## REVISION HISTORY

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<tr>
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<th>Date</th>
<th>Comments</th>
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<tr>
<td>1.0</td>
<td>September 2013</td>
<td>Posted on NH Medicaid EHR Incentive Program website</td>
</tr>
<tr>
<td>2.0</td>
<td>November 2014</td>
<td>Annual update</td>
</tr>
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Eligible Professional – NH Medicaid EHR Incentive Program

EHR Incentive Program

Introduction

The American Recovery and Reinvestment Act of 2009 (ARRA) provides for Electronic Health Record (EHR) Incentive Program payments to eligible professionals (EPs) and eligible hospitals (EHs) including critical access hospitals (CAH) participating in Medicare and Medicaid programs as they demonstrate adoption, implementation, upgrade or meaningful use of certified EHR technology (CEHRT).

To facilitate the vision of transforming our nation’s health care system to improve quality, safety and efficiency of care to EHR technology, the Health Information Technology for Economic and Clinical Health Act (HITECH) established programs under Medicare and Medicaid.

The Centers for Medicare and Medicaid Services (CMS) and Office of the National Coordinator (ONC) have released final rules to guide and implement the provisions of ARRA.

The New Hampshire Office of Medicaid Business and Policy (OMBP) is responsible for the implementation of New Hampshire’s Medicaid EHR Incentive Program. OMBP will disburse payments to providers who adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology in their first year of participation in the program and successfully demonstrate meaningful use in subsequent years throughout the duration of the program.

These incentive programs are designed to support providers in this period of Health Information Technology (HIT) transition, accelerate the adoption of HIT and instill the use of qualified EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care.

New Hampshire’s Medicaid EHR Incentive Program

The New Hampshire Department of Health and Human Services has fiduciary responsibility to ensure that Medicaid supplemental funds are disbursed accurately in compliance with federal and state regulations. Providers must meet eligibility criteria mandated by federal statute in order to receive a Medicaid EHR Incentive Program payment. In addition, the use of EHR technology that has been certified by the ONC Authorized Testing and Certification Body and is listed on the Certified Health Information Technology Product List is required.

Two key components of the Medicaid EHR Incentive Program are registration and attestation.

Registration
The registration process allows providers to participate in the Medicaid EHR Incentive Program. Providers must complete Federal- and State-level registration processes.

Attestation
The attestation process allows providers to attest to the Medicaid EHR Incentive Program eligibility criteria as they demonstrate adoption, implementation, upgrade or meaningful use of CEHRT.
Federal

EPs can learn more information about the Medicaid EHR Incentive Program from these federal resources:

- CMS Medicare and Medicaid EHR Incentive Program Basics;
- CMS Frequently Asked Questions;
- Electronic Health Record (EHR) Information Center (for registration and attestation system inquiries): hours of operation: 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays; 1-888-734-6433 (primary number) or 888-734-6563 (TTY number);
- Office of the National Coordinator Incentives and Certification;
- Certified Health IT Product List.

State

This step-by-step reference guide will assist EPs as they attest for Meaningful Use (MU) criteria. For more information on the Medicaid EHR Incentive Program, please check the program website or contact New Hampshire Medicaid EHR Incentive Program staff at:

- Website: http://www.dhhs.nh.gov/ombp/ehr/index.htm;
- Telephone: (603) 271-9542;
- Email: info@NHMedicaidHIT.org.
The Regional Extension Center of New Hampshire (RECNH) is one of 62 RECs nationwide designated to serve New Hampshire as an unbiased, trusted resource with national perspective and local expertise to assist healthcare providers with EHR adoption, optimization and achievement of Meaningful Use.

The RECNH serves as a neutral source for credible EHR and HIT information—something much needed as healthcare providers seek to navigate EHR options and select vendors who meet new federal Meaningful Use requirements.

The RECNH strives to fully identify and provide solutions to the challenges New Hampshire healthcare providers face in adopting EHR systems. Finally, and most important, the program provides critical, “hands-on” services for EHR adoption as outlined below.

| Regional Extension Center Services
| General and Technical Assistance |
|--------------------------------|--------------------------------|
| • Outreach and education    |                                  |
| • Workforce support         |                                  |
| • Tools and resources in all aspects of EHR and HIT | |
| • Vendor selection and preferred pricing |               |
| • Project Management        |                                  |
| • Practice and workflow redesign |                          |
| • System implementation     |                                  |
| • Interoperability and health information exchange (HIE) |    |
| • Privacy and security      |                                  |

The RECNH has a unique national perspective and local expertise and is committed to building connection and collaboration among the state’s healthcare community, ensuring that the individuals and organizations are connected to the right people, tools and resources to optimize success of EHRs and achievement of Meaningful Use of EHRs.

To take advantage of the RECNH services, please contact them directly at:

**Regional Extension Center of New Hampshire**

c/o New Hampshire Hospital Association
125 Airport Road
Concord NH 03301
603.717.5420
www.recnh.org
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Annual Eligibility Requirements

Eligible Professional Criteria

EPs must meet program eligibility criteria during each year of participation in the Medicaid EHR Incentive Program in order to receive a payment for that year.

Provider Type

EPs must be one of these provider types:

- Physician who holds a Doctor of Medicine or Doctor of Osteopathy degree;
- Physician classified as a Pediatrician who holds a Doctor of Medicine or Doctor of Osteopathy degree and is board certified in pediatric medicine; a pediatrician's provider enrollment with New Hampshire Medicaid must indicate 'pediatrician' as a specialty or the provider must be a member of the American Academy of Pediatrics;
- Dentist who holds a Doctor of Dental Surgery or Dental Medicine degree
- Nurse practitioners;
- Certified nurse-midwives;
- Physician assistants (PA) who furnish services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant.

PAs in FQHCs/RHCs have an additional requirement; they must meet one of the following in order to participate in the EHR Incentive Program:

- PA is the primary provider in a clinic (Example: part-time physician and full-time PA);
- PA is a clinical or medical director at a clinical site of practice; or
- PA is an owner of an RHC.

Provider Qualifications

Providers must:

- Be enrolled in New Hampshire Medicaid;
- Be licensed to practice in New Hampshire;
- Not be sanctioned or otherwise deemed ineligible to receive payments from New Hampshire Medicaid;
- Be non-hospital-based (more than 10 percent of Medicaid patient encounters must be outside of an inpatient hospital setting or emergency department during the prior calendar year);
- Practice predominantly (if working at an FQHC/RHC, more than 50 percent of encounters must have occurred at the FQHC/RHC in a 6-month period during the prior calendar year).

Patient Volume Methodologies

EPs are required to meet, or exceed, a specific patient volume threshold during each payment year. Reporting methods include Medicaid patient volume or the option of Needy Individual patient volume for providers in FQHCs/RHCs. Pediatricians using Medicaid patient volume may qualify based on a
Annual Eligibility Requirements

reduced patient volume threshold than other provider types. EPs also have an option to attest using individual patient volume or their Practice’s aggregate patient volume.

EPs may optionally include out-of-state patient encounters in their individual or Practice aggregate patient volume. If electing to do so, they must report each state’s Medicaid encounters separately. This will trigger an eligibility verification audit and require the New Hampshire Medicaid Office to contact the other state(s) to confirm patient encounter data. This will delay payment until the data is properly validated.

Patient Volume Type - Medicaid

Medicaid patient volume is calculated by dividing the total Medicaid encounters in any representative continuous 90-day period during the prior calendar year (numerator) by the total of all encounters during the same 90-day period (denominator) and multiplying this fraction by 100 to obtain a percentage.

EPs attesting based on Medicaid Patient Volume must have a minimum threshold of 30 percent to qualify for a Medicaid EHR Incentive Program payment. Pediatricians have an exception; they have an option of attesting to a minimum threshold of 30 percent to receive a full incentive payment or 20 to 29 percent for a 2/3 payment.

Under the Stage 2 Final Rule, a Medicaid patient encounter in New Hampshire is defined as “All services provided in a day by a specific provider to a Medicaid-enrolled individual.” This includes:

(Definition for January 1 through November 30, 2013)

- Services in which Medicaid or out-of-state Medicaid or out-of-state Medicaid Managed Care programs paid for part or all of the services (including premiums, co-payments, and/or cost sharing); or
- Encounters where Medicaid paid zero dollars where Medicare (in the case of patients that are dually eligible for both Medicaid and Medicare) or another third party paid for the encounter; or
- Encounters provided to Medicaid beneficiaries for which no payments were received; or
- Medical services provided to Medicaid beneficiaries that were not covered under New Hampshire’s Medicaid program.

(Definition for December 1, 2013 through December 31, 2013)

- Services in which Medicaid or Medicaid Managed Care programs (including out-of-state programs) paid for part or all of the services (including premiums, co-payments, and/or cost sharing); or
- Encounters where Medicaid paid zero dollars where Medicare (in the case of patients that are dually eligible for both Medicaid and Medicare) or another third party paid for the encounter; or
- Encounters provided to Medicaid beneficiaries for which no payments were received; or
- Medical services provided to Medicaid beneficiaries that were not covered under New Hampshire’s Medicaid program.
Patient Volume Type - Needy Individual

Needy Individual patient volume is calculated by dividing the total Needy Individual encounters in any representative continuous 90-day period during the prior calendar year (numerator) by the total of all encounters during the same 90-day period (denominator) and multiplying this fraction by 100 to obtain a percentage.

EPs working in FQHCs/RHCs can attest using Medicaid patient volume or Needy Individual patient volume. In both cases, EPs must have a minimum threshold of 30 percent to qualify for a Medicaid EHR Incentive Program payment.

Under the Stage 2 Final Rule, a Needy Individual patient encounter in New Hampshire is defined as “All services provided in a day by a specific provider to a Needy individual.” This includes:

(Definition for January 1 through November 30, 2013)

- Services in which:
  - Medicaid or out-of-state Medicaid or out-of-state Medicaid Managed Care programs paid for part or all of the services (including premiums, co-payments, and/or cost sharing); or
  - Out-of-State CHIP paid for part or all of the services (including premiums, co-payments, and/or cost-sharing); or
  - Services were rendered to an individual on a sliding scale; or
  - Services were uncompensated;
- Encounters where Medicaid paid zero dollars where Medicare (in the case of patients that are dually eligible for both Medicaid and Medicare) or another third party paid for the encounter; or
- Encounters provided to Medicaid beneficiaries for which no payments were received; or
- Medical services provided to Medicaid beneficiaries that were not covered under New Hampshire’s Medicaid program.

(Definition for December 1, 2013 through December 31, 2013)

- Services in which:
  - Medicaid or Medicaid Managed Care programs (including out-of-state programs) paid for part or all of the services (including premiums, co-payments, and/or cost sharing); or
  - Out-of-State CHIP paid for part or all of the services (including premiums, co-payments, and/or cost-sharing); or
  - Services were rendered to an individual on a sliding scale; or
  - Services were uncompensated;
- Encounters where Medicaid paid zero dollars where Medicare (in the case of patients that are dually eligible for both Medicaid and Medicare) or another third party paid for the encounter; or
- Encounters provided to Medicaid beneficiaries for which no payments were received; or
- Medical services provided to Medicaid beneficiaries that were not covered under New Hampshire’s Medicaid program.
Patient Volume Methodology
EPs have the option to attest based on one of the following methodologies:

- Individual patient volume: the sum of the EP's encounters during the reporting period; or
- Aggregate patient volume: the sum of a Practice's encounters during the reporting period; encounters from all Medicaid providers (including those that are not eligible for a Medicaid EHR Incentive Program payment, must be included in the calculation.

To use aggregate patient volume, EPs must meet federal- and state-specific rules. In the event of audit, the EP and Practice must demonstrate that these rules have been satisfied during the payment year:

- The Practice's patient volume is appropriate as a patient volume methodology calculation for the EP (i.e., for EPs that only see Medicare, commercial or self-pay patients, this is not an appropriate calculation);
- There is an auditable data source to support the Practice's patient volume determination;
- All of the EPs in the Practice must use the same methodology for the payment year;
- The Practice uses the entire Practice’s patient volume and does not limit aggregate patient volume in any way;
- If the EP works both inside and outside of the Practice, then the patient volume calculation includes only those encounters associated with the Practice and not the EP's outside encounters;
- Each Practice can include the encounters made by the EP at its own Practice in the aggregate calculation, however, the EP can register for only one incentive payment (i.e., the EP cannot register for an incentive payment at every Practice that uses his/her encounter information in its group calculation); and
- For purposes of the aggregate calculation, if two providers in the Practice provide services to the same Medicaid patient on the same day, then multiple encounters for the same Medicaid patient on the same day may be counted.

Practices must submit an ‘Establish Practice Request Form’ with the requisite supporting documents to the New Hampshire Medicaid Office. The New Hampshire Medicaid Office will verify the aggregate patient volume data and establish the Practice in ePIP (Electronic Provider Incentive Payment System), the New Hampshire Medicaid EHR Incentive Program state registration and attestation system. The New Hampshire Medicaid Office will conduct pre-payment verifications of the Practice-submitted aggregate data and supporting documents and notify the Practice when EPs are permitted to attest on ePIP.

Encounter Examples
Under the Stage 2 Final Rule, examples of encounters that may be counted in the patient volume calculation include:

- Claims denied due to service limitation audits;
- Claims denied due to non-covered services;
- Claims denied due to timely filing; and
- Services rendered on Medicaid members that were not billed due to the provider's understanding of Medicaid business rules.
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Annual Eligibility Requirements

Examples of encounters that may not be counted in the patient volume calculation include:

- Claims denied due to the provider being ineligible for the date of service; and
- Claims denied due to the member being ineligible for the date of service.

**Medicaid Hospital-based Criteria**

This criterion is applicable only to EPs that attest to Medicaid patient volume. These EPs must attest that they are not hospital-based, i.e., do not provide more than 90 percent of their Medicaid covered professional services in a hospital setting. In the New Hampshire Medicaid EHR Incentive Program, a hospital setting is defined as Medicaid encounters at Place of Service (POS) codes for HIPPA standard transactions 21 (Inpatient Hospital) and 23 (Emergency Department).

The Medicaid hospital-based criterion is calculated using each individual EP’s encounters data. (EPs may not use Practice data to attest to this criterion.) Provider attestations will be evaluated to determine if services rendered in Medicaid hospital-based POS 21 and POS 23 exceed the 90 percent threshold.

Medicaid Hospital-based is calculated by dividing the sum of the EP’s Medicaid POS 21 and 23 encounters during the prior calendar year (numerator) by the total of all Medicaid patient encounters during the same full-year reporting period (denominator) and multiplying this fraction by 100 to obtain a percentage.

This criterion is not applicable to EPs in FQHCs/RHCs that attest using Needy Individual patient volume encounter data.

**Practice Predominantly Criteria**

This criterion is applicable only to EPs that attest to Needy Individual patient volume. These EPs must attest that during a six-month reporting period during the prior calendar year, the clinical location for over 50 percent of their patient encounters occurred at the FQHC/RHC facility.

The practice predominantly criterion is based on each individual EP’s encounters data. (EPs may not use Practice data to attest to this criterion.) Provider attestations will be evaluated to determine if services rendered at the FQHC/RHC facility exceed the 50 percent threshold.

Practice predominantly is calculated by dividing the sum of the EP’s FQHC/RHC encounters during the six-month prior year reporting period (numerator) by the total of all patient encounters during the same six-month reporting period (denominator) and multiplying this fraction by 100 to obtain a percentage.

This criterion is not applicable to EPs that attest using Medicaid patient volume encounter data.
Eligible Professional Payment Schedule

The maximum incentive payment amount that an EP can receive in the Medicaid EHR Incentive Program is $63,750. Pediatricians meeting reduced patient volume thresholds (from 20 to 29 percent) can receive a maximum amount of $42,500. Both incentive payment amounts are paid over a six year schedule as denoted in the following table.

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>Attestation Type</th>
<th>Payment Amount (Based on Patient Volume Percentage)</th>
<th>30%</th>
<th>20% (Pediatricians Only)</th>
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<tr>
<td>1</td>
<td>AIU</td>
<td>$21,250</td>
<td>$14,167</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>MU</td>
<td>$8,500</td>
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<td></td>
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<tr>
<td>3</td>
<td>MU</td>
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<td>5</td>
<td>MU</td>
<td>$8,500</td>
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<tr>
<td>6</td>
<td>MU</td>
<td>$8,500</td>
<td>$5,667</td>
<td></td>
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Payment Rules

EP payments are made based on calendar year; EPs may receive payments on a non-consecutive, annual basis. EPs must receive their first Medicaid EHR Incentive Program payment by 2016 in order to participate in the program. The last year that providers may request payments is 2021.

EPs may be eligible for both the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program but can only receive an EHR Incentive Program payment per year from one EHR Incentive Program. EPs may switch one time between the Medicare EHR Incentive Program and Medicaid EHR Incentive Program but the switch must occur before 2015.

EPs assign incentive payments to a Tax Identification Number (TIN) in the CMS Registration System. This TIN must be associated with either the EP or re-assigned to a group or clinic with which the EP is affiliated in the New Hampshire Medicaid database.

There are currently no payment adjustments or penalties for Medicaid EPs. Payments may be recouped in cases of fraud or abuse or if a NH DHHS audit determines that a provider was not eligible to receive a Medicaid EHR Incentive Program payment.
Stage 1 Meaningful Use Requirements

Overview

The Stage 1 Meaningful Use (MU) reporting period is 90-days in the current calendar year during the first year of MU attestation and a full year (based on the current calendar year) for each subsequent attestation. 2014 is an exception; all providers, regardless of their payment year in the program, will only be required to report 90-days of MU based on the current calendar year. The intent is to allow vendors and providers the time to upgrade EHRs in accordance with Stage 2 requirements.

It is important to note the distinction between attestation reporting periods. Patient volume attestations are based on 90-days of data from the prior calendar year; MU, regardless of the reporting period, will always be based on data from the current calendar year.

Stage 1 Meaningful Use Measures

To meet Stage 1 Meaningful Use requirements, EPs must attest to meeting Meaningful Use criteria that consist of Core measures; Menu measures; and Clinical Quality Measures (CQMs). Each measure requires a unique response. Some responses can be yes/no attestations while others involve numerical entries such as a numerator and denominator. The following guidelines apply to Stage 1 MU attestations:

- For EPs that work at multiple practice locations, at least 50 percent of their total patient encounters must take place at a location(s) where certified EHR technology is available. (These EPs would base all MU measures only on those encounters that occurred at locations with certified EHR technology.) For the purpose of calculating this 50 percent threshold, all encounters (and not just Medicaid and/or Needy Individual encounters) should be considered in this calculation.
- Data for several of the Core and Menu measures does not necessarily have to be entered directly from reports generated by certified EHR technology; to provide complete and accurate information for certain measures, EPs may also include information from paper-based patient records or from records maintained in uncertified EHR technology.
- CQM data must be reported directly from information generated by certified EHR technology.
- Regardless of the method used to generate Core, MU, and CQM data, all associated supporting documentation, screen shots, and reports must be uploaded at the time of attestation in order for the payment request to be processed with protected health information, i.e., HIPAA protected information, redacted (removed or blacked out).
- Each Core, Menu, or CQM measure webpage in ePIP includes a link to detailed information from the CMS website on that measure.
- MU measures may not be applicable to every clinical practice. (For example, dentists do not typically perform immunizations.) In these cases, providers would not have any eligible patients or actions for the measure denominator and could attest to an exclusion (i.e., be excluded from having to meet that measure). Claiming an exclusion (i.e., providing a ‘yes’ response to an exclusion) for a specific measure qualifies as submission of that measure.
Stage 1 Meaningful Use Requirements

- Denominators entered must be greater than or equal to numerators entered. The numerator and denominator entries must be positive whole numbers.
- Measure results do not round up. For example, a numerator of 199 and a denominator of 1,000 is 19%.
- Measures that require a result greater than a given percentage must be more than that given percentage to pass. For example, in a measure requiring a result of greater than 80%, a result of 80.10% will pass, but a result of 80.0% will not pass.
- After completing all of the measures in a module, ePip will indicate that the module is complete; this does not mean that the measures have passed or failed, only that they have been completed. Evaluation of the measures is made after the attestation is electronically signed and submitted to the Medicaid EHR Office.
- Users must adequately answer each measure by filling in the numerator and denominator or claiming exclusion (if exclusion requirements are met). There are two types of percentage-based measures used in demonstrating Meaningful Use; with this, there are two types of denominators:
  - All patients seen during the EHR reporting period. (The denominator is all patients regardless of whether their records are kept using certified EHR technology); or
  - Actions or subsets of patients seen during the EHR reporting period whose records are kept using certified EHR technology.

Core Measures
EPs must meet 13 (of 13) Core measures based on thresholds established by CMS. If EPs meet applicable criteria that allow them to claim exclusion for certain measures, then those measures are also considered to be met.

Menu Measures
EPs must meet 5 (of 9) Menu measures based on thresholds established by CMS. The State of New Hampshire is currently unable to accept data for either of the Public Health measures, EPs must attest to an exclusion for one of these measures. The public health measure will not count towards the 5 required Menu measures.

Clinical Quality Measures
EPs using 2014 certified EHR technology must attest to 9 (of 64) CQMs which must cover a minimum of 3 of the 6 National Quality Strategy domains. These include:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population/Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness

Special Exception for 2014 – CEHRT Flexibility Option
EPs may attest to 2013 Core and Menu measures and CQMs if they attest that they have not transitioned to 2014 CEHRT due to delays in 2014 CEHRT availability.
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Stage 1 Meaningful Use Requirements

Denominators for Meaningful Use Measures

There are two ways that percentage-based denominators are reported for MU measures. The first is when the denominator equals all patients seen or admitted during the EHR reporting period. In this instance, the denominator is all patients regardless of whether their records are maintained using certified EHR technology.

The second way that denominators are reported is based on actions or subsets of patients seen or admitted during the EHR reporting period. In this instance, the denominator only includes patients, or actions taken on behalf of those patients, whose records are maintained using certified EHR technology.

Meaningful Use and CQM Supporting Documentation

EPs must upload copies of EHR screenshots and other reports that fully support each attestation at the time of attestation in order for the payment request to be processed. Screenshots must be dated within the meaningful use reporting period; if they are outside of the reporting period, they will be deemed ineligible to receive an incentive payment. Supporting documentation must have all Protected Health Information (PHI), i.e., HIPAA protected information, redacted (removed or blacked out). To prevent risk of modification of audit documents, print to a version that is not modifiable such as PDF and/or paper. Per the federal statute, EPs must retain documentation supporting their demonstration of meaningful use for 6 years.

Certified EHR Technology Documentation

All certified modules or EHRs that are available at a practice(s) at the start of the EHR reporting period must be added to the cart on the Office of the National Coordinator Certified Health IT Product List (CHPL) website to generate an accurate CMS EHR Certification ID. EPs must upload a screenshot of the CHPL webpage with the CMS EHR Certification ID at the time of attestation.

Core, Menu, and CQM Documentation

The primary MU and CQM documentation are the source documents that the EP used when completing the attestation. These documents should provide a summary of the data that supports the information entered during attestation. Ideally, this would be reports from the CEHRT, but EPs may upload other documents that demonstrate how the data was accumulated and calculated. All claimed exclusions must also have supporting documentation.

For Core and Menu measures, documentation must:

- Show proof that the report was generated from certified EHR technology (examples: EHR logo on report or step-by-step screenshots that demonstrate that the report was generated by an EHR);
- Have Protected Health Information data redacted (removed or blacked out);
Stage 1 Meaningful Use Requirements

- Include the time period covered by the report (that is within the meaningful use reporting period);
- Show proof that the report is for the attesting EP (National Provider Identifier; CMS Certification Number; provider name; etc.);
- Show a summary of data that supports the attestation (ideally, these should be reports from CEHRT that demonstrate how data was accumulated and calculated);
- For percentage-based measures, include numerators and denominators;
- For Yes/No measures, include one or more CEHRT screenshots that are dated during the MU reporting period and provide evidence that the report was generated for the EP that is attesting (with PHI data redacted); (exception: the security risk analysis does not need to be uploaded, however, it must be made available upon request);
- Show proof that supports claimed exclusions

CQM data must be reported directly from the CEHRT; associated reports must identify the EHR, date, etc., and evidence that the report was generated for the EP that is attesting with PHI, i.e., HIPAA protected information, redacted (removed or blacked out).
Registration

To request a Medicaid EHR Incentive Program payment in year 1, EPs must first register on two websites: the CMS Registration System and Electronic Provider Incentive Payment System (ePIP), New Hampshire’s registration and attestation system.

In subsequent payment years, when requesting Medicaid EHR Incentive Program payments, EPs do not have to re-register with CMS or ePIP if their registration and payment information is up to date. They can log on directly to ePIP to begin the attestation process.

If registration and payment information has changed, EPs can access either, or both, the CMS Registration website and ePIP to update data.

ePIP Home Page

EPs attest for New Hampshire Medicaid EHR Incentive Program payments through the Electronic Provider Incentive Payment System (ePIP).

ePIP can be accessed at https://www.nhmedicaidepip.com.

There is also a link to ePIP on the NH DHHS public website at http://www.dhhs.nh.gov/ombp/ehr/registration.htm. (Click the ePIP logo.)

To register for a Medicaid EHR Incentive Program Year 1 payment, click the Register tab (on the left panel). In subsequent payment years, EPs do not need to re-register, but can select the Log On tab to enter the usernames and passwords required to access ePIP. Once logged into ePIP, EPs are able to revise registration information that is out of date.
Eligible Professional – NH Medicaid EHR Incentive Program

Pre-Attestation

Log On Screen

EPs enter their username (7-digit NH Medicaid Provider ID) and password to log on to ePIP.

ePIP requires that passwords be changed every 60 days. If a password has expired, ePIP will navigate the user to create a new password.

Welcome to Your ePIP Account

Once logged on to ePIP, EPs may navigate to these options:

- **Welcome**: Display the Welcome page.
- **Manage My Account**: Review and edit contact information.
- **Attest**: Create attestations for separate program years.
- **Payments**: Track payments for separate program years.
- **Manage Documents**: Upload and maintain supporting documents.
- **Log Off**: Log off ePIP.

**EHR Cert Tool**: Validate CMS EHR Certification IDs.

Click **Attest** to begin an attestation.
EPs are required to attest to five modules: Patient Volume; General Requirements; Meaningful Use Core Measures; Meaningful Use Menu Measures; and Meaningful Use Clinical Quality Measures.

EPs begin their attestation by entering data into the Patient Volume module, followed by the General Requirements module. Once criteria for both modules have been met, EPs can attest in the meaningful use modules. (No particular sequence is required).

If EPs do not meet criteria in the Patient Volume and General Requirements modules, ePIP will not allow entry into the three Meaningful Use modules.

Click Begin to attest in the Patient Volume module.
Core Measures Overview

This module includes the 13 required Stage 1 Meaningful Use Core Measures. Each measure is denoted on a separate webpage with the objective listed first, followed by a description of the measure that must be met. A link at the top of each page connects you to the CMS Meaningful Use specification sheet that provides detailed information about that measure.

The following are general guidelines for attesting to Stage 1 Meaningful Use Core Measures in New Hampshire.

- A numerator and denominator or Yes/No response are required for each measure with the exception of an exclusion (which may require a different response).
- Fields denoted with red asterisks (*) are required and must be populated.
- Denominators must be greater than, or equal to, their associated numerators.
- Data must be entered as non-negative, whole numbers.
- Once a measure has been completed, click Next to validate the data.
  - A red message will display at the top of the webpage if an error(s) is detected.
  - If no error(s) exists, the data will be saved, and you may select the next Core Measure.
- Click Delete to remove data that has been entered for a measure.
- Click Cancel to return to the Core Measures webpage.
- Click Help at the top of each Core measure webpage to display CMS specifications for that measure.

If an attestation is not completed during a session, the system will save Meaningful Use Core Measure data that has been entered so it is available to the EP (or designated representative) at a future time.
### Core Measure Summary

**Core Measures**

The following are Meaningful Use core measures. Each must complete all 13 core measures.

<table>
<thead>
<tr>
<th>Measure#</th>
<th>Objective</th>
<th>Attestation</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.</td>
<td>More than 50 percent of all unique patients with at least one medication in their medication list seen to the EP have at least one medication order entered using CPOE.</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.</td>
<td>More than 50 percent of medication orders entered by the EP during the EHR reporting period are recorded using CPOE.</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Implement drug-drug and drug-allergy interaction checks.</td>
<td>The EP has enabled this functionality for the entire EHR reporting period.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Attestation data for all 13 core measures will display in the **Attestation** column once all measures have been completed.

Click **Return to Modules** to return to the **Submit an Attestation** webpage.
Menu Measures Overview

This module includes the 9 Stage 1 Meaningful Use Menu measures. Eligible Professionals are required to complete 5 of the Menu measures as well as a Public Health Menu measure. Each measure is denoted on a separate webpage with the objective listed first, followed by a description of the measure that must be met. A link at the top of each page connects you to the CMS Meaningful Use specification sheet that provides detailed information about that measure.

**IMPORTANT:** At this time, New Hampshire is not able to accept either of the two Public Health Menu Measures (immunization registry and syndromic surveillance data). As a result, Eligible Professionals will select one Public Health Menu Measure for which they will be authorized to claim exclusion. This Public Health Menu Measure will not count towards the 5 required Menu Measures. Hence, EPs will need to attest to 5 additional non-Public Health Menu Measures.

The following are general guidelines for attesting to Stage 1 Meaningful Use Menu Measures in New Hampshire.

- A numerator and denominator or Yes/No response are required for each measure with the exception of an exclusion (which may require a different response).
- Fields denoted with red asterisks (*) are required and must be populated.
- Denominators must be greater than, or equal to, their associated numerators.
- Data must be entered as non-negative, whole numbers.
- Once a measure has been completed, click **Next** to validate the data.
  - A red message will display if an error(s) is identified.
  - If no error(s) exists, the data will be saved, and the next Menu Measure will display.
- Click **Delete** to remove data that has been entered for a measure.
- Click **Cancel** to return to the **Menu Measures** webpage.
- Click **Help** at the top of each Menu measure webpage to display CMS specifications for that measure.

If an attestation is not completed during a session, the system will save Meaningful Use Core Measure data that has been entered so it is available to the EP (or designated representative) at a future time.
## Menu Measures Summary

### Measure 1
- **Objective:** Ability to submit electronic data to immunization registries or immunization information systems and submit data according to applicable law and practice.
- **Measure:** 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 such data electronically, except where prohibited.
- **Attestation:** Yes
- **Select:** Yes

### Measure 2
- **Objective:** Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
- **Measure:** More than 10 percent of all unique patients seen by the EP are provided patient-specific education resources.
- **Attestation:** Yes
- **Select:** Yes

### Measure 3
- **Objective:** 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.
- **Measure:** The EP who transfers their patient to another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
- **Attestation:** Yes
- **Select:** Yes

### Measure 4
- **Objective:** The EP who transfers their patient to another setting of care or provider of care or believes an encounter is relevant should provide a summary of care record for more than 10 percent.
- **Measure:** The EP who transfers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent.
- **Attestation:** Yes
- **Select:** Yes

---

Attestation data for 5 of 9 Menu measures will display in the **Attestation** column once all have been completed.

Click **Return to Modules** to return to the **Submit an Attestation webpage.**
Clinical Quality Measures Overview

Clinical Quality Measures (CQMs) measure and track the quality of healthcare services provided by Eligible Professionals. EPs must submit CQM data from certified EHR technology in order to receive a Medicaid EHR Incentive Program payment.

In 2014, EPs may attest based on 2013 CQMs (if using non-2014 CEHRT Editions) or, if using 2014 Edition CEHRT, attest to 9 (of 64) CQMs from at least 3 of the 6 National Quality Strategy domains.

The National Quality Strategy domains include:
- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population/Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness

The following are general guidelines for attesting to Stage 1 Meaningful Use Clinical Quality Measures in New Hampshire.

- It is acceptable to enter 0 as a CQM denominator as long as the value was reported from certified EHR technology.
- A numerator and denominator are required for each measure.
- Fields denoted with red asterisks (*) are required and must be populated.
- Denominators must be greater than, or equal to, their associated numerators.
- Data must be entered as non-negative, whole numbers.
- Once a measure has been completed, click **Next** to validate the data.
  - A red message will display at the top of the webpage if an error(s) is detected.
  - If no error(s) exists, the data will be saved, and you may select the next CQM Measure.
- **Click Delete** to remove data that has been entered for a measure.
- **Click Cancel** to return to the Clinical Quality Measures webpage.
- **Click Help** at the top of each CQM webpage to display CMS specifications for that measure.

If an attestation is not completed during a session, the system will save CQM data that has been entered so it is available to the EP (or designated representative) in the future.
## Clinical Quality Measures (CQMs) Summary

<table>
<thead>
<tr>
<th>Additional CQMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>IQF 0054: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (ICD-9): Engagement</td>
</tr>
<tr>
<td>Percentage of patient with a new episode of alcohol and other drug (AOD) dependence who initiated treatment through an intervention.denominator is the number of patients who were new to treatment at the time the intervention was offered.</td>
</tr>
<tr>
<td>Population: N: 361 D: 550</td>
</tr>
<tr>
<td>Attestation data will display on the Clinical Quality Measures webpage as each measure is completed.</td>
</tr>
<tr>
<td>Once the requisite number of Core CQMs, Alternate Core CQMs, and Additional Core CQMs are completed, click Return to Modules at the bottom of the Clinical Quality Measures webpage. ePIP will display the Submit An Attestation webpage.</td>
</tr>
<tr>
<td>IQF 0042: Preventing Care for Human Immunodeficiency Virus (HIV)</td>
</tr>
<tr>
<td>Percentage of patients regardless of age, who were pregnant during a 12-month period who were pregnant for HIV infection during the first or second prenatal care visit.</td>
</tr>
<tr>
<td>Population: N: 161 D: 643</td>
</tr>
<tr>
<td>Return to Modules</td>
</tr>
</tbody>
</table>
Eligible Professional – NH Medicaid EHR Incentive Program

Complete An Attestation

Submit An Attestation

Once the requirements of a module have been fully met, ePIP will display a status of **Completed**.

Once the requirements of all five modules display a status of **Completed**, a **Continue Attestation** button will display that will allow EPS to complete the remaining attestation requirements.

Click **Continue Attestation** to navigate to the Submission Process: Attestation Statements webpage.

Submission Process: Attestation Statements

Click the checkbox next to each of the five attestation statements to affirm agreement.

Click **Agree** to continue with the attestation submission process.

Click **Disagree** to return to the Select A Payment Year webpage. (If **Disagree** is selected, the attestation will not be processed.)
Attestation Disclaimer

Attestation Notification

The EHR Incentive Program payment is considered a Medicaid payment to the provider. In addition to any other remedies available to it, the New Hampshire Medicaid Office reserves the right to offset any overpayments of Medicare or Medicaid (including EHR Incentive Program payments), and any sanctions or civil monetary penalties imposed by Medicare or Medicaid from any amounts due to the Provider from the New Hampshire Medicaid Office including but not limited to EHR Incentive Program payments.

Note: The State does not use the incentive payment to pay for its own program administration or to fund other State priorities.

Attestation Disclaimer

I certify that the foregoing information is true, accurate and complete. I understand that the New Hampshire Medicaid EHR Incentive Program payment will be paid from Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a New Hampshire Medicaid EHR Incentive Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

I certify that the foregoing information is true, accurate and complete. I understand that the New Hampshire Medicaid EHR Incentive Program payment will be paid from Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a New Hampshire Medicaid EHR Incentive Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

I understand that the New Hampshire Medicaid Office reserves the right to perform an audit of this information. The audit may include an on-site visit by New Hampshire Medicaid Office staff or designers to gather supporting data. I hereby agree to keep such records as are necessary, for ten years, to demonstrate that I met all the New Hampshire Medicaid EHR Incentive Program requirements and to furnish such records to the New Hampshire Medicaid Office, or contractor acting on their behalf.

By clicking on this checkbox, I agree to the above Attestation Notification and Disclaimer.

Submit Attestation
Eligible Professional – NH Medicaid EHR Incentive Program

Complete An Attestation

Submission Receipt

ePIP will display a Submission Receipt for EPs that successfully submitted an attestation.

*** IMPORTANT ***
The attestation is not complete until supporting documentation has been uploaded. Click the Manage Documents tab in the Main Menu to upload supporting documents.

Click Print to print the Submission Receipt.

Click Home to return to the Select A Payment Year webpage.

Select A Payment Year

If Home is selected, the Select A Payment Year webpage will display a status of Attestation Complete for Medicaid Payment year attestation.

*** IMPORTANT ***
The attestation is not complete until supporting documentation has been uploaded. Click the Manage Documents tab in the Main Menu to upload supporting documents.
Complete An Attestation

Manage Documents

**IMPORTANT**

Regardless of the method used to generate Core, MU, and CQM data, all associated supporting documents, screen shots, and reports must be uploaded at the time of attestation in order for the payment request to be processed.

PLEASE ENSURE THAT ALL PROTECTED HEALTH INFORMATION, I.E., HIPAA DATA, HAS BEEN REDACTED (REMOVED OR BLACKED OUT).

Documents uploaded from prior year attestations will display as read-only files.

Click Create New to upload a supporting document.
Eligible Professional – NH Medicaid EHR Incentive Program

Complete An Attestation

Upload Document

*** IMPORTANT ***

PLEASE ENSURE THAT ALL PROTECTED HEALTH INFORMATION, I.E., HIPAA DATA, HAS BEEN REDACTED (REMOVED OR BLACKED OUT).

Files names must clearly identify the file contents. NH Medicaid EHR staff will require EPs to delete, and replace, files for which the content is unclear. This will delay payment processing.

Identify the file type that is being uploaded by selecting an option from the Select a Document drop down list.

Type clarification notes as needed in the Memo field. Select Browse to locate the file to be uploaded; select Upload Document to enter the file into ePIP.

EPs may upload as many supporting documents as are required to support their attestations. Once all files have been uploaded, the attestation is complete, and EPs may log off ePIP.

EPs may check the status of their payment at anytime by logging onto ePIP and selecting the Payments tab.
Acronyms and Definitions

**AIU:** Adopt, Implement, or Upgrade are legal terms defined by federal law.

**CEHRT:** Certified EHR Technology are EHR systems that have been designated as such by the Office of the National Coordinator.

**CHIP:** Children’s Health Insurance Program.

**CMS:** Centers for Medicare and Medicaid Services.

**EHR:** Electronic Health Record as defined by the Health Information Technology for Economic and Clinical Health Act (HITECH).

**EP:** Eligible Professional.

**ePIP:** Electronic Provider Incentive Payment System.

**FQHC/RHC:** Federally Qualified Health Center/Rural Health Center.

**Hospital-based:** a professional furnishing more than ten percent (10%) of Medicaid patient encounters must be outside of a hospital setting during the prior calendar year reporting period.

**Medicaid Encounter:** All services provided in a day by a specific provider to a Medicaid-enrolled individual. This includes:

(Definition for January 1 through November 30, 2013)

- Services in which Medicaid or out-of-state Medicaid or out-of-state Medicaid Managed Care programs paid for part or all of the services (including premiums, co-payments, and/or cost sharing); or
- Encounters where Medicaid paid zero dollars where Medicare (in the case of patients that are dually eligible for both Medicaid and Medicare) or another third party paid for the encounter; or
- Encounters provided to Medicaid beneficiaries for which no payments were received; or
- Medical services provided to Medicaid beneficiaries that were not covered under New Hampshire’s Medicaid program.

(Definition for December 1, 2013 through December 31, 2013)

- Services in which Medicaid or Medicaid Managed Care programs (including out-of-state programs) paid for part or all of the services (including premiums, co-payments, and/or cost sharing); or
- Encounters where Medicaid paid zero dollars where Medicare (in the case of patients that are dually eligible for both Medicaid and Medicare) or another third party paid for the encounter; or
- Encounters provided to Medicaid beneficiaries for which no payments were received; or
Eligible Professional – NH Medicaid EHR Incentive Program

Acronyms and Definitions

- Medical services provided to Medicaid beneficiaries that were not covered under New Hampshire's Medicaid program.

**MU:** Meaningful Use.

**Needy Individual Encounter:** All services provided in a day by a specific provider to a Needy individual. This includes:

(Definition for January 1 through November 30, 2013)

- Services in which:
  - Medicaid or out-of-state Medicaid or out-of-state Medicaid Managed Care programs paid for part or all of the services (including premiums, co-payments, and/or cost sharing); or
  - Out-of-State CHIP paid for part or all of the services (including premiums, co-payments, and/or cost-sharing); or
  - Services were rendered to an individual on a sliding scale; or
  - Services were uncompensated;
- Encounters where Medicaid paid zero dollars where Medicare (in the case of patients that are dually eligible for both Medicaid and Medicare) or another third party paid for the encounter; or
- Encounters provided to Medicaid beneficiaries for which no payments were received; or
- Medical services provided to Medicaid beneficiaries that were not covered under New Hampshire's Medicaid program.

(Definition for December 1, 2013 through December 31, 2013)

- Services in which:
  - Medicaid or Medicaid Managed Care programs (including out-of-state programs) paid for part or all of the services (including premiums, co-payments, and/or cost sharing); or
  - Out-of-State CHIP paid for part or all of the services (including premiums, co-payments, and/or cost-sharing); or
  - Services were rendered to an individual on a sliding scale; or
  - Services were uncompensated;
- Encounters where Medicaid paid zero dollars where Medicare (in the case of patients that are dually eligible for both Medicaid and Medicare) or another third party paid for the encounter; or
- Encounters provided to Medicaid beneficiaries for which no payments were received; or
- Medical services provided to Medicaid beneficiaries that were not covered under New Hampshire’s Medicaid program.

**NPI (National Provider Identifier):** 10-digit number unique to each health care provider.
Acronyms and Definitions

**ONC (Office of the National Coordinator for Health Information Technology):**
Maintains the Certified Health IT Product list that allows providers to obtain a CMS EHR Certification Number required for attestation.

**Pediatrician:** New Hampshire defines a pediatrician as a provider that holds a Doctor of Medicine or Doctor of Osteopathy degree and holds a current license and is board certified in pediatric medicine. Further, a pediatrician’s provider enrollment with New Hampshire Medicaid must indicate that one of his/her specialties is a pediatrician.

**Practice Predominantly:** Eligible Professional for whom the clinical location for over 50 percent of his or her patient encounters over a period of 6 months in the prior calendar year occur at a Federally Qualified Health Center or a Rural Health Center.

**RECNH (Regional Extension Center of New Hampshire):** one of 62 Regional Extension Centers nationwide designated to serve New Hampshire as an unbiased, trusted resource with national perspective and local expertise to assist healthcare providers with EHR adoption, optimization and achievement of Meaningful Use.

**TIN (Tax Identification Number):** EP’s have the option of reassigning Medicaid EHR Incentive Program payments to another entity. A payee TIN that is a Social Security Number (SSN) indicates that the provider will receive the payment; a payee TIN of Employer Identification Number (EIN) indicates that another qualified entity will receive the payment.