



IDAHO DEPARTMENT OF

HEALTH & WELFARE

Division of Medicaid



EHR Incentive Programs
A program of the Centers for Medicare & Medicaid Services

Eligible Professional User Manual

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Document Change Log

Date	Changed By	Change
09/10/12	Wheaton	Creation
10/01/14	Kinne / Kellerman	Added Flexibility Rule information.
01/01/15	Kinne / Kellerman	Corrected screenshots which were outdated and added data flow charts of IIMS.
09/15/15	Coyle	Update of information, removal of screenshots, add links.
04/01/16	Coyle, Leavitt, Brewington	Inclusion of 2015 Modification Rule, modified screens, mandatory documents, and changes to dates.

Acronyms

AIU	–	Adopt, Implement, Upgrade
ALOS	–	Average Length of Stay
ARRA	–	American Recovery and Reinvestment Act of 2009
ATCB	–	Authorized Testing and Certification Body
BMI	–	Body Mass Index
BP	–	Blood Pressure
CAH	–	Critical Access Hospital
CAHPS	–	Consumer Assessment of Healthcare Providers and Systems
CCHIT	–	Certification Commission for Health Information Technology
CCN	–	CMS Certification Number
CEHRT	–	Certified Electronic Health Record Technology
CHIP	–	Children’s Health Insurance Plan
CHIPRA	–	Children’s Health Insurance Plan Reauthorization Act of 2009
CHPL	–	Certified HIT Product List
CMS	–	Center for Medicare and Medicaid Services
CNM	–	Certified Nurse Midwife
CPOE	–	Computer Process Order Entry
CQM	–	Clinical Quality Measure
CY	–	Calendar Year
DHHS	–	Department of Health and Human Services
ED	–	Emergency Department
EH	–	Eligible Hospital
EHR	–	Electronic Health Record
EIN	–	Employer Identification Number
EMR	–	Electronic Medical Record
EP	–	Eligible Professional
eRX	–	Electronic Prescribing
FEIN	–	Federal Employer Identification Number
FFY	–	Federal Fiscal Year
FQHC	–	Federally Qualified Health Center
HHS	–	Department of Health and Human Services
HIE	–	Health Information Exchange
HIO	–	Health Information Organization

- HIPAA – Health Insurance Portability and Accountability Act of 1996
- HIT – Health Information Technology
- HITECH – Health Information Technology for Economic and Clinical Health
- IAPD – Implementation Advanced Planning Document
- IDHW – Idaho Department of Health and Welfare
- IIMS – Idaho Incentive Management System
- IHC – Indian Health Clinic
- IHS – Indian Health Services
- IPA – Independent Practice Association
- IPPS – Inpatient Prospective Payment System
- IT – Information Technology
- MMIS – Medicaid Management Information System
- MU – Meaningful Use
- NHIN – National Health Information Network
- NP – Nurse Practitioner
- NPI – National Provider Identifier
- NPRM – Notice of Proposed Rule Making
- OIG – Office of the Inspector General
- ONC – Office of the National Coordinator
- PA – Physician Assistant
- PAPD – Planning Advanced Planning Document
- PCA – Program Cost Account
- PHR – Personal Health Record
- PV – Patient Volume
- RA – Remittance Advice
- RHC – Rural Health Center
- RHIO – Regional Health Information Organization
- RNA – Registered Nurse Anesthetist
- SFY – State Fiscal Year
- SMHP – State Medicaid HIT Plan
- TIN – Tax Identification Number

Business Links

CMS EHR Incentives Registration and Attestation System

<https://ehrincentives.cms.gov/hitech/login.action>

CMS EHR Incentive Program FAQ

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/FAQ.html>

CMS EHR Incentive Program Regulations and Guidance

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/>

CMS HITECH TA Portal

<https://www.medicaidhitechta.org/>

ONC CHPL

<http://www.healthit.gov/policy-researchers-implementers/certified-health-it-product-list-chpl>

Idaho Medicaid EHR Incentive Program

<https://healthandwelfare.idaho.gov/default.aspx?TabId=1405>

Idaho Medicaid EHR Incentive Program FAQ

<https://healthandwelfare.idaho.gov/default.aspx?TabId=1405>

Idaho Incentive Management System

<https://iims.dhw.idaho.gov/login.aspx>

Idaho Medicaid EHR Incentive Program Staff

ehrincentives@dhw.idaho.gov

(208) 332-7989

Purpose, Introduction, and Overview

The purpose of this document is to provide EPs with a reference guide and a training tool for new staff. Additionally this document gives an overview of the Idaho Medicaid EHR Incentive Program, what needs to be done to receive payment, and step-by-step enrollment and attestation instructions.

Through provisions of ARRA, CMS implemented incentive payments to EPs participating in Medicare and Medicaid programs and are meaningful users of CEHRT. The incentive payments are not a reimbursement; rather they are intended to encourage EPs to adopt, implement, or upgrade a CEHRT and use it in a meaningful manner.

Goals for the national program include:

- Reduce paperwork and improve efficiencies
- Enhance care coordination and patient safety
- Enable data sharing using the state HIE and the NHIN
- Facilitate electronic information sharing across hospitals, payers, and state lines

Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce the costs of health care nationwide. Idaho Medicaid will work closely with federal and state partners to ensure the Idaho Medicaid EHR Incentive Program fits into the overall strategic plan for the HIE exchange, thereby advancing national and Idaho goals for HIE.

The Medicaid EHR Incentive Programs provide incentive payments to EPs, EHs, and CAHs as they adopt, implement, upgrade or demonstrate MU of CEHRT. There are two EHR Incentive Programs. CMS oversees the Medicare EHR Incentive Program, and the state Medicaid agencies (IDHW) manage the Medicaid EHR Incentive Program. The two programs are similar, but there are some differences between them.

Medicare EHR Incentive Program	Medicaid EHR Incentive Program
Run by CMS	Run by the State Medicaid Agency
Maximum incentive amount is \$44,000	Maximum incentive amount is \$63,750
Payments over 5 consecutive years	Payments over 6 years, does not have to be consecutive
Payment adjustments will begin in 2015 for providers who are eligible but decide not to participate	No payment adjustments for providers who are only eligible for the Medicaid program
Providers must demonstrate meaningful use every year to receive incentive payments	In the first year providers can receive an incentive payment for adopting, implementing, or upgrading EHR technology. Providers must demonstrate meaningful use in the remaining years to receive incentive payments

For more information, see the presentation at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_Medicaid_Guide_Remediated_2012.pdf

Eligibility

A EP's eligibility to receive EHR incentive payments is based on the following four qualifications:

- Provider type and specialty
- PV
- State of licensure and good standing
- Qualifying CEHRT system

Provider Type and Specialty

The first provider eligibility requirement is based on provider type and specialty. Currently CMS has determined the following EPs are eligible to participate:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Advanced Practice Professional Nurses
 - NP
 - CNM
 - RNA
 - Clinical Nurse Specialist
- Dentist
- PA who furnishes services in a FQHC or RHC that is led by a PA

The EHR incentive payments can only be made to Idaho Medicaid providers (EPs with an Idaho Medicaid Provider Agreement with MMIS). The only exception is if the EP does not bill the MMIS system; but rather bills a MCO in-lieu of Medicaid.

PV

The second provider eligibility requirement is based on PV. PV thresholds must be established every year a provider applies for an incentive payment. To qualify for an EHR incentive payment the EP must meet the following requirements.

- Not be hospital-based. Hospital-based means an EP who furnishes 90 percent or more of covered professional services in a hospital, inpatient, or emergency room setting (POS 21 and 23) in the calendar year or rolling calendar year preceding the payment year.
- Have a minimum of 30 percent PV attributable to individuals receiving Medicaid funded services; or
- Have a minimum of 20 percent PV attributable to individuals receiving Medicaid funded services **and** be a pediatrician.
- Practice predominantly in an FQHC or RHC **and** have a minimum of 30 percent PV attributable to needy individuals.

CHIP Encounters for PV

Encounters with Medicaid participants receiving services funded by Title XXI **cannot** be included in the PV calculation unless the EP practices predominantly in an FQHC or RHC **and** is basing the PV on needy patient encounters. Due to the fact EPs cannot always distinguish between funding sources, Idaho Medicaid has received permission from CMS to use a CHIP PV Average strategy to help EPs determine their Medicaid PV.

Idaho's payment system differentiates the paying source using detailed codes for eligibility which are traceable to the claim. Using this information, Idaho Medicaid has identified a statewide average proportion for CHIP encounters for EPs. The CHIP PV average is currently seven (7) percent. The CHIP PV average was reviewed again in 2013, and it was determined to still be seven (7) percent; therefore, there will be no change in the current methodology for determining CHIP PV. These CHIP averages are based on an analysis of three years of claims history. This percent gives the statewide average of CHIP-to-total Medicaid encounters. EPs must identify their total number of Medicaid encounters and reduce that by the CHIP PV average percent when applying for incentives.

Using this method will benefit some providers whose actual CHIP PV is higher than the statewide average, and may disadvantage those whose CHIP PV is lower than the statewide average. To ensure EPs are not falsely denied eligibility based on this strategy, EPs can request the state provide them with the actual number of Medicaid and CHIP PV for the 90-day period of their choosing if they are unable to meet the PV threshold with the CHIP PV average reduction and believe otherwise they would meet it. EPs can contact the Idaho Medicaid EHR Incentive Program Help Desk staff at (208) 332-7989 for more information about this process.

Institutional License and Good Standing

The third provider eligibility requirement is based on institutional license and good standing. All participating EPs must have a current institutional license (provisional licenses are accepted) and must be free of both state and federal sanctions and exclusions. Institutional license and good standing must be established every year a provider applies for an incentive payment.

Qualifying CEHRT

The fourth provider eligibility requirement is based on the use of CEHRT. ONC for HIT has issued rules defining CEHRT and has identified entities who can certify systems. The CEHRT used by the EP must be tested and certified by an ONC ACB/ATCB in order for the EP to qualify for EHR incentive payments. Once certified, the product is listed on the ONC CHPL website where an EP can obtain the product's unique CCN. The CCN must be provided as part of the attestation and registration process.

Important Attestation Information

Getting your EHR Certification

The EHR Incentive Program requires the use of CEHRT. It is not enough for a EHR product to be certified by the Certification Commission for Health Information Technology. Standards, implementation specifications, and certification criteria for CEHRT have been adopted by the Secretary of the DHHS. The CEHRT in use by the EP must be tested and certified by an ONC ATCB in order for the EP to qualify for EHR incentive payments. Once certified, the CEHRT product is listed on the ONC's CHPL website where an EP must obtain a unique CMS EHR Certification ID Number. This certification number must be provided as part of the attestation process for either the Medicare or Medicaid incentive program.

The ONC CHPL Product Number issued to your vendor for each CEHRT is different than the CMS EHR Certification ID Number issued to an EP for registration and attestation purposes. Only a CMS EHR Certification ID Number (obtained from the CHPL site) unique to the practice will be accepted at attestation.

EPs can obtain the CMS EHR Certification ID Number for their EHR product by following the steps on the ONC CHPL website.

Note: The CMS EHR Certification ID will not be generated until your product(s) meet 100 percent of CMS required criteria.

Vendor Enrollment

In order to receive EHR incentive payments from Idaho Medicaid, the entity receiving the payment must be enrolled as a vendor with the state of Idaho. If you are unsure of prior vendor enrollment, contact the Idaho Medicaid EHR Incentive Program Help Desk.

To enroll as a vendor who receives paper warrants and paper RAs, you must complete an IRS W-9 form and submit it to the Idaho Medicaid EHR Incentive Program using one of three methods:

Mail: EHR Incentive Payments
Division of Medicaid
PO Box 83720
Boise, ID 83720-0009

Fax: (208) 334-6515

Email: ehrincentives@dhw.idaho.gov

To enroll as a vendor who receives direct deposits (EFT), you must complete the "Combined Substitute W-9/EFT Direct Deposit Authorization Form" (on the Idaho Office of the State Controller's website). This form must be mailed in along with a voided check (originals only: copied, scanned, or faxed documents will not be accepted) to:

EHR Incentive Payments
Division of Medicaid
PO Box 83720
Boise, ID 83720-0009

Processing the completed EFT form includes verifying the vendor's TIN and name with the IRS to make sure they match, and verifying the vendor's financial institution. This process usually takes a couple of weeks. Once the submitted EFT paperwork and voided check have been processed, the state controller's office will send you a letter or e-mail with your logon information, password, and instructions for accessing the state controller's vendor website to view RAs.

Note: If you sign up for EFT, you will not receive paper warrants or paper RAs.

Attestation System

Idaho has implemented a web-based interface, called IIMS, for providers to apply and attest at the state level. To successfully use IIMS to apply and attest, you must:

- Be successfully registered on the CMS website for the Incentive Management Program.
- Have the following information available:
 - NPI you used to register at the CMS website.
 - CMS Registration Identification Number that is associated with your NPI (provided by CMS during registration).
 - Supporting documentation on PV, EHR details, and PA-led clinics (if applicable)

Steps to complete your application/attestation in IIMS include:

1. Log into IIMS.
2. Enroll for a new year of attestation, if this is not the EP's first year.
3. Review the CMS registration data.
4. Enter the eligibility details.
5. Review the incentive payment calculation.
6. Upload required supporting documentation.
7. Submit the application/attestation.

The login process and step-by-step instructions for application, attestation, and information verification are discussed below.

PV Calculation

Idaho Medicaid includes all eligible encounters including zero-dollar paid claims. Idaho Medicaid also includes any claim for a Medicare dual eligible.

Non-FQHC/RHC Calculation

PV for EPs not practicing predominantly in an FQHC or RHC is calculated by dividing the number of unduplicated Medicaid patient encounters during any representative and continuous 90-day period in the calendar year or rolling 12 month calendar year prior to attestation reduced by the seven percent CHIP average by the total number of unduplicated patient encounters in that same period.

In other words, PV is a percentage derived from a fraction. The numerator is Medicaid encounters reduced by the CHIP average. The denominator is the total patient encounters.

The equation for this PV calculation is:

$$\left(\begin{array}{|l} \text{Unduplicated Medicaid} \\ \text{patient encounters during} \\ \text{specified 90-day period.} \end{array} - \begin{array}{|l} \text{Statewide} \\ \text{CHIP} \\ \text{average} \end{array} \right) / \begin{array}{|l} \text{Total number of} \\ \text{unduplicated} \\ \text{patient encounters} \end{array} = \begin{array}{|l} \text{PV} \end{array}$$

FQHC/RHC Calculation

PV for EPs practicing predominantly in an FQHC or RHC **and** basing PV on needy encounters is calculated by dividing the number of unduplicated needy patient encounters during any representative and continuous 90-day period in the calendar year or rolling 12 month calendar year prior to attestation by the total number of unduplicated patient encounters in that same period.

In other words, PV is a percentage derived from a fraction. The numerator is Medicaid encounters reduced by the CHIP average. The denominator is the total patient encounters.

The equation for this PV calculation is:

$$\begin{array}{|l} \text{Unduplicated Medicaid patient encounters} \\ \text{during specified 90-day period.} \end{array} / \begin{array}{|l} \text{Total number of unduplicated} \\ \text{patient encounters} \end{array} = \begin{array}{|l} \text{PV} \end{array}$$

Group Proxy Calculation

The Idaho Medicaid EHR Incentive Program has developed a group proxy roster calculation worksheet to help facilitate consistent attestation of PV by EPs and to streamline PV verification. It is important for EPs to remember the following:

- The entity responsible for the group must complete a group proxy roster calculation worksheet and make it available to all EPs.
- Every EP must upload the same copy of the group proxy roster calculation worksheet and the supporting PV report during the application/attestation process.

- A new group proxy calculation worksheet must be completed every year and for each phase of the program (e.g., AIU, MU Stage 1, etc.) the group's EPs apply for a Medicaid incentive if using the group proxy calculation approach that year.

The group proxy calculation can be set at the organizational level or the clinic level. If using an organizational level proxy calculation, the clinics included cannot be an arbitrary group of clinics to maximize PV. An organizational level proxy must include all of the organization's clinics within the state of Idaho. No out-of-state clinics will be allowed to be included in the proxy.

Attestation Stages

The Medicare and Medicaid EHR Incentive Programs provide incentive payments to EPs, EHs, and CAHs as they adopt, implement, upgrade or demonstrate MU of CEHRT.

AIU

All EPs must verify they have adopted, implemented, or upgraded to a CEHRT system. While each of these stages are grouped together, they are individually unique.

- **Adopt: *acquire, purchase, or secure access to a CEHRT***
There is evidence an EP demonstrated actual installation prior to the incentive, rather than “efforts” to install. This evidence serves to differentiate between activities that may not result in installation (for example, researching EHRs or interviewing EHR vendors) and actual purchase/acquisition or installation.
- **Implement: *install or commence utilization of a CEHRT***
The EP has installed a CEHRT and has started using the CEHRT in clinical practice. Implementation activities would include staff training in the CEHRT, the data entry of their patients' demographic data into the EHR, or establishing data exchange agreements and relationships between the EP's CEHRT and other EPs.
- **Upgrade: *expand the available functionality of a CEHRT***
The EP has added clinical decision support, electronic prescribing functionality, or other enhancements that facilitate MU of CEHRT. An example of upgrading that would qualify for the EHR incentive payment would be upgrading from an existing EHR to a newer version that is certified according to the EHR certification criteria promulgated by the ONC related to MU. Upgrading may also mean expanding the functionality of an EHR in order to render it certifiable according to the ONC's EHR certification criteria.

MU

All EPs must verify they are meaningfully using the CEHRT in ways that can positively impact patient care. Meaningfully using a CEHRT is designed to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Ultimately, it is hoped MU compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

MU sets specific objectives EPs and EHs must achieve to qualify for CMS Incentive Programs. MU contains three stages and while these stages are grouped together, they are individually unique. These stages will evolve over the next five years.

- Stage 1. *Data sharing and capturing.*
- Stage 2. *Advance clinical processes.*
- Stage 3. *Improved outcomes.*

Payment Status

You can see the detailed information regarding your past and current payments in IIMS on the left-hand menu's "Payments" link. Here, you are able to review payments and any payment adjustments for each program year you participated in Idaho's incentive program. If you participated in a different state's Medicaid incentive program or the Medicare incentive program in other payment years, the information from those sources **is not available here**. You should be able to access that payment information from the other state's Medicaid incentive program's site or the CMS EHR Incentive Program Registration and Attestation System.

Accessing IIMS and Attesting

Before you apply with Idaho Medicaid for an EHR incentive payment, you must first successfully register in the CMS EHR Incentive Registration & Attestation System. The Idaho Medicaid EHR Incentive Program then receives notification from CMS and conducts a preliminary review of eligibility. You will be contacted regarding any issues with your CMS registration affecting your Idaho eligibility. When the verification is complete, you will receive an email inviting you to complete your application/attestation.

The following information will be required to sign in to IIMS to complete your Idaho application/attestation:

- The NPI you used to register at the CMS site
- The associated 10-digit CMS Registration Identification Number

If you don't recall your CMS Registration Identification Number, you must return to the CMS EHR Incentive Program R&A System to reference it.

Once you have completed your application/attestation in IIMS, and attached required supporting documentation, the EHR program staff will complete the eligibility determination. Once a provider is determined eligible, the Idaho Medicaid EHR Program will notify CMS of your eligibility status.

Logon Screen

1. Enter the NPI used when registering at the CMS EHR Incentive Program site and the 10-digit CMS-assigned Registration Identification Number.

Note: If the data entered here does not match the NPI or the CMS-assigned Registration Identification Number on file, the message, "Invalid NPI/Registration ID combination" will be displayed.

2. Select "Submit" to log in and proceed to the CMS Registration Information page.

Note: If you encounter the message "Application is in process at Idaho Medicaid. You can expect to receive an email in 7-10 days informing you of your application status", this indicates Idaho Medicaid is conducting a preliminary review of the registration record received from CMS. Once this preliminary review is completed you will be allowed to login and begin your application/attestation.

Landing Screen

The EP is presented with a landing page upon a successful login that will show four separate sections:

- Announcements and Messages

- Provider Information
- Provider Status Flow
- Program Year Attestations

Announcements and Messages

This area is used to communicate major program update information.

Provider Information

This area shows the program attestation, state of attestation, payment year (AIU, MU1, MU2), and the current status. This area can always be used to reference at what stage the next attestation will be.

Provider Status Flow

This area can be used to check and track where your attestation is at currently as it is updated in real-time. If you believe your attestation to be stuck in any section, contact the Idaho Medicaid EHR Incentive Program Help Desk immediately for resolution.

Program Year Attestation

This area will show the aggregate year, status, and actions for an attestation. This area can always be used to reference at what stage the next attestation will be.

Helpful Tips

- Make sure your numbers are accurately entered when you attest.
- Keep your supporting documentation.
- Know that dated screen shots provide a good source of documentation.
- Save paper or electronic copies of reports used to attest if the practice's EHR automatically changes numerator and denominator values after the reporting period ends.
- Turn on, for the entire reporting period, EHR features which track functionality issues such as drug interaction checks and clinical decision support.
- Understand the security risk analysis must be specific to the EHR and the practice and it is required every year.

AIU Attestation Walkthrough

The current status of the payment year is displayed in the “Provider Status Flow” section of the page. To begin your attestation after logging in to IIMS, you must select “Begin/Modify Attestation”, and it will bring you to the CMS Registration Information Page.

Screen 1 – CMS Registration Information

1. Review this information carefully. This information is populated directly from your CMS registration information and you cannot update the information on this page. If you need to make updates to this information, you need to return to the CMS website, make your changes, and save them. Once you have completed your update on the CMS website, your information will again be sent to Idaho and this page will be updated. Please allow 24 hours for the update to be received and processed.

Note: As you make your changes at the CMS website, make sure you go through the screens, selecting “Save” and “Continue”, until you get to the Verify Registration page and select “Submit”. Unless you select “Submit”, your updated data will not be sent to Idaho and your payment will be delayed.

2. Answer the question, “Have you worked with WIREC?”.
3. If you are licensed in Idaho, skip to the next step. If you are **not**, complete the fields “State licensed in” and “Other State License #”.
4. Select “Next” to go to the next page.

Screen 2 – Provider Eligibility Details

Here there are three separate sections:

- Program Year
- Patient Volume
- EHR Details

Program Year

Select the program year. This selection is only available if the current date within the designated attestation tail-period of any year. This allows you to choose the previous program year during the tail-period where it is allowed to attest for either the previous or current program year. After the end of the tail-period, the program year will be defaulted to the current program year.

Patient Volume

1. Select the appropriate answer from the drop down menu to indicate if your patient volume was calculated using the group proxy method.

2. If you answered “Yes”, enter the NPI of the proxy entity (Idaho Medicaid will verify the NPI). If you entered “No”, skip to the next step.
3. Select the starting date of the 90-day period to calculate the Medicaid/needly PV percentage.

Note: The date must be a valid date within the previous calendar year or rolling calendar year to 90 days before the current date. This accommodates the EP’s choice of using the previous calendar year or the most recent 12 months.

4. Enter the Medicaid/needly PV during this period.

Note: If using PV based only on unduplicated Medicaid encounters, exclude seven (7) percent for CHIP encounters. If you are basing PV on needly, disregard the exclusion of CHIP encounters. The following is an example for excluding CHIP encounters for PV based on unduplicated Medicaid encounters:

- *Total unduplicated Medicaid patient encounters = 120*
- *Calculated CHIP amount based on seven percent state average, rounded to the nearest whole number = 8.4 = 8*
- *Net unduplicated Medicaid patient encounters: 120 - 8 = 112*
- *Result: use 112 for the unduplicated Medicaid patient encounters*

5. Enter the number of total unduplicated patient encounters during this period.
6. Only EPs who practice predominately at a FQHC or RHC can be based on needly (“Yes”). All others must use Medicaid encounters only (“No”).
- 6a. If you do not practice predominately at a FQHC or RHC, select “No”. If you do practice predominately at a FQHC or RHC, select “Yes”.
- 6b. Use the drop down menu to indicate whether or not you are Hospital Based.
7. This will auto-calculate based on your answers to numbers 4 and 5.

Note: The following messages will appear if you do not meet the PV threshold.

- *If the provider specialty is Pediatrics and PV is based on unduplicated Medicaid patient encounters but is below the 20 percent PV threshold, this message will be displayed:
"x.xx% - you must meet the threshold of 20% to get an EHR Incentive Payment".*
- *For other provider specialties (regardless of how PV is based) and those below the 30 percent PV threshold, this message will be displayed:
"x.xx% - you must meet the threshold of 30% to get an EHR Incentive Payment".*

EHR Details

8. The CMS EHR Certification ID of your EHR will be auto-populated from your CMS registration information if it was provided there. If not, the EHR Certification ID must be input here. Only a valid ID will be allowed for you to continue your attestation.
9. Select the status of your EHR – “Adopt”, “Implement”, “Upgrade”, or “Meaningful Use”.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – *If you have not saved your entries, this will cancel your entries and take you to the previous page.*
- “Next” – *will save your entries and take you to the next page.*
- “Save” – *will save your current entries on the page and you will remain on that page.*
- “Cancel” – *will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.*

Screen 3 – Certified EHR Technology Locations

On this page, there are four items which you need to answer.

1. Select “Yes” or “No” to indicate if you have multiple practice locations.
2. If you selected “Yes”, enter the total number of locations. If you selected “No”, the box will auto populate the number “1”.
3. Enter the total number of the locations indicated that have adopted, implemented, or upgraded to CEHRT. This number of locations cannot be higher than the total number of locations. Additionally, if you only have one location then this must be populated with “1”.
4. Use the table provided to fill in the address, city, state, and ZIP code for each service location indicated.

Note: Click “Add” after each location entered. You may modify or delete your entries as necessary. You must enter the same number of service locations as you identified in number 3 above.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – *If you have not saved your entries, this will cancel your entries and take you to the previous page.*
- “Next” – *will save your entries and take you to the next page.*
- “Save” – *will save your current entries on the page and you will remain on that page.*
- “Cancel” – *will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.*

Screen 4 – Incentive Payment Calculations

On this page, there is one item which you need to review.

1. Review the incentive payment amount. Contact the Idaho Medicaid EHR Incentive Program Help Desk if you have any questions.

Note: If you see a \$0 estimated amount of Medicaid EHR incentive payment, you may not have met eligibility requirements. Click on the “Previous” button, and check your responses to the questions on the Provider Eligibility Details page.

After reviewing your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – will take you to the previous page.
- “Next” – will take you to the next page.

Screen 5 – Document Upload

On this page, you need to upload the following mandatory documents.

1. System-generated PV report. This can come from either your EHR or your billing service. Screenshots of your generated report may be requested from the EHR Team if further verification is required.
2. EHR documentation. This must be either dually signed vendor contract, recent receipt of payment, user agreement, receipt of purchase, lease agreement, or other acceptable legally binding documentation.

Note: A vendor letter is not acceptable unless submitted with additional binding documentation. The documentation submitted must include the exact name of the EHR system purchased including the software version number.

3. Group proxy roster (if applicable).

Additional for PA-Led

Whether AIU or MU attestations, PAs are required to submit documentation to support PA-led.

1. Medical director. This must be a job description, employment agreement/contract, organization chart from clinic.
2. Primary provider. This must be clinic appointment records or work hours relative to other EPs. May use PV reports relative to other EPs.
3. RHC owner. This must be the ownership record.
4. Other. Please work with program staff to identify acceptable documentation to support PA-led.

To ensure reviewing accuracy, use the following naming convention for your documents:
EP Last Name, Document Type (or) Objective Number, Program Year

For Example

Smith, PV, 2015.pdf
Smith, Objective 4, 2015.pdf
Smith, CQM 62, 2015.pdf
Smith, Group Proxy, 2015.pdf

Note: Only PDF documents can be uploaded into IIMS. If you need to upload a different file format, contact the Idaho Medicaid EHR Incentive Program Help Desk for further instructions. Documents uploaded not using the above naming convention or correct document type will cause a delay in processing your incentive payment application. You will still be able to upload documents as necessary throughout the attestation process.

After loading your documents, you must select one of the following buttons from the bottom of the screen:

- “Previous” – will cancel your entries and take you to the previous page.
- “Next” – will save your entries and take you to the next page.

Screen 6 – Attestation

On this page, there are many items you need to review and answer.

1. Review all the data on this page. Once you submit the attestation, you **cannot make any changes**.
2. Enter **your initials** and the EP’s NPI at the bottom-left of the screen.
3. Enter **your name, e-mail**, and the EP’s e-mail at the bottom-right of the screen.

Completing these sections serve as your electronic signature. By entering this information, you attest to the validity of all data submitted for consideration by the Idaho Medicaid EHR Incentive Program.

After reviewing and entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – will cancel your entries and take you to the previous page.
- “Submit” – notify Idaho Medicaid the attestation is ready for final eligibility review.

Note: Once you select “Submit”, it will take you to the first page of your attestation, CMS Registration Information (Screen 1), to review. You can select “Previous” and “Next” to view the attestation pages in a review mode only.

Logout when finished.

MU Attestation Walkthrough

The current status of the payment year is displayed in the “Provider Status Flow” section of the page. To begin your attestation after logging in to IIMS, you must select “Begin/Modify Attestation”, and it will bring you to the CMS Registration Information Page.

Screen 1 – CMS Registration Information

1. Review this information carefully. This information is populated directly from your CMS registration information and you cannot update the information on this page. If you need to make updates to this information, you need to return to the CMS website, make your changes, and save them. Once you have completed your update on the CMS website, your information will again be sent to Idaho and this page will be updated. Please allow 24 hours for the update to be received and processed.

Note: As you make your changes at the CMS website, make sure you go through the screens, selecting “Save” and “Continue”, until you get to the Verify Registration page and select “Submit”. Unless you select “Submit”, your updated data will not be sent to Idaho and your payment will be delayed.

2. Answer the question, “Have you worked with WIREC?”.
3. If you are licensed in Idaho, skip to the next step. If you are **not**, complete the fields “State licensed in” and “Other State License #”.
4. Select “Next” to go to the next page.

Screen 2 – Provider Eligibility Details

5. Here there are three separate sections:
 - Program Year
 - Patient Volume
 - EHR Details

Program Year

Select the program year. This selection is only available if the current date within the designated attestation tail-period of any year. This allows you to choose the previous program year during the tail-period where it is allowed to attest for either the previous or current program year. After the end of the tail-period, the program year will be defaulted to the current program year.

Patient Volume:

1. Select the appropriate answer from the drop down menu to indicate if your patient volume was calculated using the group proxy method.

2. If you answered “Yes”, enter the NPI of the proxy entity (Idaho Medicaid will verify the NPI). If you entered “No”, skip to the next step.
3. Select the starting date of the 90-day period to calculate the Medicaid/needy PV percentage.

Note: The date must be a valid date within the previous calendar year or rolling calendar year to 90 days before the current date. This accommodates the EP’s choice of using the previous calendar year or the most recent 12 months.

4. Enter the Medicaid/needy PV during this period.

Note: If using PV based only on unduplicated Medicaid encounters, exclude seven (7) percent for CHIP encounters. If you are basing PV on needy, disregard the exclusion of CHIP encounters. The following is an example for excluding CHIP encounters for PV based on unduplicated Medicaid encounters:

- *Total unduplicated Medicaid patient encounters = 120*
- *Calculated CHIP amount based on seven percent state average, rounded to the nearest whole number = 8.4 = 8*
- *Net unduplicated Medicaid patient encounters: 120 - 8 = 112*
- *Result: use 112 for the unduplicated Medicaid patient encounters*

5. Enter the number of total unduplicated patient encounters during this period.
6. Only EPs who practice predominately at a FQHC or RHC can be based on needy (“Yes”). All others must use Medicaid encounters only (“No”).
- 6a. If you do not practice predominately at a FQHC or RHC, select “No”. If you do practice predominately at a FQHC or RHC, select “Yes”.
- 6b. Use the drop down menu to indicate whether or not you are Hospital Based.
7. This will auto-calculated based on your answers to numbers 4 and 5.

Note: The following messages will appear if you do not meet the PV threshold.

- *If the provider specialty is Pediatrics and PV is based on unduplicated Medicaid patient encounters but is below the 20 percent PV threshold, this message will be displayed:
"x.xx% - you must meet the threshold of 20% to get an EHR Incentive Payment".*
- *For other provider specialties (regardless of how PV is based) and those below the 30 percent PV threshold, this message will be displayed:
"x.xx% - you must meet the threshold of 30% to get an EHR Incentive Payment".*

EHR Details:

8. The CMS EHR Certification ID of your EHR will be auto-populated from your CMS registration information if it was provided there. If not, the EHR Certification ID must be input here. Only a valid ID will be allowed for you to continue your attestation.
9. Select the status of your EHR – “Adopt”, “Implement”, “Upgrade”, or “Meaningful Use”.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – *If you have not saved your entries, this will cancel your entries and take you to the previous page.*
- “Next” – *will save your entries and take you to the next page.*
- “Save” – *will save your current entries on the page and you will remain on that page.*
- “Cancel” – *will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.*

Screen 3 – Meaningful Use Questionnaire

On this page, there are two sections which you need to answer.

- EHR Reporting Period
- Certified EHR Technology Locations

EHR Reporting Period

1. Enter the EHR reporting period start date.
2. Enter the EHR reporting period end date.

Note: First year MU reporting periods must be 90-days. Second year MU reporting periods must be 365-days. The 2015 Modification Rule allows all MU attestations for program year 2015 to select a 90-day reporting period. You will receive an error if the reporting period is not 90 days, if the start date is not at least 90 days prior to current date, or if the end date is not prior to current date.

3. Enter the percentage of unduplicated patients who have structured data recorded in your CEHRT as of the EHR reporting period.

Note: You will receive an error if the number you enter is not a whole number, if less than 80, or is more than 100.

Certified EHR Technology Locations

4. Select “Yes” or “No” to indicate if you have multiple practice locations.
5. If you selected “Yes”, enter the total number of locations. If you selected “No”, the box will auto populate the number “1”.
6. Enter the total number of the locations indicated that have adopted, implemented, or upgraded to CEHRT. This number of locations cannot be higher than the total number of locations. Additionally, if you only have one location then this must be populated with “1”.
7. Use the table provided to fill in the address, city, state, and ZIP code for each service location indicated.

Note: Click “Add” after each location entered. You may modify or delete your entries as necessary. You must enter the same number of service locations as you identified in number 3 above.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – *If you have not saved your entries, this will cancel your entries and take you to the previous page.*
- “Next” – *will save your entries and take you to the next page.*
- “Save” – *will save your current entries on the page and you will remain on that page.*
- “Cancel” – *will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.*

Screen 4 – Summary of Measures

On this page, you can view your progression through attestation objectives and measures. You can review this page at any time by clicking on the “MU Summary” link on the left-hand side menu. As you advance through the objectives and measures, these categories will become hyperlinks to enable you to quickly return to where you left off.

After reviewing your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – *will take you to the previous page.*
- “Next” – *will take you to the next page.*

Screens 5 through 15 – Attestation Objectives and Measures

On these pages, you will need to answer the 10 objectives and their correlating measure(s) and/or exclusion(s) as appropriate. For the objectives which require a Yes/No answer, select either “Yes” or “No”. For the objectives/measures which require a percentage answer, input your numerator and denominator in the required fields.

- Objective 1 – Protect Patient Health Information
- Objective 2 – Clinical Decision Support
- Objective 3 – Computerized Provider Order Entry (CPOE)
- Objective 4 – Electronic Prescribing (eRx)
- Objective 5 – Health Information Exchange
- Objective 6 – Patient Specific Education
- Objective 7 – Medication Reconciliation

- Objective 8 – Patient Electronic Access
- Objective 9 – Secure Electronic Messaging
- Objective 10 – Public Health Reporting

Note: Measures within the same objective may not have the same threshold requirements for percentages. If the numerator/denominator you enter do not support the mandatory minimum, you will receive an error message.

Objective 1 – Protect Patient Health Information

Number of Measures: 1
 Answer Type: Yes/No
 Description: Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

Objective 2 – Clinical Decision Support

Number of Measures: 2
 Answer Type: Yes/No
 Description: Use clinical decision support to improve performance on high-priority health conditions.

Objective 3 – Computerized Provider Order Entry (CPOE)

Number of Measures: 3
 Answer Type: Percentage
 Description: Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

Objective 4 – Electronic Prescribing (eRx)

Number of Measures: 1
 Answer Type: Percentage
 Description: Generate and transmit permissible prescriptions electronically (eRx).

Objective 5 – Health Information Exchange

Number of Measures: 1
 Answer Type: Percentage
 Description: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

Objective 6 – Patient Specific Education

Number of Measures: 1
Answer Type: Percentage
Description: Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

Objective 7 – Medication Reconciliation

Number of Measures: 1
Answer Type: Percentage
Description: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

Objective 8 – Patient Electronic Access

Number of Measures: 2
Answer Type: Percentage
Description: Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

Objective 9 – Secure Electronic Messaging

Number of Measures: 1
Answer Type: Percentage
Description: Use secure electronic messaging to communicate with patients on relevant health information.

Objective 10 – Public Health Reporting

Number of Measures: 1
Answer Type: Yes/No
Description: 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.

After entering your data in each screen, you must select one of the following buttons from the bottom of the screen:

- “Previous” – *If you have not saved your entries, this will cancel your entries and take you to the previous page.*
- “Next” – *will save your entries and take you to the next page.*
- “Save” – *will save your current entries on the page and you will remain on that page.*

- “Cancel” – will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Screen 16 – Clinical Quality Measures

On this page, you must report on 9 CQMs from a selection of 64. The 9 reported CQMs must come from 3 of the 6 domains. The responses entered must be generated from your CEHRT for the EHR reporting period even if the report states zero. After you enter the data for each CQM, click “Next” and it will save the data and advance to the next CQM. If you would like to save the data and exit the screen, you must click “Save”. Your data will not be saved if you click “Back” or “Previous”.

Note: Providers reporting a zero in one or more CQM denominators must attest to all 64 CQMs regardless of practice specialty.

Each program year, the specific CQMs available for attestation differ while the 6 domains remain the same.

- Domain 1 – Clinical Process/Effectiveness
- Domain 2 – Patient Safety
- Domain 3 – Efficient Use of Healthcare Resources
- Domain 4 – Population/Public Health
- Domain 5 – Patient and Family Engagement
- Domain 6 – Care Coordination

Program Year 2015 CQMs

CMS eMeasure	NQF	PQRS	Domain	Measure
CMS137v3	0004	305	1 – Clinical Process/Effectiveness	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
CMS165v3	0018	236 GPRO HTN-2	1 – Clinical Process/Effectiveness	Controlling High Blood Pressure
CMS124v3	0032	309	1 – Clinical Process/Effectiveness	Cervical Cancer Screening
CMS130v3	0034	113 GPRO PREV-6	1 – Clinical Process/Effectiveness	Colorectal Cancer Screening
CMS126v3	0036	311	1 – Clinical Process/Effectiveness	Use of Appropriate Medications for Asthma
CMS127v3	0043	111 GPRO PREV-8	1 – Clinical Process/Effectiveness	Pneumonia Vaccination Status for Older Adults
CMS131v3	0055	117	1 – Clinical Process/Effectiveness	Diabetes: Eye Exam

CMS eMeasure	NQF	PQRS	Domain	Measure
CMS123v3	0056	163	1 – Clinical Process/ Effectiveness	Diabetes: Foot Exam
CMS122v3	0059	1 GPRO DM-2	1 – Clinical Process/ Effectiveness	Diabetes: Hemoglobin A1c Poor Control
CMS148v3	0060	365	1 – Clinical Process/ Effectiveness	Hemoglobin A1c Test for Pediatric Patients
CMS134v3	0062	119	1 – Clinical Process/ Effectiveness	Diabetes: Urine Protein Screening
CMS163v3	0064	2	1 – Clinical Process/ Effectiveness	Diabetes: Low Density Lipoprotein (LDL) Management
CMS164v3	0068	204 GPRO IVD-2	1 – Clinical Process/ Effectiveness	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
CMS145v3	0070	7	1 – Clinical Process/ Effectiveness	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
CMS182v4	0075	241 GPRO IVD-1	1 – Clinical Process/ Effectiveness	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
CMS135v3	0081	5	1 – Clinical Process/ Effectiveness	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS144v3	0083	8 GPRO HF-6	1 – Clinical Process/ Effectiveness	Heart Failure (HF): Beta- Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS143v3	0086	12	1 – Clinical Process/ Effectiveness	Primary Open- Angle Glaucoma (POAG): Optic Nerve Evaluation
CMS167v3	0088	18	1 – Clinical Process/ Effectiveness	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
CMS142v3	0089	19	1 – Clinical Process/ Effectiveness	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
CMS161v3	0104	107	1 – Clinical Process/ Effectiveness	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS128v3	0105	9	1 – Clinical Process/ Effectiveness	Anti-depressant Medication Management

CMS eMeasure	NQF	PQRS	Domain	Measure
CMS136v4	0108	366	1 – Clinical Process/ Effectiveness	ADHD: Follow- Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication
CMS169v3	0110	367	1 – Clinical Process/ Effectiveness	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
CMS141v4	0385	72	1 – Clinical Process/ Effectiveness	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
CMS140v3	0387	71	1 – Clinical Process/ Effectiveness	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer
CMS52v3	0405	160	1 – Clinical Process/ Effectiveness	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
CMS133v3	0565	191	1 – Clinical Process/ Effectiveness	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
CMS159v3	0710	370	1 – Clinical Process/ Effectiveness	Depression Remission at Twelve Months
CMS160v3	0712	371	1 – Clinical Process/ Effectiveness	Depression Utilization of the PHQ-9 Tool
CMS125v3	N/A	112 GPRO PREV-5	1 – Clinical Process/ Effectiveness	Breast Cancer Screening
CMS149v3	N/A	281	1 – Clinical Process/ Effectiveness	Dementia: Cognitive Assessment
CMS158v3	N/A	369	1 – Clinical Process/ Effectiveness	Pregnant women that had HBsAg testing
CMS61v4	N/A	316	1 – Clinical Process/ Effectiveness	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed
CMS62v3	N/A	368	1 – Clinical Process/ Effectiveness	HIV/AIDS: Medical Visit
CMS64v4	N/A	316	1 – Clinical Process/ Effectiveness	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)
CMS65v4	N/A	373	1 – Clinical Process/ Effectiveness	Hypertension: Improvement in Blood Pressure
CMS75v3	N/A	378	1 – Clinical Process/ Effectiveness	Children Who Have Dental Decay or Cavities

CMS eMeasure	NQF	PQRS	Domain	Measure
CMS77v3	N/A	381	1 – Clinical Process/ Effectiveness	HIV/AIDS: RNA Control for Patients with HIV
CMS74v4	N/A	379	1 – Clinical Process/ Effectiveness	Primary Caries Prevention Intervention as Offered by Primary Care Provider
CMS156v3	0022	238	2 – Patient Safety	Use of High- Risk Medications in the Elderly
CMS139v3	0101	318 GPRO CARE-2	2 – Patient Safety	Falls: Screening for Future Fall Risk
CMS68v4	0419	130	2 – Patient Safety	Documentation of Current Medications in the Medical Record
CMS132v3	0564	192	2 – Patient Safety	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
CMS177v3	1365	382	2 – Patient Safety	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS179v3	N/A	380	2 – Patient Safety	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range
CMS146v3	0002	66	3 – Efficient Use of Healthcare Resources	Appropriate Testing for Children with Pharyngitis
CMS166v4	0052	312	3 – Efficient Use of Healthcare Resources	Use of Imaging Studies for Low Back Pain
CMS154v3	0069	65	3 – Efficient Use of Healthcare Resources	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
CMS129v4	0389	102	3 – Efficient Use of Healthcare Resources	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
CMS155v3	0024	239	4 – Population/ Public Health	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
CMS138v3	0028	226 GPRO PREV-10	4 – Population/ Public Health	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
CMS153v3	0033	310	4 – Population/ Public Health	Chlamydia Screening for Women
CMS117v3	0038	240	4 – Population/ Public Health	Childhood Immunization Status
CMS147v4	0041	110 GPRO PREV-7	4 – Population/ Public Health	Preventive Care and Screening: Influenza Immunization

CMS eMeasure	NQF	PQRS	Domain	Measure
CMS2v4	0418	134 GPRO PREV-12	4 – Population/ Public Health	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
CMS69v3	0421	128 GPRO PREV-9	4 – Population/ Public Health	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
CMS82v2	1401	372	4 – Population/ Public Health	Maternal Depression Screening
CMS22v3	N/A	317 GPRO PREV-11	4 – Population/ Public Health	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
CMS157v3	0384	143	5 – Patient and Family Engagement	Oncology: Medical and Radiation – Pain Intensity Quantified
CMS56v3	N/A	376	5 – Patient and Family Engagement	Functional Status Assessment for Hip Replacement
CMS66v3	N/A	375	5 – Patient and Family Engagement	Functional Status Assessment for Knee Replacement
CMS90v4	N/A	377	5 – Patient and Family Engagement	Functional Status Assessment for Complex Chronic Conditions
CMS50v3	N/A	374	6 – Care Coordination	Closing the Referral Loop: Receipt of Specialist Report

Program Year 2016 CQMs

CMS eMeasure	NQF	PQRS	Domain	Measure
CMS137v4	0004	305	1 – Clinical Process/ Effectiveness	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
CMS165v4	0018	236 GPRO HTN-2	1 – Clinical Process/ Effectiveness	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
CMS124v4	0032	309	1 – Clinical Process/ Effectiveness	Cervical Cancer Screening
CMS130v4	0034	113 GPRO PREV-6	1 – Clinical Process/ Effectiveness	Diabetes: Eye Exam
CMS126v4	0036	311	1 – Clinical Process/ Effectiveness	Use of Appropriate Medications for Asthma
CMS127v4	0043	111 GPRO PREV-8	1 – Clinical Process/ Effectiveness	Pneumonia Vaccination Status for Older Adults
CMS131v4	0055	117 GPRO DM-7	1 – Clinical Process/ Effectiveness	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
CMS123v4	0056	163	1 – Clinical Process/ Effectiveness	Diabetes: Foot Exam
CMS122v4	0059	001 GPRO DM-2	1 – Clinical Process/ Effectiveness	Diabetes: Hemoglobin A1c Poor Control
CMS148v4	0060	365	1 – Clinical Process/ Effectiveness	Diabetes: Low Density Lipoprotein (LDL) Management
CMS134v4	0062	119	1 – Clinical Process/ Effectiveness	ADHD: Follow- Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication
CMS164v4	0068	204 GPRO IVD-2	1 – Clinical Process/ Effectiveness	HIV/AIDS: RNA Control for Patients with HIV
CMS145v4	0070	7	1 – Clinical Process/ Effectiveness	Depression Remission at Twelve Months
CMS135v4	0081	5	1 – Clinical Process/ Effectiveness	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
CMS144v4	0083	008 GPRO HF-6	1 – Clinical Process/ Effectiveness	Pregnant women that had HBsAg testing
CMS143v4	0086	12	1 – Clinical Process/ Effectiveness	Dementia: Cognitive Assessment
CMS167v4	0088	18	1 – Clinical Process/ Effectiveness	Appropriate Treatment for Children with Upper Respiratory Infection (URI)

CMS eMeasure	NQF	PQRS	Domain	Measure
CMS142v4	0089	19	1 – Clinical Process/ Effectiveness	Hemoglobin A1c Test for Pediatric Patients
CMS161v4	0104	107	1 – Clinical Process/ Effectiveness	Hypertension: Improvement in Blood Pressure
CMS128v4	0105	9	1 – Clinical Process/ Effectiveness	Anti-depressant Medication Management
CMS136v5	0108	366	1 – Clinical Process/ Effectiveness	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer
CMS141v5	0385	72	1 – Clinical Process/ Effectiveness	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
CMS140v4	0387	71	1 – Clinical Process/ Effectiveness	Heart Failure (HF): Beta- Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS52v4	0405	160	1 – Clinical Process/ Effectiveness	Falls: Screening for Future Fall Risk
CMS133v4	0565	191	1 – Clinical Process/ Effectiveness	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS159v4	0710	370 GPRO MH-1	1 – Clinical Process/ Effectiveness	HIV/AIDS: Medical Visit
CMS160v4	0712	371	1 – Clinical Process/ Effectiveness	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)
CMS125v4	N/A	112 GPRO PREV-5	1 – Clinical Process/ Effectiveness	Breast Cancer Screening
CMS149v4	N/A	281	1 – Clinical Process/ Effectiveness	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
CMS158v4	N/A	369	1 – Clinical Process/ Effectiveness	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed
CMS163v4	N/A	2	1 – Clinical Process/ Effectiveness	Children Who Have Dental Decay or Cavities
CMS169v4	N/A	367	1 – Clinical Process/ Effectiveness	Use of Imaging Studies for Low Back Pain

CMS eMeasure	NQF	PQRS	Domain	Measure
CMS182v5	N/A	241	1 – Clinical Process/ Effectiveness	Functional Status Assessment for Hip Replacement
CMS61v5	N/A	316	1 – Clinical Process/ Effectiveness	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS62v4	N/A	368	1 – Clinical Process/ Effectiveness	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range
CMS64v5	N/A	316	1 – Clinical Process/ Effectiveness	Documentation of Current Medications in the Medical Record
CMS65v5	N/A	373	1 – Clinical Process/ Effectiveness	Childhood Immunization Status
CMS74v5	N/A	379	1 – Clinical Process/ Effectiveness	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
CMS75v4	N/A	378	1 – Clinical Process/ Effectiveness	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
CMS77v4	N/A	381	1 – Clinical Process/ Effectiveness	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
CMS156v4	0022	238	2 – Patient Safety	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
CMS139v4	0101	318 GPRO CARE-2	2 – Patient Safety	Primary Open- Angle Glaucoma (POAG): Optic Nerve Evaluation
CMS68v5	0419	130 GPRO CARE-3	2 – Patient Safety	Preventive Care and Screening: Influenza Immunization
CMS132v4	0564	192	2 – Patient Safety	Diabetes: Urine Protein Screening
CMS177v4	1365	382	2 – Patient Safety	Primary Caries Prevention Intervention as Offered by Primary Care Provider
CMS179v4	N/A	380	2 – Patient Safety	Oncology: Medical and Radiation – Pain Intensity Quantified
CMS146v4	0002	66	3 – Efficient Use of Healthcare Resources	Depression Utilization of the PHQ-9 Tool
CMS166v5	0052	312	3 – Efficient Use of Healthcare Resources	Appropriate Testing for Children with Pharyngitis
CMS154v4	0069	65	3 – Efficient Use of Healthcare Resources	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

CMS eMeasure	NQF	PQRS	Domain	Measure
CMS129v5	0389	102	3 – Efficient Use of Healthcare Resources	Colorectal Cancer Screening
CMS155v4	0024	239	4 – Population/ Public Health	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
CMS138v4	0028	226 GPRO PREV- 10	4 – Population/ Public Health	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
CMS153v4	0033	310	4 – Population/ Public Health	Controlling High Blood Pressure
CMS117v4	0038	240	4 – Population/ Public Health	Childhood Immunization Status
CMS147v5	0041	110 GPRO PREV-7	4 – Population/ Public Health	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS2v5	0418	134 GPRO PREV- 12	4 – Population/ Public Health	Functional Status Assessment for Complex Chronic Conditions
CMS69v4	0421	128 GPRO PREV-9	4 – Population/ Public Health	Chlamydia Screening for Women
CMS22v4	N/A	317 GPRO PREV- 11	4 – Population/ Public Health	Functional Status Assessment for Knee Replacement
CMS82v3	N/A	372	4 – Population/ Public Health	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
CMS157v4	0384	143	5 – Patient and Family Engagement	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
CMS56v4	N/A	376	5 – Patient and Family Engagement	Use of High- Risk Medications in the Elderly
CMS66v4	N/A	375	5 – Patient and Family Engagement	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
CMS90v5	N/A	377	5 – Patient and Family Engagement	Maternal Depression Screening
CMS50v4	N/A	374	6 – Care Coordination	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – *If you have not saved your entries, this will cancel your entries and take you to the previous page.*

- “Next” – will save your entries and take you to the next page.
- “Save” – will save your current entries on the page and you will remain on that page.
- “Cancel” – will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel” you will see blank fields.

Screen 17 – Summary of Measures

On this page, you can return to either the Meaningful Use Objectives, or the CQMs and edit any individual question you have answered.

After reviewing your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – will take you to the previous page.
- “Next” – will take you to the next page.

Screen 18 – Incentive Payment Calculations

On this page, there is one item which you need to review.

1. Review the incentive payment amount. Contact the Idaho Medicaid EHR Incentive Program Help Desk if you have any questions.

Note: If you see a \$0 estimated amount of Medicaid EHR incentive payment, you may not have met eligibility requirements. Click on the “Previous” button, and check your responses to the questions on the Provider Eligibility Details page.

After reviewing your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – will take you to the previous page.
- “Next” – will take you to the next page.

Screen 19 – Document Upload

On this page, you need to upload the following mandatory documents.

1. System-generated PV report. This must be from either your CEHRT or your billing service. Screenshots of your generated report may be requested from the EHR Team if further verification is required.
2. Objective documentation. This must be an EHR-generated de-identified report generated from the CEHRT used to substantiate attestation. Screenshots of your generated report may be requested from the EHR Team if further verification is required.

3. Public Health Registry documentation. This must identify the type of active engagement with relevant public health registry, date(s) of active engagement, and must be from the public health registry to which you are attesting. Most often, this is a connection confirmation letter from the public health registry. Other documentation can be approved on a case-by-case basis.
4. CQM documentation. This must be an EHR-generated de-identified report generated from the CEHRT used to substantiate attestation. Screenshots of your generated report may be requested from the EHR Team if further verification is required.
5. Group proxy roster (if applicable).

Additional for PA-Led

Whether AIU or MU attestations, PAs are required to submit documentation to support PA-led.

6. Medical director. This must be a job description, employment agreement/contract, organization chart from clinic.
7. Primary provider. This must be clinic appointment records or work hours relative to other EPs. May use PV reports relative to other EPs.
8. RHC owner. This must be the ownership record.
9. Other. Please work with program staff to identify acceptable documentation to support PA-led.

To ensure reviewing accuracy, use the following naming convention for your documents:

EP Last Name, Document Type (or) Objective Number, Program Year

For Example

Smith, PV, 2015.pdf

Smith, Objective 4, 2015.pdf

Smith, CQM 62, 2015.pdf

Smith, Group Proxy, 2015.pdf

Note: Only PDF documents can be uploaded into IIMS. If you need to upload a different file format, contact the Idaho Medicaid EHR Incentive Program Help Desk for further instructions. Documents uploaded not using the above naming convention or correct document type will cause a delay in processing your incentive payment application. You will still be able to upload documents as necessary throughout the attestation process.

After loading your documents, you must select one of the following buttons from the bottom of the screen:

- “Previous” – will cancel your entries and take you to the previous page.
- “Next” – will save your entries and take you to the next page.

Screen 20 – Attestation

On this page, there are many items you need to review and answer.

1. Review all the data on this page. Once you submit the attestation, you **cannot make any changes**.
2. Enter **your initials** and the EP’s NPI at the bottom-left of the screen.
3. Enter **your name, e-mail**, and the EP’s e-mail at the bottom-right of the screen.

Completing these sections serve as your electronic signature. By entering this information, you attest to the validity of all data submitted for consideration by the Idaho Medicaid EHR Incentive Program.

After reviewing and entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” – *will cancel your entries and take you to the previous page.*
- “Submit” – *notify Idaho Medicaid the EP’s attestation is ready for final eligibility review.*

Note: Once you select “Submit”, it will take you to the first page of your attestation, CMS Registration Information (Screen 1), to review. You can select “Previous” and “Next” to view the attestation pages in a review mode only.

Logout when finished.

Other Information

Out-of-State Providers

Idaho Medicaid EHR incentive payments are only be made to Idaho Medicaid providers. Idaho must be the only state the provider is requesting an incentive payment from during that program year.

Medicaid Program Integrity and Audit

Idaho Medicaid conducts regular reviews of attestations and incentive payments. These reviews are selected as part of the approved audit selection process, including risk assessment, receipt of a complaint, or incorporation into reviews selected for other objectives.

For EPs selected for audited and who have used the CHIP PV average, the auditor will assess whether the total Idaho Medicaid encounters were accurately represented and will not attempt to evaluate an EP's actual Medicaid-only PV. There would be no penalty for EPs who have an actual CHIP PV higher than the statewide patient volume average. For EPs who request their specific data, the audit will assess whether the Medicaid-only encounters were accurately represented, given the information provided by the state.

Retention of Documentation

Providers are required by CMS to retain documentation uploaded in their initial IIMS application for a minimum period of six years from the date of an approved application that resulted in an Idaho Medicaid EHR Incentive payment.

If a provider does not retain the required documentation for the six year period, it may result in adverse action against that provider, including, but not limited to, recoupment of incentive payments and sanctions following audits by the Idaho Medicaid EHR Incentive Program team or independent auditors.

Appeals

Providers can choose to appeal the determination made by the Idaho Medicaid EHR Incentive Program about the incentive payment application. All contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." Within IIMS, on the left-hand menu, the "Appeals" link will give you detailed information regarding a request for an appeal.

Idaho Medicaid Attestation Support

As the Idaho Medicaid EHR Incentive Program team, we are happy to answer any questions you may have. Feel free to call us at (208) 332-7989 or e-mail us at ehrincentives@dhw.idaho.gov. We strive to respond within two business days if we are unable to answer your call or e-mail immediately. We update our program website often, so be sure to check there for the latest news.