



**STATE MEDICAID
ELECTRONIC HEALTH RECORD INCENTIVE PROGRAM
2017 STAGE 3
ATTESTATION REFERENCE GUIDE
ELIGIBLE PROFESSIONALS**



November 6, 2018
<https://www.azepip.gov/>

AHCCCS
801 East Jefferson Street
Phoenix, Arizona 85034
(602)417-4000
www.azahcccs.gov

Contents

DISCLAIMER.....	4
IMPORTANT NOTICE – THIRD PARTY ATTESTATION.....	4
ABOUT EPIP	5
WELCOME TO THE EPIP SYSTEM HOME PAGE.....	6
REGISTRATION (PROVIDERS WITHOUT AN EPIP ACCOUNT).....	7
EHR DOCUMENT LIBRARY.....	8
LOG ON.....	9
WELCOME TO YOUR EPIP ACCOUNT HOME PAGE.....	10
MY ACCOUNT – HOW TO MANAGE MY ACCOUNT	11
MY ACCOUNT – HOW TO MANAGE MY PASSWORD	13
MY ACCOUNT – HOW TO MANAGE MY SECURITY QUESTIONS	14
MY ACCOUNT – HOW TO MANAGE MY PAYMENTS	15
MY ACCOUNT – HOW TO MANAGE MY DOCUMENTS	16
MY ACCOUNT – HOW TO MANAGE MY EHR CERTIFICATION NUMBER	17
ATTESTATION.....	18
ATTESTATION INSTRUCTIONS.....	19
ATTESTATION PROGRESS	21
PROVIDER CONTACT INFORMATION	22
PATIENT VOLUME CRITERIA	23
REPORT MEDICAID PATIENT VOLUME DATA ELEMENTS.....	24
REPORT HOSPITAL-BASED DATA ELEMENTS	25
REPORT NEEDY PATIENT VOLUME DATA ELEMENTS	26
REPORT PRACTICE PREDOMINANTLY DATA ELEMENTS.....	28
ATTESTATION PROGRESS (AFTER PATIENT VOLUME)	29
ATTESTATION INFORMATION	30
PROGRAM YEAR 2017 FLEXIBILITY INFORMATION	31
ATTESTATION PROGRESS (AFTER ATTESTATION INFORMATION)	32
MEANINGFUL USE REQUIREMENTS FOR PROGRAM YEAR 2017 STAGE 3.....	33
STAGE 3 OBJECTIVE 1 MEASURE 1 PROTECTED HEALTH INFORMATION	34
STAGE 3 OBJECTIVE 2 MEASURE 1 ELECTRONIC PRESCRIBING	35
STAGE 3 OBJECTIVE 3 MEASURE 1 CLINICAL DECISION SUPPORT.....	36
STAGE 3 OBJECTIVE 3 MEASURE 2 CLINICAL DECISION SUPPORT.....	37

STAGE 3 OBJECTIVE 4 MEASURE 1 COMPUTERIZED PROVIDER ORDER ENTRY	38
STAGE 3 OBJECTIVE 4 MEASURE 2 COMPUTERIZED PROVIDER ORDER ENTRY	39
STAGE 3 OBJECTIVE 4 MEASURE 3 COMPUTERIZED PROVIDER ORDER ENTRY	40
STAGE 3 OBJECTIVE 5 MEASURE 1 PATIENT ELECTRONIC ACCESS	41
STAGE 3 OBJECTIVE 5 MEASURE 2 PATIENT ELECTRONIC ACCESS	42
STAGE 3 OBJECTIVE 6 MEASURE 1 COORDINATION OF CARE.....	43
STAGE 3 OBJECTIVE 6 MEASURE 2 COORDINATION OF CARE.....	44
STAGE 3 OBJECTIVE 6 MEASURE 3 COORDINATION OF CARE.....	45
STAGE 3 OBJECTIVE 7 MEASURE 1 HEALTH INFORMATION EXCHANGE.....	46
STAGE 3 OBJECTIVE 7 MEASURE 2 HEALTH INFORMATION EXCHANGE.....	47
STAGE 3 OBJECTIVE 7 MEASURE 3 HEALTH INFORMATION EXCHANGE.....	48
STAGE 3 OBJECTIVE 8 MEASURE 1 PUBLIC HEALTH REPORTING.....	49
STAGE 3 OBJECTIVE 8 MEASURE 2 PUBLIC HEALTH REPORTING.....	50
STAGE 3 OBJECTIVE 8 MEASURE 3 PUBLIC HEALTH REPORTING.....	51
STAGE 3 OBJECTIVE 8 MEASURE 4 PUBLIC HEALTH REPORTING.....	52
STAGE 3 OBJECTIVE 8 MEASURE 5 PUBLIC HEALTH REPORTING.....	53
ATTESTATION PROGRESS (AFTER OBJECTIVE MEASURES)	54
CLINICAL QUALITY MEASURES.....	55
CLINICAL QUALITY MEASURES FOR PERSON AND CAREGIVER-CENTERED EXPERIENCE & OUTCOMES...	56
CLINICAL QUALITY MEASURES FOR PATIENT SAFETY.....	57
CLINICAL QUALITY MEASURES FOR COMMUNICATION AND CARE COORDINATION.....	58
CLINICAL QUALITY MEASURES FOR COMMUNITY / POPULATION HEALTH.....	59
CLINICAL QUALITY MEASURES FOR EFFICIENCY AND COST REDUCTION.....	61
CLINICAL QUALITY MEASURES FOR EFFECTIVE CLINICAL CARE.....	62
ATTESTATION STATEMENTS	67
SUBMISSION RECEIPT.....	70
APPENDICES.....	71
APPENDIX A – MEDICAID PATIENT VOLUME REPORT LAYOUT.....	72
APPENDIX B – MEDICAID HOSPITAL-BASED REPORT LAYOUT	73
APPENDIX C – NEEDY PATIENT VOLUME REPORT LAYOUT	74
APPENDIX D – NEEDY PRACTICE PREDOMINANTLY REPORT LAYOUT	75
APPENDIX E – DEFINITIONS	76
APPENDIX F – FREQUENTLY ASKED QUESTIONS REGARDING PROGRAM PARTICIPATION.....	77
APPENDIX F – FREQUENTLY ASKED QUESTIONS REGARDING REGISTRATION	78
APPENDIX F – FREQUENTLY ASKED QUESTIONS REGARDING ATTESTATIONS.....	79
APPENDIX F – FREQUENTLY ASKED QUESTIONS REGARDING MEANINGFUL USE.....	80
APPENDIX F – FREQUENTLY ASKED QUESTIONS REGARDING PAYMENT.....	81

APPENDIX G – ELECTRONIC FUNDS TRANSFER ACH FORM INSTRUCTIONS	82
APPENDIX H – ELECTRONIC FUNDS TRANSFER ACH FORM SAMPLE	84
APPENDIX I – CONTACT US	85

Disclaimer

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

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

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

Important Notice – Third Party Attestation

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

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

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

About ePIP

About ePIP

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

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

Administration:

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

Resources:

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

Eligible to Participate:

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

Eligible Hospitals (EHs)

Medicaid EHs include:

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

Eligible Professionals (EPs)

Medicaid EPs include:

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

Additionally, Medicaid EPs must also:

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

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

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



TIP

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

Go to the ePIP System by [clicking here](#)

Welcome to the ePIP System Home Page

AHCCCS EHR Electronic Provider Incentive Payment (ePIP) System

Welcome to the AHCCCS EHR Electronic Provider Incentive Payment (ePIP) System.

This is the official web site for the Arizona EHR Incentive 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 EHR Incentive 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 EHR Incentive 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 Electronic Health Records (EHR) Incentive Programs. For more information please see the [CMS.gov EHR Incentive Programs](#)

ePIP Program Announcements

- Program Year 2017 will be open from March 29th 2018 thru July 2nd 2018
- Program Year 2017 will introduce Stage 3 of Meaningful Use
- Stage 3 Meaningful Use in Program Year 2017 is optional



Beginning in 2011, the Electronic Health Records (EHR) Incentive Programs were 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 EHR Incentive Payments 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

Meaningful Use (MU) for Program Year 2017: 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. EHR Doc Library
6. Contact Us

ePIP Program Announcement Update:

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



TIP

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

Registration (Providers Without an ePIP Account)

Provider Registration

ePIP New Account Creation / Registration Notice

New providers who have not yet participated in the EHR Incentive Program will not be permitted to register to set-up an ePIP account after July 1st, 2017.

Transferring providers who have participated in the EHR Incentive Program outside of Arizona and received a payment are permitted to register to set-up an ePIP account.
Existing providers who have participated in the EHR Incentive Program in Arizona and received a payment are permitted to update their registration by modifying their CMS registration.

User Agreement

User Agreement / Identification / Verify Information / Register

Provider Incentive Payments User Agreement

Registration Instructions

Welcome to the Registration page. Arizona Medicaid providers must register for the Arizona Medicaid EHR Incentive Program using this system. Completing the State registration is a prerequisite for completing the State attestation.

User Electronic Funds Transfer (EFT) Records

Providers and if applicable, their payee (entity receiving payment) must have an active Electronic Funds Transfer record with AHCCCS in order to receive payments. If you are not currently set up to receive electronic payment, please [Click Here](#) to set up electronic funds transfer record.

Data Requirements

Please be prepared to provide the following information:

- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- CMS Registration ID: (Obtained when registered with www.cms.gov)
- AHCCCS Provider Number (APN)
- CCN (For Hospitals Only)

AHCCCS User Agreement Terms & Conditions:

This site displays confidential information from AHCCCS Administration and is to be used only by AHCCCS providers intending to receive incentive payments. You are liable for the accuracy of all data that you provide to this site in order to receive incentive payments from AHCCCS. If you use the system for any other purpose other than intended, your account may be canceled, your payments withheld and you may be subject to criminal prosecution.

I have reviewed and agree to the Terms & Conditions in the AHCCCS User Agreement listed above.

Regarding Providers without an ePIP Account:

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

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

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

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



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

EHR Document Library

ePIP Documentation Library				
CMS Final Rule for PY 2015-2017				
Type	File Name	Size	File Updated	Download
	Medicare and Medicaid Programs DHR Incentive Meaningful Use in PY 2015-2017	1.11 MB	October 2015	Download
Program Year 2017 Modified Stage 2 Objectives				
Type	File Name	Size	File Updated	Download
	Objective 1 - Protect Patient Health Information (Modified Stage 2)	599 KB	November 2016	Download
	Objective 2 - Clinical Decision Support (Modified Stage 2)	619 KB	November 2016	Download
	Objective 3 - Computerized Provider Order Entry (Modified Stage 2)	772 KB	November 2016	Download
	Objective 4 - Electronic Prescribing (Modified Stage 2)	745 KB	November 2016	Download
	Objective 5 - Health Information Exchange (Modified Stage 2)	930 KB	November 2016	Download
	Objective 6 - Patient-Specific Education (Modified Stage 2)	711 KB	November 2016	Download
	Objective 7 - Medication Reconciliation (Modified Stage 2)	697 KB	November 2016	Download
	Objective 8 - Patient Electronic Access (Modified Stage 2)	910 KB	November 2016	Download
	Objective 9 - Secure Electronic Messaging (Modified Stage 2)	688 KB	November 2016	Download
	Objective 10 - Public Health Reporting (Modified Stage 2)	692 KB	November 2016	Download
Program Year 2017 Stage 2 Tip Sheets				
Type	File Name	Size	File Updated	Download
	Health Information Exchange Objective (Modified Stage 2)	717 KB	November 2016	Download
	Patient Electronic Access (Modified Stage 2)	801 KB	November 2016	Download
	Guide for Eligible Professionals Practicing in Multiple Locations	648 KB	November 2016	Download
	Public Health Reporting (Modified Stage 2)	631 KB	November 2016	Download
	Security Risk Analysis (Modified Stage 2)	965 KB	November 2016	Download
Program Year 2017 Stage 3 Objectives				
Type	File Name	Size	File Updated	Download
	Objective 1 - Protect Patient Health Information (Stage 3)	755 KB	November 2016	Download
	Objective 2 - Electronic Prescribing (Stage 3)	801 KB	November 2016	Download
	Objective 3 - Clinical Decision Support (Stage 3)	725 KB	November 2016	Download
	Objective 4 - Computerized Provider Order Entry (Stage 3)	946 KB	November 2016	Download
	Objective 5 - Patient Electronic Access to Health Information (Stage 3)	925 KB	November 2016	Download
	Objective 6 - Coordination of Care through Patient Engagement (Stage 3)	849 KB	November 2016	Download
	Objective 7 - Health Information Exchange (Stage 3)	1.12 MB	November 2016	Download
	Objective 8 - Public Health and Clinical Data Registry Reporting (Stage 3)	849 KB	November 2016	Download
Program Year 2017 Stage 3 Tip Sheets				
Type	File Name	Size	File Updated	Download
	Health Information Exchange Objective (Stage 3)	882 KB	November 2016	Download
	Guide for Eligible Professionals Practicing in Multiple Locations (Stage 3)	768 KB	November 2016	Download
	Patient Electronic Access to Health Information (Stage 3)	744 KB	November 2016	Download
	Public Health Reporting (Stage 3)	615 KB	November 2016	Download
	Security Risk Analysis (Stage 3)	854 KB	November 2016	Download

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

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

For more information on the 2017 Program Requirements at CMS, [click here](#).

Log On

Log On

User name

Password

Remember me?

Forgot your password? Click [Here](#) to reset your password.

If you do not have an account, please [Register](#)

The AHCCCS EHR Incentive Program is currently accepting Attestations for Program Year 2017.

Any questions or concerns should be directed to the EHR Incentive Team at 602-417-4333 or EHRIncentivePayments@azahcccs.gov

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](#)

Password Reset

To reset your password please enter your UserName.

User Name



TIP

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

Welcome to Your ePIP Account Home Page

Welcome To Your ePIP Account

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

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

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

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

ePIP Program Announcements

- Program Year 2017 will be open from March 29th 2018 thru July 2nd 2018
- Program Year 2017 will introduce Stage 3 of Meaningful Use
- Stage 3 Meaningful Use in Program Year 2017 is optional

←

HOME
Returns you to this page.

MY ACCOUNT

- Manage My Account: Review & edit your contact information.
- Change My Password: Change the password for your account
- Modify My Security Questions: Create or modify the security questions associated with your account
- Payments: Track your payments for separate program years.
- Manage Documents: Upload supporting documentation for your attestations

ATTEST
Create & maintain attestations for separate program years.

CONTACT US
Contact the AHCCCS EHR Incentive Payments Group

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

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

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

ePIP Program Announcement Update:

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



TIP

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

My Account – How to Manage My Account

My Account Details

CMS Information

National Provider Identifier (NPI):	<p>Your data will appear here.</p> <p>If incorrect or incomplete, follow the instructions below to modify.</p> <p>Allow 48 hours for an update.</p>	
Tax Identification Number (TIN):		
Payee NPI:		
Payee TIN:		
Payee TIN Type:		
Provider Name:		
Address:		
Email:		
Phone:		
CMS EHR Certification ID:		
Provider Type:		

If the above information is incorrect, please navigate to the [CMS Registration & Attestation System](#) to correct the above data.

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

State Information

AHCCCS Provider Number: Your Data Here
Provider Type Classification:

If AHCCCS Provider information above is incorrect, please go to [Provider Registration](#) and contact AHCCCS Provider Registration.

Account Information

Contact Person Contact Email Contact Person Phone	<p>Your data will appear here.</p> <p>If any of it is incorrect, Click on the "Edit My Account" button below.</p>
Date Created Date Modified Last Date Password Changed Modified By	

If any of the information above is incorrect you can updated it here: [Edit 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 Password

Change Password

Use the form below to change your password.
New passwords must meet the complexity requirements listed below.

Password Complexity Requirements:

- Minimum length of nine characters.
- Must contain at least one UPPER case alpha character. (ex: A)
- Must contain at least one lower case alpha character. (ex: a)
- Must contain at least one numeric character (ex: 1, 2, 3, etc.).
- Must contain at least one special character (!, @, #, \$, etc.).
- The password cannot contain three or more consecutive characters. For example: "111" or "aAa" would not be accepted.
- The password cannot have 3 or more characters in common with the user name.

Account Information

Current password

New password

Confirm new 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

Change Question

Use the form below to change/create your security question.

Account Information

Password

Security Question #1

Answer

Security Question #2

AnswerTwo

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

Payment Status History		Example Data Only		
	Program Year	Amount	Payment Date	Payment For
Details	2012	\$21,250.00	8/26/2013	AIU
Processing Status	<i>Initial Payment: Payment made by AHCCCS on 8/26/2013 for \$21250.00. Payment reference # 2688</i>			
Details	2013	\$8,500.00	11/25/2013	MU
Processing Status	<i>Initial Payment: Payment made by AHCCCS on 11/25/2013 for \$8500.00. Payment reference # 2989</i>			
Details	2014	\$8,500.00	12/23/2015	MU
Processing Status	<i>Initial Payment: Payment made by AHCCCS on 12/23/2015 for \$8500.00. Payment reference # 4574</i>			
Details	2016	\$8,500.00	7/24/2017	MU
Processing Status	<i>Initial Payment: Payment made by AHCCCS on 7/24/2017 for \$8500.00. Payment reference # 6306</i>			

Instructions

Here is where you can track your incentive payments for separate program years. The processing status of your incentive payments will be displayed along with other payment details in the table above.

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

Manage Documents								
My Documents								
Attestation Type	Attestation Year	File Name	Document Type	Memo	Size	Uploaded	Delete	
MU3	4	Ltr of Intent to AHCCCS re MU 07-12-16.pdf	Other Documentation	Letter of Intent proving group volume report was submitted prior to attestation	589.9 KB	5/23/2017 11:13 AM	Delete	
MU3	4	ERCHC_SRA_November 2015.docx	Meaningful Use EHR Report	Security Risk Analysis - November 2015	443.4 KB	2/26/2017 2:34 PM	Delete	
MU3	4	PI-Total Encounter QTR4 -	Meaningful Use EHR Report	Total encounters and unique patients during the measure period	27.0 KB	2/26/2017 2:34 PM	Delete	
MU3	4	Summary_Report_CQM_100316 to 123116_	Meaningful Use EHR Report	CQM Report	37.5 KB	2/26/2017 2:34 PM	Delete	
MU3	4	Core Obj_100316 to 123116_010417.xlsx	Meaningful Use EHR Report	Core Objectives Report	22.3 KB	2/26/2017 2:33 PM	Delete	

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.



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

CMS EHR Certification Validation

First find the **CMS EHR Certification ID** for your system using the instructions in the following CMS Link:
[CMS EHR Incentive Program Web Site](#)

Once obtained, enter your **CMS EHR Certification ID** into the *CMS EHR Certification ID Validator* below and click the **Verify Certification Number** button.

CMS EHR Certification ID Validator

CMS EHR Certification ID

Verify Certification Number

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

Let's take a look at:

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

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



TIP

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

Attestation

This Screen Shows Example Data Only

Attest					
My Attestations					
	Medicaid Payment Year	Program Year	CMS EHR Certification ID	Attestation Date	Attestation Type
Details View	First Year	2012	30000001SVGWEAS	3/26/2013	AIU
Attestation Completed.					
Details View	Second Year	2013	30000001SVGWEAS	9/30/2013	MU
Attestation Completed.					
Details View	Third Year	2014	A0H1301O5JBJEAB	7/15/2015	MU
Attestation Completed.					
Details View	Fourth Year	2016	1314E01QOS1WEAH	3/16/2017	MU
Attestation Completed.					
Begin	Fifth Year	2017			

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.

Before Submission:

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

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

Click the Edit button to complete your attestation.



After Submission:

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

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

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

Attestation Instructions

Attestation Instructions

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

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

Attest Options

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

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

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

Meaningful Use Stage Overview

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

Requirements for Meaningful Use Measures for EPs

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

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

Changes include:

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

Attestation Instructions cont'd.

Data Requirements	
<p>Please be prepared to provide the following information:</p> <p>Medicaid Patient Volume</p> <ul style="list-style-type: none"> • 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] <p>Notes:</p> <ul style="list-style-type: none"> • ¹ Reporting periods are from the prior calendar year that precedes the payment year. • ² For Individual Patient Volume Methodology: <ul style="list-style-type: none"> ◦ Patient Volume criteria is based on Provider's data ◦ Hospital-Based criteria is based on Provider's data • ² For Aggregate Patient Volume Methodology: <ul style="list-style-type: none"> ◦ Patient Volume criteria is based on Practice's data ◦ Hospital-Based criteria is based on Provider's data <p>Additional Requirement:</p> <p>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.</p>	<p>Needy Individual Patient Volume</p> <ul style="list-style-type: none"> • 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 <p>Notes:</p> <ul style="list-style-type: none"> • ¹ Reporting periods <ul style="list-style-type: none"> ◦ 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 <p>Additional Requirement:</p> <p>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.</p>

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

Instructions

The data required for this attestation is grouped into categories. In order to complete your attestation, you must complete ALL of the tasks listed below.

Click on the **Begin** button to start performing a given step. If a step has been started, but not completed click on the **Continue** button to finish a step. Once a step is finished you can click on the **Modify** button to change any information that was previously entered.

Program Year Notes

The AHCCCS EHR Incentive Program is currently open for Program Year 2017.

Program Year Requirements

We encourage all providers to review the CMS documentation for Program Year before attesting.

These documents are available at the [CMS EHR website](#), or in ePIP in the [ePIP Document Library](#)

MU Program Year 2017 Attestation Requirements

<p>Practice Contact Information</p> <p>Incomplete →</p>	<p>Enter Contact Information ?</p>	<p>Begin</p>
<p>Patient Volume (Unlocked)</p> <p>Incomplete →</p>	<p>Enter Patient Volume ?</p>	<p>Begin</p>
<p>Meaningful Use (Unlocked)</p> <p>Incomplete →</p>	<p>Enter Attestation Info ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Attest to Objective Measures ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Attest to Clinical Quality Measures ?</p>	<p>Begin</p>
<p>Supporting Documentation Uploads</p> <p>Incomplete →</p>	<p>Practice Predominantly Report ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Meaningful Use EHR Report ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Security Risk Analysis Supporting Documentation ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Public Health Reporting Supporting Documentation ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>CEHRT Documentation ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Exclusion Supporting Documentation ?</p>	<p>Begin</p>
<p>Finalize Attestation</p> <p>Incomplete →</p>	<p>Attestation Statements</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Payment Assignment Agreement</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>MU Attestation Disclaimer and Submit Attestation</p>	<p>Begin</p>

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.

Click the **Begin** button to complete each step.



TIP

Click the **Continue** button to finish a step.

Click the **Modify** button to change information previously entered.

Provider Contact Information

Example Data Only

Provider Contact Information

(*) Red asterisk indicates a required field.

Provider Contact Information

Provider Name (CMS)

Provider Name (State)

* Provider Phone

* Provider Email

Provider Business Phone

Provider Business Address

Provider Authorized Alternate Contact Information (optional)

Third Party Contact Name

Third Party Contact Phone

Third Party Contact Email

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.

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



TIP

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

Select Patient Volume Criteria

Patient Volume Type

Medicaid Patient Volume
 Needy Individuals Patient Volume (option for FQHC/RHC only)

Patient Volume Type is the technique used to perform measurements. EPs participating in the EHR Incentive Program must select either Medicaid Patient Volume or Needy Individual Patient Volume.

- **Medicaid Patient Volume:** any provider can utilize
- **Needy Individual Patient Volume:** only available as an option for FQHC/RHC providers

Patient Volume Methodology

Individual
 Aggregate

Patient Volume Methodology is the way in which EPs will report their patient volume. These providers have the option of selecting either the Individual or Aggregate Patient Volume Methodology.

- **Individual:** sum of patient encounters for a single provider
- **Aggregate:** sum of patient encounters for multiple providers in a Group Practice or Clinic

[Next](#)

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.



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

Report Patient Volume

Please enter 90-day patient volume data from the calendar year prior to the Program Year for which you are attesting. For example, a Program Year 2017 attestation should have patient volume data from calendar year 2016

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

Patient Volume Reporting Period Start Date

Patient Volume Reporting Period End Date

All 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).

Medicaid Patient Encounters^(90 days in year prior to Program Year)

Arizona Medicaid 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 Title XIX places of services when reporting the above Medicaid patient encounters (numerator).

Optional Border States

California Medicaid Patient Encounters

Colorado Medicaid Patient Encounters

New Mexico Medicaid Patient Encounters

Nevada Medicaid Patient Encounters

Utah Medicaid Patient Encounters

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

Report Hospital-Based Patient Encounters

Reporting Period(12 months in year prior to Program Year)

Hospital-Based Reporting Period Start Date

Hospital-Based Reporting Period End Date

All Medicaid Patient Encounters(12 months in year prior to Program Year)

EP Total Medicaid 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 Title XIX places of services when reporting the above total (denominator).

Medicaid Hospital-Based Patient Encounters(12 months in year prior to Program Year)

EP Medicaid Inpatient Hospital Patient Encounters [POS21]

EP Medicaid Emergency Department Patient Encounters [POS23]

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 Title XIX Inpatient Hospital (places of service 21) & Emergency Department (places of service 23) only when reporting the hospital-based patient encounters (numerator).

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	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

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

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

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

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



TIP

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

The numerator is Needy Patient Encounters only.

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

Report Needy Patient Volume Data Elements cont'd.

Optional Border States			
State	Medicaid Title XIX	CHIP Title XXI	Patients Paying Below Cost
California Needy Individual Patient Encounters	<input type="text"/>	<input type="text"/>	<input type="text"/>
Colorado Needy Individual Patient Encounters	<input type="text"/>	<input type="text"/>	<input type="text"/>
New Mexico Needy Individual Patient Encounters	<input type="text"/>	<input type="text"/>	<input type="text"/>
Nevada Needy Individual Patient Encounters	<input type="text"/>	<input type="text"/>	<input type="text"/>
Utah Needy Individual Patient Encounters	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Report Practice Predominantly Patient Encounters

Reporting Period

Practice Predominantly Reporting Period Start Date

Practice Predominantly Reporting Period End Date

All Patient Encounters

EP Total Patient Encounters (in Practice Predominantly Reporting Period)

Practice Predominantly Encounters

EP FQHC/RHC Facility Patient Encounters (in Practice Predominantly Reporting Period)

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)

Instructions

The data required for this attestation is grouped into categories. In order to complete your attestation, you must complete ALL of the tasks listed below.

Click on the **Begin** button to start performing a given step. If a step has been started, but not completed click on the **Continue** button to finish a step. Once a step is finished you can click on the **Modify** button to change any information that was previously entered.

Program Year Notes

The AHCCCS EHR Incentive Program is currently open for Program Year 2017.

Program Year Requirements

We encourage all providers to review the CMS documentation for Program Year 2017 before attesting.

These documents are available at the [CMS EHR website](#), or in ePIP in the [ePIP Document Library](#)


MU Program Year 2017 Attestation Requirements

<p>Practice Contact Information</p> <p><input checked="" type="checkbox"/> Completed</p>	<p>Enter Contact Information ?</p>	<p>Modify</p>
<p>Patient Volume (Unlocked)</p> <p><input checked="" type="checkbox"/> Completed</p>	<p>Enter Patient Volume ?</p>	<p>Modify</p>
<p>Meaningful Use (Unlocked)</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p>	<p>Enter Attestation Info ?</p> <p>Attest to Objective Measures ?</p> <p>Attest to Clinical Quality Measures ?</p>	<p>Begin</p> <p>Begin</p> <p>Begin</p>
<p>Supporting Documentation Uploads</p> <p>Incomplete →</p> <p><input checked="" type="checkbox"/> Completed</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p>	<p>Patient Volume Report ?</p> <p>Medicaid Hospital Based Report ?</p> <p>Meaningful Use EHR Report ?</p> <p>Security Risk Analysis Supporting Documentation ?</p> <p>Public Health Reporting Supporting Documentation ?</p> <p>CEHRT Documentation ?</p> <p>Exclusion Supporting Documentation ?</p>	<p>Begin</p> <p>Zero HB</p> <p>Begin</p> <p>Begin</p> <p>Begin</p> <p>Begin</p> <p>Begin</p>
<p>Finalize Attestation</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p>	<p>Attestation Statements</p> <p>Payment Assignment Agreement</p> <p>MU Attestation Disclaimer and Submit Attestation</p>	<p>Begin</p> <p>Begin</p> <p>Begin</p>

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: 2017 (selecting your reporting period from Calendar Year 2017)
 Please select an EHR Reporting Period of 90 days.

* EHR Reporting Period Start Date:

* EHR Reporting Period End Date:

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:				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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:

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

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

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

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

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

Program Year 2017 Flexibility Information

Program Year 2017 - Flexibility Information

Program Year 2017 introduces the Stage 3 Objective measures to the EHR Incentive Program. Some providers will have the option of attesting to Stage 3 Objective measures.

The rules for Stage 3 participation are:

- A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures.
- A provider who has technology certified for the 2015 Edition may potentially attest to the Stage 3 requirements.
- The provider must be in the second year or greater of Meaningful Use participation.

Stage 3 participation is optional in Program Year 2017, no providers are required to attest to Stage 3 in this program year.

Flexibility Selection

Based on the CEHRT year entered and your MU Participation Year you have the option of Attesting to either of the Program Year 2017 Stages

We encourage providers to review the details of Stage 3. Details can be found at CMS [Here](#)

NOTE: Once a Stage is chosen, it cannot be undone without deleting your attestation. All information entered so far will be lost and you will need to re-enter.

Please Select a Stage for Program Year 2017

Attest to Modified Stage 2

Attest to Stage 3

Return to Attestation Progress

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

Rules for Stage 3 participation:

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

Providers with technology certified for the 2015 Edition.

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

Flexibility:

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

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

Click one of the following buttons:



TIP

- Attest to Stage 2 ^{Modified}
- Attest to Stage 3

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

Attestation Progress (After Attestation Information)

Instructions

The data required for this attestation is grouped into categories. In order to complete your attestation, you must complete ALL of the tasks listed below.

Click on the **Begin** button to start performing a given step. If a step has been started, but not completed click on the **Continue** button to finish a step. Once a step is finished you can click on the **Modify** button to change any information that was previously entered.

Program Year Notes

The AHCCCS EHR Incentive Program is currently open for Program Year 2017.

Program Year Requirements

We encourage all providers to review the CMS documentation for Program Year 2017 before attesting.

These documents are available at the [CMS EHR website](#), or in ePIP in the [ePIP Document Library](#)

MU Program Year 2017 Attestation Requirements

<p>Practice Contact Information</p> <p><input checked="" type="checkbox"/> Completed</p>	<p>Enter Contact Information ?</p>	<p>Modify</p>
<p>Patient Volume (Unlocked)</p> <p><input checked="" type="checkbox"/> Completed</p>	<p>Enter Patient Volume ?</p>	<p>Modify</p>
<p>Meaningful Use (Unlocked)</p> <p><input checked="" type="checkbox"/> Completed</p>	<p>Enter Attestation Info ?</p>	<p>Modify</p>
<p>Incomplete →</p>	<p>Attest to Objective Measures ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Attest to Clinical Quality Measures ?</p>	<p>Begin</p>
<p>Supporting Documentation Uploads</p>		
<p>Incomplete →</p>	<p>Patient Volume Report ?</p>	<p>Begin</p>
<p><input checked="" type="checkbox"/> Completed</p>	<p>Medicaid Hospital Based Report ?</p>	<p>Zero HB</p>
<p>Incomplete →</p>	<p>Meaningful Use EHR Report ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Security Risk Analysis Supporting Documentation ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Public Health Reporting Supporting Documentation ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>CEHRT Documentation ?</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Exclusion Supporting Documentation ?</p>	<p>Begin</p>
<p>Finalize Attestation</p>		
<p>Incomplete →</p>	<p>Attestation Statements</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>Payment Assignment Agreement</p>	<p>Begin</p>
<p>Incomplete →</p>	<p>MU Attestation Disclaimer and Submit Attestation</p>	<p>Begin</p>

Note that as you complete each step:

- Column on the left changes from “Incomplete” to “Completed” status
- Column on the right changes from “Begin” to “Modify” designation.

Remember that each requirement task must be followed sequentially.



TIP

Click the Begin button to complete each step.

Click Continue button to finish a step.

Click Modify button to change information previously entered.

Meaningful Use Requirements for Program Year 2017 Stage 3

Meaningful Use Objectives for Stage 3 (Optional)	
Providers with systems certified with a 2015 CEHRT as of 12.31.2017	
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.

Welcome to Stage 3

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

A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures.

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

Please note there are no alternate exclusions or specifications available.

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

Stage 3 includes flexibility within certain objectives to allow providers to choose the measures most relevant to their patient population or practice. Stage 3 flexible measures include:



TIP

- Coordination of Care & Patient Engagement ... You must meet thresholds for at least 2 of 3 measures
- Health Information Exchange... You must meet the thresholds for at least 2 of 3 measures
- Public Health Reporting ... You must report on at least 2 of 3 measures.

Stage 3 Objective 1 Measure 1 Protected Health Information

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 1 of 19 - CMS Meaningful Use Objective 1, Measure 1
 Protect Patient Health Information

Objective Details:

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

Measure Requirements:

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

Additional Information

Conducting or reviewing a Security Risk Analysis (SRA) to meet the standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule is included in the meaningful use requirements of the Medicaid EHR Incentive Program. Eligible Professionals (EPs) must attest and demonstrate compliance by performing a Security Risk Analysis each calendar year, upon installation of a new CEHRT system and/or upgrade to a new CEHRT Edition.

The analysis must meet below requirements:

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

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

Note: (Please Review before attesting to this measure): Further information about SRA can be found in the CMS SRA Fact 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 164.308(d)(3) and implemented security updates as necessary and corrected identified security deficiencies as part of your risk management process?

Yes No

Enter the date you completed your security risk analysis:

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 3 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 3 Objective 2 Measure 1 Electronic Prescribing

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 2 of 19 - CMS Meaningful Use Objective 2, Measure 1
 Electronic Prescribing (eRx)

Objective Details:

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

Measure Requirements:

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

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

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

Exclusion 1: Based on ALL patient records: Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?
 Yes No

Exclusion 2: Based on ALL patient records: Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?
 Yes No

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

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

Complete the following information:

Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.

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

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

Stage 3 Screen 2

Electronic Prescribing (eRx)

Measure 1

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 3 Measure 1 Clinical Decision Support

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 3 of 19 - CMS Meaningful Use Objective 3, Measure 1
 Clinical Decision Support - Measure 1 of 2

Objective Details:

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

Measure Requirements:

Implement **five** clinical decision support interventions related to **four** or more CQMs at a relevant point in patient care for the entire EHR reporting period.
 Absent four CQMs related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)
 For detailed information about the Clinical Decision Support objective, please click [here](#)

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

Complete the following information:

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

Yes No

Meaningful Use Objectives - Navigation

Stage 3 **Screen 3**

Clinical Decision Support

Measure 1

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 3 Measure 2 Clinical Decision Support

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 4 of 19 - CMS Meaningful Use Objective 3, Measure 2
 Clinical Decision Support - Measure 2 of 2

Objective Details:

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

Measure Requirements:

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

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

[For detailed information about the Clinical Decision Support objective, please click here](#)

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

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

* Does this exclusion apply to you?

Yes No

Complete the following information:

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

Yes No

Meaningful Use Objectives - Navigation

Stage 3 **Screen 4**

Clinical Decision Support

Measure 2

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 4 Measure 1 Computerized Provider Order Entry

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 5 of 19 - CMS Meaningful Use Objective 4, Measure 1
 Computerized Provider Order Entry - Measure 1 of 3

Objective Details:

Computerized Provider Order Entry - Measure 1 of 3 : Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

Measure Requirements:

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

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

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the 'Attestation Progress' page as a required step in the attestation process.

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

Measure Entry

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

* Does this exclusion apply to you?
 Yes No

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

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

Complete the following information:
 Numerator: The number of medication orders in the denominator during the EHR reporting period that are recorded using CPOE.
 Denominator: The number of medication orders created by the EP during the EHR reporting period.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 2^M Screen 5

Computerized Provider Order Entry

Measure 1

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 4 Measure 2 Computerized Provider Order Entry

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 6 of 19 - CMS Meaningful Use Objective 4, Measure 2
 Computerized Provider Order Entry - Measure 2 of 3

Objective Details:

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

Measure Requirements:

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

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

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

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

* Does this exclusion apply to you?
 Yes No

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

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

Complete the following information:
 Numerator: The number of laboratory orders in the denominator during the EHR reporting period that are recorded using CPOE.
 Denominator: The number of laboratory orders created by the EP during the EHR reporting period.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 3 **Screen 6**

Computerized Provider Order Entry

Measure 2

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 4 Measure 3 Computerized Provider Order Entry

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 7 of 19 - CMS Meaningful Use Objective 4, Measure 3
 Computerized Provider Order Entry - Measure 3 of 3

Objective Details:

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

Measure Requirements:

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

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

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

Exclusion: Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.

* Does this exclusion apply to you?
 Yes No

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

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

Complete the following information:
 Numerator: The number of orders in the denominator recorded using CPOE.
 Denominator: Number of diagnostic imaging orders created by the EP during the EHR reporting period.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 3 Screen 7

Computerized Provider Order Entry

Measure 3

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 5 Measure 1 Patient Electronic Access

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 8 of 19 - CMS Meaningful Use Objective 5, Measure 1
 Patient Electronic Access to Health Information - Measure 1 of 2

Objective Details:

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

Measure Requirements:

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

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

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): Further information about Patient Electronic Access objective can be found in the CMS Tip Sheet, please click here

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

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

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

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

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

Complete the following information:

Numerator: The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.

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

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 3 Screen 8

Patient Electronic Access

Measure 1

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 5 Measure 2 Patient Electronic Access

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 9 of 19 - CMS Meaningful Use Objective 5, Measure 2
 Patient Electronic Access to Health Information - Measure 2 of 2

Objective Details:

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

Measure Requirements:

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

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)
[For detailed information about the Patient Electronic Access objective, please click here](#)

Note: (Please Review before attesting to this measure): [Further information about Patient Electronic Access objective can be found in the CMS Tip Sheet, please click here](#)

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

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

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

Complete the following information:

Numerator: The number of patients in the denominator (or patient-authorized representative) who view, download, or transmit to a third party their health information.
 Denominator: Number of unique patients seen by the EP during the EHR reporting period.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 3 Screen 9

Patient Electronic Access

Measure 2

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 6 Measure 1 Coordination of Care

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 10 of 19 - CMS Meaningful Use Objective 6, Measure 1
 Coordination of Care through Patient Engagement - Measure 1 of 3

Objective Details:

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

Measure Requirements:

For an EHR reporting period in 2017, more than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either:

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

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

[For detailed information about the Coordination of Care through Patient Engagement objective, please click here](#)

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

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

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

Complete the following information:

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

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

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 3 Screen 10

Coordination of Care

Measure 1

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 6 Measure 2 Coordination of Care

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 11 of 19 - CMS Meaningful Use Objective 6, Measure 2
 Coordination of Care through Patient Engagement - Measure 2 of 3

Objective Details:

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

Measure Requirements:

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

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

[For detailed information about the Coordination of Care through Patient Engagement objective, please click here](#)

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

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

* Does this exclusion apply to you?

Yes No

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

* Does this exclusion apply to you?

Yes No

Complete the following information:

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

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

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 3 **Screen 11**

Coordination of Care

Measure 2

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 6 Measure 3 Coordination of Care

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 12 of 19 - CMS Meaningful Use Objective 6, Measure 3
 Coordination of Care through Patient Engagement - Measure 3 of 3

Objective Details:

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

Measure Requirements:

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

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

[For detailed information about the Coordination of Care through Patient Engagement objective, please click here](#)

Supporting Documentation Requirements

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process.

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

Measure Entry

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

* Does this exclusion apply to you?

Yes No

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

* Does this exclusion apply to you?

Yes No

Complete the following Information:

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

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

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 3 **Screen 12**

Coordination of Care

Measure 3

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 7 Measure 1 Health Information Exchange

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 13 of 19 - CMS Meaningful Use Objective 7, Measure 1
 Health Information Exchange - Measure 1 of 3

Objective Details:

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

Measure Requirements:

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

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

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

Measure Entry

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

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

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

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

Complete the following information:

Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.
 Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 3 **Screen 13**

Health Information Exchange

Measure 1

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 7 Measure 2 Health Information Exchange

Stage 3 Screen 14

Health Information Exchange

Measure 2

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 14 of 19 - CMS Meaningful Use Objective 7, Measure 2
 Health Information Exchange - Measure 2 of 3

Objective Details:

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

Measure Requirements:

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

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

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

Measure Entry

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

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

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

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

Complete the following information:
 Numerator: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the certified EHR technology.
 Denominator: Number of patient encounters during the EHR reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation



TIP

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

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

Stage 3 Objective 7 Measure 3 Health Information Exchange

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 15 of 19 - CMS Meaningful Use Objective 7, Measure 3
 Health Information Exchange - Measure 3 of 3

Objective Details:

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

Measure Requirements:

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

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

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

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

Measure Entry

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

* Does this exclusion apply to you?
 Yes No

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

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

Complete the following information:

Numerator: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.

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

* Numerator:

* Denominator:

Meaningful Use Objectives - Navigation

Stage 3 Screen 15

Health Information Exchange

Measure 3

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 8 Measure 1 Public Health Reporting

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 16 of 19 - CMS Meaningful Use Objective 8, Measure 1
 Public Health and Clinical Data Registry Reporting - Measure 1 of 4

Objective Details:

Public Health and Clinical Data Registry Reporting - Measure 1 of 4 : The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Measure Requirements:

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

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

Note: (Please Review before attesting to this measure): [For more information regarding the Public Health Reporting objective, please click here](#)

Supporting Documentation Requirements

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

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

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

Measure Entry

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

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

Exclusion: Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data as of 6 months prior to the start of the EHR reporting period.

* Does this exclusion apply to you?
 Yes No

Complete the following information:

* Are you in active engagement with a public health agency to submit immunization data?
 Yes No

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

Stage 3 **Screen 16**

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 3 Objective 8 Measure 2 Public Health Reporting

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 17 of 19 - CMS Meaningful Use Objective 8, Measure 2
 Public Health and Clinical Data Registry Reporting - Measure 2 of 4

Objective Details:

Public Health and Clinical Data Registry Reporting - Measure 2 of 4: The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Measure Requirements:

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

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

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

Supporting Documentation Requirements

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

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

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

Measure Entry

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

* Does this exclusion apply to you?

Yes No

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

* Does this exclusion apply to you?

Yes No

Exclusion: Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs as of 6 months prior to the start of the EHR reporting period.

* Does this exclusion apply to you?

Yes No

Complete the following information:

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

Yes No

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

Save & Continue
Return to Attestation Progress

Stage 3 **Screen 17**

Public Health Reporting

Measure 2

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 8 Measure 3 Public Health Reporting

Public Health and Clinical Data Registry Reporting		Stage 3 Public Health Reporting <input checked="" type="checkbox"/> Measure 3 Electronic Case Reporting is not required until 2018, since we believe that the standards will be mature and that jurisdictions will be able to accept these types of data by that time.
Effective	Starting January 1, 2018 <i>(no applicadtoin to 2017 attestations)</i>	
Measure	Measure 3 Electronic Case Reporting	
Objective	The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.	
Measure Options	The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.	
Exclusions	Any EP meeting one or more of the following criteria may be excluded from the case reporting measure if the EP— <ul style="list-style-type: none"> ○ Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction’s reportable disease system during the EHR reporting period; ○ Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or ○ Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the EHR reporting period. 	
Action Required	No Action Required for Program Year 2017.	


TIP

ePIP will not reflect this objective for Program Year 2017.

Stage 3 Objective 8 Measure 4 Public Health Reporting

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 18 of 19 - CMS Meaningful Use Objective 8, Measure 4
 Public Health and Clinical Data Registry Reporting - Measure 3 of 4

Objective Details:

Public Health and Clinical Data Registry Reporting - Measure 3 of 4 : The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

Measure Requirements:

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

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

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

Supporting Documentation Requirements

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

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

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

Measure Entry

Exclusion: Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

Complete the following information:

* Are you in active engagement with a public health agency to submit data to public health registries?
 Yes No

Meaningful Use Objectives - Navigation

Stage 3 **Screen 18**

Public Health Reporting

Measure 4

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Stage 3 Objective 8 Measure 5 Public Health Reporting

Meaningful Use Objectives - Stage 3 for Program Year 2017
 ePIP Measure 19 of 19 - CMS Meaningful Use Objective 8, Measure 5
 Public Health and Clinical Data Registry Reporting - Measure 4 of 4

Objective Details:

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

Measure Requirements:

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

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

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

Supporting Documentation Requirements

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

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

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

Measure Entry

Exclusion: Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the EHR reporting period.

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

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

* Does this exclusion apply to you?
 Yes No

Complete the following information:

* Are you in active engagement with a public health agency to submit data to a clinical data registry?
 Yes No

Meaningful Use Objectives - Navigation

Stage 3 Screen 19

Public Health Reporting

Measure 5

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Attestation Progress (After Objective Measures)

Instructions

The data required for this attestation is grouped into categories. In order to complete your attestation, you must complete ALL of the tasks listed below.

Click on the **Begin** button to start performing a given step. If a step has been started, but not completed click on the **Continue** button to finish a step. Once a step is finished you can click on the **Modify** button to change any information that was previously entered.

Program Year Notes

The AHCCCS EHR Incentive Program is currently accepting Program Year 2017 attestations for Meaningful Use (MU) until March 31, 2018.

Program Year Requirements

We encourage all providers to review the CMS documentation for Program Year 2017 before attesting.

These documents are available at the [CMS EHR website](#), or in ePIP in the [ePIP Document Library](#)

MU Program Year 2017 Attestation Requirements

<p>Practice Contact Information</p> <p>☑ Completed</p>	<p>Enter Contact Information ?</p>	<p>Modify</p>
<p>Patient Volume (Unlocked)</p> <p>☑ Completed</p>	<p>Enter Patient Volume ?</p>	<p>Modify</p>
<p>Meaningful Use (Unlocked)</p> <p>☑ Completed</p> <p>☑ Completed</p> <p>Incomplete →</p>	<p>Enter Attestation Info ?</p> <p>Attest to Objective Measures ?</p> <p>Attest to Clinical Quality Measures ?</p>	<p>Modify</p> <p>Modify</p> <p>Begin</p>
<p>Supporting Documentation Uploads</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p>	<p>Patient Volume Report ?</p> <p>Medicaid Hospital Based Report ?</p> <p>Meaningful Use EHR Report ?</p> <p>Security Risk Analysis Supporting Documentation ?</p> <p>Public Health Reporting Supporting Documentation ?</p> <p>CEHRT Documentation ?</p> <p>Exclusion Supporting Documentation ?</p>	<p>Begin</p> <p>Begin</p> <p>Begin</p> <p>Begin</p> <p>Begin</p> <p>Begin</p> <p>Begin</p>
<p>Finalize Attestation</p> <p>Incomplete →</p> <p>Incomplete →</p> <p>Incomplete →</p>	<p>Attestation Statements</p> <p>Payment Assignment Agreement</p> <p>MU Attestation Disclaimer and Submit Attestation</p>	<p>Begin</p> <p>Begin</p> <p>Begin</p>

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

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



TIP

Click the Begin button to complete each step.

Click Continue button to finish a step.

Click Modify button to change information previously entered.

Clinical Quality Measures

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

Clinical Quality Measures (CQMs) Selection:

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

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

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

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

Report the CQMs for which there is patient data

Report the remaining required CQMs as “zero denominators” as displayed by your certified EHR technology.



TIP

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

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

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

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

Person and Caregiver-Centered Experience & Outcomes

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

4 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Clinical Quality Measures for Patient Safety

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

Patient Safety

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

5 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Clinical Quality Measures for Communication and Care Coordination

Communication and Care Coordination		
Objective	Measure	Selected
CMS 50v5 - Closing the Referral Loop: Receipt of Specialist Report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	<input type="checkbox"/>

Communication and Care Coordination

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

1 of 53 CQMs is available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Clinical Quality Measures for Community / Population Health

Community/Population Health		
Objective	Measure	Selected
CMS 155v5 \ NQF 0024 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician / Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. <ul style="list-style-type: none"> 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 	<input type="checkbox"/>
CMS 138v5 \ NQF 0028 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	<input type="checkbox"/>
CMS 153v5 \ NQF 0033 - Chlamydia Screening for Women	Percentage of women 16- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	<input type="checkbox"/>
CMS 117v5 \ NQF 0038 - Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	<input type="checkbox"/>
CMS 147v6 \ NQF 0041 - Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	<input type="checkbox"/>

Community / Population Health

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

9 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

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

<p>CMS 2v6 \ NQF 0418 - Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</p>	<p>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.</p>	<input type="checkbox"/>
<p>CMS 69v5 \ NQF 0421 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</p>	<p>Percentage of patients aged 18 years and older with an encounter during the reporting period with a documented calculated BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, follow-up plan is documented during the encounter or during the previous 6 months of the encounter with the BMI outside of normal parameters. Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 Age 18-64 years BMI ≥ 18.5 and < 25.</p>	<input type="checkbox"/>
<p>CMS 82v4 \ NQF1401 - Maternal depression screening</p>	<p>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.</p>	<input type="checkbox"/>
<p>CMS 22v5 - Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</p>	<p>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.</p>	<input type="checkbox"/>

Community / Population Health

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

9 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Clinical Quality Measures for Efficiency and Cost Reduction

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

Efficiency and Cost Reduction

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

4 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Clinical Quality Measures for Effective Clinical Care

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

Effective Clinical Care

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

30 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Clinical Quality Measures for Effective Clinical Care cont'd.

Effective Clinical Care

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

30 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

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



TIP

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

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

Clinical Quality Measures for Effective Clinical Care cont'd.

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

Effective Clinical Care

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

30 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Clinical Quality Measures for Effective Clinical Care cont'd.

<p>CMS 136v6 \ NQF 0108 - ADHD: Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication</p>	<p>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.</p> <p>1) Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.</p> <p>2) Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.</p>	<input type="checkbox"/>
<p>CMS 169v5 - Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use</p>	<p>Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.</p>	<input type="checkbox"/>
<p>CMS 52v5 \ NQF 0405 - HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis</p>	<p>Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.</p>	<input type="checkbox"/>
<p>CMS 133v5 \ NQF 0565 - Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</p>	<p>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.</p>	<input type="checkbox"/>
<p>CMS 158v5 - Pregnant women that had HBsAg testing</p>	<p>This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.</p>	<input type="checkbox"/>
<p>CMS 159v5 \ NQF 0710 - Depression Remission at Twelve Months</p>	<p>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.</p>	<input type="checkbox"/>

Effective Clinical Care

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

30 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

Clinical Quality Measures for Effective Clinical Care cont'd

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

Effective Clinical Care

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

30 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.



TIP

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

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

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. 300j(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. 300j(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

Payment Assignment Agreement

(*) Red asterisk indicates a required field.

Payment Information

Payment No:

Program Year:

Payee NPI:

Payee TIN:

Payee TIN Type:

Payee Name:

*Employer:

Home Address:
 If you are not reassigning a payment (you are the direct recipient), please provide your personal address below. This address will only be used in the instance that your personal 1099 is returned to AHCCCS and must be sent out again.

Address: Suite #: City: State: Zip Code:

Payment Assignment Disclaimer

NOTICE: An Eligible Professional (EP) may only assign incentive payments to his/her employer or to an entity with which the EP has a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services. All required tax statements, including Form 1099 regarding miscellaneous income, will be sent to the payee listed above.

By clicking on this checkbox, I certify that the payee listed above is either myself, my employer or an entity with which I have a contractual arrangement that the terms of my employment and/or the contract allows the employer or entity to bill and receive payment for my professional services.

Important Information: 1099 Reporting for EHR Incentive Payments

The IRS has provided written guidance regarding 1099 reporting for EHR incentive payments. Please note that providers may have EHR incentive payments reported to the IRS whether or not they assign the payment to another entity. Because tax issues fall under IRS jurisdiction, AHCCCS cannot offer advice or assistance on this issue. Any questions pertaining to this matter should be referred to your accountant and/or attorney.

[1099 Reporting for EHR Incentive Payments](#)

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

Attestation Disclaimer

Attestation Notification

The EHR Incentive Program payment is considered a Medicaid payment to the provider. In addition to any other remedies available to it, AHCCCS reserves the right to offset any overpayment of Medicare or Medicaid (including EHR Incentive Program payments), and any sanctions or civil monetary penalties imposed by Medicare or Medicaid from any amounts due to the Provider from AHCCCS including but not limited to EHR Incentive Program payments.

Note: The State does not use the incentive payment to pay for its own program administration or to fund other State priorities.

Routine Uses(s)

Information from this Medicaid EHR Incentive Program application and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state local and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity and civil and criminal litigation related to the operation of the Medicaid EHR Incentive Program.

Disclosures

This program is an incentive program. Therefore, while submission of the information for this program is voluntary, failure to provide necessary information will result in delay in an incentive payment or may result in denial of a Medicaid EHR Incentive Program payment. Failure to furnish subsequently requested information or documents to support the attestation will result in the issuance of an overpayment demand letter followed by recoupment procedure.

Attestation Disclaimer

NOTICE: With the notable exception of Eligible Hospitals, separate attestations must be completed and submitted by each provider, including each individual provider in a group practice or clinic. The attestation may NOT be completed by anyone on the provider's behalf. Attestations that are submitted by anyone other than the individual provider named in the attestation constitutes a false claim for Medicaid reimbursement which may result in civil and criminal penalties against the person submitting the attestation and/or the provider. In addition, civil and criminal penalties and/or other administrative remedies may be imposed for any material misrepresentation or false statement made to obtain EHR incentive payments.

I certify that the foregoing information is true, accurate and complete. I understand that the Arizona Medicaid EHR Incentive Program payment will be paid from Federal funds, that by filing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain an Arizona Medicaid EHR Incentive Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

I understand that AHCCCS reserves the right to perform an audit of this information. The audit may include an on-site visit by AHCCCS staff or designee to gather supporting data. I hereby agree to keep such records as are necessary, for six years, to demonstrate that I met all Arizona Medicaid EHR Incentive Program requirements and to furnish those records to the Medicaid State Agency, Arizona Health Care Cost Containment System Administration (AHCCCS), Department of Health and Human Services or contractor acting on their behalf.

I agree that the Medicaid EHR Incentive Program payment may NOT be paid unless this attestation is completed and accepted as required by existing law and regulations.

I agree to notify the State if I believe that I have been overpaid under the Medicaid EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 6402, Section 11283, provides penalties for withholding this information.

By clicking on this check box, I agree to the above Attestation Notification and Disclaimer.

The information submitted is accurate to the knowledge and belief of the EP.

Submit Attestation Cancel

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

Appendix E – Definitions

Attestation

The attestation process allows the providers to attest to the EHR Incentive Program’s as they demonstrate adoption, implementation, upgrade (AIU), or meaningful use of EHR technology. *AIU attestations are not available after 2016.*

Electronic Health Record (EHR)

A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician’s workflow. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.

Eligible Professionals (EP)

Physicians (Doctor of Medicine, Doctor of Osteopathy), Dentists, Nurse Practitioners, Certified Nurse Midwives and Physician Assistants (PA) practicing in a FQHC/RHC/Tribal Clinic led by the PA.

ePIP

An online application that interfaces with the CMS Registration and Attestation system and the Prepaid Medicaid Management Information System (PMMIS) to allow providers to complete applications for the Medicaid EHR Incentive Program for Arizona.

Meaningful Use

Use of certified EHR technology (CEHRT) to Improve quality, safety, efficiency, & reduce health disparities; Engage patients & families in their health care; Improve care coordination; Improve population & public health and all the while maintaining privacy and security.

Meaningful Use Exclusion

A reason or reasons associated with a Meaningful Use objective that can be selected, if applicable, to exempt a provider from having to meet the measure

Meaningful Use Exemption

Found mainly in the Clinical Quality Measures, this counts the number of members that were seen by a provider during the Meaningful Use Reporting Period, but were not eligible to be included in the measure being reported.

Meaningful Use Stages

Stage 1 Data Capture & Information Sharing: Requirements focus on electronic data capture and information sharing with the patient or other health care professionals.

Stage 2 / Stage 2^{Modified} Advanced Clinical Processes: Requirements focus on expanding Stage 1 requirements by emphasizing patient engagement and care coordination. Improvements to ease reporting requirements and align with other quality reporting programs (*Stage 2^{Modified}*).

Stage 3 Improved Outcome: Requirements focus on using CEHRT to improve health outcomes.

Patient Volume Methodology

Method in which an EP reports his/her patient encounters. Individual is the sum of patient encounters for a single EP. Aggregate is the sum of patient encounters for the entire practice (includes all providers).

Program Year

The calendar year in which a provider is attesting. Providers can participate and receive payment up to a maximum of 6 years.

Registration

The registration process allows the provider to participate in the EHR Incentive Program. Providers must complete a federal and state level registration process. *Only providers transferring from other States are permitted to register to set-up an ePIP account after Program Year 2016.*

Appendix F – Frequently Asked Questions regarding Program Participation

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

Appendix F – Frequently Asked Questions regarding Registration

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

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?
	<p>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.</p> <p>If your previous attestation was denied or rejected, you may need to have your attestation refreshed.</p> <p>In any instance if you cannot start a new Program Year, please email the EHR Incentive Program team at EHRIncentivePayments@azahcccs.gov.</p>
Q11	How do I know if my electronic health record (EHR) system is certified?
	<p>The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a set of standards and certification criteria.</p> <p>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.</p>
Q12	How do we submit documentation to support the attestation?
	<p>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.</p> <p>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.</p>
Q13	How can I change my attestation information after I have attested for the Medicaid EHR Incentive Program?
	<p>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.</p>


Appendix F – Frequently Asked Questions regarding Meaningful Use

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

Appendix F – Frequently Asked Questions regarding Payment

Q18	I am choosing to reassign my EHR incentive payment to my practice. Will I have any financial liability if I do so?
	<p>The State of Arizona issues 1099s to the Payee (recipient) of the EHR funds. If you have reassigned your payment to your practice, you will not personally receive a 1099. For more information on 1099s, visit the AHCCCS website at https://www.azahcccs.gov/PlansProviders/CurrentProviders/EHR/.</p> <p>Click the Payment drop down and see IMPORTANT TAX INFORMATION.</p>
Q19	How is the Eligible Professional payment amounts determined?
	<p>Medicaid EPs can receive a maximum of \$63,750 over a six year period.</p> <p><i>Note: There are special eligibility & payment options for Pediatricians.</i></p>
Q20	How often are payments made?
	<p>Payments are disbursed once per month via Electronic Funds Transfer.</p>
Q21	Are payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs subject to federal income tax?
	<p>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.</p>
Q22	Are payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs subject to recoupments?
	<p>Both Medicare and Medicaid are required to recoup any or all portions of the EHR incentive payment if any of the following conditions are determined:</p> <ul style="list-style-type: none"> • 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?
	<p>We must first perform the pre-payment audit. The EHR Incentive Team strives to complete within eight (8) weeks of attestation during off peak periods. Delays are experienced when waiting for missing information, resolving issues, during peak periods, training or staffing changes.</p>

Appendix G – Electronic Funds Transfer ACH Form Instructions

STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM			
Electronic Funds Transfer (EFT) Authorization Agreement Instructions			
Attn: AHCCCS Finance- MD 5400, P.O. Box 25520, Phoenix, AZ 85002			
			
SECTION 1	PROVIDER INFORMATION		
	Provider Name	Complete legal name of institution, corporate entity, practice or individual provider	Required
	Doing Business As Name (DBA)	The trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name, the legal person (or persons) who actually own it and are responsible for it	Optional
	Provider Address		
	<i>Street</i>	The number and street name where a person or organization can be found	Required
	<i>City</i>	City associated with provider address field	Required
	<i>State/Province Zip Code/ Postal Code</i>	2 Character Code associated with the State/Province/Region of the applicable Country 5 or 15 Character Code	Required
SECTION 2	PROVIDER IDENTIFIERS INFORMATION		
	Provider Identifiers		
	<i>Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)</i>	A Federal Tax Identification Number also known as an Employer Identification Number (EIN) used to identify a business entity; Numeric, 9 digits	Required
	<i>National Provider Identifier (NPI)</i>	A Health Insurance Portability Accountability Act (HIPAA) - Required when provider has been enumerated with an NPI; Numeric, 10 digits	Optional
	<i>Trading Partner ID</i>	AHCCCS Provider ID; 6 digits- 2 digits	Required
SECTION 3	PROVIDER CONTACT INFORMATION		
	Provider Contact Name	Name of a contact in provider office for handling EFT issues	Required
	<i>Title</i>		Optional
	<i>Tel Number</i>	Number associated with contact person; Numeric, 10 digits	Required
	<i>Tel Number Ext</i>		Optional may not have one
	<i>Email Address</i>	An electronic mail address at which AHCCCS might contact the provider	Optional may not have one
	<i>Fax Number</i>	A number at which the provider can be sent facsimiles	Optional
SECTION 4	PROVIDER AGENT INFORMATION - IF APPLICABLE		
	Provider Agent Name	Name of provider's authorized agent	Required
	Agent Address		
	<i>Street</i>	The number and street name where a person or organization can be found	Required
	<i>City</i>	City associated with provider address field	Required
	<i>State/Province Zip Code/Postal Code</i>	2 Character Code associated with the State 5 or 15 Character Code	Required
	Provider Agent Contact Name	Name of a contact in agent office for handling EFT issues	Required
	<i>Tel Number</i>	Number associated with contact person; Numeric, 10 digits	Required
	<i>Tel Number Ext</i>		Optional Required, may not have one
		<i>Email Address</i>	An electronic mail address at which AHCCCS might contact the provider
	<i>Fax Number</i>	A number at which the provider can be sent facsimiles	Optional

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

FINANCIAL INSTITUTION INFORMATION			
SECTION 5	Financial Institution Name	Official name of the provider's financial institution	
	Institution Address		
	<i>Street</i>	Street address associated with receiving depository financial institution name field	Required
	<i>City</i>	City associated with receiving depository financial institution address field	Required
	<i>State/Province Code</i>	2 Character Code associated with the State	Required
	<i>Code</i>	5 or 15 Character Code	
	<i>Tel Number</i>	A contact telephone number at the provider's bank	Optional
	<i>Tel Number Ext</i>		Optional
	Institution Routing Number at Financial Institution	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited	Required
	Account Number with Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving	Required
Account Number Linkage to Provider Identifier	Provider's account number at the financial institution to which EFT payments are to be deposited	Required	
	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice	Required; select from one of the two below	
	<i>Provider Federal Tax Identification Number (TIN) or</i>	Numeric, 9 digits	Optional – required if NPI is not applicable
	<i>National Provider Identifier (NPI)</i>	Numeric, 10 digits	Optional – required if TIN is not applicable
SUBMISSION INFORMATION			
SECTION 6	Reason for Submission		
	<i>New Enrollment</i>		Required
	<i>Change Enrollment</i>		Required
	<i>Cancel Enrollment</i>		Required
	Include with Enrollment Submission		
	<i>Voided Check or Bank Letter</i>	A voided check is attached to provide confirmation of identification/account numbers A letter on bank letterhead that formally certifies the account owners routing and account numbers	Required
AUTHORIZATION			
SECTION 7	Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate modify or terminate an enrollment.	Required
	<i>Print Name of Authorized Signer</i>	The printed name of the person submitting the form	Required
	<i>Title</i>	The title of person signing the form	Optional
	Submission Date Requested EFT Start/Change/Cancel Date	The date on which the enrollment is submitted - CCYYMMDD	Required
		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		AHCCCS 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)	*	
PROVIDER CONTACT INFORMATION			
SECTION 2	Provider Contact Name *	Title *	
	Telephone Number & Extension *		
	Email Address *	Fax Number	
	Trading Partner ID (AHCCCS Provider 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 +		
FINANCIAL INSTITUTION INFORMATION			
SECTION 4	Financial Institution Name *		
	Financial Institution Address	Street *	City * State * Zip Code] *
	Financial Institution Telephone Number & Extension		
	Financial Institution Routing Number	*	
	Type of Account at Financial Institution	* Checking _____ Savings _____	
	Provider's Account Number with Financial Institution	*	
	Account Number Linkage to Provider Identifier	Provider's Federal Tax Identification Number	OR
SUBMISSION INFORMATION			
SECTION 5	Reason for Submission *	New Enrollment _____ Change Enrollment _____ Cancel Enrollment _____	
	Include with Enrollment Submission *	<input type="checkbox"/> Voided Check : A voided check is attached to provide confirmation of identification/account numbers OR <input type="checkbox"/> Bank Letter : A letter on bank letterhead that formally certifies the account owners routing and account numbers	
	AUTHORIZATION		
SECTION 6	Pursuant to A.R.S. Sec. 35-185, I authorize the Arizona 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		*

For a full, printable PDF of this document, please click on the following link,
[Click Here](#)

Appendix I – Contact Us

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



Website: [Arizona Medicaid EHR Incentive Program](#)

📞 602.417.4333

✉️ EHRIncentivePayments@azahcccs.gov

Thank you for your interest in the EHR Incentive Program

