North Carolina Medicaid Electronic Health Record Incentive Program

Eligible Professional Adopt, Implement, Upgrade Attestation Guide
Year 1 Only

NC-MIPS 2.0

Issue
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The North Carolina Medicaid Electronic Health Record (EHR) Incentive Program is providing this attestation guide as a reference for Eligible Professionals (EP). For additional information, please contact the NC-MIPS Help Desk by email, phone or mail.

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Using This Guide

Introduction

This guide can be used as a reference to help an EP understand the information needed to register and attest for an NC Medicaid EHR incentive payment on the NC Medicaid EHR Incentive Payment System (NC-MIPS). Step by step guidance and screenshots are provided throughout the attestation guide to assist participants through their attestation. Please note, this is not a static document and it is subject to updates, so please check NC-MIPS for the most up-to-date guide each year of participation.

The NC-MIPS Portal is available online at https://ncmips.nctracks.nc.gov/. Please check the NC-MIPS Home Page for important program updates and announcements. For additional help, there is a link on each page of the Portal entitled *Click for Page Help*. Upon clicking the link, a PDF version of this attestation guide will appear, showing the section of the guide that pertains to the Portal page in use.

Website Resources

The links below contain additional information regarding program requirements, important program announcements and more.

- EPs may attest for incentive payments on the NC-MIPS Portal at https://ncmips.nctracks.nc.gov/.
- The NC Department of Health and Human Services (DHHS) administers this program. More information on the NC Medicaid EHR Incentive Program can be found on the NC Medicaid EHR Incentive Program website at www.ncdhhs.gov/dma/provider/ehr.htm.
- Additional information on both EHR Incentive Programs is available from the Centers for Medicare & Medicaid Services' (CMS) EHR Incentive Program website at www.cms.gov/Regulations- and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/.

Technical Assistance

We provide program resources on NC-MIPS, our incentive program website, and our frequently asked questions page. If these resources are not sufficient in providing attestation assistance, please contact one of our technical assistance partners listed below or a local professional organization to provide more personalized attestation assistance.

The Carolinas Center for Medical Excellence
www.CCMEConsulting.org
919-461-5699
CCMEconsulting@thecarolinascenter.org

NC Area Health Education Centers (AHECs)/Regional Extension Centers (REC)
http://www.ncahec.net
919-966-2461 ncahec@med.unc.edu

NC Medical Society
http://www.ncmedsoc.org
919-833-3836

Unsure of Eligibility?

To determine program eligibility, CMS has developed an online tool that can be accessed at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligibility.html.

To be eligible to receive an NC Medicaid EHR incentive payment, a provider must:

1. Meet the 30% Medicaid Patient Volume (PV) threshold (this needs to be calculated every year of program participation);
2. Have a certified EHR technology (new 2014 certification standards are issued, please see ONC's product health IT website for additional information); and,
3. Be an eligible provider type.

***Please note, eligibility requirements must be met every year of program participation.**

Please see the NC Medicaid EHR Incentive Program website for more information about these eligibility requirements. The website also contains helpful program announcements, program guidance, requirements, resources, useful links and more.

If the user is experiencing NC-MIPS issues, please email NCMedicaid.HIT@dhhs.nc.gov. Please include the provider name, NCID, NPI, program year, a screenshot of the error message being received (if applicable) and a brief explanation of the problem.

EHR Incentive Program Overview

The NC Medicaid EHR Incentive Program awards incentive payments to EPs who use certified EHR technology in their daily operations.

As a part of the federally-funded Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, the goal of the program is to provide more effective health care by encouraging EPs to adopt, implement, or upgrade (AIU) to a certified EHR technology, and then to demonstrate Meaningful Use (MU) of that technology. The program is slated to continue through 2021.

EPs may receive up to $63,750 in incentive payments over six years of program participation. Participation years do not need to be consecutive, but EPs need six years of participation to have the opportunity to earn the full incentive payment. So, EPs must begin their first year of participation no later than Program Year 2016.

The first incentive payment for those who meet the 30% Medicaid PV threshold is $21,250. Five additional payments of $8,500 are available for providers who successfully demonstrate MU. For the first program year, EPs will only need to attest that they adopted, implemented, or upgraded (AIU) to a certified EHR technology. EPs may elect to bypass AIU and attest to MU in their first year of program participation, but every participant will be required to attest to MU in participation years two through six (please reference the EP MU Attestation Guide if attesting for MU).

AIU is defined as:

- Adopt – acquired, purchased or secured access to certified EHR technology.
- Implement – installed or commenced utilization of certified EHR technology.
- Upgrade – expanded the available functionality of certified EHR technology.

Before You Begin Attesting

Registering for the Program

If new to the program, the first step is to register on CMS' Registration & Attestation System (CMS' R&A) at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/RegistrationandAttestation.html.

Although CMS doesn't require it, please enter the EHR Certification Number when prompted by CMS. EHR certification numbers are required by North Carolina.

It is during CMS registration that you will assign payment to a specific payee NPI/payee TIN. Please check to ensure that the payee information is accurate & that the payee NPI and payee TIN are on file with NCTracks.

If the provider has never attested for an incentive payment with NC, but have registered with CMS, set up an account in NC-MIPS by completing a **one-time** First Time Account Set-up. EPs will be prompted to enter the following information to create an NC-MIPS account:

- CMS Registration ID;
- Same provider National Provider Identifier (NPI) used when registering with CMS;
- Last four digits of Social Security Number (SSN) or Employee Identification Number (EIN) used when registering with CMS; and,
- Same North Carolina individual Medicaid Provider Number (MPN) used when registering with CMS. *NOTE: If a provider registered with NC Medicaid on or after July 1, 2013, please enter an MPN of XXXXXXX for that provider. If a pop-up warning message indicates the MPN is invalid, ignore it and move forward with the attestation.*

NCID Username and Password

NCID is the standard identity management and access service used by the state. To access NC-MIPS, a unique working NCID username and password is required. ***Groups cannot share a username and password***. Before attesting, please check to ensure the NCID username and password are valid by logging onto NCID's website at http://ncid.nc.gov.

If an EP does not have a NCID account, go to the NCID website and register by following the instructions below:

1. Visit NCID's website at https://ncid.nc.gov.
2. The NCID login website displays.
3. Click on the *Register!* Link.
4. Select the type of account from the drop down list.
5. Click *Submit*.
6. Enter information in the required fields.
7. Click Create Account.

If there are any issues with an EP's NCID, please contact the NCID help desk by email at its.incidents@its.nc.gov or by phone at 919-754-6000 or 1-800-722-3946.

Forgot an NCID username or password? No problem! The *Forgot Username* link takes the user to the NCID website for recovering the NCID. The *Forgot Password* link takes the user to the NCID website for recovering the password. If you need assistance with setting up an NCID account, or for login or password assistance, please call the NCID Customer Support Center at 800-722-3946 or 919-754-6000.

If the EP's NCID username changes after completing an NC-MIPS First Time Account Setup, please let us know so we can update the EP's NC-MIPS username to match that of the updated NCID username.

Additional Tips

NC-MIPS will save unfinished attestations for 30 days, during which time a user will be able to return and complete a submission.

If at any point in the attestation process, the EP realizes they do not meet the eligibility requirements for participation in this program, the attestation may be canceled on the status page within the NC-MIPS Portal (refer to the Provider Status page for more information). Please remember that even if an EP does not qualify for participation in the Medicaid EHR Incentive Program this Program Year, they may re-attest. *EPs need six years of participation to have the opportunity to earn the full incentive payment and must begin their first year of participation no later than Program Year 2016.*

Recommended Documentation

After attesting, it is recommended that the following documents be emailed or mailed with the EP's signed and printed attestation:

- A copy of the EP's medical license;
- Documentation illustrating that an EP has adopted, implemented, or upgraded to certified EHR technology (for example: a purchase order or contract); and,
- Confirmation of group affiliation. If not listed in NCTracks, we require correspondence on the group's letterhead confirming the provider's affiliation with the group. The correspondence must include the following information:

GROUP	***INDIVIDUAL EP(s)***
• Name	• Name
• MPN	• MPN
• NPI	• NPI
• TIN	• TIN

A group may choose to produce one letter on behalf of all individuals claiming affiliation with that group. In such case, the name, MPN, NPI and TIN must be included for each individual provider.

Attestation Process Overview

The purpose of attesting to AIU is to show that an EP has adopted, implemented, or upgraded to certified EHR technology. After the first program year, the EP will need to demonstrate MU of that certified EHR technology. Please use the EP MU Attestation Guide if attesting to MU.

The figures below reflect what EPs may attest to each year of program participation.

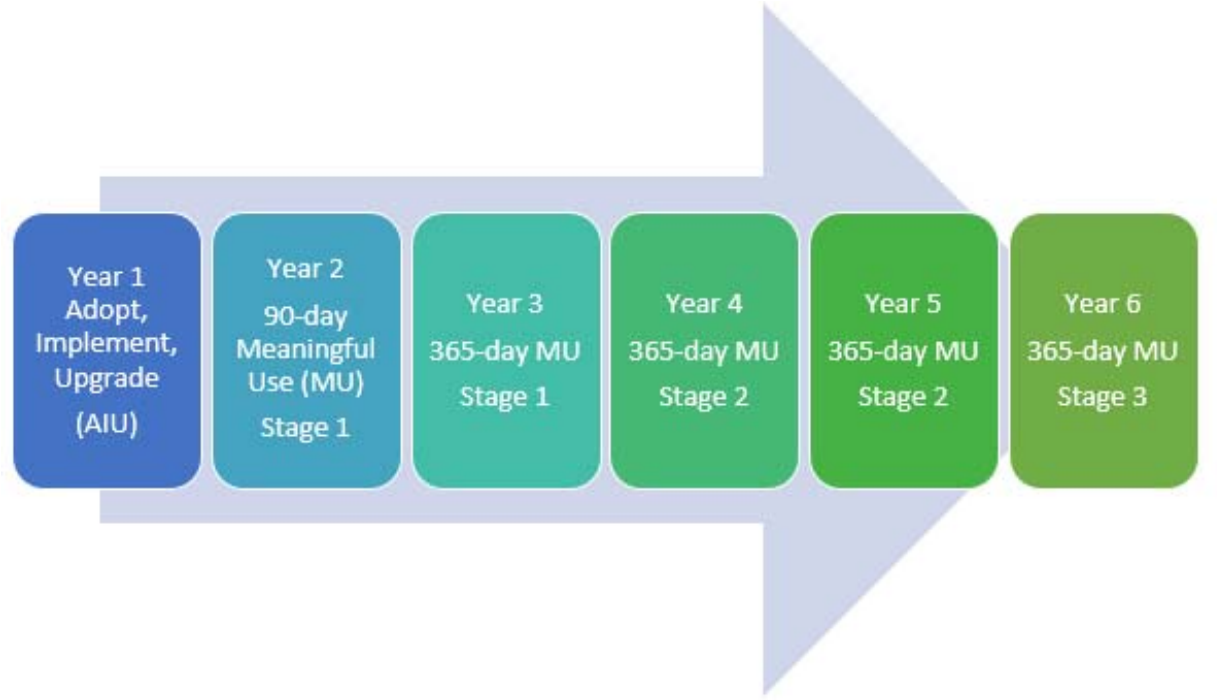


Figure 1 - Path to Payment, Attesting to AIU in Year 1

Figure 2 - Path to Payment, Attesting to MU in Year 1

NC-MIPS Portal

The NC-MIPS Portal consists of interactive web pages that will guide a user through the attestation process, prompting the user to provide information and answer questions about their use of certified EHR technology. Dialog boxes and messages help a user enter the required information and will provide tips when the system recognizes a problematic entry. Required information is marked with a red asterisk.

The NC-MIPS Portal is compatible with Internet Explorer 7 (or later), as well as Firefox 8 (or later).

The NC-MIPS Portal can be accessed online at https://ncmips.nctracks.nc.gov/. When attesting for the first time, users will be guided through the following pages:

- Welcome
- First Time Account Setup
- Provider Status
- Demographics
- Contact Information
- License
- Practice Predominantly/Hospital-Based
- Patient Volume
- AIU/MU
- Congratulations
- Electronic Submission
- Print, Sign, Send

Each one of these steps will be covered in detail in this guide. The goal is to help EPs attest properly so that incentive payments are made as quickly as possible, without the need to request additional information after the attestation is completed.

NC-MIPS Portal Page Layout

To ensure consistent navigation, each page of the Portal has a similar look and feel.

Figure 3 - NC-MIPS Portal Page Layout

The top left logo is a link to the North Carolina Health Information Technology (HIT) website.
The top right logo is a link to the CMS website for the EHR Incentive Program.

The right side of the page contains five commonly used navigation tools:

- Sign In
- Page Help
- Jump to…
- Additional Information
- Contact Information

Sign In

First time users must first register with CMS. After receiving CMS confirmation, EPs should log onto the NC-MIPS Portal and create an NC-MIPS Account by clicking *First Time Account Setup.* **If an EP already has an account with NC-MIPS, please do not complete another *First Time Account Setup*.**

The *First Time Account* link takes the user to the *First Time Account Setup* page. Here the EP enters their unique NCID username and password along with other identifying information to create a unique provider record within NC-MIPS.

Trouble logging in?

If a user is having difficulty logging into NC-MIPS, try some of the possible solutions:

1. Refer to the NC-MIPS EP AIU/MU Attestation User Guide and the Quick Attestation Reference Guide for guidance.
2. Use the exact same CMS Registration ID, Social Security Number & NPI used during CMS Registration.
3. Please ensure the EP's NCID is working with http://ncid.nc.gov. Again, if the EP has updated their NCID since their last attestation, please email us the new NCID so we can link it to the EP's account.

If the user has issues with NC-MIPS, please send an email to NCMedicaid.HIT@dhhs.nc.gov and include the following information: Provider's name, NPI, NCID username, CMS Registration ID, MPN (if applicable), Program Year, a screenshot of the information being entered and the error message being received, and a brief description of the issue.

Page Help

The *Click for Page Help* link opens a PDF version of this attestation guide to the page that corresponds to the page the user is viewing. If the user does not have Adobe Acrobat to view the PDF, there is a link to download the free Adobe Reader software in the "Additional Information" area below.

Jump to…

Clicking *Next* will allow a user to follow the normal attestation process flow in the Portal. However, there may be occasions that a user wants to jump to a particular page. *Jump to* provides links to other pages so that a user can easily navigate the Portal.
NOTE: A user is only able to jump only to the pages where data has been entered.

Additional Information

This area provides links to attestation guides and helpful web sites.

The *Eligible Professional Attestation Guide* link opens this attestation guide in a new browser.

To download the free Adobe Reader software, click *Download Adobe Acrobat*.

To learn more about the NC EHR Incentive Program, click *DMA Incentive Program home page*.

Contact Information

This area contains the email address for the NC-MIPS Help Desk. Please email if there are questions about the attestation process that cannot be answered using the resources provided.

Footer

Found at the bottom of the page, the footer has a *Contact us* link to contact the NC-MIPS Help Desk. It also has a link to view the NC-MIPS Portal *Disclaimer*.

The version number is the release number of the NC-MIPS Portal software.

Navigation

The NC-MIPS Portal is designed to help a user navigate seamlessly through NC-MIPS. Once completing the information requested on a page, click *Next* to proceed to the next page. NOTE: If any required fields are left blank, a message will prompt the user to complete the missing fields.

To change some previously entered information, can click the *Previous* Button and to navigate a user back to the previous page. The typical Portal page navigation is shown in the figure below.

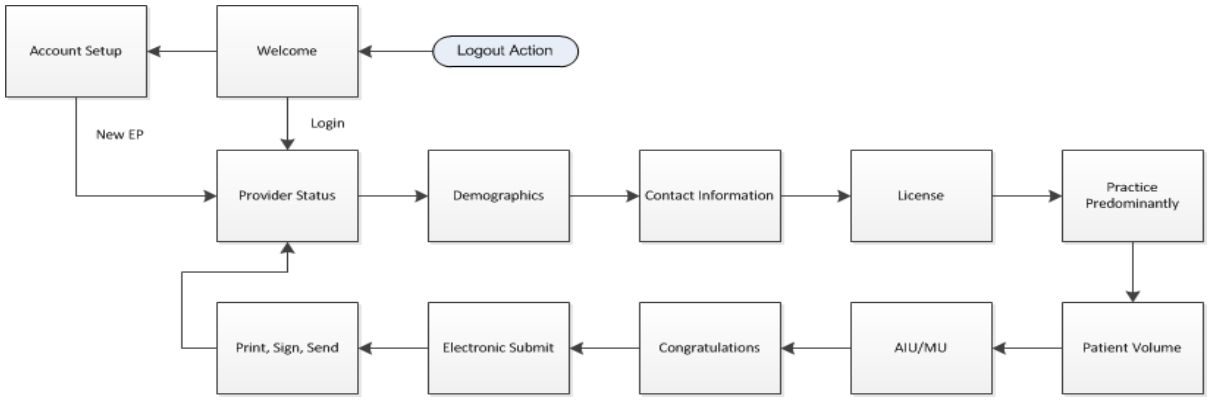


Figure 4 - Portal Navigation

Welcome

The Welcome page is the first page that a user will see when accessing the NC-MIPS Portal.

Figure 5 - Welcome Page

There may be important announcements at the top of the page, so please read that section carefully before attesting.

First-time users:

1. Click the link First Time Account Setup.
2. The First Time Account Setup page opens.

Returning users:

1. Sign in by entering the EP's unique NCID Username and NCID Password. (Please let us know if the NCID username has been updated since creating an NC-MIPS First Time Account Setup).
2. Click *Login*.
3. The Provider Status page opens.

First Time Account Setup

The First Time Account Setup page is used for setting up an NC-MIPS account for the first time. This will only be done **one time**.

Figure 6 - First Time Account Setup Page

To complete a First Time Account Setup with NC-MIPS:

1. Enter EP's CMS Registration ID.
2. Enter the same NPI used during CMS registration.
3. Enter the same Last 4 digits of EP's SSN/EIN used during CMS registration.
4. Enter EP's NC MPN. *If the provider was enrolled with Medicaid on or after July 1, 2013, enter XXXXXXX in this text box. If a pop-up warning message is received, ignore it and to move forward with the attestation.*
5. Enter EP's NCID unique username.
6. Enter EP's NCID unique password.
7. Click *Next***.**
8. The Provider Status page opens.

Provider Status

The Provider Status page shows a history of the EP's past and present attestations.

Figure 7 - Provider Status Page

The Provider Status page shows the:

- Program Year: the calendar year for which the EP attested.
- Payment Year: the participation year (1 through 6).
- Status: an automatically updated description of where the EP is in the attestation validation process for a submitted attestation.

NOTE: The Status page will pre-populate the providers' status based on their history of participation.

Users are able to track their attestation as it moves through the attestation validation process, by logging into NC-MIPS and visiting the Status page. Possible statuses are:

- Closed – no attestation submitted: no attestation was submitted for that Program Year.
- Attestation in process: the EP is in the process of attesting.
- Waiting for Signed Attestation: the signed attestation has not yet been received. We cannot begin validations without a signed attestation (signed by the attesting EP).
- Validating Attestation: after the attestation is submitted, it will go through a series of validation checks and approvals at the state and federal levels. We will send an outreach email if any additional information is required to validate the attestation.
- Awaiting Provider Information: additional information was requested and we are waiting for the discrepancy to be addressed before moving forward with validations.

- Canceled: EP cancels their 'in-process' attestation, thereby signaling they would not like to participate for the current calendar year.
- Withdrawn: EP withdraws their 'submitted' attestation, thereby signaling they no longer wish to continue the attestation process for the current calendar year. Please note, when an attestation is withdrawn, previously entered information will be saved in the system.
- Paid: the attestation has been paid.
- Attestation denied: attestation resulted in a denial.
- Activity Date: date of the last activity.

There are five buttons that may be available for each attestation:

- Proceed: proceed to the attestation.
- Cancel: before submitting the attestation, stop this attestation. The contact person will no longer be contacted about a canceled attestation. This is not a permanent action. The EP may return to the attestation after the attestation is canceled.
- Withdrawn: after submitting the attestation, stop this attestation. The contact person will no longer be contacted about a canceled attestation. This is not a permanent action. The EP may return to the attestation after the attestation is canceled.
- Re-Attest: the EP may re-attest at any point after being denied.
- View/Print: view the attestation in a form that can be printed.

If the EP has not attested in years past, there will only be one attestation for the current program year. To proceed with an attestation:

1. Click *Proceed* for the attestation you want to continue.
2. The Demographics page opens, and from here NC-MIPS will lead the EP through the attestation process.

If the EP wants to cancel participation in a given year:

1. Click *Cancel* for that program year.
2. There will be a pop-up warning message: "Canceling participation will stop communications regarding activities for this program year. The attestation can be reinstated any time by clicking *Proceed*."
3. To cancel the program year, click *OK*. The status changes to "Canceled."
4. If the EP does not wish to cancel the program year, click *Cancel*. The warning message box closes with no action performed.

To view or print an attestation:

1. Click *View/Print* to view or print a particular attestation.
2. A PDF of the attestation opens.
3. To print the attestation, use the window controls for printing.

Once reaching the Status page, users will see one of the scenarios described below.

Example 1: 'Program Year' 2012 has expired and the EP is ready to attest for 2013. The Program Year 2012 row will be marked as "Closed-No Attestation Submitted" and the Program Year 2013 row will be active.

Figure 8 - Screenshot of Example 1

Example 2: The Program Year 2011 row is marked as 'paid,' the Program Year 2012 row has expired, and the EP is ready to attest for Program Year 2013. The Program Year 2012 row will be marked as "Closed-No Attestation Submitted."

Figure 9 - Screenshot of Example 2

Example 3: Program Year 2012 and Program Year 2013 are both active; therefore, the EP can choose to attest for either Program Year 2012 or Program Year 2013. The red message does not prevent an EP from moving forward with an attestation. Please click 'Proceed' next to the Program Year for which they're attesting.

Status

Please complete your attestation with the current program year 2012 before attesting for 2013.

Provider Name	Meg One
CMS Registration ID	1000001475
NPI	2000001475
MPN	1475147

Program Year	Payment Year	Current Status	Activity Date		
2013	2	Attestation in Process			Proceed
2012	2	Attestation in Process			Proceed
2011	1	Paid	02/04/2013	View/Print	

Figure 10 - Screenshot of Example 3

Example 3a: When the EP chooses to attest for Program Year 2012, the Program Year 2013 row will be deleted and the Program Year 2012 row will auto-populate to read "Attestation in Process."

Status

Please complete your attestation with the current program year 2012 before attesting for 2013.

Provider Name	Meg One
CMS Registration ID	1000001475
NPI	2000001475
MPN	1475147

Program Year	Payment Year	Current Status	Activity Date			
2012	2	Attestation in Process			Cancel	Proceed
2011	1	Paid	02/04/2013	View/Print		

Figure 11 - Screenshot of Example 3a

Example 3i: The EP chooses to attest for Program Year 2013. When they do, a pop-up message will appear.

Figure 12 - Screenshot of Example 3i

Example 3ii: If the EP selects 'OK' to the pop-up message, the Program Year 2012 row will be marked as "Closed-No Attestation Submitted," and the Program Year 2013 row will auto-populate to read, "Attestation in Process."

Alternatively, the EP may choose to "Cancel" the pop-up message, which will keep them on the page.

Figure 13 - Screenshot of Example 3ii

Example 4: If the previous payment year (i.e., Program Year 2012) has been 'Denied' the EP will be provided with two options:

- Scenario 1: Re-attest for the denied attestation; or,
- Scenario 2: Attest for the current program year.

Figure 14 - Screenshot of Example 4

Scenario 1: Program Year 2012 has been denied; however, the EP is ready to attest for Program Year 2013. When the EP chooses to re-attest for a denied 2012 payment, a Program Year 2012 row will auto-populate and the Program Year 2013 row will be removed.

The EP chooses to re-attest by selecting the "Re-attest" button. A second Program Year 2012 row will auto-populate to read, "Attestation in Process."

Figure 15 - Screenshot of Scenario 1

Scenario 2: Provider chooses to attest for Program Year 2013. If the EP selects the "OK" button when the pop-up message displays, they will start with a Program Year 2013 attestation. The Program Year 2012 row will remain labeled as, "Attestation Denied."

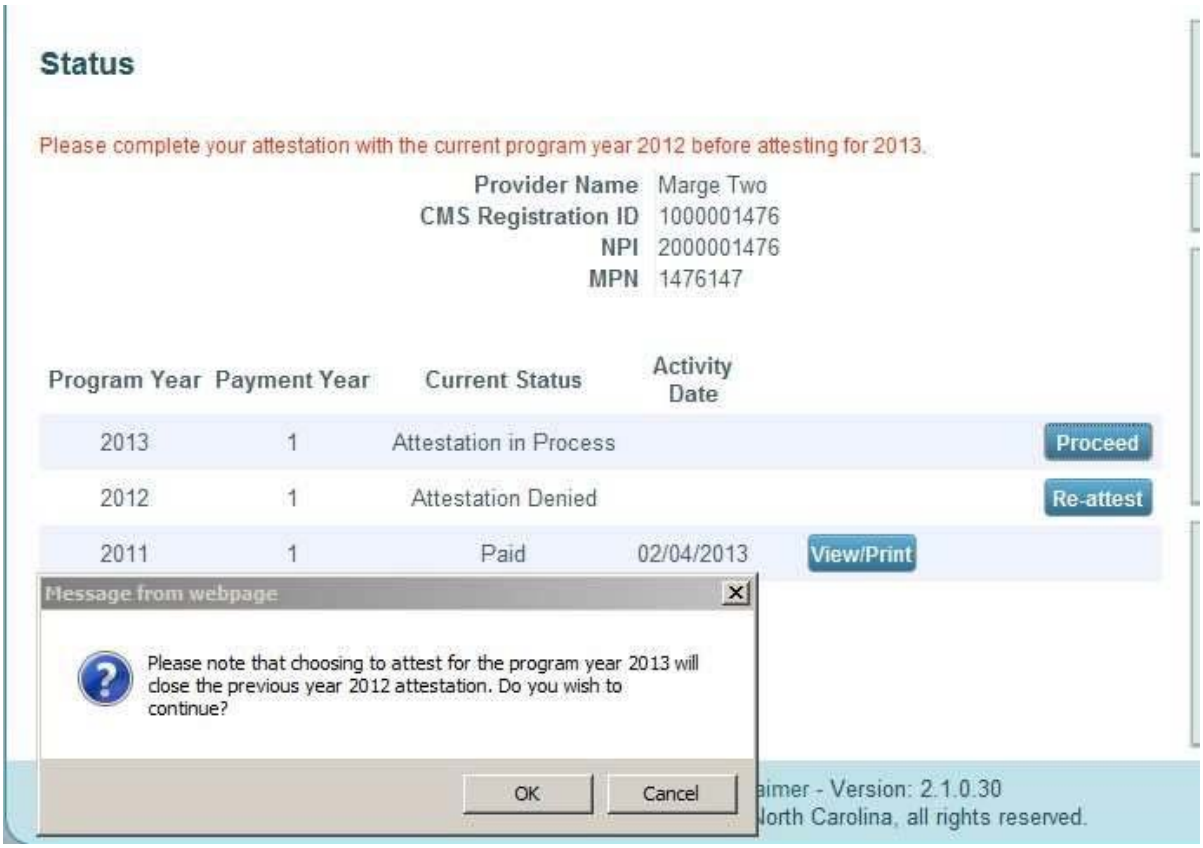


Figure 16 - Screenshot of Scenario 2

Scenario 2a: Alternatively, the EP can select the "Cancel" button on the warning pop-up message box, and they will remain on the same page.

Figure 17 - Screenshot of Scenario 2a

Demographics

The Demographics page allows EPs to clearly see the demographic and payee information that was submitted on CMS' Registration & Attestation (R&A) system. EPs are encouraged to cross reference the information housed on NC Medicaid's NCTracks to ensure they match between both sources prior to attesting.

Please note, if the North Carolina demographic information is not automatically populating within NC-MIPS, please verify the information on NCTracks (additional information below).

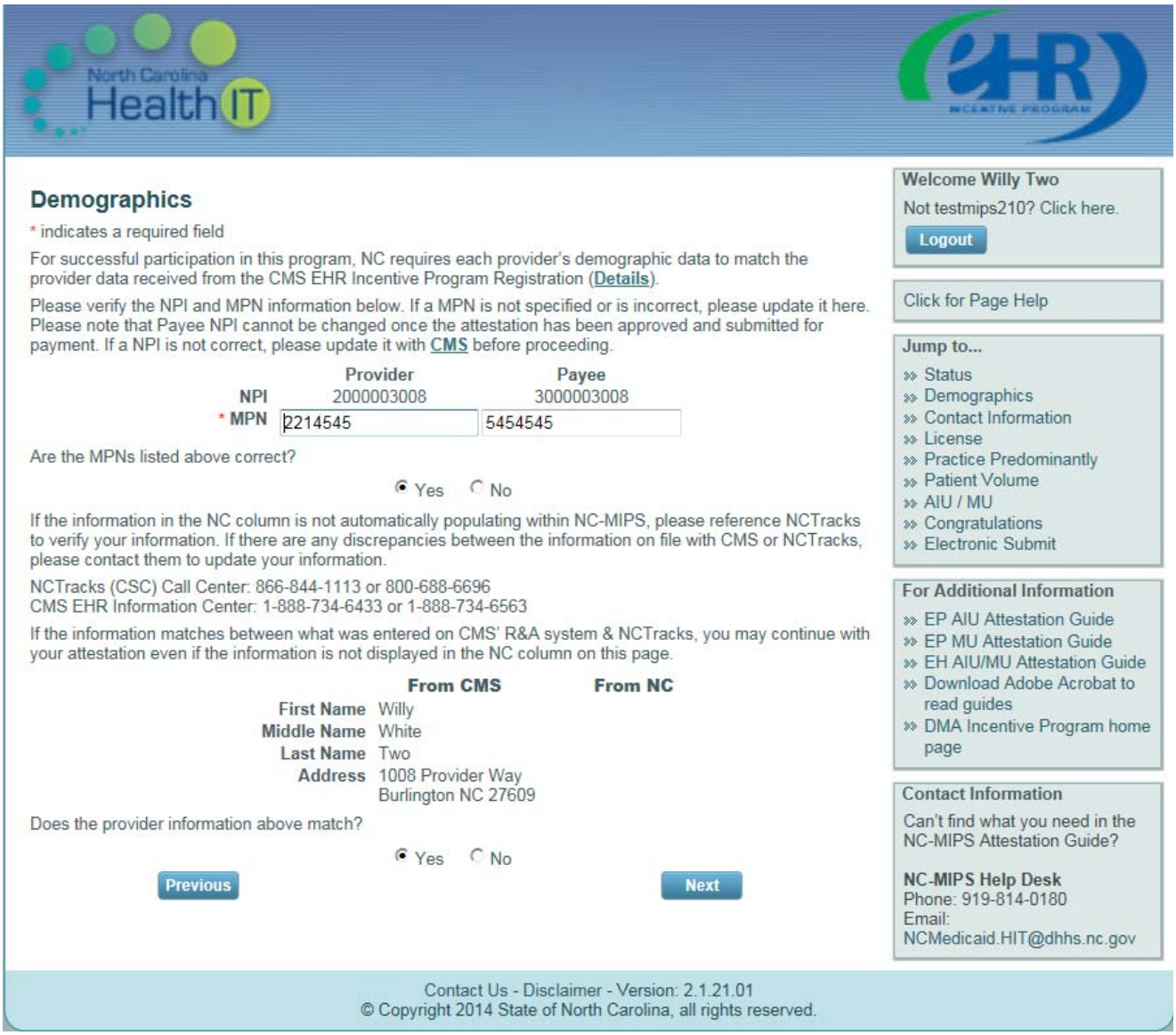


Figure 18 - Demographics Page

Only the MPNs can be updated or corrected on this page.

Unmatched demographic information may result in the delay or denial of an incentive payment. If the information does not match, please update the information with CMS or NCTracks, before continuing:

NCTracks (CSC) Call Center: 800-688-6696
CMS EHR Information Center: 1-888-734-6433 or 1-888-734-6563

To check the demographic information:

1. Review the EP's NPI and MPN numbers. *If the provider was enrolled with Medicaid on or after July 1, 2013, enter XXXXXXX for the provider's MPN.*
2. If the MPN is blank or incorrect, type in the correct MPN.
3. Answer the question "Is the MPN listed above correct?" by clicking the *Yes* button.
4. Compare the information from CMS and NC (NC column may not auto-populate, so check NCTracks and verify the information matches between CMS & NCTracks).
5. If the CMS information does not match, or is incorrect, please update the information with CMS or NCTracks before continuing (contact information can be found on the NC-MIPS Welcome Page).
6. If the information matches and is correct, click the *Yes* button for "Does the provider information above match?" Proceed even if the NC column is blank.
7. Click *Next*.
8. The Contact Information page opens.

Contact Information

The Contact Information page is used to provide the contact information for the appropriate personnel in the event that there are questions about the attestation. *NOTE: Email requests to update the contact person are not accepted. To update the contact person, withdraw, re-attest and update the information on this page.*

Figure 19 - Contact Information Page

To enter the personal contact information:

1. Enter the Contact's Name.
2. Enter the Contact's Phone Number.
3. Enter the Contact's Email Address.
4. Click *Next*.
5. The License page opens.

License

The License page is used to enter an EP's professional license information.

Figure 20 - License Page

To enter the EP's license information:

1. Select the EP's License Type from the drop down list.
2. Select the EP's License State from the drop down list.
3. Enter the EP's License Number.
4. Enter the EP's License Effective Date using the calendar tool or by typing the date.
5. Enter the EP's License Expiration Date using the calendar tool or by typing the date.
6. Click *Next*.
7. The Practice Predominantly/Hospital-Based page opens.

*Note - Please note the license number is not the same as the license approval number.

Practice Predominantly/Hospital-Based

The Practice Predominantly/Hospital-Based page is used to indicate if the EP practiced predominantly at a Federally-Qualified Health Center (FQHC), or Rural Health Center (RHC) in the previous calendar year (for which the EP attested) or the 12 months immediately preceding the date of attestation. If an EP meets the requirement for practicing predominantly, they are permitted to use non-Medicaid needy individual encounters toward their 30% Medicaid PV threshold.

An EP who has more than 50% of his/her total patient encounters at a FQHC/RHC during any continuous six-month period within the preceding calendar year (for which the EP attested) or the preceding 12-month period from the date of attestation, qualifies as "practicing predominately" at a FQHC/RHC. A single patient encounter is one or more services rendered to an individual patient on any one day.

If the EP practiced predominantly (greater than 50% of all patient encounters during a six- month period) at an FQHC/RHC, refer to Figure 21. If the EP did not practice predominantly at an FQHC/RHC and is not hospital-based, refer to Figure 22. If the EP did not practice predominantly at an FQHC/RHC and is hospital-based, refer to Figure 23.

This page is also used to determine if the EP is hospital-based. This means the EP provided 90% or more of his/her Medicaid-covered encounters in a hospital setting. A hospital-based EP is only eligible to participate in the NC Medicaid EHR Incentive Program if they can demonstrate they funded the acquisition, implementation and maintenance of certified EHR technology. This includes the purchase of supporting hardware and any interfaces necessary to meet MU, without reimbursement from an EH or CAH.

If the EP practiced predominantly (greater than 50% of all patient encounters during a six-month period) at an FQHC/RHC (Figure 21):

1. Select the *Yes* button for "Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at an FQHC, or RHC?"
2. Select the date range on the drop down list. Providers can choose to report on a continuous 90-day period from the previous calendar year (for which the EP is attesting) or from the 12 months preceding the date of attestation.
3. Enter the Start Date of the 6-Month Period using the calendar tool or by typing the date.
4. Enter the number of Total Patient Encounters at FQHC/RHC during the 6-Month Period reported in Step 1. Note that these are the individual EP's encounters only, <u>not</u> those of a practice group.
5. Enter the number of Total Patient Encounters at all locations. Note that these are the individual EP's encounters only, <u>not</u> those of a practice group.

6. Review the ratio of encounters that is automatically calculated and displayed to ensure it is greater or equal to 50%.
7. Click *Next*.
8. The Patient Volume page opens.

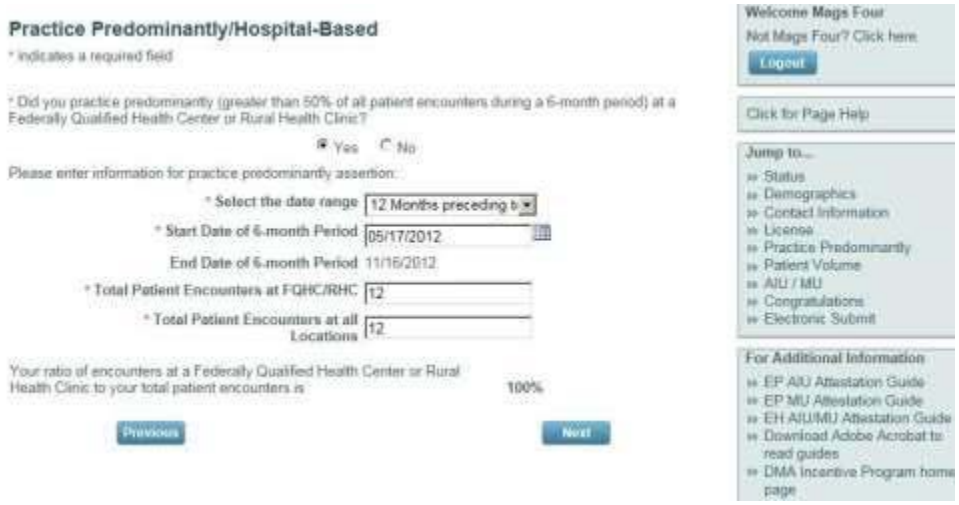


Figure 21 - Practice Predominantly/Hospital-Based Page if you answer "Yes" to practicing predominantly

If the EP **did not** practice predominantly (greater than 50% of all patient encounters during a 6-month period) at a FQHC/RHC and **are not** hospital-based (Figure 22):

1. Select *No* when asked "Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at an FQHC, or RHC?"
2. Select *No* for "Did you provide 90% or more of your Medicaid-covered encounters in an emergency or inpatient setting?"
3. Click *Next*.
4. The Patient Volume page opens.

Figure 22 - Practice Predominantly/Hospital-Based Page if you answer "No" to practicing at an FQHC/RHC and "No" to being hospital-based

If the EP **did not** practice predominantly (greater than 50% of all patient encounters during a 6-month period) at a FQHC/RHC and **are** hospital-based (Figure 23):

1. Select *No* when asked "Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at an FQHC, or RHC?"
2. Select *Yes* for "Did you provide 90% or more of your Medicaid-covered encounters in an emergency or inpatient setting?"
3. Select *Yes* or *No* when asked, "Can you demonstrate that you have funded the acquisition, implementation and maintenance of certified EHR technology?"
4. Click *Next*.
5. The Patient Volume page opens.

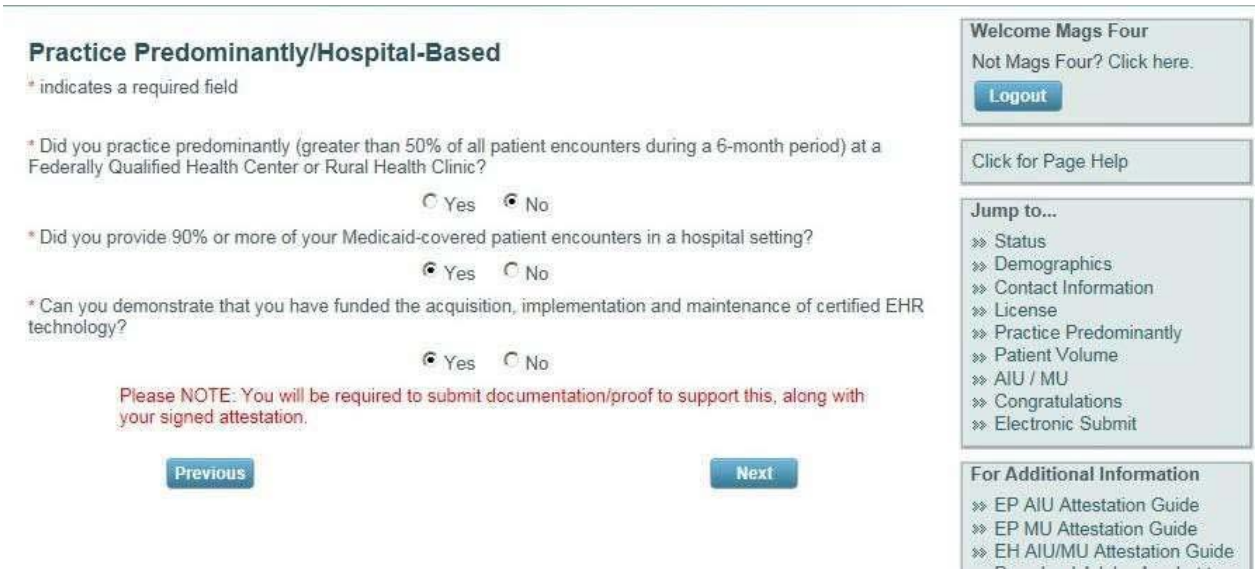


Figure 23 - Practice Predominantly/Hospital-Based Page if you answer "No" to practicing at an FQHC/RHC, but responded "Yes" to being hospital-based

Patient Volume

On the Patient Volume page, the EP reports her/his patient volume information including:

- patient volume methodology (individual or group)
- patient volume reporting period
- practice(s) from which patient volume was drawn
- number of encounters

Under individual methodology, an EP will report on only her/his personal patient encounters. Refer to Figure 24 if the EP is attesting using individual methodology.

Under group methodology, a practice will calculate the entire group's patient encounters and may use the same patient volume numbers and 90-day patient volume reporting period for every EP that is currently affiliated with the group. So long as s/he has a current affiliation, an EP may use the group's PV even if s/he wasn't with the group during the PV reporting period.

Group methodology uses the patient encounter information for the entire group practice (including non-eligible provider types, such as lab technicians) to determine Medicaid patient volume, and may not be limited in any way. You must report encounters from all providers in the practice, including those who are ineligible to participate in the NC Medicaid EHR Incentive Program.

EPs in a group practice may use either individual or group methodology for determining Medicaid patient volumes. However, encounters reported during a 90-day PV reporting period by an EP using individual methodology cannot be included in the group's number of encounters using group methodology for the same 90-day PV reporting period. An EP in such a group who wishes to use her/his encounters at that group to attest with individual methodology may do so by selecting a different 90-day PV reporting period than the 90-day period used by the EP(s) attesting with group methodology. It is important that the members of a group practice reach consensus among their affiliated EPs on the methodology each EP will use, prior to the first attestation. If possible, we suggest using group methodology to calculate PV as you'll have to calculate PV only one time for the whole group.

Refer to Figure 25 if the EP is attesting using group methodology.

For more information on calculating patient volume, please refer to the Patient Volume podcast or the 'Patient Volume' tab on our website. To be eligible to participate in the NC Medicaid EHR Incentive Program, EPs are required to have a minimum of 30 percent Medicaid-enrolled patient encounters. Pediatricians not meeting the 30 percent threshold may participate for a reduced payment by meeting a 20 percent threshold.

The formula to calculate patient volume is as follows:

$$\frac{\textbf{All Medicaid-enrolled encounters in a continuous 90-day period (includes zero paid claims)}}{\textbf{Total encounters in the same continuous 90-day period}}$$

To calculate the Medicaid patient volume, providers have the option to:

1. Select a continuous 90-day period from the calendar year prior to the program year for which they're attesting (so if attesting for Program Year 2014, this would be a 90-day period in 2013 regardless of the date of attestation); **OR,**
2. A continuous 90-day period in the 12-month period preceding the date of the attestation.

Providers practicing predominantly at a FQHC/RHC may use non-Medicaid needy patient encounters in addition to Medicaid-enrolled patient encounters to meet the required 30 percent Medicaid patient volume threshold. Non-Medicaid needy individuals include: 1) Individuals receiving assistance from Medicare or the Children's Health Insurance Program (Health Choice); 2) Individuals provided uncompensated care by the EP; and 3) Individuals who received services at no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

PV tips

Please carefully read and answer the questions at the bottom of the PV page as they will help mitigate the need for outreach.

If an EP (or a group) has unique billing practices, please include with your signed attestation a memo on practice letterhead explaining the situation.

If you are a behavioral health provider and bill any of your Medicaid claims through an LME, you will need to complete the behavioral health template (available under the Links & Resources tab on our website) and then submit the completed template with your signed attestation.

For more information about patient volume, please see the Patient Volume tab on the NC Medicaid EHR Incentive Program website. Also visit the FAQ page for frequently asked PV questions.

Patient Volume

* indicates a required field

Enter the start and end dates of the continuous 90-day period for your patient volume reporting period.

* Select the date range 1
* Start Date 2
* End Date 3
* Patient Volume Reporting Method Individual 4 Group

FQHCs and RHCs can reach the 30 percent threshold by including needy individuals, e.g., sliding scale and no pay, in addition to their Medicaid PV in their numerator. For more information on FQHCs and RHCs, visit the DMA EHR FAQ page at http://www.ncdhhs.gov/dma/ehr/ehrfaq.htm .

You may use your individual patient volume from multiple practices where you worked to meet the threshold. It is not required to report on more than one practice.

* Do your patient volume numbers come from your work with more than one practice?

Yes 5 No

Enter the patient volume information for your selected 90-day period below. Add a separate line for each billing MPN/NPI if the practice used more than one during the 90-day period.

Medicaid patient volume from eligible billable services that were not billed or were not reimbursed ('zero-pay') should be included separately from Medicaid patient volume from paid claims. Enter the 'zero-pay' portion of your numerator in the 'zero-pay' column below.

Practice Name 6 Your Total Encounters at Practice 7

Practice's Billing MPN	Practice's Billing NPI	Medicaid Encounters Billed under this MPN	Medicaid Enrolled Zero Pay Encounters	Were you Listed as Attending for all these Encounters?
8	9	10	11	Yes No 12

Add another MPN for this Practice 13

Add Another Practice Name 14

Medicaid Patient Encounters (Numerator) 15
Total Patient Encounters (Denominator) 16
Medicaid Patient Volume Percentage (Medicaid / Total) 17

Figure 24 -Patient Volume Page using Individual Methodology (part 1)

If the EP is attesting using individual methodology:

1. Select the date range. From the drop down box, choose either *12 months preceding today* (any consecutive 90-day range from the 12 months preceding today) or *previous calendar year* (any consecutive 90-day range from the calendar year preceding the program year for which you are attesting, e.g., if you are attesting for program year 2014, previous calendar year would be 2013 regardless of today's date).
2. Enter the Start Date of your selected 90-day PV reporting period, using the calendar tool or by typing the date. Your start date must fall within your selected date range.
3. Enter the End Date of your selected 90-day PV reporting period, using the calendar tool or by

typing the date. The PV reporting period must be exactly 90 days including the start date and end date. Your end date must fall within your selected date range.

4. Click the *Individual* button to report that you used individual methodology to calculate your patient volume.
5. Click on *Yes* or *No* for "Do your patient volume numbers come from your work with more than one practice?"
6. Enter the Practice Name – the name of the individual practice or group practice where your patient volume comes from.
7. Enter the Total Encounters at Practice – total of all your patient encounters with this practice, no matter the payer. Enter only YOUR encounters (Do not enter encounters that were billed under your NPI but that belong to another provider. Do not enter the number of encounters for all providers at the practice.)
8. Enter the MPN that this practice used as billing MPN on Medicaid claims during your selected 90-day patient volume reporting period. (This will not be your personal MPN unless you used your personal MPN as both billing and rendering on Medicaid claims.) If your practice joined Medicaid after 6/30/13 and does not have an MPN, enter XXXXXXX (must be all uppercase Xs).
9. Enter the NPI that this practice used as billing NPI on Medicaid claims during your selected 90-day patient volume reporting period. (This will not be your personal NPI unless you used your personal NPI as both billing and rendering on Medicaid claims.)
10. Enter the Medicaid Encounters Billed under this MPN - This is the number of encounters that you personally had with this practice during your selected 90-day PV reporting period that were paid for at least in part by Medicaid. Enter only YOUR Medicaid-paid encounters with this practice (Do not enter encounters that were billed under your NPI but that belong to another provider. Do not enter the number of encounters for all providers at the practice.) Note: Health Choice cannot be included here.
11. Enter the number of Medicaid Enrolled Zero Pay Encounters. Zero-pay Medicaid encounters are encounters with Medicaid patients that were billable services but where Medicaid did not pay. Enter only YOUR zero-pay encounters with this practice (Do not enter encounters that were billed under your NPI but that belong to another provider. Do not enter the number of encounters for all providers at the practice.) See the Patient Volume tab on our FAQ page for guidance on billable services. Note: Health Choice cannot be included here.
12. Click the *Yes* or *No* button for "Were you Listed as Attending for all these Encounters?" If you were not listed as attending/rendering on Medicaid claims for all of your Medicaid encounters, you will need to answer question 25, "If another provider was listed as attending on any of the Medicaid-paid encounters included in your PV, enter that other provider's NPI and the number of encounters attributable to that other provider."
13. If encounters were billed under more than one MPN, click the link for Add another MPN for this Practice and repeat steps 8 through 12.
14. If you are reporting patient volume from more than one practice, click the link for Add another Practice Name and repeat steps 6 through 13.
15. The numerator is automatically calculated and displayed. The numerator is all Medicaid encounters – Medicaid-paid encounters plus Medicaid zero-pay encounters.
16. The denominator is automatically displayed. The denominator is the total of all your patient encounters with this practice, no matter the payer

17. The Medicaid Patient Volume Percentage is automatically calculated and displayed. The percentage is the numerator divided by the denominator. Your percentage must be at least 30% to qualify for the incentive. Or if you are a pediatrician, you can qualify for a reduced payment if your percentage is at least 20%. If your percentage does not meet the required threshold, your attestation will be denied.

When using individual methodology, the numerator and denominator should include only encounters where the EP was the attending or supervising provider. Did you enter only those encounters attributable to the individual EP in the numerator and denominator, NOT the patient volume numbers for the entire group? ○ Yes ○ No **18**

An EP must report all MPN(s) under which encounters were billed during the 90-day reporting period from all locations on which the EP is reporting, even if one or more MPN(s) is no longer used. Did you report all MPN(s) under which the EP's encounters were billed during the 90-day reporting period, even those not currently in use? ○ Yes ○ No **19**

A Medicaid encounter is defined as services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under Section 1115 of the Social Security Act paid for part or all of the service.

a) Did you include in the numerator all encounters covered by Medicaid, even where Medicaid paid for only part of a service? ○ Yes ○ No **20**

b) Did you exclude from the numerator denied claims that were never paid at a later date? ○ Yes ○ No **21**

Encounters included in the patient volume numbers must have occurred during the 90-day period attested to above, regardless of when any claims were submitted or paid. Are your patient volume numbers based on date of service and not date of claim or date of payment? ○ Yes ○ No **22**

An encounter is one patient per provider per day and may be different from the number of claims. Do the numbers you entered represent encounters and not claims? ○ Yes ○ No **23**

The denominator must include all encounters regardless of payment method. Did you include encounters in the denominator where services were provided at no charge? ○ Yes ○ No **24**

If you had a different MPN (from the MPN you listed for the provider on the demographics screen) or more than one MPN during the 90-day period, enter that number here. **25**

If any other EP(s) used your MPN during the 90-day period, list the name(s) and number of encounters attributable to that EP. **26**

If another EP was listed as attending on any of the encounters you included in your patient volume, enter that EP's MPN and number of encounters attributable to that EP. **27**

Figure 25 -Patient Volume Page using Individual Methodology (part 2)

18. Click the *Yes* or *No* button for "Did you enter only those encounters attributable to the individual EP in the numerator and denominator, NOT the patient volume numbers for the entire group?" With individual methodology, you should enter only YOUR encounters - NOT encounters that were billed under your NPI but that belong to another provider, NOT the group's encounters. If your answer is *No*, you need to review your numbers and re-enter only YOUR encounters.
19. Click the *Yes* or *No* button for "Did you report all MPN(s) under which the EP's encounters were billed during the 90-day reporting period, even those not currently in use?" You must enter all the MPNs and NPIs that the practice(s) used as billing MPN and billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period. The billing MPN and billing NPI used during your 90-day patient volume reporting period may be different than the billing NPI that you currently use. If you answer *No*, go back and click *Add another billing MPN for the practice* to report patient volume under additional billing MPNs/NPIs used during the PV reporting period.
20. Click the *Yes* or *No* button for "Did you include in the numerator all encounters covered by Medicaid, even where Medicaid paid for only part of a service?" Medicaid-paid encounters include encounters where Medicaid paid only part, e.g., where Medicaid was the secondary payer.
21. Click the *Yes* or *No* button for "Did you exclude from the numerator denied claims that were never paid at a later date?" The number you enter for Medicaid-paid encounters can include only encounters that were paid at least in part by Medicaid. If you answer *No*, please review your numbers and for *Medicaid encounters billed under this MPN*, enter only encounters paid at least in part by Medicaid. Some denied claims can be included as zero-pay Medicaid encounters. See the Patient Volume tab on our FAQ page for guidance on billable services.
22. Click the *Yes* or *No* button for "Are your patient volume numbers based on date of service and not date of claim or date of payment?" All of your encounters must have a date of service that falls within your selected 90-day PV reporting period, regardless of when any claims were submitted or paid. If you answer *No*, please revise your numbers to report only encounters with date of service that falls within your selected 90-day PV reporting period.
23. Click the *Yes* or *No* button for "Do the numbers you entered represent encounters and not claims?" An encounter is one patient per provider per day and may be a lower number than the number of claims. For example, a provider could have two paid claims for a patient for the same date of service (e.g., one claim for a physical and one claim for a flu shot) but this counts as only one encounter. If you answer No, please revise your numbers to report encounters.
24. Click the *Yes* or *No* button for "Did you include encounters in the denominator where services were provided at no charge?" Your denominator must include all encounters during the PV reporting period with the listed practice, regardless of payment. If you answer *No*, please revise the number you entered in the *Your Total Encounters at Practice* box (box #7) to include ALL of your encounters with the listed practice.
25. If the EP had different MPNs or more than one MPN during the 90-day period, enter that number in the text field. If you had another personal MPN or NPI that you used as attending/rendering on Medicaid claims during your selected 90-day PV reporting period, list all here.
26. If any other provider billed encounters under the attesting EP's MPN during the 90-day

period, list the name(s) and number of encounters attributable to that other provider. If this does not apply to you, enter N/A. If any other provider, such as a nurse practitioner that you supervised or a physician that was new to your practice, used your personal NPI or MPN as attending/rendering on their Medicaid claims, then you must enter the name of that other provider and the number of Medicaid-paid encounters that belong to that other provider. For the other provider(s), include only Medicaid-paid encounters with the practice listed. If more than one provider used your NPI as rendering on their Medicaid claims, list all.

27. If another provider was listed as attending on any of the encounters included in the EP's patient volume, enter that provider's MPN and number of encounters attributable to that provider. If this does not apply to you, enter N/A. If another provider was listed as attending/rendering on any or all of the Medicaid-paid encounters included in your numerator, enter that other provider's NPI or MPN and number of Medicaid-paid encounters attributable to that other provider. For the other provider, include only Medicaid-paid encounters with the practice listed. If your Medicaid-paid encounters were billed using more than provider's NPI as rendering, list all.
28. Click *Next*.
29. The AIU/MU page opens.

GROUP METHODOLOGY

Patient Volume

* indicates a required field

Enter the start and end dates of the continuous 90-day period for your patient volume reporting period.

* Select the date range 1
* Start Date 2
+ * End Date 3
* Patient Volume Reporting Method ○ Individual 4 ◉ Group

FQHCs and RHCs can reach the 30 percent threshold by including needy individuals, e.g., sliding scale and no pay, in addition to their Medicaid PV in their numerator. For more information on FQHCs and RHCs, visit the DMA EHR FAQ page at http://www.ncdhhs.gov/dma/ehr/ehrfaq.htm .

Enter the patient volume information for your selected 90-day period below. Add a separate line for each billing MPN/NPI if the group used more than one during the 90-day period.

Medicaid patient volume from eligible billable services that were not billed or were not reimbursed ('zero-pay') should be included separately from Medicaid patient volume from paid claims. Enter the 'zero-pay' portion of your numerator in the 'zero-pay' column below.

Group Name	Number of Group Members During 90-day Period	Total Encounters for All Group Members
5	6	7

Group's Billing MPN	Group's Billing NPI	Medicaid Encounters Billed under this MPN	Medicaid Enrolled Zero Pay Encounters
8	9	10	11

Add another Group MPN 12

Medicaid Patient Encounters (Numerator) 13
Total Patient Encounters (Denominator) 14
Medicaid Patient Volume Percentage (Medicaid / Total) 15

Figure 265 -Patient Volume Page using Group Methodology (part 1)

If the EP is attesting using group methodology:

1. Select the date range. From the drop down box, choose either *12 months preceding today* (any consecutive 90-day range from the 12 months preceding today) or *previous calendar year* (any consecutive 90-day range from the calendar year preceding the program year for which you are attesting, e.g., if you are attesting for program year 2014, previous calendar year would be 2013 regardless of today's date).
2. Enter the Start Date of your selected 90-day PV reporting period, using the calendar tool or by typing the date. Your start date must fall within your selected date range.
3. Enter the End Date of your selected 90-day PV reporting period, using the calendar tool or by typing the date. The PV reporting period must be exactly 90 days including the start date and end date. Your end date must fall within your selected date range.

4. Click the *Group* button to report that you used group methodology to calculate your patient volume.
5. Enter the Group Name – the name of the group practice where your patient volume comes from.
6. Enter the Number of Group Members During the 90-day Period. This is the total number of providers that were in the group during your selected 90-day patient volume reporting period. *NOTE:* This number includes ALL providers in the group, not just the ones who are eligible to participate in the NC Medicaid EHR Incentive Program.
7. Enter the Total Encounters for All Group Members. This is the number of encounters for all group members regardless of payer during your selected 90-day patient volume reporting period. *NOTE:* This number includes ALL encounters with ALL payers for ALL providers in the group, not just the encounters for the providers who are eligible to participate in the NC Medicaid EHR Incentive Program.
8. Enter the Group's Billing MPN. This is the MPN that your group used as billing MPN on Medicaid claims during your selected 90-day patient volume reporting period. (This will not be your personal MPN unless you used your personal MPN as both billing and rendering on Medicaid claims.) If your group joined Medicaid after 6/30/13 and does not have an MPN, enter XXXXXXX (must be all uppercase Xs).
9. Enter the NPI that your group used as billing NPI on Medicaid claims during your selected 90-day patient volume reporting period. (This will not be your personal NPI unless you used your personal NPI as both billing and rendering on Medicaid claims.)
10. Enter the Medicaid Encounters Billed under this MPN - This is the number of encounters for all group members that were paid for at least in part by Medicaid. Note: Health Choice cannot be included here.
11. Enter the number of Medicaid Enrolled Zero Pay Encounters (regardless of payment liability). This is the number of encounters for all group members with Medicaid patients that were billable services but Medicaid did not pay.
12. If the group has billed encounters under more than one MPN/NPI, click the link for *Add another Group MPN* and repeat steps 8 through 11.
13. The numerator is automatically calculated and displayed. The numerator is all Medicaid encounters – Medicaid-paid encounters plus Medicaid zero-pay encounters.
14. The denominator is automatically displayed. The denominator is the total of all patient encounters for this group, no matter the payer
15. The Medicaid Patient Volume Percentage is automatically calculated and displayed. The percentage is the numerator divided by the denominator. Your percentage must be at least 30% to qualify for the incentive. Or if you are a pediatrician, you can qualify for a reduced payment if your percentage is at least 20%. If your percentage does not meet the required threshold, your attestation will be denied.

An encounter is one patient per provider per day and may be different from the number of claims. Do the numbers you entered represent encounters and not claims? Yes No **16**

If the group's reported encounters span more than one location and/or were billed with Medicaid under multiple MPNs, NC requires provision of all MPNs associated with each location under which Medicaid claims were billed during the 90-day reporting period.

a) If you are reporting patient encounters from multiple locations, have you provided all associated MPNs? Yes No N/A **17**

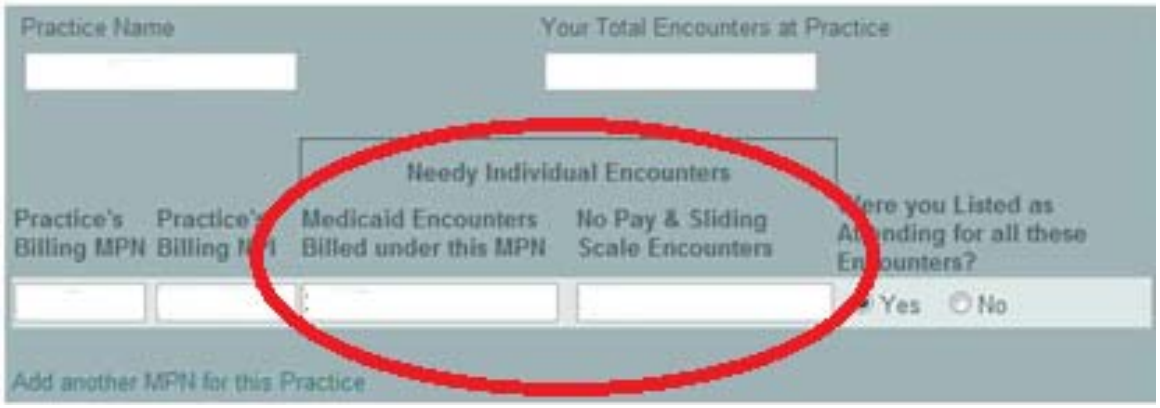
b) During the 90-day reporting period, did the group have a different (outdated) billing MPN or more than one billing MPN? Yes No N/A **18**

Figure 275 -Patient Volume Page using Group Methodology (part 2)

16. Click the *Yes* or *No* button for "Do the numbers you entered represent encounters and not claims?" An encounter is one patient per provider per day and may be a lower number than the number of claims. For example, a provider could have two paid claims for a patient for the same date of service (e.g., one claim for a physical and one claim for a flu shot) but this counts as only one encounter. If you answer No, please revise your numbers to report encounters.
17. Click the *Yes* or *No* button for "If you are reporting patient volume from multiple locations, have you provided all associated MPNs?" You define your group based on location(s). [note: Guidance on defining your group is available under the Patient Volume tab on our website.] If you are using patient volume from multiple locations, you must enter all the MPNs and NPIs that the group used as billing MPN and billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period for those locations. The billing MPN and billing NPI used during your 90-day patient volume reporting period may be different than the billing NPI that you currently use. If you answer *No*, go back and click *Add another Group MPN* to report patient volume under additional billing MPNs/NPIs used during the PV reporting period.
18. Click the *Yes* or *No* button for "During the 90-day reporting period, did the group have a different (outdated) billing MPN or more than one billing MPN?" You must enter all the MPNs and NPIs that the group used as billing MPN and billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period. The billing MPN and billing NPI used during your 90-day patient volume reporting period may be different than the billing NPI that you currently use. If you answer *Yes*, go back and click *Add another Group MPN* to report patient volume under additional billing MPNs/NPIs used during the PV reporting period.

PRACTICING PREDOMINANTLY

Providers practicing predominantly at a FQHC/RHC may use non-Medicaid needy patient encounters in addition to Medicaid-enrolled patient encounters to meet the required 30 percent Medicaid patient volume threshold.



If you are a provider attesting to practicing predominantly, on the patient volume screen in MIPS you will see that your numerator is called Needy Individual Encounters (circled in red above), which is broken out into Medicaid Encounters Billed under this MPN and No Pay & Sliding Scale Encounters. When attesting, you will complete the patient volume page using individual or group methodology (see instructions above) but as a provider who practices predominantly you also have the option to report non-Medicaid needy encounters in the box labeled No Pay & Sliding Scale Encounters. Non-Medicaid needy individuals include: 1) Individuals receiving assistance from Medicare or the Children's Health Insurance Program (Health Choice); 2) Individuals provided uncompensated care by the EP; and 3) Individuals who received services at no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

AIU/MU

The Adopt, Implement, or Upgrade (AIU) or Meaningful Use page is used to collect information on the activities the EP undertook to adopt, implement, or upgrade to a certified EHR technology. For the definition of AIU, see page 7 of this guide.

NOTE: Attesting to AIU can only be done in the first year of program participation. In subsequent participation years, an EP will attest to Meaningful Use.

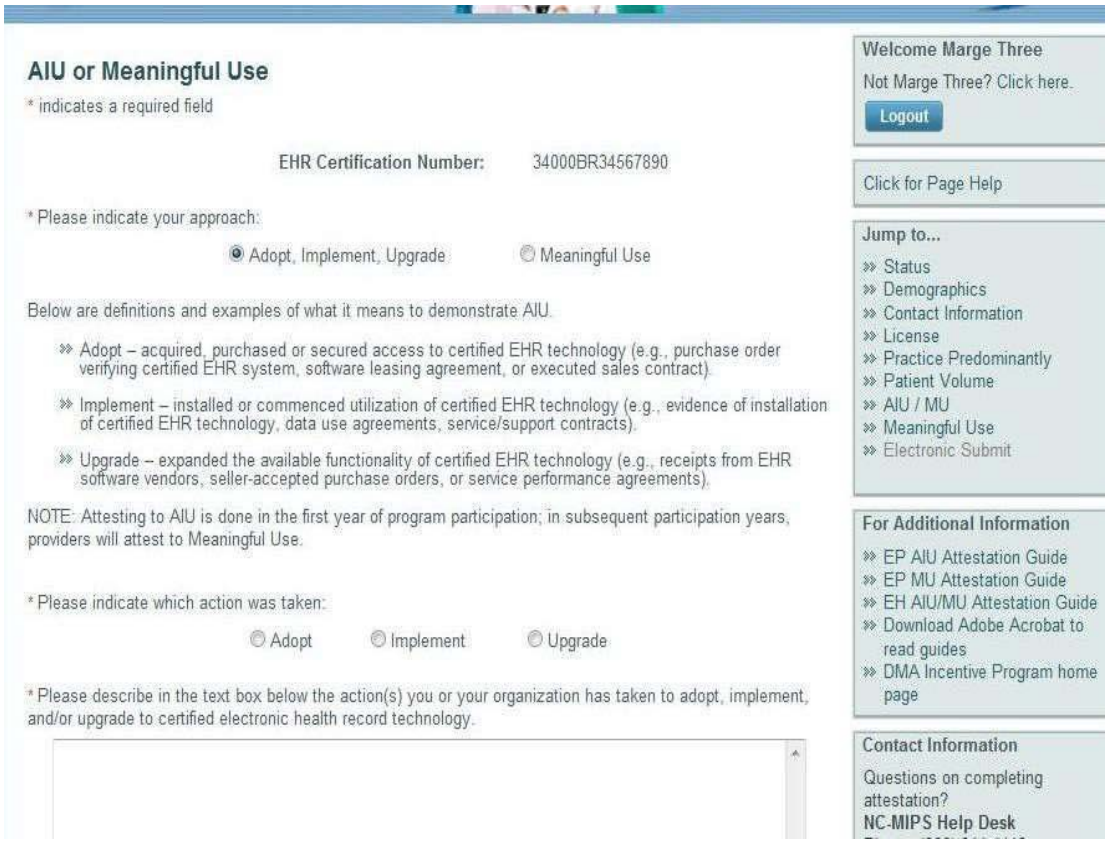


Figure 28 - AIU Page

If the EHR Certification Number has changed, please update it on CMS' R&A System.

To enter AIU activities:

1. When it asks "Please indicate your approach," click the *Adopt, Implement, Upgrade* button.
2. Select a button to indicate which activity was undertook during the program year: *Adopt, Implement* or *Upgrade*.
3. Enter details of the EP's AIU activities. For example, purchasing an EHR for the first time, upgrading an existing EHR product, training staff on new functionalities, adapting workflow or any number of other related activities.
4. Click *Next.*
5. The Congratulations Page opens.

Congratulations

Congratulations! The attestation questions are now complete. Click *Next* to continue to the Electronic Submission page.

Figure 29 - Congratulations Page

1. Click *Next* to move to the Electronic Submission page.
2. The Electronic Submission Page opens.

Electronic Submission

The Electronic Submission page is used to submit the electronic attestation and formally attest to the accuracy of the reported information.

Figure 30 - Submission Page

To attest to the accuracy of the reported information:

1. Read all the statements on the page.
2. If the EP agrees, check the box for "I have read the above statements and attest to my responses."
3. Click *Next*.
4. The Print, Sign, Send page opens.

Print, Sign, Send

Use the Print, Sign, Send page to print the attestation. The printed attestation must be signed and dated by the EP (reflecting the date of the most recently submitted attestation) and sent to the NC-MIPS Help Desk.

Print, Sign, and Send Attestation

You have completed the online attestation for the NC Medicaid EHR Incentive Program. In order to have the attestation validated for payment, we need a signed copy of your attestation.

Please follow the steps listed below:

1. Print a copy of your attestation. Attestations may also be printed from the status page.
2. Sign and date the attestation.
3. Submit all pages of the signed attestation along with any supporting documentation (what's this?) to the NC-MIPS Help Desk using one of the methods listed:
   - Email a scanned copy to NCMedicaid.HIT@dhhs.nc.gov
   - Mail a copy to:
     NC Medicaid EHR Incentive Program
     2501 Mail Service Center
     Raleigh, NC 27699-2501

Remember to retain all records in support of your submitted attestation.

The State of North Carolina looks forward to working with you on this important program. Please refer to the DMA EHR Incentive Program Website for more information on the attestation validation process. You may also track the status of your attestation on the status page.

Figure 31 - Print, Sign, Send Page

To finish the attestation process:

1. Click *Print* to print the attestation.
2. The attesting EP must sign and date the printed attestation him/herself and the date must reflect that of the most recently submitted attestation. A third party, such as a practice manager, **may not** sign the printed attestation on behalf of the EP. *Electronic signatures are not accepted in lieu of a manual signature.*
3. Collect any supporting documentation to send with the signed attestation (optional). This may include a copy of the EP's medical license, a purchase order or contract with an EHR vendor, and/or any additional information in support of attested information. Send the signed attestation and supporting documentation to the NC-MIPS Help Desk using one of the following methods:

*Email: NCMedicaid.HIT@dhhs.nc.gov
Mailing Address: NC Medicaid EHR Incentive Program
2501 Service Center
Raleigh, NC 27699-2501
*Email is the preferred method of contact.

Please note, effective June 1, 2013, the N.C. Medicaid EHR Incentive Program no longer accepts documentation via fax.

Next Steps

Please return to the NC-MIPS Portal at https://ncmips.nctracks.nc.gov/ anytime to review the status of an attestation(s) on the Status Page. If there are any found discrepancies we will conduct outreach and an EP has 15 calendar days to address any issues. While not guaranteed, error-free attestations (where no outreach is conducted) can be processed in roughly six to 10 weeks. The payment will be noted in the Financial Summary section of the Medicaid Remittance Advice. In addition, once we received notice the payment was successfully proceed, we will send a payment confirmation email to the contact person listed in NC-MIPS specifying the payment was made.

After attesting to AIU, the next attestation will be MU. Please refer to the EP MU Attestation Guide for attestation assistance.

Thank you for participating in the NC Medicaid EHR Incentive Program. We look forward to working with you to achieve meaningful use and improve patient care.

Glossary

AIU	Adopt, Implement, or Upgrade
CCN	CMS Certification Number
CMS	Centers for Medicare & Medicaid Services
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance
EHR	Electronic Health Record
EP	Eligible Professional
FQHC	Federally-Qualified Health Center
HIT	Health Information Technology
MPN	Medicaid Provider Number
MU	Meaningful Use
NC-MIPS	North Carolina Medicaid EHR Incentive Payment System
NCID	North Carolina Identity Management
NPI	National Provider Identifier
RHC	Rural Health Center
SSN	Social Security Number