IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Medicaid

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Promoting Interoperability (PI) Program

Eligible Professional User Manual

December 2018

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Document Change Log

Date	Changed By	Change
09/10/12	Wheaton	Creation
10/01/14	Kinne / Kellerman	Added Flexibility Rule information.
01/01/15	Kinne / Kellerman	Corrected screenshots which were outdated and added data flow charts of IIMS.
09/15/15	Coyle	Update of information, removal of screenshots, add links.
04/01/16	Coyle, Leavitt, Brewington	Inclusion of 2015 Modification Rule, modified screens, mandatory documents, and changes to dates.
04/01/17	Leavitt, Brewington	Inclusion of 2017 Stage 3 updates
12/01/17	Smith, Leavitt, Brewington	Inclusion of IPPS Final Rule
12/03/18	Toomey, Leavitt, Brewington	Inclusion of 2018 updates, program name change

Acronyms

AIU – Adopt, Implement, Upgrade
ALOS – Average Length of Stay
ARRA – American Recovery and Reinvestment Act of 2009
ATCB – Authorized Testing and Certification Body
BMI – Body Mass Index
BP – Blood Pressure
CAH – Critical Access Hospital
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CCHIT – Certification Commission for Health Information Technology
CCN – CMS Certification Number
CEHRT – Certified Electronic Health Record Technology
CHIP – Children's Health Insurance Plan
CHIPRA – Children's Health Insurance Plan Reauthorization Act of 2009
CHPL – Certified HIT Product List
CMS – Center for Medicare and Medicaid Services
CNM – Certified Nurse Midwife
CPOE – Computer Process Order Entry
CQM – Clinical Quality Measure
CY – Calendar Year
DHHS – Department of Health and Human Services
ED – Emergency Department
EH – Eligible Hospital
EHR – Electronic Health Record
EIN – Employer Identification Number
EMR – Electronic Medical Record
EP – Eligible Professional
eRX – Electronic Prescribing
FEIN – Federal Employer Identification Number
FFY – Federal Fiscal Year
FQHC – Federally Qualified Health Center
HHS – Department of Health and Human Services
HIE – Health Information Exchange
HIO – Health Information Organization

HIPAA – Health Insurance Portability and Accountability Act of 1996
HIT – Health Information Technology
HITECH – Health Information Technology for Economic and Clinical Health
IAPD – Implementation Advanced Planning Document
IDHW – Idaho Department of Health and Welfare
IIMS – Idaho Incentive Management System
IHC – Indian Health Clinic
IHS – Indian Health Services
IPA – Independent Practice Association
IPPS – Inpatient Prospective Payment System
IT – Information Technology
MCO – Managed Care Organization
MMIS – Medicaid Management Information System
MU – Meaningful Use
NHIN – National Health Information Network
NP – Nurse Practitioner
NPI – National Provider Identifier
NPRM – Notice of Proposed Rule Making
OIG – Office of the Inspector General
ONC – Office of the National Coordinator
PA – Physician Assistant
PAPD – Planning Advanced Planning Document
PCA – Program Cost Account
PHR – Personal Health Record
PI – Promoting Interoperability
PV – Patient Volume
RA – Remittance Advice
RHC – Rural Health Center
RHIO – Regional Health Information Organization
RNA – Registered Nurse Anesthetist
SFY – State Fiscal Year
SMHP – State Medicaid HIT Plan
TIN – Tax Identification Number

Business Links

CMS Promoting Interoperability (PI) Registration and Attestation System
https://ehrincentives.cms.gov/hitech/login.action

CMS PI Program FAQ
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html

CMS PI Program Regulations and Guidance
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/

CMS HITECH TA Portal
http://www.medicaidhitechta.org/

ONC CHPL
https://chpl.healthit.gov

Idaho Medicaid PI Program
https://healthandwelfare.idaho.gov/default.aspx?TabId=1405

Idaho Incentive Management System (IIMS)
https://iims.dhw.idaho.gov/login.aspx

Idaho Office of the State Controller (W-9/Direct Deposit form)
https://www.sco.idaho.gov/web/DSADoc.nsf/537A2603FE4B9E198725709800689EDF/$FILE/W9andEFT.pdf

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Purpose, Introduction, and Overview

The purpose of this document is to provide EPs with a reference guide and a training tool for new staff. Additionally, this document gives an overview of the Idaho Medicaid Promoting Interoperability (PI) Program, formerly known as the EHR Incentive Program. This manual describes the requirements to receive payment and step-by-step enrollment and attestation instructions.

Through provisions of ARRA, CMS implemented incentive payments to EPs participating in Medicare and Medicaid programs and are meaningful users of CEHRT. The incentive payments are not a reimbursement; rather they are intended to encourage EPs to adopt, implement, or upgrade a CEHRT and use it in a meaningful manner.

Goals for the national program include:

- Reduce paperwork and improve efficiencies
- Enhance care coordination and patient safety
- Enable data sharing using the state HIE and the NHIN
- Facilitate electronic information sharing across hospitals, payers, and state lines

Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce the costs of healthcare nationwide. Idaho Medicaid will work closely with federal and state partners to ensure the Idaho Medicaid PI Program fits into the overall strategic plan for the HIE exchange, thereby advancing national and Idaho goals for HIE.

The Medicaid PI Programs provide incentive payments to EPs, EHs, and CAHs as they adopt, implement, upgrade or demonstrate MU of CEHRT. There are two PI Programs. CMS oversees the Medicare PI Program, and the state Medicaid agencies (IDHW) manage the Medicaid PI Program. The two programs are similar, but there are some differences between them.

Medicare PI Program	Medicaid PI Program
Run by CMS	Run by the State Medicaid Agency
Maximum incentive amount is $44,000	Maximum incentive amount is $63,750
Payments over 5 consecutive years	Beginning with PY 2017, all EH and CAH incentive payments must be concurrent to the year prior. EP payments do not have to be consecutive.
Payment adjustments began in 2015 for providers who are eligible but decide not to participate	No payment adjustments for providers who are only eligible for the Medicaid program
Providers must demonstrate meaningful use every year to receive incentive payments	In the first year, providers can receive an incentive payment for AIU. Providers must demonstrate MU in the remaining years to receive incentive payments. PY 2016 is the last year that providers may enter the program and attest to AIU.

Eligibility

An EP's eligibility to receive incentive payments is based on the following four qualifications:

- Provider type and specialty
- Patient Volume
- State of licensure and good standing
- Qualifying CEHRT system

Provider Type and Specialty

CMS has determined the following EPs are eligible to participate:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Advanced Practice Professional Nurses
  - Nurse Practitioner
  - Certified Nurse Midwife
  - Registered Nurse Anesthetist
  - Clinical Nurse Specialist
- Dentist
- PA who furnishes services in an FQHC or RHC that is led by a PA

The incentive payments can only be made to Idaho Medicaid providers (EPs with an Idaho Medicaid Provider Agreement with MMIS). The only exception is if the EP does not bill the MMIS system, but rather bills an MCO in-lieu of Medicaid.

Patient Volume

PV thresholds must be established every year a provider applies for an incentive payment. To qualify for an incentive payment, the EP must meet the following requirements:

- 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 calendar year or rolling calendar year preceding the payment year.
- Have a minimum of 30 percent PV attributable to individuals receiving Medicaid funded services; or
- Have a minimum of 20 percent PV 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 PV attributable to needy individuals.

CHIP Encounters for PV

Encounters with Medicaid participants receiving services funded by Title XXI **cannot** be included in the PV calculation unless the EP practices predominantly in an FQHC or RHC **and** is basing the PV on needy patient encounters. Due to the fact EPs cannot always distinguish between

funding sources, Idaho Medicaid has received permission from CMS to use a CHIP PV Average strategy to help EPs determine their Medicaid PV.

Idaho's payment system differentiates the paying source using detailed codes for eligibility which are traceable to the claim. Using this information, Idaho Medicaid has identified a statewide average proportion for CHIP encounters for EPs. The CHIP PV average is currently seven (7) percent. The CHIP PV average was reviewed again in 2013, and it was determined to still be seven (7) percent; therefore, there will be no change in the current methodology for determining CHIP PV. These CHIP averages are based on an analysis of three years of claims history. This percent gives the statewide average of CHIP-to-total Medicaid encounters. EPs must identify their total number of Medicaid encounters and reduce that by the CHIP PV average percent when applying for incentives.

Using this method will benefit some providers whose actual CHIP PV is higher than the statewide average, and may disadvantage those whose CHIP PV is lower than the statewide average. To ensure EPs are not falsely denied eligibility based on this strategy, EPs can request the state provide them with the actual number of Medicaid and CHIP PV for the 90-day period of their choosing if they are unable to meet the PV threshold with the CHIP PV average reduction and believe otherwise they would meet it. EPs can contact the Idaho Medicaid PI Program Help Desk staff at (208) 332-7989 for more information about this process.

Institutional License and Good Standing

All participating EPs must have a current institutional license (provisional licenses are accepted) and must be free of both state and federal sanctions and exclusions. Institutional license and good standing must be established every year a provider applies for an incentive payment.

Qualifying CEHRT

ONC for HIT has issued rules defining CEHRT and has identified entities who can certify systems. The CEHRT used by the EP must be tested and certified by an ONC ACB/ATCB in order for the EP to qualify for PI incentive payments. Once certified, the product is listed on the ONC CHPL website where an EP can obtain the product's unique CCN. The CCN must be provided as part of the attestation and registration process. The CEHRT must meet the following requirements for the available stages:

- Modified Stage 2: must use technology certified to either a 2014 Edition, 2015 Edition, or a combination of 2014 and 2015 Editions for program years 2016-2018.
- Stage 3: must use technology certified to the 2015 Edition. A provider who has technology certified to a combination of the 2014 Edition and 2015 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. A provider who has technology certified to the 2014 Edition only *may not* attest to Stage 3.

Important Attestation Information

Getting your EHR Certification

The Medicaid PI Program requires the use of CEHRT. It is not enough for an EHR product to be certified by the Certification Commission for Health Information Technology. Standards, implementation specifications, and certification criteria for CEHRT have been adopted by the Secretary of the DHHS. The CEHRT in use by the provider (EP, EH, or CAH) must be tested and certified by an ONC ATCB in order for the provider to qualify for PI incentive payments. Once certified, the CEHRT product is listed on the ONC's CHPL website where the provider 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 PI program.

The ONC CHPL Product Number issued to your vendor for each CEHRT is different than the CMS EHR Certification ID Number issued to a provider for registration and attestation purposes. Only a CMS EHR Certification ID Number (obtained from the CHPL site) unique to the practice will be accepted at attestation.

Providers can obtain the CMS EHR Certification ID Number for their EHR product by following the steps on the ONC CHPL website.

Note: The CMS EHR Certification ID will not be generated until your product(s) meet 100 percent of CMS required criteria.

Vendor Enrollment

To receive PI incentive payments from Idaho Medicaid, the entity receiving the payment must be enrolled as a vendor with the state of Idaho. If you are unsure of prior vendor enrollment, contact the Idaho Medicaid PI Program Help Desk.

To enroll as a vendor who receives paper warrants and paper RAs, you must complete an IRS W-9 form and submit it to the Idaho Medicaid PI 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), you 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 in along with a voided check (originals only: copied, scanned, or faxed documents will not be accepted) to:

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

Processing the completed EFT form includes verifying the vendor's TIN and name with the IRS to make sure they match, and verifying the vendor's financial institution. This process usually takes a couple of weeks. Once the submitted EFT paperwork and voided check have been processed, the state controller's office will send you a letter or e-mail with your login information, password, and instructions for accessing the state controller's vendor website to view RAs.

Note: If you sign up for EFT, you will not receive paper warrants or paper RAs.

Attestation System

Idaho has implemented a web-based interface, called IIMS, for providers to apply and attest at the state level. To successfully use IIMS to apply and attest, you must:

- Be successfully registered on the CMS website for the PI Program.
- Have the following information available:
  - NPI you used to register at the CMS website.
  - CMS Registration Identification Number that is associated with your NPI (provided by CMS during registration).
  - Supporting documentation on PV, EHR details, and PA-led clinics (if applicable)

Steps to complete your application/attestation in IIMS include:

1. Log into IIMS.
2. Enroll for a new year of attestation, if this is not the EP's first year.
3. Review the CMS registration data.
4. Enter the eligibility details.
5. Review the incentive payment calculation.
6. Upload required supporting documentation.
7. Submit the application/attestation.

The login process and step-by-step instructions for application, attestation, and information verification are discussed below.

PV Calculation

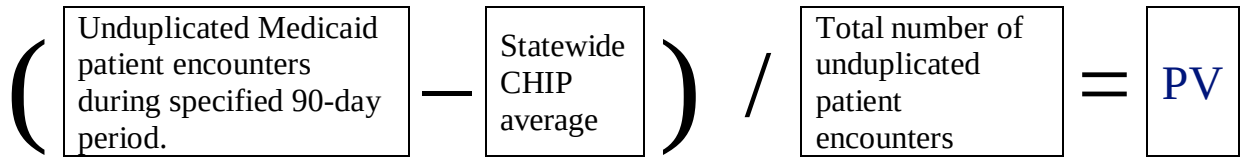
Idaho Medicaid includes all eligible encounters including zero-dollar paid claims. Idaho Medicaid also includes any claim for a Medicare dual eligible.

Non-FQHC/RHC Calculation

PV for EPs not practicing predominantly in an FQHC or RHC is calculated by dividing the number of unduplicated Medicaid patient encounters during any representative and continuous 90-day period in the calendar year or rolling 12-month calendar year prior to attestation reduced by the seven percent CHIP average by the total number of unduplicated patient encounters in that same period.

In other words, PV is a percentage derived from a fraction. The numerator is Medicaid encounters reduced by the CHIP average. The denominator is the total patient encounters.

The equation for this PV calculation is:

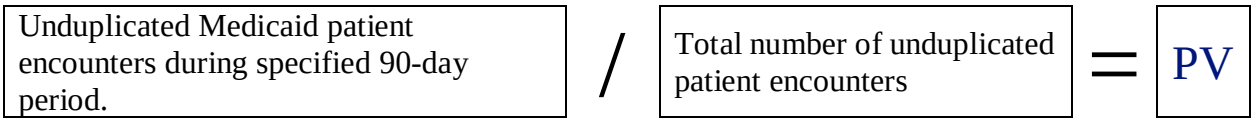


FQHC/RHC Calculation

PV for EPs practicing predominantly in an FQHC or RHC **and** basing PV on needy encounters is calculated by dividing the number of unduplicated needy patient encounters during any representative and continuous 90-day period in the calendar year or rolling 12-month calendar year prior to attestation by the total number of unduplicated patient encounters in that same period.

In other words, PV is a percentage derived from a fraction. The numerator is Medicaid encounters reduced by the CHIP average. The denominator is the total patient encounters.

The equation for this PV calculation is:



Group Proxy Calculation

The Idaho Medicaid PI Program has developed a group proxy roster calculation worksheet to help facilitate consistent attestation of PV by EPs and to streamline PV verification. It is important for EPs to remember the following:

- The entity responsible for the group must complete a group proxy roster calculation worksheet and make it available to all EPs.
- Every EP must upload the same copy of the group proxy roster calculation worksheet and the supporting PV report during the application/attestation process.
- A new group proxy calculation worksheet must be completed every year and for each phase of the program (e.g., AIU, MU 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 included cannot be an arbitrary group of clinics to maximize PV. An organizational level proxy must include all of the organization's clinics within the state of Idaho. No out-of-state clinics will be allowed to be included in the proxy.

Attestation Stages

The Medicare and Medicaid PI Programs provide incentive payments to EPs, EHs, and CAHs as they adopt, implement, upgrade or demonstrate MU of CEHRT.

AIU

All EPs must verify they have adopted, implemented, or upgraded to a CEHRT system. While each of these stages are grouped together, they are individually unique. PY 2016 is the last year that providers may enter the program and attest to AIU instead of MU.

- Adopt: *acquire, purchase, or secure access to a CEHRT*
  There is evidence 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 (for example, researching EHRs or interviewing EHR vendors) and actual purchase/acquisition or installation.
- Implement: *install or commence utilization of a CEHRT*
  The EP has installed a CEHRT and has started using the CEHRT in clinical practice. Implementation activities would include staff training in the CEHRT, the data entry of their patients' demographic data into the EHR, or establishing data exchange agreements and relationships between the EP's CEHRT and other EPs.
- Upgrade: *expand the available functionality of a CEHRT*
  The EP has added clinical decision support, electronic prescribing functionality, or other enhancements that facilitate MU of CEHRT. An example of upgrading that would qualify for the incentive payment would be upgrading from an existing EHR to a newer version that is certified according to the EHR certification criteria promulgated by the ONC related to MU. Upgrading may also mean expanding the functionality of an EHR in order to render it certifiable according to the ONC's EHR certification criteria.

MU

All EPs must verify they are meaningfully using the CEHRT in ways that can positively impact patient care. Meaningfully using a CEHRT is designed to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Ultimately, it is hoped MU compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

MU sets specific objectives which EPs and EHs must achieve to qualify for CMS Incentive Programs. MU now contains two stages and while these stages are grouped together, they are individually unique.

- Modified Stage 2. *Data sharing and capturing.*
- Stage 3. *Advance clinical processes and improved outcomes.*

Payment Status

You can see the detailed information regarding your past and current payments in IIMS on the left-hand menu's "Payments" link. Here, you can review payments and any payment adjustments for each program year you participated in Idaho's incentive program. If you participated in a different state's Medicaid incentive program or the Medicare incentive program in other payment years, the information from those sources **is not available here**. You should be able to access that payment information from the other state's Medicaid incentive program's site or the CMS PI Program Registration and Attestation System.

Accessing IIMS and Attesting

Before you apply with Idaho Medicaid for an incentive payment, you must first successfully register in the CMS PI Program Registration & Attestation System. The Idaho Medicaid PI Program then receives notification from CMS and conducts a preliminary review of eligibility. You will be contacted regarding any issues with your CMS registration affecting your Idaho eligibility. When the verification is complete, you will receive an email inviting you to complete your application/attestation.

The following information will be required to sign in to IIMS to complete your Idaho application/attestation:

- The NPI you used to register at the CMS site
- The associated 10-digit CMS Registration Identification Number

If you don't recall your CMS Registration Identification Number, you must return to the CMS PI Program R&A System to reference it.

Once you have completed your application/attestation in IIMS, and attached required supporting documentation, the PI Program staff will complete the eligibility determination. Once a provider is determined eligible, the Idaho Medicaid PI Program will notify CMS of your eligibility status.

Login Screen

1. Enter the NPI used when registering at the CMS PI Program site and the 10-digit CMS-assigned Registration Identification Number.

Note: If the data entered here does not match the NPI or the CMS-assigned Registration Identification Number on file, the message, "Invalid NPI/Registration ID combination" will be displayed.

2. Select "Submit" to log in and proceed to the CMS Registration Information page.

Note: If you encounter the message "Application is in process at Idaho Medicaid. You can expect to receive an email within 7-10 days informing you of your application status", this indicates Idaho Medicaid is conducting a preliminary review of the registration record received from CMS. Once this preliminary review is completed you will be allowed to login and begin your application/attestation.

Landing Screen

The EP is presented with a landing page upon a successful login that will show four separate sections:

- Announcements and Messages
- Provider Information

- Provider Status Flow
- Program Year Attestations

Announcements and Messages

This area is used to communicate major program update information.

Provider Information

This area shows the program attestation, state of attestation, payment year (AIU, MU1, MU2), and the current status. This area can always be used to reference at what stage the next attestation will be.

Provider Status Flow

This area can be used to check and track where your attestation is at currently as it is updated in real-time. If you believe your attestation to be stuck in any section, contact the Idaho Medicaid PI Program Help Desk immediately for resolution.

Program Year Attestation

This area will show the aggregate year, status, and actions for an attestation. This area can always be used to reference at what stage the next attestation will be.

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 which track functionality issues such as drug interaction checks and clinical decision support.
- Understand the security risk analysis must be specific to the EHR and the practice and it is required every year.

AIU Attestation Walkthrough

The current status of the payment year is displayed in the "Provider Status Flow" section of the page. To begin your attestation after logging in to IIMS, you must select "Begin/Modify Attestation", and it will bring you to the CMS Registration Information Page.

Screen 1 – CMS Registration Information

1. Review this information carefully. This information is populated directly from your CMS registration information and you cannot update the information on this page. If you need to make updates to this information, you need to return to the CMS website, make your changes, and save them. 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 and processed.

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 and your payment will be delayed.

2. Answer the question, "Have you worked with WIREC?".

3. If you are licensed in Idaho, skip to the next step. If you are **not**, complete the fields "State licensed in" and "Other State License #".

4. Select "Next" to go to the next page.

Screen 2 – Provider Eligibility Details

Here there are three separate sections:

- Program Year
- Patient Volume
- EHR Details

Program Year

Select the program year. This selection is only available if the current date within the designated attestation tail-period of any year. This allows you to choose the previous program year during the tail-period where it is allowed to attest to either the previous or current program year. After the end of the tail-period, the program year will default to the current program year.

When attesting to PY 2017, you will have the option to use Modified Stage 2 or Stage 3 measures. Starting in PY 2018, all providers must use Stage 3 measures.

Patient Volume

1. Select the appropriate answer 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 the next step.
3. Select the starting date of the 90-day period to calculate the Medicaid/needy PV percentage.

Note: The date must be a valid date within the previous calendar year or rolling calendar year 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.

4. Enter the Medicaid/needy PV during this period.

Note: If using PV based only on unduplicated Medicaid encounters, exclude seven (7) percent for CHIP encounters. If you are basing PV on needy, disregard the exclusion of CHIP encounters. The following is an example for excluding CHIP encounters for PV based on unduplicated Medicaid encounters:

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

5. Enter the number of total unduplicated patient encounters during this period.
6. Only EPs who practice predominately at an FQHC or RHC can be based on needy ("Yes"). All others must use Medicaid encounters only ("No").

6a. If you do not practice predominately at an FQHC or RHC, select "No". If you do practice predominately at an FQHC or RHC, select "Yes".

6b. Use the drop-down menu to indicate whether or not you are Hospital Based.

7. This will auto-calculate based on your answers to numbers 4 and 5.

Note: The following messages will appear if you do not meet the PV threshold.

- *If the provider specialty is Pediatrics and PV is based on unduplicated Medicaid patient encounters but is below the 20 percent PV threshold, this message will be displayed:*
  "x.xx% - you must meet the threshold of 20% to get a PI Incentive Payment".
- *For other provider specialties (regardless of how PV is based) and those below the 30 percent PV threshold, this message will be displayed:*
  "x.xx% - you must meet the threshold of 30% to get a PI Incentive Payment".

EHR Details

8. The CMS EHR Certification ID of your EHR 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", "Upgrade", or "Meaningful User". When attesting to PY 2017 or later, the only option will be to attest to meaningful use.

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.*

Screen 3 – Certified EHR Technology Locations

On this page, there are four items which you need to answer.

1. Select "Yes" or "No" to indicate if you have multiple practice locations.
2. If you selected "Yes", enter the total number of locations. If you selected "No", the box will auto-populate the number "1".
3. Enter the total number of the locations indicated that have adopted, implemented, or upgraded to CEHRT. This number of locations cannot be higher than the total number of locations. Additionally, if you only have one location then this must be populated with "1".
4. Use the table provided to fill in the address, city, state, and ZIP code for each service location indicated.

Note: Click "Add" after each location entered. You may modify or delete your entries as necessary. You must enter the same number of service locations as you identified in number 3 above.

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.*

Screen 4 – Incentive Payment Calculations

On this page, there is one item which you need to review.

1. Review the incentive payment amount. Contact the Idaho Medicaid PI Program Help Desk if you have any questions.

Note: If you see a $0 estimated amount of Medicaid incentive payment, you may not have met eligibility requirements. Click on the "Previous" button, and check your responses to the questions on the Provider Eligibility Details page.

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

- "Previous" – *will take you to the previous page.*
- "Next" – *will take you to the next page.*

Screen 5 – Document Upload

On this page, you need to upload the following mandatory documents.

1. System-generated PV report. This can come from either your EHR or your billing service. Screenshots of your generated report may be requested from the Idaho Medicaid PI team if further verification is required.
2. EHR documentation. This must be either a dually signed vendor contract or agreement, recent receipt of payment, receipt of purchase, lease agreement, or other acceptable legally binding documentation.

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 purchased including the software version number.

3. Group proxy roster (if applicable).

Additional for PA-Led

Whether AIU or MU attestations, PAs are required to submit documentation to support PA-led.

1. Medical director. This must be a job description, employment agreement/contract, organization chart from the clinic.
2. Primary provider. This must be clinic appointment records or work hours relative to other EPs. May use PV reports relative to other EPs.

3. RHC owner. This must be the ownership record.
4. Other. Please work with PI Program staff to identify acceptable documentation to support PA-led.

To ensure reviewing accuracy, use the following naming convention for your documents:
EP Last Name, Document Type (or) Objective Number, Program Year

For Example
Smith, PV, 2016.pdf
Smith, Group Proxy, 2016.pdf
Smith, EHR doc, 2016.pdf

Note: Only PDF documents can be uploaded into IIMS. If you need to upload a different file format, contact the Idaho Medicaid PI Program Help Desk for further instructions. Documents uploaded not using the above naming convention or correct document type will cause a delay in processing your incentive payment application. You will still be able to upload documents as necessary throughout the attestation process.

After loading your documents, you must select one of the following buttons from the bottom of the screen:

- "Previous" – *will cancel your entries and take you to the previous page.*
- "Next" – *will save your entries and take you to the next page.*

Screen 6 – Attestation

On this page, there are many items you need to review and answer.

1. Review all the data on this page. Once you submit the attestation, you **cannot make any changes**.
2. Enter **your initials** and the EP's NPI at the bottom-left of the screen.
3. Enter **your name, e-mail,** and the EP's e-mail at the bottom-right of the screen.

Completing these sections serve as your electronic signature. By entering this information, you attest to the validity of all data submitted for consideration by the Idaho Medicaid PI Program.

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

- "Previous" – *will cancel your entries and take you to the previous page.*
- "Submit" – *notify Idaho Medicaid the attestation is ready for final eligibility review.*

Note: Once you select "Submit", it will take you to the first page of your attestation, CMS Registration Information (Screen 1), to review. You can select "Previous" and "Next" to view the attestation pages in a review mode only.

Logout when finished.

MU Attestation Walkthrough

The current status of the payment year is displayed in the "Provider Status Flow" section of the page. To begin your attestation after logging in to IIMS, you must select "Begin/Modify Attestation", and it will bring you to the CMS Registration Information Page.

Screen 1 – CMS Registration Information

1. Review this information carefully. This information is populated directly from your CMS registration information and you cannot update the information on this page. If you need to make updates to this information, you need to return to the CMS website, make your changes, and save them. 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 and processed.

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 and your payment will be delayed.

2. Answer the question, "Have you worked with WIREC?".

3. If you are licensed in Idaho, skip to the next step. If you are **not**, complete the fields "State licensed in" and "Other State License #".

4. Select "Next" to go to the next page.

Screen 2 – Provider Eligibility Details

5. Here there are three separate sections:

   - Program Year
   - Patient Volume
   - EHR Details

Program Year

Select the program year. This selection is only available if the current date within the designated attestation tail-period of any year. This allows you to choose the previous program year during the tail-period where it is allowed to attest to either the previous or current program year. After the end of the tail-period, the program year will default to the current program year.

Patient Volume:

1. Select the appropriate answer 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 the next step.
3. Select the starting date of the 90-day period to calculate the Medicaid/needy PV percentage.

Note: The date must be a valid date within the previous calendar year or rolling calendar year 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.

4. Enter the Medicaid/needy PV during this period.

Note: If using PV based only on unduplicated Medicaid encounters, exclude seven (7) percent for CHIP encounters. If you are basing PV on needy, disregard the exclusion of CHIP encounters. The following is an example for excluding CHIP encounters for PV based on unduplicated Medicaid encounters:

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

5. Enter the number of total unduplicated patient encounters during this period.
6. Only EPs who practice predominately at an FQHC or RHC can be based on needy ("Yes"). All others must use Medicaid encounters only ("No").

6a. If you do not practice predominately at an FQHC or RHC, select "No". If you do practice predominately at an FQHC or RHC, select "Yes".

6b. Use the drop-down menu to indicate whether or not you are Hospital Based.

7. This will auto-calculated based on your answers to numbers 4 and 5.

Note: The following messages will appear if you do not meet the PV threshold.

- *If the provider specialty is Pediatrics and PV is based on unduplicated Medicaid patient encounters but is below the 20 percent PV threshold, this message will be displayed:*
  "x.xx% - you must meet the threshold of 20% to get a PI Incentive Payment".
- *For other provider specialties (regardless of how PV is based) and those below the 30 percent PV threshold, this message will be displayed:*
  "x.xx% - you must meet the threshold of 30% to get a PI Incentive Payment".

EHR Details:

8. The CMS EHR Certification ID of your EHR 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 – "Meaningful Use." Adopt, Implement, or Upgrade are no longer available as options after program 2016.

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.*

Screen 3 – Meaningful Use Questionnaire

On this page, there are two sections which you need to answer.

- EHR Reporting Periods
  - Meaningful Use Reporting Period associated with the Objectives and Measures
  - Meaningful Use Reporting Period associated with the Clinical Quality Measures
- Certified EHR Technology Locations

EHR Reporting Periods

1. Enter the EHR reporting period start and end dates. This will be the time period associated with the Objectives and Measures for this attestation.

Note: MU reporting periods must be a minimum of a continuous 90-day period, to a maximum of one year. You will receive an error if the reporting period is not at least 90 days, if the start date is not at least 90 days prior to the current date, or if the end date is not prior to the current date. The reporting period must fall within the program year in which you are attesting.

2. Enter the CQM reporting period start and end dates. This will be the time period associated with the Clinical Quality Measures for this attestation.

Note: For EPs demonstrating MU for the first time, the reporting period must be a minimum of a continuous 90-day period, to a maximum of one year. You will receive an error if the reporting period is not at least 90 days, if the start date is not at least 90 days prior to the current date, or if the end date is not prior to the current date. For EPs who have previously demonstrated meaningful use, the reporting period is one full year. The reporting period must fall within the program year in which you are attesting.

3. Enter the percentage of unique patients who have structured data recorded in your CEHRT as of the EHR reporting period(s).

Note: You will receive an error if the number you enter is not a whole number, if less than 80, or is more than 100.

Certified EHR Technology Locations

4. Select "Yes" or "No" to indicate if you have multiple practice locations.
5. If you selected "Yes", enter the total number of locations. If you selected "No", the box will auto-populate the number "1".
6. Enter the total number of the locations indicated that have adopted, implemented, or upgraded to CEHRT. This number of locations cannot be higher than the total number of locations. Additionally, if you only have one location then this must be populated with "1".
7. Use the table provided to fill in the address, city, state, and ZIP code for each service location indicated.

Note: Click "Add" after each location entered. You may modify or delete your entries as necessary. You must enter the same number of service locations as you identified in number 3 above.

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.*

Screen 4 – Summary of Measures

On this page, you can view your progression through attestation objectives and measures. You can review this page at any time by clicking on the "MU Summary" link on the left-hand side menu. As you advance through the objectives and measures, these categories will become hyperlinks to enable you to quickly return to where you left off.

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

- "Previous" – *will take you to the previous page.*
- "Next" – *will take you to the next page.*

Screens 5 through 15 – Attestation Objectives and Measures

On these pages, you will need to answer the objectives and their correlating measure(s) and/or exclusion(s) as appropriate. For the objectives which require a Yes/No answer, select either "Yes" or "No". For the objectives/measures which require a percentage answer, input your numerator and denominator in the required fields.

Modified Stage 2 Objectives

- Objective 1 – Protect Electronic Patient Health Information
- Objective 2 – Clinical Decision Support
- Objective 3 – Computerized Provider Order Entry (CPOE)
- Objective 4 – Electronic Prescribing (eRx)
- Objective 5 – Health Information Exchange
- Objective 6 – Patient Specific Education
- Objective 7 – Medication Reconciliation
- Objective 8 – Patient Electronic Access
- Objective 9 – Secure Electronic Messaging
- Objective 10 – Public Health Reporting

Stage 3 Objectives

- Objective 1 – Protect Electronic Patient Health Information
- Objective 2 – Electronic Prescribing (eRx)
- Objective 3 – Clinical Decision Support
- Objective 4 – Computerized Provider Order Entry (CPOE)
- Objective 5 – Patient Electronic Access
- Objective 6 – Coordination of Care
- Objective 7 – Health Information Exchange
- Objective 8 – Public Health Reporting

Note: Measures within the same objective may not have the same threshold requirements for percentages. If the numerator/denominator you enter does not support the mandatory minimum, you will receive an error message.

Protect Electronic Patient Health Information

Number of Measures:	1 for Modified Stage 2 and Stage 3
Answer Type:	Yes/No
Description:	Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.

Clinical Decision Support

Number of Measures:	2 for Modified Stage 2 and Stage 3

Answer Type: Yes/No/Exclusion
Description: Use/Implement clinical decision support interventions focused on improving performance on high-priority health conditions.

Computerized Provider Order Entry (CPOE)

Number of Measures: 3 for Modified Stage 2 and Stage 3
Answer Type: Threshold/Exclusion
Description: Use computerized provider order entry (CPOE) for medication, laboratory, and radiology/diagnostic imaging orders directly entered by any licensed healthcare professional, medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

Electronic Prescribing (eRx)

Number of Measures: 1 for Modified Stage 2 and Stage 3
Answer Type: Threshold/Exclusion
Description: Generate and transmit permissible prescriptions electronically (eRx).

Health Information Exchange

Number of Measures: 1 for Modified Stage 2; 3 for Stage 3
Answer Type: Threshold/Exclusion
Modified Stage 2
Description: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
Stage 3 Description: The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

Patient Specific Education

Number of Measures: 1 for Modified Stage 2
Answer Type: Threshold/Exclusion
Description: Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

Medication Reconciliation

Number of Measures: 1 for Modified Stage 2
Answer Type: Threshold/Exclusion

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

Patient Electronic Access

Number of Measures:	2 for Modified Stage 2 and Stage 3
Answer Type:	Threshold/Exclusion
Modified Stage 2 Description:	Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.
Stage 3 Description:	The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

Coordination of Care

Number of Measures:	3 for Stage 3
Answer Type:	Threshold/Exclusion
Description:	Use CEHRT to engage with patients or their authorized representatives about the patient's care.

Secure Electronic Messaging

Number of Measures:	1 for Modified Stage 2
Answer Type:	Yes/No/Exclusion
Description:	Use secure electronic messaging to communicate with patients on relevant health information.

Public Health Reporting

Number of Measures:	3 for Modified Stage 2; 5 for Stage 3
Answer Type:	Yes/No/Exclusion
Modified Stage 2 Description:	The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.
Stage 3 Description:	The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

After entering your data in each screen, 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.*

Screen 16 – Clinical Quality Measures

On this page, you must report on 6 CQMs for program years 2017 and 2018. There are no domain requirements for these program years. The responses entered must be generated from your CEHRT for the EHR reporting period, even if the report states zero. After you enter the data for each CQM, click "Next" and it will save the data and advance to the next CQM. If you would like to save the data and exit the screen, you must click "Save". Your data will not be saved if you click "Back" or "Previous".

Note: Providers reporting a zero in one or more CQM denominators must attest to all CQMs regardless of practice specialty.

Program Year 2017 CQM Domains

- Domain 1 – Person and Caregiver-Centered Experience and Outcomes
- Domain 2 – Patient Safety
- Domain 3 – Communication and Care Coordination
- Domain 4 – Community/Population Health
- Domain 5 – Efficiency and Cost Reduction
- Domain 6 – Effective Clinical Care

Program Year 2018 CQM Domains

- Domain 1 – Person and Caregiver-Centered Experience and Outcomes
- Domain 2 – Patient Safety
- Domain 3 – Community/Population Health
- Domain 4 – Efficiency and Cost Reduction
- Domain 5 – Effective Clinical Care

Program Year 2017 CQMs

CMS eCQM ID	NQF ID	MIPS Quality ID	Quality Domain	Measure Name
CMS137v5	0004	305	Effective Clinical Care	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

CMS eCQM ID	NQF ID	MIPS Quality ID	Quality Domain	Measure Name
CMS165v5	0018	236	Effective Clinical Care	Controlling High Blood Pressure
CMS124v5	0032	309	Effective Clinical Care	Cervical Cancer Screening
CMS130v5	0034	113	Effective Clinical Care	Colorectal Cancer Screening
CMS127v5	0043	111	Community/Population Health	Pneumococcal Vaccination Status for Older Adults
CMS131v5	0055	117	Effective Clinical Care	Diabetes: Eye Exam
CMS123v5	0056	163	Effective Clinical Care	Diabetes: Foot Exam
CMS122v5	0059	001	Effective Clinical Care	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
CMS134v5	0062	119	Effective Clinical Care	Diabetes: Medical Attention for Nephropathy
CMS164v5	0068	204	Effective Clinical Care	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet
CMS145v5	N/A	007	Effective Clinical Care	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
CMS135v5	2907	005	Effective Clinical Care	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS144v5	2908	008	Effective Clinical Care	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS143v5	0086	012	Effective Clinical Care	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
CMS167v5	0088	018	Effective Clinical Care	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
CMS142v5	0089	019	Communication and Care Coordination	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
CMS161v5	0104	107	Effective Clinical Care	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS128v5	0105	009	Effective Clinical Care	Anti-depressant Medication Management

CMS eCQM ID	NQF ID	MIPS Quality ID	Quality Domain	Measure Name
CMS136v6	0108	366	Effective Clinical Care	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
CMS52v5	0405	160	Effective Clinical Care	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
CMS133v5	0565	191	Effective Clinical Care	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
CMS159v5	0710	370	Effective Clinical Care	Depression Remission at Twelve Months
CMS160v5	0712	371	Effective Clinical Care	Depression Utilization of the PHQ-9 Tool
CMS125v5	2372	112	Effective Clinical Care	Breast Cancer Screening
CMS149v5	N/A	281	Effective Clinical Care	Dementia: Cognitive Assessment
CMS158v5	N/A	369	Effective Clinical Care	Pregnant women that had HBsAg testing
CMS169v5	N/A	367	Effective Clinical Care	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
CMS65v6	N/A	373	Effective Clinical Care	Hypertension: Improvement in Blood Pressure
CMS74v6	N/A	379	Effective Clinical Care	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists
CMS75v5	N/A	378	Community/Population Health	Children Who Have Dental Decay or Cavities
CMS156v5	0022	238	Patient Safety	Use of High-Risk Medications in the Elderly
CMS139v5	0101	318	Patient Safety	Falls: Screening for Future Fall Risk
CMS68v6	0419	130	Patient Safety	Documentation of Current Medications in the Medical Record
CMS132v5	0564	192	Patient Safety	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
CMS177v5	1365	382	Patient Safety	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS146v5	N/A	066	Efficiency and Cost Reduction	Appropriate Testing for Children with Pharyngitis

CMS eCQM ID	NQF ID	MIPS Quality ID	Quality Domain	Measure Name
CMS166v6	0052	312	Efficiency and Cost Reduction	Use of Imaging Studies for Low Back Pain
CMS154v5	0069	065	Efficiency and Cost Reduction	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
CMS129v6	0389	102	Efficiency and Cost Reduction	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
CMS155v5	0024	239	Community/Population Health	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
CMS138v5	0028	226	Community/Population Health	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
CMS153v5	0033	310	Community/Population Health	Chlamydia Screening for Women
CMS117v5	0038	240	Community/Population Health	Childhood Immunization Status
CMS147v6	0041	110	Community/Population Health	Preventive Care and Screening: Influenza Immunization
CMS2v6	0418	134	Community/Population Health	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
CMS69v5	0421	128	Community/Population Health	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
CMS22v5	N/A	317	Community/Population Health	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
CMS82v4	N/A	372	Community/Population Health	Maternal Depression Screening
CMS157v5	0384	143	Person and Caregiver-Centered Experience and Outcomes	Oncology: Medical and Radiation – Pain Intensity Quantified
CMS56v5	N/A	376	Person and Caregiver-Centered Experience and Outcomes	Functional Status Assessment for Total Hip Replacement
CMS66v5	N/A	375	Person and Caregiver-Centered Experience and Outcomes	Functional Status Assessment for Total Knee Replacement

CMS eCQM ID	NQF ID	MIPS Quality ID	Quality Domain	Measure Name
CMS90v6	N/A	377	Person and Caregiver-Centered Experience and Outcomes	Functional Status Assessment for Congestive Heart Failure
CMS50v5	N/A	374	Communication and Care Coordination	Closing the Referral Loop: Receipt of Specialist Report

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.*

Program Year 2018 CQMs

CMS eCQM ID	NQF ID	MIPS Quality ID	Quality Domain	Measure Name
CMS137v6	0004	305	Effective Clinical Care	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
CMS165v6	0018	236	Effective Clinical Care	Controlling High Blood Pressure
CMS124v6	0032	309	Effective Clinical Care	Cervical Cancer Screening
CMS130v6	0034	113	Effective Clinical Care	Colorectal Cancer Screening
CMS127v6	N/A	111	Community/Population Health	Pneumococcal Vaccination Status for Older Adults
CMS131v6	0055	117	Effective Clinical Care	Diabetes: Eye Exam
CMS123v6	0056	163	Effective Clinical Care	Diabetes: Foot Exam
CMS122v6	0059	001	Effective Clinical Care	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
CMS134v6	0062	119	Effective Clinical Care	Diabetes: Medical Attention for Nephropathy
CMS164v6	0068	204	Effective Clinical Care	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet

CMS eCQM ID	NQF ID	MIPS Quality ID	Quality Domain	Measure Name
CMS145v6	0070	007	Effective Clinical Care	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
CMS135v6	0081	005	Effective Clinical Care	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS144v6	0083	008	Effective Clinical Care	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS143v6	0086	012	Effective Clinical Care	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
CMS167v6	0088	018	Effective Clinical Care	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
CMS142v6	0089	019	Communication and Care Coordination	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
CMS161v6	0104	107	Effective Clinical Care	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS128v6	0105	009	Effective Clinical Care	Anti-depressant Medication Management
CMS136v7	0108	366	Effective Clinical Care	Follow-Up Care for Children Prescribed ADHD Medication (ADD)
CMS52v6	0405	160	Effective Clinical Care	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
CMS133v6	0565	191	Effective Clinical Care	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
CMS159v6	0710	370	Effective Clinical Care	Depression Remission at Twelve Months
CMS160v6	0712	371	Effective Clinical Care	Depression Utilization of the PHQ-9 Tool
CMS125v6	2372	112	Effective Clinical Care	Breast Cancer Screening
CMS149v6	2872	281	Effective Clinical Care	Dementia: Cognitive Assessment

CMS eCQM ID	NQF ID	MIPS Quality ID	Quality Domain	Measure Name
CMS158v6	N/A	369	Effective Clinical Care	Pregnant women that had HBsAg testing
CMS169v6	N/A	367	Effective Clinical Care	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
CMS65v7	N/A	373	Effective Clinical Care	Hypertension: Improvement in Blood Pressure
CMS645v1	N/A	N/A	Effective Clinical Care	Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy
CMS74v7	N/A	379	Effective Clinical Care	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists
CMS75v6	N/A	378	Community/Population Health	Children Who Have Dental Decay or Cavities
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CMS153v6	0033	310	Community/Population Health	Chlamydia Screening for Women
CMS117v6	0038	240	Community/Population Health	Childhood Immunization Status
CMS147v7	0041	110	Community/Population Health	Preventive Care and Screening: Influenza Immunization
CMS2v7	0418	134	Community/Population Health	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
CMS69v6	0421	128	Community/Population Health	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
CMS22v6	N/A	317	Community/Population Health	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
CMS82v5	N/A	372	Community/Population Health	Maternal Depression Screening
CMS157v6	0384	143	Person and Caregiver-Centered Experience and Outcomes	Oncology: Medical and Radiation – Pain Intensity Quantified
CMS56v6	N/A	376	Person and Caregiver-Centered Experience and Outcomes	Functional Status Assessment for Total Hip Replacement
CMS66v6	N/A	375	Person and Caregiver-Centered Experience and Outcomes	Functional Status Assessment for Total Knee Replacement
CMS90v7	N/A	377	Person and Caregiver-Centered Experience and Outcomes	Functional Status Assessment for Congestive Heart Failure
CMS50v6	N/A	374	Communication and Care Coordination	Closing the Referral Loop: Receipt of Specialist Report

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- "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.*

Screen 17 – Summary of Measures

On this page, you can return to either the Meaningful Use Objectives or the CQMs and edit any individual question you have answered.

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

- "Previous" – *will take you to the previous page.*
- "Next" – *will take you to the next page.*

Screen 18 – Incentive Payment Calculations

On this page, there is one item which you need to review.

1. Review the incentive payment amount. Contact the Idaho Medicaid PI Program Help Desk if you have any questions.

Note: If you see a $0 estimated amount for your incentive payment, you may not have met eligibility requirements. Click on the "Previous" button, and check your responses to the questions on the Provider Eligibility Details page.

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

- "Previous" – *will take you to the previous page.*
- "Next" – *will take you to the next page.*

Screen 19 – Document Upload

On this page, you need to upload the following mandatory documents.

1. System-generated PV report. This must be from either your CEHRT or your billing service. Screenshots of your generated report may be requested from the Idaho Medicaid PI team if further verification is required.
2. EHR documentation. This must be either a dually signed vendor contract or agreement, recent receipt of payment, receipt of purchase, lease agreement, or other acceptable legally binding documentation.

3. Objective documentation. This must be an EHR-generated de-identified report generated from the CEHRT used to substantiate attestation. Screenshots of your generated report may be requested from the Idaho Medicaid PI team if further verification is required.
4. Public Health Registry documentation. This must identify the type of active engagement with relevant public health registry, date(s) of active engagement, and must be from the public health registry to which you are attesting. Most often, this is a connection confirmation letter from the public health registry. Other documentation can be approved on a case-by-case basis.
5. CQM documentation. This must be an EHR-generated de-identified report generated from the CEHRT used to substantiate attestation. Screenshots of your generated report may be requested from the Idaho Medicaid PI team if further verification is required.
6. Group proxy roster (if applicable).

Additional for PA-Led

PAs are required to submit documentation to support PA-led. Any of the following documentation is acceptable.

1. Medical director. This must be a job description, employment agreement/contract, organization chart from the clinic.
2. Primary provider. This must be clinic appointment records or work hours relative to other EPs. May use PV reports relative to other EPs.
3. RHC owner. This must be the ownership record.
4. Other. Please work with PI Program staff to identify acceptable documentation to support PA-led.

To ensure reviewing accuracy, use the following naming convention for your documents:
EP Last Name, Document Type (or) Objective Number, Program Year

For Example
Smith, PV, 2016.pdf
Smith, Objective 4, 2016.pdf
Smith, Public Health, 2016.pdf
Smith, CQM, 2016.pdf
Smith, Group Proxy, 2016.pdf
Smith, EHR doc, 2016.pdf

Note: Only PDF documents can be uploaded into IIMS. If you need to upload a different file format, contact the Idaho Medicaid PI Program Help Desk for further instructions. Documents uploaded not using the above naming convention or correct document type will cause a delay in processing your incentive payment application. You will still be able to upload documents as necessary throughout the attestation process.

After loading your documents, you must select one of the following buttons from the bottom of the screen:

- "Previous" – *will cancel your entries and take you to the previous page.*
- "Next" – *will save your entries and take you to the next page.*

Screen 20 – Attestation

On this page, there are many items you need to review and answer.

1. Review all the data on this page. Once you submit the attestation, you **cannot make any changes**.
2. Enter **your initials** and the EP's NPI at the bottom-left of the screen.
3. Enter **your name, e-mail,** and the EP's e-mail at the bottom-right of the screen.

Completing these sections serve as your electronic signature. By entering this information, you attest to the validity of all data submitted for consideration by the Idaho Medicaid PI Program.

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

- "Previous" – *will cancel your entries and take you to the previous page.*
- "Submit" – *notify Idaho Medicaid the EP's attestation is ready for final eligibility review.*

Note: Once you select "Submit", it will take you to the first page of your attestation, CMS Registration Information (Screen 1), to review. You can select "Previous" and "Next" to view the attestation pages in a review mode only.

Logout when finished.

Other Information

Out-of-State Providers

Idaho Medicaid PI incentive payments are only to be made to Idaho Medicaid providers. Idaho must be the only state the provider is requesting an incentive payment from during that program year.

Medicaid Program Integrity and Audit

Idaho Medicaid conducts regular reviews of attestations and incentive payments. These reviews are selected as part of the approved audit selection process, including risk assessment, receipt of a complaint, or incorporation into reviews selected for other objectives.

For EPs selected for auditing and who have used the CHIP PV 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 PV. There would be no penalty for EPs who have an actual

CHIP PV 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.

Retention of Documentation

Providers are required by CMS to retain documentation uploaded in their initial IIMS application for a minimum period of six years from the date of an approved application that resulted in an Idaho Medicaid PI Incentive payment.

If a provider does not retain the required documentation for the six-year period, it may result in adverse action against that provider, including, but not limited to, recoupment of incentive payments and sanctions following audits by the Idaho Medicaid PI team or independent auditors.

Appeals

Providers can choose to appeal the determination made by the Idaho Medicaid PI 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." Within IIMS, on the left-hand menu, the "Appeals" link will give you detailed information regarding a request for an appeal.

Idaho Medicaid Attestation Support

As the Idaho Medicaid PI team, we are happy to answer any questions you may have. Feel free to call us at (208) 332-7989 or e-mail us at ehrincentives@dhw.idaho.gov. We strive to respond within two business days if we are unable to answer your call or e-mail immediately. We update our program website often, so be sure to check there for the latest news.