2021 MEDICARE PROMOTING INTEROPERABILITY PROGRAM: CERTIFIED ELECTRONIC HEALTH RECORD TECHONOLOGY FACT SHEET

For those participating in the Medicare Promoting Interoperability Program, in order to be considered a meaningful user and avoid a downward payment adjustment, eligible hospitals and critical access hospitals (CAHs) may use (1) existing 2015 Edition certification criteria, (2) the 2015 Edition Cures Update criteria, or (3) a combination of the two in order to meet the certified electronic health record technology (CEHRT) definition, as finalized in the [Calendar Year (CY) 2021 Physician Fee Schedule final rule (85 FR 84818 through 84828)](#).

For CY 2021, the CEHRT functionality must be in place by the first day of the EHR reporting period and the product must be certified by the last day of the EHR reporting period. The eligible hospital or CAH must be using their selected version's functionality for the full EHR reporting period. In many situations the product may be deployed but pending certification.

2015 Edition Cures Update

ONC's 21st Century Cures Act Final Rule made several changes to the existing 2015 Edition Health IT Certification Criteria. The following changes constitute the 2015 Edition Cures Update:

- Introduced new technical certification criteria to advance interoperability and make it easier for patients to access their own electronic health information on their smartphones.
- Added new privacy and security certification criteria.
- Revised the standards referenced by several existing 2015 Edition certification criteria, including United States Core Data for Interoperability updates.
- Removed and time-limited several 2015 Edition certification criteria.

To learn more about the 2015 Edition Cures Update, please review [ONC's 21st Century Cures Act final rule](#). To check whether a health IT product has been certified to the 2015 Edition Cures Update criteria, visit the [Certified Health IT Product List](#).

Benefits of CEHRT

- Improves interoperability by adopting new and updated vocabulary and content standards for the structured capture and exchange of health information, including a Common Clinical Data Set (CCDS) composed primarily of data expressed using adopted standards; and rigorously tested and identified content exchange standard (Consolidated Clinical Document Architecture). Standards-based electronic exchange supports patient care by ensuring that health care data is consistently available to the right person, at the right place, and at the right time.
- Includes "application access" certification criteria that requires health IT to demonstrate it can provide application access to the CCDS via an application programming interface (API).

- Supports patient electronic access to health information through new functionalities and a range of potential technologies including the use of APIs. These technologies allow patients greater flexibility and choice in how they access and share their health information.
- Includes a revised View, Download, and Transmit criterion that continues to support patients' access to their health information, including via email transmission to any third party the patient chooses (including to any email address, so long as the patient is properly advised of the risks of doing so) and through a second encrypted method of transmission.