AHCCCS
Arizona Health Care Cost Containment System

STATE MEDICAID PROMOTING INTEROPERABILITY PROGRAM 2018 STAGE 2 MODIFIED ATTESTATION REFERENCE GUIDE

ELIGIBLE PROFESSIONALS

AHCCCS
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https://www.azepip.gov/

Contents

Disclaimer

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

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

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

Important Notice – Third Party Attestation

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

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

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

About ePIP

About ePIP

The Arizona Medicaid 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 Arizona EHR Incentive Program if they meet the program's requirements. For detailed information, visit **AHCCCS website**

Eligible Hospitals (EHs)

Medicaid EHs include:

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

Eligible Professionals (EPs)

Medicaid EPs include:

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

Additionally, Medicaid EPs must also:

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

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

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

TIP

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

Go to the ePIP System by clicking here

Welcome to the ePIP System Home Page

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

- CMS has re-branded the program as the Promoting Interoperability Program
- Program Year 2018 will be open from January 1st 2019 thru December 31st 2019
- Stage 3 Meaningful Use in Program Year 2018 is optional

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 2017-2018

Meaningful Use (MU) for Program Year 2017-2018: EPs with systems certified with a 2014 CEHRT will be attesting to Modified Stage 2 Objectives:

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

Starting with Program Year 2017, providers with systems that have a 2015 CEHRT will be eligible to attest (optional) 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.

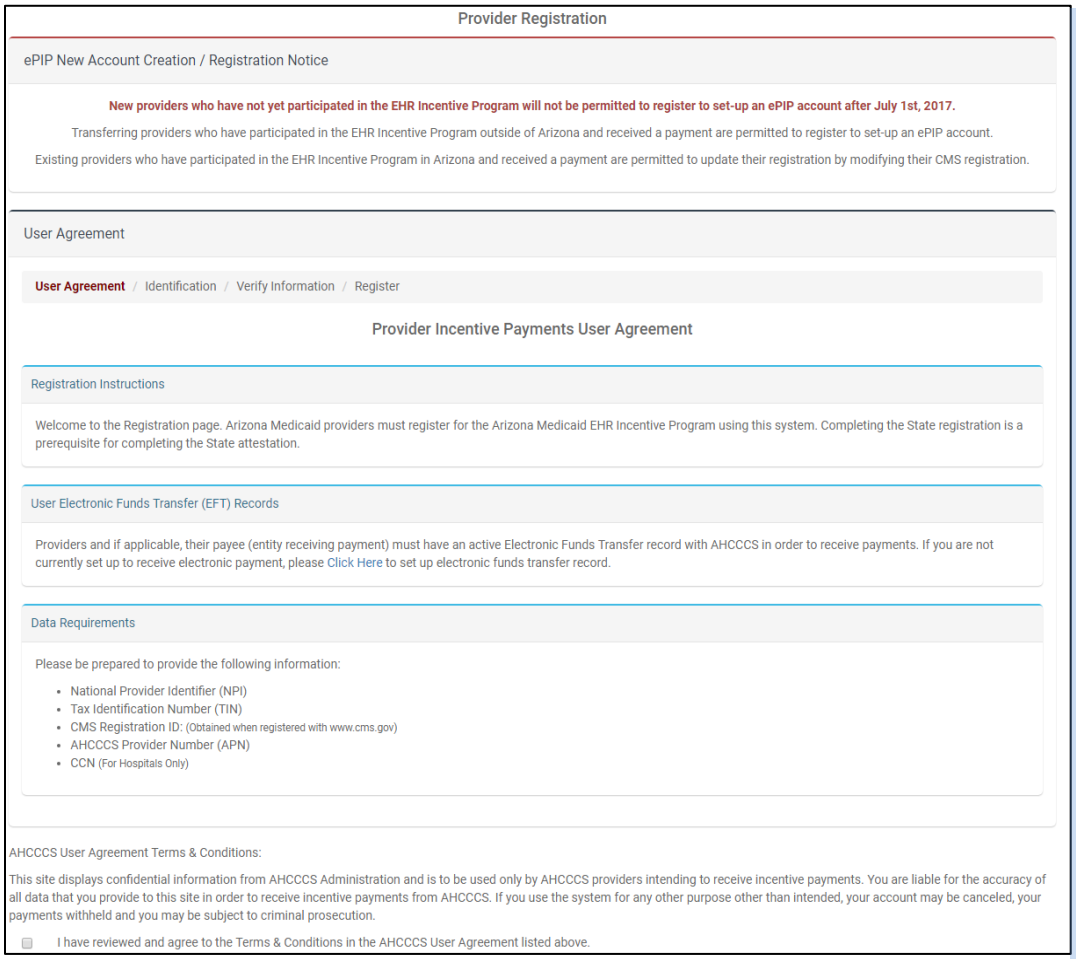
The ePIP System Welcome screen consists of six menu navigational topics.

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 2018 until August 31, 2019 (*subject to CMS approval)*.

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.

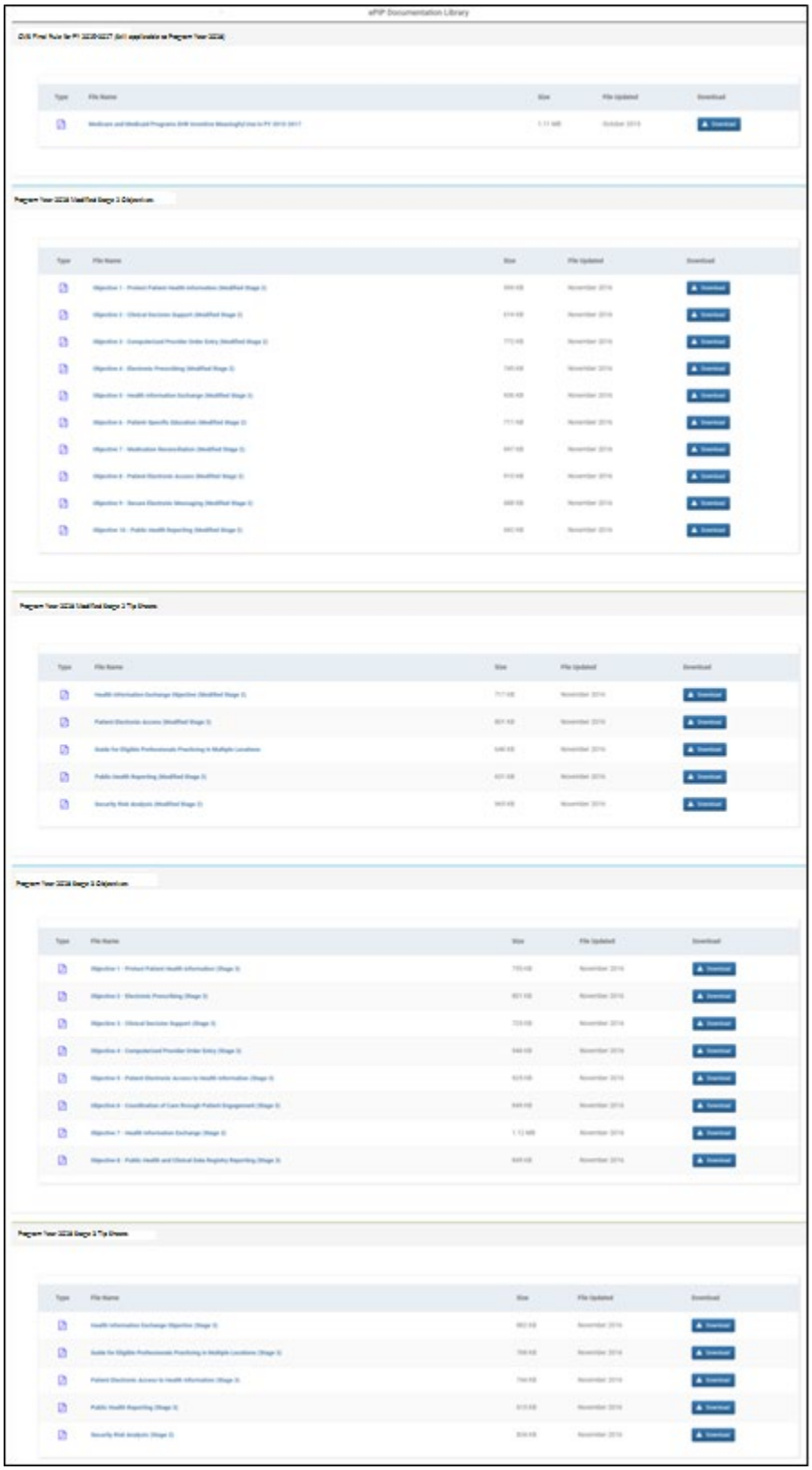
Program Year 2016 was the last year for providers to begin participation in the Promoting Interoperability Program.

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



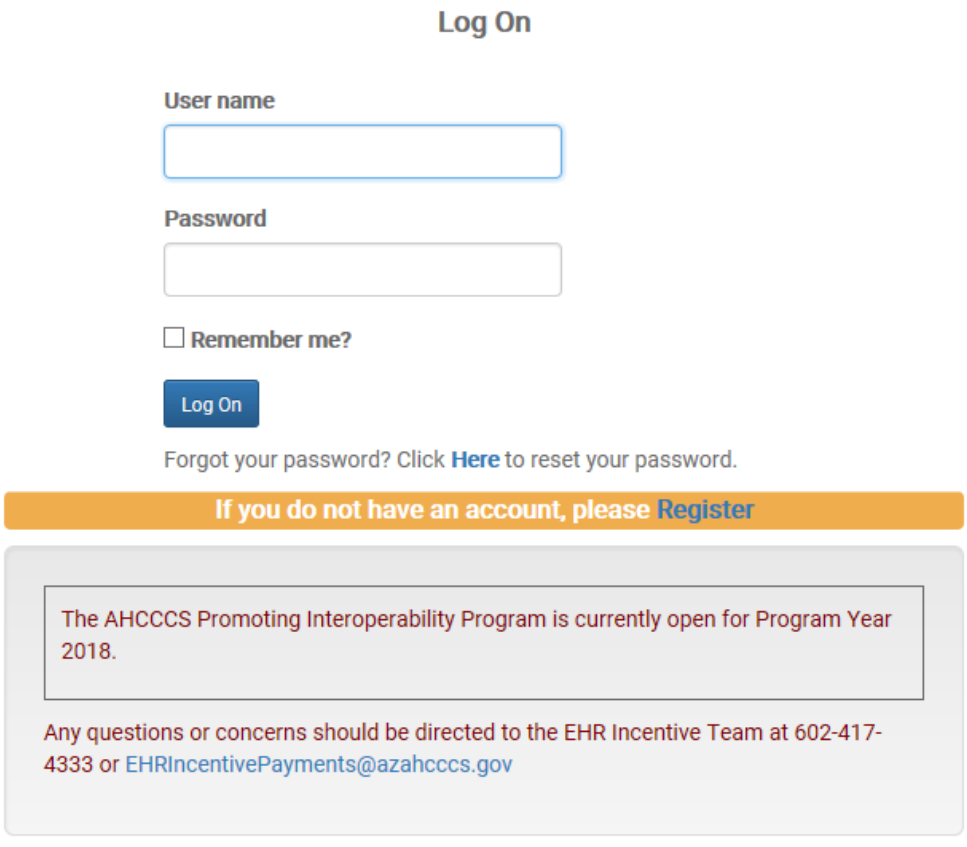
Use our PI Document Library to navigate quickly to the Meaningful Use requirements.

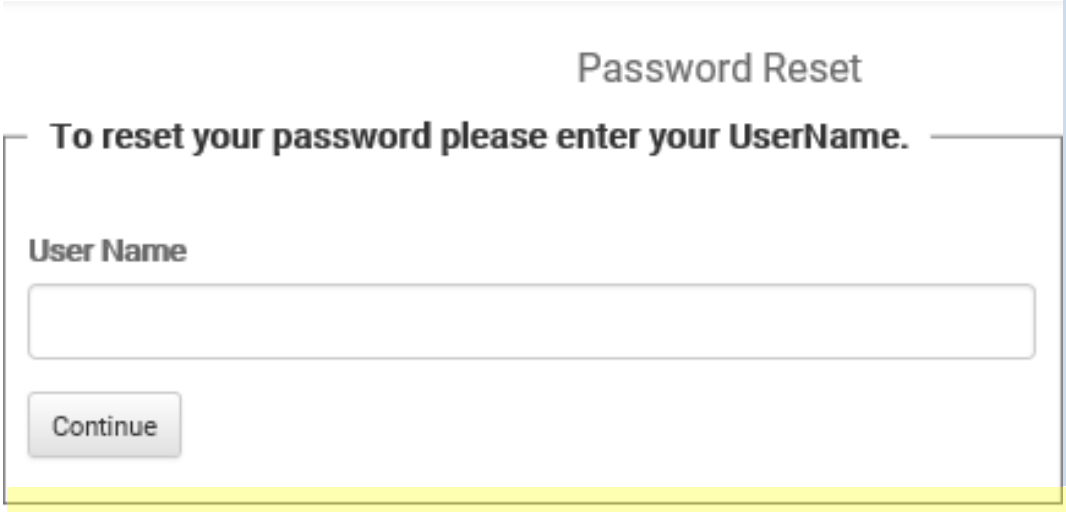
Click the link or

Click the download button to view details on the 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.

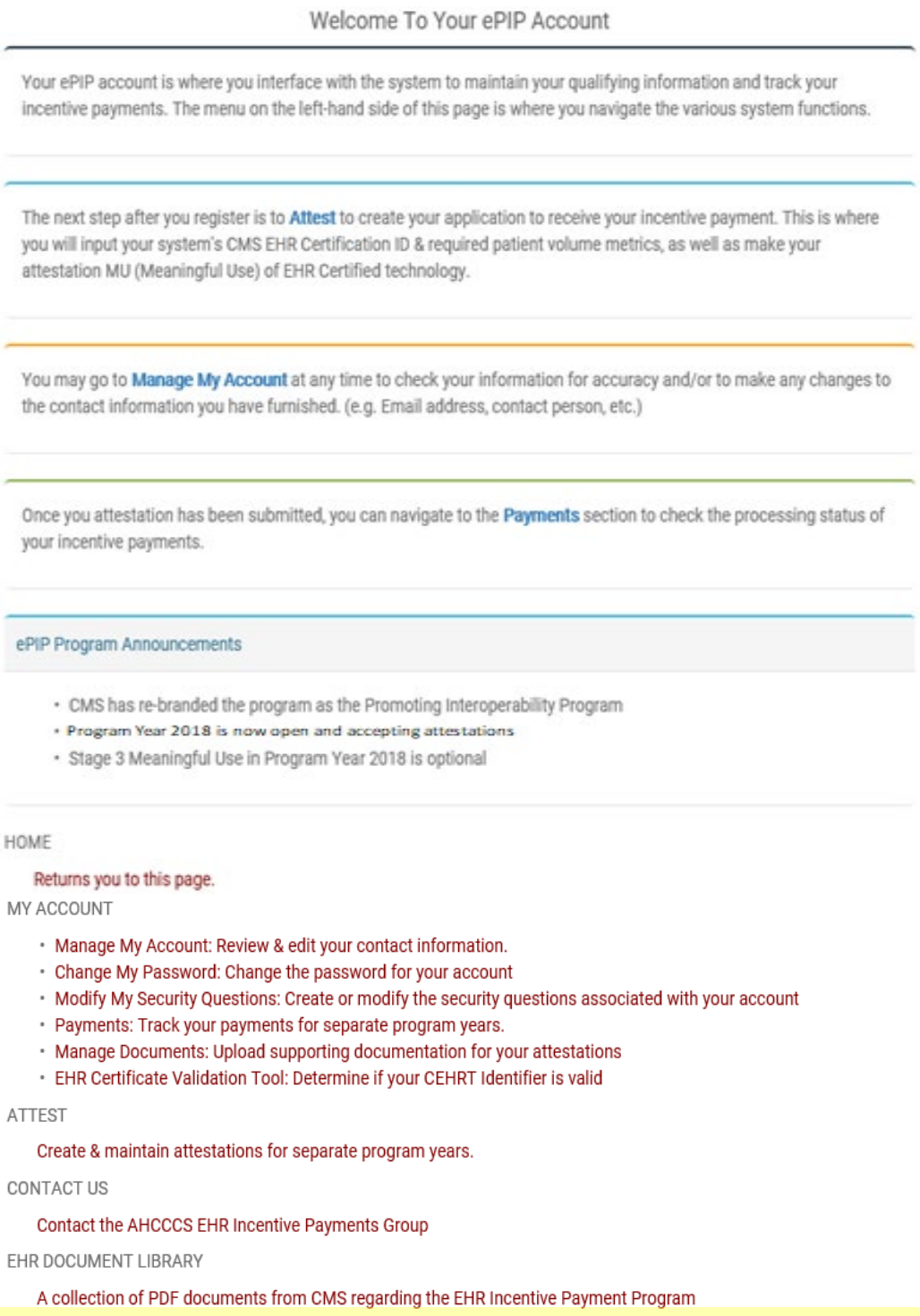
Please allow an hour for server to respond to your request.

Go to the ePIP System by clicking here

TIP

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

Welcome to Your ePIP Account Home Page



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

1. Home
2. My Account
   - Manage My Account
   - Change My Password
   - Modify My Security Questions
   - Payments
   - Manage Documents
   - EHR Certificate Validation Tool
3. Attest
4. Contacts
   - PI Team
   - Other AHCCCS Contacts
5. PI Doc Library
6. Log Off

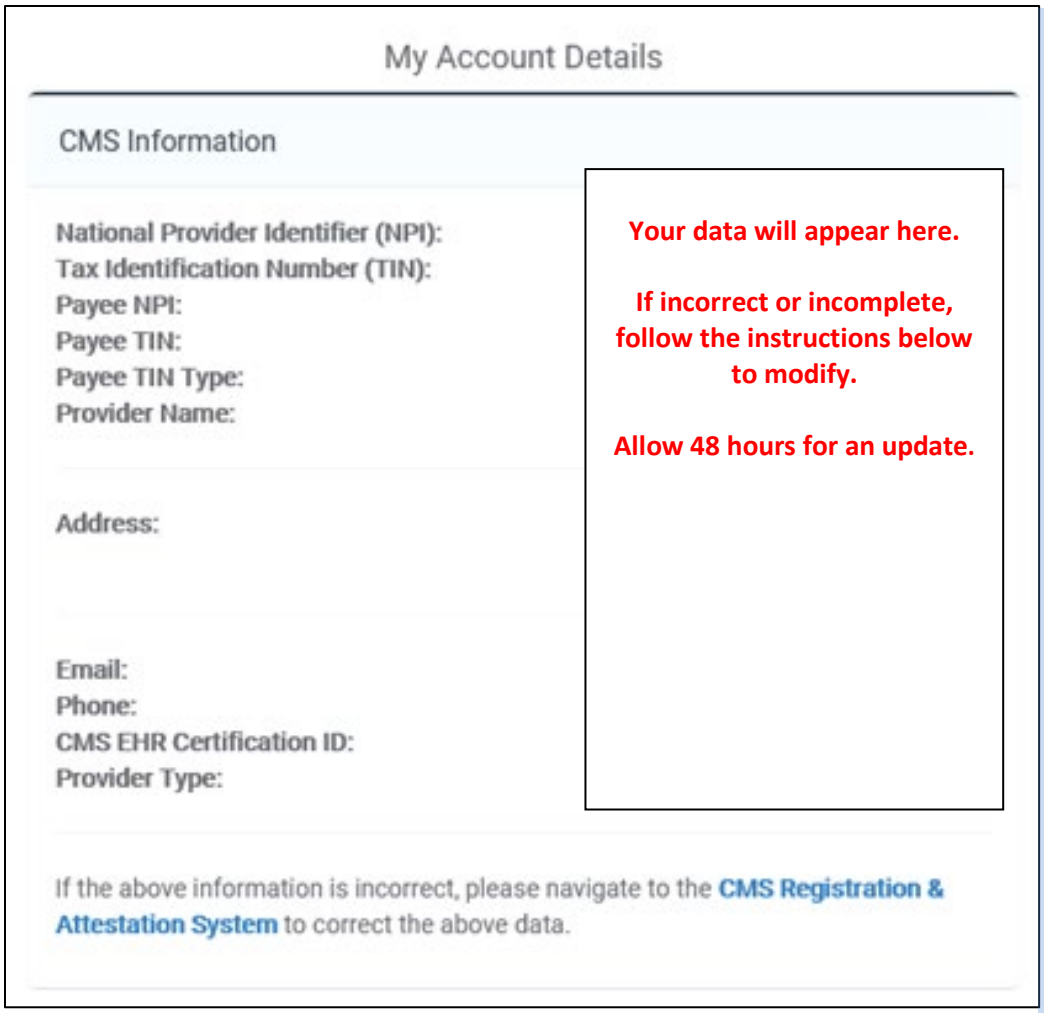
ePIP Program Announcement Update:

ePIP is accepting attestations for Program Year 2018 until August 31, 2019 (*subject to CMS approval)*.

TIP

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

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

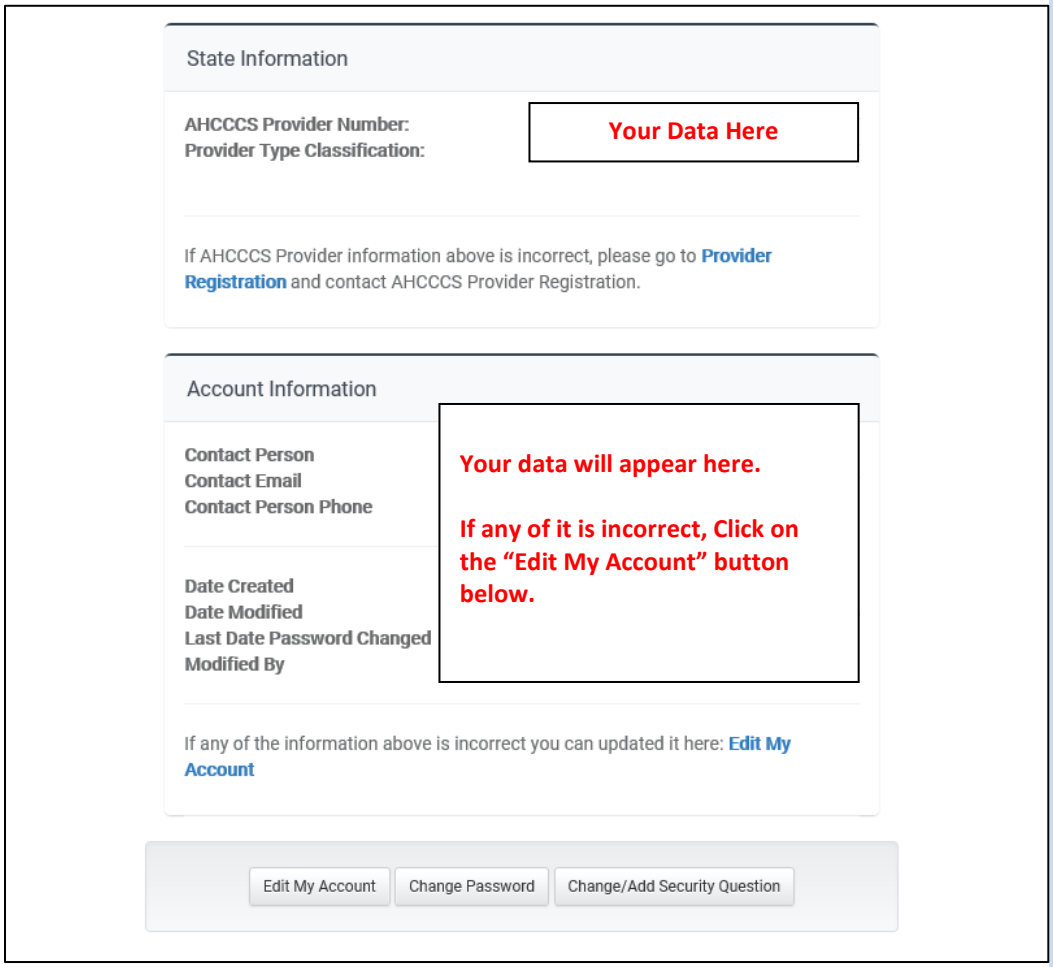
Manage My Account allows you to add an authorized secondary contact *(optional)*.

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
- Change My Password
- Modify My Security Questions
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- Manage Documents
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TIP

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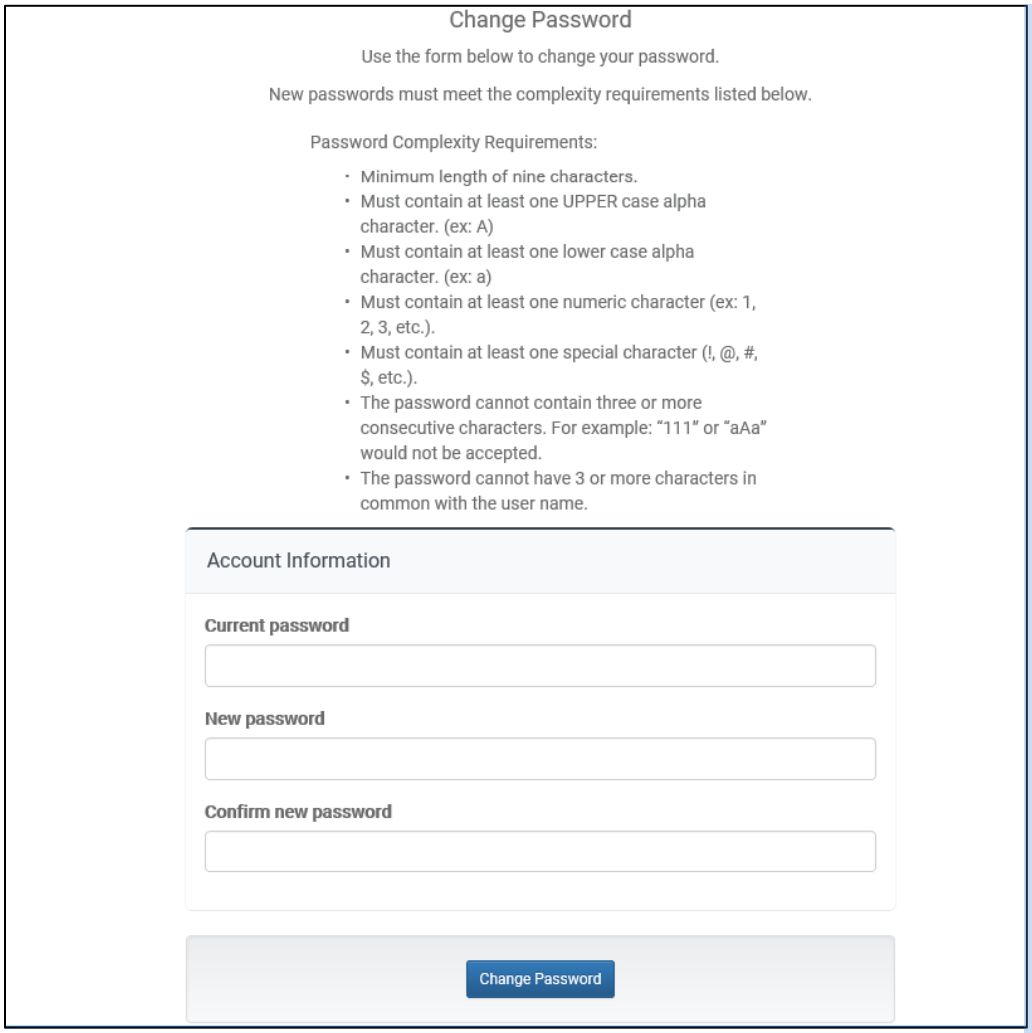
My Account – How to Manage My Password



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

Let's take a look at:

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

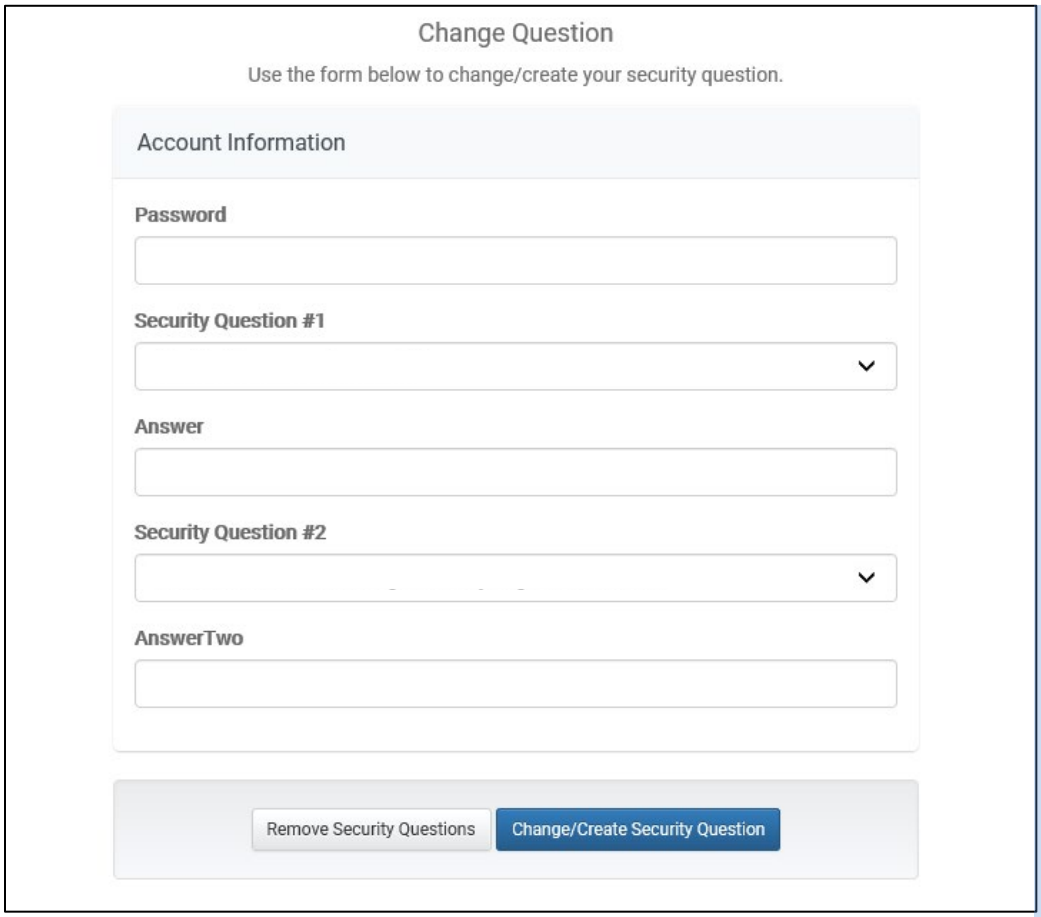
Change My Password allows you to modify your password at any time.

Enter your current password and then your new password.

TIP

Passwords must meet the complexity requirements displayed on the screen.

My Account – How to Manage My Security Questions



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

Let's take a look at:

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

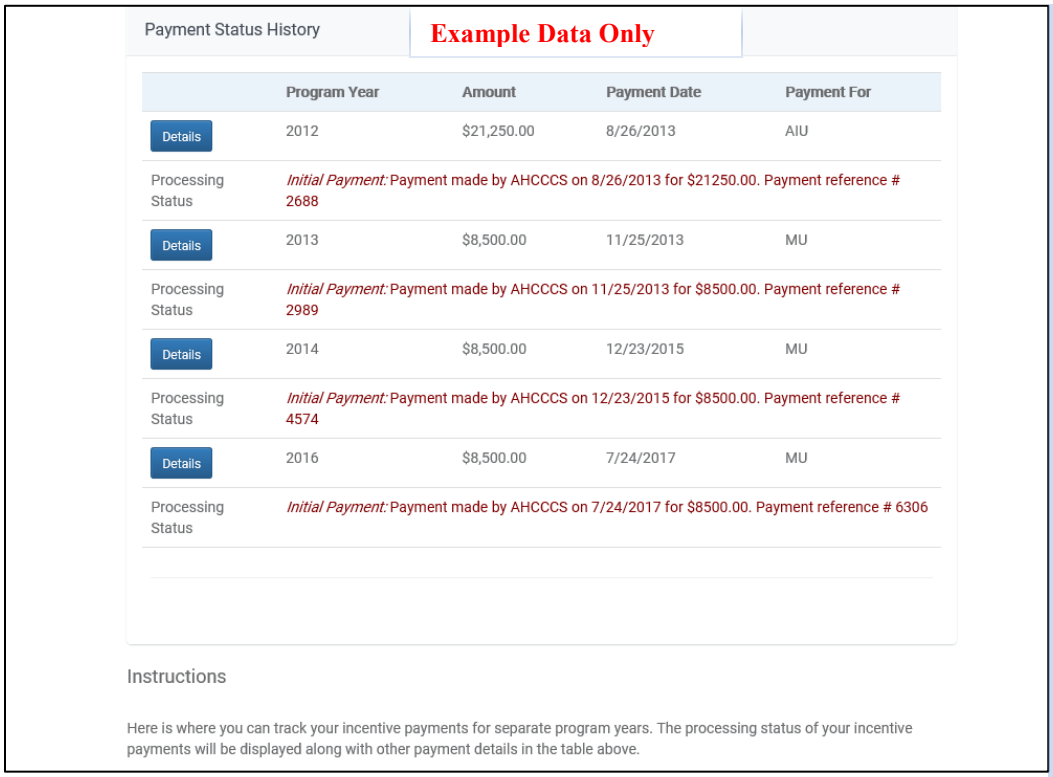
Modify My Security Questions allows you to create or change your security questions and answers.

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

TIP

You must enter your password to modify your security questions.

My Account – How to Manage My Payments



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

Let's take a look:

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

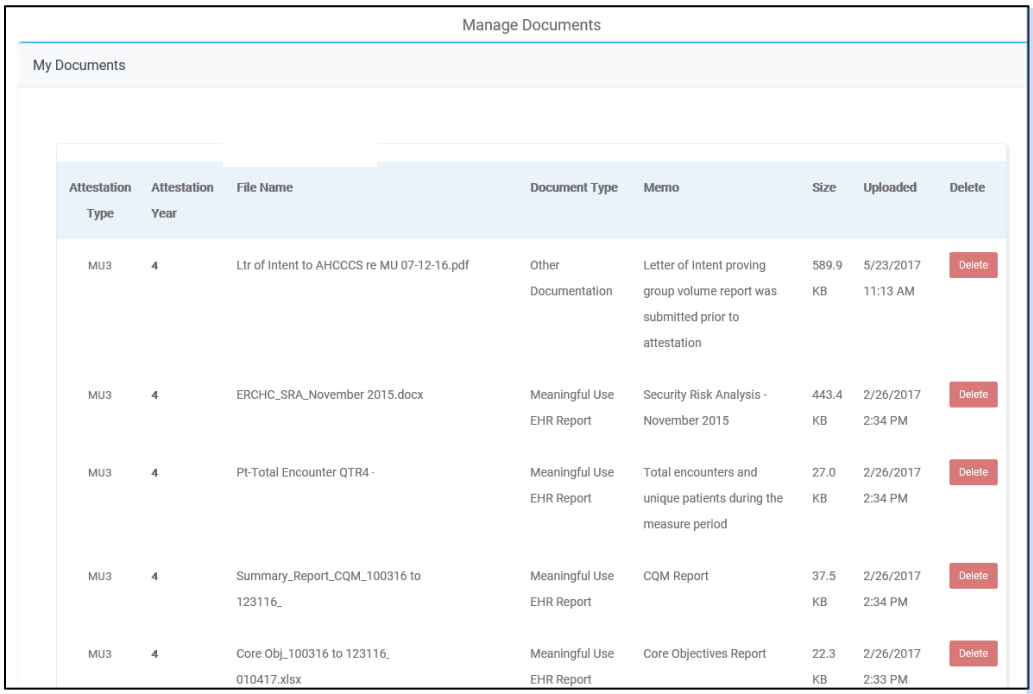
Payments allow you to view your payment history and processing status.

TIP

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

My Account – How to Manage My Documents

Example Data Only



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

Let's take a look at:

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

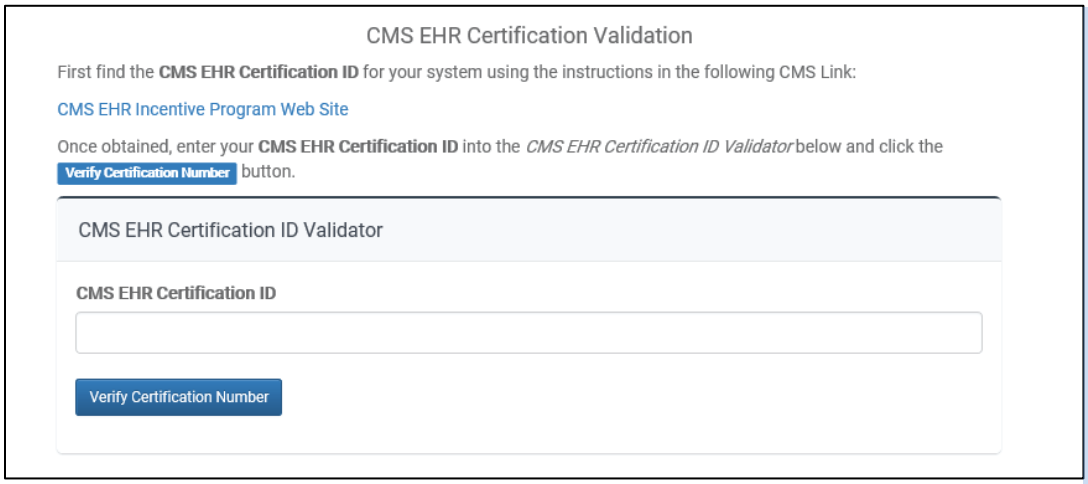
Manage Documents allows you to upload your documentation that supports your attestation.

Click Create New to upload documents.

TIP

Tag your documents by selecting the appropriate label from the drop down list:
☑ Attestation Year – describes the program year for the document
☑ Document Type – describes the type of document you are uploading.

My Account – How to Manage My EHR Certification Number



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

Let's take a look at:

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

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

TIP

The EHR Certification Number is a unique alpha-numeric character string assigned by ONC-Authorized Testing & Certification Board after an PI 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 2 consists of 10 Meaningful Use Objectives that must be met according to CMS threshold. If an EP meets the criteria for and can claim an exclusion for measures that have that option, then the measure(s) is also considered met.
- Meaningful Use Stage 3 consists of 8 Meaningful Use Objectives that must be met according to CMS threshold. If an EP meets the criteria for and can claim an exclusion for measures that have that option, then the measure(s) is also considered met.

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

Changes include:

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

Attestation Instructions 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:

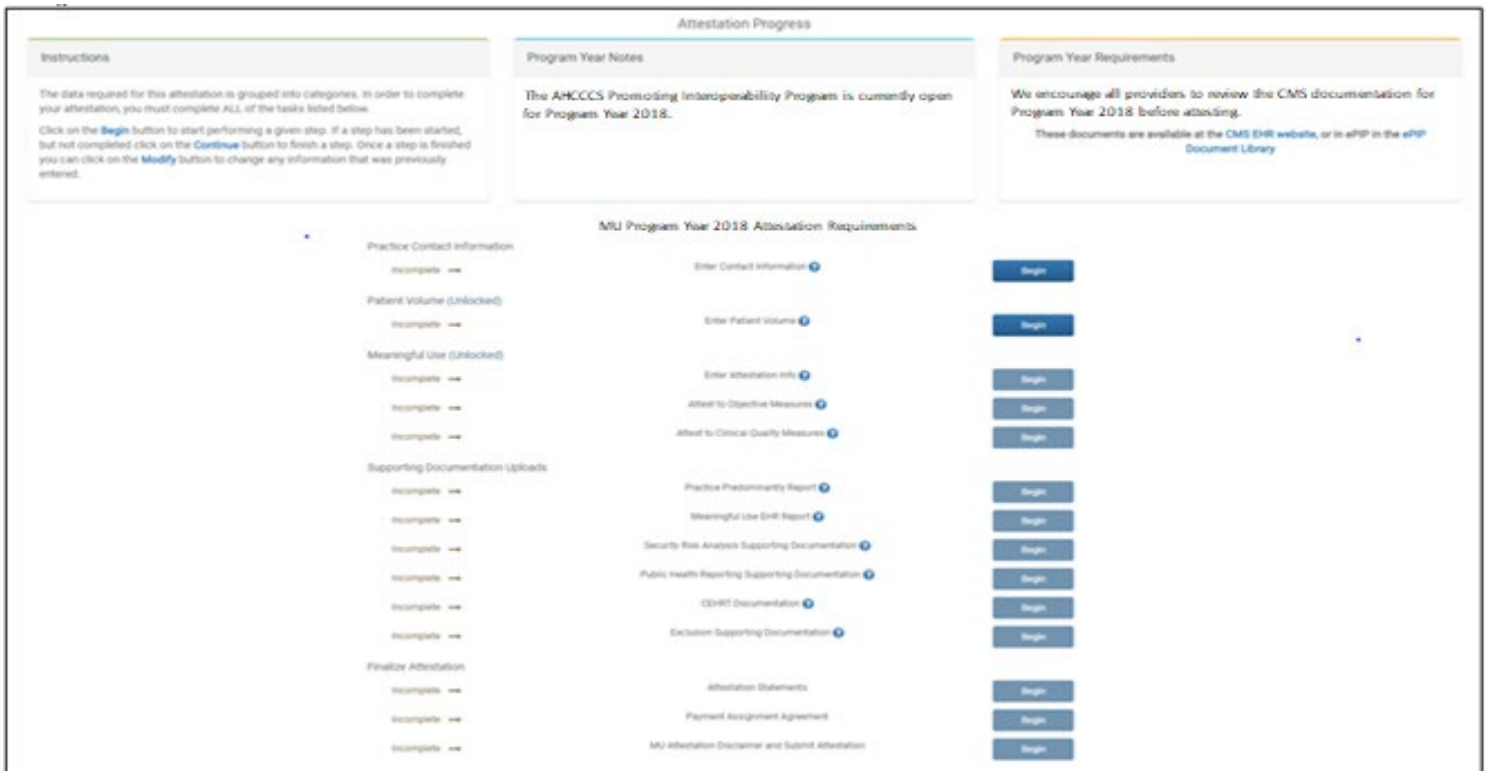
Practice Predominantly Criteria
EPs selecting Needy Individual Patient Volume Type must practice predominantly at FQHC/RHC facilities. Practice Predominantly EPs have more than 50 percent of patient encounters at FQHC/RHC facilities place of service during the 6-month reporting period.

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

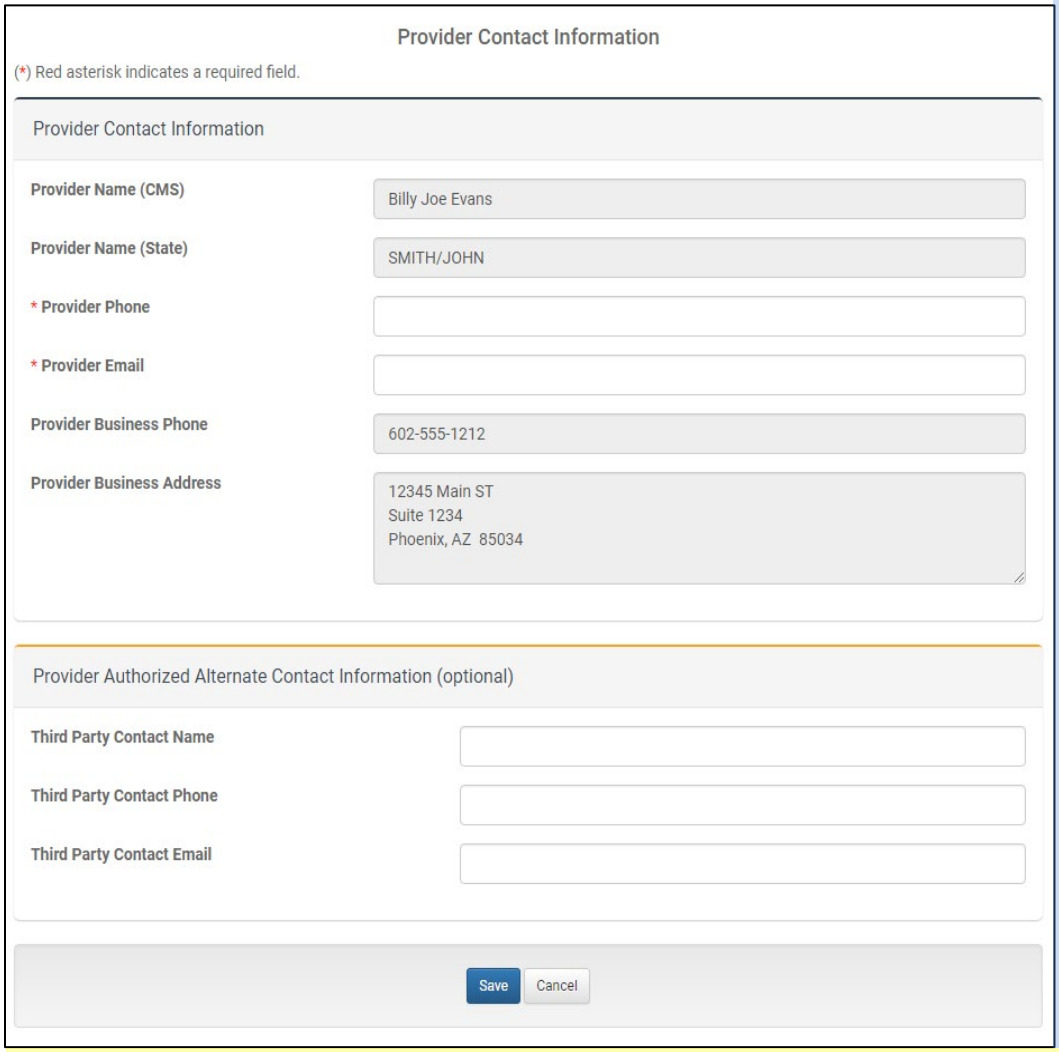
Click the Begin button to complete each step.

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.

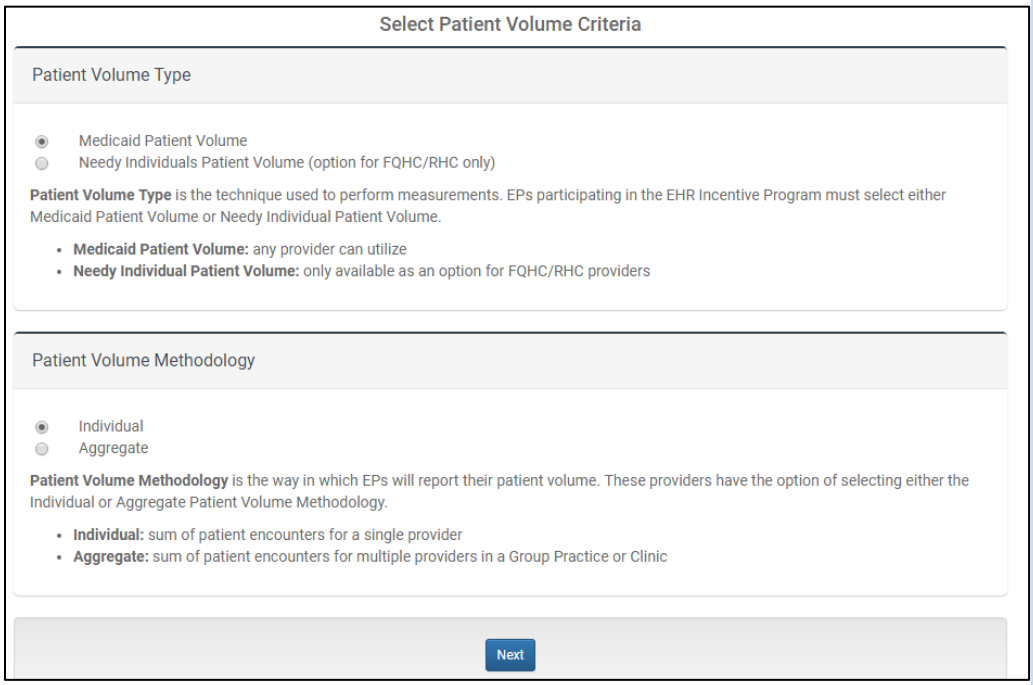
TIP

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.

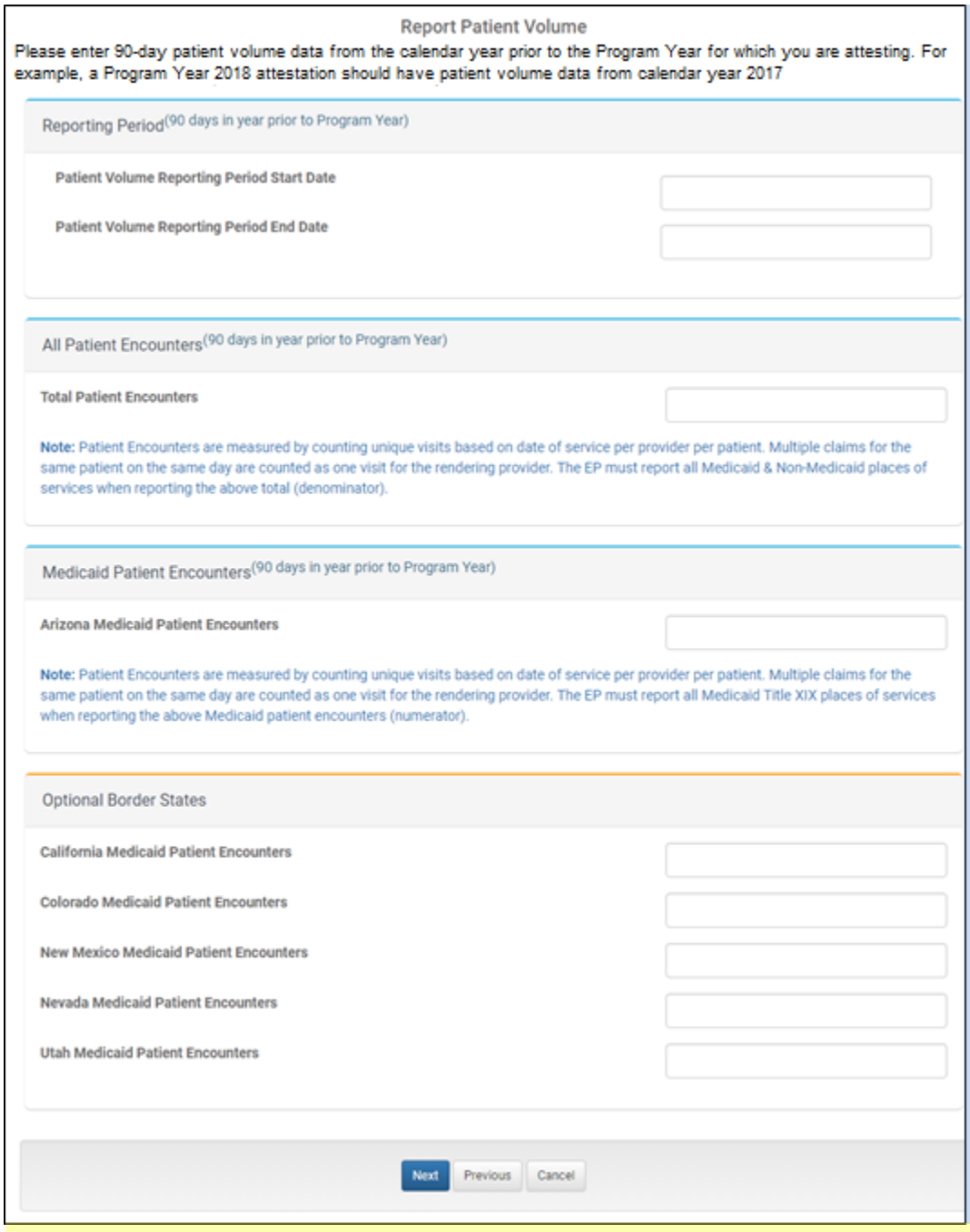
If you are attesting using your group Aggregate patient volume, every provider in the group must also select aggregate".

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.

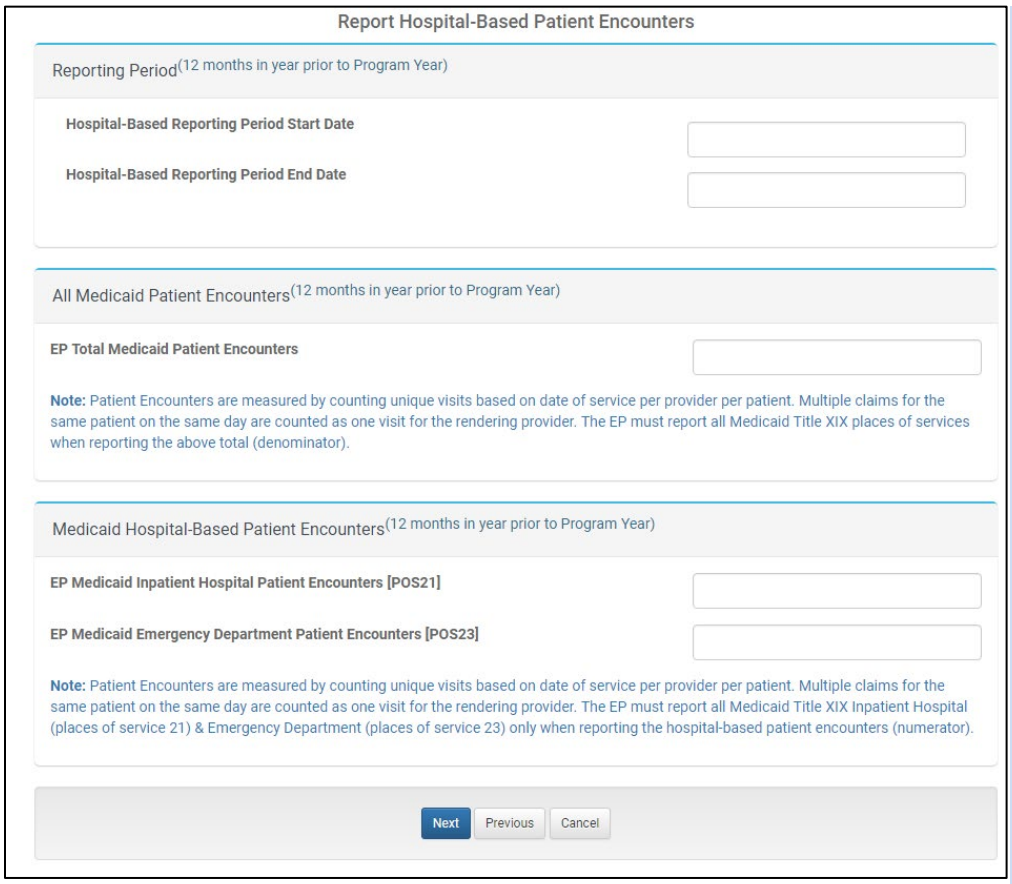
TIP

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

Report Patient Volume

Reporting Period(90 days in year prior to Program Year)

Patient Volume Reporting Period Start Date

Patient Volume Reporting Period End Date

EP Total Patient Encounters(90 days in year prior to Program Year)

Total Patient Encounters

Note: 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 the rendering provider. The EP must report all Medicaid & Non-Medicaid places of services when reporting the above total (denominator).

Arizona Encounters(90 days in year prior to Program Year)

	Medicaid Title XIX	CHIP Title XXI	Patients Paying Below Cost
Arizona Needy Individual Patient Encounters			

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.

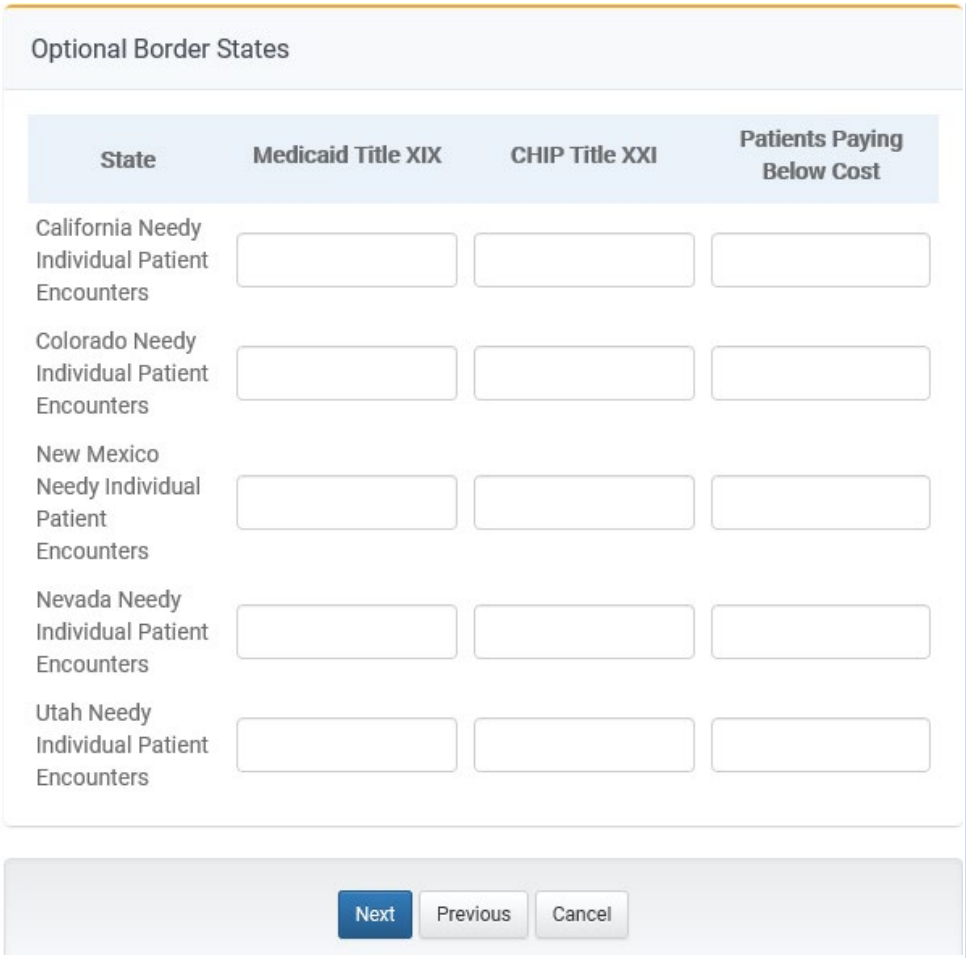
TIP

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



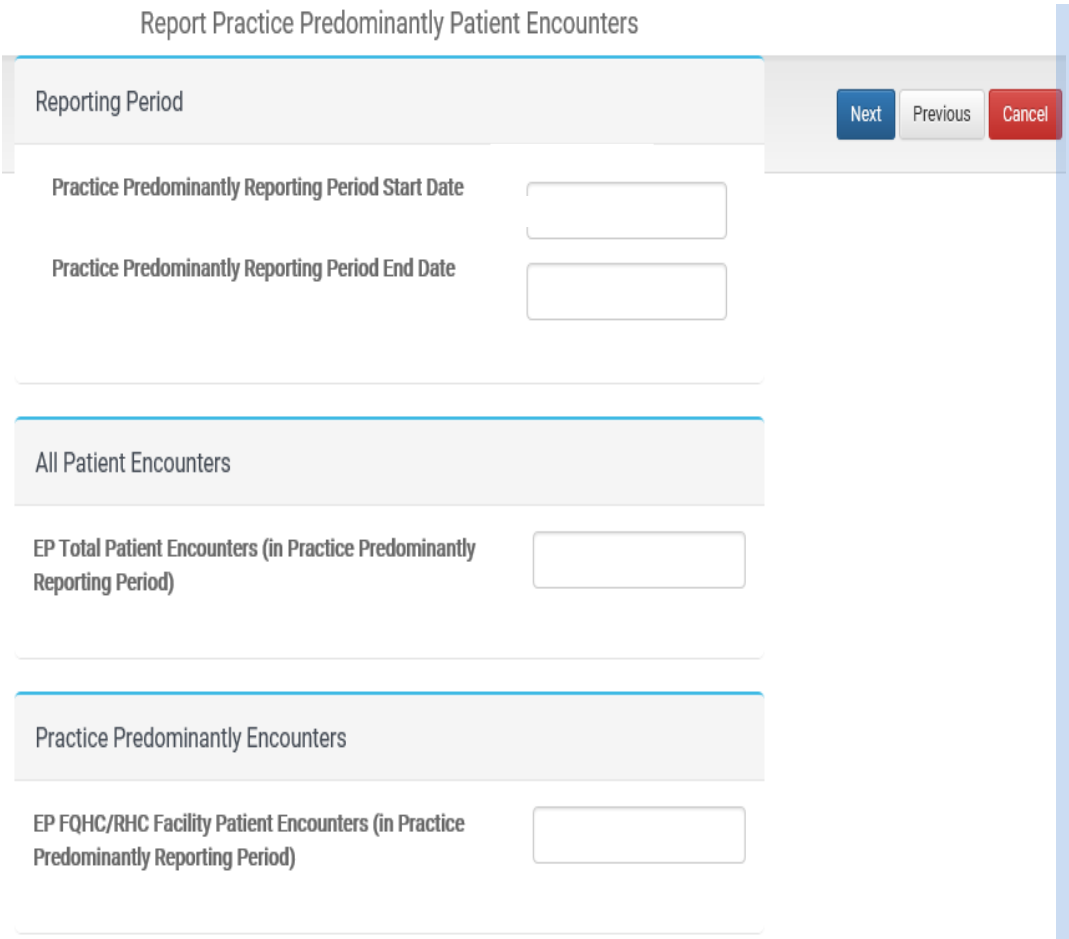
Here is where you report your Medicaid out of state patient encounters for our Border States *(optional if you wish to include in the numerator)*.

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.

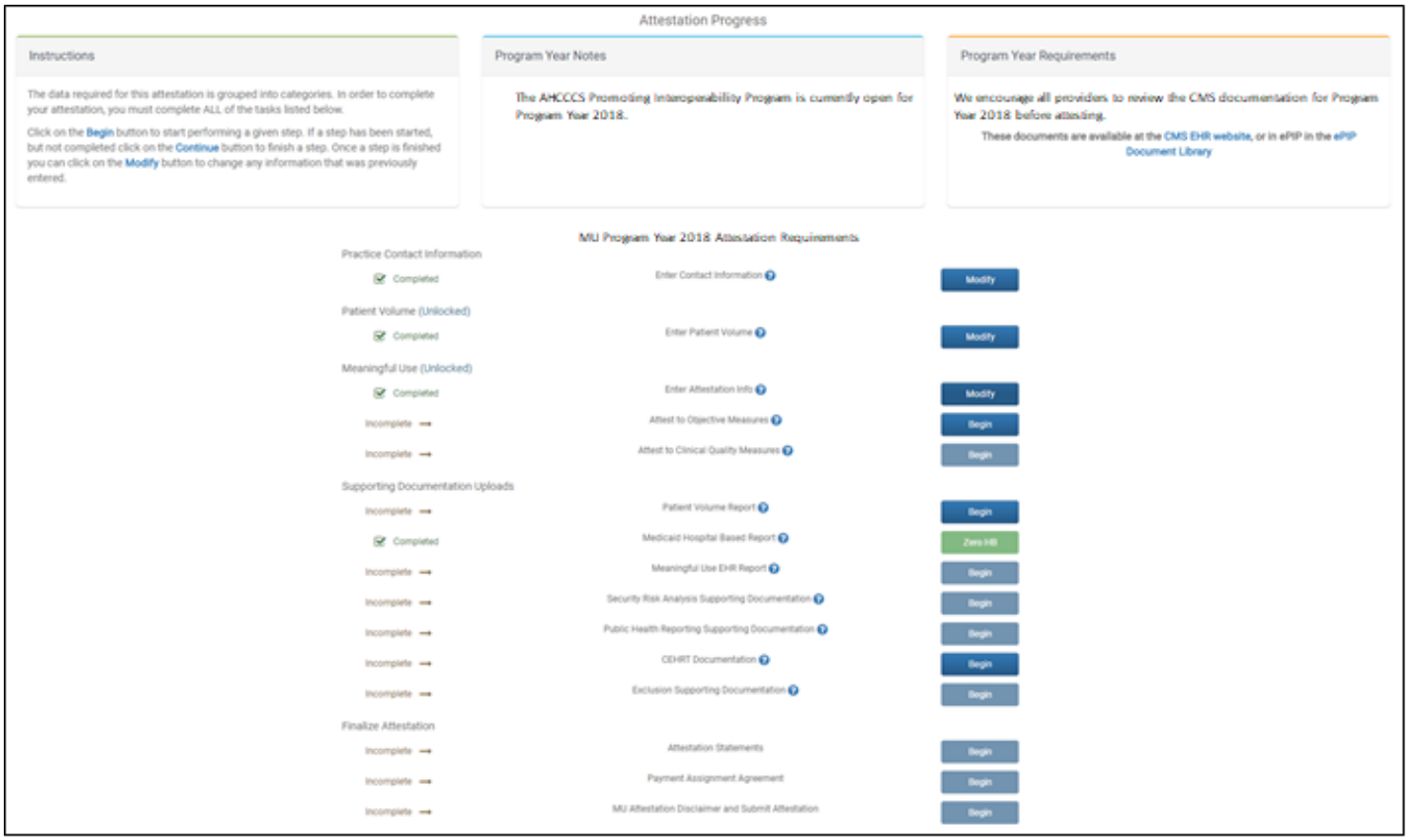
TIP

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.

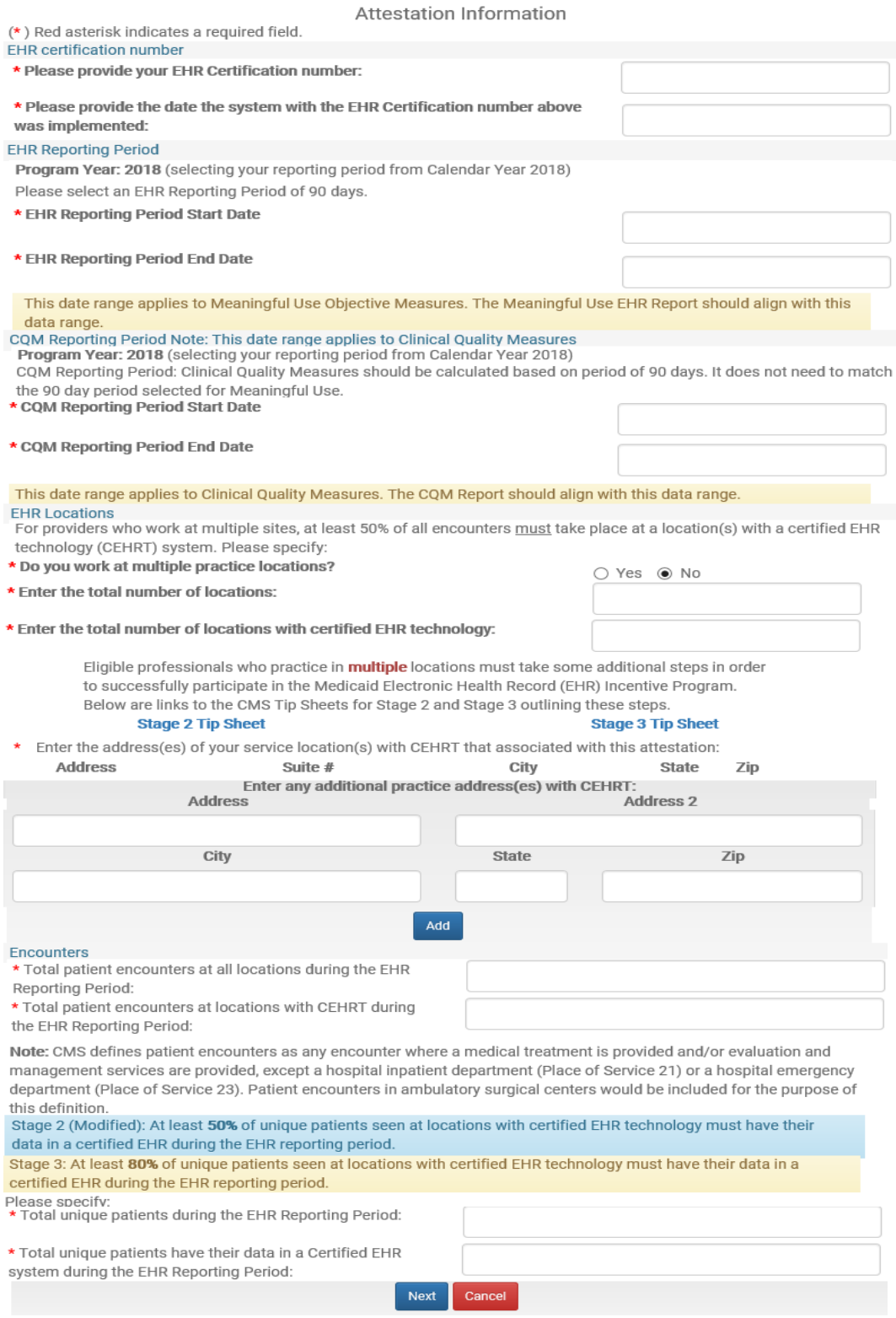
TIP

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


Attestation Information

(*) Red asterisk indicates a required field.

EHR certification number

* Please provide your EHR Certification number:

* Please provide the date the system with the EHR Certification number above was implemented:

EHR Reporting Period

Program Year: 2018 (selecting your reporting period from Calendar Year 2018)

Please select an EHR Reporting Period of 90 days.

* EHR Reporting Period Start Date

* EHR Reporting Period End Date

This date range applies to Meaningful Use Objective Measures. The Meaningful Use EHR Report should align with this data range.

CQM Reporting Period Note: This date range applies to Clinical Quality Measures

Program Year: 2018 (selecting your reporting period from Calendar Year 2018)

CQM Reporting Period: Clinical Quality Measures should be calculated based on period of 90 days. It does not need to match the 90 day period selected for Meaningful Use.

* CQM Reporting Period Start Date

* CQM Reporting Period End Date

This date range applies to Clinical Quality Measures. The CQM Report should align with this data range.

EHR Locations

For providers who work at multiple sites, at least 50% of all encounters must take place at a location(s) with a certified EHR technology (CEHRT) system. Please specify:

* Do you work at multiple practice locations? Yes No

* Enter the total number of locations:

* Enter the total number of locations with certified EHR technology:

Eligible professionals who practice in multiple locations must take some additional steps in order to successfully participate in the Medicaid Electronic Health Record (EHR) Incentive Program. Below are links to the CMS Tip Sheets for Stage 2 and Stage 3 outlining these steps.

Stage 2 Tip Sheet Stage 3 Tip Sheet

* Enter the address(es) of your service location(s) with CEHRT that associated with this attestation:

Address Suite # City State Zip

Enter any additional practice address(es) with CEHRT:

Address Address 2

City State Zip

Add

Encounters

* Total patient encounters at all locations during the EHR Reporting Period:

* Total patient encounters at locations with CEHRT during the EHR Reporting Period:

Note: CMS defines patient encounters as any encounter where a medical treatment is provided and/or evaluation and management services are provided, except a hospital inpatient department (Place of Service 21) or a hospital emergency department (Place of Service 23). Patient encounters in ambulatory surgical centers would be included for the purpose of this definition.

Stage 2 (Modified): At least 50% of unique patients seen at locations with certified EHR technology must have their data in a certified EHR during the EHR reporting period.

Stage 3: At least 80% of unique patients seen at locations with certified EHR technology must have their data in a certified EHR during the EHR reporting period.

Please specify:

* Total unique patients during the EHR Reporting Period:

* Total unique patients have their data in a Certified EHR system during the EHR Reporting Period:

Next Cancel

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

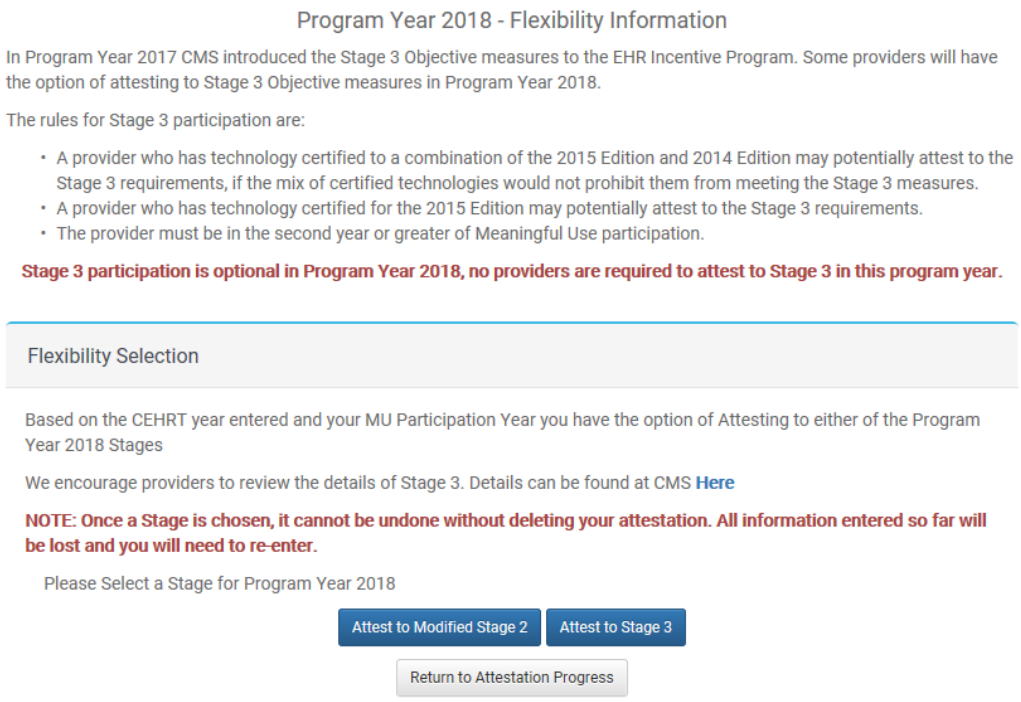
First, we will need some general information about your PI system. Be sure to tell us if you have patients that are still maintained on paper records (Non-CEHRT).

You must select your PI Reporting Period start & end date from calendar year 2018 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.

Program Year 2018 Flexibility Information



Providers have the option of attesting to Stage 2 or Stage 3 depending on their system's certification *(in effect no later than December 31, 2018)*.

Rules for Stage 3 participation:

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

☑ Providers with technology certified for the 2015 Edition.

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

Flexibility:

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

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

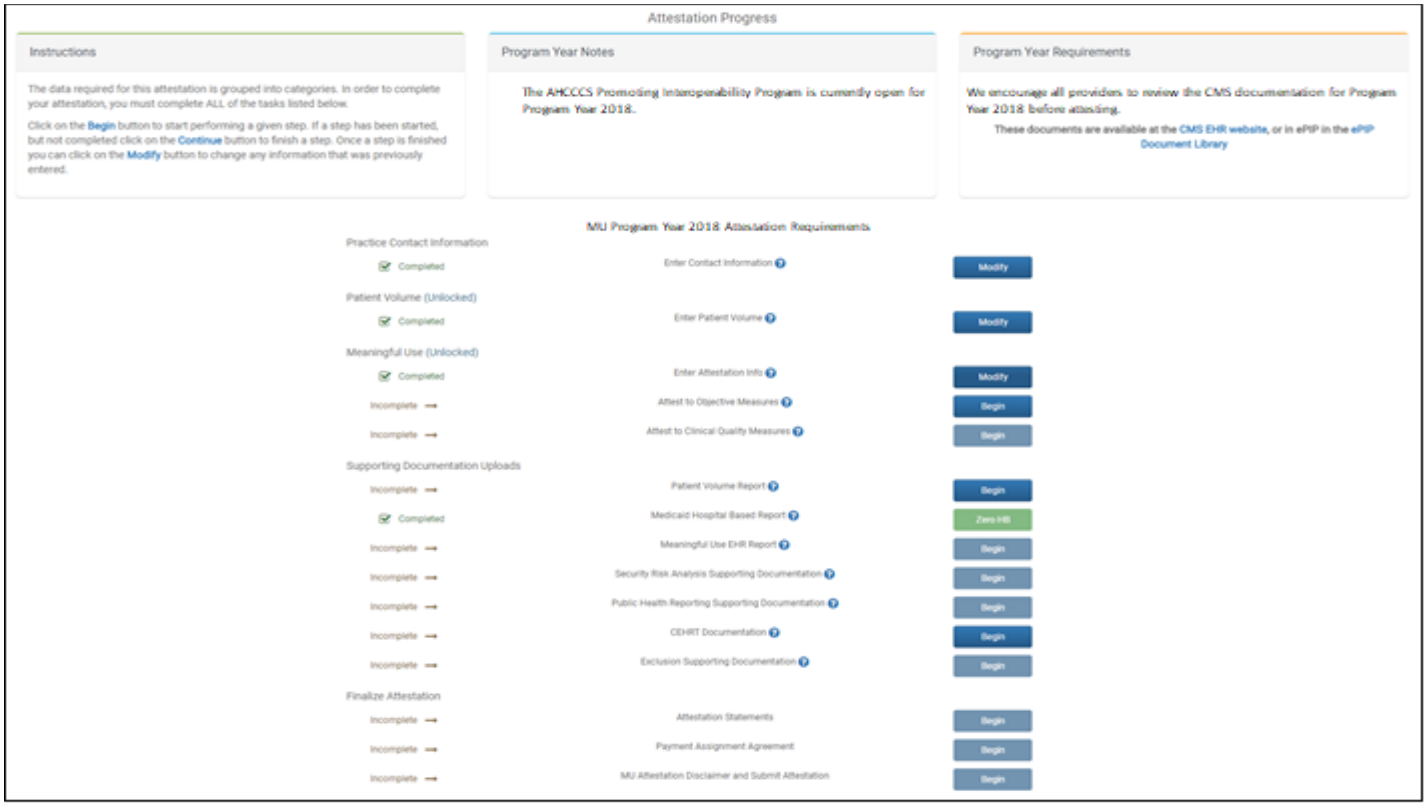
TIP

Click one of the following buttons:

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

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

Attestation Progress (After Attestation Information)



Note that as you complete each step:

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

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

Remember that each requirement task must be followed sequentially.

TIP

Click the Begin button to complete each step.

Click Continue button to finish a step.

Click Modify button to change information previously entered.

Meaningful Use Requirements for Program Year 2018 Stage 2 Modified

	Meaningful Use Objectives for Stage 2 Modified
	Providers with systems certified with a 2014 CEHRT as of 12.31.2018
1	Protect electronic protected health information (ePHI) created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.
2	Use clinical decision support (CDS) to improve performance on high-priority health conditions.
3	Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.
4	Generate and transmit permissible prescriptions electronically (eRx).
5	The eligible professional (EP) who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
6	Use clinically relevant information from certified electronic health record technology (CEHRT) to identify patient-specific education resources and provide those resources to the patient.
7	The eligible professional (EP) who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.
8	Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the eligible professional (EP)..
9	Use secure electronic messaging to communicate with patients on relevant health information.
10	The eligible professional (EP) is in active engagement with a public health agency (PHA) to submit electronic public health data from certified electronic health record technology (CEHRT) except where prohibited and in accordance with applicable law and practice.

Welcome to Stage 2Modified

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

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

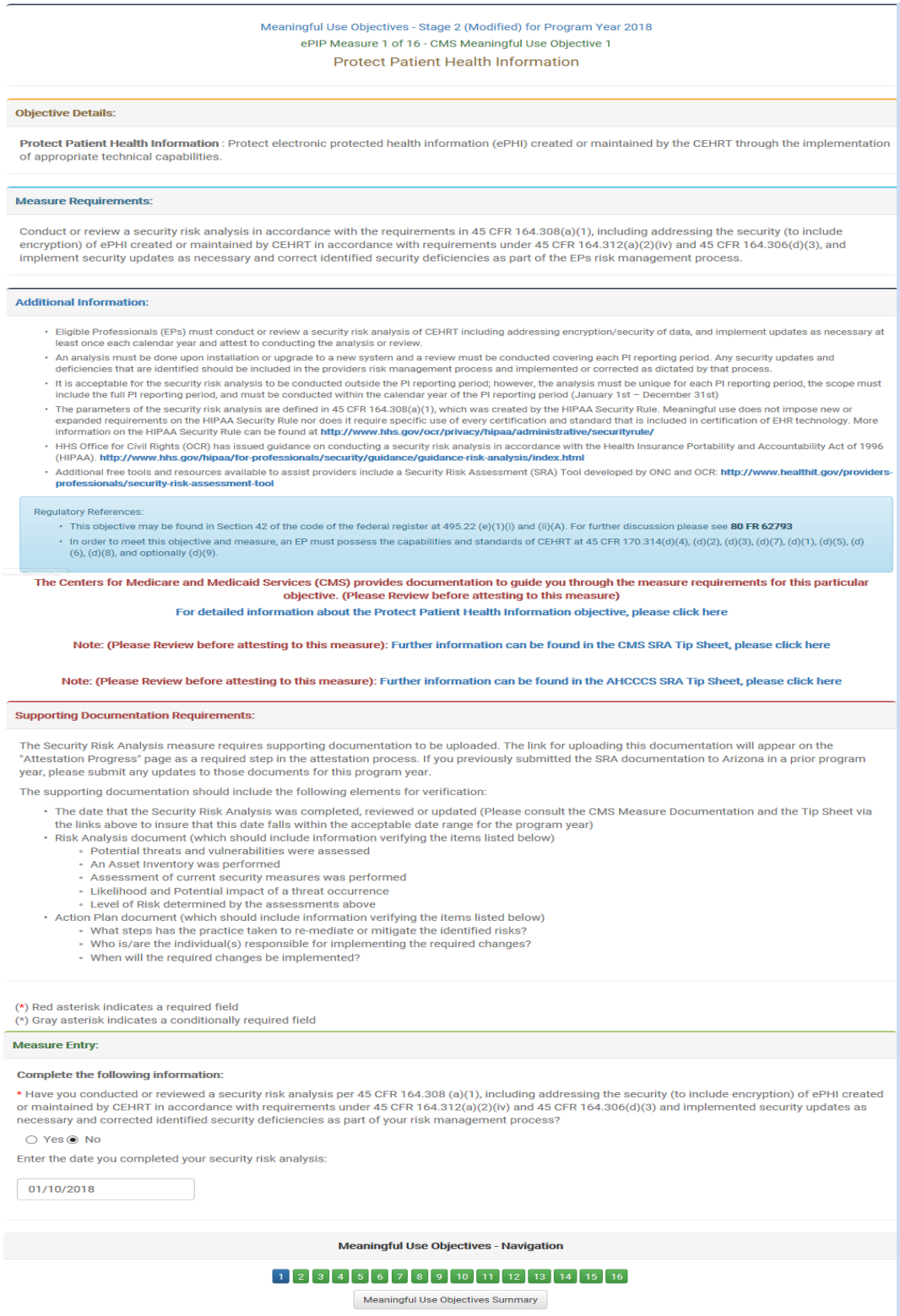
There are changes to the measure calculations policy, which specifies that actions included in the numerator must occur during the PI reporting period.

TIP

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

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

Stage 2 Modified Objective 1 Measure 1 Protected Health Information



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 1 of 16 - CMS Meaningful Use Objective 1
Protect Patient Health Information

Objective Details:

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

Measure Requirements:

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

Additional Information:

- Eligible Professionals (EPs) must conduct or review a security risk analysis of CEHRT including addressing encryption/security of data, and implement updates as necessary at least once each calendar year and attest to conducting the analysis or review.
- 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 providers risk management process and implemented or corrected as dictated by that process.
- It is acceptable for the security risk analysis to be conducted outside the PI reporting period; however, the analysis must be unique for each PI reporting period, the scope must include the full PI reporting period, and must be conducted within the calendar year of the PI reporting period (January 1st – December 31st)
- 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 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62793**
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.314(d)(4), (d)(2), (d)(3), (d)(7), (d)(1), (d)(5), (d)(6), (d)(8), and optionally (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 can be found in the CMS SRA Tip Sheet, please click here

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

Supporting Documentation Requirements:

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

The supporting documentation should include the following elements for verification:

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

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

Measure Entry:

Complete the following information:

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

○ Yes ◉ No

Enter the date you completed your security risk analysis:

01/10/2018

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2M **Screen 1**

Protected Health Information

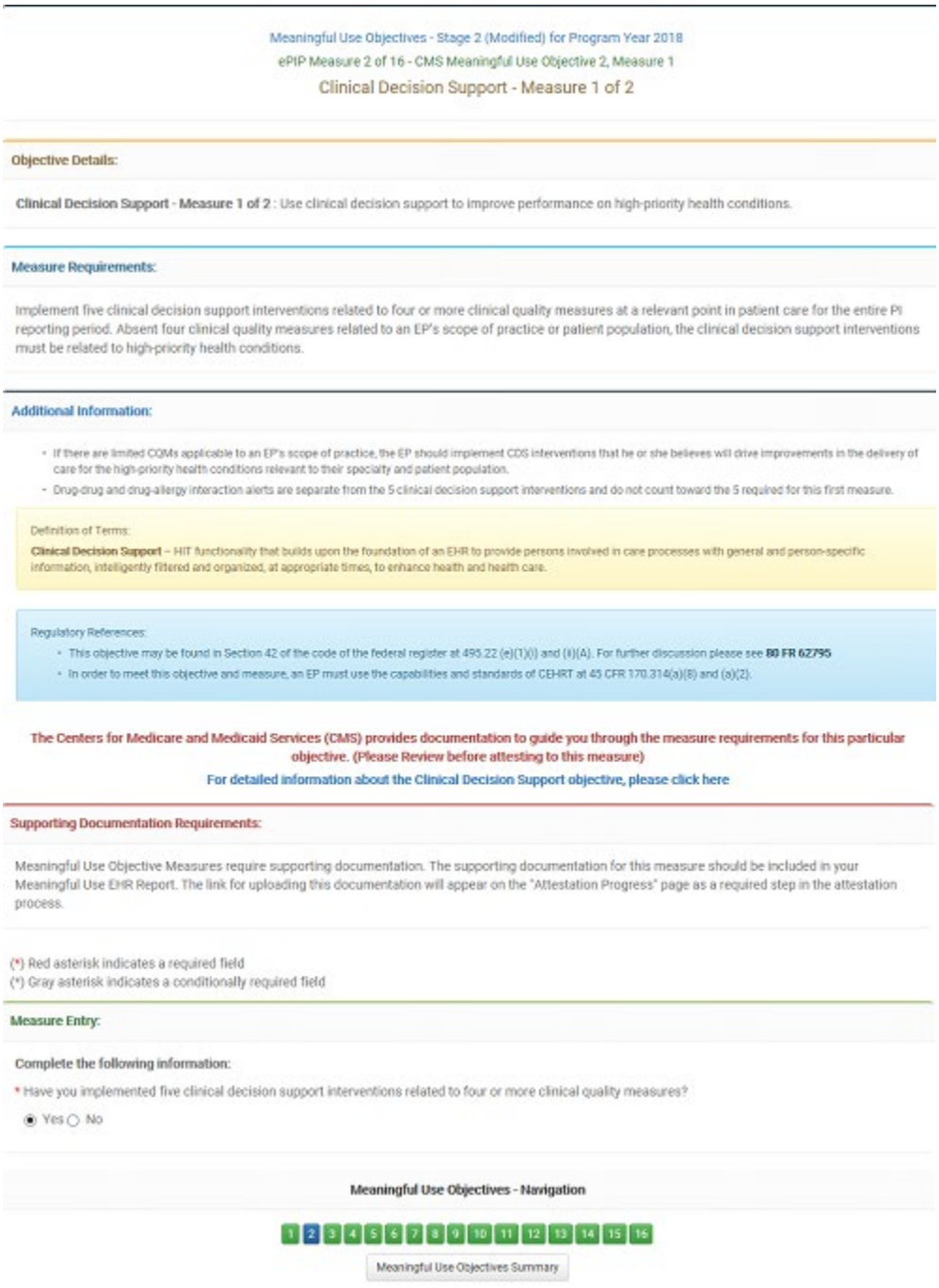
☑ Measure 1

Complete all required fields.
You must upload your Security Risk Analysis Report documentation separately.
You must have completed the Security Risk Analysis in 2017.
CEHRT is *"certified electronic health record technology"*
The Navigation bar at the bottom will monitor your progress.

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

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

Stage 2 Modified Objective 2 Measure 1 Clinical Decision Support



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018

ePIP Measure 2 of 16 - CMS Meaningful Use Objective 2, Measure 1

Clinical Decision Support - Measure 1 of 2

Objective Details:

Clinical Decision Support - Measure 1 of 2 : Use clinical decision support to improve performance on high-priority health conditions.

Measure Requirements:

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

- 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 the high-priority health conditions relevant to their specialty and patient population.
- Drug-drug and drug-allergy interaction alerts are separate from the 5 clinical decision support interventions and do not count toward the 5 required for this first measure.

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 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62795**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(8) and (a)(2).

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?

◉ Yes ○ No

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2[M] **Screen 2**

Clinical Decision Support

☑ Measure 1

Complete all required fields.

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

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

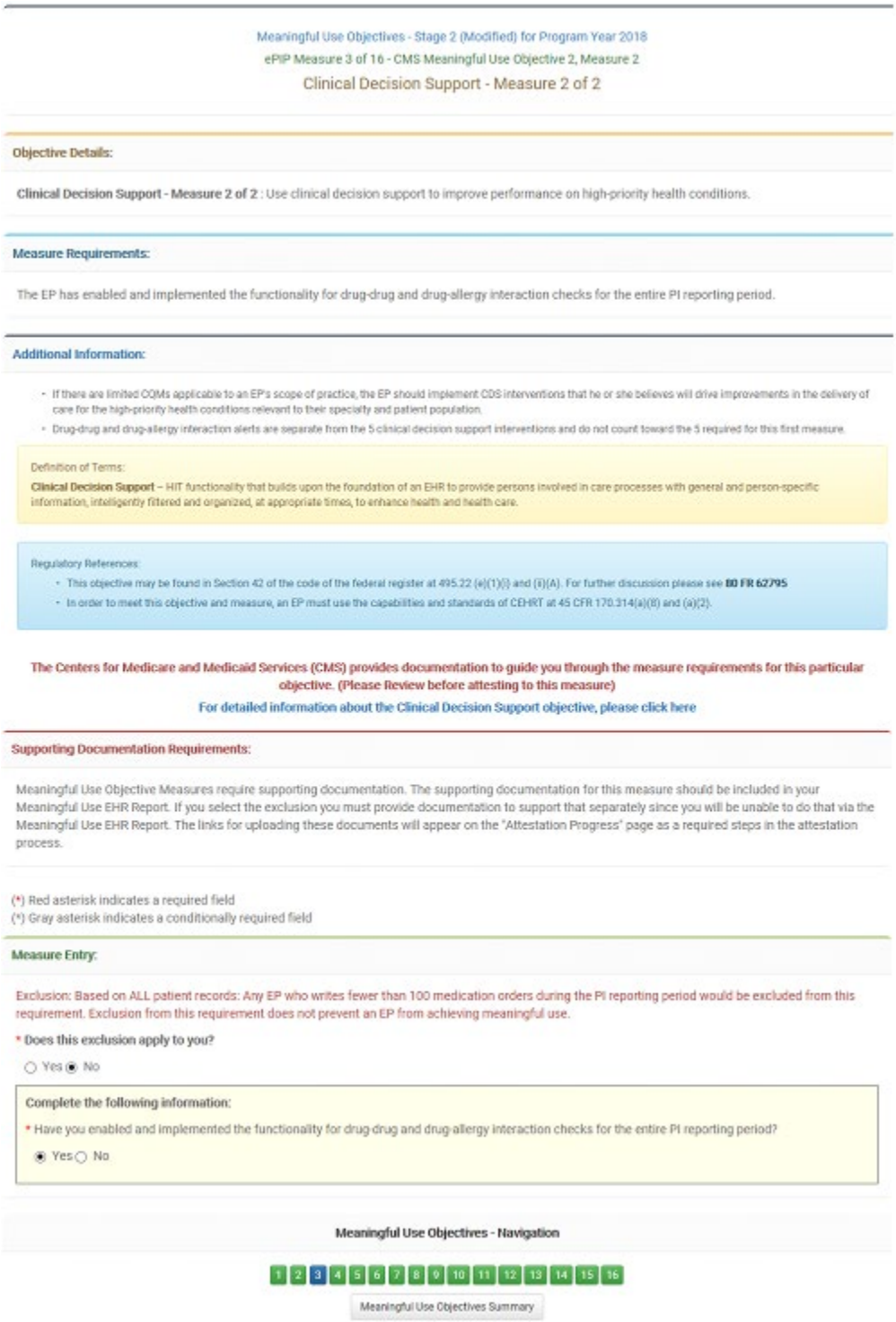
The Navigation bar at the bottom will monitor your progress.

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 2 Modified Objective 2 Measure 2 Clinical Decision Support



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 3 of 16 - CMS Meaningful Use Objective 2, Measure 2
Clinical Decision Support - Measure 2 of 2

Objective Details:

Clinical Decision Support - Measure 2 of 2 : Use clinical decision support to improve 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:

- 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 the high-priority health conditions relevant to their specialty and patient population.
- Drug-drug and drug-allergy interaction alerts are separate from the 5 clinical decision support interventions and do not count toward the 5 required for this first measure.

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 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62795**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(8) and (a)(2).

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

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

Measure Entry:

Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 medication orders during the 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 PI reporting period?
◉ Yes ○ No

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

Stage 2^{M} **Screen 3**

Clinical Decision Support

☑ Measure 2

Complete all required fields.

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

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

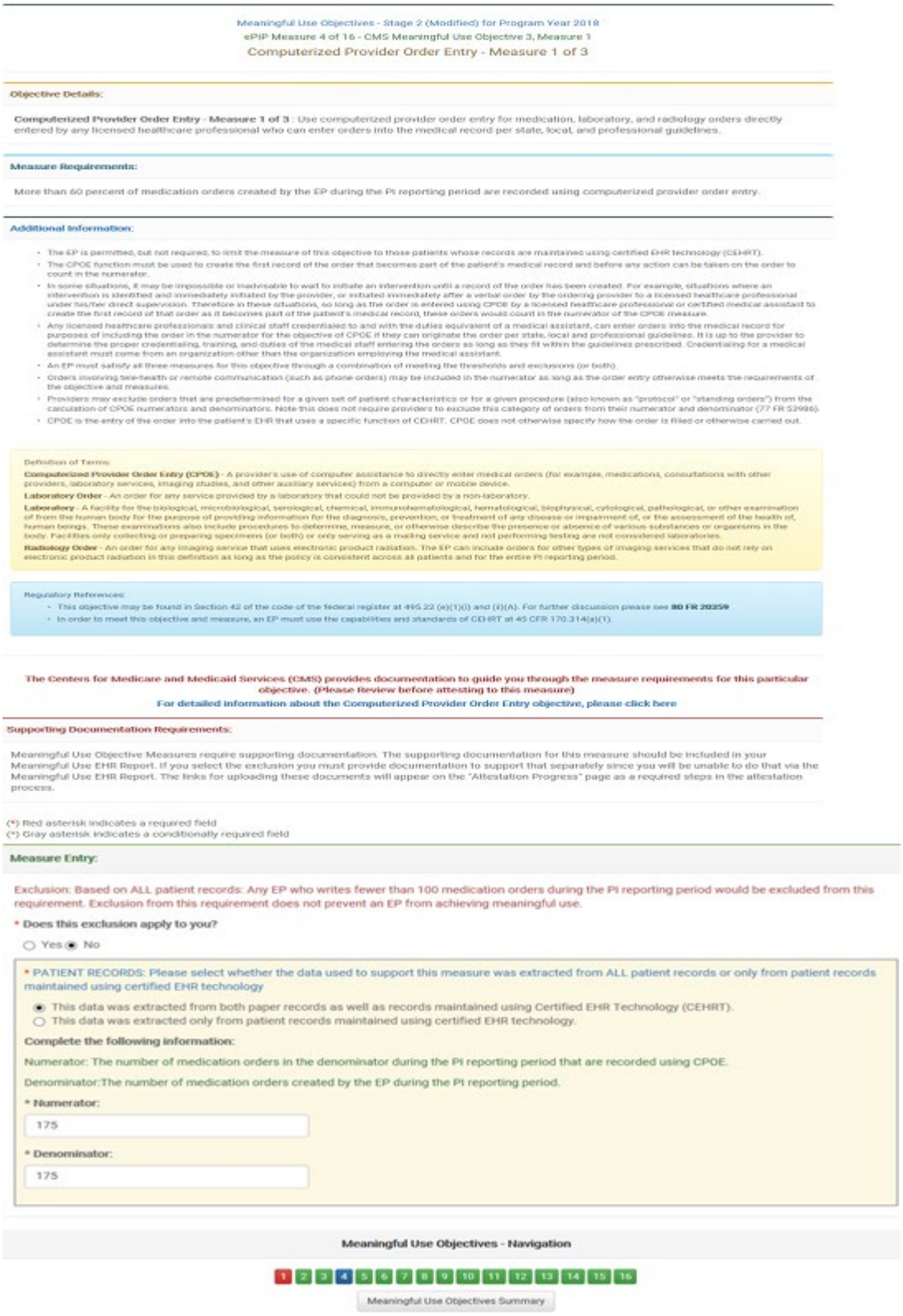
The Navigation bar at the bottom will monitor your progress.

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 under Meaningful Use PI Report.

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

Stage 2 Modified Objective 3 Measure 1 Computerized Provider Order Entry



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 4 of 16 - CMS Meaningful Use Objective 3, Measure 1
Computerized Provider Order Entry - Measure 1 of 3

Objective Details:

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

Measure Requirements:

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

Additional Information:

- The EP is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- 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 to count in the numerator.
- 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 provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under his/her direct supervision. Therefore in these situations, so long as the order is entered using CPOE by a licensed healthcare professional or certified medical assistant to create the first record of that order as it becomes part of the patient's medical record, these orders would count in the numerator of the CPOE measure.
- Any licensed healthcare professionals and clinical staff credentialed to and with the duties equivalent of a medical assistant, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. It is up to the provider 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 (or both).
- Orders involving tele-health 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 objective and measures.
- Providers 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. Note this does not require providers to exclude this category of orders from their numerator and denominator (77 FR 53986).
- 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.

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 495.22 (e)(1)(i) and (ii)(A). For further discussion please see 80 FR 20359
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(1).

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

Supporting Documentation Requirements:

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

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

Measure Entry:

Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 medication orders during the 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:

175

* Denominator:

175

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2M **Screen 4**

Computerized Provider Order Entry

☑ Measure 1

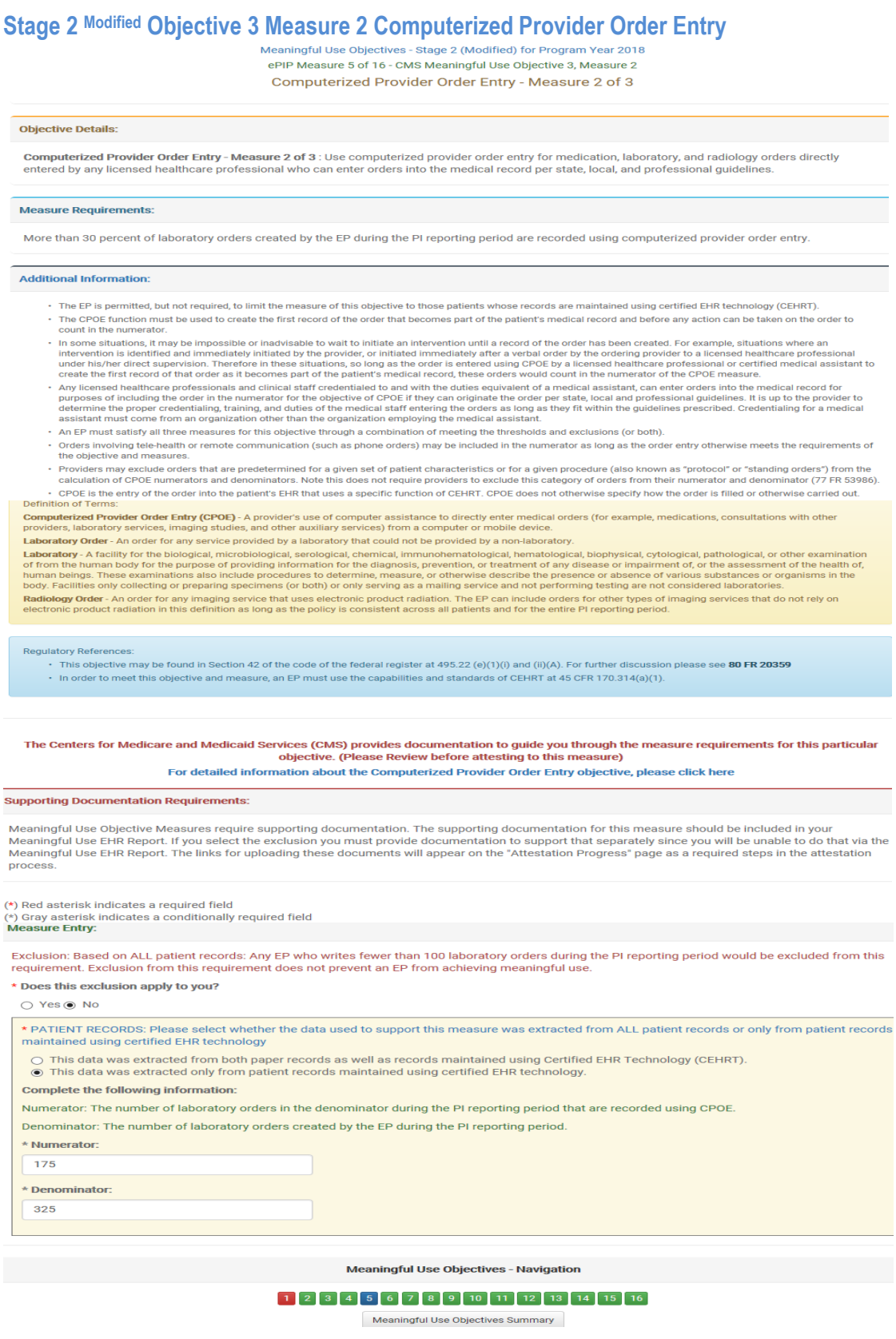
Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.

TIP:
Make sure that you upload all documents that support the above entries in your attestation.
You can do so on the Attestation Progress page.
Click the hyperlink on the ePIP screen to learn more about this requirement.



Stage 2 Modified Objective 3 Measure 2 Computerized Provider Order Entry

Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 5 of 16 - CMS Meaningful Use Objective 3, 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 for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

Measure Requirements:

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

Additional Information:

- The EP is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- 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 to count in the numerator.
- 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 provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under his/her direct supervision. Therefore in these situations, so long as the order is entered using CPOE by a licensed healthcare professional or certified medical assistant to create the first record of that order as it becomes part of the patient's medical record, these orders would count in the numerator of the CPOE measure.
- Any licensed healthcare professionals and clinical staff credentialed to and with the duties equivalent of a medical assistant, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. It is up to the provider 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 (or both).
- Orders involving tele-health 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 objective and measures.
- Providers 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. Note this does not require providers to exclude this category of orders from their numerator and denominator (77 FR 53986).
- 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.

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 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 20359**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(1).

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

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

Supporting Documentation Requirements:

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

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

Measure Entry:

Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 laboratory 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:**

175

* **Denominator:**

325

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2M **Screen 5**

Computerized Provider Order Entry

☑ Measure 2

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.

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

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

Stage 2 Modified Objective 3 Measure 3 Computerized Provider Order Entry

Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 6 of 16 - CMS Meaningful Use Objective 3, Measure 3
Computerized Provider Order Entry - Measure 3 of 3

Objective Details:

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

Measure Requirements:

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

Additional Information:

- The EP is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- 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 to count in the numerator.
- 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 provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under his/her direct supervision. Therefore in these situations, so long as the order is entered using CPOE by a licensed healthcare professional or certified medical assistant to create the first record of that order as it becomes part of the patient's medical record, these orders would count in the numerator of the CPOE measure.
- Any licensed healthcare professionals and clinical staff credentialed to and with the duties equivalent of a medical assistant, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. It is up to the provider 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 (or both).
- Orders involving tele-health 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 objective and measures.
- Providers 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. Note this does not require providers to exclude this category of orders from their numerator and denominator (77 FR 53986).
- 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.

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 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 20359**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(a)(1).

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

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

Supporting Documentation Requirements:

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

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

Measure Entry:

Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 radiology orders during the 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 radiology orders in the denominator during the PI reporting period that are recorded using CPOE.

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

* **Numerator:**

175

* **Denominator:**

325

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2M Screen 6

Computerized Provider Order Entry

☑ Measure 3

Complete all required fields.

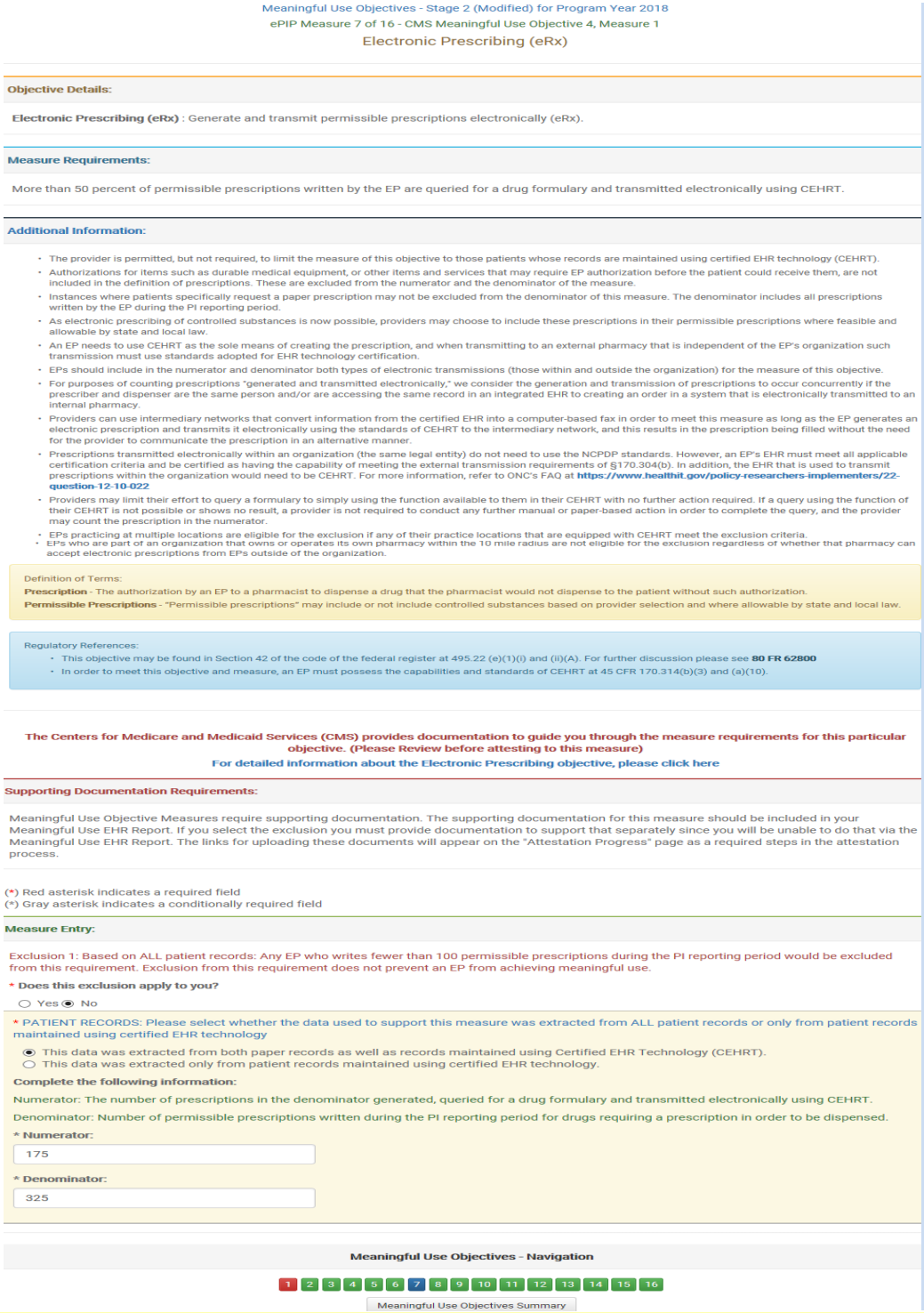
If you select the exclusions, you must upload documentation to support that separately.

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

The Navigation bar at the bottom will monitor your progress.

TIP:
Make sure that you upload all documents that support the above entries in your attestation.
You can do so on the Attestation Progress page.
Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 4 Measure 1 Electronic Prescribing



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 7 of 16 - CMS Meaningful Use Objective 4, Measure 1
Electronic Prescribing (eRx)

Objective Details:

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

Measure Requirements:

More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

Additional Information:

- 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.
- 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 - "Permissible prescriptions" may include or not include controlled substances based on provider selection and where allowable by state and local law.

Regulatory References:
- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62800**
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHRT at 45 CFR 170.314(b)(3) and (a)(10).

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

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

Measure Entry:

Exclusion 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

* 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 permissible prescriptions written during the PI reporting period for drugs requiring a prescription in order to be dispensed.

* **Numerator:**
175

* **Denominator:**
325

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2M **Screen 7**

Electronic Prescribing (eRx)

☑ Measure 1

Complete all required fields.

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

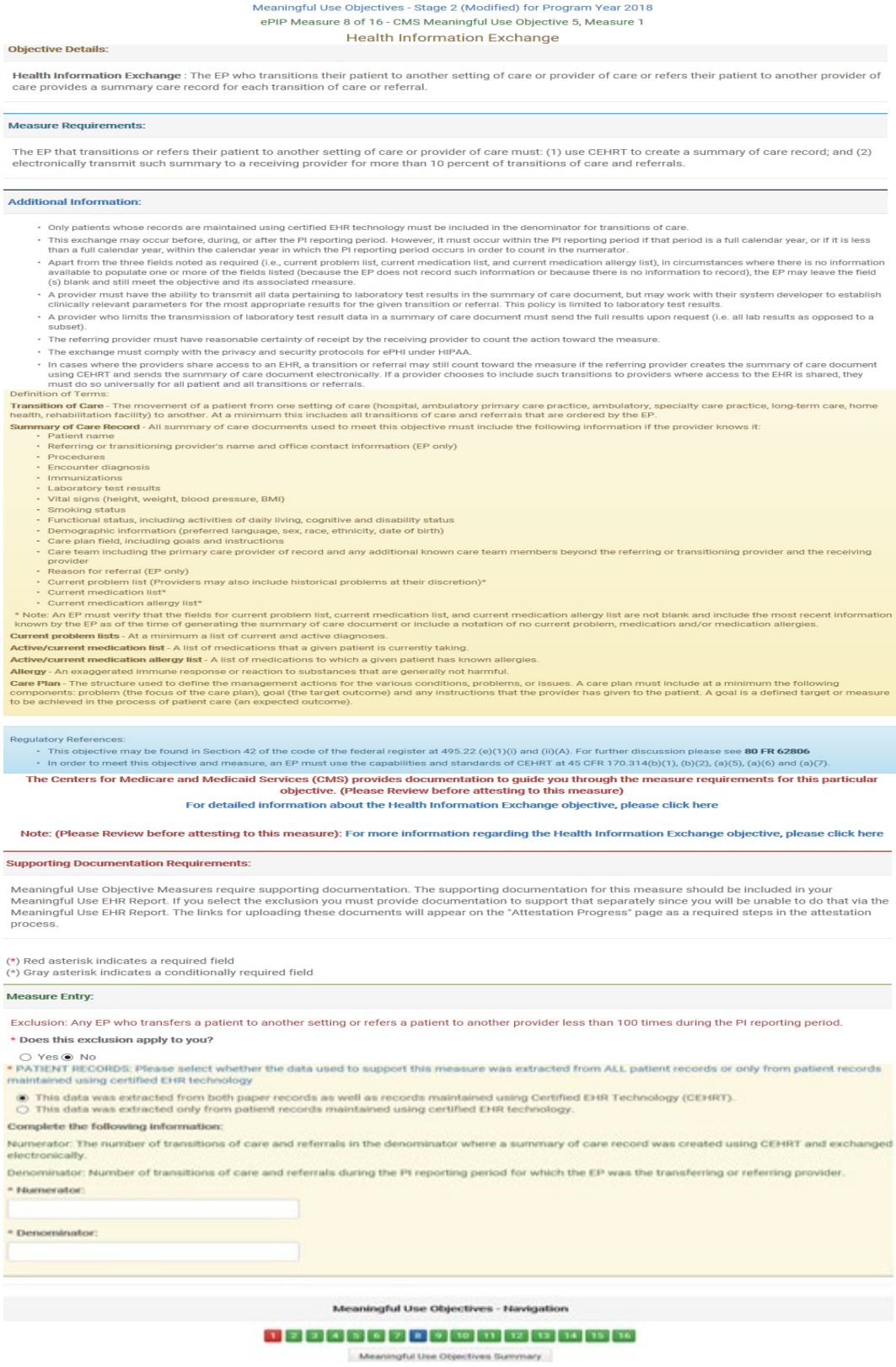
The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Stage 2 Modified Objective 5 Measure 1 Health Information Exchange



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 8 of 16 - CMS Meaningful Use Objective 5, Measure 1
Health Information Exchange

Objective Details:

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

Measure Requirements:

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

Additional Information:

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- This exchange may occur before, during, or after the PI reporting period. However, it must occur within the PI 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 PI reporting period occurs in order to count in the numerator.
- Apart from the three fields noted as required (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.
- A provider 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. This policy is limited to laboratory test results.
- A provider 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 referring provider must have reasonable certainty of receipt by the receiving provider to count the action toward the measure.
- The exchange must comply with the privacy and security protocols for ePHI under 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 a provider 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.

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).

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62806**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(b)(1), (b)(2), (a)(5), (a)(6) and (a)(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 Health Information Exchange objective, please click here

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

Supporting Documentation Requirements:

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

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

Measure Entry:

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

Meaningful Use Objectives Summary

Stage 2M **Screen 8**

Health Information Exchange

☑ Measure 1

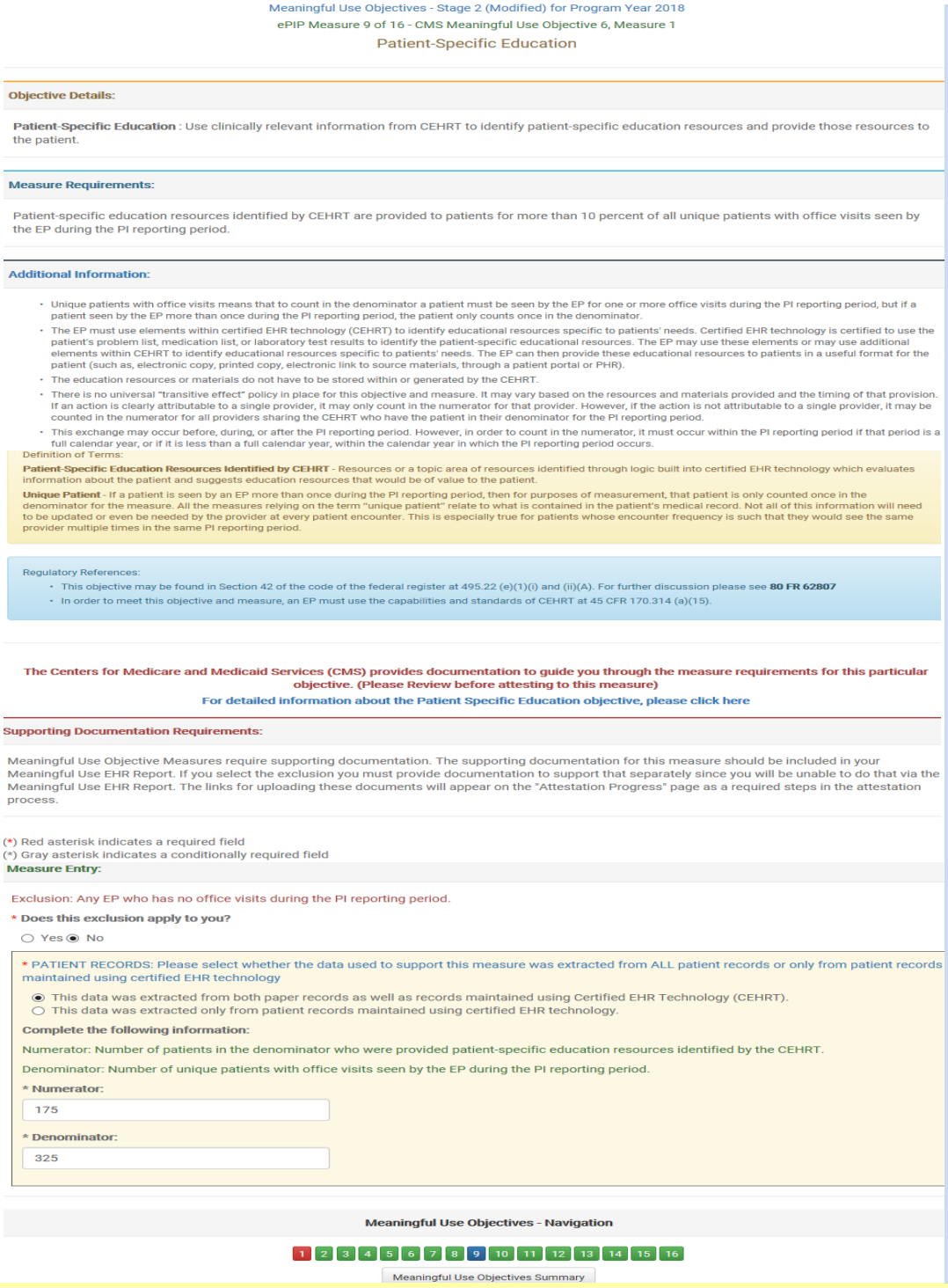
Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.

TIP:
Make sure that you upload all documents that support the above entries in your attestation.
You can do so on the Attestation Progress page.
Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 6 Measure 1 Patient Specific Education



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 9 of 16 - CMS Meaningful Use Objective 6, Measure 1
Patient-Specific Education

Objective Details:

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

Measure Requirements:

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

Additional Information:

- Unique patients with office visits means that to count in the denominator a patient must be seen by the EP for one or more office visits during the PI reporting period, but if a patient seen by the EP more than once during the PI reporting period, the patient only counts once in the denominator.
- The EP must use elements within certified EHR technology (CEHRT) to identify educational resources specific to patients' needs. Certified EHR technology is certified to use the patient's problem list, medication list, or laboratory test results to identify the patient-specific educational resources. The EP may use these elements or may use additional elements within CEHRT to identify educational resources specific to patients' needs. The EP can then provide these educational resources to patients in a useful format for the patient (such as, electronic copy, printed copy, electronic link to source materials, through a patient portal or PHR).
- The education resources or materials do not have to be stored within or generated by the CEHRT.
- There is no universal "transitive effect" policy in place for this objective and measure. It may vary based on the resources and materials provided and the timing of that provision. If an action is clearly attributable to a single provider, it may only count in the numerator for that provider. However, if the action is not attributable to a single provider, it may be counted in the numerator for all providers sharing the CEHRT who have the patient in their denominator for the PI reporting period.
- This exchange may occur before, during, or after the PI reporting period. However, in order to count in the numerator, it must occur within the PI 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 PI reporting period occurs.

Definition of Terms:

Patient-Specific Education Resources Identified by CEHRT - Resources or a topic area of resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient.

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 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62807**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (a)(15).

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

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

Supporting Documentation Requirements:

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

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

Measure Entry:

Exclusion: Any EP who has no office visits during the 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: Number of patients in the denominator who were provided patient-specific education resources identified by the CEHRT.

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

* **Numerator:**

175

* **Denominator:**

325

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2^{M} **Screen 9**

Patient Specific Education

☑ Measure 1

Complete all required fields.

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

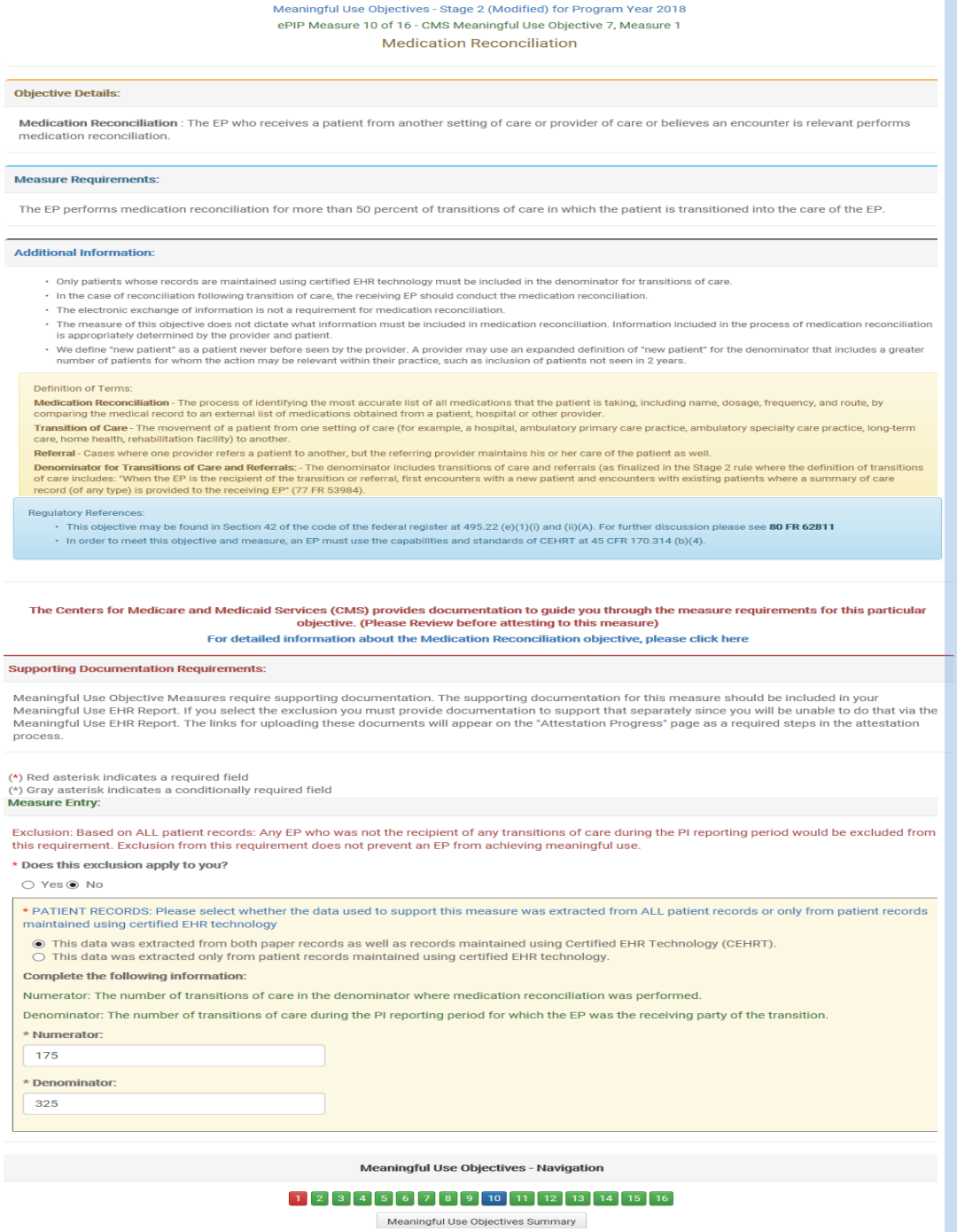
The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Stage 2 Modified Objective 7 Measure 1 Medication Reconciliation



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 10 of 16 - CMS Meaningful Use Objective 7, Measure 1
Medication Reconciliation

Objective Details:

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

Measure Requirements:

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

Additional Information:

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- In the case of reconciliation following transition of care, the receiving EP should conduct the medication reconciliation.
- The electronic exchange of information is not a requirement for medication reconciliation.
- The measure of this objective does not dictate what information must be included in medication reconciliation. Information included in the process of medication reconciliation is appropriately determined by the provider and patient.
- We define "new patient" as a patient never before seen by the provider. A provider may use an expanded definition of "new patient" for the denominator that includes a greater number of patients for whom the action may be relevant within their practice, such as inclusion of patients not seen in 2 years.

Definition of Terms:
Medication Reconciliation - The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.
Transition of Care - The movement of a patient from one setting of care (for example, a hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
Referral - Cases where one provider refers a patient to another, but the referring provider maintains his or her care of the patient as well.
Denominator for Transitions of Care and Referrals: - The denominator includes transitions of care and referrals (as finalized in the Stage 2 rule where the definition of transitions of care includes: "When the EP is the recipient of the transition or referral, first encounters with a new patient and encounters with existing patients where a summary of care record (of any type) is provided to the receiving EP" (77 FR 53984).

Regulatory References:
- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62811**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (b)(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 Medication Reconciliation objective, please click here

Supporting Documentation Requirements:

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

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

Measure Entry:

Exclusion: Based on ALL patient records: Any EP who was not the recipient of any transitions of care during the 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 transitions of care in the denominator where medication reconciliation was performed.

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

* **Numerator:**
175

* **Denominator:**
325

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2M **Screen 10**

Medication Reconciliation

☑ Measure 1

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Stage 2 Modified Objective 8 Measure 1 Patient Electronic Access

Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018

ePIP Measure 11 of 16 - CMS Meaningful Use Objective 8, Measure 1

Patient Electronic Access - Measure 1 of 2

Objective Details:

Patient Electronic Access - Measure 1 of 2 : Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

Measure Requirements:

More than 50 percent of all unique patients seen by the EP during the PI reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EPs discretion to withhold certain information.

Additional Information:

- In order to meet this objective, the following information must be made available to patients electronically 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.
- In circumstances where there is no information available to populate one or more of the fields previously listed, 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 or 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 VDT, the measure does not replace the covered entity's responsibilities to meet the broader requirements under HIPAA to provide an individual, upon request, with access to PHI in a designated record set.
- Providers should also be aware that 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. Providers 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, patient health information needs to be made available to each patient for view, download, and transmit within 4 business days of the information being available to the provider for each and every time that information is generated whether the patient has been "enrolled" for three months or for three years.
- A patient who has multiple encounters during the PI reporting period, or even in subsequent PI 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, the provider 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 provider.
- For Measure 2, the patient action may occur before, during, or after the PI reporting period. However, in order to count in the numerator, it must occur within the PI 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 PI reporting period occurs.

Definition of Terms:

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 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62815**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (e)(1).

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

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

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

Supporting Documentation Requirements:

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

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

Measure Entry:

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

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

◉ Yes ○ No

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2[M] **Screen 11**

Patient Electronic Access

☑ Measure 1

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.

TIP:
Make sure that you upload all documents that support the above entries in your attestation.
You can do so on the Attestation Progress page.
Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 8 Measure 2 Patient Electronic Access

Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 12 of 16 - CMS Meaningful Use Objective 8, Measure 2
Patient Electronic Access - Measure 2 of 2

Objective Details:

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

Measure Requirements:

For an PI reporting period in 2018, more than 5 percent of unique patients seen by the EP during the PI reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the PI reporting period.

Additional Information:

- In order to meet this objective, the following information must be made available to patients electronically 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.
- In circumstances where there is no information available to populate one or more of the fields previously listed, 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 or 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 VDT, the measure does not replace the covered entity's responsibilities to meet the broader requirements under HIPAA to provide an individual, upon request, with access to PHI in a designated record set.
- Providers should also be aware that 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. Providers 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, patient health information needs to be made available to each patient for view, download, and transmit within 4 business days of the information being available to the provider for each and every time that information is generated whether the patient has been "enrolled" for three months or for three years.
- A patient who has multiple encounters during the PI reporting period, or even in subsequent PI 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, the provider 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 provider.
- For Measure 2, the patient action may occur before, during, or after the PI reporting period. However, in order to count in the numerator, it must occur within the PI 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 PI reporting period occurs.

Definition of Terms:

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 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62815**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (e)(1).

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

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

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

Supporting Documentation Requirements:

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

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

Measure Entry:

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

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

◉ Yes ○ No

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

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

◉ Yes ○ No

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2M **Screen 12**

Patient Electronic Access

☑ Measure 2

Complete all required fields.

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

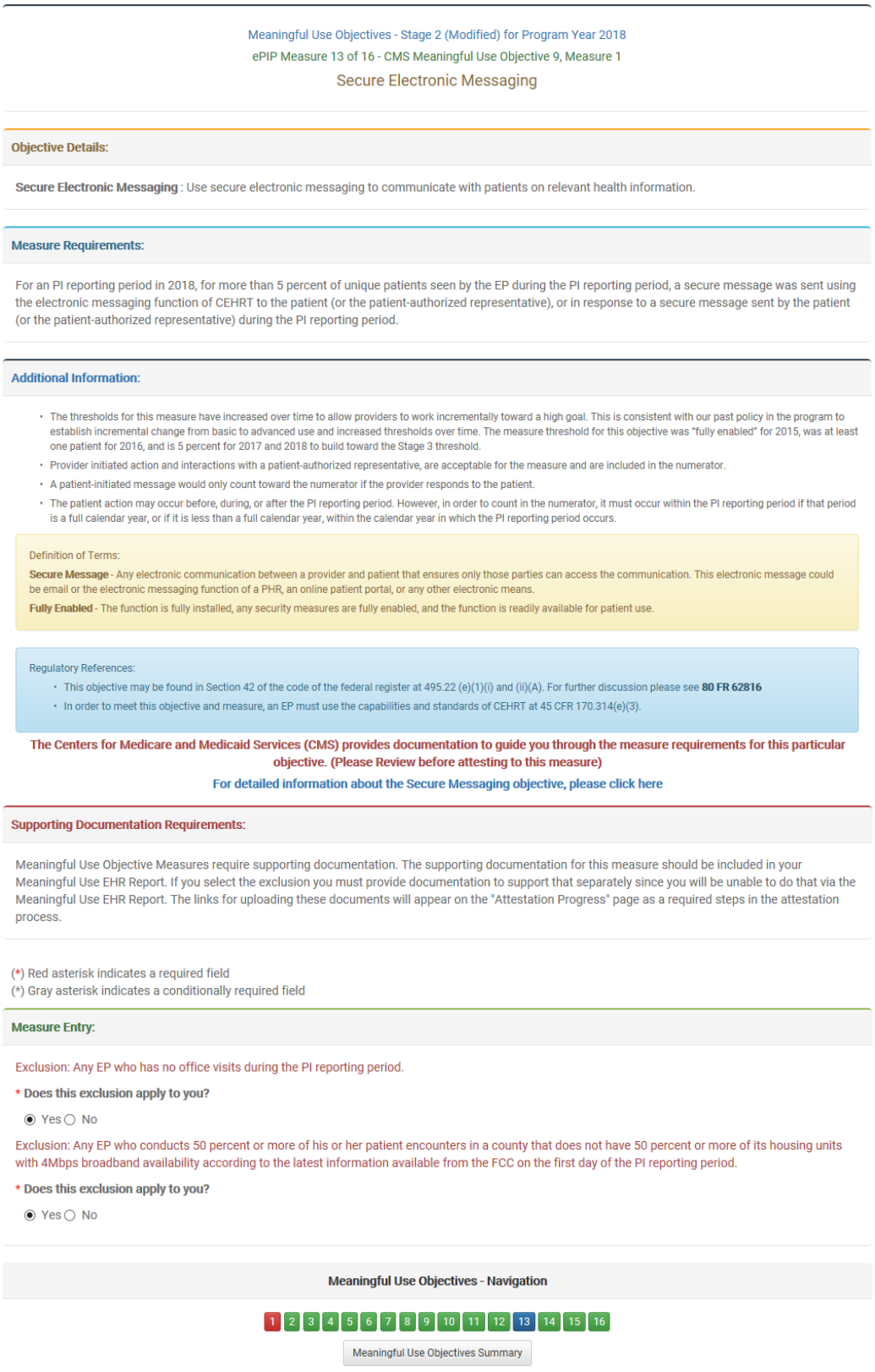
The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Stage 2 Modified Objective 9 Measure 1 Secure Electronic Messaging



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018

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

Secure Electronic Messaging

Objective Details:

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

Measure Requirements:

For an PI reporting period in 2018, for more than 5 percent of 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 the patient-authorized representative) during the PI reporting period.

Additional Information:

- The thresholds for this measure have increased over time to allow providers to work incrementally toward a high goal. This is consistent with our past policy in the program to establish incremental change from basic to advanced use and increased thresholds over time. The measure threshold for this objective was "fully enabled" for 2015, was at least one patient for 2016, and is 5 percent for 2017 and 2018 to build toward the Stage 3 threshold.
- Provider initiated action and interactions with a patient-authorized representative, are acceptable for the measure and are included in the numerator.
- A patient-initiated message would only count toward the numerator if the provider responds to the patient.
- The patient action may occur before, during, or after the PI reporting period. However, in order to count in the numerator, it must occur within the PI 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 PI reporting period occurs.

Definition of Terms:

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.

Fully Enabled - The function is fully installed, any security measures are fully enabled, and the function is readily available for patient use.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62816**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314(e)(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 Secure Messaging objective, please click here

Supporting Documentation Requirements:

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

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

Measure Entry:

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

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

◉ Yes ○ No

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

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

◉ Yes ○ No

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2^{M} **Screen 13**

Secure Electronic Messaging

☑ Measure 1

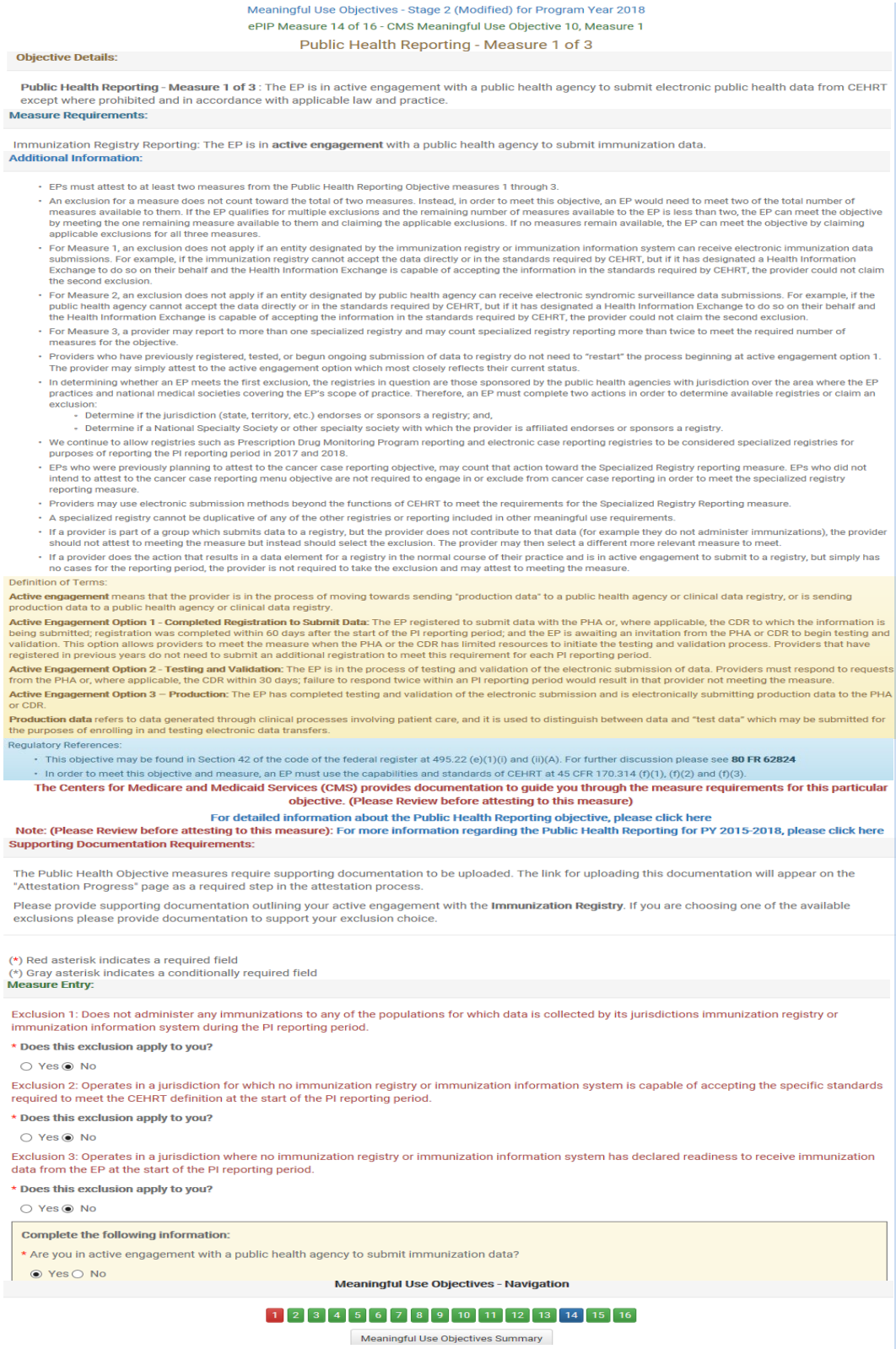
Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.

TIP:
Make sure that you upload all documents that support the above entries in your attestation.
You can do so on the Attestation Progress page.
Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 10 Measure 1 Public Health Reporting



Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 14 of 16 - CMS Meaningful Use Objective 10, Measure 1
Public Health Reporting - Measure 1 of 3

Objective Details:

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

Measure Requirements:

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

Additional Information:

- EPs must attest to at least two measures from the Public Health Reporting Objective measures 1 through 3.
- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP would need to meet two of the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting the one remaining measure available to them and claiming the applicable exclusions. If no measures remain available, the EP can meet the objective by claiming applicable exclusions for all three measures.
- For Measure 1, an exclusion does not apply if an entity designated by the immunization registry or immunization information system 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 if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 2, an exclusion does not apply if an entity designated by public health agency can receive electronic syndromic surveillance data submissions. For example, if the public health agency cannot accept the data directly or in the standards required by CEHRT, but if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 3, a provider may report to more than one specialized registry and may count specialized registry reporting more than twice to meet the required number of measures for the objective.
- Providers who have previously registered, tested, or begun ongoing submission of data to registry do not need to "restart" the process beginning at active engagement option 1. The provider may simply attest to the active engagement option which most closely reflects their current status.
- In determining whether an EP meets the first exclusion, the registries in question are those sponsored by the public health agencies 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 determine 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.
- We continue to allow registries such as Prescription Drug Monitoring Program reporting and electronic case reporting registries to be considered specialized registries for purposes of reporting the PI reporting period in 2017 and 2018.
- EPs who were previously planning to attest to the cancer case reporting objective, may count that action toward the Specialized Registry reporting measure. EPs who did not intend to attest to the cancer case reporting menu objective are not required to engage in or exclude from cancer case reporting in order to meet the specialized registry reporting measure.
- Providers may use electronic submission methods beyond the functions of CEHRT to meet the requirements for the Specialized Registry Reporting measure.
- A specialized registry cannot be duplicative of any of the other registries or reporting included in other meaningful use requirements.
- 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.

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.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62824**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (f)(1), (f)(2) and (f)(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 Public Health Reporting objective, please click here

Note: (Please Review before attesting to this measure): For more information regarding the Public Health Reporting for PY 2015-2018, please click here

Supporting Documentation Requirements:

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

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

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

Measure Entry:

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

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

○ Yes ◉ No

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

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

○ Yes ◉ No

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

Meaningful Use Objectives Summary

Stage 2M Screen 14

Public Health Reporting

☑ Measure 1

Complete all required fields.
If you select the exclusions, you must upload documentation to support that separately.
If you are in active engagement to submit immunization data to a public health agency, you must upload documentation to support that separately.
The Navigation bar at the bottom will monitor your progress.

TIP:
Make sure that you upload all documents that support the above entries in your attestation.
You can do so on the Attestation Progress page.
Click the hyperlink on the ePIP screen to learn more about this requirement.

Stage 2 Modified Objective 10 Measure 2 Public Health Reporting

Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 15 of 16 - CMS Meaningful Use Objective 10, Measure 2
Public Health Reporting - Measure 2 of 3

Objective Details:

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

Measure Requirements:

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

Additional Information:

- EPs must attest to at least two measures from the Public Health Reporting Objective measures 1 through 3.
- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP would need to meet two of the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting the one remaining measure available to them and claiming the applicable exclusions. If no measures remain available, the EP can meet the objective by claiming applicable exclusions for all three measures.
- For Measure 1, an exclusion does not apply if an entity designated by the immunization registry or immunization information system 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 if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 2, an exclusion does not apply if an entity designated by public health agency can receive electronic syndromic surveillance data submissions. For example, if the public health agency cannot accept the data directly or in the standards required by CEHRT, but if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 3, a provider may report to more than one specialized registry and may count specialized registry reporting more than twice to meet the required number of measures for the objective.
- Providers who have previously registered, tested, or begun ongoing submission of data to registry do not need to "restart" the process beginning at active engagement option 1. The provider may simply attest to the active engagement option which most closely reflects their current status.
- In determining whether an EP meets the first exclusion, the registries in question are those sponsored by the public health agencies 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 determine 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.
- We continue to allow registries such as Prescription Drug Monitoring Program reporting and electronic case reporting registries to be considered specialized registries for purposes of reporting the PI reporting period in 2017 and 2018.
- EPs who were previously planning to attest to the cancer case reporting objective, may count that action toward the Specialized Registry reporting measure. EPs who did not intend to attest to the cancer case reporting menu objective are not required to engage in or exclude from cancer case reporting in order to meet the specialized registry reporting measure.
- Providers may use electronic submission methods beyond the functions of CEHRT to meet the requirements for the Specialized Registry Reporting measure.
- A specialized registry cannot be duplicative of any of the other registries or reporting included in other meaningful use requirements.
- 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.

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.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62824**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (f)(1), (f)(2) and (f)(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 Public Health Reporting objective, please click here

Note: (Please Review before attesting to this measure): For more information regarding the Public Health Reporting for PY 2015-2018, 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.

Measure Entry:

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

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

◉ Yes ○ No

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

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

◉ Yes ○ No

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

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

◉ Yes ○ No

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2M Screen 15

Public Health Reporting

☑ Measure 2

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Stage 2 Modified Objective 10 Measure 3 Public Health Reporting

Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 16 of 16 - CMS Meaningful Use Objective 10, Measure 3
Public Health Reporting - Measure 3 of 3

Objective Details:

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

Measure Requirements:

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

Additional Information:

- EPs must attest to at least two measures from the Public Health Reporting Objective measures 1 through 3.
- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP would need to meet two of the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting the one remaining measure available to them and claiming the applicable exclusions. If no measures remain available, the EP can meet the objective by claiming applicable exclusions for all three measures.
- For Measure 1, an exclusion does not apply if an entity designated by the immunization registry or immunization information system 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 if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 2, an exclusion does not apply if an entity designated by public health agency can receive electronic syndromic surveillance data submissions. For example, if the public health agency cannot accept the data directly or in the standards required by CEHRT, but if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 3, a provider may report to more than one specialized registry and may count specialized registry reporting more than twice to meet the required number of measures for the objective.
- Providers who have previously registered, tested, or begun ongoing submission of data to registry do not need to "restart" the process beginning at active engagement option 1. The provider may simply attest to the active engagement option which most closely reflects their current status.
- In determining whether an EP meets the first exclusion, the registries in question are those sponsored by the public health agencies 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 determine 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.
- We continue to allow registries such as Prescription Drug Monitoring Program reporting and electronic case reporting registries to be considered specialized registries for purposes of reporting the PI reporting period in 2017 and 2018.
- EPs who were previously planning to attest to the cancer case reporting objective, may count that action toward the Specialized Registry reporting measure. EPs who did not intend to attest to the cancer case reporting menu objective are not required to engage in or exclude from cancer case reporting in order to meet the specialized registry reporting measure.
- Providers may use electronic submission methods beyond the functions of CEHRT to meet the requirements for the Specialized Registry Reporting measure.
- A specialized registry cannot be duplicative of any of the other registries or reporting included in other meaningful use requirements.
- 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.

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.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(1)(i) and (ii)(A). For further discussion please see **80 FR 62824**
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.314 (f)(1), (f)(2) and (f)(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 Public Health Reporting objective, please click here

Note: (Please Review before attesting to this measure): For more information regarding the Public Health Reporting for PY 2015-2018, please click here

Supporting Documentation Requirements:

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

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

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

Measure Entry:

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

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

(•) Yes ( ) No

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

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

(•) Yes ( ) No

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

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

(•) Yes ( ) No

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 2M **Screen 16**

Public Health Reporting

☑ Measure 3

Complete all required fields.

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

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

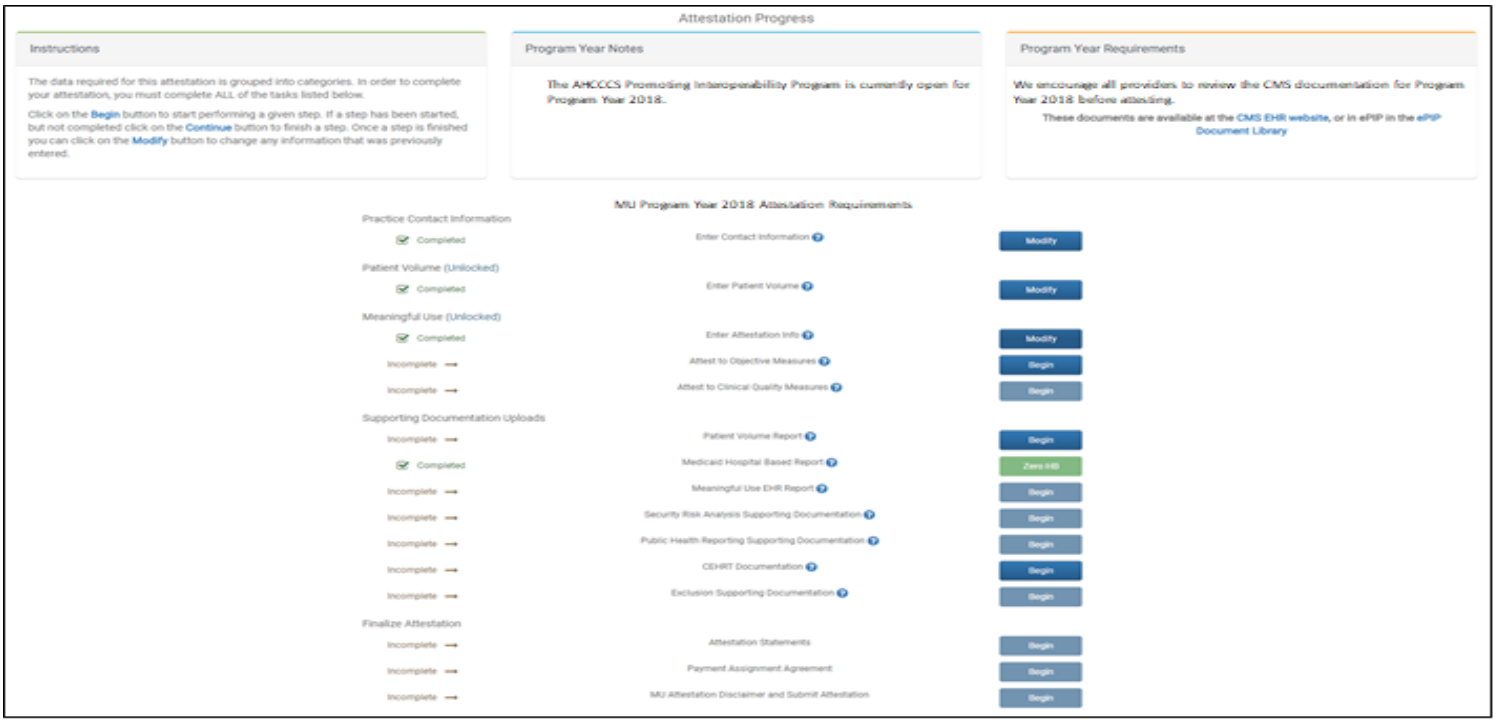
The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Attestation Progress (After Objective Measures)



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

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

TIP

Click the Begin button to complete each step.
Click Continue button to finish a step.
Click Modify button to change information previously entered.

Clinical Quality Measures

	Meaningful Use Clinical Quality Measures	
	National Quality Strategy (NQS) Domains	**Number CQMs Available**
1	Person and Caregiver-Centered Experience and Outcomes	4
2	Patient Safety	5
3	Communication and Care Coordination	2
4	Community/Population Health	11
5	Efficiency and Cost Reduction	4
6	Effective Clinical Care	29

Clinical Quality Measures (CQMs) Selection:

Providers are required to report on 6 of 55 separate CQMs from any of the National Quality Strategy domains.

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

The CQM Reporting Period is a 90-day period selected from 2018.

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

☑ Report the CQMs for which there is patient data

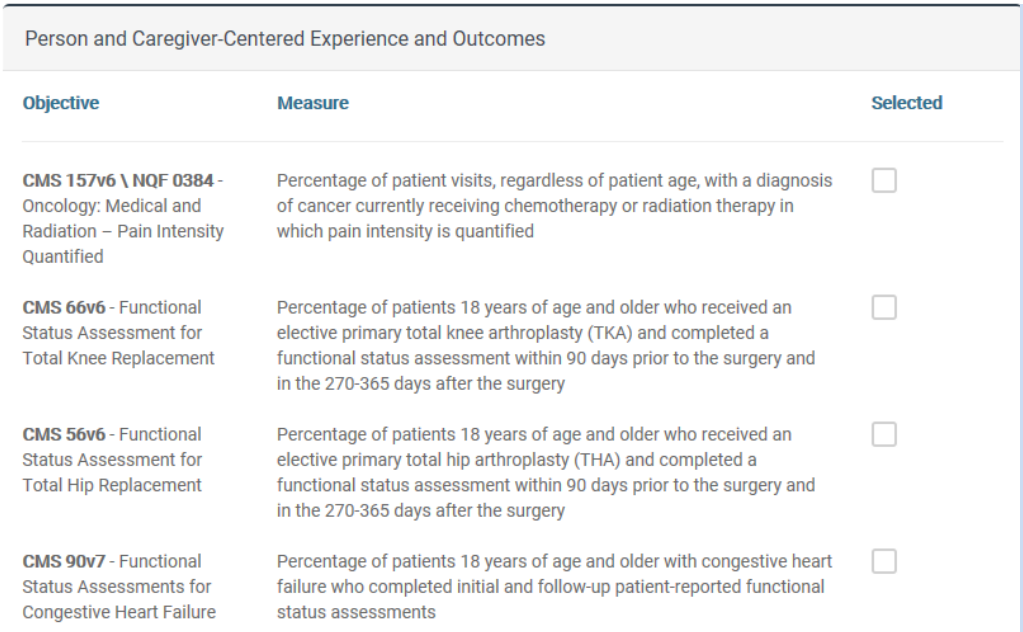
☑ Report the remaining required CQMs as "zero denominators" as displayed by your certified EHR technology.

TIP

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

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

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



Person and Caregiver-Centered Experience and Outcomes

Objective	Measure	Selected
CMS 157v6 \ NQF 0384 - Oncology: Medical and Radiation – Pain Intensity Quantified	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	☐
CMS 66v6 - 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	☐
CMS 56v6 - 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	☐
CMS 90v7 - 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

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

4 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Clinical Quality Measures for Patient Safety

Patient Safety

Objective	Measure	Selected
CMS 156v6 \ 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.	☐
CMS 139v6 \ NQF 0101 - Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	☐
CMS 68v7 \ NQF 0419 - Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration.	☐
CMS 132v6 \ 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 177v6 \ NQF 1365 - Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	☐

Patient Safety

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

5 of 55 CQMs are available under this domain.

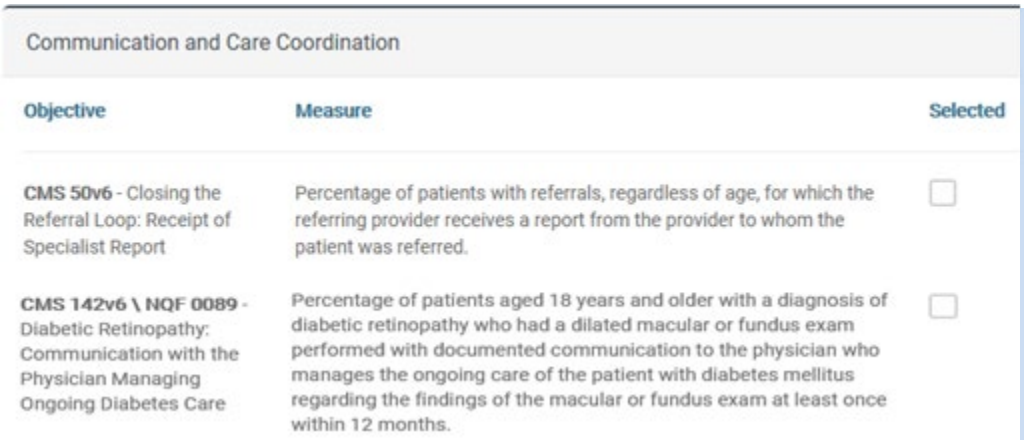
The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Clinical Quality Measures for Communication and Care Coordination



Communication and Care Coordination

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

2 of 55 CQMs is available under this domain.

The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Clinical Quality Measures for Community / Population Health

Community/Population Health

Objective	Measure	Selected
CMS 155v6 \ 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 138v6 \ 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.	☐
CMS 153v6 \ 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 117v6 \ NQF 0038 - Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday	☐
CMS 147v7 \ NQF 0041 - Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	☐

Community / Population Health

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

11 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Clinical Quality Measures for Community / Population Health continued

CMS 2v7 \ 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 69v6 \ 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 82v5 \ 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 22v6 - 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 75v6 - 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 127v6 \ NQF 0043 - Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	☐

Community / Population Health

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

11 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Clinical Quality Measures for Efficiency and Cost Reduction

Efficiency and Cost Reduction

Objective	Measure	Selected
CMS 146v6 \ NQF 0002 - 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.	☐
CMS 166v7 \ NQF 0052 - Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	☐
CMS 154v6 \ NQF 0069 - Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	☐
CMS 129v7 \ NQF 0389 - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	☐

Efficiency and Cost Reduction

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

4 of 55 CQMs are available under this domain.

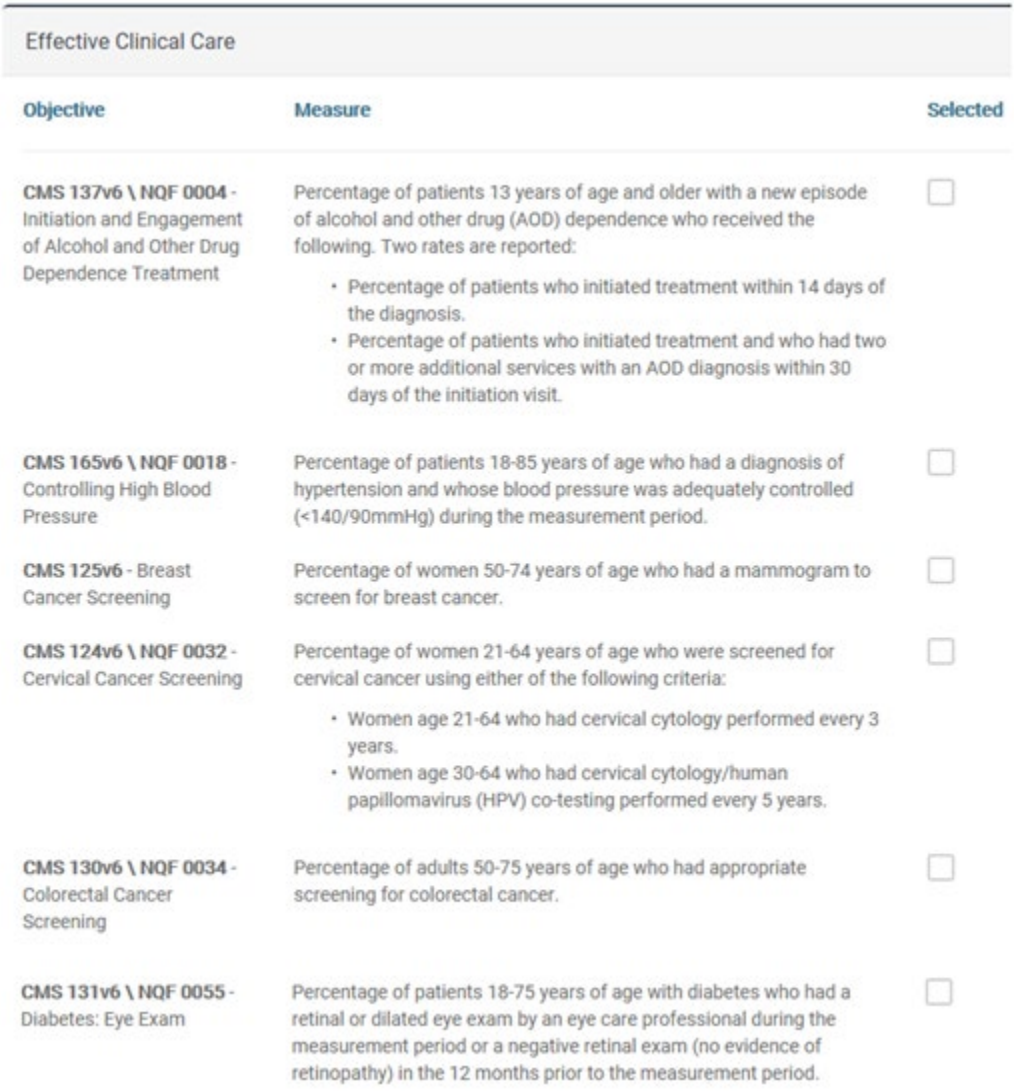
The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Clinical Quality Measures for Effective Clinical Care



Effective Clinical Care

Objective	Measure	Selected
CMS 137v6 \ 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.	☐
CMS 165v6 \ NQF 0018 - Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	☐
CMS 125v6 - Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	☐
CMS 124v6 \ 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 130v6 \ NQF 0034 - Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	☐
CMS 131v6 \ 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

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

29 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

TIP

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

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

Clinical Quality Measures for Effective Clinical Care continued

CMS 123v6 \ NQF 0056 - Diabetes: Foot Exam	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year	☐
CMS 122v6 \ 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 134v6 \ 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 164v6 \ NQF 0068 - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period	☐
CMS 145v6 \ 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 135v6 \ NQF 0081 - Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	☐

Effective Clinical Care

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Clinical Quality Measures for Effective Clinical Care continued

CMS 136v7 \ 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 169v6 - Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	☐
CMS 52v6 \ NQF 0405 - HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.	☐
CMS 133v6 \ NQF 0565 - Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.	☐
CMS 158v6 - Pregnant women that had HBsAg testing	This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.	☐
CMS 159v6 \ NQF 0710 - Depression Remission at Twelve Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	☐

Effective Clinical Care

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Clinical Quality Measures for Effective Clinical Care continued

CMS 144v6 \ 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 143v6 \ NQF 0086 - Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months.	☐
CMS 167v6 \ NQF 0088 - Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	☐
CMS 161v6 \ 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	☐
CMS 128v6 \ 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).	☐

Effective Clinical Care

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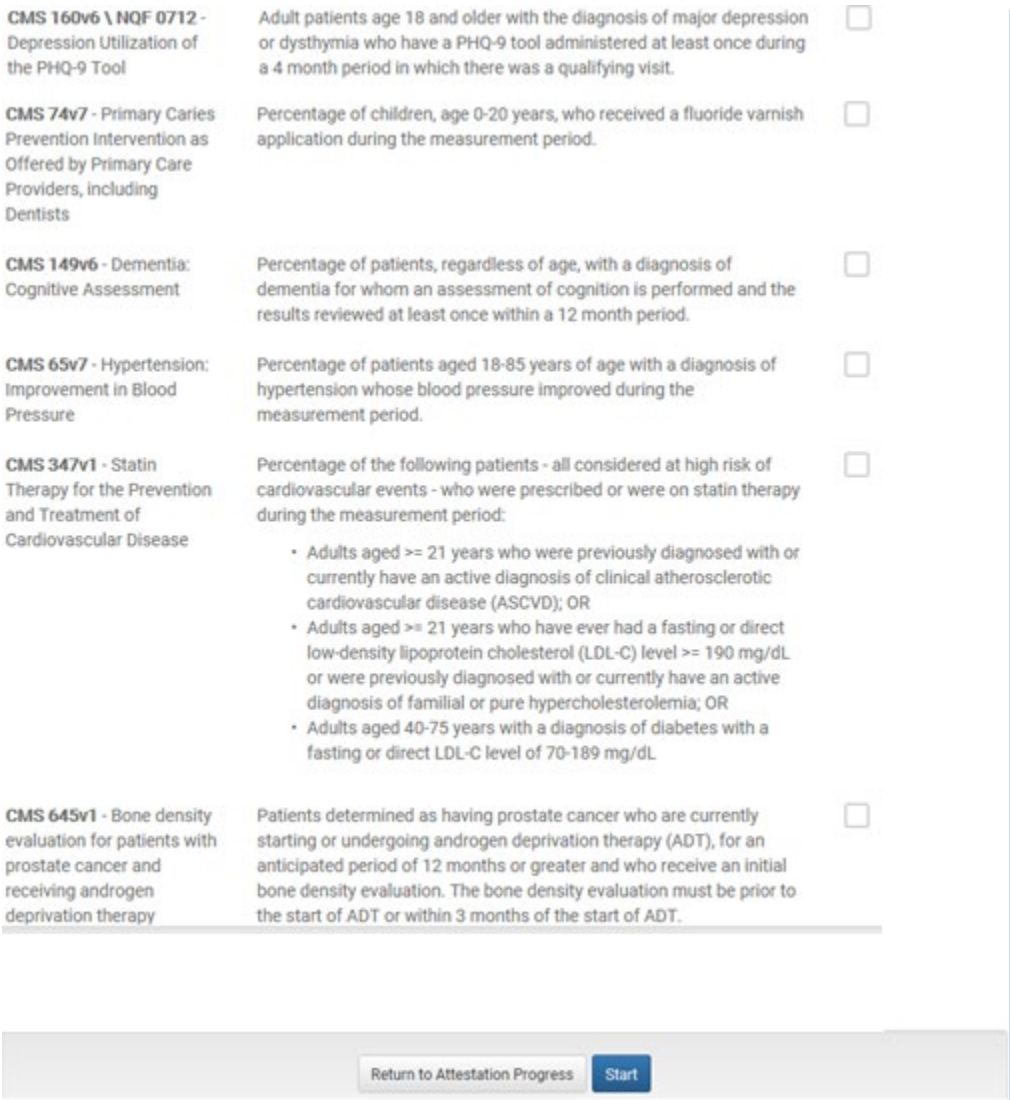
Clinical Quality Measures for Effective Clinical Care continued



CMS 160v6 \ NQF 0712 - Depression Utilization of the PHQ-9 Tool	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit.	☐
CMS 74v7 - 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 149v6 - Dementia: Cognitive Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.	☐
CMS 65v7 - Hypertension: Improvement in Blood Pressure	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	☐
CMS 347v1 - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: • Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged >= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL	☐
CMS 645v1 - Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy	Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.	☐

Effective Clinical Care

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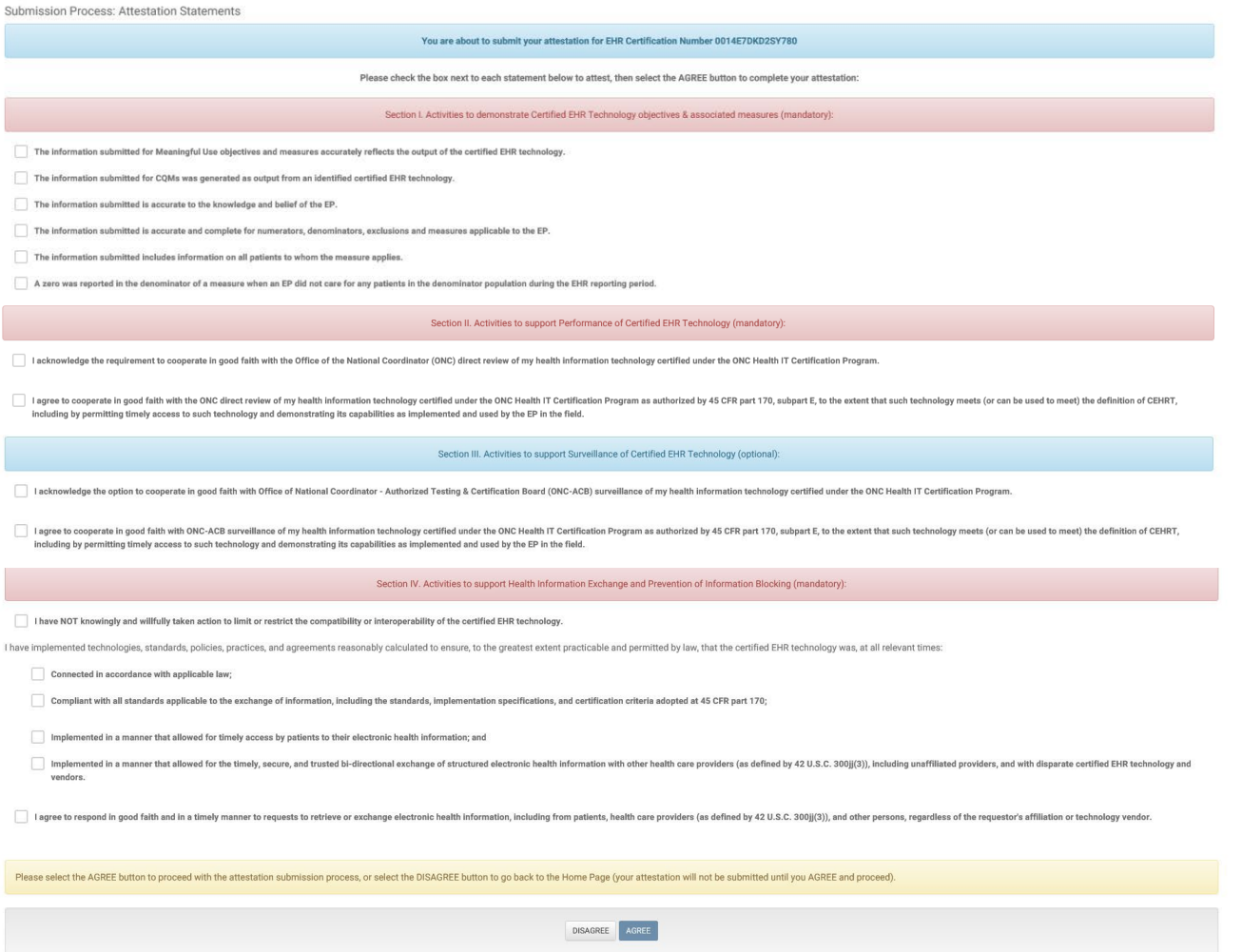
Attestation Statements



Submission Process: Attestation Statements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DISAGREE AGREE

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

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

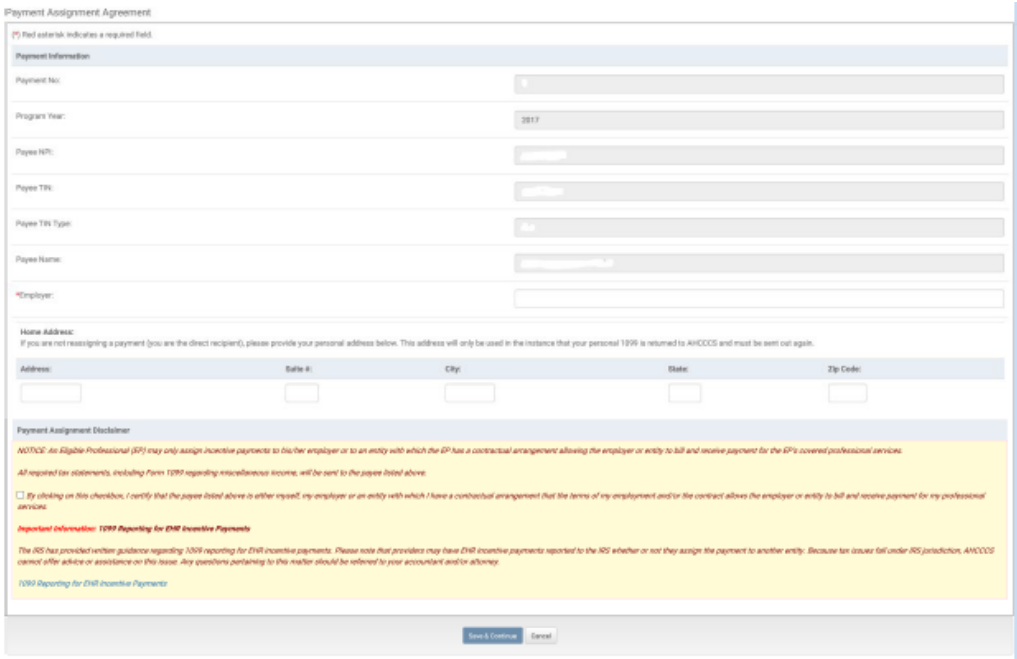
TIP

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

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

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

Payment Reassignment



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

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

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

TIP

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

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

Attestation Disclaimer

Step 1
You must first read the Attestation Disclaimer.

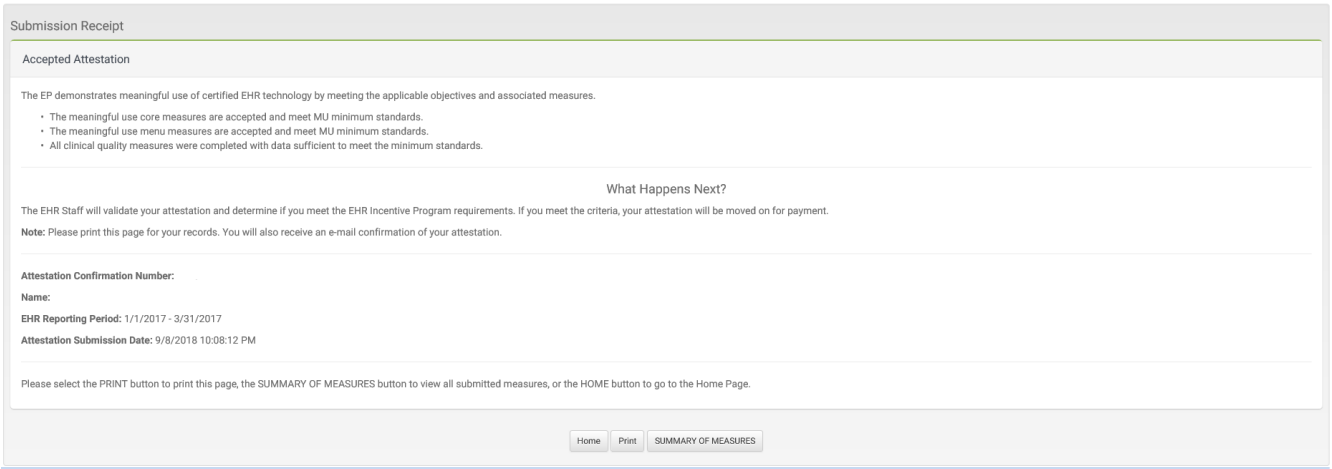
- Attestation Notification
- Routine Uses
- Disclosures
- Attestation Disclaimer

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

TIP

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

Submission Receipt


Submission Receipt

Accepted Attestation

The EP demonstrates meaningful use of certified EHR technology by meeting the applicable objectives and associated measures.

- The meaningful use core measures are accepted and meet MU minimum standards.
- The meaningful use menu measures are accepted and meet MU minimum standards.
- All clinical quality measures were completed with data sufficient to meet the minimum standards.

What Happens Next?

The EHR Staff will validate your attestation and determine if you meet the EHR Incentive Program requirements. If you meet the criteria, your attestation will be moved on for payment.

Note: Please print this page for your records. You will also receive an e-mail confirmation of your attestation.

Attestation Confirmation Number:

Name:

EHR Reporting Period: 1/1/2017 - 3/31/2017

Attestation Submission Date: 9/8/2018 10:08:12 PM

Please select the PRINT button to print this page, the SUMMARY OF MEASURES button to view all submitted measures, or the HOME button to go to the Home Page.

Home | Print | SUMMARY OF MEASURES

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

- ☑ Attestation Confirmation Number
- ☑ Provider's Name
- ☑ EHR Reporting Period (MU)
- ☑ Attestation Date

TIP

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

Appendices

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

Appendix A – Medicaid Patient Volume Report Layout

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

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

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

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

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

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

Appendix B – Medicaid Hospital-Based Report Layout

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

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

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

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

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

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

Appendix C – Needy Patient Volume Report Layout

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

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

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

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

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

Appendix D – Needy Practice Predominantly Report Layout

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

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

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

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

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

Appendix E – Definitions

Attestation
The attestation process allows the providers to attest to the PI 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 PI automates and streamlines the clinician's workflow. The PI 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 PI Program. Providers must complete a federal and state level registration process. *Only providers transferring from other States are permitted to register to set-up an ePIP account after Program Year 2016.*

Appendix F – Frequently Asked Questions regarding Program Participating

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 PI 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 PI Payments be subject to audit?**
	Incentive payments made to Eligible Professionals under the Medicaid Promoting Interoperability (PI) Program is subject to audit by the PI 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 PI 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 PI 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 an PI 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 PI 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 2018?**
	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 2018 has been extended to **August 31, 2019**.
Q15	**What are the reporting periods for Eligible Professionals participating in the Promoting Interoperability (PI) Program?**
	For Program Year 2018, the reporting periods are as follows: *Volume (select a period from 2017):* 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 2018):* The PI 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 an PI 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 PI 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 PI 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 PI 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 PI 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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Click Here

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 PI 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 Provider Registration** 602-417-7670 (option 5) Maricopa County 800-794-6862 Outside Maricopa County 800-523-0231 Out-of-State Website: AHCCCS Provider Registration Unit
Electronic Funds Transfer (EFT)	**AHCCCS Finance** 602-417-5500 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	**Arizona Health-e Connection (AzHeC)** 602-688-7200 Email: ehr@azhec.org

AHCCCS
Arizona Health Care Cost Containment System

Website: Arizona Medicaid EHR Incentive Program
602.417.4333
EHRIncentivePayments@azahcccs.gov

Thank you for your interest in the Promoting Interoperability Program