Eligible Professionals User Manual Electronic Health Records Incentive Program

Idaho Department of Health and Welfare
Division of Medicaid

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PART I: PROGRAM OVERVIEW

Purpose

The purpose of this manual is to provide eligible professionals (EPs) with an overview of the Idaho Medicaid Electronic Health Records (EHR) Incentive Program, information about what needs to be done to receive payments, and step-by-step instructions about how to enroll and attest.

Introduction

Through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), the Centers for Medicare & Medicaid Services (CMS) has implemented incentive payments to EPs that are participating in Medicare and Medicaid programs and are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are intended to encourage EPs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator (ONC) for Health Information Technology has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at http://www.healthit.hhs.gov.

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines; and 4) enable data sharing using the state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce the costs of health care nationwide.
Idaho Medicaid staff will work closely with federal and state partners to ensure the Idaho Medicaid EHR Incentive Program fits into the overall strategic plan for the Idaho HIE, thereby advancing Idaho and national goals for HIE.

Eligibility

A provider's eligibility to receive EHR incentive payments is based on the provider type and specialty, patient volume, state of licensure and good standing, and verification that a qualifying EHR system is in place and the provider is meaningfully using it.

Provider Type and Specialty

The first tier of provider eligibility for the Idaho Medicaid EHR Incentive Program is based on provider type and specialty. At this time, CMS has determined that the following providers are potentially eligible to enroll in the Idaho Medicaid EHR Incentive Program:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioners
- Certified nurse-midwives
- Dentists
- Physician assistants who furnish services in a federally qualified health center (FQHC) or rural health clinic (RHC) that is led by a physician assistant

The EHR incentive payments will only be made to Idaho Medicaid providers (EPs with an Idaho Medicaid Provider Agreement), unless the provider predominantly practices in an RHC or FQHC.

Patient Volume

Patient volume thresholds must be established every year a provider applies for an incentive payment. To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must not be hospital-based (hospital-based means an EP who furnishes 90 percent or more of covered professional services in a hospital, inpatient, or emergency room setting (POS 21 and 23) in the year preceding the payment year) and must meet one of the following patient volume criteria:

- Have a minimum of 30 percent Medicaid patient volume attributable to individuals receiving Medicaid funded services.
- Have a minimum of 20 percent patient volume attributable to individuals receiving Medicaid funded services **and** be a pediatrician.
- *Practice predominantly* in an FQHC or RHC **and** have a minimum of 30 percent patient volume attributable to *needy individuals*.
    - To *practice predominantly* means an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of six months in the most recent calendar year occurs at an FQHC or RHC. In Idaho, the most recent calendar year is defined as the previous completed calendar year. This is a statutory requirement that is not subject to the interpretation of the state. If an FQHC or RHC must use non-Medicaid encounters to reach the minimum 30 percent threshold, an EP hired in the current calendar year should have the appropriate track record for a six month period in the previous calendar year. This attestation will be subject to post-payment audit. Examples of non-eligible professionals include:
        - A doctor who is on staff at the FQHC but who was on sabbatical last year and didn't practice at all.
        - A new EP whose last job in the previous calendar year was at a university medical center.
        - A staff EP who performed only 1-49 percent of his or her encounters at an FQHC last year.
    - Services attributable to *needy individuals* are defined as those that meet one of the following:
        - Services rendered to an individual who is receiving assistance under Title XlX, who is receiving assistance under Title XXI, who is furnished uncompensated care by the provider, or for whom charges are reduced by the provider on a sliding scale based on the individual's ability to pay.
        - Services rendered on any one day to an individual where Medicaid or the Children's Health Insurance Program (CHIP) or a Medicaid or CHIP demonstration project under section 1115 of the Social Security Act paid all or part of their premiums, co-payments, or cost sharing.
        - Services rendered to an individual on any one day that were on a sliding scale or that were charity care.

CHIP Encounters for Patient Volume and Payment Calculation

Encounters with Medicaid participants receiving services funded by Title XXI **cannot** be included in the patient volume calculation unless the EP practices predominantly in an FQHC or RHC **and** is basing the patient volume on needy patient encounters. Because EPs can't always distinguish between funding sources, Idaho Medicaid has received permission from CMS to use a "CHIP patient volume average" strategy to help EPs determine their Medicaid patient volume.

Idaho's payment system differentiates the paying source using detailed codes for eligibility that are traceable to the claim. Using this information, Idaho Medicaid has identified a statewide average proportion for CHIP encounters for professionals. The CHIP patient volume average is currently seven percent. The CHIP patient volume average was reviewed again in 2013, and it was determined to still be seven percent, therefore, there will be no change in the current methodology for determining CHIP patient encounters. This is based on an analysis of three years of claims history. This percent gives the statewide average of CHIP-to-total Medicaid encounters. Eligible professionals must identify their total number of Medicaid encounters and reduce that by the CHIP patient volume average percent when applying for incentives.

Using this method will benefit some providers whose actual CHIP patient encounters are higher than the statewide average, and may disadvantage those whose CHIP volume is lower than average. Idaho Medicaid wants to work with EPs to ensure that they are not falsely denied eligibility based on this strategy. Providers can request the state provide them with the **actual** number of Medicaid and CHIP encounters for the 90-day period of their choosing **if** they are unable to meet the patient volume threshold with the CHIP patient volume average reduction and believe that they could meet it otherwise. Medicaid staff will give the number to the provider making the request. Professionals can contact the Idaho Medicaid EHR Incentive Program Help Desk staff at (208) 332-7989 for more information about this process.

Eligible Professionals Patient Volume Calculator

To calculate Medicaid patient volume, EPs who are not practicing predominantly in an FQHC or RHC must divide:

- The total Medicaid patient encounters in any representative, continuous 90-day calendar period in the preceding calendar year reduced by the seven percent CHIP average; by
- The total patient encounters in the same 90-day period.

To calculate Medicaid patient volume, EPs practicing predominantly in an FQHC or RHC and basing patient volume on needy encounters must divide:

- The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
- The total patient encounters in the same 90-day period.

Medicaid will count only claims where Medicaid has paid $.01 or more. If there is a $0 paid claim, it will not be counted as an eligible encounter. If an EP believes the omission of $0 paid claims for participants whose premiums were paid by Medicaid will push them under the 30 percent threshold, Idaho Medicaid staff can run a unique report that includes the amount of $0 paid claims for the 90 days where Medicaid paid the premium. Medicaid will also include any claim for a Medicare dual eligible when Medicaid paid at least $.01.

Statewide Average for CHIP and Impact on Auditing

For EPs that are audited and have used the CHIP patient volume average, the auditor will assess whether the total Idaho Medicaid encounters were accurately represented and will not attempt to evaluate an EP's actual Medicaid-only encounters. There would be no penalty for EPs who have an actual CHIP patient volume higher than the statewide patient volume average. For EPs who request their specific data, the audit will assess whether the Medicaid-only encounters were accurately represented, given the information provided by the state.

Group Proxy Calculation

The Idaho Medicaid EHR Incentive Program has developed a group proxy calculation worksheet to help facilitate consistent attestation of patient volumes by eligible professionals and to streamline patient volume verification. It is important for EPs to remember that:

- The entity responsible for the group must complete a group proxy calculation worksheet and make it available to all eligible professionals.
- Every eligible professional must attach a copy of the group proxy calculation worksheet and its supporting patient encounter report during the application/attestation process for the Idaho Incentive Management System (IIMS).
  Note: The 90-day patient encounter report of needy/total patient encounters is required to support the proxy calculation.
- A **new** group proxy calculation worksheet must be completed every year and for each phase of the program (e.g., AIU, meaningful use Stage 1, etc.) the group's EPs apply for a Medicaid incentive if using the group proxy calculation approach that year.

The group proxy calculation can be set at the organizational level or the clinic level. If using an organizational level proxy calculation, the clinics that are included cannot be an arbitrary group of clinics to maximize patient volumes. An organizational level proxy must include all of the organization's clinics that are within the state of Idaho. **No out-of-state clinics will be allowed to be included in the proxy.**

After the group proxy calculation worksheet is completed, it needs to be converted to a PDF format and submitted during application/attestation in the IIMS.

Provider Roster

The Idaho Medicaid EHR Incentive Program plans to leverage EP rosters completed by clinics that have more than one provider registering for the EHR Incentives Program as the initial point of reference for verification. The *Provider Roster Workbook* will be used to establish what eligible providers will be applying to each clinic.

The Idaho EHR Incentive Program has developed a *Provider Roster Workbook* with three tabs. The first tab is the provider roster template for clinics to complete to document their active providers. The second tab is a sample of a completed FQHC/RHC provider roster template. The third tab is a sample of a non-FQHC/RHC clinic. Clinic staff must decide who will complete and submit the provider roster, as only one is needed from each clinic. This should be done before clinic providers register for an incentive payment. The provider roster should list all **eligible professionals** or their authorized representatives at that clinic location, **not all practitioners**. Professionals can contact the Idaho Medicaid EHR Incentive Program Helpdesk at (208) 332-7989 with questions.

After the provider roster is completed, please email it to the Idaho Medicaid EHR Incentive Program (please see the directions included with the provider roster template).

The provider roster will serve as a key initial reference that will facilitate preliminary verification that an EP is active and is the correct eligible provider type. It's important to remember that:

- All clinics with more than one provider will be required to complete an EP provider roster and send it to the Idaho Medicaid EHR Incentive Program. The program will use the EP provider roster as a reference to perform initial verification of EPs from these clinics.
- Idaho Medicaid will ask for an updated provider roster when new providers enter the practice and apply to the Idaho Medicaid EHR Incentives Program or yearly, whichever is sooner.

The EP provider roster template and instructions are posted on the Idaho Medicaid EHR Incentive Program website at www.MedicaidEHR.dhw.idaho.gov. This *Provider Roster Workbook* contains the template, a guide about how to complete the template, examples of completed forms and information about how to submit the form to Idaho Medicaid staff.

Institutional License and Good Standing

All participating EPs must have a current institutional license (provisional licenses will be accepted) and must be free of both state- and federal-level sanctions and exclusions to be eligible for incentive payments.

Adopt, Implement, or Upgrade

All EPs must verify that they have adopted, implemented, or upgraded to a certified EHR system. Below are the criteria for each:

- **Adopt:** "acquire, purchase, or secure access to certified EHR technology."
  There is evidence that an EP demonstrated actual installation prior to the incentive, rather than "efforts" to install. This evidence serves to differentiate between activities that may not result in installation (e.g., researching EHRs or interviewing EHR vendors) and actual purchase/acquisition or installation.

- **Implement:** "install or commence utilization of certified EHR technology."
  The EP has installed certified EHR technology and has started using the certified EHR technology in his or her clinical practice. Implementation activities would include staff training in the certified EHR technology, the data entry of their patients' demographic data into the EHR, or establishing data exchange agreements and relationships between the EP's certified EHR technology and other EPs, such as laboratories and pharmacies.

- **Upgrade:** "expand the available functionality of certified EHR technology."
  The EP has added clinical decision support, electronic prescribing functionality, or other enhancements that facilitate the meaningful use of certified EHR technology. An example of upgrading that would qualify for the EHR incentive payment would be upgrading from an existing EHR to a newer version that is certified per the EHR certification criteria promulgated by the ONC related to meaningful use. Upgrading may also mean expanding the functionality of an EHR to ensure that the practice location has certified electronic health record technology (CEHRT) that is listed on the ONC's Certified Health IT Product List (CHPL) site.

Please see the "Preparing the Documentation Required for Attestation" section of this handbook for details about what documentation will be required as proof of AIU.

Getting Your EHR Certification

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology. Standards, implementation specifications, and certification criteria for EHR technology have been adopted by the Secretary of the Department of Health and Human Services. The EHR technology in use by the EP must be tested and certified by an ONC Authorized Testing and Certification Body (ATCB) in order for that EP to qualify for EHR incentive payments. Once certified, the product is listed on the ONC's website, often referred to as the Certified Health IT Product List (CHPL), where an EP must obtain a unique CMS EHR Certification ID Number. This certification number must be provided as part of the attestation process for either the Medicare or Medicaid incentive program.

Eligible professionals can obtain the CMS EHR Certification ID Number for their EHR product by following these steps:

1. Go to the ONC CHPL website: http://healthit.hhs.gov/chpl.
2. Select the practice type by selecting either the "Ambulatory" or "Inpatient" button.
3. Search for EHR products by browsing all products, searching by product name, or searching by criteria.
4. Add products to your cart to determine if they meet 100 percent of the CMS required criteria.
5. Request a CMS EHR Certification ID Number for CMS attestation (this number should contain 15 alphanumeric characters).
   Note: The "Get CMS EHR Certification ID" button will not be activated until the products in your cart meet 100 percent of the CMS required criteria. If the EHR products don't meet 100 percent of the CMS required criteria to demonstrate meaningful use, a CMS EHR Certification ID Number will not be issued.

Important Clarifications

- The ONC CHPL Product Number issued to your vendor for each certified technology is different than the CMS EHR Certification ID Number issued to a professional for registration and attestation purposes. Only a CMS EHR Certification ID Number (obtained from the CHPL site) that is unique to the practice will be accepted at attestation.
- It is not enough for a provider's EHR product to be certified by the Certification Commission for Health Information Technology (more commonly known as CCHIT certification). The product must be certified by an ONC-ATCB specifically for the Medicare and Medicaid EHR Incentive Programs and listed on the ONC's website.
- An EP doesn't need to have a certified EHR technology in place to register with CMS for the Medicare and Medicaid EHR Incentive Programs. However, the professional must adopt, implement, or upgrade to a certified EHR system under the Medicaid EHR Incentive Program or successfully demonstrate meaningful use of certified EHR technology under the Medicare EHR Incentive Program before the professional can receive an EHR incentive payment.

The ONC's website of certified products has the final rules related to certification standards, fact sheets, frequently asked questions, a list of ONC-ATCBs, and a wealth of information about certified products and obtaining certification.

Special Eligibility Issues for FQHCs and RHCs

EPs that practice at FQHCs and RHCs encounter special eligibility issues other EPs do not.

Physician Assistants

Unlike other eligible provider types, physician assistants (PAs) can apply for an EHR incentive only if they are practicing at an FQHC or RHC that is led by a PA. The definition of PA leadership is the key to PA eligibility.

In the Medicare and Medicaid EHR Incentive Program Final Rule p. 44483, CMS interprets the statutory language regarding "PA-led" as follows:

> *"We believe a PA would be leading an FQHC or RHC under any of the following circumstances:*
>
> 1) *When a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider);*
> 2) *When a PA is a clinical or medical director at a clinical site of practice; or*
> 3) *When a PA is an owner of an RHC.*
>
> *We agree that FQHCs and RHCs that have PAs in these leadership roles can be considered PA-led. Furthermore, since RHCs can be practitioner owned (FQHCs cannot), we will allow ownership to be considered PA-led."*

Circumstances (2) and (3) above can usually be validated with internal data, public documents, and even clinic websites. Circumstance (1), in which a PA is the primary provider, is more difficult and cumbersome to authenticate, especially given the simplicity of the CMS example. In some cases - for instance, when full-time PAs outnumber full-time physicians, or a small rural clinic has only a single EP - primary providership may be easily established. To avoid making improper payments in cases that are less clear, the state will request dated, documented evidence from FQHCs and RHCs from which one or more PAs apply. Documentation might include position descriptions, work schedules, appointment calendars, emails, meeting minutes, and other organizational documents that yield conclusive indications of clinical leadership.

CMS has offered the following guidance to FQHCs and RHCs as they evaluate if the clinic is PA-led when a PA does not have the title of Medical Director. Consider if the PA:

- Sets the amount of clinical time and administrative time for the other EPs.
- Reviews and signs the policies and procedures for clinical practices.
- Sets the schedule for the other EPs.
- Leads the EP meetings.
- Sets quality goals for the clinic.
- Completes performance evaluations for the other EPs.

Payments

How to Become a Vendor With the State

Idaho Medicaid is using the state fiscal system to set up financial transactions for incentive payments. This fiscal system is not the same payment system that is used to process Medicaid payments to current EPs. Providers will need to ensure they are enrolled as a vendor in this system in order to receive payments. If EPs are unsure of prior vendor enrollment, they can call the Idaho Medicaid EHR Incentive Program Help Desk at (208) 332-7989 to see if they have previously enrolled.

- To enroll as a vendor who receives paper warrants and paper remittance advices (RAs), the EP must complete a W-9 form (http://www.irs.gov/pub/irs-pdf/fw9.pdf) and submit it to the Idaho Medicaid EHR Incentive Program using one of three methods:

  Mail: EHR Incentive Payments
  Division of Medicaid
  PO Box 83720
  Boise, ID 83720-0009

  Fax: (208) 334-6515

  Email: EHRIncentives@dhw.idaho.gov

- To enroll as a vendor who receives direct deposits (EFT), the EP must complete the *Combined Substitute W-9/EFT Direct Deposit Authorization Form* (on the Idaho Office of the State Controller's website). This form must be **mailed** along with a voided check (originals only, copies/faxes/scanned documents will not be accepted) to:

  EHR Incentive Payments
  Division of Medicaid
  PO Box 83720
  Boise, ID 83720-0009

Processing of the completed EFT form includes verifying the vendor's tax identification number (TIN) and name with the IRS to make sure they match, and verifying the vendor's financial institution. This process usually takes a few weeks. Once the submitted EFT paperwork and voided check have been processed, the controller's office sends the EP a letter or email with their logon information, password, and instructions for accessing the state controller's vendor website so the EP can view the RAs.
Note: EPs who sign up for EFT will not receive paper warrants or paper RAs. If an EP is reassigning payment, the clinic or group to whom the payment is reassigned must be enrolled as a vendor with the state of Idaho and follow the instructions above to receive a paper warrant or EFT.

Understanding Payment Timelines

The maximum incentive payment an EP can receive from Idaho Medicaid equals $63,750 over a period of six years, or $42,500 for pediatricians with a 20-29 percent CMS patient volume as shown below.

Provider	**EP: Patient Volume 30 Percent**	**EP-Pediatrician (Medicaid**): **20-29 Percent**
Year 1	$21,250	$14,167
Year 2	$8,500	$5,667
Year 3	$8,500	$5,667
Year 4	$8,500	$5,667
Year 5	$8,500	$5,667
Year 6	$8,500	$5,667
Total Incentive	**$63,750**	**$42,500**

Pediatricians may qualify to receive the full incentive if they can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements. In Idaho, a pediatrician will be considered any physician whose National Provider Identifier (NPI) is associated with a pediatric taxonomy code, including specialties, all of which begin with 2080. In addition, any physician who predominantly treats individuals under 21 years of age and believes the above definition will negatively impact potential eligibility can contact the program eligibility specialist to discuss verification for pediatric focus.
Note: EPs must reapply to Medicaid and demonstrate volume thresholds each year they wish to receive a payment.

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than calendar year 2016. EPs can choose to receive the EHR payment **or** choose to re-assign the payment to a Medicaid contracted clinic or group to which the EP is associated. This decision must be made when the EP registers with the CMS EHR Registration and Attestation (R&A) website. The TIN of the individual or entity receiving the incentive payment is required when registering with CMS and must be associated to a TIN linked to the individual EP in the IIMS. All EPs who assign payment to themselves (and not a group or clinic) will be required to provide Idaho Medicaid with updated information.
Note: If Idaho Medicaid determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS.

Out-of-State Providers

The EHR incentive payments will only be made to Idaho Medicaid providers (EPs with an Idaho Medicaid Provider Agreement), unless they predominantly practice in an RHC or FQHC.

Program Integrity and Audit

Idaho Medicaid will conduct regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint, or incorporation into reviews selected for other objectives. EPs must keep their supporting documentation for six years after each payment is received.

Administrative Appeals

EPs can choose to appeal the determination made by the Idaho Medicaid EHR Incentive Program about the incentive payment application. All contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings".

Meaningful Use

Clinical Quality Measures

Clinical quality measures are tools that help measure and track the quality of health care services provided by EPs, eligible hospitals, and critical access hospitals within our health care system. These measures use a wide variety of data that are associated with a provider's ability to deliver high-quality care or relate to long-term goals for health care quality. The clinical quality measures gauge many aspects of patient care including health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagements, population, public health, and clinical guidelines. Continuously measuring and reporting these clinical quality measures helps to ensure that our health care system can deliver effective, safe, efficient, patient-centered, equitable, and timely care.

Requirements

Meaningful use includes both a core set and a menu set of objectives that are specific to EPs. For EPs, there are a total of 24 meaningful use objectives. To qualify for an incentive payment 18 of these 24 meaningful use objectives must be met: 13 required core objectives and 5 objectives chosen from a list of 9 menu set objectives.

In addition to meeting the core and menu objectives, EPs are also required to report clinical quality measures. All EPs must report on 6 total clinical quality measures: 3 required core measures (or 3 alternate core measures) and 3 additional measures (selected from a set of 38 clinical quality measures) in order to receive an incentive payment from the Idaho Medicaid EHR Incentive Program.

Provider Attestation Process and Validation

It is the policy of Idaho Medicaid that EPs may permit an authorized representative to complete the CMS registration and Idaho application/attestation forms on behalf of an EP. For instructions on how to act on behalf of an EP, go to the CMS Registration and Attestation website (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html). The following is a description of information that must be reported or attested to during the process:

- After registering for the incentive program on the CMS EHR R&A website at http://www.cms.gov/EHRIncentivePrograms/, Idaho Medicaid will receive notification of registration from CMS. Idaho Medicaid will do some pre-verification and then contact the EP using the contact information provided to CMS. The EP will be given the link to the IIMS where the EP can log in to begin the application/attestation process. To log into the IIMS, the EP will need the CMS EHR Registration ID Number and EP NPI.
- The EP will then be asked to view the information that is displayed with the pre-populated data received from the CMS EHR R&A process.
- EPs will then be asked to enter the patient volume characteristics and EHR details.

The EP will be asked to attest to:

- Assigning the incentive payment to a specific TIN, if applicable (the name of the EP and the TIN to which the payment was assigned will be displayed).
- Not working as a hospital-based professional (this will be verified by Idaho Medicaid through claims analysis).
- Not applying for an incentive payment from another state or Medicare.
- Not applying for an incentive payment under another Idaho Medicaid ID Number.
- Adopting, implementing, or upgrading the certified EHR technology.

Once the electronic attestation is submitted by a qualifying EP or authorized representative and appropriate documentation provided, Idaho Medicaid will conduct a review that will include cross-checking for potential duplication payment requests, checking EP exclusion lists, and verifying supporting documentation.

The attestation itself is electronic and will require the EP to attest to meeting all requirements defined in the federal regulations. Some documentation must be provided to support specific elements of attestation. All EPs are required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation is provided in the IIMS.

Meaningful use of certified electronic technology is designed to happen in stages and the clinical quality measures tied to meaningful use will change over time. The state of Idaho will revise this provider user manual as the rules and measures change over time.

Preparing the Documentation Required for Attestation

The following is a description of the documentation that an EP must upload to the IIMS (https://IIMS.dhw.idaho.gov) during attestation:

- Proof of adopting, implementing, or upgrading to certified EHR technology – this must be a document showing a binding agreement between the EP (or the healthcare organization) and the vendor, such as a contract between entities. Idaho Medicaid only needs the most current documents for proof, not all historical documents relating to the EHR system.
- An invoice showing payment or acquisition for the certified EHR system (actual numbers may be blacked out).
- A purchase order (only for AIU).
  Note: A vendor letter is not acceptable unless submitted with additional binding documentation. The documentation submitted must include the exact name of the EHR system including the software version number.
- A provider roster and PA-led documentation (if applicable).
- A patient volume encounter report - in the Idaho Medicaid EHR Incentive Program, all EPs are required to submit a 90-day patient volume report to support their attestation for Medicaid or needy patient encounters. The report must be from an auditable source and system generated from the practice's administrative or clinic care system. The content of the report is intended to provide the state sufficient information to validate patient encounters reported. The particular format of the

report is not as important as the content; however, it will be important to make the content clear on the report by using headings and labels. The following are definitions of the content we require on the report:

- **Date:** The date the report was generated.
- **90-Day Period:** The start and end date of the 90 calendar days used to determine patient volume. Please use the most recently completed calendar year (12 month period: January-December) prior to the year you are completing the application/attestation. We will allow you to use an additional two months after the calendar year, called the "tail period," if you need to use this time frame to complete your attestation.
- **Name of EP:** The name of the individual EP or, if an EP is using a clinic/group proxy calculation, the name of the clinic/group.
- **Provider NPI:** The NPI for all of the **eligible providers** included in the report. Every encounter must have an NPI if it is a service provided by an EP. If the report is to support a group proxy patient volume calculation, the report will list all encounters of all practitioners. Medicaid understands that some non-eligible practitioners may not have an NPI.
- **Clinic NPI:** The NPI for the clinic that is connected to this EP or group of EPs, if using the group proxy approach for establishing patient volume.
- **Total Medicaid or Needy Encounters:** The total number of Medicaid or needy encounters attributable to the EP or, if using a group proxy calculation, all practitioners at the clinic/group practice. The report could show daily, weekly, or monthly sub-totals if the EP desires. If the report includes out-of-state Medicaid/needy encounters, they must be identified and included in both the numerator and the denominator for the patient volume calculation.
- **Total Patient Encounters:** The total number of patient encounters attributable to the EP or, if using a group proxy calculation, all practitioners at the clinic/group practice. If the report includes out-of-state Medicaid/needy encounters, they must be identified and included in both the numerator and the denominator for the patient volume calculation. Claims that are billed as a global service are counted as one encounter in the numerator and denominator for all payer sources. **Note:** If providers have out-of-state encounters for the period, they may include them in their encounters only if this is needed to meet the patient volume threshold. When using out-of-state encounters, include these numbers in both the "Total Medicaid" or "Needy Encounters" and the "Total Patient Encounters". Identify the state and total encounters separately in these totals to provide visibility to these numbers.

- Meaningful use documentation
  - **Core Measures:** One de-identified report from the certified EHR software that was used for a **core** attestation item.
  - **Menu Measures:** One de-identified report from the certified EHR software that was used for a **menu** attestation item.
  - **Clinical Quality Measures:** One de-identified report from the certified EHR software that was used for a **clinical quality measure** attestation item.

When naming your document, please use the following naming conventions:

- For core measures use the EP's last name, core number (in IIMS) you are attesting to, and date (e.g., smith_mucore6_mmddyy).
- For menu measures use the EP's last name, menu number (in IIMS) you are attesting to, and date (e.g., smith_mumenu8_mmddyy).
- For clinical quality measures use the EP's last name, clinical quality measure number (assigned by CMS and in IIMS) you are attesting to, and date (e.g., smith_NQF0024_mmddyy).

PART II: STEP BY STEP INSTRUCTIONS

Overview

The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs are staged in three steps with increasing requirements for participation. All providers begin participating by meeting the Stage 1 requirements for a 90-day period in their first year of meaningful use (MU) and a full year in their second year of MU, except in 2014. The reporting period for 2014, regardless of the stage, is 90 days due to EHR system upgrade requirements by the Centers for Medicare and Medicaid Services (CMS). After meeting the Stage 1 requirements, providers will have to meet Stage 2 requirements for two full years. All eligible professionals (EPs) participate in the program according to calendar years, while eligible hospitals and critical access hospitals participate according to the federal fiscal year. Idaho has implemented a web-based interface, called the Idaho Incentive Management System (IIMS), for providers to apply and attest at the Idaho state level. To successfully use the IIMS to apply and attest, you must:

- Be successfully registered on the CMS website for the EHR Incentive program.
- Have the following information available:
  - The National Provider Identifier (NPI) you used to register at the CMS website.
  - The CMS Registration Identification Number that is associated with your NPI (provided by CMS during registration).
  - Supporting documentation on patient volume, EHR details, and physician assistant led clinics (if applicable).

Steps to complete your application/attestation in the IIMS include:

1. Log into the IIMS.
2. Review the CMS registration data.
3. Enter the eligibility details.
4. Review the incentive payment calculation.
5. Upload supporting documentation.
6. Submit the application/attestation.

The log-in process and step-by-step instructions for application, attestation, and information verification are discussed on the following pages.

Menu Flow for Adopting, Implementing, or Upgrading and Meaningful Use

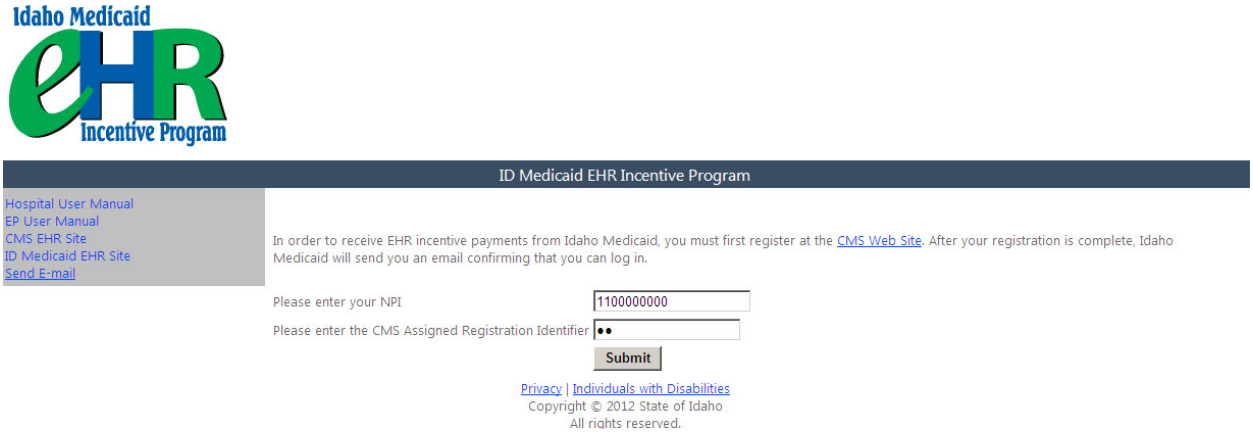
Below is a comparison between the adopting, implementing, or upgrading (AIU) attestation steps and the MU attestation steps. The step-by-step instructions are organized by steps in the attestation process for both types of attestations with specifics for AIU and/or MU.

Adopt, Implement, or Upgrade Steps	Meaningful Use Attestation Steps
1. Review the CMS information	1. Review the CMS information
2. Enter the eligibility details.	2. Enter the eligibility details.
3. Enter the Certified EHR Technology Locations	3. Complete Meaningful Use Questionnaire
4. Review the incentive payment calculation.	4. Review Summary of Menu Options
5. Upload supporting documentation.	5. Complete Meaningful Use Core Questions
6. Submit the application/attestation.	6. Complete Meaningful Use Menu
	7. Complete Core Clinical Quality Measures
	7.1 Complete Alternate Core Clinical Quality Measures
	8. Complete Additional Clinical Quality Measures
	9. Review Summary of Measures
	10. Review the incentive payment calculation.
	11. Upload supporting documentation.
	12. Submit the application/attestation.

Logging Into the IIMS

Begin the Idaho Medicaid EHR Incentive Program application and attestation process by accessing the IIMS at https://IIMS.dhw.idaho.gov.

The following page is displayed:



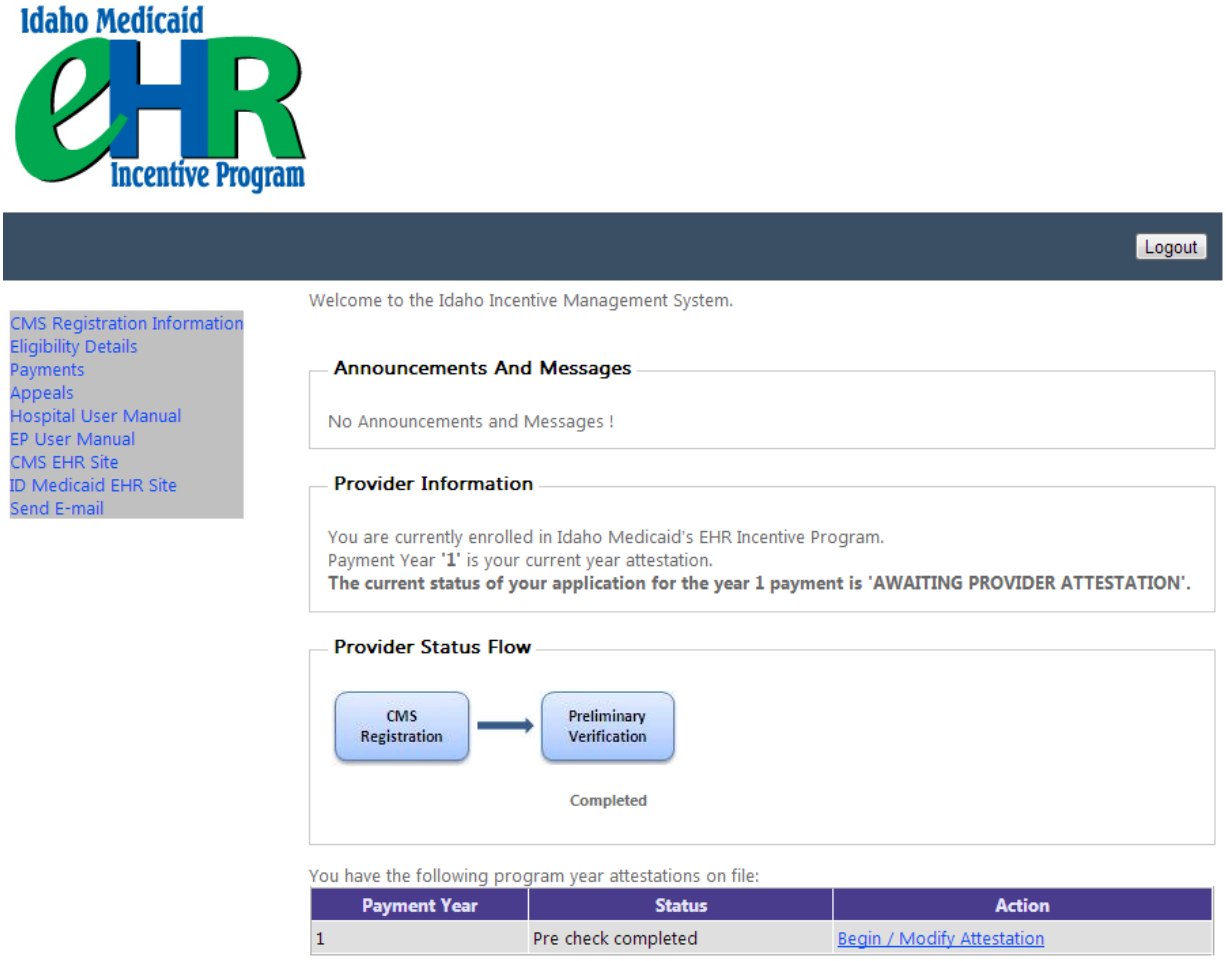
When this page appears:

- Enter the NPI used when registering at the CMS EHR Incentive Program site and the 10 digit CMS-assigned Registration ID Number. If the data entered here does not match the NPI or the CMS-assigned Registration ID Number on file, the message "Invalid NPI/Registration ID combination" will be displayed.
- If you do not remember your CMS-assigned Registration Identification Number, you must return to the Medicare & Medicaid EHR Incentive Program Registration and Attestation System to reference it. If you cannot remember your password to the CMS site, contact the PECOS Help Desk at (866) 484-8049 or visit https://pecos.cms.hhs.gov for assistance.
- Select "Submit" to log in and proceed to the Idaho Medicaid AIU landing page.

Adopt, Implement, or Upgrade Attestation

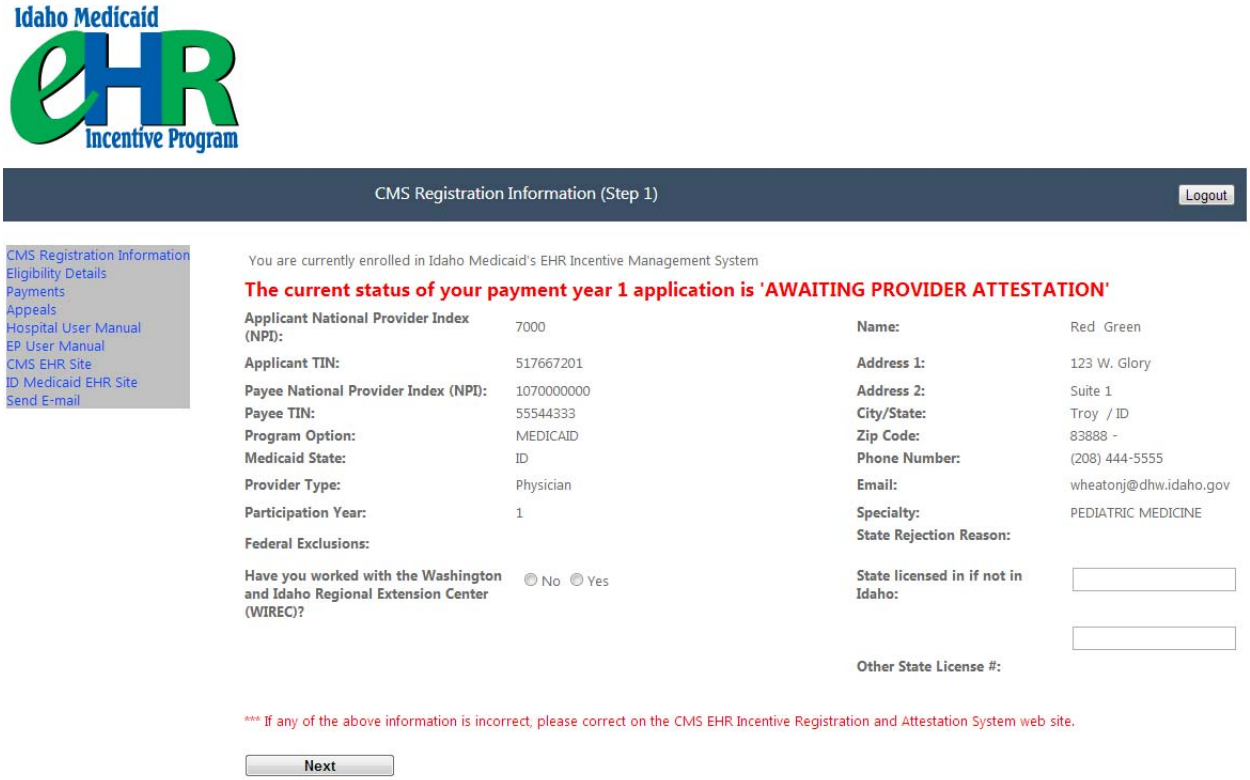
Adopt, Implement, or Upgrade Landing Page

After logging on, you will see the AIU landing page (see graphic below). The current status of the payment year will be displayed in the "Provider Status Flow" section of the page.



To start the attestation process, you must select "Begin/Modify Attestation" and it will bring you to the CMS Registration Information page.

CMS Registration Information (AIU Step 1)

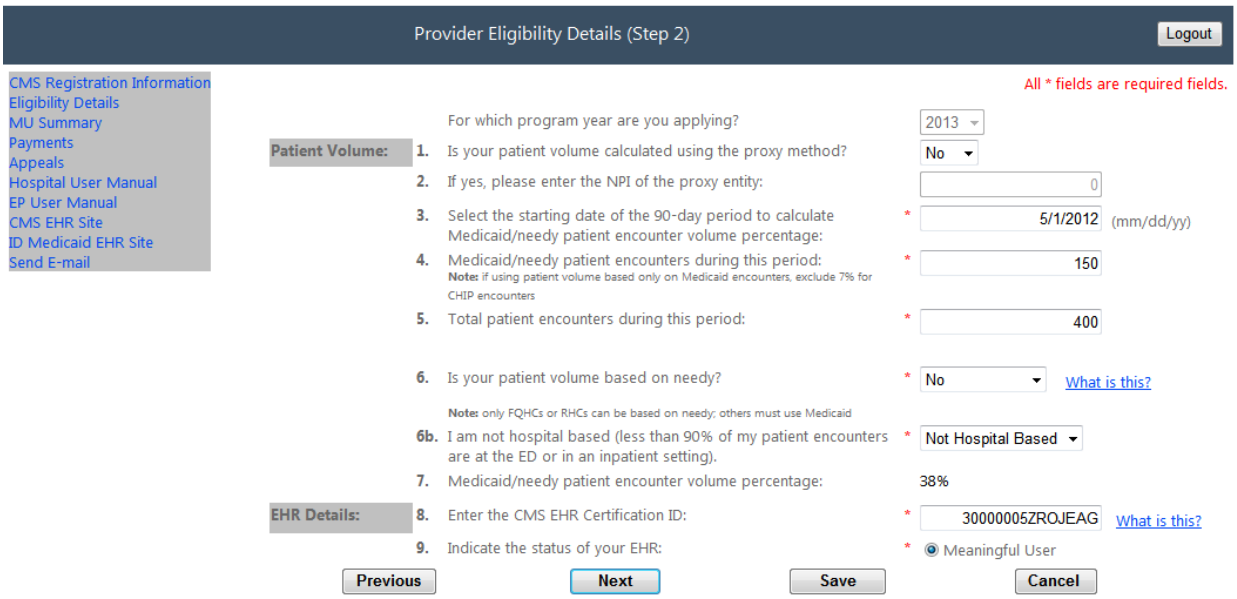


Some of the information on this page is for review only, but some information you'll need to provide. When this page appears:

- Review this information carefully. This information is populated directly from your CMS registration information. You cannot update the existing demographic information on this page. If you need to make updates to the demographic information, return to the CMS website and make your changes. Once you have completed your update on the CMS website, your information will again be sent to Idaho and this page will be updated. Please allow 24 hours for the update to be received by Idaho.
- **Important Note:** As you make your changes at the CMS website, make sure you go through the screens, selecting "Save" and "Continue", until you get to the Verify Registration page and select "Submit". **Unless you select "Submit", your updated data will not be sent to Idaho, your status will be set to "In Progress at CMS" and your payment will likely be delayed.**
- Select either "Yes" or "No" to answer the question, "Have you worked with WIREC?"
  Note: An answer is required.
- If you're licensed in Idaho, skip to step #4; if you are **NOT** licensed in Idaho:
  - Type the name of the state where you are licensed in the "State licensed in if not in Idaho" field (if you're not licensed in the state of Idaho, an answer is required).
  - Type the license number in the "Other State License" field (if you're not licensed in Idaho, an answer is required).
- Select "Next" to proceed to the Provider Eligibility Details page.

Provider Eligibility Details (AIU Step 2)

A graphic of the Provider Eligibility Details page is shown below. Use the step-by-step instructions below to complete this page.



Program Year:

Select the program year. This selection is only available if the current date is between January 1 and the end of February. This allows you to choose the previous program year during the two month period where it is allowed to attest for either program year. After the end of February, the program year will be defaulted to the current calendar year, which will be equal to the current active program year.

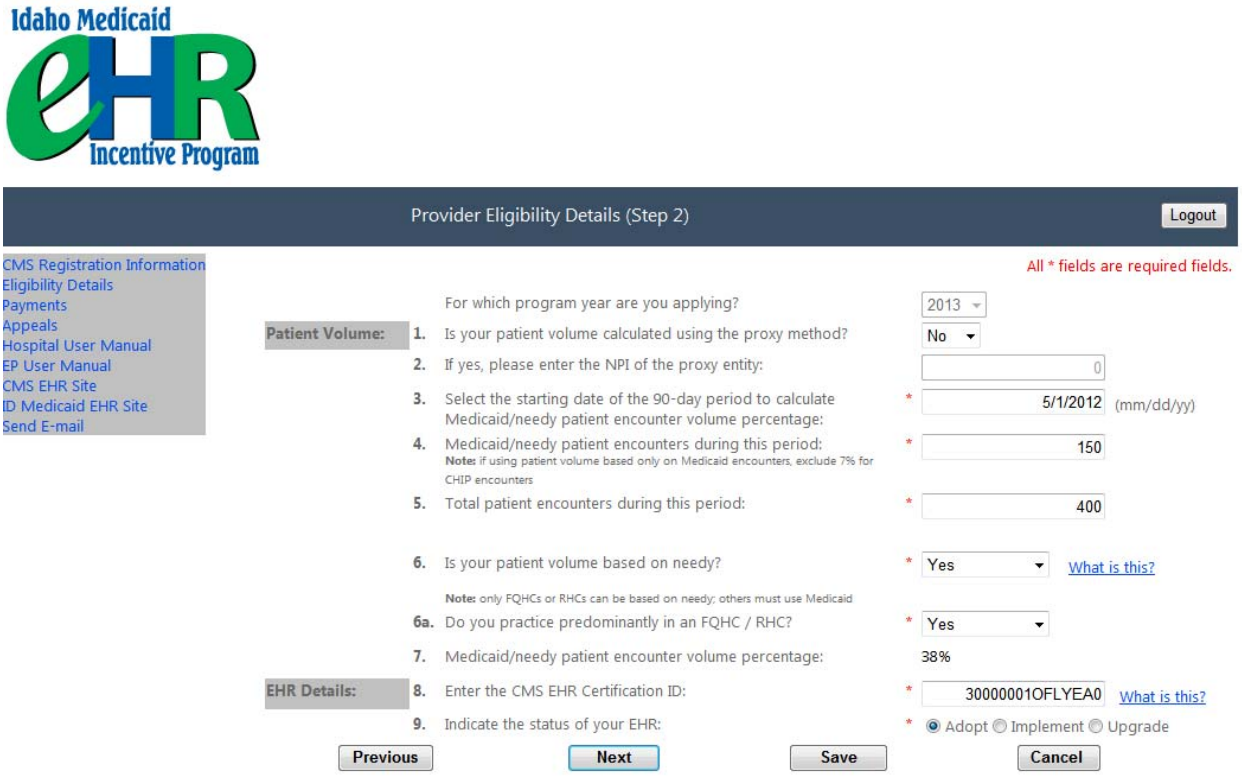
Patient Volume:

1. Select "Yes" or "No" from the drop down menu to indicate if your patient volume was calculated using the group proxy method.
2. If you answered "Yes", enter the NPI of the proxy entity (Idaho Medicaid will verify the NPI). If you entered "No", skip to question #3.
3. Select the starting date of the 90-day period to calculate the Medicaid/needy patient encounter volume percentage. If you do not enter a valid date, you will not be allowed to continue with attestation.
   Note: The date must be a valid date within the previous calendar year to 90 days before the current date (January 1 to 90 days before the current date). This accommodates the EP's choice of using the previous calendar year or the most recent 12 months for the 90-day patient volume period.

4. Enter the Medicaid/needy patient encounters during this period.
   Note: If using patient volume based only on Medicaid encounters, exclude seven percent for CHIP encounters. If you are basing patient volume on needy, disregard the exclusion of CHIP encounters. The following is an example for excluding CHIP encounters for patient volumes based on Medicaid:
   - Total Medicaid encounters = 120
   - Calculated CHIP amount based on seven percent state average: 8.4 and round to the nearest whole number 8
   - Net Medicaid encounters: 120 - 8 = 112
   - Result: use 112 for the Medicaid patient encounters
5. Enter the number of total patient encounters during this period.
6. *There are two options for this question. Please read both options before completing this question.*

   Option #1: If you are basing your patient volume on needy encounters, select "Yes" from the drop down menu and answer question 6a when it appears (see graphic below). **Only FQHCs or RHCs can be based on needy; others must use Medicaid encounters.**

   6a. Select "Yes" or "No" from the drop down menu to indicate if you practice predominantly at an FQHC or RHC (see graphic below). If you don't practice predominantly in an FQHC or RHC, you will not be allowed to continue with attestation.



   Option #2: If you are not basing your patient volume on needy encounters, select "No" from the drop down menu and answer question 6b (see graphic below) when it appears.

   6b. Use the drop down menu to indicate if you are **NOT** Hospital Based. If you are hospital based, you will not be allowed to continue with attestation.

Idaho Medicaid eHR Incentive Program

Provider Eligibility Details (Step 2) Logout

CMS Registration Information
Eligibility Details
Payments
Appeals
Hospital User Manual
EP User Manual
CMS EHR Site
ID Medicaid EHR Site
Send E-mail

All * fields are required fields.

For which program year are you applying? 2013

Patient Volume:

1. Is your patient volume calculated using the proxy method? No
2. If yes, please enter the NPI of the proxy entity: 0
3. Select the starting date of the 90-day period to calculate Medicaid/needy patient encounter volume percentage: * 5/1/2012 (mm/dd/yy)
4. Medicaid/needy patient encounters during this period: * 150
   Note: if using patient volume based only on Medicaid encounters, exclude 7% for CHIP encounters
5. Total patient encounters during this period: * 400
6. Is your patient volume based on needy? * No What is this?
   Note: only FQHCs or RHCs can be based on needy; others must use Medicaid
6b. I am not hospital based (less than 90% of my patient encounters are at the ED or in an inpatient setting). * Not Hospital Based
7. Medicaid/needy patient encounter volume percentage: 38%

EHR Details:

8. Enter the CMS EHR Certification ID: * 30000001OFLYEA0 What is this?
9. Indicate the status of your EHR: * Adopt Implement Upgrade

Previous Next Save Cancel

---

7. Medicaid/needy patient volume percentage (calculated).
   Note: When items #4 and #5 are entered and the cursor is moved to the next entry, the patient volume percentage is displayed.

   The following edits with messages apply; if you do not meet these thresholds, you will not be allowed to continue with attestation:

   - If the provider specialty is pediatrics and patient volume is based on Medicaid volumes but is below the 20 percent patient volume threshold, this message will be displayed: "x.xx% - you must meet the threshold of 20% to get an EHR Incentive Payment".
   - For other provider specialties (regardless of how patient volume is based) and those below the 30 percent patient volume threshold, this message will be displayed: "x.xx% - you must meet the threshold of 30% to get an EHR Incentive Payment".

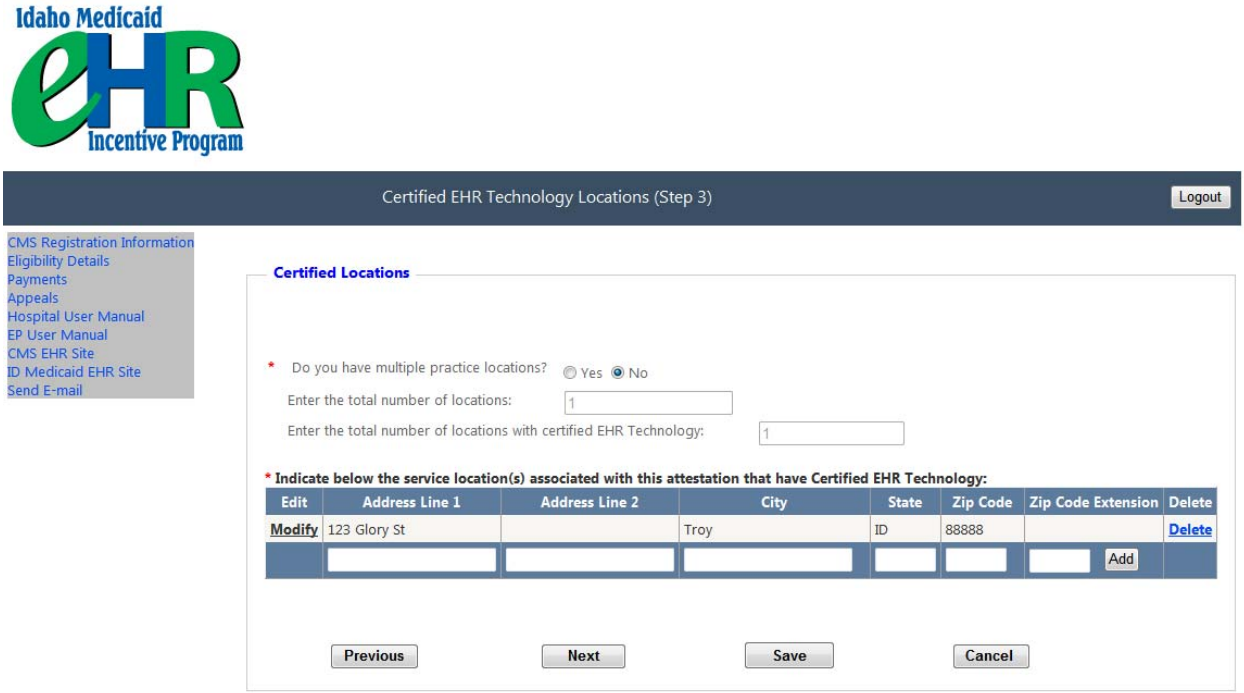
EHR Details:

8. Enter the CMS EHR Certification ID of your EHR: This is your CMS EHR Certification ID, which will be auto-populated from your CMS registration information if it was provided there. If not, the EHR Certification ID must be input here. Only a valid ID will be allowed for you to continue your attestation.
9. Select the status of your EHR – “Adopt”, “Implement”, or “Upgrade”.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Certified EHR Technology Locations page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel”, you will see blank fields.

Certified EHR Technology Locations (AIU Step 3)



When this page appears:

- Select "Yes" or "No" to indicate if you have multiple practice locations.
- If you selected "Yes", enter the total number of locations (if you selected "No", the box will auto populate the number "1").
- Enter the total number of the locations indicated that have adopted, implemented, or upgraded to certified EHR technology.
- Use the table provided to fill in the address, city, state, and ZIP code for each service location indicated. **Note:** You may modify or delete your entries.

You will receive an error message if:

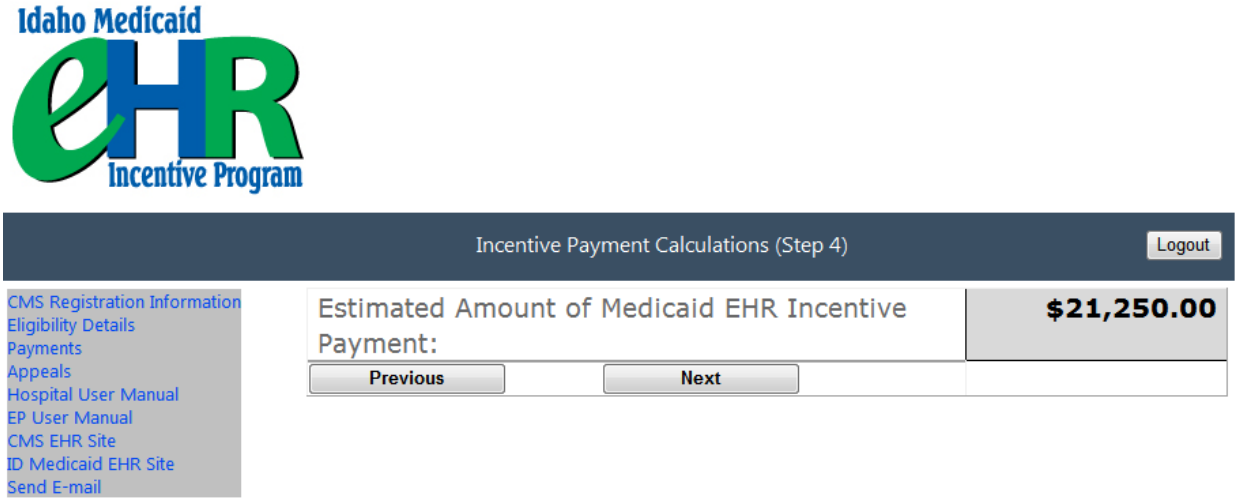
- You select "Yes" to indicate that you have multiple practice locations but leave **any** of the other fields blank (if you select "Yes", all fields on this page are required).
- The total number of locations with certified EHR technology is greater than the total number of service locations entered.
- The number of service locations that have certified EHR technology (the number entered in the second box) is different from the number of location addresses entered in the table (e.g., if you indicate that you have 5 service locations with certified EHR technology, you must enter 5 physical addresses into the table).

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.

- “Next” - Will save your entries and take you to the Incentive Payment Calculations page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel”, you will see blank fields.

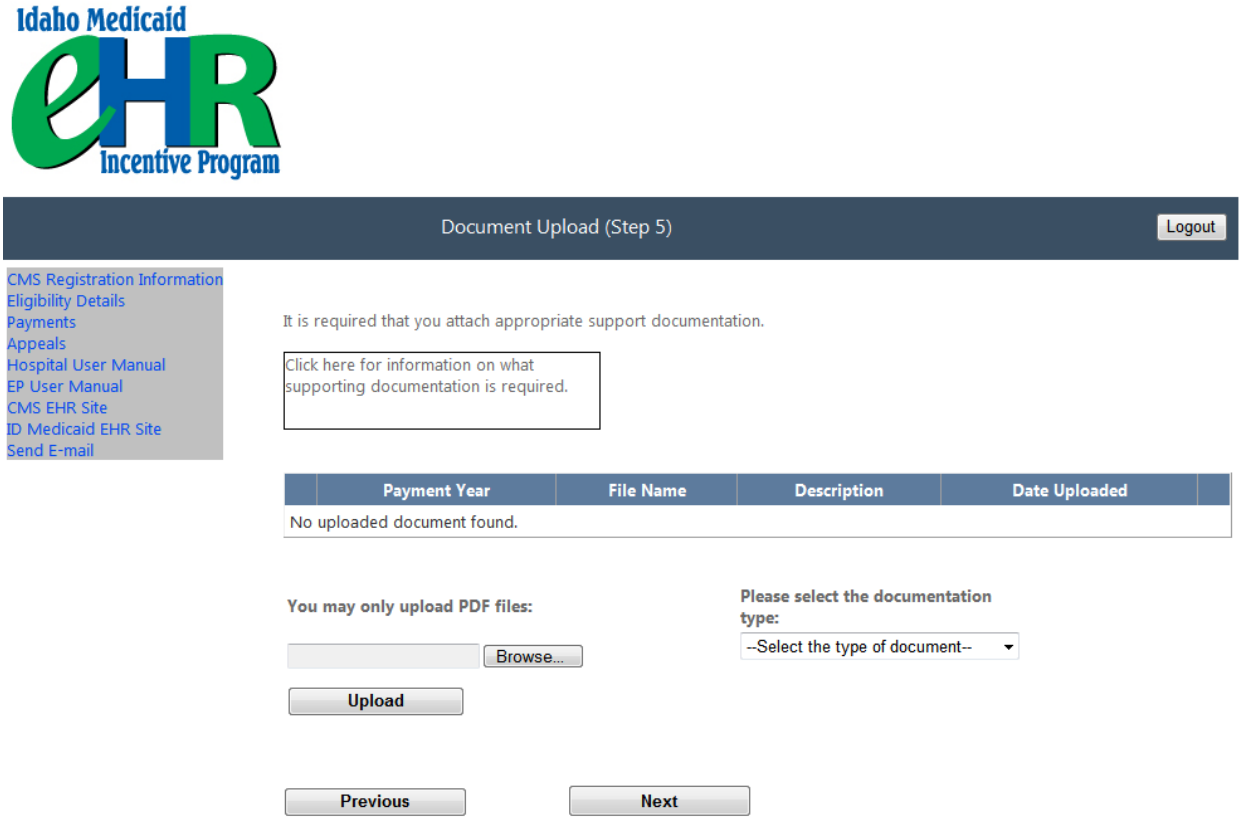
Incentive Payment Calculations (AIU Step 4)



When this page appears:

- Review the incentive payment amount and contact the Idaho Medicaid EHR Incentive Program Help Desk at EHRincentives@dhw.idaho.gov or (208) 332-7989 if you have questions.
- If you see a $0 estimated amount of Medicaid EHR incentive payment, you may not have met eligibility requirements; click on the "Previous" button, which will take you back to the Provider Eligibility Details page, and check your responses to the questions. If you have questions, contact the Idaho Medicaid EHR Incentive Help Desk.
- If your payment amount looks correct, select "Next" to go to the Document Upload page.

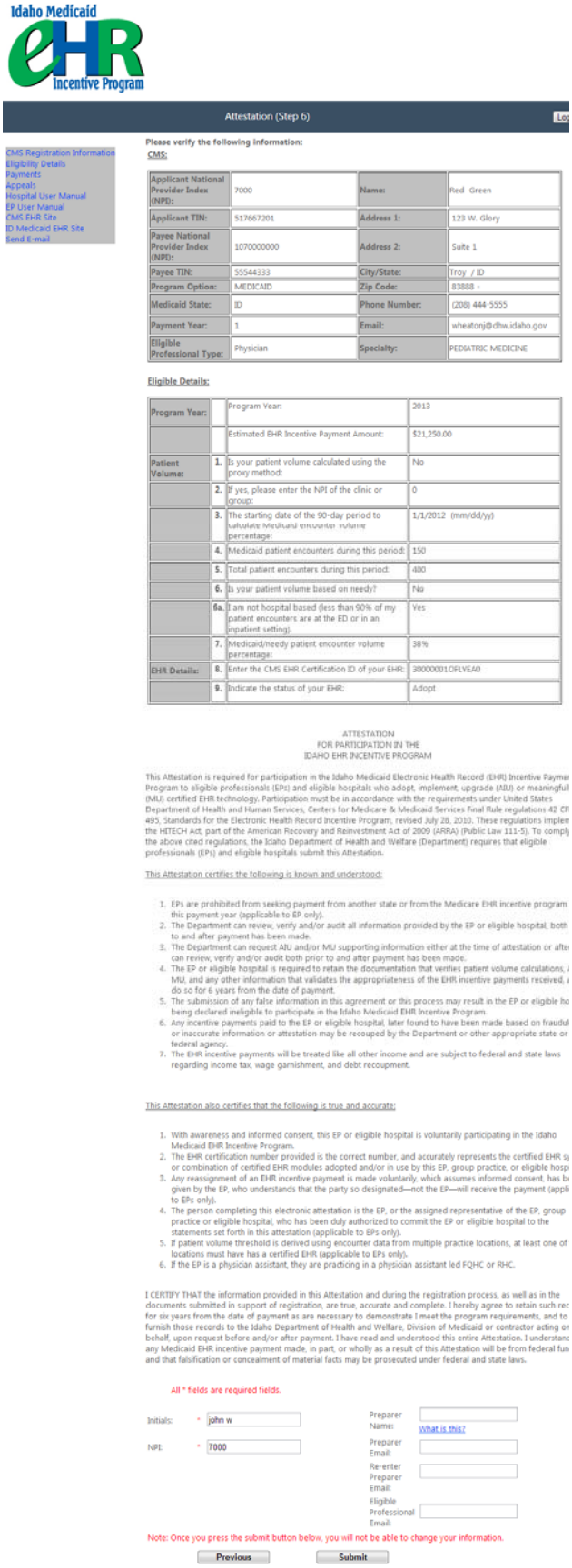
Document Upload (AIU Step 5)



When this page appears:

- You may not have to do anything. Medicaid should have all the pertinent information to support your attestation; however, you may be instructed to upload additional documentation.
  Note: Only PDF files can be uploaded.
- You will still be able to upload files even after you have completed your attestation.
- Selecting "Next" will take you to the Attestation page of the IIMS.

Attestation (AIU Step 6)



Idaho Medicaid eHR Incentive Program

Attestation (Step 6)

CMS Registration Information
Eligibility Details
Payments
Appeals
Hospital User Manual
EP User Manual
CMS EHR Site
ID Medicaid EHR Site
Send E-mail

Please verify the following information:

CMS:

Applicant National Provider Index (NPI):	7000	Name:	Red Green
Applicant TIN:	517667201	Address 1:	123 W. Glory
Payee National Provider Index (NPI):	1070000000	Address 2:	Suite 1
Payee TIN:	555544333	City/State:	Troy / ID
Program Option:	MEDICAID	Zip Code:	83888 -
Medicaid State:	ID	Phone Number:	(208) 444-5555
Payment Year:	1	Email:	wheatonj@dhw.idaho.gov
Eligible Professional Type:	Physician	Specialty:	PEDIATRIC MEDICINE

Eligible Details:

Program Year:		Program Year:	2013
		Estimated EHR Incentive Payment Amount:	$21,250.00
Patient Volume:	1.	Is your patient volume calculated using the proxy method:	No
	2.	If yes, please enter the NPI of the clinic or group:	0
	3.	The starting date of the 90-day period to calculate Medicaid encounter volume percentage:	1/1/2012 (mm/dd/yy)
	4.	Medicaid patient encounters during this period:	150
	5.	Total patient encounters during this period:	400
	6.	Is your patient volume based on needy?	No
	6a.	I am not hospital based (less than 90% of my patient encounters are at the ED or in an inpatient setting).	Yes
	7.	Medicaid/needy patient encounter volume percentage:	38%
EHR Details:	8.	Enter the CMS EHR Certification ID of your EHR:	30000001OFLYEA0
	9.	Indicate the status of your EHR:	Adopt

ATTESTATION
FOR PARTICIPATION IN THE
IDAHO EHR INCENTIVE PROGRAM

This Attestation is required for participation in the Idaho Medicaid Electronic Health Record (EHR) Incentive Payme Program to eligible professionals (EPs) and eligible hospitals who adopt, implement, upgrade (AIU) or meaningful (MU) certified EHR technology. Participation must be in accordance with the requirements under United States Department of Health and Human Services, Centers for Medicare & Medicaid Services Final Rule regulations 42 CF 495, Standards for the Electronic Health Record Incentive Program, revised July 28, 2010. These regulations implem the HITECH Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5). To compl the above cited regulations, the Idaho Department of Health and Welfare (Department) requires that eligible professionals (EPs) and eligible hospitals submit this Attestation.

This Attestation certifies the following is known and understood:

1. EPs are prohibited from seeking payment from another state or from the Medicare EHR incentive program this payment year (applicable to EP only).
2. The Department can review, verify and/or audit all information provided by the EP or eligible hospital, both to and after payment has been made.
3. The Department can request AIU and/or MU supporting information either at the time of attestation or afte can review, verify and/or audit both prior to and after payment has been made.
4. The EP or eligible hospital is required to retain the documentation that verifies patient volume calculations, MU, and any other information that validates the appropriateness of the EHR incentive payments received, do so for 6 years from the date of payment.
5. The submission of any false information in this agreement or this process may result in the EP or eligible ho being declared ineligible to participate in the Idaho Medicaid EHR Incentive Program.
6. Any incentive payments paid to the EP or eligible hospital, later found to have been made based on fraudul or inaccurate information or attestation may be recouped by the Department or other appropriate state or federal agency.
7. The EHR incentive payments will be treated like all other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment.

This Attestation also certifies that the following is true and accurate:

1. With awareness and informed consent, this EP or eligible hospital is voluntarily participating in the Idaho Medicaid EHR Incentive Program.
2. The EHR certification number provided is the correct number, and accurately represents the certified EHR s or combination of certified EHR modules adopted and/or in use by this EP, group practice, or eligible hosp
3. Any reassignment of an EHR incentive payment is made voluntarily, which assumes informed consent, has b given by the EP, who understands that the party so designated—not the EP—will receive the payment (appli to EPs only).
4. The person completing this electronic attestation is the EP, or the assigned representative of the EP, group practice or eligible hospital, who has been duly authorized to commit the EP or eligible hospital to the statements set forth in this attestation (applicable to EPs only).
5. If patient volume threshold is derived using encounter data from multiple practice locations, at least one of locations must have has a certified EHR (applicable to EPs only).
6. If the EP is a physician assistant, they are practicing in a physician assistant led FQHC or RHC.

I CERTIFY THAT the information provided in this Attestation and during the registration process, as well as in the documents submitted in support of registration, are true, accurate and complete. I hereby agree to retain such rec for six years from the date of payment as are necessary to demonstrate I meet the program requirements, and to furnish those records to the Idaho Department of Health and Welfare, Division of Medicaid or contractor acting o behalf, upon request before and/or after payment. I have read and understood this entire Attestation. I understan any Medicaid EHR incentive payment made, in part, or wholly as a result of this Attestation will be from federal fun and that falsification or concealment of material facts may be prosecuted under federal and state laws.

All * fields are required fields.

Initials: * john w

NPI: * 7000

Preparer Name: What is this?

Preparer Email:

Re-enter Preparer Email:

Eligible Professional Email:

Note: Once you press the submit button below, you will not be able to change your information.

Previous Submit

Required:

- Enter your initials or name and the provider's NPI at the bottom of the screen.
  - This will serve as your electronic signature.
  - By entering this information, you attest to the validity of all data submitted for consideration by the Idaho Medicaid EHR Incentive Program.
- Select "Submit".
  Important: After you select "Submit", **YOU CANNOT GO BACK AND MAKE ANY CHANGES.**
  - Once you select "Submit", it will take you to the first page of your attestation, CMS Registration Information (Step 1), to review. You can select "Previous" and "Next" to view the attestation pages in a review mode only.
  - Selecting "Submit" will notify Idaho Medicaid that the provider's attestation is ready for final eligibility review.

The attestation text is shown here:

ATTESTATION

FOR PARTICIPATION IN THE

IDAHO MEDICAID EHR INCENTIVE PROGRAM

This Attestation is required for participation in the Idaho Medicaid Electronic Health Record (EHR) Incentive Payment Program to eligible professionals (EPs) and eligible hospitals who adopt, implement, upgrade (AIU), or meaningfully use (MU) certified EHR technology. Participation must be in accordance with the requirements under United States Department of Health and Human Services, Centers for Medicare & Medicaid Services Final Rule regulations 42 CFR 495, "Standards for the Electronic Health Record Incentive Program", revised July 28, 2010. These regulations implement the HITECH Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5). To comply with the above cited regulations, the Idaho Department of Health and Welfare (Department) requires that EPs and eligible hospitals submit this Attestation.

This Attestation certifies the following is known and understood:

1. EPs are prohibited from seeking payment from another state or from the Medicare EHR incentive program in this payment year (applicable to EP only).
2. The Department can review, verify, and/or audit all information provided by the EP or eligible hospital, both prior to and after payment has been made.
3. The Department can request AIU and/or MU supporting information either at the time of attestation or after, and can review, verify, and/or audit both prior to and after payment has been made.
4. The EP or eligible hospital is required to retain the documentation that verifies patient volume calculations, AIU, MU, and any other information that validates the appropriateness of the EHR incentive payments received, and do so for six years from the date of payment.
5. The submission of any false information in this agreement or this process may result in the EP or eligible hospital being declared ineligible to participate in the Idaho Medicaid EHR Incentive Program.
6. Any incentive payments paid to the EP or eligible hospital that are later found to have been made based on fraudulent or inaccurate information or attestation may be recouped by the Department or other appropriate state or federal agency.
7. The EHR incentive payments will be treated like all other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment.

This Attestation also certifies that the following is true and accurate:

1. With awareness and informed consent, this EP or eligible hospital is voluntarily participating in the Idaho Medicaid EHR Incentive Program.
2. The EHR certification number provided is the correct number and accurately represents the certified EHR system or combination of certified EHR modules adopted and/or in use by this EP, group practice, or eligible hospital.
3. Any reassignment of an EHR incentive payment is made voluntarily, which assumes informed consent has been given by the EP, who understands that the party so designated—not the EP—will receive the payment (applicable to EPs only).
4. The person completing this electronic attestation is the EP or the assigned representative of the EP, group practice, or eligible hospital who has been duly authorized to commit the EP or eligible hospital to the statements set forth in this attestation (applicable to EPs only).
5. If patient volume threshold is derived using encounter data from multiple practice locations, at least one of those locations must have a certified EHR (applicable to EPs only).
6. If the EP is a physician assistant, he or she is practicing in a physician assistant led FQHC or RHC.

I CERTIFY THAT the information provided in this Attestation and during the registration process, as well as in the documents submitted in support of registration, are true, accurate, and complete. I hereby agree to retain such records for six years from the date of payment as are necessary to demonstrate I meet the program requirements, and to furnish those records to the Idaho Department of Health and Welfare, Division of Medicaid, or contractor acting on their behalf, upon request, before and/or after payment. I have read and understood this entire Attestation. I understand that any Medicaid EHR incentive payment made, in part or wholly as a result of this Attestation, will be from federal funds and that falsification or concealment of material facts may be prosecuted under federal and state laws.

Meaningful Use Attestation

The documentation that follows provides screen shots of what the IIMS requires EPs to do in order to complete the MU attestation.

Helpful Tips:

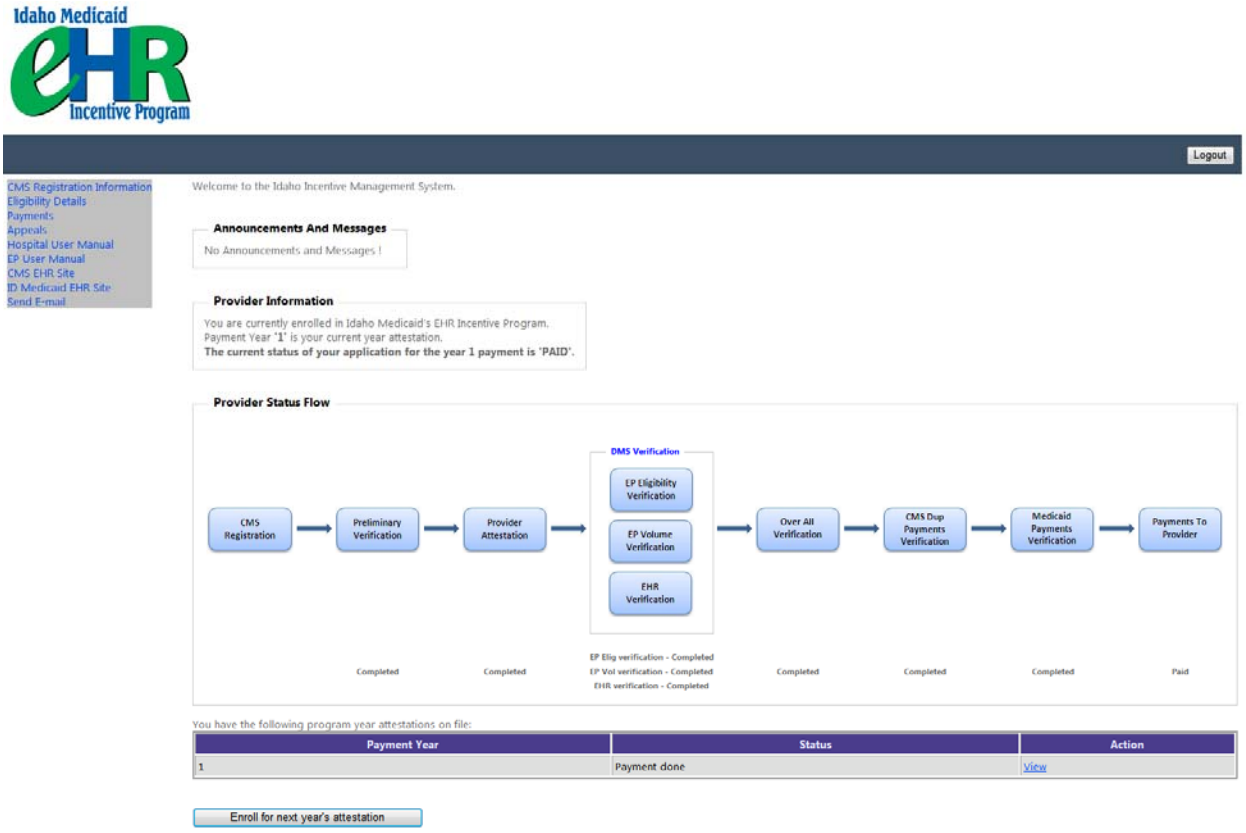
- Make sure your numbers are accurately entered when you attest.
- Keep your supporting documentation.
- Know that dated screen shots provide a good source of documentation.
- Save paper or electronic copies of reports used to attest if the practice's EHR automatically changes numerator and denominator values after the reporting period ends.
- Turn on, for the entire reporting period, EHR features that track functionality issues such as drug interaction checks and clinical decision support.
- Understand that the security risk analysis must be specific to the EHR and the practice and that it is required every year.

Meaningful Use Landing Page

After logging on, you will see the MU landing page (see graphic below). The current status of the payment year will be displayed in the "Provider Status Flow" section of the page.

You will see one of the following on the bottom of this page:

- The "Enroll for next year's attestation" button – You will see this if you are already enrolled with the Idaho Medicaid EHR Incentive Program and have received a payment in the past (see graphic below).
- The "Begin/Modify Attestation" button under the "Action" column of the table shown – You will see this link if you have never received a payment from the Idaho Medicaid EHR Incentive Program and your payment year is at least Year 2. This indicates that you are a new registrant to the Idaho Medicaid EHR Incentive Program and your CMS registration information has been reviewed by Idaho Medicaid.



To enroll for the next year's attestation:

- Select the "Enroll for next year's attestation" button on the bottom of the page - the page will refresh and you will see a new payment year added to the table displayed (see graphic below).

Idaho Medicaid eHR Incentive Program

Logout

CMS Registration Information
Eligibility Details
Payments
Appeals
Hospital User Manual
EP User Manual
CMS EHR Site
ID Medicaid EHR Site
Send E-mail

Welcome to the Idaho Incentive Management System.

Announcements And Messages

No Announcements and Messages !

Provider Information

You are currently enrolled in Idaho Medicaid's EHR Incentive Program.
Payment Year **'2'** is your current year attestation.
The current status of your application for the year 2 payment is 'AWAITING PROVIDER ATTESTATION'.

Provider Status Flow

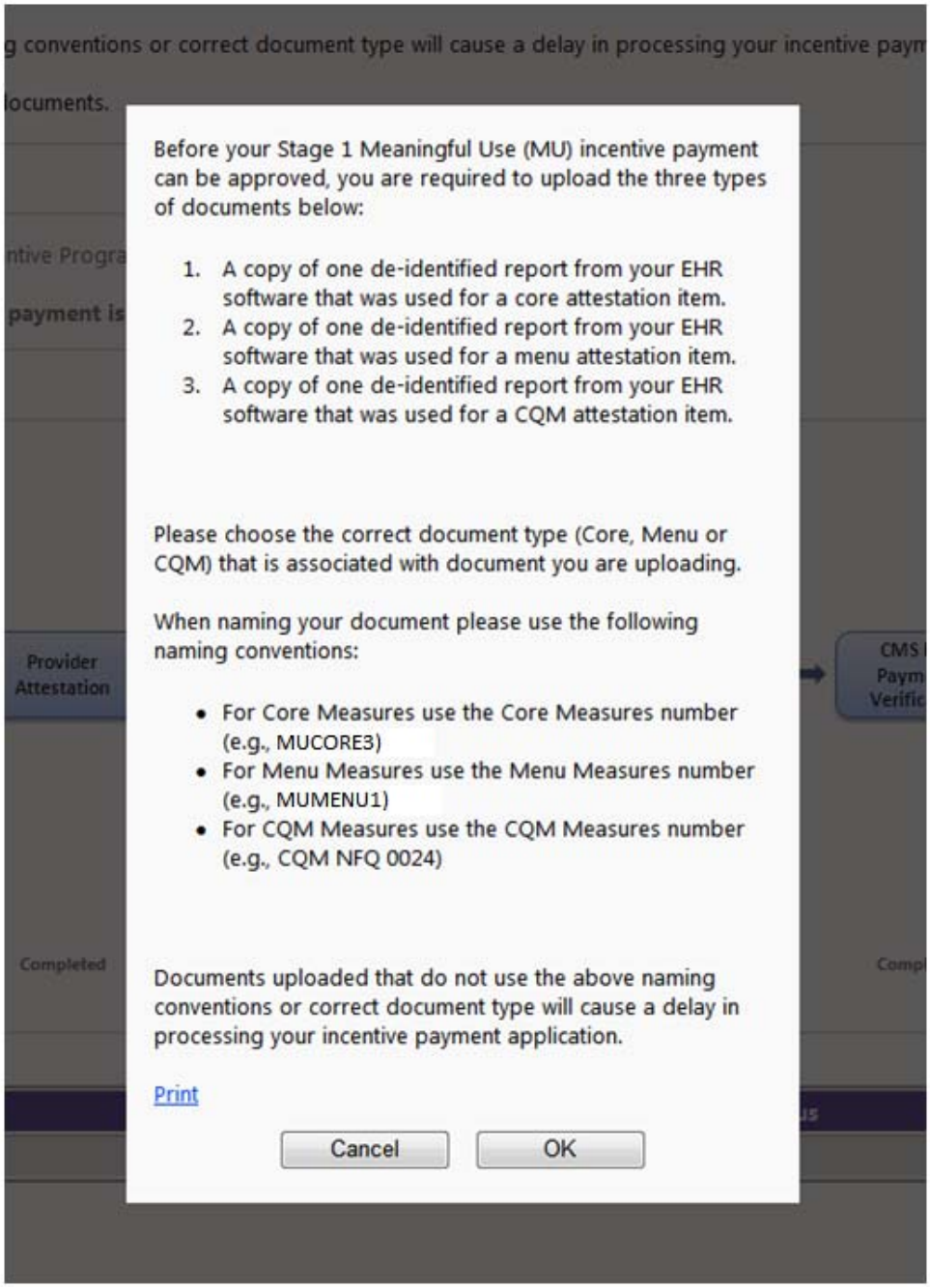
CMS Registration → Preliminary Verification → Provider Attestation

Completed In Process

You have the following program year attestations on file:

Payment Year	Status	Action
2	Attestation in process	Begin / Modify Attestation
1	Payment done	View

- Select the "Begin/Modify Attestation" button – a new window will be displayed (see graphic below).

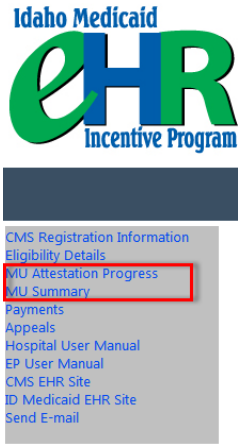


This is a message to all EPs that are attesting for payment year 2 and beyond. When this window appears, you must select one of the following buttons from the bottom of the screen:

- "Print" - will bring up a separate browser window where the window contents can be printed.
- "Cancel" - will close the window and return you to the previous page without enrolling you in the next year.
- "OK" - will close the window, enroll you for the next year's attestation, and take you to the CMS Registration Information Page.

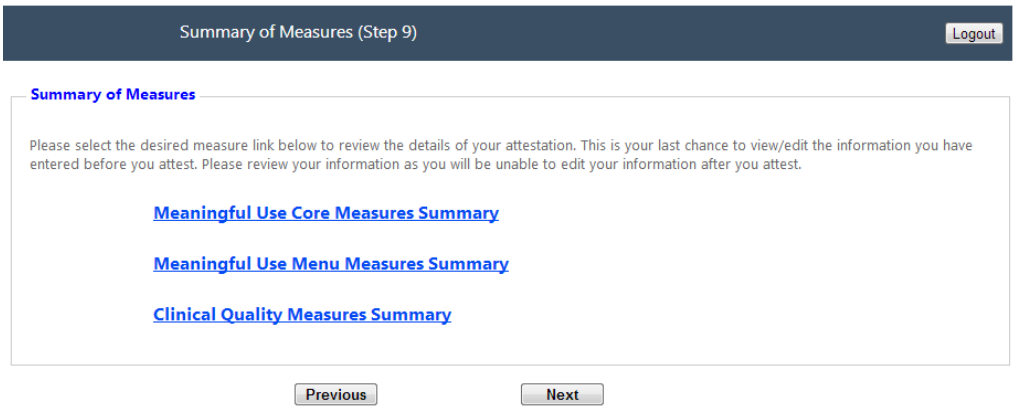
Important Note: Now that you have selected the "Begin/Modify Attestation" button, the following two links should appear on the left side menu to help you quickly access MU pages and resume attestation:

- "MU Attestation Progress" link – will take you to the Summary of Menu Options page for MU (Step 4)
- "MU Summary" link – will take you to the Summary of Measures page for MU (Step 9)

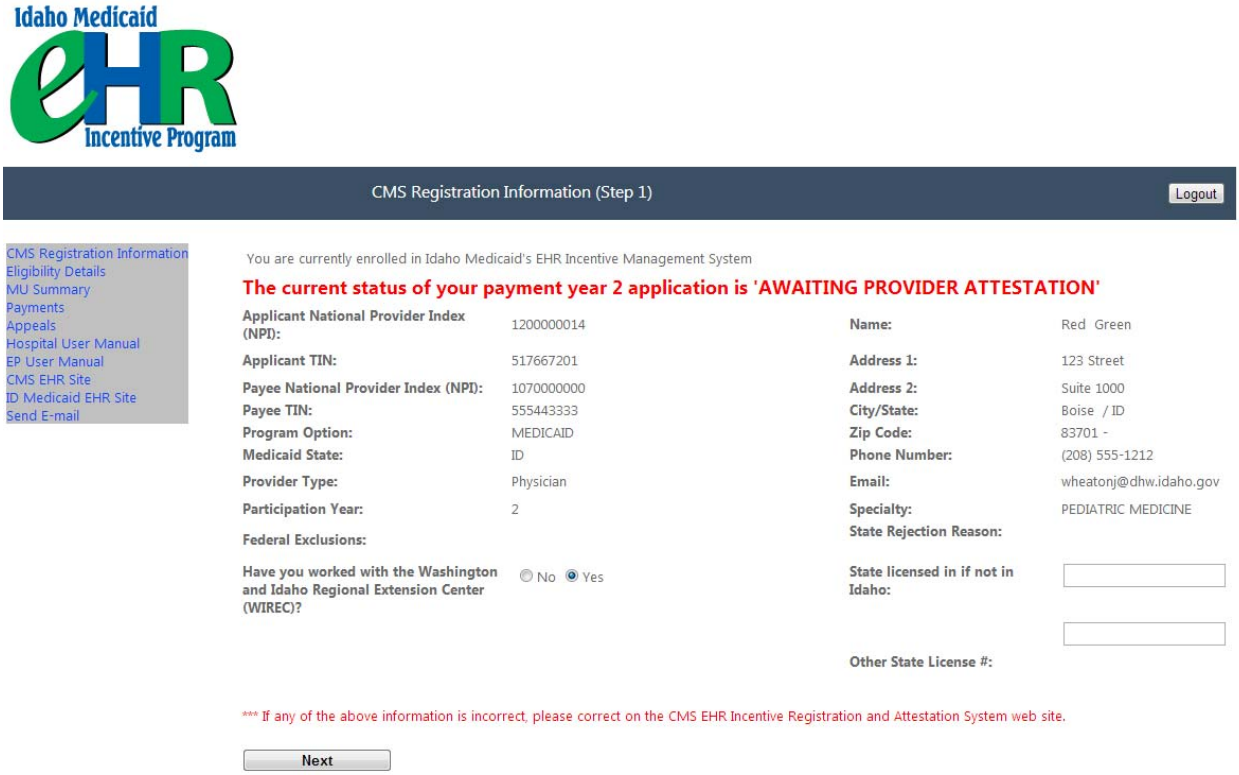


Selecting the "MU Attestation Progress" link shown above will take you to this page:

Selecting the "MU Summary" link shown above will take you to this page:



CMS Registration Information (MU Step 1)



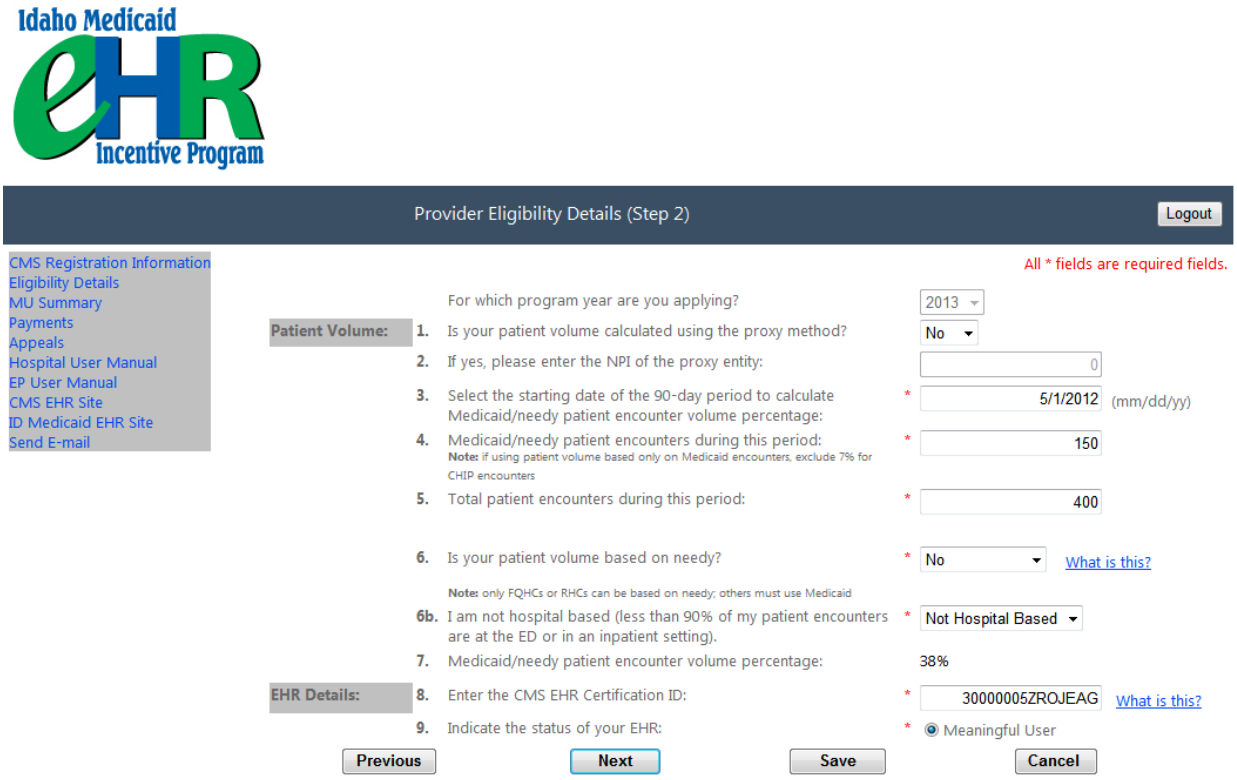
Some of the information on this page is for review only, but some information you'll need to provide.

When this page appears:

- Review this information carefully. This information is populated directly from your CMS registration information. You cannot update the existing demographic information on this page. If you need to make updates to the demographic information, return to the CMS website and make your changes. Once you have completed your update on the CMS website, your information will again be sent to Idaho and this page will be updated. Please allow 24 hours for the update to be received by Idaho.
- **Important Note:** As you make your changes at the CMS website, make sure you go through the screens, selecting "Save" and "Continue", until you get to the Verify Registration page and select "Submit". **Unless you select "Submit", your updated data will not be sent to Idaho, your status will be set to "In Progress at CMS" and your payment will likely be delayed.**
- Select either "Yes" or "No" to answer the question, "Have you worked with WIREC?"
  Note: An answer is required.
- If you're licensed in Idaho, skip to step #4; if you are **NOT** licensed in Idaho:
  - Type the name of the state where you are licensed in the "State licensed in if not in Idaho" field (if you're not licensed in Idaho, an answer is required).
  - Type the license number in the "Other State License" field (if you're not licensed in Idaho, an answer is required).
- Select "Next" to proceed to the Provider Eligibility Details page.

Provider Eligibility Details (MU Step 2)

Use the step-by-step instructions below to complete this page.



Program Year:

Select the program year. This selection is only available if the current date is between January 1 and the end of February. This allows you to choose the previous program year during the two month period where it is allowed to attest for either program year. After the end of February, the program year will be defaulted to the current calendar year, which will be equal to the current active program year.

Patient Volume:

1. Select "Yes" or "No" from the drop down menu to indicate if your patient volume was calculated using the group proxy method.
2. If you answered "Yes", enter the NPI of the proxy entity (Idaho Medicaid will verify the NPI). If you entered "No", skip to question #3.
3. Select the starting date of the 90-day period to calculate the Medicaid/needy patient encounter volume percentage. If you do not enter a valid date, you will not be allowed to continue with attestation.
   Note: The date must be a valid date within the previous calendar year to 90 days before the current date (January 1 to 90 days before the current date). This accommodates the EP's choice of using the previous calendar year or the most recent 12 months for the 90-day patient volume period.
4. Enter the Medicaid/needy patient encounters during this period.

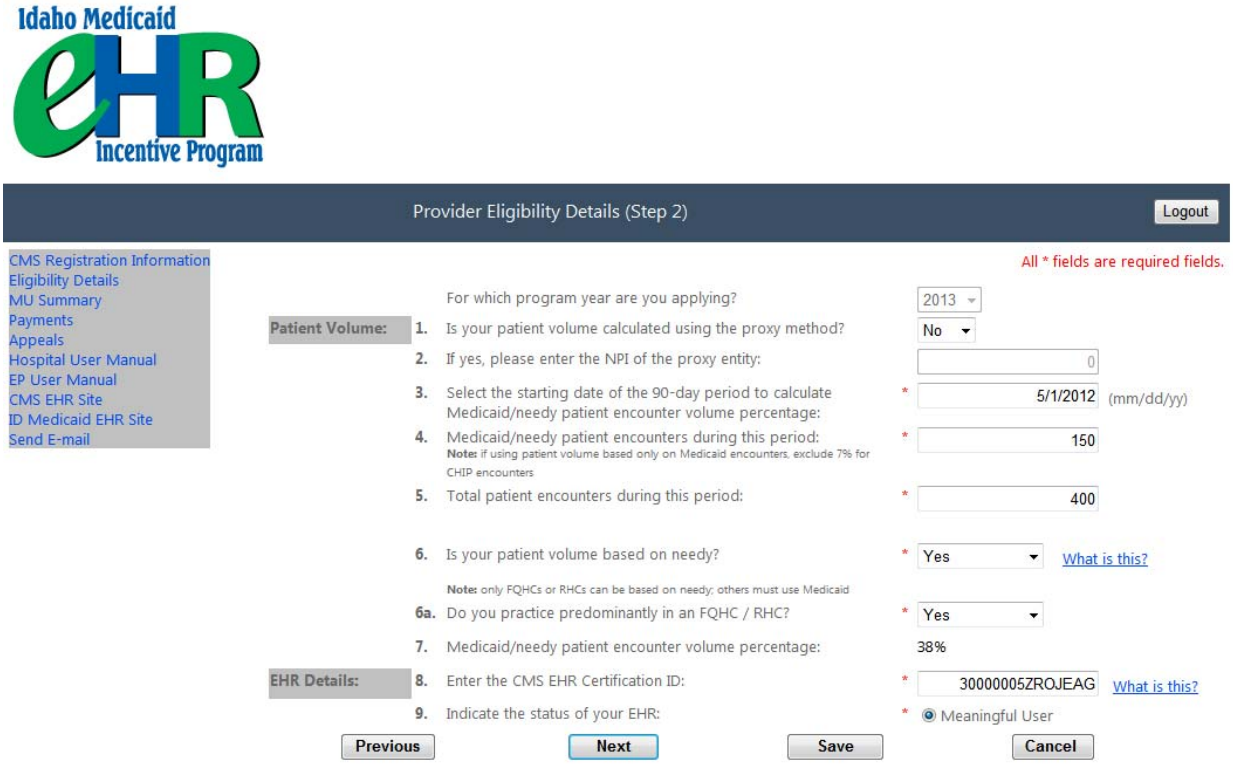
Note: If using patient volume based only on Medicaid encounters, exclude seven percent for CHIP encounters. If you are basing patient volume on needy, disregard the exclusion of CHIP encounters. The following is an example for excluding CHIP encounters for patient volumes based on Medicaid:

- Total Medicaid encounters = 120
- Calculated CHIP amount based on seven percent state average: 8.4 and round to the nearest whole number 8
- Net Medicaid encounters: 120 - 8 = 112
- Result: use 112 for the Medicaid patient encounters

5. Enter the number of total patient encounters during this period.
6. *There are two options for this question. Please read both options before completing this question.*

Option #1: If you are basing your patient volume on needy encounters, select "Yes" from the drop down menu and answer question 6a when it appears (see graphic below). **Only FQHCs or RHCs can be based on needy**; **others must use Medicaid encounters.**

6a. Select "Yes" or "No" from the drop down menu to indicate if you practice predominantly at an FQHC or RHC (see graphic below). If you don't practice predominantly in an FQHC or RHC, you will not be allowed to continue with attestation.



Option #2: If you are not basing your patient volume on needy encounters, select "No" from the drop down menu and answer question 6b (see graphic below) when it appears.

6b. Use the drop down menu to indicate if you are **NOT** hospital based. If you are hospital based, you will not be allowed to continue with attestation.

Idaho Medicaid eHR Incentive Program

Provider Eligibility Details (Step 2) Logout

CMS Registration Information
Eligibility Details
MU Summary
Payments
Appeals
Hospital User Manual
EP User Manual
CMS EHR Site
ID Medicaid EHR Site
Send E-mail

All * fields are required fields.

For which program year are you applying? 2013

Patient Volume:

1. Is your patient volume calculated using the proxy method? No
2. If yes, please enter the NPI of the proxy entity: 0
3. Select the starting date of the 90-day period to calculate Medicaid/needy patient encounter volume percentage: * 5/1/2012 (mm/dd/yy)
4. Medicaid/needy patient encounters during this period: * 150
   Note: if using patient volume based only on Medicaid encounters, exclude 7% for CHIP encounters
5. Total patient encounters during this period: * 400
6. Is your patient volume based on needy? * No What is this?
   Note: only FQHCs or RHCs can be based on needy; others must use Medicaid
6b. I am not hospital based (less than 90% of my patient encounters are at the ED or in an inpatient setting). * Not Hospital Based
7. Medicaid/needy patient encounter volume percentage: 38%

EHR Details:

8. Enter the CMS EHR Certification ID: * 30000005ZROJEAG What is this?
9. Indicate the status of your EHR: * Meaningful User

Previous Next Save Cancel

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7. Medicaid/needy patient volume percentage (calculated).
   Note: When items #4 and #5 are entered and the cursor is moved to the next entry, the patient volume percentage is displayed.

   The following edits with messages apply, if you do not meet these thresholds, you will not be allowed to continue with attestation.

   - If the provider specialty is pediatrics and patient volume is based on Medicaid volumes but is below the 20 percent patient volume threshold, this message will be displayed: "x.xx% - you must meet the threshold of 20% to get an EHR Incentive Payment".
   - For other provider specialties (regardless of how patient volume is based) and those below the 30 percent patient volume threshold, this message will be displayed: "x.xx% - you must meet the threshold of 30% to get an EHR Incentive Payment".

EHR Details:

8. Enter the CMS EHR Certification ID of your EHR:

   This is your CMS EHR Certification ID, which will be auto-populated from your CMS registration information, if it was provided there. If not, the EHR Certification ID must be input here. Only a valid ID will be allowed for you to continue your attestation.

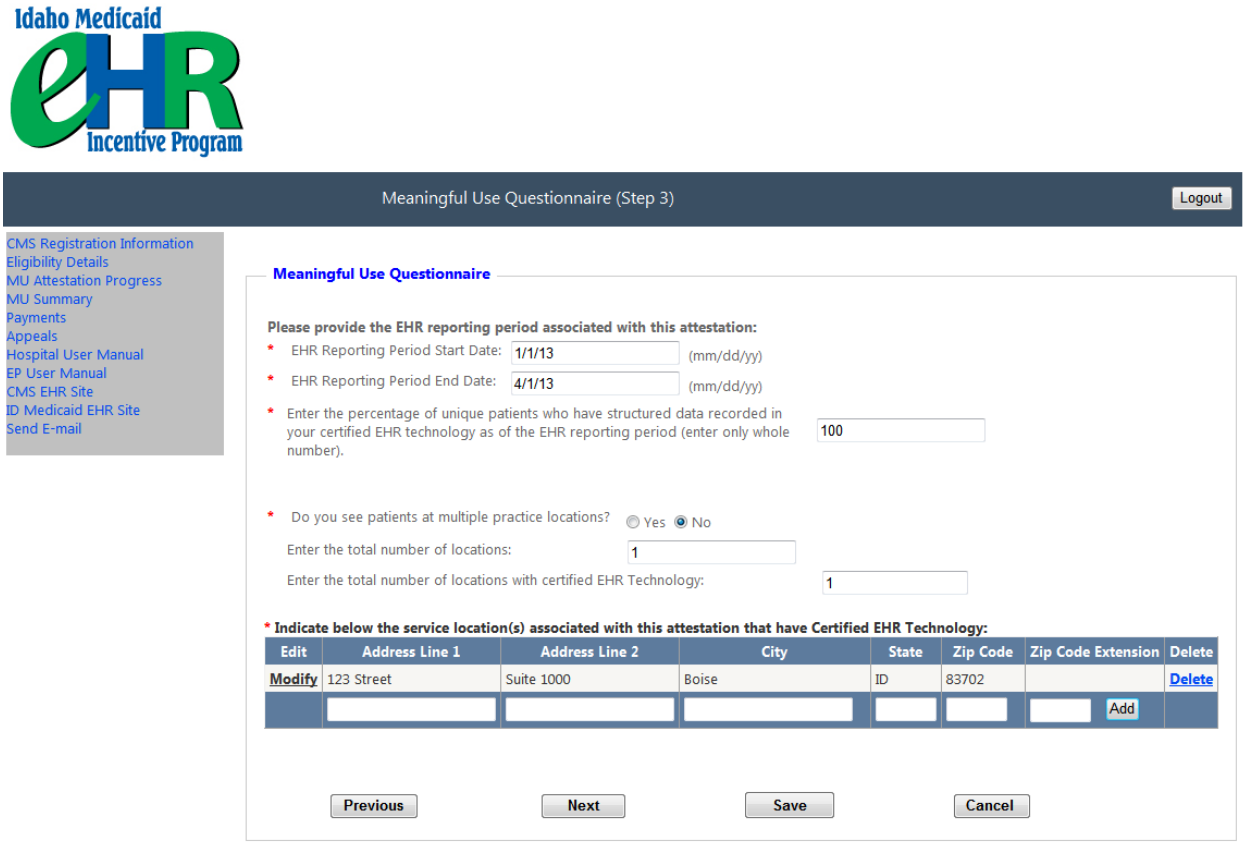
9. Indicate the status of your EHR: Select "Meaningful User".

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Meaningful Use Questionnaire page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Meaningful Use Questionnaire (MU Step 3)

Use the step-by-step directions below to complete this page.
Note: A red asterisk indicates a required field.



EHR Reporting Period:

- Enter the EHR reporting period start date in the following format: MM/DD/YY.
- Enter the EHR reporting period end date in the following format: MM/DD/YY.

You will receive an error message if:

- The reporting period you enter is not a period of at least 90 days.
- The start date is not at least 90 days before the current date.
- The end date is not earlier than the current date.

Percentage of Unique Patients with Structured Data:

- Enter the percentage of unique patients who have structured data recorded in your certified EHR technology as of the EHR reporting period. **Note:** Only enter whole numbers.

You will receive an error message if:

- The number you enter is not a whole number greater than 80 and no greater than 100.

Location Addresses:

- Select “Yes” or “No” to indicate if you have multiple practice locations.
- If you select “Yes”, type the total number of locations (if you select “No”, the box will auto populate the number “1”).
- Enter the total number of locations indicated that have adopted, implemented, or upgraded to certified EHR technology.
- Use the table provided to fill in the address, city, state, and ZIP code for each service location indicated. **Note:** you may modify or delete your entries.

You will receive an error message if:

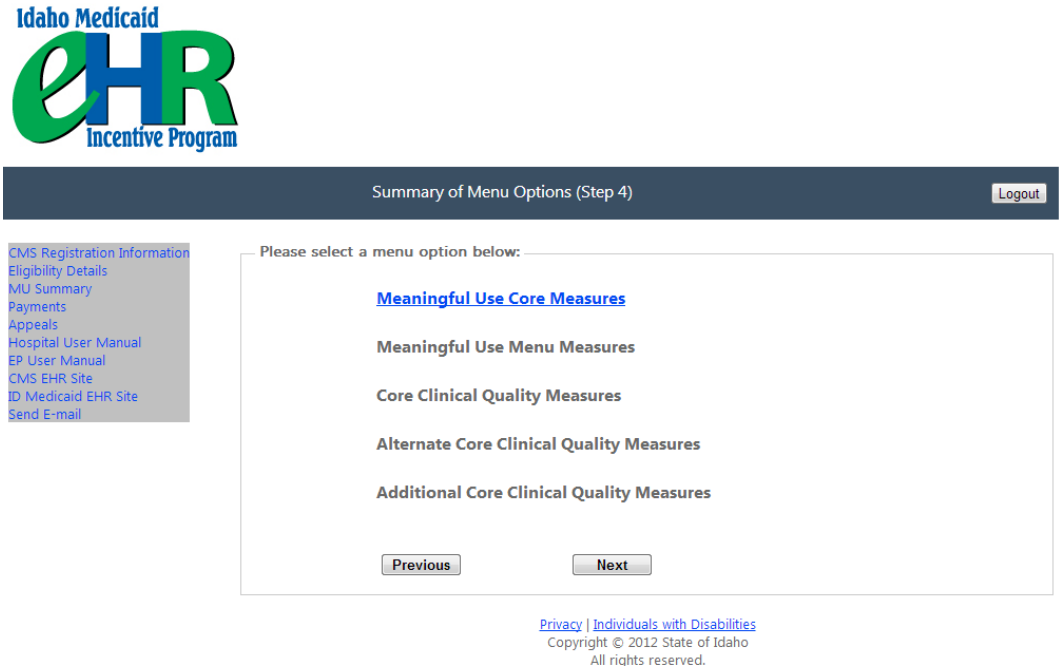
- You select “Yes” to indicate that you have multiple practice locations but leave any of the other fields blank (if you select “Yes”, all fields on this page are required).
- The total number of locations with certified EHR technology is greater than the total number of service locations entered.
- The number of service locations that have certified EHR technology (the number entered in the second box) is different from the number of location addresses typed in the table (e.g., if you indicate that you have 5 service locations with certified EHR technology, you must enter 5 physical addresses into the table).

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Summary of Menu Options page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Summary of Menu Options (MU Step 4)

The Summary of Menu Options page shows the progression through attestation. You can review this page periodically by clicking on the "MU Summary" link on the left side menu. As you progress through the sections the categories on the page will become hyperlinks so you can quickly return to where you left off when you are done reviewing. If "Alternate Core Clinical Quality Measures" do not apply, that category will not become a hyperlink.



When this page appears:

- Select "Next" to proceed to the Meaningful Use Core Measures page.

Meaningful Use Core Measures (MU Step 5)

Use the step-by-step directions below to complete this page.
Note: A red asterisk indicates a required field.

Meaningful Use Core (Step 5) Logout

Questionnaire 1 of 15

(*) Red asterisk indicates a required field.

Objective: Use Computerized Provider Order Entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines. (MUCORE1)

Choose a Measure:

- (●) More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.
- ( ) More than 30 percent of the medication orders created by the EP during the EHR reporting period are recorded using CPOE.

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

- (●) This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- ( ) This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION: Based on All Patient Records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

( ) Yes (●) No

Complete the following information:

Numerator = The number of patients in the denominator that have at least one medication order entered using CPOE.

Denominator = Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Choose a Measure:

Select one of the following two measures shown on the screen:

- "More than 30 percent of all unique patients…"
- "More than 30 percent of the medication orders…"

Patient Records:

Select whether the data for the measure chosen was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusion:

Read the exclusion statement carefully and do one of the following:

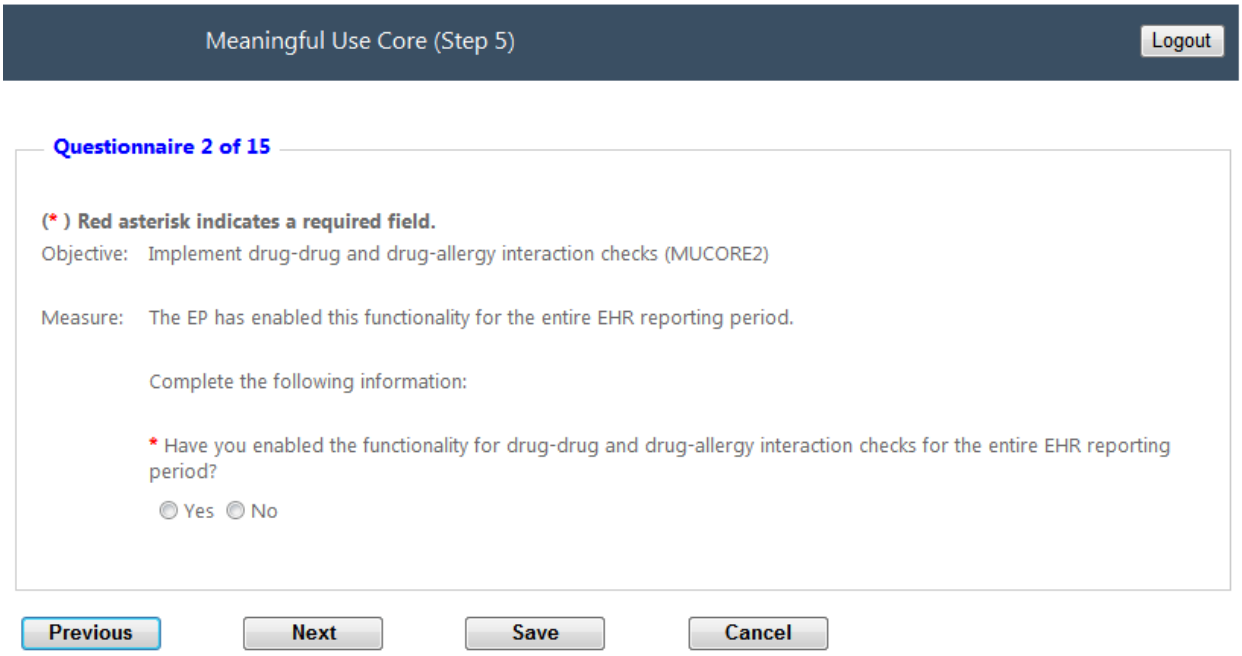
- Select "Yes" if the exclusion applies to you. If you select "Yes", you do not need to fill in the rest of the information on the screen. Select the "Next" link at the bottom of the screen and continue to the Drug Interaction Checks page.
- Select "No" if the exclusion does not apply to you. If you select "No", you must:
  - Enter a number in the box labeled "Numerator" according to the directions on the screen.
  - Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Drug Interaction Checks page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Drug Interaction Checks



Read the "Objective" and "Measure" descriptions carefully and do the following:

- If you selected "Yes" to the exclusion statement on the previous screen:
  - Select the "Next" button and continue to the Maintain Problem List page.
- If you selected "No" to the exclusion statement on the previous screen, on this screen you must:
  - Select "Yes" if you enabled functionality for interaction checks for the entire reporting period.
  - Select "No" if you didn't enable functionality for interaction checks for the entire reporting period.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Maintain Problem List page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Maintain Problem List

Meaningful Use Core (Step 5) Logout

Questionnaire 3 of 15

(*) Red asterisk indicates a required field.

Objective: Maintain an up-to-date problem list of current and active diagnoses. (MUCORE3)

Measure: More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to the directions on the screen.
- Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the E-Prescriptions page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

E-Prescriptions

Meaningful Use Core (Step 5) Logout

Questionnaire 4 of 15

(*) Red asterisk indicates a required field.

Objective: Generate and transmit permissible prescriptions electronically (eRx). (MUCORE4)

Measure: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.

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

- (●) This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- ( ) This data was extracted only from patient records maintained using certified EHR technology.

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

* Does this exclusion apply to you?

( ) Yes (●) No

EXCLUSION 2: Based on All Patient Records: Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of the EHR reporting period. 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:

Numerator = Number of prescriptions in the denominator generated and transmitted electronically.
Denominator = Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.

* **Numerator :** * **Denominator :**

* Which eRx service is used?

* Name a pharmacy that you transmit to

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusion 1 and Exclusion 2:

Read the exclusion statements carefully and:

- Select "Yes" if the exclusion applies to you. If you select "Yes" to **either** of the exclusions, you do not need to fill in the rest of the information on the screen. Select the "Next" link at the bottom of the screen and continue to the Active Medication List page.

- Select “No” if the exclusion does not apply to you. If you select “No” to **both** exclusions, you must:
  - Enter a number in the box labeled “Numerator” according to the directions on the screen.
  - Enter a number in the box labeled “Denominator” according to the directions on the screen.

    Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.
  - Enter the name of the eRX service you used in the box provided.
    Note: an answer is required; if you don’t know, type “unknown”.
  - Enter the name of the pharmacy you transmit to in the box provided.
    Note: an answer is required; if you don’t know, type “unknown”.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Active Medication List page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Active Medication List

Meaningful Use Core (Step 5) Logout

Questionnaire 5 of 15

(*) Red asterisk indicates a required field.

Objective: Maintain active medication list. (MUCORE5)

Measure: More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to the directions on the screen.
- Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Active Medication Allergy List page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Active Medication Allergy List

Meaningful Use Core (Step 5) Logout

Questionnaire 6 of 15

(*) Red asterisk indicates a required field.

Objective: Maintain active medication allergy list. (MUCORE6)

Measure: More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.

Complete the following information:

Numerator = Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to the directions on the screen.
- Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Record Demographics page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Record Demographics

Meaningful Use Core (Step 5) Logout

Questionnaire 7 of 15

(*) Red asterisk indicates a required field.

Objective: Record all of the following demographics:

- Preferred language
- Gender
- Race
- Ethnicity
- Date of birth

(MUCORE7)

Measure: More than 50% of all unique patients seen by the EP have demographics recorded as structured data.

Complete the following information:

Numerator = Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to the directions on the screen.
- Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Record Vital Signs page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Record Vital Signs

Meaningful Use Core (Step 5) Logout

Questionnaire 8 of 15

(*) Red asterisk indicates a required field.

Objective: Record and chart changes in vital signs:

- Height
- Weight
- Blood pressure
- Calculate and display body mass index (BMI)
- Plot and display growth charts for children 3-20 years, including BMI.

(MUCORE8)

Measure: More than 50% of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and have height and weight (for all ages) recorded as structured data.

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

- (●) This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- ( ) This data was extracted only from patient records maintained using certified EHR technology.

Please select which of the following cases applies to you:

- (●) None of the following exclusions apply to me
- ( ) An EP who believes that all three vital signs of height, weight and blood pressure have no relevance to their scope of practice is excluded from this requirement.
- ( ) An EP who sees no patients 3 years or older is excluded from recording blood pressure.
- ( ) An EP who believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.
- ( ) An EP who believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

Complete the following information:

Numerator = Number of patients in the denominator who have at least one entry of their height, weight, and blood pressure recorded as structured data.
Denominator = Number of unique patients age 3 or over seen by the EP during the EHR reporting period.

* **Numerator :** [ ] * **Denominator :** [ ]

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusions (i.e., cases):

Read each of the exclusion statements (i.e., cases) carefully and select the one that best applies to you.

- If you select case #1, "None of the following exclusions apply to me", you must meet the 50 percent threshold.
- If you select case #2, "An EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from this requirement", you have met the 50 percent threshold.
- If you select case #3, "An EP who sees no patients 3 years or older is excluded from recording blood pressure", you must meet the 50 percent threshold.
- If you select case #4, "An EP who believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure", you must meet the 50 percent threshold.
- If you select case #5, "An EP who believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight", you must meet the 50 percent threshold.

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to the directions on the screen.
- Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Record Smoking Status page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Record Smoking Status

Meaningful Use Core (Step 5) Logout

Questionnaire 9 of 15

(*) Red asterisk indicates a required field.

Objective: Record smoking status for patients 13 years old or older. (MUCORE9)

Measure: More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

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

- (●) This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- ( ) This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION: Based on All Patient Records: An EP who sees no patients 13 years or older 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:

Numerator = Number of patients in the denominator with smoking status recorded as structured data.

Denominator = Number of unique patients age 13 or older seen by the EP during the EHR reporting period.

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusion:

Read the exclusion statement carefully and:

- Select "Yes" if the exclusion applies to you.
- Select "No" if the exclusion does not apply to you.

Numerator and Denominator:

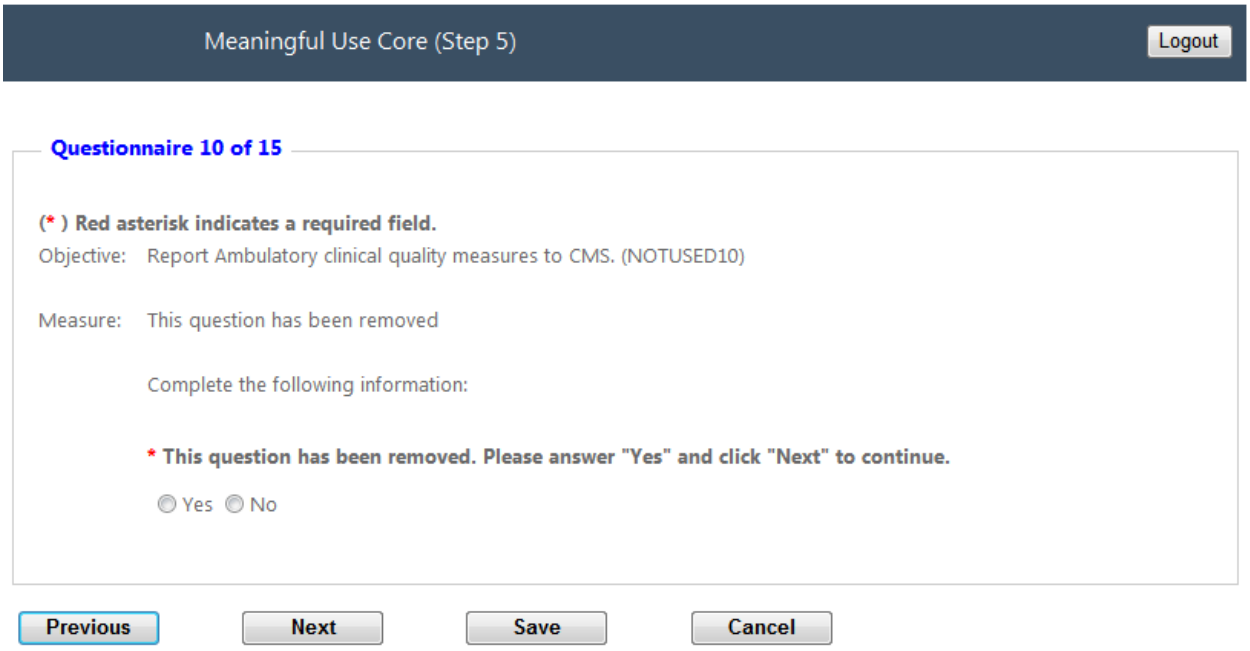
- Enter a number in the box labeled "Numerator" according to the directions on the screen.
- Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Report Clinical Quality Measures page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

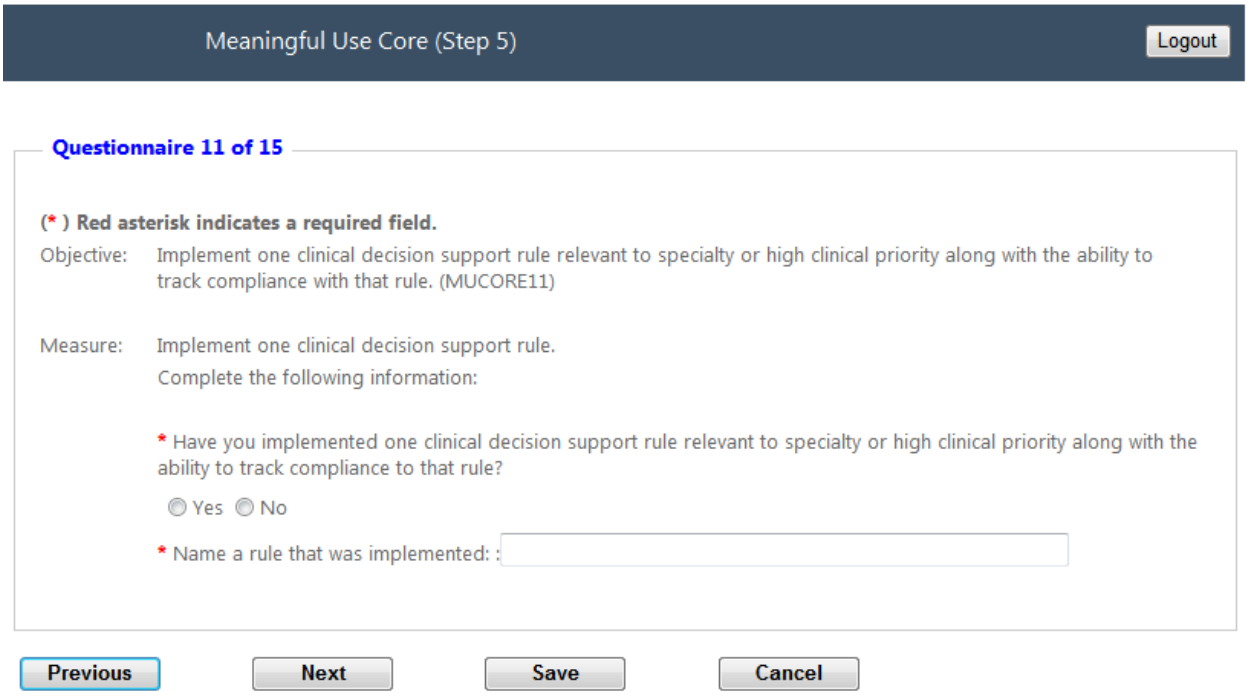
Report Clinical Quality Measures – THIS REQUIREMENT HAS BEEN REMOVED



The "Clinical Quality Measures" requirement has been removed as of program year 2013.

- Select "Yes" and then "Next" to continue to the Implement Clinical Decision Support Rule page.
- If you select "No", you will not be allowed to proceed.

Implement Clinical Decision Support Rule



Read the "Objective" and "Measure" descriptions carefully and do one of the following:

- Select "Yes" if you have implemented one clinical decision support rule and the ability to track compliance to that rule.
- Select "No" if you have not implemented one clinical decision support rule or the ability to track compliance to that rule.
- Enter the name of the rule that was implemented in the box provided.
  Note: An answer is required; if you don't know, type "unknown". If you selected "No", type "none".

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Electronic Copy of Health Information page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Electronic Copy of Health Information

Meaningful Use Core (Step 5) Logout

Questionnaire 12 of 15

(*) Red asterisk indicates a required field.

Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request. (MUCORE12)

Measure: More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.

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

- (●) This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- ( ) This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION: Based on All Patient Records: An EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

( ) Yes (●) No

Complete the following information:

Numerator = Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.

Denominator = Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusion:

Read the exclusion statement carefully and:

- Select "Yes" if the exclusion applies to you.
- Select "No" if the exclusion does not apply to you.

Numerator and Denominator:

- Enter a number in the box labeled “Numerator” according to the directions on the screen.
- Enter a number in the box labeled “Denominator” according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Clinical Summaries page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Clinical Summaries

Meaningful Use Core (Step 5) Logout

Questionnaire 13 of 15

(*) Red asterisk indicates a required field.

Objective: Provide clinical summaries for patients for each office visit. (MUCORE13)

Measure: Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.

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

- (●) This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- ( ) This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION: Based on All Patient Records: Any EP who has no office visits during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

( ) Yes (●) No

Complete the following information:

Numerator = Number of office visits in the denominator for which a clinical summary of Is provided within three business days.

Denominator = Number of office visits for the EP during the EHR reporting period.

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusion:

Read the exclusion statement carefully and:

- Select "Yes" if the exclusion applies to you.
- Select "No" if the exclusion does not apply to you.

Numerator and Denominator:

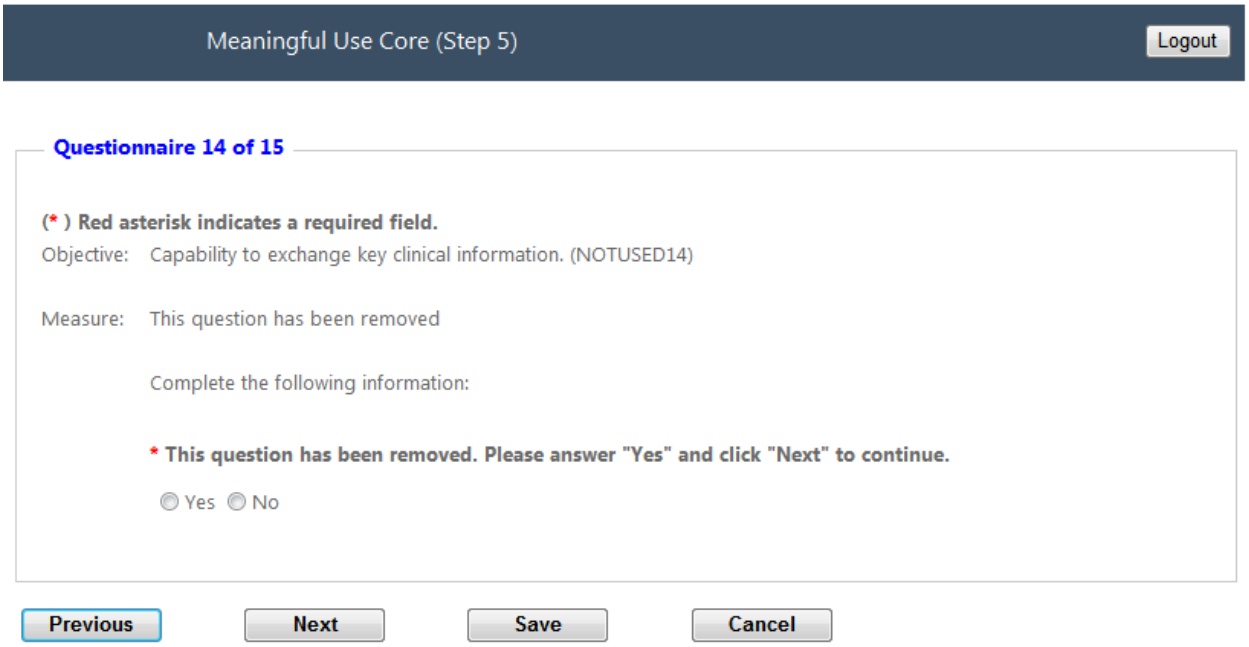
- Enter a number in the box labeled “Numerator” according to the directions on the screen.
- Enter a number in the box labeled “Denominator” according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Electronic Exchange of Clinical Information page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

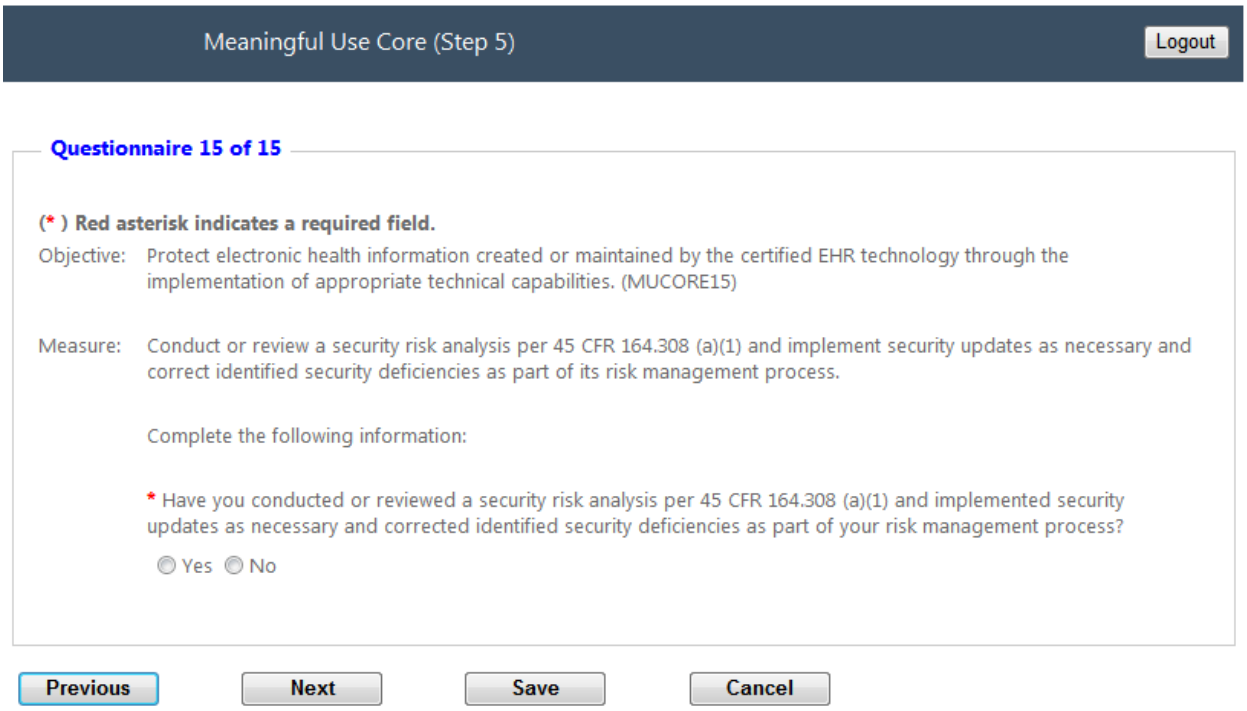
Electronic Exchange of Clinical Information – THIS REQUIREMENT HAS BEEN REMOVED



The Electronic Exchange of Key Clinical Information requirement has been removed as of program year 2013.

- Select “Yes” and “Next” to continue to the Security Review page.
- If you select “No”, you will not be allowed to proceed.

Security Review



Read the "Objective" description, "Measure" description, and question provided and do one of the following:

- Select "Yes" if you have conducted or reviewed a security risk analysis and implemented updates or corrected deficiencies.
- Select "No" if you have not conducted or reviewed a security risk analysis and implemented updates or corrected deficiencies.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Meaningful Use Menu (Step 6) page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Meaningful Use Menu Measures (MU Step 6)

When this screen appears, you must select a minimum of five menu measures from the table (you may select more than 5 if desired). At least one of these measures must be from the Public Health Measure list. You must choose a measure that can be met unless an exclusion can be claimed for both public health measures open to eligible providers.

Meaningful Use Menu (Step 6) Logout

Questionnaire

Instructions:

EPs must report on a total of five (5) Meaningful Use Menu Measures. At least one of the five measures must be from the public health menu measures. Should the EP be able to successfully meet only one of these public health menu measures, the EP must select and report on that measure to CMS or the State. Having met one public health menu measure, the EP must then select any other four measures from the Meaningful Use Menu Measures. In selecting the remaining four measures, the EP may select any combination of the remaining public health menu measure or from the additional Meaningful Use Menu Measures in the list below.

If an EP meets the criteria for and can claim an exclusion for both of the public health menu measures, the EP must still select one public health menu measure and attest that EP qualifies for the exclusion. The EP must then select any other four measures from the menu measures, which can be any combination of the remaining public health menu measure or from the additional Meaningful Use Menu Measures in the list below. CMS encourages EPs to select menu measures that are relevant to their scope of practice and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they qualify or if there are no remaining menu measures that are relevant to their scope of practice.
You must submit at least one Meaningful Use Menu Measure from the public health list even if an Exclusion applies to both:

Select	Objective	Measure
☐	Capability to submit electronic data to immunization registries or immunization information systems and an actual submission according to applicable law and practice except where prohibited. (MUMENU1)	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).
☐	Capability to submit electronic syndromic surveillance data to public health agencies and an actual submission in accordance with applicable law and practice except where prohibited. (MUMENU2) Note: Idaho currently does not have the capability to receive syndromic surveillance data from EPs.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically). Note: Note: Idaho currently does not have the capability to receive syndromic surveillance data from EPs.

You must submit additional menu measure objectives until a total of five Meaningful Use Menu Measure Objectives have been selected, even if an Exclusion applies to all of the menu measure objectives that are selected (total of five includes the public health menu measure objectives):

Select	Objective	Measure
☐	Implement drug formulary checks (MUMENU3)	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.
☐	Incorporate clinical lab-test results into EHR as structured data. (MUMENU4)	More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.
☐	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach. (MUMENU5)	Generate at least one report listing patients of the EP with a specific condition.
☐	Send reminders to patients per patient preference for preventive/follow up care. (MUMENU6)	More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
☐	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP. (MUMENU7)	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.
☐	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate. (MUMENU8)	More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.
☐	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. (MUMENU9)	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.
☐	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral. (MUMENU10)	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.

Previous Next Save Cancel

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Electronic Data to Immunization Registries page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Public Health Menu Measure – Electronic Data to Immunization Registries

Meaningful Use Menu (Step 6) Logout

(*)Red asterisk indicates a required field.

Objective: Capability to submit electronic data to immunization registries or immunization information systems and an actual submission according to applicable law and practice except where prohibited. (MUMENU1)

Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).

EXCLUSION 1 - Based on All Patient Records: An EP who does not perform immunizations during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

*Does this exclusion apply to you?

Yes No

EXCLUSION 2 - Based on All Patient Records: If there is no immunization registry that has the capacity to receive the information electronically, an EP 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:

*Did you perform at least one test of certified EHR technologys capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically)?

Yes No

*Has a follow up test been submitted?

Yes No

*What was the result of the test?

Successful Failed

Please Note: Neither a failed test nor failure to follow-up a test submission will prevent a provider from meeting Meaningful Use.

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Exclusion 1 and Exclusion 2:

Read the exclusion statements carefully and:

- Select "Yes" if the exclusion applies to you.
- Select "No" if the exclusion does not apply to you.

Additional Information:

- Select "Yes" or "No" to indicate if you performed a test and follow-up submission of your EHR's ability to submit data to immunization registries.
- Select "Yes" or "No" to indicate if the follow-up test was submitted.
- Select "Successful" or "Failed" to indicate the result of the test.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Public Health Measure – Electronic Syndromic Surveillance Data page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Public Health Menu Measure – Electronic Syndromic Surveillance Data

Meaningful Use Menu (Step 6) Logout

(*)Red asterisk indicates a required field.

Objective: Capability to submit electronic syndromic surveillance data to public health agencies and an actual submission in accordance with applicable law and practice except where prohibited. (MUMENU2)

Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically).

Note: Note: Idaho currently does not have the capability to receive syndromic surveillance data from EPs.

EXCLUSION 1 - Based on All Patient Records: If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period, then the EP is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2 - Based on All Patient Records: If there is no public health agency that has the capacity to receive the information electronically, then the EP is 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:

*Did you perform at least one test of certified EHR technologys capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information have the capacity to receive the information electronically)?

◉ Yes ○ No

*Has a follow up test been submitted?

○ Yes ○ No

*What was the result of the test?

○ Successful ○ Failed

Please Note: Neither a failed test nor failure to follow-up a test submission will prevent a provider from meeting Meaningful Use.

Previous Next Save Cancel

Important Note: The system instructions for this screen might differ from the information below. In that case, the system will provide additional information to walk you through what you need to do to complete this screen.

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Exclusion 1 and Exclusion 2:

Read the exclusion statements carefully and:

- Select "Yes" if the exclusion applies to you.
- Select "No" if the exclusion does not apply to you.

Additional Information:

- Select “Yes” or “No” to indicate if you performed a test and follow-up submission of your EHR’s ability to provide electronic syndromic surveillance data to public health agencies.
- Select “Yes” or “No” to indicate if the follow-up test was submitted.
- Select “Successful” or “Failed” to indicate the result of the test.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Drug Formulary Checks page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Drug Formulary Checks

Meaningful Use Menu (Step 6) Logout

(*)Red asterisk indicates a required field.

Objective: Implement drug formulary checks (MUMENU3)

Measure: The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.

EXCLUSION - Based on All Patient Records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period can 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 the drug formulary check functionality and did you have access to at least one internal or external drug formulary for the entire EHR reporting period?

Yes No

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Exclusion:

Read the exclusion statements carefully and:

- Select "Yes" if the exclusion applies to you.
- Select "No" if the exclusion does not apply to you.

Additional Information:

- Select "Yes" or "No" to indicate if you enabled drug formulary check functionality and had access to an internal or external formulary for the reporting period.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Clinical Lab Test Results page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Clinical Lab Test Results

Meaningful Use Menu (Step 6) Logout

(*)Red asterisk indicates a required field.

Objective: Incorporate clinical lab-test results into EHR as structured data. (MUMENU4)

Measure: More than 40% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are in either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

EXCLUSION - Based on All Patient Records: Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

Yes No

Complete the following information:

Numerator = Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
Denominator = Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.

* **Numerator:** * **Denominator:**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Exclusion:

- Select "Yes" if the exclusion applies to you. If you select "Yes", you do not need to fill in the rest of the information on the screen. Select the "Next" link at the bottom of the screen and continue to the Patient List page.
- Select "No" if the exclusion does not apply to you. If you select "No", you must:
  - Enter a number in the box labeled "Numerator" according to the directions on the screen.
  - Enter a number in the box labeled "Denominator" according to the directions on the screen.

  Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Patient List page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Patient List

Meaningful Use Menu (Step 6) Logout

(*)Red asterisk indicates a required field.

Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach. (MUMENU5)

Measure: Generate at least one report listing patients of the EP with a specific condition.

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

- This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- This data was extracted by only from patient records maintained using certified EHR technology.

Complete the following information:

* Have you generated at least one report listing your patients with a specific condition?

Yes No

*Name at least one specific condition for which a list was created

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Additional Information:

- Select "Yes" or "No" to indicate if you generated at least one report listing your patients with a specific condition.
- If you selected "Yes", type the condition for which the list was created in the box provided.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Patient Reminders page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Patient Reminders

Meaningful Use Menu (Step 6) Logout

(*) Red asterisk indicates a required field.

Objective: Send reminders to patients per patient preference for preventive/follow up care. (MUMENU6)

Measure: More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.

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

- (●) This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- ( ) This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION: Based on All Patient Records: Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology is 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:

Numerator = Number of patients in the denominator who were sent the appropriate reminder.
Denominator = Number of unique patients 65 years old or older or 5 years older or younger.

* **Numerator :** [ ] * **Denominator :** [ ]

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusion:

- Select "Yes" if the exclusion applies to you. If you select "Yes", you do not need to fill in the rest of the information on the screen. Select the "Next" link at the bottom of the screen and continue to the Patient Electronic Access to Their Health Information page.
- Select "No" if the exclusion does not apply to you. If you select "No", you must:
  - Enter a number in the box labeled "Numerator" according to the directions on the screen.
  - Enter a number in the box labeled "Denominator" according to the directions on the screen.

  Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Patient Electronic Access to Their Health Information page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Patient Electronic Access to Their Health Information

Meaningful Use Menu (Step 6) Logout

(*)Red asterisk indicates a required field.

Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP. (MUMENU7)

Measure: At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.

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

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

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

EXCLUSION - Based on All Patient Records: Any EP who neither orders nor creates lab tests or information that would be contained in the problem list, medication list, or medication allergy list during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

Yes No

Complete the following information:

Numerator = Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.

* **Numerator:** * **Denominator:**

*Does your practice have an online patient portal?

Yes No

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusion:

- Select "Yes" if the exclusion applies to you. If you select "Yes", you do not need to fill in the rest of the information on the screen. Select the "Next" link at the bottom of the screen and continue to the Patient Education Resources page.
- Select "No" if the exclusion does not apply to you. If you select "No", you must:
  - Enter a number in the box labeled "Numerator" according to the directions on the screen.
  - Enter a number in the box labeled "Denominator" according to the directions on the screen.

  Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.
- Select "Yes" or "No" to indicate if your practice has an online patient portal.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Patient Education Resources page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Patient Education Resources

Meaningful Use Menu (Step 6) Logout

(*)Red asterisk indicates a required field.

Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate. (MUMENU8)

Measure: More than 10% of all unique patients seen by the EP during the EHR reporting period are provided patient-specific education resources.

Complete the following information:

Numerator = Number of patients in the denominator who are provided patient education specific resources.
Denominator = Number of unique patients seen by the EP during the EHR reporting period.

* **Numerator:** * **Denominator:**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to the directions on the screen.
- Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Medication Reconciliation page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Medication Reconciliation

Meaningful Use Menu (Step 6) Logout

(*) Red asterisk indicates a required field.

Objective: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. (MUMENU9)

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

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

- (●) This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- ( ) This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION: Based on All Patient Records: An EP who was not on the receiving end of any transition of care during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

( ) Yes (●) No

Complete the following information:

Numerator = Number of transitions of care in the denominator where medication reconciliation was performed.
Denominator = Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusion:

- Select "Yes" if the exclusion applies to you. If you select "Yes", you do not need to fill in the rest of the information on the screen. Select the "Next" link at the bottom of the screen and continue to the Transition of Care Summary page.
- Select "No" if the exclusion does not apply to you. If you select "No", you must:
  - Enter a number in the box labeled "Numerator" according to the directions on the screen.
  - Enter a number in the box labeled "Denominator" according to the directions on the screen.

  Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Transition of Care Summary page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Transition of Care Summary

Meaningful Use Menu (Step 6) Logout

(*)Red asterisk indicates a required field.

Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral. (MUMENU10)

Measure: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.

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

- (●) This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- ( ) This data was extracted by only from patient records maintained using certified EHR technology.

EXCLUSION 1 - Based on All Patient Records: An EP who does not transfer any patients to another setting during the EHR reporting period would be excluded from this requirement.

* Does this exclusion apply to you?

( ) Yes (●) No

EXCLUSION 2 - Based on All Patient Records: An EP who does not refer any patients to another provider during the EHR reporting period would be excluded from this requirement.

* Does this exclusion apply to you?

( ) Yes (●) No

Complete the following information:

Numerator = Number of transitions of care and referrals in the denominator where a summary of care record was provided.
Denominator = Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

* **Numerator:** * **Denominator:**

Previous Next Save Cancel

Read the "Objective" and "Measure" descriptions carefully and answer the following sections on the screen:

Patient Records:

Select whether the data for the measure was:

- "…extracted from ALL patient records not just those maintained using certified EHR technology."
- "…extracted only from patient records maintained using certified EHR technology."

Exclusion 1 and Exclusion 2:

Read the exclusion statements carefully and:

- Select "Yes" if the exclusion applies to you. If you select "Yes" to either of the exclusions, you do not need to fill in the rest of the information on the screen. Select the "Next" link at the bottom of the screen and continue to the Hypertension: Blood Pressure Management page.
- Select "No" if the exclusion does not apply to you. If you select "No" to both exclusions, you must:
  - Enter a number in the box labeled "Numerator" according to the directions on the screen.
  - Enter a number in the box labeled "Denominator" according to the directions on the screen.

  Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

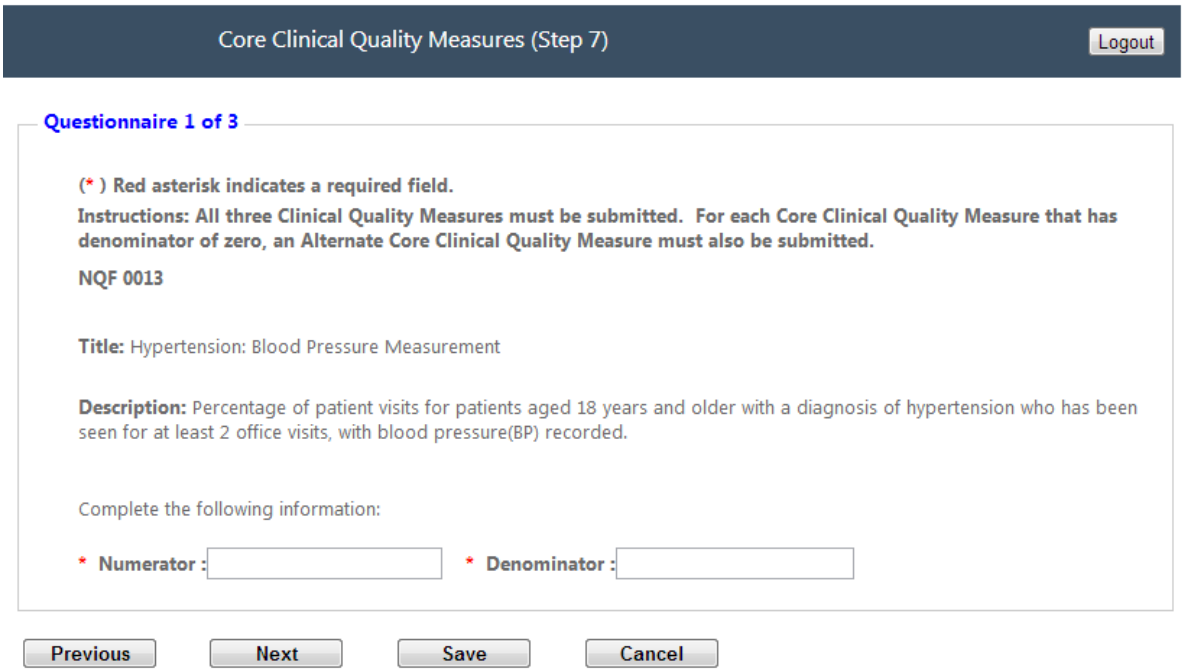
After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Core Clinical Quality Measures (MU Step 7) page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Core Clinical Quality Measures (MU Step 7)

Providers must report on all three core clinical quality measures. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero. For each core measure that has a denominator of zero, you will be prompted to select a substitute from the alternate core clinical quality measures.

Hypertension: Blood Pressure Management



Read the "Instructions", "Title", and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Preventive Care and Screening Measure Pair page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Preventive Care and Screening Measure Pair

Core Clinical Quality Measures (Step 7) Logout

Questionnaire 2 of 3

(*) Red asterisk indicates a required field.

Instructions: All three Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.

NQF 0028 /PQRI 114

Title: Preventive Care and Screening Measure Pair

a.Tobacco Use Assessment

Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months.

Complete the following information:

* **Numerator :** * **Denominator :**

b.Tobacco Cessation Intervention

Description: Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.

Complete the following information:

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Instructions", "Titles", and "Descriptions" carefully and answer the following sections on the screen:

Numerator and Denominator:

For both sections, "a. Tobacco Use Assessment" and "b. Tobacco Cessation Intervention", do the following:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Adult Weight Screening and Follow-up page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Adult Weight Screening and Follow-up

Core Clinical Quality Measures (Step 7) Logout

Questionnaire 3 of 3

(*) Red asterisk indicates a required field.

Instructions: All three Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.

NQF 0421 /PQRI 128

Title: Adult Weight Screening and Follow-up

Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if most recent BMI is outside parameters, a follow-up plan is documented.

Population Criteria 1: Age >= 65
Population Criteria 2: Ages 18-64

Complete the following information:

Population Criteria 1: * **Numerator 1:** 99 * **Denominator:** 100 * **Exclusion:** 0

Population Criteria 2: * **Numerator 2:** 99 * **Denominator:** 100 * **Exclusion:** 0

Previous Next Save Cancel

Read the "Instructions", "Title", and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

For both sections, "Population Criteria 1" and "Population Criteria 2", do the following:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Alternate Core Clinical Quality Measures (MU Step 7.1) page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Alternate Core Clinical Quality Measures (MU Step 7.1)

Choose from this menu only if one or more core clinical quality measures have denominators of zero. (The instructions below adjust based on what was submitted in the core clinical quality section, showing how many of the alternate core items need to be selected.) If none of the denominators are zero for the core clinical quality measures, then go to the additional clinical core measures.

Alternate Core Clinical Quality Measures(Step 7.1) Logout

Instructions:

You have entered a denominator of zero for one or more of your Core Clinical Quality Measures. Please select your Alternate Clinical Quality Measure(s) from the list below.

Please select one Alternate Clinical Quality Measure from the list below.

Note: An Alternate Clinical Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.

Selection	Measure#	Title	Description
☐	NQF 0024	Weight Assessment and Counseling for Children and Adolescents	Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
☐	NQF 0041 / PQRI 110	Preventive Care and Screening: Influenza Immunization for Patients >= 50 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
☐	NQF 0038	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis(DTaP); three polio(IPV); one measles, mumps and rubella(MMR); two H influenza type B(HiB); three hepatitis B(Hep B); one chicken pox(VZV); four pneumococcal conjugate(PCV); two hepatitis A(Hep A); two or three rotavirus(RV); and two influenza(flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Previous Next Save Cancel

Weight Assessment and Counseling for Children and Adolescents

Alternate Core Clinical Quality Measures(Step 7.1) Logout

(*) Red asterisk indicates a required field.

NQF 0024

Title: Weight Assessment and Counseling for Children and Adolescents

Description: Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Complete the following information:

Ages 12-16:	* Numerator 1:		* Denominator:	
	* Numerator 2:		* Denominator:	
	* Numerator 3:		* Denominator:	
Ages 2-10:	* Numerator 1:		* Denominator:	
	* Numerator 2:		* Denominator:	
	* Numerator 3:		* Denominator:	
Ages 11-16:	* Numerator 1:		* Denominator:	
	* Numerator 2:		* Denominator:	
	* Numerator 3:		* Denominator:	

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

For each age group identified, do the following:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
  - For "Numerator 1" enter the BMI percentile.
  - For "Numerator 2" enter the counseling for nutrition percentile.
  - For "Numerator 3" enter the counseling for physical activity percentile.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Preventive Care and Screening: Influenza Immunization for Patients > = 50 Years Old page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Preventive Care and Screening: Influenza Immunization for Patients > = 50 Years Old

Alternate Core Clinical Quality Measures(Step 7.1) Logout

(*) Red asterisk indicates a required field.

NQF 0041/PQRI 110

Title: Preventive Care and Screening: Influenza Immunization for Patients >= 50 Years Old

Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).

Complete the following information:

* Numerator: * Denominator: * Exclusion

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the Childhood Immunization Status page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Childhood Immunization Status

Alternate Core Clinical Quality Measures(Step 7.1) Logout

(*) Red asterisk indicates a required field.

NQF 0038

Title: Childhood Immunization Status

Description: 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); two H influenza type B(HiB); three hepatitis B(Hep B); one chicken pox(VZV); four pneumococcal conjugate(PCV); two hepatitis A(Hep A); two or three rotavirus(RV); and two influenza(flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Complete the following information:

4 or more counts DTaP vaccine
* **Numerator 1:** * **Denominator:**

3 or more counts IPV
* **Numerator 2:** * **Denominator:**

1 or more counts MMR
* **Numerator 3:** * **Denominator:**

2 or more counts HiB
* **Numerator 4:** * **Denominator:**

3 or more counts of hepatitis B vaccine
* **Numerator 5:** * **Denominator:**

1 or more counts VZV
* **Numerator 6:** * **Denominator:**

4 or more counts pneumococcal vaccine
* **Numerator 7:** * **Denominator:**

2 or more counts of hepatitis A vaccine
* **Numerator 8:** * **Denominator:**

2 or more counts rotavirus vaccine
* **Numerator 9:** * **Denominator:**

2 or more counts of influenza vaccine
* **Numerator 10:** * **Denominator:**

4 or more counts of DTaP vaccine,3 or more counts IPV, 1 or more counts MMR, 1 or more counts VZV, and 3 or more counts hepatitis B vaccine
* **Numerator 11:** * **Denominator:**

4 or more counts of DTaP vaccine, 3 or more counts IPV,1 or more counts MMR, 1 or more counts VZV, 3 or more counts hepatitis B vaccine and 4 or more counts pneumococcal vaccine
* **Numerator 12:** * **Denominator:**

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

For each vaccine section identified, do the following:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Additional Clinical Quality Measures (MU Step 8) page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Additional Clinical Quality Measures (MU Step 8)

Note: This menu will display the clinical quality measures sorted by NQF; however, the presentation of the selected items may not reflect this sort.

Additional Clinical Quality Measures (Step 8) Logout

Questionnaire

Instructions: Select three Additional Clinical Quality Measures from the list below. You will be prompted to enter numerator(s), denominator(s), and exclusion(s), if applicable, for all three Additional Clinical Quality Measures after you select the NEXT button below.

Deselect All

Selection	Measure#	Title	Measure Description
☐	NQF 0001	Asthma Assessment	Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, which were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.
☐	NQF 0002/PQRI 66	Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
☐	NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement	Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
☐	NQF 0012	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.
☐	NQF 0014	Prenatal Care: Anti-D Immune Globulin	Percentage of D(Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.
☐	NQF 0018	Controlling High Blood Pressure	The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.
☐	NQF 0027/PQRI 115	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies	Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.
☐	NQF 0031/PQRI 112	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.
☐	NQF 0032	Cervical Cancer Screening	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.
☐	NQF 0033	Chlamydia Screening for Women	Percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.
☐	NQF 0034/PQRI 113	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
☐	NQF 0036	Use of Appropriate Medications for Asthma	Percentage of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).
☐	NQF 0043/PQRI 111	Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
	NQF		Percentage of patients aged 5 through 40 years with a diagnosis of mild,

Additional Clinical Quality Measures (MU Step 8)

	NQF 0047/PQRI 53	Asthma Pharmacologic Therapy	Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
	NQF 0052	Low Back Pain: Use of Imaging Studies	Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.
	NQF 0055/PQRI 117	Diabetes: Eye Exam	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.
	NQF 0056/PQRI 163	Diabetes: Foot Exam	The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).
	NQF 0059/PQRI 1	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c > 9.0%.
	NQF 0061/PQRI 3	Diabetes: Blood Pressure Management	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.
	NQF 0062/PQRI 119	Diabetes: Urine Screening	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
	NQF 0064/PQRI 2	Diabetes Low Density Lipoprotein (LDL) Management and Control	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C < 100 mg/dL.
	NQF 0067/PQRI 6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD)	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
	NQF 0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.
	NQF 0070/PQRI 7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.
	NQF 0073/PQRI 201	Ischemic Vascular Disease (IVD): Blood Pressure Management	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).
	NQF 0074/PQRI 197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	Percentage of patients aged 18 years and older with a diagnosis of CAD who was prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
	NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100 mg/dL.
	NQF 0081/PQRI 5	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 and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.
	NQF 0083/PQRI 8	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
	NQF	Heart Failure (HF): Warfarin Therapy	Percentage of all patients aged 18 years and older with a diagnosis of heart

Additional Clinical Quality Measures (MU Step 8)

	8	Dysfunction (LVSD)	who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
☐	NQF 0084/PQRI 200	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation	Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation that were prescribed warfarin therapy.
☐	NQF 0086/PQRI 12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least two office visits who have an optic nerve head evaluation during one or more office visits within 12 months.
☐	NQF 0088/PQRI 18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.
☐	NQF 0089/PQRI 19	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
☐	NQF 0105/PQRI 9	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment	Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.
☐	NQF 0385/PQRI 72	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.
☑	NQF 0387/PQRI 71	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.
☑	NQF 0389/PQRI 102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.
☑	NQF 0575	Diabetes: Hemoglobin A1c Control (<8.0%)	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c < 8.0%.

Previous Save & Next

When this page appears:

- Select three of the additional clinical quality measures from the list.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Save & Next" - Will save your entries and take you to the next screen according to your selections.

Asthma Assessment

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0001

Title: Asthma Assessment

Description: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, which were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.

Complete the following information:

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Appropriate Testing for Children and Pharyngitis

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0002 PQRI 66

Title: Appropriate Testing for Children with Pharyngitis

Description: Percentage of children 2-18 years of age, who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.

Complete the following information:

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0004

Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement

Description: Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Complete the following information:

Ages 13-17:	* Numerator 1:		* Denominator:	
	* Numerator 2:		* Denominator:	
Patients who will reach age 18 years or greater during the reporting period	* Numerator 1:		* Denominator:	
	* Numerator 2:		* Denominator:	
Patients who will reach age 13 years or greater during the reporting period	* Numerator 1:		* Denominator:	
	* Numerator 2:		* Denominator:	

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

For each age group identified, do the following:

- Enter a number in the boxes labeled "Numerator 1" and "Numerator 2" according to your certified EHR reporting.
  - For "Numerator 1" enter the patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
  - For "Numerator 2" enter the Patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

- Enter a number in the box labeled “Denominator” according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the next page.
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Prenatal Care: Screening for Human Immunodeficiency Virus

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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Prenatal Care: Anti-D Immune Globulin

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Controlling High Blood Pressure

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0018

Title: Controlling High Blood Pressure

Description: The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.

Complete the following information:

* Numerator : * Denominator :

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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Smoking and Tobacco Use Medical Assistance

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0027 PQRI 115

Title: Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies

Description: Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.

Complete the following information:

* Numerator 1: * Denominator:

* Numerator 2: * Denominator:

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

In each of the appropriate boxes provided do the following:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
  - For "Numerator 1", enter the percentage of patients who were tobacco users <=one year before or simultaneously to the measurement period.
  - For "Numerator 2", enter the encounters with patients for tobacco use cessation counseling <=one year before or simultaneously to the measurement period or communicated to the patient about tobacco use cessation counseling <+one year before or simultaneously to the measurement end date.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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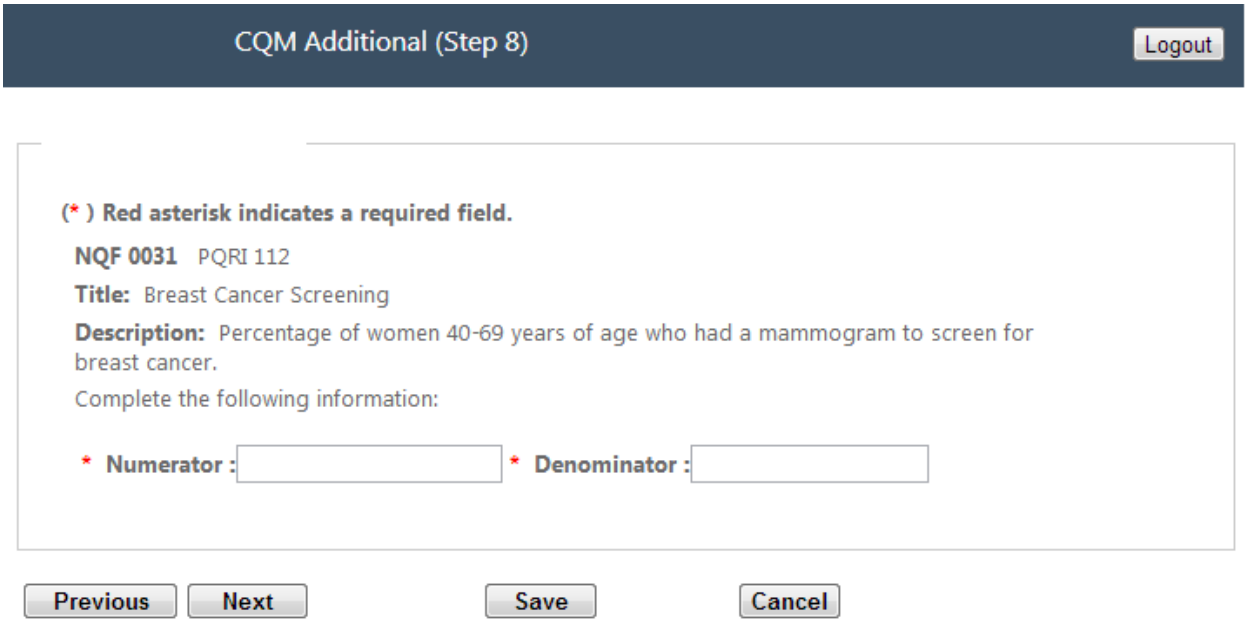
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Breast Cancer Screening



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to the directions on the screen.
- Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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Cervical Cancer Screening

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

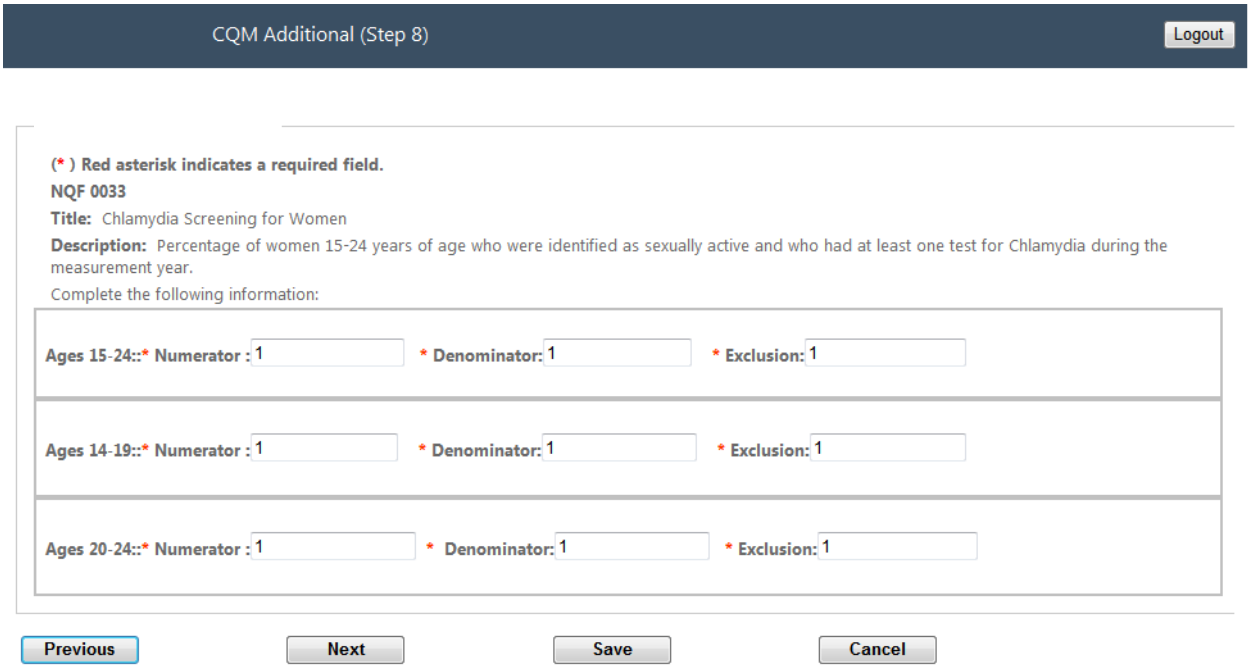
- Enter a number in the box labeled "Numerator" according to the directions on the screen.
- Enter a number in the box labeled "Denominator" according to the directions on the screen.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Chlamydia Screeing for Women



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

For each age group identified, do the following:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
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Colorectal Cancer Screening

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
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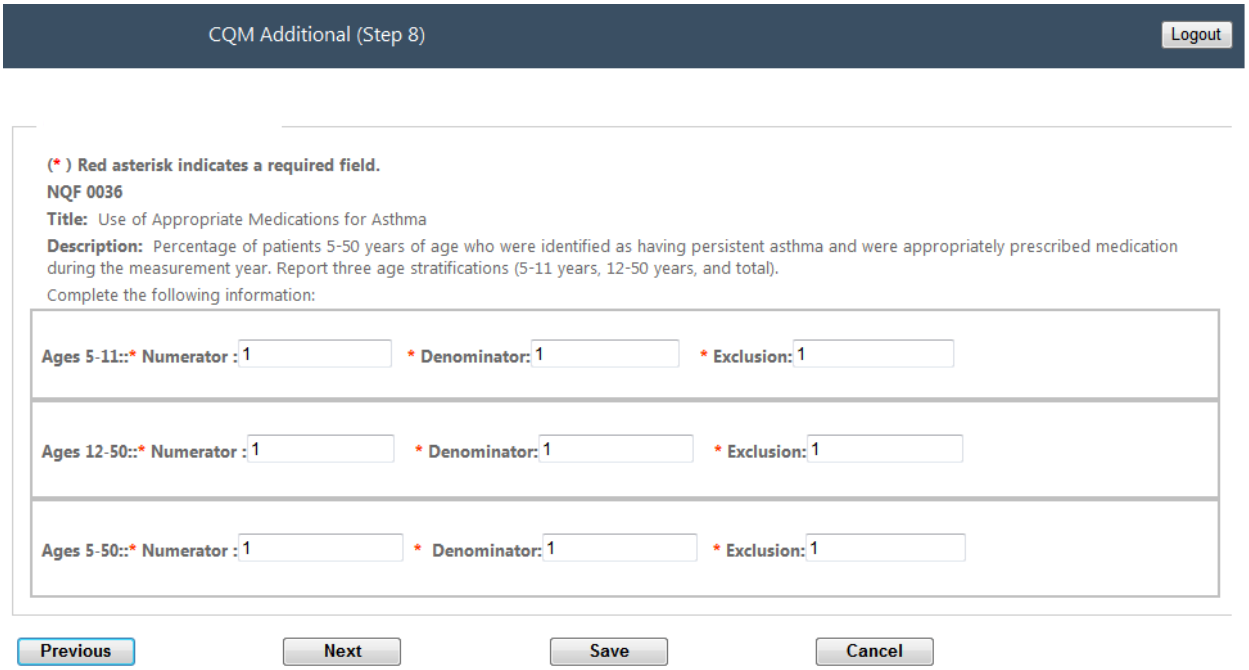
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Use of Appropriate Medications for Asthma



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

For each age group identified, do the following:

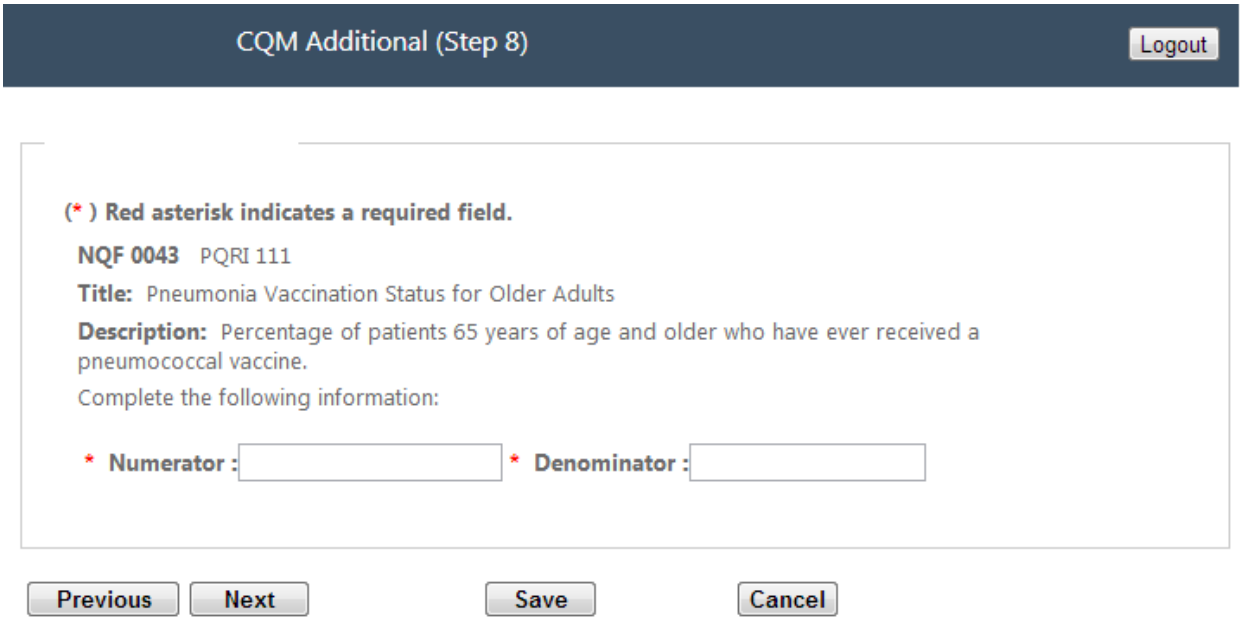
- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Pneumonia Vaccination Status for Older Adults



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

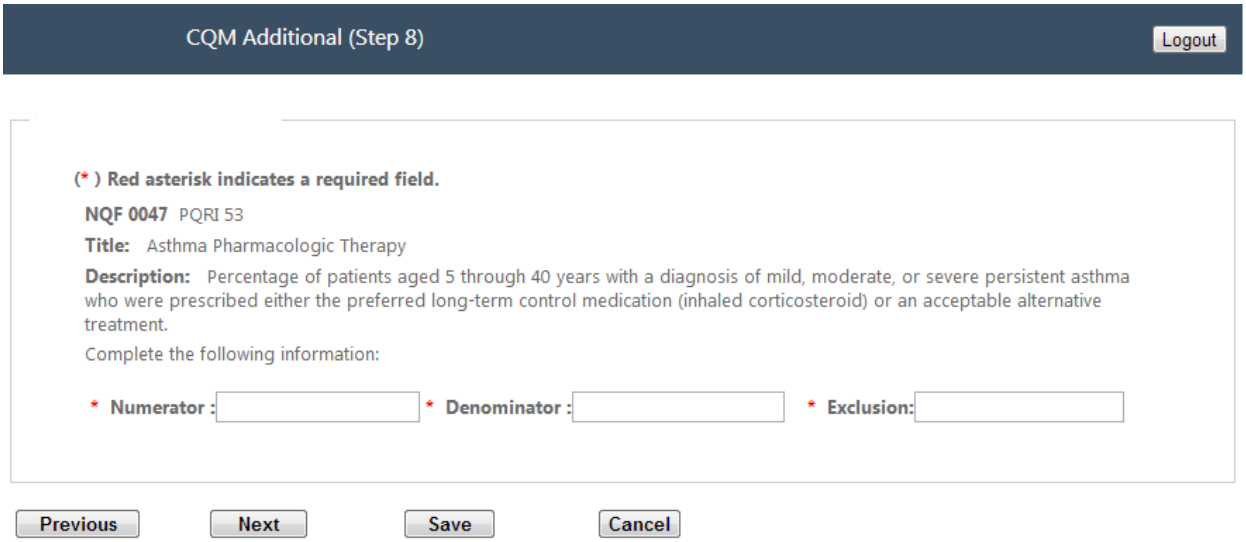
- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Asthma Pharmacologic Therapy



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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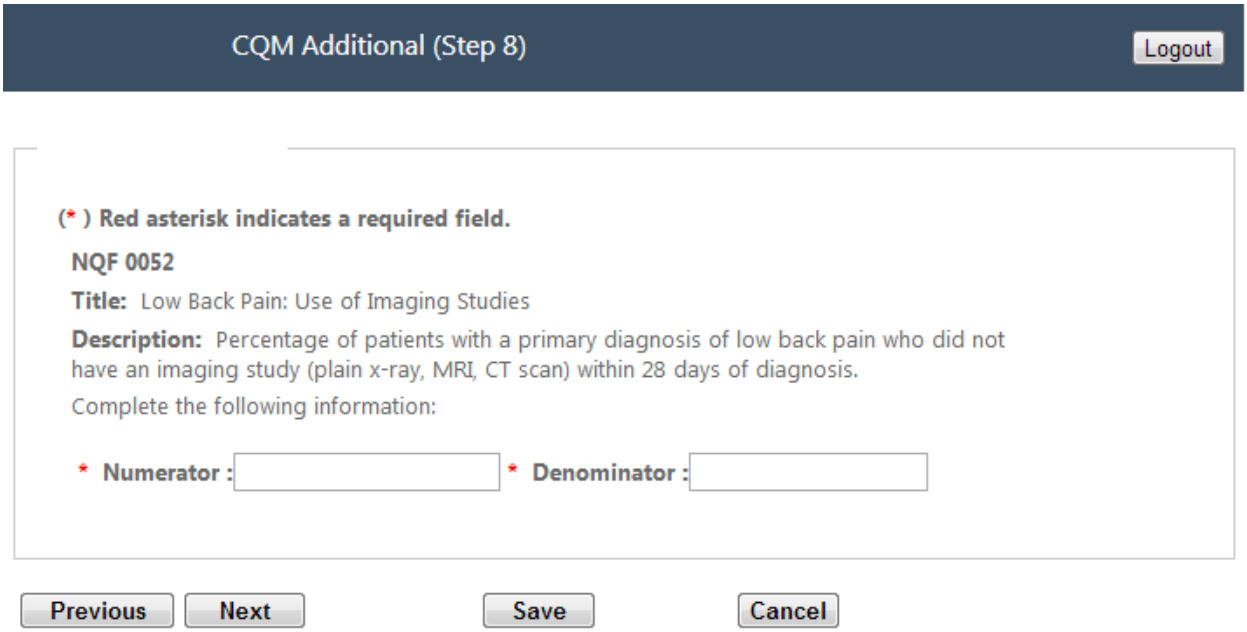
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Low Back Pain: Use of Imaging Studies



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

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Diabetes: Eye Exam

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0055 PQRI 117

Title: Diabetes: Eye Exam

Description: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.

Complete the following information:

* **Numerator :** * **Denominator :** * **Exclusion:**

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

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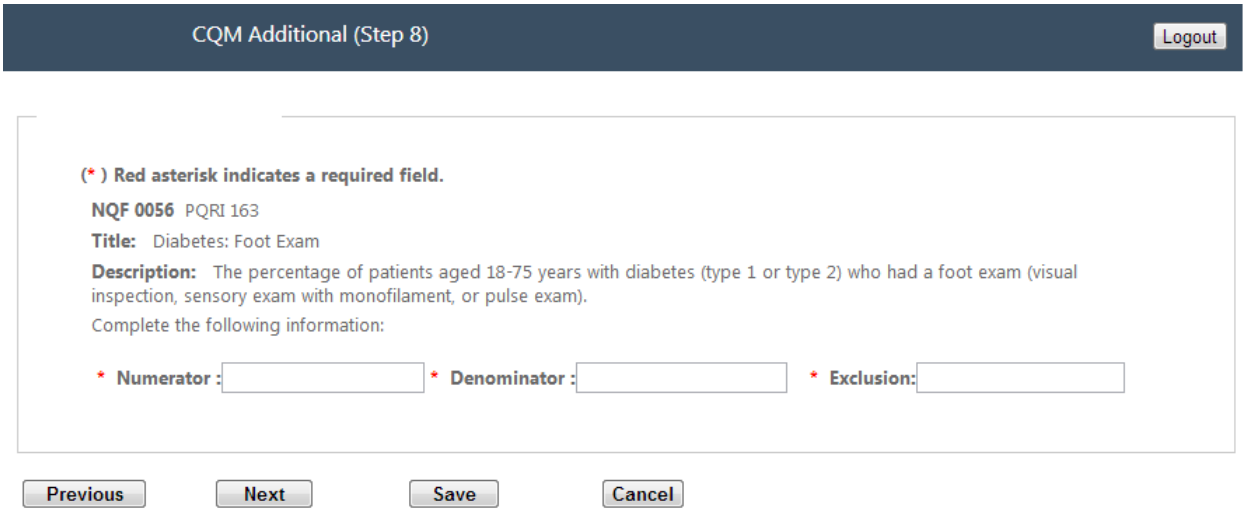
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Diabetes: Foot Exam



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

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Diabetes: Hemoglobin A1c Poor Control

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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Diabetes: Blood Pressure Management

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0061 PQRI 3

Title: Diabetes: Blood Pressure Management

Description: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.

Complete the following information:

* **Numerator :** * **Denominator :** * **Exclusion:**

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Diabetes: Urine Screening

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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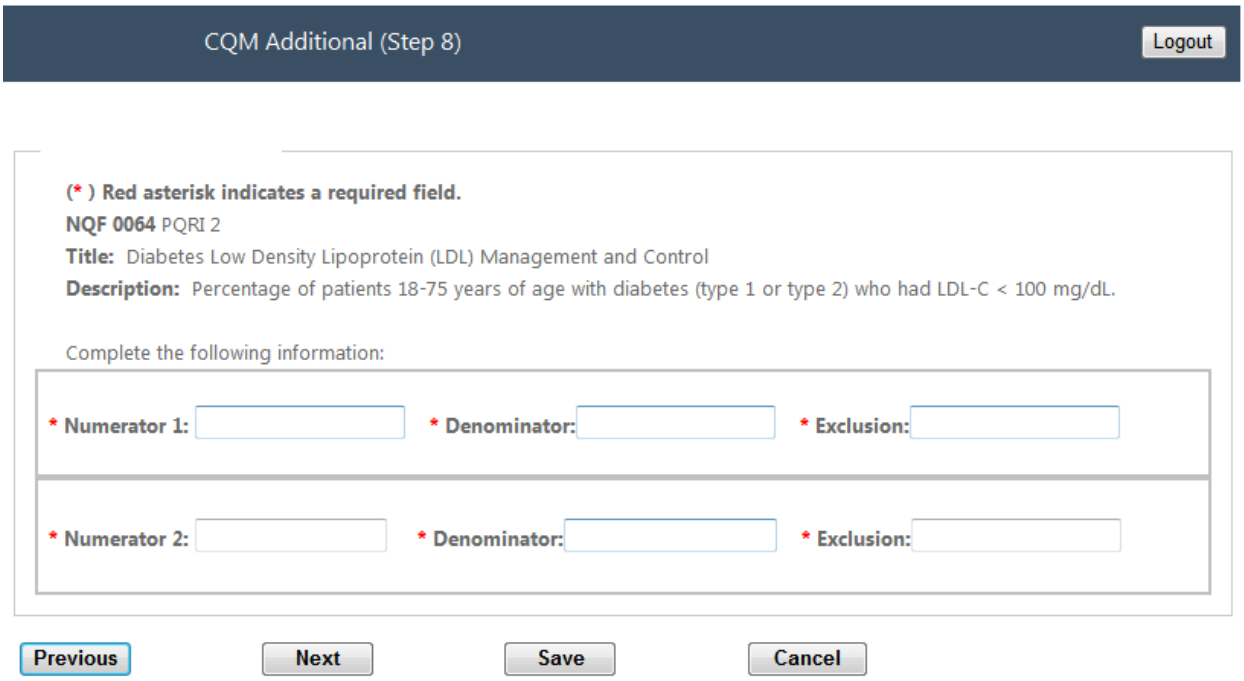
Diabetes: Low Density Lipoprotein (LDL) Management and Control



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

For each of the appropriate boxes, do the following:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
  - For "Numerator 1", enter the patients who had an LDL test.
  - For "Numerator 2", enter the patients who had an LDL test with a value < 100 mg/dL.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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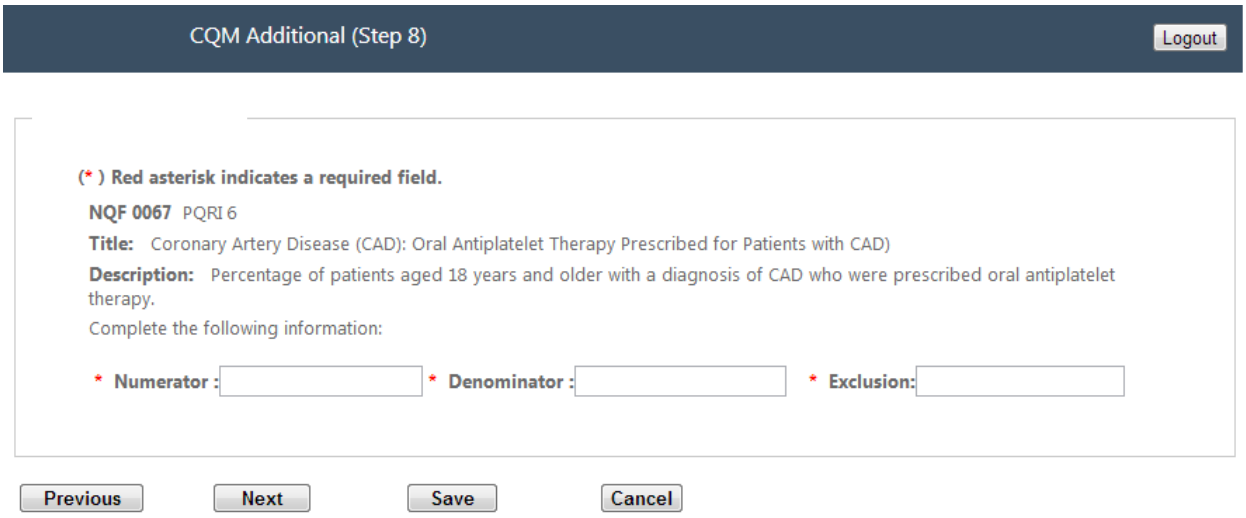
Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

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- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithormbotic

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0068

Title: Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.

Complete the following information:

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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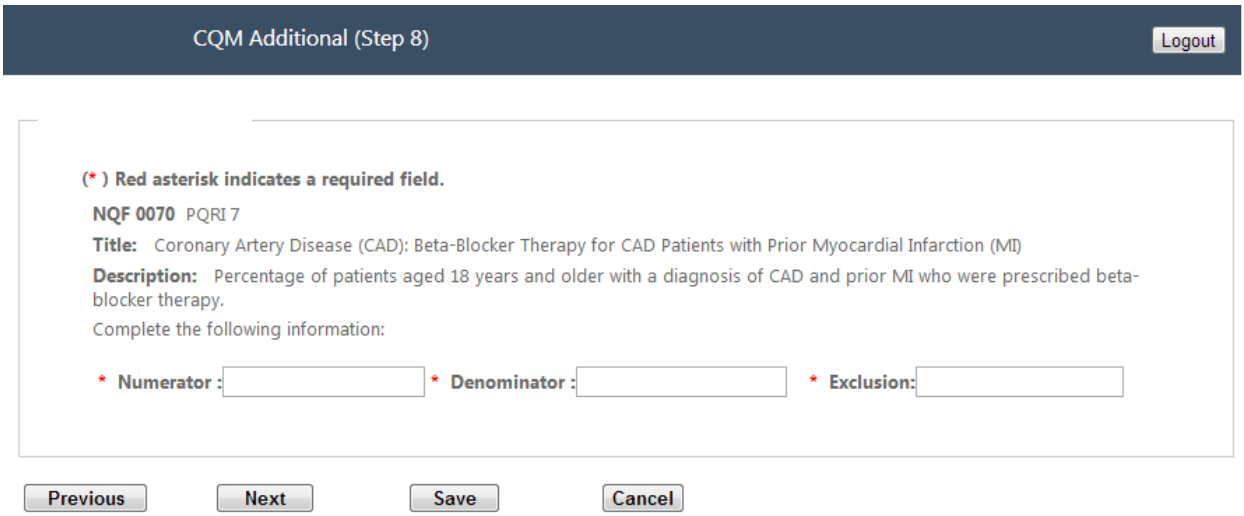
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Coronary Artery Disease (CAD): Beta Blocker Therapy for CAD Patients with Prior Myocaridal Infarction (MI)



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

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- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Ischemic Vasular Disease (IVD): Blood Pressure Management

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0073 PQRI 201

Title: Ischemic Vascular Disease (IVD): Blood Pressure Management

Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).

Complete the following information:

* **Numerator :** * **Denominator :**

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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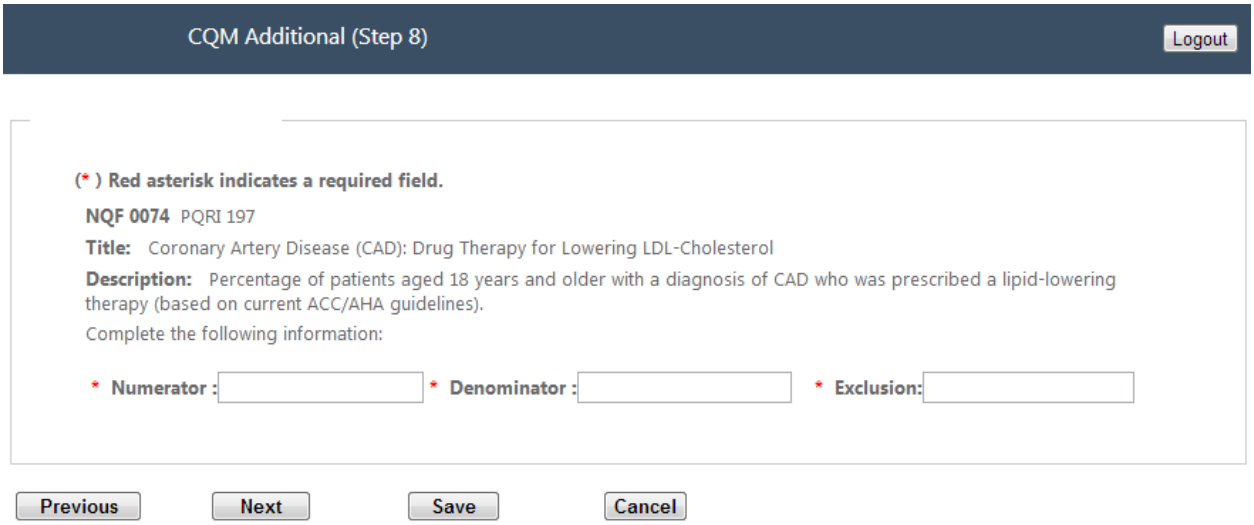
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL - Cholesterol



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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Ischemic Vascular Disease (IVD): Completed Limpid Panel and LDL Control

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0075

Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control

Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C<100 mg/dL.

Complete the following information:

* **Numerator 1:** * **Denominator:**

* **Numerator 2:** * **Denominator:**

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

For each of the appropriate boxes, do the following:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
  - For "Numerator 1", enter patients for which LDL test and/or HDL, total cholesterol and triglycerides tests were performed.
  - For "Numerator 2", enter patients for which LDL-C<100 mg/dL and/or triglycerides value < 400 mg/dL, total cholesterol value, HDL value, triglyceride value/5 < 100 mg/dL were performed.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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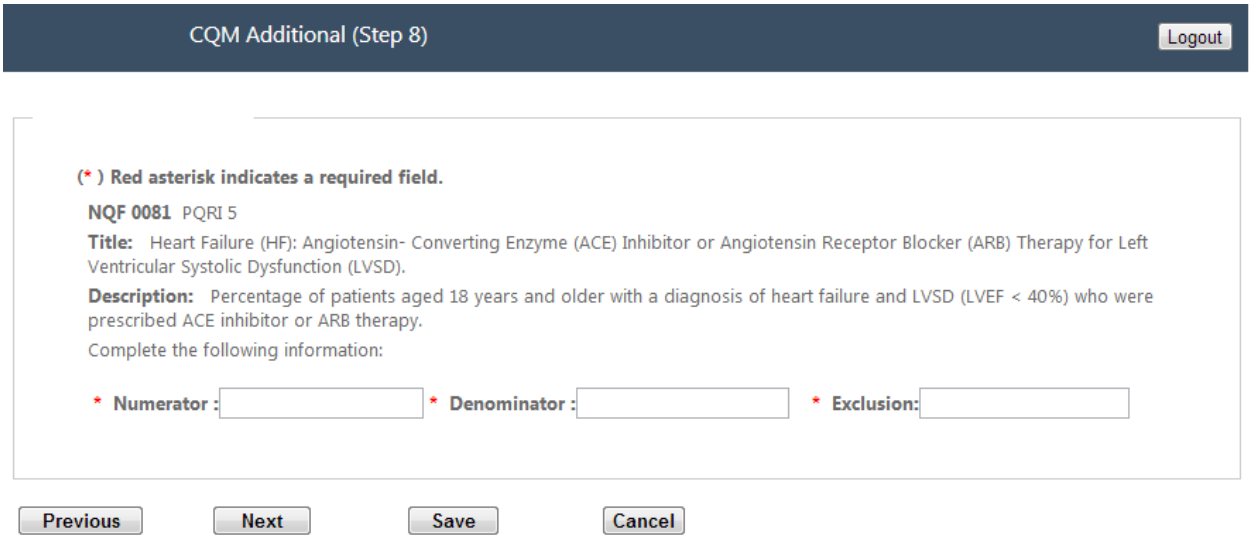
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Heart Failure (HV): Angiotensin-Converting Enzyme Inhibitor (ACE) or Angiotensin Receptor Blocker Therapy for LVSD



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

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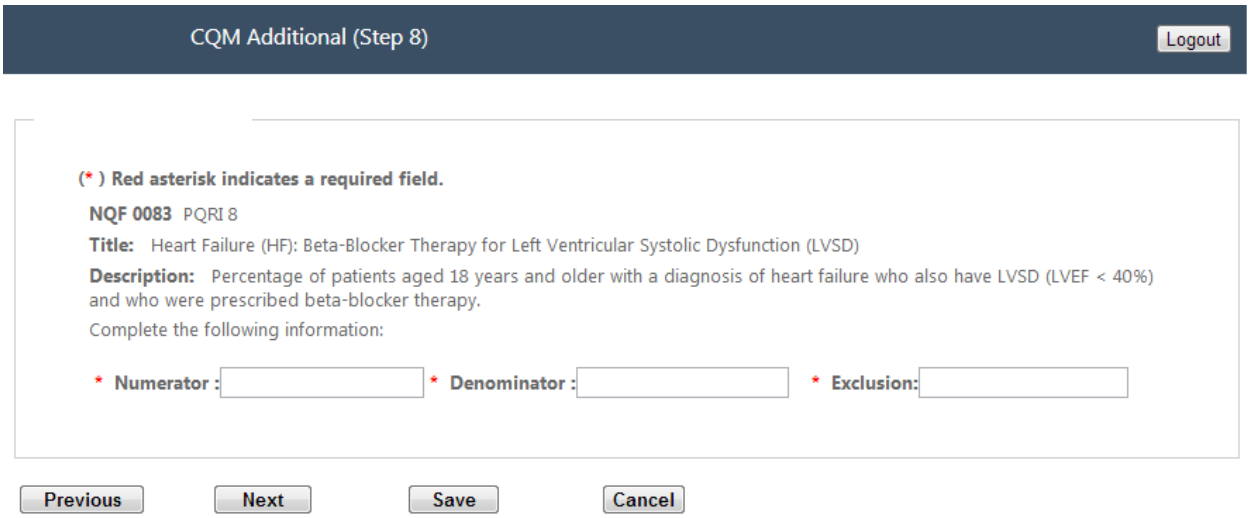
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Heart Failure (HV): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

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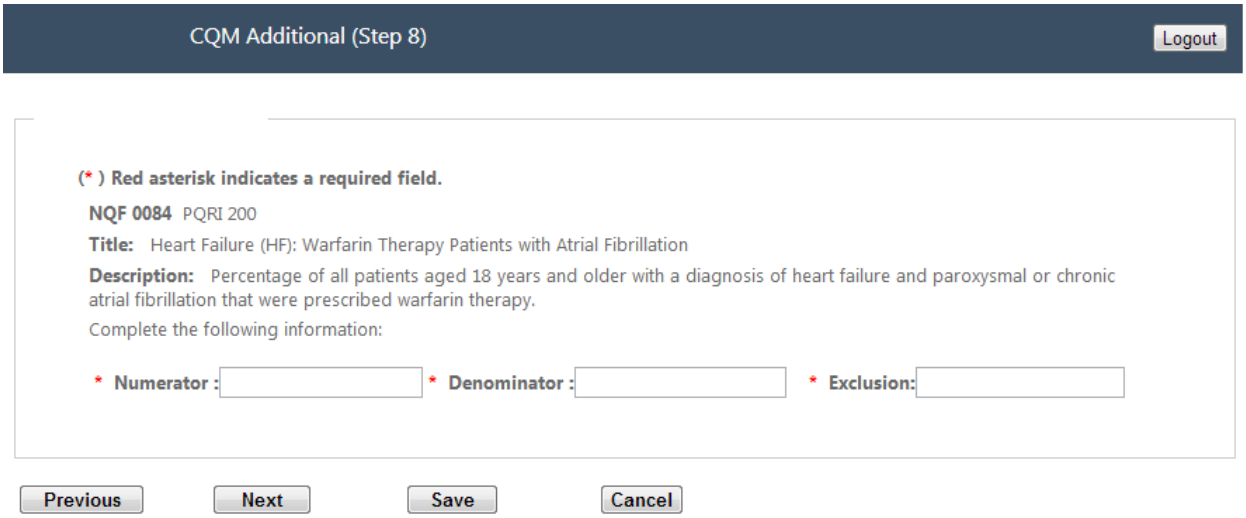
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Heart Failure (HV): Warfarin Therapy Patients with Atrial Fibrillation



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

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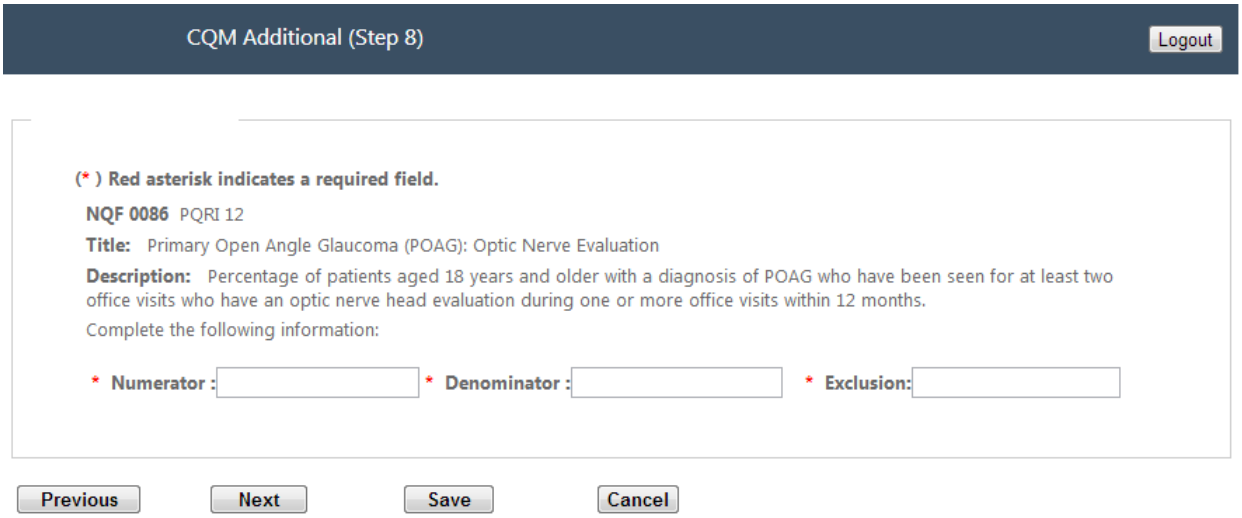
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

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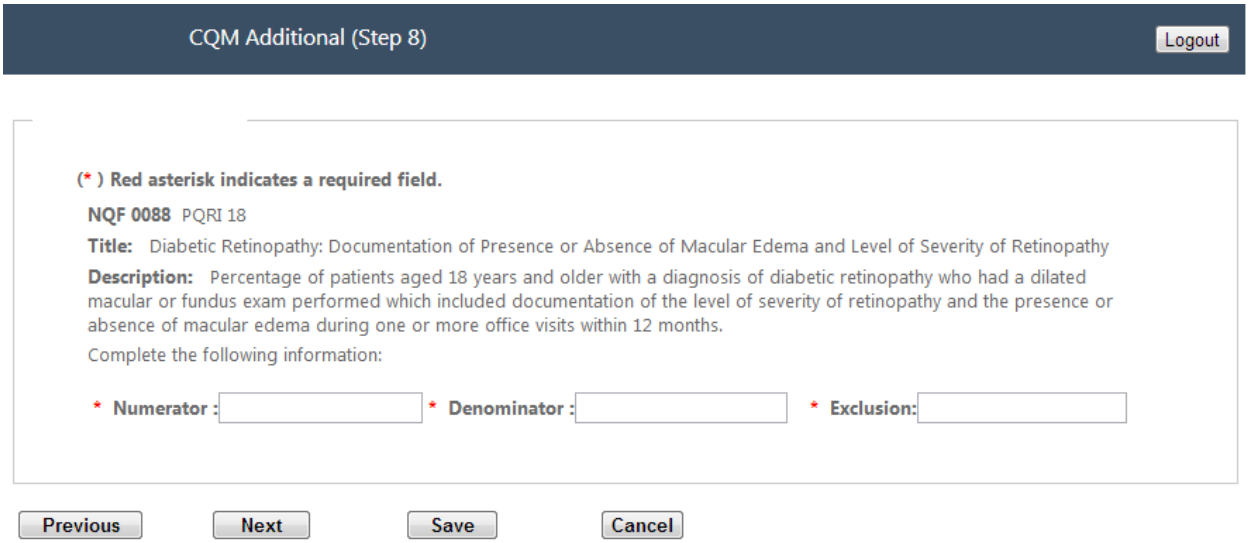
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
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- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0089 PQRI 19

Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

Description: 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.

Complete the following information:

* **Numerator :** * **Denominator :** * **Exclusion:**

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Anit-depressant Medication Management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment

CQM Additional (Step 8) Logout

(*) Red asterisk indicates a required field.

NQF 0105 PQRI 9

Title: Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment

Description: Percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.

Complete the following information:

* Denominator:	* Numerator 1:
* Denominator:	* Numerator 2:

Previous Next Save Cancel

Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator and Denominator:

For each of the appropriate boxes, do the following:

- Enter a number in each box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in each box labeled "Numerator" according to your certified EHR reporting.
  - For "Numerator 1", enter patients who were dispensed antidepressant medication 84 days or longer after being diagnosed with a new episode of major depression.
  - For "Numerator 2", enter patients who were dispensed antidepressant medication 180 days or longer after being diagnosed with a new episode of major depression.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
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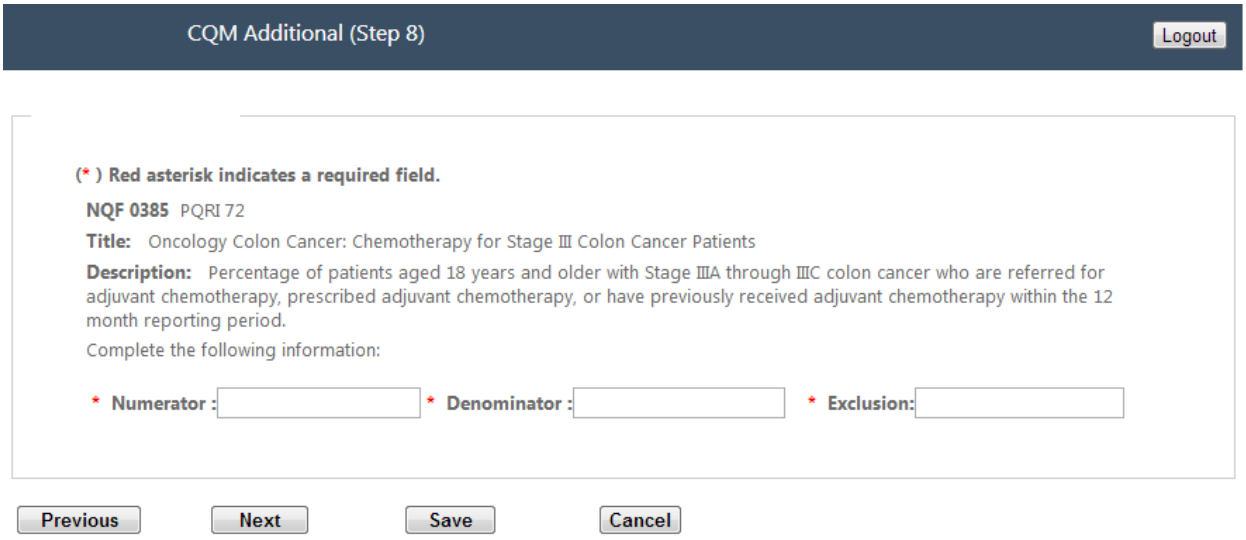
- “Save”- Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

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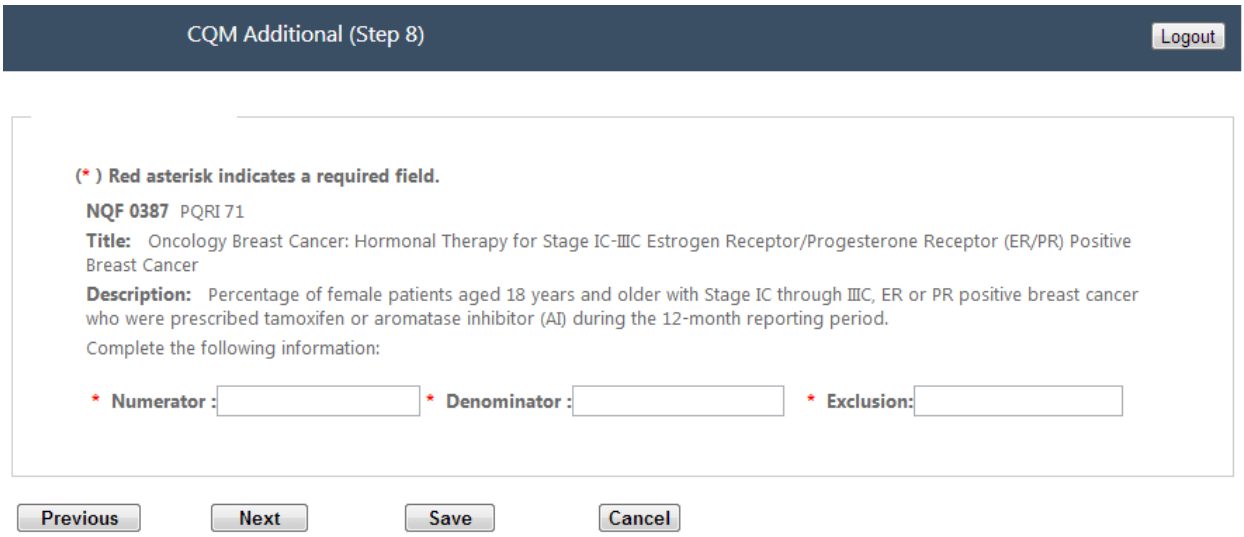
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC ER/PR Positive Breast Cancer



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

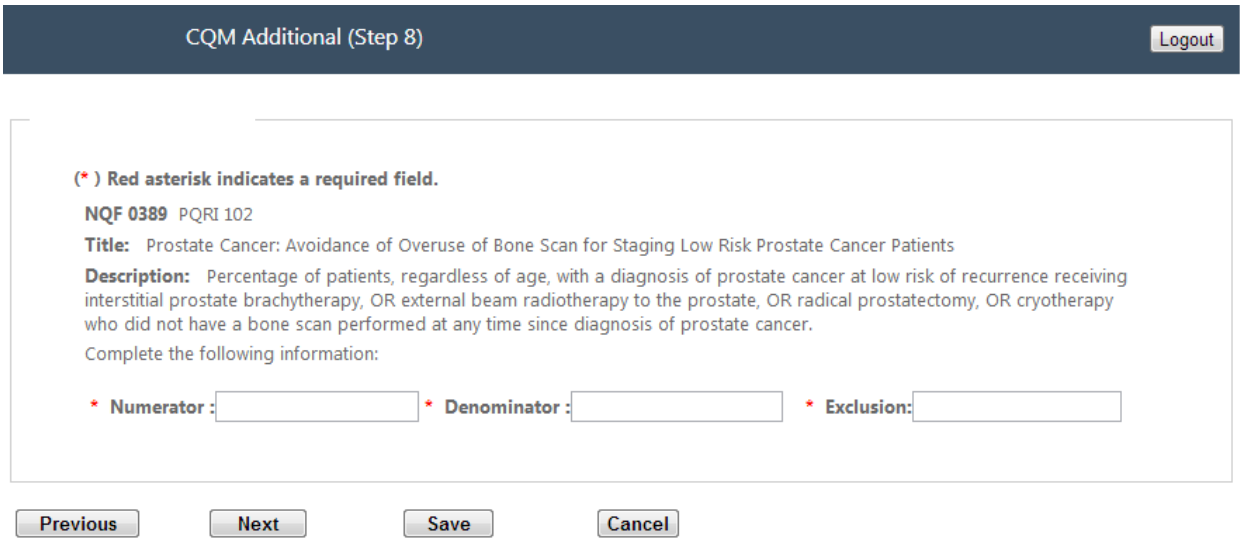
- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

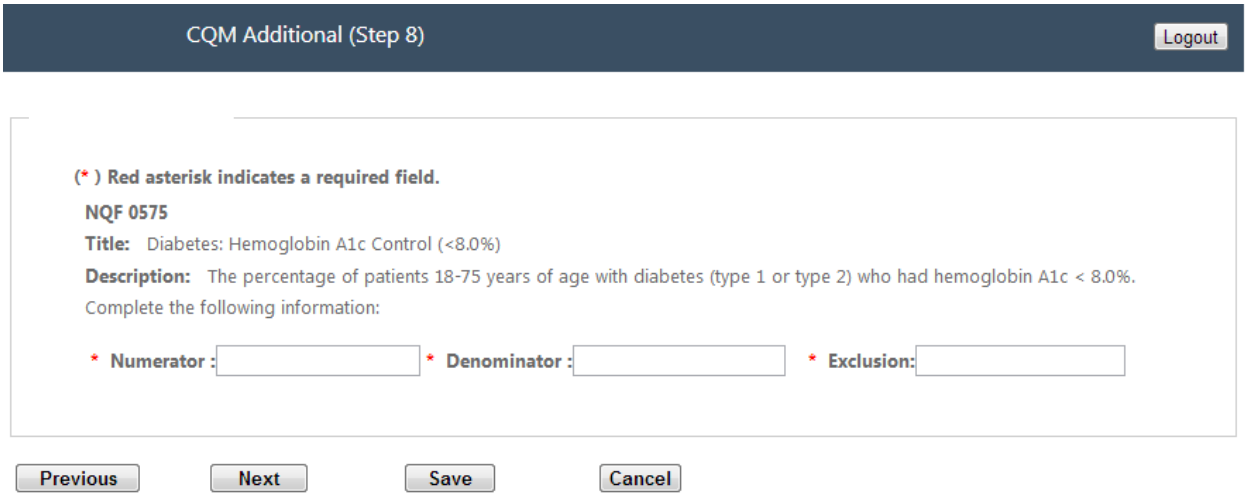
- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Diabetes: Hemoglobin A1c Control (< 8%)



Read the "Title" and "Description" carefully and answer the following sections on the screen:

Numerator, Denominator, and Exclusion:

- Enter a number in the box labeled "Numerator" according to your certified EHR reporting.
- Enter a number in the box labeled "Denominator" according to your certified EHR reporting.
- Enter a number in the box labeled "Exclusion" according to your certified EHR reporting.

Note: The number you enter into these fields must be a whole number and the numerator must be less than or equal to the denominator.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- "Previous" - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- "Next" - Will save your entries and take you to the next page.
- "Save"- Will save your current entries on the page and you will remain on that page.
- "Cancel" - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting "Cancel" you will see blank fields.

Summary of Measures (MU Step 9)

After the last additional clinical quality measure, the following page is presented. This page allows you to return to a major section and edit any individual question you have answered.

Summary of Measures (Step 9) Logout

Summary of Measures

Please select the desired measure link below to review the details of your attestation. This is your last chance to view/edit the information you have entered before you attest. Please review your information as you will be unable to edit your information after you attest.

Meaningful Use Core Measures Summary

Meaningful Use Menu Measures Summary

Clinical Quality Measures Summary

Previous Next

Here is an example of a page from the Clinical Quality Measures Summary:

CQM Summary Logout

Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue .

Core Clinical Quality Measure List Table

Measure#	Title	Measure	Data Entered	Selection
NQF 0013	Hypertension: Blood Pressure Measurement	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who has been seen for at least 2 office visits, with blood pressure(BP) recorded.	Denominator = 2 Numerator = 1	Edit
NQF 0028	Preventive Care and Screening Measure Pair	**a.Tobacco Use Assessment** **Description:** Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months. **b.Tobacco Cessation Intervention** **Description:** Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.	Denominator = 2 Numerator = 1 Denominator = 2 Numerator = 1	Edit
NQF 0421	Adult Weight Screening and Follow-up	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.	Denominator = 0 Numerator = 0 Exclusion = 0 Denominator = 0 Numerator = 0 Exclusion = 0	Edit

Alternate Core Clinical Quality Measure List Table

Title	Measure	Data Entered	
NQF 0041 - Preventive Care and Screening: Influenza Immunization for Patients >= 50 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	Numerator = 1 Denominator = 2 Exclusion = 0	Edit

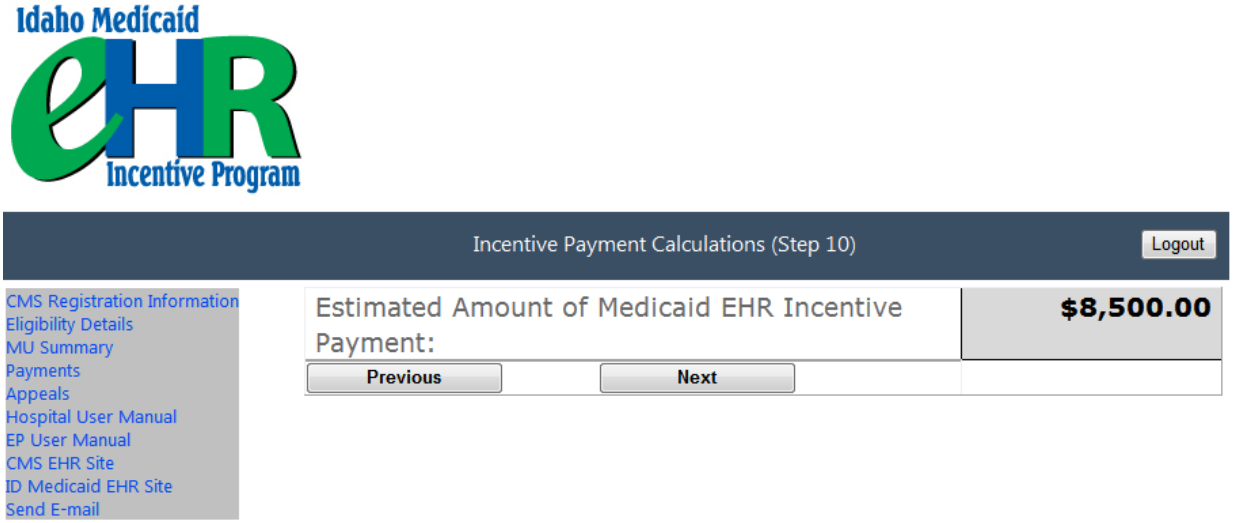
Additional Clinical Quality Measure List Table

Measure#	Title	Measure	Data Entered	Selection
NQF 0575	Diabetes: Hemoglobin A1c Control (<8.0%)	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c < 8.0%.	Denominator = 1 Numerator = 1 Exclusion = 1	Edit
NQF 0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	Denominator = 1 Numerator = 1 Exclusion = 1	Edit
NQF 0387	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.	Denominator = 1 Numerator = 1 Exclusion = 1	Edit

Previous Next

Note: Selecting "Previous" prior will result in moving to the previous link of the "Summary of Measures" link (e.g., Meaningful Use Menu Measures Summary). If the user clicks on "Next" the Incentive Payment Calculations page will display.

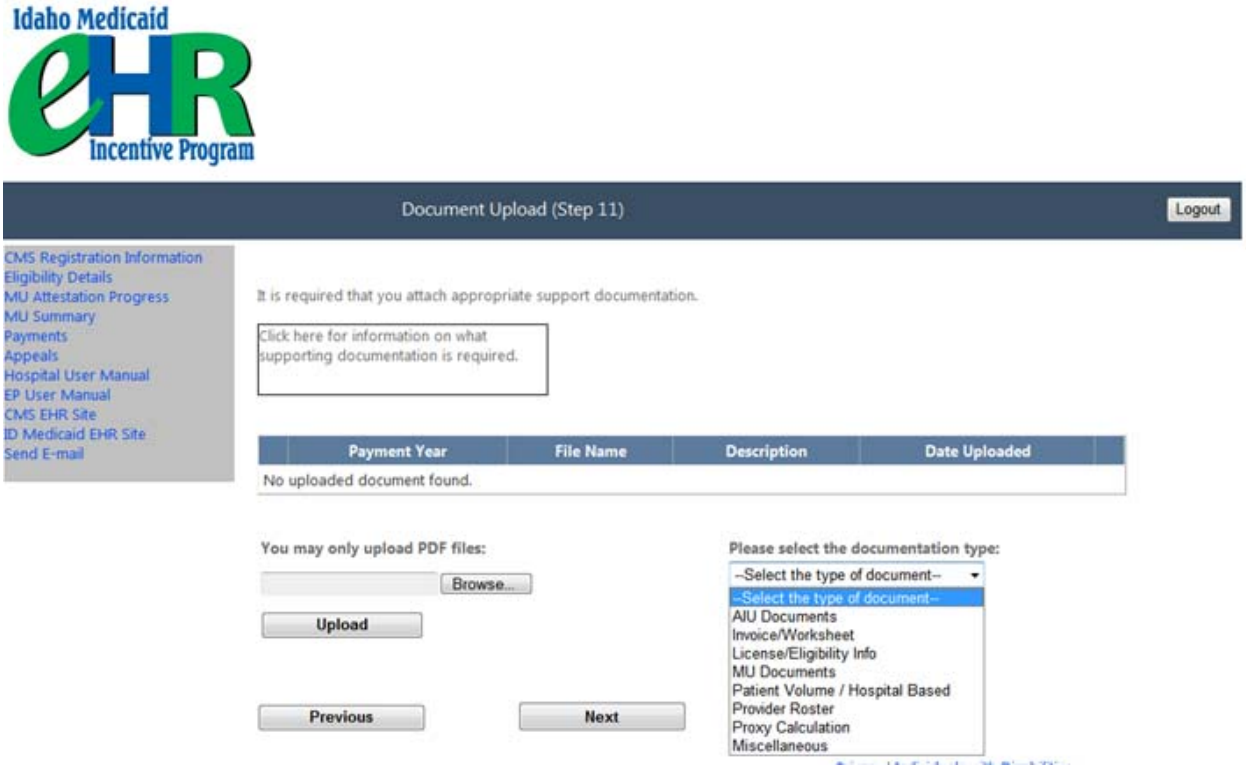
Incentive Payment Calculations (MU Step 10)



When this page appears:

- Review the incentive payment amount and contact the Idaho Medicaid EHR Incentive Program Help Desk if you have questions.
- If you see a $0 estimated amount of Medicaid EHR incentive payment, you may not have met eligibility requirements; click on the "Previous" button, which will take you back to the Provider Eligibility Details page, and check your responses to the questions. If you have questions, contact the Help Desk at EHRincentives@dhw.idaho.gov or call (208) 332-7989.
- If your payment amount looks correct, select "Next" to go to the Document Upload page.

Document Upload (MU Step 11)



When this page appears:

- In addition to the Meaningful Use documentation listed below, you will also be required to upload your patient volume report and proof of EHR purchase/upgrade (copy of current paid invoice, cancelled check, etc.).
  Note: Only PDF files can be uploaded.
- You will still be able to upload files even after you have completed your attestation.
- Selecting "Next" will take you to the Attestation page of the IIMS.
- Meaningful use documentation
  - Core Measures: One de-identified report from the certified EHR software that was used for a core attestation item
  - Menu Measures: One de-identified report from the certified EHR software that was used for a menu attestation item
  - Clinical Quality Measures: One de-identified report from the certified EHR software that was used for a clinical quality measure attestation item
  - When naming your document, please use the following naming conventions:
    - For core measures use the core measures number (e.g., Core 170.302a)
    - For menu measures use the menu measures number (e.g., Menu 170.302b)
    - For clinical quality measures, use the clinical quality measures number (e.g., CQM NFQ 0024)

Attestation (MU Step 12)

Idaho Medicaid eHR Incentive Program

Attestation (Step 12)

CMS Registration Information
Eligibility Details
MU Summary
Payments
Appeals
Hospital User Manual
EP User Manual
CMS EHR Site
ID Medicaid EHR Site
Send E-mail

Please verify the following information:

CMS:

Applicant National Provider Index (NPI):	1200000011	Name:	Red Green
Applicant TIN:	517667201	Address 1:	123 Street
Payee National Provider Index (NPI):	1070000000	Address 2:	Suite 1000
Payee TIN:	555443333	City/State:	Boise / ID
Program Option:	MEDICAID	Zip Code:	83701 -
Medicaid State:	ID	Phone Number:	(208) 555-1212
Payment Year:	2	Email:	wheatonj@dhw.idaho.gov
Eligible Professional Type:	Physician	Specialty:	PEDIATRIC MEDICINE

Eligible Details:

Program Year:		Program Year:	2013
Patient Volume:	1.	Is your patient volume calculated using the proxy method:	No
	2.	If yes, please enter the NPI of the clinic or group:	0
	3.	The starting date of the 90-day period to calculate Medicaid encounter volume percentage:	5/1/2012 (mm/dd/yy)
	4.	Medicaid patient encounters during this period:	150
	5.	Total patient encounters during this period:	400
	6.	Is your patient volume based on needy?	Yes
	6a.	Do you practice predominantly in an FQHC / RHC?	Yes
	7.	Medicaid/needy patient encounter volume percentage:	38%
EHR Details:	8.	Enter the CMS EHR Certification ID of your EHR:	30000005ZKOJEAG
	9.	Indicate the status of your EHR:	Meaningful Use

ATTESTATION
FOR PARTICIPATION IN THE
IDAHO EHR INCENTIVE PROGRAM

This Attestation is required for participation in the Idaho Medicaid Electronic Health Record (EHR) Incentive Paym Program to eligible professionals (EPs) and eligible hospitals who adopt, implement, upgrade (AIU) or meaningf (MU) certified EHR technology. Participation must be in accordance with the requirements under United States Department of Health and Human Services, Centers for Medicare & Medicaid Services Final Rule regulations 42 495, Standards for the Electronic Health Record Incentive Program, revised July 28, 2010. These regulations impl the HITECH Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5). To comp the above cited regulations, the Idaho Department of Health and Welfare (Department) requires that eligible professionals (EPs) and eligible hospitals submit this Attestation.

This Attestation certifies the following is known and understood:

1. EPs are prohibited from seeking payment from another state or from the Medicare EHR incentive progra this payment year (applicable to EP only).
2. The Department can review, verify and/or audit all information provided by the EP or eligible hospital, bo to and after payment has been made.
3. The Department can request AIU and/or MU supporting information either at the time of attestation or af can review, verify and/or audit both prior to and after payment has been made.
4. The EP or eligible hospital is required to retain the documentation that verifies patient volume calculation MU, and any other information that validates the appropriateness of the EHR incentive payments received do so for 6 years from the date of payment.
5. The submission of any false information in this agreement or this process may result in the EP or eligible being declared ineligible to participate in the Idaho Medicaid EHR Incentive Program.
6. Any incentive payments paid to the EP or eligible hospital, later found to have been made based on fraud or inaccurate information or attestation may be recouped by the Department or other appropriate state federal agency.
7. The EHR incentive payments will be treated like all other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment.

This Attestation also certifies that the following is true and accurate:

1. With awareness and informed consent, this EP or eligible hospital is voluntarily participating in the Idaho Medicaid EHR Incentive Program.
2. The EHR certification number provided is the correct number, and accurately represents the certified EHR or combination of certified EHR modules adopted and/or in use by this EP, group practice, or eligible ho
3. Any reassignment of an EHR incentive payment is made voluntarily, which assumes informed consent, has given by the EP, who understands that the party so designated—not the EP—will receive the payment (ap to EPs only).
4. The person completing this electronic attestation is the EP, or the assigned representative of the EP, grou practice or eligible hospital, who has been duly authorized to commit the EP or eligible hospital to the statements set forth in this attestation (applicable to EPs only).
5. If patient volume threshold is derived using encounter data from multiple practice locations, at least one locations must have has a certified EHR (applicable to EPs only).
6. If the EP is a physician assistant, they are practicing in a physician assistant led FQHC or RHC.

I CERTIFY THAT the information provided in this Attestation and during the registration process, as well as in the documents submitted in support of registration, are true, accurate and complete. I hereby agree to retain such for six years from the date of payment as are necessary to demonstrate I meet the program requirements, and furnish those records to the Idaho Department of Health and Welfare, Division of Medicaid or contractor acting behalf, upon request before and/or after payment. I have read and understood this entire Attestation. I understa any Medicaid EHR incentive payment made, in part, or wholly as a result of this Attestation will be from federal and that falsification or concealment of material facts may be prosecuted under federal and state laws.

All * fields are required fields.

Initials: *

NPI: *

Preparer Name: What is this?

Preparer Email:

Re-enter Preparer Email:

Eligible Professional Email:

Note: Once you press the submit button below, you will not be able to change your information.

Previous Submit

Required:

1. Enter your initials or name and the provider's NPI at the bottom of the screen.
   - This will serve as your electronic signature.
   - By entering this information, you attest to the validity of all data submitted for consideration by the Idaho Medicaid EHR Incentive Program.
2. Select "Submit".
   Important: After you select "Submit", **YOU CANNOT GO BACK AND MAKE ANY CHANGES.**
   - Once you select "Submit", it will take you to the first page of your attestation, "CMS Registration Information (Step 1)", to review. You can select "Previous" and "Next" to view the attestation pages in a review mode only.
   - Selecting "Submit" will notify Idaho Medicaid that the provider's attestation is ready for final eligibility review.

The attestation text is shown here:

ATTESTATION

FOR PARTICIPATION IN THE

IDAHO MEDICAID EHR INCENTIVE PROGRAM

This Attestation is required for participation in the Idaho Medicaid Electronic Health Record (EHR) Incentive Payment Program to eligible professionals (EPs) and eligible hospitals who adopt, implement, upgrade (AIU), or meaningfully use (MU) certified EHR technology. Participation must be in accordance with the requirements under United States Department of Health and Human Services, Centers for Medicare & Medicaid Services Final Rule regulations 42 CFR 495, "Standards for the Electronic Health Record Incentive Program", revised July 28, 2010. These regulations implement the HITECH Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5). To comply with the above cited regulations, the Idaho Department of Health and Welfare (Department) requires that EPs and eligible hospitals submit this Attestation.

This Attestation certifies the following is known and understood:

8. EPs are prohibited from seeking payment from another state or from the Medicare EHR incentive program in this payment year (applicable to EP only).
9. The Department can review, verify, and/or audit all information provided by the EP or eligible hospital, both prior to and after payment has been made.
10. The Department can request AIU and/or MU supporting information either at the time of attestation or after, and can review, verify, and/or audit both prior to and after payment has been made.
11. The EP or eligible hospital is required to retain the documentation that verifies patient volume calculations, AIU, MU, and any other information that validates the appropriateness of the EHR incentive payments received, and do so for six years from the date of payment.
12. The submission of any false information in this agreement or this process may result in the EP or eligible hospital being declared ineligible to participate in the Idaho Medicaid EHR Incentive Program.
13. Any incentive payments paid to the EP or eligible hospital that are later found to have been made based on fraudulent or inaccurate information or attestation may be recouped by the Department or other appropriate state or federal agency.
14. The EHR incentive payments will be treated like all other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment.

This Attestation also certifies that the following is true and accurate:

7. With awareness and informed consent, this EP or eligible hospital is voluntarily participating in the Idaho Medicaid EHR Incentive Program.
8. The EHR certification number provided is the correct number and accurately represents the certified EHR system or combination of certified EHR modules adopted and/or in use by this EP, group practice, or eligible hospital.
9. Any reassignment of an EHR incentive payment is made voluntarily, which assumes informed consent has been given by the EP, who understands that the party so designated—not the EP—will receive the payment (applicable to EPs only).
10. The person completing this electronic attestation is the EP or the assigned representative of the EP, group practice, or eligible hospital who has been duly authorized to commit the EP or eligible hospital to the statements set forth in this attestation (applicable to EPs only).
11. If patient volume threshold is derived using encounter data from multiple practice locations, at least one of those locations must have a certified EHR (applicable to EPs only).
12. If the EP is a physician assistant, he or she is practicing in a physician assistant led FQHC or RHC.

I CERTIFY THAT the information provided in this Attestation and during the registration process, as well as in the documents submitted in support of registration, are true, accurate, and complete. I hereby agree to retain such records for six years from the date of payment as are necessary to demonstrate I meet the program requirements, and to furnish those records to the Idaho Department of Health and Welfare, Division of Medicaid, or contractor acting on their behalf, upon request, before and/or after payment. I have read and understood this entire Attestation. I understand that any Medicaid EHR incentive payment made, in part or wholly as a result of this Attestation, will be from federal funds and that falsification or concealment of material facts may be prosecuted under federal and state laws.

Other Supporting Pages

The following pages are additional resources the provider may find useful when interacting with the Idaho Medicaid EHR Incentive Program.

The provider must be logged into the IIMS to see the left side menu items as shown below. The highlighted links will be described in the following pages.

Payments

To access this page, select "Payments" from the left side menu. After payment has been disbursed, the provider may review payments and any payment adjustments for each payment year they participated in Idaho's incentive program. If a provider participated in another state's Medicaid incentive program or the Medicare incentive program in other payment years, the information from those sources will not be made available here. The provider should be able to access that payment information from the other state's Medicaid incentive program's site or the CMS EHR Incentive Program Registration and Attestation System.

Payment Year	Payment Amount	Payment Date	Payment Type
2	8500.00	5/8/2013 12:00:00 AM	Initial
1	21250.00	8/1/2012 12:00:00 AM	Initial

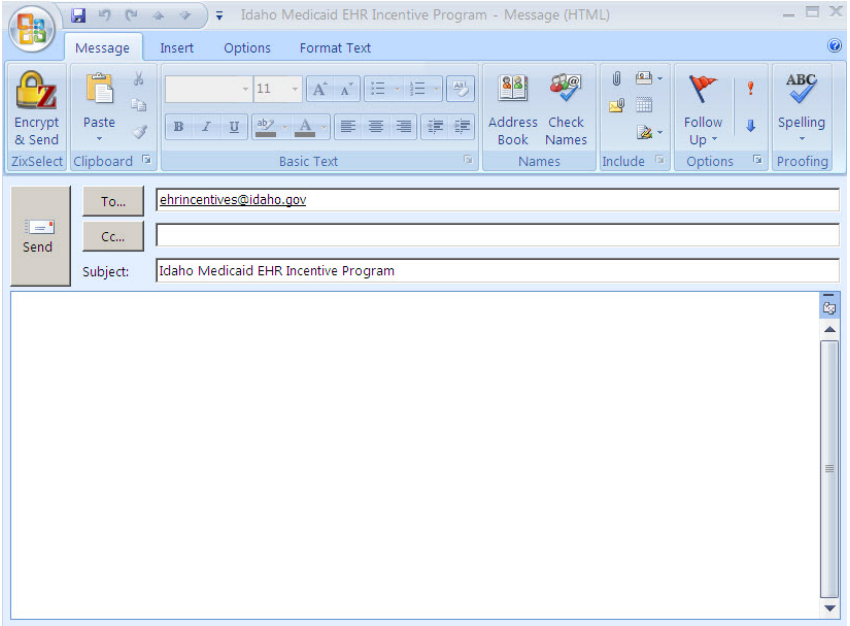
The payment details shows payments for the first two payment years, the amount paid and the payment type (initial for the program year or adjustment for the program year).

Appeals

To access this page:

- Select "Appeals" from the left side menu.
- Review the information to ensure any appeals you would like to file are sent to the correct location. **Note:** A provider can only submit appeals in writing.

Send E-mail



To access this page:

- Select "Send E-mail" from the left side menu to initiate the e-mail application on the provider's computer.
  Note: This is the same as clicking on the "Send email to: EHRincentives@dhw.idaho.gov" on the Idaho Medicaid EHR Incentive Program website.
- Enter the message and send the email.
  Note: If you have problems with your email system, please contact your local office's IT support for assistance before contacting the Idaho Medicaid EHR Incentive Program Help Desk.

APPENDIX

Resources

CMS Stage 2 Final Rule

A CMS website that provides the latest in final rules and overviews of Stage 2 Meaningful Use.
http://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/stage_2.html

Medicare and Medicaid Electronic Health Records (EHR) Incentive Program

The CMS website with information about EHR incentives and how to get started to register for the incentive program http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/

Eligible Professional and Eligible Hospital Attestation Portal for Idaho

Idaho Incentive Management System (IIMS) where you may log in and begin to attest is located at http://www.MedicaidEHR.dhw.idaho.gov.

Office of the National Coordinator for Health Information Technology (ONC)

Certified Health IT Product List (CHPL):
http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl

Regional Extension Centers (RECs)

The Washington Idaho Regional Extension Center (WIREC) is designated to provide technical assistance to Idaho's eligible professionals. WIREC provides a full range of assistance related to EHR selection and training.

Qualis Health
PO Box 33400
Seattle, WA 98133-0400
Phone: (206) 364-9700
Toll-free: (800) 949-7536
Fax: (206) 366-3370
http://www.wirecqh.org/

Peggy Evans, PhD, CPHIT
WIREC Director
peggye@qualishealth.org
(206) 288-2471

Kristin Johnson
WIREC Project Coordinator
kristinj@qualishealth.org
(206) 288-2357

Frequently Asked Questions About Using a Provider Roster

Is using a group proxy required?
The Medicaid EHR Incentive Program does not require an EP to use one method of patient volume calculation over the other. All EPs are free to use an individual patient volume calculation or a group proxy calculation. All EPs are encouraged to talk with their clinic's or organization's administration as they may have a preference.

What's the best way to establish a group proxy approach?
All EPs participating in the Medicaid EHR Incentive Program from a clinic/organization must use the same approach for any given calendar year to meet patient volume requirements. The first provider approved for payment will set the approach for the clinic/organization. For example:

- If the first provider participating from a clinic/organization attests to individual patient volumes (and is approved for payment), all providers subsequently participating for that calendar year from that clinic/organization will be required to attest to individual patient volumes and are not allowed to use a group proxy at either the organization or clinic level.
- If the first provider enrolling from a clinic/organization attests to the group proxy calculation for the clinic/organization, subsequent providers associated with that clinic/organization are required to attest to the same overall patient volumes using the same group proxy worksheet. They will not be given the opportunity to use individual patient volumes.

Is there an example of a group proxy calculation?
The following excerpt from the CMS FAQ# 2293 illustrates how the group proxy calculation is to be applied:

If an eligible professional (EP) in the Medicaid EHR Incentive Program wants to leverage a clinic or group practice's patient volume as a proxy for the individual EP, how should a clinic or group practice account for EPs practicing with them part-time and/or applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?

EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (e.g., if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2. There is an auditable data source to support the clinic's patient volume determination; and
3. So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities.

If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from clinic A in calculating his or her individual patient volume.

The intent of the flexibility for the proxy volume (requiring all EPs in the group practice or clinic to use the same methodology for the payment year) was to ensure against EPs within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume EPs from applying using their individual patient volume, where the lower Medicaid patient volume EPs then use the clinic volume, which would of course be inflated for these lower-volume EPs.

CLINIC A (with a fictional EP and provider type)

- EP #1 (physician): individually had 40% Medicaid encounters (80/200 encounters)
- EP #2 (nurse practitioner): individually had 50% Medicaid encounters (50/100 encounters)
- Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)
- Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)
- EP #3 (physician): individually had 10% Medicaid encounters (30/300)
- EP #4 (dentist): individually had 5% Medicaid encounters (5/100)
- EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35% of the clinic's volume. This means that 5 of the 7 professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program. (Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included.)

The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35% Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5).

If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic-level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other.

Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP # 4 could choose to use the proxy-level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid patient volume. In addition, her Clinic A patient encounters would be included in determining such clinic's overall Medicaid patient volume.

Related FAQs From CMS's Website Regarding Getting EHR Certification

How do I know if my EHR system is certified? How can I get my EHR system certified?
The following excerpt is from CMS FAQ #2811.

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments. The Certified Health IT Product List (CHPL) is available at http://www.healthit.hhs.gov/CHPL. This is a list of complete EHRs and EHR modules that have been certified for the purposed of this program.

Through the temporary certification program, new certification bodies have been established to test and certify EHR technology. Vendors can submit their EHR products to the certifying bodies to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC web site: http://www.healthit.hhs.gov/CHPL.

Must providers have their EHR technology certified prior to beginning the EHR reporting period in order to demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs?
The following excerpt is from CMS FAQ #2893.

No. An EP or hospital may begin the EHR reporting period for demonstrating meaningful use before their EHR technology is certified. Certification need only be obtained prior to the end of the EHR reporting period. However, meaningful use must be completed using the capabilities and standards outlined in the ONC Standards and Certification Regulation for certified EHR technology. Any changes to the EHR technology after the beginning of the EHR reporting period that are made in order to get the EHR technology certified would be evidence that the provider was not using the capabilities and standards necessary to accomplish meaningful use because those capabilities and standards would not have been available, and thus, any such change (no matter how minimal) would disqualify the provider from being a meaningful EHR user. If providers begin the EHR reporting period prior to certification of their EHR technology, they are taking the risk that their EHR technology will not require any changes for certification. Any changes made to gain certification must be done prior to the beginning of the EHR reporting period during which meaningful use will be demonstrated. This does not apply to changes made to EHR technology that were not necessary for certification.

My EHR system is CCHIT certified, does that mean it is certified for the EHR Incentive Programs? The following excerpt is from CMS FAQ #2623.

No. All EHR systems and technology must be certified specifically for this program. The Certified Health IT Product List is available at http://www.healthit.hhs.gov/CHPL. This is a list of all complete EHRs and EHR modules that have been certified for the purposes of this program.

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments.

Through the temporary certification program, new certification bodies have been established to test and certify EHR technology. Vendors can submit their EHR products to the certifying bodies to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC web site – http://www.healthit.hhs.gov/CHPL.

If a provider purchases a certified complete EHR or has a combination of certified EHR modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that provider be able to successfully demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs? The following excerpt is from CMS FAQ #3211.

No, the EP would not be able to successfully demonstrate meaningful use. To successfully demonstrate meaningful use, a provider must do three things:

1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules;
2. Meet the measures or exclusions for 17 meaningful use objectives (19 objectives for eligible hospitals and Critical Access Hospitals (CAHs)); and
3. Meet those measures using the capabilities and standards that were certified to accomplish each objective.

A provider using uncertified EHR technology to meet one or more of the core or menu set measures would not be using the capabilities and standards that were certified to accomplish each objective. Please note that this does not apply to the use of uncertified EHR technology and/or paper-based records for purposes of reporting on certain meaningful use measures (i.e., measures other than clinical quality measures), which is addressed in FAQ #10589.

Additional Information

If you have questions or issues concerning the Idaho Medicaid EHR Incentive Program, please visit www.MedicaidEHR.dhw.idaho.gov. There you will find an "Ask the Program" feature that will allow you to send questions to program staff. You can also e-mail questions to EHRincentives@dhw.idaho.gov or call (208) 332-7989. You may also visit the Idaho Medicaid EHR website (www.MedicaidEHR.dhw.idaho.gov) or CMS's website (http://www.healthit.hhs.gov) for additional FAQs.