



North Carolina Medicaid Electronic Health Record  
Incentive Program

Eligible Professional Stage 3 Meaningful Use Attestation Guide  
for Program Year 2020

NC-MIPS 2.0

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## Using this Guide

This guide is a reference to help an eligible professional (EP) understand what is needed to attest for a Stage 3 Meaningful Use (MU) NC Medicaid Electronic Health Record (EHR) incentive payment on the NC Medicaid EHR Incentive Payment System (NC-MIPS).

Step-by-step guidance and screenshots are provided throughout the attestation guide to assist participants with 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.

The NC-MIPS Portal is available 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*. When you click 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.

For additional information, please visit the NC Medicaid EHR Incentive Program website, or contact <https://medicaid.ncdhhs.gov/medicaid-ehr-incentive> our help desk by email at [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).

## 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 this program can be found on the NC Medicaid EHR Incentive Program website at <https://medicaid.ncdhhs.gov/medicaid-ehr-incentive>.

Additional information on both the Medicare and Medicaid EHR Incentive programs is available from the Centers for Medicare & Medicaid Services' (CMS) Promoting Interoperability Program website at <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/>.

## Technical Assistance

We provide program resources on [NC-MIPS](#), our [NC Medicaid EHR Incentive Program website](#), and our [frequently asked questions page](#). For any issues not covered in this guidance, please contact our help desk by email at [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).

In addition to these resources, you can contact our technical assistance partners at your regional [Area Health Education Center \(AHEC\)](#) to provide individualized on-site assistance at no cost to you.

AHEC contacts:

[Area L AHEC](#) - Shannon Cambra, [shannon.cambra@arealahec.org](mailto:shannon.cambra@arealahec.org), 252-813-8613. Serving Edgecombe, Halifax, Nash, Northampton, and Wilson counties.

[Charlotte AHEC](#) - Erin Cloutier, [Erin.Cloutier@carolinashealthcare.org](mailto:Erin.Cloutier@carolinashealthcare.org), 704-512-6052. Serving Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Stanly, and Union counties.

[Eastern AHEC](#) - Angel Moore, [MOOREAN@ECU.EDU](mailto:MOOREAN@ECU.EDU), 252-744-5221 (office) or 252-327-0207 (cell). Serving Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Gates, Greene, Hertford, Hyde, Jones, Lenoir, Martin, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, and Wayne counties.

[Greensboro AHEC](#) - Suzanne Lineberry, [suzanne.lineberry@conehealth.com](mailto:suzanne.lineberry@conehealth.com), 336-832-4393 (office) or 336-662-5810 (cell). Serving Alamance, Caswell, Chatham, Guilford, Montgomery, Orange, Randolph, and Rockingham counties.

[Mountain AHEC](#) – Leslie McDowell, [leslie.mcdowell@mahec.net](mailto:leslie.mcdowell@mahec.net), 828-257-4459. Serving Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey counties.

[Northwest AHEC](#) - Chris Jones, [cjones@wakehealth.edu](mailto:cjones@wakehealth.edu), 336 939-6737. Serving Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Catawba, Davidson, Davie, Forsyth, Iredell, Rowan, Stokes, Surry, Watauga, Wilkes, and Yadkin counties.

[SEAHEC](#) - Jessica Williams, [Jessica.ReedWilliams@seahec.net](mailto:Jessica.ReedWilliams@seahec.net), 910-667-9350. Serving Brunswick, Columbus, Duplin, New Hanover, and Pender counties.

[Southern Regional AHEC](#) - Donna Bowen, [Donna.Bowen@sr-ahec.org](mailto:Donna.Bowen@sr-ahec.org), 910-678-0119. Serving Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Robeson, Sampson, and Scotland counties.

[Wake AHEC](#) - Lora Wright, [Lowright@wakeahec.org](mailto:Lowright@wakeahec.org), 919-350-0472. Serving Durham, Franklin, Granville, Johnston, Lee, Person, Vance, Wake, and Warren counties.

In addition to helping your practice meet MU, the NC AHEC staff can also help select, implement and optimize EHRs, help the practice use EHRs to improve the quality of patient care and assist the practice in attesting for an NC Medicaid EHR Incentive payment.

### **EHR Incentive Program Overview**

The NC Medicaid EHR Incentive Program awards MU 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, implement, or upgrade (AIU) to a certified EHR technology, and then to demonstrate MU of that technology. The program is slated to continue through Program Year 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 earn the full incentive payment and must have begun their first year of participation no later than Program Year 2016. The EP will attest to MU in participation years two through six.

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

- The use of a certified EHR in a meaningful manner, such as e-prescribing.
- The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
- 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.

### 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 NC Medicaid EHR incentive payment, a Medicaid provider must:

1. Have a certified EHR technology (CEHRT). EPs attesting in Program Year 2020 are required to attest using a 2015 Edition of CEHRT. Please check the CMS EHR Certification ID number on [ONC's Certified Health IT Product List website](#);
2. Meet the required Medicaid Patient Volume (PV) threshold (this needs to be calculated every year of program participation); and,
3. Meet Stage 3 MU objectives and Program Year 2020 clinical quality measures (CQMs).

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

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

If the user is experiencing NC-MIPS issues, please email [NCMedicaid.HIT@dhhs.nc.gov](mailto: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.

## Reminders to returning providers

If an EP is new to North Carolina, please update the Medicaid State/Territory on CMS' Registration & Attestation System and send an email to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) so we can add you to our system.

If the EP already has an account with NC-MIPS, do not complete another First Time Account Setup.

Each attesting EP needs a working NCID username and password to complete an attestation. If the EP's NCID username has been updated since completing a First Time Account Setup, please use the [NCID Username Update Tool](#) in the Sign In box on the Welcome Page to sync the EP's NCID username in NC-MIPS. 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. Note that it takes up to two business days for changes made with CMS to be reflected in NC-MIPS.

In Program Year 2020, all providers must have a 2015 Edition CEHRT to meet Stage 3 MU. Please check [ONC's certified Health IT Product List](#) to ensure your EHR is certified. Please update your CEHRT number on [CMS' Registration & Attestation System](#) before attesting on NC-MIPS. Although CMS doesn't require it, NC requires you to enter a valid EHR certification number.

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 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, the EP realizes s/he does 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 [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, s/he may attest for a later program year. *EPs must successfully attest for six program years to earn the full incentive payment.*

## Attesting for MU in Program Year 2020

For Program Year 2020, EPs are required to attest to Stage 3 MU using a 2015 Edition of CEHRT. EPs can check their CEHRT here: <https://chpl.healthit.gov/#/search>.

## Outreach and Denials

If discrepancies are found on the attestation, we will send an outreach email to the contact person listed in NC-MIPS.

However, if an EP cannot demonstrate meaningful use (MU attestations submitted with an incomplete/invalid MU measure set or attesting to AIU in participation years two through six), s/he will be automatically denied.

If an EP is denied, s/he may re-attest for the same program year without penalty prior to the close of the program year. If the EP is denied and the program year has closed, s/he can attest for the next program year. So long as the EP attests for a total of six years by Program Year 2021, s/he may earn the full incentive payment.

## Attestation Tail Period

North Carolina has a 120-day attestation tail period to allow for attestation beyond the end of the calendar year. This means, EPs have until April 30, 2021 to attest for Program Year 2020. We guarantee to review the provider's attestation, and conduct outreach if needed, if we receive the signed attestation and required documentation via email by February 28, 2021.

The information submitted on NC-MIPS must be complete and valid by April 30, 2021. We will not accept memorandums in lieu of accurate information submitted through NC-MIPS. NC-MIPS will close for Program Year 2020 on April 30, 2021 so no changes may be made to the attestation after this date.

## Before Attesting

Before getting started, work with your EHR vendor to ensure the EHR is a 2015 Edition and certified to capture the required Program Year 2020 Stage 3 MU objectives and CQMs.

## Reporting Periods

PV  MU

EPs will be required to report at least **two separate reporting periods**: PV and MU. These reporting periods are not synonymous and may be different from one another. When entering these reporting periods into NC-MIPS, ensure the reporting periods are accurate based on an auditable data source.

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

For example: If attesting on February 1, 2021 for Program Year 2020, the previous calendar year is 2019 and the 12 months immediately preceding the date attestation would be 2/1/20-1/31/21.
- **MU reporting period**– This is specific to the individual EP and should be a consecutive 90-day or full calendar year reporting period from the program year for which you're attesting. For example: If attesting for Program Year 2020, the MU reporting period will be a consecutive 90-day period or full calendar year in 2020 (1/1/2020- 12/31/2020). In Program Year 2020, CMS is allowing all providers to use a 90-day MU reporting period.
- **CQM reporting period** - In Program Year 2020, all EPs may use a 90-day CQM reporting period.

## NC-MIPS Portal

You can access NC-MIPS at <https://ncmips.nctracks.nc.gov>. Once you are logged in, NC-MIPS will take you through the portal one page at a time.

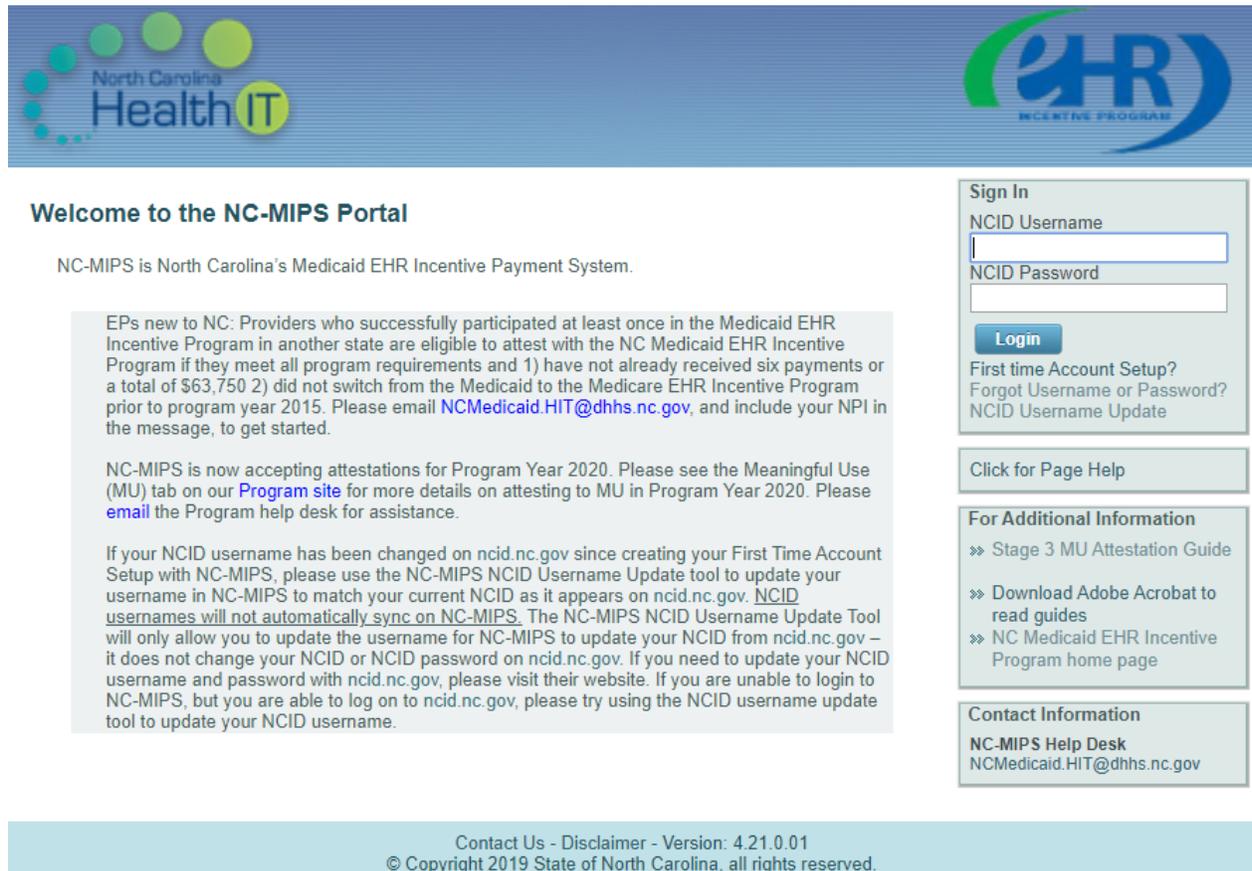
NC-MIPS is compatible with Internet Explorer 7 (or later), as well as Firefox 8 (or later).

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

- [Welcome](#)
- [First Time Account Setup](#) (for new users only!)
- [Status](#)
- [Assistance from NC AHEC](#)
- [Demographics](#)
- [Contact Information](#)
- [License](#)
- [Practice Predominantly/Hospital-Based](#)
- [Patient Volume](#)
- [Measure Reporting Period](#)
- [Measure Navigation Home page](#)
- [MU Objectives](#)
- [Clinical Quality Measures](#)
- [Congratulations](#)
- [Electronic Submission](#)
- [Print, Sign, Send](#)

## NC-MIPS Provider Portal Layout

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



The screenshot shows the NC-MIPS Provider Portal layout. At the top left is the North Carolina Health IT logo, and at the top right is the EHR Incentive Program logo. Below the logos is a blue header bar. The main content area is white and contains a welcome message, a sign-in box, and several informational sections. The sign-in box includes fields for NCID Username and NCID Password, a Login button, and links for First Time Account Setup, Forgot Username or Password, and NCID Username Update. Below the sign-in box are sections for Click for Page Help, For Additional Information (with links to Stage 3 MU Attestation Guide, Download Adobe Acrobat to read guides, and NC Medicaid EHR Incentive Program home page), and Contact Information (NC-MIPS Help Desk, NCMedicaid.HIT@dhhs.nc.gov). At the bottom of the page is a light blue footer bar with contact information and a disclaimer.

**Welcome to the NC-MIPS Portal**

NC-MIPS is North Carolina's Medicaid EHR Incentive Payment System.

EPs new to NC: Providers who successfully participated at least once in the Medicaid EHR Incentive Program in another state are eligible to attest with the NC Medicaid EHR Incentive Program if they meet all program requirements and 1) have not already received six payments or a total of \$63,750 2) did not switch from the Medicaid to the Medicare EHR Incentive Program prior to program year 2015. Please email [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov), and include your NPI in the message, to get started.

NC-MIPS is now accepting attestations for Program Year 2020. Please see the Meaningful Use (MU) tab on our [Program site](#) for more details on attesting to MU in Program Year 2020. Please [email](#) the Program help desk for assistance.

If your NCID username has been changed on [ncid.nc.gov](http://ncid.nc.gov) since creating your First Time Account Setup with NC-MIPS, please use the NC-MIPS NCID Username Update tool to update your username in NC-MIPS to match your current NCID as it appears on [ncid.nc.gov](http://ncid.nc.gov). NCID usernames will not automatically sync on NC-MIPS. The NC-MIPS NCID Username Update Tool will only allow you to update the username for NC-MIPS to update your NCID from [ncid.nc.gov](http://ncid.nc.gov) – it does not change your NCID or NCID password on [ncid.nc.gov](http://ncid.nc.gov). If you need to update your NCID username and password with [ncid.nc.gov](http://ncid.nc.gov), please visit their website. If you are unable to login to NC-MIPS, but you are able to log on to [ncid.nc.gov](http://ncid.nc.gov), please try using the NCID username update tool to update your NCID username.

**Sign In**

NCID Username

NCID Password

**Login**

First Time Account Setup?  
Forgot Username or Password?  
NCID Username Update

Click for Page Help

**For Additional Information**

- » Stage 3 MU Attestation Guide
- » Download Adobe Acrobat to read guides
- » NC Medicaid EHR Incentive Program home page

**Contact Information**

NC-MIPS Help Desk  
[NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)

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The top left logo is a link to the [North Carolina Health Information Technology \(HIT\) website](#).

The top right logo is a link to [CMS' Promoting Interoperability \(PI\) Program website](#) (formerly referred to as the EHR Incentive Program).

For your convenience, the right side of the page contains five commonly used navigation tools:

- Sign In (once the EP has signed in, this box will change to *Logout*)
- Page Help
- Jump to... (*Jump to* is available once the EP is logged in)
- Additional Information
- Contact Information

## Sign In

All EPs will use their current working NCID username and password to sign in to NC-MIPS. If the EP's NCID username has been updated since the last time you logged in to NC-MIPS, please use the [NC-MIPS NCID Username Update Tool](#) to sync the new NCID username with NC-MIPS.

## Trouble logging in?

1. Has the EP's NCID username been updated since last logging in to NC-MIPS? If so, use the NC-MIPS NCID Username Update Tool to update the EP's NCID username in NC-MIPS.
2. Are you able to log in to [ncid.nc.gov](https://ncid.nc.gov)? If you are having problems logging in to <https://ncid.nc.gov>, please contact the NCID help desk.

If the user continues to have issues with NC-MIPS, please send an email to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) and include the following information: Provider's name, NPI, NCID username, CMS Registration ID, 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. The *Jump to* area provides links to other pages so that a user can easily navigate the Portal. NOTE: A user is only able to jump to the pages where data has been entered.

## Additional Information

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

The *EP Stage 3 MU Attestation Guide* link opens this attestation guide in a new browser. To download the free Adobe Reader software, click *Download Adobe Acrobat*.

To learn more about the NC Medicaid EHR Incentive Program, click the [NC Medicaid Incentive Program home page](#) link.

### Contact Information

This area contains the email address for the help desk. Please contact our help desk by email at [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).

### Footer

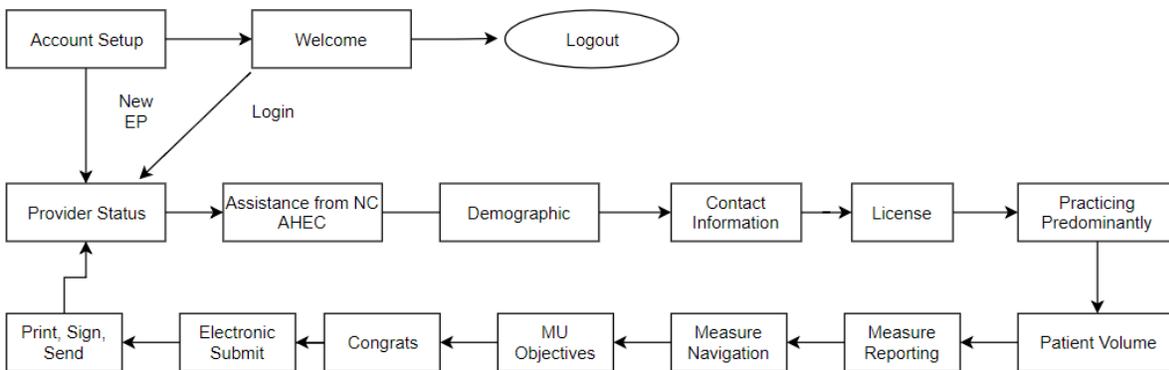
Found at the bottom of the page, the footer has a *Contact us* link to contact the NC-MIPS Help Desk. It also has a link to view the NC-MIPS Portal *Disclaimer*.

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

### Navigation

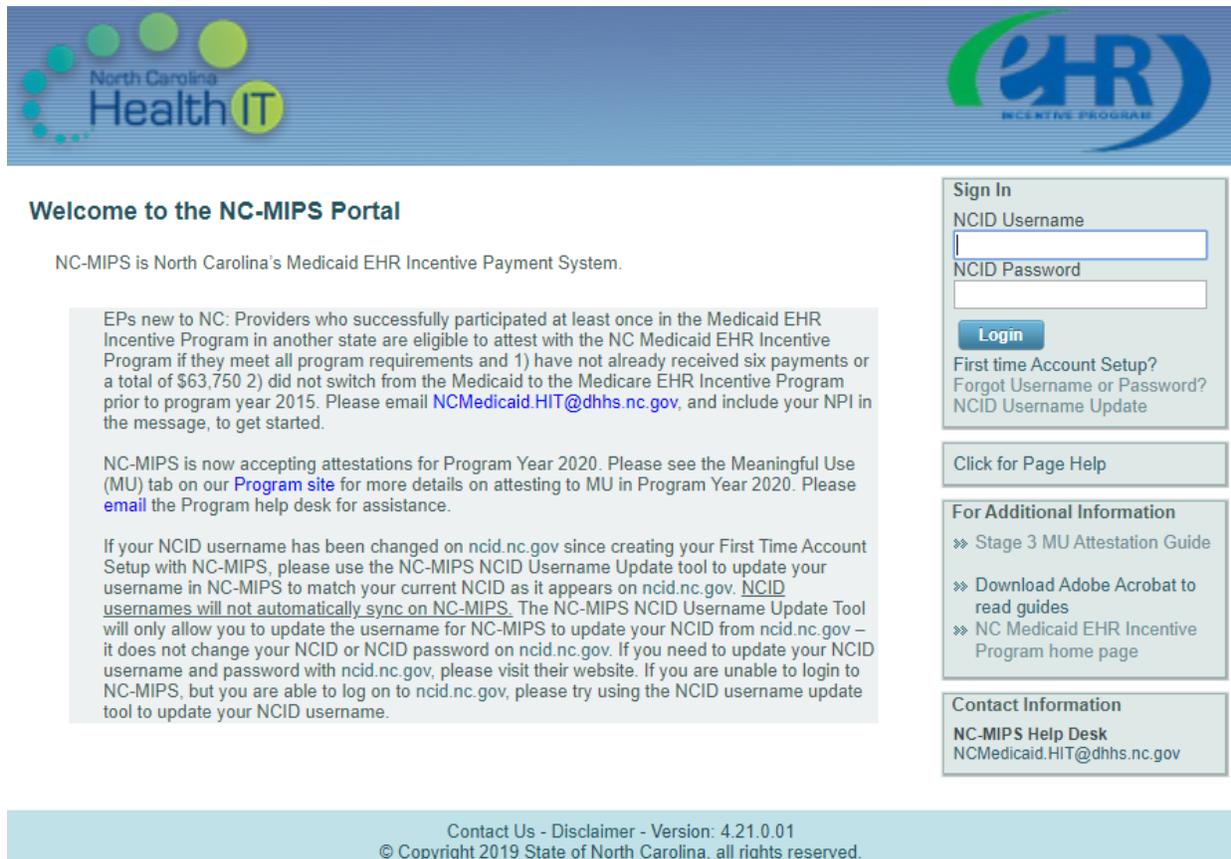
The NC-MIPS Portal is designed to help a user navigate seamlessly through NC-MIPS. Once you have completed the information requested on a page, click *Next* to proceed to the next page. NOTE: If any required fields are left blank, a message will prompt the user to complete the missing fields.

To change previously entered information, click the *Previous* Button to navigate back to the previous page. The typical Portal page navigation is shown below.



## Welcome

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



**Welcome to the NC-MIPS Portal**

NC-MIPS is North Carolina's Medicaid EHR Incentive Payment System.

EPs new to NC: Providers who successfully participated at least once in the Medicaid EHR Incentive Program in another state are eligible to attest with the NC Medicaid EHR Incentive Program if they meet all program requirements and 1) have not already received six payments or a total of \$63,750 2) did not switch from the Medicaid to the Medicare EHR Incentive Program prior to program year 2015. Please email [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov), and include your NPI in the message, to get started.

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**Sign In**  
 NCID Username  
  
 NCID Password  
  
  
[First time Account Setup?](#)  
[Forgot Username or Password?](#)  
[NCID Username Update](#)

**For Additional Information**  
 » [Stage 3 MU Attestation Guide](#)  
 » [Download Adobe Acrobat to read guides](#)  
 » [NC Medicaid EHR Incentive Program home page](#)

**Contact Information**  
 NC-MIPS Help Desk  
[NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)

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

First-time users:

- Click the link *First Time Account Setup*. The [First Time Account Setup](#) page opens.

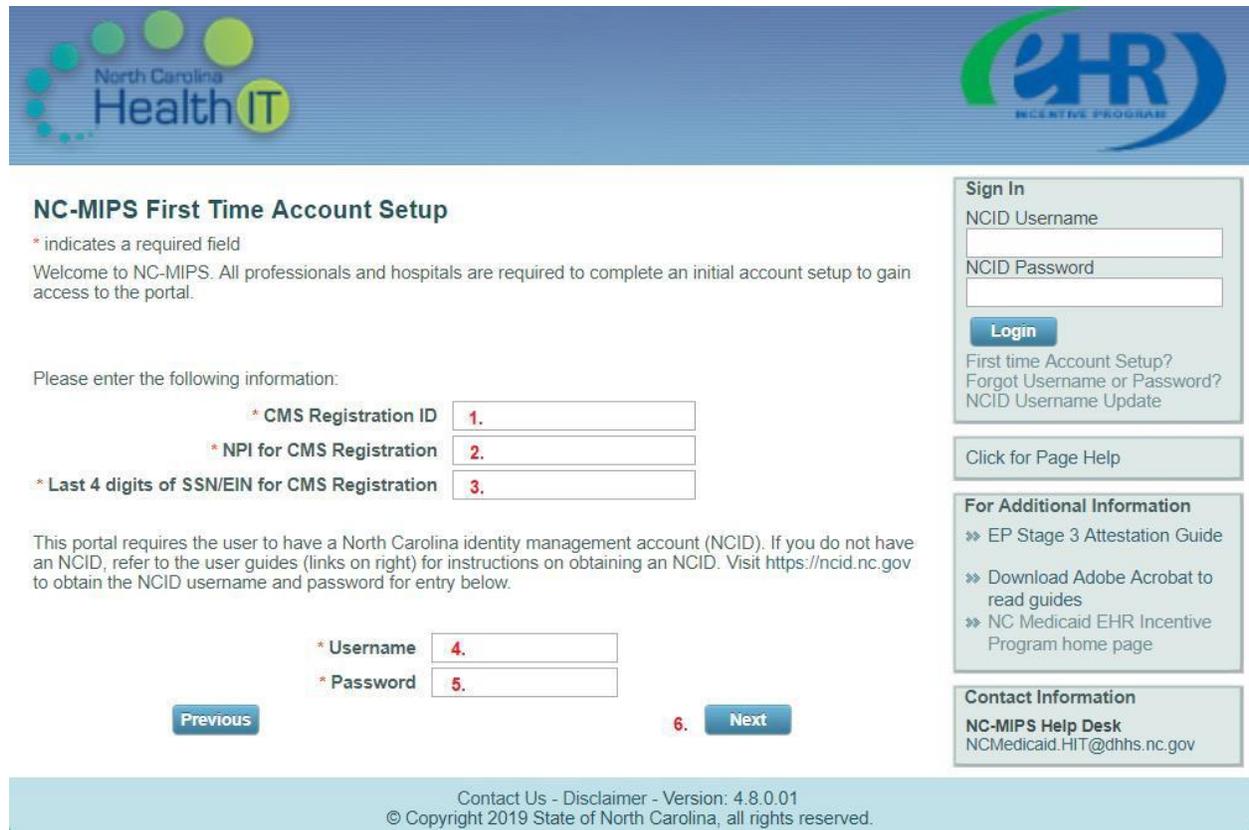
Returning users:

- Sign in by entering the EP's unique NCID Username and NCID Password. (If the EP's NCID username has been updated since completing a First Time Account Setup, please select the *NCID Username Update* option in the Sign In box to update the EP's NCID username.)
- Click *Login*.

The [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**.



**NC-MIPS First Time Account Setup**

\* indicates a required field

Welcome to NC-MIPS. All professionals and hospitals are required to complete an initial account setup to gain access to the portal.

Please enter the following information:

\* CMS Registration ID

\* NPI for CMS Registration

\* Last 4 digits of SSN/EIN for CMS Registration

This portal requires the user to have a North Carolina identity management account (NCID). If you do not have an NCID, refer to the user guides (links on right) for instructions on obtaining an NCID. Visit <https://ncid.nc.gov> to obtain the NCID username and password for entry below.

\* Username

\* Password

**Sign In**  
 NCID Username   
 NCID Password   
  
[First time Account Setup?](#)  
[Forgot Username or Password?](#)  
[NCID Username Update](#)

[Click for Page Help](#)

**For Additional Information**  
 » [EP Stage 3 Attestation Guide](#)  
 » [Download Adobe Acrobat to read guides](#)  
 » [NC Medicaid EHR Incentive Program home page](#)

**Contact Information**  
**NC-MIPS Help Desk**  
 NCMedicaid.HIT@dhhs.nc.gov

Contact Us - Disclaimer - Version: 4.8.0.01  
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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 EP's NPI used during CMS registration.
3. Enter the same last 4 digits of the EP's TIN used during CMS registration (most likely the EP's SSN).
4. Enter the EP's unique NCID username.
5. Enter the EP's unique NCID password.
6. Click *Next*.

The [Status](#) page opens.

## NCID Username Update Tool

If the EP's NCID username has been changed since completing a First Time Account Setup, use the NC-MIPS NCID Username Update Tool to update the EP's NCID username in NC-MIPS. Please note, the NC-MIPS NCID Username Update Tool will only allow the EP to update the username for NC-MIPS to match his/her NCID from [ncid.nc.gov](http://ncid.nc.gov) – it does not change the NCID or NCID password on [ncid.nc.gov](http://ncid.nc.gov).

To update the EP's NCID username in 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 EP's NPI.
3. Click the *Update NCID Username* button.

4. Enter the EP's new NCID username
5. Click *Save*.

Then the [Welcome](#) page will open so the EP can sign in by entering the updated NCID Username and the EP's NCID Password.

## Status

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



**Status**

Provider Name John26043 Public26043  
 CMS Registration ID 1000000001  
 NPI 1234567890

Program Year	Payment Year	Current Status	Payment Date	
2020	3	Ready to Attest		<a href="#">Proceed</a>
2019	3	Closed - No Attestation Submitted		
2018	2	Paid	01/15/2019	<a href="#">View/Print</a>
2017	2	Closed - No Attestation Submitted		
2016	1	Paid	05/30/2017	<a href="#">View/Print</a>
2016	1	Attestation Denied		<a href="#">View/Print</a>
2016	1	Attestation Denied		<a href="#">View/Print</a>

Welcome John26043  
 Public26043  
 Not testmips231? Click here.  
[Logout](#)

Click for Page Help

**For Additional Information**

- » Stage 3 MU Attestation Guide
- » Download Adobe Acrobat to read guides
- » NC Medicaid EHR Incentive Program home page

**Contact Information**

NC-MIPS Help Desk  
 NCMedicaid.HIT@dhhs.nc.gov

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The Status page shows the:

- **Program Year:** the program year for which the EP attested (up to six years from 2011-2021).
- **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 may 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.
- **Ready to attest –** the EP may begin attesting for the 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.
- **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 her/his 'in-process' attestation, thereby signaling s/he would not like to participate for the current program year.
- Withdrawn: EP withdraws her/his 'submitted' attestation to remove the attestation from consideration. The EP can return to proceed with a withdrawn attestation until the close of the program year. Please note, when an attestation is withdrawn, previously entered information is saved in the system.
- Paid: the attestation has been paid.
- Attestation denied: attestation was denied because the EP did not demonstrate that s/he met all of the program requirements.
- 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.
- Withdraw: after submitting the attestation, remove the attestation from consideration. The contact person will no longer be contacted about an attestation that was withdrawn. This is not a permanent action. The EP may return to the attestation after the attestation is withdrawn.
- Re-Attest: If denied, the EP may re-attest at any point before the end of the tail period.
- View/Print: view the attestation in a form that can be printed.

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

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

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

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

To view or print an attestation:

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

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

**Example 1:** ‘Program Year’ 2019 has expired and the EP is ready to attest for Program Year 2020. The row will be marked as “Closed-No Attestation Submitted” and the Program Year 2020 row will be active.

**Status**

**Provider Name** John26043 Public26043  
**CMS Registration ID** 1000000001  
**NPI** 1234567890

Program Year	Payment Year	Current Status	Payment Date
2020	3	Ready to Attest	<a href="#">Proceed</a>
2019	3	Closed - No Attestation Submitted	
2018	2	Paid	01/15/2019 <a href="#">View/Print</a>
2017	2	Closed - No Attestation Submitted	

**Example 2:** If the Program Year 2020 has been ‘Denied’, the EP has the option to re-attest for the denied attestation if the program year is active.

**Status**

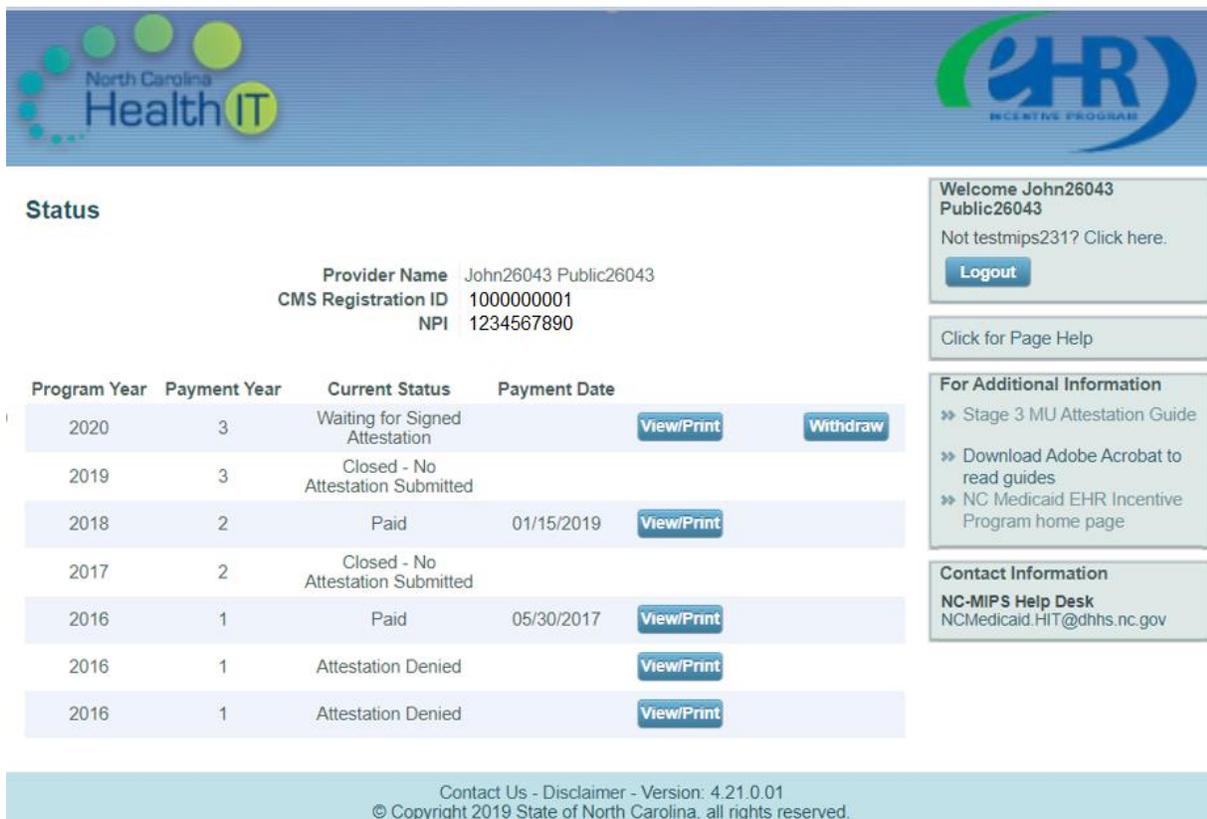
**Provider Name** John27205 Public27205  
**CMS Registration ID** 1000000001  
**NPI** 1234567890

Program Year	Payment Year	Current Status	Payment Date
2020	4	Attestation Denied	<a href="#">Re-attest</a>
2019	4	Closed - No Attestation Submitted	
2018	4	Closed - No Attestation Submitted	

**Example 3:** If the EP wants to withdraw their attestation to address an attestation discrepancy or withdraw participation in a given program year:

1. Click *Withdraw* for that program year.
2. There will be a pop-up warning message: “By withdrawing participation, your submitted attestation will no longer be processed for payment and communications will stop regarding activities for this program year. You can restart the attestation at any time by clicking “Proceed”. Click OK to confirm.”
3. To withdraw the attestation, click *OK*. The status changes to “Attestation in Process.”
4. If the EP does not wish to withdraw the attestation, click *Cancel*. The warning message box closes with no action performed.
5. To resubmit an attestation, or make changes to an attestation, click the *Proceed* button to go into the attestation.

When an attestation is withdrawn, previously entered data is saved in the system, so you can update incorrect fields without re-entering all information. Please note, withdrawing pauses the attestation, so the help desk will no longer contact you about the attestation and no actions, such as denial, will be processed. Withdrawing is not a permanent action; you may return to continue the attestation until the close of the program year.



The screenshot shows the user interface for the EHR Incentive Program. At the top, there are logos for North Carolina Health IT and the EHR Incentive Program. Below the logos, the user's status is displayed as 'Welcome John26043 Public26043'. A table lists attestations for various program years, with the 2020 entry showing a 'Withdraw' button. On the right side, there are links for 'Logout', 'Click for Page Help', 'For Additional Information' (including a link to the Stage 3 MU Attestation Guide), and 'Contact Information' (including the NC-MIPS Help Desk email).

Program Year	Payment Year	Current Status	Payment Date	View/Print	Withdraw
2020	3	Waiting for Signed Attestation		<a href="#">View/Print</a>	<a href="#">Withdraw</a>
2019	3	Closed - No Attestation Submitted			
2018	2	Paid	01/15/2019	<a href="#">View/Print</a>	
2017	2	Closed - No Attestation Submitted			
2016	1	Paid	05/30/2017	<a href="#">View/Print</a>	
2016	1	Attestation Denied		<a href="#">View/Print</a>	
2016	1	Attestation Denied		<a href="#">View/Print</a>	

Provider Name: John26043 Public26043  
 CMS Registration ID: 1000000001  
 NPI: 1234567890

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When the pop-up appears, click *OK* to confirm that you want to withdraw.

nc-mips-portal-test.nc.gov/ProviderStatus.aspx

nc-mips-portal-test.nc.gov says

By withdrawing participation, your submitted attestation will no longer be processed for payment and communications will stop regarding activities for this program year. You can restart the attestation any time by clicking "Proceed". Click OK to confirm.

OK Cancel

**Status**

Program Year	Payment Year	Current Status	Payment Date	
2020	5	Waiting for Signed Attestation		<a href="#">View/Print</a> <a href="#">Withdraw</a>
2019	5	Closed - No Attestation Submitted		
2018	4	Paid	04/18/2019	<a href="#">View/Print</a>
2017	3	Paid	05/24/2018	<a href="#">View/Print</a>
2016	2	Paid	04/17/2017	<a href="#">View/Print</a>
2015	1	Paid	08/25/2015	<a href="#">View/Print</a>

John27474  
74  
ps231? Click here.

Click for Page Help

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**Contact Information**

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**Example 4:** The EP has been paid for Program Year 2020.

**Status**

**Provider Name** John26043 Public26043  
**CMS Registration ID** 1000000001  
**NPI** 1234567890

Program Year	Payment Year	Current Status	Payment Date	
2020	3	Paid	03/12/2020	<a href="#">View/Print</a>
2019	3	Closed - No Attestation Submitted		
2018	2	Paid	01/15/2019	<a href="#">View/Print</a>
2017	2	Closed - No Attestation Submitted		

## Assistance from NC AHEC

The Assistance from NC AHEC Page gives us information about your experience with the NC AHEC.

### Assistance from NC AHEC

\* indicates a required field

1. \* 1) Have you received any assistance related to health information technology (HIT) and/or electronic health record (EHR) technology since January 1, 2020 from the North Carolina Area Health Education Centers (AHEC)?

Yes
  No

The NC Area Health Education Centers Program (NC AHEC) provides individualized, on-site electronic health record (EHR) consulting tailored to meet a practice's specific needs at no cost to the practice. The NC AHEC staff can also assist providers in meeting Meaningful Use.

In addition to helping your practice meet Meaningful Use, the NC AHEC REC staff can also help select, implement and optimize EHRs, help the practice use EHRs to improve the quality of patient care, and assist the practice in attesting for an NC Medicaid EHR Incentive payment.

**Area L AHEC** - serving Edgecombe, Halifax, Nash, Northampton, and Wilson counties  
**Charlotte AHEC** - serving Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Stanly, and Union counties  
**Eastern AHEC** - serving Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Gates, Greene, Hertford, Hyde, Jones, Lenoir, Martin, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, and Wayne counties  
**Greensboro AHEC** - serving Alamance, Caswell, Chatham, Guilford, Montgomery, Orange, Randolph, and Rockingham counties  
**MAHEC** - serving Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey counties  
**Northwest AHEC** - serving Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Catawba, Davidson, Davie, Forsyth, Iredell, Rowan, Stokes, Surry, Watauga, Wilkes, and Yadkin counties  
**SEAHEC** - serving Brunswick, Columbus, Duplin, New Hanover, and Pender counties  
**Southern Regional AHEC and Duke AHEC** - serving Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Robeson, Sampson, and Scotland counties  
**Wake AHEC** - serving Durham, Franklin, Granville, Johnston, Lee, Person, Vance, Wake, and Warren counties

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WELCOME JOHN20439  
Public26439  
Not testmips232? [Click here.](#)

[Logout](#)

[Click for Page Help](#)

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- » NC Medicaid EHR Incentive Program home page

**Contact Information**

NC-MIPS Help Desk  
NCMedicaid\_HIT@dhs.nc.gov

1. Select *yes* or *no* for the question, “Have you received any assistance related to electronic health record (EHR) technology since January 1, 2020 from the North Carolina Area Health Education Centers (AHEC)?”

If you select *no*, you will click *Next* and will be routed to the [Demographics](#) page.

If you select *yes*, questions 2-6 will populate.

2) Since January 1, 2020, have you received general EHR consulting (e.g., selecting, implementing, or optimizing your EHR; enhancing practice workflows related to your EHR; assisting with health information exchange; etc.) from the NC AHEC?

Yes  No

3) Since January 1, 2020, have you received assistance from the NC AHEC with understanding and/or meeting meaningful use or other program requirements for any of the following? Select all that apply.

No  
 Yes, for Medicaid EHR Incentive Program  
 Yes, for Merit-based Incentive Payment System (MIPS)  
 Yes, for Advanced Alternative Payment Models (APMs)

Please use "Ctrl" key to select multiple options from the list box.

4) Since January 1, 2020, have you received assistance from the NC AHEC with attesting for the NC Medicaid EHR Incentive Program?

Yes  No

5) Since January 1, 2020, have you utilized any of the following services NC AHEC provides in support of NC HealthConnex? Select all that apply.

No  
 Training at your practice location on NC HealthConnex features and/or specific use cases  
 Virtual training on NC HealthConnex features and specific use cases  
 Video tutorials on using specific features of NC HealthConnex for patient care and/or quality improvement

Please use "Ctrl" key to select multiple options from the list box.

6) Which regional office of the NC AHEC assisted you?

Select

The NC Area Health Education Centers Program (NC AHEC) provides individualized, on-site electronic health record (EHR) consulting tailored to meet a practice's specific needs at no cost to the practice. The NC AHEC staff can also assist providers in meeting Meaningful Use.

In addition to helping your practice meet Meaningful Use, the NC AHEC REC staff can also help select, implement and optimize EHRs, help the practice use EHRs to improve the quality of patient care, and assist the practice in attesting for an NC Medicaid EHR Incentive payment.



- Area L AHEC** - serving Edgecombe, Halifax, Nash, Northampton, and Wilson counties
- Charlotte AHEC** - serving Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Stanly, and Union counties
- Eastern AHEC** - serving Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Gates, Greene, Hertford, Hyde, Jones, Lenoir, Martin, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, and Wayne counties
- Greensboro AHEC** - serving Alamance, Caswell, Chatham, Guilford, Montgomery, Orange, Randolph, and Rockingham counties
- MAHEC** - serving Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey counties
- Northwest AHEC** - serving Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Catawba, Davidson, Davie, Forsyth, Iredell, Rowan, Stokes, Surry, Watauga, Wilkes, and Yadkin counties
- SEAHEC** - serving Brunswick, Columbus, Duplin, New Hanover, and Pender counties
- Southern Regional AHEC and Duke AHEC** - serving Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Robeson, Sampson, and Scotland counties
- Wake AHEC** - serving Durham, Franklin, Granville, Johnston, Lee, Person, Vance, Wake, and Warren counties

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2. Select *yes* or *no* for the question, “Since January 1, 2020, have you received general EHR consulting (e.g., selecting, implementing, or optimizing your EHR; enhancing practice workflows related to your EHR; assisting with health information exchange; etc.) from the NC AHEC?”
  3. For the question, “Since January 1, 2020, have you received assistance from the NC AHEC with understanding and/or meeting meaningful use or other program requirements for any of the following?” use the list box and select all that apply from the following choices (use ‘Ctrl’ to select multiple choices):
    - No
    - Yes, for Medicaid EHR Incentive Program
    - Yes, for Merit-based Incentive Payment System (MIPS)
    - Yes, for Advanced Alternative Payment Models (APMs)
    - Yes, for Performance Excellence Project (PEP)
  4. Select *yes* or *no* for the question, “Since January 1, 2020, have you received assistance from the NC AHEC with attesting for the NC Medicaid EHR Incentive Program?”
  5. For the question, “Since January 1, 2020, have you utilized any of the following services NC AHEC provides in support of NC HealthConnex? Select all that apply.” use the list box and select all that apply from the following choices (use ‘Ctrl’ to select multiple options):
    - No
    - Training at your practice location on NC HealthConnex features and/or specific use cases
    - Virtual training on NC HealthConnex features and special use cases
    - Video tutorials on using specific features of NC HealthConnex for patient care and/or quality improvement
    - Regional group workshops and/or trainings on NC HealthConnex
    - Reviewing your NC HealthConnex participant data quality report with an AHEC coach
  6. Using the drop-down menu, please select the NC AHEC regional office that assisted you: Area L AHEC, Charlotte AHEC, Eastern AHEC, Greensboro AHEC, MAHEC, Northwest AHEC, SEAHEC, Southern Regional AHEC, Wake AHEC or you may select that you do not know.
  7. Click *Next*.
- The [Demographics](#) page opens.

## Demographics

The Demographics page allows EPs to see the demographic and payee information that was submitted on CMS' R&A system.

EPs need to cross reference the information from CMS with the information on file with NC Medicaid's NCTracks to ensure their demographic information matches between both sources. Unmatched demographic information may result in the delay or denial of an incentive payment.

**Demographics**

NC requires the provider's demographic data on file with NCTracks match the provider's demographic data received from CMS' Registration & Attestation System ([Details](#)).

Please note that the Payee NPI cannot be changed once the attestation has been approved and submitted for payment. If an NPI is not correct, please update it on [CMS' R&A System](#) before proceeding.

	Provider	Payee
1.	NPI 1234567890	9876543210

If there are discrepancies between the information on file with CMS or NCTracks, please visit CMS' R&A System or NCTracks to update the information.

	From CMS
2.	First Name John1899
	Middle Name Q
	Last Name Public1899
	Address 1899 Main street1899 Raleigh NC 27609 5919

Does the information above from CMS match that which is on file with NCTracks?

3.  Yes  No

4. [Next](#)

[Previous](#)

Welcome John1899 Public1899  
Not testmips553? [Click here.](#)  
[Logout](#)

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If there are discrepancies between the information on file with CMS or NCTracks, please visit [CMS' R&A System](#) or [NCTracks](#) to update the information.

To check the demographic information:

1. Review the EP's NPI, the payee NPI and that the payee TIN type (SSN/EIN) is associated with the payee NPI on NCTracks.
2. Check NCTracks and verify the information matches between CMS and NCTracks. If the CMS information does not match, or is incorrect, please update the information with CMS or NCTracks before continuing.
3. If the information matches and is correct, click the Yes button for "Does the information

abovefromCMSmatch that which is on file with NCTracks?”

4. Click *Next*.

The [Contact Information](#) page opens.

To update a payee TIN (group EIN) type on CMS’ R&A system, please follow the guidance below:

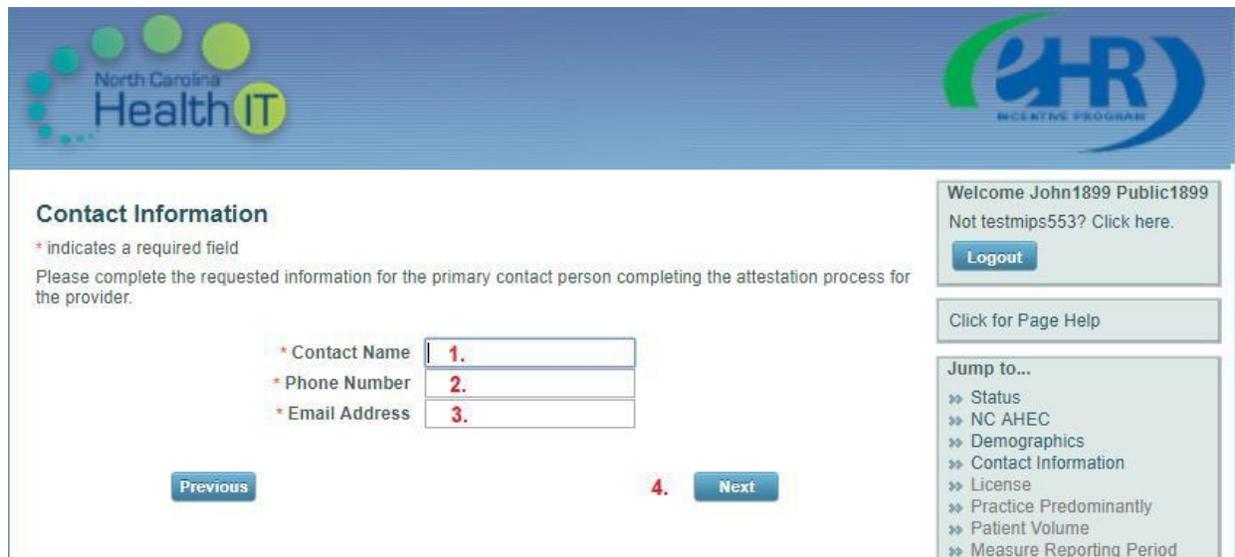
1. Go to <https://ehrincentives.cms.gov>
2. Click Continue
3. Check the box, click continue
4. Log in using the NPPES username & password
5. Click on the Registration tab to continue
6. Click on Modify in the Action column to continue
7. Click on Topic 2
8. Change the Payee TIN Type to Group Reassignment
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 on [CMS’ R&A System](#), please use [CMS’ Registration User Guide for Eligible Professionals](#).

It takes up to two business days for CMS updates to be reflected in NC-MIPS.

## Contact Information

This page is where you will enter the contact information for the person you want us to contact if there are issues with your attestation. If additional information is needed to validate your attestation, we will contact the person listed on this page. Please remember that our ability to assist you is dependent upon being able to reach the contact person listed in NC- MIPS. *The only way to update the contact person is to withdraw, update the information on this page and resubmit the attestation.*



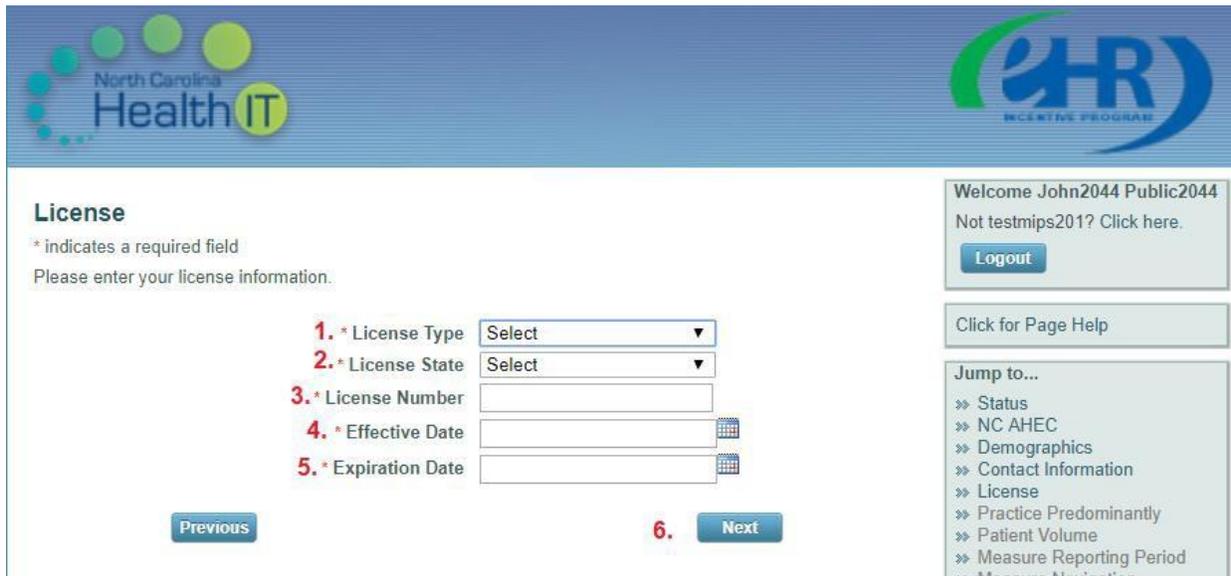
To enter the primary contact person's information:

1. Enter the Contact's Name.
2. Enter the Contact's Phone Number with area code (enter 10 numbers).
3. Enter the Contact's Email Address.
4. Click *Next*.

The [License](#) page opens.

## License

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



To enter the EP's license information:

1. Select the EP's License Type from the drop-down list (for example, MDs will select *Medical*, nurse practitioners will select *Nurse Practitioner*, etc.). Note, if you select *Physician Assistant*, you must submit a PA-led memo – see instructions in the [Recommended Documentation](#) section.
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*.

The [Practice Predominantly/Hospital-Based](#) page opens.

If the license is no longer active as of the date of attestation, please submit a memo, signed by the attesting EP with 1) an explanation of the situation (e.g., retirement) and 2) the following statement: 'I understand that I am personally liable for all information submitted on the attestation accompanying this memo and that I am personally liable for repaying an incentive payment if it is determined in post-payment audit that I did not meet the program requirements.' NOTE: EPs who receive incentive payments are required to maintain attestation documentation for at least six years for post-payment audit.

## Practice Predominantly/Hospital-Based

The Practice Predominantly/Hospital-Based page is used to report whether the EP practiced predominantly at an FQHC or RHC and whether the EP is hospital-based.

An EP who has more than 50 percent of her/his total patient encounters at an FQHC/RHC during any consecutive six-month period within the calendar year prior to the program year for which the EP is attesting or in the preceding 12-month period from the date of attestation, qualifies as “practicing predominately” at an FQHC/RHC. If an EP meets the requirement for practicing predominantly, s/he is permitted to use non-Medicaid needy individual encounters toward her/his 30 percent Medicaid PV threshold.

Even if an EP practiced predominantly at an FQHC/RHC, s/he is not required to attest to practicing predominantly if s/he is not using non-Medicaid needy individual encounters to count toward her/his PV threshold.

Hospital-based means the EP provided 90 percent or more of her/his Medicaid-covered claims in an inpatient or emergency room hospital setting. A hospital-based EP is only eligible to participate in the NC Medicaid EHR Incentive Program if s/he can demonstrate s/he 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 percent of all patient encounters during a six- month period) at an FQHC/RHC:

**Practice Predominantly/Hospital-Based**  
\* indicates a required field

\* Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at a Federally Qualified Health Center or Rural Health Clinic?

1.  Yes  No

Please enter information for practice predominantly assertion:

2. \* Select the date range

3. \* Start Date of 6-month Period

End Date of 6-month Period

4. \* Total Patient Encounters at FQHC/RHC

5. \* Total Patient Encounters at all Locations

Your ratio of encounters at a Federally Qualified Health Center or Rural Health Clinic to your total patient encounters is 6. 0%

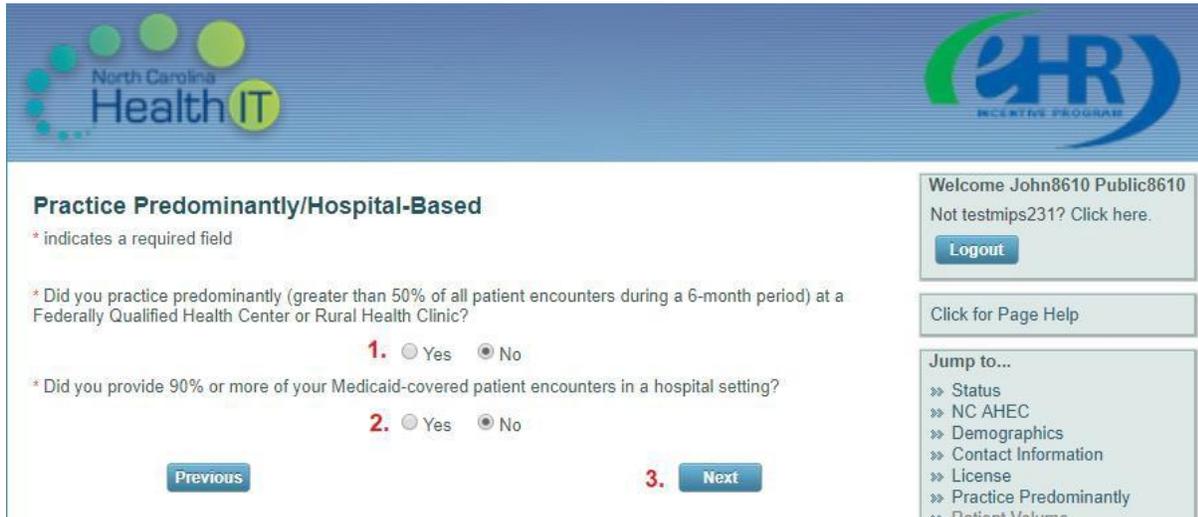
7.

Right sidebar navigation:  
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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 consecutive 6-month Period from the calendar year prior to the program year for which the provider is attesting or from the 12 months preceding the date of attestation.
  3. Enter the Start Date of the 6-month Period using the calendar tool or by typing the date.
  4. Enter the number of Total Patient Encounters at FQHC/RHC during the 6-month Period reported in Step 1. Note that these are the individual EP’s encounters only, not 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, not those of a practice group.
  6. Review the ratio of encounters that is automatically calculated and displayed to ensure it is greater or equal to 50percent.
  7. Click Next.
- The [Patient Volume](#) page opens.

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



The screenshot shows a web application interface for the EP Stage 3 MU Attestation Guide. The header includes the North Carolina Health IT logo on the left and the HR Incentive Program logo on the right. The main content area is titled "Practice Predominantly/Hospital-Based" and contains two questions with radio button options for "Yes" and "No".

\* indicates a required field

\* Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at a Federally Qualified Health Center or Rural Health Clinic?  
1.  Yes  No

\* Did you provide 90% or more of your Medicaid-covered patient encounters in a hospital setting?  
2.  Yes  No

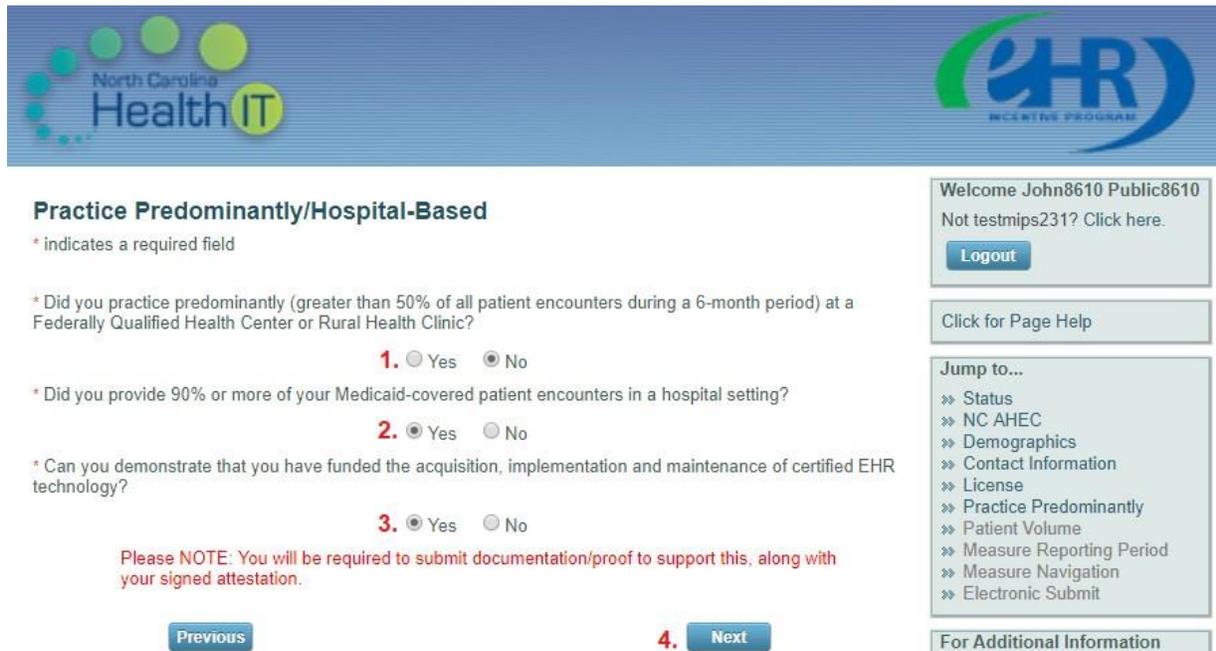
Navigation buttons: Previous, Next (3. Next)

Right sidebar: Welcome John8610 Public8610, Not testmips231? Click here., Logout, Click for Page Help, Jump to... (Status, NC AHEC, Demographics, Contact Information, License, Practice Predominantly, Patient Volume)

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*.

The [Patient Volume](#) page opens.

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



The screenshot shows a web-based form titled "Practice Predominantly/Hospital-Based". It includes three questions with radio button options for Yes and No. A red note states: "Please NOTE: You will be required to submit documentation/proof to support this, along with your signed attestation." The form has "Previous" and "Next" buttons. On the right side, there is a user welcome message, a "Logout" button, a "Click for Page Help" button, a "Jump to..." menu with options like Status, NC AHEC, Demographics, Contact Information, License, Practice Predominantly, Patient Volume, Measure Reporting Period, Measure Navigation, and Electronic Submit, and a "For Additional Information" button.

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*.

The [Patient Volume](#) page opens.

## Patient Volume

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

1. Patient volume methodology (individual or group)
2. Patient volume reporting period
3. Practice(s) from which patient volume was drawn
4. Number of patient volume encounters

Under individual methodology, an EP will report on only her/his personal patient encounters.

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 attesting Medicaid provider that is currently affiliated with the group. So long as the attesting Medicaid provider has a current affiliation with the practice and the group practice's PV is appropriate as a PV methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation), 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 RNs and 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 may use a clinic or group practice's PV as a proxy for their own under five conditions:

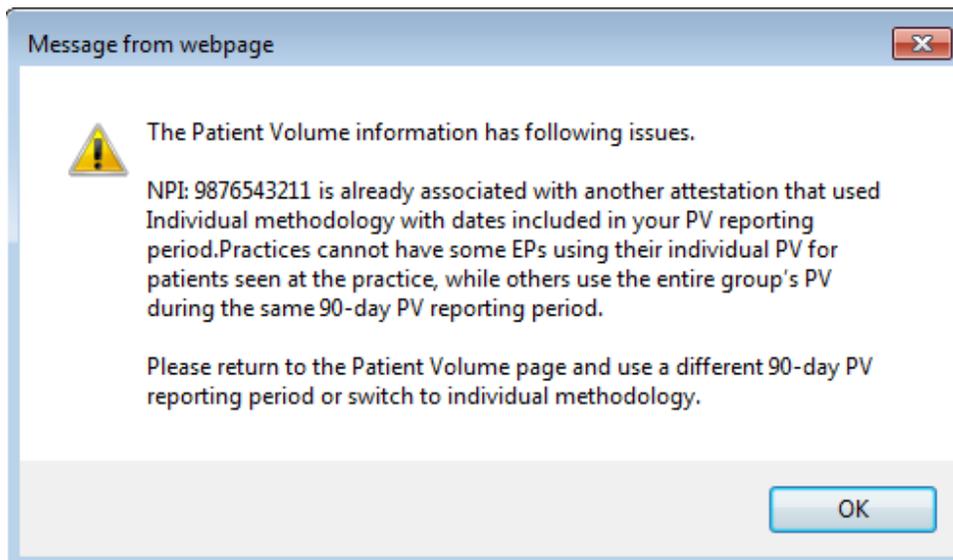
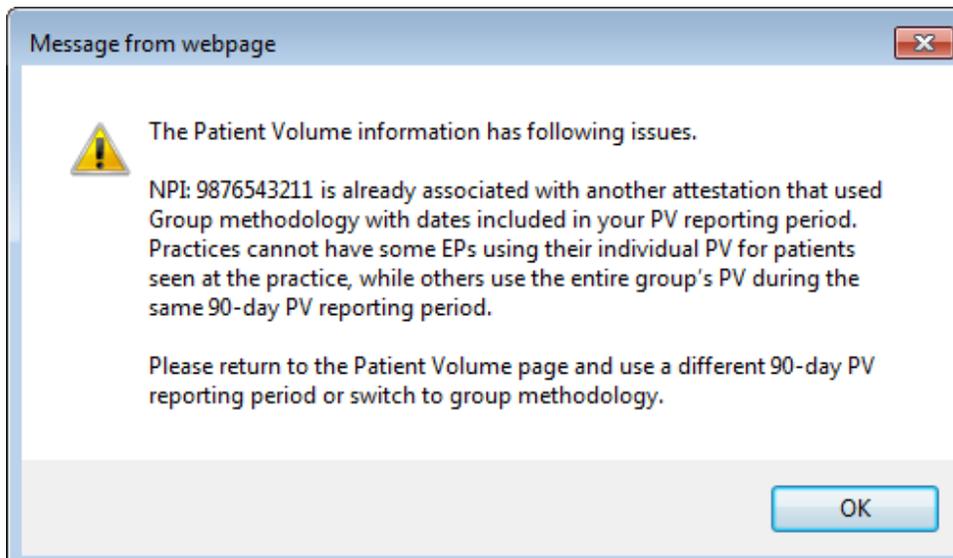
1. The attesting EP had at least one encounter with a Medicaid-enrolled patient during the program year;
2. The clinic or group practice's PV is appropriate as a PV methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
3. There is an auditable data source to support the clinic's PV determination;
4. The EP has a current affiliation **at the time of attestation** with the group whose PV they are using to attest; and,
5. So long as the practice and EPs decide to use one methodology for a 90-day reporting period (in other words, practices could not have some of the EPs using their individual PV for patients seen at the practice, while others use the practice-level data during the same 90-day reporting period).

If the EP works both in the practice and outside the practice, then the practice-level determination includes only those encounters associated with that practice.

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 need to be calculated only one time for the whole group.

If there are issues, the EP will see one of two error messages:



To resolve this issue, the EP can use a different the PV reporting period or switch the methodology used by the other providers in the group and move forward with the attestation.

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 for a consecutive 90-day PV reporting is as follows:  
**(All Medicaid-paid encounters + all Medicaid-enrolled zero-pay encounters)/Total encounters**

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

1. A consecutive 90-day period from the calendar year prior to the program year for which they're attesting (so if attesting for Program Year 2020, this would be a 90-day period in calendar year 2019 regardless of the date of attestation); **OR,**
2. A consecutive 90-day period in the 12-month period preceding the date of the attestation. For example: If attesting on February 1, 2021 for Program Year 2020, the previous calendar year is 2019 and the 12 months immediately preceding the date attestation would be 2/1/20-1/31/21.

Providers practicing predominantly at an 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 to help us provide focused outreach if necessary.

If the EP bills any of their Medicaid claims indirectly through another entity, such as a behavioral health provider billing through an LME, please complete the behavioral health template (available under the Resources and Webinars tab on our [website](#)) and then submit the completed template with the signed attestation.

If some of your Medicaid encounters were for patients covered by another state's Medicaid program, please submit a billing memo on practice letterhead regarding this with your signed attestation. Include a break-out of Medicaid encounters by state. If the EP had both Medicaid-paid and zero-pay, please break out each category of encounter by state. An EP must include any identifiers (e.g., rendering and billing NPIs and any required state identifiers) 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. For more information on calculating patient volume, please refer to the Patient Volume podcasts or the 'Patient Volume' tab on [our website](#).

## Individual Methodology

### Patient Volume

\* indicates a required field

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

1. \* Select the date range

2. \* Start Date

3. \* End Date

4. \* Patient Volume Reporting Method  Individual  Group

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?

5.  Yes  No

Enter the patient volume information for your selected 90-day period below. Add a separate line for each billing 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	Your Total Encounters at Practice	
<input type="text" value="6."/>	<input type="text" value="7."/>	
Practice's Billing NPI	Medicaid Encounters Billed under this NPI	Medicaid Enrolled Zero Pay Encounters
<input type="text" value="8."/>	<input type="text" value="9."/>	<input type="text" value="10."/>

Add another NPI for this Practice **11.**

Add Another Practice Name **12.**

Medicaid Patient Encounters (Numerator) 0 **13.**  
 Total Patient Encounters (Denominator) 0 **14.**  
 Medicaid Patient Volume Percentage (Medicaid / Total) 0% **15.**

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 the date of attestation) 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 2020, previous calendar year would be 2019 regardless of the date of attestation).

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?” Your PV numbers do not need to be across all of your sites of practice. However, at least one of the locations where the EP is meaningfully using certified EHR technology should be included in the PV. If you select *Yes* because your PV numbers come from more than one practice, you must report each practice by clicking *Add Another Practice Name* (step 12).
6. Enter the Practice Name – the name of the 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 with your NPI as rendering on Medicaid claims but that belong to another provider. Do not enter the number of encounters for all providers at the practice. Do not include encounters that you had with any other practice.)
8. 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.)
9. Enter the Medicaid Encounters Billed under this NPI - 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, including encounters where Medicaid was the secondary payer. Enter only YOUR Medicaid-paid encounters with this practice (Do not enter Medicaid encounters that were billed with your NPI listed as rendering but that belong to another provider. Do not enter the number of Medicaid encounters for all providers at the practice. Do not include Medicaid encounters that you had with any other practice or that were billed under any other billing NPI.) Note: Health Choice cannot be included here.
10. 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 with your NPI listed as rendering but that belong to another provider. Do not enter the number of encounters for all providers at the practice. Do not include encounters you had with any other practice.) See the Patient

Volume tab on our [FAQ page](#) for guidance on billable services. Note: Health Choice cannot be included here.

11. If Medicaid-paid encounters included in your reported patient volume were billed under more than one NPI, click the link for *Add another NPI for this Practice* and repeat steps 8 through 10.
12. If you are reporting patient volume from more than one practice, click the link for *Add another Practice Name* and repeat steps 6 through 11.
13. The numerator is automatically calculated and displayed. The numerator is all Medicaid encounters – Medicaid-paid encounters plus Medicaid zero-pay encounters.
14. The denominator is automatically displayed. The denominator is the total of all your patient encounters with this practice, no matter the payer.
15. The Medicaid Patient Volume Percentage is automatically calculated and displayed. The percentage is the numerator divided by the denominator. Your percentage must be at least 30 percent 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 percent. If your percentage does not meet the required threshold or is greater than 100 percent, your attestation will be automatically denied.

1) 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 **16.**

2) An EP must report all NPI(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 NPIs is no longer used. Did you report all NPI(s) under which the EP's encounters were billed during the 90-day reporting period, even those not currently in use?  Yes  No **17.**

3) 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 **18.**

b) Did you exclude from the Medicaid Encounters Billed under this NPI denied claims that were never paid at a later date?  Yes  No **19.**

4) 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 **20.**

5) 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 **21.**

6) 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 **22.**

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

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16. 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, and NOT the group’s encounters. If your answer is *No*, you need to review your numbers and then enter only YOUR encounters.

17. Click the *Yes* or *No* button for “Did you report all NPI(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 NPIs that the practice(s) used as billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period. The 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 NPI for the practice* to report patient volume under

additional billing NPIs used on your Medicaid encounters with this practice during the PV reporting period.

18. 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. If you answer *No*, the following error message will be displayed:

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

Please recalculate the numerator(s) to include all encounters where Medicaid paid in part or in whole for a service.

19. Review your numerator(s) and include all encounters where Medicaid paid in part or in whole for a service. Click the *Yes* or *No* button for “Did you exclude from the Medicaid Encounters Billed under this NPI denied claims that were never paid at a later date?” The number you enter for Medicaid-paid encounters can include only encounters that were paid at least in part by Medicaid. If you answer *No*, the following error message will be displayed:

b) Did you exclude from the Medicaid Encounters Billed under this NPI denied claims that were never paid at a later date?  Yes  No

Please update the numerator(s) to exclude denied claims from Medicaid Encounters Billed under this NPI.

Review your numerator(s) and for *Medicaid encounters billed under this NPI*, 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.

20. 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.
21. 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.
22. 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.

23. If the EP had different NPIs or more than one NPI during the 90-day period, enter that number in the text field. If you had another personal NPI that you used as rendering on Medicaid claims during your selected 90-day PV reporting period, list all here.
  24. Click *Next*.
- The [Measure Reporting Period](#) page will open.

## Group Methodology

### Patient Volume

\* indicates a required field

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

\* Select the date range  ▼

\* Start Date

\* End Date

\* Patient Volume Reporting Method  Individual 4.  Group

Enter the patient volume information for your selected 90-day period below. Add a separate line for each billing 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
<input type="text" value="5."/>	<input type="text" value="6."/>	<input type="text" value="7."/>
Group's Billing NPI	Medicaid Encounters Billed under this NPI	Medicaid Enrolled Zero Pay Encounters
<input type="text" value="8."/>	<input type="text" value="9."/>	<input type="text" value="10."/>
<a href="#">Add another Group NPI 11.</a>		

Medicaid Patient Encounters (Numerator) 0 12.

Total Patient Encounters (Denominator) 0 13.

Medicaid Patient Volume Percentage (Medicaid / Total) 0% 14.

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 the date of attestation) 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 2020, previous calendar year would be 2019 regardless of the date of attestation).
2. Enter the Start Date of your selected 90-day PV reporting period, using the calendar tool or by typing the date. Your start date must fall within your selected date range.
3. Enter the End Date of your selected 90-day PV reporting period, using the calendar tool or by typing the date. The PV reporting period must be exactly 90 days including the start date and end date. Your end date must fall within your selected date range.

4. Click the *Group* button to report that you used group methodology to calculate your patient volume.
5. Enter the Group Name – the name of the practice where your patient volume comes from.
6. Enter the Number of Group Members During the 90-day Period. This is the total number of providers that were in the group during your selected 90-day patient volume reporting period. *NOTE:* This number includes 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 Total Encounters for All Group Members. This is the number of all 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 for the providers who are eligible to participate in the NC Medicaid EHR Incentive Program.
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 for this group.)
9. Enter the Medicaid Encounters Billed under this NPI - this is the number of encounters for all group members that were paid for at least in part by Medicaid, including encounters where Medicaid was the secondary payer. 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. See the Patient Volume tab on our [FAQ page](#) for guidance on billable services.
11. If the group has billed encounters under more than one NPI, click the link for *Add another Group NPI* and repeat steps 8 through 10.
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 percent 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 percent. If your percentage does not meet the required threshold or is greater than 100 percent, your attestation will be automatically denied.

- 1) When using group methodology, the patient volume must include all patient encounters with both EPs and non-eligible provider types (e.g., RNs, phlebotomists). Did you include all encounters?  Yes  No **15**
- 2) 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 **16**
- b) Did you exclude from the Medicaid Encounters Billed under this NPI denied claims that were never paid at a later date?  Yes  No **17**
- 3) Encounters included in the patient volume must have occurred during the 90-day reporting period, regardless of when claims were submitted or paid. Are your reported encounters based on date of service and not date of claim or date of payment?  Yes  No **18**
- 4) The denominator must include all encounters regardless of payment method. Did you include all encounters in the denominator where services were paid by Medicaid, by any payer other than Medicaid, self-paid, and provided at no charge?  Yes  No **19**
- 5) 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 **20**
- 6) If the group's reported encounters span more than one location and/or were billed with Medicaid under multiple NPIs, NC requires reporting of all NPIs 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 NPIs?  Yes  No  N/A **21**
- b) During the 90-day reporting period, did the group have a different (outdated) billing NPI or more than one billing NPI?  Yes  No  N/A **22**

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- Click the Yes or No button for “Did you include all encounters?” With group methodology, you must report encounters 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. If you cannot answer Yes to this question, you need to review your numbers and then report encounters for EVERY professional in the group who provided services.
- 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 also include encounters where Medicaid paid only part, e.g., where Medicaid was the secondary payer. If you answer No, the following error message will be displayed:

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

Please recalculate the numerator(s) to include all encounters where Medicaid paid in part or in whole for a service.

Review your numerator(s) and include all encounters where Medicaid paid in part or in whole for a service.

17. Click the Yes or No button for “Did you exclude from the Medicaid Encounters Billed under this NPI denied claims that were never paid at a later date?” The number you enter for Medicaid-paid encounters can include only encounters that were paid at least in part by Medicaid. If you answer No, the following error message will be displayed:

b) Did you exclude from the Medicaid Encounters Billed under this NPI denied claims that were never paid at a later date?  Yes  No

Please update the numerator(s) to exclude denied claims from Medicaid Encounters Billed under this NPI.

Review your numerator(s) and for Medicaid encounters billed under this NPI, 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.

18. 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 encounters must have a date of service that falls within your group’s 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 group’s selected 90-day PV reporting period.
19. Click the Yes or No button for “Did you include all encounters in the denominator where services were paid by Medicaid, by any payer other than Medicaid, self-paid and provided at no charge?” Your denominator must include all encounters for all group members 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 (see step #7) to include ALL of your encounters with the listed practice.
20. 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.
21. Click the Yes or No button for “If you are reporting patient volume from multiple locations, have you provided all associated NPIs?” 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 NPIs that the group used as billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period for those locations. The 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 NPI to report patient volume under additional billing NPIs used during the PV reporting period.

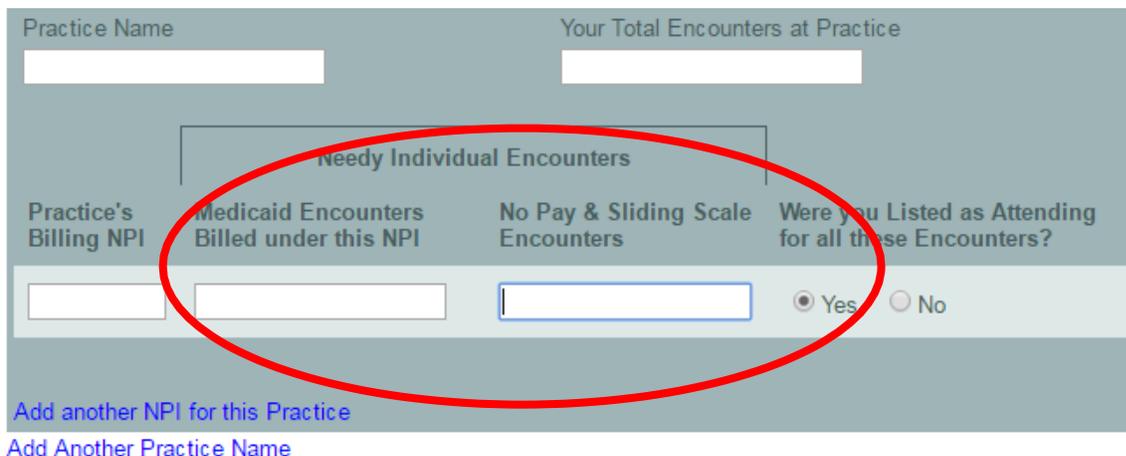
22. Click the Yes or No button for “During the 90-day reporting period, did the group have a different (outdated) billing NPI or more than one billing NPI?” You must enter all the NPIs that the group used as billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period. The 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 NPI to report patient volume under additional billing NPIs used during the PV reporting period.

23. Click Next.

The [Measure Reporting Period](#) page will open.

### Practicing Predominantly

Providers practicing predominantly at an 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.



Practice Name	Your Total Encounters at Practice		
<input type="text"/>	<input type="text"/>		
<b>Needy Individual Encounters</b>			
Practice's Billing NPI	Medicaid Encounters Billed under this NPI	No Pay & Sliding Scale Encounters	Were you Listed as Attending for all these Encounters?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="radio"/> Yes <input type="radio"/> No
<a href="#">Add another NPI for this Practice</a>			
<a href="#">Add Another Practice Name</a>			

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 NPI 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 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.

## Measure Reporting Period

On the Measure Reporting Period page, the EP reports her/his individual MU reporting period, as well as the location(s) where s/he worked at during the MU 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). All EPs will be attesting to Stage 3 MU with a 2015 Edition of CEHRT.

**Measure Reporting Period Page**

\* indicates a required field

EHR Certification Number: 0015EG4CC4XW52M

In Program Year 2020, providers must attest to Stage 3 using a 2015 Edition of certified EHR technology. Please check [ONC's certified Health IT Product List](#) to ensure your EHR meets all program requirements.

Please enter your 90-day MU reporting period date range.

1. \* Start Date

2. \* End Date

\* Is your CQM reporting period different from your MU reporting period?  Yes  No 3.

Please enter your 90-day CQM reporting period date range.

4. \* Start Date

5. \* End Date

Please enter all locations where you had encounters during the MU reporting period.

* Practice Name	* Address	* EPs individual encounters for the MU (not PV) reporting period	* CEHRT?
6. <input type="text"/>	7. <input type="text"/>	8. <input type="text"/>	<input type="radio"/> Yes 9. <input type="radio"/> No

[Add a location](#) 10.

Percentage of encounters at a location with certified EHR technology: 0% 11.

12.

Right sidebar:

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- 
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To enter Meaningful Use activities:

1. Enter the 'Start Date' of the consecutive 90-day MU reporting period.
2. Enter the 'End Date' of the consecutive 90-day MU reporting period.
3. Click the *Yes* or *No* button for "Is your CQM reporting period different from your MU reporting period?" Choose *Yes* if the CQM reporting period you used was different from your MU reporting period. Choose *No* if you used the same reporting period for the MU objectives and CQMs.
  - If you choose *No*, you will not be prompted to enter a separate CQM reporting period. Skip to step 6.
  - If you choose *Yes* during step 4, you will be prompted to enter a 90-day CQM reporting period.

4. If you choose *Yes* during step 3, enter the 'Start Date' of the consecutive 90-day CQM reporting period.
5. If you choose *Yes* during step 3, enter the 'End Date' of the consecutive 90-day CQM reporting period.
6. Enter the Practice Name(s) where the individual EP had encounters during the MU reporting period.
7. Enter the Practice Address(es) where the EP had encounters during the MU reporting period.
8. Enter the individual EP's encounters for the MU reporting period. NOTE: This number should reflect the individual attesting EP's MU encounters at that practice location within the MU reporting period; this includes all payers and is separate from the information submitted on the PV page.
9. 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.
10. If you worked at more than one location during the MU reporting period, click 'Add a location' to enter to the additional practice's information and follow steps 6-9.
11. The percentage of the EP's encounters equipped with certified EHR technology will be automatically displayed. NOTE: This percentage must be 50 percent or more to meet meaningful use requirements, otherwise the attestation will be automatically denied.
12. Click Next.

The [Measure Navigation Home page](#) will open.

## Meaningful Use Objectives and Measures

### Measure Navigation Home Page

The Measure Navigation Home page is where the user will go to begin attesting to the MU Objectives and CQMs.

This page will also allow the user to track their progress as they attest to MU.

Measure Set	Actions	Complete	Valid
Meaningful Use Objectives	<a href="#">Begin</a> <a href="#">Review</a>	✓	✓
Clinical Quality Measures	<a href="#">Begin</a> <a href="#">Review</a>	✓	✓
Percentage at location with CEHRT			✓

Buttons: [Previous](#) [Next](#)

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Jump to...: Status, NC AHEC, Demographics, Contact Information, License

If at any time the user has any questions on what to enter (numerator, denominator, exclusion, etc.) for a 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](mailto: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.

Measure Set	Actions	Complete	Valid
Meaningful Use Objectives	<a href="#">Begin</a> <a href="#">Review</a>	✓	✓
Clinical Quality Measures	<a href="#">Begin</a> <a href="#">Review</a>	✓	✓
Percentage at location with CEHRT			✗

Message: At least 50 percent of the EP's encounters must have occurred at a location with certified EHR technology. If you attest to less than 50 percent, this attestation will be automatically denied.

Buttons: [Previous](#) [Next](#)

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Jump to...: Status, NC AHEC, Demographics, Contact Information, License, Practice Predominantly, Patient Volume

The Measure Navigation 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 Objectives, the user will be directed to Objective 1 of 8. For the CQMs, the user will be directed to the CQM Instructions page, where they will have the opportunity to select those measures they wish to report. The **Review** button will direct the user to the measure set summary page and allow the user to review and edit their attested information.
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 objectives/measures within the measure set. A red 'x' indicates the user has not completed all required objectives/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 objectives/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. A red 'x' for Percentage at Location with CEHRT means that the user didn't meet the required 50 percent for "Percentage of encounters at a location with certified EHR technology:" field on the Measure Reporting Period Page.

**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.
- The percentage of patient encounters that occurred at a location with CEHRT that were reported on the Measure Reporting Period Page is not at least 50 percent.

***If the user sees a red 'x,' the user should review answers for accuracy and validity.***

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 s/he has not successfully met the meaningful use requirements for that measure set and submitting the attestation at that time **will result in a denial of payment.**

On the Measure Navigation 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.

Once all measures are complete and valid, select *Next* to be routed to the [Congratulations](#) page.

## Things to keep in mind while attesting to Stage 3 MU...

EPs will attest to eight required Stage 3 MU Objectives.

On the Measure Navigation 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 both measure sets.

After completing a measure set, the user will be routed to the MU Objective or CQM 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 Navigation 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.

EPs are required to submit a copy of their CQM report directly from their EHR demonstrating they have met the CQMs for which they are attesting. The CQM report must be emailed to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) with the signed attestation printed from NC-MIPS.

As a user navigates through the MU objectives, they are 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 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 Objectives Pages

The user will be directed to Objective 1 of 8 and will navigate through the seven remaining objectives by clicking the *Next* button. Each MU page will display the requirements for meeting the objective and measure(s).

1. Some measures require a *Yes* or *No* answer to report whether the EP satisfied the measure criteria (Objectives 1, 3 and 8).
  - If after reading the measure, the criteria was met, click *Yes*.
  - If after reading the measure, the criteria was not met, click *No*. *Note, if the EP selects No, they will not meet the objective and will not meet MU.*
2. Other measures require the user to enter a numerator and denominator (Objectives 2, 4, 5, 6 and 7).
  - The user may be asked to report on an entire population of patients, or just a subset.
  - The user should ensure the numerator(s) and denominator(s) they enter match exactly the reports produced by their EHRs (or combination of such reports and other data sources, where applicable).



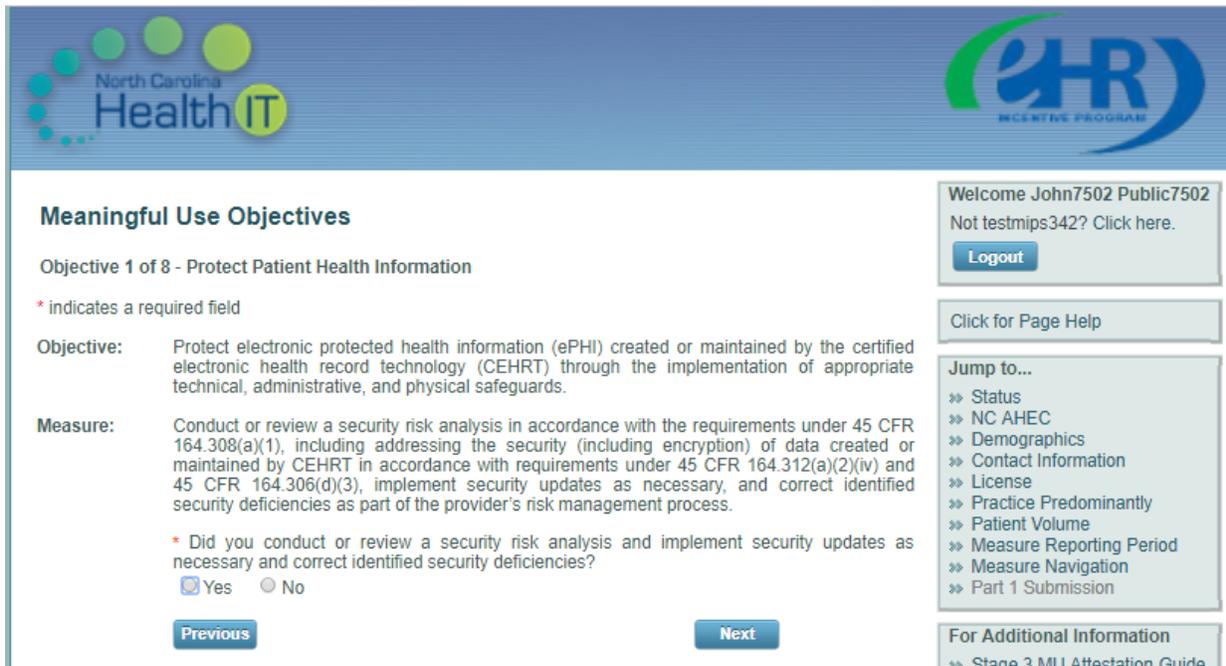
An EP is required to attest with complete data from all locations equipped with certified EHR technology in order to demonstrate meaningful use.

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

The following pages will show users each of the eight objectives for which they will be required to attest. Follow the guidelines listed above for each objective and follow the directions given on each page in NC-MIPS.

**If you have questions about meeting a [Meaningful Use objective](#), please contact CMS as they are the authority on all MU requirements and specifications.**

**Objective 1:** Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical, administrative and physical safeguards.



To meet Objective 1, EPs must have conducted or reviewed a security risk analysis and implemented security updates as necessary and corrected identified security deficiencies.

It is acceptable for the security risk analysis to be conducted outside the MU reporting period; however, the analysis must be conducted for the certified EHR technology used during the MU reporting period and the analysis or review must be conducted on an annual basis prior to the date of attestation. In other words, the provider must conduct a unique analysis or review applicable for the MU reporting period and the scope of the analysis or review must include the full MU reporting period. For the Security Risk Analysis Tip sheet click on the following link:

[https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAnalysis\\_Tipsheet\\_Stage3\\_Medicaid.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAnalysis_Tipsheet_Stage3_Medicaid.pdf).

For more information, see <https://www.cms.gov/files/document/medicaid-ep-2020-protect-patient-health-information-objective-1.pdf>.

**Objective 2:** Generate and transmit permissible prescriptions electronically (eRx).


INCENTIVE PROGRAM

### Meaningful Use Objectives

Objective 2 of 8 - Electronic Prescribing (eRx)

\* indicates a required field

**Objective:** Generate and transmit permissible prescriptions electronically.

**Measure:** More than 60 percent of all permissible prescriptions written by the eligible professional (EP) are queried for a drug formulary and transmitted electronically using CEHRT.

**Exclusions:** An EP may take an exclusion if any of the following apply:

- Writes fewer than 100 permissible prescriptions during the Meaningful Use (MU) reporting period; or
- Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of her or his MU reporting period.

\* Do either of these exclusions 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 number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.

**\* Denominator:**

Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the MU reporting period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the MU reporting period.

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If the exclusions do not apply, EPs meet Objective 2 if **more than 60%** of all permissible prescriptions written by the EP during the MU reporting period were queried for a drug formulary and transmitted electronically using CEHRT.

Note that because the EP is permitted, but not required, to limit the measure of Objective 2 to those patients whose records are maintained using certified EHR technology (CEHRT), you must report whether your data was extracted from all patient records or from only patient records maintained using CEHRT.

For more information, see <https://www.cms.gov/files/document/medicaid-ep-2020-erx-objective-2.pdf>.

**Objective 3:** Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.



The screenshot shows a web page titled "Meaningful Use Objectives" for "Objective 3 of 8 - Clinical Decision Support". The page includes a header with the North Carolina Health IT and EHR Incentive Program logos. A sidebar on the right contains user information (John27495, Public27495), a "Logout" button, and a "Jump to..." menu with links to Status, NC AHEC, Demographics, Contact Information, License, Practice Predominantly, Patient Volume, Measure Reporting Period, Measure Navigation, and Electronic Submit. Below the sidebar is a "For Additional Information" section with links to the Stage 3 MU Attestation Guide, Adobe Acrobat guides, and the NC Medicaid EHR Incentive Program home page. At the bottom of the sidebar is "Contact Information" for the NC-MIPS Help Desk (NCMedicaid.HIT@dhhs.nc.gov). The main content area lists the objective and three measures with associated questions and radio button options for Yes/No. A "Previous" and "Next" button are at the bottom of the main content area. The footer contains contact information and a copyright notice for 2019.

If the exclusion does not apply, EPs meet Objective 3 if they satisfy both measures:

**Measure 1:** Implemented five clinical decision support interventions related to four or more CQMs at a relevant point in patient care for the entire MU reporting period (Measure 1). Absent four CQMs related to an EP’s scope of practice or patient population, the CDS interventions must be related to high-priority health conditions; and,

**Measure 2:** Enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire MU reporting period (Measure 2).

For more information, see <https://www.cms.gov/files/document/medicaid-ep-2020-clinical-decision-support-objective-3.pdf>.

**Objective 4:** Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the record per state, local and professional guidelines.




### Meaningful Use Objectives

Objective 4 of 8 - Computerized Provider Order Entry (CPOE)

\* indicates a required field

**Objective:** Use CPOE for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions.

**Measure 1:** More than 60 percent of medication orders created by the EP during the MU reporting period are recorded using CPOE.

**Measure 2:** More than 60 percent of laboratory orders created by the EP during the MU reporting period are recorded using CPOE.

**Measure 3:** More than 60 percent of diagnostic imaging orders created by the EP during the MU reporting period are recorded using CPOE.

**Measure 1 Exclusion:** Any EP who writes fewer than 100 medication orders during the MU reporting period.

\* Does this exclusion apply to you?  
 Yes  No

**Measure 2 Exclusion:** Any EP who writes fewer than 100 laboratory orders during the MU reporting period.

\* Does this exclusion apply to you?  
 Yes  No

**Measure 3 Exclusion:** Any EP who writes fewer than 100 diagnostic imaging orders during the MU reporting period.

\* Does this exclusion apply to you?  
 Yes  No

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**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.

**Measure 1: Medication**

\*Numerator 1:

The number of orders in the denominator recorded using CPOE.

\*Denominator 1:

Number of medication orders created by the EP during the MU reporting period.

**Measure 2: Laboratory**

\*Numerator 2:

The number of orders in the denominator recorded using CPOE.

\*Denominator 2:

Number of laboratory orders created by the EP during the MU reporting period.

**Measure 3: Diagnostic Imaging**

\*Numerator 3:

The number of orders in the denominator recorded using CPOE.

\*Denominator 3:

Number of diagnostic imaging orders created by the EP during the MU reporting period.

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If the exclusions do not apply, EPs meet Objective 4 if they meet the following thresholds for each measure:

**Measure 1: More than 60%** of medication orders created by the EP during the MU reporting period are recorded using CPOE.

**Measure 2: More than 60%** of laboratory orders created by the EP during the MU reporting period are recorded using CPOE.

**Measure 3: More than 60%** of diagnostic imaging orders created by the EP during the MU reporting period are recorded using CPOE.

Note that because the EP is permitted, but not required, to limit the measure of Objective 4 to those patients whose records are maintained using certified EHR technology (CEHRT), you must report whether your data was extracted from all patient records or from only patient records maintained using CEHRT.

For more information, see <https://www.cms.gov/files/document/medicaid-ep-2020-cpoe-objective-4.pdf>.

**Objective 5:** The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.




### Meaningful Use Objectives

Objective 5 of 8 - Patient Electronic Access to Health Information

\* indicates a required field

**Objective:** The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

An EP must satisfy both measures for this objective through a combination of meeting the thresholds and exclusions.

**Measure 1:** For more than 80 percent of all unique patients seen by the EP:  
 (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit her or his health information; and  
 (2) The provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT.

**Measure 2:** The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the MU reporting period.

**Measure 1 and Measure 2 Exclusion :** An EP may take the exclusion for either measure, or both, if they have no office visits during the MU reporting period.

\* Does this exclusion apply to you?  
 Yes  No

**Measure 1 and Measure 2 Exclusion :** An EP may take the exclusion for either measure, or both, if they conduct 50 percent or more of her or his patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the MU reporting period.  
 NOTE: There are no counties in NC that are eligible for this exclusion.

\* Does this exclusion apply to you?  
 Yes  No

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\*Measure 1 Numerator:   
 The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.

\*Measure 1 Denominator:   
 The number of unique patients seen by the EP during the MU reporting period.

\*Measure 2 Numerator:   
 The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the MU reporting period.

\*Measure 2 Denominator:   
 The number of unique patients seen by the EP during the MU reporting period.

If the action for Measure 2 occurred in a reporting period other than the one entered on the Measure Reporting Period Page, please report that here:

Start Date:  

End Date:  

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If the exclusions do not apply, EPs meet Objective 5 if they meet the following thresholds for both measures:

**Measure 1:** For **more than 80%** of all unique patients seen by the EP: 1) the patient (or patient-authorized representative) is provide timely access to view online, download, and transmit his or her health information; and 2) the provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's CEHRT.

EPs may meet the second part of this measure if they (1) have enabled an API during the calendar year of the reporting period, (2) make data available via that API for 80% of the patients seen during their reporting period, (3) provide those patients with detailed instructions on how to authenticate their access through the API and provide the patient with supplemental information on available applications that leverage the API, and (4) maintain availability of the API, i.e., it can't be turned on for one day and then disabled.

**Measure 2:** The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to **more than 35%** of unique patients seen by the EP during the MU reporting period.

For Measure 2, actions included in the numerator must occur within the MU reporting period if



that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the MU reporting period occurs (between January 1st and December 31st). For the Patient Electronic Access Tip sheet click on the following link:

[https://www.cms.gov/Regulations- and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidStage3\\_PatientElectronicAccessTipsheet.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidStage3_PatientElectronicAccessTipsheet.pdf)

For more information, see <https://www.cms.gov/files/document/medicaid-ep-2020-patient-electronic-access-objective-5.pdf>.

**Objective 6:** Use CEHRT to engage with patients or their authorized representatives about the patient’s care.



**Meaningful Use Objectives**

**Objective 6 of 8 - Coordination of Care through Patient Engagement**

\* indicates a required field

**Objective:** Use CEHRT to engage with patients or their authorized representatives about the patient’s care.

An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

**Measure 1:** More than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the EHR made accessible by the EP and either—  
 (1) View, download or transmit to a third party their health information; or  
 (2) Access their health information through the use of an Application Programming Interface (API) that can be used by applications chosen by the patient and configured to the API in the EP’s CEHRT; or  
 (3) A combination of (1) and (2).

**Measure 2:** For more than 5 percent of all unique patients seen by the EP during the MU reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative.

**Measure 3:** Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the MU reporting period.

**Measure 1, 2 and 3 Exclusion:** An EP may take an exclusion for any or all measures if they have no office visits during the MU reporting period.

\* Does this exclusion apply to you?

Yes  No

**Measure 1, 2 and 3 Exclusion:** An EP may take an exclusion for any or all measures if they conduct 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the MU reporting period.  
 NOTE: There are no counties in NC that are eligible for this exclusion.

\* Does this exclusion apply to you?

Yes  No

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\*Measure 1 Numerator:

The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the MU reporting period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the MU reporting period.

\*Measure 1 Denominator:

Number of unique patients seen by the EP during the MU reporting period.

If the action for Measure 1 occurred in a reporting period other than the one entered on the Measure Reporting Period Page, please report that here:

Start Date:



End Date:



\*Measure 2 Numerator:

The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the MU reporting period.

\*Measure 2 Denominator:

Number of unique patients seen by the EP during the MU reporting period.

If the action for Measure 2 occurred in a reporting period other than the one entered on the Measure Reporting Period Page, please report that here:

Start Date:



End Date:



\*Measure 3 Numerator:

The number of patients in the denominator for whom data from non-clinical settings, which may include patient-generated health data, is captured through the CEHRT into the patient record during the MU reporting period.

\*Measure 3 Denominator:

Number of unique patients seen by the EP during the MU reporting period.

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If the exclusions do not apply, EPs meet Objective 6 if they satisfy all three measures and meet the thresholds for at least two of the following measures:

**Measure 1: More than 5%** of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either—

1. View, download or transmit to a third party their health information; or
2. Access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or,
3. A combination of (1) and (2).

**Measure 2: More than 5%** of all unique patients seen by the EP during the MU reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

**Measure 3:** Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for **more than 5%** of all unique patients seen by the EP during the MU reporting period.

For the numerator for Measures 1 and 2, the action must occur within the MU reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the MU reporting period occurs (between January 1st and December 31st).

For more information, see <https://www.cms.gov/files/document/medicaid-ep-2020-coordination-care-objective-6.pdf>.

**Objective 7:** The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.



## Meaningful Use Objectives

### Objective 7 of 8 - Health Information Exchange

\* indicates a required field

**Objective:** The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.

An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

**Measure 1:** For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care:  
 (1) Creates a summary of care record using CEHRT; and  
 (2) Electronically exchanges the summary of care record.

**Measure 2:** For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never encountered the patient before, they incorporate into the patient's EHR an electronic summary of care document.

**Measure 3:** For more than 80 percent of transitions or referrals received and patient encounters in which the EP has never encountered the patient before, they perform a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets:  
 (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication.  
 (2) Medication allergy. Review of the patient's known medication allergies.  
 (3) Current Problem list. Review of the patient's current and active diagnoses.

**Measure 1 Exclusion:** An EP may take an exclusion if either or both of the following apply:

- They transfer a patient to another setting or refers a patient to another provider less than 100 times during the MU reporting period.
- They conduct 50 percent or more of her or his patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the MU reporting period may exclude the measures.

NOTE: There are no counties in NC that are eligible for this exclusion.

\* Does this exclusion apply to you?

Yes  No

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**Measure 2 Exclusion:**

An EP may take an exclusion if either or both of the following apply:

- The total transitions or referrals received and patient encounters in which they have never before encountered the patient, is fewer than 100 during the MU reporting period.
- They conduct 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the MU reporting period.

NOTE: There are no counties in NC that are eligible for this exclusion.

\* Does this exclusion apply to you?

Yes  No

**Measure 3 Exclusion:**

An EP may take an exclusion if the total transitions or referrals received and patient encounters in which they have never encountered the patient before, is fewer than 100 during the MU reporting period.

\* Does this exclusion apply to you?

Yes  No

**\*Measure 1 Numerator:**

The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

**\*Measure 1 Denominator:**

Number of transitions of care and referrals during the MU reporting period for which the EP was the transferring or referring provider.

For Measure 1, if the exchange occurred in a reporting period other than the one entered on the Measure Reporting Period Page, please report that here:

Start Date:

End Date:

**\*Measure 2 Numerator:**

The number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the CEHRT.

**\*Measure 2 Denominator:**

Number of patient encounters during the MU reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.

**\*Measure 3 Numerator:**

The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.

**\*Measure 3 Denominator:**

Number of transitions of care or referrals during the MU reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient.

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If the exclusions do not apply, EPs meet Objective 7 if they satisfy all three measures and meet the threshold for at least two of the following measures:

**Measure 1:** For **more than 50%** of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: 1) Creates a summary of care record using CEHRT; and 2) Electronically exchanges the summary of care record.

For measure 1, in order to count in the numerator, the exchange must occur within the MU reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the MU reporting period occurs.

**Measure 2:** For **more than 40%** of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.

**Measure 3:** For **more than 80%** of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs a clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: 1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. 2) Medication allergy. Review of the patient's known medication allergies. 3) Current Problem list. Review of the patient's current and active diagnoses.

For more information, see <https://www.cms.gov/files/document/medicaid-ep-2020-health-information-exchange-objective-7.pdf>.

**Objective 8:** The EP is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.



## Meaningful Use Objectives

### Objective 8 of 8 - Public Health and Clinical Data Registry Reporting

\* indicates a required field

**Objective:** The EP is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.

An EP must satisfy two measures for this objective. If the EP cannot satisfy at least two measures, they may take exclusions from all measures they cannot meet.

**Measure 1:** Immunization Registry Reporting: The EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS)

**Measure 2:** Syndromic Surveillance Reporting: The EP is in active engagement with a PHA to submit syndromic surveillance data.

**Measure 3:** Electronic Case Reporting: The EP is in active engagement with a PHA to submit case reporting of reportable conditions.

**Measure 4:** Public Health Registry Reporting: The EP is in active engagement with a PHA to submit data to public health registries.

**Measure 5:** CDR Reporting: The EP is in active engagement to submit data to a CDR.

**Measure 1 Exclusion:** An EP may take an exclusion if any of the following apply:  
 (1) They do not administer immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or IIS during the MU reporting period;  
 (2) They practice in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the MU reporting period; or  
 (3) They practice in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of six months prior to the start of the MU reporting period.

\* Does this exclusion apply to you?

Yes  No

\* Are you in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS)?

Yes  No

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**Measure 2 Exclusion:** An EP may take an exclusion if any of the following apply:  
(1) They are not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;  
(2) They practice in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the MU reporting period; or  
(3) They practice in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs as of six months prior to the start of the MU reporting period.

\* Does this exclusion apply to you?

Yes  No

\* Are you in active engagement with a PHA to submit syndromic surveillance data from an urgent care setting?

Yes  No

**Measure 3 Exclusion:** An EP may take an exclusion if any of the following apply:  
(1) They do not diagnose or directly treat any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the MU reporting period;  
(2) They practice in a jurisdiction for which no PHA is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the MU reporting period; or  
(3) They practice in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of six months prior to the start of the MU reporting period.

\* Does this exclusion apply to you?

Yes  No

\* Are you in active engagement with a PHA to submit case reporting of reportable conditions?

Yes  No

\* Select your stage of active engagement:

**Completed Registration to Submit Data:** The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the MU reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows EPs to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. EPs that have registered in previous years do not need to submit an additional registration to meet this requirement for each MU reporting period.

**Testing and Validation:** The EP is in the process of testing and validation of the electronic submission of data. EPs must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an MU reporting period would result in that EP not meeting the measure.

**Production:** The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

\* Select the name of the public health registry that you are in active engagement with to submit data.

Please choose specialized registry ▼

\* Are you actively engaged with more than one public health registry?

Yes  No

**Measure 4 Exclusion:**

An EP may take an exclusion if any of the following apply:

- (1) They do diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the MU reporting period;
- (2) They practice in a jurisdiction for which no PHA is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the MU reporting period; or
- (3) They practice in a jurisdiction where no PHA for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the MU reporting period.

\* Does this exclusion apply to you?

Yes  No

\* Are you in active engagement with a PHA to submit data to public health registries?

Yes  No

\* Select your stage of active engagement:

**Completed Registration to Submit Data:** The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the MU reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows EPs to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. EPs that have registered in previous years do not need to submit an additional registration to meet this requirement for each MU reporting period.

**Testing and Validation:** The EP is in the process of testing and validation of the electronic submission of data. EPs must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an MU reporting period would result in that EP not meeting the measure.

**Production:** The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

\* Select the name of the public health registry that you are in active engagement with to submit data.

Please choose specialized registry ▼

\* Are you actively engaged with more than one public health registry?

Yes  No

**Measure 5 Exclusion:** An EP may take an exclusion if any of the following apply:  
 (1) They do diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the MU reporting period;  
 (2) They practice in a jurisdiction for which no CDR is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the MU reporting period; or  
 (3) They practice in a jurisdiction where no CDR for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the MU reporting period.

\* Does this exclusion apply to you?

Yes  No

\* Are you in active engagement to submit data to a CDR?

Yes  No

\* Select your stage of active engagement:

**Completed Registration to Submit Data:** The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the MU reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows EPs to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. EPs that have registered in previous years do not need to submit an additional registration to meet this requirement for each MU reporting period.

**Testing and Validation:** The EP is in the process of testing and validation of the electronic submission of data. EPs must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an MU reporting period would result in that EP not meeting the measure.

**Production:** The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

\* Select the name of the clinical data registry that you are in active engagement.

Please choose specialized registry

\* Are you actively engaged with more than one clinical data registry?

Yes  No

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If the exclusions do not apply, EPs meet Objective 8 if they satisfy at least two measures from the following measures:

**Measure 1 - Immunization Registry Reporting:** The attesting EP is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

**Measure 2 – Syndromic Surveillance Reporting:** The attesting EP is in active engagement with a public health agency to submit syndromic surveillance data from an urgent care setting.

**Measure 3 - Electronic Case Reporting:** The EP is in active engagement with a PHA to submit case reporting of reportable conditions.

**Measure 4 – Public Health Registry Reporting:** The attesting EP is in active engagement with a public health agency to submit data to public health registries.

**Measure 5** – Clinical Data Registry Reporting: The attesting EP is in active engagement to submit data to a clinical data registry.

An exclusion for a measure does not count toward the total of two measures. Instead, in order to meet this objective, an EP would need to meet two of the total number of measures available to them. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than three, the EP can meet the objective by meeting all of the remaining measures available to them and claiming the applicable exclusions. Available measures include ones for which the EP does not qualify for an exclusion.

For more information, see <https://www.cms.gov/files/document/medicaid-ep-2020-public-health-reporting-objective-8.pdf>.

If you cannot find the name of your registry in the drop-down list, please select “Other” and type the name of the registry in the text box that appears.

## Meaningful Use Objectives Summary

The Meaningful Use Objectives Summary page will give the user an overview of their attested information for each of the eight MU Objectives.

**Meaningful Use Objectives Summary**

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

Objective	Data Entered	Edit
Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (CEHRT) through the implementation of appropriate technical, administrative, and physical safeguards.	Yes	<a href="#">Edit</a>
Generate and transmit permissible prescriptions electronically.	Excluded	<a href="#">Edit</a>
Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.	Yes	<a href="#">Edit</a>
Use CPOE for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.	Excluded	<a href="#">Edit</a>
The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.	Excluded	<a href="#">Edit</a>
Use CEHRT to engage with patients or their authorized representatives about the patient's care.	Excluded	<a href="#">Edit</a>
The EP provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT.	Numerator 1=100 Denominator 1=100 Numerator 2=100 Denominator 2=100 Excluded	<a href="#">Edit</a>
The EP is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using CEHRT, except where prohibited, and in accordance with applicable law and practice.	Yes Excluded Yes Excluded Yes	<a href="#">Edit</a>

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- Select *Edit* to change or modify any question within the measure set. If an objective is highlighted in red, this indicates the EP does not meet the objective. If the EP does not meet the objective, s/he will not meet MU and the attestation will be automatically denied.
- Click *Next* to be routed back to the [Measure Navigation Home Page](#).

## Clinical Quality Measures Instructions

After clicking **Begin** for the CQMs on the Measure Navigation Home page, users will be routed to the Clinical Quality Measure Instruction page where they will select **six** of 47 CQMs for which they would like to attest.

EPs may still attest to **any** six of the 47 CQMs. However, in Program Year 2020, CMS is encouraging EPs to report at least one outcome and one high priority measure. If any outcome or high priority CQMs are relevant to your scope of practice, report them first.

If there are no outcome and/or high priority CQMs that are relevant to your scope of practice, please select N/A for that section.

At least one selection must be made for each section and N/A does not count toward the required six CQMs.

**Clinical Quality Measure Instructions**

From the 47 CQMs listed below, you must submit data for six CQMs relevant to your scope of practice. Per CMS, at least one of the CQMs must be an outcome measure, if any are relevant. If no outcome measures are relevant, you must select at least one other high priority measure. If no high priority measures are relevant, you may report on any six CQMs that are relevant to your scope of practice.

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

At least one selection must be made for each section. If there are no outcome and/or high priority CQMs that are relevant to your scope of practice, please select N/A for that section.

Section 1: Outcome Measures	
<i>Of your six CQMs, select at least one outcome measure that is relevant to your scope of practice.</i>	
<input type="checkbox"/> CMS 75v8	Children Who Have Dental Decay or Cavities
<input type="checkbox"/> CMS 122v8	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
<input type="checkbox"/> CMS 133v8/NQF 0565	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
<input type="checkbox"/> CMS 159v8/NQF 0710	Depression Remission at Twelve Months
<input type="checkbox"/> CMS 165v8	Controlling High Blood Pressure
<input type="checkbox"/> CMS 771v1	International Prostate Symptom Score (IPSS) or American Urological Association-Symptom Index (AUA-SI) Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia
<input type="checkbox"/> N/A	None of these CQMs are relevant to my scope of practice
Section 2: High Priority Measures	
<i>If there are no outcome measures that are relevant to your scope of your practice, select at least one high priority measure.</i>	
<input type="checkbox"/> CMS 2v9/NQF 0418	Preventative Care and Screening: Screening for Depression and Follow-Up Plan
<input type="checkbox"/> CMS 50v8	Closing the Referral Loop: Receipt of Specialist Report
<input type="checkbox"/> CMS 56v8	Functional Status Assessment for Total Hip Replacement
<input type="checkbox"/> CMS 66v8	Functional Status Assessment for Total Knee Replacement
<input type="checkbox"/> CMS 68v9/NQF 0419	Documentation of Current Medications in the Medical Record
<input type="checkbox"/> CMS 90v9	Functional Status Assessments for Congestive Heart Failure
<input type="checkbox"/> CMS 125v8	Breast Cancer Screening
<input type="checkbox"/> CMS 128v8	Anti-depressant Medication Management
<input type="checkbox"/> CMS 129v9/NQF 0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

- Click the box next to the CQMs for which you would like to attest.
- After six CQMs are selected, click 'Next' to route to the first of the six selected CQMs.

## Clinical Quality Measures Summary

After completing six CQMs, the user will be routed to the Clinical Quality Measures Summary page.



**Clinical Quality Measures Summary**

Clinical Quality Measures Summary 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
CMS 154v7/NQF 0069	Numerator = 5 Denominator = 5	<a href="#">Edit</a>
CMS 155v7/NQF 0024	Numerator 1 = 10 Denominator 1 = 10 Numerator 2 = 10 Denominator 2 = 10 Numerator 3 = 10 Denominator 3 = 10	<a href="#">Edit</a>
CMS 82v6	Numerator = 90 Denominator = 90	<a href="#">Edit</a>
CMS 143v7/NQF 0086	Numerator = 50 Denominator = 50	<a href="#">Edit</a>
CMS 145v7/NQF 0070	Numerator = 3 Denominator = 7	<a href="#">Edit</a>
CMS 149v7/NQF 2872	Numerator = 10 Denominator = 10	<a href="#">Edit</a>

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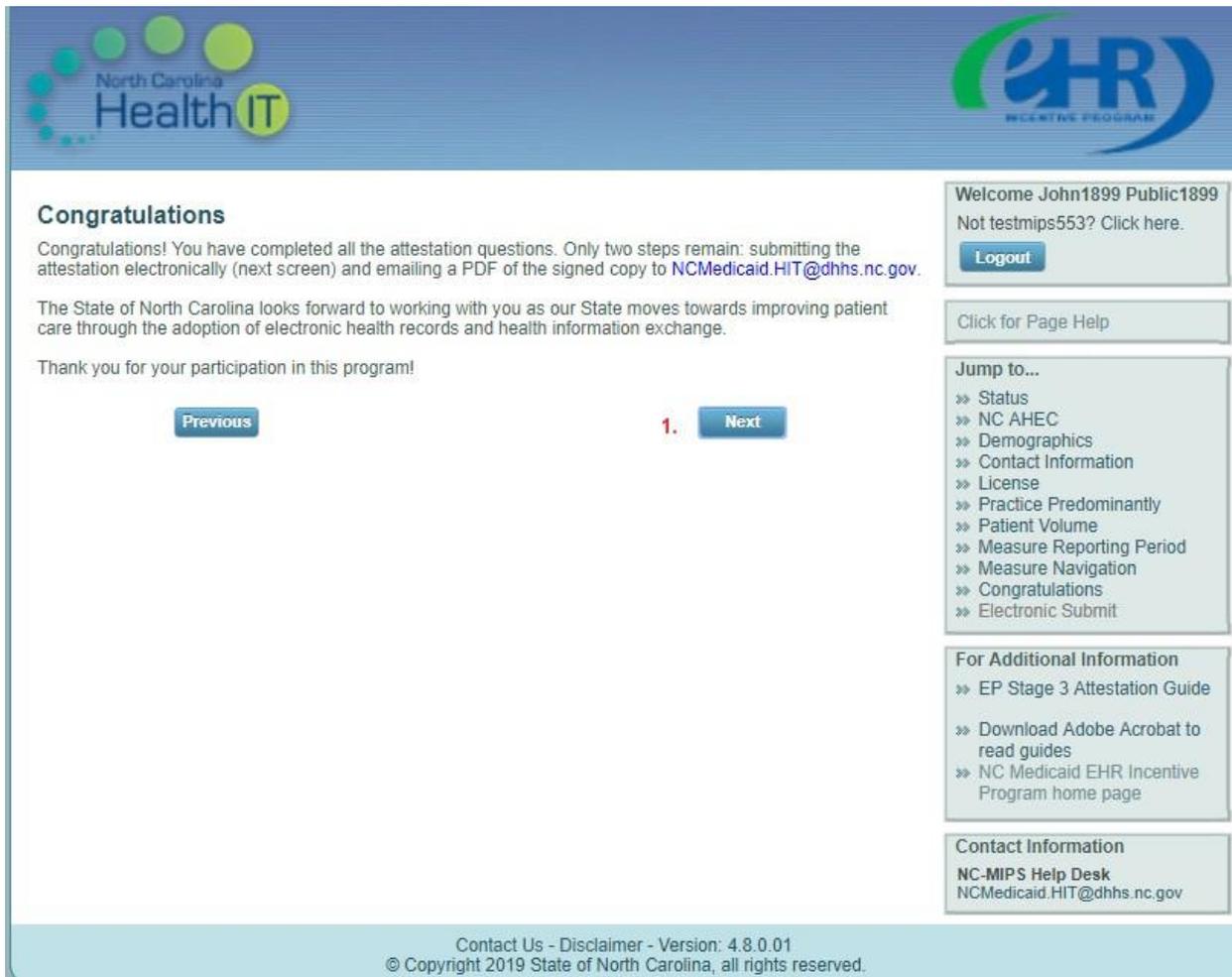
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- Select *Edit* to change or modify any question within the measure set.
- Click *Next* to be routed back to the [Measure Navigation Home Page](#).

## Congratulations

Congratulations! The attestation questions are now complete.



**Congratulations**

Congratulations! You have completed all the attestation questions. Only two steps remain: submitting the attestation electronically (next screen) and emailing a PDF of the signed copy to [NCMedicaid.HIT@dhs.nc.gov](mailto:NCMedicaid.HIT@dhs.nc.gov).

The State of North Carolina looks forward to working with you as our State moves towards improving patient care through the adoption of electronic health records and health information exchange.

Thank you for your participation in this program!

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1. Click [Next](#) to move to the Electronic Submission page.

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.



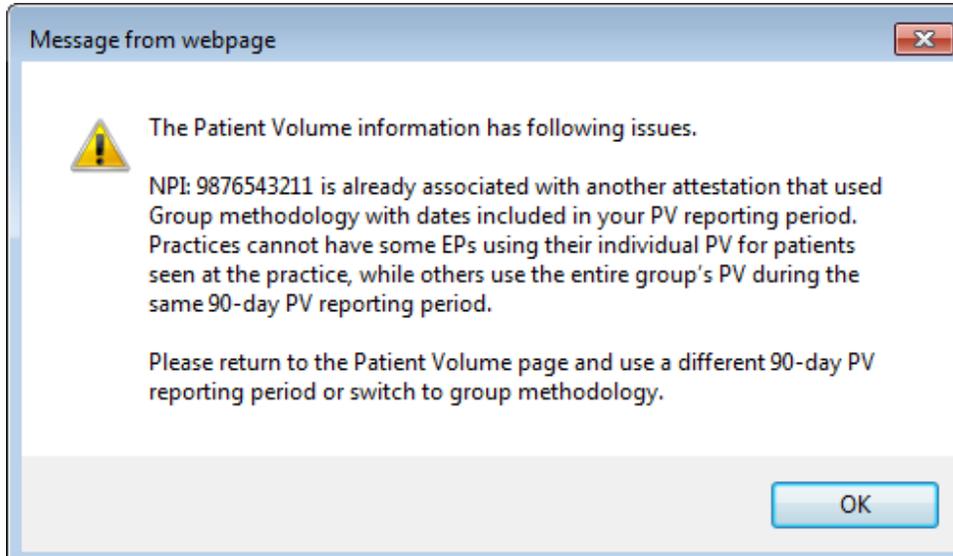
The screenshot shows the 'Electronic Submission' page. At the top left is the 'North Carolina Health IT' logo, and at the top right is the 'EHR INCENTIVE PROGRAM' logo. The main heading is 'Electronic Submission'. Below it is a numbered list with one item: '1. Concealment or falsification of material facts regarding incentive payment can result in Medicaid Provider Payment suspension, civil prosecution pursuant to the False Claims Act (31 USC 3729-3733), Medical Assistance Provider Fraud (N.C.G.S. 108A-63), Medical Assistance Provider False Claims Act (N.C.G.S. 108A-70.10 to 70-16), the North Carolina False Claims Act (N.C.G.S. 1-605 to 1-618), and/or criminal prosecution pursuant to criminal fraud statutes of North Carolina.' Below this is a statement: 'This is to certify that the foregoing information is true, accurate, and complete. I understand that Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State law.' Item 2 is a checkbox with the text 'I have read the above statements and attest to my responses.' Below this are 'Previous' and 'Submit' buttons. On the right side, there are several utility boxes: 'Welcome John1899 Public1899' with a 'Logout' button; 'Click for Page Help'; 'Jump to...' with a list of links including Status, NC AHEC, Demographics, Contact Information, License, Practice Predominantly, Patient Volume, Measure Reporting Period, Measure Navigation, Congratulations, and Electronic Submit; 'For Additional Information' with links to 'EP Stage 3 Attestation Guide', 'Download Adobe Acrobat to read guides', and 'NC Medicaid EHR Incentive Program home page'; and 'Contact Information' with 'NC-MIPS Help Desk' and 'NCMedicaid.HIT@dhhs.nc.gov'. At the bottom, a footer contains 'Contact Us - Disclaimer - Version: 4.8.0.01' and '© Copyright 2019 State of North Carolina, all rights reserved.'

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*.

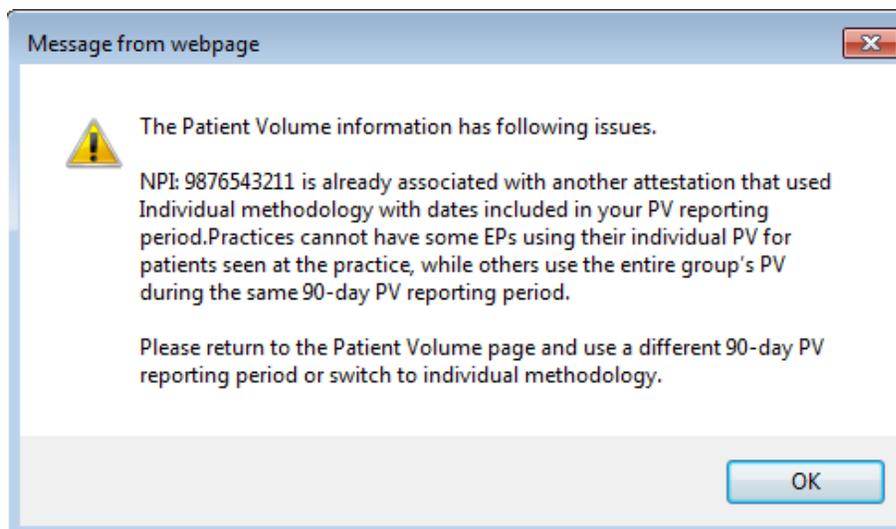
The [Print, Sign, Send](#) page opens.

If you attested using individual methodology for PV and another provider previously attested using group methodology with the same billing NPI you used during the same PV reporting period, you will see the following error message:



As instructed, please return to the PV page and use a different 90-day PV reporting period or switch to group methodology.

If you attested using group methodology for PV and another provider previously attested using individual methodology with the same billing NPI you used during the same PV reporting period, you will see the following error message:

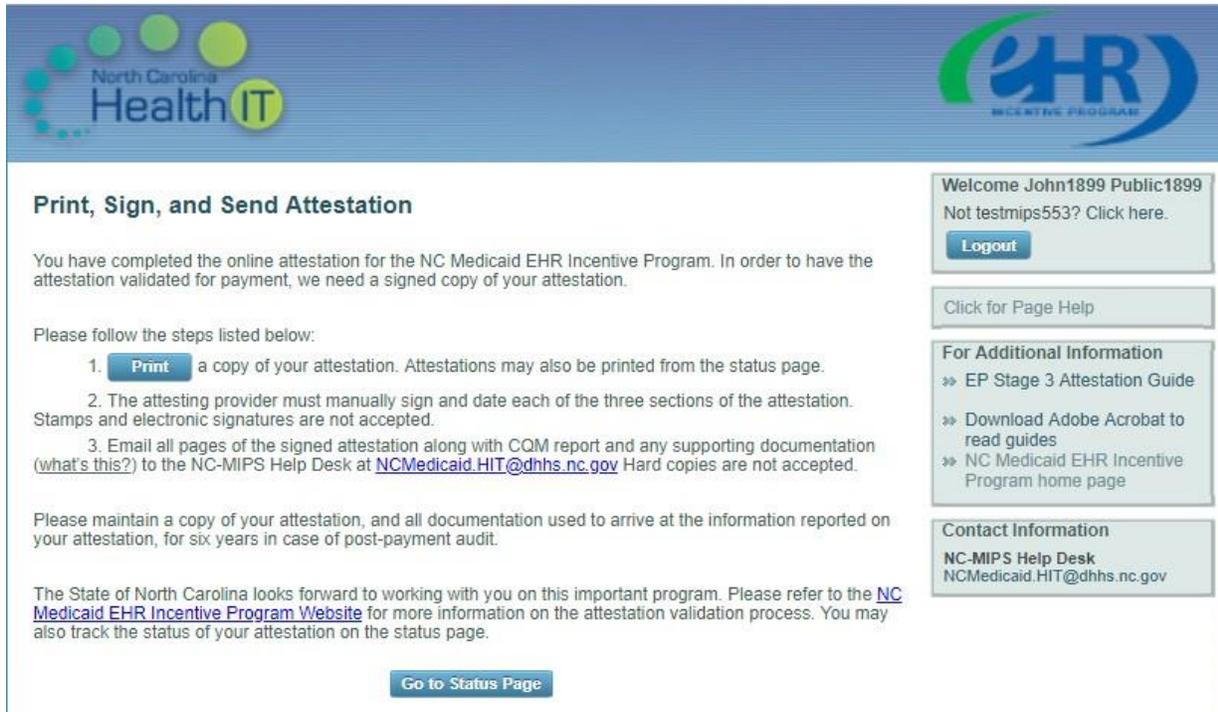


As instructed, please return to the PV page and use a different 90-day PV reporting period or switch to individual methodology.

Providers who are in the same practice must use only one methodology per 90-day reporting period (in other words, clinics could not have some of the EPs using their individual PV for patients seen at the clinic, while others use the practice-level data during the same 90-day reporting period).

## 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 emailed to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).



**Print, Sign, and Send Attestation**

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

Please follow the steps listed below:

1. **Print** a copy of your attestation. Attestations may also be printed from the status page.
2. The attesting provider must manually sign and date each of the three sections of the attestation. Stamps and electronic signatures are not accepted.
3. Email all pages of the signed attestation along with CQM report and any supporting documentation ([what's this?](#)) to the NC-MIPS Help Desk at [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov). Hard copies are not accepted.

Please maintain a copy of your attestation, and all documentation used to arrive at the information reported on your attestation, for six years in case of post-payment audit.

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

[Go to Status Page](#)

Welcome John1899 Public1899  
Not testmips553? Click here.  
[Logout](#)

[Click for Page Help](#)

**For Additional Information**  
 » EP Stage 3 Attestation Guide  
 » Download Adobe Acrobat to read guides  
 » NC Medicaid EHR Incentive Program home page

**Contact Information**  
 NC-MIPS Help Desk  
[NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)

To finish the attestation process:

1. Click *Print* to print the attestation.
2. The attesting EP must sign and date the printed attestation her/himself 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. Email the signed attestation, the signed MU Objectives Summary Page, the signed CQM Summary Page, the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs and any supporting documentation to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).
5. Physician assistants (PAs) are only eligible to participate if they furnish services at a PA-led FQHC or RHC. This applies to all PAs in a practice. If an EP is attesting to meeting PA eligibility requirements, s/he must submit on letterhead a memo explaining s/he meets one of the three following criteria:

1. The 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. The PA is a clinical or medical director at a clinical site of practice; or,
3. The PA is an owner of an RHC.

## Attestation Statements in Program Year 2020

For EPs, the summary PDF will include this section covering the attestation statements below. The attesting provider must review each attestation statement. The provider's signature is acknowledgement that the statements are true, accurate and complete.

With my signature below, I attest that I

1. Acknowledge the requirement to cooperate in good faith with ONC direct review of my health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received; and
2. If requested, cooperated in good faith with ONC direct review of my health information technology certified under the ONC Health IT Certification Program as authorized by 45 CFR part 170, subpart E, to the extent that such technology meets (or can be used to meet) the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the EP in the field.
3. Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.
4. Implemented technologies, standards, policies, practices, and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times—
  - a. Connected in accordance with applicable law;
  - b. Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;
  - c. Implemented in a manner that allowed for timely access by patients to their electronic health information; and
  - d. Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300jj(3)), including unaffiliated providers, and with disparate certified EHR technology and vendors.
5. Responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers (as defined by 42 U.S.C. 300jj(3)), and other persons, regardless of the requestor's affiliation or technology vendor.

### Certification Statement

Concealment or falsification of material facts regarding incentive payment can result in Medicaid Provider Payment suspension, civil prosecution pursuant to the False Claims Act (31 USC 3729- 3733), Medical Assistance Provider Fraud (N.C.G.S. 108A-63). Medical Assistance Provider False Claims Act (N.C.G.S. 108A-70.10 to 70-16), the North Carolina False Claims Act (N.C.G.S. 1-605 to 1-618), and/or criminal prosecution pursuant to criminal fraud statutes of North Carolina.

This is to certify that the foregoing information is true, accurate, and complete. I understand



that Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State law.

I will keep all documentation, including patient-level detail, supporting the information attested to for six years from the date payment is received. I understand that if I fail post-payment audit, the incentive payment must be returned to the state.

I have read the above statements and attest *my* responses.

## Next Steps

Please email the signed attestation, the signed MU Objectives Summary Page, the signed CQM Summary Page, the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs and any supporting documentation to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) within seven days of submitting the attestation through NC-MIPS. We cannot begin the validation process until we have received the email with the required documents.

EPs can 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. It typically takes eight to 12 weeks to complete the validation process, however, it can be longer for attestations received during our high-volume peak time of March through April.

The deadline to attest for the NC Medicaid EHR Incentive Program for Program Year 2020 is April 30, 2021. All Program Year 2020 attestations must be submitted through NC-MIPS. The information submitted on NC-MIPS must be complete and valid by April 30, 2021. We will not accept memorandums in lieu of accurate information submitted through NC-MIPS. NC-MIPS will close for Program Year 2020 on April 30, 2021 so no changes may be made to the attestation after this date.

We guarantee to review the provider's attestation, and conduct outreach if needed, if we receive the signed attestation and required documentation via email by February 28, 2021. Attestations received after this date are not guaranteed to be reviewed, so it is extremely important that EPs review their attestation before submitting.

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

Typically speaking, payments are made via electronic funds transfer (EFT). If in the rare case a paper check is issued, the check will be sent 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.

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



## Additional Resources

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

[NC Medicaid EHR Incentive Program website](#)

[CMS' Promoting Interoperability Program Website](#)

[Program Year 2020 Clinical Quality Measures](#)

[HealthIT.gov](#)

[ONC's Certified Health IT Product List](#)

If you're having issues identifying which measure you should report or how you should report them, the best resource is 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.