

Alaska Medicaid Program



ALASKA ELECTRONIC HEALTH RECORDS Incentive Program

**Updated
April 2014
Provider Manual**

1	Background.....	4
2	How Do I use this manual?	6
3	How do I get help?.....	7
4	Eligible provider types	8
	Eligible professionals.....	8
	Eligible hospitals	8
5	Enrollment requirements	9
	Requirements for an eligible professional.....	9
	Requirements for an eligible hospital	10
	Qualifying providers by provider type and patient volume	10
	Out-of-state providers.....	10
6	Patient volume methodology	11
	Eligible professional patient encounter calculation.....	11
	Eligible professional Medicaid encounter.....	11
	Eligible professional needy individual encounter	12
	Group practice patient encounter calculation	13
	Group Medicaid encounters.....	13
	Group needy individual encounters	13
	Eligible hospital patient encounter calculation	14
7	Electronic health record functions.....	15
	Adopt, Implement or Upgrade (AIU).....	15
	Meaningful Use (MU).....	15
	Adopt, Implement, Upgrade in Year 1	16
	Stage 1 Meaningful Use criteria.....	17
	Stage 2 Meaningful Use criteria.....	17
	Stage 3 Meaningful Use criteria.....	61
8	Enrollment process.....	62
	Program attestation preparation	62
	Medicare and Medicaid Registration and Attestation System.....	63
	Alaska Medicaid State Level Registry	64
9	What is the payment methodology?	65
	Payment methodology for eligible professionals	65
	Payments for Medicaid eligible professionals.....	65

Payment methodology for eligible hospitals	66
Eligible hospital incentive payment calculation methodology	66
Payments for Medicaid eligible hospitals	70
10 Validation and Approval Process	71
Requesting payment	71
Administrative Appeals	71
Program Integrity	72
Payment recoupment	72
11 State Level Registry Provider Registration.....	73
SLR Provider Outreach page -Want to get a jump start?	73
Create Account-SLR Registration	75
12 State Level Registry Provider Attestation.....	77
Eligible Professional and Hospital Provider SLR Attestation	77
Login to the SLR.....	77
End User License Agreement and Terms of Use Agreement.....	78
SLR home page	78
Step 1-About You-EP.....	79
Step 1-About You-EH.....	82
Step 2-Confirm Medicaid Eligibility-EP.....	83
Step 2-Confirm Medicaid Eligibility-EH.....	88
Step 3-Attestation of EHR-Adopt, Implement, Upgrade.....	92
Step 3-Attestation of EHR-AIU Method.....	93
Step 3-Attestation of EHR-EHR Certification.....	95
Step 4-Review and Sign Agreement	98
Step 5-Send Year 1 Submission.....	99
13 Definitions for the EHR Incentive Program.....	101
Addendum 1: EP Stage 2 MU Screen Shots.....	103
Addendum 2: EH Stage 2 MU Screen Shots	120

1 Background

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs who adopt, implement, upgrade, or meaningfully use certified Electronic Health Records (EHR) technology. Under ARRA, states are responsible for identifying professionals and hospitals that are eligible for these Medicaid EHR incentive payments, making payments, and monitoring use of the payments. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt and meaningfully use certified EHR technology.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://oncchpl.force.com/ehrcert?q=chpl>

Goals for the national program include:

- Enhance care coordination and patient safety;
- Reduce paperwork and improve efficiencies;
- Facilitate electronic information sharing across providers, payers, and state lines; and
- Enable data sharing using 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 costs of health care nationwide.

Resources:

- 7 AAC 165 – Alaska Medicaid Electronic Health Records Incentive Program [http://www.legis.state.ak.us/basis/folioproxy.asp?url=http://www.jnu01.legis.state.ak.us/cgi-bin/folioisa.dll/aac/query=\[JUMP:'t!2E+7!2C+p!2E+9'\]/doc/{@1}?firsthit](http://www.legis.state.ak.us/basis/folioproxy.asp?url=http://www.jnu01.legis.state.ak.us/cgi-bin/folioisa.dll/aac/query=[JUMP:'t!2E+7!2C+p!2E+9']/doc/{@1}?firsthit)
- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule <http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf>
- Alaska State Medicaid HIT Plan (SMHP) [http://dhss.alaska.gov/HIT/Pages/State-Medicaid-HIT-Plan-\(SMHP\).aspx](http://dhss.alaska.gov/HIT/Pages/State-Medicaid-HIT-Plan-(SMHP).aspx)
- CMS information on the EHR Program www.cms.gov/EHRIncentivePrograms
- ONC website <http://www.healthit.gov/providers-professionals>

List of Acronyms

AAC=Alaska Administrative Code	HIE=Health Information Exchange
ARRA=American Recovery and Reinvestment act of 2009	HIT=Health Information Technology
AIU=Adopt, Implement, Upgrade (certified EHR Technology)	IHS=Indian Health Service
CAH=Critical Access Hospital	IT=Information Technology
CCN=CMS Certification Number	MMIS=Medicaid Management Information Systems
CEHRT=Certified Electronic Health Record Technology	NAAC=Net Average Allowable Cost
CFR=Code of Federal Regulations	NHIN=National Health Information Network
CHIP=Children’s Health Insurance Program	NLR=National Level Registry (CMS)
CMS=Centers for Medicare & Medicaid Services	NPI=National Provider Identifier
CPOE=Computerized Physician Order Entry	ONC=Office of National Coordinator for Health Information Technology
CQM=Clinical Quality Measure	PECOS=Provider Enrollment, Chain, and Ownership System
CY=Calendar Year	POS=Place of Service
EHR=Electronic Health Records	PQRI=Physician Quality Reporting Initiative
EH=Eligible Hospital	RHC=Rural Health Clinic
EP=Eligible Professional	SLR=State Level Registry
FFY=Federal Fiscal Year	SMHP=State Medicaid Health Information Technology Plan
FQHC=Federal Qualified Health Center	SSN=Social Security Number
FY=Fiscal Year	TIN=Tax Identification Number

2 How Do I use this manual?

The Alaska Electronic Health Records Incentive Program Provider Manual is a resource for healthcare professionals and hospitals who wish to learn more about the Alaska Medicaid EHR Incentive Program including detailed information and resources on eligibility and attestation criteria. This manual provides details on how to apply for program incentive payments via the Alaska Medicaid State Level Registry (SLR), which is the Department's web-based EHR Incentive Program attestation system.

The best way for a new user to orient themselves to the EHR Incentive Program requirements and processes is to read through each section of this manual in its entirety prior to starting the application process.

This manual is organized by EHR Incentive program eligibility requirements, patient volume methodology, program payment methodology, meaningful use quality measures and program registration requirements for both EPs and EHRs, information on Stage 1 and Stage 2 Meaningful Use, along with the SLR application process.

3 How do I get help?

If you have any questions or problems, please contact the Health Information Technology, EHR Incentive Program Office. EHR Incentive Program Office is the central point-of-contact to aid providers in enrolling in the Alaska Medicaid EHR Incentive Program and providing education and outreach to all Alaska Medical Assistance enrolled providers.

Address: 3601 C Street, Suite 902, Anchorage, AK 99503

Email Address: hss.hitinfo@alaska.gov

As an alternative, the Regional Extension Center (REC) within the Alaska eHealth Network (AeHN) is available to provide support services for healthcare providers assisting in the adoption of EHR's with the goal of helping providers achieve Meaningful Use. Their consulting services consist of the following:

- EHR Readiness Assessment
- Selecting an EHR/Contracting with Vendor
- Work Flow Design/Redesign
- Training
- Implementation Support
- IT Support

AeHN/REC contact information:

Telephone: 866.966.9030

Website: <http://www.ak-ehealth.org/regional-extension-center-rec/>

There are a number of resources available to assist providers with the Alaska Medicaid EHR Incentive Program application process. These resources can be found on our Provider Outreach Page at: <http://ak.aincentive.com/>.

4 Eligible provider types

Per the federal rule, EPs must begin participation in the program no later than calendar year (CY) 2016 and EHs must begin by federal fiscal year (FFY) 2016. The following Alaska Medical Assistance providers and out-of-state providers who are enrolled in the Alaska Medicaid Program are eligible to participate in the Alaska Medicaid EHR Incentive Program.

Eligible professionals

- physician (MD and DO)
- dentist
- certified nurse-midwife
- nurse practitioner
- physician assistant practicing in a Federally Qualified Health Center (FQHC) led by a physician assistant or a rural health clinic (RHC), that is so led by a physician assistant

For the purposes of the EHR Incentive Program a Tribal clinic is considered a FQHC. A physician assistant practicing in a Tribal clinic must meet the same requirements of a physician assistant practicing in a FQHC. Any other provider that practices in a Tribal clinic follows the same rules as a FQHC.

Physician Assistant (PA) led Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC) means 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);
- a clinical or medical director at a clinical site of practice; or
- an owner of an RHC.

Eligible hospitals

- Acute care hospitals, including critical access hospitals (CAHs)
- Children's hospitals

5 Enrollment requirements

Requirements for an eligible professional

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must meet the following criteria:

- Meet one of the following patient volume criteria:
 - Have a minimum of 30 percent patient volume attributable to services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability (specific criteria apply)
 - Have a minimum 20 percent patient volume attributable to services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability (specific criteria apply), and be a pediatrician*; or
 - Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals
- Have a valid contract with Alaska Medical Assistance**;
- Have no sanctions and/or exclusions;
- Hospital-based providers may be eligible if they purchase and use their own EHR program (hospital based is defined as 90% or more of services are performed in a hospital inpatient or emergency room setting)

* For the purposes of this program, the Department defines pediatricians as a practitioner who is board certified through the American Board of Pediatrics web site *or* through the American Osteopathic Board of Pediatrics.

** A valid contract means that the provider is currently enrolled with Alaska Medicaid Program to provide services. An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he/she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System. The TIN of the individual or entity receiving the incentive payment must match a TIN linked to the individual provider in the Medicaid Management Information System (MMIS). For entities that do not link providers to their MMIS enrollment, the provider must be in contractual arrangement with the group or clinic to which they assign their payment.

Providers and hospitals currently ineligible for the Alaska Medicaid EHR Incentive Program include behavioral health (substance abuse and mental health) providers and facilities and long-term care providers and facilities. Note that some provider types eligible for the Medicare program, such as chiropractors, are not eligible for the Alaska Medicaid EHR Incentive Program per federal regulations.

Requirements for an eligible hospital

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must meet the following criteria:

- An acute care hospital including Critical Access Hospitals (CAH)
 - Acute Care and Critical Access Hospitals must have:
 - Medicaid discharges of at least 10% for the Medicaid patient volume,
 - An average Length of Stay (LOS) of 25 days or less,
 - A CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment.
- A children’s hospital
 - Children’s Hospitals without a CCN, because they do not serve Medicare beneficiaries but have received alternate numbers from CMS for Incentive Program participation are eligible. They do not have to meet the patient volume threshold.

Qualifying providers by provider type and patient volume

Provider Types	Patient Volume over 90-days Period
Eligible Hospital	
Acute Care Hospital (includes Critical Assess Hospitals)	• 10% Medicaid related encounters
Children’s Hospital	• No Medicaid volume requirement
Eligible Professional	
Physicians (M.D., D.O.)	<ul style="list-style-type: none"> • 30% Medicaid related encounters • For EP’s practicing in a FQHC/RHC - 30% Needy Individuals
Dentists	
Certified Nurse Midwives	
Nurse Practitioners	
PA’s when practicing at an FQHC/RHC that is led by a PA	
Pediatrician	<ul style="list-style-type: none"> • 30% Medicaid related encounters • If Pediatrician patient volume = 20-29%, the provider may qualify for 2/3 of incentive payment

Out-of-state providers

The Alaska Medicaid EHR Incentive Program allows out-of-state provider to participate in this advantageous program. Out-of-state providers have the same eligibility requirements as in-state providers. Alaska must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Alaska Department of Health and Social Services or Centers for Medicare and Medicaid Services. Records must be maintained as applicable by law in the State of practice or Alaska, whichever is deemed longer. The out of state provider must be enrolled with Alaska Medicaid Program in order to participate in the Alaska Medicaid EHR Incentive Program.

6 Patient volume methodology

A Medicaid provider must annually meet patient volume requirements for the Alaska Medicaid EHR Incentive Program as established through the State’s CMS approved SMHP.

Eligible professional patient encounter calculation

EP patient volume for those not practice predominantly in a Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal clinic will be calculated based on Medicaid and out-of-state Medicaid patients. For EPs practicing predominantly in a FQHC or RHC the patient volume is calculated using the needy individual patient volume requirements. Practicing predominantly is defined as an EP practicing at an FQHC or a RHC clinical location for over 50 percent of his or her total patient encounters over a period of 6 months.

The EP Medicaid patient volume or needy individual patient volume is calculated based on the number of encounters for a representative 90-day period in the previous calendar year or in the twelve months preceding the providers’ attestation date.

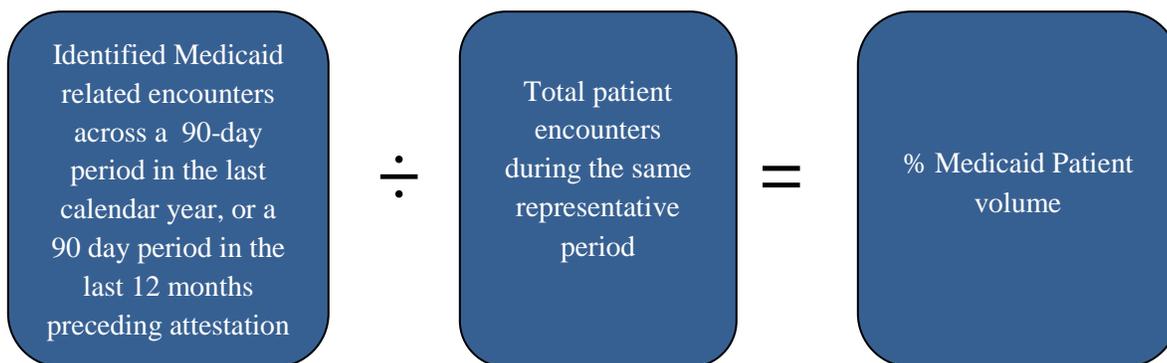
Eligible professional Medicaid encounter

For purposes of calculating the EP patient volume, a Medicaid encounter is defined as services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims and encounters. Zero-pay claims include:

- Claims denied because the Medicaid beneficiary has maxed out the service limit
- Claims denied because the service wasn’t covered under the State’s Medicaid Program
- Claim paid at \$0 because another payer’s payment exceeded the Medicaid payment
- Claim denied because the claim wasn’t submitted timely.

To calculate Medicaid patient volume, an EP must divide:

- The total identified Medicaid or out of-state Medicaid related patient encounters
 - a. in any representative 90-day period in the preceding calendar year, or
 - b. in any 3 month period in the preceding year that is 90-days or greater, or
 - c. the full preceding calendar year, or
 - d. in any 90-day period in the last 12 months preceding the provider’s attestation; by
- The total patient encounters in the same time period.



Eligible professional needy individual encounter

For purposes of calculating the patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- The identified Eligible Professional Medicaid Encounter definition listed on the prior page
- Furnished by the provider as uncompensated care, or **
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

**For providers practicing in a Tribal clinic, uncompensated care is a calculated figure, using charity care and bad debt to determine the number of encounters that are considered uncompensated care. Indian Health Services (IHS) has defined uncompensated care as:

Total Visits - Paid Visits (regardless of payer)* - Charity Care (special fund that people qualify for [this is 0 for Tribes/Urban]) – Bad Debt = Uncompensated Care.

*Under the paid visits figure IHS is not considered a payer.

To calculate needy individual patient volume, an EP must divide:

1. The total identified needy individual Medicaid or out-of-state Medicaid related patient encounters
 - a. in any representative 90-day period in the preceding calendar year, or
 - b. in any 3 month period in the preceding year that is 90-days or greater, or
 - c. the full preceding calendar year, or
 - d. in any 90-day period in the last 12 months preceding the provider's attestation; by
2. The total patient encounters in the same time period.

Group practice patient encounter calculation

Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP;
- There is an auditable data source to support the clinic's or group practice's patient volume determination;
- All EPs in the group practice or clinic must use the same methodology for the payment year;
- The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EPs outside encounters.

The group patient volume for a non-Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal clinic will be calculated based on eligible Medicaid Encounters and out-of-state Medicaid patients. The group patient volume for a FQHC, RHC or Tribal clinic is calculated using the needy individual patient volume requirements if the providers within the group practiced predominantly in the FQHC, RHC or Tribal clinic in the previous calendar year.

Group Medicaid encounters

To calculate the group practice patient volume, a group must divide:

1. The group's total identified Medicaid or out of-state Medicaid related patient encounters
 - a. in any representative 90-day period in the preceding calendar year, or
 - b. in any 3 month period in the preceding year that is 90-days or greater, or
 - c. the full preceding calendar year, or
 - d. in any 90-day period in the last 12 months preceding the provider's attestation; by
2. The total patient encounters in the same time period.

For groups choosing to use "in any 90-day period in the last 12 months preceding the provider's attestation", there is a CMS FAQ that addresses the likelihood of the group attestations being completed on different days and then having different time periods. FAQ #9822 can be found at this website:

<https://questions.cms.gov/?isDept=0&search=9822&searchType=faqId&submitSearch=1&id=5005>

Group needy individual encounters

In order for providers to use the group needy individual patient volume, all providers within the group must have practiced predominantly in the FQHC, RHC or Tribal clinic for 50% of their encounters over a 6 month time period in the previous calendar year or in the 12 months preceding the attestation.

To calculate the group needy individual patient volume, a group must divide:

1. The group's total identified needy individual Medicaid or out of-state Medicaid related patient encounters
 - a. in any representative 90-day period in the preceding calendar year, or
 - b. in any 3 month period in the preceding year that is 90-days or greater, or
 - c. the full preceding calendar year, or
 - d. in any 90-day period in the last 12 months preceding the provider's attestation; by
2. The total patient encounters in the same 90-day or greater period.

Eligible hospital patient encounter calculation

For purposes of calculating EH patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims. Zero pay claims include:

- Claims denied because the Medicaid beneficiary has maxed out the service limit
- Claims denied because the service wasn't covered under the State's Medicaid Program
- Claim paid at \$0 because another payer's payment exceeded the Medicaid payment
- Claim denied because the claim wasn't submitted timely.

In order for emergency room encounters to count towards the patient volume the emergency department must be part of the hospital.

Exception - A children's hospital is not required to meet Medicaid patient volume requirements.

To calculate Medicaid patient volume, an EH must divide:

1. The total identified Medicaid or out of-state Medicaid related patient encounters
 - a. in any representative 90-day period in the preceding federal fiscal year, or
 - b. in any 3 month period in the preceding federal fiscal year that is 90-days or greater, or
 - c. the full preceding federal fiscal year, by
2. The total encounters in the same identified period.
 - a. Total number of inpatient discharges for the selected period; the encounters also include discharges within the 90 days in which the patient was admitted prior to the start of the selected period plus could include the total number of emergency department visits in the same identified period.

7 Electronic health record functions

Adopt, Implement or Upgrade (AIU)

Adopt, Implement or Upgrade (AIU). Federal regulations allow EPs and EHs who participate in the Alaska Medicaid EHR Incentive Program to receive incentive payments if they adopt, implement or upgrade to a certified EHR technology in the first year of participation. (This option is not available through the Medicare Incentive Program in which all providers must meet meaningful use in the first year.) At the time of attestation, the EP or EH will be required to provide documentation supporting the claim of AIU, such as a contract or paid invoice.

What does Adopt, Implement or Upgrade Mean?	
Adopt	Acquire, purchase, or secure access to certified EHR technology
Implement	Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements;
Upgrade	Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

Meaningful Use (MU)

The Medicare and Medicaid EHR Incentive Programs provide financial incentives for the “meaningful use” of certified EHR technology to improve patient care. To receive an EHR incentive payment, providers have to show that they are “meaningfully using” their EHRs by meeting thresholds for a number of objectives. CMS has established the objectives for “meaningful use” that eligible professionals, eligible hospitals, and critical access hospitals (CAHs) must meet in order to receive an incentive payment.

The Medicare and Medicaid EHR Incentive Programs are staged in three stages with increasing requirements for participation. Eligible professionals participate in the program on the calendar years, while eligible hospitals and CAHs participate according to the federal fiscal year.

Stage 2 Meaningful Use Requirements

On September 4 2012, CMS published a final rule that specifies the Stage 2 criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2.

Stage 2 uses a core and menu structure for objectives that providers must to achieve in order to demonstrate meaningful use. Core objectives are objectives that all providers must meet. There is also a predetermined number of menu objectives that providers must select from a list and meet in order to demonstrate meaningful use.

More detailed information on Core and Menu Objectives for Stage 1 and Stage 2 are in the following pages.

Adopt, Implement, Upgrade in Year 1

EPs that adopt, implement, or upgrade in their first year of participation do not have to report meaningful use during the first payment year. In the second year of participation, EPs must display meaningful use for a selected 90 day reporting period. Providers must report a full year of meaningful use for all other subsequent payment years. Payment years do not have to be consecutive until 2016. EPs who display meaningful use of EHR technology in the first year of participation must report 90 days of meaningful use, all other subsequent years provider must report a full calendar year. The exception to the 365-day reporting requirement is for calendar year 2014 when all providers have a 90-day reporting period.

EHR Incentive Payment Timelines

	1st Payment Received in 2011	1st Payment Received in 2012	1st Payment Received in 2013	1 st Payment Received in 2014	1st Payment Received in 2015	1st Payment Received in 2016
2011 Payment amount	\$21,250.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2012 Payment amount	\$8,500.00	\$21,250.00	\$0.00	\$0.00	\$0.00	\$0.00
2013 Payment amount	\$8,500.00	\$8,500.00	\$21,250.00	\$0.00	\$0.00	\$0.00
2014 Payment amount	\$8,500.00	\$8,500.00	\$8,500.00	\$21,250.00	\$0.00	\$0.00
2015 Payment amount	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00	\$21,250.00	\$0.00
2016 Payment amount	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00	\$21,250.00
2017 Payment amount	\$0.00	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00
2018 Payment amount	\$0.00	\$0.00	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00
2019 Payment amount	\$0.00	\$0.00	\$0.00	\$8,500.00	\$8,500.00	\$8,500.00
2020 Payment amount	\$0.00	\$0.00	\$0.00	\$0.00	\$8,500.00	\$8,500.00
2021 Payment amount	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$8,500.00
Total Payments	\$63,750.00	\$63,750.00	\$63,750.00	\$63,750.00	\$63,750.00	\$63,750.00

Stage 1 Meaningful Use criteria

If an EH received an incentive payment for AIU in the first year of participation in the Alaska Medicaid EHR Incentive Program, they will need to successfully demonstrate meaningful use of certified EHR technology in the second year of participation for a selected 90 day reporting period in the Federal fiscal year. The reporting period for all subsequent years will be the entire Federal fiscal year.

EPs do not need to successfully demonstrate meaningful use in their first year of participation in order to receive an incentive payment. The reporting period in the second calendar year of participation is 90 days during the calendar year. The reporting period for all remaining calendar years will be the entire calendar year (The exception to this is 2014 where all Stages of MU will attest to 90 days)

Meaningful use includes both a core set and a menu set of objectives that are specific to eligible professionals or eligible hospitals and CAHs. For eligible professionals, there are a total of 22 meaningful use objectives. To qualify for an incentive payment, 18 of these 22 objectives must be met:

- 13 required core objectives
- 5 objectives chosen from a list of 9 menu set objectives.

For eligible hospitals and CAHs, there are a total of 22 meaningful use objectives. To qualify for an incentive payment, 18 of these 22 objectives must be met:

- 11 required core objectives
- 5 objectives chosen from a list of 10 menu set objectives

A particular objective may be excluded if the following criteria are met:

1. Meets the criteria in the applicable objective that would permit the attestation; and
2. Attests that the objective is not applicable.
3. Exclusions may apply to certain measures; these exclusions are identified within each measure. An exclusion reduces the number of objectives that otherwise apply. For instance, an EP that qualifies for the exclusion of an objective from the menu set will be required to select only four from the menu set. The EP must still report at least one of the public health objectives.

Stage 2 Meaningful Use criteria

On September 4, 2012, CMS published a final rule that specifies the Stage 2 Criteria that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) must meet in order to continue to participate in the Medicare and Medicaid Electronic Health Record Incentive Program.

Stage 2 uses a core and menu structure for objectives that providers must achieve in order to demonstrate meaningful use. Core objectives are objectives that all providers must meet. There is also a predetermined number of menu objectives that providers must select from a list and meet in order to demonstrate meaningful use.

To demonstrate meaningful use under Stage 2 criteria—

- EPs must meet 17 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 20 core objectives.
- Eligible hospitals and CAHs must meet 16 core objectives and 3 menu objectives that they select from a total list of 6, or a total of 19 core objectives.

Screenshots of Stage 2 Core and Menu Objectives for both EPs and EHs are in Addendum 1

Timelines for Stage 1 and Stage 2

1 st Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

Note that providers who were early demonstrators of meaningful use in 2011 will meet three consecutive years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in 2014. All other providers would meet two years of meaningful use under the Stage 1 criteria before advancing to the Stage 2 criteria in their third year

The tables on following pages are Stage 1 and Stage 2 comparisons for Core Objectives and Menu Objectives for both EPs and EHRs. The tables' show what is the Stage 1 Objective/Measure compared to how it is for Stage 2. There is a section on Clinical Quality Measures that are applicable to both EPs and EHRs after the table for EPs.

Stage 1 vs Stage 2 Comparison Table for Eligible Professionals

Core Objectives (17 Total)

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Use 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	More than 30% of unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE
Implement drug-drug and drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the Stage 2 Clinical Decision Support measure</i>

Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology	Generate and transmit permissible prescriptions electronically (eRx)	More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology
Record demographics <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth 	More than 50% of all unique patients seen by the EP have demographics recorded as structured data	Record the following demographics <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth 	More than 80% of all unique patients seen by the EP have demographics recorded as structured data
Maintain an up-to-date problem list of current and active diagnoses	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	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i>
Maintain active medication list	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	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i>
Maintain active medication allergy list	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	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i>
Record and chart changes	For more than 50% of all	Record and chart changes	More than 80% of all

<p>in vital signs:</p> <ul style="list-style-type: none"> • Height • Weight • Blood pressure • Calculate and display BMI <p>Plot and display growth charts for children 2-20 years, including BMI</p>	<p>unique patients age 2 and over seen by the EP, blood pressure, height and weight are recorded as structured data</p>	<p>in vital signs:</p> <ul style="list-style-type: none"> • Height • Weight • Blood pressure (age 3 and over) • Calculate and display BMI <p>Plot and display growth charts for patients 0-20 years, including BMI</p>	<p>unique patients seen by the EP have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data</p>
<p>Record smoking status for patients 13 years old or older</p>	<p>More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data</p>	<p>Record smoking status for patients 13 years old or older</p>	<p>More than 80% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data</p>
<p>Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule</p>	<p>Implement one clinical decision support rule</p>	<p>Use clinical decision support to improve performance on high-priority health conditions</p>	<p>1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period.</p> <p>2. The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period</p>
<p>Report clinical quality measures (CQMs) to CMS or the States</p>	<p>Provide aggregate numerator, denominator, and exclusions through attestation or through the PQRS Electronic Reporting Pilot</p>	<p><i>No longer a separate objective for Stage 2, but providers must still submit CQMs to CMS or the States in order to achieve meaningful use</i></p>	<p><i>Starting in 2014, all CQMs will be submitted electronically to CMS</i></p>
<p>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies),</p>	<p>More than 50% of all patients of the EP who request an electronic copy of their health information are provided it within 3 business days</p>	<p>Provide patients the ability to view online, download and transmit their health information within four business days of the information being</p>	<p>i. More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the</p>

upon request		available to the EP	information is available to the EP) online access to their health information ii. More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information
Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days	Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients within one business day for more than 50% of office visits
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	<i>This objective is eliminated from Stage 1 in 2013 and is no longer an objective for Stage 2</i>	<i>This measure is eliminated from Stage 1 in 2013 and is no longer a measure for Stage 2</i>
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data at rest and implement security updates as necessary and correct identified security deficiencies as part of its risk management process
Implement drug-formulary checks	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the e-Prescribing measure for Stage 2</i>
Incorporate clinical lab-test results into certified	More than 40% of all clinical lab tests results	Incorporate clinical lab-test results into Certified	More than 55% of all clinical lab tests results

EHR technology as structured data	ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data	EHR Technology as structured data	ordered by the EP during the EHR reporting period whose results are 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	Generate at least one report listing patients of the EP with a specific condition	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	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	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	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care	Use EHR to identify and provide reminders for preventive/follow-up care for more than 10% of patients with two or more office visits in the last 2 years
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP	More than 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	<i>This objective is eliminated from Stage 1 in 2014 and is no longer an objective for Stage 2</i>	<i>This measure is eliminated from Stage 1 in 2014 and is no longer a measure for Stage 2</i>
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients seen by the EP are provided patient-specific education resources	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	Patient-specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is

should perform medication reconciliation	transitioned into the care of the EP	should perform medication reconciliation	transitioned into the care of the EP
<p>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</p>	<p>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</p>	<p>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</p>	<ol style="list-style-type: none"> 1. 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 2. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record either a) electronically transmitted to a recipient using CEHRT or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or is validated through an ONC-established governance mechanism to facilitate exchange for 10% of transitions and referrals 3. The EP who transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period
<p>Capability to submit electronic data to</p>	<p>Performed at least one test of certified EHR</p>	<p>Capability to submit electronic data to</p>	<p>Successful ongoing submission of electronic</p>

immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice	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)	immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice	immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period
NEW	NEW	Use secure electronic messaging to communicate with patients on relevant health information	A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 5% of unique patients seen during the EHR reporting period

Menu Objectives (EPs must select 3 of 6 menu objectives)

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	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, eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period
NEW	NEW	Record electronic notes in patient records	Enter at least one electronic progress note created, edited and signed by an EP for more than

			30% of unique patients
NEW	NEW	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT	More than 10% of all scans and tests whose result is an image ordered by the EP for patients seen during the EHR reporting period are incorporated into or accessible through Certified EHR Technology
NEW	NEW	Record patient family health history as structured data	More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been reviewed
NEW	NEW	Capability to identify and report cancer cases to a State cancer registry, except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of cancer case information from Certified EHR Technology to a cancer registry for the entire EHR reporting period
NEW	NEW	Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice	Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period

(CMS, 2012)

Meaningful Use Clinical Quality Measures (CQMs) for both EPs and EHs

In 2014, all providers, regardless of whether they are in Stage 1 or Stage 2 of meaningful use, will be required to report on the 2014 clinical quality Measures (CQM's). EPs will need to report 9 measures and EHs will need to report 16.

Also in 2014, there is the requirement that the quality measures selected must cover at least three of the six domains based on the National Quality Strategy's (NQS) domains, which represent the Department of Health and Human Services' NQS priorities for health care quality improvement.

The 6 NQS domains are:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population/Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness

There is not a required core of CQM's. Instead, CMS has identified two recommended core sets of CQM's – one for adults and one for children – that focus on high-priority health conditions and best practices for care delivery. Below are the links for the two core sets:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_CQM_PediaticRecommended_CoreSetTable.pdf

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_CQM_AdultRecommend_CoreSetTable.pdf

CMS eMeasure ID	NQF	Measure Title	Measure Description	Numerator Statement	Denominator Statement	Measure Steward	Domain
CMS146v2	0002	Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis	Children age 2-18 years who had an outpatient or emergency department (ED) visit with a diagnosis of pharyngitis during the measurement period and an antibiotic ordered on or three days after the visit	National Committee for Quality Assurance	Efficient Use of Healthcare Resources

CMS137v2	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	Numerator 1: Patients who initiated treatment within 14 days of the diagnosis Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS165v2	0018	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS156v2	0022	Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk	Numerator 1: Patients with an order for at least one high-risk medication during the measurement period. Numerator 2: Patients with an order for at least two different high-risk medications during the measurement period.	Patients 66 years and older who had a visit during the measurement period	National Committee for Quality Assurance	Patient Safety

			medications.				
CMS155v2	0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation - Percentage of patients with counseling for nutrition - Percentage of patients with counseling for physical activity	Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period Numerator 2: Patients who had counseling for nutrition during the measurement period Numerator 3: Patients who had counseling for physical activity during the measurement period	Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period	National Committee for Quality Assurance	Population/ Public Health
CMS138v2	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user	All patients aged 18 years and older	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Population/ Public Health
CMS125v2	0031	Breast Cancer Screening	Percentage of women 40–69 years of age who had a mammogram to screen for breast cancer.	Women with one or more mammograms during the measurement period or the year prior to the measurement period	Women 41–69 years of age with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS124v2	0032	Cervical Cancer	Percentage of women 21-64 years of age, who	Women with one or more Pap tests during the	Women 23-64 years of age with a visit during	National Committee for	Clinical Process/

		Screening	received one or more Pap tests to screen for cervical cancer.	measurement period or the two years prior to the measurement period	the measurement period	Quality Assurance	Effectiveness
CMS153v2	0033	Chlamydia Screening for Women	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	Women with at least one chlamydia test during the measurement period	Women 16 to 24 years of age who are sexually active and who had a visit in the measurement period	National Committee for Quality Assurance	Population/ Public Health
CMS130v2	0034	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria below: - Fecal occult blood test (FOBT) during the measurement period - Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period - Colonoscopy during the measurement period or the nine years prior to the measurement period	Patients 50-75 years of age with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS126v2	0036	Use of Appropriate Medications for Asthma	Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.	Patients who were dispensed at least one prescription for a preferred therapy during the measurement period	Patients 5-64 years of age with persistent asthma and a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness

CMS117v2	0038	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday	Children who turn 2 years of age during the measurement period and who have a visit during the measurement period	National Committee for Quality Assurance	Population/ Public Health
CMS147v2	0041	Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization	All patients aged 6 months and older and seen for a visit between October 1 and March 31	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Population/ Public Health
CMS127v2	0043	Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	Patients who have ever received a pneumococcal vaccination	Patients 65 years of age and older with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS166v3	0052	Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an	Patients without an imaging study conducted on the date of the outpatient or emergency	Patients 18-50 years of age with a diagnosis of low back pain during an outpatient or emergency	National Committee for Quality	Efficient Use of Healthcare Resources

			imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	department visit or in the 28 days following the outpatient or emergency department visit	department visit	Assurance	
CMS131v2	0055	Diabetes: Eye Exam	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS123v2	0056	Diabetes: Foot Exam	Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.	Patients who received visual, pulse and sensory foot examinations during the measurement period	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS122v2	0059	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS148v2	0060	Hemoglobin A1c Test for Pediatric Patients	Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period	Patients with documentation of date and result for a HbA1c test during the measurement period	Patients 5 to 17 years of age with a diagnosis of diabetes and a face-to-face visit between the physician and the patient	National Committee for Quality Assurance	Clinical Process/ Effectiveness

					that predates the most recent visit by at least 12 months		
CMS134v2	0062	Diabetes: Urine Protein Screening	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	Patients with a screening for nephropathy or evidence of nephropathy during the measurement period	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS163v2	0064	Diabetes: Low Density Lipoprotein (LDL) Management	Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.	Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL	Patients 18-75 years of age with diabetes with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS164v2	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another	Patients who have documentation of use of aspirin or another antithrombotic during the measurement period	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness

			antithrombotic during the measurement period.				
CMS154v2	0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory infection	Children age 3 months to 18 years who had an outpatient or emergency department (ED) visit with a diagnosis of upper respiratory infection (URI) during the measurement period	National Committee for Quality Assurance	Efficient Use of Healthcare Resources
CMS145v2	0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy	Patients who were prescribed beta-blocker therapy	All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI or a current or prior LVEF <40%	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS182v3	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 coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic	Numerator 1: Patients with a complete lipid profile performed during the measurement period Numerator 2: Patients whose most recent LDL-C level performed during the measurement period is <100 mg/dL	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) during the measurement period, or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or	National Committee Quality Assurance	Clinical Process/ Effectiveness

			vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).		percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period		
CMS135v2	0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge	Patients who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS144v2	0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at	Patients who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness

			each hospital discharge				
CMS143v2	0086	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months	Patients who have an optic nerve head evaluation during one or more office visits within 12 months	All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS167v2	0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months	Patients 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	All patients aged 18 years and older with a diagnosis of diabetic retinopathy	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS142v2	0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes	Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care	All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness

			mellitus regarding the findings of the macular or fundus exam at least once within 12 months				
CMS139v2	0101	Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	Patients who were screened for future fall risk at least once within the measurement period	Patients aged 65 years and older with a visit during the measurement period	National Committee for Quality Assurance	Patient Safety
CMS161v2	0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS128v2	0105	Anti-depressant Medication Management	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an	Numerator 1: Patients who have received antidepressant medication for at least 84 days (12 weeks) of continuous treatment during the 114-day period following the Index Prescription Start Date Numerator 2: Patients who have received antidepressant medications for at least 180 days (6 months) of continuous treatment during the 231-day	Patients 18 years of age and older with a diagnosis of major depression in the 270 days (9 months) prior to the measurement period or the first 90 days (3 months) of the measurement period, who were treated with antidepressant medication, and with a visit during the measurement period	National Committee for Quality Assurance	Clinical Process/ Effectiveness

			antidepressant medication for at least 180 days (6 months).	period following the Index Prescription Start Date			
CMS136v3	0108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Numerator 1: Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSD Numerator 2: Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation Phase, and at least two follow-up visits during the Continuation and Maintenance Phase. One of the two visits during the Continuation and Maintenance Phase may be a telephone visit with a practitioner.	Initial Patient Population 1: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period Initial Patient Population 2: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who remained on the medication for at least 210 days out of the 300 days following the IPSD, and who had a visit during the measurement period.	National Committee for Quality Assurance	Clinical Process/ Effectiveness
CMS169v2	0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Patients in the denominator with evidence of an assessment for alcohol or other substance use following or concurrent with the new diagnosis, and prior to or concurrent with the initiation of treatment for that	Patients 18 years of age or older at the start of the measurement period with a new diagnosis of unipolar depression or bipolar disorder during the first 323 days of the measurement period, and	Center for Quality Assessment & Improvement in Mental Health (CQAIMH)	Clinical Process/ Effectiveness

				<p>diagnosis. (Note: the endorsed measure calls for the assessment to be performed prior to discussion of the treatment plan with the patient, but the current approach was considered more feasible in an EHR setting. The "Assessment for Alcohol or Other Drug Use" required in the numerator is meant to capture a provider's assessment of the patient's symptoms of substance use. The essence of the measure is to avoid treating the patient for unipolar depression or bipolar disorder without an assessment of their use of alcohol or other drugs.)</p>	<p>evidence of treatment for unipolar depression or bipolar disorder within 42 days of diagnosis. The existence of a 'new diagnosis' is established by the absence of diagnoses and treatments of unipolar depression or bipolar disorder during the 180 days prior to the diagnosis.</p>		
CMS157v2	0384	Oncology: Medical and Radiation – Pain Intensity Quantified	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified	Patient visits in which pain intensity is quantified	All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Patient and Family Engagement

CMS141v3	0385	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.	Patients who are referred for chemotherapy, prescribed chemotherapy, or who have previously received adjuvant chemotherapy within the 12 month reporting period	All patients aged 18 through 80 years with colon cancer with AJCC Stage III colon cancer	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS140v2	0387	Breast Cancer: Hormonal Therapy for Stage IC-III C 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	Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period	All female patients aged 18 years and older with a diagnosis of breast cancer with stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS129v3	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	Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer	Equals Initial Patient Population at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Efficient Use of Healthcare Resources

			have a bone scan performed at any time since diagnosis of prostate cancer				
CMS62v2	0403	HIV/AIDS: Medical Visit	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit	Patients with at least two medical visits during the measurement year with a minimum of 90 days between each visit	All patients, regardless of age, with a diagnosis of HIV/AIDS seen within a 12 month period	National Committee for Quality Assurance (NCQA)	Clinical Process/ Effectiveness
CMS52v2	0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) prophylaxis	Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	Numerator 1: Patients who were prescribed pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm3 Numerator 2: Patients who were prescribed pneumocystic jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/ mm3 or a CD4 percentage below 15% Numerator 3: Patients who were prescribed Pneumocystic jiroveci pneumonia (PCP) prophylaxis at the time of diagnosis of HIV	Denominator 1: All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm3 who had at least two visits during the measurement year, with at least 90 days in between each visit Denominator 2: All patients aged 1-5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm3 or a CD4 percentage below 15% who had at least two visits during the measurement year, with at least 90 days in between each visit Denominator 3: All patients aged 6 weeks to 12 months with a diagnosis of HIV who	National Committee for Quality Assurance (NCQA)	Clinical Process/ Effectiveness

					had at least two visits during the measurement year, with at least 90 days in between each visit		
CMS77v2	TBD	HIV/AIDS: RNA Control for Patients with HIV	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL.	Patients whose most recent HIV RNA level is <200 copies/mL.	All patients aged 13 years and older with a diagnosis of HIV/AIDS with at least two visits during the measurement year, with at least 90 days between each visit.	Centers for Medicare & Medicaid Services (CMS)	Clinical Process/ Effectiveness
CMS2v3	0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period.	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Population/ Public Health
CMS68v3	0419	Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources	Eligible professional attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list	All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Patient Safety

			available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration			
CMS69v2	0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter Normal Parameters: Age 65 years and older BMI \geq 23 and $<$ 30 Age 18-64 years BMI \geq 18.5 and $<$ 25	Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters.	There are two (2) Initial Patient Populations for this measure NOTE: The most recent quality code submitted will be used for performance calculation. Initial Patient Population 1: All patients 65 years of age and older before the beginning of the measurement period with at least one eligible encounter during the measurement period NOT INCLUDING encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Population/ Public Health

					<p>jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate.</p> <p>Initial Patient Population 2: All patients 18 through 64 years before the beginning of the measurement period with at least one eligible encounter during the measurement period NOT INCLUDING encounters where the patient is receiving palliative care, refuses measurement of height and/or weight, the patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status, or there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate</p>		
CMS132v2	0564	Cataracts: Complications within 30 Days	Percentage of patients aged 18 years and older with a diagnosis of	Patients who had one or more specified operative procedures for any of the	All patients aged 18 years and older who had cataract surgery and no	American Medical Association-	Patient Safety

		Following Cataract Surgery Requiring Additional Surgical Procedures	uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence	following major complications within 30 days following cataract surgery: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence	significant ocular conditions impacting the surgical complication rate	convened Physician Consortium for Performance Improvement® (AMA-PCPI)	
CMS133v2	0565	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery	Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery	All patients aged 18 years and older who had cataract surgery	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/
CMS158v2	0608	Pregnant women that had HBsAg testing	This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their	Patients who were tested for Hepatitis B surface antigen (HBsAg) during pregnancy within 280	All female patients aged 12 and older who had a live birth or delivery during the measurement	OptumInsight	Clinical Process/ Effectiveness

			pregnancy.	days prior to delivery.	period.		
CMS159v2	0710	Depression Remission at Twelve Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment	Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter.	MN Community Measurement	Clinical Process/ Effectiveness
CMS160v2	0712	Depression Utilization of the PHQ-9 Tool	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4-month period in which there was a qualifying visit.	Adult patients who have a PHQ-9 tool administered at least once during the four-month period.	Adult patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during each four month period	MN Community Measurement	Clinical Process/ Effectiveness
CMS75v2	TBD	Children Who Have Dental Decay or Cavities	Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.	Children who had cavities or decayed teeth.	Children, age 0-20 years, with a visit during the measurement period.	Centers for Medicare & Medicaid Services (CMS)	Clinical Process/ Effectiveness
CMS177v2	1365	Child and Adolescent Major Depressive Disorder:	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with	Patient visits with an assessment for suicide risk	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder	American Medical Association-convened Physician	Patient Safety

		Suicide Risk Assessment	an assessment for suicide risk			Consortium for Performance Improvement® (AMA-PCPI)	
CMS82v1	1401	Maternal depression screening	The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.	Children with documentation of maternal screening or treatment for postpartum depression for the mother.	Children with a visit who turned 6 months of age in the measurement period.	National Committee for Quality Assurance	Population/ Public Health
CMS74v3	TBD	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	Children who receive a fluoride varnish application	Children, age 0-20 years, with a visit during the measurement period.	Centers for Medicare & Medicaid Services (CMS)	Clinical Process/ Effectiveness
CMS61v3	TBD	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed	Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.	Numerator 1: (High Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period Numerator 2 : (Moderate Risk) Patients who had a fasting LDL-C test performed or a calculated	Denominator 1: (High Risk) All patients aged 20 through 79 years who have CHD or CHD Risk Equivalent OR 10-Year Framingham Risk > 20% Denominator 2 : (Moderate Risk) All patients aged 20	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Clinical Process/ Effectiveness

				<p>LDL-C during the measurement period Numerator 3 : (Low Risk) Patients who had a fasting LDL-C test performed or a calculated LDL-C during the measurement period or up to four (4) years prior to the current measurement period</p>	<p>through 79 years who have 2 or more Major CHD Risk Factors OR 10-Year Framingham Risk 10-20% Denominator 3 : (Low Risk) All patients aged 20 through 79 years who have 0 or 1 Major CHD Risk Factors OR 10-Year Framingham Risk <10% ** For Denominator 2 and Denominator 3, Fasting HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)</p>		
CMS64v3	TBD	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)	Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.	<p>Numerator 1: Patients whose most recent fasting LDL-C test result is in good control, defined as <100 mg/dL Numerator 2: Patients whose most recent fasting LDL-C test result is in good control, defined as <130 mg/dL Numerator 3: Patients whose most recent fasting LDL-C test result is in good control, defined as <160 mg/dL</p>	<p>Denominator 1: (High Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have CHD or CHD Risk Equivalent OR 10 year Framingham risk > 20% Denominator 2: (Moderate Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed during the measurement period and have 2 or more Major</p>	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid Services	Clinical Process/ Effectiveness

					<p>CHD Risk Factors OR 10 year Framingham Risk 10-20%. Denominator 3: (Low Risk) All patients aged 20 through 79 years who had a fasting LDL-C or a calculated LDL-C test performed up to 4 years prior to the current measurement period and have 0 or 1 Major CHD Risk Factors OR 10 year Framingham risk <10%. ** For Denominator 2 and Denominator 3, HDL-C > or equal to 60 mg/dL subtracts 1 risk from the above (This is a negative risk factor.)</p>		
CMS149v2	Not Applicable	Dementia: Cognitive Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period	Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period	All patients, regardless of age, with a diagnosis of dementia	American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)	Clinical Process/ Effectiveness
CMS65v3	TBD	Hypertension: Improvement in Blood Pressure	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Patients whose follow-up blood pressure is at least 10 mmHg less than their baseline blood pressure or is adequately controlled. If a follow-up blood pressure reading is not	All patients aged 18-85 years of age, who had at least one outpatient visit in the first six months of the measurement year, who have a diagnosis of hypertension	Centers for Medicare & Medicaid Services (CMS)	Clinical Process/ Effectiveness

				recorded during the measurement year, the patient’s blood pressure is assumed “not improved.”	documented during that outpatient visit, and who have uncontrolled baseline blood pressure at the time of that visit		
CMS50v2	TBD	Closing the referral loop: receipt of specialist report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.	Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.	Centers for Medicare & Medicaid Services (CMS)	Care Coordination
CMS66v2	TBD	Functional Status Assessment for Knee Replacement	Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10 Global Health, PROMIS-29, KOOS) not more than 180 days prior to the primary TKA procedure, and at least 60 days and not more than 180 days after TKA procedure	Adults, aged 18 and older, with a primary total knee arthroplasty (TKA) and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after TKA procedure.	Centers for Medicare & Medicaid Services (CMS)	Patient and Family Engagement
CMS56v2	TBD	Functional Status Assessment for Hip Replacement	Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments	Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10-Global Health, PROMIS-29, HOOS) not more than 180 days prior to the primary THA procedure, and at least 60 days and not more than 180 days after THA procedure.	Adults aged 18 and older with a primary total hip arthroplasty (THA) and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after THA procedure.	Centers for Medicare & Medicaid Services (CMS)	Patient and Family Engagement
CMS90v3	TBD	Functional Status	Percentage of patients aged 65 years and older	Patients with patient reported functional status assessment results (e.g.,	Adults aged 65 years and older who had two	Centers for Medicare &	Patient and Family

		Assessment for Complex Chronic Conditions	with heart failure who completed initial and follow-up patient-reported functional status assessments	VR-12; VR-36; MLHF-Q; KCCQ; PROMIS-10 Global Health, PROMIS-29) present in the EHR at least two weeks before or during the initial encounter and the follow-up encounter during the measurement year.	outpatient encounters during the measurement year and an active diagnosis of heart failure.	Medicaid Services (CMS)	Engagement
CMS179v2	TBD	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.	Measure Observations statement: Average percentage of time that patients in the measure population have INR results within the therapeutic range (i.e., TTR)	Initial Patient Population statement: Patients aged 18 and older with atrial fibrillation without valvular heart disease who had been on chronic warfarin therapy for at least 180 days before the start of and during the measurement period. Patient should have at least one outpatient visit during the measurement period Measure Population statement: Equals All in Initial Patient Population with sufficient international normalized ratio (INR) results to calculate a warfarin time in therapeutic range (TTR)	Centers for Medicare & Medicaid Services (CMS)	Patient Safety
CMS22v2	TBD	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up	Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or	Percentage of patients aged 18 years and older before the start of the measurement period	Quality Insights of Pennsylvania/ Centers for Medicare & Medicaid	Population/ Public Health

		Documented	plan is documented based on the current blood pressure (BP) reading as indicated	hypertensive		Services	
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Stage 1 vs Stage 2 Comparison Table for Eligible Hospitals

Core Objectives (16 total)

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Use 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	More than 30% of unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE	Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE
Implement drug-drug and drug-allergy interaction checks	The eligible hospital/CAH has enabled this functionality for the entire EHR reporting period	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the Stage 2 Clinical Decision Support measure</i>
Record demographics <ul style="list-style-type: none"> Preferred language Gender Race Ethnicity Date of birth Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data	Record the following demographics <ul style="list-style-type: none"> Preferred language Gender Race Ethnicity Date of birth Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i>

	structured data		
Maintain active medication list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i>
Maintain active medication allergy list	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the Stage 2 measure of Summary of Care Document at Transitions of Care and Referrals</i>
Record and chart changes in vital signs: <ul style="list-style-type: none"> • Height • Weight • Blood pressure • Calculate and display BMI Plot and display growth charts for children 2-20 years, including BMI	More than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), blood pressure height and weight are recorded as structured data	Record and chart changes in vital signs: <ul style="list-style-type: none"> • Height • Weight • Blood pressure (age 3 and over) • Calculate and display BMI Plot and display growth charts for patients 0-20 years, including BMI	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data
Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data	Record smoking status for patients 13 years old or older	More than 80% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data

<p>Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance that rule</p>	<p>Implement one clinical decision support rule</p>	<p>Use clinical decision support to improve performance on high-priority health conditions</p>	<p>1. Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period.</p> <p>2. The eligible hospital or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period</p>
<p>Report clinical quality measures (CQMs) to CMS or the States</p>	<p>For 2011, provide aggregate numerator, denominator, and exclusions through attestation or electronically through the Hospital Reporting Pilot</p>	<p><i>No longer a separate objective for Stage 2, but providers must still submit CQMs to CMS or the States in order to achieve meaningful use</i></p>	<p><i>Starting in 2014, all CQMs will be submitted electronically to CMS.</i></p>
<p>Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request</p>	<p>More than 50% of all patients of the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days</p>	<p>Provide patients the ability to view online, download and transmit their health information within 36 hours after discharge from the hospital</p>	<p>i. More than 50% of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period are provided timely (available to the patient within 36 hours after discharge from the hospital.) online access to their health information</p> <p>ii. More than 5% of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their</p>

Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it	<i>This objective is eliminated from Stage 1 in 2014 and is no longer a separate objective for Stage 2</i>	<i>This measure has been incorporated into the View, Download, and Transmit objective for Stage 2</i>
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	<i>This objective is eliminated from Stage 1 in 2013 and is no longer an objective for Stage 2</i>	<i>This measure is eliminated from Stage 1 in 2013 and is no longer a measure for Stage 2</i>
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process	Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data at rest and implement security updates as necessary and correct identified security deficiencies as part of its risk management process
Implement drug-formulary checks	The eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period	<i>No longer a separate objective for Stage 2</i>	<i>This measure is incorporated into the e-Prescribing measure for Stage 2</i>
Incorporate clinical lab-test results into certified EHR technology as structured data	More than 40% of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or	Incorporate clinical lab-test results into Certified EHR Technology as structured data	More than 55% of all clinical lab tests results ordered by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23

	23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data		during the EHR reporting period whose results are 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	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient and emergency departments (POS 21 and 23) are provided patient-specific education resources identified by Certified EHR Technology
The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)	The eligible hospital or CAH that receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)
The eligible hospital or CAH that 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	The eligible hospital or CAH that 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	The eligible hospital or CAH that 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	<p>1. The eligible hospital, or CAH that 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</p> <p>2. The eligible hospital or CAH that transitions or refers their patient to another setting of care or</p>

			<p>provider of care provides a summary of care record either a) electronically transmitted to a recipient using CEHRT or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or is validated through an ONC-established governance mechanism to facilitate exchange for 10% of transitions and referrals</p> <p>3. The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS-designed test EHR during the EHR reporting period</p>
<p>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice</p>	<p>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 eligible hospital or CAH submits such information have the capacity to receive the information electronically)</p>	<p>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice</p>	<p>Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period</p>
<p>Capability to submit electronic data on</p>	<p>Performed at least one test of certified EHR</p>	<p>Capability to submit electronic data on</p>	<p>Successful ongoing submission of electronic</p>

reportable (as required by state or local law) lab results to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)	reportable (as required by state or local law) lab results to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	reportable laboratory results from Certified EHR Technology to public health agencies for the entire EHR reporting period as authorized, and in accordance with applicable State law and practice
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	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 eligible hospital or CAH submits such information have the capacity to receive the information electronically)	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and in accordance with applicable law and practice	Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period
NEW	NEW	Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR)	More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked are tracked using eMAR

Menu Objectives (Eligible Hospitals and CAHs must report on 3 of 6 menu objectives)

Stage 1 Objective	Stage 1 Measure	Stage 2 Objective	Stage 2 Measure
Record advance directives for patients 65 years old or older	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded	Record whether a patient 65 years old or older has an advance directive	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data
NEW	NEW	Record electronic notes in patient records	Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period
NEW	NEW	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	More than 10% of all scans and tests whose result is an image ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period are incorporated into or accessible through Certified EHR Technology
NEW	NEW	Record patient family health history as structured data	More than 20% of all unique patients admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data

			entry for one or more first-degree relatives or an indication that family health history has been reviewed
NEW	NEW	Generate and transmit permissible discharge prescriptions electronically (eRx)	More than 10% of hospital discharge medication orders for permissible prescriptions (for new or changed prescriptions) are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology
NEW	NEW	Provide structured electronic lab results to ambulatory providers	Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20% of electronic lab orders received

Stage 3 Meaningful Use criteria

Stage 3 of the CMS EHR Incentive Program is scheduled to begin in 2016 but the rule has not been finalized. Policy and Standards committees are developing recommendations to continue to expand meaningful use objectives to improve health care outcomes.

8 Enrollment process

In order for providers to meet the qualifications for the Alaska Medicaid EHR Incentive Program providers are required to attest that the information submitted in their application is true and accurate.

In order for an EP to qualify for an incentive payment in a particular calendar year they must have completed their attestation in the SLR within 60 days of the close of the calendar year to count towards that payment year (calendar year). Hospital are paid on a federal fiscal year, hospitals must submit their attestation in the SLR within 60 days of the close of the federal fiscal year (October 1-September 30) to count towards that payment year.

Program attestation preparation

1. Register at the Centers for Medicare and Medicaid Registration and Attestation System at <https://ehrincentives.cms.gov/hitech/login.action>.
2. Create an SLR account at <http://ak.rraincentive.com/>.
3. Locate a copy of your signed contract or invoice with a vendor for the purchase, implementation or upgrade of a certified EHR system. This contract or invoice would need to identify the current vendor and version of your EHR.
4. Verify your EHR is certified and is on the list from ONC at <http://onc-chpl.force.com/ehrcert>.
5. EPs must locate your active medical license number and Medicaid ID.
6. EHs must locate the most recent 4 years of cost report data.
7. Determine your Medicaid patient volume you will be reporting for the selected 90 days or greater period.
8. Determine which method of certified EHR technology you will be attesting to - adopt, implement, upgrade or meaningful use.
9. Complete the Eligibility workbook and Adopt/Implement/Upgrade Attestation workbook.
10. Complete the application in the SLR and sign and complete the attestation.

Medicare and Medicaid Registration and Attestation System

Both EPs and EHs are required to begin by registering at the national level with the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System.

EPs registering in the Medicaid EHR Incentive Program must enter their National Plan and Provider Enumeration System (NPPES) web user account, user ID and password to log into the registration system. EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong. The EP must select where their payment will go in the payee TIN type. EPs must provide the SSN payee TIN type to indicate that the provider receives the payment. The EIN payee TIN type indicated the group receives the incentive payment. Providers will have to enter the group name, group payee TIN and the group NPI in order for the provider to issue the payment to the group in which they are associated. In order for the group or clinic to receive the incentive payments from Alaska, the EP must have a billing provider contract to which the payment is being assigned.

EPs must select between the Medicare and Medicaid incentive programs (Prior to 2015 a provider may switch programs once after receiving an incentive payment). If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the CMS Registration and Attestation System to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment.

Hospital representative must enter their Identification and authentication User ID and Password to log into the Centers for Medicare and Medicaid EHR Incentive Program Registration and Attestation System. Hospitals must provide their CCN and the NPI for the hospital. The hospital must select the Medicaid state and the hospital type in which they will participate.

EHs seeking payment from both Medicare and Medicaid will be required to visit the Medicare and Medicaid EHR Incentive Program Registration and Attestation System annually to attest to meaningful use before returning to SLR website to complete the attestation for Alaska's Medicaid EHR Incentive Program. Alaska Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The Medicare and Medicaid EHR Incentive Program Registration and Attestation System will electronically notify the Alaska Medicaid SLR of a provider's choice to enroll in the Alaska Medicaid EHR Incentive Program. The information completed by the provider at the national website is sent to the SLR electronically within 24-48 hours.

Below are user guides for Medicaid and Medicare EPs and EHs.

Medicaid User Guide:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHRMedicaidEP_RegistrationUserGuide.pdf

Medicare User guide:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHRMedicareEP_RegistrationUserGuide.pdf

EH User Guide

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHRHospital_RegistrationUserGuide.pdf

Alaska Medicaid State Level Registry

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation is provided, the Alaska Medicaid EHR Incentive Program Office will conduct a review to validate that the EP or EH meets the qualifications of the program and will verify supporting documentation.

The attestation itself will require the EP or EH to attest to meeting all requirements defined in the federal regulations. Some documentation will be required to be provided to support specific elements of the attestation. For instance, providers who attest to AIU of certified EHR technology will be required to submit a copy of a signed contract or paid invoice. All providers will be required to mail the originally signed attestation to the Alaska Medicaid EHR Incentive Program Office.

During the first year of the program, EPs or EHs will be able to attest to adopting, implementing or upgrading to certified EHR technology or attest to meaningful use. It should be noted that the documentation for AIU of certified EHR technology for EPs or EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable *if the system and version of EHR technology has been certified by ONC* (the Certified Health IT Product List can be located at ONC's website at <http://oncchpl.force.com/ehrcert?q=chpl>). All providers will be required to attest to meeting meaningful use to receive incentive payments after the first year.

Below is the website to create an account on the State Level Registry

<https://ak.ara incentive.com/CreateNewAccount.aspx>

Webpage to logon to the State Level Registry

<https://ak.ara incentive.com/Login.aspx>

9 What is the payment methodology?

Payment methodology for eligible professionals

Payment for EPs equals 85 percent of net average allowable costs or NAAC. NAAC are capped by statute at \$25,000 in the first year, and \$10,000 for each of 5 subsequent years. NAAC for pediatricians with Alaska Medicaid patient volume between 20-29 percent are capped at two thirds of those amounts respectively. Thus, the maximum incentive payment an EP could receive from Alaska Medicaid equals \$63,750, over a period of 6 years, or \$42,500 for pediatricians with a 20-29 percent Medicaid patient volume.

<u>Provider</u>	<u>EP</u>	<u>EP-Pediatrician</u>
Patient Volume	30%	20-29%
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	5,666
Year 6	<u>8,500</u>	<u>5,666</u>
Total Incentive Payments	<u>\$63,750</u>	<u>\$42,500</u>

Pediatricians may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

Payments for Medicaid eligible professionals

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The TIN must be associated with either the EP directly or a group or clinic with which the EP has a contractual relationship. State of Alaska policy requires a State of Alaska Substitute Form W9 for each payee. If all EPs within a group/clinic assign their payment to the clinic, only one Substitute W9 is required; if the payment is directed to each EP, one Substitute W9 for each EP.

The State of Alaska substitute W-9 may be found at http://doa.alaska.gov/dof/forms/resource/sub_form_w9.pdf

The Alaska Medicaid EHR Incentive program does not include a future reimbursement rate reduction for non-participating Medicaid providers. (Medicare requires providers to implement and meaningfully using certified EHR technology by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that he/she was a meaningful user of EHR technology during that year, except in year one in which the provider may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021.

Payment Amount for Year:	First Year Medicaid EP Qualifies to Receive Payment 2011	First Year Medicaid EP Qualifies to Receive Payment 2012	First Year Medicaid EP Qualifies to Receive Payment 2013	First Year Medicaid EP Qualifies to Receive Payment 2014	First Year Medicaid EP Qualifies to Receive Payment 2015	First Year Medicaid EP Qualifies to Receive Payment 2016
2011	\$21,250	-	-	-	-	-
2012	\$8,500	\$21,250	-	-	-	-
2013	\$8,500	\$8,500	\$21,250	-	-	-
2014	\$8,500	\$8,500	\$8,500	\$21,250	-	-
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	-
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	-	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	-	-	\$8,500	\$8,500	\$8,500	\$8,500
2019	-	-	-	\$8,500	\$8,500	\$8,500
2020	-	-	-	-	\$8,500	\$8,500
2021	-	-	-	-	-	\$8,500
TOTAL Possible Incentive Payments	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Maximum Incentive Payments for EPs

In the event that the Department of Health and Social Services determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. Providers may refund the money to the State of Alaska in a lump sum, or an accounts receivable account will be created. The existing practice allows the Department of Health and Social Services to work out an acceptable repayment period.

Payment methodology for eligible hospitals

Eligible hospital incentive payment calculation methodology

Calculating the overall incentive payment is a multi-step process and utilizes hospital data on total discharges (excluding nursery discharges) to compute a growth rate which is used to determine projected eligible discharges. A base amount of \$2,000,000 is added to the eligible discharge amount and a transition factor is applied to arrive at the overall EHR amount. The overall EHR amount needs to be adjusted for charity care before Medicaid's share can be calculated. The aggregate EHR hospital incentive payment is calculated as the product of the [overall EHR amount] times [the Medicaid Share].

Calculating the overall EHR amount is a multistep process, hospitals are required to provide and attest to the following information for the incentive payment to be calculated:

- Total Inpatient Discharges for the most recent 4 fiscal years
- Total Number of Medicaid Inpatient Bed Days
- Total Number of Inpatient Bed Days
- Total Hospital Charges
- Total Charges for Charity Care

This is an example of the steps that will be followed to calculate incentive payments to EHS.

How the Annual Discharge Data is Used

Step 1: Calculating the Average Annual Growth Rate:

To calculate the average annual growth rate the hospital reports the total discharges for the 4 most recent hospital fiscal year cost reports. Total discharges are the sum of all inpatient discharges (excluding nursery discharges).

Fiscal year	Total Discharges	Calculating Annual Growth Rate	Average Annual Growth Rate	Average Annual Growth Rate 4.61%
2007	23,500	$2008 - 2007 \div 2007 = \text{Growth Rate}$	5.11	
2008	24,700	$24,700 - 23,500 \div 23,500 = 5.11\%$	+ 4.45	
2009	25,800	$25,800 - 24,700 \div 24,700 = 4.45\%$	+ <u>4.26</u>	
2010	26,900	$26,900 - 25,800 \div 2,5800 = 4.26\%$	= 13.82 \div 3 = 4.61%	

Step 2: Applying the average annual growth rate to the base number of discharges

The number of discharges for the base year of fiscal year 2010 is multiplied by the average annual growth rate of 4.61% (1.0461) to project the number of discharges over the next 3 years:

Projected Inpatient Discharge			
Fiscal year 2010	Fiscal year 2011	Fiscal year 2012	Fiscal year 2013
26,900			
x 1.0461	→ 28,140		
	x 1.0461	→ 29,437	
		x 1.0461	→ 30,794

Step 3: Determine the number of eligible discharges and multiply by the discharge payment amount

1. For the first through the 1,149th discharge, \$0
2. For the 1,150th through the 23,000th discharge, \$200 per discharge
3. For any discharge greater than the 23,000th, \$0

In this example, discharges for each year were greater than both 1,149 and 23,000, so the maximum number of discharges that can be counted are 21,851 (23,000 – 1,149) which then gets multiplied by the \$200 per discharge.

Fiscal year	Calculated Discharges	Eligible Discharges	@ \$200 Per Discharge	Eligible Discharge Payments
2010	26,900 (max 23,000 -1,149)	21,851	x \$200	\$4,370,200
2011	28,140	21,851	x \$200	\$4,370,200
2012	29,437	21,851	x \$200	\$4,370,200
2013	30,794	21,851	x \$200	\$4,370,200

Step 4: Add the Base Year Amount of \$2,000,000 per payment year to the eligible discharges payments

Step 5: Multiply the Medicaid Transition Factor to the Eligible Discharge Payment to arrive at the Overall EHR Amount

The transition factor equals 1 for year 1, $\frac{3}{4}$ for year 2, $\frac{1}{2}$ for year 3 and $\frac{1}{4}$ for year 4. All four years are then added together.

Step 4					Step 5				
Fiscal year	Base Year Amount		Eligible Discharge Payments		Total Eligible Discharge Payments		Transition Factor		Overall EHR Amount
2010	\$2,000,000	+	\$4,370,200	=	\$6,370,200	x	1	=	\$6,370,200
2011	\$2,000,000	+	\$4,370,200	=	\$6,370,200	x	.75	=	\$4,777,650
2012	\$2,000,000	+	\$4,370,200	=	\$6,370,200	x	.50	=	\$3,185,100
2013	\$2,000,000	+	\$4,370,200	=	\$6,370,200	x	.25	=	\$1,592,550
Total EHR Amount									\$15,925,500

How the Total Number of Medicaid Inpatient Bed Days, Total Inpatient Days, Total Hospital Charges and Total Charity Care Charges are used

Step 6: Calculate the Medicaid Share

The next step requires that the Medicaid Share be applied to the total EHR amount. The Medicaid Share is the percentage of Medicaid inpatient bed-days divided by the estimated total inpatient bed days adjusted for charity care. **Note: All inpatient bed day totals should exclude nursery care.** To calculate the Medicaid Share, the hospital will need to provide the following information from the most recently filed cost report. The most recently filed cost report is defined as the hospital costs report ending prior to the start of the current federal fiscal year.

Total of Medicaid Inpatient Bed Days	Total Inpatient Days	Total Hospital Charges	Total Charity Care Charges
7,251	21,250	\$135,500,000	\$12,300,000

The “Medicaid Share”, against which the overall EHR amount is multiplied, is essentially the percentage of a hospital’s inpatient, non-charity care days that are attributable to Medicaid inpatients. More specifically, the Medicaid share is a fraction expressed:

$$\text{Medicaid Inpatient Bed Days} \div \text{Total Inpatient Days} \times \left(\frac{\text{Total Hospital Charges} - \text{Charity Care Charges}}{\text{Total Hospital Charges}} \right)$$

$$(\text{Total Hospital Charges} - \text{Charity Care Charges}) \div \text{Total Hospital Charges} = \text{Charity Care Adjustment}$$

Total Hospital Charges – Charity Care Charges		Total Charges less Charity Care Charges		Total Hospital Charges		Charity Care Adjustment
\$135,500,000 - \$12,300,000	=	\$123,200,000	÷	\$135,500,000	=	.909

$$\text{Total Inpatient Days} \times \text{Charity Care Adjustment}$$

Total Inpatient Days		Charity Care Adjustment		Adjusted Inpatient Days by Charity Care
21,250	x	.909	=	19,316

$$\text{Medicaid Inpatient Bed Days} \div \text{Adjusted Inpatient Days}$$

Total of Medicaid Inpatient Bed Days		Adjusted Inpatient Days		Medicaid Share
7,251	÷	19,316	=	.3754
Medicaid Share Percentage 37.54%				

Step 7: Calculate the Aggregate Incentive Payment Amount

To arrive at the aggregate incentive amount multiply the overall EHR Amount of \$15,925,500 by the Medicaid Share of 37.54%.

$$15,925,500 \times .3754 = \$5,978,433$$

Total Incentive Payment Amount	\$5,978,433
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Step 8: Distributed over 3 Incentive Payments

The Department will issue hospital incentive payments in 3 incentive payment amounts. The following illustrates an example of how the payments will be issued in 3 payment years at 50, 40 and 10% respectively. The hospital would need to continue to meet the eligibility requirements and meaningful use criteria in all incentive payment years. Participate does not have to be in consecutive years until 2016.

Incentive Payment Timeline	Payment Amounts
Year 1 - 50%	\$2,989,216.50
Year 2 - 40%	\$2,391,373.20
Year 3 - 10%	\$597,843.30

Payments for Medicaid eligible hospitals

EH payments will be made in alignment with the federal fiscal year and an EH must begin receiving incentive payments no later than FFY 2016. EHs will assign the incentive payments to a tax ID (TIN) in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The hospital in which the payment will be issued will be required to provide Alaska Medical Assistance with a State of Alaska Substitute Form W-9 to which the payment will be issued.

The State of Alaska substitute W-9 may be found at: http://doa.alaska.gov/dof/forms/resource/sub_form_w9.pdf

For each year a hospital wishes to receive a Medicaid incentive payment, a determination must be made that the hospital was a meaningful user of EHR technology during that year, except in year one in which the hospital may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Alaska Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program. Medicaid EHs are not required to participate on a consecutive annual basis, however, the last year a hospital may begin receiving payments is 2016, and the last year the hospital can receive payments is 2021.

Alaska Medical Assistance currently requires that all hospitals to submit a valid NPI as a condition of Alaska Medicaid provider enrollment. Each hospital will be enrolled as an Alaska Medical Assistance provider and will therefore, meet the requirement to receive an NPI.

In the event that Department of Health and Social Services determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. Providers may refund the money to the State of Alaska in a lump sum, or an accounts receivable account will be created. The existing practice allows the Department of Health and Social Services to work out an acceptable repayment period.

10 Validation and Approval Process

Requesting payment

Once the attestation is complete the EHR Incentive Program Office will validate that the provider meets all of qualifications for the program.

If additional information is needed to support the attestation, the Alaska Medicaid EHR Incentive Program Office may request any missing or additional information from the provider. If missing or additional information is required, the program office will notify the provider by electronic mail of the specific information needed. A provider must submit the additional information to the program office no later than 30 days after the date of the electronic mail notice. If the provider fails to submit the required information during that period, the department will determine the registration incomplete, although the program office will work with the provider office to complete the application.

Before determining if the provider meets the requirements of the program, the EHR Incentive Program Office will evaluate the facts to which the provider has attested and may request additional information from sources other than the provider to validate the providers attestation submitted.

Upon completion of the attestation process, the EHR Incentive Program Office will review and validate the attestation. If all criteria are met and passed an incentive payment will be approved. The State of Alaska will issue the payment to the tax ID identified in the Centers for Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The same payee information must be input on the Substitute W9 form.

If the EHR Incentive Program Office determines that the provider does not meet the requirements of the program the provider will be notified by letter of the reason for denial. The provider will be notified of their right to request an appeal. If a change occurs in the information that the department used to deny participation, or that previously resulted in a failure to receive CMS validation, the provider may submit a new or updated attestation at any time during that payment year.

Administrative Appeals

Administrative appeals of decisions related to the Alaska EHR Incentive Payment program will be handled under the procedures described in the Alaska Medicaid EHR Incentive Program Regulations.

A provider may appeal the department's decision to do any of the following:

- deny participation in the Alaska Medicaid electronic health records incentive program under 7 AAC 165.030;
- suspend an incentive payment under 7 AAC 165.050;
- require repayment of all or a portion of an incentive payment under 7 AAC 165.050;
- terminate participation in the Alaska Medicaid electronic health record incentive program under 7 AAC 165.050.
- terminate or suspend participation in the Medicaid program in this state under 7 AAC165.050

To appeal a decision of the program office a provider must submit a written request for a first-level appeal to the EHR Incentive Program Office no later than 30 days after the date of the EHR Incentive Program Office letter denying participation. The request for a first-level appeal must specify the basis upon which the department's decision is challenged and include any supporting documentation. A first-level appeal will be conducted by the supervisor who oversees the health information technology program in the department.

Upon receipt of a request for a first-level appeal, if the department has suspended an incentive payment, the department may continue suspending the payment until a final determination is made regarding the appropriateness of the suspension. The department will notify the provider in writing of the department's first-level appeal decision.

The first level appeal may be sent to:

Department of Health & Social Services
Division of Health Care Services
EHR Incentive Program Office
3601 C Street, Suite 902
Anchorage, AK 99503

A provider who is not satisfied with the first-level appeal decision may request a second-level appeal by submitting a written request to the commissioner no later than 30 days after the date of the first-level appeal decision.

The request for second-level appeal must include:

- a copy of the department's first-level appeal decision;
- a description of the basis upon which the decision is being appealed;
- a copy of the first-level appeal submitted by the provider; and
- any additional supporting documentation that supports the basis upon which the provider is making the appeal.

The commissioner's review of the original appeal record, decision, and any additional material submitted by the provider and the department constitutes the second-level appeal. A decision by the commissioner under this subsection is the final administrative decision of the department. The department will notify the provider of the provider's right to appeal to the superior court under the Alaska Rules of Appellate Procedure.

This request must be submitted to:

Office of the Commissioner
Department of Health and Social Services
Attn: Alaska Medicaid EHR Incentive Program Appeals
P.O. Box 110601
Juneau, Alaska 99811-0601

Program Integrity

The department will conduct regular reviews of attestations and incentive payments. These reviews will be selected as part of our current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Be sure to retain supporting documentation for information you report for the incentive program for the standard IRS business retention (approximately 7 years)

Payment recoupment

In the event of a recoupment, the provider will be notified by letter of the request for recoupment, along with the provider's right to appeal the decision. When an erroneous payment occurs which results in an overpayment, repayment options will be discussed with the provider. A provider has an option to refund the full payment in one payment or in multiple segments; the final decision is made by the department. The refund will be made to the State of Alaska. The provider can send payment in full to:

State of Alaska
Program Integrity Unit
PO Box 240249

11 State Level Registry Provider Registration

Once the CMS registration information is received in the SLR the provider may complete the registration process in the SLR web portal. The Alaska Medicaid EHR Incentive Program will utilize the secure Alaska Medicaid SLR to house the attestation system.

SLR Provider Outreach page -Want to get a jump start?

Alaska Medicaid State Level Registry for Provider Incentive Payments

Provider Outreach Home | FAQ | Contact Us

Need to create an SLR account?

Click here to [create an SLR account](#) for accessing the Medicaid Provider Incentive Program site.

Already have an SLR account?

Click here to [go directly to the State Level Registry for Provider Incentive Payments](#) site.

Mail signed original Alaska Medicaid EHR Incentive Program Attestation Form, [Substitute Form - Vb](#) and [EDI Payment Agreement Form](#) (if applicable) to:

State of Alaska
Department of Health and Social Services
Division of Health Care Services
EHR Incentive Program Office
1835 South Dragaw St., Suite 300
Anchorage, AK 99508-3469

Welcome to the Alaska State Level Registry (SLR) — Provider Outreach Page

As the healthcare landscape continues to modernize, recent

Select “Want to get a jump start? Click Here!” to receive step-by-step instructions on how to complete the registration and attestation process by role

Want to get a jump start? Click Here!

[Click here to view information that will give you a jump start on getting your ARRA incentive payment.](#)

managing your EHR Incentive Program information
T news and updates from other federal organizations such
e a part of transforming the quality, efficiency and safety of
healthcare delivery.

Are You Eligible?

Run the [CMS Eligibility Wizard](#) and quickly see if you may qualify for incentive payments.

Frequently Asked Questions

Have a question? Click here to [view a list of frequently asked questions](#).

Important Web Resources (all links open in new window)

- [CMS EHR Incentive Program Registration site](#)
- [Centers for Medicare & Medicaid Services \(CMS\)](#)
- [Office of the National Coordinator for Health Information Technology \(ONC\) Certified Health IT Product List](#)
- [State of Alaska — Health Information Technologies](#)
- [State of Alaska — Department of Health and Social Services](#)
- [State of Alaska — Division of Health Care Services](#)
- [Alaska Medical Assistance](#)
- [State of Alaska — Medicaid Management Information System](#)

Regional Extension Centers (REC) (all links open in new window)

- [Alaska eHealth Network \(AeHN\)](#)

Centers for Medicare & Medicaid Services

SLR Provider Outreach page-Select your Role (cont.)



Alaska Medicaid
State Level Registry
for Provider Incentive Payments

[Provider Outreach Home](#) | [FAQ](#) | [Contact Us](#)

[Provider Outreach home page](#)

Let's get started!

Please select your role. Select... [more info...](#)

CMS

Beginning January 3, 2011, the Electronic Health Record (EHR) Information Center will be open to assist the EHR Provider Community with both program and system inquiries from 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays, at 1-888-734-6433 (primary number) or 888-734-6563 (TTY number). [more info...](#)

[CMS EHR Incentive Program Registration site](#)

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

[Office of the National Coordinator for Health Information Technology \(ONC\) Certified Health IT Product List](#)

Complete the registration process by role:

- Individual Eligible Professional (EP)
- Eligible Hospital (EH)
- Group Administrative (Group)

It's as easy as

1,2,3

4 & 5 ;-)



Please Note: This information is provided for Medicaid practitioners interested in applying for the Medicaid EHR Incentive Program. If you are a Medicare practitioner looking for information on the Medicare EHR Incentive Program, please visit www.cms.gov/EHRIncentivePrograms for more information.

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SLR Provider Outreach page-Step by Step Instructions

Let's get started!

Please select your role. Individual Eligible Professional (EP) [more info...](#)

Below are the step by step instructions on how to complete the registration process. [Click here to print this list](#)

1. Locate the National Provider Identified (NPI) and Tax Identification Number (TIN) you'll need to register at CMS's EHR Incentive Program Registration site. You'll also need this to create an SLR account. [If you don't have an NPI, visit CMS's site to apply for one.](#) [Need a TIN? Visit IRS.gov.](#)
2. [Register at CMS's EHR Incentive Program Registration site.](#)
3. You must have an active Alaska Medicaid Provider Number. To enroll or check the status of your enrollment, [visit the enrollment site.](#)
4. Create or locate an electronic copy of your signed contract with a vendor for the purchase, implementation or upgrade of a [certified EHR system](#).
5. Locate information related to your medical license such as your license number and effective dates.
6. Identify an individual who will be the contact for your application - you'll need their name, phone and email.
7. [Determine the Medicaid Patient volume you'll be reporting.](#)
8. Determine which method of Certified EHR technology you will be attesting to — [adopt](#), [implement](#), or [upgrade](#).
9. Certified EHR info — [verify that your system is on the list from ONC.](#)
10. [Create an SLR account](#) to register for the Alaska Medicaid EHR Incentive Program.
11. Ensure that you have access to a scanner or electronic faxing technology such as RightFax™.
12. [Contact the Help Desk](#) to schedule an appointment after January 24th to continue the application process with an ACS support agent.

Step by step instructions vary by role selected

The following workbooks are designed to help you in gathering the necessary attestation information:

- [Eligibility workbook](#)
- [Adopt / Implement / Upgrade Attestation workbook](#)

Create Account-SLR Registration (cont.)

Alaska Medicaid State Level Registry for Provider Incentive Payments

Need to create an SLR account?

Click here to [create an SLR account](#) for accessing the Medicaid Provider Incentive Program site.

Already have an SLR account?

Click here to [go directly to the State Level Registry for Provider Incentive Payments](#) site.

Mail signed original Alaska Medicaid EHR Incentive Program Attestation Form, [Substitute Form - W9](#) and [EDI Payment Agreement Form](#) (if applicable) to:

State of Alaska
Department of Health and Social Services
Division of Health Care Services
EHR Incentive Program Office
1835 South Bragaw St., Suite 300
Anchorage, AK 99508-3469

Centers for Medicare & Medicaid Services

Welcome to
As the healthcare legislation was passed, Healthcare Record care. As a result of 2009, beginning offered financial meaningful use management of
To streamline the provide support web portal central additional program access Alaska's Registry (SLR). IT Services (DHSS) quality of health following:

- A central
- Organize as CMS E healthcare

Important We

- [CMS EHR Incentive Program Registration site](#)
- [Centers for Medicare & Medicaid Services \(CMS\)](#)
- [Office of the National Coordinator for Health Information Technology \(ONC\) Certified Health IT Product List](#)
- [State of Alaska — Health Information Technologies](#)
- [State of Alaska — Department of Health and Social Services](#)
- [State of Alaska — Division of Health Care Services](#)
- [Alaska Medical Assistance](#)
- [State of Alaska — Medicaid Management Information System](#)

Regional Extension Centers (REC) (all links open in new window)

- [Alaska eHealth Network \(AeHN\)](#)

Click on "Create a SLR account" to register for the Alaska Medicaid EHR Incentive Program

Create Account-Identify Yourself

Alaska Medicaid State Level Registry for Provider Incentive Payments

Create Account

If you are an Eligible Professional, Eligible Hospital Representative, or Group Practice/Clinic Representative, you can create a user account for the SLR. Please enter the following identification information to start the process of creating your user account.

Identify Yourself

Enter the necessary information below and click Continue. * Indicates required fields.

What is your role? *

NPI *

TIN *

733jj

Enter the letters/numbers from the image above

Letters are case sensitive.
If you have difficulty identifying the characters in the image above, click the link to display a new image.

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Must match NPI and TIN used to register with CMS and AK Medical Assistance Program

Create Account-Create Login ID and Password (cont.)

Create Account

Is This You?

Name: Mouse LLC

Address: 1111 5th Ave #205 Juneau AK 1111 99801

Create Login

Enter the necessary information below and click Create Account. * Indicates required fields.

User ID *

Password *

Confirm Password *

Select a Challenge Question *

Your Answer to the Challenge Question *

Phone
9999999999 (no spaces, dashes, parens)

E-mail Address *
name@domain.com

**Must be between 8 - 20 characters
No spaces / special characters allowed**

**Must have between 8 - 20 characters,
at least 1 upper and 1 lower case letter, 1
number, 1 special character (@ or # or
!), not your User ID
and not an old
password**

12 State Level Registry Provider Attestation

Eligible Professional and Hospital Provider SLR Attestation

The attestation is an amendment and becomes part of the to the provider’s contract. Following are descriptions of the information that a provider will have to enter into the SLR and attest to upon completion of the application.

Login to the SLR

alaska HIT Health Information TECHNOLOGIES

Alaska Medicaid
State Level Registry
for Provider Incentive Payments

Contact Us

Existing Users

Enter the User ID and password you created to login to the SLR. If you have not already created a User ID, please select the Create Account option to create a new User ID. * Indicates required fields.

User ID *

Password *

[Forgot User ID?](#)

[Forgot Password?](#)

Need to Create an Account?

If you are an Eligible Professional, Eligible Hospital Representative, or Group Practice/Clinic Representative, you can create a user account for the SLR. If you have not already created a User ID, please select the Create Account button below to create a new User ID.

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End User License Agreement and Terms of Use Agreement

Alaska Medicaid State Level Registry for Provider Incentive Payments

ACS State Healthcare, LLC
ALASKA MEDICAID
ELECTRONIC HEALTH RECORDS INCENTIVE PROGRAM
WEB PORTAL
End User License Agreement and Terms of Use
ACCEPTANCE OF TERMS

Indicate your acceptance of the End User License Agreement below. * indicates required fields.

THE SERVICES THAT ACS STATE HEALTHCARE, LLC ("ACS") PROVIDES TO YOU THROUGH THIS WEB PORTAL ARE SUBJECT TO THE END USER LICENSE AGREEMENT AND TERMS OF USE ("AGREEMENT") AVAILABLE AT THIS SITE ("SITE"). PLEASE READ THIS AGREEMENT CAREFULLY BEFORE YOU ACCESS OR USE THIS SITE. BY CLICKING ON TERMS OF USE AT THE BOTTOM OF EVERY PAGE ON THIS SITE, YOU ARE ACCEPTING THIS AGREEMENT AND ACCESSING OF THIS SITE BY THE PROVIDER WILL CONSTITUTE THE PROVIDER'S FAILURE TO FOLLOW THE TERMS AND CONDITIONS FOR ACCESSING OF THIS SITE. YOUR FAILURE TO FOLLOW THE TERMS AND CONDITIONS FOR ACCESSING OF THIS SITE, MAY RESULT IN SUSPENSION OR TERMINATION OF YOUR ACCESS TO THIS SITE, IN ADDITION TO OTHER REMEDIES AVAILABLE TO ACS. IF THE PROVIDER FAILS TO FOLLOW THE TERMS AND CONDITIONS FOR ACCESSING OF THIS SITE, OTHER PAGES OF THIS SITE WILL BE DENIED.

1. DEFINITIONS

IN ADDITION TO THE TERMS DEFINED IN THE AGREEMENT, THE TERMS OF THIS AGREEMENT SHALL BE AS SPECIFIED BELOW:

I Agree with the End User License Agreement. [Print EULA](#)

[Continue](#) | [Cancel and return to Log In](#)

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SLR home page

Alaska Medicaid State Level Registry for Provider Incentive Payments

Welcome, Minnie Mouse
This is your Dashboard for working through the attestation process.

Begin your Year 1 submission today!
Start with section [1. About You](#)

Data has been received from the NLR. [View NLR data](#)

System (0) | Reports (0) | Payment Status (0)
Audit (0) | Appeals (0)

Year 1

- 1. About You**
Additional Registration Information and NLR data
- 2. Confirm Medicaid Eligibility**
Practice Demographics and Volumes
- 3. Attestation of EHR**
Related to Adopting, Implementing, Upgrading or Meaningful Use
- 4. Review and Sign Agreement**
Review, Print, Sign and Upload the SLR Agreement
- 5. Send Year 1 Submission**
Send and lock all information to State

Steps to complete the Attestation workflow

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The SLR home page is known as the Dashboard, which displays basic system and account management information, provider reports, and identifies the steps for attestation. On the Dashboard you can open the Help guide which provides detailed instructions on how to complete the SLR application.

Step 1-About You-EP

1. About You

In addition to the registration information you provided to NLR, the State of Alaska requires that you provide additional information to be used to help in determining your eligibility to participate in the Medicaid Incentive Program.

CMS National Level Repository (NLR) Record

✔ Data has been received from the NLR [View NLR data](#) | [Visit NLR website](#)

Attestations

* I attest that I DO NOT perform 90% or more of my services in an inpatient hospital or emergency room setting. [Why is this important?](#)

I attest that I am a pediatrician and am eligible for a reduced incentive payment if I achieve 20% Medicaid eligibility.

I attest that I am a Physician Assistant that practices predominantly in a PA led FQHC or RHC.

License Information

✔ Your license information is complete

Medicaid Number * Required field

Do you practice in a Tribal * Yes No
Health Program or other
federal clinic without an
Alaska license?

Alaska Professional License * Required field
Number

Licensing Board Name *

- **CMS National Level Repository (NLR) Record**- Identifies if your CMS registration data has been received.
- **Hospital based attestation**- Eligible professional may not be hospital based to qualify for the program. Eligible professionals are considered hospital based if 90% or more of their services are rendered in an inpatient or emergency room setting. If they are not hospital based, providers they must attest that they DO NOT perform 90% or more of their services in an inpatient hospital or emergency room setting.
- **Pediatrician attestation**-A pediatrician who is qualifying for the program at the minimum 20% Medicaid patient volume must attest that they are a pediatrician and are eligible to receive a reduced incentive payment amount if they achieve 20% Medicaid eligibility. Doctors who qualify as pediatricians may receive a reduced incentive payment if they achieve between 20%-29% Medicaid patient volume.
- **Physician Assistant attestation**-Physician assistants may only qualify for the Medicaid EHR Incentive Program if they practice in a FQHC or RHC that is led by a physician assistant, they must attest the they are a physician assistant that practices predominantly in a PA led FQHC or RHC and attached auditable documentation to who the EP meets the definition of a PA in a PA-led facility.
- **License Information**-EPs must enter their Alaska Medicaid provider number, their Alaska professional license number and select the licensing board name. Eligible professionals must identify if they practice in an IHS clinic without an Alaska license.

Step 1-About You-EP (cont.)

Practice in an IHS Clinic or Tribal Clinic

- **Practice in Indian Health Clinic**-EPs must identify if they practice in a Tribal clinic or other federal clinic without an Alaska license.
- **Other License Number and State**-If the EP practices in an IHS/Tribal clinic and does not have an Alaska professional license they must select the licensing board name and must enter the other professional license number and the state in which they were licensed in the Other License Number and Other License State data fields. If the provider is only licensed in Alaska then they must enter their Alaska Professional license number.

Licensed in another State

License Information

✔ Your license information is complete

Medicaid Number * MD12345

Do you practice in a Tribal * Yes No
Health Program or other
federal clinic without an
Alaska license?

Licensing Board Name * Other

Other License Number * 45678
Enter your federal or other state license number.

Other License State * FL
Select the state in which you are licensed.

Alaska Professional License Number

License Information

✔ Your license information is complete

Medicaid Number * MD12345

Do you practice in a Tribal * Yes No
Health Program or other
federal clinic without an
Alaska license?

Alaska Professional License * 12345
Number

Licensing Board Name * State Medical Board

Step1-About You-License Information-EP (cont.)

Note: If you receive a message Professional License Number not found, you may still proceed to the next step of the application. Your professional license number will be validated at the payment approval process.

1. About You

In addition to the registration information you provided to NLR, the State of Alaska requires that you provide additional information to be used to help in determining your eligibility to participate in the Medicaid Incentive Program.

 Professional License Number not found.

Step 1-About You-EP (cont.)

Contact Person

Changing the contact information here does not change the contact information set up under the My Account page or the contact information provided to CMS in the registration process. SLR generated messages will be sent to all email accounts recorded for this provider.

 Your contact information is complete

Name *

Title

Phone Number *
9999999999 (no spaces, dashes, parens)

Email Address *
name@domain.com

Attach Documentation

File(s) Attached - {0}

After all of the required fields have been completed select Save About You to save all information entered

[Cancel and lose About You changes](#)

- **Contact Person**-EPs may identify another contact person name phone number and email address who may be contacted if there are any issues with your attestation in addition to the contact information set up under the My Account page.

Step 1-About You-EH

1. About You

In addition to the registration information you provided to NLR, the State of Alaska requires that you provide additional information to be used to help determine eligibility to participate in the Medicaid Incentive Program.

CMS National Level Repository (NLR) Record

✔ Data has been received from the NLR [View NLR data](#) | [Visit NLR website](#) ↗

Contact Person

Changing the contact information here does not change the contact information set up under the My Account page or the contact information provided to CMS in the registration process. SLR generated messages will be sent to all email accounts recorded for this provider.

Enter your contact information below. * indicates required fields.

Name *

Phone Number *
9999999999 (no spaces, dashes, parens)

Email Address *
name@domain.com

[Cancel and lose About You changes](#)

- **Contact Person**-EHs may identify another contact person name phone number and email address who may be contacted if there are any issues with your attestation in addition to the contact information set up under the My Account page.

Alaska Medicaid
State Level Registry
for Provider Incentive Payments

My Account | [Help](#) | [Contact Us](#) | [Logout](#)
Filing as Eligible Professional

Welcome
This is your Dashboard

Complete
Complete S...

✔ Data has b...

Payment In...

Reports

Audit

Appeals

System Messages (0)

Year 1

✔ **1. About You**
Additional Registration Information and NLR data

2. **Confirm Medicaid Eligibility**
Practice Demographics and Volumes

3. **Attestation of EHR**
Related to Adopting, Implementing, Upgrading or Meaningful Use

4. **Review and Sign Agreement**
Review, Print, Sign and Upload the SLR Agreement

5. **Send Year 1 Submission**
Send and lock all information to State

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Step 2-Confirm Medicaid Eligibility-EP

2. Confirm Medicaid Eligibility

Please complete the requested information related to your Medicaid and/or Medically Needy patient encounters, including volumes for multiple states, for the 90-Day or greater Representative Period you have chosen to determine eligibility. This information is used to verify that you meet the criteria established for patient volume thresholds and practicing predominately in a FQHC or RHC. [more info](#)

Practice Eligibility Details

Enter your eligibility information below. * Red asterisk indicates a required field.

To qualify, Eligible Professionals (EPs) must achieve at least 30% Alaska Medicaid patient volumes, though Pediatricians who achieve a 20% volume may qualify to receive a reduced incentive payment amount. However Pediatricians who practice predominately in a FQHC/RHC must achieve at least 30%. Medicaid encounters are to include services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims and encounters with patients in Title XX-funded Medicaid expansions, but not separate CHIP programs.

Enter Representative Period * **Select**
 90-day period in previous calendar year
 Full calendar year period
 Total Encounters * Consecutive 3-month period >= 90 days
 90-day Period in 12 months preceding the attestation reporting period

Total Medicaid Encounters *
 Please enter your total Medicaid Patient Encounters for the selected reporting period.

Do you have Medicaid Patients *
 from more than one State?
 Yes No

Do you practice predominately in a
 Federally Qualified Health Care
 Center (FQHC) or Rural Health
 Center (RHC)? Predominately is
 defined by CMS as greater than
 50% in the previous calendar year
 or the most recent 12 months.

FQHC RHC None

Eligibility Formula * 99.99%

Use this formula

Calculate

(Total Medicaid Encounters/Total Encounters or, if predominant practice is selected, then Other Needy
 Individuals Patient Encounters + Medicaid Encounters/ Total Patient Encounters)

Meets Eligibility Requirements?



Attach Documentation

The following attachments are optional:

- Eligibility Workbook
- Practice Management Report
- Other - Please Describe

File Name	Subject	Remove
No records to display.		

Add Files Remove Selected

Save & Continue

Cancel and lose Medicaid Eligibility changes

- **Enter the Start date of your 90-day or greater period**-The provider must select from the calendar the start date for the 90 days or greater representative period use to enter the patient volume data. The patient volume calculation must include a 90 day or greater selection period within the calendar year previous to the payment year.
- If you select a:
 - **90 day period** - you must select the start date of the selected 90 day period and the SLR will calculate the end date
 - **Full calendar year period** - you must enter the start date of January 1st of the previous calendar year and the SLR will calculate the end date
 - **Other period** - the period must be greater than 90 day and must be within the previous calendar year, you must select the start date and the end date of the greater than 90 day period
 - **90-day period in 12 months preceding the attestation** – this 90-day period will end the day before the attestation submission date. The date will change if you do not start and complete the attestation on the same day.

Step 2-Confirm Medicaid Eligibility-EP (cont.)

Total Encounters *
Please enter your total patient encounters for the selected reporting period.

Total Medicaid Encounters *
Please enter your total Medicaid Patient Encounters for the selected reporting period.

Do you practice in more than one state? * Yes No

Do you practice predominantly in a Federally Qualified Health Care Center (FQHC) or Rural Health Center (RHC)? * FQHC RHC None
Predominantly is defined by CMS as greater than 50%

Eligibility Formula 1 99.99%

Use this formula

*(Total Medicaid Encounters/Total Encounters
OR,
if predominant practice is selected, then Medically Needy Patient
Encounters + Medicaid Encounters/Total Patient Encounters)*

Meets Medicaid Eligibility Requirements?

- **Total Encounters-** Enter the total number of encounters for the selected representative period.
- **Total Medicaid Encounters-** Enter the total number of Title XIX Medicaid encounters for the same representative period.
- **Do you practice in more than one state?** The eligible professional must identify if they practice in more than state. If the eligible professional does not practice in more than one state they may proceed to the next question. If the EP selects yes, they will have the option of using the Medicaid patient volume from the other state, although they are not required to use the out of state Medicaid patient volume.

Step 2-Confirm Medicaid Eligibility-EP (cont.)

Do you practice in more than ***** Yes No
one state?

Do you want your volumes for ***** Yes No
all states to be used to
determine eligibility?

State	Total Encounters	Total Medicaid Encounters	Remove
Alaska	150	30	<input type="checkbox"/>
Washington	100	15	<input type="checkbox"/>

Add a State  Remove Selected 

The sum of each State's Total Encounters must match the Total Encounters entered above.

The sum of each State's Total Medicaid Encounters must match the Total Medicaid Encounters entered above.

Other State Encounters

Do you want your volumes for all states to be used to determine eligibility?-If the EP identifies that they practices in more than one state they must identify if they want to use the Medicaid and total encounters from that state. If they select yes, they will be asked to enter the State, the total encounters from that state and the total Medicaid encounters for that state.

Note: If the EP uses the other states encounter volume they are required to enter the number of Medicaid encounters and total encounters for each of the states in which they practice, including Alaska, in these date fields. The total encounters and total Medicaid encounters entered in these fields must match the total encounters and total Medicaid encounters entered in the initial patient volume data entry.

Total Encounters *****
Please enter your total patient encounters for the selected reporting period.

Total Medicaid Encounters *****
Please enter your total Medicaid Patient Encounters for the selected reporting period.

Step 2-Confirm Medicaid Eligibility-EP (cont.)

Practice Eligibility Details

✔ Your eligibility information is complete

Enter the Start date of your 90- * Year 1 End Date 3/31/2010
 day period

Total Encounters *
Please enter your total patient encounters for the selected reporting period.

Total Medicaid Encounters *
Please enter your total Medicaid Patient Encounters for the selected reporting period.

Do you practice in more than * Yes No
 one state?

Do you practice predominantly * FQHC RHC
 in a Federally Qualified Health
 Care Center (FQHC) or Rural
 Health Center (RHC)?
 Predominantly is defined by
 CMS as greater than 50%

Other Needy Individuals *
 Patient Encounters [more info...](#)

Eligibility Formula 1 50.00%

Use this formula

$$\frac{\text{(Total Medicaid Encounters / Total Encounters)}}{\text{OR,}}$$
if predominant practice is selected, then

$$\frac{\text{(Other Needy Individuals Patient Encounters + Medicaid Encounters)}}{\text{Total Patient Encounters}}$$

Meets Medicaid Eligibility Requirements?

✔ Yes! Meets Medicaid Eligibility Requirements.

Other Needy Individuals ✕

Please enter your Other Needy Individuals Patient Encounters that are NOT included in your Total Medicaid Encounters.

- CHIP enrollees
- Patients furnished uncompensated care by the provider
- Furnished services at either no cost or on a sliding scale for the selected reporting period

EP Practicing Predominantly in a FQHC or RHC

- **Needy Individual Patient Encounters**-Medicaid EPs practicing predominantly in a FQHC or RHC may use a needy individual patient volume. In the SLR the EP must enter the total number of needy individual encounters that are not included in the Total Medicaid Encounter volume entered in the initial patient volume data entry.
- **Practicing predominantly**- An EP practices predominantly in a FQHC or RHC when the clinical location is over 50% of the EPs total patient encounters over a 6 month time period.

Step 2-Confirm Medicaid Eligibility EP-Complete (cont.)

Practice Eligibility Details

✔ Your eligibility information is complete

Enter Representative Period * Year 1 End Date

Total Encounters *
Please enter your total patient encounters for the selected reporting period.

Total Medicaid Encounters *
Please enter your total Medicaid Patient Encounters for the selected reporting period.

Do you practice in more than one state? Yes No

Do you practice predominantly in a Federally Qualified Health Care Center (FQHC) or Rural Health Center (RHC)? FQHC RHC None
Predominantly is defined by CMS as greater than 50%

Eligibility Formula 1 48.00%
Use this formula
(Total Medicaid Encounters / Total Encounters OR, if predominant practice is selected, then Other Needy Individuals Patient Encounters + Medicaid Encounters Patient Encounters).

Attach Documentation
File(s) Attached - {0}

Meets Medicaid Eligibility Requirements?
✔ Yes! Meets Medicaid Eligibility Requirements.

To determine if you meet the patient volume criteria select Calculate and then Save to ensure that all of the information entered has been saved

Step 2-Confirm Medicaid Eligibility-EH

2. Confirm Medicaid Eligibility

For purposes of calculating hospital patient volume, the following are considered Medicaid services:

1. Services rendered to an individual per inpatient discharges where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service;
2. Services rendered to an individual per inpatient discharge where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing;
3. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act either paid for part or all of the service; or
4. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost sharing.
5. [more info](#)

Medicaid Volume

Enter your Medicaid Volume information below. * indicates required fields.

Enter Representative Period *

End Date

Total Discharges for *
Representative Period

Medicaid Discharges for *
Representative Period

Do you have Medicaid patients * Yes No
from more than one state?

Average Length of Stay, in days, *
for the hospital fiscal year that ends during the prior federal fiscal year. Excluding Swing and Nursery Bed days. [more info...](#)

Medicaid Volume 21.95%

(Medicaid discharges for representative period/Total discharges for representative period)

Meets Medicaid Eligibility Requirements?

Yes! Meets Medicaid Eligibility Requirements.

Enter Representative Period

Enter Representative Period *

End Date

Total Discharges for *
Representative Period

<Select...>
90-day period
Hospital FY ending in prior Federal FY
Previous Federal FY (10/1-9/31)
Other

- Select a 90 day or greater period to enter the hospital patient encounter information to establish the patient volume calculation.
- If the hospital selects a:
 - **90 day period**-you must select the start date of the selected 90 day period
 - **Hospital FY ending in the prior Federal FY**- you must enter the start date of the hospital fiscal year that end of the previous federal fiscal year of September 30th
 - **Previous Federal FY**- (10/1-09/30)
 - **Other period**-the period must be greater than 90 day and must be within the previous federal fiscal year

Step 2-Confirm Medicaid Eligibility-EH (cont.)

Medicaid Volume

Enter your Medicaid Volume information below. * indicates required fields.

Enter Representative Period * Other 05/01/2010
End Date 09/30/2010

Total Discharges for Representative Period * 1,025

Medicaid Discharges for Representative Period * 225

Do you have Medicaid patients from more than one state? * Yes No

Average Length of Stay, in days, for the hospital fiscal year that ends during the prior federal fiscal year. Excluding Swing and Nursery Bed days. [more info...](#) 4

Medicaid Volume 21.95% Calculate
(Medicaid discharges for representative period/Total discharges for representative period)

Meets Medicaid Eligibility Requirements?

✓ Yes! Meets Medicaid Eligibility Requirements.

Medicaid Volume

- **Total Discharges for Representative period**-Enter the Total discharges over the selected representative period
- **Medicaid Discharges for Representative period**-Enter the Medicaid inpatient discharges and emergency room discharges over the selected representative period
- **Medicaid patients from another state**-Identify if the hospital has Medicaid patients outside the state of Alaska
- **Average Length of Stay**-Enter the average length of stay for the hospital fiscal year that ends in the prior federal fiscal year, the average length of stay calculation is calculated by the Total inpatient bed days divided by Total Discharges
- **Medicaid Volume Calculation**- Select the calculate button to determine if the hospital meets the minimum patient volume

Step 2-Confirm Medicaid Eligibility-EH (cont.)

Hospital Demographics Information

 Enter your Hospital Demographics information below. * indicates required fields.

The first year data comes from the hospital's cost report filed in the previous federal fiscal year. The specific data sources for your state can be found in the state provided Eligibility Workbook or Hospital Calculation Worksheets. [more info...](#)

Enter the year for the current cost report.

Current Cost Report Year *

Current cost report entered will adjust the field labels under question #1 (see below).

1. Enter the Discharges for the last four years of available data from your CMS Cost Reports. [more info...](#)

2007 * 2008 * 2009 * 2010 *

This data is used to calculate your Average Growth Rate for the incentive payment.

2007 – Enter the total discharges from the cost report 3 years prior to the cost report used for the first year data.

2008 – Enter the total discharges from the cost report 2 years prior to the cost report used for the first year data.

2009 – Enter the total discharges from the cost report 1 year prior to the cost report used for the first year data.

2010 – Enter the total discharges from the cost report filed in the previous federal fiscal year.

2. Enter the Total Discharges from the 2010 cost report. [more info...](#)

Total Discharges *

Nursery and Swing Beds should be excluded from the Total Discharges.

3. Enter the Total Medicaid Inpatient Bed Days from the 2010 cost report. [more info...](#)

Total Medicaid Inpatient Bed *
Days

Nursery and Swing Beds should be excluded from the Total Medicaid Inpatient Bed Days.

Hospital Demographic Information

Current Cost Report Year-Enter the year from the hospital cost report that has ended in the previous federal fiscal year

4 years of Discharge data-Enter the total discharges for the acute care portion of the hospital, this excludes nursery discharges, for the previous 4 most recent years of hospital cost report discharge data.

Total Discharges-Enter the total discharges for the acute care portion of the hospital from the hospital cost report ending in the federal fiscal prior to the payment year. The discharges also exclude nursery discharges. Note: Payments years are based on the federal fiscal year for hospitals.

Example: If a hospital is applying for an incentive payment in federal fiscal year 2011 (October 1, 2010-September 30, 2011), and the hospital fiscal year runs from July 1-June 30, the hospital cost report data used would be collected from the hospital cost report ending on June 30, 2010.

Total Medicaid Inpatient Bed Days-Enter the total Medicaid Inpatient Bed days from the hospital cost report ending in the federal fiscal year prior to the payment year. The Medicaid inpatient bed days exclude nursery days. If a patient is dually eligible for both Medicare and Medicaid, if the Medicare inpatient bed days would count for the purposes of calculating the Medicare share they cannot be counted in the numerator for the Medicaid share.

Step 2-Confirm Medicaid Eligibility-EH (cont.)

4. Enter the Total Medicaid Managed Care Inpatient Bed Days from the 2010 cost report . [more info...](#)

Total Medicaid Managed Care *
Inpatient Bed Days

Nursery and Swing Beds should be excluded from the Total Medicaid Managed Care Inpatient Bed Days.

5. Enter the Total Inpatient Bed Days from the 2010 cost report . [more info...](#)

Total Inpatient Bed Days *

Nursery and Swing Beds should be excluded from the Total Inpatient Bed Days.

6. Enter the Total hospital charges from the 2010 cost report. [more info...](#)

Total Hospital Charges *

7. Enter the Total charges attributable to Charity Care from the 2010 cost report. [more info...](#)

Hospital Charity Care Charges *

If neither charity care nor uncompensated care charges are identifiable on the cost report, enter 1. The charity care ratio will be set to 1 for the incentive calculation.

Attach Documentation

File(s) Attached - {0}

[Cancel and lose Eligibility changes](#)

Hospital Demographic Information

Medicaid Managed Care Inpatient Bed Days-The Alaska Medical Assistance Program does not have a Medicaid Managed Care program. Hospitals may enter "0" in this field in the SLR.

Total Inpatient Bed Day- Enter the total inpatient bed days for the acute care portion of the hospital from the hospital cost report ending in the federal fiscal prior to the payment year. The inpatient bed days excludes nursery days.

Total Hospital Charges-Enter the total hospital charges from the hospital cost report ending in the federal fiscal year prior to the payment year.

Hospital Charity Care Charges-Enter the total hospital charity care charges from the hospital cost report ending in the federal fiscal year prior to the payment year.

Save Eligibility-Once all of the information has been entered select save eligibility and you will be taken to the next screen Step 3. Attestation of EHR

SLR Home page-Confirm Medicaid Eligibility-Complete

Alaska Medicaid State Level Registry for Provider Incentive Payments

Welcome, ERIN NEATHLER
This is your Dashboard for working through the attestation process.

Year 1

1. About You
Additional Registration information and NLR data
2. Confirm Medicaid Eligibility
Practice Demographics and Volumes
3. Attestation of EHR
Related to Adopting, Implementing, Upgrading or Meaningful Use
4. Review and Sign Agreement
Review, Print, Sign and Upload the SLR Agreement
5. Send Year 1 Submission
Send and lock all information to State

Note: The Confirm Medicaid Eligibility tab has been completed and is highlighted green, Step 3 has been unlocked to allow you to continue to the next step

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Step 3-Attestation of EHR-Adopt, Implement, Upgrade

3. Attestation of EHR

Attest to Adopt, Implement, Upgrade

Attest to Meaningful Use

Select this option to attest to your Adoption, Implementation or Upgrade of certified EHR technology. AIU is available for your first year of participation only, and does not require entering data for a specific reporting period.

This feature will be available later in 2011.

Select
Attest to Adopt, Implement, Upgrade
Or
Attest to Meaningful Use

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Attestation of EHR- In the first year of participation in the Medicaid EHR Incentive Program eligible professionals and eligible hospitals have the option to attest to Adopt, Implement or Upgrade to a certified EHR Technology or to meaningful use. In the second year of participation they may attest to meaningful use.

Note: The attestation of meaningful use will be available for the Alaska Medicaid EHR Incentive Program in the beginning of 2012.

Step 3-Attestation of EHR-AIU Method

Alaska Medicaid
State Level Registry
for Provider Incentive Payments

My Account | Help | Contact Us | Logout |
Filing as Eligible Professional
Mouse LLC
1111 5th Ave #205
Juneau, AK 99801-1111
Last Updated: Minnie Mouse 05/16/2011 12:50 PM

Back to Dashboard

3. Attestation of EHR

Attestation Process

- Criteria
- Certified EHR Technology

Legend

- Not Started
- In Progress
- Complete
- Locked
- View Only

Criteria

Choose a Method (Adopt, Implement, or Upgrade) to declare your attestation for Year 1 submission. Enter a brief description and attach any document that shows how you have met the criteria. [more info](#)

Criteria Method

Enter your criteria information below. * indicates required fields.

Method * **Select**

Documentation that supports your attestation of Adopt, Implement or Upgrade must be attached before this step can be marked complete.

Click the Save button to save any changes to your file attachments.

Save Criteria | Cancel and lose Criteria changes

Eligible professionals and eligible hospitals must select the method of attestation: Either Adopt, Implement or Upgrade

Step 3-Attestation of EHR-AIU Method (cont.)

3. Attestation of EHR

Criteria

Choose a Method (Adopt, Implement, or Upgrade) to declare your attestation for Year 1 submission. Enter a brief description and attach any document that shows how you have met the criteria. [more info](#)

Criteria Method

Your criteria information is complete

Method * **Adopt**

Acquire, purchase or access to certified EHR technology. Evidence of actual acquisition or installation of the technology is required to demonstrate adoption. [more info...](#)

Please describe briefly how you meet the criteria for Adoption of EHR Technology.

Mouse LLC signed a contract with our EHR vendor on September 16, 2010 with purchase agreement to install the certified version of EHR technology by April 15, 2011.

Attach Adopt Documentation *

File(s) Attached - {1}

Documentation that supports your attestation of Adopt, Implement or Upgrade must be attached before this step can be marked complete.

Click the Save button to save any changes to your file attachments.

Save Criteria | Cancel and lose Criteria changes

Providers must enter a description of how they meet the criteria of Adopt, Implement or Upgrade; Note: Providers may enter up to 1,000 characters

Step 3-Attestation of EHR-AIU Method-Attach Document (cont.)

Manage Files

Filename	Subject	Remove
----------	---------	--------

Add Another File + Remove Selected x

i Click the Save Files button to save any changes to your file attachments.

Add a File

Subject * Select...
Select...
Contract
Work plan
Action plan
Staffing work plan

i You must attach at least one document with subject of "Contract."

Save Files | Cancel and lose Manage Files changes

Manage Files

Providers must upload a file that supports the criteria for Adopt, Implement or Upgrade. At a minimum, providers are required to upload a document with a subject of "Contract" in order to complete the SLR attestation process. Other acceptable documents could include a work plan, action plan or staffing work plan.

Note: A letter of agreement that has been signed by both the provider/group and the EHR vendor is an acceptable document to upload under "Contract"

Step 3-Attestation of EHR-EHR Certification



Alaska Medicaid
State Level Registry
for Provider Incentive Payments

My Account | Help | Contact Us | Logout |
Filing as Eligible Professional
Mouse LLC
1111 5th Ave #205
Juneau, AK 99801-1111
Last Updated: Minnie Mouse 05/16/2011 04:06 PM

[Back to Dashboard](#)

3. Attestation of EHR

Attestation Process

- Criteria
- Certified EHR Technology**

Legend

- Not Started
- In Progress
- Complete
- Locked
- View Only

Certified EHR Technology

Providers must provide information demonstrating that their EHR technology is certified through the Office of the National Coordinator (ONC). ONC provides a public web service that contains a list of all certified EHR technology, including the name of the vendor and product, the product's unique certification code, and the meaningful use criteria for which the product was certified. The State is required to validate the verification of the Certified EHR information before making any payment to providers.

It is the provider's responsibility to ensure that its certified EHR technology code is listed on the ONC public web service before attesting to the State. Failure to do so could result in a false negative result that may disqualify the provider from receiving payment.

To proceed, please indicate your understanding of this responsibility by agreeing to the following statement

Your Understanding

Enter your Certified EHR Technology information below. * indicates required fields.

I understand that it is my responsibility, as the representative of the provider, to ensure that my certified EHR technology code is listed on the ONC public web service before submitting my attestation to the State. I understand that failing to ensure my code is listed may result in a false negative result that may disqualify me from receiving payment.

Click the Save button to save any changes to your file attachments.

Save Certified EHR Technology | Cancel and lose Certified EHR Technology changes

Your Understanding-The provider or representative of the provider must agree to the following statement:

I understand that it is my responsibility, as the representative of the provider, to ensure that my certified EHR technology code is listed on the ONC public web service before submitting my attestation to the State. I understand that failing to ensure my code is listed may result in a false negative result that may disqualify me from receiving payment.

Once you agree with the “Your Understanding” statement, additional steps will appear where you will be required to enter the EHR Certification Information

Step 3-Attestation of EHR - EHR Certification (cont.)

Your Understanding

Enter your Certified EHR Technology information below. * indicates required fields.

I understand that it is my responsibility, as the representative of the provider, to ensure that my certified EHR technology code is listed on the [ONC public web service](#) before submitting my attestation to the State. I understand that failing to ensure my code is listed may result in a false negative result that may disqualify me from receiving payment.

Your EHR Certification Information

Enter your CMS EHR Certification Number

CMS EHR Certification ID *

1) Go to the ONC website: <http://onc-chpl.force.com/ehrcert>
2) Search for your product(s) and add each to the shopping cart by clicking "Add to Cart."
3) When you have added all product(s) to your shopping cart, click the "View Cart" link.
4) Click "Get CMS EHR Certification ID."
5) Your CMS EHR Certification ID will be displayed on the screen. This is the number you will need to enter above as part of your attestation.

NOTE: ONC does not allow you to mix Inpatient products and Ambulatory products together to represent a complete EHR solution. Additionally, if the product(s) you add to your shopping cart do not represent a complete EHR solution capable of achieving meaningful use criteria, you will not be able to click "Get CMS EHR Certification ID" in step 4.

Supporting Documentation

File(s) Attached - {0}

If your vendor has provided you with documentation displaying the EHR Certification Number you can attach it here. Attaching supporting documentation for your EHR Certification Number is optional.

Click the Save button to save any changes to your file attachments.

CMS EHR Certification ID-You must enter the CMS EHR Certification ID

- 1) Go to the ONC website: <http://onc-chpl.force.com/ehrcert>
- 2) Search for your product(s) and add each to the shopping cart by clicking "Add to Cart."
- 3) When you have added all product(s) to your shopping cart, click the "View Cart" link.
- 4) Click "Get CMS EHR Certification ID."
- 5) Your CMS EHR Certification ID will be displayed on the screen. This is the number you will need to enter above as part of your attestation.

Ex. Your CMS EHR Certification ID is: 300000MCAID4AK

Note: ONC does not allow you to mix Inpatient products and Ambulatory products together to represent a complete EHR solution. Additionally, if the product(s) you add to your shopping cart do not represent a complete EHR solution capable of achieving meaningful use criteria, you will not be able to click "Get CMS EHR Certification ID" in step 4."

Supporting Documentation-If your vendor has provided you with documentation displaying the EHR Certification Number the document may be attached here. Attaching the additional supporting documentation for your EHR Certification number is optional.

SLR Home page-Attestation of EHR-Complete



Alaska Medicaid
State Level Registry
for Provider Incentive Payments

My Account | Help | Contact Us | Logout | *Filing as Eligible Professional*

Welcome,
This is your Dashboard for working through the attestation process.

Complete your Year 1 submission.
Complete Section 4. [Review and Sign Agreement](#)

✓ Data has been received from the NLR. [View NLR data](#)

[Payment Information](#)
[Reports](#)
[Audit](#)
[Appeals](#)
[System Messages](#)

Step 3 Attestation of EHR is complete and highlighted green, you may move to the next step

Year 1

- 1. About You**
Additional Registration Information and NLR data
- 2. Confirm Medicaid Eligibility**
Practice Demographics and Volumes
- 3. Attestation of EHR**
Related to Adopting, Implementing, Upgrading or Meaningful Use
- 4. Review and Sign Agreement**
Review, Print, Sign and Upload the SLR Agreement
- 5. Send Year 1 Submission**
Send and lock all information to State

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Step 4-Review and Sign Agreement

4. Review, Sign, and Attach Attestation

 Review and attach your signed attestation below. * Indicates required fields.

Step 1: Print to Sign Attestation

The information you entered in support of your attestation is displayed below. Please carefully review the entire document and all attachments before signing.

Alaska Medicaid Electronic Health Record Incentive Program Attestation Agreement

State of Alaska

Department of Health and Social Services

This Attestation Agreement is required for participation in the Electronic Health Record (EHR) incentive payment program to individual providers who adopt, implement, upgrade (AIU) or meaningfully use (MU) certified EHR technology in accordance with 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** which implements the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111-5). As part of the cited regulations, the State of Alaska requires that all applicants for EHR payments submit a signed Attestation Agreement.

By signing this agreement, I attest that the following information entered below is true, accurate and complete:

1. I am authorized to seek one payment from the Alaska Medicaid EHR Incentive program and I have not, nor will I seek a payment from another state or Medicare EHR incentive program in this payment year.
2. I am seeking payment to Adopt/Implement/Upgrade for Year 1 of the program. I meet the requirements for Adopt as specified in the Medicare and Medicaid EHR Incentive Program rules and by the State of Alaska EHR Incentive Program rules.

 Print Attestation

Step 2: Scan and Upload Signed Attestation

After you have signed your attestation, please attach the signed copy for submission to the State and click the Save button below. If you have a problem attaching your document, please contact our Help Desk at (866) 879-0109 for assistance.

Locate Signed Attestation *



Review, Sign and Attach Attestation

- After reviewing and printing the completed attestation agreement you must sign the attestation and upload the signed agreement into the SLR
 - To upload the signed attestation agreement click Browse and select the saved agreement and click Save Signed Attestation to save the agreement in the SLR

Step 5-Send Year 1 Submission

The screenshot shows the Alaska Medicaid State Level Registry dashboard. At the top, there is a header with the Alaska Medicaid logo and the text "Alaska Medicaid State Level Registry for Provider Incentive Payments". On the right side of the header, there are links for "My Account", "Help", "Contact Us", and "Logout". Below the header, there is a navigation menu on the left with items like "Complete", "Data has been", "Payment Information", "Reports", "Audit", "Appeals", and "System Messages (0)". The main content area is titled "Year 1" and contains a list of five steps, each with a document icon and a checkmark:

- 1. About You**
Additional Registration Information and NLR data
- 2. Confirm Medicaid Eligibility**
Practice Demographics and Volumes
- 3. Attestation of EHR**
Related to Adopting, Implementing, Upgrading or Meaningful Use
- 4. Review and Sign Agreement**
Review, Print, Sign and Upload the SLR Agreement
- 5. Send Year 1 Submission**
Send and lock all information to State

A blue callout box points to the "4. Review and Sign Agreement" step, containing the text: "Step 4 Review and Sign Agreement is complete; ensure the signed attestation has been loaded into the SLR".

Send Attestation

The screenshot shows a confirmation screen titled "Send Attestation to State" with a close button (X) in the top right corner. The main text reads: "You have successfully submitted your attestation for Year 1 to the State of Alaska. Your attestation will be validated by the State to determine your eligibility to receive the incentive payment. Once the State has completed the validation process, your information will be submitted to CMS to verify you are eligible to receive Federal funds. Upon receiving confirmation from CMS that you are eligible to receive payment, the State will initiate the payment process. The validation process may take up to 17 – 33 business days to complete."

PLEASE NOTE: The State may elect to audit any and all information submitted as part of your attestation prior to or after approving your payment.

Please periodically check the State Level Registry Dashboard message area for information about the status of your attestation and payment.

At the bottom, there are two buttons: "Send Attestation" (with a document icon) and "Cancel and do not send attestation".

To complete the attestation you must send the attestation and send the originally signed attestation agreement to:

State of Alaska
Department of Health and Social Services
EHR Incentive Program Office
3601 C Street, Suite 902
Anchorage, Alaska 99503

Send Year 1 Submission

Sent Attestation Confirmation

 **Attestation Submitted**

You have successfully submitted your attestation for Year 1 to the State of Alaska. Your attestation will be validated by the State to determine your eligibility to receive the incentive payment. Once the State has completed the validation process, your information will be submitted to CMS to verify you are eligible to receive Federal funds. Upon receiving confirmation from CMS that you are eligible to receive payment, the State will initiate the payment process. The validation process may take up to 17 – 33 business days to complete.

PLEASE NOTE: The State may elect to audit any and all information submitted as part of your attestation prior to or after approving your payment.

Please periodically check the State Level Registry Dashboard message area for information about the status of your attestation and payment.

Sent Attestation Confirmation – Once your attestation has been send, the SLR will provide a message that confirms that the attestation has been submitted

Year 1 Attestation Complete



My Account |  Help | Contact Us | Logout |

Filing as Eligible Hospital
Alaskas Best Hospital
8900 E Benson St
Anchorage, AK 99510-8900
Last Updated: 05/23/2011 02:15 PM

Welcome, Alaskas Best Hospital
This is your Dashboard for working through the attestation process.

 **Your Year 1 submission is complete**
Please check your payment status.

 Data has been received from the NLR. [View NLR data](#)

[Payment Information](#)

[Reports](#)

[Audit](#)

[Appeals](#)

[System Messages \(1\)](#)

Year 1

-  **1. About You**
Additional Registration Information and NLR data
-  **2. Confirm Medicaid Eligibility**
Hospital Demographics and Volumes
-  **3. Attestation of EHR**
Related to Adopting, Implementing, Upgrading or Meaningful Use
-  **4. Review and Sign Agreement**
Review, Print, Sign and Upload the SLR Agreement
-  **5. Send Year 1 Submission**
Send and lock all information to State

Once the Year 1 Attestation has been sent, the SLR Dashboard will be locked

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13 Definitions for the EHR Incentive Program

Acceptable documentation means satisfactorily completed written evidence of an approved phase of work or contract and acceptance of the evidence thereof by Alaska Medicaid. Acceptable documentation will refer to the certified EHR technology by name and will include financial and/or contractual commitment. Document date does not have to be within the preceding fiscal year, if the reported version of the EHR technology was certified after the document date. See examples below:

- Copy of contract
- Copy of invoice
- Copy of receipt
- Copy of purchase agreement
- Copy of user license agreement

Acute care hospital means a health care facility— (1) Where the average length of patient stay is 25 days or fewer; and (2) With a CMS certification number (previously known as the Medicare provider number) that has the last four digits in the series 0001–0879 or 1300–1399; or (3) Critical Access Hospitals

Adopt, implement, or upgrade (AIU) means— (1) Acquire, purchase, or secure access to certified EHR technology (proof of purchase or signed contract will be an acceptable indicator); (2) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or (3) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

Children’s hospital means a separately certified children’s hospital, either freestanding or hospital-within hospital that— (1) Has a CMS certification number, (previously known as the Medicare provider number), that has the last 4 digits in the series 3300–3399; and (2) Predominantly treats individuals less than 21 years of age.

Hospital-Based means a professional furnishes ninety percent (90%) or more of their Alaska Medicaid-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or emergency Room, through the use of the facilities and equipment of the hospital; verified by MMIS claims analysis.

Meaningful Use is using certified electronic health record (EHR) technology to: Improve quality, safety, efficiency, and reduce health disparities, engage patients and family, improve care coordination, and population and public health.

Medicaid Encounter for an EP means services rendered to an individual on any one day where:

- Medicaid paid for part or all of the service; or
- Medicaid paid all or part of the individual’s premiums, copayments, and cost-sharing
- Claims denied because the Medicaid beneficiary has maxed out the service limit, or
- Claims denied because the service wasn’t covered under the State’s Medicaid Program, or
- Claim paid at \$0 because another payer’s payment exceeded the Medicaid payment, or
- Claim denied because the claim wasn’t submitted timely

Medicaid Encounter for an EH For purposes of calculating EH patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims. Zero pay claims include:

- Claims denied because the Medicaid beneficiary has maxed out the service limit
- Claims denied because the service wasn't covered under the State's Medicaid Program
- Claim paid at \$0 because another payer's payment exceeded the Medicaid payment
- Claim denied because the claim wasn't submitted timely.

Medicaid Management Information System (MMIS) means the Medicaid claims payment system.

Needy individuals mean individuals that meet one of following:

- Were furnished medical assistance paid for by Title XIX Medicaid or Title XXI Children's Health Insurance Program funding including Alaska Medicaid, out-of-state Medicaid programs, or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- Were furnished uncompensated care by the provider; or
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay

Patient volume means the proportion of an EPs or EHs patient encounters that qualify as a Medicaid encounter. This figure is estimated through a numerator and denominator and is defined as:

- $\frac{[\text{Total (Medicaid) patient encounters in any representative continuous 90-day or greater period in the preceding calendar year or in the 12 months immediately preceding the attestation date}]}{[\text{Total patient encounters in that same 90-day or greater period}]} * 100$

Pediatrician means a Medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must (1) hold a valid, unrestricted medical license, **and** (2) hold a board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP).

Practices predominantly means an EP for whom more than 50 percent of his or her total patient encounters occur at a federally qualified health center or rural health clinic. The calculation is based on a period of 6 months in the most recent calendar year.

State Medicaid HIT Plan (SMHP) means a document that describes the State's current and future HIT activities.

Addendum 1: EP Stage 2 MU Screen Shots

Below are examples of how the EP Core objectives look on the SLR. More information on Core Objectives, refer to page 18 of this manual.

EP Core 1 CPOE

Questionnaire (1 of 17)

 * Red asterisk indicates a required field.

Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

Measure #1: More than 60% of medication orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion #1: Any EP who writes fewer than 100 medication orders during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
* Does this exclusion apply to you?
 Yes No

Measure #2: More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion #2: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.
* Does this exclusion apply to you?
 Yes No

Measure #3: More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion #3: Any EP who writes fewer than 100 radiology orders during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from meeting meaningful use.
* Does this exclusion apply to you?
 Yes No

EP Core 2 – Electronic Prescriptions

Questionnaire (2 of 17)

 * Red asterisk indicates a required field.

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

Measure: More than 50% of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

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

* Does this exclusion apply to you?

Yes No

EP Core 3 – Demographics

Questionnaire (3 of 17)

 * Red asterisk indicates a required field.

Objective: Record all of the following demographics: preferred language, sex, race, ethnicity, and date of birth.

Measure: More than 80 % of all unique patients seen by the EP during the EHR reporting period have demographics recorded as structured data.

Complete the following information:

Numerator = The number of patients in the denominator who have all the elements of demographics (or a specific notation 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:

EP Core 4 – Record Vitals

Questionnaire (4 of 17)

 * Red asterisk indicates a required field.

Objective: Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0 - 20 years, including BMI.

Measure: More than 80 % of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data.

Exclusion 1: Any EP who sees no patients 3 years or older is excluded from recording blood pressure.

* Does this exclusion apply to you?

Yes No

EP Core 5 – Smoking Status

Questionnaire (5 of 17)

 * Red asterisk indicates a required field.

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

Measure: More than 80 % of all unique patients 13 years old or older seen by the EP during the EHR reporting period have smoking status recorded as structured data.

Exclusion: Any EP who sees no patients aged 13 years old or older is excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Yes No

EP Core 6 – Clinical Decision Support

Questionnaire (6 of 17)

 * Red asterisk indicates a required field.

Objective: Use clinical decision support to improve performance on high-priority health conditions.

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency.

Complete the following information:

* Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

Yes No

List the five clinical decision support interventions you have implemented.

1	
2	
3	
4	
5	

These clinical decision support interventions are related to:

4 or more clinical quality measures 4 or more high priority health conditions

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting is excluded from meeting this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

Yes No

Complete the following information:

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

Yes No

EP Core 7 – Clinical Lab Test Results

Questionnaire (7 of 17)

 * Red asterisk indicates a required field.

Objective: Incorporate clinical lab test results into CEHRT as structured data.

Measure: More than 55% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated into CEHRT as structured data.

Exclusion: Any EP who orders no lab tests where results are either in a positive/negative affirmation or numeric format during 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 = The number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT 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:

EP core 8 – Lists of Specific Conditions

Questionnaire (8 of 17)

 * 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.

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

Complete the following information:

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

Yes No

* Please name at least one condition for which a list was generated.

enter text...

EP Core 9 – Patient Reminders – Follow up/Preventive Care

Questionnaire (9 of 17)

 * Red asterisk indicates a required field.

Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.

Measure: More than 10% of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.

Exclusion: Any EP who has had no office visits in the 24 months before the EHR reporting period would be excluded from meeting 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 who were sent a reminder per patient preference when available during the EHR reporting period.

Denominator = Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR reporting period.

Numerator:

Denominator:

EP Core 10 – Patients Ability to View Online, Download, and Transmit Health Records

Questionnaire (10 of 17)

 * Red asterisk indicates a required field.

Objective: Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP.

Measure #1: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP's discretion to withhold certain information.

Exclusion #1: Any EP who neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient Name" and "Provider's name and office contact information" may exclude both measures. 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 who have timely (within 4 business days after the information is available to the EP) online access to their health information.

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

Numerator:

Denominator:

Measure #2: More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their health information.

Exclusion #2: Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude only the second measure. 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 unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded or transmitted to a third party the patient's health information.

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

Numerator:

Denominator:

EP Core 11 – Provide Clinical Summaries for Each Office Visit

Questionnaire (11 of 17)

 * Red asterisk indicates a required field.

Objective: Provide clinical summaries for patients for each office visit.

Measure: Clinical summaries provided to patients or patient-authorized representatives within 1 business day for more than 50% of office visits.

Complete the following information:

Exclusion: Any EP who has no office visits during the EHR reporting period is excluded from meeting 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 office visits in the denominator where the patient or a patient-authorized representative is provided a clinical summary of their visit within one business day.

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

Numerator:

Denominator:

EP Core 12 – Identify Patient – Specific Education Resources

Questionnaire (12 of 17)

 * Red asterisk indicates a required field.

Objective: Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.

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

Exclusion: Any EP who has no office visits during the EHR reporting period would be excluded from meeting 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 who were provided patient-specific education resources identified by the Certified EHR Technology.

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

Numerator:

Denominator:

EP Core 13 – Secure Electronic Messaging

Questionnaire (13 of 17)

 * Red asterisk indicates a required field.

Objective: Use secure electronic messaging to communicate with patients on relevant health information.

Measure: A secure message was sent using the electronic messaging function of CEHRT by more than 5% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

Exclusion: Any EP who has no office visits during the EHR reporting period, or any EP who conducts more than 50% of his or her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the FCC on the first day of the EHR reporting period would be excluded from meeting this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

Yes No

* Select all exclusions that apply to you.

The EP has no office visits during the EHR reporting period.

The EP conducts more than 50% of his or her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the FCC on the first day of the EHR reporting period.

EP Core 14 – Medication Reconciliation

Questionnaire (14 of 17)

 * 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.

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.

Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period would be excluded from meeting 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 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:

EP Core 15 – Transition of Care

Questionnaire (15 of 17)

 * 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 provides a summary of care record for each transition of care or referral.

Measure #1: The EP that 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.

Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all 3 measures. 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 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:

Measure #2: The EP that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.

Complete the following information:

Numerator = The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization.

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:

EP Core 16 – Immunization Registry

Questionnaire (16 of 17)

 * Red asterisk indicates a required field.

Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission or electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.

Exclusion: Any EP that meets one or more of the following criteria may be excluded from this objective:

- 1) the EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;
- 2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period; ***Note: if an entity designated by the immunization registry or immunization information system can receive electronic data submissions, a provider may not claim this exclusion.**
- 3) the EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or
- 4) the EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

* Does this exclusion apply to you?

Yes No

Complete the following information:

* Do you have successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period?

Yes No

Immunization Registry or Information System

Select

Date of Registration of Intent

Have you received Acknowledgement from the Immunization Registry? Yes No

EP Core 17 – Protect Health Information

Questionnaire (17 of 17)

 * Red asterisk indicates a required field.

Objective: Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(l), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CRF 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process at §495.6(j)(16) (ii).

Placeholder for help text regarding the security questionnaire. Help text is configurable for each client and is hidden by default.

Complete the following information:

* Have you conducted or reviewed a security risk analysis in accordance with the requirements?

Yes No

Stage 2 EP Menu Objectives

Below are examples of how the EP Menu objectives look on the SLR. More information on Core Objectives, refer to page 24 of this manual.

EP Menu Objective – Syndromic Surveillance

Questionnaire (X of Y)

 * Red asterisk indicates a required field.

Objective: Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.

Exclusion: Any EP that meets one or more of the following criteria may be excluded from this objective:

- 1) the EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period;
- 2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period;
- 3) the EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or
- 4) the EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.

* Does this exclusion apply to you?

Yes No

* Select all exclusions that apply to you. Exclusion from the requirement does not prevent an EP from achieving meaningful use.

- the EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period
- the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period
- the EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data
- the EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs

* Does this exclusion apply to you?

Yes No

Complete the following information:

* Do you have successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period?

Yes No

EP Menu Objective – Record Electronic Notes in Patient Records

Questionnaire (X of Y)

 * Red asterisk indicates a required field.

Objective: Record electronic notes in patient records.

Measure: Enter at least one electronic progress note created, edited, and signed by an EP for more than 30% of unique patients with at least one office visit during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with searchable text notes under this measure.

Complete the following information:

Numerator = The number of unique patients in the denominator who have at least one progress note from an eligible professional recorded as text-searchable data.

Denominator = Number of unique patients with at least one office visit during the EHR reporting period.

Numerator:

Denominator:

EP Menu Objective – Imaging Results

Questionnaire (X of Y)

 * Red asterisk indicates a required field.

Objective: Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.

Measure: More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.

Exclusion: Any EP who orders less than 100 tests whose result is an image during the EHR reporting period would be excluded from meeting this requirement. Exclusion from the requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

Yes No

EP Menu Objective – Family History

Questionnaire (X of Y)

 * Red asterisk indicates a required field.

Objective: Record patient family health history as structured data.

Measure: More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.

Exclusion: Any EP who has no office visits during the EHR reporting period would be excluded from this requirement. Exclusion from the requirements does not prevent the 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 with a structured data entry for one or more first-degree relatives.

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

Numerator:

Denominator:

EP Menu Objective – Cancer Registry

Questionnaire (X) of (Y)

 * Red asterisk indicates a required field.

Objective: Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.

Exclusion: Any EP that meets one or more of the following criteria may be excluded from this objective:

- 1) the EP does not diagnose or directly treat cancer;
- 2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the start of their EHR reporting period;
- 3) the EP operates in a jurisdiction where no public health agency provides information timely on capability to receive electronic cancer case information; or
- 4) the EP operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required by CEHRT at the start of their EHR reporting period can still enroll additional EPs.

* Does this exclusion apply to you?

Yes No

* Select all exclusions that apply to you.

- the EP does not diagnose or directly treat cancer;
- the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required by CEHRT at the start of their EHR reporting period
- the EP operates in a jurisdiction where no public health agency provides information timely on capability to receive electronic cancer case information; or
- the EP operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required by CEHRT at the start of their EHR reporting period can still enroll additional EPs

* Does this exclusion apply to you?

Yes No

Complete the following information:

* Do you have successful ongoing submission of electronic cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period?

Yes No

* Name of the Cancer Registry

enter text...

EP Menu Objective – Other Specialized Registry

Questionnaire ({X} of {Y})

 Red asterisk indicates a required field.

Objective: Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.

Exclusion: Any EP that meets one or more of the following criteria may be excluded from this objective:

- 1) the EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction;
- 2) the EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the start of their EHR reporting period;
- 3) the EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their registries; or
- 4) the EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable of receiving electronic specific case information in the specific standards required by CEHRT at the start of their EHR reporting period can still enroll additional EPs.

* Does this exclusion apply to you?

Yes No

* Select all exclusions that apply to you.

- the EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction;
- the EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the start of their EHR reporting period
- the EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their specialized registries; or
- the EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable of receiving electronic specific case information in the specific standards required by CEHRT at the start of their EHR reporting period can still enroll additional EPs

* Does this exclusion apply to you?

Yes No

Complete the following information:

* Do you have successful ongoing submission of specific case information from CEHRT to specialized registry for the entire EHR reporting period?

Yes No

* Name of the Specialized Registry:

enter text...

Addendum 2: EH Stage 2 MU Screen Shots

Below are examples of how the EH Core objectives look on the SLR. More information on Core Objectives, refer to page 52 of this manual.

EH Core 1 – CPOE

Questionnaire (1 of 16)

 * Red asterisk indicates a required field.

Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

Measure #1: More than 60% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

Complete the following information:

Numerator = The number of orders in the denominator recorded using CPOE.

Denominator = Number of medication orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

Measure #2: More than 30% of laboratory orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

Complete the following information:

Numerator = The number of orders in the denominator recorded using CPOE.

Denominator = Number of laboratory orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

Measure #3: More than 30% of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

Complete the following information:

Numerator = The number of orders in the denominator recorded using CPOE.

Denominator = Number of radiology orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

EH Core 2 – Record Demographics

Questionnaire (2 of 16)

 * Red asterisk indicates a required field.

Objective: Record all of the following demographics: preferred language, sex, race, ethnicity, date of birth, date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.

Measure: More than 80 % of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.

Complete the following information:

Numerator = The number of patients in the denominator who have all the elements of demographics (or a specific notation 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 admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

EH Core 3 – Vital Signs

Questionnaire (3 of 16)

 * Red asterisk indicates a required field.

Objective: Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0 - 20 years, including BMI.

Measure: More than 80 % of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data.

Complete the following information:

Numerator = The number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.

Denominator = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

EH Core 4 – Smoking Status

Questionnaire (4 of 16)

 * Red asterisk indicates a required field.

Objective: Record smoking status for patients 13 year old or older.

Measure: More than 80 % of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data.

Exclusion: Any eligible hospital or CAH that admits no patients aged 13 years old or older is excluded from this requirement. Exclusion from this requirement does not prevent an EH from achieving meaningful use.

Yes No

Complete the following information:

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

Denominator = Number of unique patients age 13 or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

EH Core – Clinical Decision Support

Questionnaire (5 of 16)

 * Red asterisk indicates a required field.

Objective: Use clinical decision support to improve performance on high-priority health conditions.

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the eligible hospital's or CAH's scope of practice the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency.

Complete the following information:

* Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?

Yes No

List the five clinical decision support interventions you have implemented.

1	
2	
3	
4	
5	

These clinical decision support interventions are related to:

4 or more clinical quality measures 4 or more high priority health conditions

A cross reference listing of the Clinical Quality Measures is located in the User Guide to assist you with identifying the applicable CQM numbers, if needed.

Measure #2: The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

Complete the following information:

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

Yes No

EH Core 6 – Clinical Lab Test Results

Questionnaire (6 of 16)

 * Red asterisk indicates a required field.

Objective: Incorporate clinical lab test results into CEHRT as structured data.

Measure: More than 55% of all clinical lab tests results ordered by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated into CEHRT as structured data.

Complete the following information:

Numerator = The number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data.

Denominator = Number of lab tests ordered during the EHR reporting period by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) whose results are expressed in a positive or negative affirmation or as a number.

Numerator:

Denominator:

EH core 7 – Condition List

Questionnaire (7 of 16)

 * 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.

Measure: Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.

Complete the following information:

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

Yes No

Questionnaire (8 of 16)

 * Red asterisk indicates a required field.

Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).

Measure: More than 10% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.

Exclusion: Any hospital with an average daily inpatient census of fewer than ten (10) patients would be excluded from this requirement. Exclusion from the requirement does not prevent the eligible hospital or CAH from achieving meaningful use.

* Does this exclusion apply to you?

Yes No

Complete the following information:

Numerator = The number of orders in the denominator for which all doses are tracked using eMAR.

Denominator = Number of medication orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

EH Core 9 – View Patient Data Online

Questionnaire (9 of 16)

 * Red asterisk indicates a required field.

Objective: Provide patients the ability to view online, download and transmit information about a hospital admission.

Measure #1: More than 50% of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge.

Complete the following information:

Numerator = The number of patients in the denominator whose information is available online within 36 hours of discharge.

Denominator = Number of unique patients discharged from the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

Questionnaire (9 of 16)

 * Red asterisk indicates a required field.

Objective: Provide patients the ability to view online, download and transmit information about a hospital admission.

Measure #2: More than 5% of all unique patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the EHR reporting period..

Exclusion: Any eligible hospital or CAH will be excluded from the second measure if it is located in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

* Does this exclusion apply to you?

Yes No

Complete the following information:

Numerator = The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded or transmitted to a third party the discharge information provided by the eligible hospital or CAH.

Denominator = Number of unique patients discharged from the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

EH Core 10 – Patient Education Resources

Questionnaire (10 of 16)

 * Red asterisk indicates a required field.

Objective: Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.

Measure: More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology.

Complete the following information:

Numerator = The number of patients in the denominator who are subsequently provided patient-specific education resources identified by the Certified EHR Technology.

Denominator = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

EH Core 11 – Medication Reconciliation

Questionnaire (11 of 16)

 * Red asterisk indicates a required field.

Objective: The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

Measure: The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).

Complete the following information:

Numerator = The 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 eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.

Numerator:

Denominator:

EH Core 12 – Transitions of Care

Questionnaire (12 of 16)

 * Red asterisk indicates a required field.

Objective: The eligible hospital or CAH 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 of care record for each transition of care or referral.

Measure #1: The eligible hospital or CAH that 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.

Complete the following information:

Numerator = The 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 eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.

Numerator:

Denominator:

Questionnaire (12 of 16)

 * Red asterisk indicates a required field.

Objective: The eligible hospital or CAH 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 of care record for each transition of care or referral.

Measure #2: The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10% of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.

Complete the following information:

Numerator = The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization.

Denominator = Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider.

Numerator:

Denominator:

EH Core – Transitions of Care, continued

Questionnaire (12 of 16)

 * Red asterisk indicates a required field.

Objective: The eligible hospital or CAH 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 of care record for each transition of care or referral.

Measure #3: An eligible hospital or CAH must satisfy one of the two following criteria:

* Conducts one or more successful electronic exchanges of a summary of care document, which is counted in Measure 2, with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or

* Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

Complete the following information:

- I conducted one or more successful electronic exchanges of a summary of care document with a recipient who has EHR technology that was developed by a different EHR technology developer than my EHR technology
- I conducted one or more successful tests with the CMS designated test EHR during the EHR reporting period.

EH Core 13 – Immunization Registry

Questionnaire (13 of 16)

 * Red asterisk indicates a required field.

Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.

Exclusion: Any eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective:

- 1) the eligible hospital or CAH does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;
- 2) the eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period; ***Note: if an entity designated by the immunization registry or immunization information system can receive electronic data submissions, a provider may not claim this exclusion.**
- 3) the eligible hospital or CAH operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or
- 4) the eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.

* Does this exclusion apply to you?

Yes No

* Select all exclusions that apply to you. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

- the eligible hospital or CAH does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period
- the eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period; ***Note: if an entity designated by the immunization registry or immunization information system can receive electronic data submissions, a provider may not claim this exclusion.**
- the eligible hospital or CAH operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data
- the eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.

EH Core 13 – Immunization Registry, continued

* Does this exclusion apply to you?

Yes No

Complete the following information:

* Do you have successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period?

Yes No

EH Core 14 – Reportable Lab Results

Questionnaire (14 of 16)

 * Red asterisk indicates a required field.

Objective: Capability to submit electronic reportable laboratory results to public health agencies, except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission of electronic reportable laboratory results from CEHRT to a public health agency for the entire EHR reporting period.

Exclusion: Any eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective:

- 1) the eligible hospital or CAH operates in a jurisdiction for which no public health agency is capable of receiving electronic reportable laboratory results in the specific standards required for CEHRT at the start of their EHR reporting period;
- 2) the eligible hospital or CAH operates in a jurisdiction where no public health agency provided information timely on capability to receive electronic reportable laboratory results; or
- 3) the eligible hospital or CAH operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs..

* Does this exclusion apply to you?

Yes No

* Select all exclusions that apply to you. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

- the eligible hospital or CAH operates in a jurisdiction for which no public health agency is capable of receiving electronic reportable laboratory results in the specific standards required for CEHRT at the start of their EHR reporting period;
- the eligible hospital or CAH operates in a jurisdiction where no public health agency provides information timely on capability to receive immunization data
- the eligible hospital or CAH operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.

* Does this exclusion apply to you?

Yes No

Complete the following information:

* Do you have successful ongoing submission of electronic reportable laboratory results from CEHRT to a public health agency for the entire EHR reporting period?

Yes No

EH core 15 – Syndromic Surveillance

Questionnaire (15 of 16)

 * Red asterisk indicates a required field.

Objective: Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.

Exclusion: Any eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective:

- 1) the eligible hospital or CAH does not have an emergency or urgent care department;
- 2) the eligible hospital or CAH operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period;
- 3) the eligible hospital or CAH operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or
- 4) the eligible hospital or CAH operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.

* Does this exclusion apply to you?

Yes No

* Select all exclusions that apply to you. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

- the eligible hospital or CAH is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting does not have an emergency or urgent care department
- the eligible hospital or CAH operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period
- the eligible hospital or CAH operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data
- the eligible hospital or CAH operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.

* Does this exclusion apply to you?

Yes No

Complete the following information:

* Do you have successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period?

Yes No

EH Core 16 – Protect Health Records

Questionnaire (16 of 16)

 * Red asterisk indicates a required field.

Objective: Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(l), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process at §495.6(l)(15) (ii).

Placeholder for help text regarding the security questionnaire. Help text is configurable for each client and is hidden by default.

Complete the following information:

* Have you conducted or reviewed a security risk analysis in accordance with the requirements?

Yes No

EH Menu Objectives

Below are examples of how the EH Menu objectives look on the SLR. More information on Core Objectives, refer to page 59 of this manual.

EH Menu Objective – Advanced Directives

Questionnaire (X) of (Y)

 * Red asterisk indicates a required field.

Objective: Record whether a patient 65 years old or older has an advance directive.

Measure: More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.

Exclusion: Any eligible hospital that admits no patients age 65 years old or older during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.

* Does this exclusion apply to you?

Yes No

Complete the following information:

Numerator = The number of patients in the denominator who have an indication of an advance directive status entered using structured data.

Denominator = Number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.

Numerator:

Denominator:

EH Menu Objective – Record Electronic Notes

Questionnaire ({X} of {Y})

 * Red asterisk indicates a required field.

Objective: Record electronic notes in patient records.

Measure: Enter at least one electronic progress note created, edited, and signed by an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) for more than 30% of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department during the EHR reporting period. Electronic progress notes must be text-searchable. Non-searchable notes do not qualify, but this does not mean that all of the content has to be character text. Drawings and other content can be included with searchable text notes under this measure.

Complete the following information:

Numerator = The number of unique patients in the denominator who have at least one progress note from an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) recorded as text-searchable data.

Denominator = Number of unique patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

EH Menu Objective – Imaging Results

Questionnaire ({X} of {Y})

 * Red asterisk indicates a required field.

Objective: Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.

Measure: More than 10% of all tests whose result is one or more images ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period are accessible through CEHRT.

Complete the following information:

Numerator = The number of results in the denominator that are accessible through CEHRT.

Denominator = Number of tests whose result is one or more images ordered by an authorized provider on behalf of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

Numerator:

Denominator:

EH Menu Objective – Family History

Questionnaire (X of Y)

 * Red asterisk indicates a required field.

Objective: Record patient family health history as structured data.

Measure: More than 20% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives.

Complete the following information:

Numerator = The number of patients in the denominator with a structured data entry for one or more first-degree relatives.

Denominator = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period..

Numerator:

Denominator:

EH Menu Objective – Electronic Lab Results

Questionnaire (X of Y)

 * Red asterisk indicates a required field.

Objective: Provide structured electronic lab results to ambulatory providers.

Measure:

- Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20% of electronic lab orders received.
- Hospital labs send structured electronic lab results to the ordering provider for more than 20% of lab orders received.