Oregon's Medicaid EHR Incentive Program
(aka Promoting Interoperability Program)
2019 REQUIRED DOCUMENTATION

This checklist details what documentation **must be provided** in support of your attestation. Your attestation cannot be fully processed for payment until the documentation is received. For security purposes, and to promote efficient processing, please upload documentation directly into MAPIR.

Required Documentation Checklist	
☐	**Certified EHR Technology (CEHRT) Documentation** – Supports the adoption, implementation, or upgrade to a 2015 Edition CEHRT. Your 2015 CEHRT must be in place by the beginning of your 90-day EHR reporting period. Acceptable sources include software licensing agreements, signed contract, or vendor letter (as long as it verifies the upgrade to a 2015 certified system).
☐	**EHR Scorecard/Reports** – Demonstrates requirements for Meaningful Use/Promoting Interoperability Objectives and Electronic Clinical Quality Measures (eCQMs) were met during the reporting period selected (90-days for Objectives, full year for eCQMs). The EHR report(s) must match your MAPIR attestation and your Clinical Quality Metrics Registry eCQM submission, and must be the unaltered, original report from your CEHRT. This document should be exported to .PDF format and include the attesting provider's name or NPI, EHR reporting period, EHR name, MU objectives, and eCQMs. **Note**: A full year eCQMs scorecard only needs to be uploaded into MAPIR if you submit your eCQMs to the CQMR via the Excel template.
☐	**Security Risk Analysis (SRA)** – Demonstrates risks to electronic protected health information (ePHI) have been assessed. A unique SRA must be reviewed or conducted for each EHR reporting period, after the 2015 CEHRT upgrade occurs, and within the calendar year of the EHR reporting period (2019). Documentation must include: - Date SRA was completed - Organization SRA was completed for, and name of person/vendor who completed SRA - Identified risks, threats, or vulnerabilities to ePHI **Note**: One SRA can be provided for group submissions, as long as it was completed in calendar year 2019 and prior to date of attestation for all members of the group.
☐	**Public Health and Clinical Data Registry Reporting** (Objective 8 Measures 3, 4, & 5) – Required documentation for these measures includes two components: 1. A letter from the registry that identifies a. The name of the attesting EP/clinic b. The attesting EP's/clinic's status of active engagement (1 - completed registration, 2 – testing and validation, 3 – production) ○ If in option 1, the letter must identify the date of the registration. This date must be before, or within 60 days of the start of the attesting provider's EHR reporting period.

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- If in option 2, the letter must identify whether any requests were made, and that the clinic has responded to requests in a timely fashion (within 30 days).
- If in option 3, the letter must contain a statement that the EP/clinic is actively submitting production data.

Notes:

- A registry screenshot is acceptable in lieu of a letter from registry, if it can substantiate the details of the letter. This is the expected documentation for EPs attesting to Oregon's Prescription Drug Monitoring Program (PDMP) for Measure 4. EPs would obtain this themselves, not contact PDMP staff for the document.
- If the EP was already in option 3 (production) in 2018, there is no need to obtain a new letter; simply upload the 2018 letter from PH.
- **2019 Update:** For Measure 4, an EP may count a specialized registry (such as prescription drug monitoring) if the EP achieved Active Engagement Option 3 in a prior year under the applicable requirements of the PI Programs for that year.

2. List of providers and NPI's (preferably in Excel format) created by the clinic that identifies all the individual providers submitting to that registry.

Other documentation may be required on a case-by-case basis. The below documents may not be required for everyone, but may be requested as we process your attestation.

☐ **Practice Predominantly Form** – Verifies over 50% of patient encounters have occurred in an FQHC/RHC in a designated 6 month period. **This is only for providers who primarily work in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).** The form is on our Manuals and Other Resources webpage.

☐ **Patient Volume Report** – Documentation that supports your 90-day patient volume period (in an Excel spreadsheet format). During our pre-payment review, we may find that 1) the patient volume is at risk of not meeting the 30% (or 20% for pediatricians) Medicaid patient volume threshold, or 2) we cannot validate your attested patient volume amounts. A patient volume report displays ONLY Medicaid and needy (if FQHC/RHC) encounters during the 90-day patient volume timeframe used for the provider's numerator, and must include the following data fields:

- Date of Service
- Medicaid Patient ID
- Amount Billed (if available in current report)
- Rendering Provider NPI (if doing group patient volume)