STATE MEDICAID
PROMOTING INTEROPERABILITY PROGRAM
2019 STAGE 3
ATTESTATION REFERENCE GUIDE
ELIGIBLE PROFESSIONALS

September 1, 2020
https://www.azepip.gov/
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Disclaimer

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

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


Important Notice – Third Party Attestation

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

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

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

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

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

Administration:

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

Resources:

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

Eligible to Participate:

Providers under the AHCCCS Medicaid program are eligible to participate in the Medicaid Promoting Interoperability Program if they meet the program’s requirements. For detailed information, visit AHCCCS website.

Eligible Hospitals (EHs)

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

Eligible Professionals (EPs)

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

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

NOTES: EPs may NOT be hospital-based. This is defined as any provider who furnishes 90% or more of their services in a hospital setting (inpatient or emergency department).

Practice predominantly is defined as any provider who furnishes over 50% of their services over a 6-month period at a FQHC/RHC facility.

TIP

Providers must complete and submit an attestation in the ePIP System each program year in order to apply for the program. Go to the ePIP System by clicking here.
Welcome to the ePIP System Home Page

AHCCCS Promoting Interoperability Program (formerly referred to as the EHR Incentive Payment Program)

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

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

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

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

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

ePIP Program Announcements

- Program Year 2019 is now open and attestations can be submitted until midnight September 30, 2020
- Stage 3 Meaningful Use and 2015 CEHRTs will be required for participation in Program Years 2019

Beginning in 2011, the Promoting Interoperability Program (formerly the Electronic Health Records (EHR) Incentive Program) was developed to encourage eligible professionals and eligible hospitals to adopt, implement, upgrade (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 Promoting Interoperability Program are up to $63,750 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 2019-2021

Program Years 2019-2021: All providers must have systems with a 2015 Edition CEHRT and must attest to Stage 3 Objectives.

1. Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.
2. Generate and transmit permissible prescriptions electronically (eRx)
3. Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.
4. Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.
5. The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.
6. Use CEHRT to engage with patients or their authorized representatives about the patient’s care.
7. The EP provides a summary of care record when transitioning or referring their patient to another segment 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.

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

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

ePIP Program Announcement Update:

ePIP is accepting attestations for Program Year 2019 until September 30, 2020 (subject to CMS approval).

Website Updates

Check our PI Program website for updates regarding the attestation deadline.

September 1, 2020
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Registration (Providers Without an ePIP Account)

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 Promoting Interoperability Program.

You must agree by checking the box in order to proceed.

Your NPI number can be verified at the following link:
https://npiregistry.cms.hhs.gov/registry/
## Program Year 2019 Stage 3 Objectives

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<th>File Name</th>
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<td>Objective 2 - Electronic Prescribing (Stage 3)</td>
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<td>Objective 3 - Clinical Decision Support (Stage 3)</td>
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<td>Objective 4 - Computerized Provider Order Entry (Stage 3)</td>
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<td>Objective 5 - Patient Electronic Access to Health Information (Stage 3)</td>
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<td>Objective 6 - Coordination of Care through Patient Engagement (Stage 3)</td>
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## Program Year 2019 Stage 3 Tip Sheets

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<td>Guide for Eligible Professionals Practicing in Multiple Locations (Stage 3)</td>
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<tr>
<td></td>
<td>Patient Electronic Access to Health Information (Stage 3)</td>
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<td>CMS Security Risk Analysis (Stage 3)</td>
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## Program Year 2019 CQM's

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<th>File Name</th>
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<td>Eligible Professional / Eligible Clinician eCQM's for Program Year 2018</td>
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For reference purposes only:

Stage 2 Objective Measure Specifications

Please note that Stage 2 is no longer available in the PI Program for Meaningful Use. This documentation is provided for reference purposes only.

Use our PI Document Library to navigate quickly to the Meaningful Use requirements.

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

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

Log On

WARNING! This system contains State of Arizona and U.S. Government information. By using this information system, you are consenting to system monitoring for law enforcement and other purposes. Unauthorized or improper use of, or access to, this system may subject you to state and federal criminal prosecution and penalties as well as civil penalties. At anytime, the government may intercept, search, and seize any communication or data transiting or stored on this information system.

User name

Password

☐ Remember me?

Log On

Forgot your password? Click Here to reset your password.

If you do not have an account, please Register

The AHCCCS Promoting Interoperability (PI) Program Year 2019 is now open.

Any questions or concerns should be directed to the AHCCCS Promoting Interoperability Team at 602-417-4333 or EHRIncentivePayments@azahcccs.gov

Password Reset

To reset your password please enter your UserName.

User Name

Continue

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
Welcome to Your ePIP Account Home Page

Welcome To Your ePIP Account

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

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

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

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

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ePIP Program Announcements

- CMS has re-branded the program as the Promoting Interoperability Program
  - Program Year 2019 is now open and attestations can be submitted until midnight September 30, 2020
  - Stage 3 Meaningful Use and 2015 CEHRTs will be required for participation in Program Years 2019

HOME

- Returns you to this page.

MY ACCOUNT

- Manage My Account: Review & edit your contact information.
- Change My Password: Change the password for your account
- Modify My Security Questions: Create or modify the security questions associated with your account
- Payments: Track your payments for separate program years
- Manage Documents: Upload supporting documentation for your attestations
- EHR Certificate Validation Tool: Determine if your CEHRT identifier is valid

ATTEST

Create & maintain attestations for separate program years.

CONTACT US

- Contact the AHCCCS EHR Incentive Payments Group

EHR DOCUMENT LIBRARY

- A collection of PDF documents from CMS regarding the EHR Incentive Payment Program

---

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

1. Home
2. My Account
   - Manage My Account
   - Change My Password
   - Modify My Security Questions
   - Payments
   - Manage Documents
   - EHR Certificate Validation Tool
3. Attest
4. Contacts
   - PI Team
   - Other AHCCCS Contacts
5. PI Doc Library
6. Log Off

---

ePIP Program Announcement Update:

ePIP is accepting attestations for Program Year 2019 until September 30, 2020 (subject to CMS approval).
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.

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

Click Edit My Account to add or update an authorized secondary contact.

TIP

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

Click Edit My Account to add or update an authorized secondary contact.

TIP
My Account – How to Manage My Account - Continued

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

Let’s take a look at:

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

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

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

TIP

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 UPPERCASE character. (ex: A)
- Must contain at least one lowercase 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

Passwords must meet the complexity requirements displayed on the screen.

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.
My Account – How to Manage My Security Questions

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

Modify My Security Questions allows you to create or change your security questions and answers.

Select your security question from the drop down menu and enter your answer.

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>AU</td>
</tr>
<tr>
<td>2013</td>
<td>$8,500.00</td>
<td>11/25/2013</td>
<td>MU</td>
</tr>
<tr>
<td>2014</td>
<td>$8,500.00</td>
<td>12/23/2015</td>
<td>MU</td>
</tr>
<tr>
<td>2016</td>
<td>$8,500.00</td>
<td>7/24/2017</td>
<td>MU</td>
</tr>
</tbody>
</table>

Example Data Only

Processing Status

Initial Payment: Payment made by AHCCCS on 8/26/2013 for $21,250.00. Payment reference #2688

Initial Payment: Payment made by AHCCCS on 11/25/2013 for $8,500.00. Payment reference #2989

Initial Payment: Payment made by AHCCCS on 12/23/2015 for $8,500.00. Payment reference #4574

Initial Payment: Payment made by AHCCCS on 7/24/2017 for $8,500.00. Payment reference #6306

Instructions

Here is where you can track your incentive payments for separate program years. The processing status of your incentive payments will be displayed along with other payment details in the table above.

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

Let’s take a look:

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

Payments allow you to view your payment history and processing status.

A payment processing status message is displayed to keep you updated.
My Account – How to Manage My Documents

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.
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 a CEHRT 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.

<table>
<thead>
<tr>
<th>CMS EHR Certification ID Validator</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS EHR Certification ID</td>
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</table>

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

**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**

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.

**After Submission:**

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.

This Screen Shows Example Data Only
Attestation Instructions

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

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

Attest Options

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

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

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

Meaningful Use Stage Overview

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

Requirements for Meaningful Use Measures for EPs

- Meaningful Use Stage 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 Promoting Interoperability Program with those available to professionals participating in the Merit-based Incentive Payment System (MIPS).

Changes include:

- Medicaid EPs are required to report on 6 out of 50 Clinical Quality Measures (CQMs or eCQMs).
- The 2019 Physician Fee Schedule (PFS) Final Rule established that in 2019, Medicaid EPs who are returning participants must report on a one year eCQM reporting period, and first-time meaningful users must report on a 90-day eCQM reporting period.
- Medicaid EPs are required to report on any 6 eCQMs related to their scope of practice.
- Medicaid EPs are required to report on at least one outcome measure.
- If no outcome measures are relevant to that EP, they must report on at least one high-priority measure.
- If there are no outcome or high priority measures relevant to an EP’s scope of practice, they must report on any six relevant measures.
- The information entered in the eCQMs should be supported by the CQM Report.
Attestation Instructions - Continued

Data Requirements

Please be prepared to provide the following information:

Medicaid Patient Volume
- Patient Volume Reporting Period (60 days) ¹
- Hospital-Based Reporting Period (12 months) ¹
- Patient Volume Methodology (Individual/Aggregate) ²
- Total Patient Encounters
- Medicaid Patient Encounters (Individual/Aggregate) ²
- Hospital-Based Patient Encounters (Individual/Aggregate) ²

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
- ² For Aggregate Patient Volume Methodology:
  - Patient Volume criteria is based on Practice’s data
  - Hospital-Based criteria is based on Provider’s data

Additional Requirement:

Needy Individual Patient Volume
- Patient Volume Reporting Period ¹
- Practice Predominantly Reporting Period ¹
- Patient Volume Methodology
- Total Patient Encounters
- Needy Individual Patient Encounters (Medicaid Title XIX, CHC Title XXI & Patients Paying Below Guideline)
- 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 60-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.

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)*.

![Example Data Only](https://www.azepip.gov/)

#### Provider Contact Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Example Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name (CMS)</td>
<td>Billy Joe Evans</td>
</tr>
<tr>
<td>Provider Name (State)</td>
<td>SMITH/JOHN</td>
</tr>
<tr>
<td>* Provider Phone</td>
<td></td>
</tr>
<tr>
<td>* Provider Email</td>
<td></td>
</tr>
<tr>
<td>Provider Business Phone</td>
<td>602-555-1212</td>
</tr>
<tr>
<td>Provider Business Address</td>
<td>12345 Main ST Suite 1234 Phoenix, AZ 85024</td>
</tr>
</tbody>
</table>

---

**TIP**

Example Data Only
Patient Volume Criteria

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

Medicaid Patient Volume is an available option for all providers.

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

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

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

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

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].

TIP

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

- **Total Patient Encounters**

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

### Arizona Encounters

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

**TIP**

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

The numerator is Needy Patient Encounters only.

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

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

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

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

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

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

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

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

Note that inclusion of out of state patient encounters is optional in the numerator and slows the approval process since we must validate with the respective state(s).
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.
You are now ready to being attesting to the Meaningful Use portion of the attestation.

CMS EHR Certificate number must be valid.

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

You must select your PI Reporting Period start & end date from calendar year 2019 for the Meaningful Use Objectives & Clinical Quality Measures that you are attesting to.

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

Complete the number of unique patients in your PI reporting period.
Attestation Progress (After Attestation Information)

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 Objectives for Stage 3

#### Providers with systems certified with a 2015 CEHRT as of 12.31.2019

<table>
<thead>
<tr>
<th></th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (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 eligible professional (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 certified electronic health record technology (CEHRT) to engage with patients or their authorized representatives about the patient’s care.</td>
</tr>
<tr>
<td>7</td>
<td>The eligible professional (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 electronic health record (EHR) using the functions of certified EHR technology (CEHRT).</td>
</tr>
<tr>
<td>8</td>
<td>The eligible professional (EP) is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified electronic health record technology (CEHRT), except where prohibited, and in accordance with applicable law and practice.</td>
</tr>
</tbody>
</table>

#### MU Objectives Criteria:

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

#### Select PI Reporting Period:

- 90 days from CY 2019

#### CEHRT System Criteria:

A provider attesting for Program Year 2019 will be required to use Stage 3 Meaningful Use and 2015 CEHRTs.

**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.

The measure calculations policy specifies that actions included in the numerator must occur during the PI reporting period.

---

Stage 3 Meaningful Use and 2015 CEHRTs are required for participation in Program Year 2019.
Stage 3 Objective 1 Measure 1 Protect Patient 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 2019.

CEHRT is “certified electronic health record technology”

The Navigation bar at the bottom will monitor your progress.

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

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

Stage 3 Electronic Prescribing (eRx)

☑️ Measure 1

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.

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 1 Clinical Decision Support

Clinical Decision Support - Measure 1 of 2

Measure Requirements:

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

Additional Information:

- EPs must use 2015 edition to meet Stage 3 meaningful use.
- EPs should implement the CDS intervention at a relevant point in clinical work flow when the intervention can influence clinical decision making before diagnostic or treatment action is taken in response to the intervention.
- Well-designed CDS incorporates a variety of well-organized optimization tools, which case presenters to providers, clinical and support staff, patients, and other caregivers at various points in time. These may include but are not limited to: computerized alerts and reminders for providers and patients; information displays or links; context aware knowledge retrieval specifications that provide a standard mechanism to incorporate information from online resources (commonly referred to as infobuttons); clinical guidelines; condition-specific order sets; focused patient data reports and summaries; documentation templates; diagnostic support; and contextually relevant reference information. These functionalities may be deployed on a variety of platforms (e.g., mobile cloud-based, desktop).
- The same interventions do not have to be implemented for the entire EHR reporting period as long as the threshold of five is maintained for the duration of the EHR reporting period.
- If there are limited CQMs applicable to an EP’s scope of practice, the EP should implement CDS interventions that he or she believes will drive improvements in the delivery of care for high-priority health conditions relevant to their specialty and patient population. These high-priority conditions must be determined prior to the start of the EHR reporting period in order to implement the appropriate CDS to allow for improved performance.
- Drugdrug and drug-drug interaction alerts are separate from the five CDS interventions and do not count toward the five required for Measure 1.

Definition of Terms:

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

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 491.24 (a)(3)(A)(6) and (B). For further discussion please see 80 FR 62836
- In order to meet this objective, an EP must use the capabilities and standards of CDS at 45 CFR 170.315(a)(6) and (a)(4).

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

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

Supporting Documentation Requirements:

Meaningful Use Objective Requirements support requiring 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

Meaningful Use Objective - Navigation

Meaningful Use Objective Summary

Stage 3 Clinics

Complete all required fields.

You must have implemented five clinical decision support interventions related to four or more clinical quality measures for the entire PI 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

Stage 3 Screen 4

Clinical Decision Support

☑️ Measure 2

Complete all required fields.

You must have enabled drug-drug and drug-allergy for the entire PI 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.

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 4 Measure 1 Computerized Provider Order Entry

Meaningful Use Objectives - Stage 3 for Program Year 2019

Computerized Provider Order Entry - Measure 1 of 3

Objective Details:
Computerized Provider Order Entry - Measure 1 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 60 percent of medication orders created by the EP during the reporting period are recorded using computerized provider order entry.

Additional Information:
- IPs must use 2015 Edition to meet Stage 3 meaningful use
- IPs are permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT)

TIP:
- Complete all required fields. If you select the exclusions, you must upload documentation to support that separately.
- If you are not certain how to run the medication orders using CPOE report, you may need to contact your CEHRT vendor.
- The Navigation bar at the bottom will monitor your progress.

For detailed information about the Computerized Provider Order Entry objective, please click here.

Supporting Documentation Requirements:

- 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)

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 495.14 (d)(4)(A)(a) and (B). For further discussion please see 80 FR 62540
- To meet this objective and measure, an EHR must use the capabilities and standards of CEHRT at 45 CFR 170.315(a)(1) through (3)

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 4 Measure 2 Computerized Provider Order Entry

Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 6 of 29 - CMS Meaningful Use Objective 4, Measure 2
Computerized Provider Order Entry - Measure 2 of 3

Objective Details:

Computerized Provider Order Entry - Measure 2 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 60 percent of laboratory orders created by the EP during the PI reporting period are recorded using computerized provider order entry.

Additional Information:

- EPs must use 2015 Edition to meet stage 3 meaningful use.
- EPs are permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology (CEHRT).
- To count in the numerator, the CPOE function must be used to create the first record of the order that becomes part of the patient's medical record and before any action can be taken on the order.
- In some situations, it may be impossible or unreasonable to wait to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the EP or initiated immediately after a verbal order by the ordering EP to a licensed healthcare professional by his or her direct supervision. In these situations, as long as the first record of that order as it becomes part of the patient's medical record is entered by a licensed healthcare professional, certified medical assistant or other appropriately credentialed staff member using CPOE, it would count in the numerator.
- Any licensed healthcare professional and clinical staff credentialed to and with the duties equivalent of a medical assistant, or is appropriately credentialed and performs services similar to a medical assistant, but carries a more specific title due to other specialization of their duties or to the specialty of the medical professional they assist can enter orders into the medical record for purposes of including the order in the numerator if they can originate the order per state, local, and professional guidelines. It is up to the EP to determine the proper credentialing, training, and duties of the medical staff entering the orders as long as they fill within the guidelines prescribed. Credentialing for a medical assistant must come from an organization other than the organization employing the medical assistant.
- An EP must submit three measures for this objective through a combination of meeting the threshold and exceptions.
- Orders involving telehealth remote communication (such as phone orders) may be included in the numerator as long as the order entry otherwise meets the requirements of the measure.
- EPs may exclude orders that are predetermined for a given set of patient characteristics or for a given procedure (i.e., known as "protocol" or "standing orders") from the calculation of CPOE numerators and denominators. This does not require EPs to exclude these categories of orders from their numerator and denominator.
- CPM is the entry into the patients EHR that uses a specific function of CEHRT. CPOE does not otherwise specify how the order is filled or otherwise carried out.

Definition of Terms:

Computerized Provider Order Entry (CPOE): A provider's use of computer assistance to directly enter medical orders (for example, medications, consultations with other providers, laboratory services, imaging studies, and other auxiliary services) from a computer or mobile device.

Diagnostic Imaging: Includes other imaging tests such as ultrasonic, magnetic resonance, and computed tomography in addition to traditional radiology.

Laboratory Order: An order for any service provided by a laboratory that could not be provided by a non-laboratory laboratory.

- A facility for the biological, microbiological, serological, chemical, immunohematological, hemato-biological, cytological, pathological, or other examination of the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of the health of the human being. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (sub) or only serving as a mailing service and not performing testing are not considered laboratories.

Radiology Order: An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not rely on electronic product radiation in this definition as long as the policy is consistent across patients. If a patient is not being followed in the PI reporting period.

Regulatory References:

- This objective may be found in Section 42 of the code of the federal register at 459.24 (d)(3)(v)(D) and (E). For further discussion please see 80 FR 62980
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 C.F.R. 170.315(a)(1) through (3).

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

For detailed information about the Computerized Provider Order Entry 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.

(*) Red asterisk indicates a required field

(*) Gray asterisk indicates a conditionally required field

Measure Entry:

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

* Does this exclusion apply to you?

Yes ☐ No ☐

* 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 laboratory orders in the denominator during the PI reporting period that are recorded using CPOE.

Denominator: The number of laboratory orders created by the EP during the PI 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 4 Measure 3 Computerized Provider Order Entry

Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 7 of 24 - CMS Meaningful Use Objective 4 - Measure 3
Computerized Provider Order Entry - Measure 3 of 3

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

Measure Requirements:
More than 46 percent of diagnostic imaging orders created by the EP during the Preparing period are recorded using computerized provider order entry.

Additional Information:
- EPs must use CPOE for all CPOE orders for the current year.
- To avoid inappropriate or inadequate medication orders, CPOE should be used to create the first record of the order that becomes part of the patient’s medical record and before any action can be taken on the order.
- In some situations, it may be impossible or unachievable to initiate an intervention until a record of the order has been created. For example, situations where an intervention is identified and immediately initiated by the EP or initiated immediately after a verbal order by the ordering EP to licensed healthcare professional under his or her direct supervision. In these situations, as long as the first record of the order as it becomes part of the patient’s medical record is entered by a licensed healthcare professional, certified medical assistant or other appropriately credentialed staff member using CPOE, it would count in the numerator.
- Any licensed healthcare professional and clinical staff certified to perform the duties equivalent of a medical assistant, or a similar role, or perform similar tasks in a medical setting as part of the medical staff. To be counted as one order, at least one order must be included in the numerator.
- Any licensed healthcare professional and clinical staff certified to perform the duties equivalent of a medical assistant, or a similar role, or perform similar tasks in a medical setting as part of the medical staff. To be counted as one order, at least one order must be included in the numerator.
- CPOE is the order entered by the clinician/EHR that uses a specific function of CEHRT. CPOE does not otherwise specify how the order is filled or otherwise carried out.

Definition of Terms:
Computerized Provider Order Entry (CPOE): A provider’s computerized application to enter orders in electronic order sets. This includes the originating, writing, recording, and relaying of orders to the ordering system or the documentation of the order in a computerized system.

Diagnostic Imaging: Includes other imaging tests such as ultrasonic, magnetic resonance, and computer tomography in addition to traditional radiology.

Laboratory Order: An order for any service performed by a laboratory that could not be provided by a non-laboratory.

Laboratory: A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, toxicological, or other examination of the human body for the purpose of providing information for the diagnosis, prognosis, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (e.g., stool) or only serving as a mailing service and not performing testing are not considered laboratories.

Radiology Order: An order for any imaging service that uses electronic product radiation. The EP can include orders for other types of imaging services that do not use electronic product radiation in this definition as long as the policy is consistent across all patients and for the entire PI reporting period.

Regulatory References:
- This objective may be found in Section 42 of the code of the federal register at 45 CFR 153.150 (a) and (b). For further discussion please see 80 FR 62940
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315(a)(1) through (3).

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

For detailed information about the Computerized Provider Order Entry 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.

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

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

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

Complete the following information:
Denominator: Number of diagnostic imaging orders created by the EP during the PI reporting period.
Numerator: Number of diagnostic imaging orders entered by the EP during the PI reporting period.

Meaningful Use Objectives - Navigation: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Meaningful Use Objectives Summary:

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

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

Stage 3 Objective 5 Measure 1: Patient Electronic Access

Meaningful Use Objectives: Stage 3 for Program Year 2019

ePIP Measure B of 10: "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 3: The EP provides patients (or patient-authorized representatives) with timely electronic access to their patient-specific education.

Measure Requirements:

- For more than 80% 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 their health information or their health information.
  2. The provider ensures the patient's health information is available for the patient (or patient-authorized representatives) 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 CEHRT.

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- To implement an API, an EP needs to fully enable the API functionality, such that any application chosen by the patient would enable the patient to gain access to their individual health information, provided that the application is compliant to meet the technical specifications of the API. The EP may provide patients with detailed instructions on how to authenticate their access through the API and provide the patient with supplemental information on available applications that leverage the API.
- Similar to how EPs support patient access to review, transmit, and order capabilities, EPs should continue to have the ability to provide patients with electronic access to their health information.
- In circumstances where there is no information available to populate one or more fields, either because the EP can be excluded from recording such information or because there is no information to record (for example, no medication allergies or laboratory tests), the EP may have no indication that the information is not available and still meet the objective and its associated measure.
- The patient must be able to access their information on demand, such as through a stated period, a personal health record (PHR), or other online electronic means. We note that a covered entity may be able to fully satisfy a patient's request for information through viewing, download, and transmit. The measure does not replace the covered entity's responsibilities to follow broader requirements under health information Portability and Accountability Act (HIPAA) to provide an individual, upon request, with access to a patient health information (PHI) in a designated record set.
- While meaningful use is limited to the capabilities of CEHRT, prior to online access there may be patients who cannot access their EHRs electronically because of a disability. EPs are expected to provide patients with disabilities equal access to information and appropriate auxiliary aids and services as provided in the applicable statutes and regulations.
- For Measure 1, this must occur at your functionality (view, download, and access through API) for the patient and must be made available in each encounter.
- For Measure 2, this must occur through your functionality (view, download, and access through API) for the patient and must be made available in each encounter.
- For Measure 3, this must occur through your functionality (view, download, and access through API) for the patient and must be made available in each encounter.
- 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 5 Measure 2 Patient Electronic Access

The EP must use clinically relevant information from CHERIT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the PI reporting period.

**Additional Information:**

- EPs must use 2016 Edition to meet Stage 3 meaningful use.
- To implement an AP, EPs need to fully enable the AP functionality, such that any application chosen by a patient would enable the patient to gain access to their individual health information, provided that the application is certified to meet the technical specifications of the AP. EPs are expected to provide patients with detailed instructions on how to authenticate their access through the AP and provide the patient with supplemental information on available applications that average the AP.
- Similar to how EPs support patient access to view, download, and transmit capabilities, EPs should continue to have identity verification processes in place to ensure that a patient using an application, which is leveraging the AP, is provided access to their health information.
- In circumstances where there is no information available to populate see a more field, either because the EP cannot elicit from the patient information or because the EP cannot elicit from the patient information, regardless of whether the patient has been consented.
- The patient must be able to access this information immediately through the patient portal or a personal health record (PHR), or any other online electronic means. Words to enable a feedback loop may be able to fully satisfy a patient request for information through view, download, and transmit, the measure does not replace the covered entity's responsibilities to meet other requirements.
- For Measure 1, EPs must meet the following requirements: for each patient seen, an EP must be able to view within 24 hours of the information available to the patient seen for each and every time that information is generated, regardless of whether the patient has been consented.
- For Measure 2, an EP must have enabled an AP within the PI reporting period, or if it is less than a full calendar year, within the calendar year in which the EP reporting period occurs. (3) EPs are expected to provide patients with detailed instructions on how to authenticate their access through the AP and provide the patient with supplemental information on available applications that leverage the AP, and (4) maintain availability of the AP.
- 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 6 Measure 1 Coordination of Care

Meaningful Use Objectives - Stage 1 for Program Year 2019

Coordinating Care Through Patient-Engagement - Measure 1 of 3

Measure Purpose: To ensure patients have access to care plans.

Measure Requirements:

Stage 3.

Stage 3 Coordination of Care

Stage 3 Measure 1 Coordination of Care

Stage 3 Coordination of Care

Stage 3 Measure 1 Coordination of Care

Measure 1 Coordination of Care through Patient Engagement - Measure 1 of 3

Measure Title: Use CEHR to engage with patients or their authorized representatives about the patient’s care.

Measure Definition:

For a PI reporting period in 2019, more than 3 percent of all unique patients (or their authorized representatives) seen by the PI actively engage with the electronic health record made accessible by the provider and either:

- View, download, or transmit to a third party their health information.
- Access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API by the provider CEHR.

A combination of 1 and 2.

Additional Information:

- The patient must select 3 measures and must meet the thresholds for at least two measures to meet the objective.
- There are four options a patient might see as part of Measure 1:
  - View information
  - Download information
  - Transmit their information to a third party
  - Access information through an API

These options may overlap, but CEHR is able to count the patient in the numerator if they take any and all actions. Therefore, for the first measure, CEHR may combine a threshold for view, download, and transmit API actions, or if their technology functions overlap, then any view, download, transmit, or API actions favor the patient using CEHR would count toward the threshold.

- To avoid double counting, the following information must be available 24 hours a day in the information being made available to the CE.
  - Patient name
  - Provider’s name and contact information
  - Current and past problem list
  - Procedures
  - Laboratory tests
  - Current medication list and medication history
  - Current medication allergies and medication allergy history
  - Vital signs (height, weight, blood pressure, BMI growth chart)
  - Smoking status
  - Diagnostic information (physician language, sex, race, ethnicity, date of birth)
  - Case plan (files), including goals and instructions
  - Any known drug allergies or contraindications
  - 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.

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

Attestation Guide

https://www.azepip.gov/
Stage 3 Objective 6 Measure 2 Coordination of Care

Meaningful Use Objectives - Stage 3 for Program Year 2016

ePIP Measure 11 of 23 - CMS Meaningful Use Objective 5, Measure 2
Coordination of Care through Patient Engagement - Measure 2 of 3

Objective Details:

**Coordination of Care through Patient Engagement - Measure 2 of 3:** Use CEMHT to engage with patients or their authorized representatives about the patient’s care.

**Measure Requirements:**

For an eHR reporting period in 2016, more than 5 percent of all unique patients seen by the EP during the eHR reporting period, a claim message was sent using the electronic messaging function of CEMHT to the patient (or the patient’s authorized representative), or in response to a claim message sent to the patient or their authorized representative.

**Additional Information:**

- **IPS must use 2016 Edition to meet Stage 3 meaningful use.
- **For the numerator for Measures 1 and the action must occur within the eHR reporting period of that period in a calendar year, or if it is less than a full calendar year, within the calendar year in which the eHR reporting period occurs.
- **IPS must submit three measures and must meet the thresholds for at least two measures to meet the objective.
- **There is no active patient profile included as part of Measure 1.
- **View their information.
- **Download their information.
- **Transmit their information to a third party.
- **Access health information through an API.

These actions may overlap, but an IPS is able to count the patient in the numerator if they take any and all actions. Therefore, for the first measure, eHR must be combined in a threshold of view/download, and send and API actions, or if all technology functions overlap then any view/download, transmit, or API actions taken for a patient using CEMHT would count towards the measure.

To order to meet the objective, the following information must be available within 4 business days of the information being made available to the EP:

- **User name.
- **Provider name and office contact information.
- **Current and previous list.
- **Prescription.
- **Laboratory test results.
- **Current medication list and medication history.
- **Allergies.
- **Medication reconciliation alert capability.
- **Vital signs (height, weight, blood pressure, BMI, growth chart).
- **Vaccination status.
- **Demographic information (preferred language, sex, race, ethnicity, date of birth).
- **Care plan(s), medications, and instructions.
- **Any times care team members include the primary care provider (PCP) of record.

An EP can maintain additional information and still align with the objective.

**Restricted who can provide initiated communications (when a provider sends a message to a patient or the patient’s authorized representatives), and provider-to-provider communications if the patient is included. A provider can only send messages in the numerator when the provider participates in the communication (i.e., any patient-initiated communication only if the provider responds to the patient. Note: Providers are not required to respond to every message received if no response is necessary.

- **For Measure 3, the types of data that would satisfy the measure are broad. It may include, but is not limited to, social service data, data generated by a patient or a patient’s authorized representative, advance directives, medical device data, home health monitoring data, and fitness monitor data. In addition, the sources of data vary and may include government agencies, public/other providers, or other sources. It must meet the threshold of 75%, which means that the number of unique patients who meet the threshold must include at least 75% of the total number of patients who have been seen by the EP during the eHR reporting period. For example, activity trackers or sensors, data from health or fitness devices, or different models that track different processes that work best for their practice and needs. For example, if data provided can be easily incorporated into a structured format or into an existing workflow within the EHR such as a PCP or care team member reported that data in a patient report or patient reported family health history and demographic information) the provider may send to its care team. Additionally, a provider may maintain the data between the claims and the patient record to avoid repeat data collection.

**Definition of Terms:**

- **Application Programming Interface (API):** A set of programming protocols established for multiple purposes. APIs may be utilized by a provider or provider organization to provide the patient with access to their health information through a third-party application with more flexibility than is found in many current patient portals.
- **Patient:** The patient (or authorized representative) accessing their health information online.
- **Excluded data type:** If the provider initiates communication only if the provider participates in the communication (i.e., any patient-initiated communication only if the provider responds to the patient. Note: Providers are not required to respond to every message received if no response is necessary.
- **Data governed by a patient or a patient’s authorized representative.

**Screen 11**

国土 of Care

- **Measure 2**

Complete all required fields.

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

The Navigation bar at the bottom will monitor your progress.

**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

Meaningful Use Objectives - Stage 3 for Program Year 2019

ePIP Measure 12 of 20 - CMS Meaningful Use Objective 6, Measure 3 Coordination of Care Through Patient Engagement - Measure 3 of 3

Objective Details:
Coordination of Care through Patient Engagement - Measure 3 of 3: Use CEHR to engage with patients or their authorized representatives about the patient's care.

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

Additional Information:
- EPs must use the ePIP screen to meet Stage 3 meaningful use.
- For the numerator for Measures 1 and 2 the action must occur within the EP’s reporting period if that period is a full calendar year; if it is less than a full calendar year, within the calendar year in which the EP’s reporting period occurs.
- EPs must use the ePIP screen to meet Stage 3 meaningful use.
- There are two aspects of this measure: (1) role of the patient and (2) role of the provider.

This stage requires all measures and must meet the thresholds for at least two measures to meet the objective.

For Measure 3, the types of data that would satisfy the measure are broad. It may include, but is not limited to, social service data, data generated by a patient or a patient’s authorized representative, advance directives, credit or credit score data, home health monitoring data, and fitness monitor data. In addition, the sources of data vary and may include data collected from the ePIP screen, data from the EMR, data from other healthcare providers or organizations, data from activity trackers or heart rate monitors, patient-reported outcome data, and other methods of input for the patient and non-clinical setting generated health data. (Note: Data related to billing or payment or other insurance information would not satisfy this measure.)

For Measure 3, providers in non-clinical settings may include, but are not limited to, care providers such as nutritionists, physical therapists, occupational therapists, psychologists, and or other health care providers. Other key providers in the care team such as behavioral health care providers, may also be included, and we encourage providers to consider ways in which this measure can incorporate this essential information from the broader care team.

For the Patient Generated Health Data measure, the data may not be information the patient provided to the EP or location during the office visit as such data does not meet the definition of “health data” as defined in the Stage 3 Objective 6. The data must be generated since the EP last saw the patient outside the clinic setting.

For Measure 3, we do not specify the manner in which providers are required to incorporate the data. Providers may use their EHR to develop and maintain records and processes that work best for their practice and needs. For example, if data provided can be easily incorporated in a structured format into an existing EHR within the EHR, then the data could be recorded directly into the patients EHR. If the data provided is less structured, a provider may utilize some combination of data entry and charting to incorporate the data into the patient’s EHR.

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.

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

Supporting Documentation Requirements:

Meaningful Use Objectives Measurements require supporting documentation. The supporting documentation for this measure should be included in your Meaningful Use EHRR 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 PI reporting period.
- Does this exclusion apply to you? Yes [X] | 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 CEHR into the patient record during the PI reporting period.

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

September 1, 2020

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Stage 3 Objective 7 Measure 1 – 3 Health Information Exchange

Additional Information:
- EPs must use 2015 Edition to meet Stage 3 meaningful use.
- For Measure 1 in order to count in the numerator, the exchange must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs.
- For Measure 1, the referring EP must have reasonable certainty of receipt by the receiving provider to count the action toward the measure. An EP must have a confirmation of receipt or a query of the summary of care record has occurred in order to count the action in the numerator.
- Apart from the three fields noted as required for the summary of care record (i.e., current problem list, current medication list, and current medication allergy list), in circumstances where there is no information available to provide one or more of the fields listed because the EP does not record such information or because there is no information to record, the EP may leave the fields blank and still meet the objective and its associated measure.
- While an EP’s CMCDA must be capable of sending the full consolidated clinical document architecture (CCDA) summary of care and an EP must do so upon request, an EP may use any document template within the C-CDA-HL7 standard for purposes of meeting these measures.
- An EP must have the ability to transmit claims pertaining to laboratory test results in the summary of care document, but may work with their system developer to establish clinically relevant parameters for the most appropriate results for the given transition or referral.
- An EP who limits the transmission of laboratory test result data in a summary of care document must send the full results upon request (i.e., all lab results as opposed to a subset).
- The exchange must comply with the privacy and security protocols for electronic protected health information (ePHI) under the Health Insurance Portability and Accountability Act (HIPAA).
- It is clear where the provider’s access to the EHR of a transition or referral is granted to the provider, the sending provider must also be able to securely deliver the patient to the receiving provider.
- For Measure 1, the referring EP must send a C-CDA document that the receiving provider would be capable of electronically incorporating as a C-CDA on the receiving end. In other words, if an EP sends a C-CDA and the receiving provider converts the C-CDA into a PDF or some other format, the sending EP may still count the transition or referral in the numerator. If the sending provider sends the C-CDA in a format that the receiving provider could not electronically receive and incorporate as a C-CDA, the sending EP may not count the transition or referral in the numerator.
- For the purposes of defining the cases in the denominator for Measure 2, we stated that what constitutes “unavailable” and therefore, may be excluded from the denominator, will be that a provider:
  - Rejected an electronic summary of care record be sent and did not receive an electronic summary of care document; and
  - The provider either:
    - Cancelled at least one external source via HIE functionality and did not locate a summary of care for the patient, or the provider does not have access to HIE functionality to support such a query; or
    - Confirmed that HIE functionality supporting query for summary of care documents was not operational in the provider’s geographic region and not available in the provider’s EHR network as of the start of the reporting period.
- For Measure 2, a record cannot be considered incorporated if it is discarded without the reconciliation of clinical information or if it is stored in a manner that is not accessible for EP use within the EHR.
- For Measure 3, the process may include both automated and manual reconciliation to allow the receiving EP to work with both the electronic data provided with any necessary review to work directly with the patient to reconcile their health information.
- For Measure 3, if an update is necessary, the process of reconciliation may consist of simply verifying that fact or reviewing a record received on referral and determining that such information is merely duplicative of existing information in the patient record.
- Non-medical staff may conduct reconciliation under the direction of the EP so long as the EP or other credentialed medical staff is responsible and accountable for review of the information and for the assessment of and action on any relevant clinical decision support alert.

Definition of Terms:

Transition of Care: The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory, specialty care practice, long-term care, home health, rehabilitation facility) to another. At a minimum this includes all transitions of care and referrals that are ordered by the EP.

Summary of Care Record - All summary of care documents used to meet this objective must include the following information if the provider knows it:
- Patient name
- Referring or transitioning provider’s name and office contact information (EP only)
- Procedures
- Encounter diagnosis
- Immunizations
- Laboratory test results
- Vital signs (height, weight, blood pressure, BMI)
- Smoking status
- Functional status, including activities of daily living, cognitive and disability status
- Demographic information (preferred language, sex, race, ethnicity, date of birth)
- Care plan field, including goals and instructions
- Care team including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
- Reason for referral (EP only)
- Current problem list (Providers may also include historical problems at their discretion)*
- Current medication list**
- Current medication allergy list**

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

Current Problem Lists - At a minimum a list of current and active diagnoses.
Active/Current medication list - A list of medications that a given patient is currently taking.
Active/Current medication allergy list - A list of medications which a given patient has known allergies.
Allergy - An exaggerated immune response or reaction to substances (that are generally not harmful)
Care Plan - The structure used to define the management actions for the various conditions, problems, or issues. A care plan must include at a minimum the following components: problem (the focus of the care plan), goal (the target outcome) and any instructions that the provider has given to the patient. A goal is a defined target or measure to be achieved in the process of patient care (an expected outcome).
Stage 3 Objective 7 Measure 1 Health Information Exchange

Objective Details:
Health Information Exchange - Measure 1 of 3: The EP provides a summary of care 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 CHERT.

Measure Requirements:
For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care, creates a summary of care record using CHERT and electronically exchanges the summary of care record.

Regulatory References:
- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(7)/(A) and (B). For further discussion please see 80 FR 62861.
- In order to meet this objective and measure, an EP must use the capabilities and standards of CHERT at 45 CFR 170.315 (b)(1) through (b)(9) and (a)(6) through (a)(9).

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)

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.

Tips:

- Red asterisk indicates a required field
- Gray asterisk indicates a conditionally required field

Measure Entry:
- Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the PI reporting period.
  - Does this exclusion apply to you?
    - Yes
    - No

Exclusion: Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4 Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measures.
- 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 transitions of care and referrals in the denominator where a summary of care record was created using CHERT and exchanged electronically.

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

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

Stage 3 Screen 13

Health Information Exchange

☑️ Measure 1

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.

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 2 Health Information Exchange

**Objective Details:**
Health Information Exchange - Measure 2 of 3: 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 record from other providers into their EHR using the functions of CEHRT.

**Measure Requirements:**
For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.

**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:**
Exclusion: 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 PI reporting period is excluded from this measure.

- **Hospital Exclusion:**
  - Does this exclusion apply to you?
    - Yes
    - No
  - Exclusion: Any EP that conducts 50 percent or more of his 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 PI reporting period may exclude the measure.
  - **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.

**Numerator:**
Number of patient encounters in the denominator where an electronic summary of care record is incorporated by the provider into the certified EHR technology.

**Denominator:**
Number of patient encounters during the PI reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and to which an electronic summary of care record is available.

**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 3 Health Information Exchange

Health Information Exchange

☐ Measure 3

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

If you are in active engagement to submit syndromic surveillance data to a public health agency, you must upload documentation to support that separately.

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 1 – 5 Public Health and Clinical Data Registry Reporting

Additional Information:

- EPs must use 2015 Edition to meet Stage 3 Meaningful Use.
- EPs must attest to at least one measure from the Public Health Reporting Objective.
- An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP needs to meet two of the following: the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of available measures is less than two, the EP can meet the objective by meeting all of the remaining available measures and claiming the applicable exclusions. Available measures are ones for which the EP does not qualify for an exclusion.
- For Measure 1, an EP's CEHR may layer additional information on the immunization history forecast, and still successfully meet this measure.
- Bi-directionally provides that CEHR must be able to receive and display a consolidated immunization history and forecast in addition to sending the immunization record.
- For Measure 1, non-vaccinating EPs can meet the measure if they query and receive results (e.g., the consolidated immunization record and forecast) from the IS and integrate the data into their CEHR, in accordance with HL7 Version 3.1 Implementation Guide Immunization Messaging Release 1.5 (October 2014). A non-vaccinating provider may also submit historical immunizations provided from another source; however, this alone would not meet the measure.
- For Measure 1, the exclusion does not apply if an entity designated by the immunization registry or IS can receive electronic immunization data submissions. For example, if the immunization registry cannot accept the data directly or in the standards required by CEHR but has designated a Health Information Exchange (HIE) to do so on their behalf, and the HIE is capable of accepting the information in the standards required by CEHR, the EP could not claim the second exclusion.
- For Measure 2, the exception does not apply if an entity designated by the PAH can receive electronic syndromic surveillance data submissions. For example, if the PAH cannot accept the data directly or in the standards required by CEHR, but has designated an HEI to do so on their behalf, and the HEI is capable of accepting the information in the standards required by CEHR, the EP could not claim the second exclusion.
- For Measure 4, EPs may choose to report to more than one public health registry to meet the number of measures required to meet the objective.
- For Measure 4, an EP may count a specialized registry (such as prescription drug monitoring) if the EP achieved Active Engagement Option 3 in a prior year under the applicable requirements of the PI Program for that PAH.
- For Measure 5, EPs may choose to report to more than one HIE to meet the number of measures required to meet the objective.
- For Measure 5, the definition of jurisdiction is generic, and the scope may vary at the state, regional, or national level. The definition will be dependent on the type of registry to which the EP is reporting. A registry that is a repository would be considered a registry at the national level and would be included for purposes of this measure.
- For Measures 4 and 5, if the PAH or CEHR does not use a specific standard, it must use another standard specified in 170.305(b)(2) to meet the measure. For example, if the transmission could be in the form of a Consolidated Clinical Document Architecture (CCDA) per 170.305(b)(4) or QualiMed Reporting Document Architecture (QRDA) per 170.305(b)(2). If an EP practices in a jurisdiction where no PAH or CEHR for which they are eligible to submit data has declared readiness to receive electronic registry transactions in accordance with the 2013 Edition standards as of six months prior to the start of the EP reporting period, they may take an exclusion from these measures, as appropriate.
- EPs who have previously registered, tested, or began sending data submission to a registry do not need to restart the process beginning at Active Engagement Option 1. The EP may simply attach to the active engagement option which most closely reflects the current data.
- For the first exclusion of each measure, the registries in question are those sponsored by the PAH with jurisdiction over the area where the EP practices and national medical societies covering the EPs scope of practice. Therefore, an EP must complete two actions in order to avoid exclusions or claim an exclusion:
  - Determine if the jurisdiction (state, territory, etc.) endorses or sponsors a registry, and;
  - Determine if NAPHS or the specialty society with which the provider is affiliated endorses or sponsors a registry.
- For Measure 1 and Measure 2, the provider does not contribute to that data (for example they do not administer immunizations), the provider should not attest to meeting the measure but instead select the exclusion. The provider may then select a different more relevant measure to meet.
- If a provider marks the data as opt-in, this data will only be available to a registry in the normal course of their practice and in active engagement to submit to a registry, but simply has no cases for the reporting period, the provider is not required to take the exclusion and may attest to meeting the measure.
- CAG has published a centralized registry for public health agencies (PAH) and clinical data registry (CDR) reporting. That centralized registry is available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivesPrograms/ControlledDataRegistry.html

Definition of Terms:

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

Active Engagement Option 1 – Completed Registration for Subimal Data: The EP registered to submit data with the PAH or, where applicable, the CDR during the period in which the information is being submitted; registration was completed within 60 days after the start of the EP reporting period; and the EP is awaiting an invitation from the PAH or CDR to begin testing and validation. This option allows providers to meet the measure when the PAH or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EP reporting period.

Active Engagement Option 2 – Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PAH or, where applicable, the CDR within 30 days; failure to respond twice within an EP reporting period would result in the provider not meeting the measure.

Active Engagement Option 3 – Production: The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PAH or CDR.

Production data refers to data generated through clinical processes involving patient care, and it is used to distinguish between data and “test data” which may be submitted for the purposes of enrolling in and testing electronic data transfers.

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

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

The Navigation bar at the bottom will monitor your progress.
Stage 3 Objective 8 Measure 1 Public Health and Clinical Data Registry Reporting

Stage 3 Public Health and Clinical Data Registry Reporting

Measure 1

Complete all required fields.

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

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

The Navigation bar at the bottom will monitor your progress.

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 and Clinical Data Registry Reporting

Stage 3 Objective 8 Measure 2 of 5: The EP is in active engagement with a public health agency or clinical data registry to submit electronic public health data is 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.

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.

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 and Clinical Data Registry Reporting

Meaningful Use Objectives - Stage 3 for Program Year 2019

ePIP Measure 18 of 20 - CMS Meaningful Use Objective 8, Measure 3
Public Health and Clinical Data Registry Reporting - Measure 3 of 5

**Objective Details:**
Public Health and Clinical Data Registry Reporting - Measure 3 of 5: 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 case reporting of reportable conditions.

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**Regulatory References:**
- This objective may be found in Section 42 of the Code of Federal Register at 45CFR155.103-103A, and 104. For further discussion please see 45CFR155.103
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHR at 45CFR155.103A, 103B, 104A, 104B, 104C, and 104D.

---

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

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

**Measure 3**

**Screen 18**

**Stage 3**

**Public Health and Clinical Data Registry Reporting**

☒ **Measure 3**

Complete all required fields.

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

If you are in active engagement to submit immunization data to a public health agency, 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 8 Measure 4 Public Health and Clinical Data Registry Reporting

Meaningful Use Objectives - Stage 3 for Program Year 2019
ePIP Measure 19 of 20 - CMS Meaningful Use Objective 8, Measure 4
Public Health and Clinical Data Registry Reporting - Measure 4 of 5

Objective Details:
Public Health and Clinical Data Registry Reporting - Measure 4 of 5: 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 data to public health registries.

Regulatory References:
- This objective may be found in Section 42 of the code of the federal register at 495.24 (d)(8)(i)(A) and (B). For further discussion please see 86 FR 62370
- In order to meet this objective and measure, an EP must use the capabilities and standards of CEHRT at 45 CFR 170.315 (f)(1), (f)(2), (f)(4), (f)(5), (f)(6) and (f)(7).

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

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.

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

Measure Entry:
Exclusion: Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the PI reporting period
- Does this exclusion apply to you?
  ○ Yes
  ○ No

Exclusion: Operates in a jurisdiction for which no public health agency is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the PI reporting period
- Does this exclusion apply to you?
  ○ Yes
  ○ No

Exclusion: Operates in a jurisdiction where no public health 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 PI 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 and Clinical Data Registry Reporting

Meaningful Use Objectives - Stage 3 for Program Year 2011

Attestation Guide
https://www.azepip.gov/

Stage 3 Screen 20
Public Health and Clinical Data Registry Reporting

☑ Measure 5

Complete all required fields.

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

If you are in active engagement to submit immunization data to a public health agency, 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.
Attestation Progress (After Objective Measures)

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

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

**TIP**

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

<table>
<thead>
<tr>
<th>National Quality Strategy (NQS) Domains</th>
<th>Number eCQMs 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>10</td>
</tr>
<tr>
<td>5 Efficiency and Cost Reduction</td>
<td>4</td>
</tr>
<tr>
<td>6 Effective Clinical Care</td>
<td>26</td>
</tr>
</tbody>
</table>

#### Clinical Quality Measures (eCQMs) Selection:

**eCQMs Criteria:**
Providers are required to report on 6 of 50 separate eCQMs from any of the National Quality Strategy domains.

**Select eCQM Reporting Period:**
- 90 days for first time MU
- 365 days for returning MU

*All reporting periods are from 2019*

**Select your eCQMs:**
- At least 1 Outcome Measure
- At least 1 High Priority Measure
- Then other Relevant Measures to your scope of practice

If the certified EHR technology system does not contain patient data for at least 6 CQMs:
- Report the CQMs for which there is patient data
- Report the remaining required CQMs as “zero denominators” as displayed by your certified EHR technology.

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

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

#### Person and Caregiver-Centered Experience and Outcomes

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 15V7 \ NQF 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 66v7 - Functional Status Assessment for Total Knee Replacement</td>
<td>Percentage of patients 18 years of age and older who received an elective primary total knee arthroplasty (TKA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 56v7 - Functional Status Assessment for Total Hip Replacement</td>
<td>Percentage of patients 18 years of age and older who received an elective primary total hip arthroplasty (THA) and completed a functional status assessment within 90 days prior to the surgery and in the 270-365 days after the surgery</td>
<td>☐</td>
</tr>
<tr>
<td>CMS 90v8 - Functional Status Assessments for Congestive Heart Failure</td>
<td>Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments</td>
<td>☐</td>
</tr>
</tbody>
</table>

4 of 50 CQMs are available under this domain.

### Select your eCQMs:
- ☑ At least 1 Outcome Measure
- ☑ At least 1 High Priority Measure
- ☑ Then other Relevant Measures to your scope of practice

### Measure Codes:
- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

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.
### Clinical Quality Measures for Patient Safety

**Patient Safety**

5 of 50 CQMs are available under this domain.

**Select your eCQMs:**
- At least 1 Outcome Measure
- At least 1 High Priority Measure
- Then other Relevant Measures to your scope of practice

**Measure Codes:**
- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

The Navigation bar at the bottom will monitor your progress.

---

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
</table>
| CMS 156v7 \ NQF022 - Use of High-Risk Medications in the Elderly | Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported.  
- Percentage of patients who were ordered at least one high-risk medication.  
- Percentage of patients who were ordered at least two of the same high-risk medications. |          |
| CMS 139v7 \ 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 68v8 \ 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-counters, herbas, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications name, dosage, frequency and route of administration. |          |
| CMS 132v7 \ NQF 0564 - Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures | Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence. |          |
| CMS 177v7 \ 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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Make sure that you upload all documents that support the above entries in your attestation. You can do so on the Attestation Progress.

**TIP**

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

Communication and Care Coordination

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS 50v7 - 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>

1 of 50 CQMs is available under this domain.

Select your eCQMs:
- At least 1 Outcome Measure
- At least 1 High Priority Measure
- Then other Relevant Measures to your scope of practice

Measure Codes:
- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

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.
### Clinical Quality Measures for Community / Population Health

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
</table>
| **CMS 155v7 \ NQF 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 138v7 \ NQF 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. Three Rates are Reported:  
  - Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months  
  - Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention  
  - Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user |          |
| **CMS 159v7 \ NQF 0033 - Chlamydia Screening for Women**                  | Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period |          |
| **CMS 117v7 \ NQF 0038 - Childhood Immunization Status**                  | Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); 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 |          |

**Community / Population Health**

10 of 50 CQMs are available under this domain.

**Select your eCQMs:**
- [x] At least 1 Outcome Measure
- [x] At least 1 High Priority Measure
- [x] Then other Relevant Measures to your scope of practice

**Measure Codes:**
- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

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.
Clinical Quality Measures for Community / Population Health - Continued

10 of 50 CQMs are available under this domain.

Select your eCQMs:
- At least 1 Outcome Measure
- At least 1 High Priority Measure
- Then other Relevant Measures to your scope of practice

Measure Codes:
- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

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.
Clinical Quality Measures for Efficiency and Cost Reduction

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4 of 50 CQMs are available under this domain.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Select your eCQMs:**
- At least 1 Outcome Measure
- At least 1 High Priority Measure
- Then other Relevant Measures to your scope of practice

**Measure Codes:**
- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

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.
Clinical Quality Measures for Effective Clinical Care

26 of 50 CQMs are available under this domain.

Select your eCQMs:
- At least 1 Outcome Measure
- At least 1 High Priority Measure
- Then other Relevant Measures to your scope of practice

Measure Codes:
- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

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.
### Clinical Quality Measures for Effective Clinical Care - Continued

<table>
<thead>
<tr>
<th>Measure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O CMS 122v7</td>
<td>Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period</td>
</tr>
<tr>
<td>O CMS 314v7</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>
</tr>
<tr>
<td>O CMS 145v7</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>
</tr>
<tr>
<td>O CMS 135v7</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>
</tr>
<tr>
<td>O CMS 144v7</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>
</tr>
<tr>
<td>O CMS 134v7</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>
</tr>
</tbody>
</table>

### Effective Clinical Care

26 of 50 CQMs are available under this domain.

### Select your eCQMs:

- [ ] At least 1 Outcome Measure
- [ ] At least 1 High Priority Measure
- [ ] Then other Relevant Measures to your scope of practice

### Measure Codes:

- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

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.
Clinical Quality Measures for Effective Clinical Care - Continued

- 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.

- Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

- 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:
  - Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).
  - Percentage of patients who remained on an antidepressant medication for at least 168 days (6 months).

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

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

**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.

- Effective Clinical Care

26 of 50 CQMs are available under this domain.

**Select your eCQMs:**
- At least 1 Outcome Measure
- At least 1 High Priority Measure
- Then other Relevant Measures to your scope of practice

**Measure Codes:**
- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

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

26 of 50 CQMs are available under this domain.

Select your eCQMs:
☑ At least 1 Outcome Measure
☑ At least 1 High Priority Measure
☑ Then other Relevant Measures to your scope of practice

Measure Codes:
O - Outcome Measure
H - High Priority Measure
A - Adult Core Measure
C - Child Core Measure

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.
Clinical Quality Measures for Effective Clinical Care - Continued

CMS 347v2 - Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period:

- Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR
- Adults aged >= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL, or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR
- Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-180 mg/dL

CMS 645v2 - Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy
Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.

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

Select your eCQMs:
- At least 1 Outcome Measure
- At least 1 High Priority Measure
- Then other Relevant Measures to your scope of practice

Measure Codes:
- O - Outcome Measure
- H - High Priority Measure
- A - Adult Core Measure
- C - Child Core Measure

The Navigation bar at the bottom will monitor your progress.

Click the hyperlink on the ePIP screen to learn more about this requirement.
<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>
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<td>C</td>
<td>Needy Patient Volume Report Layout</td>
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<td>Contacts</td>
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<td>J</td>
<td>Webinars for Eligible Professionals</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>
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<tr>
<td>Patient Date of Birth</td>
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</tr>
<tr>
<td>Patient Identifier (unique ID or if not available, SSN)</td>
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<tr>
<td>Patient Insurance ID (AHCCCS Member ID or Other Member ID)</td>
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</tr>
<tr>
<td>Patient Name</td>
<td>Alpha</td>
</tr>
<tr>
<td>Payer Financial Class</td>
<td>Alpha</td>
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<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></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>
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<td>Two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.</td>
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</tr>
<tr>
<td>Rendering/Servicing Provider Name</td>
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<tr>
<td>Visit Count - Numerator (Enter 1 = unique visit; 0 = duplicate visit)</td>
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</tr>
<tr>
<td>Visit Count – Denominator (Enter 1 = unique visit; 0 = duplicate visit)</td>
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</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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<tbody>
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<tr>
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<td>Patient Name</td>
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<tr>
<td>Payer Financial Class</td>
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</tr>
<tr>
<td>Medicaid, CHIP (KidsCare), Medicare, Private Insurance, Self-Pay, Commercial, etc.</td>
<td></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>
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</tr>
<tr>
<td>† For CHIP (KidsCare) Title XXI: Enter CHIP Primary, CHIP Secondary, CHIP Tertiary, etc.</td>
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<td>Visit Count – Denominator (Enter1= unique visit; 0 = duplicate visit)</td>
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*Correctional Facility is a practice location for providers rendering care to inmates in a prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. **NOTE:** Incarceration & Release Date must be included in your report.
Appendix C – Needy Patient Volume Report Layout

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

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

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

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

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

<table>
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<tr>
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<tbody>
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<tr>
<td>Correctional Facilities: Use Medicaid or Non-Medicaid description</td>
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</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>
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<tr>
<th>Description</th>
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</tr>
<tr>
<td>Visit Count - Denominator (Enter 1= unique visit; 0 = duplicate visit)</td>
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</tbody>
</table>
Appendix E – Definitions

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

**Promoting Interoperability (PI)**
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 Promoting Interoperability automates and streamlines the clinician’s workflow. The Promoting Interoperability 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 Promoting Interoperability (PI) 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 Promoting Interoperability 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 Registration

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

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

<table>
<thead>
<tr>
<th>Q4</th>
<th>Is my practice eligible to apply &amp; receive payments through the Medicare and Medicaid Promoting Interoperability (PI) Programs?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No, your practice cannot apply for payment.</td>
</tr>
<tr>
<td></td>
<td>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 Promoting Interoperability Payments be subject to audit?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Incentive payments made to Eligible Professionals under the Medicaid Promoting Interoperability (PI) Program is subject to audit by the Promoting Interoperability Programs.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>PI audit questions can be directed to the Promoting Interoperability Post Payment Audit Team at: <a href="mailto:EHRPost-PayAudits@azahcccs.gov">EHRPost-PayAudits@azahcccs.gov</a> or 602.417.4440</td>
</tr>
</tbody>
</table>
### Appendix F – Frequently Asked Questions regarding Registration

<table>
<thead>
<tr>
<th>Q6</th>
<th>How often do I need to Register?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You need to Register once in order to participate in the Promoting Interoperability 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 ‘Sent for State Approval’, please send an inquiry to Medicaid at <a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a> for assistance. If your CMS registration status shows 'Registration Started/Modified/In Progress', please re-submit your CMS registration.</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Q10</th>
<th>I am ready to start a new attestation but I do not see that option when I log in to ePIP. What are the possible reasons for such?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>If a payment decision has not been issued for the prior Program Year in which you attested, you cannot begin a new Program Year attestation.</td>
</tr>
<tr>
<td></td>
<td>If your previous attestation was denied or rejected, you may need to have your attestation refreshed.</td>
</tr>
<tr>
<td></td>
<td>In any instance if you cannot start a new Program Year, please email the Promoting Interoperability Program team at <a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a>.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Q11</th>
<th>How do I know if my Promoting Interoperability (PI) system is certified?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>The Medicare and Medicaid Promoting Interoperability (PI) Programs require the use of certified EHR technology, as established by a set of standards and certification criteria.</td>
</tr>
<tr>
<td></td>
<td>EHR technology needs to be certified by an ONC-authorized Testing and Certification Body (ONC-ATCB) in order to qualify for incentive payments. The Certified Health IT Product List (CHPL) is available at <a href="http://www.healthit.hhs.gov/CHPL">http://www.healthit.hhs.gov/CHPL</a>. Providers must maintain the proper certification requirements &amp; submit the required documentation to demonstrate that their EHR technology is properly certified.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q12</th>
<th>How do we submit documentation to support the attestation?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ePIP is the State’s repository for storing your attestation information. Providers are required to upload their documentation at the time of attestation. Passwords should follow standard operating procedures to prevent access to your ePIP accounts.</td>
</tr>
<tr>
<td></td>
<td>The ePIP website, <a href="https://www.azepip.gov/">https://www.azepip.gov/</a>, has a Hypertext Transfer Protocol Secure (HTTPS) feature which has a built in communications protocol for secure communication over a computer network. Therefore, documents uploaded to ePIP are secure and encrypted.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q13</th>
<th>How can I change my attestation information after I have attested for the Medicaid Promoting Interoperability (PI) Program?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If you discover that the information you entered during your Medicaid attestation was not complete and accurate for some reason, please email Medicaid at <a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a>.</td>
</tr>
</tbody>
</table>
### Q14  What is the deadline for Medicaid Eligible Professionals to submit attestations for Program Year 2019?

Eligible Professionals participate in the Medicaid Promoting Interoperability (PI) Programs on a calendar year basis.

Generally, the Medicaid attestation deadline is 90-days following the end of the calendar year. At this time, the deadline for Program Year 2019 has been extended to **September 30, 2020**.

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

For Program Year 2019, the reporting periods are as follows:

**Volume (select a period from 2018):**
- 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 2019):**
- The Promoting Interoperability reporting period for the Meaningful Use Objectives & the Clinical Quality Measures is a continuous 90-day period within the calendar year.

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Q22</th>
<th>Are payments from the Medicare and Medicaid Promoting Interoperability (PI) Programs subject to recoupments?</th>
</tr>
</thead>
</table>
|     | Both Medicare and Medicaid are required to recoup any or all portions of the Promoting Interoperability 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 Promoting Interoperability 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

### SECTION 1 – Provider Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Required/Optional</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 legal name, or business name, under which the business or operation 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 of the applicable country</td>
<td>Required</td>
</tr>
<tr>
<td>Zip Code/Postal Code</td>
<td>A 5 or 15 Character Code</td>
<td>Required</td>
</tr>
</tbody>
</table>

### SECTION 2 – Provider Identifiers Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Required/Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Federal Tax Identification Number (FTIN) or Employer Identification Number (EIN)</td>
<td>A Federal Tax Identification Number also known as an Employer Identification Number (EIN) used to identify a business entity. Needs 9 digits</td>
<td>Required</td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>A Health Insurance Portability and Accountability Act (HIPAA) - Required when provider has been enumerated with an NPI</td>
<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>

### SECTION 3 – Provider Contact Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Required/Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
<td>Name of a contact in provider office responsible for handling EFT Tissues</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>Optional</td>
</tr>
<tr>
<td>Tel Number Ext</td>
<td></td>
<td>Optional</td>
</tr>
<tr>
<td>Email Address</td>
<td>An electronic mail address at which AHCCCS might contact the provider</td>
<td>Optional</td>
</tr>
<tr>
<td>Fax Number</td>
<td>A number at which the provider can be sent facsimile</td>
<td>Optional</td>
</tr>
</tbody>
</table>

### SECTION 4 – Provider Agent Information – If Applicable

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
<th>Required/Optional</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/Province of the applicable country</td>
<td>Required</td>
</tr>
<tr>
<td>Zip Code/Postal Code</td>
<td>A 5 or 15 Character Code</td>
<td>Required</td>
</tr>
<tr>
<td>Provider Agent Contact Name</td>
<td>Name of a contact in provider office responsible for handling EFT Tissues</td>
<td>Required</td>
</tr>
<tr>
<td>Tel Number</td>
<td>Number associated with contact person. Numeric, 10 digits</td>
<td>Optional</td>
</tr>
<tr>
<td>Tel Number Ext</td>
<td></td>
<td>Optional</td>
</tr>
<tr>
<td>Email Address</td>
<td>An electronic mail address at which AHCCCS might contact the provider</td>
<td>Optional</td>
</tr>
<tr>
<td>Fax Number</td>
<td>A number at which the provider can be sent facsimile</td>
<td>Optional</td>
</tr>
</tbody>
</table>
### Appendix G – Electronic Funds Transfer ACH Form Instructions (continued)

#### SECTION 5

**FINANCIAL INSTITUTION INFORMATION**

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

**SECTION 6**

**Reason for Submission**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Enrollment</td>
<td>Required</td>
</tr>
<tr>
<td>Change Enrollment</td>
<td>Required</td>
</tr>
<tr>
<td>Cancel Enrollment</td>
<td>Required</td>
</tr>
</tbody>
</table>

**Instrument Enrollment Submission**

- **Bank Letter**
  - A letter on bank letterhead that formally notifies the account owner of routing and account numbers

**SECTION 7**

**AUTHORIZATION**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorized Signature</strong></td>
<td>The signature of an individual authorized by the provider or its agent to initiate modify or terminate an enrollment</td>
</tr>
<tr>
<td><strong>Joint Name of Authorized Signer</strong></td>
<td>The printed name of the person submitting the form</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>The title of person signing the form</td>
</tr>
</tbody>
</table>

**Submission Date**

- **Requested EFT Start/Change/Cancel Date**
  - The date on which the enrollment is submitted: CCYYMMDD

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**

- **Name:** Arizona Health Care Cost Containment System (AHCCCS)
- **Address:** P.O. Box 1570, Phoenix, AZ 85001
- **Telephone:** 800-352-1646

#### PROVIDER IDENTIFIER INFORMATION

**Provider Name:**

**Doing Business As Name (DBA):**

**Provider Address:**

- **Street:**
- **City:**
- **State/Province:**
- **Zip Code/Postal 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:**
- **Fax Number:**

#### PROVIDER AGENT INFORMATION – IF APPLICABLE

**Provider Agent Name:**

**Agent Address:**

- **Street:**
- **City:**
- **State/Province:**
- **Zip Code/Postal Code:**

**Provider Agent Contact Name:**

**Title:**

- **Telephone Number & Extension:**

#### FINANCIAL INSTITUTION INFORMATION

**Financial Institution Name:**

**Financial Institution Address:**

- **Street:**
- **City:**
- **State:**
- **Zip Code:**

**Financial Institution Telephone Number & Extension:**

- **Financial Institution Routing Number:**
- **Type of Account at Financial Institution:**
  - Checking
  - Savings

**Provider’s Account Number with Financial Institution:**

**Account Number Linkage to Provider:**

**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:**
  - Voided Check: A voided check is attached to provide confirmation of identification account numbers
  - OR
  - Bank Letter: A letter on bank letterhead that formally certifies the account owners routing and account numbers

#### AUTHORIZATION

- **Pursuant to A.R.S. Sec. 33-1310, I authorize the Arizona Department of Administration (ADOA), General Accounting Office (GAO) and the Arizona Health Care Cost Containment System (AHCCCS) to process payment events via the Automated Check Stopping (ACS) system. The State of Arizona and AHCCCS shall deposit the ACS payments in the financial institution and account designated above.**

- **I understand that if I fail to provide complete and accurate information on this authorization form, the processing of the form may be delayed or made impossible, or any electronic payments may be erroneously made.**

- **I authorize the State of Arizona and AHCCCS to withdraw from the designated account all amounts deposited in error in accordance with ADOA’s rules and procedures.**

- **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 adopted, amended, or replaced. I am aware, and agree to, comply with these rules even if I conflict with this authorization form.**

- **I certify that I have read and agree to comply with the State of Arizona and AHCCCS’s rules governing payments and electronic transfers as they exist on the date of my signature on this form or as subsequently adopted, amended, or replaced. I am aware, and agree to, comply with these rules even if I conflict with this authorization form.**

- **I authorize the State of Arizona and AHCCCS to stop making electronic transfers to any account without advance notice.**

- **I certify that I am authorized to execute the entry receiving instructions, pursuant to this agreement, and that all information provided in advance.**

**The financial institution has pressed CCE payments transactions along with address information.**

**Yes**

**No**

**Authorized Signature:**

**Print Name of Authorized Signature:**

**Title:**

**Submission Date:**

**Requested EFT Start Date:**

For a full, printable PDF of this document, please click on the following link, **Click Here**.
## Appendix I – Contact Us

<table>
<thead>
<tr>
<th>Need Help with:</th>
<th>Contact Us:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Promoting Interoperability (PI) Program</td>
<td><strong>AHCCCS PI Pre-Payment Staff</strong> 602-417-4333</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:EHRIncentivePayments@azahcccs.gov">EHRIncentivePayments@azahcccs.gov</a></td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://www.azahcccs.gov">Arizona Medicaid EHR Incentive Program</a></td>
</tr>
<tr>
<td><strong>AHCCCS Promoting Interoperability Post Payment Staff</strong></td>
<td>602-417-4440</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:EHRPost-PayAudits@azahcccs.gov">EHRPost-PayAudits@azahcccs.gov</a></td>
</tr>
<tr>
<td>Having Trouble with:</td>
<td>Help is Available:</td>
</tr>
<tr>
<td>CMS Registration process</td>
<td><strong>CMS Information Center</strong> 888-734-6433</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://www.cms.gov">CMS Medicare and Medicaid EHR Incentive Programs</a></td>
</tr>
<tr>
<td>AHCCCS Provider Number, NPI, or TIN</td>
<td><strong>AHCCCS Member &amp; Provider Services</strong> 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: <a href="https://www.azahcccs.gov">AHCCCS Provider Enrollment</a></td>
</tr>
<tr>
<td>Electronic Funds Transfer (EFT)</td>
<td><strong>AHCCCS Finance</strong> 602-417-5500</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://www.azahcccs.gov">Automated Clearing House (ACH) Vendor Authorization Form</a></td>
</tr>
<tr>
<td>ePIP System</td>
<td><strong>AHCCCS PI Staff</strong> 602-417.4333</td>
</tr>
<tr>
<td></td>
<td>Website: <a href="https://www.azahcccs.gov">ePIP Systems for Registration &amp; Attestation</a></td>
</tr>
<tr>
<td>No-Cost Education &amp; Assistance for HIT / HIE</td>
<td><strong>Health Current</strong> 602-688-7200</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:ehr@healthcurrent.org">ehr@healthcurrent.org</a></td>
</tr>
</tbody>
</table>
## Appendix J – Webinars for Eligible Professionals

Click: [Program Year 2019 Stage 3 Webinar](#)
Click: [Electronic Clinical Quality Measures Webinar](#)
Click: [Documentation Retention Webinar](#)
Click: [Documentation Retention Tip Sheet (2018/2019)](#)
Click: [Medicaid Individual Patient Volume Webinar](#)
Click: [Medicaid Aggregate Patient Volume Webinar](#)
Click: [Using HIT in A Meaningful Way Webinar](#)

<table>
<thead>
<tr>
<th>Meaningful Use Objectives</th>
<th>Other Webinars</th>
<th>Additional Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Protect Patient Health Information</td>
<td>SRA Webinar</td>
<td><a href="#">2019 Security Risk Analysis Requirement Tip Sheet</a> <a href="#">Tips for Completing a SRA</a></td>
</tr>
<tr>
<td>2 Electronic Prescribing (eRX)</td>
<td>eRX Webinar</td>
<td><a href="#">eRX Frequently Asked Questions</a></td>
</tr>
<tr>
<td>3 Clinical Decision Support (CDS)</td>
<td>CDS Webinar</td>
<td><a href="#">CDS Frequently Asked Questions</a></td>
</tr>
<tr>
<td>4 Computerized Provider Order Entry (CPOE)</td>
<td>CPOE Webinar</td>
<td><a href="#">CPOE Frequently Asked Questions</a></td>
</tr>
<tr>
<td>6 Coordination of Care</td>
<td>Coordination of Care Webinar</td>
<td><a href="#">Coordination of Care Frequently Asked Questions</a></td>
</tr>
<tr>
<td>7 Health Information Exchange</td>
<td>HIE Webinar</td>
<td><a href="#">HIE Frequently Asked Questions</a></td>
</tr>
<tr>
<td>8 Public Health Reporting</td>
<td>1 of 2 AHCCCS Public Health Webinar</td>
<td><a href="#">Public Health Frequently Asked Questions</a></td>
</tr>
<tr>
<td></td>
<td>2 of 2 ADHS Public Health Webinar</td>
<td></td>
</tr>
</tbody>
</table>

### Other References:

(a) State Registries (ADHS)
[https://www.azdhs.gov/preparedness/epidemiology-disease-control/meaningful-use/index.php](#)

(b) CDC National Health Care Survey Registries:
[https://www.cdc.gov/nchs/dhcs/nhcs_registry_landing.htm](#)

(c) National Institute Health Registries:
[https://www.nih.gov/health-information/nih-clinical-research-trials-you/list-registries](#)
Thank you for your interest in the Promoting Interoperability Program