North Carolina Medicaid Electronic Health Record
Incentive Program

Eligible Professional Stage 3 Meaningful Use
Attestation Guide for Program Year 2019

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 MU NC Medicaid EHR incentive payment on the NC Medicaid EHR Incentive Payment System (NC-MIPS).

Step-by-step guidance and screenshots are provided throughout the attestation guide to assist participants 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.
Website Resources
The links below contain additional information regarding program requirements, important program announcements and more.


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.


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.

In addition to these resources, you can contact our technical assistance partners at your local 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, 252-813-8613. Serving Edgecombe, Halifax, Nash, Northampton, and Wilson counties.


   **Eastern AHEC** - Angel Moore, 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, 336-832-4393 (office) or 336-662-5810 (cell). Serving Alamance, Caswell, Chatham, Guilford, Montgomery, Orange, Randolph, and Rockingham counties.

Northwest AHEC - Chris Jones, 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, 910-667-9350. Serving Brunswick, Columbus, Duplin, New Hanover, and Pender counties.

Southern Regional AHEC - Donna Bowen, Donna.Bowen@sr-ahec.org, 910-678-0119. Serving Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Robeson, Sampson, and Scotland 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 be responsible for attesting 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 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 2019 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](http://www.certifiedhealthit.gov);
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 2019 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](http://www.medicaid.gov) 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 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 2019, 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 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 2019
For Program Year 2019, 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 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, 2020 to attest for Program Year 2019. 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, 2020.

The information submitted on NC-MIPS must be complete and valid by April 30, 2020. We will not accept memorandums in lieu of accurate information submitted through NC-MIPS. NC-MIPS will close for Program Year 2019 on April 30, 2020 so no changes may be made to the attestation after this date.

Before Attesting
Before getting started, check the MU measures that will be collected during the MU objective and CQM reporting period and work with the EHR vendor to ensure the EHR is a 2015 Edition and certified to capture those measures.
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 the EP’s 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, 2020 for Program Year 2019, the previous calendar year is 2018 and the 12 months immediately preceding the date attestation would be 2/1/19-1/31/20.

- **Meaningful Use (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 2019, the MU reporting period will be a consecutive 90-day period or full calendar year 2019 (1/1/19-12/31/19). In Program Year 2019, CMS is allowing all providers to use a 90-day MU reporting period.

- **CQM reporting period** - In Program Year 2019, EPs attesting to meaningful use for the first time may use a 90-day CQM reporting period. EPs who have attested successfully to MU in a prior program year will be required to use a full calendar year CQM reporting period.

Recommended Documentation

After attesting, it is recommended that the following documents (if applicable) be emailed with the EP’s signed attestation:

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

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

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

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

- Welcome
- First Time Account Setup (for new users only!)
- 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 top left logo is a link to the [North Carolina Health Information Technology (HIT) website](https://www.healthit.nc.gov).

The top right logo is a link to [CMS’ Promoting Interoperability (PI) Program website](https://www.cms.gov) (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 completing a First Time Account Setup? 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? If you are having problems logging in to [https://ncid.nc.gov](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 if there are questions.

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.

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 on one time.

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 NCIDusername.
5. Enter the EP’s unique NCIDpassword.
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 – it does not change the NCID or NCID password on 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.

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’ 2018 has expired and the EP is ready to attest for Program Year 2019. The row will be marked as “Closed-No Attestation Submitted” and the Program Year 2019 row will be active.

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Payment Year</th>
<th>Current Status</th>
<th>Payment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>2</td>
<td>Ready to Attest</td>
<td>Proceed</td>
</tr>
<tr>
<td>2018</td>
<td>2</td>
<td>Closed - No Attestation Submitted</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>2</td>
<td>Closed - No Attestation Submitted</td>
<td></td>
</tr>
</tbody>
</table>

**Example 2:** If the Program Year 2019 has been ‘Denied’, the EP has the option to re-attest for the denied attestation if the program year is active.

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Payment Year</th>
<th>Current Status</th>
<th>Payment Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td>2</td>
<td>Attestation Denied</td>
<td>Re-attest</td>
</tr>
<tr>
<td>2018</td>
<td>2</td>
<td>Closed - No Attestation Submitted</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>2</td>
<td>Closed - No Attestation Submitted</td>
<td></td>
</tr>
</tbody>
</table>
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.
When the pop-up appears, click **OK** to confirm that you want to withdraw.

Example 4: The EP has been paid for Program Year 2019.
1. Select yes or no for the question, “Have you received any assistance related to electronic health record (EHR) technology since January 1, 2019 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, 2016, 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, 2016, 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.
   - 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, 2019, have you received assistance from the NC AHEC with attesting for the NC Medicaid EHR Incentive Program?
   - Yes □
   - No □

* 5) Since January 1, 2019, have you utilized any of the following services NC AHEC provides in support of NC HealthConnex? Select all that apply.
   - 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 ▼

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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, Catawba, Cleveland, 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
2. Select yes or no for the question, “Since January 1, 2019, 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, 2019, 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, 2019, have you received assistance from the NC AHEC with attesting for the NC Medicaid EHR Incentive Program?”

5. For the question, “Since January 1, 2019, 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 specific 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.

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 above from CMS match 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 predominately, 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:

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 50 percent.
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:

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:

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:

\[
\text{(All Medicaid-paid encounters + all Medicaid-enrolled zero-pay encounters)}/\text{Total encounters}
\]

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 2019, this would be a 90-day period in 2018 regardless of the date of attestation); **OR,**
2. A consecutive 90-day period in the 12-month period preceding the date of the attestation.

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
   - 12 months preceding today
   - Previous calendar year

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.

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Your Total Encounters at Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice’s Billing NPI</th>
<th>Medicaid Encounters Billed under this NPI</th>
<th>Medicaid Enrolled Zero Pay Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Add another NPI for this Practice
Add Another Practice Name

Medicaid Patient Encounters (Numerator)
13.
Total Patient Encounters (Denominator)
14.
Medicaid Patient Volume Percentage (Medicaid / Total)
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 2019, previous calendar year would be 2018 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.
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
- 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.

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Number of Group Members During 90-day Period</th>
<th>Total Encounters for All Group Members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.</td>
<td>6.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group’s Billing NPI</th>
<th>Medicaid Encounters Billed under this NPI</th>
<th>Medicaid Enrolled Zero Pay Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.</td>
<td>9.</td>
</tr>
</tbody>
</table>

**Add another Group NPI**

1. Medicaid Patient Encounters (Numerator) 0
2. Total Patient Encounters (Denominator) 0
3. Medicaid Patient Volume Percentage (Medicaid / Total) 0%

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 2019, previous calendar year would be 2018 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.
15. 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.

16. 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:
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?  

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.

![Image of patient volume screen](image)

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.

EPs who are attesting to MU for the first time will see the following when they reach the Measure Reporting Period page:

To enter Meaningful Use activities:
1. Under “Please identify your Meaningful Use (MU) reporting period,” select a button to indicate the reporting period to which you are attesting. In Program Year 2019, CMS is allowing all providers to use a 90-day MU reporting period. Note: When attesting for Program Year 2019, the MU objective data will come from calendar year 2019.
2. Enter the ‘Start Date’ of the consecutive 90-day or full calendar year MU reporting period.
3. Enter the ‘End Date’ of the consecutive 90-day or full calendar year MU reporting period.
4. 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 8.
   - If you choose Yes during step 4, you will be prompted to enter a 90-day or full calendar year CQM reporting period. **EPs attesting to MU for the first time in Program Year 2019 may use a 90-day CQM reporting period.**

5. If you choose Yes during step 4, select a button to indicate the reporting period to which you are attesting.

6. If you choose Yes during step 4, enter the ‘Start Date’ of the consecutive 90-day or full calendar year CQM reporting period.

7. If you choose Yes during step 4, enter the ‘End Date’ of the consecutive 90-day or full calendar year CQM reporting period.

8. Enter the Practice Name(s) where the individual EP had encounters during the MU reporting period.

9. Enter the Practice Address(es) where the EP had encounters during the MU reporting period.

10. 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.

11. 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.

12. If you worked at more than one location during the MU reporting period, click ‘Add a location’ to enter the additional practice’s information and follow steps 8-11.

13. 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.

14. Click Next. The **Measure Navigation Home page** will open.
EPs who had successfully attested to MU in a previous program year will see the following when they reach the Measure Reporting Period page:

To enter Meaningful Use activities:

1. Under “Please identify your Meaningful Use objective reporting period,” select a button to indicate the reporting period to which you are attesting. In Program Year 2019, CMS is allowing all providers to use a 90-day MU reporting period. Note: When attesting for Program Year 2019, the MU objective data will come from calendar year 2019.

2. Enter the ‘Start Date’ of the consecutive 90-day or full calendar year MU reporting period.

3. Enter the ‘End Date’ of the consecutive 90-day or full calendar year MU reporting period.

4. Enter the Practice Name(s) where the individual EP had encounters during the MU reporting period.

5. Enter the Practice Address(es) where the EP had encounters during the MU reporting period.

6. Enter the individual EP’s encounters for the MU reporting period. NOTE: This number should reflect the individual attesting EP’s 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.

7. Select Yes if the practice location was equipped with CEHRT. Select No if the practice location was not equipped with CEHRT.

8. If the EP 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 4-7.

9. The percentage of the EP’s encounters equipped with CEHRT 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.

10. 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 Meaningful Use Objectives and Clinical Quality Measures.

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

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. Please include the provider name, NCID, NPI, program year, a screenshot of the error message being received (if applicable) and a brief explanation of the problem.
The Measure 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 Clinical Quality Measures (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** with the signed attestation.

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_Stage3Medicaid.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAnalysis_Tipsheet_Stage3Medicaid.pdf).

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

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.

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

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 clinical quality measures (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).

**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 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
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.

**Objective 5:** The EP provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.
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 provided timely access to view online, download, and transmit their 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 reporting period.
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:


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

**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.
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.

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.
* 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 PI reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each PI reporting period.

- **Testing and Validation:** The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an PI reporting period would result in that provider 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.

**Measure 2 Exclusion:** An EP may take an exclusion if any of the following apply:

1. S/he is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system;
2. S/he or s/he practices 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. S/he or s/he practices 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

**Measure 3 Exclusion:** An EP may take an exclusion if any of the following apply:

1. S/he or s/he does 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. S/he or s/he practices 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. S/he or s/he practices 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
Measure 4 Exclusion: An EP may take an exclusion if any of the following apply:
(1) S/he does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the MU reporting period;
(2) S/he practices 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) S/he practices 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 PI reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each PI reporting period.
  ☐ Testing and Validation: The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an PI reporting period would result in that provider 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) S/he does not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the MU reporting period;
(2) S/he practices 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) S/he practices 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
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.

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.

- 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 Clinical Quality Measures Measure set on the Measure Navigation Home page, users will be routed to the Clinical Quality Measures Instruction page where they will select six of 50 CQMs for which they would like to attest.

EPs may still attest to any six of the 50 CQMs. However, in Program Year 2019, 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.

- 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 Clinical Quality Measures, the user will be routed to the Clinical Quality Measures Summary page.

- 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.

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.

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 group 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.

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. Collect any supporting documentation to send with the signed attestation (optional).
5. 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.
Attestation Statements in Program Year 2019

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 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 2019 is April 30, 2020. All Program Year 2019 attestations must be submitted through NC-MIPS. The information submitted on NC-MIPS must be complete and valid by April 30, 2020. We will not accept memorandums in lieu of accurate information submitted through NC-MIPS. NC-MIPS will close for Program Year 2019 on April 30, 2020 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, 2020. 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 2019 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.