North Carolina Medicaid Electronic Health Record Incentive Program

Eligible Professional Stage 1 Meaningful Use Attestation Guide

NC-MIPS 2.0

Issue Number 1.11

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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.

***Email:** NCMedicaid.HIT@dhhs.nc.gov

*An EP attesting to Meaningful Use **must** submit their attestation via email. A hard copy is NOT required.

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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 attest for a Meaningful Use (MU) NC Medicaid EHR incentive payment on the NC Medicaid 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 your local professional organization to provide you with 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://cms.gov/apps/ehealth-eligibility/ehealth-eligibility-assessment-tool.aspx.

To be eligible to receive an EHR incentive payment with NC Medicaid's EHR Incentive Program, 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.

***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.

Outreach and Denials

Unless an EP attests to AIU in participation years two through six or submit their MU attestation with an incomplete/invalid MU Measure Set (which results in an automatic denial), if there are problems with the attestation we will conduct outreach with guidance to correct the issue. An EP has 15 calendar days to address the discrepancies. If the issue is not resolved and the EP gets denied, they may re-attest without penalty. This means if attesting for a second year payment, the EP will still have the opportunity to attest for their second year payment. So long as the EP attests for a total of six years, they may still earn the full incentive payment.

Please note, if the EP is denied and the program year has closed, they will need to re-attest for the next available program year.

EHR Incentive Program Overview

The NC Medicaid EHR Incentive Program awards incentive payments to EPs who 'meaningfully' use certified EHR technology in their day-to-day 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. EPs may choose not to participate in consecutive years, but 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.

The first incentive payment 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 attest to MU in their first year of program participation. Regardless of what is attested to in the first year of participation, the EP will be responsible for attesting to MU in participation years two through six (please reference the EP AIU Attestation Guide if attesting for AIU).

The American Recovery and Reinvestment Act of 2009 specifies three main components of MU:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and other measures.

Simply put, MU is the first step toward standardizing the way EPs use certified EHR technology so data can be shared among different entities.

Reminders to returning providers

If the EP already have an account with NC-MIPS, do not need to complete another First Time Account Setup. If this is the EPs first year of participation and they do not have an NC- MIPS account, please refer to the EP AIU Attestation Guide for registration information.

Each attesting EP needs a working NCID username and password to complete an attestation. If the EPs NCID username has been updated since completing a First Time Account Setup, please send us an email with the provider's name, NPI and new NCID username so we can manually update the provider's NC-MIPS username. If you need to update your NCID or have questions about your NCID, please contact NCID. More information can be found at https://ncid.nc.gov.

Please update any updated/new information on CMS' R&A System at https://ehrincentives.cms.gov/hitech/login.action. This includes having a new EHR certification number, site address, payee NPI/payee TIN type, etc.

EPs are required to have a 2014 certified EHR technology (CEHRT) when attesting in Program Year 2014 and beyond. Please check ONC's certified Health IT Product List to ensure your EHR is 2014 certified. Update your CEHRT number on CMS' Registration & Attestation System before attesting on NC-MIPS.

Note: It is during CMS registration that you will assign the payment to a specific payee NPI/payee TIN. Please check to make sure that the payee NPI and payee TIN are correct and also on file with NCTracks.

The NC-MIPS Portal will save unfinished attestations for 30 days, during which time you will be able to return and complete your submission.

If at any point in the attestation process, it is determined the EP does not meet the eligibility requirements for participation in this program, they may cancel the attestation on the status page within the NC-MIPS Portal. Please remember that even if the EP does not qualify for participation in the Medicaid EHR Incentive Program this Program Year, you 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.*

Attestation Tail Period

North Carolina has a 120-day attestation tail period to allow for attestation beyond the end of the payment year. This means, EPs have until April 30, 2016 to attest for Program Year 2015. That being said, **do not** wait until the last minute to attest so there is time to address any attestation discrepancies. EPs will not be able to update information in NC-MIPS once a program year has closed after the end of the tail period.

Attesting for MU

EPs have the option to attest to AIU or MU in their first year of participation, but MU is required in participation years two through six. Please use the EP AIU Attestation Guide if attesting to AIU. The figures below reflect what EPs may attest to each year of program participation.

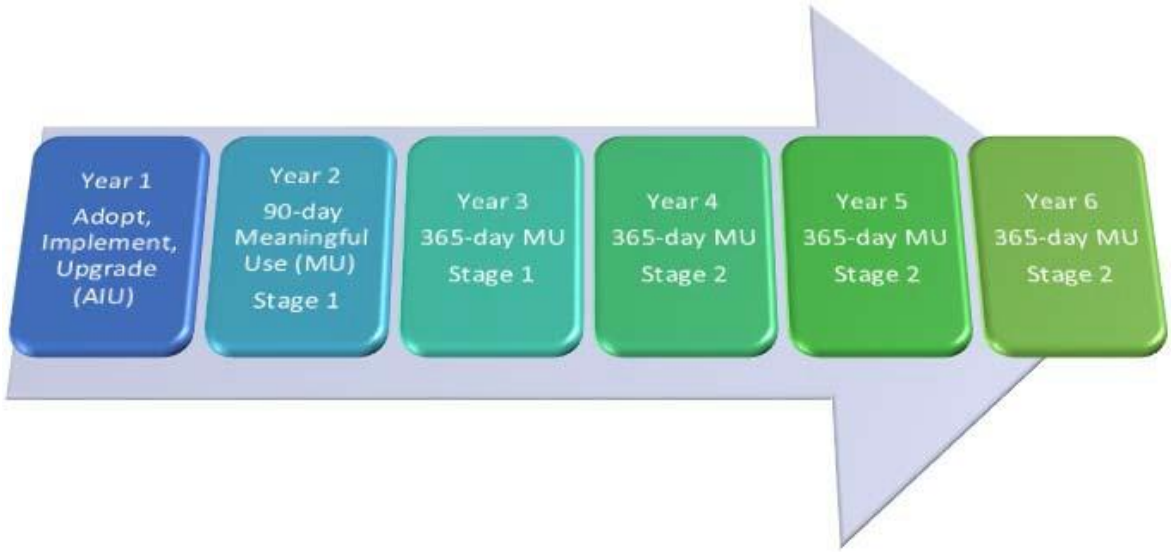


Figure 1 - Path to Payment, Attesting to AIU in Year 1

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

Before Attesting

Before getting started, check the MU measures that will be collected during the MU reporting period and work with the EHR vendor to ensure the EHR is certified to capture those measures.

Reporting Periods

PV $\neq$ MU

EPs will be required to report at least **<u>two separate reporting periods</u>**: PV and MU. These reporting periods are not synonymous. Pay particular attention when entering these reporting periods into NC-MIPS that the reporting periods are accurate based on the EPs auditable data source.

- **PV Reporting Period** – A consecutive 90-day period in:
  1. The previous calendar year for which you're attesting; or,
  2. The 12 months immediately preceding the date of attestation.

  For example: If attesting on August 13th, 2015 for Program Year 2015, the previous calendar year is 2014 and the 12 months immediately preceding the date attestation would be 8/12/14-8/12/15.

- **MU Reporting Period**– This is specific to the **individual EP**. It should be reported A consecutive 90- or 365-day in the current calendar year for which you're attesting. For example: If attesting in Program Year 2015, the MU reporting period will be a consecutive 90-day period in 2014 or a full 2014 calendar year 1/1/15-12/31/15.

Meaningful Use Summary Pages

Providers will need to print their MU summary pages during the attestation before submitting the attestation.

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);
- Confirmation of group affiliation. If the EP is using group methodology to calculate patient volume, but their group affiliation is not listed in NCTracks, we require correspondence on the group's letterhead confirming the provider's current affiliation with the group. The correspondence must include the group and individual's name, MPN (if applicable), NPI & 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*; and,
- Physician assistant (PA) eligibility documentation. PAs are only eligible to participate if they furnish services at a PA-led FQHC/RHC. This applies to all PAs in a practice. If an EP

is attesting to meeting PA eligibility requirements, they must submit on letterhead a memo explaining they meet one of the three following criteria:

1. When a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider);
2. When a PA is a clinical or medical director at a clinical site of practice; or,
3. When a PA is an owner of an RHC.

NC-MIPS Portal

As a reminder, you can access NC-MIPS at https://ncmips.nctracks.nc.gov/. Once you are logged on, the Portal will take you through the attestation process one page at a time.

NC-MIPS is compatible with Internet Explorer 7 (or later), as well as Firefox 8 (or later). The following MU pages will be covered in this guide: Measure Selection Home Page, MU Measure Instructional Pages, Core Measures, Menu Measures and Clinical Quality Measures.

If you have difficulty running EHR reports or have questions about which measures your EHR is capable of reporting, please work with your EHR vendor.

When attesting, the user will be guided through the following pages:

- Welcome
- First Time Account Setup (**for new users only!**)
- Provider Status
- Provider Demographics
- Personal Contact
- Practice Predominantly/Hospital-Based
- Patient Volume
- AIU/MU
- MU Measure Selection Home Page
- Congratulations
- Submit
- Print, Sign, Send

NC-MIPS Provider Portal Layout

To ensure consistent navigation, each page of NC-MIPS has a similar look and feel.

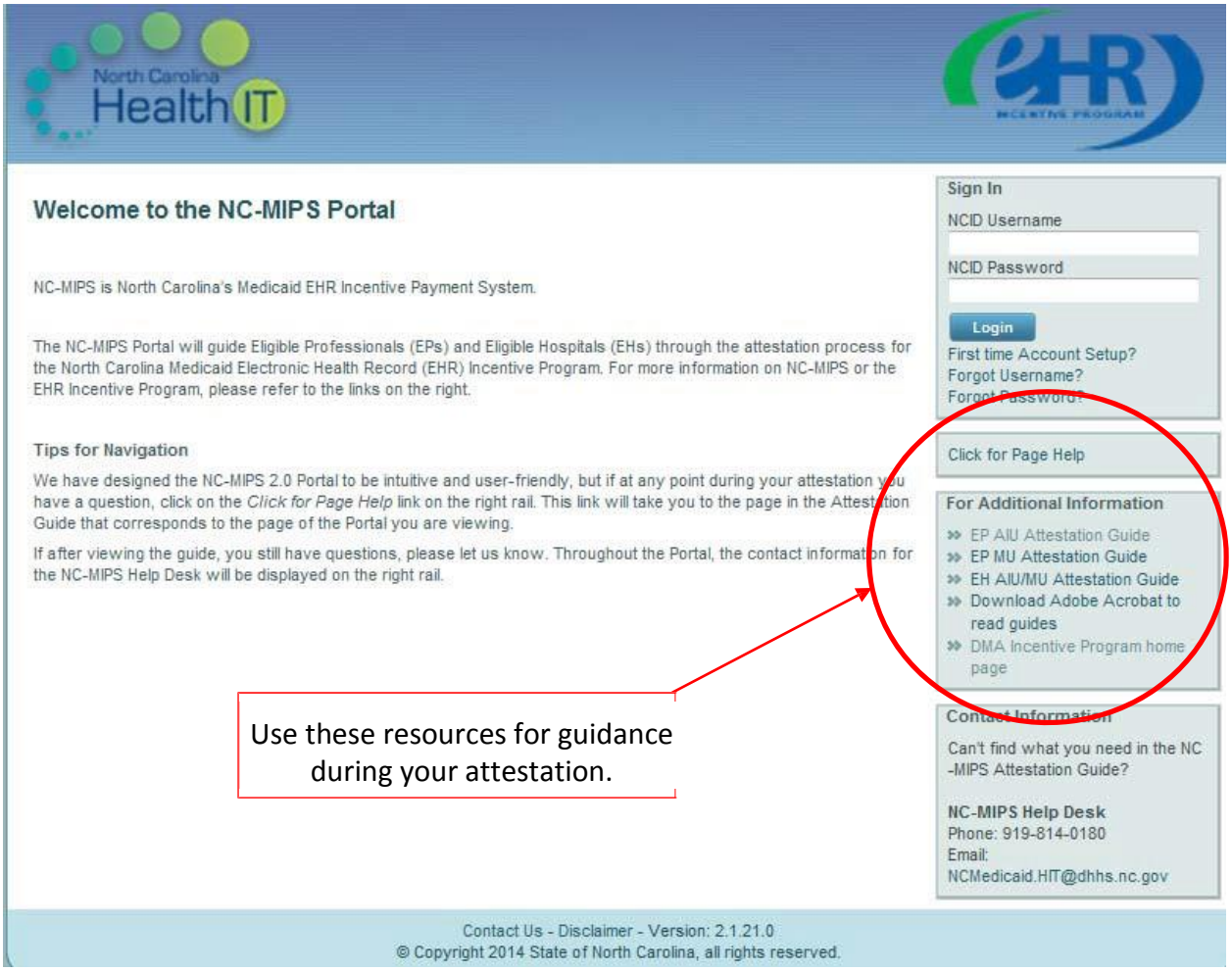


Figure 3 - NC-MIPS Portal Page Layout

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.

For your convenience, 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 these 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 read guides,* and it will take you to a free download.

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 you have 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.

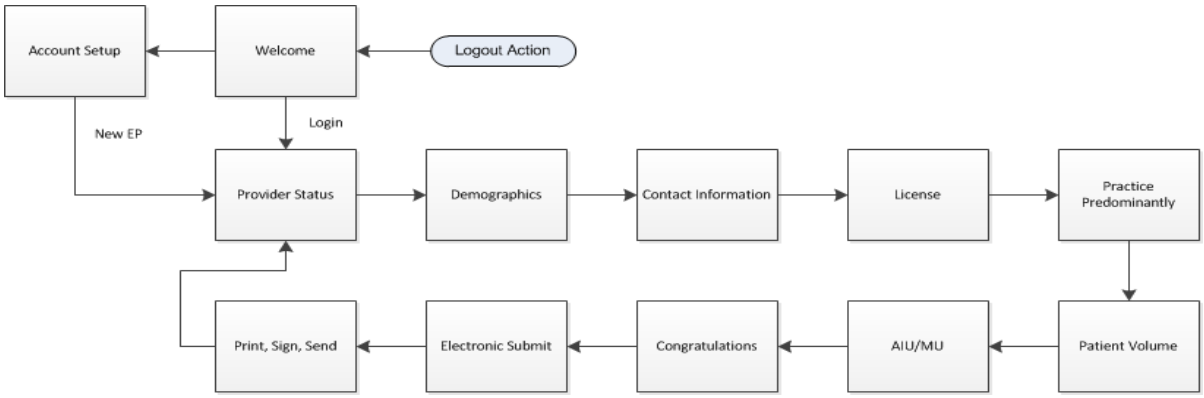


Figure 4 - Portal Navigation

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. This number is always provided by CMS after an EP registers on CMS' Registration & Attestation (R&A) System.
2. Enter the same NPI used during CMS registration.
3. Enter the same Last 4 digits of payee TIN type used during CMS registration.
4. Enter the same Last 4 digits of payee TIN type used during CMS registration.
    a. Generally speaking, if an EP is assigning the payment to themselves, they will use their social security number as the TIN type.
    b. Generally speaking, if an EP is assigning the payment to the group, they will use the group's EIN number as the TIN type.

    EPs may update the payee information at any time on CMS' R&A system.
5. Enter EP's NC MPN. *If the MPN is unknown or 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 displayed, ignore it and to move forward with the attestation.*
6. Enter EP's NCID unique username.
7. Enter EP's NCID unique password.
8. Click *Next***.**
9. The Provider Status page opens.

Provider Status

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

Status

Provider Name	Jose Four
CMS Registration ID	1000003024
NPI	2000003024
MPN	2154455

Program Year	Payment Year	Current Status	Activity Date	
2015	1	Attestation in Process		Proceed
2014	1	Closed - No Attestation Submitted		

Figure 7 - Provider Status Page

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.

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. Please note, these examples are not from the current program year.

Example 1: 'Program Year' 2014 has expired and the EP is ready to attest for 2015. The Program Year 2014 row will be marked as "Closed-No Attestation Submitted" and the Program Year 2015 row will be active.

Status

Provider Name	Jose Four
CMS Registration ID	1000003024
NPI	2000003024
MPN	2154455

Program Year	Payment Year	Current Status	Activity Date	
2015	1	Attestation in Process		Proceed
2014	1	Closed - No Attestation Submitted		

Figure 8 - Screenshot of Example 1

Example 2: The Program Year 2012 has expired and 2013 program year has been "Paid". EP didn't return for program Year 2014 and is ready to attest again for Program Year 2015.

Program Year	Payment Year	Current Status	Activity Date		
2015	2	Attestation in Process		Cancel	Proceed
2014	2	Closed - No Attestation Submitted			
2013	1	Paid	03/28/2013	View/Print	
2012	1	Closed - No Attestation Submitted			

Figure 9 - Screenshot of Example 2

Example 3: Program Year 2014 and Program Year 2015 are both active; therefore, the EP can choose to attest for either Program Year 2014 or Program Year 2015. 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 2014 before attesting for 2015.

Provider Name	General Hospital
CMS Registration ID	1000003081
NPI	2000003081
MPN	4764376

Program Year	Payment Year	Current Status	Activity Date		
2015	1	Attestation in Process			Proceed
2014	1	Attestation in Process			Proceed
2013	1	Closed - No Attestation Submitted			

Figure 10 - Screenshot of Example 3

Example 4: Two program years (2014 & 2015) are active. When the EP chooses to attest for Program Year 2014, the status for Program Year 2015 becomes "Cancelled".

Program Year	Payment Year	Current Status	Activity Date		
2015	1	Cancelled			Proceed
2014	1	Attestation in Process		Cancel	Proceed
2013	1	Closed - No Attestation Submitted			

Figure 11 - Screenshot of Example 4

Example 5: If the Program Year 2014 has been 'Denied', the EP will be provided with two options:

- Re-attest for the denied attestation; or,
- Attest for the current program year.

Status

Please complete your attestation with the current program year 2014 before attesting for 2015.

Provider Name	John13569 Public13569
CMS Registration ID	1000535274
NPI	1740201458
MPN	7006259

Program Year	Payment Year	Current Status	Activity Date	
2015	1	Attestation in Process		Proceed
2014	1	Attestation Denied		Re-attest
2013	1	Closed - No Attestation Submitted		

Figure 12 - Screenshot of Example 5

Demographics

The Demographics page allows EPs to clearly see the demographic and payee information that was submitted on CMS' 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).

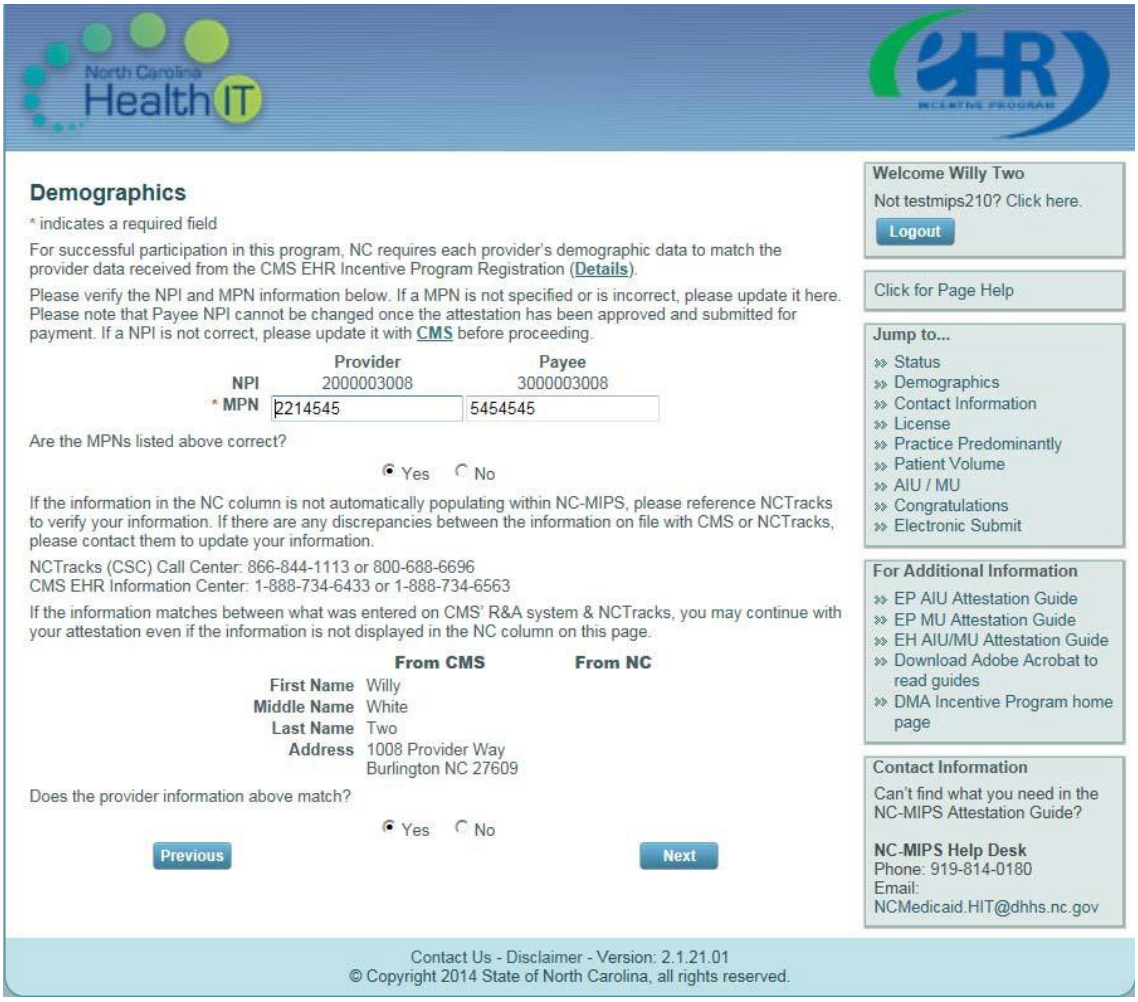


Figure 13 - Demographics Page

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 *(CMS updates take 24 hours to populate in NC-MIPS)*

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.

To update a payee TIN type on CMS' R&A system, please follow the guidance below:

1. Go to https://ehrincentives.cms.gov
2. Click Continue
3. Check the box, click continue
4. Log in using the NPPES username & password
5. Click on the Registration tab to continue
6. Click on Modify in the Action column to continue
7. Click on Topic 2
8. Change the Payee TIN Type to Group Reassignment
9. Enter the Group information
10. Click Save & Continue
11. Click Save & Continue
12. Click on Proceed with Submission
13. Review the information then click Submit Registration
14. Click Agree

If you have questions about making this update, please contact the CMS EHR Information Center, Monday through Friday at 1-888-734-6433 or 1-888-734-6563 (TTY number) (Hours of Operation 7:30 a.m. – 6:30 p.m – CST – excluding Federal Holidays).

It takes 24 hours for an update to be reflected in NC-MIPS.

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 14 - 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 15 - License Page

To enter your 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.

* *Please enter the license number not 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.
* Even if an EP is an FQHC/RHC, they are not required to attest to practicing predominantly if they are not using non-Medicaid needy individual encounters to count toward their 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 16. If the EP did not practice predominantly at an FQHC/RHC and is not hospital-based, refer to Figure 17. If the EP did not practice predominantly at an FQHC/RHC and is hospital-based, refer to Figure 18.

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 16):

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 you're 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. Review the ratio of

encounters that is automatically calculated and displayed to ensure it is greater or equal to 50%.

6. Click *Next*.
7. The Patient Volume page opens.

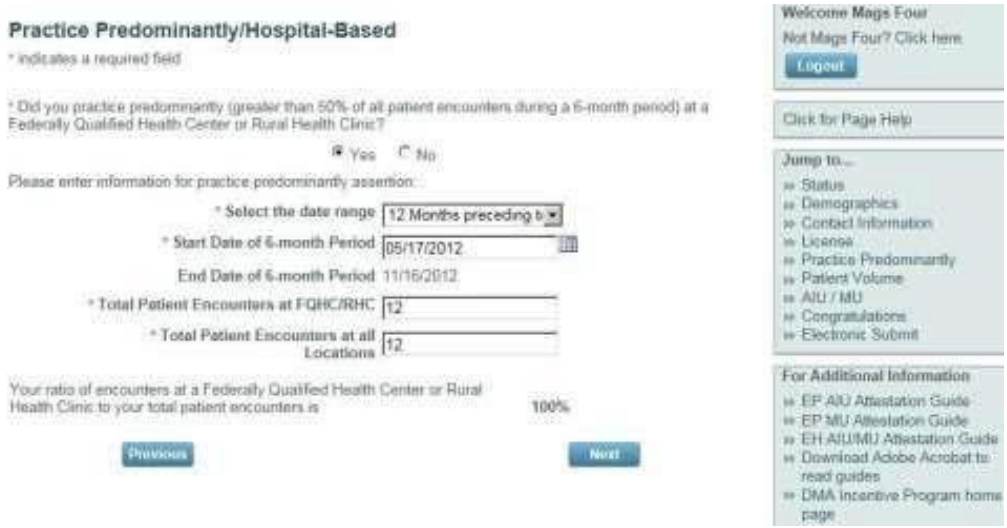


Figure 16 - Practice Predominantly/Hospital-Based Page if you answer "Yes" to practicing predominantly

If the EP **did not** practice predominantly (greater than 50% of all patient encounters during a 6-month period) at a FQHC/RHC and **<u>are not</u>** hospital-based (Figure 17):

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.

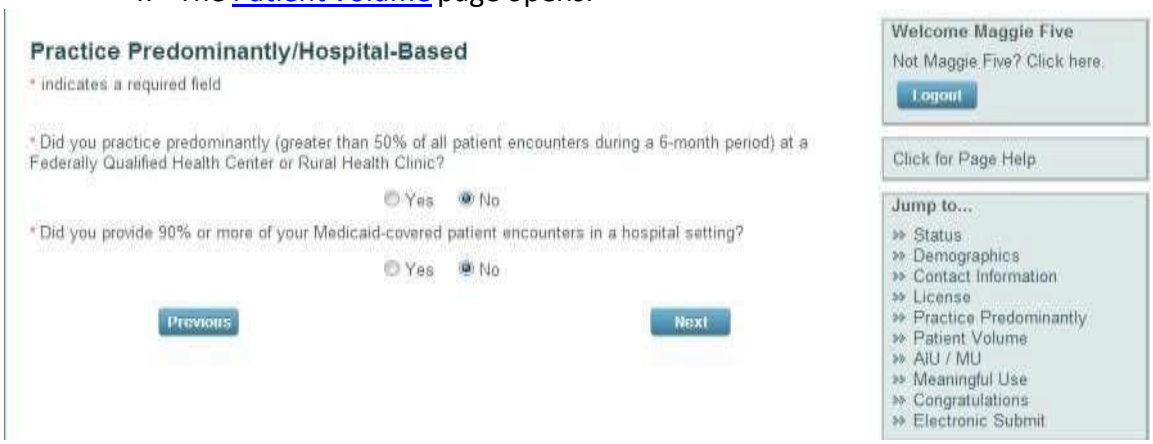


Figure 17 - Practice Predominantly/Hospital-Based Page if you answer "No" to practicing at an FQHC/RHC and "No" to being hospital-based

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 18)**:**

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.

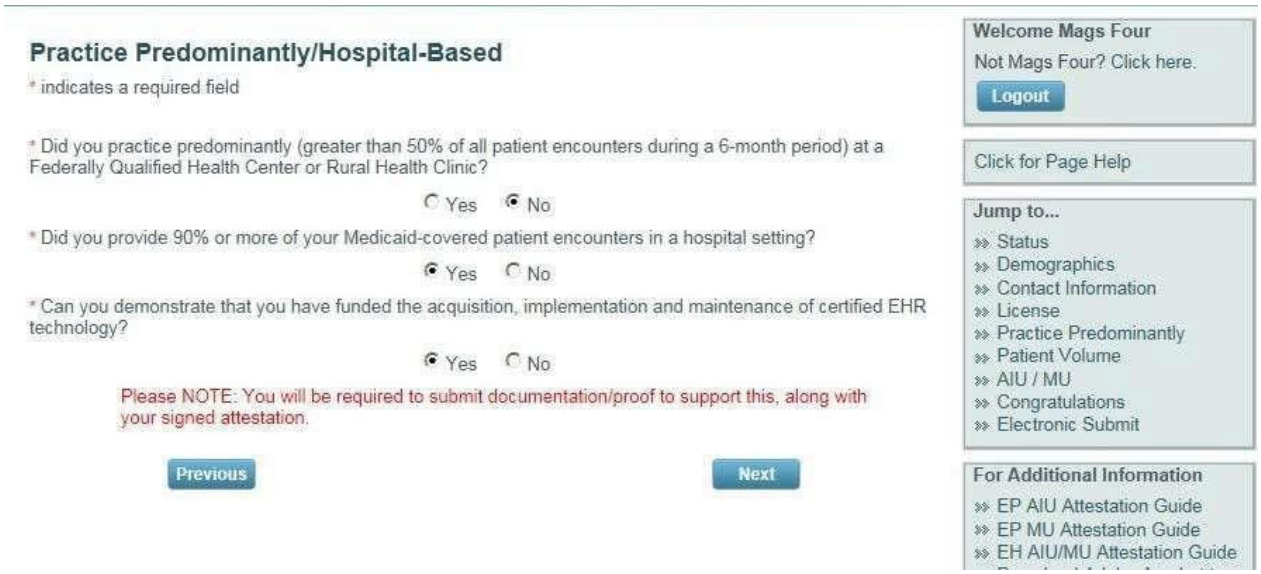


Figure 18 - Practice Predominantly/Hospital-Based Page if you answer "No" to practicing at an FQHC/RHC, yes responded "Yes" to being hospital-based

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 patient volume encounters

Under individual methodology, an EP will report on only her/his personal patient encounters. Refer to Figure 19 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. The EP 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 it will only need to be calculated one time for the whole group. Refer to Figure 21 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:

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

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 2015, this would be a 90-day period in 2014 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 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 a memo on practice letterhead explaining the situation and submit it with the signed attestation.

If the EP is a behavioral health provider and bill any of their Medicaid claims through an LME, please complete the behavioral health template (available under the Links & Resources tab on our website) and then submit the completed template with the signed attestation.

If some of their Medicaid encounters were for patients covered by another state's Medicaid program, please submit a billing memo on practice letterhead regarding this and submit it with their attestation. Include a break-out of Medicaid encounters by state. If the EP had both Medicaid-paid and zero-pay, they'll need break out each category of encounter by state. An EP must include any identifiers (similar to North Carolina's MPN) that were used on claims for the other state(s). We will reach out to the other state(s) to verify the encounters reported.

When calculating PV, use an auditable data source and keep all documentation for at least six years post-payment in case of audit.

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.

If the EP is having difficulty calculating patient volume, please contact one of our technical assistance partners for more hands on patient volume assistance.

INDIVIDUAL 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 .

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 19 - 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 2015, previous calendar year would be 2014 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 20 - 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 werenever 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 NPI or MPN and number of encounters attributable to that other 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 one 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 21 - 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. Click the *Group* button to report that you used group methodology to calculate your patient volume.
4. Enter the Group Name – the name of the group practice where your patient volume comes from.
5. 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 EVERY professional in the group who provided services, not just the ones who are eligible to participate in the NC Medicaid EHR Incentive Program.
6. Enter the Total Encounters for All Group Members. This is the number of encounters during your selected 90-day patient volume reporting period for all group members regardless of payer. *NOTE:* This number includes ALL encounters with ALL payers for EVERY professional in the group who provided services, not just the ones who are eligible to participate in the NC Medicaid EHR Incentive Program.
7. 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).
8. 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.)
9. 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.
10. 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.
11. 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.
12. The numerator is automatically calculated and displayed. The numerator is all Medicaid encounters – Medicaid-paid encounters plus Medicaid zero-pay encounters.
13. The denominator is automatically displayed. The denominator is the total of all patient encounters for this group, no matter the payer.
14. 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 22 - Patient Volume Page using Group Methodology (part 2)

15. 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.
16. 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.
17. 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.

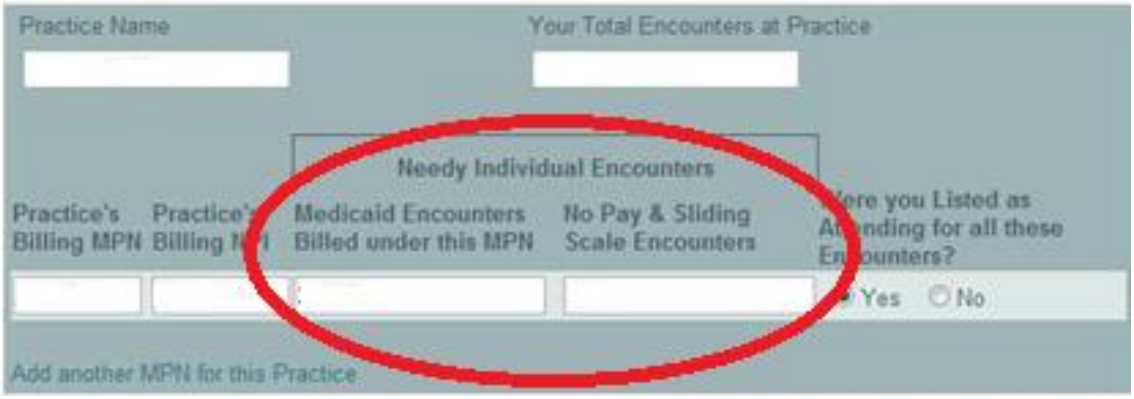


Figure 23 - Needy Individual Encounters

If the EP is a provider attesting to practicing predominantly, on the patient volume screen in MIPS they will see that their 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, complete the patient volume page using individual or group methodology (see instructions above) but as a provider who practices predominantly the EP has 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 or Meaningful Use Page

The AIU/MU page identifies the EPs individual MU reporting period, as well as ALL of the locations an EP worked at during the reporting period. Please note, the information submitted on the attestation from this point forward **will reflect that of the individual EP** (even if the EP used group methodology to calculate PV).
***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.

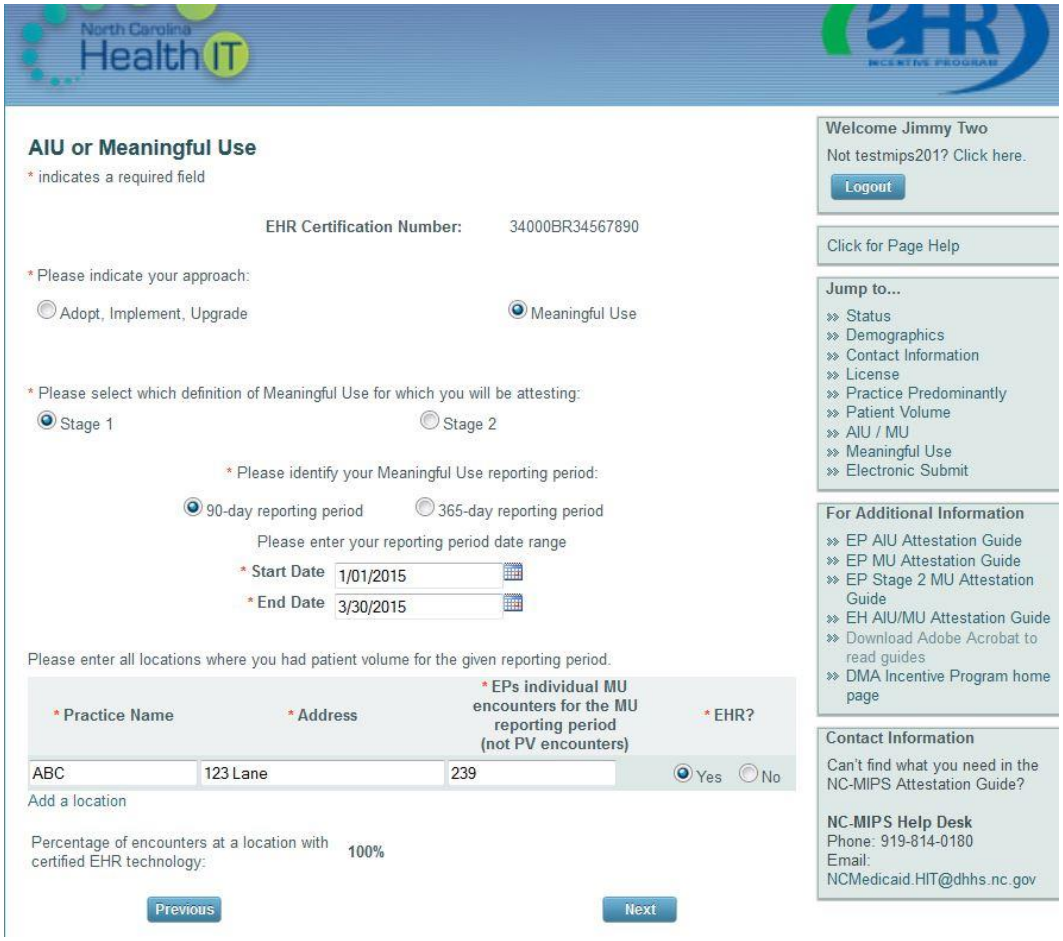


Figure 24 - AIU or MU Page

To enter Meaningful Use activities:

1. Under "Please indicate your approach," click the *Meaningful Use* radio button.
2. Under "Please indicate your Meaningful Use reporting period", select a button to indicate the reporting period you are attesting for: *90-day reporting period or 365-day reporting period.* ***Note: this will be a 90- or 365-day period in the calendar year for which you're attesting. If attesting for Program Year 2015, the MU reporting period will come from calendar year 2015.***
3. Enter the 'Start Date' of the continuous 90- or 365-day MU reporting period.

4. Enter the 'End Date' of the continuous 90- or 365-day MU reporting period. Enter the 'Practice Name' for every practice the **individual EP** had patient encounters during the continuous 90- or 365-day MU reporting period.
5. Enter the 'Practice Address' for every practice where the EP had patient encounters during the continuous 90- or 365-day MU reporting period.
6. Enter the individual EPs 'Total MU Encounters for the MU reporting period.' *NOTE*: *This number should reflect the* ***individual EPs MU encounters*** *at that practice location within the continuous 90-day MU reporting period; this includes all payers.* **Please pay close attention that the MU encounters accurately reflect that of the individual EP.**
7. Select *Yes* if the practice location was equipped with certified EHR technology. Select *No* if the practice location was not equipped with certified EHR technology.
8. The percentage of the EPs total MU encounters equipped with certified EHR technology will be automatically displayed. *NOTE*: This percentage must be 50 percent or greater to meet meaningful use requirements.
9. Click *Next*.
10. The Measure Selection Home page will open.

Measure Selection Home Page

The Measure Selection Home page is where the user will go to begin each measure set. These Measure Sets are: Meaningful Use Core Measures, Meaningful Use Menu Measures and Clinical Quality Measures.

This page will also allow the user to track their progress as they attest to MU. The user can jump to this page at any time by selecting the 'Meaningful Use' link on the right rail.

Figure 25 - Measure Selection Home Page

NOTE: If at any time the user has any questions on what to enter (numerator, denominator, exclusion, etc.) for a particular measure, or has difficulty determining what measure they should attest to, they should contact their EHR vendor.

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.

The Measure Selection Home page displays four columns:

1. Measure Set: These are the sets of objectives and measures that the EP will report.
2. Actions: The ***Begin*** action button will launch the user into the first page of the measure set. For the MU Core & MU Core Clinical Quality Measures, the user will be directed to the first question in the measure set. For all other measure sets, the user will be directed to a Measure Instructions page, where they will have the opportunity to select those measures they wish to report on. The ***Review*** button will direct the user to the measure set summary page, and allow the user to review and edit their attested information.

***NOTE*: Once the attestation is submitted, EPs will not be able to go back into the system to print these summary pages – please print the MU Summary Pages during the attestation prior to submission. The EP is required to sign and date all applicable MU Summary Pages and email them in with their signed attestation.**

3. Complete: The user will see either a green check or a red 'x' in this column. A green check indicates the user has completed all required measures within the measure set. A red 'x' indicates the user has not completed all required measures within the measure set.
4. Valid: The user will see either a green check or a red 'x' in this column. A green check indicates the user has entered valid responses for all measures within the measure set. A red 'x' indicates the user has entered at least one invalid response to a measure within the measure set.

Common reasons for invalid responses:

- Measure threshold not met.
- The user did not enter responses for the required number of measures.
- The user entered only partial data for one or more measures.

Helpful Hint - If the user sees a red 'x,' the user should review answers for accuracy and validity. If the user continues to experience issues with reporting, they should contact their EHR vendor.

The user will be permitted to submit their attestation even if there is a red 'x' in the 'Valid' column. However, if a red 'x' displays under the 'Valid' column, a warning message will display telling the user that they have not successfully met the meaningful use requirements for that measure set, and submitting their attestation at that time **will result in a denial of payment.**

On the Measure Selection Home page, the *Next* button will only be enabled once the user enters all required measures, and the 'Complete' column displays a green check mark in all applicable measure sets.

Things to keep in mind while attesting to Stage 1 MU…

On the Measure Selection Home page, the *Next* button will only be enabled once the user enters all required measures, and the 'Complete' column displays a green check mark beside all measure sets.

After completing a measure set, the user will be routed to the respective MU Summary page. Here the user can review and edit their attested information. If the user clicks the *Next* button, they will be routed back to the Measure Selection Home page. At that time, the Complete and Valid columns will populate a green check or a red 'x' based on the completeness and validity of all the attested measures within a measure set.

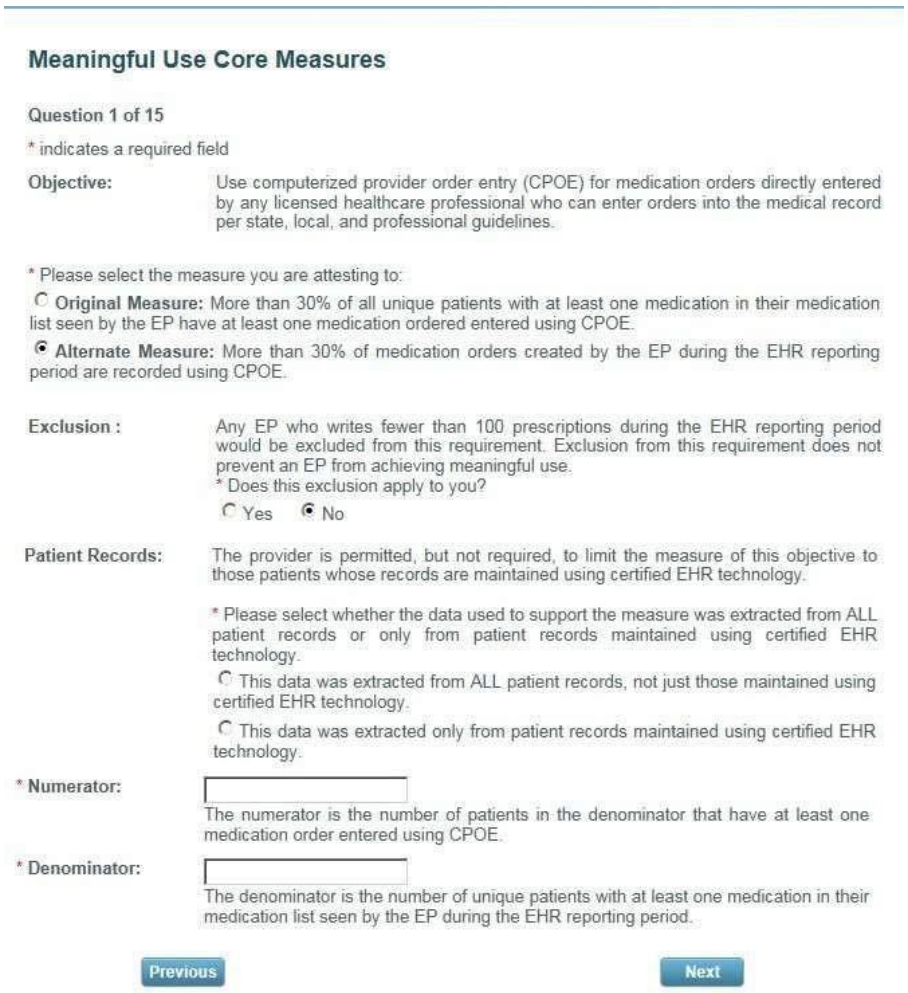
To reiterate, please print and sign the MU Summary Pages after successfully completing the MU measure set because once the EP submits the attestation, they need to withdraw & re-attest to retrieve the MU pages.

Please note, as a user navigates through the meaningful use measures, the user is permitted to click the *Previous* button at any time during their attestation; however, all information entered on the page will not be saved. It is not until the user clicks the *Next* button that a particular page's information will be saved in the system. A user will have the opportunity to alter any entered information after completing a measure set, by clicking *Review.*

Meaningful Use Pages

Meaningful Use Core Measures Pages

The user is required to report on all 13 Core Measures.



Meaningful Use Core Measures

Question 1 of 15

* indicates a required field

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

* Please select the measure you are attesting to:

○ **Original Measure:** More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication ordered entered using CPOE.

◉ **Alternate Measure:** More than 30% of medication orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion : Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

○ Yes ◉ No

Patient Records: The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

* Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

○ This data was extracted from ALL patient records, not just those maintained using certified EHR technology.

○ This data was extracted only from patient records maintained using certified EHR technology.

*** Numerator:**

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

*** Denominator:**

The denominator is the number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.

Previous Next

Figure 26 - Core Measure Page Example

1. The user will be directed to Core Measure Question 1 of 15, and will navigate through the remaining 14 Core Measure pages by clicking the *Next* button. Each question will always display the Objective and Measure. These definitions will tell the user what the objective is and how they can meet the measure.

2. Per the Stage 2 Final Rule, MU Core Measure 1 & 8 gives a provider the option to select the original or alternate measure. Users will select the 'Original Measure' or 'Alternate Measure' radio button for the measure set they are attesting to.

3. If an objective contains *Exclusion* criteria, the criteria will be displayed.
   - If after reading the *Exclusion* criteria, the exclusion applies, click '*Yes*.' If *Yes* is selected, no additional information will displayed.
   - If after reading the *Exclusion* criteria, the exclusion does not apply, click '*No.'* If *No* is selected, additional fields will populate.
4. Some measures require entering the source of the measure data being reported.
   - If the measure data being reported is from all patient records, select the first radio button.
   - If the measure data is from patient records maintained using certified EHR technology, select the second radio button.
5. Some measures require the user to enter a numerator and denominator.
   - The user may be asked to report on an entire population of patients, or just a subset.
   - A user should ensure the numerators and denominators they enter align with the numerator and denominator descriptions provided and match exactly the reports produced by their EHRs (or combination of such reports and other data sources, where applicable).
6. At the end of Question 15 of 15, the user will click *Next* and the Core Measure Summary Page opens.
7. Per the Stage 2 Final Rule, Core Measures 10 and 14 are no longer required, and will see the screenshot below.

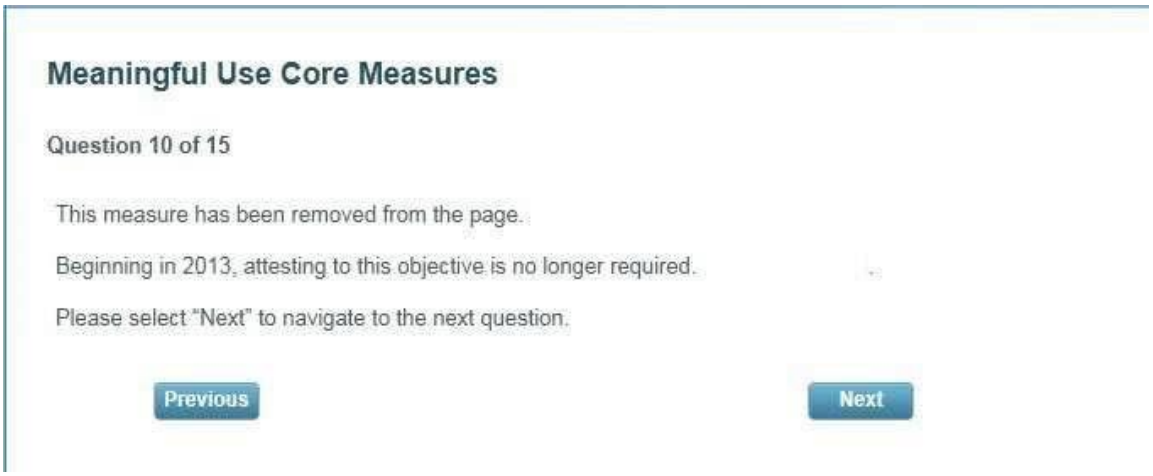
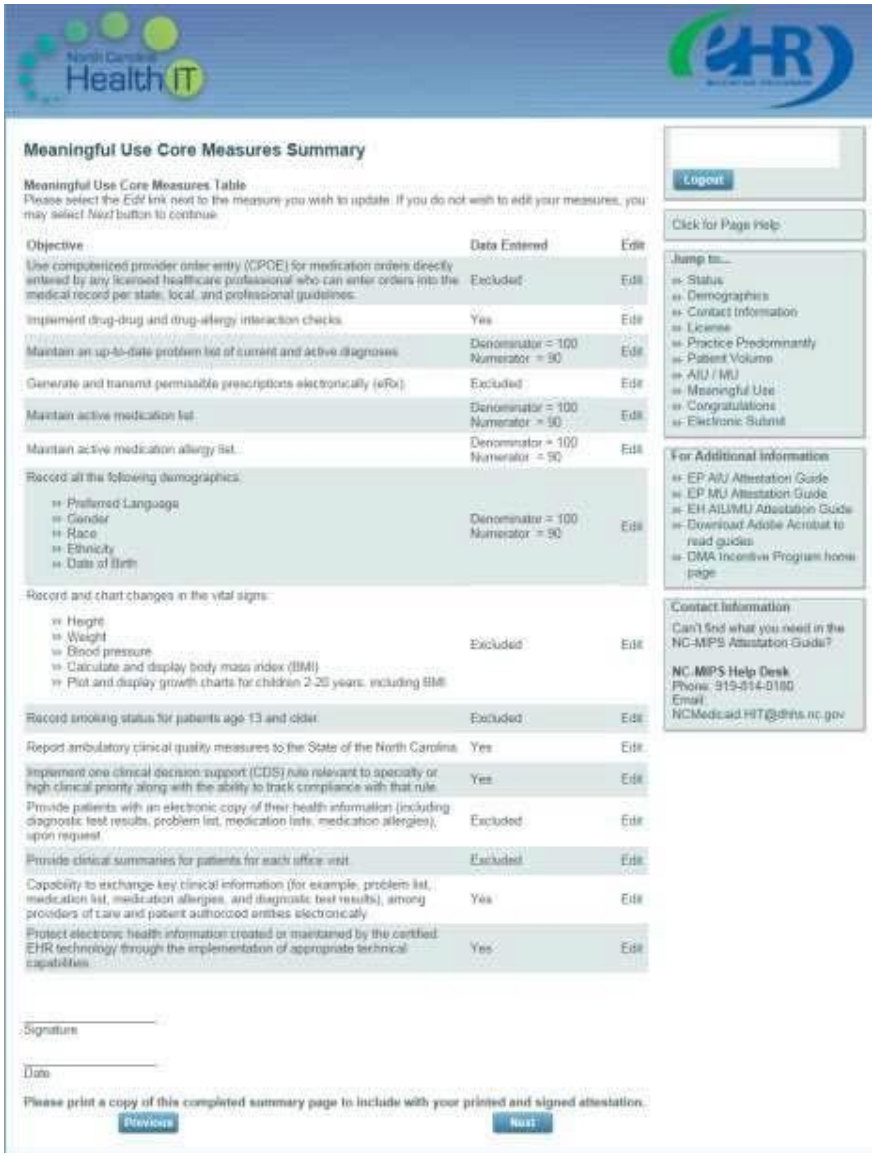


Figure 27 - Screenshot of a measure which is no longer required

Meaningful Use Core Measure Summary Page

The Meaningful Use Core Measure Summary page will give the user an overview of their attested information for each of the 13 Core Measures in the Core Measure Set.



Meaningful Use Core Measures Summary

Meaningful Use Core Measures Table
Please select the *Edit* link next to the measure you wish to update. If you do not wish to edit your measures, you may select *Next* button to continue.

Objective	Data Entered	Edit
Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	Excluded	Edit
Implement drug-drug and drug-allergy interaction checks.	Yes	Edit
Maintain an up-to-date problem list of current and active diagnoses.	Denominator = 100 Numerator = 90	Edit
Generate and transmit permissable prescriptions electronically (eRx).	Excluded	Edit
Maintain active medication list.	Denominator = 100 Numerator = 90	Edit
Maintain active medication allergy list.	Denominator = 100 Numerator = 90	Edit
Record all the following demographics: » Preferred Language » Gender » Race » Ethnicity » Date of Birth	Denominator = 100 Numerator = 90	Edit
Record and chart changes in the vital signs: » Height » Weight » Blood pressure » Calculate and display body mass index (BMI) » Plot and display growth charts for children 2-20 years, including BMI	Excluded	Edit
Record smoking status for patients age 13 and older.	Excluded	Edit
Report ambulatory clinical quality measures to the State of the North Carolina.	Yes	Edit
Implement one clinical decision support (CDS) rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	Yes	Edit
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	Excluded	Edit
Provide clinical summaries for patients for each office visit.	Excluded	Edit
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Yes	Edit
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Yes	Edit

Signature

Date

Please print a copy of this completed summary page to include with your printed and signed attestation.

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Click for Page Help

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» Meaningful Use
» Congratulations
» Electronic Submit

For Additional Information
» EP AIU Attestation Guide
» EP MU Attestation Guide
» EH AIU/MU Attestation Guide
» Download Adobe Acrobat to read guides
» DMA Incentive Program home page

Contact Information
Can't find what you need in the NC-MIPS Attestation Guide?

NC-MIPS Help Desk
Phone: 919-814-0180
Email:
NCMedicaid.HIT@dhhs.nc.gov

Figure 28 - Core Measure Summary Page

- Select *Edit* to change or modify any question within the measure set.
- Once the user reviews the page for accuracy, they will be required to **print, sign and send** the Core Measure Summary page to the NC-MIPS Help Desk to be eligible for an incentive payment. **Print the summary page before submitting the attestation**.
- Click *Next* to be routed back to the Measure Selection Home page.

Meaningful Use Menu Measure Instructions Page

The Menu Measure Instructions page will give the user the opportunity to select the measures that they would like to attest for. A user is required to attest to five Menu Measures.
NOTE: The user must select at least one Public Health Menu Measure, but may be able to claim an exclusion. Please refer to the guidance at the top of this page for more timely information.

Meaningful Use Menu Measure Instructions

EPs must report on a total of five (5) MU menu measures, one of which must be a public health measure. Currently, the North Carolina Division of Public Health is neither able to accept electronic submission of immunization data nor syndromic surveillance data from EPs; therefore, an exclusion may be claimed for either of these public health measures. To successfully report on a public health measure, you must enter an exclusion response in the measure reporting space. CMS encourages EPs to select menu measures that are relevant to their scope of practice and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they qualify or if there are no remaining menu measures that are relevant to their scope of practice.

Public Health Menu Measures

Selection	Objective
☐	Capability to submit electronic syndromic surveillance data to public health agencies and an actual submission except where prohibited and in accordance with applicable law and practice.
☐	Capability to submit electronic syndromic surveillance data to public health agencies and an actual submission in accordance with applicable law and practice.

If an EP claims an exclusion for one of the public health measures above, the EP must select four of the remaining MU menu measures. If an EP claims an exclusion for both of the public health measures above, the EP must select three of the remaining MU menu measures. You must select additional menu measures until a total of five MU menu measure objectives have been selected, even if exclusions apply.

Additional Menu Measures

Selection	Objective
☐	Implement drug formulary checks.
☐	Incorporate clinical lab-test results into EHR as structured data.
☐	Generate lists of patients by specific condition to use for quality improvement, reduction of disparities, research or outreach.
☐	Send reminders to patients per patient preference for preventative/ follow-up care.
☐	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within four business days of the information being available to the EP.
☐	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
☐	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
☐	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

Previous Next

Figure 29 - Menu Measure Instructions Page

Click *Next* to route to the first of the five selected Menu Measures.

Meaningful Use Menu Measures

A user is required to attest to five Menu Measures.

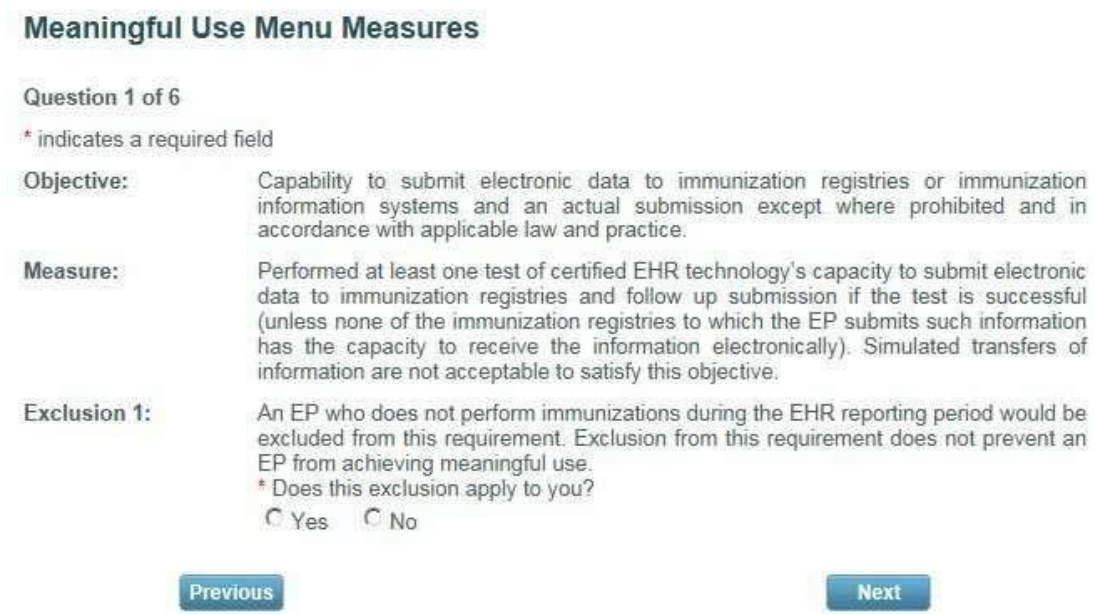


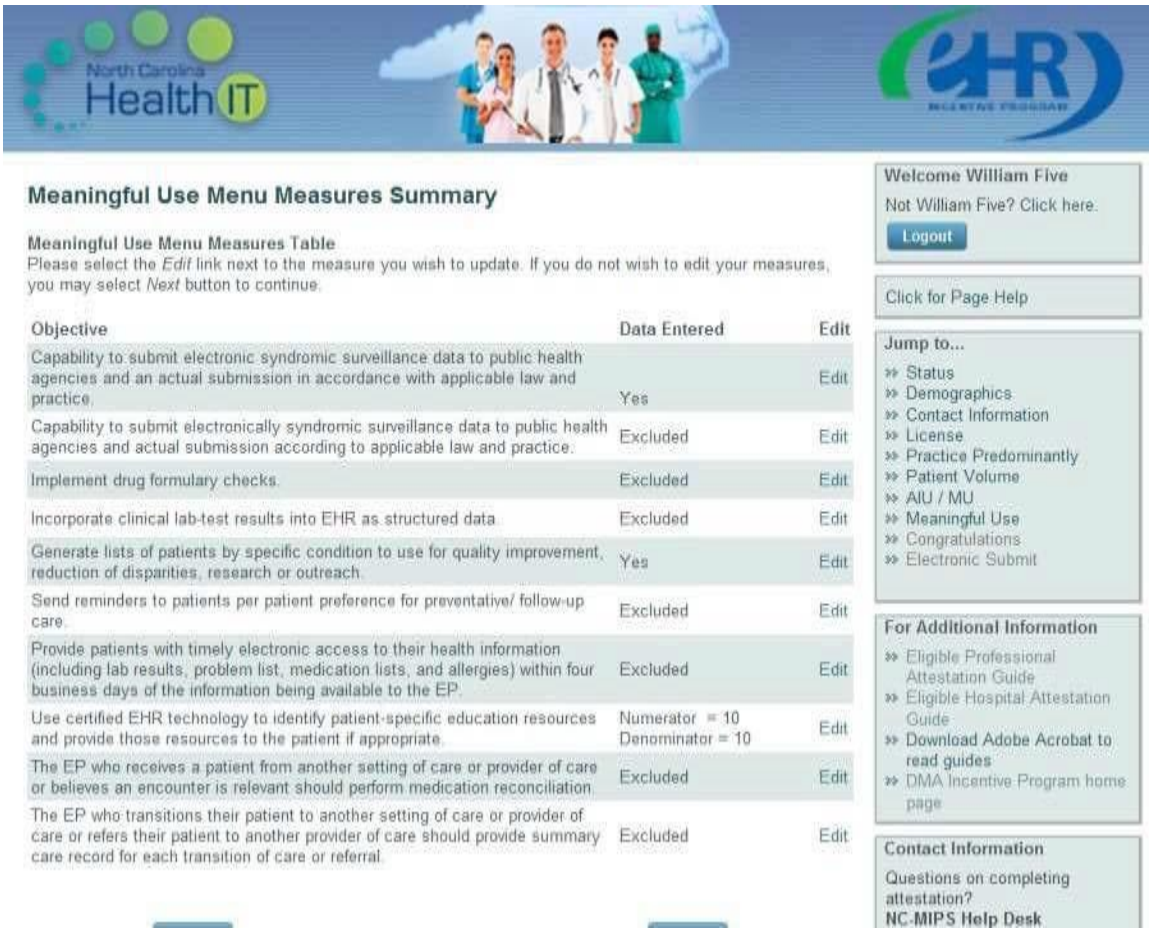
Figure 30 - Menu Measure Screenshot

The user will be directed to Menu Measure Question 1 of 5, and will navigate through the remaining four Menu Measure pages by clicking the *Next* button.

1. Each question will always display the Objective and Measure. These definitions will tell the user what the objective is and how they can meet the measure.
2. If an objective contains exclusion criteria, the criteria will be displayed.
   - If after reading the exclusion criteria, the exclusion applies to you, click '*Yes*.' If *Yes* is selected, no additional information will displayed.
   - If after reading the exclusion criteria, the exclusion does not apply to you, click '*No.*' If *No* is selected, additional fields will populate.
3. Some measures require entering the source of the measure data being reported.
   - If the measure data being reported is from all patient records, select the first radio button.
   - If the measure data is from patient records maintained using certified EHR technology, select the second radio button.
4. Some measures require the user to enter a numerator and denominator.
   - The user may be asked to report on an entire population of patients, or just a subset.
   - The user should ensure the numerators and denominators they enter align with the numerator and denominator descriptions provided.
5. At the end of Question 5 of 5, the user will click *Next* and the Menu Measure Summary page opens.

Menu Measures Summary Page

The Menu Measure Summary page will give the user an overview of their attested information for each of the five Menu Measures in the Menu Measure Set.



Meaningful Use Menu Measures Summary

Meaningful Use Menu Measures Table
Please select the *Edit* link next to the measure you wish to update. If you do not wish to edit your measures, you may select *Next* button to continue.

Objective	Data Entered	Edit
Capability to submit electronic syndromic surveillance data to public health agencies and an actual submission in accordance with applicable law and practice.	Yes	Edit
Capability to submit electronically syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.	Excluded	Edit
Implement drug formulary checks.	Excluded	Edit
Incorporate clinical lab-test results into EHR as structured data.	Excluded	Edit
Generate lists of patients by specific condition to use for quality improvement, reduction of disparities, research or outreach.	Yes	Edit
Send reminders to patients per patient preference for preventative/ follow-up care.	Excluded	Edit
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within four business days of the information being available to the EP.	Excluded	Edit
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	Numerator = 10 Denominator = 10	Edit
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	Excluded	Edit
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	Excluded	Edit

Welcome William Five
Not William Five? Click here.
Logout

Click for Page Help

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- Eligible Hospital Attestation Guide
- Download Adobe Acrobat to read guides
- DMA Incentive Program home page

Contact Information
Questions on completing attestation?
NC-MIPS Help Desk

Figure 31 - Menu Measure Summary Page

1. Select *Edit* to change or modify any question within the measure set.
2. Once the user reviews the page for accuracy, they will be required to **print, sign and send** the Menu Measure Summary page to the NC-MIPS Help Desk to be eligible for an incentive payment. Print the summary before submitting your attestation.
3. Click *Next* to be routed back to the Measure Selection Home page.

2014 Clinical Quality Measures Instruction Page

Beginning Program Year 2014, EPs attesting to MU will select nine of 64 CQMs. Three of the nine CQMs must represent three of the six National Quality Strategy (NQS) domains.

Clinical Quality Measure Instructions

From the 64 2014 Clinical Quality Measures (CQMs) listed below, check the box next to the nine CQMs to which the eligible professional (EP) would like to attest. Please note, three of the nine CQMs must represent three of the six National Quality Strategy (NQS) domains.

You will be prompted to enter numerator(s), denominator(s), and exclusion(s), for all selected CQMs after you select the "Next" button below.

NQS Domain 1: Patient and family engagement

☐	NQF 0384	Oncology: Medical and Radiation – Pain Intensity Quantified
☐	NQF 5001	Functional status assessment for knee replacement
☐	NQF 5002	Functional status assessment for hip replacement
☐	NQF 5003	Functional status assessment for complex chronic conditions

1. When an EP sees a CQM for which they'd like to attest, click the box next to that measure.
2. After nine CQMs are selected, click '*Next*' to route to the first of the nine selected CQMs.

The six National Quality Strategy (NQS) domains include:

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population and Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Processes/Effectiveness

When the EP has completed the attestation, please send an email to NCMedicaid.HIT@dhhs.nc.gov with the following documentation:

1. **The signed Clinical Quality Measures Summary Page;**
2. **A CQM report directly from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs; and,**
3. **The EP's signed attestation and Meaningful Use Summary Pages.**

2014 Clinical Quality Measure Summary Page

After completing nine Clinical Quality Measures, the user will be routed to the Clinical Quality Measure Summary Page.

Clinical Quality Measures Summary

Clinical Quality Measures Summary
Please select the *Edit* link next to the measure you wish to update. If you do not wish to edit your measures, you may select *Next* button to continue.

Objective	Domain	Data Entered	Edit
NQF 0022	NQS Domain 2: Patient Safety	Numerator1 = 80 Denominator1 = 100 Numerator2 = 90 Denominator2 = 100	Edit
NQF 0101	NQS Domain 2: Patient Safety	Numerator = 90 Denominator = 100	Edit
NQF 0419	NQS Domain 2: Patient Safety	Numerator = 90 Denominator = 100	Edit
NQF 5005	NQS Domain 3: Care Coordination	Numerator = 90 Denominator = 100	Edit
NQF 0024	NQS Domain 4: Population/Public Health	Numerator1 = 70 Denominator1 = 100 Numerator2 = 80 Denominator2 = 100 Numerator3 = 90 Denominator3 = 100	Edit
NQF 0028	NQS Domain 4: Population/Public Health	Numerator = 90 Denominator = 100	Edit
NQF 0033	NQS Domain 4: Population/Public Health	Numerator = 90 Denominator = 100	Edit
NQF 0004	NQS Domain 5: Clinical Process/Effectiveness	Numerator1 = 80 Denominator1 = 100 Numerator2 = 90 Denominator2 = 100	Edit
NQF 0018	NQS Domain 5: Clinical Process/Effectiveness	Numerator = 90 Denominator = 100	Edit

Signature

Date

Please print a copy of this completed summary page to include with your printed and signed attestation. You will not be able to print this at the end of the attestation.

Previous Next

Figure 32 - CQM Summary Page

1. Select *Edit* to change or modify any question within the measure set.
2. Check to see that the Clinical Quality Measures covered at least three National Quality Strategy domains.
3. Once the user reviews the page for accuracy, they will be required to **print, sign and send** the Clinical Quality Measure Summary page to the NC-MIPS Help Desk to be eligible for an incentive payment. Print the summary before submitting your attestation. The EP will also be required to send the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs via email.
4. Click *Next* to be routed back to the Measure Selection Home page.

Attestation Statement Page

Please ensure you have printed off all the MU Summary Pages before submitting the attestation. An EP will not be able to access the MU Summary Pages once they submit the attestation without withdrawing and re-attesting. Once a user has successfully attested to meaningful use (all measures are complete and valid), they will be routed to the Attestation Statement page. The user will confirm that the attested information is complete and accurate.

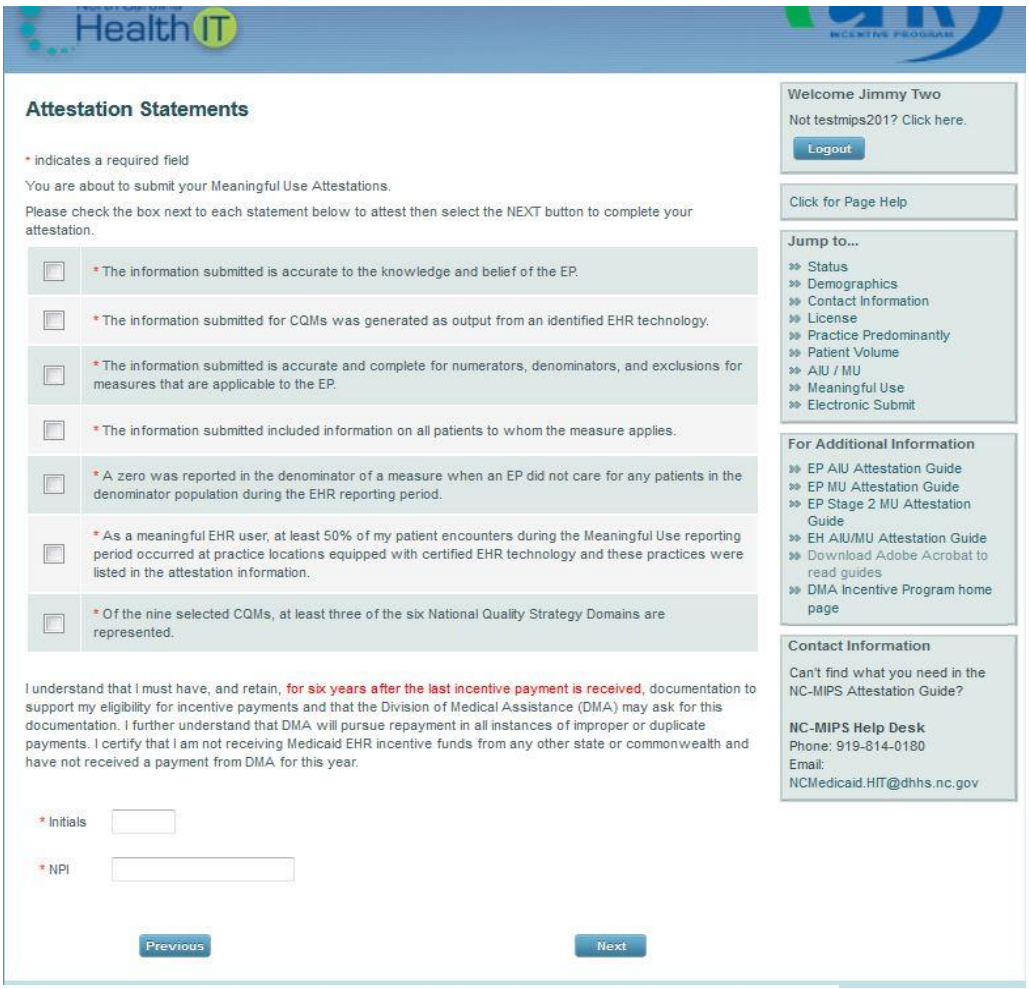

Figure 33 - Attestation Statement Page

1. Select all the check boxes that apply.
2. Click *Next*.
3. The Congratulations page opens.

Attestation Not Accepted Page

The user will be routed to the Attestation Not Accepted page when they have submitted an invalid measure within any measure set. The user will be permitted to submit their attestation; however, submittal of an attestation with invalid measures will result in a denial of payment.

Figure 34 - Attestation Not Accepted Page

- Click *Previous* to route back to the Measure Selection Home page.
- The Measure Selection Home page opens.

OR

- Click *Next* to submit the attestation.
- The Congratulations page opens.

Congratulations

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

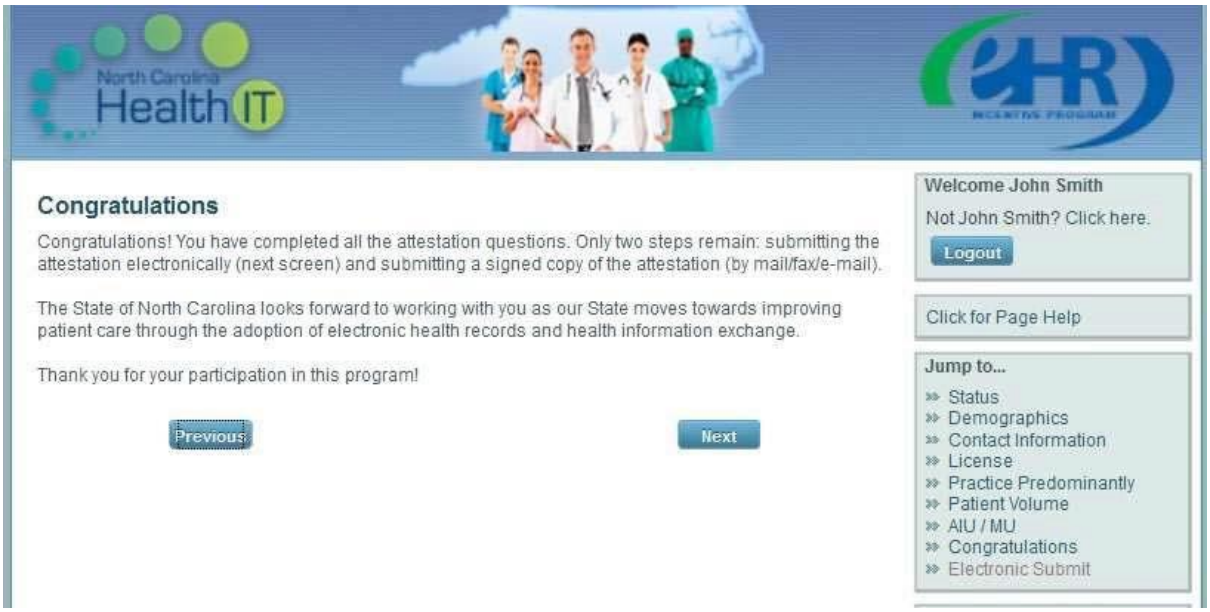

Figure 35 - Congratulations Page

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 36 - Electronic 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*. (We **do not** require you submit this page with your attestation documentation).
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 attesting EP (reflecting the date of the most recently submitted attestation) and sent to the NC-MIPS Help Desk. No third party, electronic, or stamped signatures will be accepted.

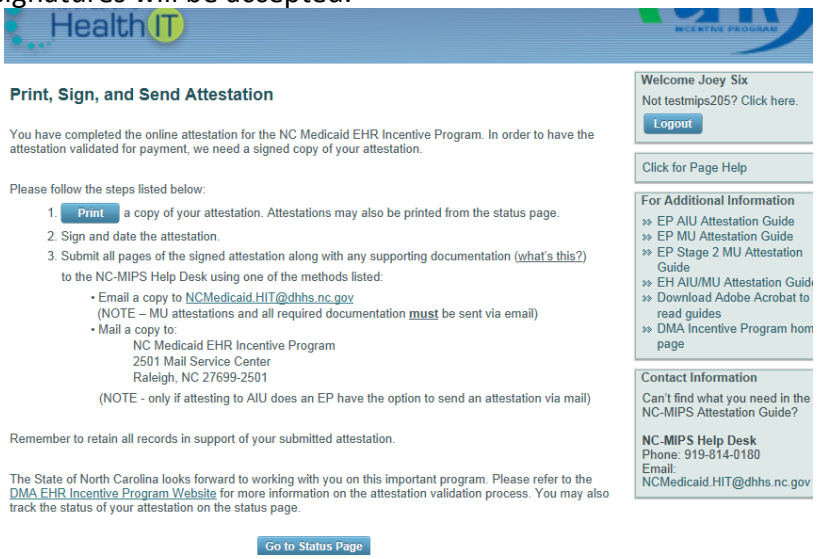

Figure 37 - Print, Sign, Send Page

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 or later. Some tips:
    a. Attestations signed with a date preceding that of the most recently submitted attestation will not be accepted;
    b. A third party, such as a practice manager, **may not** sign the printed attestation on behalf of the EP; and,
    c. Electronic signatures are not accepted in lieu of a manual signature.
3. Gather the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs.
4. 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 all information in support of attested information.
5. Electronically send the signed attestation, the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs, the signed meaningful use summary pages and supporting documentation to the NC- MIPS Help Desk:

    Email: NCMedicaid.HIT@dhhs.nc.gov

    We do not accept faxes.

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. An EP has 15 calendar days to address any issues. If the EP gets denied, they may re-attest without penalty. This means if attesting for your second payment year, you will not lose that payment year. So long as the EP attests for a total of six years, they may still earn the full incentive payment.

If the EP withdraws and re-attests, they must submit a newly signed attestation.

While not guaranteed, error-free attestations (where no outreach is conducted) can be processed in roughly six to 10 weeks. Typically speaking, payments are made via electronic funds transfer (EFT). If in the rare case a paper check has to be issued, the check will be send to the address associated with the payee NPI that is on file with NCTracks. Please be sure the address on file with NCTracks is accurate.

Once the payment has been processed, the payment will be noted in the Financial Summary section of the Medicaid Remittance Advice. Once we received notice the payment was successfully proceed, we will post payment information to our website under the “Path to Payment” tab.

Please keep all documentation for at least six years in case of post-payment audit.

Additional Resources

We have provided some additional resources which may help a user during the attestation process below:

NC Medicaid EHR Incentive Program website
CMS Meaningful Use EHR Overview
CMS Meaningful Use Clinical Quality Measures
HealthIT.gov
ONC's Health IT Product List

Having issues identifying which measure you should report or how you should report them? Call your EHR vendor!

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.