Meaningful Use Attestation

Eligible Professional

August 2018
NY Medicaid EHR Incentive Program
August 2018

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Purpose

This document serves as a guide for eligible professionals (EPs) using the Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) to attest meaningful use (MU) of certified EHR technology.

Requirements

Prior to attesting, the provider must have completed registration for the NY Medicaid EHR Incentive Program in the CMS Registration and Attestation System and obtained an ePACES user account with MEIPASS privileges.

Home Page

Log into MEIPASS at https://meipass.emedny.org/ehr with your ePACES user name and password.
CMS Registration

Enter the provider's CMS Registration ID.
If you need help obtaining the registration ID, please contact the CMS Help Desk at 888-734-6433.

Review the provider's registration information.
NOTE: The email address on the registration serves as the primary contact for the provider participating in the NY Medicaid EHR Incentive Program.

- If the information displayed is correct, click Begin Attestation to proceed forward.
- If it is not correct, go to the CMS Registration and Attestation System to update the provider's record. Allow at least 1 business day for the information to be updated in MEIPASS.
- Make sure to update the provider's CMS registration prior to submitting the attestation in MEIPASS. Otherwise, updating the CMS registration while an attestation is under state review will reset the provider's submission in MEIPASS.
The EP Summary page displays the status of each section in the attestation: Eligibility, Objectives, and Clinical Quality Measures. Each section must be passed in order for the EP to submit the attestation.

Click **Edit** to access the Eligibility section.

**Locations with CEHRT**

Answer the questions about patient encounters and stored data at locations with certified EHR technology (CEHRT).

**Payment Year**

Select the Payment Year the provider is attesting meaningful use.
Practice at FQHC or RHC

Review FAQ EP29 for more information about practicing predominantly at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

- Answer No if the provider is using the Standard Patient Volume method. Proceed to the Eligibility Information section.
- Answer Yes if the provider is using the Needy Patient Volume method. Complete the following fields:
  - FQHC/RHC Reporting Year
  - Start Date of the 6-month period
  - Name of the FQHC or RHC
  - Patient Encounters at the FQHC or RHC during this period
  - Total Patient Encounters during this period

Eligibility Information


Select a reporting year of either Previous Calendar Year or Preceding 12 Month Period from the Date of Attestation.

Based on this response, use the calendar tool to select the Start Date of the 90-day patient volume reporting period. The End Date will automatically populate.

Pediatrician

Review FAQ EP28 and about pediatrician eligibility.
Physician Assistant
If the provider answered No to the previous question about practicing at a FQHC or RHC and using needy patient volume, then MEIPASS defaults the physician assistant answer to No.

NOTE: If the physician assistant wants to attest to the standard patient volume method, then please review FAQ EP37 for a workaround procedure.

Hospital Based Status
A hospital-based provider is defined as a provider who furnishes 90% or more of his/her covered Medicaid services in either inpatient (code 21) or emergency department (code 23) of a hospital. Hospital–based providers do not qualify for Medicare or Medicaid Electronic Health Record incentive payments. This determination is based solely on the individual provider’s covered Medicaid services during the calendar year immediately preceding the payment year.

For example, if the provider is attesting for payment year 2017, then calendar year 2016 is used to determine hospital based status.

<table>
<thead>
<tr>
<th>* Hospital Based Provider:</th>
<th>?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Answer No to attest that the provider is not hospital based.

Organization / Group Patient Volume
EPs in a group may use aggregate data as a proxy for individual patient volume. 

NOTE: All EPs in the group must attest to the same group patient volume.


<table>
<thead>
<tr>
<th>* Include Organization Encounters:</th>
<th>?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- Answer Yes to use group aggregate patient volume. Enter the organization’s NPI.
- Answer No to use the EP’s individual patient volume.
Encounters
Review FAQ EP07 for encounter definitions.

Enter the provider’s Total Medicaid Encounters and Total Encounters during the patient volume reporting period.

Alternate Patient Panel
A provider may use alternate patient panel volume if he/she meets certain criteria, which includes reviewing encounter data two years prior to the start of the reporting period. Please review the information available on the program website and the patient panel decision tool to determine if this method is appropriate for the provider.

- Answer Yes to use the alternate patient panel method. Complete the encounter and panel fields.
- Answer No to use standard patient volume.

Encounters Outside NY
Review FAQ EP34 about out of state encounters for patient volume reporting.

- Answer Yes if including encounters for patients outside of New York and select the state(s).
- Answer No if only including New York patient encounters.
EHR Certification Information

EHR Reporting Period
Complete the EHR Reporting Period, which is the period for which the EP is attesting meaningful use. For 2017, the minimum EHR Reporting requirement is 90 continuous days.

MU Attestation Option
For 2017, EPs may attest either Modified Stage 2 or Stage 3. Based on the attestation option selected, the corresponding MU objectives and measures will display in the Objectives section.

CQM Reporting Period
- Answer **Yes** if the EP is attesting the same period as the EHR Reporting Period.
- Answer **No** if the EP is attesting a different period. Enter the start and end dates.
- For 2017, the minimum CQM Reporting requirement is 90 continuous days.

EHR Certification Number
Add the **EHR Certification Number(s)** of the CEHRT used by the EP during the EHR Reporting Period. To locate an EHR product’s CEHRT number, visit the Certified Health IT Product List at [https://chpl.healthit.gov/](https://chpl.healthit.gov/).

After clicking **Save**, a message will display the provider’s patient volume percentage. Click **OK** to proceed forward.
Objectives

After completing the Eligibility section, enter the EP’s MU data in the Objectives section.

- Modified Stage 2 has 10 required objectives.
- Stage 3 has 8 required objectives.

The EP Meaningful Use Objectives page displays the status of each objective:

- “Incomplete” by default
- ✔️ if the EP has satisfied an objective
- ☠️ if the EP has failed an objective

Click an objective’s link to navigate to its specific page.

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**EP Meaningful Use Objectives**

*Demonstration of Meaningful Use:*

In order to qualify for incentive payments for meaningful use of Certified EHR Technology (CEHRT), EPs must demonstrate that they have met minimum thresholds for meaningful use objectives.

- EHR Reporting: For 2017 and 2018, the minimum measurement period for the meaningful use objectives is a continuous 90-day EHR reporting period during the calendar year.
- Modified Stage 2: Providers must pass all objectives by either meeting the minimum thresholds or qualifying for the exclusion criteria. Objectives with exclusions will not prevent a provider from successfully demonstrating meaningful use.

Providers practicing in multiple locations: When calculating meaningful use measures, providers must aggregate data from all locations equipped with CEHRT during the EHR reporting period.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective One (1): Protect Patient Health Information</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Objective Two (2): Clinical Decision Support</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Objective Three (3): Computerized Provider Order Entry (CPOE)</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Objective Four (4): Electronic Prescribing (eRx)</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Objective Five (5): Health Information Exchange</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Objective Six (6): Patient-Specific Education</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Objective Seven (7): Medication Reconciliation</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Objective Eight (8): Patient Electronic Access</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Objective Nine (9): Secure Electronic Messaging</td>
<td>Incomplete</td>
</tr>
<tr>
<td>Objective Ten (10): Public Health Reporting</td>
<td>Incomplete</td>
</tr>
</tbody>
</table>

*Click on the EP Summary button at any time to return to the Eligible Provider Summary Page*

Continue to Clinical Quality Measures
**Activity Measures**

Activity measures require a **Yes** or **No** response. The EP may also have to enter additional information. For example, the EP must enter the completion date of the security risk analysis for the Protect Patient Health Information objective.

![Objective One: Protect Patient Health Information](image)

Click **Next** to save the response and proceed to the next objective.

**Threshold Measures**

Threshold measures, such as Electronic Prescribing, require numerator and denominator data. If the EP qualifies and claims an exclusion for a measure, the remaining fields are grayed out.

![Objective Four: Electronic Prescribing (eRx)](image)
**Public Health Reporting**

Select the Public Health Reporting measures the EP is attesting for the payment year. Measure information will display when a measure is selected.

If the EP is attesting active engagement for a measure, then the Public Health Agency Name must be entered. Click **Add** to enter additional names (maximum of three).
When all objectives have been satisfied, click **Continue to Clinical Quality Measures**.
Clinical Quality Measures

The Clinical Quality Measures Summary page displays links to the recommended sets and domains.

For 2017, EPs must attest to at least 6 Clinical Quality Measures (CQMs).

<table>
<thead>
<tr>
<th>Domains and Completed Clinical Quality Measures</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Clinical Quality Measures</td>
<td>Remove All</td>
</tr>
<tr>
<td>Clinical Process/Effectiveness Domain</td>
<td></td>
</tr>
<tr>
<td>Care Coordination Domain</td>
<td></td>
</tr>
<tr>
<td>Patient Safety Domain</td>
<td></td>
</tr>
<tr>
<td>Efficient Use of Healthcare Resources Domain</td>
<td></td>
</tr>
<tr>
<td>Population/Public Health Domain</td>
<td></td>
</tr>
<tr>
<td>Patient and Family Engagement Domain</td>
<td></td>
</tr>
</tbody>
</table>

After satisfying the CQM requirements, click Return to EP Summary to Complete Attestation.
Submit Attestation

Carefully review the New York Medicaid EHR Incentive Program Attestation page.

This is to certify that the foregoing information is true, accurate, and complete. I understand that Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, that by filing this registration I am submitting a claim for federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicaid EHR Incentive Program payment, may be prosecuted under Federal and State laws and may also be subject to civil penalties.

USER WORKING ON BEHALF OF A PROVIDER: I certify that I am attesting on behalf of a provider who has given me authority to act as his/her agent. I understand that both the provider and I can be held personally responsible for all information entered. I understand that a user attesting on behalf of a provider must have one of the following Identity and Access Management system web user account types associated with the provider for whom he/she is attesting: Authorized Official, Delegated Official, Staff End User, and Surrogate. I understand that the associated Identity and Access Management system web user account must be established prior to the date of attestation.

I acknowledge the requirement to cooperate in good faith with ONC direct review of health information technology certified under the ONC Health IT Certification Program if a request to assist in ONC direct review is received as authorized by 45 CFR part 170, subpart E to the extent that such technology meets the definition of CEHRT, including by permitting timely access to such technology and demonstrating its capabilities as implemented and used by the provider in the field.

I have not knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology. I have implemented technologies, standards, policies, practices and agreements reasonably calculated to ensure, to the greatest extent practicable and permitted by law, that the certified EHR technology was, at all relevant times -

i. Connected in accordance with applicable law;
ii. Compliant with all standards applicable to the exchange of information, including the standards, implementation specifications, and certification criteria adopted at 45 CFR part 170;
iii. Implemented in a manner that allowed for timely access by patients to their electronic health information; and
iv. Implemented in a manner that allowed for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers (as defined by 42 U.S.C. 300j (3)), including unaffiliated providers, and with disparate certified EHR technology and vendors.

I have responded in good faith and in a timely manner to requests to retrieve or exchange information, including from patients and other health care providers (as defined by 42 U.S.C. 300j (3)), and other persons, regardless of the requestor’s affiliation or technology vendor. I hereby agree to keep such records as are necessary to demonstrate that I met all Medicaid EHR Incentive Program requirements and to furnish those records in the event of audit or ONC direct review.

No Medicaid EHR Incentive Program payment may be paid unless this registration form is completed and accepted as required by existing law and regulations (42 CFR 495.60). A provider may not begin receiving payments any later than payment year 2016 (42 CFR 495.310). By submitting and completing this attestation, the provider agrees to these regulations.

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

ROUTINE USE(S): Information from this Medicaid EHR Incentive Program registration form and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made. Appropriate disclosures may be made to other federal, state, local, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the Medicaid EHR Incentive Program.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of EHR incentive payment. With the one exception listed below, there are no penalties under this program for refusing to supply information. However, failure to furnish information on this registration form will prevent the EHR incentive payment from being issued. Failure to furnish subsequently requested information or documents will result in the issuance of an overpayment demand letter followed by recoupment procedures.

It is mandatory that you tell DOH if you believe that you have been overpaid under the Medicaid EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 8402, Section 11281, provides penalties for withholding this information.

I understand that by electronically signing and submitting this attestation it is the legal equivalent of having placed my handwritten signature on the submitted attestation and this affirmation.

User Name: RPARt11
Date: 06/18/2018
☐ I accept the terms and conditions
Enter Initials: 
Submit

- After reviewing the agreement, check the box to accept the terms and conditions.
- Enter the initials of the provider, Authorized Official, Delegated Official, Staff End User or Surrogate (as defined in the terms and conditions) for who is attesting.
- Click Submit to submit the attestation.
Attestation Document
A confirmation message displays after submitting the attestation. Click MEIPASS Attestation Document to open a PDF copy of the attestation. Please retain this document. In the event of a possible post-payment audit, providers should retain documentation to support all attestations for no less than six years after each payment year.

NOTE: Effective payment year 2017, EP attestations are submitted completely online via MEIPASS. The MEIPASS attestation document does not need to be mailed to the NY Medicaid EHR Incentive Program.
**Glossary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEHRT</td>
<td>Certified EHR Technology</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>CQM</td>
<td>Clinical Quality Measure</td>
</tr>
<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
</tr>
<tr>
<td>EP</td>
<td>Eligible Professional</td>
</tr>
<tr>
<td>ePACES</td>
<td>Electronic Provider Assisted Claim Entry System</td>
</tr>
<tr>
<td>ETIN</td>
<td>Electronic Transmitter Identification Number</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>MEIPASS</td>
<td>Medicaid EHR Incentive Program Administrative Support Service</td>
</tr>
<tr>
<td>MU</td>
<td>Meaningful Use</td>
</tr>
<tr>
<td>MURPH</td>
<td>Meaningful Use Registration for Public Health</td>
</tr>
<tr>
<td>PDF</td>
<td>Portable Document Format</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
</tr>
</tbody>
</table>

**Questions?**

Contact the NY Medicaid EHR Incentive Program Support Line.  
Hours: Monday – Friday, 8:30am – 5:00pm Eastern Standard Time  
Phone: 1-877-646-5410

- Option 1 – ETIN certification, ePACES, and MEIPASS credentials  
- Option 2 – Program Policies, Patient Volume, Meaningful Use, and Attestation Review  
- Option 3 – Public Health Reporting Guidance, MURPH Registration, and Status

Visit [https://health.ny.gov/ehr](https://health.ny.gov/ehr) for more information about the program.