STATE MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM 2017 STAGE 2 MODIFIED ATTESTATION REFERENCE GUIDE

ELIGIBLE PROFESSIONALS

AHCCCS
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https://www.azepip.gov/

Contents

Disclaimer

The Arizona Health Care Cost Containment System Administration (AHCCCS) is providing this material as an informational reference for physician and non-physician practitioner providers.

Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of posting, the Medicare and Medicaid program is constantly changing, and it is the responsibility of each physician, non-physician practitioner; supplier or provider to remain abreast of the Medicare and Medicaid program requirements.

Medicare and Medicaid regulations can be found on the CMS Web site at ***http://www.cms.gov.***

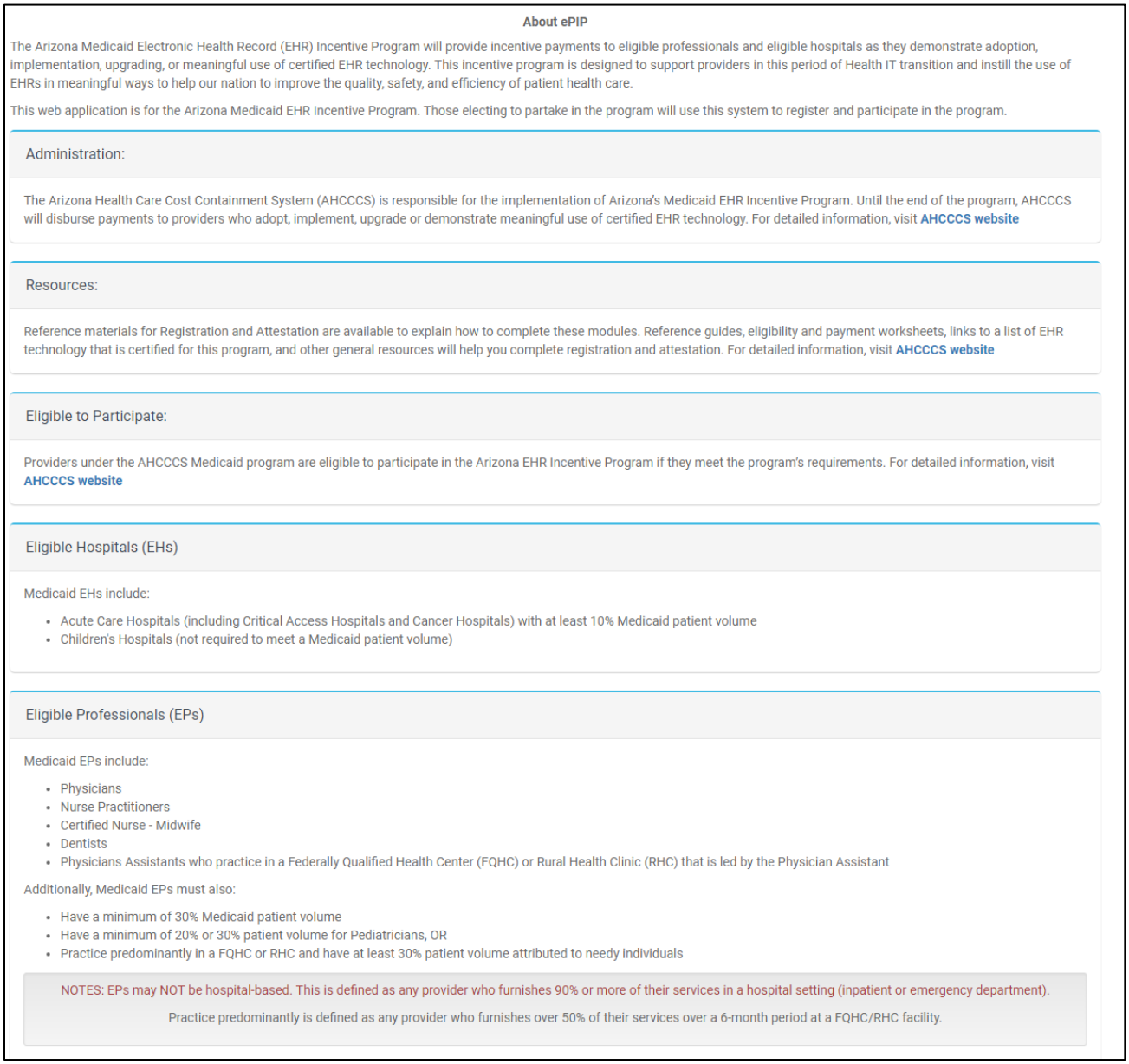
Important Notice – Third Party Attestation

The Arizona Medicaid Program does not allow third party attestation for Eligible Providers in the Electronic Provider Incentive Payment System (ePIP).

Eligible Providers should actively participate in the attestation process in ePIP.

Eligible providers are responsible for the completeness and accuracy of the information provided in their attestation in ePIP.

About ePIP



About ePIP

The Arizona Medicaid Electronic Health Record (EHR) Incentive Program will provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. This incentive program is designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care.

This web application is for the Arizona Medicaid EHR Incentive Program. Those electing to partake in the program will use this system to register and participate in the program.

Administration:

The Arizona Health Care Cost Containment System (AHCCCS) is responsible for the implementation of Arizona's Medicaid EHR Incentive Program. Until the end of the program, AHCCCS will disburse payments to providers who adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. For detailed information, visit **AHCCCS website**

Resources:

Reference materials for Registration and Attestation are available to explain how to complete these modules. Reference guides, eligibility and payment worksheets, links to a list of EHR technology that is certified for this program, and other general resources will help you complete registration and attestation. For detailed information, visit **AHCCCS website**

Eligible to Participate:

Providers under the AHCCCS Medicaid program are eligible to participate in the Arizona EHR Incentive Program if they meet the program's requirements. For detailed information, visit **AHCCCS website**

Eligible Hospitals (EHs)

Medicaid EHs include:

- Acute Care Hospitals (including Critical Access Hospitals and Cancer Hospitals) with at least 10% Medicaid patient volume
- Children's Hospitals (not required to meet a Medicaid patient volume)

Eligible Professionals (EPs)

Medicaid EPs include:

- Physicians
- Nurse Practitioners
- Certified Nurse - Midwife
- Dentists
- Physicians Assistants who practice in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by the Physician Assistant

Additionally, Medicaid EPs must also:

- Have a minimum of 30% Medicaid patient volume
- Have a minimum of 20% or 30% patient volume for Pediatricians, OR
- Practice predominantly in a FQHC or RHC and have at least 30% patient volume attributed to needy individuals

NOTES: EPs may NOT be hospital-based. This is defined as any provider who furnishes 90% or more of their services in a hospital setting (inpatient or emergency department).

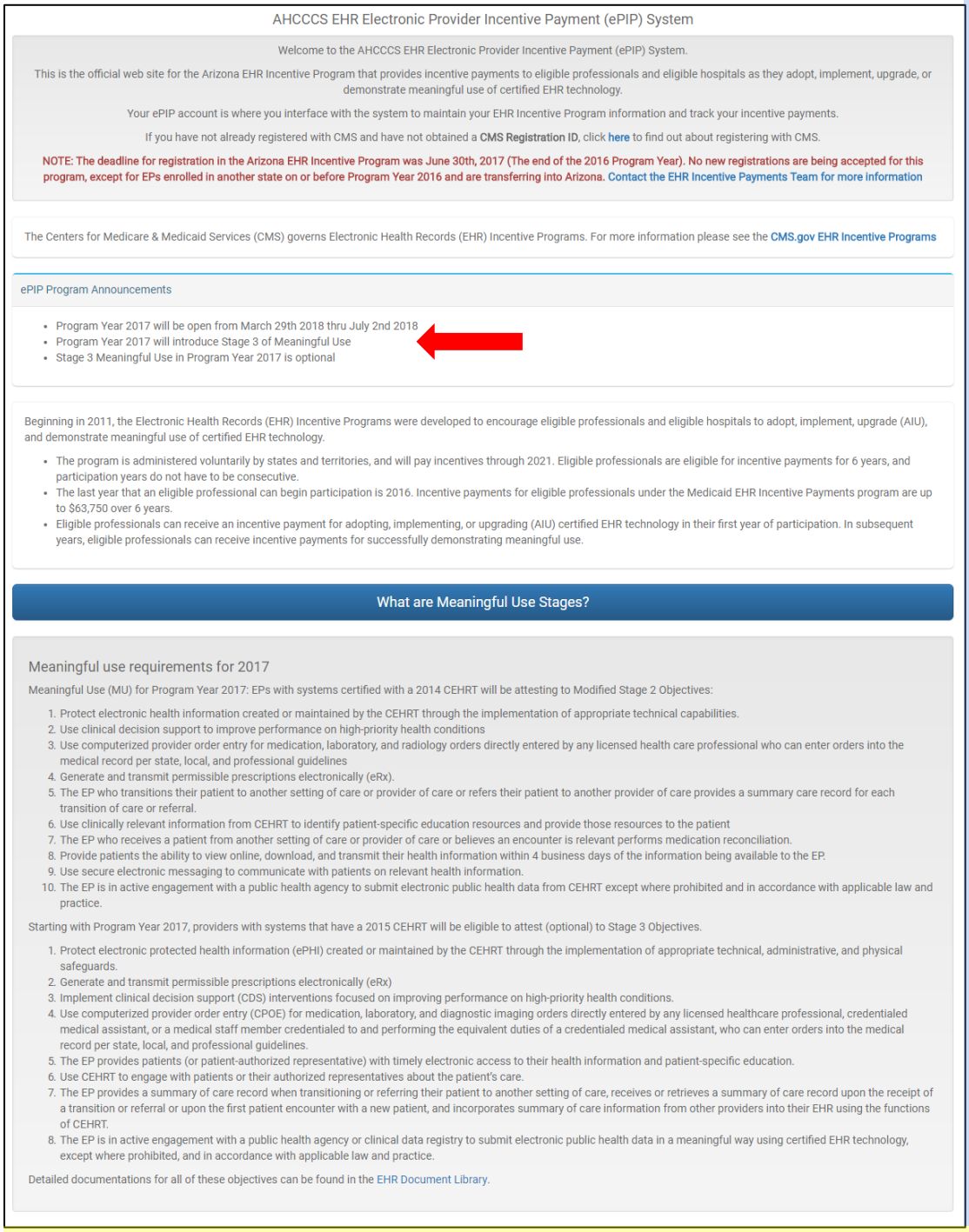
Practice predominantly is defined as any provider who furnishes over 50% of their services over a 6-month period at a FQHC/RHC facility.

TIP

Providers must complete and submit an attestation in the ePIP System each program year in order to apply for the program.

Go to the ePIP System by clicking here

Welcome to the ePIP System Home Page



The ePIP System Welcome screen consists of six menu navigational topics.

1. Home
2. Log On
3. Register
4. About
5. EHR Doc Library
6. Contact Us

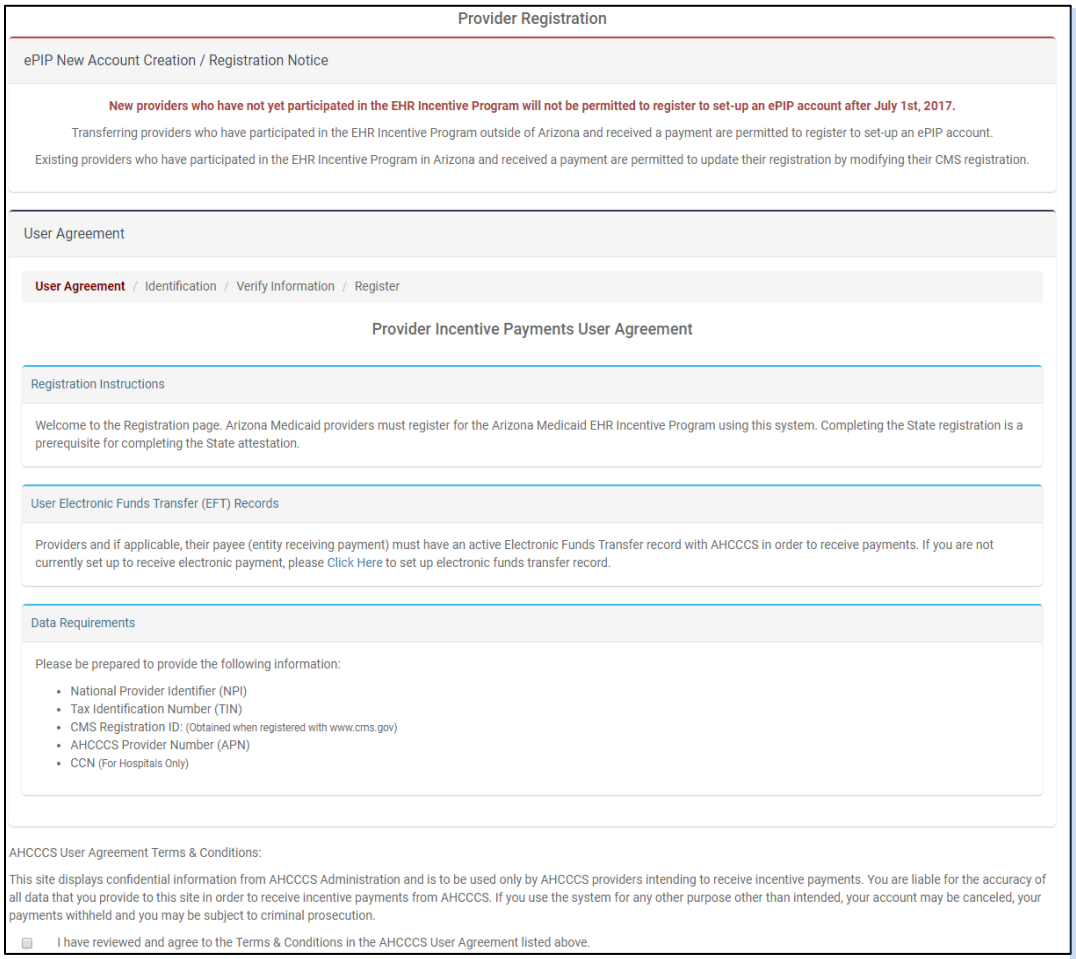
ePIP Program Announcement Update:

ePIP is accepting attestations for Program Year 2017 until August 31, 2018 (*subject to CMS approval)*.

TIP

Helpful links are located in the footer of the web page.

Registration (Providers Without an ePIP Account)



Regarding Providers without an ePIP Account:

Only providers who already received payment and transferring to Arizona from other states can still set-up an ePIP account.

Providers must agree to the Terms & Conditions in order to register.

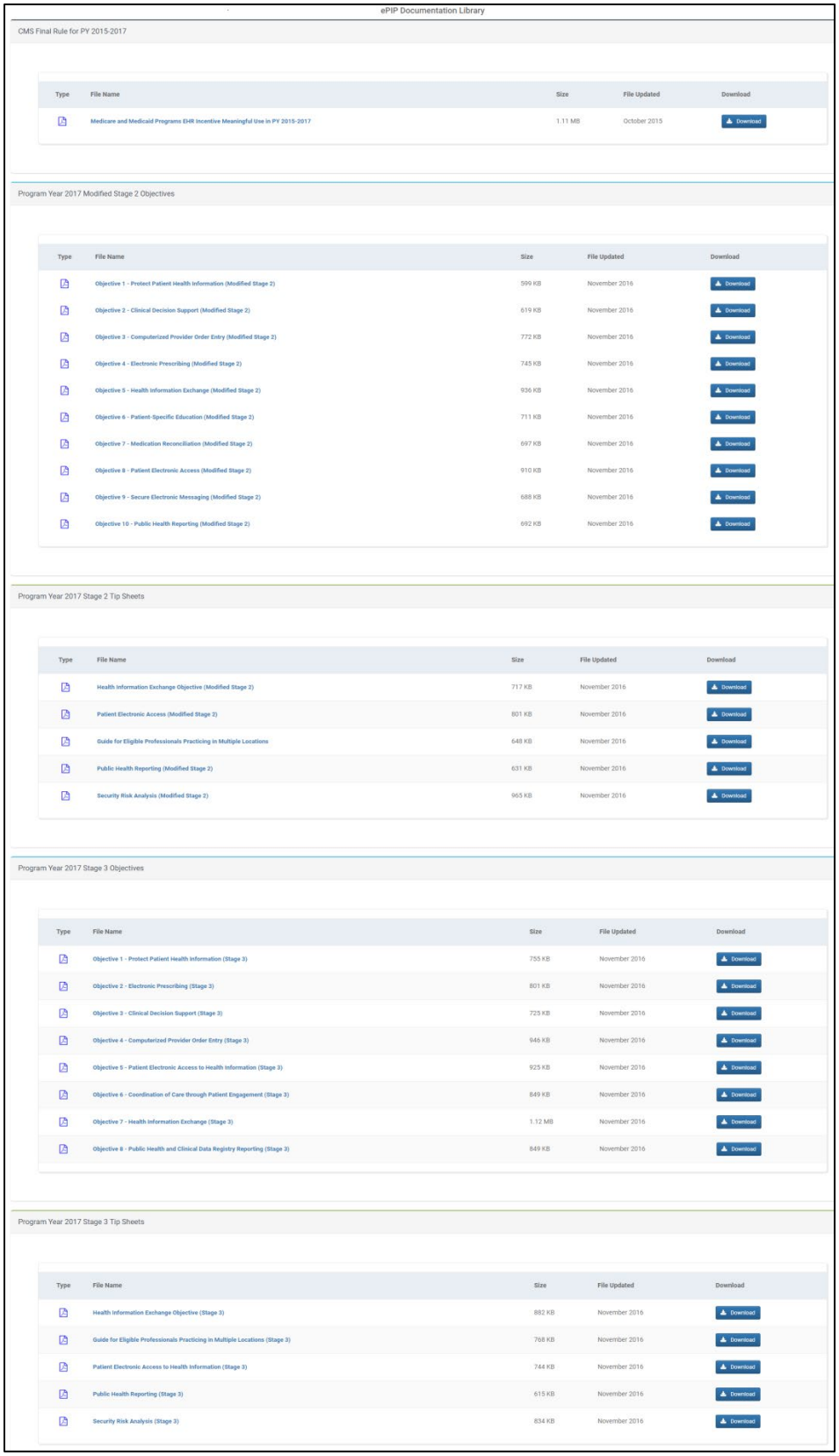
Program Year 2016 was the last year for providers to begin participation in the EHR Incentive Program.

You must agree by checking the box in order to proceed.

TIP

Your NPI number can be verified at the following link:
https://npiregistry.cms.hhs.gov/registry/

EHR Document Library



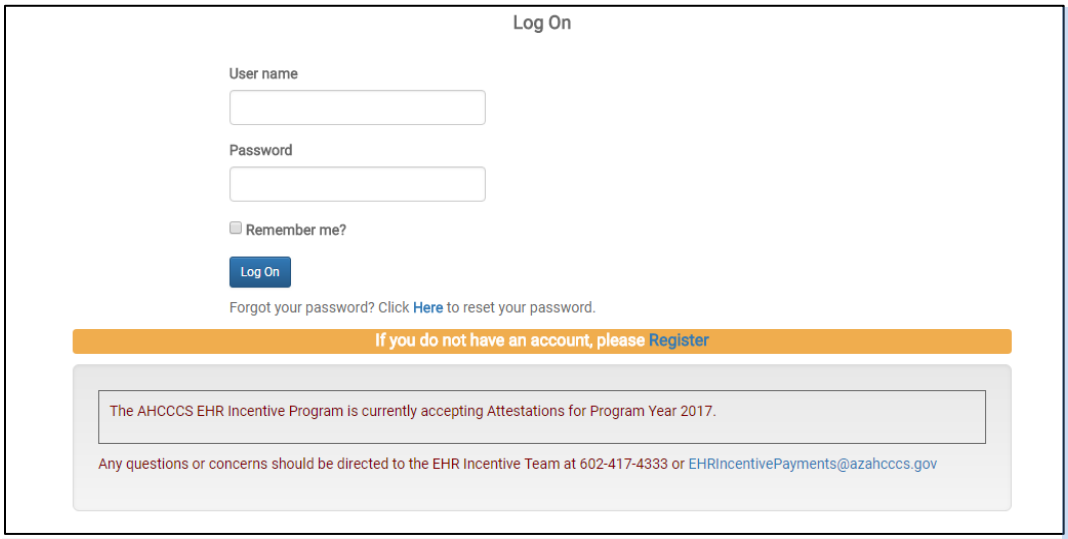
Use our EHR Document Library to navigate quickly to the Meaningful Use requirements.

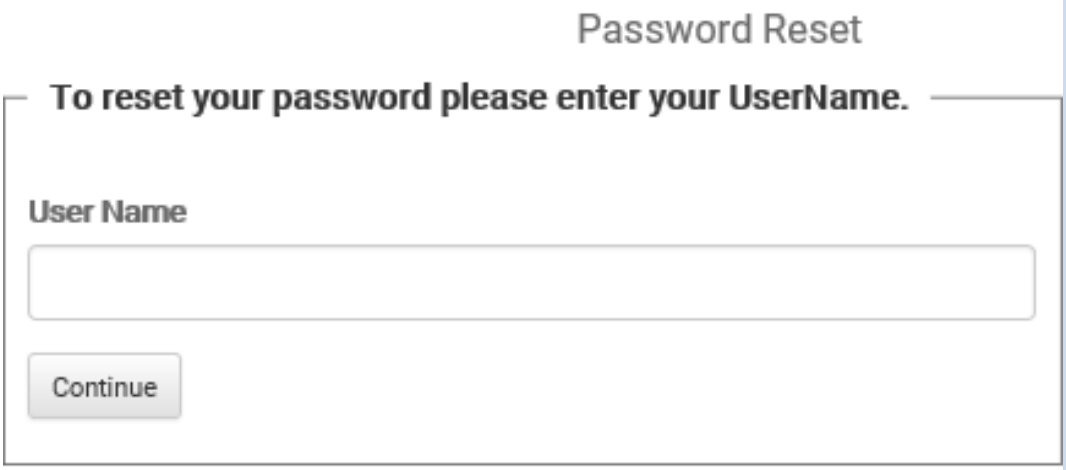
Click the link or

Click the download button to view details on the 2017 Meaningful Use Objectives for Stage 2 Modified or Stage 3.

For more information on the 2017 Program Requirements at CMS, click here.

Log On





Providers who already have an ePIP account must log on in order to access their account.

If you forgot your password, you can reset your password by clicking the link below the Log On button.

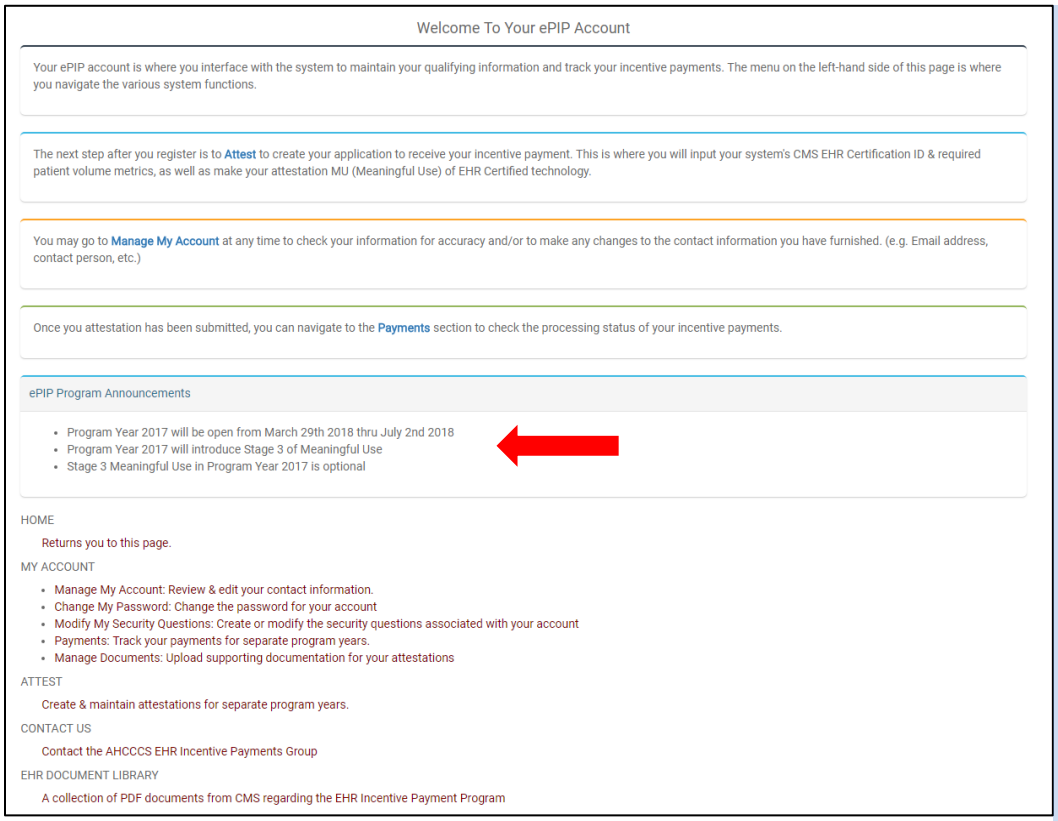
Please allow an hour for server to respond to your request.

Go to the ePIP System by clicking here

TIP

Need help? E-mail the EHR Incentive Program Team at EHRIncentivePayments@azahcccs.gov or call us at 602-417-4333.

Welcome to Your ePIP Account Home Page



The ePIP Account Welcome screen consists of six menu topics to navigate through the attestation.

1. Home

2. My Account
   - Manage My Account
   - Change My Password
   - Modify My Security Questions
   - Payments
   - Manage Documents
   - EHR Certificate Validation Tool

3. Attest

4. Contacts
   - EHR Team
   - Other AHCCCS Contacts

5. EHR Doc Library

6. Log Off

ePIP Program Announcement Update:

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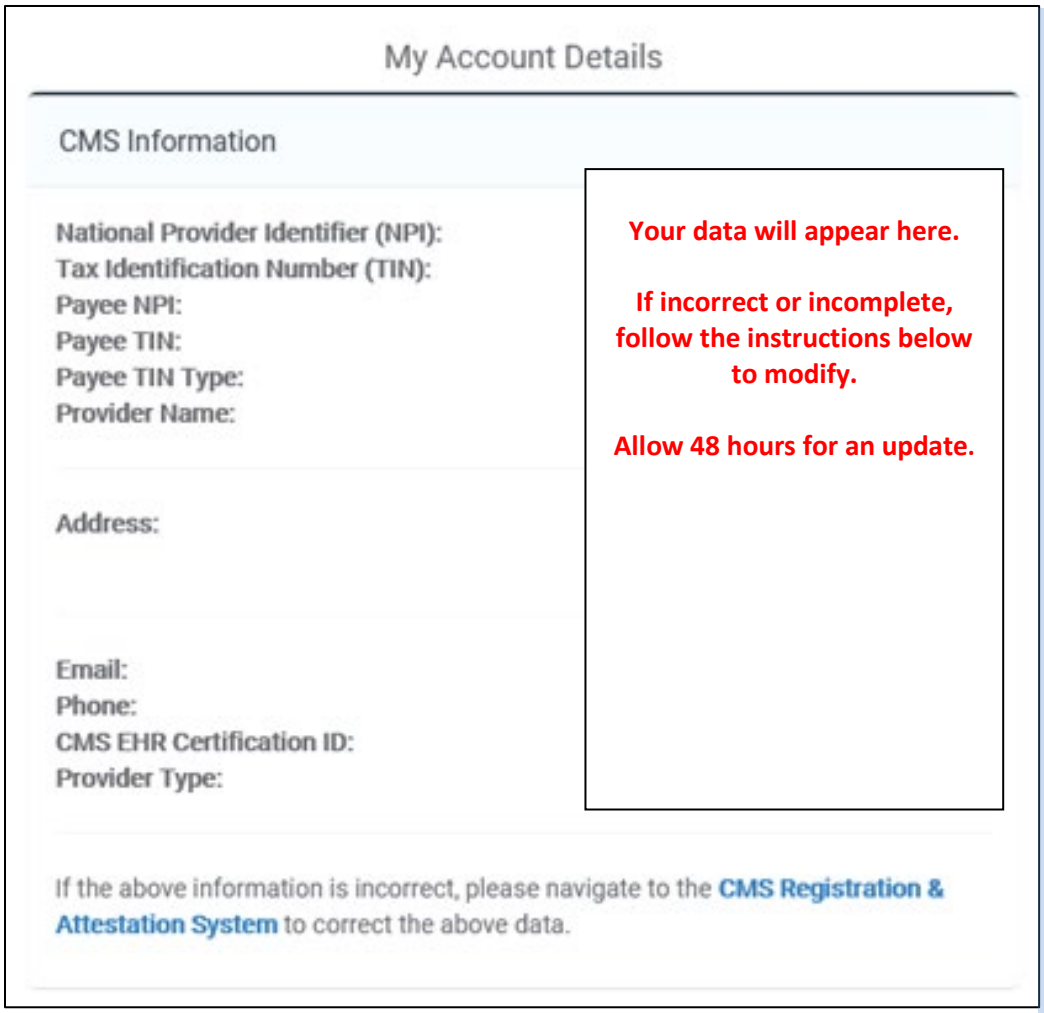
My Account – How to Manage My Account



My Account page has six drop down navigation menus to help you manage your ePIP Account.

Let's take a look at:

- Manage My Account
- Change My Password
- Modify My Security Questions
- Payments
- Manage Documents
- EHR Certificate Validation Tool

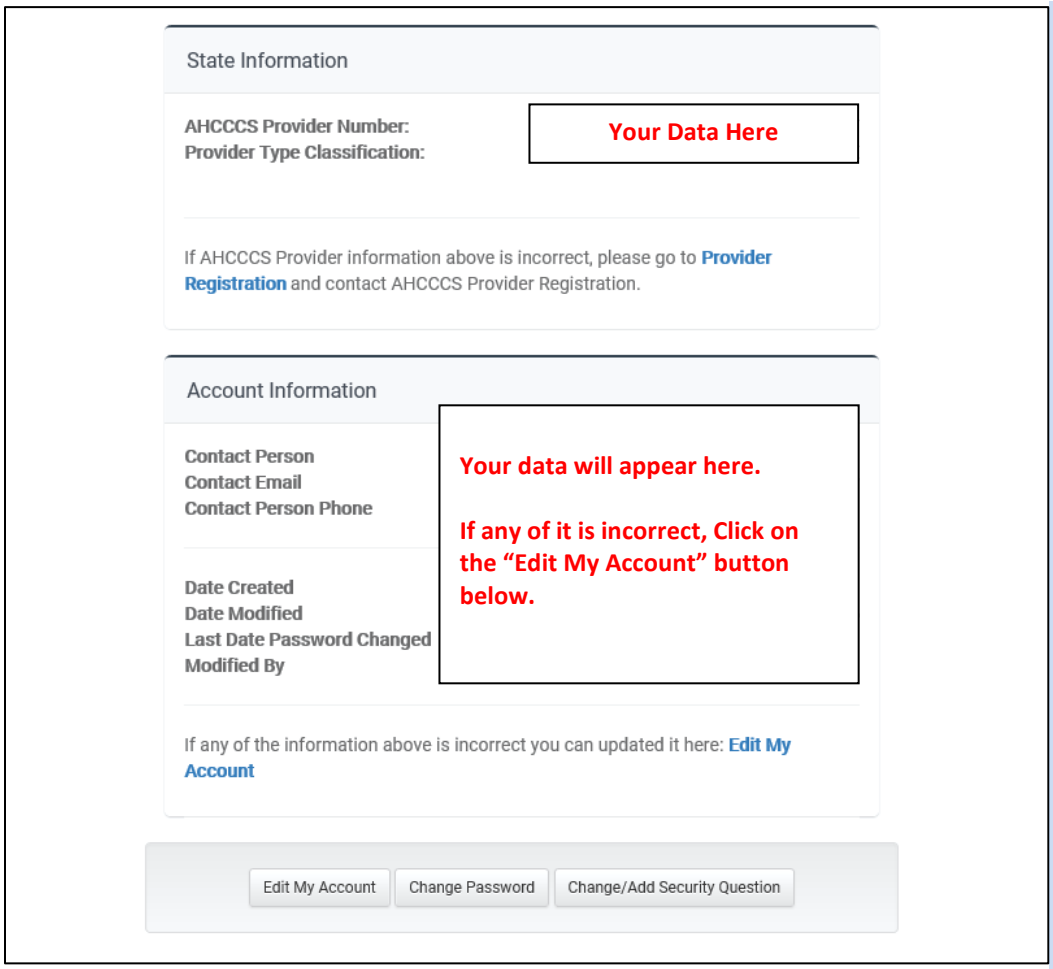
Manage My Account allows you to add an authorized secondary contact *(optional)*.

This person does not have access to ePIP but is permitted to communicate with the State to answer general program inquiries and to help you gather your documentation for the attestation.

TIP

Click Edit My Account to add or update an authorized secondary contact.

My Account – How to Manage My Account - Continued



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- Change My Password
- Modify My Security Questions
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TIP

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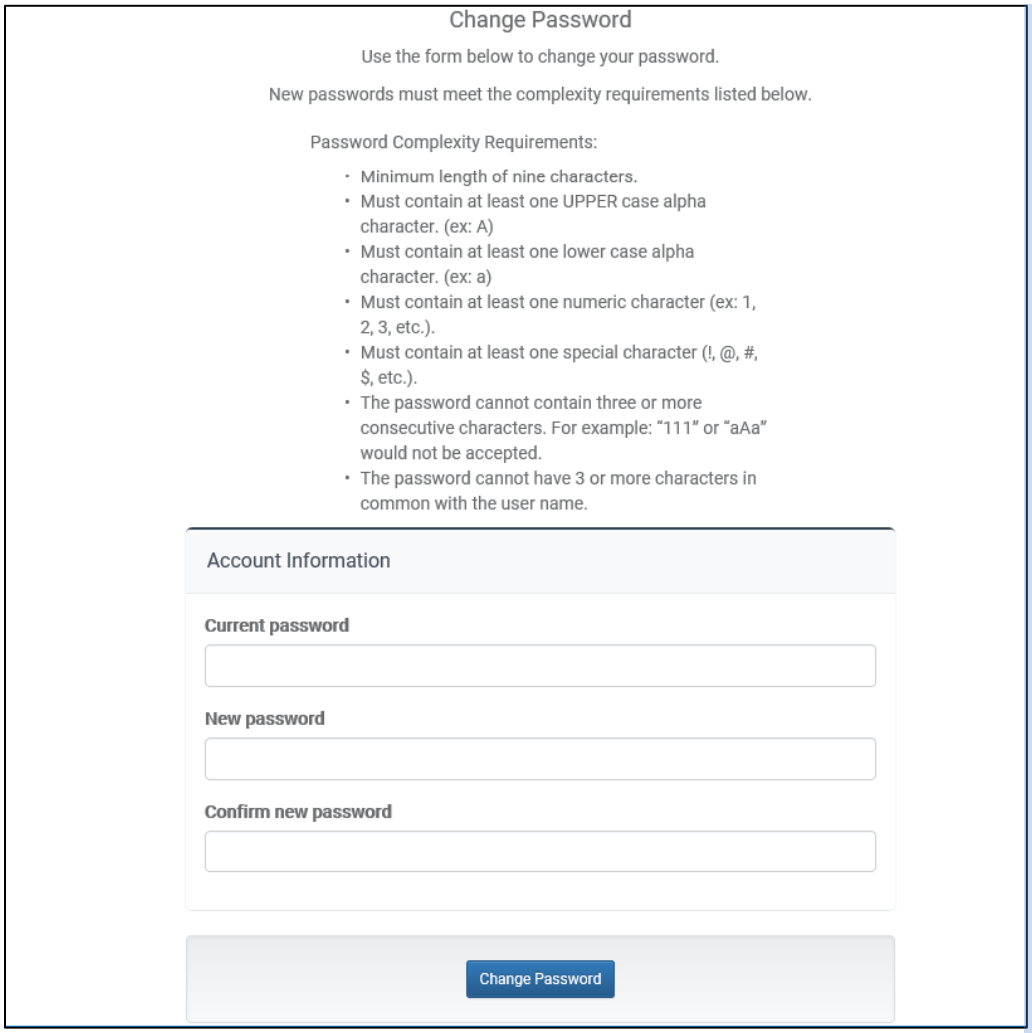
My Account – How to Manage My Password



My Account page has six drop down navigation menus to help you manage your ePIP Account.

Let's take a look at:

- Manage My Account
- **Change My Password**
- Modify My Security Questions
- Payments
- Manage Documents
- EHR Certificate Validation Tool

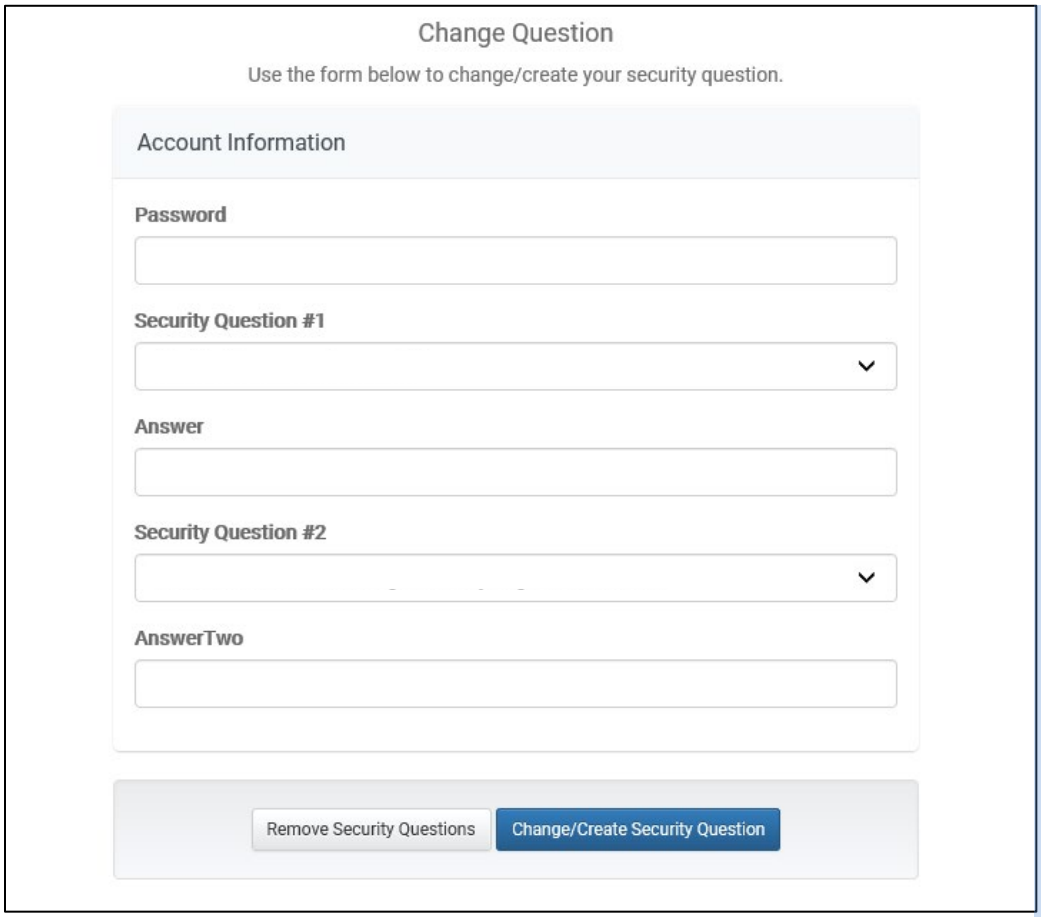
Change My Password allows you to modify your password at any time.

Enter your current password and then your new password.

TIP

Passwords must meet the complexity requirements displayed on the screen.

My Account – How to Manage My Security Questions



My Account page has six drop down navigation menus to help you manage your ePIP Account.

Let's take a look at:

- Manage My Account
- Change My Password
- **Modify My Security Questions**
- Payments
- Manage Documents
- EHR Certificate Validation Tool

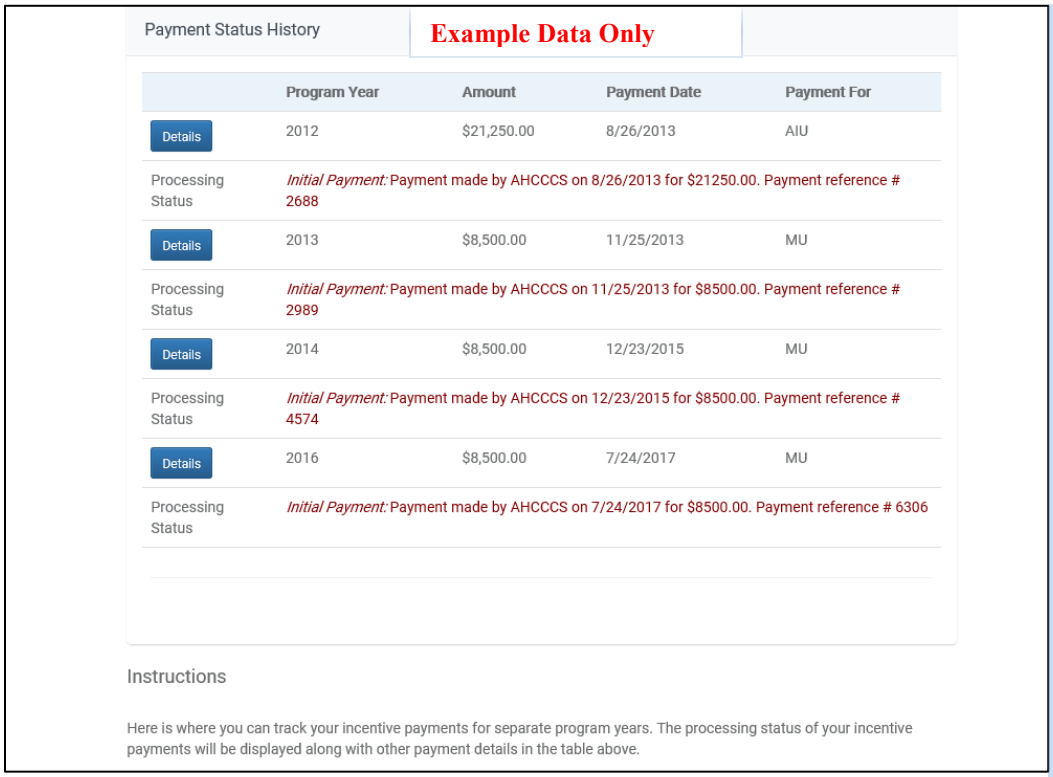
Modify My Security Questions allows you to create or change your security questions and answers.

Select your security question from the drop down menu and enter your answer.

TIP

You must enter your password to modify your security questions.

My Account – How to Manage My Payments



My Account page has six drop down navigation menus to help you manage your ePIP Account.

Let's take a look:

- Manage My Account
- Change My Password
- Modify My Security Questions
- **Payments**
- Manage Documents
- EHR Certificate Validation Tool

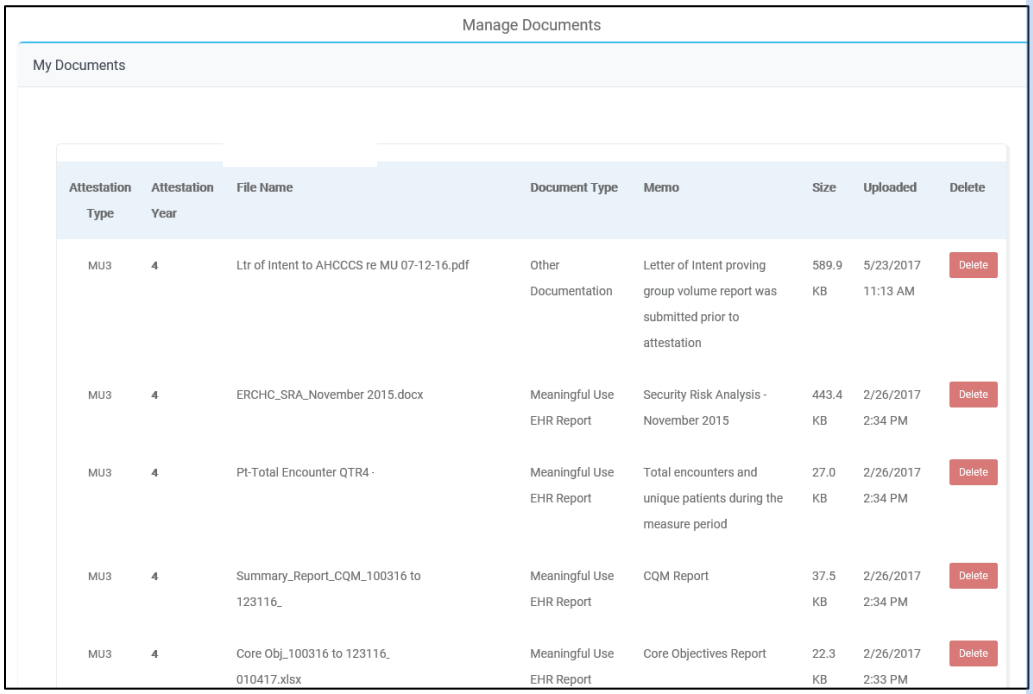
Payments allow you to view your payment history and processing status.

TIP

A payment processing status message is displayed to keep you updated.

My Account – How to Manage My Documents

Example Data Only



My Account page has six drop down navigation menus to help you manage your ePIP Account.

Let's take a look at:

- Manage My Account
- Change My Password
- Modify My Security Questions
- Payments
- **Manage Documents**
- EHR Certificate Validation Tool

Manage Documents allows you to upload your documentation that supports your attestation.

Click Create New to upload documents.

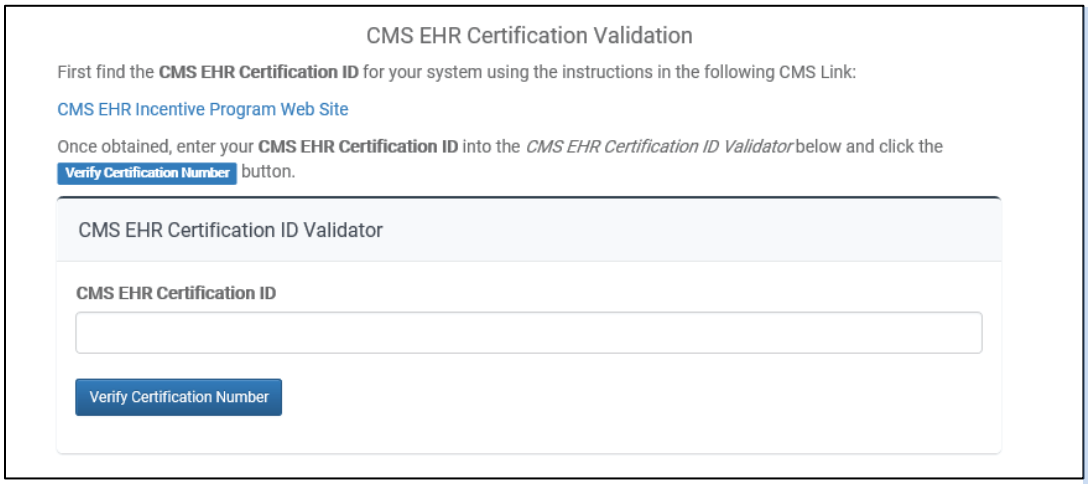
TIP

Tag your documents by selecting the appropriate label from the drop down list:

☑ Attestation Year – describes the program year for the document

☑ Document Type – describes the type of document you are uploading.

My Account – How to Manage My EHR Certification Number



My Account page has six drop down navigation menus to help you manage your ePIP Account.

Let's take a look at:

- Manage My Account
- Change My Password
- Modify My Security Questions
- Payments
- Manage Documents
- **EHR Certificate Validation Tool**

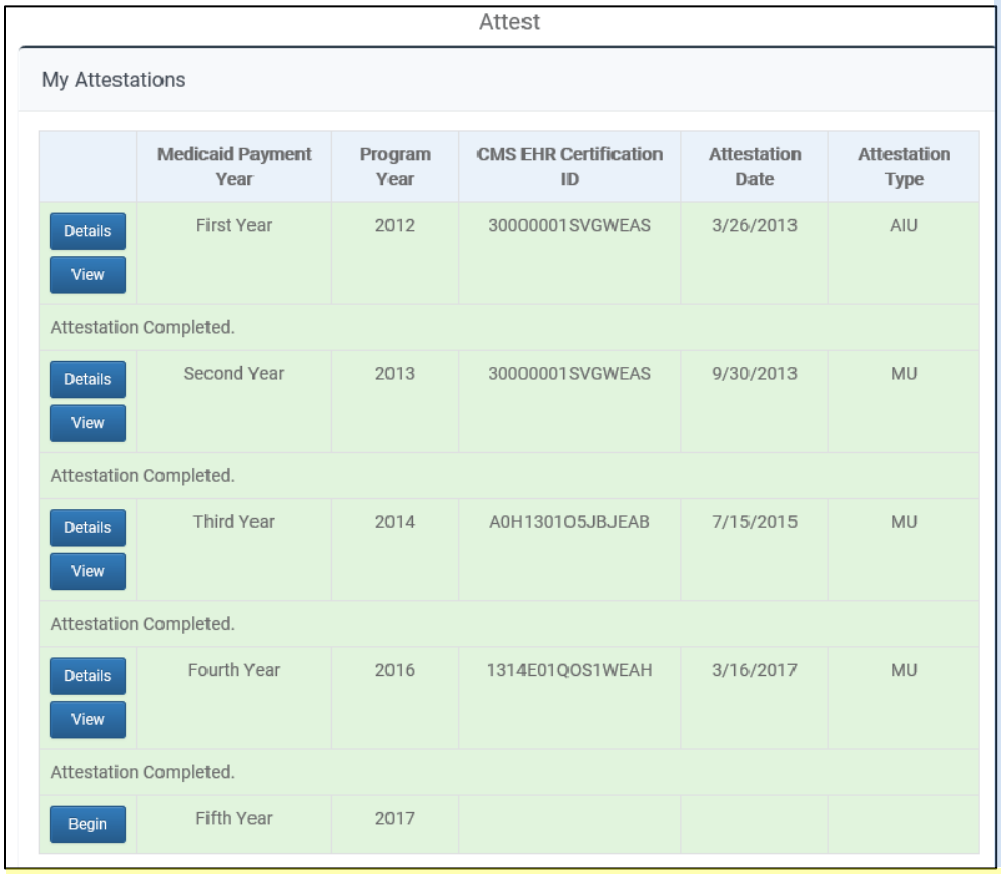
EHR Certificate Validation Tool allows you to verify your EHR Certification Number using the online CMS EHR Certification ID Validator.

TIP

The EHR Certification Number is a unique alpha-numeric character string assigned by ONC-Authorized Testing & Certification Board after an EHR system has been successfully certified.

Attestation

This Screen Shows Example Data Only



The Attest page is where you create your attestation & view your attestation activity.

Providers must attest if they want to participate in the program (maximum of 6 payments).

Please be sure to read the Meaningful Use Stage Review and the Data Requirements.

TIP

Before Submission:

Click the Create New button to start a new attestation *(new users)*.

Click the Begin button to start a new attestation *(existing users)*.

Click the Edit button to complete your attestation.

After Submission:

Click the Re-submit button to modify a previously failed/rejected attestation.

Click the Details button to view the details of your attestation.

Click the View button to see a status of your Attestation Progress.

Attestation Instructions

Attestation Instructions

Welcome to the Attestation page. Arizona Medicaid providers must attest each payment year for the Medicaid EHR Incentive Program. Completing the State attestation is a prerequisite for determining the EHR Incentive Program payment.

In your first participation year, you demonstrated that you Adopted, Implemented or Upgraded your system to certified EHR technology. That was the first step in transforming our nation's health care system to improve quality, safety and efficiency of care to EHR technology.

Attest Options

Depending on the current status of your attestation, please select one of the following actions:

- Begin: Begin Meaningful Use Attestation. *
- Edit: Edit a previously started Meaningful Use Attestation that has not yet been submitted.
- Resubmit: Resubmit a failed or rejected attestation.
- Detail: View detail Meaningful Use Attestation that has been submitted and accepted.

* If you are a new user of the Arizona ePIP system, please select the "Create New" option at the top of the page.

Meaningful Use Stage Overview

Meaningful Use attestations require Medicaid Eligible Professionals (EPs) participating in the EHR Incentive Program to successfully demonstrate "meaningful use" of certified EHR technology. The reporting period for Meaningful Use is a minimum of 90 days.

Requirements for Meaningful Use Measures for EPs

- Meaningful Use Stage 2 consists of 10 Meaningful Use Objectives that must be met according to CMS threshold. If an EP meets the criteria for and can claim an exclusion for measures that have that option, then the measure(s) is also considered met.
- Meaningful Use Stage 3 consists of 8 Meaningful Use Objectives that must be met according to CMS threshold. If an EP meets the criteria for and can claim an exclusion for measures that have that option, then the measure(s) is also considered met.

Beginning in Program Year 2017, CMS adopted final policies to align specific CQMs available to EPs participating in the Medicaid EHR Incentive Program with those available to professionals participating in the Merit-based Incentive Payment System (MIPS).

Changes include:

- The minimum amount of CQMs EPs must attest to has been reduced from 9 CQMs to 6 CQMs
- EPs are no longer required to attest to CQMs that cover a minimum amount of NQS domains
- 11 CQMS have been removed, leaving EPs the option to attest to 53 CQMs instead of 64 CQMs

Attestation Instructions cont'd.

Data Requirements

Please be prepared to provide the following information:

Medicaid Patient Volume

- Patient Volume Reporting Period [90 days] [1]
- Hospital-Based Reporting Period [12 months] [1]
- Patient Volume Methodology (Individual/Aggregate) [2]
- Total Patient Encounters
- Medicaid Patient Encounters [Medicaid Title XIX]
- Hospital-Based Patient Encounters [Medicaid Title XIX Inpatient Hospital & Emergency Department]

Notes:

- [1] Reporting periods are from the prior calendar year that precedes the payment year.
- [2] For Individual Patient Volume Methodology:
  - Patient Volume criteria is based on Provider's data
  - Hospital-Based criteria is based on Provider's data
- [2] For Aggregate Patient Volume Methodology:
  - Patient Volume criteria is based on Practice's data
  - Hospital-Based criteria is based on Provider's data

Additional Requirement:

Non-Hospital-Based Criteria:
EPs selecting Medicaid Patient Volume Type cannot be hospital-based. Hospital-Based Patient Encounters are encounters received at an inpatient hospital or an emergency department place of service. Hospital-Based EPs have 90 percent or more of their covered professional services in a hospital setting during the 12-month reporting period.

Needy Individual Patient Volume

- Patient Volume Reporting Period [1]
- Practice Predominantly Reporting Period [1]
- Patient Volume Methodology
- Total Patient Encounters
- Needy Individual Patient Encounters [Medicaid Title XIX, CHIP Title XXI & Patients Paying Below Cost]
- FQHC/RHC Facility Patient Encounters in Practice Predominantly Reporting Period
- Total Patient Encounters in Practice Predominantly Reporting Period

Notes:

- [1] Reporting periods
  - Patient Volume Reporting Period is a 90-day period in prior calendar year
  - Practice Predominantly Reporting Period is a 6-month period in prior calendar year

Additional Requirement:

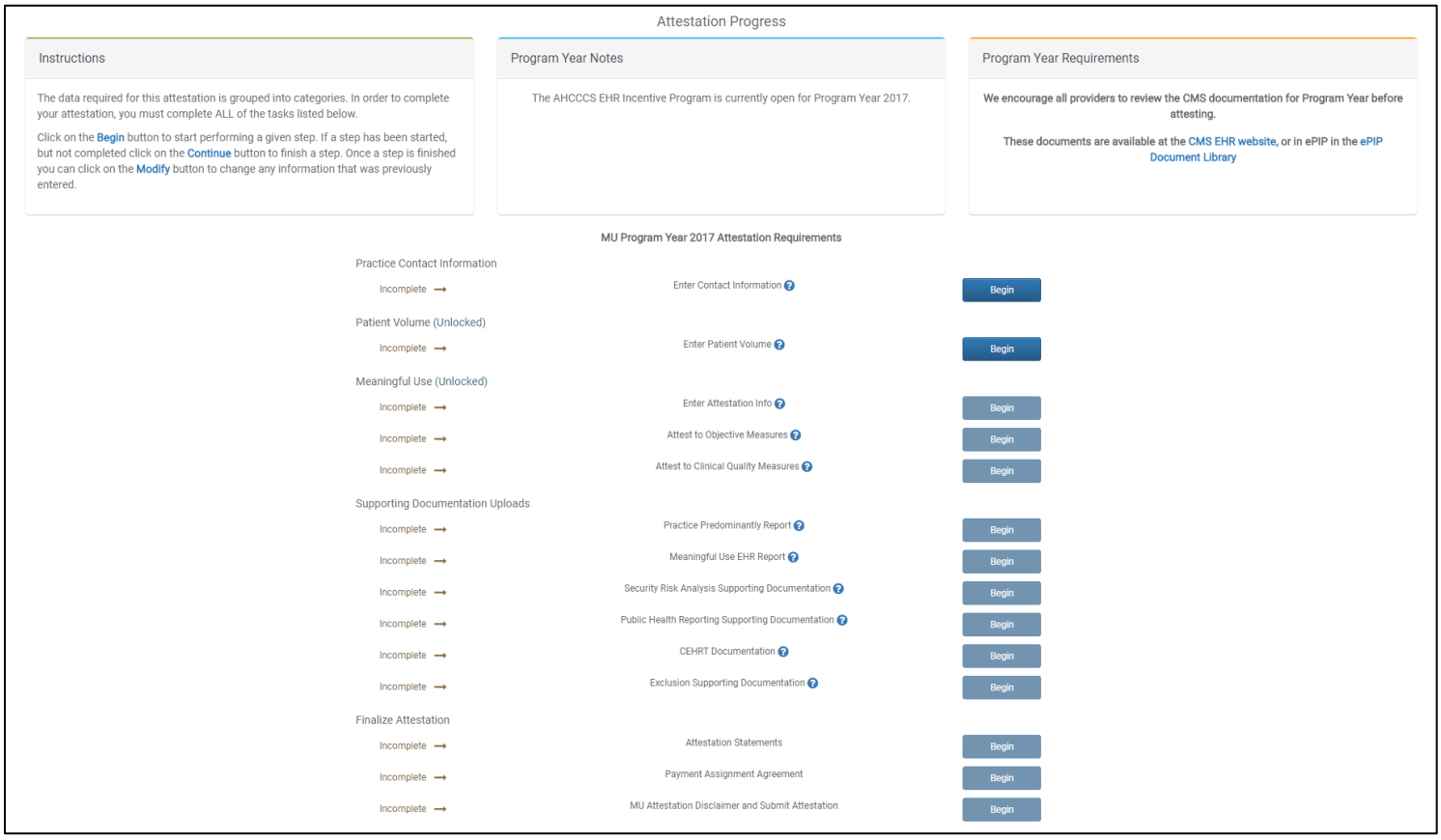
Practice Predominantly Criteria
EPs selecting Needy Individual Patient Volume Type must practice predominantly at FQHC/RHC facilities. Practice Predominantly EPs have more than 50 percent of patient encounters at FQHC/RHC facilities place of service during the 6-month reporting period.

AIU Selection

Note: As of the end of Program Year 2016 (June 30th, 2017) the AIU Selection is no longer available

- **Adopted Certified EHR**
  Adoption of an EHR system requires that a provider acquired, purchased or secured access to certified EHR technology.
- **Implemented Certified EHR**
  Implementation of an EHR system requires that a provider installed or commenced utilization of certified EHR technology.
- **Upgraded Certified EHR**
  Upgrade of an EHR system requires that a provider upgraded from existing EHR technology to certified EHR technology or expanded the functionality of existing certified EHR technology.

Attestation Progress



This is where you will monitor your progress towards completion of your attestation.

Note that the ability to complete the steps on this page is sequential. You must complete the steps in sequence (top down) to access subsequent sections.

The supporting documentation must be uploaded after you complete each step.

TIP

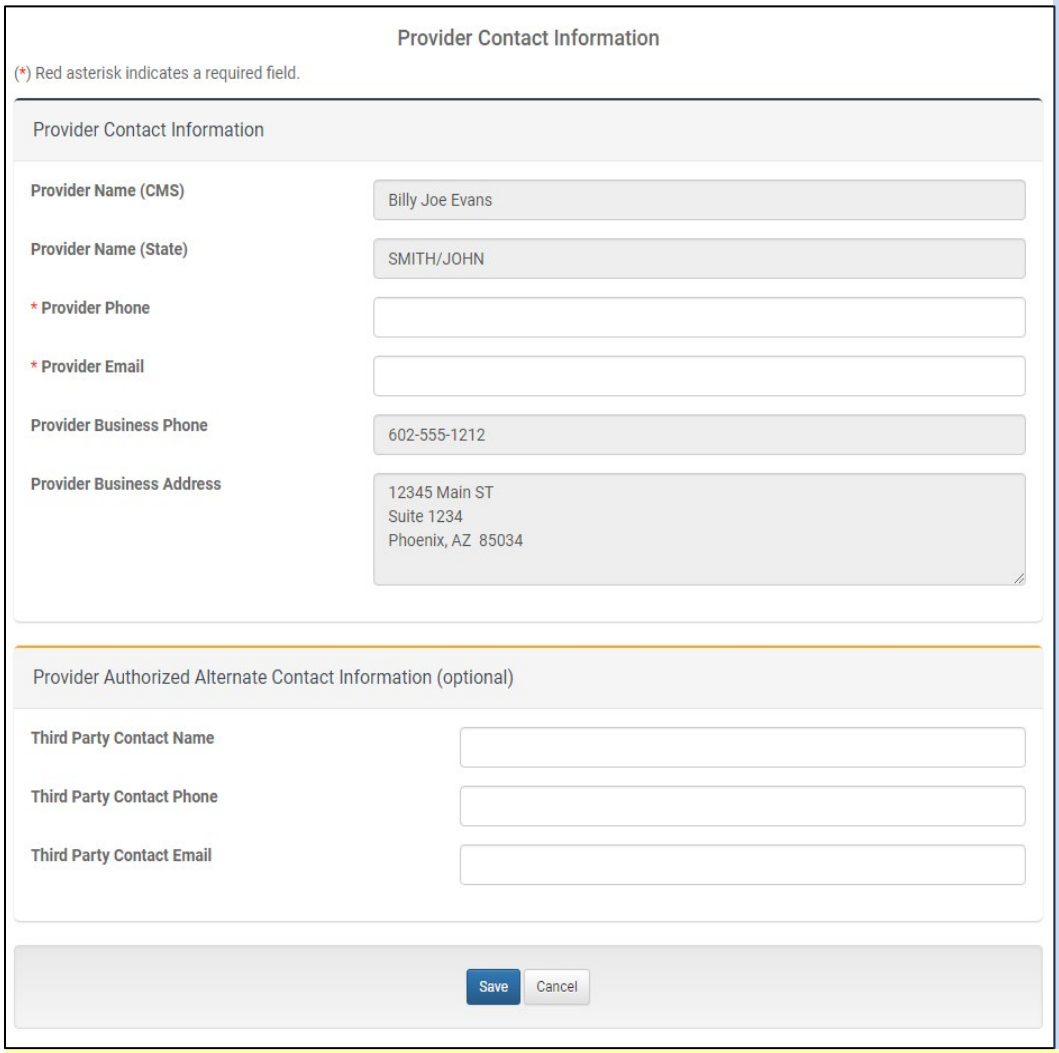
Click the Begin button to complete each step.

Click the Continue button to finish a step.

Click the Modify button to change information previously entered.

Provider Contact Information

Example Data Only



Please make certain that your contact detail is always up to date.

You must first update your contact changes in the CMS Registration and Attestation System at the following Link: Click Here

Wait at least 48 hours for the information you modified in the CMS Registration and Attestation System to feed to your ePIP account.

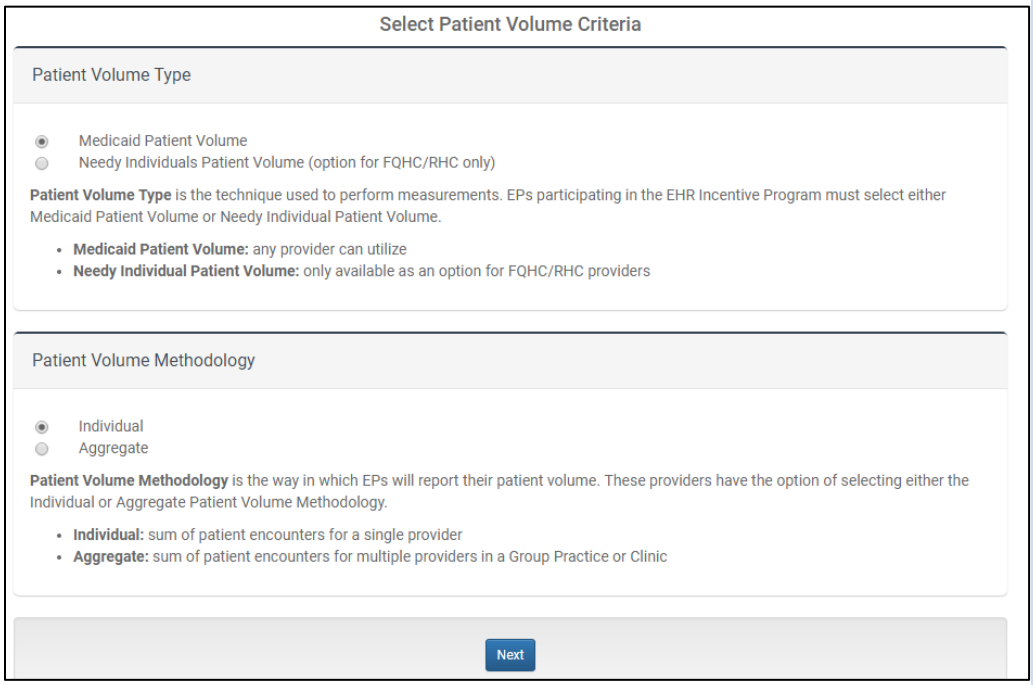
TIP

Did you know that you can enter an authorized secondary contact in ePIP?

This person does not have access to ePIP but is permitted to communicate with the State to answer general program inquiries and to help you gather your documentation for the attestation.

Go to My Account, Click Manage My Account and Click Edit My Account to update your authorized secondary contact *(optional)*.

Patient Volume Criteria



Patient volume is required each time you apply for the program.

Medicaid Patient Volume is an available option for all providers.

Needy Patient Volume is only an available option for providers practicing in a FQHC, RHC, or Tribal Clinic.

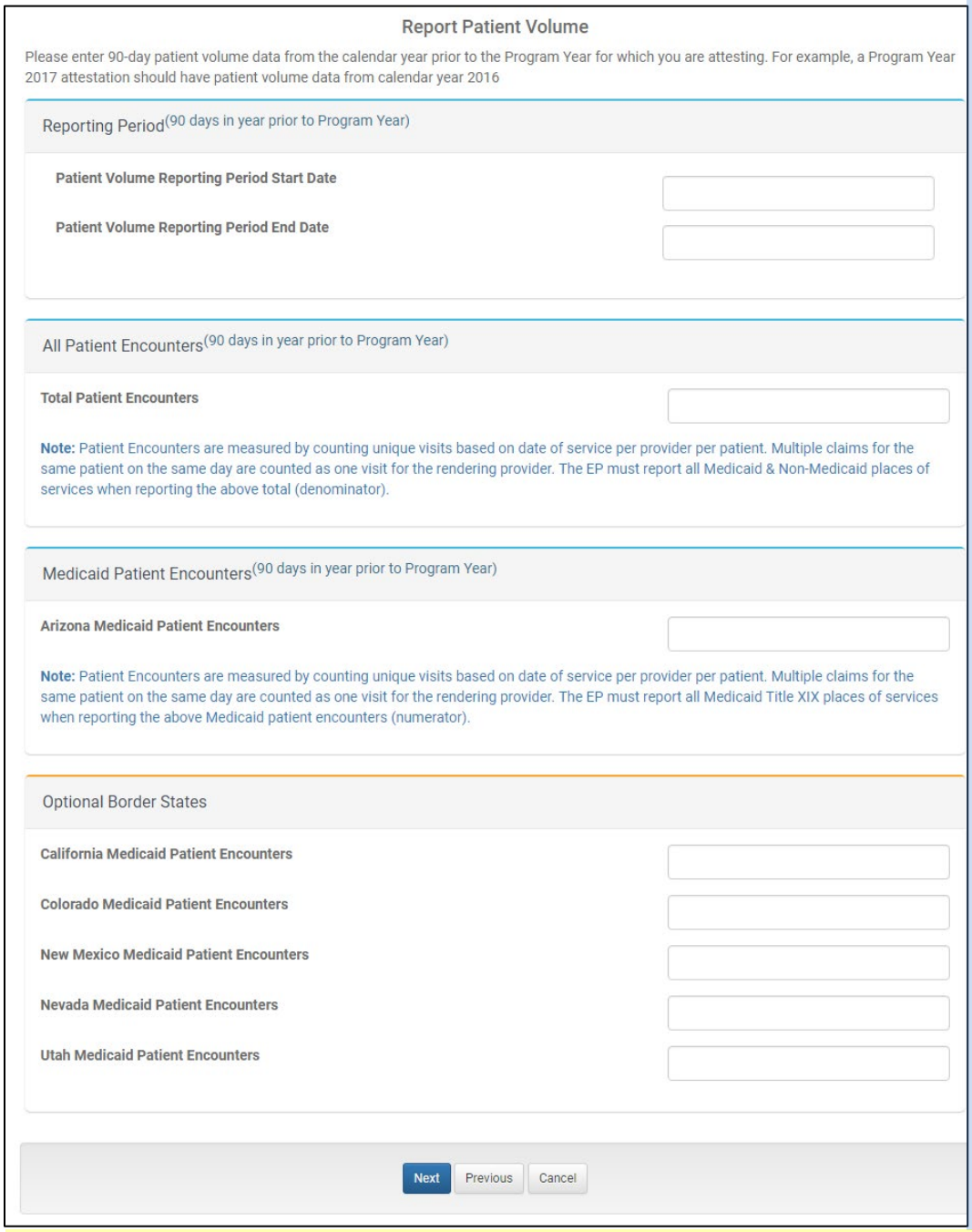
If you are attesting using your group Aggregate patient volume, every provider in the group must also select aggregate".

Out of State Medicaid Patient encounters can be excluded in the numerator *(if not needed to meet the patient volume)* but must be reported in the denominator.

TIP

Note that inclusion of out of state patient encounters is optional in the numerator and slows the approval process since we must validate with the respective state(s).

Report Medicaid Patient Volume Data Elements



Medicaid Patient Volume is the percentage of Medicaid Title XIX patient encounters in the reporting period.

Providers selecting this option must also demonstrate that they are not hospital-based.

Patient Volume Reporting dates must be a continuous 90-day period selected from the year prior to the program year.

Out of State Medicaid Patient encounters can be excluded in the numerator *(if not needed to meet the patient volume)* but must be reported in the denominator.

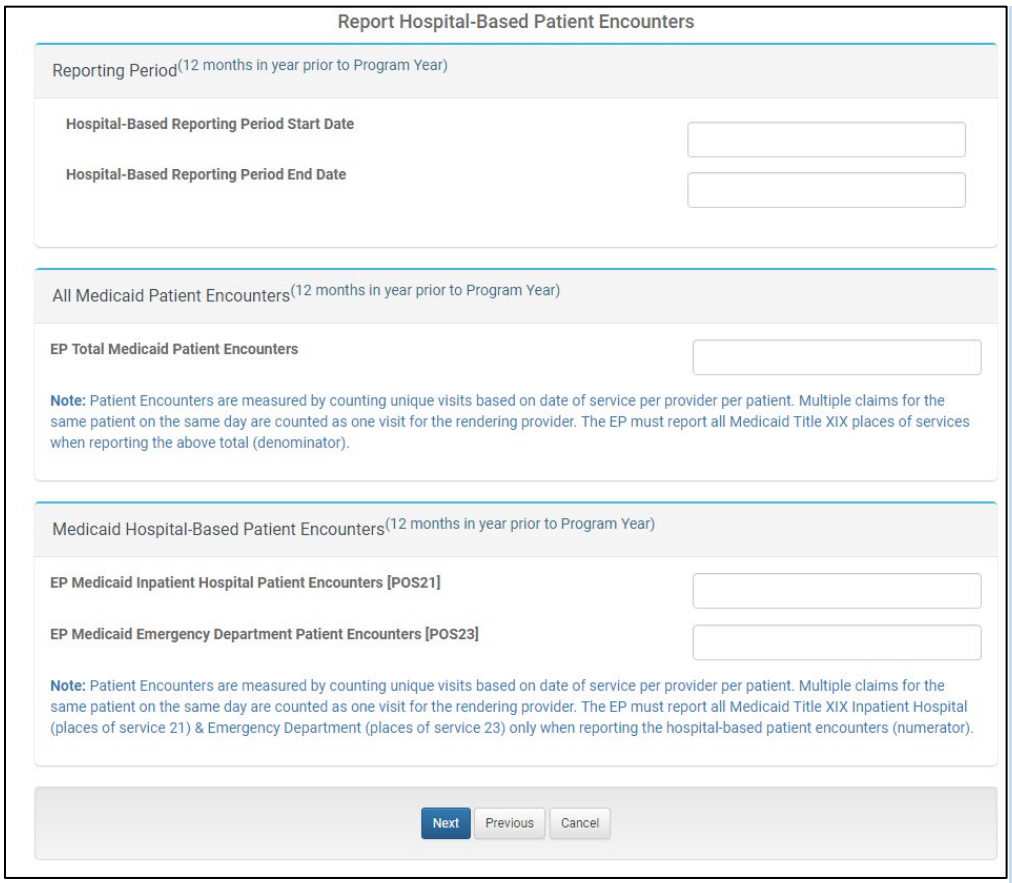
TIP

Data to determine the Patient Volume includes all Place of Services.

The numerator is Medicaid Title XIX patient encounters only.

The denominator is All patient encounters [Medicaid and Non-Medicaid].

Report Hospital-Based Data Elements



Providers selecting Medicaid Patient Volume must demonstrate that they are not hospital-based.

The Hospital-based Reporting date is the 12-month period from the year prior to the program year.

Hospital-Based providers have 90% or more of their Medicaid Title XIX patient encounters in a hospital setting defined as:
- ➥Inpatient Hospital [POS 21]
- ➥Emergency Department [POS 23]

Providers may need to obtain patient encounter data from the hospital and should consider requesting it in advance.

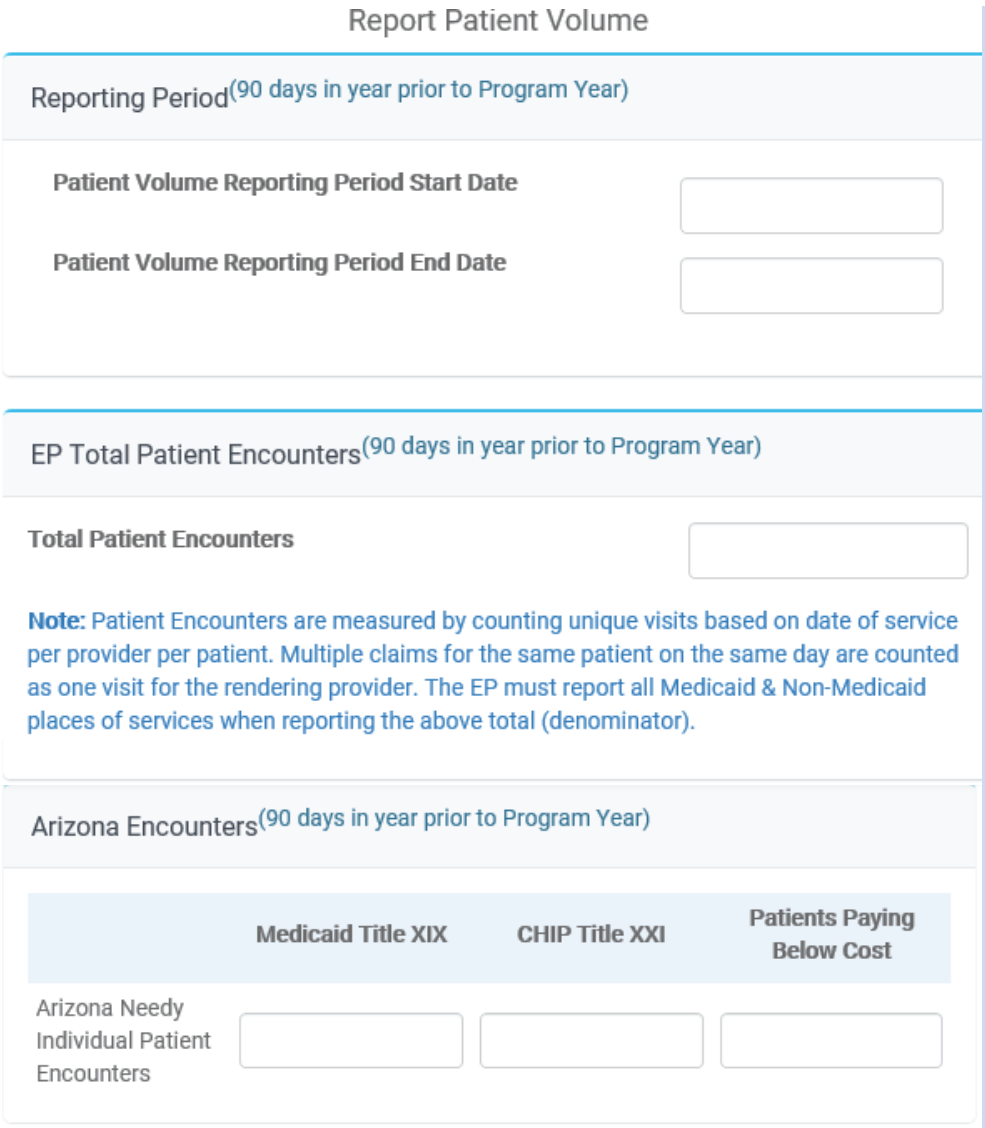
TIP

Data to determine the Medicaid Hospital-Based includes all Place of Services.

Numerator is Medicaid Title XIX IP & ED patient encounters only [POS 21 & POS 23].

Denominator is All Medicaid Title XIX patient encounters [All Place of Services].

Report Needy Patient Volume Data Elements



Needy Patient Volume is the percentage of needy patient encounters in the reporting period.

Needy patient encounters are classified as Medicaid Title XIX, CHIP Title XXI & Patients Paying Below Cost (sliding scale) encounters.

Non-Needy patient encounters are Medicare, Private Insurance, Self-Pay, Commercial, etc.

Providers selecting this option must also demonstrate that they practiced predominantly in a FQHC, RHC or Tribal Clinic.

Patient Volume Reporting dates must be a continuous 90-day period selected from the year prior to the program year.

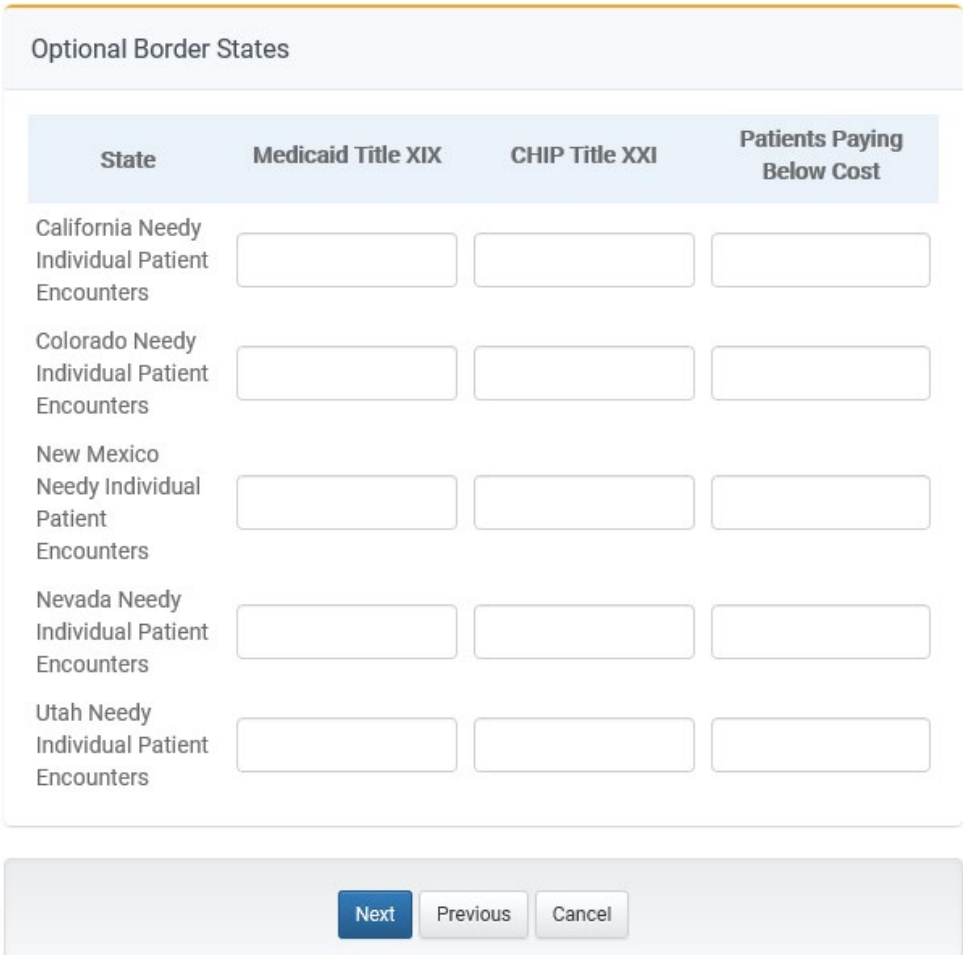
TIP

Data to determine the Patient Volume includes all Place of Services.

The numerator is Needy Patient Encounters only.

The denominator is All patient encounters [Needy & Non-Needy].

Report Needy Patient Volume Data Elements cont'd.



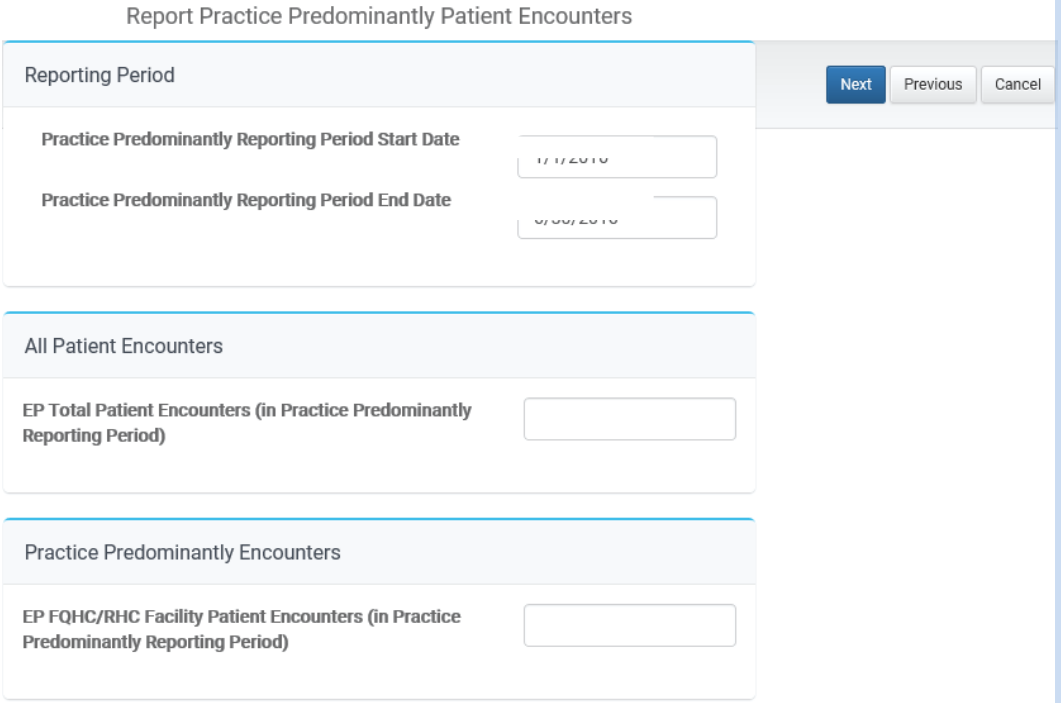
Here is where you report your Medicaid out of state patient encounters for our Border States *(optional if you wish to include in the numerator)*.

Please note that Out of State Medicaid Patient encounters can be excluded in the numerator *(if not needed to meet the patient volume)* but must be reported in the denominator.

TIP

Note that inclusion of out of state patient encounters is optional in the numerator and slows the approval process since we must validate with the respective state(s).

Report Practice Predominantly Data Elements



Providers selecting Needy Patient Volume must demonstrate that they practiced predominantly in a FQHC, RHC or Tribal Clinic.

Practice Predominantly Reporting dates is a 6-month period from the year prior to the program year.

Practice predominantly providers have more than 50% of their patient encounters in a FQHC, RHC or Tribal Clinic.

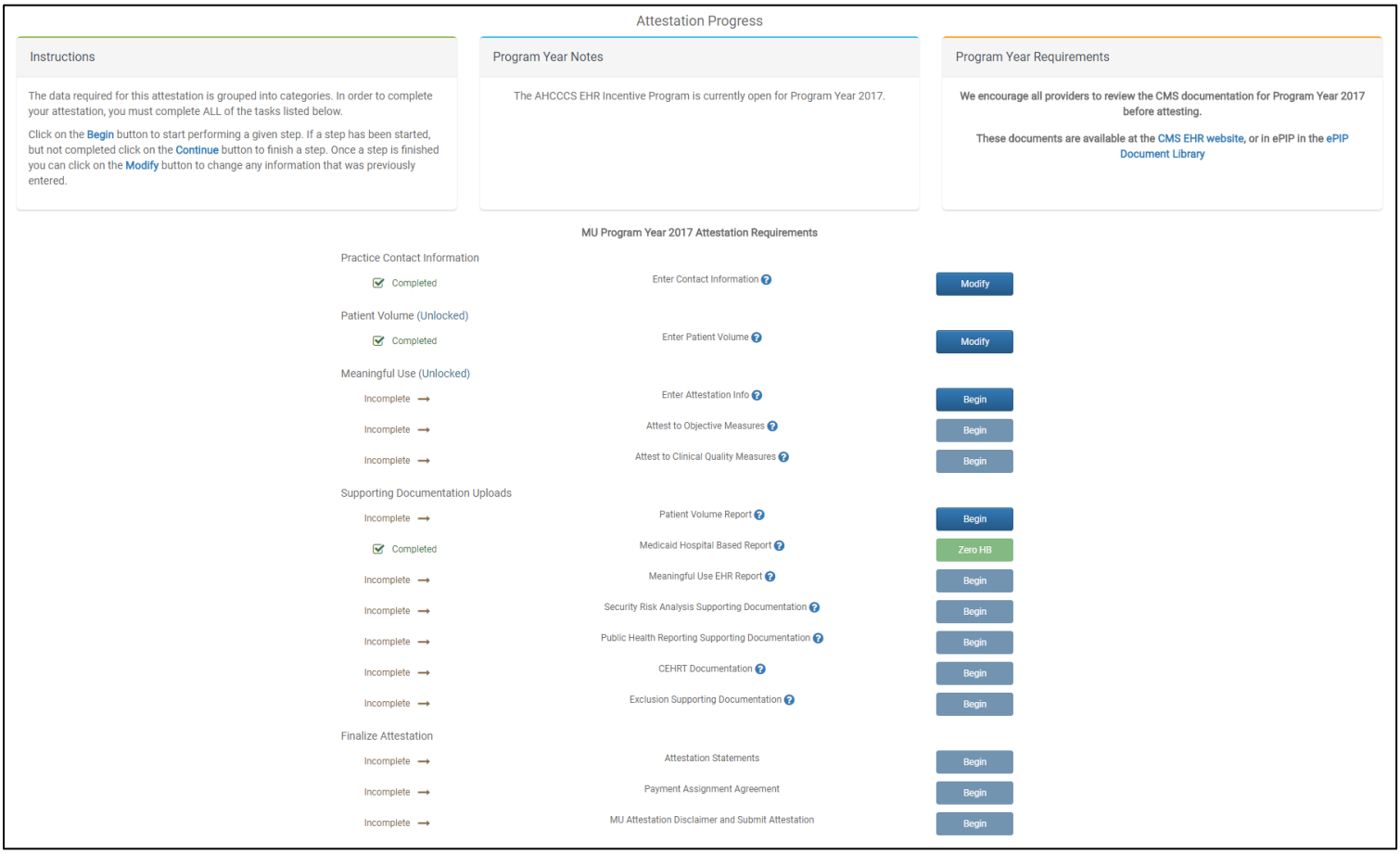
TIP

Data to determine the Practice Predominantly includes all Place of Services.

Numerator is FQHC, RHC or Tribal Clinic patient encounters only [inside facility].

Denominator is for All Place of Services [inside & outside the facility].

Attestation Progress (After Patient Volume)



Note that as you complete each step:

☑ Column on the left changes from “Incomplete” to “Completed” status

☑ Column on the right changes from “Begin” to “Modify” designation.

Remember that each requirement task must be followed sequentially.

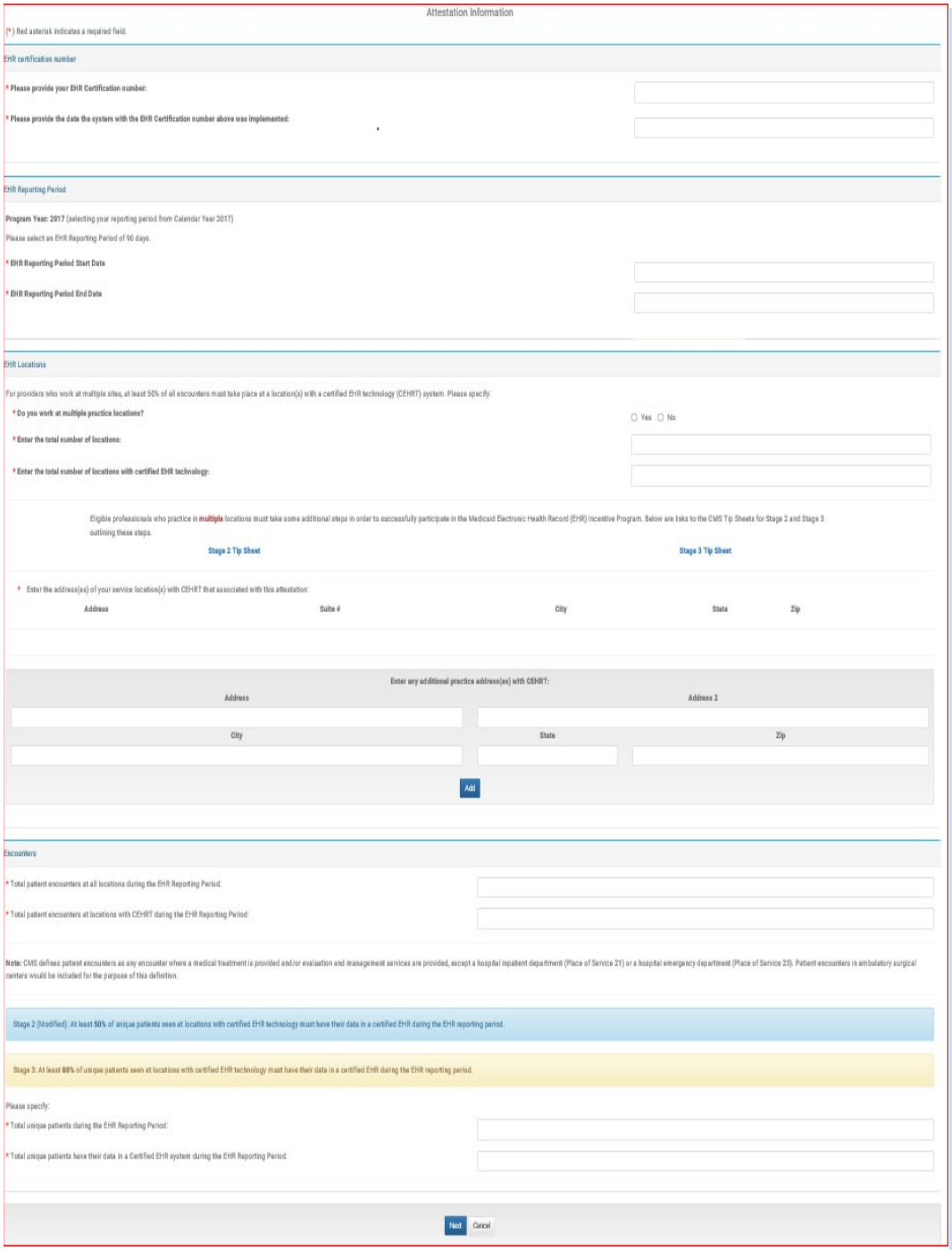
TIP

Click the Begin button to complete each step.

Click Continue button to finish a step.

Click Modify button to change information previously entered.

Attestation Information



You are now ready to being attesting to the Meaningful Use portion of the attestation.

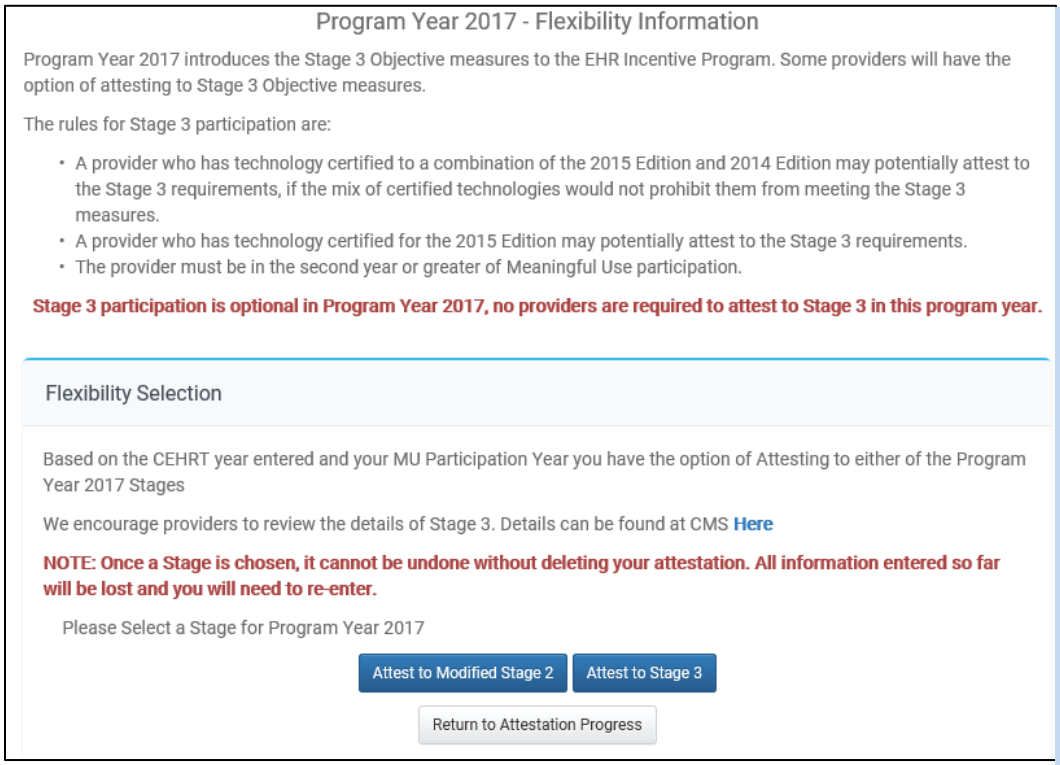
First, we will need some general information about your EHR system. Be sure to tell us if you have patients that are still maintained on paper records (Non-CEHRT).

You must select your EHR Reporting Period start & end date from calendar year 2017 for the Meaningful Use Objectives & Clinical Quality Measures that you are attesting to.

Complete the number of unique patient encounters in your EHR reporting period.

Complete the number of unique patients in your EHR reporting period.

Program Year 2017 Flexibility Information



Providers have the option of attesting to Stage 2 or Stage 3 depending on their system's certification *(in effect no later than December 31, 2017)*.

Rules for Stage 3 participation:

☑ Providers with technology certified to a combination of the 2015 Edition & 2014 Edition *(if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures)*.

☑ Providers with technology certified for the 2015 Edition.

☑ Providers in the second year or greater of Meaningful Use participation.

Flexibility:

Based on the CEHRT year entered & your MU Participation Year you have the option of attesting to either Stage 2 or Stage 3.

Providers must review the details of Stage 3 before making a selection.

TIP

Click one of the following buttons:

- ☐ Attest to Stage 2 Modified
- ☐ Attest to Stage 3

NOTE: Once a Stage is selected, it cannot be undone without the EHR Staff deleting your attestation *(will cause re-work for the provider)*.

Attestation Progress (After Attestation Information)

Note that as you complete each step:

☑ Column on the left changes from “Incomplete” to “Completed” status

☑ Column on the right changes from “Begin” to “Modify” designation.

Remember that each requirement task must be followed sequentially.

TIP

Click the Begin button to complete each step.

Click Continue button to finish a step.

Click Modify button to change information previously entered.

Meaningful Use Requirements for Program Year 2017 Stage 2 Modified

	Meaningful Use Objectives for Stage 2 Modified
	Providers with systems certified with a 2014 CEHRT as of 12.31.2017
1	Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.
2	Use clinical decision support to improve performance on high-priority health conditions.
3	Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed health care professional that can enter orders into the medical record per state, local, and professional guidelines.
4	Generate and transmit permissible prescriptions electronically (eRx).
5	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
6	Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.
7	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.
8	Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.
9	Use secure electronic messaging to communicate with patients on relevant health information.
10	The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

Welcome to Stage 2Modified

Providers must attest to 10 Meaningful Use Objectives using EHR technology certified to the 2014 Edition.

Optional: If it is available, providers may also attest using EHR technology certified to the 2015 Edition, or a combination of the two.

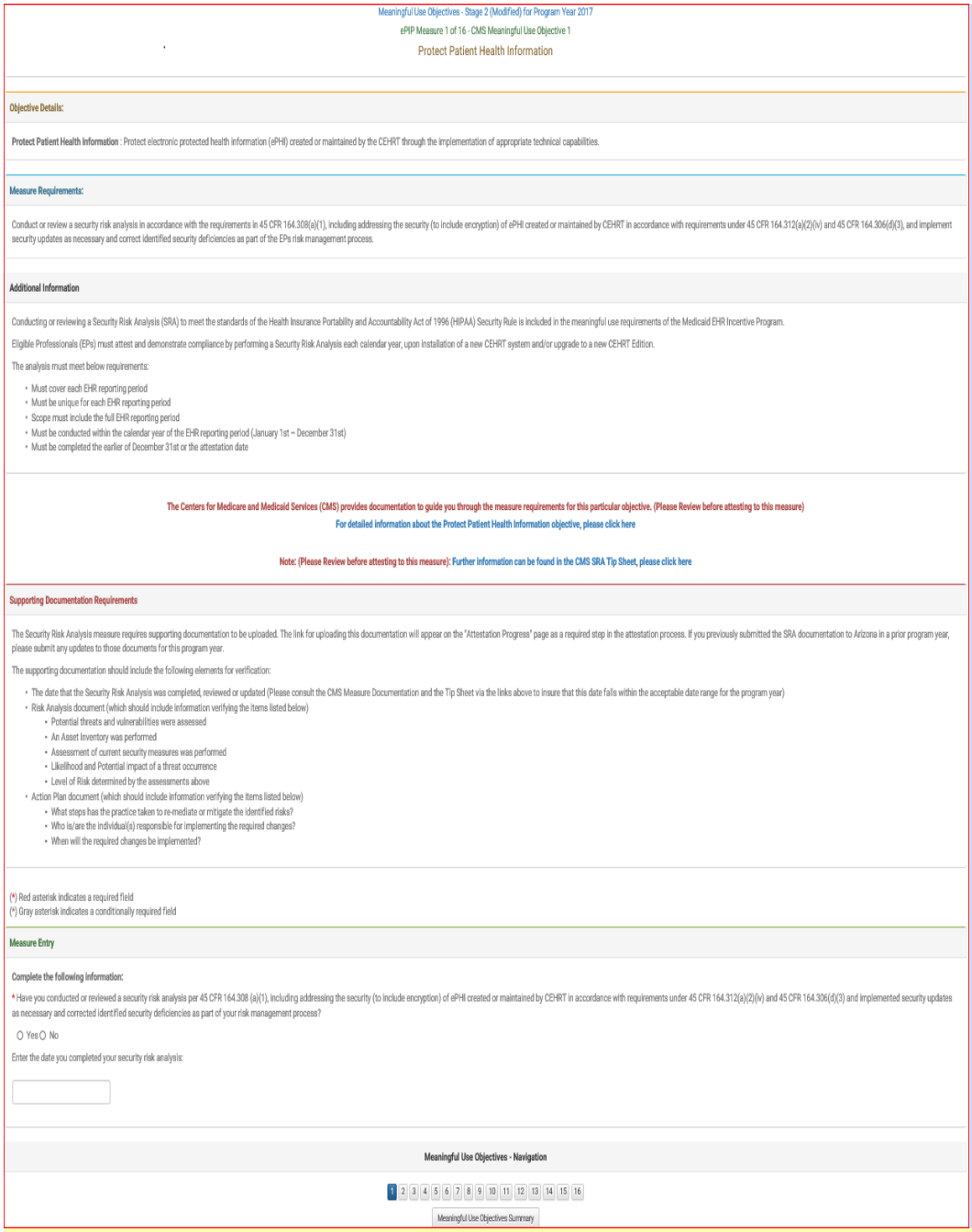
There are changes to the measure calculations policy, which specifies that actions included in the numerator must occur during the EHR reporting period.

TIP

Objective 8, Measure 2, Patient Electronic Access: More than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.

Objective 9, Secure Messaging: More than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

Stage 2 Modified Objective 1 Measure 1 Protected Health Information



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017

ePIP Measure 1 of 16 - CMS Meaningful Use Objective 1

Protect Patient Health Information

Objective Details:

Protect Patient Health Information : Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

Measure Requirements:

Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EPs risk management process.

Additional Information

Conducting or reviewing a Security Risk Analysis (SRA) to meet the standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule is included in the meaningful use requirements of the Medicaid EHR Incentive Program.

Eligible Professionals (EPs) must attest and demonstrate compliance by performing a Security Risk Analysis each calendar year, upon installation of a new CEHRT system and/or upgrade to a new CEHRT Edition.

The analysis must meet below requirements:

- Must cover each EHR reporting period
- Must be unique for each EHR reporting period
- Scope must include the full EHR reporting period
- Must be conducted within the calendar year of the EHR reporting period (January 1st – December 31st)
- Must be completed the earlier of December 31st or the attestation date

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)

For detailed information about the Protect Patient Health Information objective, please click here

Note: (Please Review before attesting to this measure): Further information can be found in the CMS SRA Tip Sheet, please click here

Supporting Documentation Requirements

The Security Risk Analysis measure requires supporting documentation to be uploaded. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process. If you previously submitted the SRA documentation to Arizona in a prior program year, please submit any updates to those documents for this program year.

The supporting documentation should include the following elements for verification:

- The date that the Security Risk Analysis was completed, reviewed or updated (Please consult the CMS Measure Documentation and the Tip Sheet via the links above to insure that this date falls within the acceptable date range for the program year)
- Risk Analysis document (which should include information verifying the items listed below)
  - Potential threats and vulnerabilities were assessed
  - An Asset Inventory was performed
  - Assessment of current security measures was performed
  - Likelihood and Potential impact of a threat occurrence
  - Level of Risk determined by the assessments above
- Action Plan document (which should include information verifying the items listed below)
  - What steps has the practice taken to re-mediate or mitigate the identified risks?
  - Who is/are the individual(s) responsible for implementing the required changes?
  - When will the required changes be implemented?

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Complete the following information:

* Have you conducted or reviewed a security risk analysis per 45 CFR 164.308 (a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3) and implemented security updates as necessary and corrected identified security deficiencies as part of your risk management process?

○ Yes ○ No

Enter the date you completed your security risk analysis:

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Stage 2[M] **Screen 1**

Protected Health Information

☑ Measure 1

Complete all required fields.

You must upload your Security Risk Analysis Report documentation separately.

You must have completed the Security Risk Analysis in 2017.

CEHRT is *"certified electronic health record technology"*

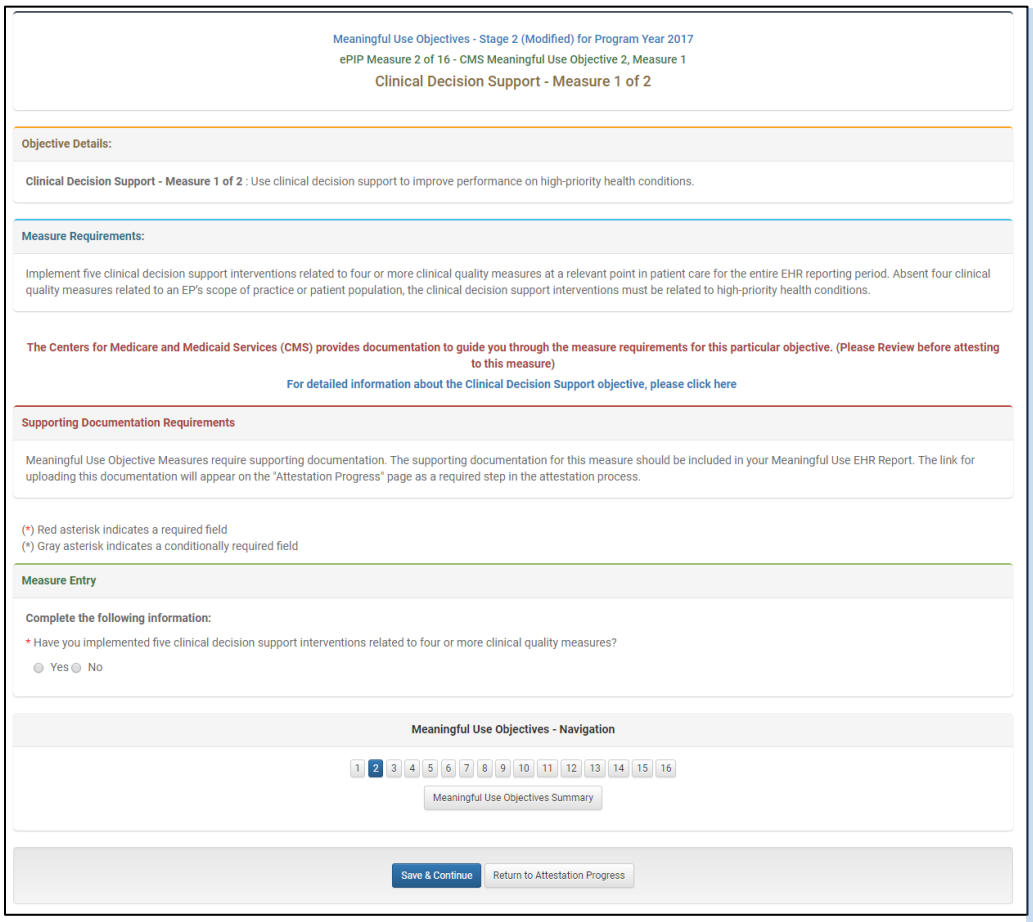
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 2 Measure 1 Clinical Decision Support



Stage 2M **Screen 2**

Clinical Decision Support

☑ Measure 1

Complete all required fields.

You must have implemented five clinical decision support interventions related to four or more clinical quality measures for the entire EHR reporting period.

If you implemented the required clinical decision support, you must upload documentation to support that separately.

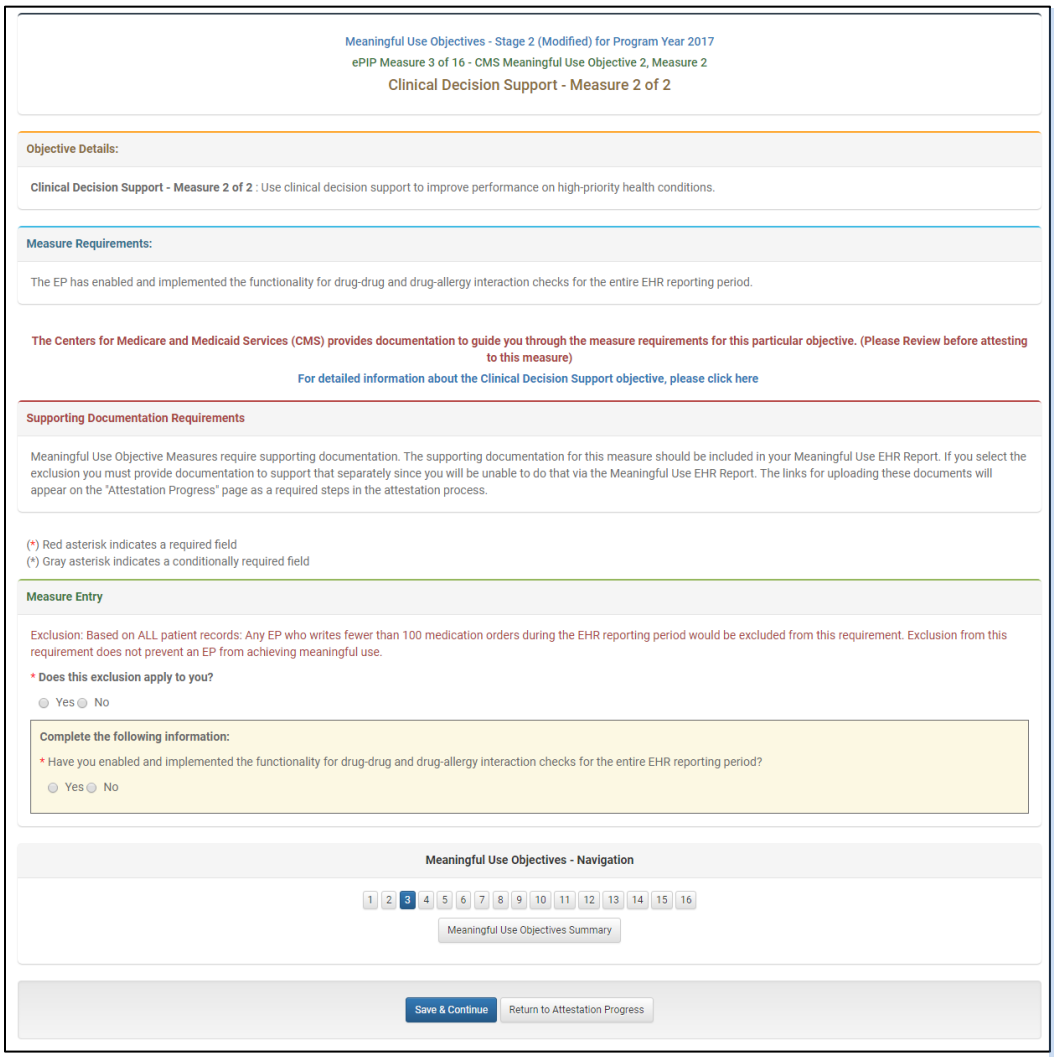
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 2 Measure 2 Clinical Decision Support



Stage 2[M] **Screen 3**

Clinical Decision Support

☑ Measure 2

Complete all required fields.

You must have enabled drug-drug and drug-allergy for the entire EHR reporting period.

If you enabled and implemented the required drug-drug and drug-allergy functionality, you must upload documentation to support that separately.

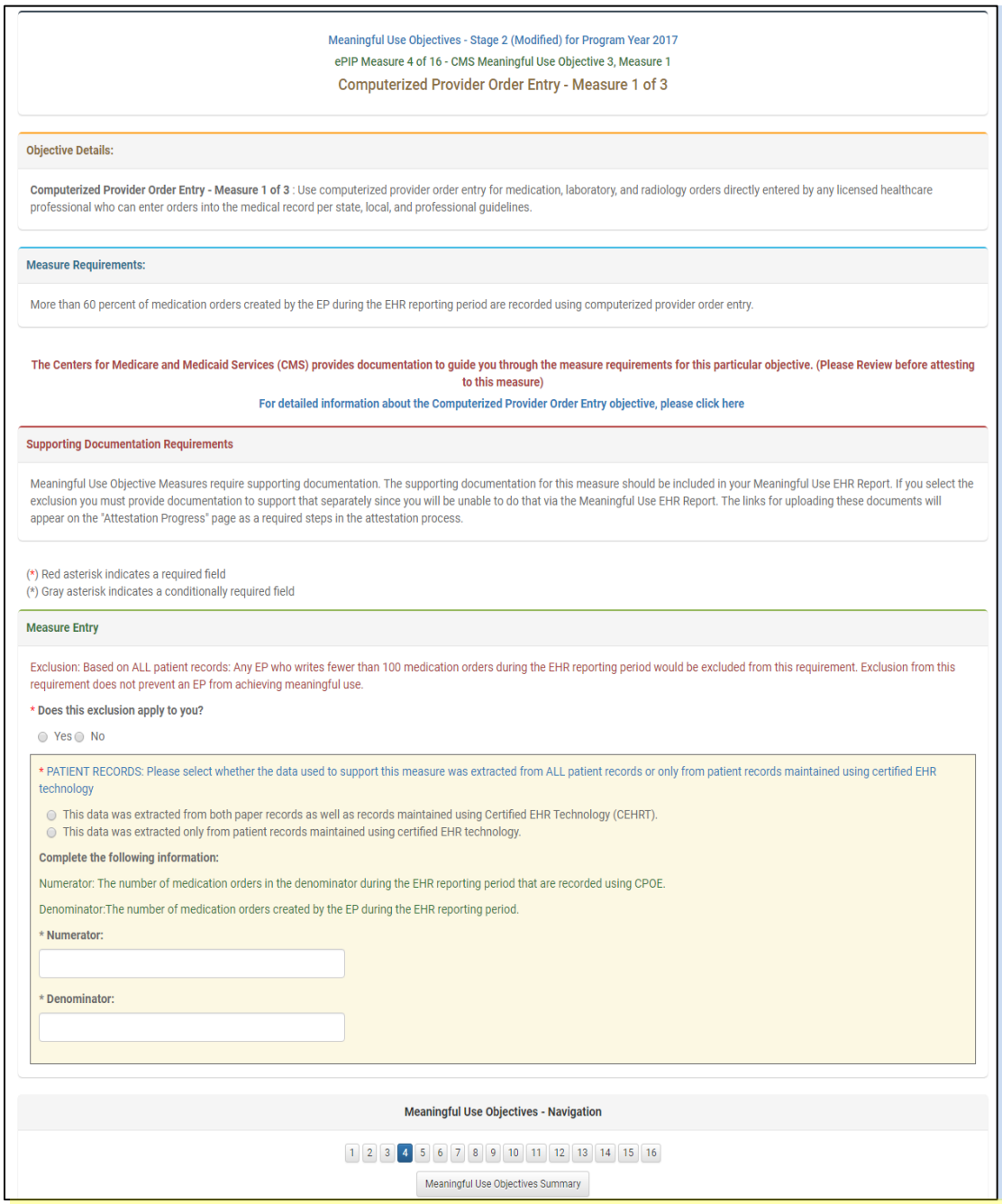
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 3 Measure 1 Computerized Provider Order Entry



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017
ePIP Measure 4 of 16 - CMS Meaningful Use Objective 3, Measure 1
Computerized Provider Order Entry - Measure 1 of 3

Objective Details:

Computerized Provider Order Entry - Measure 1 of 3 : Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

Measure Requirements:

More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)
For detailed information about the Computerized Provider Order Entry objective, please click here

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. If you select the exclusion you must provide documentation to support that separately since you will be unable to do that via the Meaningful Use EHR Report. The links for uploading these documents will appear on the "Attestation Progress" page as a required steps in the attestation process.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 medication orders during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?
Yes No

* PATIENT RECORDS: Please select whether the data used to support this measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology
This data was extracted from both paper records as well as records maintained using Certified EHR Technology (CEHRT).
This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator: The number of medication orders in the denominator during the EHR reporting period that are recorded using CPOE.

Denominator:The number of medication orders created by the EP during the EHR reporting period.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Stage 2M **Screen 4**

Computerized Provider Order Entry

☑ Measure 1

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

If you are not certain how to run the medication orders using CPOE report, you may need to contact your CEHRT vendor.

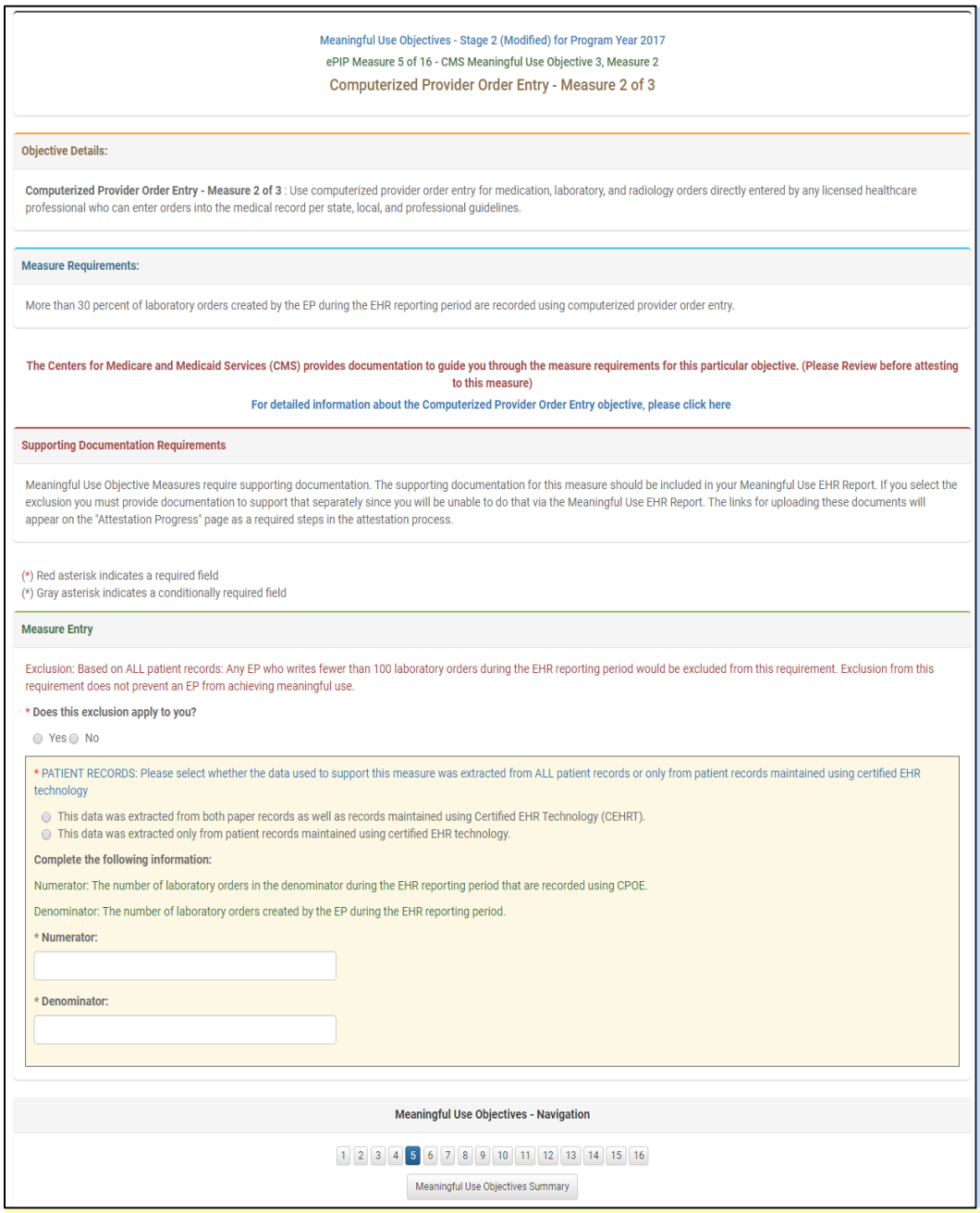
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 3 Measure 2 Computerized Provider Order Entry



Stage 2M **Screen 5**

Computerized Provider Order Entry

☑ Measure 2

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

If you are not certain how to run the laboratory orders using CPOE report, you may need to contact your CEHRT vendor.

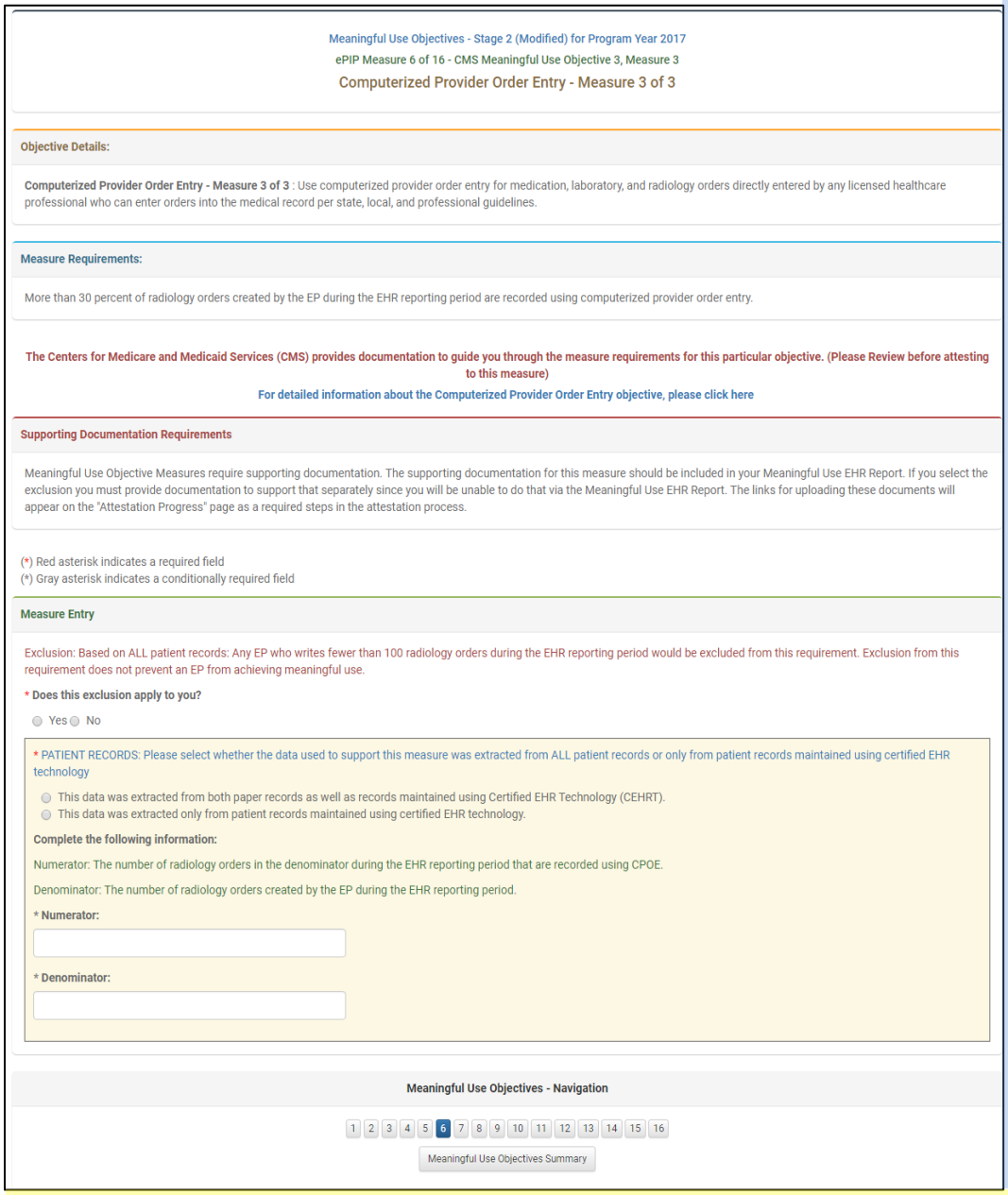
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 3 Measure 3 Computerized Provider Order Entry



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017

ePIP Measure 6 of 16 - CMS Meaningful Use Objective 3, Measure 3

Computerized Provider Order Entry - Measure 3 of 3

Objective Details:

Computerized Provider Order Entry - Measure 3 of 3 : Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

Measure Requirements:

More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)

For detailed information about the Computerized Provider Order Entry objective, please click here

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. If you select the exclusion you must provide documentation to support that separately since you will be unable to do that via the Meaningful Use EHR Report. The links for uploading these documents will appear on the "Attestation Progress" page as a required steps in the attestation process.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 radiology orders during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* **Does this exclusion apply to you?**

Yes No

* PATIENT RECORDS: Please select whether the data used to support this measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology

This data was extracted from both paper records as well as records maintained using Certified EHR Technology (CEHRT).
This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator: The number of radiology orders in the denominator during the EHR reporting period that are recorded using CPOE.

Denominator: The number of radiology orders created by the EP during the EHR reporting period.

* **Numerator:**

* **Denominator:**

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Stage 2M **Screen 6**

Computerized Provider Order Entry

☑ Measure 3

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

If you are not certain how to run the radiology orders using CPOE report, you may need to contact your CEHRT vendor.

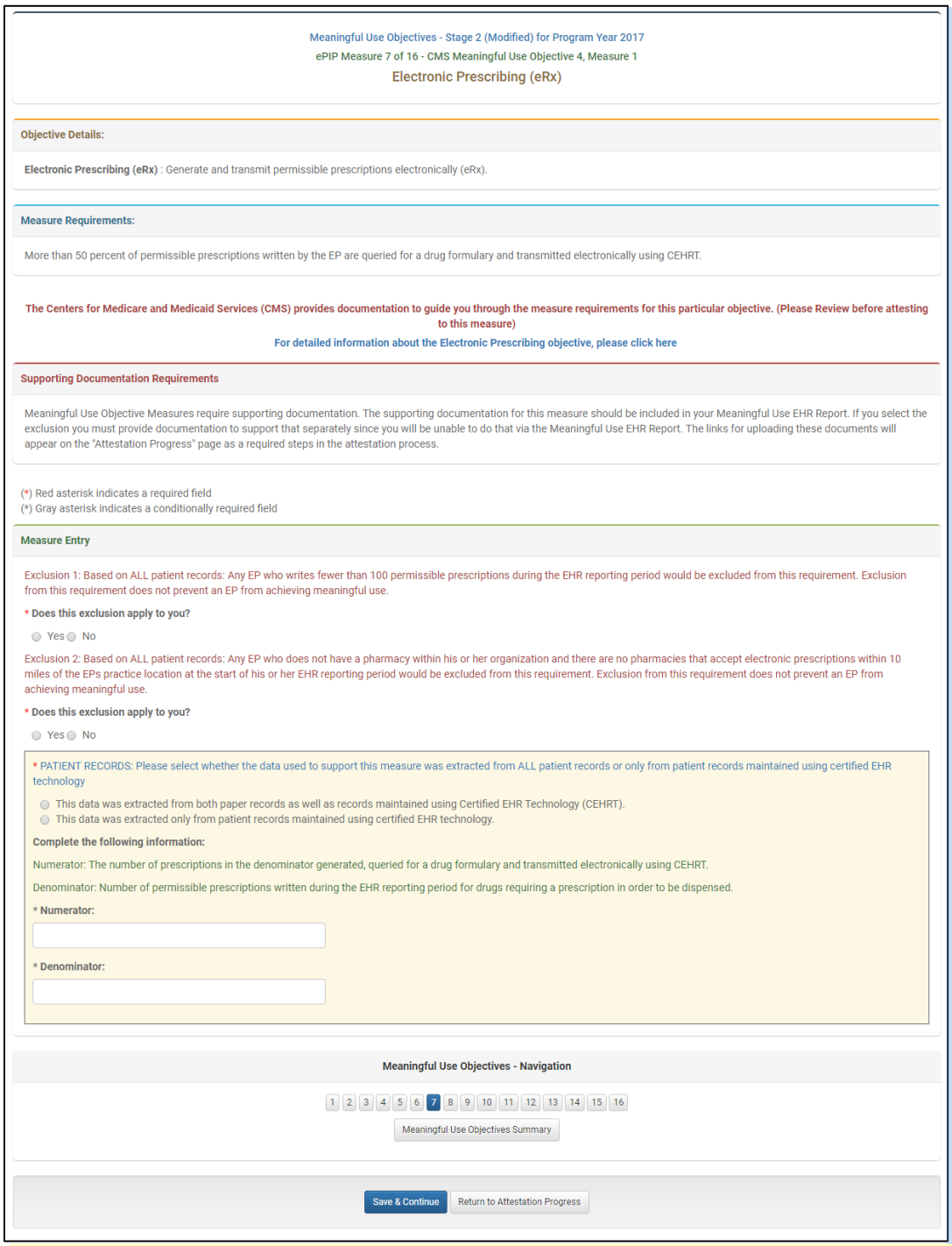
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 4 Measure 1 Electronic Prescribing



Stage 2^{M} **Screen 7**

Electronic Prescribing (eRx)

☑ Measure 1

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

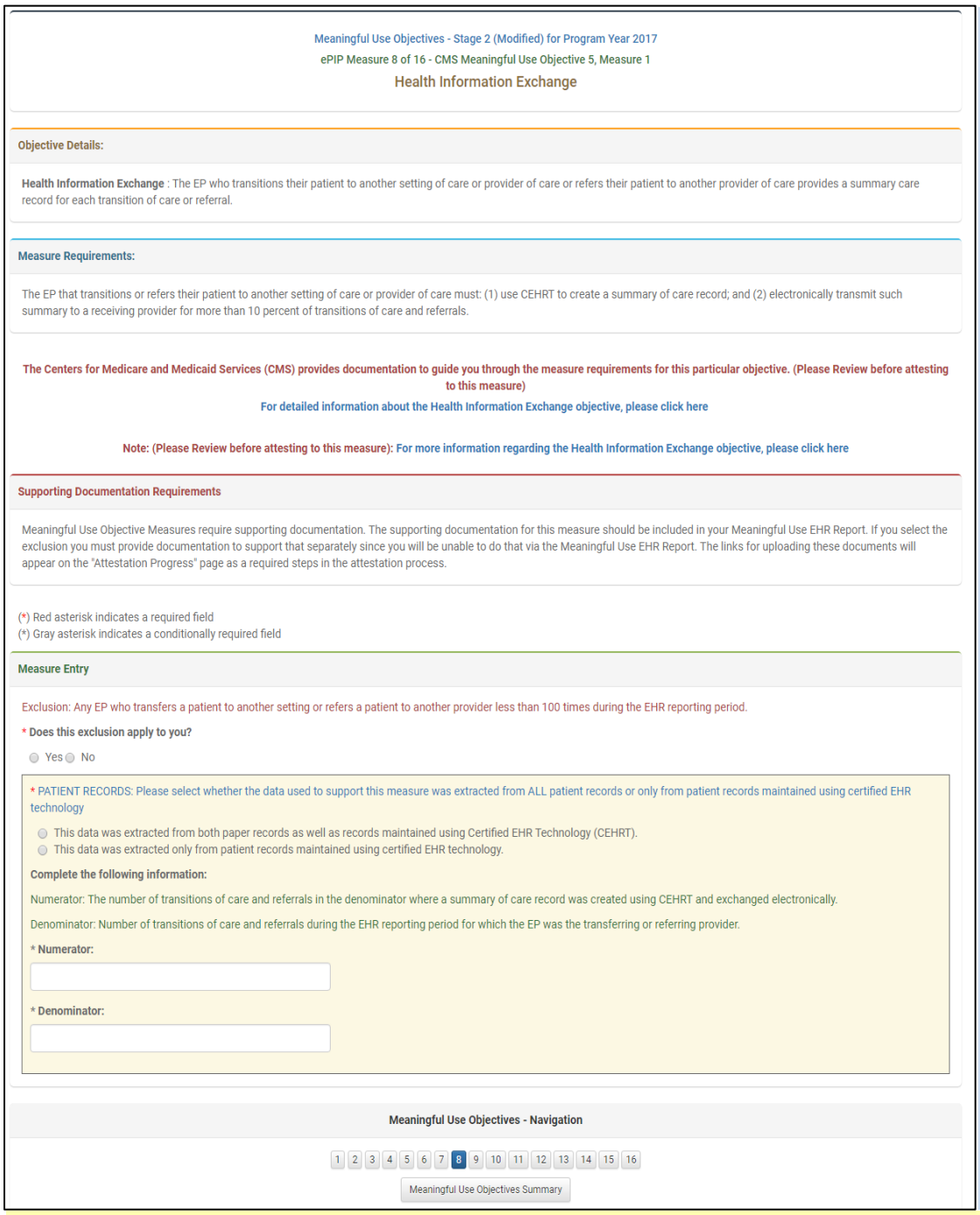
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 5 Measure 1 Health Information Exchange



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017

ePIP Measure 8 of 16 - CMS Meaningful Use Objective 5, Measure 1

Health Information Exchange

Objective Details:

Health Information Exchange : The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

Measure Requirements:

The EP that transitions or refers their patient to another setting of care or provider of care must: (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)

For detailed information about the Health Information Exchange objective, please click here

Note: (Please Review before attesting to this measure): For more information regarding the Health Information Exchange objective, please click here

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. If you select the exclusion you must provide documentation to support that separately since you will be unable to do that via the Meaningful Use EHR Report. The links for uploading these documents will appear on the "Attestation Progress" page as a required steps in the attestation process.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

* PATIENT RECORDS: Please select whether the data used to support this measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology

This data was extracted from both paper records as well as records maintained using Certified EHR Technology (CEHRT).
This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

* **Numerator:**

* **Denominator:**

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Stage 2^{M} **Screen 8**

Health Information Exchange

☑ Measure 1

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

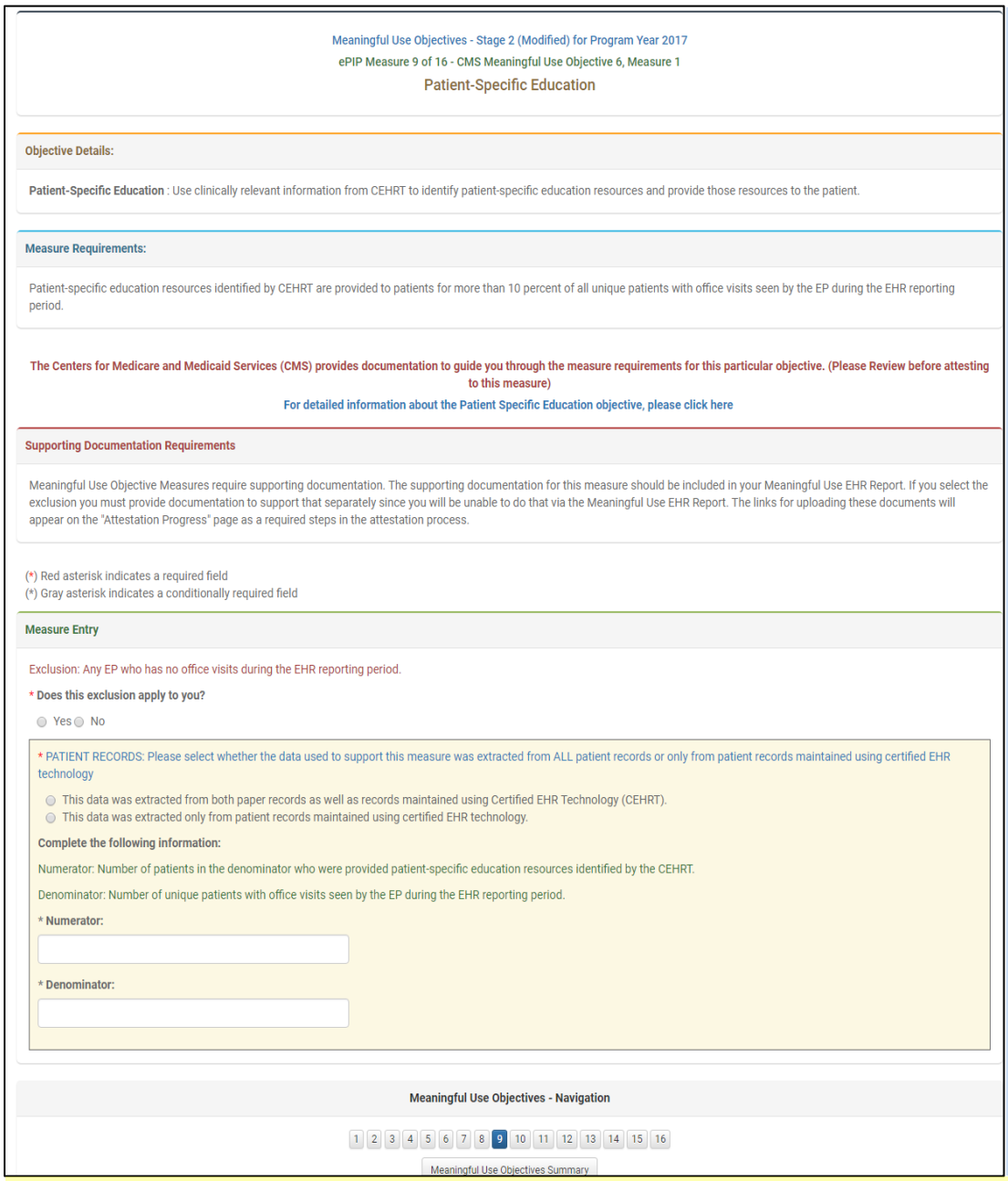
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 6 Measure 1 Patient Specific Education



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017
ePIP Measure 9 of 16 - CMS Meaningful Use Objective 6, Measure 1
Patient-Specific Education

Objective Details:

Patient-Specific Education : Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

Measure Requirements:

Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)

For detailed information about the Patient Specific Education objective, please click here

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. If you select the exclusion you must provide documentation to support that separately since you will be unable to do that via the Meaningful Use EHR Report. The links for uploading these documents will appear on the "Attestation Progress" page as a required steps in the attestation process.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion: Any EP who has no office visits during the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

* PATIENT RECORDS: Please select whether the data used to support this measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology

This data was extracted from both paper records as well as records maintained using Certified EHR Technology (CEHRT).
This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator: Number of patients in the denominator who were provided patient-specific education resources identified by the CEHRT.

Denominator: Number of unique patients with office visits seen by the EP during the EHR reporting period.

* **Numerator:**

* **Denominator:**

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Stage 2M **Screen 9**

Patient Specific Education

☑ Measure 1

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

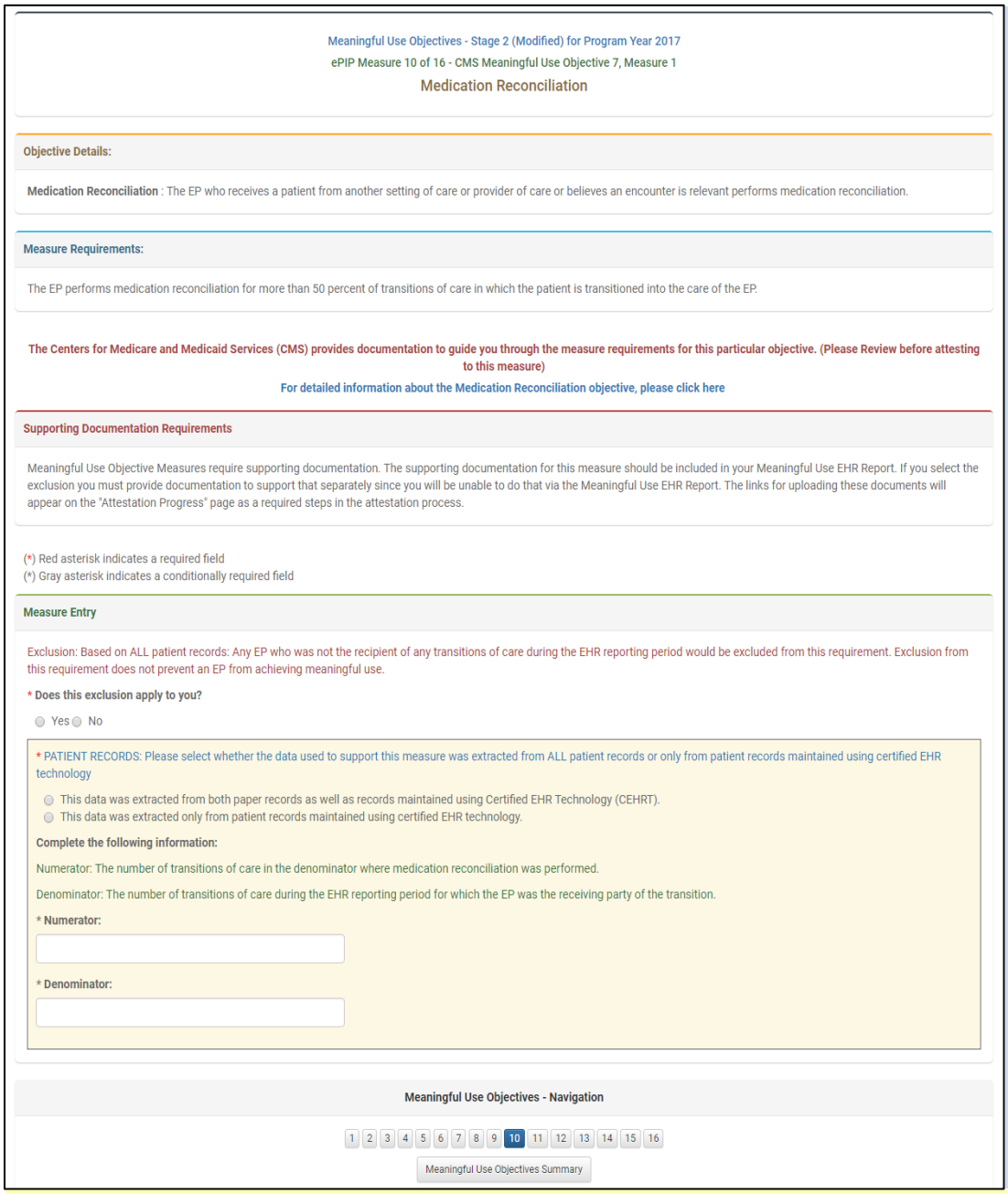
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 7 Measure 1 Medication Reconciliation



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017

ePIP Measure 10 of 16 - CMS Meaningful Use Objective 7, Measure 1

Medication Reconciliation

Objective Details:

Medication Reconciliation : The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

Measure Requirements:

The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)

For detailed information about the Medication Reconciliation objective, please click here

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. If you select the exclusion you must provide documentation to support that separately since you will be unable to do that via the Meaningful Use EHR Report. The links for uploading these documents will appear on the "Attestation Progress" page as a required steps in the attestation process.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion: Based on ALL patient records: Any EP who was not the recipient of any transitions of care during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* **Does this exclusion apply to you?**

Yes No

* PATIENT RECORDS: Please select whether the data used to support this measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology

This data was extracted from both paper records as well as records maintained using Certified EHR Technology (CEHRT).
This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.

Denominator: The number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

* **Numerator:**

* **Denominator:**

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Stage 2M **Screen 10**

Medication Reconciliation

☑ Measure 1

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

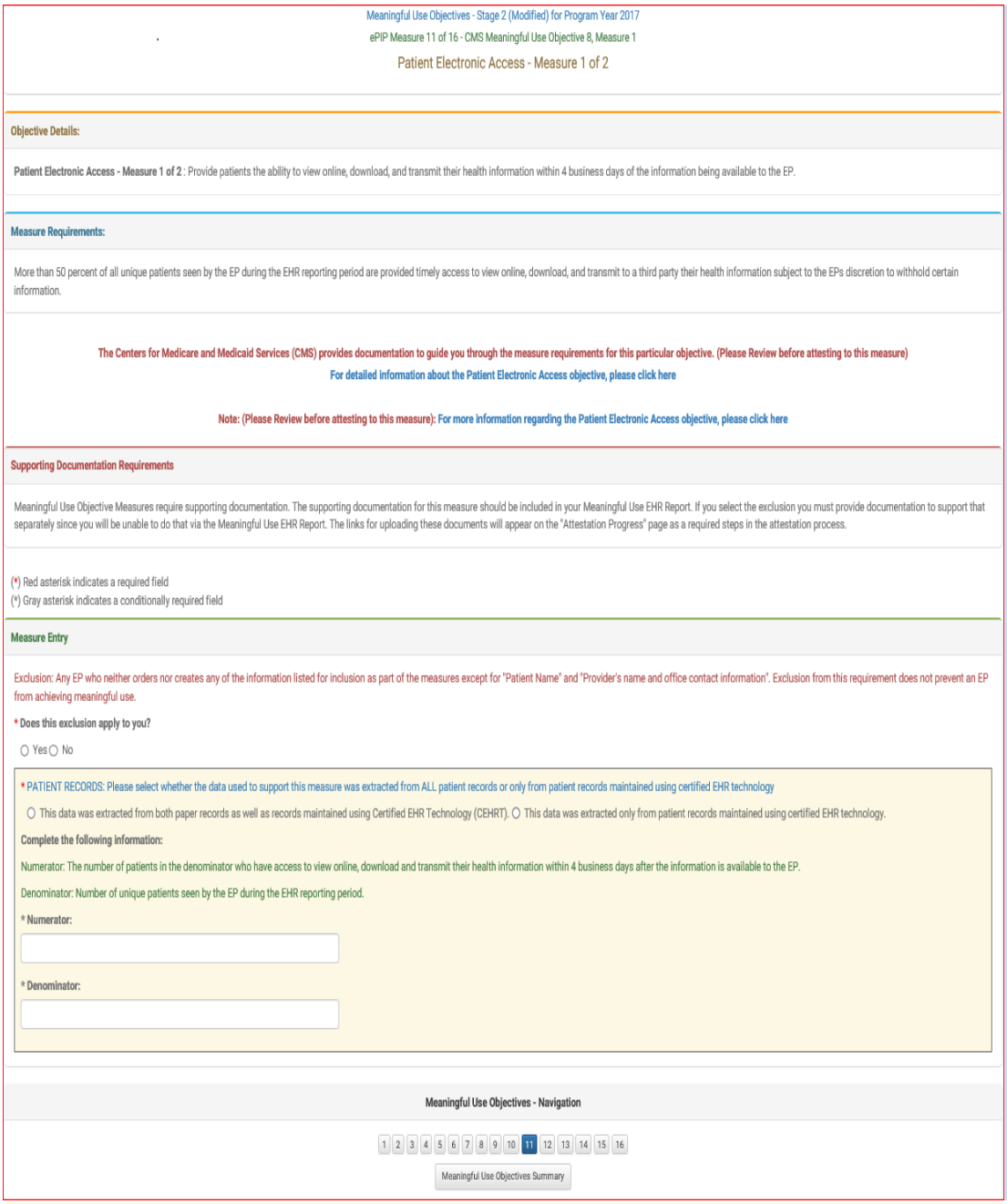
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 8 Measure 1 Patient Electronic Access



Stage 2[M] **Screen 11**

Patient Electronic Access

☑ Measure 1

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

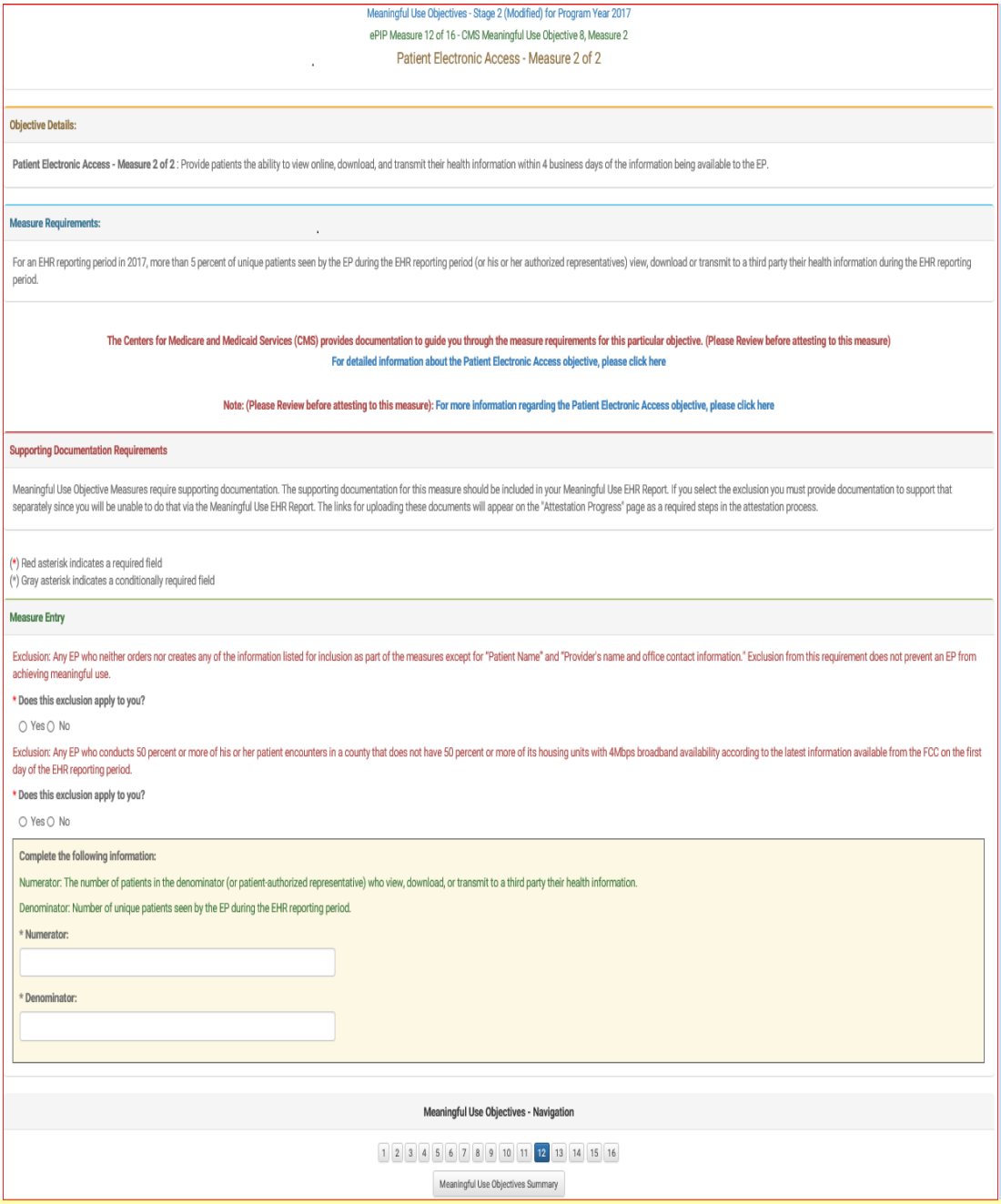
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 8 Measure 2 Patient Electronic Access


Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017

ePIP Measure 12 of 16 - CMS Meaningful Use Objective 8, Measure 2

Patient Electronic Access - Measure 2 of 2

Objective Details:

Patient Electronic Access - Measure 2 of 2 : Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

Measure Requirements:

For an EHR reporting period in 2017, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)

For detailed information about the Patient Electronic Access objective, please click here

Note: (Please Review before attesting to this measure): For more information regarding the Patient Electronic Access objective, please click here

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. If you select the exclusion you must provide documentation to support that separately since you will be unable to do that via the Meaningful Use EHR Report. The links for uploading these documents will appear on the "Attestation Progress" page as a required steps in the attestation process.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion: Any EP who neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information." Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

○ Yes ○ No

Exclusion: Any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ○ No

Complete the following information:

Numerator: The number of patients in the denominator (or patient-authorized representative) who view, download, or transmit to a third party their health information.

Denominator: Number of unique patients seen by the EP during the EHR reporting period.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Stage 2[M] **Screen 12**

Patient Electronic Access

☑ Measure 2

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

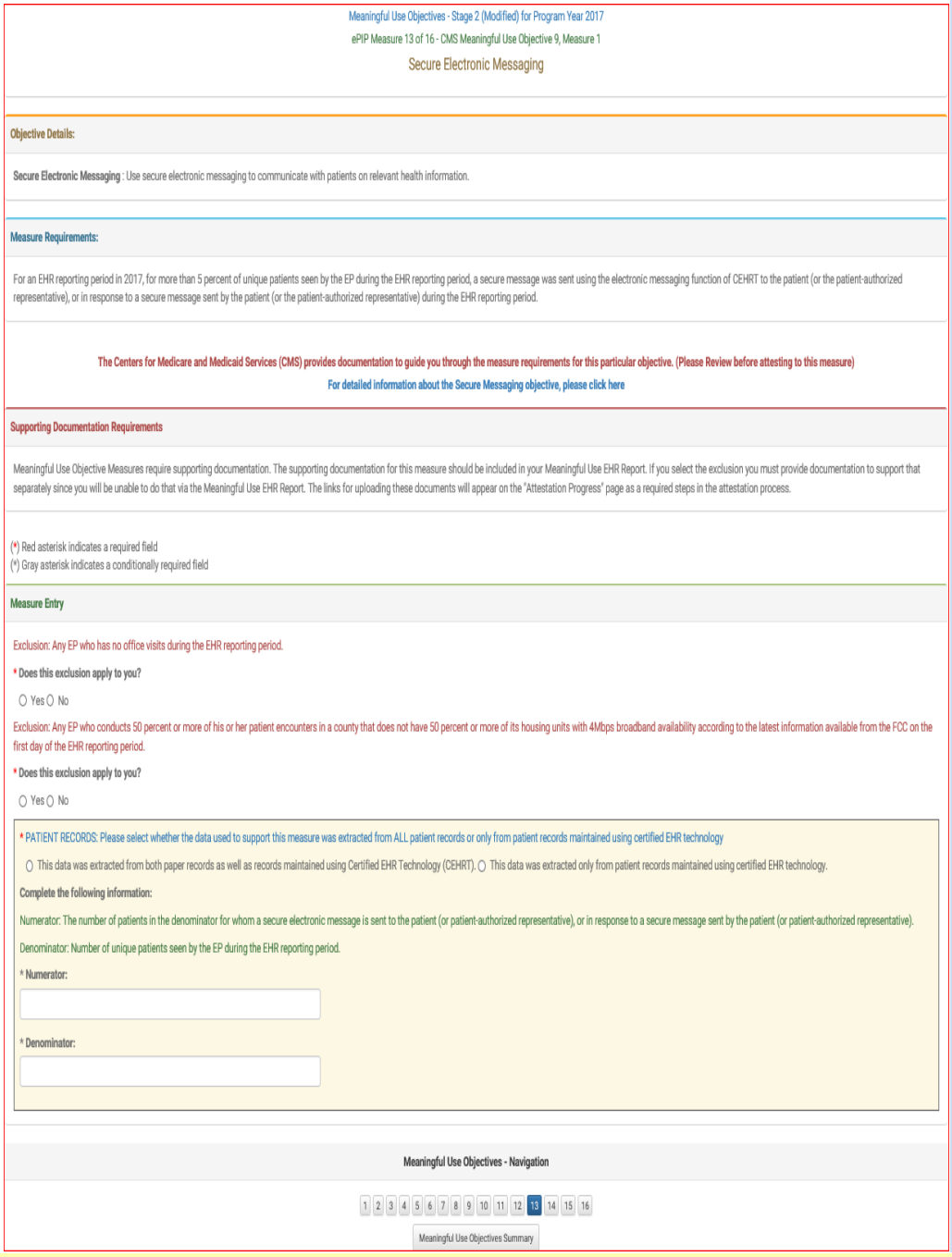
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 9 Measure 1 Secure Electronic Messaging



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017

ePIP Measure 13 of 16 - CMS Meaningful Use Objective 9, Measure 1

Secure Electronic Messaging

Objective Details:

Secure Electronic Messaging : Use secure electronic messaging to communicate with patients on relevant health information.

Measure Requirements:

For an EHR reporting period in 2017, for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)

For detailed information about the Secure Messaging objective, please click here

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. If you select the exclusion you must provide documentation to support that separately since you will be unable to do that via the Meaningful Use EHR Report. The links for uploading these documents will appear on the 'Attestation Progress' page as a required steps in the attestation process.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion: Any EP who has no office visits during the EHR reporting period.

* **Does this exclusion apply to you?**

○ Yes ○ No

Exclusion: Any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

* **Does this exclusion apply to you?**

○ Yes ○ No

* PATIENT RECORDS: Please select whether the data used to support this measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology

○ This data was extracted from both paper records as well as records maintained using Certified EHR Technology (CEHRT). ○ This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative).

Denominator: Number of unique patients seen by the EP during the EHR reporting period.

* **Numerator:**

* **Denominator:**

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Stage 2M **Screen 13**

Secure Electronic Messaging

☑ Measure 1

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

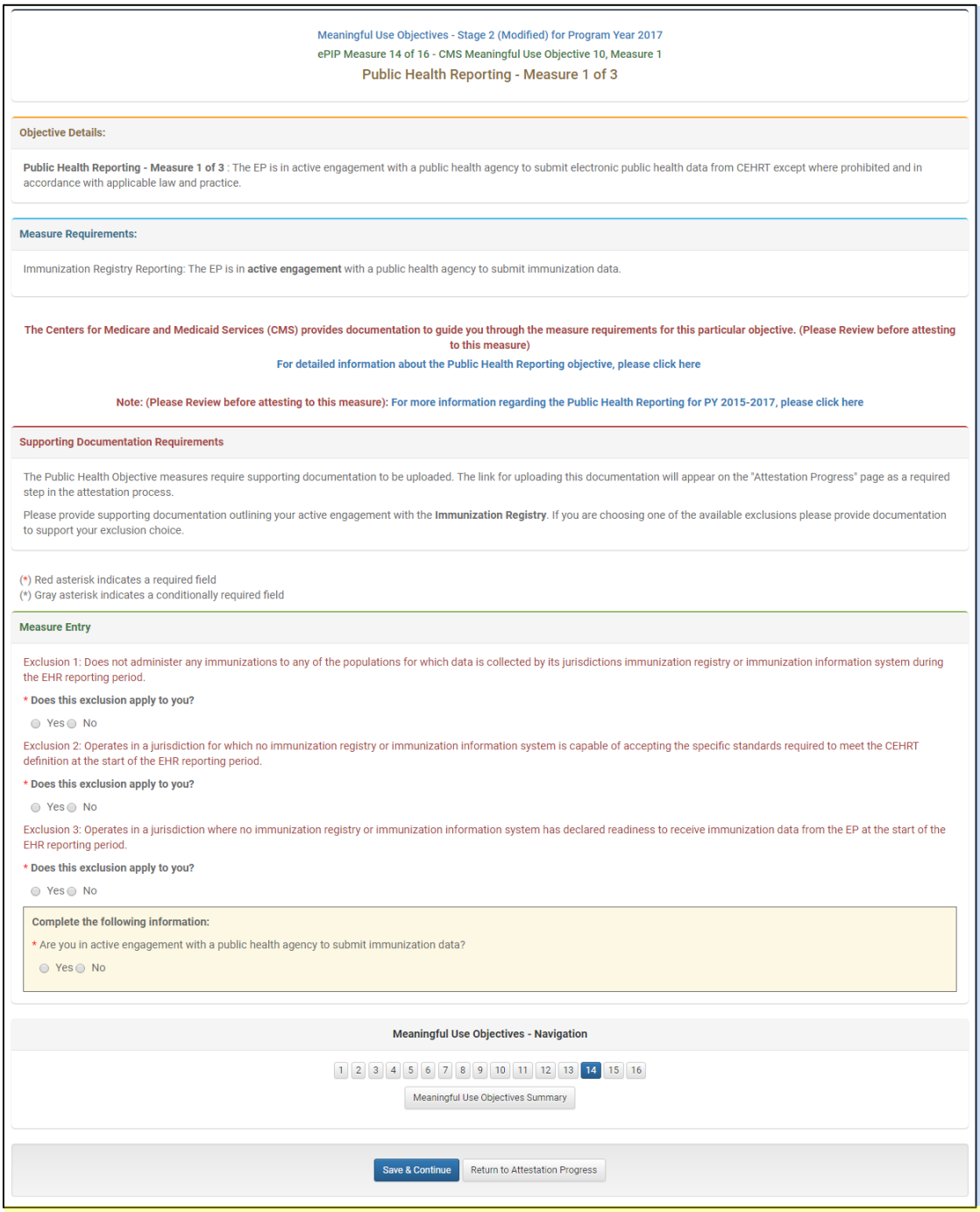
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 10 Measure 1 Public Health Reporting



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017
ePIP Measure 14 of 16 - CMS Meaningful Use Objective 10, Measure 1
Public Health Reporting - Measure 1 of 3

Objective Details:

Public Health Reporting - Measure 1 of 3 : The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

Measure Requirements:

Immunization Registry Reporting: The EP is in **active engagement** with a public health agency to submit immunization data.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)
For detailed information about the Public Health Reporting objective, please click here

Note: (Please Review before attesting to this measure): For more information regarding the Public Health Reporting for PY 2015-2017, please click here

Supporting Documentation Requirements

The Public Health Objective measures require supporting documentation to be uploaded. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

Please provide supporting documentation outlining your active engagement with the **Immunization Registry**. If you are choosing one of the available exclusions please provide documentation to support your exclusion choice.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion 1: Does not administer any immunizations to any of the populations for which data is collected by its jurisdictions immunization registry or immunization information system during the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

Exclusion 2: Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

Exclusion 3: Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

Complete the following information:

* Are you in active engagement with a public health agency to submit immunization data?

Yes No

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Save & Continue | Return to Attestation Progress

Stage 2M **Screen 14**

Public Health Reporting

☑ Measure 1

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

If you are in active engagement to submit immunization data to a public health agency, you must upload documentation to support that separately.

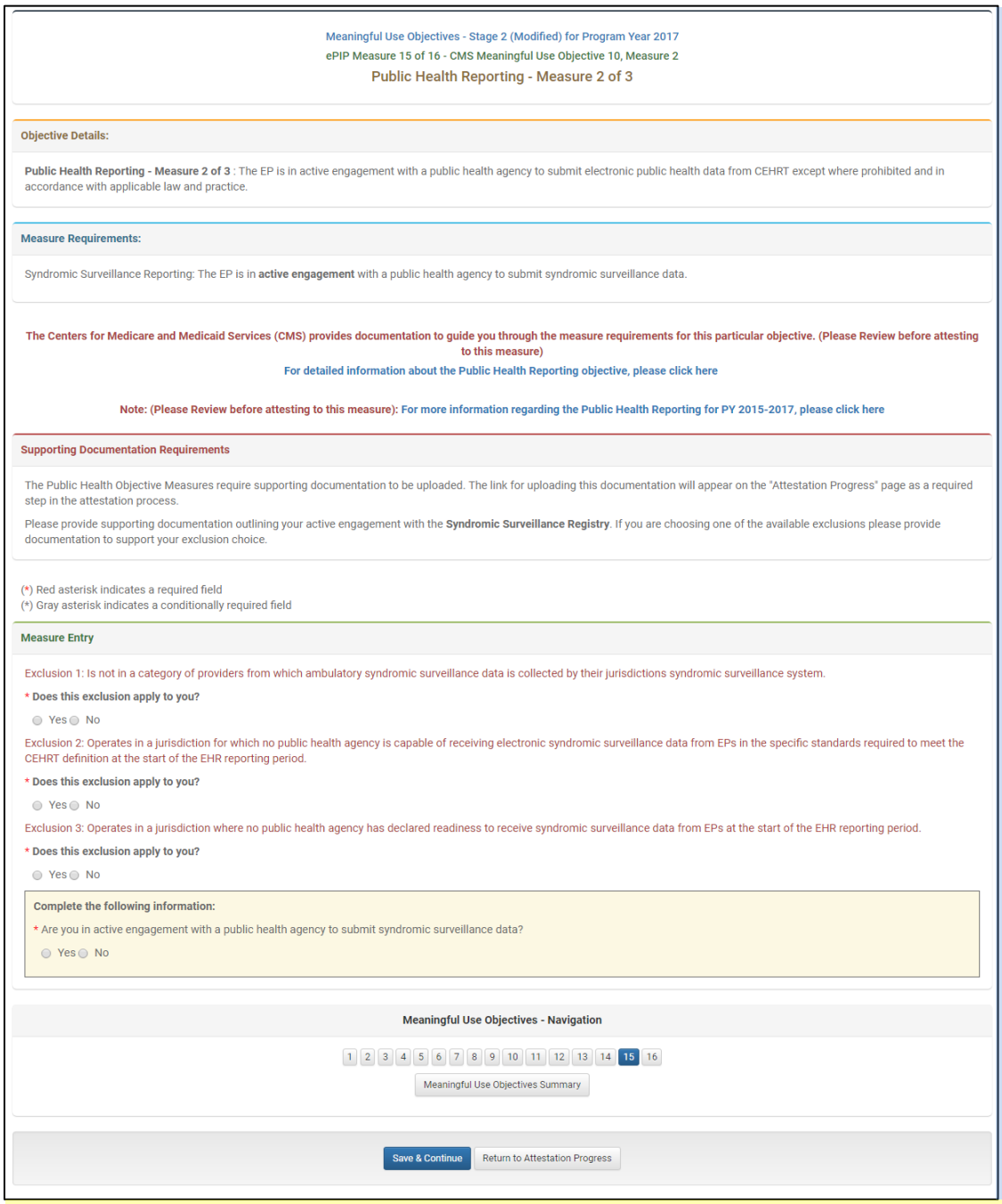
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 10 Measure 2 Public Health Reporting



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017
ePIP Measure 15 of 16 - CMS Meaningful Use Objective 10, Measure 2
Public Health Reporting - Measure 2 of 3

Objective Details:

Public Health Reporting - Measure 2 of 3 : The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

Measure Requirements:

Syndromic Surveillance Reporting: The EP is in **active engagement** with a public health agency to submit syndromic surveillance data.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)
For detailed information about the Public Health Reporting objective, please click here

Note: (Please Review before attesting to this measure): For more information regarding the Public Health Reporting for PY 2015-2017, please click here

Supporting Documentation Requirements

The Public Health Objective Measures require supporting documentation to be uploaded. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

Please provide supporting documentation outlining your active engagement with the **Syndromic Surveillance Registry**. If you are choosing one of the available exclusions please provide documentation to support your exclusion choice.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion 1: Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdictions syndromic surveillance system.

* **Does this exclusion apply to you?**

Yes No

Exclusion 2: Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

Exclusion 3: Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

Complete the following information:

* Are you in active engagement with a public health agency to submit syndromic surveillance data?

Yes No

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Save & Continue | Return to Attestation Progress

Stage 2^{M} **Screen 15**

Public Health Reporting

☑ Measure 2

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

If you are in active engagement to submit syndromic surveillance data to a public health agency, you must upload documentation to support that separately.

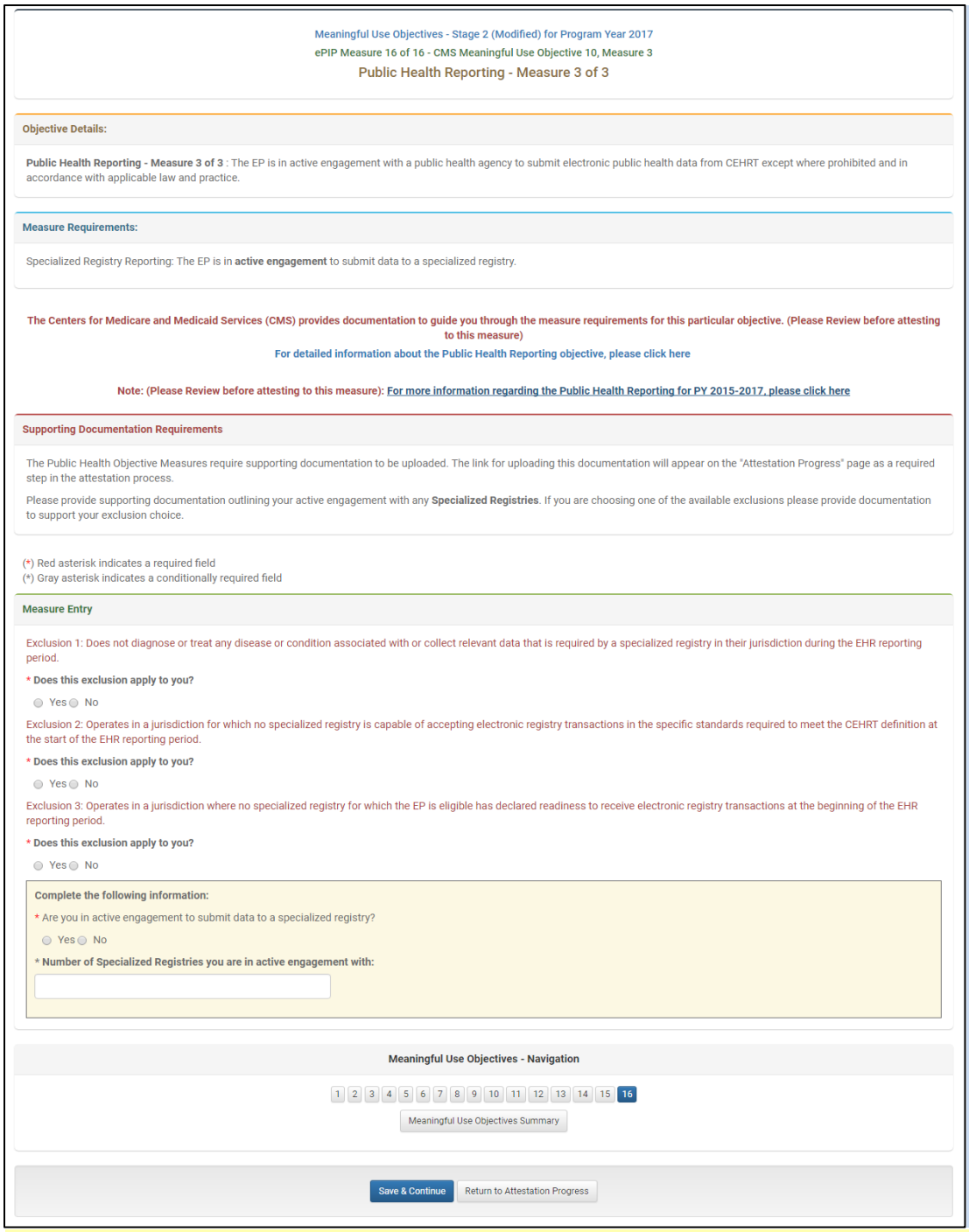
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 10 Measure 3 Public Health Reporting



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2017
ePIP Measure 16 of 16 - CMS Meaningful Use Objective 10, Measure 3
Public Health Reporting - Measure 3 of 3

Objective Details:

Public Health Reporting - Measure 3 of 3 : The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

Measure Requirements:

Specialized Registry Reporting: The EP is in **active engagement** to submit data to a specialized registry.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)

For detailed information about the Public Health Reporting objective, please click here

Note: (Please Review before attesting to this measure): For more information regarding the Public Health Reporting for PY 2015-2017, please click here

Supporting Documentation Requirements

The Public Health Objective Measures require supporting documentation to be uploaded. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

Please provide supporting documentation outlining your active engagement with any **Specialized Registries**. If you are choosing one of the available exclusions please provide documentation to support your exclusion choice.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field

Measure Entry

Exclusion 1: Does not diagnose or treat any disease or condition associated with or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

Exclusion 2: Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

Exclusion 3: Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

* **Does this exclusion apply to you?**

Yes No

Complete the following information:

* Are you in active engagement to submit data to a specialized registry?

Yes No

* **Number of Specialized Registries you are in active engagement with:**

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Meaningful Use Objectives Summary

Save & Continue | Return to Attestation Progress

Stage 2M **Screen 16**

Public Health Reporting

☑ Measure 3

Complete all required fields.

If you select the exclusions, you must upload documentation to support that separately.

If you are in active engagement to submit data to a specialized registry, you must upload documentation to support that separately.

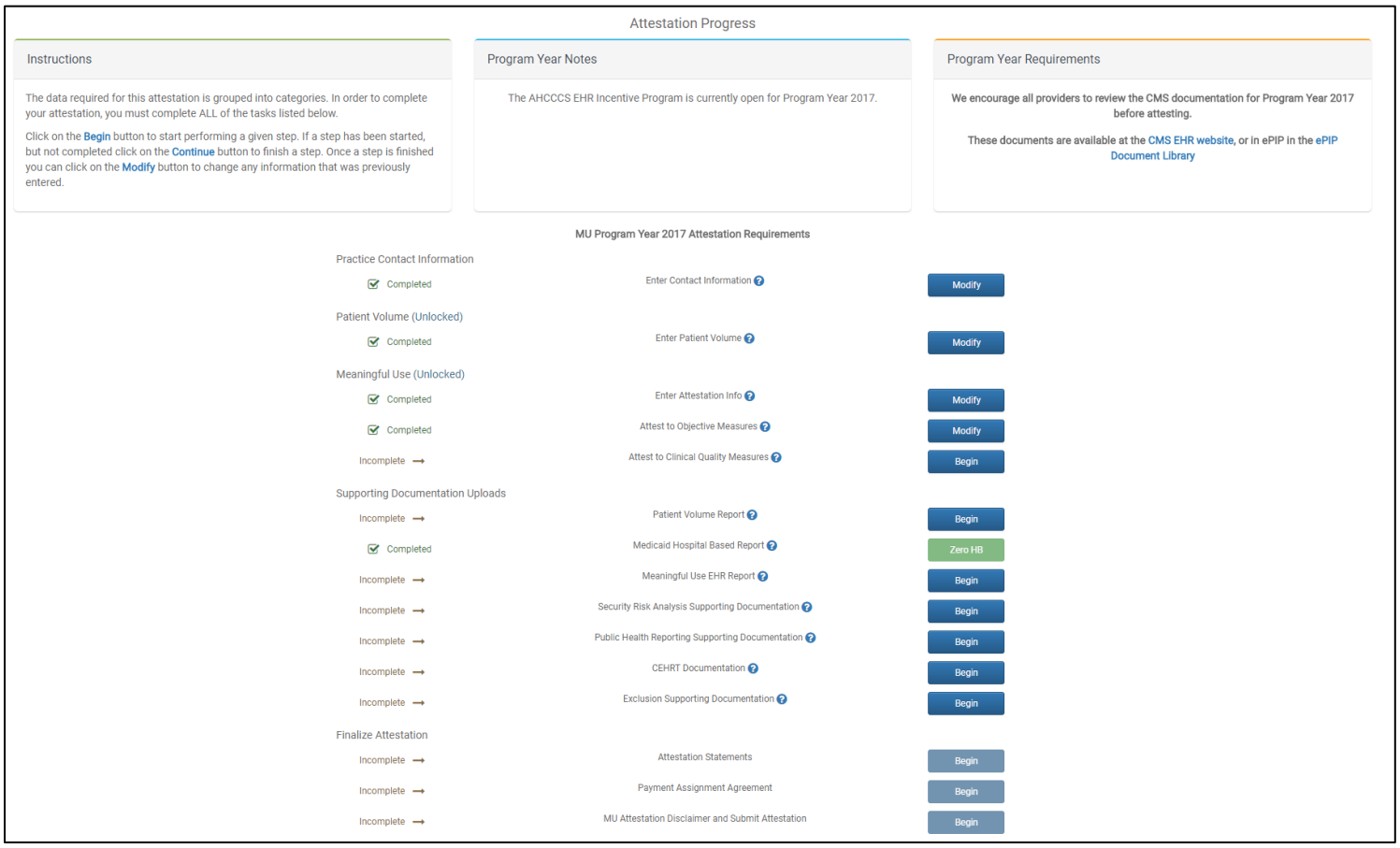
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Attestation Progress (After Objective Measures)



When you complete a step and the status has changed from “Begin” to “Modify”, you can close the program and it will automatically save your work.

You can return later and modify previous steps in this section.

TIP

Click the Begin button to complete each step.

Click Continue button to finish a step.

Click Modify button to change information previously entered.

Clinical Quality Measures

	Meaningful Use Clinical Quality Measures	
	National Quality Strategy (NQS) Domains	**Number CQMs Available**
1	Person and Caregiver-Centered Experience and Outcomes	4
2	Patient Safety	5
3	Communication and Care Coordination	1
4	Community/Population Health	9
5	Efficiency and Cost Reduction	4
6	Effective Clinical Care	30

Clinical Quality Measures (CQMs) Selection:

Providers are required to report on 6 of 53 separate CQMs from any of the National Quality Strategy domains.

Select the CQMs that best apply to your scope of practice.

The CQM Reporting Period is a 90-day period selected from 2017.

If your certified EHR technology does not contain patient data for at least 6 CQMs:

☑ Report the CQMs for which there is patient data

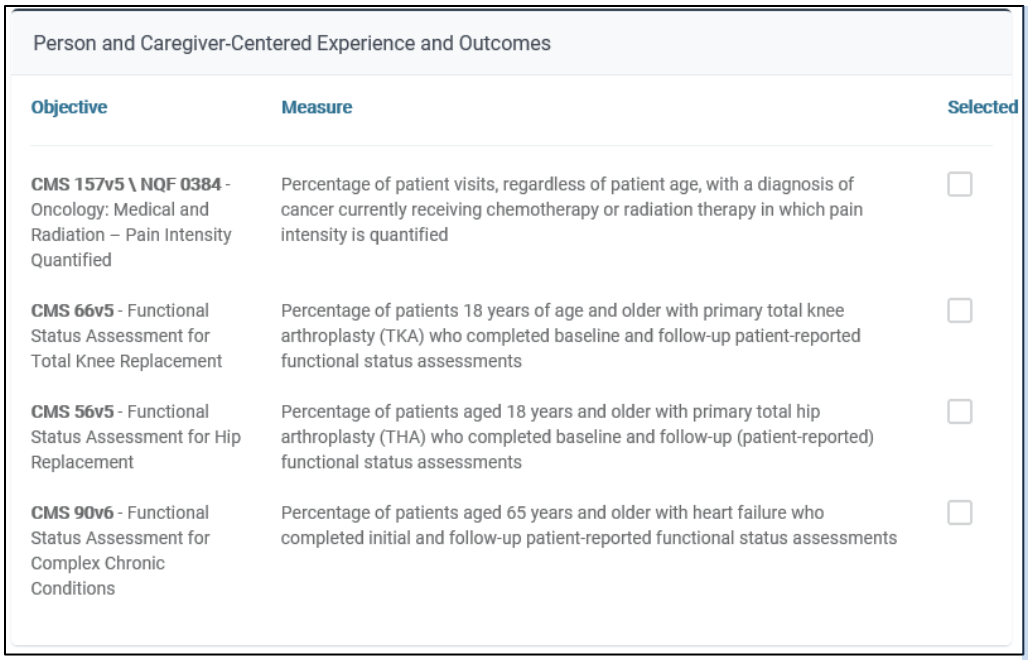
☑ Report the remaining required CQMs as "zero denominators" as displayed by your certified EHR technology.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page under Meaningful Use EHR Report.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Clinical Quality Measures for Person and Caregiver-Centered Experience & Outcomes



Person and Caregiver-Centered Experience and Outcomes

Objective	Measure	Selected
CMS 157v5 \ NQF 0384 - Oncology: Medical and Radiation – Pain Intensity Quantified	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	☐
CMS 66v5 - Functional Status Assessment for Total Knee Replacement	Percentage of patients 18 years of age and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported functional status assessments	☐
CMS 56v5 - Functional Status Assessment for Hip Replacement	Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments	☐
CMS 90v6 - Functional Status Assessment for Complex Chronic Conditions	Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments	☐

Person and Caregiver-Centered Experience & Outcomes

Select the CQMs that best apply to your scope of practice.

4 of 53 CQMs are available under this domain.

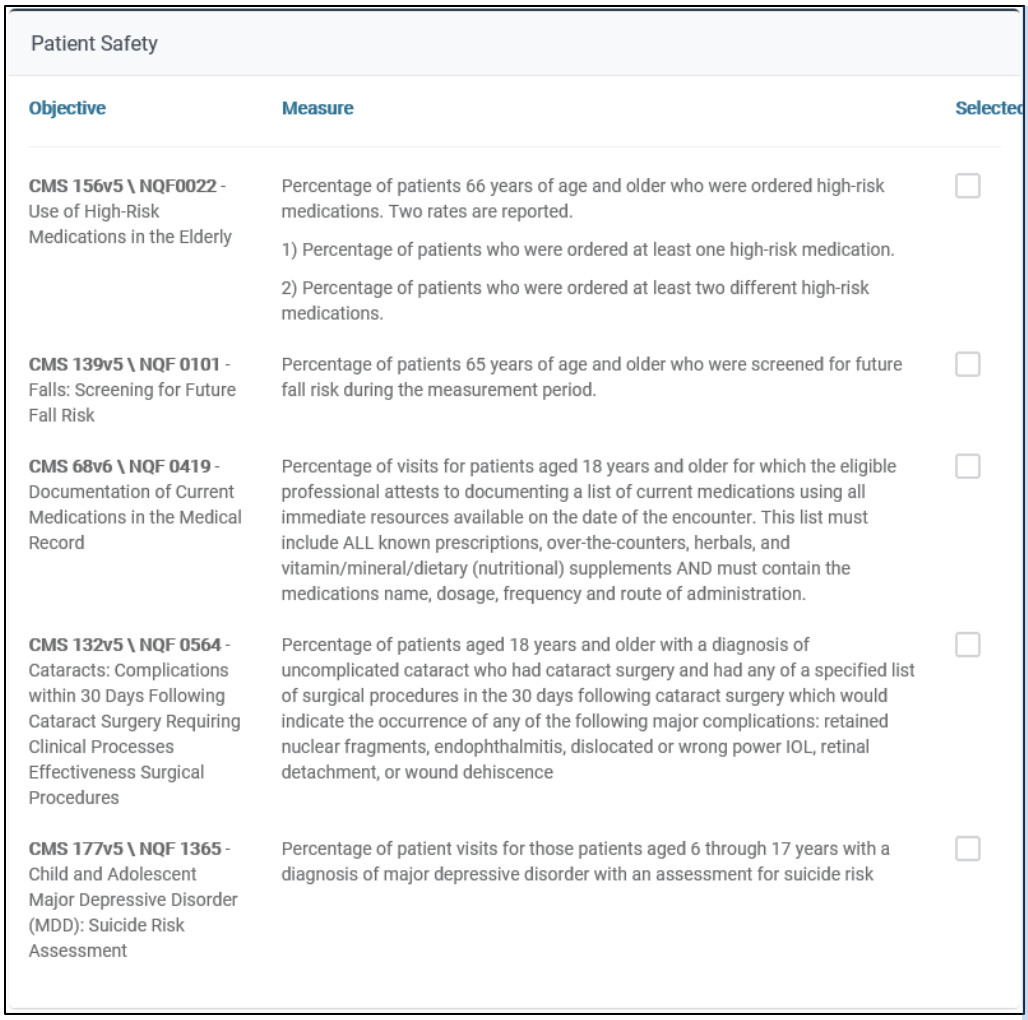
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page under Meaningful Use EHR Report.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Clinical Quality Measures for Patient Safety



Patient Safety

Objective	Measure	Selected
CMS 156v5 \ NQF0022 - Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. 1) Percentage of patients who were ordered at least one high-risk medication. 2) Percentage of patients who were ordered at least two different high-risk medications.	☐
CMS 139v5 \ NQF 0101 - Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	☐
CMS 68v6 \ NQF 0419 - Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration.	☐
CMS 132v5 \ NQF 0564 - Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Clinical Processes Effectiveness Surgical Procedures	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence	☐
CMS 177v5 \ NQF 1365 - Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	☐

Patient Safety

Select the CQMs that best apply to your scope of practice.

5 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page under Meaningful Use EHR Report.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Clinical Quality Measures for Communication and Care Coordination

Communication and Care Coordination

Select the CQMs that best apply to your scope of practice.

1 of 53 CQMs is available under this domain.

The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page under Meaningful Use EHR Report.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Clinical Quality Measures for Community / Population Health

Community/Population Health

Objective	Measure	Selected
CMS 155v5 \ NQF 0024 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician / Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. • Percentage of patients with height, weight, and body mass index (BMI) percentile documentation • Percentage of patients with counseling for nutrition • Percentage of patients with counseling for physical activity	☐
CMS 138v5 \ NQF 0028 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	☐
CMS 153v5 \ NQF 0033 - Chlamydia Screening for Women	Percentage of women 16- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	☐
CMS 117v5 \ NQF 0038 - Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	☐
CMS 147v6 \ NQF 0041 - Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	☐

Community / Population Health

Select the CQMs that best apply to your scope of practice.

9 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page under Meaningful Use EHR Report.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Clinical Quality Measures for Community / Population Health cont'd.

CMS 2v6 \ NQF 0418 - Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.	☐
CMS 69v5 \ NQF 0421 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with an encounter during the reporting period with a documented calculated BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, follow-up plan is documented during the encounter or during the previous 6 months of the encounter with the BMI outside of normal parameters. Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 Age 18-64 years BMI ≥ 18.5 and < 25.	☐
CMS 82v4 \ NQF1401 - Maternal depression screening	The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.	☐
CMS 22v5 - Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	☐

Community / Population Health

Select the CQMs that best apply to your scope of practice.

9 of 53 CQMs are available under this domain.

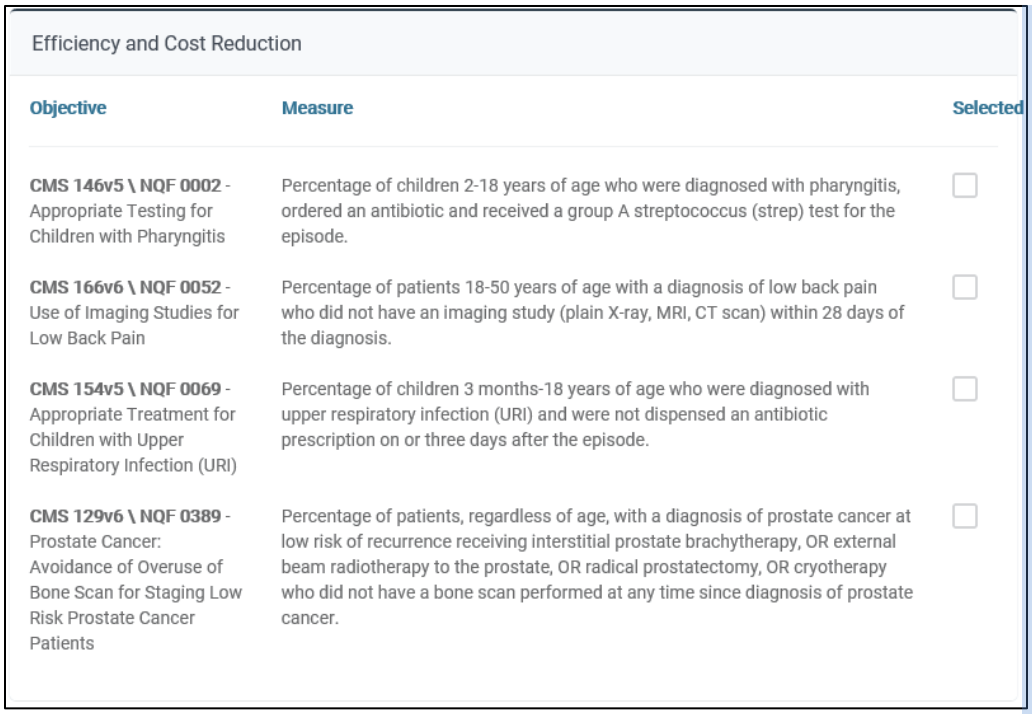
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page under Meaningful Use EHR Report.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Clinical Quality Measures for Efficiency and Cost Reduction



Efficiency and Cost Reduction

Objective	Measure	Selected
CMS 146v5 \ NQF 0002 - Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	☐
CMS 166v6 \ NQF 0052 - Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	☐
CMS 154v5 \ NQF 0069 - Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	☐
CMS 129v6 \ NQF 0389 - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	☐

Efficiency and Cost Reduction

Select the CQMs that best apply to your scope of practice.

4 of 53 CQMs are available under this domain.

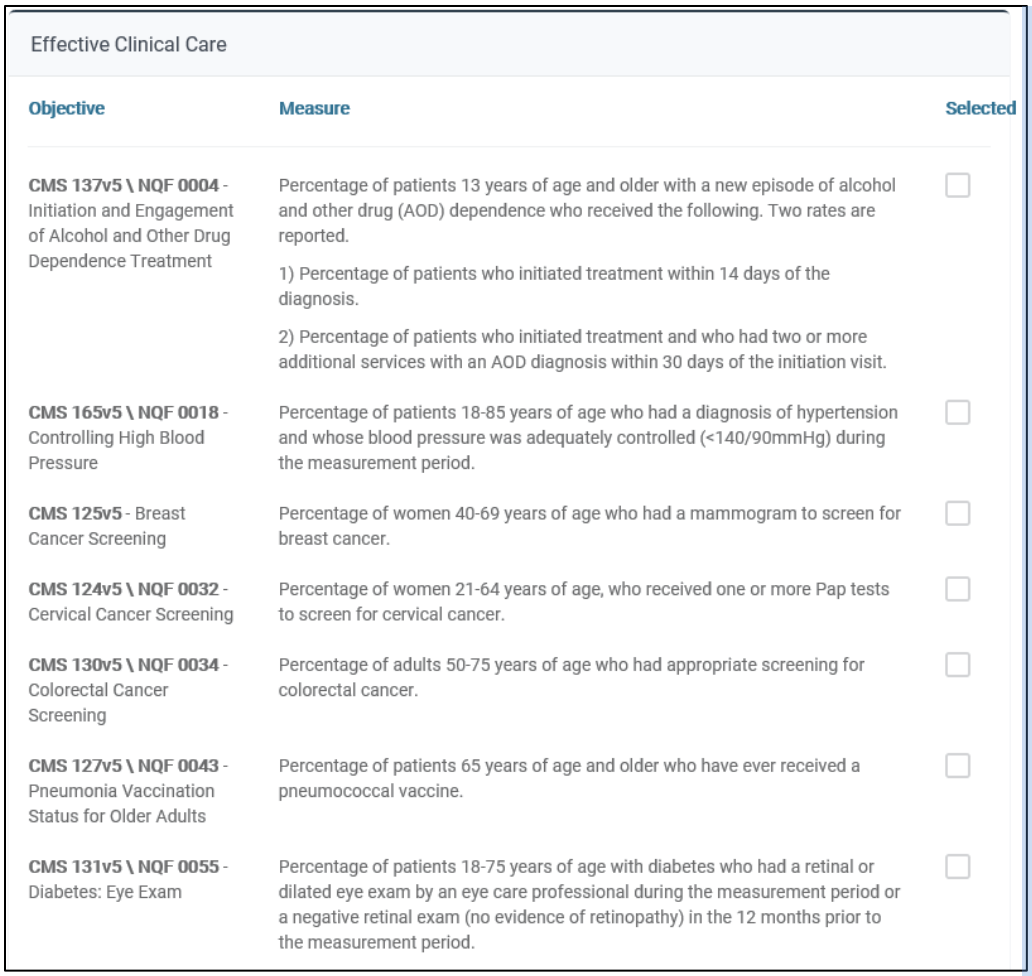
The Navigation bar at the bottom will monitor your progress.

TIP

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page under Meaningful Use EHR Report.

Click the hyperlink on the ePIP screen to learn more about this requirement.

Clinical Quality Measures for Effective Clinical Care



Effective Clinical Care

Objective	Measure	Selected
CMS 137v5 \ NQF 0004 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. 1) Percentage of patients who initiated treatment within 14 days of the diagnosis. 2) Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	☐
CMS 165v5 \ NQF 0018 - Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	☐
CMS 125v5 - Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	☐
CMS 124v5 \ NQF 0032 - Cervical Cancer Screening	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	☐
CMS 130v5 \ NQF 0034 - Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	☐
CMS 127v5 \ NQF 0043 - Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	☐
CMS 131v5 \ NQF 0055 - Diabetes: Eye Exam	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	☐

Effective Clinical Care

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Clinical Quality Measures for Effective Clinical Care cont'd.

CMS 123v5 \ NQF 0056 - Diabetes: Foot Exam	Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.	☐
CMS 122v5 \ NQF 0059 - Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	☐
CMS 134v5 \ NQF 0062 - Diabetes: Urine Protein Screening	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	☐
CMS 164v5 \ NQF 0068 - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.	☐
CMS 145v5 \ NQF 0070 - Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.	☐
CMS 135v5 \ NQF 0081 - Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	☐

Effective Clinical Care

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Clinical Quality Measures for Effective Clinical Care cont'd.

CMS 144v5 \ NQF 0083 - Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	☐
CMS 143v5 \ NQF 0086 - Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months.	☐
CMS 167v5 \ NQF 0088 - Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	☐
CMS 142v5 \ NQF 0089 - Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	☐
CMS 161v5 \ NQF 0104 - Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.	☐
CMS 128v5 \ NQF 0105 - Anti-depressant Medication Management	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported. 1) Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). 2) Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	☐

Effective Clinical Care

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Clinical Quality Measures for Effective Clinical Care cont'd.

CMS 136v6 \ NQF 0108 - ADHD: Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/ hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. 1) Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. 2) Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	☐
CMS 169v5 - Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	☐
CMS 52v5 \ NQF 0405 - HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.	☐
CMS 133v5 \ NQF 0565 - Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.	☐
CMS 158v5 - Pregnant women that had HBsAg testing	This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.	☐
CMS 159v5 \ NQF 0710 - Depression Remission at Twelve Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	☐

Effective Clinical Care

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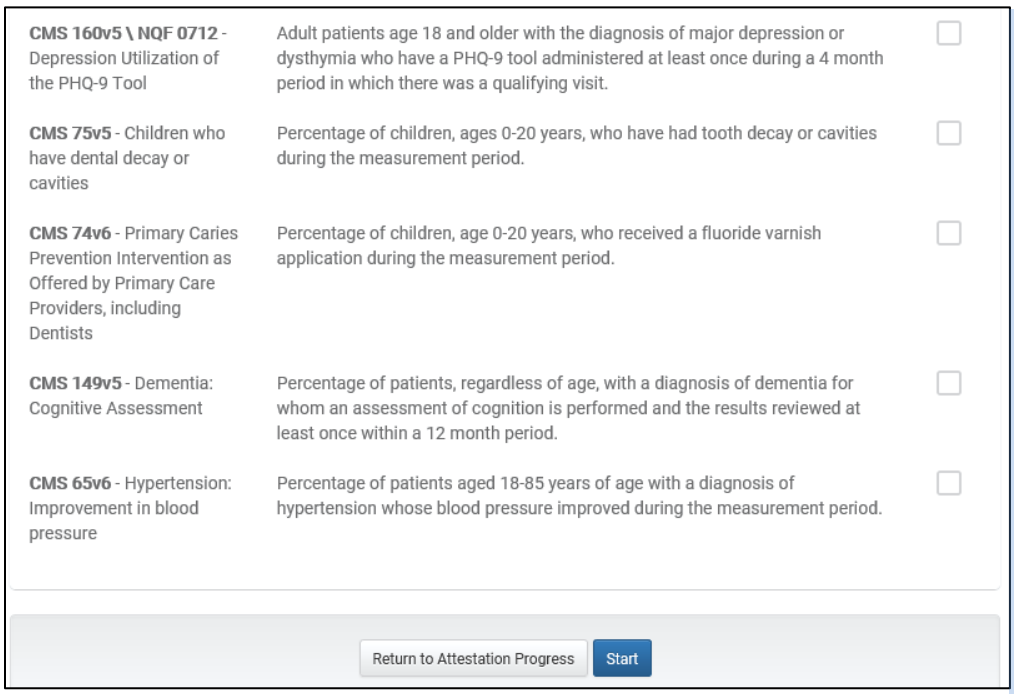
Clinical Quality Measures for Effective Clinical Care cont'd



CMS 160v5 \ NQF 0712 - Depression Utilization of the PHQ-9 Tool	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit.	☐
CMS 75v5 - Children who have dental decay or cavities	Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period.	☐
CMS 74v6 - Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	☐
CMS 149v5 - Dementia: Cognitive Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.	☐
CMS 65v6 - Hypertension: Improvement in blood pressure	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	☐

Effective Clinical Care

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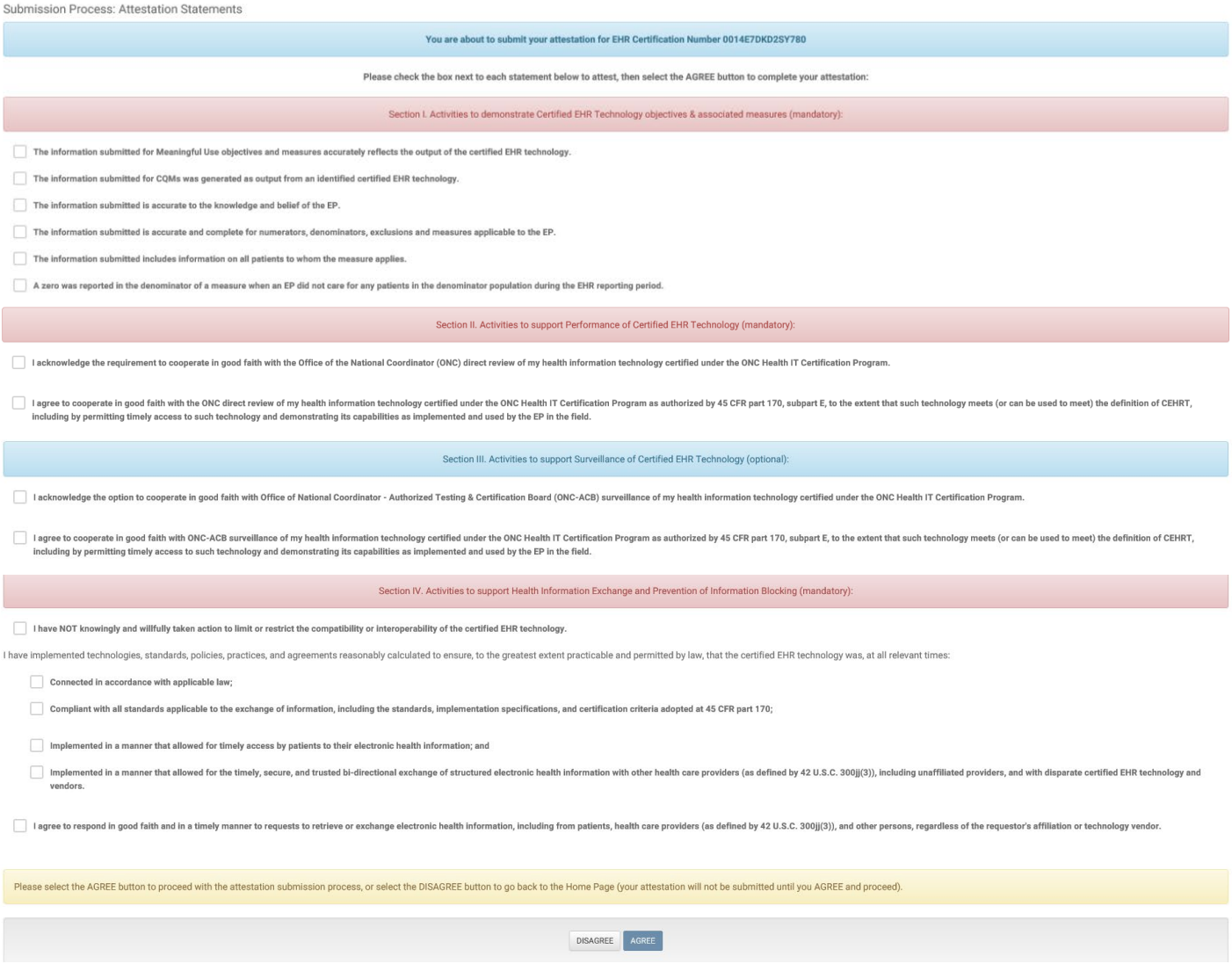
Attestation Statements



Submission Process: Attestation Statements

You are about to submit your attestation for EHR Certification Number 0014E7DKD2SY780

Please check the box next to each statement below to attest, then select the AGREE button to complete your attestation:

Section I. Activities to demonstrate Certified EHR Technology objectives & associated measures (mandatory):

- The information submitted for Meaningful Use objectives and measures accurately reflects the output of the certified EHR technology.
- The information submitted for CQMs was generated as output from an identified certified EHR technology.
- The information submitted is accurate to the knowledge and belief of the EP.
- The information submitted is accurate and complete for numerators, denominators, exclusions and measures applicable to the EP.
- The information submitted includes information on all patients to whom the measure applies.
- A zero was reported in the denominator of a measure when an EP did not care for any patients in the denominator population during the EHR reporting period.

Section II. Activities to support Performance of Certified EHR Technology (mandatory):

- I acknowledge the requirement to cooperate in good faith with the Office of the National Coordinator (ONC) direct review of my health information technology certified under the ONC Health IT Certification Program.
- I agree to cooperate in good faith with the ONC direct review of my health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the EP in the field.

Section III. Activities to support Surveillance of Certified EHR Technology (optional):

- I acknowledge the option to cooperate in good faith with Office of National Coordinator - Authorized Testing & Certification Board (ONC-ACB) surveillance of my health information technology certified under the ONC Health IT Certification Program.
- I agree to cooperate in good faith with ONC-ACB surveillance of my health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the EP in the field.

Section IV. Activities to support Health Information Exchange and Prevention of Information Blocking (mandatory):

- I have NOT knowingly and willfully taken action to limit or restrict the compatibility or interoperability of the certified EHR technology.

I have implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times:

- Connected in accordance with applicable law;
- Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;
- Implemented in a manner that allowed for timely access by patients to their electronic health information; and
- Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and vendors.

- I agree to respond in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

Please select the AGREE button to proceed with the attestation submission process, or select the DISAGREE button to go back to the Home Page (your attestation will not be submitted until you AGREE and proceed).

DISAGREE AGREE

You must read, Agree or Disagree with the Attestation Statements in order to proceed with attesting.

Section I Activities to demonstrate Certified EHR Technology objectives & associated measures *(mandatory)*.
Section II Activities to support Performance of Certified EHR Technology *(mandatory)*.
Section III Activities to support Surveillance of Certified EHR Technology *(optional)*.
Section IV Activities to support Health Information Exchange and Prevention of Information Blocking *(mandatory)*.

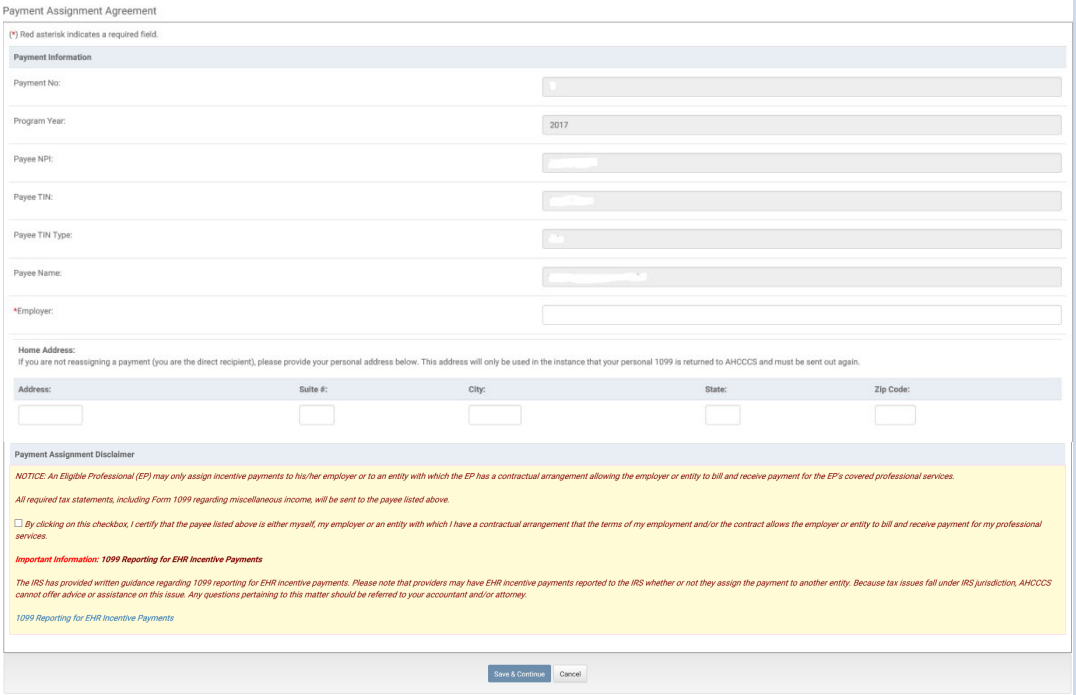
TIP

Click the Box next to each item to confirm the statement is true *(Section III is optional)*.

Click the Agree button to signify your agreement with the statements.

Click the Disagree button to signify your disagree with the statements *(exit attestation)*.

Payment Reassignment



You must confirm your employer at the time of attestation and enter your home address if you are not reassigning your payment.

To prevent improper payments, this information will be used to verify your Payee information prior to disbursement of payment.

Note: Only the provider has authority to re-assign the payment.

TIP

Any reassignment of payment must be voluntary and the decision as to whether an EP reassigns the incentive payment to a specific TIN is an issue which EPs and these other parties should resolve.

Any reassignment of payment must be consistent with applicable laws, rules, and regulations, including, without limitation, those related to fraud, waste and abuse.

Attestation Disclaimer

Step 1
You must first read the Attestation Disclaimer.

➥Attestation Notification

➥Routine Uses

➥Disclosures

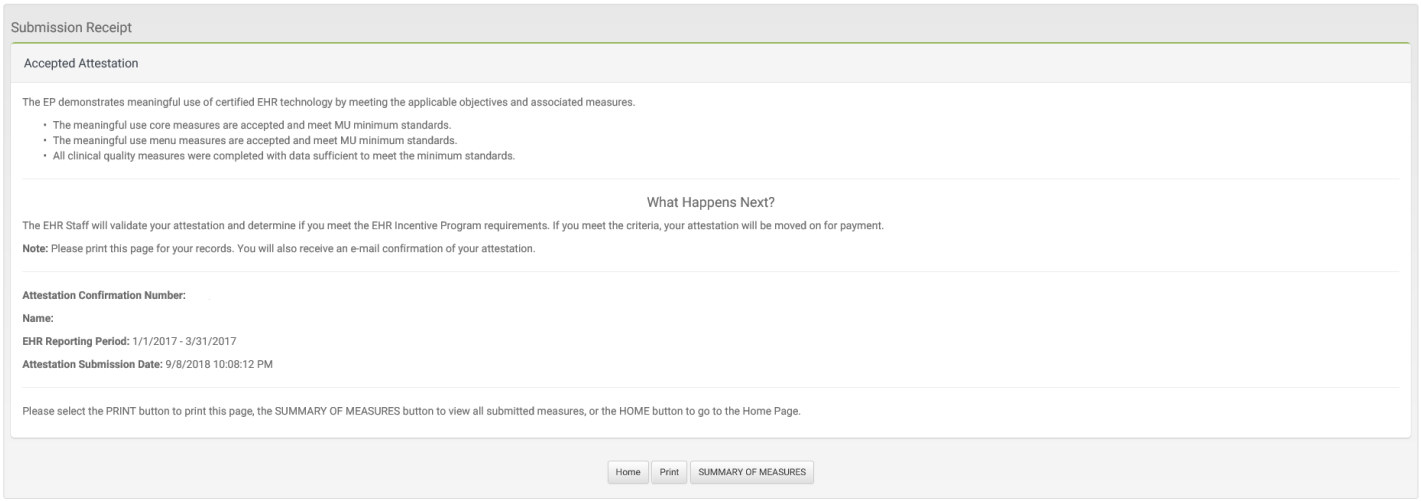
➥Attestation Disclaimer

Step 2
You must click the Box to confirm your agreement with the Attestation Disclaimer notice.

TIP

If you do not agree with the Attestation Disclaimer, then you cannot proceed with your submission and must exit the attestation.

Submission Receipt



You will receive a submission receipt after you successfully submit your attestation. The notice will include the following:

☑ Attestation Confirmation Number

☑ Provider's Name

☑ EHR Reporting Period (MU)

☑ Attestation Date

TIP

If you do not receive the submission receipt, then your attestation is not submitted.

Appendices

Appendix	Description
A	Medicaid Patient Volume Report Layout
B	Medicaid Hospital-Based Report Layout
C	Needy Patient Volume Report Layout
D	Needy Practice Predominantly Report Layout
E	Definitions
F	Frequently Asked Questions
G	Electronic Funds Transfer – ACH Form Instructions
H	Electronic Funds Transfer – ACH Form
I	Contacts

Appendix A – Medicaid Patient Volume Report Layout

Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

The Medicaid Patient Volume calculation using **all** places of services is:

- Numerator: Medicaid Title XIX Patient Encounters
- Denominator: All Patient Encounters [Medicaid + Non-Medicaid]
  - ➥Non-Medicaid includes CHIP Title XXI (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, Sliding Scale, etc.

Reporting Period is a continuous 90-day period in the prior calendar year.

Description	Field Format
Date of Service*	MM/DD/YYYY
Patient Date of Birth	MM/DD/YYYY
Patient Identifier *(unique ID or if not available, SSN)*	Alpha or Numeric
Patient Insurance ID *(AHCCCS Member ID or Other Member ID)*	Alpha or Numeric
Patient Name	Alpha
Payer Financial Class *Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.* *Correctional Facilities: Use Medicaid or Non-Medicaid description*	Alpha
Payer Name *(if applicable specify Health Plan Name)*	Alpha
Payer Health Plan ID / Site ID *(Medicaid or CHIP)*	Numeric
Payer Medicaid/CHIP Coordination of Benefits ✓For Medicaid Title XIX: *Enter Medicaid Primary, Medicaid Secondary, Medicaid Tertiary, etc.* ✓For CHIP (KidsCare) Title XXI: *Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.*	Alpha
Place of Service (POS) Codes *(include all Place of Services)* *Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.*	Alpha or Numeric
Rendering/Servicing Provider Name	Alpha
Visit Count - Numerator *(Enter 1= unique visit; 0 = duplicate visit)*	Numeric
Visit Count – Denominator *(Enter 1= unique visit; 0 = duplicate visit*	Numeric

Correctional Facility is a practice location for providers rendering care to inmates in a prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.* ***NOTE:* *Incarceration & Release Date must be included in your report.*

Appendix B – Medicaid Hospital-Based Report Layout

Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

The Medicaid Hospital-Based calculation using **all** Medicaid Title XIX places of service only is:

- Numerator: Medicaid Title XIX Hospital-Based Patient Encounters [Place of Service 21 & 23 Only]
- Denominator: All Medicaid Title XIX Patient Encounters [All Place of Services]

Reporting Period is a continuous 12-month period in the prior calendar year.

Description	Field Format
Date of Service*	MM/DD/YYYY
Patient Date of Birth	MM/DD/YYYY
Patient Identifier *(unique ID or if not available, SSN)*	Alpha or Numeric
Patient Insurance ID *(AHCCCS Member ID or Other Member ID)*	Alpha or Numeric
Patient Name	Alpha
Payer Financial Class *Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.* *Correctional Facilities: Use Medicaid or Non-Medicaid description*	Alpha
Payer Name *(if applicable specify Health Plan Name)*	Alpha
Payer Health Plan ID / Site ID *(Medicaid or CHIP)*	Numeric
Payer Medicaid/CHIP Coordination of Benefits ✓For Medicaid Title XIX: *Enter Medicaid Primary, Medicaid Secondary, Medicaid Tertiary, etc.* ✓For CHIP (KidsCare) Title XXI: *Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.*	Alpha
Place of Service (POS) Codes *(include all Place of Services)* *Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.*	Alpha or Numeric
Rendering/Servicing Provider Name	Alpha
Visit Count - Numerator *(Enter 1= unique visit; 0 = duplicate visit)*	Numeric
Visit Count – Denominator *(Enter1= unique visit; 0 = duplicate visit)*	Numeric

Correctional Facility is a practice location for providers rendering care to inmates in a prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders.* ***NOTE:* *Incarceration & Release Date must be included in your report.*

Appendix C – Needy Patient Volume Report Layout

Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

The Needy Patient Volume calculation using **all** places of services is:

- Numerator *(Needy Patient Encounters)*:
  ➥Needy includes Medicaid Title XIX, CHIP Title XXI *(KidsCare)* & Patients Paying Below Cost *(Sliding Scale)*
- Denominator: All Patient Encounters [Needy + Non-Needy]
  ➥Non-Needy includes Medicare, Private Insurance, Self-Pay, Commercial, etc.

Reporting Period is a continuous 90-day period in the prior calendar year.

Description	Field Format
Date of Service*	MM/DD/YYYY
Patient Date of Birth	MM/DD/YYYY
Patient Identifier *(unique ID or if not available, SSN)*	Alpha or Numeric
Patient Insurance ID *(AHCCCS Member ID or Other Member ID)*	Alpha or Numeric
Patient Name	Alpha
Payer Financial Class *Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.* *Correctional Facilities: Use Medicaid or Non-Medicaid description*	Alpha
Payer Name *(if applicable specify Health Plan Name)*	Alpha
Payer Health Plan ID / Site ID *(Medicaid or CHIP)*	Numeric
Payer Medicaid/CHIP Coordination of Benefits ✓For Medicaid Title XIX: *Enter Medicaid Primary, Medicaid Secondary, Medicaid Tertiary, etc.* ✓For CHIP (KidsCare) Title XXI: *Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.*	Alpha
Place of Service (POS) Codes *(include all Place of Services)* *Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.*	Alpha or Numeric
Rendering/Servicing Provider Name	Alpha
Visit Count - Numerator *(Enter 1= unique visit; 0 = duplicate visit)*	Numeric
Visit Count - Denominator *(Enter 1= unique visit; 0 = duplicate visit)*	Numeric

Appendix D – Needy Practice Predominantly Report Layout

Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

The Practice Predominantly calculation using **all** places of services is:

- Numerator: All FQHC/RHC/Tribal Clinic Patient Encounters [Place of Services inside facility only]
- Denominator: All Total Patient Encounters [All Place of Services inside & outside facility]

Reporting Period is a continuous 6-month period in the prior calendar year.

Description	Field Format
Date of Service*	MM/DD/YYYY
Patient Date of Birth	MM/DD/YYYY
Patient Identifier *(unique ID or if not available, SSN)*	Alpha or Numeric
Patient Insurance ID *(AHCCCS Member ID or Other Member ID)*	Alpha or Numeric
Patient Name	Alpha
Payer Financial Class *Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.* *Correctional Facilities: Use Medicaid or Non-Medicaid description*	Alpha
Payer Name *(if applicable specify Health Plan Name)*	Alpha
Payer Health Plan ID / Site ID *(Medicaid or CHIP)*	Numeric
Payer Medicaid/CHIP Coordination of Benefits ✓For Medicaid Title XIX: *Enter Medicaid Primary, Medicaid Secondary, Medicaid Tertiary, etc.* ✓For CHIP (KidsCare) Title XXI: *Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.*	Alpha
Place of Service (POS) Codes *(include all Place of Services)* *Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.*	Alpha or Numeric
Rendering/Servicing Provider Name	Alpha
Visit Count - Numerator *(Enter 1= unique visit; 0 = duplicate visit)*	Numeric
Visit Count - Denominator *(Enter 1= unique visit; 0 = duplicate visit)*	Numeric

Appendix E – Definitions

Attestation
The attestation process allows the providers to attest to the EHR Incentive Program's as they demonstrate adoption, implementation, upgrade (AIU), or meaningful use of EHR technology. *AIU attestations are not available after 2016.*
Electronic Health Record (EHR)
A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.
Eligible Professionals (EP)
Physicians (Doctor of Medicine, Doctor of Osteopathy), Dentists, Nurse Practitioners, Certified Nurse Midwives and Physician Assistants (PA) practicing in a FQHC/RHC/Tribal Clinic led by the PA.
ePIP
An online application that interfaces with the CMS Registration and Attestation system and the Prepaid Medicaid Management Information System (PMMIS) to allow providers to complete applications for the Medicaid EHR Incentive Program for Arizona.
Meaningful Use
Use of certified EHR technology (CEHRT) to Improve quality, safety, efficiency, & reduce health disparities; Engage patients & families in their health care; Improve care coordination; Improve population & public health and all the while maintaining privacy and security.
Meaningful Use Exclusion
A reason or reasons associated with a Meaningful Use objective that can be selected, if applicable, to exempt a provider from having to meet the measure
Meaningful Use Exemption
Found mainly in the Clinical Quality Measures, this counts the number of members that were seen by a provider during the Meaningful Use Reporting Period, but were not eligible to be included in the measure being reported.
Meaningful Use Stages
Stage 1 Data Capture & Information Sharing: Requirements focus on electronic data capture and information sharing with the patient or other health care professionals. *Stage 2 / Stage 2 ^{Modified} Advanced Clinical Processes:* Requirements focus on expanding Stage 1 requirements by emphasizing patient engagement and care coordination. Improvements to ease reporting requirements and align with other quality reporting programs *(Stage 2 ^{Modified})*. *Stage 3 Improved Outcome:* Requirements focus on using CEHRT to improve health outcomes.
Patient Volume Methodology
Method in which an EP reports his/her patient encounters. Individual is the sum of patient encounters for a single EP. Aggregate is the sum of patient encounters for the entire practice (includes all providers).
Program Year
The calendar year in which a provider is attesting. Providers can participate and receive payment up to a maximum of 6 years.
Registration
The registration process allows the provider to participate in the EHR Incentive Program. Providers must complete a federal and state level registration process. *Only providers transferring from other States are permitted to register to set-up an ePIP account after Program Year 2016.*

Appendix F – Frequently Asked Questions regarding Program Participation

Q1	**Can I switch between Medicare and Medicaid programs?**
	Providers can switch between the Medicare and Medicaid programs any time before they receive their first incentive payment. Eligible Professionals can switch one time (before 2015) between the Medicare and Medicaid Incentive Programs if they have received one incentive payment.
Q2	**Can I skip a year after I have started the EHR incentive program?**
	Eligible Professionals (EPs) in the Medicaid EHR incentive program can skip a year without a Medicaid penalty. It is not necessary to notify Medicaid that you are skipping a year. When you return, you continue with the next payment year.
Q3	**Are physicians who work in hospitals eligible to receive Medicaid electronic health record (EHR) incentive payments?**
	Physicians who furnish substantially all, defined as 90% or more, of their covered professional services in an inpatient (POS 21) and emergency department (POS 23) of a hospital are not eligible for incentive payments under the Medicare and Medicaid EHR Incentive Programs.
Q4	**Is my practice eligible to apply & receive incentive payments through the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?**
	No, your practice cannot apply for payment. Attestations are submitted by individual Eligible Professionals (EPs) who can voluntarily re-assign payment to their practice.
Q5	**Will EHR Incentive Payments be subject to audit?**
	Incentive payments made to Eligible Professionals under the Medicaid EHR Incentive Program is subject to audit by the EHR Incentive Programs. AHCCCS is responsible for conducting the audit for your attestation. Unless otherwise indicated, you will be contacted by AHCCCS with instructions when you are selected for the State audit. EHR audit questions can be directed to the EHR Post Payment Audit Team at: EHRPost-PayAudits@azahcccs.gov or 602.417.4440

Appendix F – Frequently Asked Questions regarding Registration

Q6	**How often do I need to Register?**
	You need to Register once in order to participate in the EHR Incentive Program. Thereafter, you must keep your registration information updated in each system. When updating information in your CMS registration, make sure that you "re-submit" your Registration information and allow 24 – 48 hours to feed to ePIP. Each time you attest, it is recommended that you review and update the "Contact Information" in both systems as needed.
Q7	**I registered in the CMS Registration & Attestation System but my registration is still showing 'Send for State Approval'. How can I troubleshoot the problem?**
	After completing the registration in the CMS Registration and Attestation System, allow 24 to 48 hours for your registration information to transfer from that system to Arizona's Electronic Provider Incentive Payment System (ePIP). If your CMS registration status shows ***'Sent for State Approval'***, please send an inquiry to Medicaid at EHRIncentivePayments@azahcccs.gov for assistance. **If your CMS registration status shows *'Registration Started/Modified/In Progress'*, please re-submit your CMS registration.**
Q8	**Can providers participating in the Medicare or Medicaid EHR Incentive Programs update their information (for example, if an address was mistakenly entered)? If so, will the State receive an update or full refresh of this information for its Medicaid EHR Incentive Program?**
	Yes, providers who have registered for the Medicare or Medicaid EHR Incentive Programs may correct errors or update information through the registration module on the CMS registration website https://ehrincentives.cms.gov/hitech/login.action The updated registration information will be sent to the State.
Q9	**I previously received an EHR payment from another Medicaid State and have since moved to Arizona. Can I continue to participate in the program?**
	Yes, you can continue to participate in the Arizona Medicaid EHR Incentive Program. First you must update your changes in the CMS Registration & Attestation System and then register in the State's Registration & Attestation System to create your ePIP account.

Appendix F – Frequently Asked Questions regarding Attestations

Q10	**I am ready to start a new attestation but I do not see that option when I log in to ePIP. What are the possible reasons for such?**
	If a payment decision has not been issued for the prior Program Year in which you attested, you cannot begin a new Program Year attestation. If your previous attestation was denied or rejected, you may need to have your attestation refreshed. In any instance if you cannot start a new Program Year, please email the EHR Incentive Program team at EHRIncentivePayments@azahcccs.gov.
Q11	**How do I know if my electronic health record (EHR) system is certified?**
	The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a set of standards and certification criteria. EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) in order to qualify for incentive payments. The Certified Health IT Product List (CHPL) is available at http://www.healthit.hhs.gov/CHPL. Providers must maintain the proper certification requirements & submit the required documentation to demonstrate that their EHR technology is properly certified.
Q12	**How do we submit documentation to support the attestation?**
	ePIP is the State's repository for storing your attestation information. Providers are required to upload their documentation at the time of attestation. Passwords should follow standard operating procedures to prevent access to your ePIP accounts. The ePIP website, https://www.azepip.gov/, has a Hypertext Transfer Protocol Secure (HTTPS) feature which has a built in communications protocol for secure communication over a computer network. Therefore, documents uploaded to ePIP are secure and encrypted.
Q13	**How can I change my attestation information after I have attested for the Medicaid EHR Incentive Program?**
	If you discover that the information you entered during your Medicaid attestation was not complete and accurate for some reason, please email Medicaid at EHRIncentivePayments@azahcccs.gov.

Appendix F – Frequently Asked Questions regarding Meaningful Use

Q14	**What is the deadline for Medicaid Eligible Professionals to submit attestations for Program Year 2017?**
	Eligible Professionals participate in the Medicaid EHR Incentive Programs on a calendar year basis. Generally, the Medicaid attestation deadline is 90-days following the end of the calendar year. At this time, the deadline for Program Year 2017 has been extended to **December 31, 2018**.
Q15	**What are the reporting periods for Eligible Professionals participating in the electronic health record (EHR) Incentive Program?**
	For Program Year 2017, the reporting periods are as follows: *Volume (select a period from 2016):* Patient Volume - a continuous 90-day period in the prior calendar year Hospital-Based - a 12-month period in the prior calendar year Practice Predominantly - continuous 6-month period in the prior calendar year *Meaningful Use (select a period from 2017):* The EHR reporting period for the Meaningful Use Objectives & the Clinical Quality Measures is a continuous 90-day period within the calendar year.
Q16	**Under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, who is responsible for demonstrating meaningful use of certified EHR technology, the provider or the vendor?**
	To receive an EHR incentive payment, the Eligible Professional is responsible for demonstrating meaningful use of certified EHR technology under both the Medicare and Medicaid EHR incentive programs.
Q17	**Is there a penalty if I start the EHR incentive program and do not attest to Meaningful Use?**
	Providers who have a Medicare patient population and have not attested to Meaningful Use will have a reduction in Medicare payments. Providers that do not serve Medicare members are not penalized if they do not attest or if they withdraw from the Medicaid EHR Incentive Program after receiving an incentive payment.

Appendix F – Frequently Asked Questions regarding Payment

Q18	**I am choosing to reassign my EHR incentive payment to my practice. Will I have any financial liability if I do so?**
	The State of Arizona issues 1099s to the Payee (recipient) of the EHR funds. If you have reassigned your payment to your practice, you will not personally receive a 1099. For more information on 1099s, visit the AHCCCS website at https://www.azahcccs.gov/PlansProviders/CurrentProviders/EHR/. Click the Payment drop down and see IMPORTANT TAX INFORMATION.
Q19	**How is the Eligible Professional payment amounts determined?**
	Medicaid EPs can receive a maximum of $63,750 over a six year period. *Note: There are special eligibility & payment options for Pediatricians.*
Q20	**How often are payments made?**
	Payments are disbursed once per month via Electronic Funds Transfer.
Q21	**Are payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs subject to federal income tax?**
	We note that nothing in the Act excludes such payments from taxation or as tax-free income. Therefore, it is our belief that incentive payments would be treated like any other income. Providers should consult with a tax advisor or the Internal Revenue Service regarding how to properly report this income on their filings.
Q22	**Are payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs subject to recoupments?**
	Both Medicare and Medicaid are required to recoup any or all portions of the EHR incentive payment if any of the following conditions are determined: • Provider or Payee received an improper payment • Provider does not meet the requirements of the program • Evidence of fraud and abuse
Q23	**How long will it take to receive a payment?**
	We must first perform the pre-payment audit. The EHR Incentive Team strives to complete within eight (8) weeks of attestation during off peak periods. Delays are experienced when waiting for missing information, resolving issues, during peak periods, training or staffing changes.

Appendix G – Electronic Funds Transfer ACH Form Instructions

STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Electronic Funds Transfer (EFT) Authorization Agreement Instructions

Attn: AHCCCS Finance- MD 5400, P.O. Box 25520, Phoenix, AZ 85002

SECTION 1	**PROVIDER INFORMATION**			
	Provider Name		Complete legal name of institution, corporate entity, practice or individual provider	Required
	Doing Business As Name (DBA)		The trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name, the legal person (or persons) who actually own it and are responsible for it	Optional
	Provider Address			
		Street	The number and street name where a person or organization can be found	Required
		City	City associated with provider address field	Required
		State/Province	2 Character Code associated with the State/Province/Region of the applicable Country	Required
		Zip Code/ Postal Code	5 or 15 Character Code	Required
SECTION 2	**PROVIDER IDENTIFIERS INFORMATION**			
	Provider Identifiers			
		Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number also known as an Employer Idenfication Number (EIN) used to identify a business entity; Numeric, 9 digits	Required
		National Provider Identifier (NPI)	A Health Insurance Poratbilty Accountabilty Act (HIPAA) - Required when provider has been enumerated with an NPI; Numeric, 10 digits	Optional
		Trading Partner ID	AHCCCS Povider ID; 6 digits- 2 digits	Required
SECTION 3	**PROVIDER CONTACT INFORMATION**			
	Provider Contact Name		Name of a contact in provider office for handling EFT issues	Required
		Title		Optional
		Tel Number	Number associated with contact person; Numeric, 10 digits	Required
		Tel Number Ext		Optional
		Email Address	An electronic mail address at which AHCCCS might contact the provider	may not have one
		Fax Number	A number at which the provider can be sent facsimiles	Optional
SECTION 4	**PROVIDER AGENT INFORMATION - IF APPLICABLE**			
	Provider Agent Name		Name of provider's authorized agent	Required
	Agent Address			
		Street	The number and street name where a person or organization can be found	Required
		City	City associated with provider address field	Required
		State/Province	2 Character Code associated with the State	Required
		Zip Code/Postal Code	5 or 15 Character Code	Required
	Provider Agent Contact Name		Name of a contact in agent office for handling EFT issues	Required
		Tel Number	Number associated with contact person; Numeric, 10 digits	Required
		Tel Number Ext		Optional
		Email Address	An electronic mail address at which AHCCCS might contact the provider	Required, may not have one
		Fax Number	A number at which the provider can be sent facsimiles	Optional

Appendix G – Electronic Funds Transfer ACH Form Instructions (continued)

		FINANCIAL INSTITUTION INFORMATION		
SECTION 5	**Financial Institution Name**		Official name of the provider's financial institution	
	Institution Address			
		Street	Street address associated with receiving depository financial institution name field	Required
		City	City associated with receiving depository financial institution address field	Required
		State/Province	2 Character Code associated with the State	Required
		Code	5 or 15 Character Code	
		Tel Number	A contact telephone number at the provider's bank	Optional
		Tel Number Ext		Optional
	Institution Routing Number		A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Required
	at Financial Institution		The type of account the provider will use to receive EFT payments, e.g., Checking, Saving	Required
	Account Number with Financial Institution		Provider's account number at the financial institution to which EFT payments are to be deposited	Required
	Account Number Linkage to Provider Identifier		Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice	Required; select from one of the two below
		Provider Federal Tax Identification Number (TIN)	Numeric, 9 digits	Optional – required if NPI is not applicable
		or		
		National Provider Identifier (NPI)	Numeric, 10 digits	Optional – required if TIN is not applicable
		SUBMISSION INFORMATION		
SECTION 6	**Reason for Submission**			
		New Enrollment		Required
		Change Enrollment		Required
		Cancel Enrollment		Required
	Include with Enrollment Submission			
		Voided Check	A voided check is attached to provide confirmation of identification/account numbers	Required
		or		
		Bank Letter	A letter on bank letterhead that formally certifies the account owners routing and account numbers	Required
		AUTHORIZATION		
SECTION 7	**Authorized Signature**		The signature of an individual authorized by the provider or its agent to initiate modify or terminate an enrollment.	Required
		Print Name of Authorized Signer	The printed name of the person submitting the form	Required
		Title	The title of person signing the form	Optional
	Submission Date		The date on which the enrollment is submitted - CCYYMMDD	Required
	Requested EFT Start/Change/Cancel Date		The date on which the requested action is to begin - CCYYMMDD	Required

For a full, printable PDF of this document, please click on the following link,
Click Here

Appendix H – Electronic Funds Transfer ACH Form Sample

STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Electronic Funds Transfer (EFT) Authorization Agreement
Attn: AHCCCS Finance- MD 5400, P.O. Box 25520, Phoenix, AZ 85002
Fax Number: 602-258-5943

* REQUIRED FIELD + REQUIRED FIELD IF SECTION IS APPLICABLE (SECTION 3)

SECTION 1 – PROVIDER IDENTIFIER INFORMATION

Provider Name * _____ Doing Business As Name (DBA) _____

Provider Address _____
Street * City * State/Province * Zip Code/Postal Code *

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *

National Provider Identifier (NPI) * Trading Partner ID(AHCCCS Provider Number) *

SECTION 2 – PROVIDER CONTACT INFORMATION

Provider Contact Name * Title *

Telephone Number & Extension *

Email Address * Fax Number

SECTION 3 – PROVIDER AGENT INFORMATION - IF APPLICABLE

Provider Agent Name +

Agent Address Street + City + State/Province + Zip Code/Postal Code +

Provider Agent Contact Name + Title

Telephone Number & Extension +

Email Address + Fax Number

SECTION 4 – FINANCIAL INSTITUTION INFORMATION

Financial Institution Name *

Financial Institution Address Street * City * State * Zip Code/ *

Financial Institution Telephone Number & Extension

Financial Institution Routing Number *

Type of Account at Financial Institution * Checking _____ Savings _____

Provider's Account Number with Financial Institution *

Account Number Linkage to Provider Identifier *
Provider's Federal Tax Identification Number OR National Provider Identifier Number

SECTION 5 – SUBMISSION INFORMATION

Reason for Submission * New Enrollment _____ Change Enrollment _____ Cancel Enrollment _____

Include with Enrollment Submission *
_____ Voided Check : A voided check is attached to provide confirmation of identification/account numbers
OR
_____ Bank Letter : A letter on bank letterhead that formally certifies the account owners routing and account numbers

SECTION 6 – AUTHORIZATION

Pursuant to A.R.S. Sec. 35-185, I authorize theArizona Department of Administration (ADOA), General Accounting Office (GAO) and the Arizona Health Care Cost Containment System (AHCCCSA) to process payments owed to me via Automated Clearing House (ACH) deposits. The State of Arizona and AHCCCSA shall deposit the ACH payments in the financial institution and account designated above.

* **I recognize that if I fail to provide complete and accurate information** on this authorization form, the processing of the form may be delayed or made impossible, or my electronic payments may be erroneously made.

I authorize the State of Arizona and AHCCCSA to withdraw from the designated account all amounts deposited electronically in error in accordance with NACHA rules and timelines. If the designated account is closed or has an insufficient balance to allow withdrawal, then I authorize the State of Arizona and AHCCCSA to withhold any payment owed to me by the State of Arizona and AHCCCSA until the erroneous deposited amounts are repaid. If I decide to change or revoke this authorization, I recognize that I must forward such notice to AHCCCSA, Attn: Finance Dept., Mail Drop 5400, P.O. Box 25520, Phoenix, AZ 85002. The change or revocation is effective on the day that ADOA/GAO and AHCCCSA process the request.

I certify that I have read and agree to comply with the State of Arizona and AHCCCSA' s rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended, or repealed. I consent to, and agree to, comply with these rules even if they conflict with this authorization form.

I authorize the State of Arizona and AHCCCSA to stop making electronic transfers to my account without advance notice.
I certify that I am authorized to contract for the entity receiving deposits, pursuant to this agreement, and that all information provided is accurate.

The financial institution can process CCD+ payments/transactions along with addendum information. * Yes____ No____

Authorized Signature * Print Name of Authorized Signer * Title

Submission Date * _____ Requested EFT Start/Change/Cancel Date * _____

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Click Here

Appendix I – Contact Us

Need Help with:	Contact Us:
Medicaid EHR Incentive Program	**AHCCCS EHR Pre-Payment Staff** 602-417-4333 Email: EHRIncentivePayments@azahcccs.gov Website: Arizona Medicaid EHR Incentive Program
	AHCCCS EHR Post Payment Staff 602-417-4440 Email: EHRPost-PayAudits@azahcccs.gov
Having Trouble with:	**Help is Available:**
CMS Registration process	**CMS EHR Information Center** 888-734-6433 Website: CMS Medicare and Medicaid EHR Incentive Programs
AHCCCS Provider Number, NPI, or TIN	**AHCCCS Provider Registration** 602-417-7670 (option 5) Maricopa County 800-794-6862 Outside Maricopa County 800-523-0231 Out-of-State Website: AHCCCS Provider Registration Unit
Electronic Funds Transfer (EFT)	**AHCCCS Finance** 602-417-4175 Website: Automated Clearing House (ACH) Vendor Authorization Form
ePIP System	**AHCCCS EHR Staff** 602-417.4333 Website: ePIP Systems for Registration & Attestation
No-Cost Education & Assistance for HIT / HIE	**Arizona Health-e Connection (AzHeC)** 602-688-7200 Email: ehr@azhec.org

AHCCCS
Arizona Health Care Cost Containment System

Website: Arizona Medicaid EHR Incentive Program

602.417.4333

EHRIncentivePayments@azahcccs.gov

Thank you for your interest in the EHR Incentive Program