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

ELIGIBLE PROFESSIONALS

May 10, 2019
https://www.azepip.gov/

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Disclaimer

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

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


Important Notice – Third Party Attestation

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

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

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

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

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

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

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

Eligible to Participate:
Providers under the AHCCCS Medicaid program are eligible to participate in the 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

https://www.azepip.gov/
Welcome to the ePIP System Home Page

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

Your ePIP account is where you interface with the system to maintain your Promoting Interoperability Program information and track your incentive payments. If you have not already registered with CMS and have not obtained a CMS Registration ID, click here to find out about registering with CMS.

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

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

ePIP Program Announcements

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

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

The program is administered by states and territories, and will pay incentives through 2021. Eligible professionals are eligible for incentive payments for 5 years, and participation years do not have to be consecutive.

- The last year that an eligible professional can begin participating is 2016. Incentive payments for eligible professionals under the Medicaid Promoting Interoperability Program are up to $63,750 over 6 years.
- Eligible professionals can receive an incentive payment for adopting, implementing, or upgrading (AIU) certified EHR technology in their first year of participation. In subsequent years, eligible professionals can receive incentive payments for successfully demonstrating meaningful use.

What are Meaningful Use Stages?

Meaningful use requirements for 2017-2018:

**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 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 documentation for all of these objectives can be found in the EHR Document Library.

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

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

ePIP Program Announcement Update:

ePIP is accepting attestations for Program Year 2018 until August 31, 2019 (subject to CMS approval).
Registration (Providers Without an ePIP Account)

User Agreement

Provider Incentive Payments User Agreement

Data Requirements

Please be prepared to provide the following information:

- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- CMS Registration ID (Displayed when registered with www.cms.gov)
- AHCCCS Provider Number (APN)
- CIN (For Hospital 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.

TIP

Your NPI number can be verified at the following link:
https://npiregistry.cms.hhs.gov/registry/
Use our PI Document Library to navigate quickly to the Meaningful Use requirements.

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

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

Need help? E-mail the PI Program Team at EHRIncentivePayments@azahcccs.gov or call us at 602-417-4333.
Welcome to Your ePIP Account Home Page

Welcome To Your ePIP Account

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

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

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

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

ePIP Program Announcements:

- CMS has re-branded the program as the Promoting Interoperability Program
- Program Year 2018 is now open and accepting attestations
- Stage 3 Meaningful Use in Program Year 2018 is optional

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

1. Home

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

3. Attest

4. Contacts
   - PI Team
   - Other AHCCCS Contacts

5. PI Doc Library

6. Log Off

ePIP Program Announcement Update:

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

Helpful links are located in the footer of the web page.
My Account – How to Manage My Account

<table>
<thead>
<tr>
<th>My Account Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS Information</strong></td>
</tr>
<tr>
<td>National Provider Identifier (NPI):</td>
</tr>
<tr>
<td>Tax Identification Number (TIN):</td>
</tr>
<tr>
<td>Payee NPI:</td>
</tr>
<tr>
<td>Payee TIN:</td>
</tr>
<tr>
<td>Payee TIN Type:</td>
</tr>
<tr>
<td>Provider Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>CMS EHR Certification ID:</td>
</tr>
<tr>
<td>Provider Type:</td>
</tr>
</tbody>
</table>

Your data will appear here.
If incorrect or incomplete, follow the instructions below to modify.
Allow 48 hours for an update.

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

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.

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 UPPPER 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.

<table>
<thead>
<tr>
<th>Account Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current password</td>
</tr>
<tr>
<td>New password</td>
</tr>
<tr>
<td>Confirm new password</td>
</tr>
</tbody>
</table>

Change 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.

Passwords must meet the complexity requirements displayed on the screen.
My Account – How to Manage My Security Questions

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.

You must enter your password to modify your security questions.
My Account – How to Manage My Payments

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

Example Data Only

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Amount</th>
<th>Payment Date</th>
<th>Payment For</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$21,250.00</td>
<td>8/26/2013</td>
<td>AU</td>
</tr>
<tr>
<td>2013</td>
<td>$8,500.00</td>
<td>11/25/2013</td>
<td>MU</td>
</tr>
<tr>
<td>2014</td>
<td>$8,500.00</td>
<td>12/23/2015</td>
<td>MU</td>
</tr>
<tr>
<td>2016</td>
<td>$8,500.00</td>
<td>7/24/2017</td>
<td>MU</td>
</tr>
</tbody>
</table>

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.
### My Account – How to Manage My Documents

#### Manage Documents

<table>
<thead>
<tr>
<th>Attestation Type</th>
<th>Attestation Year</th>
<th>File Name</th>
<th>Document Type</th>
<th>Name</th>
<th>Size</th>
<th>Uploaded</th>
<th>Delete</th>
</tr>
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<tbody>
<tr>
<td>MU3</td>
<td>4</td>
<td>Letter of Intent to AHCCCS re: MU3 13:2:16.pdf</td>
<td>Other Documentation</td>
<td>Letter of intent proving group volume report was submitted prior to attestation</td>
<td>586.9</td>
<td>5/23/2017 11:13 AM</td>
<td></td>
</tr>
<tr>
<td>MU3</td>
<td>4</td>
<td>PI: Total Encounter QTR4</td>
<td>Meaningful Use DHR Report</td>
<td>Total encounters and unique patients during the measure period</td>
<td>27.0</td>
<td>2/23/2017 2:34 PM</td>
<td></td>
</tr>
<tr>
<td>MU3</td>
<td>4</td>
<td>Summary, Report, QDM, 100916 to 120316</td>
<td>Meaningful Use DHR Report</td>
<td>QDM Report</td>
<td>57.5</td>
<td>2/23/2017 2:34 PM</td>
<td></td>
</tr>
<tr>
<td>MU3</td>
<td>4</td>
<td>Core QOL, 100316 to 123116, C113067-1253</td>
<td>Meaningful Use DHR Report</td>
<td>Core Objectives Report</td>
<td>22.3</td>
<td>2/23/2017 2:33 PM</td>
<td></td>
</tr>
</tbody>
</table>

#### TIP

- **Tag your documents by selecting the appropriate label from the drop down list:**
  - **Attestation Year** – describes the program year for the document
  - **Document Type** – describes the type of document you are uploading.
The EHR Certification Number is a unique alpha-numeric character string assigned by ONC-Authorized Testing & Certification Board after an PI system has been successfully certified.
### Attestation

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.

#### TIP

#### 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.

---

<table>
<thead>
<tr>
<th>Medicaid Payment Year</th>
<th>Program Year</th>
<th>CMS EHR Certification ID</th>
<th>Attestation Date</th>
<th>Attestation Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Year</td>
<td>2012</td>
<td>30000001SVGWEAS</td>
<td>3/26/2013</td>
<td>AIU</td>
</tr>
<tr>
<td>Second Year</td>
<td>2013</td>
<td>30000001SVGWEAS</td>
<td>9/30/2013</td>
<td>MU</td>
</tr>
<tr>
<td>Third Year</td>
<td>2014</td>
<td>A9H1301C5JBJEA8</td>
<td>7/15/2015</td>
<td>MU</td>
</tr>
<tr>
<td>Fourth Year</td>
<td>2016</td>
<td>1314E01Q5S1WEAH</td>
<td>3/16/2017</td>
<td>MU</td>
</tr>
<tr>
<td>Fifth Year</td>
<td>2018</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Attestation Instructions

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

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

Attest Options

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

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

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

Meaningful Use Stage Overview

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

Requirements for Meaningful Use Measures for EPs

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

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

Changes Include:

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

Please be prepared to provide the following information:

Medicaid Patient Volume

- Patient Volume Reporting Period (90 days) \(^1\)
- Hospital-Based Reporting Period (12 months) \(^1\)
- Patient Volume Methodology (Individual/Aggregate) \(^2\)
- Total Patient Encounters
- Medicaid Patient Encounters (Medicaid Title XIX)
- Hospital-Based Patient Encounters (Medicaid Title XIX Inpatient Hospital & Emergency Department)

Notes:

- \(^1\) Reporting periods are from the prior calendar year that precedes the payment year.
- \(^2\) For Individual Patient Volume Methodology:
  - Patient Volume criteria is based on Provider’s data
  - Hospital-Based criteria is based on Provider’s data
- \(^3\) For Aggregate Patient Volume Methodology:
  - Patient Volume criteria is based on Practice’s data
  - Hospital-Based criteria is based on Provider’s data

Additional Requirement:

Non-Hospital-Based Criteria:
EPs selecting Medicaid Patient Volume Type cannot be hospital-based. Hospital-Based Patient Encounters are encounters received at an inpatient hospital or an emergency department place of service. Hospital-Based EPs have 90 percent or more of their covered professional services in a hospital setting during the 12 month reporting period.

Additional Requirement:

Non-Hospital-Based Criteria:
EPs selecting Medicaid Patient Volume Type cannot be hospital-based. Hospital-Based Patient Encounters are encounters received at an inpatient hospital or an emergency department place of service. Hospital-Based EPs have 90 percent or more of their covered professional services in a hospital setting during the 12 month reporting period.

Needy Individual Patient Volume

- Patient Volume Reporting Period \(^1\)
- Practice-Predominantly Reporting Period \(^1\)
- Patient Volume Methodology
- Total Patient Encounters
- Needy Individual Patient Encounters (Medicaid Title XIX, CHIP Title XXI & Patients Paying Below Cost)
- FQHC/RHC Facility Patient Encounters in Practice-Predominantly Reporting Period
- Total Patient Encounters in Practice-Predominantly Reporting Period

Notes:

- \(^1\) Reporting periods:
  - Patient Volume Reporting Period is a 90 day period in prior calendar year
  - Practice-Predominantly Reporting Period is a 6-month period in prior calendar year

Additional Requirement:

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

AIU Selection

Note: As of the end of Program Year 2016 (June 30th, 2017) the AIU Selection is no longer available

- **Adopted Certified EHR**
  Adoption of an EHR system requires that a provider acquired, purchased or secured access to certified EHR technology.

- **Implemented Certified EHR**
  Implementation of an EHR system requires that a provider installed or commenced utilization of certified EHR technology.

- **Upgraded Certified EHR**
  Upgrade of an EHR system requires that a provider upgraded from existing EHR technology to certified EHR technology or expanded the functionality of existing certified EHR technology.
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.

Click the Continue button to finish a step.

Click the Modify button to change information previously entered.
Provider Contact Information

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?

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

Go to My Account, Click Manage My Account and Click Edit My Account to update your authorized secondary contact (optional).
Patient Volume Criteria

Patient volume is required each time you apply for the program.

Medicaid Patient Volume is an available option for all providers.

Needy Patient Volume is only an available option for providers practicing in a FQHC, RHC, or Tribal Clinic.

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

Out of State Medicaid Patient encounters can be excluded in the numerator (if not needed to meet the patient volume) but must be reported in the denominator.

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 2018 attestation should have patient volume data from calendar year 2017.

<table>
<thead>
<tr>
<th>Reporting Period (90 days in year prior to Program Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Volume Reporting Period Start Date</td>
</tr>
<tr>
<td>Patient Volume Reporting Period End Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Patient Encounters (90 days in year prior to Program Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Encounters</td>
</tr>
</tbody>
</table>

**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).

<table>
<thead>
<tr>
<th>Medicaid Patient Encounters (90 days in year prior to Program Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Medicaid Patient Encounters</td>
</tr>
</tbody>
</table>

**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).

<table>
<thead>
<tr>
<th>Optional Border States</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Medicaid Patient Encounters</td>
</tr>
<tr>
<td>Colorado Medicaid Patient Encounters</td>
</tr>
<tr>
<td>New Mexico Medicaid Patient Encounters</td>
</tr>
<tr>
<td>Nevada Medicaid Patient Encounters</td>
</tr>
<tr>
<td>Utah Medicaid Patient Encounters</td>
</tr>
</tbody>
</table>

**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].

**TIP**

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.

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 Reporting dates must be a continuous 90-day period selected from the year prior to the program year.
Report Hospital-Based Data Elements

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

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>90 days in year prior to Program Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Volume Reporting Period Start Date</td>
<td></td>
</tr>
<tr>
<td>Patient Volume Reporting Period End Date</td>
<td></td>
</tr>
</tbody>
</table>

#### EP Total Patient Encounters

<table>
<thead>
<tr>
<th>Total Patient Encounters</th>
<th></th>
</tr>
</thead>
</table>

**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

<table>
<thead>
<tr>
<th>Medicaid Title XIX</th>
<th>CHIP Title XXI</th>
<th>Patients Paying Below Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona Needy Individual Patient Encounters</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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].

---

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.
Report Needy Patient Volume Data Elements continued

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

Please note that Out of State Medicaid Patient encounters can be excluded in the numerator (if not needed to meet the patient volume) but must be reported in the denominator.

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**

### Reporting Period

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Predominantly Reporting Period Start Date</td>
<td></td>
</tr>
<tr>
<td>Practice Predominantly Reporting Period End Date</td>
<td></td>
</tr>
</tbody>
</table>

### All Patient Encounters

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP Total Patient Encounters (in Practice Predominantly Reporting Period)</td>
<td></td>
</tr>
</tbody>
</table>

### Practice Predominantly Encounters

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>EP FQHC/RHC Facility Patient Encounters (in Practice Predominantly Reporting Period)</td>
<td></td>
</tr>
</tbody>
</table>

---

**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].

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.
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.

Click the Begin button to complete each step.
Click Continue button to finish a step.
Click Modify button to change information previously entered.
You are now ready to being attesting to the Meaningful Use portion of the attestation.

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

You must select your PI Reporting Period start & end date from calendar year 2018 for the Meaningful Use Objectives & Clinical Quality Measures that you are attesting to.

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

Complete the number of unique patients in your PI reporting period.
Providers have the option of attesting to Stage 2 or Stage 3 depending on their system’s certification (in effect no later than December 31, 2018).

Rules for Stage 3 participation:

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

- Attest to Stage 2 Modified
- Attest to Stage 3

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

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 Objectives for Stage 2 Modified

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

#### Welcome to Stage 2 Modified

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

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

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

---

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

**TIP**

**Objective 9, Secure Messaging:** More than 5 percent of unique patients seen by the eligible professional (EP) during the PI reporting period, a secure message was sent using the electronic messaging function of certified electronic health record technology (CEHRT) to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the PI reporting period.
Stage 2 Modified Objective 1 Measure 1 Protected Health Information

Protected Health Information

☑ Measure 1

Complete all required fields. You must upload your Security Risk Analysis Report documentation separately.

You must have completed the Security Risk Analysis in 2017. CEHRT is “certified electronic health record technology” The Navigation bar at the bottom will monitor your progress.

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 2 Measure 1 Clinical Decision Support

Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2018
ePIP Measure 2 of 16 – CMS Meaningful Use Objective 2, Measure 1
Clinical Decision Support - Measure 1 of 2

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

Measure Requirements:
Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire PI reporting period. Absten four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.

Additional Information:
- If there are limited CDSs applicable to an EP’s scope of practice, the EP should implement CDSs interventions that he or she believes will improve the delivery of care for the high-priority health conditions relevant to their specialty and patient population.
- Drug-drug and drug-allergy interaction alerts are separate from the 5 clinical decision support interventions and do not count toward the 5 required for this first measure.

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

Regulatory References:
- This objective may be found in Section 42 of the code of the federal register at 495.22 (e)(15) and (11)(A). For further discussion please see 80 FR 47795
- In order to meet this objective and measure, an EP must meet the capabilities and standards of CEHRT at 41 CFR 170.314(a)(5) and (a)(2).

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

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

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

Measure Entry:
Complete the following information:
* Have you implemented five clinical decision support interventions related to four or more clinical quality measures?
  * Yes  ☐ No

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

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 2 Measure 2 Clinical Decision Support

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

Measure Requirements:

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

Additional Information:

- If there are limited CQMs applicable to an EP’s scope of practice, the EP should implement CDS interventions that he or she believes will drive improvements in the delivery of care for the high-priority conditions relevant to their specialty and patient population.
- Drug-drug and drug-allergy interaction alerts are separate from the 3-clinical decision support interventions and do not count toward the 5 required for this first measure.

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

Regulatory References:
- This objective may be found in Section 2 of the code of the federal register at 45CF 22 (a)(15) and (i)(i). For further discussion please see 45CFR 17.033(A).
- In order to meet this objective and measure, an EP must meet the capabilities and standards of 10CFR 2.175(A)(ii) and (ii)(ii).

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

For detailed information about the Clinical Decision Support objective, please click here

Supporting Documentation Requirements:

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

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

Measure Entry:

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

* Does this exclusion apply to you?
  ○ Yes ○ No

Complete the following information:

* Have you enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period?
  ○ Yes ○ No

Meaningful Use Objectives - Navigation

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

Meaningful Use Objectives Summary

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 3 Measure 1 Computerized Provider Order Entry

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

Computerized Provider Order Entry - Measure 1 of 3

**Purpose:**

To reduce the risk of medication errors and improve patient safety by promoting the use of computerized provider order entry (CPOE) systems to electronically enter medication orders into the electronic health record.

**Measure Requirements:**

- Complete all required fields. If you select the exclusions, you must upload documentation to support that separately.

**Additional Information:**

- The exclusion is permitted, but not required, to arrive at the measure's objective for those patients whose records are maintained using certified EHR technology (CEHRT).
- The CPOE function must be used to create the first record of the order that becomes part of the patient's medical record and before any action can be taken on the order to order the medication.
- In some situations, it may be impossible or inadvisable to follow all the provisions of this exclusion; a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional who is not the ordering provider.
- 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 by clicking the hyperlink on the ePIP screen to learn more about this requirement.
Computerized Provider Order Entry

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Measure 2

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.

TIP:

Make sure that you upload all documents that support the above entries in your attestation.

You can do so on the Attestation Progress page.

Click the hyperlink on the ePIP screen to learn more about this requirement.
**Stage 2 Modified Objective 3 Measure 3 Computerized Provider Order Entry**

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

**ePIP Measure 5 of 14 - CMS Meaningful Use Objective 3, Measure 3**

**Computerized Provider Order Entry - Measure 3 of 3**

**Objective Details:**

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

**Measure Requirements:**

More than 50 percent of radiology orders created by the EP during the PI reporting period are recorded using computerized provider order entry.

**Additional Information:**

- The KP is permitted, but required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- The CPOE function must be used to create the first record of the order that becomes part of the patient’s medical record and before any action can be taken on the order in the numerator.
- In some situations, it may be impossible or impractical to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is pre-authorized and immediately initiated by the provider, or initiated immediately after a verbal order by the ordering provider to a licensed healthcare professional under the direct supervision. Therefore in these situations, so long as the order is entered using CPOE by a licensed healthcare professional or certified medical assistant to create the first record of that order as it becomes part of the patient’s medical record, those orders would count in the numerator of the CPOE measure.
- Any licensed healthcare professionals and clinical staff credentialed to and with the duties equivalent of a medical assistant, can enter orders into the medical record for purposes of including the order in the numerator for the objective of CPOE if they can originate the order per state, local and professional guidelines. It is up to the provider to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fit within the guidelines prescribed. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.
- An EP must satisfy all three measures for this objective through a combination of meeting the follow-up and exclusion criteria (or both).
- Orders involving telehealth or remote communication (such as phone orders) may be included in the numerator as long as the order entry otherwise meets the requirements of the objective and measure.
- Providers may exclude orders that are preauthorized for a given set of patient characteristics or for a given procedure (also known as “protocol” or “standing orders”) from the calculation of CPOE numerators and denominators. Note this does not require providers to exclude this category of orders from their numerator and denominator (77 FR 59446).

**Definition of Terms:**

- Computerized Provider Order Entry (CPOE): A provider’s use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.
- Laboratory Order: An order for any service provided by a laboratory that would not be provided by a non-laboratory laboratory. A facility for the biological, microbiological, serological, chemical, immunological, hematological, pathological, bacteriological, pathologizing, or other examination of materials from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of the health of humans, or the cause or manifestation of any biologically determined characteristic of an individual. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Examples: only collecting or preparing specimens (for both or only serving as a mailing service and not performing testing) are not considered laboratories.
- Radiology Order: An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long as the policy is consistent across all patients and for the entire PI reporting period.

**Supporting Documentation Requirements:**

Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. If you select the exclusion you must provide documentation to support that a patient is excluded which will be submitted to the AHCCCS Latent Audit. All the links for uploading this document will appear on the “Attestation Progress” page as a required step in the attestation process.

(*) Min asterisk indicates a required field
(“) Gray asterisk indicates a conditionally required field

**Exclusions:**

Exclusions based on ALL patient records: Any EP who writes fewer than 100 radiology orders during the PI reporting period would be excluded from this requirement. Exclusion from this requirement will not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?
  ✔ Yes  ☐ No

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

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

**Complete the following information:**

- **Numerator:** The number of radiology orders in the denominator during the PI reporting period that are recorded using CPOE.
  - **Numerator:** 179
- **Denominator:** The number of radiology orders created by the EP during the PI reporting period.
  - **Denominator:** 365

**Meaningful Use Objectives Summary**

**TIP:**

Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page. Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 4 Measure 1 Electronic Prescribing

Meaningful Use Objectives - Stage 2 (Modified) for Program Year 2019
ePIP Measure 7 of 18 - CMY Meaningful Use Objective 4, Measure 1
Electronic Prescribing (eRx)

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

Measure Requirements:
More than 90 percent of permissible prescriptions written by the EP are queued for a drug formulary and transmitted electronically using CEMI/HT.

Additional Information:
- The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHR).
- Authorizations for items such as durable medical equipment, or other items and services that may require EP authorization before the patient could receive them, are not included in the definition of prescriptions. These are excluded from the numerator and the denominator of the measure.
- Medications where patients specifically request a paper prescription may not be excluded from the denominator of this measure. The denominator includes all prescriptions written by the EP during the PI reporting period.
- Each electronic prescribing of controlled substances is now possible; providers may choose to include these prescriptions in their permissible prescriptions where feasible and allowed by law.
- For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur concurrently if the prescription is electronically transmitted to an external pharmacy.
- An EP needs to use CEHR as the sole means of creating the prescription, and when transmitting to an external pharmacy that is independent of the EP's organization such transmission must use standards adopted for EHR technology certification.
- EDI should include in the numerator and denominator both types of electronic transmissions (those within and outside the organization) for the measure of this objective.
- For purposes of counting prescriptions "generated and transmitted electronically," we consider the generation and transmission of prescriptions to occur concurrently if the prescription is electronically transmitted to an external pharmacy.
- Providers can use intermediary networks that connect information from the certified EHR into a computerized based fax in order to meet this measure as long as the EP generates an electronic prescription in electronic form using the standards of CEHR, to the intermediary network, and this results in the prescription being transmitted without the need for the provider to communicate the prescription in an alternative manner.
- Prescriptions transmitted electronically within an organization (even if same legal entity) do not need to use the NCPDP standards. However, an EP's EHR must meet all applicable certification criteria and be certified as having the capability of meeting the external transmission requirements of STS-3040c. In addition, the EHR that is used to transmit prescriptions within the organization would need to be CEHR. For more information, refer to ONC/NSA’s FAQ of the rule 2800ATQuestion 12 10-19-19. Providers may limit their effort to a formula of a pharmacy to simple the function available to them in CEHR without further action required. If a pharmacy using the function of their CEHR is not possible or chooses no report, a provider is not required to conduct any further manual or paper-based action in order to complete the task, and the provider may close the prescription to the provider.
- Providers should include EDI for the intermediary or the internal part of their practice locations that are accepted with CEHR that meet the requirements for this measure.
- EDI forms are not part of an organization’s records and are not an extension of the organization’s records, the exclusion requirements on the measure do not apply to EDIs.
- CEHR forms are part of an organization’s records and are an extension of the organization’s records, the exclusion requirements on the measure do apply to CEHR forms.

Prewrite: The authorization for an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.

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

Regulatory References:
- This objective may be found in Section 42 of the code of the federal register at 45 CFR 170.3460(b) and (c)(3). For further discussion please see 40 FR 6290.
- In order to meet this objective and measure, an EP must possess the capabilities and standards of CEHR at 45 CFR 170.3440(b)(2) and (c)(3).

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

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

(1) Red asterisk indicates a required field
(2) Gray asterisk indicates a conditionally required field

Measures:

Exclusion 1: Based on all patient records: Any EP who writes fewer than 100 permissible prescriptions during the PI reporting period will 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 (CEHR).

This data was extracted only from paper records maintained using certified EHR technology.

Complete the following information:
Num

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

(2) Denominator: Number of permissible prescriptions written during the PI reporting period for drugs requiring a prescription in order to be dispensed.

Numerator: 175
Denominator: 325

Meaningful Use Objectives - Navigation
Meaningful Use Objectives Summary

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 5 Measure 1 Health Information Exchange

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

Health Information Exchange

Measure Requirements:

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

Additional Information:

- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- This exchange may occur before, during, or after the PI reporting period. However, it must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs in order to count in the numerator.
- Apart from the above fields noted as required (i.e., current problem list, current medication list, and current medication allergy list), circumstances where there is no information available to populate one or more of the fields noted (because the EP does not record such information or because there is no information to record), the EP may leave the fields (x) blank and still meet the objective and its associated measure.
- A provider must have the ability to transmit all data pertaining to laboratory test results in the summary of care document, but may work with their system developer to establish clinically relevant parameters for the most appropriate results to be transmitted to the receiving provider. This policy is limited to laboratory test results.
- A provider who sends the transmission of laboratory test result data in a summary of care document must send the full results upon request (i.e., all lab results as opposed to a subset).
- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- The exchange must comply with the privacy and security protocols for ePHI under HIPAA.
- In addition, the summary of care document is only transmitted electronically if the sender chooses to include such transitions to providers where access to the EHR is shared, they may choose not to be included in the numerator.

Definition of Terms:

- Transition of Care: The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.
- Summary of Care Document: All summary of care documents used to meet this objective must include the following information if the provider knows it:
  - Referring or transitioning provider's name and office contact information (EIP only)
  - Procedures
  - Encounter diagnosis
  - Immunizations
  - Lab test results: VITAL (blood type, weight, blood pressure, BMI)
  - Vital signs: Temperature, respiratory rate, pulse, blood pressure, weight
  - Allergies: Including activities of daily living, cognition and disability status
  - Demographic information (preferred language, race, sex, virtual, dates of birth)
  - Care plan field, including goals and instructions
  - Care plans including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
  - Reason for referral (EIP only)
  - Current problem list (Provider may also include historical problems at their discretion)
  - Current medication list
  - Current allergy list

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

Current problem list: All a comprehensive list of current and active diagnoses.

Current medication list: A list of medications that a given patient is currently taking.

Current medication allergy list: A list of medications to which a given patient has known allergies.

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

Relevant References:

1. This objective may be found in Section 42 of the code of the federal register at 45CFR226, (a)(5) and (c)(1). For further discussion please see 80 FR 2986.

For detailed information about the Health Information Exchange objective, please click here.

Note: Please review before attempting to use this measure. For more information regarding the Health Information Exchange objective, please click here.

Supporting Documentation Requirements:

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

(1) Red asterisk indicates a required field
(2) Gray asterisk indicates a conditionally required field

Measure Entry:

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

- Does this exclusion apply to you?
  - Yes
  - No

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

- This data was extracted from both paper records as well as records maintained using Certified EHR Technology (CEHR).
- 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 CEHR and exchanged electronically.

Denominator: Number of transitions of care and referrals during the PI reporting period for which the EP was the transferring or referring provider.

- Numerator:
- Denominator:

TIP: Make sure that you upload all documents that support the above entries in your attestation.

The Navigation bar at the bottom will monitor your progress.

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 6 Measure 1 Patient Specific Education

Stage 2 Modified Objective 6 - CMS Meaningful Use Objective 6 - Measure 1: Patient Specific Education

Objective Details:
Patient Specific Education: Use clinically relevant information from CEDR to identify patient-specific educational resources and provide those resources to the patient.

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

Additional Information:
- Unique patients with office visits means that to count in the denominator a patient must be seen by the EP for one or more office visits during the PI reporting period, but if a patient is seen by the EP more than once during the PI reporting period, the patient only counts once in the denominator.
- The EP must use elements within certified EHR technology (CEHR) to identify educational resources specific to patients’ needs. Certified EHR technology is certified to use the patient’s problem list, medication list, or laboratory test results to identify the patient-specific educational resources. The EP may use these elements or may use additional methods to determine the patient-specific educational resources available to patients in a useful format to the patient (such as, electronic copy, printed copy, electronic text-to-voice materials, through a patient portal or PIHR).
- The education resources or materials do not have to be stored within or generated by the CEHR.
- There is no “translational effect” policy in place for this objective and measure. It may vary based on the resources and materials provided and the timing of that provision. If a patient is not found to be attributable to a single provider, it may only count in the numerator for that provider. However, if the patient is attributable to a single provider, it may be counted in the numerator for all providers who have the patient in their denominator for the PI reporting period.
- This exchange may occur before, during, or after the PI reporting period. However, in order to count in the numerator, it must occur within the PI reporting period. If that period is a full calendar year, or if it is less than a full calendar year, within the calendar year on which the PI reporting period occurs.

Patient Specific Educational Resources Identified by CEHR:
Resources or a topic area of resources identified through logic built into certified EHR technology which evaluates information across the patient’s and suggests educational resources that would be of value to the patient.

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

Regulatory References:
- This objective may be found in section 401 of the code of the federal register at 454.25 (XI)(8) and (III)(A). For further discussion please see 80 FR 62027.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHR at 45 CFR 170.316 (g)(1)(ii).

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

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

Supporting Documentation Requirements:
Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHR Report. The links for uploading these documents will appear on the “Attestation Progress” page as a required steps in the attestation process.

(*) Red asterisk indicates a required field
(*) Gray asterisk indicates a conditionally required field
Measure Entity:

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

Do these 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 (CEHR).
☐ This data was extracted only from patient records maintained using certified EHR technology.

Numerator: Number of patients in the denominator who were provided patient-specific educational resources identified by the CEHR.

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

Numerator:

Denominator:

Meaningful Use Objectives - Navigation

Meaningful Use Objectives Summary:

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 7 Measure 1 Medication Reconciliation

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

Objective Details:

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

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

Additional Information:
- Only patients whose records are maintained using certified EHR technology must be included in the denominator for transitions of care.
- If the experience of reconciliation does not occur following transition of care, the receiving EP should conduct the medication reconciliation.
- The use of medication reconciliation is not a requirement for medication reconciliation.
- If you select the exclusions, you must upload documentation to support that separately.
- The Navigation bar at the bottom will monitor your progress.

Definition of Terms:
Medication Reconciliation: The process of identifying the most accurate list of medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

Stage 2 Measures:

Measure 1: Complete all required fields.

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

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. For detailed information about the Medication Reconciliation objective, please click here.

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

TIP: Make sure that you upload all documents that support the above entries in your attestation. You can also do so on the Attestation Progress page under Meaningful Use PI Report. Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 8 Measure 1 Patient Electronic Access

Meaningful Use Objective: Stage 2 (Modified) for Program Year 2018

ePIP Measure 11 of 16 - CMS Meaningful Use Objective 8, Measure 1: Patient Electronic Access - Measure 1 of 2

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

Additional Information:
- In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:
  - Patient name
  - Admission and other contact information
  - Current and past problem list
  - Procedures
  - Laboratory test results
  - Current medication list and medication history
  - Current medication allergy list and medication allergy history
  - Vital signs (height, weight, blood pressure, BMI, growth chart)
  - Smoking status
  - Demographic information (preferred language, sex, race, ethnicity, date of birth)
  - Care plan fields, including goals and instructions
  - Any known care team members including the primary care provider (PCP) of record
- An EP may include additional information and still align with the objective.
- In circumstances where there is no information available to populate one or more of the fields previously listed, either because the EP can be excluded from recording such information or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have an indication that the information is not available and still meet the objective and its associated measure.
- The provider must be able to access this information on demand, such as through a patient portal or personal health record (PHR) or by other online electronic means. We note that while a covered entity may be able to fairly satisfy a patient's request for information through VIST, the measure does not replace the covered entity's responsibilities to meet the broader requirements under HIPAA to provide an individual, upon request, with access to PHI in a reasonably accessible record set.
- Providers should also be aware that while meaningful use is limited to the capabilities of CHERT to provide online access, there may be patients who cannot access their EPs electronically because of a disability. Providers who are covered by civil rights laws must provide individuals with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- For Measure 1, patient health information requests to be made available to each patient for view, download, and transmit within 4 business days of the information being available to the provider for each and every time that information is generated whether the patient has been "enrolled" for three months or for three years.
- A patient who has multiple encounters during the PI reporting period, or in subsequent PI reporting periods in future years, needs to be provided access for each encounter where they are seen by the EP.
- If a patient elects to "opt out" of participation, that patient should still be included in the denominator.
- If a patient elects to "opt out" of participation, the provider may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access their information, obtain access through a patient authorized representative, or otherwise ask back in without further follow up action required by the provider.
- For Measure 2, the patient action may occur before, during, or after the PI reporting period; however, in order to count in the numerator, it must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs.

TIP:
Make sure that you upload all documents that support the above entries in your attestation.
You can do so on the Attestation Progress page.
Click the hyperlink on the ePIP screen to learn more about this requirement.
**Stage 2 Modified Objective 8 Measure 2 Patient Electronic Access**

**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.

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**Objective Details:**

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

**Measure Requirements:**

For an PI reporting period in 2019, more than 5 percent of unique patients seen by the EP during the PI reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the PI reporting period.

**Additional Information:**

- In order to meet this objective, the following information must be made available to patients electronically within 4 business days of the information being made available to the EP:
  - **Patient name**
  - **Provider’s name and office contact information**
  - **Current and past problem list**
  - **Procedures**
  - **Laboratory test results**
  - **Current medication list and medication history**
  - **Current medication allergy list and medication allergy history**
  - **Vital signs (height, weight, blood pressure, BMI, growth charts)**
  - **Smoking status**
  - **Demographic information (preferred language, sex, race, ethnicity, date of birth)**
  - **Care plan titles, including goals and instructions**
  - **Any known care team members, including the primary care provider (PCP) of record**

- An EP may make available additional information and still align with the objective.

- In circumstances where there is no information available to populate one or more of the fields previously listed, either because the EP can be excluded from recording such information or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have an indication that the information is not available and still meet the objective and its associated measure.

- The patient must be able to access this information and the personal health record, such as through a patient portal or personal health record (PHR) or by other electronic means. We note that unless a covered entity has a policy or procedure to notify patients that information is not available, the navigation at the bottom will monitor progress towards the measure.

- Providers should also be aware that while meaningful use is limited to the capabilities of CHERIT to provide online access there may be patients who cannot access their EP’s portal electronically because of a disability. Providers who are covered under this measure may provide patient access to HIS access to information and appropriate auxiliary aids and services provided in the appropriate settings and arrangements.

- For Measure 1, patient health information needs to be made available to each patient for view, download, and transmit within 4 business days of the information becoming available to the provider for each and every time that information is generated whether the patient has been “enrolled” for these months or for three years.

- A patient who has multiple encounters during the PI reporting period, or even in subsequent PI reporting periods in future years, needs to be provided access for each encounter where they are seen by the EP.

- If a patient elects to “opt-out” of participation, that patient must still be included in the denominator.

- If a patient elects to “opt-out” of participation, the provider may count that patient in the numerator if the patient is provided all of the necessary information to subsequently access the information through a patient portal or to provide access to a patient authorizing representative, or otherwise to assure that he or she is not further followed up in active care as required by the provider.

- For Measure 2, the patient action may occur before, during, or after the PI reporting period. However, if the patient count in the numerator, it must occur within the PI reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the PI reporting period occurs.

**Definitions of Terms:**

- **Provider Access:** A patient’s access to the information related to their care through a patient portal or personal health record (PHR) or by other electronic means.

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

- **Transmittal:** Patient may use any means of electronic transmission according to any transport standard(s) (SMTP, FTP, REST, SCAP, etc.). However, the facilitation of physical electronic media (for example, USB, CD) does not qualify as transmission.

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

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

- **Requiritory References:**
  - This objective may be found in Section 3 of the code of the federal register at 45CFR 170.314(a)(1).
  - For further discussion please see 80 FR 63015.

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**Meaningful Use Objective Measures require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use audit report. The links for uploading these documents will appear on the “Attestation Progress” page as a required step in the attestation process.**

(*) Red asterisk indicates a required field

(?) Grey asterisk indicates a conditionally required field

**Measure Entry:**

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

  - **Does this exclusion apply to you?**
    - Yes ☐ No ☑

- **Exclusion:** Any EP who conducts 90 percent or more of his or her patient encounters in a county that does not have 90 percent or more of its housing units with broadband availability according to the latest information available from the FCC on the first day of the PI reporting period.

  - **Does this exclusion apply to you?**
    - Yes ☐ No ☑
Stage 2 Modified Objective 9 Measure 1 Secure Electronic Messaging

Secure Electronic Messaging

Measure 1

Complete all required fields.

The Navigation bar at the bottom will monitor your progress.

TIP:
Make sure that you upload all documents that support the above entries in your attestation.
You can do so on the Attestation Progress page.
Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 10 Measure 1 Public Health Reporting

**Objective Details:**

Public Health Reporting - Measure 1 of 3: The EP is in active engagement with a public health agency to submit electronic public health data from CEPHRT and/or other systems to CEHRT with public health reporting.

**Measure Requirements:**

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

**Additional Information:**

- EPs must attest to at least two measures from the Public Health Reporting Objective measures 1 through 3.
- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP must meet at least two of the following measures. The remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting the remaining measures available to them and claiming the appropriate exclusions. If no measures remain available, the EP can meet the objective by claiming applicable exclusions in these measures.
- For Measure 1, an exclusion does not apply if an entity designated by the immunization registry or immunization information system can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by CEHRT, but it has designated a health information exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 3, a provider may report to more than one regulated registry and may count specialized registry reporting more than twice to meet the required number of measures for the objective.
- Providers who have previously registered, tested, or began ongoing submission of data to registries do not need to "retest" the process beginning at active engagement option 1. The provider may simply attest to the active engagement option which most closely reflects their current status.
- In determining whether an EP meets the first exclusion, the registries in question are those sponsored by the public health agencies with jurisdiction over the area where the EP practices and national medical societies covering the EP's scope of practice. Therefore, an EP must complete two actions in order to determine available registries or claim an exclusion:
  - Determine if the jurisdiction (state, territory, etc.) endorses or sponsors a registry; and,
  - Determine if a National Specialty Society or other specialty society with which the provider is affiliated endorses or sponsors a registry.
- We continue to allow registries such as Prescription Drug Monitoring Program reporting and electronic case reporting registries to be considered specialized registries for purposes of reporting if the CEHRT reporting period is in 2017 and 2018.
- EPs who were previously planning to attend to the cancer case reporting objective, may count that action toward the specialized Registry reporting measure. EPs who did not intend to attend to the cancer case reporting measure objective are not required to engage in or exclude from cancer case reporting in order to meet the specialized registry reporting measure.
- Providers may use electronic submission methods beyond the functions of CEHRT to meet the requirements for the Specialized Registry Reporting measure.
- A specialized registry cannot be duplicative of any of the other registries or reporting excluded in other meaningful use requirements.

**Definition of Terms:**

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

**Active Engagement Option 1 - Complete Exclusions to Submit Data:** The EP is required to submit with the PHA or, where applicable, the CDR, for which the information is being submitted, registration was completed within 60 days after the start of the PHI reporting period; and the EP is sending an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has invited measures to initiate the testing and validation process. Providers who have registered in previous years do not need to submit an additional registration in order to start this requirement for the PHI reporting period.

**Active Engagement Option 2 - Complete Exclusions to Submit Data:** The EP has completed testing and validation of the electronic submission and electronically submitting production data to the PHA or CDR.

**Production Data:** refers to data generated through clinical processes involving patient care, and it is used for diagnostic purposes and to support administrative and electronic data transfers.

**Reimbursement References:**

- This objective may be found in Section 42 of the code of the federal register at 49.22 (42 U.C.) and (46). For further discussion please see 88 FR 62924.
- In order to meet this objective the EP must exhibit the capability and standards of CEHRT at 49.22 (42 U.C.) and (46).
- The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please review before attesting to this measure)

**For detailed information about the Public Health Reporting objective, please click here**

**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.

**Notes:**

1. Red asterisk indicates a required field
2. Gray asterisk indicates a conditionally required field

**Measure Entry:**

**Exclusion 1:** Does not administer any immunizations to any of the populations for which data is collected by its Jurisdictions immunization registry or immunization information systems during the PHI reporting period.

- **Does this exclusion apply to you?**
  - Yes [ ]
  - No [ ]

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

- **Does this exclusion apply to you?**
  - Yes [ ]
  - No [ ]

**Exclusion 3:** Operates in a jurisdiction where no Immunization registry or immunization information system has declared readiness to receive immunization data from the ER at the start of the PHI 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 [ ]

---

**TIP:**
Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress page. Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 2 Modified Objective 10 Measure 2 Public Health Reporting

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

Objective Details:

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

Measure Requirements:

- EPs must attest to at least two measures from the Public Health Reporting Objective measures 1 through 3.
- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP would need to meet two of the total number of measures available to them. If the EP specifies for multiple exclusions and the remaining number of measures available to the EP is less than two, the EP can meet the objective by meeting the remaining measure available to them and claiming the applicable exclusions. If no measures remain available, the EP can meet the objective by claiming applicable exclusions for all three measures.
- For Measure 1, an exclusion does not apply if an entity designated by the immunization registry or immunization information system can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or if the standards required by CEMHRT, but if it has designated a Health Information Exchange to do so on their behalf and the Health Information Exchange is capable of accepting the information in the standards required by CEMHRT, the provider could not claim the second exclusion.
- For Measure 3, if a provider submits more than one specialized registrant and may count specialized registry reporting more than twice to meet the required number of measures for the objective.
- Providers who have previously registered, tested, or begun ongoing submission of data to a registry do not need to "restart" the process beginning at active engagement option 1. The provider may simply attest to the active engagement option which most closely reflects their current status.
- In determining whether an EP meets the first exclusion, the register in question is those sponsored by the public health agencies with jurisdiction over the area where the EP practices and national medical societies covering the EP's scope of practice. Therefore, an EP must complete two actions in order to determine available registries or claim an exclusion:
  - Determine if the jurisdiction (state, territory, etc.) endorses or sponsors a registry. If yes:
    - Determine if a National Specialty Society or other specialty society with which the provider is affiliated endorses or sponsors a registry.
  - If the provider is required to register with a public health agency, they must verify that the EP is in active engagement to submit syndromic surveillance data to a public health agency.
- The Navigation bar at the bottom will monitor your progress.

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.
Stage 2 Modified Objective 10 Measure 3 Public Health Reporting

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

Public Health Reporting - Measure 3 of 3

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

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

Additional Information:
- EPs must attest to at least two measures from the Public Health Reporting Objective measures 1 through 3.
- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP would need to meet two of the total number of measures applicable to them.
- If an exclusion applies, the EP must select the exclusion.
- If no measures are applicable to the EP, the EP can attest to completing the measure.
- For Measure 1, a exclusion does not apply if an entity designated by the immunization registry or immunization information system can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by CEHRT, but it has a designated health information Exchange to do so on their behalf and the health information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 2, an exclusion does not apply if an entity designated by public health agency can receive electronic syndromic surveillance data submissions. For example, if the public health agency cannot accept the data directly or in the standards required by CEHRT, but it has designated a health information Exchange to do so on their behalf and the health information Exchange is capable of accepting the information in the standards required by CEHRT, the provider could not claim the second exclusion.
- For Measure 3, a provider may report more than one specialized registry and may count specialized registry reporting more than twice to meet the required number of measures for the objective.
- Providers who have previously registered, tested, or began submitting data to a registry do not need to "restart" the process beginning at active engagement option 1. The provider may simply attest to the active engagement option which most closely reflects their current status.
- In reporting another CEHRT data set the first exclusion, the registries in question are those sponsored by the public health agencies with jurisdiction over the area where the EP practices and national medical societies covering the EP’s scope of practice. Therefore, an EP must complete two actions in order to determine available registries or claim an exclusion.

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

Active Engagement Objective 1: Completed Registration to Submit Data: The EP registered to submit data to the PHA or, where applicable, the ODS to attest the information is being submitted, registration was completed within 60 days after the start of the PI reporting period, and the EP is attesting to the completeness of the registration. This attestation allows providers to meet the measure when the PHA or the ODS have tested resources to indicate the testing and validation process providers that have registered in previous years do not need to submit an additional registration to meet this requirement for the PI reporting period.

Active Engagement Objective 2: The EP submits data to a Specialized Registry. The EP has completed testing and validation of the electronic submission and electronically submitting production data to the PHA or ODS.

Public data refers to data generated through research processes involving patient care, and is used to steer information between data and "test data" which may be submitted for the purposes of researching and testing electronic data transfers.

Regulatory Requirements:
- This objective may be found in Section 42 of the code of the federal register at 45CFR 170.125 and 170.126.
- For further discussion please see 80 FR 62824.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to help you through the measure requirements for this particular objective. For detailed information about the Public Health Reporting objectives, 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 "Assessment Progress" page as a required step in the attestation process.
- Please provide supporting documentation outlining your active engagement with any Specialized Registries. If you are choosing one of the available exclusions please provide documentation to support your exclusion choice. (1) Red asterisk indicates a required field (1) Gray asterisk indicates a conditionally required field

Measure Entry:
- Exclusion 1: Does not diagnose or treat any disease or condition associated with or collect-relevant data that is required by a specialized registry in their jurisdiction during the PI reporting period.
  - Does this exclusion apply to you?
    - Yes ☐ No ☐
  Exclusion 2: Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period.
  - Does this exclusion apply to you?
    - Yes ☐ No ☐
  Exclusion 3: Operates in a jurisdiction where no specialized registry for which the EP is eligible has declined more than one electronic registry transactions at the beginning of the PI reporting period.
  - Does this exclusion apply to you?
    - Yes ☐ No ☐

Meaningful Use Objectives - Navigation

Meaningful Use Objectives Summary

Click the Hyperlink on the ePP screen to learn more about this requirement.

Stage 2M Screen 16

Public Health Reporting

☐ Measure 3

Complete all required questions separately.

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

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

The Navigation bar at the bottom will monitor your progress.
Attestation Progress (After Objective Measures)

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

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

TIP
Click the Begin button to complete each step.
Click Continue button to finish a step.
Click Modify button to change information previously entered.
### Clinical Quality Measures

#### Meaningful Use Clinical Quality Measures

<table>
<thead>
<tr>
<th>National Quality Strategy (NQS) Domains</th>
<th>Number CQMs Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person and Caregiver-Centered Experience and Outcomes</td>
<td>4</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>5</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>2</td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>11</td>
</tr>
<tr>
<td>Efficiency and Cost Reduction</td>
<td>4</td>
</tr>
<tr>
<td>Effective Clinical Care</td>
<td>29</td>
</tr>
</tbody>
</table>

**Clinical Quality Measures (CQMs) Selection:**

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

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

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

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

- **☐** Report the CQMs for which there is patient data
- **☑** Report the remaining required CQMs as “zero denominators” as displayed by your certified EHR technology.

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
## Clinical Quality Measures for Person and Caregiver-Centered Experience & Outcomes

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 15/v6 \ NOF 0384 - Oncology: Medical and Radiation – Pain Intensity Quantified</td>
<td>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</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 66/v6 - Functional Status Assessment for Total Knee Replacement</td>
<td>Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 56/v6 - Functional Status Assessment for Total Hip Replacement</td>
<td>Percentage of patients 18 years of age and older who received an elective primary total hip arthroplasty (THA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 90/v7 - Functional Status Assessments for Congestive Heart Failure</td>
<td>Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Person and Caregiver-Centered Experience & Outcomes**

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

4 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

---

**TIP**

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

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

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

5 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
</table>
| CMS 135v6 \ QOF 0022 - Use of High-Risk Medications in the Elderly        | Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported.  
- Percentage of patients who were ordered at least one high-risk medication.  
- Percentage of patients who were ordered at least two of the same high-risk medications.                                                                                                                                  |          |
| CMS 139v6 \ QOF 0101 - Falls: Screening for Future Fall Risk             | Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.                                                                                                                                                                                                                   |          |
| CMS 68v7 \ QOF 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-counter medications, herbs, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration. |          |
| CMS 132v6 \ QOF 0564 - Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures | Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence. |          |
| CMS 177v6 \ QOF 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                                                                                                                        |          |

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Clinical Quality Measures for Communication and Care Coordination

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 50v6 - Closing the Referral Loop: Receipt of Specialist Report</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>CMS 142v6 \ NQF 0089 - Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

**TIP**

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
## Clinical Quality Measures for Community / Population Health

<table>
<thead>
<tr>
<th>Community/Population Health</th>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CMS 159w6 \ NQF 0024 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</strong></td>
<td>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.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td></td>
<td>- Percentage of patients with height, weight, and body mass index (BMI) percentile documentation</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td></td>
<td>- Percentage of patients with counseling for nutrition</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td></td>
<td>- Percentage of patients with counseling for physical activity</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td><strong>CMS 138w6 \ NQF 0028 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</strong></td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. Three Rates are Reported:</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td></td>
<td>- Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td></td>
<td>- Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td></td>
<td>- Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td><strong>CMS 153w6 \ NQF 0033 - Chlamydia Screening for Women</strong></td>
<td>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</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td><strong>CMS 117w6 \ NQF 0038 - Childhood Immunization Status</strong></td>
<td>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</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td><strong>CMS 147w7 \ NQF 0041 - Preventive Care and Screening: Influenza Immunization</strong></td>
<td>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.</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

**TIP**

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

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

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

11 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.
### Clinical Quality Measures for Community / Population Health continued

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 2v7 \ NQF 0418 - Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>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.</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 6v6 \ NQF 0421 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Normal Parameters: Age 18 years and older BMI =&gt; 18.5 and &lt; 25 kg/m²</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 82v5 \ NQF1401 - Maternal depression screening</td>
<td>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.</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 22v6 - Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented</td>
<td>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.</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 7v6 - Children Who Have Dental Decay or Cavities</td>
<td>Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period.</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 127v6 \ NQF 0043 - Pneumonia Vaccination Status for Older Adults</td>
<td>Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.</td>
<td>☐</td>
</tr>
</tbody>
</table>

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**TIP**

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Clinical Quality Measures for Efficiency and Cost Reduction

### Efficiency and Cost Reduction

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 146v6 \ NQF 00052 - Appropriate Testing for Children with Pharyngitis</td>
<td>Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.</td>
<td></td>
</tr>
<tr>
<td>CMS 166v7 \ NQF 0052 - Use of Imaging Studies for Low Back Pain</td>
<td>Percentage of patients 18-90 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.</td>
<td></td>
</tr>
<tr>
<td>CMS 154v6 \ NQF 0069 - Appropriate Treatment for Children with Upper Respiratory Infection (URI)</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>CMS 129v7 \ NQF 0389 - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

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

4 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

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**TIP**

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
### Clinical Quality Measures for Effective Clinical Care

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
</table>
| CMS 137v6 \ NQF 0004 - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported:  
  - Percentage of patients who initiated treatment within 14 days of the diagnosis.  
  - Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit. |          |
| CMS 165v6 \ NQF 0018 - Controlling High Blood Pressure                   | Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period.                                      |          |
| CMS 125v6 - Breast Cancer Screening                                      | Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.                                                                                                               |          |
| CMS 124v6 \ NQF 0032 - Cervical Cancer Screening                         | Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:  
  - Women age 21-64 who had cervical cytology performed every 3 years.  
  - Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. |          |
| CMS 130v6 \ NQF 0034 - Colorectal Cancer Screening                      | Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.                                                                                                             |          |
| CMS 131v6 \ NQF 0055 - Diabetes: Eye Exam                               | Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period. |          |

**TIP**

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

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

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

29 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.
Clinical Quality Measures for Effective Clinical Care continued

| CMS 123v6 \ NQF 0056 - Diabetes: Foot Exam | The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year |
| CMS 122v6 \ NQF 0059 - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) | Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period |
| CMS 134v6 \ NQF 0062 - Diabetes: Medical Attention for Nephropathy | The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period |
| CMS 164v6 \ NQF 0068 - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet | Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antiplatelet during the measurement period |
| CMS 145v6 \ NQF 0070 - Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) | Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy. |
| CMS 139v6 \ NQF 0081 - Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) | Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge. |

**Effective Clinical Care**

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

29 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

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**TIP**

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Clinical Quality Measures for Effective Clinical Care continued

CMS 136v7, NQF 0108 - Follow-Up Care for Children Prescribed ADHD Medication (ADD)
Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported.
- Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.
- Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

CMS 169v6 - Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.

CMS 169v6 - Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.

CMS 133v6, NQF 0565 - Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.

CMS 158v6 - Pregnant women that had HBsAg testing
This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.

CMS 159v6, NQF 0710 - Depression Remission at Twelve Months
Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
### Clinical Quality Measures for Effective Clinical Care continued

<table>
<thead>
<tr>
<th>CQMs</th>
<th>Description</th>
<th>Box</th>
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<tbody>
<tr>
<td>CMS 144v6</td>
<td>NQF 0083 - Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
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<tr>
<td>CMS 143v6</td>
<td>NQF 0086 - Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation</td>
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<tr>
<td>CMS 167v6</td>
<td>NQF 0088 - Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</td>
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<tr>
<td>CMS 161v6</td>
<td>NQF 0104 - Adult Major Depressive Disorder (MDD): Suicide Risk Assessment</td>
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<tr>
<td>CMS 128v6</td>
<td>NQF 0105 - Anti-depressant Medication Management</td>
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</table>

- **Select the CQMs that best apply to your scope of practice.**
- **29 of 55 CQMs are available under this domain.**
- **The Navigation bar at the bottom will monitor your progress.**

**TIP**

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Clinical Quality Measures for Effective Clinical Care continued

<table>
<thead>
<tr>
<th>CQM</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 1606/90F 0712</td>
<td>Depression Utilization of the PHQ-9 Tool</td>
<td>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.</td>
</tr>
<tr>
<td>CMS 74v7</td>
<td>Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists</td>
<td>Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.</td>
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<tr>
<td>CMS 149v6</td>
<td>Dementia: Cognitive Assessment</td>
<td>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.</td>
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<tr>
<td>CMS 65v7</td>
<td>Hypertension: Improvement in Blood Pressure</td>
<td>Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.</td>
</tr>
<tr>
<td>CMS 34v1</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</td>
<td>Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period:</td>
</tr>
<tr>
<td></td>
<td>• Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adults aged ≥ 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level &gt; 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.</td>
<td></td>
</tr>
</tbody>
</table>

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

TIP

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

29 of 55 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

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

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)

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

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**

<table>
<thead>
<tr>
<th>Payment Assignment Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Not served or required to assign.</td>
</tr>
<tr>
<td>[ ] Served or required to assign.</td>
</tr>
</tbody>
</table>

**Payment Information**

- **Payment Id:**
- **Program Year:** 2017
- **Payee ID:**
- **Payment TIN:**
- **Payment Type:**
- **Payment Name:**

**Payment Assignment Agreement**

- **Reasons for Assignment:**
  - [ ] Request for change of location
  - [ ] Request for change of employment

**Payment Assignment Agreement by Compliance**

**Important Information:**

- **EPR Reporting for EPs who receive Payments:**
  - Failure to report payments as required may result in compliance issues.

**Note:** Only the provider has authority to reassign the payment.

---

**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.**

**TIP**

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 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

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 denial of payment or may result in denial of a Medicaid EHR incentive Program payment, notice 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 behalf of the provider. 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 an EHR Incentive Program payment.

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 punished 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 designate to gather supporting data. I hereby agree to keep such records as are necessary, for five years, to demonstrate that I meet 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 laws and regulations.

☐ I agree to notify the State if I believe that I have been exposed under the Medicaid EHR Incentive Program, The Patient Protection and Affordable Care Act, Section 6407, Section 11283, imposes 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 DP.

Submit Attestation  Cancel

TIP

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

Accepted Attestation

The EHR 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 measure measures are accepted and meet all 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 email confirmation of your attestation.

Attestation Confirmation Number:

Names:
EHR Reporting Period: 1/1/2017 - 3/31/2017
Attestation Submission Date: 5/10/2018 10:00:13 PM

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

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Medicaid Patient Volume Report Layout</td>
</tr>
<tr>
<td>B</td>
<td>Medicaid Hospital-Based Report Layout</td>
</tr>
<tr>
<td>C</td>
<td>Needy Patient Volume Report Layout</td>
</tr>
<tr>
<td>D</td>
<td>Needy Practice Predominantly Report Layout</td>
</tr>
<tr>
<td>E</td>
<td>Definitions</td>
</tr>
<tr>
<td>F</td>
<td>Frequently Asked Questions</td>
</tr>
<tr>
<td>G</td>
<td>Electronic Funds Transfer – ACH Form Instructions</td>
</tr>
<tr>
<td>H</td>
<td>Electronic Funds Transfer – ACH Form</td>
</tr>
<tr>
<td>I</td>
<td>Contacts</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
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<td>Patient Name</td>
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<td>Payer Financial Class</td>
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<tr>
<td>Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.</td>
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</tr>
<tr>
<td>Correctional Facilities: Use Medicaid or Non-Medicaid description</td>
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<tr>
<td>Payer Name (if applicable specify Health Plan Name)</td>
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<tr>
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</tr>
<tr>
<td>Payer Medicaid/CHIP Coordination of Benefits</td>
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<tr>
<td>† For Medicaid Title XIX: Enter Medicaid Primary, Medicaid Secondary, Medicaid Tertiary, etc.</td>
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</tr>
<tr>
<td>† For CHIP (KidsCare) Title XXI: Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.</td>
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<td>Place of Service (POS) Codes (include all Place of Services)</td>
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<td>Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.</td>
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</tbody>
</table>

*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.

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<tr>
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</tr>
<tr>
<td>‘For CHIP (KidsCare) Title XXI: Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.</td>
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<td>Place of Service (POS) Codes (include all Place of Services)</td>
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<td>Visit Count – Denominator (Enter1= unique visit; 0 = duplicate visit)</td>
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*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.

<table>
<thead>
<tr>
<th>Description</th>
<th>Field Format</th>
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<td>Visit Count - Numerator (Enter 1= unique visit; 0 = duplicate visit)</td>
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<td>Visit Count - Denominator (Enter 1= unique visit; 0 = duplicate visit)</td>
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### 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.**

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<tr>
<td>Payer Financial Class</td>
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<td><em>Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.</em></td>
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<td>Payer Name <em>(if applicable specify Health Plan Name)</em></td>
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<td>†For CHIP <em>(KidsCare)</em> Title XXI: <em>Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.</em></td>
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<td>Place of Service (POS) Codes <em>(include all Place of Services)</em></td>
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Appendix E – Definitions

<table>
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<th>Attestation</th>
</tr>
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<tbody>
<tr>
<td>The attestation process allows the providers to attest to the PI Program’s as they demonstrate adoption, implementation, upgrade (AIU), or meaningful use of EHR technology. <strong>AIU attestations are not available after 2016.</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ePIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>An online application that interfaces with the CMS Registration and Attestation system and the Prepaid Medicaid Management Information System (PMMIS) to allow providers to complete applications for the Medicaid Promoting Interoperability (PI) Program for Arizona.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meaningful Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of certified EHR technology (CEHRT) to Improve quality, safety, efficiency, &amp; reduce health disparities; Engage patients &amp; families in their health care; Improve care coordination; Improve population &amp; public health and all the while maintaining privacy and security.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meaningful Use Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meaningful Use Exemption</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meaningful Use Stages</th>
</tr>
</thead>
</table>
| **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. |

<table>
<thead>
<tr>
<th>Patient Volume Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>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).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>The calendar year in which a provider is attesting. Providers can participate and receive payment up to a maximum of 6 years.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>The registration process allows the provider to participate in the PI Program. Providers must complete a federal and state level registration process. <strong>Only providers transferring from other States are permitted to register to set-up an ePIP account after Program Year 2016.</strong></td>
</tr>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>----</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q2</th>
<th>Can I skip a year after I have started the PI program?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Eligible Professionals (EPs) in the Medicaid Promoting Interoperability (PI) program can skip a year without a Medicaid penalty. It is not necessary to notify Medicaid that you are skipping a year. When you return, you continue with the next payment year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q3</th>
<th>Are physicians who work in hospitals eligible to receive Medicaid Promoting Interoperability (PI) payments?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physicians who furnish substantially all, defined as 90% or more, of their covered professional services in an inpatient (POS 21) and emergency department (POS 23) of a hospital are not eligible for incentive payments under the Medicare and Medicaid Promoting Interoperability (PI) Programs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4</th>
<th>Is my practice eligible to apply &amp; receive payments through the Medicare and Medicaid Promoting Interoperability (PI) Programs?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, your practice cannot apply for payment. Attestations are submitted by individual Eligible Professionals (EPs) who can voluntarily re-assign payment to their practice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q5</th>
<th>Will PI Payments be subject to audit?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incentive payments made to Eligible Professionals under the Medicaid Promoting Interoperability (PI) Program is subject to audit by the PI Programs. AHCCCS is responsible for conducting the audit for your attestation. Unless otherwise indicated, you will be contacted by AHCCCS with instructions when you are selected for the State audit. PI audit questions can be directed to the PI Post Payment Audit Team at: <a href="mailto:EHRPost-PayAudits@azahcccs.gov">EHRPost-PayAudits@azahcccs.gov</a> or 602.417.4440</td>
</tr>
</tbody>
</table>
### Appendix F – Frequently Asked Questions regarding Registration

<table>
<thead>
<tr>
<th>Q6</th>
<th>How often do I need to Register?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You need to Register once in order to participate in the PI Program. Thereafter, you must keep your registration information updated in each system.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Each time you attest, it is recommended that you review and update the “Contact Information” in both systems as needed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q7</th>
<th>I registered in the CMS Registration &amp; Attestation System but my registration is still showing ‘Send for State Approval’. How can I troubleshoot the problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>If your CMS registration status shows ‘Send for State Approval’, please send an inquiry to Medicaid at <a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a> for assistance.</td>
</tr>
<tr>
<td></td>
<td>If your CMS registration status shows ‘Registration Started/Modified/In Progress’, please re-submit your CMS registration.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q8</th>
<th>Can providers participating in the Medicare or Medicaid Promoting Interoperability (PI) Programs update their information (for example, if an address was mistakenly entered)? If so, will the State receive an update or full refresh of this information for its Medicaid Promoting Interoperability (PI) Program?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes, providers who have registered for the Medicare or Medicaid Promoting Interoperability (PI) Programs may correct errors or update information through the registration module on the CMS registration website <a href="https://ehrincentives.cms.gov/hitech/login.action">https://ehrincentives.cms.gov/hitech/login.action</a></td>
</tr>
<tr>
<td></td>
<td>The updated registration information will be sent to the State.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q9</th>
<th>I previously received an PI payment from another Medicaid State and have since moved to Arizona. Can I continue to participate in the program?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes, you can continue to participate in the Arizona Medicaid Promoting Interoperability (PI) Program.</td>
</tr>
<tr>
<td></td>
<td>First you must update your changes in the CMS Registration &amp; Attestation System and then register in the State’s Registration &amp; Attestation System to create your ePIP account.</td>
</tr>
</tbody>
</table>
## Appendix F – Frequently Asked Questions regarding Attestations

<table>
<thead>
<tr>
<th>Q10</th>
<th>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?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>If your previous attestation was denied or rejected, you may need to have your attestation refreshed.</td>
</tr>
<tr>
<td></td>
<td>In any instance if you cannot start a new Program Year, please email the PI Program team at <strong><a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a></strong>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q11</th>
<th>How do I know if my Promoting Interoperability (PI) system is certified?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Medicare and Medicaid Promoting Interoperability (PI) Programs require the use of certified EHR technology, as established by a set of standards and certification criteria.</td>
</tr>
<tr>
<td></td>
<td>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 <a href="http://www.healthit.hhs.gov/CHPL">http://www.healthit.hhs.gov/CHPL</a>. Providers must maintain the proper certification requirements &amp; submit the required documentation to demonstrate that their EHR technology is properly certified.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q12</th>
<th>How do we submit documentation to support the attestation?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>The ePIP website, <a href="https://www.azepip.gov/">https://www.azepip.gov/</a>, 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q13</th>
<th>How can I change my attestation information after I have attested for the Medicaid Promoting Interoperability (PI) Program?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If you discover that the information you entered during your Medicaid attestation was not complete and accurate for some reason, please email Medicaid at <strong><a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a></strong>.</td>
</tr>
</tbody>
</table>
### Q14 What is the deadline for Medicaid Eligible Professionals to submit attestations for Program Year 2018?

Eligible Professionals participate in the Medicaid Promoting Interoperability (PI) Programs on a calendar year basis. Generally, the Medicaid attestation deadline is 90-days following the end of the calendar year. At this time, the deadline for Program Year 2018 has been extended to **August 31, 2019**.

### Q15 What are the reporting periods for Eligible Professionals participating in the Promoting Interoperability (PI) Program?

For Program Year 2018, the reporting periods are as follows:

**Volume (select a period from 2017):**
- Patient Volume - a continuous 90-day period in the prior calendar year
- Hospital-Based - a 12-month period in the prior calendar year
- Practice Predominantly - continuous 6-month period in the prior calendar year

**Meaningful Use (select a period from 2018):**
- The PI reporting period for the Meaningful Use Objectives & the Clinical Quality Measures is a continuous 90-day period within the calendar year.

### Q16 Under the Medicare and Medicaid Promoting Interoperability (PI) Program, who is responsible for demonstrating meaningful use of certified EHR technology, the provider or the vendor?

To receive an PI payment, the Eligible Professional is responsible for demonstrating meaningful use of certified EHR technology under both the Medicare and Medicaid Promoting Interoperability (PI) programs.

### Q17 Is there a penalty if I start the PI program and do not attest to Meaningful Use?

Providers who have a Medicare patient population and have not attested to Meaningful Use will have a reduction in Medicare payments.

Providers that do not serve Medicare members are not penalized if they do not attest or if they withdraw from the Medicaid Promoting Interoperability (PI) Program after receiving an incentive payment.
### Appendix F – Frequently Asked Questions regarding Payment

<table>
<thead>
<tr>
<th>Q18</th>
<th>I am choosing to reassign my PI payment to my practice. Will I have any financial liability if I do so?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The State of Arizona issues 1099s to the Payee (recipient) of the PI funds. If you have reassigned your payment to your practice, you will not personally receive a 1099. For more information on 1099s, visit the AHCCCS website at <a href="https://www.azahcccs.gov/PlansProviders/CurrentProviders/EHR/">https://www.azahcccs.gov/PlansProviders/CurrentProviders/EHR/</a>. Click the Payment drop down and see IMPORTANT TAX INFORMATION.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q19</th>
<th>How is the Eligible Professional payment amounts determined?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicaid EPs can receive a maximum of $63,750 over a six year period. Note: There are special eligibility &amp; payment options for Pediatricians.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q20</th>
<th>How often are payments made?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payments are disbursed once per month via Electronic Funds Transfer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q21</th>
<th>Are payments from the Medicare and Medicaid Promoting Interoperability (PI) Programs subject to federal income tax?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q22</th>
<th>Are payments from the Medicare and Medicaid Promoting Interoperability (PI) Programs subject to recoupments?</th>
</tr>
</thead>
</table>
|     | Both Medicare and Medicaid are required to recoup any or all portions of the PI payment if any of the following conditions are determined:  
  - Provider or Payee received an improper payment  
  - Provider does not meet the requirements of the program  
  - Evidence of fraud and abuse |

<table>
<thead>
<tr>
<th>Q23</th>
<th>How long will it take to receive a payment?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>We must first perform the pre-payment audit. The PI Team strives to complete within eight (8) weeks of attestation during off peak periods. Delays are experienced when waiting for missing information, resolving issues, during peak periods, training or staffing changes.</td>
</tr>
</tbody>
</table>
# Appendix G – Electronic Funds Transfer ACH Form Instructions

## STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

### Electronic Funds Transfer (EFT) Authorization Agreement Instructions

Att: AHCCCS Finance - MD 5400, P.O. Box 25920, Phoenix, AZ 85032

---

### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Complete legal name of institution, corporate entity, practice or individual provider</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing Business As Name (DBA)</td>
<td>The alias name, or fictitious business name under which the business or operation is conducted and presented to the world for the legal name; the legal person(s) or person(s) who actually own and are responsible for</td>
<td>Optional</td>
</tr>
<tr>
<td>Provider Address</td>
<td>Street: The number and street name where a person or organization can be found</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>City: City associated with provider address field</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>State/Province: 2 Character Code associated with the State/Province of the applicable County</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Zip Code/Postal Code: 5 or 15 Character Code</td>
<td>Required</td>
</tr>
</tbody>
</table>

### PROVIDER IDENTIFIERS INFORMATION

<table>
<thead>
<tr>
<th>Provider Identifiers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)</td>
<td>A Federal Tax Identification Number also known as an Employer Identification Number (EIN) used to identify a business entity; Needs 9 digits</td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>A Health Insurance Portability and Accountability Act (HIPAA): Required when provider has been enumerated with an NPI</td>
</tr>
<tr>
<td>Trading Partner ID</td>
<td>AHCCCS Provider ID; 6 digits - 2 digits</td>
</tr>
</tbody>
</table>

### PROVIDER CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Provider Contact Name</th>
<th>Name of a contact in provider office for handling EFT Issues</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td></td>
<td>Optional</td>
</tr>
<tr>
<td>Tel Number</td>
<td>Number associated with contact person; Numeric, 10 digits</td>
<td>Optional</td>
</tr>
<tr>
<td>Tel Number Ext</td>
<td></td>
<td>Optional</td>
</tr>
<tr>
<td>Email Address</td>
<td>An electronic mail address at which AHCCCS might contact the provider</td>
<td>Optional</td>
</tr>
<tr>
<td>FAX Number</td>
<td>A number at which the provider can be sent facsimile</td>
<td>Optional</td>
</tr>
</tbody>
</table>

### PROVIDER AGENT INFORMATION - IF APPLICABLE

<table>
<thead>
<tr>
<th>Provider Agent Name</th>
<th>Name of provider’s authorized agent</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agent Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td>The number and street name where a person or organization can be found</td>
<td>Required</td>
</tr>
<tr>
<td>City</td>
<td>City associated with provider address field</td>
<td>Required</td>
</tr>
<tr>
<td>State/Province</td>
<td>2 Character Code associated with the State</td>
<td>Required</td>
</tr>
<tr>
<td>Zip Code/Postal Code</td>
<td>5 or 15 Character Code</td>
<td>Required</td>
</tr>
<tr>
<td>Provider Agent Contact Name</td>
<td>Name of a contact in agent office for handling EFT Issues</td>
<td>Required</td>
</tr>
<tr>
<td>Tel Number</td>
<td>Number associated with contact person; Numeric, 10 digits</td>
<td>Required</td>
</tr>
<tr>
<td>Tel Number Ext</td>
<td></td>
<td>Optional</td>
</tr>
<tr>
<td>Email Address</td>
<td>An electronic mail address at which AHCCCS might contact the provider</td>
<td>Optional</td>
</tr>
<tr>
<td>FAX Number</td>
<td>A number at which the provider can be sent facsimile</td>
<td>Optional</td>
</tr>
</tbody>
</table>
### Appendix G – Electronic Funds Transfer ACH Form Instructions (continued)

#### FINANCIAL INSTITUTION INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Institution Name</td>
<td>Official name of the provider's financial institution</td>
</tr>
<tr>
<td>Institution Address</td>
<td>Street address associated with receiving depositing financial institution name field</td>
</tr>
<tr>
<td>City</td>
<td>City associated with receiving depositing financial institution address field</td>
</tr>
<tr>
<td>State/Province</td>
<td>2 Character Code associated with the State</td>
</tr>
<tr>
<td>Code</td>
<td>6 or 8 Character Code</td>
</tr>
<tr>
<td>Tel Number</td>
<td>A contact telephone number at the provider's bank</td>
</tr>
</tbody>
</table>

#### SECTION 6 - Electronic Funds Transfer ACH Form Instructions (continued)

#### Submission Information

<table>
<thead>
<tr>
<th>Reason for Submission</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Enrollment</td>
<td>Required</td>
</tr>
<tr>
<td>Change Enrollment</td>
<td>Required</td>
</tr>
<tr>
<td>Cancel Enrollment</td>
<td>Required</td>
</tr>
<tr>
<td>Vested Check or Bank Letter</td>
<td>A voided check is attached to provide confirmation of identification number. Required</td>
</tr>
</tbody>
</table>

#### Authorization

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorized Signature</td>
<td>The signature of an individual authorized by the provider or its agent to initiate modify terminate an enrollment. Required</td>
</tr>
<tr>
<td>Name of Authorized Signature</td>
<td>The signature of the person submitting the form. Required</td>
</tr>
<tr>
<td>Date</td>
<td>The title of person signing the form. Optional</td>
</tr>
<tr>
<td>Requested EFT Start/Change/Cancel Date</td>
<td>The date on which the requested action is to begin - CCYYMMDD. Required</td>
</tr>
</tbody>
</table>

For a full, printable PDF of this document, please click on the following link, [Click Here](https://www.azepip.gov/).
### Appendix H – Electronic Funds Transfer ACH Form Sample

STATE OF ARIZONA – ARIZONA HEALTH CARE COST CONTainment System

Electronic Funds Transfer (EFT) Authorization Agreement

Attn: AHCCCS Finance, MD 1200, P.O. Box 15720, Phoenix, AZ 85016

Fax Number: 602-256-5932

**REQUIRED FIELD** + REQUIRED FIELD IF SECTION IS APPLICABLE (SECTION 1)

<table>
<thead>
<tr>
<th>PROVIDER IDENTIFIER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name *</td>
</tr>
<tr>
<td>Provider Address</td>
</tr>
<tr>
<td>Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *</td>
</tr>
<tr>
<td>National Provider Identifier (NPI) *</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVIDER CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Contact Name *</td>
</tr>
<tr>
<td>Telephone Number &amp; Extension</td>
</tr>
<tr>
<td>Email Address *</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVIDER AGENT INFORMATION - IF APPLICABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Agent Name</td>
</tr>
<tr>
<td>Provider Agent Address</td>
</tr>
<tr>
<td>Provider Agent Contact Name *</td>
</tr>
<tr>
<td>Telephone Number &amp; Extension</td>
</tr>
<tr>
<td>Email Address</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FINANCIAL INSTITUTION INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Institution Name *</td>
</tr>
<tr>
<td>Financial Institution Address</td>
</tr>
<tr>
<td>Financial Institution Telephone Number &amp; Extension</td>
</tr>
<tr>
<td>Financial Institution Routing Number</td>
</tr>
<tr>
<td>Type of Account at Financial Institution</td>
</tr>
<tr>
<td>Provider’s Account Number with Financial Institution</td>
</tr>
<tr>
<td>Account Number Linkage to Provider Identifier</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUBMISSION INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payee for Submission *</td>
</tr>
<tr>
<td>Include with Enrollment Submission *</td>
</tr>
<tr>
<td>New Enrollment</td>
</tr>
<tr>
<td>OR Bank Letter - A letter on bank letterhead that formally notifies the account owners routing and account numbers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AUTHORIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>I authorize the Arizona Department of Administration (ADOA), General Accounting Office (GAO) and the Arizona Health Care Cost Containment System (AHCCCS) to process payment event via Automated Clearing House (ACH) deposit. The State of Arizona and AHCCCS shall deposit the ACH payments in the financial institution and account designated above.</td>
</tr>
<tr>
<td>I authorize the State of Arizona and AHCCCS to verify the designated account of amounts deposited in error in accordance with NACHA rules and standards. If the designated account is closed or has insufficient funds to cover the charge, I authorize the State of Arizona and AHCCCS to withdraw any payment event in the State of Arizona and AHCCCS until the minimum deposited amounts are repaid. I authorize the State of Arizona and AHCCCS to stop making electronic transfers to any account without advance notice.</td>
</tr>
<tr>
<td>I certify that I have read and agree to comply with the State of Arizona and AHCCCS’s rules governing payments and electronic transfers as they exist on the date of this agreement or at the date of my signature on this form, or at any time afterwards, amended, or replaced. I am in, and agree to be, subject to and bound by these rules even if I conflict with this authorization form.</td>
</tr>
<tr>
<td>I have read and agree to comply with the State of Arizona and AHCCCS’s rules governing payments and electronic transfers as they exist on the date of this agreement or at the date of my signature on this form, or at any time afterwards, amended, or replaced. I am in, and agree to be, subject to and bound by these rules even if I conflict with this authorization form.</td>
</tr>
</tbody>
</table>

For a full, printable PDF of this document, please click on the following link, [Click Here](https://www.azepip.gov/)
# Appendix I – Contact Us

<table>
<thead>
<tr>
<th>Need Help with:</th>
<th>Contact Us:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Promoting Interoperability (PI) Program</td>
<td>AHCCCS PI Pre-Payment Staff</td>
</tr>
<tr>
<td></td>
<td>602-417-4333</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a></td>
</tr>
<tr>
<td></td>
<td>Website: Arizona Medicaid EHR Incentive Program</td>
</tr>
<tr>
<td></td>
<td>AHCCCS PI Post Payment Staff</td>
</tr>
<tr>
<td></td>
<td>602-417-4440</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:EHRPost-PayAudits@azahcccs.gov">EHRPost-PayAudits@azahcccs.gov</a></td>
</tr>
<tr>
<td>Having Trouble with:</td>
<td>Help is Available:</td>
</tr>
<tr>
<td>CMS Registration process</td>
<td>CMS Information Center</td>
</tr>
<tr>
<td></td>
<td>888-734-6433</td>
</tr>
<tr>
<td></td>
<td>Website: CMS Medicare and Medicaid EHR Incentive Programs</td>
</tr>
<tr>
<td>AHCCCS Provider Number, NPI, or TIN</td>
<td>AHCCCS Provider Registration</td>
</tr>
<tr>
<td></td>
<td>602-417-7670 (option 5) Maricopa County</td>
</tr>
<tr>
<td></td>
<td>800-794-6862 Outside Maricopa County</td>
</tr>
<tr>
<td></td>
<td>800-523-0231 Out-of-State</td>
</tr>
<tr>
<td></td>
<td>Website: AHCCCS Provider Registration Unit</td>
</tr>
<tr>
<td>Electronic Funds Transfer (EFT)</td>
<td>AHCCCS Finance</td>
</tr>
<tr>
<td></td>
<td>602-417-5500</td>
</tr>
<tr>
<td></td>
<td>Website: Automated Clearing House (ACH) Vendor Authorization Form</td>
</tr>
<tr>
<td>ePIP System</td>
<td>AHCCCS PI Staff</td>
</tr>
<tr>
<td></td>
<td>602-417.4333</td>
</tr>
<tr>
<td></td>
<td>Website: ePIP Systems for Registration &amp; Attestation</td>
</tr>
<tr>
<td>No-Cost Education &amp; Assistance for HIT / HIE</td>
<td>Arizona Health-e Connection (AzHeC)</td>
</tr>
<tr>
<td></td>
<td>602-688-7200</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:ehr@azhec.org">ehr@azhec.org</a></td>
</tr>
</tbody>
</table>
Thank you for your interest in the Promoting Interoperability Program