AHCCCS
Arizona Health Care Cost Containment System

STATE MEDICAID PROMOTING INTEROPERABILITY PROGRAM 2019 STAGE 3 ATTESTATION REFERENCE GUIDE

ELIGIBLE PROFESSIONALS

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https://www.azepip.gov/

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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

The Arizona Medicaid Promoting Interoperability Program (formerly the Electronic Health Record 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 Promoting Interoperability 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 Promoting Interoperability 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 Medicaid Promoting Interoperability 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

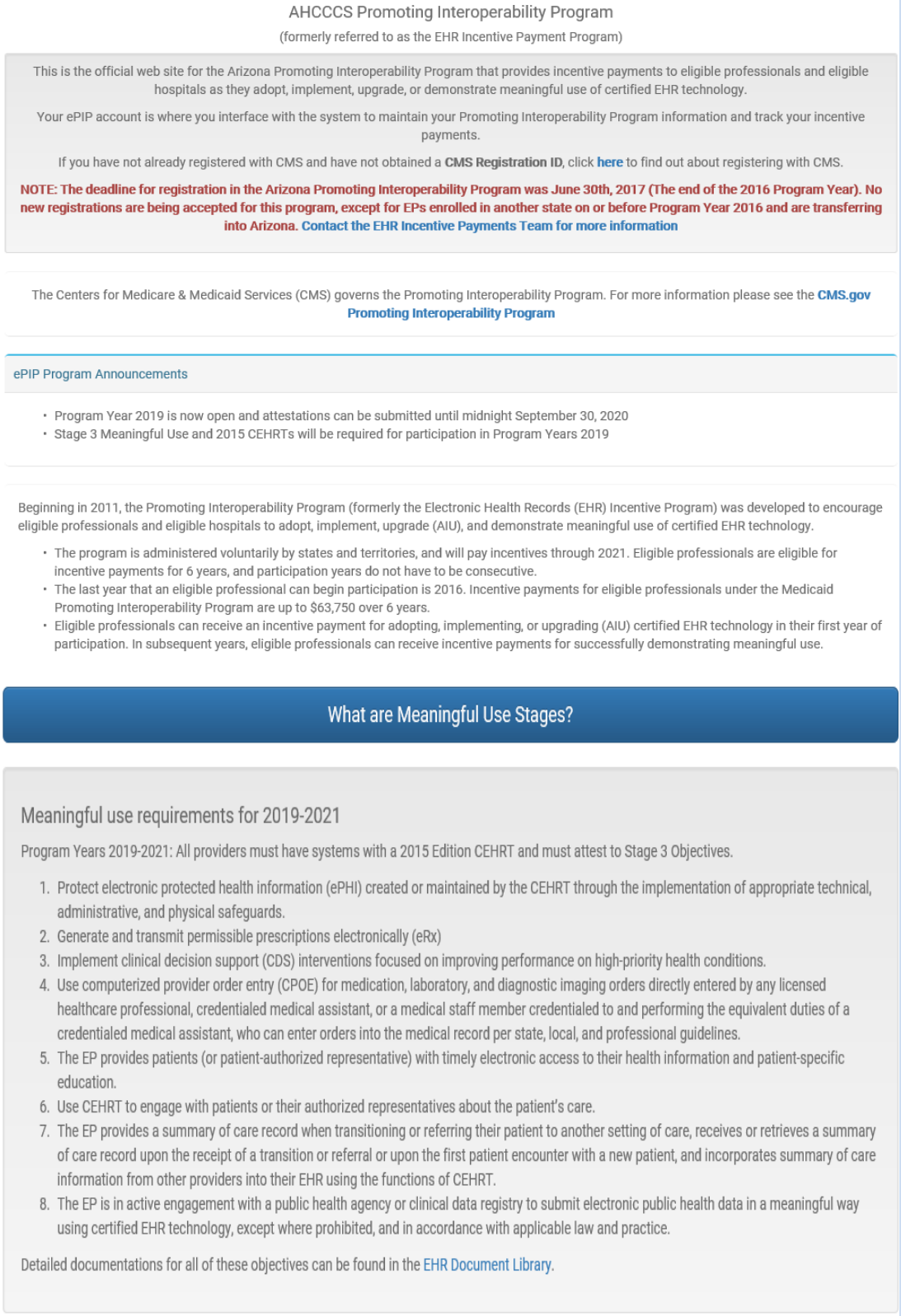
NOTES: EPs may NOT be hospital-based. This is defined as any provider who furnishes 90% or more of their services in a hospital setting (inpatient or emergency department).

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



AHCCCS Promoting Interoperability Program

(formerly referred to as the EHR Incentive Payment Program)

This is the official web site for the Arizona Promoting Interoperability Program that provides incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Your ePIP account is where you interface with the system to maintain your Promoting Interoperability Program information and track your incentive payments.

If you have not already registered with CMS and have not obtained a **CMS Registration ID**, click **here** to find out about registering with CMS.

NOTE: The deadline for registration in the Arizona Promoting Interoperability Program was June 30th, 2017 (The end of the 2016 Program Year). No new registrations are being accepted for this program, except for EPs enrolled in another state on or before Program Year 2016 and are transferring into Arizona. Contact the EHR Incentive Payments Team for more information

The Centers for Medicare & Medicaid Services (CMS) governs the Promoting Interoperability Program. For more information please see the **CMS.gov Promoting Interoperability Program**

ePIP Program Announcements

- Program Year 2019 is now open and attestations can be submitted until midnight September 30, 2020
- Stage 3 Meaningful Use and 2015 CEHRTs will be required for participation in Program Years 2019

Beginning in 2011, the Promoting Interoperability Program (formerly the Electronic Health Records (EHR) Incentive Program) was developed to encourage eligible professionals and eligible hospitals to adopt, implement, upgrade (AIU), and demonstrate meaningful use of certified EHR technology.

- The program is administered voluntarily by states and territories, and will pay incentives through 2021. Eligible professionals are eligible for incentive payments for 6 years, and participation years do not have to be consecutive.
- The last year that an eligible professional can begin participation is 2016. Incentive payments for eligible professionals under the Medicaid Promoting Interoperability Program are up to $63,750 over 6 years.
- Eligible professionals can receive an incentive payment for adopting, implementing, or upgrading (AIU) certified EHR technology in their first year of participation. In subsequent years, eligible professionals can receive incentive payments for successfully demonstrating meaningful use.

What are Meaningful Use Stages?

Meaningful use requirements for 2019-2021

Program Years 2019-2021: All providers must have systems with a 2015 Edition CEHRT and must attest to Stage 3 Objectives.

1. Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.
2. Generate and transmit permissible prescriptions electronically (eRx)
3. Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.
4. Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.
5. The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.
6. Use CEHRT to engage with patients or their authorized representatives about the patient's care.
7. The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.
8. The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Detailed documentations for all of these objectives can be found in the EHR Document Library.

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

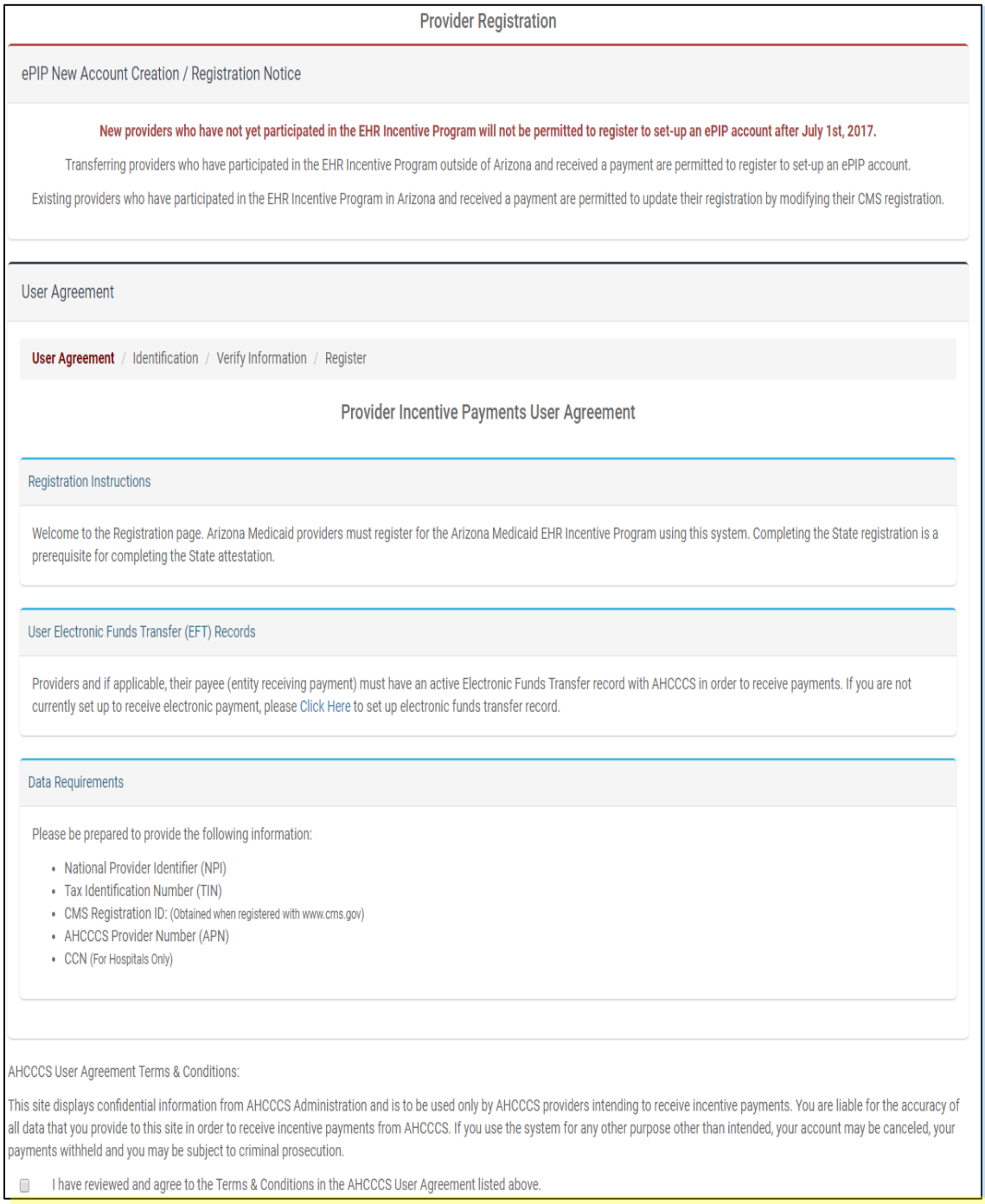
1. Home
2. Log On
3. Register
4. About
5. PI Doc Library
6. Contact Us

ePIP Program Announcement Update:

ePIP is accepting attestations for Program Year 2019 until September 30, 2020 (*subject to CMS approval)*.

Website Updates
Check our PI Program website for updates regarding the attestation deadline.

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.

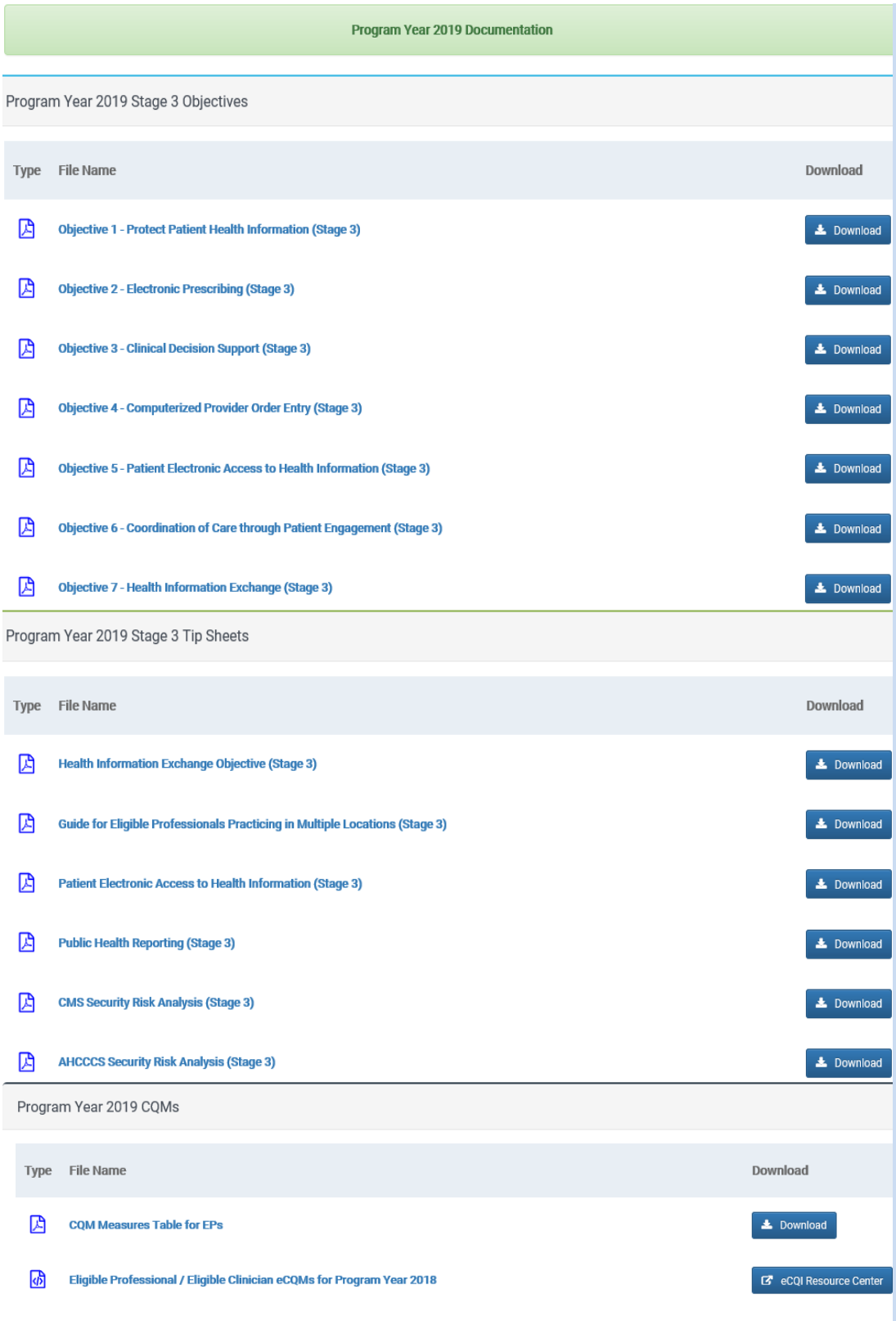
Program Year 2016 was the last year for providers to begin participation in the Promoting Interoperability Program.

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/

PI Document Library



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

Click the link or Click the download button to view details on the 2019 Meaningful Use Objectives for Stage 3.

For more information on the 2019 Program Requirements at CMS, click here.

PI Document Library - Continued

Stage 2 Objective Measure Specifications

Please note that Stage 2 is no longer available in the PI Program for Meaningful Use. This documentation is provided for reference purposes only.

Program Year 2018 Modified Stage 2 Objectives

Type	File Name	Download
	Objective 1 - Protect Patient Health Information (Modified Stage 2)	Download
	Objective 2 - Clinical Decision Support (Modified Stage 2)	Download
	Objective 3 - Computerized Provider Order Entry (Modified Stage 2)	Download
	Objective 4 - Electronic Prescribing (Modified Stage 2)	Download
	Objective 5 - Health Information Exchange (Modified Stage 2)	Download
	Objective 6 - Patient-Specific Education (Modified Stage 2)	Download
	Objective 7 - Medication Reconciliation (Modified Stage 2)	Download
	Objective 8 - Patient Electronic Access (Modified Stage 2)	Download
	Objective 9 - Secure Electronic Messaging (Modified Stage 2)	Download
	Objective 10 - Public Health Reporting (Modified Stage 2)	Download

For reference purposes only:

Stage 2 Objective Measure Specifications

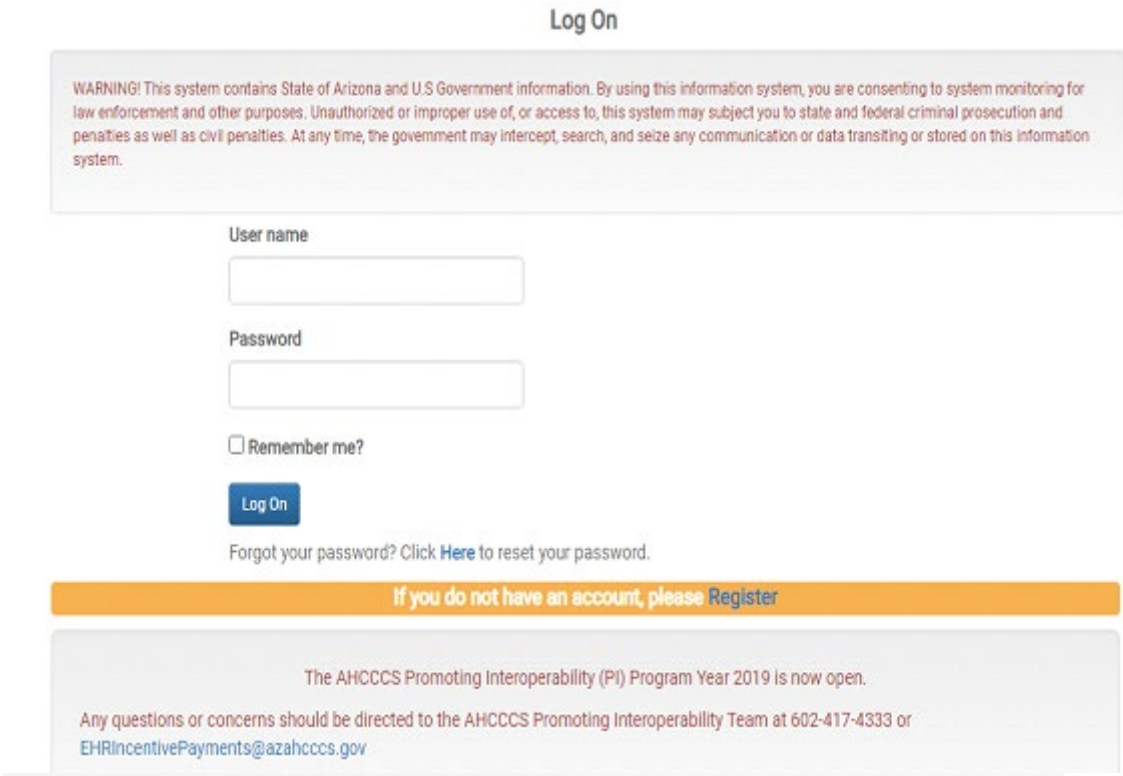
Please note that Stage 2 is no longer available in the PI Program for Meaningful Use. This documentation is provided for reference purposes only.

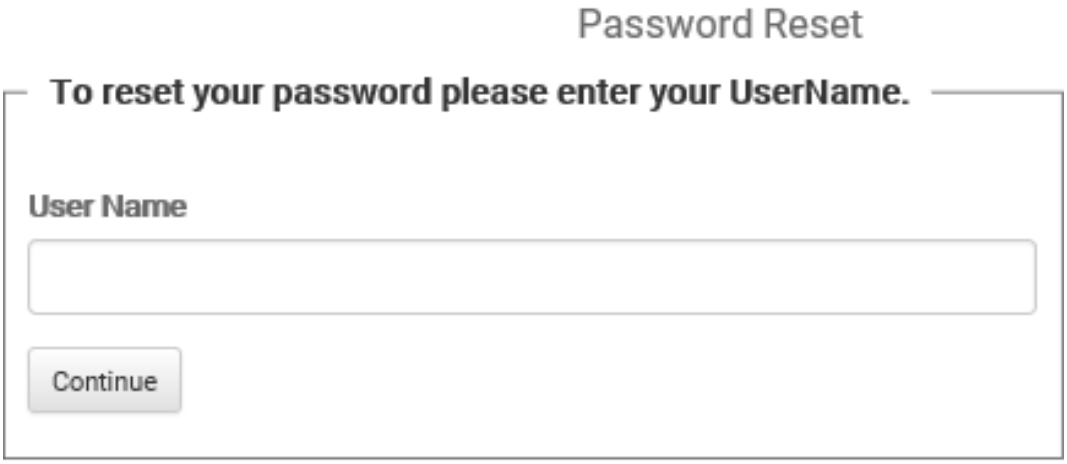
Use our PI Document Library to navigate quickly to the Meaningful Use requirements.

Click the link or Click the download button to view details on the 2018 Meaningful Use Objectives for Stage 2 Modified or Stage 3.

For more information on the 2018 Program Requirements at CMS, click here.

Log On





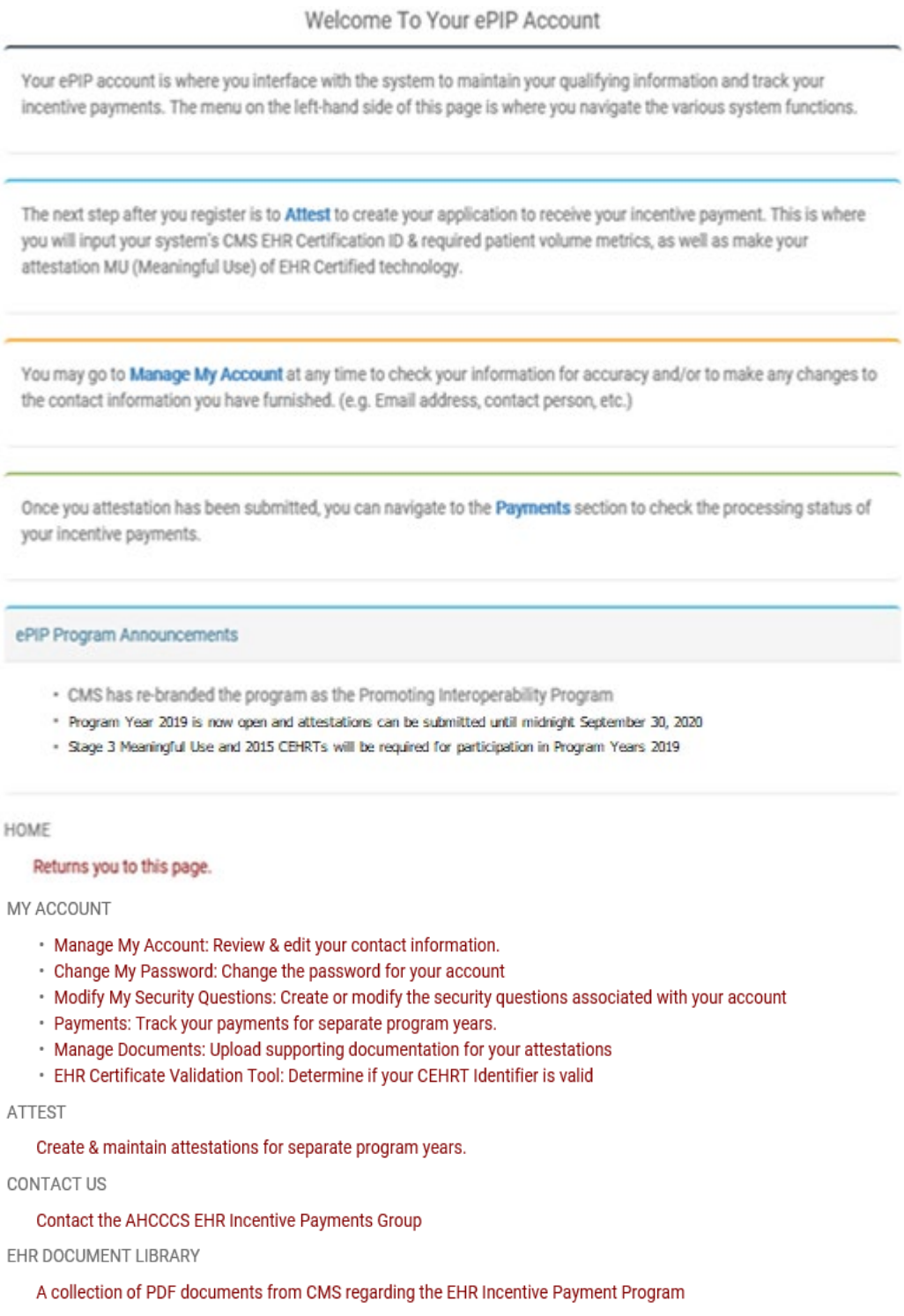
Providers who already have an ePIP account must log on in order to access their account.

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

Welcome to Your ePIP Account Home Page



Welcome To Your ePIP Account

Your ePIP account is where you interface with the system to maintain your qualifying information and track your incentive payments. The menu on the left-hand side of this page is where you navigate the various system functions.

The next step after you register is to **Attest** to create your application to receive your incentive payment. This is where you will input your system's CMS EHR Certification ID & required patient volume metrics, as well as make your attestation MU (Meaningful Use) of EHR Certified technology.

You may go to **Manage My Account** at any time to check your information for accuracy and/or to make any changes to the contact information you have furnished. (e.g. Email address, contact person, etc.)

Once you attestation has been submitted, you can navigate to the **Payments** section to check the processing status of your incentive payments.

ePIP Program Announcements

- CMS has re-branded the program as the Promoting Interoperability Program
- Program Year 2019 is now open and attestations can be submitted until midnight September 30, 2020
- Stage 3 Meaningful Use and 2015 CEHRTs will be required for participation in Program Years 2019

HOME

Returns you to this page.

MY ACCOUNT

- Manage My Account: Review & edit your contact information.
- Change My Password: Change the password for your account
- Modify My Security Questions: Create or modify the security questions associated with your account
- Payments: Track your payments for separate program years.
- Manage Documents: Upload supporting documentation for your attestations
- EHR Certificate Validation Tool: Determine if your CEHRT Identifier is valid

ATTEST

Create & maintain attestations for separate program years.

CONTACT US

Contact the AHCCCS EHR Incentive Payments Group

EHR DOCUMENT LIBRARY

A collection of PDF documents from CMS regarding the EHR Incentive Payment Program

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
   - PI Team
   - Other AHCCCS Contacts

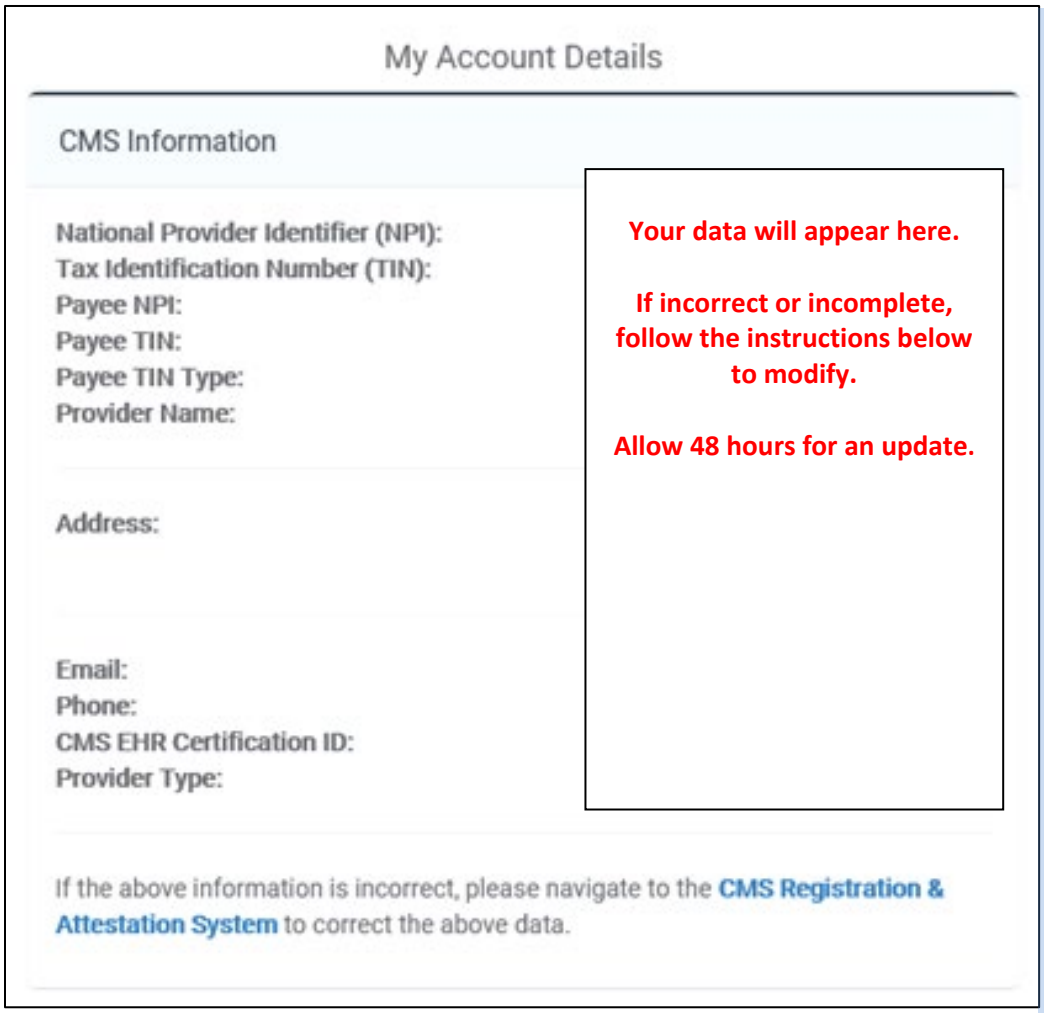
5. PI Doc Library

6. Log Off

ePIP Program Announcement Update:

ePIP is accepting attestations for Program Year 2019 until September 30, 2020 (*subject to CMS approval)*.

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

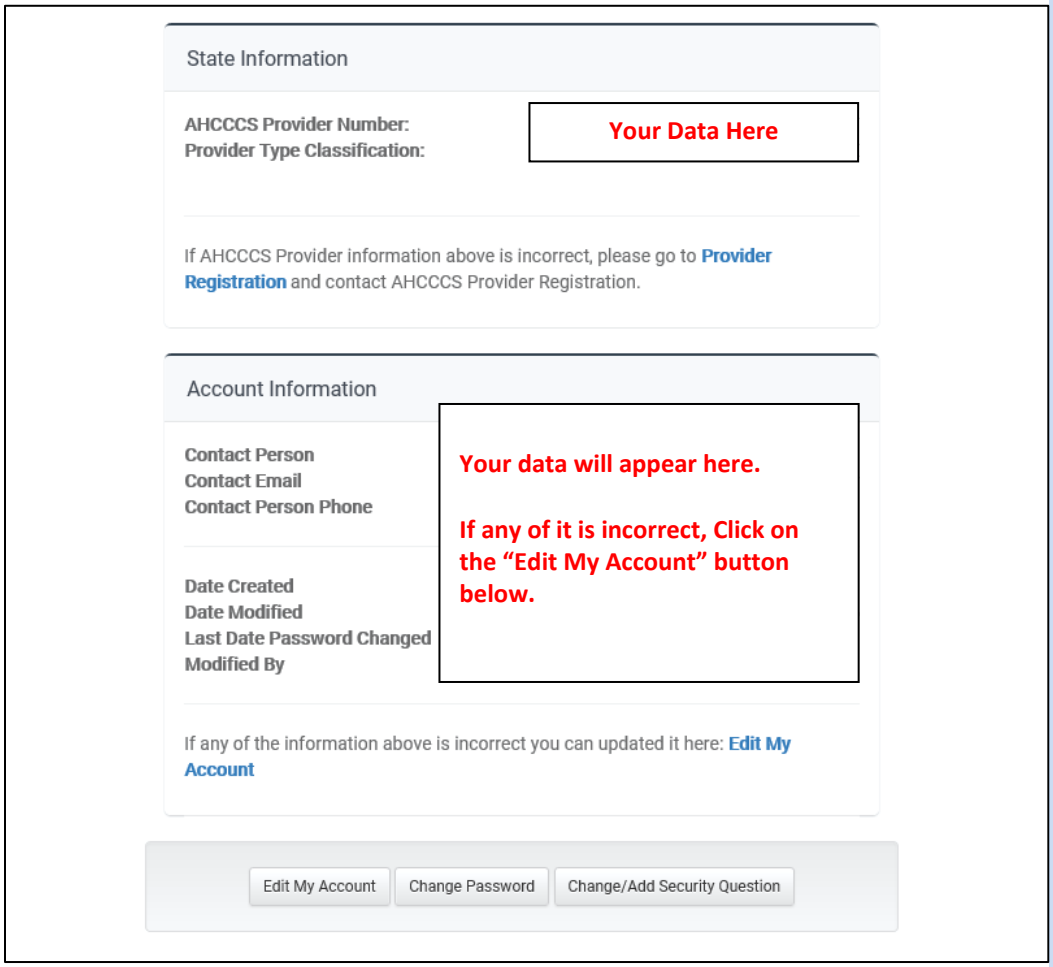
Manage My Account allows you to add an authorized secondary contact *(optional)*.

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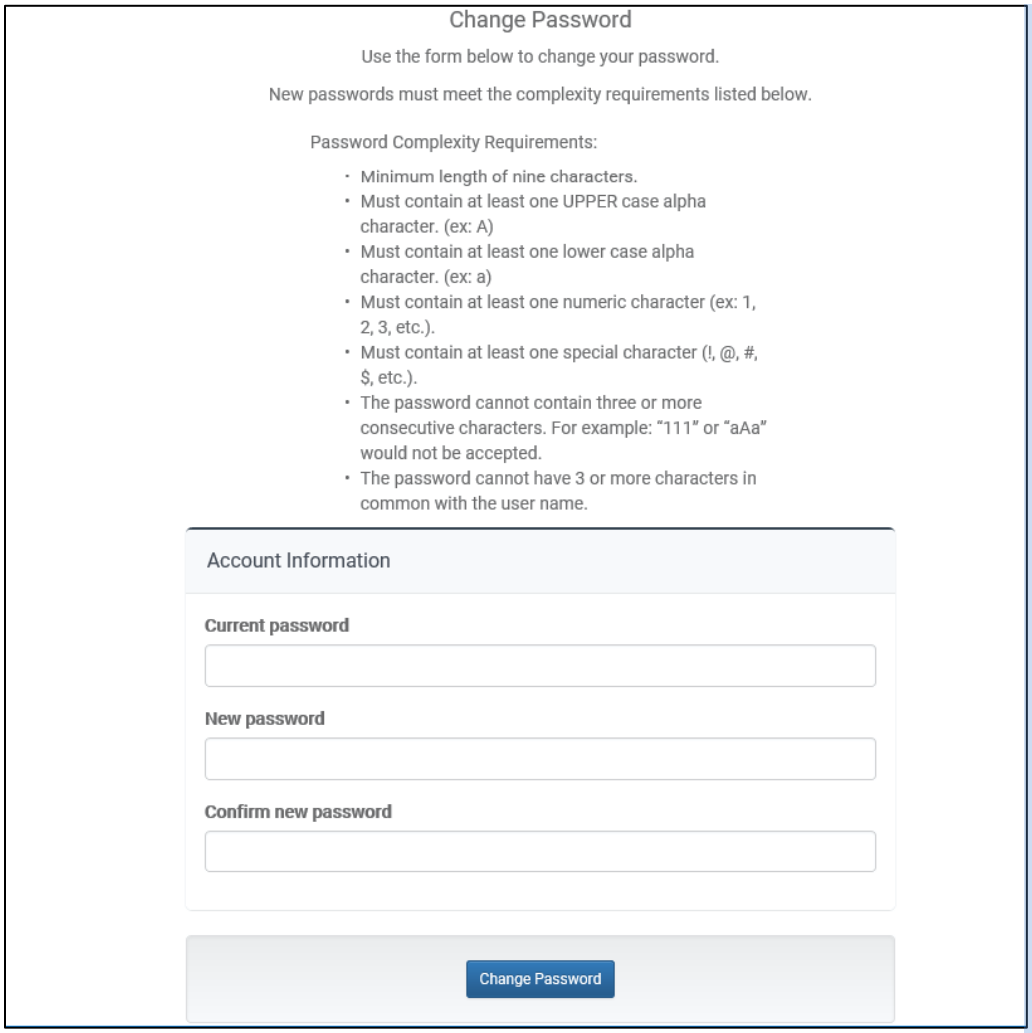
This person does not have access to ePIP but is permitted to communicate with the State to answer general program inquiries and to help you gather your documentation for the attestation.

TIP

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

My Account – How to Manage My 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

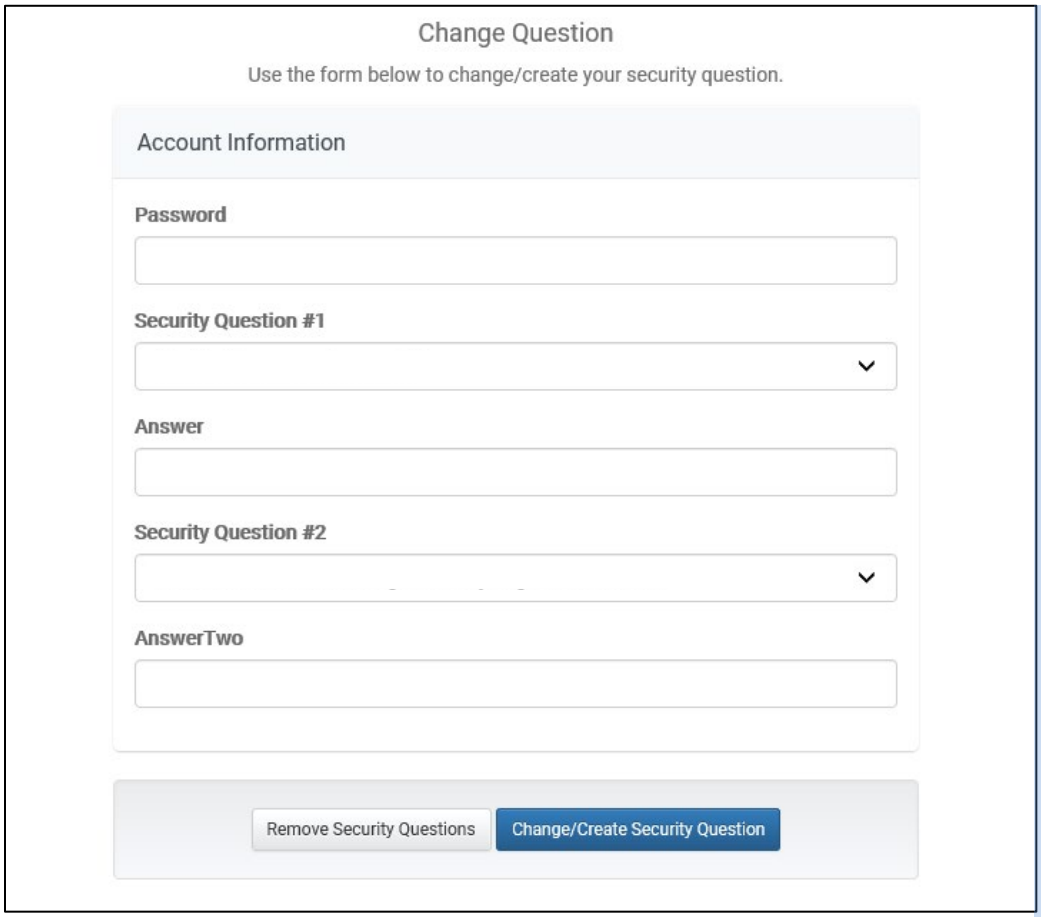
Change My Password allows you to modify your password at any time.

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

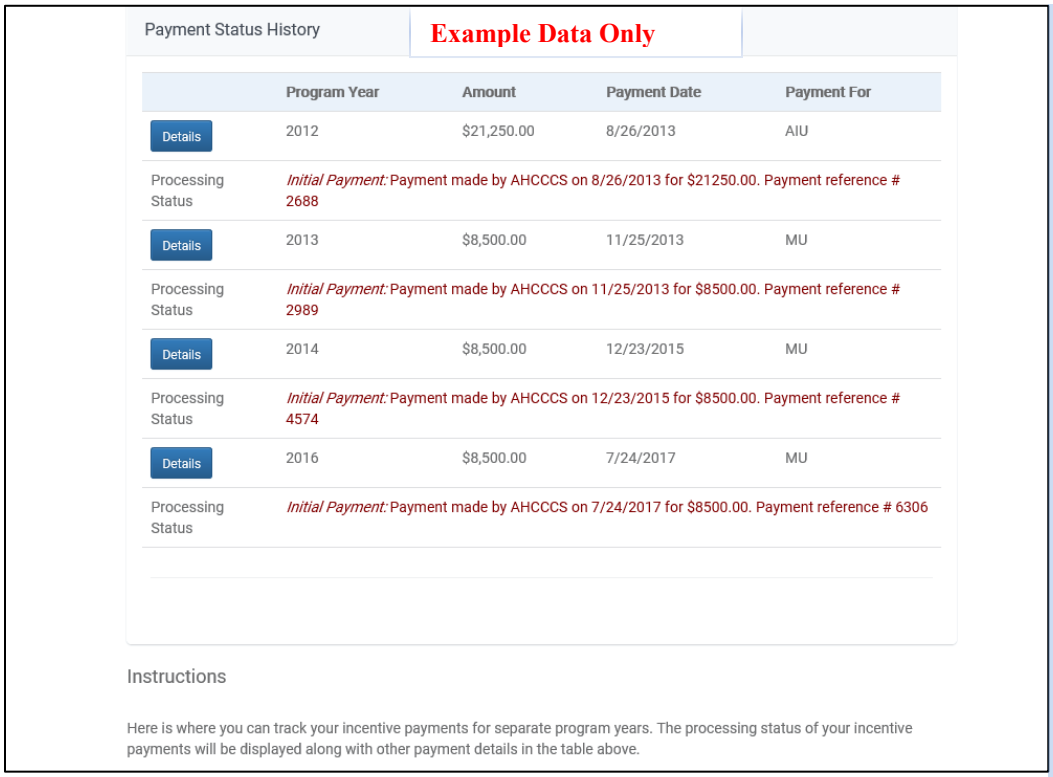
Modify My Security Questions allows you to create or change your security questions and answers.

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

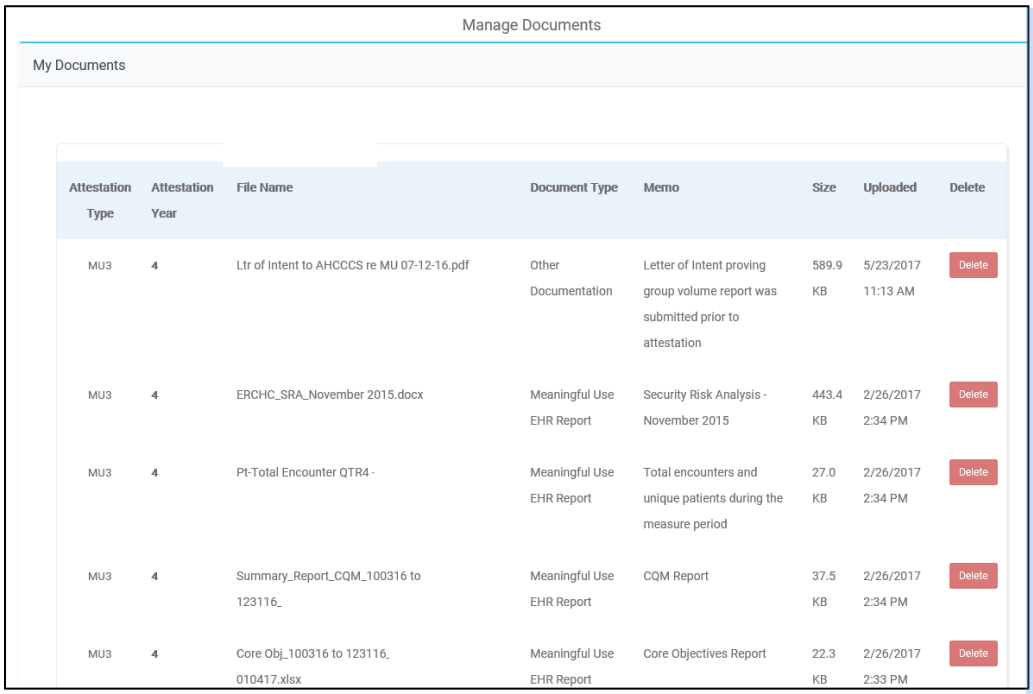
Payments allow you to view your payment history and processing status.

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

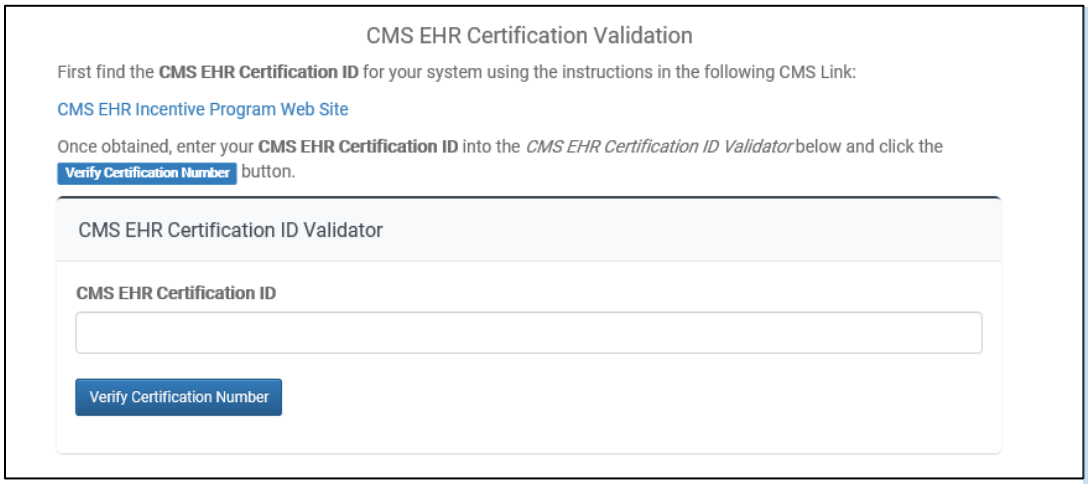
Manage Documents allows you to upload your documentation that supports your attestation.

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 a CEHRT 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 Promoting Interoperability 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 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 Promoting Interoperability Program with those available to professionals participating in the Merit-based Incentive Payment System (MIPS).

Changes include:

- Medicaid EPs are required to report on 6 out of 50 Clinical Quality Measures (CQMs or eCQMs).
- The 2019 Physician Fee Schedule (PFS) Final Rule established that in 2019, Medicaid EPs who are returning participants must report on a one year eCQM reporting period, and first-time meaningful users must report on a 90-day eCQM reporting period.
- Medicaid EPs are required to report on any 6 eCQMs related to their scope of practice.
- Medicaid EPs are required to report on at least one outcome measure.
- If no outcome measures are relevant to that EP, they must report on at least one high-priority measure.
- If there are no outcome or high priority measures relevant to an EP's scope of practice, they must report on any six relevant measures.
- The information entered in the eCQMs should be supported by the **CQM Report**.

Attestation Instructions - Continued

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:

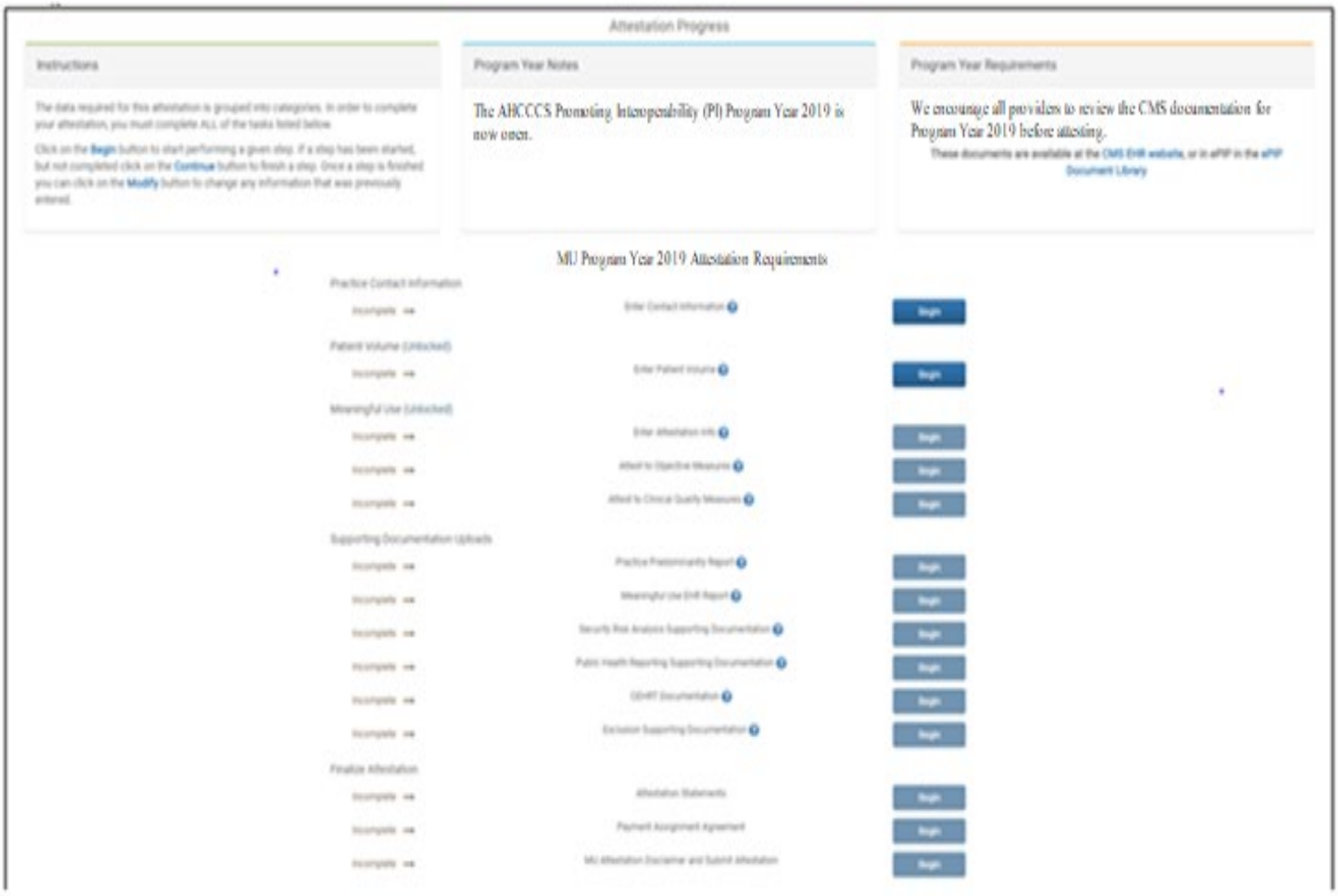
Practice Predominantly Criteria
EPs selecting Needy Individual Patient Volume Type must practice predominantly at FQHC/RHC facilities. Practice Predominantly EPs have more than 50 percent of patient encounters at FQHC/RHC facilities place of service during the 6-month reporting period.

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

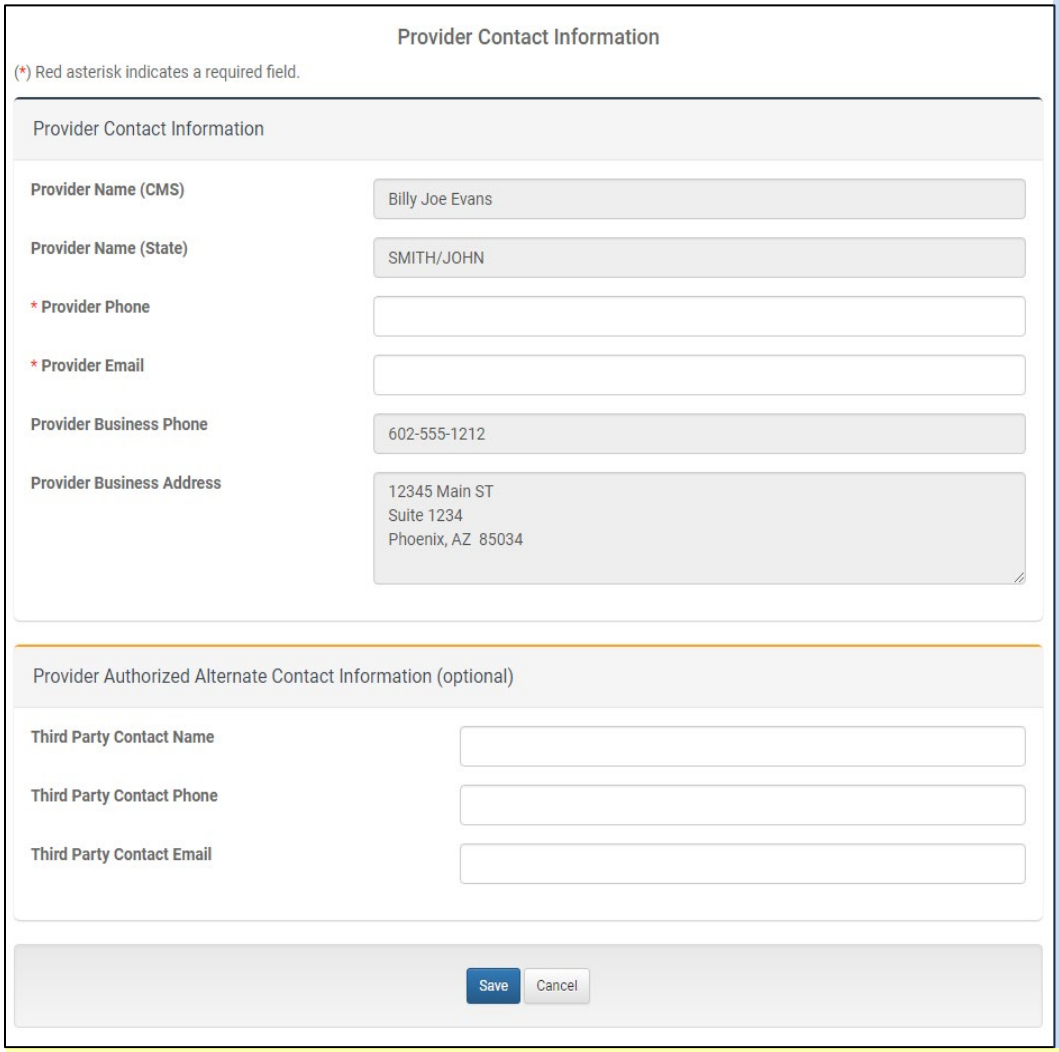
Click the Begin button to complete each step.

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.

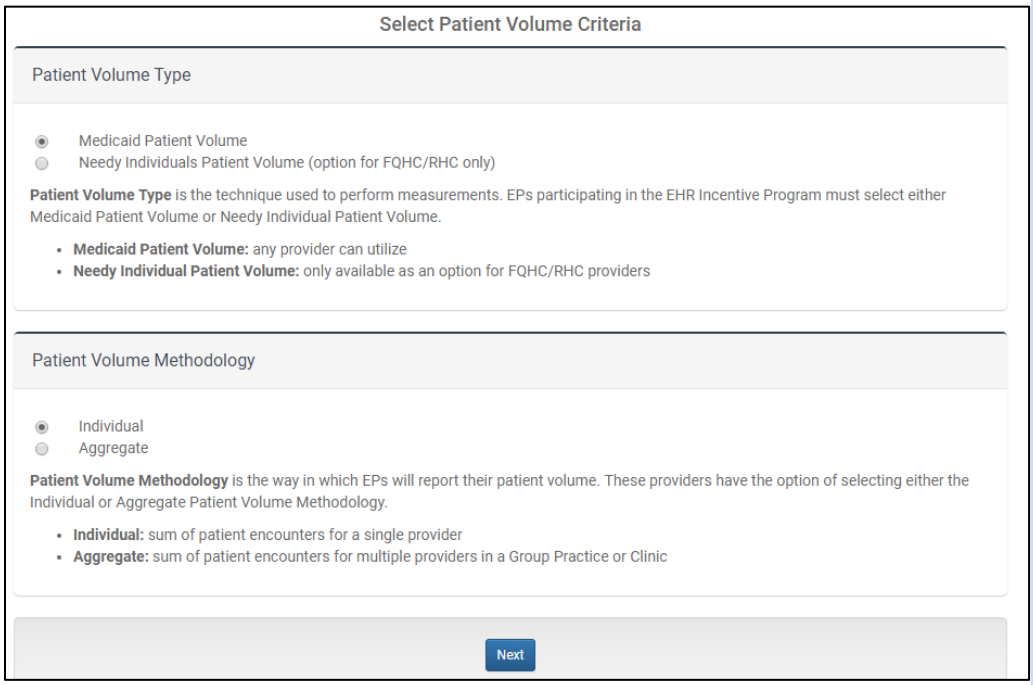
TIP

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.

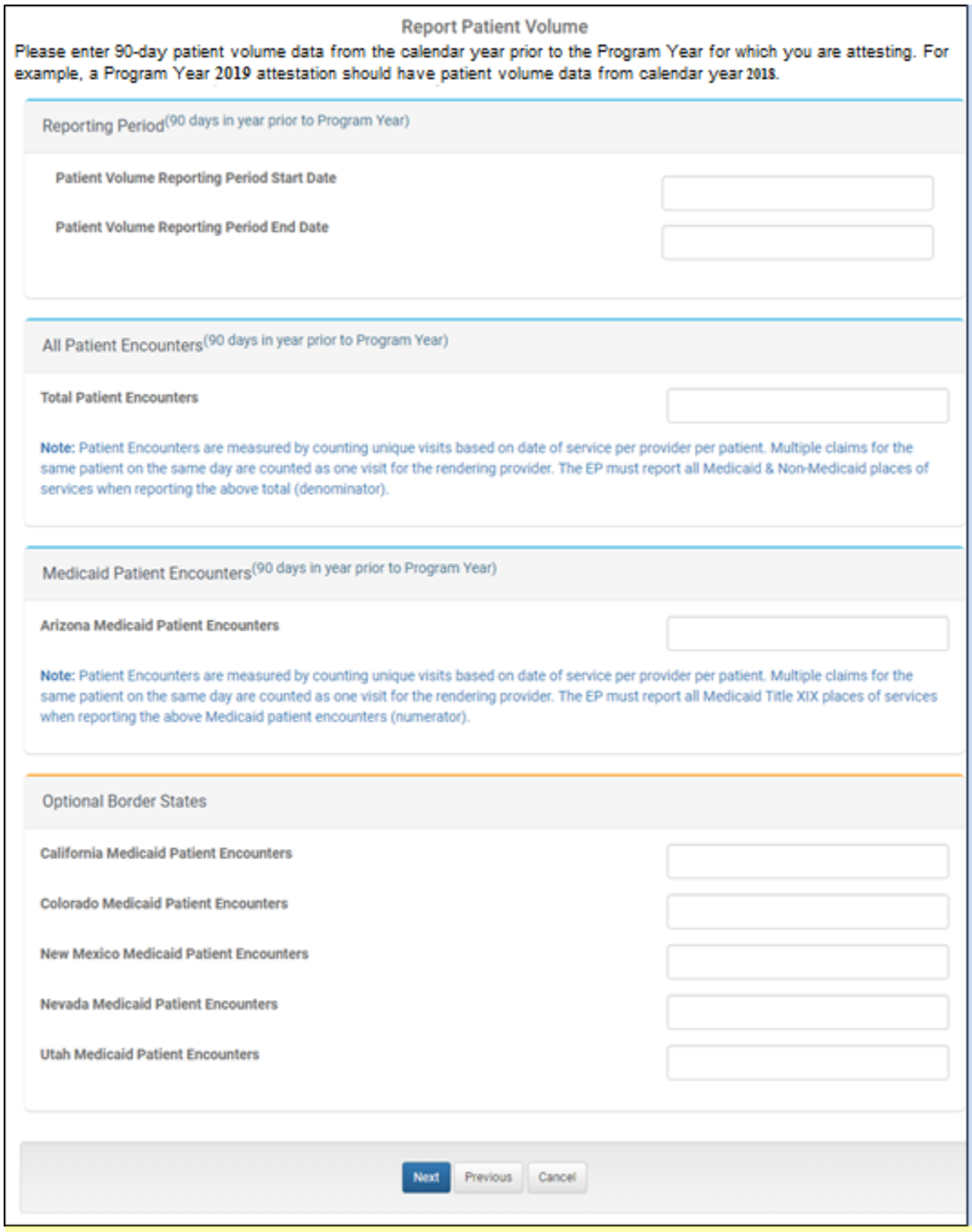
If you are attesting using your group Aggregate patient volume, every provider in the group must also select aggregate".

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.

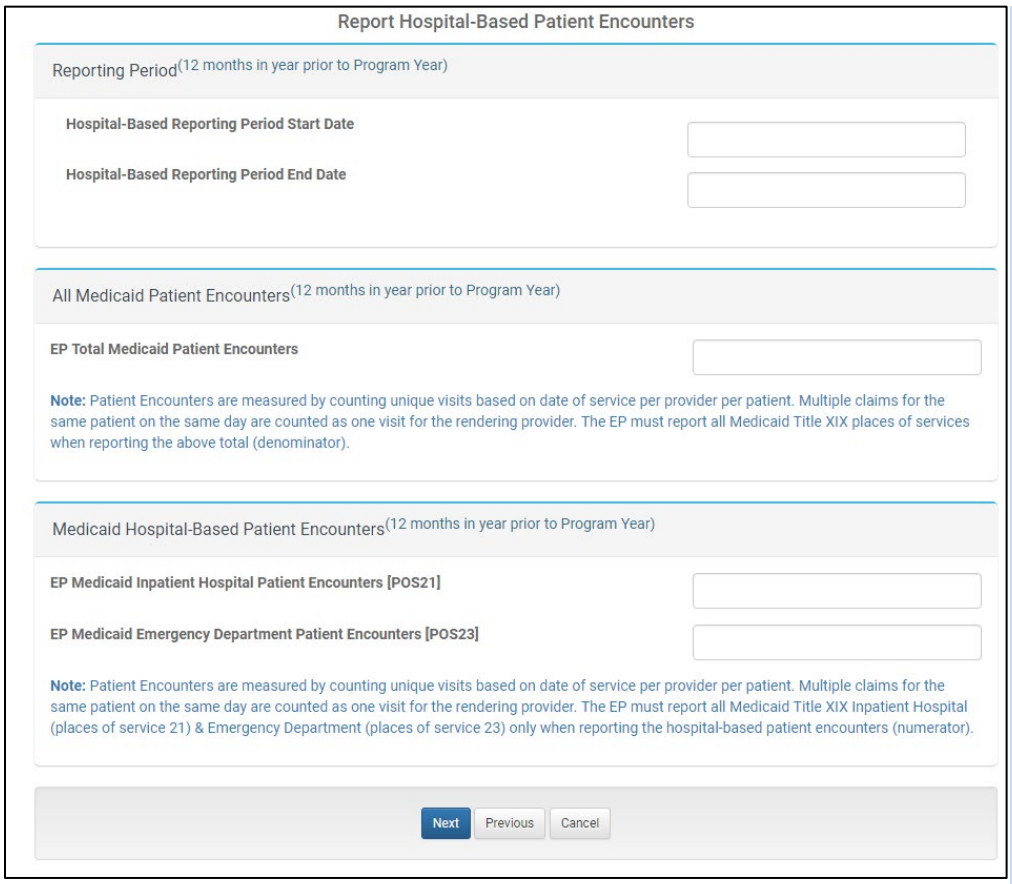
TIP

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.

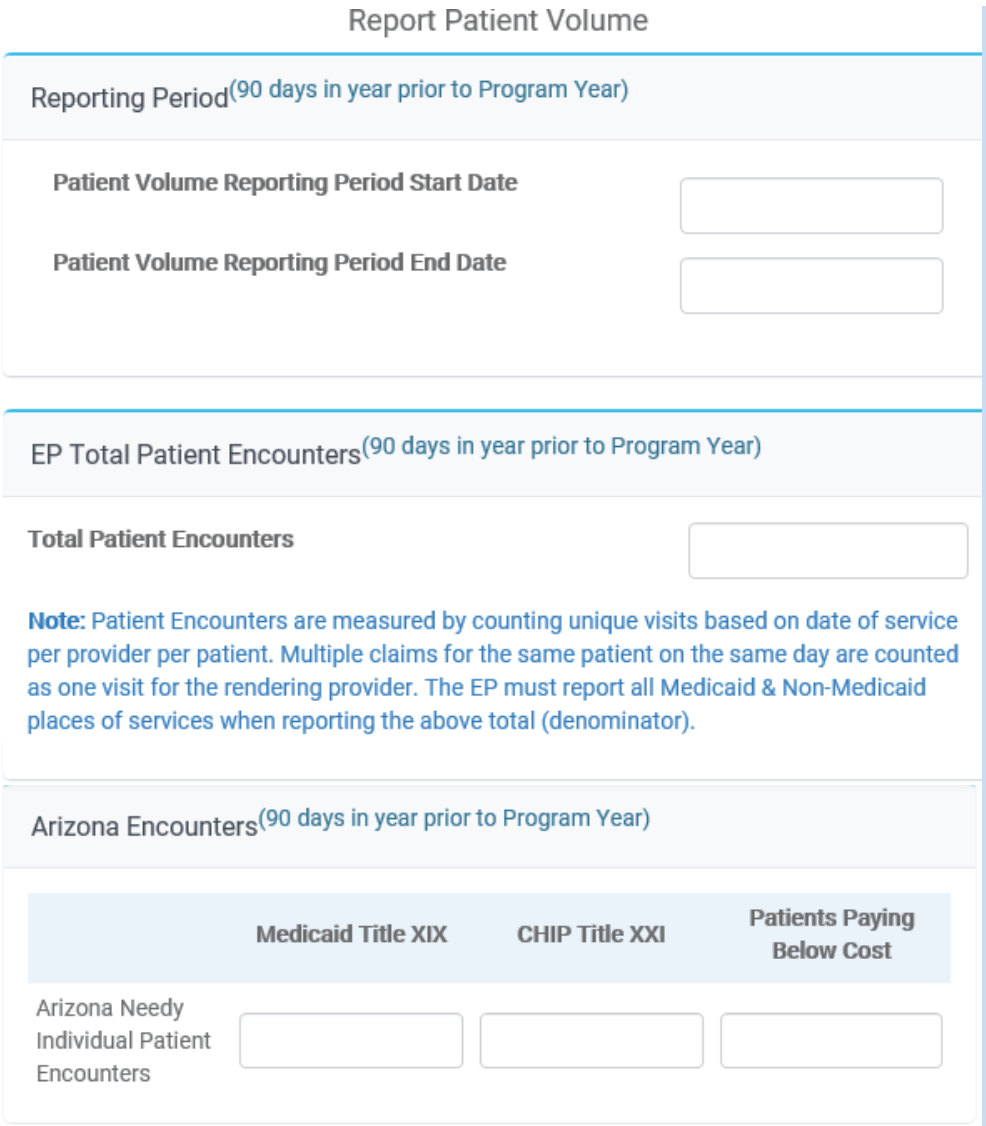
TIP

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.

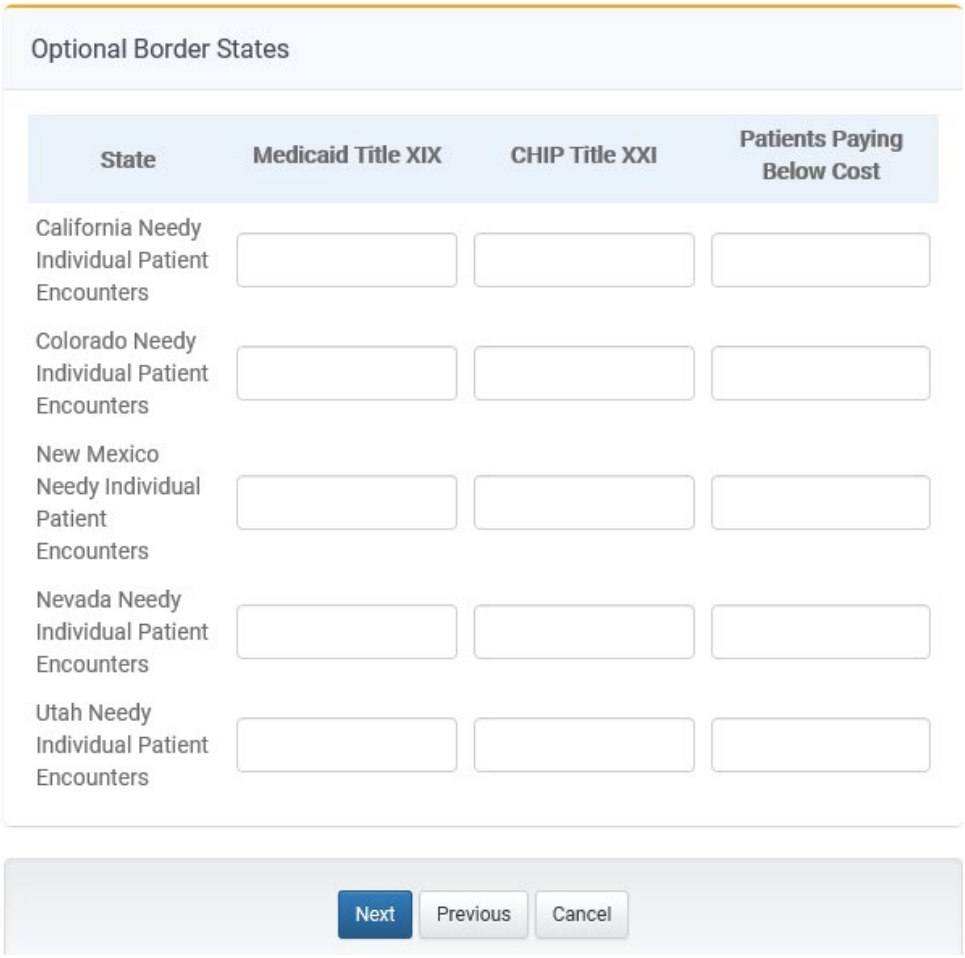
TIP

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 - Continued



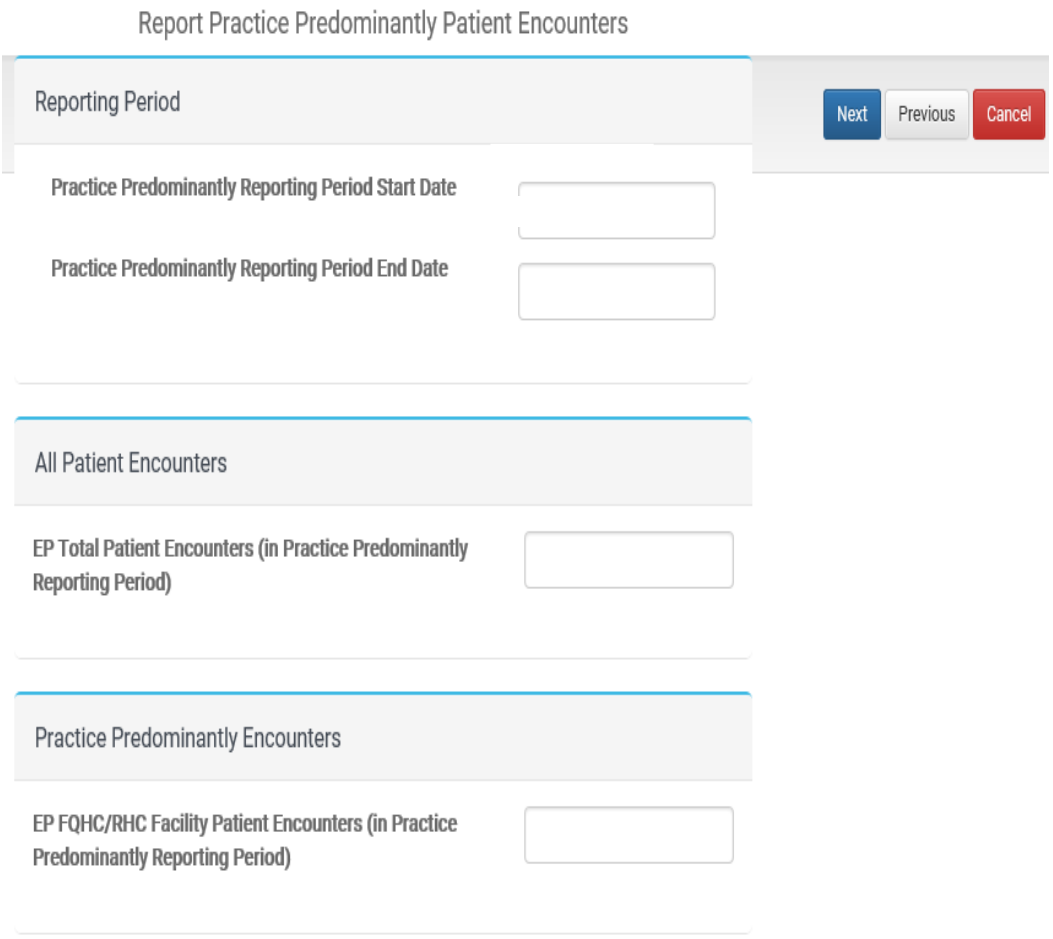
Here is where you report your Medicaid out of state patient encounters for our Border States *(optional if you wish to include in the numerator)*.

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.

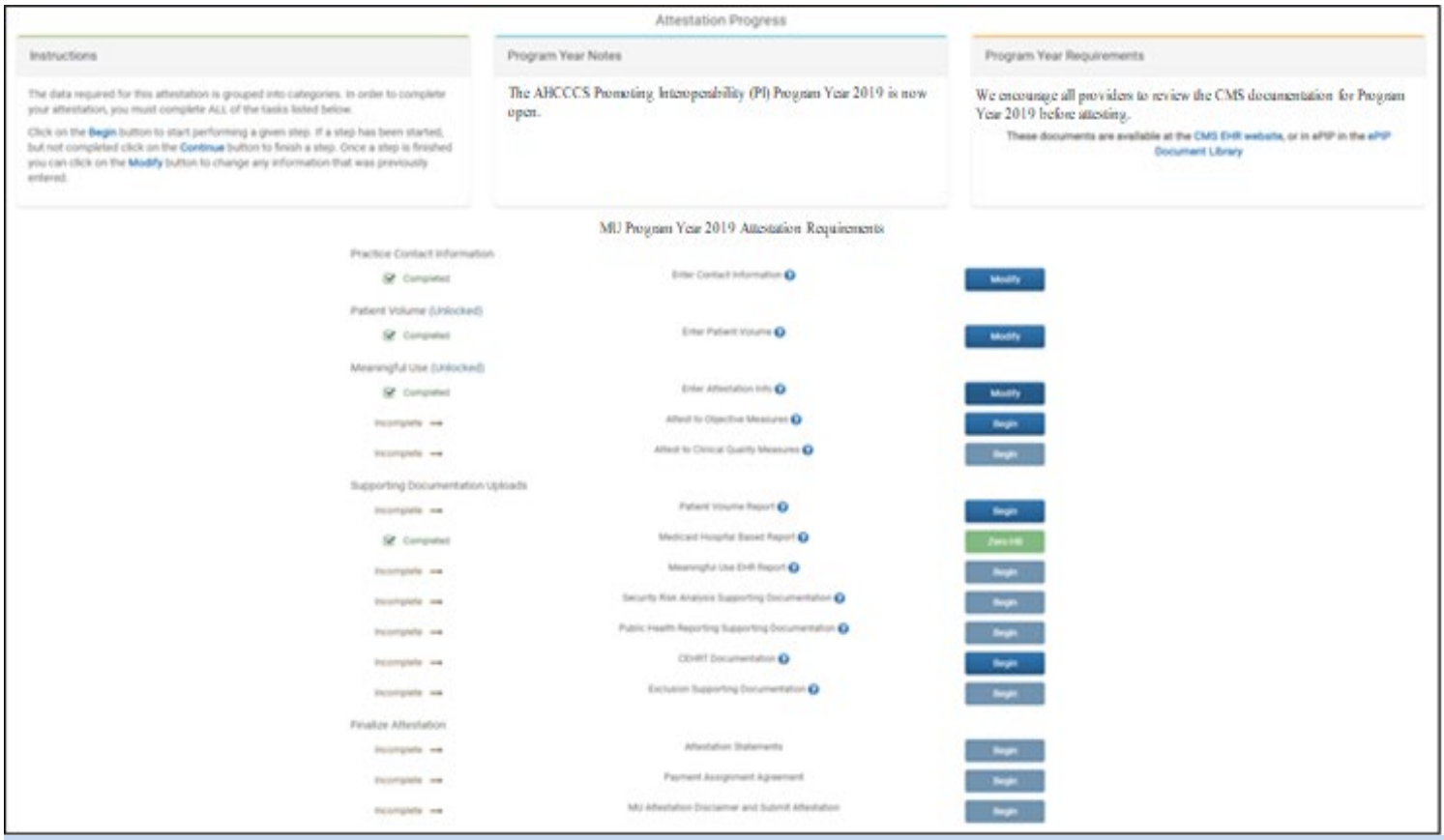
TIP

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.

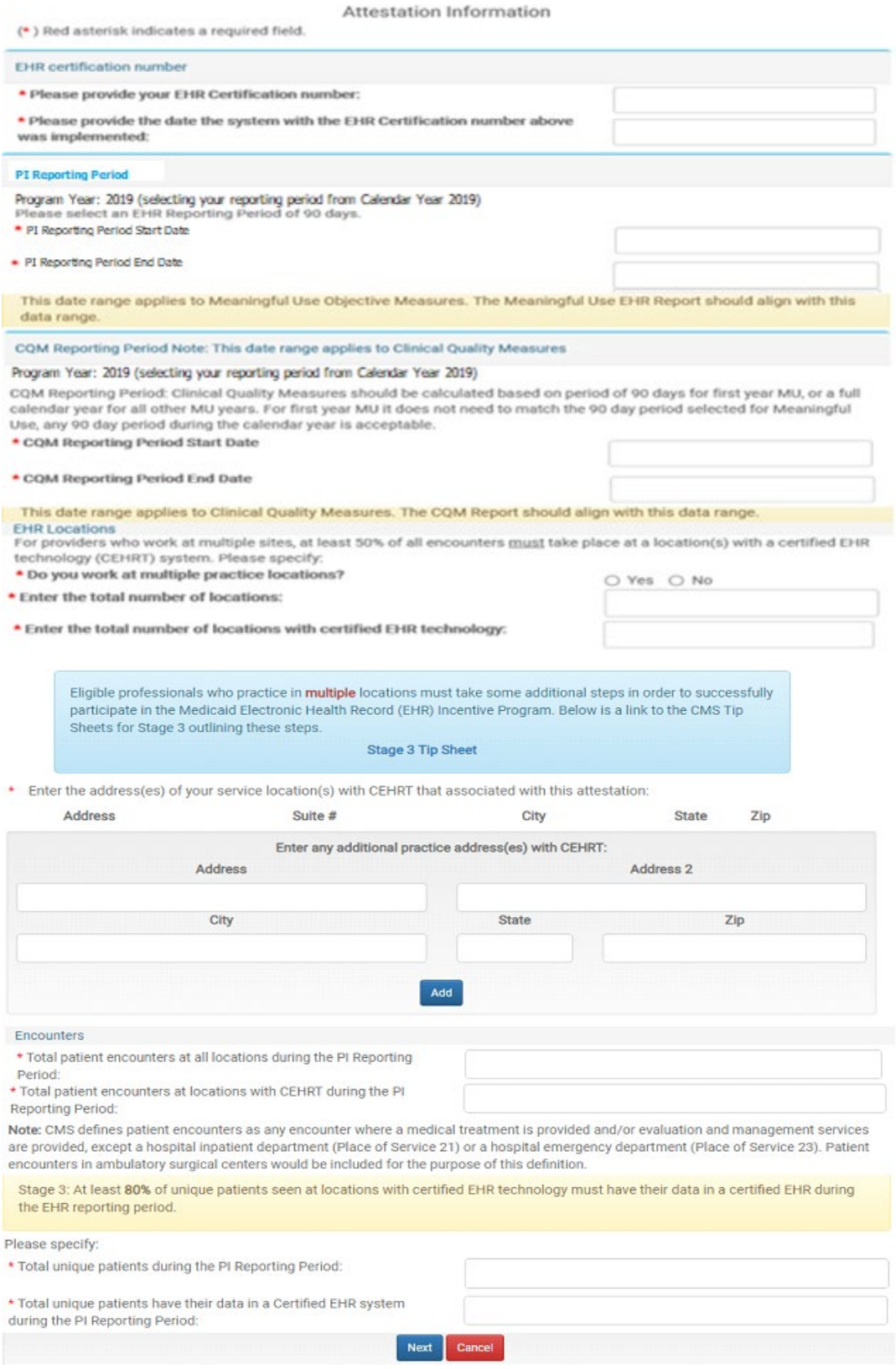
TIP

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.

CMS EHR Certificate number must be valid.

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

You must select your PI Reporting Period start & end date from calendar year 2019 for the Meaningful Use Objectives & Clinical Quality Measures that you are attesting to.

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

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

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 2019 Stage 3

	Meaningful Use Objectives for Stage 3 Providers with systems certified with a 2015 CEHRT as of 12.31.2019
1	Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.
2	Generate and transmit permissible prescriptions electronically (eRx)
3	Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.
4	Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.
5	The eligible professional (EP) provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.
6	Use certified electronic health record technology (CEHRT) to engage with patients or their authorized representatives about the patient's care.
7	The eligible professional (EP) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified EHR technology (CEHRT).
8	The eligible professional (EP) is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified electronic health record technology (CEHRT), except where prohibited, and in accordance with applicable law and practice.

Welcome to Stage 3

MU Objectives Criteria:
Providers must attest to 8 Meaningful Use Objectives using EHR technology certified to the 2015 Edition.

Select PI Reporting Period:
☑ 90 days from CY 2019

CEHRT System Criteria:
A provider attesting for Program Year 2019 will be required to use Stage 3 Meaningful Use and 2015 CEHRTs.

However, a provider who has technology certified to the 2014 Edition only may not attest to Stage 3.

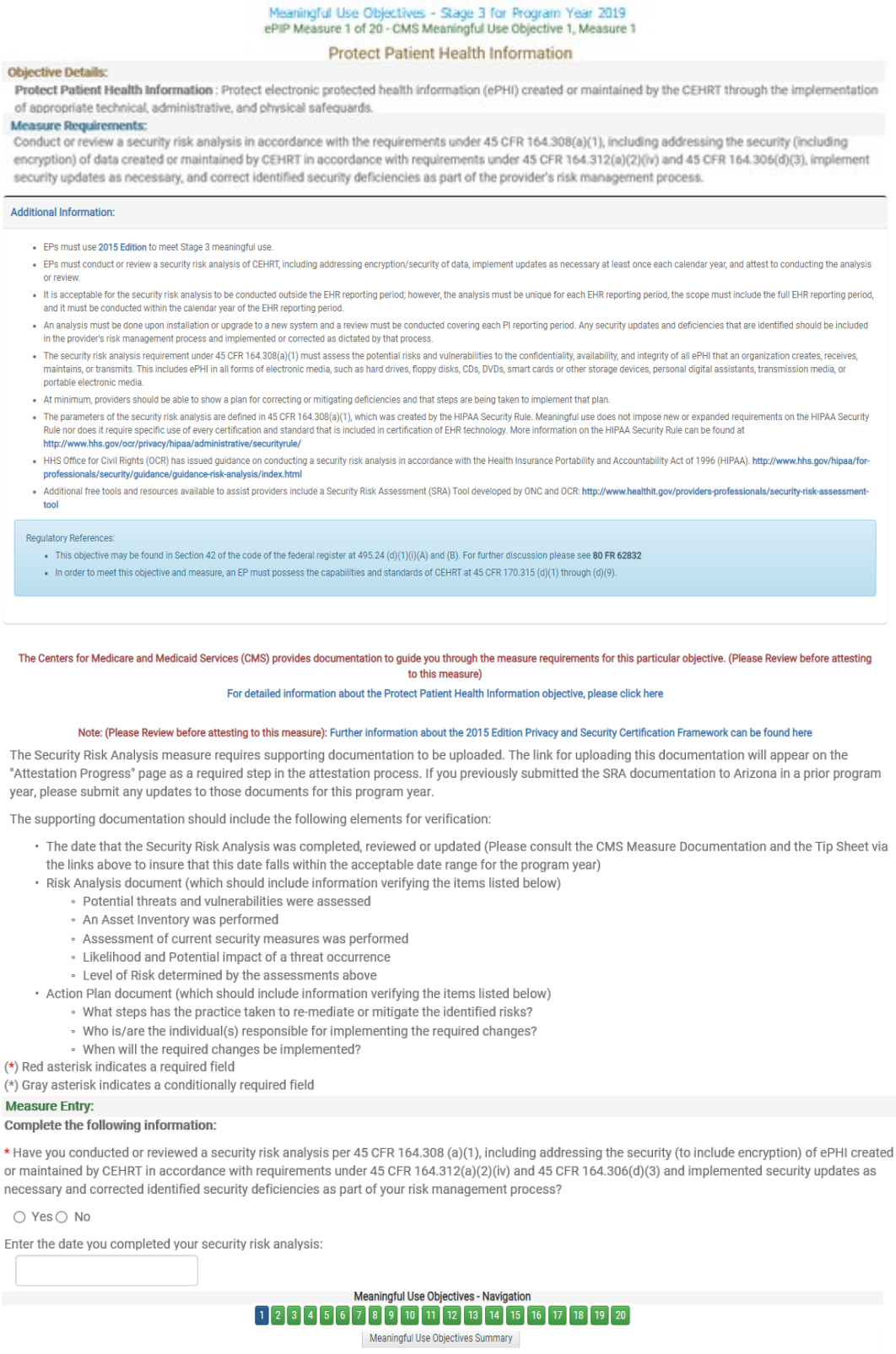
Please note there are no alternate exclusions or specifications available.

The measure calculations policy specifies that actions included in the numerator must occur during the PI reporting period.

TIP

Stage 3 Meaningful Use and 2015 CEHRTs are required for participation in Program Year 2019.

Stage 3 Objective 1 Measure 1 Protect Patient Health Information



Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 1 of 20 - CMS Meaningful Use Objective 1, Measure 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, administrative, and physical safeguards.

Measure Requirements:

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

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- EPs must conduct or review a security risk analysis of CEHRT, including addressing encryption/security of data, implement updates as necessary at least once each calendar year, and attest to conducting the analysis or review.
- It is acceptable for the security risk analysis to be conducted outside the EHR reporting period; however, the analysis must be unique for each EHR reporting period, the scope must include the full EHR reporting period, and it must be conducted within the calendar year of the EHR reporting period.
- An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each PI reporting period. Any security updates and deficiencies that are identified should be included in the provider's risk management process and implemented or corrected as dictated by that process.
- The security risk analysis requirement under 45 CFR 164.308(a)(1) must assess the potential risks and vulnerabilities to the confidentiality, availability, and integrity of all ePHI that an organization creates, receives, maintains, or transmits. This includes ePHI in all forms of electronic media, such as hard drives, floppy disks, CDs, DVDs, smart cards or other storage devices, personal digital assistants, transmission media, or portable electronic media.
- At minimum, providers should be able to show a plan for correcting or mitigating deficiencies and that steps are being taken to implement that plan.
- The parameters of the security risk analysis are defined in 45 CFR 164.308(a)(1), which was created by the HIPAA Security Rule. Meaningful use does not impose new or expanded requirements on the HIPAA Security Rule nor does it require specific use of every certification and standard that is included in certification of EHR technology. More information on the HIPAA Security Rule can be found at http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/
- HHS Office for Civil Rights (OCR) has issued guidance on conducting a security risk analysis in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). http://www.hhs.gov/hipaa/for-professionals/security/guidance/guidance-risk-analysis/index.html
- Additional free tools and resources available to assist providers include a Security Risk Assessment (SRA) Tool developed by ONC and OCR: http://www.healthit.gov/providers-professionals/security-risk-assessment-tool

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(1)(i)(A) and (B). For further discussion please see 80 FR 62832
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.315 (d)(1) through (d)(9).

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 about the 2015 Edition Privacy and Security Certification Framework can be found here

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 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 1**

Protect Patient 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 2019.

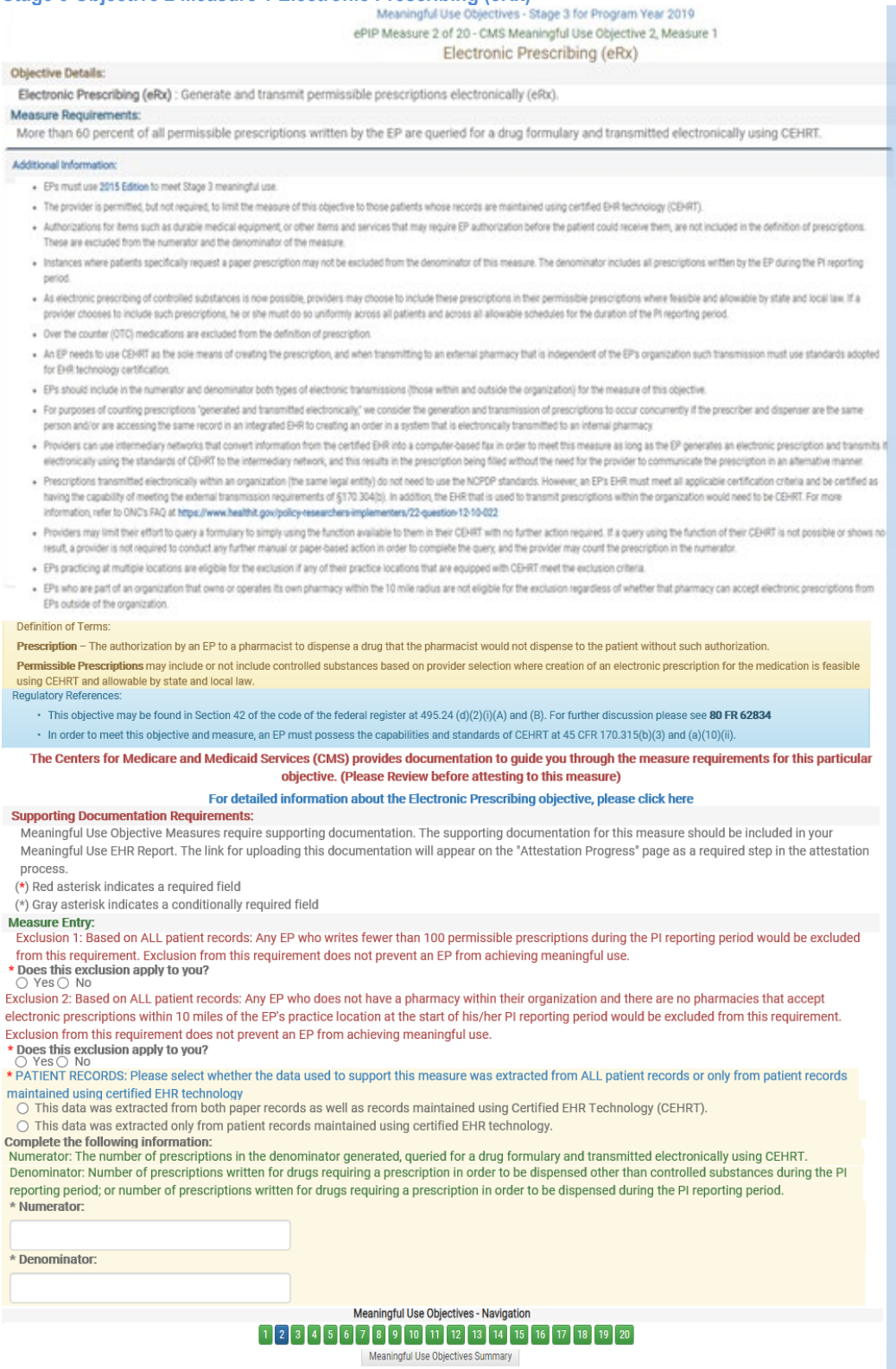
CEHRT is *"certified electronic health record technology"*

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 3 Objective 2 Measure 1 Electronic Prescribing (eRx)



Meaningful Use Objectives - Stage 3 for Program Year 2019

ePIP Measure 2 of 20 - CMS Meaningful Use Objective 2, Measure 1

Electronic Prescribing (eRx)

Objective Details:

Electronic Prescribing (eRx) : Generate and transmit permissible prescriptions electronically (eRx).

Measure Requirements:

More than 60 percent of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- Authorizations for items such as durable medical equipment, or other items and services that may require EP authorization before the patient could receive them, are not included in the definition of prescriptions. These are excluded from the numerator and the denominator of the measure.
- Instances where patients specifically request a paper prescription may not be excluded from the denominator of this measure. The denominator includes all prescriptions written by the EP during the PI reporting period.
- As electronic prescribing of controlled substances is now possible, providers may choose to include these prescriptions in their permissible prescriptions where feasible and allowable by state and local law. If a provider chooses to include such prescriptions, he or she must do so uniformly across all patients and across all allowable schedules for the duration of the PI reporting period.
- Over the counter (OTC) medications are excluded from the definition of prescription.
- An EP needs to use CEHRT as the sole means of creating the prescription, and when transmitting to an external pharmacy that is independent of the EP's organization such transmission must use standards adopted for EHR technology certification.
- EPs should include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective.
- For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur concurrently if the prescriber and dispenser are the same person and/or are accessing the same record in an integrated EHR to creating an order in a system that is electronically transmitted to an internal pharmacy.
- Providers can use intermediary networks that convert information from the certified EHR into a computer-based fax in order to meet this measure as long as the EP generates an electronic prescription and transmits it electronically using the standards of CEHRT to the intermediary network, and this results in the prescription being filled without the need for the provider to communicate the prescription in an alternative manner.
- Prescriptions transmitted electronically within an organization (the same legal entity) do not need to use the NCPDP standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of §170.304(b). In addition, the EHR that is used to transmit prescriptions within the organization would need to be CEHRT. For more information, refer to ONC's FAQ at https://www.healthit.gov/policy-researchers-implementers/22-question-12-10-022.
- Providers may limit their effort to query a formulary to simply using the function available to them in their CEHRT with no further action required. If a query using the function of their CEHRT is not possible or shows no result, a provider is not required to conduct any further manual or paper-based action in order to complete the query, and the provider may count the prescription in the numerator.
- EPs practicing at multiple locations are eligible for the exclusion if any of their practice locations that are equipped with CEHRT meet the exclusion criteria.
- EPs who are part of an organization that owns or operates its own pharmacy within the 10 mile radius are not eligible for the exclusion regardless of whether that pharmacy can accept electronic prescriptions from EPs outside of the organization.

Definition of Terms:

Prescription – The authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.

Permissible Prescriptions may include or not include controlled substances based on provider selection where creation of an electronic prescription for the medication is feasible using CEHRT and allowable by state and local law.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(2)(i)(A) and (B). For further discussion please see **80 FR 62834**
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.315(b)(3) and (a)(10)(ii).

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 Electronic Prescribing 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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

(*) Red asterisk indicates a required field

(*) Gray asterisk indicates a conditionally required field

Measure Entry:

Exclusion 1: Based on ALL patient records: Any EP who writes fewer than 100 permissible prescriptions during the PI 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

Exclusion 2: Based on ALL patient records: Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her PI 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 prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.

Denominator: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the PI reporting period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the PI reporting period.

* **Numerator:**

* **Denominator:**

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 2**

Electronic Prescribing (eRx)

☑ Measure 1

Complete all required fields.

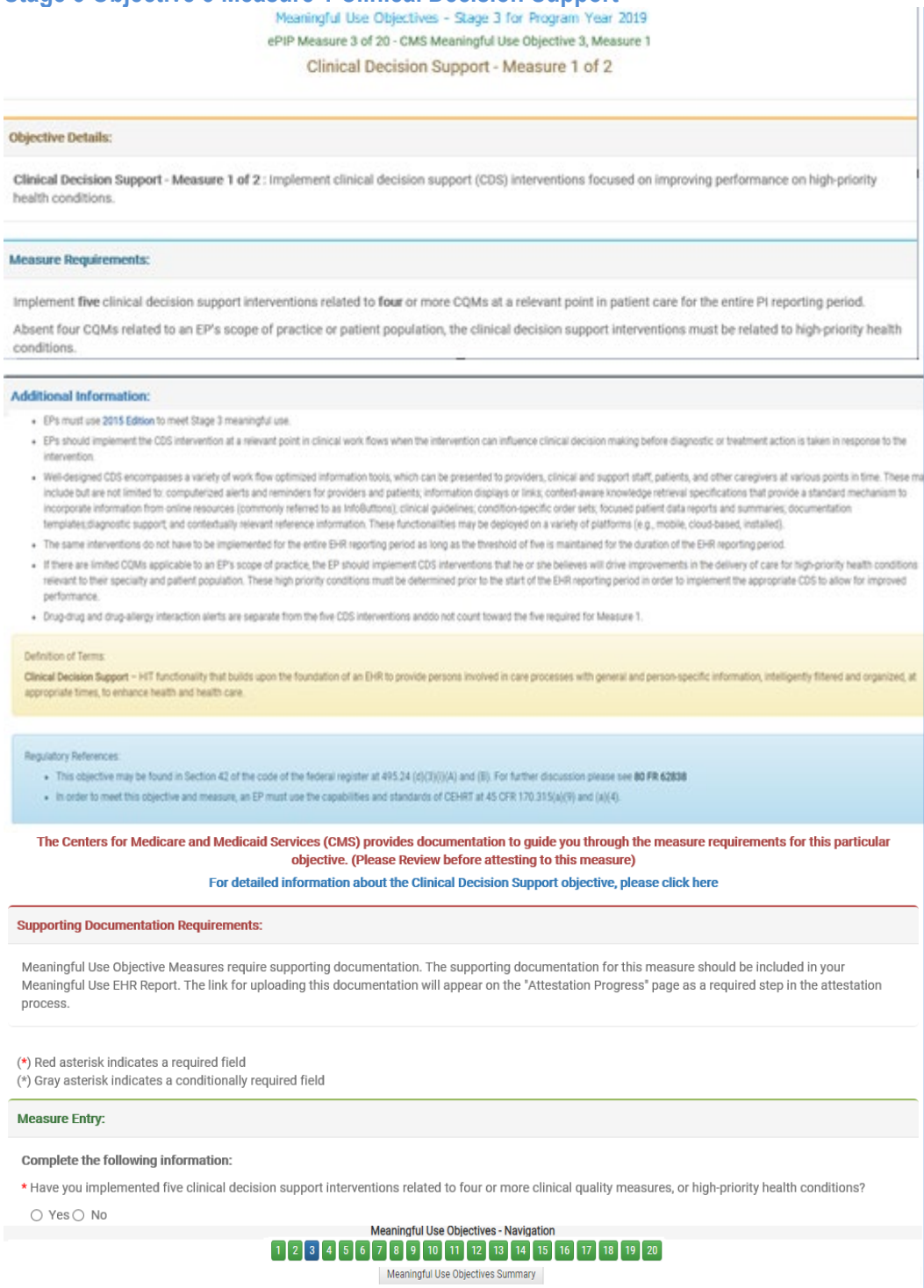
If you select the exclusions, you must upload documentation to support that separately.

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 3 Objective 3 Measure 1 Clinical Decision Support


Meaningful Use Objectives - Stage 3 for Program Year 2019

ePIP Measure 3 of 20 - CMS Meaningful Use Objective 3, Measure 1

Clinical Decision Support - Measure 1 of 2

Objective Details:

Clinical Decision Support - Measure 1 of 2 : Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

Measure Requirements:

Implement **five** clinical decision support interventions related to **four** or more CQMs at a relevant point in patient care for the entire PI reporting period.

Absent four CQMs related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- EPs should implement the CDS intervention at a relevant point in clinical work flows when the intervention can influence clinical decision making before diagnostic or treatment action is taken in response to the intervention.
- Well-designed CDS encompasses a variety of work flow optimized information tools, which can be presented to providers, clinical and support staff, patients, and other caregivers at various points in time. These may include but are not limited to: computerized alerts and reminders for providers and patients; information displays or links; context-aware knowledge retrieval specifications that provide a standard mechanism to incorporate information from online resources (commonly referred to as InfoButtons); clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates;diagnostic support; and contextually relevant reference information. These functionalities may be deployed on a variety of platforms (e.g., mobile, cloud-based, installed).
- The same interventions do not have to be implemented for the entire EHR reporting period as long as the threshold of five is maintained for the duration of the EHR reporting period.
- If there are limited CQMs applicable to an EP's scope of practice, the EP should implement CDS interventions that he or she believes will drive improvements in the delivery of care for high-priority health conditions relevant to their specialty and patient population. These high priority conditions must be determined prior to the start of the EHR reporting period in order to implement the appropriate CDS to allow for improved performance.
- Drug-drug and drug-allergy interaction alerts are separate from the five CDS interventions anddo not count toward the five required for Measure 1.

Definition of Terms:

Clinical Decision Support – HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(3)(i)(A) and (B). For further discussion please see **80 FR 62838**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315(a)(9) and (a)(4).

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 Clinical Decision Support 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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry:

Complete the following information:

* Have you implemented five clinical decision support interventions related to four or more clinical quality measures, or high-priority health conditions?

○ Yes ○ No

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 3**

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 PI reporting period.

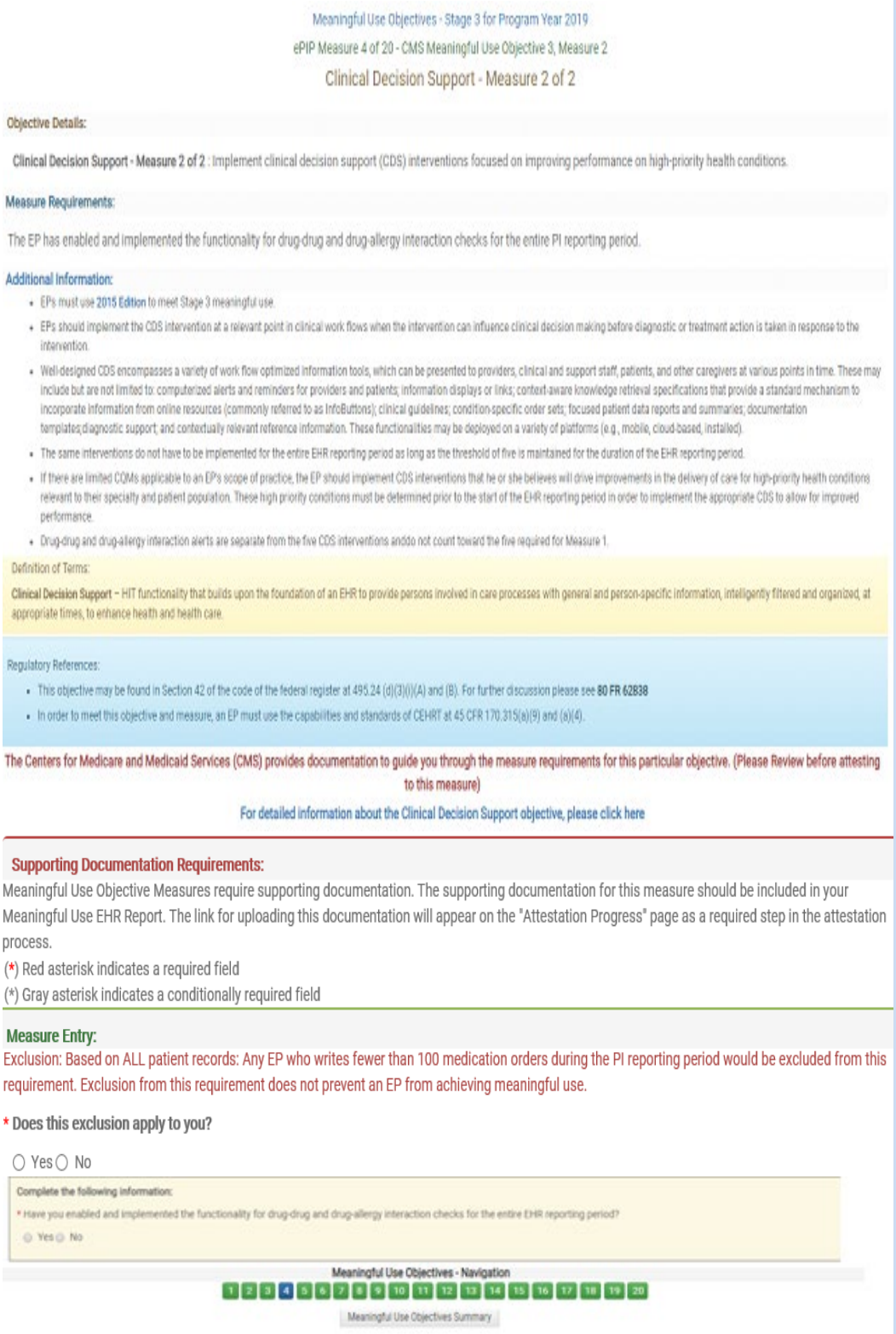
If you implemented the required clinical decision support, you must upload documentation to support that separately.

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 3 Objective 3 Measure 2 Clinical Decision Support



Meaningful Use Objectives - Stage 3 for Program Year 2019

ePIP Measure 4 of 20 - CMS Meaningful Use Objective 3, Measure 2

Clinical Decision Support - Measure 2 of 2

Objective Details:

Clinical Decision Support - Measure 2 of 2 : Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

Measure Requirements:

The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period.

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- EPs should implement the CDS intervention at a relevant point in clinical work flows when the intervention can influence clinical decision making before diagnostic or treatment action is taken in response to the intervention.
- Well-designed CDS encompasses a variety of work flow optimized information tools, which can be presented to providers, clinical and support staff, patients, and other caregivers at various points in time. These may include but are not limited to: computerized alerts and reminders for providers and patients; information displays or links; context-aware knowledge retrieval specifications that provide a standard mechanism to incorporate information from online resources (commonly referred to as InfoButtons); clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates;diagnostic support; and contextually relevant reference information. These functionalities may be deployed on a variety of platforms (e.g., mobile, cloud-based, installed).
- The same interventions do not have to be implemented for the entire EHR reporting period as long as the threshold of five is maintained for the duration of the EHR reporting period.
- If there are limited CQMs applicable to an EP's scope of practice, the EP should implement CDS interventions that he or she believes will drive improvements in the delivery of care for high-priority health conditions relevant to their specialty and patient population. These high priority conditions must be determined prior to the start of the EHR reporting period in order to implement the appropriate CDS to allow for improved performance.
- Drug-drug and drug-allergy interaction alerts are separate from the five CDS interventions anddo not count toward the five required for Measure 1.

Definition of Terms:

Clinical Decision Support – HIT functionality that builds upon the foundation of an EHR to provide persons involved in care processes with general and person-specific information, intelligently filtered and organized, at appropriate times, to enhance health and health care.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(3)(i)(A) and (B). For further discussion please see **80 FR 62838**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315(a)(9) and (a)(4).

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 Clinical Decision Support 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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step 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 PI 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

Complete the following information:

* Have you enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

○ Yes ○ No

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 4**

Clinical Decision Support

☑ Measure 2

Complete all required fields.

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

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

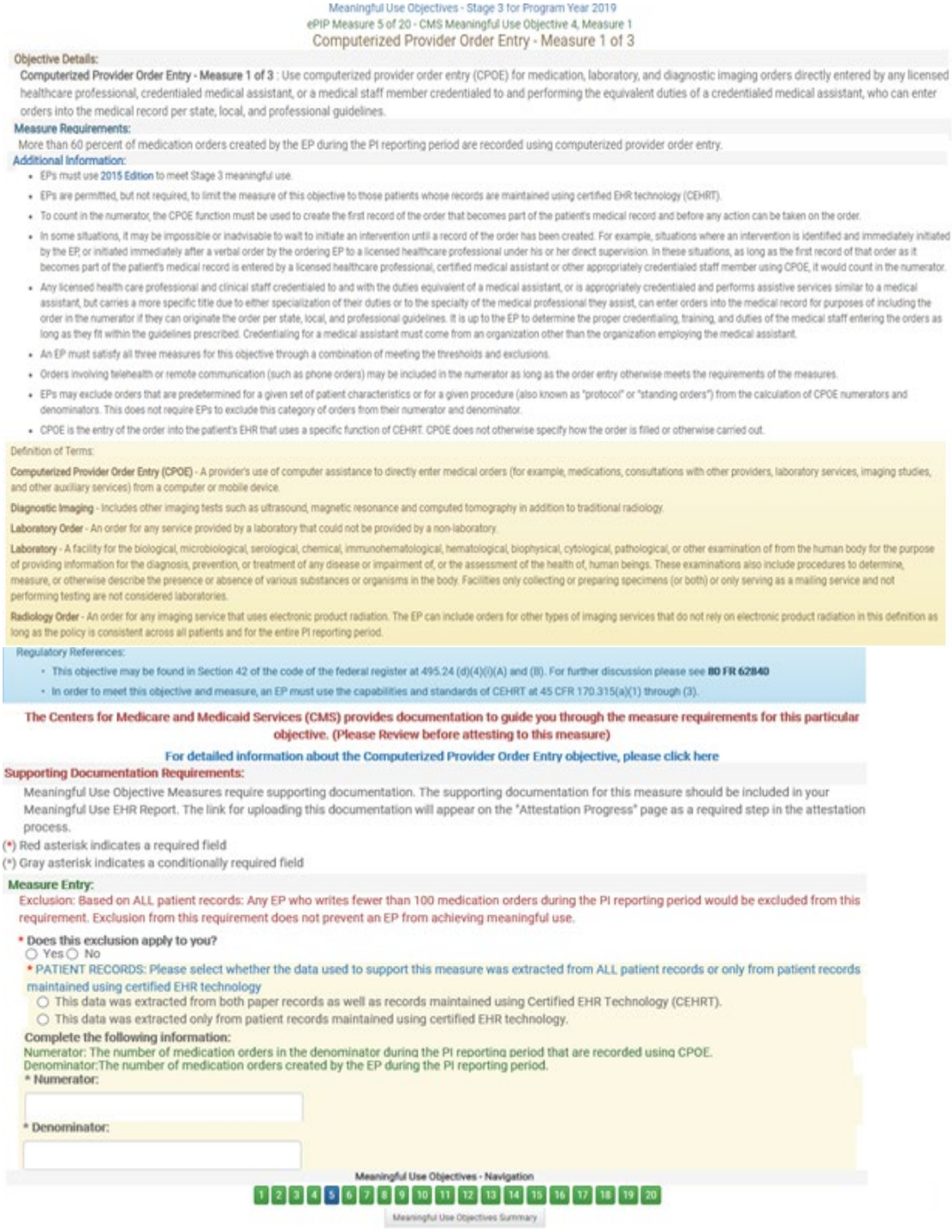
The Navigation bar at the bottom will monitor your progress.

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 3 Objective 4 Measure 1 Computerized Provider Order Entry



Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 5 of 20 - CMS Meaningful Use Objective 4, 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 (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, 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 PI reporting period are recorded using computerized provider order entry.

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- EPs are permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- To count in the numerator, the CPOE function must be used to create the first record of the order that becomes part of the patient's medical record and before any action can be taken on the order.
- In some situations, it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the EP, or initiated immediately after a verbal order by the ordering EP to a licensed healthcare professional under his or her direct supervision. In these situations, as long as the first record of that order as it becomes part of the patient's medical record is entered by a licensed healthcare professional, certified medical assistant or other appropriately credentialed staff member using CPOE, it would count in the numerator.
- Any licensed health care professional and clinical staff credentialed to and with the duties equivalent of a medical assistant, or is appropriately credentialed and performs assistive services similar to a medical assistant, but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, can enter orders into the medical record for purposes of including the order in the numerator if they can originate the order per state, local, and professional guidelines. It is up to the EP to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines prescribed. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.
- An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions.
- Orders involving telehealth or remote communication (such as phone orders) may be included in the numerator as long as the order entry otherwise meets the requirements of the measures.
- EPs may exclude orders that are predetermined for a given set of patient characteristics or for a given procedure (also known as "protocol" or "standing orders") from the calculation of CPOE numerators and denominators. This does not require EPs to exclude this category of orders from their numerator and denominator.
- CPOE is the entry of the order into the patient's EHR that uses a specific function of CEHRT. CPOE does not otherwise specify how the order is filled or otherwise carried out.

Definition of Terms:

Computerized Provider Order Entry (CPOE) - A provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.

Diagnostic Imaging - Includes other imaging tests such as ultrasound, magnetic resonance and computed tomography in addition to traditional radiology.

Laboratory Order - An order for any service provided by a laboratory that could not be provided by a non-laboratory.

Laboratory - A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Radiology Order - An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long as the policy is consistent across all patients and for the entire PI reporting period.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(4)(i)(A) and (B). For further discussion please see **80 FR 62840**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315(a)(1) through (3).

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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step 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 PI 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 PI reporting period that are recorded using CPOE.
Denominator:The number of medication orders created by the EP during the PI reporting period.

* **Numerator:**

* **Denominator:**

Meaningful Use Objectives - Navigation
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Meaningful Use Objectives Summary

Stage 3 **Screen 5**

Computerized Provider Order Entry

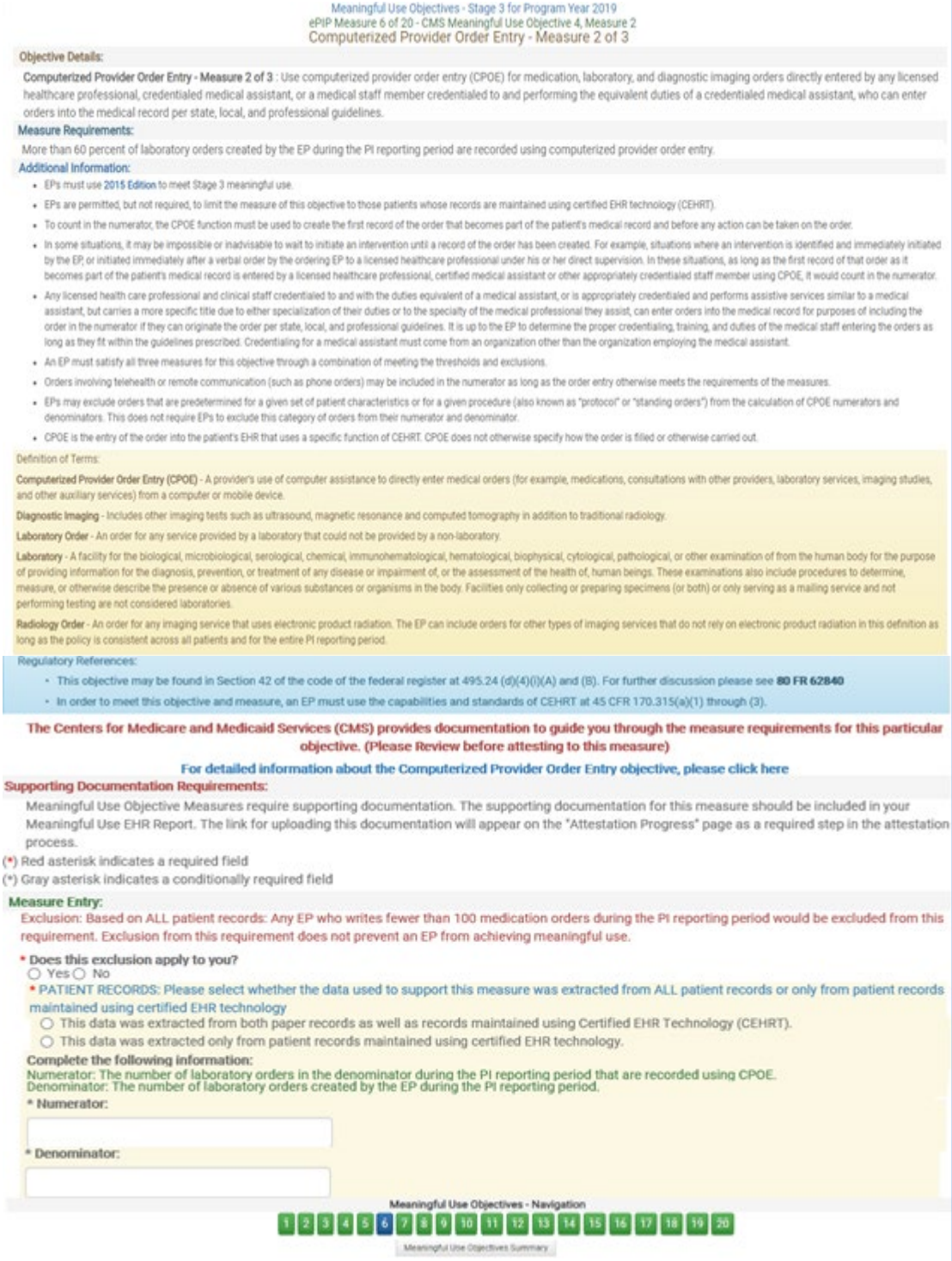
☑ Measure 1

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 3 Objective 4 Measure 2 Computerized Provider Order Entry



Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 6 of 20 - CMS Meaningful Use Objective 4, Measure 2
Computerized Provider Order Entry - Measure 2 of 3

Objective Details:

Computerized Provider Order Entry - Measure 2 of 3 : Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

Measure Requirements:

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

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- EPs are permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- To count in the numerator, the CPOE function must be used to create the first record of the order that becomes part of the patient's medical record and before any action can be taken on the order.
- In some situations, it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the EP, or initiated immediately after a verbal order by the ordering EP to a licensed healthcare professional under his or her direct supervision. In these situations, as long as the first record of that order as it becomes part of the patient's medical record is entered by a licensed healthcare professional, certified medical assistant or other appropriately credentialed staff member using CPOE, it would count in the numerator.
- Any licensed health care professional and clinical staff credentialed to and with the duties equivalent of a medical assistant, or is appropriately credentialed and performs assistive services similar to a medical assistant, but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, can enter orders into the medical record for purposes of including the order in the numerator if they can originate the order per state, local, and professional guidelines. It is up to the EP to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines prescribed. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.
- An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions.
- Orders involving telehealth or remote communication (such as phone orders) may be included in the numerator as long as the order entry otherwise meets the requirements of the measures.
- EPs may exclude orders that are predetermined for a given set of patient characteristics or for a given procedure (also known as "protocol" or "standing orders") from the calculation of CPOE numerators and denominators. This does not require EPs to exclude this category of orders from their numerator and denominator.
- CPOE is the entry of the order into the patient's EHR that uses a specific function of CEHRT. CPOE does not otherwise specify how the order is filled or otherwise carried out.

Definition of Terms:

Computerized Provider Order Entry (CPOE) - A provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.

Diagnostic Imaging - Includes other imaging tests such as ultrasound, magnetic resonance and computed tomography in addition to traditional radiology.

Laboratory Order - An order for any service provided by a laboratory that could not be provided by a non-laboratory.

Laboratory - A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Radiology Order - An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long as the policy is consistent across all patients and for the entire PI reporting period.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(4)(i)(A) and (B). For further discussion please see **80 FR 62840**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315(a)(1) through (3).

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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step 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 PI 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 laboratory orders in the denominator during the PI reporting period that are recorded using CPOE.
Denominator: The number of laboratory orders created by the EP during the PI reporting period.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Meaningful Use Objectives Summary

Stage 3 **Screen 6**

Computerized Provider Order Entry

☑ Measure 2

Complete all required fields.

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

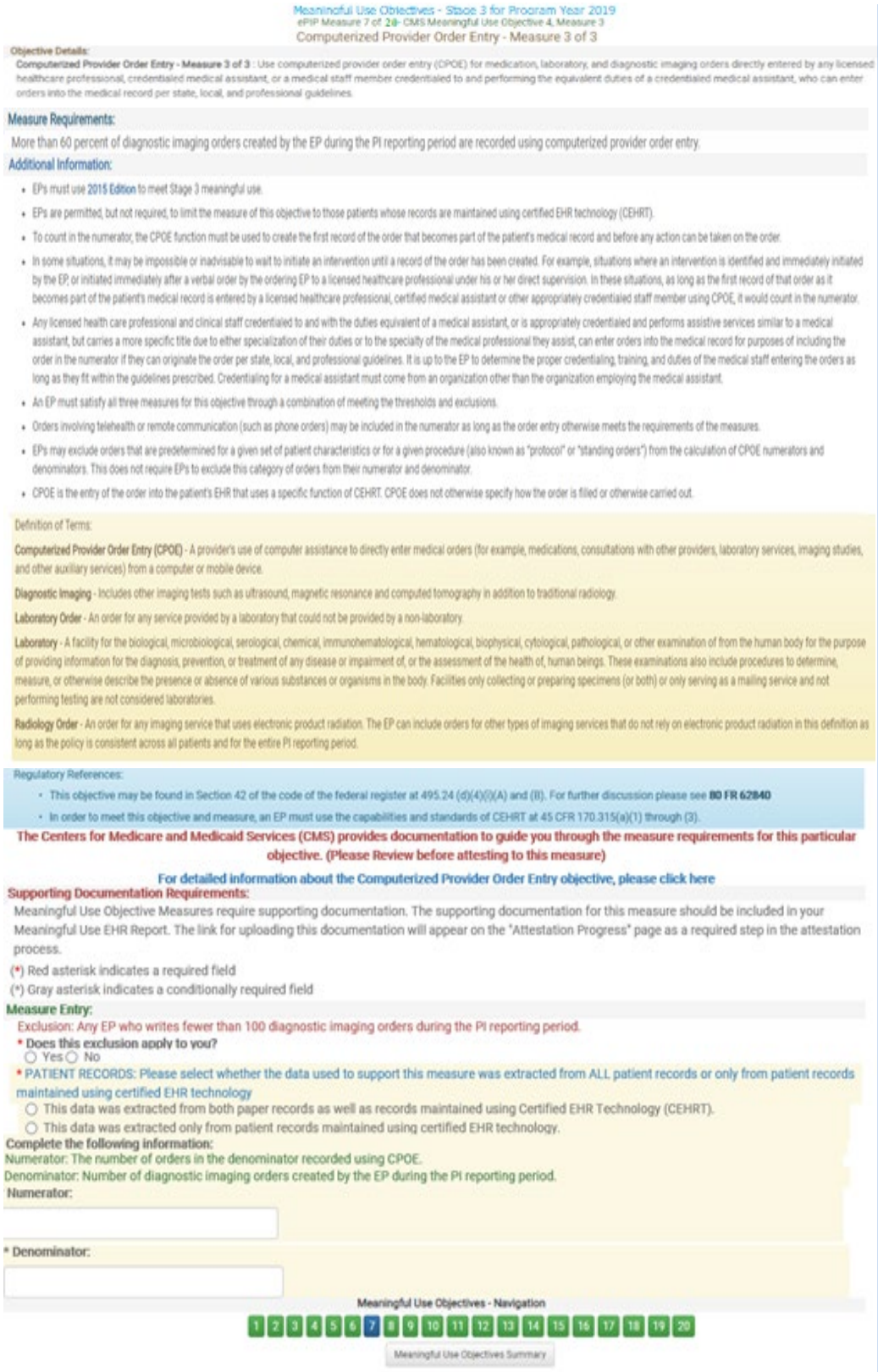
If you are not certain how to run the laboratory orders using CPOE report, you may need to contact your CEHRT vendor.

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 3 Objective 4 Measure 3 Computerized Provider Order Entry



Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 7 of 20- CMS Meaningful Use Objective 4, 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 (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

Measure Requirements:

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

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- EPs are permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- To count in the numerator, the CPOE function must be used to create the first record of the order that becomes part of the patient's medical record and before any action can be taken on the order.
- In some situations, it may be impossible or inadvisable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the EP, or initiated immediately after a verbal order by the ordering EP to a licensed healthcare professional under his or her direct supervision. In these situations, as long as the first record of that order as it becomes part of the patient's medical record is entered by a licensed healthcare professional, certified medical assistant or other appropriately credentialed staff member using CPOE, it would count in the numerator.
- Any licensed health care professional and clinical staff credentialed to and with the duties equivalent of a medical assistant, or is appropriately credentialed and performs assistive services similar to a medical assistant, but carries a more specific title due to either specialization of their duties or to the specialty of the medical professional they assist, can enter orders into the medical record for purposes of including the order in the numerator if they can originate the order per state, local, and professional guidelines. It is up to the EP to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines prescribed. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.
- An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions.
- Orders involving telehealth or remote communication (such as phone orders) may be included in the numerator as long as the order entry otherwise meets the requirements of the measures.
- EPs may exclude orders that are predetermined for a given set of patient characteristics or for a given procedure (also known as "protocol" or "standing orders") from the calculation of CPOE numerators and denominators. This does not require EPs to exclude this category of orders from their numerator and denominator.
- CPOE is the entry of the order into the patient's EHR that uses a specific function of CEHRT. CPOE does not otherwise specify how the order is filled or otherwise carried out.

Definition of Terms:

Computerized Provider Order Entry (CPOE) - A provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.

Diagnostic Imaging - Includes other imaging tests such as ultrasound, magnetic resonance and computed tomography in addition to traditional radiology.

Laboratory Order - An order for any service provided by a laboratory that could not be provided by a non-laboratory.

Laboratory - A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Radiology Order - An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long as the policy is consistent across all patients and for the entire PI reporting period.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(4)(i)(A) and (B). For further discussion please see **80 FR 62840**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315(a)(1) through (3).

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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry:

Exclusion: Any EP who writes fewer than 100 diagnostic imaging orders during the PI 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 orders in the denominator recorded using CPOE.
Denominator: Number of diagnostic imaging orders created by the EP during the PI reporting period.

Numerator:

* **Denominator:**

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 7**

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 3 Objective 5 Measure 1 Patient Electronic Access

Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 8 of 20 - CMS Meaningful Use Objective 5, Measure 1
Patient Electronic Access to Health Information - Measure 1 of 2

Objective Details:

Patient Electronic Access to Health Information - Measure 1 of 2: The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

Measure Requirements:

For more than 80 percent of all unique patients seen by the EP:

1. The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information.
2. The provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT.

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- To implement an API, an EP needs to fully enable the API functionality, such that any application chosen by a patient would enable the patient to gain access to their individual health information, provided that the application is configured to meet the technical specifications of the API. EPs may not prohibit patients from using any application, including third-party applications, which meet the technical specifications of the API, including the security requirements of the API. EPs are expected to provide patients with detailed instructions on how to authenticate their access through the API and provide the patient with supplemental information on available applications that leverage the API.
- Similar to how EPs support patient access to view, download, and transmit capabilities, EPs should continue to have identity verification processes to ensure that a patient using an application, which is leveraging the API, is provided access to their health information.
- In circumstances where there is no information available to populate one or more fields, either because the EP can be excluded from recording such information or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have an indication that the information is not available and still meet the objective and its associated measure.
- The patient must be able to access this information on demand, such as through a patient portal, a personal health record (PHR), or by other online electronic means. We note that while a covered entity may be able to fully satisfy a patient's request for information through view, download, and transmit, the measure does not replace the covered entity's responsibilities to meet the broader requirements under Health Insurance Portability and Accountability Act (HIPAA) to provide an individual, upon request, with access to patient health information (PHI) in a designated record set.
- While meaningful use is limited to the capabilities of CEHRT to provide online access there may be patients who cannot access their EHRs electronically because of a disability. EPs who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- For Measure 1, EPs must offer all four functionalities (view, download, transmit, and access through API) to their patients, and PHI needs to be made available to each patient for view, download, and transmit, including via API, within 48 hours of the information being available to the EP for each and every time that information is generated, regardless of how long the patient has been "enrolled".
- For 2019 only, due to confusion about this measure, an EP may meet Measure 1 if they (1) have enabled an API within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs, (2) make data available via that API for 80% of the patients seen during their reporting period, (3) provide those patients with detailed instructions on how to authenticate their access through the API and provide the patient with supplemental information on available applications that leverage the API, and (4) maintain availability of the API.
- A patient who has multiple encounters during the EHR reporting period, or even in subsequent EHR reporting periods in future years, needs to be provided access for each encounter where they are seen by the EP.
- If a patient elects to "opt out" of participation, that patient must still be included in the denominator.
- If a patient elects to "opt out" of participation, an EP may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access their information, obtain access through a patient-authorized representative, or otherwise opt-back-in without further follow up action required by the EP.
- For Measure 2, actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.
- Paper-based actions are no longer allowed or required to be counted for Measure 2 calculations. EPs may still provide paper based educational materials for their patients, but they may no longer be included in measure calculations.

Definition of Terms:

Application Programming Interface (API) - A set of programming protocols established for multiple purposes. APIs may be enabled by a provider or provider organization to provide the patient with access to their health information through a third-party application with more flexibility than is often found in many current 'patient portals'.

Provide Access - When a patient possesses all of the necessary information needed to view, download, or transmit their information. This could include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information.

View - The patient (or authorized representative) accessing their health information online.

Download - The movement of information from online to physical electronic media.

Transmission - This may be any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.

Business Days - Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

Diagnostic Test Results - All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(5)(i)(A) and (B). For further discussion please see **80 FR 62846**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (a)(13) and (g)(8) and (9).

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

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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.
In addition, supporting documentation will be required that relates to the Application Programming Interface or API.
This documentation should include:

- An EHR screen shot or vendor letter that confirms the API was enabled prior to or during the PI Reporting Period.
- A copy of instructions provided to patients on how to authenticate their access through an API.
- A copy of the information given to patients on available applications that leverage the API.
- A copy of the VDT and/or Audit log if the API was enabled after the start of the PI Reporting Period.

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

Measure Entry:

Exclusion: An EP may exclude from the measure if they have no office visits during the PI reporting period.
* Does this exclusion apply to you?
Yes No

Exclusion: Any EP that 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 PI reporting period may exclude the measure.
* 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 (or patient-authorized representative) who are provided timely access (within 48 hours) to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the EP's CEHRT.

Denominator: Number of unique patients seen by the EP during the PI reporting period.
* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Meaningful Use Objectives Summary

Stage 3 **Screen 8**

Patient Electronic Access

☑ Measure 1

Complete all required fields

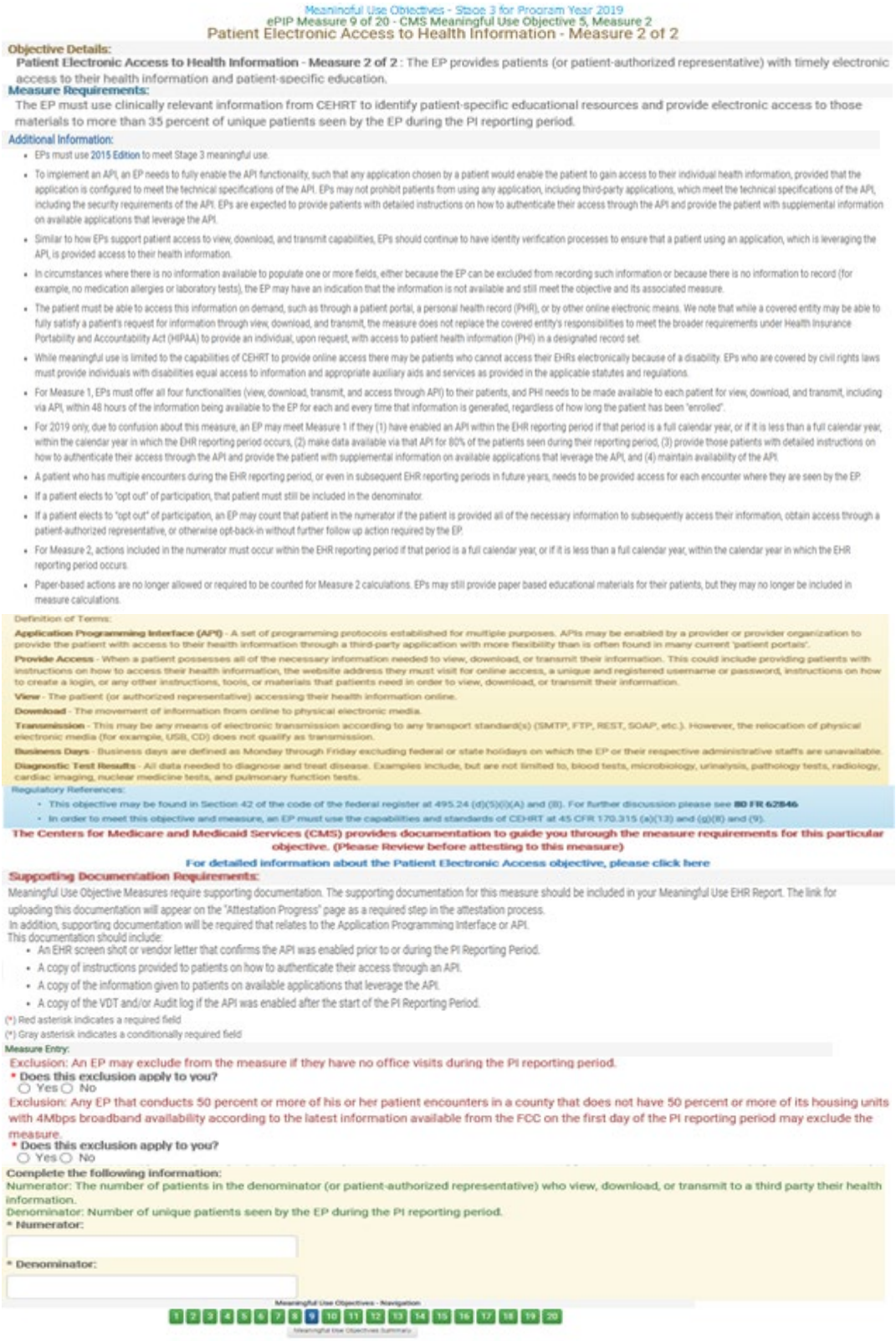
If you select the exclusions, you must upload documentation to support that separately.

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 3 Objective 5 Measure 2 Patient Electronic Access



Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 9 of 20 - CMS Meaningful Use Objective 5, Measure 2
Patient Electronic Access to Health Information - Measure 2 of 2

Objective Details:

Patient Electronic Access to Health Information - Measure 2 of 2: The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

Measure Requirements:

The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the PI reporting period.

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- To implement an API, an EP needs to fully enable the API functionality, such that any application chosen by a patient would enable the patient to gain access to their individual health information, provided that the application is configured to meet the technical specifications of the API. EPs may not prohibit patients from using any application, including third-party applications, which meet the technical specifications of the API, including the security requirements of the API. EPs are expected to provide patients with detailed instructions on how to authenticate their access through the API and provide the patient with supplemental information on available applications that leverage the API.
- Similar to how EPs support patient access to view, download, and transmit capabilities, EPs should continue to have identity verification processes to ensure that a patient using an application, which is leveraging the API, is provided access to their health information.
- In circumstances where there is no information available to populate one or more fields, either because the EP can be excluded from recording such information or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have an indication that the information is not available and still meet the objective and its associated measure.
- The patient must be able to access this information on demand, such as through a patient portal, a personal health record (PHR), or by other online electronic means. We note that while a covered entity may be able to fully satisfy a patient's request for information through view, download, and transmit, the measure does not replace the covered entity's responsibilities to meet the broader requirements under Health Insurance Portability and Accountability Act (HIPAA) to provide an individual, upon request, with access to patient health information (PHI) in a designated record set.
- While meaningful use is limited to the capabilities of CEHRT to provide online access there may be patients who cannot access their EHRs electronically because of a disability. EPs who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- For Measure 1, EPs must offer all four functionalities (view, download, transmit, and access through API) to their patients, and PHI needs to be made available to each patient for view, download, and transmit, including via API, within 48 hours of the information being available to the EP for each and every time that information is generated, regardless of how long the patient has been "enrolled".
- For 2019 only, due to confusion about this measure, an EP may meet Measure 1 if they (1) have enabled an API within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs, (2) make data available via that API for 80% of the patients seen during their reporting period, (3) provide those patients with detailed instructions on how to authenticate their access through the API and provide the patient with supplemental information on available applications that leverage the API, and (4) maintain availability of the API.
- A patient who has multiple encounters during the EHR reporting period, or even in subsequent EHR reporting periods in future years, needs to be provided access for each encounter where they are seen by the EP.
- If a patient elects to "opt out" of participation, that patient must still be included in the denominator.
- If a patient elects to "opt out" of participation, an EP may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access their information, obtain access through a patient-authorized representative, or otherwise opt-back-in without further follow up action required by the EP.
- For Measure 2, actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.
- Paper-based actions are no longer allowed or required to be counted for Measure 2 calculations. EPs may still provide paper based educational materials for their patients, but they may no longer be included in measure calculations.

Definition of Terms:

Application Programming Interface (API) - A set of programming protocols established for multiple purposes. APIs may be enabled by a provider or provider organization to provide the patient with access to their health information through a third-party application with more flexibility than is often found in many current 'patient portals'.

Provide Access - When a patient possesses all of the necessary information needed to view, download, or transmit their information. This could include providing patients with instructions on how to access their health information, the website address they must visit for online access, a unique and registered username or password, instructions on how to create a login, or any other instructions, tools, or materials that patients need in order to view, download, or transmit their information.

View - The patient (or authorized representative) accessing their health information online.

Download - The movement of information from online to physical electronic media.

Transmission - This may be any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.

Business Days - Business days are defined as Monday through Friday excluding federal or state holidays on which the EP or their respective administrative staffs are unavailable.

Diagnostic Test Results - All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(5)(i)(A) and (B). For further discussion please see **80 FR 62846**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (a)(13) and (g)(8) and (9).

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

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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.
In addition, supporting documentation will be required that relates to the Application Programming Interface or API.
This documentation should include:

- An EHR screen shot or vendor letter that confirms the API was enabled prior to or during the PI Reporting Period.
- A copy of instructions provided to patients on how to authenticate their access through an API.
- A copy of the information given to patients on available applications that leverage the API.
- A copy of the VDT and/or Audit log if the API was enabled after the start of the PI Reporting Period.

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

Measure Entry:

Exclusion: An EP may exclude from the measure if they have no office visits during the PI reporting period.
* Does this exclusion apply to you?
○ Yes ○ No

Exclusion: Any EP that 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 PI reporting period may exclude the measure.
* 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 PI reporting period.
* Numerator:
* Denominator:

Meaningful Use Objectives - Navigation
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Meaningful Use Objectives Summary

Stage 3 **Screen 9**

Patient Electronic Access

☑ Measure 2

Complete all required fields.

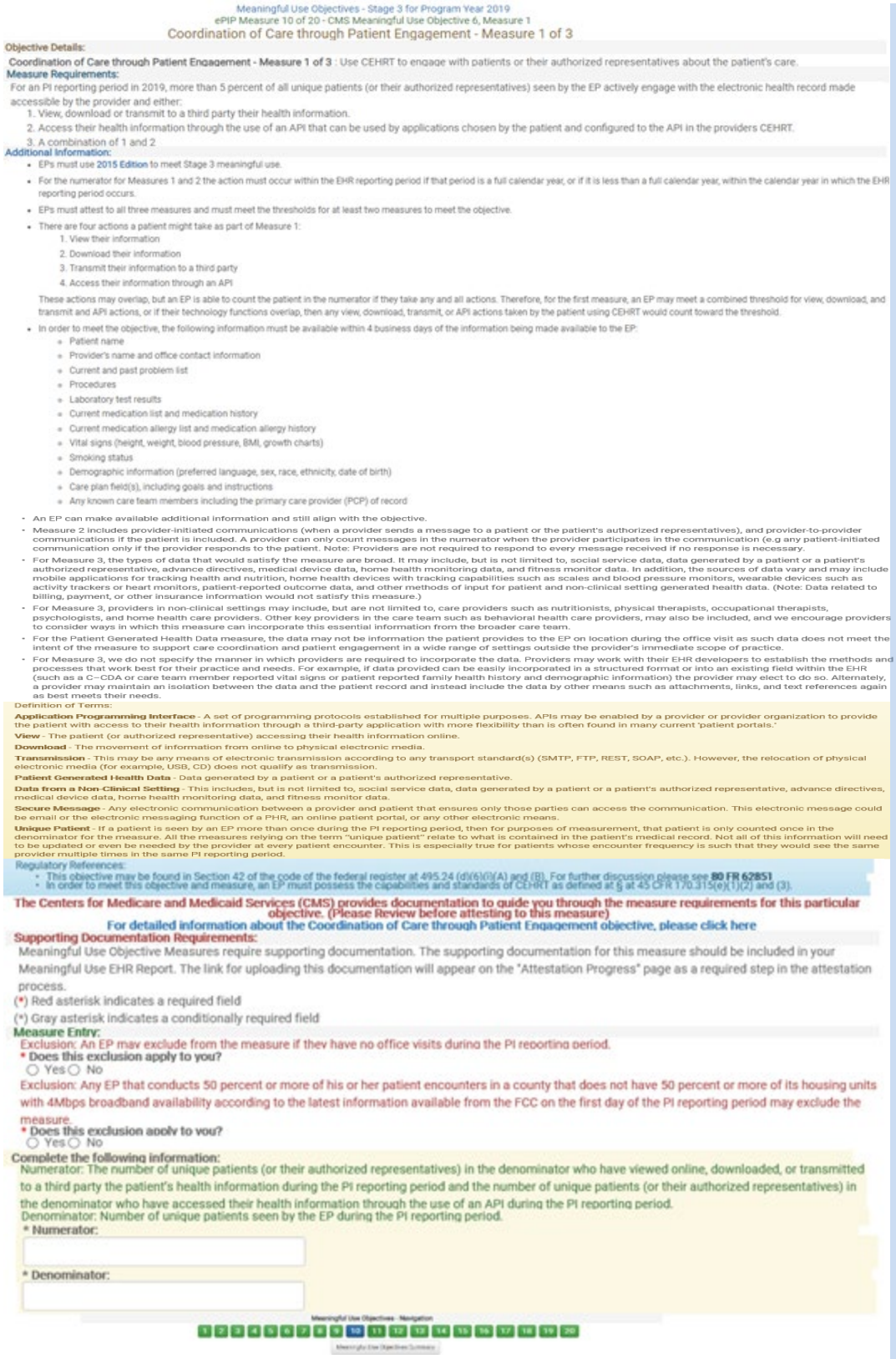
If you select the exclusions, you must upload documentation to support that separately.

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 3 Objective 6 Measure 1 Coordination of Care



Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 10 of 20 - CMS Meaningful Use Objective 6, Measure 1
Coordination of Care through Patient Engagement - Measure 1 of 3

Objective Details:

Coordination of Care through Patient Engagement - Measure 1 of 3 : Use CEHRT to engage with patients or their authorized representatives about the patient's care.

Measure Requirements:

For an PI reporting period in 2019, more than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either:

1. View, download or transmit to a third party their health information.
2. Access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the providers CEHRT.
3. A combination of 1 and 2

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- For the numerator for Measures 1 and 2 the action must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.
- EPs must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- There are four actions a patient might take as part of Measure 1:
  1. View their information
  2. Download their information
  3. Transmit their information to a third party
  4. Access their information through an API

  These actions may overlap, but an EP is able to count the patient in the numerator if they take any and all actions. Therefore, for the first measure, an EP may meet a combined threshold for view, download, and transmit and API actions, or if their technology functions overlap, then any view, download, transmit, or API actions taken by the patient using CEHRT would count toward the threshold.
- In order to meet the objective, the following information must be available within 4 business days of the information being made available to the EP:
  - Patient name
  - Provider's name and office contact information
  - Current and past problem list
  - Procedures
  - Laboratory test results
  - Current medication list and medication history
  - Current medication allergy list and medication allergy history
  - Vital signs (height, weight, blood pressure, BMI, growth charts)
  - Smoking status
  - Demographic information (preferred language, sex, race, ethnicity, date of birth)
  - Care plan field(s), including goals and instructions
  - Any known care team members including the primary care provider (PCP) of record

- An EP can make available additional information and still align with the objective.
- Measure 2 includes provider-initiated communications (when a provider sends a message to a patient or the patient's authorized representatives), and provider-to-provider communications if the patient is included. A provider can only count messages in the numerator when the provider participates in the communication (e.g any patient-initiated communication only if the provider responds to the patient. Note: Providers are not required to respond to every message received if no response is necessary.
- For Measure 3, the types of data that would satisfy the measure are broad. It may include, but is not limited to, social service data, data generated by a patient or a patient's authorized representative, advance directives, medical device data, home health monitoring data, and fitness monitor data. In addition, the sources of data vary and may include mobile applications for tracking health and nutrition, home health devices with tracking capabilities such as scales and blood pressure monitors, wearable devices such as activity trackers or heart monitors, patient-reported outcome data, and other methods of input for patient and non-clinical setting generated health data. (Note: Data related to billing, payment, or other insurance information would not satisfy this measure.)
- For Measure 3, providers in non-clinical settings may include, but are not limited to, care providers such as nutritionists, physical therapists, occupational therapists, psychologists, and home health care providers. Other key providers in the care team such as behavioral health care providers, may also be included, and we encourage providers to consider ways in which this measure can incorporate this essential information from the broader care team.
- For the Patient Generated Health Data measure, the data may not be information the patient provides to the EP on location during the office visit as such data does not meet the intent of the measure to support care coordination and patient engagement in a wide range of settings outside the provider's immediate scope of practice.
- For Measure 3, we do not specify the manner in which providers are required to incorporate the data. Providers may work with their EHR developers to establish the methods and processes that work best for their practice and needs. For example, if data provided can be easily incorporated in a structured format or into an existing field within the EHR (such as a C–CDA or care team member reported vital signs or patient reported family health history and demographic information) the provider may elect to do so. Alternately, a provider may maintain an isolation between the data and the patient record and instead include the data by other means such as attachments, links, and text references again as best meets their needs.

Definition of Terms:

Application Programming Interface - A set of programming protocols established for multiple purposes. APIs may be enabled by a provider or provider organization to provide the patient with access to their health information through a third-party application with more flexibility than is often found in many current "patient portals."
View - The patient (or authorized representative) accessing their health information online.
Download - The movement of information from online to physical electronic media.
Transmission - This may be any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.
Patient Generated Health Data - Data generated by a patient or a patient's authorized representative.
Data from a Non-Clinical Setting - This includes, but is not limited to, social service data, data generated by a patient or a patient's authorized representative, advance directives, medical device data, home health monitoring data, and fitness monitor data.
Secure Message - Any electronic communication between a provider and patient that ensures only those parties can access the communication. This electronic message could be email or the electronic messaging function of a PHR, an online patient portal, or any other electronic means.
Unique Patient - If a patient is seen by an EP more than once during the PI reporting period, then for purposes of measurement, that patient is only counted once in the denominator for the measure. All the measures relying on the term "unique patient" relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same PI reporting period.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(6)(i)(A) and (B). For further discussion please see 80 FR 62851
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT as defined at § at 45 CFR 170.315(e)(1)(2) and (3).

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 Coordination of Care through Patient Engagement 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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry:

Exclusion: An EP may exclude from the measure if they have no office visits during the PI reporting period.
* Does this exclusion apply to you?
○ Yes ○ No

Exclusion: Any EP that 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 PI reporting period may exclude the measure.
* Does this exclusion apply to you?
○ Yes ○ No

Complete the following information:

Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the PI reporting period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the PI reporting period.
Denominator: Number of unique patients seen by the EP during the PI reporting period.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Stage 3 **Screen 10**

Coordination of Care

☑ Measure 1

Complete all required fields.

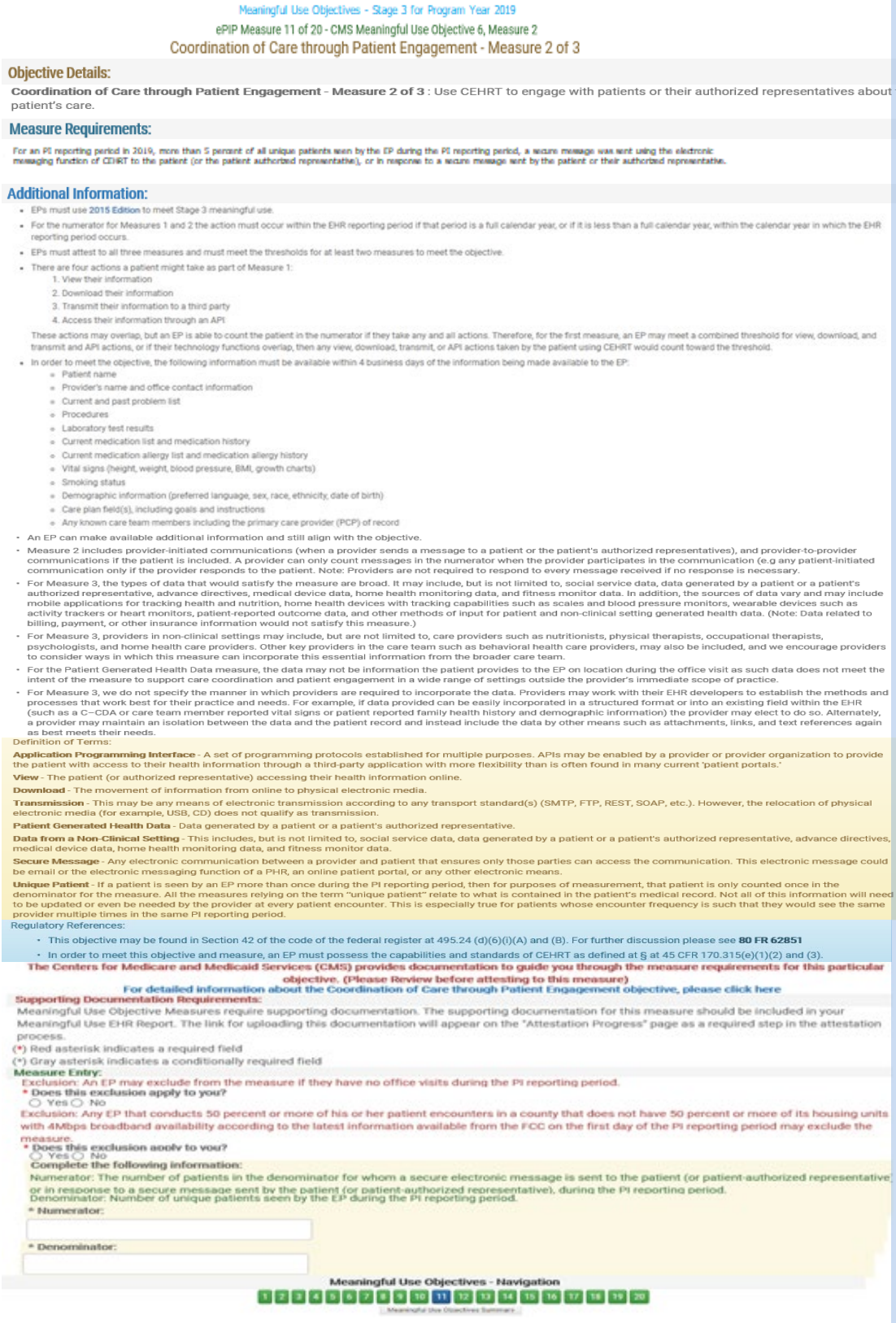
If you select the exclusions, you must upload documentation to support that separately.

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 3 Objective 6 Measure 2 Coordination of Care



Meaningful Use Objectives - Stage 3 for Program Year 2019

ePIP Measure 11 of 20 - CMS Meaningful Use Objective 6, Measure 2

Coordination of Care through Patient Engagement - Measure 2 of 3

Objective Details:

Coordination of Care through Patient Engagement - Measure 2 of 3 : Use CEHRT to engage with patients or their authorized representatives about the patient's care.

Measure Requirements:

For an PI reporting period in 2019, more than 5 percent of all unique patients seen by the EP during the PI 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 their authorized representative.

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- For the numerator for Measures 1 and 2 the action must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.
- EPs must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- There are four actions a patient might take as part of Measure 1:
  1. View their information
  2. Download their information
  3. Transmit their information to a third party
  4. Access their information through an API

  These actions may overlap, but an EP is able to count the patient in the numerator if they take any and all actions. Therefore, for the first measure, an EP may meet a combined threshold for view, download, and transmit and API actions, or if their technology functions overlap, then any view, download, transmit, or API actions taken by the patient using CEHRT would count toward the threshold.
- In order to meet the objective, the following information must be available within 4 business days of the information being made available to the EP:
  - Patient name
  - Provider's name and office contact information
  - Current and past problem list
  - Procedures
  - Laboratory test results
  - Current medication list and medication history
  - Current medication allergy list and medication allergy history
  - Vital signs (height, weight, blood pressure, BMI, growth charts)
  - Smoking status
  - Demographic information (preferred language, sex, race, ethnicity, date of birth)
  - Care plan field(s), including goals and instructions
  - Any known care team members including the primary care provider (PCP) of record
- An EP can make available additional information and still align with the objective.
- Measure 2 includes provider-initiated communications (when a provider sends a message to a patient or the patient's authorized representatives), and provider-to-provider communications if the patient is included. A provider can only count messages in the numerator when the provider participates in the communication (e.g any patient-initiated communication only if the provider responds to the patient. Note: Providers are not required to respond to every message received if no response is necessary.
- For Measure 3, the types of data that would satisfy the measure are broad. It may include, but is not limited to, social service data, data generated by a patient or a patient's authorized representative, advance directives, medical device data, home health monitoring data, and fitness monitor data. In addition, the sources of data vary and may include mobile applications for tracking health and nutrition, home health devices with tracking capabilities such as scales and blood pressure monitors, wearable devices such as activity trackers or heart monitors, patient-reported outcome data, and other methods of input for patient and non-clinical setting generated health data. (Note: Data related to billing, payment, or other insurance information would not satisfy this measure.)
- For Measure 3, providers in non-clinical settings may include, but are not limited to, care providers such as nutritionists, physical therapists, occupational therapists, psychologists, and home health care providers. Other key providers in the care team such as behavioral health care providers, may also be included, and we encourage providers to consider ways in which this measure can incorporate this essential information from the broader care team.
- For the Patient Generated Health Data measure, the data may not be information the patient provides to the EP on location during the office visit as such data does not meet the intent of the measure to support care coordination and patient engagement in a wide range of settings outside the provider's immediate scope of practice.
- For Measure 3, we do not specify the manner in which providers are required to incorporate the data. Providers may work with their EHR developers to establish the methods and processes that work best for their practice and needs. For example, if data provided can be easily incorporated in a structured format or into an existing field within the EHR (such as a C–CDA or care team member reported vital signs or patient reported family health history and demographic information) the provider may elect to do so. Alternately, a provider may maintain an isolation between the data and the patient record and instead include the data by other means such as attachments, links, and text references again as best meets their needs.

Definition of Terms:

Application Programming Interface - A set of programming protocols established for multiple purposes. APIs may be enabled by a provider or provider organization to provide the patient with access to their health information through a third-party application with more flexibility than is often found in many current 'patient portals.'

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Patient Generated Health Data - Data generated by a patient or a patient's authorized representative.

Data from a Non-Clinical Setting - This includes, but is not limited to, social service data, data generated by a patient or a patient's authorized representative, advance directives, medical device data, home health monitoring data, and fitness monitor data.

Secure Message - Any electronic communication between a provider and patient that ensures only those parties can access the communication. This electronic message could be email or the electronic messaging function of a PHR, an online patient portal, or any other electronic means.

Unique Patient - If a patient is seen by an EP more than once during the PI reporting period, then for purposes of measurement, that patient is only counted once in the denominator for the measure. All the measures relying on the term "unique patient" relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same PI reporting period.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(6)(i)(A) and (B). For further discussion please see **80 FR 62851**
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT as defined at § at 45 CFR 170.315(e)(1)(2) and (3).

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 Coordination of Care through Patient Engagement 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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

(*) Red asterisk indicates a required field

(*) Gray asterisk indicates a conditionally required field

Measure Entry:

Exclusion: An EP may exclude from the measure if they have no office visits during the PI reporting period.

* Does this exclusion apply to you?

○ Yes ○ No

Exclusion: Any EP that 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 PI reporting period may exclude the measure.

* Does this exclusion apply to you?

○ Yes ○ No

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), during the PI reporting period.

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

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 11**

Coordination of Care

☑ Measure 2

Complete all required fields.

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

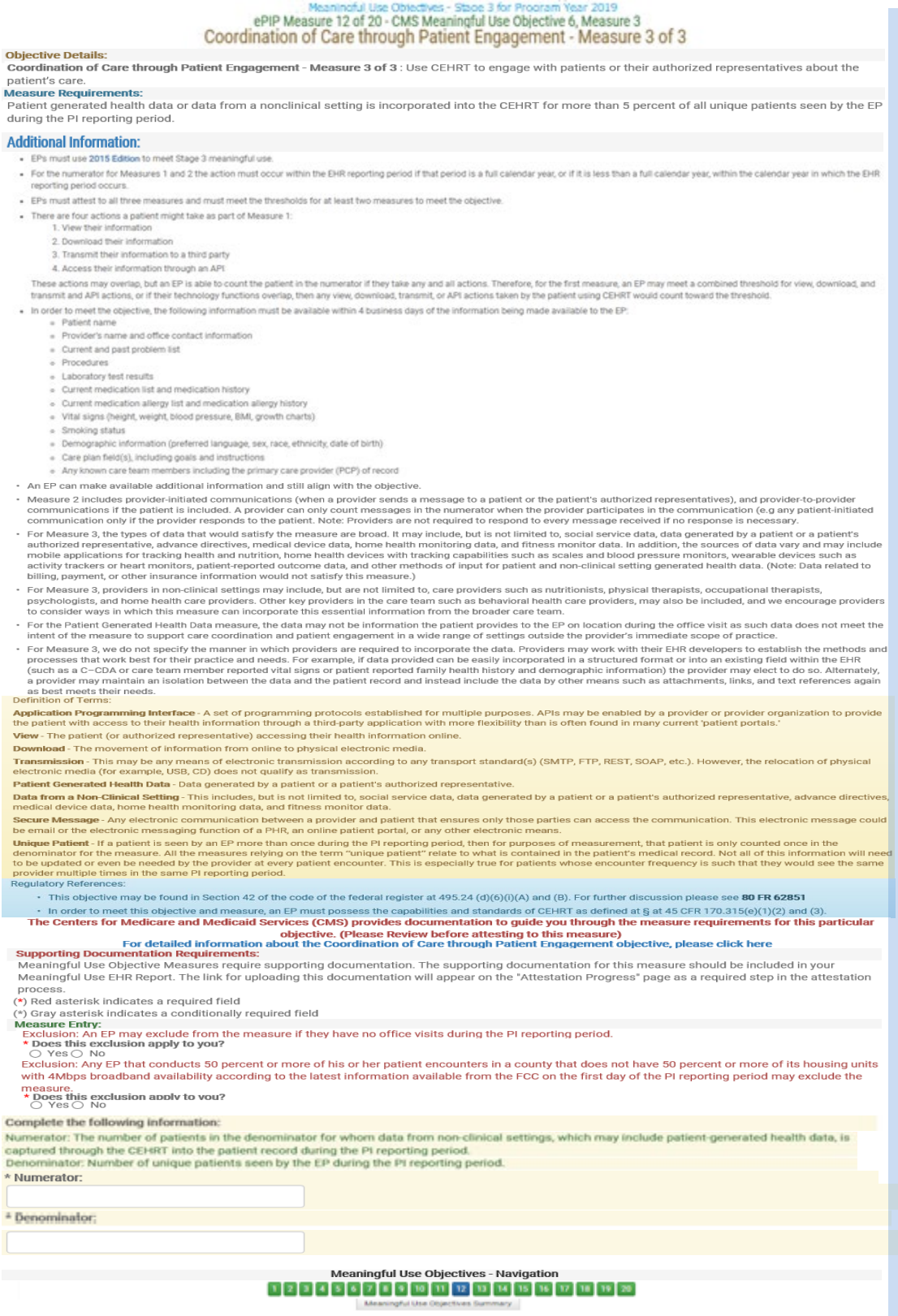
The Navigation bar at the bottom will monitor your progress.

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 3 Objective 6 Measure 3 Coordination of Care



Meaningful Use Objectives - Stage 3 for Program Year 2019

ePIP Measure 12 of 20 - CMS Meaningful Use Objective 6, Measure 3

Coordination of Care through Patient Engagement - Measure 3 of 3

Objective Details:

Coordination of Care through Patient Engagement - Measure 3 of 3 : Use CEHRT to engage with patients or their authorized representatives about the patient's care.

Measure Requirements:

Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the PI reporting period.

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- For the numerator for Measures 1 and 2 the action must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.
- EPs must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- There are four actions a patient might take as part of Measure 1:
  1. View their information
  2. Download their information
  3. Transmit their information to a third party
  4. Access their information through an API

  These actions may overlap, but an EP is able to count the patient in the numerator if they take any and all actions. Therefore, for the first measure, an EP may meet a combined threshold for view, download, and transmit and API actions, or if their technology functions overlap, then any view, download, transmit, or API actions taken by the patient using CEHRT would count toward the threshold.
- In order to meet the objective, the following information must be available within 4 business days of the information being made available to the EP:
  - Patient name
  - Provider's name and office contact information
  - Current and past problem list
  - Procedures
  - Laboratory test results
  - Current medication list and medication history
  - Current medication allergy list and medication allergy history
  - Vital signs (height, weight, blood pressure, BMI, growth charts)
  - Smoking status
  - Demographic information (preferred language, sex, race, ethnicity, date of birth)
  - Care plan field(s), including goals and instructions
  - Any known care team members including the primary care provider (PCP) of record
- An EP can make available additional information and still align with the objective.
- Measure 2 includes provider-initiated communications (when a provider sends a message to a patient or the patient's authorized representatives), and provider-to-provider communications if the patient is included. A provider can only count messages in the numerator when the provider participates in the communication (e.g any patient-initiated communication only if the provider responds to the patient. Note: Providers are not required to respond to every message received if no response is necessary.
- For Measure 3, the types of data that would satisfy the measure are broad. It may include, but is not limited to, social service data, data generated by a patient or a patient's authorized representative, advance directives, medical device data, home health monitoring data, and fitness monitor data. In addition, the sources of data vary and may include mobile applications for tracking health and nutrition, home health devices with tracking capabilities such as scales and blood pressure monitors, wearable devices such as activity trackers or heart monitors, patient-reported outcome data, and other methods of input for patient and non-clinical setting generated health data. (Note: Data related to billing, payment, or other insurance information would not satisfy this measure.)
- For Measure 3, providers in non-clinical settings may include, but are not limited to, care providers such as nutritionists, physical therapists, occupational therapists, psychologists, and home health care providers. Other key providers in the care team such as behavioral health care providers, may also be included, and we encourage providers to consider ways in which this measure can incorporate this essential information from the broader care team.
- For the Patient Generated Health Data measure, the data may not be information the patient provides to the EP on location during the office visit as such data does not meet the intent of the measure to support care coordination and patient engagement in a wide range of settings outside the provider's immediate scope of practice.
- For Measure 3, we do not specify the manner in which providers are required to incorporate the data. Providers may work with their EHR developers to establish the methods and processes that work best for their practice and needs. For example, if data provided can be easily incorporated in a structured format or into an existing field within the EHR (such as a C–CDA or care team member reported vital signs or patient reported family health history and demographic information) the provider may elect to do so. Alternately, a provider may maintain an isolation between the data and the patient record and instead include the data by other means such as attachments, links, and text references again as best meets their needs.

Definition of Terms:

Application Programming Interface - A set of programming protocols established for multiple purposes. APIs may be enabled by a provider or provider organization to provide the patient with access to their health information through a third-party application with more flexibility than is often found in many current 'patient portals.'

View - The patient (or authorized representative) accessing their health information online.

Download - The movement of information from online to physical electronic media.

Transmission - This may be any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SOAP, etc.). However, the relocation of physical electronic media (for example, USB, CD) does not qualify as transmission.

Patient Generated Health Data - Data generated by a patient or a patient's authorized representative.

Data from a Non-Clinical Setting - This includes, but is not limited to, social service data, data generated by a patient or a patient's authorized representative, advance directives, medical device data, home health monitoring data, and fitness monitor data.

Secure Message - Any electronic communication between a provider and patient that ensures only those parties can access the communication. This electronic message could be email or the electronic messaging function of a PHR, an online patient portal, or any other electronic means.

Unique Patient - If a patient is seen by an EP more than once during the PI reporting period, then for purposes of measurement, that patient is only counted once in the denominator for the measure. All the measures relying on the term "unique patient" relate to what is contained in the patient's medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same PI reporting period.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(6)(i)(A) and (B). For further discussion please see **80 FR 62851**
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT as defined at § at 45 CFR 170.315(e)(1)(2) and (3).

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 Coordination of Care through Patient Engagement 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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

(*) Red asterisk indicates a required field

(*) Gray asterisk indicates a conditionally required field

Measure Entry:

Exclusion: An EP may exclude from the measure if they have no office visits during the PI reporting period.

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

○ Yes ○ No

Exclusion: Any EP that 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 PI reporting period may exclude the measure.

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

○ Yes ○ No

Complete the following information:

Numerator: The number of patients in the denominator for whom data from non-clinical settings, which may include patient-generated health data, is captured through the CEHRT into the patient record during the PI reporting period.

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

* **Numerator:**

* **Denominator:**

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 12**

Coordination of Care

☑ Measure 3

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 3 Objective 7 Measure 1 – 3 Health Information Exchange

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- For Measure 1 in order to count in the numerator, the exchange must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.
- For Measure 1, the referring EP must have reasonable certainty of receipt by the receiving provider to count the action toward the measure. An EP must have a confirmation of receipt or that a query of the summary of care record has occurred in order to count the action in the numerator.
- Apart from the three fields noted as required for the summary of care record (i.e., current problem list, current medication list, and current medication allergy list), in circumstances where there is no information available to populate one or more of the fields listed (because the EP does not record such information or because there is no information to record), the EP may leave the field(s) blank and still meet the objective and its associated measure.
- While an EP's CEHRT must be capable of sending the full consolidated clinical document architecture (C-CDA) summary of care and an EP must do so upon request, an EP may use any document template within the C-CDA HL-7 standard for purposes of meeting these measures.
- An EP must have the ability to transmit all data pertaining to laboratory test results in the summary of care document, but may work with their system developer to establish clinically relevant parameters for the most appropriate results for the given transition or referral.
- An EP who limits the transmission of laboratory test result data in a summary of care document must send the full results upon request (i.e., all lab results as opposed to a subset).
- The exchange must comply with the privacy and security protocols for electronic protected health information (ePHI) under the Health Insurance Portability and Accountability Act (HIPAA).
- In cases where the providers share access to an EHR, a transition or referral may still count toward the measure if the referring provider creates the summary of care document using CEHRT and sends the summary of care document electronically. If an EP chooses to include such transitions to providers where access to the EHR is shared, they must do so universally for all patient and all transitions or referrals.
- For Measure 1, the initiating EP must send a C–CDA document that the receiving provider would be capable of electronically incorporating as a C–CDA on the receiving end. In other words, if an EP sends a C–CDA and the receiving provider converts the C–CDA into a pdf, a fax, or some other format, the sending EP may still count the transition or referral in the numerator. If the sending provider converts the file to a format the receiving provider could not electronically receive and incorporate as a C–CDA, the initiating EP may not count the transition in their numerator.
- For the purposes of defining the cases in the denominator for Measure 2, we stated that what constitutes "unavailable" and, therefore, may be excluded from the denominator, will be that a provider:
  - Requested an electronic summary of care record to be sent and did not receive an electronic summary of care document; and
  - The provider either:
    - Queried at least one external source via HIE functionality and did not locate a summary of care for the patient, or the provider does not have access to HIE functionality to support such a query, or
    - Confirmed that HIE functionality supporting query for summary of care documents was not operational in the provider's geographic region and not available within the provider's EHR network as of the start of the PI reporting period.
- For Measure 2, a record cannot be considered incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for EP use within the EHR.
- For Measure 3, the process may include both automated and manual reconciliation to allow the receiving EP to work with both the electronic data provided with any necessary review, and to work directly with the patient to reconcile their health information.
- For Measure 3, if no update is necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received on referral and determining that such information is merely duplicative of existing information in the patient record.
- Non-medical staff may conduct reconciliation under the direction of the EP so long as the EP or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant clinical decision support alert.

Definition of Terms:

Transition of Care - The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

Summary of Care Record - All summary of care documents used to meet this objective must include the following information if the provider knows it:

- Patient name
- Referring or transitioning provider's name and office contact information (EP only)
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral (EP only)
- Current problem list (Providers may also include historical problems at their discretion)*
- Current medication list*
- Current medication allergy list*

* Note: An EP must verify that the fields for current problem list, current medication list, and current medication allergy list are not blank and include the most recent information known by the EP as of the time of generating the summary of care document or include a notation of no current problem, medication and/or medication allergies.

Current problem lists - At a minimum a list of current and active diagnoses.

Active/current medication list - A list of medications that a given patient is currently taking.

Active/current medication allergy list - A list of medications to which a given patient has known allergies.

Allergy - An exaggerated immune response or reaction to substances that are generally not harmful.

Care Plan - The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).

Stage 3
Screens 13 - 15

Health Information Exchange

Additional Information and Definition of Terms applicable to:

☑ Measure 1

☑ Measure 2

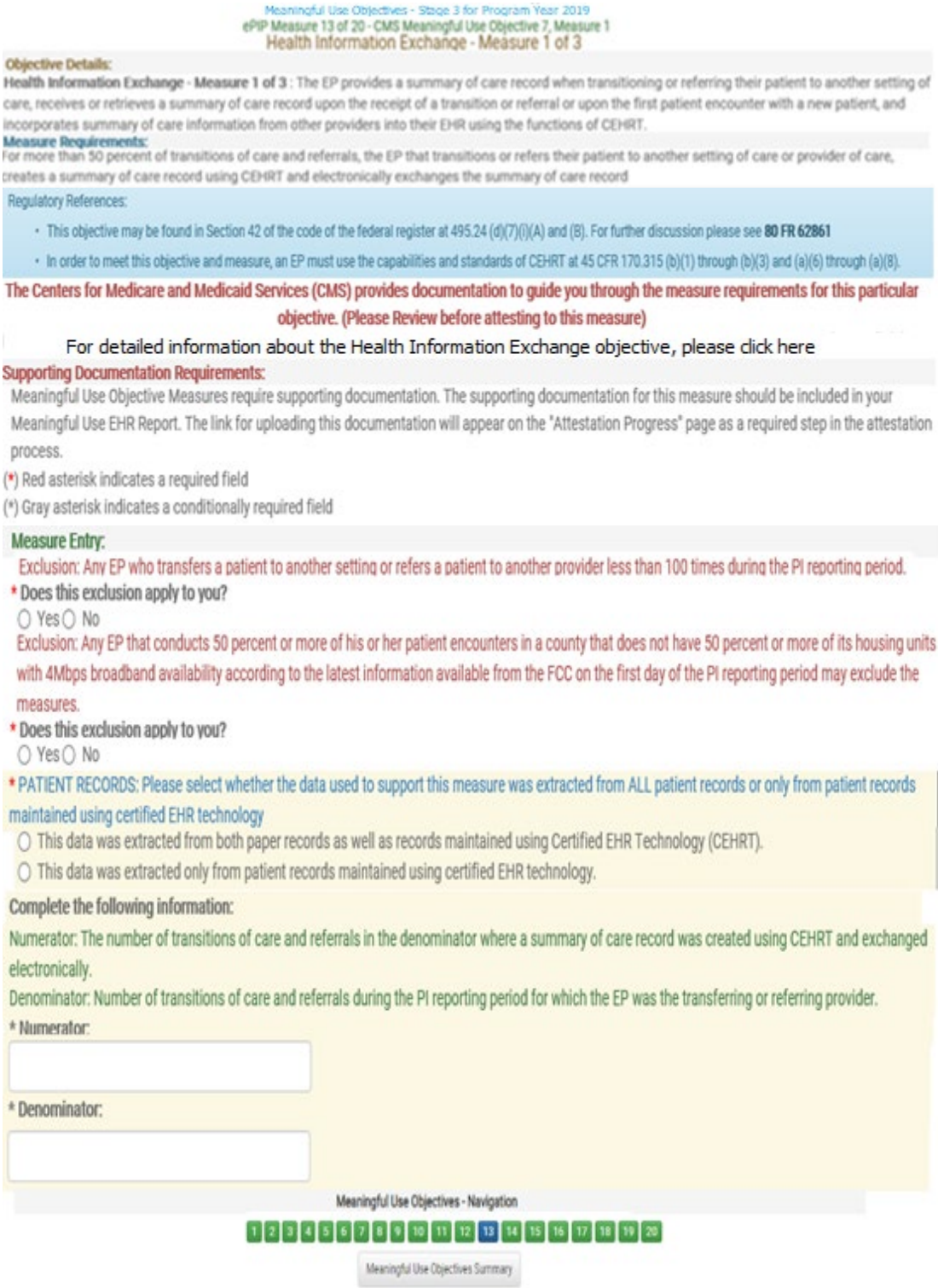
☑ Measure 3

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.

Stage 3 Objective 7 Measure 1 Health Information Exchange


Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 13 of 20 - CMS Meaningful Use Objective 7, Measure 1
Health Information Exchange - Measure 1 of 3

Objective Details:
Health Information Exchange - Measure 1 of 3 : The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

Measure Requirements:
For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care, creates a summary of care record using CEHRT and electronically exchanges the summary of care record

Regulatory References:
- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(7)(i)(A) and (B). For further discussion please see **80 FR 62861**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (b)(1) through (b)(3) and (a)(6) through (a)(8).

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

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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step 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 PI reporting period.
* Does this exclusion apply to you?
○ Yes ○ No
Exclusion: Any EP that 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 PI reporting period may exclude the measures.
* 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 PI 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 17 18 19 20
Meaningful Use Objectives Summary

Stage 3 **Screen 13**

Health Information Exchange

☑ Measure 1

Complete all required fields.

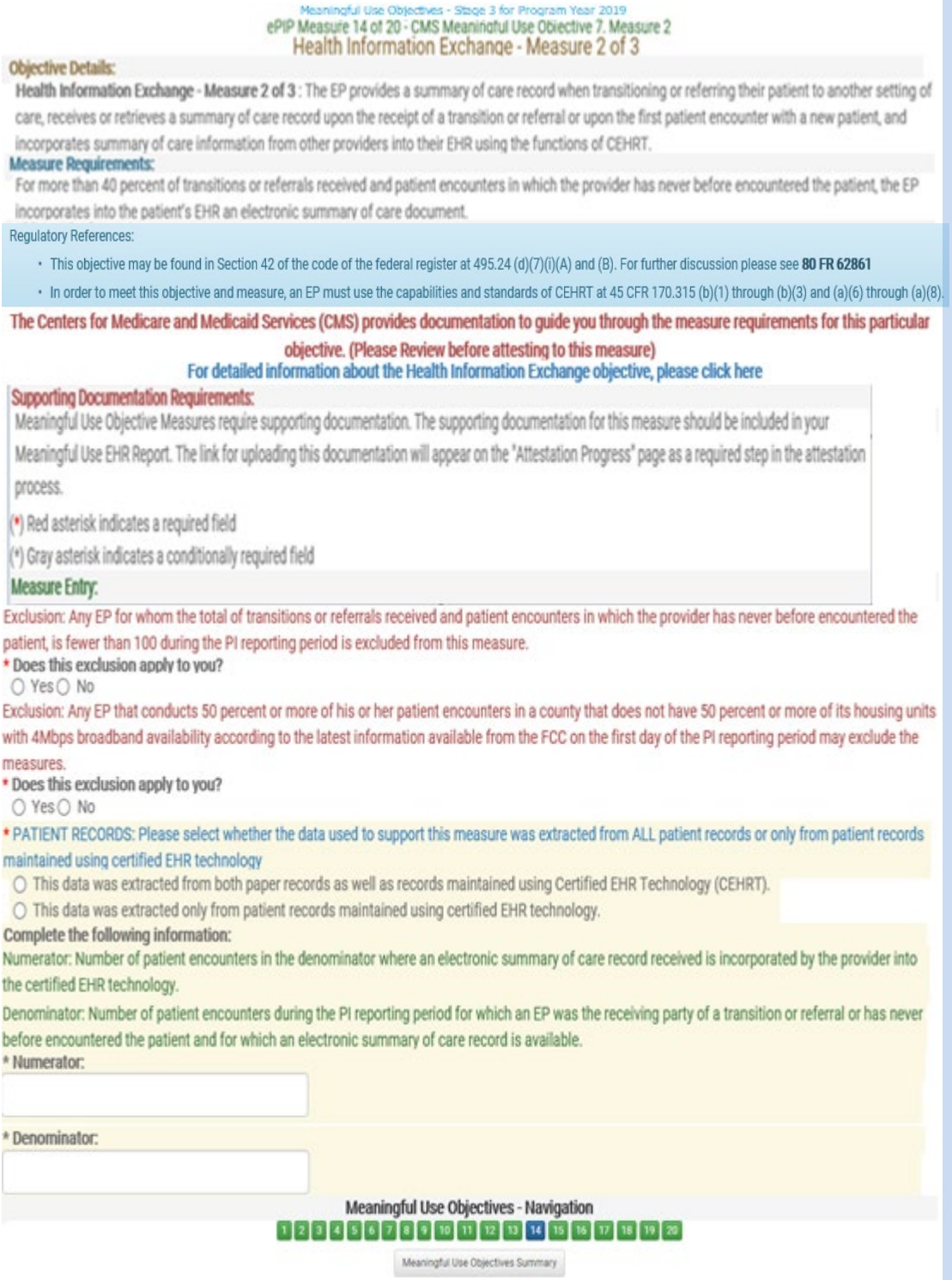
If you select the exclusions, you must upload documentation to support that separately.

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 3 Objective 7 Measure 2 Health Information Exchange


Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 14 of 20 - CMS Meaningful Use Objective 7, Measure 2
Health Information Exchange - Measure 2 of 3

Objective Details:

Health Information Exchange - Measure 2 of 3 : The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

Measure Requirements:

For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(7)(i)(A) and (B). For further discussion please see **80 FR 62861**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (b)(1) through (b)(3) and (a)(6) through (a)(8).

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

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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

(*) Red asterisk indicates a required field

(*) Gray asterisk indicates a conditionally required field

Measure Entry:

Exclusion: Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.

* Does this exclusion apply to you?

○ Yes ○ No

Exclusion: Any EP that 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 PI reporting period may exclude the measures.

* 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 patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the certified EHR technology.

Denominator: Number of patient encounters during the PI reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 14**

Health Information Exchange

☑ Measure 2

Complete all required fields.

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

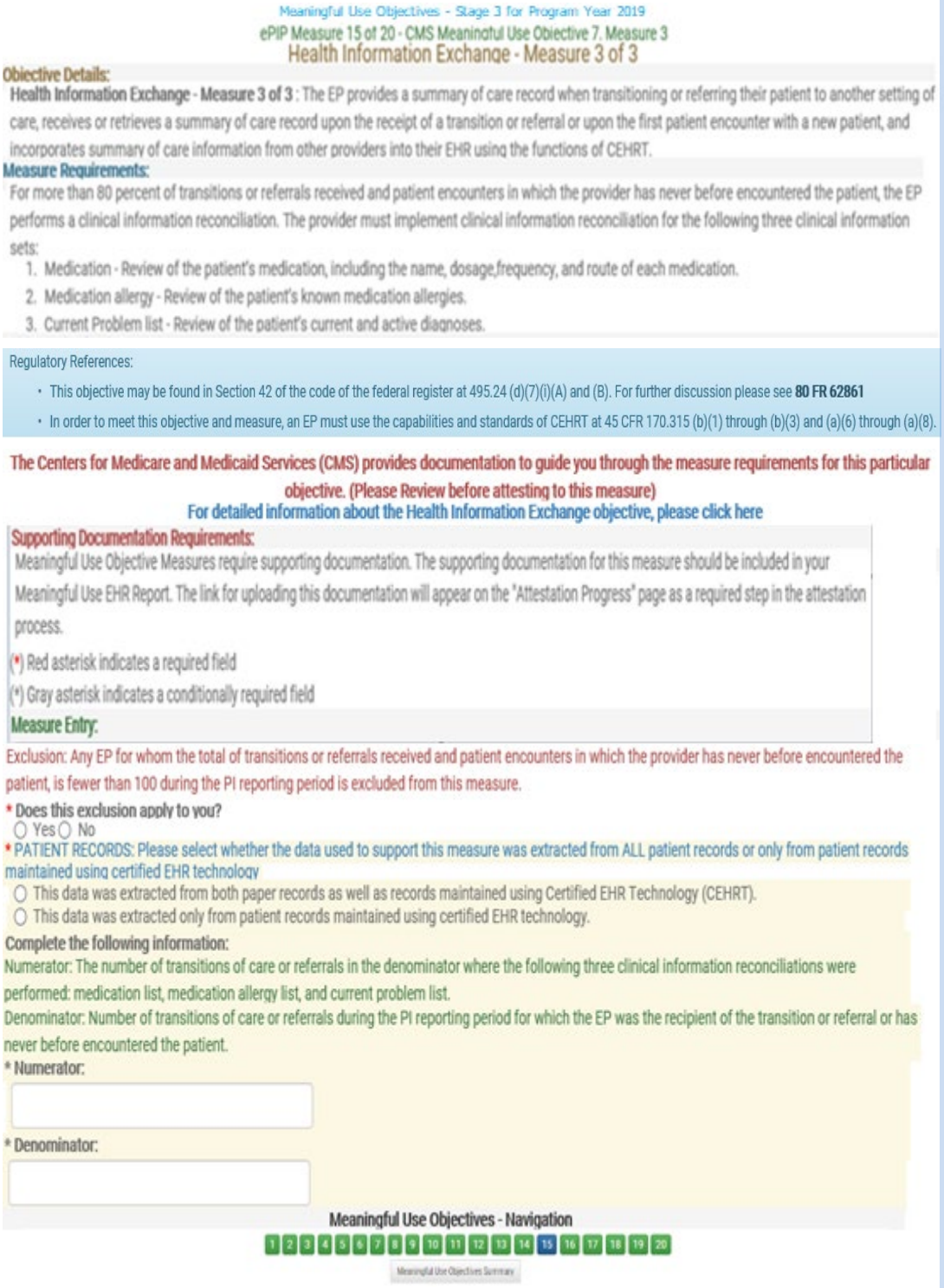
If you are in active engagement to submit immunization data to a public health agency, you must upload documentation to support that separately.

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 3 Objective 7 Measure 3 Health Information Exchange



Meaningful Use Objectives - Stage 3 for Program Year 2019

ePIP Measure 15 of 20 - CMS Meaningful Use Objective 7, Measure 3

Health Information Exchange - Measure 3 of 3

Objective Details:

Health Information Exchange - Measure 3 of 3 : The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

Measure Requirements:

For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets:

1. Medication - Review of the patient's medication, including the name, dosage,frequency, and route of each medication.
2. Medication allergy - Review of the patient's known medication allergies.
3. Current Problem list - Review of the patient's current and active diagnoses.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(7)(i)(A) and (B). For further discussion please see **80 FR 62861**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (b)(1) through (b)(3) and (a)(6) through (a)(8).

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

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. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

(*) Red asterisk indicates a required field

(*) Gray asterisk indicates a conditionally required field

Measure Entry:

Exclusion: Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the PI reporting period is excluded from this measure.

* 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 or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.

Denominator: Number of transitions of care or referrals during the PI reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 15**

Health Information Exchange

☑ 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 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 3 Objective 8 Measure 1 – 5 Public Health and Clinical Data Registry Reporting

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- EPs must attest to *at least two measures* from the Public Health Reporting Objective.
- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP needs to meet two of the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of available measures is less than two, the EP can meet the objective by meeting all of the remaining available measures and claiming the applicable exclusions. Available measures are ones for which the EP does not qualify for an exclusion.
- For Measure 1, an EP's CEHRT may layer additional information on the immunization history,forecast, and still successfully meet this measure.
- Bi-directionality provides that CEHRT must be able to receive and display a consolidated immunization history and forecast in addition to sending the immunization record.
- For Measure 1, non-vaccinating EPs can meet the measure if they query and receive results(i.e., the consolidated immunization record and forecast) from the IIS and integrate the data into their CEHRT, in accordance with HL7 Version 2.5.1: Implementation Guide forImmunization Messaging, Release 1.5 (October 2014). A non-vaccinating provider may also submit historical immunizations provided from another source; however, this alone would not meet the measure.
- For Measure 1, the exclusion does not apply if an entity designated by the immunization registry or IIS can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by CEHRT,but has designated a Health Information Exchange (HIE) to do so on their behalf, and the HIEis capable of accepting the information in the standards required by CEHRT, the EP could not claim the second exclusion.
- For Measure 2, the exclusion does not apply if an entity designated by the PHA can receive electronic syndromic surveillance data submissions. For example, if the PHA cannot accept the data directly or in the standards required by CEHRT, but has designated an HIE to do so on their behalf, and the HIE is capable of accepting the information in the standards required by CEHRT, the EP could not claim the second exclusion.
- For Measure 4, EPs may choose to report to more than one public health registry to meet the number of measures required to meet the objective.
- For Measure 4, an EP may count a specialized registry (such as prescription drug monitoring)if the EP achieved Active Engagement Option 3 in a prior year under the applicable requirements of the PI Programs for that year.
- For Measure 5, EPs may choose to report to more than one CDR to meet the number of measures required to meet the objective.
- For Measure 5, the definition of jurisdiction is general, and the scope may be at the local,state, regional, or national level. The definition will be dependent on the type of registry to which the EP is reporting. A registry that is borderless would be considered a registry at the national level and would be included for purposes of this measure.
- For Measures 4 and 5, if the PHA or CDR does not use a specified standard, it must use another standard specified in 170.205 to meet the measure. For example, the transmission could be in the form of a Consolidated Clinical Document Architecture (C-CDA) per 170.205(a)(4), or Quality Reporting Document Architecture (QRDA) per 170.205(h)(2). If an EP practices in a jurisdiction where no PHA or CDR for which they are eligible to submit data has declared readiness to receive electronic registry transactions in accordance with the 2015 Edition standards as of six months prior to the start of the EHR reporting period, they may take an exclusion from these measures, as appropriate.
- EPs who have previously registered, tested, or begun ongoing data submission to a registry do not need to restart the process beginning at Active Engagement Option 1. The EP may simply attest to the active engagement option which most closely reflects their current status.
- For the first exclusion of each measure, the registries in question are those sponsored by the PHAs with jurisdiction over the area where the EP practices and national medical societies covering the EP's scope of practice. Therefore, an EP must complete two actions in order to find available registries or claim an exclusion:
  - Determine if the jurisdiction (state, territory, etc.) endorses or sponsors a registry; and,
  - Determine if a National Specialty Society or other specialty society with which the provider is affiliated endorses or sponsors a registry.
- If a provider is part of a group which submits data to a registry, but the provider does not contribute to that data (for example they do not administer immunizations), the provider should not attest to meeting the measure but instead should select the exclusion. The provider may then select a different more relevant measure to meet.
- If a provider does the action that results in a data element for a registry in the normal course of their practice and is in active engagement to submit to a registry, but simply has no cases for the reporting period, the provider is not required to take the exclusion and may attest to meeting the measure.
- CMS has published a centralized repository for public health agency (PHA) and clinical data registry (CDR) reporting. That centralized registry is available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/CentralizedRepository-html

Definition of Terms:

Active engagement means that the provider is in the process of moving towards sending "production data" to a public health agency or clinical data registry, or is sending production data to a public health agency or clinical data registry.

Active Engagement Option 1 - Completed Registration to Submit Data: The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the PI reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each PI reporting period.

Active Engagement Option 2 - Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an PI reporting period would result in that provider not meeting the measure.

Active Engagement Option 3 – Production: The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

Production data refers to data generated through clinical processes involving patient care, and it is used to distinguish between data and "test data" which may be submitted for the purposes of enrolling in and testing electronic data transfers.

Stage 3
Screens 16 - 20

Public Health and Clinical Data Registry Reporting

Additional Information and Definition of Terms applicable to:

☑ Measure 1

☑ Measure 2

☑ Measure 3

☑ Measure 4

☑ Measure 5

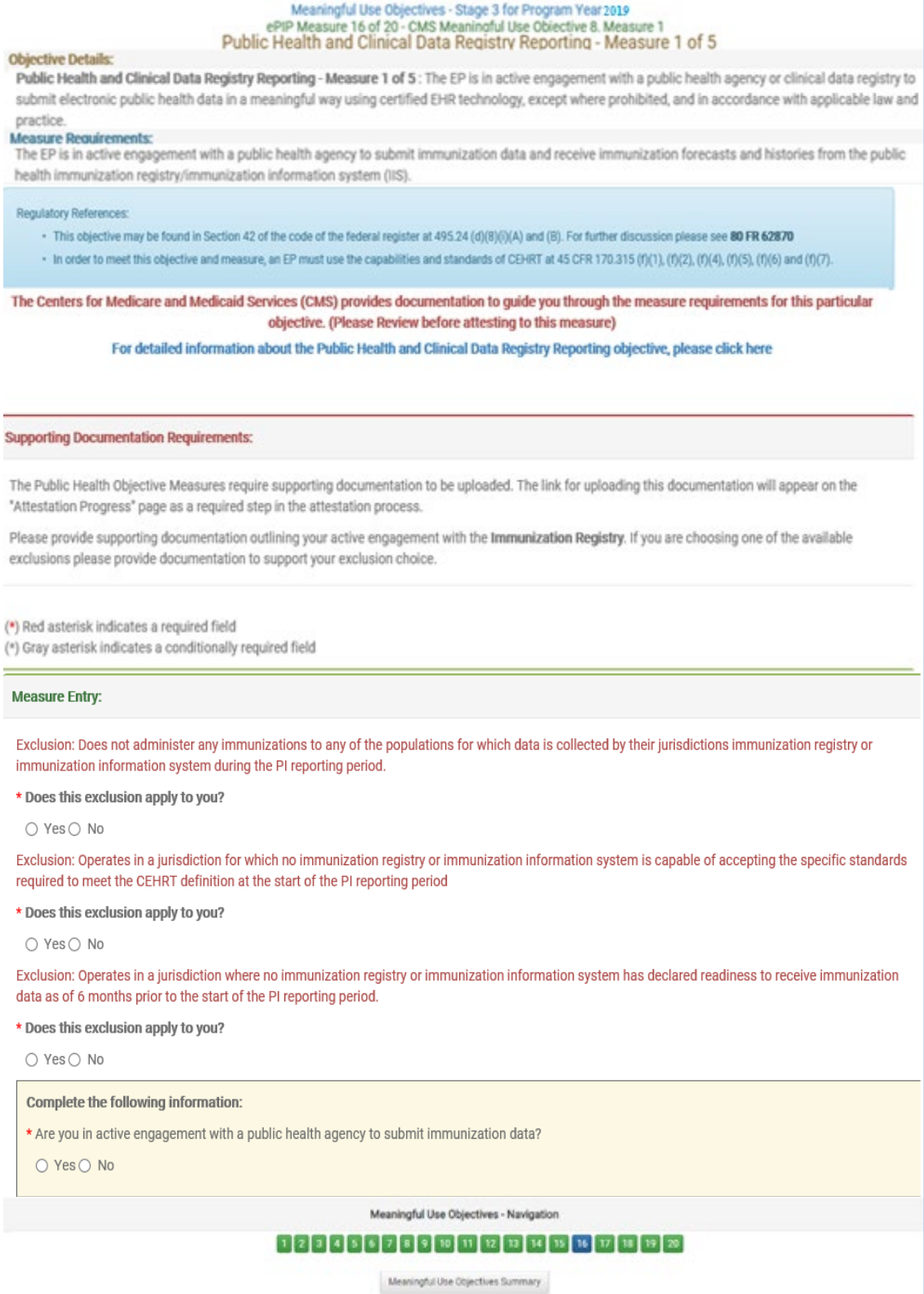
Complete all required fields.

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.

Stage 3 Objective 8 Measure 1 Public Health and Clinical Data Registry Reporting



Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 16 of 20 - CMS Meaningful Use Objective 8, Measure 1
Public Health and Clinical Data Registry Reporting - Measure 1 of 5

Objective Details:

Public Health and Clinical Data Registry Reporting - Measure 1 of 5 : The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Measure Requirements:

The EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(8)(i)(A) and (B). For further discussion please see **80 FR 62870**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (f)(1), (f)(2), (f)(4), (f)(5), (f)(6) and (f)(7).

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 and Clinical Data Registry Reporting objective, 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: Does not administer any immunizations to any of the populations for which data is collected by their jurisdictions immunization registry or immunization information system during the PI reporting period.

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

Yes No

Exclusion: 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 PI reporting period

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

Yes No

Exclusion: Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the PI 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 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 16**

Public Health and Clinical Data Registry Reporting

☑ Measure 1

Complete all required fields.

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

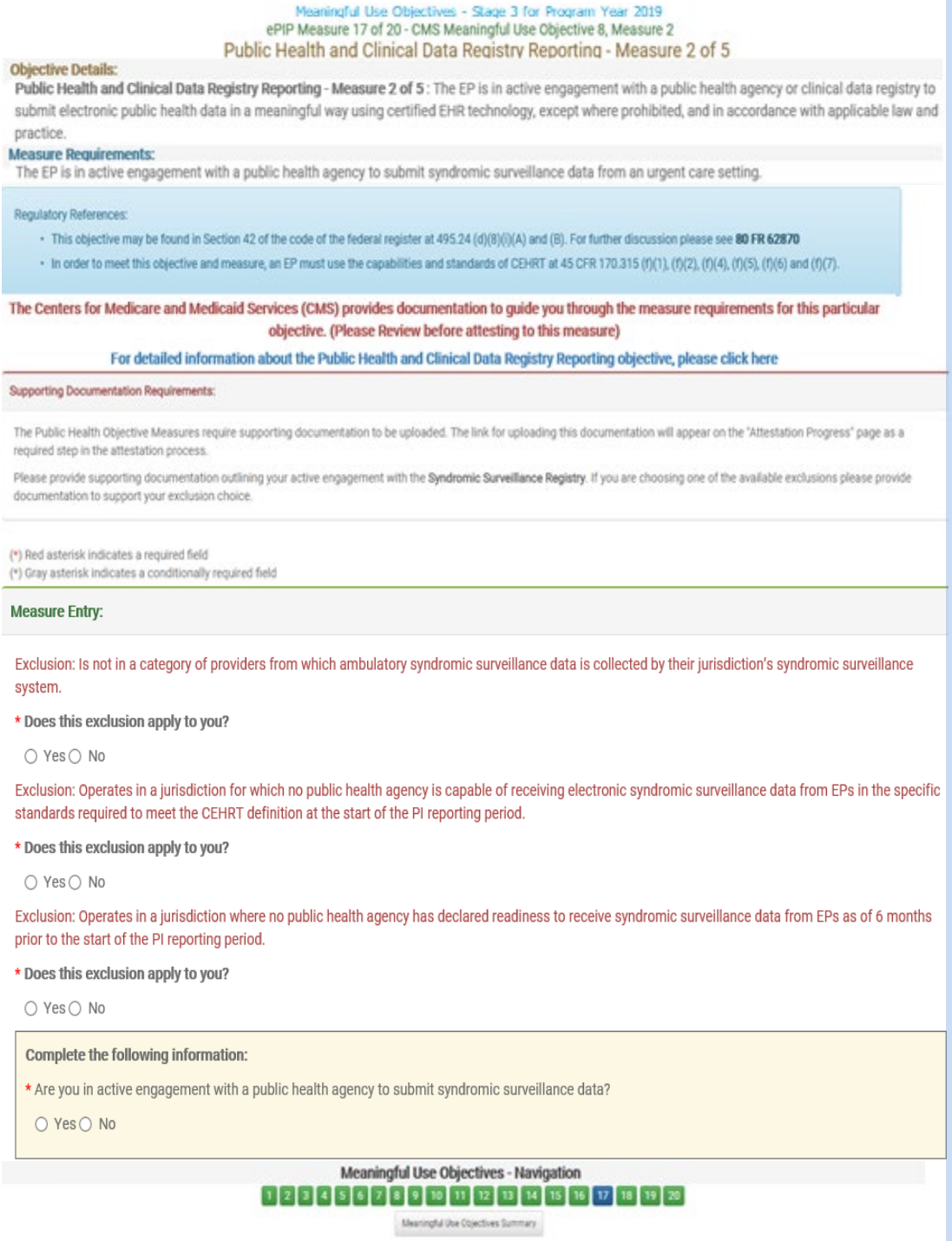
If you are in active engagement to submit data to a specialized registry, you must upload documentation to support that separately.

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.

Stage 3 Objective 8 Measure 2 Public Health and Clinical Data Registry Reporting


Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 17 of 20 - CMS Meaningful Use Objective 8, Measure 2
Public Health and Clinical Data Registry Reporting - Measure 2 of 5

Objective Details:

Public Health and Clinical Data Registry Reporting - Measure 2 of 5: The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Measure Requirements:

The EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(8)(i)(A) and (B). For further discussion please see **80 FR 62870**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (f)(1), (f)(2), (f)(4), (f)(5), (f)(6) and (f)(7).

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 and Clinical Data Registry Reporting objective, 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: Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system.

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

○ Yes ○ No

Exclusion: 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 PI reporting period.

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

○ Yes ○ No

Exclusion: Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs as of 6 months prior to the start of the PI 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 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 17**

Public Health and Clinical Data Registry 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 immunization data to a public health agency, you must upload documentation to support that separately.

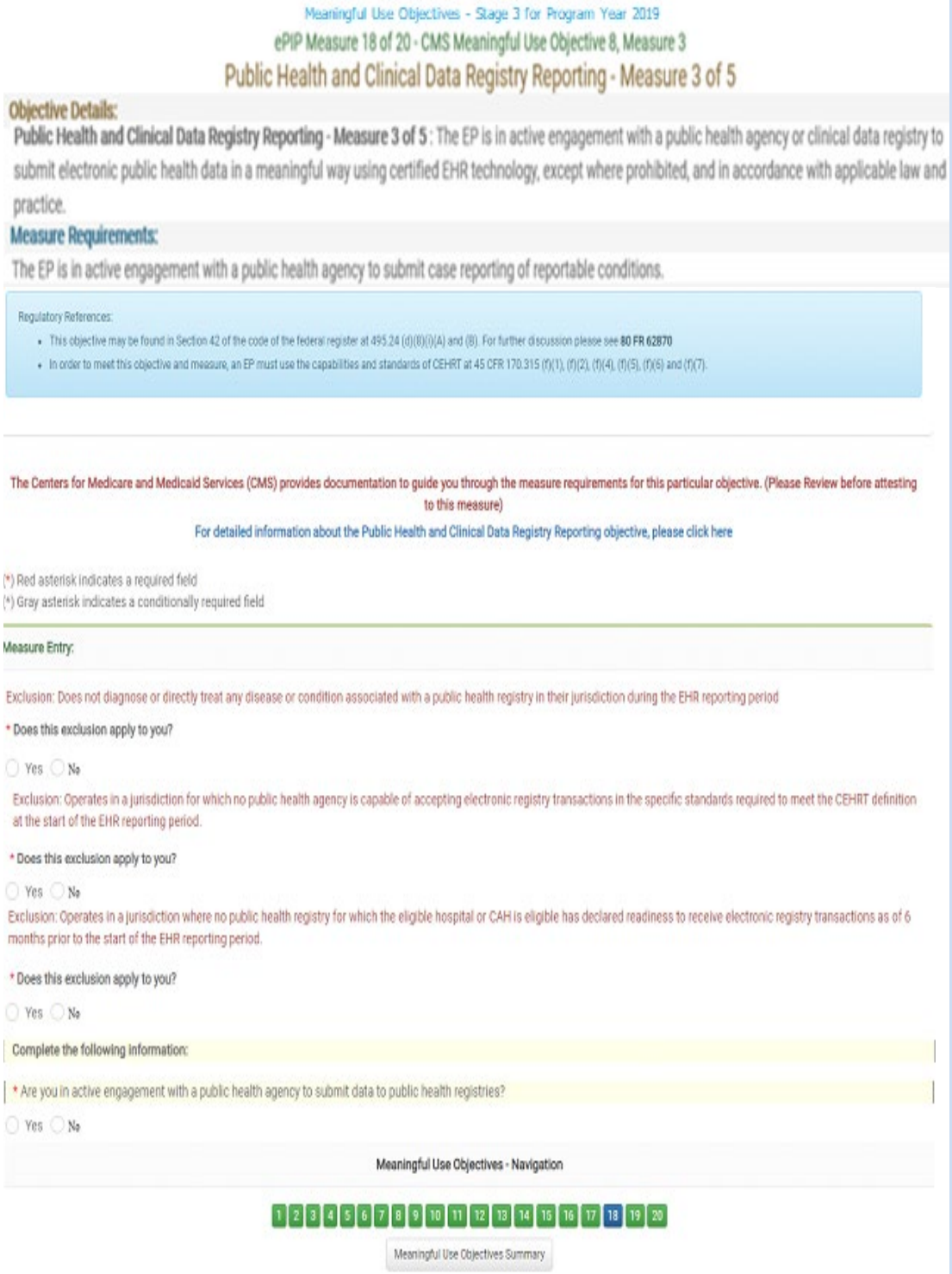
The Navigation bar at the bottom will monitor your progress.

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 3 Objective 8 Measure 3 Public Health and Clinical Data Registry Reporting



Stage 3 **Screen 18**

Public Health and Clinical Data Registry Reporting

☑ Measure 3

Complete all required fields.

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

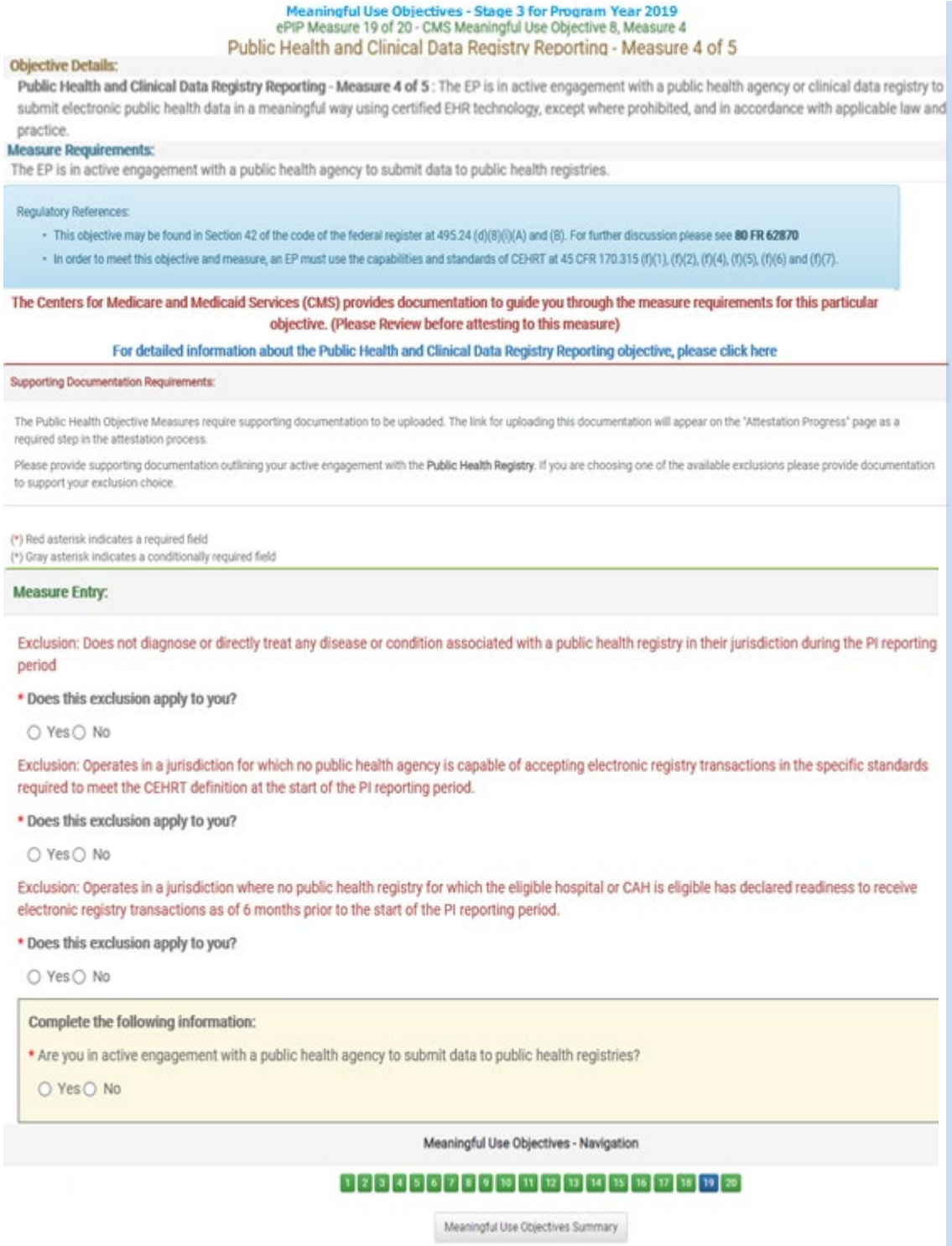
If you are in active engagement to submit immunization data to a public health agency, you must upload documentation to support that separately.

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 3 Objective 8 Measure 4 Public Health and Clinical Data Registry Reporting


Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 19 of 20 - CMS Meaningful Use Objective 8, Measure 4
Public Health and Clinical Data Registry Reporting - Measure 4 of 5

Objective Details:

Public Health and Clinical Data Registry Reporting - Measure 4 of 5 : The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Measure Requirements:

The EP is in active engagement with a public health agency to submit data to public health registries.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(8)(i)(A) and (B). For further discussion please see 80 FR 62870
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (f)(1), (f)(2), (f)(4), (f)(5), (f)(6) and (f)(7).

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 and Clinical Data Registry Reporting objective, 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 Public Health 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: Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the PI reporting period

* Does this exclusion apply to you?

Yes No

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

* Does this exclusion apply to you?

Yes No

Exclusion: Operates in a jurisdiction where no public health registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the PI 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 data to public health registries?

Yes No

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 19**

Public Health and Clinical Data Registry Reporting

☑ Measure 4

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.

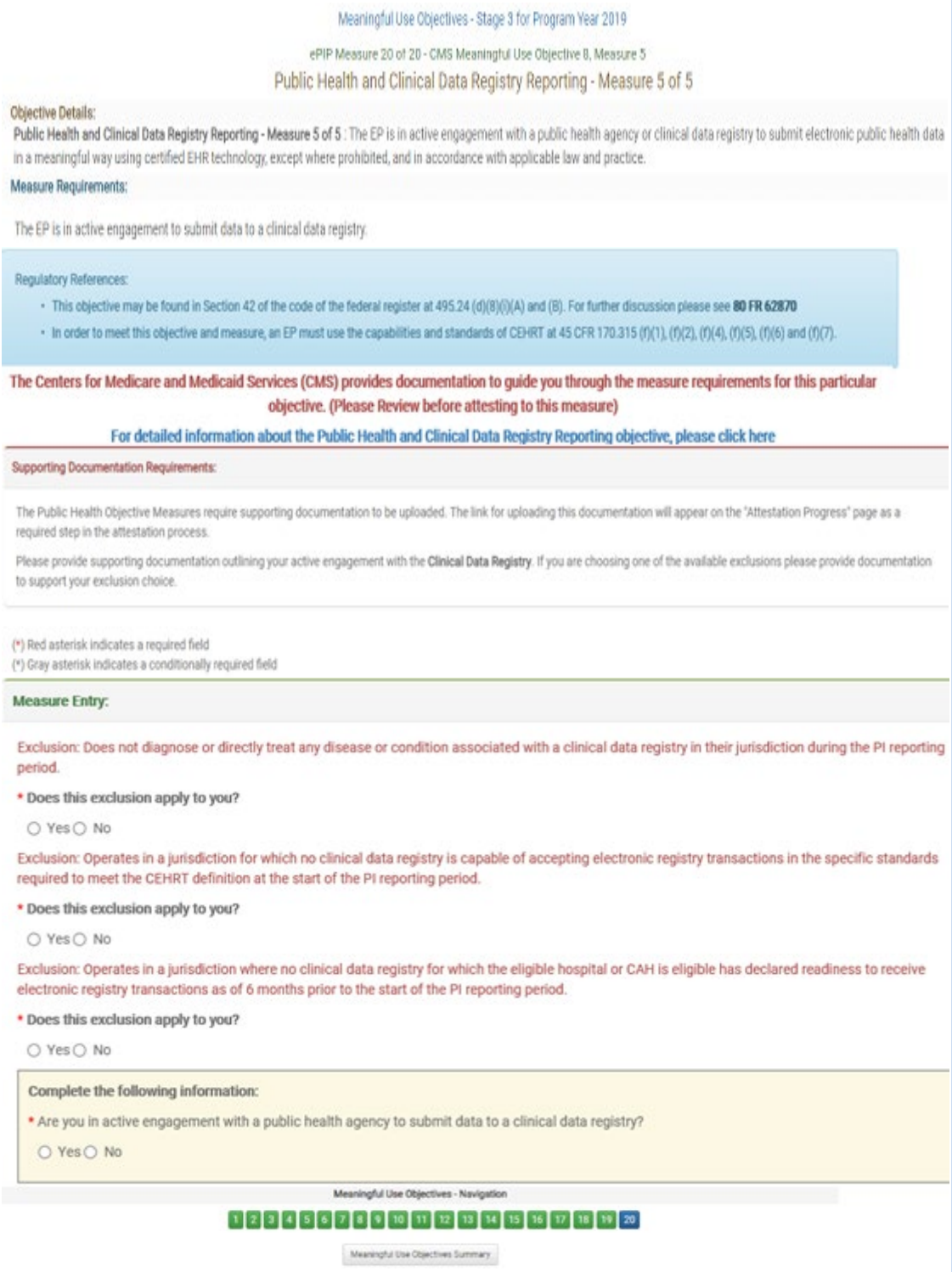
The Navigation bar at the bottom will monitor your progress.

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 3 Objective 8 Measure 5 Public Health and Clinical Data Registry Reporting



Meaningful Use Objectives - Stage 3 for Program Year 2019

ePIP Measure 20 of 20 - CMS Meaningful Use Objective 8, Measure 5

Public Health and Clinical Data Registry Reporting - Measure 5 of 5

Objective Details:

Public Health and Clinical Data Registry Reporting - Measure 5 of 5 : The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Measure Requirements:

The EP is in active engagement to submit data to a clinical data registry.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(8)(i)(A) and (B). For further discussion please see **80 FR 62870**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (f)(1), (f)(2), (f)(4), (f)(5), (f)(6) and (f)(7).

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 and Clinical Data Registry Reporting objective, 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 **Clinical Data 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: Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the PI reporting period.

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

○ Yes ○ No

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

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

○ Yes ○ No

Exclusion: Operates in a jurisdiction where no clinical data registry for which the eligible hospital or CAH is eligible has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the PI 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 data to a clinical data registry?

○ Yes ○ No

Meaningful Use Objectives - Navigation

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary

Stage 3 **Screen 20**

Public Health and Clinical Data Registry Reporting

☑ Measure 5

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.

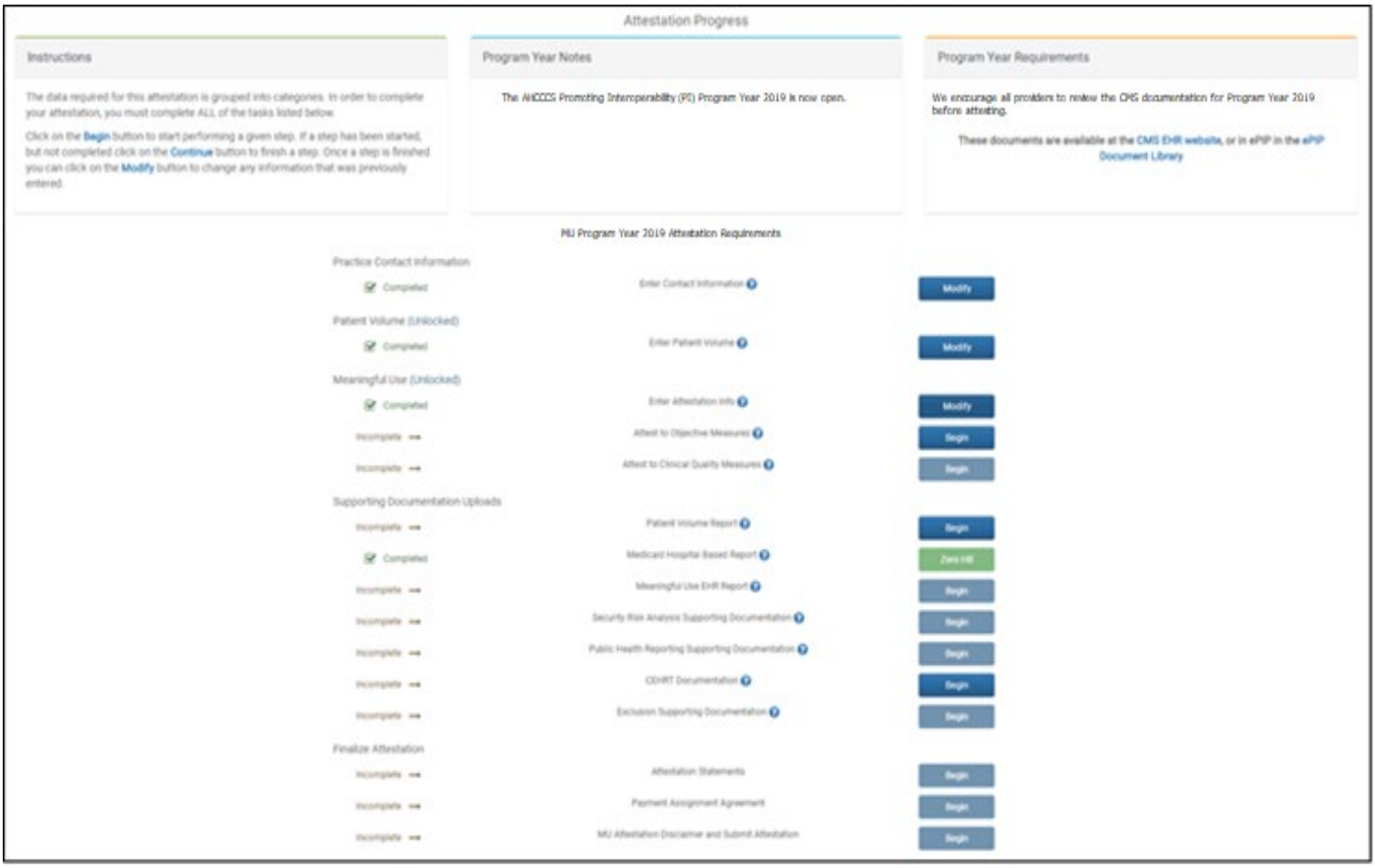
The Navigation bar at the bottom will monitor your progress.

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.

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 eCQMs Available**
1	Person and Caregiver-Centered Experience and Outcomes	4
2	Patient Safety	5
3	Communication and Care Coordination	1
4	Community/Population Health	10
5	Efficiency and Cost Reduction	4
6	Effective Clinical Care	26

Clinical Quality Measures (eCQMs) Selection:

eCQMs Criteria:
Providers are required to report on 6 of 50 separate eCQMs from any of the National Quality Strategy domains.

Select eCQM Reporting Period:
☑ 90 days for first time MU
☑ 365 days for returning MU

All reporting periods are from 2019

Select your eCQMs:

☑ At least 1 Outcome Measure

☑ At least 1 High Priority Measure

☑ Then other Relevant Measures to your scope of practice

If the certified EHR technology system 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.

Click the hyperlink on the ePIP screen to learn more about the requirements.

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

Person and Caregiver-Centered Experience and Outcomes

Objective	Measure	Selected
H **CMS 157v7 \ 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	☐
H **CMS 66v7** - Functional Status Assessment for Total Knee Replacement	Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery	☐
H **CMS 56v7** - Functional Status Assessment for Total Hip Replacement	Percentage of patients 18 years of age and older who received an elective primary total hip arthroplasty (THA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery	☐
H **CMS 90v8** - Functional Status Assessments for Congestive Heart Failure	Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments	☐

Person and Caregiver-Centered Experience & Outcomes

4 of 50 CQMs are available under this domain.

Select your eCQMs:

☑ At least 1 Outcome Measure

☑ At least 1 High Priority Measure

☑ Then other Relevant Measures to your scope of practice

Measure Codes:

O - Outcome Measure

H - High Priority Measure

A - Adult Core Measure

C - Child Core Measure

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.

Clinical Quality Measures for Patient Safety

Patient Safety

Objective	Measure	Selected
H CMS 156v7 \ NQF0022 - Use of High-Risk Medications in the Elderly	Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported. • Percentage of patients who were ordered at least one high-risk medication. • Percentage of patients who were ordered at least two of the same high-risk medications.	☐
H CMS 139v7 \ 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.	☐
H CMS 68v8 \ 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.	☐
O H CMS 132v7 \ NQF 0564 - Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional 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 177v7 \ 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

5 of 50 CQMs are available under this domain.

Select your eCQMs:

☑ At least 1 Outcome Measure

☑ At least 1 High Priority Measure

☑ Then other Relevant Measures to your scope of practice

Measure Codes:

O - Outcome Measure

H - High Priority Measure

A - Adult Core Measure

C - Child Core Measure

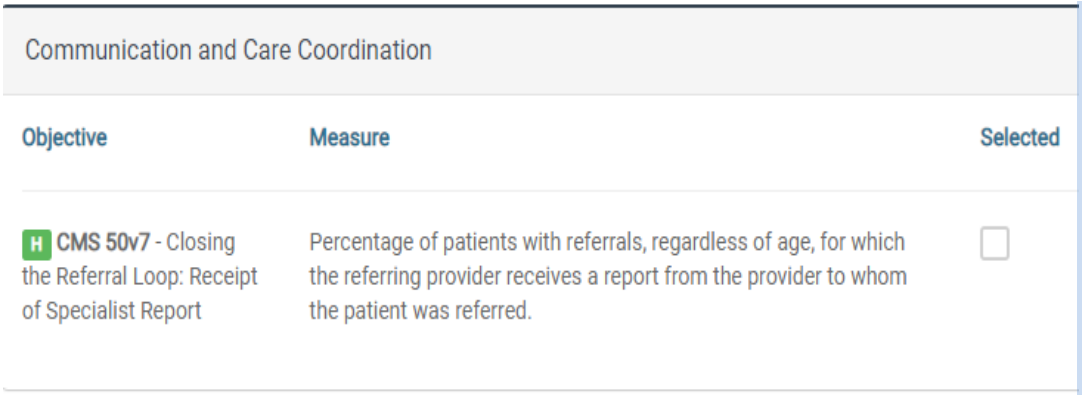
The Navigation bar at the bottom will monitor your progress.

TIP

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

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

1 of 50 CQMs is available under this domain.

Select your eCQMs:

☑ At least 1 Outcome Measure

☑ At least 1 High Priority Measure

☑ Then other Relevant Measures to your scope of practice

Measure Codes:

O - Outcome Measure

H - High Priority Measure

A - Adult Core Measure

C - Child Core Measure

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.

Clinical Quality Measures for Community / Population Health

Community/Population Health

Objective	Measure	Selected
C CMS 155v7 \ 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 138v7 \ 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. Three Rates are Reported: • Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months. • Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco 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 tobacco cessation intervention if identified as a tobacco user.	☐
A C CMS 153v7 \ 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 117v7 \ 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	☐

Community / Population Health

10 of 50 CQMs are available under this domain.

Select your eCQMs:

☑ At least 1 Outcome Measure

☑ At least 1 High Priority Measure

☑ Then other Relevant Measures to your scope of practice

Measure Codes:

O - Outcome Measure

H - High Priority Measure

A - Adult Core Measure

C - Child Core Measure

The Navigation bar at the bottom will monitor your progress.

TIP

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

Clinical Quality Measures for Community / Population Health - Continued

CMS 147v8 \ 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.	☐
A C **CMS 2v8 \ 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 69v7 \ NQF 0421 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2	☐
CMS 82v6 \ 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 22v7 - 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.	☐
CMS 349v1 - HIV Screening	Percentage of patients 15-65 years of age who have been tested for HIV within that age range	☐

Community / Population Health

10 of 50 CQMs are available under this domain.

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☑ At least 1 Outcome Measure

☑ At least 1 High Priority Measure

☑ Then other Relevant Measures to your scope of practice

Measure Codes:

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H - High Priority Measure

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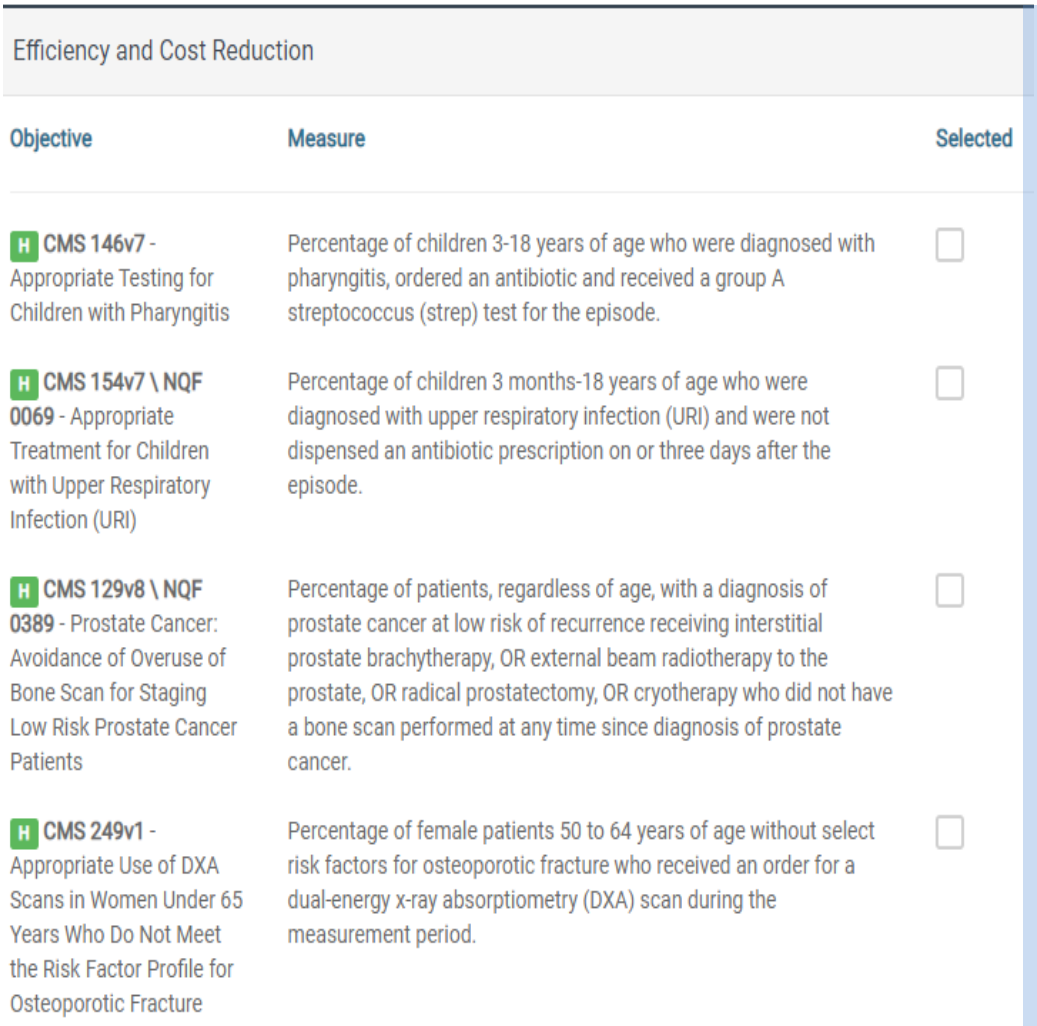
Clinical Quality Measures for Efficiency and Cost Reduction



Efficiency and Cost Reduction

Objective	Measure	Selected
H CMS 146v7 - Appropriate Testing for Children with Pharyngitis	Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	☐
H CMS 154v7 \ 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.	☐
H CMS 129v8 \ 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.	☐
H CMS 249v1 - Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture	Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.	☐

Efficiency and Cost Reduction

4 of 50 CQMs are available under this domain.

Select your eCQMs:

☑ At least 1 Outcome Measure

☑ At least 1 High Priority Measure

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Clinical Quality Measures for Effective Clinical Care

Effective Clinical Care

Objective	Measure	Selected
A CMS 137v7 \ 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: • Percentage of patients who initiated treatment within 14 days of the diagnosis. • 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.	☐
O H A CMS 165v7 \ 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.	☐
A CMS 125v7 \ NQF 2372 - Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	☐
CMS 124v7 \ NQF 0032 - Cervical Cancer Screening	Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: • Women age 21-64 who had cervical cytology performed every 3 years. • Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.	☐
CMS 130v7 \ NQF 0034 - Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	☐
CMS 127v7 \ 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 131v7 \ 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

26 of 50 CQMs are available under this domain.

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Clinical Quality Measures for Effective Clinical Care - Continued

O H A **CMS 122v7 \ NQF 0059** - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
CMS 134v7 \ NQF 0062 - Diabetes: Medical Attention for Nephropathy	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 145v7 \ 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 135v7 \ 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.
CMS 144v7 \ 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 143v7 \ 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.

Effective Clinical Care

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Clinical Quality Measures for Effective Clinical Care - Continued

H **CMS 142v7 \ 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 161v7 \ NQF 0104 - Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified
A **CMS 128v7 \ 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. • Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). • Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).
C **CMS 136v8 \ NQF 0108** - Follow-Up Care for Children Prescribed ADHD Medication (ADD)	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. • Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. • 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 52v7 \ 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.

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Clinical Quality Measures for Effective Clinical Care - Continued

O H **CMS 133v7 \ 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.	☐
O H **CMS 159v7 \ 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.	☐
CMS 160v7 \ 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.	☐
O H **CMS 75v7** - 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 74v8 - 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 149v7 - 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.	☐

Effective Clinical Care

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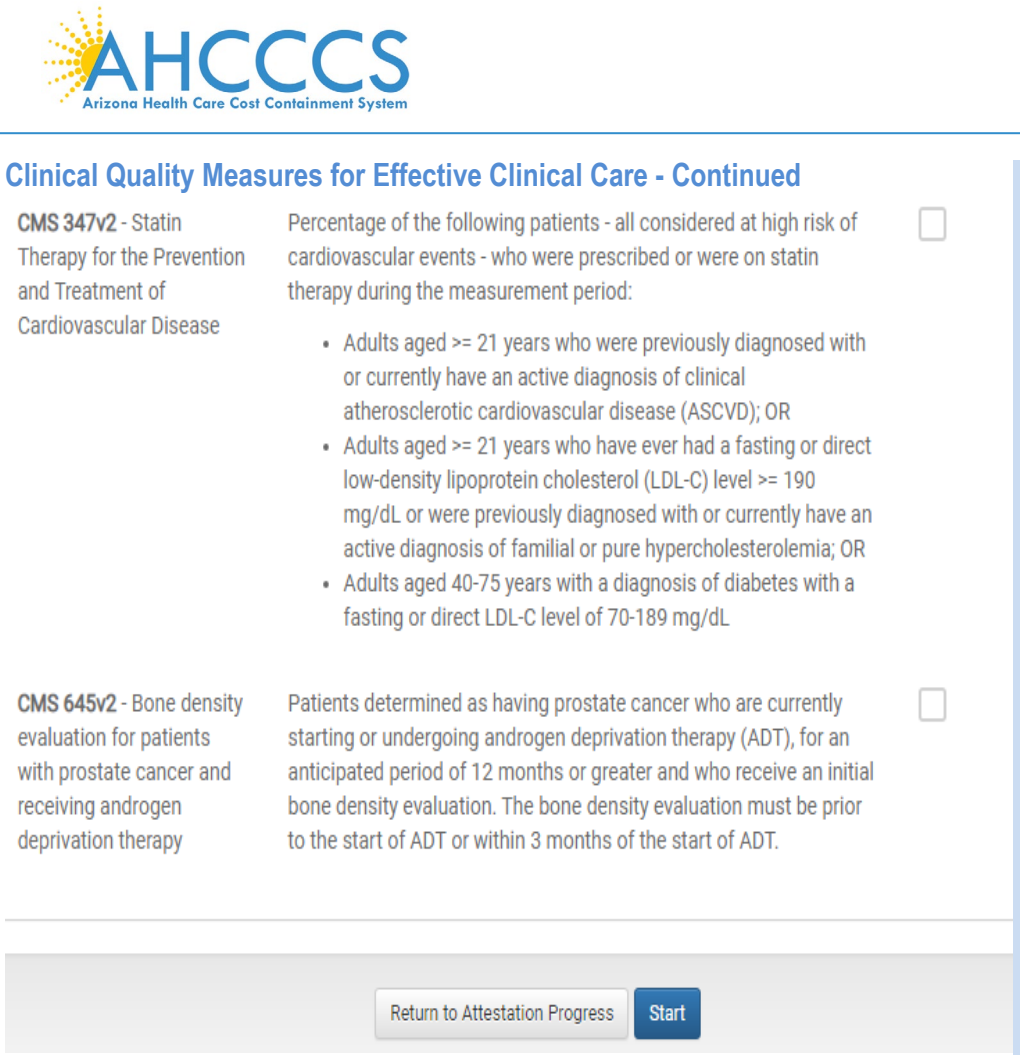

Effective Clinical Care

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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
J	Webinars for Eligible Professionals

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 Promoting Interoperability Program's as they demonstrate adoption, implementation, upgrade (AIU), or meaningful use of EHR technology. *AIU attestations are not available after 2016.*

Promoting Interoperability (PI)

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 Promoting Interoperability automates and streamlines the clinician's workflow. The Promoting Interoperability 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 Promoting Interoperability (PI) 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 Promoting Interoperability 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 Registration

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 Promoting Interoperability program?**
	Eligible Professionals (EPs) in the Medicaid Promoting Interoperability (PI) 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 Promoting Interoperability (PI) 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 Promoting Interoperability (PI) Programs.
Q4	**Is my practice eligible to apply & receive payments through the Medicare and Medicaid Promoting Interoperability (PI) 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 Promoting Interoperability Payments be subject to audit?**
	Incentive payments made to Eligible Professionals under the Medicaid Promoting Interoperability (PI) Program is subject to audit by the Promoting Interoperability 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. PI audit questions can be directed to the Promoting Interoperability 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 Promoting Interoperability 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 Promoting Interoperability (PI) 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 Promoting Interoperability (PI) Program?**
	Yes, providers who have registered for the Medicare or Medicaid Promoting Interoperability (PI) 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 a Promoting Interoperability 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 Promoting Interoperability (PI) 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 Promoting Interoperability Program team at EHRIncentivePayments@azahcccs.gov.
Q11	**How do I know if my Promoting Interoperability (PI) system is certified?**
	The Medicare and Medicaid Promoting Interoperability (PI) 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 Promoting Interoperability (PI) 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 2019?**
	Eligible Professionals participate in the Medicaid Promoting Interoperability (PI) 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 2019 has been extended to **September 30, 2020**.
Q15	**What are the reporting periods for Eligible Professionals participating in the Promoting Interoperability (PI) Program?**
	For Program Year 2019, the reporting periods are as follows: *Volume (select a period from 2018):* 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 2019):* The Promoting Interoperability 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 Promoting Interoperability (PI) Program, who is responsible for demonstrating meaningful use of certified EHR technology, the provider or the vendor?**
	To receive a Promoting Interoperability payment, the Eligible Professional is responsible for demonstrating meaningful use of certified EHR technology under both the Medicare and Medicaid Promoting Interoperability (PI) programs.
Q17	**Is there a penalty if I start the Promoting Interoperability 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 Promoting Interoperability (PI) Program after receiving an incentive payment.

Appendix F – Frequently Asked Questions regarding Payment

Q18	**I am choosing to reassign my PI 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 Promoting Interoperability 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 Promoting Interoperability (PI) 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 Promoting Interoperability (PI) Programs subject to recoupments?**
	Both Medicare and Medicaid are required to recoup any or all portions of the Promoting Interoperability 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 Promoting Interoperability 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

		PROVIDER INFORMATION		
SECTION 1	**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
		PROVIDER IDENTIFIERS INFORMATION		
SECTION 2	**Provider Identifiers**			
		Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number also known as an Employer Identfication 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
		PROVIDER CONTACT INFORMATION		
SECTION 3	**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
		PROVIDER AGENT INFORMATION - IF APPLICABLE		
SECTION 4	**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)

SECTION 5	**FINANCIAL INSTITUTION INFORMATION**			
	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
SECTION 6	**SUBMISSION INFORMATION**			
	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
SECTION 7	**AUTHORIZATION**			
	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/I *

_____
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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Appendix I – Contact Us

Need Help with:	Contact Us:
Medicaid Promoting Interoperability (PI) Program	**AHCCCS PI Pre-Payment Staff** 602-417-4333 Email: EHRIncentivePayments@azahcccs.gov Website: Arizona Medicaid EHR Incentive Program
	AHCCCS Promoting Interoperability Post Payment Staff 602-417-4440 Email: EHRPost-PayAudits@azahcccs.gov
Having Trouble with:	**Help is Available:**
CMS Registration process	**CMS Information Center** 888-734-6433 Website: CMS Medicare and Medicaid EHR Incentive Programs
AHCCCS Provider Number, NPI, or TIN	**AHCCCS Member & Provider Services** 602-417-7670 (option 5) Maricopa County 800-794-6862 Outside Maricopa County 800-523-0231 Out-of-State Website: AHCCCS Provider Enrollment
Electronic Funds Transfer (EFT)	**AHCCCS Finance** 602-417-5500 Website: Automated Clearing House (ACH) Vendor Authorization Form
ePIP System	**AHCCCS PI Staff** 602-417.4333 Website: ePIP Systems for Registration & Attestation
No-Cost Education & Assistance for HIT / HIE	**Health Current** 602-688-7200 Email: ehr@healthcurrent.org

Appendix J – Webinars for Eligible Professionals

Click: Program Year 2019 Stage 3 Webinar

Click: Electronic Clinical Quality Measures Webinar

Click: Documentation Retention Webinar

Click: Documentation Retention Tip Sheet (2018/2019)

Click: Medicaid Individual Patient Volume Webinar

Click: Medicaid Aggregate Patient Volume Webinar

Click: Using HIT in A Meaningful Way Webinar

Meaningful Use Objectives		Other Webinars	Additional Resources
1	Protect Patient Health Information	SRA Webinar	2019 Security Risk Analysis Requirement Tip Sheet Tips for Completing a SRA
2	Electronic Prescribing (eRX)	eRX Webinar	eRX Frequently Asked Questions
3	Clinical Decision Support (CDS)	CDS Webinar	CDS Frequently Asked Questions
4	Computerized Provider Order Entry (CPOE)	CPOE Webinar	CPOE Frequently Asked Questions
5	Patient Electronic Access	Patient Electronic Access Webinar	2019 Patient Electronic Access API Documentation Requirements Patient Electronic Access Frequently Asked Questions
6	Coordination of Care	Coordination of Care Webinar	Coordination of Care Frequently Asked Questions
7	Health Information Exchange	HIE Webinar	HIE Frequently Asked Questions
8	Public Health Reporting	**1 of 2** AHCCCS Public Health Webinar **2 of 2** ADHS Public Health Webinar	Public Health Frequently Asked Questions **Other References:** (a) State Registries (ADHS) https://www.azdhs.gov/preparedness/epidemiology-disease-control/meaningful-use/index.php (b) CDC National Health Care Survey Registries: https://www.cdc.gov/nchs/dhcs/nhcs_registry_landing.htmc (c) National Institute Health Registries: https://www.nih.gov/health-information/nih-clinical-research-trials-you/list-registries

Website: Arizona Medicaid EHR Incentive Program

☎ 602.417.4333

EHRIncentivePayments@azahcccs.gov

Thank you for your interest in the Promoting Interoperability Program