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

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

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https://www.azepip.gov/
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Disclaimer

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

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


Important Notice – Third Party Attestation

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

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

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

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

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

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

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

Eligible to Participate:
Providers under the AHCCCS Medicaid program are eligible to participate in the Arizona EHR Incentive Program if they meet the program’s requirements. For detailed information, visit [AHCCCS website](https://www.azepip.gov/)

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

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

Additionally, Medicaid EPs must also:
- Have a minimum of 30% Medicaid patient volume
- Have a minimum of 20% or 30% patient volume for Pediatrics, OR
- Practice predominantly in a FQHC/RHC and have at least 30% patient volume attributed to needy individuals

**NOTES:** EPs may NOT be hospital-based. This is defined as any provider who furnishes 90% or more of their services in a hospital setting (inpatient or emergency department). Practice predominantly is defined as any provider who furnishes over 50% of their services over a 6-month period at a FQHC/RHC facility.

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

Go to the ePIP System by [clicking here](https://www.azepip.gov/).
Welcome to the ePIP System Home Page

AHCCCS EHR Electronic Provider Incentive Payment (ePIP) System

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

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

Your ePIP account is where you interface with the system to maintain your EHR Incentive Program information and track your incentive payments.

If you have not already registered with CMS and have not obtained a CMS Registration ID, click here to find out about registering with CMS.

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

The Centers for Medicare & Medicaid Services (CMS) governs Electronic Health Records (EHR) Incentive Programs. For more information please see the CMS.gov EHR Incentive Programs.

ePIP Program Announcements

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

Beginning in 2011, the Electronic Health Records (EHR) Incentive Programs were developed to encourage eligible professionals and eligible hospitals to adopt, implement, upgrade (AU), and demonstrate meaningful use of certified EHR technology.

- The program is administered voluntarily by states and territories, and will pay incentives through 2021. Eligible professionals are eligible for incentive payments for 6 years, and participation years do not have to be consecutive.
- The last year that an eligible professional can begin participation is 2016. Incentive payments for eligible professionals under the Medicaid EHR Incentive Payments Program are up to $38,531,750 over 6 years.
- Eligible professionals can receive an incentive payment for adopting, implementing, or upgrading (AU) certified EHR technology in their first year of participation. In subsequent years, eligible professionals can receive incentive payments for successfully demonstrating meaningful use.

What are Meaningful Use Stages?

Meaningful use requirements for 2017

Meaningful Use (MU) for Program Year 2017: EPs with systems certified with a 2014 CEHRT will be attesting to Modified Stage 2 Objectives:

1. Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.
2. Use clinical decision support to improve performance on high-priority health conditions.
3. Use computerized provider order entry for medications, laboratory, and radiology orders directly entered by any licensed health care professional who can enter orders into the electronic record per state, local, and professional guidelines.
4. Generate and transmit permissible prescriptions electronically (ebc).
5. The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.
6. Use clinical decision support from CEHRT to identify patient-specific education resources and provide those resources to the patient.
7. The EP provides patients the ability to view, download, and transmit their health information within 4 business days of the information being available to the EP.
8. Use secure electronic messaging to communicate with patients on relevant health information.
9. The EP is actively engaging with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

Starting with Program Year 2017, providers with systems that have a 2015 CEHRT will be eligible to attest (optional) to Stage 3 Objectives:

1. Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.
2. Generate and transmit permissible prescriptions electronically (ebc).
3. Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.
4. Use computerized provider order entry (CPOE) for medications, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.
5. The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.
6. Use CEHRT to engage with patients or their authorized representatives about the patient's care.
7. The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.
8. The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.

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

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

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

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

ePIP Program Announcement Update:

ePIP is accepting attestations for Program Year 2017 until August 31, 2018 (subject to CMS approval).
### Registration (Providers Without an ePIP Account)

#### ePIP New Account Creation / Registration Notice

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

Existing providers who have participated in the EHR Incentive Program in Arizona and received a payment are permitted to register to set-up an ePIP account.

#### User Agreement

- Identification / Verify Information / Register

#### Provider Incentive Payments User Agreement

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

#### User Electronic Funds Transfer (EFT) Records

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

#### Data Requirements

Please be prepared to provide the following information:

- National Provider Identifier (NPI)
- Tax Identification Number (TIN)
- CMS Registration ID (if obtained when registered with www.cms.gov)
- AHCCCS Provider Number (APN)
- CDI (For hospital only)

AHCCCS User Agreement Terms & Conditions:

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

I have reviewed and agree to the Terms & Conditions in the AHCCCS user agreement listed above.

#### Your NPI number can be verified at the following link:

https://nipregistry.cms.hhs.gov/registry/

### Regarding Providers without an ePIP Account:

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

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

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

You must agree by checking the box in order to proceed.
Use our EHR Document Library to navigate quickly to the Meaningful Use requirements.

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

For more information on the 2017 Program Requirements at CMS, [click here](https://www.azepip.gov/).
Providers who already have an ePIP account must log on in order to access their account.

If you forgot your password, you can reset your password by clicking the link below the Log On button.

*Please allow an hour for server to respond to your request.*

Go to the ePIP System by clicking here.

Need help? E-mail the EHR Incentive Program Team at EHRIncentivePayments@azahcccs.gov or call us at 602-417-4333.
The ePIP Account Welcome screen consists of six menu topics to navigate through the attestation.

1. Home

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

3. Attest

4. Contacts
   - EHR Team
   - Other AHCCCS Contacts

5. EHR Doc Library

6. Log Off

**ePIP Program Announcement Update:**

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

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

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

Let’s take a look at:

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

Manage My Account allows you to add an authorized secondary contact (optional).

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

TIP

Click Edit My Account to add or update an authorized secondary contact.
My Account page has six drop down navigation menus to help you manage your ePIP Account.

Let’s take a look at:

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

Manage My Account allows you to add an authorized secondary contact (optional).

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

Click Edit My Account to add or update an authorized secondary contact.
My Account – How to Manage My Password

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

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

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

Change Password

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

Let’s take a look at:
- Manage My Account
- Change My Password
- Modify My Security Questions
- Payments
- Manage Documents
- EHR Certificate Validation Tool

Change My Password allows you to modify your password at any time.

Enter your current password and then your new password.

TIP

Passwords must meet the complexity requirements displayed on the screen.
TIP

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

#### Payment Status History

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

**Example Data Only**

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

---

**TIP**

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

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

Payments allow you to view your payment history and processing status.
My Account – How to Manage My Documents

Example Data Only

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

Let’s take a look at:

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

Manage Documents allows you to upload your documentation that supports your attestation.

Click Create New to upload documents.

Tag your documents by selecting the appropriate label from the drop down list:

- **Attestation Year** – describes the program year for the document
- **Document Type** – describes the type of document you are uploading.

<table>
<thead>
<tr>
<th>Attestation Type</th>
<th>Attestation Year</th>
<th>File Name</th>
<th>Document Type</th>
<th>Memo</th>
<th>Size</th>
<th>Uploaded</th>
<th>Delete</th>
</tr>
</thead>
<tbody>
<tr>
<td>MU3</td>
<td>4</td>
<td>Letter of Intent to AHCCCS re MU 67-12-16.pdf</td>
<td>Other</td>
<td>Letter of intent proving group volume report was submitted prior to attestation</td>
<td>59.9</td>
<td>5/23/2017 11:13 AM</td>
<td></td>
</tr>
<tr>
<td>MU3</td>
<td>4</td>
<td>PT-Total Encounter QTR 4</td>
<td>Meaningful Use</td>
<td>Total encounters and unique patients during the measurement period</td>
<td>27.0</td>
<td>2/26/2017 2:54 PM</td>
<td></td>
</tr>
<tr>
<td>MU3</td>
<td>4</td>
<td>Summary_Report_OHM1006916 to 123116</td>
<td>Meaningful Use</td>
<td>OQM Report</td>
<td>37.5</td>
<td>2/26/2017 2:54 PM</td>
<td></td>
</tr>
<tr>
<td>MU3</td>
<td>4</td>
<td>Core Objective 100316 to 123116</td>
<td>Meaningful Use</td>
<td>Core Objectives Report</td>
<td>22.3</td>
<td>2/26/2017 2:54 PM</td>
<td></td>
</tr>
</tbody>
</table>
My Account – How to Manage My EHR Certification Number

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

CMS EHR Certification Validation
First find the CMS EHR Certification ID for your system using the instructions in the following CMS Link:

CMS EHR Incentive Program Web Site
Once obtained, enter your CMS EHR Certification ID into the CMS EHR Certification ID Validator below and click the "Verify Certification Number" button.

CMS EHR Certification ID Validator

CMS EHR Certification ID

Verify Certification Number

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

Let’s take a look at:

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

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

This Screen Shows Example Data Only

<table>
<thead>
<tr>
<th>Medicaid Payment Year</th>
<th>Program Year</th>
<th>CMS EHR Certification ID</th>
<th>Attestation Date</th>
<th>Attestation Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Year</td>
<td>2012</td>
<td>30000001SVGWEAS</td>
<td>3/26/2013</td>
<td>A1U</td>
</tr>
<tr>
<td>Second Year</td>
<td>2013</td>
<td>30000001SVGWEAS</td>
<td>9/30/2013</td>
<td>MU</td>
</tr>
<tr>
<td>Third Year</td>
<td>2014</td>
<td>A01301OSJ5BFEAH</td>
<td>7/15/2015</td>
<td>MU</td>
</tr>
<tr>
<td>Fourth Year</td>
<td>2016</td>
<td>1314E01QOS1WEAH</td>
<td>3/16/2017</td>
<td>MU</td>
</tr>
<tr>
<td>Fifth Year</td>
<td>2017</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Before Submission:

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

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

Click the Edit button to complete your attestation.

TIP

After Submission:

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

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

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

The Attest page is where you create your attestation & view your attestation activity.

Providers must attest if they want to participate in the program (maximum of 6 payments).

Please be sure to read the Meaningful Use Stage Review and the Data Requirements.

Providers must attest if they want to participate in the program (maximum of 6 payments).

Please be sure to read the Meaningful Use Stage Review and the Data Requirements.

Providers must attest if they want to participate in the program (maximum of 6 payments).

Please be sure to read the Meaningful Use Stage Review and the Data Requirements.
Attestation Instructions

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

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

Attest Options

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

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

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

Meaningful Use Stage Overview

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

Requirements for Meaningful Use Measures for EPs

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

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

Changes include:

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

Data Requirements

Please be prepared to provide the following information:

Medicaid Patient Volume

- Patient Volume Reporting Period (90 days)¹
- Hospital-Based Reporting Period (12 months)¹
- Patient Volume Methodology (Individual/Aggregate)²
- Total Patient Encounters
- Medicaid Patient Encounters [Medicaid Title XVI (Outpatient Hospital & Emergency Department)]
- Hospital-Based Patient Encounters [Medicaid Title XVI (Inpatient Hospital & Emergency Department)]

Notes:

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

Additional Requirement:

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

Needy Individual Patient Volume

- Patient Volume Reporting Period ¹
- Practice Predominantly Reporting Period ¹
- Patient Volume Methodology
- Total Patient Encounters
- Needy Individual Patient Encounters [Medicaid Title XVI (Outpatient Hospital & Emergency Department)]
- FQHC/RHC Facility Patient Encounters in Practice Predominantly Reporting Period
- Total Patient Encounters in Practice Predominantly Reporting Period

Notes:

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

Additional Requirement:

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

AIU Selection

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

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

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

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

This is where you will monitor your progress towards completion of your attestation.

Note that the ability to complete the steps on this page is sequential. You must complete the steps in sequence (top down) to access subsequent sections.

The supporting documentation must be uploaded after you complete each step.

Click the Begin button to complete each step.

Click the Continue button to finish a step.

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

Please make certain that your contact detail is always up to date.

You must first update your contact changes in the CMS Registration and Attestation System at the following Link: [Click Here](https://www.azepip.gov/)

Wait at least 48 hours for the information you modified in the CMS Registration and Attestation System to feed to your ePIP account.

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

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

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

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

Medicaid Patient Volume is an available option for all providers.

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

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

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

Note that inclusion of out of state patient encounters is optional in the numerator and slows the approval process since we must validate with the respective state(s).
Medicaid Patient Volume is the percentage of Medicaid Title XIX patient encounters in the reporting period.

Providers selecting this option must also demonstrate that they are not hospital-based.

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

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

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

The numerator is Medicaid Title XIX patient encounters only.

The denominator is All patient encounters [Medicaid and Non-Medicaid].
Report Hospital-Based Data Elements

Providers selecting Medicaid Patient Volume must demonstrate that they are not hospital-based.

The Hospital-based Reporting date is the 12-month period from the year prior to the program year.

Hospital-Based providers have 90% or more of their Medicaid Title XIX patient encounters in a hospital setting defined as:
- Inpatient Hospital [POS 21]
- Emergency Department [POS 23]

Providers may need to obtain patient encounter data from the hospital and should consider requesting it in advance.

Data to determine the Medicaid Hospital-Based includes all Place of Services.

Numerator is Medicaid Title XIX IP & ED patient encounters only [POS 21 & POS 23].

Denominator is All Medicaid Title XIX patient encounters [All Place of Services].
Report Needy Patient Volume Data Elements

### Report Patient Volume

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

### EP Total Patient Encounters

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

**Note:** Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for the rendering provider. The EP must report all Medicaid & Non-Medicaid places of services when reporting the above total (denominator).

### Arizona Encounters

<table>
<thead>
<tr>
<th>Arizona Encounters</th>
<th>90 days in year prior to Program Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Title XIX</td>
<td></td>
</tr>
<tr>
<td>CHIP Title XXI</td>
<td></td>
</tr>
<tr>
<td>Patients Paying Below Cost</td>
<td></td>
</tr>
<tr>
<td>Arizona Needy Individual Patient Encounters</td>
<td></td>
</tr>
</tbody>
</table>

**TIP**

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

The numerator is Needy Patient Encounters only.

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

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

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

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

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

Patient Volume Reporting dates must be a continuous 90-day period selected from the year prior to the program year.
Here is where you report your Medicaid out of state patient encounters for our Border States *(optional if you wish to include in the numerator)*.

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

---

**Note that inclusion of out of state patient encounters is optional in the numerator and slows the approval process since we must validate with the respective state(s).**
## Report Practice Predominantly Data Elements

#### Reporting Period

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

#### All Patient Encounters

| EP Total Patient Encounters (in Practice Predominantly Reporting Period) |   |

#### Practice Predominantly Encounters

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

---

**TIP**

Providers selecting Needy Patient Volume must demonstrate that they practiced predominantly in a FQHC, RHC or Tribal Clinic.

Practice Predominantly Reporting dates is a 6-month period from the year prior to the program year.

Practice predominantly providers have more than 50% of their patient encounters in a FQHC, RHC or Tribal Clinic.

Data to determine the Practice Predominantly includes all Place of Services.

Numerator is FQHC, RHC or Tribal Clinic patient encounters only [inside facility].

Denominator is for All Place of Services [inside & outside the facility].
Attestation Progress (After Patient Volume)

Note that as you complete each step:

☑ Column on the left changes from “Incomplete” to “Completed” status

☑ Column on the right changes from “Begin” to “Modify” designation.

Remember that each requirement task must be followed sequentially.

Click the Begin button to complete each step.

Click Continue button to finish a step.

Click Modify button to change information previously entered.
Attestation Information

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

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

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

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

Complete the number of unique patients in your EHR reporting period.
Program Year 2017 Flexibility Information

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

The rules for Stage 3 participation are:

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

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

Flexibility Selection

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

We encourage providers to review the details of Stage 3. Details can be found at CMS here.

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

Please Select a Stage for Program Year 2017:

- [ ] Attest to Modified Stage 2
- [ ] Attest to Stage 3
- Return to Attestation Progress

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

Rules for Stage 3 participation:

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

- Providers with technology certified for the 2015 Edition.

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

Flexibility:

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

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

Click one of the following buttons:

- [ ] Attest to Stage 2 Modified
- [ ] Attest to Stage 3

NOTE: Once a Stage is selected, it cannot be undone without the EHR Staff deleting your attestation (will cause re-work for the provider).
Note that as you complete each step:

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

Remember that each requirement task must be followed sequentially.

TIP

Click the Begin button to complete each step.

Click Continue button to finish a step.

Click Modify button to change information previously entered.
Meaningful Use Requirements for Program Year 2017 Stage 3

Meaningful Use Objectives for Stage 3 (Optional)

<table>
<thead>
<tr>
<th></th>
<th>Providers with systems certified with a 2015 CEHRT as of 12.31.2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.</td>
</tr>
<tr>
<td>2</td>
<td>Generate and transmit permissible prescriptions electronically (eRx)</td>
</tr>
<tr>
<td>3</td>
<td>Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.</td>
</tr>
<tr>
<td>4</td>
<td>Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.</td>
</tr>
<tr>
<td>5</td>
<td>The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.</td>
</tr>
<tr>
<td>6</td>
<td>Use CEHRT to engage with patients or their authorized representatives about the patient’s care.</td>
</tr>
<tr>
<td>7</td>
<td>The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.</td>
</tr>
<tr>
<td>8</td>
<td>The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.</td>
</tr>
</tbody>
</table>

Welcome to Stage 3

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

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

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

Please note there are no alternate exclusions or specifications available.

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

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

- Coordination of Care & Patient Engagement … You must meet thresholds for at least 2 of 3 measures
- Health Information Exchange… You must meet the thresholds for at least 2 of 3 measures
- Public Health Reporting … You must report on at least 2 of 3 measures.
Stage 3 Objective 1 Measure 1 Protected Health Information

Protected Health Information

Stage 3

Protected Health Information

☑ Measure 1

Complete all required fields.

You must upload your Security Risk Analysis Report documentation separately.

You must have completed the Security Risk Analysis in 2017.

CEHRT is “certified electronic health record technology”

The Navigation bar at the bottom will monitor your progress.

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 2 Measure 1 Electronic Prescribing

Electronic Prescribing (eRx)

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 3 Measure 1 Clinical Decision Support

Clinical Decision Support

☑ Measure 1

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.

TIP

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 3 Measure 2 Clinical Decision Support

Clinical Decision Support

☑ Measure 2

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 4 Measure 1 Computerized Provider Order Entry

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 4 Measure 2 Computerized Provider Order Entry

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 4 Measure 3 Computerized Provider Order Entry

Computerized Provider Order Entry - Measure 3 of 3

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

Measure Requirements:
More than 90 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

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

Measure Entry:
Exclusion: Any EP who orders fewer than 100 diagnostic imaging orders during the EHR reporting period.
* Does this exclusion apply to you?
- Yes ( ) No ( )

PATIENT RECORDS: Please select whether the data used to support this measure was extracted from all patient records or only from patient records maintained using certified EHR technology.
- This data was extracted from both paper records as well as records maintained using Certified EHR Technology (CEHRT).
- This data was extracted only from patient records maintained using certified EHR technology.

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

TIP

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 5 Measure 1 Patient Electronic Access

Meaningful Use Objective - Stage 2 for Program Year 2017
ePIP Measure 5.10 - CMS Meaningful Use Objective 5, Measure 1
Patient Electronic Access to Health Information - Measure 1 of 2

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

Measure Requirements:
For more than 90 percent of all unique patients seen by the EP:
1. The patient (or the patient authorized representative) is provided timely access to view, online, download, and transmit his or her health information.
2. The provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's EHR.

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

For detailed information about the Patient Electronic Access objective, please click here.

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

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

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

Measure Entry
Exclusion: An EP may exclude from the measure if they have no office visits during the EHR reporting period.
* Does this exclusion apply to you?
  (Y) Yes (N) No
Exclusion: Any EP that conducts 50 percent or more of its office visits in a county that does not have 50 percent or more of its housing units with wireline broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.
* Does this exclusion apply to you?
  (Y) Yes (N) No

**PATIENT RECORDS:** Please select whether the data used to support this measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology:
  (Y) This data was extracted from both paper records as well as records maintained using Certified EHR Technology (CEHRT).
  (N) This data was extracted only from patient records maintained using Certified EHR Technology

Complete the following information:
Numerator: The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.
Denominator: Number of unique patients seen by the EP during the EHR reporting period.
* Numerator:
* Denominator:

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

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

TIP
Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 5 Measure 2 Patient Electronic Access

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 6 Measure 1 Coordination of Care

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
### Stage 3 Objective 6 Measure 2 Coordination of Care

#### Measure Requirements:

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

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. ([Please Review before attesting to this measure](https://www.azepip.gov/)). For detailed information about the Coordination of Care through Patient Engagement objective, please [click here](https://www.azepip.gov/).

#### Supporting Documentation Requirements

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

(*) Red asterisk indicates a required field

(*) Gray asterisk indicates a conditionally required field

#### Measure Entry

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

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

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

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

Complete the following information:

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

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

#### TIP

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
### Stage 3 Objective 6 Measure 3 Coordination of Care

**Objective Details:**
- Coordination of Care through Patient Engagement - Measure 3 of 3

**Measure Requirements:**
- Patient generated health data or data from a non-clinical setting is incorporated into the EHR for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.

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

**Measure Entry**
- Red asterisk indicates a required field
- Gray asterisk indicates a conditionally required field

- **Exclusions:**
  - An EP may exclude from the measure if they have no office visits during the EHR reporting period.
  - Does this exclusion apply to you?
    - Yes
    - No

- **Exclusions:**
  - Any EP that conducts 50 percent or more of its in-person patient encounters in a county that does not have 50 percent or more of its housing units with 4Gbps broadband availability according to the latest information available from the FCC on the first day of the EHRM reporting period may exclude the measure.
  - Does this exclusion apply to you?
    - Yes
    - No

- **Complete the following information:**
  - Numerator: The number of patients in the denominator for whom data from non-clinical settings, which may include patient-generated health data, is captured through the EHR and entered into the patient record during the EHRM reporting period.
  - Denominator: Number of unique patients seen by the EP during the EHRM reporting period.

- **Meaningful Use Objectives - Navigation**

The Navigation bar at the bottom will monitor your progress.

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**TIP**

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 7 Measure 1 Health Information Exchange

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.

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

TIP

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 7 Measure 2 Health Information Exchange

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

TIP

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 7 Measure 3 Health Information Exchange

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

Measure Requirements:
For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. Provider must implement clinical information reconciliation for the following three clinical information fields:
1. Medication - Review of the patient's medication, including the name, dosage, frequency, and route of each medication.

The Centers for Medicare and Medicaid Services (CMS) provides documentation to guide you through the measure requirements for this particular objective. (Please Review before attesting to this measure)
For detailed information about the Health Information Exchange objective, please click here
Note: (Please Review before attesting to this measure) For more information regarding the Health Information Exchange objective, please click here

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

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

Measure Entry:
Exclusions: Any EP for whom the total of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, is fewer than 100 during the EHR reporting period is excluded from this measure.
* Does this exclusion apply to you?
○ Yes ○ No

[Diagram of EHR system]

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

Tip
Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 8 Measure 1 Public Health Reporting

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

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

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

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

**Supporting Documentation Requirements**
The Public Health Objective Measures require supporting documentation to be uploaded. The link for uploading this documentation will appear on the "Attestation Progress" page as a required step in the attestation process. Please provide supporting documentation outlining your active engagement with the Immunization Registry. If you are choosing one of the available exclusions, please provide documentation to support your exclusion choice.

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

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

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

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

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

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

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

Complete the following information:

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

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 8 Measure 2 Public Health Reporting

Meaningful Use Objectives - Stage 3 for Program Year 2017
ePIP Measure 7 of 17 - CMS Meaningful Use Objective 8, Measure 2
Public Health and Clinical Data Registry Reporting - Measure 2 of 4

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

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

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

For detailed information about the Public Health and Clinical Data Registry Reporting objective, please click here

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

Supporting Documentation Requirements:
The Public Health Objective Measures require supporting documentation to be uploaded. The link for uploading this documentation will appear on the ‘Attestation Progress’ page as a required step in the attestation process.
Please provide supporting documentation outlining your active engagement with the Syndromic Surveillance Registry. If you are choosing one of the available exclusions please provide documentation to support your exclusion choice.

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

Measure Entry
Exclusions: Is not in a category of providers from which syndromic surveillance data is collected by their jurisdiction’s syndromic surveillance system.

* Does this exclusion apply to you?

☐ Yes ☐ No

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

* Does this exclusion apply to you?

☐ Yes ☐ No

Exclusions: Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs as of 5 months prior to the start of the EHR reporting period.

* Does this exclusion apply to you?

☐ Yes ☐ No

Complete the following information:

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

☐ Yes ☐ No

The Navigation bar at the bottom will monitor your progress.

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
### Stage 3 Objective 8 Measure 3 Public Health Reporting

<table>
<thead>
<tr>
<th>Public Health and Clinical Data Registry Reporting</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective</strong></td>
<td>Starting January 1, 2018 <em>(no applicadtoin to 2017 attestations)</em></td>
</tr>
<tr>
<td><strong>Measure</strong></td>
<td>Measure 3 Electronic Case Reporting</td>
</tr>
<tr>
<td><strong>Objective</strong></td>
<td>The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.</td>
</tr>
<tr>
<td><strong>Measure Options</strong></td>
<td>The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>Any EP meeting one or more of the following criteria may be excluded from the case reporting measure if the EP—</td>
</tr>
<tr>
<td></td>
<td>o Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction’s reportable disease system during the EHR reporting period;</td>
</tr>
<tr>
<td></td>
<td>o Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</td>
</tr>
<tr>
<td></td>
<td>o Operates in a jurisdiction where no public health agency has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the EHR reporting period.</td>
</tr>
<tr>
<td><strong>Action Required</strong></td>
<td>No Action Required for Program Year 2017.</td>
</tr>
</tbody>
</table>

TIP

*ePIP will not reflect this objective for Program Year 2017.*

Stage 3 Public Health Reporting

☑ Measure 3

Electronic Case Reporting is not required until 2018, since we believe that the standards will be mature and that jurisdictions will be able to accept these types of data by that time.
Stage 3 Objective 8 Measure 4 Public Health Reporting

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

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

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

Notes:
(*) Red asterisk indicates a required field
(?) Grey asterisk indicates a conditionally required field

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

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

Exclusion: Operates in a jurisdiction where no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CENHR requirements.

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

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

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

Complete the following information:

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

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Stage 3 Objective 8 Measure 5 Public Health Reporting

Meaningful Use Objective - Stage 3 for Program Year 2017
ePIP Measure 19 of 39 - CMS Meaningful Use Objective 8, Measure 5
Public Health and Clinical Data Registry Reporting - Measure 4 of 4

Objective Details:

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

Measure Requirements:

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

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

For detailed information about the Public Health and Clinical Data Registry Reporting objective, please click here

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

Supporting Documentation Requirements:

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

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

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

Measure Details:

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

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

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

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

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

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

Complete the following information:

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

TIP

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
Attestation Progress (After Objective Measures)

Instructions

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

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

TIP

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

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

Click the Begin button to complete each step.

Click Continue button to finish a step.

Click Modify button to change information previously entered.
### Clinical Quality Measures

#### Meaningful Use Clinical Quality Measures

<table>
<thead>
<tr>
<th>National Quality Strategy (NQS) Domains</th>
<th>Number CQMs Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Person and Caregiver-Centered Experience and Outcomes</td>
<td>4</td>
</tr>
<tr>
<td>2 Patient Safety</td>
<td>5</td>
</tr>
<tr>
<td>3 Communication and Care Coordination</td>
<td>1</td>
</tr>
<tr>
<td>4 Community/Population Health</td>
<td>9</td>
</tr>
<tr>
<td>5 Efficiency and Cost Reduction</td>
<td>4</td>
</tr>
<tr>
<td>6 Effective Clinical Care</td>
<td>30</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

---

**TIP**

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

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

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 157v5 / NOF 0384 - Oncology; Medical and Radiation – Pain Intensity Quantified</td>
<td>Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified</td>
<td></td>
</tr>
<tr>
<td>CMS 60v5 - Functional Status Assessment for Total Knee Replacement</td>
<td>Percentage of patients 18 years of age and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up patient-reported functional status assessments</td>
<td></td>
</tr>
<tr>
<td>CMS 50v5 - Functional Status Assessment for Hip Replacement</td>
<td>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</td>
<td></td>
</tr>
<tr>
<td>CMS 90v6 - Functional Status Assessment for Complex Chronic Conditions</td>
<td>Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments</td>
<td></td>
</tr>
</tbody>
</table>

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

TIP

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

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

4 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.
### Patient Safety

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

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**TIP**

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

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

---

5 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.
## Clinical Quality Measures for Communication and Care Coordination

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 50v5 - Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred</td>
<td></td>
</tr>
</tbody>
</table>

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

1 of 53 CQMs is available under this domain.

The Navigation bar at the bottom will monitor your progress.

---

**TIP**

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

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

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
</table>
| CMS 155v5 \ NOF 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 |  
| CMS 138v5 \ NOF 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. |  
| CMS 153v5 \ NOF 0033 - Chlamydia Screening for Woman | 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. |  
| CMS 117v5 \ NOF 0038 - Childhood Immunization Status | Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polo (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. |  
| CMS 147v6 \ NOF 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. |  

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

9 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

---

**TIP**

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

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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 787</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan&lt;br&gt;Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.</td>
</tr>
<tr>
<td>CMS 69v5</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up&lt;br&gt;Percentage of patients aged 18 years and older with an encounter during the reporting period with a documented calculated BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, follow-up plan is documented during the encounter or during the previous 6 months of the encounter with the BMI outside of normal parameters. Normal Parameters: Age 65 years and older BMI ≥ 23 and &lt; 30 Age 18-64 years BMI ≥ 18.5 and &lt; 25.</td>
</tr>
<tr>
<td>CMS 82w4</td>
<td>Maternal depression screening&lt;br&gt;The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child’s first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.</td>
</tr>
<tr>
<td>CMS 22w5</td>
<td>Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented&lt;br&gt;Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.</td>
</tr>
</tbody>
</table>

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

9 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

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

Click the hyperlink on the ePIP screen to learn more about this requirement.
### Efficiency and Cost Reduction

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

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

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

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

4 of 53 CQMs are available under this domain.

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

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 137v5 \ NQF 0004 - Initiation and engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>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. 1) Percentage of patients who initiated treatment within 14 days of the diagnosis. 2) Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.</td>
<td></td>
</tr>
<tr>
<td>CMS 165v5 \ NQF 0018 - Controlling High Blood Pressure</td>
<td>Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90mmHg) during the measurement period.</td>
<td></td>
</tr>
<tr>
<td>CMS 125v5 - Breast Cancer Screening</td>
<td>Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.</td>
<td></td>
</tr>
<tr>
<td>CMS 124v5 \ NQF 0032 - Cervical Cancer Screening</td>
<td>Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.</td>
<td></td>
</tr>
<tr>
<td>CMS 130v5 \ NQF 0034 - Colorectal Cancer Screening</td>
<td>Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.</td>
<td></td>
</tr>
<tr>
<td>CMS 127v5 \ NQF 0043 - Pneumonia Vaccination Status for Older Adults</td>
<td>Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.</td>
<td></td>
</tr>
<tr>
<td>CMS 131v5 \ NQF 0055 - Diabetes: Eye Exam</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Effective Clinical Care

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

30 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.
### Clinical Quality Measures for Effective Clinical Care cont’d.

<table>
<thead>
<tr>
<th>CMS</th>
<th>NQF</th>
<th>Domain</th>
<th>Description</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 123v5</td>
<td>NQF 0056</td>
<td>Diabetes: Foot Exam</td>
<td>Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.</td>
<td>[ ]</td>
</tr>
<tr>
<td>CMS 122v5</td>
<td>NQF 0099</td>
<td>Diabetes: Hemoglobin A1c Poor Control</td>
<td>Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period.</td>
<td>[ ]</td>
</tr>
<tr>
<td>CMS 134v5</td>
<td>NQF 0062</td>
<td>Diabetes: Urine Protein Screening</td>
<td>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.</td>
<td>[ ]</td>
</tr>
<tr>
<td>CMS 164v5</td>
<td>NQF 0068</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic</td>
<td>Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.</td>
<td>[ ]</td>
</tr>
<tr>
<td>CMS 145v5</td>
<td>NQF 0070</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF &lt;40%)</td>
<td>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 &lt;40% who were prescribed beta-blocker therapy.</td>
<td>[ ]</td>
</tr>
<tr>
<td>CMS 135v5</td>
<td>NQF 0081</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
<td>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) &lt; 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.</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

**Effective Clinical Care**

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

30 of 53 CQMs are available under this domain.

The Navigation bar at the bottom will monitor your progress.

---

**TIP**

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

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

### ePIP Attestation Guide

**https://www.azepip.gov/**

Clinical Quality Measures for Effective Clinical Care cont’d.

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Applicable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 144v5</td>
<td>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) &lt; 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.</td>
<td>No</td>
</tr>
<tr>
<td>CMS 143v5</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months.</td>
<td>No</td>
</tr>
<tr>
<td>CMS 167v5</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed 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.</td>
<td>No</td>
</tr>
<tr>
<td>CMS 142v5</td>
<td>Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.</td>
<td>No</td>
</tr>
<tr>
<td>CMS 161v5</td>
<td>Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.</td>
<td>No</td>
</tr>
<tr>
<td>CMS 129v5</td>
<td>Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported. 1) Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). 2) Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).</td>
<td>No</td>
</tr>
</tbody>
</table>

**Effective Clinical Care**

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Clinical Quality Measures for Effective Clinical Care cont’d.

<table>
<thead>
<tr>
<th>CQM 136v9 \ NQF 0108 - ADHD: Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 169v5 - Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use</td>
<td>Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.</td>
</tr>
<tr>
<td>CMS 52v5 \ NQF 0405 - HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis</td>
<td>Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.</td>
</tr>
<tr>
<td>CMS 133v5 \ NQF 0565 - Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery</td>
<td>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.</td>
</tr>
<tr>
<td>CMS 150v5 - Pregnant women that had HBsAg testing</td>
<td>This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.</td>
</tr>
<tr>
<td>CMS 159v5 \ NQF 0710 - Depression Remission at Twelve Months</td>
<td>Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score &gt; 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.</td>
</tr>
</tbody>
</table>

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

TIP

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

Effective Clinical Care

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

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### Clinical Quality Measures for Effective Clinical Care cont’d

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

---

**Effective Clinical Care**

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

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---

**TIP**

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

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

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

Section I Activities to demonstrate Certified EHR Technology objectives & associated measures (mandatory).
Section II Activities to support Performance of Certified EHR Technology (mandatory).
Section III Activities to support Surveillance of Certified EHR Technology (optional).
Section IV Activities to support Health Information Exchange and Prevention of Information Blocking (mandatory).

Click the Box next to each item to confirm the statement is true (Section III is optional).
Click the Agree button to signify your agreement with the statements.
Click the Disagree button to signify your disagree with the statements (exit attestation).
## Payment Reassignment

### Payment Assignment Agreement

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Payment Information</td>
<td></td>
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<tr>
<td>Payment No.</td>
<td></td>
</tr>
<tr>
<td>Program Year</td>
<td>2017</td>
</tr>
<tr>
<td>Payee TIN</td>
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</tr>
<tr>
<td>Payee Name</td>
<td></td>
</tr>
<tr>
<td><em>Employer</em></td>
<td></td>
</tr>
</tbody>
</table>

**Home Address:**

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

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Address</td>
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<td>Suite #</td>
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<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip Code</td>
<td></td>
</tr>
</tbody>
</table>

**Payment Assignment Disclaimer**

- **Notice:** An Eligible Professional (EP) may only assign incentive payments to the fee-earner or in an entity with whom the EP has a contractual arrangement allowing the fee-earner or entity to bill and receive payment for the EP's services.
- All reported tax statements, including Form 1099 regarding miscellaneous income, will be sent to the payer listed above.

- **By checking the box above, I certify that the fee-earner listed above is either myself, my employer, or an entity with which I have a contractual arrangement allowing the fee-earner or entity to bill and receive payment for my professional services.**

### Important Information: UFR Reporting for Eligible Recipients

The AHCCCS has established written guidelines regarding UFR reporting for the EP's incentive payments. Please note that providers may have UFR incentives payments reported to the IRS whether or not they assign the payments to another entity. Revenue issues fall under IRS jurisdiction, AHCCCS cannot offer advice or assistance on this issue. Any questions pertaining to this matter should be referred to your accountant and/or attorney.

UFR Reporting for Eligible Recipients

### TIP

Any reassignment of payment must be voluntary and the decision as to whether an EP reassigns the incentive payment to a specific TIN is an issue which EPs and these other parties should resolve.

**TIP**

Any reassignment of payment must be consistent with applicable laws, rules, and regulations, including, without limitation, those related to fraud, waste and abuse.

---

You must confirm your employer at the time of attestation and enter your home address if you are not reassigning your payment.

To prevent improper payments, this information will be used to verify your Payee information prior to disbursement of payment.

Note: Only the provider has authority to re-assign the payment.
Attestation Disclaimer

Step 1
You must first read the Attestation Disclaimer.
- Attestation Notification
- Routine Uses
- Disclosures
- Attestation Disclaimer

Step 2
You must click the Box to confirm your agreement with the Attestation Disclaimer notice.

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

Attestation Disclaimer

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

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

Routine Uses(s)

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

Disclosures

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

Attestation Disclaimer

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

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

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

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

☐ I agree to notify the State if I believe that I have been overpaid under the Medicaid EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 6402, Section 11235, provides penalties for withholding this information.

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

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

Submit Attestation  Cancel
You will receive a submission receipt after you successfully submit your attestation. The notice will include the following:

- **Attestation Confirmation Number**
- **Provider’s Name**
- **EHR Reporting Period (MU)**
- **Attestation Date**

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

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

Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

The Medicaid Patient Volume calculation using all places of services is:
• Numerator: Medicaid Title XIX Patient Encounters
• Denominator: All Patient Encounters [Medicaid + Non-Medicaid]
  ➔ Non-Medicaid includes CHIP Title XXI (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, Sliding Scale, etc.

Reporting Period is a continuous 90-day period in the prior calendar year.

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

*Correctional Facility is a practice location for providers rendering care to inmates in a prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. NOTE: Incarceration & Release Date must be included in your report.
Appendix B – Medicaid Hospital-Based Report Layout

Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

The Medicaid Hospital-Based calculation using all Medicaid Title XIX places of service only is:
- **Numerator:** Medicaid Title XIX Hospital-Based Patient Encounters [Place of Service 21 & 23 Only]
- **Denominator:** All Medicaid Title XIX Patient Encounters [All Place of Services]

Reporting Period is a continuous 12-month period in the prior calendar year.

<table>
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<tr>
<th>Description</th>
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</thead>
<tbody>
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<tr>
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<td>Patient Name</td>
<td>Alpha</td>
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<tr>
<td>Payer Financial Class</td>
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<tr>
<td>Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.</td>
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</tr>
<tr>
<td>Correctional Facilities: Use Medicaid or Non-Medicaid description</td>
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<tr>
<td>Payer Name (if applicable specify Health Plan Name)</td>
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<td>Payer Medicaid/CHIP Coordination of Benefits</td>
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<tr>
<td>For Medicaid Title XIX: Enter Medicaid Primary, Medicaid Secondary, Medicaid Tertiary, etc.</td>
<td>Alpha</td>
</tr>
<tr>
<td>For CHIP (KidsCare) Title XXI: Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.</td>
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</tr>
<tr>
<td>Place of Service (POS) Codes (include all Place of Services)</td>
<td>Alpha or Numeric</td>
</tr>
<tr>
<td>Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.</td>
<td>Alpha or Numeric</td>
</tr>
<tr>
<td>Rendering/Servicing Provider Name</td>
<td>Alpha</td>
</tr>
<tr>
<td>Visit Count - Numerator (Enter 1 = unique visit; 0 = duplicate visit)</td>
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Appendix C – Needy Patient Volume Report Layout

Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

The Needy Patient Volume calculation using **all** places of services is:

- **Numerator (Needy Patient Encounters):**
  - Needy includes Medicaid Title XIX, CHIP Title XXI (KidsCare) & Patients Paying Below Cost (Sliding Scale)

- **Denominator:** All Patient Encounters [Needy + Non-Needy]
  - Non-Needy includes Medicare, Private Insurance, Self-Pay, Commercial, etc.

Reporting Period is a continuous 90-day period in the prior calendar year.

<table>
<thead>
<tr>
<th>Description</th>
<th>Field Format</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
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<td>Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.</td>
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<tr>
<td>Correctional Facilities: Use Medicaid or Non-Medicaid description</td>
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<tr>
<td>Payer Name <em>(if applicable specify Health Plan Name)</em></td>
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<td>For Medicaid Title XIX: Enter Medicaid Primary, Medicaid Secondary, Medicaid Tertiary, etc.</td>
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<tr>
<td>For CHIP (KidsCare) Title XXI: Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.</td>
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<tr>
<td>Place of Service (POS) Codes <em>(include all Place of Services)</em></td>
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<tr>
<td>Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.</td>
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</tr>
<tr>
<td>Rendering/Servicing Provider Name</td>
<td>Alpha</td>
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<tr>
<td>Visit Count - Numerator <em>(Enter 1= unique visit; 0 = duplicate visit)</em></td>
<td>Numeric</td>
</tr>
<tr>
<td>Visit Count - Denominator <em>(Enter 1= unique visit; 0 = duplicate visit)</em></td>
<td>Numeric</td>
</tr>
</tbody>
</table>
Appendix D – Needy Practice Predominantly Report Layout

Patient Encounters are measured by counting unique visits based on date of service per provider per patient. Multiple claims for the same patient on the same day are counted as one visit for each rendering provider.

The Practice Predominantly calculation using all places of services is:
- Numerator: All FQHC/RHC/Tribal Clinic Patient Encounters [Place of Services inside facility only]
- Denominator: All Total Patient Encounters [All Place of Services inside & outside facility]

Reporting Period is a continuous 6-month period in the prior calendar year.

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
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<tr>
<td>Patient Insurance ID (AHCCCS Member ID or Other Member ID)</td>
<td>Alpha or Numeric</td>
</tr>
<tr>
<td>Patient Name</td>
<td>Alpha</td>
</tr>
<tr>
<td>Payer Financial Class</td>
<td>Alpha</td>
</tr>
<tr>
<td>Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.</td>
<td>Alpha</td>
</tr>
<tr>
<td>Correctional Facilities: Use Medicaid or Non-Medicaid description</td>
<td>Alpha</td>
</tr>
<tr>
<td>Payer Name (if applicable specify Health Plan Name)</td>
<td>Alpha</td>
</tr>
<tr>
<td>Payer Health Plan ID / Site ID (Medicaid or CHIP)</td>
<td>Numeric</td>
</tr>
<tr>
<td>Payer Medicaid/CHIP Coordination of Benefits</td>
<td>Alpha</td>
</tr>
<tr>
<td>Φ For Medicaid Title XIX: Enter Medicaid Primary, Medicaid Secondary, Medicaid Tertiary, etc.</td>
<td>Alpha</td>
</tr>
<tr>
<td>Φ For CHIP (KidsCare) Title XXI: Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.</td>
<td>Alpha</td>
</tr>
<tr>
<td>Place of Service (POS) Codes (include all Place of Services)</td>
<td>Alpha or Numeric</td>
</tr>
<tr>
<td>Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.</td>
<td></td>
</tr>
<tr>
<td>Rendering/Servicing Provider Name</td>
<td>Alpha</td>
</tr>
<tr>
<td>Visit Count - Numerator (Enter 1 = unique visit; 0 = duplicate visit)</td>
<td>Numeric</td>
</tr>
<tr>
<td>Visit Count - Denominator (Enter 1 = unique visit; 0 = duplicate visit)</td>
<td>Numeric</td>
</tr>
</tbody>
</table>
## Appendix E – Definitions

### Attestation

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

### Electronic Health Record (EHR)

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

### Eligible Professionals (EP)

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

### ePIP

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

### Meaningful Use

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

### Meaningful Use Exclusion

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

### Meaningful Use Exemption

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

### Meaningful Use Stages

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

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

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

### Patient Volume Methodology

Method in which an EP reports his/her patient encounters. Individual is the sum of patient encounters for a single EP.

Aggregate is the sum of patient encounters for the entire practice (includes all providers).

### Program Year

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

### Registration

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

<table>
<thead>
<tr>
<th>Q1</th>
<th>Can I switch between Medicare and Medicaid programs?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Providers can switch between the Medicare and Medicaid programs any time before they receive their first incentive payment. Eligible Professionals can switch one time (before 2015) between the Medicare and Medicaid Incentive Programs if they have received one incentive payment.</td>
</tr>
</tbody>
</table>

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

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

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

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

<table>
<thead>
<tr>
<th>Q6</th>
<th>How often do I need to Register?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You need to Register <em>once</em> in order to participate in the EHR Incentive Program. Thereafter, you must keep your registration information updated in each system. When updating information in your CMS registration, make sure that you “re-submit” your Registration information and allow 24 – 48 hours to feed to ePIP. Each time you attest, it is recommended that you review and update the “Contact Information” in both systems as needed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q7</th>
<th>I registered in the CMS Registration &amp; Attestation System but my registration is still showing ‘Send for State Approval’. How can I troubleshoot the problem?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>After completing the registration in the CMS Registration and Attestation System, allow 24 to 48 hours for your registration information to transfer from that system to Arizona’s Electronic Provider Incentive Payment System (ePIP). If your CMS registration status shows ‘<em>Sent for State Approval</em>’, please send an inquiry to Medicaid at <a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a> for assistance. <strong>If your CMS registration status shows ‘Registration Started/Modified/In Progress’, please re-submit your CMS registration.</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Q9</th>
<th>I previously received an EHR payment from another Medicaid State and have since moved to Arizona. Can I continue to participate in the program?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes, you can continue to participate in the Arizona Medicaid EHR Incentive Program. First you must update your changes in the CMS Registration &amp; Attestation System and then register in the State’s Registration &amp; Attestation System to create your ePIP account.</td>
</tr>
</tbody>
</table>
### Q10

I am ready to start a new attestation but I do not see that option when I log in to ePIP. What are the possible reasons for such?

- If a payment decision has not been issued for the prior Program Year in which you attested, you cannot begin a new Program Year attestation.
- If your previous attestation was denied or rejected, you may need to have your attestation refreshed.
- In any instance if you cannot start a new Program Year, please email the EHR Incentive Program team at EHRIncentivePayments@azahcccs.gov.

### Q11

How do I know if my electronic health record (EHR) system is certified?

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a set of standards and certification criteria.

EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) in order to qualify for incentive payments. The Certified Health IT Product List (CHPL) is available at http://www.healthit.hhs.gov/CHPL. Providers must maintain the proper certification requirements & submit the required documentation to demonstrate that their EHR technology is properly certified.

### Q12

How do we submit documentation to support the attestation?

ePIP is the State’s repository for storing your attestation information. Providers are required to upload their documentation at the time of attestation. Passwords should follow standard operating procedures to prevent access to your ePIP accounts.

The ePIP website, https://www.azepip.gov/, has a Hypertext Transfer Protocol Secure (HTTPS) feature which has a built in communications protocol for secure communication over a computer network. Therefore, documents uploaded to ePIP are secure and encrypted.

### Q13

How can I change my attestation information after I have attested for the Medicaid EHR Incentive Program?

If you discover that the information you entered during your Medicaid attestation was not complete and accurate for some reason, please email Medicaid at EHRIncentivePayments@azahcccs.gov.
### Q14  What is the deadline for Medicaid Eligible Professionals to submit attestations for Program Year 2017?

Eligible Professionals participate in the Medicaid EHR Incentive Programs on a calendar year basis. Generally, the Medicaid attestation deadline is 90-days following the end of the calendar year. At this time, the deadline for Program Year 2017 has been extended to **December 31, 2018**.

### Q15  What are the reporting periods for Eligible Professionals participating in the electronic health record (EHR) Incentive Program?

For Program Year 2017, the reporting periods are as follows:

**Volume (select a period from 2016):**
- Patient Volume - a continuous 90-day period in the prior calendar year
- Hospital-Based - a 12-month period in the prior calendar year
- Practice Predominantly - continuous 6-month period in the prior calendar year

**Meaningful Use (select a period from 2017):**
- The EHR reporting period for the Meaningful Use Objectives & the Clinical Quality Measures is a continuous 90-day period within the calendar year.

### Q16  Under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, who is responsible for demonstrating meaningful use of certified EHR technology, the provider or the vendor?

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

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

Providers who have a Medicare patient population and have not attested to Meaningful Use will have a reduction in Medicare payments. Providers that do not serve Medicare members are not penalized if they do not attest or if they withdraw from the Medicaid EHR Incentive Program after receiving an incentive payment.
# Appendix F – Frequently Asked Questions regarding Payment

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

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

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

<table>
<thead>
<tr>
<th>Q21</th>
<th>Are payments from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs subject to federal income tax?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>We note that nothing in the Act excludes such payments from taxation or as tax-free income. Therefore, it is our belief that incentive payments would be treated like any other income. Providers should consult with a tax advisor or the Internal Revenue Service regarding how to properly report this income on their filings.</td>
</tr>
</tbody>
</table>

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

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

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

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

**Attn:** AHCCCS Finance MD 5400, P.O. Box 25320, Phoenix, AZ 85029

#### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Complete legal name of institution, corporate entity, practice or individual provider</td>
<td>Required</td>
</tr>
<tr>
<td>Doing Business As Name (DBA)</td>
<td>The trade name, or fictitious business name under which the business or organization is conducted and presented to the world</td>
<td>Optional</td>
</tr>
<tr>
<td>Provider Address</td>
<td>The number and street name where a person or organization can be found</td>
<td>Required</td>
</tr>
<tr>
<td>City</td>
<td>City associated with provider address field</td>
<td>Required</td>
</tr>
<tr>
<td>State/Province</td>
<td>2 Character Code associated with the State/Province/Region of the applicable Country</td>
<td>Required</td>
</tr>
<tr>
<td>Zip Code/Postal Code</td>
<td>5 or 9 Character Code</td>
<td>Required</td>
</tr>
</tbody>
</table>

#### PROVIDER IDENTIFIERS INFORMATION

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

#### PROVIDER CONTACT INFORMATION

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

#### PROVIDER AGENT INFORMATION - IF APPLICABLE

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Agent Name</td>
<td>Name of provider’s authorized agent</td>
<td>Required</td>
</tr>
<tr>
<td>Agent Address</td>
<td></td>
<td>Optional</td>
</tr>
<tr>
<td>Street</td>
<td>The number and street name where a person or organization can be found</td>
<td>Required</td>
</tr>
<tr>
<td>City</td>
<td>City associated with provider address field</td>
<td>Required</td>
</tr>
<tr>
<td>State/Province</td>
<td>2 Character Code associated with the State</td>
<td>Required</td>
</tr>
<tr>
<td>Zip Code/Postal Code</td>
<td>5 or 9 Character Code</td>
<td>Required</td>
</tr>
<tr>
<td>Provider Agent Contact Name</td>
<td>Name of a contact in agent office for handling EFT issues</td>
<td>Required</td>
</tr>
<tr>
<td>Tel Number</td>
<td>Number associated with contact person Numeric, 10 digits</td>
<td>Required</td>
</tr>
<tr>
<td>Tel Number Ext</td>
<td></td>
<td>Optional</td>
</tr>
<tr>
<td>Email Address</td>
<td>An electronic mail address at which AHCCCS might contact the provider</td>
<td>Required</td>
</tr>
<tr>
<td>Fax Number</td>
<td>A number at which the provider can be sent facsimile</td>
<td>Optional</td>
</tr>
</tbody>
</table>
### Appendix G – Electronic Funds Transfer ACH Form Instructions (continued)

#### FINANCIAL INSTITUTION INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Required/Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Name</td>
<td>Official name of the provider's financial institution</td>
<td>Optional</td>
</tr>
<tr>
<td>Address</td>
<td>Street address associated with receiving depositary financial institution name field</td>
<td>Required</td>
</tr>
<tr>
<td>City</td>
<td>City assocaited with receiving depositary financial institution address field</td>
<td>Required</td>
</tr>
<tr>
<td>State/Province</td>
<td>2 Character Code associated with the State</td>
<td>Required</td>
</tr>
<tr>
<td>Code</td>
<td>6 or 8 Character Code</td>
<td>Optional</td>
</tr>
<tr>
<td>Tel Number</td>
<td>A contact telephone number at the provider's bank</td>
<td>Optional</td>
</tr>
<tr>
<td>Institution Routing Number</td>
<td>A 9 digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited</td>
<td>Required</td>
</tr>
<tr>
<td>Financial Institution</td>
<td>Name of the financial institution</td>
<td>Optional</td>
</tr>
<tr>
<td>Account Number</td>
<td>The type of account the provider wishes to receive EFT payments, e.g., Checking, Savings</td>
<td>Required</td>
</tr>
<tr>
<td>Account Number with Financial Institution</td>
<td>Provider's account number at the financial institution to which EFT payments are to be deposited</td>
<td>Required</td>
</tr>
<tr>
<td>Account Number Linkage to Provider Identifier</td>
<td>Provider preference for grouping (batching) claim payments – must match preference for 835/837 and 836 remittance advice</td>
<td>Required</td>
</tr>
<tr>
<td>Provider Federal Tax Identification Number (TIN)</td>
<td>Unique, 9 digit</td>
<td>Optional, negotiable, NPI is not applicable</td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>Unique, 11 digit</td>
<td>Optional, negotiable, TIN is not applicable</td>
</tr>
</tbody>
</table>

#### SUBMISSION INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Required/Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Submission</td>
<td>New Enrollment</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Change Enrollment</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td>Cancel Enrollment</td>
<td>Required</td>
</tr>
<tr>
<td>User with Enrollment Submission</td>
<td>A voided check is attached to provide confirmation of identification/account number</td>
<td>Required</td>
</tr>
<tr>
<td>Bank Letter</td>
<td>A letter on bank letterhead that formally certifies the account owner's routing and account numbers</td>
<td>Required</td>
</tr>
</tbody>
</table>

#### AUTHORIZATION

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

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

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

**Electronic Funds Transfer (EFT) Authorization Agreement**

Providers must complete and submit the below form to AHCCCS to authorize ACH payments.

### PROVIDER IDENTIFIER INFORMATION

- **Provider Name:**
- **Doing Business As Name (DBA):**
- **Provider Address:**
  - **Street:**
  - **City:**
  - **State:**
  - **Zip Code:**
- **Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):**
- **National Provider Identifier (NPI):**
- **Trading Partner ID (AHCCCS Provider Number):**

### PROVIDER CONTACT INFORMATION

- **Provider Contact Name:**
- **Title:**
- **Telephone Number & Extension:**
- **Email Address:**
- **Fax Number:**

### PROVIDER AGENT INFORMATION — IF APPLICABLE

- **Provider Agent Name:**
- **Agent Address:**
  - **Street:**
  - **City:**
  - **State:**
  - **Zip Code:**
- **Provider Agent Contact Name:**
- **Title:**
- **Telephone Number & Extension:**
- **Email Address:**
- **Fax Number:**

### FINANCIAL INSTITUTION INFORMATION

- **Financial Institution Name:**
- **Financial Institution Address:**
  - **Street:**
  - **City:**
  - **State:**
  - **Zip Code:**
- **Financial Institution Telephone Number & Extension:**
- **Type of Account at Financial Institution:**
  - Checking
  - Savings
- **Provider's Account Number with Financial Institution:**
- **Account Number Linkage to Provider Identifier:**
  - Provider's Federal Tax Identification Number
  - National Provider Identifier Number

### SUBMISSION INFORMATION

- **Reason for Submission:**
  - New Enrollment
  - Change Enrollment
  - Cancel Enrollment
- **Include with Enrollment Submission:**
  - Yes
  - No
  - Voided Check: A voided check is attached to provide confirmation of identification account numbers
  - Bank Letter: A letter on bank letterhead that formally notifies the account owners routing and account numbers

### AUTHORIZATION

- **Pursuant to A.R.S. Sec. 35-185:** I authorize the Arizona Department of Administration (ADOA), General Accounting Office (GAO) and the Arizona Health Care Cost Containment System (AHCCCS) to process payments owed to me via Automated Clearing House (ACH) deposits.

- **Certify that I have read and agree to comply with the State of Arizona and AHCCCS’s rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently amended, amended, or stated. I certify that the information provided in this agreement is true and correct and that all information provided is accurate. The financial institution can present ACH payments/transactions along with institution identification information.**

### For a full, printable PDF of this document, please click on the following link,

[Click Here](https://www.azepip.gov/)
### Appendix I – Contact Us

<table>
<thead>
<tr>
<th>Need Help with:</th>
<th>Contact Us:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid EHR Incentive Program</td>
<td>AHCCCS EHR Pre-Payment Staff</td>
</tr>
<tr>
<td></td>
<td>602-417-4333</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a></td>
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<tr>
<td></td>
<td>Website: Arizona Medicaid EHR Incentive Program</td>
</tr>
<tr>
<td></td>
<td><strong>AHCCCS EHR Post Payment Staff</strong></td>
</tr>
<tr>
<td></td>
<td>602-417-4440</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:EHRPost-PayAudits@azahcccs.gov">EHRPost-PayAudits@azahcccs.gov</a></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Having Trouble with:</th>
<th>Help is Available:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS Registration process</td>
<td>CMS EHR Information Center</td>
</tr>
<tr>
<td></td>
<td>888-734-6433</td>
</tr>
<tr>
<td></td>
<td>Website: CMS Medicare and Medicaid EHR Incentive Programs</td>
</tr>
<tr>
<td>AHCCCS Provider Number, NPI, or TIN</td>
<td><strong>AHCCCS Provider Registration</strong></td>
</tr>
<tr>
<td></td>
<td>602-417-7670 (option 5) Maricopa County</td>
</tr>
<tr>
<td></td>
<td>800-794-6862 Outside Maricopa County</td>
</tr>
<tr>
<td></td>
<td>800-523-0231 Out-of-State</td>
</tr>
<tr>
<td></td>
<td>Website: AHCCCS Provider Registration Unit</td>
</tr>
<tr>
<td>Electronic Funds Transfer (EFT)</td>
<td><strong>AHCCCS Finance</strong></td>
</tr>
<tr>
<td></td>
<td>602-417-4175</td>
</tr>
<tr>
<td></td>
<td>Website: Automated Clearing House (ACH) Vendor Authorization Form</td>
</tr>
<tr>
<td>ePIP System</td>
<td><strong>AHCCCS EHR Staff</strong></td>
</tr>
<tr>
<td></td>
<td>602-417.4333</td>
</tr>
<tr>
<td></td>
<td>Website: ePIP Systems for Registration &amp; Attestation</td>
</tr>
<tr>
<td>No-Cost Education &amp; Assistance for HIT / HIE</td>
<td><strong>Arizona Health-e Connection (AzHeC)</strong></td>
</tr>
<tr>
<td></td>
<td>602-688-7200</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:ehr@azhec.org">ehr@azhec.org</a></td>
</tr>
</tbody>
</table>
Thank you for your interest in the EHR Incentive Program