Medicaid Promoting Interoperability (PI) Program

Frequently Asked Questions: Program Year 2021 Stage 3

#	Question and Answer
1	**Q: Are Eligible Professionals (EPs) required to attest to Stage 3 in Program Year (PY) 2021?**
	A: Yes, all EPs must attest to Stage 3 in PY 2021 to meet the requirements of the program.
2	**Q: When does an EP have to implement 2015 Edition CEHRT to attest for PY 2021?**
	A: 2015 Edition CEHRT must be implemented by the first day of the PI (EHR) reporting period. The CEHRT must be certified by ONC as a 2015 Edition product by the last day of the PI (EHR) reporting period. See the ONC website to learn when various CEHRT products were certified.
3	**Q: Are EPs required to meet the patient volume (PV) requirement for PY 2021?**
	A: Yes, the EP should select a 90-day PV period within calendar year 2020 and the EP must have either: 1) greater than or equal to 30% Medicaid patient volume *(20% for pediatricians with reduced payment)* **or** 2) greater than or equal to 30% Needy patient volume if practicing predominantly at a FQHC or RHC *(20% for pediatricians with reduced payment)*.
4	**Q: What changed between Program Year (PY) 2020 and 2021 for meaningful use?**
	A: The following changes occurred between PY 2020 and 2021 for meaningful use: • The last day of the PI (EHR) reporting period and eCQM reporting period must fall on or before October 31, 2021. • The SRA must be completed inside calendar year (CY) 2021 and no later than **December 31, 2021**.
5	**Q: How long is the PI (EHR) reporting period be for PY 2021?**
	A: The PI (EHR) reporting period in PY 2021 is 90 days for all EPs and the end of the PI (EHR) reporting period must fall **on or before** October 31, 2021.
6	**Q: How long is the eCQM reporting period be for PY 2021?**
	A: The eCQM reporting period in PY 2021 is 90 days for all EPs and the end of the eCQM reporting period must fall **on or before** October 31, 2021.

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7	**Q: What are the eCQM requirements for PY 2021?**
	A: EPs must attest to 6 out of 47 available eCQMs. • **Priority Level 1:** If relevant, at least one eCQM should be an outcome measure. o **Priority Level 2:** If no outcome measure is relevant, at least one eCQM should be a high priority measure. ▪ **Priority Level 3:** If no outcome or high priority measures are relevant, the EP should report on relevant measures if possible.
8	**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.
9	**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.
10	**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).

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#	Question and Answer
11	**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 16 for details. **Percentage-Based Standard Documentation:** See question 12 for details. **Additional Documentation**: The EP must submit standard documentation and additional documentation if applicable. See AHCCCS Program Year 2021 – Stage 3 webinar[A]. **Alternate Documentation**: The EP has the option to submit alternate documentation in lieu of the standard documentation. See AHCCCS Program Year 2021 – Stage 3 webinar[A].
12	**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:** Additional documentation is required, see SRA webinar for additional 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.
13	**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.

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14	**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.
15	**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.
16	**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.
17	**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.

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#	Question and Answer
18	**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 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 a date within 60 days of the start of the PI (EHR) reporting period. *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).
19	**Q: What elements must be included in the organization's annual security risk analysis (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.
20	**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).
21	**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, but the SRA must be completed and dated in CY 2021 and no later than December 31, 2021.
22	**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.

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23	**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).
24	**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).
25	**Q: How many of the possible 2 measures under Patient Electronic Access (objective 5) must an EP meet?**
	A: An EP, through a combination of meeting the thresholds and exclusions, must satisfy both measures to meet this objective.
26	**Q: Can an EP in the state of Arizona claim and meet the exclusion for broadband availability allowed in objective 5 and 6?**
	A: No, the state of Arizona does not have any counties that meet the broadband availability exclusion requirements. For PYs 2015-2017 CMS identified the counties in the U.S. who conducted 50 percent or more patient encounters in a county where 50 percent or more of its housing units do not have 4Mbps broadband availability and therefore meet the broadband exclusion. The state of Arizona does not have any counties listed; therefore, an EP in AZ is not able to meet this exclusion.
27	**Q: How many of the possible 3 measures under Coordination of Care (objective 6) must an EP meet?**
	A: An EP must meet the minimum threshold for 2 of the 3 measures or meet one of the two available exclusions. The exclusions for all 3 measures are the same; therefore, if an EP meets one of the exclusions the EP is able to claim an exclusion for all 3 measures.

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28	**Q: How many of the possible 3 measures under Health Information Exchange (objective 7) must an EP meet?**
	A: An EP must meet the minimum threshold for 2 of the 3 measures. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.
29	**Q: How many of the possible 5 measures under Public Health and Clinical Data Registry Reporting (objective 8) must an EP meet?**
	A: An EP must satisfy two of the five available measures for this objective. If the EP cannot satisfy at least two measures, they may still meet the objective if they qualify for exclusions from all measures they cannot meet. For example, if an EP meets measure 1 and meets an exclusion for measure 2 the EP must meet the remaining exclusions for measures 3-5 in order to meet the objective.
30	**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) within 60 days of the start of the PI (EHR) reporting period. 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 EP was actively engaged between January 1, 2021 and 60 days of the start of the PI (EHR) reporting period. 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).

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