Medicaid Promoting Interoperability (PI) Program

Frequently Asked Questions: Program Year 2021 Documentation Requirements

#	Question and Answer
1	**Q: What types of meaningful use documents will an EP be required to upload during attestation?**
	A: The meaningful use documentation requirements vary depending on the measure. However, the following four types of meaningful use documents can be requested: **Yes/No Standard Documentation:** See question 13 for details. **Percentage-Based Standard Documentation:** See question 7 for details. **Additional Documentation**: The EP must submit standard documentation and additional documentation if applicable. See AHCCCS Program Year 2021 – Documentation Retention webinar[A]. **Alternate Documentation**: The EP has the option to submit alternate documentation in lieu of the standard documentation. See AHCCCS Program Year 2021 – Documentation Retention webinar[A].
2	**Q: What type of documentation is required for each measure?**
	A: Submit the following type of documentation for each objective: 1. **Protect Patient Health Information:** See the SRA webinar for documentation details. 2. **Electronic Prescribing:** Percentage-based standard documentation* is required. 3. **Clinical Decision Support:** Yes/no standard documentation is required. 4. **Computerized Provider Order Entry:** Percentage-based standard documentation is required. 5. **Patient Electronic Access:** Percentage-based standard and additional documentation is required. 6. **Coordination of Care:** Percentage-based standard documentation* is required. 7. **Health Information Exchange:** Percentage-based standard documentation* is required. 8. **Public Health Reporting:** Yes/no standard documentation* is required. *Additional documentation may be requested if exclusion is claimed.
3	**Q: How long is the PI (EHR) reporting period for PY 2021?**
	A: The PI (EHR) reporting period in PY 2021 is 90 days for all EPs. The PI (EHR) reporting period must be within CY 2021 and end **on or before** October 31, 2021.
4	**Q: What date needs to be shown on the 2015 Edition CEHRT documentation?**
	A: 2015 Edition CEHRT documentation should show an implementation date by the first day of the PI (EHR) reporting period or before. The CEHRT must be certified by ONC as a 2015 Edition product by the last day of the PI (EHR) reporting period.

[A] AHCCCS Program Year 2021 – Documentation Retention webinar
[B] AHCCCS Program Year 2021 – Patient Electronic Access webinar

#	Question and Answer
5	**Q: What types of patients should be included when determining whether at least 80% of all unique patients seen by the EP during the PI (EHR) reporting period had data maintained in CEHRT?**
	A: To qualify as a meaningful user, EPs must maintain at least 80% of all unique patients' data at locations with CEHRT in the CEHRT. Calculate the numerator and denominator as follows. Include only locations with CEHRT in the calculation. **Numerator:** Every unique patient who has data maintained in the CEHRT. Any places of services (POS) except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the numerator of the calculation. **Denominator:** Every unique patient seen at locations with CEHRT. Any POS except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the denominator of the calculation.
6	**Q: What types of encounters should be included when determining whether at least 50% of all encounters during the PI (EHR) reporting period occurred at a location(s) equipped with CEHRT?**
	A: EPs who practice in multiple locations must have 50% or more of their encounters during the PI (EHR) reporting period at a location(s) equipped with CEHRT. Calculate the numerator and denominator as follows. Include all locations in the denominator calculation. **Numerator:** Every encounter that occurred at a location equipped with CEHRT. Any POS except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the numerator of the calculation, which would include patient encounters in an ambulatory surgical center (POS 24). **Denominator:** Every encounter that occurred at all location(s). Any POS except a hospital inpatient department (POS 21) or a hospital emergency department (POS 23) should be included in the denominator of the calculation, which would include patient encounters in an ambulatory surgical center (POS 24).
7	**Q: What is the percentage-based standard documentation?**
	A: A CEHRT dashboard covering the entire PI (EHR) reporting period that: • Reflects the correct (PI) EHR reporting period; • Includes the provider name; • Reflects all percentage-based measures; and • Matches the attestation. If attesting to an exclusion for a measure, the CEHRT dashboard may be utilized to support meeting the exclusion criteria for certain measures. If the exclusion is not supported by the CEHRT dashboard, additional documentation is required.

[A] AHCCCS Program Year 2021 – Documentation Retention webinar
[B] AHCCCS Program Year 2021 – Patient Electronic Access webinar

#	Question and Answer
8	**Q: Should the EP run the CEHRT dashboard for all percentage-based measures based on the practice or the individual?**
	A: The EP must attest to meaningful use based on his/her individual data (numerator/denominator). Therefore, the CEHRT dashboard submitted should demonstrate the EP's individual numerators and denominators for each measure, rather than the data for the practice.
9	**Q: Which locations should be included in the reported numerators and denominators?**
	A: The reported numerators and denominators should include the EP's data from all CEHRT locations. For example, if the EP worked at three locations using CEHRT, all three CEHRT dashboard reports (one from each location) should be used to calculate a combined numerator and denominator for each measure. Each CEHRT dashboard used to complete the attestation should be uploaded in ePIP.
10	**Q: What POS codes should be included the CEHRT dashboard?**
	A: The attested numerator and denominator should be comprised of the number of patients seen in the outpatient setting, since this setting is where the EP is eligible to receive PI incentive payments. For example, if an EP has patients in both the inpatient and outpatient settings (hospital and clinic) and where CEHRT is available at each location, only the patients seen at the clinic should be included in the CEHRT dashboard.
11	**Q: If a provider excludes a measure because it is not relevant to their specialty, scope of practice, etc., what documentation is required?**
	A: There are many reasons why a measure may not apply to a provider; therefore, there is not a "one size fits all" answer regarding appropriate supporting documentation. We recommend providers upload a letter explaining why the measure is not applicable to them. AHCCCS will then determine if additional documentation is required to support your reason.
12	**Q: When would a provider need to submit an Opt-Out Patient Audit Log?**
	A: If the provider adds opt-out patients to the numerator on the CEHRT dashboard for objective 5, measures 1 and/or 2 the provider will need to submit an Opt-Out Patient Audit Log. For additional information, see the Patient Electronic Access[B] webinar.

[A] AHCCCS Program Year 2021 – Documentation Retention webinar
[B] AHCCCS Program Year 2021 – Patient Electronic Access webinar

#	Question and Answer
13	**Q: What is the yes/no standard documentation?**
	A: Documentation to show yes/no measures were met: • Includes the provider and/or practice name, as applicable; • Reflects results for the measure; • Is clearly legible; and • Reflects the date the requirement was met. The CEHRT dashboard alone cannot be used to support these measures. Documentation could include screen shots from the CEHRT or vendor letters to support the applicable functionalities were enabled or the actions required were performed.
14	**Q: If I do not have dated screen shots, can I use letters/email verification from my vendor?**
	A: Yes. However, the documentation from the vendor must explicitly state the functionality for the measure was enabled or the required action for the measure occurred during the PI (EHR) reporting period. Letters explaining the CEHRT capabilities will not be accepted as supporting documentation.
15	**Q: What should the screen shots to support "yes" attestations include?**
	A: A way to verify the required functionality was enabled or action occurred, information showing the practice and/or provider name, and a date to support this occurred within the PI (EHR) reporting period. When taking screen shots, the date is usually displayed in the bottom right corner on your computer screen.
16	**Q: What is the correct date that should be reflected on each supporting document for the different yes/no measures?**
	A: The appropriate date* of supporting documentation varies depending on the yes/no measure. • **Security Risk Analysis (SRA) (Objective 1):** The SRA must be completed during CY 2021 and no later than December 31, 2021. • **Clinical Decision Support Rule (CDS) and Drug-Drug and Drug-Allergy Interaction Checks**: Reflect a date the requirement was met during the PI (EHR) reporting period. • **Public Health Measures**: Reflect the date** the EP active engagement option (1, 2, or 3) milestone was achieved. *Documentation should reflect the date the requirements were met. For example, if submitting a screen shot, capture the date the screenshot was taken (i.e. the date in the toolbar). **See question 26 for the appropriate date for each active engagement option.

[A] AHCCCS Program Year 2021 – Documentation Retention webinar
[B] AHCCCS Program Year 2021 – Patient Electronic Access webinar

#	Question and Answer
17	**Q: What elements must be included in the organization's annual SRA?**
	A: The elements listed below must be included in the SRA regardless of the methodology used by the organization: • Asset inventory to identify the scope of the assessment • Physical, administrative, and technical safeguards (including encryption) to e-PHI • Identified threats and vulnerabilities • Likelihood and impact of occurrence of each identified threat/vulnerability • Overall level of risk for each threat/vulnerability based on the likelihood and impact determination • Remediation/action plan for moderate to high risk areas • Completion date of assessment Review the guidance issued by the Office of Civil Rights for more information.
18	**Q: When must an SRA be completed to be sufficient for PY 2021?**
	A: The SRA must be completed in CY 2021 and no later than December 31, 2021 and must show date completed (Month/Day/Year).
19	**Q: When should the EP submit the SRA if it's completed after the attestation close date (October 31, 2021) but before December 31, 2021?**
	A: The EP should submit the SRA as soon as possible; however, the EP is allowed to submit the SRA by January 14, 2022. The SRA must be completed and dated in CY 2021 and no later than December 31, 2021.
20	**Q: What will happen if the EP does not submit the SRA by January 14, 2022?**
	A: If the EP does not submit a sufficient SRA by January 14, 2022, the EP's incentive payment will be recouped.
21	**Q: Can a provider update a SRA if it was determined that a required element was missing from the document?**
	A: The SRA must be completed in CY 2021 and no later than December 31, 2021. If an error is discovered prior to receiving the payment or prior to the end of the calendar year, the provider may provide a corrected copy to AHCCCS for consideration until January 14, 2022. However, the provider must correct and update the SRA by December 31, 2021, and submit the revised SRA to AHCCCS by January 14, 2022. The provider cannot make changes to the SRA after December 31, 2021. For example, a practice completed their PY 2021 SRA on 3/31/2021. The provider discovers an issue with the SRA subsequent to submitting the SRA to AHCCCS. The provider can revise their SRA as long as the revision is completed by 12/31/2021 and submitted to AHCCCS for consideration prior to 1/14/2022. If the error was not corrected by 12/31/2021 or not submitted to AHCCCS by 1/14/2022, it may adversely impact the 2021 incentive payment.

[A] AHCCCS Program Year 2021 – Documentation Retention webinar
[B] AHCCCS Program Year 2021 – Patient Electronic Access webinar

#	Question and Answer
22	**Q: How should my SRA address encryption?**
	A: Practices should implement a mechanism to encrypt and decrypt electronic protected health information. Per 45 CFR 164.312(a)(2)(iv) encryption is an addressable implementation specification. Per 45 CFR 164.306(d)(3) addressable implementation specifications must be assessed to determine whether the specification is a reasonable and appropriate safeguard in its environment. The SRA should include your findings from this assessment.
23	**Q: The practice did not identify any changes in the SRA update compared to the prior year SRA, what SRA documentation is required?**
	A: If the prior report contained all required elements (refer to SRA tip sheet), and there were no new updates to the SRA report in a subsequent year it is not necessary to perform a full SRA assessment. The practice simply performs a 'Review of the prior full assessment'. The practice should document what the review process entailed, how the practice determined no updates were required, and the date(s) the review occurred. The documentation should have a verifiable audit trail, such as time stamped emails.
24	**Q: What should the documentation show to reflect that CDS rules (objective 3, measure 1) were enabled during the PI (EHR) reporting period?**
	A: The documentation should show that 5 CDS rules related to 4 or more eCQMs were enabled for the entire PI (EHR) reporting period. For example, screen shots from the CEHRT showing the 5 different CDS rules were enabled during the PI (EHR) reporting period. When taking screen shots, capture the date on your computer screen (usually located in the bottom right corner).
25	**Q: What should the documentation show to reflect that drug-drug and drug-allergy interaction checks (objective 3, measure 2) were enabled during the PI (EHR) reporting period?**
	A: The documentation should show that drug-drug and drug-allergy interaction checks were enabled for the entire PI (EHR) reporting period. For example, screen shots from the CEHRT showing that drug-drug and drug-allergy interaction checks were enabled during the PI (EHR) reporting period. When taking screen shots, capture the date on your computer screen (usually located in the bottom right corner).

[A] AHCCCS Program Year 2021 – Documentation Retention webinar
[B] AHCCCS Program Year 2021 – Patient Electronic Access webinar

#	Question and Answer
26	**Q: What is an appropriate date for objective 8 for each active engagement option (1, 2, or 3) milestone achieved?**
	A: The appropriate date for objective 8 changes depending on the active engagement option milestone achieved by the provider. The information below explains what dates are appropriate for each active engagement option. • **Active Engagement Option 1:** The completion date can occur before calendar year 2021 if the EP has not progressed and is still in active engagement option 1, but no later than 60 days from the start of the PI (EHR) reporting period. • **Active Engagement Option 2:** The completion date can occur before calendar year 2021 if the EP has not progressed and is still in active engagement option 2. • **Active Engagement Option 3:** The completion date can occur before calendar year 2021 if the EP is still in active engagement option 3.
27	**Q: What should the documentation show to reflect that the EP was actively engaged with a Public Health and Clinical Data Registry (objective 8)?**
	A: The documentation should indicate that the EP was actively engaged with the applicable public health or clinical data registry (or registries). The documentation should: • Include the provider or practice name; • Reflect that the EP was meeting one of the three levels of active engagement; • Be clearly legible; and • Reflect the appropriate date*. Providers that complete registration in a previous year meet active engagement option 1 and do not have to register again (exceptions apply to the immunization registry). **See question 26 for the appropriate date for each active engagement option.
28	**Q: Do the eCQM numerators and denominators have to be calculated by the CEHRT?**
	A: Yes, the eCQM data must be calculated by a 2015 Edition CEHRT. The supporting eCQM report should demonstrate the source of the data.
29	**Q: How long is the eCQM reporting period for PY 2021?**
	A: The eCQM reporting period in PY 2021 is 90 days for all EPs. The eCQM reporting period must be within CY 2021 and end **on or before** October 31, 2021.

[A] AHCCCS Program Year 2021 – Documentation Retention webinar
[B] AHCCCS Program Year 2021 – Patient Electronic Access webinar

#	Question and Answer
30	**Q: What type of documentation can be submitted to show a physician assistant (PA) meets the PA led requirement?**
	A: The documentation needs to show the PA led the practice. The documentation should support the PA works at a practice where a PA is either the primary provider, clinic/medical director, or is the owner. Examples include, but are not limited to, job description, detailed encounter reports, and employment contracts.
31	**Q: I was selected for a post-payment audit. My attestation was approved by AHCCCS prior to receiving a payment. Why are they asking questions about my attestation now?**
	A: Pre-payment procedures are intended to be a cursory review of provider attestations. Due to the volume of attestations received and the focus on ensuring timely payments, AHCCCS is not able to do a full comprehensive review of each attestation and its supporting documentation prior to payment. CMS requires the agency put in place adequate oversight activities. This is why post-payment audits are required and conducted for a sample of providers. If you are selected for a post-payment audit, you should expect more in depth procedures to be conducted on the documentation you submitted during pre-payment. The post-payment analysts may ask questions or request additional documentation.
32	**Q: How long do we need to retain documentation?**
	A: A minimum of 6 years from the date of the attestation for each incentive payment received.

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