



Iowa Medicaid Enterprise State Medicaid HIT Plan 2013

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Change History

Date:	Changed By:	Changes:	Version :
09/08/2010	Jody Holmes Kelly Peiper Dane Pelfrey	Completed version 1.0 for submission to CMS	1.0
11/08/2010	Kelly Peiper Dane Pelfrey	Updated SMHP per Appendix Y - CMS SHMP Approval letter dated Oct 12, 2010 – Enclosures A & B	1.1
7/14/2011	Jody Holmes Kelly Peiper	<ul style="list-style-type: none"> ✓ The Medicaid enrollment numbers and graphs have been updated. ✓ Strategic Planning section has been updated to reflect current status. ✓ HIE Background has been updated to reflect ONC grant. ✓ Update on the Regional Extension Center progress. ✓ Section A has been updated to reflect the most recent assessment information. ✓ A section was added on the Community College Consortium. ✓ Section B was updated to reflect current information from additional planning for the Health Information Exchange by the stakeholder group. ✓ Section C has been updated to note the Iowa progress on the EHR incentive program. ✓ Section C now includes lessons learned. ✓ Section C process flows have been updated to reflect changes made to the process following implementation. ✓ Section D has been modified to identify changes to the pre-payment audit strategy. 	2.0



		<ul style="list-style-type: none">✓ The section E roadmap has been updated to reflect new timelines, and notes which tasks have been completed. Each section has been reviewed and a status update note added to reflect progress on the goals and action items. The tables with specific timelines have been updated to reflect the shift in deliverable timeframes.✓ Appendix. The sections from the Iowa e-Health strategic and operational plan have been removed. The updated plan can be reviewed at www.iowaehealth.org✓ The project abstract for the Immunization and lab grants have been removed.✓ The hospital calculator has been updated.✓ The Iowa Administrative Code rules section has been updated to reflect the current rules.✓ The provider agreement has been included as appendix F, including the PA addendum.✓ Appendix G has been added to show the providers who have expressed interest in participating in the HIE, by provider type.✓ Appendix H has been added to show the questions for Meaningful Use attestation.	
9/19/2011	Jody Holmes	✓ Modify Appendix F, to clarify language in sections II and IV	2.1



08/01/2012	Kelly Peiper	<ul style="list-style-type: none"> ✓ Annual update ✓ Updated hospital calculator ✓ Modify language in Section C to reflect current processes 	3.0
09/13/2013	Jody Holmes Rachel Lunsford	<ul style="list-style-type: none"> ✓ Annual update ✓ Modified background to reflect the new Iowa Health and Wellness Plan ✓ Added State Innovation Model Design to the Background ✓ Updated Section A with general updates on as-is landscape and specific updates on AIU and MU rates ✓ Updated Section C to reflect stage 2 changes ✓ Modified language in Section D to reflect changes requested in a letter dated December 4, 2012 regarding changes to Iowa's comprehensive audit strategy <ul style="list-style-type: none"> ○ Updated strategy to reflect changes to Stage 1 and new Stage 2 rules ○ Defined audit approach for each meaningful use measure ○ Provided auditor checklists ○ Define risk pools for audit strategy ○ Indicated state use of E7/E8 process ✓ Updated Section E to reflect shift in strategy for technical assistance and provided general updates in our roadmap 	4.0
11/21/2014	Rachel Lunsford	<ul style="list-style-type: none"> ✓ Included the summary of the Stage 2 Regulations Changes which starts on page 77 in the clean version and 107 in the marked up version. 	4.1





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Iowa Medicaid Enterprise State Health Information Technology Plan

Document Purpose

The Iowa Medicaid Enterprise (IME) created this updated State Medicaid Health Information Technology Plan (SMHP) as a deliverable to the Centers for Medicare and Medicaid Services (CMS) to continue operation of Iowa's electronic health record (EHR) incentive payment program. The updated SMHP describes how IME will continue to administer the program and enhance the program for Year Two and Three incentives, as authorized under section 4201 of the American Reinvestment and Recovery Act (ARRA). The SMHP also outlines the Health Information Technology (HIT) initiatives the IME believes will encourage the adoption and meaningful use of certified EHR technology. The IME's goal is to use the SMHP as a tool to improve the quality of healthcare our members receive through the exchange of health care information.

This SMHP also serves as the IME's strategic Health Information Technology (HIT) planning document. The IME expects that medical advances, HIT advances, federal and state legislation, and provider needs will evolve, therefore, the IME will continue to revise the SMHP on an annual basis to show a rolling five (5) year vision of HIT needs within Iowa. This annual revision cycle aligns the needs of the IME's members, provider network, and HIT investments.

The IME recognizes that the funding of the individual projects and technologies within this document may come from different sources – Medicaid Management Information System (MMIS) Funding, HITECH Funding, State Funding Grants, etc. Funding for individual projects will be determined as part of the project planning and kickoff activities.

Key Stakeholders

Jennifer Vermeer, Iowa Medicaid Director

Iowa Medicaid Enterprise Policy and Contracting Staff

IME Members

IME Providers

Audience

Centers for Medicare and Medicaid Services (CMS)

Iowa e-Health - Iowa Department of Public Health (IDPH)

Office of the National Coordinator for Health Information Technology (ONC)



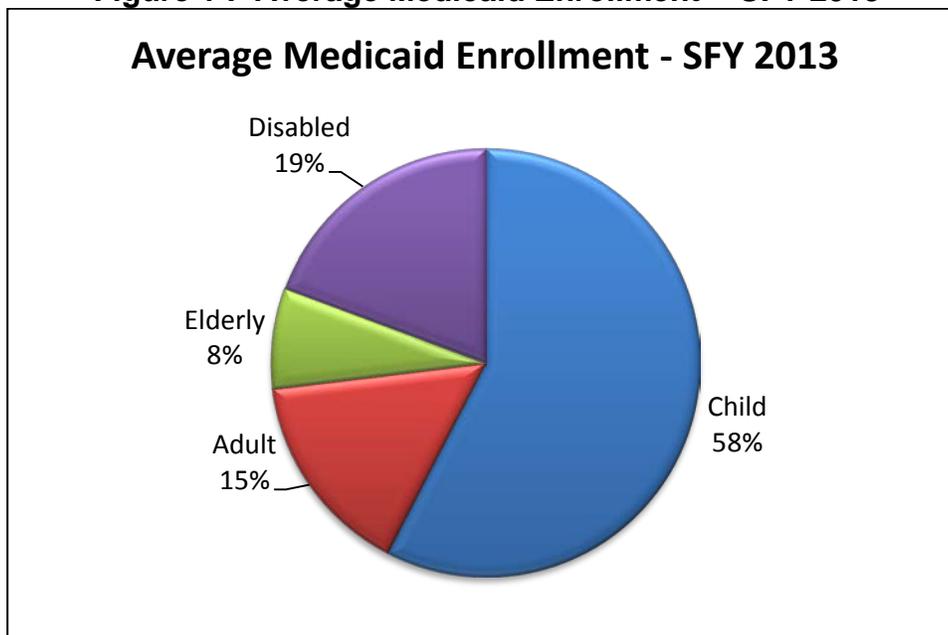
Iowa Medicaid Enterprise – Background

Iowa Medicaid Program

Medicaid is an entitlement program designed to provide medical care to low-income individuals who are aged, blind, or disabled, pregnant, under 21 years of age, or members of a family with dependent children. The program was authorized under Title XIX of the Social Security Act of 1965. The Medicaid program is funded jointly by the state and federal governments.

The Iowa Department of Human Services provided coverage to more than 618,000 individuals in SFY 2011 through full and limited benefit programs, including 1115 waivers and S-CHIP. This is over 19% of Iowa's population. The Medicaid population consists of four general categories: and served the following in SFY 2013:

Figure 1 : Average Medicaid Enrollment -- SFY 2013



Average monthly enrollment in Medicaid by enrollment category

- 230,962 children
- 62,178 low-income parents and adults
- 77,474 persons with disabilities
- 30,515 elderly persons

To be eligible for Medicaid, individuals must not only be low-income, they must also fall into one of the federally mandated categories: children, frail elderly, disabled persons, pregnant



women, or very low-income parents. This leaves many single persons and couples without dependent children ineligible for Medicaid, even if they have no income. Iowa currently covers this population under the 1115 demonstration waiver program entitled “IowaCare” (see below). The program currently covers approximately 60,000 members with a limited provider network and benefit package.

On June 20, 2013, Senate File 446 was signed by the Governor which established the Iowa Health and Wellness Plan. This program begins on January 1, 2014. The plan provides healthcare coverage designed to drive patient outcomes and quality care for low-income individuals not covered under traditional Medicaid.

The Iowa Health and Wellness Plan will replace the 1115 demonstration waiver program entitled “IowaCare”. IowaCare currently covered approximately 80,000 members with a limited provider and network benefit package. The Iowa Health and Wellness Plan will expand the provider network and provided services that meet the Alternative Benefit Plan as defined in the Affordable Care Act. The new program will include components of managed care and accountable care organizations, rewarding providers and members for engaging in health management.

The Iowa Health and Wellness Plan will assure universal access to health insurance for all Iowans. The plan will implement three options that offer coverage to adults between 19 and 64 years of age with income not exceeding 133%¹ Federal Poverty Level. Current IowaCare enrollees who are above the 133% FPL will be eligible to receive advance premium tax credits through the Iowa Marketplace. The three components of the Iowa Health and Wellness Plan are:

- 1) the Iowa Wellness Plan serving non-medically frail eligible individuals up to and including 100% FPL and medically frail eligible individuals with income up to 133% FPL through a 1115 demonstration that promotes coordinated care, managed care, and the development of Accountable Care Organizations (ACOs);
- 2) the Iowa Marketplace Choice Plan serving non-medically frail individuals with income 101% FPL up to and including 133% FPL by offering premium assistance for eligible individuals to enroll in Qualified Health Plans through the health insurance marketplace (Marketplace); and
- 3) offering premium assistance for cost-effective employer sponsored insurance (ESI) under Iowa’s Health Insurance Premium Payment (HIPP) program.

Iowans found to be eligible for the Iowa Wellness Plan will be screened prior to enrollment to determine if they qualify for medically frail status as described at 42 CFR §440.315(f0 and

¹ With the 5% of FPL disregarded, 133% FPL will include individuals with income up to and including 138% FPL. All notations of 133% FPL in this document are inclusive of the 5% disregard to 138% FPL unless otherwise stated.



a retrospective process will be implemented to identify individuals who become medically frail post enrollment.

State Innovation Model

Iowa is one of 19 State Innovation Model (SIM) Design States, a Centers for Medicare and Medicaid Services sponsored program, with the goal of a multipayer broad-based transformation in healthcare. Iowa has three main strategies: establish a Medicaid Accountable Care Organization (ACO) delivery model that aligns with Medicare and private payors in Iowa; Integrate Long Term Care Services and Supports (LTCSS) and Behavioral Health into the delivery system; and support the Healthiest State Initiative².

The product at the end of the eight month design grant is to develop a State Healthcare Innovation Plan (SHIP). Iowa will submit a SHIP to CMS in December of 2013 that outlines a five year vision of healthcare in Iowa, explains what steps we will take to make the transformation, and why those steps will move us towards the State's goals. Iowa has outlined three goals, become the healthiest state in the nation, reduce the rate of growth in healthcare cost for the state compared to the Consumer Price Index, and reduce the total cost of healthcare by 5 - 8% for each ACO.

As we work towards these goals, health IT will play a crucial role in sharing health information within the ACO and will provide the IME a way to gather data to ascertain the model's success.

Medicaid Coverage

The Medicaid programs serve Iowa's most vulnerable population, including children, disabled and the elderly. The cost of medical care for different Medicaid populations varies significantly. The average cost for each child in Medicaid is much lower than the average cost for each disabled or elderly person, since elderly and disabled individuals utilize more long-term care services. As shown in the charts, although children make up 57% of the Medicaid population, they account for only 18% of total expenditures. This difference is true nationally as well.

Typically nineteen percent (19%) of Medicaid beneficiaries account for 51% of the Medicaid expenditures. These members with the most challenging health care needs are served in a fragmented and uncoordinated fee-for-service delivery system, with limited communication among providers. More than 50% of Medicaid beneficiaries with disabilities are diagnosed with mental illness. Behavioral health services are typically provided separately from physical health, with little or no coordination between the two delivery systems. Almost 20% of Medicaid members are dually enrolled in Medicare, increasing the complexity in providing

² For more information on the Healthiest State Initiative, please visit: <http://www.iowahealthieststate.com/>.



coordinated care, often resulting in unnecessary emergency room utilization, hospitalizations, and nursing home placements.

³Table 1 : Historical Medicaid Enrollment

	<u>SFY</u> <u>2009</u>	<u>SFY</u> <u>2010</u>	<u>SFY</u> <u>2011</u>	<u>SFY</u> <u>2012</u>	<u>SFY</u> <u>2013</u>
Aged	30,100	30,250	29,935	30,035	30,515
Adult	52,680	57,077	61,043	62,902	62,178
Disabled	66,514	69,895	72,395	75,255	77,474
Child	180,992	204,163	217,376	225,473	230,962
Total	330,286	361,385	380,749	393,664	401,129

Table 2: Historical Medicaid Expenditures

	<u>SFY 2009</u>	<u>SFY 2010</u>	<u>SFY 2011</u>	<u>SFY 2012</u>	<u>SFY 2013</u>
Aged	531,195,317	560,855,596	604,759,937	621,581,880	645,625,824
Adult	323,429,760	349,999,871	365,211,344	367,686,041	389,434,499
Disabled	1,412,087,523	1,490,953,121	1,544,947,414	1,642,231,287	1,696,148,703
Child	495,307,142	535,356,610	573,980,678	583,503,386	636,390,928
Total	\$2,762,019,743	\$2,937,165,197	\$3,088,899,373	\$3,215,002,594	\$3,367,599,954

For more information on Iowa Medicaid coverage refer to the following information:
<http://www.ime.state.ia.us/Members/index.html>

Medicaid members typically receive care from an array of providers who may be unaware of one another’s treatment plans. This can result in duplication of services, inappropriate treatment and unnecessary prescriptions being prescribed. Many providers decline to serve the Medicaid population, saying they tend to have complicated medical problems, skip appointments, and have difficulty complying with their treatment plans.

Iowa Medicaid Enterprise

Iowa Medicaid Enterprise (IME) is responsible for administering the Iowa Medicaid Program. It exists under the Iowa Department of Human Services, and is staffed with approximately 29 state employees. The Department has implemented a model for the IME where professional services vendors work cooperatively with the Department staff to perform the Medicaid functions as described below. These functions are handled by one fiscal agent in many other states. Iowa has been successful with this unique model.

³ The numbers reflect average monthly enrollment.



The IME established an environment and structures which enable the vendors to work together with Department policy and program staff to achieve common goals for the IME. Each vendor brings its specific best of breed expertise and knowledge to the IME. With this model, the IME functions much like a commercial health insurer - where the Department maintains ultimate authority and responsibility for the Medicaid program and hires those with expertise in specific domains.

The specific units within the IME:

- Provider Services
- Member Services
- Medical Services
- Pharmacy Medical Services
- Core MMIS (includes mailroom, imaging, workflow and claims administration)
- Program Integrity / Analysis and Provider Audits
- Revenue Collection / Estate Recovery Services
- Provider Cost Audit and Rate Setting
- Pharmacy Point-of-Sale
- Data Warehouse and Medical Systems

Iowa Medicaid Strategic Planning

The leadership staff at the IME is planning for multiple initiatives driven by state and federal regulations. These projects will impact, and be impacted, by HIT initiatives undertaken at the IME.

Table 3: IME Initiatives

Project	Description	Timeline
ICD-10	Expansion of code sets from ICD-9 to ICD-10. Gap analysis is completed. Implementation strategies identified and selected.	Current: Oct 2013
Integrated Eligibility Program	The contract has been awarded for a new integrated eligibility system. The project kick off is scheduled for August 2012, with Medicaid eligibility expected to go live October 1 2013.	Oct 2013
Health Home	Iowa has received approval for the State Plan Amendment for Health Homes for chronically ill members. The program	Implement ed July 2012



Project	Description	Timeline
	launched July 2012. Quality metrics for monitor performance outcomes will be collected through the Health Information Network beginning August 2012.	
MIDAS (Medicaid Integrated Data Administration Services)	The contracts have been awarded for MMIS Systems and Operations, and Pharmacy Point of Sale. Project kick-off occurred in June, 2012. Anticipated MMIS implementation Feb 2015.	Feb 2015
Affordable Care Act	ACA is a large project crossing multiple policy and technical areas. Current activities include planning for CORE Operating Rules, eligibility modifications, and a potential health benefit exchange.	Ongoing
Iowa Health and Wellness Plan	The Iowa Legislature enacted the "Iowa Health and Wellness Plan" to cover all Iowans age 19-64 with incomes under 138% of the Federal Poverty Line.	January 1, 2014

Iowa e-Health

In 2008, the Iowa Legislature enacted House File 2539, which established eleven advisory councils charged with making recommendations for health reform in Iowa. One of the eleven advisory councils is the e-Health Executive Committee and Advisory Council administered by the Iowa Department of Public Health (IDPH). The e-Health Executive Committee, with technical assistance from the e-Health Advisory Council and IDPH, is charged with the following:

- a) Developing a statewide health information technology plan by July 1, 2009;
- b) Identifying existing and potential health IT efforts, and integrating with state and national efforts to avoid incompatibility and duplication;
- c) Coordinating public and private efforts to provide the network and communications backbone for health IT;
- d) Promoting the use of telemedicine defined as the use of communications and information technology for the delivery of care, usually in ways not otherwise available in the patient's immediate environment;
- e) Addressing workforce needs generated by increased use of health IT;
- f) Recommending rules to be adopted in accordance with Iowa Code chapter 17A to implement all aspects of the plan and the network;
- g) Coordinating, monitoring and evaluating the adoption, use, interoperability, and efficiencies of health IT in the state;
- h) Seeking and applying for any federal or private funding to assist in implementation and support of the health IT system;



- i) Identifying state laws and rules that present barriers to development of the health IT system.

The 2010 Iowa e-Health Strategic and Operational Plan⁴ was created as a required deliverable of ONC's HIE Cooperative Agreement Program and will allow Iowa to access \$8,375,000 of planning and implementation funds from 2010 to 2014. Through its IAPD approved in early, 2012, Iowa Medicaid secured another \$2,295,000 over through FFY 2013 to support HIE implementation activities. These ARRA funds will help Iowa e-Health execute the tasks and activities described in the Plan.

Direct Secure Messaging was implemented in December 2012. There are currently 57 organizations signed up with Participation Agreements, 809 Direct Secure Messaging users, and over 1700 transactions since implementation. Sixteen hospitals are currently enrolled. IME worked with providers, particularly dentists, in SFY13 to sign up and use this function to send prior authorization requests and clinical quality measures. Five hospitals are currently engaged in testing the query function and look forward to a launch in November 2013.

As a voting member of the Iowa e-Health Advisory Council, the IME is an active participant in all e-Health workgroups, and meets monthly with the Iowa Department of Public Health to coordinate efforts regarding Health Information Exchange, Health Information Technology, and the adoption of electronic health records. IME is also meeting weekly with the IHIN vendor to provide requirements for quality measure reporting.

Iowa HIT Regional Extension Center

Telligen, (formerly known as The Iowa Foundation for Medical Care (IFMC)) received the ONC grant to be the Health Information Technology Regional Extension Center (HIT REC)⁵ for Iowa. The REC is charged with assisting 1,200 primary care providers and 84 critical access/rural hospitals with improving patient care through the adoption and meaningful use of electronic health records. The REC provides technical assistance to primary care practices with ten or fewer professionals with prescriptive privileges. They also assist public and critical access hospitals (CAHs) providing primary care, and community and rural health centers that predominantly serve the uninsured, underinsured and underserved.

The Iowa REC achieved full recruitment of 1200 Priority Primary Care Providers (PPCPs) on December 8, 2011, and has continued to enroll providers, reaching 1322 PPCPs as of July 2012. The REC achieved full recruitment of 84 hospitals on March 30, 2012. REC efforts now focus entirely on accelerating EHR adoption and meaningful use achievement. The Iowa REC achieved 100% of all clients at "Go-Live" status on a certified EHR in December 2013. The REC program commends its partners and stakeholders in achieving these goals, in particular the Iowa Department of Public Health (IDPH) and Iowa

⁴ More information regarding Iowa e-Health and the Strategic and Operational Plan is available on the e-Health website: <http://www.iowahealth.org/>

⁵ More information on the Iowa HIT REC can be found on their website: <http://www.telligenhitrec.org/>.



Medicaid for their collaboration and support. The fact that Iowa was one of the first states ready to release Medicaid incentive payments in January 2011 has greatly benefitted REC recruitment efforts and Iowa providers.

As a member of the advisory council for the HITREC, Iowa Medicaid participates in quarterly meetings with other key stakeholders to provide practical input that guides the operations, vision and outcomes of the REC. Participation in the advisory council enables the HITREC to provide consistent communication to providers regarding EHR adoption, meaningful use, and available incentives, and also educates the other stakeholders with the same messages.

Iowa Medicaid also participates in monthly strategy sessions with Iowa eHealth (State HIE) and the REC. These meetings include leadership from the three organizations and due to their frequency and face-to-face nature, a special collaboration has formed with straightforward, honest discussion, and support for goals common to all three initiatives. This collaboration is unique to Iowa and has been a requested presentation topic for the REC at several ONC national meetings.

The REC's funding ends February 7, 2014. Telligen is transitioning their team to a fee-based service so that providers can still benefit from their extensive knowledge and experience to rely on them for support in implementing EHRs and working toward being meaningful users of EHRs.



Section A: Iowa's "As-Is" HIT Landscape

Overview

Iowa's "As-Is" HIT landscape describes the level of HIT adoption by Iowa's health care providers.

Provider EHR Adoption

In 2010, the IME conducted provider surveys in collaboration with Iowa e-Health to understand the barriers and utilization of EHR in Iowa. Surveys were developed and reviewed by e-Health workgroups and the IME staff. The IME promoted the surveys through meeting with professional organizations and utilizing our existing provider outreach processes.

Additional provider types, including home health care, long term care, laboratories, and pharmacies were included in the surveys. The results from this survey can be found in Appendix A. IME is planning to conduct another environmental scan in Fall 2013 through Winter 2014.

The IME's provider portal was enhanced to survey providers regarding their EHR implementation and meaningful use status and future plans. This survey is collected as part of provider re-enrollment and allows Iowa to continue to monitor EHR adoption progress within the state, beyond those providers who are receiving incentives. Provider re-enrollment launched in May 2013.

Results as of August 28, 2013, 11,987 providers responded to questions about EHRs and health information exchange as part of the re-enrollment process. When asked if the provider currently used electronic health records, 76% responded that they did compared to the 24% who did not. For those who responded that they didn't use an EHR, we asked if they had plans to purchase one. While just under half had plans to purchase an EHR in the next five years, 55% of providers responded that they did not have any plans to purchase an EHR.

Of the providers who responded affirmatively that they used an EHR, we asked if the EHR was certified for meaningful use⁶, about current or planned connection to the health information exchange (Iowa Health Information Network), barriers to EHR use, and what Medicaid could do to assist providers. A majority of providers are using a certified EHR ready to meet meaningful use with 91% responding yes. Providers are either currently connected to IHIN to exchange information (19%) or have plans to connect in the next year

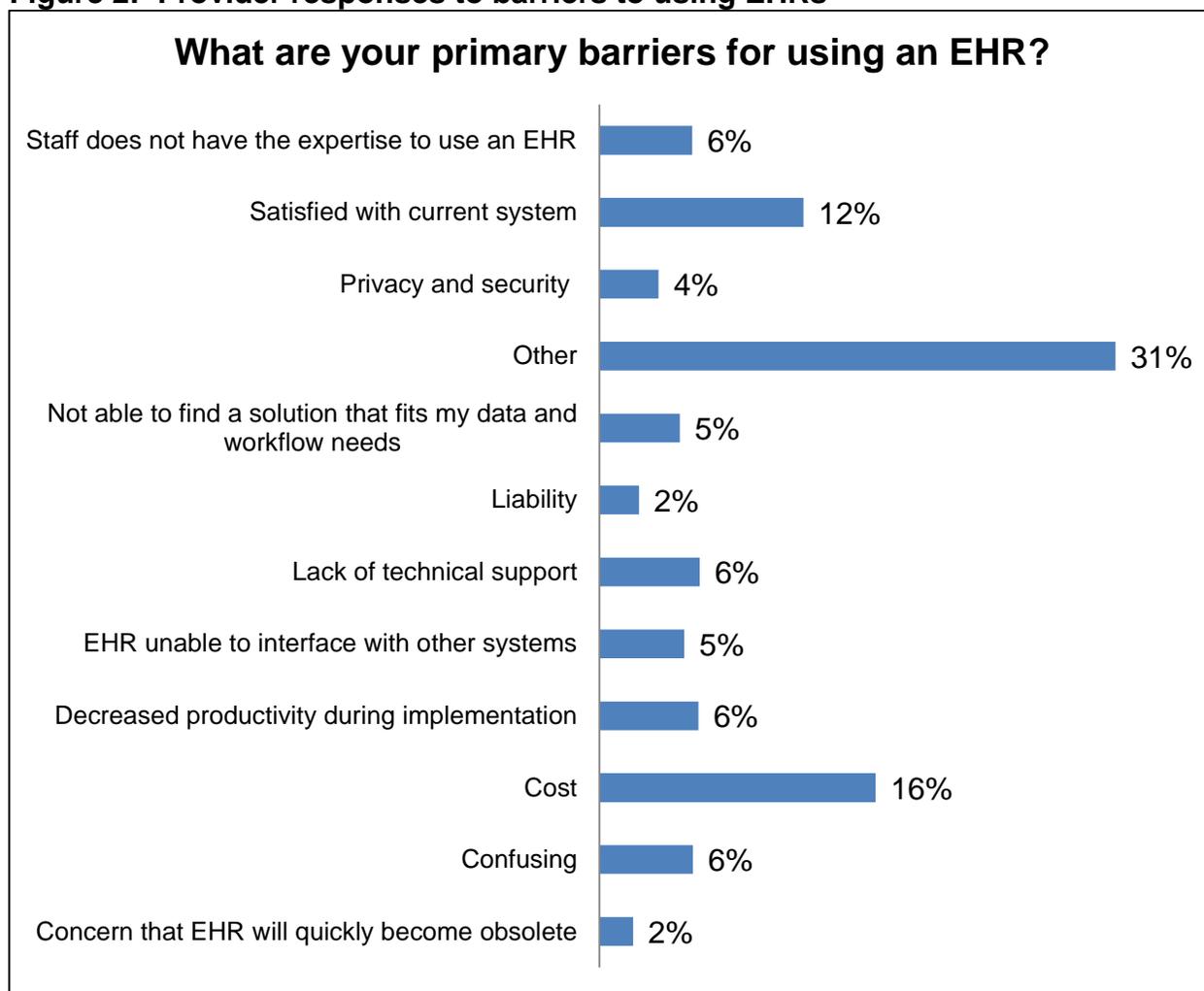
⁶This question was presented during Stage 1 and did not take into account plans for Stage 2 certified systems.



(25%) or 2-3 years (14%). Under half (46%) of providers who responded noted that they had no plans to exchange information.

When asked what the primary barriers for using an EHR were, providers responded that costs concerned them. They also noted that 6% of providers stated that staff does not have the expertise to use an EHR, the provider lacked technical support, there was decreased productivity during implementation, and that they found it confusing. Thirty-one percent of providers surveyed noted that other unidentified barriers were attributed as a barrier to using an EHR.

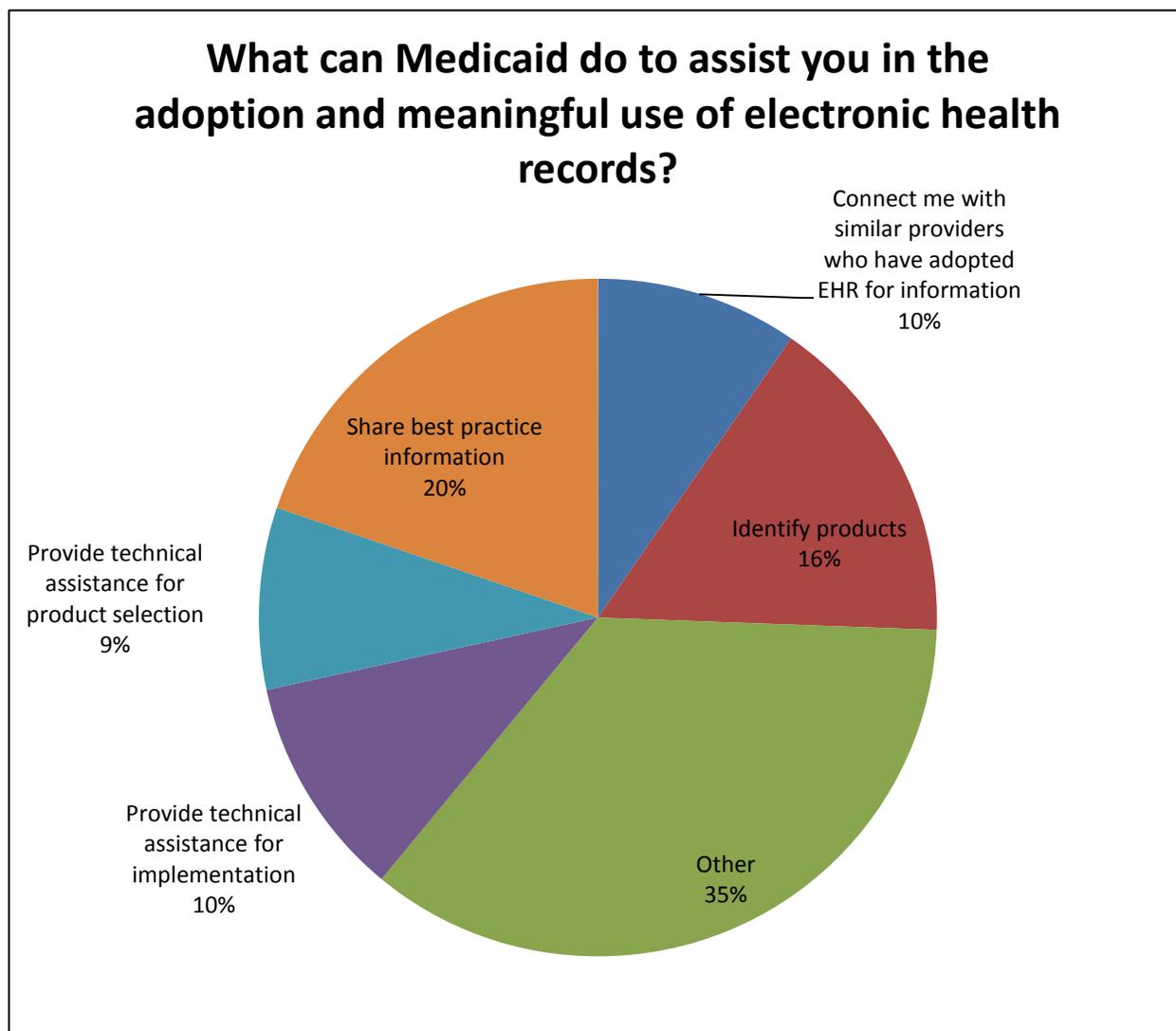
Figure 2: Provider responses to barriers to using EHRs





Finally, 20% of providers suggested that Iowa Medicaid Enterprise could assist them in the adoption and meaningful use of EHRs by sharing best practice information. Other areas included providing technical assistance for implementation and connecting providers to similar providers who have adopted EHR. We will take these recommendations into consideration for our communication and outreach plan in 2014.

Figure 3: Provider responses to how the IME could assist adoption and meaningful use of EHRs





Below we outline the number of incentives paid relative to numbers licensed in Iowa as of July 1, 2013. As illustrated in table 5, approximately 30% of Iowa’s provider population have adopted and attested to having an EHR.

Table 4: Incentives paid to licensed providers in Iowa by provider type as of July 2013

	Number in Iowa	Number Medicare	Number Medicaid	Total incentives	Total incentives
Physicians	6,178	2187	854	3056	49%
Nurse Practitioners	1,329	-	241	241	18%
CNM	80	-	20	20	25%
PA	1,099	-	16	16	1.5%
Dentists	1,635	1	84	85	5%
Podiatrists	247	93	-	93	37%
Chiropractors	1,814	213	-	213	11%
Optometrists	691	185	-	185	26%
Total	13,073	2679	1215	3909	29.9%

EHR Adoption - Hospital

In 2009, 85% of Iowa Hospitals were using some form of electronic health record. However, only 11% of the 85% reported that they “relied entirely on an electronic health record system.” This indicates there is a significant effort needed to move hospitals towards achieving meaningful use of EHRs.

The major barrier to implementation is the capital to purchase and implement systems (65% of respondents). Additional barriers include ongoing cost to maintain the system, resistance from physicians, and finding an EHR that meets the hospital’s needs.

As of July 1, 2013, we have 92 hospitals attested to adopting an EHR and 49 hospitals as meaningful users. From a Medicaid perspective, we have not seen 24 hospitals attest for an incentive payment.



EHR Adoption – Long Term Care

Costs associated with Long Term Care (LTC) are a significant portion of the IME's annual expenses. The IME will continue to research the value of HIT within the Long Term Care setting. The IME continues to meet with several organizations within the Iowa Department of Human Services to discuss EHR Incentives available to their eligible providers, and documenting their HIT needs.

As the HIT environment continues to mature, Iowa's SMHP will be revised to reflect the needs of the LTC community, specifically in relation to EHR/HIE adoption and sharing of continuity of care and discharge instructions between providers. IME is currently working with vendors, including the Iowa REC, to determine technical assistance availability to all providers who do not qualify for the REC services, including long term care providers.

Behavioral Health – Mental Health – Substance Abuse

Iowa Medicaid participated in the Substance Abuse Mental Health Services Administration (SAMHSA) sponsored conference on the use of Health Information Technology for Behavioral Health, Mental Health and Substance Abuse. This conference was the beginning of the dialog to determine how state efforts can best be aligned for these provider and population groups.

Federally Qualified Health Centers

Iowa's health center controlled network, INConcert Care, Inc, received an EMR implementation grant from Health Resource and Services Administration (HRSA). The grant, totaling over \$1.3 million, along with a variety of other funding sources, is helping fund implementation of GE Centricity EMR in six Federally Qualified Health Centers (FQHCs) in Iowa and one in Nebraska. Next Gen, and EHS EHR systems have been selected for implementation within other individual FQHC locations. The grant's project period is September 1, 2009 – August 31, 2012.

Participating FQHCs in Iowa include:

- Primary Health Care, Des Moines and Marshalltown
- Peoples Community Health Clinic, Waterloo and Clarksville
- Crescent Community Health Center, Dubuque
- Community Health Center of Fort Dodge, Fort Dodge
- River Hills Community Health Center, Ottumwa, Richland, and Centerville
- Siouxland Community Health Center, Sioux City

Currently, Siouxland Community Health Center in Sioux City, Peoples Community Health Clinic in Waterloo and Clarksville, Primary Health Care in Des Moines and Marshalltown, and Crescent Community Health Center in Dubuque are all live on Centricity EMR, Community Health Center of Fort Dodge in the process of going live in July and River Hills Community Health Center will go live in August. Proteus, the FQHC, which is a migrant



program, decided against proceeding with the Centricity implementation due to it having more capacity and ongoing operating costs than they need and can afford. An FQHC look-alike in Sioux Center, Greater Sioux Community Health Center just learned in late June it was awarded a grant and now has FQHC status. They attested to having SuccessEHR in Fall 2012.

All FQHCs have providers who attested to AIU by 2013. We look forward to seeing them return to attest for meaningful use.

INConcert Care provides other services including dental clinical information systems to eight FQHC's and population health management software (registry) to 15 centers. All software applications, including e-mail, are served up out of a data center located in Davenport, IA. INConcert Care has executed a teaming agreement with the Regional Extension Center and participates in the Iowa Health Systems (Health Net Connect) FCC connectivity project. This connectivity provides for up to 160 mg connectivity for the exchange of EMR data through the Statewide Health Information Exchange.

Recently, INConcert Care, Inc purchased GE's patient portal software and will be implementing that software in the next 60 days to allow the FQHC's to participate in the secure messaging function of the State e-health network.

Veterans Administration & Indian Health Services

Within Iowa, the Veterans Health Administration (VHA) has Medical Centers in Des Moines and Iowa City, and 11 Community Based Outpatient Clinics. Every location is connected within the VA's infrastructure using VistA and Computerized Patient Record System (CPRS) to share clinical information both within state VA locations, and worldwide within the VA's infrastructure.

The IME contacted the Iowa tribes under the Indian Health Services umbrella and found that the Winnebago tribe utilizes the certified for meaningful use Resource and Patient Management System (RPMS) provided by Indian Health Services. The Ponca Tribe also implemented the IHS RPMS EHR about a year ago. The Ponca tribe looks forward to enhancing their electronic data exchange capabilities, particularly with outside labs. The Meskwaki Settlement has plans to utilize the RPMS in the future. The IME will continue to work with all tribes to move them toward meaningful use.

Provider Incentive Payments

The IME's provider outreach efforts on the EHR incentive requirements and path to payment have been extensive. The IME has participated in presentations at Critical Access Hospital Meetings, Iowa Hospital Association Meetings, Iowa e-health Seminars, Iowa Medical Group Management Association, Regional Extension Center-sponsored webinars, and at Medicaid Provider annual training seminars. Additionally, EHR incentive information has



been shared through the IME’s provider portal, through IME informational letters, and through several provider webinars.

The table below describes the number of Medicaid participants the IME estimates becoming eligible for EHR Incentives, along with an update of payouts:

Table 5: Estimated number of participants in Iowa Medicaid's EHR Incentive program

Provider Type	No. of Providers enrolled in Medicaid	Estimated % Eligible	Estimated No. Eligible	No. Paid
Eligible Professionals				
Physician	8528	10%	853	854
Nurse Practitioner	813	10%	81	241
Dentist	1254	10%	125	84
Certified Nurse Midwife	41	10%	4	20
Physician Assistants				16
Total			1063	1215
Acute Care Hospitals	37	100%	37	92
Children’s Hospitals	0	0	0	0
Critical Access Hospitals	82	90%	72	75
Total			109	92

The variance between IME’s estimates for the number of nurse practitioners and certified nurse midwives being eligible and the number actually paid is because they are able to see Medicaid patients at facilities that enroll at the facility level, and therefore these EPs are not required to enroll separately in Medicaid. However, they qualify for the incentives because they treat Medicaid patients, but it is a challenge to predict how many are potentially eligible. In addition, Physician Assistants (PAs) are not currently tracked as a separate provider type within the IME’s MMIS system. The IME estimates that up to 50 PA’s may become eligible for EHR Incentive.

Based on our communication with hospitals and the payments made to date, the IME believes that nearly all Acute Care and Critical Access Hospitals will meet the 10% Medicaid patient/encounter thresholds. More difficult to predict is the number of Eligible Professionals who will meet 30% Medicaid patient/encounter thresholds (20% for pediatricians).

Informally, the IME estimated that approximately 10% of Eligible Professionals would meet their Medicaid encounter requirements. The IME utilized claims information as a numerator and an average number of encounters per year as estimated by the American Academy of Family Physicians as a denominator. The IME determined a rough order of magnitude estimate that approximately 1,200 eligible providers will meet Medicaid encounter



requirements. This rough order of magnitude is assumed accurate within a range of -50% to +200%.

As of July 2, 2013, the IME has paid out \$78,509,607.00 in incentive payments to 1215EPs and 92 EHs for AIU. We have many providers and hospitals attesting to meaningful use – 489 EPs and 47 EHs. However, over 200 EPs registered for Medicaid incentives at the CMS Registration and Attestation site have yet to attest. The IME will continue its outreach efforts targeting these providers to determine their barriers and assist them in completing attestation in Iowa.

The IME projected that approximately half (50%) of the estimated 1,200 eligible providers would request EHR incentive payment during 2011 based on Iowa’s EHR adoption percentages, and the required adoption of certified EHR technology. Of the 600 expected to attest for a 2011 payment, 776 did so. Since then, IME has paid an additional 439 providers for adopting/implementing/upgrading their EHR. The breakdown of the number of payments by provider type can be seen in figure 2 while figure 3 illustrates the dollar amount of incentive amounts by provider.

Figure 4: Number of eligible providers who received a Medicaid incentive payment

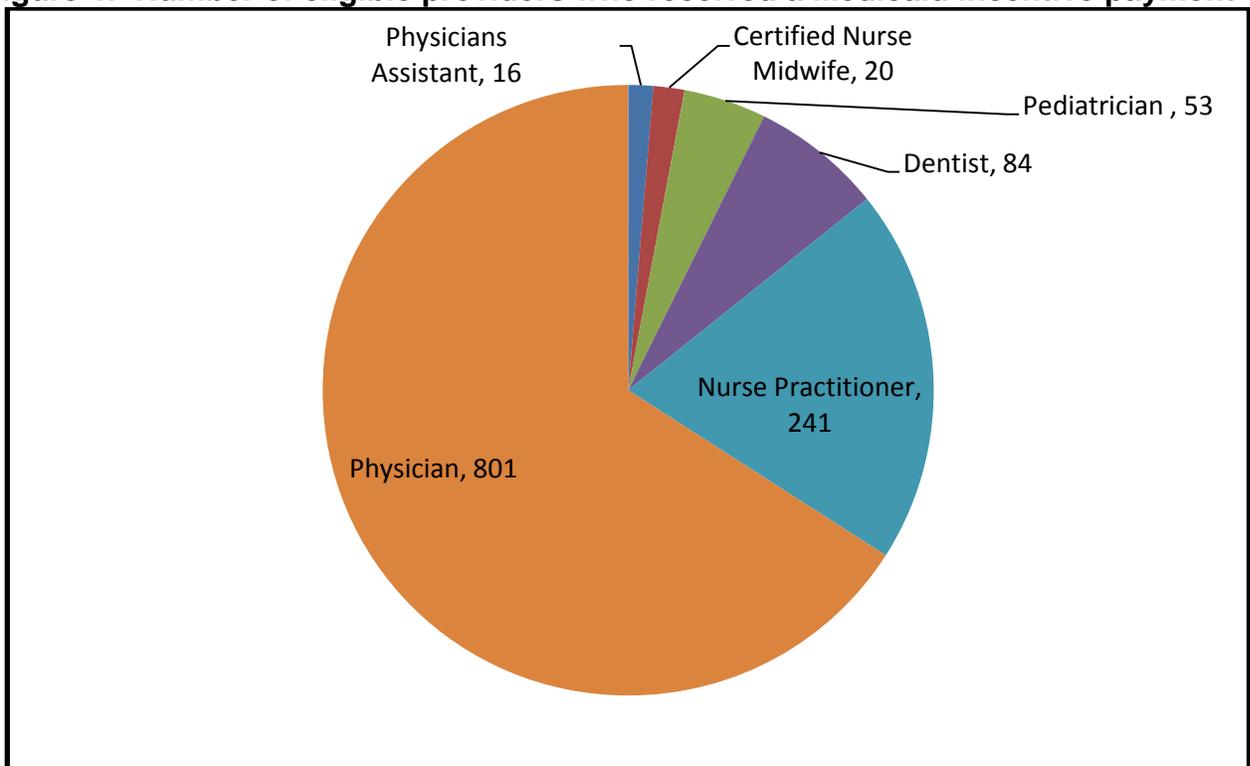
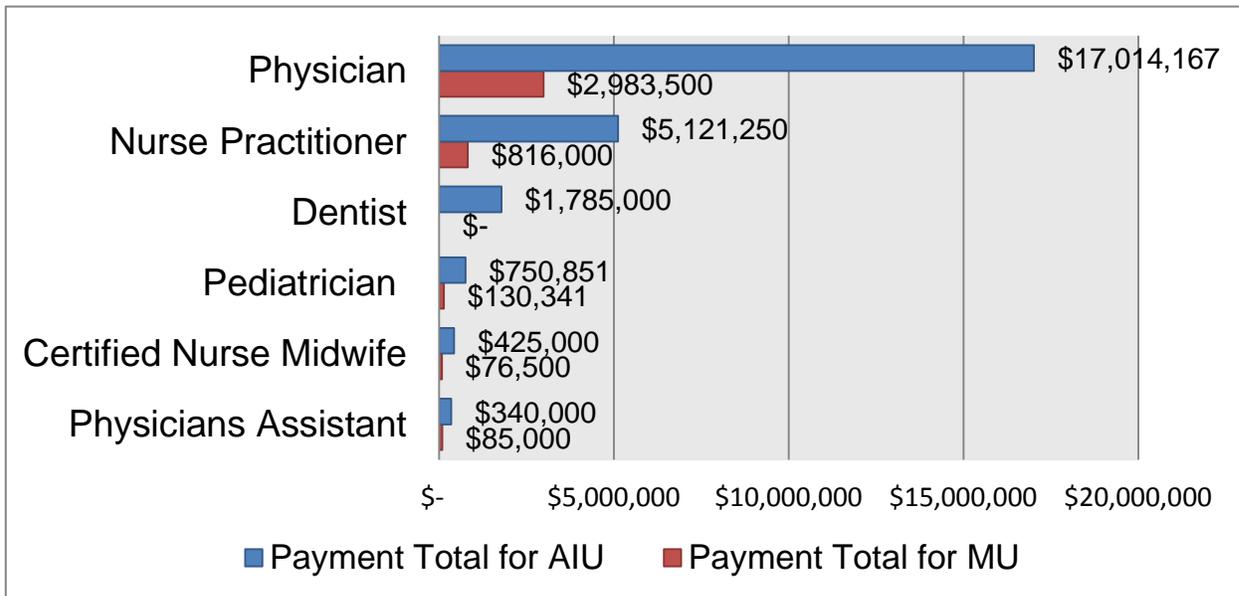


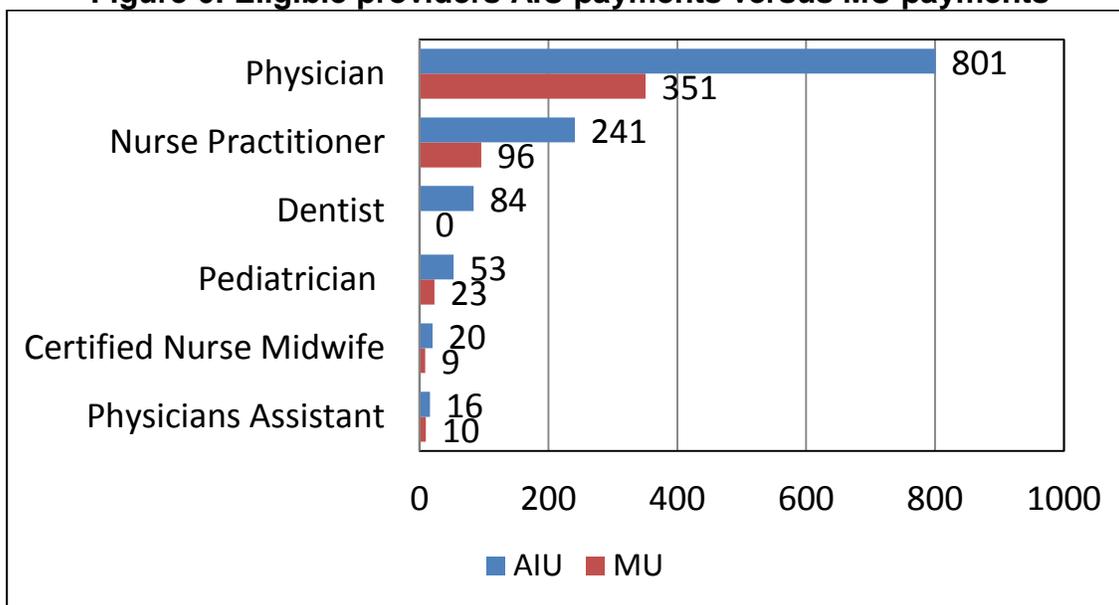


Figure 5: Cumulative payments made to eligible providers (July 1, 2013)



Of the payments made to physicians, 53 were made to pediatricians qualifying with a Medicaid patient volume between 20% and 30%. In figure 4, we can see that roughly 40% of providers move on from the adoption and implementation stage to meaningful use of their EHR. IME hopes to see many more MU users in 2013, up to the 545 we anticipated.

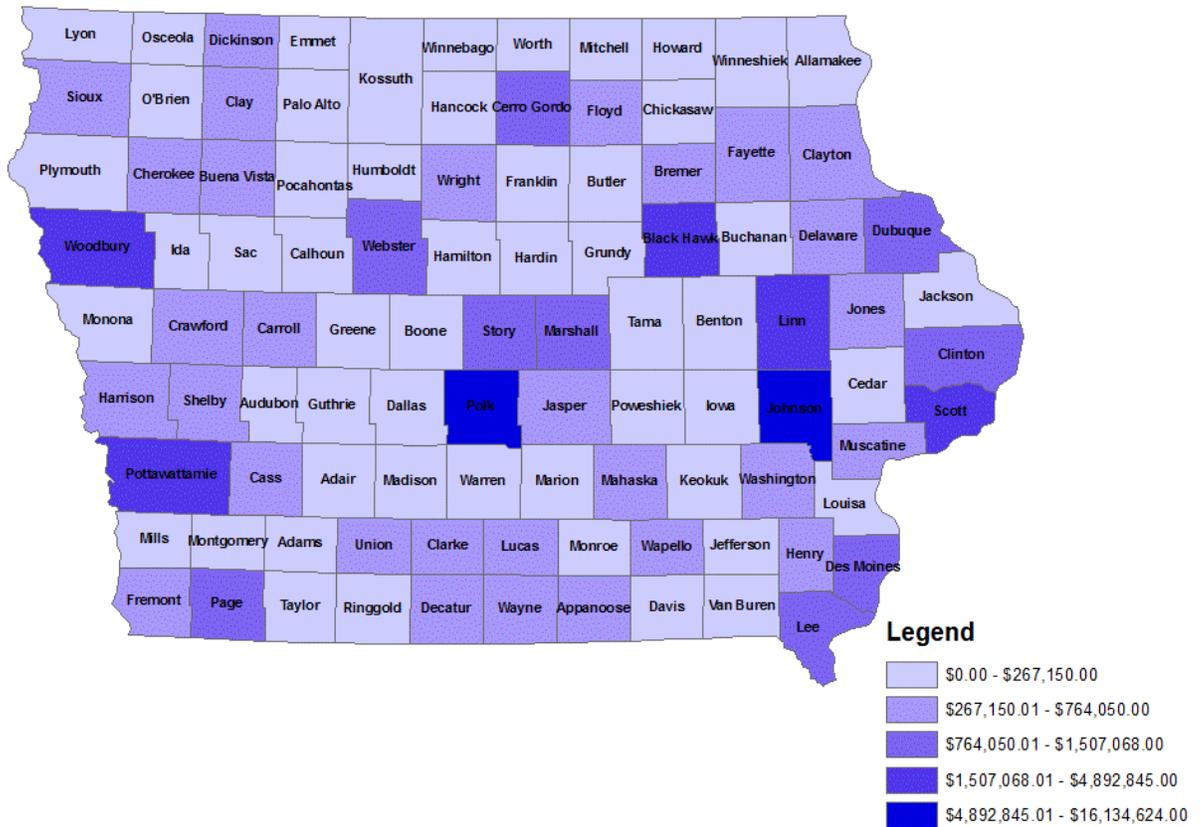
Figure 6: Eligible providers AIU payments versus MU payments



The map below depicts payments made to providers across the State of Iowa as of July 12, 2013.

Figure 7: Map of Medicaid EHR Incentive Payments by County as of 7/12/2013

Medicaid EHR Incentive Payments by County as of 7/12/2013



Initially, the number of hospitals attesting fell short of IME expectations. IME projected paying 65 hospitals for 2011. Instead, only 50 hospitals attested for a 2011 payment. In 2012, our goal was to have 82 hospitals receive a year one payment. We had 39 additional hospitals receiving their first year payment in 2012, for a cumulative 89 hospitals since program inception. So far for 2013, we have 3 additional hospitals receive their first year payment which brings us to our target of 92 for 2013. All of these hospitals received incentives payments totaling \$48,981,998 as of July 1, 2013. The break down between AIU payments and MU payments can be seen in Figure 6.

Through extensive collaboration with the Regional Extension Center and the Iowa Hospital Association, IME discovered many errors in how hospitals were calculating patient volume and believed they did not qualify for the Medicaid incentive. We reached out and worked



with those hospitals to make adjustments to the errors. For many, IME underpaid them and paid out what they should have received.

Currently, 47 hospitals, or 51%, have attested to meaningful use, as seen in figure 10. This level falls behind IME's target of 70 hospitals attest to second year payments. A priority for IME is to continue to reach out to hospitals to encourage attesting to meaningful use to meet or exceed our goal of 70 hospitals receiving a second year payment.

Figure 8: Medicaid incentive payments to acute care hospitals

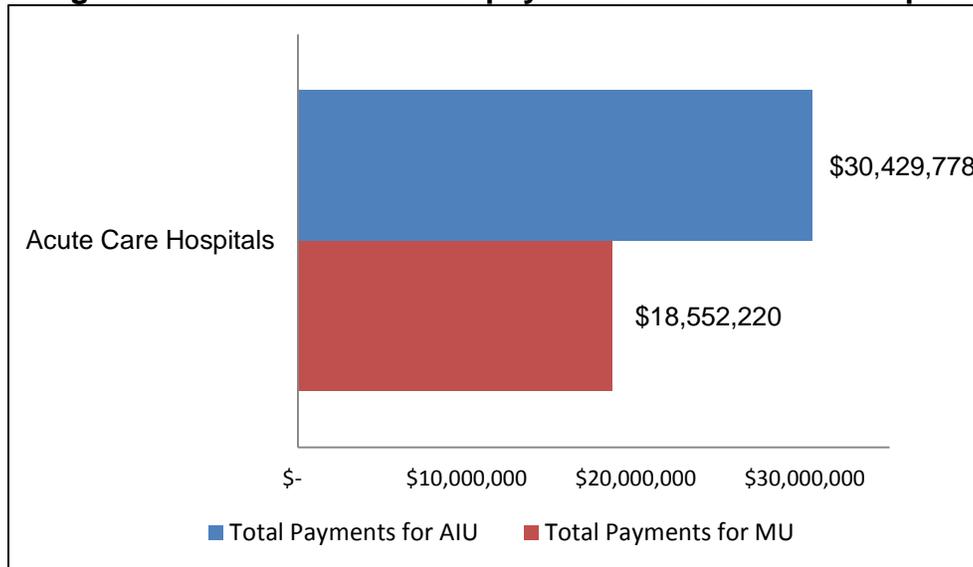
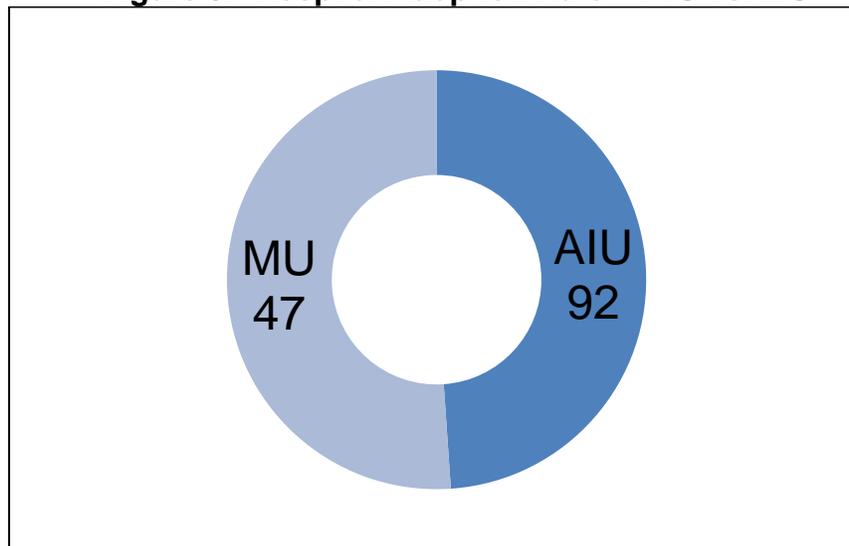


Figure 9: Hospital Adoption Rate -- AIU vs. MU



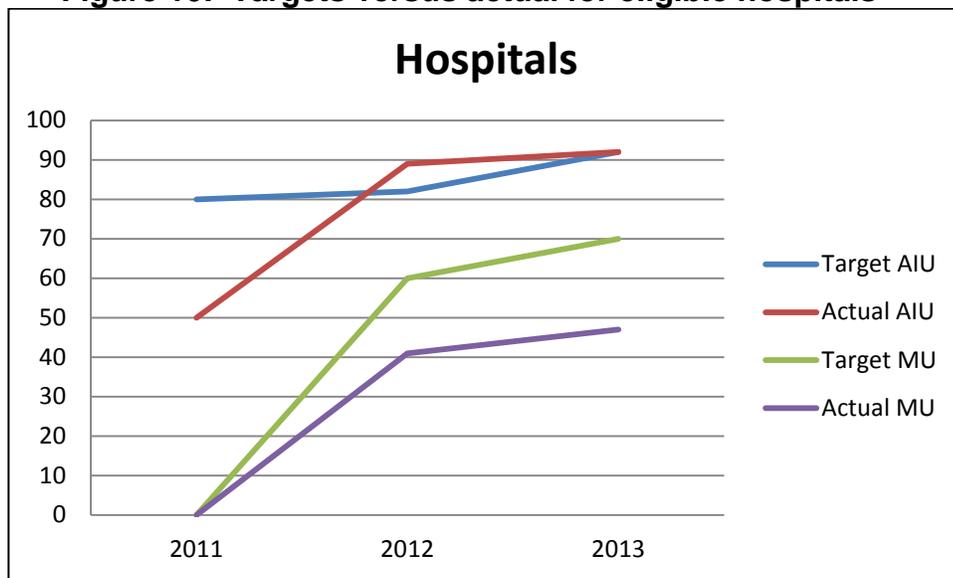


Target versus Actual Attestations

From the initiation of our program, we established targets for eligible providers and eligible hospitals in terms of AIU and MU. In the following graphs, we provide a comparison of those targets to the actual rates of AIU and MU. Overall, we met our targets for AIU for EPs and EHs for 2012. We still have some progress to make in the area of meaningful use attestations.

Initially, we saw fewer EHs attesting to AIU than targeted. By 2012, we exceeded our goal for AIU and have already met our goal of 92 in 2013. EHs have so far not met our target goals for MU. As of July 12, 2013, we have had 47 met MU while we targeted 70.

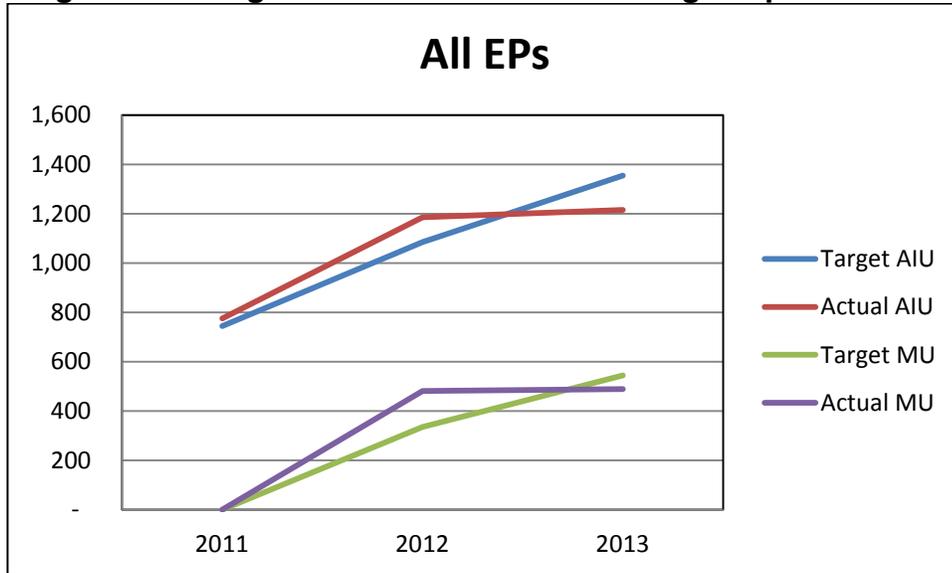
Figure 10: Targets versus actual for eligible hospitals



For eligible providers, we have broken them out to clearly see each group’s attestation rates and progress towards our goals. As a whole, we consistently exceeded our goals for 2011 and 2012 for AIU and constantly pushing upwards to our 2013 goal.

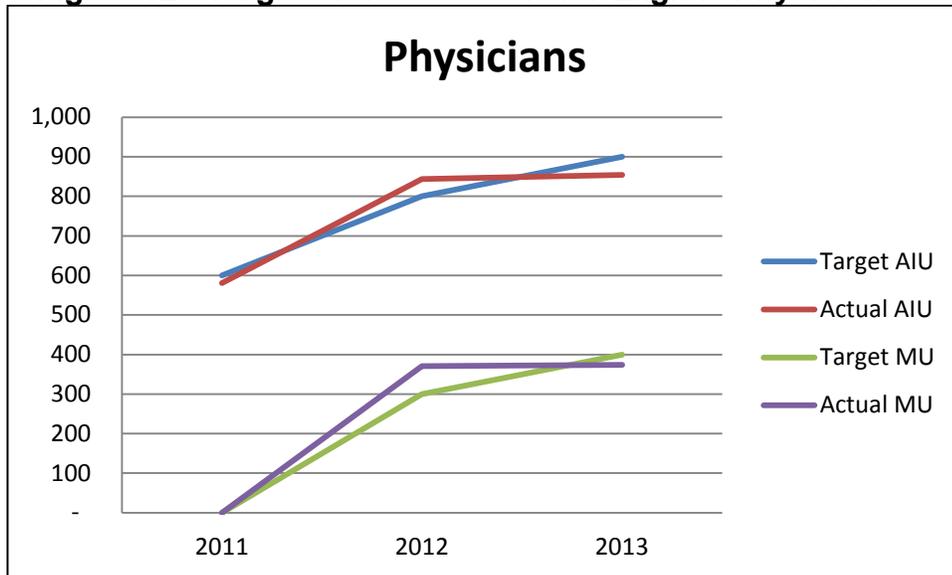


Figure 11: Targets versus actuals for all eligible providers



Physicians have largely met and exceeded our targets in 2011 and 2012 for AIU and MU. We are starting to see a slowdown in AIU attestations and anticipate seeing an uptick in meaningful use attestations since the patient volume methodology has become more inclusive of all Medicaid-eligible members. We are very close to meeting our goal for 2013 and continue outreach and education opportunities to assist providers in their adoption and attestation efforts.

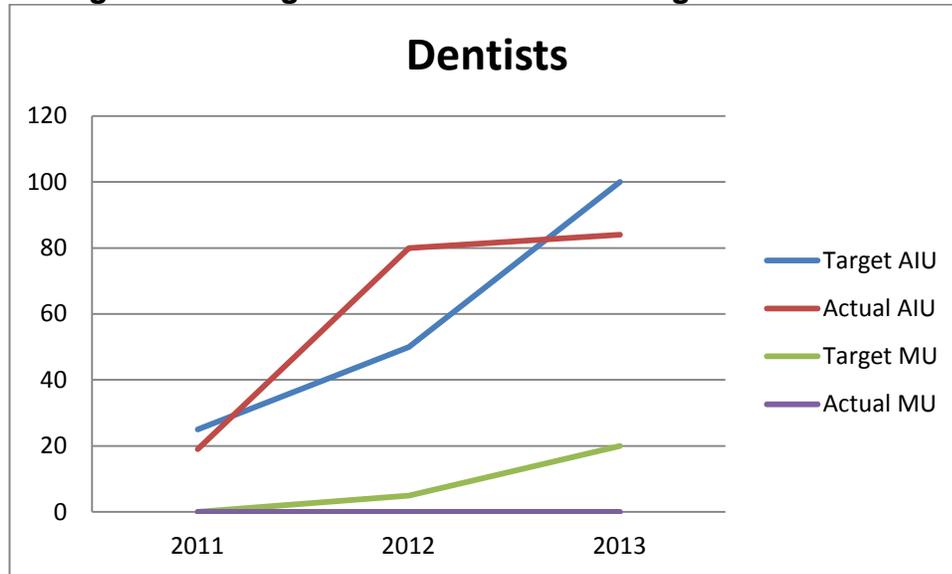
Figure 12: Targets versus actuals for Eligible Physicians





Dentists have had a slow start in AIU and have not attested to MU at all. In 2011, we saw fewer attesting to AIU than we anticipated while 84 attested in 2012. We know that dentists' lack of meaningful use of EHRs is not unique to Iowa. We endeavor to reach out to our dentist providers in 2013 and 2014 to encourage MU attestation.

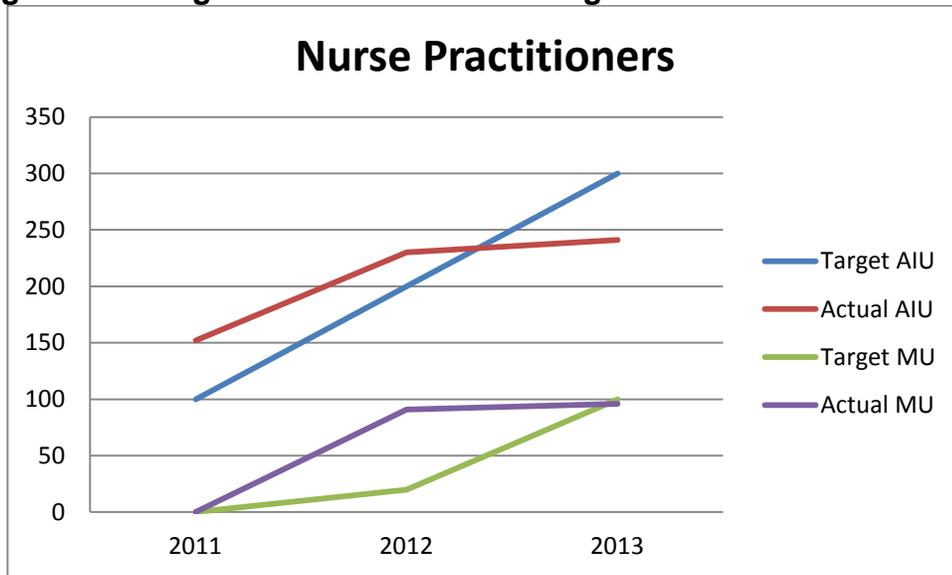
Figure 13: Targets versus actuals for eligible dentists



Iowa's Nurse Practitioners far exceeded our goals in both 2011 and 2012, with 152 and 230 attesting to AIU, respectively. Nurse Practitioners also attested to MU in large numbers in 2012. Since many of them attested to MU last year, we anticipate seeing them later in 2013 or early 2014.

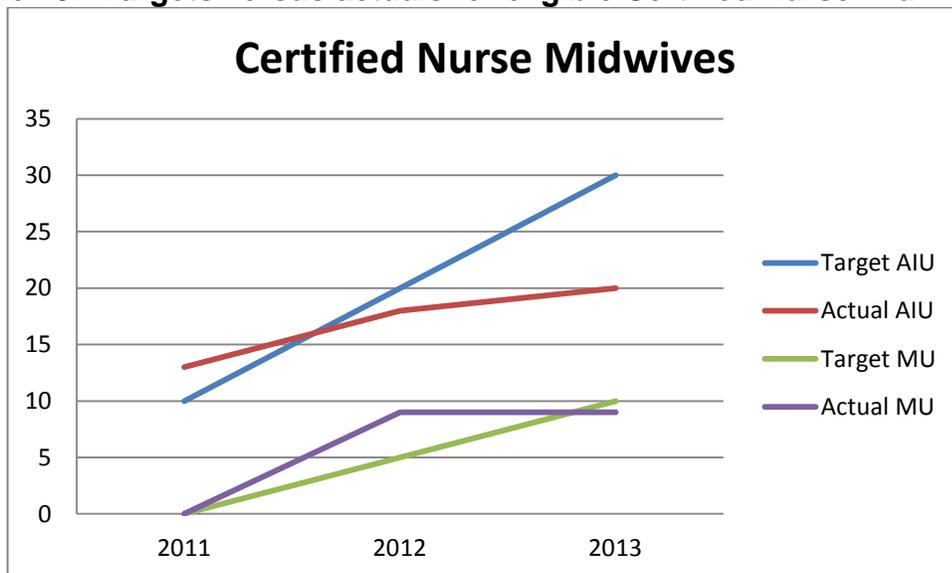


Figure 14: Targets versus actuals for eligible Nurse Practitioners



Certified Nurse Midwives exceeded our initial goals for AIU in 2011 and MU in 2012, but has since tapered off in AIU in 2013. We need to review our original estimates to ensure that we accurately reflected the baseline of CNMs and reach out to CNMs to see if there is something more we could be doing to assist in this transition.

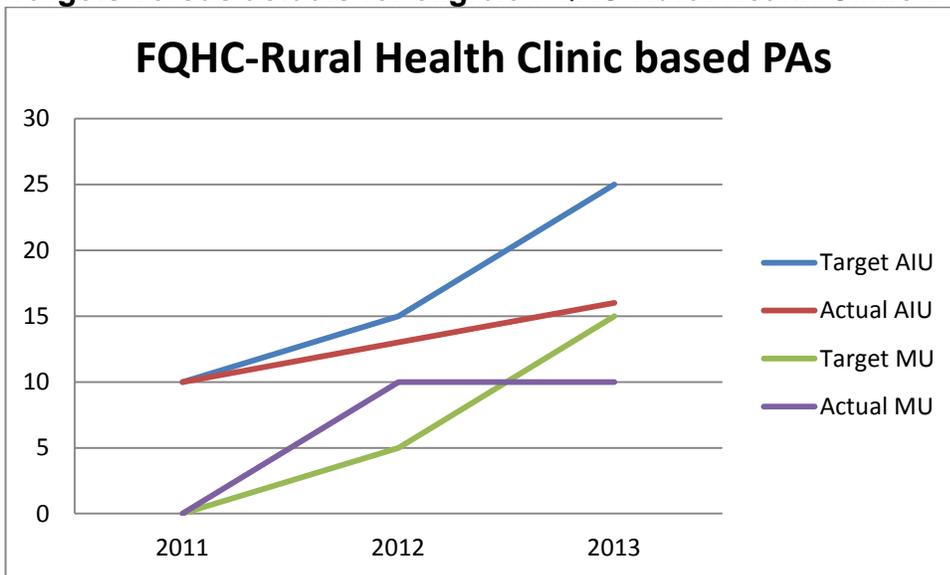
Figure 15: Targets versus actuals for eligible Certified Nurse Midwives





AIU rates for the FQHC/Rural Health Clinic based Physician Assistants are steady but far less than we targeted. However, MU attestations exceeded our goals in 2012. We hope to conduct targeted outreach to provide assistance on understanding the patient volume methodology for FQHC/RHC based PAs to ensure they understand the unique methodology available to them.

Figure 16: Targets versus actuals for eligible FQHC-Rural Health Clinic Based PAs





Meaningful Use

In 2012 program year, the IME had 178 providers and 29 hospitals attest to meaningful use. The breakdown is as follows:

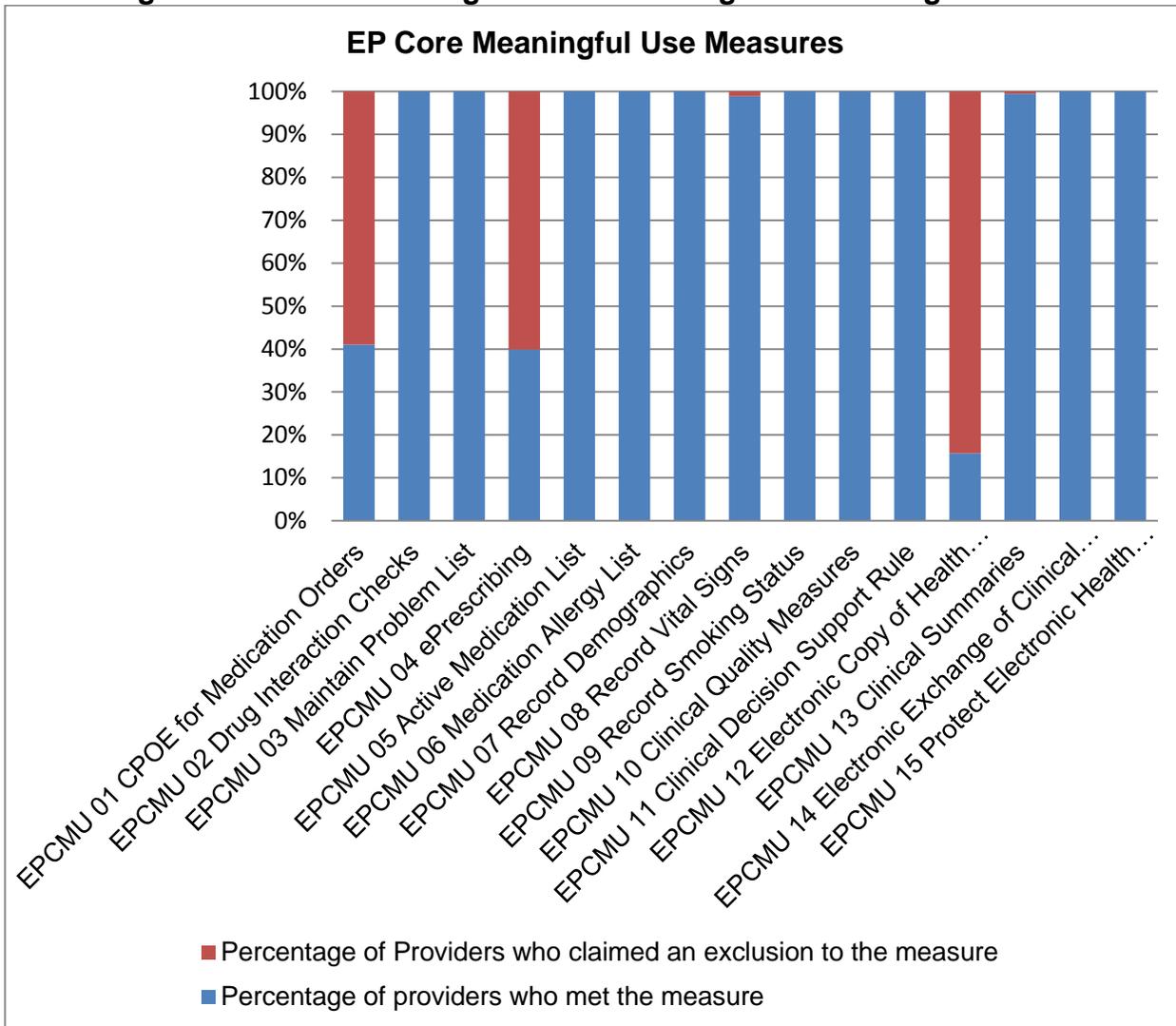
Table 6: Breakdown of meaningful use attestations

Provider Type	Total Providers
Physician	137
Nurse Practitioner	27
Dentist	0
Optometrist	1
Certified Nurse Midwives	0
Pediatricians	13
Physician's Assistant practicing predominantly in a FQHC or RHC that is led by a physician's assistant	0
Acute Care Hospital	20
Critical Access Hospital	9
Children's Hospital	0

The providers and hospitals reported on the required core, menu, and clinical quality measures. In the core measures, we had measures with nearly 100% of the providers meeting the measures. Measures 01 Computerized Physician Order Entry, 04 ePrescribing, and 12 Electronic Copy of Health Information had over 50% of the providers claiming and exclusion. The following table details all 15 core meaningful use measures in terms of met or excluded the measure.



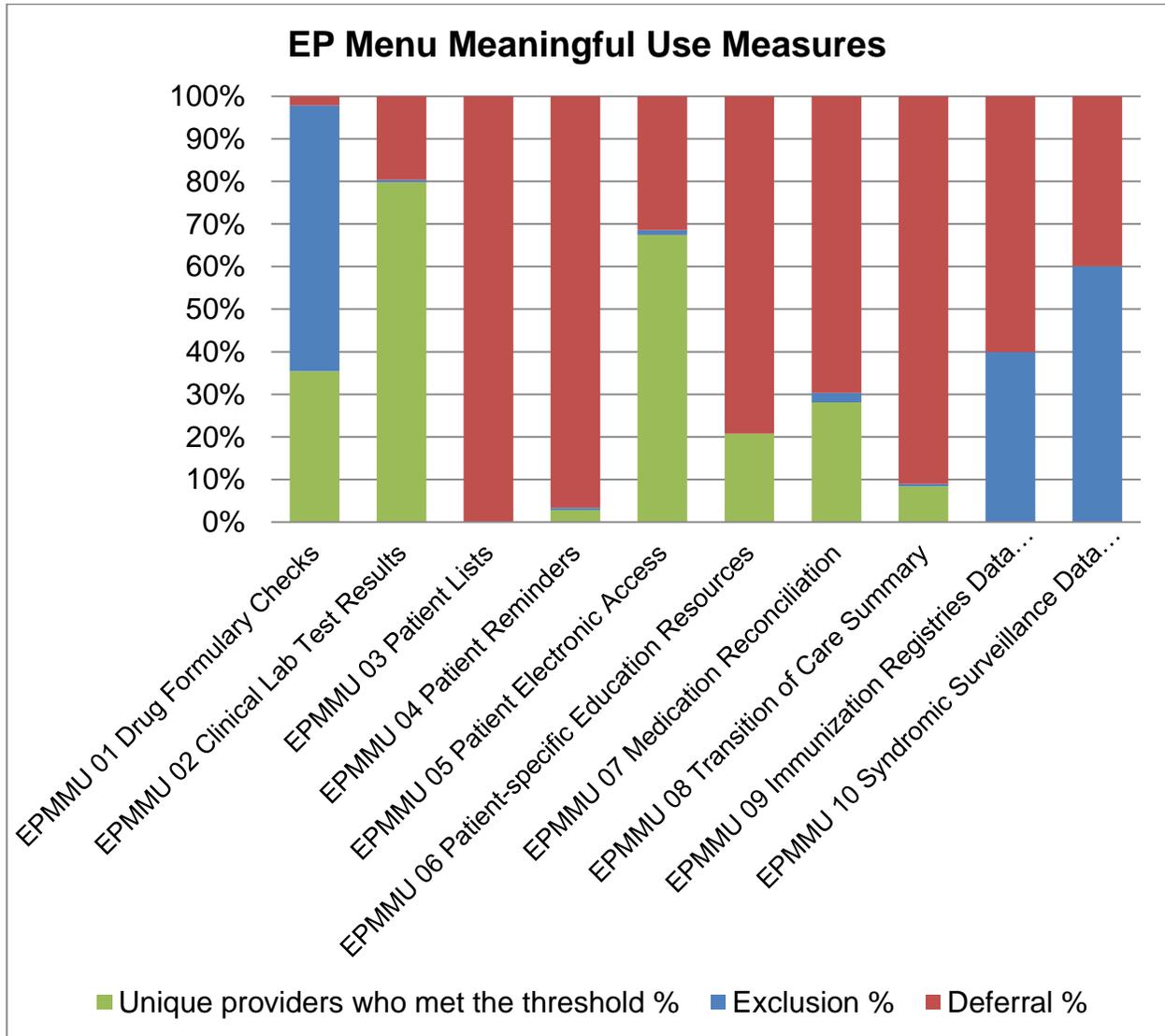
Table 7: Eligible Providers meeting versus excluding core meaningful use measures



In terms of the menu meaningful use measures, we had a large number of deferrals with all providers deferring reporting on patient lists and many deferring reporting patient reminders and transition of care summaries. Measure 09 for Immunization Registries Data Submission had a 60% deferral rate with 40% claiming an exclusion. We should see many of those deferring providers in 2013 return for testing with our Immunization Registry Information System as it opened for testing May 1, 2013. The following graph illustrates the percentage of providers who met, deferred, or claimed an exclusion for each measure.



Table 8: Eligible Providers meeting versus excluding menu meaningful use measures



The clinical quality measures had a wide spread of reporting. We saw 50-80% providers report on the core measures and 30-40% on the alternative measures. In the additional category, two measures – cervical cancer screening and controlling high blood pressure – had over 50% of the providers reporting on. The following tables show the percentage of providers reporting on the clinical quality measures.



Table 9: Eligible providers' attestation rates for core CQMs

Core	Percentage of providers who attested to this CQM
CCQM 1 - NQF 0013 Hypertension: Blood Pressure Measurement	52.25%
CCQM 2 - NQF 0028 a. Tobacco Use Assessment	71.91%
CCQM 2 - NQF 0028 b. Tobacco Cessation Intervention	52.25%
CCQM 3 - NQF 0421 Adult Weight Screening and Follow-up (Population 1)	53.93%
CCQM 3 - NQF 0421 Adult Weight Screening and Follow-up (Population 2)	88.20%

Table 10: Eligible providers' attestation rates for alternate CQMs

Alternate	Percentage of providers who attested to this CQM
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents	42.70%
ACCQM 2 - NQF 0038 Childhood Immunization Status	31.46%
ACCQM 3 - NQF 0041 Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	18.54%



Table 11: Eligible providers' attestation rates for additional CQMs

Additional	Percentage of providers who attested to this CQM
ACQM 1 - NQF 0001 Asthma Assessment	19.10%
ACQM 2 - NQF 0002 Appropriate Testing for Children with Pharyngitis	14.04%
ACQM 3 - NQF 0004 Weight Assessment and Counseling for Children and Adolescents	0.56%
ACQM 4 - NQF 0012 Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	0.56%
ACQM 5 - NQF 0014 Prenatal Care: Anti-D Immune Globulin	0.56%
ACQM 6 - NQF 0018 Controlling High Blood Pressure	50.00%
ACQM 7 - NQF 0027 a Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit	10.67%
ACQM 7 - NQF 0027 b Smoking and Tobacco Use Cessation, Medical assistance: b. Discussing Smoking and Tobacco Use Cessation Medications or c. Discussing Smoking and Tobacco Use Cessation Strategies	10.67%
ACQM 8 - NQF 0031 Breast Cancer Screening	5.62%
ACQM 9 - NQF 0032 Cervical Cancer Screening	55.62%
ACQM 10 - NQF 0033 Chlamydia Screening for Women	11.80%
ACQM 11 - NQF 0034 Colorectal Cancer Screening	3.93%
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma	46.07%
ACQM 13 - NQF 0043 Pneumonia Vaccination Status for Older Adults	2.81%
ACQM 14 - NQF 0047 Asthma Pharmacologic Therapy	7.87%



Table 12: Eligible providers' attestation rates for additional CQMs

Additional	Percentage of providers who attested to this CQM
ACQM 15 - NQF 0052 Low Back Pain: Use of Imaging Studies	0.56%
ACQM 16 - NQF 0055 Diabetes: Eye Exam	2.25%
ACQM 17 - NQF 0056 Diabetes: Foot Exam	2.25%
ACQM 18 - NQF 0059 Diabetes: Hemoglobin A1c Poor Control	9.55%
ACQM 19 - NQF 0061 Diabetes: Blood Pressure Management	15.17%
ACQM 20 - NQF 0062 Diabetes: Urine Screening	16.29%
ACQM 21 - NQF 0064 Diabetes Low Density Lipoprotein (LDL) Management and Control	28.65%
ACQM 22 - NQF 0067 Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	1.12%
ACQM 23 - NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	1.69%
ACQM 24 - NQF 0070 Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	0.56%
ACQM 25 - NQF 0073 Ischemic Vascular Disease (IVD): Blood Pressure Management	1.12%
ACQM 26 - NQF 0074 Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	1.12%
ACQM 27 - NQF 0075 Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	0.56%
ACQM 28 - NQF 0081 Heart Failure (HF): Angiotensin- Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0.56%
ACQM 29 - NQF 0083 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	0.56%
ACQM 30 - NQF 0084 Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation	0.56%



Table 13: Eligible providers' attestation rates for additional CQMs

Additional	Percentage of providers who attested to this CQM
ACQM 31 - NQF 0086 Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	0.56%
ACQM 32 - NQF 0088 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	0.56%
ACQM 33 - NQF 0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	0.56%
ACQM 34 - NQF 0105 Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment	0.56%
ACQM 35 - NQF 0385 Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	0.56%
ACQM 36 - NQF 0387 Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIc Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	0.56%
ACQM 37 - NQF 0389 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging LowRisk Prostate Cancer Patients	0.56%
ACQM 38 - NQF 0575 Diabetes: Hemoglobin A1c Control (<8.0%)	0.56%

EHR Incentive Program Administration

The EHR incentive payment process was successfully integrated within the existing business processes at the IME. The administration of the EHR incentive program is discussed in further detail in Sections C and D.

The IME's provider portal was enhanced to survey providers regarding their EHR implementation and meaningful use status and future plans. This survey is collected as part of provider re-enrollment and allows Iowa to continue to monitor EHR adoption progress within the state, beyond those providers who are receiving incentives. Provider re-enrollment launched in May, 2012.

On April 2, 2012, IME launched its new software, the Provider Incentive Payment Program (PIPP) for attestation submission and review. This software interfaces with the MMIS claims payment system to disburse the payments to providers.



In 2011, Iowa focused on collecting data elements and items required for Adopt/ Implement/ Upgrade attestation. EHR Incentive workflow processes were enhanced in 2012 to include collection of all necessary data elements for tracking and verifying meaningful use. In late 2013, IME will ensure that our portal is ready to fully receive 2014 attestations for AIU and MU.

Although allowed for in the final rule, Iowa has not requested that the four public-health related objectives be moved from the menu set of meaningful use measures to the core set of meaningful use measures in 2012. In 2013 or beyond, Iowa will again evaluate the need to move the public health measures from the menu set to the core set.

As allowed in the final rule, Iowa has determined that Hospital EHR incentive payments will be paid over three years. 40% of the total incentive paid in Year One, 40% in Year Two, and the remaining 20% in Year Three. This payment approach rewards hospitals for A/I/U, supports efforts to meet meaningful use, and increases the likelihood of maintaining meaningful use. Iowa considered balancing the payments across additional years, but acknowledges that the incentive will best be placed at the beginning of the transition to meaningful use.

The IME continues to work with the providers and the Regional Extension Center to identify qualified providers and encourage them to attest. The IME still anticipates that during 2012-2016, an additional 10% of the remaining eligible providers will request EHR incentive payment each year.

The IME continues to revise the estimates based on information as it becomes available. In response to a request from ONC in meetings the 100,000 MU challenge, and in collaboration with the Department of Public Health and the Regional Extension Center, Iowa developed the following estimates:

Number of eligible professionals who have received an EHR incentive payment from the Medicare or Medicaid EHR Incentive Programs by December 31, 2013.

Statewide Goal:

- 1900 EP's who received Medicare EHR Incentive Payment by December 31, 2013
- 1150 EP's who received Medicaid EHR Incentive Payment by December 31, 2013

Number of eligible hospitals that have received a payment from the Medicare or Medicaid EHR Incentive Programs by December 31, 2012.

Statewide Goal:

- 112 EH's who received Medicare or Medicaid EHR Incentive Payment by December 31, 2013.



Number of eligible professionals in rural areas who have received a payment from the Medicare or Medicaid EHR Incentive Programs by December 31, 2013.

Statewide Goal:

714 EP's in rural areas who received a Medicare or Medicaid EHR incentive payment by December 31, 2013

80 EH's in rural areas who received a Medicare or Medicaid EHR incentive payment by December 31, 2013

Iowa Health Information Network

Iowa's health information exchange is called the Iowa Health Information Network, or IHIN. The IME and Iowa Department of Public Health (IDPH), as part of the Iowa e-Health EHR/IHIN adoption initiative have actively engaged Iowa's healthcare providers, insured citizens, and insurers. Due to the IME's expected use of IHIN services and expected funding of IHIN activities, the IME provides a strong presence on many of the workgroups and council sessions. The IME representatives on these groups focus on containing costs by improving the quality of care our members receive.

The current governance model for the Iowa e-Health initiative is best described as a government-led model with accountability to a multi-stakeholder, public-private e-Health Executive Committee and Advisory Council. The governance structure was established by a comprehensive health reform bill (HF 2539, 2008 Iowa Acts, Chapter 1188). The legislation specified nine organizations be represented on the Executive Committee and eight organizations represented on the Advisory Council. Additional members of the Advisory Council were appointed by the Director of the Iowa Department of Public Health. The nine voting members of the Executive Committee include: three chief information officers from the three largest private health care systems in the state; the chief information officer of the University of Iowa Hospitals and Clinics; a representative from a rural hospital selected by Iowa Hospital Association; a consumer member of the State Board of Health; a licensed practicing physician selected by the Iowa Medical Society; a licensed and practicing nurse selected by the Iowa Nurses Association; and an insurance carrier selected by the Federation of Iowa Insurers.

The 19 non-voting members of the Advisory Council include: a pharmacist; a licensed practicing physician; a consumer member of the State Board of Health; a member from the Iowa Medicare Quality Improvement Organization; the executive director of the Iowa Communications Network; a representative of the private telecommunications industry; a representative of the Iowa collaborative safety net provider network; a nurse informaticist; and eleven additional members representing key stakeholder groups, including the IME.



With the current government-led model, the IDPH provides accountability and transparency for planning and execution of project activities. The IDPH provides the personnel resources to coordinate planning activities and convene the e-Health

The e-Health Executive Committee and Advisory Council began meeting in January 2009, and continues to meet bi-monthly to engage in critical planning discussions, establish priorities, and execute project activities. Workgroups meet more frequently to further define, research, and carry out project activities. In short, the IME and the IDPH have brought together a cross section of Iowa's healthcare providers, insurance providers, government entities, and patient advocates to create an engaged executive board and active workgroups to promote provider adoption of EHR and exchange technology within Iowa.

On April 12, 2012, Governor Branstad signed the e-Health bill (SF 2318) into law. The bill includes liability protections for providers related to the use of information obtained through the Iowa Health Information Network (IHIN). If patient health care information is correct as presented to the IHIN but misused or mishandled by the retriever or end recipient, liability remains with the recipient. If information that is available and received through the IHIN is incorrect, liability would remain with the source of that information as long as appropriate best practices are followed by the recipient. If health information such as allergies or medication must always be verified with the patient, this would continue even though recent information was available through the IHIN.

The bill also establishes a fee collection for participation in the IHIN and creates a separate fund for revenue and expense activities. The bill gives the Iowa Department of Public Health the authority to use this nonrevertible funding for the specific requirements of the IHIN and the Iowa e-Health collaborative work of the Health Information Exchange grant. The department will do so through an annual budget approved by the e-Health Advisory Council and the State Board of Health. The advisory council will review the e-Health budget and the financial model annually and make recommendations to the State Board of Health. The legislation also establishes that Iowa is an opt-out state where patients must provide notification of their choice not to have their health information exchanged through the IHIN. The bill directs the department to establish that notification process in administrative rule. The choice not to have health information exchanged through the IHIN will begin as a statewide choice but the process could change in the future to provide patients more specific choices for opting out of IHIN exchange rather than only statewide. The rule itself will be rewritten and approved as technology advances which allows this more granular choice to be easily administered and with clear understanding by both providers and patients.

More information on Iowa e-Health can be found on their website:
<http://www.iowahealth.org/>.



IHIN Operations

Iowa e-Health issued a Request for Proposal for the creation of Iowa's statewide HIE, or IHIN. The IDPH issued a Notice of Intent to Award and recently executed the contract to the selected vendor. The IDPH plans to have the IHIN infrastructure installed and pilot IHIN implementations by late summer of 2012.

In 2012, IDPH selected a vendor to build the IHIN infrastructure. The Direct Secure Messaging feature was implemented in December 2012. Since then, 57 organizations signed Participation Agreements which represents over 809 users as of August 2, 2013. The IME has signed up dentists for Prior Authorization and have at least one provider using it for this as of August 1, 2013. In late 2013, we anticipate the query and look-up functionality to become live via the IHIN for providers to find their patients' records wherever they may be located.

IHIN Structure

As described in the Iowa e-Health Strategic and Operational Plan (<http://www.iowahealth.org/documents/plans/64.pdf>), Iowa brings significant assets to IHIN adoption. Experience in the Adoption of EHRs, Infrastructure and Networks, Data Exchange, and Planning and Education as described within the plan will be utilized for IHIN success. The Iowa Health Information Network will utilize a federated model with a centralized master patient index, record locator service, auditing, secure messaging, and translation services where appropriate. The structure will allow for point to point messaging, query/response, and publish/subscribe technology.

Iowa Medicaid plans to utilize the publish/subscribe technology to capture quality metrics for verification of meaningful use and medical home performance payments. IME procured a quality metrics capture tool for both the meaningful use and the health home programs. The tool was ready for use by December 2012. However, there have been technical issues and IME is working with providers and their vendors to resolve the issue.

Multi-State/Border State HIEs

Iowa shares borders with Minnesota, Wisconsin, Illinois, Missouri, Nebraska, and South Dakota. Currently, the most prevalent HIE serving Iowans is Nebraska's Health Information Initiative (NeHII) HIE.

NeHII currently shares Continuity of Care Documentation, lab, image, and discharge instructions across a wide provider base in the Omaha, NE/Council Bluffs, IA, care delivery area. More information on NeHII can be found on their website, <http://www.nehii.org/>. NeHII currently provides HIE services to several Iowa hospitals near the Iowa-Nebraska border including the following: Mercy Hospital in Council Bluffs, IA; Mercy Hospital in



Corning, IA; Community Memorial Hospital in Missouri Valley, IA; and Cass County Health System in Atlantic, IA. There is a pending implementation in Red Oak, IA for the Montgomery County Memorial Hospital.

The IME will continue to monitor HIE adoption within our border communities and expects that once Iowa's HIE is established, National Health Information Networking (NHIN) connectivity between HIEs will be prevalent for our border members and providers.

Broadband Access

During winter 2009/spring 2010, Iowa e-Health developed its ONC- required 2010 Iowa e-Health Strategic and Operational Plan. As Iowa's state designated entity, the IDPH was required to submit its strategic and operational plan to ONC to receive funding through the state HIE cooperative agreement program.

Goal 3 of the strategic and operational plan – Enable the Electronic Exchange of Health Information - discusses in depth the broadband access speeds found within Iowa practices. From the National Broadband plan, (Chart 3.2b), which recommends ten megabits (mb) per second or greater download access for the majority of Iowa's provider locations, currently only 18% of providers have access to 11mb download speeds. The ConnectIowa organization makes ongoing attempts to obtain connectivity and speed information from all community anchor institutions across Iowa, including from hospitals and clinics.

Connect Iowa's mission is to change lives through technology by leading the effort to increase high-speed Internet access, adoption and use across the state. As mentioned above, one of our grant requirements is the collection of speed and connectivity data from CAI's. When looking specifically at health care providers, having this information is key to knowing where broadband inadequacies lie, and helping to find solutions so that HIT efforts can move forward.

The Iowa Communications Network "Bridging the Digital Divide for Iowa's Communities" award proposes to upgrade the existing 3,000-mile network to provide 10 Gbps-capable points of presence in each county, while enabling a system upgrade for as many as 1,000 community anchor institutions statewide to 1 Gbps Ethernet service. This infrastructure award of \$16,230,118, which partners with Iowa Health System, will allow for a comprehensive statewide fiber network that serves public sector, private sector, and non-profit entities. All reports submitted for this grant project can be found at: <http://www2.ntia.doc.gov/grantee/central-iowa-hospital-corporation-dba-iowa-health-des-moines>.

The Iowa Health System received \$17,714,919 for their Iowa Healthcare Plus Broadband Extension Project. This project proposes to make significant upgrades to the health



system's existing 3,200-mile fiber network that services over 200 healthcare facilities across the state and bolster their wireline capabilities with wireless technology.

The IME, as an active participant on Iowa's e-Health Council, will continue to support and leverage any and all grant opportunities available for the expansion of Iowa broadband network, per Strategy 3.2.1.

State Immunization & Public Health Surveillance

Connection to the Iowa Immunization Registry Information System (IRIS) has been identified as a priority service for the IHIN by provider organizations. In the absence of the ACA funding, Iowa sought and received HITECH funding to support connecting IRIS to the Iowa e-Health systems.

The IDPH received \$573,833 as part of the lab surveillance grant, approximately one-half the requested grant amount to begin the process of upgrading the Iowa Disease Surveillance system (IDSS) to accept electronic laboratory reporting. Iowa received HITECH funds to fill the \$500,000 gap in funding needed to complete this project.

The Iowa Department of Public Health announced on May 1, 2013 that they have the capacity to receive immunization data electronically from electronic health records. The initial process is to test files to ensure they can be correctly captured in the Immunization Registry Information System (IRIS) by having providers submit a fake patient file. IDPH will process the file and inform the provider if it passed or if there are corrections to make. From there, IDPH place providers in a queue for ongoing data transmission.

IDPH does not maintain a syndromic surveillance data registry at this time. An assessment is being conducted to determine if syndromic data will be electronically collected in the future.

Member / Consumer

Iowa Medicaid began baselining our member's knowledge of EHR/HIE technologies during July 2010.

In the latest survey from March 2013, IME found that there was a slight tick upwards in consumer awareness of electronic health records from 46% to 51%. We also saw a small increase in support for providers sharing electronic records up from 74% to 78%. Finally, in the area of viewing health records online, 51% of our members said that they would view their records on a website if it was available, which is up from 49%. It does appear that knowledge and support is growing as we move forward with increasing provider adoption and implementing member services online.



Figure 17: Member awareness of electronic health records

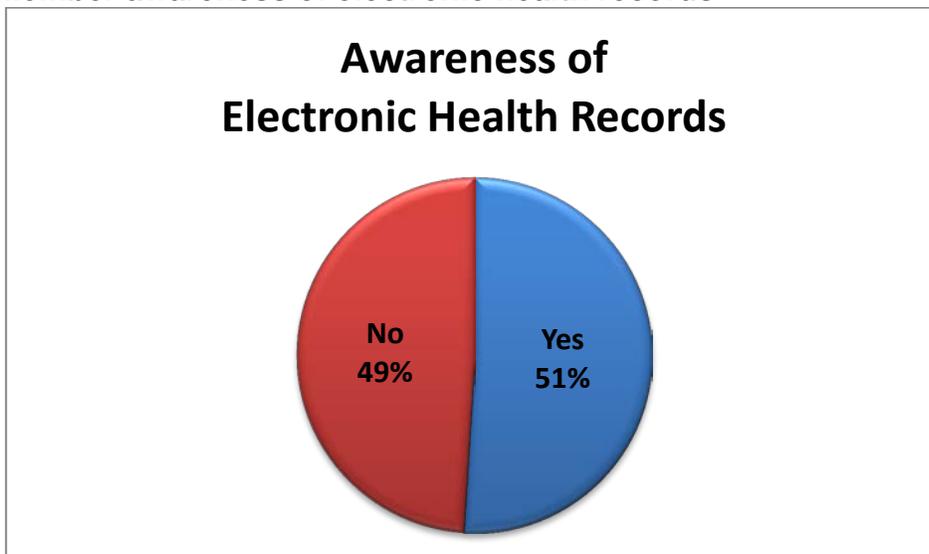


Figure 18: Member support of providers sharing EHR

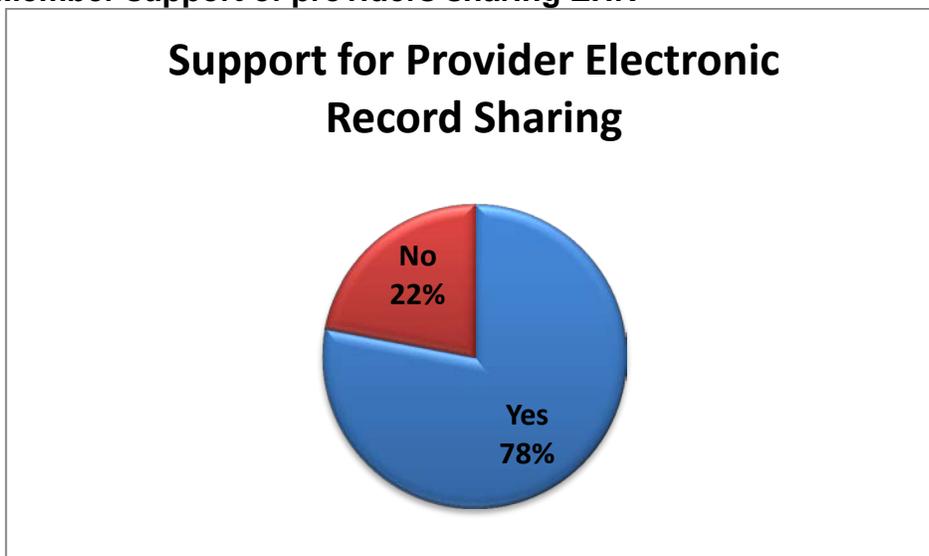
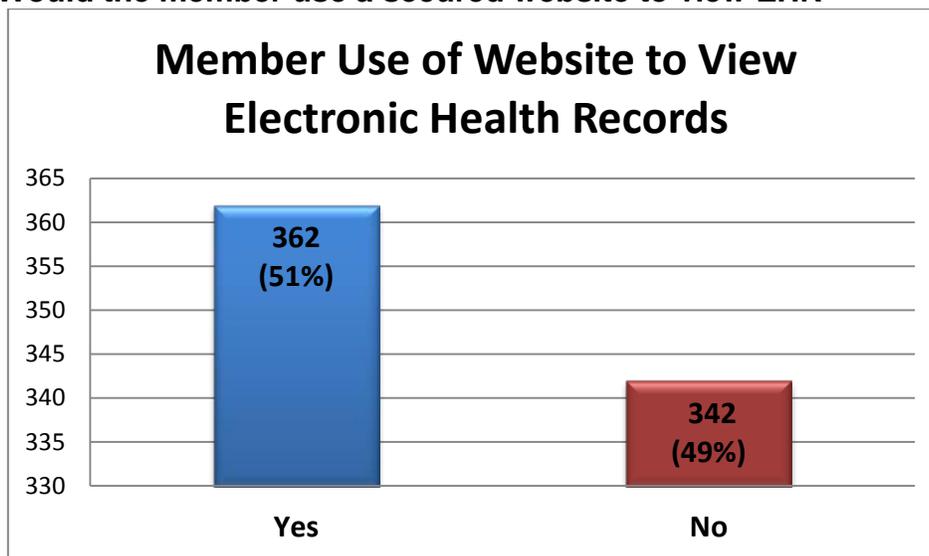




Figure 19: Would the member use a secured website to view EHR



Medicaid Information Technology Architecture

Iowa Medicaid continues to move towards increased levels of MITA maturity with commitments to map operations to the business processes and improve technology. Recent steps towards improvement include:

- ✓ Migration to a multi-state, SOA, cloud based system to support the EHR Incentive Payment program. The PIPP system, developed and supported by Maximus, was implemented in Iowa in April 2012. Iowa benefited from the reuse of work completed for the state of Tennessee and continues to partner on enhancements that will benefit both state operations.
- ✓ Medicaid Integrated Data Administration Services (MIDAS). The planned MMIS system will include a COTS claims engine, business rules engine, workflow engine and APHP web portals that will take advantage of services, rules and integrated data.
- ✓ Integrated Eligibility Project. Iowa DHS has awarded a contract to replace the existing legacy eligibility system with a MITA aligned, SOA, and rules-based application. The system will support reuse for TANF and SNAP programs and will integrate with the Federal HUB for real time eligibility determination. The system will expose web services that will allow the eligibility system to be connected to the Health Benefits Exchange.



Community College Consortium

Approximately 50,000 qualified health IT workers will be needed to meet the needs of hospitals and health care providers as they adopt electronic health records and connect to health information exchanges. The Bureau of Labor Statistics, Department of Education, and independent studies estimate a workforce shortfall over the next five years. Iowa community colleges, Kirkwood Community College in Cedar Rapids (<http://www.kirkwood.edu/hitconsortium>) and Des Moines Area Community College in Des Moines (<https://go.dmacc.edu/conteddesc/hit/Pages/welcome.aspx>), are two of the 17 community colleges that make up the Midwest Community College HIT Consortium funded by the ONC. Both colleges offer the 6-month certificate program to address the workforce need. The programs offer training in the following roles:

- Practice workflow & information management redesign specialists
- Clinician/practitioner consultants
- Implementation support specialists
- Implementation managers
- Technical/software support staff
- EHR trainers

Instruction is delivered online and internship opportunities are available through Iowa's Regional Extension Center. From this program to date, the REC has had fifteen interns. The REC provides job shadowing opportunities so that the students can experience a site visit to a clinic setting and/or hospital setting with an experienced EHR Advisor. The job shadow is typically 1-2 working days; although two interns have completed extended summer sessions of 6-8 weeks. The REC selects site visits that will expose the students to meaningful use and/or EHR implementation issues where actual assessments are completed, or workflow redesign is mapped out, or reports of findings from previous assessments are discussed with the local teams.

The partnership between the REC and the Workforce programs benefits both entities - the REC has the opportunity to meet potential future staff and the Workforce program benefits from seeing the REC staff firsthand. And of course the students benefit. As an example, one of the students who job shadowed with the Iowa REC finished the program and was hired by the Washington, DC REC.

DMACC stated that by July 2013, three students graduated with two finding employment and one continuing on to a Bachelor's degree. DMACC anticipates having three more graduates by the end of 2013, ten in 2014, and upwards of thirteen in 2015. By 2015, they anticipate graduating a total of 29 students ready to join the HIT field.



Section B: Iowa's "To-Be" HIT Landscape

Overview

Iowa's "To-Be" HIT landscape describes the vision for health care improvement through the adoption and meaningful use of HIT by Iowa's health care providers.

IME- Five Year Goals

The IME established four primary goals for the next five years to maximize the quality and efficiency of the healthcare services our members receive.

- ✓ Increase provider adoption of electronic health records and health information exchange
- ✓ Improve administrative efficiencies and contain costs
- ✓ Improve quality outcomes for members
- ✓ Improve member wellness

The dramatic increase expected in the number of Medicaid members means the IME must make every effort to improve the efficiency of the services our providers deliver. The IME is committed to supporting healthy outcomes for its members, and efficient and effective payments to providers.

Increase Provider adoption of Electronic Health Records (EHR) and Iowa Health Information Network (IHIN)

Central to the IME's HIT strategy is the need for clinical information in electronic format. The IME encourages Iowa's providers in gathering clinical information at the time of care through use of EHRs.

The IME supports EHR adoption through provider outreach, the administration of the EHR Incentive program, and use of EHR enabled processes within the IME. The ongoing successful EHR incentive program is a key measure of success in supporting EHR adoption in the state.

The IME works closely with IDPH and Iowa's HIT REC to coordinate our outreach efforts and message. Often the IME, IDPH, and HIT REC co-present information. The IME plans to continue these activities throughout the lifespan of the EHR incentive program and beyond. Ongoing outreach efforts describe EHR adoption rates within Iowa, total dollars the IME providers have received in EHR Incentive payments, success stories from providers utilizing EHRs and HIEs, etc.

The table below establishes goals for the adoption and implementation of electronic health records for Iowa Medicaid providers. IME is planning to conduct another environmental scan in 2013 to gauge adoption rates since 2010.



Table 14: Target adoption and meaningful use rates

Group	2013		2014		2015		2016		2017	
	AIU	MU								
Hospitals	92	70	108	80	108	90	108	100	108	108
Physicians	900	400	1000	500	1100	700	1100	800	1100	900
Dentists	100	20	150	30	200	40	220	50	220	60
Nurse Practitioners	300	100	330	200	400	275	450	325	450	375
Certified Nurse Midwives	30	10	40	20	45	25	50	30	50	35
FQHC-Rural Health Clinic PA	25	15	30	20	35	25	40	30	40	35

*Cumulative numbers

Table 15: Target percentages for CEHRT use by other groups⁷

Group	2013	2014
	Utilize Certified EHR	Utilize Certified EHR
Pharmacy	85%	90%
Lab	30%	40%
Imaging/Radiology	30%	40%
Home Health	20%	25%
Long Term Care Facilities	20%	25%
Behavioral Health	20%	25%

- Meaningful Use of EHR percentages are meant to represent the percentage of the entire group achieving Meaningful Use – not only the subgroup utilizing EHR.
- Meaningful Use Standards have not been established for Pharmacy, Lab, Imaging/Radiology, Home Health, Long Term Care, or Behavioral Health at time of writing.
- Note – Pharmacies, Labs, Imaging/Radiology Centers, Home Health, Long Term Care, and Behavioral health are not currently eligible for EHR incentive payments.

Objectives:

- 1.1 Providers will capture medical clinical information electronically and exchange the information with other providers.
 - 1.1.1 Administer Medicaid EHR Incentive Payment Program.
- 1.2 Support Iowa’s Health Information Network (IHIN), Support the National Health Information Network (NHIN) connectivity model.
- 1.3 Identify providers who are not currently eligible for Medicaid incentive payments or HITREC assistance and determine the appropriate technical assistance and support required to help those providers access appropriate electronic clinical information or adopt EHRs and exchange health information.

⁷Will provide an update once we complete an environmental scan.



Improve Administrative Efficiencies and Contain Costs

As Iowa's providers continue to adopt EHRs, the IME will research and implement methods for transmitting clinical information between the IME and providers in the most efficient manner.

Objectives:

- 2.1 Utilize the IHIN and EHRs where possible to provide information to providers.
- 2.2 Utilize the IHIN where possible to eliminate the need for mailing or faxing of medical information between providers and the IME.
- 2.3 Provide access to the IHIN for targeted providers where quality improvements yield cost reductions or containment for Medicaid.

Improve Quality Outcomes for Members

The IME believes that the continued use of EHR/HIE technology will improve the care members receive. More complete information at the time of care will decrease errors in care delivery and improve the overall care members receive.

Objectives:

- 3.1 Improve care transitions between provider settings.
 - a. Decrease hospital readmissions from Long Term Care Facilities. Provide Discharge Instructions and Continuity of Care information real-time from Hospitals to LTC via EHR & HIE adoption.
 - b. Decrease LTC readmissions from Home Health Services. Provide Discharge Instructions and Continuity of Care information real-time from LTC to Home Health Services via EHR & HIE adoption.
 - c. Support patient/home health collection of relevant vitals via HIE patient/home health portals.
- 3.2 Utilize Health Information Technology to expand the application of evidence based treatment.
- 3.3 Capture Quality Measures for monitoring provider performance.
 - a. Determine if correlations between quality measures and underserved populations exist.

Improve Member Wellness

Providing members with access to their clinical information and information on wellness/self care practices will improve member's wellness and decrease the need for treatment.

Objectives:

- 4.1 Provide members with information regarding their personal health.
- 4.2 Provide Medicaid member's care teams with clinical information.



4.3 Provide members with wellness education.

4.4 Create a Medical Home model that promotes healthy outcomes and manages the member's chronic health conditions.

Medicaid Information Technology Architecture

At the end of FY 2015, the IME anticipates significant progress will be made towards the following goals:

1. Develop seamless and integrated systems that communicate effectively to achieve common Medicaid goals through interoperability and common standards.

Iowa anticipates a rapid increase in the ability to communicate the appropriate medical information between providers, providers and members, and providers and Medicaid.

2. Promote an environment that supports flexibility, adaptability, and rapid responses to changes in programs and technology.

Iowa's eligibility, enrollment, and claims adjudication systems will be updated to utilize rules engines and service oriented architecture.

3. Promote an enterprise view that supports enabling technologies that are aligned with Medicaid business processes and technologies.

Iowa will continue to support the 'best of breed' utilization of tools. These tools will be appropriate to the business process requirements and integrate seamlessly with other systems, where appropriate.

4. Provide data that is timely, accurate, usable, and easily accessible in order to support analysis and decision making for health care management and program administration.

With the addition of new data mining tools, Iowa anticipates an increased ability to apply health informatics to improve program management. As provider's adoption of electronic health records systems expands, we anticipate the ability to collect clinical data and quality metrics for improved analysis and decision support.

5. Provider performance measurement for accountability and planning.

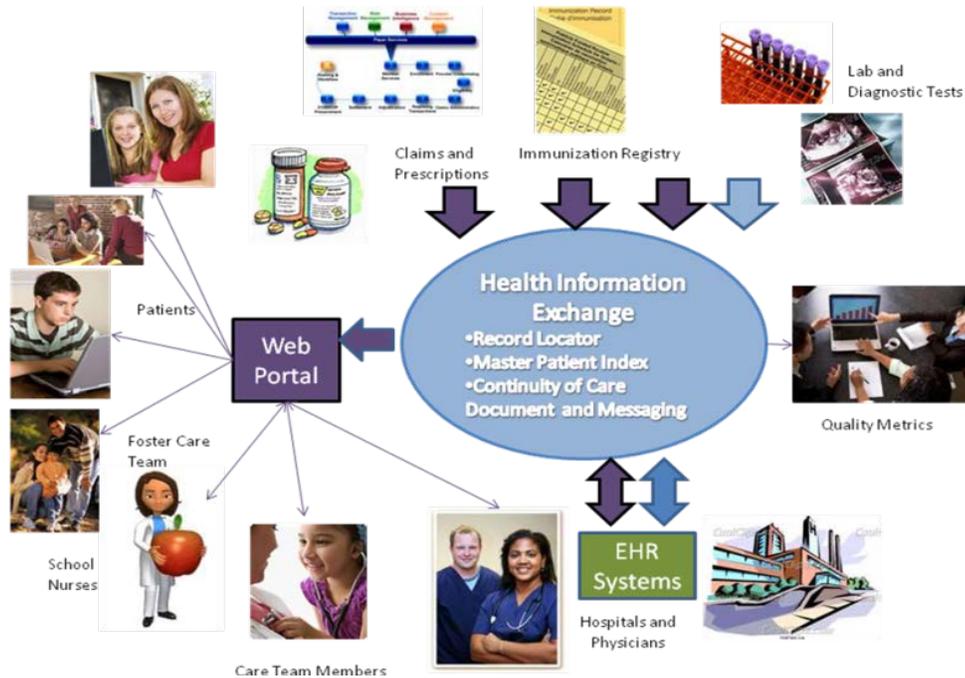
Performance measures will be available for establishing pay-for-performance initiatives, and best practices technical assistance for providers.

6. Coordination with public health and other partners, and integrated health outcomes within the Medicaid community.



Iowa Health Information Network (IHIN)

Iowa will have a sustainable health information exchange managed by Iowa e-Health, a division of the Iowa Department of Public Health. The Iowa e-Health board is appointed by the Iowa legislature and supported by the Iowa Department of Public Health.



The Iowa e-Health health information network will work in partnership with Iowa health care providers, payers, and consumers to build a sustainable infrastructure for the secure exchange of electronic health records. The IME will continue to participate as a partner in this venture with IDPH, as described in Section E “Support HIE”, ensuring that the needs of the Medicaid members and providers are met through this utility. The IME will build upon this model to continue to expand access to the appropriate members of the care team.

The IME believes the benefits of sharing information contained within EHRs via the Iowa Health Information Network will improve the quality of care our members receive. Decreased impact of drug interactions, improved coordination of care across providers, and real time access to clinical information during emergency care are only a few of the benefits the IME is expecting from EHR & IHIN adoption. The IME will provide funding support for the creation of the state-wide IHIN based upon a cost allocation model. To secure the CMS funding for the IHIN build, IME submitted the sustainability plan and received funding approval for the Medicaid portion of the fair share cost of the build. The build had a delayed start based on delays in executing the contract with the vendor. However, the IHIN build is expected to be completed in 2016, when it is anticipated to be self-sustaining.



The IME will also ensure that an option exists for the IME Member's care teams who may not need the full functionality of an EHR. Care team members who may need limited EHR/IHIN functionality could include care coordinators, school nurses, foster care parents, parents, case workers, and others as appropriate.



Section C: Iowa's EHR Incentive Payment Program

Overview

This section describes the process(es) required for the Year Three administration of the incentive payment program, including capturing attestation for meaningful use and clinical quality measures.

Outreach and Provider Support

The IME has implemented several communication mechanisms to educate providers on the incentive program. The primary methods of outreach include:



Method	Implementation Date	Resource
Informational letters sent to all eligible provider types to complete the online questionnaire and indicate interest in the program	January 2010 - ongoing	http://www.ime.state.ia.us/Providers/Bulletins.html http://www.ime.state.ia.us/docs/938_RadiologyAssessment.pdf http://www.ime.state.ia.us/docs/1014_MedicaidEHRIncentivePaymentProgram.pdf
Collection of contact information for all interested providers	January 2010 – ongoing	Collected from providers responding to informational letters
One point of contact for providers to learn of incentive program	January 2010 - ongoing	Advertised to providers through informational letters
Educational webinars for providers	Six in 2011 Three in 2011 March 2012	Most recent posted at EHs: http://www.ime.state.ia.us/docs/Microsoft%20PowerPoint%20-%20Medicaid%20EH%20Registration..pdf EPs: http://www.ime.state.ia.us/docs/Microsoft%20PowerPoint%20-%20EP%20Registration..pdf



Method	Implementation Date	Resource
Presentations at professional organizations	February 2010 – ongoing	Iowa Hospital Association IMGMA Rural HITECH Conference Iowa Regional Extension Center Annual e-Health Summit Linn County Medical Managers Iowa HIMSS Iowa Rural Health Association IANEP Critical Access Hospital Association Iowa Advocates for MH Recovery Conference Indian Health Services, Aberdeen and Billings Area MU Conference
Coordination with the Iowa Department of Public Health (IDPH) and presentations at e-Health Council meetings	January 2010 – ongoing	http://www.iowahealth.org/
Development of incentive program webpage	July 2010	http://www.ime.state.ia.us/Providers/EHRIncentives.html



Method	Implementation Date	Resource
Administration of online questionnaire regarding program readiness	April, 2010 – December, 2010	http://www.tfaforms.com/148942
E-mails sent to interested providers to complete online questionnaire regarding EHR readiness	April, 2010 - September 2010	
Incentive program module added to the annual provider training curriculum	April – August, each year	http://www.ime.state.ia.us/Providers/TrainingSchedule.html http://www.ime.state.ia.us/Providers/Bulletins.html
Informational letter sent to advertise HIT module	June 2011	



Since 2010 submission of the State Medicaid HIT Plan (SMHP), the IME has built out the website to include the following:

Method	Implementation Date
Instructions on how to apply for incentives	December 2010
Frequently Asked Questions document	May 2011
Informational letters to eligible providers advertising the go-live date	December 2010
Copy of the final, approved SMHP	December 2010 Revised SMHP December 2011

Future outreach efforts include:

Method	Target Implementation Date
Educational materials to be included in new provider enrollment packets	January 2014
Webinars - including training on how to apply for the incentive program and Q and A sessions.	Ongoing
Information to be disseminated and collected during provider re-enrollment	June 2012 – December 2012
Additional targeted outreach (phone calls and e-mails) to providers appearing to meet the minimum patient threshold	Ongoing
Periodic announcements on remittance advice statements regarding the program	2011-2021



Presentations regarding the EHR incentive program and the planned strategic use of HIT at the IME Annual Training. Sixteen training sessions will be held around Iowa. Informational letters were sent to providers targeting eligible professional and hospitals.	June 2011 - August 2011 June 2012 – August 2012 May 2013 – August 2013 May 2014 – August 2014
Iowa Annual e-Health Summit	August 11 and 12, 2011 August 8 and 9, 2012 June 11 and 12, 2013 Summer 2014
Offer Continuing Education Credit classes and webinars. In the evaluations by providers who attend the IME Annual Training, they noted they would like classes that offer credit.	Fall 2013 Winter 2014

During the implementation phase, the IME continued to have a single point of contact, the incentive payment program coordinator, who answered provider questions regarding the incentive program. Since program launch, the ongoing level of provider support has required an additional one and a half FTE to handle the following aspects of the program:

- Continued provider outreach
- Provider help line for answering basic provider questions, including technical assistance for the online tool
- Responding to provider e-mails to a dedicated incentive program e-mail box
- Verification of provider eligibility and attestation review
- Approval of payments
- Assistance during appeals

The incentive payment program coordinator role offers additional guidance to the EHR staff and addresses unique provider questions or escalated issues, as well as interactions with CMS and the systems support staff at the CMS Registration and Attestation site. The IME continues to monitor the level of effort and will adjust staffing levels accordingly to adequately meet the demand. Audit functions, described in further detail in section D of this document, are assigned to the current staffing level in the program integrity unit.



Provider Incentive Payment Program Highlights

As planned, the provider incentive payment program launched on January 3, 2011. The IME identified the following items as highlights for the program since inauguration through August 1, 2013:

- ✓ Conducted outreach via phone, email, in-person training, and webinars to support EHR and HIE adoption and meaningful use
- ✓ Received a cumulative 1219 provider and 49 hospital AIU attestations
- ✓ Co-hosted the Iowa e-Health Summit to give an opportunity for providers to learn about EHR and HIE
- ✓ Completed an update to the Iowa Code administrative rule to support administration of the EHR incentive program

IME has denied applications for payment for the following reasons:

- EPs failed to meet patient volume requirements.
- Hospitals using incorrect fiscal year (later re-attested and was paid).
- Providers registering with incorrect NPI.
- Applicants not enrolled in Iowa Medicaid.
- EP using incorrect 90-day timeframe.

Lessons Learned

As an early launcher, the IME has many lessons learned and has identified numerous invalid assumptions. The IME has shared these on a regular basis at conferences, CMS communities of practice, and through phone calls with other states. The lessons learned are divided into two categories: those learned for providers and those for states. We share the provider lessons to help educate other states on what to look out for and to assist in their educational efforts to their providers. A list of these can be found in appendix H.

Business Process Flows

In designing the incentive payment process, the IME developed high-level process flows to serve as a visual point of reference. Process narratives follow the flows along with additional details on the specific steps involved in each phase.

Process flows depict

- Registration and Attestation Process
- Eligibility and Pre-Payment Verification of Adopt, Implement and/or Upgrade
- Eligibility and Pre-Payment Verification – Subsequent Years (Meaningful Use)



Registration and Attestation Process

This section describes from a provider's perspective the application steps to receiving an incentive payment. This section has been updated to describe the current process using the new Provider Incentive Payment Program (PIPP) system.

Registration and Attestation Process

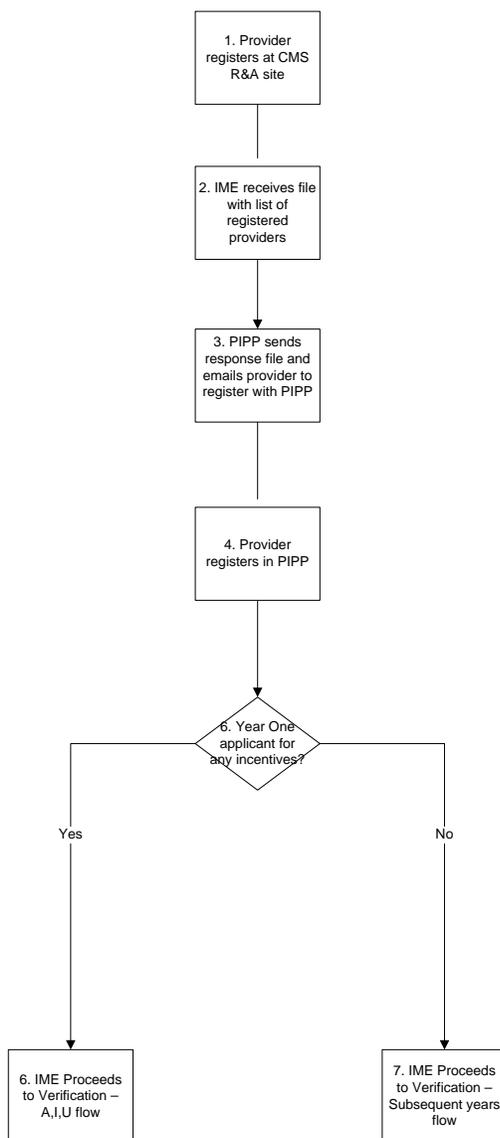




Figure 20: Registration and Attestation Process Narrative

Step	Action
1	Provider (EP or Hospital) registers with the CMS Registration and Attestation site. This is a site maintained by CMS where providers declare the state from which they are applying to receive Medicaid incentive payments. This registry is also used to prevent duplicative payments with Medicare for EPs. Providers are required to provide basic data, such as their NPI, SSN, payee TIN (if assigning their payment) and hospitals provide their CCN.
2	The IME is notified of a provider’s application via daily batch file from CMS. The daily batch is fed into the Provider Incentive Payment Program (PIPP) system, an online attestation system (www.imeincentives.com).
3.	When PIPP receives the registration file from CMS, it sends a response file to CMS reflecting that the providers may register in PIPP. In addition, an email notification goes to the provider telling them to register in the PIPP system and proceed with attestation.
4.	The provider accesses the Iowa PIPP system at www.imeincentives.com and establishes a user name and password by entering the NPI, tax id and CMS registration number. This triggers an activation email to the email address received from the CMS R&AS site. The provider clicks on a link within the email to activate the account.
5.	The questions presented to the provider in PIPP may vary depending on whether the provider is a Year one or subsequent year applicant.
6.	If the provider is applying for a Year One payment, then meaningful use questions are not displayed and the verification process follows the AIU flow, below,
7.	If the provider is applying for a subsequent year payment, then meaningful use questions are displayed and the verification process follows the MU flow, below,

Eligibility and Pre-Payment Verification

In this section, the IME describes the process for reviewing attestations. For hospitals, in accordance with the deeming requirements of the final rule, if Medicare approves meaningful use payments to hospitals, Medicaid will accept the finding of meaningful use. However, IME will continue to validate the patient volume threshold and average length of patient stay requirements eligible hospitals, as well as the hospital payment calculations.



Figure 21: Eligibility and Pre-Payment Verification Process

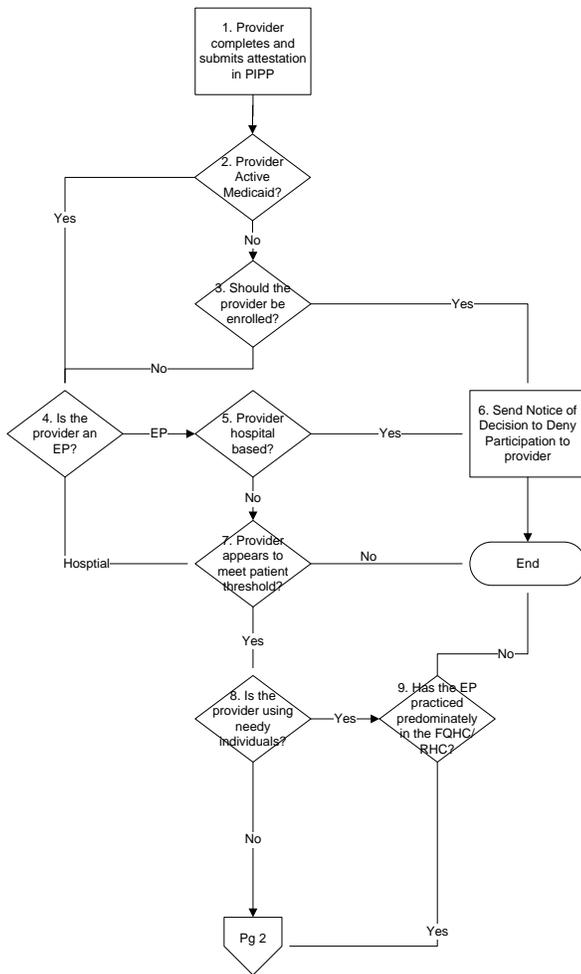




Figure 22: Eligibility and Pre-Payment Verification continued

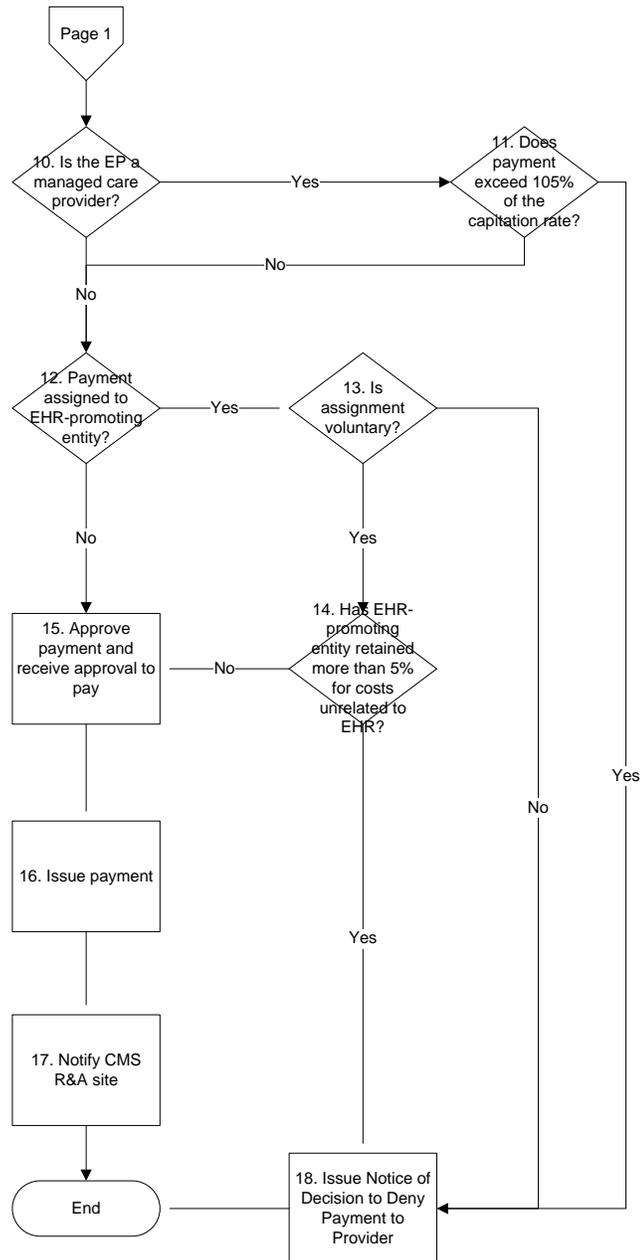




Table 16: Verification Process Narrative

Step	Action
1	<p>The provider completes online attestation in PIPP. Legal requirements include signature (obtained electronically), provider payment information, minimum patient volume and the designated continuous 90-day or 365-day period. Hospitals attest that average length of patient stay is 25 days or fewer. When attesting, providers affirmatively acknowledge that proof of all assertions should be maintained for six years in the event of an audit. Examples of proof of purchase or upgrade to certified EHR technology for attestation could include: Proof of purchase of certified EHR – invoice listing EHR version purchased and subsequent proof of payment, etc. Proof of certification is completed automatically when PIPP calls the CHPL webservice at the time the provider saves the EHR certification number. If the entry fails validation, the system prevents the provider from submitting the attestation.</p> <p>The system documents that these requirements have been sworn to and provides an audit trail to track the secure login id of the person attesting.</p>
2	<p>Provider active Medicaid? An active Medicaid provider is one who is active in MMIS and approved to bill for services. Active Medicaid providers are not currently under sanctions and are duly licensed within the State of Iowa. IME staff research the NPI in MMIS to ensure the provider is enrolled. In the case of a PA, or other EP who is not required to enroll in Medicaid per enrollment rules, the worker researches the applicable Licensing Boards website to ensure the EP is licensed in Iowa. Proof of Medicaid billing through a physician is also required. If the provider is active Medicaid according to the MMIS, the provider has passed the OIG sanctions and licensing checks as part of the enrollment process. The CMS Registration and Attestation site will also have checked for OIG sanctions. If the provider is not active Medicaid, proceed to Step 3. If the provider is active Medicaid, proceed to Step 4.</p>
3	<p>Should the provider be enrolled? The IME does not require certain provider types to be enrolled as Medicaid providers such as Advanced Registered Nurse Practitioners who practice under a supervising physician and Physician’s Assistants. In addition, providers practicing in an FQHC or RHC are not required to enroll individually with Medicaid. The IME works with these providers to identify eligibility and if additional documentation is requested the provider uploads the documentation through PIPP. If the provider appears eligible for incentives, proceed to Step 4. If an ineligible provider has applied, proceed to Step 6.</p>
4	<p>Is the provider an EP? If the applicant is an eligible professional, proceed to Step 5. If the provider is a not an EP, i.e., is a hospital, proceed to Step 9.</p>



Step	Action
5	<p>Is the provider hospital based? Individual providers who are deemed to be “hospital-based” are not eligible to receive the incentive payment unless they can demonstrate that the EP funds the acquisition, implementation, and maintenance of Certified EHR Technology, including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an eligible hospital or CAH; and uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT). If this exception does not apply to the hospital-based EP, proceed to and proceed to Step 6. If the provider is not hospital-based, proceed to Step 7. This step may require coordination with other states if the providers see patients across state lines.</p>
6	<p>Through PIPP, issue the Notice of Decision to Deny Payment to provider. If the provider is not an eligible professional or hospital, is not active Medicaid, has applied to receive Medicare payments or Medicaid payments from another state, is not using a certified EHR, does not meet patient volume requirements, or has failed to demonstrate A/I/U, inform the provider they are not eligible for payment by issuing the Notice of Decision to Deny Payment. This notice contains language of alternate solutions to providers to help them with EHR adoption (such as the HITREC), as well as notice of their appeal rights. This is communicated by issuing a paper document from PIPP, and the denial is passed to the CMS Registration and Attestation site in a B7 file. This ends the process.</p>



Step	Action
7	<p>The IME accesses claims data to determine the number of Medicaid encounters for the provider in the designated reporting period from the previous calendar year. The provider is required to indicate both the numerator and the denominator, along with the beginning and end dates of the reporting period.</p> <p>Proof of patient volume is required and can be EHR reports or other documentation with de-identified patient data for the designated reporting period. In the event more patient information is required for validation, IME requests the member ID and date of service.</p> <p>Providers must also attest whether their numbers include inpatient encounters or encounters from their managed care population. The IME runs separate reports to validate these encounters based on the how the provider reports the numbers.</p> <p>IME has modified our encounter query to ensure:</p> <ul style="list-style-type: none">• Managed care (Magellan and Meridian) encounters are calculated separately,• To include or not include inpatient encounters as desired by the provider, and• To include the number of patients on a provider’s Medipass panel that had a claim in the 12-month period preceding but not in the 90-day designated period for proving patient volume.• Query to determine the number of Medicaid patient encounters in which Medicaid did not make a payment (zero paid encounters and unbilled encounters) or Medicare crossover encounters <p>Providers who want to use the clinic-level proof of patient volume may do so by counting all of the clinic encounters and excluding encounters an EP has outside the clinic. Iowa defines “clinic” as being a separate billing NPI, tax id, or physical location. Providers attesting that they are using clinic-level must indicate how they are defining clinic and all other providers matching that criteria are required to use the same approach for reporting patient volume.</p> <p>This step may also require coordination with other states for those providers seeing patients covered by other state’s Medicaid program.</p> <p>Providers that do not meet the required patient threshold are not eligible to receive an incentive payment and the process ends; proceed to Step 6. If the provider appears to meet the minimum patient threshold, proceed to Step 8.</p>



Step	Action
8	Is the provider using needy individuals to determine patient volume?.When answered yes, this response requires additional scrutiny; proceed to Step 9. Otherwise, proceed to Step 10.
9	Has the EP practiced predominately in the FQHC/RHC? Providers attesting that they practice in an FQHC/RHC who are using needy individuals to reach their 30% are required to show they practice predominately in an FQHC/RHC. This means a showing that the clinical location for over 50 percent of his or her total patient encounters over a period of 6 months in the most recent calendar year occurs at a federally qualified health center or rural health clinic. If the provider has not practiced predominately, proceed to Step 6. Otherwise, proceed to Step 10.
10	Is the EP a managed care provider? In Iowa, this check is restricted to Magellan providers. Magellan is Iowa's only Managed Care Organization (MCO). If the provider is Managed Care and a payment may be issued to Magellan, proceed to Step 11. Otherwise, proceed to Step 12.
11	Ensure payment does not exceed 105% of the capitation rate. Payments made through managed care plans cannot exceed 105% of the capitation rate, in compliance with Medicaid managed care incentive payment rules. This rule applies only for providers who will be paid through Magellan, as Iowa's one and only managed care organization. If the payment is found to exceed 105% of the capitation rate, the payment cannot be made; proceed to Step 18. If the payment is found to not exceed 105%, proceed to step 12.
12	Payment assigned to EHR-promoting entity? Providers are permitted to assign their incentive payments to state-designated entities promoting the use of EHR and HIT. There is no such state-designated entity in Iowa. If there is such an assignment in place, go to Step 13. Otherwise, go to Step 15. The verification of voluntary assignment and 5% spending applies only to EHR-promoting entities, not to payments assigned to employers. We do not see any additional requirements around assignment of payments to employers. We understand the check will be to verify the TIN/NPI combination, a check that will take place regardless of whether there is an assignment.
13	Verify assignment is voluntary. The provider must assert the assignment to the entity is voluntary. The rule requires all assignments to an entity promoting the adoption of certified EHR technology are voluntary to the EP involved. Proceed to Step 14. If the assignment is found to be voluntary, proceed to step 14. Otherwise, proceed to Step 18.



Step	Action
14	Verify EHR-promoting entity does not retain more than 5% for costs unrelated to EHR. The rule requires entities promoting EHR technology to not retain more than 5% for costs not related to certified EHR technology. Since Iowa has not designated an EHR-promoting entity, there is no existing process for this step. If Iowa does designate an entity in the future, we will update this SMHP with those processes. If the EHR-promoting entity is found to spend more than 5% of the incentive payment for costs unrelated to EHR adoption, proceed to Step 18. Otherwise, proceed to Step 15.
15	Prior to issuing payment, there is one final check against the CMS Registration and Attestation site through the D16 request and response files to ensure no payments have been made to the provider by another state or Medicare. Proceed to Step 16.
16	Issue payment. With the implementation of the PIPP system, this is no longer a manual step. When IME receives the D16 approval, a file is generated automatically to the MMIS to issue payment. The status in PIPP is also updated so the provider can view payment status. This step includes the MMIS issuing the payment as part of the weekly payment cycle. The payment shows up on the regular remittance advice statement as a separate line item with a comment that the payment is an EHR incentive payment. The payment is documented for reporting and auditing purposes. Proceed to Step 17.
17	Notify CMS Registration and Attestation site. This notice is provided to prevent duplicative payments by Medicare (EPs only) and to ensure payments made from only one state. This is completed through the D18 transaction.
18	Through PIPP, use the return to provider function to have the provider re-attest. If the provider is not an eligible professional or hospital, is not active Medicaid, has applied to receive Medicare payments or Medicaid payments from another state, is not using a certified EHR, does not meet patient volume requirements, or has failed to demonstrate AIU, inform the provider they are not eligible for payment by issuing the Notice of Decision to Deny Payment. This notice contains language of alternate solutions to providers to help them with EHR adoption (such as the HITREC), as well as notice of their appeal rights. This is communicated by issuing a paper document from PIPP, and the denial is passed to the CMS Registration and Attestation site in a B7 transaction. This ends the process.

Review Process

The IME instituted a process in which the entire review is completed twice by two EHR review staff working independently. This approach serves not only a quality control function, but also ensures that not one person has control over the entire approval process. In the event there is disagreement on whether to issue the payment, the application goes to a conflict queue in PIPP for the incentive payment coordinator to review and break the tie.



Even with the two-level review, applications are reviewed on a timely basis, usually with both reviews completed within one week of attestation.

Provider Attestation

As indicated in step one, the attestation form contains a number of data elements, many of which the IME verifies, with more in-depth verifications occurring in the event of a post-payment audit.

The IME verifies the TIN and NPI combination received from the CMS Registration and Attestation site in the MMIS in compliance with 42 CFR 495.10(f). This check ensures that the individual NPI has a relationship with the TIN provided. We have found many provider applicants whose enumeration with NPPES is different from how they are enrolled with, and subsequently bill, the IME. In these instances, the IME verifies the relationship through a check of NPPES data. If necessary, the IME will request proof from the provider of the relationship with the payee TIN indicated on the application.

Providers are required to submit receipts or other proof of financial commitment to their certified EHR at attestation. In the event of an audit, providers may be required to provide additional receipts/documentation. Providers are also required to submit proof of patient volume in the form of an EHR report or other auditable data source. In most cases, providers submit reports showing the patient totals with a breakdown for those covered by Medicaid. Occasionally, specific patient listings may be required to verify the numerator.

Iowa has modified its approach to patient volume as “trust but verify”. Per the Stage 2 final rule, IME re-defined allowable encounters to any Medicaid-eligible encounter including claims which Medicaid did not pay. We expect more providers will be able to meet the patient volume threshold through this rule change and thus we have asked providers to give more documentation upfront to avoid re-work on both sides. We ask providers to attach supporting documentation when they attest to explain how the patient volume was determined. Providers should be prepared to breakout their patient volume into the following categories:

- Paid Claims
- Zero-Paid Claims
- Unbilled encounters
- Managed Care, known as Medipass encounters
- HMO encounters provided by Megellan and Meridian
- Medicare crossover encounters

Providers need to prepare documentation to support unbilled and Medicare crossover encounters by providing a list of state Medicaid ID numbers and dates of services.

Provider attestation is completed online, with the use of an electronic signature. The electronic signature contains a statement that the “signing” provider is authorized to receive



payment, that all information provided is accurate, the provider is subject to legal penalty for providing false information, and that any funds expended under false pretenses will be recouped. An additional agreement is required for those providers who are not enrolled in Iowa Medicaid individually, such as Physician's Assistants or providers employed by a rural health clinic who bill under the RHC. The attestation questions and both EHR provider agreements are provided in Appendix E.

Adopt, Implement, Upgrade

For providers applying for payments based on adopting, implementing, or upgrading to a certified EHR, PIPP verifies that the EHR that was adopted, implemented or upgraded is certified. All providers are required to provide a certification number that can be verified with the Certified HIT Product List (CHPL) through a webservice.

The provider as part of attestation must provide proof of adoption/ implementation or upgrade. Acceptable proof includes a contract, service agreement or a purchase receipt.

Payment Calculation EPs

For the first payment year, payment will not exceed 85 percent of the maximum threshold, or \$21,250. Year two payments based on 90-days of meaningful use will be \$8,500. Pediatricians with a Medicaid patient volume between 20% and 30% receive 2/3 of that amount, \$14,167 for the first payment year and \$5,667 for subsequent years, not to exceed \$42,500.

Eligible professionals are permitted to assign their incentive payments to state-designated entities promoting the use of EHR and HIT. At this time, Iowa has not designated such an entity. If, however, this changes and the state does designate an entity, the IME has built verification steps into the flows to ensure that the assignment is voluntary and that the entity does not retain more than 5% for costs unrelated to EHR promotion.

To date no payments have been assigned to managed care organizations. If this happens, the process to assure payments through Medicaid managed care plans do not exceed 105 percent of the capitation rate is included in the review process.

Hospitals

The IME calculates the hospital payment based on a template spreadsheet found in Appendix D. The auditable data source for the hospital-specific entries is typically the hospital's submitted Medicare cost report. For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Therefore, the inpatient bed day of a dually eligible patient cannot be counted in the Medicaid share numerator. In addition, nursery and swing bed (skilled nursing) days are not counted in the discharge number for purposes of calculating the incentive payment amount.

The hospital formula in PIPP is automated to ensure payments are made according to the statute and regulations. In verifying hospital data, the IME will depend on the following data sources:



- Provider's cost reports
- Payment and utilization information from the MMIS
- Hospital financial statements and hospital accounting records

The requested data for hospital discharges is based on the previous hospital fiscal year. The IME pays hospitals on a three-year basis, with 40% of the payment in year one, 40% of the payment in year two, and 20% of the payment in year three, assuming the hospital meets the patient volume threshold each year, and meaningful use requirement are met for years two and three. In the event there is a significant error to the hospital numbers that requires a recalculation of the incentive payment amount, the IME is willing to re-visit the initial payment amount determined in the year one participation year. However, IME will not re-calculate the payment for hospitals who want to re-calculate their payment simply because they would have received a higher amount if they had waited for a later payment year.

Payment Frequency

Once approved, incentive payments are issued from MMIS as part of the weekly payment cycle. Most providers receive their payments within 30 days of successfully completing their registration and attestation requirements.

Pre-payment Verification Meaningful Use

Eligible providers who meaningfully use certified EHR technology will qualify for the Medicaid incentive payments. Iowa's new PIPP system includes questions for meaningful use and clinical quality measures. These questions are for both the yes-or -no questions and for those that require a numerator and denominator. This section describes the process for verifying meaningful use and issuing payment. Pre-payment reviewer verify certain meaningful use measures in the following ways:

- All yes-or -no questions must be answered yes.
- Check that the right amount of core and menu objectives and clinical quality measures were selected for attestation.
- Ensure that all measures that have the same denominator do, in fact, report the same numbers as the denominator.

For detailed information on pre-payment verification methods, please see appendix H.

For providers applying for payments based on meaningful use, PIPP repeats the certification verification web service with the CHPL as was done in year one. If the certification numbers vary from year to year, PIPP requires providers to upload proof of acquisition of the newest EHR system.



All participating providers must demonstrate meaningful use for the second participation year. Usually eligible hospitals and providers may choose to demonstrate meaningful use in their first year. The IME has found many participating hospitals applied for the Medicare incentives before applying for Medicaid. These hospitals were approved for a year one meaningful use payment

For EPs, PIPP collects meaningful use measures and clinical quality measures. For meaningful use requirements, the IME relies on the provider and their EHR to track and provide documentation. The provider manually enters clinical quality measures into PIPP. Providers will be able to submit clinical quality measures to the IHIN beginning in early 2013. The questions for meaningful use from the EPs can be found in Appendix H. The IME has no plans to mandate additional meaningful use criteria to the minimum measures required under the rules.



Systems Support

Iowa is committed to the use of electronic tools to support the outreach, communication, application and processing of the Electronic Health Record incentive program.

To conduct outreach to providers, the team uses webinars, web-sites, Google groups, electronic informational letters, and electronic survey tools, as well as attending numerous professional group meetings and seminars. Communication is handled via e-mail, web applications and electronic documentation.

In late 2011, IME procured a new system, Provider Incentive Payment Program (PIPP), for supporting administration of the EHR incentive payment program. PIPP launched on April 2, 2012. Providers begin the registration process through the CMS registration and attestation site, and complete the attestation process through PIPP. Applications are tracked and processed through PIPP and electronic payments are made through the Iowa Medicaid Management Information System (MMIS).

CMS Registration and Attestation Site

This system provides the registration for provider applications and ensures no duplicate payments between Medicare and the State Medicaid agencies. Iowa successfully completed testing of all files from CMS, including those around Medicare cost reports and meaningful use data and has been receiving registration files from the site since January 3, 2011.

Provider Incentive Payment Program (PIPP)

The IME issued a request for information in May 2011. After reviewing the responses, Iowa determined the best use of resources would be to request proposals for an existing or multi-state solution to capture attestation for meaningful use. IME awarded the contract in November 2011 and the new PIPP system launched April 2, 2012.

The IME is currently updating PIPP for Stage 2 attestations. The following table provides a summary of our progress.



Table 17: Stage 2 Regulation Changes Summary

Stage 2 Regulation Changes					State Checklist			Notes
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			
					Not Started	In Process	Complete	
General Policy Changes	90-day Reporting Period – Just for 2014 (State option to require attestations on the fiscal quarter).	\$495.4	10/1/13 – EHS 1/1/14 -EPs	1/1/14		X		
	Exclusion Changes – Can no longer count exclusion toward minimum number of menu objectives if there are other menu objectives provider can meet.	\$495.6	10/1/13 – EHS 1/1/14 -EPs	10/1/13 –EH 1/1/14 – EP			X	This is part of the manual review process. Since Iowa only has one public health measure available for testing, others may have to count with exclusions and review staff would make that judgment.
	Batch reporting – State has option to allow batch reporting of MU data with approval from CMS.	\$495.332	10/1/13 – EHS 1/1/14 -EPs	N/A				Iowa opted to not accept this at this time. We are exploring options through our Quality Metrics Tool that would enable this in the future.
Stage 1 Core MU Measure changes	Vital Signs <i>Alternate Measure from 2013</i> replaces the original measure: More than 50% of all unique patients seen by the provider during the EHR reporting period have blood pressure (for patients age 3 and over only), height and weight (for all ages) recorded as structured data. <i>EPs Only Exclusions</i> Any provider who (1) Sees no patients 3 years or older is excluded from recording blood pressure; (2) Believes that height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording all three; (3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; (4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.	\$495.6	10/1/13 – EHS 1/1/14 -EPs	1/1/14		X		
	EP Core Measure Removed: More than 50% of all patients who request an electronic copy of their health information are provided a copy within 3 business days.			1/1/14		X		



Stage 2 Regulation Changes				State Checklist				
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			Notes
					Not Started	In Process	Complete	
	EH Core Measure Removed: More than 50% of all patients of the inpatient or emergency departments of the eligible hospital (EH) or critical access hospital (CAH) (POS 21 or 23) who request an electronic copy of their health information are provided a copy within 3 business days.			1/1/14		X		
	EH Core Measure Removed: More than 50% of all patients who are discharged from an EH or CAH's inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided these instructions upon request.			1/1/14		X		
	New EP Core Measure: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information, subject to the EP's discretion to withhold certain information.			1/1/14		X		
	New Core EH Measure: More than 50% of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH have their information available online within 36 hours of discharge.			1/1/14		X		
	Stage 1 Menu Measure Changes			EP Menu Measure Removed: At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information, subject to the EP's discretion to withhold certain information.	1/1/14		X	
EP Core Measure for Stage 2	States will need to allow navigation to the following 17 new Stage 2 Core MU Measures:	§495.6 (j)	1/1/14 -EPs	1/1/14		X		
	CPOE - More than 60% of medication, 30% of laboratory, and 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry (CPOE).			1/1/14		X		
	E-Prescribing - More than 50% of all permissible prescriptions written by the EP are compared to at least one drug formulary and transmitted electronically using Certified EHR Technology (CEHRT).			1/1/14		X		
	Demographics - More than 80% of all unique patients seen by the EP have demographics recorded as structured data.			1/1/14		X		
	Vital Signs - More than 80% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only), height and weight (for all ages) recorded as structured data.			1/1/14		X		
	Smoking Status - More than 80% of all unique patients 13 years old or older seen by the EP have			1/1/14		X		



Stage 2 Regulation Changes				State Checklist				
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			Notes
					Not Started	In Process	Complete	
	smoking status recorded as structured data.							
	Clinical Decision Support - A. EPs must implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period, B. The EP, EH, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.			1/1/14		X		
	Clinical Lab Tests - More than 55% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in CEHRT as structured data.			1/1/14		X		
	Patient Lists - Generate at least one report listing patients of the EP with a specific condition.			1/1/14		X		
	Patient Reminders - Use EHR to identify and provide reminders for preventive/follow-up care for more than 10% of patients with two or more office visits in the last 2 years.			1/1/14		X		
	Patient health information online - i. More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information, ii. More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.			1/1/14		X		
	Clinical Summaries - Clinical summaries provided to patients within one business day for more than 50% of office visits.			1/1/14		X		
	Patient Education - Patient-specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period.			1/1/14		X		
	Medication Reconciliation - The EP performs medication reconciliation for more than 50 % of transitions of care in which the patient is transitioned into the care of the EP.			1/1/14		X		
	Summary Care Record - 1. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals, 2. The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record either a) electronically transmitted to a recipient using CEHRT or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a Nationwide Health Information Network (NwHIN) Exchange participant or is validated through an Office of the National Coordinator for Health Information Technology ONC-established governance mechanism to facilitate exchange for 10% of transitions and referrals, 3. The EP who transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the			1/1/14		X		



Stage 2 Regulation Changes					State Checklist			
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			Notes
					Not Started	In Process	Complete	
	sender's, or b) conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period.							
	Immunization Registry - Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.			1/1/14		X		
	Protect Electronic Health Information - Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308 (a)(1), including addressing the encryption/security of data at rest, implement security updates as necessary, and correct identified security deficiencies as part of its risk management process.			1/1/14		X		
	Secure Messaging - A secure message was sent using the electronic messaging function of CEHRT by more than 5% of unique patients seen during the EHR reporting period.			1/1/14		X		
EP Menu Measure for Stage 2	For Stage 2, an EP must meet 3 of the 6 following MU Menu Measures:	§495.6 (k)	1/1/14 -EPs	1/1/14		X		
	Imaging Results - More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.			1/1/14		X		
	Family Health History - More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.			1/1/14		X		
	Syndromic Surveillance - Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.			1/1/14		X		
	Cancer Registry - Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.			1/1/14		X		
	Specialized Registry - Successful ongoing submission of specific case information from CEHRT-to a specialized registry for the entire EHR reporting period.			1/1/14		X		
	Electronic Notes - Enter at least one electronic progress note created, edited, and signed by an EP for more than 30% of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text-searchable and may contain drawings and other content.			1/1/14		X		
EH Core Measure for Stage 2	States will need to allow navigation to the following 16 new Stage 2 Core MU Measures:	§495.6 (l)	10/1/13 – EHs	1/1/14		X		
	CPOE - (A) 60% of medication orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE, (B) 30% of laboratory orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded			1/1/14		X		



Stage 2 Regulation Changes					State Checklist			
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			Notes
					Not Started	In Process	Complete	
	using CPOE, and (C) 30% of radiology orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.							
	Demographics - More than 80% of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.			1/1/14		X		
	Vital Signs - More than 80% of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only), height/length, and weight (for all ages) recorded as structured data.			1/1/14		X		
	Smoking Status - More than 80% of all unique patients 13 years old or older admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data.			1/1/14		X		
	Clinical Decision Support - (A)EHs must implement five clinical decision support 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 EH's or CAH's patient population, the clinical decision support interventions must be related to high-priority health conditions; and (B) The EH or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.			1/1/14		X		
	Clinical Lab Results - More than 55% of all clinical lab tests results ordered by authorized providers of the EH or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in CEHRT as structured data.			1/1/14		X		
	Patient Lists - Generate at least one report listing patients of the EH or CAH with a specific condition.			1/1/14		X		
	Admission Data Online - (A) More than 50% of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH have their information available online within 36 hours of discharge; and (B) More than 5 percent of all unique patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an EH or CAH (or their authorized representative) view, download or transmit to a third party their information during the EHR reporting period.			1/1/14		X		
	Patient Education - More than 10% of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources identified by CEHRT.			1/1/14		X		
	Medication Reconciliation - The EH or CAH performs medication reconciliation for more than 50			1/1/14		X		



Stage 2 Regulation Changes				State Checklist				
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			Notes
					Not Started	In Process	Complete	
	% of transitions of care in which the patient is admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23).							
	Summary of Care Record - (A) The EH or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 % of transitions of care and referrals, (B) The EH or CAH that transitions their patient to another setting of care or provider of care provides a summary of care record for more than 10 % of such transitions and referrals.			1/1/14		X		
	Immunization Registry - Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.			1/1/14		X		
	Reportable Labs to Public Health - Successful ongoing submission of electronic reportable laboratory results from CEHRT to a public health agency for the entire EHR reporting period.			1/1/14		X		
	Syndromic Surveillance - Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.			1/1/14		X		
	Protect Health Information - Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EH's or CAH's risk management process.			1/1/14		X		
	eMAR - More than 10% of medication orders created by authorized providers of the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using electronic medication administration record (eMAR).			1/1/14		X		
EH Menu Measure for Stage 2	For Stage 2, an EH must meet 3 of the 6 following MU Menu Measures:	\$495.6 (m)	10/1/13 – EHs	1/1/14		X		
	Advance Directive - More than 50% of all unique patients 65 years old or older admitted to the EH's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.			1/1/14		X		
	Imaging Results - more than 10% of all tests whose result is an image ordered by an authorized provider of the EH or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period are accessible through CEHRT.			1/1/14		X		
	Family Health History - More than 20% of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives.			1/1/14		X		
	e-Prescribing - More than 10% of hospital discharge medication orders for permissible prescriptions (for new, changed and refilled prescriptions) are queried for a drug formulary and			1/1/14		X		



Stage 2 Regulation Changes				State Checklist				
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			Notes
					Not Started	In Process	Complete	
	transmitted electronically using CEHRT.							
	Electronic Notes - Enter at least one electronic progress note created, edited and signed by an authorized provider of the EH's or CAH's inpatient or emergency department (POS 21 or 23) for more than 30% of unique patients admitted to the EH's or CAH's inpatient or emergency department during the EHR reporting period. The text of the electronic note must be text-searchable and may contain drawings and other content.			1/1/14		X		
	Lab Results to Ambulatory Providers - Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20% of— (A) The electronic lab orders received; or (B) The lab orders received.			1/1/14		X		
CQM Changes for EPs for Stage 1 and Stage 2	Report 9 of 64 CQMs – This is a change from previous requirement to report 6 of 44. Two recommended Core sets available: one for adults and one for children.	\$495.8 See Link Below	1/1/14 -EPs	1/1/14		X		
	CQMs to Cover 9 CQMs from at least 3 Domains – Must report for 9 even if “zero denominators.”			1/1/14		X		
	Electronic Capture & Reporting of CQMs - States can require providers submit CQMs electronically through a proscribed method, subject to CMS approval.			N/A				
	Group Reporting CQMs – States have the option to allow group reporting CQMs, subject to CMS approval. Must address EPs who switch practices during EHR reporting period; EPs reporting under group must still attest for MU objectives individually.			N/A				
CQM Changes for EHs for Stage 1 and Stage 2	Report 16 of 29 CQMs – This is a change from previous requirement to report 15 of 25.		10/1/13 – EHs	1/1/14		X		
	CQMs must Cover at Least 3 Domains			1/1/14		X		
	http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html							
CQM Exemptions for EHs or CAHs for Stage 1 and Stage 2	To be Exempt from a specific individual CQM the CQMs denominator population must equal: - 5 or fewer inpatient discharges/quarter for 90-day reporting period - 20 or fewer inpatient discharges/year for full year reporting period	\$495.8	10/1/13 – EHs	1/1/14		X		
	To Report Fewer than 16 CQM – Must qualify for the case threshold exemption for more than 13 of the 29 CQMs.			1/1/14		X		
	To be Exempt from Covering at least 3 Domains – The hospital would be exempt from requirement to cover the remaining domains, if the CQMs for which the hospital can meet the case threshold of discharges do not cover at least 3 domains.			1/1/14		X		
	To be Eligible for the Exemption – Medicaid-only hospitals must report the aggregate population and sample size counts for Medicaid and non-Medicaid discharges as defined			1/1/14		X		



Stage 2 Regulation Changes				State Checklist				
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			Notes
					Not Started	In Process	Complete	
	by the CQM's denominator for the EHR reporting period to the state to which they attest as specified by state. This data can come from administrative sources rather than the EHR.							

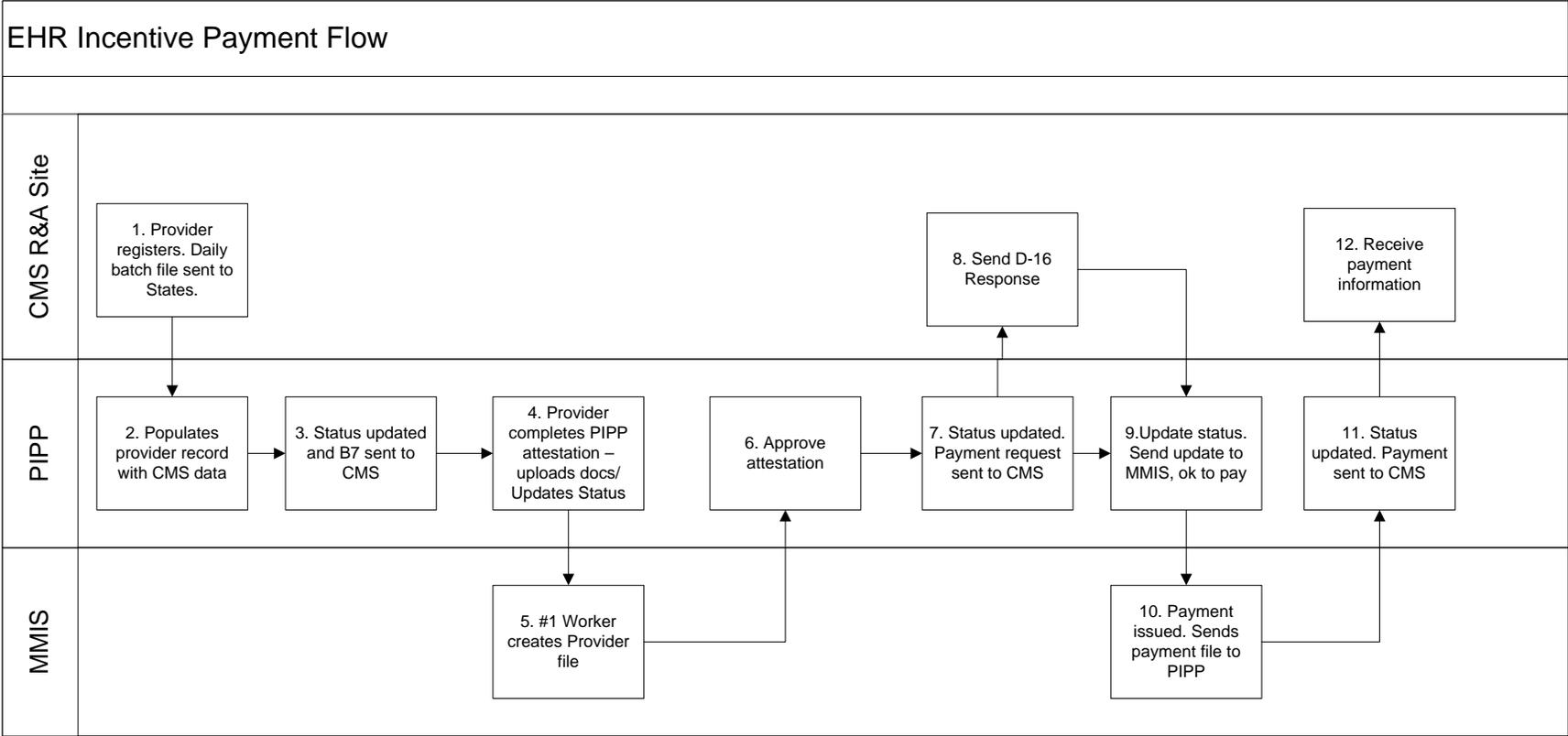


Medicaid Management Information System (MMIS)

The MMIS system manages the provider data store, adjudicates claims and makes payments. All payments are made on a weekly basis through the use of Electronic File Transfers (EFT) or Electronic Benefits Transfers (EBT) debit cards. A special provider type was added to support the EHR incentive payment program to aid in tracking and incentive payment issuance.

A diagram showing the workflow interaction between these systems is found on the next page.

Figure 23: Workflow between PIPP, MMIS, and CMS





Attestation Questions – EP

These screenshots are from our Provider Incentive Payment Portal (PIPP). They show what a provider sees and uses for attestation today.

Figure 24: Provider attestation screen

Provider Questions

1. Are you currently enrolled as an Iowa Medicaid provider?
2. My professional license number is
3. Do you have any sanctions pending against you?
4. What is the NPI of the organization for which you bill?
5. Hospital-based EPs are not eligible for the incentive payment. Are you a hospital-based provider?
6. Are you a Pediatrician?
7. Do you practice predominately in an FQHC/RHC?
- How is your clinic 'so led' by a PA?
8. Are you attesting at group or individual level?
9. Are you currently seeing Medicaid patients billed through a supervising physician?
- Enter your supervising physicians NPI:
10. Do you practice in multiple locations?

Address		
<input type="text"/>	<input type="button" value="Remove"/>	<input type="button" value="Edit"/>
<input type="text"/>	<input type="button" value="Remove"/>	<input type="button" value="Edit"/>

10. EPs can choose to attest to AIU or MU in their first year of program participation without reducing their payments or years of eligibility. To what are you attesting?



Figure 25: Provider attestation screen for EHR

EHR Questions

1. Have you adopted, implemented, or upgraded to certified electronic health record (EHR) technology?

2. CMS EHR Certification number:

2a. Name, version, and description of Certified EHR System:

Providers are required to submit proof that they have adopted, implemented, or upgrades to certified EHR technology. The following is acceptable documentation for such proof.

- A page of the contract or lease showing the provider, vendor, and name of the certified EHR technology and the dated signature page.
- If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology.
- A copy of your purchase order identifying the vendor and certified EHR technology being acquired and proof of payment.

A screenshot of CHPL showing a certified EHR system and/or module(s) is not sufficient documentation of proof of A/I/U.
If you have a question about what is acceptable documentation, please contact the Iowa Medicaid



Figure 26: Provider attestation screen for patient volume

Patient Volume Questions

1. To be eligible for the incentive, 30% of your patient encounters (20% for pediatricians) over a consecutive 90-day period in the previous calendar year must be attributable to Medicaid (needy individuals for those practicing predominantly in an FQHC or RHC). Provide the beginning and end dates for the 90-day period you are claiming to prove patient volume requirements.

Beginning Date:

End Date:

2. What is the total number of patient encounters within the selected 90-day period?
(I.e. your denominator)

3. What is the total number of paid Medicaid encounters for the selected 90-day period?
(I.e. your numerator)

4. Percentage of patient encounters over the selected 90-day period that were PAID by Medicaid:

5. Are any of your Medicaid patients covered by another state's Medicaid program?

5a. Enter covered patient number by state, including Iowa:

State	Medicaid Patient Count	Medicaid No

6. Does your 30% include needy individuals?

6a. Of your patients who are needy individuals, provide the number of patients falling into each of the following categories during the designated 90-day period:

IME/Medicaid:	<input type="text" value="0"/>
hawk-i/CHIP:	<input type="text" value="0"/>
Uncompensated:	<input type="text" value="0"/>
No cost or reduced cost:	<input type="text" value="0"/>

7. What is the auditable data source you are using to calculate patient volume?

8. Are you including inpatient encounters in your patient volume?

9. Are you including encounters covered by Magellan in your numerator?

10. Are you including patients for whom you did not have an encounter in the 90 day period from your MediPASS panel (but for whom you did see in the previous 24 months) in your numerator?



Attestation Questions – EH

Figure 27: EH Attestation Questions

EHR Questions

1. Has the hospital adopted, implemented or upgraded to certified electronic health record (EHR) technology?
2. The hospital's CMS EHR Certification number:
3. Name/Description of certified EHR
4. For what type of payment is the hospital applying?
5. Have you attested with Medicare for a meaningful use payment?

Providers are required to submit proof that they have adopted, implemented, or upgrades to certified EHR technology. The following is acceptable documentation for such proof.

- A page of the contract or lease showing the provider, vendor, and name of the certified EHR technology and the dated signature page.
- If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology.
- A copy of your purchase order identifying the vendor and certified EHR technology being acquired and proof of payment.
- A signed and dated letter on the vendor's letterhead showing the provider and the name of the certified EHR technology provided.

A screenshot of CHPL showing a certified EHR system and/or module(s) is not sufficient documentation of proof of A/I/U. If you have a question about what is acceptable documentation, please contact the Iowa Medicaid EHR Incentive Program staff at imeincentives@dhs.state.ia.us.



Figure 28: EH Patient Volume Questions

Patient Volume Questions

What is your hospital's fiscal year end date? MM/DD 15

1. To be eligible for the incentive, 10% of your patient encounters (ED and inpatient) over a consecutive 90-day period in the previous hospital fiscal year that ended during the previous Federal Fiscal Year must be attributable to Medicaid. Which 90-day period will you be using?

Beginning Date: MM/DD 15

End Date: MM/DD 15

2. What is the total number of patient encounters within the selected 90-day period?
(I.e. your denominator)

3. What is the total number of paid Medicaid encounters for the selected 90-day period?
(I.e. your numerator)

4. Percentage of patient encounters over the selected 90-day period that were PAID by Medicaid:

5. Are any of your Medicaid patients covered by another state's Medicaid program?

6. What is the auditable data source you are using to calculate patient volume?

Please describe

To avoid a possible delay in the processing of your EHR incentive payment, please upload proof of your Patient Volume.
Do NOT include patient medical records as your documentation.



Figure 29: Hospital Payment Calculation

Payment Estimate Questions

Hospitals can use any auditable data source for calculating the incentive payment. References to the Medicare cost report are for guidance only. Critical access hospitals may use an independent auditors report for proof of charity care, minus bad debt. Please indicate which auditable data source you are using for calculating the hospital incentive payment.

Other CMS Hospital Cost Report Both

Overall EHR Amount

Per the Medicare cost report 2552-10, worksheet S-3, part I, line 14, column 15 - Total discharges

Current Year Discharges: Average Growth Rate:

Prior Year 1:

Prior Year 2:

Prior Year 3:

Medicaid Computation

Total Medicaid Days: Total Medicaid Days:
w/s S-3 part I, col. 7, SUM of line 1 and lines 8-12

Total Medicaid HMO Days: 0
w/s S-3 part I, col. 7, line 2

Total Hospital Charges: Non-charity Percentage:
w/s C part I, col. 8, line 200

Charity Care:
w/s S-10, column 3, line 20 (excludes bad debt)

Total Hospital Days: Medicaid Percentage:
w/s S-3 part I, col. 8, lines 1, 2 + 8-12

Total Non-charity Hospital Days: Medicaid Aggregate EHR Incentive Amount:

Are you including patients also covered by Medicare Part A or Medicare Advantage in your total Medicaid days?

Medicaid Payments

Year 1 Payment (40%):

Year 2 Payment (40%):

Year 3 Payment (20%):



At any time during or after attestation, the provider may upload documentation in support of the application. While only a few document types are required to apply, the provider may choose to supply proof to prevent supplying it if selected for an audit.

Possible supporting documentation may include the following information:

- License issued by the Iowa Board of Physician Assistants (required for PA)
- Provider of ownership for RHC (required for PH working in RHC that is owned by PA)
- Proof of patient volume (required)
- Copy of EHR invoice or contract (required)
- Proof of EP's contract or employment agreement

The provider may return to PIPP to complete/change any responses at any time prior to signing. Once the provider attaches a digital signature, the answers are locked. PIPP stores the responses and moves the application to the review queue in PIPP.

PIPP also supports the workflow processes. This includes tracking the steps through verification and submitting the official request for payment.

The IME uses two reviewers to review the provider's application/attestation prior to payment. This approach not only ensures accuracy, but also helps to prevent fraud. Once the attestation is complete, the worker verifies the patient volume responses against MMIS data to verify enrollment and claims history. The workers also verify other aspects of the application, depending on provider type and existing provider-submitted documentation. If the worker is satisfied that payment is appropriate, the worker moves the application in PIPP for a second worker review. Once the second worker approves, the application moves to a completed queue in PIPP that triggers the D16 transaction to the CMS site.

If the returned D16 indicates it is ok to pay, PIPP automatically sends a file to the MMIS to trigger issuance of the incentive payment. The approach uses the existing functionality for issuing payments. When the MMIS makes the payment, a file is sent to PIPP which then sends the D18 to CMS.

MMIS Enhancements

MMIS was enhanced to support issuing payments to providers who qualify for the EHR incentive program. A new provider type (provider type 66) was created to indicate a provider file created solely for purposes of the incentive payment program. While MMIS already contains files for most of the applying providers (with the exception of physician assistants), the creation of a separate provider was necessary to ensure that payments can go directly to providers who are enrolled as rendering-only providers.



EHR incentive payments appear on the remittance advice statement along with other regularly paid claims, but with a code indicating an EHR payment. A new EOB code was added to indicate the payment is attributable to the EHR incentive payment program.

Medicaid payments to providers are paid through the MMIS. The payments are made directly to the provider, or to an employer or facility to which such the EP has assigned payment without any deduction or rebate.

The MMIS reports used to support the CMS-64 and claiming for federal funding of the incentive program have been modified to separately identify the incentive payments.

The IME issues incentive payments to providers according to its regular payment weekly payment schedule.



Appeals

The existing provider appeals process was expanded to include appeals from providers on the basis of the incentive payment amount, provider eligibility determinations and demonstrations of efforts to adopt, implement or upgrade and meaningfully use certified EHR technology. In 2010, the IME adopted an administration rule to support the appeals process. The rule was amended in early 2011 to include the definition of pediatrician. Because IME must include the attestation questions as part of the rule, the rule was amended July 2013 to include questions on meaningful use and to clarify the timeframe for hospital patient volume. The text of this rule can be found in Appendix E.

The appropriate IME unit tasked with tracking the appeal depends on the basis for the appeal. Provider Services will handle provider contests to eligibility determinations. The Program Integrity unit will handle contests based on findings of A/I/U or meaningful use. Payment amount disputes will be handled by Provider Cost Audit. To date, there have been no appeals filed as a result of the EHR incentive payment program.

This section provides details of the existing appeals processes as defined in the MITA State Self-Assessment conducted in January 2009. The IME does expect providers to contact the IME prior to initiating a formal appeal. The IME will work with providers to resolve issues without the need for using the appeals process.

The Manage Provider Complaint, Grievance and Appeal business process handles provider appeals of adverse decisions or communications of a complaint or grievance. A complaint, grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process. The complaint, grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; an appeals hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the appeals hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process.

This process supports the Program Management Business Area by providing data about the types of complaints, grievances and appeals it handles; complaint, grievance and appeals issues; parties that file or are the target of the complaint, grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to complaints, grievances and appeals.



Figure 30: Appeals Process Flow

Appeal Process

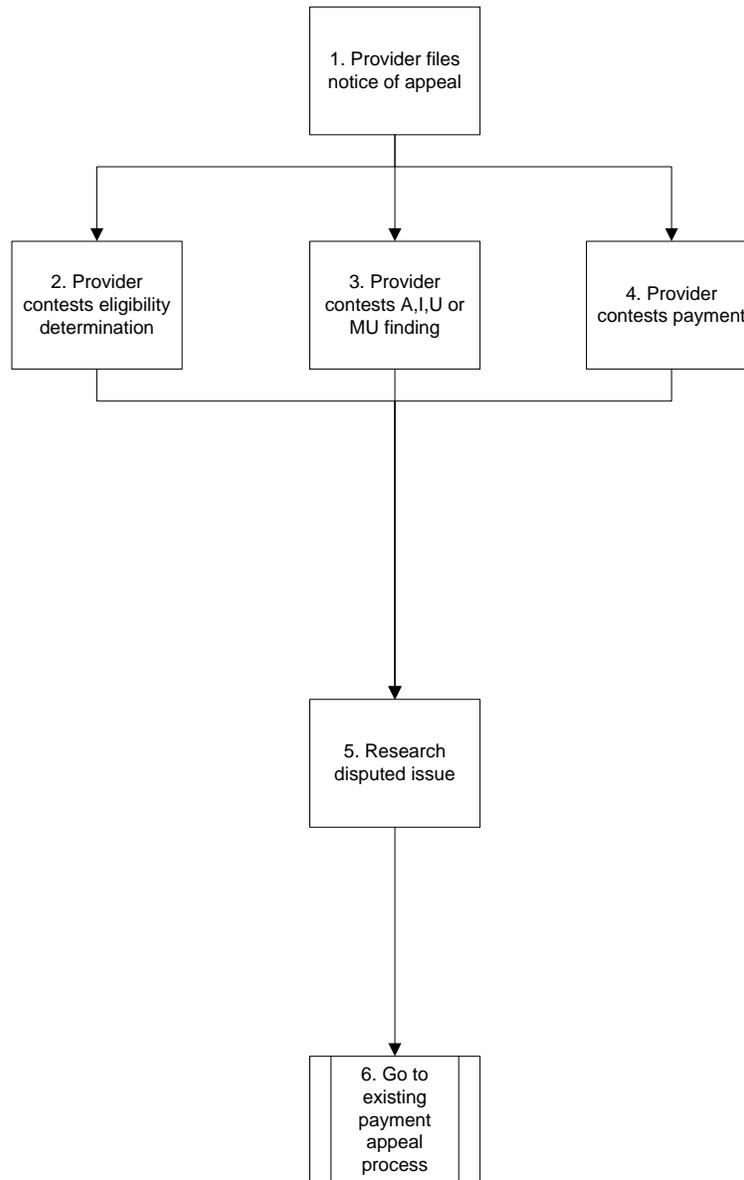




Table 18: Appeal Process Narrative

Step	Action
1	<p>Provider files notice of appeal by one of three mechanisms: Complete an appeal electronically at https://dhssecure.dhs.state.ia.us/forms/appealrequest.htm, or Write a letter telling us why you think a decision is wrong, or Fill out an <i>Appeal and Request for Hearing</i> form. The IME expects providers to contact the IME prior to initiating a formal appeal. The IME will work with providers to resolve issues without the need for using the appeals process. For the nine applications that have been denied, the IME staff reached out to the denied providers to explain the reason for denial, as well as options for re-applying.</p>
2	<p>Provider contests eligibility determination? Providers may be denied eligibility for the incentive program if they do not meet the minimum patient threshold or if they are not the correct provider type. Providers may contest this finding.</p>
3	<p>Provider contests A/I/U or MU finding? Providers may be denied incentive payments on the basis they did not successfully demonstrate efforts to adopt, implement or upgrade, or to show meaningful use. Providers may contest this finding.</p>
4	<p>Provider contests payment? The amount providers are paid is based on their participation year, whether the provider is a pediatrician, and possibly other factors, particularly with the hospital payment formula. Providers may contest this finding.</p>
5	<p>Verify disputed issue. Providers must submit documentation to support their claim. This documentation is researched to determine whether the IME decision is found to be correct. Providers may appeal that the process was not followed, but cannot appeal the process itself.</p>
6	<p>Go to existing payment appeal process. This is the existing process for responding to provider appeals.</p>



Claiming FFP

The IME provides assurances that amounts received with respect to sums expended that are attributable to payments to a Medicaid provider for the adoption of EHR are paid directly to the provider, or to an employer or facility to which the provider has assigned payments without any deduction or rebate.

This section describes the process for ensuring no more than 100% FFP is claimed for reimbursement of incentive payments made to providers, and that no more than 90% of FFP is claimed for the administrative costs of administering the program. These steps leverage existing processes followed for claiming FFP for Medicaid expenditures.

Figure 31: Claim Federal Reimbursement Flow

Claim Federal Reimbursement

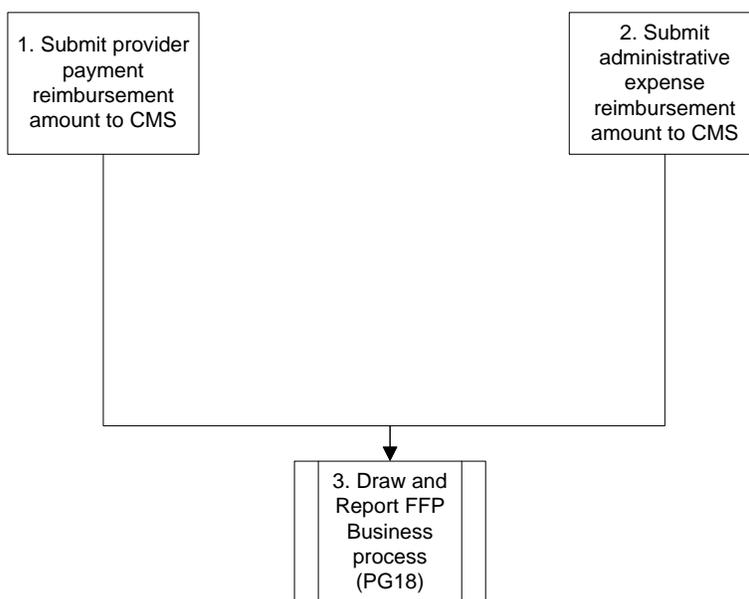




Table 19: Claim Federal Reimbursement Narrative

Step	Action
1	495.332(c)(7) a description of the process in place to ensure that no amounts higher than 100 percent of FFP will be claimed for reimbursement of expenditures for State payments to Medicaid EPs for the incentive program and a methodology for verifying such information is available. Payments claimed will be consistent with the guidance provided in SMD# 10-016.
2	495.332(c)(7) a description of the process in place to ensure that no amounts higher than 90 percent of FFP will be claimed for administrative expenses in administering the incentive program and a methodology for verifying such information is available. The new CMS-64 forms provide lines for the reporting of HIT administrative activities reimbursable at 90% (Lines 24A – 24D)
3	Existing processes as documented in the IME MITA State Self-Assessment Report, June 1, 2009, (Business Process Number: PG18) will be followed for both types of reimbursement reporting.

The Draw and Report FFP business process (PG18) involves the activities to assure that federal funds are properly drawn and reported to CMS. The state is responsible for assuring that the correct FFP rate is applied to all expenditures in determining the amount of federal funds to draw. When CMS has approved a State Plan, it makes quarterly grant awards to the state to cover the federal share of expenditures for services, training, and administration. The grant award authorizes the state to draw federal funds as needed to pay the federal share of disbursements. The state receives federal financial participation in expenditures.

CMS can increase or decrease grant awards because of an underestimate or overestimate for prior quarters. Payment of a claim or any portion of a claim for FFP can be deferred or disallowed if CMS determines that the FFP claim is incorrectly reported or is not a valid expenditure.



Other Process Design Considerations

MITA Impacts

The IME intends to leverage the following business processes, as defined in the MITA 2009 self-assessment:

1. PM01 – Enroll Provider
2. PM03 – Inquire Provider Information
3. PM04 – Manage Provider Communication
4. PM05 – Manage Provider Grievance and Appeal
5. PM06 – Manage Provider Information
6. PM07 – Perform Provider Outreach
7. PG08 – Manage FFP for MMIS
8. PG09 - Manage F-Map
9. PG10 – Manage State Funds
10. PG11 – Manage 1099s
11. PG18 – Draw and report FFP
12. PG19 – Manage FFP for Services
13. PI01 – Identify Candidate Case
14. PI02 – Manage Program Integrity Case

IME Assumptions and Dependencies

The IME has the following assumptions and dependencies:

- The IME expects to receive daily batch updates from CMS, with an eventual manual, web-based, look-up capability for the IME to check the status of any given provider
- The IME expects timely reimbursement, or advance payment, from CMS in alignment with the payment schedule to providers
- The IME's anticipated challenges include operating under budget constraints, numerous other initiatives, and staff reductions

CMS Data Elements

The IME receives the following data elements from the CMS daily batch:

- Provider name
- Provider individual NPI
- Provider type
- Provider business address
- Provider business phone



- TIN to which the provider wants the payment made
- CCN for eligible hospitals
- Provider registration number

The IME sends to CMS the following data elements:

- Amount of payment (if a previous payment was made from Medicare or another state)
- Date of payment (if a previous payment was made from Medicare or another state)
- Reason codes for ineligibility (if previously denied by Medicare or another state)



Section D: Iowa's Incentive Payment Audit Strategy

Proposed Program Integrity Strategies

Iowa's Incentive Payment Audit Strategy describes the processes required for ensuring the accurate payment of the EHR Incentives to Iowa's providers. This section describes the process for combating fraud and abuse by verifying criteria related to the EHR incentives payment program, as well as a description of the process and methodology to address Federal laws and regulations designed to prevent fraud, waste, and abuse. IME strives to minimize fraud and abuse and to reduce the potential for error in payments. Iowa intends to leverage the existing audit strategies and resources in place for fraud and abuse detection for the incentive payment program.

While the IME employs an approach of random audits, the IME also focuses audit efforts on targeted provider categories. We will use risk pools to ensure that providers are selected for an audit based on their associated risk. Since we rely on out-of-state resources for verification processes, we will assign out-of-state providers to the high risk category as it may be easier for a provider to attempt to supply fraudulent information. Since Physician Assistants are not currently enrolled in Medicaid, PAs will also be in the high risk category along with providers who marginally meet the minimum patient volume requirements. Finally, smaller provider practices that do not have the advantage of an in-house compliance office may be at greater risk of not meeting all requirements for the program. As these audits yield results, the IME will continue to hone its audit strategy.

The IME has elected to have the Centers for Medicare and Medicaid conduct the audit process for hospitals. This process includes all audits and appeals per CMS policy and procedure. If it is deemed necessary, IME will work to recoup payments found to be made in error. If an eligible hospital wishes to appeal this process, it would be subject to the CMS appeals process.

Existing Audit Strategy and Process

This section provides details of the existing Manage Program Integrity Case processes as defined in the MITA State Self-Assessment conducted in January 2009.

The Manage Program Integrity Case business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or member from the Medicaid program; or the case may be terminated or suspended. Responsibility for the process is centralized, within the Program Integrity Unit at the IME. The Medical Services Unit at the IME and the IME policy staff provide support. When a case is determined as resulting in a fraud or criminal situation, the case is turned over to either the Department of Inspections and Appeals Bureau of Economic Fraud (Member) or the DIA Medicaid Fraud Control Unit (Provider), as appropriate. Individual state policy determines what evidence is needed to support different types of cases.



In the case of the EHR Incentive program, Program Integrity will select five percent of payments made in the previous quarter for audit. The following sections will explain how pre-payment reviewers and Program Integrity will conduct the audit process on providers by risk categories and what definitions they use in their review.

Pre-Payment Verification Areas

Prior to issuing payment, the IME staff reviews the attestation information to verify the following items:

- The provider is enrolled in Iowa Medicaid, if the provider is a type required to enroll in Medicaid in order to treat Medicaid patients;
- The provider has not been sanctioned;

From a high level check of claims volume or managed care and/or medical home members, the minimum patient volume threshold

- is achieved during the desired 90-day period of the previous calendar year for EPs or fiscal year for eligible hospitals; and
- Proof of patient volume for the denominator.

For providers attesting to adoption/implement/upgrade, the reviewers will confirm the following items:

- For providers claiming incentives based on adopt, implement, upgrade, that no previous year payment was made and that the provider has adopted certified EHR technology. Proof of EHR purchase. This can be in the form of an invoice, receipt or purchase order between the provider and the EHR vendor.
- Verify that all required documents have been uploaded.

For providers attesting to meaningful use of their electronic health record, the reviewers will verify the following information:

- Check the Meaningful Use sections have been completed appropriately. This broad review includes checking to insure that all measures that should have the same denominator do in-fact have the same denominator, and that the appropriate number of core, menu, and CQM objectives have been selected and answered.
 - For Stage 1, EPs are required to complete 15 core objectives, 5 out of 10 menu objectives, and 6 clinical quality measures; EHs are required to complete 14 core objectives, 5 out of 10 menu objectives, and 15 clinical quality measures.



- For Stage 2, EPs must meet and complete 17 core objectives, 3 out of 6 menu objectives, and 9 clinical quality measures; EHs must meet and complete 16 core objectives, 3 out of 6 menu objectives, and 16 clinical quality measures.

During this review, the reviewers will determine the risk category and if the provider should be flagged for audit. This will place the provider in the pool of potential audits and does not guarantee that they will be audited.

If any documentation is missing or if there is an error found on the application during the primary or secondary review, the application is returned to the provider to make the necessary correction or upload the missing documentation. The pre-payment review team will continue to work with the provider to ensure that all of the requirements of the program have been met prior to issuing payment. If the dovetail period has closed for that attestation year, program staff will contact providers via email to advise providers with outstanding issues for their application that they will have an additional 45-day period to complete their application or it will be considered denied for the year.

Providers are required to affirm that they understand they are to keep proof of all attestation requirements for a minimum of six years.

Post Payment Audit Strategy

The Program Integrity Unit audits a subset of the payments determined by random sampling methodologies. Five percent (5%) of the A/I/U and meaningful use payments per quarter are selected for audited. The existing program integrity team performs audit activities. In the post payment audit process, IME will continue to use risk pools for the purposes of identifying those providers most at risk for fraudulent activity. The pool will largely include Moderate and High risk providers, though some low risk providers may be selected.

Table 20: Audit Categories and Strategies

Risk Category	Audit Strategy
<p>Low Risk - EPs utilizing only their encounters (no group practice encounters), for Iowa Medicaid members. The provider must also attest with at least 37% Medicaid utilization according to both the provider’s submitted calculator and the Medicaid encounter volume supported by the Medicaid FFS and</p>	<p>These providers generally would not be subject to an audit unless the provider was found to be in violation of a separate and distinct Federal or State Regulation surrounding the Medicaid Program.</p> <p>In the event that a provider is found to be in violation of a Federal or State Regulation surrounding the Medicaid Program the provider will also be selected to an EHR audit to verify eligibility for any incentive payments received.</p> <p>Providers selected for audit from this category who are</p>



<p>managed care paid encounter claims as reported by the Medicaid Management Information System (MMIS).</p>	<p>attesting to Meaningful Use will be audited on all Meaningful Use as outlined below.</p>
<p>Moderate Risk - EPs that utilized the group practice methodology for encounters with Iowa Medicaid members. A provider must also attest with at least 33% to 36% Medicaid utilization according to both the provider's submitted calculator and the Medicaid encounter volume supported by the Medicaid FFS and managed care paid encounter claims as reported by the Medicaid Management Information System (MMIS). A random sample of providers in this category will be selected for audit.</p> <p>EPs that attest as a pediatrician paid at the reduced rate with attestation between 20% and 22%.</p>	<p>Verify:</p> <ul style="list-style-type: none"> • Patient volume – providers will be required to supply additional proof to support their attestation of patient volume, including appointment books or billing statements covering their designated 90-day period. This should supply information for validating both the numerator and denominator. Providers will be required to explain their process for determining 30% of their population is attributable to Medicaid. • A/I/U or MU of certified EHR – providers are required to supply proof of EHR adoption or upgrade, as well as proof of certification of the EHR. This will be accomplished through copies of purchase agreements and contracts. • Hospital-based – the Program Integrity Unit verifies through claims query that not more 90% of their Medicaid encounters took place in a hospital setting (POS code 21 or 23). • If a pediatrician, must prove they meet the requirements as a pediatrician. Iowa's rule-based definition of pediatrician is: a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification. • For out-of-state providers, coordinate with other state's Medicaid agencies to verify patient volume. <p>Providers selected for audit from this category who are attesting to Meaningful Use will be audited on all Meaningful Use as outlined below.</p>
<p>High Risk – EPs who are out-of-state, or who are not currently enrolled in Iowa Medicaid as providers, Providers, including PA's, who practice predominately in an FQHC or RHC, and EP hospital based encounters (POS types 21 and 23). Any</p>	<p>Verify:</p> <ul style="list-style-type: none"> • Proof of licensure as a PA in Iowa • Proof that the FQHC/RHC is so led by a PA, as declared in the attestation: <ul style="list-style-type: none"> ○ PA is the primary provider – look at appointment books and any patient assignment documentation ○ PA is the clinical or medical director – this should be documented in the business plan



EP who attests with Medicaid Utilization between 30% and 33% according to both the provider's submitted calculator and the Medicaid encounter volume supported by the Medicaid FFS and managed care paid encounter claims as reported by the Medicaid Management Information System (MMIS).

Any provider manually flagged by the reviewer in the pre-payment audit process is automatically assigned high risk.

- PA is the owner of the RHC – proof of ownership Proof of “practices predominately”, defined as in the clinical location for over 50 percent of total patient encounters over a period of six months in the most recent calendar year occurs at a federally qualified health center or rural health clinic.

Patient volume – providers will be required to supply additional proof to support their attestation of patient volume, including appointment books or billing statements covering their designated reporting period. This should supply information for validating both the numerator and denominator. Providers will be required to explain their process for determining 30% of their population is attributable to Medicaid.

CHIP patient volume

Patients receiving uncompensated care or care on a reduced or sliding scale

Hospital-based – the Program Integrity Unit verifies through claims query that not more 90% of their Medicaid encounters took place in a hospital setting (POS code 21 or 23).

If a pediatrician, must prove they meet the requirements as a pediatrician. Iowa's rule-based definition of pediatrician is: a physician who is board-certified in pediatrics by the American Board of Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

A/I/U or MU of certified EHR – providers are required to supply proof of EHR adoption or upgrade, as well as proof of certification of the EHR. This will be accomplished through copies of purchase agreements and contracts.

For out-of-state providers, coordinate with other state's Medicaid agencies to verify patient volume.

Providers selected for audit from this category who are attesting to Meaningful Use will be audited on all Meaningful Use as outlined below.



Failed Audits

The post-payment auditor will work with a provider to ensure they are correctly determining and reporting patient volume, meaningful use, and other criteria. In the event of a failed audit, the provider's status will be put into a credit balance to recoup the money. The provider will be ineligible for that year's funding, although the provider is welcome to return for subsequent years if he or she meets program eligibility requirements. We will report this audit status to the National Level Respository using the E7/E8 process. This process required changes to the Provider Incentive Payment Portal (PIPP) to send and receive those files which were implemented in January 2013.

Auditor Checklist

To conduct a thorough review of the providers eligibility, the audit staff use the following checklist during audit:



Figure 32: Auditor check list for provider eligibility

**Electronic Health Record (E.H.R.) Incentive Payment Program
Post-Payment Audit Checklist**

Explanation of Numbered Notes

(1)EP - Eligible Professional

(2)EH - Eligible Hospital

(3)American Recovery & Reinvestment Act of 2009 (Public Law 111-5); Health Information Technology for Economic & Clinical Health Act (HITECH)

(4)42 CFR Parts 412, 413, 422 and 495; Medicare and Medicaid Programs; EHR Incentive Program Final Rule.

(5)Not required of EP in IHS facilities.

Eligibility Requirements	EP ⁽¹⁾	EH ⁽²⁾	Statute ⁽³⁾	Final Rule ⁽⁴⁾	Post-payment Review Process Risk Profile Process and Data Elements
1. EP or EH must be one of the permissible professional or hospital types	x	x	42 USC § 1396b(t)(2)(A-B)	§ 495.368 (a)(1)(i) Combating fraud and abuse	a) Verify that the EP or EH is one of the following provider types in MMIS: 01 - General Hospital 02 - Physician MD 03 - Physician DO 04 - Dentist 38 - Certified Nurse Midwife 49 - Federal Qualified Health Center (FQHC) 50 - Nurse Practitioner
2. EP or EH must be licensed to practice in the State ⁽⁵⁾	x	x		§ 495.368 (a)(1)(i) Combating fraud and abuse	a) Verify the provider included a copy of a license to practice medicine in the pre-payment process. b) If no license is included, one must be requested from the provider.
3. EP or EH must be a Medicaid provider in that State.	x	x		§ 495.304 (a) Medicaid provider scope and eligibility	a) Verify the provider has a valid Medicaid provider number in MMIS b) If the provider is a Physician Assistant (PA) working in a RHC or FQHC, the provider may not have a Medicaid provider number. In these cases, an employee/employer agreement should be requested from the RHC or FQHC.
4. EP or EH cannot be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State (e.g. already received incentive payment)	x	x		§ 495.368 (a)(1)(i) Combating fraud and abuse	Verify the provider did not receive multiple incentive payments for the same calendar year.
5. EP must have at least a 30% Medicaid patient volume (or 20% for pediatricians), unless s/he is practicing predominantly in an FQHC or RHC	x		42 USC § 1396b(t)(2)(A)	§ 495.304(c)(1) Medicaid provider scope and eligibility	a) Review all patient encounters submitted by the provider. b) Verify the Medicaid encounters provided by the EP using the Iowa DHS-DW12 claims data. c) If the provider did not include a list of all patient encounters by date of service, such a list must be requested from the provider.
6. EP must have at least a 30% needy individual patient volume, if s/he is practicing predominantly in an FQHC or RHC	x		42 USC § 1396b(t)(2)(A)	§ 495.304(c)(3) Medicaid provider scope and eligibility	a) Review all patient encounters submitted by the provider. b) If the provider did not include a list of needy patients by date of service, such a list must be requested from the provider.
7. EPs must have more than 50% of his/her patient encounters occur at a FQHC or RHC in a six month period during the prior calendar year to practice predominantly in an FQHC or RHC	x			§495.366 (b)(4) Financial oversight and monitoring of expenditures	a) Review all patient encounters submitted by the provider. b) If the provider did not include a list of patient encounters at a FQHC or RHC in a six month period by date of service, such a list must be requested from the provider.



Hospitals

The IME designated the Centers for Medicare and Medicaid to conduct the Meaningful Use audit process for hospitals. CMS will carry out all audits and appeals and the IME is bound by the audit and appeal findings. The IME will perform any necessary recoupments arising from the audits. . IME recognizes CMS proposed revision of regulations at §495.370 that any adverse CMS audits would be subject to the CMS administrative appeals process and not the state appeals process.

Patient Volume

One of the audit categories is verification of patient volume. The IME uses a methodology for calculating patient volume that is as inclusive as possible, while balancing the administrative burden on the IME and providers and being compliant with final federal regulations. The IME understands that in order to be eligible for payments eligible professionals must have at least 30% of the practice attributable to Medicaid (or 20% in the case of pediatricians, 10% for acute care hospitals.). EPs practicing predominately in an FQHC or RHC must attribute 30% of patient encounters over a 90-day period to “needy individuals.”

Since providers may be in various stages of EHR adoption and implementation, the approach for proving patient volume must be flexible. Providers with an existing EHR are usually able to prove patient volume with systems reports, whereas paper-based practices depend on manual calculations and patient appointment books. In selecting which 90-day period during the calendar year or previous 12-month period to select for proving patient volume, the IME encourages providers to select a period in which they are most likely to qualify for the incentives.

Iowa accepts either one of the two methods for calculating patient volume as provided in the final rule. The first permits calculation based on the number of Medicaid encounters during any given 90-day period as selected by the provider. Iowa does have some managed care providers who manage care for patients on their panel. These providers are permitted to include in their numerator patients on their panel whom they have seen at any time in the previous calendar year or 12-month period prior to attestation, regardless of whether they were seen in the designated 90-day period. If the panel patient is also seen during the 90-day period, the provider counts the patient only one time, or for the number of times seen during the 90-day period. Providers will be required to attest that they are using the same approach in calculating the numerator as that in calculating the denominator. The IME also includes in the numerator patients who are covered by any of the Medicaid waiver programs, as well as all patients enrolled (but for whom no claim was paid) in Medicaid during the 90-day period, as result of the Stage 2 final rule.

Iowa permits clinics and group practices to use the clinic-wide Medicaid patient volume and apply it to all EPs in their practice under three conditions:



1. The clinic or group practice's patient volume is appropriate as a patient volume methodology (for example, if an EP sees only Medicare, commercial, or self-pay patients, this is not an appropriate calculation)
2. There is an auditable data source to support the clinic's patient volume determination and
3. So long as the practice and EPs decide to use one methodology in each year (clinics cannot have some of the EPs using their individual patient volume for patients seen at all the clinic, while others use the clinic-level data)

Iowa includes the encounters of ancillary providers such as pharmacists, educators, etc. when determining if the EPs are eligible, per patient volume requirements. If these non-EP encounters are included in the numerator, they must be included in the denominator as well. Iowa defines "clinic" as being a separate billing NPI, tax id, or physical location. If the entire clinic or group practice uses the entire practice or clinic's patient volume, they are not permitted to limit patient volume in any way. Likewise, if a physician's assistant (PA) provides services, but they are billed through the supervising physician, Iowa permits consideration of the patient as part of the patient volume for both professionals. This policy is applied consistently in calculating both the numerator and denominator.

While the IME has an indication of the number of Medicaid patients seen based on claims and enrollment data, the total number of Medicaid patients must be supplied by the provider. To ensure accuracy and to increase the chances of meeting the threshold, the numerator will also include patients covered by other state's Medicaid, as well as the IME patients who were seen, but not billed, as a result of primary insurance coverage. Because these numbers contribute to the numerator, but will not be reflected in the IME claims, providers are required to supply these figures. The IME verifies patients covered by another state's Medicaid by contacting the other state's Medicaid agency. The IME also includes in the numerator patients who are covered by any of the Medicaid 1115 waiver or, starting in 2013, Medicaid expansion programs.

Verification Methods

During an audit, the IME will use a list generated by the provider to identify patients enrolled in other state's Medicaid programs and will facilitate verification of enrollment with the other state. Providers who already have an existing EHR may be able to electronically generate reports that indicate the percentage of patients covered by Medicaid. Figure 31 is an example of a report depicting patient count by payer. The EHR can also create lists of patients by payer. The IME will use these lists to identify patients enrolled in other state's Medicaid programs and will facilitate verification of enrollment with the other state.

For providers who do not have an EHR, or whose EHR does not provide adequate patient reporting, the IME will work with the providers to determine what they can submit



as proof, with minimum work for the providers, but enough information to be dependable for the IME audit purposes. Examples of acceptable proof include copies of schedules or copies of claims to different payers. This proof is required only on cases the IME selects for audit.

In addition, the IME depends on the records of the FQHCs and RHCs when calculating their needy patient volume. The IME works with these facilities individually to ensure that all patients on Medicaid, CHIP, or whose fees are adjusted according to their income, are counted in their numerator. If possible, the Iowa Medicaid encounters are confirmed based upon claims paid during the qualification time period. However, due to enrollment and billing rules, this is not always the case. In cases where the IME cannot verify Medicaid patient volume, the providers are contacted to supply documentation of patient volume. The IME also has agreements with neighboring states to verify the patient volume to ensure the accuracy when providers claim patients covered by another state's Medicaid.

The IME works closely with providers to determine overall patient volume. The IME ensures that providers understand the definition of an "encounter" and that a common definition is being applied to both the numerator and denominator. When selected for an audit, as with the numerator, providers who already have an EHR may be able to supply reports that indicate overall patient volume. The provider produces a report indicating the aggregate number of Medicaid encounters (by state if the provider serves multiple states), and the total number of patient encounters. The volume of total patient encounters is checked to ensure the number is reasonable based upon the practice type.



Figure 33: Sample patient volume report

Sturdevant

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Page 1

MISYS Insurance Company
Patient Percentage

Filter Used: Charge Entry

Instr	Ins Name	Pat Count	% of Insu
1	BLUE CROSS BLUE SHIELD	361	27.33%
2	AETNA	34	2.57%
3	PRINCIPAL	49	3.71%
4	UNITED HFAL THCARF	30	2.25%
5	MIDLANDS GROUP	60	4.54%
7	CONNECTICUT GENERAL	1	0.08%
9	INTERPLAN HFAL TH GROUP	1	0.08%
19	ASSOCIATED BENEFITS	2	0.15%
24	TRICARE	13	0.98%
26	CIGNA	14	1.06%
30	CORPORATE BENEFIT SERVICE	1	0.08%
31	COVENTRY HFAL TH CARE	7	0.53%
39	GREAT WEST	1	0.08%
44	MAIL HANDLERS	1	0.08%
53	SANFORD HEALTH PLAN	11	0.83%
61	FEDERATED INSURANCE	1	0.08%
64	UMR	6	0.46%
90	DAKOTACARE	11	0.83%
95	SELF INSURED SERVICE	1	0.08%
101	MEDICAID IOWA	490	37.09%
102	MEDICAID NEBRASKA	108	8.18%
103	MEDICAID SD DEPT OF SOCIAL SVC	7	0.53%
118	GOLDEN RULE	2	0.15%
124	PRIVATE PAY	18	1.36%
138	FIRST ADMINISTRATORS	56	4.24%
153	MEGA LIFE AND HEALTH	1	0.08%
155	MEDICA	2	0.15%
210	AVERA HFAL TH PLANS	19	1.44%
270	ASSOCIATES FOR HEALTH CARE	1	0.08%
284	DEFINITY HEALTH CLAIMS	1	0.08%
344	PHYSICIANS PLUS INSURANCE CO	1	0.08%
347	MOUNTAIN STATES ADMINISTRATIVE	1	0.08%
357	PROGRESSIVE INSURANCE	1	0.08%
Total Patients:		1324	

Printing Date: 4/1/2009 10:16:23 AM
Instr: 1-9999

Report: C:\Iowa\Misys\Query\workspace\4 1 09 6 30 09 RWTR.rpt
Database User: C:\Query Copyright 2007 American Medical Association. All rights reserved.



Adopt/Implement/Upgrade

As part of an in-depth audit, the IME performs the following to verify, adopt, implement and upgrade activities around certified EHR technology:

- Review the contract, purchase order, or documentation supporting A/I/U activities.
- Confirm the certification number is a certified product as per the CHPL.

Meaningful Use

We will select meaningful use payments to audit per quarter that are included in the 5% of cases chosen for audit using a random sampling method. Because each EP selected will be audited for each measure, Iowa did not develop risk categories for each measure. As patterns emerge on how meaningful use is being demonstrated, we will consider changing our strategy to sample some MU measures for all EPs. We will also consider other flags, such as those who claimed a high number of exemptions for their provider type.

Once providers begin submitting meaningful use and clinical quality measures, program integrity staff will conduct the following checks:

- Confirm that clinical quality measures have been submitted to the state and/or CMS (in the case of dually eligible hospitals). For the state this will be completed through the HIN or other quality metrics tool, once available.
- Review aggregate or statistical reports generated by the EHR confirming the measures of meaningful use (Core and selected menu measures) match those indicated via attestation. If a standard report is not available, the Program Integrity Unit will work with the provider to determine an acceptable process for verification.
- Review documentation confirming the exchange or testing of electronic health records. Once operational, the IHIN will be a source of verification.
- Verify certain meaningful use measures in the following ways (stage 1 and stage 2 represented in tables below):



Table 21: Audit strategy for EPs Stage 1 Meaningful Use Core Measures

Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPGMU 02:</p> <p>At least 80% of unique patients must have their data in the certified EHR during the EHR reporting period</p>		<p>Attestation of Numerator / Denominator</p> <p>Denominator- Number of unique patients seen by the EP during the EHR reporting period</p> <p>Numerator- Number of patients in the denominator with data maintained in the CEHRT during the EHR reporting period</p>	<p>No Exclusion</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Must have 80% of unique patient records in the CEHRT</p>	<p>List of Unique patients indicating if they are or are not in CEHRT</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 01:</p> <p>4956(d)(1)(i) Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines</p>	<p>More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator - Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period</p> <p>Numerator - The number of patients in the denominator that have at least one medication order entered using CPOE</p> <p>Or</p> <p>Exclusion</p>	<p>Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Review a random sample of patient records to check for CPOE</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
EPCMU 02: 4956(d)(2)(i) Implement drug-drug and drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period	Yes or No Attestation	No Exclusion	Check EHR reports for when functionality was enabled, this must be on or before the start date of the EHR Reporting period	EHR Report / log from software
EPCMU 03: 4956(d)(3)(i) Maintain an up-to-date problem list of current and active diagnoses	More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data	Attestation of Numerator / Denominator Denominator- Number of unique patients seen by the EP during the EHR reporting period Numerator- Number of patients in the denominator who have at least one entry or an indication that no	No Exclusion	Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)	Random sample of patient records



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		<p>problems are known for the patient recorded as structured data in their problem list</p>		<p>Review a random sample of patient records to check for a high level of indication of NO Problems on their problem lists</p>	
<p>EPCMU 04: 4956(d)(4)(i) Generate and transmit permissible prescriptions electronically (eRx)</p>	<p>More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator - Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period</p> <p>Numerator - Number of</p>	<p>Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period</p>	<p>Review a random sample of patient records to check if ePrescribing was used</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		prescriptions in the denominator generated and transmitted electronically Or Exclusion			
EPCMU 05: 4956(d)(5)(i) Maintain active medication list	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data	Attestation of Numerator / Denominator Denominator- Number of unique patients seen by the EP during the EHR reporting period Numerator - Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any	No Exclusion	Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)	Random sample of patient records EHR Report / log from software



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		medication) recorded as structured data		Random sample of patient records to see if they have at least 1 medication in their medication list or that it is indicated that the patient is not currently taking any medications	
EPCMU 06: 4956(d)(6)(i) Maintain active medication allergy list	More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data	Attestation of Numerator / Denominator Denominator - Number of unique patients seen by the EP during the EHR reporting period Numerator - Number of unique patients in the denominator who have at least one	No Exclusion	Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07,	Random sample of patient records EHR Report / log from software



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list		EPMMU 05, EPMMU 06) Random sample of patient records to see if there is a medication allergy entry or an indication of no known allergies	
EPCMU 07: 4956(d)(7)(i) Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth	More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data	Attestation of Numerator / Denominator Denominator - Number of unique patients seen by the EP during the EHR reporting period Numerator - Number of patients in the denominator who have all the	No Exclusion	Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05,	Random sample of patient records EHR Report / log from software



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		elements of demographics recorded as structured data		EPMMU 06) Random sample of patient records to see if they have demographics recorded as structured data	
EPCMU 08: 4956(d)(8)(i) Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals	Attestation of Numerator / Denominator Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition Numerator: Number of transitions of care in the	Exclusion 1: Based on ALL patient records: An EP who does not transfer a patient to another setting during the EHR reporting period would be excluded from this requirement Exclusion 2: Based on ALL patient records: An EP who does not refer a patient to another	Random sampling of patient records to see if a summary of care document was provided for transitions of care to another provider or setting	Random sample of patient records EHR Report / log from software



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		denominator where medication reconciliation was performed Or Exclusion	provider during the EHR reporting period would be excluded from this requirement		



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 09: 4956(d)(9)(i) Record smoking status for patients 13 years old or older</p>	<p>More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator - Number of unique patients age 13 or older seen by the EP during the EHR reporting period</p> <p>Numerator - Number of patients in the denominator with smoking status recorded as structured data</p> <p>Or</p> <p>Exclusion</p>	<p>An EP who sees no patients 13 years or older would be excluded from this requirement</p> <p>Exclusion from this requirement does not prevent an EP from achieving meaningful use</p>	<p>Validate that the denominator is equal to or less than the denominators for measures EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06</p> <p>Random sample of patient records to see if smoking status is recorded as structured data</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 10: 4956(d)(10)(i) Report ambulatory clinical quality measures to the State</p>	<p>Successfully report to the State ambulatory clinical quality measures selected by the State in the manner specified by the State</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>Validate clinical quality measures submitted</p>	<p>None Beginning 2013, this objective/measure is reflected in the definition of a meaningful EHR user in §4954 and is no longer listed as an objective / measure in this paragraph (d)</p>
<p>EPCMU 11: 4956(d)(11)(i) Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule</p>	<p>Implement one clinical decision support rule</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>Review to see which CDS was listed as being implemented, check to make sure that it is appropriate to their specialty or clinical practice Check EHR reports for when functionality was</p>	<p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
				enabled, this must be on or before the start date of the EHR Reporting period	
<p>EPCMU 12: 4956(d)(12)(i) Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request</p>	<p>More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days</p>	<p>Attestation of Numerator / Denominator Denominator – Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period Numerator - Number of patients in the denominator who receive an electronic copy of their electronic</p>	<p>Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period Exclusion from this requirement does not prevent an EP from achieving meaningful use</p>	<p>Look at EPs policies and procedures on how they provide health information to patients to insure they adhere to the response time</p>	<p>Copy of policies and procedures</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		health information within three business days Or Exclusion			
EPCMU 13: 4956(d)(13)(i) Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days	<p>Attestation of Numerator / Denominator</p> <p>Denominator – Number of unique patients seen by the EP for an office visit during the EHR reporting period</p> <p>Numerator - Number of office visits in the denominator for which a clinical summary is provided within three business days</p>	Any EP who has no office visits during the EHR reporting period	<p>Review EHR documentation to see when clinical summaries were provided for patients during the EHR reporting period</p> <p>Review clinical summary to ensure that the minimum data was provided</p> <p>Verify eligibility for exclusion by checking against the provider type and clinical specialty</p>	<p>EHR Report / log from software</p> <p>Copy of Clinical Summary</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		Or Exclusion			



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
EPCMU 14 ⁸ : 4956(d)(14)(i) Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorize identities electronically	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	Yes or No Attestation	No Exclusion	Review EHR documentation for exchange details – date, time, and entity	Detail of the exchange of clinical information, date, time, entity EHR Report / log from software

⁸ This objective is eliminated from Stage 1 in 2013 and is no longer an objective for Stage 2.



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 15: 4956(d)(15)(i) Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</p>	<p>Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>Review supporting documentation on risk assessment</p>	<p>Detail on risk analysis including approach, results and who performed the assessment</p> <p>Details on security updates performed as a result of the security risk analysis</p>



Table 22: Audit Strategy for EPs Stage 1 Meaningful Use Menu Measures

Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
EPMMU 01: 4956(e)(1)(i) Implement drug formulary checks	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period	Yes or No Attestation Or Exclusion	Based on ALL patient records: An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this requirement	Check EHR reports for when functionality was enabled, this must be on or before the start date of the EHR Reporting period	EHR Report / log from software Documentation on internal/external drug formulary



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPMMU 02: 4956(e)(2)(i) Incorporate clinical lab test results into EHR as structured data</p>	<p>More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of labs ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number</p> <p>Numerator: Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data</p>	<p>Based on ALL patient records: Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period would be excluded from this requirement</p>	<p>Random sampling of patient records to see if lab test results have been incorporated into the EHR as structured data</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement Or Exclusion	Exclusion	Audit Criteria	Supporting Documents



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
EPMMU 3: 4956(e)(3)(i) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach	Generate at least one report listing patients of the EP with a specific condition	Yes or No Attestation	No Exclusion	Check EHR reports for when functionality was enabled, and when list was generated, this must be on or before the start date of the EHR Reporting period	EHR Report / log from software



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPMMU 04: 4956(e)(4)(i) Send reminders to patients per patient preference for preventive/ follow-up care</p>	<p>More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of unique patients 65 years old or older or 5 years old or younger</p> <p>Numerator: Number of patients in the denominator who were sent the appropriate reminder Or Exclusion</p>	<p>Based on ALL patient records: Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology would be excluded from this requirement</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Review a random sample of patient records to see if they have been sent an appropriate reminder during the EHR reporting</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
				period	



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPMMU 05⁹: 4956(e)(5)(i) Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP</p>	<p>At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of unique patients 65 years old or older or 5 years older or younger</p> <p>Numerator: Number of patients in the denominator who were sent the appropriate reminder Or Exclusion</p>	<p>Based on ALL patient records: Any EP who neither orders nor creates any of the information listed at 45 CFR 170304(g) (problem list, medication list, or medication allergy list) during the EHR reporting period would be excluded from this requirement</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06) Random sampling of patient records to see if they have been given timely electronic access to their health information during the EHR reporting</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>

⁹ This objective is eliminated from Stage 1 in 2014 and is no longer an objective for Stage 2.



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
				period	



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPMMU 06: 4956(e)(6)(i) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate</p>	<p>More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of unique patients seen by the EP during the EHR reporting period</p> <p>Numerator: Number of patients in the denominator who are provided patient-specific education resources</p>	<p>No Exclusion</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPMMU 07:</p> <p>4956(e)(7)(i) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation</p>	<p>The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition</p> <p>Numerator: Number of transitions of care in the denominator where medication reconciliation was performed</p> <p>Or</p> <p>Exclusion</p>	<p>Based on ALL patient records: An EP who was not the recipient of any transitions of care during the EHR reporting period would be excluded from this requirement</p>	<p>Random sampling of patient records to see if they have performed medication reconciliation-use</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 08:</p> <p>The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.</p>	<p>The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition</p> <p>Numerator: Number of transitions of care in the denominator where medication reconciliation was performed</p> <p>Or</p> <p>Exclusion</p>	<p>Exclusion 1: Based on ALL patient records: An EP who does not transfer a patient to another setting during the EHR reporting period would be excluded from this requirement</p> <p>Exclusion 2: Based on ALL patient records: An EP who does not refer a patient to another provider during the EHR reporting period would be excluded from this requirement</p>	<p>Random sampling of patient records to see if a summary of care document was provided for transitions of care to another provider or setting</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPMMU 09: 4956(e)(9)(i) Capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited according to applicable law and practice</p>	<p>Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically)</p>	<p>Yes or No Attestation</p>	<p>Exclusion 1: Based on ALL patient records: An EP who administers no immunizations during the EHR reporting period would be excluded from this requirement Exclusion 2: If none of the registries to which the EP submits such information has the capacity to receive the information electronically the EP would be excluded from this requirement</p>	<p>Iowa began testing on May 1, 2013. Any attestation with a reporting period inclusive of that date or after that date should have tested with the registry. Validate the test date and time with the Immunization Registry Review supporting documentation submitted</p>	<p>Approval message receipt from Iowa Department of Public Health submitted from the provider</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPMMU 10: 4956(e)(10)(i) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited according to applicable law and practice</p>	<p>Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically)</p>	<p>Yes or No Attestation</p>	<p>Exclusion 1: Based on ALL patient records: If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period the EP is excluded from this requirement Exclusion 2: If there is no public health agency that has the capacity to receive the information electronically the EP is excluded from this requirement</p>	<p>At this time Iowa is not accepting syndromic surveillance data from EPs At such time Iowa enables this functionality: Validate the test date and time with the Immunization Registry Review supporting documentation submitted</p>	<p>EHR Report / log from software</p>



Table 23: Audit strategy for EPs Stage 2 Meaningful Use Core Measures

Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 01: 495.6(j)(1)(i) Use computerized provider order entry (CPOE) 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</p>	<p>More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.</p>	<p>Measure 1 - Medication: Numerator: The number of orders in the denominator record using CPOE; Denominator: Number of Medication orders created by the EP during the EHR reporting period. Measure 2 - Radiology: Numerator: The number of orders in the denominator recorded using CPOE; Denominator: Number of radiology orders created by the EP during the EHR reporting period. Measure 3 -- Laboratory: Numerator: The number of orders in</p>	<p>Measure 1 -- Any EP who writes fewer than 100 medication orders during the EHR reporting period. Measure 2 -- Any EP who writes fewer than 100 radiology orders during the EHR reporting period. Measure 3 -- Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.</p>	<p>Review a random sample of patient records to check for CPOE</p>	<p>Random sample of patient records EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		the denominatory recorded using CPOE; Denominator: Number of radiology orders created by the EP during the EHR reporting period.			
EPCMU 02: 495.6(j)(2)(i)Generate and transmit permissible prescriptions electronically (eRx)	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are compared to at least one drug formulary and transmitted electronically using certified EHR technology	Attestation of Numerator / Denominator Denominator - Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting	Exclusion 1: Writes fewer than a 100 permissible prescriptions during the EHR reporting period. Exclusion 2: Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting	Review a random sample of patient records to check if ePrescribing was used	Random sample of patient records EHR Report / log from software



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
		period. Numerator - Number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically Or Exclusion	period.		



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 03:</p> <p>495.6(j)(3)(i)) Record the following demographics: - Preferred language - Gender -Race - Ethnicity -Date of birth</p>	<p>More than 80% of all unique patients seen by the EP have demographics recorded as structured data.</p>	<p>Attestation of Numerator / Denominator Denominator - Number of unique patients seen by the EP during the EHR reporting period Numerator - Number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data</p>	<p>No Exclusion</p>	<p>Random sample of patient records to see if they have demographics recorded as structured data</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 04:</p> <p>495.6(j)(4)(i) Record and chart changes in vital signs: (A) Height (B) Weight (C) Blood pressure (age 3 and over) (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI</p>	<p>More than 80% of all unique patients seen by the EP have blood pressure (for age 3 and over only) and height and weight (for all ages) recorded as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of unique patients seen by the EP during the EHR reporting period.</p> <p>Numerator: Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.</p> <p>Or Exclusion</p>	<p>Exclusion 1: Sees no patients 3 years or older is excluded from recording blood pressure.</p> <p>Exclusion 2: Believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.</p> <p>Exclusion 3: Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.</p>	<p>Random sample of patient records to see if they have vital signs recorded</p>	<p>Random sample of patient records</p> <p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
			<p>Exclusion 4: Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.</p>		
<p>EPCMU 05: 495.6(j)(5)(i) Record smoking status for patients 13 years old or older</p>	<p>More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as</p>	<p>Attestation of Numerator / Denominator Denominator- Number of unique patients age 13 or older seen by the EP during the EHR reporting period Numerator - Number of patients in the denominator with</p>	<p>Any EP that neither sees nor admits any patients 13 years old or older.</p>	<p>Random sample of patient records to see if they have smoking status recorded as structured data.</p>	<p>Random sample of patient records EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
	structured data	smoking status recorded as structured data. Or Exclusion			
<p>EPCMU 06: 495.6(j)(6)(i) Use clinical decision to improve performance on high-priority health conditions</p>	<p>Measure 1: Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the entire EHR reporting period. Measure 2: The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p>	<p>Yes or No Attestation Or Exclusion</p>	<p>For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.</p>	<p>Review to see which CDS was listed as being implemented, check to make sure that it is appropriate to their specialty or clinical practice</p> <p>Check EHR reports for when functionality was enabled, this must be on or before the start date of the EHR Reporting period</p>	<p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 07: 495.6(j)(10)(i) Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.</p>	<p>Measure 1: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information. Measure 2: More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.</p>	<p>Attestation of Numerator / Denominator Measure 1: Denominator - Number of unique patients seen by the EP during the EHR reporting period Numerator - The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health information. Measure 2: Denominator - Number of unique patients seen by the EP during the EHR reporting period. Numerator - The number of unique patients (or their</p>	<p>Exclusion 1: Any EP who neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and Provider's name and office contact information, may exclude both measures. Exclusion 2: Any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the</p>	<p>Measure 1: Check EHR reports for timely access to information. Measure 2: Check EHR reports for percentage of patients viewing, downloading, or transmitting their health information.</p>	<p>EHR Report / log from software</p>
<p>2013 SMHP</p>		<p>authorized representatives) in the denominator who have viewed online,</p>	<p>latest information available from the FCC on the first day of the EHR reporting period</p>	<p>Page 151 of 381</p>	



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 08: 495.6(j)(11)(i) Provide clinical summaries for patients for each office visit</p>	<p>Clinical summaries provided to patients within one business day for more than 50% of office visits</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator – Number of office visits conducted by the EP during the EHR reporting period.</p> <p>Numerator - Number of office visits in the denominator where the patient or a patient-authorized representative is provided a clinical summary of their visit within one (1) business day.</p> <p>Or Exclusion</p>	<p>Any EP who has no office visits during the EHR reporting period</p>	<p>Review EHR documentation to see when clinical summaries were provided for patients during the EHR reporting period</p> <p>Review clinical summary to ensure that the minimum data was provided</p> <p>Verify eligibility for exclusion by checking against the provider type and clinical specialty</p>	<p>EHR Report / log from software</p> <p>Copy of Clinical Summary</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 09: 4956(d)(16)(i) Protect electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.</p>	<p>Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164308(a)(1), including addressing the encryption/security of data at rest and implement security updates as necessary and correct identified security deficiencies as part of its risk management process</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>Review supporting documentation on risk assessment</p>	<p>Detail on risk analysis including approach, results and who performed the assessment</p> <p>Details on security updates performed as a result of the security risk analysis</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 10: 495.6(j)(7)(i) Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data</p>	<p>More than 55% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data</p>	<p>Attestation of Numerator/Denominator or Denominator: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number. Numerator: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a numeric format which are incorporated in CEHRT as structured data.</p>	<p>Any EP who orders no lab tests where results are either in a positive/negative affirmation or numerical format during the EHR reporting period.</p>	<p>Random sample of patient records to see if they have clinical labs incorporated into the record as structured data.</p>	<p>Random sample of patient records EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 11: 495.6(j)(8)(i) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</p>	<p>Generate at least one report listing patients of the EP with a specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>Review EHR log to see that report was generated. Review report to see that it is a specific condition.</p>	<p>De-identified condition report. EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 12: 495.6(j)(9)(i) Send reminders to patients per patient preference for preventative/follow up care</p>	<p>More than 20% of all unique patients 65 years or older or 5 years or younger were sent an appropriate reminder during the EHR reporting period.</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator – Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR period.</p> <p>Numerator - Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period.</p> <p>Or Exclusion</p>	<p>Any EP who has no office visits in the 24 months before the EHR reporting period</p>	<p>Review EHR log to see correct percentage of patients were sent reminders.</p>	<p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 13: 495.6(j)(12)(i) Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient if appropriate</p>	<p>Patient-specific education resources identified by the CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator – Number of unique patients with office visits seen by the EP during the EHR reporting period.</p> <p>Numerator - Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology.</p> <p>Or Exclusion</p>	<p>Any EP who has no office visits during the EHR reporting period</p>	<p>Review EHR report log to see that provider generated and provided patient-specific education resources correct percentage of the time. Random sample of patient records to see notated that patient was provided education material.</p>	<p>Random sample of patient records. EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 14:</p> <p>495.6(j)(13)(i) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.</p>	<p>The EP performs medication reconciliation for more than 50% of the transitions of care in which the patient is transitioned into the care of the EP.</p>	<p>Attestation with Numerator/Denominator or Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition. Numerator: The number of transitions of care in the denominator where medication reconciliation was performed. Or Exclusion</p>	<p>Any EP who was not the recipient of any transitions of care during the EHR reporting period.</p>	<p>Review Report log for transitions of care received and number of medication reconciliation conducted. Random sample of patient records to see notated that medication reconciliation was conducted.</p>	<p>Random sample of patient records. EHR Report / log from software</p>
<p>EPCMU 15:</p> <p>495.6(j)(14)(i) The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provider</p>	<p>Measure 1: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions or care</p>	<p>Attestation with Numerator/Denominator or Measure 1: Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.</p>	<p>Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.</p>	<p>Measure 1: Review Report log for transitions of care sent to appropriate location per the correct percentage of patients. Measure 2:</p>	<p>EHR Report / log from software. Audit log of IHIN.</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
summary of care record for each transition of care or referral.	and referrals. Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record either a) electronically transmitted to a recipient using CEHRT or b) where the recipient receives record via exchange facilitated by an organization that is a NwHIN Exchange participant or is validated through an ONC-established governance mechanism to	Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was provided. Measure 2: Denominator: Number of transitions of care or referrals during the EHR reporting period for which the EP was the transferring or referring provider. Numerator: THE number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange		Review report log for transitions of care sent via exchange methods described in objective. Verify transmission with IHIN audit logs. MEasure 3: Verify test concluded with documentation provided. Verify with audit logs of transmission.	



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
	<p>facilitate exchange for 10% of transitions and referrals. Measure 3: The EP who transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS-designated test EHR during</p>	<p>facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization. Measure 3: Yes/No Attestation</p> <p>Or Exclusion.</p>			



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
	the EHR reporting period.				
EPCMU 16: 495.6 (j) (15) (i) Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice	Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.	Yes or No Attestation	Any EP that meets one or more of the following criteria may be excluded from this objective: 1) the EP does not administer any of the immunizations to any of the populations for which data is collected by their	Review EHR log to see that data is reported appropriately. Review IHIN audit logs or other transmission mechanism logs to verify sending. Speak with IDPH staff to verify provider appropriately enrolled to	EHR Report / log from software. Audit log of IHIN. Verification with Immunization organization (part of Iowa Department of Public Health)



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
			jurisdiction's immunization registry or immunization information system during the EHR reporting period; 2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period; 3) the EP operates in a jurisdiction where no immunization registry or	send data.	



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
			immunization information system provides information timely on capability to receive immunization data; or 4) the EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.		



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPCMU 17: 495.6 (j) (17) (i) Use secure electronic messaging to communicate with patients on relevant health information</p>	<p>A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 5% of unique patients seen during the EHR reporting period.</p>	<p>Attestation with Numerator/Denominator or -- Denominator: Number of unique patients seen by the EP during the EHR reporting period. Numerator: The number of patients or patients-authorized representatives in the denominatory who send electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period.</p>	<p>Any EP who: 1) has no office visits during the EHR reporting period. 2) Conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.</p>	<p>Review EHR logs for transmission of secure messages to appropriate number of patients.</p>	<p>EHR Report / log from software</p>



Table 24: Audit strategy for EPs Stage 2 Meaningful Use Menu Measures

Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
<p>EPMMU 01: 495.6(k)(3)(i) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited according to applicable law and practice</p>	<p>Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.</p>	<p>Yes or No Attestation</p>	<p>Any EP that meets one or more of the following criteria may be excluded from this objective: 1) the EP is no in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period; 2) the EP operates in a jurisdiction for which no public</p>	<p>At this time Iowa is not accepting syndromic surveillance data from EPs</p> <p>At such time Iowa enables this functionality:</p> <p>Validate the test date and time with the Immunization Registry</p> <p>Review supporting documentation submitted</p>	<p>EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
			health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period; 3) the EP operates in a jurisdiction for which no public health agency provides information timely on capability to receive syndromic		



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
			surveillance data: or 4) the EP operates in a jurisdiction for which no public health agency that is capable of accepting that specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional EPs.		
EPMMU 02: 495.6 (k)(6)(i) Record electronic notes in patient records.	Enter at least one electronic progress note created, edited and signed by an EP for more	Attestation with Numerator/ Denominator: Denominator: Number of unique patients with	No Exclusion	Random sampling of patient records to see electronic recorded notes	Random sample of patient records EHR Report / log from



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
	<p>than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.</p>	<p>at least one office visit during the EHR reporting period. Numerator: The number of unique patients in the denominator who have at least one electronic progress note from an eligible professional recorded as text searchable data.</p>		<p>for the correct percentage of patients and that it is searchable.</p>	<p>software</p>
<p>EPMMU 03: 495.6 (k)(1)(i) Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT</p>	<p>More than 10% of all scans and tests whose result is an image ordered by the EP for patients seen during the EHR reporting period are incorporated into or accessible</p>	<p>Attestation Numerator/Denominator: Denominator: Number of tests whose result is one or more images ordered by EP during the EHR reporting period. Numerator: The number of results in the</p>	<p>Any EP who orders less than 100 tests whose results an image during the EHR reporting period; or any EP who has no access to electronic imaging results</p>	<p>Random sampling of patient records to see images and explanation incorporated into or accessible through CEHRT.</p>	<p>Random sample of patient records EHR Report / log from software</p>



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
	through Certified EHR Technology	denominator that are accessible through CEHRT.	at the start of the EHR reporting period.		
EPMMU 04: 495.6 (k)(2)(i) Record patient family health history as structured data	More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been reviewed	Attestation Numerator/Denominator: Denominator: Number of unique patients seen by the EP during the EHR reporting period. Numerator: The number of patients in the denominator with a structured data entry for one or more first-degree relatives.	Any EP who has no office visits during the EHR reporting period.	Random sampling of patient records to see if family health history is recorded as structured data.	Random sample of patient records EHR Report / log from software
EPMMU 05: 495.6 (k)(4)(i) Capability to identify and report cancer cases to a state cancer registry, except where	Successful ongoing submission of cancer case information from CEHRT to a	Yes or No Attestation Or Exclusion	Any EP that meets at least 1 of the following criteria may be excluded from this objective: 1)	Check EHR reports for when functionality was enabled, this must be on or before the	EHR Report / log from software



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
prohibited, and in accordance with applicable law and practice	cancer registry for the entire EHR reporting period.		the EP does not diagnose or directly treat cancer; 2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case; 3) the EP operates in a jurisdiction where no PHA provides information timely on capability to receive electronic cancer case information; or 4) the EP	start date of the EHR Reporting period.	



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
			operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period can enroll additional EPs.		
EPMMU 06: 495.6 (k)(5)(i) Capability to identify and report specific cases to a specialized registry (other than a cancer	Successful ongoing submission of specific case information from Certified EHR	Yes or No Attestation Or Exclusion	Any EP that meets at least 1 of the following criteria may be excluded from this objective: 1)	Check EHR reports for when functionality was enabled, this must be on or before the start date of the	EHR Report / log from software



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
registry), except where prohibited, and in accordance with applicable law and practice	Technology to a specialized registry for the entire EHR reporting period.		the EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national speciality society for which the EP is eligible, or the public health agencies in their jurisdiction; 2) the EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a	EHR Reporting period.	



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
			national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting; 3) the EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides		



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
			information timely on capability to receive information into their specialised registries; or 4) the EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable of receiving electronic specific case information in the		



Objective	Measure	Reporting Requirement	Exclusion	Audit Criteria	Supporting Documents
			specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional EPs.		



Iowa is not yet capable of collecting the public health measures for syndromic surveillance data. Once those systems are ready, we will use them as an audit source. Iowa has begun testing its Immunization Registry Information System (IRIS), so providers must still comply with testing with IRIS for stage 1 MU. IRIS is not yet ready for ongoing submission, so stage 2 requirement for on-going submission is not possible. We will educate providers that we still expect that they have tested with IRIS and demonstrate by providing the appropriate documentation. If they are ready for stage 2, we will allow an exclusion or deferral until Iowa Department of Public Health is ready to accept submissions through IRIS.

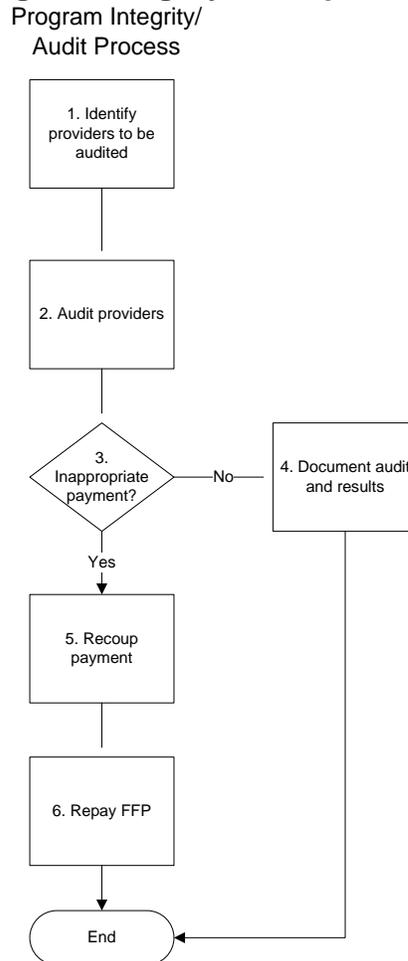
Iowa's attestation includes a question regarding whether the EP sees patients in multiple locations. If the answer is yes, the provider is required to indicate the addresses of those locations, the percentage of patients seen in each location and whether the location is equipped with certified EHR technology during the EHR reporting period. Auditors will verify these answers through documentation supplied by the provider. This documentation may consist of patient appointments to determine overall patient volume, then another calculation to ensure that at least 50 percent of patients are seen at locations equipped with certified EHR technology.

As the IME conducts more post-pay audits for meaningful use, if program integrity identifies certain measures where providers appear to be having issues, the IME will consider moving those checks to pre-payment verification.



Program Integrity/Audit Process Flow

Figure 34: Program Integrity/Audit process workflow





Program Integrity/Audit Process Narrative

Table 25: Program Integrity/Audit Process Narrative

Step	Action
1	Identify providers to be audited. This will include a random, statistically valid sampling of providers who received incentive payments. There may also be systems triggers to identify providers claiming meaningful use, but who may not be using electronic claims, for example. Pre-payment reviewers also flag cases in PIPP when they feel a secondary audit might be appropriate. It is also possible an audit could be triggered by a pattern of complaints from patients or other providers. The IME will work with the provider to identify acceptable forms of proof of eligibility. If additional documentation is requested as a result of an audit, the provider will upload the documentation to PIPP.
2	Audit providers. This step includes addressing each item contained in the audit template, including verification of items on the attestation form.
3	Inappropriate payment? If the audit reveals the incentive payment was appropriate, proceed to Step 4. Otherwise, proceed to Step 5.
4	Document audit and results.
5	Recoup payment. This step includes all tasks required for recoupment, including notice to the provider.
6	Repay FFP.

Section E: Iowa’s HIT Roadmap

Overview

Iowa’s HIT Roadmap describes the overall journey to achieving the To Be vision and EHR Incentive payments – with the appropriate milestones for achievement.

Description of Journey

Iowa’s made measurable progress on its HIT journey in SFY2012. Major milestones include Implementing policy levers for the meaningful use of electronic health records, meeting payment goals, onboarding dentists for prior authorization through the IHIN using Direct, and onboarding health home providers to submit clinical quality measures through the IHIN.. The IME continues its focus on electronic exchange of patient data among Iowa’s Health Care Providers, thereby improving the quality and efficiency of care received by all Iowans.

The five major components of Iowa’s HIT Roadmap:

- Support the Adoption of Electronic Health Records
- Support Health Information Exchange
- Expand the Availability of Health Records
- Support Medical Homes and Meaningful Use of Exchanged Information
- Capture Quality Measures Data



Support the Adoption of Electronic Health Records

Advances these “to-be” goals:

- Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange (HIE)
- Improve Administrative Efficiencies and Contain Costs
- Improve Quality Outcomes for Members
- Improve Member Wellness

The foundation of a more efficient healthcare delivery system starts with Iowa’s providers and their adoption of Electronic Health Records.





Administer Medicaid EHR Incentive Payment

The IME implemented the appropriate EHR incentive payment systems and procured new software to capture the attestations online. This software became available on April 1, 2012, the earliest date EPs could apply for year two incentive payments. We will continue administer the incentive program by updating our attestation portal as appropriate.

We will continue offering regular webinar series in hot topics for attestation including how to calculate and document patient volume, how to complete an immunization test and attest to that, and upcoming stage 2 changes. We want to ensure providers are able to successfully understand the requirements for attestation and complete the application the first time around.

To ensure we have more providers return to attest to meaningful use, we will work on identifying Medicaid Adopter Champions. These individuals would be asked to volunteer time to discuss the benefits and process to adopting and meaningfully using an EHR to reluctant providers. We would highlight their successes and mitigation strategies on our website and ask them to present in webinars facilitated by IME.

Fill EHR Technical Assistance Gaps

IME will investigate and design the opportunity to provide continuing education classes for credit through local community colleges and universities. The classes would fill the need to provide technical assistance to providers by giving them broad exposure to how EHRs and HIE work. We would hope to work with EHR vendors to provide targeted education opportunities.

Each year, IME conducts annual training for providers which covers a broad range of topics including health IT programs at IME. In past years, the HIT team joined the Provider Outreach team on the 3-month summer tour of Iowa to conduct education sessions to a variety of providers who may or may not be interested in HIT. In FY14, we will look into offering a targeted HIT class during annual provider training. We would target those who actually do MU reporting or want to learn more about EHR, HIE, and other eHealth happenings can sign up for just this class.

IME will investigate through our environmental scan the desire and potential effectiveness of creating informal user groups for providers and healthcare staff to meet with other users of the same software in the state. We will look in to using web-based technology, in-person events, and any other avenues to help providers fill the technical gap.



Support Health Information Exchange

Advances these “to-be” goals:

- Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange (HIE)
- Improve Administrative Efficiencies and Contain Costs
- Improve Quality Outcomes for Members
- Improve Member Wellness

As Iowa’s providers adopt EHR Technology, the IME must support the creation of Iowa’s Health Information Network.



This project requires participation in the planning of a statewide health information network. Iowa eHealth, led by the Iowa Department of Public Health and under the direction of the eHealth Executive Committee and Advisory Council. Iowa Medicaid Enterprise (IME) participates in the Executive Committee, Advisory Council and workgroups to ensure the unique needs of the Medicaid population and Medicaid program are considered.

IME will track the progression of the IHIN usage and report back to CMS on an annual basis. This includes HIE related benchmarks and performance measures. IME is also planning for further expansion of personal health records and alert notifications within the IHIN.

The most recent Iowa Health Information Technology Implementation Advance Planning Document Update (HIT IAPD-U) was approved by CMS on December 4, 2012. The funding expenditures for the Iowa HIN have been delayed due to a delayed project start and a directive for accelerated spending of ONC funds. A contract for a total of \$7.450,000 has been signed with the Iowa Department of Human Services to support the build of the IHIN between 7/1/2013 and 9/30/2015.

IME intends to use policy levers to encourage providers’ participation. Within the Health Home participation agreement and State Program Amendments (SPA) to be an eligible Health Home Provider they must be meaningful users and be able to submit quality measures through the Iowa Health Information Network through an EHR. We will continue this approach with Accountable Care Organizations as we begin those discussions in FY14. We will require ACOs to use the IHIN capabilities



of the currently available Direct secure messaging and the Patient Look-up function, once it becomes available.

Continued Collaboration on EHR/HIE Adoption

The IME is a member of the Iowa e-Health Advisory Council, and actively participates in the security, governance, finance, provider adoption, communications and outreach, assessment, and privacy and security work groups.

The IME, IDPH and HIT REC meet monthly to ensure that the efforts of the three organizations are aligned and collaborative. The IME has committed dedicated staff to ensure that these relationships continue.

Financial Support of Iowa's HIE

The IME will support the creation and ongoing operational costs of a state-wide HIE to the extent that it supports the Medicaid population.

I

ME anticipates the Iowa HIN will need four years to build the core functionality and connect enough providers to make the project financially sustainable. The core functionality includes:

- Provider Directory
- Master patient index
- Record Locator Service
- Authentication, Access and Authorization Management
- Patient Consent tracking
- Auditing and logging
- Data Security
- Direct connections to EHR
- Provider portal for viewing access for providers without and EHR
- Secure provider to provider messaging
- Connection to the Healthway

In December 2012, Direct Secure Messaging went into production. This is the step-forward for providers to securely share health information with other providers.

Support HIE Enabled Communications and Services

IME has begun utilization of Direct messaging by collect CCD documents from Health Home electronic health records systems to perform quality measures. In FFY 13 IME will expand the use of Direct secure messaging to policy, medical services, and provider services business units.



Pharmacy claims. IME explored the possibility of making data from pharmacy paid claims available to providers electronically. Currently the information is available through a secure web portal (Iowa Medical Electronic Records systems). Provider discussions informed IME that the data must be available via their EHR systems, and the majority of the population must have a complete data set to make the use of the data work in their workflow processes. IME reviewed the costs associated with providing the information via a third party vendor, such as Sure Scripts. IME also met with Wellmark, the largest private payer administrator in Iowa. Medicare has not indicated that it will make claim information available. The project was unable to receive enough traction at this time.

Electronic Prior Authorization. IME on-boarded several dentists to as pilot providers for dental prior authorization. As of July, one dentist sent in his prior authorization request via Direct Secure Messaging. We have conducted outreach and training webinars to assist dentists in using Direct for prior authorization and hope to see more start using that avenue instead of faxing or mailing their requests.

Expand the Availability of Health Records

Advances these “to-be” goals:

- Improve Administrative Efficiencies and Contain Costs
- Improve Quality Outcomes for Members
- Improve Member Wellness

Provide Web Portal Access to Health Information

The IME will increase access to appropriate clinical information concerning its members through the development and deployment of a web portal. The IME believes that higher quality health care is achieved by sharing information between all care providers. Improved care contains costs and improves member wellness.



The portal would serve as a tool for sharing health information collected from multiple sources.

The web portal functionality would be used by:



- Medicaid Staff – for use in Prior Authorization, Program Integrity, EHR Incentive Payment Processing, and related functions. The portal would connect to the HIE to provide access to medical records from providers, eliminating the need for information to be sent via physical mail or faxing.
- Long Term Care & Home Health organizations – for use in utilizing Continuity of Care and Discharge Instructions from hospitals and providers.
- Medicaid members - as an electronic personal health record. This portal would provide the opportunity to distribute wellness education, and alerts/reminders for preventative care and disease management.
- Care Teams – The portal could be expanded to additional people in the care management team of the member, such as school nurses, social workers, care coordinators, foster parents, and others as determined necessary.

Authorization to access information would be role based and limited to the appropriate information for the appropriate role. Significant work will be required to establish the correct policies, rules, and, as needed, laws to insure the secured, authorized, and correct access to this information.

Through the Iowa Health Information Network (IHIN), clinical information will be made available via a web portal to appropriate care team members who do not have access. The web portal will be used for secure messaging between providers. This messaging will include the receipt of continuity of care documents at the time of transition of care. Issues of privacy and security must be identified and addressed as part of this project.

This project focuses on obtaining IME staff member's access to the IHIN to assist in pre and post medical reviews for payment processing and related functions and disease management. Additionally this project will research and identify the foster care systems needs to provide access to the appointed team member(s) to ensure continuity of medical care for those children placed in the custody of the Department of Human Services.

In FY14 the IME plans to continue to plan for the utilization of the Health Information Network web portal and work with the e-Health workgroups to establish the appropriate participation agreements and authorization roles.

Member Portal Access

The goal of the Member Access to Personal Health Records via a Patient Portal project is to foster trust, appeal to strategic interest of the medical community as a



whole (private and public), and meet stakeholders expectations of benefits from quality measurements, enhance care coordination, protected patient security & privacy, and track population health interventions.

Plan:

- Identify what works and what doesn't work in relation to HIEs/ Patient Portal Identify successful models based on knowledge of the needs, expectations, and motivation of stakeholders (physicians, their practices, hospitals, patients) regarding HIEs.
- Overcome technical challenges, several studies indicate minority populations and people without a college education are less inclined to participate in Web-based self-management programs.
- Identify payment methodology for Medicaid Providers using (e-health consultancy)
- Identify the barriers to patient adoption, and usage of Patient Portal
- Identify the technical requirements for the functionality of the Patient Portal

Implement:

- Educate Medicaid patients about the positives of Patient Portals
- Educate Medicaid patients about secure messaging
- Advertise to Medicaid patients about the availability and accessibility of the Patient Portal
- Monitor the numbers of patients accessing the Patient Portal
- Identify additional functionalities that can be enhanced for the Patient Portal

The IME HIT team will participate in requirements verification sessions with the MIDAS MMIS project in FY14 to set the ground work for personal health records in the planned member portal.

Support Medical Home/Health Home and Meaningful Use of Exchanged Information

Advances these "to-be" goals:

- Increase Provider adoption of Electronic Health Records (EHR) and Health Information Exchange (HIE)
- Improve Administrative Efficiencies and Contain Costs
- Improve Quality Outcomes for Members
- Improve Member Wellness



Iowa's Medical Home/Health Home Initiative

The IME began a medical home initiative on October 1, 2010. The provider set includes the IowaCare providers and serves as a pilot to establish a model that can be expanded to other providers throughout the state.



Components of the IowaCare Medical Home/Health Home include the following:

1. Have National Committee for Quality Assurance (NCQA) Level 1 certification, or other national equivalent measurement within 18 months.
2. Provide provider-directed care coordination of services.
3. Provide members with access to health care and information.
4. Provide wellness and disease prevention services.
5. Create and maintain chronic disease information in a searchable disease registry.
6. Demonstrate evidence of implementation of an electronic health record system.
7. Participate in and report on quality improvement measures.

Iowa's State Plan Amendment option under Section 2703 of the Affordable Care Act to implement a statewide health home program for Medicaid members with qualifying chronic conditions was approved in early 2012. The health home program components are similar to the IowaCare Medical Home stated above which follows the seven principles of a patient-centered medical home. The program has a strong emphasis on comprehensive care coordination and use of the statewide HIE. The program launched June 1, 2012. As of July 2013, there are over 560 practitioners in 25 Health Homes with over 3,600 members assigned.

The Second State Plan Amendment for SPMI members was approved by CMS. Integrated Health Homes for members with SPMI started in July 2013 for five Iowa counties.



Improve Clinical Information Access at Transitions of Care

Hospital and Nursing Home re-admission rates contribute to a large portion of healthcare costs. A recent study showed that Medicare Members Inpatient charges accounted for 31% of all Medicare costs and that 18% of Medicare patients who were in a hospital are re-admitted to the hospital within 30 days.

http://www.academyhealth.org/files/publications/Reducing_Hospital_Readmissions.pdf

The IME will help decrease readmission rates between provider settings by supporting the use of the HIE for the exchange of continuity of care and discharge information among care teams (members, guardians, long term care providers, home health providers, etc) as determined appropriate. Iowa anticipates significant legal research and potential legislation changes will be needed to ensure patient privacy and medical record security.

As of August 2013, the IHIN functionality has been built and tested. Now individual organizations are making their connections so that we can share exchanging health information in Iowa. Many organizations applied and have been approved. Once that list is finalized, we can provide an update.

Capture Quality Measures Data

Advances these "to-be" goals:

- Improve Administrative Efficiencies and Contain Costs
- Improve Quality Outcomes for Members
- Improve Member Wellness

A requirement of both the EHR incentive program and the health home program is that providers will report on clinical quality measures. The provider must submit the results of the measures to the Iowa Medicaid Enterprise. The tool for submission has been procured as an optional component of the Iowa Health Information Network vendor contract. IME will obtain the results either through the IHIN, beginning in August, 2012. IME will use the data to validate quality reporting for the health home program, and for other IME projects, such as disease management.





It is the IME's hope that while the rules do not require providers to report all clinical quality measures, providers will choose to report beyond the minimal number of measures as their EHR allows.

Receive Quality Measures Data

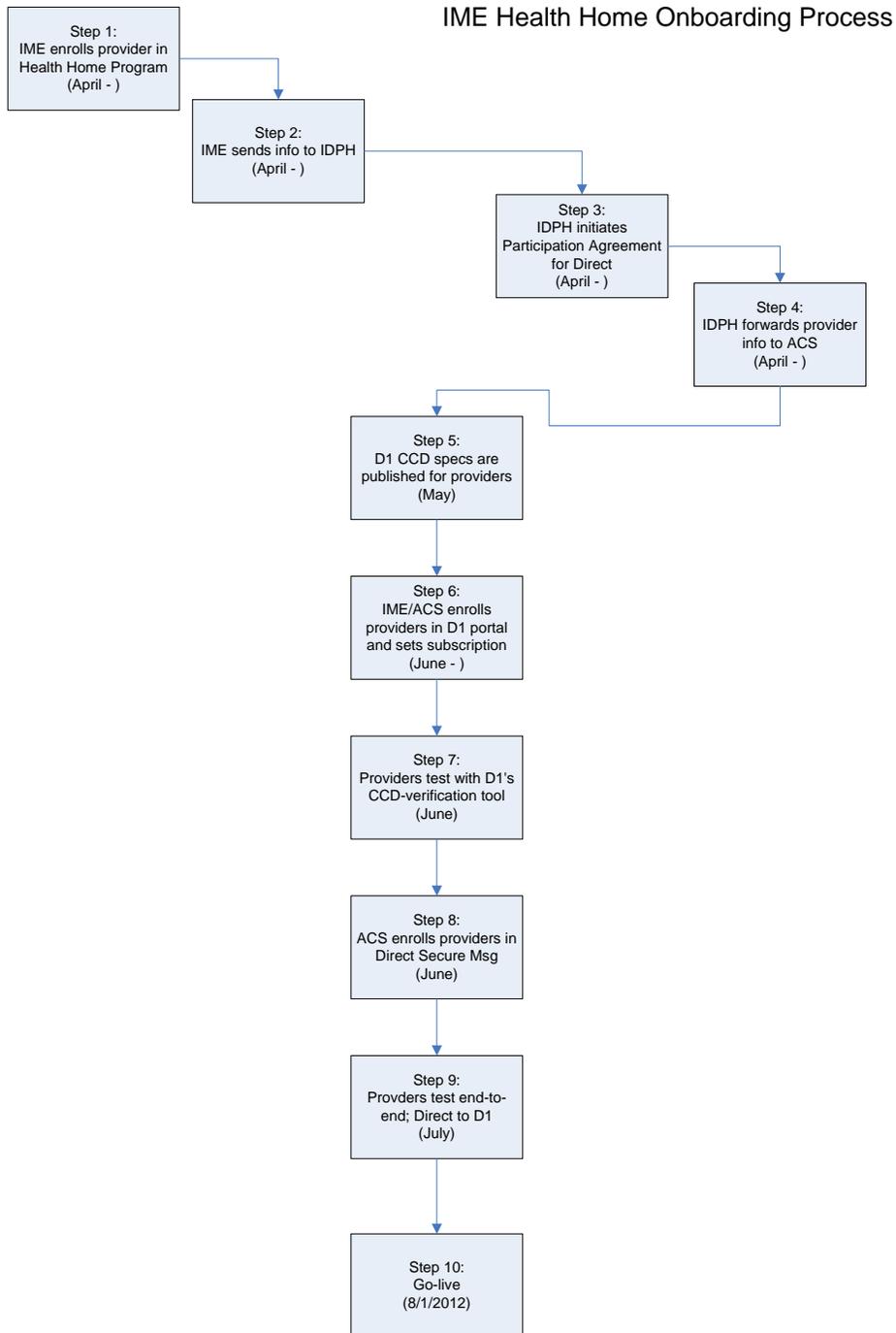
The IME has identified a solution to capture quality measures for meaningful use through the Iowa Health Information Exchange. Providers who are connected to the HIE will be able to publish their metrics directly to the Iowa Medicaid solution. In addition to providing data for verification of meaningful use, the tool will allow the IME to support pay for performance for Health Home programs and potentially confirm quality performance for future Accountable Care Organizations (ACOs).

Health Homes will receive an annual payment for quality measure outcomes. IME plans to collect the clinical information to support the performance payments through the use of the quality metrics data tool contained within the IHIN. A key component of medical home is the MU of electronic health records, and the ability to share clinical information between the medical home and specialty care.

The IHIN plans capture quality metrics from clinical and claims information from the provider after an encounter and store the discrete data items in a database. This will be used for Meaningful Use and Health Home quality measure verification. Iowa Medicaid plans to contract with the Iowa Department of Public Health for the utilization of the tool. The analytics tool has the capability of supporting both the providers, and the department in showing progress on all metrics. Drill down capability will be available to providers (with the appropriate security) to allow the data to be used to meet the member's needs.



Figure 35: IME Health Home Onboarding Process





Deliver Education and Interventions

Based on trends identified within the capture of quality metrics, The IME will look for opportunities to improve the care members receive through provider education. This education would include information on Quality Measures, the associated standards of care members should receive, and EHR usage best practices.

The IME anticipates FY 2013 will be a year of learning about the availability of metrics and how to interpret the data. Education and Intervention are longer term goals for SFY 2014 and SFY 2015.

Strategies

The information below, is the high level (a.k.a. Vision Level) planning and estimating which has been performed to date. The IME expects that the individual IAPD line items will include the required implementation level planning and estimates for the deliverables described above.



SFY13	Action	Status
Support Adoption of EHR	Continue to administer the EHR Incentive Program.	Completed.
	Prepare attestation and program administration for meaningful use stage 2.	In progress
	Evaluate and assess the success and progress of the EHR incentive program and Medicaid provider's use of electronic health records.	Completed
	Provide technical assistance to providers to transition to the meaningful use of electronic health records.	Procurement information put together; decided to put on hold.
Support Health Information Exchange	Participate in council and workgroup meetings of the e-Health project.	On going
	Provide technical and financial assistance to support connectivity between public health reporting systems and the HIE.	On going. IME provides financial and technical support to onboard providers to support information exchange and reporting of clinical quality measures.
Expand the Availability of Health Records	Continue to expand the usage of the Web Portal to members of the care team.	On Hold.
	DIRECT secure messaging is available and will be marketed in FFY13 by IME.	Completed.
	Plan for integration of personal health records and quality alert messages to Medicaid Members.	On hold.
	Provide access to clinical data through the HIE for the purposes of disability determination services.	On hold.
Support Medical Home & Meaningful Use	Review the rules for Medical and Health home and update as appropriate to increase the meaningful use of EHR.	Completed.



Capture Quality Data	Analyze quality data looking for performance and education opportunities.	Completed.
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SFY14	Action
Support Adoption of EHR	Continue to administer the EHR Incentive Program.
	Update attestation and program administration for meaningful use stage 2.
	Evaluate and assess the success and progress of the EHR incentive program and Medicaid provider's use of electronic health records.
	Provide technical assistance to providers to transition to the meaningful use of electronic health records.
Support Health Information Exchange	Participate in council and workgroup meetings of the e-Health project.
	Provide technical and financial assistance to support connectivity between public health reporting systems and the HIE.
Expand the Availability of Health Records	Continue to expand the usage of the Web Portal to members of the care team.
	Explore opportunities for health IT with the implementation of ACA mandates
	Plan for integration of personal health records and quality alert messages to Medicaid Members.
Support Medical Home & Meaningful Use	Review the rules for Medical and Health home and update as appropriate to increase the meaningful use of EHR.
Capture Quality Data	Analyze quality data looking for performance and education opportunities.



SFY15	Action
Support Adoption of EHR	Continue to administer the EHR Incentive Program.
	Prepare attestation and program administration for meaningful use stage 3.
	Evaluate and assess the success and progress of the EHR incentive program and Medicaid provider's use of electronic health records.
	Provide technical assistance to providers to transition to the meaningful use of electronic health records.
Support Health Information Exchange	Participate in council and workgroup meetings of the e-Health project.
	Final year of financial assistance for the "build" of the core Health Information Exchange Services.
Expand the Availability of Health Records	Promote the personal health records portal to members, and where appropriate parents, to encourage personal responsibility toward health care.
	Explore opportunities to align with MIDAS capabilities
	Expand quality alert messages to Medicaid Members through the personal health records portal.
Support Medical Home & Meaningful Use	Review the rules for Medical and Health home and update as appropriate to increase the meaningful use of EHR.
Capture Quality Data	Analyze quality data looking for performance and education opportunities.



Progress Tracking & Audit and Oversight

The IME's HIT Coordinator is accountable for tracking overall progress of the IME's SMHP and the submission of the Implementation Advance Planning Document (IAPD). Within the SHMP/HIT IAPD, the IME describes the project tracking methodology required for individual project completion.

The IME will also revise this SMHP on an annual basis to describe progress and continue to align the IME's vision with industry trends, adoption cycles, and applicable legislation.



Appendices

Appendix A – Physician Practice Survey

Current Health Information Technology (HIT) Capabilities in Iowa ¹⁰	
Provider Type	Electronic Health Record (EHR) Use:
Provider Practices/Clinics (362 Respondents)	46% of Iowa’s Provider Practices and Clinics use an Electronic Health Records (EHR) system.
Hospitals (93 Respondents)	10% of Iowa’s Hospitals use an Electronic Health Record (EHR) for all patient records.
Home Health Care Agencies (72 Respondents)	35% of Iowa’s Home Health Care Agencies use an Electronic Health Record (EHR) – urban and larger agencies are more likely to have access to this resource.
Long Term Care Facilities (90 Respondents)	25% of Iowa’s Long Term Care Facilities use an Electronic Health Record (EHR) – larger systems are more likely to have access to this resource.
Pharmacies (282 Respondents)	27% of Iowa’s Pharmacies have the ability to electronically transfer patient clinical information to patient providers.
Laboratory Facilities (127 Respondents)	35% of Iowa’s Laboratory Facilities are able to share electronic data with other providers (physicians/hospitals).
Radiology Facilities (34 Respondents)	44% of Iowa’s Radiology Facilities provide electronic reports or images to other providers.

Value of Electronic Health Records (EHRs)	
Provider Type	Benefits of EHR use include:
Physicians	<ul style="list-style-type: none"> ▪ Timely availability of clinical data ▪ Increased workflow efficiencies
Hospitals	<ul style="list-style-type: none"> ▪ Timely availability of clinical data ▪ Increased workflow efficiencies
Home Health Care Agencies	<ul style="list-style-type: none"> ▪ Timely availability of clinical data ▪ Less time to document patient care-related activities
Long Term Care Facilities	<ul style="list-style-type: none"> ▪ Better communication with providers ▪ Improved patient safety (e.g., drug-related interactions or allergies)
Pharmacies	<ul style="list-style-type: none"> ▪ Timely availability of clinical data

¹⁰ 2010 Environmental Scan



	<ul style="list-style-type: none"> ▪ Better communication with providers
Laboratory Facilities	<ul style="list-style-type: none"> ▪ Timely availability of clinical data ▪ Less staff time to process test orders
Radiology Facilities	<ul style="list-style-type: none"> ▪ Timely availability of clinical data ▪ Less staff time to process test orders

Value of Participation in a Health Information Exchange (HIE)	
Provider Type	Valuable data for sharing through an HIE:
<p>Physicians Percentage interested in participating in an HIE not available.</p>	<ul style="list-style-type: none"> ▪ Summary of patient care records (e.g., CCD) ▪ Medication lists
<p>Hospitals Percentage interested in participating in an HIE not available.</p>	<ul style="list-style-type: none"> ▪ Summary of patient care records (e.g., CCD) ▪ Managing patient care from one healthcare setting to another
<p>Home Health Care Agencies 75% surveyed are interested in participating in an HIE</p>	<ul style="list-style-type: none"> ▪ Summary of patient care records (e.g., CCD) ▪ Discharge summary
<p>Long Term Care Facilities 55% surveyed are interested in participating in an HIE</p>	<ul style="list-style-type: none"> ▪ Summary of patient care records (e.g., CCD) ▪ Managing patient care from one healthcare setting to another
<p>Pharmacies 55% surveyed are interested in participating in an HIE</p>	<ul style="list-style-type: none"> ▪ Ability to request consultation for clinical advice from physicians or other providers ▪ Immunization status
<p>Laboratory Facilities 63% surveyed are interested in participating in an HIE</p>	<ul style="list-style-type: none"> ▪ Lab results ▪ Reporting communicable diseases to the State Hygienic Laboratory and to the IDPH



Radiology Facilities

88% surveyed are interested in participating in an HIE

- Radiology results, images and image orders
- Patient allergies or contraindications



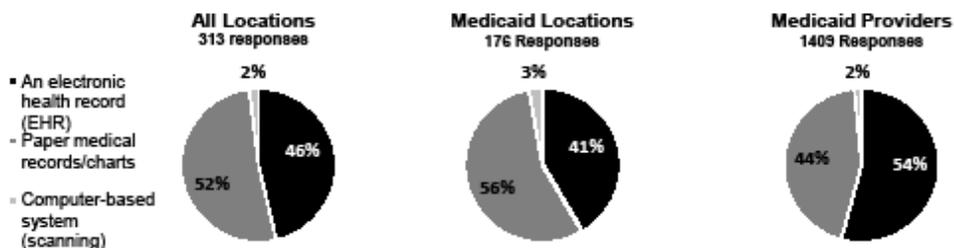
Potential Barriers to Participation in a Health Information Exchange (HIE)							
Perceived Barriers	Physicians	Hospitals	Home Health Care	Long Term Care	Pharmacies	Labs	Radiology
Patient Privacy/Liability <ul style="list-style-type: none"> The Iowa e-Health proposed legislation includes protections for good faith use of the HIE. 	X	X	X	X	X	X	X
Financial Issues/Cost <ul style="list-style-type: none"> Center for Medicare & Medicaid Services (CMS) provides Meaningful Use Incentives to providers to help cover costs of upgrading, adopting or implementing electronic health records. 	X	X	X	X	X	X	X
Staffing and/or Workforce Issues <ul style="list-style-type: none"> The Midwest Community College HIT Consortium provides training to support electronic health records implementation through campus-based training and distance learning. DMACC and Kirkwood Community College are both part of this consortium. 	X	X	X	X			



Analysis of Medicaid Providers Further Understanding the Health IT Landscape in Iowa

The following information represents a summary of data from an ambulatory practices/clinic assessment conducted by Iowa e-Health between December 2009 and January 2010.

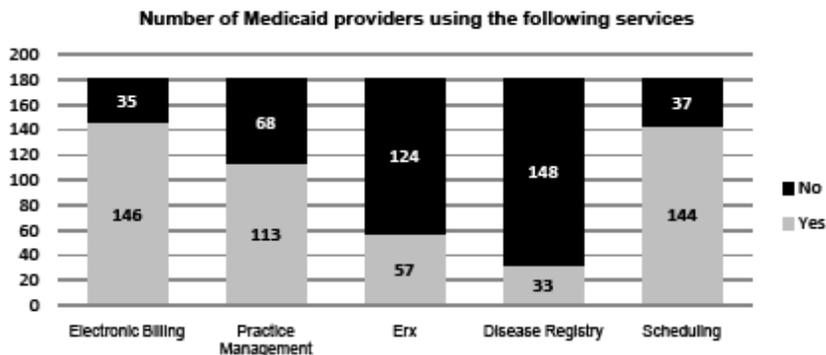
1. EHR status among ambulatory practices and clinics in Iowa:



Response to the question: Do you currently use an EHR?



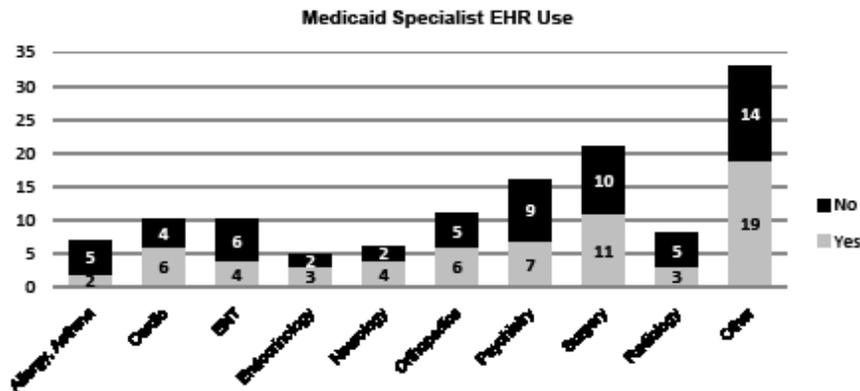
2. Types of EHR services used among Medicaid providers:







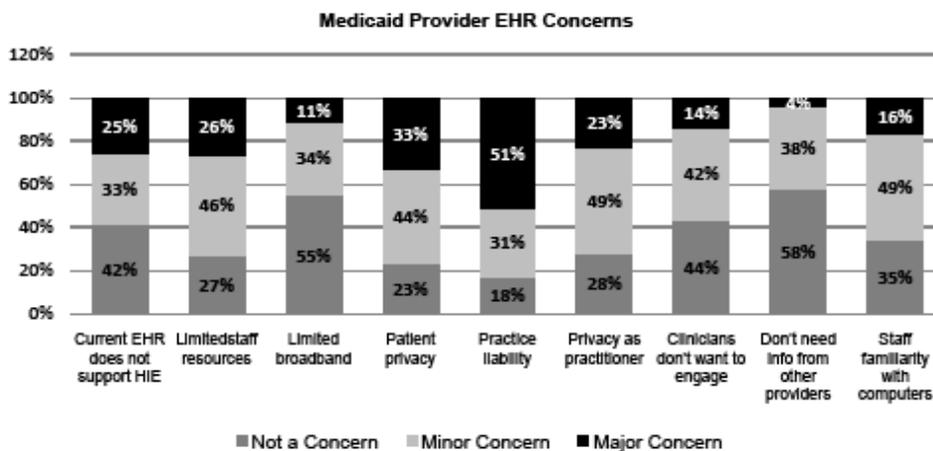
3. Medicaid providers that use an EHR system by their specialty:



4. Common certified or previously certified EHR vendors in use by Medicare providers.

- Allscripts
- GE Healthcare
- McKesson
- Cerner
- Healthland
- NextGen
- CPSI
- LSS Data Systems
- Sage

5. Concerns about adopting EHRs among Medicaid providers.

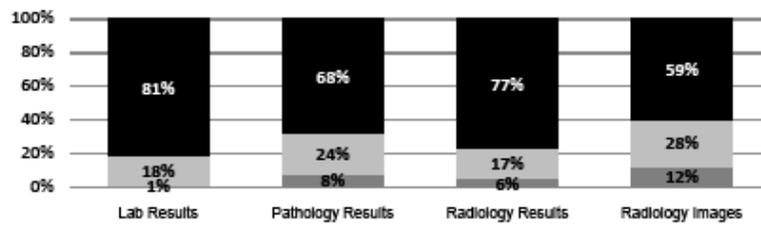




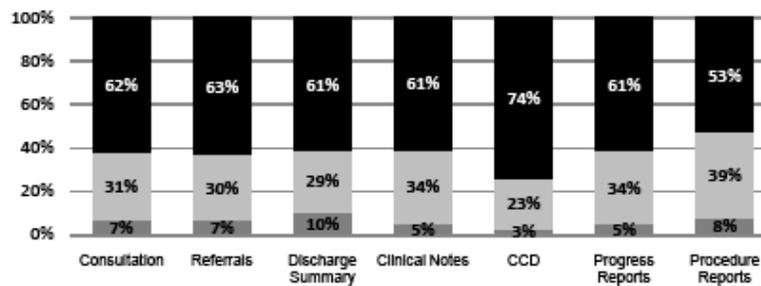
6. Value of various types of clinical data exchange through a health information exchange.

■ Not Valuable ■ Somewhat Valuable ■ Very Valuable

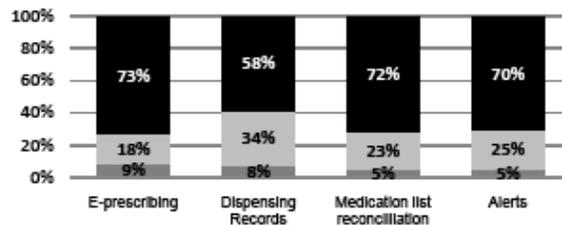
Results Delivery



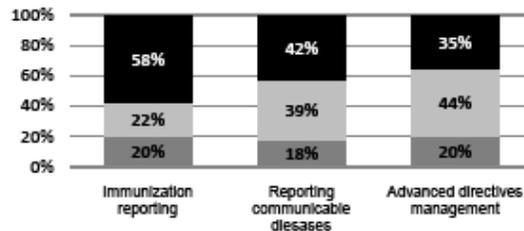
Clinical Documentation



Medication Management



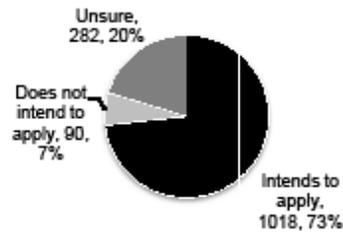
Public Health





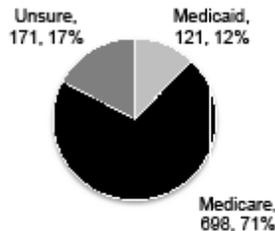
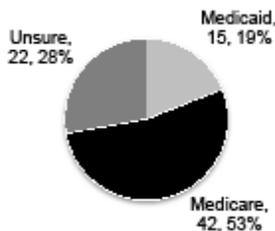
7a. Ambulatory practices/clinics intending to apply for meaningful use provider incentives available through Medicare and Medicaid:
(Intention, number of responses, percentage)

7b. Ambulatory practitioners intending to apply for meaningful use provider incentives available through Medicare and Medicaid:
(Intention, number of responses, percentage)



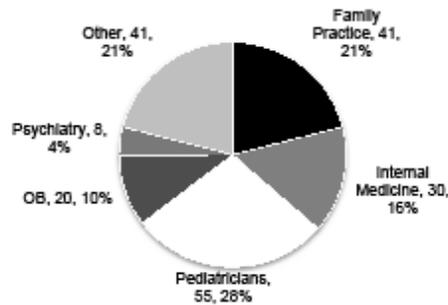
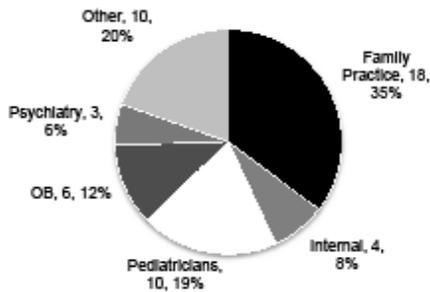
8a. Of those practices interested in meaningful use incentives, the source from which they intend to seek funding:
(Intention, number of responses, percentage)

8b. Of those practitioners interested in meaningful use incentives, the source from which they intend to seek funding:
(Intention, number of responses, percentage)



9a. Interest in Medicaid Funding by Practice Type
(Practice type, number of locations expressing interest, percent in relation to all respondents)

9b. Interest in Medicaid Funding by Practice Type
(Practice type, number of practitioners expressing interest, percent in relation to all respondents)



For additional assessment results (not specific to Medicaid providers), see Appendix I of the Strategic and Operational Plan (<http://www.idph.state.ia.us/ehealth/reports.asp>).

Appendix B – Summary Results from the 2009 MITA Self Assessment

Table 26 Alignment of the IME Priorities with MITA Goals

IME's Priorities	MITA Goals					
	(3) Promote an enterprise view	(2) Promote flexibility, adaptability, and changeability	(5) Provide performance metrics	(4) Provide timely, accurate, usable and accessible data	(1) Develop integrated systems	(6) Coordination with other partners
<i>Number of Priorities Matching a Goal</i>	8	7	7	6	4	4
1. Improved Web-based options for stakeholders						
2. Automated verification/credentialing						
3. Monitor contractor performance						
4. Strategic Management						
5. Training in program analysis						
6. Medicaid Value Management						
7. Improve data analysis – access, tools, resources						
8. Improve member services						
9. Modular approach to replacing system functionality						
10. Expansion of document management and workflow management capabilities						
11. Improving waiver programs						
12. Rules-based engine						
13. Standardization of data and reports						
14. Credentialed as a MCO						
15. Expand Care Management						
16. Self-audit of Program Integrity						
17. Program Integrity in every unit						
18. Shifting the focus of Policy unit						
19. Ongoing evaluation of Prior Authorization						

Table 27 As-Is Maturity Level Assessment at the Business Area Level

Business Area Name	Maturity Level Summary
Member Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 12.5% level 1 – 7 BPs – 87.5%
Provider Management	This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 14.29% level 1 – 6 BPs – 85.71%
Contractor Management	This area as a whole is currently at level 1. The business processes within this area are at the following levels: level 2 – 1 BPs – 1.11% level 1 – 8 BPs – 88.89%



Business Area Name	Maturity Level Summary
<p>Operations Management</p>	<p>This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 12 BPs –46.15% level 1 – 13 BPs –53.85%</p> <p>Note: There are 26 Operations Management business processes, but one of these is not currently a part of the Iowa MITA Enterprise.</p>
<p>Program Management</p>	<p>This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 4 BPs – 20% level 1 – 16 BPs – 80%</p>
<p>Business Relationship Management</p>	<p>This area has 4 BPs, all at level one level 1 – 4 BPs – 100%</p>
<p>Program Integrity Management</p>	<p>This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 50% level 1 – 1 BPs – 50%</p>
<p>Care Management</p>	<p>This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 2 BPs – 66.67% level 1 – 1 BPs – 33.33%</p> <p>Note: There are four Care Management business processes but one of them is not currently a part of the Iowa MITA Enterprise.</p>



Table 28 As-Is Maturity Assessment at the Technical Area Level

Technical Area	Maturity Level Summary
Business Enabling Services	<p>This area as a whole is currently at level one.</p> <p>The technical functions within this area are at the following levels:</p> <p>level 2 – 5 – 45.45%</p> <p>level 1 – 6 – 54.55%</p>
Access Channels	<p>This area as a whole is currently at level one.</p> <p>The technical functions within this area are at the following levels:</p> <p>level 1 – 2 – 100%</p>
Interoperability	<p>This area as a whole is currently at level one.</p> <p>The technical functions within this area are at the following levels:</p> <p>level 2 – 1 – 20%</p> <p>level 1 – 4 – 80%</p>
Data Management and Sharing	<p>This area as a whole is currently at level one.</p> <p>The technical functions within this area are at the following levels:</p> <p>level 1 – 2 – 100%</p>
Performance Measurement	<p>This area as a whole is currently at level one.</p> <p>The technical functions within this area are at the following levels:</p> <p>level 2 – 1 – 50%</p> <p>level 1 – 1 – 50%</p>
Security and Privacy	<p>This area is currently at level one</p> <p>IME does not currently perform one technical process , Intrusion Detection</p> <p>The technical functions within this area are at the following levels:</p> <p>level 2 – 3 – 60%</p> <p>level 1 – 2 – 40%</p>
Flexibility – Adaptability and Extensibility	<p>This area is currently at level one.</p> <p>The technical functions within this area are at the following levels:</p> <p>level 2 – 1 – 25%</p> <p>level 1 – 3 – 75%</p>



Table 29 As-Is Maturity Level Assessment at the Business Area Level

Business Area Name	Maturity Level Summary
Member Management	<p>This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 12.5% level 1 – 7 BPs – 87.5%</p>
Provider Management	<p>This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 14.29% level 1 – 6 BPs – 85.71%</p>
Contractor Management	<p>This area as a whole is currently at level 1. The business processes within this area are at the following levels: level 2 – 1 BPs – 1.11% level 1 – 8 BPs – 88.89%</p>
Operations Management	<p>This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 12 BPs –46.15% level 1 – 13 BPs –53.85%</p> <p>Note: There are 26 Operations Management business processes, but one of these is not currently a part of the Iowa MITA Enterprise.</p>
Program Management	<p>This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 4 BPs – 20% level 1 – 16 BPs – 80%</p>
Business Relationship Management	<p>This area has 4 BPs, all at level one level 1 – 4 BPs – 100%</p>
Program Integrity Management	<p>This area as a whole is currently at level 1 The business processes within this area are at the following levels: level 2 – 1 BPs – 50% level 1 – 1 BPs – 50%</p>



Business Area Name	Maturity Level Summary
Care Management	<p>This area as a whole is currently at level 2 The business processes within this area are at the following levels: level 2 – 2 BPs – 66.67% level 1 – 1 BPs – 33.33%</p> <p>Note: There are four Care Management business processes but one of them is not currently a part of the Iowa MITA Enterprise.</p>



Table 30 As-Is Maturity Assessment at the Technical Area Level

Technical Area	Maturity Level Summary
Business Enabling Services	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 5 – 45.45% level 1 – 6 – 54.55%
Access Channels	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 1 – 2 – 100%
Interoperability	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 1 – 20% level 1 – 4 – 80%
Data Management and Sharing	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 1 – 2 – 100%
Performance Measurement	This area as a whole is currently at level one. The technical functions within this area are at the following levels: level 2 – 1 – 50% level 1 – 1 – 50%
Security and Privacy	This area is currently at level one IME does not currently perform one technical process , Intrusion Detection The technical functions within this area are at the following levels: level 2 – 3 – 60% level 1 – 2 – 40%
Flexibility – Adaptability and Extensibility	This area is currently at level one. The technical functions within this area are at the following levels: level 2 – 1 – 25% level 1 – 3 – 75%



Appendix C – Hospital EHR Incentive Worksheet

Medicaid EHR Hospital Incentive Worksheet

<Hospital Name>

<Hospital NPI>

The overall "EHR" amount is the sum over 4 years of (a) the base amount of \$2,000,000 plus (b) the discharge related amount defined as \$200 for the 1,150 through the 23,000 discharge for the first payment year then a pro-rated amount of 75% in yr 2, 50% in yr 3, and 25% in yr 4

For years 2-4 the rate of growth is assumed to be the previous 3 years' average.

Step 1: Compute the average annual growth rate over 3 years using previous Medicare cost

Per the Medicare cost report 2552-10, worksheet S-3, part I, line 14, column 15 - Total disch

	PY	FY	Inc	% Inc
Prior Fiscal Year 3		759		
Prior Fiscal Year 2	759	877	118	15.55%
Prior Fiscal Year 1	877	549	(328)	-37.40%
Current Year Discharges	549	417	(132)	-24.04%
	Total % Inc 2005-2009			-45.9%
	Divide by 3 years			3



The average annual growth rate over 3 years

-15.30%

Step 2: Compute total discharge related amount using proper transition factors

> discharges are capped at 23,000
each year

Total Discharges from worksheet S-3, part I, line 14, column 15 (Medicare cost report 2552-10)

Year 1	(allowed dischg - 1,149) x \$200	-	allowd dischg
Year 2	((allowed dischg - 1,149) x \$200)	-	allowd dischg
Year 3	((allowed dischg - 1,149) x \$200)	-	allowd dischg
Year 4	((allowed dischg - 1,149) x \$200)	-	allowd dischg
Total 4 year discharge related amount		-	

Step 3: Compute the initial amount for 4 years

	Year 1	Year 2	Year 3
Years 1 - 4 base amount of \$2,000,000 per year	2,000,000	2,000,000	2,000,000
Years 1-4 discharge related amount (step 2)	-	-	-
Aggregate EHR amount for 4 years <i>*Medicare Share Set at 1</i>	-	2,000,000	2,000,000

Step 4: Apply Transition Factor

-	1,500,000	1,000,000
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Step 5: Compute the overall EHR amount for 4 years

3,000,000

Step 6: Computation of Medicaid Share from the Medicare cost report

(estimated Medicaid inpatient-bed-days + estimated Medicaid HMO inpatient-bed-days) / (est. Medicaid IP-bed-days x ((est. total charges - est. charity care charges) / est. total charges))

Total Medicaid Days	w/s S-3 part I, col. 7, SUM of line 1 and lines 8-12	579
Total Medicaid HMO days	w/s S-3 part I, col. 7, line 2	-
Total Medicaid and HMO Medicaid days		
Total Hospital Charges	w/s C part I, col. 8, line 200	53,933,696
Charity Care	w/s S-10, column 3, line 20 (excludes bad debt)	3,290,484
Total Hospital Charges - charity chgs		50,643,212
divided by Total Hospital Charges		53,933,696
Non-charity percentage		93.90%
Total Hospital Days	w/s S-3 part I, col. 8, lines 1, 2 + 8-12	5,818

Non-charity total Hospital Days

(Total Medicaid and HMO Medicaid days) divide non-charity hospital days

Step 7: Computation of Medicaid aggregate EHR incentive amount

Aggregate EHR amount for 4 years



(Total Medicaid and HMO Medicaid days) divide non-charity hospital days

**Medicaid Aggregate EHR Incentive
Amount**

***Step 8: Computation of Medicaid EHR incentive amount by
year***

Year One payment = 40%

Year Two payment = 40%

Year Three payment = 20%



Appendix C – Final Iowa Administrative Rule

The Administrative Rule for Iowa's electronic health record incentive program was updated, adopted, and filed on July 8, 2013. In summary, the following additions were made to the rule:

1. Set the previous hospital year as the base year for calculating the hospital incentive payment.
2. Permit an alternate option for children's hospitals to participate, using a specially assigned number by the Centers for Medicare and Medicaid Services (CMS).
3. Clarify and update the application, agreement and payment processes, including that dually eligible hospitals will report to CMS.

This amendment will be effective September 1, 2013.

The newly adopted rule is below with additions underline and deletions struck-out.

441—79.16(249A) Electronic health record incentive program. The department has elected to participate in the electronic health record (EHR) incentive program authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law No. 111-5. The electronic health record incentive program provides incentive payments to eligible hospitals and professionals participating in the Iowa Medicaid program that adopt and successfully demonstrate meaningful use of certified electronic health record technology.

79.16(1) State elections. In addition to the statutory provisions in ARRA Section 4201, the electronic health record incentive program is governed by federal regulations at 42 CFR Part 495 as published in the Federal Register, Vol. 75, No. 144, on July 28, 2010 as amended to September 4, 2012. In compliance with the requirements of federal law, the department establishes the following state options under the Iowa electronic health record incentive program:

a. For purposes of the term "hospital-based eligible professional (EP)" as set forth in 42 CFR Section 495.4 as amended to July 28, 2010 September 4, 2012, the department elects the calendar year preceding the payment year as the period used to ~~calculate~~ gather data to determine whether or not an eligible professional is "hospital-based" for purposes of the regulation.

b. For purposes of calculating patient volume as required by 42 CFR Section 495.306 as amended to July 28, 2010 September 4, 2012, the department has elected that eligible providers may elect to use either:

- (1) The patient encounter methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010 September 4, 2012, or
- (2) The patient panel methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010 September 4, 2012.



c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to ~~July 28, 2010~~ September 4, 2012, the

“12-month period selected by the state” shall mean the hospital fiscal year.

d. For purposes of 42 CFR Section 495.310(g)(2)(i) as amended to ~~July 28, 2010~~ September 4, 2012, the “12-month period selected by the state” shall mean the hospital fiscal year.

79.16(2) Eligible providers. To be deemed an “eligible provider” for the electronic health record incentive program, a provider must satisfy the applicable criterion in each paragraph of this subrule:

a. The provider must be currently enrolled as an Iowa Medicaid provider.

b. The provider must be one of the following:

(1) An eligible professional, listed as:

1. A physician,

2. A dentist,

3. A certified nurse midwife,

4. A nurse practitioner, or

5. A physician assistant practicing in a federally qualified health center or a rural health clinic when the physician assistant is the primary provider, clinical or medical director, or owner of the site.

(2) An acute care hospital, ~~defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399~~ as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

(3) A children’s hospital, ~~defined as a separately certified children’s hospital, either freestanding or a hospital within hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399~~ as defined in 42 CFR Section 495.302 as amended to September 4, 2012.

c. For the year for which the provider is applying for an incentive payment:

(1) An acute care hospital must have 10 percent Medicaid patient volume.

(2) An eligible professional must have at least 30 percent of the professional’s patient volume ~~covered by~~ enrolled in Medicaid, except that:

1. A pediatrician must have at least 20 percent Medicaid patient volume. For purposes of this subrule, a “pediatrician” is a physician who is board-certified in pediatrics by the American Board of

Pediatrics or the American Osteopathic Board of Pediatrics or who is eligible for board certification.

2. When a professional has at least 50 percent of patient encounters in a federally qualified health center or rural health clinic, patients who were furnished services either at no cost or at a reduced cost based on a sliding scale or ability to pay, patients covered by the HAWK-I program, and Medicaid members may be counted to meet the 30 percent threshold.

79.16(3) Application and agreement. Any eligible provider who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the ~~National Level Repository~~ CMS Registration and Attestation Web site, as developed by the Centers for Medicare and Medicaid Services (CMS). CMS will notify the department of an eligible provider’s application for the incentive payment.

a. Upon receipt of an application for participation in the program, the department will contact the applicant with instructions for accessing the Iowa EHR Medicaid incentive payment program ~~section of the Iowa Medicaid portal access (IMPA)~~ administration Web site at



Appendix D – Provider EHR Agreements

IOWA DEPARTMENT OF HUMAN SERVICES
IOWA MEDICAID ENTERPRISE

**Iowa Electronic Health Record
Incentive Program Provider Agreement**

Eligible professionals complete Section I, eligible hospitals complete Section II.

I. Eligible Professionals

- a. I am an eligible professional based on the following provider type (select one)
 - i. Physician
 - ii. Nurse Practitioner
 - iii. Dentist
 - iv. Certified Nurse Midwife
 - v. Physicians Assistant practicing predominately in a Federally Qualified Health Center or Rural Health Clinic that is so led by a Physician Assistant (PA)
- b. I am currently enrolled in Iowa Medicaid and have no sanctions pending against me. (select one) Yes or No
- c. I am a Physician Assistant (PA) practicing predominately in a Federally Qualified Health Center or Rural Health Clinic that is so led by a PA (select one) Yes or No
 - i. I am currently seeing Medicaid patients billed through my supervising physician. (select one) Yes or No
 - ii. My supervising physician is enrolled in Medicaid and the billing National Provider Identifier (NPI) is (_____)
 - iii. Indicate whether you practice predominately in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
 1. If you answered RHC, how is your clinic "so led" by a Physician Assistant (PA)? (choose all that apply): 1) A PA is the primary provider in the clinic 2) a PA is the clinical or medical director in the facility 3) A PA is the owner of the RHC
 2. Enter your license number. Note: You will be required to upload a copy of your license at the end of this attestation.
- d. Provide the NPI of the organization through which you bill (e.g., if working at an FQHC, provide the NPI the FQHC uses to bill the IME)
- e. I am not hospital-based. (select one) Yes or No
- f. What percentage of your patients are seen in a hospital setting (ED or inpatient)?



- g. I am applying for incentives because I have adopted, implemented or upgraded to certified electronic health record (EHR) technology.
 - i. 1) Adopted 2) Implemented 3) Upgraded
- h. The certification number of my certified EHR is ____

To complete this section, please complete the appropriate sections of the Payment Justification Worksheet, found at

<http://www.ime.state.ia.us/docs/CalculatingEPcontributionsworksheet..pdf>

- i. What is your total, individual cost of the EHR, including original purchase amount, hardware, connectivity, training, etc. (line 8 of Worksheet 1, Section 1)
- j. I have not received State or local government contribution to funding that is directly attributable to the cost of the EHR technology. (select one) Yes or No
- k. I have spent at least \$3750 on the adoption, implementation or upgrade to certified EHR technology. (select one) Yes or No
- l. This amount was spent on the following: (choose all that apply):
 - i. Hardware costs
 - ii. Software costs
 - iii. Staff training
 - iv. Maintenance fees
 - v. Connectivity
 - vi. Loss of productivity
 - vii. Other, please specify (free form text box)
- m. Are you a pediatrician seeking payment based on 20% of your practice attributable to Medicaid? (select one) Yes or No
- n. To be eligible for the incentive, 30% of your patient encounters (20% for pediatricians) over a consecutive 90-day period in the previous calendar year must be attributable to Medicaid (needy individuals for those practicing predominantly in an FQHC or RHC). This calculation can be made at the individual provider level, or at the clinic level. Are you attesting to patient volume based on a clinic-level calculation? (select one) Yes or No
 - i. If yes, indicate the tax id and NPI of the clinic
- o. To be eligible for the incentive, 30% of your patient encounters (20% for pediatricians) over a consecutive 90-day period in the previous calendar year must be attributable to Medicaid (needy individuals for those practicing predominantly in an FQHC or RHC). Provide the beginning and end dates for the 90-day period you are claiming to prove patient volume requirements



- p. Provide the total number of patient encounters for the specified 90 day reporting period
- q. Provide the NPI and tax id under which you bill Medicaid
- r. Are any of your Medicaid patients covered by another state's Medicaid program? If so, indicate which states.
- s. Are you a Medicaid managed care provider? (i.e., see patients covered by Magellan or MediPASS?) (select one) Yes or No
 - i. If yes, are you claiming Medicaid patients from your panel who you have seen in the past year, but not in the designated 90-day period, in your Medicaid patient percentage calculation? (select one) Yes or No
- t. Do you see patients in more than one location?
 - i. If yes, did at least 50% of your patient encounters during the EHR reporting period occur at a practice/location or practices/locations equipped with certified EHR?
 - ii. Provide the addresses of each location where you see patients, and indicate the percentage of your practice at each location and whether those locations are equipped with certified EHR technology.
- u. What is the verifiable data source you are using to calculate patient volume?
- v. Do you practice predominately in an FQHC or RHC? "Yes or No"
 - i. If yes, are 30% of your encounters for needy individuals?
 - ii. Provide the number and percentage of patients falling into the following categories during the 90-day period:
 1. Iowa Medicaid
 2. other state's Medicaid (indicate the State)
 3. **hawk-i**
 4. Patients receiving uncompensated care
 5. Patients receiving care at no cost or reduced cost based on a sliding scale determined by the individual's ability to pay

II. Eligible Hospitals

- a. I represent an acute care hospital
- b. My hospital's CCN is _____
- c. My average patient length of stay is less than 25 days
- d. My average patient length of stay is _____
- e. I have adopted, implemented or upgraded to certified electronic health record (EHR) technology. 1) Adopted 2) Implemented 3) Upgraded
- f. The certification number of my certified EHR is _____
- g. To be eligible for the incentive, 10% of your patient encounters (ED and inpatient) over a consecutive 90-day period in the previous hospital fiscal



- year must be attributable to Medicaid. Indicate which 90-day period you are using.
- h. Indicate the total number of patient encounters for the specified 90 day reporting period
 - i. Are any of your Medicaid patients covered by another state's Medicaid program? If so, indicate which states.
 - j. What is the verifiable data source you are using to calculate patient volume?
 - k. To determine the average annual growth rate, using the 3 previous years Medicare cost reports, worksheet s-3, Part 1, line 23, column 15 Enter the following:
 - i. Past FY -3
 - ii. Past FY -2
 - iii. Past FY -1
 - iv. Past FY
 - l. Using your most recent Medicare cost report please enter the following information :
 - i. Total Medicaid Days w/s S-3 part I, col. 5, SUM of lines 1, 6-10
 - ii. Total Medicaid HMO days w/s S-3 Part I, col. 5, line 2
 - iii. Total Hospital Charges w/s C part I, col. 8, line 101
 - iv. Other uncompensated care charges w/s S-10 line 30 (excludes bad debt)
 - v. Total Hospital Days w/s S-3 part 1, col. 6, lines 1, 6-10

III. Attestation

1. By clicking in the following box, you certify and agree to the following:
2. The foregoing information provided in this application is true, accurate and complete.
3. This Agreement is supplementary to the usual provider agreement entered into for participation in the Iowa Medical Assistance Program and all provisions of that agreement shall remain in full force and effect.
4. The Medicaid EHR incentive payments submitted under this National Provider Identifier (NPI) are from Federal funds, and that any falsification or concealment of material fact may be prosecuted under Federal and State laws.
5. You will maintain documentation in support of your qualifications to receive the funds for a minimum period of six years:
6. In the event the IME asks for additional information or proof on any of the information submitted as part of this application, you will cooperate in supplying any information necessary for any audit.



7. The IME will pursue repayment in all instances of improper or duplicate payment, regardless of whether there was an assignment of the payment to another entity.

IV. Definitions:

1. So led: An FQHC/RHC is “so led” by a PA when:
 - i. A PA is the primary provider in a clinic
 - ii. A PA is a clinical or medical director at a clinical site of practice; or
 - iii. A PA is an owner of a RHC
- b. Hospital-based: An eligible professional is considered to be “hospital-based” when the EP provides substantially all of his or her professional services in a hospital setting. “Substantially all” means that 90 percent or more of the services are performed in the hospital setting (patients seen in an inpatient or emergency department setting).
- c. A/I/U: Adopt, implement, upgrade. Eligible professionals and eligible hospitals who meet minimum patient thresholds qualify for the first year Medicaid incentive payment by demonstrating they have adopted, implemented or upgraded to certified EHR technology.
 - i. Adopt: Acquired and installed. E.g., Evidence of acquisition, installation.
 - ii. Implement: Commenced utilization E.g., staff training, data entry of patient demographic information into EHR, data use agreements.
 - iii. Upgrade: Version 2.0, expanded functionality E.g., ONC EHR certification.
- d. Needy individuals: In determining the minimum patient volume for EPs practicing predominately in an FQHC or RHC, EPs may count needy individuals in the numerator.
 - i. Needy individuals are those patients who are:
 - ii. Covered by Medicaid or **hawk-i**
 - iii. Receiving uncompensated care by the provider
 - iv. Furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay
- b. Practices predominately: An EP practices predominately when the FQHC/RHC is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year
- c. Patient encounter: A patient encounter for an EP is defined as:



- i. Services rendered on any one day to an individual where Medicaid or a Medicaid 1115 grant paid for part or all of the service; or
 - ii. Services rendered on any one day to an individual where Medicaid or a Medicaid 1115 grant paid all or part of the premiums, copayments and/or cost sharing.
- d. Hospital encounters: For purposes of calculating hospital patient volume, the following are to be considered Medicaid encounters:
- i. Services rendered to an individual per inpatient discharges where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service;
 - ii. Services rendered to an individual per inpatient discharge where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing;
 - iii. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act either paid for part or all of the service; or
 - iv. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or costsharing.

PA Addendum

Additional Terms and Conditions for Physician Assistants Practicing in an FQHC or RHC that is so led by a Physician Assistant

This Agreement is between the State of Iowa, Department of Human Services, (the "Department") and the Provider (the "Provider"). The operations management responsibility for the Iowa Medicaid Program is through the Iowa Medicaid Enterprise (the "IME").

Section 1. Provider Agrees to:

Adhere to professional standards and levels of service as set forth in all applicable local, State and Federal laws, statutes, rules and regulations as well as administrative policies and procedures set forth by the Department relating to the Provider's performance under this Agreement.



I. Abide, to the extent required, by the provisions of:

✓

- a. Title VI of the Civil Rights Act of 1964 as amended (42 U.S.C. § 2000e), which prohibits discrimination against any employee or applicant for employment or an applicant or member of services, on the basis of race, religion, color, national origin, age or sex;
- b. Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. § 794) as well as the terms, conditions and requirements of Americans with Disabilities Act of 1990 (P.L. 101-336), 42 U.S.C. 12101, and associated regulations found at 28 C.F.R. §§ 36.101 through 36.999, which prohibit discrimination against disabled persons.
- c. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and associated regulations found at 45 C.F.R. parts 160 and 164, and all laws protecting the confidentiality of patient information.

II. Comply with applicable Federal, State and local laws, regulations, administrative rules, and executive orders, including without limitation, all laws applicable to the prevention of discrimination in employment, and business permits and licenses that may be required.

III. Comply with all applicable Federal and State laws, administrative rules and written policies of the Iowa Medicaid program, including but not limited to Title XIX of the Social Security Act (as amended), the Code of Federal Regulations, the provisions of the Code of Iowa and administrative rules of the Iowa Department of Human Services and written Department policies, including but not limited to policies contained in the Iowa Medicaid Provider Manual, and the terms of this Agreement. This section neither creates nor negates due process rights of either party.

✓

IV. Check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships. Provider agrees to check the HHS-OIG website (<http://exclusions.oig.hhs.gov/>) or <http://www.oig.hhs.gov/fraud/exclusions.asp>) by the name of any individual or entity for their exclusion status before the provider hires or enters into any contractual relationship with the person or entity. In addition, Provider agrees to check the HHS-OIG website monthly to capture exclusions and reinstatements that have occurred since the last search. Provider must report to the IME any exclusion.

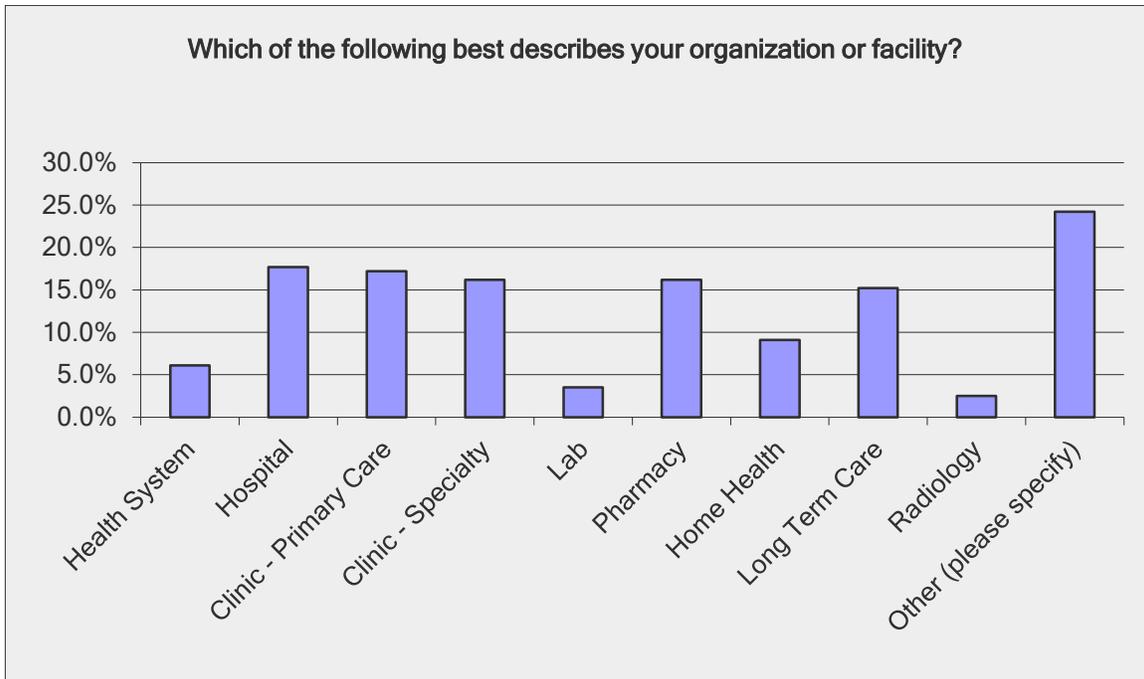


V. The Provider shall maintain books, records and documents which sufficiently and properly document and calculate all charges billed to the Department throughout the term of this Agreement for a period of at least six (6) years following the date of final payment or completion of any required audit. Records to be maintained include both financial records and service records. The Provider shall permit the Auditor of the State of Iowa or any authorized representative of the State and where federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States government, to access and examine, audit, excerpt and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records or other records of the Provider relating to orders, invoices or payments or any other documentation or materials pertaining to this Agreement, wherever such records may be located. The Provider shall not impose a charge for audit or examination of the Provider's books and records.

VI. Choice of Law and Forum. The laws of the State of Iowa shall govern and determine all matters arising out of or in connection with this Agreement without regard to the choice of law provisions of Iowa law. In the event of any proceeding of a quasi-judicial or judicial nature is commenced in connection with this Agreement, the proceeding shall be brought and maintained in Polk County District Court for the State of Iowa, Des Moines, Iowa or in the United States District Court for the Southern District of Iowa, Central Division, Des Moines, Iowa wherever jurisdiction is appropriate. This provision shall not be construed as waiving any immunity to suit or liability including without limitation sovereign immunity in State or Federal court, which may be available to the Department or the State of Iowa.

Appendix E - HIE Participation Form Received by Iowa E-Health

The following table summarizes the number of providers who have completed an HIE participation interest form as of July 24, 2012.





Appendix F - Meaningful Use Questions

EP

EP Provider Attestation Information (Meaningful Use Years)

When attesting to Meaningful Use in Payment Years 2 through 6 you must complete the Meaningful Use Core, Menu and Clinical Quality Measure (CQM) pages in addition to the Provider Questions, EHR Questions and Patient Volume Question pages prior to submitting your attestation for review.

To access the Meaningful Use Core Set Questions, click on the "Attest" link next to the Criteria named „Meaningful Use Core Set Questions.



UserID:
User Role:
Provider:

[My Profile](#) [Log Out](#)

[Home](#)

[Apply for Incentive \(Attest\)](#)

[Appeals](#)

[CMS Registration site](#)

Provider Attestation

[Help](#)

Current Case

Provider:	Provider Type:	Print
Address:	NPI:	
City/State:	Payee NPI:	
Zip:	Tax Id:	Application ID:
Email:	Payee TaxId:	Imported Data:
Status:	Status Date:	Program Year
		MU Stage:

Contact Us

Provider Information:
515-974-3071 or 515-974-3123
imeincentives@dhs.state.ia.us

Quick Links

[CMS EHR Incentive Program Overview](#)
[Certified Health IT Product List \(CHPL\)](#)
[CMS Meaningful Use Calculator](#)

Provider EHR Criteria

	Criteria	Status	Audit Flag	Received Date	Denial Reason	Attested?
Attest	Provider Questions	Pending				Yes
Attest	EHR Questions	Pending				No
Attest	Patient Volume Questions	Pending				No
Attest	Meaningful Use Core Set Questions	Pending				No
Attest	Meaningful Use Menu Set Questions	Pending				No
Attest	Meaningful Use Clinical Quality Measures	Pending				No



Reporting Period Payment Year 2

If this is your first year attesting to Meaningful Use: Your reporting period is “any continuous 90-day period within the calendar year.” per 42 CFR § 495.4 (1)(ii)(B).

Enter your selected Reporting Period in the first row of the Meaningful Use Core Set Questions page:



Meaningful Use Core Set Questions

Instructions
To qualify for an incentive payment the EP must specify the EHR reporting period, answer the general questions below and attest to all 15 required Core objectives.

#	Measure
	EHR Reporting Period Start Date: <input type="text"/>  End Date: <input type="text"/> 
	Objective: 1234 Sesame St Anytown, USA 12345 - Does the Eligible Provider use a Certified Electronic Health Record technology at this location

Payment Years 3-6

If you have previously attested to Meaningful Use (you are in your third, fourth, fifth or sixth payment year): Your reporting period is “the calendar year.” per 42 CFR § 495.4 (1)(ii)(A). You will not be able to begin Meaningful Use attestation until the entire calendar year being used as your reporting period has passed.

The system will display the same calendar tool you used in the previous year. Use this calendar to select your reporting period year.

Note: Once you input data you must exit the field for additional questions to display. Some additional questions are displayed based on your answers.

There is an exception to this rule for 2014 only. The reporting period, regardless of stage, will be “any continuous 90-day period within the calendar year.”

General Questions

To be a meaningful user, at least 80% of unique patients must have their data in the certified EHR during the EHR reporting period. If you practice in multiple locations, the addresses you entered in the Provider Questions page are displayed here. Answer the question and provide numerators and denominators for each location.



	Requirement: At least 80% of unique patients must have their data in the certified EHR during the EHR reporting period
	Numerator: <input type="text"/> Denominator: <input type="text"/>
	More

	1234 West Street - Does the Eligible Provider use a Certified Electronic Health Record technology at this location during the EHR reporting period?
	<input type="radio"/> Yes <input type="radio"/> No
	456 South Street - Does the Eligible Provider use a Certified Electronic Health Record technology at this location during the EHR reporting period?
	<input type="radio"/> Yes <input type="radio"/> No

You must select the principal county in which you practice.



NOTE

GEN-3	What is the principal county in which you practice?	
		Adair
		Adams
		Allamakee
		Appanoose
		Audubon
		Benton
		Black Hawk
		Boone
		Bremer
		Buchanan
		Bueno Vista
		Butler
		Calhoun
		Carrol
		Cass
		Cedar
		Cerro Gordo
		Cherokee
		Chicksaw
		Clarke
		Clay
		Clayton
		Clinton
		Crawford
		Dallas
		Davis
		Decatur
		Delaware
		Des Moines



You must select the specialty that best describes your practice.

The screenshot shows a web form with a dropdown menu open. The dropdown menu lists the following specialties: Allergy, Cardiovascular, Dentist, Dermatology, Family/General Practice, Gastroenterology, Internal Medicine, Neurology, OB/GYN, Oncology, Ophthalmology, Optometry, Oral Surgery, Orthodontist, Otolaryngology, Pediatrics, Psychiatry, Pulmonary, and Urology. The form background is blurred, but the text 'GEN-4' and 'Select the specialty that best describes your practice.' is visible.

2.4.2.2 **EP Core Objectives**

For Stage 1 attestation, an EP must attest to all 15 Core objectives.

Starting in 2014 for Stage 2, an EP must attest to 17 core objectives.

Attestation for most objectives is accomplished by entering a numerator, denominator and exclusion information. Certain objectives do not require a numerator and denominator, but rather a Yes/No answer. Objectives that require the denominator type



will display the types of denominators allowed, you must select a denominator source. All questions require an answer unless otherwise specified.

All Meaningful Use objectives are displayed in a similar fashion. Review the section below prior to beginning attestation to become familiar with the MU questions.

Due to the nature of the program, not all of the MU objectives and associated measures are described in detail in this manual. The objectives and measures may change according to new federal regulations, and will change depending on the stage of MU you are attesting to. Please refer to the final rule, www.healthit.hhs.gov and www.cms.hhs.gov/EHRincentiveprograms for detailed information on the Meaningful Use objectives and measures.

EP Core Set Screen Shots – Stage 1

The following screen shots are for Stage 1.

Objective: §495.6(d)(1)(i) - Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines

More

Measure: More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.

Exclusion: Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Does this exclusion apply to you? Yes No

Numerator: The number of patients in the denominator that have at least one medication order entered using CPOE.

Denominator: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.

The denominator data was extracted:

from ALL patient records, not just those maintained using certified EHR technology

only from patient records maintained using certified EHR technology



5	<p>Objective: §495.6(d)(5)(i) - Maintain active medication list.</p> <p>More</p> <p>Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.</p> <p>Numerator: Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data. <input type="text"/></p> <p>Denominator: Number of unique patients seen by the EP during the EHR reporting period. <input type="text"/></p>
6	<p>Objective: §495.6(d)(6)(i) - Maintain active medication allergy list.</p> <p>More</p> <p>Measure: More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.</p> <p>Numerator: Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list. <input type="text"/></p> <p>Denominator: Number of unique patients seen by the EP during the EHR reporting period. <input type="text"/></p>
7	<p>Objective: §495.6(d)(7)(i) - Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth</p> <p>More</p> <p>Measure: More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.</p> <p>Numerator: Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data. <input type="text"/></p> <p>Denominator: Number of unique patients seen by the EP during the EHR reporting period. <input type="text"/></p>



8

Objective: §495.6(d)(8)(i) - Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI

More

Measure: For more than 50 percent of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded as structured data.

Exclusion 1: Based on ALL patient records: An EP who sees no patients 2 years or older would be excluded from this requirement.

Exclusion 2: Based on ALL patient records: An EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice would be excluded from this requirement.

Does exclusion 1 apply to you?

Yes No

Does exclusion 2 apply to you?

Yes No

Numerator: Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.

Denominator: Number of unique patients age 2 or over seen by the EP during the EHR reporting period.

The denominator data was extracted:

from ALL patient records, not just those maintained using certified EHR technology

only from patient records maintained using certified EHR technology



9

Objective: §495.6(d)(9)(i) - Record smoking status for patients 13 years old or older.

More

Measure: More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

Exclusion: An EP who sees no patients 13 years or older would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

Does this exclusion apply to you?

Yes No

Numerator: Number of patients in the denominator with smoking status recorded as structured data.

Denominator: Number of unique patients age 13 or older seen by the EP during the EHR reporting period.

The denominator data was extracted:

- from ALL patient records, not just those maintained using certified EHR technology
- only from patient records maintained using certified EHR technology

10

Objective: §495.6(d)(10)(i) - Report ambulatory clinical quality measures to CMS.

More

Measure: Successfully report to the State ambulatory clinical quality measures selected by the State in the manner specified by the State.

Numerator/Denominator: This measure only requires a yes/no answer

Numerator: N/A

Denominator: N/A

Yes No

Name one CQM:



11	Objective: §495.6(d)(11)(i) - Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
	More
	Measure: Implement one clinical decision support rule. Numerator/Denominator: This measure only requires a yes/no answer Numerator: N/A Denominator: N/A
	Which Clinical Decision Support (CDS) rule was implemented during the EHR reporting period: <input type="text"/>

Yes No

12	Objective: §495.6(d)(12)(i) - Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.
	More
	Measure: More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days. Exclusion: Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period. Exclusion from this requirement does not prevent an EP from achieving meaningful use. Does this exclusion apply to you?
	Numerator: Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days. Denominator: Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

Yes No

The denominator data was extracted:

- from ALL patient records, not just those maintained using certified EHR technology
- only from patient records maintained using certified EHR technology



13

Objective: §495.6(d)(13)(i) - Provide clinical summaries for patients for each office visit.

More

Measure: Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days.

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

Does this exclusion apply to you?

Yes No

Numerator: Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.

Denominator: Number of office visits by the EP during the EHR reporting period.

The denominator data was extracted:

- from ALL patient records, not just those maintained using certified EHR technology
- only from patient records maintained using certified EHR technology

14

Objective: §495.6(d)(14)(i) - Capability to exchange key clinical information (for example, problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.

More

Measure: Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.

Numerator/Denominator: This measure only requires a yes/no answer

Numerator: N/A

Denominator: N/A

Yes No

With whom was test done?



15	Objective: §495.6(d)(15)(i) - Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.
	More Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process. Numerator/Denominator: This measure only requires a yes/no answer Numerator: N/A Denominator: N/A

Yes No

EP Core Set Screen Shots – Stage 2

The IME has identified requirements and specifications for Stage 2 Meaningful Use for the attestation portal. We are currently in the development cycle and do not have production-ready screenshots available. We fully anticipate being ready by January 1, 2014 to enable us to make incentive payments. The screens below are mock-ups only and will be updated for approval with production-ready screenshots once they are available.



Figure 36: EP CPOE for Medication, Laboratory, and Radiology Orders

<p>1</p> <p>§ 495.6 (j)(1)(i)</p>	<p>Objective: Use computerized provider order entry (CPOE) 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.</p> <p>More</p>	
	<p>Measure: More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.</p>	
	<p>Measure 1 - Medication:</p> <p>Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period.</p> <p>Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No</p> <p>Numerator: The number of orders in the denominator recorded using CPOE.</p> <p>Denominator: Number of medication orders created by the EP during the EHR reporting period.</p>	<p>Percentage: <input type="text"/></p> <input type="text"/> <input type="text"/>
	<p>Measure 2 - Radiology:</p> <p>Exclusion: Any EP who writes fewer than 100 radiology orders during the EHR reporting period.</p> <p>Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No</p> <p>Numerator: The number of orders in the denominator recorded using CPOE.</p> <p>Denominator: Number of radiology orders created by the EP during the EHR reporting period.</p>	<p>Percentage: <input type="text"/></p> <input type="text"/> <input type="text"/>
	<p>Measure 3 - Laboratory:</p> <p>Exclusion: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.</p> <p>Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No</p> <p>Numerator: The number of orders in the denominator recorded using CPOE.</p> <p>Denominator: Number of radiology orders created by the EP during the EHR reporting period.</p>	<p>Percentage: <input type="text"/></p> <input type="text"/> <input type="text"/>
	<p>The denominator data was extracted:</p> <p><input type="radio"/> from ALL patient records, not just those maintained using certified EHR technology</p> <p><input type="radio"/> only from patient records maintained using certified EHR technology</p>	



Figure 37: e-Prescribing

<p>2</p> <p>§ 495.6 (j)(2)(i)</p>	<p>Objective: Generate and transmit permissible prescriptions electronically (eRx).</p> <p>More</p>		
	<p>Measure: More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.</p>		
	<p>Exclusion: Any EP who: (1) Writes fewer than 100 permissible prescriptions during the EHR reporting period. Or (2) Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period</p>		
	<p>Does the exclusion 1 apply to you: <input type="radio"/> Yes <input type="radio"/> No</p> <p>Does the exclusion 2 apply to you: <input type="radio"/> Yes <input type="radio"/> No</p>		
	<p>Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.</p> <p>Denominator: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.</p> <p style="text-align: right;">Percentage: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table></p>		
<p>The denominator data was extracted:</p> <p><input type="radio"/> from ALL patient records, not just those maintained using certified EHR technology</p> <p><input type="radio"/> only from patient records maintained using certified EHR technology</p>			



Figure 38: Record Demographics

3 § 495.6 (j)(3)(i)	Objective: Record the following demographics: preferred language, sex, race, ethnicity, date of birth.	
	More	
	Measure: More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.	
	Exclusion: None	
	Numerator: The number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data..	<input type="text"/>
	Denominator: Number of unique patients seen by the EP during the EHR reporting period.	Percentage: <input type="text"/>



Figure 39: Record Vital Signs

<p>4</p> <p>§ 495.6 (j)(4)(i)</p>	<p>Objective: Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.</p>			
	<p>More</p>			
	<p>Measure: More than 80 percent of all unique patients seen by the EP have blood pressure (for age 3 and over only) and/or height and weight calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.</p>			
	<p>Exclusion: Any EP who:</p> <p>(1) Sees no patients 3 years or older is excluded from recording blood pressure.</p> <p>(2) Believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.</p> <p>(3) Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.</p> <p>(4) Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.</p>			
	<p>Does the exclusion 1 apply to you: <input type="radio"/> Yes <input type="radio"/> No</p>			
	<p>Does the exclusion 2 apply to you: <input type="radio"/> Yes <input type="radio"/> No</p>			
<p>Does the exclusion 3 apply to you: <input type="radio"/> Yes <input type="radio"/> No</p>				
<p>Does the exclusion 4 apply to you: <input type="radio"/> Yes <input type="radio"/> No</p>				
<p>Numerator: Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.</p>	<table border="1"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>			
<p>Denominator: Number of unique patients seen by the EP during the EHR reporting period.</p>				
<p style="text-align: right;">Percentage:</p>	<table border="1"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>			
<p>The denominator data was extracted:</p> <p><input type="radio"/> from ALL patient records, not just those maintained using certified EHR technology</p> <p><input type="radio"/> only from patient records maintained using certified EHR technology</p>				



Figure 43: Clinical Summaries

<p style="text-align: center;">8</p> <p>§ 495.6 (j)(11)(i)</p>	<p>Objective: Provide clinical summaries for patients for each office visit.</p> <p>More</p>
	<p>Measure: Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.</p>
	<p>Exclusion: Any EP who has no office visits during the EHR reporting period.</p>
	<p>Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No</p>
	<p>Numerator: Number of office visits in the denominator where the patient or a patient-authorized representative is provided a clinical summary of their visit within one (1) business day.</p>
	<p>Denominator: Number of office visits conducted by the EP during the EHR reporting period.</p>
Percentage:	
<p>The denominator data was extracted:</p> <p><input type="radio"/> from ALL patient records, not just those maintained using certified EHR technology</p> <p><input type="radio"/> only from patient records maintained using certified EHR technology</p>	

Figure 44: Patient Electronic Health Information

<p style="text-align: center;">9</p> <p>§ 495.6 (j)(16)(i)</p>	<p>Objective: Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.</p> <p>More</p>
	<p>Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs</p>
	<p>Exclusion: None</p>
	<p>Did you meet the criteria for measure? <input type="radio"/> Yes <input type="radio"/> No</p>



Figure 45: Clinical Lab Test Results

10 § 495.6 (j)(7)(i)	Objective: Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data More
	Measure: More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data
	Exclusion: Any EP who orders no lab tests where results are either in a positive/negative affirmation or numeric format during the EHR reporting period.
	Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No
	Numerator: Number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data.
	Denominator: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.

Percentage:

The denominator data was extracted:
<input type="radio"/> from ALL patient records, not just those maintained using certified EHR technology
<input type="radio"/> only from patient records maintained using certified EHR technology

Figure 46: Patient Lists

11 § 495.6 (j)(8)(i)	Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. More
	Measure: Generate at least one report listing patients of the EP with a specific condition.
	Exclusion: None
	Did you meet the criteria for this measure? <input type="radio"/> Yes <input type="radio"/> No



Figure 47: Preventive Care

<p style="text-align: center;">12</p> <p>§ 495.6 (j)(9)(i)</p>	<p>Objective: Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.</p>	
	<p>More</p>	
	<p>Measure: More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.</p>	
	<p>Exclusion: Any EP who has had no office visits in the 24 months before the EHR reporting period.</p>	
	<p>Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No</p>	
<p>Numerator: Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period.</p>		
<p>Denominator: Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR reporting period.</p>		
	Percentage:	<input style="width: 50px; height: 20px;" type="text"/> <input style="width: 50px; height: 20px;" type="text"/> <input style="width: 50px; height: 20px;" type="text"/>

Figure 48: Patient Specific Education Resources

<p style="text-align: center;">13</p> <p>§ 495.6 (j)(12)(i)</p>	<p>Objective: Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.</p>	
	<p>More</p>	
	<p>Measure: Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.</p>	
	<p>Exclusion: Any EP who has no office visits during the EHR reporting period.</p>	
	<p>Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No</p>	
<p>Numerator: Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology.</p>		
<p>Denominator: Number of unique patients with office visits seen by the EP during the EHR reporting period.</p>		
	Percentage:	<input style="width: 50px; height: 20px;" type="text"/> <input style="width: 50px; height: 20px;" type="text"/> <input style="width: 50px; height: 20px;" type="text"/>



Figure 49: Medication Reconciliation

14 § 495.6 (j)(13)(i)	Objective: The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation. More			
	Measure: The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP. Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period. Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No Numerator: The number of transitions of care in the denominator where medication reconciliation was performed. Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.			
	Percentage: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>			



Figure 50: Summary of Care

<p>15 § 495.6 (j)(14)(i)</p>	<p>Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.</p>	
	<p>More</p>	
	<p>EPs must satisfy both of the following measures in order to meet this objective.</p>	
	<p>Measure 1: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.</p>	
	<p>Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN.</p>	
	<p>Measure 3: An EP must satisfy one of the following criteria: Conducts one or more successful electronic exchanges of a summary of care document, as part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B) with a recipient who has EHR technology that was developed designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.</p>	
	<p>Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.</p>	
	<p>Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No</p>	
	<p>Measure 1: Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was provided. Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.</p>	<p>Percentage: <input type="text"/> <input type="text"/> <input type="text"/></p>
	<p>Measure 2: Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization. Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.</p>	<p>Percentage: <input type="text"/> <input type="text"/> <input type="text"/></p>
<p>Measure 3: Did you meet the criteria for this measure?</p>	<p><input type="radio"/> Yes <input type="radio"/> No</p>	



Figure 51: Immunization Registries Data Submission

16 § 495.6 (j)(15)(i)	Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice. More
	Measure: Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.
	Exclusion: Any EP that meets one or more of the following criteria may be excluded from this objective: (1) the EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period; (2) the EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period; (3) the EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or (4) the EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.
	Does the exclusion 1 apply to you: <input type="radio"/> Yes <input type="radio"/> No
	Does the exclusion 2 apply to you: <input type="radio"/> Yes <input type="radio"/> No
	Does the exclusion 3 apply to you: <input type="radio"/> Yes <input type="radio"/> No
Does the exclusion 4 apply to you: <input type="radio"/> Yes <input type="radio"/> No	
Did you meet the criteria for this measure? <input type="radio"/> Yes <input type="radio"/> No	



EP Menu Objectives

For Stage 1, an EP must choose a total of 5 Meaningful Use Menu objectives. At least one of the 5 objectives must be public health objectives (495.6(e)(9) or 495.6(e)(10)). If you can attest to exclusions for both public health objectives, you must choose one of the two objectives and attest to the exclusion.

Starting in 2014 for Stage 2, an EP must choose 3 menu objectives from a total list of 6.

If the EP can claim an exclusion to an objective, as long as the EP meets the criteria to claim the exclusion and attests to the exclusion, the objective is counted toward the required menu set objectives per each stage. EPs are encouraged to select objectives they are able to report on, where the exclusion does not apply to them.

Menu Objective Selection

To access the Meaningful Use Menu Set Questions, click on the „Attest“ link next to the Criteria name „Meaningful Use Menu Set Questions“.

The grids displayed list the menu set objectives. The top portion of the grid contains the public health objectives. The bottom portion of the grid contains the additional menu objectives.

Use the checkboxes on the left of the objectives to select the objective. You must select at least 5 objectives to attest to; at least one of those objectives must be from the top section of the grid – the public health objectives.

Please select the objectives carefully. Once you select your menu objectives the system will display a screen that will allow you enter your attestation data. You will not be able to save some of your objective measure data and return to the selection screen to change the objectives you elected to attest to.

EP Menu Set Screen Shots – Stage 1

The following screenshots show the attestation system for providers in Stage 1 of meaningful use.



UserID:

User Role:

Provider:

[My Profile](#) [Log Out](#)

[Home](#)

[Apply for Incentive \(Attest\)](#)

[Appeals](#)

[CMS Registration site](#)

Meaningful Use Menu Set Questions

Instructions

Use the grid below to select 5 Meaningful Use Menu Set Objectives. An EP must choose at least one objective from the public health menu measure objectives. If the EP can meet one of the public health objectives and can attest to an exclusion to the other, the EP must choose the public health menu objective they are able to meet. An EP who can attest to exclusions to both public health menu objectives must still choose one of the two objectives and attest to the exclusion.

After the EP chooses one or both public health menu objectives the EP must select additional menu set objectives until a total of five (5) Meaningful Use Menu Set Objectives have been selected. EPs should choose objectives that are relevant to their scope of practice. If the EP is unable to choose the required number of menu objectives that are relevant to their scope of practice, they can choose menu set objectives with an exclusion until a total of five (5) Meaningful Use Menu Objectives are chosen. An EP should not claim an exclusion for a menu set objective if there are additional menu set objectives that are relevant to their scope of practice and for which they are able to meet the measure.

Select at least one from the list below.

Select	Public Health Objective
<input type="checkbox"/>	§495.6(e)(9)(i) - Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.
<input type="checkbox"/>	§495.6(e)(10)(i) - Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.

Select at least 5 overall questions.

Select	Objective
<input type="checkbox"/>	§495.6(e)(1)(i) - Implement drug formulary checks.
<input type="checkbox"/>	§495.6(e)(2)(i) - Incorporate clinical lab test results into EHR as structured data.
<input type="checkbox"/>	§495.6(e)(3)(i) - Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
<input type="checkbox"/>	§495.6(e)(4)(i) - Send reminders to patients per patient preference for preventive/follow-up care.
<input type="checkbox"/>	§495.6(e)(5)(i) - Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.
<input type="checkbox"/>	§495.6(e)(6)(i) - Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
<input type="checkbox"/>	§495.6(e)(7)(i) - The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
<input type="checkbox"/>	§495.6(e)(8)(i) - The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

Contact Us

Provider Information:
5-974-3071 or 515-974-3123
incentives@dhs.state.ia.us

Quick Links

[MS EHR Incentive Program Overview](#)

[Certified Health IT Product List \(HPL\)](#)

[MS Meaningful Use Calculator](#)

The menu objectives are displayed in the same manner the core objectives. Refer to section 2.4.2.2 for the layout of the objectives and measures.



Objective: §495.6(e)(9)(i) - Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice. Upload supporting documentation (failed test, letter from IR, etc) if applicable.

More

Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).

Exclusion 1: Based on ALL patient records: An EP who administers no immunizations during the EHR reporting period would be excluded from this requirement.

Exclusion 2: If none of the registries to which the EP submits such information has the capacity to receive the information electronically the EP would be excluded from this requirement.

Does exclusion 1 apply to you?

Yes No

Does exclusion 2 apply to you?

Yes No

Numerator/Denominator: This measure only requires a yes/no answer

Numerator: N/A

Denominator: N/A

Yes No

Enter the name of the Immunization Registry (IR):

Was test successful?

Yes No

Enter time and date of test:

Date:



Time (hh:mm am/pm):

Was there a follow up submission?

Yes No

1

The syndromic surveillance objective is required in 2013 and beyond, if the State is ready.



Objective: §495.6(e)(10)(i) - Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice. Upload supporting documentation (failed test, letter from IR, etc) if applicable.

More

Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically).

Exclusion 1: Based on ALL patient records: If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period, then the EP is excluded from this requirement."

Exclusion 2: If there is no public health agency that has the capacity to receive the information electronically, then the EP is excluded from this requirement.

2

Does exclusion 1 apply to you?

Yes No

Does exclusion 2 apply to you?

Yes No

Numerator/Denominator: This measure only requires a yes/no answer

Numerator: N/A

Denominator: N/A

Yes No

Enter the name of the State Agency with which the test was conducted:

Was the test successful?

Yes No

Was there a follow up submission?

Yes No



3	Objective: §495.6(e)(1)(i) - Implement drug formulary checks.
	More Measure: The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period. Exclusion: Based on ALL patient records: An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this requirement. Does this exclusion apply to you? <input type="radio"/> Yes <input type="radio"/> No Numerator/Denominator: This measure only requires a yes/no answer Numerator: N/A <input type="radio"/> Yes <input type="radio"/> No Denominator: N/A <input type="radio"/> Yes <input type="radio"/> No
4	Objective: §495.6(e)(2)(i) - Incorporate clinical lab test results into EHR as structured data.
	Does this exclusion apply to you? <input type="radio"/> Yes <input type="radio"/> No Numerator: <input type="text"/> Denominator: <input type="text"/> More Results entered using: <input type="checkbox"/> Health Information Exchange <input type="checkbox"/> Manually Entered The denominator data was extracted: <input type="radio"/> from ALL patient records, not just those maintained using certified EHR technology <input checked="" type="radio"/> only from patient records maintained using certified EHR technology



5	Objective: §495.6(e)(3)(i) - Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
	<u>More</u>
	Measure: Generate at least one report listing patients of the EP with a specific condition.
	Numerator/Denominator: This measure only requires a yes/no answer
	Numerator: N/A Denominator: N/A <input checked="" type="radio"/> Yes <input type="radio"/> No
Name at least one specific condition for which a list was created: <input type="text"/>	
The denominator data was extracted:	
<input type="radio"/> from ALL patient records, not just those maintained using certified EHR technology	
<input type="radio"/> only from patient records maintained using certified EHR technology	

6	Objective: §495.6(e)(4)(i) - Send reminders to patients per patient preference for preventive/follow-up care.
	<u>More</u>
	Measure: More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period.
	Exclusion: Based on ALL patient records: Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology would be excluded from this requirement.
	Does this exclusion apply to you? <input type="radio"/> Yes <input type="radio"/> No
	Numerator: Number of patients in the denominator who were sent the appropriate reminder. <input type="text"/>
	Denominator: Number of unique patients 65 years old or older or 5 years old or younger. <input type="text"/>
The denominator data was extracted:	
<input type="radio"/> from ALL patient records, not just those maintained using certified EHR technology	
<input type="radio"/> only from patient records maintained using certified EHR technology	



7

Objective: §495.6(e)(5)(i) - Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP.

More

Measure: At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.

Exclusion: Based on ALL patient records: Any EP who neither orders nor creates any of the information listed at 45 CFR 170.304(g) (problem list, medication list, or medication allergy list) during the EHR reporting period would be excluded from this requirement.

Does this exclusion apply to you?

Yes No

Numerator: Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.

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

Do you have an online patient portal?

Yes No

Describe the type of information to which the patient has access (i.e. labs, diagnosis, etc.):

8

Objective: §495.6(e)(6)(i) - Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

More

Measure: More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.

Numerator: Number of patients in the denominator who are provided patient-specific education resources.

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



Objective: §495.6(e)(7)(i) - The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.

More

Measure: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.

Exclusion: Based on ALL patient records: An EP who was not the recipient of any transitions of care during the EHR reporting period would be excluded from this requirement.

Does this exclusion apply to you?

Yes No

Numerator: Number of transitions of care in the denominator where medication reconciliation was performed.

Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

The denominator data was extracted:

- from ALL patient records, not just those maintained using certified EHR technology
- only from patient records maintained using certified EHR technology

9



10	Objective: §495.6(e)(8)(i) - The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.
	More
	Measure: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.
	Exclusion 1: Based on ALL patient records: An EP who does not transfer a patient to another setting during the EHR reporting period would be excluded from this requirement.
	Exclusion 2: Based on ALL patient records: An EP who does not refer a patient to another provider during the EHR reporting period would be excluded from this requirement.
	Does exclusion 1 apply to you? <input type="radio"/> Yes <input type="radio"/> No
Does exclusion 2 apply to you? <input type="radio"/> Yes <input type="radio"/> No	
Numerator: Number of transitions of care and referrals in the denominator where a summary of care record was provided. <input type="text"/>	
Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider. <input type="text"/>	
The denominator data was extracted:	
<input type="radio"/> from ALL patient records, not just those maintained using certified EHR technology	
<input type="radio"/> only from patient records maintained using certified EHR technology	

EP Menu Set Screen Shots – Stage 2

The following screenshots are mock-ups only of what the providers will see when they attest to Stage 2 Meaningful Use.



Figure 53: Meaningful Use Menu Set Selection Screen

Meaningful Use Menu Set Objectives

Instructions:

For Stage 2 Meaningful Use an Eligible Professional (EP) must meet three (3) of the following objectives and associated measures. While a provider can continue to claim exclusions if applicable for menu objectives, these exclusions will no longer count towards the number of menu objectives needed. If the EP has an exclusion from 4 or more objectives, the EP must meet all remaining objectives and associated measures. Iowa Medicaid Enterprise encourages EPs to select menu objectives that are relevant to their scope of practice, and claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice. EPs may also select more than three measures to which to attest, giving Iowa Medicaid Enterprise with a more complete picture of successes and challenges regarding these measures.

Select at least three objectives from the list below:

Select	Objective
<input type="checkbox"/>	Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.
<input type="checkbox"/>	Record electronic notes in patient records.
<input type="checkbox"/>	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.
<input type="checkbox"/>	Record patient family health history as structured data.
<input type="checkbox"/>	Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.
<input type="checkbox"/>	Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.

OK

Cancel



Figure 54: Syndromic Surveillance Data Submission

1 § 495.6 (k)(3)(i)	Objective: Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.
	More
	Measure: Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.
	Exclusion: Any EP that meets one or more of the following criteria may be excluded from this objective: (1) the EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period; (2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by CEHRT at the start of their EHR reporting period; (3) the EP operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or (4) the EP operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional EPs.
	Does exclusion 1 apply to you: <input type="radio"/> Yes <input type="radio"/> No
	Does exclusion 2 apply to you: <input type="radio"/> Yes <input type="radio"/> No
Does exclusion 3 apply to you: <input type="radio"/> Yes <input type="radio"/> No	
Does exclusion 4 apply to you: <input type="radio"/> Yes <input type="radio"/> No	
Did you meet the criteria for this measure? <input type="radio"/> Yes <input type="radio"/> No	



Figure 55: Electronic Notes

2 § 495.6 (k)(6)(i)	Objective: Record electronic notes in patient records.		
	More		
	Measure: Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content		
	Exclusion: None		
	Numerator: The number of unique patients in the denominator who have at least one electronic progress note from an eligible professional recorded as text searchable data.		
	Denominator: Number of unique patients with at least one office visit during the EHR reporting period for EPs during the EHR reporting period.	Percentage:	<input type="text"/>
			<input type="text"/>
			<input type="text"/>

Figure 56: Imaging Results

3 § 495.6 (k)(1)(i)	Objective: Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.		
	More		
	Measure: More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.		
	Exclusion: Any EP who orders less than 100 tests whose result is an image during the EHR reporting period; or any EP who has no access to electronic imaging results at the start of the EHR reporting period.		
	Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No		
	Numerator: The number of results in the denominator that are accessible through CEHRT.		<input type="text"/>
	Denominator: Number of tests whose result is one or more images ordered by the EP during the EHR reporting period.	Percentage:	<input type="text"/>
			<input type="text"/>



Figure 57: Family Health History

4 § 495.6 (k)(2)(i)	Objective: Record patient family health history as structured data.	
	More	
	Measure: More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.	
	Exclusion: Any EP who has no office visits during the EHR reporting period. Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No	
	Numerator: The number of patients in the denominator with a structured data entry for one or more first-degree relatives.	<input type="text"/>
	Denominator: Number of unique patients seen by the EP during the EHR reporting period.	<input type="text"/>
		Percentage: <input type="text"/>



Figure 58: Report Cancer Cases

5 § 495.6 (k)(4)(i)	Objective: Capability to identify and report cancer cases to a public health central cancer registry, except where in accordance with applicable law and practice.
	More
	Measure: Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the prohibited, and in accordance with applicable law and practice.
	Exclusion: Any EP that meets at least 1 of the following criteria may be excluded from this objective: (1) The EP does not diagnose or directly treat cancer; (2) The EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period; (3) The EP operates in a jurisdiction where no PHA provides information timely on capability to receive electronic cancer case information; or (4) The EP operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period can enroll additional EPs.
	Does exclusion 1 apply to you: <input type="radio"/> Yes <input type="radio"/> No
	Does exclusion 2 apply to you: <input type="radio"/> Yes <input type="radio"/> No
Does exclusion 3 apply to you: <input type="radio"/> Yes <input type="radio"/> No	
Does exclusion 4 apply to you: <input type="radio"/> Yes <input type="radio"/> No	
Did you meet the criteria for this measure? <input type="radio"/> Yes <input type="radio"/> No	



Figure 59: Report Specific Cases

6 § 495.6 (k)(5)(i)	Objective: Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except in accordance with applicable law and practice.
	More
	Measure: Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the where prohibited, and in accordance with applicable law and practice.
	Exclusion: Any EP that meets at least 1 of the following criteria may be excluded from this objective: (1) The EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction; (2) The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required period; by CEHRT at the beginning of their EHR reporting (3) The EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their specialized registries; or (4) The EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional EPs.
	Does exclusion 1 apply to you: <input type="radio"/> Yes <input type="radio"/> No
	Does exclusion 2 apply to you: <input type="radio"/> Yes <input type="radio"/> No
Does exclusion 3 apply to you: <input type="radio"/> Yes <input type="radio"/> No	
Does exclusion 4 apply to you: <input type="radio"/> Yes <input type="radio"/> No	
Did you meet the criteria for this measure? <input type="radio"/> Yes <input type="radio"/> No	

Core Clinical Quality Measures

To qualify for the incentive payment for Stage 1 in 2013, the EP must attest to a sum total of up to 6 CQMs. Each EP must report on 3 Core CQMs (or 3 Alternate CQMs, if needed), and 3 Additional quality measures. EPs must report calculated CQMs directly from their certified EHR technology.

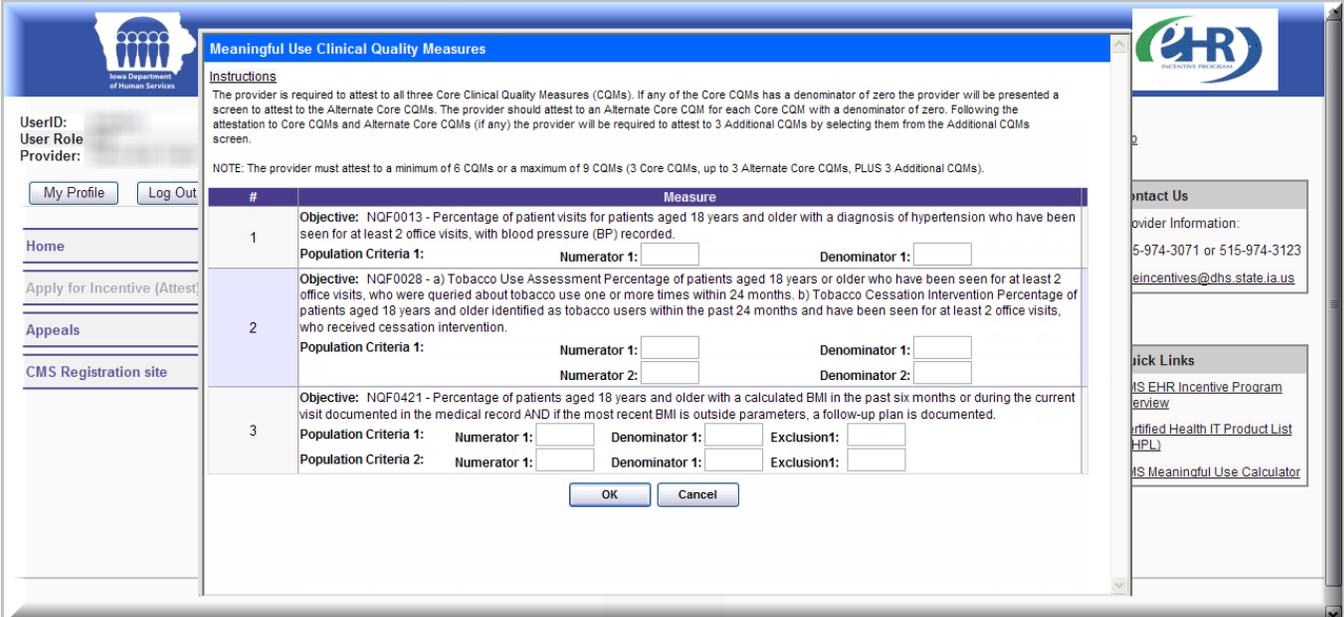
To qualify for the incentive payment for either Stage 1 or 2 in 2014, the EP and EH must report on 9 of the 64 approved CQMs. There are recommended core CQMs based on populations including adult and pediatric, though this is not required. The selected measures must cover at least 3 of the National Quality Strategy domains.

If you can attest to all 3 core CQMs without a zero denominator, you will be prompted to select 3 additional CQMs.

If you attest to any of the 3 core CQMs using a zero denominator; for each core CQM with a zero denominator, you will need to select an equal number of the 3 alternative CQMs. Using this logic you could essentially attest to all 6 core CQMs. Regardless of the number of core CQMs you attest to you will still be required to attest to 3 additional CQMs

Instructions: All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an alternate core clinical quality measure must also be submitted.

Figure 60: Attestation for Stage 1 CQMs screen





Meaningful Use Clinical Quality Measures

Instructions

The provider is required to attest to all three Core Clinical Quality Measures (CQMs). If any of the Core CQMs has a denominator of zero the provider will be presented a screen to attest to the Alternate Core CQMs. The provider should attest to an Alternate Core CQM for each Core CQM with a denominator of zero. Following the attestation to Core CQMs and Alternate Core CQMs (if any) the provider will be required to attest to 3 Additional CQMs by selecting them from the Additional CQMs screen.

NOTE: The provider must attest to a minimum of 6 CQMs or a maximum of 9 CQMs (3 Core CQMs, up to 3 Alternate Core CQMs, PLUS 3 Additional CQMs).



UserID:
User Role:
Provider:

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#	Measure
1	<p>Objective: NQF0013 - Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.</p> <p>Population Criteria 1: Numerator 1: <input type="text"/> Denominator 1: <input type="text"/></p>
2	<p>Objective: NQF0028 - a) Tobacco Use Assessment Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months. b) Tobacco Cessation Intervention Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.</p> <p>Population Criteria 1: Numerator 1: <input type="text"/> Denominator 1: <input type="text"/> Numerator 2: <input type="text"/> Denominator 2: <input type="text"/></p>
3	<p>Objective: NQF0421 - Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.</p> <p>Population Criteria 1: Numerator 1: <input type="text"/> Denominator 1: <input type="text"/> Exclusion1: <input type="text"/></p> <p>Population Criteria 2: Numerator 1: <input type="text"/> Denominator 1: <input type="text"/> Exclusion1: <input type="text"/></p> <p style="text-align: center;"><input type="button" value="OK"/> <input type="button" value="Cancel"/></p>

Contact Us

Provider Information:
5-974-3071 or 515-974-3123
incentives@dhs.state.ia.us

Quick Links

[IS EHR Incentive Program Review](#)

[Certified Health IT Product List \(HPL\)](#)

[IS Meaningful Use Calculator](#)



Figure 61: Stage 2 CQMs selection screen mock-up

Meaningful Use Clinical Quality Measures

Instructions:

You must attest to a total of 9 CQMs covering at least 3 domains from the list below. Providers should select CQMs that best apply to their scope of practice and/or unique patient population. CMS has identified two core sets of CQMs, one for adults and one for children. Providers are encouraged to report to one of the recommended sets to the extent those CQMs are applicable. If a provider's CEHRT does not contain patient data for at least 9 CQMs covering three domains, then the provider must report the CQMs for which there is patient data and report the remaining CQMs as "zero denominators" as displayed by the CEHRT.

Use the radio buttons below to select to attest to the recommended Core CQMs if they apply to the scope or your practice and/or unique patient population. If neither option applies you may choose to manually select the appropriate CQMs.

CMS Recommended Core CQMs					
Adult Patient Population			Pediatric Patient Population		
eCQM ID	NQF #	CQM Title	eCQM ID	NQF #	CQM Title
CMS165v1	NQF 0018	Controlling High Blood Pressure	CMS146v1	NQF 0002	Appropriate Testing for Children with Pharyngitis
CMS156v1	NQF 0022	Use of High-Risk Medications in the Elderly	CMS155v1	NQF 0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
CMS138v1	NQF 0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS153v1	NQF 0033	Chlamydia Screening for Women
CMS166v1	NQF 0052	Use of Imaging Studies for Low Back Pain	CMS126v1	NQF 0036	Use of Appropriate Medications for Asthma
CMS2v1	NQF 0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	CMS117v1	NQF 0038	Childhood Immunization Status
CMS68v1	NQF 0419	Documentation of Current Medications in the Medical Record	CMS154v1	NQF 0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
CMS69v1	NQF 0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS136v1	NQF 0108	ADHD: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication
CMS50v1	TBD	Closing the referral loop: receipt of specialist report	CMS2v1	NQF 0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
CMS90v1	TBD	Functional status assessment for complex chronic conditions	CMS75v1	TBD	Children who have dental decay or cavities

Adult Patient Population
 Pediatric Patient Population
 Manual Selection

OK

Cancel



Figure 62: Stage 2 Provider opts to manually select CQMs screen mock-up

Instructions:
 You must attest to a total of 9 CQMs covering at least 3 domains from the list below. Providers should select CQMs that best apply to their scope of practice and/or unique patient population. If a provider’s CEHRT does not contain patient data for at least 9 CQMs covering three domains, then the provider must report the CQMs for which there is patient data and report the remaining CQMs as “zero denominators” as displayed by the CEHRT.

CQM Selection				
Select	NQF #	eCQM #	Title	Domain
<input type="checkbox"/>	NQF0002	CMS146v2	Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources.
<input type="checkbox"/>	NQF0004	CMS137v2	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Clinical Process/ Effectiveness.
<input type="checkbox"/>	NQF0018	CMS165v2	Controlling High Blood Pressure	Clinical Process/ Effectiveness.
<input type="checkbox"/>	NQF0022	CMS156v2	Use of High-Risk Medications in the Elderly	Patient Safety.
<input type="checkbox"/>	NQF0024	CMS155v2	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Population/Public Health.
<input type="checkbox"/>	NQF0028	CMS138v2	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Population/Public Health.
<input type="checkbox"/>	NQF0031	CMS125v2	Breast Cancer Screening	Clinical Process/ Effectiveness.
<input type="checkbox"/>	NQF0032	CMS124v2	Cervical Cancer Screening	Clinical Process/ Effectiveness.
<input type="checkbox"/>	NQF0033	CMS153v2	Chlamydia Screening for Women	Population/Public Health.
<input type="checkbox"/>	NQF0034	CMS130v2	Colorectal Cancer Screening	Clinical Process/ Effectiveness.
<input type="checkbox"/>	NQF0036	CMS126v2	Use of Appropriate Medications for Asthma	Clinical Process/ Effectiveness.
<input type="checkbox"/>	NQF0038	CMS117v2	Childhood Immunization Status	Population/Public Health.



Figure 63: Stage 2 Sample CQM screen mock-up

Meaningful Use Clinical Quality Measures			
Instructions: Please complete the information for the selected CQMs. Providers should select CQMs that best apply to their scope of practice and/or unique patient population. Providers should report on CQMs for which there is sufficient patient data available in their CEHRT. If an EP's CEHRT does not contain patient data for at least 9 CQMs covering at least 3 domains, then the EP must report the CQMs for which there is patient data and report the remaining required CQMs as "zero denominators" as displayed by the EP's CEHRT. If there are no CQMs applicable to the EP's scope of practice and patient population, EPs must still report 9 CQMs even if zero is the result in either the numerator or the denominator of the measure. If all applicable CQMs have a value of zero from their CEHRT, then EPs must report any 9 CQMs.			
3	NQF#:	NQF0018	eCQM #: CMS165v2 Domain: Clinical Process/ Effectiveness
Title: Controlling High Blood Pressure			
Description: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.			
Numerator <input type="text"/>		Denominator <input type="text"/>	Exclusion <input type="text"/>
4	NQF#:	NQF0022	eCQM #: CMS156v2 Domain: Population/Public Health.
Title: Use of High-Risk Medications in the Elderly			
Description: 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.			
Numerator 1: Patients who were ordered at least one high-risk medication <input type="text"/>		Numerator 2 <input type="text"/>	Denominator 1 <input type="text"/>
62	NQF#:	NQFXXXX	eCQM #: CMS90v3 Domain: Patient and Family Engagement.
Title: Functional status assessment for complex chronic conditions			
Description: Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments			
Numerator <input type="text"/>		Denominator <input type="text"/>	Exclusions <input type="text"/>
No Documents Found			
<input type="button" value="Add Document"/>		<input type="button" value="OK"/>	<input type="button" value="Cancel"/>

Alternate Clinical Quality Measures

Instructions: You have entered a denominator of zero for one of your Core Clinical Quality Measures. You must submit one Alternate Clinical Quality Measure. Please select one Alternate Clinical Quality Measure from the list below.

Note: An Alternate Clinical Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.

Measure#	Title	Description	Selection
NQF 0024	Weight Assessment and Counseling for Children and Adolescents	Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for	



		nutrition and counseling for physical activity during the measurement year.	
NQF 0041 / PQRS 110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	
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); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	

Instructions: You have entered a denominator of zero for two of your Core Clinical Quality Measures. You must submit two Alternate Clinical Quality Measures. Please select two Alternate Clinical Quality Measures from the list below. Note: An Alternate Clinical Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.

Measure#	Title	Description	Selection
NQF 0024	Weight Assessment and Counseling for Children and	Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI	



	Adolescents	percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	
NQF 0041 / PQRS 110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	
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); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	

Instructions: You have entered a denominator of zero for all of your Core Clinical Quality Measures. You must submit all of the Alternate Clinical Quality Measures. Please select all of the Alternate Clinical Quality Measures from the list below. Note: An Alternate Clinical Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.

Measure#	Title	Description
NQF 0024	Weight Assessment and Counseling for Children and	Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the



	Adolescents	measurement year.
NQF 0041 / PQRS 110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
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); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

NQF 0024

Title: Weight Assessment and Counseling for Children and Adolescents

Description: Percentage of patients 2 -17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Complete the following information:

Population Criteria 1	Denominator:	Numerator 1:
	Denominator:	Numerator 2:
	Denominator:	Numerator 3:
Population Criteria 2	Denominator:	Numerator 1:
	Denominator:	Numerator 2:
	Denominator:	Numerator 3:
Population Criteria 3	Denominator:	Numerator 1:
	Denominator:	Numerator 2:
	Denominator:	Numerator 3:

NQF 0041 / PQRI 110

Title: Preventive Care and Screening: Influenza Immunization for Patients 50 Years Old

Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).

Complete the following information:

Denominator:	Numerator:	Exclusion:
--------------	------------	------------

NQF 0038

Title: Childhood Immunization Status

Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.

Complete the following information:

Denominator:	Numerator 1:	Denominator:	Numerator 7:
Denominator:	Numerator 2:	Denominator:	Numerator 8:
Denominator:	Numerator 3:	Denominator:	Numerator 9:
Denominator:	Numerator 4:	Denominator:	Numerator 10:
Denominator:	Numerator 5:	Denominator:	Numerator 11:
Denominator:	Numerator 6:	Denominator:	Numerator 12:

Additional Clinical Quality Measures

Instructions: Select three Additional Clinical Quality Measures from the list below. You will be prompted to enter numerator(s), denominator(s), and exclusion(s), if applicable, for all three Additional Clinical Quality Measures after you select the CONTINUE button below.

Measure#	Title	Description	Notes
NQF 0001 / PQRI 64	Asthma Assessment	Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.	Removed for 2014
NQF 0002 / PQRI 66	Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.	



NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement	Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	
NQF 0012	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.	Removed for 2014
NQF 0014	Prenatal Care: Anti-D Immune Globulin	Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.	Removed for 2014
NQF 0018	Controlling High Blood Pressure	The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.	
NQF 0022	Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medication. Two rates are reported. a) Percentage of patients	New in 2014



		<p>who were ordered at least one high-risk medication.</p> <p>b) Percentage of patients who were ordered at least two different high-risk medications.</p>	
NQF 0027 / PQRI 115	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies	Percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.	Removed in 2014
NQF 0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	
NQF 0031 / PQRI 112	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	
NQF 0032	Cervical Cancer Screening	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	
NQF 0033	Chlamydia Screening for Women	Percentage of women 15- 24 years of age who were identified as sexually active and who had at least one	



		test for chlamydia during the measurement year.	
NQF 0034 / PQRI 113	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	
NQF 0036	Use of Appropriate Medications for Asthma	Percentage of patients 5 - 64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year.	Updated in 2014
NQF 0043 / PQRI 111	Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	
NQF 0047 / PQRI 53	Asthma Pharmacologic Therapy	Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.	Removed in 2014
NQF 0052	Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 of age with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.	Updated in 2014
NQF 0055 / PQRI 117	Diabetes: Eye Exam	Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the 12	Updated in 2014



		months prior to the measurement period.	
NQF 0056 / PQRI 163	Diabetes: Foot Exam	The percentage of patients aged 18 - 75 years with diabetes who had a foot exam during the measurement period.	Updated in 2014
NQF 0059 / PQRI 1	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18 - 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Updated in 2014
NQF 0060	Hemoglobin A1c Test for Pediatric Patients	Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period.	New in 2014
NQF 0061 / PQRI 3	Diabetes: Blood Pressure Management	Percentage of patients 18 - 75 years of age with diabetes (type 1 or type 2) who had blood pressure <140/90 mmHg.	Removed in 2014.
NQF 0062 / PQRI 119	Diabetes: Urine Protein Screening	Percentage of patients 18 - 75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	Updated in 2104
NQF 0064 / PQRI 2	Diabetes Low Density Lipoprotein (LDL) Management and Control	Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (< 100 mg/dL) during the measurement period.	Updated in 2014
NQF 0067 / PQRI 6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.	Removed in 2014
NQF 0068 / PQRI 204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction	Updated in 2014



		(AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) in the prior 12 months to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, who had documentation of use of aspirin or another antithrombotic during the measurement period.	
NQF 0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months to 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic on or three days after the episode.	New in 2014
NQF 0070 / PQRI 7	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.	Updated in 2014
NQF 0073 / PQRI 201	Ischemic Vascular Disease (IVD): Blood Pressure Management	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous	Removed in 2014



		transluminal coronary angioplasty (PTCA) from January 1- November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose recent blood pressure is in control (<140/90 mmHg).	
NQF 0074 / PQRI 197	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).	Removed in 2014
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (<100 mg/dL).	Updated in 2014
NQF 0081 / PQRI 5	Heart Failure (HF): Angiotensin- Converting Enzyme (ACE) Inhibitor	Percentage of patients aged 18 years and older with a diagnosis of heart failure	Updated in 2014



	or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	(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.	
NQF 0083 / PQRI 8	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%) and who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting or at each hospital discharge.	Updated in 2014
NQF 0084 / PQRI 200	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation	Percentage of all patients aged 18 years and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.	Removed in 2014
NQF 0086 / PQRI 12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have an optic nerve head evaluation during one or more office visits within 12 months.	Updated in 2014
NQF 0088 / PQRI 18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of	



		retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	
NQF 0089 / PQRI 19	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.	
NQF 0101	Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	New in 2014
NQF 0104	Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.	New in 2014
NQF 0105 / PQRI 9	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment	Percentage of patients 18 years of age and older who were diagnosed with major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Percentage of patients who remained on an	Updated in 2014



		<p>antidepressant medication for at least 84 days (12 weeks).</p> <p>b) Percentage of patients who remained on an antidepressant medication for least 180 days (6 months).</p>	
NQF 0108	ADHD: Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	<p>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.</p> <p>a) Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.</p> <p>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.</p>	New in 2014
NQF 0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance abuse	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for	New in 2014



		alcohol or chemical substance use.	
NQF 0384	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.	New in 2014
NQF 0385 / PQRI 72	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period.	Updated in 2014
NQF 0387 / PQRI 71	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.	
NQF 0389 / PQRI 102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging LowRisk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	
NQF 0403	HIV/AIDS: Medical Visit	Percentage of patients,	New in 2014



		regardless of age, which a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.	
NQF 0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) prophylaxis	Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis	New in 2014
TBD (Proposed as NQF 0407)	HIV/AIDS: RNA control for Patients with HIV	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL.	New in 2014
NQF 0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.	New in 2014
NQF 0419	Documentation of Current Medications in the Medical Record	Percentage of specified visits for patients aged 18 and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list <u>must</u> include all prescriptions, over-the-counters, herbals, and	New in 2014



		<p>vitamin/mineral/dietary (nutritional) supplements AND <u>must</u> contain the medications' name, dosage, frequency and route of administration.</p>	
NQF 0421	<p>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up</p>	<p>Percentage of patients aged 18 years and older with an encounter during the reporting period with a documented calculated BMI during the encounter or during the previous six months AND when the BMI is outside the normal parameters, follow-up plan is documented during the encounter or during the previous 6 months of the encounter with the BMI outside of normal parameters.</p> <p>Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30</p> <p>Age 18-64 years BMI ≥ 18.5 and < 25</p>	New in 2014
NQF 0564	<p>Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures</p>	<p>Percentage of patients aged 18 and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated</p>	New in 2014



		or wrong power IOL, retinal detachment, or wound dehiscence.	
NQF 0565	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.	New in 2014
NQF 0575	Diabetes: Hemoglobin A1c Control (<8.0%)	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c <8.0%.	Removed in 2014
NQF 0608	Pregnant women that had HBsAg testing	This measure identifies pregnant women who had a HBsAg (hepatitis b) test during their pregnancy.	New in 2014
NQF 0710	Depression Remission at Twelve Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	New in 2014
NQF 0712	Depression Utilization of the PHQ-9 Tool	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-	New in 2014



		9 tool administered at least once during a 4 month period in which there was a qualifying visit.	
NQF TBD	Children who have dental decay or cavities	Percentage of children ages 0-20 years, who have had tooth decay or cavities during the measurement period.	New in 2014
NQF 1365	Child and Adolescent Major Depressive Disorder: 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.	New in 2014
NQF 1401	Maternal depression screening	The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.	New in 2014
NQF TBD	Primary Care Prevention Intervention as Offered by Primary Care Providers, including Dentists	Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	New in 2014
NQF TBD	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed	Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.	New in 2014
NQF TBD	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)	Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.	New in 2014



NQF TBD	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.	New in 2014
NQF TBD	Hypertension: Improvement in blood pressure	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	New in 2014
NQF TBD	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.	New in 2014
NQF TBD	Functional status assessment for knee replacement	Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	New in 2014
NQF TBD	Functional status assessment for hip replacement	Percentage of patients aged 18 years and older with primary total hip arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	New in 2014
NQF TBD	Functional status assessment for complex chronic conditions	Percentage of patients aged 65 and older with heart failure who completed initial and follow-up patient-reported function status assessments.	New in 2014
NQF TBD	ADE Prevention and	Average percentage of time	New in 2014



	Monitoring: Warfarin Time in Therapeutic Range	in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.	
NQF TBD	Preventive Care and Screening for High Blood Pressure and Follow-Up Documented	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	New in 2014



Eligible Hospitals

The following screenshots show changes for Stage 2 Meaningful Use Attestations for eligible hospitals. These are mock-ups only as we have not completed development on the Stage 2 screens. Once production-ready screenshots are available, we will provide an update.

EH Core Set Screen Shots – Stage 2

Figure 64: CPOE for Medication, Laboratory, and Radiology Orders

1 § 495.6 (1)(1)(i)	Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	
	More	
	Measure: More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	
	Exclusion: None	
	Measure 1 - Medication:	
	Numerator: The number of orders in the denominator recorded using CPOE.	<input type="text"/>
	Denominator: Number of medication orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	<input type="text"/>
	Percentage:	<input type="text"/>
	Measure 2 - Radiology:	
	Numerator: The number of orders in the denominator recorded using CPOE.	<input type="text"/>
Denominator: Number of radiology orders created by the EP or authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.	<input type="text"/>	
Percentage:	<input type="text"/>	
Measure 3 - Laboratory:		
Numerator: The number of orders in the denominator recorded using CPOE.	<input type="text"/>	
Denominator: Number of laboratory orders created by the EP or authorized providers in the eligible hospital's	<input type="text"/>	
Percentage:	<input type="text"/>	



Figure 65: Record demographics

<p style="text-align: center;">2</p> <p>§ 495.6 (1)(2)(i)</p>	<p>Objective: Record all of the following demographics: preferred language, sex, race, ethnicity, date of birth, date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.</p>			
	<p>More</p>			
	<p>Measure: More than 80 percent of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have demographics recorded as structured data.</p>			
	<p>Exclusion: None</p> <p>Numerator: The number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.</p> <p>Denominator: Number of unique patients seen by the EP or admitted to an eligible hospital or CAH inpatient or emergency department (POS 21 or 23) during the EHR reporting period.</p>	<p>Percentage:</p> <table border="1" style="width: 100px; height: 30px; margin-left: auto;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		

Figure 66: Record Vital Signs

<p style="text-align: center;">3</p> <p>§ 495.6 (1)(3)(i)</p>	<p>Objective: Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.</p>			
	<p>More</p>			
	<p>Measure: More than 80 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and/or height/length and weight (for all ages) recorded as structured data.</p>			
	<p>Exclusion: None</p> <p>Numerator: Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.</p> <p>Denominator: Number of unique patients seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period</p>	<p>Percentage:</p> <table border="1" style="width: 100px; height: 30px; margin-left: auto;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		



Figure 67: Record smoking status

<p style="text-align: center;">4</p> <p>§ 495.6 (1)(4)(i)</p>	Objective: Record smoking status for patients 13 years old or older.
	More
	Measure: More than 80 percent of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period have smoking status recorded as structured data.
	Exclusion: Any eligible hospital or CAH that neither sees nor admits any patients 13 years old or older.
	Does the exclusion apply to you? <input type="radio"/> Yes <input type="radio"/> No
Numerator: The number of patients in the denominator with smoking status recorded as structured data.	
Denominator: Number of unique patients age 13 or older seen by the EP or admitted to an eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	
	Percentage:

Figure 68: Clinical Decision Support Rule

<p style="text-align: center;">5</p> <p>§ 495.6 (1)(5)(i)</p>	Objective: Use clinical decision support to improve performance on high-priority health conditions.
	More
	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an eligible hospital or CAH's patient population, the clinical decision support interventions must be related to high-priority health conditions. It is suggested that one of the five clinical decision support interventions be related to improving healthcare efficiency.
	Measure 2: The eligible hospital or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
	Exclusion: No exclusion.
Did you meet the criteria for measure 1?	<input type="radio"/> Yes <input type="radio"/> No
Did you meet the criteria for measure 2?	<input type="radio"/> Yes <input type="radio"/> No



Figure 69: Patient Electronic Access

<p>6</p> <p>§ 495.6 (1)(8)(i)</p>	<p>Objective: Provide patients the ability to view online, download, and transmit information about a hospital admission.</p>	
	<p>More</p>	
	<p>Measure 1: More than 50 percent of all unique patients discharged from the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) during the EHR reporting period have their information available online within 36 hours of discharge.</p>	
	<p>Measure 2: More than 5 percent of all unique patients (or their authorized representatives) who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the EHR reporting period.</p>	
	<p>Measure 1</p> <p>Numerator: The number of patients in the denominator whose information is available online within 36 hours of discharge.</p>	<input type="text"/> <input type="text"/> <input type="text"/>
	<p>Denominator: Number of unique patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.</p>	<p>Percentage:</p> <input type="text"/> <input type="text"/>
<p>Measure 2</p> <p>Exclusion: Any eligible hospital or CAH that is located in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period is excluded from the second measure.</p> <p>Does the exclusion to Measure 2 apply to you? <input type="radio"/> Yes <input type="radio"/> No</p>		
<p>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 discharge information provided by the eligible hospital or CAH.</p>	<input type="text"/> <input type="text"/> <input type="text"/>	
<p>Denominator: Number of unique patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.</p>	<p>Percentage:</p> <input type="text"/> <input type="text"/>	



Figure 70: Patient Electronic Health Information

<p style="text-align: center;">7</p> <p>§ 495.6 (I)(15)(i)</p>	<p>Objective: Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.</p>
	<p>More</p>
	<p>Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs</p>
	<p>Exclusion: None</p> <p>Did you meet the criteria for measure? <input type="radio"/> Yes <input type="radio"/> No</p>

Figure 71: Clinical Lab Test Results

<p style="text-align: center;">8</p> <p>§ 495.6 (I)(6)(i)</p>	<p>Objective: Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data</p>		
	<p>More</p>		
	<p>Measure: More than 55 percent of all clinical lab tests results ordered by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative affirmation or numerical format are incorporated in Certified EHR Technology as structured data.</p>		
	<p>Exclusion: No Exclusion</p> <p>Numerator: Number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data.</p> <p>Denominator: Number of lab tests ordered during the EHR reporting period by the EP or by authorized providers of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) whose results are expressed in a positive or negative affirmation or as a number.</p> <p style="text-align: right;">Percentage: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td style="width: 50px; height: 20px;"></td></tr><tr><td style="width: 50px; height: 20px;"></td></tr><tr><td style="width: 50px; height: 20px;"></td></tr></table></p>		



Figure 72: Patient Lists

9 § 495.6 (1)(6)(i)	Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach. More
	Measure: Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.
	Exclusion: None
	Did you meet the criteria for this measure? <input type="radio"/> Yes <input type="radio"/> No

Figure 73: Patient Specific Education Resources

10 § 495.6 (1)(9)(i)	Objective: Use clinically relevant information from Certified EHR Technology to identify patient specific education resources and provide those resources to the patient. More
	Measure: More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient-specific education resources identified by Certified EHR Technology.
	Exclusion: No exclusion.
	Numerator: Number of patients in the denominator who are subsequently provided patient-specific education resources identified by CEHRT.
	Denominator: Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.

Percentage:



Figure 74: Medication Reconciliation

11 § 495.6 (I)(10)(i)	Objective: The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
	More
	Measure: The eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).
	Exclusion: No exclusion.
	Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.
	Denominator: Number of transitions of care during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the receiving party of the transition.
	Percentage: <input type="text"/> <input type="text"/> <input type="text"/>



Figure 75: Summary of Care

<p>12</p> <p>§ 495.6 (I)(11)(i)</p>	<p>Objective: The eligible hospital or CAH 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.</p> <p>More</p> <p>Measure 1: The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals.</p> <p>Measure 2: The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network.</p> <p>Measure 3: The eligible hospital or CAH must satisfy one of the two following criteria: * Conducts one or more successful electronic exchanges of a summary of care document, which is counted in "measure 2" (for eligible hospitals and CAHs the measure at §495.6(I)(11)(ii)(B)) with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2); or * Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.</p> <p>Exclusion: No exclusion</p>	
	<p>Measure 1: Medication</p> <p>Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was provided.</p> <p>Denominator: Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider. Percentage:</p>	<input type="text"/> <input type="text"/> <input type="text"/>
	<p>Measure 2: Radiology</p> <p>Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization.</p> <p>Denominator: Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) was the transferring or referring provider. Percentage:</p>	<input type="text"/> <input type="text"/> <input type="text"/>
	<p>Measure 3: Laboratory</p> <p>Did you meet the criteria for this measure?</p>	<p>O Yes O No</p>



Figure 76: Immunization Registries Data Submission

<p>13 § 495.6 (I)(12)(i)</p>	<p>Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.</p>
	<p>More</p>
	<p>Measure: Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.</p>
	<p>Exclusion: Any eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective:</p> <p>(1) The eligible hospital or CAH does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;</p> <p>(2) The eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for Certified EHR Technology at the start of their EHR reporting period;</p> <p>(3) The eligible hospital or CAH operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or</p> <p>(4) The eligible hospital or CAH operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.</p>
	<p>Does the exclusion 1 apply to you? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Does the exclusion 2 apply to you? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Does the exclusion 3 apply to you? <input type="radio"/> Yes <input type="radio"/> No</p> <p>Does the exclusion 4 apply to you? <input type="radio"/> Yes <input type="radio"/> No</p>
	<p>Did you meet the criteria for this measure? <input type="radio"/> Yes <input type="radio"/> No</p>



Figure 77: Electronic Reportable Laboratory Results

14 § 495.6 (I)(12)(i)	Objective: Capability to submit electronic reportable laboratory results to public health agencies, where except where prohibited, and in accordance with applicable law and practice.
	More
	Measure: Successful ongoing submission of electronic reportable laboratory results from Certified EHR Technology to a public health agency for the entire EHR reporting period.
	Exclusion: Any eligible hospital or CAH that meets one or more of the following criteria: (A) Operates in a jurisdiction for which no public health agency is capable of receiving electronic reportable laboratory results in the specific standards required for Certified EHR Technology at the start of their EHR reporting period. (B) Operates in a jurisdiction for which no public health agency provides information timely on capability to receive electronic reportable laboratory results. (C) Operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.
	Does the exclusion 1 apply to you? <input type="radio"/> Yes <input type="radio"/> No
	Does the exclusion 2 apply to you? <input type="radio"/> Yes <input type="radio"/> No
Does the exclusion 3 apply to you? <input type="radio"/> Yes <input type="radio"/> No	
Did you meet the criteria for this measure?	<input type="radio"/> Yes <input type="radio"/> No



Figure 78: Syndromic Surveillance Data Submission

15 § 495.6 (I)(14)(i)	Objective: Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice.
	More
	Measure: Successful ongoing submission of electronic syndromic surveillance data from Certified EHR Technology to a public health agency for the entire EHR reporting period.
	Exclusion: Any eligible hospital or CAH that meets one or more of the following criteria may be excluded from this objective: (1) Does not have an emergency or urgent care department; (2) Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required by Certified EHR Technology at the start of their EHR reporting period; (3) Operates in a jurisdiction where no public health agency provides information timely on capability to receive syndromic surveillance data; or (4) Operates in a jurisdiction for which no public health agency that is capable of accepting the specific standards required by Certified EHR Technology at the start of their EHR reporting period can enroll additional eligible hospitals or CAHs.
	Does exclusion 1 apply to you? <input type="radio"/> Yes <input type="radio"/> No
	Does exclusion 2 apply to you? <input type="radio"/> Yes <input type="radio"/> No
	Does exclusion 3 apply to you? <input type="radio"/> Yes <input type="radio"/> No
	Does exclusion 4 apply to you? <input type="radio"/> Yes <input type="radio"/> No
	Did you meet the criteria for this measure? <input type="radio"/> Yes <input type="radio"/> No



Figure 79: Electronic Medication Administration Record (eMAR)

16 § 495.6 (I)(16)(i)	Objective: Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication administration record (eMAR).
	More
	Measure: More than 10 percent of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period for which all doses are tracked using eMAR.
	Exclusion: Any eligible hospital or CAH with an average daily inpatient census of fewer than 10 patients.
	Does the exclusion apply to you? <input type="radio"/> Yes <input type="radio"/> No
	Numerator: The number of orders in the denominator for which all doses are tracked using eMAR.
	Denominator: Number of medication orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.
	Percentage: <input type="text"/> <input type="text"/> <input type="text"/>

EH Menu Set Screen Shots – Stage 2

The following screenshots are mock-ups of the Stage 2 EH Menu Set selection screens.



Figure 80: EH Meaningful Use Menu Set Selection Screen

Meaningful Use Menu Set Objectives

Instructions:

For Stage 2 Meaningful Use an Eligible Hospital (EH) must meet three (3) of the following objectives and associated measures. While a provider can continue to claim exclusions if applicable for menu objectives, these exclusions will no longer count towards the number of menu objectives needed. If the EH has an exclusion from 4 or more objectives, the EH must meet all remaining objectives and associated measures. Iowa Medicaid Enterprise encourages EHs to select menu objectives that are relevant to their scope of practice, and claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice. EHs may also select more than three measures to which to attest, giving Iowa Enterprise Medicaid with a more complete picture of successes and challenges regarding these measures.

Select at least three objectives from the list below:

Select	Objective
<input type="checkbox"/>	Record whether a patient 65 years old or older has an advance directive.
<input type="checkbox"/>	Record electronic notes in patient records.
<input type="checkbox"/>	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.
<input type="checkbox"/>	Record patient family health history as structured data.
<input type="checkbox"/>	Generate and transmit permissible discharge prescriptions electronically (eRx).
<input type="checkbox"/>	Provide structured electronic lab results to ambulatory providers.

OK Cancel



Figure 81: Advance Directive

1 § 495.6 (m)(1)(i)	Objective: Record whether a patient 65 years old or older has an advance directive.			
	More			
	Measure: More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period have an indication of an advance directive status recorded as structured data.			
	Exclusion: An eligible hospital or CAH that admits no patients age 65 years old or older during the EHR reporting period.			
	Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No			
	Numerator: The number of patients in the denominator who have an indication of an advance directive status entered using structured data.			
	Denominator: The number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.			
	Percentage: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>			

Figure 82: Electronic Notes

2 § 495.6 (m)(5)(i)	Objective: Record electronic notes in patient records.			
	More			
	Measure: Enter at least one electronic progress note created, edited and signed by an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) for more than 30 percent of unique patients admitted to the eligible hospital or CAH's inpatient or emergency department during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.			
	Exclusion: No exclusion			
	Numerator: The number of unique patients in the denominator who have at least one electronic progress note from an authorized provider of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) recorded as text searchable data.			
	Denominator: Number of unique patients admitted to an eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.			
	Percentage: <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>			



Figure 83: Imaging Results

3 § 495.6 (m)(2)(i)	Objective: Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	
	More	
	Measure: More than 10 percent of all tests whose result is one or more images ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period are accessible through Certified EHR Technology .	
	Exclusion: No exclusion.	
	Numerator: The number of results in the denominator that are accessible through Certified EHR Technology.	<input type="text"/>
	Denominator: Number of tests whose result is one or more images ordered by an authorized provider on behalf of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period.	<input type="text"/>
		Percentage: <input type="text"/>

Figure 84: Family Health History

4 § 495.6 (m)(3)(i)	Objective: Record patient family health history as structured data.	
	More	
	Measure: More than 20 percent of all unique patients admitted to the eligible hospital or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have a structured data entry for one or more first-degree relatives.	
	Exclusion: No exclusion.	
	Numerator: The number of patients in the denominator with a structured data entry for one or more first-degree relatives.	<input type="text"/>
	Denominator: Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) during the EHR reporting period.	<input type="text"/>
		Percentage: <input type="text"/>



Figure 85: ePrescribing

5 § 495.6 (m)(4)(i)	Objective: Generate and transmit permissible discharge prescriptions electronically (eRx).	
	More	
	Measure: More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new, changed, and refilled prescriptions) are queried for a drug formulary and transmitted electronically using certified EHR technology.	
	Exclusion: Does not have an internal pharmacy that can accept electronic prescriptions and is not located within 10 miles of any pharmacy that accepts electronic prescriptions at the start of their EHR reporting period.	
	Does the exclusion apply to you: <input type="radio"/> Yes <input type="radio"/> No	
	Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically.	
	Denominator: Number of new, changed, or refill prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances for patients discharged during the EHR reporting period.	Percentage: <input type="text"/> <input type="text"/> <input type="text"/>

Figure 86: Lab Results to Ambulatory Providers

6 § 495.6 (m)(6)(i)	Objective: Provide structured electronic lab results to ambulatory providers.	
	More	
	Measure: Hospital labs send structured electronic clinical lab results to the ordering provider for more than 20 percent of electronic lab orders received.	
	Exclusion: No exclusion. any pharmacy that accepts electronic prescriptions at the start of their EHR reporting period.	
	Numerator: The number of structured clinical lab results sent to the ordering provider.	
	Denominator: The number of electronic lab orders received.	Percentage: <input type="text"/> <input type="text"/> <input type="text"/>



Clinical Quality Measures

In 2014, EH must report on 16 out of 29 CQMs covering at least 3 domains from the following areas:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Processes/Effectiveness



EH CQM Selection

Figure 87: EH CQM selection Screen

Instructions:
 You must attest to a total of 16 CQMs covering at least 3 domains from the list below. Providers should select CQMs that best apply to their scope of practice and/or unique patient population. If a provider’s CEHRT does not contain patient data for at least 16 CQMs covering three domains, then the provider must report the CQMs for which there is patient data and report the remaining CQMs as “zero denominators” as displayed by the CEHRT.

CQM Selection				
Select	NQF #	eCQM #	Title	Domain
<input type="checkbox"/>	NQF0495	CMS55v2	Emergency Department (ED)-1 Emergency Department Throughput – Median time from ED arrival to ED departure for admitted ED patients	Patient and Family Engagement
<input type="checkbox"/>	NQF0497	CMS111v2	Emergency Department (ED)-2 Emergency Department Throughput – admitted patients – Admit decision time to ED departure time for admitted patients	Patients and Family Engagement
<input type="checkbox"/>	NQF0435	CMS104v3	Stroke-2 Ischemic stroke – Discharged on anti-thrombotic therapy.	Clinical Process/ Effectiveness
<input type="checkbox"/>	NQF0436	CMS71v3	Stroke-3 Ischemic stroke – Anticoagulation Therapy for Atrial Fibrillation/Flutter	Clinical Process/ Effectiveness
<input type="checkbox"/>	NQF0437	CMS91v3	Stroke-4 Ischemic stroke – Thrombolytic Therapy	Clinical Process/ Effectiveness
<input type="checkbox"/>	NQF0438	CMS72v3	Stroke-5 Ischemic stroke – Antithrombotic therapy by end of hospital day two	Clinical Process/ Effectiveness
<input type="checkbox"/>	NQF0439	CMS105v3	Stroke-6 Ischemic stroke – Discharged on Statin Medication	Clinical Process/ Effectiveness
<input type="checkbox"/>	NQF0440	CMS107v3	Stroke-8 Ischemic or hemorrhagic stroke – Stroke education	Patient and Family Engagement
<input type="checkbox"/>	NQF0441	CMS102v1	Stroke-10 Ischemic or hemorrhagic stroke – Assessed for Rehabilitation	Care Coordination
<input type="checkbox"/>	NQF0371	CMS108v2	Venous Thromboembolism (VTE)-1 VTE prophylaxis	Patient Safety
<input type="checkbox"/>	NQF0372	CMS190v2	VTE-2 Intensive Care Unit (ICU) VTE prophylaxis	Patient Safety
<input type="checkbox"/>	NQF0373	CMS73v2	VTE-3 VTE Patients with Anticoagulation Overlap Therapy	Clinical Process/ Effectiveness
<input type="checkbox"/>	NQF0374	CMS73v2	VTE-4 VTE Patients Receiving Unfractionated Heparin (UFH) with Doses/Platelet	Clinical Process/ Effectiveness



Figure 88: Sample CQM Screen Mock-up

Meaningful Use Clinical Quality Measures							
Instructions: Please complete the information for the selected CQMs. Providers should select CQMs that best apply to their scope of practice and/or unique patient population. Providers should report on CQMs for which there is sufficient patient data available in their CEHRT. If an EP's CEHRT does not contain patient data for at least 9 CQMs covering at least 3 domains, then the EP must report the CQMs for which there is patient data and report the remaining required CQMs as "zero denominators" as displayed by the EP's CEHRT. If there are no CQMs applicable to the EP's scope of practice and patient population, EPs must still report 9 CQMs even if zero is the result in either the numerator or the denominator of the measure. If all applicable CQMs have a value of zero from their CEHRT, then EPs must report any 9 CQMs.							
3	NQF#:	NQF0018	eCQM #:	CMS165v2	Domain:	Clinical Process/ Effectiveness	
Title: Controlling High Blood Pressure							
Description: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.							
		Numerator	<input type="text"/>	Denominator	<input type="text"/>	Exclusion	<input type="text"/>
4	NQF#:	NQF0022	eCQM #:	CMS156v2	Domain:	Population/Public Health.	
Title: Use of High-Risk Medications in the Elderly							
Description: 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.							
		Numerator 1:	Patients who were ordered at least one high-risk medication	Numerator 1:	<input type="text"/>	Denominator 1:	<input type="text"/>
62	NQF#:	NQFXXXX	eCQM #:	CMS90v3	Domain:	Patient and Family Engagement.	
Title: Functional status assessment for complex chronic conditions							
Description: Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments							
		Numerator	<input type="text"/>	Denominator	<input type="text"/>	Exclusions	<input type="text"/>
No Documents Found							
<input type="button" value="Add Document"/>		<input type="button" value="OK"/>		<input type="button" value="Cancel"/>			



Appendix G: Lessons Learned from Administering EHR incentive program

Providers

- Hospitals need an **online** PECOS account. This one came up early as our pilot hospital was unable to proceed at the CMS R&A site because they didn't have their PECOS account setup for online access. Obtaining the online account took several weeks and significantly delayed payment to this hospital. As IME identifies additional hospitals eligible for the incentives, this is still an ongoing issue.
- Hospitals need to know which fiscal year to use for what purpose. There is much confusion on the difference between payment year and which fiscal year to use for patient volume and when supplying the figures needed for the hospital incentive calculation. The final rule leaves several areas of discretion to states on determining what fiscal year to use for what purpose and states must be clear on communicating these differences to providers.
- Have your NPPES login information handy. Because it has been several years since providers obtained their NPI, they may no longer have the NPPES login credentials necessary to access the CMS R&A site.
- Know your CMS EHR certification number. Early on there was much confusion between this number and the ONC certification number. Iowa had several providers who had an ONC module certified, but not a complete EHR. Removal of the ONC number from the CHPL has reduced this confusion. A few providers are confusing the EHR certification number with the CMS registration number from the CMS R&A site, but this happens infrequently.
- Use the correct NPI. Iowa had one hospital register as a hospital, but used their clinic NPI.
- Think carefully if you are going to use clinic level or individual level approach. Providers need to understand that whichever approach they use applies to all EPs in the clinic. Iowa had a group of EPs using the individual level, but they applied at different times. The last EP to apply realized he didn't meet the patient volume requirement on his own, but would have if they had used the clinic level approach. Iowa defines "clinic" as being a separate billing NPI, tax id, or physical location.
- Know your 90-day period and use the correct year. Despite clear guidance on this, Iowa continues to receive applications in which the providers use a 90-day period from the incorrect year. However, the new PIPP system contains edits that are helping to alleviate this issue.



- Work with a vendor to get proof of volume. Providers report some difficulty in determining how to calculate patient volume. Iowa encourages them to talk to their vendors to help determine this figure. However, IME continues to hear from the REC and from providers that their EHRs do not contain patient encounter information. That information is stored in their practice management system that isn't as robust as the EHR. Often, even when there is a patient report, the systems are not able to report on encounters where Medicaid paid as a secondary payor. IME is flexible in working with providers to help them calculate the numerator.
- Make sure the EPs are enrolled if they are supposed to be. This is an issue requiring an understanding of your state's Medicaid enrollment rules. Iowa has some provider types who cannot enroll (i.e., physician assistants) and there are some providers who are not required to enroll (such as nurse practitioners working under physician-supervision, or EPs practicing in an FQHC or RHC). When Iowa receives an application from an EP whose NPI is not in the MMIS, EHR staff must research if the EP is in compliance with the IME's enrollment rules.

State Medicaid Agency

An ongoing challenge for the IME has been identifying all of the state options and making sure that these options are included in the State administrative rule. This list continues to evolve and affect our rule, which has already been amended once. Our current list of state options includes:

- Pediatrician definition
- Clinic definition
- Which fiscal year to use for hospital patient volume
- Timeframe for average length of patient stay
- Payment methodology for hospitals
- Zero Paid Encounters Method for calculating patient volume

Other administrative application processing issues are:

- Providers who are not enrolled in the Medicaid program. As stated earlier, the IME does not require certain providers to be enrolled even though they are treating Medicaid patients. A step in the IME provider enrollment process is for providers to sign the Provider Agreement. The IME making payments to EPs who are not under the obligations of the current provider agreement caused the IME to develop a separate agreement specifically for



those EPs who were not under the general provider agreement. A copy of this additional agreement is included in Appendix H.

- An assumption in the planning phase was that the IME would be able to validate the numerator in the patient volume calculation. It quickly became apparent that we would need to rely on provider records, even for the numerator. This is the case most frequently identified for the OB providers who submit one claim for the bundled services at the end of a pregnancy and for providers who bill as a clinic, such as the FQHC, RHC and family planning clinics. This is another example where EPs who are not enrolled in the Medicaid program become more problematic. We also recently discovered that we do not receive the rendering provider's NPI on cross-over claims received from Medicare. Validation of these encounters requires the provider to supply the member ID and date of service so that IME can verify payment.
- Validating the NPI/tax id (TIN) combination is challenging for some applications. Simply checking the MMIS is not accurate when providers who are enrolled, and therefore bill, with numbers different from those they received from, National Plan and Provider Enumeration System (NPPES). When the NPI was implemented, providers self-reported their NPI to the IME. The IME developed a cross-walk solution to identify the correct legacy number. Providers were able to use either their individual NPI or an organizational NPI in a number of combinations with an organizational TIN or even a social security number. When the IME is unable to validate a TIN/NPI combination on the MMIS, staff accesses the NPPES website for validation, in addition to contacting the provider for any other supporting documentation that might be necessary.

Appendix H: Pre-payment verification for Stage 1 and 2 Meaningful Use

Table 31: Stage 1 Meaningful Use Core Measures Pre-Payment Audit and Review Methods

Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPGMU 02:</p> <p>At least 80% of unique patients must have their data in the certified EHR during the EHR reporting period</p>		<p>Attestation of Numerator / Denominator</p> <p>Denominator- Number of unique patients seen by the EP during the EHR reporting period</p> <p>Numerator- Number of patients in the denominator with data maintained in the CEHRT during the EHR reporting period</p>	No Exclusion	<p>Review denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Must have 80% of unique patient records</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				in the CEHRT
<p>EPCMU 01:</p> <p>4956(d)(1)(i) Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who</p>	<p>More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator - Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period</p> <p>Numerator - The number of patients in the denominator</p>	<p>Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period</p>	<p>Review denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01,</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>can enter orders into the medical record per state, local and professional guidelines</p>		<p>that have at least one medication order entered using CPOE</p> <p>Or</p> <p>Exclusion</p>		<p>EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Verify minimum correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 02:</p> <p>495.6(d)(2)(i) Implement drug-drug and drug-allergy interaction checks</p>	<p>The EP has enabled this functionality for the entire EHR reporting period</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>If documentation is supplied, review using a random sample to confirm.</p>
<p>EPCMU 03:</p> <p>4956(d)(3)(i) Maintain an up-to-date problem list of current and active diagnoses</p>	<p>More than 80 percent of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator- Number of unique patients seen by the EP during the EHR reporting period</p> <p>Numerator- Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list</p>	<p>No Exclusion</p>	<p>Review denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Verify minimum</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				correct percentage is met. If documentation is supplied, review using a random sample to confirm.



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 04:</p> <p>4956(d)(4)(i) Generate and transmit permissible prescriptions electronically (eRx)</p>	<p>More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator - Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period</p> <p>Numerator - Number of prescriptions in the denominator generated and transmitted electronically</p> <p>Or Exclusion</p>	<p>Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period</p>	<p>Verify minimum correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 05: 4956(d)(5)(i) Maintain active medication list</p>	<p>More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator- Number of unique patients seen by the EP during the EHR reporting period</p> <p>Numerator - Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data</p>	<p>No Exclusion</p>	<p>Review denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Verify minimum correct percentage is met.</p> <p>If documentation is supplied, review using a</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				random sample to confirm.



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 06:</p> <p>4956(d)(6)(i) Maintain active medication allergy list</p>	<p>More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator - Number of unique patients seen by the EP during the EHR reporting period</p> <p>Numerator - Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list</p>	<p>No Exclusion</p>	<p>Review denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Verify minimum correct percentage is met.</p> <p>If documentation is supplied,</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				review using a random sample to confirm.
<p>EPCMU 07: 4956(d)(7)(i) Record all of the following demographics: (A) Preferred language (B) Gender (C) Race</p>	<p>More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data</p>	<p>Attestation of Numerator / Denominator Denominator - Number of unique patients seen by the EP during the EHR reporting period</p>	<p>No Exclusion</p>	<p>Review denominator equals the denominator reported for other measures requiring the EP to report the number of</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
(D) Ethnicity (E) Date of birth		Numerator - Number of patients in the denominator who have all the elements of demographics recorded as structured data		unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06) Verify minimum correct percentage is met. If Exclusion is claimed, check if it seems appropriate based for provider type. If documentation is supplied, review using a random sample



Objective	Measure	Reporting Requirement	Exclusion	Review
				to confirm.
<p>EPCMU 08: 4956(d)(8)(i) Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI</p>	<p>The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition</p> <p>Numerator: Number of transitions of care in the denominator where medication reconciliation was performed</p> <p>Or Exclusion</p>	<p>Exclusion 1: Based on ALL patient records: An EP who does not transfer a patient to another setting during the EHR reporting period would be excluded from this requirement</p> <p>Exclusion 2: Based on ALL patient records: An EP who does not refer a patient to another provider during the EHR reporting period would be excluded from this</p>	<p>Verify minimum correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
			requirement	



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 09: 4956(d)(9)(i) Record smoking status for patients 13 years old or older</p>	<p>More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator - Number of unique patients age 13 or older seen by the EP during the EHR reporting period</p> <p>Numerator - Number of patients in the denominator with smoking status recorded as structured data Or Exclusion</p>	<p>An EP who sees no patients 13 years or older would be excluded from this requirement Exclusion from this requirement does not prevent an EP from achieving meaningful use</p>	<p>Review that the denominator is equal to or less than the denominators for measures (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Verify minimum correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				If documentation is supplied, review using a random sample to confirm.
EPCMU 10: 4956(d)(10)(i) Report ambulatory clinical quality measures to the State	Successfully report to the State ambulatory clinical quality measures selected by the State in the manner specified by the State	Yes or No Attestation	No Exclusion	Ensure CQMs were attested to via PIPP.



Objective	Measure	Reporting Requirement	Exclusion	Review
EPCMU 11: 4956(d)(11)(i) Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule	Implement one clinical decision support rule	Yes or No Attestation	No Exclusion	If documentation is supplied, review for one clinical decision support rule.



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 12: 4956(d)(12)(i) Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request</p>	<p>More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator – Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period</p> <p>Numerator - Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days</p> <p>Or</p> <p>Exclusion</p>	<p>Any EP that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period</p> <p>Exclusion from this requirement does not prevent an EP from achieving meaningful use</p>	<p>Verify minimum correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 13:</p> <p>4956(d)(13)(i) Provide clinical summaries for patients for each office visit</p>	<p>Clinical summaries provided to patients for more than 50 percent of all office visits within 3 business days</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator – Number of unique patients seen by the EP for an office visit during the EHR reporting period</p> <p>Numerator - Number of office visits in the denominator for which a clinical summary is provided within three business days</p> <p>Or Exclusion</p>	<p>Any EP who has no office visits during the EHR reporting period</p>	<p>Verify minimum correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>
<p>*EPCMU 14:</p> <p>4956(d)(14)(i) Capability to exchange key clinical information (for example,</p>	<p>Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>Note: This objective was eliminated from Stage 1 in 2013.</p> <p>Verify minimum</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorize identities electronically</p>				<p>correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 15: 4956(d)(15)(i) Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities</p>	<p>Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>Review supporting documentation on risk assessment</p>



Table 32: Stage 1 Meaningful Use Menu Measures Pre-payment Audit and Review Methods

Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 01: 4956(e)(1)(i) Implement drug formulary checks</p>	<p>The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period</p>	<p>Yes or No Attestation Or Exclusion</p>	<p>Based on ALL patient records: An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this requirement</p>	<p>Verify minimum correct percentage is met. If Exclusion is claimed, check if it seems appropriate based for provider type. If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 02: 4956(e)(2)(i) Incorporate clinical lab test results into EHR as structured data</p>	<p>More than 40 percent of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of labs ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number</p> <p>Numerator: Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data</p> <p>Or Exclusion</p>	<p>Based on ALL patient records: Any EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period would be excluded from this requirement</p>	<p>Verify minimum correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>
<p>EPMMU 3: 495.6(e)(3)(i) Generate lists of patients by</p>	<p>Generate at least one report listing patients of the EP with a specific condition</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>If documentation is supplied, review using a</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>specific conditions to use for quality improvement, reduction of disparities, research, or outreach</p>				<p>random sample to confirm.</p>
<p>EPMMU 04: 4956(e)(4)(i) Send reminders to patients per patient preference for preventive/ follow-up care</p>	<p>More than 20 percent of all patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of unique patients 65 years old or older or 5 years old or younger</p> <p>Numerator: Number of patients in the denominator who were sent the appropriate reminder</p> <p>Or Exclusion</p>	<p>Based on ALL patient records: Any EP who has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology would be excluded from this requirement</p>	<p>Review denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Verify minimum</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				<p>correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 05: 4956(e)(5)(i) Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within 4 business days of the information being available to the EP</p>	<p>At least 10 percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of unique patients 65 years old or older or 5 years older or younger</p> <p>Numerator: Number of patients in the denominator who were sent the appropriate reminder</p> <p>Or Exclusion</p>	<p>Based on ALL patient records: Any EP who neither orders nor creates any of the information listed at 45 CFR 170304(g) (problem list, medication list, or medication allergy list) during the EHR reporting period would be excluded from this requirement</p>	<p>Review denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Verify minimum correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				<p>appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 06: 4956(e)(6)(i) Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate</p>	<p>More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of unique patients seen by the EP during the EHR reporting period</p> <p>Numerator: Number of patients in the denominator who are provided patient-specific education resources</p>	<p>No Exclusion</p>	<p>Review denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01, EPCMU 05, EPCMU 06, EPCMU 07, EPMMU 05, EPMMU 06)</p> <p>Verify minimum correct percentage is met.</p> <p>If documentation is supplied,</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				review using a random sample to confirm.



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 07:</p> <p>4956(e)(7)(i) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation</p>	<p>The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition</p> <p>Numerator: Number of transitions of care in the denominator where medication reconciliation was performed Or Exclusion</p>	<p>Based on ALL patient records: An EP who was not the recipient of any transitions of care during the EHR reporting period would be excluded from this requirement</p>	<p>Verify minimum correct percentage is met.</p> <p>If Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 08:</p> <p>The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.</p>	<p>The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition</p> <p>Numerator: Number of transitions of care in the denominator where medication reconciliation was performed Or Exclusion</p>	<p>Exclusion 1: Based on ALL patient records: An EP who does not transfer a patient to another setting during the EHR reporting period would be excluded from this requirement</p> <p>Exclusion 2: Based on ALL patient records: An EP who does not refer a patient to another provider during the EHR reporting period would be excluded from this requirement</p>	<p>Verify minimum correct percentage is met.</p> <p>If either Exclusion is claimed, check if it seems appropriate based for provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 09: 4956(e)(9)(i) Capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited according to applicable law and practice</p>	<p>Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically)</p>	<p>Yes or No Attestation</p>	<p>Exclusion 1: Based on ALL patient records: An EP who administers no immunizations during the EHR reporting period would be excluded from this requirement</p> <p>Exclusion 2: If none of the registries to which the EP submits such information has the capacity to receive the information electronically the EP would be excluded from this requirement</p>	<p>Iowa began testing on May 1, 2013. Any attestation with a reporting period inclusive of that date or after that date should have tested with the registry.</p> <p>Review the time-stamped confirmation message received by the provider from Iowa Department of Public Health.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 10: 4956(e)(10)(i) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited according to applicable law and practice</p>	<p>Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically)</p>	<p>Yes or No Attestation</p>	<p>Exclusion 1: Based on ALL patient records: If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period the EP is excluded from this requirement</p> <p>Exclusion 2: If there is no public health agency that has the capacity to receive the information electronically the EP is excluded from this requirement</p>	<p>At this time Iowa is not accepting syndromic surveillance data from EPs</p> <p>At such time Iowa enables this functionality:</p> <p>Validate the test date and time with the Immunization Registry</p> <p>Review supporting documentation submitted</p>



Figure 89: Stage 2 Pre-payment audit/review methods for EP Core Measures

Objective	Measure	Reporting Requirement	Exclusion	Review
Title 45 § 170.102 and §170.314 Certified EHR Technology	Must use a 2014 Certified EHR Technology	Provider must enter EHR certification number obtained from the ONC Certified Health IT Product List	None	Verify this number using CHPL list from ONC website.
EPCMU 01: 495.6(j)(1)(i) Use computerized provider order entry (CPOE) 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	More than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.	Measure 1 - Medication: Numerator: The number of orders in the denominator record using CPOE; Denominator: Number of Medication orders created by the EP during the EHR reporting period. Measure 2 - Radiology: Numerator: The number of orders in the denominator recorded using CPOE; Denominator: Number of radiology orders created by the EP during the EHR reporting period.	Measure 1 -- Any EP who writes fewer than 100 medication orders during the EHR reporting period. Measure 2 -- Any EP who writes fewer than 100 radiology orders during the EHR reporting period. Measure 3 -- Any EP who writes fewer than 100	Each measure, verify minimum correct percentage is met. Validate that the denominator is the same for laboratory orders with EPCMU 10. If an exclusion is claimed, check if it seems



Objective	Measure	Reporting Requirement	Exclusion	Review
guidelines		Measure 3 -- Laboratory: Numerator: The number of orders in the denominator recorded using CPOE; Denominator: Number of radiology orders crated by the EP during the EHR reporting period.	laboratory orders during the EHR reporting period.	appropriate based on patient volume. If documentation is supplied, review using a random sample to confirm.



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 02:</p> <p>495.6(j)(2)(i) Generate and transmit permissible prescriptions electronically (eRx)</p>	<p>More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are compared to at least one drug formulary and transmitted electronically using certified EHR technology</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator - Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.</p> <p>Numerator - Number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically</p> <p>Or Exclusion</p>	<p>Exclusion 1: Writes fewer than a 100 permissible prescriptions during the EHR reporting period.</p> <p>Exclusion 2: Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.</p>	<p>Verify minimum correct percentage is met.</p> <p>If Exclusion 1 is claimed, check if it seems appropriate based on patient volume.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 03:</p> <p>495.6(j)(3)(i) Record the following demographics:</p> <ul style="list-style-type: none"> • Preferred language • Gender • Race • Ethnicity • Date of birth 	<p>More than 80% of all unique patients seen by the EP have demographics recorded as structured data.</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator - Number of unique patients seen by the EP during the EHR reporting period</p> <p>Numerator - Number of patients in the denominator who have all the elements of demographics (or a specific notation if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data</p>	<p>No Exclusion</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPCMU 03, EPCMU 05, EPCMU 07, EPCMU 13, EPCMU 17, EPMMU 02, EPMMU 04)</p> <p>Verify minimum correct percentage is met.</p> <p>If documentation is supplied,</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				review using a random sample to confirm.
<p>EPCMU 04:</p> <p>495.6(j)(4)(i) Record and chart changes in vital signs: (A) Height (B) Weight (C) Blood pressure</p>	<p>More than 80% of all unique patients seen by the EP have blood pressure (for age 3 and over only) and height and weight (for all ages) recorded as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator: Number of unique patients seen by the EP during the EHR reporting period.</p> <p>Numerator:</p>	<p>Any EP who:</p> <p>Exclusion 1: Sees no patients 3 years or older is excluded from recording blood pressure.</p>	<p>Verify minimum correct percentage is met.</p> <p>If an exclusion is claimed, review that the</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>(age 3 and over) (D) Calculate and display body mass index (BMI) (E) Plot and display growth charts for children 2-20 years, including BMI</p>		<p>Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.</p> <p>Or Exclusion</p>	<p>Exclusion 2: Believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.</p> <p>Exclusion 3: Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.</p> <p>Exclusion 4: Believes that blood pressure is relevant to their</p>	<p>provider type matches the selected exclusion.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
			scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.	
<p>EPCMU 05: 495.6(j)(5)(i) Record smoking status for patients 13 years old or older</p>	<p>More than 80 percent of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator- Number of unique patients age 13 or older seen by the EP during the EHR reporting period</p> <p>Numerator - Number of patients in the denominator with smoking status recorded as structured data.</p>	<p>Any EP that neither sees nor admits any patients 13 years old or older.</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPCMU 03, EPCMU 05, EPCMU 07, EPCMU 13, EPCMU 17, EPMMU 02, EPMMU 04)</p> <p>Verify minimum</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				<p>correct percentage is met.</p> <p>If an exclusion is claimed, review that the provider type matches the selected exclusion.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>
<p>EPCMU 06: 495.6(j)(6)(i) Use clinical decision to improve performance on high-priority</p>	<p>Measure 1: Implement 5 clinical decision support interventions related to 4 or more clinical quality measures, if applicable, at a relevant point in patient care for the</p>	<p>Yes or No Attestation Or Exclusion</p>	<p>For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.</p>	<p>If an exclusion is claimed, review that the provider type matches the selected exclusion.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
health conditions	<p>entire EHR reporting period.</p> <p>Measure 2: The EP, eligible hospital, or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p>			<p>If documentation is supplied, review using a random sample to confirm.</p>
<p>EPCMU 07: 495.6(j)(10)(i) Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.</p>	<p>Measure 1: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information.</p> <p>Measure 2: More than 5% of all unique</p>	<p>Attestation of Numerator / Denominator</p> <p>Measure 1: Denominator - Number of unique patients seen by the EP during the EHR reporting period Numerator - The number of patients in the denominator who have timely (within 4 business days after the information is available to the EP) online access to their health</p>	<p>Exclusion 1: Any EP who neither orders nor creates any of the information listed for inclusion as part of both measures, except for "Patient name" and Provider's name and office contact information, may exclude both measures.</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPCMU 03, EPCMU 04, EPCMU 05, EPCMU 07, EPCMU 13,</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
	<p>patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.</p>	<p>information.</p> <p>Measure 2: Denominator - Number of unique patients seen by the EP during the EHR reporting period. 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.</p>	<p>Exclusion 2: Any EP who conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude only the second measure.</p>	<p>EPCMU 17, EPMMU 02, EPMMU 04)</p> <p>For each measure, verify minimum correct percentage is met.</p> <p>If only Exclusion 1 is claimed, review that the provider type matches the selected exclusion.</p> <p>If only Exclusion 2 is claimed, verify the county broadband availability is correct and that</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				<p>they still reported measure 1.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 08:</p> <p>495.6(j)(11)(i) Provide clinical summaries for patients for each office visit</p>	<p>Clinical summaries provided to patients within one business day for more than 50% of office visits</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator – Number of office visits conducted by the EP during the EHR reporting period.</p> <p>Numerator - Number of office visits in the denominator where the patient or a patient-authorized representative is provided a clinical summary of their visit within one (1) business day.</p> <p>Or Exclusion</p>	<p>Any EP who has no office visits during the EHR reporting period</p>	<p>Verify minimum correct percentage is met.</p> <p>If an Exclusion is claimed, review that the provider type matches the selected exclusion.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>
<p>EPCMU 09:</p> <p>4956(d)(16)(i) Protect</p>	<p>Conduct or review a security risk analysis in accordance with the requirements under 45</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>Verify minimum correct percentage is met.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.</p>	<p>CFR 164.308(a)(1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306 (d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.</p>			<p>If documentation is supplied, review using a random sample to confirm</p>
<p>EPCMU 10: 495.6(j)(7)(i) Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data</p>	<p>More than 55% of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data</p>	<p>Attestation of Numerator/Denominator Denominator: Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.</p>	<p>Any EP who orders no lab tests where results are either in a positive/negative affirmation or numerical format during the EHR reporting period.</p>	<p>Verify minimum correct percentage is met. If an Exclusion is claimed, review that the provider type matches the</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
		<p>Numerator: Number of lab test results which are expressed in a positive or negative affirmation or as a numeric result which are incorporated in CEHRT as structured data.</p>		<p>selected exclusion.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>
<p>EPCMU 11: 495.6(j)(8)(i) Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.</p>	<p>Generate at least one report listing patients of the EP with a specific condition t</p>	<p>Yes or No Attestation</p>	<p>No Exclusion</p>	<p>Verify minimum correct percentage is met.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 12:</p> <p>495.6(j)(9)(i) Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.</p>	<p>More than 10% of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator – Number of unique patients who have had two or more office visits with the EP in the 24 months prior to the beginning of the EHR period.</p> <p>Numerator - Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period.</p> <p>Or Exclusion</p>	<p>Any EP who has no office visits in the 24 months before the EHR reporting period</p>	<p>Verify minimum correct percentage is met.</p> <p>If an Exclusion is claimed, review that the provider type matches the selected exclusion and conduct a random sample check via MMIS for claims in prior 24 month period.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 13: 495.6(j)(12)(i) Use Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient if appropriate</p>	<p>Patient-specific education resources identified by the CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period</p>	<p>Attestation of Numerator / Denominator</p> <p>Denominator – Number of unique patients with office visits seen by the EP during the EHR reporting period.</p> <p>Numerator - Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology.</p> <p>Or Exclusion</p>	<p>Any EP who has no office visits during the EHR reporting period</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPCMU 03, EPCMU 05, EPCMU 07, EPCMU 13, EPCMU 17, EPMMU 02, EPMMU 04)</p> <p>Verify minimum correct percentage is met.</p> <p>If an Exclusion is claimed, review that the</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				<p>provider type matches the selected exclusion and conduct a random sample check via MMIS for paid claims during reporting period.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 14: 495.6(j)(13)(i) The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.</p>	<p>The EP performs medication reconciliation for more than 50% of the transitions of care in which the patient is transitioned into the care of the EP.</p>	<p>Attestation with Numerator/Denominator</p> <p>Denominator: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.</p> <p>Numerator: The number of transitions of care in the denominator where medication reconciliation was performed.</p>	<p>Any EP who was not the recipient of any transitions of care during the EHR reporting period.</p>	<p>Verify minimum correct percentage is met.</p> <p>If an Exclusion is claimed, review that the provider type matches the selected exclusion.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 15: 495.6(j)(14)(i) The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.</p>	<p>Measure 1: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions or care and referrals.</p> <p>Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record either a) electronically transmitted to a recipient using CEHRT or b) where the recipient receives record via exchange facilitated by an organization that is a NwHIN Exchange participant or is</p>	<p>Attestation with Numerator/Denominator for Measures 1 and 2</p> <p>Measure 1:</p> <p>Denominator: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.</p> <p>Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was provided.</p> <p>Measure 2:</p> <p>Denominator: Number of transitions of care or referrals during the EHR reporting period for which</p>	<p>Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period is excluded from all three measures.</p>	<p>For measures 1 and 2, verify minimum correct percentage is met.</p> <p>If an Exclusion is claimed, review that the provider type matches the selected exclusion.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
	<p>validated through an ONC-established governance mechanism to facilitate exchange for 10% of transitions and referrals.</p> <p>Measure 3: The EP who transitions or refers their patient to another setting of care or provider of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS-designated test EHR during the EHR reporting period.</p>	<p>the EP was the transferring or referring provider.</p> <p>Numerator: The number of transitions of care and referrals in the denominator where a summary of care record was a) electronically transmitted using CEHRT to a recipient or b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the nationwide health information network. The organization can be a third-party or the sender's own organization.</p> <p>Measure 3: Yes/No Attestation</p>		



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPCMU 16: 495.6 (j) (15) (i)</p> <p>Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission except where prohibited and in accordance with applicable law and practice</p>	<p>Successful ongoing submission of electronic immunization data from Certified EHR Technology to an immunization registry or immunization information system for the entire EHR reporting period.</p>	<p>Yes or No Attestation</p>	<p>Any EP that meets one or more of the following criteria may be excluded from this objective:</p> <p>1) the EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period;</p> <p>2) the EP operates in a jurisdiction for which no immunization registry or</p>	<p>Verify with Iowa Department of Public Health that provider is in queue to submit when available.</p> <p>If an Exclusion is claimed, review that the provider type matches the selected exclusion.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
			<p>immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period;</p> <p>3) the EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data; or</p> <p>4) the EP operates in a jurisdiction for</p>	



Objective	Measure	Reporting Requirement	Exclusion	Review
			<p>which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.</p>	
<p>EPCMU 17: 495.6 (j) (17) (i) Use secure electronic messaging to communicate with patients on relevant health information</p>	<p>A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 5% of unique patients seen during the EHR reporting period.</p>	<p>Attestation with Numerator/Denominator –</p> <p>Denominator: Number of unique patients seen by the EP during the EHR reporting period.</p> <p>Numerator: The number of patients or patients-authorized representatives in the denominator who send</p>	<p>Any EP who:</p> <p>1) has no office visits during the EHR reporting period.</p> <p>2) Conducts 50% or more of his or her patient encounters in a county that does not have 50% or</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPCMU 03, EPCMU 05, EPCMU 07,</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
		<p>electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period.</p>	<p>more of its housing with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.</p>	<p>EPCMU 13, EPCMU 17, EPMMU 02, EPMMU 04)</p> <p>Verify minimum correct percentage is met.</p> <p>If only Exclusion 1 is claimed, review that the provider type matches the selected exclusion.</p> <p>If only Exclusion 2 is claimed, verify the county broadband availability is correct and that they still</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				<p>reported measure 1.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>

Table 33: Stage 2 EP Menu Measures Pre-payment Audit/Review Methods

Objective	Measure	Reporting Requirement	Exclusion	Review
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Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 01: 495.6(k)(3)(i) Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited according to applicable law and practice</p>	<p>Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.</p>	<p>Yes or No Attestation</p>	<p>Any EP that meets one or more of the following criteria may be excluded from this objective: 1) the EP is not in a category of providers that collect ambulatory syndromic surveillance information on their patients during the EHR reporting period; 2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data in the specific standards required</p>	<p>At this time Iowa is not accepting syndromic surveillance data from EPs At such time Iowa enables this functionality: Verify the test date and time with the Syndromic Registry and ongoing submission. For now, providers should only claim exclusion 2. If they claim another exclusion,</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
			<p>by CEHRT at the start of their EHR reporting period;</p> <p>3) the EP operates in a jurisdiction for which no public health agency provides information timely on capability to receive syndromic surveillance data: or</p> <p>4) the EP operates in a jurisdiction for which no public health agency that is capable of accepting that specific standards required by Certified EHR Technology at the start of their EHR reporting period</p>	<p>review to see if it seems appropriate for the provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
			can enroll additional EPs.	
<p>EPMMU 02: 495.6 (k)(6)(i) Record electronic notes in patient records.</p>	<p>Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR</p>	<p>Attestation with Numerator/Denominator: Denominator: Number of unique patients with at least one office visit during the EHR reporting period.</p>	<p>No Exclusion</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
	<p>reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.</p>	<p>Numerator: The number of unique patients in the denominator who have at least one electronic progress note from an eligible professional recorded as text searchable data.</p>		<p>number of unique Patients (EPCMU 03, EPCMU 05, EPCMU 07, EPCMU 13, EPCMU 17, EPMMU 02, EPMMU 04)</p> <p>Verify minimum correct percentage is met.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 03: 495.6 (k)(1)(i) Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT</p>	<p>More than 10% of all scans and tests whose result is an image ordered by the EP for patients seen during the EHR reporting period are incorporated into or accessible through Certified EHR Technology</p>	<p>Attestation Numerator/Denominator:</p> <p>Denominator: Number of tests whose result is one or more images ordered by EP during the EHR reporting period.</p> <p>Numerator: The number of results in the denominator that are accessible through CEHRT.</p>	<p>Any EP who orders less than 100 tests whose results an image during the EHR reporting period; or any EP who has no access to electronic imaging results at the start of the EHR reporting period.</p>	<p>Verify minimum correct percentage is met.</p> <p>If an exclusion is claimed, review that it is appropriate for the provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 04: 495.6 (k)(2)(i) Record patient family health history as structured data</p>	<p>More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives or an indication that family health history has been reviewed</p>	<p>Attestation Numerator/Denominator: Denominator: Number of unique patients seen by the EP during the EHR reporting period.</p> <p>Numerator: The number of patients in the denominator with a structured data entry for one or more first-degree relatives.</p>	<p>Any EP who has no office visits during the EHR reporting period.</p>	<p>Validate denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPCMU 03, EPCMU 05, EPCMU 07, EPCMU 13, EPCMU 17, EPMMU 02, EPMMU 04)</p> <p>Verify minimum correct percentage is met.</p> <p>If an exclusion is claimed, review that it is appropriate for</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
				<p>the provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>
<p>EPMMU 05: 495.6 (k)(4)(i) Capability to identify and report cancer cases to a state cancer registry, except where prohibited, and in accordance with applicable law and practice</p>	<p>Successful ongoing submission of cancer case information from CEHRT to a cancer registry for the entire EHR reporting period.</p>	<p>Yes or No Attestation Or Exclusion</p>	<p>Any EP that meets at least 1 of the following criteria may be excluded from this objective:</p> <p>1) the EP does not diagnose or directly treat cancer;</p> <p>2) the EP operates in a jurisdiction for which no public health agency is capable of receiving electronic cancer</p>	<p>Verify ongoing submission via documentation.</p> <p>If an exclusion is claimed, review that it is appropriate for the provider type.</p> <p>If documentation is supplied, review using a random sample</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
			<p>case;</p> <p>3) the EP operates in a jurisdiction where no PHA provides information timely on capability to receive electronic cancer case information; or</p> <p>4) the EP operates in a jurisdiction for which no public health agency that is capable of receiving electronic cancer case information in the specific standards required for CEHRT at the beginning of their EHR reporting period can enroll additional EPs.</p>	<p>to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
<p>EPMMU 06: 495.6 (k)(5)(i) Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice</p>	<p>Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.</p>	<p>Yes or No Attestation Or Exclusion</p>	<p>Any EP that meets at least 1 of the following criteria may be excluded from this objective:</p> <p>1) the EP does not diagnose or directly treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible, or the public health agencies in their jurisdiction;</p> <p>2) the EP operates in a jurisdiction for which no specialized registry sponsored by a public health</p>	<p>Verify ongoing submission via documentation.</p> <p>If an exclusion is claimed, review that it is appropriate for the provider type.</p> <p>If documentation is supplied, review using a random sample to confirm.</p>



Objective	Measure	Reporting Requirement	Exclusion	Review
			<p>agency or by a national specialty society for which the EP is eligible is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting;</p> <p>3) the EP operates in a jurisdiction where no public health agency or national specialty society for which the EP is eligible provides information timely on capability to receive information into their specialized</p>	



Objective	Measure	Reporting Requirement	Exclusion	Review
			<p>registries; or</p> <p>4) the EP operates in a jurisdiction for which no specialized registry sponsored by a public health agency or by a national specialty society for which the EP is eligible that is capable of receiving electronic specific case information in the specific standards required by CEHRT at the beginning of their EHR reporting period can enroll additional EPs.</p>	