California Department of Health Care Services

Report to the Legislature: Medi-Cal Electronic Health Record Incentive Program Fiscal Years 2016-2017 and 2017-2018

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Office of Health Information Technology

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California Department of Health Care Services

Report to the Legislature
Medi-Cal Electronic Health Record Incentive Program
(October 2011 through June 2018)

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California Department of Health Care Services

Report to the Legislature:
Medi-Cal Electronic Health Record Incentive Program

Executive Summary

This report is prepared in compliance with Senate Bill 945 (Committee on Budget, Chapter 433, Statutes of 2011), Welfare and Institutions (W&I) Code, Section 14046.5. It includes reporting for fiscal years 2016-2017 and 2017-2018.

In 2009, as a result of the American Recovery and Reinvestment Act (ARRA) of 2009, Title XIII of Division A and Title IV of Division B of ARRA of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the Office of Health Information Technology (OHIT) was created within the California Department of Health Care Services (DHCS), to administer the Medi-Cal Electronic Health Record (EHR) Incentive Program (Program). In accordance with the HITECH Act, the Program will operate from 2011 through 2021. Although the law required an annual report, the necessary data was unavailable for timely reporting. Now that DHCS has established the mechanism for data collection and reporting, DHCS will begin publishing this report annually.

OHIT implemented the Program in October 2011, and as of June 2018, had provided $726 million in federal funds to 25,782 professionals and $845 million in federal funds to 330 hospitals for adoption, implementation and upgrade (AIU) and meaningful use (MU) of Electronic Health Record (EHR) technology. These incentive payments to California Medi-Cal professionals and hospitals exceed those of any other state. Studies carried out by the University of California, San Francisco have demonstrated that the Program is attaining its objective of promoting the MU of EHRs by Medi-Cal professionals and

hospitals, which has contributed to the increased use of EHRs by health professionals in California.[1]

In October 2015, DHCS implemented the California Technical Assistance Program (CTAP) to assist eligible Medi-Cal professionals, including specialists and individual practitioners, in participating in the Program and achieving AIU and MU. As of June 2018, over 7,200 eligible professionals had received services from CTAP. In addition, in 2016 OHIT conducted outreach to the 19 remaining Medi-Cal hospitals that had not participated in the Program. As of June 2017, ten of these hospitals had participated for the first time. OHIT continued conducting outreach to the other nine hospitals, and by June 2018, five of these hospitals had begun participation.

Professionals have found providing documentation of eligibility for the Program to be challenging, but DHCS addressed this by receiving permission from the Centers for Medicare and Medicaid Services (CMS) to "prequalify" many professionals and clinics by using existing data available from Medi-Cal claims payments and encounters, and from the Office of Statewide Health Planning and Development.

DHCS has been challenged by frequent changes to the Program issued by CMS via Final Rule modifications, as detailed in the Program Change Descriptions section. These changes have required extensive reprogramming of DHCS' State Level Registry, a web portal developed to accept applications from professionals and hospitals. Although these changes have delayed applications by professionals and hospitals in some cases, the changes have not prevented any from applying for, or receiving the incentive payments to which they are entitled.

If you would like a printed copy of this legislative report or have questions about the report, please contact the Medi-Cal EHR Incentive Program, by phone at (916) 552-9181 or by email at Medi-Cal.EHR@dhcs.ca.gov.

[1] Coffman, J. M., Fix, M., Hulett, D., Kang, T., & Bindman, A. B. (2014), *Availability of Electronic Health Records in California Physician Practices* (2013). Unpublished draft.

Report to the Legislature:
Medi-Cal Electronic Health Record Incentive Program

Introduction

This report is submitted in accordance with the provisions of Senate Bill 945 (Committee on Budget, Chapter 433, Statutes of 2011) which added Welfare & Institutions (W&I) Code Section 14046.5, to require the Department of Health Care Services' (DHCS) to provide the appropriate fiscal and policy committees of the Legislature and the Legislative Analyst's Office with annual reports on the implementation of this article. The law further requires that the report is to be prepared with a project status summary that identifies the progress or key milestones and objectives of the Program; an assessment of provider uptake of the Program, barriers faced by eligible providers not participating in the Program and strategies to address those barriers; copies of reports or updates developed by DHCS for submission to the federal government relating to the Program; copies of oversight reports developed by DHCS contractors and any subsequent responses from DHCS; and a description of changes made to the Program, including those required by federal law or regulations.

Program History

DHCS' Office of Health Information Technology (OHIT) was created in 2010 to implement and administer the Program, which was established under the American Recovery and Reinvestment Act (ARRA) of 2009. Title XIII of Division A and Title IV of Division B of ARRA, together cited as the HITECH Act, included provisions to promote meaningful use (MU) of Health Information Technology to improve the quality and value of American health care. DHCS issues incentive payments to Medi-Cal professionals and hospitals that adopt implement, and/or upgrade and meaningfully use certified EHR technology. The Office of the National Coordinator within the U.S. Department of Health and Human Services provides certification of EHRs. Program eligibility is determined by meeting specific objectives and measures as defined by Centers for Medicare and Medicaid Services (CMS). A separate, but comparable EHR Incentive Program is administered by CMS for Medicare professionals and hospitals. While eligible hospitals

may participate in both the Medicaid and Medicare EHR Incentive Programs, eligible professionals are limited to participation in only one of the two programs.

The Medicaid incentive payments are 100 percent federally funded, and the Program's administrative costs are funded at 90 percent federal funds. At the end of the 2017-2018 fiscal year DHCS' OHIT had distributed over $1.57 billion in federal incentive funds to Medi-Cal professionals and hospitals. The distribution of these federal funds into the state required approximately $1 million in state fund administrative expenditures. Over the course of the Program, DHCS estimates it will provide up to $2 billion in incentive payments to eligible professionals and eligible hospitals, and California will benefit from an additional $2.3 billion in economic output and 16,000 new jobs as a result of the influx of federal funds. [2]

Eligible professionals (physicians, dentists, optometrists, certified nurse-midwives, nurse practitioners, and physician assistants) can qualify for incentive payments if at least 30 percent of their encounters during a 90-day period in the previous calendar year are with Medi-Cal enrolled patients. For pediatricians, this threshold is 20 percent. To increase qualification and participation among Medi-Cal professionals, California instituted a group encounter methodology that enables professionals in a group or a clinic to aggregate the encounters of all professionals in their group. This enables those professionals who may not otherwise achieve the 30 percent Medi-Cal encounter threshold on their own, to achieve eligibility by employing the aggregate encounters of their group or clinic. Medi-Cal professionals who qualify and meet the requirements for adoption, implementation, upgrade (AIU) and MU can receive a total of $63,750 in incentives that are distributed in payments over six years. Pediatricians qualifying with only a 20 percent Medi-Cal patient volume receive reduced payments totaling $42,502 over six years. Professionals must requalify and reapply to receive a payment and participation need not be in consecutive years for professionals. Professionals must have started participation in the program by 2016 in order to receive payments thereafter.

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[2] Blue Sky Consulting Group, "The Fiscal and Economic Impacts of the Medi-Cal EHR Incentive Program," http://www.chcf.org/publications/2012/05/impacts-medical-ehr-incentives (last accessed 2/6/2015)

Hospitals are able to qualify for incentive payments if at least 10 percent of their discharges during a 90-day period in the previous federal fiscal year are for Medi-Cal discharges, and their average length of stay is less than or equal to 25 days. Children's hospitals do not need to meet the 10 percent discharge requirement. Hospitals that qualify for the Program receive incentive payments that are adjusted up or down from a base of $2 million in total, depending on the hospital discharge data, inpatient bed days, charity care, and total hospital charges. Hospitals are paid this adjusted total over four years (50 percent first year, 30 percent second year, and 10 percent third and fourth year) and must qualify each year to receive a payment. Beginning in 2015, hospitals must have qualified in consecutive years to continue in the Program and could not start the program after 2016.

To meet the AIU requirement a provider must provide proof of a signed, financially binding contract to acquire a certified EHR system. The MU requirement for EHRs is defined by CMS in three stages of objectives and measures, with each stage of MU more challenging to attain than the previous stage. Each stage requires achieving a number of administrative and clinical objectives and increased health information exchange (HIE) across care settings. Professionals and hospitals spend two years in Stage 1 MU, before progressing to Stage 2 MU. Stage 2 MU became available in 2014 and Stage 3 MU became available in 2017. Although the Program continues through the end of 2021, professionals and hospitals must have started participation by the end of program year 2016.

Program Objectives

The following are the primary goals of the Program:

By the end of 2021---

- All Medi-Cal professionals eligible for the Program will have attested to AIU of certified EHRs and will have a 75 percent attestation rate for MU.

- All California hospitals eligible for the Program will have attested to AIU of certified EHRs and will have a 100 percent attestation rate for MU.

- All dentists eligible for the Program that have attested to AIU of certified EHRs in their practices will have a 50 percent MU attestation rate.

Additional program goals include:

- Continue efforts to improve the HIE infrastructure at the state, county, and community levels.

- Leverage the existing HIE infrastructure to connect community HIEs and large hospital systems.

- Develop seamless and integrated data systems that communicate effectively and provide data that is timely, accurate, usable, and easily accessible. This will support the flow of health information throughout the state and will support analysis and decision making for health care management and program administration.

- Develop intrastate HIE capabilities as a key component of achieving increased Medicaid Information Technology Architecture maturity.

- Develop a broad-scale connectivity program encouraging hospital and ambulatory connectivity statewide.

Program Timeline

DHCS, with input from stakeholders, developed the State Level Registry (SLR), a web-based portal through which professionals and hospitals can apply to the Program by creating a secure account and supplying the information required for the state to determine eligibility. The SLR began operating October 2011 and has been modified several times to accommodate changes in federal regulations.

The following is a list of important milestone dates in the history of the Program:

- October 2011 – The SLR was launched and the state began accepting hospital AIU applications.
- November 2011 – The SLR began accepting group and clinic AIU applications.
- December 2011 – The SLR began accepting individual professional AIU applications.
- December 2011 – DHCS began issuing the first incentive payments.
- September 2012 – The SLR began accepting Stage 1 MU applications.
- October/November 2013 – The SLR was updated to reflect CMS changes to Stage 1 2013 (see http://www.gpo.gov/fdsys/pkg/FR-2010-12-29/pdf/2010-32861.pdf); See Program Change Descriptions below.
- June/September 2014 – The SLR was updated to reflect CMS changes to Stage 1 2014 (see http://www.gpo.gov/fdsys/pkg/FR-2010-12-29/pdf/2010-32861.pdf); See Program Change Descriptions below.
- June 2014 – The SLR began accepting Stage 2 MU applications from hospitals.
- September 2014 – The SLR began accepting Stage 2 MU applications from professionals.
- April 2015 – The SLR was modified to allow providers to apply using the parameters of the Flexibility Rule (delineated in the September 4, 2014 Final Rule)[3].
- September 2016 – Date the SLR began receiving Modified Stage 2 MU applications.

[3] 2014 Edition Certified Electronic Health Record Technology Flexibility Rule, https://www.gpo.gov/fdsys/pkg/FR-2014-09-04/pdf/2014-21021.pdf

- April 2017 – Date the SLR began receiving Stage 2 applications for 2017.
- June 2017 – CMS granted DHCS' request to extend the attestation period for Program Year 2016 for providers attesting to 2016 as their first program year.
- June 2018 - The SLR opened for 2018 attestations on June 21, 2018. Providers were able to attest to either Stage 2 or Stage 3. Attestation to Stage 3 is optional.

Program Change Descriptions

Stage 1 Changes

The Stage 1 Final Rule[4] was published on July 10, 2010 and included the requirements for AIU and Stage 1 MU. On September 4, 2012, CMS issued the Stage 2 Final Rule[5] which instituted changes to the Stage 1 Final Rule to be done in two parts: the Stage 1 2013 changes were to be implemented beginning in Program Year 2013; the Stage 1 2014 changes were to be implemented beginning in Program Year 2014.

- **2013 Changes**
  CMS published changes to Stage 1 MU for 2013 that modified the professional and hospital requirements for eligibility and achieving MU. The SLR was updated to reflect the new requirements in October 2013 (eligible hospitals SLR module) and November 2013 (eligible professionals SLR module).

[4] Stage 1 Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf
[5] Stage 2 Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

- **2014 Changes**
  CMS published changes to Stage 1 MU for 2014 that modified the professional and hospital requirements for achieving MU. The SLR was updated to reflect the new requirements in June 2014 (eligible hospitals SLR module) and September 2014 (eligible professionals SLR module).

Stage 2 Criteria

The Stage 2 Final Rule, published on September 4, 2012, specifies the criteria that eligible professionals, eligible hospitals, and critical access hospitals must meet in order to participate in MU Stage 2 of the Program. The SLR was updated to accept Stage 2 applications in June 2014 (eligible hospitals SLR module) and September 2014 (eligible professionals SLR module).

- **Flexibility Rule**
  In September 2014, the Final Rule was modified due to delays in availability caused by EHR vendors, allowing professionals and hospitals that were unable to fully implement a 2014 certified EHR to apply to the Program by attesting to modified MU criteria. The modified MU criteria was different from the criteria they would have otherwise been required to attest. This modification is known as the Flexibility Rule. Those attesting to MU in 2014 were required to attest to either Stage 1 MU (with the 2014 changes as defined in the Stage 2 Final Rule), or to Stage 2 MU using 2014 certified EHR software. Under the Flexibility Rule, 2014 professionals were given the ability to attest to a previous version of MU, including Stage 1 MU (with 2013 changes as defined in the Stage 2 Final Rule) and could use either 2011 certified EHR software or 2011/2014 certified EHR software.

- **Stage 2 Timeline Change**
  The normal progression in the Program is for professionals and hospitals to attest to two years of MU before progressing to the next stage of MU. Under this model, a professional would attest to two years of Stage 1, two years of Stage 2, and then move on to Stage 3. Stage 2 became available in 2014 and Stage 3 was to begin in 2016. However, in September 2014, this requirement was modified by CMS to extend Stage 2 through 2016 and delay the start of Stage 3

to 2017. Under this new timeline, professionals would potentially complete three years of Stage 2 before progressing to Stage 3.

Modified Stage 2 and Stage 3 Criteria

On October 16, 2015, CMS issued a Final Rule[6] that modified and merged Stage 1 and Stage 2 MU criteria, and specified the criteria for Stage 3 MU.

- **Modified Stage 2**
  CMS modified the MU stage timeline such that in 2015 through 2017, Stage 1 and Stage 2 objectives are no longer separate. Professionals reporting MU in Program Years 2015 through 2017 will report on the same set of objectives, known as Modified Stage 2. However, for some objectives, CMS allowed those scheduled to be in Stage 1 in 2015 to report on alternate measures (which are similar to requirements under Stage 1), or to take alternate exclusions to some measures. In 2017, professionals have the option to report under the new Modified Stage 2 requirements, or under the Stage 3 requirements. DHCS was directed by CMS to cease accepting Program Year 2015 applications until the SLR was updated to align with the new rule. The SLR resumed accepting Modified Stage 2 applications by the beginning of September 2016.

- **Stage 3**
  While professionals had the option to report Stage 3 criteria in 2017 and 2018, in 2019, all professionals will be required to report Stage 3 criteria.

Additional rules adopted by CMS also required the SLR to be updated.

- **2017 Inpatient Prospective Payment System (IPPS) Final Rule Changes**
  The number of hospital Clinical Quality Measures (CQMs) were reduced from 29 to 16. This update was implemented into the SLR with Program Year 2017, Stage 2 on May 23, 2017.

[6] Modified Stage 2 and Stage 3 Final Rule: https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25595.pdf

- **Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015/Merit-Based Incentive Payment System/Quality Payment Program Final Rule Changes**[7]
  The definition of meaningful user was updated and providers were required to attest to supporting HIE. This update was implemented into the SLR with Program Year 2017, Stage 2 on May 23, 2017.

- **Outpatient Prospective Payment System Final Rule Changes**[8]
  The MU reporting period for 2016 and 2017 was reduced to 90 days for all applicants and allowed all providers to attest to Stage 3 in 2017.

- **2018 IPPS Final Rule Changes**[9]
  The number of eligible professional CQMs required was increased from six to nine and CQM domains were removed. The number of eligible professional CQMs were reduced from 64 to 53 and the CQM reporting period was reduced to 90-days (Program Year 2017 only).

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[7] Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician- Focused Payment Models; https://www.gpo.gov/fdsys/pkg/FR-2016-11-04/pdf/2016-25240.pdf.

[8] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; EHR Incentive Programs; Payment to Non-excepted Off-Campus Provider- Based Department of a Hospital; Hospital Value-Based Purchasing Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Non-excepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital; https://www.gpo.gov/fdsys/pkg/FR-2016-11-14/pdf/2016-26515.pdf.

[9] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long- Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid EHR Incentive Program Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Provider-Based Status of Indian Health Service and Tribal Facilities and Organizations; Costs Reporting and Provider Requirements; Agreement Termination Notices; https://www.gpo.gov/fdsys/pkg/FR-2017-08-14/pdf/2017-16434.pdf.

Program Accomplishments

The Program has gained wide acceptance and interest among California's Medi-Cal professionals and hospitals.

Eligible Professionals

Notable accomplishments for eligible providers as of June 2018 are:

- The Program disbursed over $529 million in AIU incentive payments and over $197 million in MU incentive payments to eligible professionals. According to CMS data, the total number of incentive payments made by California to eligible professionals, exceeds every other state.

- A total of 25,782 professionals have received AIU payments. Over 11,300 unique professionals have received incentive payments for MU; over 14,000 payments have been made to professionals for their Stage 1 initial year and subsequent year Stage 1 attestations. Additionally, over 9,800 initial and subsequent year Stage 2 MU payments and 15 Stage 3 MU payments have been made to professionals. Stage 3 MU is not required until 2019. Approximately 44 percent of unique professionals have progressed from attesting to AIU to attesting to MU.

TABLE 1: NUMBER OF PROFESSIONALS WHO HAD APPLIED FOR THE PROGRAM ANNUALLY AS OF JUNE 2018

Program Year	AIU	MU Stage 1	MU Stage 2	MU Stage 3	Total Attestations	Completed Program
2011	6,371	0	0	0	6,371	0
2012	4,615	2,129	0	0	6,744	0
2013	3,779	4,187	0	0	7,966	0
2014	2,652	3,258	860	0	6,770	0
2015	3,296	2,476	1,634	0	7,406	0
2016	5,069	2,543	2,301	0	9,913	372
2017	0	0	5,065	15	5,080	517
2018	0	0	2	0	2	1
Total	**25,782**	**14,593**	**9,862**	**15**	**50,252**	**890**

California has far surpassed the 10,000 eligible professionals initially projected to participate in the Program according to the landscape assessment performed by the Lewin & McKinsey Group in 2009. This is due in part to the "pre-qualification" strategies developed and deployed by DHCS after receiving authorization from CMS. Public clinics with a 30 percent or greater Medi-Cal patient volume, as determined from the Office of Statewide Health Planning and Development (OSHPD) data, received notifications that all professionals treating at least one Medi-Cal patient during the previous calendar year would be considered "pre-qualified" by the Program and would not be required to submit additional documentation of eligibility. Approximately 800 public clinics have been pre-qualified each year in this way. Additionally, professionals with at least 1,160 Medi-Cal patient encounters in the previous calendar year, as reported in the Medi-Cal data warehouse, received a notice that they had been pre-qualified for the Program. An increasing number of professionals (approximately 18,000 in 2018) are pre-qualified each year in this way, likely a result of the increasing number of Medi-Cal patients seen by professionals due to Medi-Cal expansion under the Affordable Care Act.

A study of a cohort of physicians (representing 1/12 of the population of physicians applying for re-licensure) was carried out in 2011 and 2013 by researchers at University

of California, San Francisco (UCSF) with cooperation from the Medical Board of California. This study determined that "Medi-Cal incentive payments are achieving their goal of increasing MU of EHRs. Ninety-two percent of physicians (in 2013) who are registered for the Medi-Cal incentive payments have an EHR. Fifty-six percent have an EHR that can perform all 12 MU functions on which data were collected." According to this study, between 2011 and 2013 the greatest improvement in EHR usage rates in California (50 percent to 81 percent) was found to have occurred in physicians practicing in community and public clinics. This increase is likely due to the pre-qualification of these clinics using OSHPD data and the close working relationship that DHCS established with the California Primary Care Association. Medi-Cal physicians practicing in all other settings also experienced significant improvements in EHR utilization rates, but not as great as those practicing in community or public clinics.

Eligible Hospitals

The following bullets highlight notable accomplishments for eligible hospitals as of June 2018:

- The Program disbursed over $404 million in AIU incentive payments and $441 million in MU incentive payments to eligible hospitals. This is the largest amount of incentive payments for hospitals in any state.

- A total of 331 unique hospitals in California applied to the Program. Of those that applied, 271 attested to AIU, 24 hospitals attested to Stage 1 MU, and 36 hospitals attested to Stage 2 MU in their first year.

- A total of 319 unique hospitals in California applied for incentive payments for MU. Of these, 236 unique hospitals have progressed to achievement of Stage 2 MU. Program year 2016 was the last year hospitals (and professionals) could begin participation in the program.

TABLE 2: NUMBER OF HOSPITALS THAT HAD APPLIED FOR THE PROGRAM ANNUALLY AS OF JUNE 2018

Program Year	AIU	MU Stage 1	MU Stage 2	Total Attestations	Completed Program
2011	139	0	0	139	0
2012	90	76	0	166	0
2013	19	196	0	215	0
2014	8	136	76	220	63
2015	10	28	144	182	90
2016	5	35	93	133	33
2017	0	0	46	46	9
2018	0	0	0	0***	0
Total	**271**	**471***	**359****	**1,101**	**248**

*24 hospitals attested to Stage 1 MU in their first year
** 36 hospitals attested to Stage 2 MU in their first year
***No hospitals are eligible to attest until January, 2019

California Technical Assistance Program (CTAP)

To help professionals apply for the Program and implement EHRs, DHCS received 90 percent federal funding to implement the CTAP in 2015. CTAP continues and expands the services provided by the Regional Extension Centers, which exhausted their federal funding by mid-2016. CTAP contractors focus on assisting professionals, including specialists and providers in small group primary care practices, in achieving AIU and various stages of MU. In 2018, DHCS received a two year no-cost extension (through June 2020) for the CTAP.

TABLE 3: MILESTONES ACHIEVED BY CTAP CONTRACTORS AS OF JUNE 2018

Milestone Description	Number
Eligible Professionals Enrolled	7,204
Solo Practitioners Served	236
Specialists Served	1,914
Eligible Professionals On-boarded to HIE	157
AIU Attestations	3,344
MU Stage 1 Attestations	342
MU Stage 2 Attestations	3,385
Subsequent Year MU Attestations	2,141

Program Challenges

In accordance with the Final Rule, professionals were unable to begin participation in the Program after March 31, 2017. It has been difficult to accurately determine the number of eligible Medi-Cal professionals who failed to apply to the Program. In 2013, UCSF researchers estimated this number to be between 3,000-8,000 professionals. However, with the pre-qualification methodology used by California and eligibility by group membership, the actual number may surpass the upper range of this estimate. The UCSF study has identified that medical specialists in general have a lower rate of EHR use than primary care physicians (76 percent versus 81 percent) and that individual practitioners in the Medi-Cal program are particularly unlikely (13 percent) to have applied for the Program incentive payments.

DHCS has disseminated information about the Program to professionals through the Medical Board of California, the California Medical Association, and specialty organizations, such as the California Dental Association. Despite these efforts, the UCSF survey revealed that a significant number of professionals remain confused about their eligibility for the Program. Much of this confusion may be attributed to the complexity of the rules for the Medi-Cal and Medicare incentive programs and how the two programs interact. Many professionals may prefer to participate in the Medicare EHR Incentive Program even though it provides less funding because of the difficulty

documenting attainment of the 30 percent or higher Medi-Cal encounter volume required for the Program.

DHCS has found that program participation can vary among specialty groups. Compared to other specialty groups, program participation by dentists is lower. In order to better understand the reason behind lower participation levels, DHCS developed a dental specific survey and dental specific MU tip sheet. Conducted in 2018, the dental specific survey helped DHCS better understand the barriers preventing program participation by dentists. Some survey respondents cited the cost of dental software as well as the lack of integration between electronic dental records (EDR) and EHRs as a barrier. Others found that despite difficulty in meeting some requirements for MU, the use of an EDR was very beneficial as it has led to integration of care. Those that participated in the survey also had the opportunity to request the dental MU tip sheet[10], which is available on the SLR web site.

DHCS has been challenged by the frequent program changes issued by CMS that are described above. These changes have required time consuming, extensive reprogramming of the SLR that has delayed applications by professionals in most years. To date, these delays have not prevented professionals and hospitals from ultimately applying for and receiving incentive payments for which they are eligible. The most extensive revisions resulted from the issuance of the Flexibility Rule that allowed many professionals to apply in 2014 using 2013 rules (see page 9). This became necessary because of the delay by the federal government in certifying EHRs for compliance with 2014 standards. DHCS, like other state Medicaid programs, was not able to implement these changes in the SLR until the middle of 2015

Each progressive MU stage requires increasing use of HIE between professionals and hospitals. Unfortunately, the HIE architecture in California is not yet sufficiently developed to support all aspects of Stage 2 MU or Stage 3 MU regulations. In 2018 CMS delayed the required implementation of Stage 3 until 2019. These delays have contributed to the lower than anticipated number of Stage 2 and Stage 3 MU

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[10] Medi-Cal EHR Incentive Program, Tips for Dental Providers: http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/MU_Tip_Sheet_Dental_FINAL.PDF

attestations by professionals. CMS rules limit the use of administrative funds for promoting HIE. However, on February 29, 2016, CMS issued a State Medicaid Director's letter that expands the potential use of these funds for HIE. DHCS is in the process of soliciting ideas for HIE projects from stakeholders that might be supported by this additional funding. Any such HIE projects will require 10 percent non-federal funding and share of cost for non-Medi-Cal beneficiaries served.

In September of 2016, the U.S. Department of Health and Human Services Office of the Inspector General (OIG), released a report of its audit findings related to a reconciliation and review of hospital incentive payments made under the incentive program. The OIG selected 64 eligible hospitals receiving a first year incentive payment over $2 million, representing 53 percent of total incentive payments from October 1, 2011 through December 31, 2014. The OIG determined that DHCS made incorrect payments to 61 of these eligible hospitals, including over and underpayments of $22,043,234.

In written comments to the draft OIG report, DHCS agreed that incorrect incentive payments may have been made, but did not concur with the OIGs reliance on hospital generated schedules and internal financial records. Historical experience suggests actual payments and adjudicated claims data from claims payment reports yield more accurate findings, which can be supported in an appeal. DHCS committed to conducting audits of 100 percent of the hospitals participating in the incentive program, prioritizing and completing audits of the 64 eligible hospitals audited by the OIG. The remaining hospital audits will be completed by June 20, 2019. Where overpayments are identified, DHCS, to the extent possible, will offset the overpayment with future incentive payments.

Appendices: Reports to the Federal Government

Appendix 1 – Regional Office Data Tool, October 2016

1. State System

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of Implementation in Your state, you can document these in the Notes section

Benchmark	Planned Date	Actual Date	Notes
Registration Implementation This is the date the system was available for providers to register eligibility information.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
AIU Attestation Implementation This is the date the system was available for providers to attest for AIU.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
Payments Implementation This is the date the system was available for payments to providers.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Eligible Professionals 5/14/2012

Benchmark	Planned Date	Actual Date	Notes
Audits Implementation This is the date the post-payment audits began.	10/1/2014	9/1/2014	The Audit Strategy was approved in May 2014 for AIU audits. Eligible Professional post-payment audits and Eligible Hospital post-payment audits began September 2014
MU Attestation This is the date the system was available for providers to attest for MU.	9/27/2012	9/27/2012	
IAPD Expiration Date This is the date of expiration listed on the current CMS-approved IAPD. Planned Date and Actual Date will be the same for this category.	9/3/2016	9/30/2016	An IAPD update was submitted to CMS on June 30, 2016 for review and approved on August 17, 2016

2. Provider Outreach (01/01/2016 - 12/31/2016)

Instructions: Please list the outreach activity types (events, correspondence, etc.) which have occurred in your state. If a new activity begins, please add and list the number of occurrences. Time period is for calendar year 2016.

PO Outreach Activity (E-Mail/Phone/Meeting/Webinars/ Social Media/Training/ETC)	**Approximate # of Occurrences**	**Notes**	
Meetings	0	OHIT Advisory Board Meetings	The Advisory Board is being reconstituted to reflect progress in EHR implementation and expanded focus on other efforts including Technical Assistance for specialists and beneficiary outreach and opportunities associated with HIE funding per SMD 16-003. Planning for one meeting in the second quarter of 2016.
Phone Calls	8	EHR Incentive Program Update Calls	Held by OHIT and attended by various stakeholders, including health care foundations, group administrators, and other health care entities (such as previous regional and local extension centers). The call provides regular program updates as well as announcements and discussion of important items, such as changes to federal requirements, SLR updates, and policy issues.
Phone Calls	8	California Technical	Calls providing updates on program requirements,

PO Outreach Activity (E-Mail/Phone/Meeting/Webinars/ Social Media/Training/ETC)	**Approximate # of Occurrences**	**Notes**	
		Assistance Program (CTAP) Calls	discussing the requirements of various milestones, HIE, and any other topics that are brought up via email or during discussion.
Social Media	37	EHR Twitter Site	Continuous. Implemented in 2011. Used daily as a communication tool with the Medi-Cal provider population.
Newsletter	1	DHCS Stakeholder Newsletter	Continuous. Newsletter to all DHCS stakeholders, advising of meetings, program updates, CMS information and accomplishments.
Other	1	Provider Newsletters	Continuous. Collaborate on articles with Provider associations.
Other	370	Ongoing Provider Outreach	Continuous. Continued with one-on-one discussion with Providers and Hospitals during the enrollment process.
Other	1	MU Boot Camp	Boot camp hosted by California Primary Care Association. Presentations were given by the Outreach Manager and Policy Director

3. Auditing (01/01/2016 - 12/31/2016)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Benchmark	Planned	Actual	Notes
EP AIU Audits This is the number of post-payment audits for EP AIU.	208	111	100% Pre-payment validation. The Audit Strategy was approved in May 2014. 58 EP post-payment audits have been completed for the July - September 2016 quarter.
EP MU Audits This is the number of post-payment audits for EP MU.	0	0	Post payment audits will commence upon approval of the MU audits plan in the Audit Strategy.
EH Audits This is the number of post-payment EH audits conducted by state.	122	5	100% Pre-payment validations; Post-payment reviews to be integrated into normal hospital audits. The Audit Strategy was approved in May 2014. 5 EH post-payment audits have been completed for the July - September 2016 quarter.

4. State-Specific SMHP tasks (01/01/2016 - 12/31/2016)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned Date	Actual Date	Notes
SMHP Revision	12/30/2016	TBD	A comprehensive revision is still pending in order to gain more understanding of HIE needs in California.

5. Staffing Levels and Changes

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned FTEs	Actual FTEs	Notes
Operational Staff This is the number of FTEs performing as Help Desk, Provider Enrollment, Approvers, etc. (e.g., 1.5 FTEs).	22	18	Four current vacancies
IT Staff This is the number of FTEs performing Programmers, System Analysts, Testers, Project Managers, etc.	13	13	SLR Development & Other Deliverables. Fixed Price Bid. Vendor staff
Auditing Staff This is the number of FTE	2	2	

Roles	Planned FTEs	Actual FTEs	Notes
Auditors. Also list the number of contractors/vendors as a separate notation in the Notes section.			
New Staff this Quarter Identify new personnel hired this quarter, if applicable.	0	0	

6. EP/EH Counts and Amount Paid (Total since start of program)

Instructions: Only include payments which have been issued as of the reporting date. Include paid counts and amounts (not those that are registered and not paid yet). Planned counts and amounts can be obtained from your HITECH IAPD or your CMS 37 reports. Report cumulative totals since the inception of the program. States should continue to report totals as they have been reporting on the RO calls. If necessary, states can add phased implementation dates in the Notes section.

Type	Planned	Actual	Notes
EP AIU Counts Provide the cumulative number of EPs paid for AIU.	10000	20003	
EP AIU Paid Amount Provide the cumulative amount paid to EPs for AIU.	$ 212,500,000.00	$ 423,328,380.68	
EP MU Counts Provide the cumulative number of EPs paid for meeting MU.	0	10619	
EP MU Paid Amount Provide the cumulative amount paid to EPs for MU.	$ -	$ 94,245,167.08	

Type	Planned	Actual	Notes
EH AIU Counts Provide the cumulative amount paid to EHs for AIU.	250	258	
EH AIU Paid Amount Provide the cumulative number of EHs paid for meeting MU.	$ 375,000,000.00	$ 389,594,011.42	Planned EH AIU Paid Amount should be entered as 375,000,000. The system keeps defaulting our entry to 10000.
EH MU Counts Provide the cumulative amount paid to EHs for MU.	0	549	
EH MU Paid Amount Provide the cumulative amount paid to EHs for MU.	$ -	$ 314,454,453.46	

7. Other Information (01/01/2016 - 12/31/2016)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

The first SMHP Update dated 12/28/2012 was approved on 1/30/2013, with addendums submitted to CMS subsequently. An SMHP Addendum for the 2015-2017 Modification Rule was approved by CMS on 03/10/16. A comprehensive update to the SMHP is in process based on the Companion Guide which CMS issued in June, 2015. We anticipate that a comprehensive update will be completed as early as December 2016.

Once you have entered all of your data for the Quarterly Report please click the Submit button. Please note that once the Submit button has been clicked you will not be able to modify any data that has been entered into the tool.

8. Recoupment / Adjustment Amounts (01/01/2016 - 12/31/2016)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

Q2 FFY 16	Q3 FFY 16	Q4 FFY 16	Q1 FFY 17
(Jan - Mar 2016)	**(April - June 2016)**	**(July - Sept 2016)**	**(Oct - Dec 2016)**
$ 302,651.16	$ 21,250.00	$ 4,303.50	
10/28/16: Must add recoupments from all previous quarters.			

Appendix 2 – Regional Office Data Tool, January 2017

1. State System

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of Implementation in your state, you can document these in the Notes section.

Benchmark	Planned Date	Actual Date	Notes
Registration Implementation This is the date the system was available for providers to register eligibility information.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012

Benchmark	Planned Date	Actual Date	Notes
AIU Attestation Implementation This is the date the system was available for providers to attest for AIU.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
Payments Implementation This is the date the system was available for payments to providers.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Eligible Professionals 5/14/2012
Audits Implementation This is the date the post-payment audits began.	10/1/2014	9/1/2014	The Audit Strategy was approved in May 2014 for AIU audits. Eligible Professional post-payment audits and Eligible Hospital post-payment audits began September 2014.
MU Attestation This is the date the system was available for providers to attest for MU.	9/27/2012	9/27/2012	
IAPD Expiration Date This is the date of expiration listed on the current CMS-approved IAPD. Planned Date and Actual Date will be the same for this category.	9/3/2016	9/30/2016	An IAPD update was submitted to CMS on June 30, 2016 for review and approved on August 17, 2016.

2. Provider Outreach (01/01/2016 - 12/31/2016)

Instructions: Please list the outreach activity types (events, correspondence, etc.) which have occurred in your state. If a new activity begins, please add and list the number of occurrences. Time period is for calendar year 2016.

PO Outreach Activity (E-Mail/Phone/Meeting/Webinars/Social Media/Training/ETC)	**Approximate # of Occurrences**	**Notes**	
Meetings	0	OHIT Advisory Board Meetings	The Advisory Board is being reconstituted to reflect progress in EHR implementation and expanded focus on other efforts including Technical Assistance for specialists and beneficiary outreach and opportunities associated with HIE funding per SMD 16-003. Planning for one meeting in the second quarter of 2017.
Phone Calls	5	EHR Incentive Program Update Calls	Held by OHIT and attended by various stakeholders, including health care foundations, group administrators, and other health care entities (such as previous regional and local extension centers). The call provides regular program updates as well as announcements and discussion of important

PO Outreach Activity (E-Mail/Phone/Meeting/Webinars/Social Media/Training/ETC)	**Approximate # of Occurrences**	**Notes**	
			items, such as changes to federal requirements, SLR updates, and policy issues.
Phone Calls	6	California Technical Assistance Program (CTAP) Calls	Calls providing updates on program requirements, discussing the requirements of various milestones, HIE, and any other topics that are brought up via email or during discussion.
Social Media	40	EHR Twitter Site	Continuous. Implemented in 2011. Used daily as a communication tool with the Medi-Cal provider population.
Newsletter	0	DHCS Stakeholder Newsletter	Continuous. Newsletter to all DHCS stakeholders, advising of meetings, program updates, CMS information and accomplishments.
Other	0	Provider Newsletters	Continuous. Collaborate on articles with Provider associations.
Other	370	Ongoing Provider Outreach	Continuous. Continued with one-on-one discussion with Providers and Hospitals during the

PO Outreach Activity (E-Mail/Phone/Meeting/Webinars /Social Media/Training/ETC)	Approximate # of Occurrences	Notes	
			enrollment process.
Other	0	MU Boot Camp	Boot camp hosted by California Primary Care Association. Presentations were given by the Outreach Manager and Policy Director.

3. Auditing (01/01/2016 - 12/31/2016)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Benchmark	Planned	Actual	Notes
EP AIU Audits This is the number of post-payment audits for EP AIU.	208	190	100% Pre-payment validation. The Audit Strategy was approved in May 2014. 21 EP post-payment audits have been completed with no adverse findings for the October - December 2016 quarter.
EP MU Audits This is the number of post-payment audits for EP MU.	0	0	Post payment audits will commence upon approval of the MU audits plan in the Audit Strategy.

EH Audits This is the number of post-payment EH audits conducted by state.	122	12	100% Pre-payment validations; Post-payment reviews to be integrated into normal hospital audits. The Audit Strategy was approved in May 2014. 7 EH post-payment audits have been completed for the October - December 2016 quarter.

4. State-Specific SMHP tasks (01/01/2016 - 12/31/2016)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned Date	Actual Date	Notes
SMHP Revision	12/30/2016	TBD	A comprehensive revision is still pending in order to gain more understanding of HIE needs in California. We anticipate submitting a revision in the first half of 2017.

5. Staffing Levels and Changes

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned FTEs	Actual FTEs	Notes
Operational Staff This is the number of FTEs performing as Help Desk, Provider Enrollment, Approvers, etc. (e.g., 1.5 FTEs).	22	18	Four current vacancies
IT Staff This is the number of FTEs performing Programmers, System Analysts, Testers, Project Managers, etc.	13	13	SLR Development & Other Deliverables. Fixed Price Bid. Vendor staff.
Auditing Staff This is the number of FTE Auditors. Also list the number of contractors/vendors as a separate notation in the Notes section.	2	2	
New Staff this Quarter Identify new personnel hired this quarter, if applicable.	0	0	

6. EP/EH Counts and Amount Paid (Total since start of program)

Instructions: Only include payments which have been issued as of the reporting date. Include paid counts and amounts (not those that are registered and not paid yet). Planned counts and amounts can be obtained from your HITECH IAPD or your CMS 37 reports. Report cumulative totals since the inception of the program. States should continue to report totals as they have been reporting on the RO calls. If necessary, states can add phased implementation dates in the Notes section.

Type	Planned	Actual	Notes
EP AIU Counts Provide the cumulative number of EPs paid for AIU.	10000	20577	
EP AIU Paid Amount Provide the cumulative amount paid to EPs for AIU.	$ 212,500,000.00	$ 435,525,880.68	
EP MU Counts Provide the cumulative number of EPs paid for meeting MU.	0	12256	
EP MU Paid Amount Provide the cumulative amount paid to EPs for MU.	$ -	$ 108,253,167.12	
EH AIU Counts Provide the cumulative amount paid to EHs for AIU.	250	256	Payments reconciled
EH AIU Paid Amount Provide the cumulative number of EHs paid for meeting MU.	$ 375,000,000.00	$ 387,710,359.96	Planned EH AIU Paid Amount should be entered as 375,000,000. The system keeps defaulting our entry to 10000.
EH MU Counts Provide the cumulative amount paid to EHs for MU.	0	551	
EH MU Paid Amount Provide the cumulative amount paid to EHs for MU.	$ -	$ 314,948,725.26	

7. Other Information (01/01/2016 - 12/31/2016)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

The first SMHP Update dated 12/28/2012 was approved on 1/30/2013, with addendums submitted to CMS subsequently. An SMHP Addendum for the 2015-2017 Modification Rule was approved by CMS on 03/10/16. An addendum for the 2017 program year will be submitted in February, 2017. A comprehensive update to the SMHP is in process based on the CMS's Companion Guide. We anticipate that a comprehensive update will be completed during the first half of 2017.
An IAPD Update, requesting funding for FFY 2017 was submitted to CMS for review and approval on June 30, 2016 and approved on August 17, 2016

Once you have entered all of your data for the Quarterly Report please click the Submit button. Please note that once the Submit button has been clicked you will not be able to modify any data that has been entered into the tool.

8. Recoupment / Adjustment Amounts (01/01/2016 - 12/31/2016)

Instructions: Provide additional activities/tasks performed such as working on SMPH,

IAPD, MMIS modernization, Public Health, etc.

Q2 FFY 16	Q3 FFY 16	Q4 FFY 16	Q1 FFY 17
(Jan - Mar 2016)	(April - June 2016)	(July - Sept 2016)	(Oct - Dec 2016)
$ 302,651.16	$ 21,250.00	$ 4,303.50	$ -

Appendix 3 – Regional Office Data Tool, April 2017

1. State System

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of Implementation in Your state, you can document these in the Notes section

Benchmark	Planned Date	Actual Date	Notes
Registration Implementation This is the date the system was available for providers to register eligibility information.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
AIU Attestation Implementation This is the date the system was available for providers to attest for AIU.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
Payments Implementation This is the date the system was available for payments to providers.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Eligible Professionals 5/14/2012
Audits Implementation This is the date the post-payment audits began.	10/1/2014	9/1/2014	The Audit Strategy was approved in May 2014 for AIU audits. Eligible Professional post-payment audits and Eligible Hospital post-payment audits began September 2014.

Benchmark	Planned Date	Actual Date	Notes
MU Attestation This is the date the system was available for providers to attest for MU.	9/27/2012	9/27/2012	
IAPD Expiration Date This is the date of expiration listed on the current CMS-approved IAPD. Planned Date and Actual Date will be the same for this category.	9/30/2017	9/30/2017	An IAPD update was submitted to CMS on June 30, 2016 for review and approved on August 17, 2016.

2. Provider Outreach (01/01/2017 - 12/31/2017)

Instructions: Please list the outreach activity types (events, correspondence, etc.) which have occurred in your state. If a new activity begins, please add and list the number of occurrences. Time period is for calendar year 2016.

PO Outreach Activity (E-Mail/Phone/Meeting/Webinars/Social Media/Training/ETC)	**Approximate # of Occurrences**	**Notes**
Meetings	0	OHIT Advisory Board Meetings

PO Outreach Activity (E-Mail/Phone/Meeting/Webinars/Social Media/Training/ETC)	**Approximate # of Occurrences**	**Notes**
Phone Calls	5	EHR Incentive Program Update Calls
Phone Calls	6	California Technical Assistance Program (CTAP) Calls
Social Media	40	EHR Twitter Site
Newsletter	0	DHCS Stakeholder Newsletter
Other	0	Provider Newsletters
Other	975	Ongoing Provider Outreach

3. Auditing (01/01/2017 - 12/31/2017)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Benchmark	Planned	Actual
EP AIU Audits This is the number of post-payment audits for EP AIU.	242	193
EP MU Audits This is the number of post-payment audits for EP MU.	0	0
EH Audits This is the number of post-payment EH audits conducted by state.	122	25

4. State-Specific SMHP tasks (01/01/2017 - 12/31/2017)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned Date	Actual Date
SMHP Revision	12/30/2016	TBD

5. Staffing Levels and Changes

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned FTEs	Actual FTEs	Notes
Operational Staff This is the number of FTEs performing as Help Desk, Provider Enrollment, Approvers, etc. (e.g., 1.5 FTEs).	22	17	Five current vacancies
IT Staff This is the number of FTEs performing Programmers, System Analysts, Testers, Project Managers, etc.	13	13	SLR Development & Other Deliverables. Fixed Price Bid. Vendor staff.
Auditing Staff This is the number of FTE Auditors. Also list the number of contractors/vendors as a separate notation in the Notes section.	2	2	
New Staff this Quarter Identify new personnel hired this quarter, if applicable.	0	0	

6. EP/EH Counts and Amount Paid (Total since start of program)

Instructions: Only include payments which have been issued as of the reporting date. Include paid counts and amounts (not those that are registered and not paid yet). Planned counts and amounts can be obtained from your HITECH IAPD or your CMS 37 reports. Report cumulative totals since the inception of the program. States should continue to report totals as they have been reporting on the RO calls. If necessary, states can add phased implementation dates in the Notes section.

Type	Planned	Actual	Notes
EP AIU Counts Provide the cumulative	10000	21055	

Type	Planned	Actual	Notes
number of EPs paid for AIU.			
EP AIU Paid Amount Provide the cumulative amount paid to EPs for AIU.	$ 212,500,000.00	$ 445,704,630.68	
EP MU Counts Provide the cumulative number of EPs paid for meeting MU.	0	14383	
EP MU Paid Amount Provide the cumulative amount paid to EPs for MU.	$ -	$ 127,028,250.55	
EH AIU Counts Provide the cumulative amount paid to EHs for AIU.	250	262	
EH AIU Paid Amount Provide the cumulative number of EHs paid for meeting MU.	$ 375,000,000.00	$ 394,188,442.16	
EH MU Counts Provide the cumulative amount paid to EHs for MU.	0	588	
EH MU Paid Amount Provide the cumulative amount paid to EHs for MU.	$ -	$ 325,550,399.46	

7. Other Information (01/01/2017 - 12/31/2017)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

The first SMHP Update dated 12/28/2012 was approved on 1/30/2013, with addendums submitted to CMS subsequently. An SMHP Addendum for the 2015-

2017 Modification Rule was approved by CMS on 03/10/16. An addendum for the 2017 program year was submitted and approved in February, 2017. A comprehensive update to the SMHP is in process based on the CMS's Companion Guide. We anticipate that a comprehensive update will be completed during the first half of 2017.

An IAPD Update, requesting funding for FFY 2017 was submitted to CMS for review and approval on June 30, 2016 and approved on August 17, 2016

Once you have entered all of your data for the Quarterly Report please click the Submit button. Please note that once the Submit button has been clicked you will not be able to modify any data that has been entered into the tool.

8. Recoupment / Adjustment Amounts (01/01/2017 - 12/31/2017)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

Q2 FFY 17	Q3 FFY 17	Q4 FFY 17	Q1 FFY 18
(Jan - Mar 2017)	**(April - June 2017)**	**(July - Sept 2017)**	**(Oct - Dec 2017)**
$ 42,500.00			

Appendix 4 – Regional Office Data Tool, July 2017

1. State System

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of Implementation in Your state, you can document these in the Notes section

Benchmark	Planned Date	Actual Date	Notes
Registration Implementation This is the date the system was available for providers to register eligibility information.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
AIU Attestation Implementation This is the date the system was available for providers to attest for AIU.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
Payments Implementation This is the date the system was available for payments to providers.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Eligible Professionals 5/14/2012
Audits Implementation This is the date the post-payment audits began.	10/1/2014	9/1/2014	The Audit Strategy was approved in May 2014 for AIU audits. Eligible Professional post-payment audits and Eligible Hospital post-payment audits began September 2014.

Benchmark	Planned Date	Actual Date	Notes
MU Attestation This is the date the system was available for providers to attest for MU.	9/27/2012	9/27/2012	
IAPD Expiration Date This is the date of expiration listed on the current CMS-approved IAPD. Planned Date and Actual Date will be the same for this category.	9/30/2017	9/30/2017	An IAPD update was submitted to CMS on June 30, 2016 for review and approved on August 17, 2016. A revised IAPD-U, requesting additional funding for FFY 2017 was submitted to CMS for review on July 3, 2016 and is pending CMS approval. In addition, the 2018 IAPD-U is drafted and ready for submission pending approval of the 2017 update.

2. Provider Outreach (01/01/2017 - 12/31/2017)

Instructions: Please list the outreach activity types (events, correspondence, etc.) which have occurred in your state. If a new activity begins, please add and list the number of occurrences. Time period is for calendar year 2017.

PO Outreach Activity (E-Mail/Phone/ Meeting/ Webinars/ Social Media/ Training/ETC)	**Approximate # of Occurrences**	**Notes**	
Meetings	0	OHIT Advisory	The Advisory Board is being reconstituted to reflect progress in EHR implementation and

PO Outreach Activity (E-Mail/Phone/ Meeting/ Webinars/ Social Media/ Training/ETC)	**Approximate # of Occurrences**	**Notes**	
		Board Meetings	expanded focus on other efforts including Technical Assistance for specialists and beneficiary outreach and opportunities associated with HIE funding per SMD 16-003. Planning for one meeting in the third quarter of 2017.
Phone Calls	6	EHR Incentive Program Update Calls	Held by OHIT and attended by various stakeholders, including health care foundations, group administrators, and other health care entities (such as previous regional and local extension centers). The call provides regular program updates as well as announcements and discussion of important items, such as changes to federal requirements, SLR updates, and policy issues.
Phone Calls	6	California Technical Assistance Program (CTAP)	Calls providing updates on program requirements, discussing the requirements of various milestones, HIE, and any

PO Outreach Activity (E-Mail/Phone/ Meeting/ Webinars/ Social Media/ Training/ETC)	**Approximate # of Occurrences**	**Notes**	
		Calls	other topics that are brought up via email or during discussion.
Social Media	38	EHR Twitter Site	Continuous. Implemented in 2011. Used daily as a communication tool with the Medi-Cal provider population.
California HIE/HIT Summit	1		The facilitation of the California Health Information Technology (HIT) and Health Information Exchange (HIE) Stakeholder Summit ("Summit") will further coordinate and implement California's eHealth vision and goals. The Summit's primary objective is to help stakeholders understand how they and their organizations fit into the big picture of HIE in California; enable stakeholders to learn about the available assets and services that are key to planning for clinical and administrative integration; and provide a forum for stakeholders to

PO Outreach Activity (E-Mail/Phone/ Meeting/ Webinars/ Social Media/ Training/ETC)	**Approximate # of Occurrences**	**Notes**	
			have voice in shaping the future of HIE in the State.
Newsletter	0	DHCS Stakeholder Newsletter	Continuous. Newsletter to all DHCS stakeholders, advising of meetings, program updates, CMS information and accomplishments.
Other	0	Provider Newsletters	Continuous. Collaborate on articles with Provider associations.
Other	1029	Ongoing Provider Outreach	Continuous. Continued with one-on-one discussion with Providers and Hospitals during the enrollment process.

3. Auditing (01/01/2017 - 12/31/2017)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Benchmark	Planned	Actual	Notes
EP AIU Audits This is the number of post-payment audits for EP AIU.	242	210	100% Pre-payment validation. The Audit Strategy was approved in May 2014. 17 EP post-payment audits have been completed with no adverse findings for the April - June 2017 2017 quarter.
EP MU Audits This is the number of post-payment audits for EP MU.	0	0	Post payment audits will commence upon approval of the MU audits plan in the Audit Strategy.
EH Audits This is the number of post-payment EH audits conducted by state.	122	79	100% Pre-payment validations; Post-payment reviews to be integrated into normal hospital audits. The Audit Strategy was approved in May 2014. 54 EH post-payment audits have been completed for the April - June 2017 quarter.

4. State-Specific SMHP tasks (01/01/2017 - 12/31/2017)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned Date	Actual Date	Notes
SMHP Revision	12/30/2016	TBD	A comprehensive revision is still pending in order to gain more understanding of HIE needs in California. We anticipate submitting a revision in the first half of 2017.

5. Staffing Levels and Changes

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned FTEs	Actual FTEs	Notes
Operational Staff This is the number of FTEs performing as Help Desk, Provider Enrollment, Approvers, etc. (e.g., 1.5 FTEs).	20	14	Six vacancies in the April - June 2017 Quarter
IT Staff This is the number of FTEs performing Programmers, System Analysts, Testers, Project Managers, etc.	13	13	SLR Development & Other Deliverables. Fixed Price Bid. Vendor staff.
Auditing Staff This is the number of FTE Auditors. Also list the number of contractors/vendors as a separate notation in the Notes section.	2	2	

Roles	Planned FTEs	Actual FTEs	Notes
New Staff this Quarter Identify new personnel hired this quarter, if applicable.	4	0	Vacancies filled in July 2017

6. EP/EH Counts and Amount Paid (Total since start of program)

Instructions: Only include payments which have been issued as of the reporting date. Include paid counts and amounts (not those that are registered and not paid yet). Planned counts and amounts can be obtained from your HITECH IAPD or your CMS 37 reports. Report cumulative totals since the inception of the program. States should continue to report totals as they have been reporting on the RO calls. If necessary, states can add phased implementation dates in the Notes section.

Type	Planned	Actual	Notes
EP AIU Counts Provide the cumulative number of EPs paid for AIU.	10000	22160	
EP AIU Paid Amount Provide the cumulative amount paid to EPs for AIU.	$ 212,500,000.00	$ 469,185,880.68	
EP MU Counts Provide the cumulative number of EPs paid for meeting MU.	0	16104	
EP MU Paid Amount Provide the cumulative amount paid to EPs for MU.	$ -	$ 142,499,667.24	
EH AIU Counts Provide the cumulative amount paid to EHs for AIU.	250	264	
EH AIU Paid Amount Provide the cumulative number of EHs paid for	$ 375,000,000.00	$ 398,073,160.20	

Type	Planned	Actual	Notes
meeting MU.			
EH MU Counts Provide the cumulative amount paid to EHs for MU.	0	599	
EH MU Paid Amount Provide the cumulative amount paid to EHs for MU.	$ -	$ 329,681,440.94	

7. Other Information (01/01/2017 - 12/31/2017)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

The first SMHP Update dated 12/28/2012 was approved on 1/30/2013, with addendums submitted to CMS subsequently. An SMHP Addendum for the 2015-2017 Modification Rule was approved by CMS on 03/10/16. An addendum for the 2017 program year was submitted and approved in February, 2017. A comprehensive update to the SMHP is in process based on the CMS's Companion Guide. The updated SMHP will provide an assessment of the current state of HIT/HIE in California, the DHCS goals for the period 2017-2021, and the roadmap and expected outcomes by end of program.

An IAPD Update, requesting funding for FFY 2017 was submitted to CMS for review and approval on June 30, 2016 and approved on August 17, 2016. A revised IAPD- U, requesting additional funding for FFY 2017 was submitted to CMS for review on July 3, 2016 and is pending CMS approval. In addition, the 2018 IAPD-U is drafted and ready for submission pending approval of the 2017 update.

Once you have entered all of your data for the Quarterly Report please click the Submit button. Please note that once the Submit button has been clicked you will not be able to modify any data that has been entered into the tool.

8. Recoupment / Adjustment Amounts (01/01/2017 - 12/31/2017)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

Q2 FFY 17	Q3 FFY 17	Q4 FFY 17	Q1 FFY 18
(Jan - Mar 2017)	**(April - June 2017)**	**(July - Sept 2017)**	**(Oct - Dec 2017)**
$ 72,250.00			

Appendix 5 – Regional Office Data Tool, October 2017

1. State System

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of Implementation in Your state, you can document these in the Notes section

Benchmark	Planned Date	Actual Date	Notes
Registration Implementation This is the date the system was available for providers to register eligibility information.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
AIU Attestation Implementation This is the date the system was available for providers to attest for AIU.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
Payments Implementation This is the date the system was available for payments to providers.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Eligible Professionals 5/14/2012
Audits Implementation This is the date the post-payment audits began.	10/1/2014	9/1/2014	The Audit Strategy was approved in May 2014 for AIU audits. Eligible Professional post-payment audits and Eligible Hospital post-payment audits began September 2014.

Benchmark	Planned Date	Actual Date	Notes
MU Attestation This is the date the system was available for providers to attest for MU.	9/27/2012	9/27/2012	
IAPD Expiration Date This is the date of expiration listed on the current CMS-approved IAPD. Planned Date and Actual Date will be the same for this category.	9/30/2017	9/30/2017	An IAPD update was submitted to CMS on June 30, 2016 for review and approved on August 17, 2016. A revised IAPD-U, requesting additional funding for FFY 2017 was submitted to CMS for review on July 3, 2017 and approved by CMS on August 7, 2017. In addition, the FFY 2018 IAPD-U was submitted to CMS for review on September 1, 2017 and approved by CMS on September 28, 2017.

2. Provider Outreach (01/01/2017 - 12/31/2017)

Instructions: Please list the outreach activity types (events, correspondence, etc.) which have occurred in your state. If a new activity begins, please add and list the number of occurrences. Time period is for calendar year 2017.

PO Outreach Activity (E-Mail/Phone/ Meeting/ Webinars/Social Media/ Training/ETC)	**Approximate # of Occurrences**	**Notes**	
Meetings	0	OHIT Advisory	The Advisory Board is being reconstituted to reflect progress in EHR implementation and

		Board Meetings	expanded focus on other efforts including Technical Assistance for specialists and beneficiary outreach and opportunities associated with HIE funding per SMD 16-003. Planning for one meeting in the first quarter of 2018.
Phone Calls	5	EHR Incentive Program Update Calls	Held by OHIT and attended by various stakeholders, including health care foundations, group administrators, and other health care entities (such as previous regional and local extension centers). The call provides regular program updates as well as announcements and discussion of important items, such as changes to federal requirements, SLR updates, and policy issues.
Phone Calls	5	California Technical Assistance Program (CTAP) Calls	Calls providing updates on program requirements, discussing the requirements of various milestones, HIE, and any other topics that are brought up via email or during discussion.
Social Media	1	EHR Twitter Site	Continuous. Implemented in 2011. Used daily as a communication tool with the Medi-Cal provider population.

California HIE/HIT Summit	0		The facilitation of the California Health Information Technology (HIT) and Health Information Exchange (HIE) Stakeholder Summit ("Summit") will further coordinate and implement California's eHealth vision and goals. The Summit's primary objective is to help stakeholders understand how they and their organizations fit into the big picture of HIE in California; enable stakeholders to learn about the available assets and services that are key to planning for clinical and administrative integration; and provide a forum for stakeholders to have voice in shaping the future of HIE in the State. The Summit will occur on November 1st and 2nd, 2017
Newsletter	0	DHCS Stakeholder Newsletter	Continuous. Newsletter to all DHCS stakeholders, advising of meetings, program updates, CMS information and accomplishments.
Other	0	Provider Newsletters	Continuous. Collaborate on articles with Provider associations.
Other	758	Ongoing Provider	Continuous. Continued with one-on-one discussion with

		Outreach	Providers and Hospitals during the enrollment process.
Other	1	Region 9 Meeting	The annual regional meeting between the Medicaid State Agency and CMS. The Region 9 meeting was held in Seattle from September 14th through 15th, 2017.

3. Auditing (01/01/2017 - 12/31/2017)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Benchmark	Planned	Actual	Notes
EP AIU Audits This is the number of post-payment audits for EP AIU.	242	215	100% Pre-payment validation. The Audit Strategy was approved in May 2014. 5 EP post-payment audits have been completed with no adverse findings for the July - September 2017 quarter.
EP MU Audits This is the number of post-payment audits for EP MU.	0	0	Post payment audits will commence upon approval of the MU audits plan in the Audit Strategy.
EH Audits This is the number of post-payment EH audits conducted by state.	122	99	100% Pre-payment validations; Post-payment reviews to be integrated into normal hospital audits. The Audit Strategy was approved

Benchmark	Planned	Actual	Notes
			in May 2014. 20 EH post-payment audits have been completed for the July - September 2017 quarter.

4. State-Specific SMHP tasks (01/01/2017 - 12/31/2017)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned Date	Actual Date	Notes
SMHP Revision	12/30/2016	TBD	A comprehensive revision is still pending in order to gain more understanding of HIE needs in California. We anticipate submitting a revision by the end of 2017.

5. Staffing Levels and Changes

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned FTEs	Actual FTEs	Notes
Operational Staff This is the number of FTEs performing as Help Desk, Provider Enrollment, Approvers, etc. (e.g., 1.5	20	17	Two vacancies left in the July - September 2017 Quarter

FTEs).			
IT Staff This is the number of FTEs performing Programmers, System Analysts, Testers, Project Managers, etc.	13	13	SLR Development & Other Deliverables. Fixed Price Bid. Vendor staff.
Auditing Staff This is the number of FTE Auditors. Also list the number of contractors/vendors as a separate notation in the Notes section.	2	2	
New Staff this Quarter Identify new personnel hired this quarter, if applicable.	4	3	Most vacancies filled in July 2017

6. EP/EH Counts and Amount Paid (Total since start of program)

Instructions: Only include payments which have been issued as of the reporting date. Include paid counts and amounts (not those that are registered and not paid yet). Planned counts and amounts can be obtained from your HITECH IAPD or your CMS 37 reports. Report cumulative totals since the inception of the program. States should continue to report totals as they have been reporting on the RO calls. If necessary, states can add phased implementation dates in the Notes section.

Type	Planned	Actual	Notes
EP AIU Counts Provide the cumulative number of EPs paid for AIU.	10000	23409	
EP AIU Paid Amount Provide the cumulative amount paid to EPs for AIU.	$ 212,500,000.00	$ 495,684,630.70	
EP MU Counts Provide the cumulative	0	18111	

Type	Planned	Actual	Notes
number of EPs paid for meeting MU.			
EP MU Paid Amount Provide the cumulative amount paid to EPs for MU.	$ -	$ 160,028,083.98	
EH AIU Counts Provide the cumulative amount paid to EHs for AIU.	250	266	
EH AIU Paid Amount Provide the cumulative number of EHs paid for meeting MU.	$ 375,000,000.00	$ 401,369,182.91	
EH MU Counts Provide the cumulative amount paid to EHs for MU.	0	610	
EH MU Paid Amount Provide the cumulative amount paid to EHs for MU.	$ -	$ 331,604,172.86	

7. Other Information (01/01/2017 - 12/31/2017)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

The first SMHP Update dated 12/28/2012 was approved on 1/30/2013, with addendums submitted to CMS subsequently. An SMHP Addendum for the 2015-2017 Modification Rule was approved by CMS on 03/10/16. An addendum for the 2017 program year was submitted and approved in February, 2017. A comprehensive update to the SMHP is in process based on the CMS's Companion Guide. The updated SMHP will provide an assessment of the current state of HIT/HIE in California, the DHCS goals for the period 2017-2021, and the roadmap and expected outcomes by end of program.

An IAPD Update, requesting funding for FFY 2017 was submitted to CMS for review and approval on June 30, 2016 and approved on August 17, 2016. A revised IAPD- U, requesting additional funding for FFY 2017 was submitted to CMS for review on July 3, 2017 and approved by CMS on August 7, 2017. In addition, the FFY 2018 IAPD-U was submitted to CMS for review on September 1, 2017 and approved by CMS on September 28, 2017.

Once you have entered all of your data for the Quarterly Report please click the Submit button. Please note that once the Submit button has been clicked you will not be able to modify any data that has been entered into the tool.

8. Recoupment / Adjustment Amounts (01/01/2017 - 12/31/2017)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

Q2 FFY 17	Q3 FFY 17	Q4 FFY 17	Q1 FFY 18
(Jan - Mar 2017)	**(April - June 2017)**	**(July - Sept 2017)**	**(Oct - Dec 2017)**
$ 72,250.00		$72,250	

Appendix 6 – Regional Office Data Tool, January 2018

1. State System

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of Implementation in Your state, you can document these in the Notes section

Benchmark	Planned Date	Actual Date	Notes
Registration Implementation This is the date the system was available for providers to register eligibility information.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
AIU Attestation Implementation This is the date the system was available for providers to attest for AIU.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011.Eligible Professionals 01/03/2012
Payments Implementation This is the date the system was available for payments to providers.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Eligible Professionals 5/14/2012
Audits Implementation This is the date the post-payment audits began.	10/1/2014	9/1/2014	The Audit Strategy was approved in May 2014 for AIU audits and updated on January 18, 2018. Eligible Professional post-payment audits and Eligible Hospital

Benchmark	Planned Date	Actual Date	Notes
			post-payment audits began September 2014.
MU Attestation This is the date the system was available for providers to attest for MU.	9/27/2012	9/27/2012	
IAPD Expiration Date This is the date of expiration listed on the current CMS-approved IAPD. Planned Date and Actual Date will be the same for this category.	9/30/2017	9/30/2018	An IAPD update was submitted to CMS on June 30, 2016 for review and approved on August 17, 2016. A revised IAPD-U, requesting additional funding for FFY 2017 was submitted to CMS for review on July 3, 2017 and approved by CMS on August 7, 2017. In addition, the FFY 2018 IAPD-U was submitted to CMS for review on September 1, 2017 and approved by CMS on September 28, 2017.

2. Provider Outreach (01/01/2017 - 12/31/2017)

Instructions: Please list the outreach activity types (events, correspondence, etc.) which have occurred in your state. If a new activity begins, please add and list the number of occurrences. Time period is for calendar year 2017.

PO Outreach Activity (E-Mail/ Phone/ Meeting/Webinars/Social Media/Training/ETC)	**Approximate # of Occurrences**	**Notes**	
Meetings	0	OHIT Advisory Board Meetings	The Advisory Board is being reconstituted to reflect progress in EHR implementation and expanded focus on other efforts including Technical Assistance for specialists and beneficiary outreach and opportunities associated with HIE funding per SMD 16-003. Planning for one meeting in the second quarter of 2018.
Phone Calls	4	EHR Incentive Program Update Calls	Held by OHIT and attended by various stakeholders, including health care foundations, group administrators, and other health care entities (such as previous regional and local extension centers). The call provides regular program updates as well as announcements and discussion of important items, such as changes to federal requirements, SLR

			updates, and policy issues.
Phone Calls	5	California Technical Assistance Program (CTAP) Calls	Calls providing updates on program requirements, discussing the requirements of various milestones, HIE, and any other topics that are brought up via email or during discussion.
Social Media	1	EHR Twitter Site	Continuous. Implemented in 2011. Used daily as a communication tool with the Medi-Cal provider population.
California HIE/HIT Summit	1		The facilitation of the California Health Information Technology (HIT) and Health Information Exchange (HIE) Stakeholder Summit ("Summit") will further coordinate and implement California's eHealth vision and goals. The Summit's primary objective is to help stakeholders understand how they and their organizations fit into the big picture of HIE in California; enable stakeholders to learn about the available

			assets and services that are key to planning for clinical and administrative integration; and provide a forum for stakeholders to have voice in shaping the future of HIE in the State. The most recent Summit occurred on November 1st and 2nd, 2017
Newsletter	0	DHCS Stakeholder Newsletter	Continuous. Newsletter to all DHCS stakeholders, advising of meetings, program updates, CMS information and accomplishments.
Other	0	Provider Newsletters	Continuous. Collaborate on articles with Provider associations.
Other	244	Ongoing Provider Outreach	Continuous. Continued with one-on-one discussion with Providers and Hospitals during the enrollment process.

3. Auditing (01/01/2017 - 12/31/2017)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Benchmark	Planned	Actual	Notes
EP AIU Audits This is the number of post-payment audits for EP AIU.	242	235	100% Pre-payment validation. The Audit Strategy was approved in May 2014, and updated on January 18, 2018. 20 EP post-payment audits have been completed with no adverse findings for the October - December 2017 quarter. The actuals are cumulative.
EP MU Audits This is the number of post-payment audits for EP MU.	0	0	Post payment audits will commence shortly, now that MU audit strategy has been approved.
EH Audits This is the number of post-payment EH audits conducted by state.	122	123	100% Pre-payment validation. The Audit Strategy was approved in May 2014, and updated on January 18, 2018. 11 EH post-payment audits have been completed in prior quarters that were reconciled in the October - December 2017 quarter. 13 EH post-payment audits have been completed for the October - December 2017 quarter. The actuals are cumulative.

4. State-Specific SMHP tasks (01/01/2017 - 12/31/2017)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned Date	Actual Date	Notes
SMHP Revision	12/30/2016	TBD	A comprehensive revision is still pending in order to gain more understanding of HIE needs in California. We anticipate submitting a revision by February 2018.

5. Staffing Levels and Changes

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned FTEs	Actual FTEs	Notes
Operational Staff This is the number of FTEs performing as Help Desk, Provider Enrollment, Approvers, etc. (e.g., 1.5 FTEs).	18	18	
IT Staff This is the number of FTEs performing Programmers, System Analysts, Testers, Project Managers, etc.	13	13	SLR Development & Other Deliverables. Fixed Price Bid. Vendor staff.

Roles	Planned FTEs	Actual FTEs	Notes
Auditing Staff This is the number of FTE Auditors. Also list the number of contractors/vendors as a separate notation in the Notes section.	2	2	
New Staff this Quarter Identify new personnel hired this quarter, if applicable.	1	1	1 vacancy filled in November 2017

6. EP/EH Counts and Amount Paid (Total since start of program)

Instructions: Only include payments which have been issued as of the reporting date. Include paid counts and amounts (not those that are registered and not paid yet). Planned counts and amounts can be obtained from your HITECH IAPD or your CMS 37 reports. Report cumulative totals since the inception of the program. States should continue to report totals as they have been reporting on the RO calls. If necessary, states can add phased implementation dates in the Notes section.

Type	Planned	Actual	Notes
EP AIU Counts Provide the cumulative number of EPs paid for AIU.	10000	24766	
EP AIU Paid Amount Provide the cumulative amount paid to EPs for AIU.	$ 212,500,000.00	$ 524,520,880.37	
EP MU Counts Provide the cumulative number of EPs paid for meeting MU.	0	19414	
EP MU Paid Amount Provide the cumulative amount paid to EPs for MU.	$ -	$ 171,252,334.09	

Type	Planned	Actual	Notes
EH AIU Counts Provide the cumulative amount paid to EHs for AIU.	250	267	
EH AIU Paid Amount Provide the cumulative number of EHs paid for meeting MU.	$ 375,000,000.00	$ 400,892,362.80	
EH MU Counts Provide the cumulative amount paid to EHs for MU.	0	615	
EH MU Paid Amount Provide the cumulative amount paid to EHs for MU.	$ -	$ 332,707,830.02	

7. Other Information (01/01/2017 - 12/31/2017)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

The first SMHP Update dated 12/28/2012 was approved on 1/30/2013, with addendums submitted to CMS subsequently. An SMHP Addendum for the 2015-2017 Modification Rule was approved by CMS on 03/10/16. An addendum for the 2017 program year was submitted and approved in February, 2017. A comprehensive update to the SMHP is in process based on the CMS's Companion Guide. The updated SMHP will provide an assessment of the current state of HIT/HIE in California, the DHCS goals for the period 2017-2021, and the roadmap and expected outcomes by end of program.

An IAPD Update, requesting funding for FFY 2017 was submitted to CMS for review and approval on June 30, 2016 and approved on August 17, 2016. A revised IAPD- U, requesting additional funding for FFY 2017 was submitted to CMS for review on July 3, 2017 and approved by CMS on August 7, 2017. In addition, the

FFY 2018 IAPD-U was submitted to CMS for review on September 1, 2017 and approved by CMS on September 28, 2017.

Once you have entered all of your data for the Quarterly Report please click the Submit button. Please note that once the Submit button has been clicked you will not be able to modify any data that has been entered into the tool.

8. Recoupment / Adjustment Amounts (01/01/2017 - 12/31/2017)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

Q2 FFY 17	Q3 FFY 17	Q4 FFY 17	Q1 FFY 18
(Jan - Mar 2017)	**(April - June 2017)**	**(July - Sept 2017)**	**(Oct - Dec 2017)**
$ 72,250.00		$93,500	

Appendix 7 – Regional Office Data Tool, April 2018

1. State System

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of Implementation in Your state, you can document these in the Notes section

Benchmark	Planned Date	Actual Date	Notes
Registration Implementation This is the date the system was available for providers to register eligibility information.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011. Eligible Professionals 01/03/2012
AIU Attestation Implementation This is the date the system was available for providers to attest for AIU.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Group Implementation 11/3/2011.Eligible Professionals 01/03/2012
Payments Implementation This is the date the system was available for payments to providers.	10/3/2011	10/3/2011	Eligible Hospitals 10/03/2011. Eligible Professionals 5/14/2012
Audits Implementation This is the date the post-payment audits began.	10/1/2014	9/1/2014	The Audit Strategy was approved in May 2014 for AIU audits and updated on January 18, 2018 for MU audits. Eligible Professional post-payment audits and Eligible Hospital post-payment audits began September 2014.

Benchmark	Planned Date	Actual Date	Notes
MU Attestation This is the date the system was available for providers to attest for MU.	9/27/2012	9/27/2012	
IAPD Expiration Date This is the date of expiration listed on the current CMS-approved IAPD. Planned Date and Actual Date will be the same for this category.	9/30/2017	9/30/2018	An IAPD update for FFY 2018 was submitted to CMS for review on September 1, 2017 and approved by CMS on September 28, 2017. A revised IAPD-U for FFY 2018, requesting funding for a new project, was submitted to CMS on March 6, 2018 and is pending CMS review and approval.

2. Provider Outreach (01/01/2018 - 12/31/2018)

Instructions: Please list the outreach activity types (events, correspondence, etc.) which have occurred in your state. If a new activity begins, please add and list the number of occurrences. Time period is for calendar year 2017.

PO Outreach Activity (E-Mail/ Phone/ Meeting/ Webinars/Social Media/ Training/ ETC)	**Approximate # of Occurrences**	**Notes**	
Meetings	0	OHIT Advisory Board Meetings	The Advisory Board is being reconstituted to reflect progress in EHR implementation and expanded focus on other efforts including Technical Assistance for specialists

PO Outreach Activity (E-Mail/ Phone/ Meeting/ Webinars/Social Media/ Training/ ETC)	**Approximate # of Occurrences**	**Notes**	
			and beneficiary outreach and opportunities associated with HIE funding per SMD 16-003. Planning for one meeting in the second quarter of 2018.
Phone Calls	6	EHR Incentive Program Update Calls	Held by OHIT and attended by various stakeholders, including health care foundations, group administrators, and other health care entities (such as previous regional and local extension centers). The call provides regular program updates as well as announcements and discussion of important items, such as changes to federal requirements, SLR updates, and policy issues.
Phone Calls	5	California Technical Assistance Program (CTAP) Calls	Calls providing updates on program requirements, discussing the requirements of various milestones, HIE, and any other topics that are brought up via email or during discussion.

PO Outreach Activity (E-Mail/ Phone/ Meeting/ Webinars/Social Media/ Training/ ETC)	Approximate # of Occurrences	Notes	
Social Media	28	EHR Twitter Site	Continuous. Implemented in 2011. Used daily as a communication tool with the Medi-Cal provider population.
California HIE/HIT Summit	0		The facilitation of the California Health Information Technology (HIT) and Health Information Exchange (HIE) Stakeholder Summit ("Summit") will further coordinate and implement California's eHealth vision and goals. The Summit's primary objective is to help stakeholders understand how they and their organizations fit into the big picture of HIE in California; enable stakeholders to learn about the available assets and services that are key to planning for clinical and administrative integration; and provide a forum for stakeholders to have voice in shaping the future of HIE in the State. The most

PO Outreach Activity (E-Mail/ Phone/ Meeting/ Webinars/Social Media/ Training/ ETC)	**Approximate # of Occurrences**	**Notes**	
			recent Summit occurred on November 1st and 2nd, 2017
Newsletter	0	DHCS Stakeholder Newsletter	Continuous. Newsletter to all DHCS stakeholders, advising of meetings, program updates, CMS information and accomplishments.
Other	0	Provider Newsletters	Continuous. Collaborate on articles with Provider associations.
Other	637	Ongoing Provider Outreach	Continuous. Continued with one-on-one discussion with Providers and Hospitals during the enrollment process.

3. Auditing (01/01/2018 - 12/31/2018)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Benchmark	Planned	Actual	Notes
EP AIU Audits This is the number of post-payment audits for EP AIU.	50	3	100% Pre-payment validation. The Audit Strategy was approved in May 2014, and updated on January 18, 2018. 3 EP post-payment audits have been completed with no adverse findings for the January - March 2018 quarter. The actuals are cumulative.
EP MU Audits This is the number of post-payment audits for EP MU.	0	0	Post payment audits will commence shortly, now that MU audit strategy has been approved.
EH Audits This is the number of post-payment EH audits conducted by state.	110	4	100% Pre-payment validation. The Audit Strategy was approved in May 2014, and updated on January 18, 2018. 4 EH post-payment audits have been completed for the January - March 2018 quarter. The actuals are cumulative.

4. State-Specific SMHP tasks (01/01/2018 - 12/31/2018)

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned Date	Actual Date	Notes
SMHP Revision	12/30/2016	TBD	A comprehensive revision is still pending in order to gain more understanding of HIE needs in California. We anticipate submitting a revision by April 2018.

5. Staffing Levels and Changes

Instructions: Planned dates should come from dates identified in the HITECH IAPD. Actual dates are when implementation occurred. If you have additional phases of implementation in your state, you can document these in the Notes section.

Roles	Planned FTEs	Actual FTEs	Notes
Operational Staff This is the number of FTEs performing as Help Desk, Provider Enrollment, Approvers, etc. (e.g., 1.5 FTEs).	18	18	
IT Staff This is the number of FTEs performing Programmers, System Analysts, Testers, Project Managers, etc.	13	13	SLR Development & Other Deliverables. Fixed Price Bid. Vendor staff.
Auditing Staff This is the number of FTE Auditors. Also list the number of contractors/vendors as a separate notation in the Notes section.	2	2	

Roles	Planned FTEs	Actual FTEs	Notes
New Staff this Quarter Identify new personnel hired this quarter, if applicable.	0	0	

6. EP/EH Counts and Amount Paid (Total since start of program)

Instructions: Only include payments which have been issued as of the reporting date. Include paid counts and amounts (not those that are registered and not paid yet). Planned counts and amounts can be obtained from your HITECH IAPD or your CMS 37 reports. Report cumulative totals since the inception of the program. States should continue to report totals as they have been reporting on the RO calls. If necessary, states can add phased implementation dates in the Notes section.

Type	Planned	Actual	Notes
EP AIU Counts Provide the cumulative number of EPs paid for AIU.	10000	24951	
EP AIU Paid Amount Provide the cumulative amount paid to EPs for AIU.	$ 212,500,000.00	$ 528,445,047.37	
EP MU Counts Provide the cumulative number of EPs paid for meeting MU.	0	20502	
EP MU Paid Amount Provide the cumulative amount paid to EPs for MU.	$ -	$ 180,504,564.11	
EH AIU Counts	250	268	

Type	Planned	Actual	Notes
Provide the cumulative amount paid to EHs for AIU.			
EH AIU Paid Amount Provide the cumulative number of EHs paid for meeting MU.	$ 375,000,000.00	$ 402,040,016.41	Planned EH AIU Paid Amount should be entered as 375,000,000. Sometimes the system sometimes defaults the entry to 10000.
EH MU Counts Provide the cumulative amount paid to EHs for MU.	0	651	
EH MU Paid Amount Provide the cumulative amount paid to EHs for MU.	$ -	$ 342,025,191.76	

7. Other Information (01/01/2018 - 12/31/2018)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

The first SMHP Update dated 12/28/2012 was approved on 1/30/2013, with addendums submitted to CMS subsequently. An SMHP Addendum for the 2015-2017 Modification Rule was approved by CMS on 03/10/16. An addendum for the 2017 program year was submitted and approved in February, 2017. A comprehensive update to the SMHP is in process based on the CMS's Companion Guide. The updated SMHP will provide an assessment of the current state of HIT/HIE in California, the DHCS goals for the period 2017-2021, and the roadmap and expected outcomes by end of program.

An IAPD update for FFY 2018 was submitted to CMS for review on September 1, 2017 and approved by CMS on September 28, 2017. A revised IAPD-U for FFY 2018, requesting funding for a new project, was submitted to CMS on March 6, 2018 and is pending CMS review and approval.

Once you have entered all of your data for the Quarterly Report please click the Submit button. Please note that once the Submit button has been clicked you will not be able to modify any data that has been entered into the tool.

8. Recoupment / Adjustment Amounts (01/01/2018 - 12/31/2018)

Instructions: Provide additional activities/tasks performed such as working on SMPH, IAPD, MMIS modernization, Public Health, etc.

Q1 FFY 18	Q2 FFY 18	Q3 FFY 18	Q4 FFY 18
(Oct - Dec 2017)	(Jan - Mar 2018)	(April - June 2018)	(July - Sept 2018)
$0.00	$25,500		

Appendix 8 – Annual Regional Office Report to CMS, May 2017

Questions	Responses	
Report as of Date:	3/31/2017	
Total Unduplicated Providers Reported:	35438	from Quarterly RO Data Tool
MU Unduplicated Providers Reported:	14383	from Quarterly RO Data Tool
Number of FQHCs that operate in your State:	296	from 2016 submission
Select all MU Data types that will be entered:		
Stage 1 MU_2011/2012	Yes	
Stage 1 MU_2013	Yes	
Stage 1 MU_2014	Yes	
Stage 2 MU_2014	Yes	
MU 2015	Yes	
MU 2016	Yes	

AIU_MU Summary Data

Instructions: Enter the total number of FQHCs which have been assigned a payment by at least one EP (broken down by AIU and MU) since the inception of the state's EHR Incentive Program.

Section 1.1 FQHC	For AIU	For MU
How many unique FQHCs have been assigned a payment by at least one EP from the inception of the program until March 31st	855	430

Medicaid Only Provider Types and Practices

Instructions: Enter the total number of Optometrists and Children's Hospitals who have received AIU and MU payments since the inception of the state's EHR Incentive Program.

Section 1.2 Medicaid Only Provider Types and Practices		
Provider Type	Total # Providers AIU	Total # Providers MU
Optometrist	138	30
Children's Hospital	10	8

Stage 1 MU Measure Data 2011 / 2012

Instructions: Enter the total number of providers who received payment for PY 2011/2012 Stage 1 MU definitions since the inception of the program through March 31st of the current year.

Total Unduplicated Providers (EPs) to ever receive payment for 2011/2012 Program year stage 1 MU definitions	2056

Core MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may enter zero. “Exclusion %” and “# of unique providers who met the Threshold” will be automatically calculated.

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 01 CPOE for Medication Orders	91	13	227	11%	2056	1829
EPCMU 02 Drug Interaction Checks					2056	
EPCMU 03 Maintain Problem List	97	5			2056	
EPCMU 04 ePrescribing	89	13	330	16%	2056	1726
EPCMU 05 Active Medication Problem List	96	5			2056	
EPCMU 06 Medication Allergy List	97	4			2056	

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 07 Record Demographics	94	10			2056	
EPCMU 08 Record Vital Signs	91	10	37	2%	2056	2019
EPCMU 09 Record Smoking Status	89	12	10	0%	2056	2046
EPCMU 10 Clinical Quality Measures					2056	
EPCMU 11 Clinical Decision Support Rule					2056	
EPCMU 12 Electronic Copy of Health Information	98	7	1606	78%	2056	450
EPCMU 13 Clinical Summaries	81	15	26	1%	2056	2030
EPCMU 14 Electronic Exchange of Clinical Information					2056	
EPCMU 15 Protect Electronic Health Information					2056	

Menu MU Measures
Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. The number of deferrals is the count of providers who did not select the measure and the percentage is the percent of providers who did not select the measure.

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 01 Drug Formulary Checks			248	17%	622	30%	1434	1186
EPMMU 02 Clinical Lab Test Results	91	14	53	3%	455	22%	1601	1548
EPMMU 03 Patient Lists					863	42%	1193	
EPMMU 04 Patient Reminders	66	26	50	16%	1740	85%	316	266
EPMMU 05 Patient Electronic Access	90	21	32	5%	1430	70%	626	594
EPMMU 06 Patient Specific Education Resources	64	28			640	31%	1416	
EPMMU 07 Medication Reconciliation	89	14	101	10%	1072	52%	984	883
EPMMU 08 Transitions of Care Summary	90	13	122	27%	1600	78%	456	334
EPMMU 09 Immunization Registries Data Submission			690	45%	515	25%	1541	851
EPMMU 10 Syndromic Surveillance Data Submission			650	92%	1353	66%	703	53

Stage 1 MU Measure Data 2013

Instructions: Enter the total number of providers who received payment for PY 2013 Stage 1 MU definitions since the inception of the program through March 31st of the current year

Core MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may enter zero. “Exclusion %” and “# of unique providers who met the Threshold” will be automatically calculated.

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 01 CPOE for Medication Orders	93	12	383	13%	2993	2610
EPCMU 01 CPOE for Medication Orders (Alternate Measure)	92	12	0	0%	1076	1076
EPCMU 02 Drug Interaction Checks					4069	
EPCMU 03 Maintain Problem List	98	4			4069	

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 04 ePrescribing	90	13	601	15%	4069	3468
EPCMU 05 Active Medication Problem List	97	4			4069	
EPCMU 06 Medication Allergy List	98	4			4069	
EPCMU 07 Record Demographics	95	9			4069	
EPCMU 08 Record Vital Signs	93	9	64	2%	3106	3042
EPCMU 08 Record Vital Signs (Alternate Measure)	93	9	35	4%	963	928
EPCMU 09 Record Smoking Status	91	12	29	1%	4069	4040
EPCMU 10 Clinical Decision Support Rule					4069	
EPCMU 11 Electronic Copy of Health Information	97	8	3138	78%	4043	905
EPCMU 12 Clinical Summaries	83	15	44	1%	4069	4025
EPCMU 13 Protect Electronic Health Information					4069	

Menu MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. The number of deferrals is the count of providers who did not select the measure and the percentage is the percent of providers who did not select the measure.

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 01 Drug Formulary Checks			519	19%	1276	31%	2793	2274
EPMMU 02 Clinical Lab Test Results	88	15	172	5%	791	19%	3278	3106
EPMMU 03 Patient Lists					1872	46%	2197	
EPMMU 04 Patient Reminders	62	26	99	14%	3359	83%	710	611
EPMMU 05 Patient Electronic Access	74	28	50	6%	3210	79%	859	809
EPMMU 06 Patient Specific Education Resources	64	29			984	24%	3085	

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 07 Medication Reconciliation	88	13	256	12%	1946	48%	2123	1867
EPMMU 08 Transitions of Care Summary	0	0	1	100%	4068	100%	1	0
EPMMU 09 Immunization Registries Data Submission			853	26%	746	18%	3323	2470
EPMMU 10 Syndromic Surveillance Data Submission			935	89%	3024	74%	1045	110

Stage 1 MU Measure Data 2014

Instructions: Enter the total number of providers who received payment for PY 2014 Stage 1 MU definitions since the inception of the program through March 31st of the current year.

Total Unduplicated Providers (EPs) to ever receive payment for 2014 Program year stage 1 MU definitions	2323

Core MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may enter zero. "Exclusion %" and "# of unique providers who met the Threshold" will be automatically calculated.

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 01 CPOE for Medication Orders	94	12	211	9%	2323	2112
EPCMU 01 CPOE for Medication Orders (Alternate Measure)	94	12	125	5%	2323	2198
EPCMU 02 Drug Interaction Checks					2323	
EPCMU 03 Maintain Problem List	97	5			2323	
EPCMU 04 ePrescribing	91	12	454	20%	2323	1869

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 05 Active Medication Problem List	97	4			2323	
EPCMU 06 Medication Allergy List	98	4			2323	
EPCMU 07 Record Demographics	96	9			2323	
EPCMU 08 Record Vital Signs	96	17	160	7%	2323	2163
EPCMU 09 Record Smoking Status	95	8	26	1%	2323	2297
EPCMU 10 Clinical Decision Support Rule					2323	
EPCMU 11 Patient Electronic Access	0	0	0	0%	2323	2323
EPCMU 12 Clinical Summaries	85	16	207	9%	2323	2116
EPCMU 13 Protect Electronic Health Information					2323	

Menu MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. The number of deferrals is the count of providers who did not select the measure and the percentage is the percent of providers who did not select the measure.

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 01 Drug Formulary Checks			126	7%	0	0%	1774	1648
EPMMU 02 Clinical Lab Test Results	92	13	93	5%	0	0%	1961	1868
EPMMU 03 Patient Lists					0	0%	1397	
EPMMU 04 Patient Reminders	58	25	90	10%	0	0%	911	821
EPMMU 05 Patient Specific Education Resources	73	30			0	0%	1960	

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 06 Medication Reconciliation	90	13	81	5%	0	0%	1643	1562
EPMMU 07 Transitions of Care Summary	88	15	180	26%	0	0%	680	500
EPMMU 08 Immunization Registries Data Submission			211	10%	0	0%	2139	1928
EPMMU 9 Syndromic Surveillance Data Submission			257	45%	0	0%	569	312

Stage 2 MU Measure Data 2014

Instructions: Enter the total number of providers who receive payment for PY 2014 Stage 2 MU definitions since the inception of the program through March 31st of the current year.

Total Unduplicated Providers (EPs) to ever receive payment for 2014 Program year stage 2 MU definitions	359

Core MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may leave it blank.

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EP2CMU 01 CPOE for Medication Orders - Measure 1	98	5	62	0.17	359	297

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EP2CMU 01 CPOE for Radiology Orders - Measure 2	90	13	90	0.25	359	269
EP2CMU 01 CPOE for Laboratory Orders - Measure 3	97	8	227	0.63	359	132
EP2CMU 02 ePrescribing	88	9	72	0.2	359	287
EP2CMU 03 Record Demographics	97	5			359	
EP2CMU 04 Record Vital Signs	98	3	29	0.08	359	330
EP2CMU 05 Record Smoking Status	97	4	0	0	359	359
EP2CMU 06 Clinical Decision Support – Measure 1					359	
EP2CMU 06 CDS – Drug Interaction Checks – Measure 2			72	0.2	359	287
EP2CMU 07 Provide patients the ability to view online, download, and transmit health information – Measure 1	93	9	24	0.07	359	335

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EP2CMU 07 Provide patients the ability to view online, download, and transmit health information – Measure 2 - Patient Accessed the data	0	0	0	0	359	359
EP2CMU 08 Clinical Summaries	86	13	4	0.01	359	355
EP2CMU 09 Protect Electronic Health Information					359	
EP2CMU 10 Clinical Lab – Test Results	34	20	45	0.13	359	314
EP2CMU 11 Patient Lists					0	
EP2CMU 12 Preventative Care	88	21	2	0.01	359	357
EP2CMU 13 Patient -Specific Education Resources	88	21	2	0.01	359	357
EP2CMU 14 Medication Reconciliation	93	12	15	0.04	359	344
EP2CMU 15 Summary of Care – Measure 1	0	0	0	0	0	0

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EP2CMU 15 Summary of Care – Measure 2	0	0	0	0	0	0
EP2CMU 15 Summary of Care – Measure 3			0	0	0	0
EP2CMU 16 Immunization Registries Data Submission			0	0	0	0
EP2CMU 17 Use Secure Electronic Messaging	0	0	0	0	0	0

Menu MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. The number of deferrals is the count of providers who did not select the measure and the percentage is the percent of providers who did not select the measure.

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EP2MMU 01 Syndromic Surveillance Data Submission			70	0.31	0	0%	223	153
EP2MMU 02 Electronic Notes	99	5	0	0	0	0%	358	358

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EP2MMU 03 Imaging Results	79	30	59	0.32	0	0%	183	124
EP2MMU 04 Family Health History	57	22	2	0.01	0	0%	356	354
EP2MMU 05 Report Cancer Cases			62	0.93	0	0%	67	5
EP2MMU 06 Report Specific Cases			60	0.69	0	0%	87	27

MU Measures Data 2015

Instructions: Enter the total number of providers who received payment for PY 2015 MU definitions since the inception of the program through March 31st of the current year

Total Unduplicated Providers (EPs) to ever receive payment for 2015 Program year MU definitions	3791

MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may leave it blank.

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 01 Protect Patient Health Information					3791	
EPMU 02 Clinical Decision Support (Measure 1; Scheduled Stage 1)					3791	
EPMU 02 Clinical Decision Support (Measure 1; Scheduled Stage 2)					3791	
EPMU 02 Clinical Decision Support (Measure 2; Scheduled for Stage 1 and Stage 2)			609	16%	3791	3182
EPMU 03 CPOE (Measure 1; Scheduled Stage 1 Original)	96	7	173	11%	1583	1410
EPMU 03 CPOE (Measure 1; Scheduled Stage 1 Alternate)	89	19	790	50%	1583	793
EPMU 03 CPOE (Measure 1; Scheduled Stage 2)	91	14	286	18%	1583	1297

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 03 CPOE (Measure 2; Scheduled Stage 1 and Stage 2)	96	10	411	26%	1583	1172
EPMU 03 CPOE (Measure 3; Scheduled Stage 1 and Stage 2)	0	0	0	0%	0	0
EPMU 04 ePrescribing (Scheduled Stage 1)	90	12	766	20%	3791	3025
EPMU 04 ePrescribing (Scheduled Stage 2)	0	0	0	0%	0	0
EPMU 05 Health Information Exchange (Scheduled Stage 1 and Stage 2)	42	29	1274	80%	1583	309
EPMU 06 Patient Specific Education (Scheduled Stage 1 and Stage 2)	73	28	12	1%	1583	1571
EPMU 07 Medication Reconciliation (Scheduled Stage 1 and Stage 2)	89	14	130	8%	1583	1453

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 08 Patient Electronic Access (Measure 1: Scheduled Stage 1 and Stage 2)	21	23	51	3%	1583	1532
EPMU 08 Patient Electronic Access (Measure 2; Scheduled Stage 1 and Stage 2)	86	16	31	2%	1583	1552
EPMU 09 Secure Electronic Messaging (Scheduled Stage 1 and Stage 2)			115	7%	1583	1468
EPMU 10 Public Health Reporting (Measure 1 : Immunization Registry Reporting; Scheduled Stage 1 and Stage 2)			1163	73%	1583	420
EPMU 10 Public Health Reporting (Measure 2: Syndromic Surveillance Reporting; Scheduled Stage 1 and Stage 2)			982	66%	1491	509

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 10 Public Health Reporting (Measure 3: Specialized Registry Reporting; Scheduled Stage 1 and Stage 2)			527	14%	3749	3222
EPMU 10 Public Health Reporting (Measure 3: Specialized Registry Reporting; Scheduled Stage 1 and Stage 2) - 2nd Registry			0	0%	0	0

MU Measures Data 2016

Instructions: Enter the total number of providers who received payment for PY 2016 MU definitions since the inception of the program through March 31st of the current year.

Total Unduplicated Providers (EPs) to ever receive payment for 2015 Program year MU definitions	372

MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may leave it blank.

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 01 Protect Patient Health Information					372	
EPMU 02 Clinical Decision Support (Measure 1; Scheduled Stage 1 and Stage 2)					372	
EPMU 02 Clinical Decision Support (Measure 2; Scheduled for Stage 1 and Stage 2)			40	11%	372	332
EPMU 03 CPOE (Measure 1; Scheduled Stage 1 and Stage 2)	93	13	109	49%	372	112
EPMU 03 CPOE (Measure 2; Scheduled Stage 1 and Stage 2)	98	5	33	9%	372	339

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 03 CPOE (Measure 3; Scheduled Stage 1 and Stage 2)	92	14	37	17%	372	184
EPMU 04 ePrescribing (Scheduled Stage 1 and Stage 2)	88	11	38	10%	372	334
EPMU 05 Health Information Exchange (Scheduled Stage 1 and Stage 2)	36	25	256	69%	372	116
EPMU 06 Patient Specific Education (Scheduled Stage 1 and Stage 2)	65	30	7	2%	372	365
EPMU 07 Medication Reconciliation (Scheduled Stage 1 and Stage 2)	88	14	28	8%	372	344

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 08 Patient Electronic Access (Measure 1: Scheduled Stage 1 and Stage 2)	15	17	10	3%	372	362
EPMU 08 Patient Electronic Access (Measure 2; Scheduled Stage 1 and Stage 2)	82	15	14	4%	372	358
EPMU 09 Secure Electronic Messaging (Scheduled Stage 1 and Stage 2)			10	3%	372	362
EPMU 10 Public Health Reporting (Measure 1 : Immunization Registry Reporting; Scheduled Stage 1 and Stage 2)			297	96%	308	11

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 10 Public Health Reporting (Measure 2: Syndromic Surveillance Reporting; Scheduled Stage 1 and Stage 2)			200	55%	362	162
EPMU 10 Public Health Reporting (Measure 3: Specialized Registry Reporting; Scheduled Stage 1 and Stage 2)			78	22%	358	280
EPMU 10 Public Health Reporting (Measure 3: Specialized Registry Reporting; Scheduled Stage 1 and Stage 2) - 2nd Registry			0	0%	0	0

Core and Alternative Core Clinical Quality Measures Entry 2011-2013

Total Unduplicated Providers(EPs) to ever receive payment for 2011-2013 CQM definitions	5346

Core Clinical Quality Measures

Instructions: Provide the statistical data listed in the headings below for the aggregate measure data for each core clinical quality measure. The statistical data average, standard deviation, lowest and highest is representative of the aggregate measure responses to meet the threshold. Please note that exclusion count and percentage represents the providers who entered data for an exclusion on the measure (when applicable) that was greater than 0.

Core Clinical Quality Measures	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of providers who entered 0 in the denominator
CCQM 1 - NQF 0013 Hypertension: Blood Pressure Measurement	95	15			3212
CCQM 2 - NQF 0028 a. Tobacco Use Assessment	87	23			1707
CCQM 2 - NQF 0028 b. Tobacco Cessation Intervention	53	33			3892
CCQM 3 - NQF 0421 Adult Weight Screening and Follow-up (Population 1)	52	32	1223	0%	3059
CCQM 3 - NQF 0421 Adult Weight Screening and Follow-up (Population 2)	43	24	1996	0%	2114

Alternate Core Clinical Quality Measures

Instructions: Provide the statistical data listed in the headings below for the aggregate measure data for each alternate core clinical quality measure selected by a provider during attestation. The statistical data average and standard deviation is representative of the aggregate measure responses to meet the threshold. Please note that Exclusion count and percentage represents the providers who entered data for an exclusion on the measure (when applicable) that was greater than 0. The # of unduplicated providers who selected column refers to the count of unique providers who selected the measure.

Alternate Core Clinical Quality Measures	Average	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 1	86	23			2549	717
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population - 1 Numerator 2	38	31			2549	1130
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 3	38	34			2549	1188

Alternate Core Clinical Quality Measures	Average	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 1	84	25			2549	964
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 2	36	31			2549	1331
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 3	34	34			0	1374
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 1	86	23			2549	807
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 2	37	30			2549	1237

Alternate Core Clinical Quality Measures	Average	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 3	36	30			2549	1372
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 1	0	0			0	0
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 2	62	28			1474	601
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 3	61	29			1474	622
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 4	58	33			1474	550

Alternate Core Clinical Quality Measures	Average	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 5	60	34			1474	622
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 6	66	31			1474	600
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 7	70	29			1474	511
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 8	66	28			1474	602
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 9	46	31			1474	605

Alternate Core Clinical Quality Measures	Average	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 10	69	28			1474	592
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 11	59	28			1474	624
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 12	50	31			1474	683
ACCQM 3 - NQF 0041 Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	39	29	37		1434	1257

Additional Clinical Quality Measure Selection 2011-2013
Instructions: Select the clinical quality measures from the list below for which providers have submitted clinical quality measures (CQM) data including those responded to as zero. If you wish to enter from a complete list of CQMs you may click on the Select All link below to choose all the CQMs listed. The selected CQMs will be on the following screen to allow entry of the data for those measures.

Measure	Title
NQF 0001	Asthma Assessment
NQF 0002	Appropriate Testing for Children with Pharyngitis
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 1 - Numerator 1
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 1 - Numerator 2
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 2 - Numerator 1
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 2 - Numerator 2
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 3 - Numerator 1
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 3 - Numerator 2
NQF 0012	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
NQF 0014	Prenatal Care: Anti-D Immune Globulin
NQF 0018	Controlling High Blood Pressure
NQF 0027a	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit
NQF 0027b	Smoking and Tobacco Use Cessation, Medical assistance: b. Discussing Smoking and Tobacco Use Cessation Medications or c. Discussing Smoking and Tobacco Use Cessation Strategies
NQF 0031	Breast Cancer Screening

Measure	Title
NQF 0032	Cervical Cancer Screening
NQF 0033	Chlamydia Screening for Women Population 1
NQF 0033	Chlamydia Screening for Women Population 2
NQF 0033	Chlamydia Screening for Women Population 3
NQF 0034	Colorectal Cancer Screening
NQF 0036	Use of Appropriate Medications for Asthma Population 1
NQF 0036	Use of Appropriate Medications for Asthma Population 2
NQF 0036	Use of Appropriate Medications for Asthma Population 3
NQF 0043	Pneumonia Vaccination Status for Older Adults
NQF 0047	Asthma Pharmacologic Therapy
NQF 0052	Low Back Pain: Use of Imaging Studies
NQF 0055	Diabetes: Eye Exam
NQF 0056	Diabetes: Foot Exam
NQF 0059	Diabetes: Hemoglobin A1c Poor Control
NQF 0061	Diabetes: Blood Pressure Management
NQF 0062	Diabetes: Urine Screening
NQF 0064	Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 1
NQF 0064	Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 2
NQF 0067	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
NQF 0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
NQF 0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
NQF 0073	Ischemic Vascular Disease (IVD): Blood Pressure Management
NQF 0074	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol

Measure	Title
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 1
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 2
NQF 0081	Heart Failure (HF): Angiotensin- Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
NQF 0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
NQF 0084	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
NQF 0086	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
NQF 0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
NQF 0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
NQF 0105	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 1
NQF 0105	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 2
NQF 0385	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
NQF 0387	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
NQF 0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
NQF 0575	Diabetes: Hemoglobin A1c Control (<8.0%)

Additional Clinical Quality Measures Data Entry 2011-2013

Total Unduplicated Providers(EPs) to ever receive payment for 2011-2013 CQM definitions	5346

Instructions: Provide the statistical data listed in the headings below for the aggregate measure data for each alternate core clinical quality measure selected by a provider during attestation. The statistical data average and standard deviation is representative of the aggregate measure responses to meet the threshold. Please note that exclusion count and percentage represents the providers who entered data for an exclusion on the measure (when applicable) that was greater than 0. The # of unduplicated providers who selected column refers to the count of unique providers who selected the measure.

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 1 - NQF 0001 Asthma Assessment	53	35			1451	1059
ACQM 2 - NQF 0002 Appropriate Testing for Children with Pharyngitis	69	30			1280	391
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 1 - Numerator 1	58	35			92	71

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 1 - Numerator 2	41	30			92	74
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 2 - Numerator 1	55	41			92	71
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 2 - Numerator 2	39	36			92	74
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 3 - Numerator 1	51	41			92	69
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 3 - Numerator 2	30	34			92	72

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 4 - NQF 0012 Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	81	25	2		112	62
ACQM 5 - NQF 0014 Prenatal Care: Anti-D Immune Globulin	89	24	1		26	16
ACQM 6 - NQF 0018 Controlling High Blood Pressure	64	19			1889	293
ACQM 7 - NQF 0027 a Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit	25	31	0		797	281
ACQM 7 - NQF 0027 b Smoking and Tobacco Use Cessation, Medical assistance: b. Discussing Smoking and Tobacco Use Cessation Medications or c. Discussing Smoking and Tobacco Use Cessation Strategies	22	22	0		170	70

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 8 - NQF 0031 Breast Cancer Screening	39	27			1617	366
ACQM 9 - NQF 0032 Cervical Cancer Screening	52	26			1732	234
ACQM 10 - NQF 0033 Chlamydia Screening for Women Population 1	62	32	156		954	259
ACQM 10 - NQF 0033 Chlamydia Screening for Women Population 2	65	32	85		954	371
ACQM 10 - NQF 0033 Chlamydia Screening for Women Population 3	69	30	89		954	403
ACQM 11 - NQF 0034 Colorectal Cancer Screening	25	22	263		688	87
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 1	62	26	189		1376	201
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 2	59	27	205		1376	202
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 3	60	26	298		1376	133

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 13 - NQF 0043 Pneumonia Vaccination Status for Older Adults	47	28			660	127
ACQM 14 - NQF 0047 Asthma Pharmacologic Therapy	82	20	23		1366	245
ACQM 15 - NQF 0052 Low Back Pain: Use of Imaging Studies	94	17			142	15
ACQM 16 - NQF 0055 Diabetes: Eye Exam	46	36	25		253	130
ACQM 17 - NQF 0056 Diabetes: Foot Exam	41	27	100		447	149
ACQM 18 - NQF 0059 Diabetes: Hemoglobin A1c Poor Control	31	31	543		2244	513
ACQM 19 - NQF 0061 Diabetes: Blood Pressure Management	52	27	572		2496	378
ACQM 20 - NQF 0062 Diabetes: Urine Screening	73	24	118		460	24
ACQM 21 - NQF 0064 Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 1	33	23	543		1840	538

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 21 - NQF 0064 Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 2	21	17	0		1840	607
ACQM 22 - NQF 0067 Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	85	23	14		133	17
ACQM 23 - NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	74	19			245	14
ACQM 24 - NQF 0070 Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	91	20	5		44	8
ACQM 25 - NQF 0073 Ischemic Vascular Disease (IVD): Blood Pressure Management	80	18			137	3

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 26 - NQF 0074 Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	79	19	11		59	10
ACQM 27 - NQF 0075 Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 1	58	25			33	6
ACQM 27 - NQF 0075 Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 2	43	19			33	9
ACQM 28 - NQF 0081 Heart Failure (HF): Angiotensin- Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	100	0	0		3	2

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 29 - NQF 0083 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	100	0	0		5	4
ACQM 30 - NQF 0084 Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation	72	27	2		10	3
ACQM 31 - NQF 0086 Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	83	25	1		25	4
ACQM 32 - NQF 0088 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	73	32	1		30	10
ACQM 33 - NQF 0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	94	12	1		14	9

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 34 - NQF 0105 Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 1	73	32			12	3
ACQM 34 - NQF 0105 Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 2	64	30	0		12	4
ACQM 35 - NQF 0385 Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	0	0	0		4	4
ACQM 36 - NQF 0387 Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	0	0	4		6	6

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 37 - NQF 0389 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	97	0	1		4	3
ACQM 38 - NQF 0575 Diabetes: Hemoglobin A1c Control (<8.0%)	36	23	242		1029	156

Clinical Quality Measure Selection 2014
Instructions: Select the clinical quality measures from the list below for which providers have submitted clinical quality measure (CQM) data including those responded to as zero. If you wish to enter from the complete list of CQMs you may click on the Select All Link Below to Choose all the CQMs listed. The selected CQMs will be on the following screen to allow entry of the data for the measures.

Measure	Title
CMS 146	Appropriate Testing for Children with Pharyngitis
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 1 - Numerator 1
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 1 - Numerator 2
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 2 - Numerator 1
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 2 - Numerator 2

Measure	Title
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 3 - Numerator 1
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 3 - Numerator 2
CMS 165	Controlling High Blood Pressure
CMS 156	Use of High-Risk Medications in the Elderly - Numerator 1
CMS 156	Use of High-Risk Medications in the Elderly - Numerator 2
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 1 - Numerator 1
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 1 - Numerator 2
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 1 - Numerator 3
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 2 - Numerator 1
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 2 - Numerator 2
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 2 - Numerator 3
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 3 - Numerator 1
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 3 - Numerator 2
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 3 - Numerator 3
CMS 138	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure	Title
CMS 125	Breast Cancer Screening
CMS 124	Cervical Cancer Screening
CMS 153	Chlamydia Screening for Women - Stratum 1
CMS 153	Chlamydia Screening for Women - Stratum 2
CMS 153	Chlamydia Screening for Women - Stratum 3
CMS 130	Colorectal Cancer Screening
CMS 126	Use of Appropriate Medications for Asthma - Stratum 1
CMS 126	Use of Appropriate Medications for Asthma - Stratum 2
CMS 126	Use of Appropriate Medications for Asthma - Stratum 3
CMS 126	Use of Appropriate Medications for Asthma - Stratum 4
CMS 126	Use of Appropriate Medications for Asthma - Stratum 5
CMS 117	Childhood Immunization Status
CMS 147	Preventive Care and Screening: Influenza Immunization
CMS 127	Pneumonia Vaccination Status for Older Adults
CMS 166	Use of Imaging Studies for Low Back Pain
CMS 131	Diabetes: Eye Exam
CMS 123	Diabetes: Foot Exam
CMS 122	Diabetes: Hemoglobin A1c Poor Control
CMS 148	Hemoglobin A1c Test for Pediatric Patients
CMS 134	Diabetes: Urine Protein Screening
CMS 163	Diabetes: Low Density Lipoprotein (LDL) Management

Measure	Title
CMS 164	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
CMS 154	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
CMS 145	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) - Population 1
CMS 145	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) - Population 2
CMS 182	Ischemic Vascular Disease(IVD): Complete Lipid Panel and LDL Control - Numerator 1
CMS 182	Ischemic Vascular Disease(IVD): Complete Lipid Panel and LDL Control - Numerator 2
CMS 135	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS 144	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS 143	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
CMS 167	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
CMS 142	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
CMS 139	Falls: Screening for Future Fall Risk
CMS 161	Major Depressive Disorder (MDD): Suicide Risk Assessment
CMS 128	Anti-depressant Medication Management - Numerator 1
CMS 128	Anti-depressant Medication Management - Numerator 2
CMS 136	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Population 1
CMS 136	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Population 2

Measure	Title
CMS 169	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
CMS 157	Oncology: Medical and Radiation – Pain Intensity Quantified
CMS 141	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
CMS 140	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
CMS 129	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
CMS 62	HIV/AIDS: Medical Visit
CMS 52	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis - Population 1
CMS 52	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis - Population 2
CMS 52	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis - Population 3
CMS 77	HIV/AIDS: RNA control for Patients with HIV
CMS 2	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
CMS 68	Documentation of Current Medications in the Medical Record
CMS 69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up - Population 1
CMS 69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up - Population 2
CMS 132	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
CMS 133	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
CMS 158	Pregnant women that had HBsAg testing
CMS 159	Depression Remission at Twelve Months
CMS 160	Depression Utilization of the PHQ-9 Tool - Population 1
CMS 160	Depression Utilization of the PHQ-9 Tool - Population 2

Measure	Title
CMS 160	Depression Utilization of the PHQ-9 Tool - Population 3
CMS 75	Children who have dental decay or cavities
CMS 177	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
CMS 82	Maternal depression screening
CMS 74	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Stratum 1
CMS 74	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Stratum 2
CMS 74	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Stratum 3
CMS 61	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed - Population 1
CMS 61	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed - Population 2
CMS 61	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed - Population 3
CMS 64	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) - Population 1
CMS 64	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) - Population 2
CMS 64	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) - Population 3
CMS 149	Dementia: Cognitive Assessment
CMS 65	Hypertension: Improvement in blood pressure

Measure	Title
CMS 50	Closing the referral loop: receipt of specialist report
CMS 66	Functional status assessment for knee replacement
CMS 56	Functional status assessment for hip replacement
CMS 90	Functional status assessment for complex chronic conditions
CMS 179	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range
CMS 22	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Clinical Quality Measures Data Entry 2014

Total Unduplicated Providers(EPs) to ever receive payment for 2014 CQM definitions	5180

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Clinical Quality Measure selected by a provider during attestation. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold. Please note that Exclusion or Exception count and percentage represents the providers who entered data for an exclusion or exception on the measure (when applicable) that was greater than 0. The # of unduplicated providers who selected column refers to the count of unique providers who selected the measure.

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Appropriate Testing for Children with Pharyngitis	71	28	275				1834	1104
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 1 - Numerator 1	41	30	0				34	29
Initiation and Engagement of Alcohol and Other Drug	41	37	1				34	24

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Dependence Treatment - Stratum 1 - Numerator 2								
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 2 - Numerator 1	41	33	2				34	28
Initiation and Engagement of Alcohol and Other Drug Dependence	45	35	2				34	28

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Treatment - Stratum 2 - Numerator 2								
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 3 - Numerator 1	43	31	2				34	23
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment -	46	35	2				24	28

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Stratum 3 - Numerator 2								
Controlling High Blood Pressure	59	19	1784				3983	821
Use of High-Risk Medications in the Elderly - Numerator 1	26	22					2361	700
Use of High-Risk Medications in the Elderly - Numerator 2	17	18					2361	1160
Weight Assessment and Counseling	91	16	199				2262	554

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
for Nutrition and Physical Activity for Children and Adolescents - Stratum 1 - Numerator 1								
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 1 - Numerator 2	36	33	188				2261	1163
Weight Assessment and	36	32	193				2262	1243

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 1 - Numerator 3								
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 2 - Numerator 1	90	17	223				2262	459

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 2 - Numerator 2	35	29	213				2262	1198
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	36	28	218				2262	1296

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
- Stratum 2 - Numerator 3								
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 3 - Numerator 1	90	17	361				2262	317
Weight Assessment and Counseling for Nutrition and Physical Activity for	34	30	355				2262	1071

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Children and Adolescents - Stratum 3 - Numerator 3								
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	79	25					5408	790
Breast Cancer Screening	47	25	341				2484	623
Cervical Cancer Screening	38	25	900				2288	608
Chlamydia Screening	59	29	96				1835	1007

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
for Women - Stratum 1								
Chlamydia Screening for Women - Stratum 2	61	30	58				1635	1291
Chlamydia Screening for Women - Stratum 3	59	27	95				1835	886
Colorectal Cancer Screening	28	20	580				1622	324
Use of Appropriate Medications for Asthma - Stratum 1	74	29	47				898	590
Use of Appropriate Medications	77	27	37				898	643

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
for Asthma - Stratum 2								
Use of Appropriate Medications for Asthma - Stratum 3	71	27	113				898	798
Use of Appropriate Medications for Asthma - Stratum 4	92	29	28				898	821
Use of Appropriate Medications for Asthma - Stratum 5	71	27	113				898	460
Childhood Immunization Status	35	24					2130	1102

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Preventive Care and Screening: Influenza Immunization	39	25			0	0	3883	658
Pneumonia Vaccination Status for Older Adults	55	27					1528	277
Use of Imaging Studies for Low Back Pain	72	28	521				1194	452
Diabetes: Eye Exam	40	36	27				250	114
Diabetes: Foot Exam	36	28	71				652	310
Diabetes: Hemoglobin	69	32	152				2683	444

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
A1c Poor Control								
Hemoglobin A1c Test for Pediatric Patients	90	22	20				506	264
Diabetes: Urine Protein Screening	73	21	115				1513	157
Diabetes: Low Density Lipoprotein (LDL) Management	33	21	91				932	220
Ischemic Vascular Disease (IVD): Use of Aspirin or Another	74	21					977	76

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Antithrombotic								
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	79	21	1105				2186	531
Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic	73	21			0	0	42	28

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Dysfunction (LVEF <40%) - Population 1								
Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) - Population 2	81	22			0	0	422	28

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Ischemic Vascular Disease(IVD) : Complete Lipid Panel and LDL Control - Numerator 1	65	17					4	0
Ischemic Vascular Disease(IVD) : Complete Lipid Panel and LDL Control - Numerator 2	71	4					4	1
Heart Failure (HF): Angiotensin-Converting Enzyme	86	18			0	0	118	77

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
(ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)								
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	80	26			0	0	49	40

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	76	31			0	0	47	19
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	82	29			0	0	45	31
Diabetic Retinopathy: Communication with the	75	31			0	0	78	55

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Physician Managing Ongoing Diabetes Care								
Falls: Screening for Future Fall Risk	56	34			0	0	586	220
Major Depressive Disorder (MDD): Suicide Risk Assessment	65	29					30	25
Anti-depressant Medication Management - Numerator 1	50	33			0	0	158	121

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Anti-depressant Medication Management - Numerator 2	47	34			0	0	158	123
ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Population 1	67	34	58				322	208
ADHD: Follow-Up Care for	79	30	18				322	268

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Population 2								
Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	73	38					114	111
Oncology: Medical and Radiation –	67	36					79	58

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Pain Intensity Quantified								
Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	0	0			0	0	7	7
Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR)	100	0			0	0	8	7

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Positive Breast Cancer								
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	0	0			0	0	30	30
HIV/AIDS: Medical Visit	71	32					65	53
HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP)	100	0			0	0	65	53

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Prophylaxis - Population 1								
HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis - Population 2	0	0			0	0	8	6
HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis - Population 3	0	0					8	8
HIV/AIDS: RNA control	84	15					20	14

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
for Patients with HIV								
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	27	26	679		0	0	2331	1221
Documentation of Current Medications in the Medical Record	78	27			8	8	4497	638
Preventive Care and Screening: Body Mass	52	23	482				3945	1675

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Index (BMI) Screening and Follow-Up - Population 1								
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up - Population 2	43	24	1392				3945	684
Cataracts: Complications within 30 Days Following Cataract Surgery	75	43	14				154	150

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Requiring Additional Surgical Procedures								
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	90	17	3				35	23
Pregnant women that had HBsAg testing	89	16			0	0	123	40
Depression Remission at Twelve Months	43	27	18				83	32

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Depression Utilization of the PHQ-9 Tool - Population 1	45	28	12				83	46
Depression Utilization of the PHQ-9 Tool - Population 2	40	25	19				83	43
Depression Utilization of the PHQ-9 Tool - Population 3	0	0	0				0	0
Children who have dental decay or cavities	11	24					1717	679
Child and Adolescent	76	36					74	64

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Major Depressive Disorder: Suicide Risk Assessment								
Maternal depression screening	71	23					113	72
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Stratum 1	47	34					712	468
Primary Caries	43	37					712	481

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Prevention Intervention as Offered by Primary Care Providers, including Dentists - Stratum 2								
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Stratum 3	36	35					712	512

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed - Population 1	45	25	137		0	0	479	227
Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed - Population 2	33	25	78		0	0	479	280

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed - Population 3	43	29	208		0	0	479	196
Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) - Population 1	62	22	43		0	0	238	81

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) - Population 2	71	23	23		0	0	238	63
Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein	88	12	96		0	0	238	35

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
(LDL-C) - Population 3								
Dementia: Cognitive Assessment	69	31			0	0	39	27
Hypertension: Improvement in blood pressure	56	34	35				227	173
Closing the referral loop: receipt of specialist report	32	30					1728	985
Functional status assessment for knee replacement	100	0	1				64	61

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Functional status assessment for hip replacement	92	15	1				45	41
Functional status assessment for complex chronic conditions	68	36	36				499	473
ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	100	100					23	30
Preventive Care and	37	23	776		0	0	1435	268

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of Exceptions	Exception %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
Screening: Screening for High Blood Pressure and Follow-Up Documented								

Appendix 9 – Annual Regional Office Report to CMS, May 2018

Questions	Responses
Report as of Date:	03/31/18
Total Unduplicated Providers Reported:	25501
MU Unduplicated Providers Reported:	20502
Number of FQHCs that operate in your State:	296
Select all MU Data types that will be entered:	
Stage 1 MU_2011/2012	Yes
Stage 1 MU_2013	Yes
Stage 1 MU_2014	Yes
Stage 2 MU_2014	Yes
MU 2015	Yes
MU 2016	Yes
MU Modified Stage 2 2017	Yes
MU Stage 3 2017	Yes

AIU_MU Summary Data

Instructions: Enter the total number of FQHCs which have been assigned a payment by at least one EP (broken down by AIU and MU) since the inception of the state's EHR Incentive Program.

Section 1.1 FQHC	For AIU	For MU
How many unique FQHCs have been assigned a payment by at least one EP from the inception of the program until March 31st	855	430

Medicaid Only Provider Types and Practices

Instructions: Enter the total number of Optometrists and Children's Hospitals who have received AIU and MU payments since the inception of the state's EHR Incentive Program.

Section 1.2 Medicaid Only Provider Types and Practices		
Provider Type	Total # Providers AIU	Total # Providers MU
Optometrist	168	47
Children's Hospital	11	10

Stage 1 MU Measure Data 2011 / 2012
Instructions: Enter the total number of providers who received payment for PY 2011/2012 Stage 1 MU definitions since the inception of the program through March 31st of the current year.

Total Unduplicated Providers (EPs) to ever receive payment for 2011/2012 Program year stage 1 MU definitions	2056

Core MU Measures						
Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may enter zero. "Exclusion %" and "# of unique providers who met the Threshold" will be automatically calculated.						
Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 01 CPOE for Medication Orders	91	13	227	11%	2056	1829
EPCMU 02 Drug Interaction Checks					2056	
EPCMU 03 Maintain Problem List	97	5			2056	
EPCMU 04 ePrescribing	89	13	330	16%	2056	1726
EPCMU 05 Active Medication Problem List	96	5			2056	

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 06 Medication Allergy List	97	4			2056	
EPCMU 07 Record Demographics	94	10			2056	
EPCMU 08 Record Vital Signs	91	10	37	2%	2056	2019
EPCMU 09 Record Smoking Status	89	12	10	0%	2056	2046
EPCMU 10 Clinical Quality Measures					2056	
EPCMU 11 Clinical Decision Support Rule					2056	
EPCMU 12 Electronic Copy of Health Information	98	7	1606	78%	2056	450
EPCMU 13 Clinical Summaries	81	15	26	1%	2056	2030
EPCMU 14 Electronic Exchange of Clinical Information					2056	
EPCMU 15 Protect Electronic Health Information					2056	

Menu MU Measures								
Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. The number of deferrals is the count of providers who did not select the measure and the percentage is the percent of providers who did not select the measure.								
Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 01 Drug Formulary Checks			248	17%	622	30%	1434	1186
EPMMU 02 Clinical Lab Test Results	91	14	53	3%	455	22%	1601	1548
EPMMU 03 Patient Lists					863	42%	1193	
EPMMU 04 Patient Reminders	66	26	50	16%	1740	85%	316	266
EPMMU 05 Patient Electronic Access	90	21	32	5%	1430	70%	626	594

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 06 Patient Specific Education Resources	64	28			640	31%	1416	
EPMMU 07 Medication Reconciliation	89	14	101	10%	1072	52%	984	883
EPMMU 08 Transitions of Care Summary	90	13	122	27%	1600	78%	456	334
EPMMU 09 Immunization Registries Data Submission			690	45%	515	25%	1541	851
EPMMU 10 Syndromic Surveillance Data Submission			650	92%	1353	66%	703	53

Stage 1 MU Measure Data 2013

Instructions: Enter the total number of providers who received payment for PY 2013 Stage 1 MU definitions since the inception of the program through March 31st of the current year

Total Unduplicated Providers (EPs) to ever receive payment for 2013 Program year stage 1 MU definitions	4069

Core MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may enter zero. “Exclusion %” and “# of unique providers who met the Threshold” will be automatically calculated.

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 01 CPOE for Medication Orders	93	12	383	13%	2993	2610
EPCMU 01 CPOE for Medication Orders (Alternate Measure)	92	12	0	0%	1076	1076
EPCMU 02 Drug Interaction Checks					4069	
EPCMU 03 Maintain Problem List	98	4			4069	
EPCMU 04 ePrescribing	90	13	601	15%	4069	3468
EPCMU 05 Active Medication Problem List	97	4			4069	

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 06 Medication Allergy List	98	4			4069	
EPCMU 07 Record Demographics	95	9			4069	
EPCMU 08 Record Vital Signs	93	9	64	2%	3106	3042
EPCMU 08 Record Vital Signs (Alternate Measure)	93	9	35	4%	963	928
EPCMU 09 Record Smoking Status	91	12	29	1%	4069	4040
EPCMU 10 Clinical Decision Support Rule					4069	
EPCMU 11 Electronic Copy of Health Information	97	8	3138	78%	4043	905

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 12 Clinical Summaries	83	15	44	1%	4069	4025
EPCMU 13 Protect Electronic Health Information					4069	

Menu MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. The number of deferrals is the count of providers who did not select the measure and the percentage is the percent of providers who did not select the measure.

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 01 Drug Formulary Checks			519	19%	1276	31%	2793	2274
EPMMU 02 Clinical Lab Test Results	88	15	172	5%	791	19%	3278	3106
EPMMU 03 Patient Lists					1872	46%	2197	
EPMMU 04 Patient Reminders	62	26	99	14%	3359	83%	710	611
EPMMU 05 Patient Electronic Access	74	28	50	6%	3210	79%	859	809
EPMMU 06 Patient Specific Education Resources	64	29			984	24%	3085	
EPMMU 07 Medication Reconciliation	88	13	256	12%	1946	48%	2123	1867

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 08 Transitions of Care Summary	0	0	1	100%	4068	100%	1	0
EPMMU 09 Immunization Registries Data Submission			853	26%	746	18%	3323	2470
EPMMU 10 Syndromic Surveillance Data Submission			935	89%	3024	74%	1045	110

Stage 1 MU Measure Data 2014

Instructions: Enter the total number of providers who received payment for PY 2014 Stage 1 MU definitions since the inception of the program through March 31st of the current year.

Total Unduplicated Providers (EPs) to ever receive payment for 2014 Program year stage 1 MU definitions	2323

Core MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may enter zero. “Exclusion %” and “# of unique providers who met the Threshold” will be automatically calculated.

Core Meaningful Use Measure	**Average Mean**	**Standard Deviation**	**# of Exclusions**	**Exclusion %**	**# of unique providers attested to the measure**	**# of unique providers who met the threshold**
EPCMU 01 CPOE for Medication Orders	94	12	211	9%	2323	2112
EPCMU 01 CPOE for Medication Orders (Alternate Measure)	94	12	125	5%	2323	2198
EPCMU 02 Drug Interaction Checks					2323	

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 03 Maintain Problem List	97	5			2323	
EPCMU 04 ePrescribing	91	12	454	20%	2323	1869
EPCMU 05 Active Medication Problem List	97	4			2323	
EPCMU 06 Medication Allergy List	98	4			2323	
EPCMU 07 Record Demographics	96	9			2323	
EPCMU 08 Record Vital Signs	96	17	160	7%	2323	2163
EPCMU 09 Record Smoking Status	95	8	26	1%	2323	2297
EPCMU 10 Clinical Decision Support Rule					2323	
EPCMU 11 Patient Electronic Access	0	0	0	0%	2323	2323

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPCMU 12 Clinical Summaries	85	16	207	9%	2323	2116
EPCMU 13 Protect Electronic Health Information					2323	

Menu MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. The number of deferrals is the count of providers who did not select the measure and the percentage is the percent of providers who did not select the measure.

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 01 Drug Formulary Checks			126	7%	0	0%	1774	1648
EPMMU 02 Clinical Lab Test Results	92	13	93	5%	0	0%	1961	1868
EPMMU 03 Patient Lists					0	0%	1397	
EPMMU 04 Patient Reminders	58	25	90	10%	0	0%	911	821
EPMMU 05 Patient Specific Education Resources	73	30			0	0%	1960	
EPMMU 06 Medication Reconciliation	90	13	81	5%	0	0%	1643	1562

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMMU 07 Transitions of Care Summary	88	15	180	26%	0	0%	680	500
EPMMU 08 Immunization Registries Data Submission			211	10%	0	0%	2139	1928
EPMMU 9 Syndromic Surveillance Data Submission			257	45%	0	0%	569	312

Stage 2 MU Measure Data 2014

Instructions: Enter the total number of providers who receive payment for PY 2014 Stage 2 MU definitions since the inception of the program through March 31st of the current year.

Total Unduplicated Providers (EPs) to ever receive payment for 2014 Program year stage 2 MU definitions	359

Core MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may leave it blank.

Core Meaningful Use Measure	**Average Mean**	**Standard Deviation**	**# of Exclusions**	**Exclusion %**	**# of unique providers attested to the measure**	**# of unique providers who met the threshold**
EP2CMU 01 CPOE for Medication Orders - Measure 1	98	5	62	17%	359	297
EP2CMU 01 CPOE for Radiology Orders - Measure 2	90	13	90	25%	359	269
EP2CMU 01 CPOE for Laboratory Orders - Measure 3	97	8	227	63%	359	132
EP2CMU 02 ePrescribing	88	9	72	20%	359	287
EP2CMU 03 Record Demographics	97	5			359	
EP2CMU 04 Record Vital Signs	98	3	29	8%	359	330
EP2CMU 05 Record Smoking Status	97	4	0	0%	359	359

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EP2CMU 06 Clinical Decision Support – Measure 1					359	
EP2CMU 06 CDS – Drug Interaction Checks – Measure 2			72	20%	359	287
EP2CMU 07 Provide patients the ability to view online, download, and transmit health information – Measure 1	93	9	24	7%	359	335
EP2CMU 07 Provide patients the ability to view online, download, and transmit health information – Measure 2 - Patient Accessed the data	0	0	0	0%	359	359
EP2CMU 08 Clinical Summaries	86	13	4	1%	359	355
EP2CMU 09 Protect Electronic Health Information					359	
EP2CMU 10 Clinical Lab – Test Results	34	20	45	13%	359	314
EP2CMU 11 Patient Lists					0	
EP2CMU 12 Preventative Care	88	21	2	1%	359	357
EP2CMU 13 Patient -Specific Education Resources	88	21	2	1%	359	357
EP2CMU 14 Medication Reconciliation	93	12	15	4%	359	344

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EP2CMU 15 Summary of Care – Measure 1	0	0	0	0%	0	0
EP2CMU 15 Summary of Care – Measure 2	0	0	0	0%	0	0
EP2CMU 15 Summary of Care – Measure 3			0	0%	0	0
EP2CMU 16 Immunization Registries Data Submission			0	0%	0	0
EP2CMU 17 Use Secure Electronic Messaging	0	0	0	0%	0	0

Menu MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. The number of deferrals is the count of providers who did not select the measure and the percentage is the percent of providers who did not select the measure.

Menu Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of Deferrals	Deferral %	# of unique providers attested to the measure	# of unique providers who met the threshold
EP2MMU 01 Syndromic Surveillance Data Submission			70	31%	0	0%	223	153
EP2MMU 02 Electronic Notes	99	5	0	0%	0	0%	358	358
EP2MMU 03 Imaging Results	79	30	59	32%	0	0%	183	124
EP2MMU 04 Family Health History	57	22	2	1%	0	0%	356	354
EP2MMU 05 Report Cancer Cases			62	93%	0	0%	67	5
EP2MMU 06 Report Specific Cases			60	69%	0	0%	87	27

MU Measures Data 2015

Instructions: Enter the total number of providers who received payment for PY 2015 MU definitions since the inception of the program through March 31st of the current year

Total Unduplicated Providers (EPs) to ever receive payment for 2015 Program year MU definitions	3791

MU Measures

Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may leave it blank.

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 01 Protect Patient Health Information					3791	
EPMU 02 Clinical Decision Support (Measure 1; Scheduled Stage 1)					3791	
Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers	# of unique providers

					attested to the measure	who met the threshold
EPMU 02 Clinical Decision Support (Measure 1; Scheduled Stage 2)					3791	
EPMU 02 Clinical Decision Support (Measure 2; Scheduled for Stage 1 and Stage 2)			609	16%	3791	3182
EPMU 03 CPOE (Measure 1; Scheduled Stage 1 Original)	96	7	173	11%	1583	1410
EPMU 03 CPOE (Measure 1; Scheduled Stage 1 Alternate)	89	19	790	50%	1583	793
EPMU 03 CPOE (Measure 1; Scheduled Stage 2)	91	14	286	18%	1583	1297
EPMU 03 CPOE (Measure 2; Scheduled Stage 1 and Stage 2)	96	10	411	26%	1583	1172
EPMU 03 CPOE (Measure 3; Scheduled Stage 1 and Stage 2)	0	0	0	0%	0	0
EPMU 04 ePrescribing (Scheduled Stage 1)	90	12	766	20%	3791	3025
EPMU 04 ePrescribing (Scheduled Stage 2)	0	0	0	0%	0	0
EPMU 05 Health Information Exchange (Scheduled Stage 1 and Stage 2)	42	29	1274	80%	1583	309
Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers	# of unique providers

					attested to the measure	who met the threshold
EPMU 06 Patient Specific Education (Scheduled Stage 1 and Stage 2)	73	28	12	1%	1583	1571
EPMU 07 Medication Reconciliation (Scheduled Stage 1 and Stage 2)	89	14	130	8%	1583	1453
EPMU 08 Patient Electronic Access (Measure 1: Scheduled Stage 1 and Stage 2)	21	23	51	3%	1583	1532
EPMU 08 Patient Electronic Access (Measure 2; Scheduled Stage 1 and Stage 2)	86	16	31	2%	1583	1552
EPMU 09 Secure Electronic Messaging (Scheduled Stage 1 and Stage 2)			115	7%	1583	1468
EPMU 10 Public Health Reporting (Measure 1 : Immunization Registry Reporting; Scheduled Stage 1 and Stage 2)			1163	73%	1583	420
EPMU 10 Public Health Reporting (Measure 2: Syndromic Surveillance Reporting; Scheduled Stage 1 and Stage 2)			982	66%	1491	509
EPMU 10 Public Health Reporting (Measure 3: Specialized Registry Reporting; Scheduled Stage 1 and Stage 2)			527	14%	3749	3222

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 10 Public Health Reporting (Measure 3: Specialized Registry Reporting; Scheduled Stage 1 and Stage 2) - 2nd Registry			0	0%	0	0

MU Measures Data 2016

Instructions: Enter the total number of providers who received payment for PY 2016 MU definitions since the inception of the program through March 31st of the current year.

Total Unduplicated Providers (EPs) to ever receive payment for 2015 Program year MU definitions	372

MU Measures						
Instructions: Provide the statistical data listed in the headings below for the Aggregate Measure data for each Meaningful Use Core Measure. The statistical data Average and Standard Deviation is representative of the aggregate measure responses to meet the threshold (yes=100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion. If the state does not have information to enter into a cell, they may leave it blank.						
Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 01 Protect Patient Health Information					372	
EPMU 02 Clinical Decision Support (Measure 1; Scheduled Stage 1 and Stage 2)					372	

EPMU 02 Clinical Decision Support (Measure 2; Scheduled for Stage 1 and Stage 2)			40	11%	372	332
EPMU 03 CPOE (Measure 1; Scheduled Stage 1 and Stage 2)	93	13	109	49%	372	112

Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 03 CPOE (Measure 2; Scheduled Stage 1 and Stage 2)	98	5	33	9%	372	339
EPMU 03 CPOE (Measure 3; Scheduled Stage 1 and Stage 2)	92	14	37	17%	372	184
EPMU 04 ePrescribing (Scheduled Stage 1 and Stage 2)	88	11	38	10%	372	334
EPMU 05 Health Information Exchange (Scheduled Stage 1 and Stage 2)	36	25	256	69%	372	116

EPMU 06 Patient Specific Education (Scheduled Stage 1 and Stage 2)	65	30	7	2%	372	365
EPMU 07 Medication Reconciliation (Scheduled Stage 1 and Stage 2)	88	14	28	8%	372	344
Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 08 Patient Electronic Access (Measure 1: Scheduled Stage 1 and Stage 2)	15	17	10	3%	372	362
EPMU 08 Patient Electronic Access (Measure 2; Scheduled Stage 1 and Stage 2)	82	15	14	4%	372	358

EPMU 09 Secure Electronic Messaging (Scheduled Stage 1 and Stage 2)			10	3%	372	362
EPMU 10 Public Health Reporting (Measure 1 : Immunization Registry Reporting; Scheduled Stage 1 and Stage 2)			297	96%	308	11
Core Meaningful Use Measure	Average Mean	Standard Deviation	# of Exclusions	Exclusion %	# of unique providers attested to the measure	# of unique providers who met the threshold
EPMU 10 Public Health Reporting (Measure 2: Syndromic Surveillance Reporting; Scheduled Stage 1 and Stage 2)			200	55%	362	162
EPMU 10 Public Health Reporting (Measure 3: Specialized Registry Reporting; Scheduled Stage 1 and Stage 2)			78	22%	358	280

EPMU 10 Public Health Reporting (Measure 3: Specialized Registry Reporting; Scheduled Stage 1 and Stage 2) - 2nd Registry			0	0%	0	0

MU Modified Stage 2 2017

INSTRUCTIONS: Enter the total number of providers who received payment for PY 2017 Modified Stage 2 MU definitions since the inception of the program through March 31st of the current year.

State/ Territory/ District	CA
Report As Of Date	03/31/18
Total Unduplicated Providers(EPs) to ever receive payment for 2017 Program year Modified Stage 2 MU definitions	1162

INSTRUCTIONS: Provide the statistical data listed in the headings below for the aggregate measure data for each meaningful use core measure. The statistical data average and standard deviation is representative of the aggregate measure responses to meet the threshold (yes = 100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion.

Meaningful Use (MU) Measure Data for EPs using 2017 Modified Stage 2 Program Year definitions

Objective	Average	Standard Deviation	Exclusions	Exclusion %	Providers who Attested to the Measure	Providers who Met the Threshold
EP2MU 01 Protect Patient Health Information					1162	
EP2MU 02 Clinical Decision Support - Measure 1					1162	
EP2MU 02 Clinical Decision Support - Measure 2			235	20%	1162	927
EP2MU 03 CPOE - Measure 1 (Medication Orders)	98	5	228	20%	1162	934
EP2MU 03 CPOE - Measure 2 (Laboratory Orders)	90	16	299	26%	1162	863
EP2MU 03 CPOE - Measure 3 (Radiology Orders)	90	15	521	45%	1162	641
EP2MU 04 ePrescribing	89	11	271	23%	1162	891
EP2MU 05 Health Information Exchange	37	27	799	69%	1162	363

Objective	Average	Standard Deviation	Exclusions	Exclusion %	Providers who Attested to the Measure	Providers who Met the Threshold
EP2MU 06 Patient-Specific Education	66	33	28	2%	1162	1134
EP2MU 07 Medication Reconciliation	88	13	189	16%	1162	973
EP2MU 08 Patient Electronic Access - Measure 1	84	16	38	3%	1162	1124
EP2MU 08 Patient Electronic Access - Measure 2	18	16	51	4%	1162	1111
EP2MU 09 Secure Electronic Messaging			51	4%	1162	1111
EP2MU 10 Public Health Reporting - Measure 1 (Immunization Registry Reporting)			230	20%	1162	932
EP2MU 10 Public Health Reporting - Measure 2 (Syndromic Surveillance Reporting)			606	83%	731	125
EP2MU 10 Public Health Reporting - Measure 3 (Specialized Registry Reporting)			351	33%	1057	706

Objective	Average	Standard Deviation	Exclusions	Exclusion %	Providers who Attested to the Measure	Providers who Met the Threshold
EP2MU 10 Public Health Reporting - Measure 3 (Specialized Registry Reporting) 2nd Registry			0	0%	0	0

MU Stage 3 2017

INSTRUCTIONS: Enter the total number of providers who received payment for PY 2017 Stage 3 MU definitions since the inception of the program through March 31st of the current year.

State/ Territory/ District	CA
Report As Of Date	03/31/18
Total Unduplicated Providers(EPs) to ever receive payment for 2017 Program year Stage 3 MU definitions	2

INSTRUCTIONS: Provide the statistical data listed in the headings below for the aggregate measure data for each meaningful use core measure. The statistical data average and standard deviation is representative of the aggregate

measure responses to meet the threshold (yes = 100%). The number of exclusions is a count by providers who selected the exclusion and the percentage is the percent of providers who selected an exclusion.

Meaningful Use (MU) Measure Data for EPs using 2017 Program Year definitions

Objective	Average	Standard Deviation	Exclusions	Exclusion %	Providers who Attested to the Measure	Providers who Met the Threshold
EP3MU 01 Protect Patient Health Information					2	
EP3MU 02 Electronic Prescribing	71	0	1	50%	2	1
EP3MU 03 Clinical Decision Support - Measure 1					2	
EP3MU 03 Clinical Decision Support - Measure 2			2	100%	2	0
EP3MU 04 CPOE - Measure 1 (Medication Order)	100	0	1	50%	2	1
EP3MU 04 CPOE - Measure 2 (Laboratory Orders)	100	0	1	50%	2	1
EP3MU 04 CPOE - Measure 3 (Diagnostic Imaging)	100	0	1	50%	2	1

Objective	Average	Standard Deviation	Exclusions	Exclusion %	Providers who Attested to the Measure	Providers who Met the Threshold
EP3MU 05 Patient Electronic Access - Measure 1	96	8	0	0%	2	2
EP3MU 05 Patient Electronic Access - Measure 2	63	36	0	0%	2	2
EP3MU 06 Coordination of Care - Measure 1	9	6	0	0%	2	2
EP3MU 06 Coordination of Care - Measure 2	5	0	0	0%	2	2
EP3MU 06 Coordination of Care - Measure 3	5	0	0	0%	2	2
EP3MU 07 Health Information Exchange - Measure 1	53	0	1	50%	2	1
EP3MU 07 Health Information Exchange - Measure 2	53	0	0	0%	2	2
EP3MU 07 Health Information Exchange - Measure 3	90	14	1	50%	2	1
EP3MU 08 Public Health Reporting - Measure 1 (Immunization Registry Reporting)			1	50%	2	1

Objective	Average	Standard Deviation	Exclusions	Exclusion %	Providers who Attested to the Measure	Providers who Met the Threshold
EP3MU 08 Public Health Reporting - Measure 2 (Syndromic Surveillance Reporting)			1	100%	1	0
EP3MU 08 Public Health Reporting - Measure 3 (Electronic Case Reporting)			1	100%	1	0
EP3MU 08 Public Health Reporting - Measure 4 (Public Health Registry Reporting)			1	100%	1	0
EP3MU 08 Public Health Reporting - Measure 4 (Public Health Registry Reporting) 2nd Registry			1	100%	1	0
EP3MU 08 Public Health Reporting - Measure 5 (Clinical Data Registry Reporting)			1	50%	2	1
EP3MU 08 Public Health Reporting - Measure 5 (Clinical Data Registry Reporting) 2nd Registry			0	0%	0	0

Core and Alternative Core Clinical Quality Measures Entry 2011-2013	
Total Unduplicated Providers(EPs) to ever receive payment for 2011-2013 CQM definitions	5346

Core Clinical Quality Measures
Instructions: Provide the statistical data listed in the headings below for the aggregate measure data for each core clinical quality measure. The statistical data average, standard deviation, lowest and highest is representative of the aggregate measure responses to meet the threshold. Please note that exclusion count and percentage represents the providers who entered data for an exclusion on the measure (when applicable) that was greater than 0.

Core Clinical Quality Measures	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of providers who entered 0 in the denominator
CCQM 1 - NQF 0013 Hypertension: Blood Pressure Measurement	95	15			3212
CCQM 2 - NQF 0028 a. Tobacco Use Assessment	87	23			1707
CCQM 2 - NQF 0028 b. Tobacco Cessation Intervention	53	33			3892
CCQM 3 - NQF 0421 Adult Weight Screening and Follow-up (Population 1)	52	32	1223	0%	3059

Core Clinical Quality Measures	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of providers who entered 0 in the denominator
CCQM 3 - NQF 0421 Adult Weight Screening and Follow-up (Population 2)	43	24	1996	0%	2114

Alternate Core Clinical Quality Measures						
Instructions: Provide the statistical data listed in the headings below for the aggregate measure data for each alternate core clinical quality measure selected by a provider during attestation. The statistical data average and standard deviation is representative of the aggregate measure responses to meet the threshold. Please note that Exclusion count and percentage represents the providers who entered data for an exclusion on the measure (when applicable) that was greater than 0. The # of unduplicated providers who selected column refers to the count of unique providers who selected the measure.						
Alternate Core Clinical Quality Measures	**Average**	**Standard Deviation**	**# of Exclusions**	**Exclusion %**	**# of unduplicated providers who selected**	**# of providers who entered 0 in the denominator**
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 1	86	23			2549	717
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population - 1 Numerator 2	38	31			2549	1130

Alternate Core Clinical Quality Measures	Average	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 1 - Numerator 3	38	34			2549	1188
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 1	84	25			2549	964
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 2	36	31			2549	1331
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 2 - Numerator 3	34	34			0	1374
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 1	86	23			2549	807

Alternate Core Clinical Quality Measures	Average	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 2	37	30			2549	1237
ACCQM 1 - NQF 0024 Weight Assessment and Counseling for Children and Adolescents - Population 3 - Numerator 3	36	30			2549	1372
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 1	0	0			0	0
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 2	62	28			1474	601
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 3	61	29			1474	622
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 4	58	33			1474	550
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 5	60	34			1474	622
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 6	66	31			1474	600
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 7	70	29			1474	511

Alternate Core Clinical Quality Measures	**Average**	**Standard Deviation**	**# of Exclusions**	**Exclusion %**	**# of unduplicated providers who selected**	**# of providers who entered 0 in the denominator**
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 8	66	28			1474	602
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 9	46	31			1474	605
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 10	69	28			1474	592
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 11	59	28			1474	624
ACCQM 2 - NQF 0038 Childhood Immunization Status Numerator 12	50	31			1474	683
ACCQM 3 - NQF 0041 Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	39	29	37		1434	1257

Additional Clinical Quality Measure Selection 2011-2013

Instructions: Select the clinical quality measures from the list below for which providers have submitted clinical quality measures (CQM) data including those responded to as zero. If you wish to enter from a complete list of CQMs you may click on the Select All link below to choose all the CQMs listed. The selected CQMs will be on the following screen to allow entry of the data for those measures.

Measure	Title
NQF 0001	Asthma Assessment
NQF 0002	Appropriate Testing for Children with Pharyngitis
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 1 - Numerator 1
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 1 - Numerator 2
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 2 - Numerator 1
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 2 - Numerator 2

Measure	Title
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 3 - Numerator 1
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 3 - Numerator 2
NQF 0012	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
NQF 0014	Prenatal Care: Anti-D Immune Globulin
NQF 0018	Controlling High Blood Pressure
NQF 0027a	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit
NQF 0027b	Smoking and Tobacco Use Cessation, Medical assistance: b. Discussing Smoking and Tobacco Use Cessation Medications or c. Discussing Smoking and Tobacco Use Cessation Strategies
NQF 0031	Breast Cancer Screening
NQF 0032	Cervical Cancer Screening
NQF 0033	Chlamydia Screening for Women Population 1
NQF 0033	Chlamydia Screening for Women Population 2
NQF 0033	Chlamydia Screening for Women Population 3

Measure	Title
NQF 0034	Colorectal Cancer Screening
NQF 0036	Use of Appropriate Medications for Asthma Population 1
NQF 0036	Use of Appropriate Medications for Asthma Population 2
NQF 0036	Use of Appropriate Medications for Asthma Population 3
NQF 0043	Pneumonia Vaccination Status for Older Adults
NQF 0047	Asthma Pharmacologic Therapy
NQF 0052	Low Back Pain: Use of Imaging Studies
NQF 0055	Diabetes: Eye Exam
NQF 0056	Diabetes: Foot Exam
NQF 0059	Diabetes: Hemoglobin A1c Poor Control
NQF 0061	Diabetes: Blood Pressure Management
NQF 0062	Diabetes: Urine Screening
NQF 0064	Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 1
NQF 0064	Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 2

Measure	Title
NQF 0067	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
NQF 0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
NQF 0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
NQF 0073	Ischemic Vascular Disease (IVD): Blood Pressure Management
NQF 0074	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 1
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 2
NQF 0081	Heart Failure (HF): Angiotensin- Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
NQF 0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
NQF 0084	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
NQF 0086	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

Measure	Title
NQF 0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
NQF 0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
NQF 0105	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 1
NQF 0105	Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 2
NQF 0385	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
NQF 0387	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
NQF 0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
NQF 0575	Diabetes: Hemoglobin A1c Control (<8.0%)

Additional Clinical Quality Measures Data Entry 2011-2013

Total Unduplicated Providers(EPs) to ever receive payment for 2011-2013 CQM definitions	5346

Instructions: Provide the statistical data listed in the headings below for the aggregate measure data for each alternate core clinical quality measure selected by a provider during attestation. The statistical data average and standard deviation is representative of the aggregate measure responses to meet the threshold. Please note that exclusion count and percentage represents the providers who entered data for an exclusion on the measure (when applicable) that was greater than 0. The # of unduplicated providers who selected column refers to the count of unique providers who selected the measure.

Additional Core Meaningful Use Measure	**Average (Mean)**	**Standard Deviation**	**# of Exclusions**	**Exclusion %**	**# of unduplicated providers who selected**	**# of providers who entered 0 in the denominator**
ACQM 1 - NQF 0001 Asthma Assessment	53	35			1451	1059
ACQM 2 - NQF 0002 Appropriate Testing for Children with Pharyngitis	69	30			1280	391
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 1 - Numerator 1	58	35			92	71

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 1 - Numerator 2	41	30			92	74
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 2 - Numerator 1	55	41			92	71
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 2 - Numerator 2	39	36			92	74
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 3 - Numerator 1	51	41			92	69
ACQM 3 - NQF 0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Population 3 - Numerator 2	30	34			92	72

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 4 - NQF 0012 Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)	81	25	2		112	62
ACQM 5 - NQF 0014 Prenatal Care: Anti-D Immune Globulin	89	24	1		26	16
ACQM 6 - NQF 0018 Controlling High Blood Pressure	64	19			1889	293
ACQM 7 - NQF 0027 a Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit	25	31	0		797	281
ACQM 7 - NQF 0027 b Smoking and Tobacco Use Cessation, Medical assistance: b. Discussing Smoking and Tobacco Use Cessation Medications or c. Discussing Smoking and Tobacco Use Cessation Strategies	22	22	0		170	70
ACQM 8 - NQF 0031 Breast Cancer Screening	39	27			1617	366
ACQM 9 - NQF 0032 Cervical Cancer Screening	52	26			1732	234

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 10 - NQF 0033 Chlamydia Screening for Women Population 1	62	32	156		954	259
ACQM 10 - NQF 0033 Chlamydia Screening for Women Population 2	65	32	85		954	371
ACQM 10 - NQF 0033 Chlamydia Screening for Women Population 3	69	30	89		954	403
ACQM 11 - NQF 0034 Colorectal Cancer Screening	25	22	263		688	87
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 1	62	26	189		1376	201
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 2	59	27	205		1376	202
ACQM 12 - NQF 0036 Use of Appropriate Medications for Asthma Population 3	60	26	298		1376	133
ACQM 13 - NQF 0043 Pneumonia Vaccination Status for Older Adults	47	28			660	127
ACQM 14 - NQF 0047 Asthma Pharmacologic Therapy	82	20	23		1366	245

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 15 - NQF 0052 Low Back Pain: Use of Imaging Studies	94	17			142	15
ACQM 16 - NQF 0055 Diabetes: Eye Exam	46	36	25		253	130
ACQM 17 - NQF 0056 Diabetes: Foot Exam	41	27	100		447	149
ACQM 18 - NQF 0059 Diabetes: Hemoglobin A1c Poor Control	31	31	543		2244	513
ACQM 19 - NQF 0061 Diabetes: Blood Pressure Management	52	27	572		2496	378
ACQM 20 - NQF 0062 Diabetes: Urine Screening	73	24	118		460	24
ACQM 21 - NQF 0064 Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 1	33	23	543		1840	538
ACQM 21 - NQF 0064 Diabetes Low Density Lipoprotein (LDL) Management and Control Numerator 2	21	17	0		1840	607
ACQM 22 - NQF 0067 Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD	85	23	14		133	17

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 23 - NQF 0068 Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	74	19			245	14
ACQM 24 - NQF 0070 Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	91	20	5		44	8
ACQM 25 - NQF 0073 Ischemic Vascular Disease (IVD): Blood Pressure Management	80	18			137	3
ACQM 26 - NQF 0074 Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol	79	19	11		59	10
ACQM 27 - NQF 0075 Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 1	58	25			33	6
ACQM 27 - NQF 0075 Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control Numerator 2	43	19			33	9

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 28 - NQF 0081 Heart Failure (HF): Angiotensin- Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	100	0	0		3	2
ACQM 29 - NQF 0083 Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	100	0	0		5	4
ACQM 30 - NQF 0084 Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation	72	27	2		10	3
ACQM 31 - NQF 0086 Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	83	25	1		25	4
ACQM 32 - NQF 0088 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	73	32	1		30	10

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 33 - NQF 0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	94	12	1		14	9
ACQM 34 - NQF 0105 Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 1	73	32			12	3
ACQM 34 - NQF 0105 Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment Numerator 2	64	30	0		12	4
ACQM 35 - NQF 0385 Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	0	0	0		4	4
ACQM 36 - NQF 0387 Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	0	0	4		6	6

Additional Core Meaningful Use Measure	Average (Mean)	Standard Deviation	# of Exclusions	Exclusion %	# of unduplicated providers who selected	# of providers who entered 0 in the denominator
ACQM 37 - NQF 0389 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	97	0	1		4	3
ACQM 38 - NQF 0575 Diabetes: Hemoglobin A1c Control (<8.0%)	36	23	242		1029	156

Clinical Quality Measure Selection 2014

Instructions: Select the clinical quality measures from the list below for which providers have submitted clinical quality measure (CQM) data including those responded to as zero. If you wish to enter from the complete list of CQMs you may click on the Select All Link Below to Choose all the CQMs listed. The selected CQMs will be on the following screen to allow entry of the data for the measures.

Measure	Title
CMS 146	Appropriate Testing for Children with Pharyngitis
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 1 - Numerator 1
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 1 - Numerator 2
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 2 - Numerator 1
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 2 - Numerator 2
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 3 - Numerator 1

Measure	Title
CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Stratum 3 - Numerator 2
CMS 165	Controlling High Blood Pressure
CMS 156	Use of High-Risk Medications in the Elderly - Numerator 1
CMS 156	Use of High-Risk Medications in the Elderly - Numerator 2
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 1 - Numerator 1
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 1 - Numerator 2
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 1 - Numerator 3
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 2 - Numerator 1
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 2 - Numerator 2
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 2 - Numerator 3

Measure	Title
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 3 - Numerator 1
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 3 - Numerator 2
CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents - Stratum 3 - Numerator 3
CMS 138	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
CMS 125	Breast Cancer Screening
CMS 124	Cervical Cancer Screening
CMS 153	Chlamydia Screening for Women - Stratum 1
CMS 153	Chlamydia Screening for Women - Stratum 2
CMS 153	Chlamydia Screening for Women - Stratum 3
CMS 130	Colorectal Cancer Screening
CMS 126	Use of Appropriate Medications for Asthma - Stratum 1
CMS 126	Use of Appropriate Medications for Asthma - Stratum 2
CMS 126	Use of Appropriate Medications for Asthma - Stratum 3

Measure	**Title**
CMS 126	Use of Appropriate Medications for Asthma - Stratum 4
CMS 126	Use of Appropriate Medications for Asthma - Stratum 5
CMS 117	Childhood Immunization Status
CMS 147	Preventive Care and Screening: Influenza Immunization
CMS 127	Pneumonia Vaccination Status for Older Adults
CMS 166	Use of Imaging Studies for Low Back Pain
CMS 131	Diabetes: Eye Exam
CMS 123	Diabetes: Foot Exam
CMS 122	Diabetes: Hemoglobin A1c Poor Control
CMS 148	Hemoglobin A1c Test for Pediatric Patients
CMS 134	Diabetes: Urine Protein Screening
CMS 163	Diabetes: Low Density Lipoprotein (LDL) Management
CMS 164	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
CMS 154	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
CMS 145	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) - Population 1

Measure	Title
CMS 145	Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) - Population 2
CMS 182	Ischemic Vascular Disease(IVD): Complete Lipid Panel and LDL Control - Numerator 1
CMS 182	Ischemic Vascular Disease(IVD): Complete Lipid Panel and LDL Control - Numerator 2
CMS 135	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS 144	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
CMS 143	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
CMS 167	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
CMS 142	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
CMS 139	Falls: Screening for Future Fall Risk
CMS 161	Major Depressive Disorder (MDD): Suicide Risk Assessment

Measure	Title
CMS 128	Anti-depressant Medication Management - Numerator 1
CMS 128	Anti-depressant Medication Management - Numerator 2
CMS 136	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Population 1
CMS 136	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication - Population 2
CMS 169	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
CMS 157	Oncology: Medical and Radiation – Pain Intensity Quantified
CMS 141	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
CMS 140	Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
CMS 129	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
CMS 62	HIV/AIDS: Medical Visit
CMS 52	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis - Population 1
CMS 52	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis - Population 2
CMS 52	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis - Population 3

Measure	Title
CMS 77	HIV/AIDS: RNA control for Patients with HIV
CMS 2	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
CMS 68	Documentation of Current Medications in the Medical Record
CMS 69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up - Population 1
CMS 69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up - Population 2
CMS 132	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
CMS 133	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
CMS 158	Pregnant women that had HBsAg testing
CMS 159	Depression Remission at Twelve Months
CMS 160	Depression Utilization of the PHQ-9 Tool - Population 1
CMS 160	Depression Utilization of the PHQ-9 Tool - Population 2
CMS 160	Depression Utilization of the PHQ-9 Tool - Population 3
CMS 75	Children who have dental decay or cavities

Measure	Title
CMS 177	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
CMS 82	Maternal depression screening
CMS 74	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Stratum 1
CMS 74	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Stratum 2
CMS 74	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists - Stratum 3
CMS 61	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed - Population 1
CMS 61	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed - Population 2
CMS 61	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed - Population 3
CMS 64	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) - Population 1
CMS 64	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) - Population 2

Measure	Title
CMS 64	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) - Population 3
CMS 149	Dementia: Cognitive Assessment
CMS 65	Hypertension: Improvement in blood pressure
CMS 50	Closing the referral loop: receipt of specialist report
CMS 66	Functional status assessment for knee replacement
CMS 56	Functional status assessment for hip replacement
CMS 90	Functional status assessment for complex chronic conditions
CMS 179	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range
CMS 22	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Appendix 10 – Office of the Inspector General Report, September 2016

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CALIFORNIA MADE INCORRECT MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS TO HOSPITALS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

September 2016
A-09-16-02004

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

California made incorrect Medicaid electronic health record incentive payments to hospitals, resulting in a net overpayment of $22 million over approximately 4 years.

WHY WE DID THIS REVIEW

To improve the quality and value of American health care, the Federal Government promotes the use of certified electronic health record (EHR) technology by health care professionals and hospitals (collectively, "providers"). As an incentive for using EHRs, the Federal Government is making payments to providers that attest to the "meaningful use" of EHRs. The Congressional Budget Office estimates that from 2011 through 2019, spending on the Medicare and Medicaid EHR incentive programs will total $30 billion; the Medicaid EHR incentive program will account for more than a third of that amount, or about $12.4 billion.

The Government Accountability Office has identified improper incentive payments as the primary risk to the EHR incentive programs. These programs may be at greater risk of improper payments than other programs because they are new and have complex requirements. Other U.S. Department of Health and Human Services, Office of Inspector General, reports describe the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face overseeing the Medicare and Medicaid EHR incentive programs. The obstacles leave the programs vulnerable to making incentive payments to providers that do not fully meet requirements.

The California Department of Health Care Services (State agency) made approximately $971 million in Medicaid EHR incentive program payments from October 1, 2011, through December 31, 2014. Of this amount, $370 million was paid to 15,074 health care professionals, and $601 million was paid to 263 hospitals. This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals.

The objective of this review was to determine whether the State agency made Medicaid EHR incentive program payments to eligible hospitals in accordance with Federal requirements.

BACKGROUND

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), enacted as part of the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, established Medicare and Medicaid EHR incentive programs to promote the adoption of EHRs. Under the HITECH Act, State Medicaid programs have the option of receiving from the Federal Government 100 percent of their expenditures for incentive payments to certain providers. The State agency administers the Medicaid program and monitors and makes EHR incentive payments.

To receive an incentive payment, eligible hospitals attest that they meet program requirements by self-reporting data using the CMS National Level Repository (NLR). The NLR is a provider registration and verification system that contains information on providers participating in the Medicaid and Medicare EHR incentive programs. To be eligible for the Medicaid EHR

incentive program, hospitals must meet Medicaid patient-volume requirements. In general, patient volume is calculated by dividing a hospital's total Medicaid patient encounters by total patient encounters. For hospitals, patient encounters are defined as discharges, not days spent in the hospital.

Hospital incentive payments are based on a one-time calculation of a total incentive payment, which is distributed by States over a minimum of 3 years and a maximum of 6 years. The total incentive payment calculation consists of two main components: the overall EHR amount and the Medicaid share.

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through December 31, 2014, the State agency made $600,894,455 in Medicaid EHR incentive payments to eligible hospitals. We (1) reviewed and reconciled hospital incentive payments reported on the State agency's Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, with the NLR and (2) selected for further review the 64 hospitals that each received a first-year incentive payment exceeding $2 million. The State agency paid the 64 hospitals $317,444,168, which was 53 percent of the total paid from October 1, 2011, through December 31, 2014. The State agency made additional payments to 37 of the 64 hospitals, totaling $25,700,188 as of December 31, 2015, which we also reviewed.

WHAT WE FOUND

Although the State agency made Medicaid EHR incentive program payments to eligible hospitals, it did not always make these payments in accordance with Federal requirements. Specifically, from October 1, 2011, through December 31, 2015, the State agency made incorrect Medicaid EHR incentive payments to 61 of the 64 hospitals reviewed, totaling $23,227,540. These incorrect payments included both overpayments and underpayments, resulting in a net overpayment of $22,043,234. Because the incentive payment is calculated once and then paid out over 4 years, payments made after December 31, 2015, will also be incorrect. The adjustments to these payments total $6,318,006.

The State agency made incorrect hospital incentive payments because it did not review supporting documentation from the hospitals to help identify errors in its calculations.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund to the Federal Government $22,043,234 in net overpayments made to the 61 hospitals,
- adjust the 61 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of $6,318,006 after December 31, 2015),

- review the calculations for the hospitals not included in the 64 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified, and
- review supporting documentation from all hospitals to help identify any errors in incentive payment calculations.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation and agreed with our remaining recommendations. Regarding our first recommendation, the State agency agreed that incorrect Medicaid EHR incentive payments may have been made to hospitals but did not concur with our recommended refund amount. Specifically, the State agency commented that (1) it believes further detailed analysis and validation of hospital data is required to support the overpayments we identified in our review; (2) our review used hospital-generated schedules and internal financial records, which did not include detailed testing against actual payments and adjudicated claim data; and (3) as part of its approved audit strategy, it has committed to conducting audits of all hospitals participating in the EHR incentive program and has prioritized the audits of the 64 hospitals we reviewed. Regarding our second recommendation, the State agency agreed and commented that it will adjust future incentive payments where a recalculation of the total payment is necessary. The State agency agreed with our third and fourth recommendations and provided information on actions that it planned to take to address our recommendations.

After reviewing the State agency's comments, we maintain that our finding and recommendations are valid. We obtained the hospitals' (1) Medicare cost reports used to support incentive payment calculations; (2) attestation agreements certifying that all information in their applications for the EHR incentive program was accurate and complete; and (3) internal financial records, which supported the attested information. We also analyzed the hospital data and applied the relevant Federal requirements to verify that specific data elements were included in or excluded from the incentive payment calculations. We provided the State agency with a summary of the data that each hospital provided to us, including our incentive payment calculations that applied the relevant Federal requirements. We suggest that the State agency work with CMS to resolve any discrepancies that are identified between its postpayment audit calculations and our calculations of the incentive payments.

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INTRODUCTION

WHY WE DID THIS REVIEW

To improve the quality and value of American health care, the Federal Government promotes the use of certified electronic health record (EHR) technology by health care professionals and hospitals (collectively, "providers"). As an incentive for using EHRs, the Federal Government is making payments to providers that attest to the "meaningful use" of EHRs.[1] The Congressional Budget Office estimates that from 2011 through 2019, spending on the Medicare and Medicaid EHR incentive programs will total $30 billion; the Medicaid EHR incentive program will account for more than a third of that amount, or about $12.4 billion.

The Government Accountability Office has identified improper incentive payments as the primary risk to the EHR incentive programs.[2] These programs may be at greater risk of improper payments than other programs because they are new and have complex requirements. Other U.S. Department of Health and Human Services, Office of Inspector General, reports describe the obstacles that the Centers for Medicare & Medicaid Services (CMS) and States face overseeing the Medicare and Medicaid EHR incentive programs.[3] The obstacles leave the programs vulnerable to making incentive payments to providers that do not fully meet requirements.

The California Department of Health Care Services (State agency) made approximately $971 million in Medicaid EHR incentive program payments from October 1, 2011, through December 31, 2014. Of this amount, $370 million was paid to 15,074 health care professionals, and $601 million was paid to 263 hospitals. This review is one in a series of reviews focusing on the Medicaid EHR incentive program for hospitals. Appendix A lists previous reviews of the Medicaid EHR incentive program.

OBJECTIVE

Our objective was to determine whether the State agency made Medicaid EHR incentive program payments to eligible hospitals in accordance with Federal requirements.

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[1] To meaningfully use certified EHRs, providers must use numerous functions defined in Federal regulations, including functions meant to improve health care quality and efficiency, such as computerized provider order entry, electronic prescribing, and the exchange of key clinical information.

[2] *Electronic Health Records: First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements* (GAO-12-481), published April 2012.

[3] *Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight* (OEI-05-10-00080), published July 2011, and *Early Assessment Finds That CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program* (OEI-05-11-00250), published November 2012.

BACKGROUND

Health Information Technology for Economic and Clinical Health Act

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (Recovery Act), P.L. No. 111-5. Title XIII of Division A and Title IV of Division B of the Recovery Act are cited together as the Health Information Technology for Economic and Clinical Health Act (HITECH Act). The HITECH Act established EHR incentive programs for both Medicare and Medicaid to promote the adoption of EHRs.

Under the HITECH Act, State Medicaid programs have the option of receiving from the Federal Government Federal financial participation for expenditures for incentive payments to certain Medicare and Medicaid providers to adopt, implement, upgrade, and meaningfully use certified EHR technology (§ 4201). The Federal Government reimburses 100 percent of Medicaid incentive payments (42 CFR § 495.320).

Medicaid Program: Administration and Federal Reimbursement

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In California, the State agency administers the program.

States use the standard Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64 report), to report actual Medicaid expenditures for each quarter, and CMS uses it to reimburse States for the Federal share of Medicaid expenditures. The amounts reported on the CMS-64 report and its attachments must represent actual expenditures and be supported by documentation. States claim EHR incentive payments on lines 24E and 24F of the CMS-64 report.

National Level Repository

The National Level Repository (NLR) is a CMS Web-based provider registration and verification system that contains information on providers participating in the Medicare and Medicaid EHR incentive programs. The NLR is the designated system of records that checks for duplicate payments and maintains the incentive payment history files.

Incentive Payment Eligibility Requirements

To receive an incentive payment, eligible hospitals attest that they meet program requirements by self-reporting data using the NLR.[4] To be eligible for the Medicaid EHR incentive program, hospitals must meet Medicaid patient-volume requirements (42 CFR § 495.304(e)). In general,

[4] Eligible hospitals may be acute-care hospitals or children's hospitals (42 CFR §§ 495.304(a)(2) and (a)(3)); acute-care hospitals include critical access hospitals or cancer hospitals (75 Fed. Reg. 44314, 44484 (July 28, 2010)).

patient volume is calculated by dividing a hospital's total Medicaid patient encounters by total patient encounters.[5]

To meet program eligibility requirements, a hospital must:

- be a permissible provider type that is licensed to practice in the State;
- participate in the State Medicaid program;
- not be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State or Federal Government;
- have an average length of stay of 25 days or less;[6]
- have adopted, implemented, upgraded, or meaningfully used certified EHR technology;[7] and
- meet Medicaid patient-volume requirements.[8]

Eligible Hospital Payments

Hospital incentive payments are based on a one-time calculation of a total incentive payment, which is distributed by States over a minimum of 3 years and a maximum of 6 years.[9] The total incentive payment calculation consists of two main components: the overall EHR amount and the Medicaid share.

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[5] For hospitals, patient encounters are defined as discharges, not days spent in the hospital. A hospital encounter is either the total services performed during an inpatient stay or services performed in an emergency department on any one day for which Medicaid paid for all or part of the services or paid the copay, cost-sharing, or premium for the services (42 CFR § 495.306(e)(2)).

[6] The definition of "acute-care hospital" in 42 CFR § 495.302. Children's hospitals do not have to meet the average-length-of-stay requirement.

[7] A provider may only adopt, implement, or upgrade certified EHR technology in the first year it is in the program (42 CFR § 495.314(a)(1)). In subsequent years, the provider must demonstrate that during the EHR reporting period it was a meaningful EHR user, as defined in 42 CFR § 495.4.

[8] Hospitals must have a Medicaid patient volume of at least 10 percent, except for children's hospitals, which do not have a patient-volume requirement (42 CFR §§ 495.304(e)(1) and (e)(2)).

[9] No single year may account for more than 50 percent of the total incentive payment, and no 2 years may account for more than 90 percent of the total incentive payment (42 CFR §§ 495.310(f)(3) and (f)(4)). The State agency elected for incentive payments to be made over a 4-year period. Of the total, the first payment was 50 percent, the second payment was 30 percent, the third payment was 10 percent, and the fourth payment was 10 percent.

Generally stated, the overall EHR amount is an estimated dollar amount based on a total number of inpatient acute-care discharges over a theoretical 4-year period.[10] The overall EHR amount consists of two components: an initial amount and a transition factor. Once the initial amount is multiplied by the transition factor, all 4 years are totaled to determine the overall EHR amount. The table provides examples of the overall EHR amount calculation for three types of hospitals, with differing numbers of discharges during the payment year.

Table: Examples of Overall Electronic Health Record Amount Calculation

EHR Calculation	Hospitals With 1,149 or Fewer Discharges During the Payment Year	Hospitals With 1,150 Through 23,000 Discharges During the Payment Year	Hospitals With More Than 23,000 Discharges During the Payment Year
Base amount	$2 million	$2 million	$2 million
Plus discharge-related amount (adjusted in years 2 through 4 on the basis of the average annual growth rate)	$0.00	$200 multiplied by ($n$ – 1,149), where n is the number of discharges	$200 multiplied by (23,000 – 1,149)
Equals total initial amount	$2 million	Between $2 million and $6,370,200, depending on the number of discharges	Limited by law to $6,370,200
Multiplied by transition factor	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25	Year 1 – 1.00 Year 2 – 0.75 Year 3 – 0.50 Year 4 – 0.25
Overall EHR amount	Sum of all 4 years	Sum of all 4 years	Sum of all 4 years

The Medicaid share is calculated as follows:

- The numerator is the sum of the estimated Medicaid inpatient acute-care bed-days[11] for the current year and the estimated number of Medicaid managed-care inpatient acute-care bed-days for the current year (42 CFR § 495.310(g)(2)(i)).[12]

[10] The 4-year period is theoretical because the overall EHR amount is not determined annually; it is calculated once, on the basis of how much a hospital might be paid over 4 years. An average annual growth rate (calculated by averaging the annual percentage change in discharges over the most recent 3 years) is applied to the first payment year's number of discharges to calculate the estimated total discharges in years 2 through 4 (42 CFR § 495.310(g)).

[11] A bed-day is 1 day that one Medicaid beneficiary spends in the hospital.

[12] For reporting purposes, we refer to the numerator of the Medicaid share as the "Medicaid-bed-days-only portion of the Medicaid share."

- The denominator is the product of the estimated total number of inpatient acute-care bed-days for the eligible hospital during the current year multiplied by the noncharity percentage. The noncharity percentage is the estimated total amount of the eligible hospital's charges during that period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during that period (42 CFR § 495.310(g)(2)(ii)).

The total incentive payment is the overall EHR amount multiplied by the Medicaid share. The total incentive payment is then distributed over several years. (See footnote 9.) It is possible that a hospital may not receive the entire total incentive payment. Each year, a hospital must reattest that it met that year's program requirements. The hospital may not qualify for the future years' payments or could elect to end its participation in the EHR incentive program. In addition, the amount may change because of adjustments to supporting numbers used in the calculations.

Hospitals may receive incentive payments from both Medicare and Medicaid within the same year; however, they may not receive a Medicaid incentive payment from more than one State (42 CFR §§ 495.310(e) and (j)).

HOW WE CONDUCTED THIS REVIEW

From October 1, 2011, through December 31, 2014, the State agency made $600,894,455 in Medicaid EHR incentive payments to eligible hospitals. We (1) reviewed and reconciled hospital incentive payments reported on the State agency's CMS-64 report with the NLR and (2) selected for further review the 64 hospitals that each received a first-year incentive payment exceeding $2 million. The State agency paid the 64 hospitals $317,444,168, which was 53 percent of the total paid from October 1, 2011, through December 31, 2014. The State agency made additional payments to 37 of the 64 hospitals, totaling $25,700,188 as of December 31, 2015, which we also reviewed.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology.

FINDING

Although the State agency made Medicaid EHR incentive program payments to eligible hospitals, it did not always make these payments in accordance with Federal requirements. Specifically, from October 1, 2011, through December 31, 2015, the State agency made incorrect Medicaid EHR incentive payments to 61 of the 64 hospitals reviewed, totaling $23,227,540. These incorrect payments included both overpayments and underpayments, resulting in a net

overpayment of $22,043,234.[13] Because the incentive payment is calculated once and then paid out over 4 years, payments made after December 31, 2015, will also be incorrect. The adjustments to these payments total $6,318,006.

The State agency made incorrect hospital incentive payments because it did not review supporting documentation from the hospitals to help identify errors in its calculations.

FEDERAL REQUIREMENTS

Federal regulations require that unpaid Medicaid bed-days be excluded from the incentive payment calculation (75 Fed. Reg. 44314, 44500 (July 28, 2010)). CMS guidance further clarifies that unpaid Medicaid bed-days must be excluded from the Medicaid-bed-days-only portion of the Medicaid share component of the incentive payment calculation.[14]

Federal regulations restrict discharges and inpatient bed-days to those from the acute-care portion of a hospital and further explain that an eligible hospital, for purposes of the incentive payment provision, does not include psychiatric or rehabilitation units, which are distinct parts of the hospital (75 Fed. Reg. 44314, 44450, and 44497 (July 28, 2010)). Also, Federal regulations state that bed-days include all inpatient bed-days under the acute-care payment system and exclude nursery bed-days, except for those in intensive-care units of the hospital (neonatal intensive-care units (NICUs)) (75 Fed. Reg. 44314, 44453, 44454, 44498, and 44500 (July 28, 2010)).

Furthermore, CMS guidance states that nursery, rehabilitation, and psychiatric days and discharges (non-acute-care services) may not be included as inpatient acute-care services in the calculation of hospital incentive payments.[15]

Federal regulations state that providers should retain documentation to support incentive payment calculations for at least 6 years following the date of attestation (42 CFR § 495.40(c) and 77 Fed. Reg. 53968, 54112 (Sept. 4, 2012)).

The Medicaid share amount for a hospital is essentially the percentage of a hospital's inpatient, noncharity-care days that are attributable to Medicaid inpatients (75 Fed. Reg. 44314, 44498 (July 28, 2010)). Also, if a State determines that hospital data on charity care necessary to use in the calculation are not available, the State may use a hospital's uncompensated care data; however, it must include a downward adjustment to eliminate bad debt (42 CFR § 495.310(h)).

Federal regulations state that the numerator of the Medicaid share calculation must exclude Medicaid dual-eligible acute inpatient bed-days (75 Fed. Reg. 44314, 44500 (July 28, 2010)).

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[13] Several hospitals had multiple deficiencies in their incentive payment calculations, which resulted in both overpayments and underpayments. We reported the net effect of these deficiencies.

[14] CMS Frequently Asked Questions (FAQ), FAQ 7649. Available online at https://questions.cms.gov/. Accessed on March 18, 2016.

[15] CMS guidance for nursery, rehabilitation, and psychiatric days and discharges from CMS FAQs 2991, 3213, and 3261. Available online at https://questions.cms.gov/. Accessed on January 28, 2016.

In computing inpatient bed-days, a State may not include estimated acute inpatient bed-days attributable to individuals (1) for whom payment may be made under Medicare Part A or (2) who are enrolled with a Medicare Advantage organization under Medicare Part C. The denominator may include Medicaid dual-eligible acute inpatient bed-days (42 CFR § 495.310(g)(2)(iii)).

THE STATE AGENCY MADE INCORRECT HOSPITAL INCENTIVE PAYMENTS

Of the 64 hospital incentive payment calculations reviewed, 61, or 95 percent, did not comply with Federal regulations or guidance or both. Some calculations had multiple deficiencies. Specifically, the calculations included:

- unpaid Medicaid bed-days in the Medicaid-bed-days-only portion of the Medicaid share (30 hospitals);
- non-acute-care services (23 hospitals);[16]
- hospital data not supported by documentation required to be retained (21 hospitals);
- bad debt within charity-care charges (13 hospitals);
- Medicaid dual-eligible acute inpatient bed-days in the numerator (5 hospitals); and
- clerical errors, such as reporting an incorrect charity-care charge because of a keying error (5 hospitals).

In addition, the incentive payment calculations did not include services that should have been included:

- labor and delivery services (12 hospitals),
- NICU services (10 hospitals), and
- intensive-care services (8 hospitals).

The State agency followed CMS's guidance on cost-report data elements suggested for use when calculating hospital incentive payments but did not follow more specific Federal regulations and guidance. CMS's cost-report guidance tells providers where to find certain data elements on the cost report but does not include which items Federal regulations state should be removed from these data elements.[17] According to State agency officials, the State agency advised hospitals to remove items from these data elements but did not review the hospitals' supporting documentation to help identify these types of errors in the calculations.

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[16] These services consisted of nursery, rehabilitation, and psychiatric services.

[17] CMS guidance for cost-report data elements from CMS FAQ 3471. Available online at https://questions.cms.gov/. Accessed on January 28, 2016.

As a result, for the 61 hospitals, the State agency made incorrect incentive payments totaling $23,227,540. Specifically, the State agency overpaid 53 hospitals a total of $22,635,387 and underpaid 8 hospitals a total of $592,153, for a net overpayment of $22,043,234. Because the incentive payment is calculated once and then paid out over 4 years, payments after December 31, 2015, will also be incorrect. The adjustments to these payments total $6,318,006.[18]

RECOMMENDATIONS

We recommend that the State agency:

- refund to the Federal Government $22,043,234 in net overpayments made to the 61 hospitals,
- adjust the 61 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of $6,318,006 after December 31, 2015),
- review the calculations for the hospitals not included in the 64 we reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified, and
- review supporting documentation from all hospitals to help identify any errors in incentive payment calculations.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency disagreed with our first recommendation and agreed with our remaining recommendations.

Regarding our first recommendation, the State agency agreed that incorrect Medicaid EHR incentive payments may have been made to hospitals but did not concur with our recommended refund amount:

- The State agency commented that it believes further detailed analysis and validation of hospital data is required to support the overpayments we identified. The State agency also commented that it has implemented robust pre- and postpayment review and audit procedures, which are effective in confirming the accuracy of incentive payment calculations in accordance with Federal regulations.
- The State agency commented that our review used hospital-generated schedules and internal financial records, which did not include detailed testing against actual payments and adjudicated claim data. The State agency commented that, therefore, it is unable to

[18] The adjusted amount is the total net overpayment for 48 of 61 hospitals that did not receive their second-, third- and/or fourth-year payments.

rely on our audit findings because they cannot be supported in administrative appeals available to providers with identified overpayments.

- The State agency commented that as part of its approved audit strategy, it has committed to conducting audits of all hospitals participating in the EHR incentive program and has prioritized the audits of the 64 hospitals we reviewed. The State agency said that any identified overpayments will be offset against future incentive payments to the hospitals. The State agency also commented that if any identified overpayments exceed future incentive payments, it will refund to the Federal Government the remaining overpayment amount.

Regarding our second recommendation, the State agency agreed and commented that it will adjust future incentive payments where a recalculation of the total payment is necessary. The State agency agreed with our third and fourth recommendations and provided information on actions that it planned to take to address our recommendations.

The State agency's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our finding and recommendations are valid:

- We obtained the hospitals' (1) Medicare cost reports used to support incentive payment calculations; (2) attestation agreements certifying that all information in their applications for the EHR incentive program was accurate and complete; and (3) internal financial records, which supported the attested information.

- We analyzed the hospital data and applied the relevant Federal requirements to verify that specific data elements were included in or excluded from the incentive payment calculations, such as excluding unpaid Medicaid bed-days and including labor and delivery services.

We provided the State agency with a summary of the data that each hospital provided to us, including our incentive payment calculations that applied the relevant Federal requirements. We suggest that the State agency work with CMS to resolve any discrepancies that are identified between its postpayment audit calculations and our calculations of the incentive payments.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
New Jersey Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-02-14-01009	8/25/2016
Pennsylvania Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-15-00403	8/10/2016
Arizona Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-09-15-02036	8/4/2016
Delaware Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00402	9/30/2015
Oklahoma Made Incorrect Medicaid Electronic Health Record Incentive Payments to Health Care Professionals	A-06-14-00030	9/3/2015
Texas Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-06-13-00047	8/31/2015
Arkansas Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-06-14-00010	6/22/2015
The District of Columbia Made Correct Medicaid Electronic Health Record Incentive Payments to Hospitals	A-03-14-00401	1/15/2015
Massachusetts Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals	A-01-13-00008	11/17/2014
Louisiana Made Incorrect Medicaid Electronic Health Record Incentive Payments	A-06-12-00041	8/26/2014
Florida Made Medicaid Electronic Health Record Payments to Hospitals in Accordance With Federal and State Requirements	A-04-13-06164	8/8/2014
Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight	OEI-05-10-00080	7/15/2011

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

From October 1, 2011, through December 31, 2014, the State agency made $600,894,455 in Medicaid EHR incentive payments to eligible hospitals. We (1) reviewed and reconciled hospital incentive payments reported on the State agency's CMS-64 report with the NLR and (2) selected for further review the 64 hospitals that each received a first-year incentive payment exceeding $2 million. The State agency paid the 64 hospitals $317,444,168, which was 53 percent of the total paid from October 1, 2011, through December 31, 2014. The State agency made additional payments to 37 of the 64 hospitals, totaling $25,700,188 as of December 31, 2015, which we also reviewed.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

Our audit work included contacting the State agency in Sacramento, California.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with CMS officials to gain an understanding of the Medicaid EHR incentive program;
- held discussions with State agency officials to gain an understanding of State policies and controls related to the Medicaid EHR incentive program;
- reviewed and reconciled the appropriate lines from the CMS-64 report with supporting documentation and the NLR;
- selected for further review (1) the 64 hospitals that each received a first-year incentive payment exceeding $2 million during the period October 1, 2011, through December 31, 2014, and (2) all payments made to the 64 selected hospitals from January 1 through December 31, 2015;
- reviewed and verified the selected hospitals' supporting documentation;
- verified that the selected hospitals met eligibility requirements;
- determined whether the selected hospital patient-volume calculations were correct;
- determined whether the selected hospital incentive-payment calculations were correct and adequately supported; and

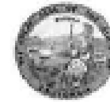
- discussed the results of our review with State agency officials and provided them with our recalculations.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: STATE AGENCY COMMENTS

JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

August 17, 2016

Ms. Lori Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 – 7TH Street, Suite 3-650
San Francisco, CA 94103

Dear Ms. Ahlstrand

The California Department of Health Care Services (DHCS) has prepared its response to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled, *California Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals (A-09-16-02004).*

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft report. Please contact Ms. Sarah Hollister, External Audit Manager, at (916) 650-0298 if you have any questions.

Sincerely,

/Jennifer Kent/

Jennifer Kent
Director

Enclosure

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Department of Health Care Services Response to the OIG draft audit report entitled, *California Made Incorrect Medicaid Electronic Health Record Incentive Payments to Hospitals* (A-09-16-02004)

Finding #1: **Although the State agency made Medicaid EHR incentive program payments to eligible hospitals, it did not always make these payments in accordance with Federal requirements. Specifically, from October 1, 2011, through December 31, 2015, the State agency made incorrect Medicaid EHR incentive payments to 61 of the 64 hospitals reviewed, totaling $23,227,540. These incorrect payments included both overpayments and underpayments, resulting in a net overpayment of $22,043,234.**

Finding #2: **Because the incentive payment is calculated once and then paid out over 4 years, payments made after December 31, 2015, will also be incorrect. The adjustments to these payments total $6,318,006.**

Recommendation 1: **DHCS should refund the Federal Government $22,043,234 in net overpayments made to the 64 hospitals.**

DHCS Response: DHCS disagrees with the recommendation.

DHCS agrees that incorrect Medicaid EHR incentive payments may have been made to eligible hospitals, but does not concur with the recommendation to refund the Federal Government $22,043,234 in net overpayments made to 64 hospitals.

DHCS was advised by CMS that over/underpayments could be addressed through adjustments of future incentive payments to Eligible Hospitals (EH). In addition, DHCS believes further detailed analysis and validation of data reported by EHs is required in order to support overpayments identified by the OIG.

DHCS has implemented robust pre and post payment review and audit procedures which are effective in validating EH eligibility, and confirming the accuracy of incentive payment calculations in accordance with Federal regulations. The pre-payment validation and post payment audits are conducted in accordance with the State Medicaid Health Information Technology Plan (SMHP) and DHCS's audit strategy, both approved by the Centers for Medicare and Medicaid Services (CMS).

Prepayment validation of the EHs eligibility and payment calculations includes a comprehensive analysis of auditable data submitted by EHs at the time of attestation. However, this validation does not include the level of review conducted as part of

the post payment audit procedures, as doing so would result in an unacceptable delay in issuing incentive payments.

The detailed review conducted by the OIG in its audit of the EHs is appreciated and DHCS acknowledges the audits were performed in accordance with generally accepted government auditing standards; however, there was a level of reliance on hospital generated schedules and internal financial records which did not include detailed testing against actual payments/adjudicated claims data. Historical experience from administrative appeal hearings requires DHCS to use actual payments/adjudicated claims data from the claims payment reports. Therefore, DHCS is unable to rely on these audit findings, as they cannot be supported in administrative appeals available to providers with identified overpayments.

As part of the approved audit strategy, DHCS has committed to conducting audits of 100% of the EHs participating in the Medi-Cal EHR incentive program. Post payment audits by DHCS audit staff include a review of EH audited cost reports and detailed testing against adjudicated claims.

DHCS has prioritized auditing of the 64 EHs reviewed by OIG, and is committed to having the audits completed within the current state fiscal year. Any identified overpayments will be offset against the EHs future recalculated incentive payments. In the instance overpayments exceed future payments, DHCS will refund to the Federal government, the remaining overpayment amount.

Recommendation 2: **Adjust the 61 hospitals' remaining incentive payments to account for the incorrect calculations (which will result in cost savings of $6,318,006 after December 31, 2016).**

DHCS Response: DHCS agrees with the recommendation.

DHCS will adjust EH future payments where a recalculation of the total payment is necessary. Recalculations will be determined at the time DHCS completes the initial post payment audits, over the current and subsequent state fiscal year.

Recommendation 3: **DHCS should review the calculations for the hospitals not included in the 64 OIG reviewed to determine whether payment adjustments are needed and refund to the Federal Government any overpayments identified.**

DHCS Response: DHCS agrees with the recommendation.

DHCS agrees that all hospitals not included in the 64 OIG reviews should be audited as had previously been identified in the DHCS audit plan and strategy. Based on the audit reviews, DHCS will

determine if payment adjustments are necessary and will apply the adjustments as offsets against the EHs future recalculated incentive payments as noted above.

DHCS plans to commence reviews of some additional EHs in the current fiscal year and anticipates completing audits of the remaining EHs in the 2017/18 state fiscal year.

Recommendation 4: **DHCS should review the supporting documentation from all hospitals to help identify any errors in incentive payment calculations.**

DHCS Response: DHCS agrees with the recommendation.

As indicated in recommendation 1 above, DHCS will conduct a comprehensive post payment audit on 100% of participating hospitals as has previously been approved by CMS in the SMHP and DHCS's audit strategy.