Medicaid EHR Incentive Program
(Promoting Interoperability)

Eligible Professional Meaningful Use Attestation Manual

Program Year 2021

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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/SMHP%202019%20Annual%20Update%20v%201.0.pdf
- Kentucky Medicaid EHR Application Portal located at https://prd.webapps.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 and 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, MU, 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 and received a payment no later than CY 2016. Program Year 2021 is the final year of participation. All attestations must be submitted no later than August 31st, 2021. Any attestation submitted after the deadline will not be eligible for the incentive payment.

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 the 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 Kentucky Medicaid 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 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 Kentucky Medicaid EHR Incentive Program (Promoting Interoperability) 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 at https://prd.webapps.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 Objective 1, Protect Patient Health Information, requires a Security Risk Analysis to be completed within the calendar year of the EHR reporting period.
    - 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 MU 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.

6 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 MU, 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.

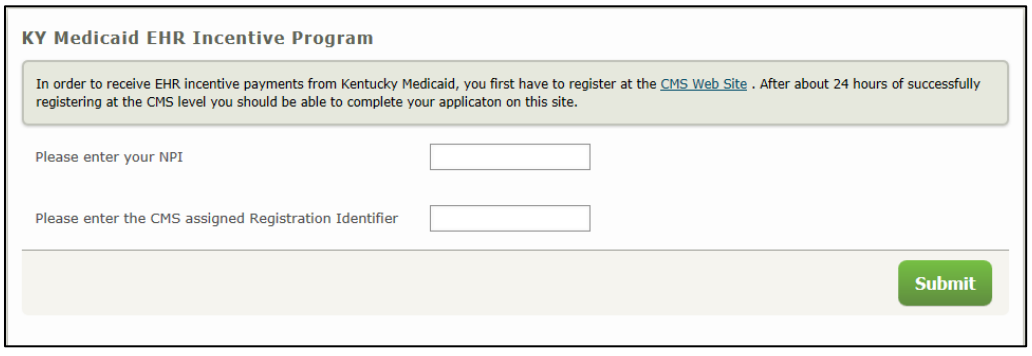
6.1 Attestation Appeal

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:

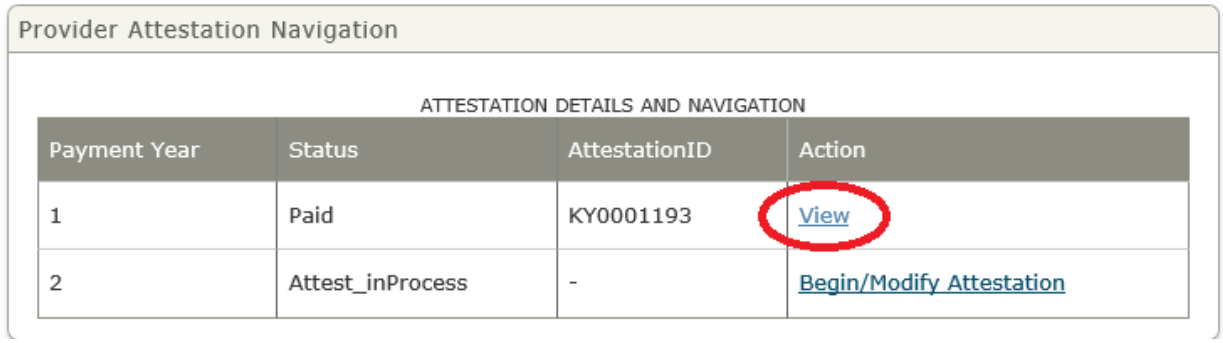
Division of Program Integrity
ATTN: EHR Appeal
Department for Medicaid Services
275 E. Main Street, 6E-A
Frankfort, KY 40621

6.2 Audit Appeal

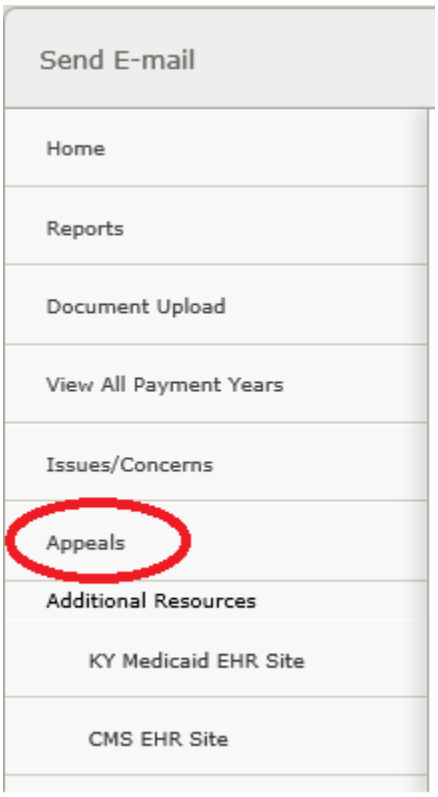
You may appeal the determination made by DMS on your post payment audit. To request an appeal, the provider must log into the attestation website at https://prd.webapps.chfs.ky.gov/KYSLR/login.aspx.



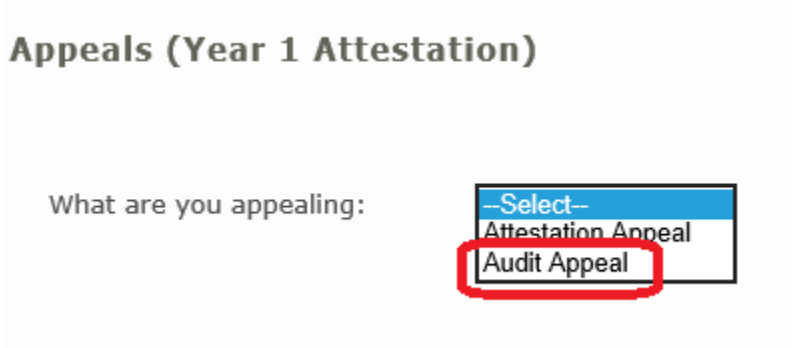
Step 1: After the provider has logged into the KYSLR, the provider will select 'view' on the Payment Year that is being appealed.



Step 2: Click 'Appeals' on the navigation pane.

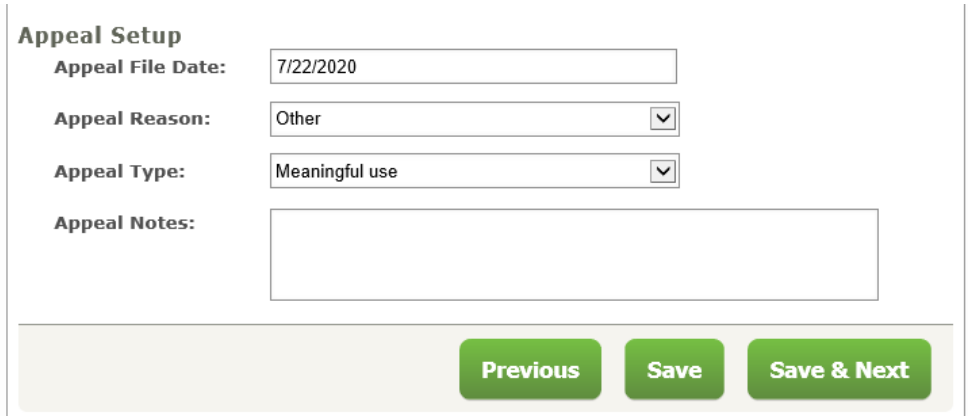


Step 3: Select Audit Appeal.

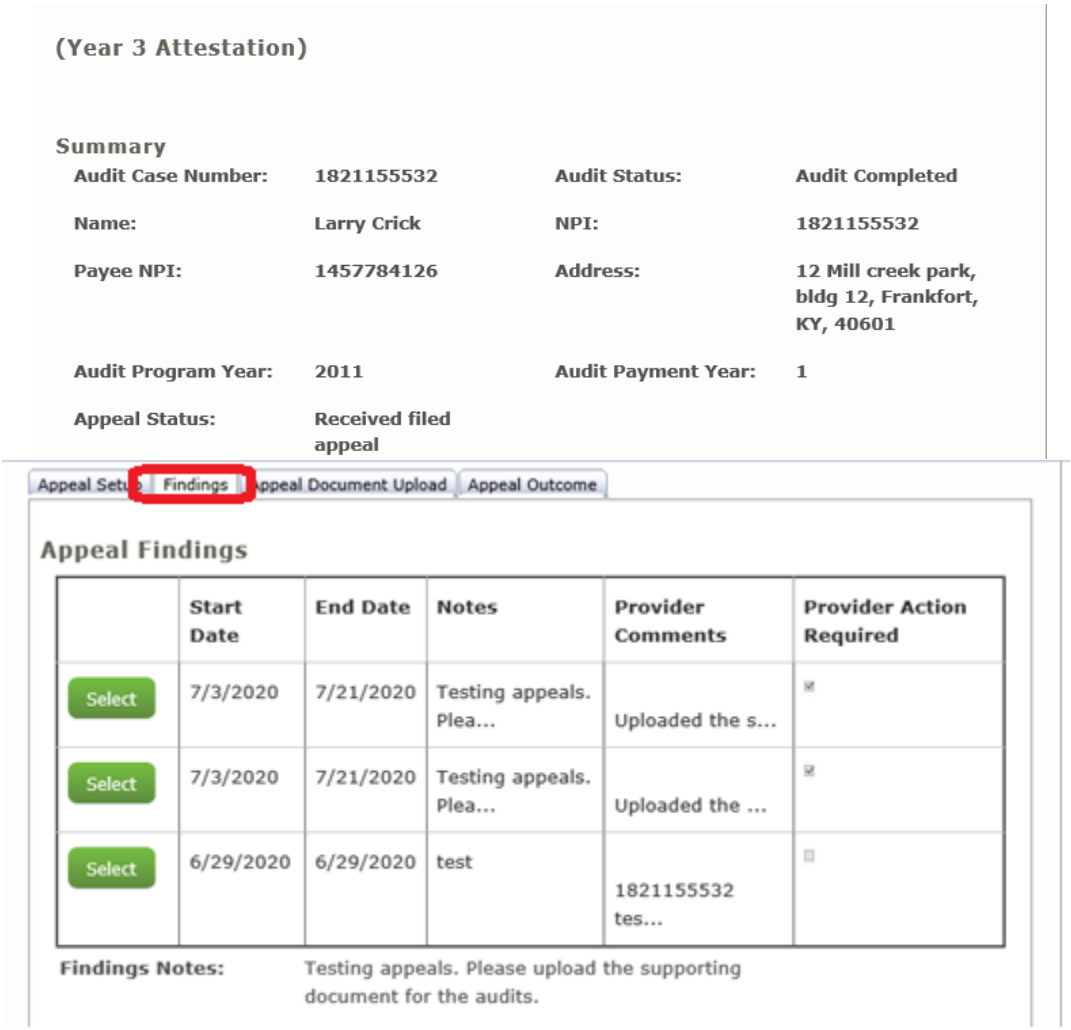


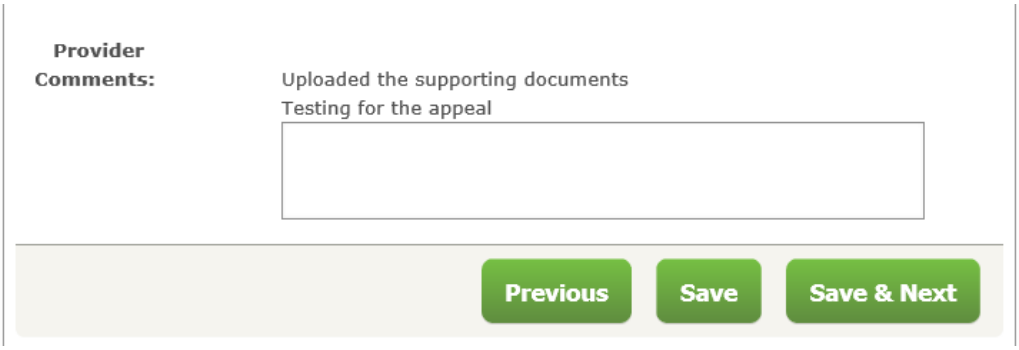
Step 4: Select the Program Year you are appealing.

Step 5: Select the Appeal File Date, Appeal Type and enter Appeal Notes. The Appeal Reason is preselected.

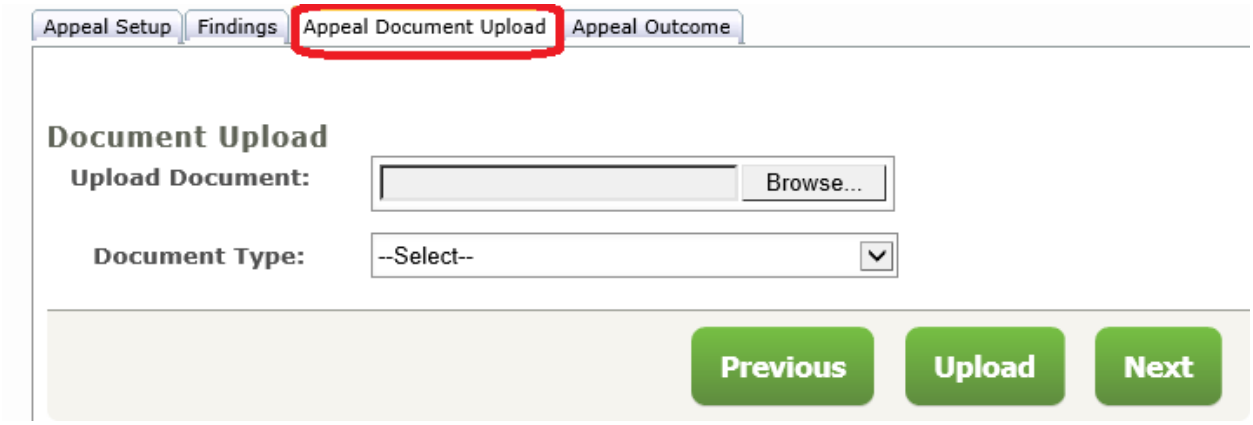


Step 6: To view the appeal findings, select the 'Findings' tab. This tab will display the appeal findings as well as any notes to and from the appeal reviewer.



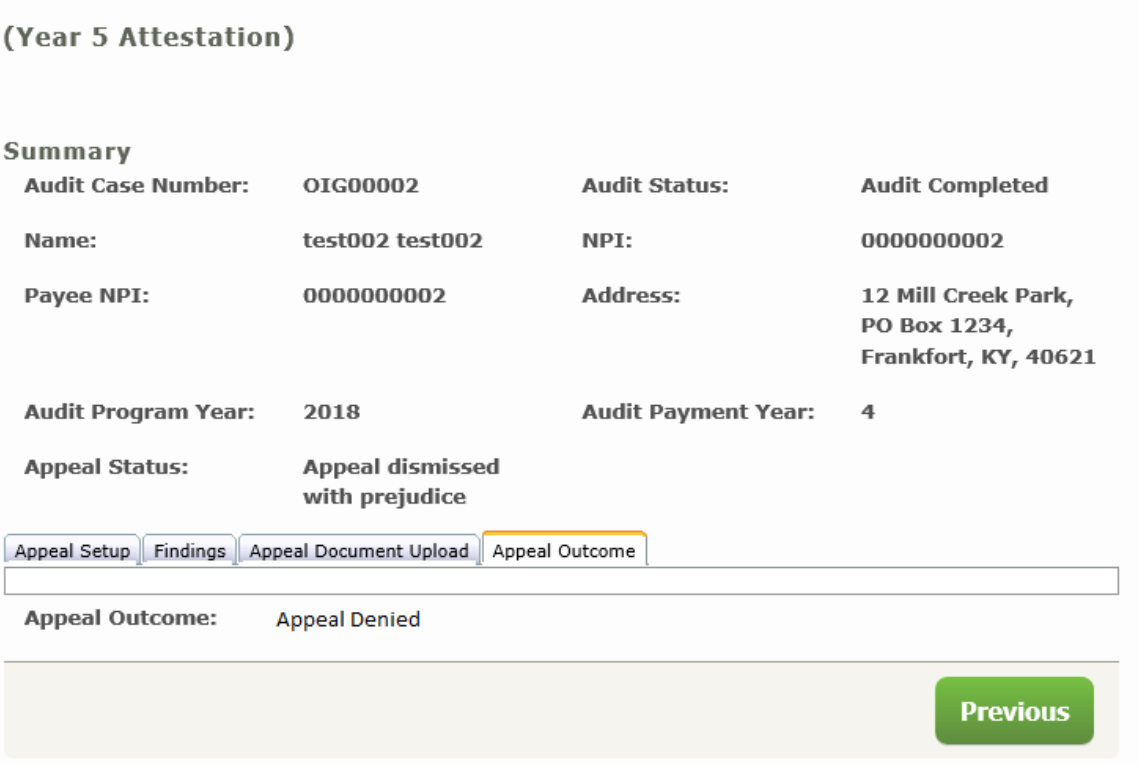


Step 7: Select the 'Appeal Document Upload' tab to upload supporting documentation to attach to your appeal. After you have uploaded your documentation, click on the 'Appeal Setup' tab to review your information. Once information is verified, click 'Next'.



The appeal has been submitted. You may make changes to the appeal until 5pm. At 5pm, the appeal will be sent to CMS and locked for internal review. You can check the status of your appeal by viewing the summary.

Step 8: Select the 'Appeal Outcome' tab to view the outcome of the appeal.

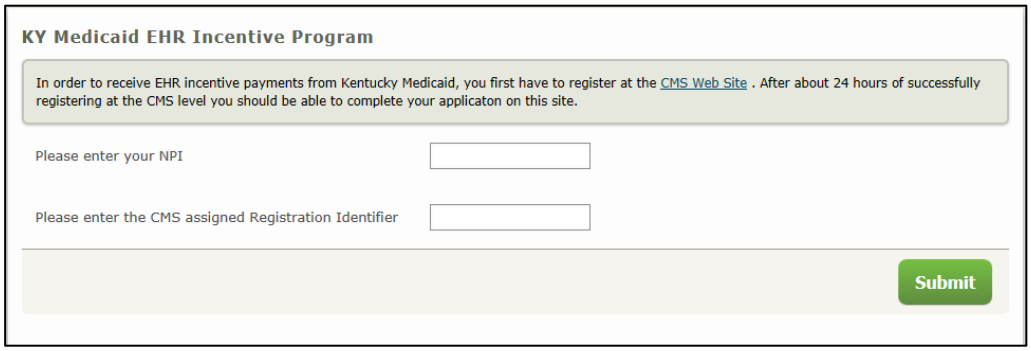


7 Getting Started

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://prd.webapps.chfs.ky.gov/KYSLR/login.aspx.

7.1 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

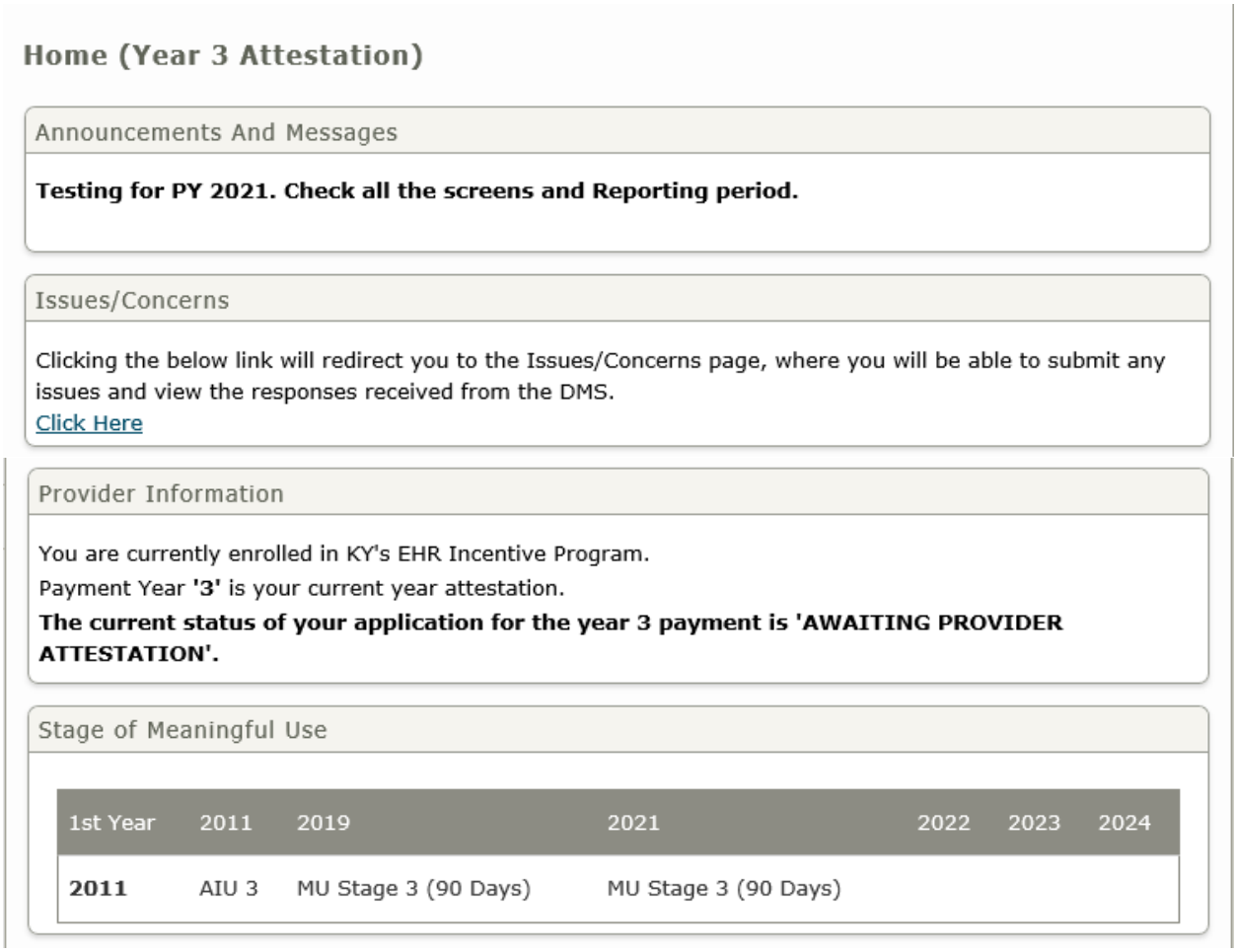
identifier. The identifier is used for accessing the KYSLR and should be safeguarded as a password.

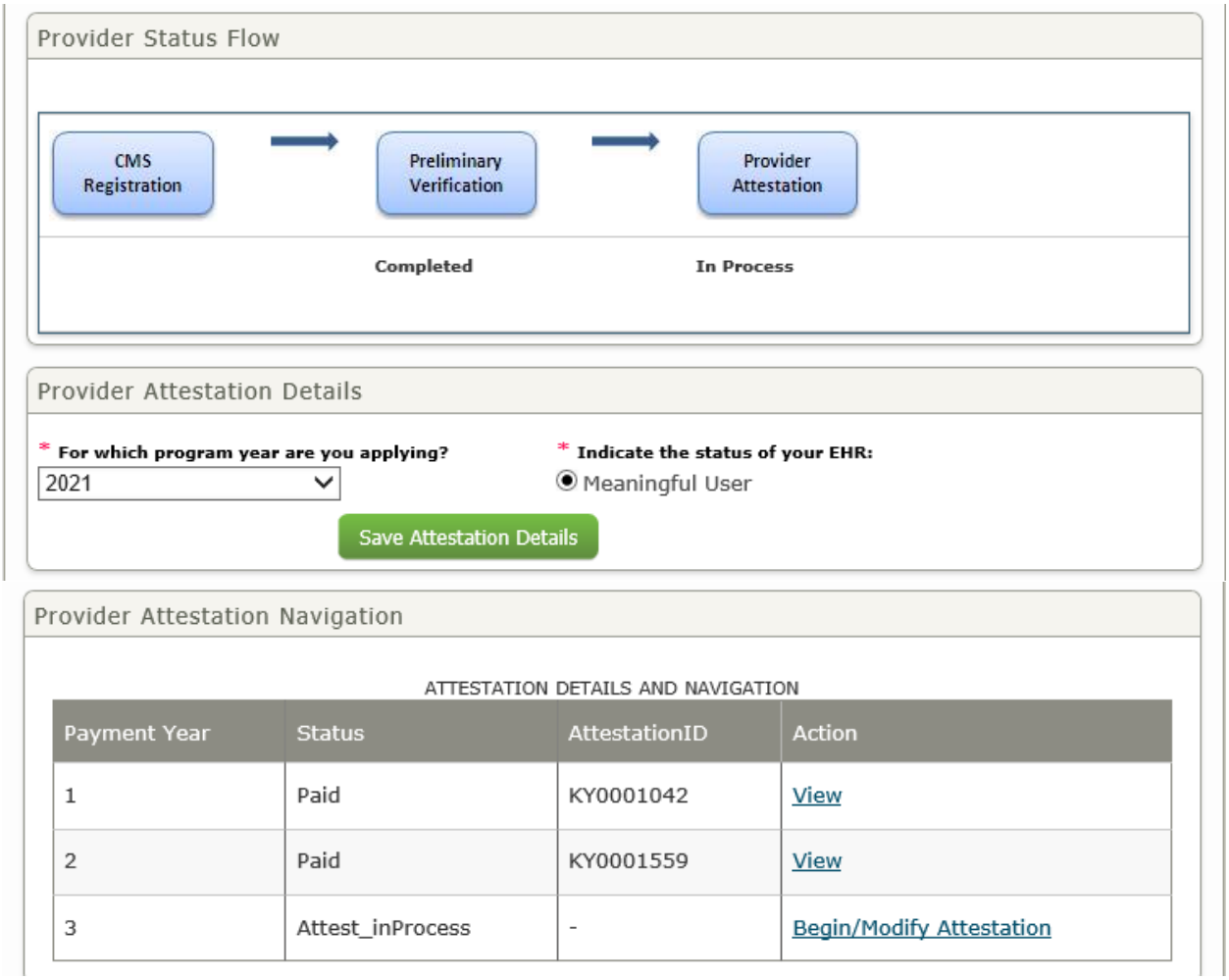
If the data submitted by the provider matches the data received from the NLR, the Home Screen will display. If the provider entry does not match, an error message with instructions will be returned. After five failed attempts, the provider will be locked out of the KYSLR for 15 minutes.

For assistance with registration, contact the NLR Production Support Help Desk toll free at (833) 238-0203 Monday through Friday, 8 a.m. to 5 p.m. Eastern time or email the help desk at NLRProdSupport@cms.hhs.gov.

7.2 Home Screen

The Home screen provides announcements, information about the provider's current Kentucky attestation review as well as allows 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 to. The status of their EHR is preselected to Meaningful User.





There are seven sections to the Home page listed below:

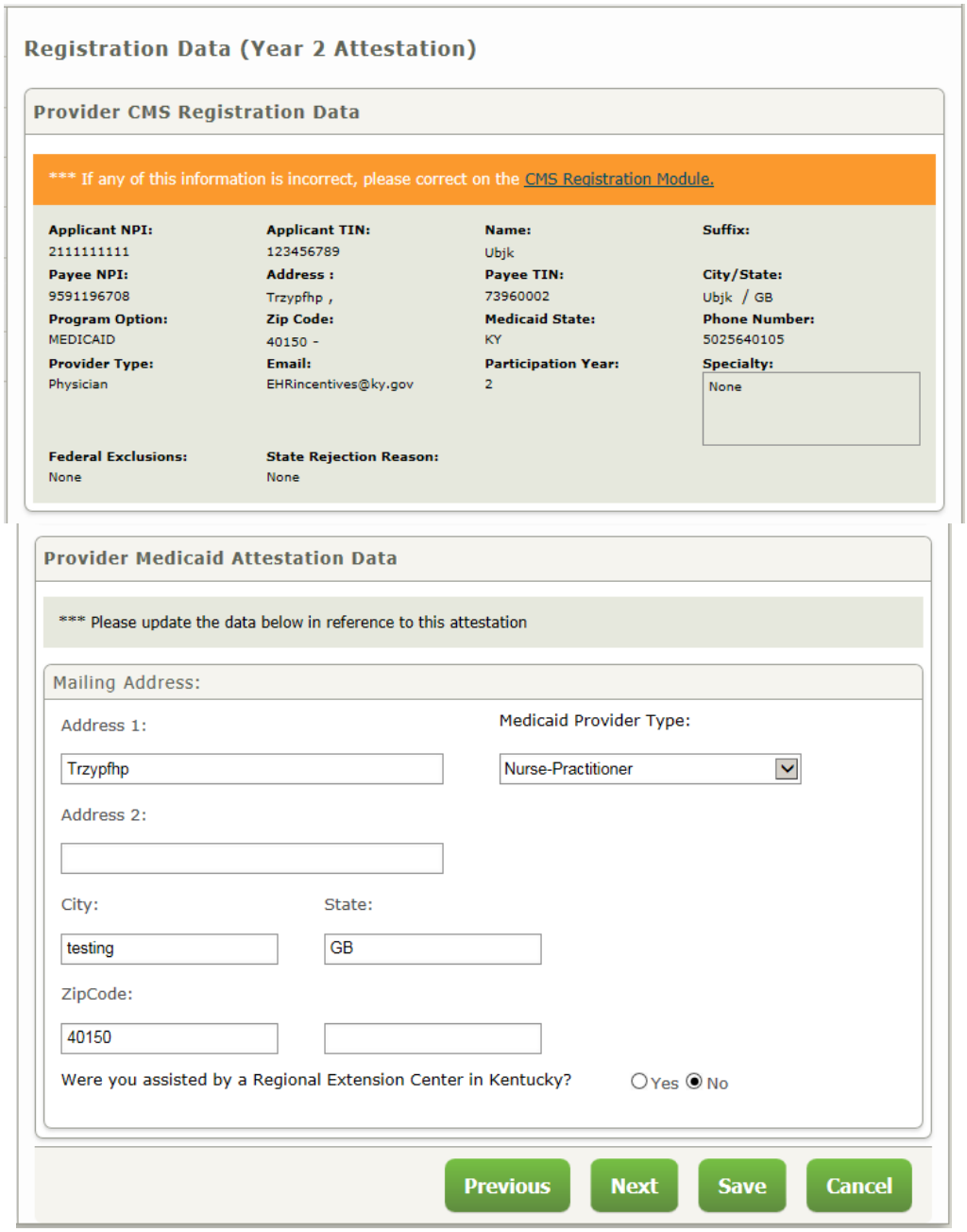
- Announcements and Messages – Displays messages or announcements for the provider.
- Issues/Concerns – Provides a link for the provider to submit a new issue or view a response to an issue.
- Provider Information – Provides a high-level status for the provider including the current payment year and the current status for the payment year.
- Stage of Meaningful Use – Supplies the stage of MU 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. EHR status is pre-selected as Meaningful User- currently meaningfully using CEHRT and are prepared to attest to MU 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.

7.3 Registration Data Screen

7.3.1 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.



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.

7.3.2 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:

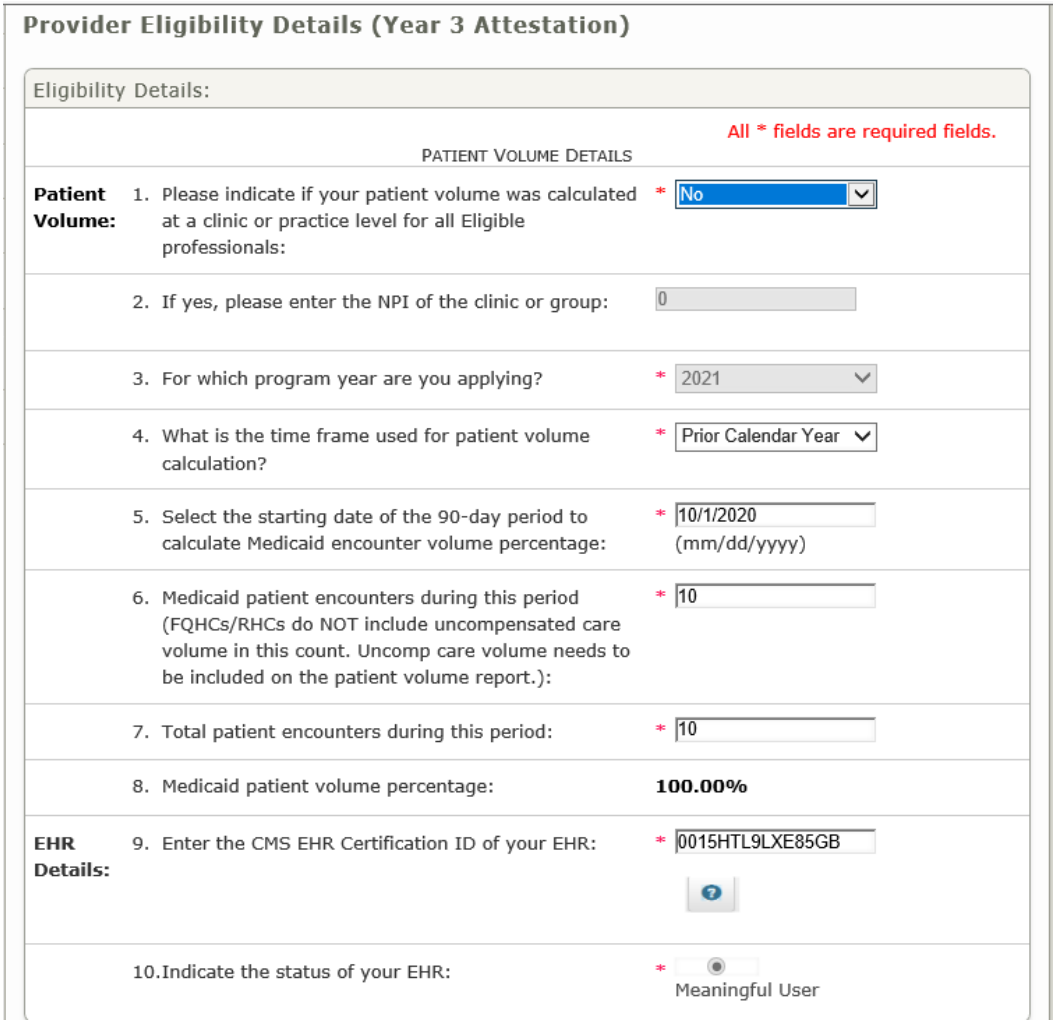
- Medicaid ID - This field only displays if you have multiple group Kentucky Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Kentucky group Medicaid Numbers. **This Medicaid Number will be used for your incentive payments.**
- 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.

7.4 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.

7.4.1 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.



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 August 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.

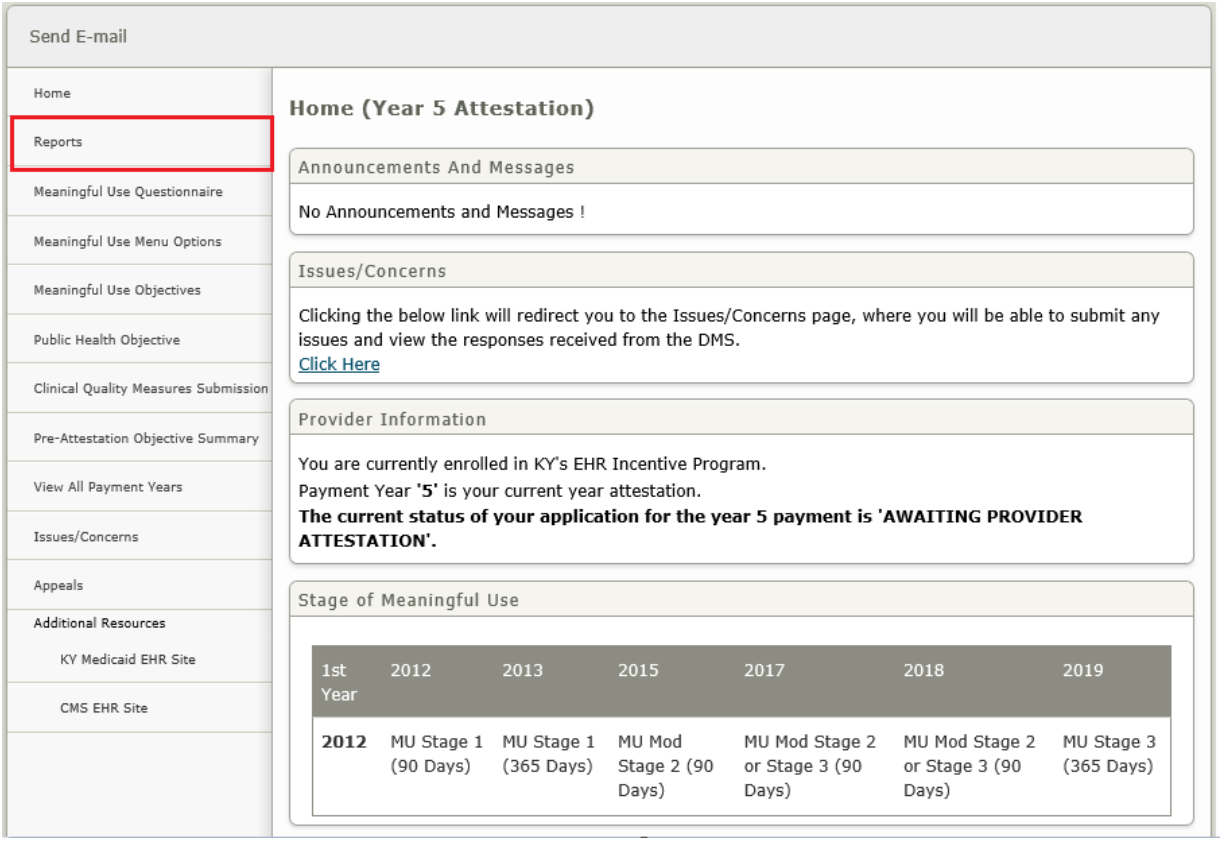
EHR Details

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

7.4.2 Requesting KCHIP Report Data

To request a KCHIP Report, the provider will need to log into the attestation website at https://prd.webapps.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.

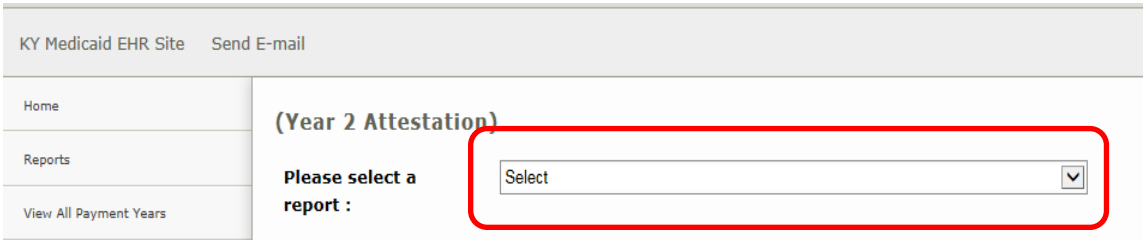


The KCHIP data report will take approximately three hours to complete. Once the report is ready to be viewed, an email will be sent to the email address on file within the attestation. This email address can be verified on the 'Registration Data' screen of the attestation. If this email address is not correct, please go to the CMS Registration website to update this

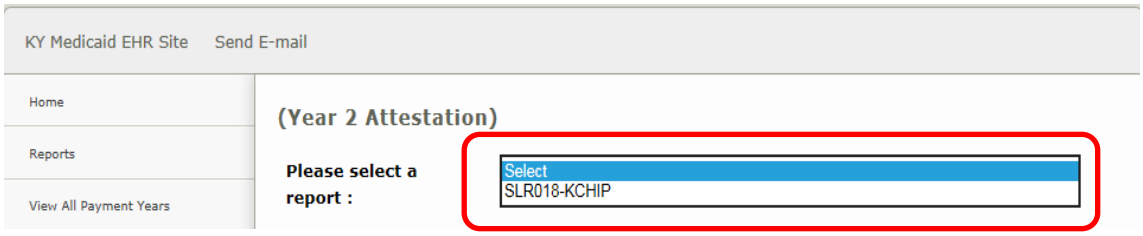
information. Email is our main form of communication with providers, so please take a moment to verify this information. Also, please be aware this update takes 24 hours to complete.

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'.

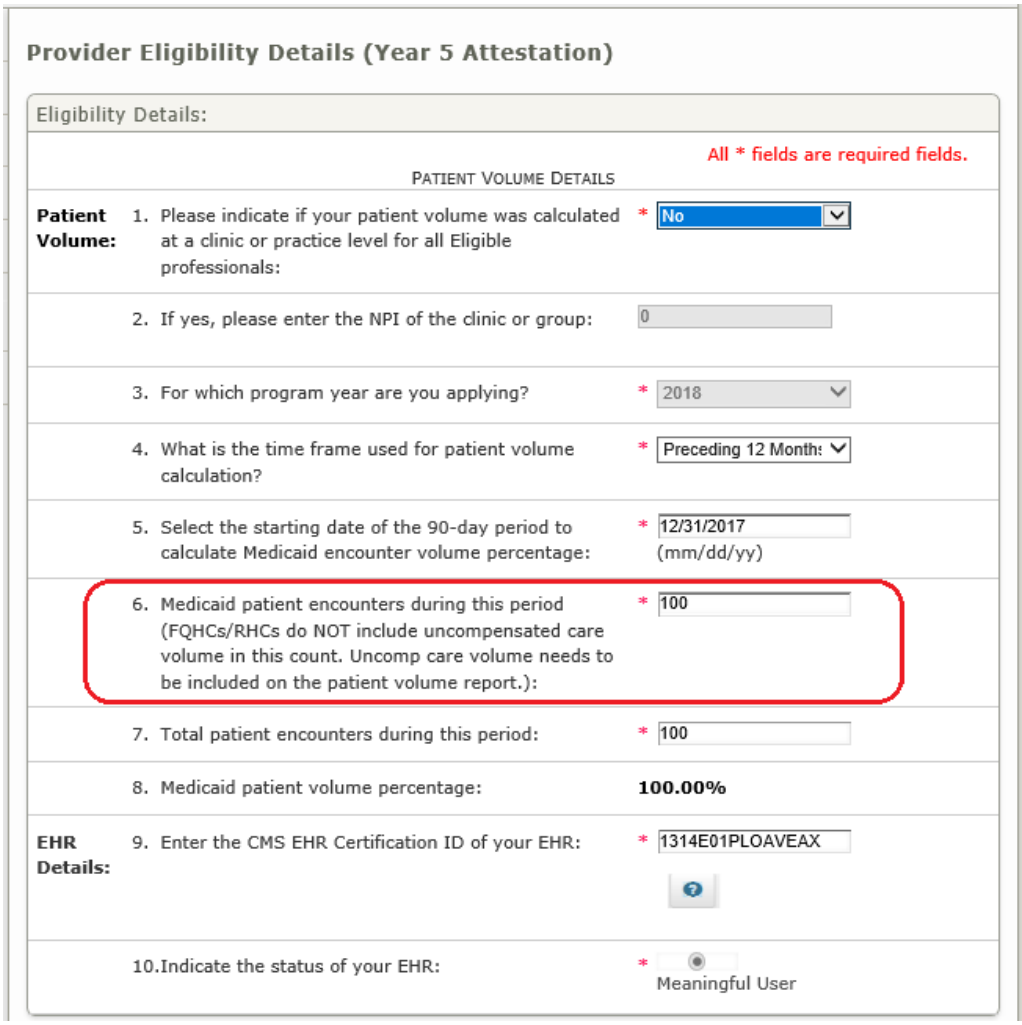


Step 3: Scroll down and locate the 'Report Request Information' heading. Click the 'Select' button next to the date you requested the report – also please confirm that the 'Start Date and End Date' are correct dates you will be attesting to for your 90 day patient volume.

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.

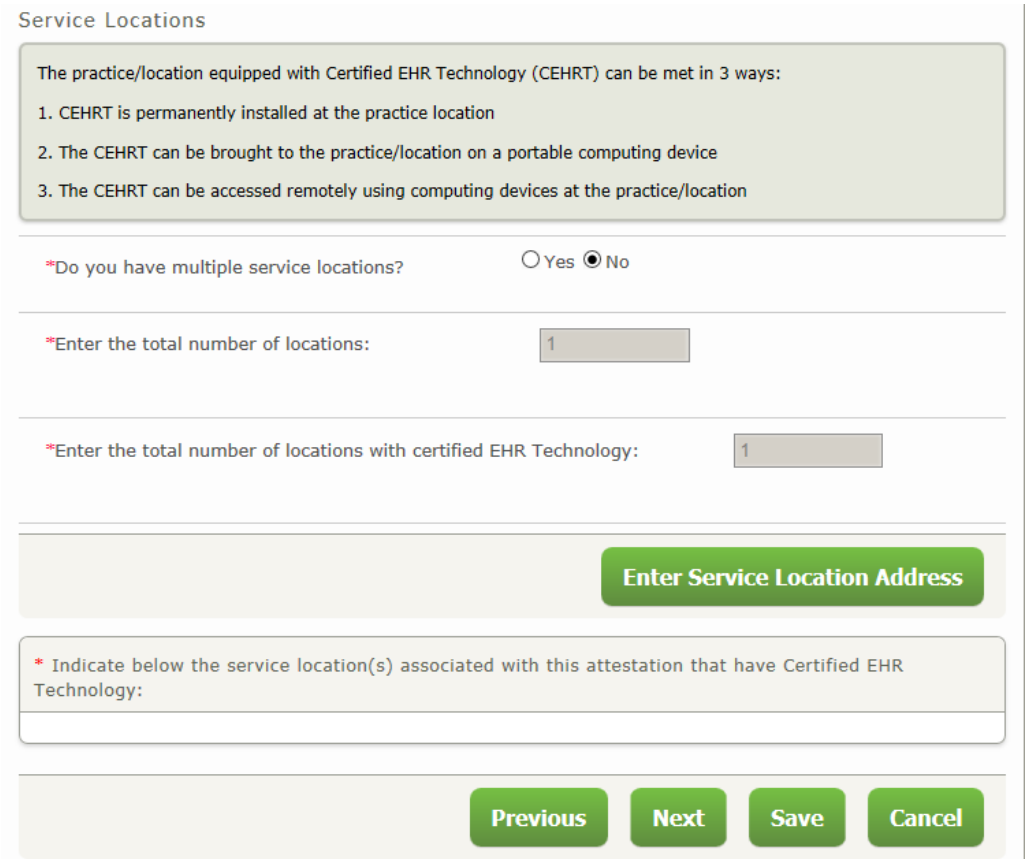
PATIENT VOLUME DETAILS

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

7.4.3 Service Locations

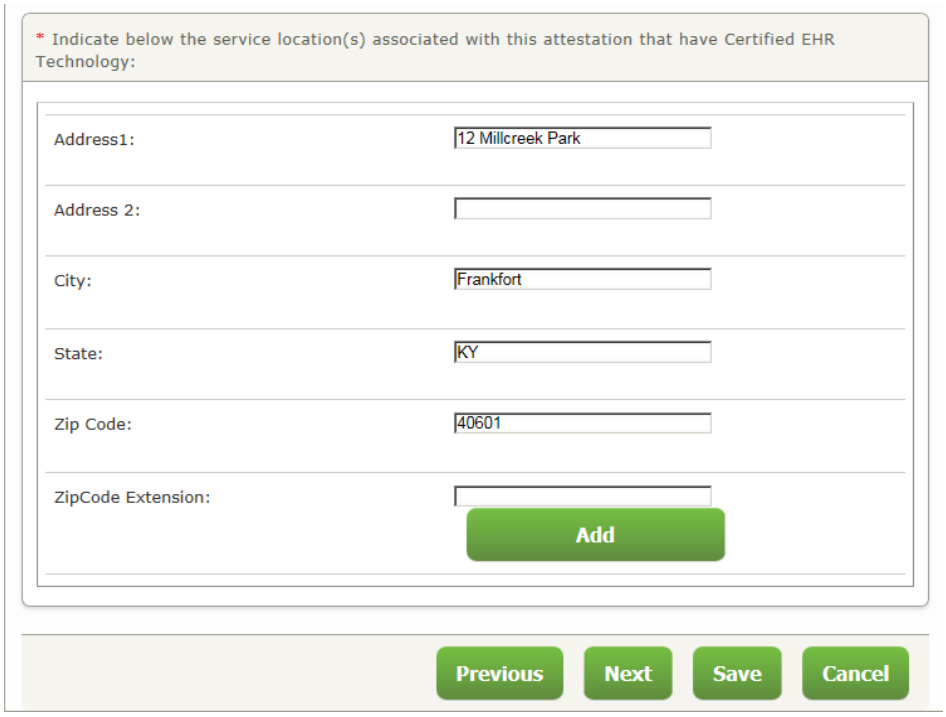
In the Service location section, enter information about the service locations equipped with a certified EHR. Practice/Locations equipped with CEHRT can qualify for MU in the following ways:

- 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.

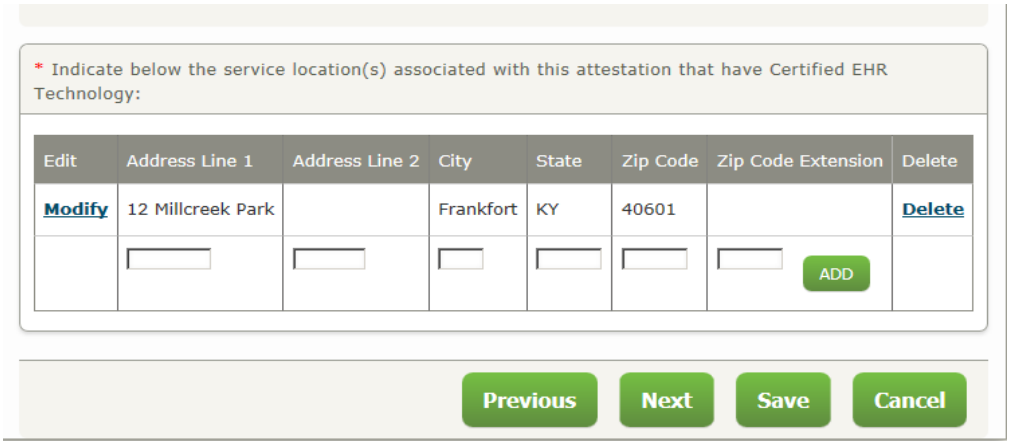


To complete this section, perform the following steps:

- 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.

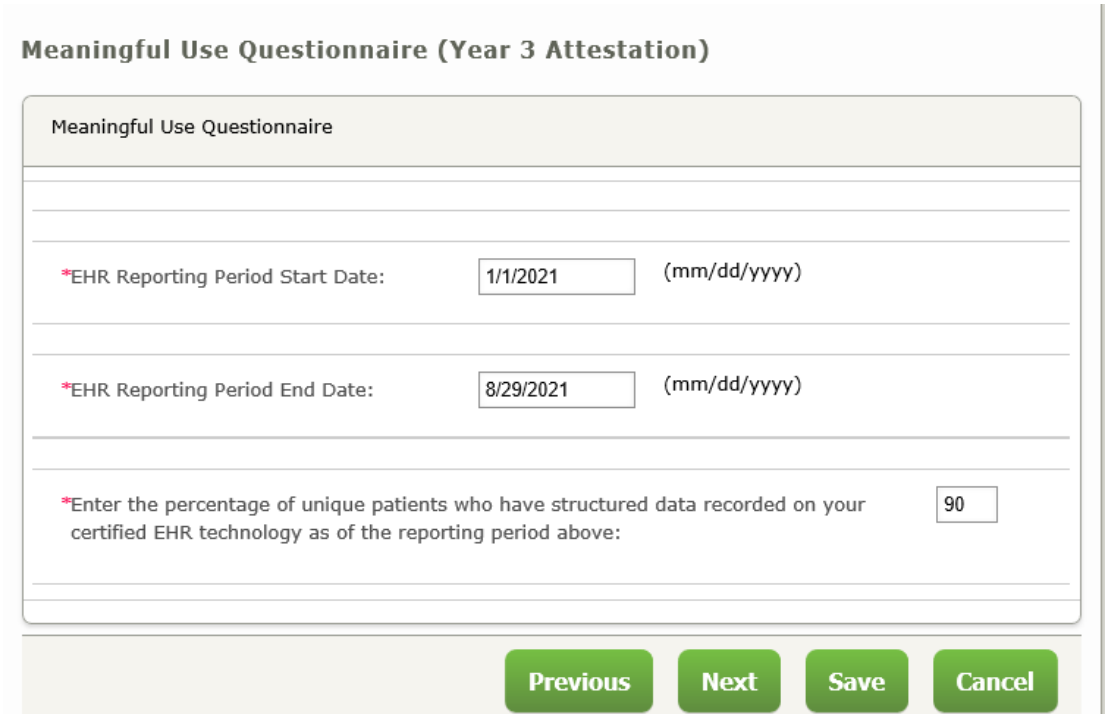
- To edit or update a Service location, click the Modify link.
- To remove a Service location, click the Delete link.
- To add a new Service location, enter address information in to the fields and click the ADD button.

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.

7.5 Meaningful Use Questionnaire Screen

After entering the provider eligibility details, EPs will be directed to the MU Questionnaire screen. Here, the EP will enter the MU reporting period. The MU 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 MU data.
- Enter EHR Reporting Period End Date
  - This is the end date of the reporting period for the MU 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.

8 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 2021, Providers must select an EHR MU reporting period that is any continuous 90-day period within the current calendar year. Providers have until August 31, 2021 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.

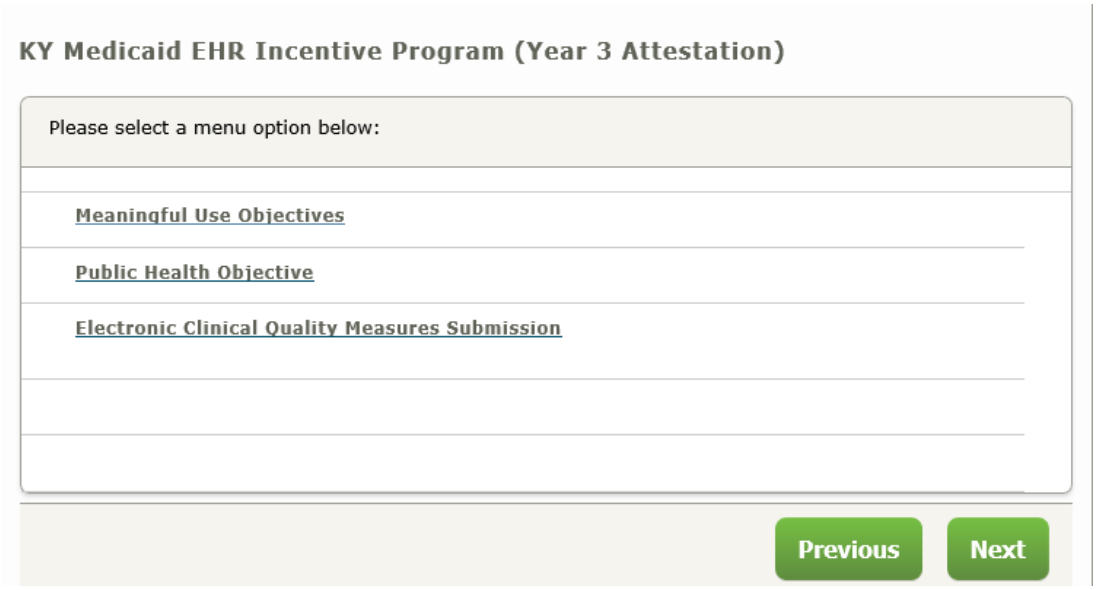
Meaningful Use Objectives

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 MU Measures, please visit the CMS Web site https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html.

8.1 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 MU Core Objectives are completed, the Public Health Objectives will be active to select.



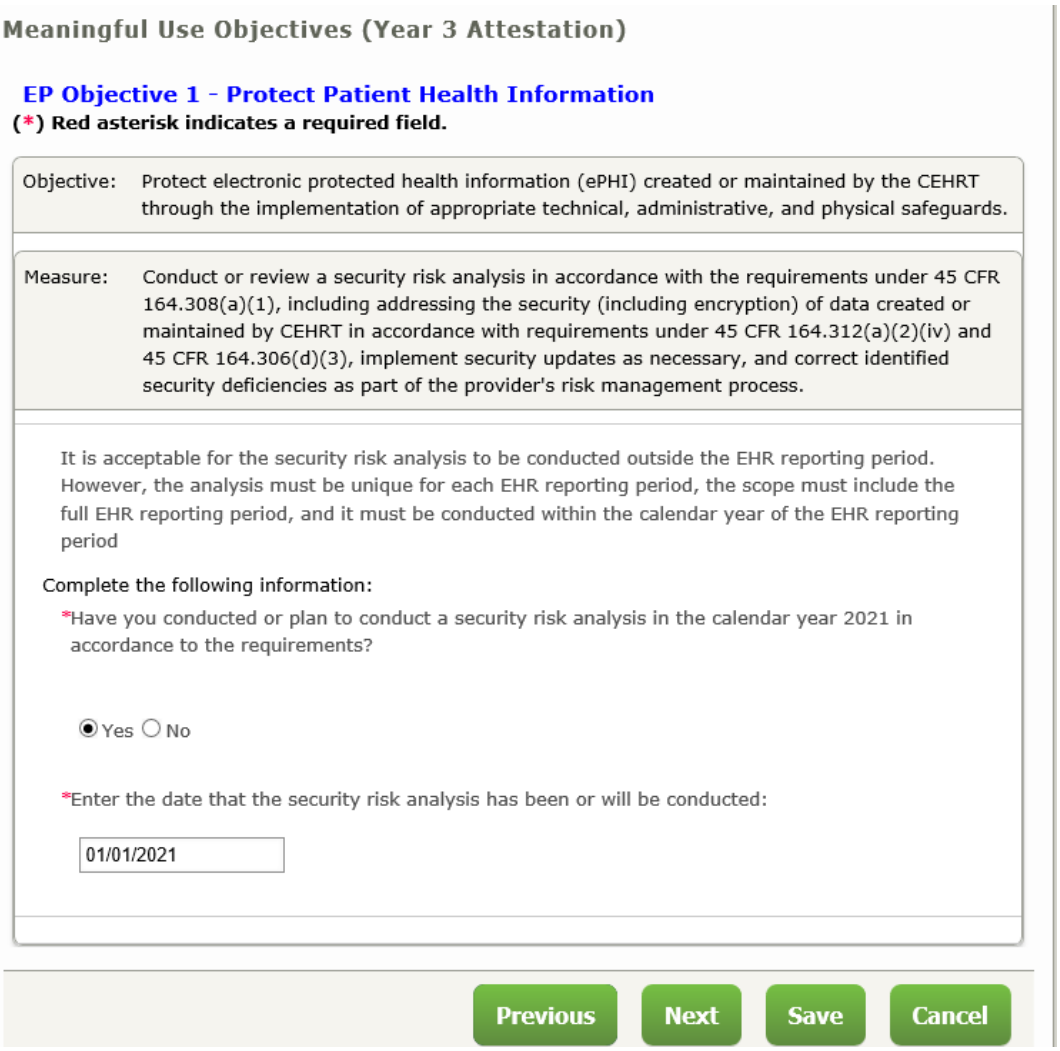
Meaningful Use Core Objectives Link – Takes the EP to the first screen of the MU Core Objectives.
Public Health Objectives Link – Takes the EP to the first screen of the Public Health Objectives. This link is only active after the MU Core Objectives are completed.
Electronic Clinical Quality Measures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

8.2 Meaningful Use Core Objectives – Stage 3

8.2.1 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 and enter the date that the security risk analysis has been or will be conducted.

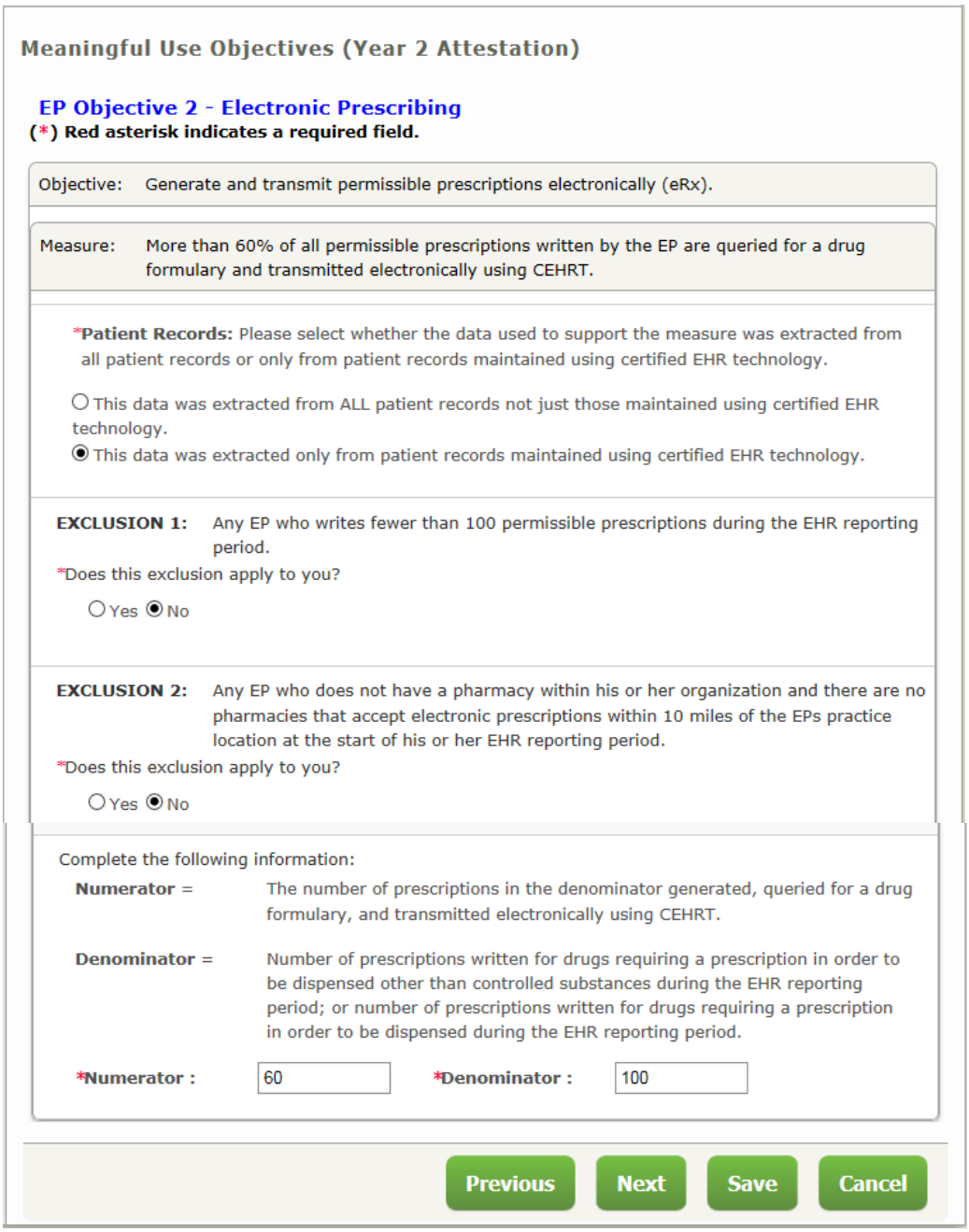
- If No is selected, upon navigation, a message will pop up stating that the entry for the measure does not meet the threshold to qualify for an incentive payment.

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.

8.2.2 MU Core Objective 2 – Electronic Prescribing (eRX)

OBJECTIVE: Generate and transmit permissible prescriptions electronically.



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.

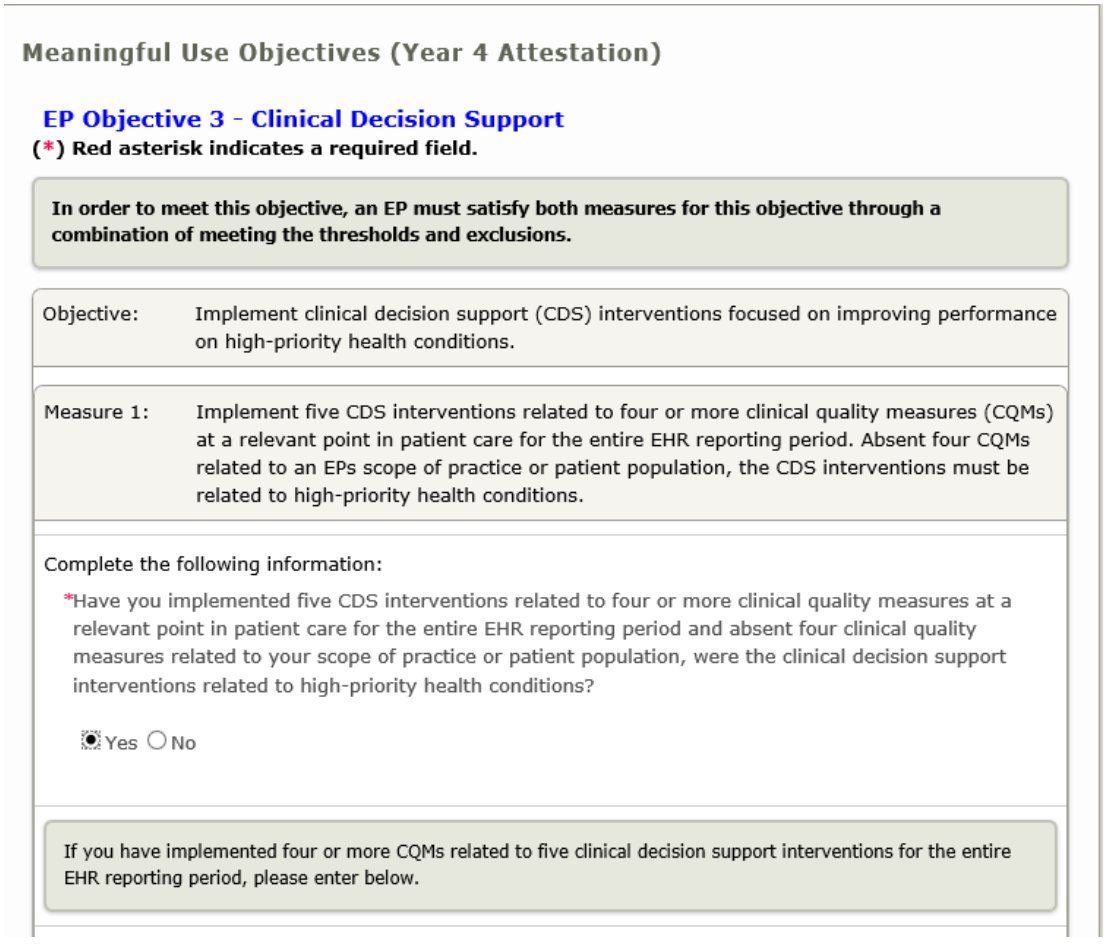
- If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 60% in order to successfully attest to the measure.

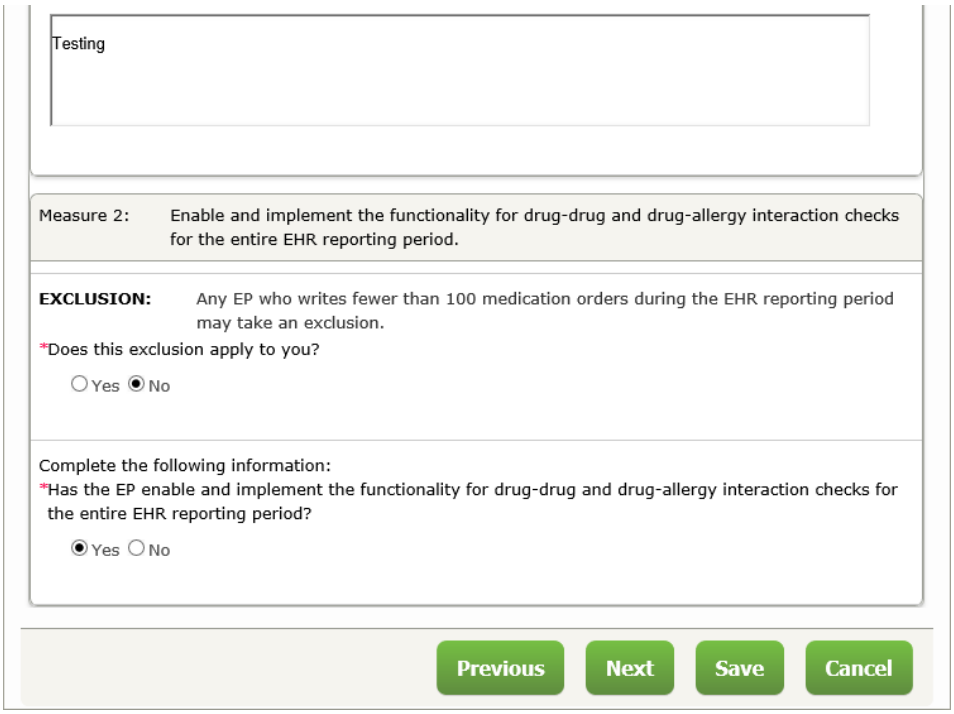
When final selections have been made, choose a navigation button at the bottom of the screen.

- 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.

8.2.3 MU Core Objective 3 – Clinical Decision Support

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





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.

8.2.4 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 2 Attestation)

EP Objective 4 - Computerized Provider Order Entry

(*) Red asterisk indicates a required field.

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

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:** 90 ***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.

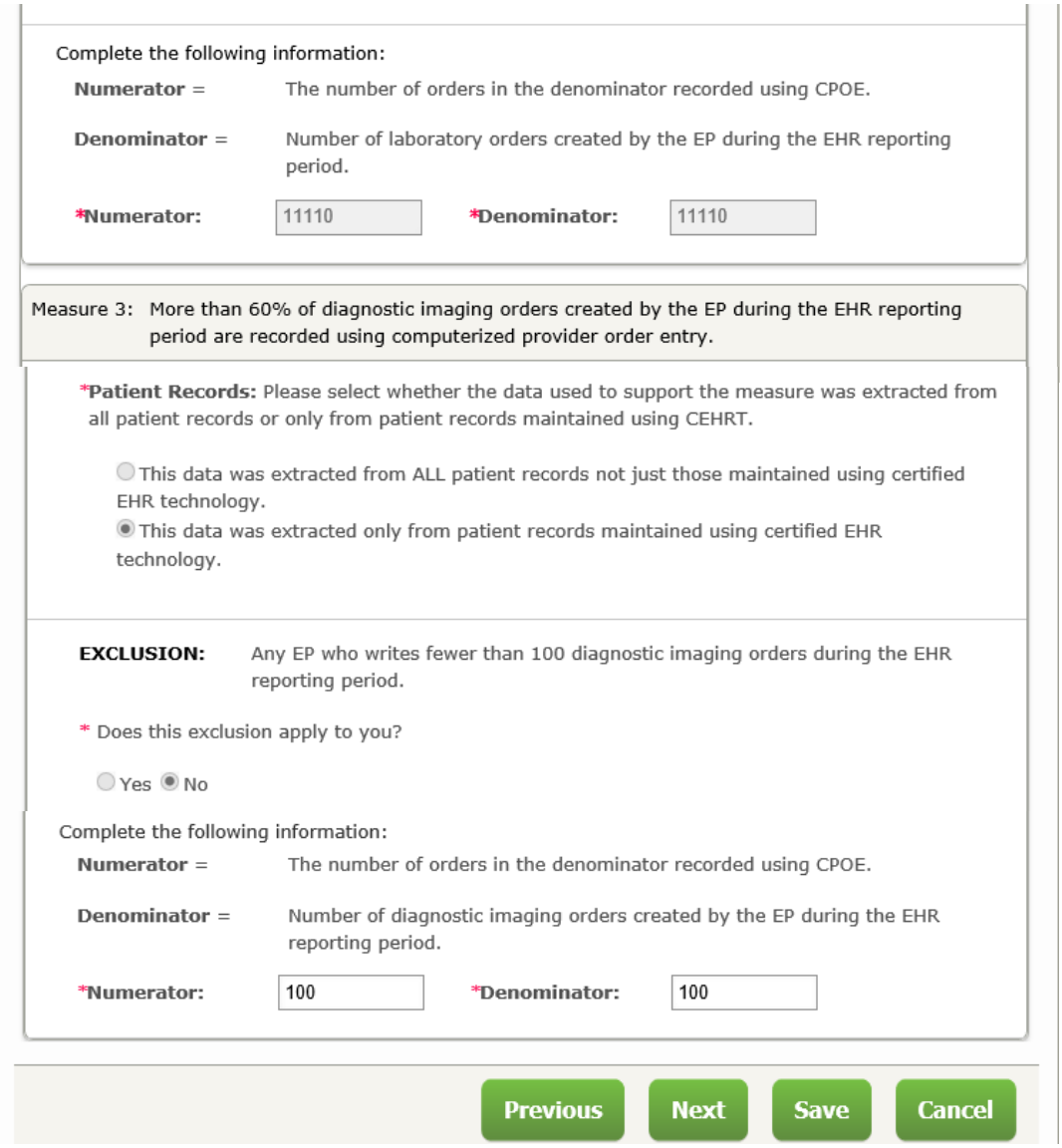
***Patient Records:** Please select whether the data used to support the measure was extracted from all patient records or only from patient records maintained using CEHRT.

- (•) 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



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.

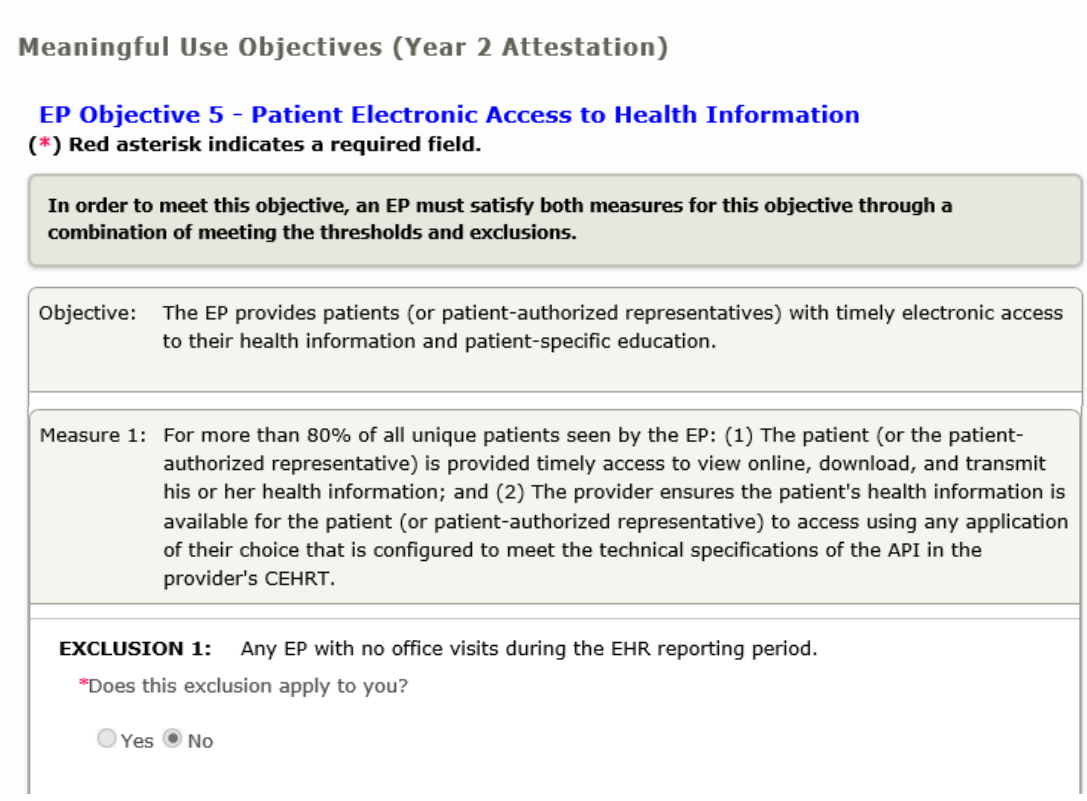
- First, respond as to whether data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.
- Second, respond to the Exclusion.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes.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

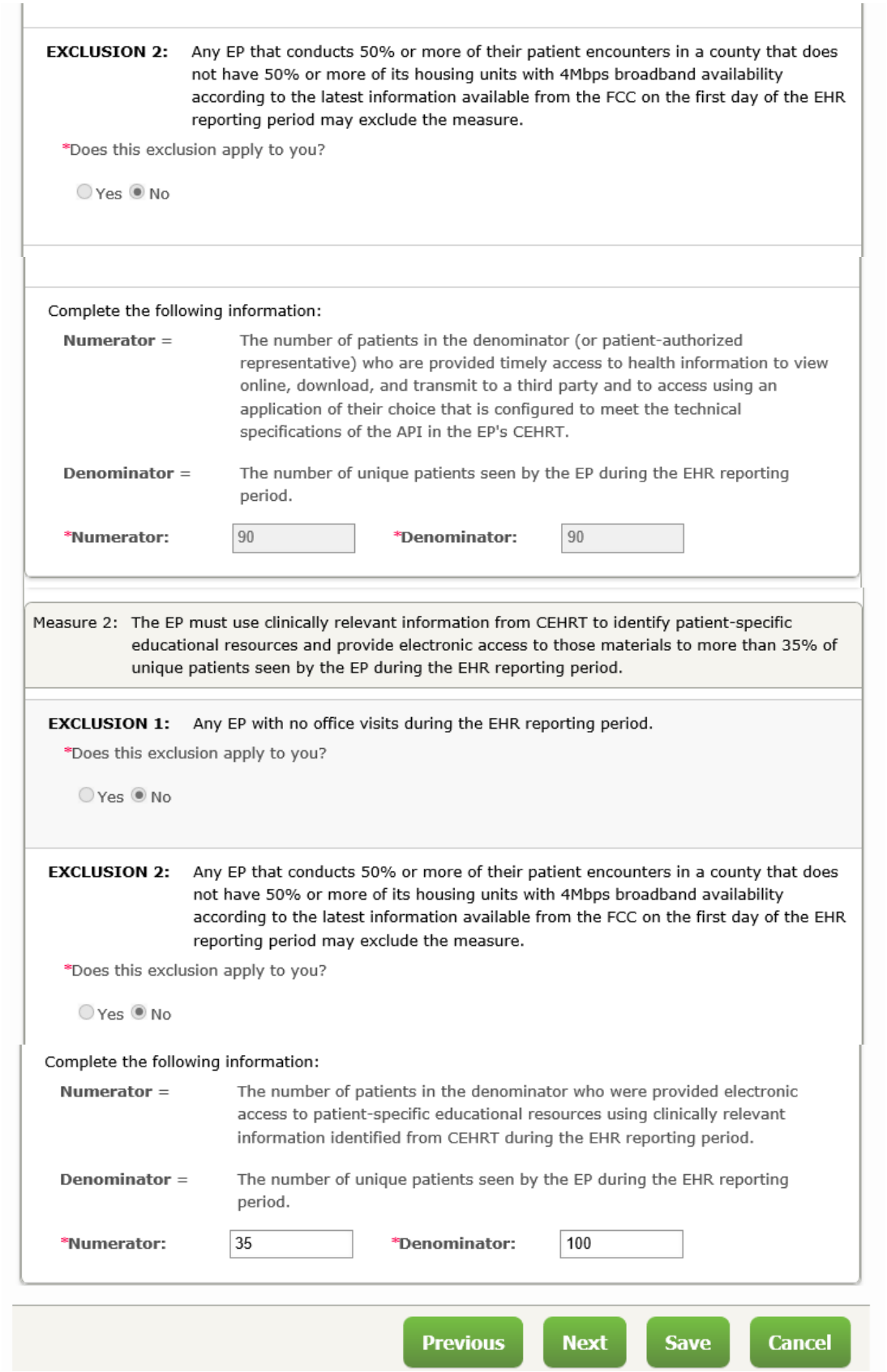
When final selections have been made, choose a navigation button at the bottom of the screen.

- 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.

8.2.5 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.





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.

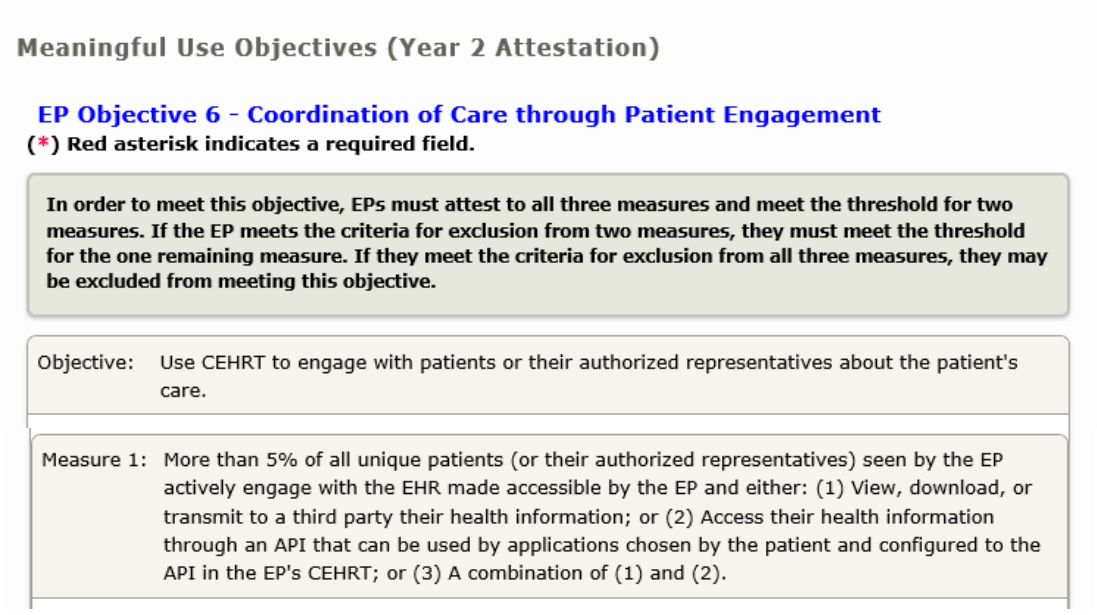
- If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 35% in order to successfully attest to the measure.

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.

8.2.6 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 2 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 meet the threshold for 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 an 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 their 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 :** 30 ***Denominator :** 30

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.

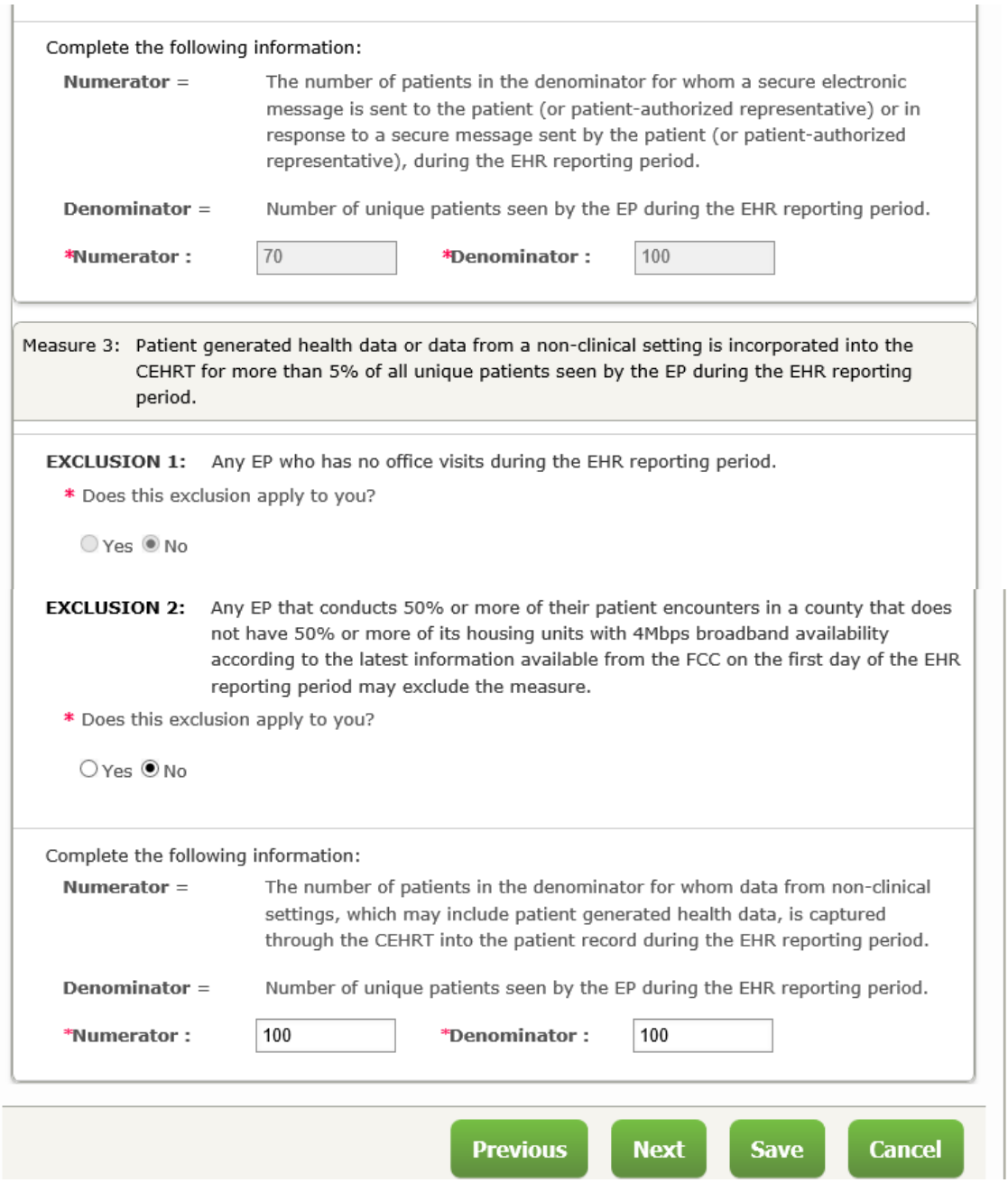
* Does this exclusion apply to you?

Yes No

EXCLUSION 2: Any EP that conducts 50% or more of their 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



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.

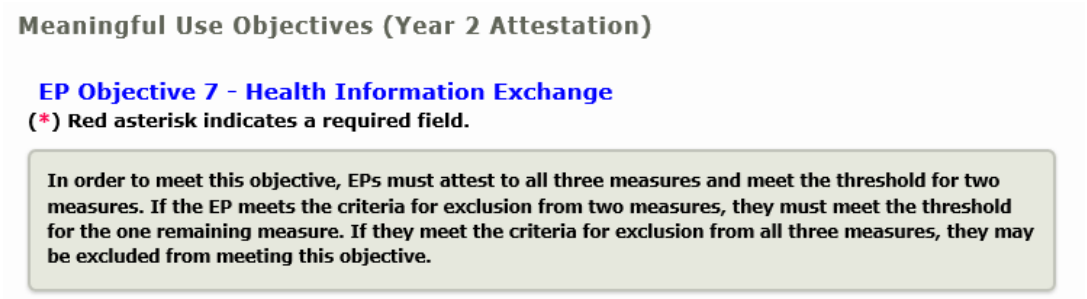
- If No is selected, respond to Exclusion 2.
    - If No is selected, enter a whole number into both the Numerator and Denominator boxes. The Numerator/Denominator must be over 5% in order to successfully attest to the measure.

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.

8.2.7 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.



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 their 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.

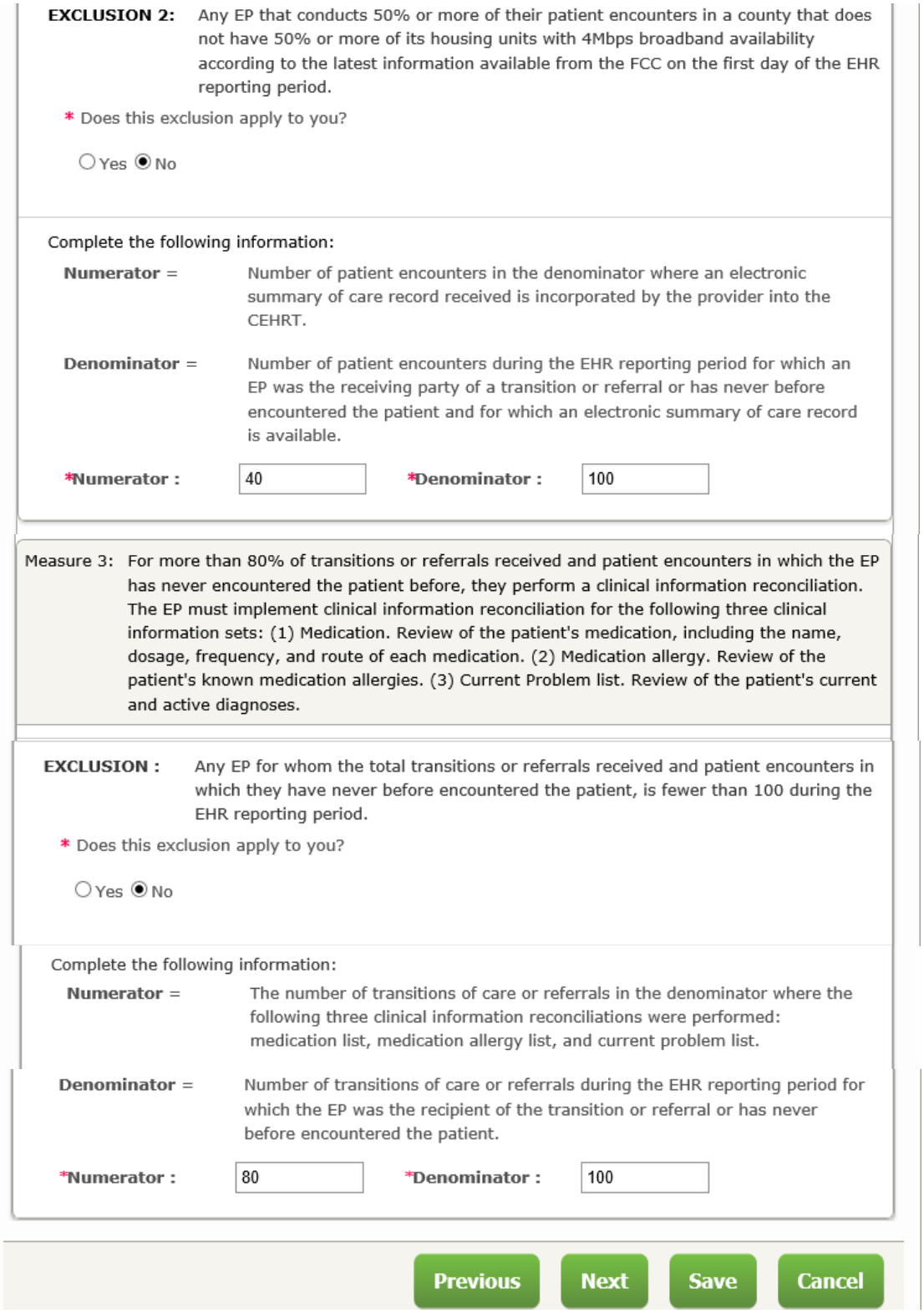
***Numerator :** 49 ***Denominator :** 100

Measure 2: For more than 40% of transitions or referrals received and patient encounters in which the EP has never encountered the patient before, they incorporate 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 they have never encountered the patient, is fewer than 100 during the EHR reporting period.

* Does this exclusion apply to you?

○ Yes ◉ No



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.

8.2.8 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.

8.2.8.1 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).

Public Health Objective Measures (Year 6 Attestation)

Immunization 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 immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

*Would you like to attest to this measure?

(•) Yes ( ) No

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.

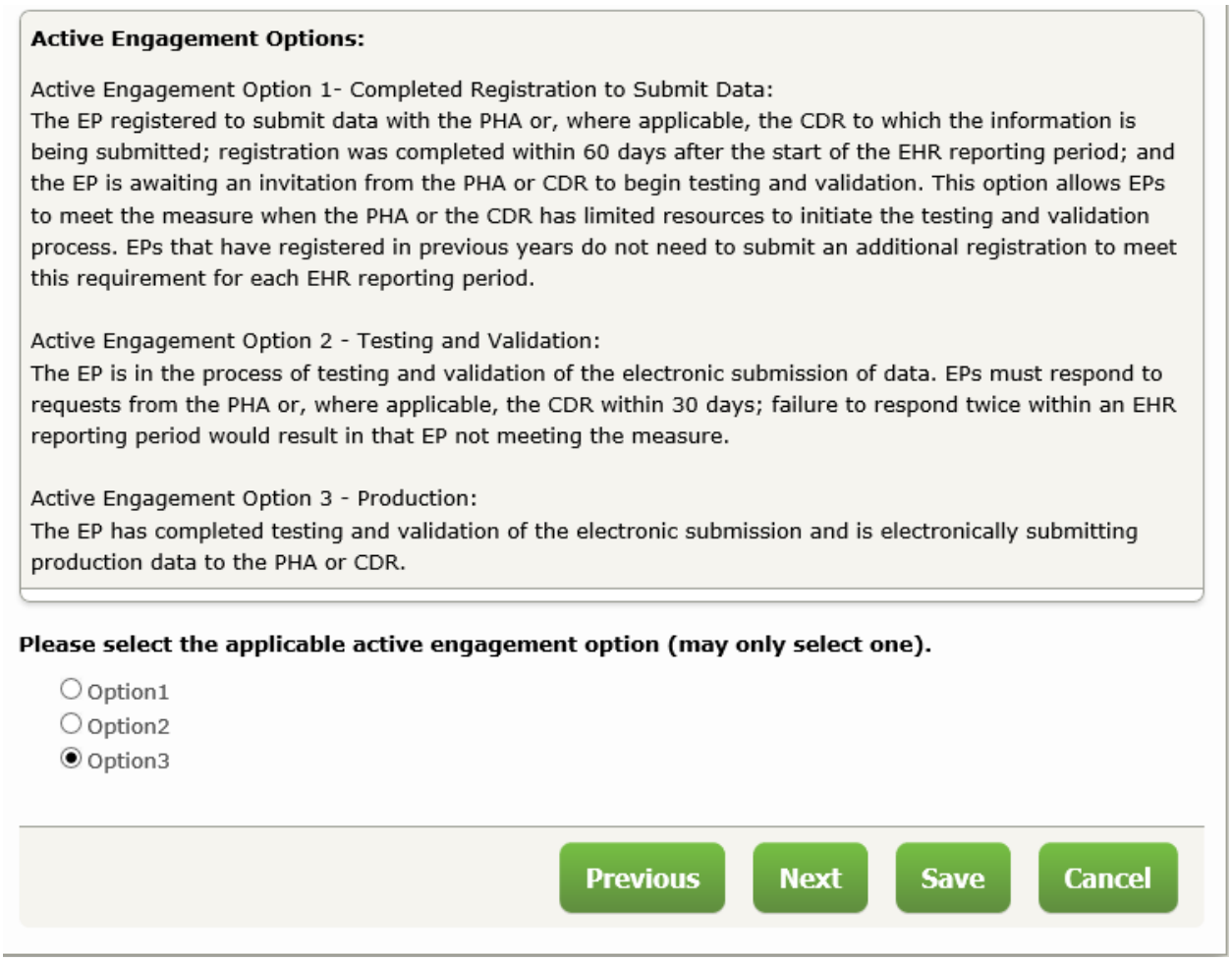
*Does this exclusion apply to you?

( ) 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



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.

8.2.8.2 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 2 Attestation)

Syndromic Surveillance 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 syndromic surveillance data.

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

(•) Yes ( ) No

EXCLUSION 1: An EP 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: The EP practices in a jurisdiction for which no PHA 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.

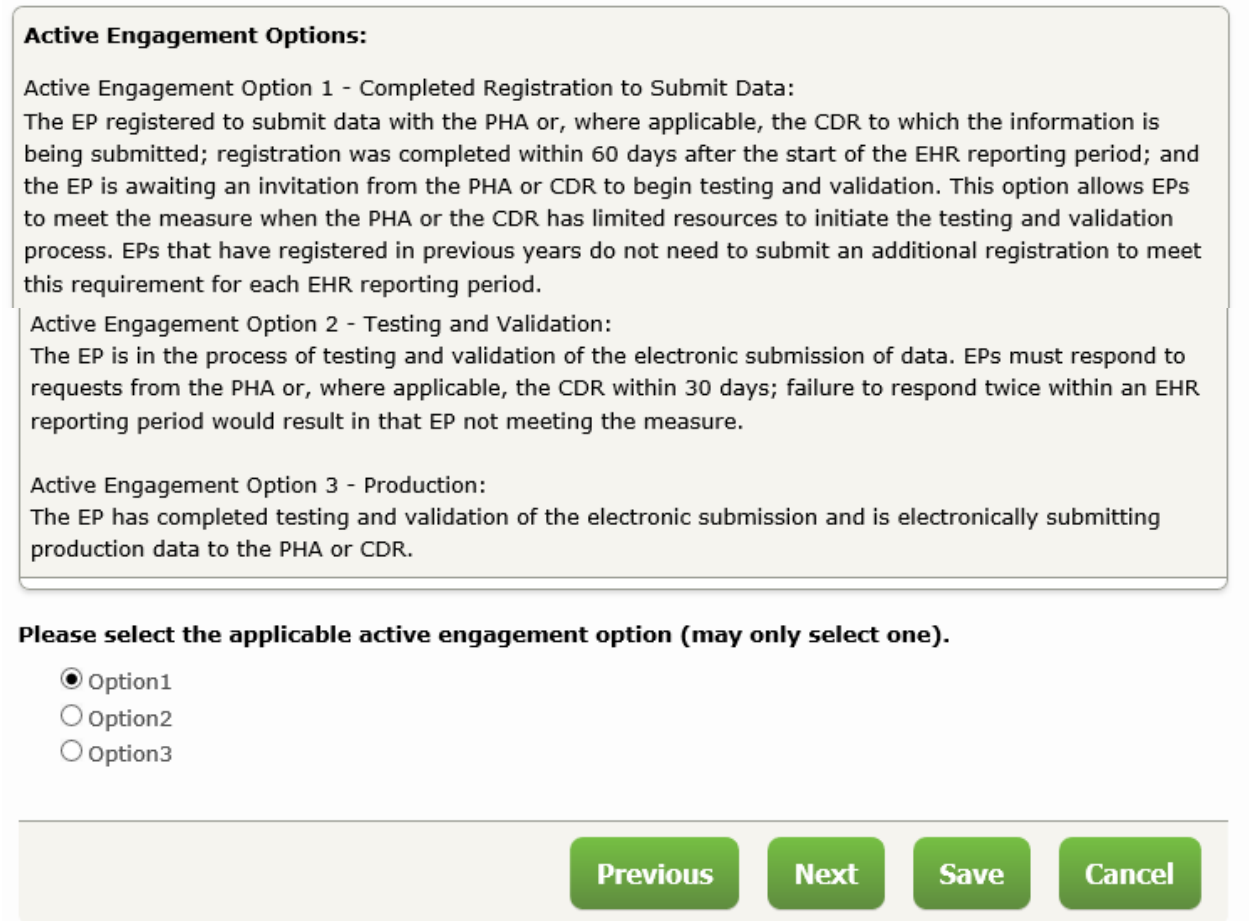
*Does this exclusion apply to you?

( ) Yes (•) No

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

*Does this exclusion apply to you?

( ) Yes (•) No



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.

8.2.8.3 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.

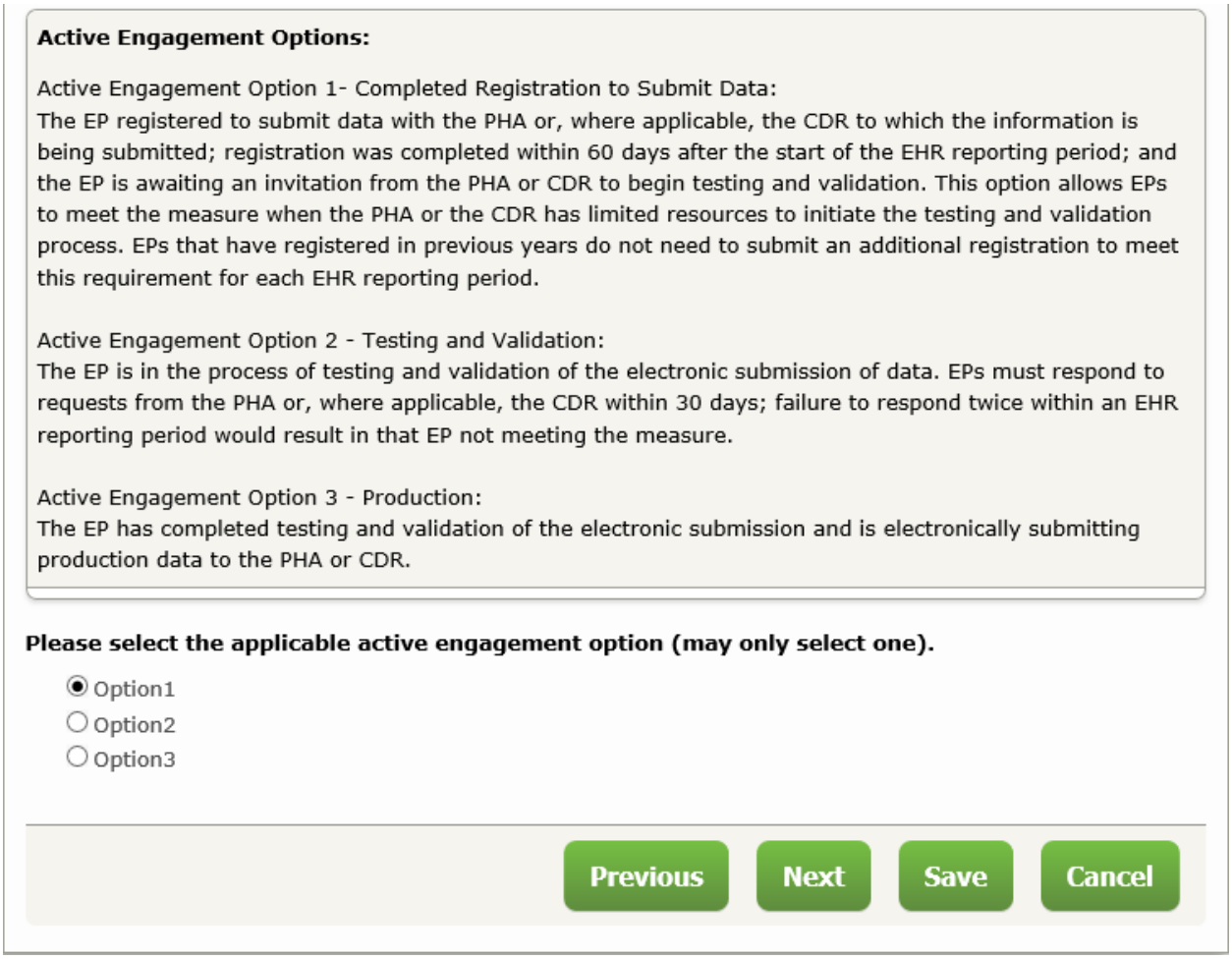
*Does this exclusion apply to you?

( ) 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



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.

8.2.8.4 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 2 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 can accept 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:

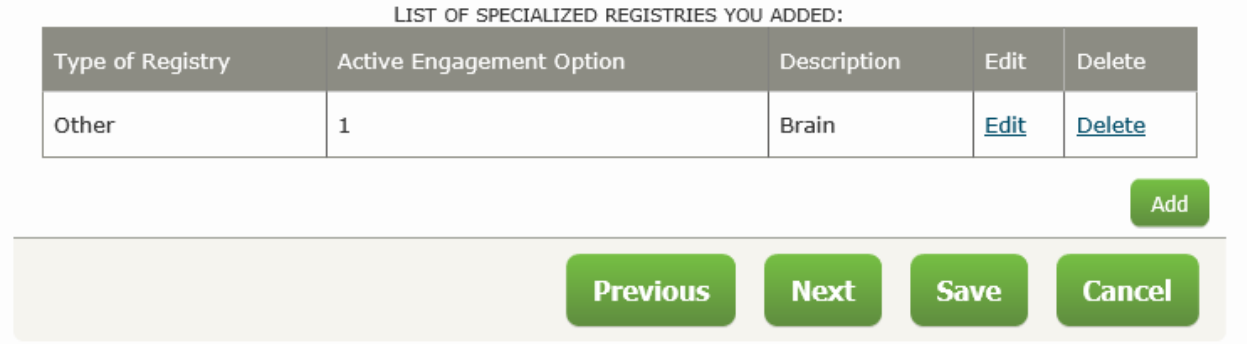
Provider may report to more than one public health registry and may count public health registry reporting more than one time to meet the required number of measures for the objective. You may enter as many registries as you wish but only two will be counted towards the objective.

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



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.

8.2.8.5 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 2 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

Instructions:

Provider may report to more than one Clinical Data Registry and may count Clinical Data 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.

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

* **Please add the clinical data registry below:**

- Other

LIST OF SPECIALIZED REGISTRIES YOU ADDED:

Type of Registry	Active Engagement Option	Description	Edit	Delete
Other	1	Radiology	Edit	Delete
Other	3	PAthology	Edit	Delete
Other	2	ECG	Edit	Delete
Other	1	X-ray	Edit	Delete

Add

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, 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.

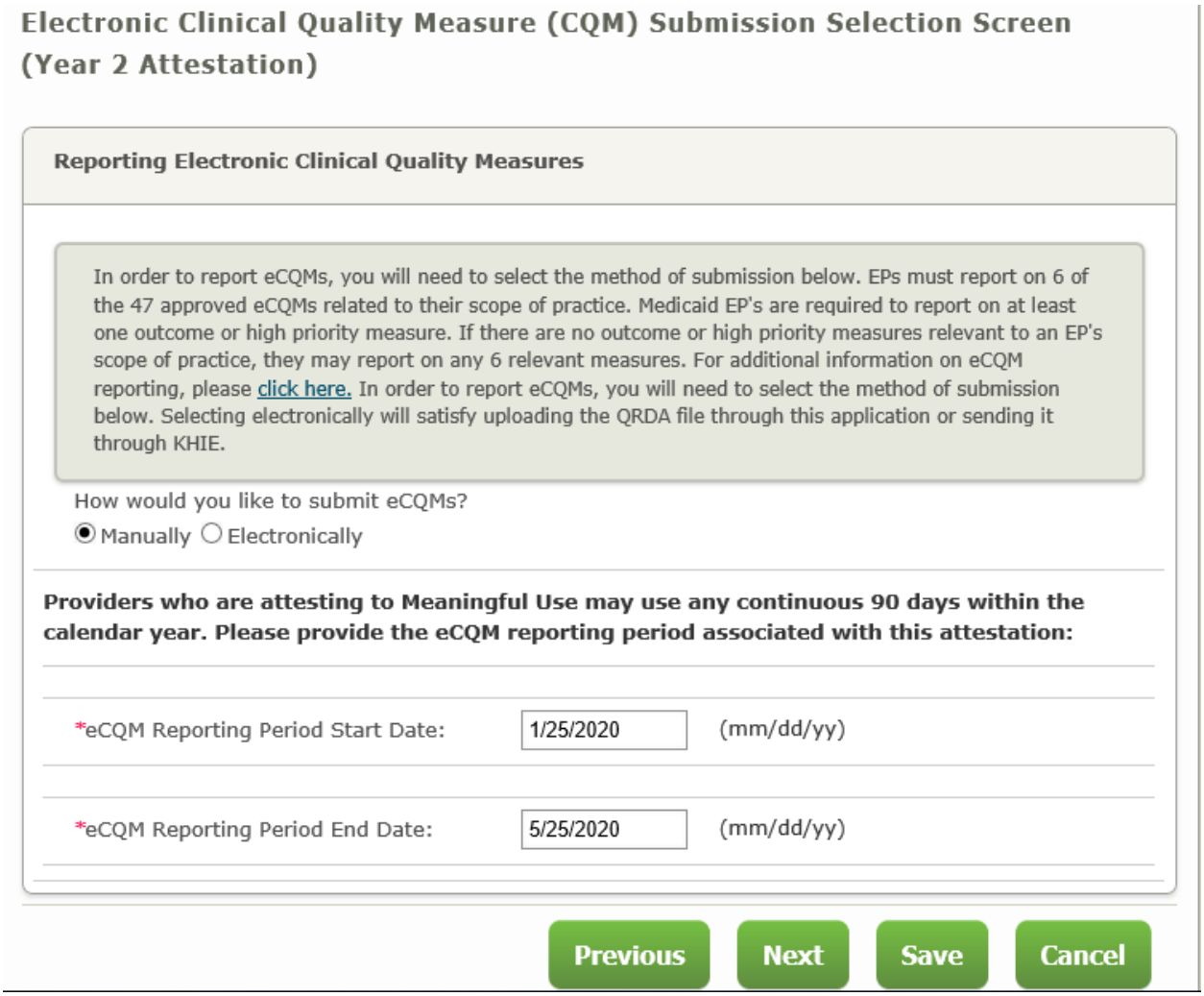
- Click **Previous** to go back to the previous screen. Selections will not be saved.
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

9 Electronic Clinical Quality Measures

Electronic clinical quality measures (eCQMs) are tools that help measure and track the quality of health care services that EPs, EHs, and CAHs provide, as generated by a provider's 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 2021 eCQM reporting period for EPs is any continuious **90-day period within the 2021 CY**. All participating EPs are required to report on any **6 eCQMs** relevant to their scope of practice from the set of 47 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.

9.1 Electronic Clinical Quality Measure Submission Selection Screen



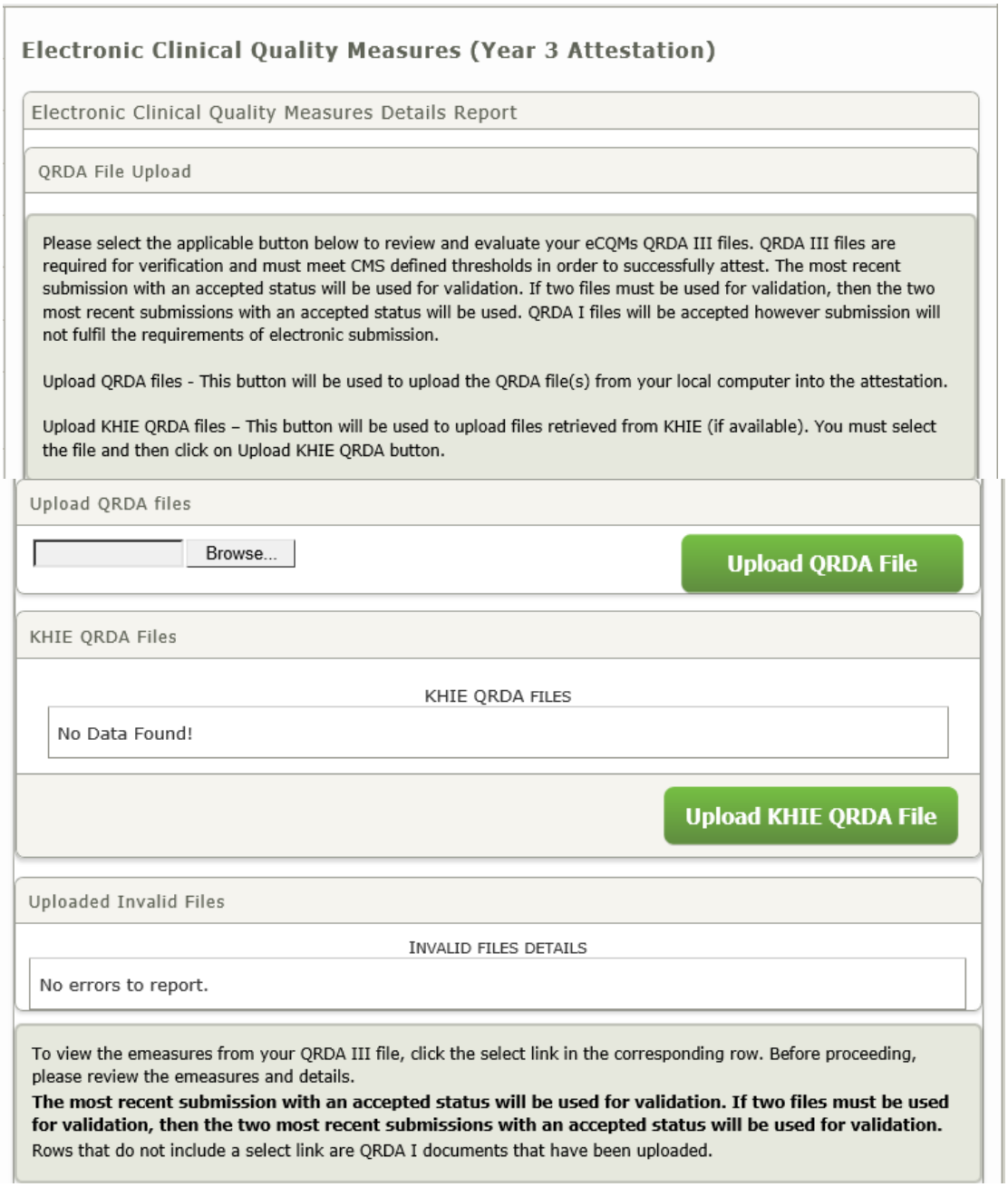
Enter responses for the following:

- How would you like to submit eCQMs?
    - Select Manually or Electronically; selecting electronically will satisfy uploading the QRDA file through the KYSLR or sending it through KHIE.
- 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.

9.2 Electronic Clinical Quality Measures Electronically Reported Selection Screen



Uploaded Valid Files

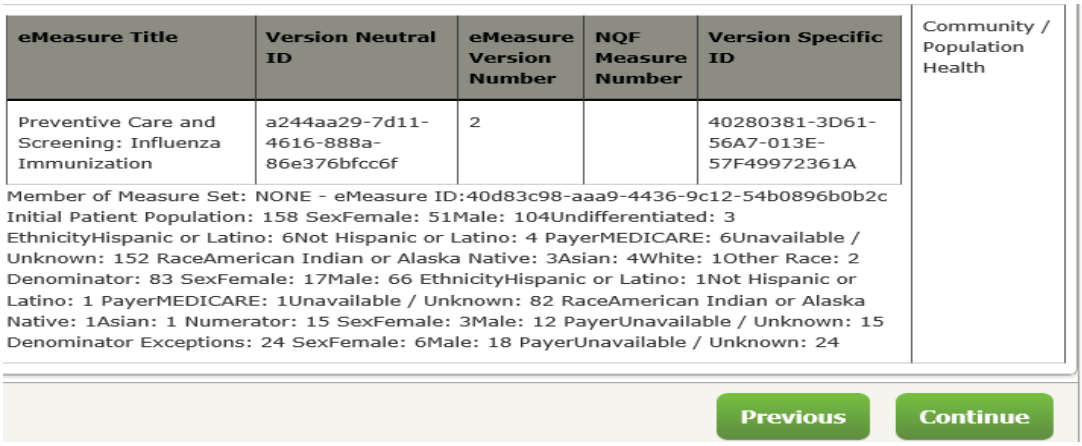
UPLOADED FILES

	FileTransmissionID	Status	DateReceived	FileName
Select	587	Pending	8/17/2018 3:2 3:00 PM	QRDA_XML2_1013165786_2MSRS_new.xml
Select	586	Pending	8/17/2018 3:0 0:32 PM	QRDA_XML2_1013165786_4MSRS_1.xml
Select	585	Accepted	8/17/2018 2:4 6:26 PM	QRDA_XML2_1013165786__4Msrs.xml
Select	584	Accepted	8/17/2018 12:3 1:16 PM	MIPS_Sample_QRDA_III_2MSRS_2.xml
Select	583	Pending	8/17/2018 12:2 2:55 PM	MIPS_Sample_QRDA_III_2MSRS_LAst.xml
Select	582	Rejected	8/17/2018 12:2 2:22 PM	MIPS_Sample_QRDA_III_1MSRS.xml
Select	580	Rejected	8/17/2018 12:2 1:57 PM	MIPS_Sample_QRDA_III_2MSRS.xml

Selected File Electronic Clinical Quality Measures

ELECTRONIC CLINICAL QUALITY MEASURE DETAILS

Measure Details	Domain
eMeasure Title: Use of High-Risk Medications in the Elderly **Version Neutral ID**: a3837ff8-1abc-4ba9-800e-fd4e7953adbd **eMeasure Version Number**: 2 **NQF Measure Number**: **Version Specific ID**: 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	Patient Safety
eMeasure Title: CERVICAL CANCER SCREENING **Version Neutral ID**: 42e7e489-790f-427a-a1a6-d6e807f65a6d **eMeasure Version Number**: 2 **NQF Measure Number**: **Version Specific ID**: 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	Effective Clinical Care



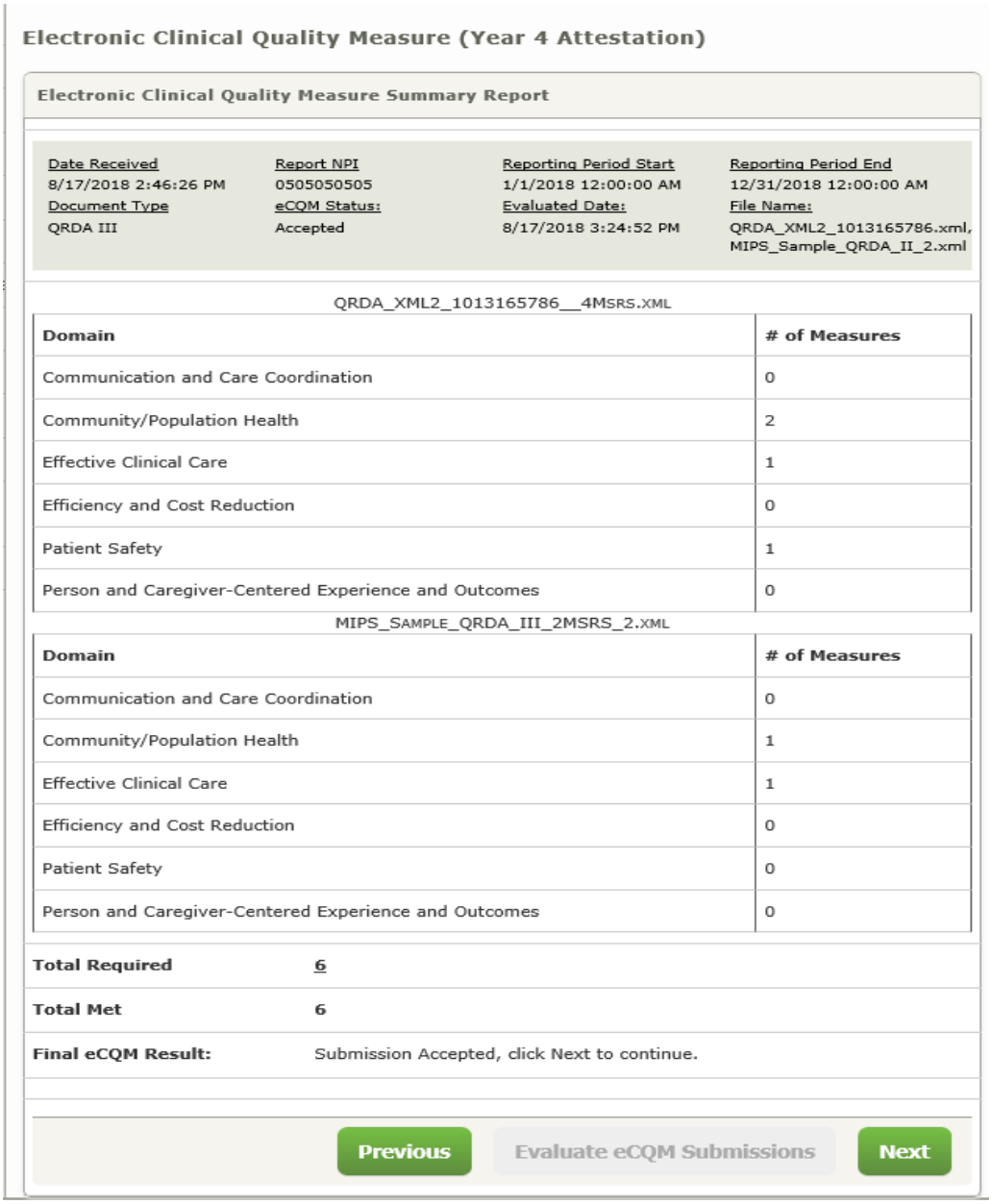
To submit eCQMs electronically, click the Browse button to select the QRDA file you wish to upload. Once the file is selected click the Upload QRDA File button. If you wish to upload a file retrieved from KHIE ,you must select the file and then click on the Upload KHIE QRDA button.

- 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 **Continue** to move to the next screen.

9.3 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.

9.4 Electronic Clinical Quality Measures Manually Reported Selection Screen

Electronic Clinical Quality Measures (eCQMs) Selection Screen (Year 3 Attestation)

Instructions:

Select a minimum of 6 eCQMs 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 eCQMs after you select the Save & Next button below.

Deselect All

PERSON AND CAREGIVER-CENTERED EXPERIENCE AND OUTCOMES

Selection	Measure #	Title
☑	CMS157v9.2/NQF 0384e	Oncology: Medical and Radiation - Pain Intensity Quantified
☑	CMS56v9.2/NQF XXXX	Functional Status Assessment for Total Hip Replacement
☑	CMS66v9.3/NQF XXXX	Functional Status Assessment for Total Knee Replacement
☑	CMS90v10.2/NQF XXXX	Functional Status Assessments for Congestive Heart Failure
☑	CMS771v2.2/NQF XXXX	Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia

PATIENT SAFETY

Selection	Measure #	Title
☑	CMS156v9.3/NQF XXXX	Use of High-Risk Medications in the Older Adults
☑	CMS139v9.2/NQF XXXX	Falls: Screening for Future Fall Risk
☑	CMS68v10.3/NQF 0419e	Documentation of Current Medications in the Medical Record
☑	CMS177v9.2/NQF 1365e	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

COMMUNICATION AND CARE COORDINATION

Selection	Measure #	Title
☑	CMS142v9.2/NQF XXXX	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
☑	CMS50v9.2/NQF XXXX	Closing the Referral Loop: Receipt of Specialist Report

COMMUNITY/POPULATION HEALTH

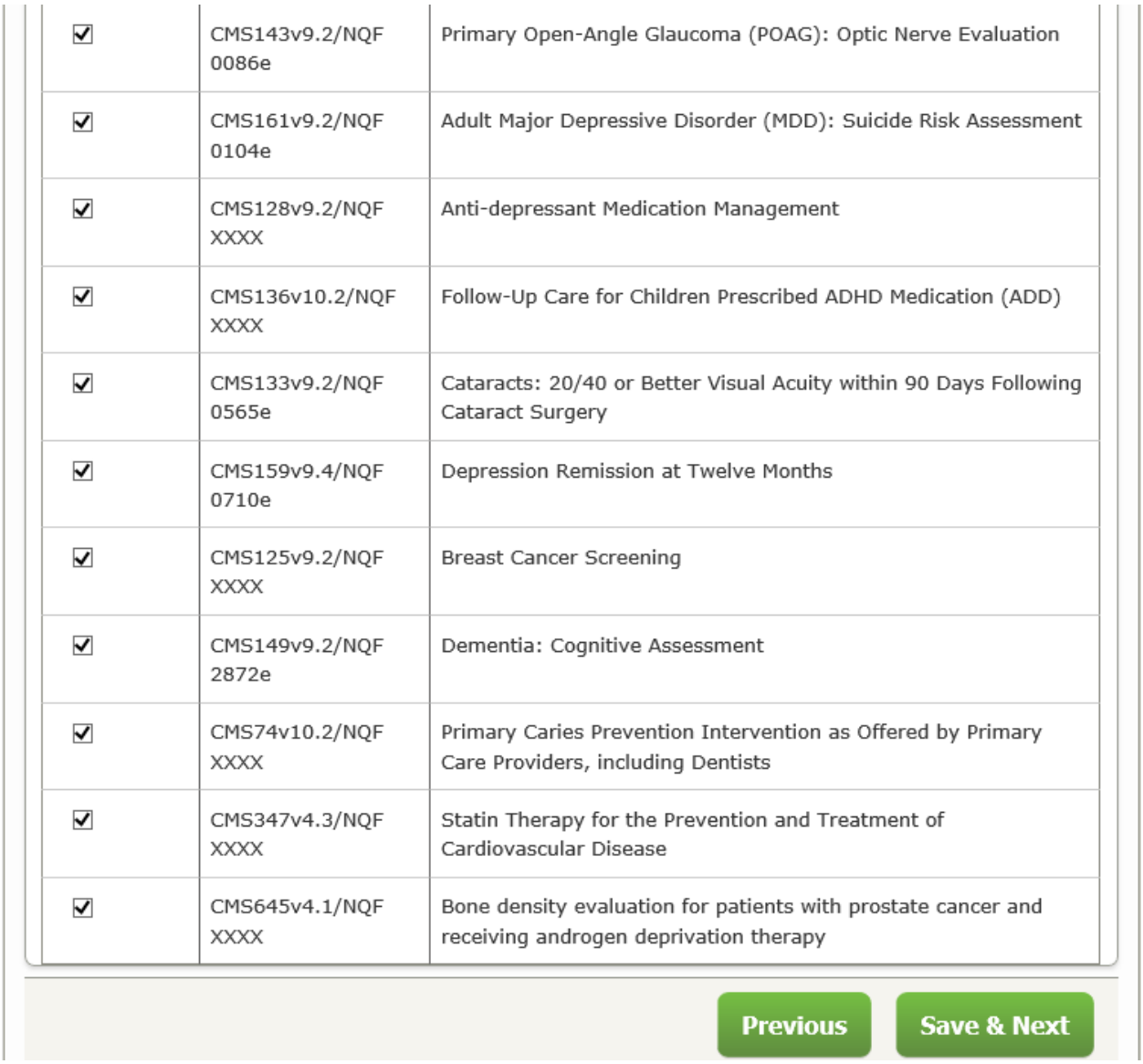
Selection	Measure #	Title
☑	CMS155v9.2/NQF XXXX	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
☑	CMS138v9.2/NQF 0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
☑	CMS153v9.2/NQF XXXX	Chlamydia Screening for Women
☑	CMS117v9.2/NQF XXXX	Childhood Immunization Status
☑	CMS147v10.2/NQF 0041e	Preventive Care and Screening: Influenza Immunization
☑	CMS127v9.2/NQF XXXX	Pneumococcal Vaccination Status for Older Adults
☑	CMS2v10.2/NQF 0418e	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
☑	CMS69v9.3/NQF XXXX	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
☑	CMS22v9.3/NQF XXXX	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
☑	CMS75v9.2/NQF XXXX	Children Who Have Dental Decay or Cavities
☑	CMS349v3.3/NQF XXXX	HIV Screening

EFFICIENCY AND COST REDUCTION

Selection	Measure #	Title
☑	CMS146v9.2/NQF XXXX	Appropriate Testing for Pharyngitis
☑	CMS154v9.2/NQF XXXX	Appropriate Treatment for Upper Respiratory Infection (URI)
☑	CMS129v10.3/NQF 0389e	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
☑	CMS249v3.2/NQF 3475e	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
☑	CMS137v9.3/NQF XXXX	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
☑	CMS165v9.2/NQF XXXX	Controlling High Blood Pressure
☑	CMS124v9.1/NQF XXXX	Cervical Cancer Screening
☑	CMS130v9.2/NQF XXXX	Colorectal Cancer Screening
☑	CMS131v9.2/NQF XXXX	Diabetes: Eye Exam
☑	CMS122v9.3/NQF XXXX	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
☑	CMS134v9.3/NQF XXXX	Diabetes: Medical Attention for Nephropathy
☑	CMS145v9.2/NQF 0070e	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)
☑	CMS135v9.2/NQF 0081e	Heart Failure (HF): ACE Inhibitor or ARB or ARNI Therapy for Left Ventricular Systolic Dysfunction (LVSD)
☑	CMS144v9.2/NQF 0083e	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)



☑	CMS143v9.2/NQF 0086e	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
☑	CMS161v9.2/NQF 0104e	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
☑	CMS128v9.2/NQF XXXX	Anti-depressant Medication Management
☑	CMS136v10.2/NQF XXXX	Follow-Up Care for Children Prescribed ADHD Medication (ADD)
☑	CMS133v9.2/NQF 0565e	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
☑	CMS159v9.4/NQF 0710e	Depression Remission at Twelve Months
☑	CMS125v9.2/NQF XXXX	Breast Cancer Screening
☑	CMS149v9.2/NQF 2872e	Dementia: Cognitive Assessment
☑	CMS74v10.2/NQF XXXX	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists
☑	CMS347v4.3/NQF XXXX	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
☑	CMS645v4.1/NQF XXXX	Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy

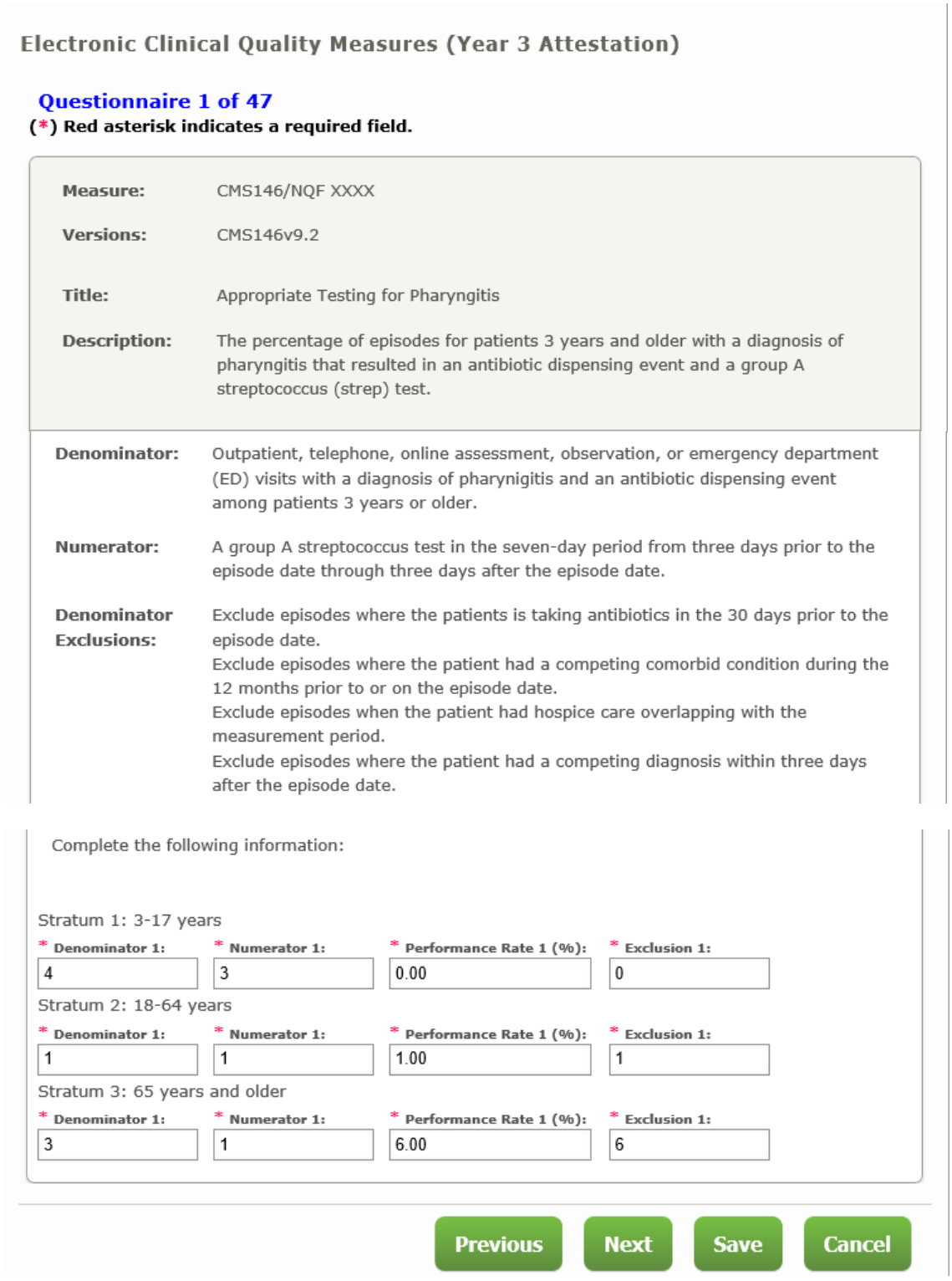
Select at least six of the eCQMs out of the 47 eCQMs available.

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.

9.5 Electronic Clinical Quality Measures Manually Reported

9.5.1 CMS146

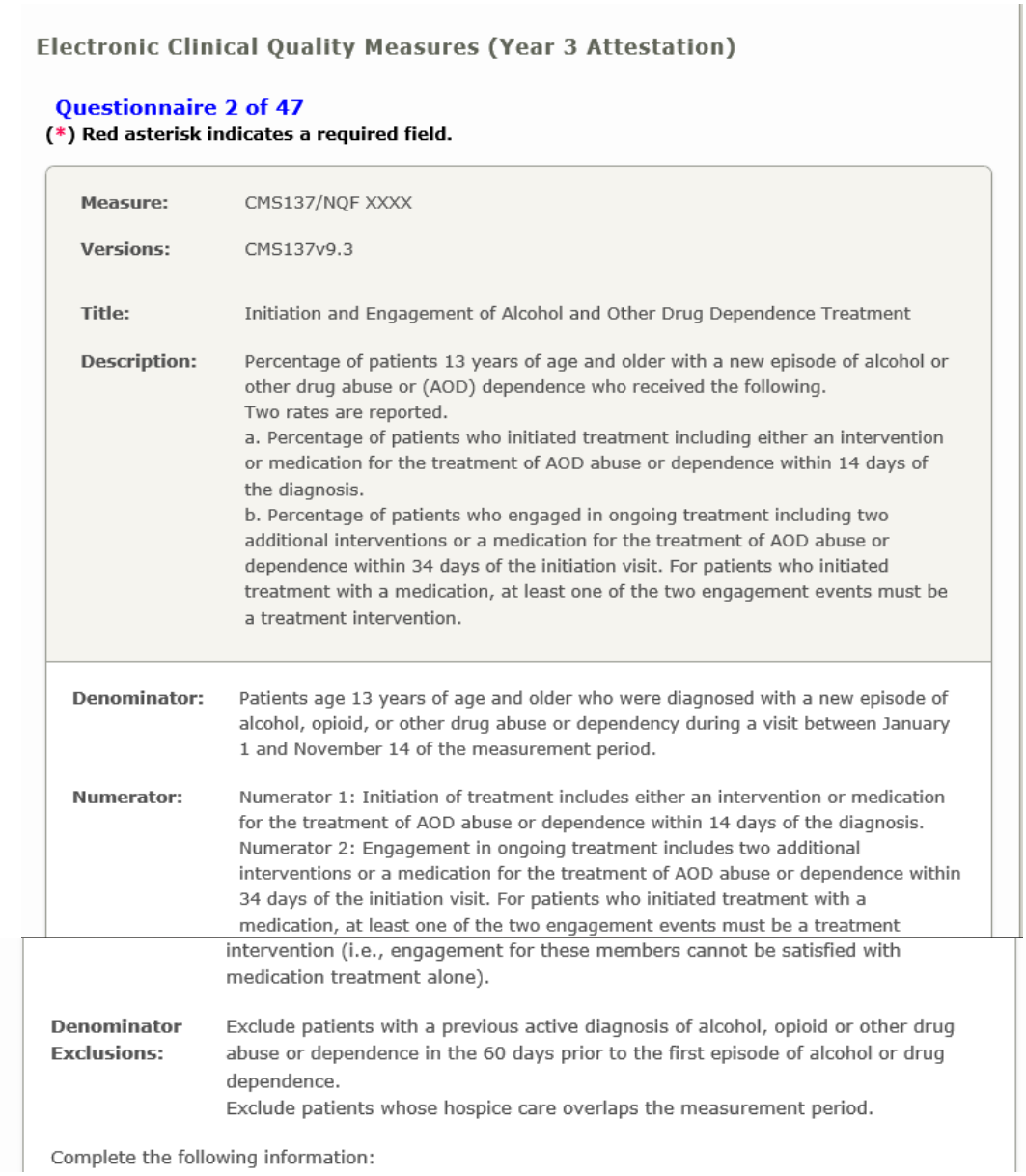


To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

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.

9.5.2 CMS137



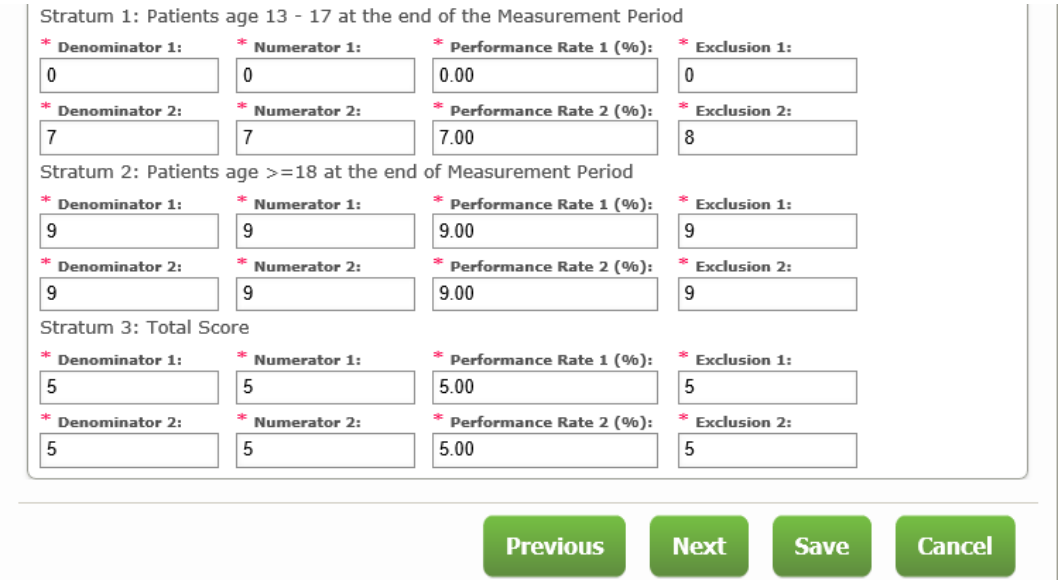
Electronic Clinical Quality Measures (Year 3 Attestation)

Questionnaire 2 of 47

(*) Red asterisk indicates a required field.

Measure:	CMS137/NQF XXXX
Versions:	CMS137v9.3
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 including either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis. b. Percentage of patients who engaged in ongoing treatment including two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention.
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 14 of the measurement period.
Numerator:	Numerator 1: Initiation of treatment includes either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis. Numerator 2: Engagement in ongoing treatment includes two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention (i.e., engagement for these members cannot be satisfied with medication treatment alone).
Denominator Exclusions:	Exclude 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:

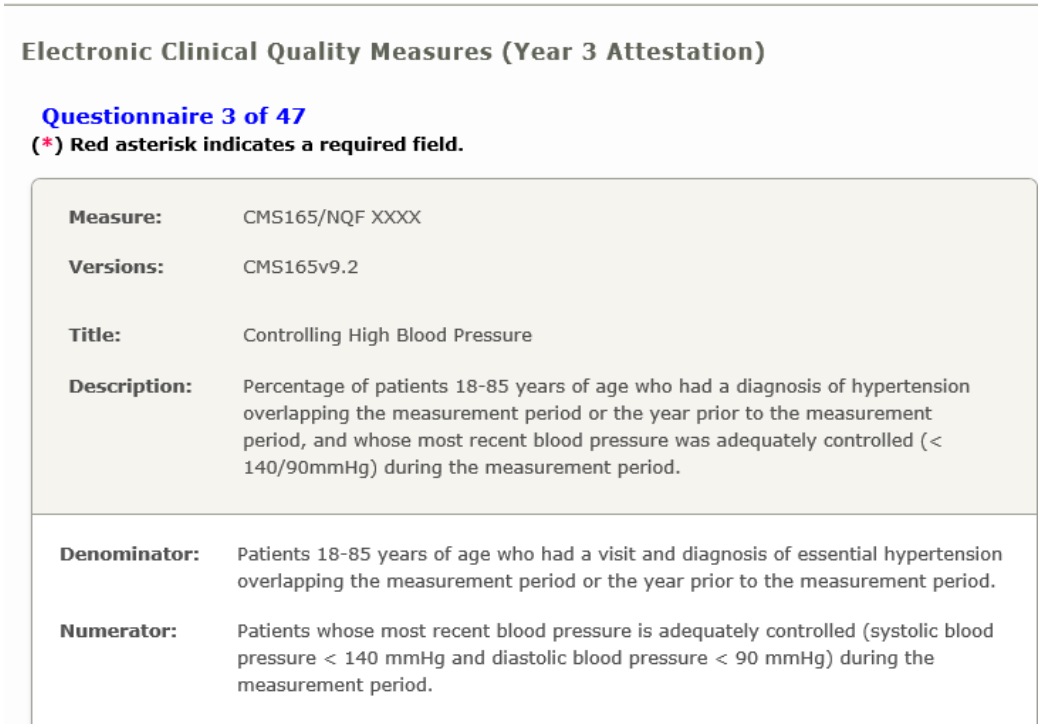


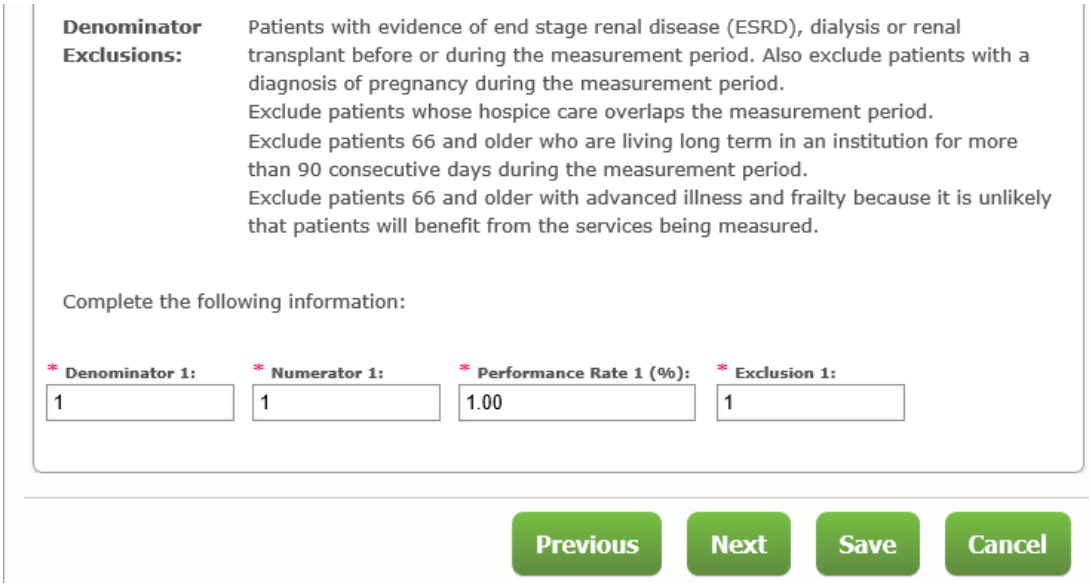
To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes.

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.

9.5.3 CMS165





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.

9.5.4 CMS156

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.

9.5.5 CMS155

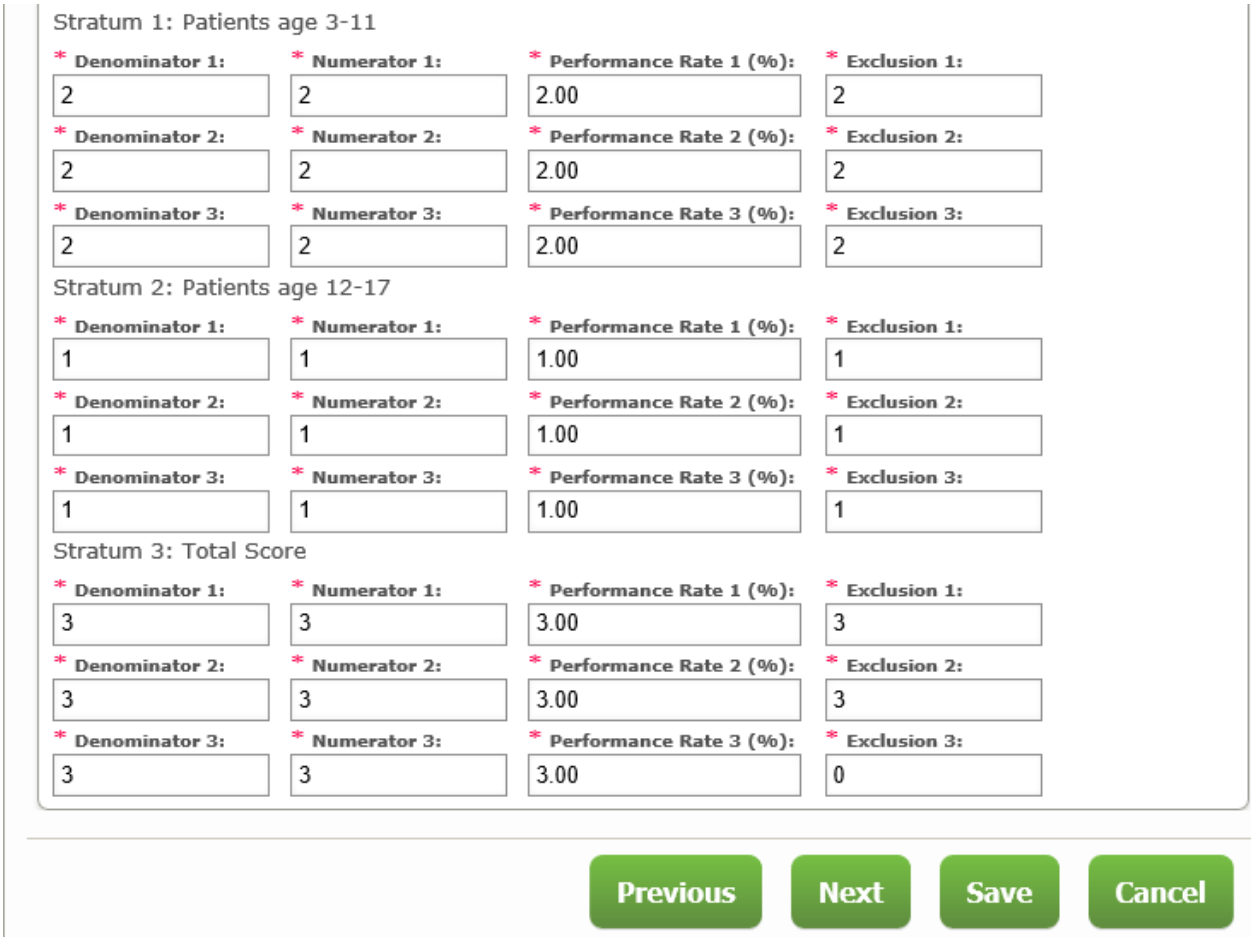
Electronic Clinical Quality Measures (Year 3 Attestation)

Questionnaire 5 of 47

(*) Red asterisk indicates a required field.

Measure:	CMS155/NQF XXXX
Versions:	CMS155v9.2
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. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation. - Percentage of patients with counseling for nutrition. - Percentage of patients with counseling for physical activity.
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:



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.

9.5.6 CMS138

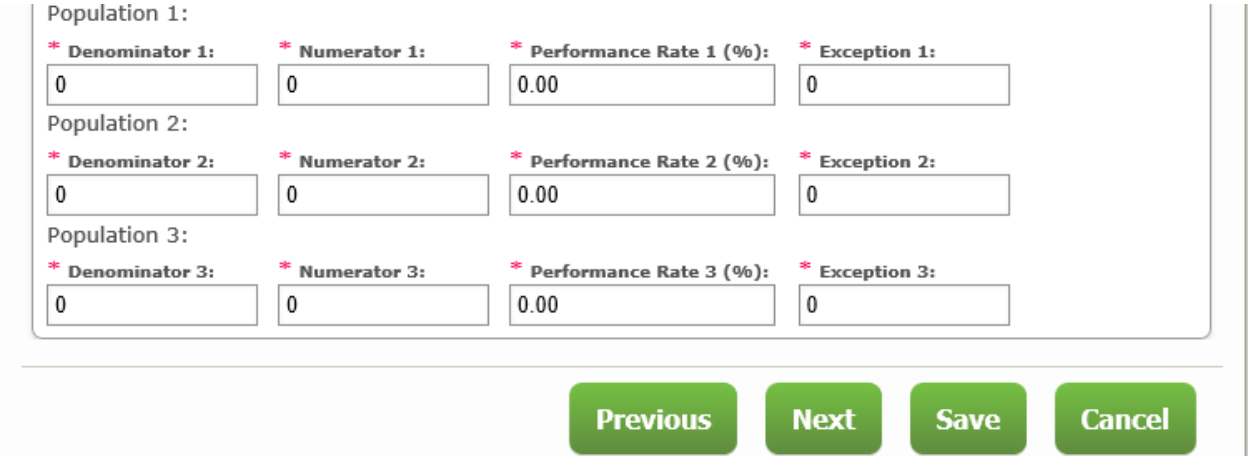
Electronic Clinical Quality Measures (Year 3 Attestation)

Questionnaire 6 of 47

(*) Red asterisk indicates a required field.

Measure:	CMS138/NQF 0028e
Versions:	CMS138v9.2
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 12 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 12 months. b. Percentage of patients aged 18 years and older who were 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 12 months AND who received tobacco cessation intervention if identified as a tobacco 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 12 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 12 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 (e.g., limited life expectancy, other medical reason). Exception 2: Population 2: Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., 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 patients identified as tobacco users (e.g., limited life expectancy, other medical reason).

Complete the following information:

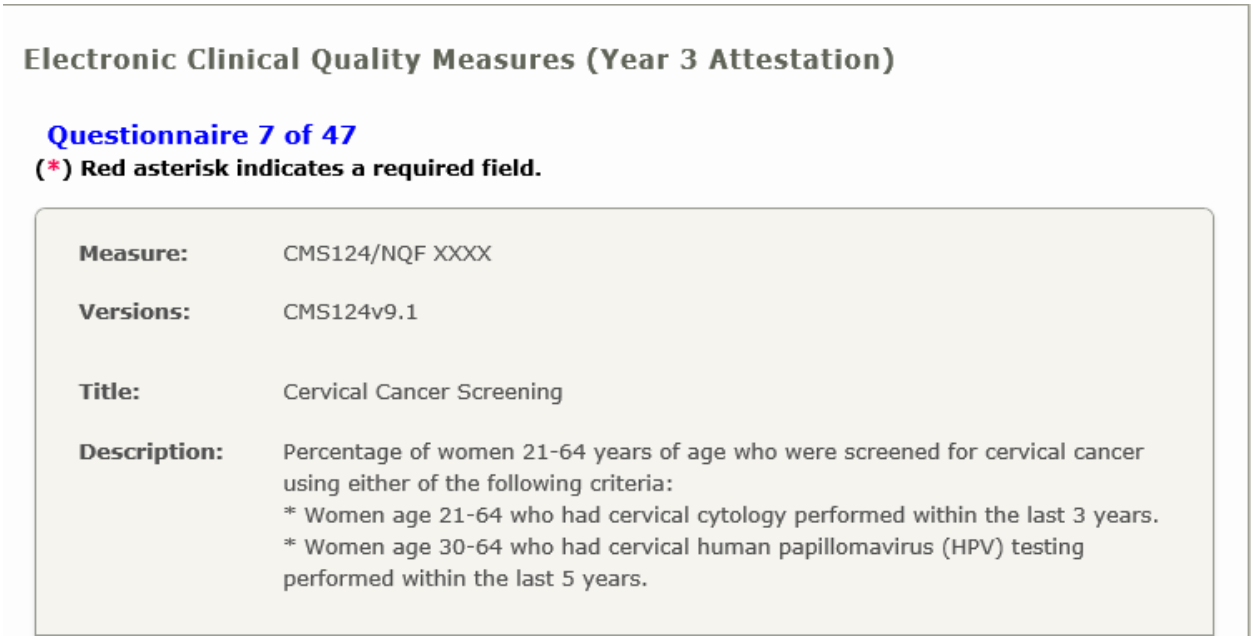


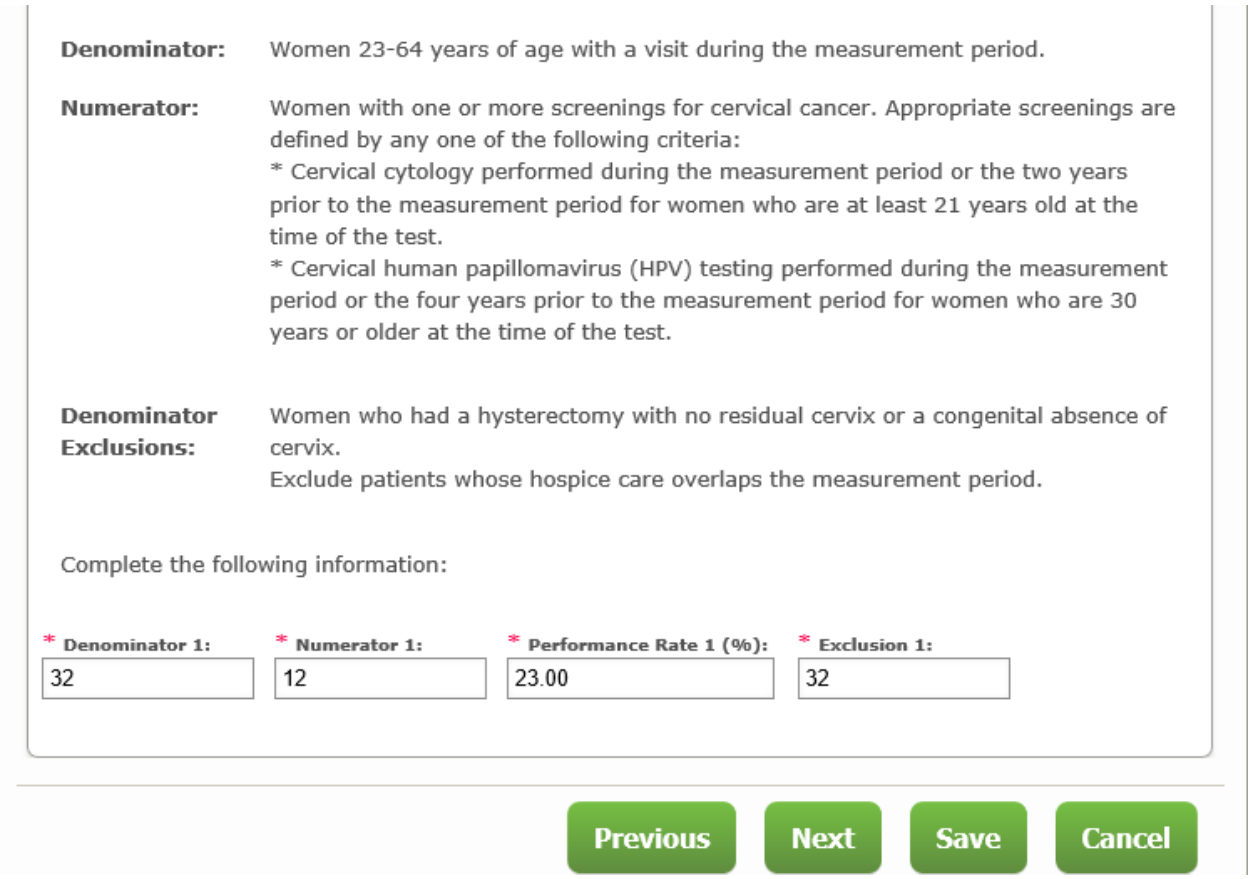
To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exception boxes.

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.
- 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.

9.5.7 CMS124



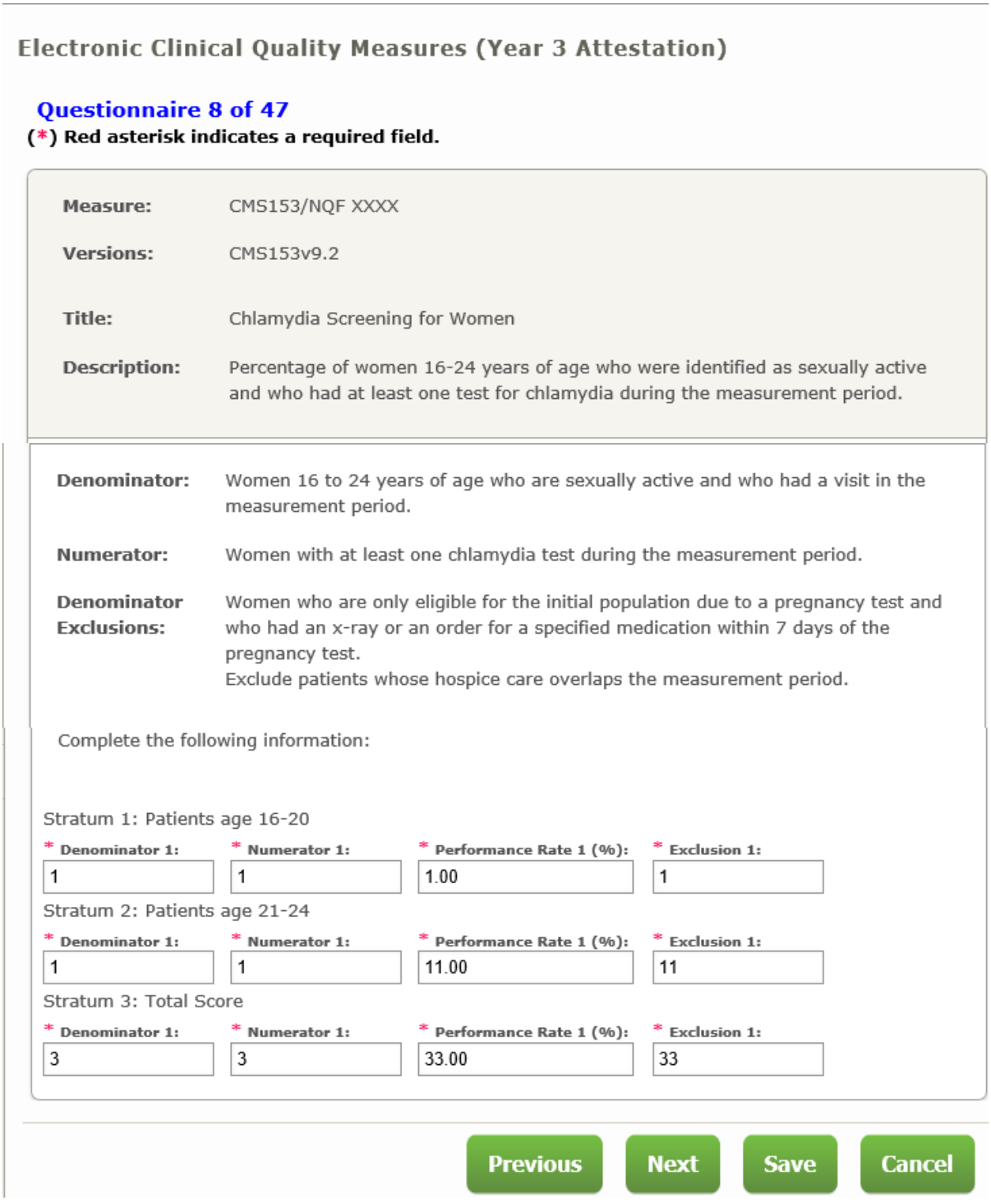


To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

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.

9.5.8 CMS153

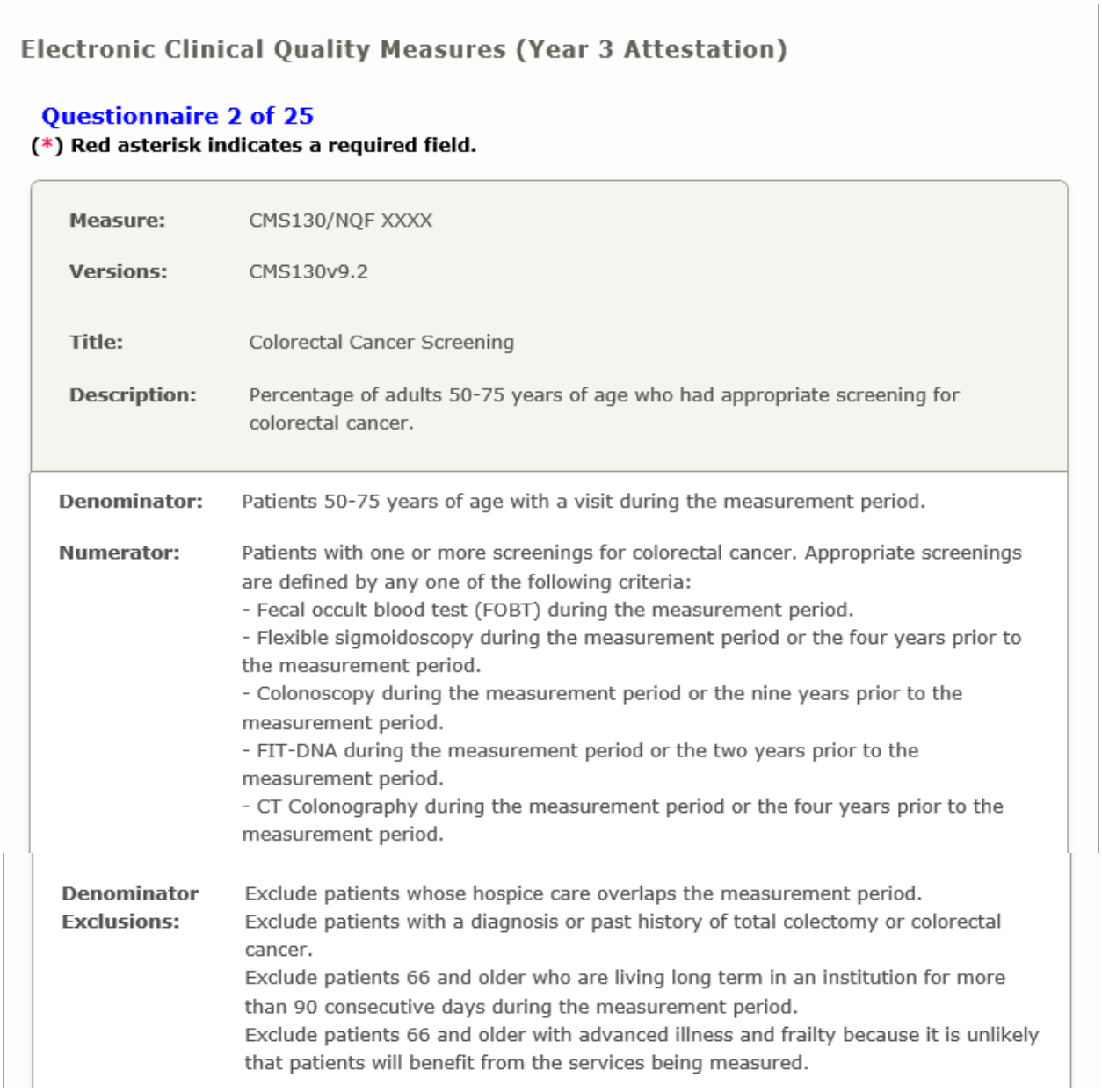


To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

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.

9.5.9 CMS130

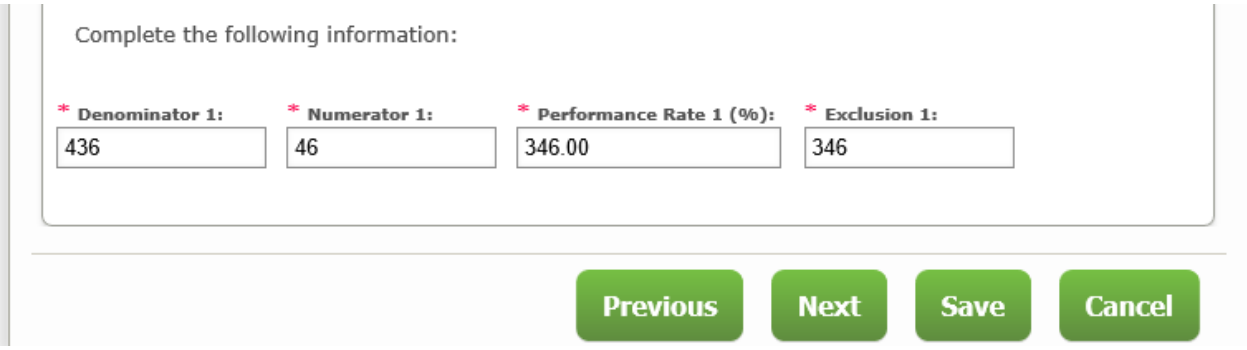


Electronic Clinical Quality Measures (Year 3 Attestation)

Questionnaire 2 of 25

(*) Red asterisk indicates a required field.

Measure:	CMS130/NQF XXXX
Versions:	CMS130v9.2
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:	Exclude patients whose hospice care overlaps the measurement period. Exclude patients with a diagnosis or past history of total colectomy or colorectal cancer. Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period. Exclude patients 66 and older with advanced illness and frailty because it is unlikely that patients will benefit from the services being measured.

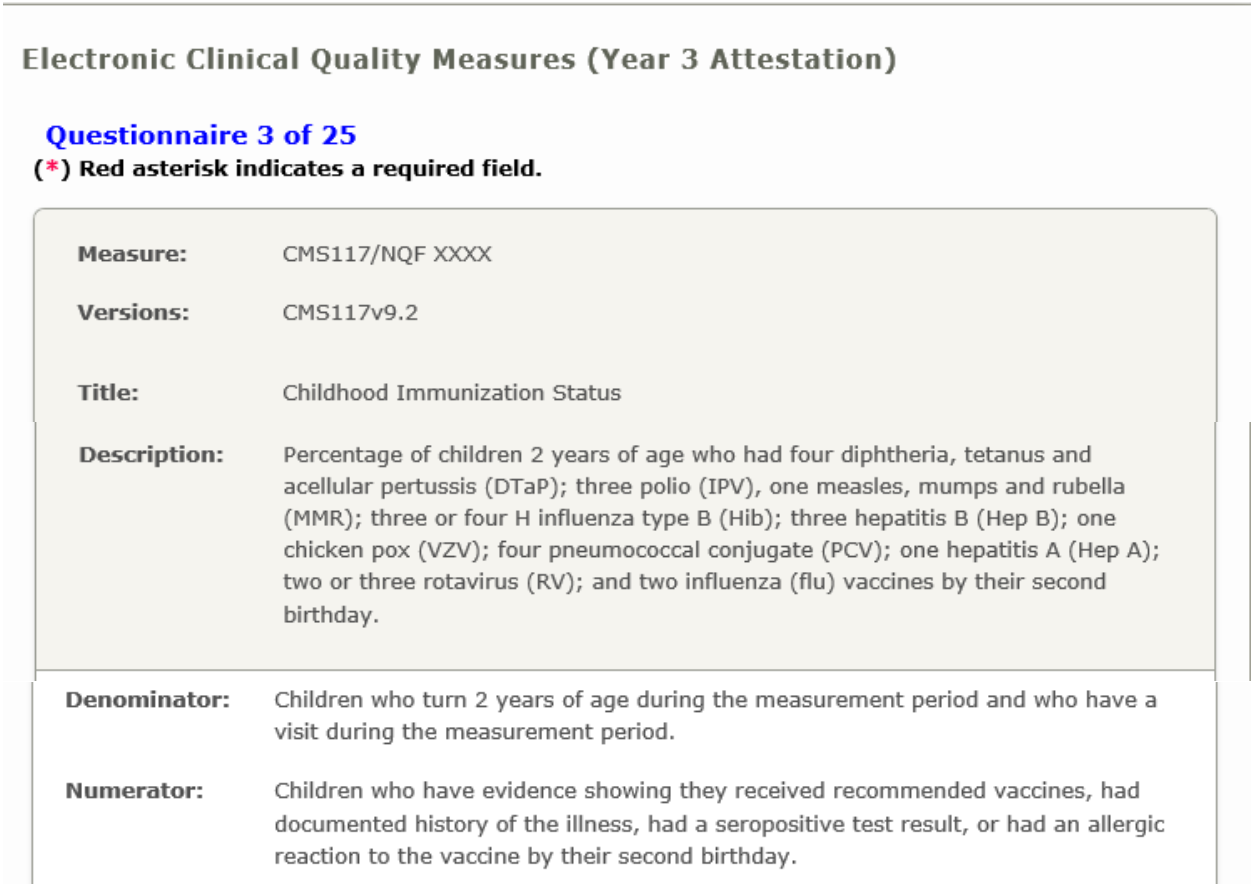


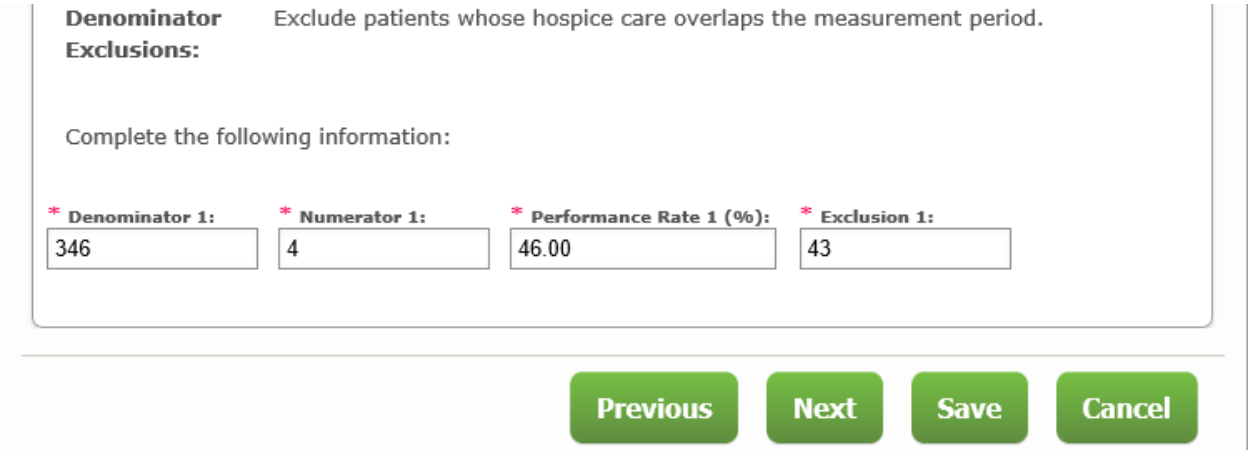
To satisfy this eCQM, enter a whole number into each of the Denominator, Numerator, Performance Rate, and Exclusion boxes.

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.

9.5.10 CMS117





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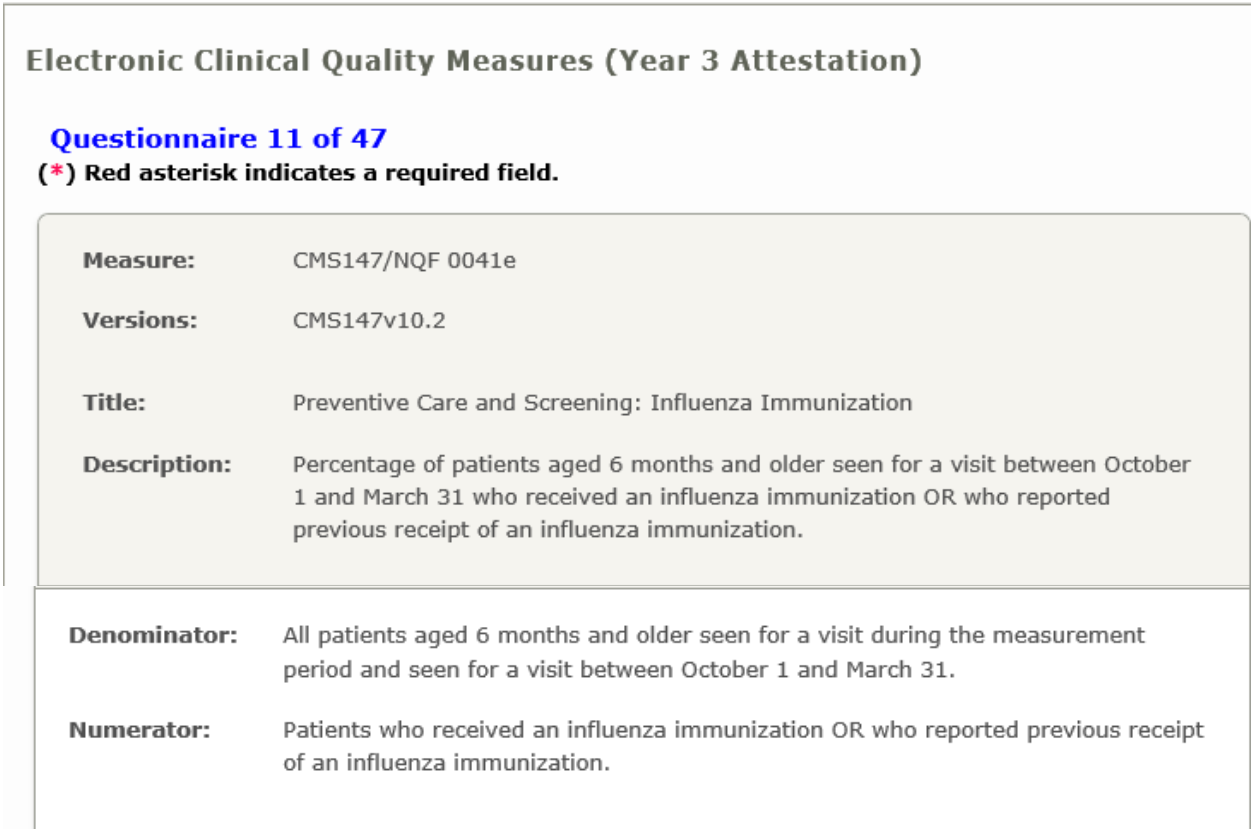
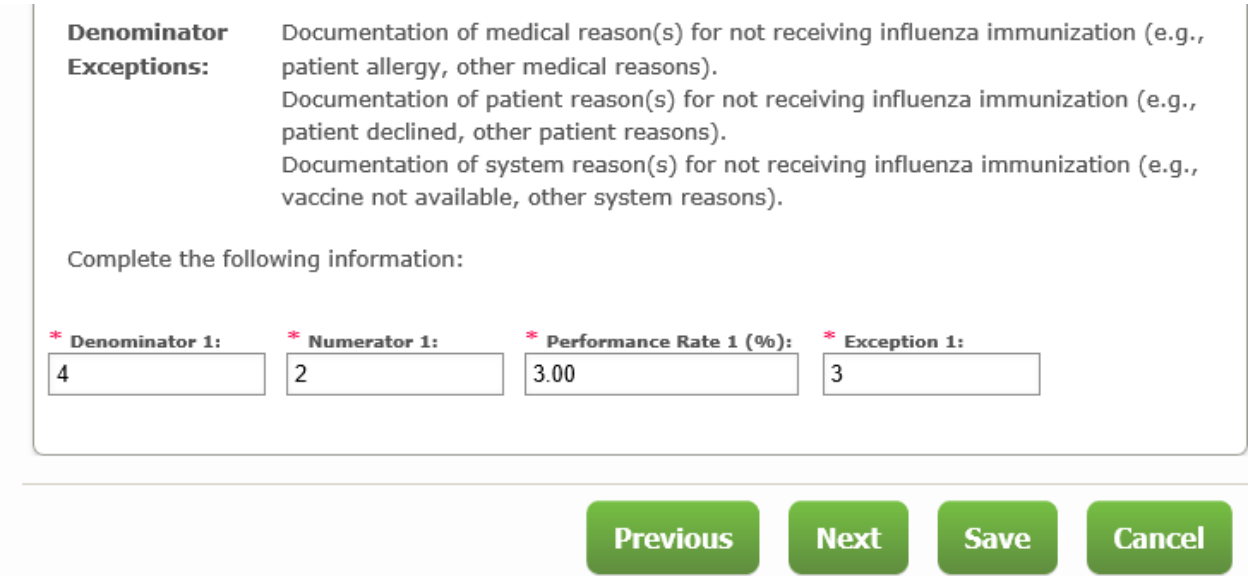
- Click **Cancel** to remove selections and stay on the current screen.

9.5.11 CMS147





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

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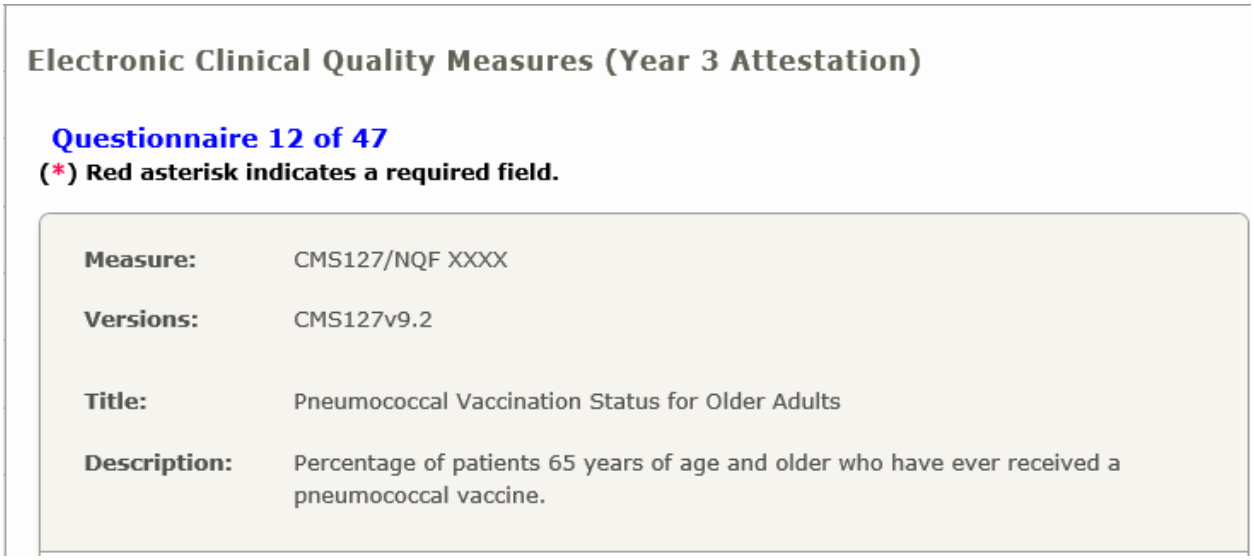
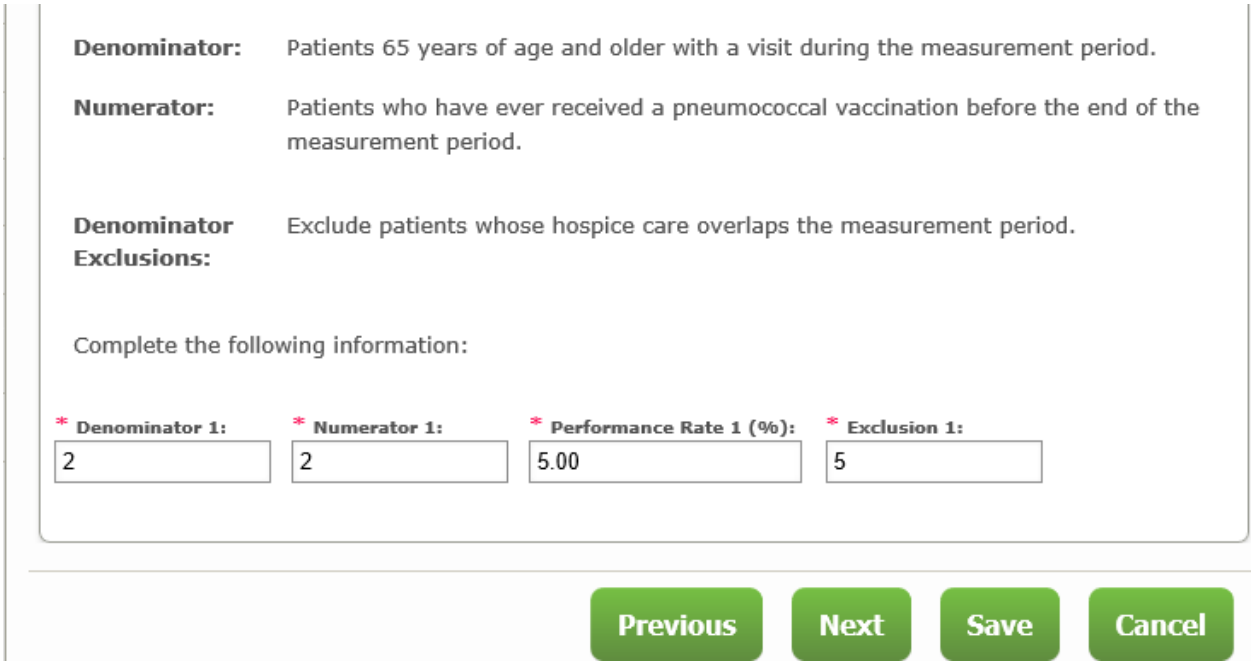
9.5.12 CMS127





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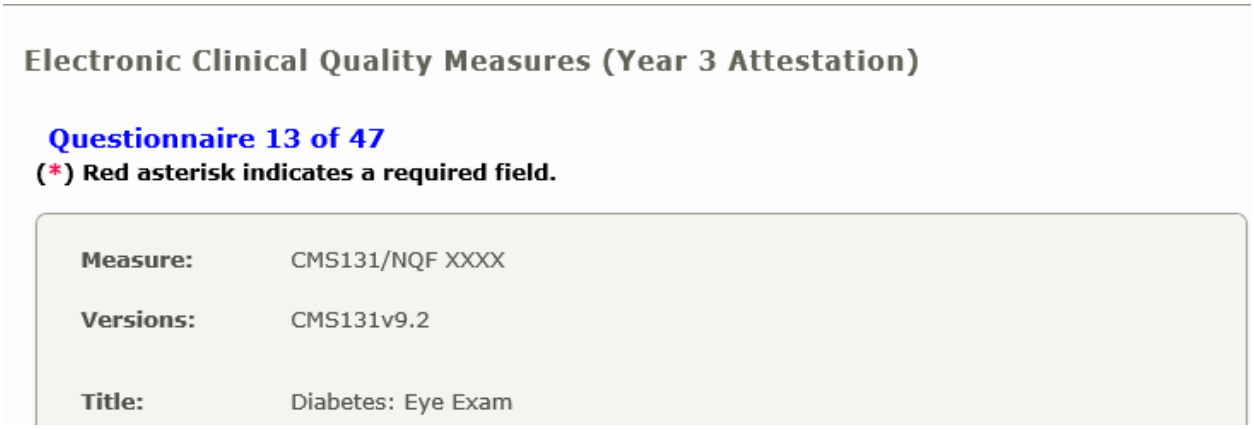
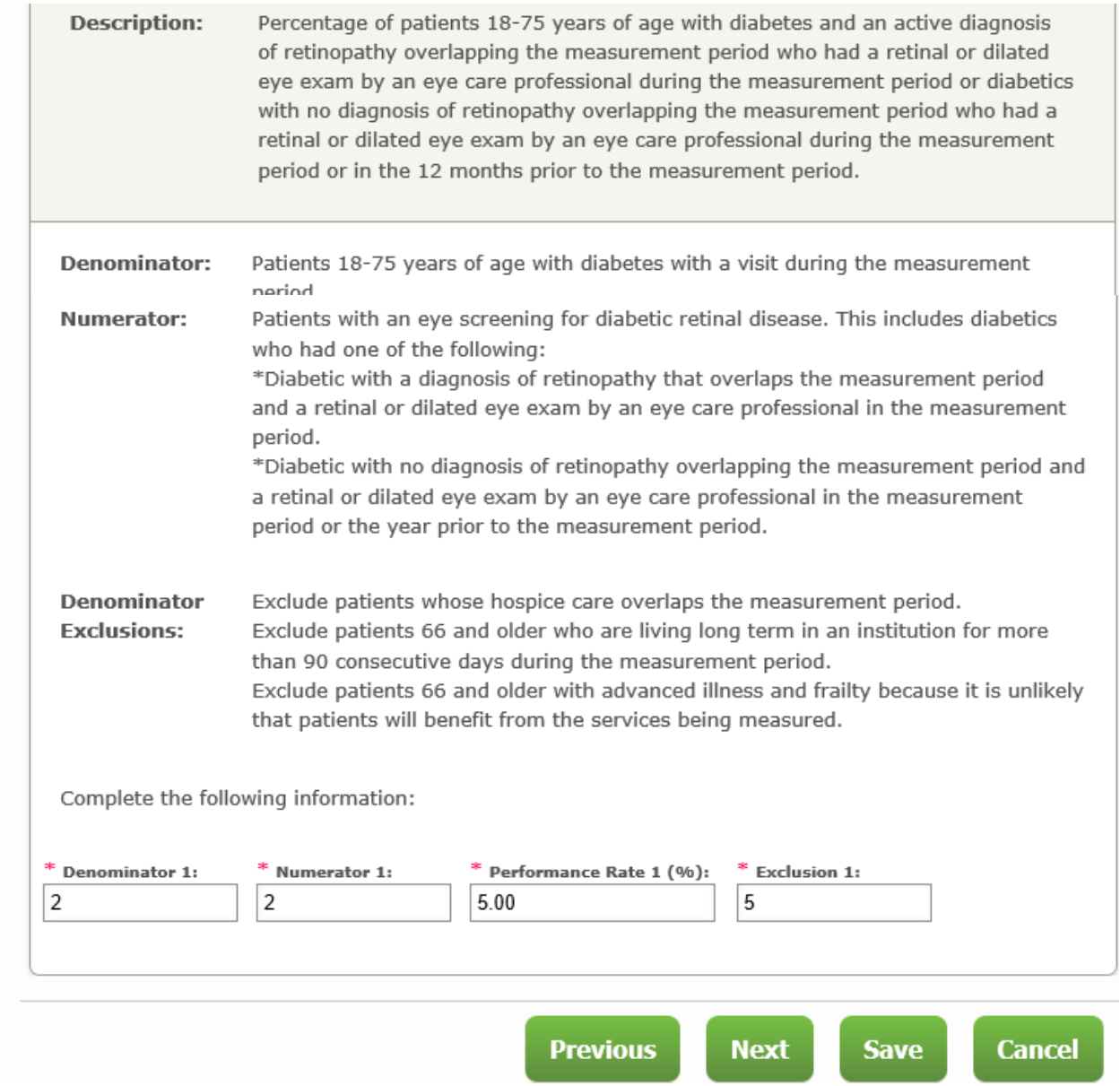
9.5.13 CMS131





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

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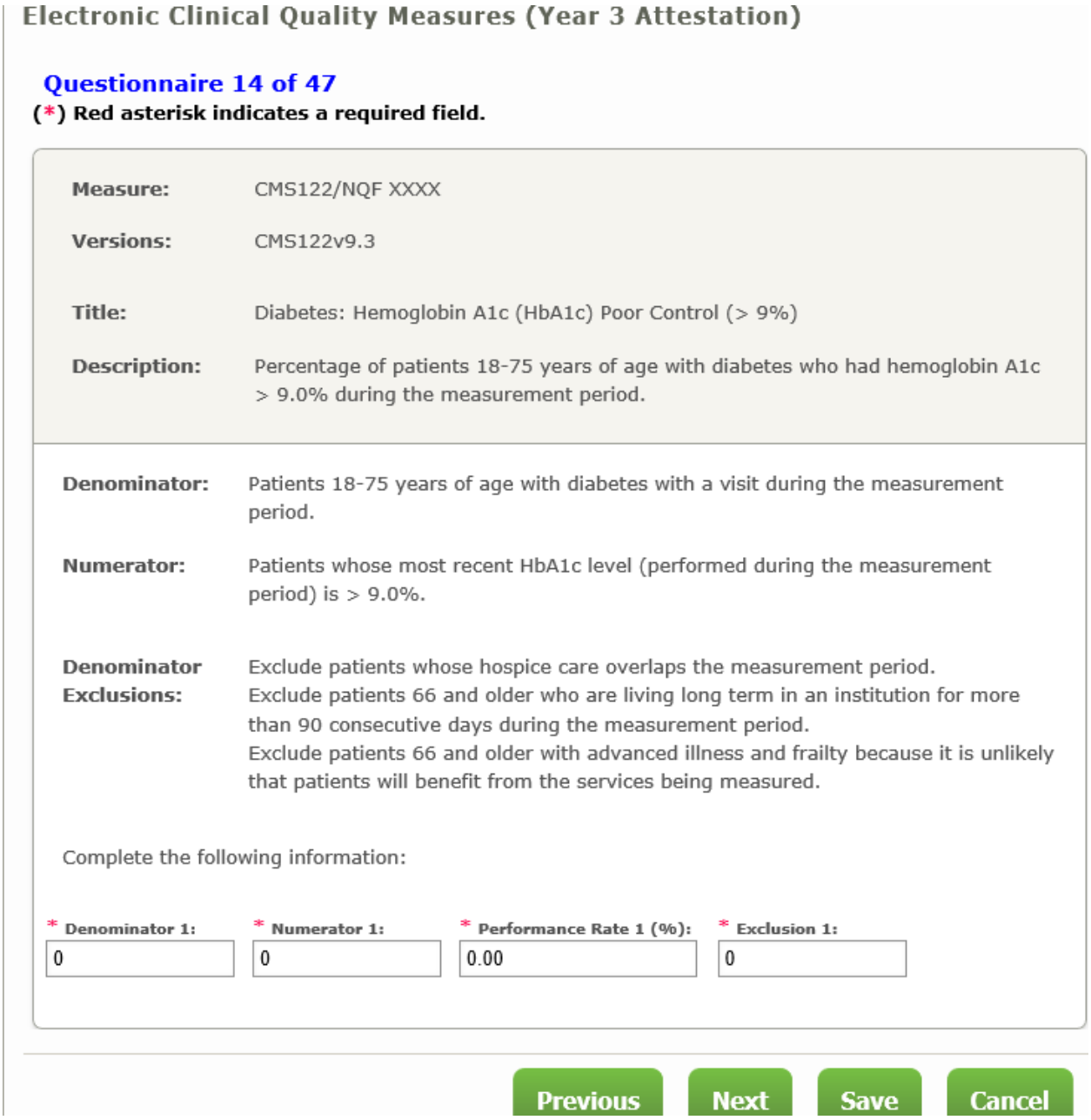
9.5.14 CMS122



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

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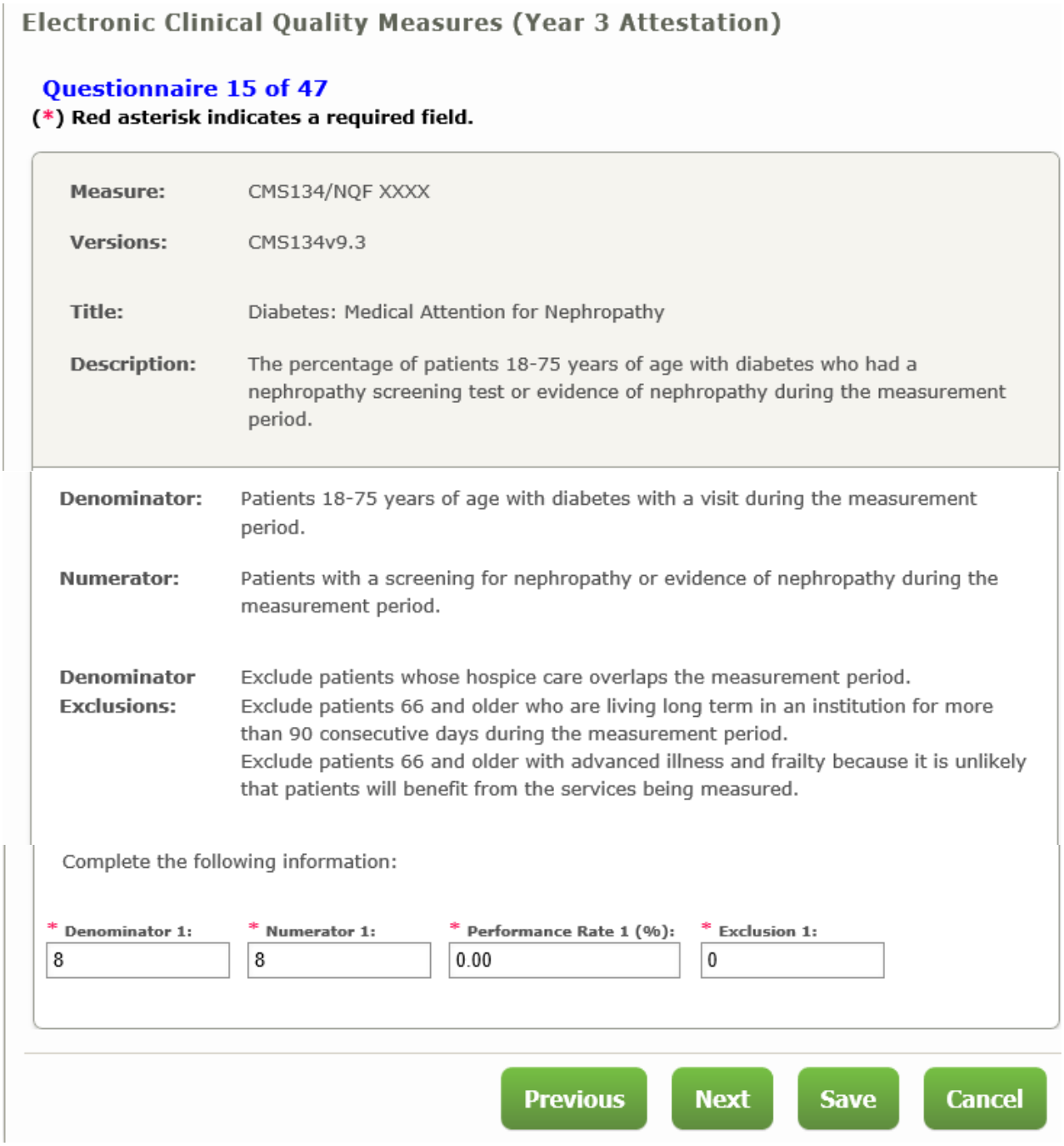
9.5.15 CMS134



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

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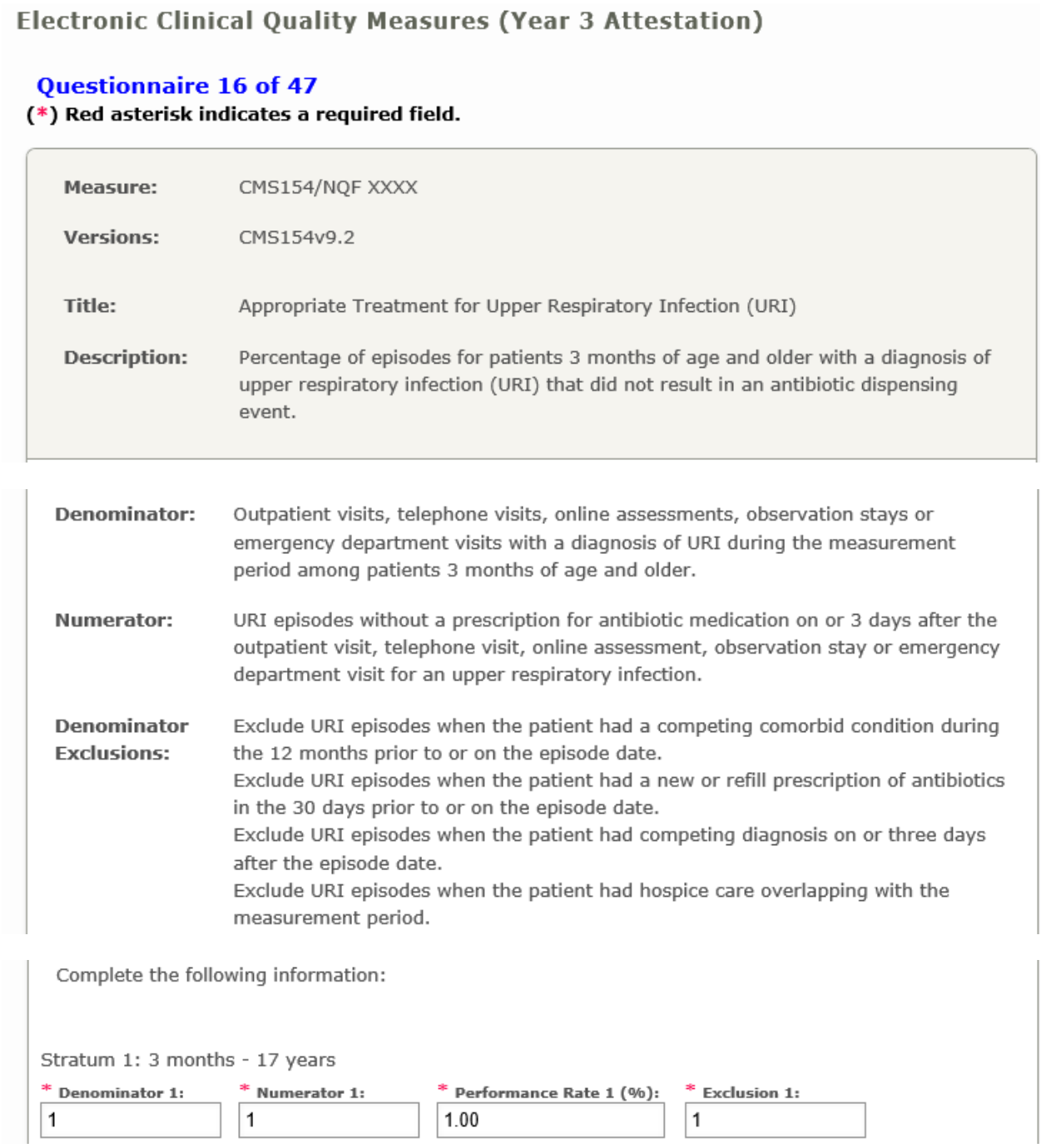
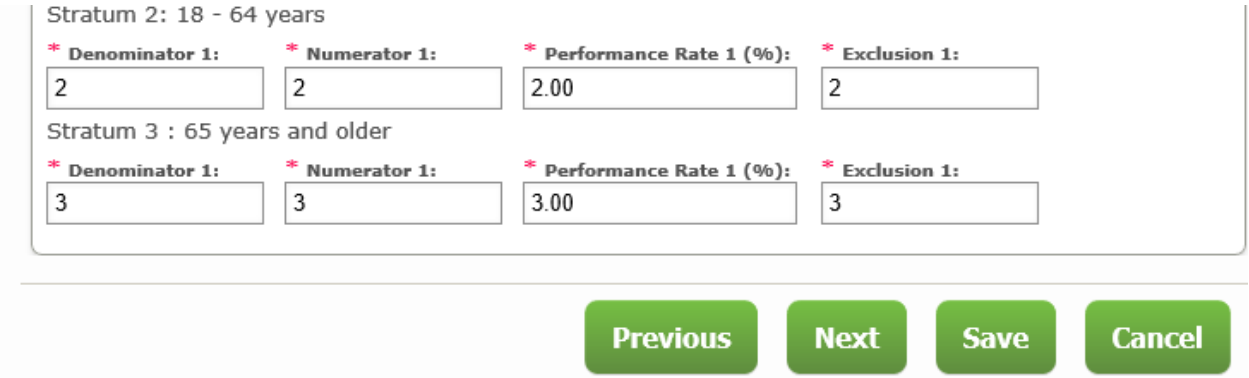
9.5.16 CMS154





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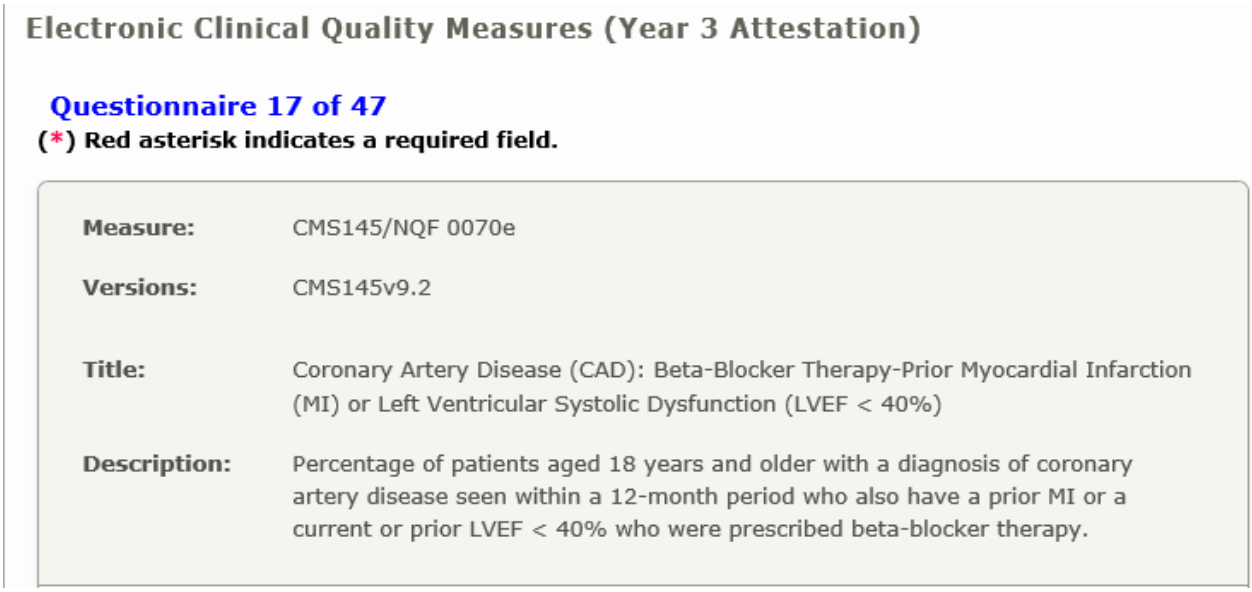
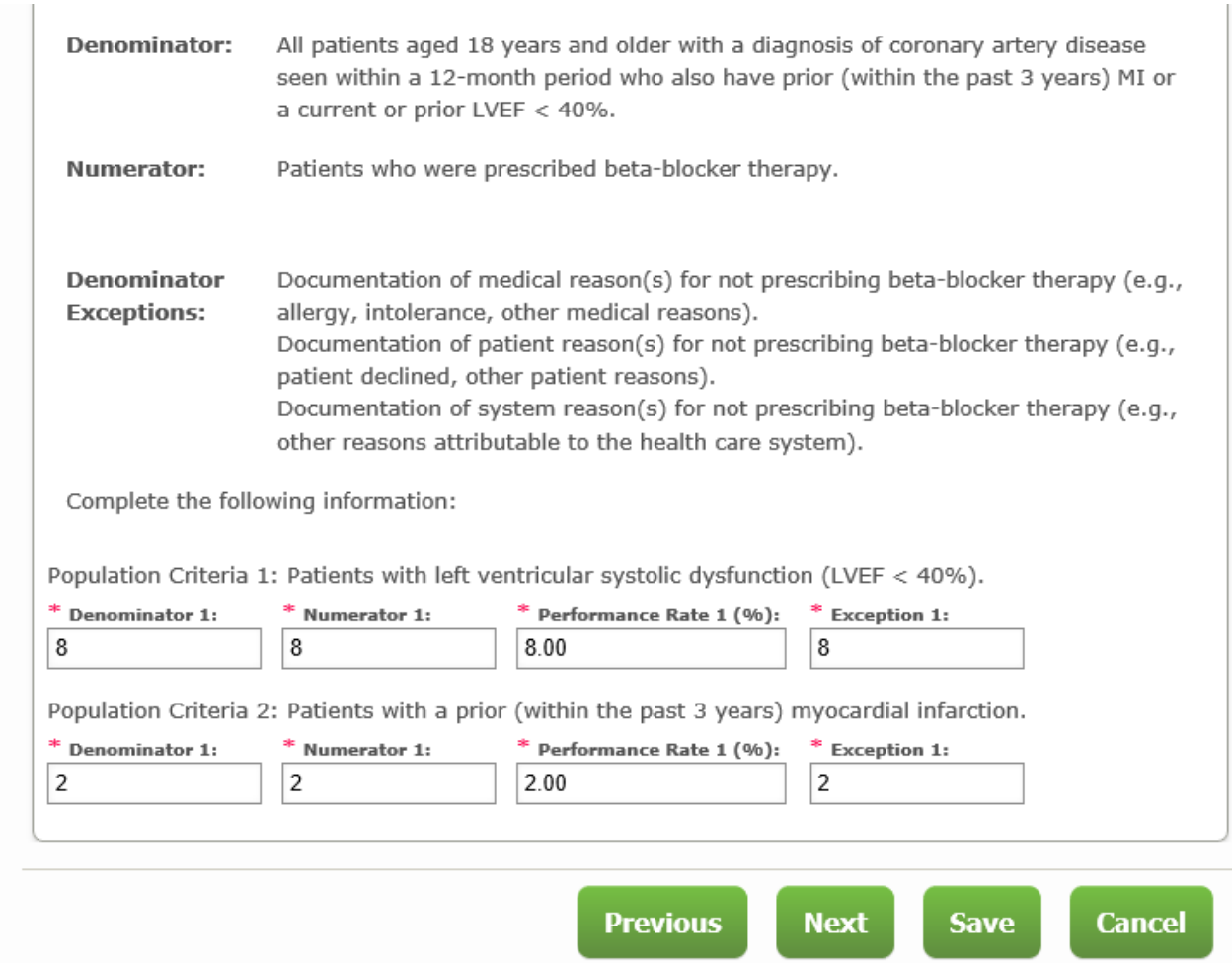
9.5.17 CMS145





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

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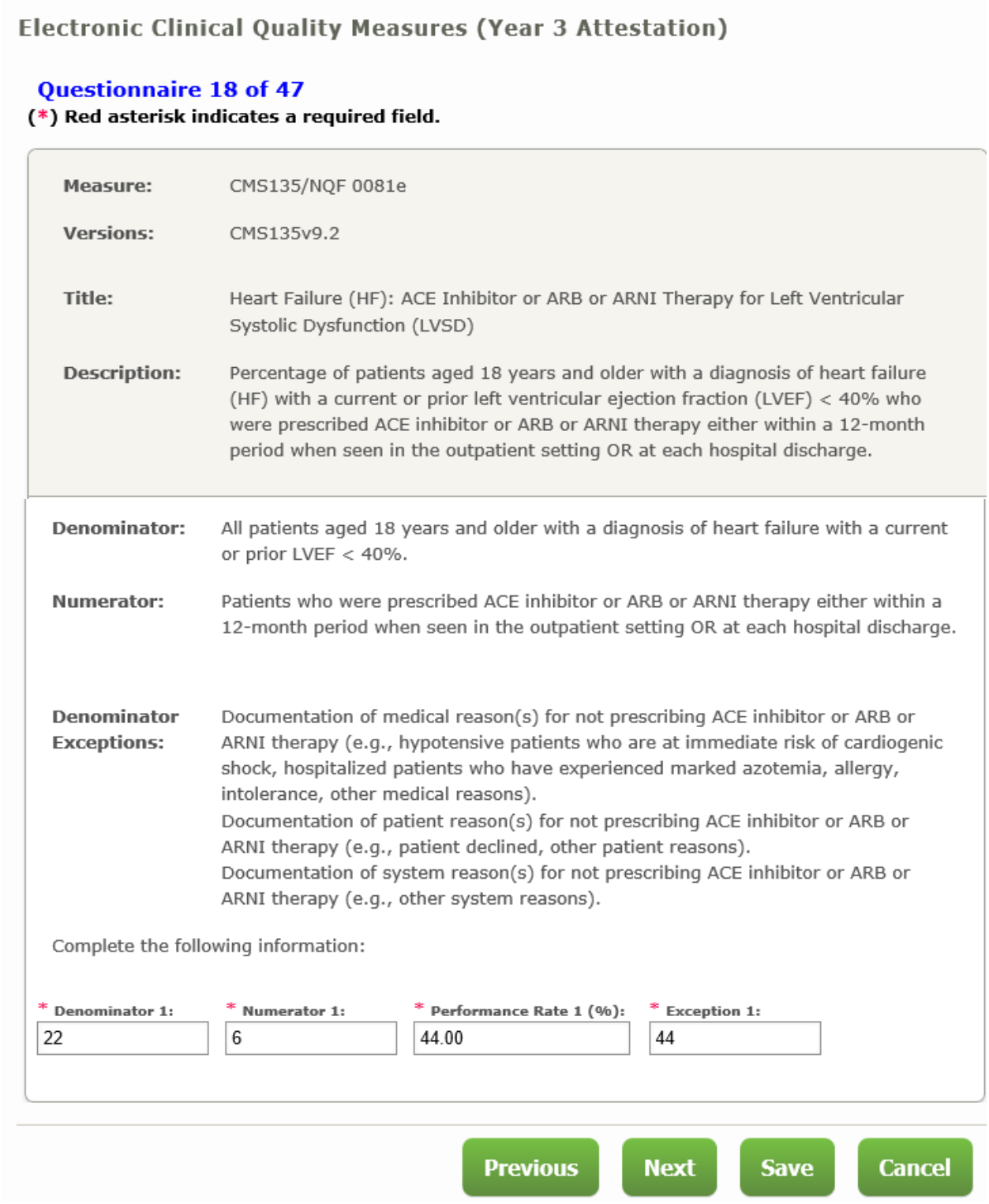
9.5.18 CMS135



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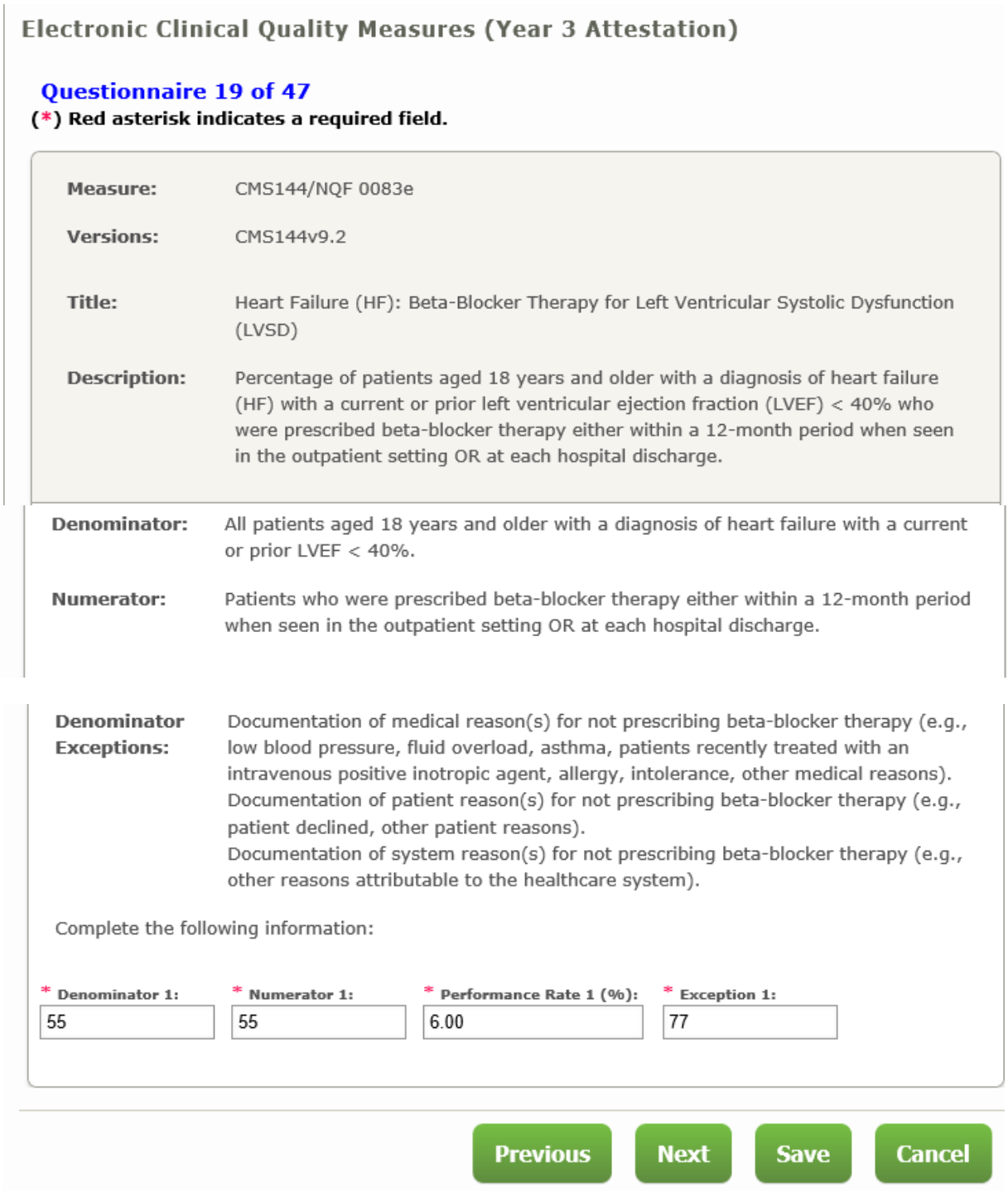
9.5.19 CMS144



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

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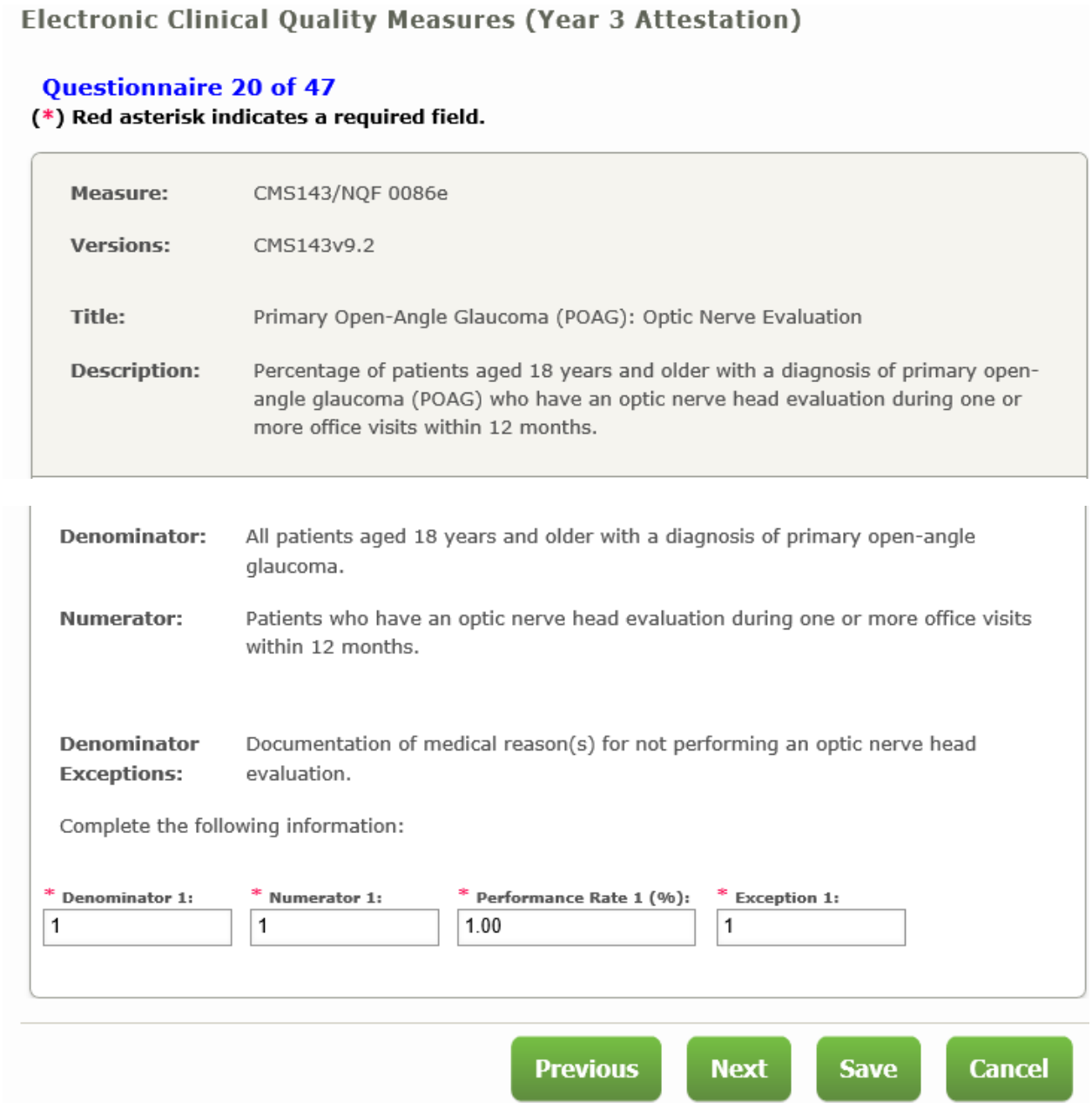
9.5.20 CMS143



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

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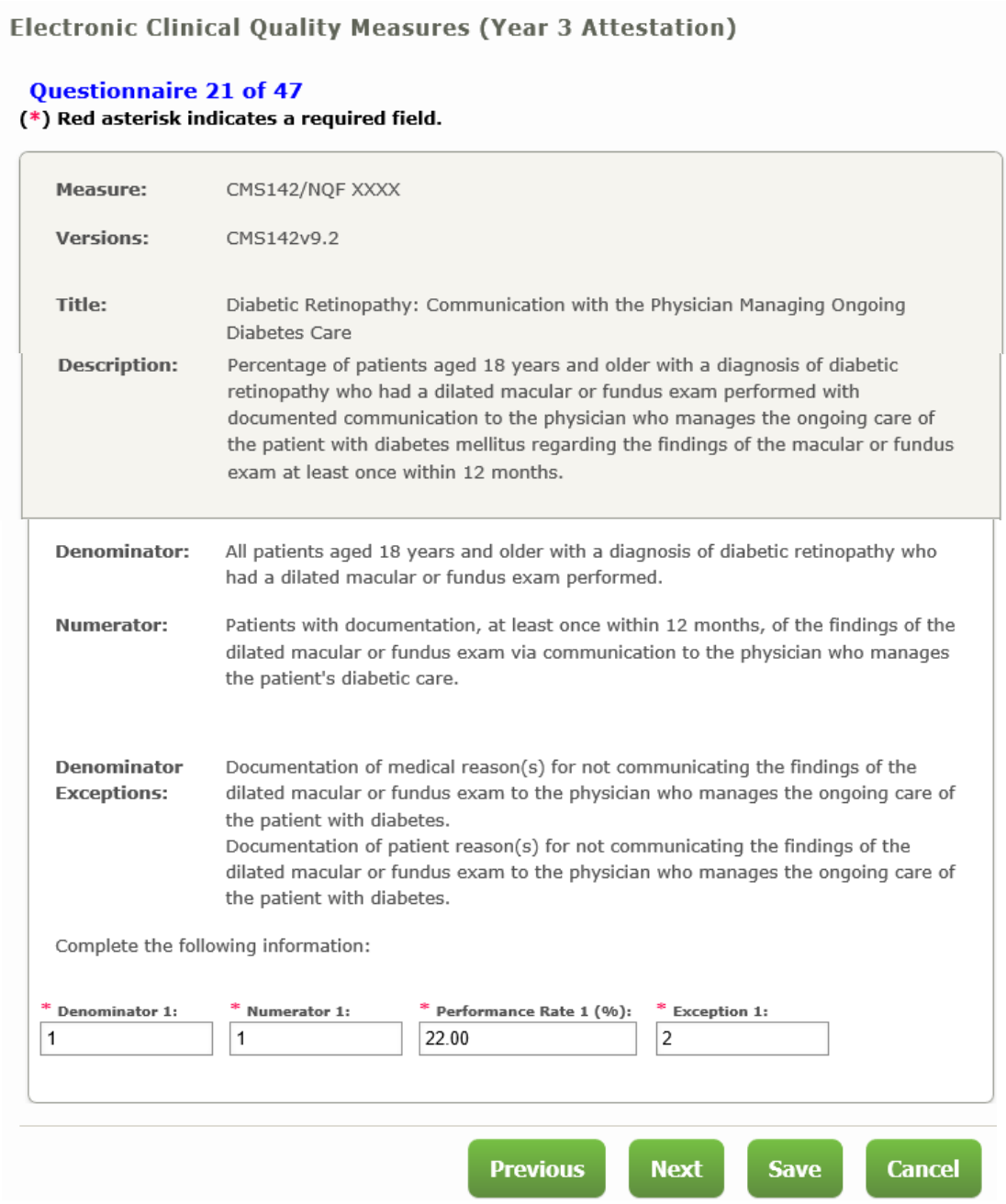
9.5.21 CMS142



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

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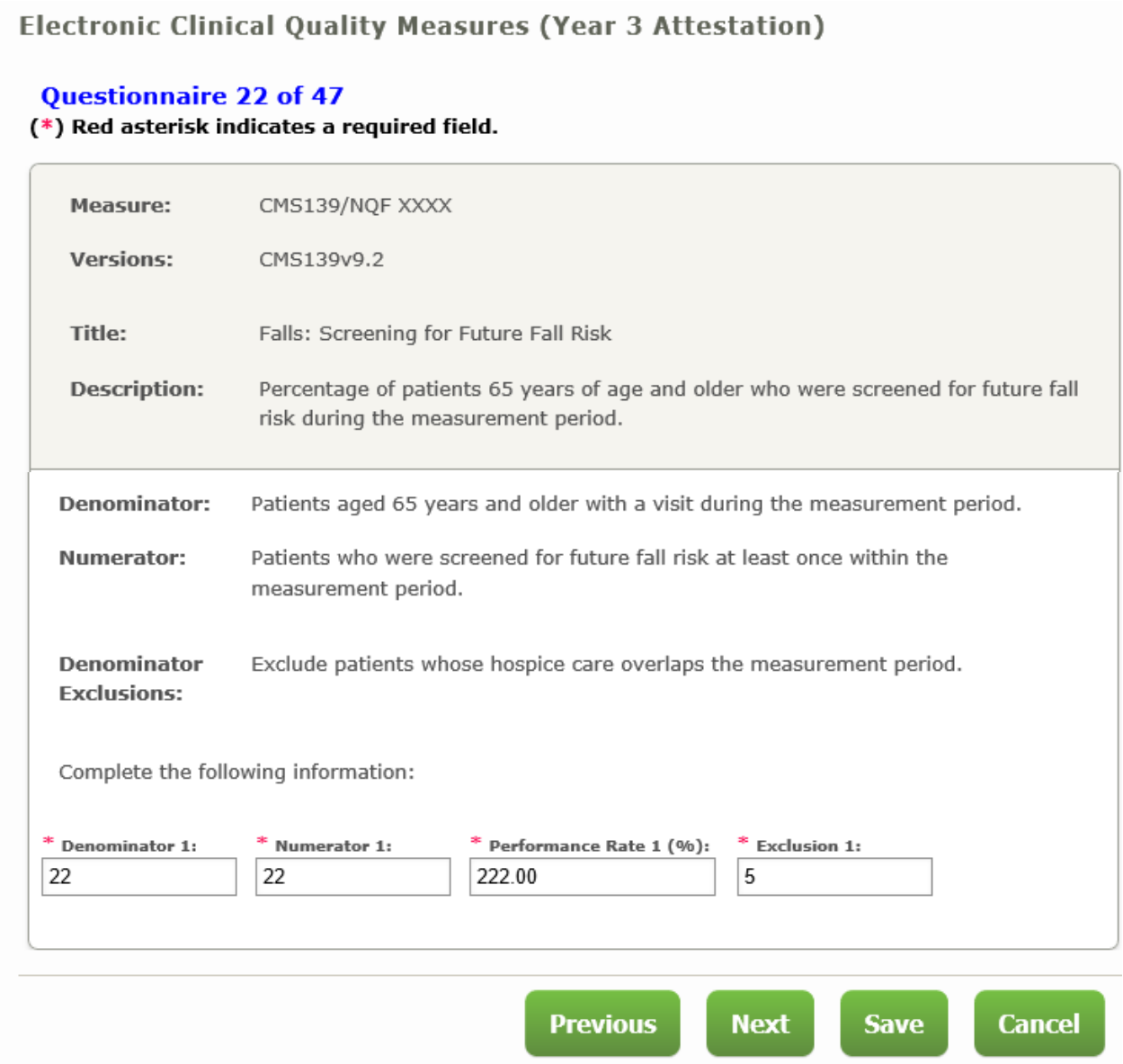
9.5.22 CMS139



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

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9.5.23 CMS161

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

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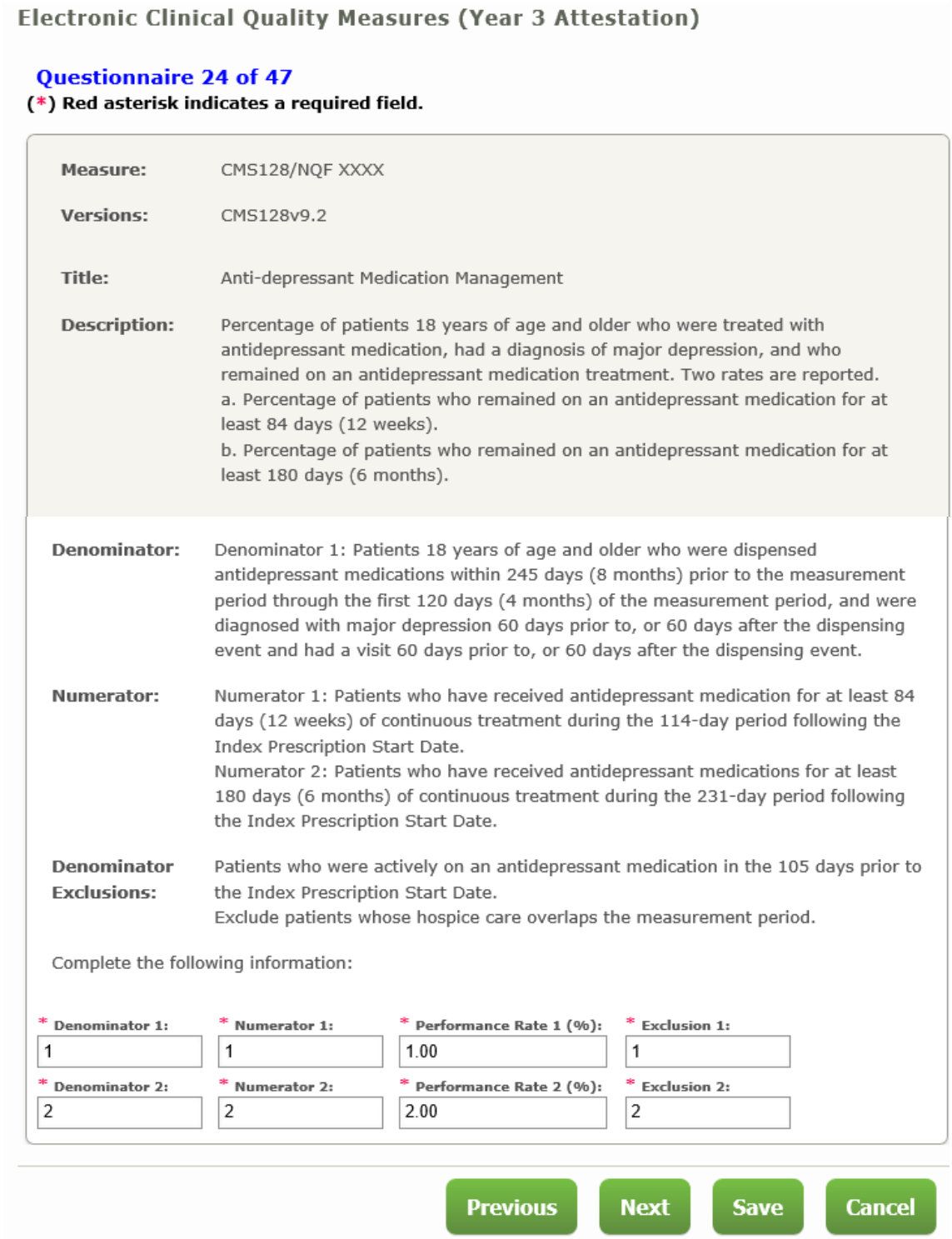
9.5.24 CMS128



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

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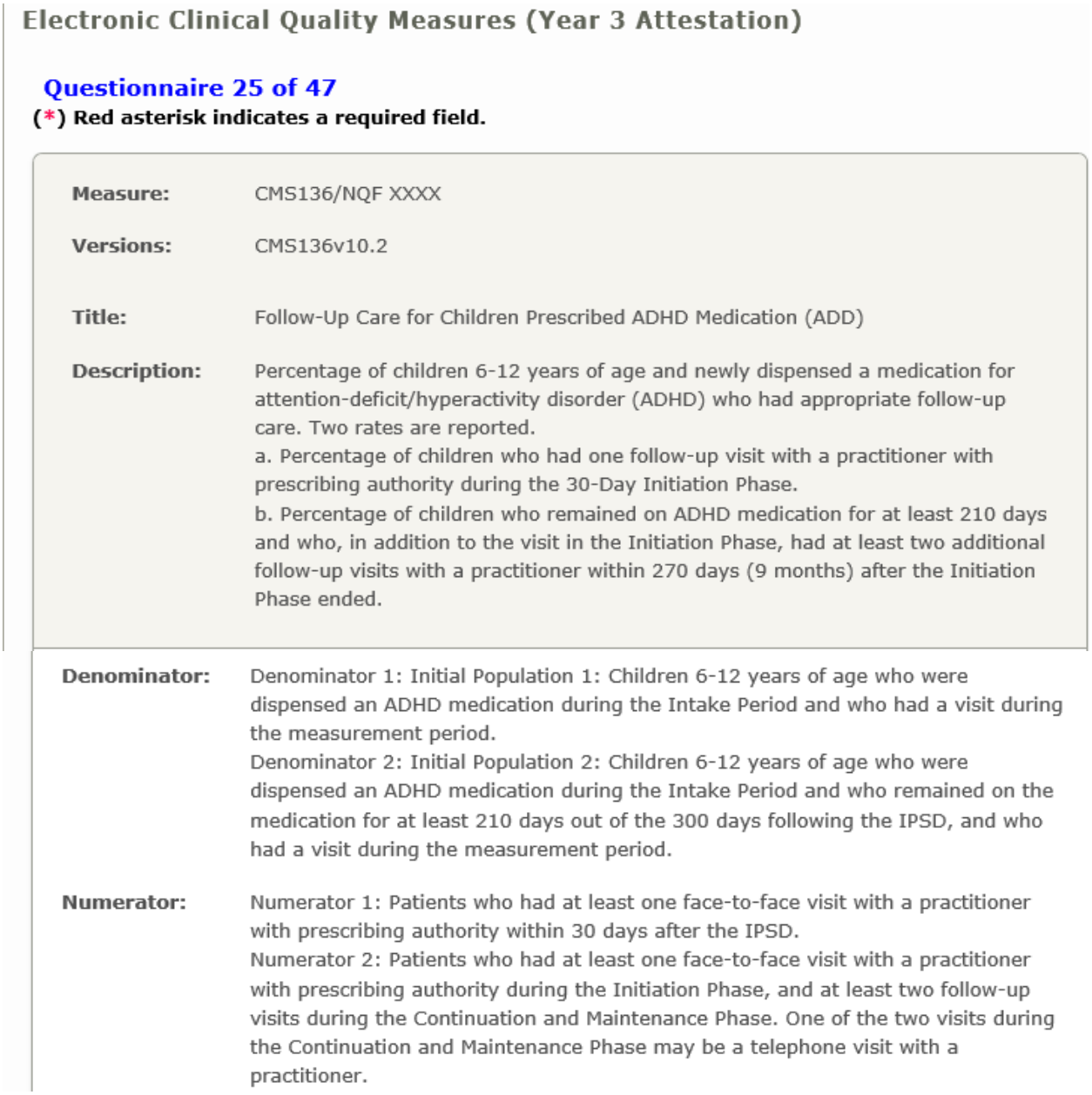
9.5.25 CMS136

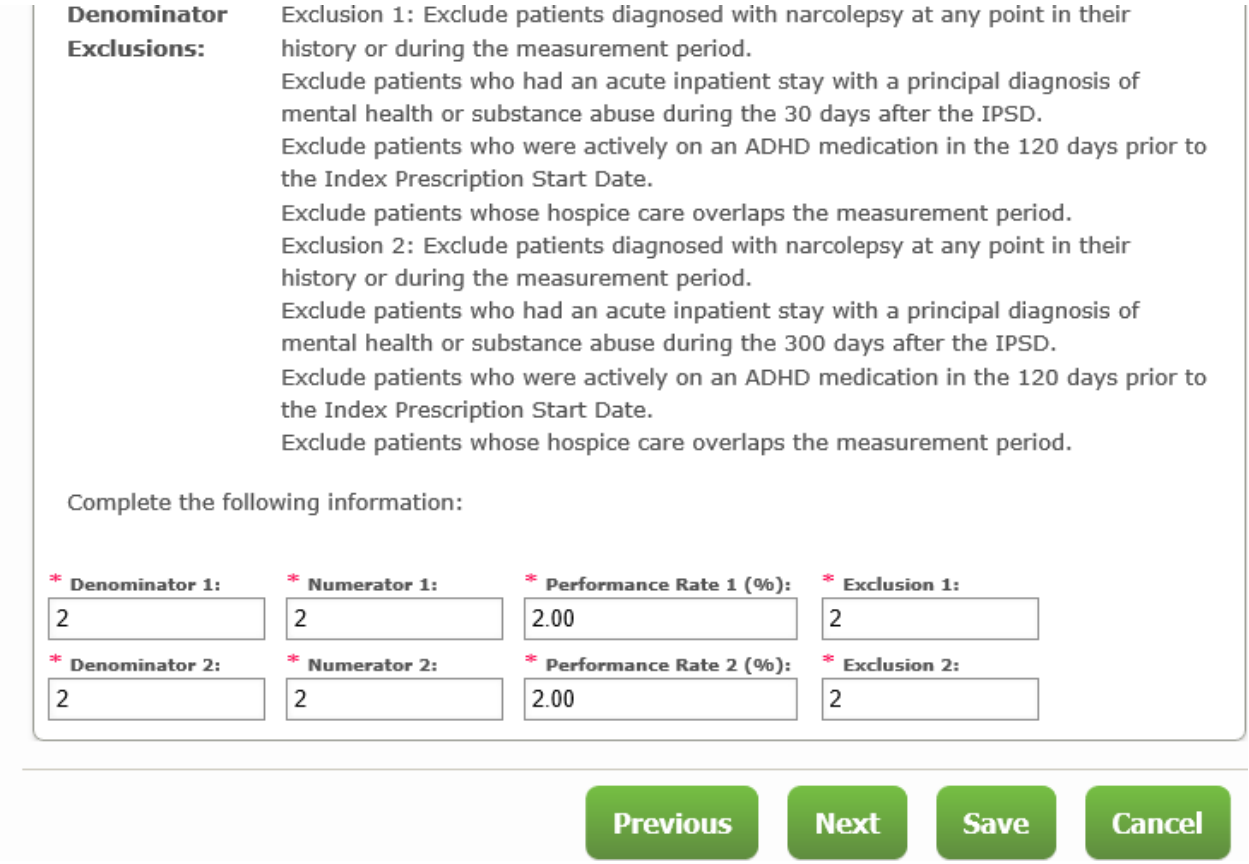


Electronic Clinical Quality Measures (Year 3 Attestation)

Questionnaire 25 of 47

(*) Red asterisk indicates a required field.

Measure:	CMS136/NQF XXXX
Versions:	CMS136v10.2
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.



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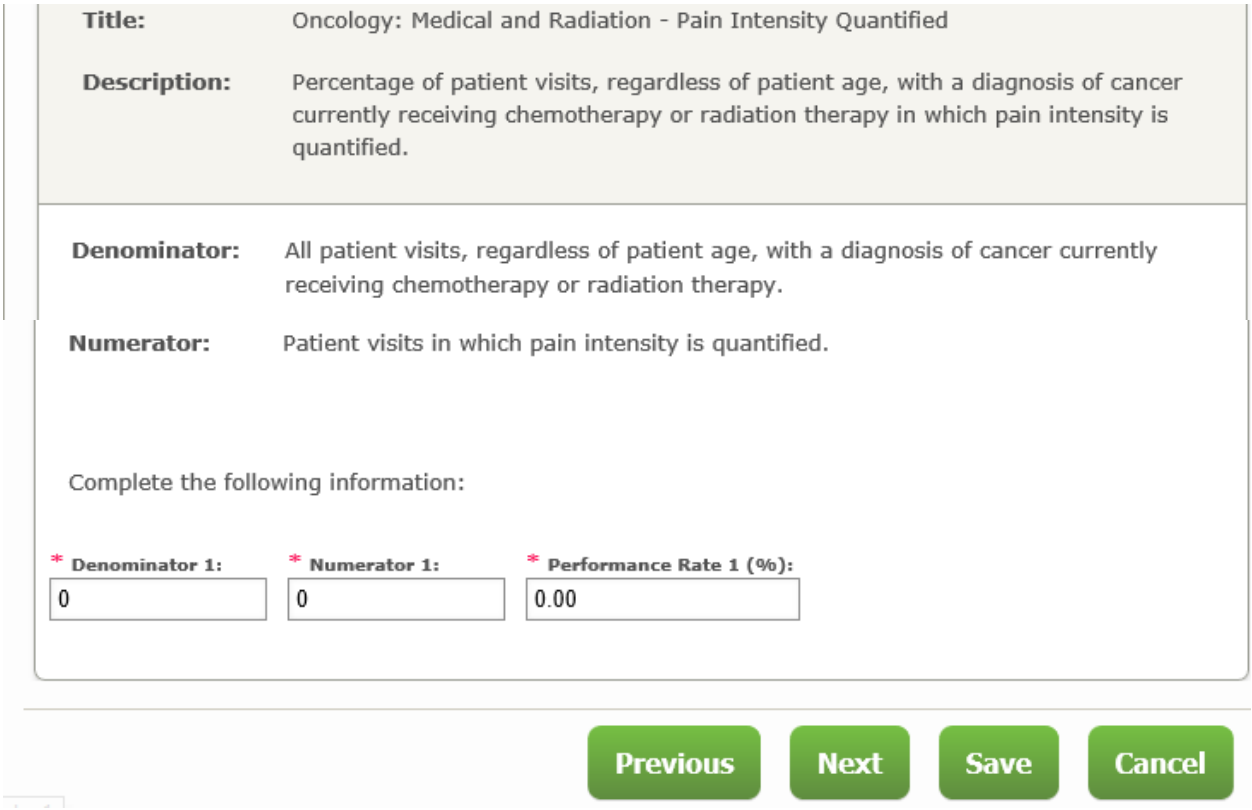
9.5.26 CMS157



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

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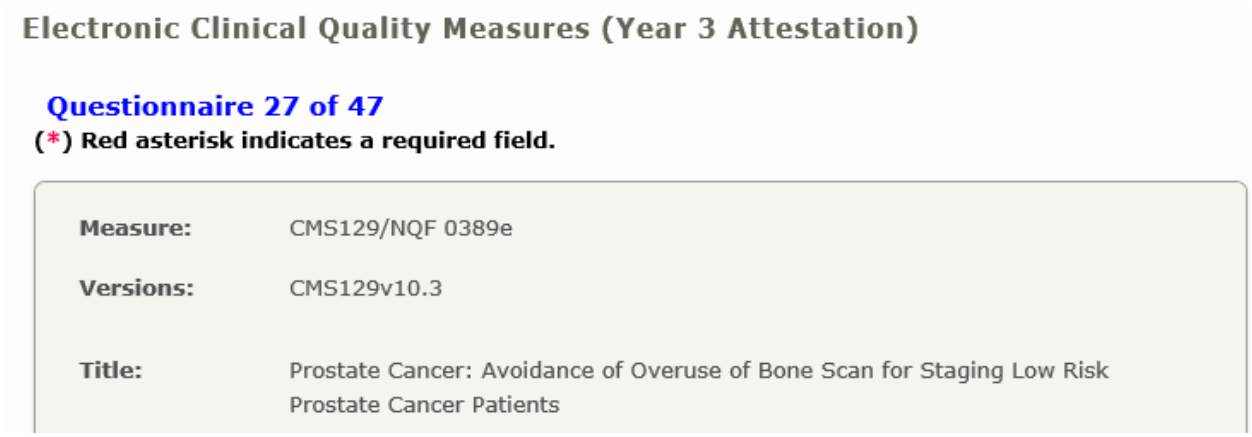
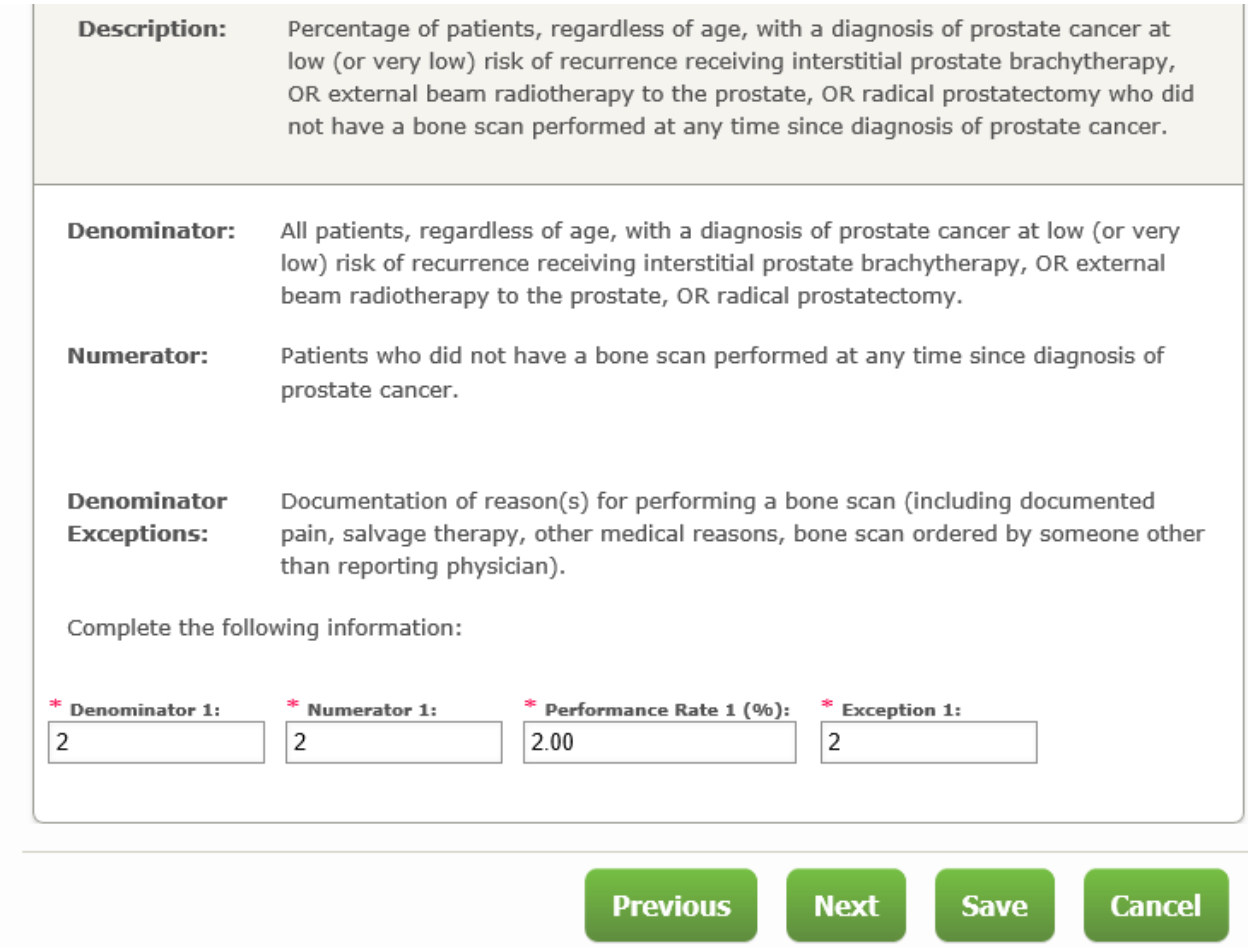
9.5.27 CMS129





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

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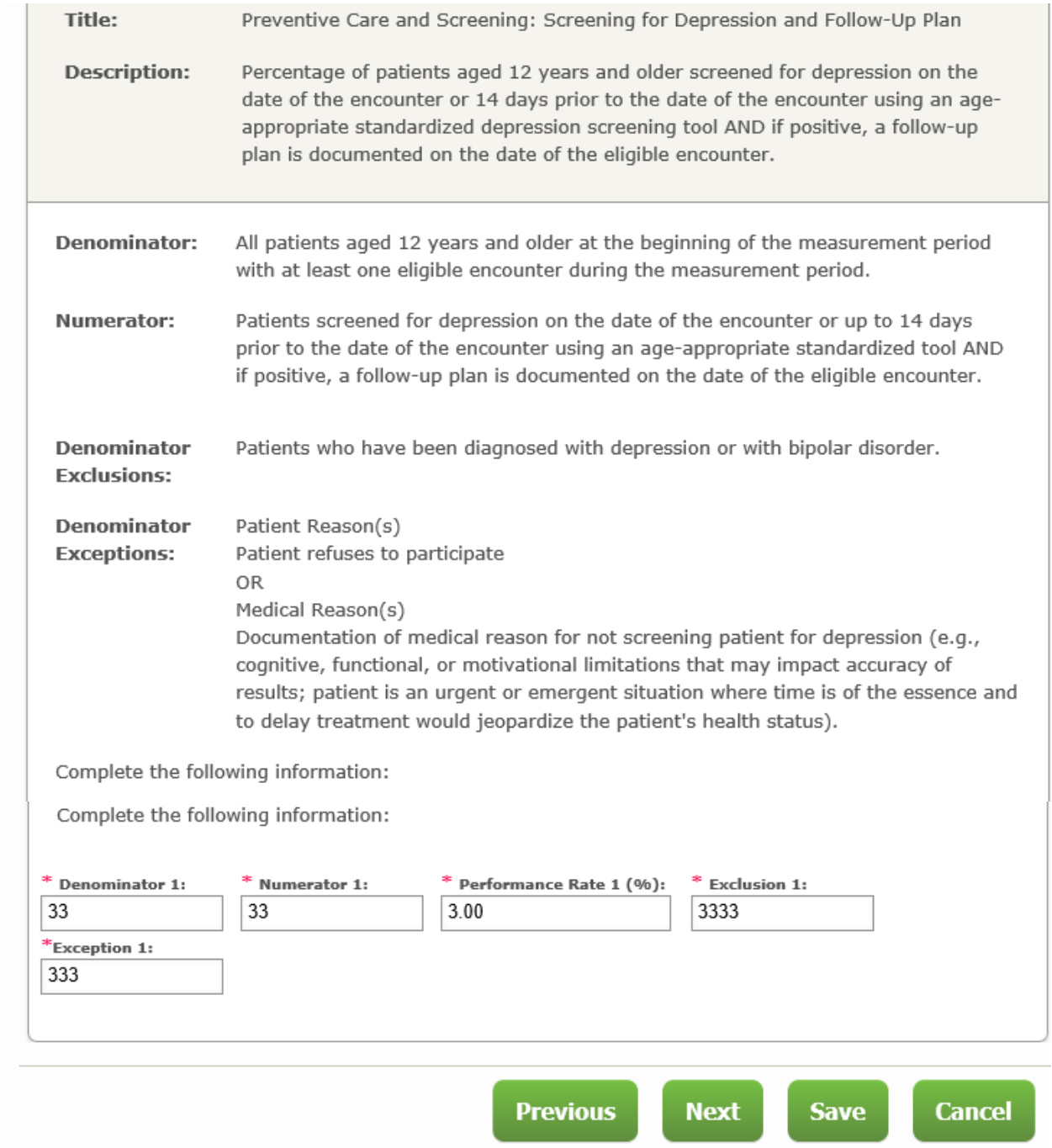
9.5.28 CMS2



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

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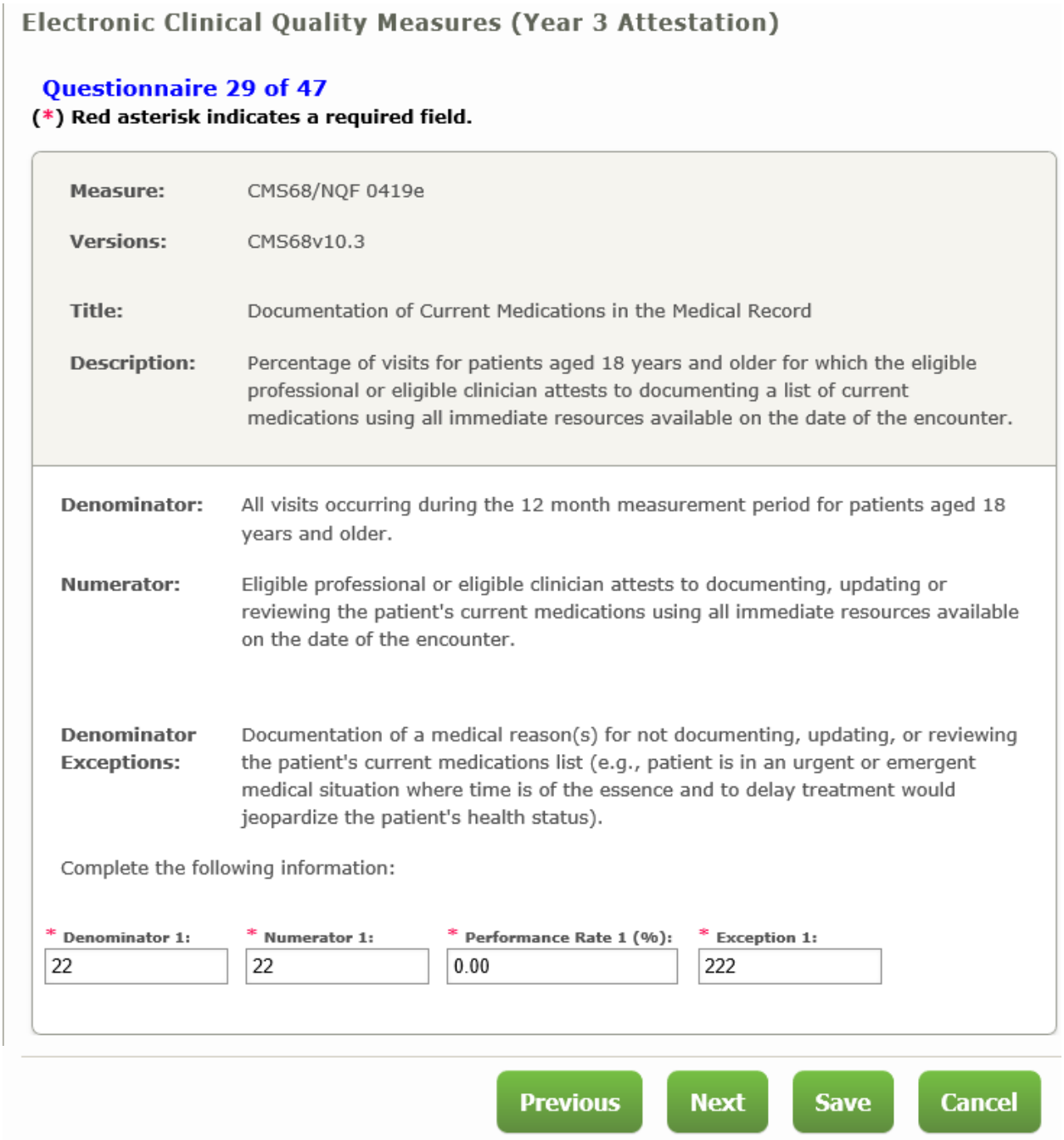
9.5.29 CMS68



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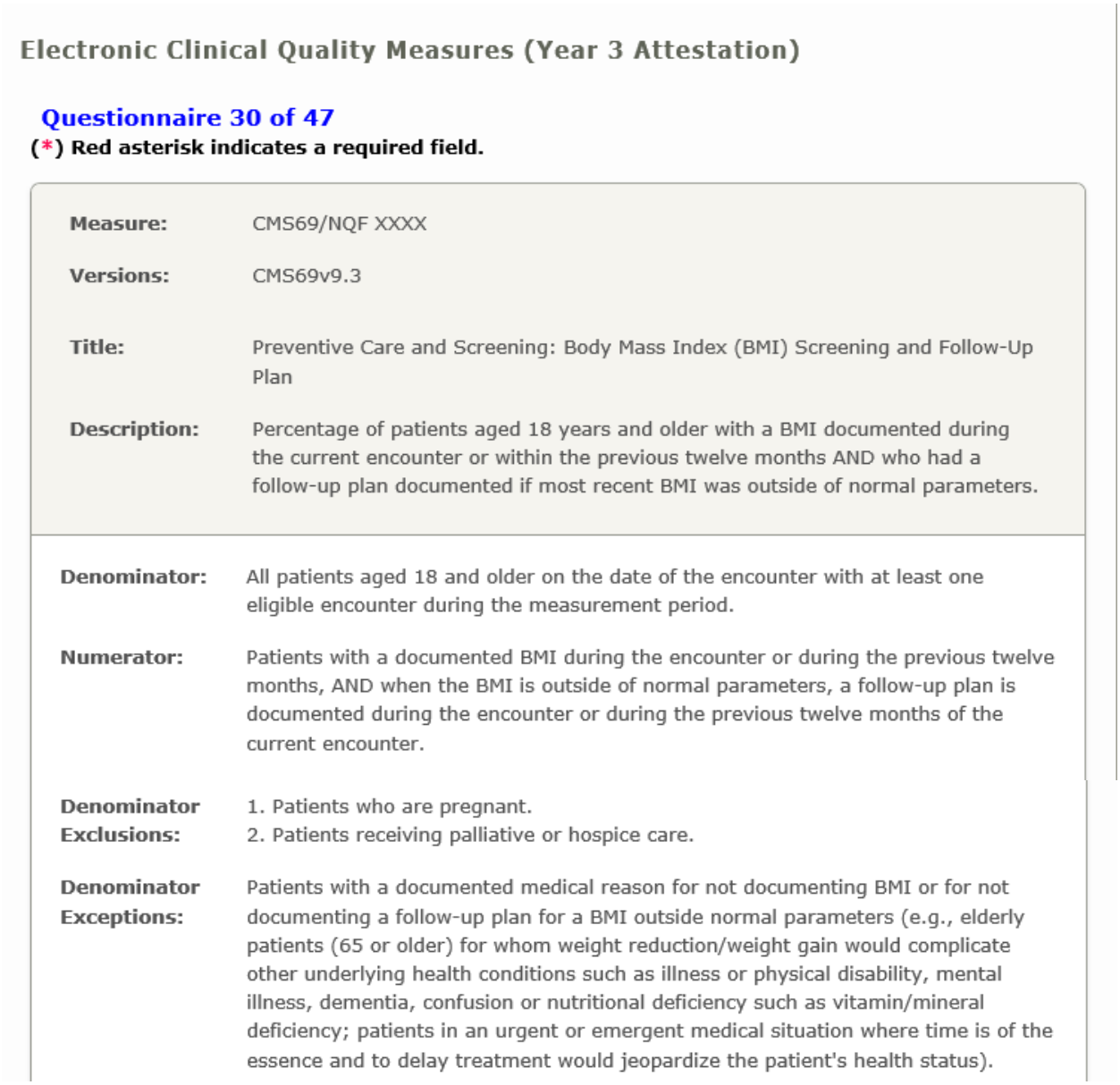
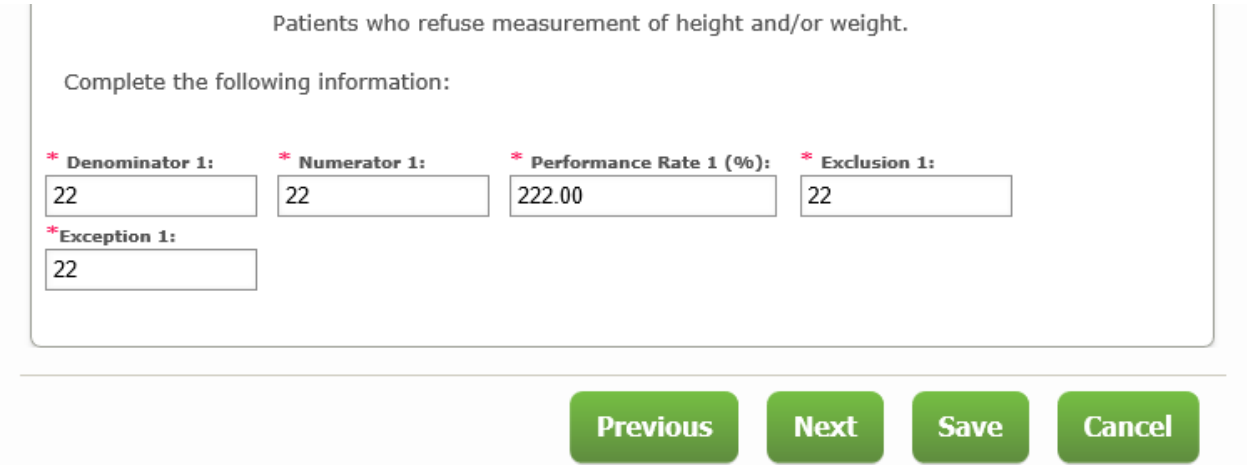
9.5.30 CMS69





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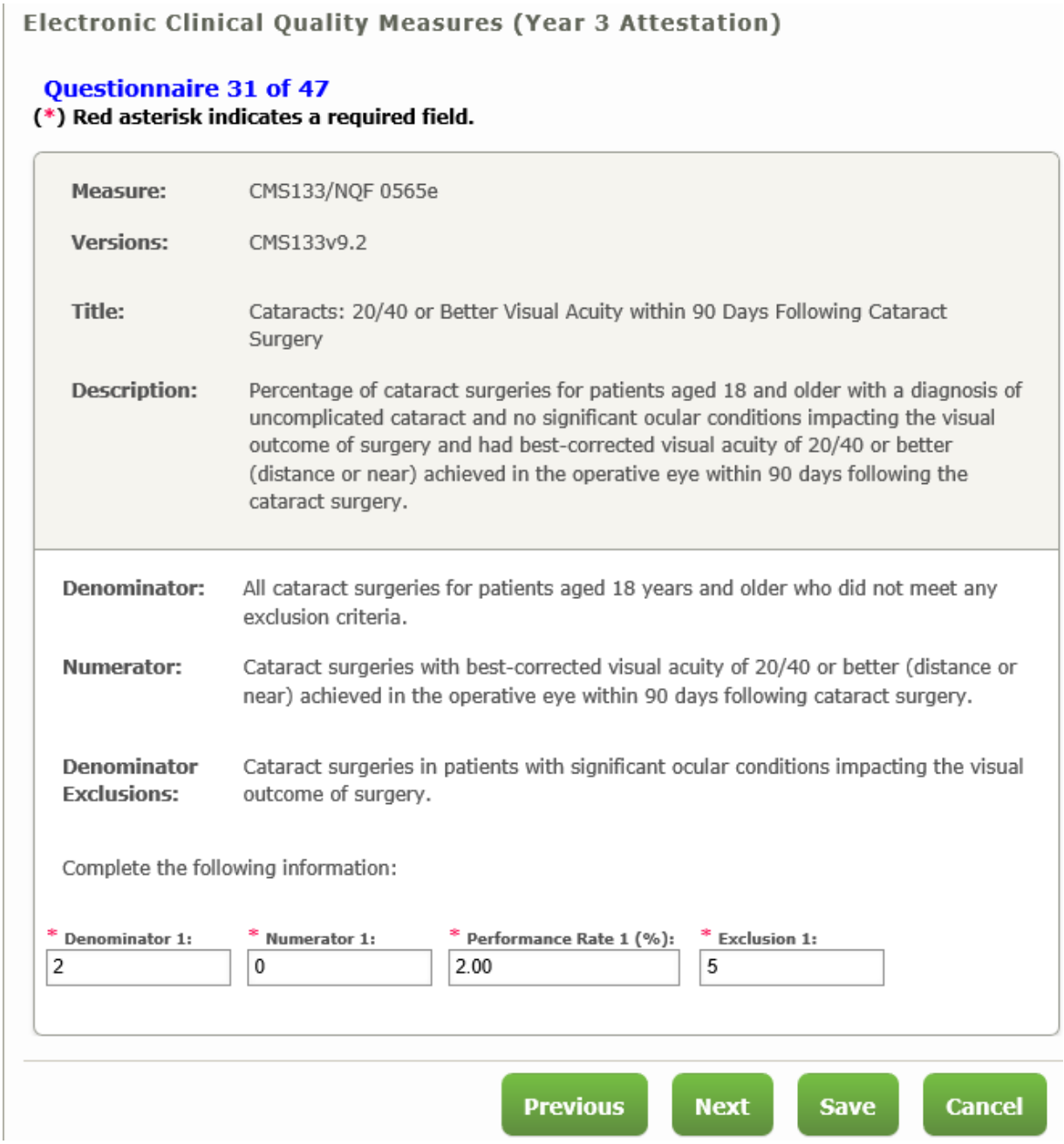
9.5.31 CMS133



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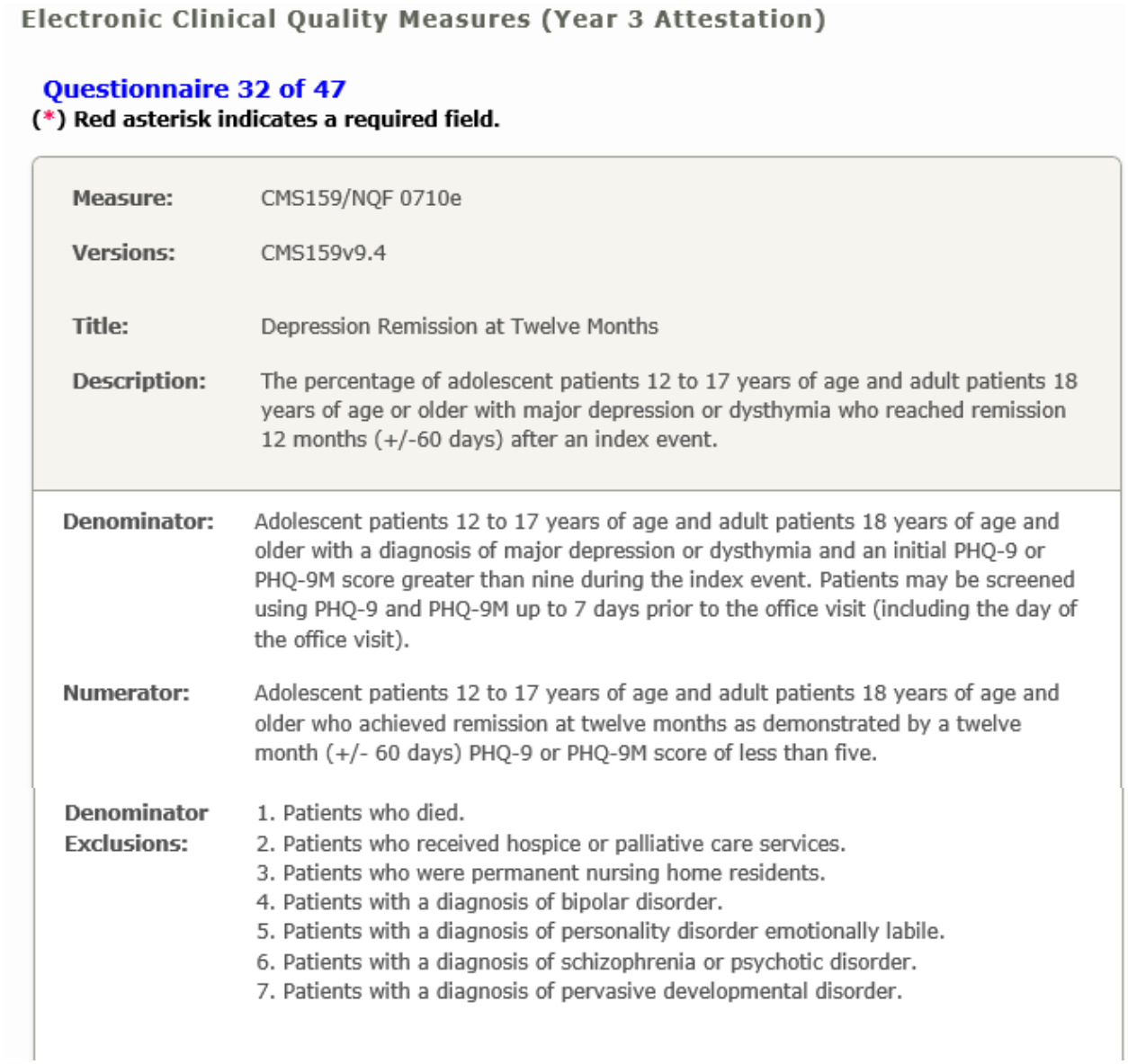
9.5.32 CMS159

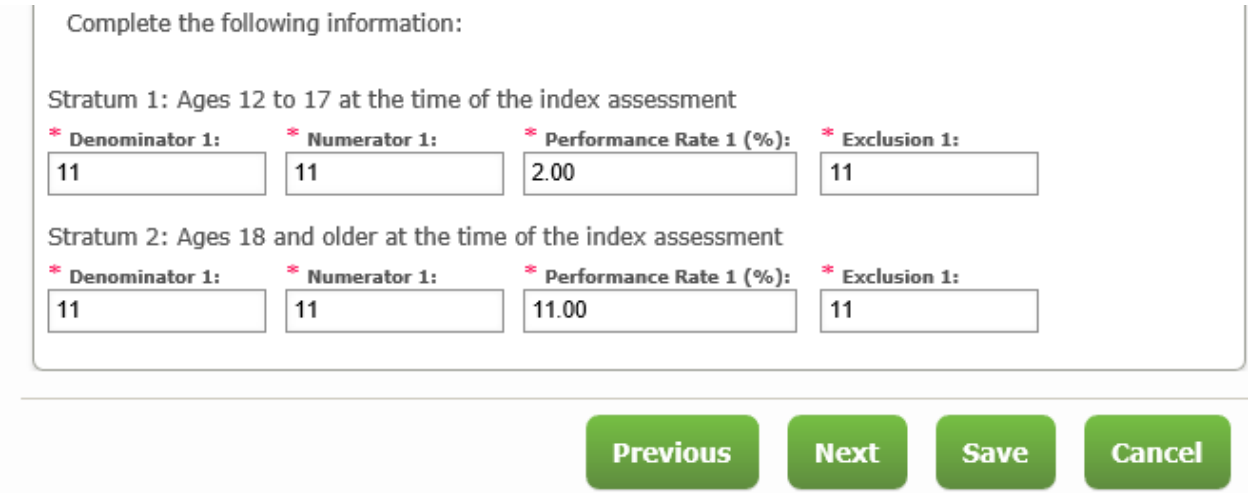


Electronic Clinical Quality Measures (Year 3 Attestation)

Questionnaire 32 of 47

(*) Red asterisk indicates a required field.

Measure:	CMS159/NQF 0710e
Versions:	CMS159v9.4
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 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. Patients may be screened using PHQ-9 and PHQ-9M up to 7 days prior to the office visit (including the day of the office visit).
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 emotionally labile. 6. Patients with a diagnosis of schizophrenia or psychotic disorder. 7. Patients with a diagnosis of pervasive developmental disorder.



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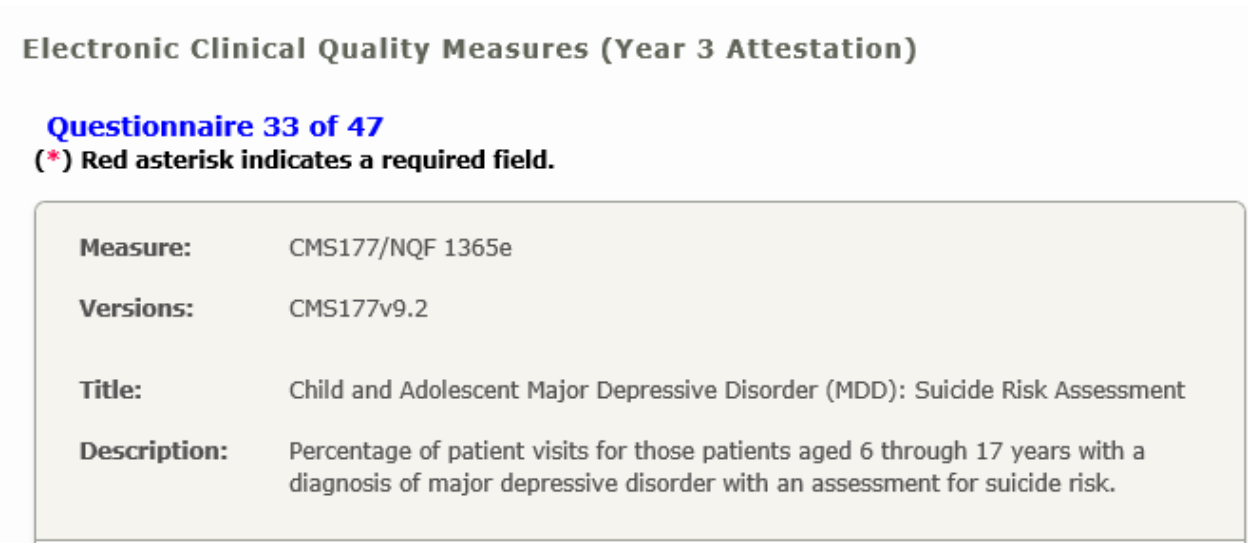
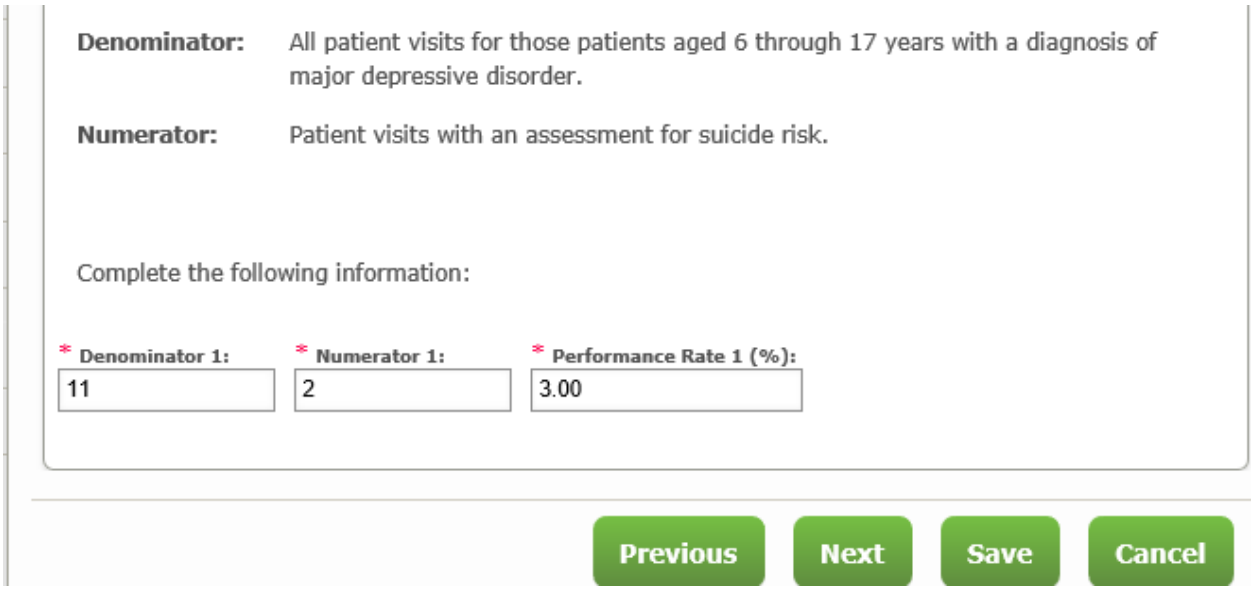
- Click **Cancel** to remove selections and stay on the current screen.

9.5.33 CMS177



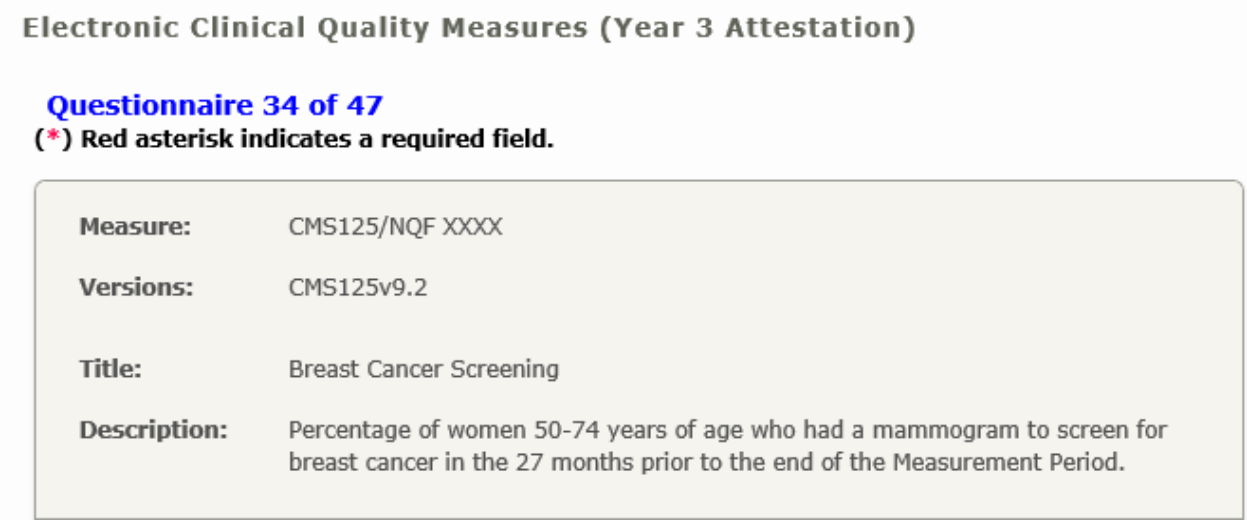


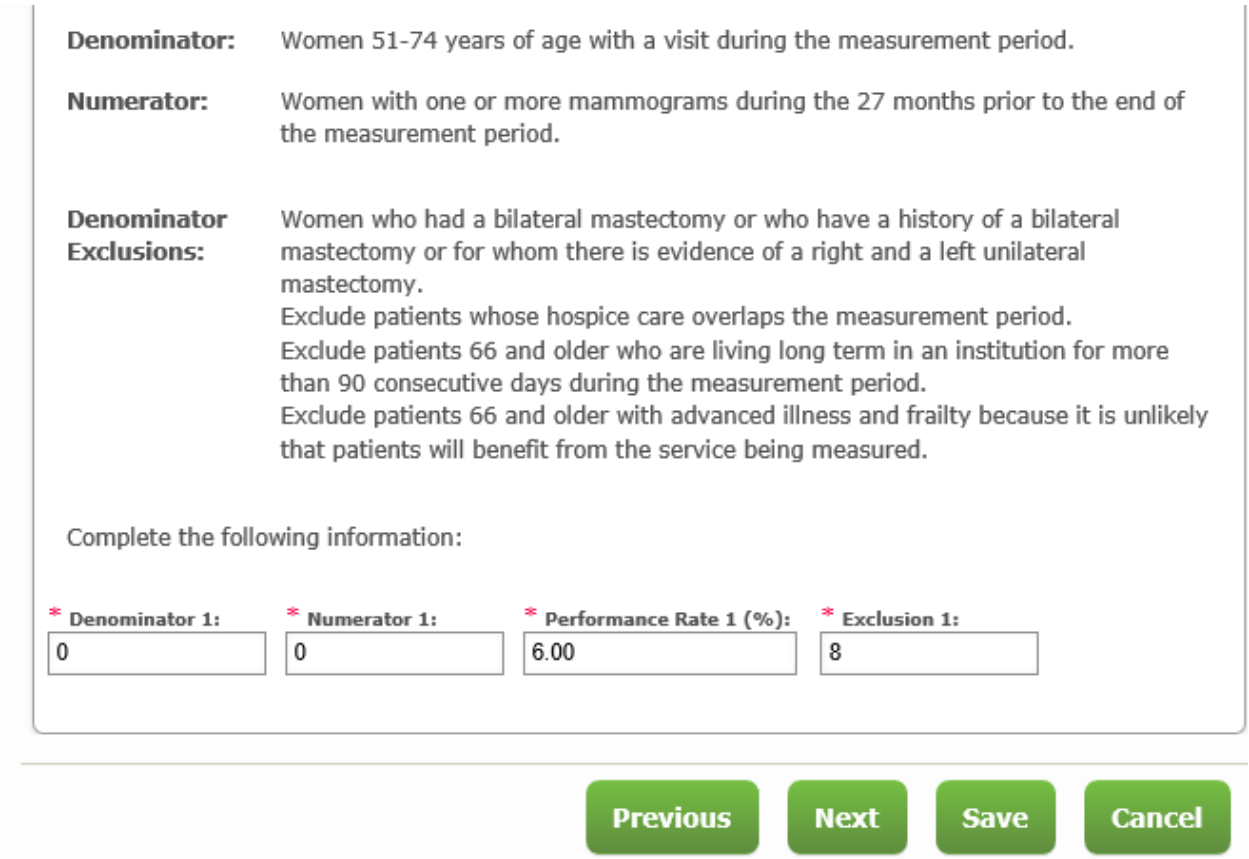
To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

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

- 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.

9.5.34 CMS125





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.

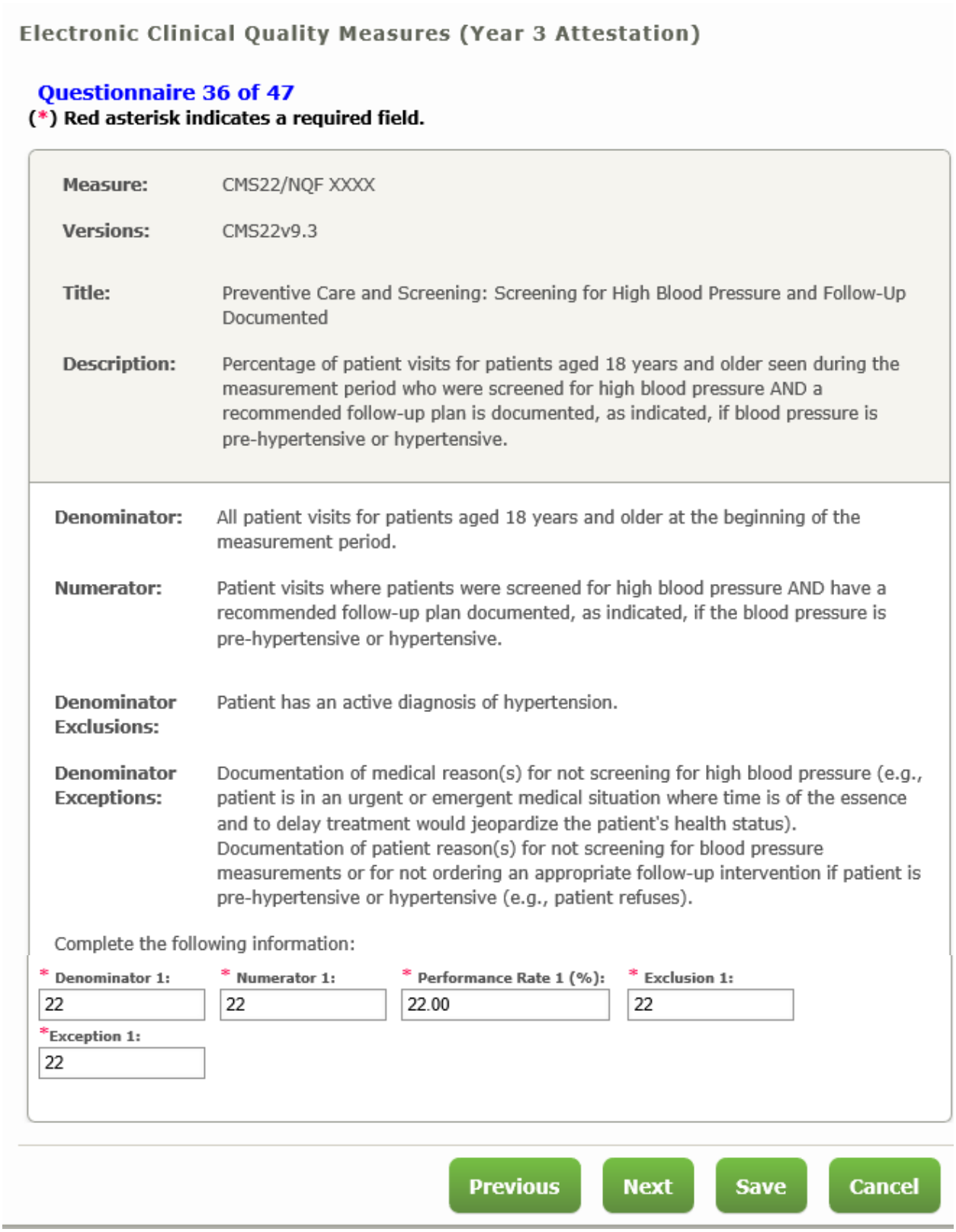
9.5.35 CMS149

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.

- 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.

9.5.36 CMS22

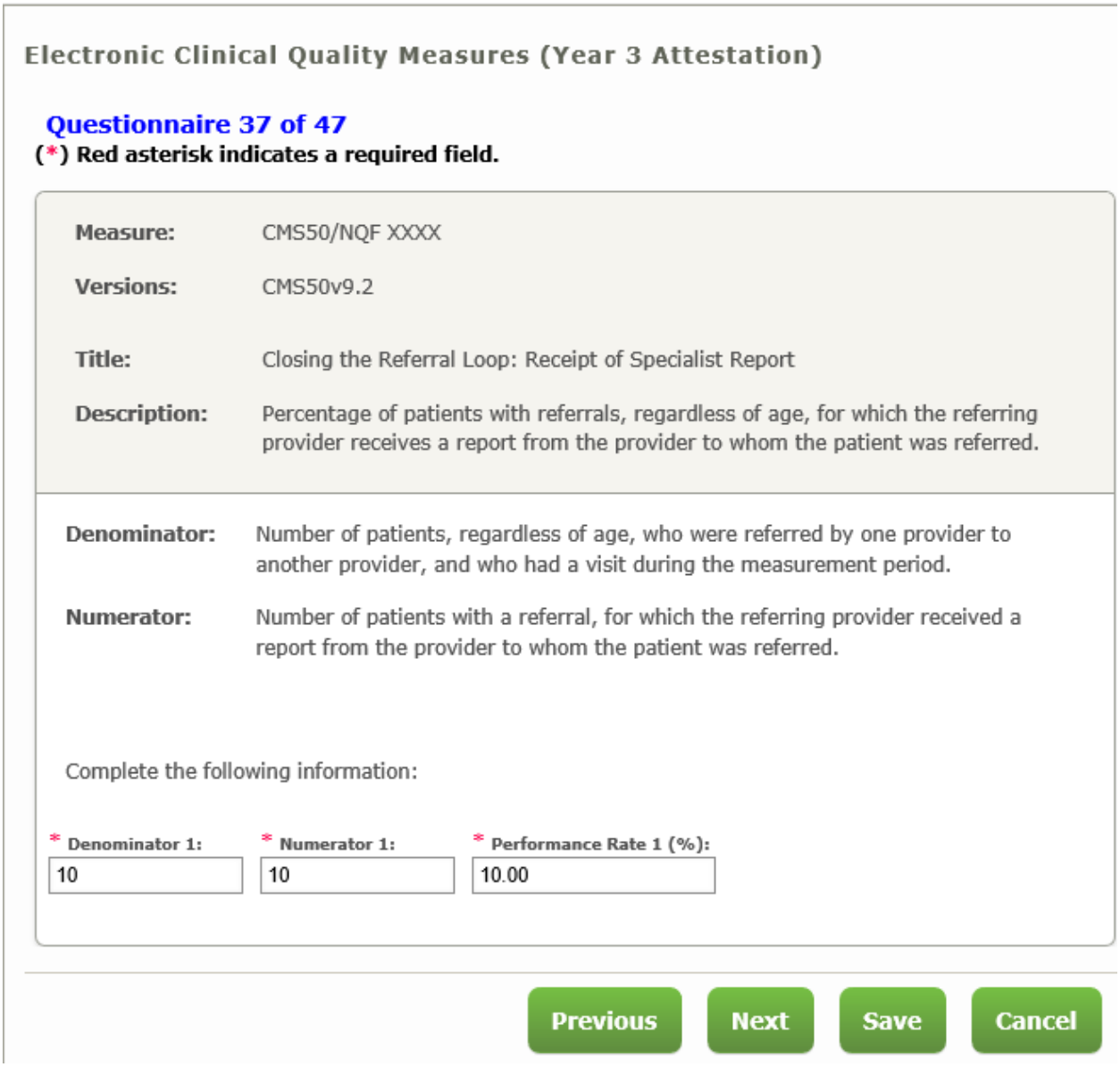

Electronic Clinical Quality Measures (Year 3 Attestation)
Questionnaire 36 of 47
(*) Red asterisk indicates a required field.
Measure: CMS22/NQF XXXX
Versions: CMS22v9.3
Title: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
Description: Percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is pre-hypertensive or hypertensive.
Denominator: All patient visits for patients aged 18 years and older at the beginning of the measurement period.
Numerator: Patient visits where patients 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: Documentation of medical reason(s) for not screening for high blood pressure (e.g., 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).
Documentation of patient reason(s) for not screening for blood pressure measurements or for not ordering an appropriate follow-up intervention if patient is pre-hypertensive or hypertensive (e.g., patient refuses).
Complete the following information:
* Denominator 1: 22
* Numerator 1: 22
* Performance Rate 1 (%): 22.00
* Exclusion 1: 22
*Exception 1: 22
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.

- 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.

9.5.37 CMS50

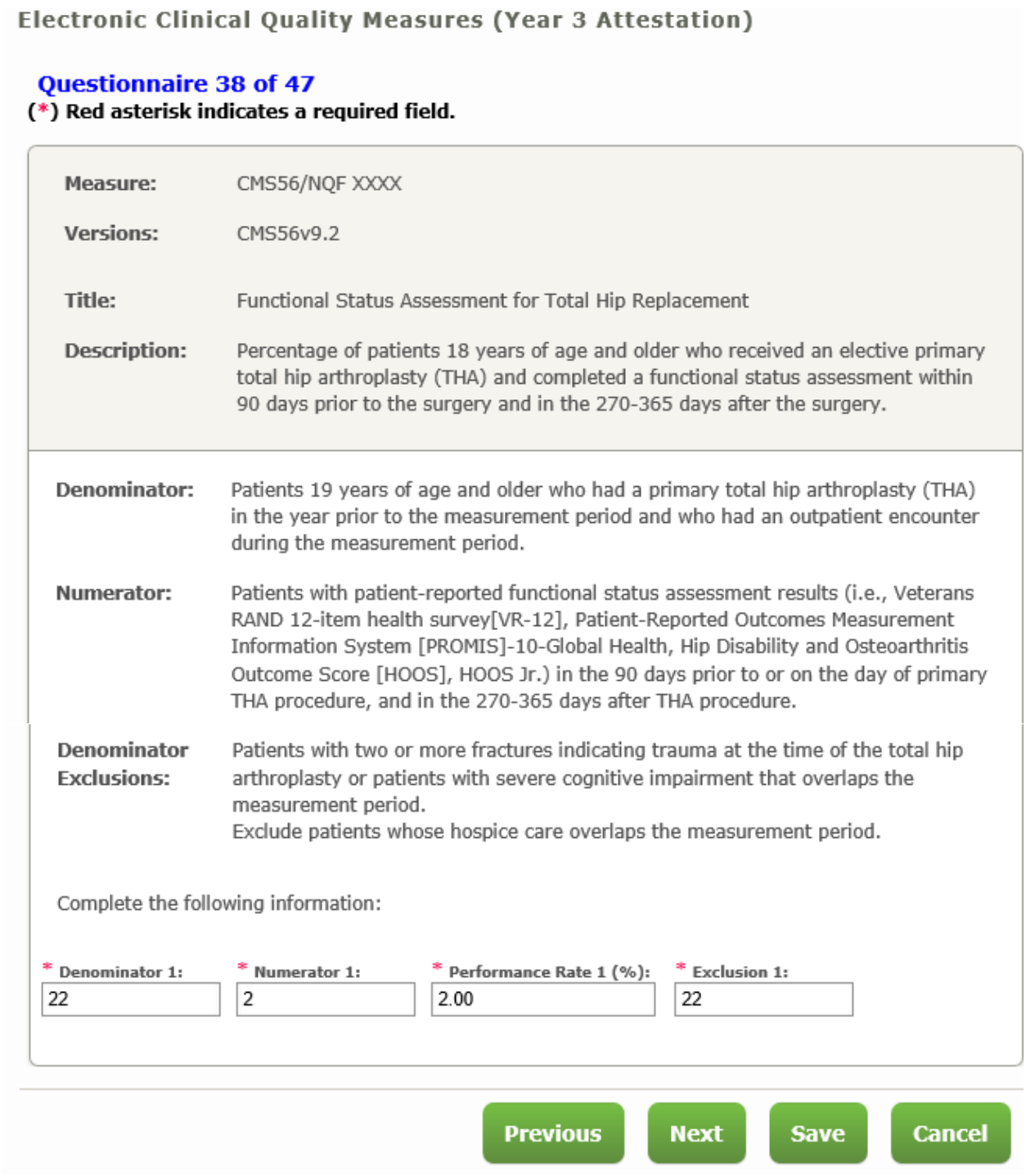


To satisfy this eCQM, enter a whole number into the Denominator, Numerator, and Performance Rate boxes.

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.

9.5.38 CMS56

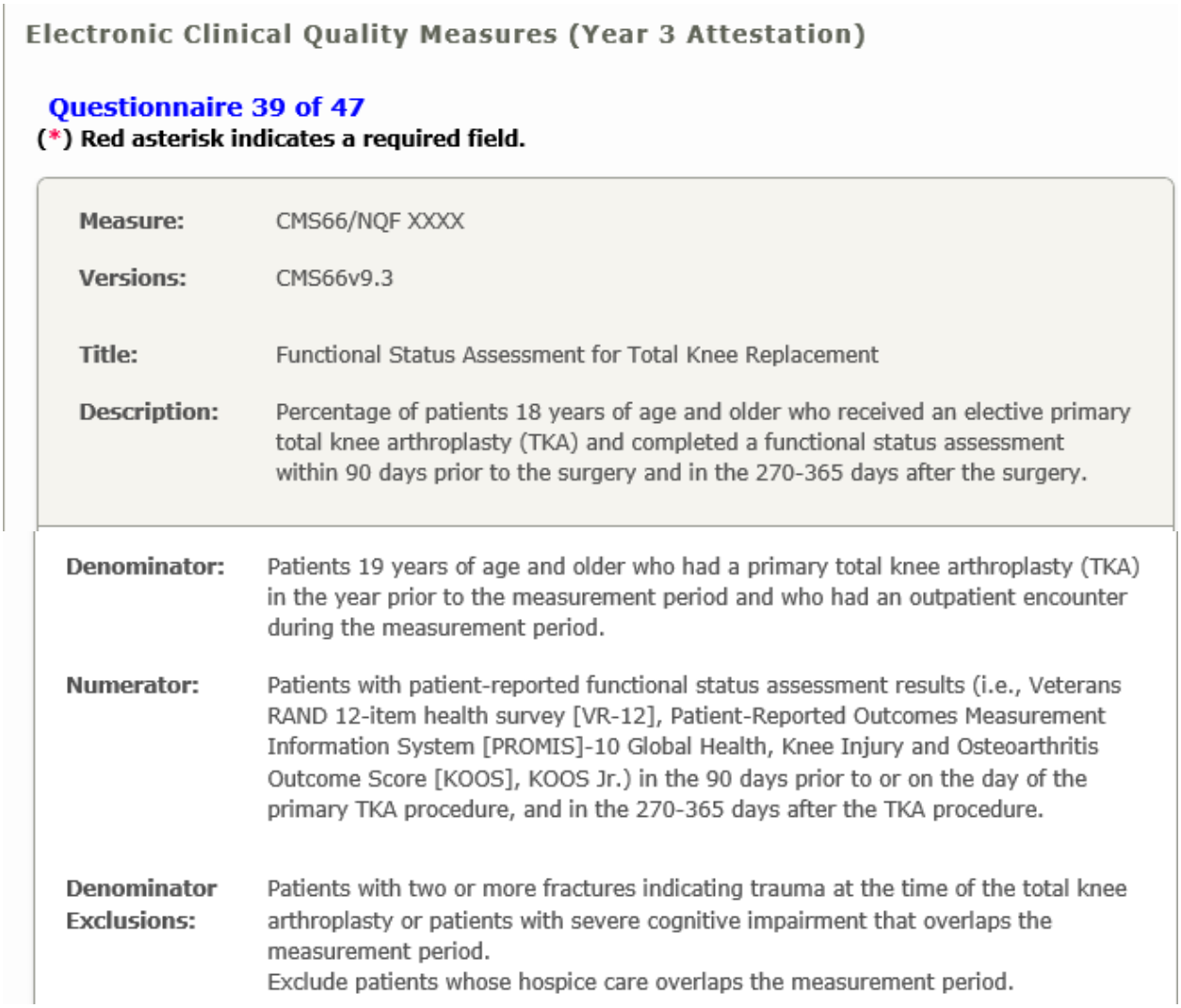


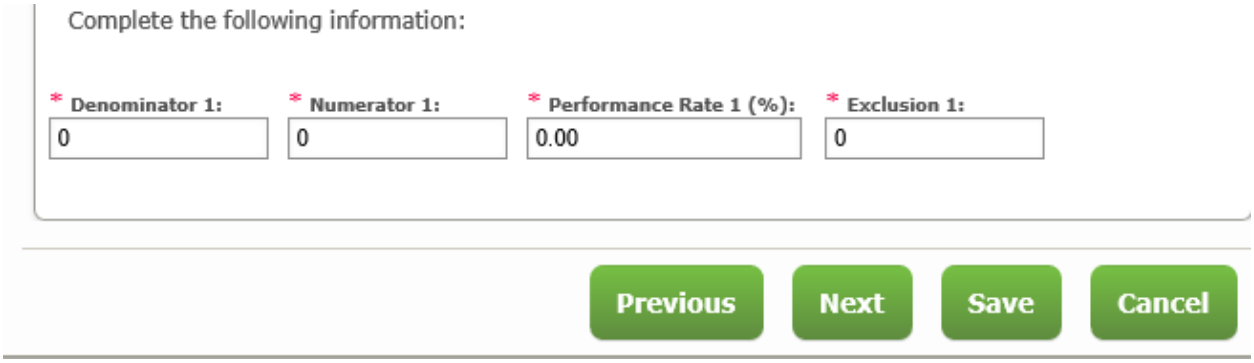
To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

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.

9.5.39 CMS66



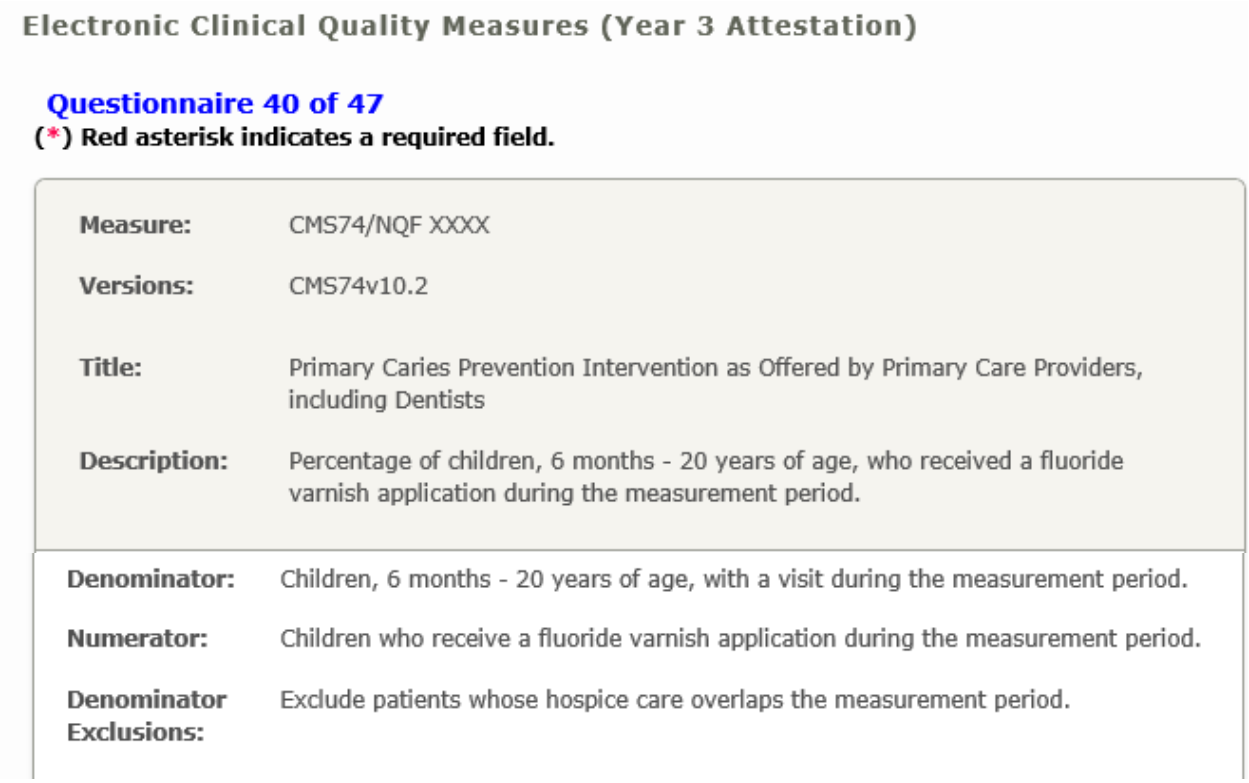


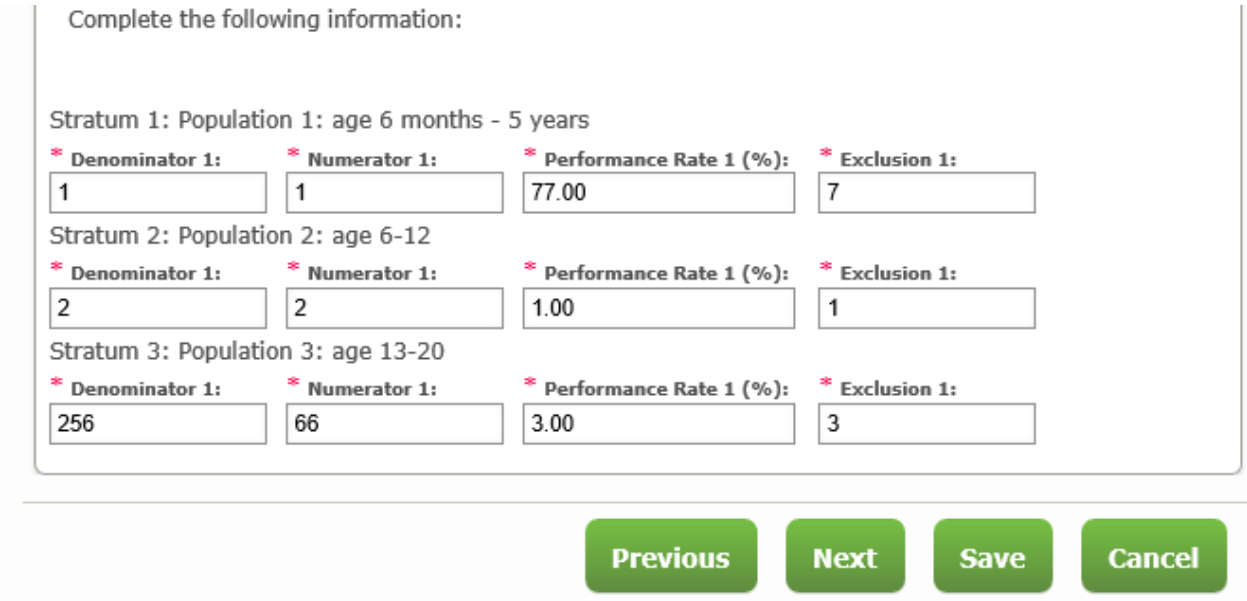
To satisfy this eCQM, enter a whole number into the Denominator, Numerator Performance Rate and Exclusion boxes.

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.

9.5.40 CMS74



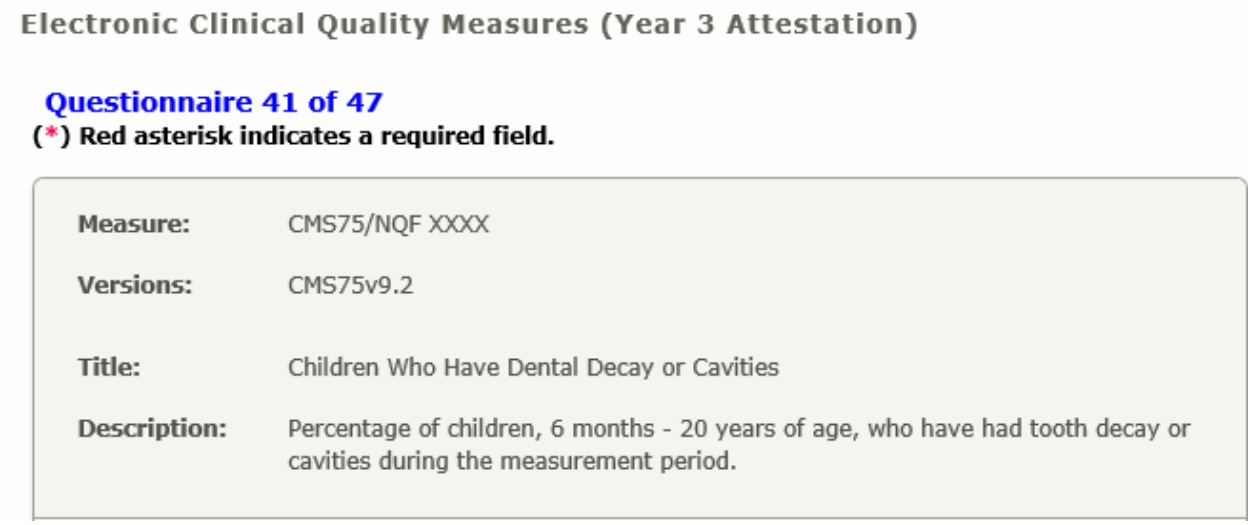


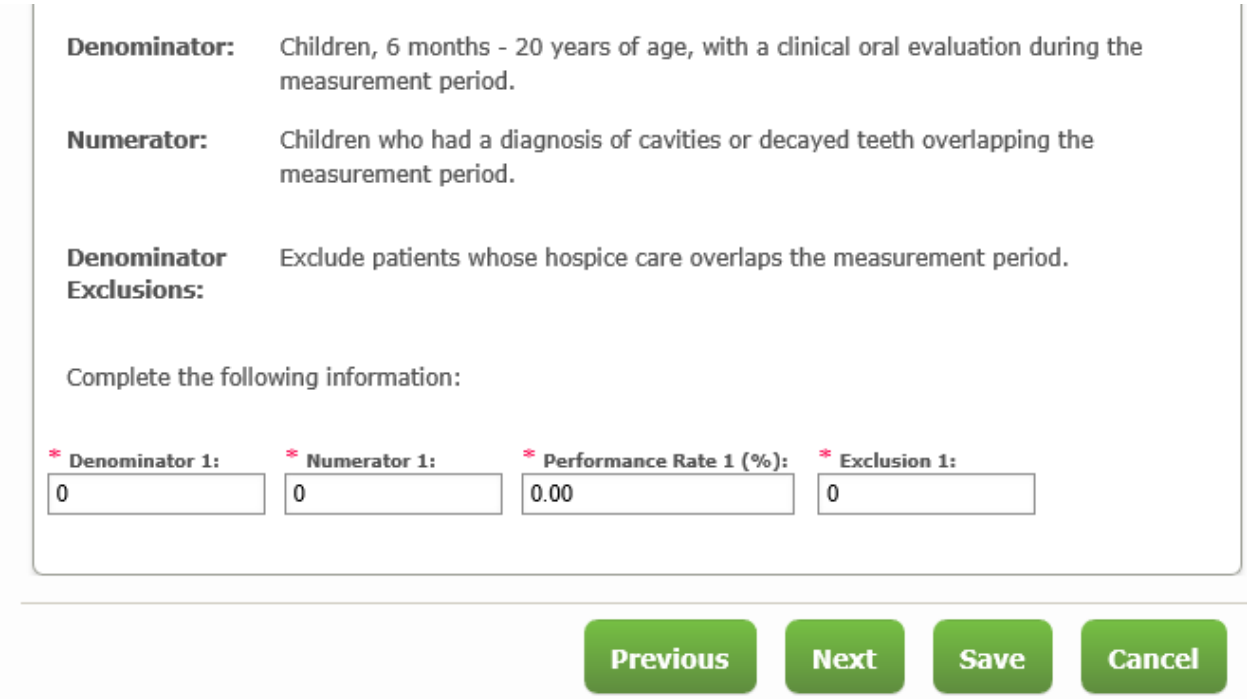
To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

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.

9.5.41 CMS75



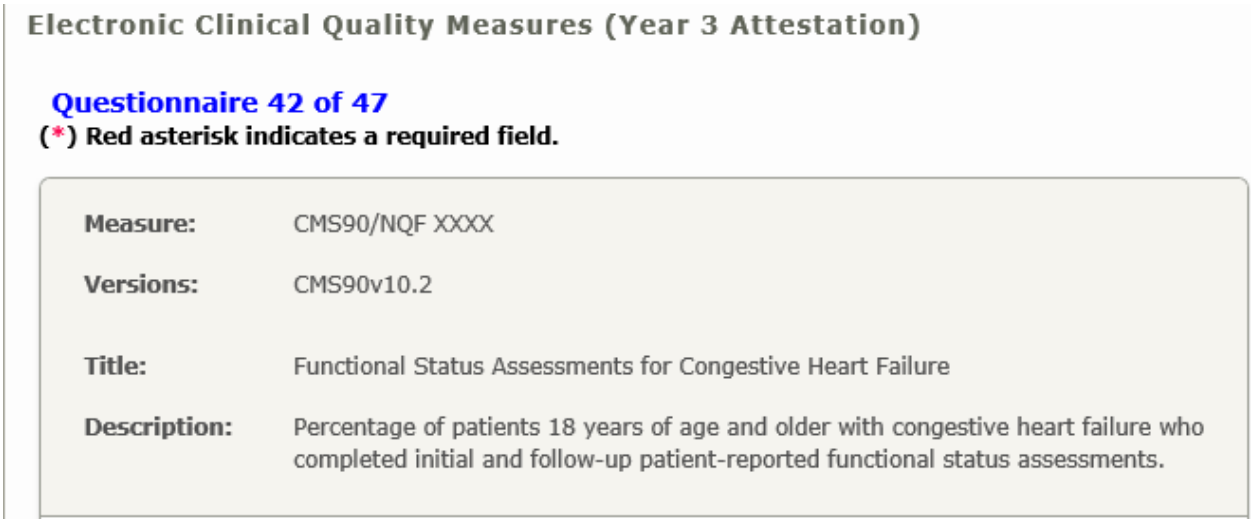


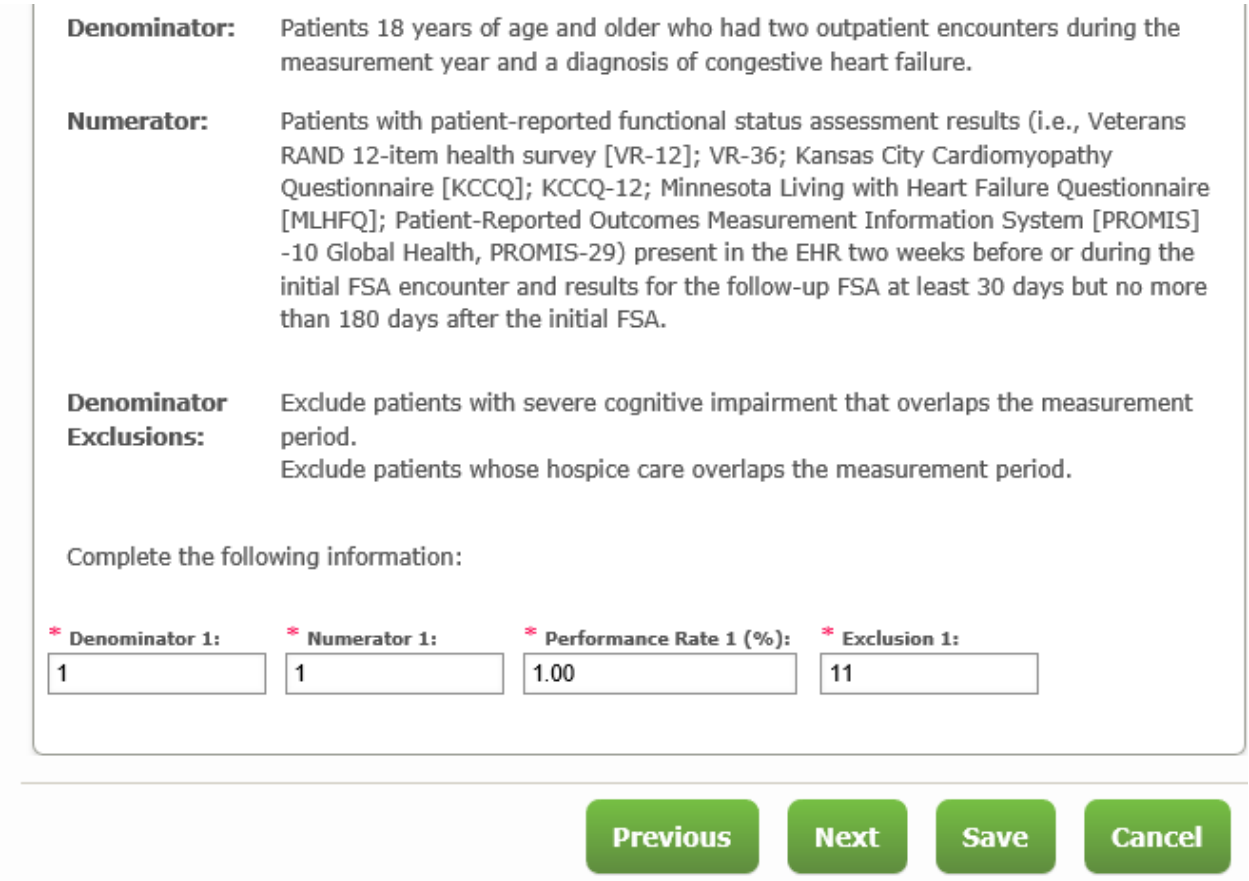
To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, and Exclusion boxes.

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.

9.5.42 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.

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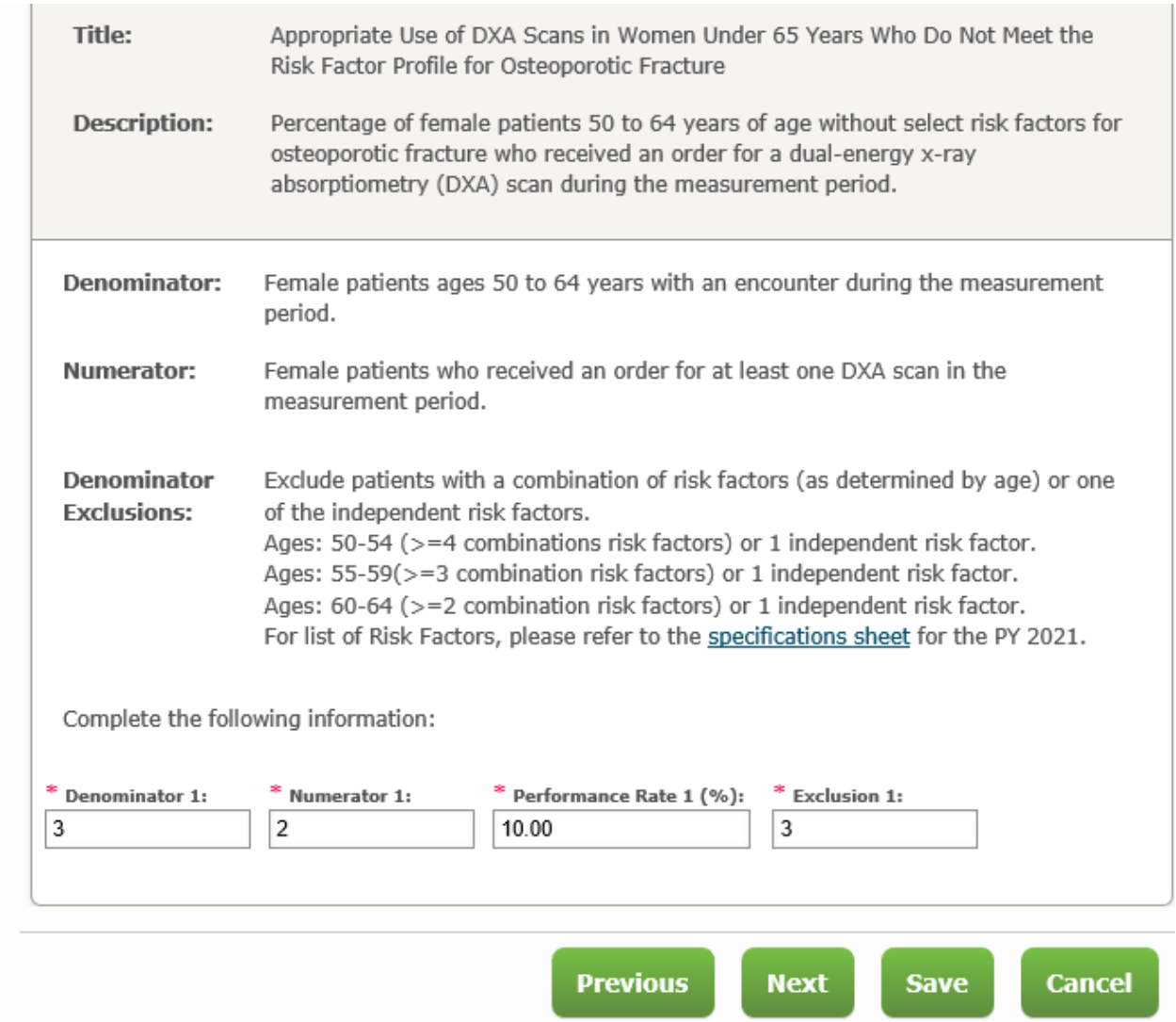
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

9.5.43 CMS249



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.
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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.

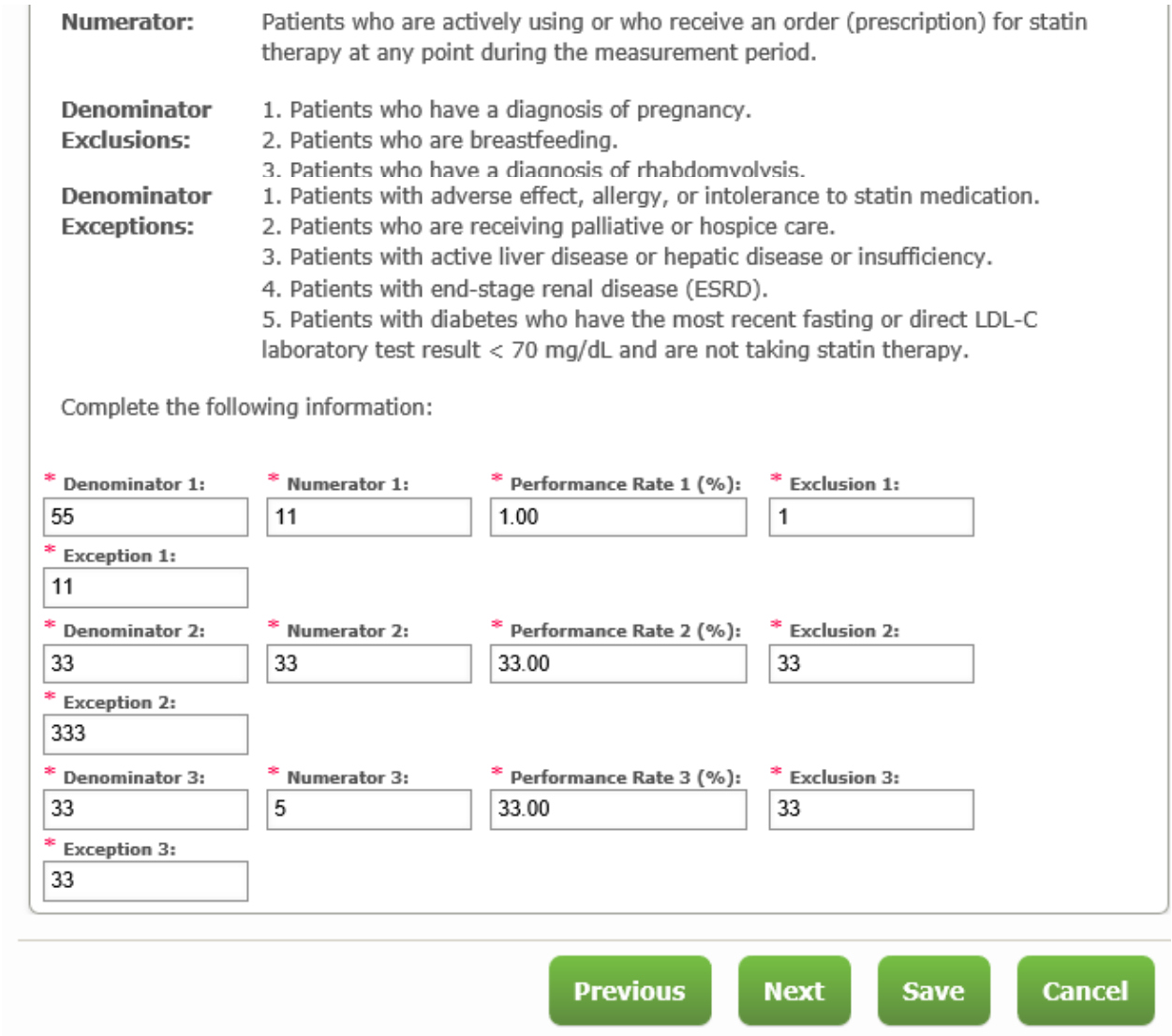
9.5.44 CMS347

Electronic Clinical Quality Measures (Year 3 Attestation)

Questionnaire 44 of 47

(*) Red asterisk indicates a required field.

Measure:	CMS347/NQF XXXX
Versions:	CMS347v4.3
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:	All patients who meet one or more of the following criteria (considered at "high risk" for cardiovascular events, under ACC/AHA guidelines): 1) Patients aged >= 21 years at the beginning of the measurement period with clinical ASCVD diagnosis. Denominator 2: 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: 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.

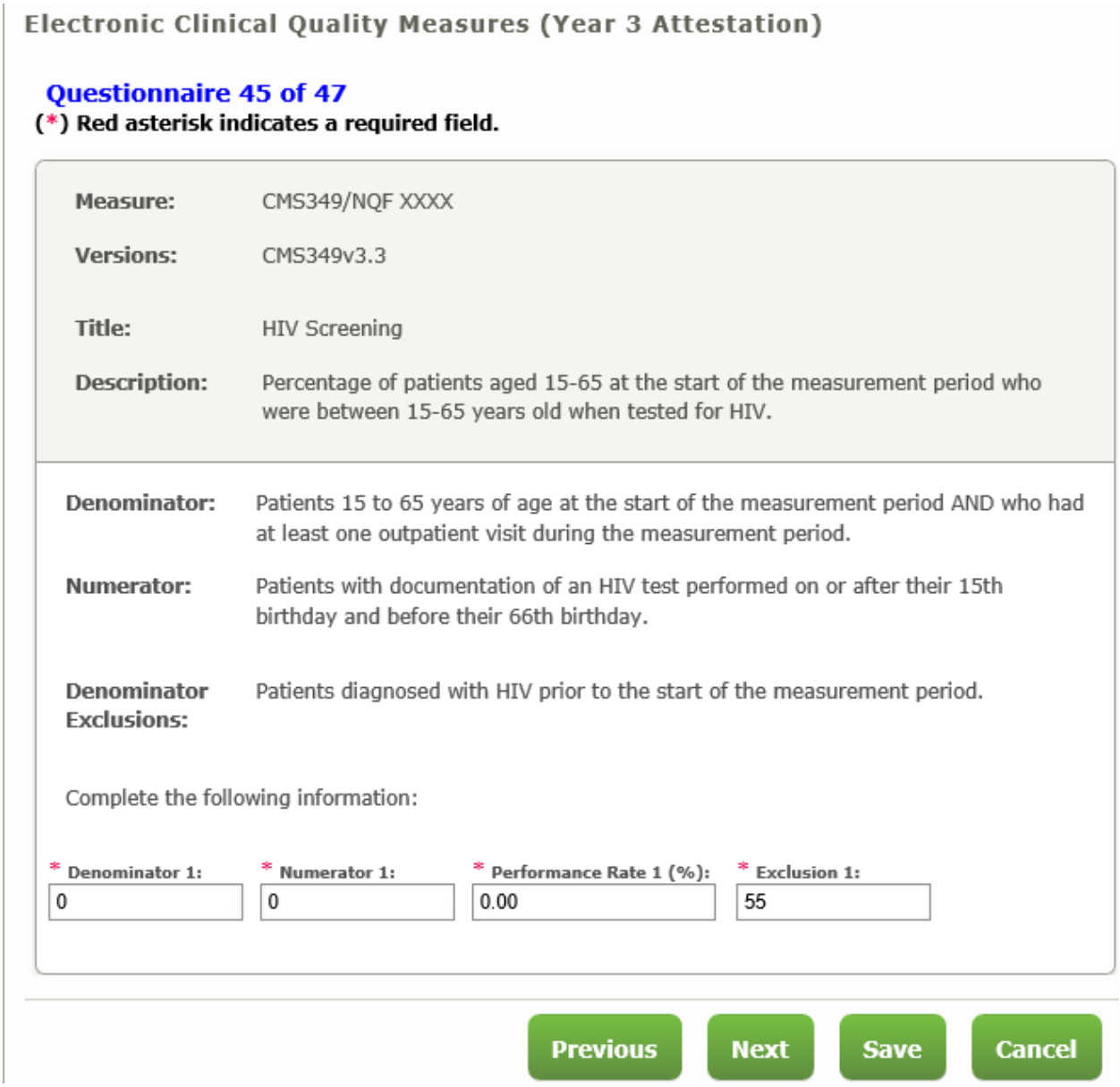


To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate, Exclusion, and Exception boxes.

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

- 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.

9.5.45 CMS349



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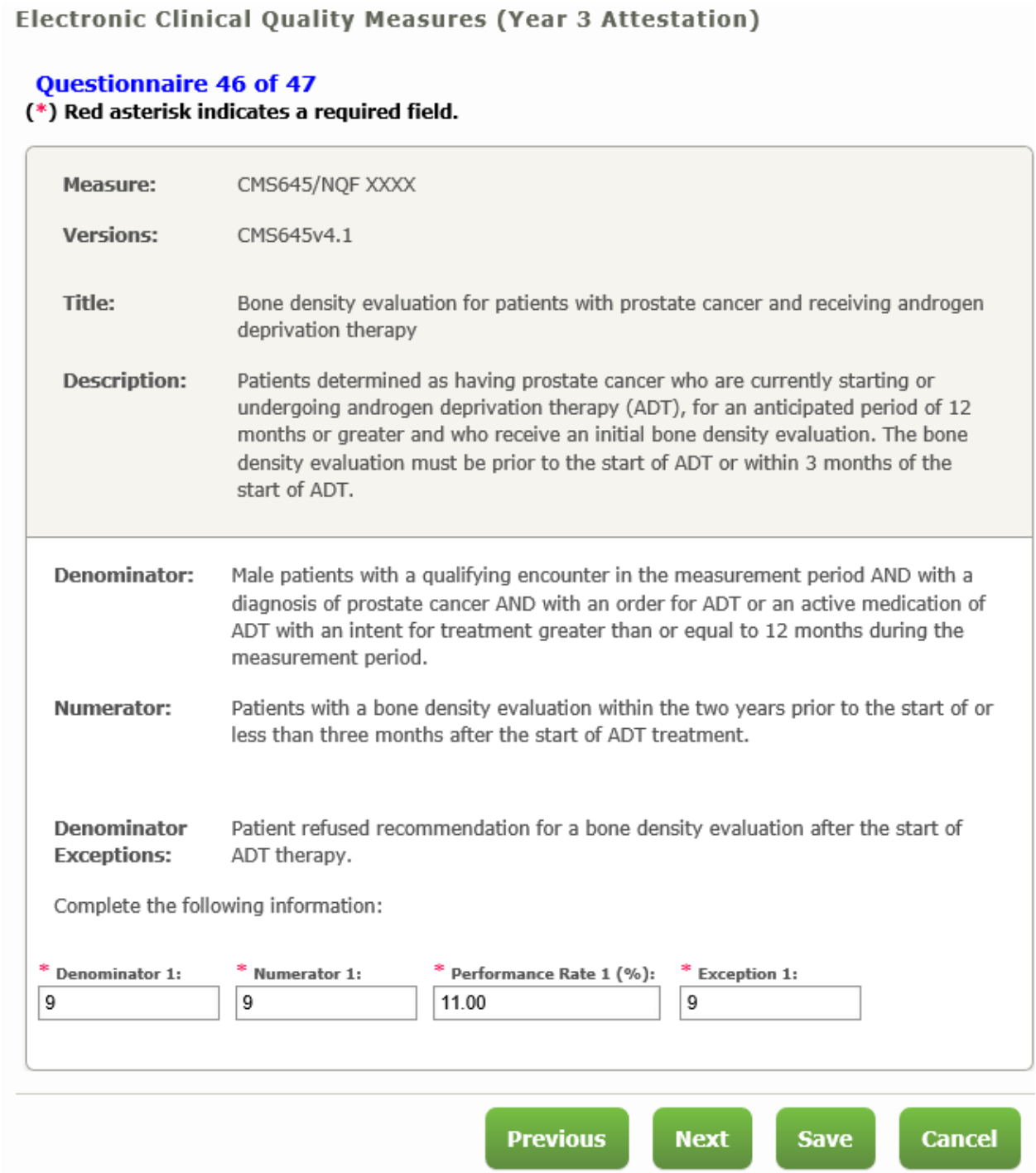
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

9.5.46 CMS645



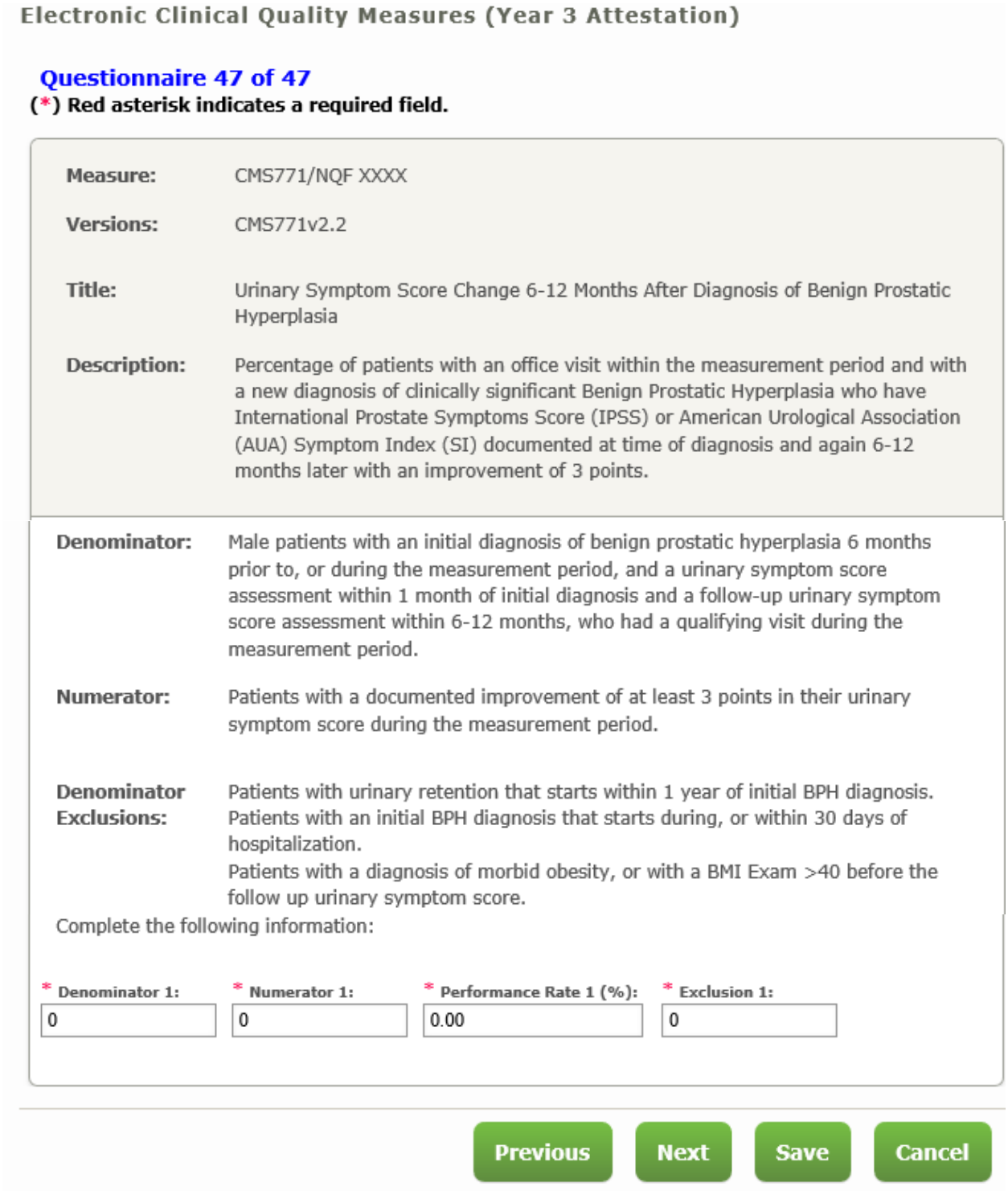
To satisfy this eCQM, enter a whole number into the Denominator, Numerator, Performance Rate and Exception boxes.

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.
- 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.

9.5.47 CMS771



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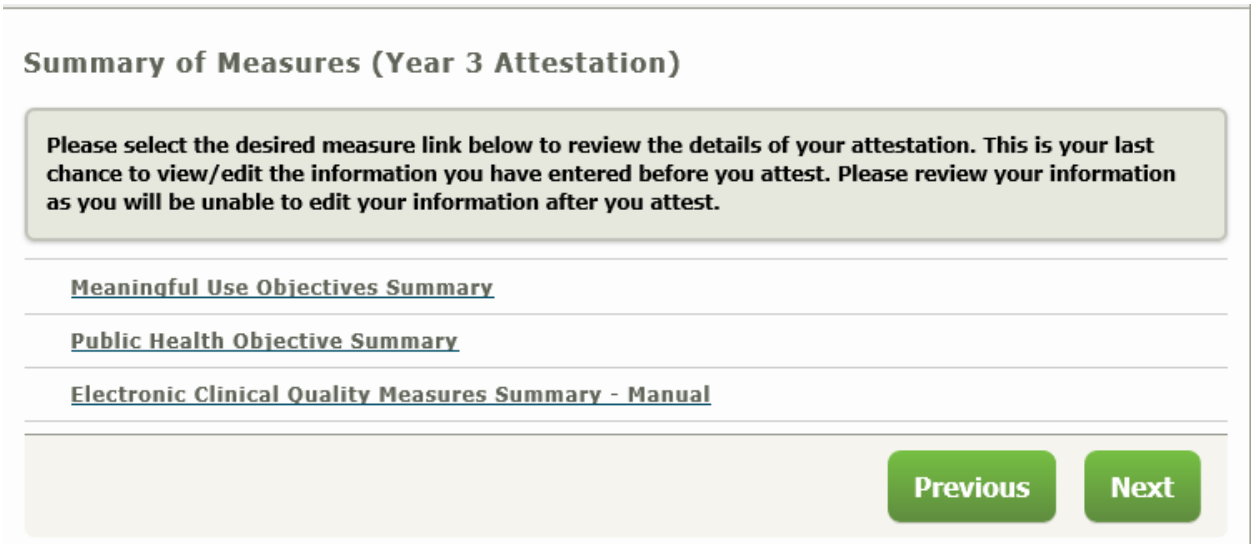
- Click **Next** to move on to the next screen. Selections will be saved.
- Click **Save** to save selections and stay on the current screen.
- Click **Cancel** to remove selections and stay on the current screen.

10 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.

10.1 Pre-Attestation Summary Screen

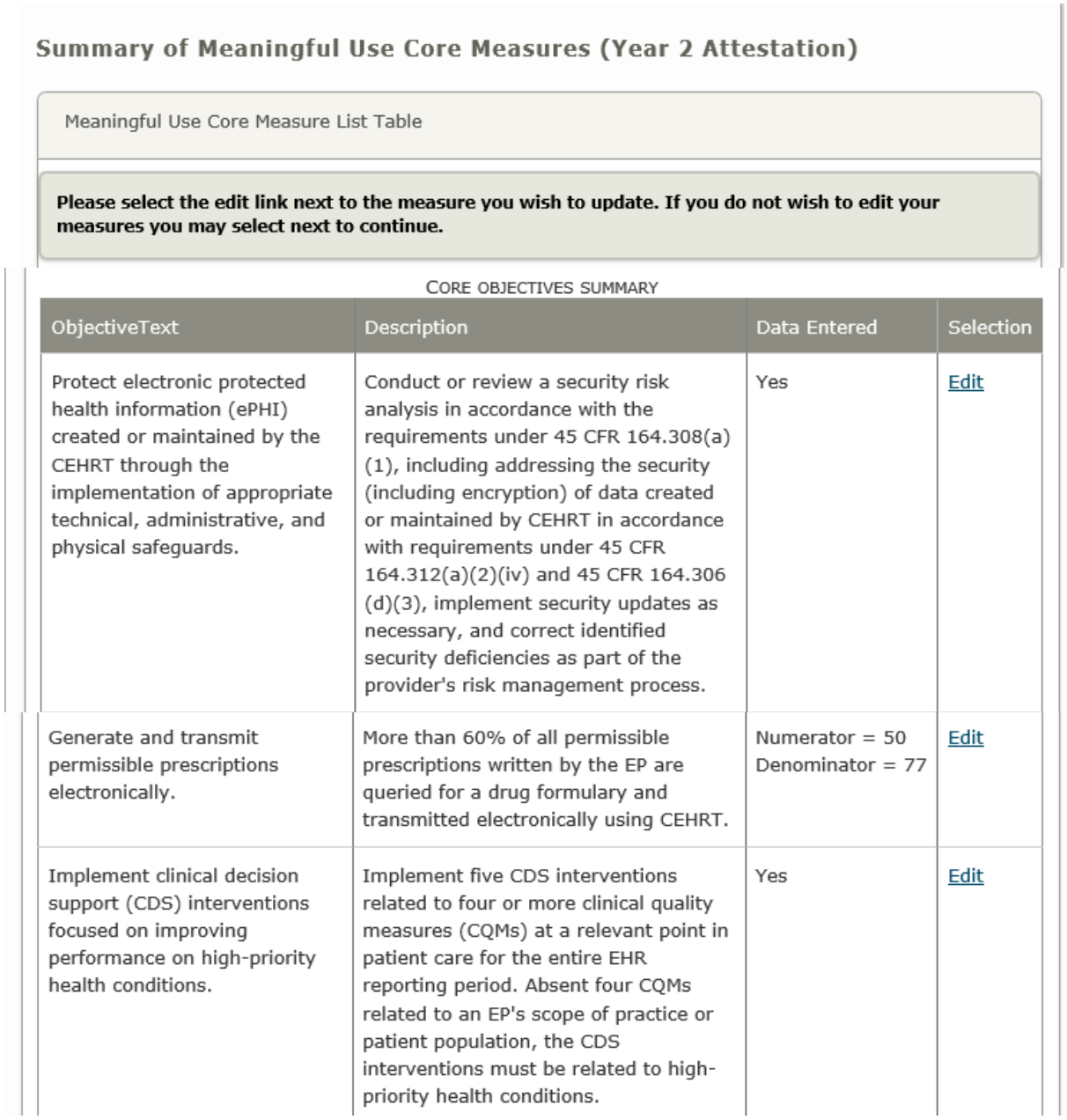


Click on a link to review the summary.

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.

10.1.1 Objectives Summary



Summary of Meaningful Use Core Measures (Year 2 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.

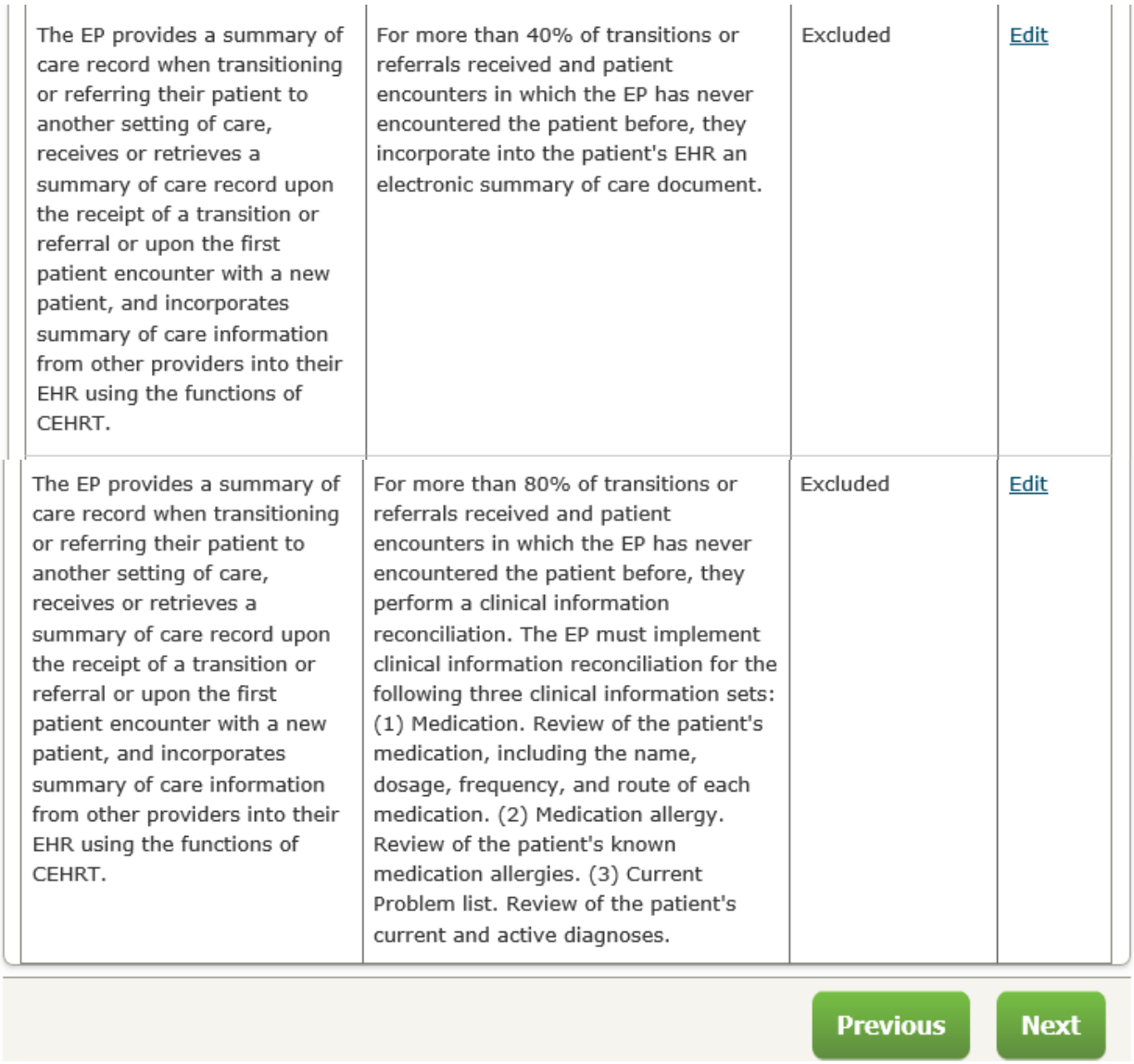
CORE OBJECTIVES SUMMARY

ObjectiveText	Description	Data Entered	Selection
Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306 (d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.	Yes	Edit
Generate and transmit permissible prescriptions electronically.	More than 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.	Numerator = 50 Denominator = 77	Edit
Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.	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 EP's scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.	Yes	Edit

Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.	Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	Yes	Edit
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.	More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	Numerator = 90 Denominator = 100	Edit
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.	More than 60% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	Numerator = 11110 Denominator = 11110	Edit

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.	More than 60% of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	Numerator = 100 Denominator = 100	Edit
The EP provides patients (or patient-authorized representatives) with timely electronic access to their health information and patient-specific education.	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 API in the provider's CEHRT.	Numerator = 90 Denominator = 90	Edit
The EP provides patients (or patient-authorized representatives) with timely electronic access to their health information and patient-specific education.	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.	Numerator = 4 Denominator = 4	Edit

Use CEHRT to engage with patients or their authorized representatives about the patient's care.	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 an 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).	Numerator = 30 Denominator = 30	Edit
Use CEHRT to engage with patients or their authorized representatives about the patient's care.	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.	Numerator = 70 Denominator = 100	Edit
Use CEHRT to engage with patients or their authorized representatives about the patient's care.	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.	Numerator = 90 Denominator = 100	Edit
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.	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.	Excluded	Edit



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.	For more than 40% of transitions or referrals received and patient encounters in which the EP has never encountered the patient before, they incorporate into the patient's EHR an electronic summary of care document.	Excluded	Edit
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.	For more than 80% of transitions or referrals received and patient encounters in which the EP has never encountered the patient before, they perform 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.	Excluded	Edit

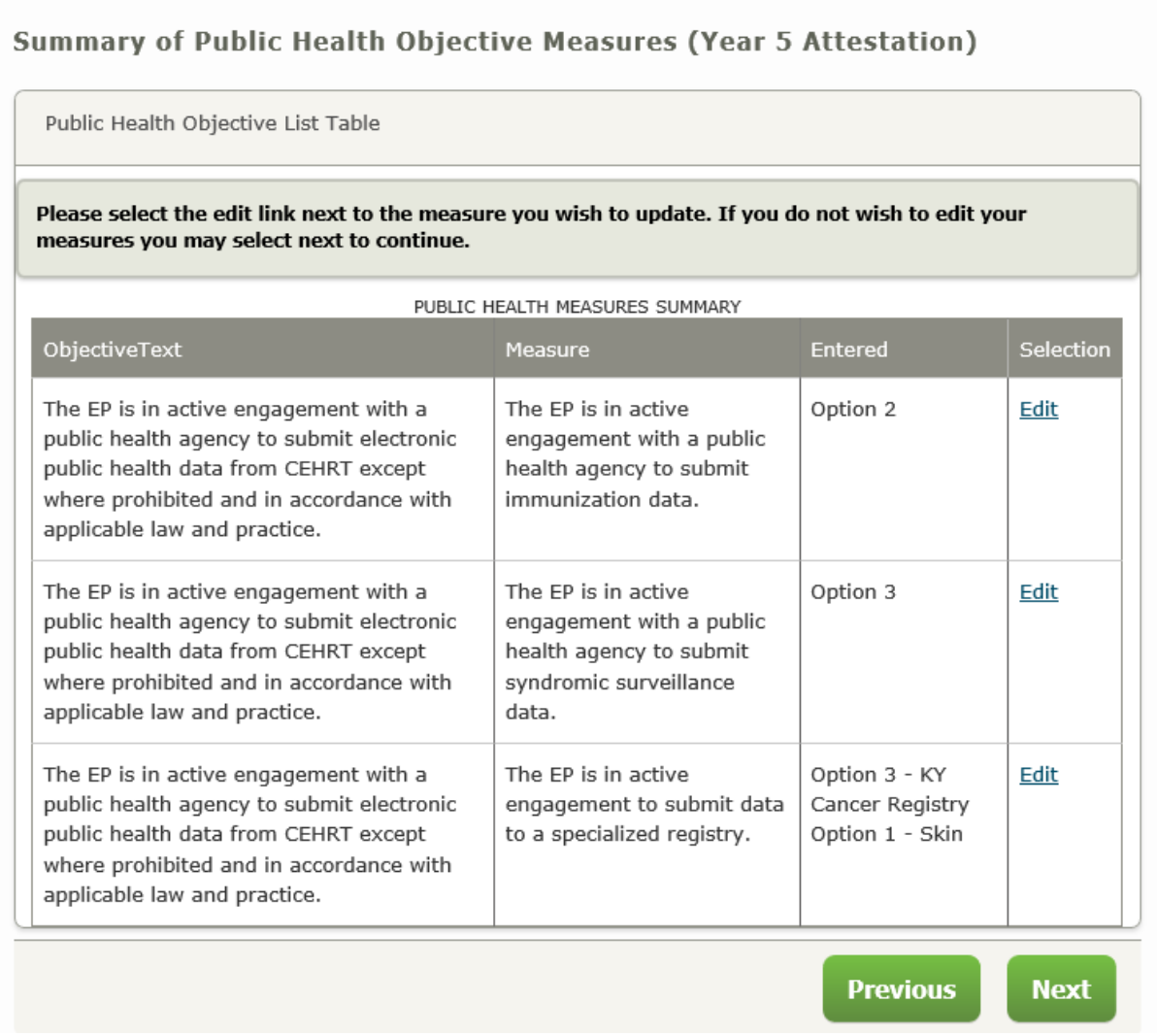
The Objectives Summary lists each MU Objective attested to, with responses.

- 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.

10.1.2 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.

10.1.3 Electronic Clinical Quality Measures Summary (Electronically Reported)

Electronic Clinical Quality Measures (Year 2 Attestation)

Electronic Clinical Quality Measures Summary Report

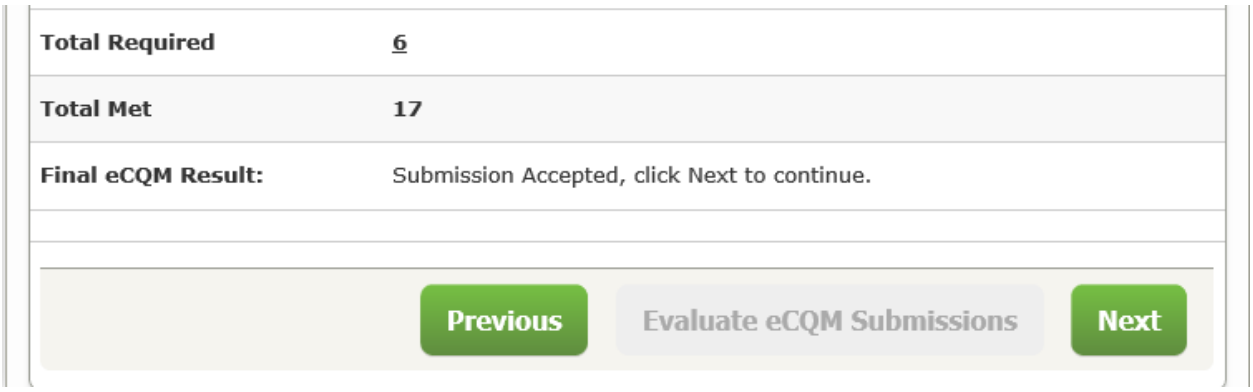
Date Received	Report NPI	Reporting Period Start	Reporting Period End
7/1/2020 1:01:24 PM	1851404065	3/1/2020 12:00:00 AM	6/22/2020 12:00:00 AM
Document Type	**eCQM Status:**	**Evaluated Date:**	
QRDA III	Accepted	7/1/2020 1:10:13 PM	
File Name:			
QRDA_XML2.xml, CPCSampleQRDA-III.xml			

QRDA_XML2_TESTFILE3.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

CPCSAMPLEQRDA-III.XML

Domain	# of Measures
Communication and Care Coordination	1
Community/Population Health	4
Effective Clinical Care	9
Efficiency and Cost Reduction	0
Patient Safety	2
Person and Caregiver-Centered Experience and Outcomes	0

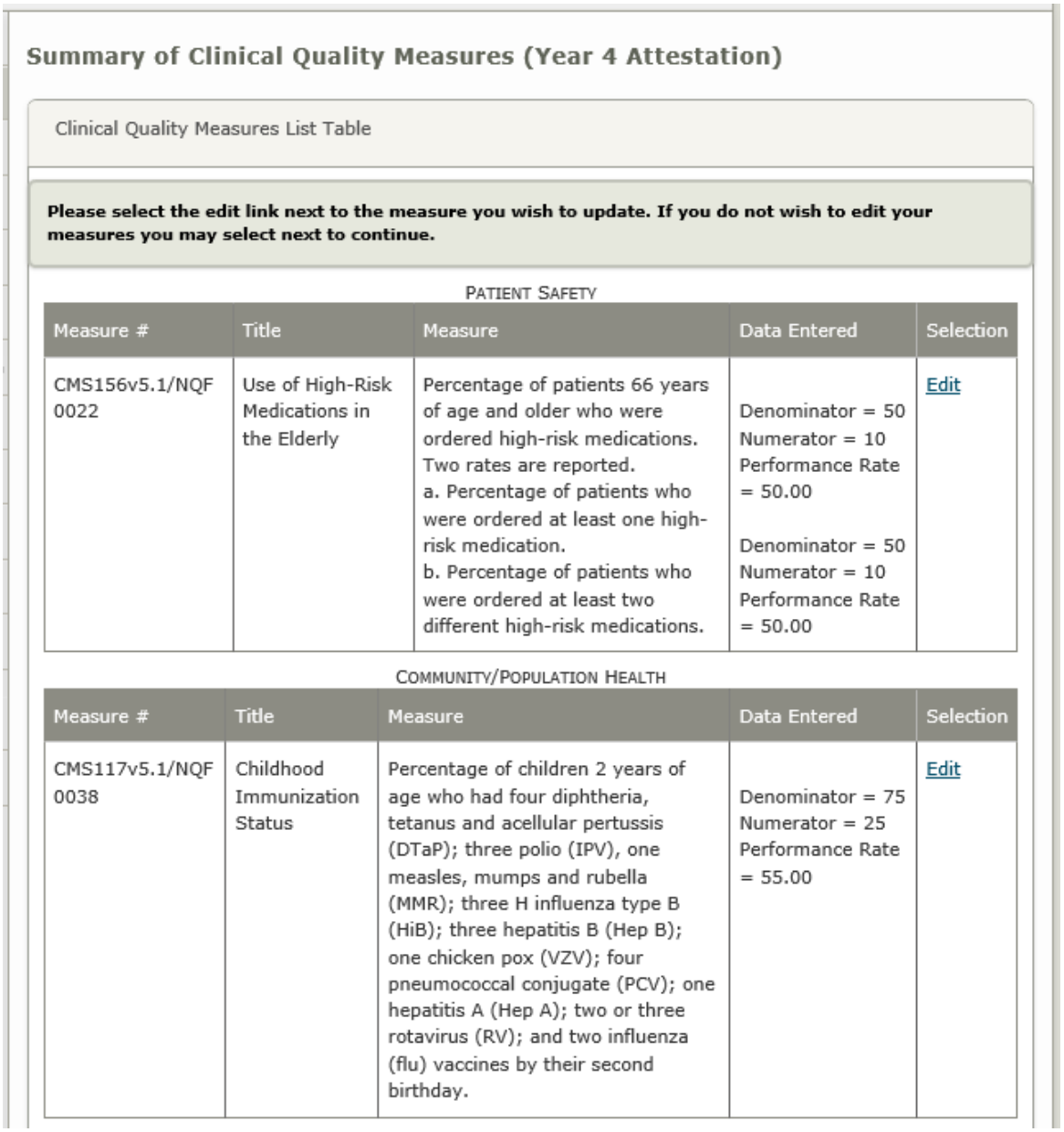


The Electronic Clinical Quality Measures Summary (Electronically Reported) lists each eCQM domain and number of measures attested to.

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.

10.1.4 Electronic Clinical Quality Measures Summary (Manually Reported)



Summary of Clinical Quality Measures (Year 4 Attestation)

Clinical Quality Measures List Table

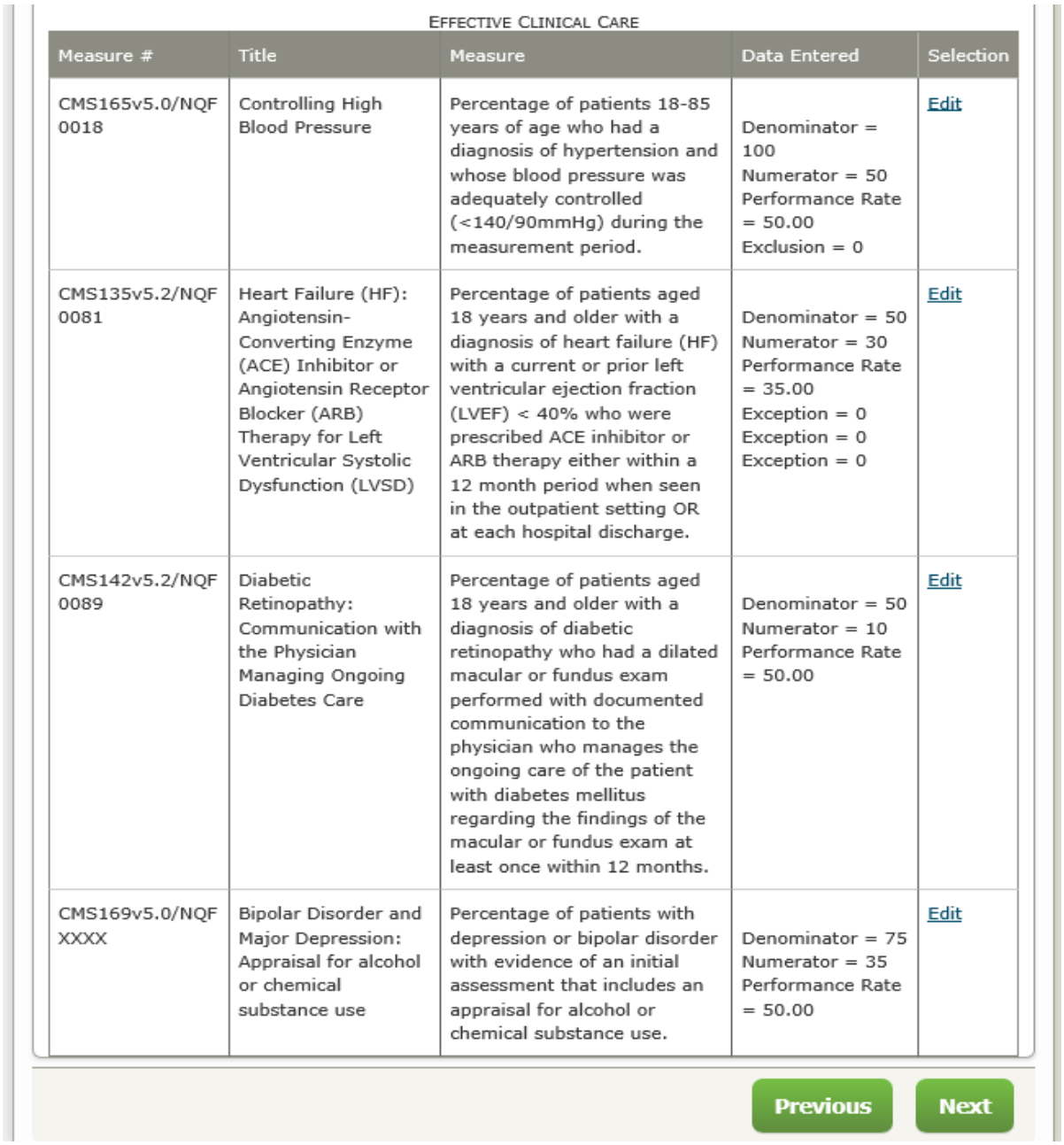
Please select the edit link next to the measure you wish to update. If you do not wish to edit your measures you may select next to continue.

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

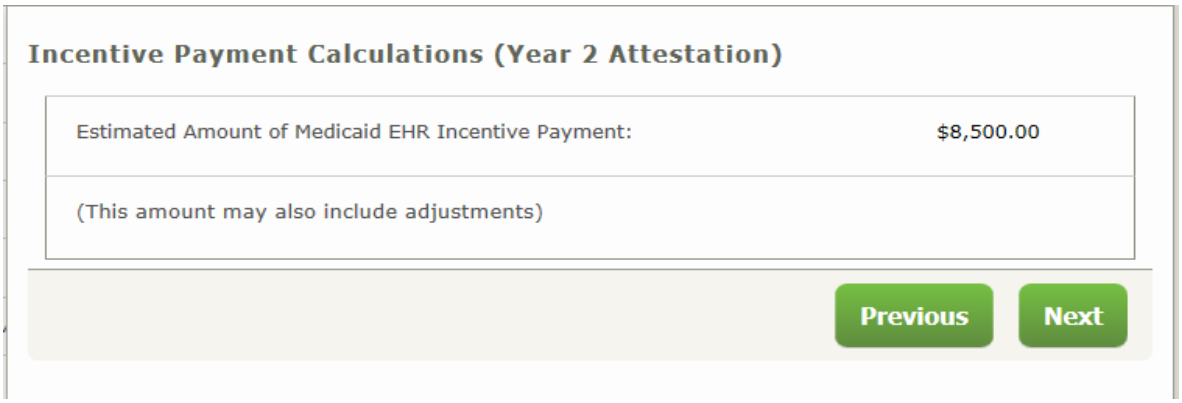
The Electronic Clinical Quality Measures Summary lists each eCQM attested to, with responses.

- 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.

10.2 Incentive Payment Calculation Screen

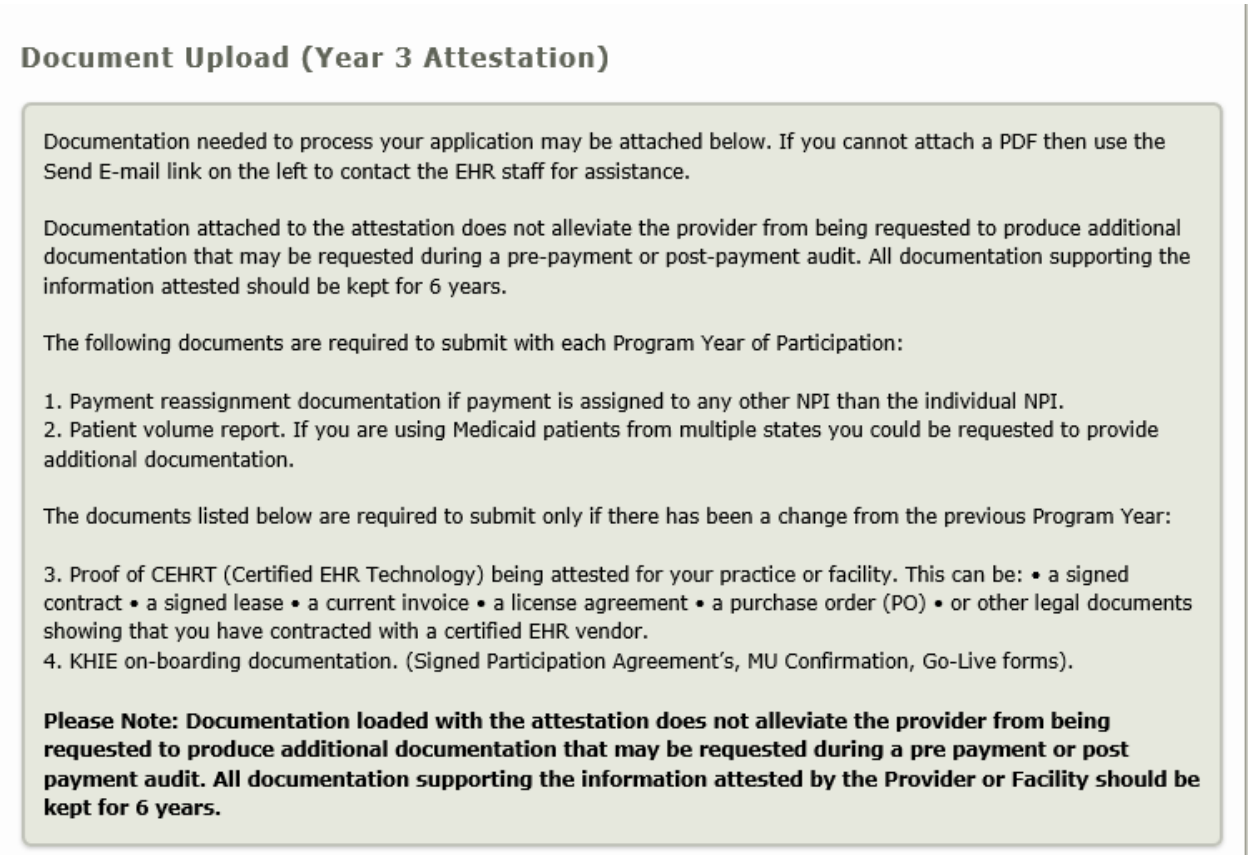


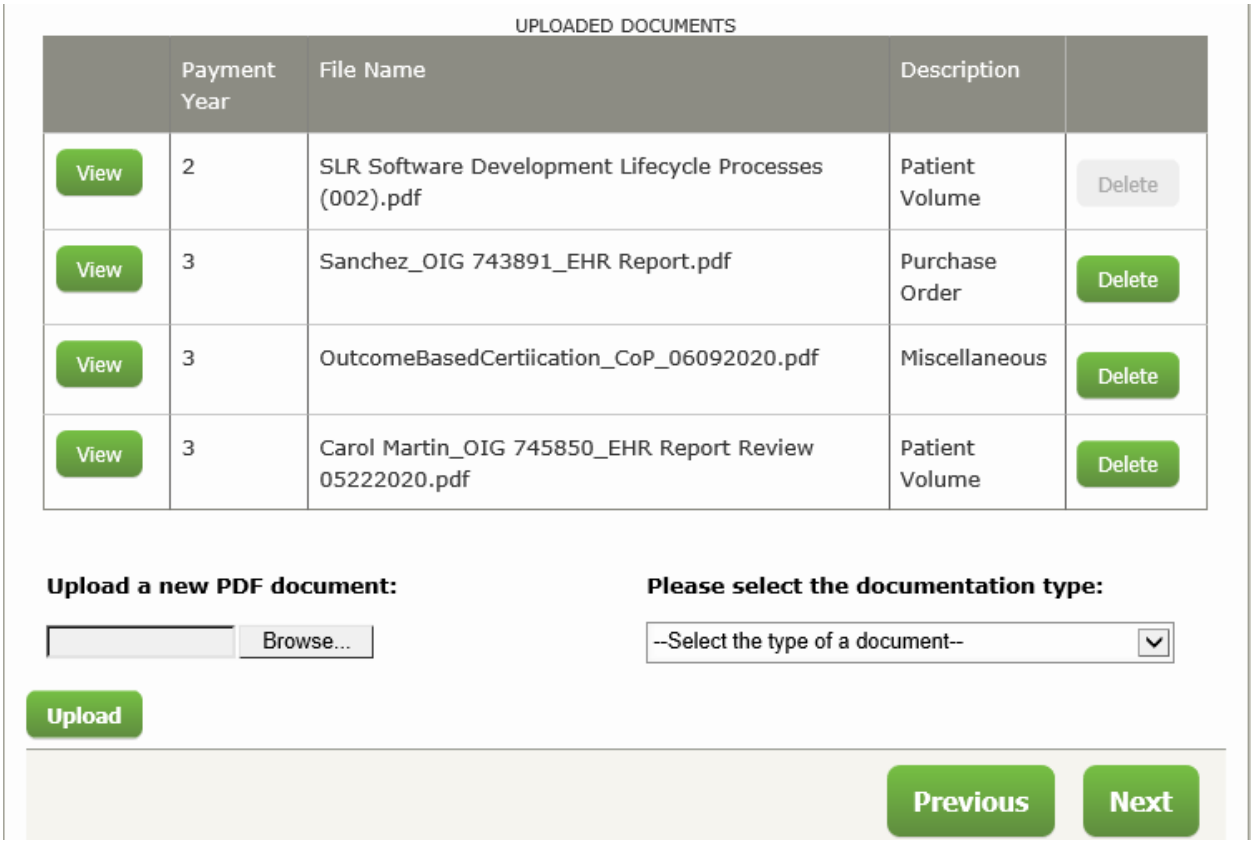
The Incentive Payment Calculation screen is view only and provides the estimated amount of Medicaid EHR incentive payment.

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.

10.3 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.)

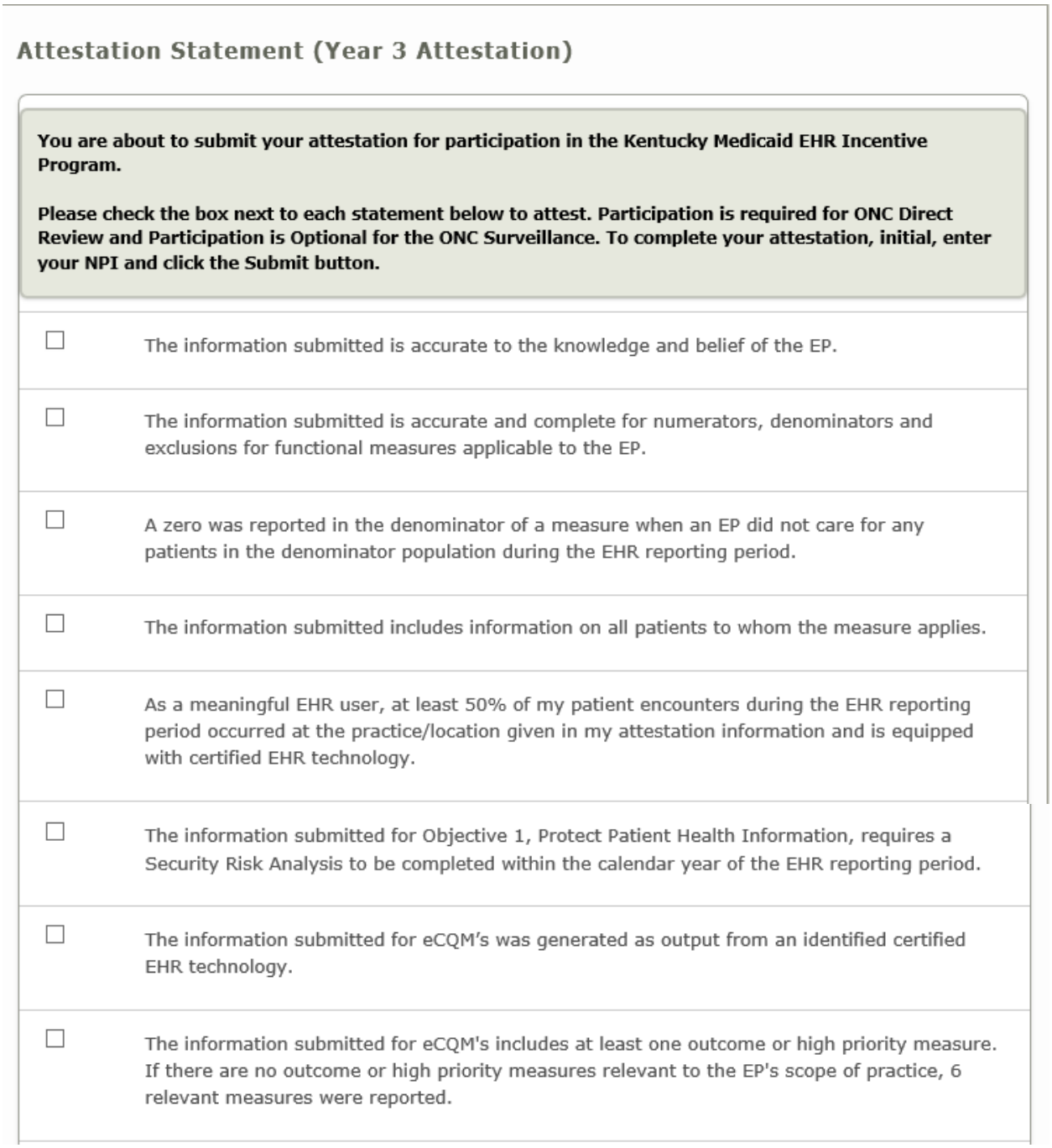
Upload PDF documents by following the below steps:

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

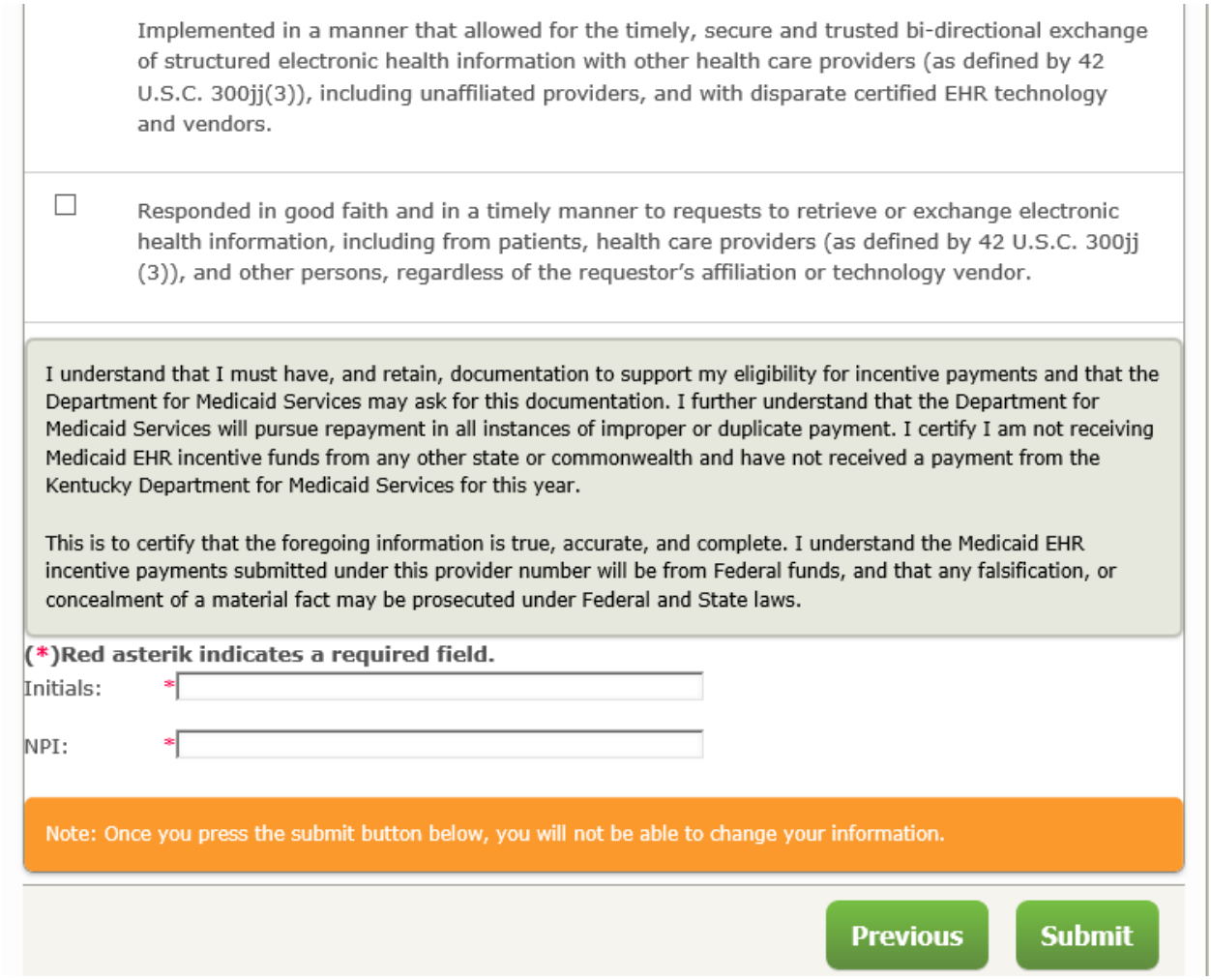
When final selections have been made, choose a navigation button at the bottom of the screen.

- 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.

10.4 Attestation Statement Screen



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

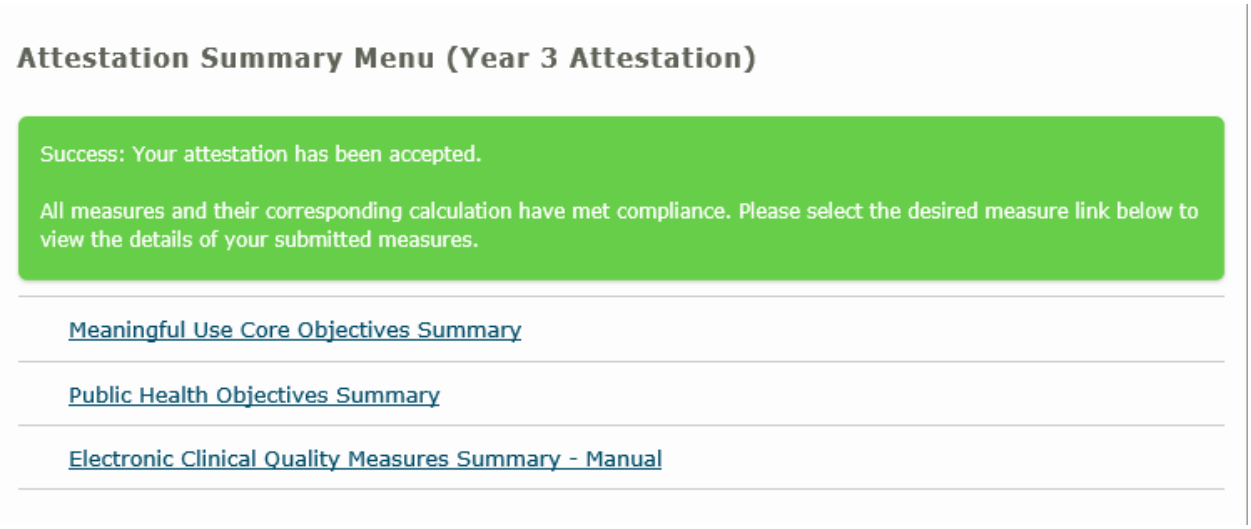


All boxes must be checked appropriately in order to submit the attestation. Enter initials and NPI to submit the attestation.

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.

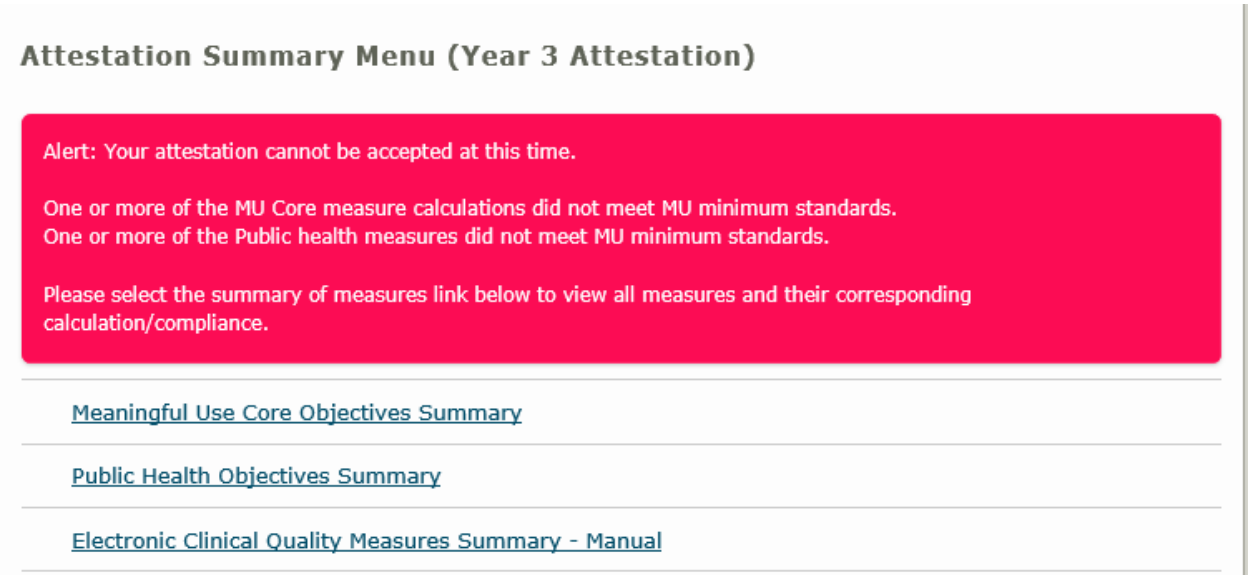
10.5 Accepted Attestation Screen



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

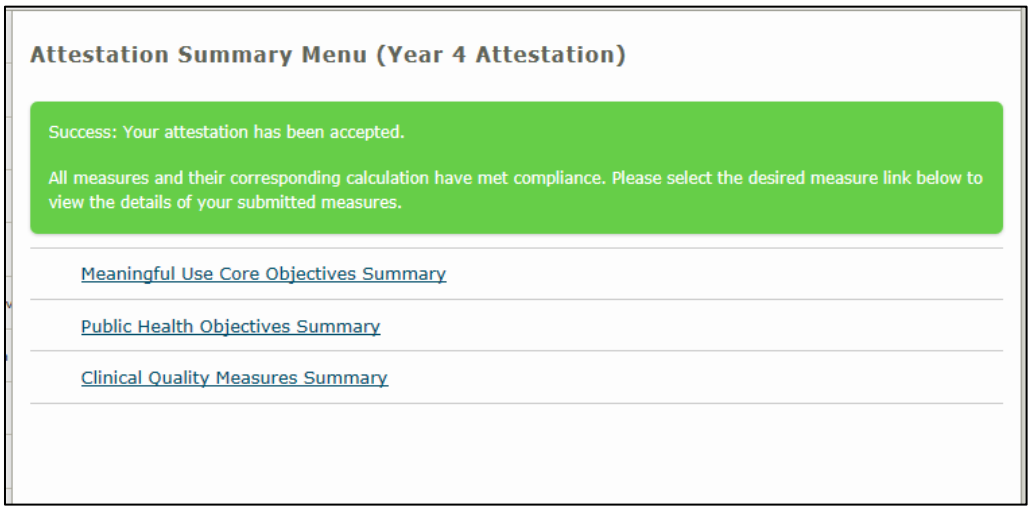
Click on the summary links to view the measure data that was submitted and accepted for attestation.

10.6 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.

10.7 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.

10.7.1 Objectives Summary

Meaningful Use Core Measure Summary (Year 3 Attestation)

CORE OBJECTIVES SUMMARY

Objective	Measure	Entered	Status
Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306 (d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.	Yes	Accepted
Generate and transmit permissible prescriptions electronically.	More than 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.	100%	Accepted

Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.	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 EP's scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.	Yes	Accepted
Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.	Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	Yes	Accepted
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.	More than 60% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	60%	Accepted
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.	More than 60% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	60%	Accepted

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.	More than 60% of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.	60%	Accepted
The EP provides patients (or patient-authorized representatives) with timely electronic access to their health information and patient-specific education.	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 API in the provider's CEHRT.	Excluded 2	Accepted
The EP provides patients (or patient-authorized representatives) with timely electronic access to their health information and patient-specific education.	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.	Excluded 2	Accepted
Use CEHRT to engage with patients or their authorized representatives about the patient's care.	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 an 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).	5%	Accepted

Use CEHRT to engage with patients or their authorized representatives about the patient's care.	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.	5%	Accepted
Use CEHRT to engage with patients or their authorized representatives about the patient's care.	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.	4%	N/A
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.	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.	100%	Accepted
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.	For more than 40% of transitions or referrals received and patient encounters in which the EP has never encountered the patient before, they incorporate into the patient's EHR an electronic summary of care document.	100%	Accepted

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.	For more than 80% of transitions or referrals received and patient encounters in which the EP has never encountered the patient before, they perform 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.	80%	Accepted

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10.7.2 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

Return to Menu

10.7.3 Electronic Clinical Quality Measures Summary (Electronically Reported)

Electronic Clinical Quality Measures (Year 2 Attestation)

Electronic Clinical Quality Measures Summary Report

Date Received	Report NPI	Reporting Period Start	Reporting Period End
7/1/2020 1:01:24 PM	1851404065	3/1/2020 12:00:00 AM	6/22/2020 12:00:00 AM
Document Type	**eCQM Status:**	**Evaluated Date:**	
QRDA III	Accepted	7/1/2020 1:10:13 PM	
File Name:			
QRDA_XML2.xml, CPCSampleQRDA-III.xml			

QRDA_XML2_TESTFILE3.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

CPCSAMPLEQRDA-III.XML

Domain	# of Measures
Communication and Care Coordination	1
Community/Population Health	4
Effective Clinical Care	9
Efficiency and Cost Reduction	0
Patient Safety	2
Person and Caregiver-Centered Experience and Outcomes	0

Total Required	**6**
Total Met	**17**
Final eCQM Result:	Submission Accepted.

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10.7.4 Electronic Clinical Quality Measures Summary (Manually Reported)

Meaningful Use Electronic Clinical Quality Measures Summary (Year 3 Attestation)

Summary of Electronic 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
Functional Status Assessment for Total Hip Replacement	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.	Accepted
Functional Status Assessment for Total Knee Replacement	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.	Accepted
Functional Status Assessments for Congestive Heart Failure	Percentage of patients 18 years of age and older with congestive heart failure who completed initial and follow-up patient-reported functional status assessments.	Accepted
Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	Percentage of patients with an office visit within the measurement period and with a new diagnosis of clinically significant Benign Prostatic Hyperplasia who have International Prostate Symptoms Score (IPSS) or American Urological Association (AUA) Symptom Index (SI) documented at time of diagnosis and again 6-12 months later with an improvement of 3 points.	Accepted

PATIENT SAFETY

Title	Description	Status
Use of High-Risk Medications in the Older Adults	Percentage of patients 65 years of age and older who were ordered at least two of the same high-risk medications.	Accepted
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
Documentation of Current Medications in the Medical Record	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.	Accepted
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Accepted

COMMUNICATION AND CARE COORDINATION

Title	Description	Status
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.	Accepted
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
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. - Percentage of patients with height, weight, and body mass index (BMI) percentile documentation. - Percentage of patients with counseling for nutrition. - Percentage of patients with counseling for physical activity.	Accepted
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 12 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 12 months. b. Percentage of patients aged 18 years and older who were 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 12 months AND who received tobacco cessation intervention if identified as a tobacco user.	Accepted

Chlamydia Screening for Women	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	Accepted
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 or four 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.	Accepted
Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Accepted
Pneumococcal Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	Accepted
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to 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 eligible encounter.	Accepted
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if most recent BMI was outside of normal parameters.	Accepted
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is pre-hypertensive or hypertensive.	Accepted
Children Who Have Dental Decay or Cavities	Percentage of children, 6 months - 20 years of age, who have had tooth decay or cavities during the measurement period.	Accepted
HIV Screening	Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV.	Accepted

EFFICIENCY AND COST REDUCTION

Title	Description	Status
Appropriate Testing for Pharyngitis	The percentage of episodes for patients 3 years and older with a diagnosis of pharyngitis that resulted in an antibiotic dispensing event and a group A streptococcus (strep) test.	Accepted
Appropriate Treatment for Upper Respiratory Infection (URI)	Percentage of episodes for patients 3 months of age and older with a diagnosis of upper respiratory infection (URI) that did not result in an antibiotic dispensing event.	Accepted

Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low (or very low) risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	Accepted
Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture	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.	Accepted

EFFECTIVE CLINICAL CARE

Title	Description	Status
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of patients 13 years of age and older with a new episode of alcohol or other drug abuse or (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment including either an intervention or medication for the treatment of AOD abuse or dependence within 14 days of the diagnosis. b. Percentage of patients who engaged in ongoing treatment including two additional interventions or a medication for the treatment of AOD abuse or dependence within 34 days of the initiation visit. For patients who initiated treatment with a medication, at least one of the two engagement events must be a treatment intervention.	Accepted
Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period or the year prior to the measurement period, and whose most recent blood pressure was adequately controlled (< 140/90mmHg) during the measurement period.	Accepted
Cervical Cancer Screening	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 within the last 3 years. * Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years.	Accepted
Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Accepted
Diabetes: Eye Exam	Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.	Accepted

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Accepted
Diabetes: Medical Attention for Nephropathy	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.	Accepted
Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12-month period who also have a prior MI or a current or prior LVEF < 40% who were prescribed beta-blocker therapy.	Accepted
Heart Failure (HF): ACE Inhibitor or ARB or ARNI 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 or ARNI therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Accepted
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting OR at each hospital discharge.	Accepted
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months.	Accepted
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	All patient visits during which a new diagnosis of MDD or new diagnosis of recurrent MDD was identified for patients aged 18 years and older with a suicide risk assessment completed during the visit.	Accepted
Anti-depressant Medication Management	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).	Accepted
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	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.	Accepted

Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Percentage of cataract surgeries for patients aged 18 and older with a diagnosis of uncomplicated cataract and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved in the operative eye within 90 days following the cataract surgery.	Accepted
Depression Remission at Twelve Months	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.	Accepted
Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the Measurement Period.	Accepted
Dementia: Cognitive Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12-month period.	Accepted
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	Percentage of children, 6 months - 20 years of age, who received a fluoride varnish application during the measurement period.	Accepted
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: *Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR *Adults aged >= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR *Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.	Accepted
Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy	Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.	Accepted

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10.8 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.

A certificate of completion will be emailed once payment is processed for your sixth year 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.

CMS released the 2018 Quality Payment Program (QPP) Experience Report to provide insights into participation during the 2018 performance year. The report includes data regarding participation and performance in the MIPS and APMs tracks of QPP during the 2018 performance year. Key 2018 findings include:

- 98% of MIPS eligible clinicians participated in the program and avoided a negative payment adjustment, a one-year increase of 3 percentage points.
- 84% of clinicians earned an “exceptional performance” designation by earning 70 points or more.
- 356,353 MIPS eligible clinicians participated in MIPS through a MIPS APM, a 15,000-clinician increase from the 2017 performance year.
- The number of clinicians achieving Qualifying APM Participant (QP) status nearly doubled in one year, from 99,076 to 183,306 clinicians. This, along with the increase in MIPS APM participation, indicates a desire from clinicians and practices to transition toward value-based arrangements.
- 84% of small practices earned a positive payment adjustment, up 10 percentage points from the year prior.
- The percentage of rural practices earning a positive payment adjustment increased from 93% in 2017 to 97% in 2018.

For more information contact the Quality Payment Program at 1-866-288-8292 or by email at: qpp@cms.hhs.gov.