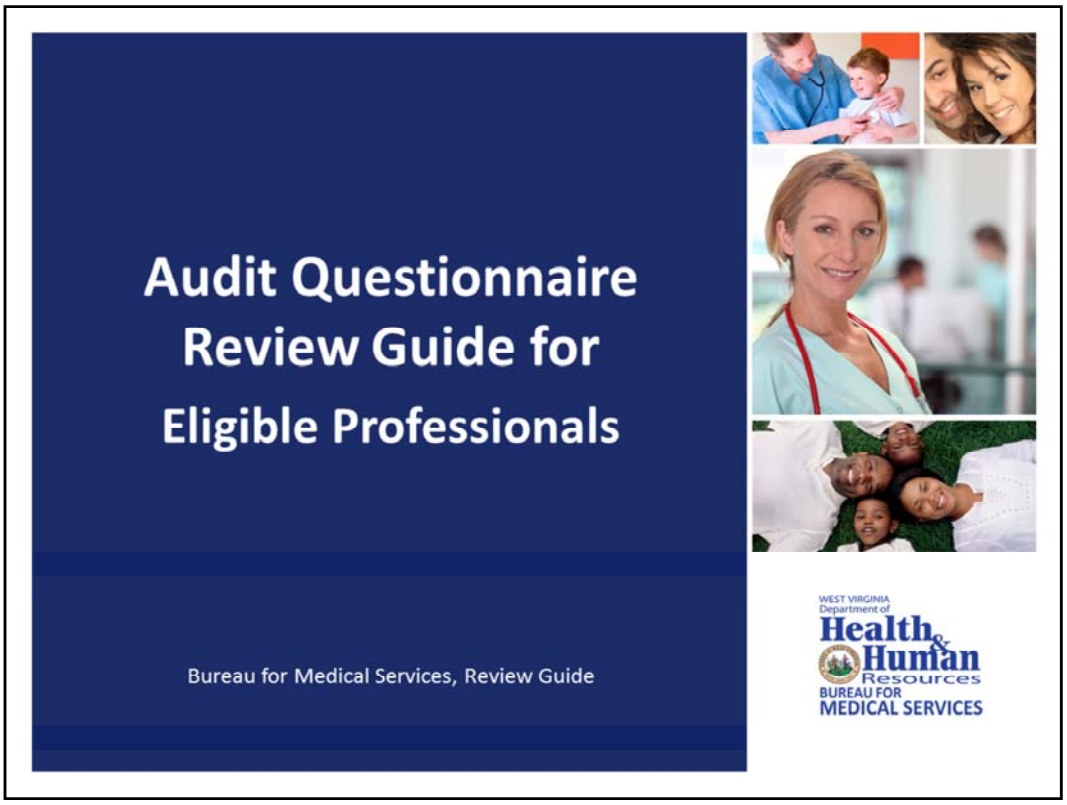
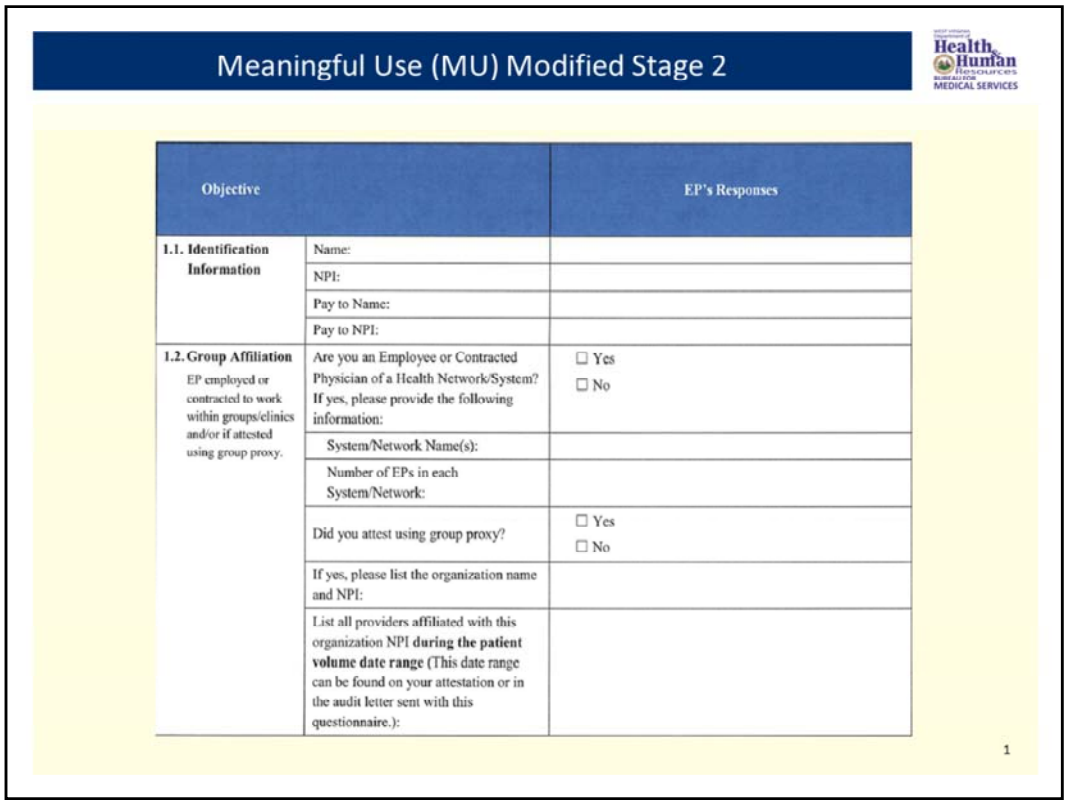


Welcome to the Eligible Professional, or "EP," questionnaire walk-through review guide. The purpose of this review guide is to give EPs a full tutorial on the audit questionnaire and all required documentation. Each listed question must be answered and supported with documentation to complete the audit. Note that if you use screenshots as supporting documentation for any part of the audit, the screenshot *must* include a date indicating when the screenshot was captured.

This presentation will cover EPs who have attested to Meaningful Use (MU) Modified Stage 2. As an EP progresses through the program, the MU measures become more challenging. Therefore, depending on what stage of the program the EP's audit year falls into, he or she should focus on additional parts of this presentation. To verify what stage the EP was in for the audit year, please review the audit notification letter and questionnaire that the State sent out or review your attestation documentation.



Meaningful Use (MU) Modified Stage 2

Objective		EP's Responses
1.1. Identification Information	Name:	
	NPI:	
	Pay to Name:	
	Pay to NPI:	
1.2. Group Affiliation EP employed or contracted to work within groups/clinics and/or if attested using group proxy.	Are you an Employee or Contracted Physician of a Health Network/System? If yes, please provide the following information:	☐ Yes ☐ No
	System/Network Name(s):	
	Number of EPs in each System/Network:	
	Did you attest using group proxy?	☐ Yes ☐ No
	If yes, please list the organization name and NPI:	
	List all providers affiliated with this organization NPI **during the patient volume date range** (This date range can be found on your attestation or in the audit letter sent with this questionnaire.):	

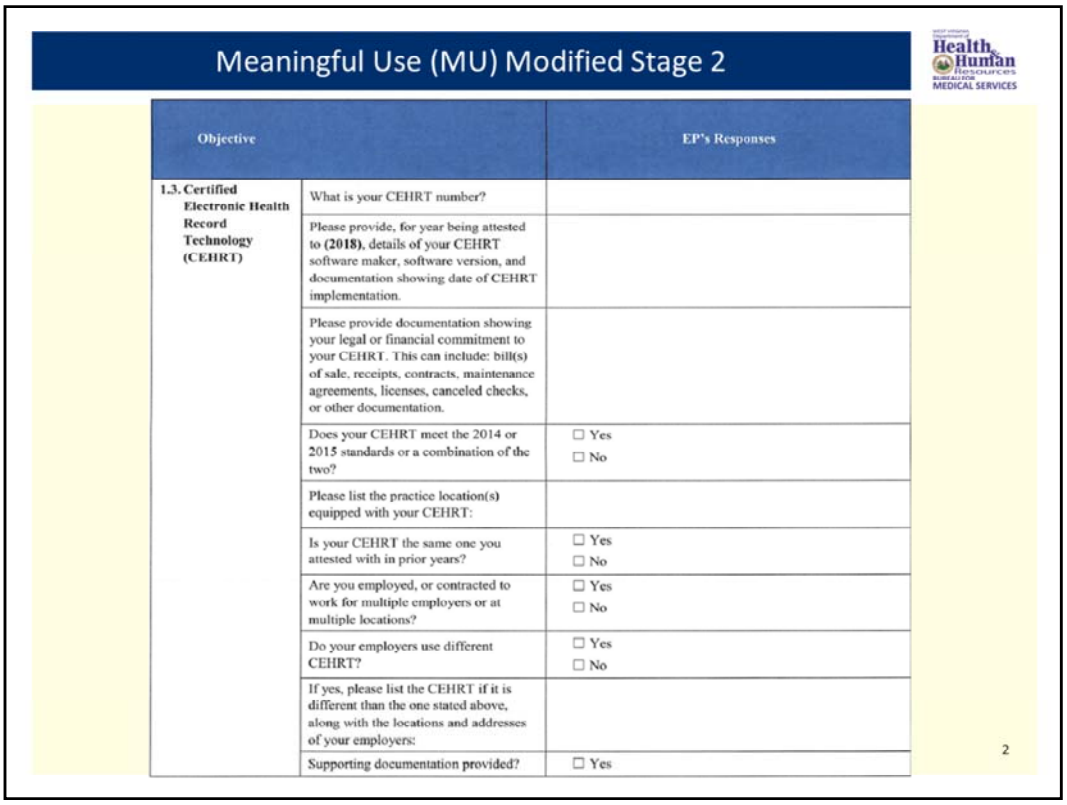
1

Objective 1.1 is designed to verify the provider's name, National Provider Identifier (NPI), pay-to name (the name of the provider or group that received the payment), along with the pay-to NPI (the NPI, either individual or group, associated with the provider's paid claims). This information should match the information that was submitted at the time of attestation.

For objective 1.2, please identify if the provider is employed or contracted to work within multiple groups or clinics. If the provider works at multiple practices, please check "Yes" and list the name of the practice or network. The EP must also list the number of providers in those networks.

Next, the provider must clarify if he or she attested using group proxy. If the EP did attest using group proxy, list the organization name and organization NPI. Next, list all of the providers that were affiliated with the organization during the patient volume period (this date range is labeled "patient volume period" on your attestation) that was selected during the time of attestation. This should be a complete list of all providers at that organization during that time period.

If the EP did not attest using group proxy, please indicate that by checking off the "No" box.



Meaningful Use (MU) Modified Stage 2

Objective		EP's Responses
1.3. Certified Electronic Health Record Technology (CEHRT)	What is your CEHRT number?	
	Please provide, for year being attested to **(2018)**, details of your CEHRT software maker, software version, and documentation showing date of CEHRT implementation.	
	Please provide documentation showing your legal or financial commitment to your CEHRT. This can include: bill(s) of sale, receipts, contracts, maintenance agreements, licenses, canceled checks, or other documentation.	
	Does your CEHRT meet the 2014 or 2015 standards or a combination of the two?	☐ Yes ☐ No
	Please list the practice location(s) equipped with your CEHRT:	
	Is your CEHRT the same one you attested with in prior years?	☐ Yes ☐ No
	Are you employed, or contracted to work for multiple employers or at multiple locations?	☐ Yes ☐ No
	Do your employers use different CEHRT?	☐ Yes ☐ No
	If yes, please list the CEHRT if it is different than the one stated above, along with the locations and addresses of your employers:	
	Supporting documentation provided?	☐ Yes

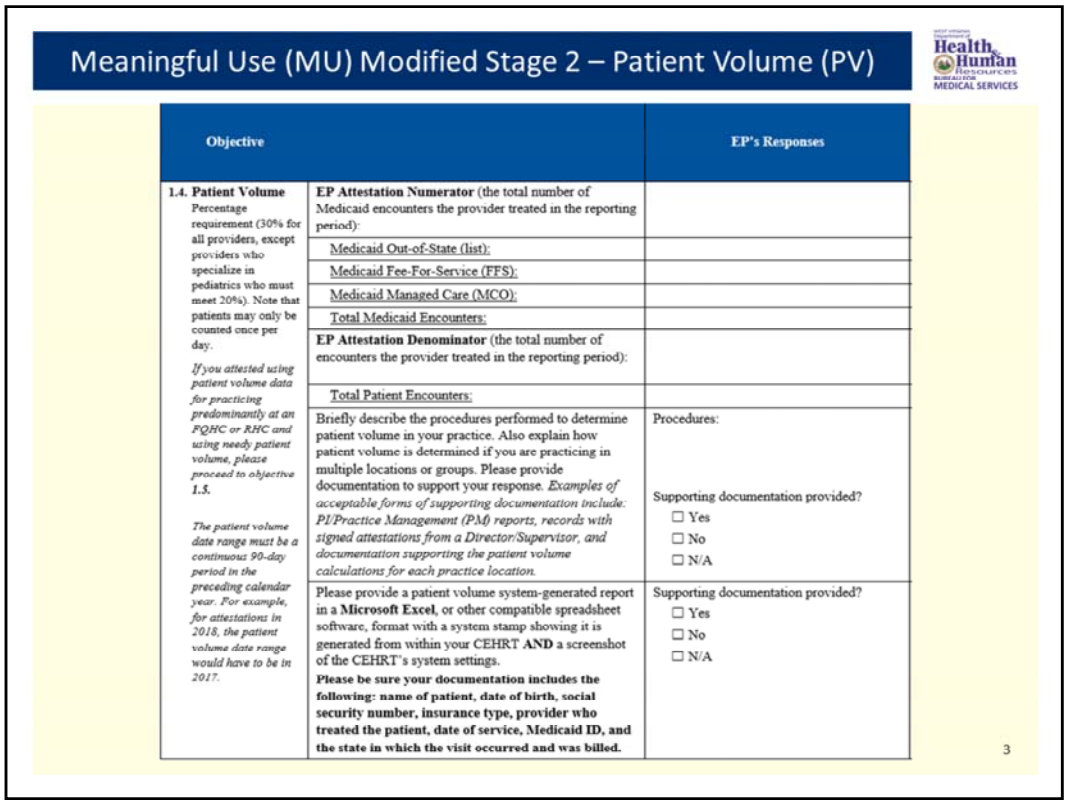
2

For objective 1.3, the EP must provide the Certified Electronic Health Record Technology (CEHRT) that was used during the attestation year that is being audited. First, provide the CEHRT number that was used during the Promoting Interoperability (PI) (formerly EHR) period of the attestation under audit. Next, list the version, vendor, product name, and date of implementation. In order to validate the information, documentation showing a financial or legal commitment, such as a bill of sale, receipts, contracts, licenses, maintenance agreements, or canceled checks, is required. These documents must have the date visible, as well as the product name or CEHRT number. All other documentation must be from the current year to show the CEHRT is still in place and being used.

Next, verify if you have a 2014 or 2015 version CEHRT or a combination of both. Also, if you have changed CEHRT systems since your first payment year, you must provide a brief description of why you changed systems.

Next, list the practice location where the CEHRT is housed. If you have attested before, check off if your CEHRT is the same as prior years.

Lastly, the EP must indicate if they are employed at multiple locations or by multiple employers. If yes, the EP must verify if the employers use different CEHRTs and list the CEHRT ID, location of the CEHRT, and the address of each practice location.



Meaningful Use (MU) Modified Stage 2 – Patient Volume (PV)

Objective		EP's Responses
1.4. Patient Volume Percentage requirement (30% for all providers, except providers who specialize in pediatrics who must meet 20%). Note that patients may only be counted once per day. *If you attested using patient volume data for practicing predominantly at an FQHC or RHC and using needy patient volume, please proceed to objective 1.5.* *The patient volume date range must be a continuous 90-day period in the preceding calendar year. For example, for attestations in 2018, the patient volume date range would have to be in 2017.*	**EP Attestation Numerator** (the total number of Medicaid encounters the provider treated in the reporting period):	
	Medicaid Out-of-State (list):	
	Medicaid Fee-For-Service (FFS):	
	Medicaid Managed Care (MCO):	
	Total Medicaid Encounters:	
	EP Attestation Denominator (the total number of encounters the provider treated in the reporting period):	
	Total Patient Encounters:	
	Briefly describe the procedures performed to determine patient volume in your practice. Also explain how patient volume is determined if you are practicing in multiple locations or groups. Please provide documentation to support your response. *Examples of acceptable forms of supporting documentation include: PI/Practice Management (PM) reports, records with signed attestations from a Director/Supervisor, and documentation supporting the patient volume calculations for each practice location.*	Procedures: Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	Please provide a patient volume system-generated report in a **Microsoft Excel**, or other compatible spreadsheet software, format with a system stamp showing it is generated from within your CEHRT **AND** a screenshot of the CEHRT's system settings. **Please be sure your documentation includes the following: name of patient, date of birth, social security number, insurance type, provider who treated the patient, date of service, Medicaid ID, and the state in which the visit occurred and was billed.**	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A

3

If you attested using needy patient volume at an FQHC or RHC for the audit year, because they were unable to satisfy the regular patient volume requirement threshold, then proceed to objective 1.5.

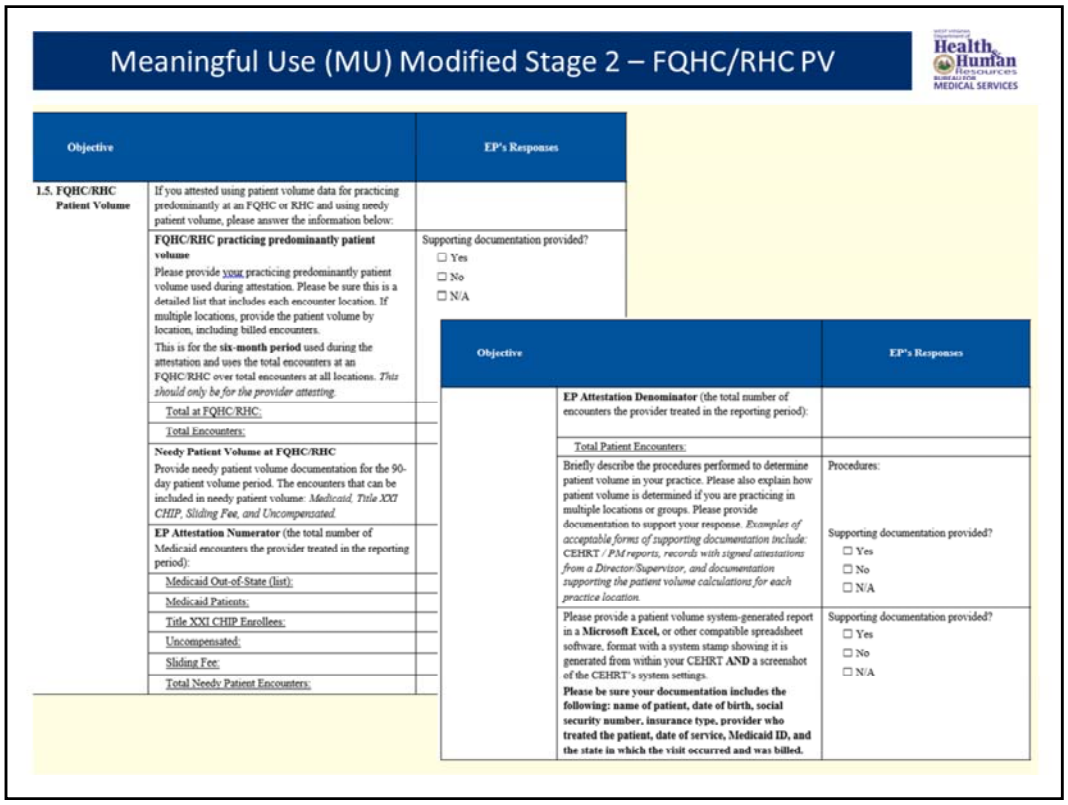
The Medicaid patient volume requirement is a minimum of 30% for all EPs except pediatricians. Pediatricians are required to have a minimum of 20% Medicaid patient volume.

First, under the reporting period section, the EP must provide the **90-day patient volume period** that was used during the attestation. This date range is labeled "patient volume period" on your attestation.

Next, provide both the numerator and denominator used to determine the patient volume percentage. The numerator should include encounters for patients enrolled in Medicaid, as well as CHIP encounters **if due to a program created under Title XIX or Title XXI-funded Medicaid expansion**. No patient should be counted more than once per calendar day regardless of the number of services the patient has during that day. The denominator is the number of total patient encounters for all insurances during the patient volume period. Again, a patient can only be counted once per day as an encounter.

For the reported numerators and denominators listed in the questionnaire, detailed supporting documentation must be submitted. **The documentation should include the patient name, place of service, date of service, insurance type, the name of the provider who treated the patient, patient's date of birth, social security number, Medicaid ID, and the state in which the visit occurred and was billed.** This level of detail must be consistent for each patient encounter. It must be evident where the numbers attested to came from. Supporting documentation should be in an Excel format with a system stamp that shows the information was pulled from the CEHRT, along with a screenshot of the CEHRT's system settings used to run the report. If patient volume provided varies from attestation patient volume, please provide an explanation for the variance.

A reminder that when you use screenshots as supporting documentation for any part of the audit, the screenshot *must* include a date indicating when the screenshot was captured.



Meaningful Use (MU) Modified Stage 2 – FQHC/RHC PV

Objective		EP's Responses
1.5. FQHC/RHC Patient Volume	If you attested using patient volume data for practicing predominantly at an FQHC or RHC and using needy patient volume, please answer the information below:	
	FQHC/RHC practicing predominantly patient volume Please provide your practicing predominantly patient volume used during attestation. Please be sure this is a detailed list that includes each encounter location. If multiple locations, provide the patient volume by location, including billed encounters. This is for the **six-month period** used during the attestation and uses the total encounters at an FQHC/RHC over total encounters at all locations. *This should only be for the provider attesting.*	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	Total at FQHC/RHC:	
	Total Encounters:	
	Needy Patient Volume at FQHC/RHC Provide needy patient volume documentation for the 90-day patient volume period. The encounters that can be included in needy patient volume: *Medicaid, Title XXI CHIP, Sliding Fee, and Uncompensated.*	
	EP Attestation Numerator (the total number of Medicaid encounters the provider treated in the reporting period):	
	Medicaid Out-of-State (list):	
	Medicaid Patients:	
	Title XXI CHIP Enrollees:	
	Uncompensated:	
	Sliding Fee:	
	Total Needy Patient Encounters:	

Objective		EP's Responses
	EP Attestation Denominator (the total number of encounters the provider treated in the reporting period):	
	Total Patient Encounters:	
	Briefly describe the procedures performed to determine patient volume in your practice. Please also explain how patient volume is determined if you are practicing in multiple locations or groups. Please provide documentation to support your response. *Examples of acceptable forms of supporting documentation include:* CEHRT / *PM reports, records with signed attestations from a Director/Supervisor, and documentation supporting the patient volume calculations for each practice location.*	Procedures: Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	Please provide a patient volume system-generated report in a **Microsoft Excel,** or other compatible spreadsheet software, format with a system stamp showing it is generated from within your CEHRT **AND** a screenshot of the CEHRT's system settings. **Please be sure your documentation includes the following: name of patient, date of birth, social security number, insurance type, provider who treated the patient, date of service, Medicaid ID, and the state in which the visit occurred and was billed.**	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A

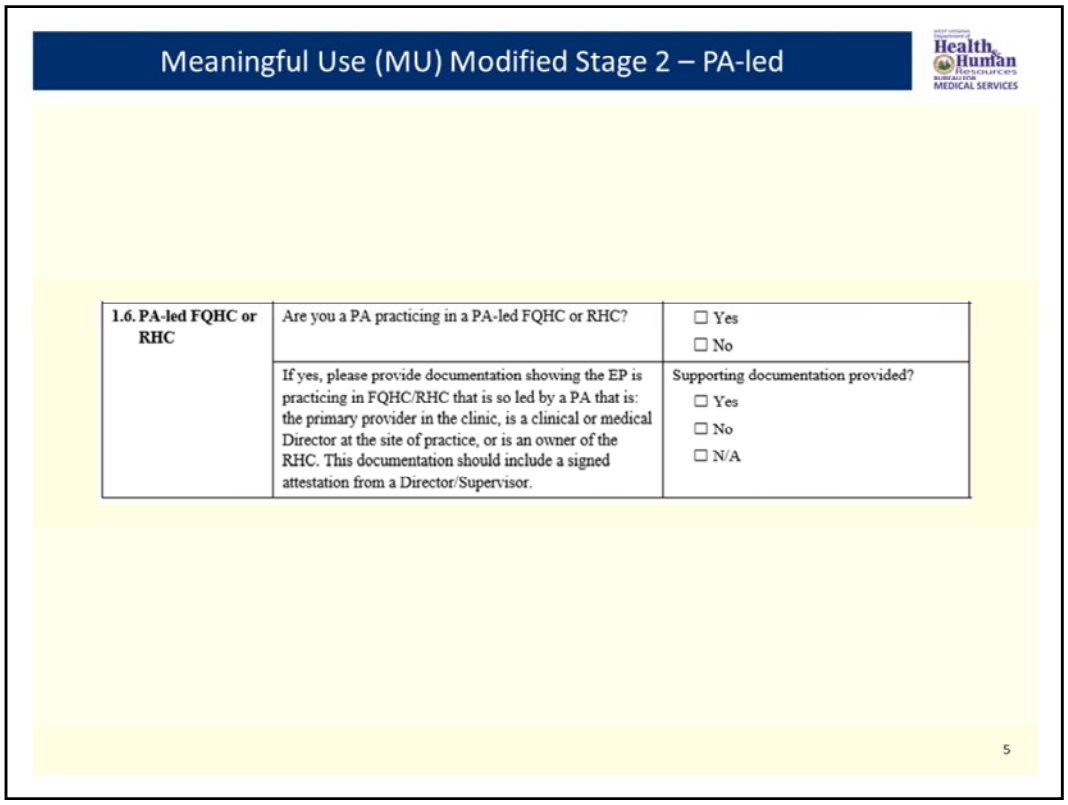
Objective 1.5 is asking if the EP is practicing predominantly at a Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC). If the EP is not practicing predominantly at one of these locations and did not attest to the needy patient volume at an FQHC/RHC, then this question can be skipped.

If the EP is practicing predominantly at one of these locations, the EP must provide documentation that shows 50% or more of the EP's encounters over a **six-month period** occurred at an FQHC or RHC. These encounters should be from the calendar year prior to the payment year or the most recent 12-month period prior to attestation. Detailed documentation must be provided for the provider attesting and must be for the entire six-month period. Each encounter must have the location of the service listed so that location of encounters can be verified.

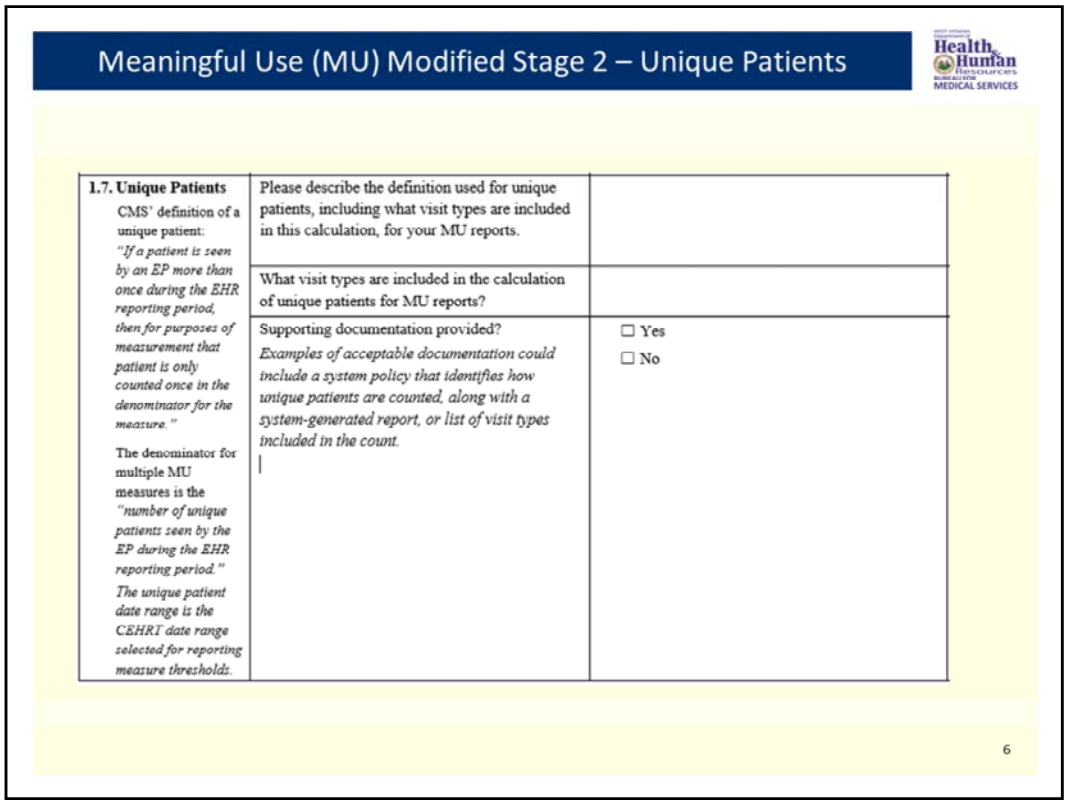
If the EP passed the above 50% practicing predominantly test, then the next step is providing documentation to show needy patient volume. This documentation should cover the **90-day patient volume period** and can include Medicaid, stand-alone Title XXI CHIP, sliding fee, and uncompensated encounters. All encounters that are Medicaid, stand-alone Title XXI CHIP, sliding fee, and uncompensated care will represent the numerator of the patient volume calculation. The denominator is a list of total encounters during the patient volume period regardless of the type of insurance. Both numerator and denominator encounters must be included. Additionally, both the numerator and denominator must be supported with **detailed documentation, including the name of the patient, insurance type, provider who treated the patient, date of service, patient's date of birth, social security number, Medicaid ID, and the state in which the visit occurred and was billed.** This should be in Excel format with a time stamp that shows it was generated with an CEHRT, along with a screenshot of the CEHRT's system settings that were used to conduct this report.

If patient volume provided varies from attestation patient volume, please provide an explanation for the variance.

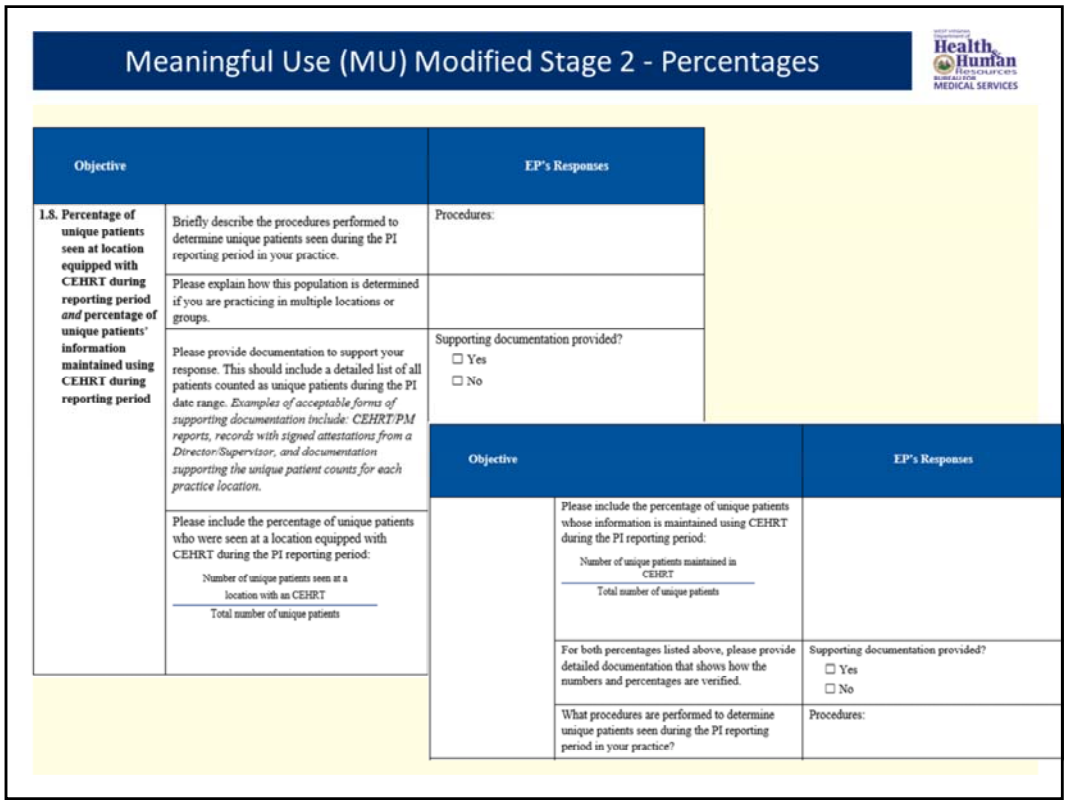
A reminder that when you use screenshots as supporting documentation for any part of the audit, the screenshot *must* include a date indicating when the screenshot was captured.



Question 1.6 is verifying if the EP is a physician assistant (PA) practicing at a FQHC or RHC that is PA-led. If the EP qualified for the program due to this definition, the provider must submit documentation showing the PA is practicing at a FQHC or RHC that is so led by a PA that is the primary provider, clinical director, medical director, or the owner of the clinic. This documentation can include a signed attestation from a director or supervisor.



Objective 1.7 is asking for the definition the EP's CEHRT used to determine unique patients. Describe the definition of a unique patient, including the visit types that are included in the calculation of the meaningful use reports that are used to determine measure outcomes (the Patient-Specific Education, Patient Electronic Access, and Secure Messaging measures all use unique patient totals as their denominator and the total unique patients on the unique patient list provided should agree to the denominator of those measures). Documentation can include any policy that lists how a unique patient is calculated. If it is system generated, a policy that explains how the system tracks unique patients, or a screenshot of the system calculating unique patients, must be included.



Meaningful Use (MU) Modified Stage 2 - Percentages

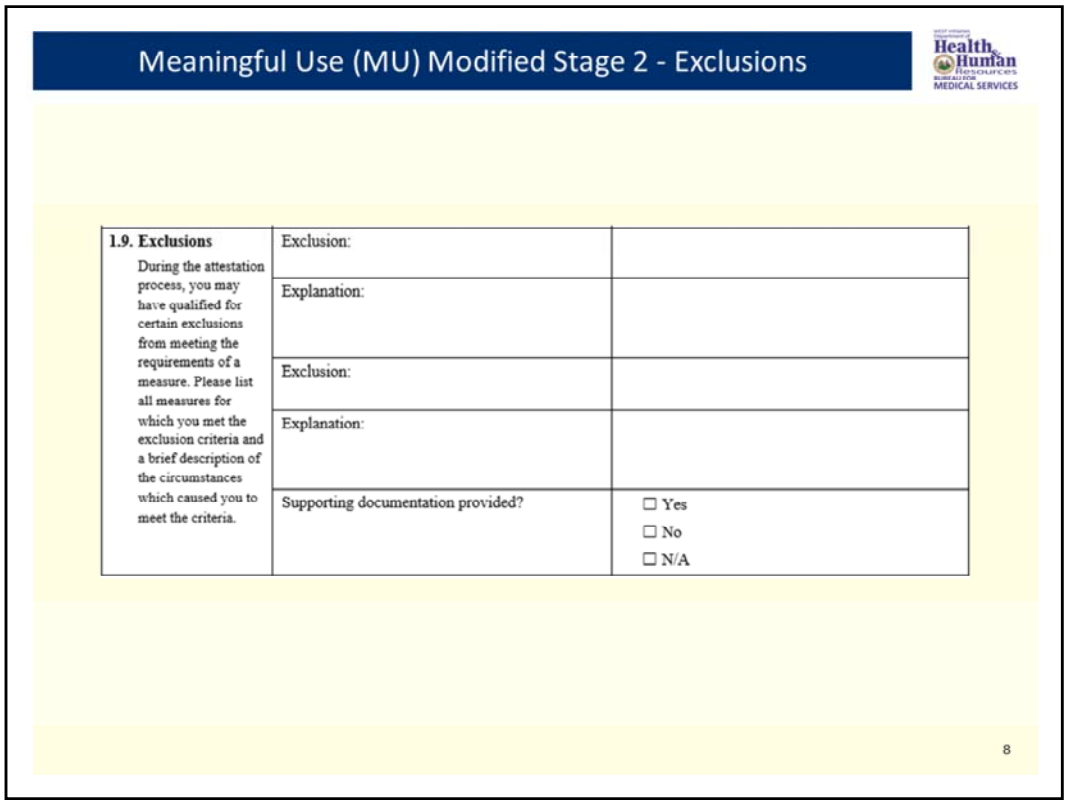
Objective		EP's Responses
1.8. Percentage of unique patients seen at location equipped with CEHRT during reporting period *and* percentage of unique patients' information maintained using CEHRT during reporting period	Briefly describe the procedures performed to determine unique patients seen during the PI reporting period in your practice.	Procedures:
	Please explain how this population is determined if you are practicing in multiple locations or groups.	
	Please provide documentation to support your response. This should include a detailed list of all patients counted as unique patients during the PI date range. *Examples of acceptable forms of supporting documentation include: CEHRT/PM reports, records with signed attestations from a Director/Supervisor, and documentation supporting the unique patient counts for each practice location.*	Supporting documentation provided? ☐ Yes ☐ No
	Please include the percentage of unique patients who were seen at a location equipped with CEHRT during the PI reporting period: Number of unique patients seen at a location with an CEHRT / Total number of unique patients	

Objective		EP's Responses
	Please include the percentage of unique patients whose information is maintained using CEHRT during the PI reporting period: Number of unique patients maintained in CEHRT / Total number of unique patients	
	For both percentages listed above, please provide detailed documentation that shows how the numbers and percentages are verified.	Supporting documentation provided? ☐ Yes ☐ No
	What procedures are performed to determine unique patients seen during the PI reporting period in your practice?	Procedures:

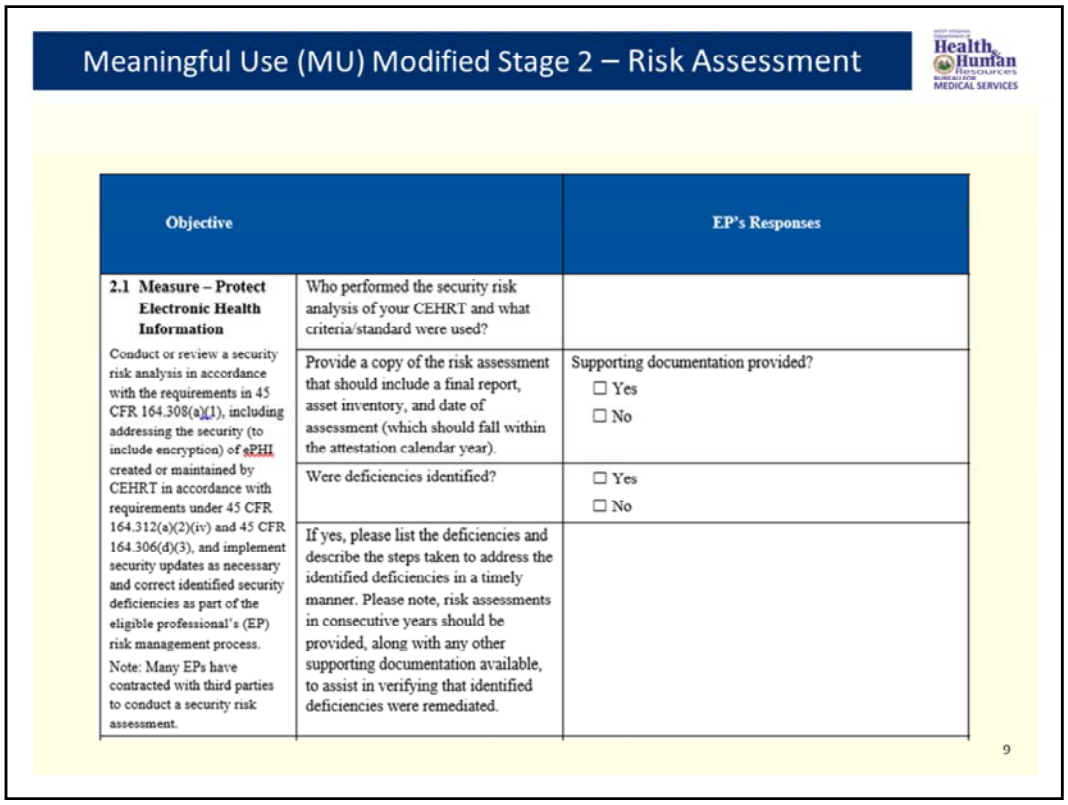
Objective 1.8 will verify the procedures performed to determine unique patients. If multiple locations are used, explain how that is integrated into the calculation of the unique patients for MU measures. In order to support this question, the EP must provide a detailed list of all unique patients that are seen and counted during the PI reporting period. It should be clear how the patients are counted and that they aren't being counted more than once per reporting period.

Next, please include the percentage of unique patients that are seen at a location equipped with an CEHRT. This percentage should be the number of patients seen at a location with an EHR divided by the total number of unique patients. Detailed documentation that clearly indicates the patients are seen at a location with an CEHRT is required.

Then, the EP must include the percentage of unique patients whose information is maintained in the CEHRT. This calculation is executed by determining the number of patients maintained in an CEHRT divided by the total number of unique patients. The supporting documentation must be detailed enough so that it is clear how each number was found in the two percentage requirements. It is important no patients are counted more than once per EHR-reporting period to determine the percentages.



For objective 1.9, list all exclusions to MU measures that the EP selected at the time of attestation. Also list the explanation that allowed you to meet the exclusion. The explanation must be a qualified reason that allows for exclusions to be met. Supporting documentation can include screenshots of the EP's CEHRT system or any documentation that proves the exclusion is allowed and met. For all measures the EP excluded, write "N/A" when asked for specific documentation for the measure excluded later in the questionnaire. Please note, exclusions taken should match the attestation. If it does not, please include a written explanation that details why there are discrepancies.



Meaningful Use (MU) Modified Stage 2 – Risk Assessment

Objective		EP's Responses
2.1 Measure – Protect Electronic Health Information Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the eligible professional's (EP) risk management process. Note: Many EPs have contracted with third parties to conduct a security risk assessment.	Who performed the security risk analysis of your CEHRT and what criteria/standard were used?	
	Provide a copy of the risk assessment that should include a final report, asset inventory, and date of assessment (which should fall within the attestation calendar year).	Supporting documentation provided? ☐ Yes ☐ No
	Were deficiencies identified?	☐ Yes ☐ No
	If yes, please list the deficiencies and describe the steps taken to address the identified deficiencies in a timely manner. Please note, risk assessments in consecutive years should be provided, along with any other supporting documentation available, to assist in verifying that identified deficiencies were remediated.	

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Objective 2.1 is regarding the Protect Electronic Health Information measure. This measure is used to ensure all patient information is secure within the CEHRT system. In order to support this, each provider must conduct a security risk assessment, or perform a detailed update/review of a previous risk assessment, **each year**.

Potential risks that should be included in the assessment are security of PHI, hardware, and software. The risk assessment/update performed in the year of the audit should be submitted, as well as the prior year's risk assessment if an update/review was performed in the year under audit. **The full risk assessment must be submitted and should include a final report, asset inventory, and date of assessment. Please also list who conducted the risk assessment and if it was performed by a third party or internally.**

If deficiencies were identified, list them and describe the steps taken to address these deficiencies. Documentation should be provided to support this such as assessments that are in consecutive years along with other supporting documentation available, to assist in verifying the identified deficiencies were remediated.

Health IT create a video that discusses planning, conducting and reviewing the vulnerabilities and risks of healthcare organizations, and how regular risk assessments can protect their practice and data. The link has been provided for your convenience.

https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-videos

Additional useful links are below:

Security Risk Analysis Tip Sheet (at the bottom of the link):
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage2MedicaidModified_Require.html

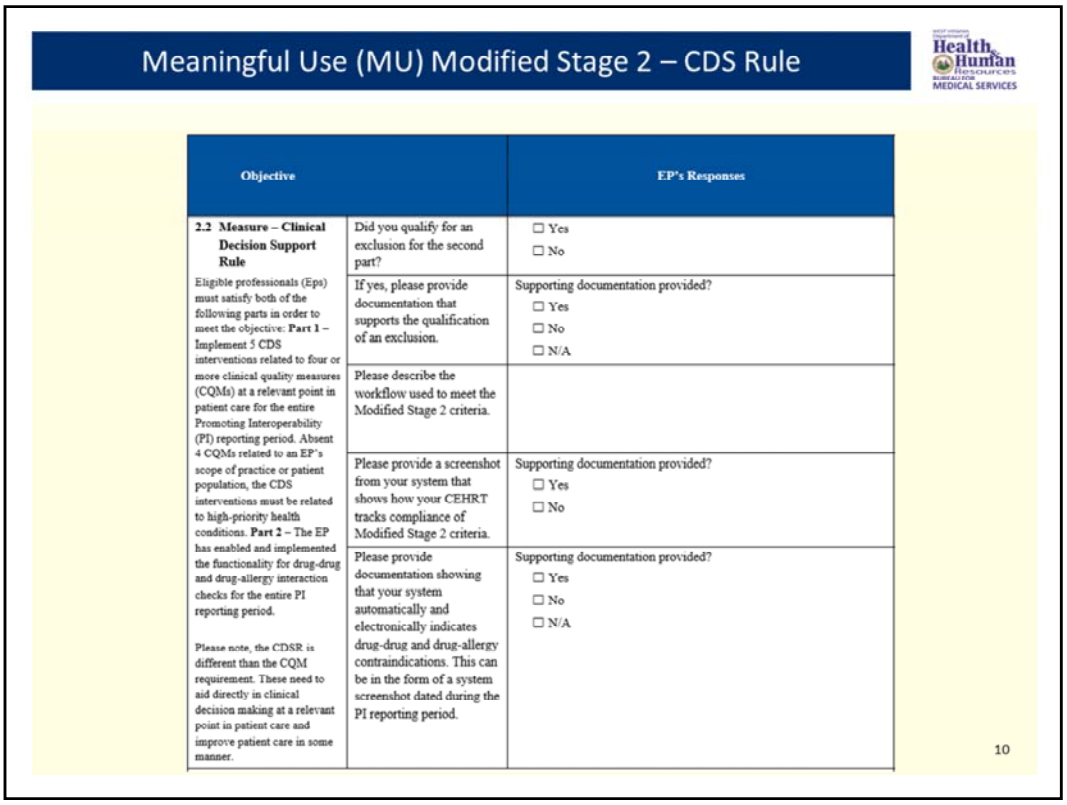
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2018ProgramRequirementsMedicaid.html

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SecurityRiskAnalysis_Tipsheet-.pdf

https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

A 10 Step Plan:

https://www.healthit.gov/topic/privacy-security-and-hipaa/top-10-myths-security-risk-analysis



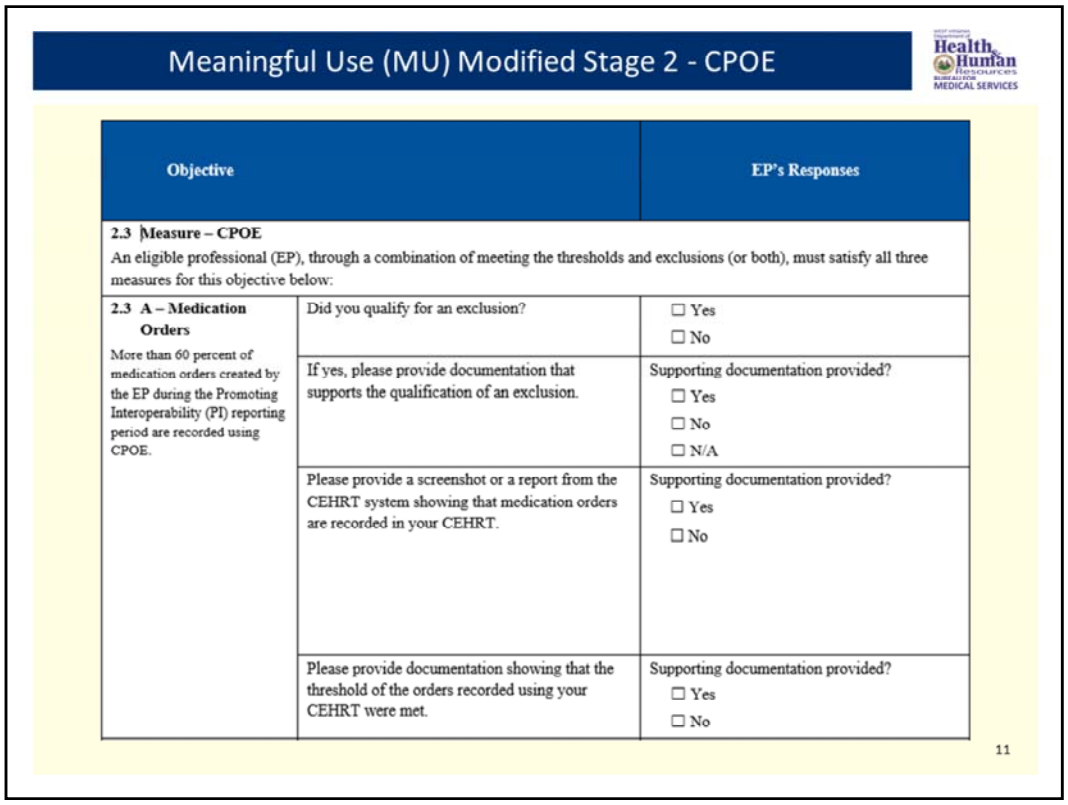
Objective		EP's Responses
2.2 Measure – Clinical Decision Support Rule Eligible professionals (Eps) must satisfy both of the following parts in order to meet the objective: **Part 1** – Implement 5 CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire Promoting Interoperability (PI) reporting period. Absent 4 CQMs related to an EP's scope of practice or patient population, the CDS interventions must be related to high-priority health conditions. **Part 2** – The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period. Please note, the CDSR is different than the CQM requirement. These need to aid directly in clinical decision making at a relevant point in patient care and improve patient care in some manner.	Did you qualify for an exclusion for the second part?	☐ Yes ☐ No
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	Please describe the workflow used to meet the Modified Stage 2 criteria.	
	Please provide a screenshot from your system that shows how your CEHRT tracks compliance of Modified Stage 2 criteria.	Supporting documentation provided? ☐ Yes ☐ No
	Please provide documentation showing that your system automatically and electronically indicates drug-drug and drug-allergy contraindications. This can be in the form of a system screenshot dated during the PI reporting period.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A

Objective 2.2 will verify the Clinical Decision Support Rule measure. To support this measure, the EP must describe the workflow used to meet the Modified Stage 2 criteria.

The EP should indicate if they qualified for an exclusion for the second part of this measure; this should be consistent with what was stated on objective 1.9. A valid exclusion can be taken for the drug-drug and drug-allergy checks if the EP writes fewer than 100 medication orders during the PI period.

The EP should show they implemented five clinical decision support interventions. The EP should also provide documentation that shows the EP enabled **and** implemented the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period. Regardless of the element of the Clinical Decision Support Rule measure that the EP attested to, system documentation that shows how the system tracks compliance with this rule is required.

A screenshot from the system that shows how the CEHRT tracks compliance for the Stage 2 criteria for all dashboard measures and their percentages must be provided. Also, the EP must provide a screenshot or printout of all five clinical decision support interventions that were implemented and a dated screenshot of the interaction checks functionality being enabled.



Meaningful Use (MU) Modified Stage 2 - CPOE

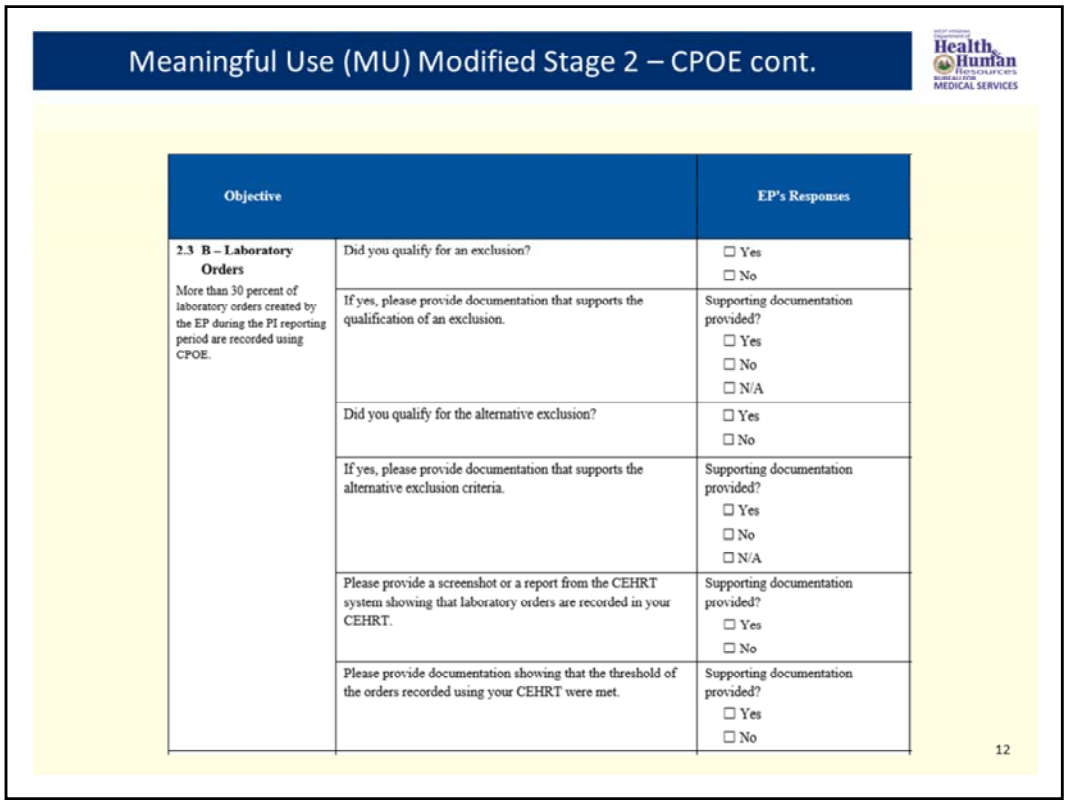
Objective		EP's Responses
2.3 Measure – CPOE An eligible professional (EP), through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective below:		
2.3 A – Medication Orders More than 60 percent of medication orders created by the EP during the Promoting Interoperability (PI) reporting period are recorded using CPOE.	Did you qualify for an exclusion?	☐ Yes ☐ No
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	Please provide a screenshot or a report from the CEHRT system showing that medication orders are recorded in your CEHRT.	Supporting documentation provided? ☐ Yes ☐ No
	Please provide documentation showing that the threshold of the orders recorded using your CEHRT were met.	Supporting documentation provided? ☐ Yes ☐ No

11

Objective 2.3 is referring to Computerized Physician Order Entries that has three components including medication, laboratory, and radiology orders.

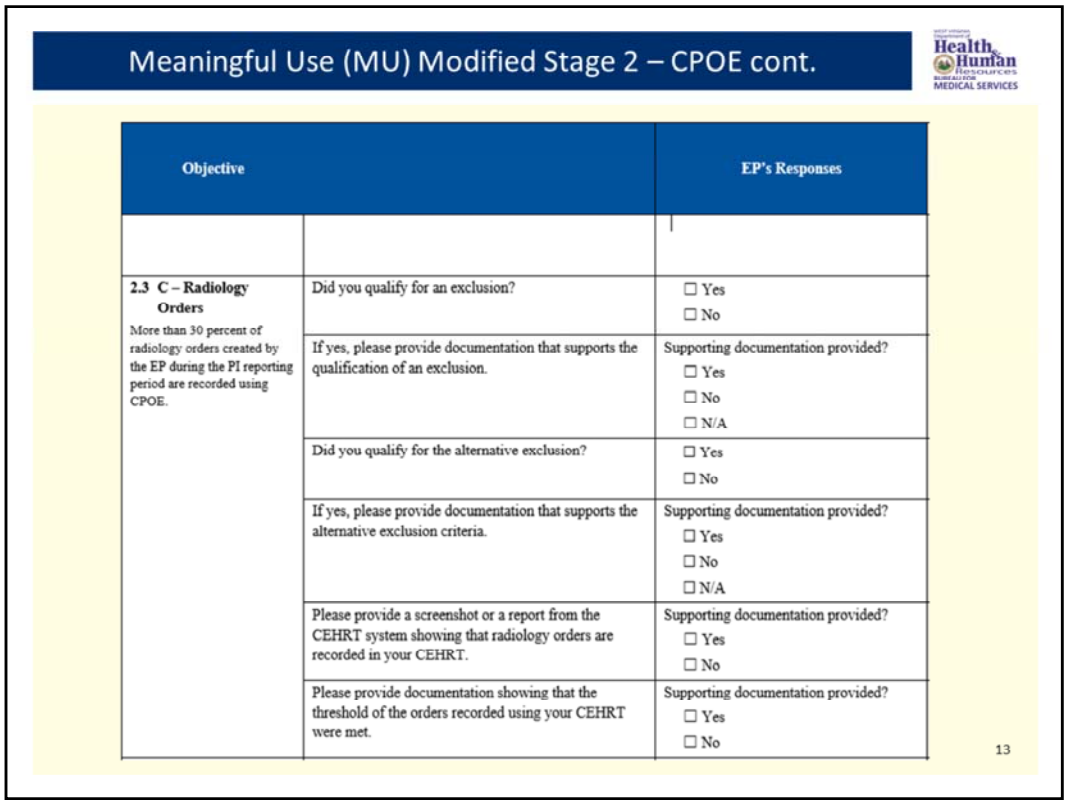
The EP should indicate if they qualified for an exclusion for this measure, this should be consistent with what was stated on objective 1.9. A valid exclusion can be taken for any EP that writes fewer than 100 medication orders during the PI reporting period.

Objective 2.3 A refers to the Medication Orders measure qualification. The EP should provide evidence that more than 60% of medication orders were captured using computerized provider order entry. Documentation that can be used to support this measure is a screenshot or report from the CEHRT that shows how these entries are recorded and tracked in the CEHRT.



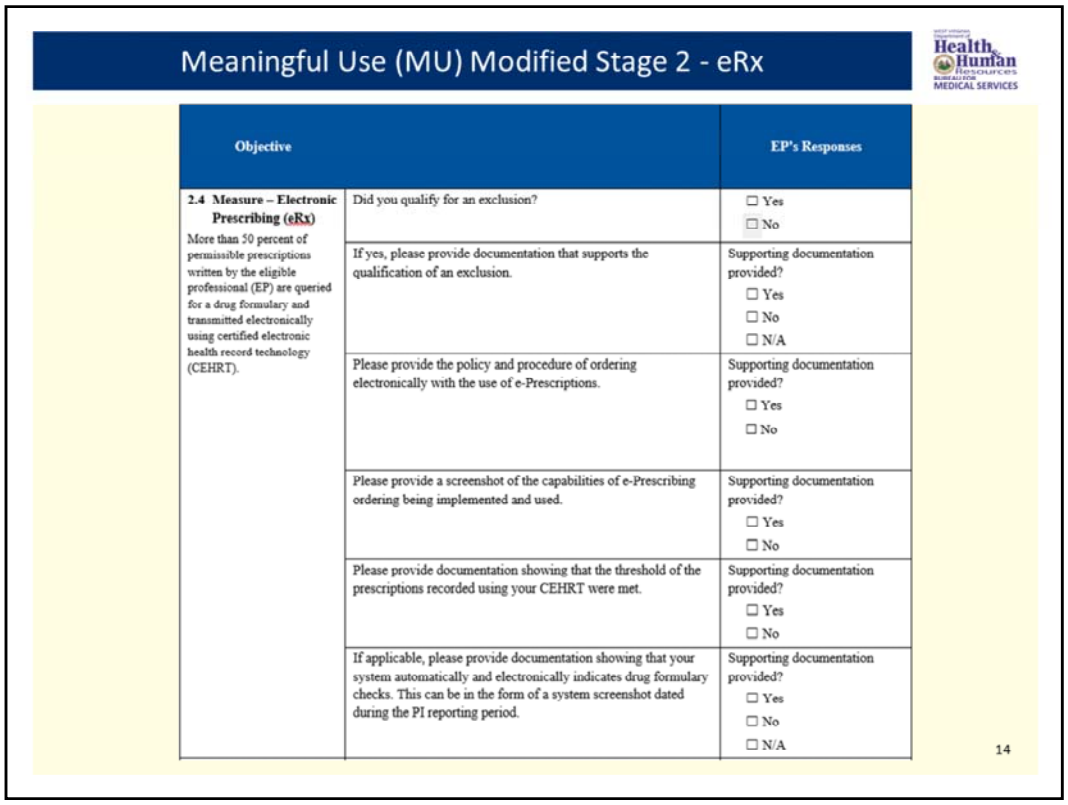
The EP should indicate if they qualified for an exclusion for laboratory; this should be consistent with what was stated on objective 1.9. A valid exclusion can be taken for an EP that writes fewer than 100 laboratory orders during the PI reporting period

Objective 2.3 B refers to the Laboratory Orders specific measure qualification. The EP should provide evidence that more than 30% of laboratory orders were captured using computerized provider order entry. Documentation that can be used to support this measure is a screenshot or report from the CEHRT that shows how these entries are recorded and tracked in the CEHRT.



The EP should indicate if they qualified for an exclusion for radiology orders; this should be consistent with what was stated and provided for objective 1.9. A valid exclusion can be taken for an EP that writes fewer than 100 radiology orders during the PI reporting period.

Objective 2.3 C refers to the Radiology Orders specific measure qualification. The EP should provide evidence that more than 30% of radiology orders were captured using computerized provider order entry. Documentation that can be used to support this measure is a screenshot or report from the CEHRT that shows how these entries are recorded and tracked in the CEHRT.



Meaningful Use (MU) Modified Stage 2 - eRx

Objective		EP's Responses
2.4 Measure – Electronic Prescribing (eRx) More than 50 percent of permissible prescriptions written by the eligible professional (EP) are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).	Did you qualify for an exclusion?	☐ Yes ☐ No
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	Please provide the policy and procedure of ordering electronically with the use of e-Prescriptions.	Supporting documentation provided? ☐ Yes ☐ No
	Please provide a screenshot of the capabilities of e-Prescribing ordering being implemented and used.	Supporting documentation provided? ☐ Yes ☐ No
	Please provide documentation showing that the threshold of the prescriptions recorded using your CEHRT were met.	Supporting documentation provided? ☐ Yes ☐ No
	If applicable, please provide documentation showing that your system automatically and electronically indicates drug formulary checks. This can be in the form of a system screenshot dated during the PI reporting period.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A

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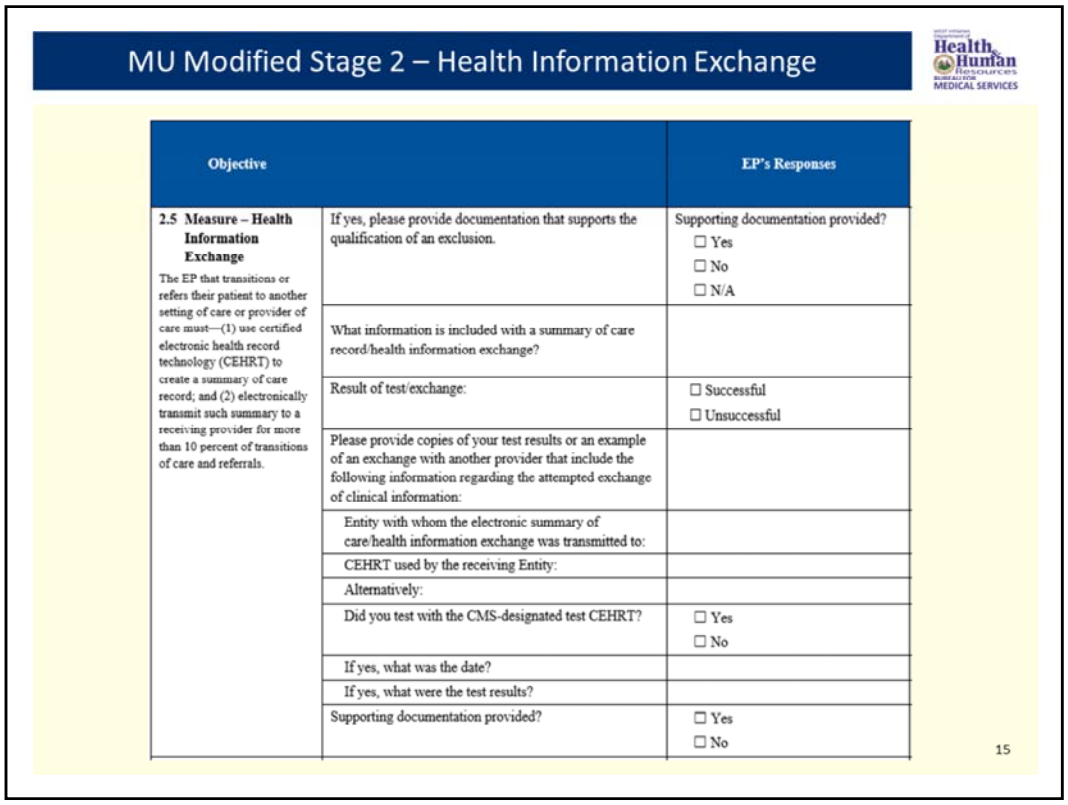
Objective 2.4 is referring to the E-Prescribing measure.

The EP should indicate if they qualified for an exclusion for this measure; this should be consistent with what was stated on objective 1.9. A valid exclusion can be taken by any EP who writes fewer than 100 permissible prescriptions during the PI reporting period, or does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of their PI reporting period.

The EP should provide evidence that more than 50% of permissible prescriptions were queried for a drug formulary and transmitted electronically to a pharmacy. Documentation should show that prescriptions are prescribed through the CEHRT and that a drug formulary was in place and checks were performed.



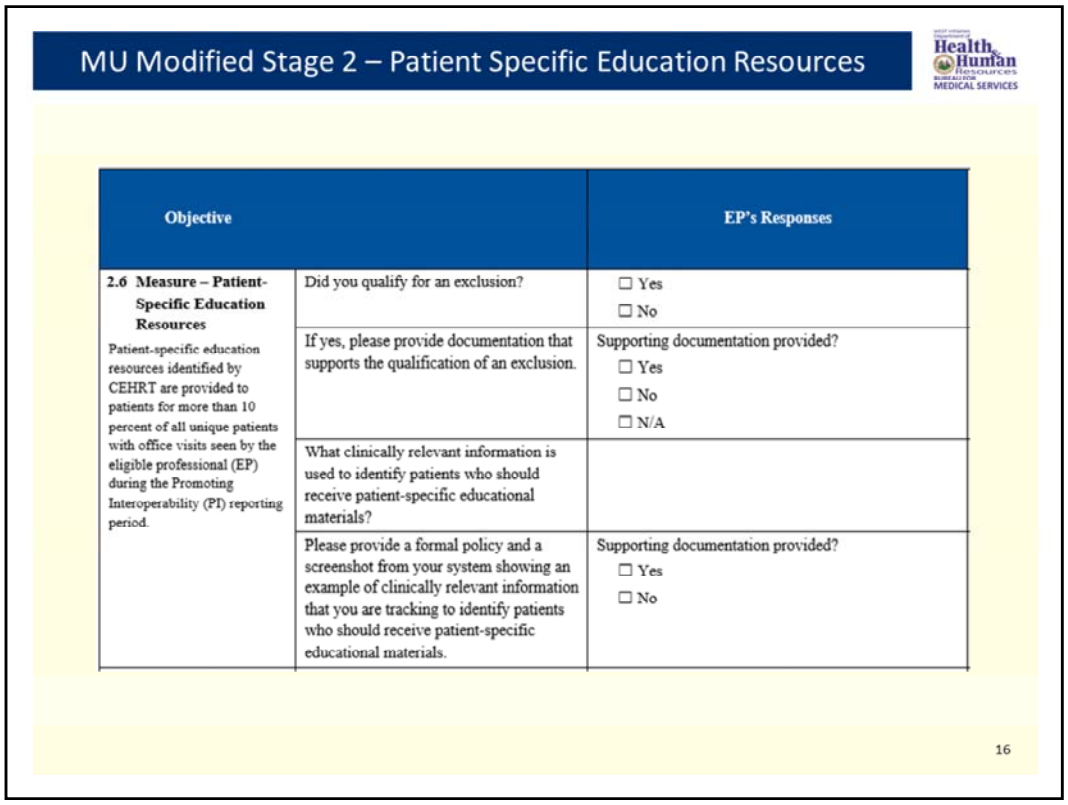
Objective		EP's Responses
2.5 Measure – Health Information Exchange The EP that transitions or refers their patient to another setting of care or provider of care must—(1) use certified electronic health record technology (CEHRT) to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	What information is included with a summary of care record/health information exchange?	
	Result of test/exchange:	☐ Successful ☐ Unsuccessful
	Please provide copies of your test results or an example of an exchange with another provider that include the following information regarding the attempted exchange of clinical information:	
	Entity with whom the electronic summary of care/health information exchange was transmitted to:	
	CEHRT used by the receiving Entity:	
	Alternatively:	
	Did you test with the CMS-designated test CEHRT?	☐ Yes ☐ No
	If yes, what was the date?	
	If yes, what were the test results?	
	Supporting documentation provided?	☐ Yes ☐ No

Objective 2.5 is for the Health Information Exchange measure.

The EP should indicate if they qualified for an exclusion for this measure; this should be consistent with what was stated and provided for objective 1.9. A valid exclusion can be taken by any EP who transfers or refers a patient to another setting of care or provider less than 100 times during the PI reporting period.

The EP should provide evidence that, for at least 10% of transitions out, a summary of care was created using the CEHRT AND transmitted electronically to the receiving provider. For this measure, list or provide an example of what information is included in the EP's summary of care information that is created in the CEHRT. Copies of test results for the attempted exchange of clinical information are required. The entity with whom the summary of care information was exchanged with and what CEHRT the receiving entity used must be included.

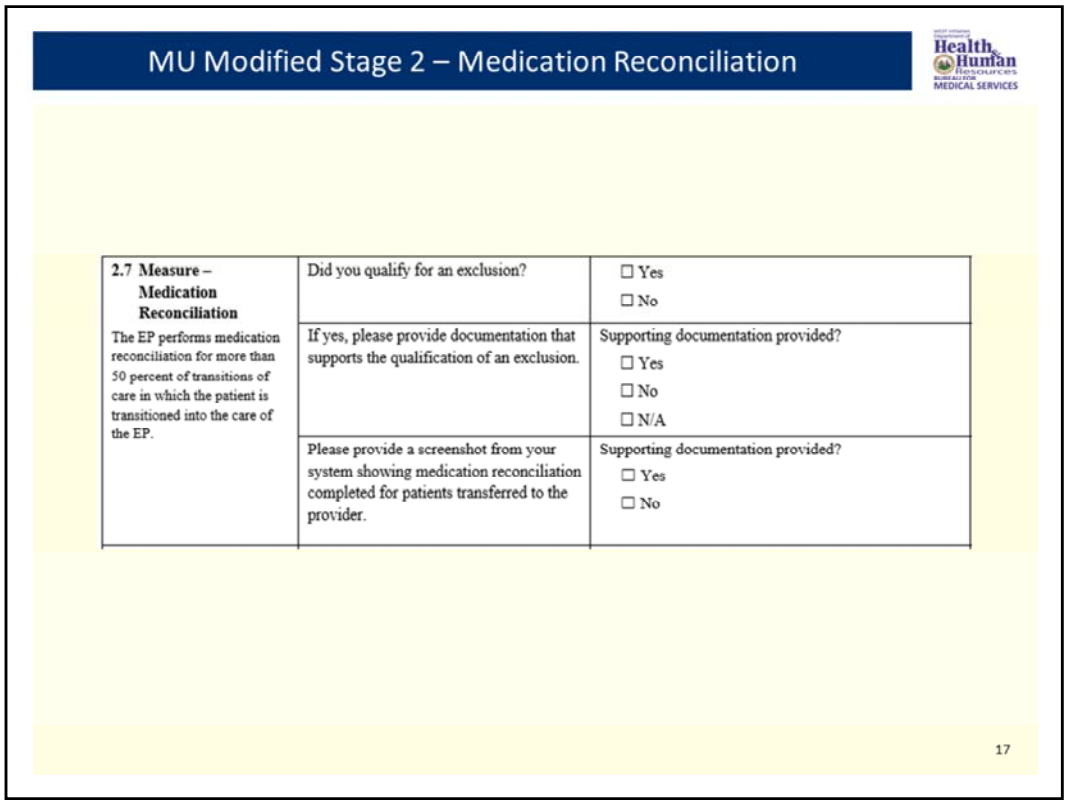
Did the EP test with the CMS designated test CEHRT? If yes, make sure both the date and test results are included. Check off whether the test results were successful or not. The test result copies should be submitted as documentation as well.



Objective 2.6 is referring to the Patient Specific Education Resources measure.

The EP should indicate if they qualified for an exclusion for this measure; this should be consistent with what was stated and provided for objective 1.9. A valid exclusion can be taken by any EP who has no office visits during the PI reporting period.

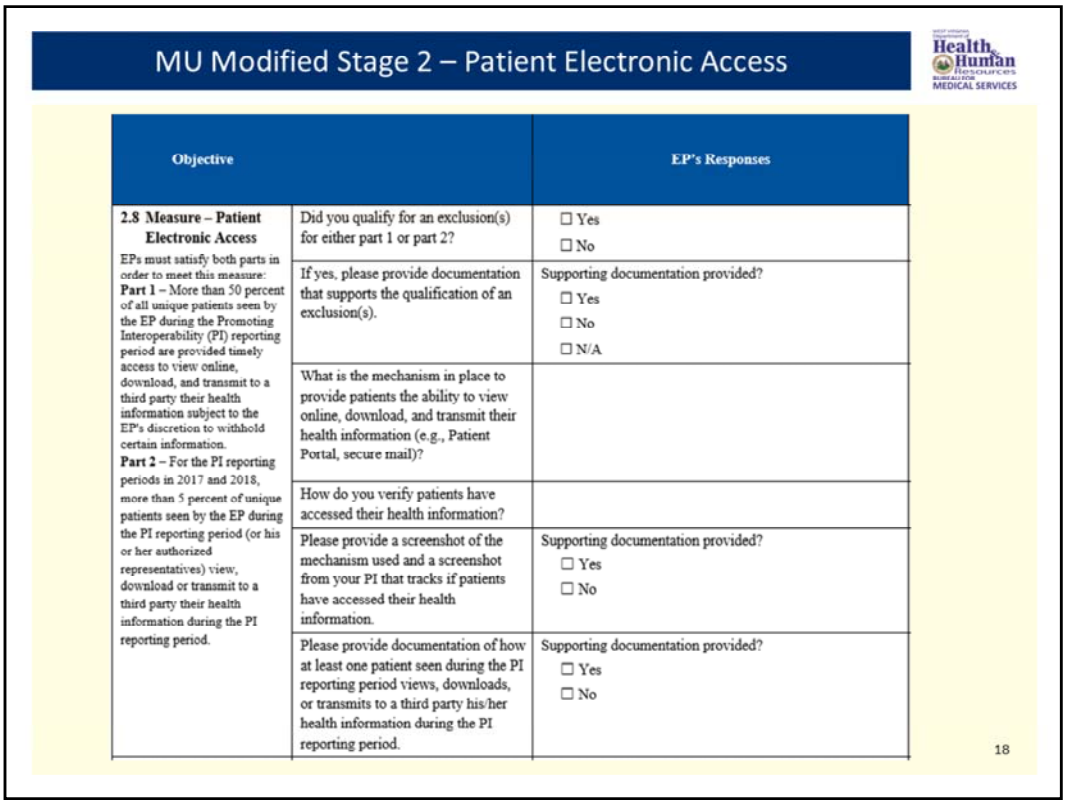
This measure tracks what clinically relevant information is used to identify patients to receive patient specific educational materials. The EP should provide evidence that more than 10% of unique patients seen during the PI reporting period received patient specific education identified by the CEHRT. Documentation for this measure must be a dashboard showing the threshold is met, and a screenshot from your system showing an example of clinically relevant information that you are tracking to identify patients who should receive patient-specific educational materials and a formal policy.



Objective 2.7 is referring to the Medication Reconciliation measure.

The EP should indicate if they qualified for an exclusion for this measure; this should be consistent with what was stated and provided for objective 1.9. A valid exclusion can be taken by any EP who does not receive any patients transitioned into their care during the PI reporting period.

The EP should provide evidence of medication reconciliation being performed for more than 50% of transitions of care into the EP's care. Upon a patient's transition into the EP's care, what clinically relevant information is included in the medication reconciliation? Documentation from the EP's system, such as a printout or screenshot, should support this answer.



MU Modified Stage 2 – Patient Electronic Access

Objective		EP's Responses
2.8 Measure – Patient Electronic Access EPs must satisfy both parts in order to meet this measure: **Part 1** – More than 50 percent of all unique patients seen by the EP during the Promoting Interoperability (PI) reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. **Part 2** – For the PI reporting periods in 2017 and 2018, more than 5 percent of unique patients seen by the EP during the PI reporting period (or his or her authorized representatives) view, download or transmit to a third party their health information during the PI reporting period.	Did you qualify for an exclusion(s) for either part 1 or part 2?	☐ Yes ☐ No
	If yes, please provide documentation that supports the qualification of an exclusion(s).	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	What is the mechanism in place to provide patients the ability to view online, download, and transmit their health information (e.g., Patient Portal, secure mail)?	
	How do you verify patients have accessed their health information?	
	Please provide a screenshot of the mechanism used and a screenshot from your PI that tracks if patients have accessed their health information.	Supporting documentation provided? ☐ Yes ☐ No
	Please provide documentation of how at least one patient seen during the PI reporting period views, downloads, or transmits to a third party his/her health information during the PI reporting period.	Supporting documentation provided? ☐ Yes ☐ No

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Objective 2.8 is referring to the Patient Electronic Access measure.

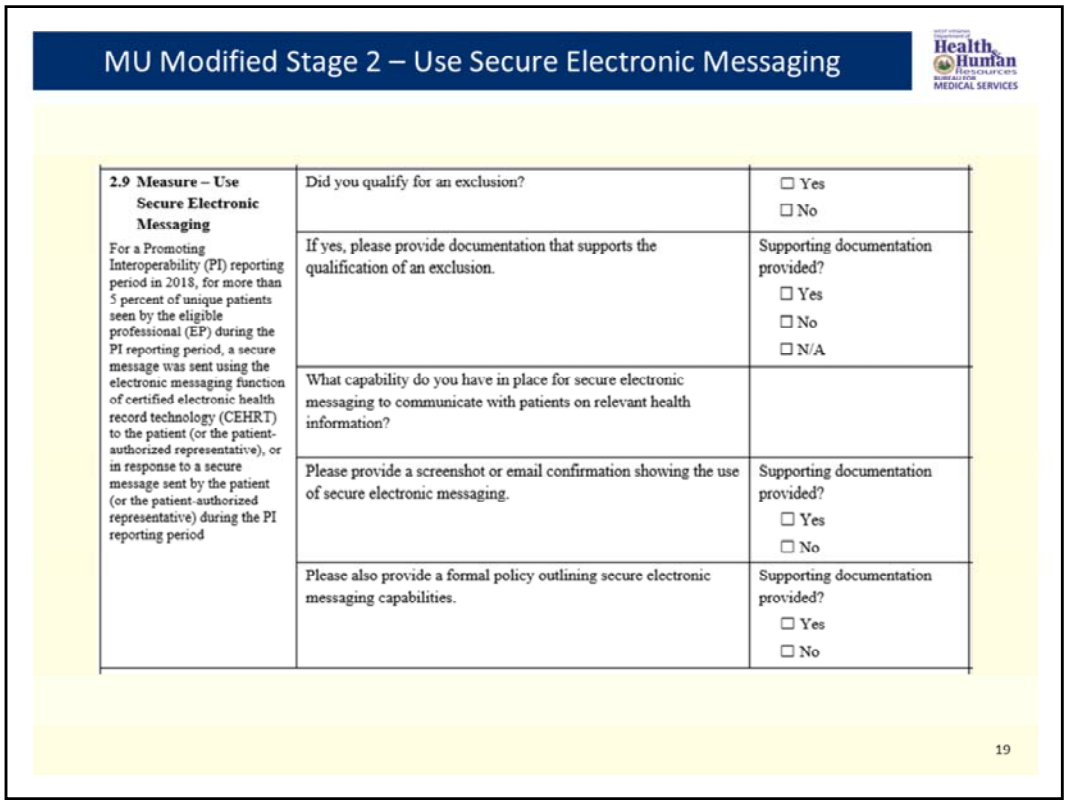
The EP should indicate if they qualified for an exclusion for this measure; this should be consistent with what was stated and provided for objective 1.9. For the first part of the measure, a valid exclusion can be taken by any EP who neither orders or creates any of the information listed for inclusion, as noted at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2018ProgramRequirementsMedicaid.html, except for "Patient Name" and "Provider's Name and Office Contact Information". For the second part of the measure, a valid exclusion can be taken for the same reason as the first part and a valid exclusion can be taken by any EP who conducts 50% or more of their encounters in a county that does not have 50% or more of its housing units with 4Mbs broadband availability according to the latest information available from the FCC on the first day of the PI reporting period.

There are two parts for this measure. First the EP must provide evidence that more than 50% of unique patients seen during the PI period are provided timely access to view online, download, and transmit to a third party their health information. An explanation of what mechanisms are in place to provide patients an electronic access of their health information should be provided. Explain how the EP verifies patients have accessed their health information. A screenshot of the mechanism used and a screenshot from your CEHRT that tracks if patients have accessed their health information. Documentation regarding the percentage of unique patients who have been provided access is needed.

For the second part, the EP must provide evidence that (a screenshot or similar evidence) of at least 5% of unique patients seen during the PI reporting period views, downloads, or transmits to a third party his/her health information during the PI reporting period. A screenshot of the portal and a screenshot of the system tracking this measure is required documentation.

NOTE: If compliance with these measures is not tracked in the CEHRT, it will be extremely

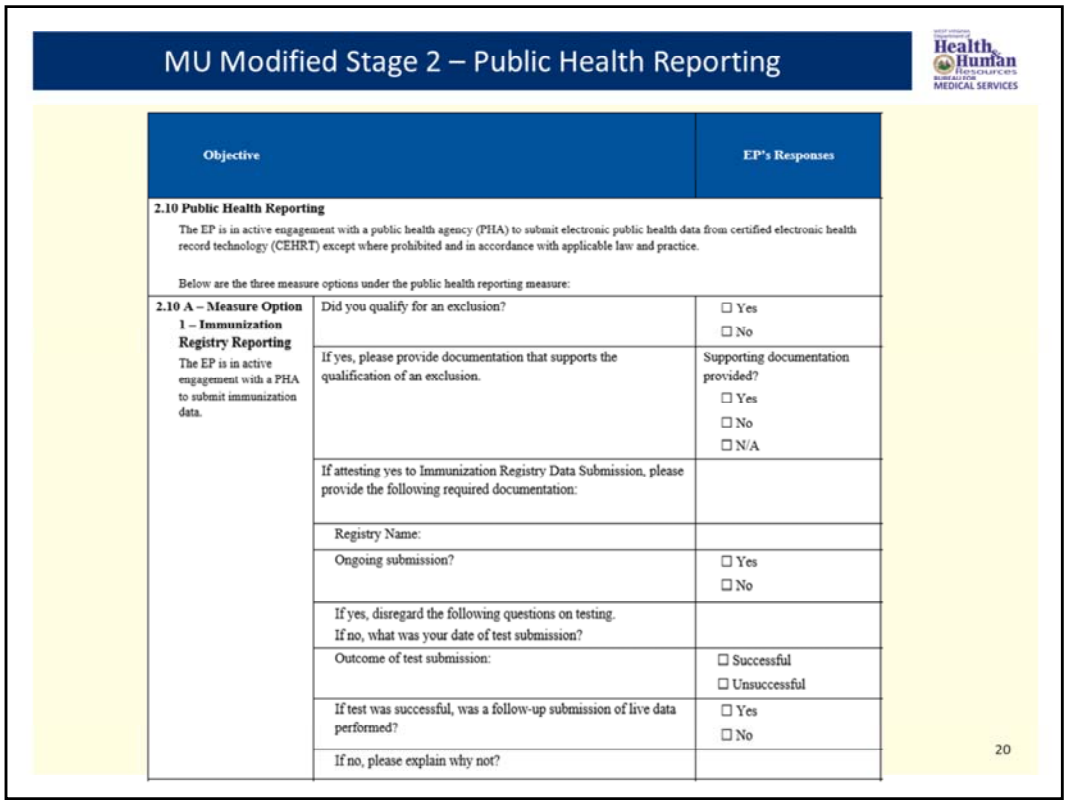
difficult for compliance to be verified since there is no way to verify that the EP posted information about the portal or told their patients about it.



Objective 2.9 refers to the Secure Electronic Messaging measure.

The EP should indicate if they qualified for an exclusion for this measure; this should be consistent with what was stated and provided for objective 1.9. A valid exclusion can be taken by any EP who conducts 50% or more of their encounters in a county that does not have 50% or more of its housing units with 4Mbs broadband availability according to the latest information available from the FCC on the first day of the PI reporting period. A valid exclusion can also be taken by any EP who has zero office visits during the PI reporting period.

The EP should provide evidence that, for at least 5% of unique patients seen by the EP during the PI reporting period, a secure message was sent using the electronic messaging function of the CEHRT (or portal) to the patient (or representative of that patient), or in response to secure message sent by the patient (or patient representative) during the PI reporting period. To support this measure, state what capability does the EP have in place for secure electronic messaging? Documentation should include a formal policy outlining secure messaging capabilities and screenshots of the messaging capabilities in the CEHRT.



MU Modified Stage 2 – Public Health Reporting

Objective		EP's Responses
2.10 Public Health Reporting The EP is in active engagement with a public health agency (PHA) to submit electronic public health data from certified electronic health record technology (CEHRT) except where prohibited and in accordance with applicable law and practice. Below are the three measure options under the public health reporting measure:		
2.10 A – Measure Option 1 – Immunization Registry Reporting The EP is in active engagement with a PHA to submit immunization data.	Did you qualify for an exclusion?	☐ Yes ☐ No
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	If attesting yes to Immunization Registry Data Submission, please provide the following required documentation:	
	Registry Name:	
	Ongoing submission?	☐ Yes ☐ No
	If yes, disregard the following questions on testing. If no, what was your date of test submission?	
	Outcome of test submission:	☐ Successful ☐ Unsuccessful
	If test was successful, was a follow-up submission of live data performed?	☐ Yes ☐ No
	If no, please explain why not?	

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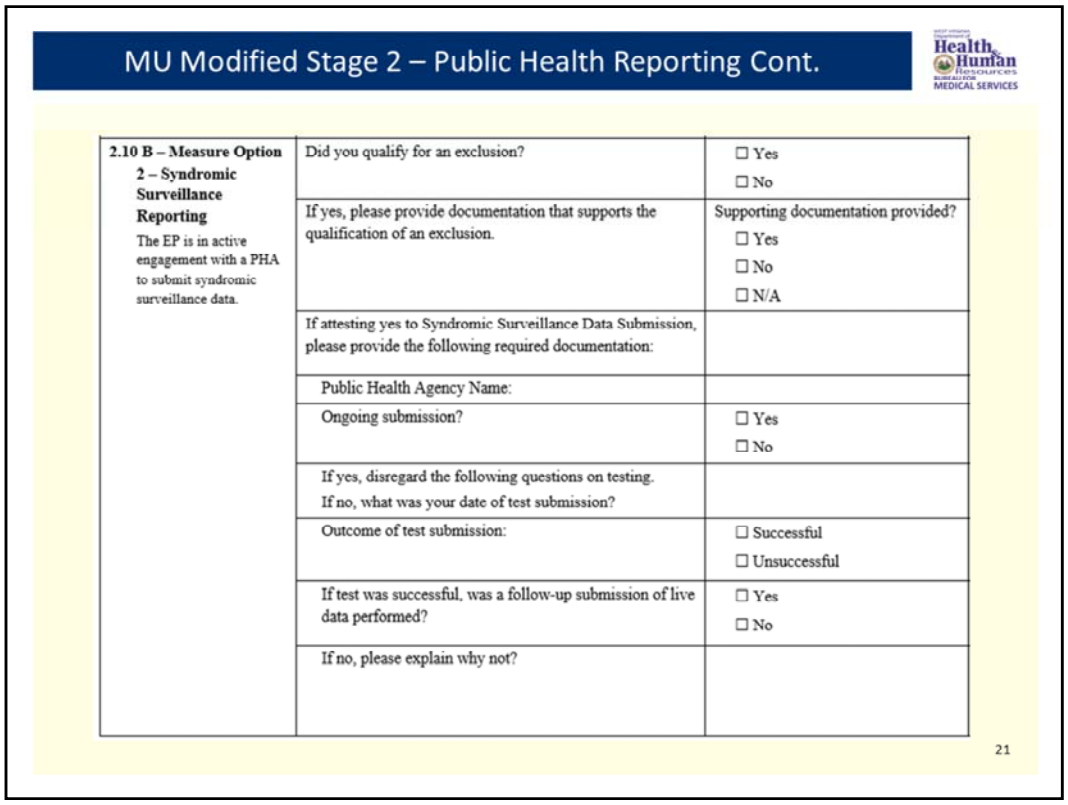
Objective 2.10 is related to the Public Health Reporting Measure. There are three possible measures, EPs must meet, or take a valid exclusion, for 2 of them. An EP is not allowed to exclude an option if they could have attested to other options.

Objective 2.10 A is related to Immunization Registries Data Submission/Registry Reporting.

The EP should indicate if they qualified for an exclusion for this measure; this should be consistent with what was stated on objective 1.9. A valid exclusion can be taken if the EP: (1) does not administer immunizations during the PI reporting period, (2) operates in a jurisdiction for which no immunization registry is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI period, or (3) operates in a jurisdiction where no immunization registry has declared readiness to receive immunization data from the EP at the start of the PI reporting period.

The required documentation for this measure is the registry name that was utilized, if there are ongoing test submissions, dates of test submissions, outcome of test submissions, and if a live data submission was performed. The provider's response must include documentation to support the data submission and results. If the EP attested to meeting the exclusion for this measure, check off the applicable reason and provide documentation to support the reason.



Objective 2.10 B is related to Syndromic Surveillance Data Submission/Reporting.

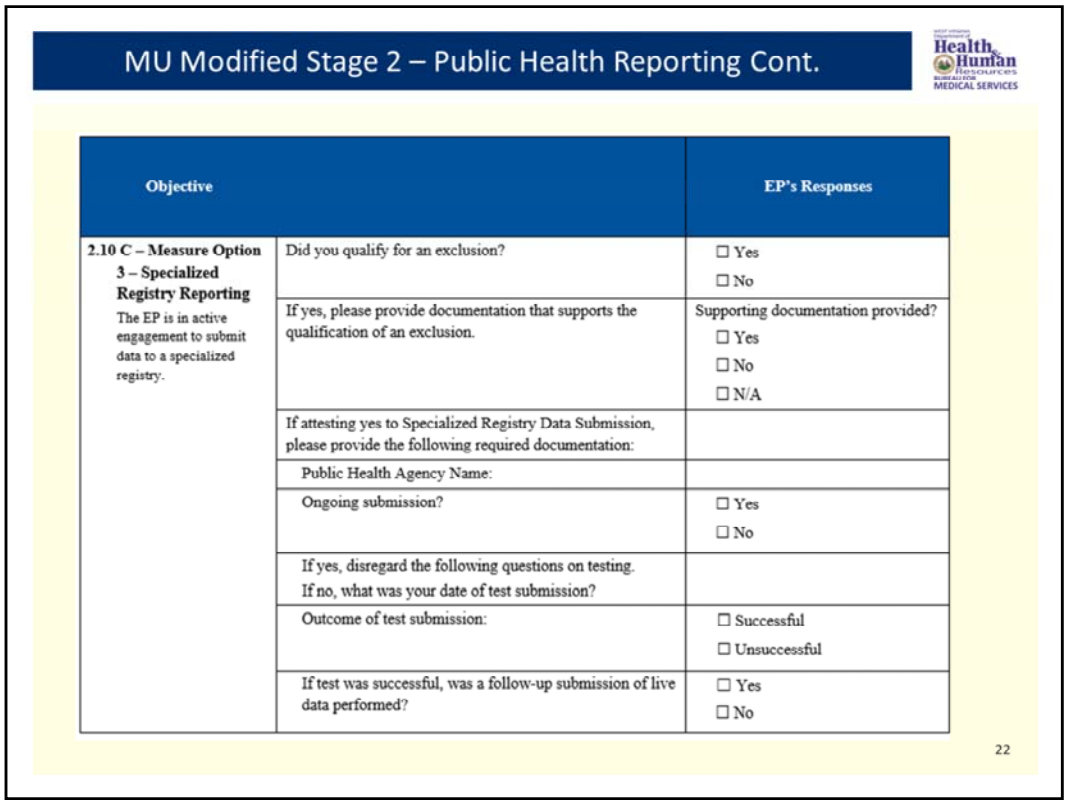
The EP should indicate if they qualified for an exclusion for this measure; this should be consistent with what was stated on objective 1.9. A valid exclusion can be taken if the EP: (1) is not in a category of providers that collect ambulatory syndromic surveillance, (2) operates in a jurisdiction for which no syndromic surveillance registry is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI period, or (3) operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from the EP at the start of the PI reporting period.

If the EP selected "yes" for this measure, then the EP must provide the public health agency name.

Is this an ongoing submission? If yes, list the date of the test submission and the outcome explaining if the test was successful.

If the test was successful, was there a follow-up submission of live data? Provide documentation of the test submission with the results documented and the date.

If the EP attested "yes" to meeting the exclusion, check off which circumstance the EP met and provide documentation that supports the exclusion.



MU Modified Stage 2 – Public Health Reporting Cont.

Objective		EP's Responses
2.10 C – Measure Option 3 – Specialized Registry Reporting The EP is in active engagement to submit data to a specialized registry.	Did you qualify for an exclusion?	☐ Yes ☐ No
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A
	If attesting yes to Specialized Registry Data Submission, please provide the following required documentation:	
	Public Health Agency Name:	
	Ongoing submission?	☐ Yes ☐ No
	If yes, disregard the following questions on testing. If no, what was your date of test submission?	
	Outcome of test submission:	☐ Successful ☐ Unsuccessful
	If test was successful, was a follow-up submission of live data performed?	☐ Yes ☐ No

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Objective 2.10 C is related to Specialized Registry Submission/Reporting.

The EP should indicate if they qualified for an exclusion for this measure; this should be consistent with what was stated on objective 1.9. A valid exclusion can be taken if the EP: (1) does not diagnose or treat any disease or condition associate with, or collect relevant data that is collected by, a specialized registry in their jurisdiction during the PI reporting period, (2) operates in a jurisdiction for which no specialized registry is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI period, or (3) operates in a jurisdiction where no specialized registry has declared readiness to receive electronic registry data from the EP at the start of the PI reporting period.

If the EP selected "yes" for this measure, then the EP must provide the public health agency name.

Is this an ongoing submission? If yes, list the date of the test submission and the outcome explaining if the test was successful.

If the test was successful, was there a follow-up submission of live data? Provide documentation of the test submission with the results documented and the date.

If the EP attested "yes" to meeting the exclusion, check off which circumstance the EP met and provide documentation that supports the exclusion.

This concludes the Eligible Provider Questionnaire Walk-Through Presentation. If you have any additional questions, please email the State at dhhrbms@wv.gov or call the State at (304) 558-1700.