North Carolina
Medicaid Special Bulletin

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Attention:
All Providers

Electronic Health Record (EHR) Incentive Program

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I. Overview and North Carolina Landscape

The Health Information Technology (HIT) Program at the N.C. Division of Medical Assistance (DMA) administers the N.C. Medicaid Electronic Health Record (EHR) Incentive Program. This program is just one of many initiatives under the U.S. Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, which is designed to promote and advance the smart use of information technology (IT) in the healthcare field. The EHR Incentive Program provides financial assistance to healthcare professionals and hospitals that serve a large number of N.C. Medicaid patients and that are making the transition from paper to electronic.

By promoting the widespread adoption and meaningful use of EHR, we hope to see N.C. Medicaid providers use HIT to improve care, gain efficiencies, and reduce costs. These benefits can be achieved by leveraging clinical data, utilizing decision support tools, and improving care coordination through meaningful health information exchange.

The N.C. Medicaid EHR Incentive Program provides the opportunity for eligible professionals (EPs) to receive up to $63,750, and eligible hospitals (EHs) are projected to receive incentive payments ranging from $388,000 to $5.6 million over the course of their participation in the program.

The N.C. Medicaid EHR Incentive Program exists within a larger and more complex HIT landscape in North Carolina. Atop a foundation of regional health information exchange and EHR adoption, the HITECH Act is at work in North Carolina on many projects statewide, including but not limited to:

- Building a statewide health information exchange for providers (NC HIE);
- Providing technical assistance to providers implementing EHRs at the practice level through a Regional Extension Center (REC) Program (N.C. Area Health Education Centers);
- Educating HIT professionals (Pitt Community College Health IT Workforce Training Program); and
- Implementing advanced health IT practices within a standout community program to develop and contribute to the national discussion on best practices (Southern Piedmont Beacon Community Program).

North Carolina was a national early adopter of the N.C. Medicaid EHR Incentive Program, disbursing the first incentive payments in March 2011. It is estimated that 3,524 North Carolina professionals and 92 North Carolina hospitals currently meet the eligibility criteria to participate in the N.C. Medicaid EHR Incentive Program. **Of those, N.C. Medicaid has paid 1,763 Medicaid providers, including 1,727 professionals and 36 hospitals, a total of $64.99 million as of October 14, 2012.**

II. Eligibility and N.C. Medicaid Patient Volume

1. Eligibility

Two EHR Incentive Programs exist under the HITECH Act: the Medicaid Incentive Program and the Medicare Incentive Program. EPs must choose to participate in either the Medicaid or the Medicare EHR Incentive Program; per CMS, EPs may only participate in one EHR Incentive Program. For more information on Medicare programs, visit the CMS Website at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/. EHs may be deemed "dually eligible" and receive incentive payments from both programs. All EHs in the state of North Carolina qualify as dually eligible.

If EPs have at least 30 percent* of a provider's patient encounters are paid in part or whole by Medicaid, they could be eligible to participate in the N.C. Medicaid EHR Incentive Program. These providers include:

- Physicians (MDs and DOs);
- Nurse practitioners;
- Certified nurse midwives;
- Dentists; and,
- Physician assistants who furnish services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) **led** by a physician assistant.

Acute Care and Critical Access Hospitals must demonstrate at least 10 percent of patient encounters were paid in part or whole by Medicaid.

**Special rules apply to professionals who practice predominantly in a FQHC or RHC and to pediatricians. For more information, please visit www.ncdhhs.gov/dma/provider/ehr.htm.*

To determine eligibility for the incentive programs, use the CMS Eligibility Wizard at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligibility.html. If eligible, please see additional information on registration and attestation in VI. Path to Payment.

2. Medicaid Patient Volume

The Medicaid Patient Volume (PV) percentage is the ratio of encounters (as defined in Attachment E) paid at least in part by Medicaid to all encounters paid by any source. EPs should calculate PV for any continuous 90-day period from the previous calendar year. EPs must count an encounter as a service rendered where medical treatment is provided and/or evaluation and management services are rendered on any one day to one individual.

Medicaid PV Percentage:
Medicaid PV = All encounters paid in part or whole by Medicaid in 90-day period
Total PV = All encounters, regardless of the payment method in the same 90-day period

EPs can attest as individuals or with their group practice. The above calculation applies for both individuals and groups.

To participate in the Medicaid EHR Incentive Program, providers' Medicaid PV Percentage must be at least 30 percent. There are two exceptions:

1. Pediatricians are allowed an exception to the 30 percent threshold and can participate with 20 percent Medicaid PV for a reduced payment. Patient volume is reported for each program year, so pediatricians qualify on an annual basis for a full or reduced incentive payment based on their PV percentage. For example, if a pediatrician qualifies for a first year payment with a 20 Percent PV threshold and receives a reduced incentive payment but is able to meet the 30 percent threshold the following year, that pediatrician qualifies for the full incentive payment and is not locked into the reduced 20 percent incentive payment for their year two payment.

2. EPs practicing predominantly at an FQHC or RHC can reach the 30 percent threshold by including needy individuals (for example, sliding scale or no pay) in addition to their Medicaid PV in their numerator.

For more information on FQHCs and RHCs, visit the DMA EHR FAQ page at http://www.ncdhhs.gov/dma/ehr/ehrfaq.htm.

DMA uses paid N.C. Medicaid claims and the EP's identification information provided at attestation to validate Medicaid PV. The total PV to which an EP attests is only verified at post-payment audit. EPs are encouraged to submit any additional documentation that explains non-standard billing practices at the time of attestation. If there is a problem verifying the Medicaid PV and DMA will request additional information.

A detailed explanation of Medicaid PV is provided in the revised guidance, *Eligible Professional Patient Volume Requirements*, which is Attachment E of this bulletin.

Eligible Hospitals

The Medicaid PV percentage for EHs is the ratio of Total Medicaid Acute Care Inpatient Discharges plus Total Medicaid Emergency Department (ED) visits to Total Acute Care Inpatient Discharges plus Total ED Visits. Hospitals may calculate their PV for any continuous 90-day period from the preceding federal fiscal year.

Medicaid PV Percentage:

Medicaid PV = Total Medicaid Acute Care Inpatient Discharges + Total Medicaid ED Visits
Total PV = Total Acute care Inpatient Discharges + Total ED Visits

To participate in the Medicaid EHR Incentive Program, an EH must have a minimum of 10 percent Medicaid PV. Medicaid EHs include acute care hospitals, and may also include critical access hospitals, cancer hospitals, and children's hospitals. Children's hospitals are allowed an exception and do not have to meet the 10 percent Medicaid PV threshold to participate in the Medicaid EHR Incentive Program.

To validate N.C. Medicaid PV, DMA uses as-filed, full 12-month Medicaid Cost Report data associated with a single CMS Certification Number and the EH's identification information provided at attestation. The total PV to which an EH attests is verified prior to issuing an incentive payment. If there is a problem verifying Medicaid PV, DMA will requests additional information to assist in the validation process.

III. Program Participation Timeline

The N.C. Medicaid EHR Incentive Program was officially launched in 2011 and is expected to continue until 2021. EPs must participate in any six of the 10 years. EHs must participate for three years.

The Medicaid EHR Incentive Program presents a phased approach to EHR adoption. The first participation year (also called a "payment year," unique to each EP's or EH's participation timeline) is reserved for what is called "AIU" or "Adopt, Implement, Upgrade." This gives participants time to adopt to a nationally certified EHR technology. Each subsequent participation year requires providers to demonstrate that they are "meaningfully using" their EHR by reporting on a variety of summary and clinical measures.

IV. What is Adopt/Implement/Upgrade (AIU)?

Medicaid provides a first-year incentive payment to EPs and EHs that adopt, implement, or upgrade (AIU) certified EHR technology. AIU encompasses a wide range of activities such as purchasing and installing certified EHR technology, preparing data use agreements and training staff.

NOTE: It is not a requirement to attest to AIU during the first year of program participation. If an EP so chooses, he/she can attest to meaningful use (MU) during their first year of participation in the NC Medicaid EHR Incentive Program. The first year payment will be the same ($21,250) regardless of whether the attestation is AIU or MU.

- **Adopt** means that a provider has acquired, purchased or secured access to certified EHR technology. For providers to qualify for EHR incentive payments, their EHR technology must be tested and certified by an Office of the National Coordinator (ONC) Authorized Testing and Certification Body (ATCB). The list of certified products is located at oncchpl.force.com/ehrcert.

- **Implementation** means a provider has installed or commenced utilization of certified EHR technology capable of meeting meaningful use requirements. Indications of implementation include staff training, data entry into the EHR, data exchange agreements, and other activities.

- **Upgrade** means expanding the available functionality of certified EHR technology, such as adding clinical decision support, e-prescribing functionality, or other enhancements that facilitate the meaningful use of the EHR technology. It could also include upgrading from an existing version of the EHR technology to a newer version.

The attestation tail period is a period of time beyond the end of the Fiscal Year (for EHs) or Calendar Year (for EPs) during which providers may attest for an incentive payment for the previous year.

For a 2012 payment, NC has extended the attestation tail period from 60 to 120 days to allow for attestation beyond the end of the Fiscal Year for EHs or the Calendar Year for EPs. This means, for EHs the last day to attest for a year 2012 payment is January 28, 2013 and for EPs the last day to attest for a year 2012 payment is April 30, 2012.

For more information on EHR incentive program deadlines, visit the DMA EHR Website www.ncdhhs.gov/dma/provider/ehr.htm.

To attest for an AIU payment, visit the N.C. Medicaid Incentive Payment System (NC-MIPS) portal at ncmips.nctracks.nc.gov/.

V. What is Meaningful Use (MU)?

"Meaningful Use" means that certified EHR technology is being used:

- In a meaningful manner, such as e-prescribing;
- For electronic exchange of health information to improve quality of health care; and
- To submit clinical quality and other measures.

EPs and EHs must demonstrate MU of their certified EHR technology to continue receiving incentive payments after receipt of a first-year payment. Attesting to MU in the second participation year requires reporting on 90 continuous days of meaningful use of the certified EHR technology. Subsequent participation years require reporting on 365 continuous days of meaningful use of the certified EHR technology.

Stage 1 MU

Stage 1 MU begins in 2012. This stage requires providers to meet and report on both a core set and a menu set of measures, as well as report Clinical Quality Measures (CQM). In 2012 CQMs will be reported through attestation in the NC-MIPS portal. Beginning in 2013, most EPs will be required to report CQMs electronically, directly from their EHR systems.

While the MU core and menu measures pertain to patients with any type of diagnosis, CQMs are focused on specific disease conditions. CQMs assess the degree to which a provider competently and safely delivers clinical services that are appropriate for the patient in an optimal timeframe.

To receive a MU incentive payment, **EPs** must meet:

- 15 **core** measures;
- 5 of 10 **menu** measures;
- 3 of 6 **core CQMs;** and,
- 3 of 38 **additional CQMs**

To receive a MU incentive payment, **EHs** must meet:

- 14 **core** measures;
- 5 of 10 **menu** measures; and,
- 15 **CQMs**

The MU measures and specifications and CQMs for EPs and EHs are attached as follows:

- Attachment A – Eligible Professional MU Measures
- Attachment B – Eligible Professional CQMs
- Attachment C – Eligible Hospital MU Measures
- Attachment D – Eligible Hospital CQMs

To attest for a MU payment, visit the NC-MIPS portal at ncmips.nctracks.nc.gov/

VI. Path to Payment

This section of the bulletin guides providers through the steps to determine eligibility and apply for incentive payments.

Adopt, Implement, Upgrade (AIU)

When applying for the N.C. Medicaid EHR Incentive Program, participants attesting to AIU will take the following steps:

1. **Eligibility**. Determine eligibility for the N.C. Medicaid EHR Incentive Program using the eligibility wizard located at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligibility.html.

2. **CMS Registration.** Register with CMS at ehrincentives.cms.gov/hitech/login.action.

3. **AIU.** Adopt, implement, or upgrade to a certified EHR system. The ONC maintains a comprehensive listing of all certified technologies that are currently available at onc-hpl.force.com/ehrcert. New vendors and products are certified and added to the list as they become available.

4. **N.C. Confirmation and Welcome.** N.C. Medicaid verifies registration information provided by CMS using the N.C. Medicaid provider record. A welcome e-mail is sent to a registered provider with an invitation to begin the attestation process.

5. **N.C. Attestation.** Once a provider receives an invitation to begin the attestation process with NC- MIPS, the provider can log onto the NC-MIPS portal, at ncmips.nctracks.nc.gov/, and complete the N.C. attestation process. Eligible providers attest to information about their patient

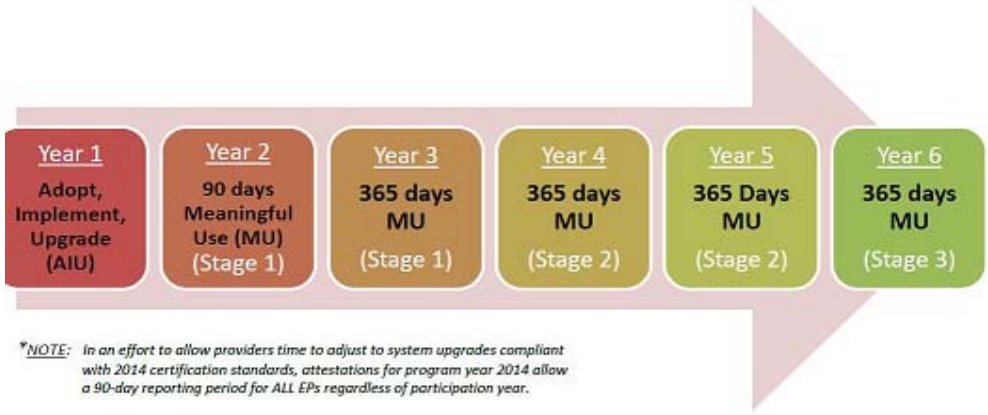
encounters and certified EHR system. Attestation guides specific to EPs and EHs are available at ncmips.nctracks.nc.gov/. Additional assistance is available from the NC-MIPS call center at 1-866- 844-1113. A printed and signed copy of the attestation must be submitted via one of the following methods:

Mail:	NC-MIPS CSC EVC Center PO Box 300020 Raleigh, NC 27622-8020
Fax:	866-844-1382
Scan & Email:	ncmips@csc.com

6. **Verification.** Upon receipt of attestation and signature, the information is verified by N.C. Medicaid before payment is issued. If a problem is found, a provider is notified with instructions on how to address the issue. The verification process, which consists of multiple internal checks at N.C. Medicaid and CMS, and can take as long as four to 10 weeks, for an error-free attestation.

7. **Notification.** A provider is notified when the verification process is complete and payment is on its way. Payments are made by Electronic Funds Transfer (EFT) according to the established N.C. Medicaid payment schedule. Payments appear on the Remittance Advice in the Financial section.

The following flowchart shows the Program's Path to Payment.



*NOTE: *In an effort to allow providers time to adjust to system upgrades compliant with 2014 certification standards, attestations for program year 2014 allow a 90-day reporting period for ALL EPs regardless of participation year.*

7 Easy Steps:

1. Register with CMS at: https://ehrincentives.cms.gov.
2. Receive welcome letter from NC-MIPS.
3. Register with NC-MIPS at: https://ncmips.nctracks.nc.gov/.
4. Attest within the NC-MIPS web portal.
5. Receive your payment!
6. In Years 2-6, repeat steps 4-5.
7. Enjoy increased workflow efficiencies and better clinical outcomes for your patients!

Meaningful Use (MU)

After the year one incentive payment is awarded, EPs are eligible for five additional MU incentive payments. The first year of MU will be based upon a 90-day reporting period, and additional years on a 365-day reporting period.

EHs are eligible for three incentive payments, which may include an AIU or MU incentive payment in the first participation year, followed by two MU incentive payments in subsequent years. For additional information, please see the N.C. Medicaid EHR Incentive Program website.

EPs and EHs participating in the N.C. Medicaid EHR Incentive Program should follow the process below when attesting to MU:

1. **MU.** Demonstrate meaningful use for 90 days or 365 days, according to the measures laid out by CMS in the document available at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP-MU- TOC.pdf.

2. **Certification Check**. Before applying for a subsequent payment, ensure that the EHR is certified to up-to-date standards. The Office of the National Coordinator for Health Information Technology (ONC) maintains a comprehensive listing of all certified technologies that are currently available at onc-chpl.force.com/ehrcert. New vendors and products are certified and added to the list as they become available.

3. **N.C. Attestation.** After receiving the initial incentive payment, a provider need not register again with CMS. Instead, the provider may proceed directly to the N.C. attestation process for a subsequent year by logging onto the NC-MIPS portal, located at ncmips.nctracks.nc.gov/. EPs attest to information about patient encounters, the certified EHR system and all relevant meaningful use measures via the NC-MIPS portal with N.C. Medicaid. EHs need only attest to relevant meaningful use measures with CMS during attestation for a Medicare incentive payment; North Carolina will subsequently receive the MU measures from CMS and accept CMS' determination of whether MU has been met for the purposes of awarding a Medicaid incentive payment. EHs will still need to indicate they are attesting to MU in the NC-MIPS Portal before being eligible to receive a Medicaid incentive payment for MU. To assist in the process, attestation guides specific to EPs and EHs are available at ncmips.nctracks.nc.gov/. Additional assistance is available from the NC-MIPS Help Desk at 1-866-844-1113. Remember to print and sign a copy of the attestation for submission via one of the following methods:

Mail:	NC-MIPS CSC EVC Center PO Box 300020 Raleigh, NC 27622-8020
Fax:	866-844-1382
Scan & Email:	ncmips@csc.com

4. **Verification.** Upon receipt of attestation and signature, the information is verified by N.C. Medicaid before payment is issued. If a problem is found, a provider is notified with

instructions on how to address the issue. The verification process consists of multiple internal checks at N.C. Medicaid and CMS, and can take as long as four to 10 weeks for an error-free attestation.

5. **Notification.** A provider is notified when the verification process is complete and payment is on its way. Payments are made by EFT according to the established N.C. Medicaid payment schedule.

Additional information about meaningful use and the associated measures can be found on the CMS Website located at:
www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html.

VII. Additional Program Notes

If the healthcare professional is eligible to participate in the N.C. Medicaid EHR Incentive Program, there are a few important points to keep in mind.

1. **EP Payment Assignment and Awareness**. Incentive payments for EPs are tied to individual professionals, but may be ***voluntarily*** reassigned to an employer or entity promoting the adoption of certified EHR technology. This is a multi-year program that demands adjustments to clinical practice and recordkeeping on the part of EPs. Managers coordinating attestation efforts for a practice group or entity should ensure EPs understand the payment assignment principle, as well as the compliance requirements of MU in years two through six.

2. **EH Payment Calculation Information.** The attestation and EHR payment calculation for EHs contains a data field for *Medicaid* (Title XIX) *HMO Inpatient Days* from Worksheet S-3, Part I of the hospital's N.C. Medicaid cost report (2552-96 / 2552-10). This cost report field is used to calculate the Medicaid share of the EHR payment. As permitted by Medicare cost reporting regulations, some hospitals have counted in the cost report field both inpatient days paid by a North Carolina LME / PIHP (Prepaid Inpatient Health Plan), and Medicaid eligible days.

   Hospitals are reminded that 42 CFR §495.310 permits only **paid** inpatient bed days in the calculation of the Medicaid share of the EHR payment. EHs who submit attestations for EHR payments should identify only those inpatient days from their Medicaid cost report which were paid by a North Carolina LME / PIHP in the *Medicaid HMO Inpatient Days* data field.

   The patient days identified by the provider in the EHR attestation are subject to review and/or audit for supporting documentation.

   When EHs submit their attestation, they will be required to submit patient level detailed documentation which substantiates the number of Medicaid HMO inpatient days listed on the provider's Medicaid EHR attestation which were paid by a Medicaid MCO/PIHP. Documentation in support of Medicaid HMO inpatient days should be sent via an encrypted CD or via encrypted email file to the NC-MIPS Help Desk.

   If DMA determines that a payment adjustment is required for hospitals, the adjusted amount of the payment will be reflected in subsequent payment years. Hospitals will be notified of the reason for the adjustment, provided with the details of the adjustment calculation, and given instructions for the appeals process if applicable.

3. **Medicare Payment Adjustments**. While there are no payment adjustments to Medicaid claims as a result of the EHR Incentive Programs, Medicare payment adjustments may apply as early as 2015 to EPs and EHs who receive a Medicaid AIU incentive payment but do not demonstrate MU in a timely fashion. For more information, see the Final Rule governing the EHR Incentive Programs at www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf.

4. **Attestation Processing Time**. Once an EP or EH has attested, multiple internal units at N.C. Medicaid validates the attestation information. This process takes about six weeks for an error-free attestation. NC-MIPS staff will work with providers on a one-on-one basis where information is incorrect or unclear, or if difficulties arise while validating Medicaid patient volume.

5. **Revised Eligible Provider Patient Volume Requirements.** On December 12, 2011, DMA released a memorandum titled *Eligible Professional Patient Volume Requirements for the EHR Incentive Program*. This guidance has since been revised and is included as Attachment E of this bulletin.

VIII. Stage 2 Meaningful Use

Stage 2 Final Rule

On August 23, 2012 the Centers for Medicare and Medicaid Services (CMS) released the Stage 2 Final Rule entitled "Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 2." This rule contains revisions to the Stage 1 Final Rule, as well as program specifications for Stage 2 MU. Stage 1 changes will be taking effect as early as October 1, 2012 for EHs and January 1, 2013 for EPs. Stage 2 requirements will become effective October 1, 2013 for EHs and January 1, 2014 for EPs.

Primary Changes in Stage 2

The Stage 2 proposed rule makes minor changes to Stage 1 MU. For a detailed look at these changes, see Attachment F of this bulletin. Stage 2 MU will continue these Stage 1 changes and add additional requirements which include:

- Placing greater emphasis on patient engagement in the healthcare process;
- Emphasizing the actual exchange of data instead of testing;
- Aligning CQMs and other measures to existing measures and standards;
- Redefining certified EHR technology with clearer definitions and greater flexibility;
- Allowing patient volume to include the preceding 12 months as opposed to the prior calendar or federal fiscal year;
- Allowing zero-pay encounters to count in patient volume calculations;
- Maintaining the current number of EP MU measures required (20), but changing the makeup of those measures;
- Decreasing the current number of EH MU measures required from 19 to 18, but changing the makeup of those measures; and
- Increasing required compliance rates for MU measures for all providers.

Providers attesting to MU in 2012 and 2013 must, at a minimum, attest to the Stage 1 requirements, which are included as Attachment A and Attachment C of this bulletin. N.C. Medicaid will publish additional information regarding the Stage 2 requirements closer to Stage 2 implementation.

IX. Documentation and Audits

All providers must maintain documentation supporting all information to which they attested to under the EHR Incentive Program. Documentation must be maintained a minimum of six years after the last incentive payment is received.

CMS requires states to conduct adequate oversight of the EHR Incentive Program in order to ensure that funds are expended wisely and in a manner that impedes waste, fraud or abuse of federal taxpayer money.

States are responsible for taking steps to make certain no duplicate or otherwise improper EHR incentive payments are made.

To accomplish these requirements, N.C. Medicaid will conduct audits of information relative to EHR Incentive Program payments. The N.C. Medicaid audit process will consist of desk audits and on-site reviews. N.C. Medicaid will audit information provided in the attestations of EPs and EHs for AIU incentive payments and will also audit EPs for demonstration of Meaningful Use. CMS will audit EHs for demonstration of MU and will make its findings available to N.C. Medicaid. N.C. Medicaid will accept CMS's decision relative to EHs' demonstration of MU, and will act accordingly.

If any N.C. Medicaid audit process results in adverse determinations for providers, they will be offered the opportunity for reconsideration reviews and appeals through rules established in 10A North Carolina Administrative Code 22F, 22J, and 22N. Appeals stemming from adverse determinations made under CMS audits of EH Meaningful Use will be subject to the CMS appeals process. Final determinations of appeal processes could result in repayment of funds or additional payments being made, depending on the nature of the findings.

X. Helpful Resources

N.C. Department of Health and Human Services

N.C. Medicaid Electronic Health Record Incentive Program. The N.C. Medicaid EHR Incentive Program homepage on the DMA Website provides guidance on eligibility, registration and attestation, meaningful use, and other program information. Resources include DMA memoranda, presentations, Frequently Asked Questions, links, guidance on NC-MIPS, and contact information.
www.ncdhhs.gov/dma/provider/ehr.htm

Frequently Asked Questions (FAQs). DMA posts answers to FAQs about the N.C. Medicaid EHR Incentive Program. Information is arranged by topic.
www.ncdhhs.gov/dma/ehr/ehrfaq.htm

NC-MIPS Eligible Professional Attestation Guide. This guide provides instructions for EPs attesting for the N.C. Medicaid EHR Incentive Program using the NC-MIPS portal.
www.ncdhhs.gov/dma/ehr/EPAttestationGuide1.19.12.pdf

NC-MIPS Eligible Hospital Attestation Guide. This guide provides instructions for EHs attesting for the N.C. Medicaid EHR Incentive Program using the NC MIPS portal.
www.ncdhhs.gov/dma/ehr/EHAttestationGuide1.19.12.pdf

NC-MIPS Portal. The NC-MIPS portal allows providers to complete the North Carolina-specific registration and attestation.
ncmips.nctracks.nc.gov/

N.C. Office of Health Information Technology (HIT). This office is the legislatively mandated HIT management structure for North Carolina. The office oversees statewide HIT/HIE and is housed under DHHS.
www.ncdhhs.gov/healthit/

N.C. Identity Management (NCID). This site provides NCID usernames and passwords. Providers need NCID usernames and passwords to access the NC-MIPS portal. Go to the NCID Website to register for an account.
ncid.nc.gov/

Centers for Medicaid & Medicare Services (CMS)

Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs (official site): This is the official site to the EHR incentive program.
www.cms.gov/Regulations-and- Guidance/Legislation/EHRIncentivePrograms/index.html

Eligibility Flow Chart. This flow chart helps professionals determine eligibility for Medicare and Medicaid EHR Incentive Programs.
cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/eligibility_flow_chart.pdf

Eligibility Wizard. This tool on the CMS Website where professionals can answer a few short "yes or no" questions to determine the EHR Incentive Programs for which they may qualify
www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligibility.html

Path to Payment. This Medicare and Medicaid EHR Incentive Programs checklist shows the necessary steps to receive incentive payments.
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PathtoPayment.html

Frequently Asked Questions (FAQs). On this site, CMS posts answers to FAQs about the EHR Incentive Programs. Visitors can search by keyword or click on "Electronic Health Records Incentive Program" in the left column to browse by topic.
https://questions.cms.gov/faq.php

Medicare & Medicaid EHR Incentive Program Registration & Attestation System. This system allows providers to enroll in the program with CMS.
https://ehrincentives.cms.gov/hitech/login.action

2011-2013 HIT Timeline. This timeline includes milestones for the EHR Incentive Programs and resources to help address milestones.
www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/HIT_Programs_timeline_2012.pdf

CMS Meaningful Use Overview. This site contains information and resources on MU criteria, meeting requirements, CQMs, and important links and downloads.
cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

Office of the National Coordinator for Health Information Technology

Office of the National Coordinator for Health Information Technology (ONC). This is the official site of the ONC.
healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

Certified Health IT Product List. On this site, the ONC maintains a comprehensive listing of all certified EHR technologies. New vendors and products are certified and added to the list as they become available.
oncchpl.force.com/ehrcert

HealthIT.gov. This site provides information on implementing EHR systems, privacy and security issues, MU, case studies, and helpful links.
www.healthit.gov/

Other HIT Resources

Final Rule. The final rule implements the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 which provides incentive payments to EPs, EHs and critical access hospitals participating in Medicare and Medicaid programs that adopt and successfully demonstrate Meaningful Use (MU) of certified EHR technology.
www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf

Notice of Proposed Rule Making - Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology. This document is the Stage 2 Final Rule Meaningful Use, published September 4, 2012 in the Federal Register.
http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

American Recovery and Reinvestment Act of 2009 (ARRA). ARRA made supplemental appropriations for job preservation and creation, infrastructure investment, energy efficiency and science, assistance to the unemployed, State and local fiscal stabilization for the fiscal year ending September 30, 2009, and for other purposes. See Title XIII HITECH Act.
www.gpo.gov/fdsys/pkg/BILLS-111hr1enr/pdf/BILLS-111hr1enr.pdf

N.C. Area Health Education Centers (AHEC). As a federally designated Regional Extension Center (REC), N.C. AHEC provides individualized, on-site EHR consulting services tailored to a professional's specific needs at no charge.
www.ahecqualitysource.com/

N.C. Health Information Exchange. The N.C. Health Information Exchange enables timely and secure exchange of electronic health information for North Carolina that connects with the nationwide health information network.
www.nchie.org

Health Resources and Services Administration (HRSA). HRSA has developed a number of technical assistance resources designed to support Medicaid providers as they adopt and implement HIT. These resources include toolkits, modules, Webinars, tip sheets, and articles highlighting provider experiences.
www.hrsa.gov/healthit.

N.C. Medical Society (NCMS). NCMS, through its consulting branch, PractEssentials, offers Meaningful Use attestation assistance to providers throughout the state. NCMS also offers webinars and training on meeting the Meaningful Use measures and Patient Centered Medical Home/Practice Improvement assistance, and has an online HIT resource center with information on funding, technology, information exchange, HIT news and helpful links.
www.ncmedsoc.org/practice_management/hit.html

N.C. Community Care Networks (N3CN) Informatics Center. N3CN is a public-private partnership between the State and 14 non-profit Community Care Networks. The N3CN Informatics Center is an electronic data exchange infrastructure maintained in connection with health care quality initiatives for North Carolina.
https://ic.n3cn.org/

N.C. Healthcare Information & Communications Alliance, Inc. (NCHICA). NCHICA's mission is to assist NCHICA members in accelerating the transformation of the U.S. healthcare system through the effective use of information technology, informatics and analytics.
www.nchica.org/

Agency for Healthcare Research and Quality (AHRQ). AHRQ's mission is to improve the quality of health care for all Americans. The agency has focused its HIT activities on improving health care decision making, supporting patient-centered care, and improving the quality and safety of medication management.
healthit.ahrq.gov/portal/server.pt/community/ahrq_national_resource_center_for_health_it/650

N.C. EHR Incentive Program Contacts

For technical issues or to inquire about the status of your attestation, contact:

- **1-866-844-1113**
- ncmips@csc.com

For questions about the program or process, contact:

- **919-855-4200**
- NCMedicaid.HIT@dhhs.nc.gov

XI. Attachments

Attachment A

ELIGIBLE PROFESSIONAL MEANINGFUL USE CRITERIA

FOR ADDITIONAL INFORMATION REGARDING THESE MEASURES, GO TO

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

CORE MEASURES

MEASURE NUMBER	OBJECTIVE	MEASURE	ATTESTATION REQUIREMENTS	ADDITIONAL INFORMATION
1	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders in the medical record	More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.	**Denominator**: Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period. **Numerator**: Number of patients in the denominator that have at least one medication order entered using CPOE.	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion:** EPs who write fewer than 100 prescriptions during the EHR reporting period.
2	Implement drug-drug and drug-allergy interaction checks	The EP has enabled this functionality for the entire EHR reporting period.	Yes/No	**No exclusion.**
3	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at last one entry or an indication that no problems are known.	**Denominator**: Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient.	Must use ICD-9 or SNOMED-CT for entry of structured data. **No exclusion.**

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
4	Generate and transmit permissible prescriptions electronically (eRx).	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.	**Denominator:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period. **Numerator:** Number of prescriptions in the denominator generated and transmitted electronically. NOTE: EPs should include in the numerator and denominator both types of electronic transmissions (those within and outside the organization).	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion**: Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
5	Maintain active medication list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	**Denominator**: Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** Number of patients in the denominator who have a medication (or an indication that the patient is not prescribed any medication).	**No exclusion.**

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
6	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies).	**Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies).	**No exclusion.**
7	Record demographics: (A)Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.	**Denominator**: Number of unique patients seen by the EP during the EHR reporting period. **Numerator**: Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law)	**No exclusion**

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
8	Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display BMI (E) Plot and display growth charts for children 2-20 years, including BMI	For more than 50% of all unique patients age 2 and over seen by the EP, height, weight, and blood pressure are recorded	**Denominator:** Number of unique patient age 2 or over seen by the EP during the EHR reporting period. **Numerator:** Number of patients in the denominator who have at least one entry of their height, weight and blood pressure recorded	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion:** Any EP who either sees no patients 2 years or older, or who believes that all three vital signs of height, weight, and blood pressure of their patients have no relevance to their scope of practice.
9	Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	**Denominator**: Number of unique patients age 13 or older seen by the EP during the EHR reporting period. **Numerator:** Number of patients in the denominator with smoking status recorded as structured data.	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion:** An EP who sees no patients 13 years or older.
10	Report ambulatory clinical quality measures to CMS	Successfully report to CMS ambulatory clinical quality measures selected by CMS in the manner specified by CMS.	Yes/No	May limit to those patients whose records are maintained using certified EHR technology. **No Exclusion.**

CORE MEASURES

MEASURE NUMBER	OBJECTIVE	MEASURE	ATTESTATION REQUIREMENTS	ADDITIONAL INFORMATION
11	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to trace compliance with that rule.	Implement one clinical decision support rule.	**Yes/No**	Drug-drug and drug-allergy interaction alerts cannot be used to meet the meaningful use objective for implementing one clinical decision support rule. **No exclusion.**
12	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.	More than 50% of all patients who request an electronic copy of their health information are provided it within three business days.	**Denominator:** Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period. **Numerator:** Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion:** EPs who have no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.
13	Provide clinical summaries for patients for each office visit.	Clinical summaries are provided to patients within three business days for more than 50% of all office visits.	**Denominator:** Number of office visits by the EP during the EHR reporting period. **Numerator:** Number of office visits in the denominator for which the patient is provided a clinical summary within three business days.	May limit to those patients whose records are maintained using certified EHR technology. The provision of the clinical summary is limited to the information contained within certified EHR technology. **Exclusion:** Any EP who has no office visits during the EHR reporting period.

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
14	Capability to exchange key clinical information among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	Yes/No	Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. An unsuccessful test of electronic exchange of key clinical information will be considered valid for meeting the measure. **No Exclusion.**
15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes/No	**No Exclusion.**

MENU MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
1	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	Yes/No	**Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period.
2	Incorporate clinical lab test results into EHR as structured data.	More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	**Denominator:** Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number. **Numerator:** Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion:** An EP who orders no lab tests whose results are either in a positive/negative or numeric format during the EHR reporting period.
3	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.	Yes/No	The report is required to include only patients whose records are maintained using certified EHR technology.
4	Send reminder to patients per patient preference for preventive/follow-up care.	More than 20% of all patients 65 or older or 50-years-old or younger were sent an appropriate reminder during the EHR reporting period.	**Denominator:** Number of unique patients 65 years old or older or 5-years-old or younger. **Numerator:** Number of patients in the denominator who were sent the appropriate reminder.	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion:** An EP who has no patients in the age ranges cited with records maintained using certified EHR technology.

MENU MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
5	Provide patients with timely electronic access to their health information (including lab results, problem lists, medication lists and allergies) within 4 business days of the information being available to the EP.	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within 4 business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.	**Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** Number of patients in the denominator who have timely electronic access to their health information online.	Business days are defined as Mon-Fri excluding federal or state holidays on which the EP or their respective administrative staff is unavailable. The EP is not responsible for ensuring that 10% request access or have the means to access, only that 10% of all unique patients could access the information if they so desired. **Exclusion:** Any EP that neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list or other information in 45 CRF 10.304(g) during the EHR reporting period.
6	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients seen by the EP are provided patient-specific education resources.	**Denominator:** Number of unique patients seen by the EP during the EHR reporting period. **Numerator:** Number of patients in the denominator who are provided patient-specific education resources	**No Exclusion.**

MENU MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
7	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP	**Denominator**: Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition. **Numerator:** Number of transitions of care in the denominator where medication reconciliation was performed.	Only patients whose records are maintained using certified EHR technology should be included in the denominator. Transition of care is the movement of a patient from one setting of care (hospital, ambulatory primary care or specialty practice, long-term care, home health, rehab facility) to another. **Exclusion:** An EP who was not the recipient of any transitions of care during the EHR reporting period.
8	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide a summary care record for each transition of care or referral.	The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	**Denominator**: Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider. **Numerator**: Number of transitions of care and referrals in the denominator where a summary of care record was provided.	Only patients whose records are maintained using certified EHR technology should be included in the denominator. The transferring party must provide the summary care record to the receiving party. **Exclusion:** An EP who neither transfers a patient to another setting nor refers a patient to another provider during the EHR reporting period.

MENU MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
9	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically).	Yes/No	An unsuccessful test satisfies this objective. **Exclusion**: An EP who administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.
10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP submits such information has the capacity to receive the information electronically.)	Yes/No	An unsuccessful test satisfies this objective. **Exclusion**: An EP who does not collect any reportable syndromic information on their patients during the EHR reporting period or does not submit such information to any public health agency that has the capacity to receive the information electronically.

Attachment B

ELIGIBLE PROFESSIONAL CLINICAL QUALITY MEASURES

FOR ADDITIONAL INFORMATION REGARDING THESE MEASURES, GO TO
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html

CORE CQMs: Report All 3 Measures[1]	
NQF 0013	Hypertension: Blood Pressure Measurement
NQF 0028	Preventive Care and Screening Measure Pair: a) Tobacco Use Assessment, b) Tobacco Cessation Intervention
NQF 0421	Adult Weight Screening and Follow-up
Alternate Core CQMs: Report 0-3 Measures[2]	
NQF 0024	Weight Assessment and Counseling for Children and Adolescents
NQF 0038	Childhood Immunization Status
NQF 0041	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old
ADDITIONAL CQMs: Report 3 Measures[3]	
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement
NQF 0012	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
NQF 0014	Prenatal Care: Anti-D Immune Globulin
NQF 0018	Controlling High Blood Pressure
NQF 0032	Cervical Cancer Screening
NQF 0033	Chlamydia Screening for Women
NQF 0036	Use of Appropriate Medications for Asthma
NQF 0052	Low Back Pain: Use of Imaging Studies
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
NQF 0575	Diabetes: Hemoglobin HbA1c Control (<8%)
NQF 0059	Diabetes: Hemoglobin A1c Poor Control
NQF 0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
NQF 0043	Pneumonia Vaccination Status for Older Adults
NQF 0031	Breast Cancer Screening
NQF 0034	Colorectal Cancer Screening
NQF 0027	Smoking and Tobacco Use Cessation, Medical Assistance: a) Advising Smokers and Tobacco Users to Quit, b) Discussing Smoking and Tobacco Use Cessation Medications, c) Discussing Smoking and Tobacco Use Cessation Strategies
NQF 0055	Diabetes: Eye Exam
NQF 0062	Diabetes: Urine Screening
NQF 0086	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
NQF 0056	Diabetes: Foot Exam
NQF 0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

ADDITIONAL CQMs, *continued*	
NQF 0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
NQF 0074	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
NQF 0064	Diabetes: Low Density Lipoprotein (LDL) Management and Control
NQF 0084	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
NQF 0073	Ischemic Vascular Disease (IVD): Blood Pressure Management
NQF 0068	Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
NQF 0061	Diabetes: Blood Pressure Management
NQF 0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
NQF 0047	Asthma Pharmacologic Therapy
NQF 0067	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
NQF 0001	Asthma Assessment
NQF 0002	Appropriate Testing for Children with Pharyngitis
NQF 0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
NQF 0387	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
NQF 0385	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
NQF 0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
NQF 0105	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b)Effective Continuation Phase Treatment

Footnotes

[1] ***If any of the three core measures are reported with zero values for the denominator, you are required to substitute an alternate core measure. For example if: NQF 0028 and NQF 0421 are zero; report two measures from the alternate core measures. All values reported in the denominator of the measure should be the values produced by the certified EHR technology.***

[2] ***If you reported a zero for two core measures you will need to report two alternate core measures, likewise, if you reported zero for one core measure you are required to report one of the three alternate core measures. Note: All values reported should be the values produced by the certified EHR technology.***

[3] ***Select any three measures that apply to your practice. It is acceptable to have zero for the denominator if that is the value produced by the certified EHR technology. Three additional measures are required for a total of six to nine measures depending on the number of core and alternate core measures.***

Attachment C

ELIGIBLE HOSPITAL MEANINGFUL USE CRITERIA

FOR ADDITIONAL INFORMATION REGARDING THESE MEASURES, GO TO
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

CORE MEASURES

MEASURE NUMBER	OBJECTIVE	MEASURE	ATTESTATION REQUIREMENTS	ADDITIONAL INFORMATION
1	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders in the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE.	**Denominator**: Number of unique patients with at least one medication in their medication list admitted to the eligible hospital's or critical access hospital's inpatient or emergency department during the EHR reporting period. **Numerator:** The number of patients in the denominator that have at least one medication order entered using CPOE.	**No exclusion.**
2	Implement drug-drug and drug-allergy interaction checks	The eligible hospital or critical access hospital has enabled this functionality for the entire EHR reporting period.	Yes/No	**No exclusion.**

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
3	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.	**Denominator**: Number of unique patients admitted to an eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period. **Numerator:** Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.	Must use ICD-9 or SNOMED-CT for entry of structured data. **No exclusion.**
4	Maintain active medication list.	More than 80% of all unique patients admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	**Denominator:** Number of unique patients admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period. **Numerator:** Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	For patients with no active medications, an entry must still be made to the active medication list indicating that there are no active medications. **No exclusion.**

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
5	Maintain active medication allergy list.	More than 80% of all unique patients admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	**Denominator:** Number of unique patients admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period. **Numerator:** Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.	For patients with no active medication allergies, an entry must still be made to the active medication allergy list indicating that there are no active medication allergies. **No exclusion.**
6	Record all of the following demographics: (A) Preferred language (B) Gender (C) Race (D) Ethnicity (E) Date of birth (F) Date and preliminary cause of death in the event of mortality in the eligible hospital or critical access hospital	More than 50% of all unique patients admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	**Denominator:** Number of unique patients admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period. **Numerator:** Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.	**No exclusion.**

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
7	Record and chart changes in the following vital signs: (A) Height (B) Weight (C) Blood pressure (D) Calculate and display BMI (E) Plot and display growth charts for children 2-20 years, including BMI	For more than 50 percent of all unique patients age 2 and over admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23), height, weight, and blood pressure are recorded as structured data.	**Denominator:** Number of unique patients age 2 or over admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period. **Numerator:** Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.	May limit to those patients whose records are maintained using certified EHR technology. **No Exclusion.**
8	Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years old or older or admitted to the eligible hospital's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.	**Denominator**: Number of unique patients age 13 or older admitted to the eligible hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period. **Numerator:** Number of patients in the denominator with smoking status recorded as structured data.	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion:** An eligible hospital or critical access hospital that admits no patients 13 years or older to their inpatient or emergency department (POS 21 or 23).
9	Report hospital clinical quality measures to CMS.	Successfully report to CMS hospital clinical quality measures selected by CMS in the manner specified by CMS.	Yes/No	May limit to those patients whose records are maintained using certified EHR technology. **No Exclusion.**

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
10	Implement one clinical decision support rule related to high priority hospital condition along with the ability to track compliance with that rule.	Implement one clinical decision support rule	Yes/No	Drug-drug and drug-allergy interaction alerts cannot be used to meet meaningful use objective for implementing one clinical decision support rule. Eligible hospitals and critical access hospitals must implement one clinical decision support rule in addition to drug-drug and drug-allergy interaction checks. **No Exclusions.**
11	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication list, medication allergies, discharge summary, procedures) upon request.	More than 50% of all patients of the inpatient or emergency departments of the eligible hospital or critical access hospitals (POS 21 or23) who request an electronic copy of their health information are provided it within three business days.	**Denominator:** Number of patients of the eligible hospital or critical access hospital who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period. **Numerator:** Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion:** Any eligible hospital or critical access hospital that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period.

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
12	Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital or critical access hospital's inpatient or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.	**Denominator:** Number of patients discharged from an eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) who request an electronic copy of their discharge instructions during the EHR reporting period. **Numerator:** The number of patients in the denominator who are provided an electronic copy of discharge instructions.	May limit to those patients whose records are maintained using certified EHR technology. **Exclusion:** An eligible hospital or critical access hospital that has no requests from patients or their agents for an electronic copy of their discharge instructions during the EHR reporting period.
13	Capability to exchange key clinical information among providers of care and patient authorized entities electronically.	Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information.	Yes/No	The test of electronic exchange of key clinical information must involve the transfer of information to another provider of care with distinct certified EHR technology or other system capable of receiving the information. An unsuccessful test of electronic exchange of key clinical information will be considered valid for meeting the measure. **No Exclusion.**

CORE MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
14	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes/No	**No Exclusion.**

MENU MEASURES BEGIN ON THE NEXT PAGE

MENU MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
1	Implement drug formulary checks.	The eligible hospital or critical access hospital has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.	Yes/No	**No Exclusion.**
2	Record advance directives for patient 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or critical access hospital's inpatient (POS 21) have an indication of an advance directive status recorded as structured data .	**Denominator:** Number of unique patients age 65 or older admitted to an eligible hospital's or critical access hospital's inpatient department (POS 21) during the EHR reporting period. **Numerator:** Number of patients in the denominator with an indication of an advanced directive entered using structured data.	**Exclusion:** An eligible hospital or critical access hospital that admits no patients age 65 years old or older during the EHR reporting period.

MENU MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
3	Incorporate clinical lab test results into EHR as structured data.	More than 40% of all clinical lab test results ordered by an authorized provider of the eligible hospital or critical access hospital for patients admitted to its inpatient or emergency department (POS 21 and 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	**Denominator:** Number of lab tests ordered during the EHR reporting period by authorized providers of the eligible hospital or critical access hospital for patients admitted to an eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 and 23) whose results are expressed in a positive or negative affirmation or as a number. **Numerator:** Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.	May limit to those patients whose records are maintained using certified EHR technology. **No Exclusion.**
4	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition	Yes/No	The report is required to include only patients whose records are maintained using certified EHR technology. **No Exclusion.**

MENU MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
5	Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of the patient's admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resource.	**Denominator:** Number of unique patients admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period. **Numerator:** Number of patients in the denominator who are provided patient education specific resources.	**No Exclusion.**
6	The eligible hospital or critical access hospital that receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or critical access hospital performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 or 23).	**Denominator:** Number of transitions of care during the EHR reporting period for which the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 to 23) was the receiving party of the transition. **Numerator:** Number of transitions of care in the denominator where medication reconciliation was performed.	Only patients whose records are maintained using certified EHR technology should be included in the denominator for transitions of care. **No Exclusion.**

MENU MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
7	The eligible hospital or critical access hospital that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	The eligible hospital or critical access hospital that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	**Denominator:** Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or critical access hospital's inpatient or emergency department (POS 21 to 23) was the transferring or referring provider. **Numerator:** Number of transitions of care and referrals in the denominator where a summary of care record was provided.	Only patients whose records are maintained using certified EHR technology should be included in the denominator. **No Exclusion.**
8	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or critical access hospital submits such information has the capacity to receive the information electronically).	Yes/No	An unsuccessful test satisfies this objective. **Exclusion:** An eligible hospital or critical access hospital that administers no immunizations during the EHR reporting period or where no immunization registry has the capacity to receive the information electronically.

MENU MEASURES				
MEASURE NUMBER	**OBJECTIVE**	**MEASURE**	**ATTESTATION REQUIREMENTS**	**ADDITIONAL INFORMATION**
9	Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or critical access hospital submits such information has the capacity to receive the information electronically).	Yes/No	An unsuccessful test to submit electronic data to public health agencies will be considered valid and would satisfy this objective. **Exclusion:** No public health agency to which the eligible hospital or critical access hospital submits such information has the capacity to receive the information electronically.
10	Capability to submit electronic syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or critical access hospital submits such information has the capacity to receive the information electronically).	Yes/No	An unsuccessful test satisfies this objective. **Exclusion:** No public health agency to which the eligible hospital or critical access hospital submits such information has the capacity to receive the information electronically.

Attachment D

ELIGIBLE HOSPITAL CLINICAL QUALITY MEASURES	
FOR ADDITIONAL INFORMATION REGARDING THESE MEASURES, GO TO www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html	
ALL 15 MEASURES ARE REQUIRED	
NQF 0495	Emergency Department (ED)-1 Emergency Department Throughput – Median time from ED arrival to ED departure for admitted ED patients
NQF 0497	ED-2 Emergency Department Throughput – Admitted patients – Admit decision time to ED departure time for admitted patients
NQF 0435	Stroke-2 Ischemic stroke – Discharged on anti-thrombotic therapy
NQF 0436	Stroke-3 Ischemic stroke – Anticoagulation Therapy for Atrial Fibrillation/Flutter
NQF 0437	Stroke-4 Ischemic stroke – Thrombolytic Therapy
NQF 0438	Stroke-5 Ischemic stroke – Antithrombotic therapy by end of hospital day two
NQF 0439	Stroke-6 Ischemic stroke – Discharged on Statin Medication
NQF 0440	Stroke-8 Ischemic or hemorrhagic stroke – Stroke education
NQF 0441	Stroke-10 Ischemic or hemorrhagic stroke – Assessed for rehabilitation
NQF 0371	Venous Thromboembolism (VTE)-1 VTE prophylaxis
NQF 0372	VTE-2 Intensive Care Unit (ICU) VTE prophylaxis
NQF 0373	VTE-3 VTE Patients with Overlap of Anticoagulation Therapy
NQF 0374	VTE-4 VTE Patients Unfractionated Heparin (UFH) Dosages/Platelet Count Monitoring by Protocol (or Nomogram) Receiving Unfractionated Heparin (UFH) with Dosages/ Platelet Count Monitored by Protocol (or Nomogram)
NQF 0375	VTE-5 VTE discharge instructions
NQF 0376	VTE-6 Incidence of potentially preventable VTE

Attachment E

Eligible Provider Patient Volume Requirements

The N.C. Division of Medical Assistance (DMA) is providing this revised guidance to explain the patient volume (PV) requirements for the N.C. Medicaid EHR Incentive Program. The goal is to alleviate confusion and help eligible professionals (EPs) apply for, and receive, Electronic Health Record (EHR) incentive payments. This document supersedes the Eligible Provider Patient Volume memorandum that was published December 12, 2011.

According to the Final Rule governing the Medicaid EHR Incentive Program, Section 495.306(c) Establishing Patient Volumes, a State must submit through their State Medicaid Health Plan (SMHP) the option or options it has selected for measuring patient volume. N.C. Medicaid has selected the following option:

> (c) *Methodology, patient encounter.*
> (1) *EPs.* To calculate Medicaid PV, an EP must divide: (*i*) The total Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year; by (*ii*) The total patient encounters in the same 90-day period.

For EPs, a Medicaid encounter is defined as services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under Section 1115 of the Social Security Act paid for part or all of the service as stated in the Final Rule. CMS further defines a patient encounter as any encounter where a medical treatment is provided and/or evaluation and management services are provided.

It is important to note that EPs must count actual encounters, defined as a unique patient on a unique day, from their own auditable data source, defined as an electronic or manual system that an external entity can use to replicate the data from the original data source to support their attested information. If there is a problem verifying the data, Medicaid may request additional information to assist in the validation process.

The Medicaid PV percentage should be calculated in the following way:

Medicaid PV (Numerator): In any continuous 90-day period, all unique encounters covered in part or whole by Medicaid.

Total PV (Denominator): In the same 90-day period, all unique encounters, no matter the payment method.

The following clarifications apply:

Participation

- Professionals must be enrolled with Medicaid to be eligible for an incentive payment.
- Physician Assistants (PAs) may participate if they are in an FQHC/RHC that is led by a PA.

General

- EPs may choose either the group or individual methodology for patient volume reporting.
- Per Member Per Month fees paid by Medicaid or another payer do not constitute encounters.

- Global billing situations such as OB/GYN visits should be counted on the date of service, not the date of billing. Each individual date of service is considered to be one encounter. In these situations, Medicaid will account for multiple visits per global billing during the validation process.
- Services provided at no charge must be included in the denominator (total encounters).
- A patient seen for multiple services by the same professional on the same day counts as only one encounter.
- A patient seen by more than one professional on one day may be counted as individual encounters by each professional for either group or individual methodology.
- Encounters whose Medicaid claims were denied but later paid should be included as Medicaid encounters for the date of service, not the date of payment.
- Encounters whose Medicaid claims were denied and not paid by Medicaid may not be included in the numerator, but must still be included in the denominator (total encounters).
- The denominator of the patient volume calculation may not be limited in any way. Any encounter included in the numerator must also be included in the denominator, and all patient encounters must be included.
- If participating with a practice group using group methodology, an EP does not need to have been with the group during the group's selected reporting period. Health Choice encounters may not be included in the numerator of the Medicaid patient volume calculation, except in the case of EPs who practice predominantly at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

Group Methodology

- Group methodology allows a group to calculate one patient volume for a single 90-day period and apply that calculation and reporting period apply to all EPs in the group.
- A group is defined for the N.C. Medicaid EHR Incentive Program as two or more eligible professionals (EPs) practicing together in one or more locations under the same management entity or Tax ID number (TIN) for the N.C. Medicaid EHR Incentive Program.
- All EPs attesting as part of a group must attest using the same patient volume calculation and the same reporting period.
- An EP attestation using the group methodology must include all encounters for that group's practice and may not limit the group patient volume calculation in any way.
- If a provider has attested using group methodology, the individual methodology is not available to other providers within the group for the same 90-day period. In this scenario, the first provider to attest has essentially set the methodology for that group and has claimed the entire group's encounters for that reporting period for use by EPs within that group using group methodology only. An individual at such a group could choose to attest using individual methodology by either demonstrating sufficient Medicaid patient volume outside of the group (if using the same reporting period) or by using his/her personal encounter data at the group with a different reporting period.
- When using the group methodology, only one group affiliation may be specified. EPs may not report patient volumes from multiple groups when using the group methodology. However, if a group practices in multiple locations that when combined see the requisite Medicaid patient volume, that group should report the patient volume at each location during attestation, the sum of which must meet the required Medicaid patient volume threshold.

Individual Methodology

- North Carolina asks the EP for the location(s) of his/her encounters by use of MPN to ensure the provider does not use encounters being reported elsewhere under group methodology.
- An EP may use numbers from multiple locations to meet the threshold, but is not required to report on more than one location.
- If an EP who is part of a group practice has attested using individual methodology, group methodology is not available for other providers at the same location for the same 90-day period.

Because DMA uses paid N.C. Medicaid claims and the provider identification information provided at attestation to validate patient volume, EPs are encouraged to submit any additional documentation that explains non-standard billing practices at the time of attestation. For example, if an EP bills for N.C. Medicaid payments under a supervising provider or group whose MPN or NPI is not listed within the attestation, a letter detailing billing practices and associated encounters would help to expedite processing and payment.

If you have further questions about the patient volume calculation or other program requirements, please contact NCMedicaid.HIT@dhhs.nc.gov or 919-855-4200.

Attachment F

Stage 1 Changes – Medicaid EHR Incentive Program

Subject	Change	Comment
Taking effect Oct 1, 2012 for EHs and Jan 1, 2013 for EPs		
MU Core - **Computerized Provider Order Entry (CPOE)**	Changes denominator from number of unique patients to total number of medication orders	**Optiona**l in 2013 and beyond
MU Core - **E-prescribing (eRx)**	Adding exclusion: no pharmacy that accepts electronic prescriptions within a 10 mile radius of EP	**Required** 2013 and beyond
MU Core - **Vital Signs**	Amends age limit to age ≥3 for BP and height/weight to all ages Also changes exclusions: sees no patients ≥3 or no relevance to scope of practice (splits out BP from height and weight)	**Optional** in 2013, **required** in 2014 and beyond
MU Core - **Electronic Exchange of Key Clinical Information**	No longer required	**Required** 2013 and beyond - moving to more robust electronic exchange (summary of care record)
MU Core - **Report CQMs**	Delete as separate objective	Redundant - **required 2013** and beyond
MU Menu - **Public Health Reporting**	Perform at least one test of ability to send data to PH agencies, unless prohibited	Required 2013 and beyond
Taking effect in 2014 (Stage 1)		
Electronic **Access to Health Information**	Replaces several objectives for providing electronic copies and electronic access of health information with objectives for online access	Aligns with 2014 certified EHR technology standards
Exclusions for **Menu** Objectives	**No Exclusions** for the five MU **menu** objectives if there are other menu objectives which can be selected	**Required** 2014
Effective for program year 2013		
Patient Volume calculation	Can include zero paid claim encounters	Includes denied claims (except for Medicaid ineligibility), third party liability paid, encounters with no claim filed, etc.
	Can include Medicaid expansion programs funded by Title XXI funds	Can count MCHIP (0-5 children) but not Health Choice
	Can use any 90-day reporting period in the 12 months preceding the attestation	States decide whether to offer this option

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