Iowa Medicaid Enterprise State Medicaid HIT Plan 2014

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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	The Medicaid enrollment numbers and graphs have been updated. Strategic Planning section ha 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	2.0

			changes made to the process following implementation. Section D has been modified to identify changes to the pre payment audit strategy. 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 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		Annual update Updated hospital calculator Modify language in Section C to reflect current processes	3.0
09/13/2013	Jody Holmes Rachel Lunsford		Annual update Modified background to reflec the new Iowa Health and Wellness Plan Added State Innovation Mode 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 Updated strategy to reflect changes to Stage 1 and new Stage 2 rules	4.0

		Defined audit approach for each meaningful use measur 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	
11/21/2013	Rachel Lunsford	Included the summary of the Stage 2 Regulations Change which starts on page 77 in the clean version and 107 in the marked up version.	4.1
07/21/2014	Tanya McAninch Carrie Ortega	Added screen shots of audit templates Updated screen shots to reflect current requirements for Stage 1 & Stage 2 Added languages of E7 (audit) Defined risk catorgies total 5% of previous quarter broken down into - 50% high, 30% mod, 20% low Put into production for providers to attest for stage 1 and stage 2 – Removed Section D – Iowa's Incentive Payment Audit Strategy to a separate document.	5.0

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Iowa Medicaid Enterprise State Health Information Technology Plan

Document Purpose

The Iowa Medicaid Enterprise (IME) updated the 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 Three and Four incentives, as authorized under section 4201 of the American Reinvestment and Recovery Act (ARRA). The SMHP outlines the Health Information Technology (HIT) initiatives the IME believes will encourage the adoption and meaningful use of certified EHR technology. The 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 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.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

Julie Lovelady, Interim 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)

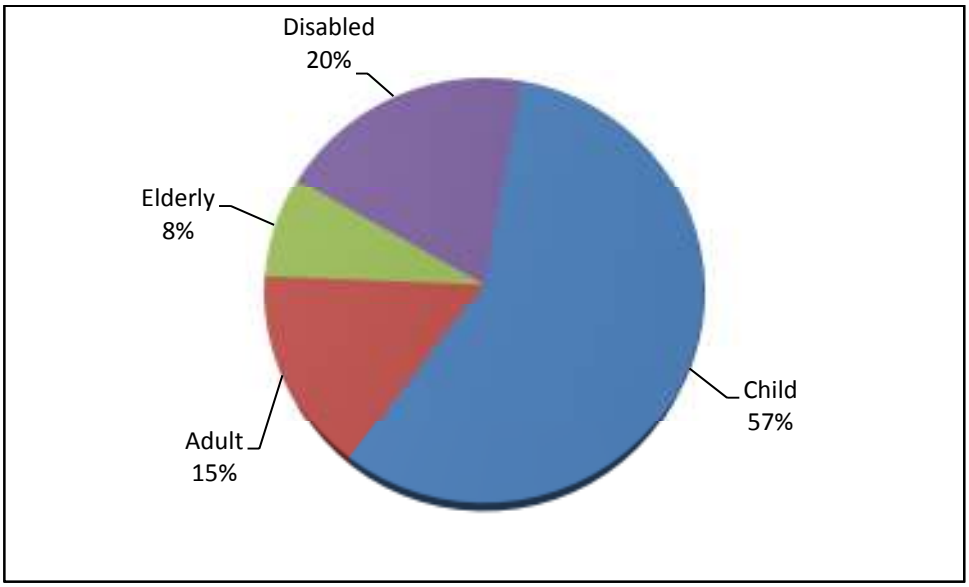
Iowa Medicaid Enterprise – Background

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 517,705 individuals in SFY 2014 through full and limited benefit programs, including 1115 waivers and S-CHIP. This is over 17.2% of Iowa's population. The Medicaid population consists of four general categories: and served the following in SFY 2014:

Figure 1 : Average Medicaid Enrollment -- SFY 2014



Average monthly enrollment in Medicaid by enrollment category

- 233,075 children
- 62,464 low-income parents and adults
- 79,244 persons with disabilities
- 30,922 elderly persons

To be eligible for Medicaid, individuals must be low-incomeand 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..

On June 20, 2013, Senate File 446 was signed by the Governor which established the Iowa Health and Wellness Plan. This program began 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 replaced the 1115 demonstration waiver program entitled "IowaCare" beginning January 1, 2014. IowaCare covers approximately 80,000 members with a limited provider and network benefit package. The Iowa Health and Wellness Plan expands the provider network and provides services that meet the Alternative Benefit Plan as defined in the Affordable Care Act. The new program includes components of managed care and accountable care organizations, rewarding providers and members for engaging in health management.

The Iowa Health and Wellness Plan assures universal access to health insurance for all Iowans. The plan implements three options that offer coverage to adults between 19 and 64 years of age with income not exceeding 133%[1] Federal Poverty Level. Applicants who are above the 133% FPL may be eligible to receive advance premium tax credits through the Iowa Marketplace.

The three components of the Iowa Health and Wellness Plan are:

1) Non-medically frail eligible individuals with income levels 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) 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

[1] With the 5% of FPL disregard, 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.

individuals to enroll in Qualified Health Plans through the health insurance marketplace (Marketplace); and

3) Premium assistance for cost-effective employer sponsored insurance (ESI) under Iowa's Health Insurance Premium Payment (HIPP) program.

Iowans eligible for the Iowa Wellness Plan are screened prior to enrollment to determine if they qualify for medically frail status as described at 42 CFR §440.315(f). A retrospective process is 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 multipayor 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 Initiative[2].

The product at the end of the eight month design grant is to develop a State Healthcare Innovation Plan (SHIP). Iowa submitted 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. They are to 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.

Iowa pursued a SIM Round Two testing grant award focused on implementing and evaluating the effectiveness of the SHIP. This four year grant allows the state to implement supports to the healthcare delivery system during the transformation phase. Supports related to health IT, including ways to improve the quality and transparency of data being shared to providers, are part of the SIM model test plan for Iowa. Iowa submitted a Model Test application in July of 2014. Award announcements are expected in October 2014.

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

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

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

[3]Table 1 : Historical Medicaid Enrollment

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Aged	30,250	29,935	30,035	30,515	30,922
Adult	57,077	61,043	62,902	62,178	62,464
Disabled	69,895	72,395	75,255	77,474	79,244
Child	204,163	217,376	225,473	230,962	233,075
Total	**361,385**	**380,749**	**393,664**	**401,129**	**405,705**

Table 2: Historical Medicaid Expenditures

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014
Aged	560,855,596	604,759,937	621,581,880	645,625,824	673,371,379
Adult	349,999,871	365,211,344	367,686,041	389,434,499	373,452,580
Disabled	1,490,953,121	1,544,947,414	1,642,231,287	1,696,148,703	1,843,421,895
Child	535,356,610	573,980,678	583,503,386	636,390,928	678,047,430
Total	**$2,937,165,197**	**$3,088,899,373**	**$3,215,002,594**	**$3,367,599,954**	**$3,568,293,285**

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

[3] The numbers reflect average monthly enrollment.

treatment and unnecessary prescriptions being prescribed. Many providers decline to serve the Medicaid population due to the complicated medical problems, trouble with maintaining 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.

The IME established an environment and structures enabling the vendors to work together with Department policy and program staff to achieve common goals for the IME. Each vendor brings its specific expertise and knowledge to the IME. This model allows the IME to function much like a commercial health insurer. 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 strategically plans 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	Current: Oct 2015

Project	Description	Timeline
	selected. Testing with external providers are taking place.	
Integrated Eligibility Program	The contract has been awarded for a new integrated eligibility system. The project kick off was held on August 2012. Medicaid eligibility go live October 1 2013.	Oct 2013
Health Home	Iowa received approval for the State Plan Amendment for Health Homes for chronically ill members. The program launched July 2012.	Implemented July 2012
MIDAS (Medicaid Integrated Data Administration Services)	The contracts were awarded for MMIS Systems and Operationsand 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, provider pre and post screening 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.	Implemented January 1, 2014

Iowa e-Health

In 2008, the Iowa Legislature enacted House File 2539 establishing 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) Develop a statewide health information technology plan by July 1, 2009;
b) Identify existing and potential health IT efforts, and integrating with state and national efforts to avoid incompatibility and duplication;
c) Coordinate public and private efforts to provide the network and communications backbone for health IT;

d) Promote 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) Address workforce needs generated by increased use of health IT;
f) Recommend rules to be adopted in accordance with Iowa Code chapter 17A to implement all aspects of the plan and the network;
g) Coordinate, monitor and evaluate the adoption, use, interoperability, and efficiencies of health IT in the state;
h) Seek and apply for any federal or private funding to assist in implementation and support of the health IT system;
i) Identify state laws and rules that present barriers to development of the health IT system.

The 2010 Iowa e-Health Strategic and Operational Plan[4] 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 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 535 organizations that have signed Participation Agreements, 1321 Direct Secure Messaging users, and more than 8600 transactions since implementation. Over 100 hospitals are currently enrolled. Query functionality was launched in January 2014. Doctors of Medicine and Doctors of Osteopathy are the largest users of the Iowa Health Information Network with Office Support Staff and Iowa Medicaid Enterprise also being strong users of the technology.

As a 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.

Iowa HIT Regional Extension Center

Telligen 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

[4] More information regarding Iowa e-Health and the Strategic and Operational Plan is available on the e-Health website: http://www.iowaehealth.org/
[5] More information on the Iowa HIT REC can be found on their website: http://www.telligenhitrec.org/.

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 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.

Iowa Medicaid participates in meetings with other key stakeholders to provide practical input that guides the operations, vision and outcomes of the REC. Participation 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 received an extension on their funding which was slated to end February 7, 201. This has been extended to February 7, 2015. Telligen is transitioning their team to a fee-based service so that providers can still benefit from their extensive knowledge and experience for support in implementing EHRs and working toward being meaningful users of EHRs.

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

Overviewlowa'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 currently coordinating a second environmental scan. This will occur in late CY2014 and early CY2015. This environmental scan will help determine how health IT adoption has evolved over the last four years in the State of Iowa. This knowledge will guide the goals, support, and program development for the IME in continuing the adoption of technology and practices.
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.

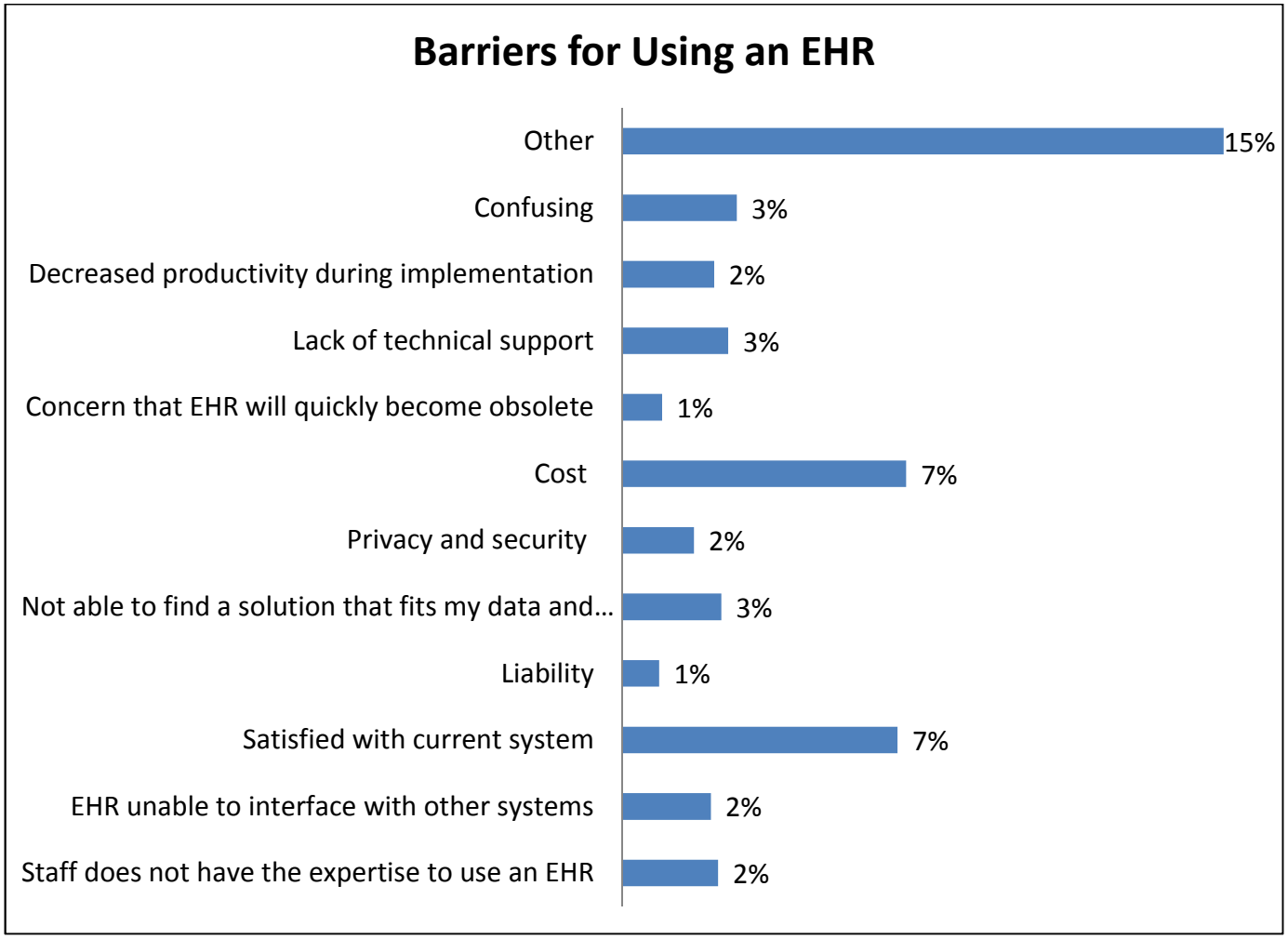
Results as of July 10, 2014, 16,114 providers responded to questions about EHRs and health information exchange as part of the re-enrollment process. When asked if the provider currently used electronic health records, 83% responded that they did compared to the 17% who did not. For those who responded 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, 58% of providers responded that they did not have any plans to purchase an EHR.

Providers that responded affirmatively to using an EHR, were asked if the EHR was certified for meaningful use[6], 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, 91%, are using a certified EHR.. Providers are either currently connected to IHIN to exchange information (11%) or have plans to connect in the next year (17%) or 2-3 years (16%). Under half (34%) of providers who responded noted that they had no plans to exchange information.

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

When asked what the primary barriers for using an EHR were, providers responded that costs concerned them. Sixty-two percent 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. Fifteen percent of providers surveyed noted that other unidentified barriers were attributed as an obstacle to using an EHR.

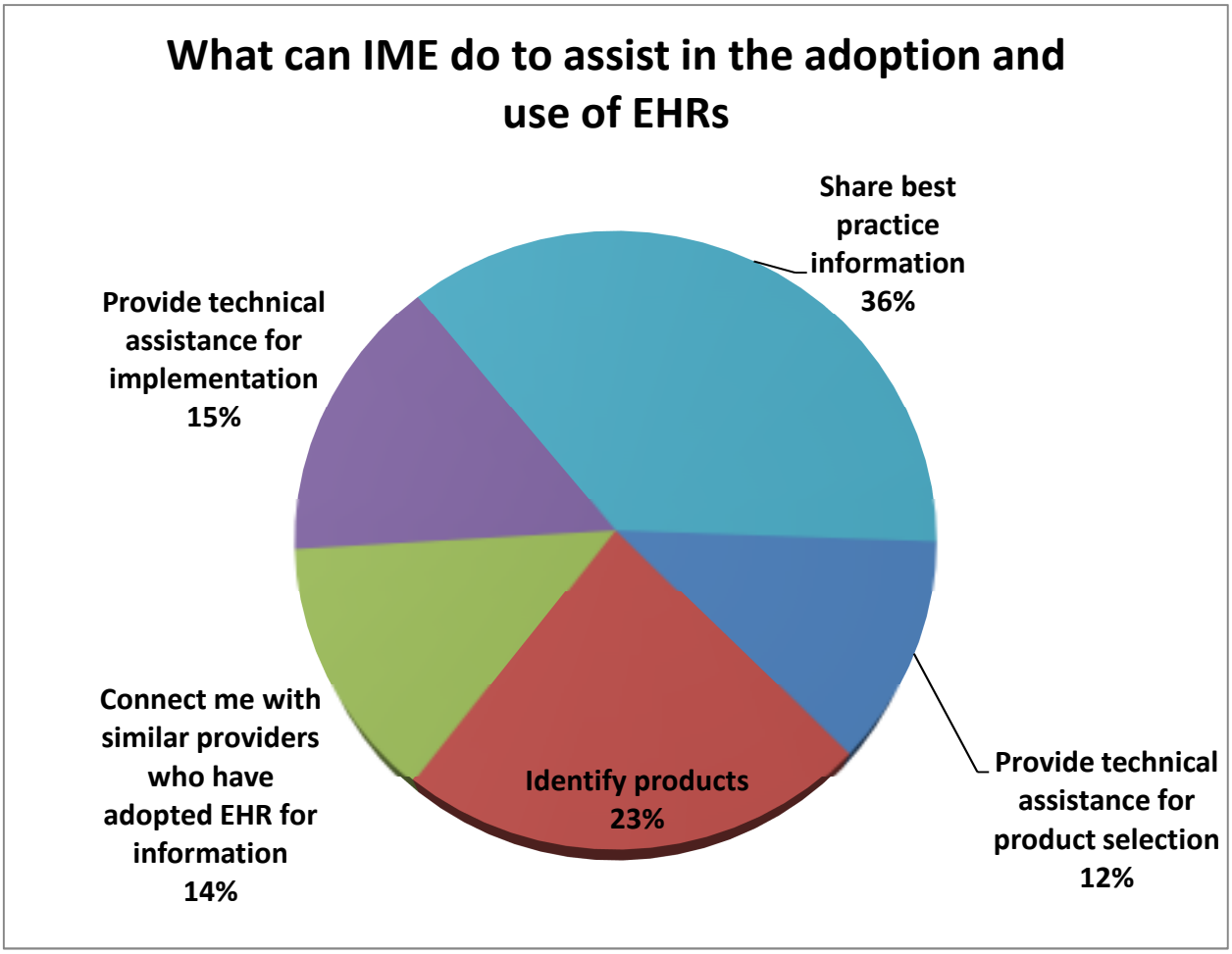
Figure 2: Provider responses to barriers to using EHRs



When asked how the IME coud assist them in the adoption and meaningful use of EHRs , 36% of providers suggested that Iowa Medicaid Enterprise could assist by sharing best practice information. Other areas included providing technical assistance for implementation and connecting providers to similar providers who have adopted EHR. We took these recommendations into consideration for our communication and outreach plan in

2014 and continue that work in to 2015.

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 the number of licensed providers in Iowa as of July 1, 2014. As illustrated in table 4, 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 2014

	Number in Iowa	Number Medicare	Number Medicaid	Total incentives	Total incentives
Physicians	6,178	2187	955	3142	50%
Nurse Practitioners	1,329	-	298	298	22%
CNM	80	-	26	26	32%
PA	1,099	-	17	17	1.5%
Dentists	1,635	1	119	120	7%
Podiatrists	247	93	-	93	37%
Chiropractors	1,814	213	-	213	11%
Optometrists	691	185	-	185	26%
Total	13,073	2679	1360	4039	30%

EHR Adoption - Hospital

In 2009, 85% of Iowa Hospitals were using some form of electronic health record. However, only 11% of those reported that they "relied entirely on an electronic health record system." This indicates 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, 2014, we have 93 unique hospitals attesting to adopting an EHR and 84 hospitals have attested as meaningful users. From a Medicaid perspective, we have not seen 14 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 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, helped to 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 were selected for implementation within other individual FQHC locations. The grant's project period was 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, Community Health Center of Fort Dodge and River Hills Community Health Centerare all live on Centricity EMR . 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 learned in June 2013 that it was awarded a grant and now has FQHC status. They attested to having SuccessEHR in Fall 2012.

All FQHCs have providers who have successfully attested to AIU as well as their first year of MU. We look forward to seeing them return to attest for additional stages of meaningful use in years to come.

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.

INConcert Care, Inc purchased GE's patient portal software and has been implementing the software that allows 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. 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 porgram

Provider Type	No. of Providers enrolled in Medicaid	Estimated % Eligible	Estimated No. Eligible	No. Paid at least 1 incentive
Eligible Professionals				
Physician	8528	10%	853	955
Nurse Practitioner	813	10%	81	298
Dentist	1254	10%	125	119
Certified Nurse Midwife	41	10%	4	26
Physician Assistants				17
Total			**1063**	**1415**
Acute Care Hospitals	37	100%	37	32
Children's Hospitals	0	0	0	0
Critical Access Hospitals	82	90%	72	66
Total			**109**	**98**

The variance between IME's estimates for the number of nurse practitioners and certified nurse midwifes 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.I 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 1, 2014, the IME has paid out $103,595,661.00 in incentive payments to 1415 EPs and 93 EHs for AIU. Additoinally, 5 EHs attested to Medicare first, therefore skipping AIU. We have many providers and hospitals attesting to meaningful use – 671 EPs and 85 EHs. As of June 30, 2014 the IME paid 34 hosptials their 3rd and final Medicaid EHR Incentive payment. Iowa still has many EPs registered for Medicaid incentives at the CMS Registration and Attestation site that 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. Since then, IME has paid an additional 639 providers for adopting/implementing/upgrading their EHR. The breakdown of the number of AIU payments by provider type can be seen in figure 4 while figure 5 illustrates the dollar amount of incentive amounts by provider for adopting, implementing or upgrading to CEHRT.

Figure 4: Eligible providers who received a Medicaid incentive payment for AIU

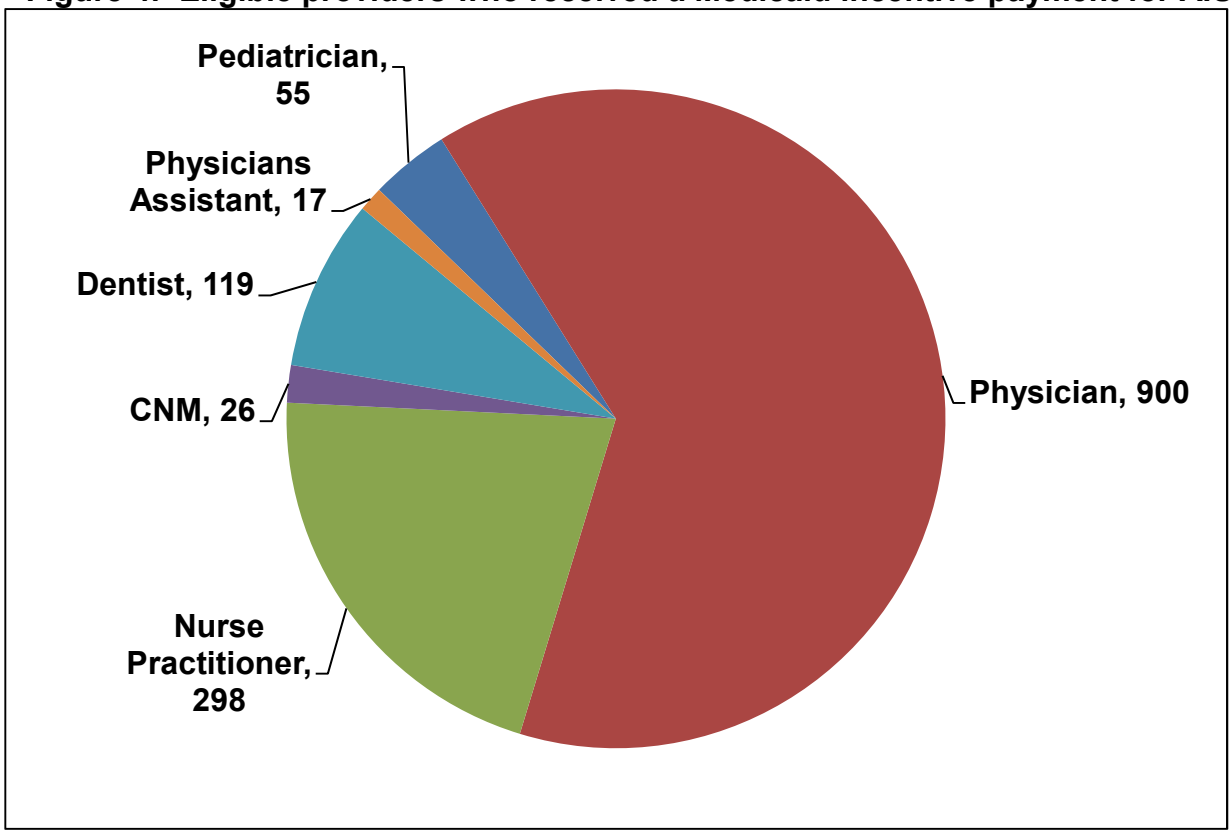
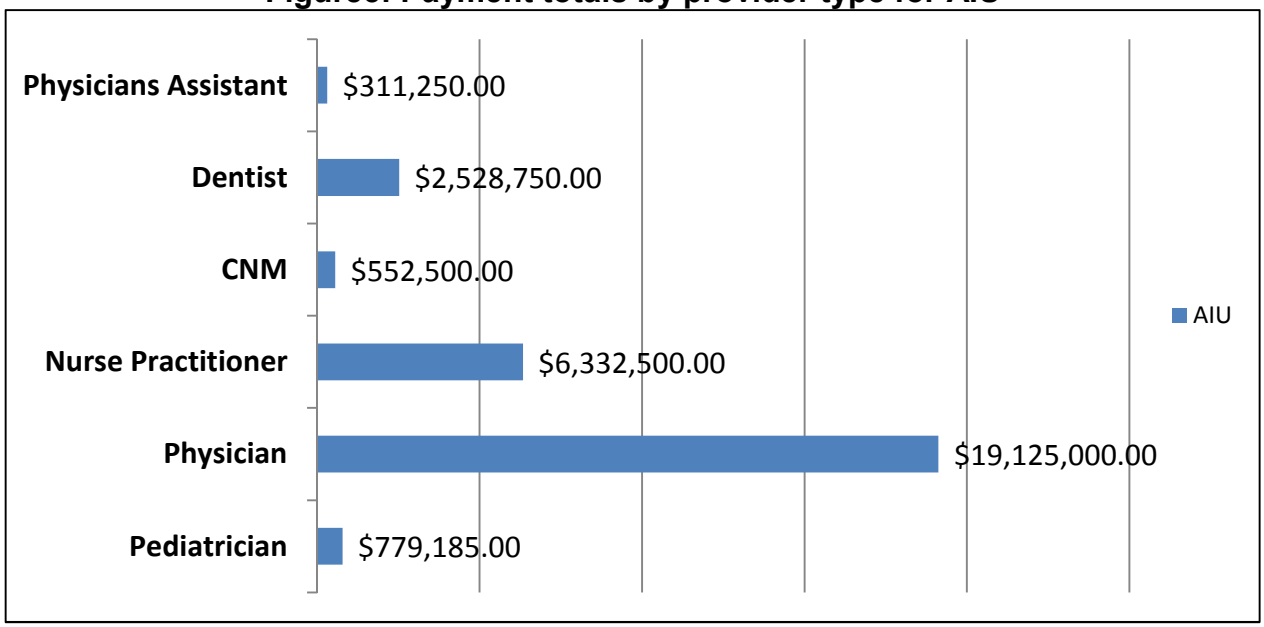


Figure5: Payment totals by provider type for AIU



In figures 6 & 7, we can see a clear progression of most providers moving on from the adoption and implementation stage to meaningful use of their EHR. The IME continues its efforts to move providers through each stage of the program.

Figure 6: Cumulative count of providers moving from AIU to MU

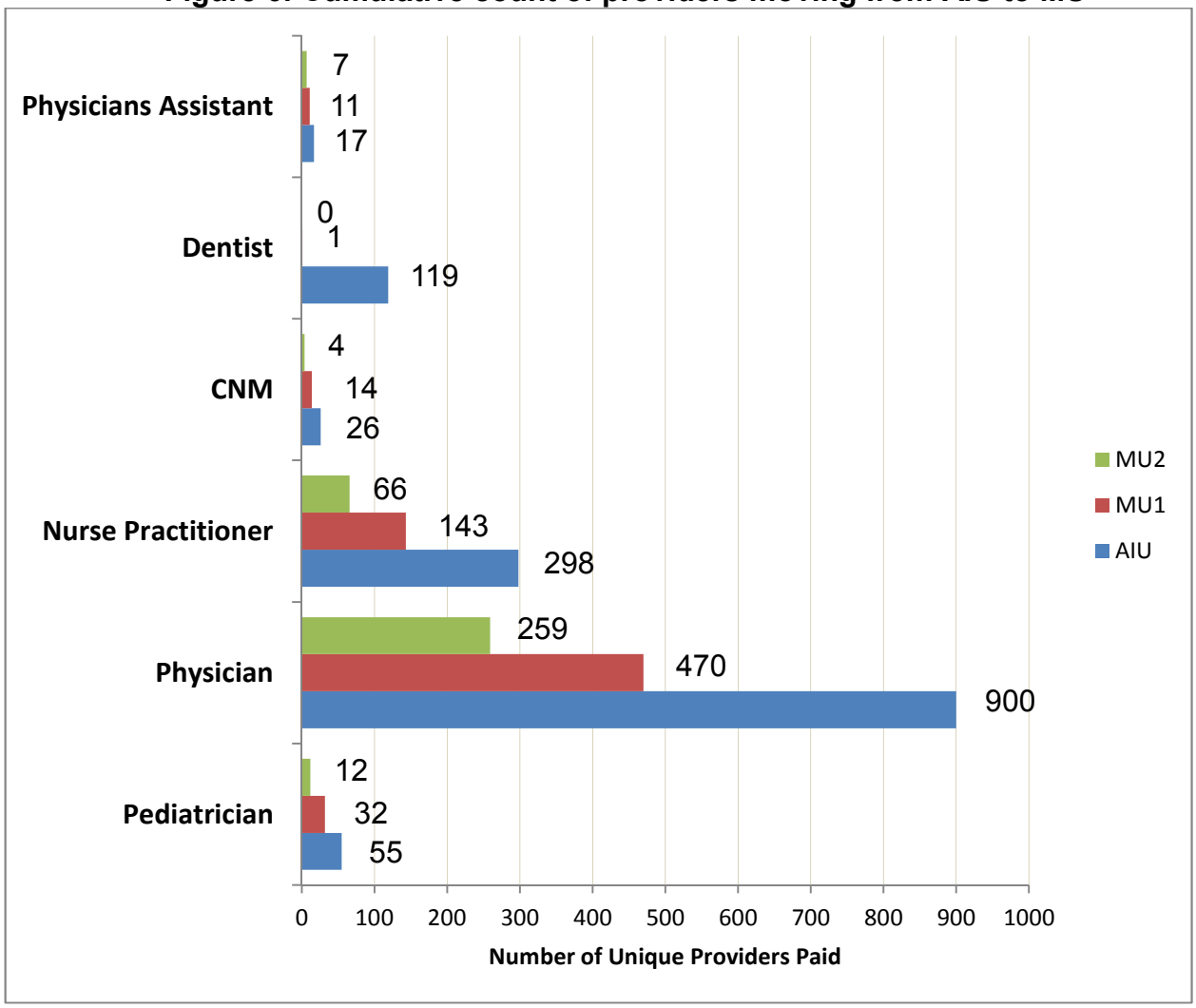
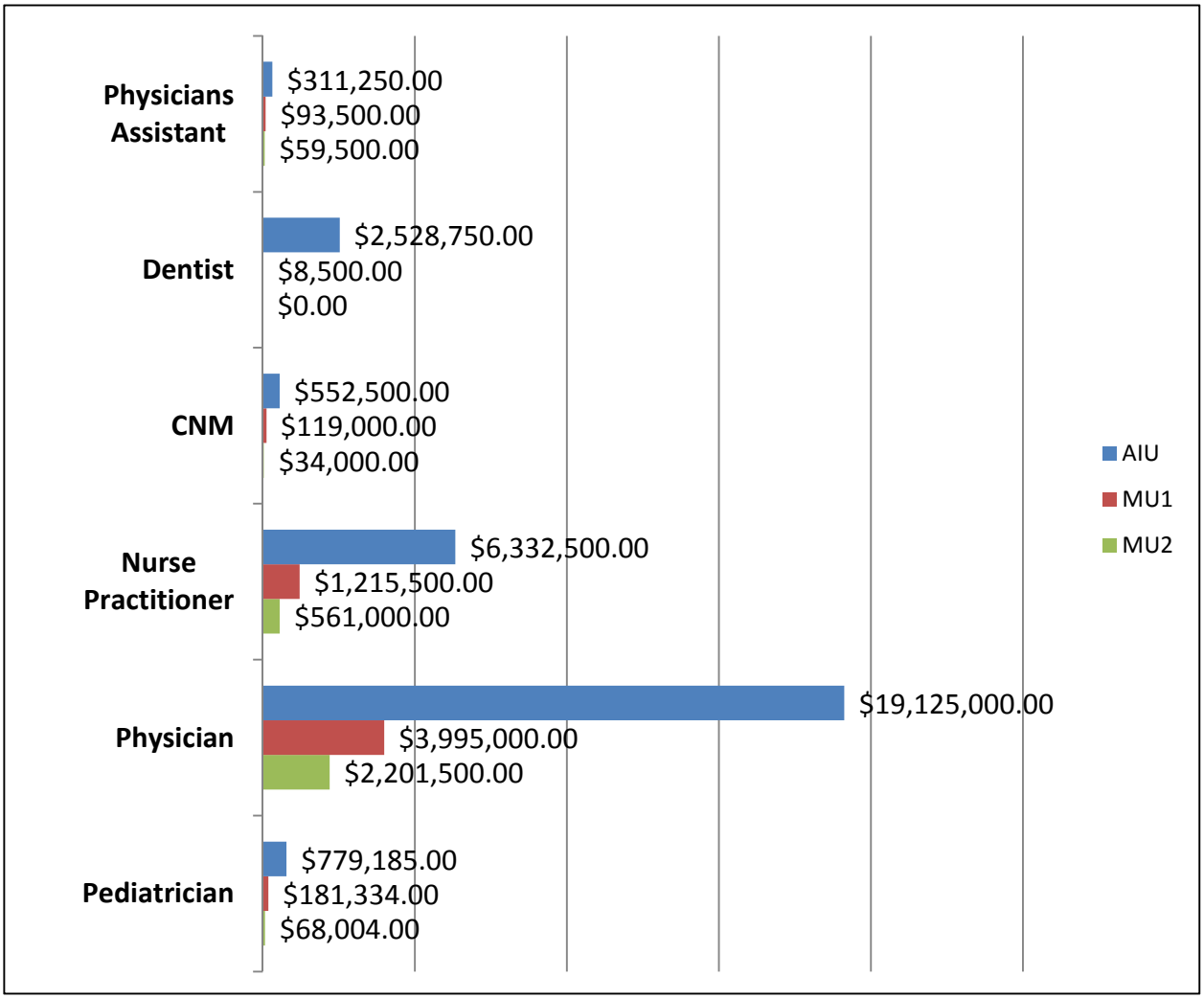
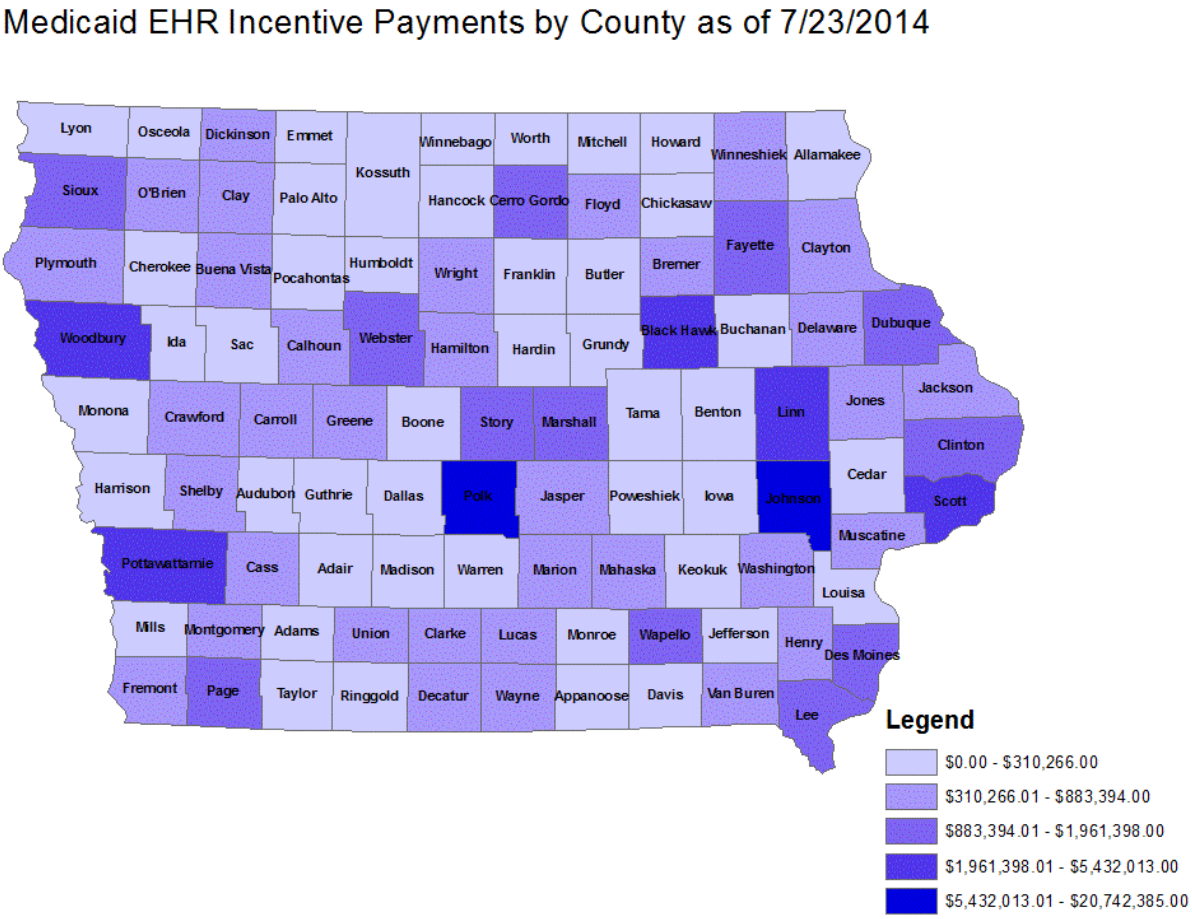


Figure 7: Cumulative payment amounts made to eligiblie providers



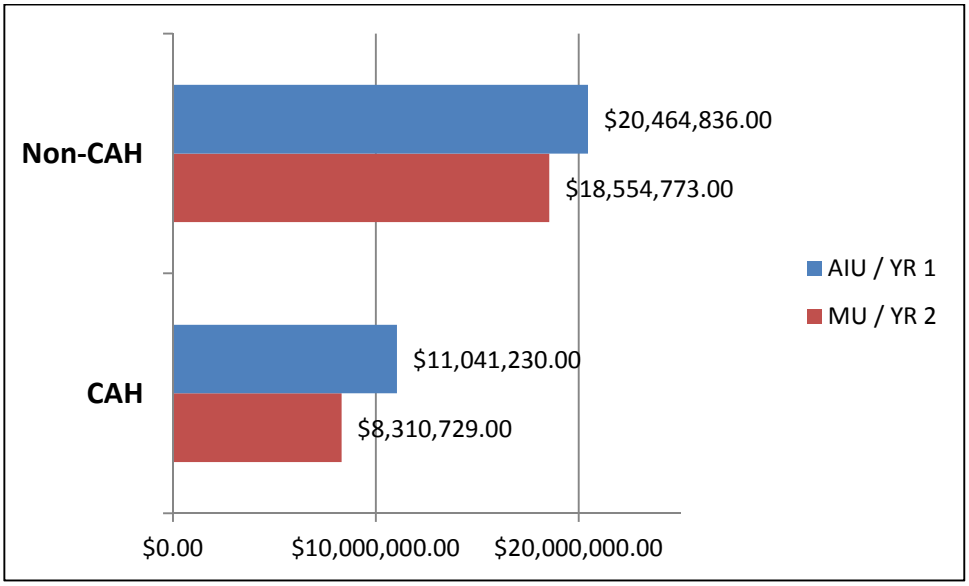
The map below depicts payments made to providers across the State of Iowa as of July 23, 2014.

Figure 4: Map of Medicaid EHR Incentive Payments by County



The number of hospitals attesting fell short of IME expectations initially. IME projected paying 65 hospitals for 2011. Only 50 hospitals attested for a 2011 payment. The goal in 2012 was to have 82 hospitals receive a year one payment. Forty-three additional hospitals received their first year payment in 2012 and five in 2013 for a cumulative 98 unique hospitals since program inception. All of these hospitals received first year incentives payments totaling $31,506,066 as of July 1, 2014. The break down between AIU / program year 1 and MU / program year 2 payments can be seen in Figure 8.

Figure 8: Hospital Incentive Payments Program Year 1 & 2

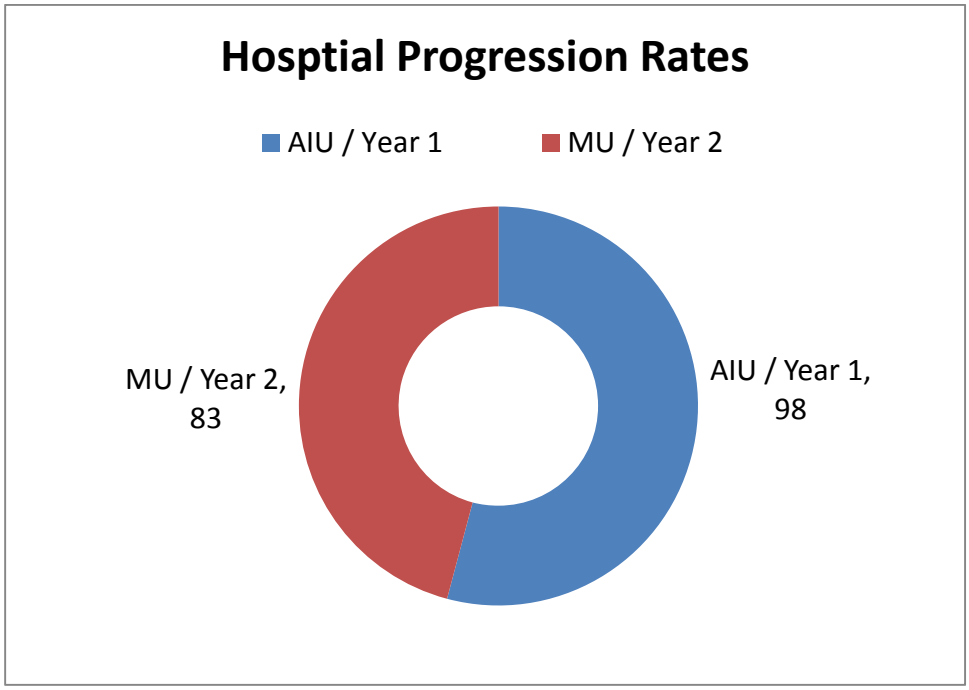


Through extensive collaboration with the Regional Extension Center and the Iowa Hospital Association, IME discovered many errors in how hospitals were calculating patient volume which lead them to believe they did not qualify for the Medicaid incentive. We reached out and worked with those hospitals to help them determine the correct way to calculate their patient volume. The majority of them found that they did indeed meet the requirement and were able to attest for their incentive payments. An additional issue that the IME encountered involved early adopters and the way they had determined their base year for their total incentive amounts. The IME worked directly with these providers and found that we had actually underpaid many of them. The necessary corrections were made and subsequent payments were issued to the providers insuring they received the correct amount due to them.

Currently 83, hospitals have progressed from program year 1 to program year 2, as seen in Figure 10. This indicates an 84% return rate for hospitals to come back and attest for their second year payments. Additionally IME has paid 34 hospitals their third and final Medicaid EHR Incentive payment. A continued priority for IME is to actively work with

hospitals and encourage ongoing attestations to meaningful use in hopes of having all of our hospitals receive all three years of incentive payments.

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

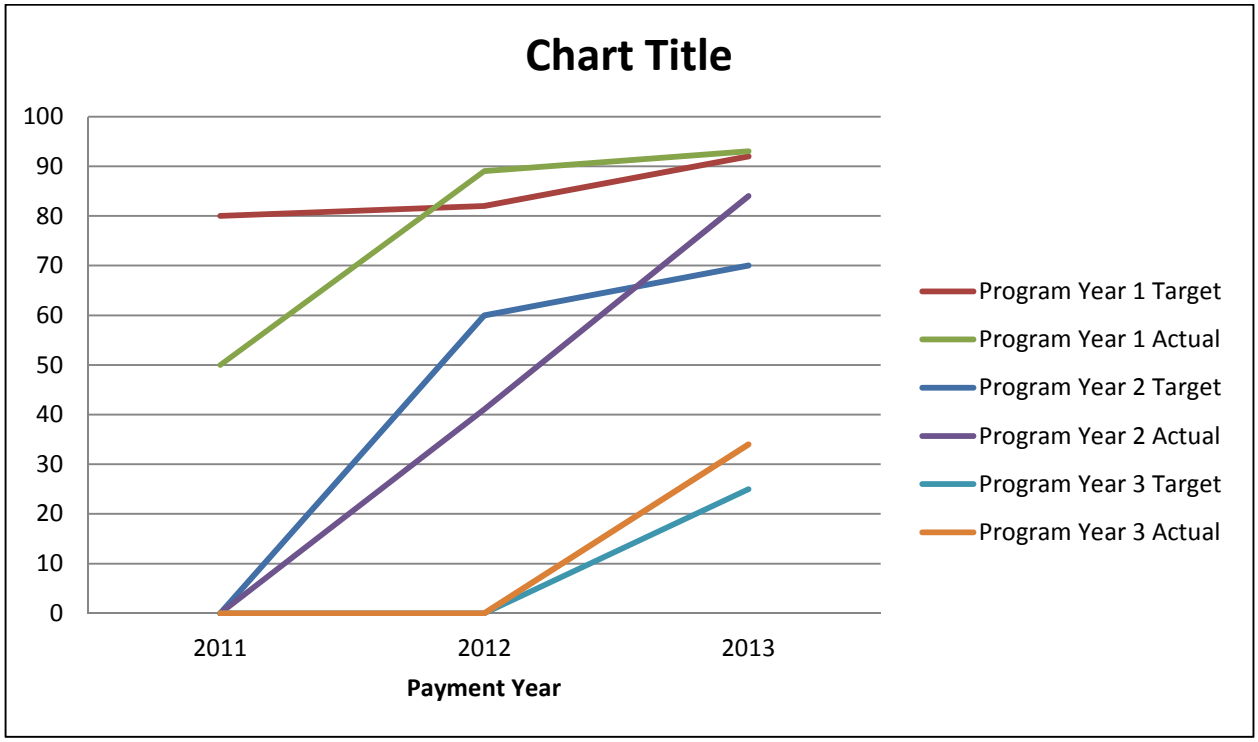


Target versus Actual Attestations

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.

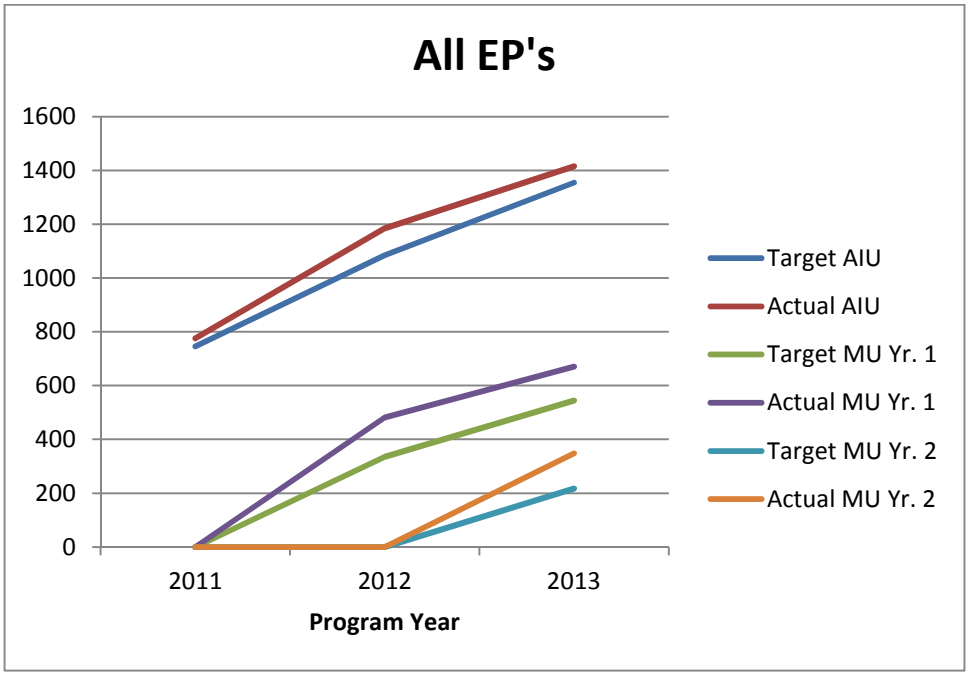
The charts below are indicative of the attestation rates by program year since its inception. The IME is proud of its success in encouraging providers to progress through the varying stages of the program and we will continue to work with providers in the years to come to ensure the meaningful use of EHR technology.

Figure 5: Targets versus actual for eligible hospitals



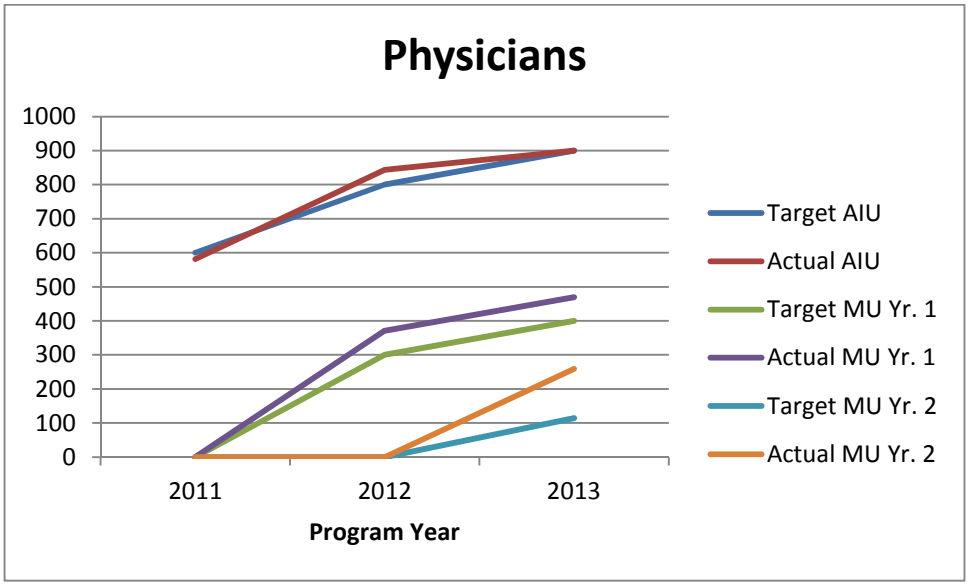
Eligible providers are broken out to clearly see each group's attestation rates and progress towards our goals. We have consistently exceeded our goals for AIU and will apply these consistent efforts toward encouraging providers towards meaningful use.

Figure 6: Targets versus actuals for all eligible providers



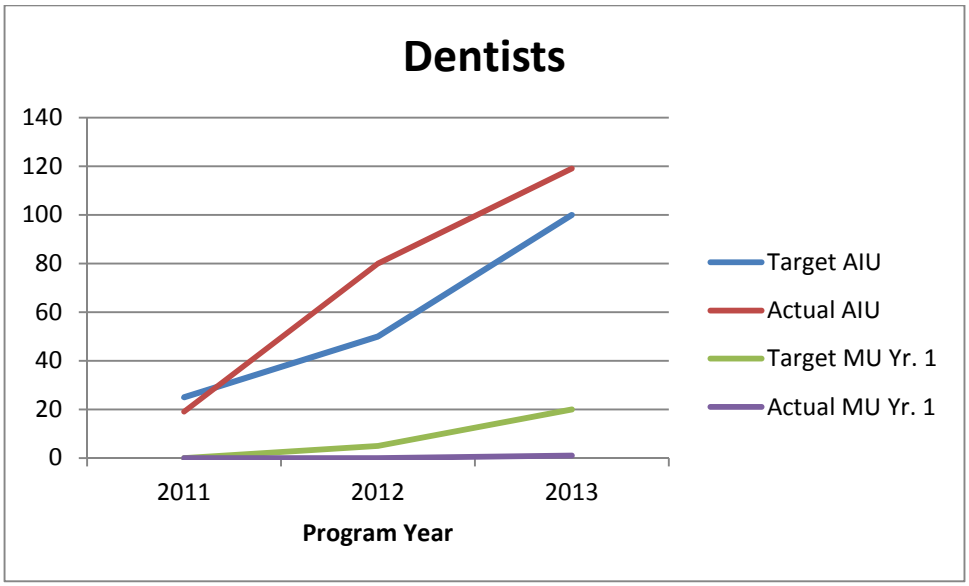
Physicians have largely met and exceeded our targets for AIU and MU. We are starting to see a slowdown in AIU attestations and anticipate seeing an uptick in meaningful use attestations since the patient volume methodology has become more inclusive of all Medicaid-eligible members. We exceeded our goal for 2014 and continue outreach and education opportunities to assist providers in their adoption and attestation efforts.

Figure 7: Targets versus actuals for Eligible Physicians



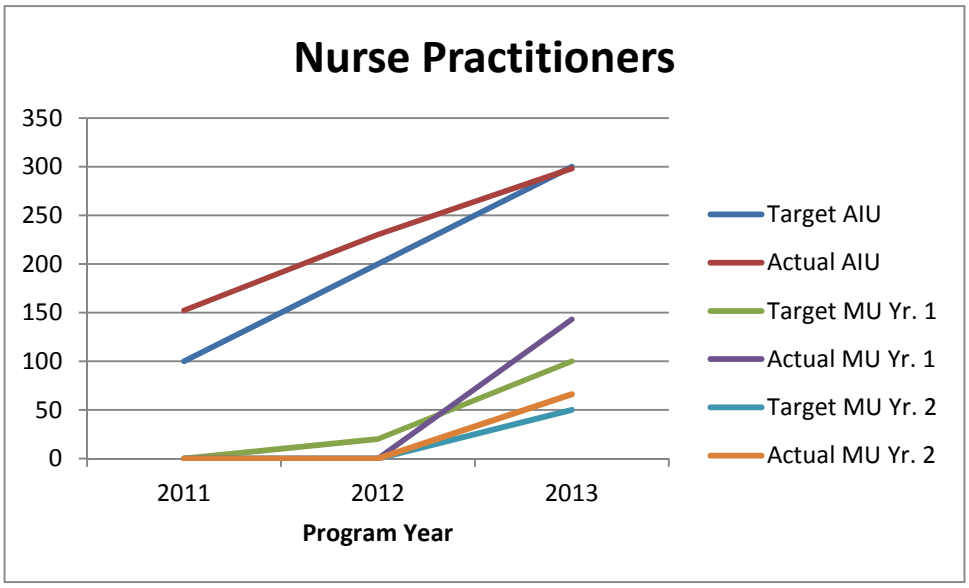
Dentists have had a slow start in AIU and only one provider has moved on to attest to MU. In 2011, we saw fewer attesting to AIU than we anticipated while 80 attested in 2012. We know that dentists' lack of meaningful use of EHRs is not unique to Iowa. We endeavor to reach out to our dentist providers in 2014 and 2015 to encourage MU attestation.

Figure 8: Targets versus actuals for eligible dentists



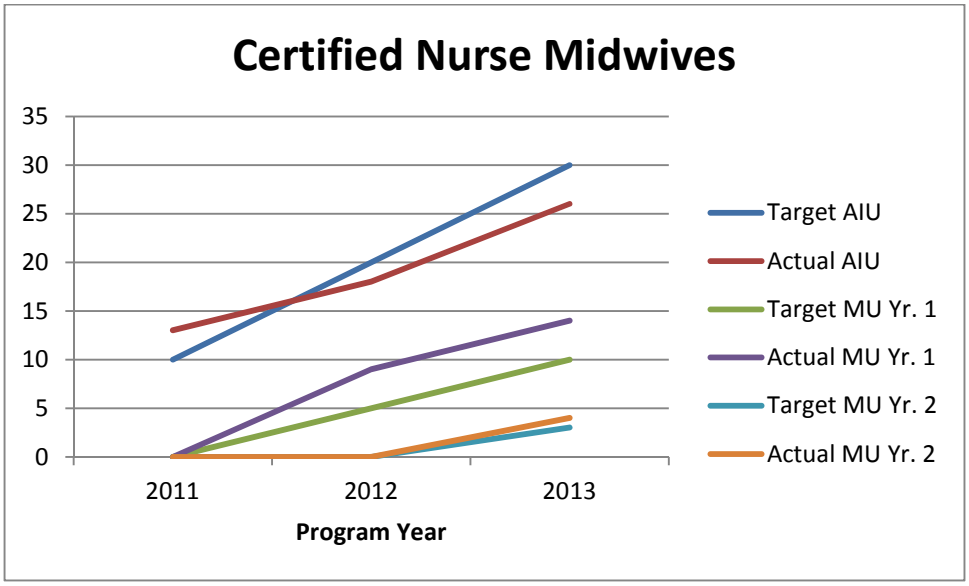
Iowa's Nurse Practitioners far exceeded our goals in both 2011 and 2012 with 152 and 230 attesting to AIU, respectively. Nurse Practitioners also attested to MU in large numbers in 2012. Consistent numbers of Nurse Practioners return for their second year of MU with 66 payments to this provider category in program year 2013.

Figure 9: Targets versus actuals for eligible Nurse Practitioners



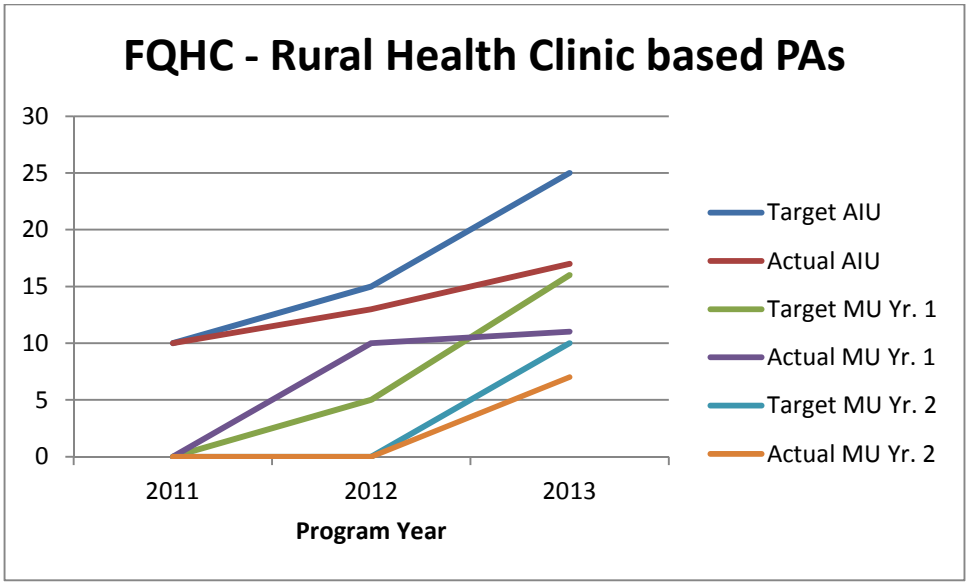
Certified Nurse Midwives exceeded our initial goals for AIU in 2011 and MU in 2012. AIU attestations by this group tapered off in 2013. Review of the original estimates ensure that we accurately reflected the baseline of CNMs. Continued outreachwill determine if there is something more we should be doing to assist in this transition.

Figure 10: 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. MU attestations exceeded our goals in 2012. We will 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 11: Targets versus actuals for eligible FQHC-Rural Health Clinic Based PAs



Meaningful Use

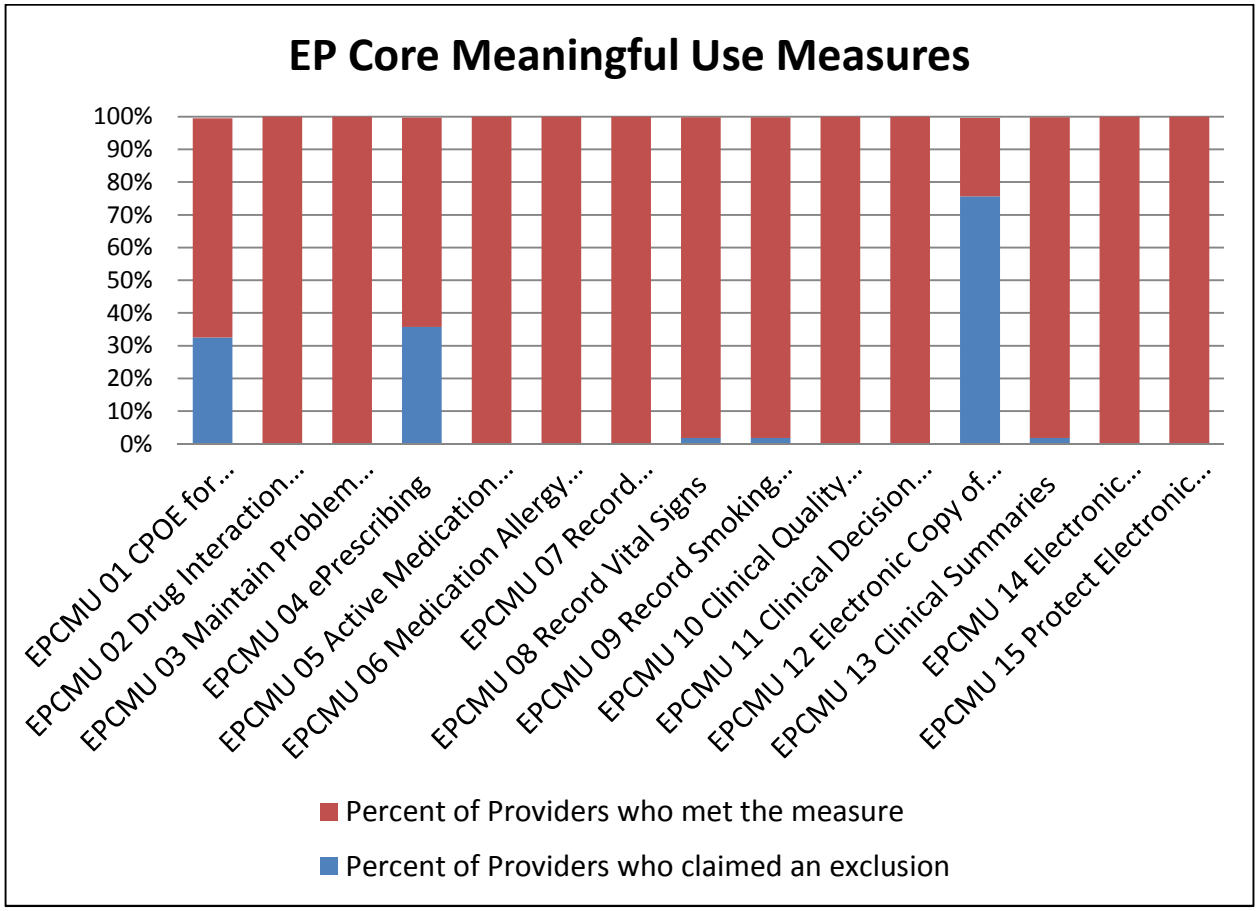
As of the end of the 2013EHR Incentive program year, the IME had 671 providers and 83 hospitals attest to to their first year of meaningful use. The breakdown is as follows:

Table 6: Breakdown of meaningful use attestations

Provider Type	Total Providers
Physician	470
Nurse Practitioner	143
Dentist	1
Optometrist	1
Certified Nurse Midwives	14
Pediatricians	32
Physician's Assistant practicing predominantly in a FQHC or RHC that is led by a physician's assistant	11
Acute Care Hospital	51
Critical Access Hospital	32
Children's Hospital	0

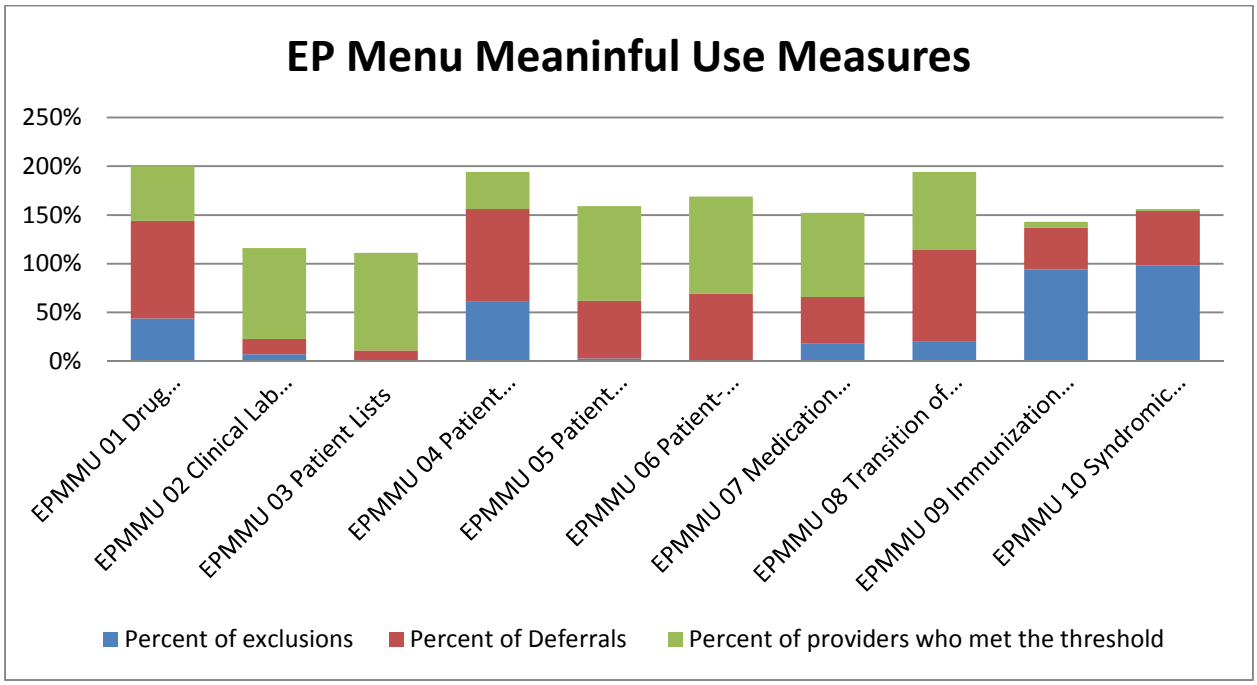
The providers and hospitals reported on the required core, menu, and clinical quality measures. Core measures had reporting of 100% of the providers meeting specific requirements. Measures 01 Computerized Physician Order Entry, and 04 ePrescribing had less than 40% of the providers claiming an exclusion. This is down from 50% during the previous reporting period. A large percentage of providers did claim an exclusion to measure 11 Electronic Copy of Health Informaiton. The IME will continue to monitor the trends and develop additional outreach to providers for assistance in understanding and meeting the measures. 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 meaningful use menu set of measures, we found that the number of deferrals decreased since the last reporting period. Previously, all providers had deferred reporting on patient lists. Our most recent report shows that only 11% of providers deferred on this same measure this year. Many providers continue to defer reporting on patient reminders and transition of care summaries. Measure 09 for Immunization Registries Data Submission deferral rate decreased from 60% to 43% . Many of those deferring providers returned for testing with the Immunization Registry Information System.I 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 showed a wide spread across the measures chosen for reporting. We saw 50-80% of providers report on the core measures and 30-40% on the alternative measures. The following tables show the percentage of providers reporting on the clinical quality measures.

Table 9: Eligible providers' attestation rates for core CQMs

Core Clinical Quality Measures	Percentage of Providers who attested to this CQM
CCQM 1 - NQF 0013 **Hypertension: Blood Pressure Measurement**	51%
CCQM 2 - NQF 0028 **a. Tobacco Use Assessment**	69%
CCQM 2 - NQF 0028 **b. Tobacco Cessation Intervention**	54%
CCQM 3 - NQF 0421 **Adult Weight Screening and Follow-up (Population 1)**	51%
CCQM 3 - NQF 0421 **Adult Weight Screening and Follow-up (Population 2)**	80%

Table 10: Eligible providers' attestation rates for alternate CQMs

Alternate Core Clinical Quality Measures	Percentage of providers who attested to this CQM
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 1	44%
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population - 1 Numerator 2	44%
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 3	44%
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 1	44%
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 2	44%
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 3	44%
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 1	44%
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 2	44%

ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 3	44%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 1	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 2	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 3	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 4	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 5	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 6	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 7	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 8	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 9	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 10	28%
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 11	28%

ACCQM 2 - NQF 0038 **Childhood Immunization Status** **Numerator 12**	28%
ACCQM 3 - NQF 0041 **Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old**	28%

Table 11: Eligible providers' attestation rates for additional CQMs

Additional Core Meaningful Use Measure	Percentage of providers who attested to this CQM
ACQM 1 - NQF 0001 **Asthma Assessment**	11.00%
ACQM 2 - NQF 0002 **Appropriate Testing for Children with Pharyngitis**	8.00%
ACQM 3 - NQF 0004 **Weight Assessment and Counseling for Children and Adolescents -** **Population 1 - Numerator 1**	1.00%
ACQM 3 - NQF 0004 **Weight Assessment and Counseling for Children and Adolescents -** **Population 1 - Numerator 2**	0.00%
ACQM 3 - NQF 0004 **Weight Assessment and Counseling for Children and Adolescents -** **Population 2 - Numerator 1**	1.00%
ACQM 3 - NQF 0004 **Weight Assessment and Counseling for Children and Adolescents -** **Population 2 - Numerator 2**	1.00%
ACQM 3 - NQF 0004 **Weight Assessment and Counseling for Children and Adolescents -** **Population 3 - Numerator 1**	0.00%

ACQM 3 - NQF 0004 **Weight Assessment and Counseling for Children and Adolescents -** **Population 3 - Numerator 2**	0.00%
ACQM 4 - NQF 0012 **Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)**	0.00%
ACQM 5 - NQF 0014 **Prenatal Care: Anti-D Immune Globulin**	0.00%
ACQM 6 - NQF 0018 **Controlling High Blood Pressure**	30.00%
ACQM 7 - NQF 0027 a **Smoking and Tobacco Use Cessation, Medical assistance:** **a. Advising Smokers and Tobacco Users to Quit**	25.00%
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**	25.00%
ACQM 8 - NQF 0031 **Breast Cancer Screening**	8.00%
ACQM 9 - NQF 0032 **Cervical Cancer Screening**	37.00%
ACQM 10 - NQF 0033 **Chlamydia Screening for Women** **Population 1**	14.00%
ACQM 10 - NQF 0033 **Chlamydia Screening for Women** **Population 2**	14.00%
ACQM 10 - NQF 0033 **Chlamydia Screening for Women** **Population 3**	14.00%
ACQM 11 - NQF 0034 **Colorectal Cancer Screening**	9.00%
ACQM 12 - NQF 0036 **Use of Appropriate Medications for Asthma** **Population 1**	29.00%

ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 2	29.00%
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 3	29.00%
ACQM 13 - NQF 0043 Pneumonia Vaccination Status for Older Adults	9.00%
ACQM 14 - NQF 0047 Asthma Pharmacologic Therapy	10.00%
ACQM 15 - NQF 0052 Low Back Pain: Use of Imaging Studies	1.00%
ACQM 16 - NQF 0055 Diabetes: Eye Exam	4.00%
ACQM 17 - NQF 0056 Diabetes: Foot Exam	1.00%
ACQM 18 - NQF 0059 Diabetes: Hemoglobin A1c Poor Control	29.00%
ACQM 19 - NQF 0061 Diabetes: Blood Pressure Management	17.00%
ACQM 20 - NQF 0062 Diabetes: Urine Screening	18.00%
ACQM 21 - NQF 0064 Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 1	26.00%
ACQM 21 - NQF 0064 Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 2	26.00%
ACQM 22 - NQF 0067 Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	0.00%
ACQM 23 - NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	0.00%

ACQM 24 - NQF 0070 **Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)**	0.00%
ACQM 25 - NQF 0073 **Ischemic Vascular Disease (IVD): Blood Pressure Management**	0.00%
ACQM 26 - NQF 0074 **Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol**	0.00%
ACQM 27 - NQF 0075 **Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control** **Numerator 1**	0.00%
ACQM 27 - NQF 0075 **Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control** **Numerator 2**	0.00%
ACQM 28 - NQF 0081 **Heart Failure (HF): Angiotensin- Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)**	0.00%
ACQM 29 - NQF 0083 **Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)**	0.00%
ACQM 30 - NQF 0084 **Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation**	0.00%
ACQM 31 - NQF 0086 **Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation**	4.00%
ACQM 32 - NQF 0088 **Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy**	0.00%
ACQM 33 - NQF 0089 **Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care**	0.00%

ACQM 34 - NQF 0105 **Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 1**	6.00%
ACQM 34 - NQF 0105 **Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 2**	6.00%
ACQM 35 - NQF 0385 **Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients**	0.00%
ACQM 36 - NQF 0387 **Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer**	0.00%
ACQM 37 - NQF 0389 **Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients**	0.00%
ACQM 38 - NQF 0575 **Diabetes: Hemoglobin A1c Control (<8.0%)**	2.00%

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. The IME has completed the programing necessary to ensure that our portal is ready to fully receive 2014 attestations for Stage 1 or Stage 2 AIU and MU attestations.

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 for Stage1. In 2014 and beyond, Iowa will continue to evaluate the need to move the public health measures from the menu set to the core set.

Iowa program set that Hospital EHR incentive payments will be paid over three years. foty percent 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 meeting 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 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 practice would continue even if 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 with clear understanding by both providers and patients.

More information on Iowa e-Health can be found on their website:
http://www.iowaehealth.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 executed the contract to the selected vendor. The IDPH has the IHIN infrastructure installed and is currently engaging in implementations.

IDPH selected a vendor in early 2012 to build the IHIN infrastructure. The Direct Secure Messaging feature was implemented in December 2012. Since then, 130 organizations signed Participation Agreements which represents over 1295 users as of July 21, 2014. The IME has signed up dentists for Prior Authorization and have at least 3 provider organizations using it for this as of July 1, 2014. In late 2013, the query and look-up functionality became 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.iowaehealth.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. One of our grant requirements is the collection of speed and connectivity data from CAI's. 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 proposed 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 partnered with Iowa Health System, allows 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.

Iowa Health System received $17,714,919 for the Iowa Healthcare Plus Broadband Extension Project. This project proposed 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. On-boarding is accomplished by utilizing test files to ensure data can be correctly captured in the Immunization Registry Information System (IRIS). IDPH processes the file and informs the provider if it passed or if there are corrections to make. From there, IDPH place providers in a queue for ongoing data transmission. There are over 300 sites that are onboarded and live submitting information to IRIS.

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 May 2013, IME found that there was a slight tick upwards in consumer awareness of electronic health records from 51% to 58%. 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, 57% of our members said that they would view their records on a website if it was available, which is up from 51%. It does appear that knowledge and support is growing as we move forward with increasing provider adoption and implementing member services online.

Figure 12: Member awareness of electronic health records

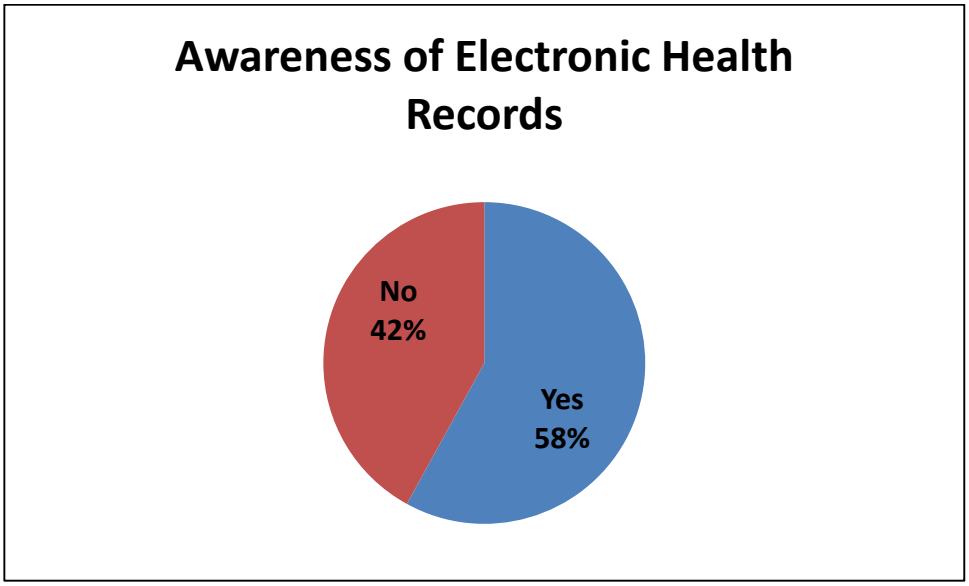


Figure 13: Member support of providers sharing EHR

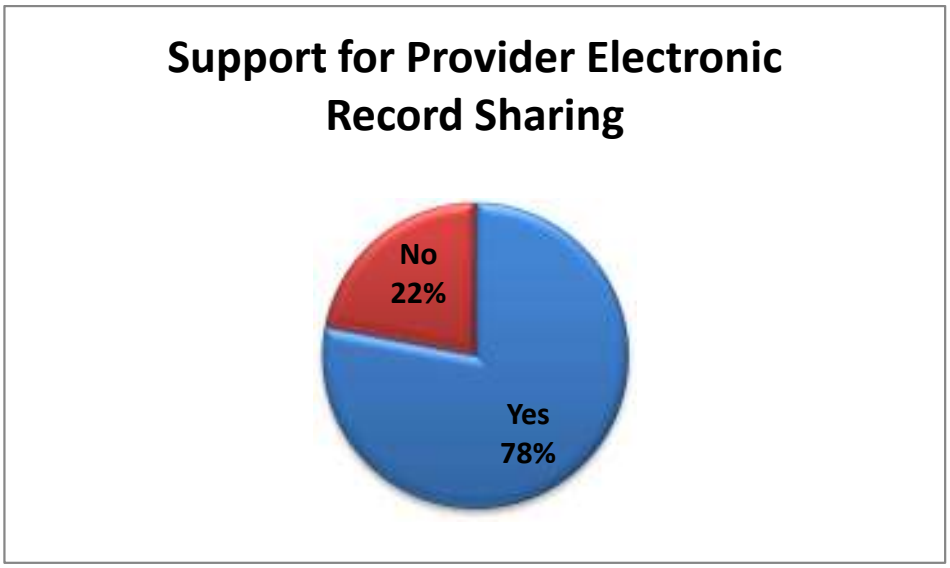
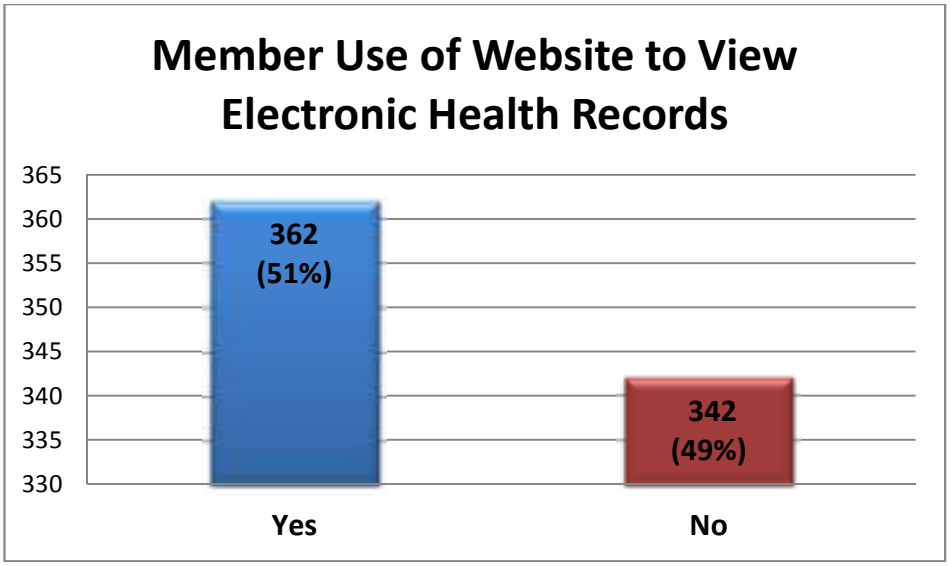


Figure 14: Would the member use a secured website to view EHR



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 August 2014, 14 students graduated with three finding employment and two continuing on to a Bachelor's degree. DMACC anticipates having seven more graduates by the end of 2015, and an additional of thirteen that will strat the program in Fall 2014. 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 complete a second environmental scan in 2015 to gauge adoption rates since 2010.

Table 12: Target adoption and meaningful use rates

Group	2013		2014		2015		2016		2017	
	AIU	MU	AIU	MU	AIU	MU	AIU	MU	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 13: Target percentages for CEHRT use by other groups[7]

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.

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

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.

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 Four 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 Additional Webinars will be added as the need for them arises.	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 IANEPCA 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.iowaehealth.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 Informational letter sent to advertise HIT module	April – August, each year June 2011	http://www.ime.state.ia.us/Providers/TrainingSchedule.html http://www.ime.state.ia.us/Providers/Bulletins.html

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.	Still in development

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

The provider incentive payment program launched on January 3, 2011. The IME identified the following items as highlights for the program since inauguration through July 1, 2014:

Conducted outreach via phone, email, in-person training, and webinars to support EHR and HIE adoption and meaningful use

Received a cumulative 1415 provider and 93 hospital AIU attestations, an additional 5 hospitals attested with Medicare first, therefor skipping AIU and receiving their first Medicaid Incentive payment as MU.

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

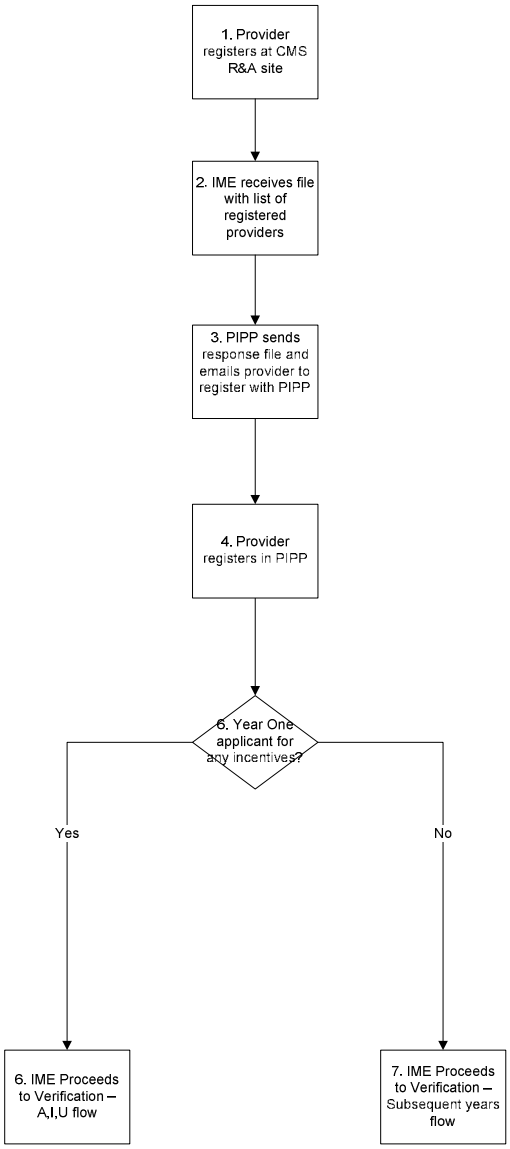


Figure 15: Registration and Attestation Process Narrative

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.imeincentvies.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.imeinecentives.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. IME will continue to validate the patient volume threshold and average length of patient stay requirements for eligible hospitals, as well as the hospital payment calculations.

Figure 16: Eligibility and Pre-Payment Verification Process

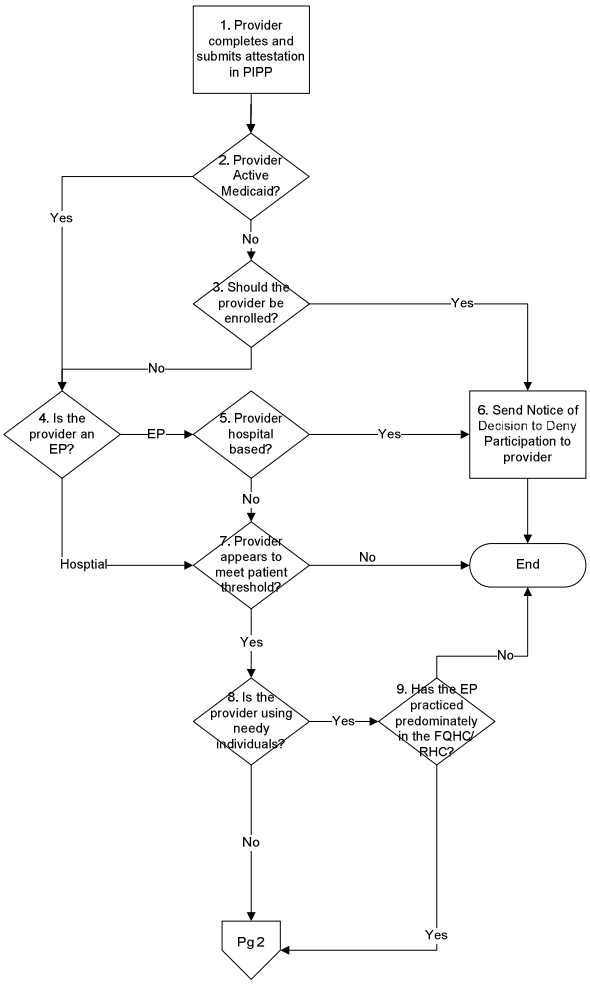


Figure 17: Eligibility and Pre-Payment Verification continued

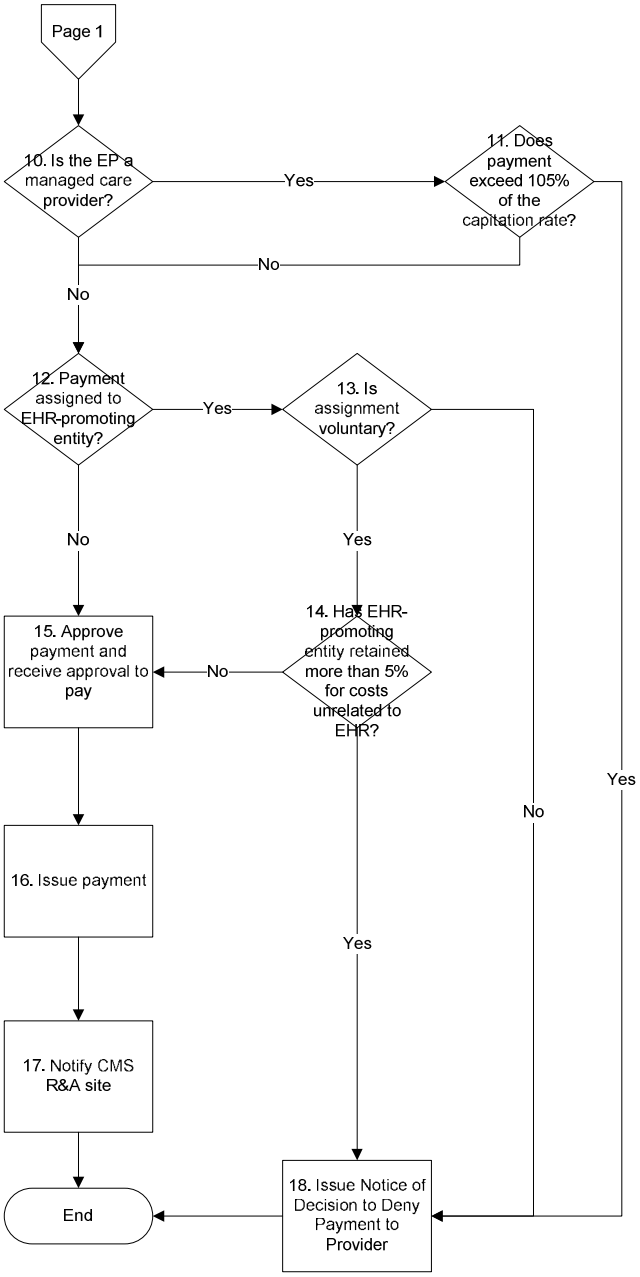


Table 14: Verification Process Narrative

Step	Action
1	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. 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.
2	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.
3	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.
4	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.

Step	Action
5	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.
6	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.

Step	Action
7	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. 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. 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. IME has modified our encounter query to ensure: • Managed care (Magellan and Meridian) encounters are calculated separately, • To include or not include inpatient encounters as desired by the provider, an • 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 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. This step may also require coordination with other states for those providers seeing patients covered by other state's Medicaid program. 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.

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 Step16.
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 as a quality control function and ensures that not one person has control over the entire approval process. In the event of a disagreement on whether or not to issue the payment, the application goes to a conflict

queue in PIPP for the incentive payment coordinator to review and break the tie. Applications are reviewed on a timely basiswith both reviews usually 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 it's 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 crossovers 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. Dually 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.. 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.

The team uses webinars, web-sites, Google groups, electronic informational letters, and electronic survey tools to conduct outreach, 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 attestations for meaningful use. IME awarded the contract in November 2011 and the new PIPP system launched April 2, 2012.

The IME has completed the program updates within PIPP for Stage 2 attestations. The following table provides a summary of our progress.

Table 15: Stage 2 Regulation Changes Summary

Stage 2 Regulation Changes				State Checklist				
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			Notes
					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			X	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 *Alternate* Measure from 2013 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. ***EPs Only Exclusions*** 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						X	
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	

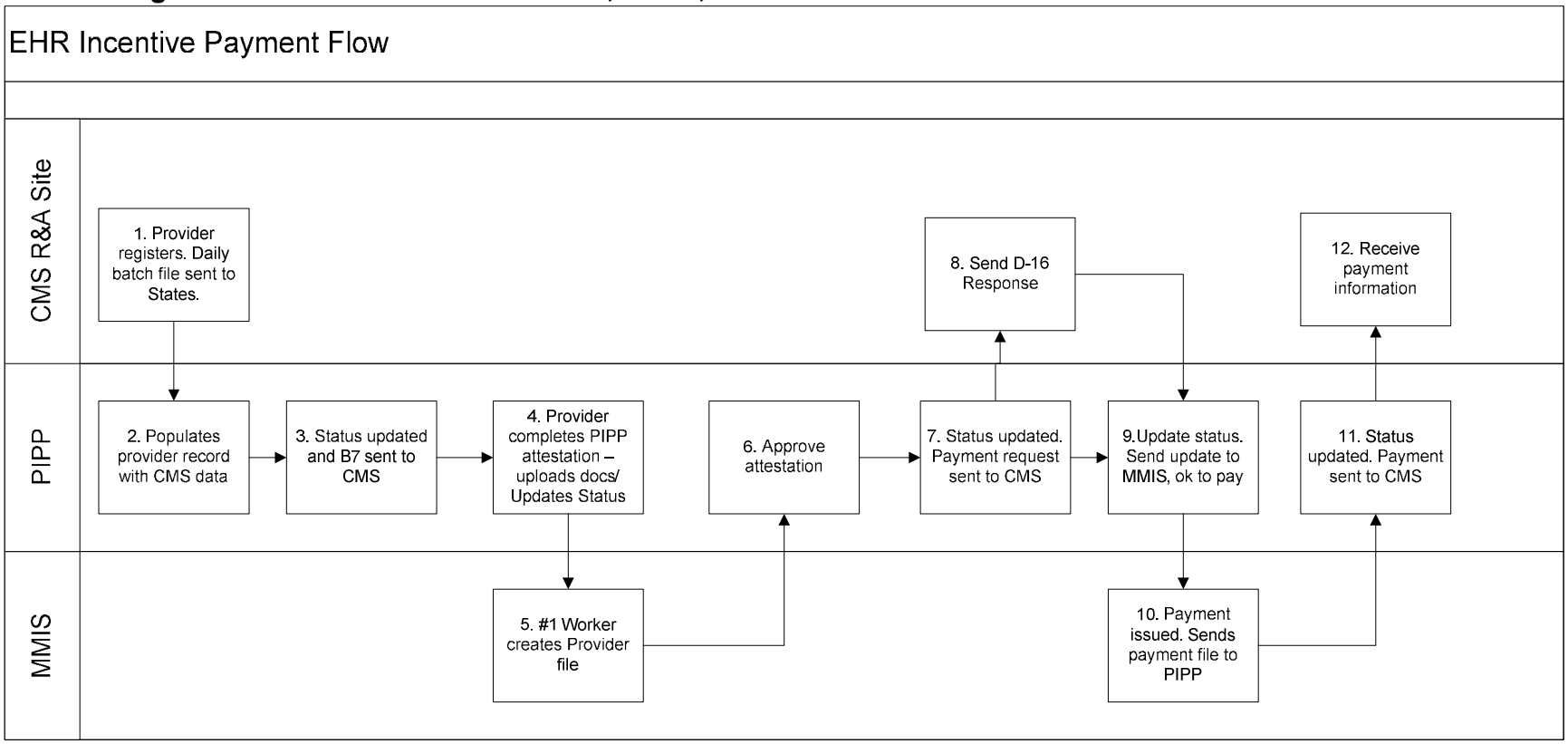
Stage 2 Regulation Changes				State Checklist				
Subject	Change	Applicable CFR Rule	Effective Date*	Target Date	Implementation Status			Notes
					Not Started	In Process	Complete	
	by the CQM's denominator for the EHR reporting period to the state to which they attest as specified by state. This data 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 18: 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 19: Provider attestation screen

Provider Questions

1. Are you currently enrolled as an Iowa Medicaid provider? Not Answered
2. My professional license number is
3. Do you have any sanctions pending against you? Not Answered
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? Yes
6. Are you a Pediatrician? Not Answered
7. Do you practice predominately in an FQHC/RHC? RHC

   How is your clinic 'so led' by a PA? Not Answered
8. Are you attesting at group or individual level? Not Answered
9. Are you currently seeing Medicaid patients billed through a supervising physician? Yes

   Enter your supervising physicians NPI:
10. Do you practice in multiple locations? Yes

Address		
	Remove	Edit
	Remove	Edit

Add

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? Not Answered

Figure 20: Provider attestation screen for EHR

EHR Questions

1. Have you adopted, implemented, or upgraded to certified electronic health record (EHR) technology?
   Not Answered

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 21: 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: <M/d/yyyy>

End Date: <M/d/yyyy>

2. What is the total number of patient encounters within the selected 90-day period?
(I.e. your denominator) 0

3. What is the total number of paid Medicaid encounters for the selected 90-day period?
(I.e. your numerator) 0

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? Not Answered

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

State	Medicaid Patient Count	Medicaid No

Add

6. Does your 30% include needy individuals? Yes

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: 0
hawk-i/CHIP: 0
Uncompensated: 0
No cost or reduced cost: 0

7. What is the auditable data source you are using to calculate patient volume? Not Answered

8. Are you including inpatient encounters in your patient volume? Not Answered

9. Are you including encounters covered by Magellan in your numerator? Not Answered

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? No

Attestation Questions – EH

Figure 22: EH Attestation Questions

EHR Questions

1. Has the hospital adopted, implemented or upgraded to certified electronic health record (EHR) technology?
   Yes
2. The hospital's CMS EHR Certification number:
3. Name/Description of certified EHR
4. For what type of payment is the hospital applying? MU
5. Have you attested with Medicare for a meaningful use payment? No

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 23: EH Patient Voliume Questons

Patient Volume Questions

What is your hospital's fiscal year end date?

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:

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? No

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

Please describe Other

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 24: 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:

Prior Year 1:

Prior Year 2:

Prior Year 3:

Average Growth Rate:

Compute

Medicaid Computation

Total Medicaid Days:
w/s S-2 part I, col. 7, SUM of line 1 and lines 8-12

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

Total Medicaid Days:

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

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

Non-charity Percentage:

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

Total Non-charity Hospital Days:

Medicaid Percentage:

Medicaid Aggregate EHR Incentive Amount:

Compute

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

No

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 send 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 25: Appeals Process Flow

Appeal Process

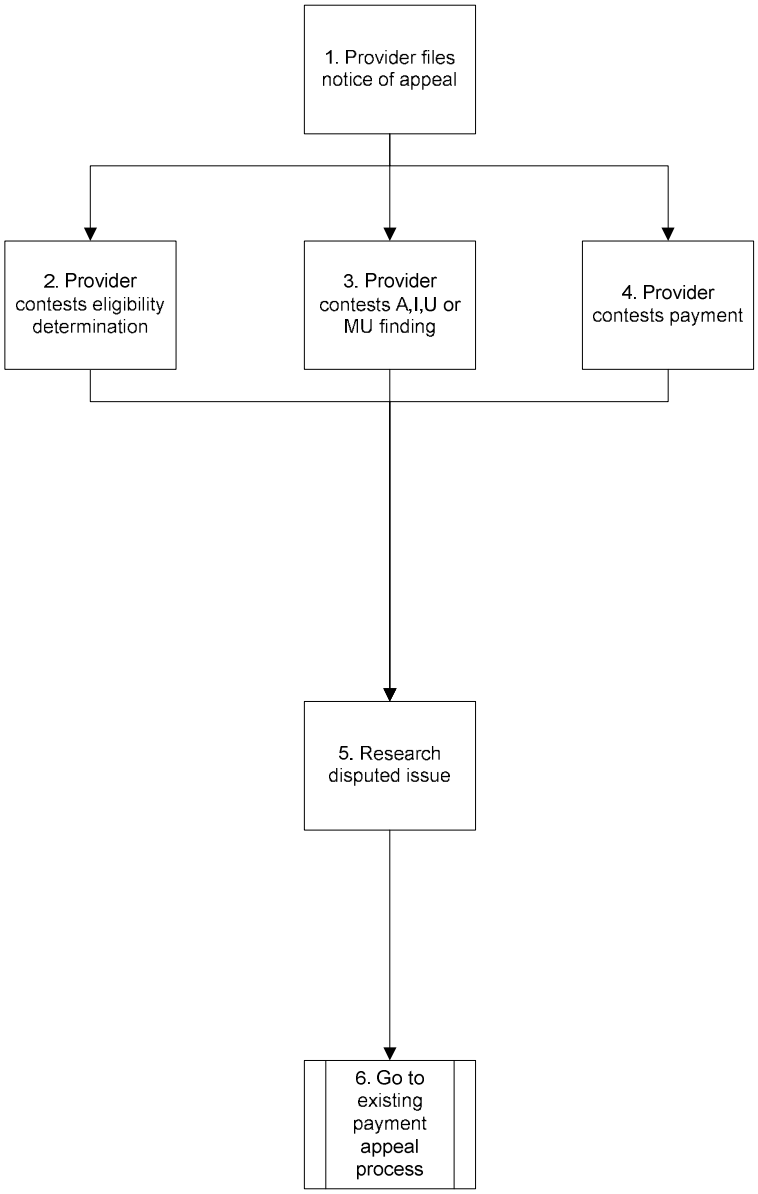


Table 16: Appeal Process Narrative

Step	Action
1	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 *Appeal and Request for Hearing* 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.
2	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.
3	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.
4	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.
5	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.
6	Go to existing payment appeal process. This is the existing process for responding to provider appeals.

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 26: Claim Federal Reimbursement Flow

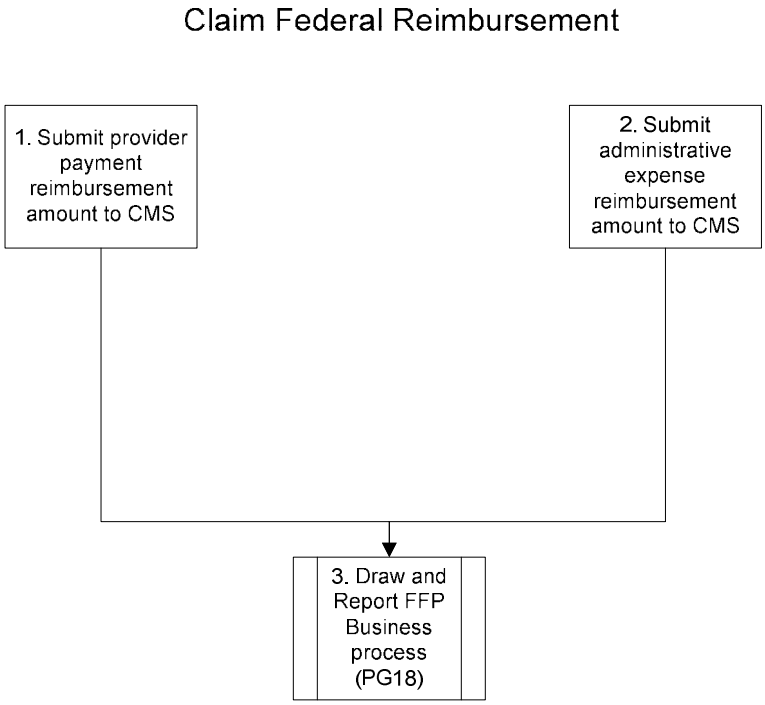


Table 17: Claim Federal Reimbursement Narrative

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 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 to administer the incentive program by updating our attestation portal as appropriate.

We will continue offering a 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 byt 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 FY15, 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 continued this approach with Accountable Care Organizations as we began those discussions in FY14. We require ACOs to use the IHIN capabilities of the currently available Direct secure messaging and the Patient Look-up function.

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 quarterly 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.

IME 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 Locater 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 Healtheway

In December 2012, Direct Secure Messenging 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 attempted to utilize Direct messaging by collecting CCD documents from Health Home electronic health records systems to perform quality measurements. This process has been unsuccessful thus far due to EHR vendors not being ready to submit quality data this way. Electronic submission of clinical quality data is still being worked on and part of a discussion with Iowa Department of Public Health.

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 as pilot providers for dental prior authorization. As of July, three dentists sent in prior authorization request via Direct Secure Messaging averaging between 10 and 15 submissions per week. 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 FY15 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 FY15 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 2014, there are over 687 practitioners in 79 locations with over 6,000 members assigned.

A second State Plan Amendment approved by CMS in July of 2013 to serve members with Serious Mental Illness (SMI) or a Serious Emotional Disturbance (SED). Known as the Integrated Health Homes (IHH), the program started in July 2013 in five Iowa counties and has expanded to state-wide as of July 2014.

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 and encouraging 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.

As of August 2013, the IHIN functionality has been built and tested. Now individual organizations are making their connections so they could begin exchanging health information in Iowa. To date over 130 participation agreements have been signed representing more than 500 individual hospital and clinic location. Well over 3000 individual Direct addresses are now available for secure provider exchange of health information which have reached a rate of 4100 messages per month, many of which are providing transition or referral of care information.

Iowa is applying for a SIM Testing grant to help accelerate transformation to a value-based delivery system. If awarded, Iowa will build an alerting/notification system which uses Admissions, Discharge, and Transfers (ADT) events as well as other triggers to generate notifications that an Iowan is now receiving care or has transferred their care. This will help those receiving responsibility for the continuation of the patient's care to be aware of thos items that could improve care. Items such as fall risk or new medication therapies to continue immediately for example. Iowa plans to pilot the alerting system within the ACO delivery system for Medicaid as a test that could then be expanded to multiple payers across the state.

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 through the Provider Incentive Payment Portal (PIPP).

Health Home providers are required to submit a CCD file using IHIN Direct Messaging to the Iowa Medicaid Enterprise. The CCDs would be analyzed using an Alere tool obtained through an optional component of the Iowa Health Information Network. IME's goal was to start collecting the clinical data through the IHIN, beginning in August, 2012. However, barriers have caused a delay in providers reporting quality measures to this tool.

The delays primary stem from Health Home providers waiting for EHR upgrades to be CCD compliant and then the IT resources to establish a process to populate the CCD and automatically push the CCDs to the Alere tool through Direct Messaging. Due to these delays, IME is researching a quality metrics reporting solution for Health Home providers that eliminates barriers while still promoting the use of health information that is transparent, meaningful and ultimately helps lower costs.

Deliver Education and Interventions

Based on trends indentified 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.	Completed
	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	Continue to expand the usage of the Web Portal to members of	On Hold.

of Health Records	the care team.	
	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.

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[8]	
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	▪ Timely availability of clinical data ▪ Increased workflow efficiencies
Hospitals	▪ Timely availability of clinical data ▪ Increased workflow efficiencies
Home Health Care Agencies	▪ Timely availability of clinical data ▪ Less time to document patient care-related activities
Long Term Care Facilities	▪ Better communication with providers ▪ Improved patient safety (e.g., drug-related interactions or allergies)

[8] 2010 Environmental Scan

Pharmacies	▪ Timely availability of clinical data ▪ Better communication with providers
Laboratory Facilities	▪ Timely availability of clinical data ▪ Less staff time to process test orders
Radiology Facilities	▪ 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:**
Physicians Percentage interested in participating in an HIE not available.	▪ Summary of patient care records (e.g., CCD) ▪ Medication lists
Hospitals Percentage interested in participating in an HIE not available.	▪ Summary of patient care records (e.g., CCD) ▪ Managing patient care from one healthcare setting to another
Home Health Care Agencies 75% surveyed are interested in participating in an HIE	▪ Summary of patient care records (e.g., CCD) ▪ Discharge summary
Long Term Care Facilities 55% surveyed are interested in participating in an HIE	▪ Summary of patient care records (e.g., CCD) ▪ Managing patient care from one healthcare setting to another
Pharmacies 55% surveyed are interested in participating in an HIE	▪ Ability to request consultation fo clinical advice from physicians or other providers ▪ Immunization status
Laboratory Facilities 63% surveyed are interested in participating in an HIE	▪ Lab results ▪ Reporting communicable diseases to the State Hygienic

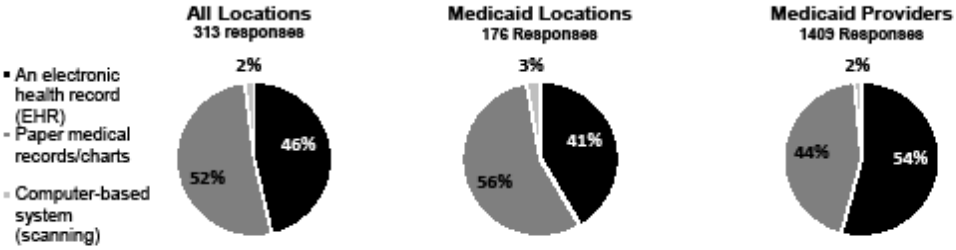
	Laboratory and to the IDPH
Radiology Facilities 88% surveyed are interested in participating in an HIE	▪ Radiology results, images and image orders ▪ Patient allergies or contraindications

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 ▪ 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 ▪ 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 ▪ 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			

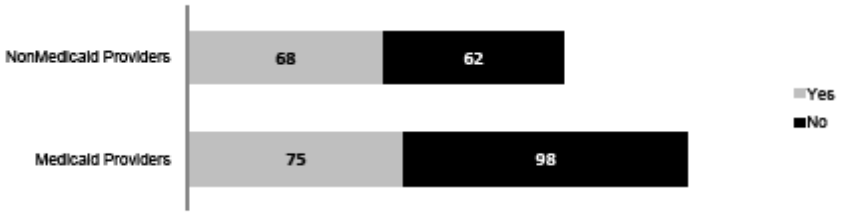
Analysis of Medicaid Providers
Further Understanding the Health IT Landscape in Iowa

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:

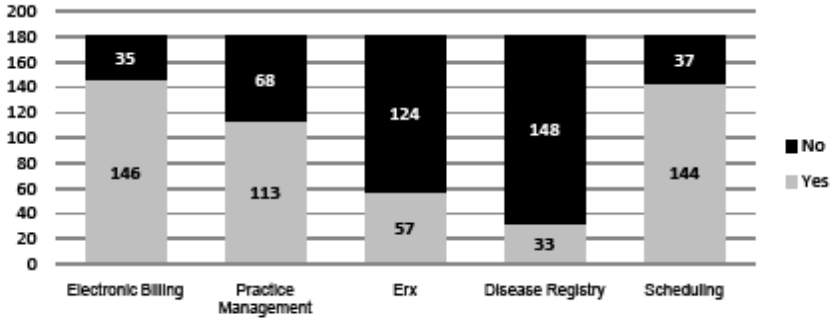


Response to the question: Do you currently use an EHR?

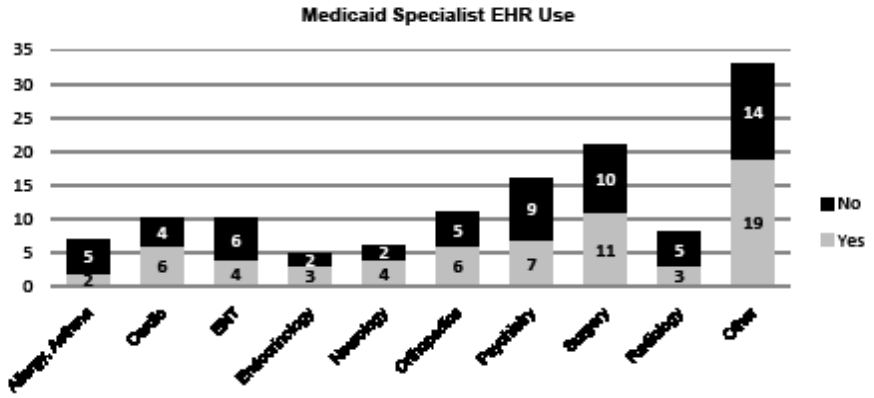


2. Types of EHR services used among Medicaid providers:

Number of Medicaid providers using the following services



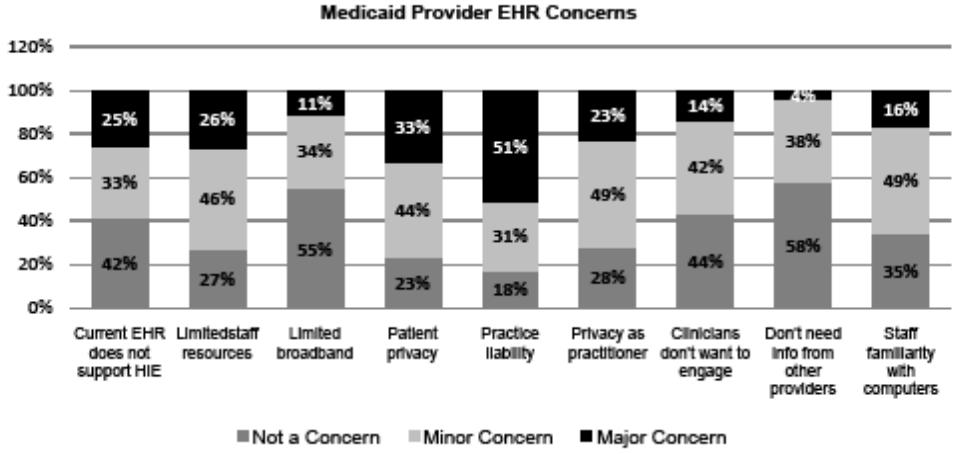
3. **Medicaid providers that use an EHR system by their specialty:**



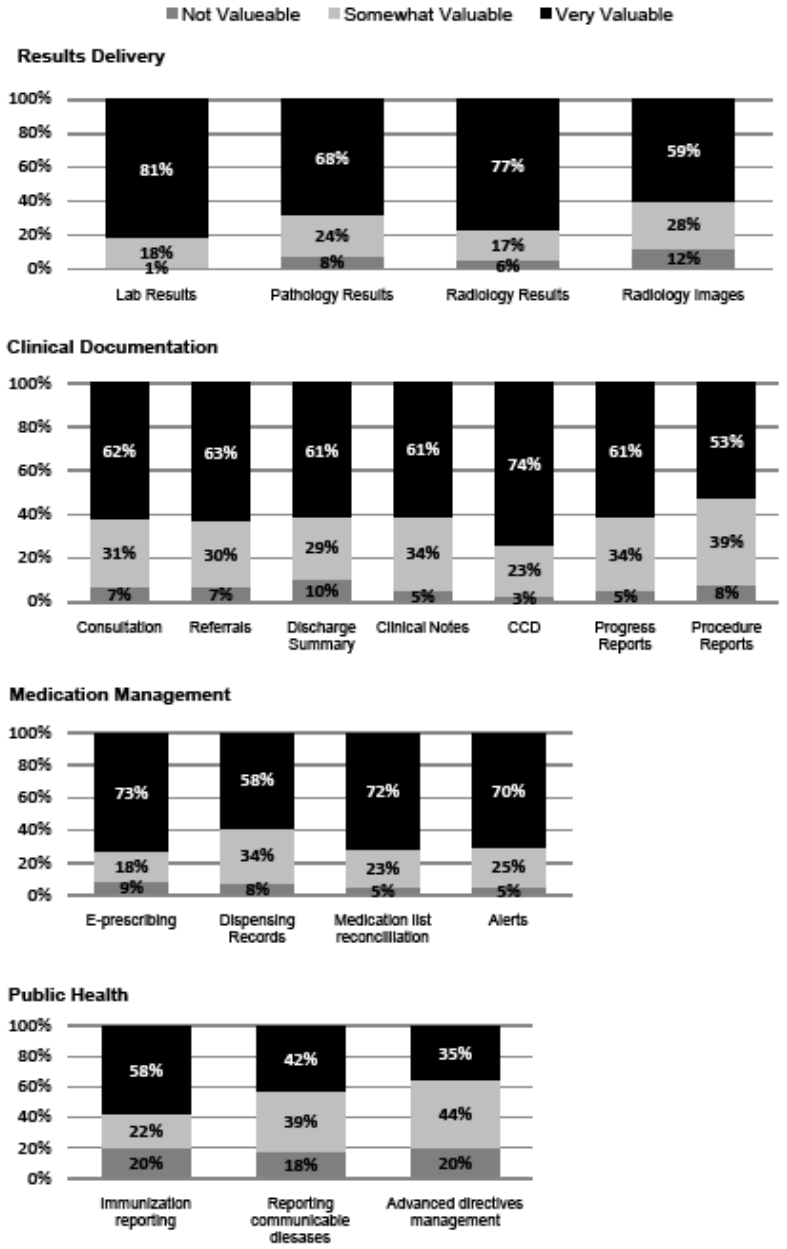
4. **Common certified or previously certified EHR vendors in use by Medicare providers.**

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

5. **Concerns about adopting EHRs among Medicaid providers.**

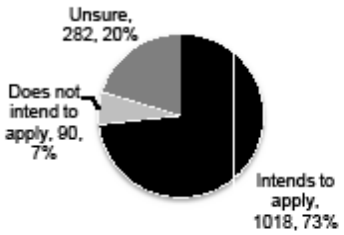


6. **Value of various types of clinical data exchange through a health information exchange.**

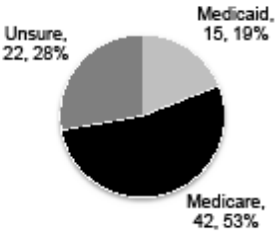


7a. Ambulatory practices/clinics intending to apply for meaningful use provider incentives available through Medicare and Medicaid:
(Intention, number of responses, percentage)

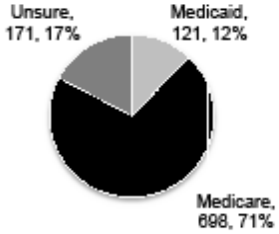
7b. Ambulatory practitioners intending to apply for meaningful use provider incentives available through Medicare and Medicaid:
(Intention, number of responses, percentage)



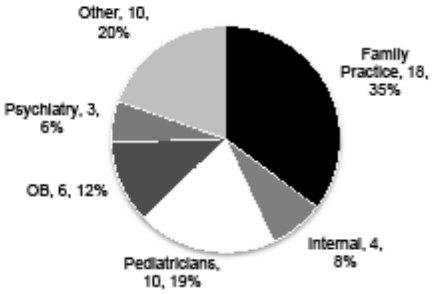
8a. Of those practices interested in meaningful use incentives, the source from which they intend to seek funding:
(Intention, number of responses, percentage)



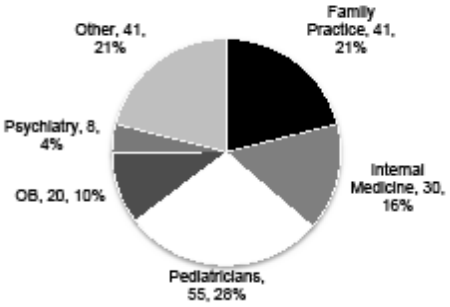
8b. Of those practitioners interested in meaningful use incentives, the source from which they intend to seek funding:
(Intention, number of responses, percentage)



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 18 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
Number of Priorities Matching a Goal	*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 19 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
Operations Management	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% Note: There are 26 Operations Management business processes, but one of these is not currently a part of the Iowa MITA Enterprise.
Program Management	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%
Business Relationship Management	This area has 4 BPs, all at level one level 1 – 4 BPs – 100%
Program Integrity 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 – 50% level 1 – 1 BPs – 50%
Care Management	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% Note: There are four Care Management business processes but one of them is not currently a part of the Iowa MITA Enterprise.

Table 20 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%

Table 21 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%
Operations Management	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% Note: There are 26 Operations Management business processes, but one of these is not currently a part of the Iowa MITA Enterprise.
Program Management	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%
Business Relationship Management	This area has 4 BPs, all at level one level 1 – 4 BPs – 100%
Program Integrity 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 – 50% level 1 – 1 BPs – 50%

Business Area Name	Maturity Level Summary
Care Management	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% Note: There are four Care Management business processes but one of them is not currently a part of the Iowa MITA Enterprise.

Table 22 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 cos

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	-	2,000,000	2,000,000

**Medicare Share Set at 1*

Step 4: Apply Transition Factor

	-	1,500,000	1,000,000

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 inMedicaid, 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 ~~https://secureapp.dhs.state.ia.us/impa~~/ www.imeincentives.com. The applicant shall use the Web site to:

(1) Attest to the applicant's qualifications to receive the incentive payment, and
(2) Digitally sign Form 470-4976, Iowa Electronic Health Record Incentive Program Provider Agreement.
b. For the second year of participation, ~~the~~ eligible providers must submit meaningful use and clinical quality measures to the department, either through attestation or electronically as required by the department.
c. The department shall verify the applicant's eligibility, including patient volume and practice type, and the applicant's use of certified electronic health record technology.

79.16(4) *Payment.* The department shall issue the incentive payment only after confirming that all eligibility and performance criteria have been satisfied. Payments will be processed and paid to the tax identification number designated by the applicant. The department will communicate the payment or denial of payment to the ~~National Level Repository~~ CMS Registration and Attestation Web site.
a. The primary communication channel from the department to the provider will be the ~~IMPA~~ Iowa EHR Medicaid incentive payment administration Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.
b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:
(1) Eligibility,
(2) Purchase of certified electronic health record technology, and
(3) Meaningful use of electronic health record technology.

79.16(5) *Administrative appeal.* Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:
a. Provider eligibility determination.
b. Incentive payments.
c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

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.

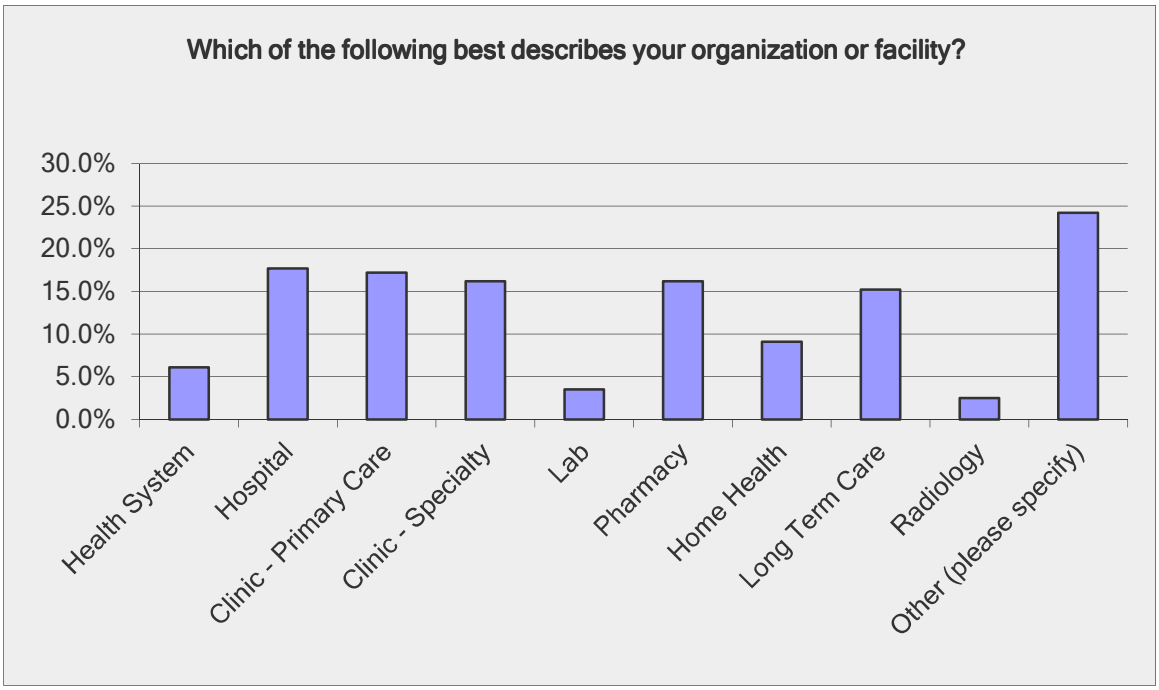
V. The Provider shall maintain books, records and documents which sufficiently and properly document and calculate all charges billed to the Department throughout

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.


Which of the following best describes your organization or facility?
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Health System
Hospital
Clinic - Primary Care
Clinic - Specialty
Lab
Pharmacy
Home Health
Long Term Care
Radiology
Other (please specify)

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.

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:

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: **Denominator:**

More

1234 West Street - Does the Eligible Provider use a Certified Electronic Health Record technology at this location during the EHR reporting period?

○ Yes ○ No

456 South Street - Does the Eligible Provider use a Certified Electronic Health Record technology at this location during the EHR reporting period?

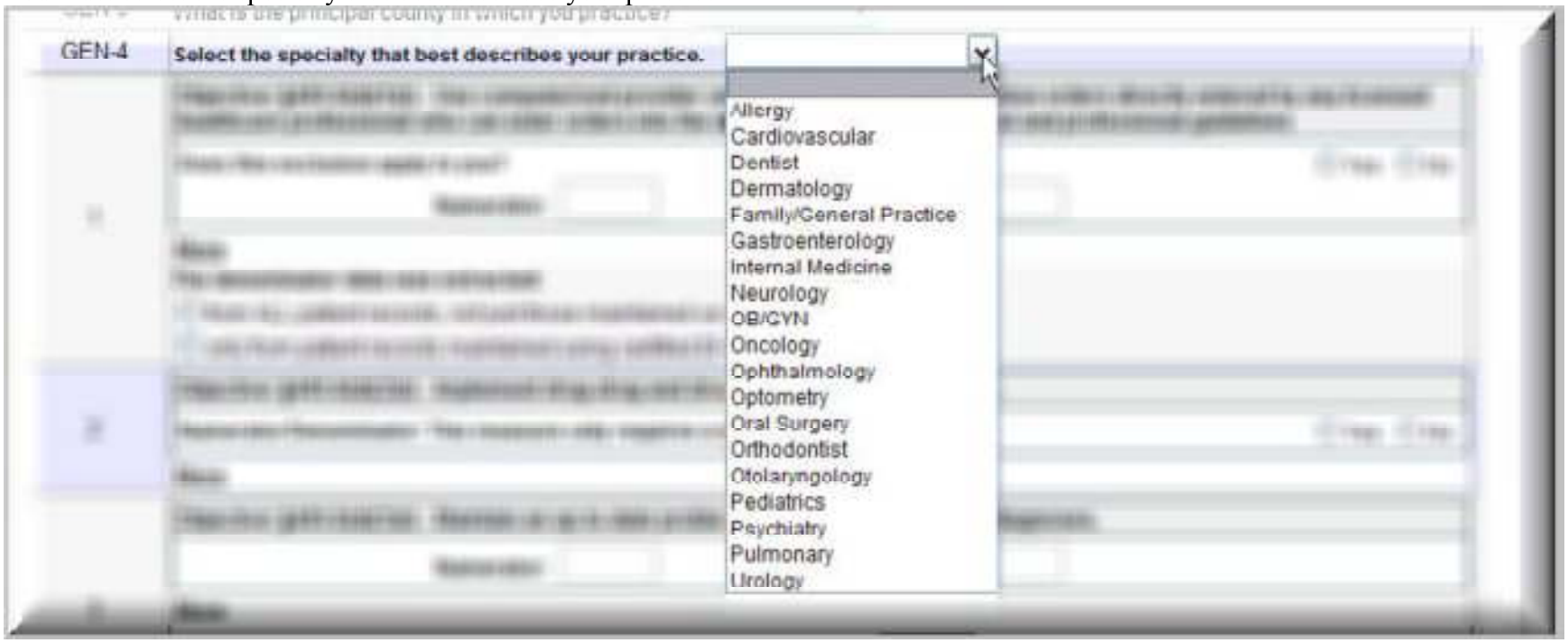
○ Yes ○ No

You must select the principal county in which you practice.

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.



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

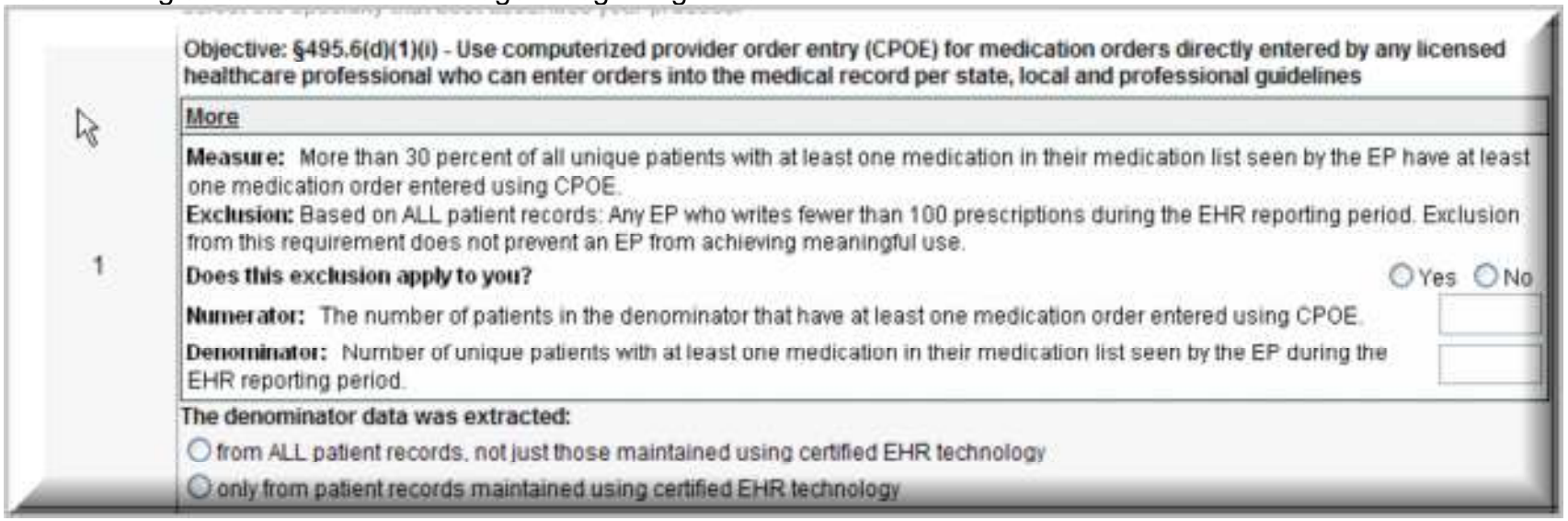
will display the types of denominators allowed, you must select a denominator source. All questions require an answer unless otherwise specified.

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 2014

The following screen shots are for Stage 1 beginning in 2014.



Objective: §495.6(d)(2)(ii) - Implement drug-drug and drug-allergy interaction checks.

2

More

Measure: The EP has enabled this functionality for the entire EHR reporting period.
Numerator/Denominator: This measure only requires a yes/no answer
Numerator: N/A
Denominator: N/A

Yes No

Objective: §495.6(d)(3)(ii) - Maintain an up-to-date problem list of current and active diagnoses.

3

More

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

Objective: §495.6(d)(4)(ii) - Generate and transmit permissible prescriptions electronically (eRx)

4

More

Measure: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.
Exclusion 1: 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.
Exclusion 2: Any EP who 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.

Does exclusion 1 apply to you? ○ Yes ○ No
Does exclusion 2 apply to you? ○ Yes ○ No

Numerator: Number of prescriptions in the denominator generated and transmitted electronically.
Denominator: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.
Percentage:

Which eRx service did you use?

Name a pharmacy to which you transmitted:

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

Objective: §495.6(d)(5)(i) - Maintain active medication list

5

More

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

6	Objective: §495.6(d)(6)(i) - Maintain active medication allergy list More **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. **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**
7	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 More **Measure:** More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data. **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**

8

NEW

Objective: §495.6(g)(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) (3) Plot and display growth charts for patients 0-20 years, including body mass index

More

Measure: More than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients age 3 and over only) and height/length and weight (for all ages) recorded as structured data.
Exclusion 1: Any EP who sees no patients 3 years or older is excluded from recording blood pressure
Exclusion 2: Any EP who believes that all three vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them
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; or
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.

Does exclusion 1 apply to you? ○ Yes ○ No
Does exclusion 2 apply to you? ○ Yes ○ No
Does exclusion 3 apply to you? ○ Yes ○ No
Does exclusion 4 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.

Percentage:

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. **Percentage:** **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. **This objective and measure have been incorporated directly into the definition of a meaningful user, so a separate affirmation of reporting CQMs will not be required as a core measure beginning in 2013. CQMs must nevertheless be reported in every year of meaningful use; see the clinical quality measures attestation screen.** More
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 Yes No

12 **NEW**	Objective: §495.6(d)(12)(ii) - Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP More **Measure:** More than 50 percent 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 subject to the EP's discretion to withhold certain information. **Exclusion:** Any EP who neither orders nor creates any of the information listed for inclusion as part of this measure. **Does this exclusion apply to you?** Yes No **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:** **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. **Percentage:** **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 clinicalinformation (for example, problem list, medication list, allergies, anddiagnostic test results), among providers of care and patient authorizedentities electronically. **This objective and measure will not be required beginning in 2013. CMS states, "the Stage 2 requirements for actual electronic exchange of summary of care records create sufficient incentive to begin testing in Stage 1 without there being an explicit meaningful use requirement to do so."** More
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 following screen shots are for Stage2

#	Measure
GEN-1	**EHR Reporting Period**
GEN-2	**Requirement: At least 80% of unique patients must have their data in the certified EHR during the EHR reporting period** **Numerator:** Number of patients in the denominator with data maintained in a certified EHR during the EHR reporting period. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**
GEN-3	**What is the principal county in which you practice?**
GEN-4	**Select the specialty that best describes your practice.**
1.1 § 495.6 (j)(1)(i)	**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.** **Medication Measure:** More than 60 percent of medication orders created by EP during the EHR reporting period are recorded using CPOE. **Exclusion:** Any EP who writes fewer than 100 medication orders during the EHR reporting period. **Does this exclusion apply to you?** Yes No **Numerator:** The number of orders in the denominator recorded using CPOE. **Denominator:** Number of medication orders created by the EP during the EHR reporting period. **Percentage:**
1.2 § 495.6 (j)(1)(i)	**Radiology Measure:** More than 30 percent of radiology orders created by EP during the EHR reporting period are recorded using CPOE. **Exclusion:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period. **Does this exclusion apply to you?** Yes No **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. **Percentage:**

1.3 § 495.6 (j)(1)(i)	**Laboratory Measure:** More than 30 percent of laboratory orders created by EP during the EHR reporting period are recorded using CPOE. **Exclusion:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. **Does this exclusion apply to you?** Yes No **Numerator:** The number of orders in the denominator recorded using CPOE. **Denominator:** Number of Laboratory orders created by the EP during the EHR reporting period. **Percentage:** **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
2 § 495.6 (j)(2)(i)	**Objective: Generate and transmit permissible prescriptions electronically (eRx).** **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. **Exclusion:** Any EP who: (1)Writes fewer than 100 permissible prescriptions during the EHR reporting period. (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 **Does exclusion 1 apply to you?** Yes No **Does exclusion 2 apply to you?** Yes No **Numerator:** The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT. **Denominator:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period. **Percentage:** **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

3 § 495.6 (j)(3)(i)	**Objective: Record the following demographics: preferred language, sex, race, ethnicity, date of birth.** **Measure:** More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data. **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**
4 § 495.6 (j)(4)(i)	**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.** **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 (for all ages) recorded as structured data. **Exclusion:** Any EP who: (1)Sees no patients 3 years or older is excluded from recording blood pressure. (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. (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. (4)Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from **Does exclusion 1 apply to you?** Yes No **Does exclusion 2 apply to you?** Yes No **Does exclusion 3 apply to you?** Yes No **Does exclusion 4 apply to you?** Yes No **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**

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 § 495.6 (j)(5)(i)	**Objective: Record smoking status for patients 13 years old or older.** **Measure:** More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data. **Exclusion:** Any EP that neither sees nor admits any patients 13 years old or older. **Does this exclusion apply to you?** Yes 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 during the EHR reporting period. **Percentage:** **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
6.1 § 495.6 (j)(6(i)	**Objective: Use clinical decision support to improve performance on high-priority health conditions.** **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 EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. **Did you achieve this objective by meeting the measure?** **Numerator:** N/A **Denominator:** N/A Yes No
6.2 § 495.6 (j)(6(i)	**Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.** Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. **Exclusion:** For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period. **Does this exclusion apply to you?** Yes No **Did you achieve this objective by meeting the measure?** **Numerator:** N/A **Denominator:** N/A Yes No

5 § 495.6 (j)(5)(i)	**Objective: Record smoking status for patients 13 years old or older.** **Measure:** More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data. **Exclusion:** Any EP that neither sees nor admits any patients 13 years old or older. **Does this exclusion apply to you?** Yes 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 during the EHR reporting period. **Percentage:** **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
6.1 § 495.6 (j)(6(i)	**Objective: Use clinical decision support to improve performance on high-priority health conditions.** **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 EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. **Did you achieve this objective by meeting the measure?** **Numerator:** N/A **Denominator:** N/A Yes No
6.2 § 495.6 (j)(6(i)	**Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.** Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. **Exclusion:** For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period. **Does this exclusion apply to you?** Yes No **Did you achieve this objective by meeting the measure?** **Numerator:** N/A **Denominator:** N/A Yes No

7.1 § 495.6 (j)(10)(i)	**Objective: 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.** **Measure 1:** More than 50 percent 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. **Exclusion:** Any EP who: (1)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. (2)Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 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. **Does exclusion 1 apply to you?** Yes No **Does exclusion 2 apply to you?** Yes No **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**
7.2 § 495.6 (j)(10)(i)	**Measure 2:** More than 5 percent 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. **Exclusion:** Any EP who: (1)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. (2)Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 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. **Does exclusion 1 apply to you?** Yes No **Does exclusion 2 apply to you?** Yes No **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**

8 § 495.6 (j)(11)(i)	**Objective: Provide clinical summaries for patients for each office visit.** **Measure:** Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits. **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 where the patient or a patient-authorized representative is provided a clinical summary of their visit within one (1) business day. **Denominator:** Number of office visits conducted by the EP during the EHR reporting period. **Percentage:** **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 § 495.6 (j)(16)(i)	**Objective: Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.** **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 **Did you achieve this objective by meeting the measure?** Yes No **Numerator:** N/A **Denominator:** N/A
10 § 495.6 (j)(7)(i)	**Objective: Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data** **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 this exclusion apply to you?** Yes 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:** from ALL patient records, not just those maintained using certified EHR technology only from patient records maintained using certified EHR technology

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.** **Measure:** Generate at least one report listing patients of the EP with a specific condition. **Did you achieve this objective by meeting the measure?** Yes No **Numerator:** N/A **Denominator:** N/A
12 § 495.6 (j)(9)(i)	**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.** **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. **Exclusion:** Any EP who has had no office visits in the 24 months before the EHR reporting period. **Does this exclusion apply to you?** Yes No **Numerator:** Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period. **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. **Percentage:**
13 § 495.6 (j)(12)(i)	**Objective: Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.** **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. **Exclusion:** Any EP who has no office visits during the EHR reporting period. **Does this exclusion apply to you?** Yes No **Numerator:** Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology. **Denominator:** Number of unique patients with office visits seen by the EP during the EHR reporting period. **Percentage:**

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.** **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 this exclusion apply to you?** Yes 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:**
15.1 § 495.6 (j)(14)(i)	**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.** EPs must satisfy both of the following measures in order to meet this objective: **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. **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. **Does this exclusion apply to you?** Yes No **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. **Percentage:**

15.2 § 495.6 (j)(14)(i)	**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. **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. **Percentage:**
15.3 § 495.6 (j)(14)(i)	**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). OR Conducts one more successful tests with the CMS designated test EHR during the EHR reporting period. **Did you achieve this objective by meeting the measure?** **Numerator:** N/A **Denominator:** N/A Yes No

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.**
	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; (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 exclusion 1 apply to you?** ○ Yes ● No **Does exclusion 2 apply to you?** ○ Yes ● No **Does exclusion 3 apply to you?** ○ Yes ● No **Does exclusion 4 apply to you?** ○ Yes ● No **Did you achieve this objective by meeting the measure?** **Numerator:** N/A **Denominator:** N/A ● Yes ○ No
	Choose the best description of how you met this measure from the options below: ○ Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period using either the current standard at 45 CFR 170.314(f)(1) and (f)(2) or the standards included in the 2011 Edition EHR certification criteria adopted by ONC during the prior EHR reporting period when ongoing submission was achieved. ○ Registration with the PHA or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved. ○ Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is still engaged in testing and validation of ongoing electronic submission. ○ Registration of intent to initiate ongoing submission was made by the deadline and the EP or hospital is awaiting invitation to begin testing and validation.

17 § 495.6 (j)(17)(i)	**Objective: Use secure electronic messaging to communicate with patients on relevant health information.** **Measure:** A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period. **Exclusion:** Any EP who: (1)Has no office visits during the EHR reporting period; (2)Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. **Does exclusion 1 apply to you?** ○ Yes ○ No **Does exclusion 2 apply to you?** ○ Yes ○ No **Numerator:** The number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period. _____ **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. _____ **Percentage:**

Figure 27: EP CPOE for Medication, Maboratory, and Radiology Orders

1 § 495.6 (j)(1)(i)	**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. More **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. **Measure 1 - Medication:** **Exclusion:** Any EP who writes fewer than 100 medication orders during the EHR reporting period. **Does the exclusion apply to you:** O Yes O No **Numerator:** The number of orders in the denominator recorded using CPOE. **Denominator:** Number of medication orders created by the EP during the EHR reporting period. **Percentage:** **Measure 2 - Radiology:** **Exclusion:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period. **Does the exclusion apply to you:** O Yes O No **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. **Percentage:** **Measure 3 - Laboratory:** **Exclusion:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period. **Does the exclusion apply to you:** O Yes O No **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. **Percentage:** **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

Figure 28: e-Prescribing

2 § 495.6 (j)(2)(i)	**Objective:** Generate and transmit permissible prescriptions electronically (eRx). More **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. **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 **Does the exclusion 1 apply to you:** O Yes O No **Does the exclusion 2 apply to you:** O Yes O No **Numerator:** The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT. **Denominator:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or Number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period. **Percentage:** **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

Figure 29: 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.. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**

Figure 30: Record Vital Signs

4 § 495.6 (j)(4)(i)	**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. More **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. **Exclusion:** Any EP who: (1) Sees no patients 3 years or older is excluded from recording blood pressure. (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. (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. (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. **Does the exclusion 1 apply to you:** O Yes O No **Does the exclusion 2 apply to you:** O Yes O No **Does the exclusion 3 apply to you:** O Yes O No **Does the exclusion 4 apply to you:** O Yes O No **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:** **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

Figure 31: Record smoking status

5 § 495.6 (j)(5)(i)	**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 seen by the EP have smoking status recorded as structured data. **Exclusion:** Any EP that neither sees nor admits any patients 13 years old or older. **Does the exclusion apply to you:** O Yes O 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 during the EHR reporting period. **Percentage:** **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

Figure 32: Clinical Decision Support Rule

6 § 495.6 (j)(6(i)	**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 EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. **Measure 2:** The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period. **Exclusion:** For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period. **Does the exclusion for Measure 2 apply to you:** O Yes O No **Did you meet the criteria for measure 1?** O Yes O No **Did you meet the criteria for measure 2?** O Yes O No

Figure 33: Patient Electronic Access

	Objective: 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.
	More
	Measure 1: More than 50 percent 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 percent 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.
	Exclusion: Any EP who: (1) 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. (2) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 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.
7	**Does exclusion 1 apply to you:** O Yes O No
§ 495.6 (j)(10)(i)	**Does exclusion 2 apply to you:** O Yes O No
	Measure 1 **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**
	Measure 2 **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. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**

Figure 34: Clinical Summaries

8 § 495.6 (j)(11)(i)	**Objective:** Provide clinical summaries for patients for each office visit. More **Measure:** Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits. **Exclusion:** Any EP who has no office visits during the EHR reporting period. **Does the exclusion apply to you:** O Yes O No **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. **Denominator:** Number of office visits conducted by the EP during the EHR reporting period. **Percentage:** **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

Figure 35: Patient Electronic Health Information

9 § 495.6 (j)(16)(i)	**Objective:** Protect electronic health information created or maintained by the certified EHR technology (CEHRT) 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), 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 **Exclusion:** None **Did you meet the criteria for measure?** O Yes O No

Figure 36: 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:** O Yes O 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:** ○ from ALL patient records, not just those maintained using certified EHR technology ○ only from patient records maintained using certified EHR technology

Figure 37: 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?** O Yes O No

Figure 38: Preventive Care

12 § 495.6 (j)(9)(i)	**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. More **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. **Exclusion:** Any EP who has had no office visits in the 24 months before the EHR reporting period. **Does the exclusion apply to you:** O Yes O No **Numerator:** Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period. **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. **Percentage:**

Figure 39: Patient Specific Education Resources

13 § 495.6 (j)(12)(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:** 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. **Exclusion:** Any EP who has no office visits during the EHR reporting period. **Does the exclusion apply to you:** O Yes O No **Numerator:** Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology. **Denominator:** Number of unique patients with office visits seen by the EP during the EHR reporting period. **Percentage:**

Figure 40: 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:** O Yes O 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:**

Figure 41: Summary of Care

	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.
	More
	EPs must satisfy both of the following measures in order to meet this objective.
	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.
	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.
	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.
15 § 495.6 (j)(14)(i)	**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. **Does the exclusion apply to you:** O Yes O No **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. [ ] **Percentage:** [ ] **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. [ ] **Percentage:** [ ]
	Measure 3: **Did you meet the criteria for this measure?** O Yes O No

Figure 42: 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:** O Yes O No **Does the exclusion 2 apply to you:** O Yes O No **Does the exclusion 3 apply to you:** O Yes O No **Does the exclusion 4 apply to you:** O Yes O No **Did you meet the criteria for this measure?** O Yes O No

Figure 43: Use Secure Electronic Messaging

17 § 495.6 (j)(17)(i)	**Objective:** Use secure electronic messaging to communicate with patients on relevant health information. More **Measure:** A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period. **Exclusion:** Any EP who: (1) Has no office visits during the EHR reporting period (2) Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 3Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period. **Does exclusion 1 apply to you:** O Yes O No **Does exclusion 2 apply to you:** O Yes O No **Numerator:** The number of patients or patient-authorized representatives in the denominator who send a secure electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**

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.

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
☐	495.6(e)(9)(i) - Capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited and according to applicable law and practice.
☐	495.6(e)(10)(i) - Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and according to applicable law and practice.

Select 5 objectives total (1 public health and 4 additional menu objectives).

Select	Objective
☐	§495.6(e)(1)(i) - Implement drug formulary checks.
☐	§495.6(e)(2)(i) - Incorporate clinical lab test results into EHR as structured data.
☐	§495.6(e)(3)(i) - Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
☐	§495.6(e)(4)(i) - Send reminders to patients per patient preference for preventive/follow-up care.
☐	**§495.6(e)(5)(i) - Beginning in 2014 this objective and measure are no longer required as part of the menu set.**
☐	§495.6(e)(6)(i) - Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
☐	§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.
☐	§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.

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.

#	Measure
1	Objective: 495.6(e)(9)(i) - Capability to submit electronic data to immunization registries or immunization information systems and actual submission except where prohibited and according to applicable law and practice. 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
2	Objective: 495.6(e)(10)(i) - Capability to submit electronic syndromic surveillance data to public health agencies and actual submission except where prohibited and according to applicable law and practice. 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. **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

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? Yes No

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

Numerator: N/A

Denominator: N/A Yes No

4

Objective: §495.6(e)(2)(i) - Incorporate clinical lab test results into EHR as structured data.

More

Measure: 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.

Exclusion: 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.

Does this exclusion apply to you? Yes No

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.

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:

Results entered using:

Health Information Exchange

Manually Entered

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	Objective: §495.6(e)(3)(ii) - 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. **Numerator/Denominator: This measure only requires a yes/no answer** **Numerator:** N/A **Denominator:** N/A 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
6	Objective: §495.6(e)(4)(ii) - Send reminders to patients per patient preference for preventive/follow-up care. More **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?** Yes No **Numerator:** Number of patients in the denominator who were sent the appropriate reminder. **Denominator:** Number of unique patients 65 years old or older or 5 years older or younger. **Percentage:** **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
8	Objective: §495.6(e)(6)(ii) - 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. **Percentage:**

9	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. **Percentage:** **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(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?** Yes No **Does exclusion 2 apply to you?** Yes No **Numerator:** 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. **Percentage:** **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

EP Menu Set Screen Shots – Stage 2

Meaningful Use Menu Set Questions

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 3 overall questions.

Select	Objective
☐	Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.
☐	Record electronic notes in patient records.
☐	Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.
☐	Record patient family health history as structured data.
☐	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.
☐	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

#	Measure
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.** **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?** Yes No **Does exclusion 2 apply to you?** Yes No **Does exclusion 3 apply to you?** Yes No **Does exclusion 4 apply to you?** Yes No **Did you achieve this objective by meeting the measure?** **Numerator:** N/A **Denominator:** N/A Yes No
2 § 495.6 (k)(6)(i)	**Objective: Record electronic notes in patient records.** **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 **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:**

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.** **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 this exclusion apply to you?** Yes No **Numerator:** The number of results in the denominator that are accessible through CEHRT. **Denominator:** Number of tests whose result is one or more images ordered by the EP during the EHR reporting period. **Percentage:**
4 § 495.6 (k)(2)(i)	**Objective: Record patient family health history as structured data.** **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 this exclusion apply to you?** Yes No **Numerator:** The number of patients in the denominator with a structured data entry for one or more first-degree relatives. **Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Percentage:**

5 § 495.6 (k)(4)(i)	**Objective: 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.** **Measure:** Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period. **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?** Yes No **Does exclusion 2 apply to you?** Yes No **Does exclusion 3 apply to you?** Yes No **Does exclusion 4 apply to you?** Yes No **Did you achieve this objective by meeting the measure?** **Numerator:** N/A **Denominator:** N/A Yes No

6 § 495.6 (k)(5)(i)	**Objective: 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.** **Measure:** Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period. **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?** Yes No **Does exclusion 2 apply to you?** Yes No **Does exclusion 3 apply to you?** Yes No **Does exclusion 4 apply to you?** Yes No **Did you achieve this objective by meeting the measure?** **Numerator:** N/A **Denominator:** N/A Yes 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.

CQM Attestation Screens – applicable to both Stage 1 and Stage 2

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			Pediatrician Patient Population		
eCQM ID	NQF #	CQM Title	eCQM ID	NQF #	CQM Title
CMS165v2	NQF0018	Controlling High Blood Pressure	CMS146v2	NQF0002	Appropriate Testing for Children with Pharyngitis
CMS156v2	NQF0022	Use of High-Risk Medications in the Elderly	CMS155v2	NQF0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
CMS138v2	NQF0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS153v2	NQF0033	Chlamydia Screening for Women
CMS166v3	NQF0052	Use of Imaging Studies for Low Back Pain	CMS126v2	NQF0036	Use of Appropriate Medications for Asthma
CMS2v3	NQF0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	CMS117v2	NQF0038	Childhood Immunization Status
CMS68v3	NQF0419	Documentation of Current Medications in the Medical Record	CMS154v2	NQF0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
CMS69v2	NQF0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow -Up	CMS136v3	NQF0108	ADHD: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication
CMS50v2	TBD	Closing the referral loop: receipt of specialist report	CMS2v3	NQF0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
CMS90v3	TBD	Functional status assessment for complex chronic conditions	CMS75v2	TBD	Children who have dental decay or cavities

○ Adult Patient Population ○ Pediatrician Patient Population ○ Manual Selection

Adult population CQM Selection

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.

#	Measure
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 :** **Denominator :** **Performance Rate %:** **Exclusion:**
4	**NQF#:**NQF0022 **eCQM#:**CMS156v2 **Domain:**Patient Safety **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. • Percentage of patients who were ordered at least one high-risk medication. • 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 who meet the specified criteria.:** **Numerator :** **Denominator :** **Performance Rate %:** **Numerator 2:Patients who were ordered at least two high-risk medications who meet the specified criteria.:** **Numerator :** **Denominator :** **Performance Rate %:**
6	**NQF#:**NQF0028 **eCQM#:**CMS138v2 **Domain:**Population/Public Health **Title:**Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention **Description:**Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user **Numerator :** **Denominator :** **Performance Rate %:** **Exception:**

15	**NQF#:**NQF0052 **eCQM#:**CMS166v3 **Domain:**Efficient Use of Healthcare Resources **Title:**Use of Imaging Studies for Low Back Pain **Description:**Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis **Numerator :** **Denominator :** **Performance Rate %:** **Exclusion:**
43	**NQF#:**NQF0418 **eCQM#:**CMS2v3 **Domain:**Population/Public Health **Title:**Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan **Description:**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. **Numerator :** **Denominator :** **Performance Rate %:** **Exclusion:** **Exception:**
44	**NQF#:**NQF0419 **eCQM#:**CMS68v3 **Domain:**Patient Safety **Title:**Documentation of Current Medications in the Medical Record **Description:**Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration. **Numerator :** **Denominator :** **Performance Rate %:** **Exception:**

44	**NQF#:**NQF0419 **eCQM#:**CMS68v3 **Domain:**Patient Safety **Title:**Documentation of Current Medications in the Medical Record **Description:**Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration. **Numerator :** **Denominator :** **Performance Rate %:** **Exception:**
45	**NQF#:**NQF0421 **eCQM#:**CMS69v2 **Domain:**Population/Public Health **Title:**Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up **Description:**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 of normal parameters, a follow-up plan is documented during the encounter or during the previous 6 months of the encounter with the BMI outside of normal parameters. Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 Age 18-64 years BMI ≥ 18.5 and < 25 **Population Criteria 1: Patients ≥ 65, BMI ≥ 23 AND < 30:** **Numerator :** **Denominator :** **Performance Rate %:** **Exclusion:** **Population Criteria 2: Patients≥ 18 AND ≤ 64, BMI ≥ 18.5 AND < 25:** **Numerator :** **Denominator :** **Performance Rate %:** **Exclusion:**
59	**NQF#:**NQFXXXX **eCQM#:**CMS50v2 **Domain:**Care Coordination **Title:**Closing the referral loop: receipt of specialist report **Description:**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. **Numerator :** **Denominator :** **Performance Rate %:**
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 :** **Denominator :** **Performance Rate %:** **Exclusion:**

Pediatrician Patient Population CQMs

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.

#	Measure
1	**NQF#:**NQF0002 **eCQM#:**CMS146v2 **Domain:**Efficient Use of Healthcare Resources **Title:**Appropriate Testing for Children with Pharyngitis **Description:**Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode. **Numerator :** **Denominator :** **Performance Rate %:** **Exclusion:**

NQF#:NQF0024 **eCQM#:**CMS155v2 **Domain:**Population/Public Health

Title: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Description: Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.

- Percentage of patients with height, weight, and body mass index (BMI) percentile documentation
- Percentage of patients with counseling for nutrition
- Percentage of patients with counseling for physical activity

5

Population Criteria 1: Patients ≥ 3 and ≤ 17 who meet the specified criteria.:

Numerator 1:	**Denominator 1:**	**Performance Rate % 1:**	**Exclusion 1:**
Numerator 2:	**Denominator 2:**	**Performance Rate % 2:**	**Exclusion 2:**
Numerator 3:	**Denominator 3:**	**Performance Rate % 3:**	**Exclusion 3:**

Population Criteria 2: Patients ≥ 3 and ≤ 11 who meet the specified criteria.:

Numerator 1:	**Denominator 1:**	**Performance Rate % 1:**	**Exclusion 1:**
Numerator 2:	**Denominator 2:**	**Performance Rate % 2:**	**Exclusion 2:**
Numerator 3:	**Denominator 3:**	**Performance Rate % 3:**	**Exclusion 3:**

Population Criteria 3: Patients ≥ 12 and ≤ 17 who meet the specified criteria.:

Numerator 1:	**Denominator 1:**	**Performance Rate % 1:**	**Exclusion 1:**
Numerator 2:	**Denominator 2:**	**Performance Rate % 2:**	**Exclusion 2:**
Numerator 3:	**Denominator 3:**	**Performance Rate % 3:**	**Exclusion 3:**

9

NQF#:NQF0033 **eCQM#:**CMS153v2 **Domain:**Population/Public Health

Title: Chlamydia Screening for Women

Description: Percentage of women 16- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.

Population Criteria 1: Patients 16 - 24 who meet the specified criteria:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

Population Criteria 2: Patients 16 - 20 who meet the specified criteria.:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

Population Criteria 3: Patients 21 - 24 who meet the specified criteria:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

11

NQF#:NQF0036 **eCQM#:**CMS126v2 **Domain:**Clinical Process/Effectiveness

Title: Use of Appropriate Medications for Asthma

Description: Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.

Population Criteria 1: Patients ≥ 5 and < 64 who meet the specified criteria.:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

Population Criteria 2: Patients ≥ 5 and ≤ 11 who meet the specified criteria.:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

Population Criteria 3: Patients ≥ 12 and ≤ 18 who meet the specified criteria.:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

Population Criteria 4: Patients ≥ 19 and ≤ 50 who meet the specified criteria.:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

Population Criteria 5: Patients ≥ 51 and < 64 who meet the specified criteria.:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

12

NQF#:NQF0038 **eCQM#:**CMS117v2 **Domain:**Population/Public Health

Title: Childhood Immunization Status

Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

Numerator : **Denominator :** **Performance Rate %:**

23

NQF#:NQF0069 **eCQM#:**CMS154v2 **Domain:**Efficient Use of Healthcare Resources

Title: Appropriate Treatment for Children with Upper Respiratory Infection (URI)

Description: Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

34

NQF#:NQF0108 **eCQM#:**CMS136v3 **Domain:**Clinical Process/Effectiveness

Title:ADHD: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication

Description: Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/ hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported.

- Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.
- Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.

Numerator 1: Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

Numerator 2: Patients who remain on ADHD medication for at least 210 days and meet the specified criteria.:

Numerator : **Denominator :** **Performance Rate %:** **Exclusion:**

43	**NQF#:**NQF0418 **eCQM#:**CMS2v3 **Domain:**Population/Public Health **Title:**Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan **Description:**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. **Numerator :** **Denominator :** **Performance Rate %:** **Exclusion:** **Exception:**
51	**NQF#:**NQFXXXX **eCQM#:**CMS75v2 **Domain:**Clinical Process/Effectiveness **Title:**Children who have dental decay or cavities **Description:**Percentage of children, ages 0-20 years, who have had tooth decay or cavities during the measurement period. **Numerator :** **Denominator :** **Performance Rate %:**

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.

Select	eCQM ID	NQF #	CQM Title	Domain
☐	CMS146v2	NQF0002	Appropriate Testing for Children with Pharyngitis	Efficient Use of Healthcare Resources
☐	CMS137v2	NQF0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Clinical Process/Effectiveness
☐	CMS165v2	NQF0018	Controlling High Blood Pressure	Clinical Process/Effectiveness
☐	CMS156v2	NQF0022	Use of High Risk Medications in the Elderly	Patient Safety
☐	CMS155v2	NQF0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Population/Public Health
☐	CMS138v2	NQF0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Population/Public Health
☐	CMS125v2	NQF0031	Breast Cancer Screening	Clinical Process/Effectiveness
☐	CMS124v2	NQF0032	Cervical Cancer Screening	Clinical Process/Effectiveness
☐	CMS153v2	NQF0033	Chlamydia Screening for Women	Population/Public Health
☐	CMS130v2	NQF0034	Colorectal Cancer Screening	Clinical Process/Effectiveness
☐	CMS126v2	NQF0036	Use of Appropriate Medications for Asthma	Clinical Process/Effectiveness
☐	CMS117v2	NQF0038	Childhood Immunization Status	Population/Public Health
☐	CMS147v2	NQF0041	Preventive Care and Screening: Influenza Immunization	Population/Public Health
☐	CMS127v2	NQF0043	Pneumonia Vaccination Status for Older Adults	Clinical Process/Effectiveness

CMS166v3	NQF0052	Use of Imaging Studies for Low Back Pain	Efficient Use of Healthcare Resources
CMS131v2	NQF0055	Diabetes: Eye Exam	Clinical Process/Effectiveness
CMS123v2	NQF0056	Diabetes: Foot Exam	Clinical Process/Effectiveness
CMS122v2	NQF0059	Diabetes: Hemoglobin A1c Poor Control	Clinical Process/Effectiveness
CMS148v2	NQF0060	Hemoglobin A1c Test for Pediatric Patients	Clinical Process/Effectiveness
CMS134v2	NQF0062	Diabetes: Urine Protein Screening	Clinical Process/Effectiveness
CMS163v2	NQF0064	Diabetes: Low Density Lipoprotein (LDL) Management	Clinical Process/Effectiveness
CMS164v2	NQF0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Clinical Process/Effectiveness
CMS154v2	NQF0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Efficient Use of Healthcare Resources
CMS145v2	NQF0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVSD <40%)	Clinical Process/Effectiveness
CMS182v3	NQF0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Clinical Process/Effectiveness
CMS135v2	NQF0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical Process/Effectiveness
CMS144v2	NQF0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical Process/Effectiveness
CMS143v2	NQF0086	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Clinical Process/Effectiveness
CMS167v2	NQF0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Clinical Process/Effectiveness
CMS142v2	NQF0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Clinical Process/Effectiveness
CMS139v2	NQF0101	Falls: Screening for Future Fall Risk	Patient Safety
CMS161v2	NQF0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinical Process/Effectiveness

☐	CMS128v2	NQF0105	Anti-depressant Medication Management	Clinical Process/Effectiveness
☐	CMS136v3	NQF0108	ADHD: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder (ADHD) Medication	Clinical Process/Effectiveness
☐	CMS169v2	NQF0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Clinical Process/Effectiveness
☐	CMS157v2	NQF0384	Oncology: Medical and Radiation – Pain Intensity Quantified	Patient and Family Engagement
☐	CMS141v3	NQF0385	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Clinical Process/Effectiveness
☐	CMS140v2	NQF0387	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	Clinical Process/Effectiveness
☐	CMS129v3	NQF0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Efficient Use of Healthcare Resources
☐	CMS62v2	NQF0403	HIV/AIDS: Medical Visit	Clinical Process/Effectiveness
☐	CMS52v2	NQF0405	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Clinical Process/Effectiveness
☐	CMS77v2	NQFXXXX	HIV/AIDS: RNA control for Patients with HIV	Clinical Process/Effectiveness
☐	CMS2v3	NQF0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Population/Public Health

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 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	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	

	Patients ≥ 50 Years Old		
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	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

	Counseling for Children and 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.

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 who were ordered at least one high-risk medication. b) Percentage of patients who were ordered at least two different high-risk medications.	New in 2014
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	Percentage of patients aged 18 years and older	

	Screening: Tobacco Use: Screening and Cessation Intervention	who were screened for tabacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tabacco 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 months prior to the measurement period.	Updated in 2014
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 ProteinScreening	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 (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.	Updated in 2014
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	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial	Removed in 2014

	Pressure Management	infarction (AMI), coronary artery bypass graft (CABG) or percutaneous 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 or Angiotensin Receptor Blocker (ARB)	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy either within a 12 month	Updated in 2014

	Therapy for Left Ventricular Systolic Dysfunction (LVSD)	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 antidepressant medication for at least 84 days (12 weeks). b) Percentage of patients who remained on an antidepressant medication for least 180 days (6 months).	Updated in 2014
NQF 0108	ADHD: Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity	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	New in 2014

	Disorder (ADHD) Medication	reported. a) Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b) Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initation Phase ended.	
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 alcohol or chemical substance use.	New in 2014
NQF 0384	Oncology: Medical and Rediation – 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	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed	

	Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	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, 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.	New in 2014
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 documentated on the	New in 2014

		date of the positive screen.	
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 must include all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	New in 2014
NQF 0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up	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. Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30 Age 18-64 years BMI ≥18.5 and < 25	New in 2014
NQF 0564	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring	Percentage of patients aged 18 and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list	New in 2014

	Additional Surgical Procedures	of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.	
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	New in 2014

		have a PHQ-9 tool administratered 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 clinican 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 Monitoring: Warfarin Time in Therapeutic Range	Average percentage of time 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 therapeautic range (i.e., TTR) during the measurement period.	New in 2014

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 HospitalsEligible hospitals are first required to attest to Medicare for their Meaningful Use Measures. Iowa relys on the data that Medicare sends via the NLR and does not require that Eligible Hospital re-enter their meaningful use data into our attestation system.

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 23: Stage 1 Meaningful Use Core Measures Pre-Payment Audit and Review Methods

Objective	Measure	Reporting Requirement	Exclusion	Review
EPGMU 02: At least 80% of unique patients must have their data in the certified EHR during the EHR reporting period		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 with data maintained in the CEHRT during the EHR reporting period	No Exclusion	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) Must have 80% of unique patient records

Objective	Measure	Reporting Requirement	Exclusion	Review
				in the CEHRT
EPCMU 01: 4956(d)(1)(i) Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who	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	Attestation of Numerator / Denominator Denominator - Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period Numerator - The number of patients in the denominator	Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period	Review denominator equals the denominator reported for other measures requiring the EP to report the number of unique Patients (EPGMU 02, EPCMU 01,

Objective	Measure	Reporting Requirement	Exclusion	Review
can enter orders into the medical record per state, local and professional guidelines		that have at least one medication order entered using CPOE Or Exclusion		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 to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
EPCMU 02: 495.6(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	If documentation is supplied, review using a random sample to confirm.
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 problems are known for the patient recorded as structured data in their problem list	No Exclusion	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) Verify minimum

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
EPCMU 04: 4956(d)(4)(i) Generate and transmit permissible prescriptions electronically (eRx)	More than 40 percent of all permissible prescriptions written by the EP are 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 Numerator - Number of prescriptions in the denominator generated and transmitted electronically Or Exclusion	Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period	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.

Objective	Measure	Reporting Requirement	Exclusion	Review
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 medication) recorded as structured data	No Exclusion	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) Verify minimum correct percentage is met. If documentation is supplied, review using a

Objective	Measure	Reporting Requirement	Exclusion	Review
				random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
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 entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list	No Exclusion	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) Verify minimum correct percentage is met. If documentation is supplied,

Objective	Measure	Reporting Requirement	Exclusion	Review
				review using a random sample to confirm.
EPCMU 07: 4956(d)(7)(i) Record all of the following demographics: (A) Preferred language (B) Gender (C) Race	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	No Exclusion	Review denominator equals the denominator reported for other measures requiring the EP to report the number of

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.
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 denominator where medication reconciliation was performed Or Exclusion	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	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.

Objective	Measure	Reporting Requirement	Exclusion	Review
			requirement	

Objective	Measure	Reporting Requirement	Exclusion	Review
EPCMU 09: 4956(d)(9)(i) Record smoking status for patients 13 years old or older	More than 50 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data	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 smoking status recorded as structured data Or 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	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) Verify minimum correct percentage is met. If Exclusion is claimed, check if it seems appropriate based for provider type.

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
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	More than 50 percent of all patients who request an electronic copy of their health information are provided it within 3 business days	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 health information within three business days Or 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	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.

Objective	Measure	Reporting Requirement	Exclusion	Review
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	Attestation of Numerator / Denominator Denominator – Number of unique patients seen by the EP for an office visit during the EHR reporting period Numerator - Number of office visits in the denominator for which a clinical summary is provided within three business days Or Exclusion	Any EP who has no office visits during the EHR reporting period	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.
*EPCMU 14: 4956(d)(14)(i) Capability to exchange key clinical information (for example,	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information	Yes or No Attestation	No Exclusion	Note: This objective was eliminated from Stage 1 in 2013. Verify minimum

Objective	Measure	Reporting Requirement	Exclusion	Review
problem list, medication list, allergies, and diagnostic test results), among providers of care and patient authorize identities electronically				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.

Objective	Measure	Reporting Requirement	Exclusion	Review
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	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	Yes or No Attestation	No Exclusion	Review supporting documentation on risk assessment

Table 24: Stage 1 Meaningful Use Menu Measures Pre-payment Audit and Review Methods

Objective	Measure	Reporting Requirement	Exclusion	Review
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	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.

Objective	Measure	Reporting Requirement	Exclusion	Review
EPMMU 02: 4956(e)(2)(i) Incorporate clinical lab test results into EHR as structured data	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	Attestation of Numerator / Denominator 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 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 Or Exclusion	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	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.
EPMMU 3: 495.6(e)(3)(i) Generate lists of patients by	Generate at least one report listing patients of the EP with a specific condition	Yes or No Attestation	No Exclusion	If documentation is supplied, review using a

Objective	Measure	Reporting Requirement	Exclusion	Review
specific conditions to use for quality improvement, reduction of disparities, research, or outreach				random sample to confirm.
EPMMU 04: 4956(e)(4)(i) Send reminders to patients per patient preference for preventive/ follow-up care	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	Attestation of Numerator / Denominator Denominator: Number of unique patients 65 years old or older or 5 years older or younger Numerator: Number of patients in the denominator who were sent the appropriate reminder Or 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	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) Verify minimum

Objective	Measure	Reporting Requirement	Exclusion	Review
				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.

Objective	Measure	Reporting Requirement	Exclusion	Review
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	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	Attestation of Numerator / Denominator Denominator: Number of unique patients 65 years old or older or 5 years older or younger Numerator: Number of patients in the denominator who were sent the appropriate reminder Or Exclusion	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	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) Verify minimum correct percentage is met. If Exclusion is claimed, check if it seems

Objective	Measure	Reporting Requirement	Exclusion	Review
				appropriate based for provider type. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
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	More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources	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 are provided patient-specific education resources	No Exclusion	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) Verify minimum correct percentage is met. If documentation is supplied,

Objective	Measure	Reporting Requirement	Exclusion	Review
				review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
EPMMU 07: 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	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	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 denominator where medication reconciliation was performed Or 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	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.

Objective	Measure	Reporting Requirement	Exclusion	Review
EPCMU 08: 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.	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 denominator where medication reconciliation was performed Or Exclusion	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	Verify minimum correct percentage is met. If either Exclusion is claimed, check if it seems appropriate based for provider type. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
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	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)	Yes or No Attestation	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	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. Review the time-stamped confirmation message received by the provider from Iowa Department of Public Health.

Objective	Measure	Reporting Requirement	Exclusion	Review
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	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)	Yes or No Attestation	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	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

Figure 44: 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
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 period. Numerator - Number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically Or Exclusion	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 period.	Verify minimum correct percentage is met. If Exclusion 1 is claimed, check if it seems appropriate based on patient volume. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
EPCMU 03: 495.6(j)(3)(i)) Record the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 80% 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 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	No Exclusion	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) Verify minimum correct percentage is met. If documentation is supplied,

Objective	Measure	Reporting Requirement	Exclusion	Review
				review using a random sample to confirm.
EPCMU 04: 495.6(j)(4)(i) Record and chart changes in vital signs: (A) Height (B) Weight (C) Blood pressure	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	Attestation of Numerator / Denominator Denominator: Number of unique patients seen by the EP during the EHR reporting period. Numerator:	Any EP who: Exclusion 1: Sees no patients 3 years or older is excluded from recording blood pressure.	Verify minimum correct percentage is met. If an exclusion is claimed, review that the

Objective	Measure	Reporting Requirement	Exclusion	Review
(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		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. Or Exclusion	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. 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. Exclusion 4: Believes that blood pressure is relevant to their	provider type matches the selected exclusion. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
			scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.	
EPCMU 05: 495.6(j)(5)(i) Record smoking status for patients 13 years old or older	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 age 13 or older seen by the EP during the EHR reporting period Numerator - Number of patients in the denominator with smoking status recorded as structured data.	Any EP that neither sees nor admits any patients 13 years old or older.	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) Verify minimum

Objective	Measure	Reporting Requirement	Exclusion	Review
				correct percentage is met. If an exclusion is claimed, review that the provider type matches the selected exclusion. If documentation is supplied, review using a random sample to confirm.
EPCMU 06: 495.6(j)(6)(i) Use clinical decision to improve performance on high-priority	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	Yes or No Attestation Or Exclusion	For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.	If an exclusion is claimed, review that the provider type matches the selected exclusion.

Objective	Measure	Reporting Requirement	Exclusion	Review
health conditions	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.			If documentation is supplied, review using a random sample to confirm.
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.	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	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	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.	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,

Objective	Measure	Reporting Requirement	Exclusion	Review
	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.	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 authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information.	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.**	EPCMU 17, EPMMU 02, EPMMU 04) For each measure, verify minimum correct percentage is met. If only Exclusion 1 is claimed, review that the provider type matches the selected exclusion. If only Exclusion 2 is claimed, verify the county broadband availability is correct and that

Objective	Measure	Reporting Requirement	Exclusion	Review
				they still reported measure 1. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
EPCMU 08: 495.6(j)(11)(i) Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients within one business day for more than 50% of office visits	Attestation of Numerator / Denominator Denominator – Number of office visits conducted by the EP during the EHR reporting period. 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. Or Exclusion	Any EP who has no office visits during the EHR reporting period	Verify minimum correct percentage is met. If an Exclusion is claimed, review that the provider type matches the selected exclusion. If documentation is supplied, review using a random sample to confirm.
EPCMU 09: 4956(d)(16)(i) Protect	Conduct or review a security risk analysis in accordance with the requirements under 45	Yes or No Attestation	No Exclusion	Verify minimum correct percentage is met.

Objective	Measure	Reporting Requirement	Exclusion	Review
electronic health information created or maintained by the Certified EHR Technology through the implementation of appropriate technical capabilities.	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.			If documentation is supplied, review using a random sample to confirm
EPCMU 10: 495.6(j)(7)(i) Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data	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	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.	Any EP who orders no lab tests where results are either in a positive/negative affirmation or numerical format during the EHR reporting period.	Verify minimum correct percentage is met. If an Exclusion is claimed, review that the provider type matches the

Objective	Measure	Reporting Requirement	Exclusion	Review
		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.		selected exclusion. If documentation is supplied, review using a random sample to confirm.
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.	Generate at least one report listing patients of the EP with a specific condition t	Yes or No Attestation	No Exclusion	Verify minimum correct percentage is met. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
EPCMU 12: 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.	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.	Attestation of Numerator / Denominator 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. Numerator - Number of patients in the denominator who were sent a reminder per patient preference when available during the EHR reporting period. Or Exclusion	Any EP who has no office visits in the 24 months before the EHR reporting period	Verify minimum correct percentage is met. 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. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
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	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	Attestation of Numerator / Denominator Denominator – Number of unique patients with office visits seen by the EP during the EHR reporting period. Numerator - Number of patients in the denominator who were provided patient-specific education resources identified by the Certified EHR Technology. Or Exclusion	Any EP who has no office visits during the EHR reporting period	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) Verify minimum correct percentage is met. If an Exclusion is claimed, review that the

Objective	Measure	Reporting Requirement	Exclusion	Review
				provider type matches the selected exclusion and conduct a random sample check via MMIS for paid claims during reporting period. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
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.	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.	Attestation with 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: The number of transitions of care in the denominator where medication reconciliation was performed.	Any EP who was not the recipient of any transitions of care during the EHR reporting period.	Verify minimum correct percentage is met. If an Exclusion is claimed, review that the provider type matches the selected exclusion. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
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 provider summary of care record for each transition of care or referral.	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. 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	Attestation with Numerator/Denominator for Measures 1 and 2 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. 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	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.	For measures 1 and 2, verify minimum correct percentage is met. If an Exclusion is claimed, review that the provider type matches the selected exclusion. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
	validated through an ONC-established governance mechanism to 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 the EHR reporting period.	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 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		

Objective	Measure	Reporting Requirement	Exclusion	Review
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 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	Verify with Iowa Department of Public Health that provider is in queue to submit when available. If an Exclusion is claimed, review that the provider type matches the selected exclusion. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
			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	

Objective	Measure	Reporting Requirement	Exclusion	Review
			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.	
EPCMU 17: 495.6 (j) (17) (i) Use secure electronic messaging to communicate with patients on relevant health information	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.	Attestation with Numerator/Denominator – 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 denominator who send	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	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,

Objective	Measure	Reporting Requirement	Exclusion	Review
		electronic message to the EP that is received using the electronic messaging function of CEHRT during the EHR reporting period.	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.	EPCMU 13, EPCMU 17, EPMMU 02, EPMMU 04) Verify minimum correct percentage is met. If only Exclusion 1 is claimed, review that the provider type matches the selected exclusion. If only Exclusion 2 is claimed, verify the county broadband availability is correct and that they still

Objective	Measure	Reporting Requirement	Exclusion	Review
				reported measure 1. If documentation is supplied, review using a random sample to confirm.

Table 25: Stage 2 EP Menu Measures Pre-payment Audit/Review Methods

Objective	Measure	Reporting Requirement	Exclusion	Review

Objective	Measure	Reporting Requirement	Exclusion	Review
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	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency 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 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	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,

Objective	Measure	Reporting Requirement	Exclusion	Review
			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 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	review to see if it seems appropriate for the provider type. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
			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 than 30 percent of unique patients with at least one office visit during the EHR	Attestation with Numerator/Denominator: Denominator: Number of unique patients with at least one office visit during the EHR reporting period.	No Exclusion	Validate denominator equals the denominator reported for other measures requiring the EP to report the

Objective	Measure	Reporting Requirement	Exclusion	Review
	reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.	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.		number of unique Patients (EPCMU 03, EPCMU 05, EPCMU 07, EPCMU 13, EPCMU 17, EPMMU 02, EPMMU 04) Verify minimum correct percentage is met. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
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	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	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 denominator that are accessible through CEHRT.	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.	Verify minimum correct percentage is met. If an exclusion is claimed, review that it is appropriate for the provider type. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
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.	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) Verify minimum correct percentage is met. If an exclusion is claimed, review that it is appropriate for

Objective	Measure	Reporting Requirement	Exclusion	Review
				the provider type. If documentation is supplied, review using a random sample to confirm.
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	Successful ongoing submission of cancer case information from CEHRT to a cancer registry for the entire EHR reporting period.	Yes or No Attestation Or 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	Verify ongoing submission via documentation. If an exclusion is claimed, review that it is appropriate for the provider type. If documentation is supplied, review using a random sample

Objective	Measure	Reporting Requirement	Exclusion	Review
			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 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.	to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
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	Successful ongoing submission of specific case information from Certified EHR Technology to a specialized registry for the entire EHR reporting period.	Yes or No Attestation Or 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	Verify ongoing submission via documentation. If an exclusion is claimed, review that it is appropriate for the provider type. If documentation is supplied, review using a random sample to confirm.

Objective	Measure	Reporting Requirement	Exclusion	Review
			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; 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	

Objective	Measure	Reporting Requirement	Exclusion	Review
			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.	