Providers are using CEHRT or whether Providers are meeting CMS deadlines as part of the attestation process. Furthermore, PHAs are not expected to be the arbiters of Providers' achievement or entitlement to any incentive payments or payment adjustments by CMS. Rather, PHAs are expected to document Providers' activities as they register their intent to on-board, respond to the PHA's requests during on-boarding, and work with the Provider to achieve the Provider's submission of production data. The communications a PHA sends to Providers or publishes will be evidence Providers can use when attesting to a Promoting Interoperability Program or if audited by CMS or the State Medicaid Program.

- Key Process Communications: PHA written requests to take action sent to Providers that have registered their intent to submit data for Incentive Program measures. Examples of written requests include but are not limited to: an invitation to begin onboarding, requests to complete on-boarding steps, and requests for corrective action during message testing and validation. Members of the Task Force created templates for Promoting Interoperability Program-related communications between PHAs and Providers, which are located at: (See PHA to Provider communication templates).
- Provider's replies and responses to the PHA's written requests to take action.

5.4 What actions can a Public Health Agency take now?

PHAs should consider providing onboarding guidance for Providers when they register their intent to submit data. This guidance can include implementation guides, checklists, a PHA's transport method requirements, and message validation resources. The goal of successful onboarding is high quality, complete, and timely data useful for both clinical decision support (in the case of immunization query and submission) and public health purposes, and it is critical for Providers to follow PHA's implementation guides and other onboarding guidance to achieve this.

PHA Promoting Interoperability Program coordinators should consider holding internal meetings with the PHA's SMEs for immunization registry reporting, syndromic surveillance reporting, electronic reportable laboratory result reporting, case reporting, and other specialized registries. During the onboarding process, the Coordinator could act as a liaison between the Provider and the PHA programs to which the Provider is attempting to submit data. The Coordinator could track the communications between the Provider and PHA, while the PHA SMEs could provide detailed technical guidance during the testing and validation of data submissions.

6 Acknowledgements of Submission of Production Data

6.1 What are Acknowledgements of Submission of Production Data?

For all Promoting Interoperability Programs, providers should be working with the PHA to achieve ongoing submission of production data. Acknowledgements of submission of production data are the official communications sent from PHAs to providers that affirm a Provider has successfully submitted public health data for public health measures. Production data refers to data generated through clinical processes involving patient care and is different than ‘‘test data’’ which does not represent care for an actual patient and may be submitted for the purposes of enrolling in and testing electronic data transfers.

6.2 What do the regulations say?

Promoting Interoperability Program regulations state that PHAs will provide written communications to affirm a provider has submitted relevant public health data to the PHA. In the event of an audit, providers will use this written PHA communication to substantiate their attestation to CMS that they met public health measures. The regulations do not specify message content or format for this written communication but do indicate that electronic formats are permissible.

6.3 What does this mean for a Public Health Agency?

The regulations allow PHAs to determine the format and medium they want to use to provide a written communication to the Provider to acknowledge/affirm the Provider has submitted the relevant public health data. This means PHAs need to determine communication content and format as well as how to issue these written communications. Options PHAs should consider for this written communication include, but are not limited to:

- Emailing a message to the Provider
- Mailing a letter to the Provider
- Publishing the names of Providers on the PHA’s website
- Using automated acknowledgements generated by systems that are receiving the Provider’s data (e.g., HL7 acknowledgement (ACK) messages from immunization submissions).

Identifying and assessing the potential issues, challenges, and limitations associated with any option should be thoroughly considered by the PHA prior to making a decision.

For the content, PHAs should acknowledge that a Provider submitted the relevant public health data in production to the PHA, the type of data (i.e. immunizations, cancer cases, syndromic surveillance, electronic laboratory reports, case reporting, etc.), and the date but should not state that a Provider has achieved or met the public health measure.

Determinations regarding attestation will be made by CMS or the State Medicaid Program.

As described in the Registration of Intent and Onboarding sections, in order for PHAs to be effective in their role, they should develop processes and tools to track any Incentive Program-related communications with Providers. These communications will include confirmation that Providers have registered their intent to submit data to the PHA, invitations to Providers to begin on-boarding, requests for action Providers need to take during on-boarding, and acknowledgements that Providers have successfully submitted data. PHAs should inform the Providers to retain the PHA communications they receive in case they are audited by CMS or the State Medicaid Program.

Key Process Communications:

- PHAs sending a Provider written communication (which may be in electronic format) to affirm the Provider has submitted the relevant public health data to the PHA.

6.4 What actions can a Public Health Agency take now?

PHAs will need to determine the type, format, and content of the acknowledgements to provide for each of the public health measures. In some states, both state and local PHAs are accepting data submissions from Providers. If the PHA has not already done so, consider convening a cross-agency/cross-program task force to coordinate the planning, implementation, and communications for Promoting Interoperability Programs. State and local agency needs, as well as coordinated efforts with Medicaid and state and local HIE and HIT bodies, should be considered to ensure stakeholders are familiar with expectations for PHAs. The fact sheets and other resources listed in the Other Resources section can help PHAs prepare.

7 Public Health Registries

Under the Promoting Interoperability Programs, public health registry reporting is one of the measures under the public health and clinical data reporting objective. The public health registries reporting measure includes cancer reporting by eligible clinicians/healthcare providers. However, clinical data registry reporting is a separate measure under the Promoting Interoperability Program.

7.1 What are Public Health Registries?

CMS hasn't specifically defined a public health registry. However, a public health registry can be defined as one that is administered by, or on behalf of, a local, state, territorial, or national public health agency and which collects data for public health purposes. CMS agrees that a variety of registries hosted by the jurisdictional public health agency may

be considered public health registries. Hence, the healthcare providers have the flexibility to report to a registry that is most helpful to their patients.

7.2 What do the regulations say?

Per the regulations the cancer registry reporting is now included in the public health registries reporting measure. A public health registry is defined as one that is administered by, or on behalf of, a local, state, territorial, or national public health agency and which collects data for public health purposes. A clinical data registry is defined as one that records information about the health status of patients and the health care they receive over varying periods of time and is administered by, or on behalf of, other non-public health agency entities.

Public health agencies should note that the state cancer registries (by EPs only), CDC's National Health Care Surveys (NHCS) and Antibiotic Use (AU) and Antibiotic Resistance (AR) registries measure have a specific HL7 standard and certification criteria mandated in the 2015 edition CEHRT.

7.3 What does this mean for Public Health Agencies?

Declaring relevant registries as available to meet the public health registry reporting measure is a great way to encourage Providers to supply data to PHA programs. If a PHA intends to declare a registry as a public health registry for interoperability programs they would have to:

- Be using the data gathered by the registry to improve population health outcomes or for another public health purpose.
- Be able to receive electronic data generated from a 2015 Edition CEHRT using a standard specified in the regulations.
- Make publicly available a declaration of readiness to accept data as a public health registry (see Declaration of Readiness section).
- Specify the means of file transmission or transport. The electronic file can be sent to the receiving entity through any appropriately secure mechanism including, but not limited to, a secure upload function on a web portal, SFTP, or Direct. Manual data entry into a web portal would not qualify for submission to a specialized registry.
- Have the following processes in place for Providers:
  - Registration of intent process,
  - Test and validation process,
  - Process to move Provider's data submission activities into production
- Be able to provide appropriate documentation for the Provider regarding Provider's Active Engagement status (see Section 4.2).

ONC will consider adoption of standards and implementation guides in future rulemaking. Should these standards subsequently be finalized, they may then be

adopted as part of the CEHRT definition as it relates to meeting the Public Health Registry Reporting measure through future rulemaking for the interoperability programs.

Any Providers that previously achieved production data submission status would need to have an EHR certified to the 2015 CEHRT Edition standards to meet the measure. PHAs should keep this in mind when deciding whether or not to declare readiness to accept data for certain registries under the Promoting Interoperability Programs.

7.4 What actions can a Public Health Agency take now?

CMS has declared that Providers may register their intent to report with a public health registry if that registry has declared their readiness at a point in time before the start of the EHR reporting, which is 90 days. This registration of intent would allow the Provider to meet the measure under Active Engagement Option 1. PHAs need to make a public declaration of readiness 6 months prior to the beginning of a Provider's EHR reporting period. If a Provider has the necessary CEHRT to submit data to a public health registry, but the PHA has not declared readiness 6 months in advance, the Provider may be able to take an exclusion to the measure.

PHAs are not responsible for tracking and making information available to Providers on clinical data repositories that have declared readiness to accept data for interoperability programs. At this time, the Task Force is not aware of any available listing of clinical data registries sponsored by national societies or other non-public health state programs that are accepting data from Providers for interoperability programs. Providers should check with the national and state specialty/medical societies covering the Provider's scope of practice with which they are affiliated and have a membership, as well as any CMS documents or FAQs for guidance.

If PHAs do become aware of other public health or clinical data registries available to Providers to meet the meaningful use measures, the PHA could provide a link to the information about the other registries on the PHA's website. The PHA could also have a disclaimer stating the PHA does not have any responsibility for registering or assisting Providers with onboarding to those other registries.

The Interoperability Standards Advisory (ISA) website maintained by ONC includes the ISA List of Jurisdictions with information about how those jurisdictions support Promoting Interoperability Programs.

Resources

- CDC Promoting Interoperability web site (www.cdc.gov/ehrmeaningfuluse)
- Interoperability Standards Advisory (ISA) website that has a listing with links to Jurisdiction Meaningful Use webpages at: ISA List of Jurisdictions
- CDC Immunization web site (http://www.cdc.gov/vaccines/programs/iis/meaningful-use/index.html)
- CDC National Program of Cancer Registries (NPCR) website at: http://www.cdc.gov/cancer/npcr/meaningful_use.htm
- CMS Promoting Interoperability web site (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html)
- ONC web site (http://www.healthit.gov/policy-researchers-implementers/meaningful-use-stage-2)

- Centers for Disease Control and Prevention (CDC) Public Health (PH) Promoting Interoperability Task Force https://www.cdc.gov/ehrmeaningfuluse/Meaningful-Use-MU-Public-Health-PH-Reporting-Requirements-Task-Force.html

Appendix

Program Name: Medicare & Medicaid Promoting Interoperability Programs (formerly known as Medicare & Medicaid EHR Incentive Programs or "Meaningful Use") Eligible entities: Eligible Professionals (EPs) and Eligible Hospitals (EHs)/Critical Access Hospitals (CAHs), treating Medicare and Medicaid patients.

Public Health Objective included in the program: Public Health Registry and Clinical Data Registry Reporting

Measures

- Immunizations
- Syndromic Surveillance
- Electronic Case Reporting
- Public Health Registries*
- Clinical Data Registries
- Electronic Laboratory Reporting (for Hospitals only).

*includes- 1) Cancer Reporting by EPs only to State Cancer Registries. 2) Reporting data by EPs and EHs/CAHs to CDC/NCHS and CDC/NHSN programs for Health Care Surveys and Antibiotic Use (AU) & Antibiotic Resistance (AR).

Certified Electronic Health Record Technology (CEHRT) required in 2019: 2015 Edition of CEHRT.

Electronic Health Records Reporting Period (from Healthcare providers to Public Health Agencies) - 90 days in Calendar Year 2019.

How the eligible entity achieves the measure – "active engagement": Being in one of three states – having registered (and possibly awaiting an invitation to begin on-boarding); in testing and validation; or in production.

Processes required on the State/Local public health side including:

1) Declaration of Readiness. State/local public health agencies should document their readiness to accept data in the recognized standard, typically on their public website and healthcare providers should register their intent with the PHA to submit data.

2) Testing & Validation of Data State/local public health agencies should provide a written (email) invitation to the Provider asking them to begin testing and validation of data exchange. To support the processes, the PHA should publish guides, tools, and sample data for Providers to use in collaboration with the PHA to test connectivity and the submission of data to ensure it meets the PHA's quality and timeliness standards.

3) Receipt of Production Data. Issuing acknowledgement letters to the Provider which the providers can use to support their attestation for active engagement.