



North Dakota Promoting Interoperability (PI) Program

# Eligible Professionals

User Guide – Meaningful Use

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## Contents

Access ND Registration and Attestation Portal .....	3
Login.....	3
User Profile .....	4
Add an EP to the profile.....	5
Meaningful Use Attestation Process .....	6
Beginning and Patient Volume .....	6
Attestation Reporting Period.....	9
Meaningful Use Objectives.....	13
Clinical Quality Measures .....	24
Select Begin on Clinical Quality Measures to access the CQM main menu .....	24
Required Documents to Upload .....	43
Attestation Submission.....	44

# North Dakota Medicaid EHR Promoting Interoperability (PI) Program

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## Registration Steps for Eligible Professionals

**Please note:** All EPs must first be registered with the CMS Promoting Interoperability Programs Registration System at: <https://ehrincentives.cms.gov/hitech/login.action>

**Please note:** The last year to register to attest for EPs and EHs was 2016

Each EP will receive a CMS EHR Confirmation number that will be needed to start the ND attestation. Please allow 24 hours after registering with CMS for the number to be valid in the ND Portal.

## Access ND Registration and Attestation Portal

<https://apps.nd.gov/dhs/mmis/hitech/login.htm>

## Login

Enter the login information – Refer to the account creation document if you have not created a User ID and Password

North Dakota  
login

**Already Registered - [Not sure?](#)**  
North Dakota Login:   
[Forgot Login](#)  
Password:   
[Forgot Password](#)  
  
[Update your account](#)

**New to North Dakota Online Services?**  
  
Benefits of North Dakota Login

- One North Dakota Login and password to access multiple [ND Online Services](#)
- Register once for secure access to State services

Need help? Read through the [FAQ](#).

For assistance with this North Dakota Login, contact the [Service Desk](#).

## User Profile

The first time a user logs in, a profile must be completed

This should be the person that is attesting on behalf of a provider or the provider if they are self-attesting

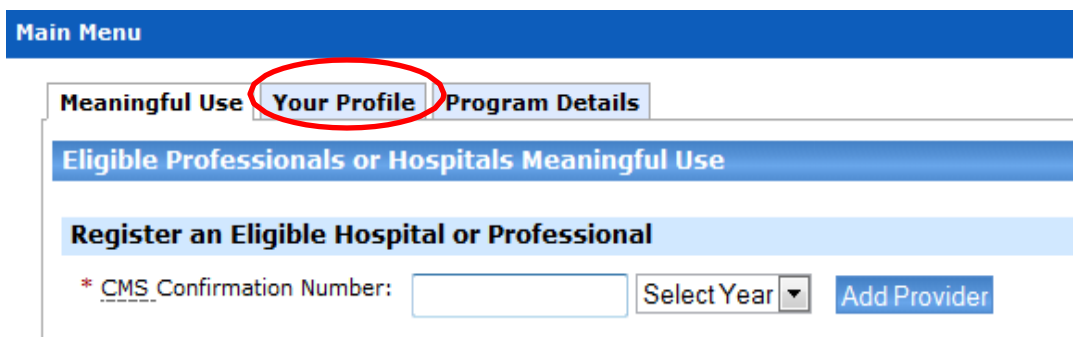


A screenshot of a web form titled "User Information". The form contains several fields, each preceded by a red asterisk indicating it is required. The fields are: Name (John Doe), Organization Name (Good Medical Center), EIN/TIN (123456789), Title (Administrator), SSN (111223333), Phone (7015555555), Email Address (JDOE@nd.gov), Address 1 (123 Street Name), Address 2 (empty), City (Anytown), State (ND), Zip (55555), and Preferred Communication (Email or Phone). A blue "Save" button is located at the bottom left of the form.

*Required	
*Name:	John Doe
*Organization Name:	Good Medical Center
*EIN/TIN:	123456789
*Title:	Administrator
*SSN:	111223333
*Phone:	7015555555
*Email Address:	JDOE@nd.gov
*Address 1:	123 Street Name
Address 2:	
*City:	Anytown
*State:	ND
*Zip:	55555
*Preferred Communication:	Email or Phone

Save

To edit this information at any time, you can access this information from the "Your Profile" tab on the main menu.



A screenshot of a web application's main menu. The menu has a blue header bar with the text "Main Menu". Below the header, there are three tabs: "Meaningful Use", "Your Profile", and "Program Details". The "Your Profile" tab is highlighted with a red circle. Below the tabs, there is a blue bar with the text "Eligible Professionals or Hospitals Meaningful Use". Below that, there is a light blue bar with the text "Register an Eligible Hospital or Professional". At the bottom, there is a form with a red asterisk followed by the text "CMS Confirmation Number:", a text input field, a dropdown menu labeled "Select Year", and a blue button labeled "Add Provider".

Main Menu

Meaningful Use **Your Profile** Program Details

Eligible Professionals or Hospitals Meaningful Use

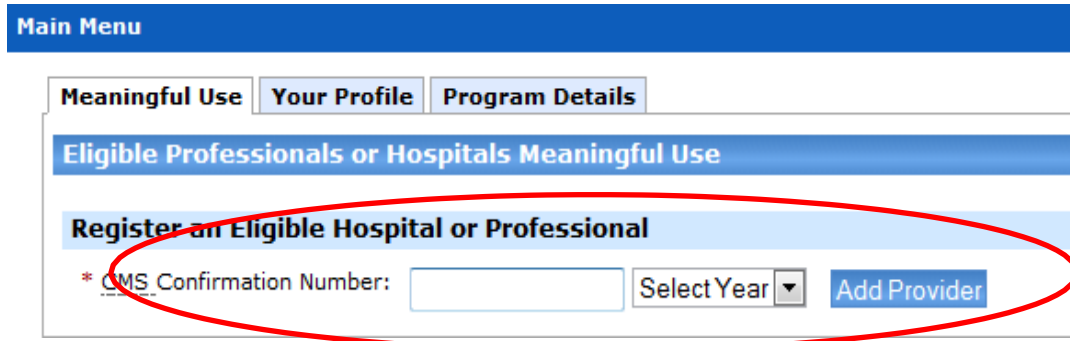
Register an Eligible Hospital or Professional

\* CMS Confirmation Number:  Select Year

## Add an EP to the profile

**Please note:** If attesting as a group of EPs using the Group Proxy patient volume method, all EPs must be added to the profile before proceeding.

Enter the CMS confirmation number that was issued when the provider was registered for the incentive program with CMS and select the attestation year for each EP that will be attesting.



The screenshot shows a web interface with a blue header bar labeled "Main Menu". Below it, there are three tabs: "Meaningful Use", "Your Profile", and "Program Details". The "Your Profile" tab is active. Under this tab, there is a section titled "Eligible Professionals or Hospitals Meaningful Use". Within this section, there is a sub-section titled "Register an Eligible Hospital or Professional". This sub-section contains a form with the following elements: a red asterisk followed by the text "CMS Confirmation Number:", a text input field, a dropdown menu labeled "Select Year", and a blue button labeled "Add Provider". A red oval is drawn around the entire form area, highlighting the input fields and the button.

Once all the providers are added to the profile, you are ready to begin the attestation process. This will need to be completed each year an individual completes the attestation process.

## Meaningful Use Attestation Process

**Please note:** Any core measures or clinical quality measures depicted throughout this document are only to be used for examples to understand how the system functions, and are not up-to-date based on current program year core measure and clinical quality measure content.

**Please note:** Menu measures have phased out, therefore the instructions are no longer included in this document.

### Beginning and Patient Volume

1. Under Action, Click Begin or Continue if you have previously started an attestation.

Delete will clear all information that was previously entered.





The Status column will indicate the status of the attestation.


Meaningful Use

Your Profile

Program Details

Eligible Professionals or Hospitals Meaningful Use

Legend:  Submitted  Approved  Denied  Incomplete

Name	NPI	TIN	CCN	Status	Action
Program Year 2013					
Lutheran Charity Association					<a href="#">Continue</a>   <a href="#">Delete</a>
FERDINAND					<a href="#">Begin</a>
Program Year 2014					
Test Hospital		SSN:299999999			<a href="#">Begin</a>
FERDINAND					<a href="#">Begin</a>
Paul					<a href="#">Begin</a>
St Josephs Hospital and Health Center					<a href="#">Begin</a>
<a href="#">View Previous Years</a>					

Register an Eligible Hospital or Professional

\* CMS Confirmation Number:

Select Year

Add Provider

2. Is this Attestation for a group of provider → If Yes, refer to the Group Proxy Methodology userguide
3. Is this attestation for a pediatrician → Must select yes if the provider is a pediatrician
4. Professional Provider Selection will indicate who the attestation is for, the program year, and the participation year.
5. 90-day Medicaid Patient Volume → Enter Begin Date (system calculates End Date) Must be from the previous calendar year or within the previous 12 months prior to the attestation date
6. Medicaid Volume Calculation → Volume must be equal to or greater than 30% or equal to or greater than 20% for pediatricians

**Medicaid Encounters** = All encounters the EP had that were from patients that were enrolled with Medicaid at the time of the encounter

**Total Encounters** = All patient encounters during the 90 day period. Medicaid Encounters + Non-Medicaid encounters

**Meaningful Use**

**\*Required**

**Group or Individual**

\*Is this Attestation for a group of providers? ☐ Yes ☒ No

**Pediatrician**

\*Is this Attestation for a Pediatrician? ☐ Yes ☒ No

**Professional Provider Selection**

Name	NPI	TIN	CCN	Program Year	Participation Year
FERDINAND	8			2014	4

**90 day Medicaid Patient Volume**

\*Begin Date: 01/01/2014 (mm/dd/yyyy)

End Date: 3/31/2014

**Medicaid Volume Calculation**

\*Paid Medicaid Encounters: 97

\*Total Encounters: 212

Return to Menu

Continue

7. Continue navigates to the MU section, Return to Menu navigates to the main menu.

## Meaningful Use Main

**Meaningful Use Information**  
Name: Paul H Freiberg NPI: 1891791836 TIN: SSN: 134287958 CCN: Pediatrician: N

**Medicaid Volume 90 Day Period - [Edit](#)**  
Begin Date: 01/01/2014  
End Date: 03/31/2014

**Medicaid Volume Calculation - [Edit](#)**  
Paid Medicaid Encounters: 97  
Total Encounters: 212  
Medicaid Volume: 45.75%

**Medicaid Number - [Add](#)**  
Medicaid Number:

**EHR Certification Information - [Add](#)**  
CMS EHR Certification ID:

**Attestation Reporting Period - [Add](#)**  
Begin Date:  
End Date:

**Attestation Selection**  
Legend: ✓ Complete ✗ Incomplete

Measure Name	Status	Status	Action
Register and Attest	0 of 9 complete	✗	<a href="#">Begin</a>
Core Measures	0 of 13 complete	✗	<a href="#">Begin</a>
Menu Measures	0 of 9 complete	✗	<a href="#">Begin</a>
Clinical Quality Measures	0 of 64 complete	✗	<a href="#">Begin</a>
<a href="#">Remove Core, Menu, and Clinical Measures</a>			

**Upload Documents**  
Legend: ✓ Complete ✗ Required — Optional

Document Name	Status	Action
Legal Authorization to attest on behalf of the facility/provider	✗	<a href="#">Upload</a>
Volume Calculation	✗	<a href="#">Upload</a>
Signed Legal Contract or EHR Certification Number	✗	<a href="#">Upload</a>
EHR MU Dashboard Report	—	<a href="#">Upload</a>
W-9	✗	<a href="#">Upload</a>
<a href="#">Add Additional Documents</a>		

Selecting the EDIT or ADD functions will allow the user to edit or enter the required information

Enter the EP's ND Medicaid Number

Enter the CMS EHR Certification ID

Enter the MU Reporting Period

[Return to Menu](#)

[Submit](#)

Select the Add/Edit links to enter or change information



## EHR Certification Information

1. Click "Add" to enter the provider's Certified Electronic Health Record Technology (CEHRT) ID. The CEHRT ID should be obtained from a letter provided by the facility or EP's EHR vendor.

**Medicaid Volume 90 Day Period** - [Edit](#)

Begin Date: 01/01/2014  
End Date: 03/31/2014

**Medicaid Volume Calculation** - [Edit](#)

Paid Medicaid Encounters: 97  
Total Encounters: 212  
Medicaid Volume: 45.75%

**EHR Certification Information** - [Add](#)

CMS EHR Certification ID:

2. A Valid certification must be entered – A valid number will show green, invalid red.

**EHR Certification Information** - [Add](#)

**EHR Certification Information**

**\*Required**

\*CMS EHR Certification ID:

Measure Name	Status	Status	Action

## Attestation Reporting Period

3. Enter the Attestation Reporting Period by selecting "Add"

**Attestation Reporting Period** - [Add](#)

Begin Date:  
End Date:

4. Select the length of reporting period → If this is the providers first year of reporting MU or program year 2014, a 90 day period can be used. If the attestation is not for program year 2014 and this is the second year and beyond of reporting MU, one year reporting is required. Reporting dates must be within the program year the attestation is for.


**Attestation Reporting Period**

**\*Required**

\*Is this attestation period for 90 days or for 1 Year.

90 day attestation reporting period. ☐

1 year attestation reporting period. ☒







\*Begin Date:   (mmddyyyy)

End Date: 12/31/2014

## Register and Attest Questions

1. Click on Begin or Continue to answer the Register and Attest questionnaire

*All of the questions will be verified. If found to be falsely answered the attestation will be flagged for further Audit.*

Attestation Selection			
Legend:  Complete  Incomplete			
Measure Name	Status	Status	Action
Register and Attest	9 of 9 complete		<a href="#">Continue</a>
Core Measures	0 of 13 complete		<a href="#">Begin</a>
Menu Measures	0 of 9 complete		<a href="#">Begin</a>
Clinical Quality Measures	0 of 64 complete		<a href="#">Begin</a>
<a href="#">Remove Core, Menu, and Clinical Measures</a>			

2. Question #1 – Is the provider currently sanctioned

### Question #1

\*Are you currently sanctioned by Medicaid or Medicare?

- ☐ Yes.
- ☒ No.

3. Question #2 – Has the provider or Organization ever been sanctioned

### Question #2

\*Has your organization ever been sanctioned by Medicaid or Medicare in North Dakota or any other state?

- ☐ Yes.
- ☒ No.

4. Question #3 – Have you applied or received an EHR incentive payment in any other state? If Yes, select the other state from the drop-down list.

### Question #3

\*Have you applied for EHR Incentive payment in any other state?

- ☐ Yes.
- ☒ No.

5. Question #4 – Does the provider practice in more than 1 location. If yes, enter the other facility information and then select "ADD"

#### Question #4

\*Do you practice at more than one location?

- ☒ Yes  
☐ No

Location	Address	City	Action
XYZ Clinic	100 Main St	Bismarck	<a href="#">Add</a>

6. Question #5 – Is the provider non-hospital based – The provider must not see more than 90% of patients in POS 21 or 23

#### Question #5

\*Are you non-hospital based (90% or more of your encounters are NOT performed in an inpatient setting (site of service code 21) or in the emergency department (site of service code 23)?

- ☒ Yes  
☐ No

7. Q #6 – Do you practice in an FQHC, RHC, or Tribal Clinic? If Yes, Do you practice predominantly Are you a Physician's Assistant → If YES, is the facility PA led? → Choose the PAtype

#### Question #7

\*Do you practice in a FQHC, RHC or Tribal Clinic?

- ☒ Yes  
☐ No

\*Do you practice predominantly at a FQHC, RHC or Tribal Clinic? (Practicing predominantly means that the FQHC/RHC is the clinical location for over 50 percent of total encounters over a period of six months in the most recent calendar year or 12 months preceding the attestation.)

- ☒ Yes  
☐ No

\*Are you a Physician's Assistant?

- ☒ Yes  
☐ No

\*Is your FQHC/RHC "so led" by a Physician's Assistant?

- ☒ Yes  
☐ No

\* Choose one of the following three options:

- ☒ PA is the primary provider in a clinic  
☐ PA is a clinical or medical director at a clinical site of practice  
☐ PA is an owner of a RHC

8. Question #7 – Payer Mix – from the same 90 day period of Medicaid Patient Volume – Total must equal 100%

#### Question #7

##### Percentage of Payer Mix

*Percentage of Paid Medicaid Encounters:	<input type="text" value="38"/>	
*Percentage of Paid Medicare Encounters:	<input type="text" value="12"/>	
*Percentage of Paid BCBSND Encounters:	<input type="text" value="30"/>	
*Percentage of Other Paid Commercial Encounters:	<input type="text" value="10"/>	Name: <input type="text" value="All Other Commercial"/>
*Percentage of Other Paid Encounters:	<input type="text" value="10"/>	Name: <input type="text" value="Sliding Fee/No Pay"/>

9. Question #8 – Do you wish to assign Payment to an Organization  
If No, Payment will be issued to the provider using the Social Security Number Provided  
If Yes, Payment will be issued to the facility indicated

#### Question #8

\*Do you wish to assign Payment to an Organization/Individual?






- ☒ Yes  
☐ No

*Organization/Individual Name:	<input type="text" value="XYZ Clinic"/>
*Address to which payment should be sent:	<input type="text" value="258 Main Ave"/>
*TIN or EIN:	<input type="text" value="123456748"/>
*Phone Number for assignee:	<input type="text" value="7015555555"/>
*Email Address for assignee:	<input type="text" value="JOE@XYZclinic.org"/>

10. Select Save & Return to return to the Menu

## Meaningful Use Objectives

Select Begin or Continue on the Meaningful Use Objectives to enter data for all measures.

Attestation Selection			
Legend:  Complete  Incomplete			
Measure Name	Status	Status	Action
Register and Attest	0 of 8 complete		<a href="#">Begin</a>
Meaningful Use Objectives	8 of 8 complete		<a href="#">Continue</a>
Clinical Quality Measures	0 of 50 complete		<a href="#">Begin</a>

## Objective 1

### Meaningful Use Objectives - Objective 1 of 8

\*Required

#### Objective Details

Objective: Protect Patient Health Information - Protect electronic protected health information (ePHI) created or maintained by the certified electronic health record technology (CEHRT) through the implementation of the appropriate technical, administrative, and physical safeguards.

#### Measure 1

Measure: Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the provider's risk management process.

#### Complete the following information:

\*Have you conducted or reviewed your security risk analysis, and if necessary implemented security updates, and corrected any identified security deficiencies per the requirements of this measure?

☒ Yes ☐ No

All fields must be completed before the EP is allowed to save and continue to the next objective.

#### Attestation Requirements: Measure 1

- Eligible professionals (EPs) must attest YES to conducting or reviewing a security risk analysis and implementing security updates as necessary and correcting identified security deficiencies to meet this measure.

**Please note:** Selecting *Save & Return* will take you to the main menu and *Save & Continue* will take you to the next Core measure.

## Objective 2

### Meaningful Use Objectives - Objective 2 of 8

\*Required

#### Objective Details

Objective: Electronic Prescribing (eRX) - Generate and transmit permissible prescriptions electronically (eRX).

#### Patient Records

\*Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using Certified Electronic Health Record Technology (CEHRT).

- ☐ This data was extracted from ALL patient records not just those maintained using CEHRT.
- ☒ This data was extracted only from patient records maintained using CEHRT.

#### Measure 1

Measure: More than 60 percent of all permissible prescriptions written by the eligible professional (EP) are queried for a drug formulary and transmitted electronically using CEHRT.

#### Exclusion

Any EP that meets one or more of the following criteria may be excluded from this measure.

Any EP who writes fewer than 100 permissible prescriptions during the Promoting Interoperability (PI) reporting period. An exclusion from this measure does not prevent an EP from achieving meaningful use.

\*Does this exclusion apply? ☐ Yes ☒ No

Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her PI reporting period. An exclusion from this measure does not prevent an EP from achieving meaningful use.

\*Does this exclusion apply? ☐ Yes ☒ No

#### Complete the following information:

Numerator: The number of prescriptions in the denominator generated, queried for a drug formulary, and transmitted electronically using CEHRT.

Denominator: Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the PI reporting period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the PI reporting period.

#### Calculation

\*Numerator:  \*Denominator:

Actual: 70.00%

All fields must be completed before the EP is allowed to save and continue to the next objective.

#### Attestation Requirements Measure 1:

- **DENOMINATOR:** Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period; or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.
- **NUMERATOR:** The number of prescriptions in the denominator that are generated, queried for a drug formulary, and transmitted electronically using CEHRT.
- **THRESHOLD:** The resulting percentage must be more than 60 percent for an EP to meet this measure.
- **EXCLUSIONS:** An EP may take an exclusion if any of the following apply:
  - Writes fewer than 100 permissible prescriptions during the EHR reporting period; or
  - Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of their EHR reporting period.

**Please note:** Selecting *Save & Return* will take you back to the main menu, *Save & Previous* will take you to the previous core measure, and *Save & Continue* will take you to the next core measure.

## Objective 3

### Meaningful Use Objectives - Objective 3 of 8

\*Required

#### Objective Details

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

Measure: EPs must satisfy both measures for this objective through a combination of meeting the thresholds and exclusions.

##### Measure 1

Measure: Implement five 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 four CQMs related to an EP's scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.

#### Complete the following information:

\*An EP must attest YES to implementing five CDS interventions related to four or more CQMs at a relevant point in patient care for the entire PI reporting period.

☒ Yes ☐ No

##### Measure 2

Measure: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period.

#### Exclusion

Any EP who writes fewer than 100 medication orders during the PI reporting period.

\*Does this exclusion apply? ☐ Yes ☒ No

#### Complete the following information:

\*EPs must attest YES to enabling and implementing the functionality for drug-drug and drug-allergy interaction checks for the entire PI reporting period.

☒ Yes ☐ No

All fields must be completed before the EP is allowed to save and continue to the next objective.

#### Attestation Requirements Measure 1:

- EPs must attest "YES" to implementing five CDS interventions related to four or more CQMs at a relevant point in patient care for the entire EHR reporting period.

#### Attestation Requirements Measure 2:

- EPs must attest "YES" to enabling and implementing the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
- EXCLUSION: Any EP who writes fewer than 100 medication orders during the EHR reporting period.

**Please note:** Selecting *Save & Return* will take you back to the main menu, *Save & Previous* will take you to the previous core measure, and *Save & Continue* will take you to the next core measure.



## Objective 4

Meaningful Use Objectives - Objective 4 of 8
<b>*Required</b>
<b>Objective Details</b>
Objective: Computerized Provider Order Entry (CPOE) - Use CPOE for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.
Measure: An EP, through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective.
<b>Patient Records</b>
<b>*Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using Certified Electronic Health Record Technology (CEHRT).</b>
<input type="radio"/> This data was extracted from ALL patient records not just those maintained using CEHRT.
<input type="radio"/> This data was extracted only from patient records maintained using CEHRT.
<b>Measure 1</b>
Measure: More than 60 percent of medication orders created by the eligible professional (EP) during the Promoting Interoperability (PI) reporting period are recorded using CPOE.
<b>Exclusion</b>
Any EP who writes fewer than 100 medication orders during the PI reporting period.
<b>*Does this exclusion apply?</b> <input type="radio"/> Yes <input type="radio"/> No
<b>Complete the following information:</b>
Numerator: The number of orders in the denominator recorded using CPOE.
Denominator: Number of medication orders created by the EP during the PI reporting period.
<b>Calculation</b>

All fields must be completed before the EP is allowed to save and continue to the next objective.

### Attestation Requirements Measure 1:

- DENOMINATOR: Number of medication orders created by the EP during the EHR reporting period.
- NUMERATOR: The number of orders in the denominator recorded using CPOE.
- THRESHOLD: The resulting percentage must be more than 60 percent for an EP to meet this measure.
- EXCLUSION: Any EP who writes fewer than 100 medication orders during the EHR reporting period.

### Attestation Requirements Measure 2:

- DENOMINATOR: Number of laboratory orders created by the EP during the EHR reporting period.
- NUMERATOR: The number of orders in the denominator recorded using CPOE.
- THRESHOLD: The resulting percentage must be more than 60 percent for an EP to meet this measure.
- EXCLUSION: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

### Attestation Requirements Measure 3:

- DENOMINATOR: Number of diagnostic imaging orders created by the EP during the HER reporting period.
- NUMERATOR: The number of orders in the denominator recorded using CPOE.
- THRESHOLD: The resulting percentage must be more than 60 percent for an EP to meet this measure.
- EXCLUSION: Any EP who writes fewer than 100 diagnostic imaging orders during the HER reporting period.

## Objective 5

### Meaningful Use Objectives - Objective 5 of 8

\*Required

#### Objective Details

Objective: Patient Electronic Access - The eligible professional (EP) provides patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education.

Measure: An EP must satisfy both measures for this objective through a combination of meeting the thresholds and exclusions.

#### Measure 1

Measure: For more than 80 percent of all unique patients seen by the EP: 1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and 2) The provider ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider's certified electronic health record (CEHRT).

#### Exclusion

Any EP that meets one or more of the following criteria may be excluded from this measure.

An EP may exclude from the measure if they have no office visits during the Promoting Interoperability (PI) reporting period.

\*Does this exclusion apply? ☐ Yes ☐ No

Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the PI reporting period may exclude the measure.

\*Does this exclusion apply? ☐ Yes ☐ No

#### Complete the following information:

Numerator: The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.

Denominator: The number of unique patients seen by the EP during the PI reporting period.

#### Calculation

\*Numerator:  \*Denominator:

Actual:

All fields must be completed before the EP is allowed to save and continue to the next objective.

#### Attestation Requirements Measure 1:

- **DENOMINATOR:** The number of unique patients seen by the EP during the EHR reporting period.
- **NUMERATOR:** The number of patients in the denominator (or patient-authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the EP's CEHRT.
- **THRESHOLD:** The resulting percentage must be more than 80 percent for an EP to meet this measure.
- **EXCLUSIONS:** An EP may take an exclusion if any of the following apply:
  - They have no office visits during the EHR reporting period.
  - They conduct 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

#### Attestation Requirements Measure 2:

- **DENOMINATOR:** The number of unique patients seen by the EP during the EHR reporting period.
- **NUMERATOR:** The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the EHR reporting period.
- **THRESHOLD:** The resulting percentage must be more than 35 percent for an EP to meet this measure.
- **EXCLUSIONS:** An EP may take an exclusion if any of the following apply:
  - They have no office visits during the EHR reporting period.
  - They conduct 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

## Objective 6

### Meaningful Use Objectives – Objective 6 of 8

\*Required

#### Objective Details

Objective: Coordination of Care Through Patient Engagement - Use certified electronic health record technology (CEHRT) to engage with patients or their authorized representatives about the patient's care.

Measure: An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

#### Measure 1

Measure: More than 5 percent of all unique patients (or their authorized representatives) seen by the eligible professional (EP) actively engage with the electronic health record made accessible by the provider and either: 1. View, download or transmit to a third party their health information; or 2. Access their health information through the use of an Application Programming Interface (API) that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or 3. A combination of (1) and (2).

#### Exclusion

**Any EP that meets one or more of the following criteria may be excluded from this measure.**

An EP may exclude from the measure if they have no office visits during the PI reporting period.

\*Does this exclusion apply? ☐ Yes ☐ No

Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the PI reporting period may exclude the measure.

\*Does this exclusion apply? ☐ Yes ☐ No

#### Complete the following information:

Numerator: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the PI reporting period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the PI reporting period.

Denominator: Number of unique patients seen by the EP during the PI reporting period.

#### Calculation

\*Numerator:  \*Denominator:

Actual:

All fields must be completed before the EP is allowed to save and continue to the next objective.  
Please note the screenshot above does not show the entire objective.

#### Attestation Requirements Measure 1:

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of unique patients (or their authorized representatives) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the EHR reporting period and the number of unique patients (or their authorized representatives) in the denominator who have accessed their health information through the use of an API during the EHR reporting period.
- THRESHOLD: The resulting percentage must be more than 5 percent.
- EXCLUSIONS: An EP may exclude from the measure if they have no office visits during the EHR reporting period, or:
  - Any EP that conducts 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

#### Attestation Requirements Measure 2:

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a

secure message sent by the patient (or patient-authorized representative), during the EHR reporting period.

- THRESHOLD: The resulting percentage must be more than 5 percent.
- EXCLUSIONS: An EP may exclude from the measure if they have no office visits during the EHR reporting period, or;
  - Any EP that conducts 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability 4 according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

Attestation Requirements Measure 3:

- DENOMINATOR: Number of unique patients seen by the EP during the EHR reporting period.
- NUMERATOR: The number of patients in the denominator for whom data from non-clinical settings, which may include patient generated health data, is captured through the CEHRT into the patient record during the EHR reporting period.
- THRESHOLD: The resulting percentage must be more than 5 percent.
- EXCLUSIONS: An EP may exclude from the measure if they have no office visits during the EHR reporting period, or;
  - Any EP that conducts 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period may exclude the measure.

***Please note:*** Selecting *Save & Return* will take you back to the main menu, *Save & Previous* will take you to the previous core measure, and *Save & Continue* will take you to the next core measure.

## Objective 7

### Meaningful Use Objectives - Objective 7 of 8

\*Required

#### Objective Details

**Objective:** Health Information Exchange - The eligible professional (EP) provides a summary of care record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon the receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their electronic health record (EHR) using the functions of certified electronic health record technology (CEHRT).

**Measure:** An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.

#### Patient Records

\*Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using Certified Electronic Health Record Technology (CEHRT).

- ☐ This data was extracted from ALL patient records not just those maintained using CEHRT.
- ☐ This data was extracted only from patient records maintained using CEHRT.

#### Measure 1

**Measure:** For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: 1) Creates a summary of care record using CEHRT; and 2) Electronically exchanges the summary of care record.

#### Exclusion

**Any EP that meets one or more of the following criteria may be excluded from this measure.**

Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the Promoting Interoperability (PI) reporting period.

\*Does this exclusion apply? ☐ Yes ☐ No

Any EP that conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the PI reporting period may exclude the measure.

\*Does this exclusion apply? ☐ Yes ☐ No

#### Complete the following information:

**Numerator:** The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

**Denominator:** Number of transitions of care and referrals during the PI reporting period for which the EP was the transferring or referring provider.

All fields must be completed before the EP is allowed to save and continue to the next objective. Please note the screenshot above does not show the entire objective.

#### Attestation Requirements Measure 1:

- **DENOMINATOR:** Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
- **NUMERATOR:** The number of transitions of care and referrals in the denominator where a summary of care record was created using certified EHR technology and exchanged electronically.
- **THRESHOLD:** The percentage must be more than 50 percent in order for an EP to meet this measure.
- **EXCLUSION:** An EP may take an exclusion from the measure if any of the following apply:
  - They transfer a patient to another setting or refers a patient to another provider fewer than 100 times during the EHR reporting period.
  - They conduct 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

#### Attestation Requirements Measure 2:

- DENOMINATOR: Number of patient encounters during the EHR reporting period for which an EP was the receiving party of a transition or referral or has never before encountered the patient and for which an electronic summary of care record is available.
- NUMERATOR: Number of patient encounters in the denominator where an electronic summary of care record received is incorporated by the provider into the certified HER technology.
- THRESHOLD: The percentage must be more than 40 percent in order for an EP to meet this measure.
- EXCLUSION: An EP may take an exclusion from the measure if any of the following apply:
  - They conduct 50 percent or more of their patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

#### Attestation Requirements Measure 3:

- DENOMINATOR: Number of transitions of care or referrals during the EHR reporting period for which the EP was the recipient of the transition or referral or has never before encountered the patient.
- NUMERATOR: The number of transitions of care or referrals in the denominator where the following three clinical information reconciliations were performed: medication list, medication allergy list, and current problem list.
- THRESHOLD: The resulting percentage must be more than 80 percent in order for an EP to meet this measure.
- EXCLUSION: An EP may take an exclusion from this measure if the total transitions or referrals received and patient encounters in which they have never before encountered the patient, is fewer than 100 during the EHR reporting period.

**Please note:** Selecting *Save & Return* will take you back to the main menu, *Save & Previous* will take you to the previous core measure, and *Save & Continue* will take you to the next core measure.

## Objective 8

### Meaningful Use Objectives - Objective 8 of 8

\*Required

#### Objective Details

**Objective:** Public Health and Clinical Data Registry Reporting - The eligible professional (EP) is in active engagement with a public health agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified electronic health record technology (CEHRT), except where prohibited, and in accordance with applicable law and practice.

**Measure:** An EP must satisfy two measures for this objective. If the EP cannot satisfy at least two measures, they may take exclusions from all measures they cannot meet.

#### Active Engagement

Active engagement may be demonstrated by any of the following options:

- **Active Engagement Option 1 - Completed Registration to Submit Data:** The EP has registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the PI reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each PI reporting period.
- **Active Engagement Option 2 - Testing and Validation:** The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within a PI reporting period would result in that provider not meeting the measure.
- **Active Engagement Option 3 - Production:** The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

#### Measure 1

**Measure:** Immunization Registry Reporting - The EP is in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).

#### Exclusion

**Any EP that meets one or more of the following criteria may be excluded from this measure.**

Does not administer any immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or IIS during the Promoting Interoperability (PI) reporting period.

\*Does this exclusion apply? ☐ Yes ☐ No

Operates in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the PI reporting period.

\*Does this exclusion apply? ☐ Yes ☐ No

Operates in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of 6 months prior to the start of the PI reporting period.

\*Does this exclusion apply? ☐ Yes ☐ No

All fields must be completed before the EP is allowed to save and continue to the next objective. Please note the screenshot above does not show the entire objective.

#### Attestation Requirements Measure 1:

- **YES/NO:** The EP must attest "YES" to being in active engagement with a PHA to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/IIS.
- **EXCLUSIONS:** An EP may take an exclusion if any of the following apply:
  - They do not administer immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or IIS during the EHR reporting period;
  - They practice in a jurisdiction for which no immunization registry or IIS is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - They practice in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of six months prior to the start of the EHR reporting period.

#### Attestation Requirements Measure 2:

- YES/NO: The EP must attest “YES” to being in active engagement with a PHA to submit syndromic surveillance data.
- EXCLUSIONS: An EP may take an exclusion if any of the following apply:
  - They are not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction’s syndromic surveillance system;
  - They practice in a jurisdiction for which no PHA is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - They practice in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs as of six months prior to the start of the EHR reporting period.

#### Attestation Requirements Measure 3:

- YES/NO: The EP must attest “YES” to being in active engagement with a PHA to submit case reporting of reportable conditions.
- EXCLUSIONS: An EP may take an exclusion if any of the following apply:
  - They do not treat or diagnose any reportable diseases for which data is collected by their jurisdiction’s reportable disease system during the EHR reporting period;
  - They practice in a jurisdiction for which no PHA is capable of receiving electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - They practice in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of six months prior to the start of the EHR reporting period.

#### Attestation Requirements Measure 4:

- YES/NO: The EP must attest “YES” to being in active engagement with a PHA to submit data to public health registries.
- EXCLUSIONS: An EP may take an exclusion if any of the following apply:
  - They do not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period;
  - They practice in a jurisdiction for which no PHA is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - They practice in a jurisdiction where no PHA for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.



Attestation Requirements Measure 5:



- YES/NO: The EP must attest “YES” to being in active engagement to submit data to a CDR.
- EXCLUSIONS: An EP may take an exclusion if any of the following apply:
  - They do not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the EHR reporting period;
  - They practice in a jurisdiction for which no CDR is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or
  - They practice in a jurisdiction where no CDR for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.




***Please note:*** Selecting Save & Continue will take you to the next measure

## Clinical Quality Measures























Select Begin on Clinical Quality Measures to access the CQM main menu

### Attestation Selection

Legend:  Complete  Incomplete

Measure Name	Status	Status	Action
Register and Attest	0 of 8 complete		<a href="#">Begin</a>
Meaningful Use Objectives	6 of 8 complete		<a href="#">Continue</a>
Clinical Quality Measures	0 of 50 complete		<a href="#">Begin</a>

## CQM Main Menu

Clinical Quality Measures				0 of 9 Complete
Legend:  Complete  Incomplete				
Requirements:				
EPs must report on 9 of the 64 approved CQMs				
<a href="#">Recommended core CQMs</a> - Encouraged but not required				
Selected CQMs must cover at least 3 of the National Quality Strategy domains				
CMS Measure ID	Objective	Status	Action	
<b>Domain - Care Coordination</b>				
50	Closing the referral loop: receipt of specialist report		<a href="#">Answer</a>	
<b>Domain - Clinical Process/Effectiveness</b>				
137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		<a href="#">Answer</a>	
165	Controlling High Blood Pressure		<a href="#">Answer</a>	
125	Breast Cancer Screening		<a href="#">Answer</a>	
124	Cervical Cancer Screening		<a href="#">Answer</a>	
130	Colorectal Cancer Screening		<a href="#">Answer</a>	
126	Use of Appropriate Medications for Asthma		<a href="#">Answer</a>	
127	Pneumonia Vaccination Status for Older Adults		<a href="#">Answer</a>	
131	Diabetes: Eye Exam		<a href="#">Answer</a>	
123	Diabetes: Foot Exam		<a href="#">Answer</a>	
122	Diabetes: HbA1c Poor Control		<a href="#">Answer</a>	
148	Hemoglobin A1c Test for Pediatric Patients		<a href="#">Answer</a>	
134	Diabetes: Urine Protein Screening		<a href="#">Answer</a>	
163	Diabetes: Low Density Lipoprotein (LDL) Management		<a href="#">Answer</a>	
164	Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic		<a href="#">Answer</a>	
145	Coronary Artery Disease (CAD): Beta-Blocker Therapy Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)		<a href="#">Answer</a>	
182	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control		<a href="#">Answer</a>	
135	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)		<a href="#">Answer</a>	
144	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)		<a href="#">Answer</a>	
143	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation		<a href="#">Answer</a>	




## CQM Requirements

The following are the requirements for the CQMs:

- EPs must report on 6 of the approved available eCQMs
- NQS domain requirement has been removed and EPs must attest to 6 eCQMs that are relevant to the EP's scope of practice
- EPs who are returning participants must attest to a full year eCQM reporting period whether submitting through attestation or electronically
- EPs who are first-time meaningful users may attest using a 90-day eCQM reporting period
- EPs are required to report to at least one outcome measure. If no outcome measures are relevant to that EP, they must report on at least one high-priority measure. If there are no outcome or high-priority measures relevant to an EP's scope of practice, they must report on any six relevant measures.

To attest to the 6 required CQM's, locate the CQM from the main menu list and select Answer

CMS Measure ID	Objective	Status	Action
<b>Domain - Care Coordination</b>			
50	Closing the referral loop: receipt of specialist report		<a href="#">Answer</a>
<b>Domain - Clinical Process/Effectiveness</b>			

**Clinical Measures - Question 1 of 64**

**\*Required**

**Measure Details**

CMS Measure ID: 50

Domain: Care Coordination

Title: Closing the referral loop: receipt of specialist report

**Complete the following information**

Description: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

\*Numerator:

\*Denominator:



Save & Return

All fields must be entered to Save & Return to the CQM selection screen. The responses entered must be reported from your certified EHR reporting for the EHR reporting period even if the report states zero. The following details are other requirements for all CQMs:

- Enter a Numerator, 0 is acceptable if that was reported by the EHR technology
- Enter a Denominator, 0 is acceptable if there is no measure population
- All numbers must be a whole number
- The Numerator must be less than or equal to the Denominator
- If the measure has an exclusion, a number must be entered and must be greater than or equal to 0.

## Clinical Quality Measures

9 of 9 Complete












Legend:  Complete  Incomplete

### Requirements:

EPs must report on 9 of the 64 approved CQMs



[Recommended core CQMs](#) - Encouraged but not required





Selected CQMs must cover at least 3 of the National Quality Strategy domains

CMS Measure ID	Objective	Status	Action
<b>Domain - Care Coordination</b>			
50	Closing the referral loop: receipt of specialist report		<a href="#">Edit</a>
<b>Domain - Clinical Process/Effectiveness</b>			
137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		<a href="#">Edit</a>
165	Controlling High Blood Pressure		<a href="#">Edit</a>
125	Breast Cancer Screening		<a href="#">Edit</a>
124	Cervical Cancer Screening		<a href="#">Edit</a>
130	Colorectal Cancer Screening		<a href="#">Answer</a>
126	Use of Appropriate Medications for Asthma		<a href="#">Answer</a>
127	Pneumonia Vaccination Status for Older Adults		<a href="#">Answer</a>
131	Diabetes: Eye Exam		<a href="#">Answer</a>
123	Diabetes: Foot Exam		<a href="#">Edit</a>
122	Diabetes: HbA1c Poor Control		<a href="#">Answer</a>




- Once the 6 CQM's have been met it will be indicated on the top of the screen.
- A green check indicates the measure was answered
- A red X indicates a measure has not been answered
- If all 6 measures have been completed and they covered at least 3 domains, the main menu will indicate the CQMs have been met by a green check.

## Attestation Selection

Legend:  Complete  Incomplete









Measure Name	Status	Status	Action
Register and Attest	0 of 9 complete		<a href="#">Begin</a>
Core Measures	13 of 13 complete		<a href="#">Continue</a>
Menu Measures	5 of 9 complete		<a href="#">Continue</a>
Clinical Quality Measures	9 of 64 complete		<a href="#">Continue</a>
<a href="#">Remove Core, Menu, and Clinical Measures</a>			

## Required Documents to Upload

-  indicates the document is required
-  indicates the document is optional and can be uploaded
-  indicates the document has been uploaded successfully

If any additional documents need to be updated to provide any explanations or assist with verification, select the Add Additional Documents link. The more verifying documents uploaded will help speed up the verification and payment process.

**Please note:** Uploading a letter of a signed legal contract or letter from vendor including the accurate CEHRT ID is now required.

Upload Documents		
Legend:  Complete  Required  Optional		
Document Name	Status	Action
Legal Authorization to attest on behalf of the facility/provider		<a href="#">Upload</a>
Volume Calculation		<a href="#">Upload</a>
Signed Legal Contract or EHR Certification Number		<a href="#">Upload</a>
EHR MU Dashboard Report		<a href="#">Upload</a>
W-9		<a href="#">Upload</a>
<a href="#">Add Additional Documents</a>		

[Return to Menu](#)[Submit](#)

- 1.1. Legal Authorization to attest → Must be a current dated letter from the CEO/CIO of the facility granting permission to the person attesting on behalf of the facility
- 1.2. Volume Calculation → **MUST** Use the calculation Template located at:  
<http://www.healthit.nd.gov/medicaid/>
- 1.3. Signed Legal Contract → Legal binding contract of the EHR system used at the facility
- 1.4. W-9 → Current W-9 to whom the payment is being made (usually the facility)
- 1.5. MU Dashboard → If attesting to MU, the Core, Menu, and CQM dashboard from the EHR must be provided to verify the MU data

## Attestation Submission

1. If complete, select "Submit" to complete the Attestation.
2. The user must agree to the terms/disclaimer

**Please note:** All documentation for each attestation must be kept for a minimum of six (6) years and the attestation can be subject to audit for up to six (6) years. If the documentation cannot be provided, the payment could be recouped.

Attestation Disclaimer
<b>General Notice</b>
NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, or misleading information may be guilty of a criminal act punishable under law and may also be subject to civil penalties.
<b>Signature of Hospital Representative</b>
I certify that the foregoing information is true, accurate, and complete. I understand that the Medicaid EHR Incentive Program payment I requested will be paid 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 applicable Federal or State criminal laws and may also be subject to civil penalties.
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 to the U.S. Department of Health and Human Services, the ND Department of Human Services Medical Services Medicaid Program, or contractor acting on their behalf.
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 499.10).
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 and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, 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 discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information on the requested information or document will result in the issuance of an overpayment demand letter followed by recoupment procedures.
It is mandatory that you tell us if you believe you have been overpaid under the Medicaid EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 6402, Section 11283, provides penalties for withholding this information.
<input checked="" type="radio"/> Agree*
I understand that submitting this form and attesting to the information requested constitutes my understanding of the legal and regulatory requirements necessary to apply for this program and that hitting the "submit" button holds the same force under North Dakota law as a written legal signature.
<input type="button" value="Cancel"/> <input type="button" value="Submit"/>