Alaska Department of Health and Social Services

Medicaid Electronic Health Record (EHR)

Incentive Program

Frequently Asked Questions
Version 1.0, March 2016

Disclaimer: The Alaska Department of Health and Social Services (DHSS) is providing this material as an informational reference for participating providers. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of posting, the Alaska EHR Incentive program is constantly changing, and it is the responsibility of each physician, non-physician practitioner, supplier or provider to remain abreast of state and federal program requirements.

Contents

I. Background:

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to Eligible Professionals (EP) and Eligible Hospitals (EH), including Critical Access Hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner. These incentive payments are part of a broader effort under the HITECH Act to accelerate the adoption of Health IT and utilization of qualified EHRs.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at www.healthit.hhs.gov.

The following FAQs are geared towards Eligible Professionals and are provided to assist providers in understanding program requirements and navigating registration and application. Providers with questions are encouraged to contact the EHR Incentive Program at hss.hitinfo@alaska.gov.

II. Participation Requirements

1. Who is eligible for the Medicaid Electronic Health Record (EHR) Incentive Program?

Eligible Professionals (EPs) are defined as:

- Non-hospital-based physicians
    - Hospital-based providers may be eligible if they purchase and use their own EHR program (hospital based is defined as 90% or more of services are performed in a hospital inpatient or emergency room setting)
- Dentists
- Advanced Registered Nurse Practitioners (ARNP)
- Certified nurse midwives
- Physician Assistants – must be working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) and that clinic led by a physician assistant

In addition, EPS must:

- Have no sanctions and/or exclusions
- Have a valid contract with Alaska Medical Assistance which means that the provider is currently enrolled with Alaska Medicaid Program to provide services.

NOTE: For the purposes of the Alaska EHR Incentive Program a Tribal clinic is considered a FQHC. A physician assistant practicing in a Tribal clinic must meet the same requirements of a physician assistant practicing in a FQHC. Any other provider that practices in a Tribal clinic follows the same rules as a FQHC.

2. How is "hospital based" status determined?

Hospital based is defined as 90% or more of encounters occurring in an inpatient or emergency room setting (place of service 21 or 23). Medicaid encounters from the calendar year prior to the Program Year are used to determine hospital status.

3. What is the Medicaid patient volume requirement?

Eligible Professionals*	Medicaid Patient Volume Over 90-Day Period
Physician (MD, DO)	30% Medicaid
Dentist	30% Medicaid
Certified Nurse Midwife	30% Medicaid
Nurse Practitioner	30% Medicaid
Physician Assistant (PA) in a RHC or FQHC led by PA	30% Medicaid
Pediatrician**	20% Medicaid

**Eligible professionals practicing at least 50% of the time in an rural health clinic (RHC) or federally qualified health center (FQHC) can count "needy individuals" when determining patient volume.*

*** Pediatricians who qualify with a 20% Medicaid patient volume receive two-thirds of the maximum incentive payment, totaling $42,500. For the purposes of this program, the Department defines pediatricians as a practitioner who is board certified through the American Board of Pediatrics web site or through the American Osteopathic Board of Pediatrics.*

Providers must meet the volume requirement for each payment year.

4. What can I use to determine my Medicaid volume?

For purposes of calculating the EP patient volume, a Medicaid encounter is defined as services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims and encounters. Zero-pay claims include:

- Claims denied because the Medicaid beneficiary has maxed out the service limit
- Claims denied because the service wasn't covered under the State's Medicaid Program
- Claim paid at $0 because another payer's payment exceeded the Medicaid payment
- Claim denied because the claim wasn't submitted timely.

5. What defines a "needy individual?"

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

- The identified Eligible Professional Medicaid Encounter definition listed on the prior page
- Furnished by the provider as uncompensated care, or **
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

**For providers practicing in a Tribal clinic, uncompensated care is a calculated figure, using charity care and bad debt to determine the number of encounters that are considered uncompensated care. Indian Health Services (IHS) has defined uncompensated care as:

6. What is the volume period?

To calculate Medicaid patient volume, an EP must divide:

- The total identified Medicaid or out of-state Medicaid related patient encounters
    a. in any representative 90-day period in the preceding calendar year, or
    b. in any 3 month period in the preceding year that is 90-days or greater, or
    c. the full preceding calendar year, or
    d. in any 90-day period in the last 12 months preceding the provider's attestation; by
- The total patient encounters in the same time period.

7. How is volume determined – individually or based on my group?

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

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

Group encounters can be totaled in one of two different ways:

- The entire clinic/group practice Medicaid encounter total, or
- Only those providers in the group encounter total that are considered eligible professionals for the Medicaid Incentive Payment Program whether or not they are attesting for the program in that year.

The group patient volume for a non-Federally Qualified Health Center (FQHC), Rural Health Center (RHC) or Tribal clinic will be calculated based on eligible Medicaid Encounters and out-of-state Medicaid patients. The group patient volume for a FQHC, RHC or Tribal clinic is calculated using the needy individual patient volume requirements if the providers within the group practiced predominantly in the FQHC, RHC or Tribal clinic in the previous calendar year.

8. Is Program Year 2016 the last year to start participating in the EHR Incentive program? Or can an Eligible Professional (EP) start after this date and just not receive the total amount of incentive money because as they are not participating for the full 6 years?

Program Year 2016 is the last year providers can start the program by either attesting to Adopt, Implement or Upgrade (AIU) or 1st reporting period of meaningful use. Providers cannot attest for their first year after Program Year 2016.

9. What are the payment adjustments for not meeting MU?

Providers that are eligible for the Medicare EHR Incentive Program but have not successfully attested to MU can be subject to an adjustment on their Medicare payments. The payment adjustments only apply to Medicare, not to Medicaid. A provider can, however, report MU under the Medicaid EHR incentive program and avoid the Medicare payment adjustments.

Providers can avoid the payment adjustment by applying for a hardship exemption through CMS. For the most up to date information, please refer to Payment Adjustments and Hardship Exemptions.

10. If our Medicaid population changes and a provider who formerly attested for in the Medicaid program is no longer eligible because they cannot meet the Medicaid volume requirement, will they incur the payment adjustments?

CMS's Medicare attestation system now allows providers to attest solely for the purpose of avoiding the Medicare payment adjustment. This "non-payment" track can be used by Medicare providers registered with Medicaid who are not going to be able to successfully attest with the Medicaid program. For example, a provider who is passing the objectives and measures but whose Medicaid enrollment was terminated or whose Medicaid volume is under the required threshold cannot successfully attest with the Medicaid program. These providers can use the Medicare attestation to avoid the Medicare payment adjustment. Attestations **must** be submitted by the Medicare attestation deadline.

11. If a provider attested for the first time for Program Year 2015, can the provider subsequently skip attesting for Program Year 2016?

Yes, the provider may skip a year. According to CMS FAQ7737 Medicaid providers are not required to participate in consecutive years of the EHR Incentive Program. However, with the advent of 2015-2017/Stage 3 Rule, all providers will be required to attest to the modified Stage 2 through 2017 and move to Stage 3 in 2018, regardless of what stage MU there were previously scheduled to attest.
Therefore, if the provider attested to AIU in 2015, skips 2016, then they will attest to Modified Stage 2 in 2017, and Stage 3 in 2018. Optionally, the provider may attest to Stage 3 in 2017. However, it should be noted that if the provider skips any subsequent years, they will not be able to receive the full 6 years of incentives, as the program ends in 2021.

III. Registration/Attestation Process

1. How do I begin the participation process?

All providers must register at the CMS Registration and Attestation (R&A) site at **https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/registrationandattestation.html** using their National Plan and Provider Enumeration System (NPPES) web user account, user ID and password to log into the registration system. Upon registration, providers should select Alaska Medicaid.

The R&A system will electronically notify the Alaska Medicaid State Level Registry (SLR) of a provider's choice to enroll in the Alaska Medicaid EHR Incentive Program. The information completed by the provider at the national website is sent to the SLR electronically within 24-48 hours.

2. Can I assign my payment?

Yes as part of the CMS R&A process, an Eligible Professional (EP) may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong by selecting where their payment will go in the payee TIN type.

EPs must provide the SSN payee TIN type to indicate that the provider receives the payment. The EIN payee TIN type indicated the group receives the incentive payment. Providers will have to enter the group name, group payee TIN and the group NPI in order for the provider to issue the payment to the group in which they are associated. In order for the group or clinic to receive the incentive payments from Alaska, the EP must have a billing provider contract to which the payment is being assigned.

State of Alaska policy requires a State of Alaska Substitute Form W9 for each payee. If all EPs within a group/clinic assign their payment to the clinic, only one Substitute W9 is required; if the payment is directed to each EP, one Substitute W9 for each EP. The State of Alaska substitute W-9 may be found at http://doa.alaska.gov/dof/forms/resource/sub_form_w9.pdf.

3. Where do I find the State Level Registry (SLR) to submit my attestation?

After successful registering at the CMS R&A site, the next business day the provider will need to access the State Level Registry (SLR) to submit the actual attestation data. The SLR can be found at http://ak.arraincentive.com/.

4. What is the payment schedule for Medicaid EPs, as well as the payment amounts?

Payment Amount for Year:	First Year Medicaid EP Qualifies to Receive Payment 2011	First Year Medicaid EP Qualifies to Receive Payment 2012	First Year Medicaid EP Qualifies to Receive Payment 2013	First Year Medicaid EP Qualifies to Receive Payment 2014	First Year Medicaid EP Qualifies to Receive Payment 2015	First Year Medicaid EP Qualifies to Receive Payment 2016
2011	$21,250	-	-	-	-	-
2012	$8,500	$21,250	-	-	-	-
2013	$8,500	$8,500	$21,250	-	-	-
2014	$8,500	$8,500	$8,500	$21,250	-	-
2015	$8,500	$8,500	$8,500	$8,500	$21,250	-
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017	-	$8,500	$8,500	$8,500	$8,500	$8,500
2018	-	-	$8,500	$8,500	$8,500	$8,500
2019	-	-	-	$8,500	$8,500	$8,500
2020	-	-	-	-	$8,500	$8,500
2021	-	-	-	-	-	$8,500
TOTAL Possible Incentive Payments	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

5. Is the incentive payment subject to federal income tax?

It is important to pay attention to who is identified as the payee on CMS's R and A site. If it is to a clinic/facility they will receive the incentive payment and 1099, if it is to the individual provider, the provider will receive the incentive payment and 1099. Incentive payments should be treated like any other income and are subject to Federal and State laws regarding income tax, wage garnishment, and debt recoupment. Providers should consult with a tax advisor or the Internal Revenue Service regarding how to properly report this income on their filings. The incentive payment will be included in 1099 reporting.

6. Can organizations request payments on behalf of their Eligible Professionals (EPs), including attesting to required information?

EPs must legally attest that they meet the requirements in order to receive payments. Organizations are not allowed to apply for incentive payments without the knowledge and consent of their employees.

IV. Program Requirements

1. What are the differences in requirements between Adopt, Implement, and Upgrade (AIU) and Meaningful Use (MU)?

Providers attesting for the first time in the EHR Incentive Program may receive incentive payments for adopting, implementing or upgrading (AIU) to certified EHR technology (CEHRT). Providers are not required to have actually implemented or be using CEHRT to qualify for an AIU payment, but they must have possession of the CEHRT. It cannot be a "planned" upgrade or procurement. At the time of attestation for AIU, the provider will be required to provide documentation such as a contract or paid invoice. Providers may also choose to skip AIU attestation and move straight to MU attestation for first year payments.
In order to qualify for second and subsequent year payments, providers must demonstrate that they have been using CEHRT in a meaningful way by meeting specific MU measures and objectives and Clinical Quality Measures (CQMs). MU measures and objectives and CQMs, including the thresholds for compliance, are set forth in federal legislation.

2. What is Meaningful Use (MU)?

Meaningful use (MU) describes the activities an Eligible Professional (EP) or Eligible Hospital (EH) engages in to use electronic health records in a way that improves care and service to their patients. The Center for Medicare and Medicaid Services (CMS) established the rule for MU that includes a set of standards, implementation specifications, and certification criteria for electronic health record (EHR) technology. For complete information on the Meaningful Use program, visit https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms.

3. What are the Stages of Meaningful Use (MU)?

Prior to the Stage 2 Modification Rule, the MU program was divided into Stage 1, Stage 2, and planned Stage 3. Providers could attest to two years of each MU stage, even if the payment (participation) years were not consecutive. The Stage 2 Modification Rule sets forth a single set of objectives and measures. Beginning in Program Year 2015, all providers will attest to Modified Stage 2, regardless of what stage (or MU reporting year) they were scheduled for in Program Year 2015. There are alternate measures in Modified Stage 2 to accommodate those providers scheduled to attest to Stage 1 (first or second MU reporting year) in 2015.

Effective with Program Year 2018, all providers will be required to attest to Stage 3 objectives and measures.

4. Do specialty providers have to meet all of the meaningful use (MU) objectives for the incentive program, or can they ignore the objectives that are not relevant to their scope of practice?

Providers must meet all of the MU objectives and measures. However, certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation. Failure to meet the measure of an objective, or to qualify for an exclusion for the objective, will prevent an EP from successfully demonstrating MU and receiving an incentive payment.

5. Can I use group numbers in proving meaningful use (MU)?

No, MU is based on the individual EP. It is important that each practitioner access the certified EHR under their own login information so that the system can capture the necessary information for demonstrating MU for each EP. Group measure information or measure information specific to another practitioner is NOT ACCEPTABLE in attesting to MU.

6. What are the requirements for MU?

To qualify for an MU payment, EPs must meet basic program requirements including: being an eligible provider type, meeting the patient volume threshold patient volume requirements, and having certified EHR technology (CEHRT).

And, providers must meet the two general MU requirements of:

a. 50% of all encounters must occur in locations equipped with CEHRT.
b. 80% of unique patients seen at locations with CEHRT must have their records in a certified EHR system.

And, meet the MU threshold for the specific objectives and measures or meet the exclusion criteria for the objective including reporting clinical quality measures.
Providers should note that MU is not limited to just Medicaid encounters and patients but is reflective of all encounters and patients.

7. What are Clinical Quality Measures (CQMs)?

Eligible Professionals (EPs) are required to report on 9 out of 64 clinical quality measures. These 9 measures must cross at least three of the 6 quality reporting domains. Providers do not have to meet a threshold for any of the 9 reported measures. For more information on CQMs, including the recommended core sets, visit: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html.

8. What should I do if there are no Clinical Quality Measures (CQMs) that apply to my practice?

Eligible Professionals (EPs) must still report CQMs even if the numerators and denominators are zero. It is understood that the CQMs available to report may be determined by your vendor's certification and may not be reflective of the provider's practice.

9. What is my Meaningful Use (MU) reporting period?

It is a 90 consecutive day period for providers reporting MU for the first time. Subsequent years require a full calendar year reporting. All providers will have a 90 day reporting period for Program Year 2015.

10. What if I change systems during the EHR reporting period?

If a provider changes EHR systems or practices at multiple practices, information from all systems utilized during the reporting period must be used.

CHANGING SYSTEMS: If the information from the old system is transitioned into the new system, and the new system can report data from the entire reporting period, then only report data and include documentation from the new system. If the data is not transferred, then the information from both systems should be combined and documentation from both systems uploaded.
MULTIPLE LOCATIONS: Information from each location for the reporting period must be uploaded. The numerators and denominators for each measure should be combined and entered into the application.
If a provider is practicing at multiple practices utilizing different systems, and different clinical quality measures (CQMs) have been selected at the varying locations, the provider should choose one set to report. Any CQMs that are the same for all practices should also be added together. Providers should upload reports for all objectives from both systems as well as a document explaining which CQMs they are choosing to report. Documentation should be maintained supporting the choice of CQMs. For more information on practicing at multiple locations, please see this Fact Sheet published by CMS.
It is recommended that before changing systems, screen shots be taken to support all MU objectives and back-up reports run and stored in case of a post-payment audit.

V. Program Year 2015 Requirements

1. What are the requirements for Meaningful Use (MU) for Program Year 2015?

All providers are required to attest to a single set of objectives and measures (Modified Stage 2). This replaces the core and menu objectives structure of previous stages. For EPs, there are 10 objectives, including one consolidated public health reporting objective. Providers must attest using EHR technology certified to the 2014 Edition.

To assist providers who may have already started working on meaningful use in 2015, there are alternate exclusions and specifications within individual objectives for providers. These include:

- Allowing providers who were previously scheduled to be in a Stage 1 EHR reporting period (first or second reporting period) for 2015 to use a lower threshold for certain measures.
- Allowing providers to exclude for Stage 2 measures in 2015 for which there is no Stage 1 equivalent.
- Allowing providers to exclude modified Stage 2 measures in 2015 where a previous menu measure is now a requirement.

Regardless of reporting year, providers will only have to attest to a 90 day meaningful use reporting period for Program Year 2015.

2. What are the Modified Stage 2 objectives and measures?

To help providers understand what is required, CMS has provided Specification Sheets for each Program Year explaining each measure and objective. For Program Year 2015, these sheets can be found at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2015ProgramRequirements.html.

In addition to the Specification Sheets, CMS issues Frequently Asked Questions (FAQs) to provide further clarification or explain any change in program policy. Providers should familiarize themselves with these resources for up-to-the date program information.

3. What documentation is necessary to support claiming an alternate measure or exclusion?

There is not mandatory documentation required for measures claiming exclusions however, there is prompting on the SLR measures to attach de-identified reports from the providers certified EHR technology to support the numerator and denominator or written proof the exclusion applies to EP – this could be a report from certified EHR technology.

4. If I was scheduled for my first reporting year (Stage 1) in 2015, do I have to claim the alternate measures and/or exclusion?

No. If you are meeting the Modified Stage 2 measure, then you can attest indicating your percentages as calculated.

5. What happens in Program Year 2016?

Providers will have to meet the same set of Modified Stage 2 measures and objectives. There will not however be as many alternate measures or exclusions available for those providers in their first or second reporting period in Program Year 2016. The CMS Specification Sheets for Program Year 2016 can be found at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2016ProgramRequirements.html.

6. Is it possible for the Clinical Quality Measures (CQM) reporting period to be greater than 365 days in 2015?

Eligible Professionals (EPs) may select any continuous 90-day period from January 1, 2015, through December 31, 2015, while Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) may select any continuous 90-day period from October 1, 2014, through December 31, 2015, to report CQMs via attestation. A provider may choose to attest to a CQM reporting period of greater than 90 days up to and including one full calendar year of data. However, the CQM reporting period cannot exceed the 365 days which occur within a single calendar year (January-December).

7. Does the Eligible Hospital (EH) eligibility reporting period transition for Program Year 2015 to calendar year like the Clinical Quality Measures (CQMs) and Meaningful Use (MU) reporting periods?

Yes, the EH reporting periods for CQMS and MU in 2015 is Oct 2014-Dec 2015 (a transitional period) and then moving forward to calendar year reporting for Program Year 2016.

8. Can the Security Risk Assessment (SRA) for the objective "Protect Electronic Health Information" be conducted outside the meaningful use reporting period? For example: for a Program Year 2015 application, could a provider conduct the SRA in January of 2016 and then attest for Program Year 2015 in February of 2016?

Yes, as long as the SRA is conducted prior to attestation it can be used to meet this objective. But it is important to note that since that SRA was used for a 2015 attestation, that the same SRA could not be used in 2016 as well even though it was conducted in the program year. It is mandatory that the most current SRA is uploaded to the SLR with each attestation.

9. What is required to meet the Electronic Reporting of Public Health Data objective?

The Public Health Reporting objective has three measure options: Immunization Registry Reporting, Syndromic Surveillance Reporting, and Specialized Registry Reporting.

Providers in their first or second reporting period of meaningful use (MU), must meet one of the measure options or be able to exclude from all three. Providers in their third or later reporting period of MU, must meet two of the three measure options or meet fewer and exclude from the rest. NOTE: A provider may report to more than one specialized registry and may count specialized registry reporting twice to meet the required number of measures.

Providers must be in "active engagement" with the Public Health Agency or Clinical Data Registry defined as:

- Completed Registration to Submit Data
    - EP has registered to submit data. Registration was completed within 60 days after the start of the EHR Reporting period and the provider is awaiting an invitation to begin testing and validation.
- Testing and Validation
    - EP is in the process of testing and validation of the electronic submission of data. Providers must to respond to requests from the sponsor of the registry within 30 days; failure to respond twice within an EHR reporting period would result in the EP not meeting the measure.
- Production
    - EP has completed testing and validation of the electronic submission and is electronically submitting production data.

What Alaska will have available for EPs:

- Immunization
- Syndromic Surveillance (you may select this registry however, you will need to select the Exclusion Criteria option: *Operates in a jurisdiction for which no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.*
- Specialized Registry
    - Cancer Registry (***only*** if you are currently reporting to the Cancer Registry)
    - Any national registry the provider is reporting to

For complete information on this objective including exclusions, refer to the CMS Specification Sheet at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2015EP_10PublicHealthObjective.pdf.

10. What steps does a provider have to take to determine if there is a specialized registry available for meeting the "Public Health Reporting" objective, or if they qualify for the exclusion?

A provider is not required to make an exhaustive search of all potential registries; however, they must follow a few steps to meet due diligence in determining if there is a registry available for them, or if they meet the exclusion criteria.

- A provider should check with their State to determine if there is an available specialized registry maintained by a public health agency
- A provider should check with any specialty society with which they are affiliated to determine if the society maintains or endorses a specialized registry

If the provider determines no registries are available, they may exclude from the measure.

11. My provider is unable to meet the measure to provide summaries of care electronically because our referral sources cannot receive the CCDA electronically. Are the providers going to have their Medicare payment adjusted?

EHR Certification/Vendor Issues (CEHRT Issues) is one of the categories for which Medicare providers can attest to as a reason for applying for the Medicare hardship exemption, category 2.2.d.
Providers who are failing measures for the 2015 Program Year due to issues with the CEHRT should apply for a hardship exemption and select option 2.2d. Failing the second measure of the Health Information Exchange objective, electronically sending the CCDA, due to a lack of referral partners being able to receive the CCDA electronically fits the criteria for 2.2d. This is the same category for which providers could apply in 2014 if they faced an issue of having CEHRT implemented but no viable means for exchanging a CCDA. In 2015, CMS expanded the transport options which should help many providers for the 2016 program year, but the timing of the guidance may mean that some providers were still unable to succeed for a reporting period for the 2015 Program Year.

VI. Audit Documentation Checklist for Eligible Professionals

As stated on the Alaska Medicaid EHR Incentive program Attestation Agreement, participants must keep all documentation necessary to support meaningful use and EHR incentive payments for seven (7) years.

Following outlines a list of suggested documents that should be retained:

- Documentation that confirms you or your organization had a legal or financial obligation to the Certified Health Technology at the time of your A/I/U (Adopt, Implement, or Upgrade) attestation.

- A copy of the signed Attestation Agreement for the Alaska Medicaid Electronic Health Record Incentive Program.

- A detailed encounter listing to support the numerator (Medicaid encounters) and denominator (total encounters) utilized in the eligibility calculation. The listing should include patient level details, particularly patient name, patient identifier, servicing physician, date of service, and payer source at the time of service (insurance). If utilizing Medicaid encounter information received from the Department of Health and Social Services (DHSS), a copy of the documentation received should be retained in order to provide upon request should you be selected for a post payment review.

- A copy of the Security Risk Analysis (assessment) completed in accordance with 45 CFR 164.308(a)(1) during the reporting period. The requirements also include addressing the security of ePHI created or maintained in the 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 your risk management process. It is important that this document contain the date it was completed/reviewed.

- A system generated Meaningful Use and Clinical Quality Measures report for the EHR reporting period to which you attested. This report should support the numerator and denominator attested for each measure as applicable.

- Screen-shots to support the reported measures which do not require a numerator and denominator (i.e. "yes" attestations and data transmission tests). The screen shot should be from the certified EHR system and demonstrate that the functionality is enabled for the specific measure.

It is recommended that the documentation be for a test patient or a de-identified patient seen during the reporting the period.