Alaska Department of Health and Social Services

Medicaid Electronic Health Record (EHR)

Incentive Program

Frequently Asked Questions
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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 was 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. Was 2016 the last Program Year for the Physician Quality Reporting System (PQRS)?

2016 was the last program year for the Physician Quality Reporting System (PQRS). PQRS was replaced by the Merit-based incentive Payment System (MIPS) under the new Quality Payment Program. The final data submission period for reporting 2016 PQRS quality data to avoid the 2018 PQRS downward payment adjustment was January through March 2017. The first MIPS performance period is January through December 2017. We encourage everyone to learn more about the Quality Payment Program by visiting qpp.cms.gov.

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 is 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.

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

4. 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 Meaningful Use and Promoting Interoperability, visit https://https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

5. 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.

To meet Stage 3 requirements, all providers must use technology certified to the 2015 Edition. A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. However, a provider who has technology certified to the 2014 Edition only may not attest to Stage 3.

Please note there are no alternate exclusions or specifications available.

There are changes to the measure calculations policy, which specifies that actions included the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs. Specific measures affected are identified in the Additional Information section of the specification sheets.

Flexibility within Objectives and Measures

Stage 3 includes flexibility within certain objectives to allow providers to choose the measures most relevant to their patient population or practice. The Stage 3 objectives with flexible measure options include:

- **Coordination of Care through Patient Engagement** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- **Health Information Exchange** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- **Public Health Reporting** – Eligible professionals must report on two measures and eligible hospitals must report on four measures.

EHR Reporting Period

Program year 2018, all providers are required to use an EHR reporting period of a full calendar year, with the exception of providers attesting to meaningful use for the first time; these providers will have a minimum of any continuous 90-days EHR reporting period.

3. 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 exclusion for the objective, will prevent an EP from successfully demonstrating MU and receiving an incentive payment.

4. 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.

5. If the 90 day Representative (eligibility) Period has to be the same for all EP's in my group does that mean that they all must have the same EHR Reporting Period if they are attesting to MU?

No. If you are attesting as a Group each EP attesting to MU can have a different EHR Reporting Period. Group attestations are only used to establish eligibility. Even though your Group may be sharing encounter volumes to be eligible, they are each attesting using their individual Meaningful use data.

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)?

Clinical quality measures (CQMs) are tools that help measure and track the quality of health care services that eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) provide. The total number of available CQMs to select from is 53. There are no domain requirements. 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 2018.

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 2018 Requirements

1. What are the requirements for Meaningful Use (MU) for Program Year 2018?

- Attesting to Meaningful Use Stage 3 criteria is an option for Program Year 2018 for those providers who have upgraded their CEHRT to 2015 standards, or a combination of 2014/2015 editions that supports MU 3
- In Program Year 2018, all providers will once again be attesting to a minimum 90-day EHR Reporting Period for the Meaningful Use Objectives and Measures.
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Changes to Specific Objectives

Eligible Providers

- Objective 8, Measure 2, Patient Electronic Access: For an EHR reporting period in 2018, more than 5 percent of unique patients seen by the EP during the EHR reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the EHR reporting period.
- Objective 9, Secure Messaging (EPs only): For an EHR reporting period in 2018, for more than 5 percent of unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.

Eligible Hospitals

- Objective 8, Measure 2, Patient Electronic Access: For an EHR reporting period in 2017 and 2018, must be more than 5 percent of unique patients discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH (or patient authorized representative) view, download or transmit to a third party their health information during the EHR reporting period.

EHR Reporting Period in 2018

- For all returning participants and all new participants, the EHR reporting period is a minimum of any continuous 90-days between January 1 and December 31, 2018.

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 2018, these sheets can be found at

CMS-Guidance for Medicaid EHR - Program Year 2018.

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 2018?

Providers attesting to a state's Medicaid EHR Incentive Program will continue to attest to the measures and objectives as finalized in the 2015 EHR Incentive Programs Final Rule. Providers have the option to use 2014 CEHRT, or 2015 CEHRT, or a combination of 2014/2015 CEHRT. Attesting to Meaningful Use Stage 3 criteria is an option for Program Year 2018 for those providers who have upgraded their CEHRT to 2015 standards, or a combination of 2014/2015 editions that supports MU stage 3. Providers may continue to attest to Modified-Meaningful Use Stage 2 Objectives and Measures in Program Year 2018.

6. Is it possible for the Clinical Quality Measures (CQM) reporting period to be greater than 365 days in 2018?

Eligible Professionals must utilize a Full-Year reporting period for reporting Clinical Quality Measures in Program Year 2018. The only exception to this requirement is for providers meeting Meaningful Use for the first time in PY 2018. Providers meeting MU for the first time in PY 2018 may utilize a 90-day CQM reporting period.

7. 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 2018 application, could a provider conduct the SRA in January of 2018 and then attest for Program Year 2018 in February of 2018?

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 2018 attestation, that the same SRA could not be used in 2019 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.

8. 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 for EPs - Modified Stage 2 and Stage 3.

9. 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.

10. While the denominator for measures used to calculate meaningful use in the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs is restricted to patients seen during the EHR reporting period, is the numerator also restricted to activity during the EHR reporting period or can actions for certain meaningful use measures be counted in the numerator if they took place after the EHR reporting period has ended?

The criteria for a numerator is not constrained to the EHR reporting period unless expressly stated in the numerator statement for a given meaningful measure & nbsp; The numerator for the following meaningful use measures should include only actions that take place within the EHR reporting period & nbsp; Preventive Care (Patient Reminders) and Secure Electronic Messaging. For all other meaningful use measures, the actions may reasonably fall outside the EHR reporting period timeframe but must take place no earlier than the start of the reporting year and no later than the date

of attestation in order for the patients to be counted in the numerator, unless a longer look-back period is specifically indicated for the objective or measure. For program year 2015 and subsequent years.

11. If an Eligible Professional (EP) entered numerator and denominator information during their Medicare Electronic Health Record (EHR) Incentive Program attestation from my certified EHR technology, but subsequently discovered that the method of calculation included in the software was flawed. The software vendor has updated the reports. If CMS audits me, will I be held responsible for the difference between what I reported and what the updated software calculates?

CMS does not plan to conduct an audit to find providers who relied on flawed software for their attestation information. We realize that providers relied on the software they used for accuracy of reporting, and we believe that most providers who were improperly deemed meaningful users would have met the requirements of the EHR Incentive Programs using the updated certified EHR technology.

12. We are trying to attest for a provider, but we see in the CMS Registration and Attestation site that he is registered for Medicare, not Medicaid. The CMS R&A is not allowing me to switch the program affiliation to Medicaid. Can we do this?

No. The last year for a provider to switch from the Medicare to Medicaid EHR was before the application deadline for submissions for Program Year 2014.

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.