Medicaid EHR Incentive Program
(Promoting Interoperability)

Eligible Professional Meaningful Use Attestation Manual

Program Year 2019

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1. Program Overview

1.1 Introduction

The Kentucky Medicaid Electronic Health Record (EHR) Incentive Program (also known as Promoting Interoperability) provides incentive payments to eligible professionals (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs) as they demonstrate meaningful use (MU) of certified EHR technology (CEHRT). The purpose of this document is to provide instructions for providers to complete an attestation for the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability) using the KYSLR system.

Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at https://www.federalregister.gov/documents/2010/07/28/2010-17207/medicare-and-medicaid-programs-electronic-health-record-incentive-program
- 42 CFR Parts 412 and 495 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program - Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule located at https://www.federalregister.gov/documents/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications
- Kentucky State Medicaid HIT Plan (SMHP) located at https://chfs.ky.gov/agencies/dms/ehr/Documents/2018 AnnualUpdatev30.pdf
- Kentucky Medicaid EHR Application Portal located at https://prdweb.chfs.ky.gov/KYSLR/Login.aspx
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program (Promoting Interoperability) located at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRincentivePrograms/
- Office of the National Coordinator for Health Information Technology located at https://www.healthit.gov/
- Kentucky Health Information Exchange located at https://khie.ky.gov/PAGES/INDEX.ASPX

Regional Extension Centers (RECs) have been designated to provide technical assistance to Kentucky providers. The RECs provide a full range of assistance related to EHR selection and training are listed below:

- Northeast Kentucky Area
  Kentucky Rural Healthcare Information Organization (KRHIO)
  Website: https://krhio.org/
  Phone: 855-385-2089
  E-mail: admin@nekyrhio.org
- Remaining Areas of Kentucky
  Kentucky Regional Extension Center
  Website: http://www.kentuckyrec.com/
  Phone: 888-KY-REC-EHR or 859-323-3090
  E-mail: kyrec@uky.edu

1.2 Background

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

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems. More information about this process is available at http://www.healthit.gov. CMS continues its advancement of CEHRT utilization, focusing on burden reduction, and improving interoperability and patient access to health information.

The Kentucky Department for Medicaid Services (DMS) works closely with federal and state partners to ensure the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability) fits into the overall strategic plan for the Kentucky Health Information Exchange (KHIE), thereby advancing national and Kentucky goals for HIE.

Providers can update their registration with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs (Promoting Interoperability) can be found at http://www.cms.gov/EHRIncentivePrograms/. The site provides general and detailed information on the programs, including tabs to guide users on the path to payment, eligibility, meaningful use, CEHRT, and frequently asked questions.

2 Eligibility

While providers could begin the program in Calendar Year (CY) 2011, they must have initiated participation in the program no later than CY 2016.

The first tier of provider eligibility for the program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the Kentucky Medicaid Partner Portal Application **does not** correspond to the provider types and specialties approved for participation in the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability), the provider will receive an error message with a disqualification statement.

At this time, CHFS DMS has determined that the following providers are potentially eligible to enroll in the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability):

- Physicians = Any provider who has a Provider Type 64 and Specialty other than 345 (Pediatrics)
- Physician Assistants (practicing in a FQHC [Provider Type 31 and Specialty 80] or RHC [Provider Type 35] led by a Physician Assistant) = Any provider with a Provider Type 95 and Specialty other than 959 (PA Group). A FQHC or RHC is considered to be PA led in the following instances:
    - The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
    - The PA is the clinical or medical director at a clinical site of the practice
    - The PA is the owner of the RHC
- Pediatricians = Any provider with a Provider Type 64 and Specialty 345
- Nurse Practitioners = Any provider with a Provider Type 78 and not Specialty 095 (CNM) or 789 (Nurse Practitioner Group)
- CNMs = Any provider with a Provider Type 78 and Specialty 095
- Dentists = Any provider with a Provider Type 60 (Individual)
- Optometrists = Any provider with a Provider Type 77
- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children's Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

2.1 Additional Requirements

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, not be hospital-based and must:

1. Meet one of the following patient volume criteria:
    a. Have a minimum of 30 percent patient volume attributable to individuals receiving TXIX and/or TXXI-CHIP (but not separate CHIPs) Medicaid services; **or**
    b. Have a minimum 20 percent patient volume attributable to individuals receiving TXIX and/or TXXI-CHIP (but not separate CHIPs) Medicaid services, **and** be a pediatrician; **or**
    c. Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient

volume attributable to needy individuals.

2. Have no sanctions and/or exclusions.

An individual EP may choose to receive the incentive directly or assign it to a Medicaid contracted clinic or group to which the provider is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the National Level Registry (NLR) and must match a TIN linked to the individual provider in DMS's system. If there is no contract on file with Kentucky Medicaid, the system will not be available to a provider for attestation until a contract has been approved by DMS. The following table is a summary of qualifying provider types and minimum patient encounter volumes.

Qualifying Providers by Type and Patient Volume

Program Entity	Percent Patient Volume Over Minimum 90-days	
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC -30% "needy individual" patient volume threshold
Pediatricians	20%	
Dentists	30%	
Optometrist	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	

2.2 Out-of-State Providers

The Kentucky Medicaid EHR Incentive Program (Promoting Interoperability) welcomes out-of-state providers to participate in this program as long as they have at least one physical location in Kentucky. Kentucky must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Kentucky DMS program or CMS. Records must be maintained as applicable by law in the state of practice or Kentucky, whichever is deemed longer.

2.3 Establishing Patient Volume

An eligible provider must annually meet patient volume requirements to participate in Kentucky's Medicaid EHR Incentive Program (Promoting Interoperability) as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP (but not separate CHIPs). All providers should calculate patient volume based on TXIX - Medicaid and/or TXXI-CHIP and out-of-state Medicaid patients.

2.3.1 Patient Encounters Methodology

- To calculate TXIX-Medicaid and/or TXXI-CHIP patient volume, an EP must divide:
  - The total TXIX and/or TXXI-CHIP Medicaid or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the prior calendar year or preceding 12 months from date of attestation; by
  - The total patient encounters in the same 90-day period.
- EPs Practicing Predominantly in an FQHC/RHC – to calculate needy individual patient volume, an EP must divide:
  - The total needy individual patient encounters in any representative, continuous 90-day period in the prior calendar year or preceding 12 months from date of attestation; by
  - The total patient encounters in the same 90-day period.

2.3.2 Eligible Professional Medicaid Encounter Definition

For purposes of calculating EP patient volume, a Medicaid encounter is defined as any service rendered on any one day to an individual enrolled in a Medicaid program whether or not Medicaid had a financial interest in the services that were rendered.

2.3.3 Definition of a Needy Individual Encounter

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

- Furnished by the provider as uncompensated care; or
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

2.3.4 Group Practices

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

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

3 Payment Methodology

The maximum incentive payment an EP could receive from Kentucky Medicaid is $63,750, over a period of six years, or $42,500 for pediatricians with a 20-29% Medicaid patient volume as shown below.

EP Patient Volume	EP (30%)	Pediatrician (20-29%)
Year 1	$21,250	$14,167
Year 2	$8,500	$5,666
Year 3	$8,500	$5,666
Year 4	$8,500	$5,666
Year 5	$8,500	$5,666
Year 6	$8,500	$5,666
Total Incentive Payment	**$63,750**	**$42,500**

Since pediatricians are qualified to participate as physicians, and therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30% Medicaid patient volume requirements.

3.1 Payments

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation National Level Repository (NLR). The TIN must be associated in the Kentucky Medicaid Partner Portal Application system with either the EP him/herself or a group or clinic with whom the EP is affiliated. EPs who assign payment to himself or herself (and not a group or clinic) will be required to provide DMS with updated information. Each EP must have a current DMS contract and be contracted for at least 90 days.

For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that provider was a meaningful user of EHR technology during that year. Medicaid EPs are not required to participate on a consecutive annual basis. However, the last year that an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021. In the event that DMS determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS.

The timeline for receiving incentive payments is illustrated below:

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$21,250					
CY 2012	$8,500	$21,250				
CY 2013	$8,500	$8,500	$21,250			
CY 2014	$8,500	$8,500	$8,500	$21,250		
CY 2015	$8,500	$8,500	$8,500	$8,500	$21,250	
CY 2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
CY 2017		$8,500	$8,500	$8,500	$8,500	$8,500
CY 2018			$8,500	$8,500	$8,500	$8,500
CY 2019				$8,500	$8,500	$8,500
CY 2020					$8,500	$8,500
CY 2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

4 Provider Registration

2016 was the last year a provider could initiate participation with the EHR Incentive Program (Promoting Interoperability). If changes to the registration need to be made, such as: address, phone number, taxpayer ID number (TIN) of the entity receiving the payment and the e-mail address; you may log into the NLR at https://ehrincentives.cms.gov/hitech/login.action.

The Quality Payment Program (QPP) is new federal legislation altering the way clinicians are reimbursed for their Medicare Part B encounters. Clinicians have two tracks, Merit-based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APMs), to choose from in the QPP based on their practice size, specialty, location or patient population. For more information, please visit https://qpp.cms.gov/.

5 Attestation Process & Validation

DMS uses the secure KYSLR system to house the attestation system. If an EP transfers from another state in which they participated in the program, updates their registration at the NLR and does not receive the link to the attestation system within two business days, assistance is available by contacting the EHR Incentive Program at EHRIncentives@ky.gov or 502-564-0105 extension 2463.

5.1 Attestation

The following is a brief description of the information that a provider must report or attest to during the process:

1. The provider will log into the KYSLR https://prdweb.chfs.ky.gov/KYSLR/Login.aspx using their NPI and CMS assigned Registration Identifier.
2. The provider is asked to view the information displayed with the pre-populated data received from the NLR.
3. EPs will then enter two categories of data to complete the Eligibility Provider Details screen including: 1) patient volume characteristics, and 2) certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules).
4. EPs will submit MU data for objectives and electronic Clinical Quality Measures (eCQMs).
5. The EP will be asked to attest that:
    - The information submitted is accurate to the knowledge and belief of the EP.
    - The information submitted is accurate and complete for numerators, denominators and exclusions for functional measures applicable to the EP.
    - A zero was reported in the denominator of a measure when an EP did not care for any patients in the denominator population during the EHR reporting period.
    - The information submitted includes information on all patients to whom the measure applies.
    - As a meaningful EHR user, at least 50% of my patient encounters during the EHR reporting period occurred at the practice/location given in my attestation information and is equipped with CEHRT.
    - The information submitted for eCQM's was generated as output from an

identified CEHRT.

- The information submitted for eCQM's includes at least one outcome or high priority measure. If there are no outcome or high priority measures relevant to the EP's scope of practice, 6 relevant measures were reported.
- Acknowledges the requirement to cooperate in good faith with ONC direct review of the EPs health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received.
- If requested, cooperated in good faith with ONC direct review of EPs health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the EP in the field.
- Acknowledges the option to cooperate in good faith with ONC-ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received
- If requested, cooperated in good faith with ONC-ACB surveillance of the EPs health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating capabilities as implemented and used by the EP in the field.

6. The providers are asked to electronically sign the attestation.
   - The provider or the agent/ staff member's initials are entered.
   - The providers NPI is entered.

The attestation itself is electronic and will require the provider to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All providers are required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation is provided in the attestation system. Once the electronic attestation is submitted by a qualifying provider and appropriate documentation is provided, DMS will conduct a pre-payment audit, which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation. All providers will be required to attest to meaningful use to receive incentive payments.

5.2 Incentive Payments

Upon submission of the attestation and receipt of required documentation, verification is completed by DMS. Providers will be notified of approval for payment by email to the email

address submitted with registration. Please be sure the email address provided is current.

5.3 Program Integrity

DMS has a contract with the Office of Inspector General (OIG) to perform audits and investigations of potential Medicaid fraud and/or abuse; therefore, OIG will conduct post payment incentive money audits. The audits conducted will investigate for all things attested; including, but not limited to the CEHRT component, percentage of Medicaid population treated, Medicaid eligibility, etc. Any documentation to which an EP or EH attests, including future meaningful use, will be audited. All reviews will ensure that no duplication of payment occurred. The OIG will submit reports on audit findings and recommendations to the DMS Division of Program Integrity. All documentation supporting the attestation is to be retained for six years.

5.4 Administrative Audits/Appeals

You may appeal the determination made by the Kentucky Department for Medicaid Services on your incentive payment application. In accordance with 907 KAR 6:005 Section 13, to appeal the provider must request a dispute resolution meeting. The request shall be in writing and mailed to and received by the department within 30 calendar days of the date the notice was received. The request must clearly identify each specific issue and dispute, and clearly state the basis on which the department's decision on each issue is believed to be erroneous. The provider shall also state the name, mailing address, and telephone number of individuals who are expected to attend the dispute resolution meeting on the provider's behalf. Any supporting documentation to the appeal should be included with the request. The address to send the request is below:

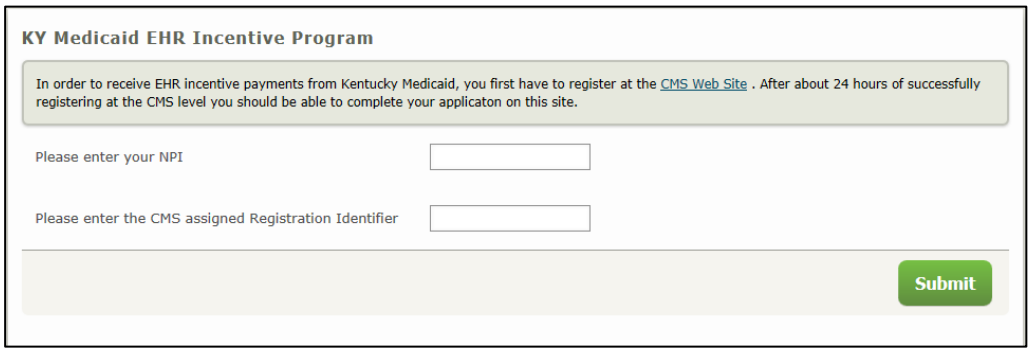
Division of Program Integrity
ATTN: EHR Appeal
Department for Medicaid Services
275 E. Main Street, 6E-A
Frankfort, KY 40621

6 Getting Started

EPs are required to provide details including patient volume characteristics, EHR details, upload requested documentation and electronically sign the attestation.

The provider begins the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability) attestation process by accessing the KYSLR system at https://prdweb.chfs.ky.gov/KYSLR/Login.aspx.

6.1 Sign-in



The provider enters the NPI and CMS assigned Registration Identifier that was returned by the NLR. Upon registration at the CMS registration site, you are assigned a CMS registration identifier. The identifier is used for accessing the KYSLR and should be safeguarded as a password.

If the data submitted by the provider matches the data received from the NLR, the Home Screen will display. If the provider entry does not match, an error message with instructions will be returned. After five failed attempts, the provider will be locked out of the KYSLR for 15 minutes.

6.2 Home Screen

The Home screen provides announcements, information about the provider's current Kentucky Attestation review as well as provides navigation for the provider to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment. This is also where the provider selects the Program Year they are attesting and selects the status of their EHR.

Home (Year 6 Attestation)

Announcements And Messages

No Announcements and Messages !

Issues/Concerns

You received the response from the DMS for the issue you have submitted.
Please click the link below to view the response you received.
Click Here

Provider Information

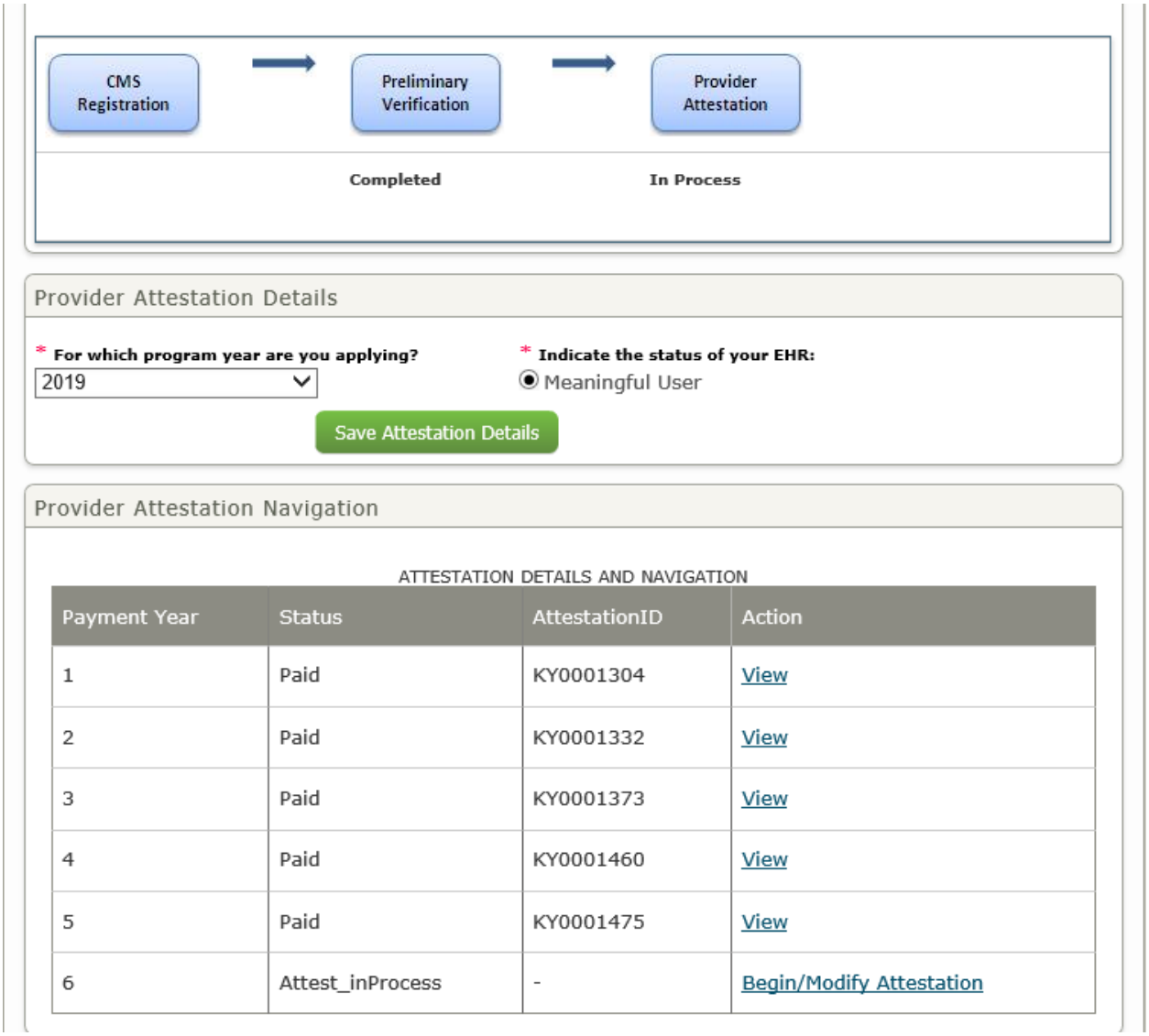
You are currently enrolled in KY's EHR Incentive Program.

Payment Year **'6'** is your current year attestation.

The current status of your application for the year 6 payment is 'AWAITING PROVIDER ATTESTATION'.

Stage of Meaningful Use

1st Year	2012	2013	2015	2017	2018	2019
2012	MU Stage 1 (90 Days)	MU Stage 1 (365 Days)	MU Mod Stage 2 (90 Days)	MU Mod Stage 2 or Stage 3 (90 Days)	MU Mod Stage 2 or Stage 3 (90 Days)	MU Stage 3 (90 Days)



There are seven sections to the Home page listed below:

- Announcements and Messages – Displays messages or announcements for the provider.
- Issues/Concerns – Provides a link for the provider to submit a new issue or view a response to an issue.
- Provider Information – Provides a high-level status for the provider including the current payment year and the current status for the payment year.
- Stage of Meaningful Use – Supplies the stage of Meaningful Use the provider will need to attest to according to the program year.
- Provider Status Flow – Displays a diagram showing the provider's current year's attestation. If the provider has been found not eligible for any reason, specific reasons for that finding is shown in this section.
- Provider Attestation Details – Provider selects the Program Year and the status of their EHR. The selection available for EHR status are:
    - (MU) Meaningful User – currently meaningfully using CEHRT and are prepared to

attest to Meaningful Use and eCQMs.

- Provider Attestation Navigation – Lists the provider's attestations by payment year and provides the navigation actions available for each year. These options may include:
  - View for a previously paid attestation;
  - View Attestation for a completed attestation;
  - Begin/Modify for a new or not yet completed attestation.

6.3 Registration Data Screen

6.3.1 Provider CMS Registration Data

The data displayed in the Provider CMS Registration Data section is view only. If any of this data is incorrect, the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected.

Provider Medicaid Attestation Data

**** Please update the data below in reference to this attestation

Mailing Address:

Address 1: Trzypfhp

Medicaid Provider Type: Nurse-Practitioner

Address 2:

City: testing

State: GB

ZipCode: 40150

Were you assisted by a Regional Extension Center in Kentucky? ○ Yes ◉ No

Previous | Next | Save | Cancel

The fields from the CMS registration are listed below:

- Applicant National Provider Identifier (NPI) – This is the eligible provider's individual NPI. The NPI registered at CMS should be the same individual NPI that is enrolled in Kentucky Medicaid.
- Applicant TIN – This is the eligible providers Tax Identification Number. This TIN should be the same TIN that is listed for the provider in MMIS.
- Payee National Provider Identifier (NPI) – This is the eligible provider's payee NPI given during the CMS registration. The Payee NPI should be enrolled in Kentucky Medicaid and listed as a payee with whom the individual provider is a member. **Note:** When a provider is linked to a Payee NPI that has multiple Medicaid ID's enrolled in Kentucky Medicaid under that Payee NPI, the provider is required to select the appropriate Medicaid ID that the provider should be paid under.
- Payee TIN – The tax identification number associated with the payee NPI. This was the tax ID given during registration that will have the tax liability of the incentive payment. The Payee TIN should match the FEIN or SSN listed for the payee NPI within Kentucky Medicaid.
- Program Option – This program option was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.
- Medicaid State – This is the state that was selected during the provider's registration.
- Provider Type – This is the provider type that was given during the registration at CMS. This type will be validated with your type of license.
- Participation year – This is the provider's participation year with the program.

- Federal Exclusion – This will list any federal exclusion found on the provider if any during registration with CMS.
- Name – The Provider's name listed on the CMS Registration.
- Address 1 – The provider's street address listed on the CMS registration. Note: This is the address where all incentive monies will be mailed.
- Address 2 – The provider's street address listed on the CMS registration.
- City/State – The provider's city/state listed on the CMS registration.
- Zip Code – The provider's zip code listed on the CMS registration.
- Phone Number – The provider's phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.
- Email – The provider's email given during the CMS registration. This email address is used for system-generated emails on updates for the provider's attestation and communication from the EHR review staff. **Note:** It is very important that this email address be accurate and up-to-date.
- Specialty – The provider's specialty listed in the CMS registration.
- State Rejection Reason – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

6.3.2 Provider Medicaid Attestation Data

The data listed under the section Provider Medicaid Attestation Data is updatable by the provider during attestation. If the Provider needs their paper check mailed to an address other than the one registered with CMS in the screen above, this is where it can be changed. Once the attestation is submitted by the provider, the data will become view only. These data fields are described below:

- Medicaid ID - This field only displays if you have multiple group Kentucky Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Kentucky group Medicaid Numbers. **This Medicaid Number will be used for your incentive payments.**
- Mailing Address - The mailing address can be updated if the provider would like to give an alternate address from the one listed from CMS for correspondence. This change will only be used for mailing the provider's incentive payment. This will not change the address listed with CMS. If the mailing address is not current, this can delay receiving the incentive payment.
- Medicaid Provider Type - Please select the provider type from the list. This type should match the type of provider listed under your Kentucky Medicaid enrollment and your type of license.
- Were you assisted by a Regional Extension Center in Kentucky - Response to this question is required. If the response is yes, then please type the name of the person who assisted you during the attestation process.

6.4 Provider Eligibility Details Screen

EPs must enter two categories of information to complete the Eligibility Provider Details screen including Eligibility Details and Service Locations. Within the Eligibility Details section, the provider will enter data for Patient Volume and EHR Details.

6.4.1 Eligibility Details

Eligibility details section allows the provider to view or enter information depending on the source of the information and the status of the attestation. Information in this section includes patient volume and information about EHR use.

Provider Eligibility Details (Year 6 Attestation)

Eligibility Details:

	PATIENT VOLUME DETAILS	
Patient Volume:	1. Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals:	* No
	2. If yes, please enter the NPI of the clinic or group:	0
	3. For which program year are you applying?	* 2019
	4. What is the time frame used for patient volume calculation?	* Preceding 12 Months
	5. Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage:	* 4/1/2019 (mm/dd/yyyy)
	6. Medicaid patient encounters during this period (FQHCs/RHCs do NOT include uncompensated care volume in this count. Uncomp care volume needs to be included on the patient volume report.):	* 50
	7. Total patient encounters during this period:	* 100
	8. Medicaid patient volume percentage:	**50.00%**
EHR Details:	9. Enter the CMS EHR Certification ID of your EHR:	* 0015EWD30V6BXE4
	10. Indicate the status of your EHR:	* Meaningful User

Patient Volume

1. Indicate if patient volume was calculated at a clinic or practice level for all eligible professionals.
    - If submitting at the clinic or practice levels, **all** EPs from the clinic or practice must also submit their volume at the clinic or practice level for the same program year.
2. If submitting at the clinic or practice level, enter the NPI of the clinic or group.
3. The Program Year is display only from your selection made on the Home screen.
    - This should be the current year or the prior year, if the current date is on or before March 31.
4. Select the time frame used for patient volume calculation.
    - From the dropdown menu, select either the "Prior Calendar Year" or "Preceding 12 Months" of the date of attestation.
5. Select the starting date of the 90-day period to calculate the Medicaid encounter volume percentage. Enter as mm/dd/yyyy.
    - This date should be a continuous 90-day period.
6. Enter Medicaid patient encounters during this period.
7. Enter Total patient encounters during this period.
8. Medicaid patient volume percentage is auto-calculated based on the volume numbers entered and is displayed as a percentage with two decimals points.
    - Volume thresholds are calculated using the EP's total number of Medicaid member encounters for the 90-day period as the numerator and *all* patient encounters for the same EP over the same 90-day period as the denominator.

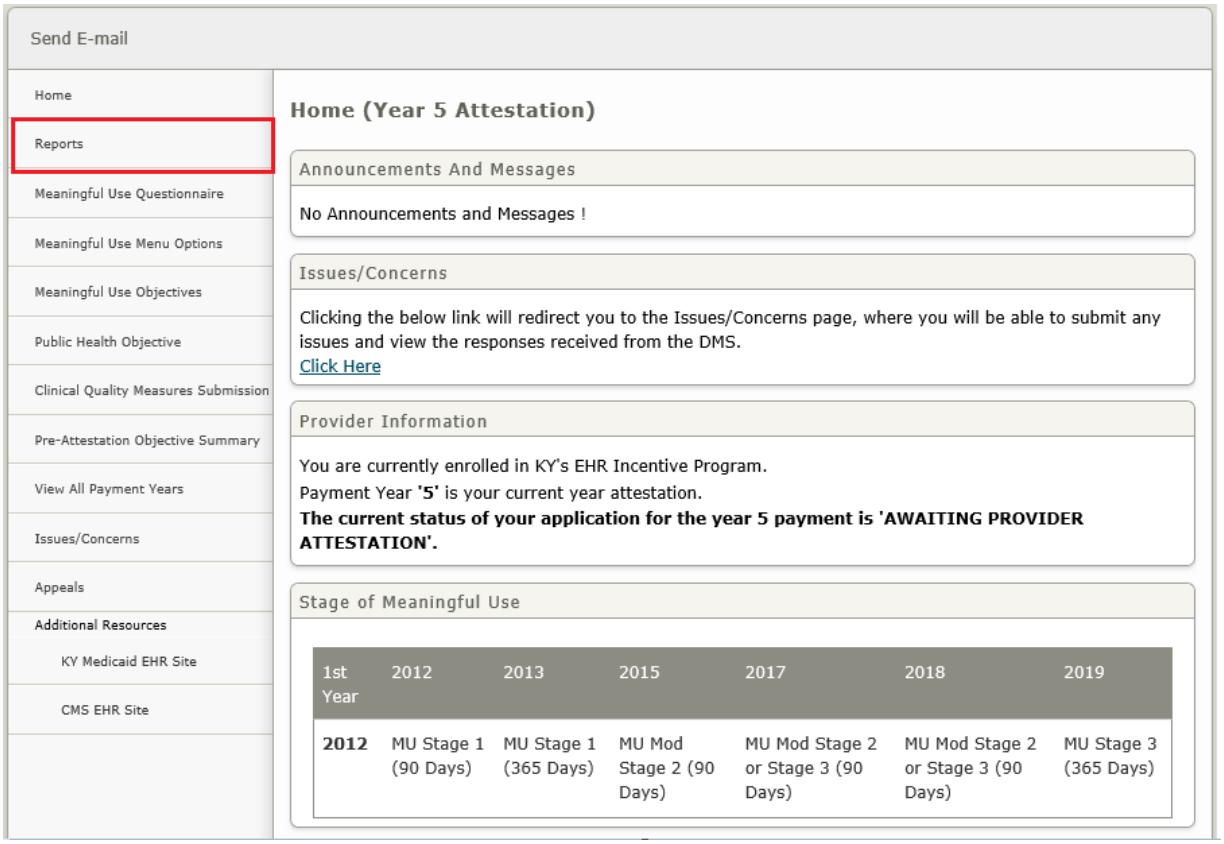
EHR Details

9. Enter the CMS EHR Certification ID
10. The status of your EHR is displayed only from your selection made on the Home screen.

6.4.2 Requesting KCHIP Report Data

To request a KCHIP Report, the provider will need to log into the attestation website at https://prdweb.chfs.ky.gov/KYSLR/Login.aspx.

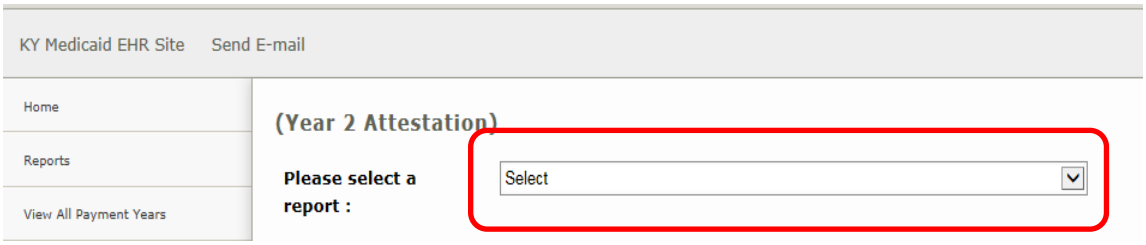
Click on the Reports link in the navigation menu and follow the instructions below to complete your request. Once the report is processed, an email will be sent to the email address provided at CMS registration.



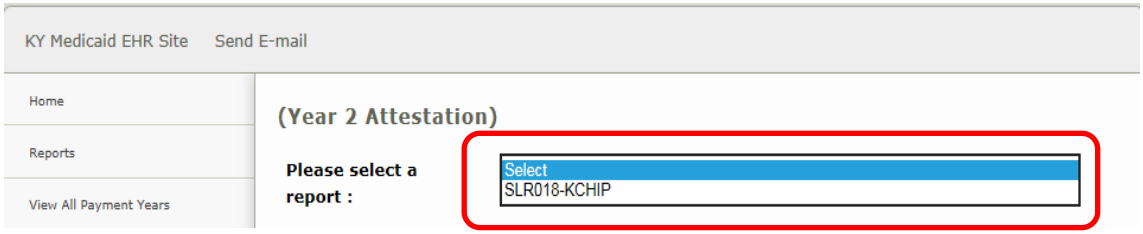
The KCHIP data report will take approximately three hours to complete. Once the report is ready to be viewed, an email will be sent to the email address on file within the attestation. This email address can be verified on the 'Registration Data' screen of the attestation. If this email address is not correct, please go to the CMS Registration website to update this information. Email is our main form of communication with providers, so please take a moment to verify this information. Also, please be aware this update takes 24 hours to complete.

Once you have received email notification that your KCHIP data is ready to be viewed, you will need to sign back into the attestation and click on the 'Reports' link located within the menu options located on the left hand side of the 'Home' screen and complete the following steps:

Step 1: Click the down arrow to select a report.



Step 2: Select 'SLR018-KCHIP'.



Step 3: Scroll down and locate the 'Report Request Information' heading. Click the 'Select' button next to the date you requested the report – also please confirm that the 'Start Date and End Date' are correct dates you will be attesting to for your 90 day patient volume.

REPORT REQUEST INFORMATION :

	Date Requested	Report Name	NPI	Start Date	End Date	Status
Select	5/24/2018 9:26:04 AM	SLR018-KCHIP	2020202020	4/1/2017 12:00:00 AM	6/29/2017 12:00:00 AM	Completed - Successful

If KCHIP data is returned, subtract this total from the numerator value of your 90-day patient volume data, which is your total 'Medicaid Encounters'. This adjusted total is what will be reported on line 6 on the 'Eligibility Details' page of the attestation. If 'No Information Found' is displayed, report your total Medicaid patients as you have calculated with no adjustments to line 6 on the 'Eligibility Details' page of the attestation and continue the completion of your attestation for review.

Provider Eligibility Details (Year 5 Attestation)

Eligibility Details:

All * fields are required fields.

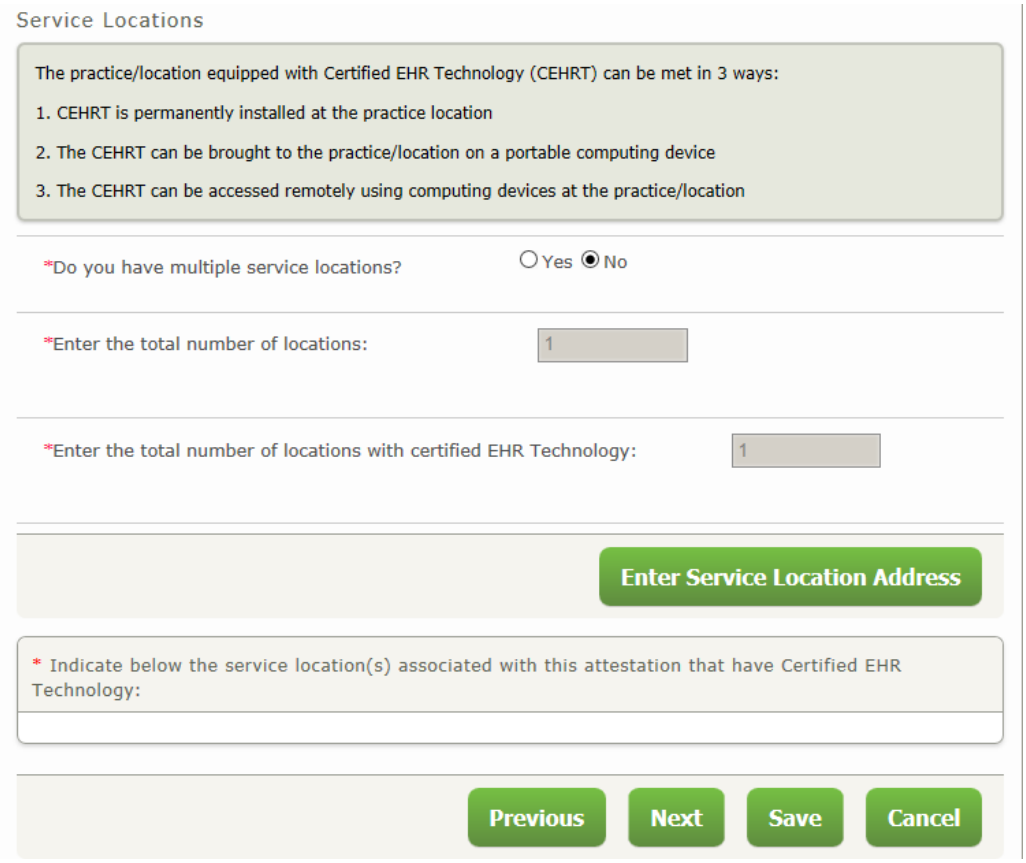
PATIENT VOLUME DETAILS

Patient Volume:	1. Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals:	* No
	2. If yes, please enter the NPI of the clinic or group:	0
	3. For which program year are you applying?	* 2018
	4. What is the time frame used for patient volume calculation?	* Preceding 12 Months
	5. Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage:	* 12/31/2017 (mm/dd/yy)
	6. Medicaid patient encounters during this period (FQHCs/RHCs do NOT include uncompensated care volume in this count. Uncomp care volume needs to be included on the patient volume report.):	* 100
	7. Total patient encounters during this period:	* 100
	8. Medicaid patient volume percentage:	**100.00%**
EHR Details:	9. Enter the CMS EHR Certification ID of your EHR:	* 1314E01PLOAVEAX
	10. Indicate the status of your EHR:	* Meaningful User

6.4.3 Service Locations

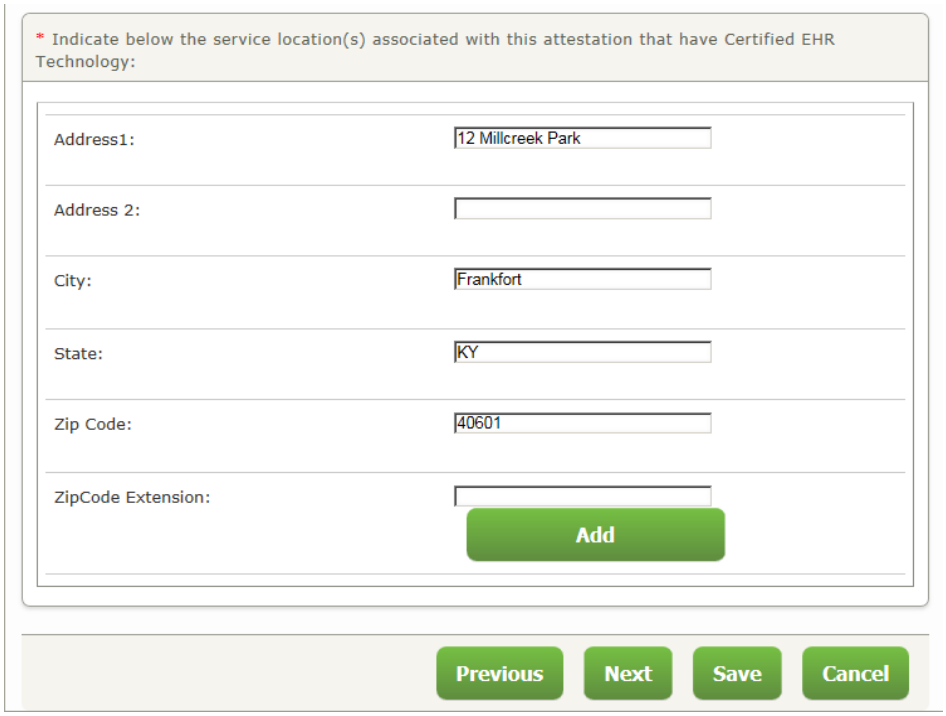
In the Service location section, enter information about the service locations equipped with a certified EHR. Practice/Locations equipped with CEHRT can qualify for meaningful use in the following ways:

- The CEHRT is permanently installed at the practice location.
- The CEHRT can be brought to the practice/location on a portable computing device.
- The CEHRT can be accessed remotely using computing devices at the practice/location.

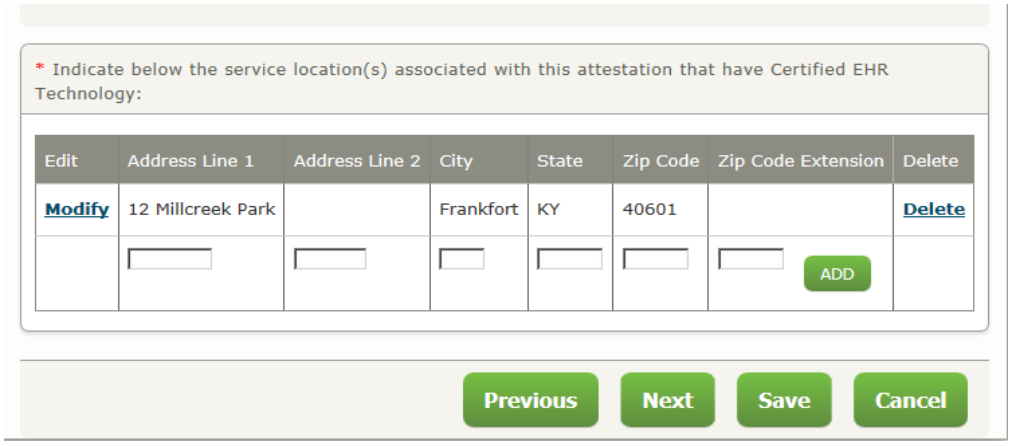


To complete this section, perform the following steps:

- Select Yes or No to indicate if there are multiple locations.
    - If Yes is selected, enter the total number of locations and the number of locations with a certified EHR.
        - A new section will open for entering an address. After entering the address, click on the Add button.
    - If No is selected, the total number of locations and locations with EHR technology will automatically populate with a 1.
- Enter the single service location address by clicking on the **Enter Service Location Address** button.



- Enter the Service location address information in the fields, then click the Add button.



Once the address is added into the table, it can be modified or deleted, and more Service locations can be added.

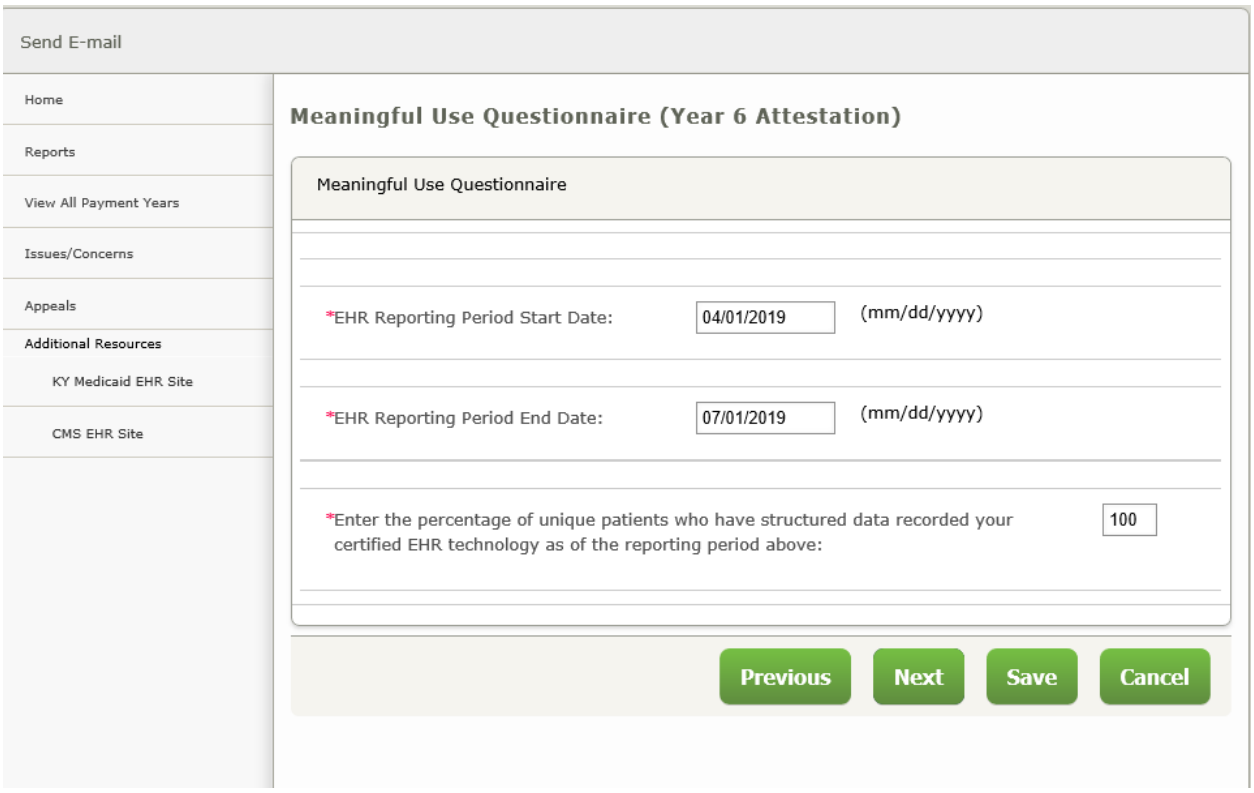
- To edit or update a Service location, click the Modify link.
- To remove a Service location, click the Delete link.
- To add a new Service location, enter address information in to the fields and click the ADD button.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen.
- Click **Next** to move on to the next screen.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

6.5 Meaningful Use Questionnaire Screen

After entering the provider eligibility details, EPs will be directed to the Meaningful Use Questionnaire screen. Here, the EP will enter the Meaningful Use reporting period. The Meaningful Use reporting period must be a 90-day consecutive period within the calendar year.



Enter responses for the following:

- Enter EHR Reporting Period Start Date
  - This is the starting date of the reporting period for the Meaningful Use data.
- Enter EHR Reporting Period End Date
  - This is the end date of the reporting period for the Meaningful Use data.
- Enter percentage of unique patients who have structured data recorded in the CEHRT as of the reporting period above.
  - This can be calculated by dividing the number of patients with structured data in your certified EHR by the total number of patients seen at service location(s) with CEHRT. Multiply by 100 to obtain the percentage. The amount of patients with structured data stored in your EHR should be at least 80%.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen.
- Click **Next** to move on to the next screen.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7 Requirements for Meaningful Use Measures

Providers who are demonstrating MU for the Kentucky Medicaid EHR Program (Promoting Interoperability) will submit and attest to the following requirements:

- Medicaid provider eligibility requirements;
- Medicaid volume requirements;
- For Program Year 2019, Providers must select an EHR MU reporting period that is any continuous 90-day period within the current calendar year. Providers have until March 31, 2020 to attest to that EHR MU reporting period;
- For providers who work at multiple locations, 50% or more of patient encounters must occur at the location equipped with CEHRT;
- 80% of unique patients must have structured data recorded in the CEHRT;
- Must meet 8 MU Objectives for Stage 3;
- Must submit six eCQMs.EPs must report on at least one outcome measure. If no outcome measure is relevant to his or her scope of practice, the EP must report on one high priority measure. If no high priority measures are relevant to their scope of practice, they may report on any six relevant measures.

Providers will be directed through the 8 MU Objectives listed below. The eCQMs will not be available for attestation until the MU Objectives have been completed.

Meaningful Use Objectives

1. Protect Electronic Protected Health Information
2. Electronic Prescribing
3. Clinical Decision Support
4. Computerized Provider Order Entry
5. Patient Electronic Access to Health Information
6. Coordination of Care Through Patient Engagement
7. Health Information Exchange
8. Public Health and Clinical Data Registry Reporting
    - Immunization Registry Reporting
    - Syndromic Surveillance Reporting
    - Electronic Case Reporting
    - Public Health Registry Reporting
    - Clinical Data Registry Reporting

For additional information on Meaningful Use Measures, please visit the CMS Web site https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

7.1 Meaningful Use Menu Screen

The menu screen will only allow the user to select a group of measures, as they are available. For example, once the Meaningful Use Core Objectives are completed, the Public Health Objectives will be active to select.

Meaningful Use Core Objectives Link – Takes the EP to the first screen of the Meaningful Use Core Objectives.

Public Health Objectives Link – Takes the EP to the first screen of the Public Health Objectives. This link is only active after the MU Core Objectives are completed.

Electronic Clinical Quality Measures Submission Link – Takes the EP to the first screen of the eCQMs. This link is only active after the Public Health Objectives are completed.

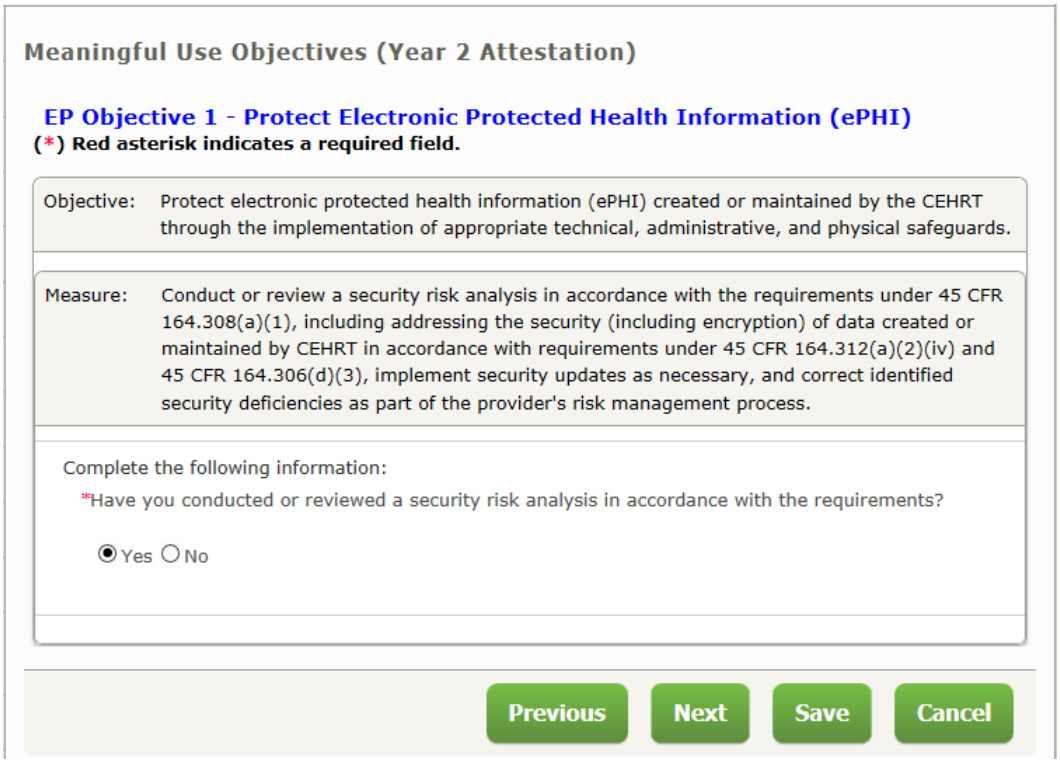
If the EP does not wish to click the links for attestation, buttons at the bottom of the screen are available for navigation.

- Click **Previous** to go back to the previous screen.
- Click **Next** to move on to the next screen.

7.2 Meaningful Use Core Objectives – Stage 3

7.2.1 MU Core Objective 1 – Protect Patient Health Information

OBJECTIVE: Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.



In order for EPs to meet the objectives, they must be able to satisfy the measure.

To satisfy the Measure, select a response to the question.

- If No is selected, upon navigation, a message will pop up stating that the entry for the measure does not meet the threshold to qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.2 MU Core Objective 2 – Electronic Prescribing (eRX)

OBJECTIVE: Generate and transmit permissible prescriptions electronically

Meaningful Use Objectives (Year 2 Attestation)

EP Objective 2 - Electronic Prescribing

(*) Red asterisk indicates a required field.

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

Measure: More than 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

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

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

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

EXCLUSION 1: Any EP who writes fewer than 100 permissible prescriptions during the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: Any EP who does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EPs practice location at the start of his or her EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

Numerator = The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.

Denominator = Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.

***Numerator :** 60 ***Denominator :** 100

Previous Next Save Cancel

In order for EPs to meet the objective, they must satisfy the measure by claiming the exclusion or meeting the threshold.

To satisfy the Measure, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

- Second, respond to Exclusion 1.
    - If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 60% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.3 MU Core Objective 3 – Clinical Decision Support

OBJECTIVE: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

Meaningful Use Objectives (Year 4 Attestation)

EP Objective 3 - Clinical Decision Support

(*) Red asterisk indicates a required field.

In order to meet this objective, an EP must satisfy both measures for this objective through a combination of meeting the thresholds and exclusions.

Objective: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.

Measure 1: Implement five CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an EPs scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.

Complete the following information:

*Have you implemented five CDS interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period and absent four clinical quality measures related to your scope of practice or patient population, were the clinical decision support interventions related to high-priority health conditions?

(•) Yes ( ) No

If you have implemented four or more CQMs related to five clinical decision support interventions for the entire EHR reporting period, please enter below.

Testing

Measure 2: Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

EXCLUSION: Any EP who writes fewer than 100 medication orders during the EHR reporting period may take an exclusion.

*Does this exclusion apply to you?

( ) Yes (•) No

Complete the following information:

*Has the EP enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

(•) Yes ( ) No

Previous Next Save Cancel

EP must satisfy both measures in order to meet the objective.

To satisfy Measure 1, respond to the question.

- If Yes is selected, enter four or more clinical quality measures related to the five clinical decision support interventions implemented.
- If No is selected, a pop up window stating the entry for the Measure does not qualify for an incentive payment.

To satisfy Measure 2, respond to the Exclusion.

- If No is selected, respond to the question for measure 2.
    - If No is selected in response to the question for measure 2, a pop up window stating the entry for Measure 2 does not qualify for an incentive payment.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.4 MU Core Objective 4 – Computerized Provider Order Entry

OBJECTIVE: Use 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.

Meaningful Use Objectives (Year 4 Attestation)

EP Objective 4 - Computerized Provider Order Entry

(*) Red asterisk indicates a required field.

In order to meet this objective, an EP must satisfy both measures for this objective through a combination of meeting the thresholds and exclusion.

Objective: Use 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 1: More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

***Patient Records:** Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using CEHRT.

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

EXCLUSION: Any EP who writes fewer than 100 medication orders during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

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

Denominator = Number of medication orders created by the EP during the EHR reporting period.

***Numerator:** 100 ***Denominator:** 100

Measure 2: More than 60% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

***Patient Records:** Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using CEHRT.

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

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

EXCLUSION: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

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

Denominator = Number of laboratory orders created by the EP during the EHR reporting period.

***Numerator:** 100 ***Denominator:** 100

Measure 3: More than 60% of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

***Patient Records:** Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using CEHRT.

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

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

EXCLUSION: Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

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

Denominator = Number of diagnostic imaging orders created by the EP during the EHR reporting period.

***Numerator:** 60 ***Denominator:** 100

Previous Next Save Cancel

An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.

To satisfy Measure 1, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to Exclusion.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 60% in order to successfully attest to the measure.

To satisfy Measure 2, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 60% in order to successfully attest to the measure.

To satisfy Measure 3, make two selections.

- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 60% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.5 MU Core Objective 5 – Patient Electronic Access to Health Information

OBJECTIVE: The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

Meaningful Use Objectives (Year 4 Attestation)

EP Objective 5 - Patient Electronic Access to Health Information

(*) Red asterisk indicates a required field.

In order to meet this objective, an EP must satisfy both measures for this objective through a combination of meeting the thresholds and exclusion.

Objective: The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

Measure 1: 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 his or her health information; and (2) The provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT.

EXCLUSION 1: Any EP with no office visits during the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

*Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

Numerator = The number of patients in the denominator (or patient-authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the EP's CEHRT.

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

***Numerator:** 80 × ***Denominator:** 100

Measure 2: The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35% of unique patients seen by the EP during the EHR reporting period.

EXCLUSION 1: Any EP with no office visits during the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

*Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

Numerator = The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the EHR reporting period.

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

***Numerator:** 35 ***Denominator:** 100

Previous Next Save Cancel

EP must satisfy both measures in order to meet the objective.

To satisfy Measure 1, respond to Exclusion 1.

- If No is selected, respond to Exclusion 2.

- If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 80% in order to successfully attest to the measure.

To satisfy Measure 2, respond to Exclusion 1.

- If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 35% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.6 MU Core Objective 6 – Coordination of Care through Patient Engagement

OBJECTIVE: Use CEHRT to engage with patients or their authorized representatives about the patients' care.

Meaningful Use Objectives (Year 4 Attestation)

EP Objective 6 - Coordination of Care Through Patient Engagement

(*) Red asterisk indicates a required field.

In order to meet this objective, EPs must attest to all three measures and must meet the thresholds for at least two measures. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

Objective:	Use CEHRT to engage with patients or their authorized representatives about the patient's care.
Measure 1:	More than 5% of all unique patients (or their authorized representatives) seen by the EP actively engage with the EHR made accessible by the EP and either: (1) View, download, or transmit to a third party their health information; or (2) Access their health information through the use of an Application Programming Interface (API) that can be used by applications chosen by the patient and configured to the API in the EP's CEHRT; or (3) A combination of (1) and (2).

EXCLUSION 1: Any EP who has no office visits during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

* Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

Numerator = The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the EHR reporting period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the EHR reporting period.

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

***Numerator :** 5 ***Denominator :** 100

Measure 2: For more than 5% of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative.

EXCLUSION 1: Any EP who has no office visits during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

* Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

Numerator = The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the EHR reporting period.

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

***Numerator :** 5 ***Denominator :** 100

Measure 3: Patient generated health data or data from a non-clinical setting is incorporated into the CEHRT for more than 5% of all unique patients seen by the EP during the EHR reporting period.

EXCLUSION 1: Any EP who has no office visits during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

* Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

Numerator = The number of patients in the denominator for whom data from non-clinical settings, which may include patient generated health data, is captured through the CEHRT into the patient record during the EHR reporting period.

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

***Numerator :** 5 ***Denominator :** 100

Previous Next Save Cancel

An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

To satisfy Measure 1, respond to Exclusion 1.

- If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 5% in order to successfully attest to the measure.

To satisfy Measure 2, respond to Exclusion 1.

- If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 5% in order to successfully attest to the measure.

To satisfy Measure 3, respond to Exclusion 1.

- If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 5% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.7 MU Core Objective 7 – Health Information Exchange

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

Meaningful Use Objectives (Year 4 Attestation)

EP Objective 7 - Health Information Exchange

(*) Red asterisk indicates a required field.

In order to meet this objective, EPs must attest to all three measures and must meet the thresholds for at least two measures. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

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

Measure 1: For more than 50% of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) Electronically exchanges the summary of care record.

EXCLUSION 1: Any EP who transfers a patient to another setting or refers a patient to another provider fewer than 100 times during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

Numerator = The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

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

***Numerator :** 50 ***Denominator :** 100

Measure 2: For more than 40% of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she incorporates into the patient's EHR an electronic summary of care document.

EXCLUSION 1: Any EP for whom the total transitions or referrals received and patient encounters in which he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: Any EP that conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

Numerator = Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the CEHRT.

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

***Numerator :** 45 ***Denominator :** 100

Measure 3: For more than 80% of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she performs a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies. (3) Current Problem list. Review of the patient's current and active diagnoses.

EXCLUSION : Any EP for whom the total transitions or referrals received and patient encounters in which he or she has never before encountered the patient, is fewer than 100 during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No

Complete the following information:

Numerator = The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.

Denominator = Number of transitions of care or referrals during the EHR reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient.

***Numerator :** 80 ***Denominator :** 100

Previous Next Save Cancel

An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

To satisfy Measure 1, the EP must respond to Exclusion 1.

- If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 50% in order to successfully attest to the measure.

To satisfy Measure 2, respond to Exclusion 1.

- If No is selected, respond to Exclusion 2.
    - If No is selected, the EP must enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 40% in order to successfully attest to the measure.

To satisfy Measure 3, respond to the Exclusion.

- If No is selected, respond to Exclusion 3.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 80% in order to successfully attest to the measure.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

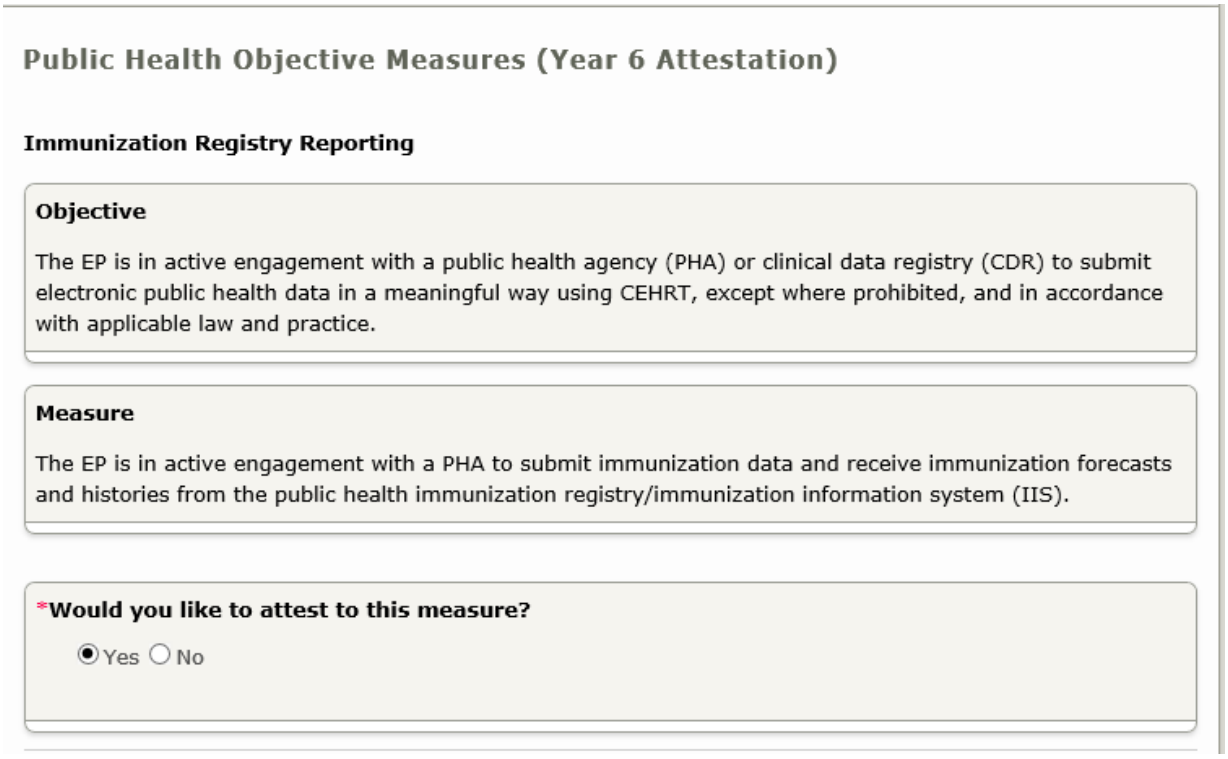
7.2.8 MU Core Objective 8 – Public Health and Clinical Data Registry Reporting

OBJECTIVE: The 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.

In order to meet this objective, EPs need to meet two of the five measures. Exclusions do not count toward meeting the objective. If the EP qualifies for multiple exclusions and the remaining number of measures available is less than two, the EP can meet the objective by meeting all of the remaining measures available and claiming the applicable exclusions. If no measures remain available, you can meet the objective by claiming applicable exclusions for all measures. Available measures are ones for which the EP does not qualify for an exclusion.

7.2.8.1 Measure 1: Immunization Registry Reporting

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



EXCLUSION 1: Does not administer immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system (IIS) during the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: EP practices in a jurisdiction for which no immunization registry or immunization information system (IIS) is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 3: The EP practices in a jurisdiction where no immunization registry or immunization information system (IIS) has declared readiness to receive immunization data as of six months prior to the start of the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

Active Engagement Options:

Active Engagement Option 1- Completed Registration to Submit Data:
The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows EPs to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. EPs that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR 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. EPs must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that EP 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 PHA or CDR.

Please select the applicable active engagement option (may only select one).

- ○ Option1
- ○ Option2
- ◉ Option3

Previous | Next | Save | Cancel

To satisfy the Measure, respond to the question.

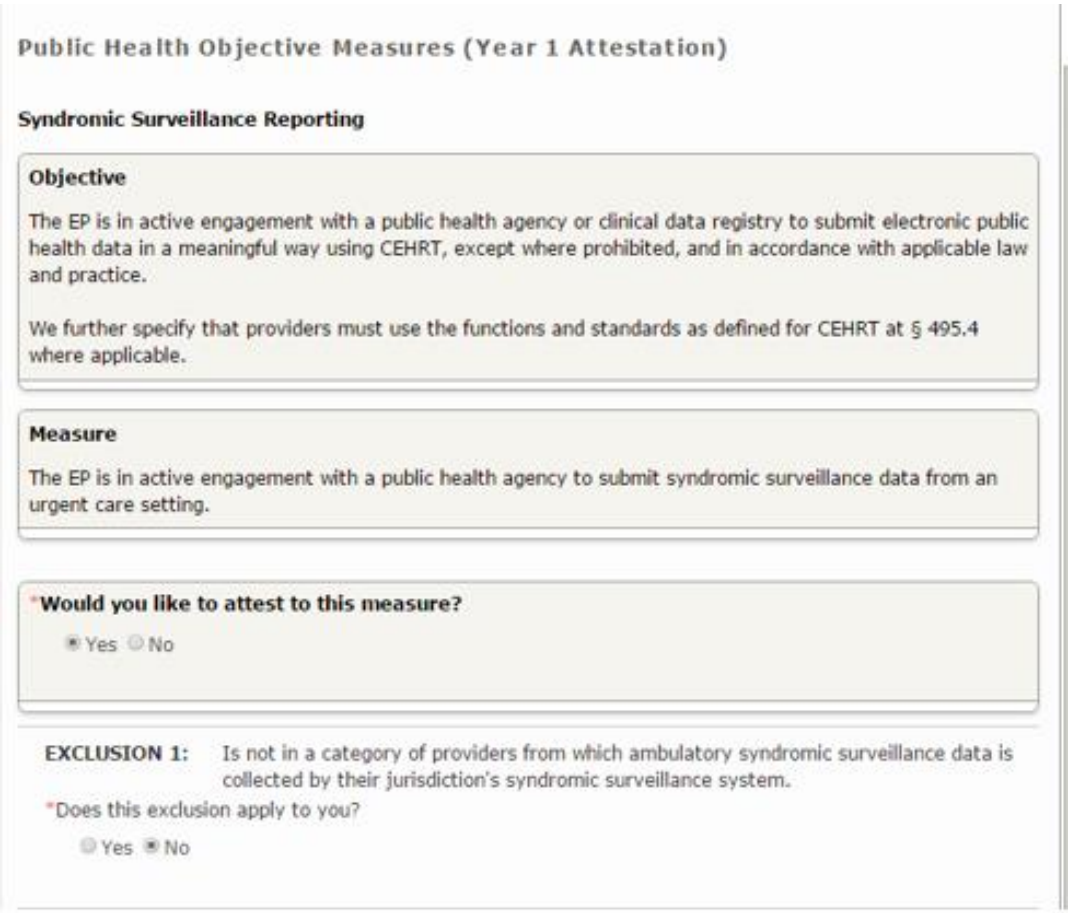
- If Yes is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
    - If No is selected, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.8.2 Measure 2: Syndromic Surveillance Reporting

MEASURE: The EP is in active engagement with a public health agency to submit syndromic surveillance data.



Public Health Objective Measures (Year 1 Attestation)

Syndromic Surveillance Reporting

Objective

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 CEHRT, except where prohibited, and in accordance with applicable law and practice.

We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable.

Measure

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

*Would you like to attest to this measure?

Yes No

EXCLUSION 1: Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system.

*Does this exclusion apply to you?

Yes No

EXCLUSION 2: Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

*Does this exclusion apply to you?

Yes No

EXCLUSION 3: Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs as of 6 months prior to the start of the EHR reporting period.

*Does this exclusion apply to you?

Yes No

Active Engagement Options:

Active Engagement Option 1–Completed Registration to Submit Data:
The EP registered to submit data with the PHA or, where applicable, the clinical data registry to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or clinical data registry to begin testing and validation. This option allows providers to meet the measure when the PHA or the clinical data registry 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 EHR 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 PHA or, where applicable, the clinical data registry within 30 days; failure to

respond to requests from the PHA or, where applicable, the clinical data registry within 30 days; failure to respond twice within an EHR reporting period would result in that 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 PHA or clinical data registry.

Please select the applicable active engagement option (may only select one).

Option1
Option2
Option3

Previous Next Save Cancel

To satisfy the Measure, respond to the question.

- If Yes is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
    - If No is selected, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.8.3 Measure 3: Electronic Case Reporting

MEASURE: The EP is in active engagement with a public health agency to submit case reporting of reportable conditions.

Public Health Objective Measures (Year 6 Attestation)

Electronic Case Reporting

Objective

The 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 CEHRT, except where prohibited, and in accordance with applicable law and practice.

Measure

The EP is an active engagement with a PHA to submit case reporting of reportable conditions.

***Would you like to attest to this measure?**

◉ Yes ○ No

EXCLUSION 1: Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: The EP practices in a jurisdiction for which no PHA is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 3: The EP practices in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of six months prior to the start of the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

Active Engagement Options:

Active Engagement Option 1- Completed Registration to Submit Data:
The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows EPs to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. EPs that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR 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. EPs must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that EP 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 PHA or CDR.

Please select the applicable active engagement option (may only select one).

- (●) Option1
- ( ) Option2
- ( ) Option3

Previous | Next | Save | Cancel

To satisfy the Measure, respond to the question.

- If Yes is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
    - If No is selected, select the applicable Active Engagement Option.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.8.4 Measure 4: Public Health Registry Reporting

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

Public Health Objective Measures (Year 6 Attestation)

Public Health Registry Reporting

Objective

The 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 CEHRT, except where prohibited, and in accordance with applicable law and practice.

Measure

The EP is in active engagement with a PHA to submit data to public health registries.

***Would you like to attest to this measure?**

◉ Yes ○ No

EXCLUSION 1: Does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 2: The EP practices in a jurisdiction for which no PHA is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

EXCLUSION 3: The EP practices in a jurisdiction where no PHA for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

Active Engagement Options:

Active Engagement Option 1- Completed Registration to Submit Data:
The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows EPs to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. EPs that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR 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. EPs must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that EP 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 PHA or CDR.

* **Please select the applicable active engagement option (may only select one).**

- Option1
- Option2
- Option3

Instructions:

Provider may report to more than one public health registry and may count public health registry reporting more than one time to meet the required number of measures for the objective. You may enter as many registries as you wish but only two will be counted towards the objective.

A provider may count a public health registry if the provider achieved the phase of active engagement defined under Active Engagement Option 3: Production, including production data submission with the specialized registry in a prior year under the applicable requirements of the EHR Incentive Programs in 2015 through 2018.

To report the first Public Health Registry, enter the information in the text box, then click 'Add'. To report the additional Public Health Registries, select the active engagement option applicable for the next registry you are reporting, enter the information in the text box and click 'Add'. Public Health Registry information you are attesting to will be displayed in the Registry table below.

* **Please add the public health data registry below:**

- Other

LIST OF SPECIALIZED REGISTRIES YOU ADDED:

Type of Registry	Active Engagement Option	Description	Edit	Delete
Other	1	Testing	Edit	Delete

Add

To satisfy the Measure, respond to the question.

- If Yes is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
    - If No is selected, make two selections.
        - Select the applicable Active Engagement Option for each registry.
        - Add each public health registry to the table.
            - If Other is selected, type the name of the registry into the text box. Click **Add** to add it to the table.
                - To Edit the entries in the table, click the Edit link next to the registry to make changes. Click **Update** to accept changes or click **Cancel Edit Mode** to remove changes.
                - To Delete the entries in the table, click the Delete link next to the registry.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

7.2.8.5 Measure 5: Clinical Data Registry Reporting

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

Public Health Objective Measures (Year 6 Attestation)

Clinical Data Registry Reporting

Objective

The 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 CEHRT, except where prohibited, and in accordance with applicable law and practice.

Measure

The EP is in active engagement to submit data to a CDR.

***Would you like to attest to this measure?**

(•) Yes ( ) No

EXCLUSION 1: Does not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the EHR reporting period.

*Does this exclusion apply to you?

( ) Yes (•) No

EXCLUSION 2: The EP practices in a jurisdiction for which no CDR is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period.

*Does this exclusion apply to you?

( ) Yes (•) No

EXCLUSION 3: The EP practices in a jurisdiction where no CDR for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.

*Does this exclusion apply to you?

○ Yes ◉ No

Active Engagement Options:

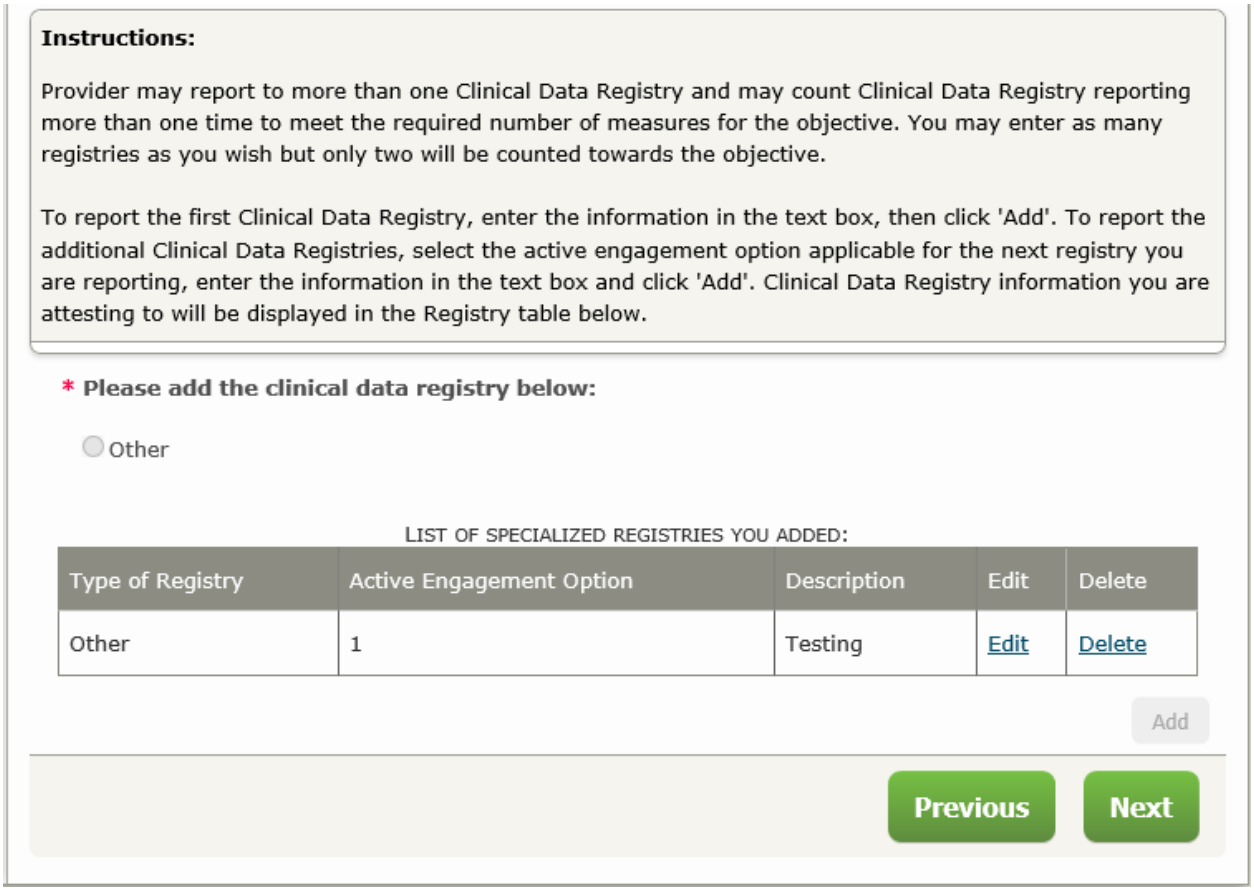
Active Engagement Option 1- Completed Registration to Submit Data:
The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows EPs to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. EPs that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR 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. EPs must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that EP 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 PHA or CDR.

* **Please select the applicable active engagement option (may only select one).**

○ Option1
○ Option2
○ Option3



To satisfy the Measure, respond to the question.

- If Yes is selected, respond to Exclusion 1.
- If No is selected, respond to Exclusion 2.
- If No is selected, respond to Exclusion 3.
    - If No is selected, make two selections.
        - Select the applicable Active Engagement Option for each registry.
        - Add each clinical data registry to the table.
            - If Other is selected, type the name of the registry into the text box. Click **Add** to add it to the table.
                - To Edit the entries in the table, click the Edit link next to the registry to make changes. Click **Update** to accept changes or click **Cancel Edit Mode** to remove changes.
                - To Delete the entries in the table, click the Delete link next to the registry.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8 Electronic Clinical Quality Measures

Electronic clinical quality measures (eCQMs) are tools that help measure and track the quality of health care services that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) provide, as generated by a provider's electronic health record (EHR). Measuring and reporting eCQMs helps to ensure that our health care system is delivering effective, safe, efficient, patient-centered, equitable, and timely care.

The 2019 eCQM reporting period for EPs is the **full 2019 CY**, except for first time meaningful users, for whom the reporting period is any **continuous 90-day period within CY 2019**. All participating EPs are required to report on any **6 eCQMs** relevant to their scope of practice from the set of 50 available. In addition, EPs must report on at least one outcome measure. If no outcome measure is relevant to his or her scope of practice, the EP must report on one high priority measure. If no high priority measures are relevant to their scope of practice, they may report on any six relevant measures.

8.1 Electronic Clinical Quality Measure Submission Selection Screen

Electronic Clinical Quality Measure (CQM) Submission Selection Screen (Year 6 Attestation)

Reporting Clinical Quality Measures

In order to report eCQMs, you will need to select the method of submission below. EPs must report on 6 of the 50 approved eCQMs related to their scope of practice. Medicaid EP's are required to report on at least one outcome or high priority measure. If there are no outcome or high priority measures relevant to an EP's scope of practice, they may report on any 6 relevant measures. For additional information on eCQM reporting, please click here.

How would you like to submit eCQMs?

◉ Manually ○ Electronically

Providers who are for the first time attesting to Meaningful Use may use any continuous 90 days within the calendar year. Providers who are returning Meaningful Users may use a full calendar year for reporting. Please provide the eCQM reporting period associated with this attestation:

*eCQM Reporting Period Start Date: 01/01/2019 (mm/dd/yy)

*eCQM Reporting Period End Date: 12/31/2019 (mm/dd/yy)

Previous Next Save Cancel

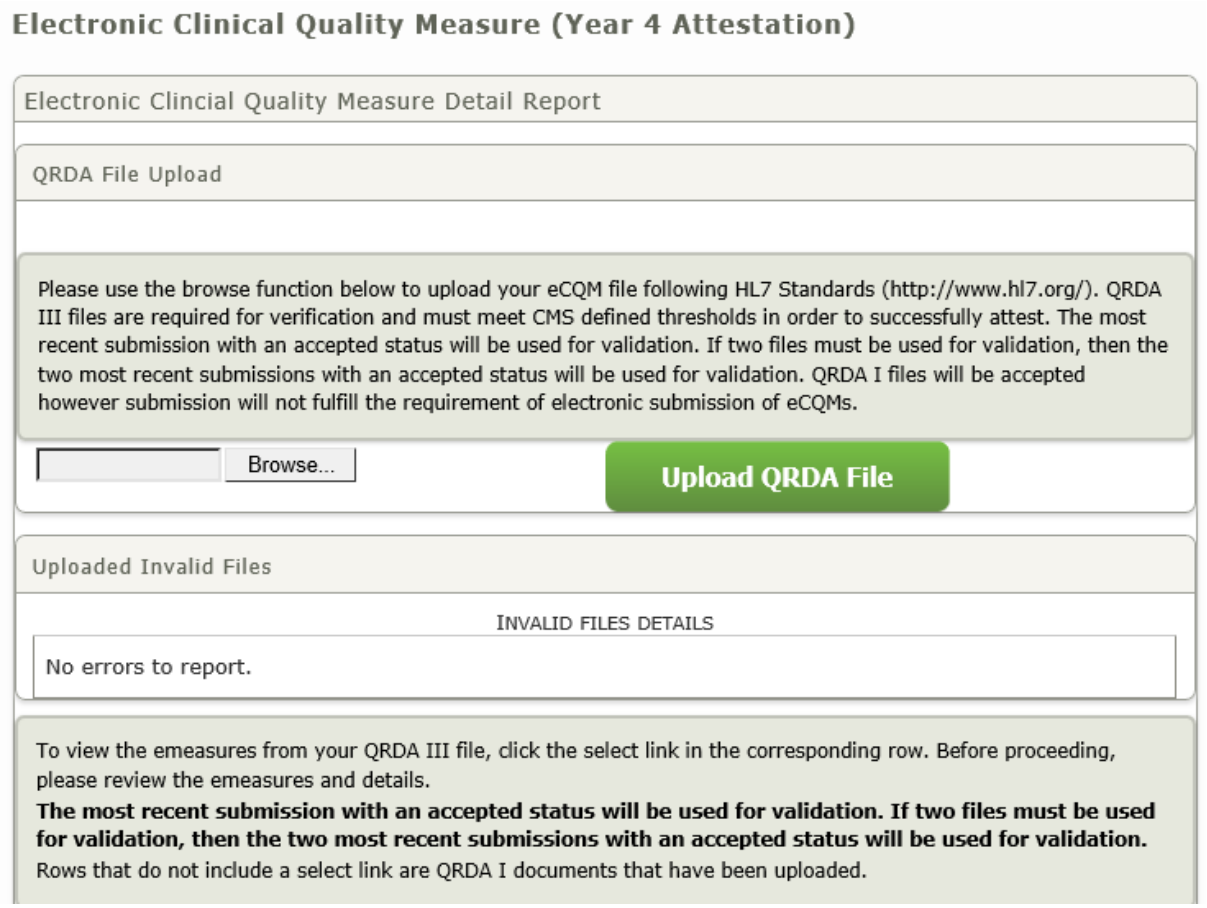
Enter responses for the following:

- How would you like to submit eCQMs?
  - Select Manually or Electronically
- Enter the eCQM Reporting Period Start Date
  - This is the start date of the reporting period for selected eCQMs.
- Enter the eCQM Reporting Period End Date
  - This is the end date of the reporting period for selected eCQMs.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.2 Electronic Clinical Quality Measures Electronically Reported Selection Screen



Uploaded Valid Files

UPLOADED FILES

	FileTransmissionID	Status	DateReceived	FileName
Select	587	Pending	8/17/2018 3:23:00 PM	QRDA_XML2_1013165786_2MSRS_new.xml
Select	586	Pending	8/17/2018 3:00:32 PM	QRDA_XML2_1013165786_4MSRS_1.xml
Select	585	Accepted	8/17/2018 2:46:26 PM	QRDA_XML2_1013165786__4Msrs.xml
Select	584	Accepted	8/17/2018 12:31:16 PM	MIPS_Sample_QRDA_III_2MSRS_2.xml
Select	583	Pending	8/17/2018 12:22:55 PM	MIPS_Sample_QRDA_III_2MSRS_LAst.xml
Select	582	Rejected	8/17/2018 12:22:22 PM	MIPS_Sample_QRDA_III_1MSRS.xml
Select	580	Rejected	8/17/2018 12:21:57 PM	MIPS_Sample_QRDA_III_2MSRS.xml

Selected File Electronic Clinical Quality Measures

ELECTRONIC CLINICAL QUALITY MEASURE DETAILS

Measure Details					Domain
eMeasure Title	**Version Neutral ID**	**eMeasure Version Number**	**NQF Measure Number**	**Version Specific ID**	Patient Safety
Use of High-Risk Medications in the Elderly	a3837ff8-1abc-4ba9-800e-fd4e7953adbd	2		40280381-3D61-56A7-013E-65C9C3043E54	
Member of Measure Set: NONE - eMeasure ID:5b3d9245-fb54-499c-b5c5-21c20564f0bd Initial Patient Population: 73 SexFemale: 48Male: 23Undifferentiated: 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 70 RaceAsian: 5Black or African American: 3White: 4Other Race: 2 Denominator: 73 SexFemale: 48Male: 23Undifferentiated: 2 EthnicityHispanic or Latino: 7Not Hispanic or Latino: 5 PayerMEDICARE: 2BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 70 RaceAsian: 5Black or African American: 3White: 4Other Race: 2 Numerator 1: 22 SexFemale: 14Male: 8 PayerUnavailable / Unknown: 22 Numerator 2: 10 SexFemale: 5Male: 5 PayerUnavailable / Unknown: 10					
eMeasure Title	**Version Neutral ID**	**eMeasure Version Number**	**NQF Measure Number**	**Version Specific ID**	Effective Clinical Care
CERVICAL CANCER SCREENING	42e7e489-790f-427a-a1a6-d6e807f65a6d	2		40280381-3D61-56A7-013E-669CBC034836	
Member of Measure Set: NONE - eMeasure ID:e1d695b0-acee-472f-bfaf-ddb6e1515933 Initial Patient Population: 107 SexFemale: 107 EthnicityNot Hispanic or Latino: 3 PayerMEDICARE: 20BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 86 RaceAmerican Indian or Alaska Native: 1Black or African American: 2 Denominator: 107 SexFemale: 107 EthnicityNot Hispanic or Latino: 3 PayerMEDICARE: 20BLUE CROSS/BLUE SHIELD: 1Unavailable / Unknown: 86 RaceAmerican Indian or Alaska Native: 1Black or African American: 2Numerator: 0Denominator Exclusions: 0					
eMeasure Title	**Version Neutral ID**	**eMeasure Version Number**	**NQF Measure Number**	**Version Specific ID**	Community / Population Health
Preventive Care and Screening: Influenza Immunization	a244aa29-7d11-4616-888a-86e376bfcc6f	2		40280381-3D61-56A7-013E-57F49972361A	
Member of Measure Set: NONE - eMeasure ID:40d83c98-aaa9-4436-9c12-54b0896b0b2c Initial Patient Population: 158 SexFemale: 51Male: 104Undifferentiated: 3 EthnicityHispanic or Latino: 6Not Hispanic or Latino: 4 PayerMEDICARE: 6Unavailable / Unknown: 152 RaceAmerican Indian or Alaska Native: 3Asian: 4White: 1Other Race: 2 Denominator: 83 SexFemale: 17Male: 66 EthnicityHispanic or Latino: 1Not Hispanic or Latino: 1 PayerMEDICARE: 1Unavailable / Unknown: 82 RaceAmerican Indian or Alaska Native: 1Asian: 1 Numerator: 15 SexFemale: 3Male: 12 PayerUnavailable / Unknown: 15 Denominator Exceptions: 24 SexFemale: 6Male: 18 PayerUnavailable / Unknown: 24					

Previous Continue

To submit eCQMs electronically, click Browse button to select QRDA file you wish to upload. Once the file is selected click the Upload QRDA File button.

- To view the emeasures from your QRDA III file, click the select link in the corresponding row. The most recent submission with an accepted status will be used for validation. If

two files must be used for validation, the two most recent submissions with an accepted status will be used.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Cancel** to remove selections and stay on the current screen.

8.3 Electronic Clinical Quality Measures Electronically Reported Summary

Electronic Clinical Quality Measure (Year 4 Attestation)

Electronic Clinical Quality Measure Summary Report

Date Received	Report NPI	Reporting Period Start	Reporting Period End
8/17/2018 2:46:26 PM	0505050505	1/1/2018 12:00:00 AM	12/31/2018 12:00:00 AM
Document Type	**eCQM Status:**	**Evaluated Date:**	**File Name:**
QRDA III	Accepted	8/17/2018 3:24:52 PM	QRDA_XML2_1013165786.xml, MIPS_Sample_QRDA_II_2.xml

QRDA_XML2_1013165786__4MSRS.XML

Domain	# of Measures
Communication and Care Coordination	0
Community/Population Health	2
Effective Clinical Care	1
Efficiency and Cost Reduction	0
Patient Safety	1
Person and Caregiver-Centered Experience and Outcomes	0

MIPS_SAMPLE_QRDA_III_2MSRS_2.XML

Domain	# of Measures
Communication and Care Coordination	0
Community/Population Health	1
Effective Clinical Care	1
Efficiency and Cost Reduction	0
Patient Safety	0
Person and Caregiver-Centered Experience and Outcomes	0

Total Required	6
Total Met	6
Final eCQM Result:	Submission Accepted, click Next to continue.

Previous | Evaluate eCQM Submissions | Next

To evaluate eCQMs submitted electronically, click Evaluate eCQM Submission button.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Cancel** to remove selections and stay on the current screen.

8.4 Electronic Clinical Quality Measures Manually Reported Selection Screen

Electronic Clinical Quality Measures (CQMs) Selection Screen (Year 6 Attestation)

Instructions:

Select a minimum of 6 Electronic Clinical Quality Measures from the list below. You will be prompted to enter numerator(s), denominator(s), performance rate(s), and exclusion(s) or exception(s), if applicable, for all selected Clinical Quality Measures after you select the Save & Next button below.

Deselect All

EFFICIENCY AND COST REDUCTION

Selection	Measure #	Title
☑	CMS146v7.2/NQF XXXX	Appropriate Testing for Children with Pharyngitis
☑	CMS154v7.2/NQF 0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
☑	CMS129v8.2/NQF 0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
☑	CMS249v1.4/NQF XXXX	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

EFFECTIVE CLINICAL CARE

Selection	Measure #	Title
☑	CMS137v7.2/NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
☑	CMS165v7.3/NQF 0018	Controlling High Blood Pressure
☑	CMS124v7.2/NQF 0032	Cervical Cancer Screening
☑	CMS130v7.2/NQF 0034	Colorectal Cancer Screening
☑	CMS131v7.2/NQF 0055	Diabetes: Eye Exam
☑	CMS122v7.4/NQF 0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
☑	CMS134v7.2/NQF 0062	Diabetes: Medical Attention for Nephropathy
☑	CMS145v7.2/NQF 0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)
☑	CMS135v7.1/NQF 0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
☑	CMS144v7.1/NQF 0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
☑	CMS143v7.1/NQF 0086	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

☑	CMS161v7.2/NQF 0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
☑	CMS128v7.2/NQF 0105	Anti-depressant Medication Management
☑	CMS136v8.3/NQF 0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)
☑	CMS52v7.2/NQF 0405	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
☑	CMS133v7.2/NQF 0565	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
☑	CMS159v7.2/NQF 0710	Depression Remission at Twelve Months
☑	CMS160v7.3/NQF 0712	Depression Utilization of the PHQ-9 Tool
☑	CMS125v7.2/NQF 2372	Breast Cancer Screening
☑	CMS149v7.3/NQF 2872	Dementia: Cognitive Assessment
☑	CMS74v8.2/NQF XXXX	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists
☑	CMS347v2.1/NQF XXXX	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
☑	CMS645v2.1/NQF XXXX	Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy

PATIENT SAFETY

Selection	Measure #	Title
☑	CMS156V7.3/NQF 0022	Use of High-Risk Medications in the Elderly
☑	CMS139v7.2/NQF 0101	Falls: Screening for Future Fall Risk
☑	CMS68v8.1/NQF 0419	Documentation of Current Medications in the Medical Record
☑	CMS132v7.2/NQF 0564	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
☑	CMS177v7.2/NQF 1365	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

COMMUNITY/POPULATION HEALTH

Selection	Measure #	Title
☑	CMS155v7.2/NQF 0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
☑	CMS138v7.1/NQF 0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
☑	CMS153v7.4/NQF 0033	Chlamydia Screening for Women
☑	CMS117v7.2/NQF 0038	Childhood Immunization Status
☑	CMS147v8.1/NQF 0041	Preventive Care and Screening: Influenza Immunization

☑	CMS127v7.2/NQF XXXX	Pneumococcal Vaccination Status for Older Adults
☑	CMS2v8.1/NQF 0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
☑	CMS69v7.1/NQF 0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
☑	CMS22v7.1/NQF XXXX	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
☑	CMS75v7.2/NQF XXXX	Children Who Have Dental Decay or Cavities
☑	CMS82v6.3/NQF XXXX	Maternal Depression Screening
☑	CMS349v1.2/NQF XXXX	HIV Screening

COMMUNICATION AND CARE COORDINATION

Selection	Measure #	Title
☑	CMS142v7.1/NQF 0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
☑	CMS50v7.1/NQF XXXX	Closing the Referral Loop: Receipt of Specialist Report

PERSON AND CAREGIVER-CENTERED EXPERIENCE AND OUTCOMES

Selection	Measure #	Title
☑	CMS157v7.4/NQF 0384	Oncology: Medical and Radiation - Pain Intensity Quantified
☑	CMS56v7.4/NQF XXXX	Functional Status Assessment for Total Hip Replacement
☑	CMS66v7.5/NQF XXXX	Functional Status Assessment for Total Knee Replacement
☑	CMS90v8.3/NQF XXXX	Functional Status Assessments for Congestive Heart Failure

Previous Save & Next

EPs are required to report on any six eCQMs related to their scope of practice. In addition, 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.

Select at least six of the eCQMs out of the 50 eCQMs available.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Save & Next** to save selections and to move on to the next screen.

8.5 Electronic Clinical Quality Measures Manually Reported

8.5.1 CMS146

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 1 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS146/NQF XXXX
Versions:	CMS146v7.2
Title:	Appropriate Testing for Children with Pharyngitis
Description:	Percentage of children 3-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.
Denominator:	Children 3-18 years of age who had an outpatient or emergency department (ED) visit with a diagnosis of pharyngitis during the measurement period and an antibiotic ordered on or three days after the visit.
Numerator:	Children with a group A streptococcus test in the 7-day period from 3 days prior through 3 days after the diagnosis of pharyngitis.
Denominator Exclusions:	Children who are taking antibiotics in the 30 days prior to the diagnosis of pharyngitis. Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.2 CMS137

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 2 of 50

(*) Red asterisk indicates a required field.

Measure: CMS137/NQF 0004

Versions: CMS137v7.2

Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Description: Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported.
a. Percentage of patients who initiated treatment within 14 days of the diagnosis.
b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.

Denominator: Patients age 13 years of age and older who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency during a visit between January 1 and November 15 of the measurement period.

Numerator: Numerator 1: Patients who initiated treatment within 14 days of the diagnosis.
Numerator 2: Patients who initiated treatment and who had two or more additional services with an alcohol, opioid, or other drug abuse or dependence diagnosis within 30 days of the initiation visit.

Denominator Exclusions: Patients with a previous active diagnosis of alcohol, opioid or other drug abuse or dependence in the 60 days prior to the first episode of alcohol or drug dependence.

Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

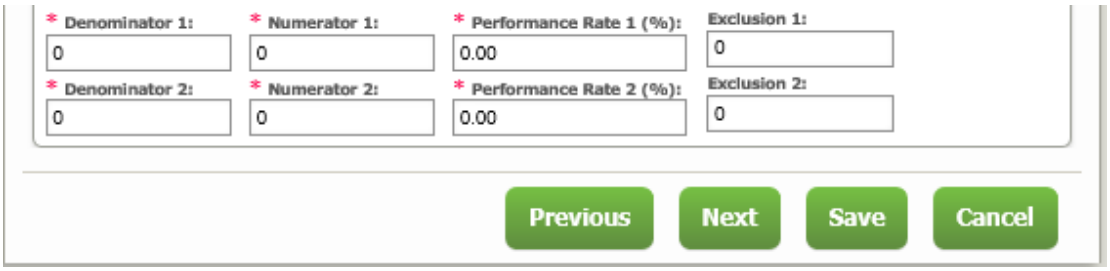
Stratum 1: Patients age 13 - 17.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):	* Exclusion 2:
0	0	0.00	0

Stratum 2: Patients age >=18.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):	* Exclusion 2:
0	0	0.00	0

Stratum 3: Total Score.



To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.3 CMS165

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 3 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS165/NQF 0018
Versions:	CMS165v7.3
Title:	Controlling High Blood Pressure
Description:	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90mmHg) during the measurement period.
Denominator:	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period.
Numerator:	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.
Denominator Exclusions:	Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period. Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.4 CMS156

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 4 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS156/NQF 0022
Versions:	CMS156V7.3
Title:	Use of High-Risk Medications in the Elderly
Description:	Percentage of patients 65 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two of the same high-risk medications.
Denominator:	Denominator 1: Patients 65 years and older who had a visit during the measurement period.
Numerator:	Numerator 1: Patients with an order for at least one high-risk medication during the measurement period. Numerator 2: Patients with at least two orders for the same high-risk medications during the measurement period.
Denominator Exclusions:	Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0
*** Denominator 2:**	*** Numerator 2:**	*** Performance Rate 2 (%):**	*** Exclusion 2:**
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, and Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.5 CMS155

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 5 of 50

(*) Red asterisk indicates a required field.

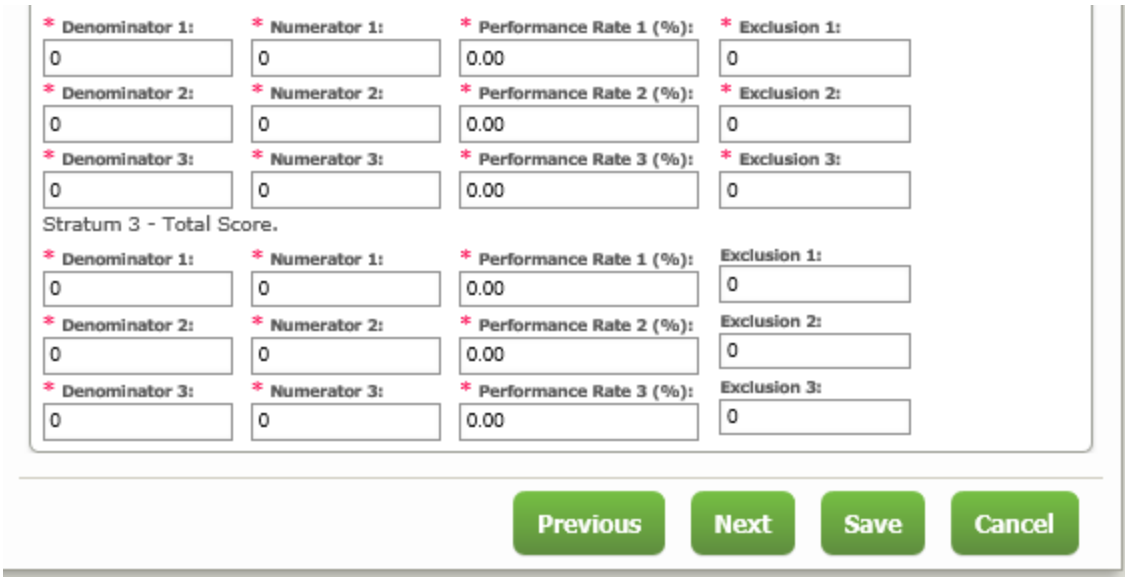
Measure:	CMS155/NQF 0024
Versions:	CMS155v7.2
Title:	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
Description:	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. a. Percentage of patients with height, weight, and body mass index (BMI) percentile documentation. b. Percentage of patients with counseling for nutrition. c. Percentage of patients with counseling for physical activity.
Denominator:	Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period.
Numerator:	Numerator 1: Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period. Numerator 2: Patients who had counseling for nutrition during the measurement period. Numerator 3: Patients who had counseling for physical activity during the measurement period.
Denominator Exclusions:	Patients who have a diagnosis of pregnancy during the measurement period. Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

Stratum 1 - Patients age 3-11.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0
*** Denominator 2:**	*** Numerator 2:**	*** Performance Rate 2 (%):**	*** Exclusion 2:**
0	0	0.00	0
*** Denominator 3:**	*** Numerator 3:**	*** Performance Rate 3 (%):**	*** Exclusion 3:**
0	0	0.00	0

Stratum 2 - Patients age 12-17.



To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.6 CMS138

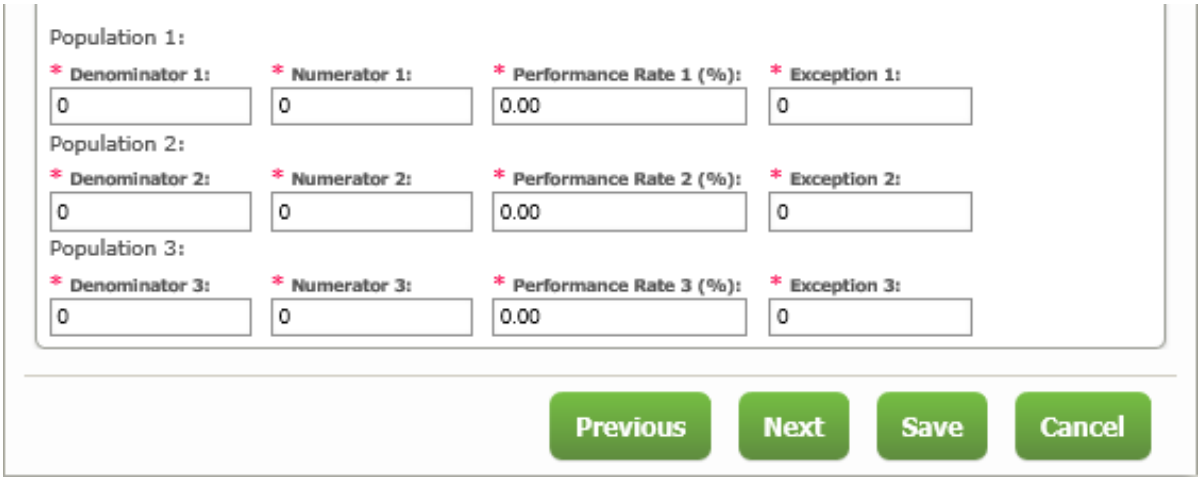
Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 6 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS138/NQF 0028
Versions:	CMS138v7.1
Title:	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
Description:	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported. a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months. b. 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. c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacoo user.
Denominator:	Denominator 1: Population 1: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period. Denominator 2: Population 2: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period who were screened for tobacco use and identified as a tobacco user. Denominator 3: Population 3: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period.
Numerator:	Numerator 1: Population 1: Patients who were screened for tobacco use at least once within 24 months. Numerator 2: Population 2: Patients who received tobacco cessation intervention. Numerator 3: Population 3: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.
Denominator Exceptions:	Exception 1: Population 1: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason). Exception 2: Population 2: Documentation of medical reason(s) for not providing tobacco cessation intervention (eg, limited life expectancy, other medical reason). Exception 3: Population 3: Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patient identified as tobacco users (eg, limited life expectancy, other medical reason).

Complete the following information:



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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- Click **Cancel** to remove selections and stay on the current screen.

8.5.7 CMS124

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 7 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS124/NQF 0032
Versions:	CMS124v7.2
Title:	Cervical Cancer Screening
Description:	Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: * Women age 21-64 who had cervical cytology performed every 3 years. * Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.
Denominator:	Women 23-64 years of age with a visit during the measurement period.
Numerator:	Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: - Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test. - Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test.
Denominator Exclusions:	Women who had a hysterectomy with no residual cervix or a congenital absence of cervix. Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.8 CMS153

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 8 of 50

(*) Red asterisk indicates a required field.

Measure: CMS153/NQF 0033

Versions: CMS153v7.4

Title: Chlamydia Screening for Women

Description: 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.

Denominator: Women 16 to 24 years of age who are sexually active and who had a visit in the measurement period.

Numerator: Women with at least one chlamydia test during the measurement period.

Denominator Exclusions: Women who are only eligible for the initial population due to a pregnancy test and who had an x-ray or an order for a specified medication within 7 days of the pregnancy test.

Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

Stratum 1: Patients age 16-20.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Stratum 2: Patients age 21-24.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Stratum 3: Total Score.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.9 CMS130

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 9 of 50

(*) Red asterisk indicates a required field.

Measure: CMS130/NQF 0034

Versions: CMS130v7.2

Title: Colorectal Cancer Screening

Description: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

Denominator: Patients 50-75 years of age with a visit during the measurement period.

Numerator: Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period.

- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period.

- Colonoscopy during the measurement period or the nine years prior to the measurement period.

- FIT-DNA during the measurement period or the two years prior to the measurement period.

- CT Colonography during the measurement period or the four years prior to the measurement period.

Denominator Exclusions: Patients with a diagnosis or past history of total colectomy or colorectal cancer.

Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Cancel** to remove selections and stay on the current screen.

8.5.10 CMS117

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 10 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS117/NQF 0038
Versions:	CMS117v7.2
Title:	Childhood Immunization Status
Description:	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); 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.
Denominator:	Children who turn 2 years of age during the measurement period and who have a visit during the measurement period.
Numerator:	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday.
Denominator Exclusions:	Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.11 CMS147

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 11 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS147/NQF 0041
Versions:	CMS147v8.1
Title:	Preventive Care and Screening: Influenza Immunization
Description:	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.
Denominator:	All patients aged 6 months and older seen for a visit during the measurement period and seen for a visit between October 1 and March 31.
Numerator:	Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization.
Denominator Exceptions:	Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other medical reasons). Documentation of patient reason(s) for not receiving influenza immunization (eg, patient declined, other patient reasons). Documentation of system reason(s) for not receiving influenza immunization (eg, vaccine not available, other system reasons).

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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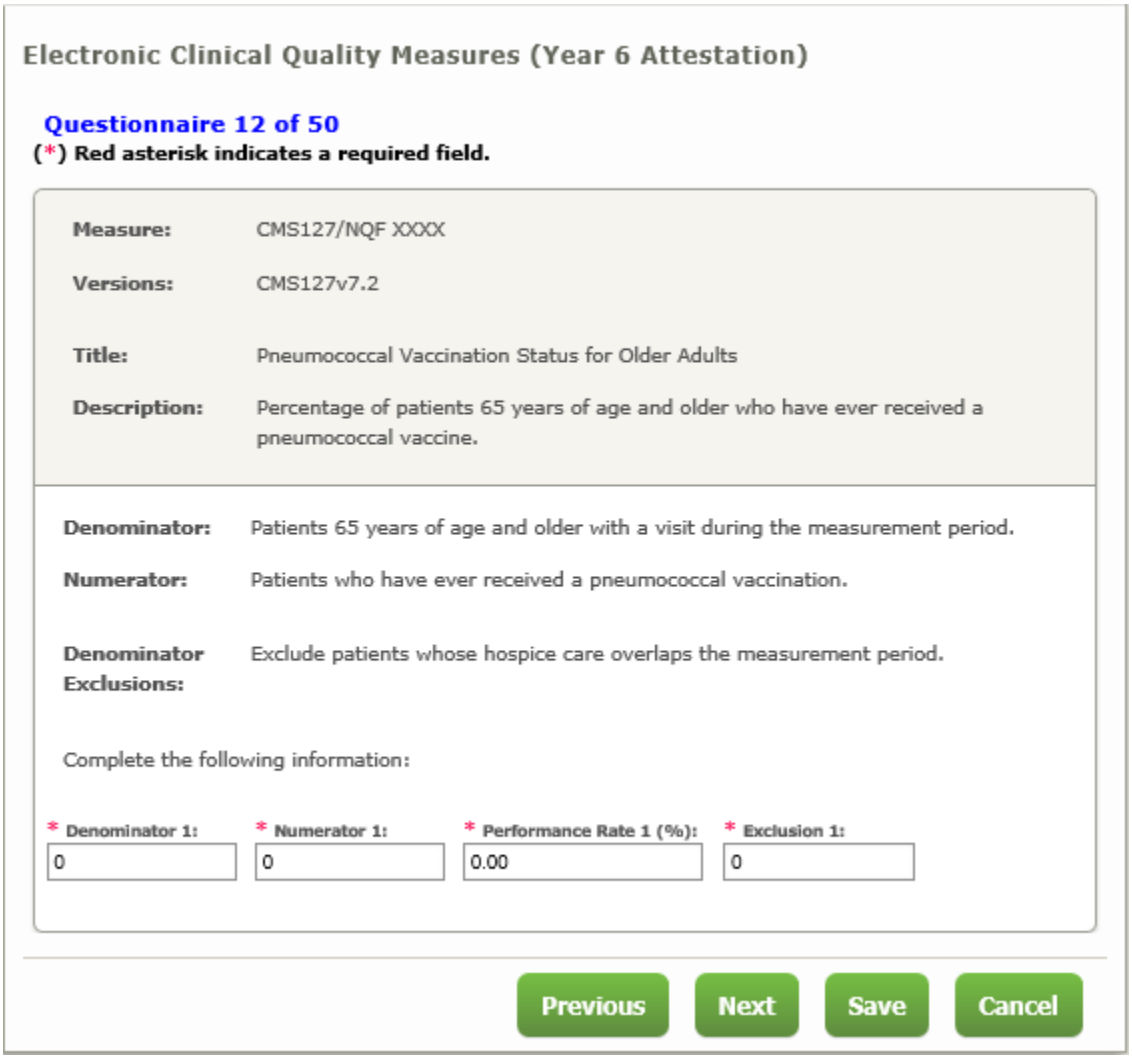
8.5.12 CMS127


Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 12 of 50

(*) Red asterisk indicates a required field.

Measure: CMS127/NQF XXXX

Versions: CMS127v7.2

Title: Pneumococcal Vaccination Status for Older Adults

Description: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.

Denominator: Patients 65 years of age and older with a visit during the measurement period.

Numerator: Patients who have ever received a pneumococcal vaccination.

Denominator Exclusions: Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.13 CMS131

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 13 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS131/NQF 0055
Versions:	CMS131v7.2
Title:	Diabetes: Eye Exam
Description:	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.
Denominator:	Patients 18-75 years of age with diabetes with a visit during the measurement period.
Numerator:	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period.
Denominator Exclusions:	Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate, and Exclusion boxes.

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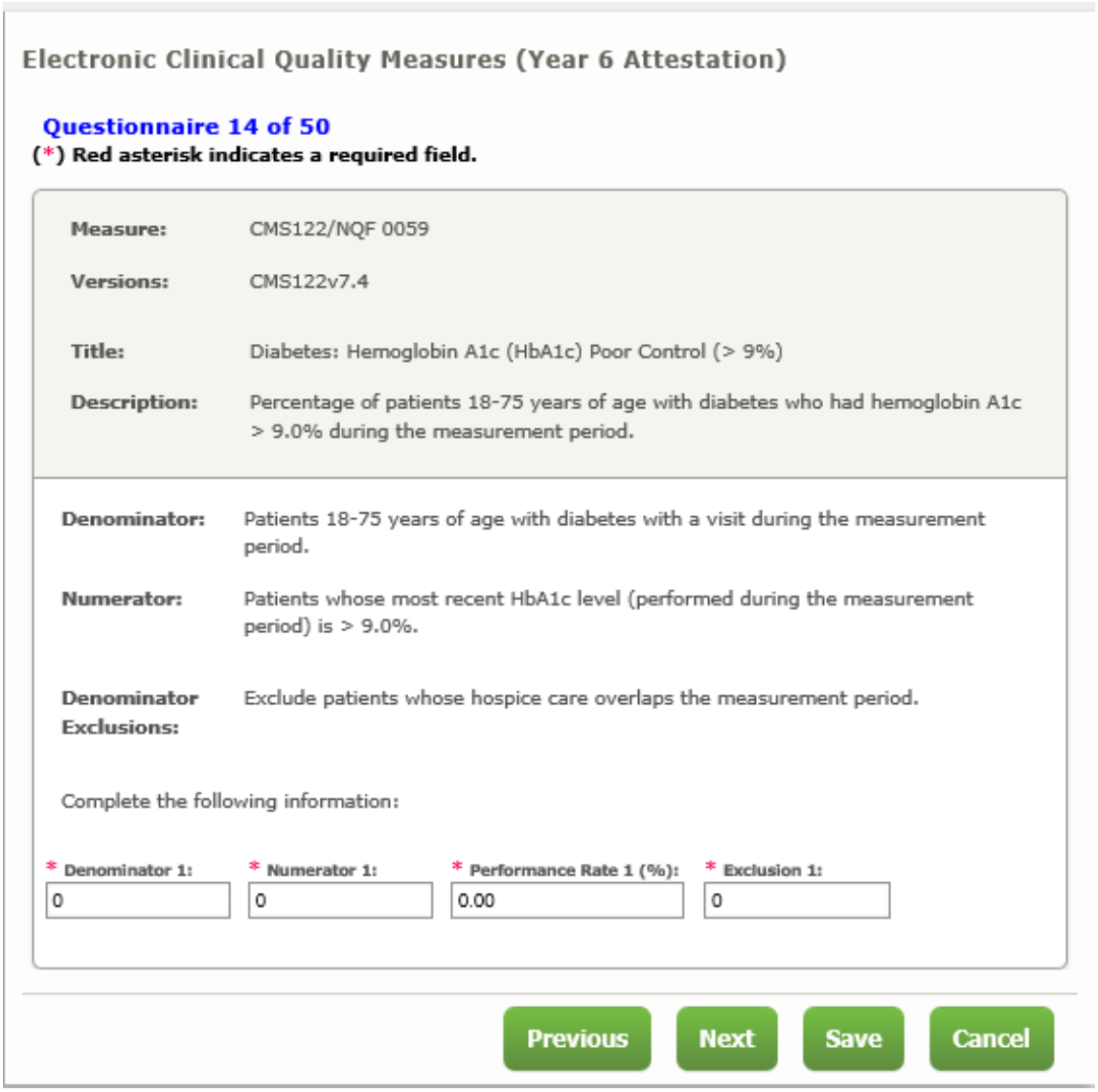
8.5.14 CMS122


Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 14 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS122/NQF 0059
Versions:	CMS122v7.4
Title:	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
Description:	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.
Denominator:	Patients 18-75 years of age with diabetes with a visit during the measurement period.
Numerator:	Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%.
Denominator Exclusions:	Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate and Exclusion boxes.

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8.5.15 CMS134

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 15 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS134/NQF 0062
Versions:	CMS134v7.2
Title:	Diabetes: Medical Attention for Nephropathy
Description:	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.
Denominator:	Patients 18-75 years of age with diabetes with a visit during the measurement period.
Numerator:	Patients with a screening for nephropathy or evidence of nephropathy during the measurement period.
Denominator Exclusions:	Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate, and Exclusion boxes.

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8.5.16 CMS154

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 16 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS154/NQF 0069
Versions:	CMS154v7.2
Title:	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Description:	Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.
Denominator:	Children age 3 months to 18 years who had an outpatient visit with a diagnosis of URI during the measurement period.
Numerator:	Children without a prescription for antibiotic medication on or 3 days after the outpatient or ED visit for an upper respiratory infection.
Denominator Exclusions:	Exclude children who are taking antibiotics in the 30 days prior to the date of the encounter during which the diagnosis was established. Exclude children who had an encounter with a competing diagnosis within three days after the initial diagnosis of URI. Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.17 CMS145

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 17 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS145/NQF 0070
Versions:	CMS145v7.2
Title:	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)
Description:	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF < 40% who were prescribed beta-blocker therapy.
Denominator:	All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior (within the past 3 years) MI or a current or prior LVEF < 40%.
Numerator:	Patients who were prescribed beta-blocker therapy.
Denominator Exceptions:	Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, allergy, intolerance, other medical reasons). Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons). Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the health care system).

Complete the following information:

Population Criteria 1: Patients with left ventricular systolic dysfunction (LVEF < 40%).

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:

Population Criteria 2: Patients with a prior (within the past 3 years) myocardial infarction.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:

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To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

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8.5.18 CMS135

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 18 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS135/NQF 0081
Versions:	CMS135v7.1
Title:	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Description:	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.
Denominator:	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%.
Numerator:	Patients who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.
Denominator Exceptions:	Documentation of medical reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia, allergy, intolerance, other medical reasons). Documentation of patient reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, patient declined, other patient reasons). Documentation of system reason(s) for not prescribing ACE inhibitor or ARB therapy (eg, other system reasons).

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

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8.5.19 CMS144

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 19 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS144/NQF 0083
Versions:	CMS144v7.1
Title:	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Description:	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.
Denominator:	All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40%.
Numerator:	Patients who were prescribed beta-blocker therapy either within a 12- month period when seen in the outpatient setting OR at each hospital discharge.
Denominator Exceptions:	Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons). Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons). Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the healthcare system).

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:
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To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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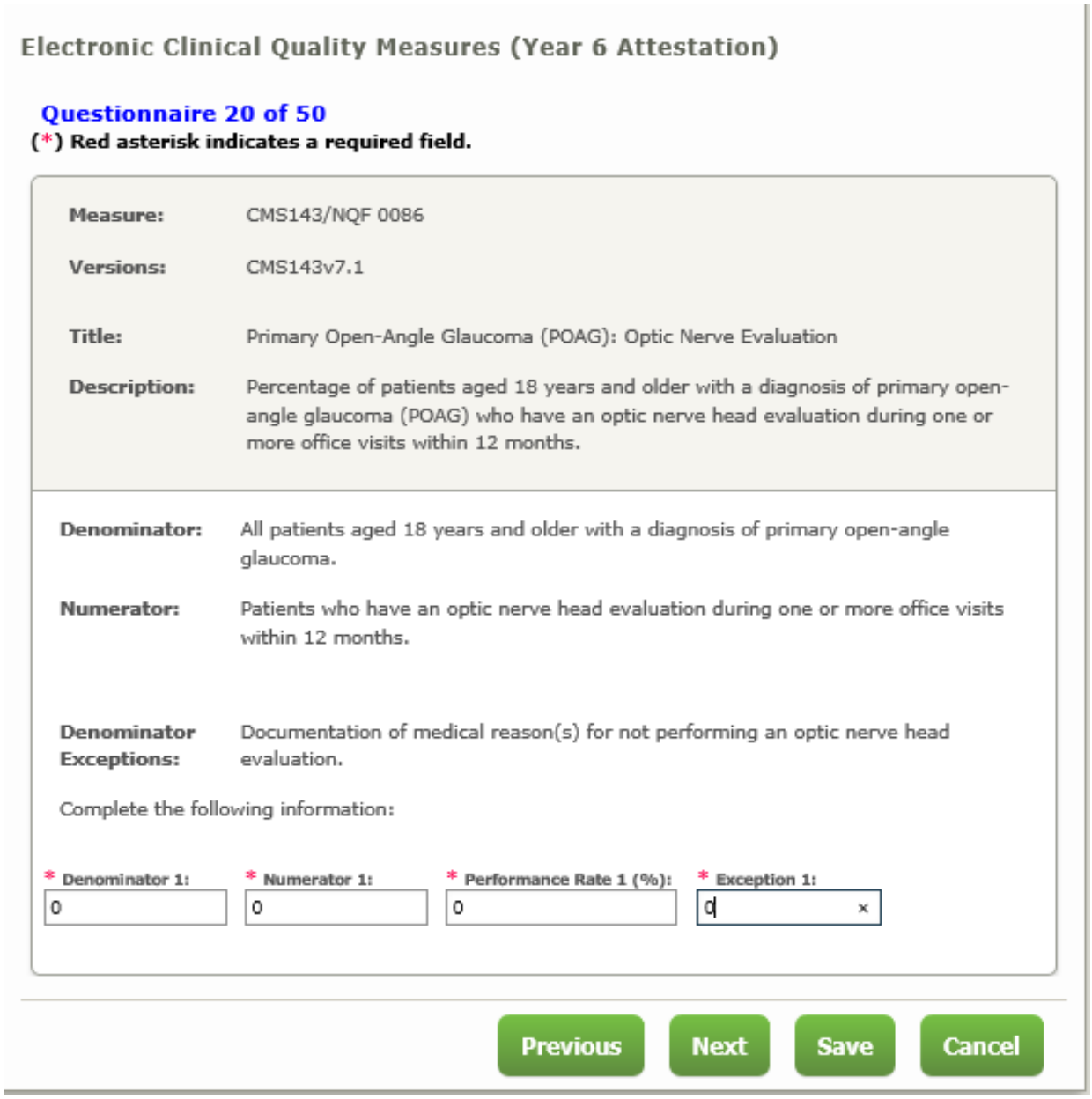
8.5.20 CMS143



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

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- Click **Cancel** to remove selections and stay on the current screen.

8.5.21 CMS142

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 21 of 50

(*) Red asterisk indicates a required field.

Measure: CMS142/NQF 0089

Versions: CMS142v7.1

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

Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.

Denominator: All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed.

Numerator: Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care.

Denominator Exceptions: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:
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Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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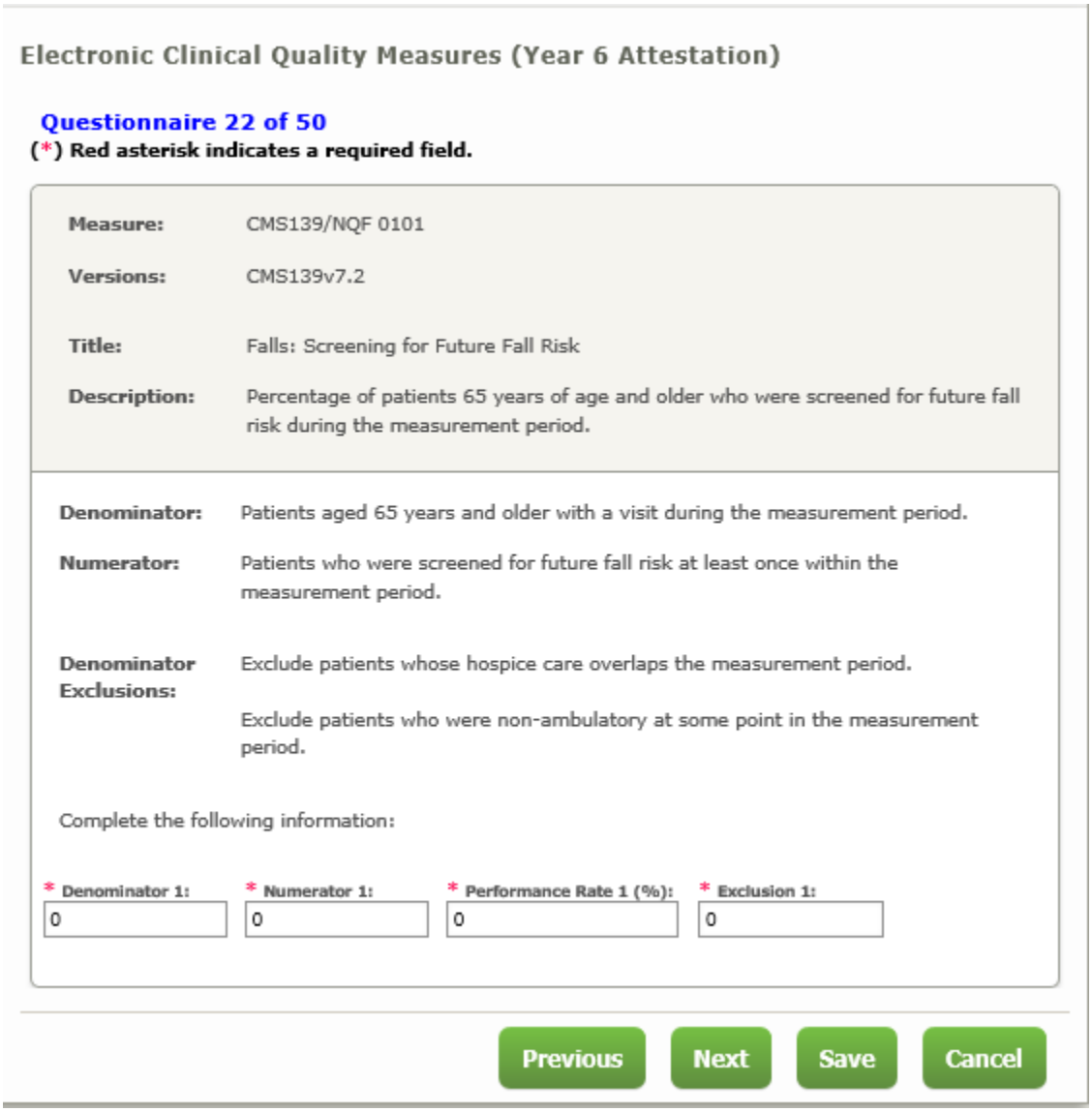
8.5.22 CMS139



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

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8.5.23 CMS161

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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- Click **Cancel** to remove selections and stay on the current screen.

8.5.24 CMS128

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 24 of 50

(*) Red asterisk indicates a required field.

Measure: CMS128/NQF 0105

Versions: CMS128v7.2

Title: Anti-depressant Medication Management

Description: Percentage of patients 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication treatment. Two rates are reported.

a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks).
b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).

Denominator: Denominator 1: Patients 18 years of age and older with a visit during the measurement period who were dispensed antidepressant medications in the time within 270 days (9 months) prior to the measurement period through the first 90 days (3 months) of the measurement period, and were diagnosed with major depression 60 days prior to, or 60 days after the dispensing event.
Denominator 2: Patients 18 years of age and older with a visit during the measurement period who were dispensed antidepressant medications in the time within 270 days (9 months) prior to the measurement period through the first 90 days (3 months) of the measurement period, and were diagnosed with major depression 60 days prior to, or 60 days after the dispensing event.

Numerator: Numerator 1: Patients who have received antidepressant medication for at least 84 days (12 weeks) of continuous treatment during the 114-day period following the Index Prescription Start Date.
Numerator 2: Patients who have received antidepressant medications for at least 180 days (6 months) of continuous treatment during the 231-day period following the Index Prescription Start Date.

Denominator Exclusions: Patients who were actively on an antidepressant medication in the 105 days prior to the Index Prescription Start Date.

Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0
*** Denominator 2:**	*** Numerator 2:**	*** Performance Rate 2 (%):**	*** Exclusion 2:**
0	0	0	0 ×

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.25 CMS136

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 25 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS136/NQF 0108
Versions:	CMS136v8.3
Title:	Follow-Up Care for Children Prescribed ADHD Medication (ADD)
Description:	Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.
Denominator:	Denominator 1: Initial Population 1: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period. Denominator 2: Initial Population 2: Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who remained on the medication for at least 210 days out of the 300 days following the IPSD, and who had a visit during the measurement period.
Numerator:	Numerator 1: Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSD. Numerator 2: Patients who had at least one face-to-face visit with a practitioner with prescribing authority during the Initiation Phase, and at least two follow-up visits during the Continuation and Maintenance Phase. One of the two visits during the Continuation and Maintenance Phase may be a telephone visit with a practitioner.
Denominator Exclusions:	Exclusion 1: Denominator Exclusion 1: Exclude patients diagnosed with narcolepsy at any point in their history or during the measurement period. Exclude patients who had an acute inpatient stay with a principal diagnosis of mental health or substance abuse during the 30 days after the IPSD. Exclude patients who were actively on an ADHD medication in the 120 days prior to the Index Prescription Start Date.

Exclude patients whose hospice care overlaps the measurement period.
Exclusion 2: Exclude patients diagnosed with narcolepsy at any point in their history or during the measurement period.
Exclude patients who had an acute inpatient stay with a principal diagnosis of mental health or substance abuse during the 300 days after the IPSD.
Exclude patients who were actively on an ADHD medication in the 120 days prior to the Index Prescription Start Date.
Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

Population Criteria 1: Children 6-12 years of age dispensed an ADHD medication.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):	* Exclusion 2:
0	0	0.00	0

Population Criteria 2: Children 6-12 years of age dispensed an ADHD medication and who remained on medication.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0.00	0
* Denominator 2:	* Numerator 2:	* Performance Rate 2 (%):	* Exclusion 2:
0	0	0.00	0

Previous Next

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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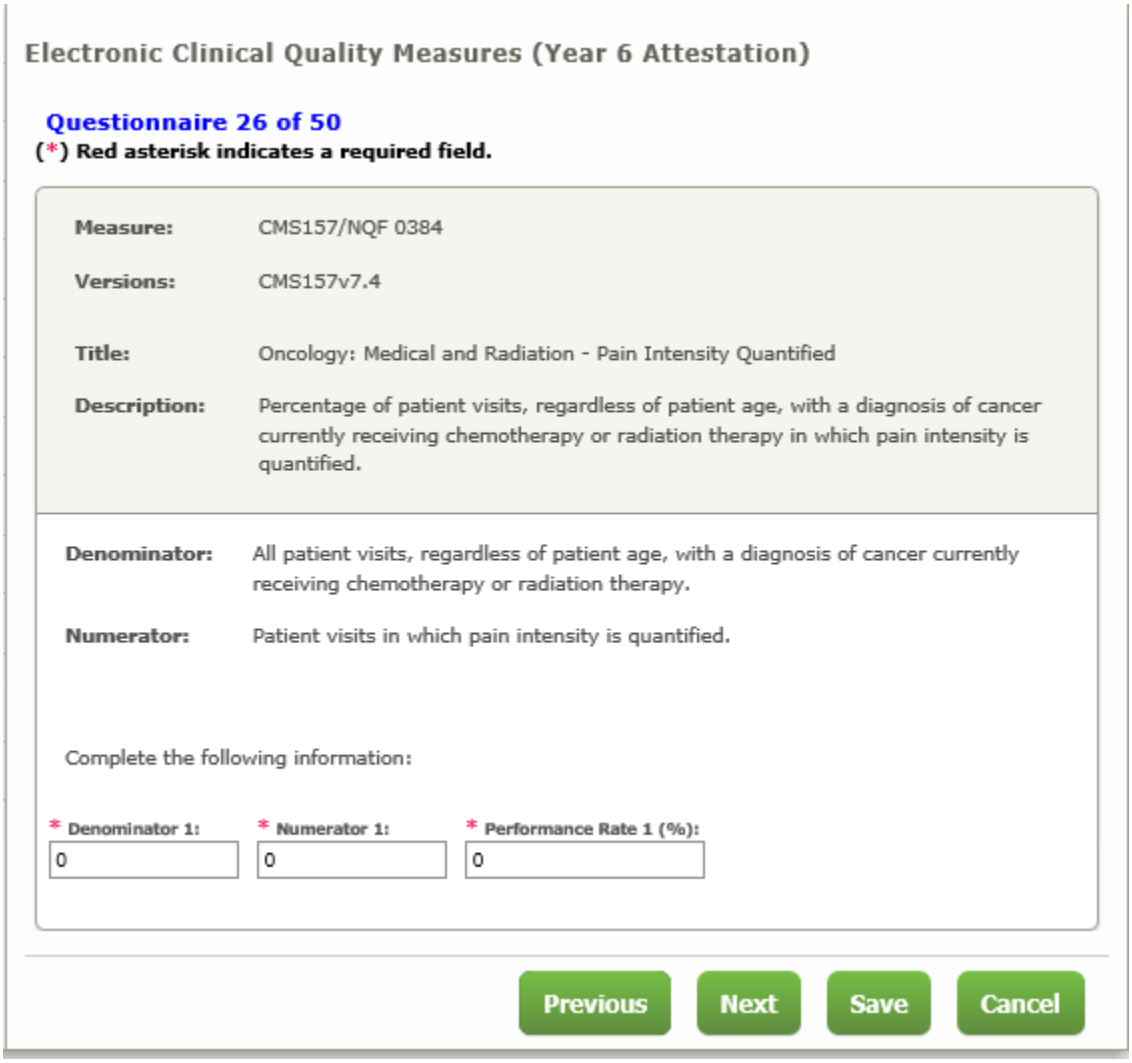
8.5.26 CMS157



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
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8.5.27 CMS129

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 27 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS129/NQF 0389
Versions:	CMS129v8.2
Title:	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
Description:	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.
Denominator:	All patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy.
Numerator:	Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer.
Denominator Exceptions:	Documentation of reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons, bone scan ordered by someone other than reporting physician).

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:
0	0	0	0 ×

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To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.28 CMS52

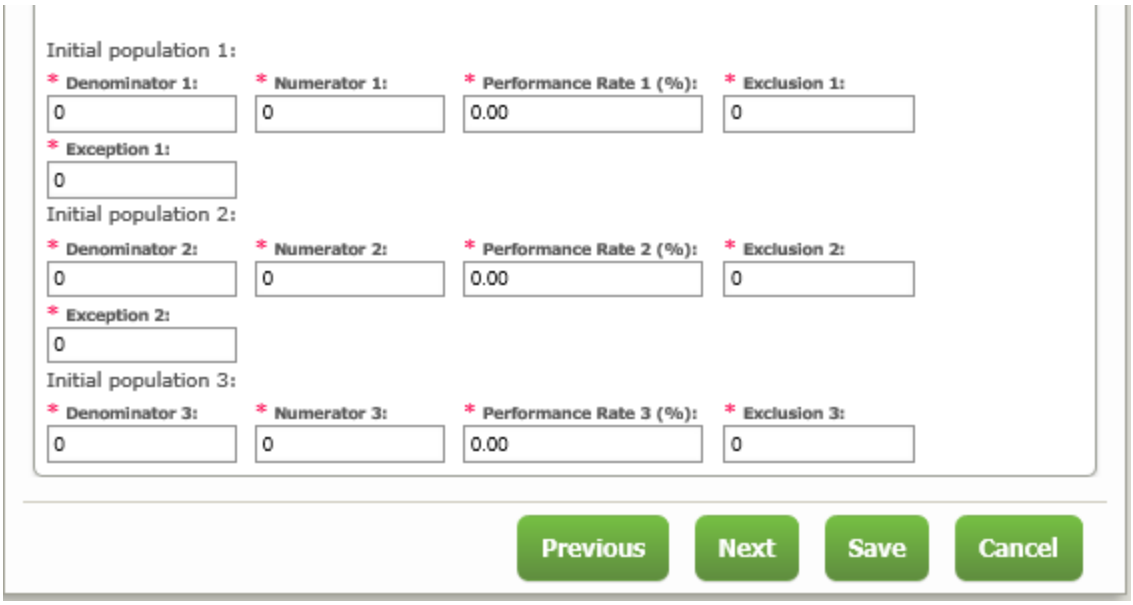
Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 28 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS52/NQF 0405
Versions:	CMS52v7.2
Title:	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
Description:	Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.
Denominator:	Denominator 1: All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm3 who had at least two visits during the measurement year, with at least 90 days in between each visit. Denominator 2: All patients aged 1-5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm3 or a CD4 percentage below 15% who had at least two visits during the measurement year, with at least 90 days in between each visit. Denominator 3: All patients aged 6 weeks to 12 months with a diagnosis of HIV who had at least two visits during the measurement year, with at least 90 days in between each visit.
Numerator:	Numerator 1: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm3. Numerator 2: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/mm3 or a CD4 percentage below 15%. Numerator 3: Patients who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis at the time of diagnosis of HIV.
Denominator Exclusions:	Exclude patients whose hospice care overlaps the measurement period.
Denominator Exceptions:	Exception 1: Denominator 1: Patient did not receive PCP prophylaxis because there was a CD4 count above 200 cells/mm3 during the three months after a CD4 count below 200 cells/mm3. Exception 2: Denominator 2: Patient did not receive PCP prophylaxis because there was a CD4 count above 500 cells/mm3 or CD4 percentage above 15% during the three months after a CD4 count below 500 cells/mm3 or CD4 percentage below 15% .

Complete the following information:



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.29 CMS2

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 29 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS2/NQF 0418
Versions:	CMS2v8.1
Title:	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
Description:	Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Denominator:	All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.
Numerator:	Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Denominator Exclusions:	Patients with an active diagnosis for depression or a diagnosis of bipolar disorder.
Denominator Exceptions:	Patient Reason(s) Patient refuses to participate OR Medical Reason(s) Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status OR Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0

*Exception 1:
0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, Exclusion and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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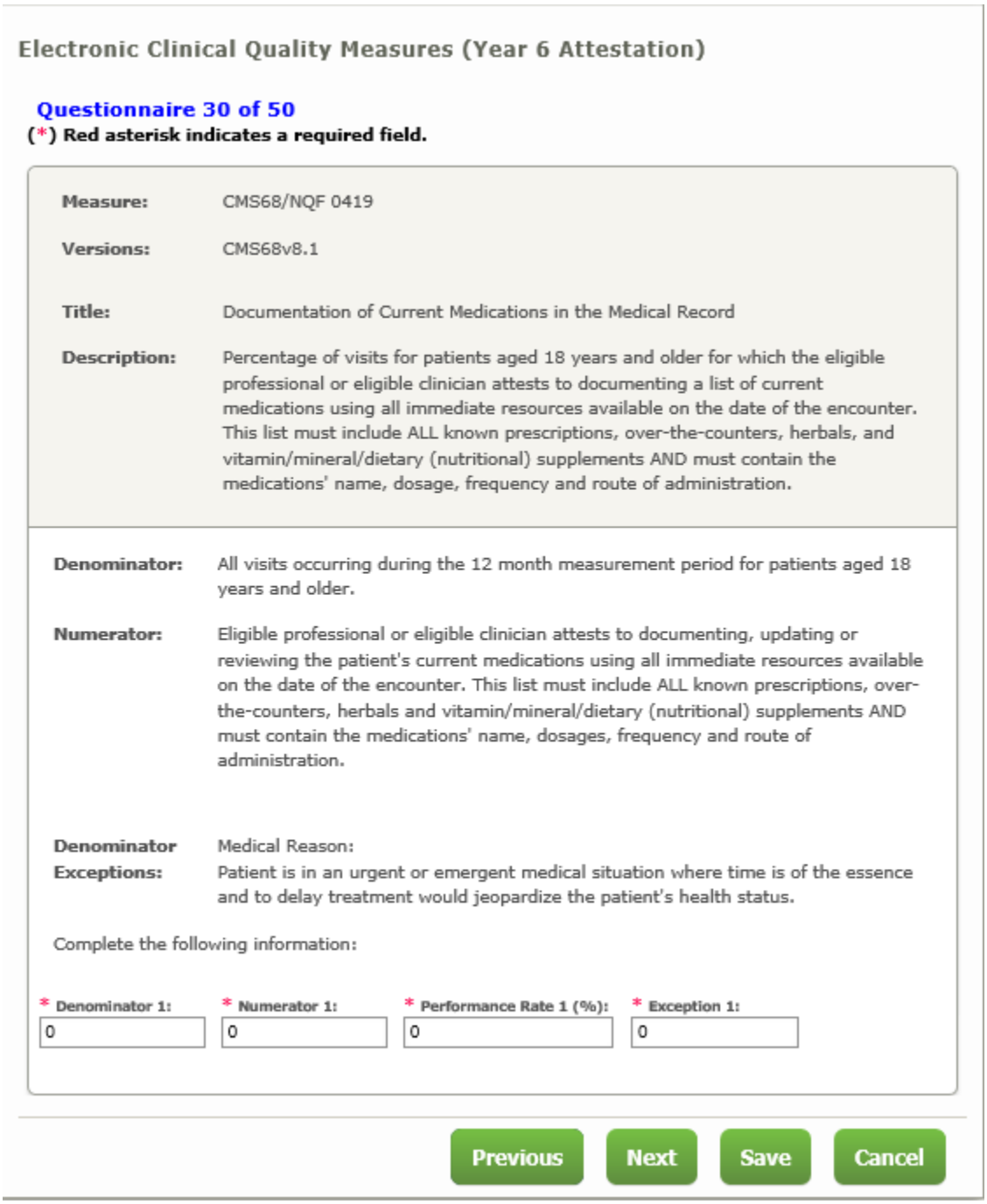
8.5.30 CMS68



Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 30 of 50

(*) Red asterisk indicates a required field.

Measure: CMS68/NQF 0419

Versions: CMS68v8.1

Title: Documentation of Current Medications in the Medical Record

Description: Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician 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, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

Denominator: All visits occurring during the 12 month measurement period for patients aged 18 years and older.

Numerator: Eligible professional or eligible clinician attests to documenting, updating or reviewing the patient's current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration.

Denominator Exceptions: Medical Reason:
Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:
0	0	0	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.31 CMS69

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 31 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS69/NQF 0421
Versions:	CMS69v7.1
Title:	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
Description:	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2
Denominator:	All patients 18 and older on the date of the encounter with at least one eligible encounter during the measurement period.
Numerator:	Patients with a documented BMI during the encounter or during the previous twelve months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.
Denominator Exclusions:	1. Patients who are pregnant. 2. Patients receiving palliative care. 3. Patients who refuse measurement of height and/or weight or refuse follow-up.
Denominator Exceptions:	Patients with a documented Medical Reason. Patients in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0

*Exception 1:
0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.32 CMS132

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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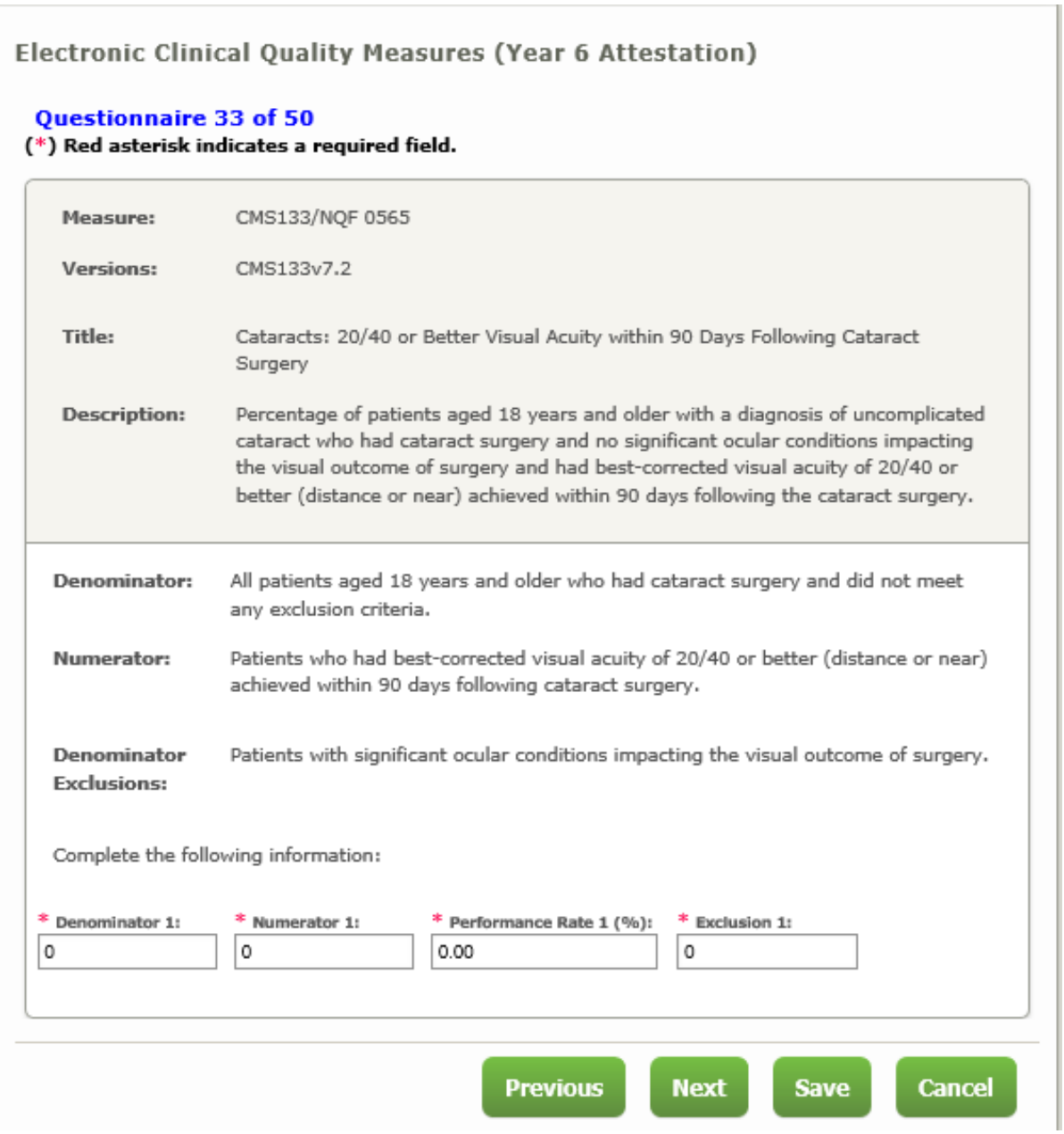
8.5.33 CMS133



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.34 CMS159

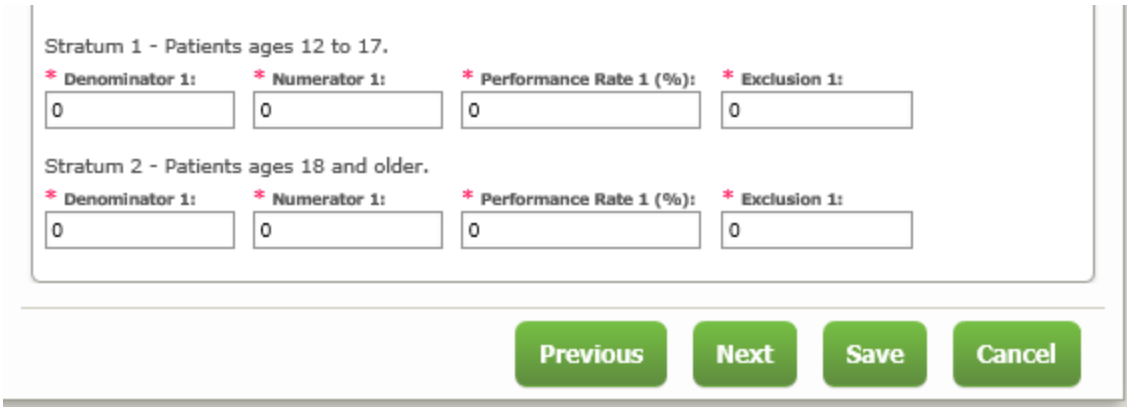
Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 34 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS159/NQF 0710
Versions:	CMS159v7.2
Title:	Depression Remission at Twelve Months
Description:	The percentage of adolescent patients 12 to 17 years of age and adult patients 18 years of age or older with major depression or dysthymia who reached remission 12 months (+/-60 days) after an index event.
Denominator:	Adolescent patients 12 to 17 years of age and adult patients age 18 years of age and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 or PHQ-9M score greater than nine during the index event.
Numerator:	Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who achieved remission at twelve months as demonstrated by a twelve month (+/- 60 days) PHQ-9 or PHQ-9M score of less than five.
Denominator Exclusions:	1. Patients who died. 2. Patients who received hospice or palliative care services. 3. Patients who were permanent nursing home residents. 4.Patients with a diagnosis of bipolar disorder. 5. Patients with a diagnosis of personality disorder. 6. Patients with a diagnosis of schizophrenia or psychotic disorder. 7. Patients with a diagnosis of pervasive developmental disorder.

Complete the following information:



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.35 CMS160

Electronic Clinical Quality Measures (Year 6 Attestation)

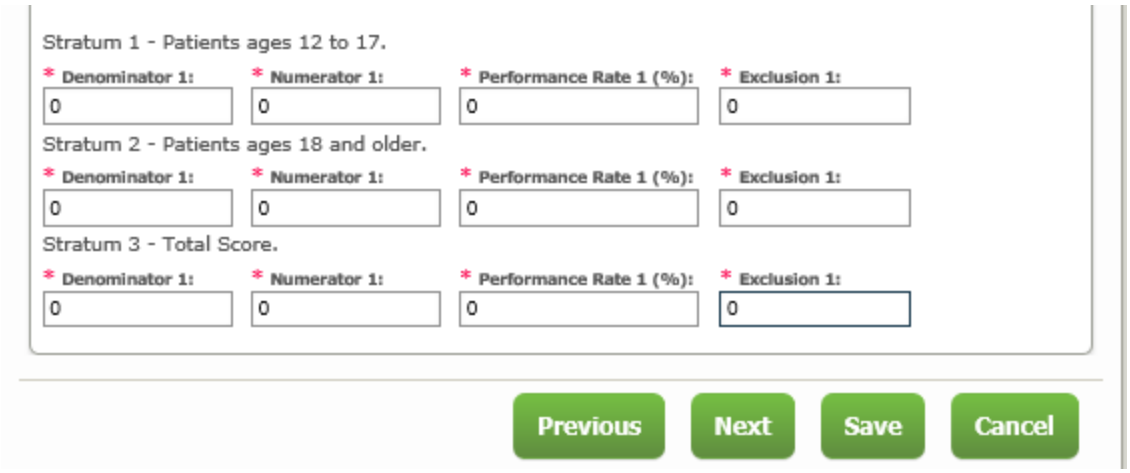
Questionnaire 35 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS160/NQF 0712
Versions:	CMS160v7.3
Title:	Depression Utilization of the PHQ-9 Tool
Description:	The percentage of adolescent patients 12 to 17 years of age and adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a completed PHQ-9 during each applicable 4 month period in which there was a qualifying depression encounter.

Denominator:	Adolescent patients 12 to 17 years of age and adult patients age 18 years of age and older with an office visit and the diagnosis of major depression or dysthymia during the four-month period.
Numerator:	Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older who have a PHQ-9 or PHQ-9M tool administered at least once during the four-month period.
Denominator Exclusions:	1. Patients who died. 2. Patients who received hospice or palliative care services. 3. Patients who were permanent nursing home residents. 4. Patients with a diagnosis of bipolar disorder. 5. Patients with a diagnosis of personality disorder. 6. Patients with a diagnosis of schizophrenia or psychotic disorder. 7. Patients with a diagnosis of pervasive developmental disorder.

Complete the following information:



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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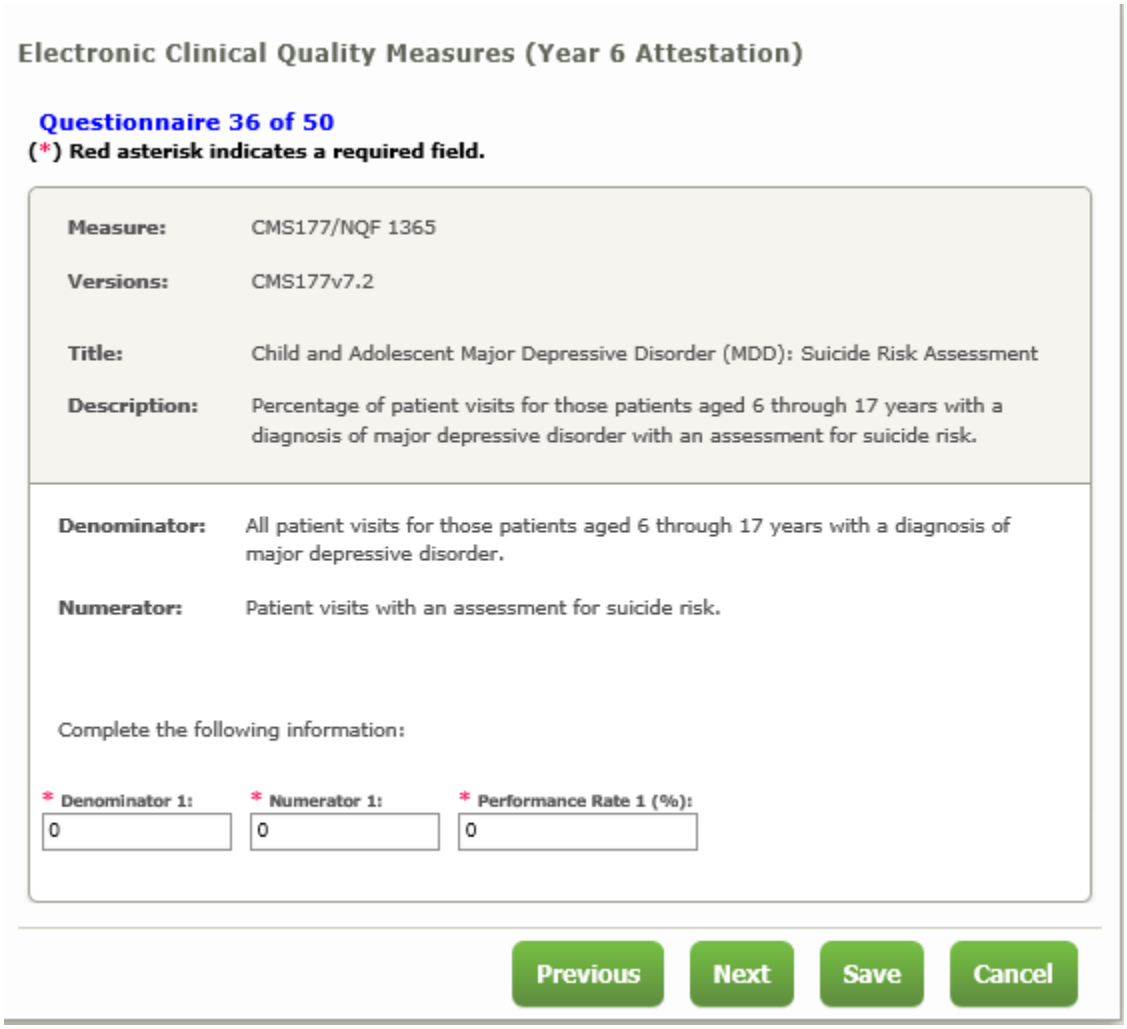
8.5.36 CMS177



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.37 CMS125

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 37 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS125/NQF 2372
Versions:	CMS125v7.2
Title:	Breast Cancer Screening
Description:	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
Denominator:	Women 51-74 years of age with a visit during the measurement period.
Numerator:	Women with one or more mammograms during the measurement period or the 15 months prior to the measurement period.
Denominator Exclusions:	Women who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy. Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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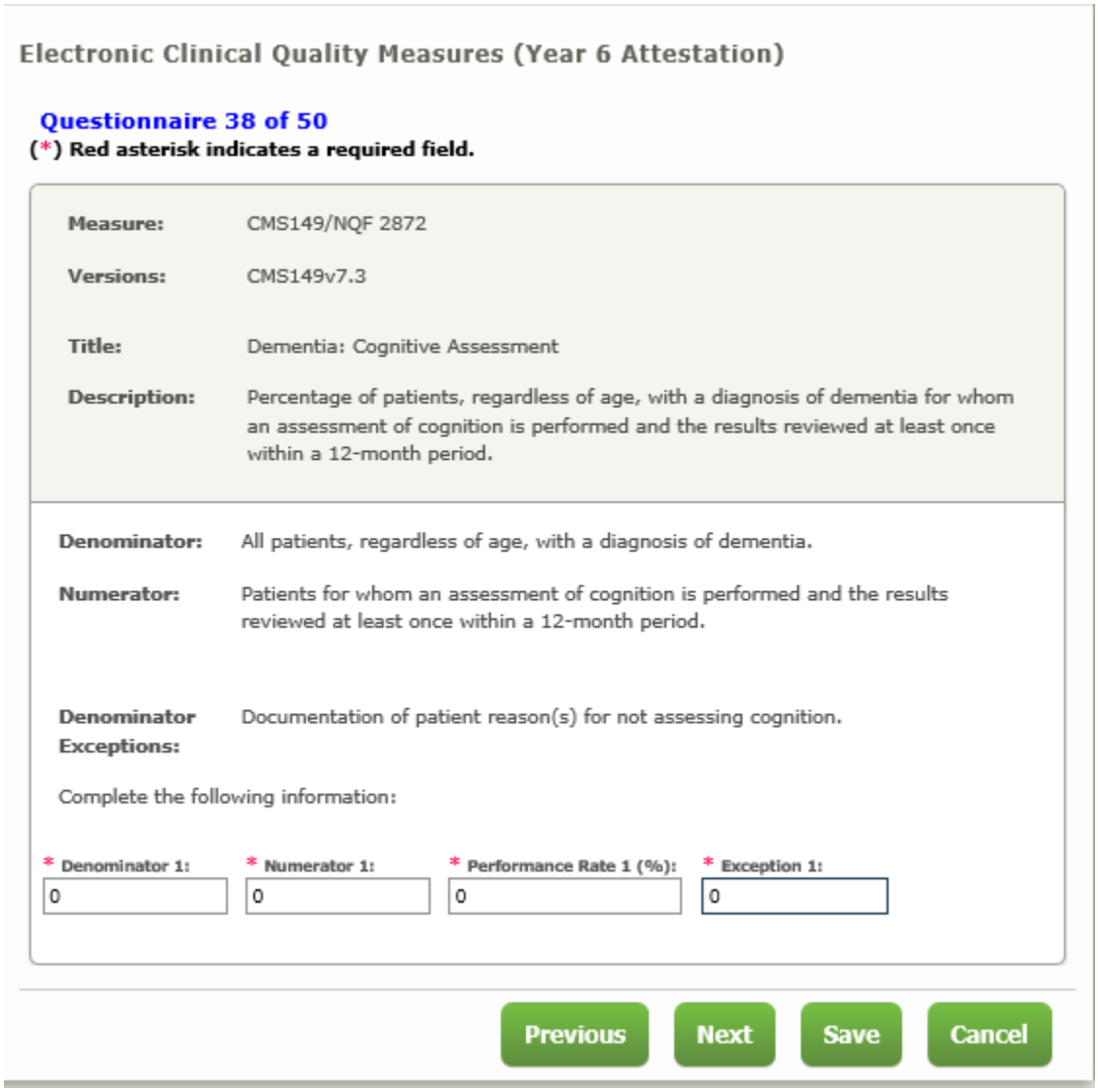
8.5.38 CMS149



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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8.5.39 CMS22

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 39 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS22/NQF XXXX
Versions:	CMS22v7.1
Title:	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
Description:	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.
Denominator:	All patients aged 18 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.
Numerator:	Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive.
Denominator Exclusions:	Patient has an active diagnosis of hypertension.
Denominator Exceptions:	Patient Reason(s): Patient refuses to participate (either BP measurement or follow-up) OR Medical Reason(s): Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
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*Exception 1:
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Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

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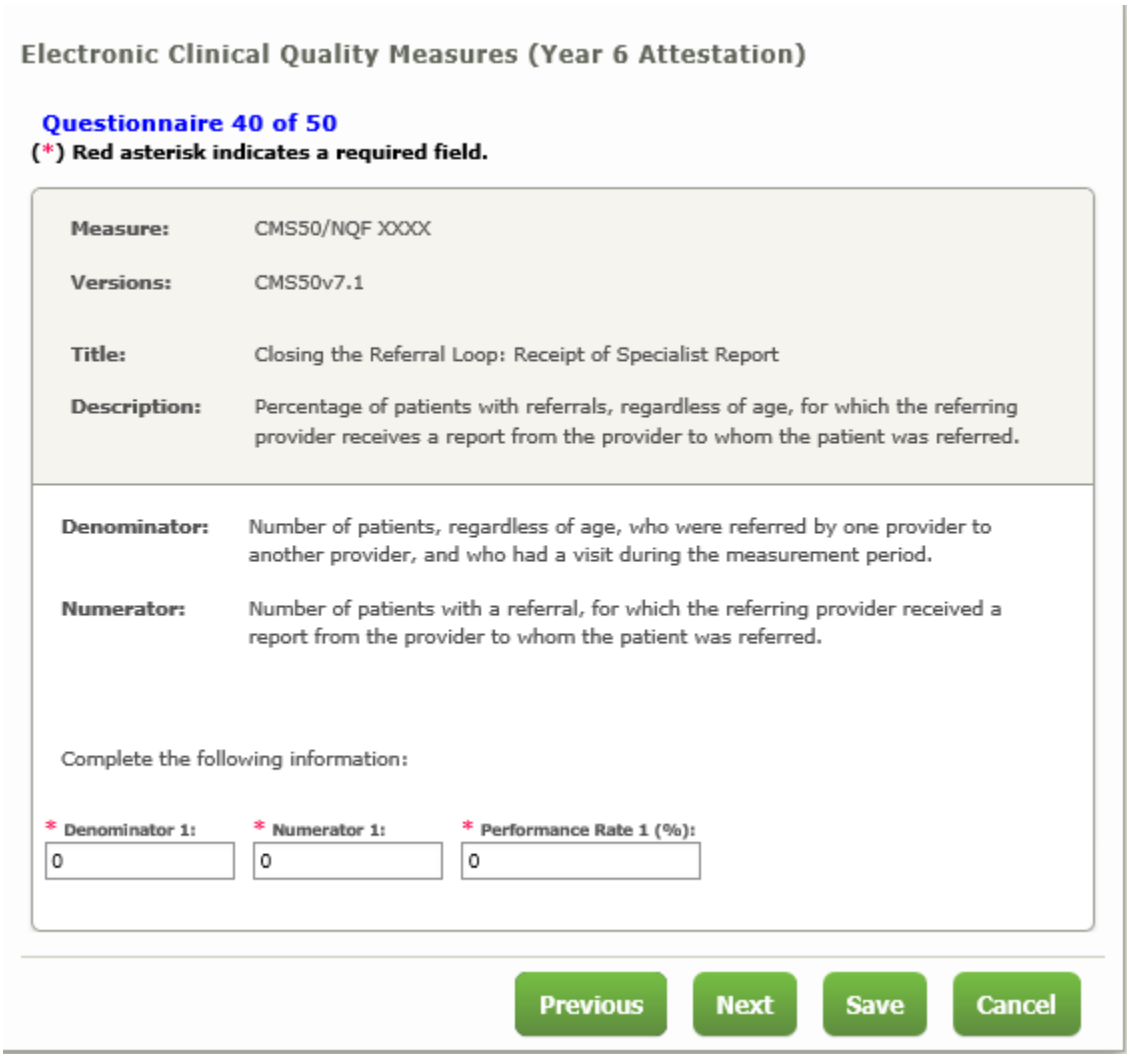
- Click **Cancel** to remove selections and stay on the current screen.

8.5.40 CMS50



To satisfy this eCQM, enter a whole number into the Denominator, Numerator and Performance Rate boxes.

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8.5.41 CMS56

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 41 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS56/NQF XXXX
Versions:	CMS56v7.4
Title:	Functional Status Assessment for Total Hip Replacement
Description:	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.
Denominator:	Patients 19 years of age and older who had a primary total hip arthroplasty (THA) in the year prior to the measurement period and who had an outpatient encounter during the measurement period.
Numerator:	Patients with patient-reported functional status assessment results (i.e., VR-12, PROMIS-10-Global Health, HOOS, HOOS Jr.) in the 90 days prior to or on the day of primary THA procedure, and in the 270-365 days after THA procedure.
Denominator Exclusions:	Patients with two or more fractures indicating trauma at the time of the total hip arthroplasty or patients with severe cognitive impairment that overlaps measurement period. Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0

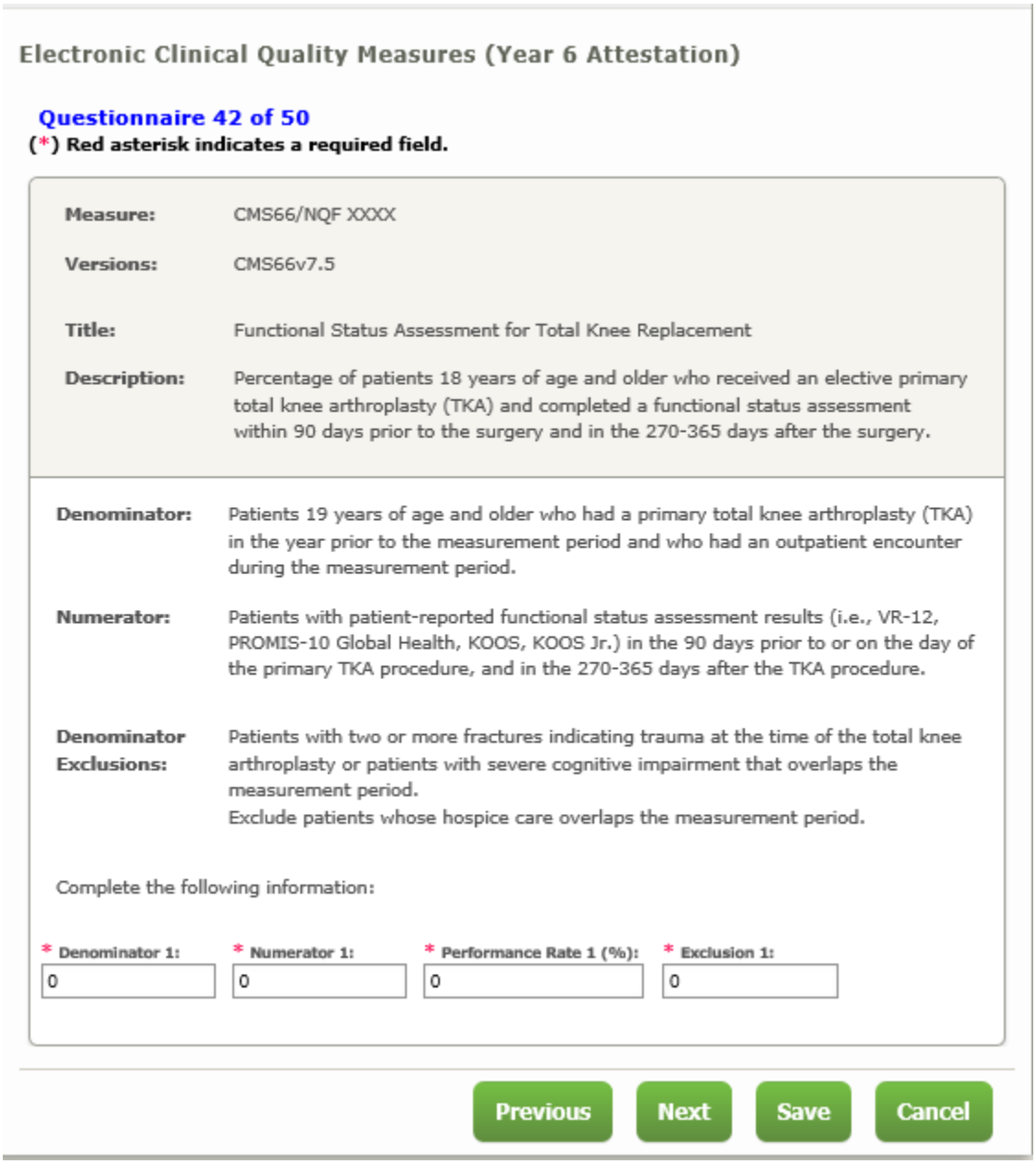
Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.42 CMS66



Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 42 of 50

(*) Red asterisk indicates a required field.

Measure: CMS66/NQF XXXX

Versions: CMS66v7.5

Title: Functional Status Assessment for Total Knee Replacement

Description: 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.

Denominator: Patients 19 years of age and older who had a primary total knee arthroplasty (TKA) in the year prior to the measurement period and who had an outpatient encounter during the measurement period.

Numerator: Patients with patient-reported functional status assessment results (i.e., VR-12, PROMIS-10 Global Health, KOOS, KOOS Jr.) in the 90 days prior to or on the day of the primary TKA procedure, and in the 270-365 days after the TKA procedure.

Denominator Exclusions: Patients with two or more fractures indicating trauma at the time of the total knee arthroplasty or patients with severe cognitive impairment that overlaps the measurement period.
Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.43 CMS74

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 43 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS74/NQF XXXX
Versions:	CMS74v8.2
Title:	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists
Description:	Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.
Denominator:	Denominator 1: Children, age 0-20 years, with a visit during the measurement period.
Numerator:	Numerator 1: Children who receive a fluoride varnish application.
Denominator Exclusions:	Exclude patients whose hospice care overlaps the measurement period.

Complete the following information:

Stratum1: Population 1: age 0-5.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0

Stratum2: Population 2: age 6-12.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0

Stratum3: Population 3: age 13-20.

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0

Stratum4: Total Score

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	Exclusion 1:
0	0	0	0

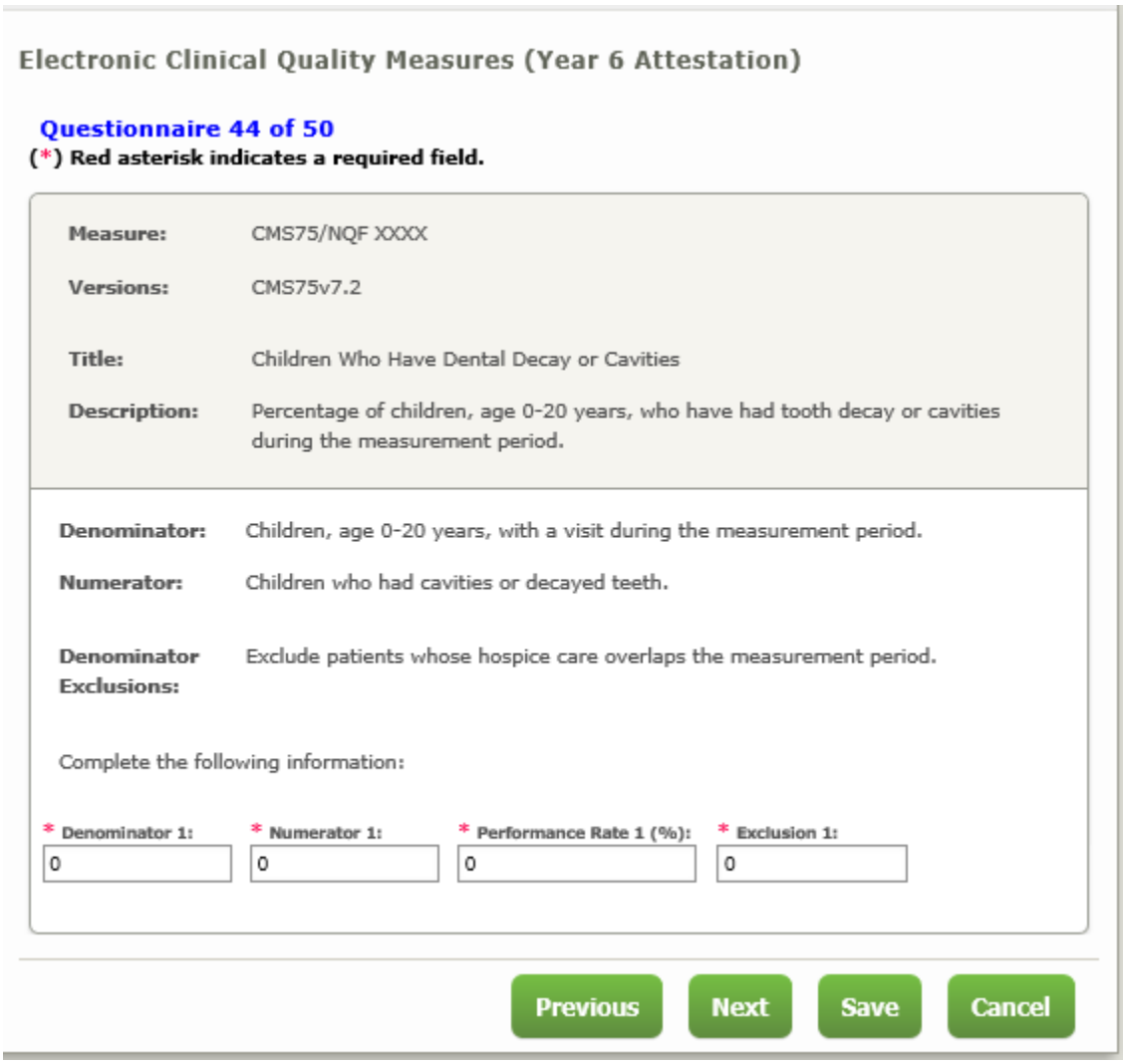
Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.44 CMS75

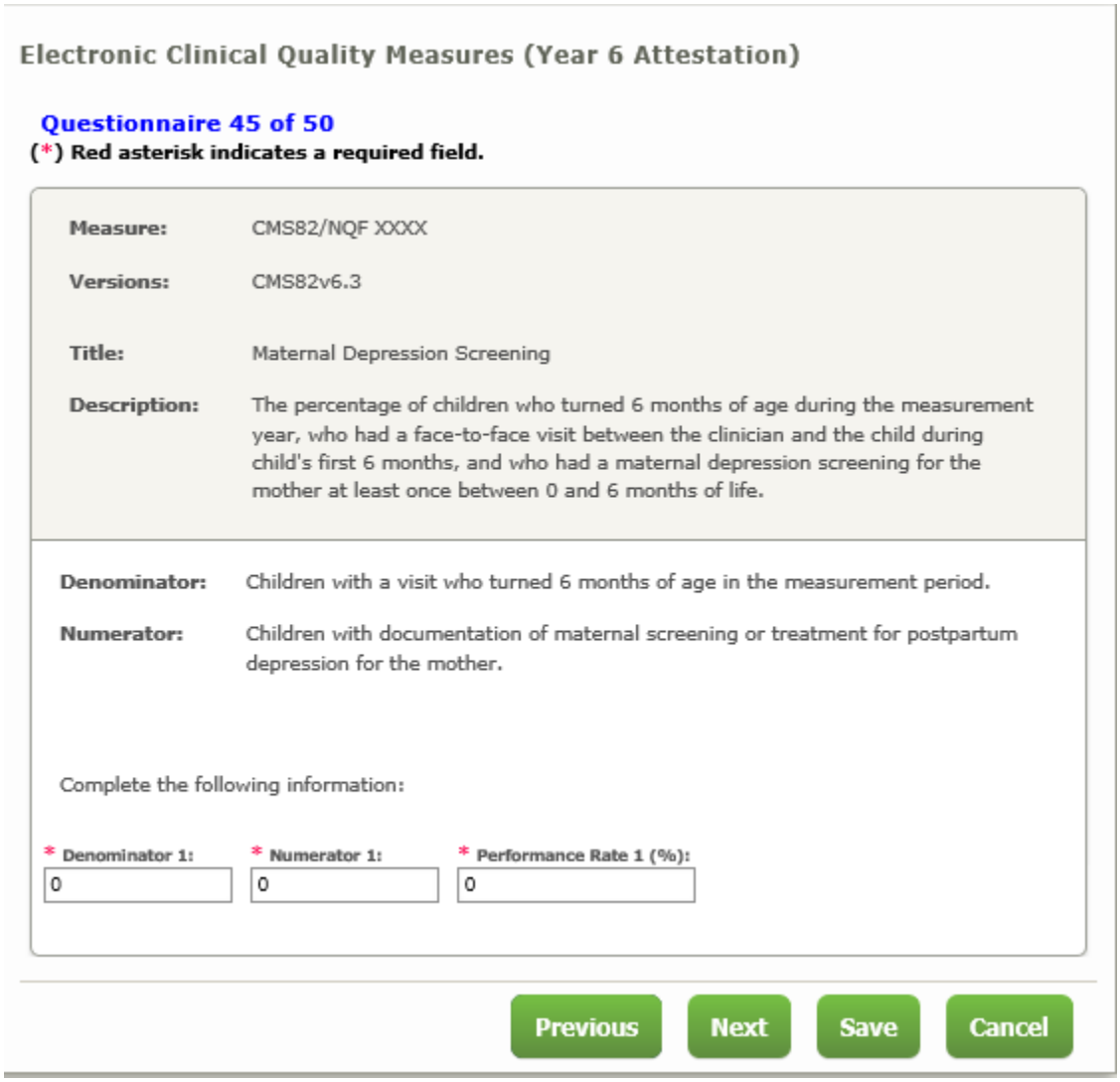


To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.45 CMS82

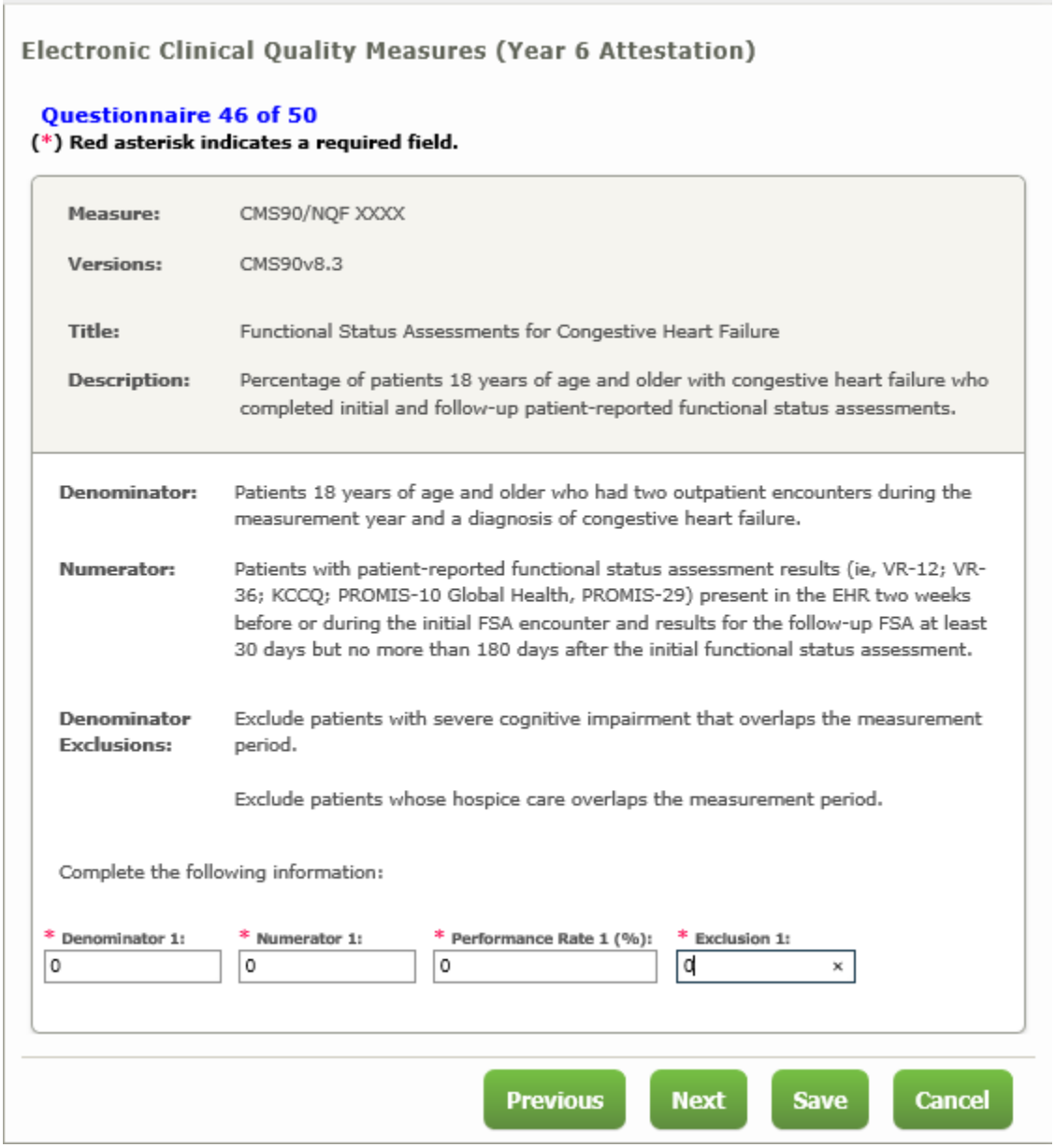


To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.46 CMS90



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.47 CMS249

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 47 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS249/NQF XXXX
Versions:	CMS249v1.4
Title:	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture
Description:	Percentage of female patients 50 to 64 years of age without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan during the measurement period.
Denominator:	Female patients ages 50 to 64 years with an encounter during the measurement period.
Numerator:	Female patients who received an order for at least one DXA scan in the measurement period.
Denominator Exclusions:	Exclude patients with a combination of risk factors (as determined by age) or one of the independent risk factors. Ages: 50-54 (>= 4 combination risk factors) or 1 independent risk factor Ages: 55-59 (>= 3 combination risk factors) or 1 independent factor Ages: 60-64 (>= 2 combination risk factors) or 1 independent risk factor For list of Risk Factors, please refer to the specification sheet for PY 2019.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0 ×

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

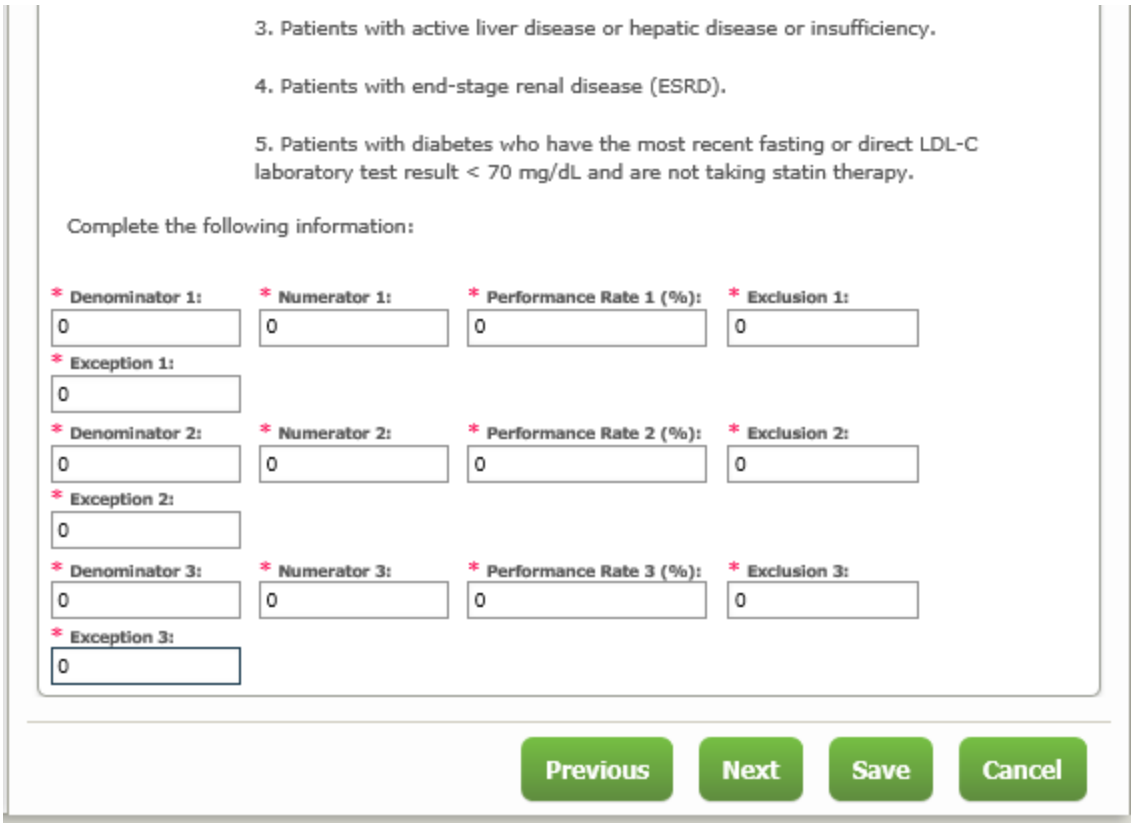
8.5.48 CMS347

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 48 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS347/NQF XXXX
Versions:	CMS347v2.1
Title:	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Description:	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 70-189 mg/dL.
Denominator:	Denominator 1: All patients who meet one or more of the following criteria (considered at "high risk" for cardiovascular events, under ACC/AHA guidelines): Denominator 1: Patients aged >= 21 years at the beginning of the measurement period with clinical ASCVD diagnosis. Denominator 2: Denominator 2: Patients aged >= 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia. Denominator 3: Denominator 3: Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period.
Numerator:	Numerator 1: Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period.
Denominator Exclusions:	1. Patients who have a diagnosis of pregnancy. 2. Patients who are breastfeeding. 3. Patients who have a diagnosis of rhabdomyolysis.
Denominator Exceptions:	1. Patients with adverse effect, allergy, or intolerance to statin medication. 2. Patients who are receiving palliative care.



To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.49 CMS349

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 49 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS349/NQF XXXX
Versions:	CMS349v1.2
Title:	HIV Screening
Description:	Percentage of patients 15-65 years of age who have been tested for HIV within that age range.
Denominator:	Patients 15 to 65 years of age who had an outpatient visit during the measurement period.
Numerator:	Patients with documentation of an HIV test between age 15-65 before the end of the measurement period.
Denominator Exclusions:	Patients diagnosed with HIV prior to the start of the measurement period.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exclusion 1:
0	0	0	0 ×

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate and Exclusion boxes.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

8.5.50 CMS645

Electronic Clinical Quality Measures (Year 6 Attestation)

Questionnaire 50 of 50

(*) Red asterisk indicates a required field.

Measure:	CMS645/NQF XXXX
Versions:	CMS645v2.1
Title:	Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy
Description:	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 (indicated by HCPCS code) 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.
Denominator:	Male patients with a diagnosis of prostate cancer and an order for ADT that is intended for greater than or equal to 12 months during the measurement period. Also included are male patients with a diagnosis of prostate cancer with ADT that was administered with an intent of 12 months or greater therapy and began during the measurement period.
Numerator:	Patients with a bone density evaluation within the two years prior to the start of or less than three months after the start of ADT treatment.
Denominator Exceptions:	Patient refused recommendation for a bone density evaluation after the start of ADT therapy.

Complete the following information:

* Denominator 1:	* Numerator 1:	* Performance Rate 1 (%):	* Exception 1:
0	0	0	0

Previous Next Save Cancel

To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate and Exclusion boxes.

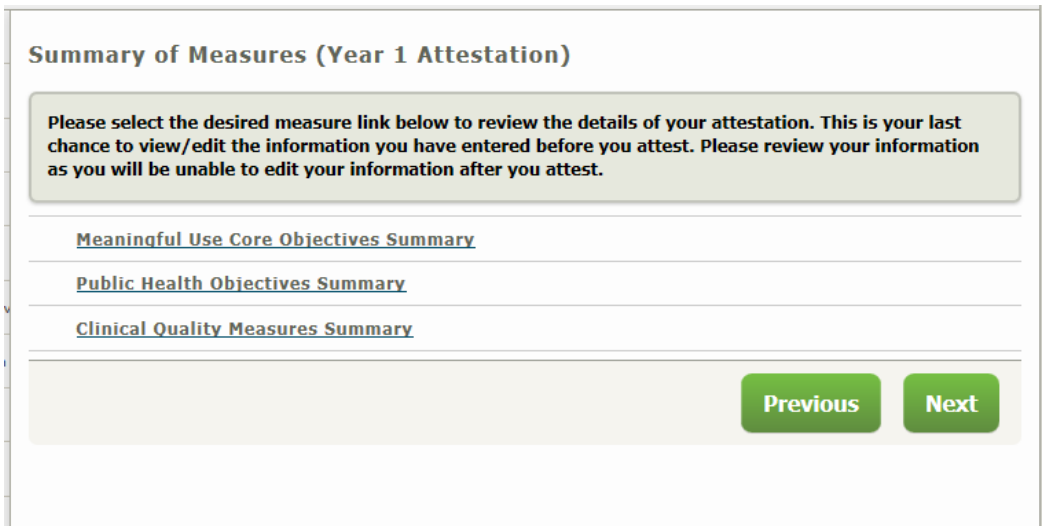
When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

9 Submitting Attestation

Prior to submitting the attestation for program staff review, EPs have the option to review and edit their responses with the Pre-Attestation Summary screens. EPs can navigate through screens and confirm their responses prior to submitting.

9.1 Pre-Attestation Summary Screen



Click on a link to review the summary.

When final reviews have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.1.2 Objectives Summary

Summary of Meaningful Use Core Measures (Year 5 Attestation)

Meaningful Use Core Measure List Table

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

CORE OBJECTIVES SUMMARY

ObjectiveText	Description	Data Entered	Selection
Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process.	Yes	Edit
Use clinical decision support to improve performance on high-priority health conditions.	Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.	Yes	Edit

Use clinical decision support to improve performance on high-priority health conditions.	The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.	Yes	Edit
Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	Numerator = 61 Denominator = 100	Edit
Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	Numerator = 30 Denominator = 100	Edit
Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	Numerator = 30 Denominator = 100	Edit

Generate and transmit permissible prescriptions electronically (eRx).	More than 50% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.	Numerator = 50 Denominator = 100	Edit
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.	The EP that transitions or refers their patient to another setting of care or provider of care must-- (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals.	Numerator = 10 Denominator = 88	Edit
Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.	Patient-specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period.	Numerator = 54 Denominator = 100	Edit
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	Numerator = 50 Denominator = 100	Edit
Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.	More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.	Numerator = 50 Denominator = 100	Edit

Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.	For an EHR reporting period in 2017 and 2018, more than 5% of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.	Numerator = 1 Denominator = 100	Edit
Use secure electronic messaging to communicate with patients on relevant health information.	For an EHR reporting period in 2018, for more than 5% of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.	Numerator = 5 Denominator = 100	Edit

Previous Next

The Objectives Summary lists each Meaningful Use Objective attested to, with responses.

- If changes need to be made, click the Edit link for the MU Objective to update. This will redirect to the MU Objective details screen for changes to be made.
- It is important to be sure any changes are saved after edit is complete.

When final reviews/edits have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.1.3 Public Health Objectives Summary

Summary of Public Health Objective Measures (Year 5 Attestation)

Public Health Objective List Table

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

PUBLIC HEALTH MEASURES SUMMARY

ObjectiveText	Measure	Entered	Selection
The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.	The EP is in active engagement with a public health agency to submit immunization data.	Option 2	Edit
The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.	The EP is in active engagement with a public health agency to submit syndromic surveillance data.	Option 3	Edit
The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.	The EP is in active engagement to submit data to a specialized registry.	Option 3 - KY Cancer Registry Option 1 - Skin	Edit

Previous Next

The Public Health Objectives Summary lists each Public Health Measure attested to, with responses.

- If changes need to be made, click the Edit link for the PH Measure to update. This will redirect to the PH Measure details screen for changes to be made.
- It is important to be sure any changes are saved after edit is complete.

When final reviews/edits have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.1.4 Electronic Clinical Quality Measures Summary (Manually Reported)

Summary of Clinical Quality Measures (Year 4 Attestation)

Clinical Quality Measures List Table

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

PATIENT SAFETY

Measure #	Title	Measure	Data Entered	Selection
CMS156v5.1/NQF 0022	Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	Denominator = 50 Numerator = 10 Performance Rate = 50.00 Denominator = 50 Numerator = 10 Performance Rate = 50.00	Edit

COMMUNITY/POPULATION HEALTH

Measure #	Title	Measure	Data Entered	Selection
CMS117v5.1/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.	Denominator = 75 Numerator = 25 Performance Rate = 55.00	Edit

EFFECTIVE CLINICAL CARE

Measure #	Title	Measure	Data Entered	Selection
CMS165v5.0/NQF 0018	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	Denominator = 100 Numerator = 50 Performance Rate = 50.00 Exclusion = 0	Edit
CMS135v5.2/NQF 0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	Denominator = 50 Numerator = 30 Performance Rate = 35.00 Exception = 0 Exception = 0 Exception = 0	Edit
CMS142v5.2/NQF 0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	Denominator = 50 Numerator = 10 Performance Rate = 50.00	Edit
CMS169v5.0/NQF XXXX	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Denominator = 75 Numerator = 35 Performance Rate = 50.00	Edit

Previous Next

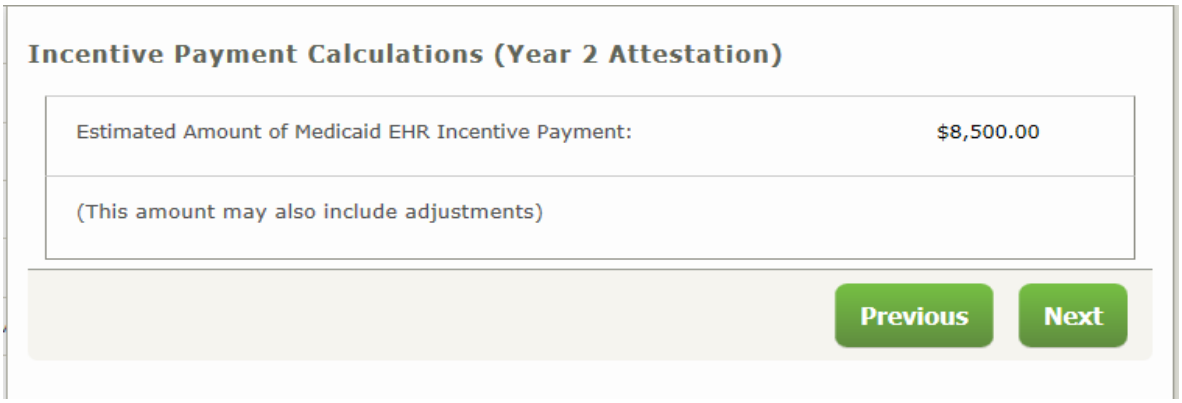
The Electronic Clinical Quality Measures Summary lists each eCQM attested to, with responses.

- If changes need to be made, click the Edit link for the eCQM to update. This will redirect to the eCQM details screen for changes to be made.
- It is important to be sure any changes are saved after edit is complete.

When final reviews/edits have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.2 Incentive Payment Calculation Screen

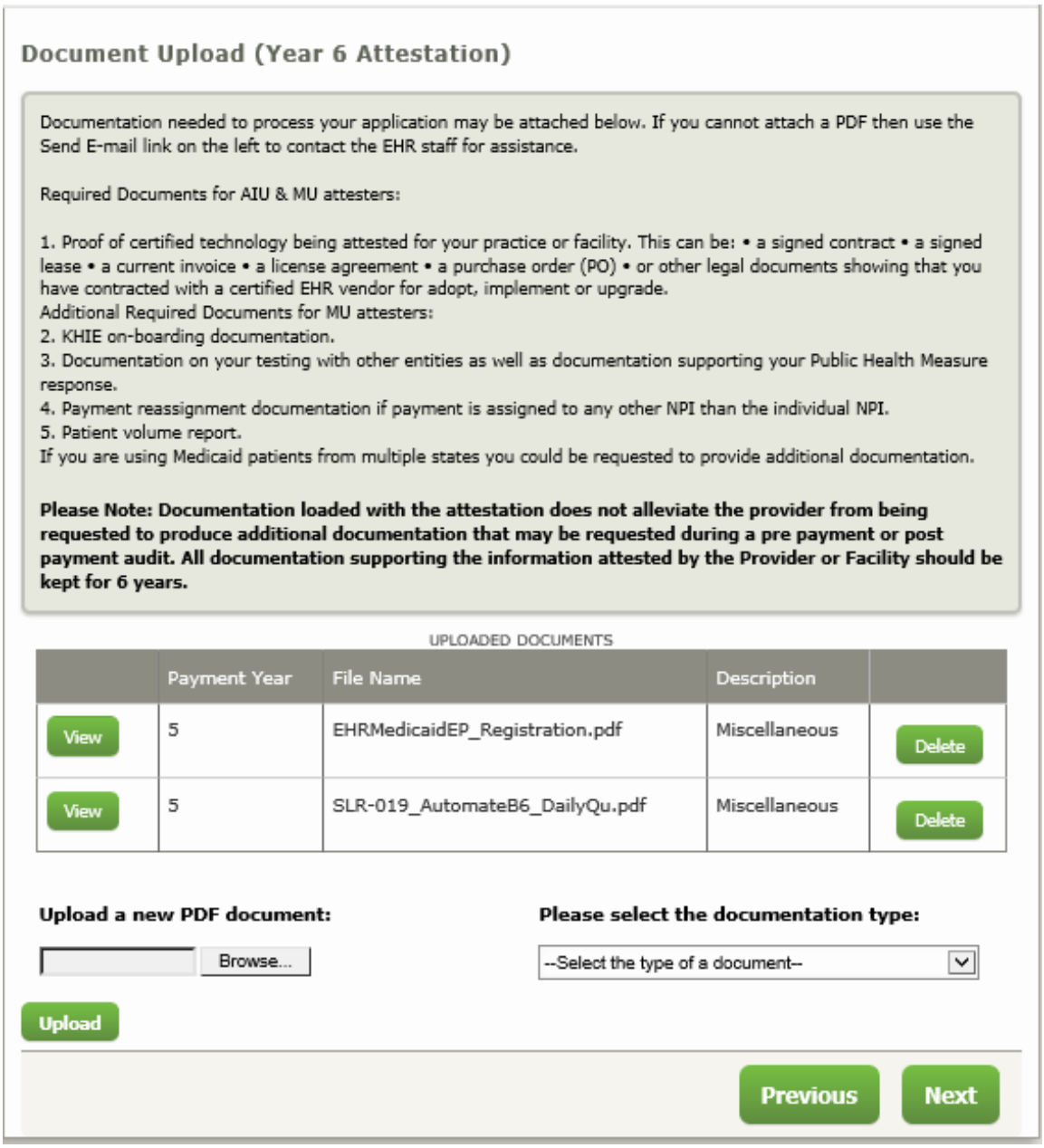


The Incentive Payment Calculation screen is view only and provides the estimated amount of Medicaid EHR incentive payment.

When final reviews have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.3 Document Upload Screen



The document upload screen allows EPs to submit PDF documents as part of the attestation. Documentation in support of the attestation includes but is not limited to; the Patient Volume Report, CEHRT ID documentation, MU report(s) from their CEHRT, and KHIE onboarding documentation. (Please note**:** the Patient Volume Report is a required upload in order to move to the next screen.) Upload PDF documents by following the below steps:

- Select **Browse** to locate a document to upload.
- Select the documentation type from the dropdown.
- Click **Upload**.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.

9.4 Attestation Statement Screen

Attestation Statement (Year 6 Attestation)

You are about to submit your attestation for participation in the Kentucky Medicaid EHR Incentive Program.

Please check the box next to each statement below to attest. To complete your attestation, initial, enter your NPI and click the Submit button.

☐	The information submitted is accurate to the knowledge and belief of the EP.
☐	The information submitted is accurate and complete for numerators, denominators and exclusions for functional measures applicable to the EP.
☐	A zero was reported in the denominator of a measure when an EP did not care for any patients in the denominator population during the EHR reporting period.
☐	The information submitted includes information on all patients to whom the measure applies.
☐	As a meaningful EHR user, at least 50% of my patient encounters during the EHR reporting period occurred at the practice/location given in my attestation information and is equipped with certified EHR technology.
☐	The information submitted for eCQM's was generated as output from an identified certified EHR technology.
☐	The information submitted for eCQM's includes at least one outcome or high priority measure. If there are no outcome or high priority measures relevant to the EP's scope of practice, 6 relevant measures were reported.

1. Participation is Required for ONC Direct Review. The provider must answer question 1 (either 1a or 1a and 1b) -

Supporting providers with the performance of CEHRT (SPPC). To engage in activities related to supporting providers with the performance of CEHRT the EP must attest that:

☐	1a. Acknowledges the requirement to cooperate in good faith with ONC direct review of the EPs health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received.

☐	1b. If requested, cooperated in good faith with ONC direct review of EPs health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the EP in the field.
2. Participation is Optional for ONC Surveillance. The provider may answer question 2 (either 2a or 2a and 2b) -	
☐	2a. Acknowledges the option to cooperate in good faith with ONC-ACB surveillance of his or her health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC-ACB surveillance is received; and
☐	2b. If requested, cooperated in good faith with ONC-ACB surveillance of the EPs health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating capabilities as implemented and used by the EP in the field.
Support for health information exchange and the prevention of information blocking.	
☐	Did not knowingly and willfully take action (such as disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.
☐	Implemented technologies, standards, policies, practices and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was at all relevant times – Connected in accordance with applicable law; Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications and certification criteria adopted at 45 CFR part 170; Implemented in a manner that allowed for timely access by patients to their electronic health information; and Implemented in a manner that allowed for the timely, secure and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and vendors.
☐	Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj (3)), and other persons, regardless of the requestor's affiliation or technology vendor.

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

(*)Red asterik indicates a required field.

Initials: *

NPI: *

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

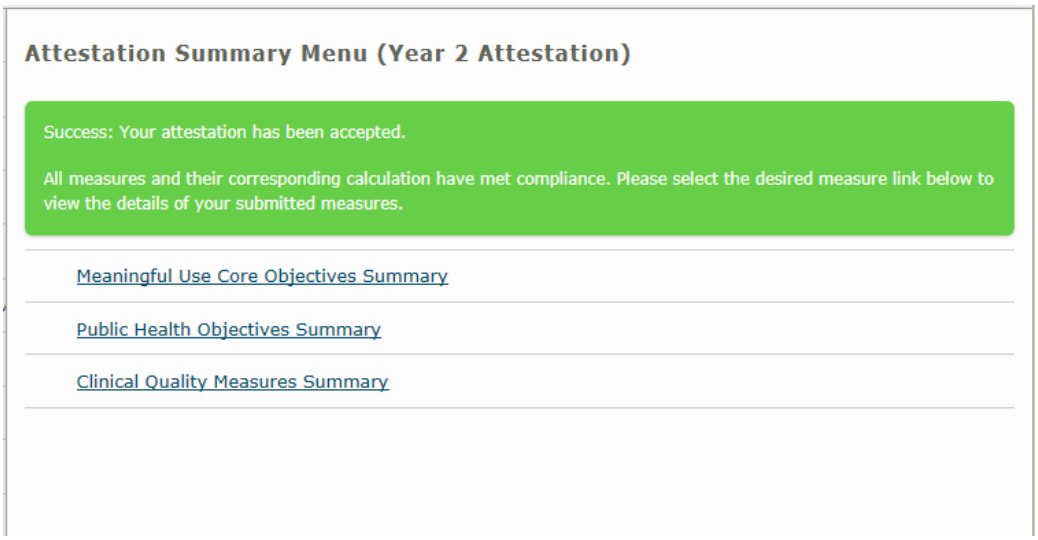
Previous Submit

All boxes must be checked appropriately in order to submit the attestation. Enter initials and NPI to submit the attestation.

When final selections have been made, choose a navigation button at the bottom of the screen.

- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Submit** to save and submit the attestation.

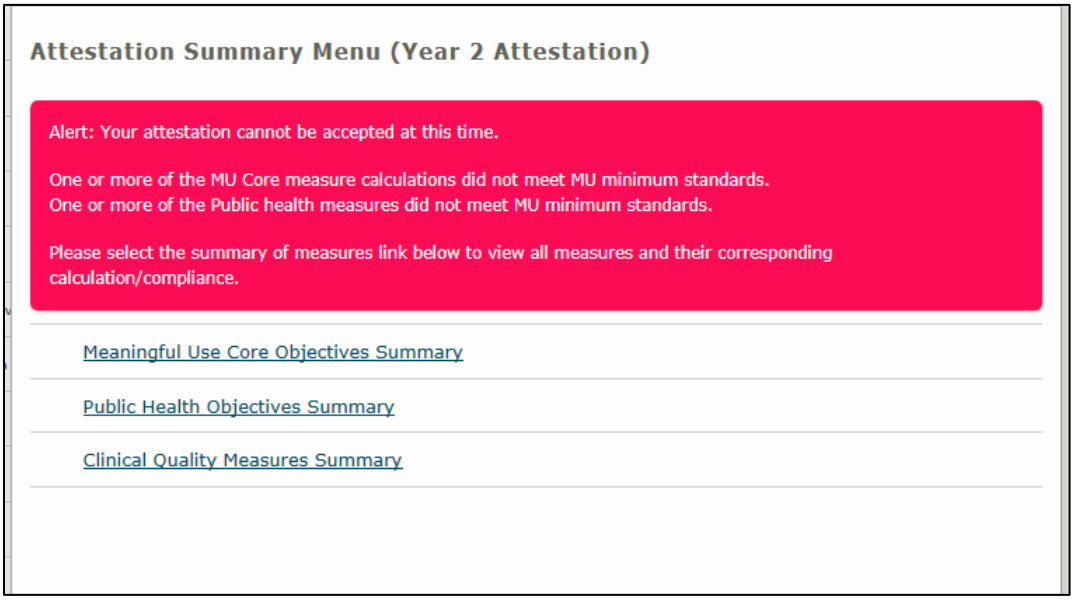
9.5 Accepted Attestation Screen



Once the attestation is accepted, no updates can be made to any data from the attestation.

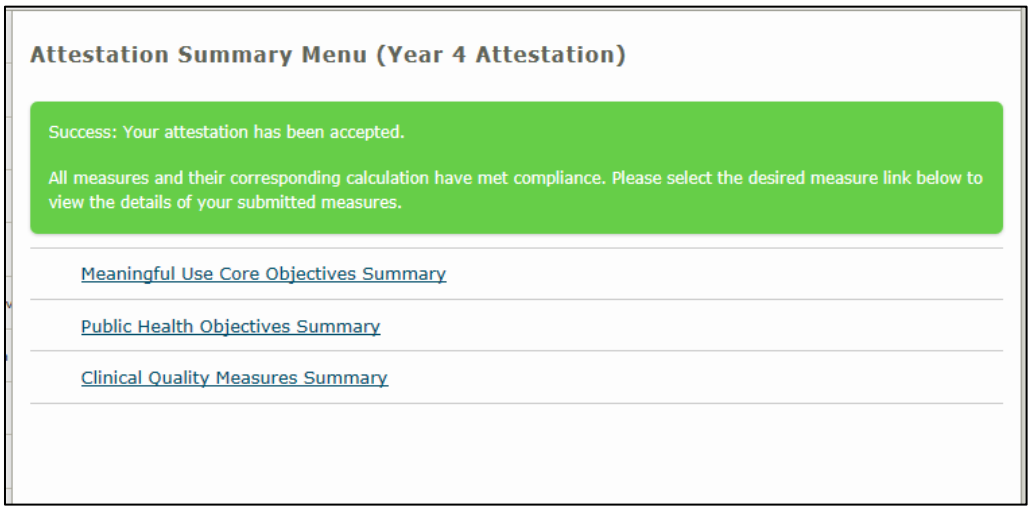
Click on the summary links to view the measure data that was submitted and accepted for attestation.

9.6 Attestation Not Accepted Screen



Click on the summary links to view the measure data responses. The summary page will indicate which measures were accepted and which were rejected.

9.7 Post Attestation Summary Screen



After attestation is completed, a statement will appear that the attestation has been accepted.

Click on the summary links to view the measure data that was submitted. The summary page will indicate which measures were accepted.

9.7.1 Objectives Summary

Meaningful Use Core Measure Summary (Year 5 Attestation)

CORE OBJECTIVES SUMMARY

Objective	Measure	Entered	Status
Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process.	Yes	Accepted
Use clinical decision support to improve performance on high-priority health conditions.	Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.	Yes	Accepted
Use clinical decision support to improve performance on high-priority health conditions.	The EP has enabled and implemented the functionality for drug-drug and drug allergy interaction checks for the entire EHR reporting period.	Yes	Accepted

Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	61%	Accepted
Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	30%	Accepted
Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	30%	Accepted
Generate and transmit permissible prescriptions electronically (eRx).	More than 50% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.	50%	Accepted

The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.	The EP that transitions or refers their patient to another setting of care or provider of care must-- (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals.	11.36%	Accepted
Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.	Patient-specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period.	11.36%	Accepted
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.	50%	Accepted
Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.	More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information.	50%	Accepted

Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.	For an EHR reporting period in 2017 and 2018, more than 5% of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.	1%	Rejected
Use secure electronic messaging to communicate with patients on relevant health information.	For an EHR reporting period in 2018, for more than 5% of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.	5%	Accepted

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9.7.2 Public Health Objectives Summary

Public Health Measures Summary (Year 4 Attestation)

ObjectiveText	Measure	Entered	Status
The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice. We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law.	The EP is in active engagement with a public health agency to submit immunization data.	Option 3	Accepted
The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice. We further specify that providers must use the functions and standards as defined for CEHRT at § 495.4 where applicable; however, as noted for measure 3, providers may use functions beyond those established in CEHRT in accordance with state and local law.	The EP is in active engagement to submit data to a specialized registry.	Option 2 - KY Cancer Registry	Accepted

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9.7.3 Electronic Clinical Quality Measures Summary (Manually Reported)

Summary of Clinical Quality Measures

PERSON AND CAREGIVER-CENTERED EXPERIENCE AND OUTCOMES

Title	Description	Status
Oncology: Medical and Radiation - Pain Intensity Quantified	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	Accepted

PATIENT SAFETY

Title	Description	Status
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.	Accepted

COMMUNICATION AND CARE COORDINATION

Title	Description	Status
Closing the Referral Loop: Receipt of Specialist Report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Accepted

COMMUNITY/POPULATION HEALTH

Title	Description	Status
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.	Accepted

EFFICIENCY AND COST REDUCTION

Title	Description	Status
Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	Accepted

EFFECTIVE CLINICAL CARE

Title	Description	Status
Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Accepted

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9.8 Next Steps

Thank you for participating in the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability). The attestation will be reviewed as quickly as possible. Please be on the lookout for emails requesting additional information. A delayed response will delay the review process and thus will also delay receipt of your incentive payment.

If the provider has additional years of participation remaining, the EHR Team will send out notifications as well as post announcements on the Home screen of when the system will be available for attestation for the next Program Year. It is beneficial to review program requirements prior to attesting to ensure the provider will meet all objectives and measures.

If this is the providers last year of participation (year 6), a certificate of completion will be emailed once payment is processed.

Once a provider has completed all eligible years of participation, you are no longer required to submit an attestation to the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability). However, providers are encouraged to participate in other programs available.

The Quality Payment Program (QPP) helps providers focus on care quality and making patients heathier. QPP also ends the Sustainable Growth Rate formula and gives the provider new tools, models, and resources to help give their patients the best possible care. Providers may select to participate in the Advanced Alternative Payment models (APMs) or the Merit-based Incentive Payment System (MIPS). If you participate in an Advanced APM, through Medicare Part B you may earn an incentive payment for participating in an innovative payment model. If you participate in MIPS, you will earn a performance-based payment adjustment. To check your participation status and for more information, providers can visit the website.