GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Eligible Hospitals User Guide for the Georgia Medicaid EHR Incentive Program

Version 1.5

August 30, 2013

Document Control

Modification Log

Version #	Date	Change/Update Details
1.0	09/05/2011	Approved document
1.1	04/06/2012	Global, Made minor editing and formatting changes. Step 1 - Getting Started, Dashboard image and information added. Part 3 of 3 - Patient Volume Cost Data, subsequent year applications information added. Step 5 - Attestation, Meaningful Use information added. Adoption Phase - Section added. Meaningful Use - New images, descriptions and instructions added. Application Status - Table added.
1.2	09/06/2012	Attestation – Updated images.
1.3	1/23/2012	Patient Volume Cost Data Part 3 of 3 images updated. Documentation Upload images updated.
1.4	6/1/2013	DCH logo updated. Introduction updated to include stage 2 information. Step 4 – Patient Volume 90-Day Period graphs and descriptions updated. Change Hospital Cost Report Data added. Attestation Phase 3 of 3 graph updated. Meaningful Use Core Measure 1 and 7 updated. Meaningful Use Core Measure 9 and 13 deleted.
1.5	8/30/2013	Meaningful Use splash pages updated. Attachment graphs and instructions updated. Post submission graphs and instructions updated for new “Document Upload” tab.

Table of Contents

Introduction

Georgia recognizes the value of having real-time medical information when providers care for their patients. The use of health information technology (HIT) including electronic health records (EHRs) to make this information available at the point-of-care has the potential to improve patient outcomes and the efficiency of the healthcare system as a whole.

The American Recovery and Reinvestment Act of 2009 (ARRA) established a program to provide incentive payments to eligible providers who adopt, implement, upgrade, or meaningfully use federally certified EHR systems. Under ARRA, states are responsible for assisting professionals and hospitals that are eligible for Medicaid EHR incentive payments, making payments, and monitoring payments. The Georgia Department of Community Health (DCH), Division of Health Information Technology (DHIT) oversees the Medicaid EHR Incentive Program in Georgia. The incentive payments are not a reimbursement, but are intended to encourage adoption and meaningful use of certified EHR technology.

The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing the provisions of the Medicare and Medicaid EHR Incentive Programs. CMS issued the Final Rule on the Medicaid EHR Incentive Program on July 28, 2010: http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf.

For information about the CMS Medicare and Medicaid EHR Incentive Programs, visit https://www.cms.gov/EHRIncentivePrograms/.

For more information on CMS EHR requirements, go to CMS FAQs at: https://www.cms.gov/EHRIncentivePrograms/95_FAQ.asp#TopOfPage

Per the final federal rule, Eligible Hospitals under the Medicaid EHR Incentive Program include:

- Acute Care Hospital are those hospitals with an average patient length of stay of 25 days or fewer, and with a Centers for Medicare and Medicaid Programs (CMS) Certification Number (CCN) that falls in the range 0001-0879 or 1300-1399
- Separately certified children's hospitals with CCNs in the 3300 – 3399 range

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an Eligible Hospital must have a minimum 10% Medicaid patient volume requirement. Children's hospitals do not have patient volume requirements.

Note: Children's Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria.

This manual provides step-by-step directions for using MAPIR and submitting your application to the Medicaid EHR Incentive Payment Program.

Note: The Meaningful Use Stage 2 Final Rule introduced specific changes for Stage 1 functionality that take effect in Program Year 2013. MAPIR Version 5.0 was enhanced to comply with the Stage 2 Final Rule. Any Program Year 2013 applications that are started prior to the implementation of MAPIR Version 5.0 will follow the processing logic that was in effect for the version of MAPIR that Georgia was using prior to implementing MAPIR Version 5.0.

How to apply for the Georgia Medicaid EHR Incentive Program

The Georgia Medicaid EHR Incentive Program uses a web-based application named the Medicaid Assistance Provider Incentive Repository (MAPIR). MAPIR allows Eligible Hospitals to complete registration and attestation for Medicaid EHR incentive payments. **This User Guide provides step-by-step instructions on how to access MAPIR and successfully submit an incentive payment application.**

The best way for a new user to become familiar with the Medicaid EHR Incentive Program requirements and processes is to read through each section of this User Guide in its entirety, prior to starting the application process.

In the event this User Guide does not answer your questions or you are unable to navigate MAPIR to complete the registration and application process, you should contact the MAPIR team by email at: hp.mapir.outreach@hp.com or utilize "Contact US" at www.mmis.georgia.gov. You may also access our website at http://dch.georgia.gov/ehr to review FAQs, webinars and other information about the EHR incentive program.

The Medicaid EHR Incentive Program Application Process

The following steps describe the Medicaid EHR Incentive Program application process:

1. **Register with CMS.** As an applicant, you **must** first register with the Centers for Medicare & Medicaid Services (CMS) at the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A) website (https://ehrincentives.cms.gov/hitech/login.action). You will need to provide information such as:

   - Payee's NPI and Tax Identification Number (TIN)
   - CMS Certification Number (CCN)
   - Incentive Program option of Medicare or Georgia Medicaid (referred to as Medicaid in the R&A) – **Note**: If Medicaid, choose Georgia as the state for which you are applying.
   - EHR Certification ID number
   - PECOS Number
   - Email contact information

   Once successfully registered with the R&A, you will receive an email with the R&A ID number and instructions to register at the state level. The state level application process uses a web-based application known as MAPIR. MAPIR is accessed through the Georgia Web Portal and will track and act as a repository for information related to applications, attestations, payments, appeals, oversight functions, and interface with R&A. Please allow at least two business days from the time you submit your R&A application before accessing MAPIR due to the necessary exchange of data between these two systems.

   IMPORTANT:
   - **You will not be able to start the state level application process using MAPRIL unless you have successfully completed registration at the CMS R&A website**.
   - **A healthcare system may have several hospitals but only a single CMS Certification Number (CCN) resulting in one Medicaid EHR incentive payment.**

2. **Choose an Applicant.** Identify one individual to complete the MAPIR application.

3. **Access the Georgia Web Portal.** You will use your Georgia Web Portal User ID and password to log into the Georgia Web Portal. (This is the same portal you use to access your secure Georgia Medicaid account.)

4. **Access the MAPIR application.** Once logged in, a link to the MAPIR application for Eligible Hospitals will be displayed in the Georgia Web Portal. By clicking on the link, the MAPIR application will search for a registration record received from the R&A. If there is a provider record match, DCH will send an e-mail notifying you that your initial information has been successfully submitted and you may continue state level registration in MAPIR. If MAPIR cannot match your R&A submission to an active Georgia Medicaid provider file, you will be contacted to correct your information at either the R&A or state level or both. If you do not receive any notifications, please contact DCH for assistance by email at hp.mapir.outreach@hp.com or utilize "Contact US" at www.mmis.georgia.gov.

   Note: Once you have started the MAPIR application process with your Internet/portal account, **you cannot switch to another account during that program year**. MAPIR will allow you to save the information entered and return later to complete an application; however, only the same individual's Internet/portal account will be permitted access to the application after it has been started.

5. **Verify your information.** You must verify the information displayed in MAPIR and attest as to the accuracy of the data entered in MAPIR. As an applicant for an Eligible Hospital, you must demonstrate that the hospital can:
   - Meet Medicaid patient volume thresholds (Children's hospitals are not required to meet patient volume thresholds)
   - Show evidence of adopting, implementing, upgrading or meaningfully using federally-certified EHR technology
   - Meet all other federal program requirements

6. **Calculating patient volume.** It is recommended that you complete the Patient Volume and Incentive Payment Calculator **prior** to entering MAPIR to estimate eligibility based on patient volume for a continuous 90-day period within your hospital's fiscal year ending within the federal fiscal year or a 90-day period aligned with the quarters of the federal fiscal year. In the patient volume and incentive payment calculations, Children's Health Insurance Program (CHIP) encounters must be excluded from the Medicaid patient volume. Eligible hospitals who are unable to differentiate Medicaid and CHIP patients should utilize the unique CHIP discount factor calculated by DCH for each hospital utilizing historical claims data. Eligible hospitals that can differentiate these patient types ***do not*** need to use the CHIP discount factor.

7. **Application approvals.** DCH will use its own information (such as Medicaid claims data) and information in MAPIR to review applications and make approval decisions. DCH will inform all applicants whether they have been approved or denied for an incentive payment. All approvals and denials are based on federal rules about the EHR Incentive Program.

8. **Payment issuance.** Incentive payments will be issued via electronic funds transfer using the standard MMIS claims payment system once a month and hospitals will see their payments on their remittance advices and their annual 1099s.

9. **Applicant contact information.** It is possible that DCH will need to contact you during the application process before a decision can be made to approve or deny an application. You are strongly encouraged to contact DCH if they have questions about the process.

10. **Appeals.** You have appeal rights if you are denied a Medicaid EHR incentive payment. DCH will convey information on the appeals process to all applicants denied. Submitting a Request for Initial Administrative Review is the first step in the appeals process. DCH's Division of Health Information Technology will conduct this review and issue a written decision. Appeals will be processed by the DCH Office of Legal Services.

Tips for a Successful Application

- **Provide a valid email address during the R&A process.** Without a valid email address, your application may be significantly delayed.
- **Obtain a CMS EHR Certification ID number.** You can obtain a CMS EHR Certification ID from the ONC Certified Health IT Product List (CHPL) Website (http://onc-chpl.force.com/ehrcert).
- **Be ready to use the Georgia Web Portal.** In order to apply for the Medicaid EHR Incentive Program, you must have a valid login ID and password for the Georgia Web Portal. If you do not already have a Georgia Web Portal login, please visit https://www.mmis.georgia.gov/portal/default.aspx to obtain one.
- **Provide the correct NPI and TIN to CMS.** The NPI and TIN information must match within the Georgia Web Portal system. This combination should be the same NPI/TIN combination that you use for Medicaid claim payment purposes.

- **Complete the patient volume and incentive payment calculator prior to registering in MAPIR.** The completed calculator must be uploaded during the attestation phase of the registration process.

- **Determine the timeframe.** Select continuous 90-day reporting period to be used for calculating Medicaid patient volume.

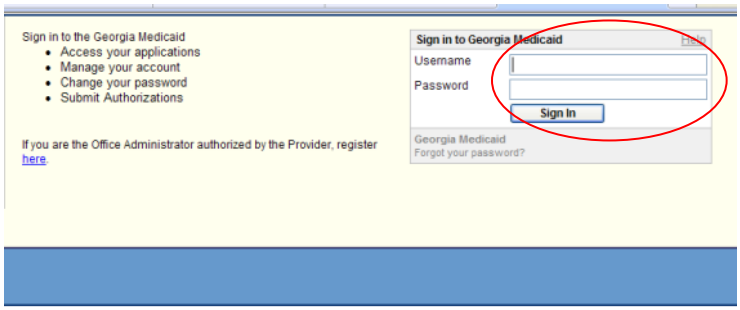
- **Have your documentation readily available.** You **must** provide evidence of adoption, implementation, or upgrade (AIU) of certified EHR technology.

Navigating MAPIR

Step 1 – Getting Started

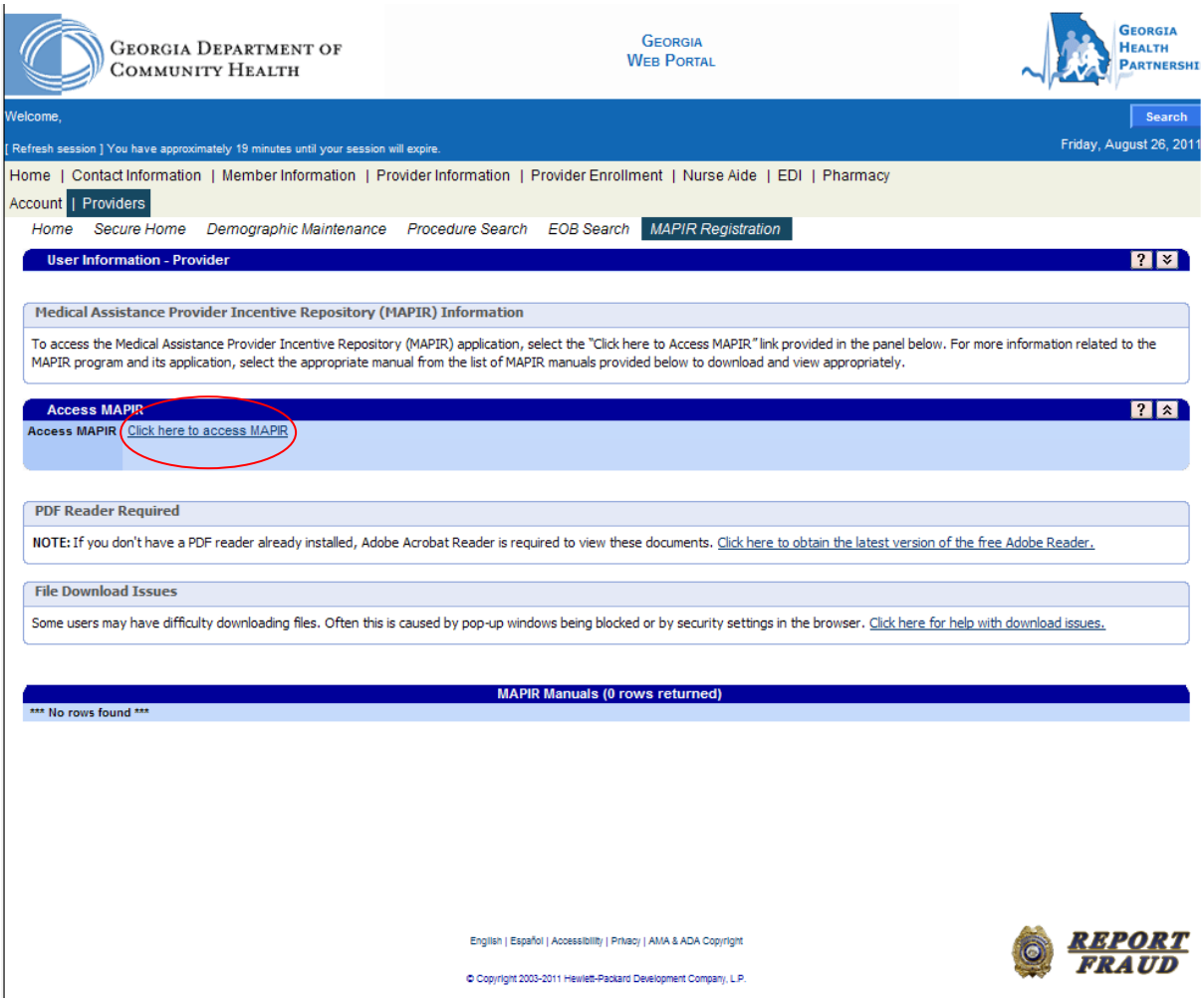
Eligible Hospitals can access MAPIR through the Georgia Web Portal at www.mmis.georgia.gov.

Log into the Georgia Web Portal.



Click the Web Portal hyperlink to access the secure Web Portal. Locate the **MAPIR Registration** page from the **Providers** menu.

Click the link to access the **MAPIR** application.



Enter your R&A Application Confirmation Number that you received from CMSand click **Submit**. You will then be directed to MAPIR application.

The remainder of the Eligible Hospital User Guide consists of instructions on how to complete each screen component within seven electronic MAPIR application tabs that comprise the registration document:

- Get Started
- R&A and Contact Info
- Eligibility
- Patient Volume
- Attestation
- Review
- Submit

The screen below, the Medicaid EHR Incentive Program Participation Dashboard, is the first screen you will see when you begin the MAPIR application process.

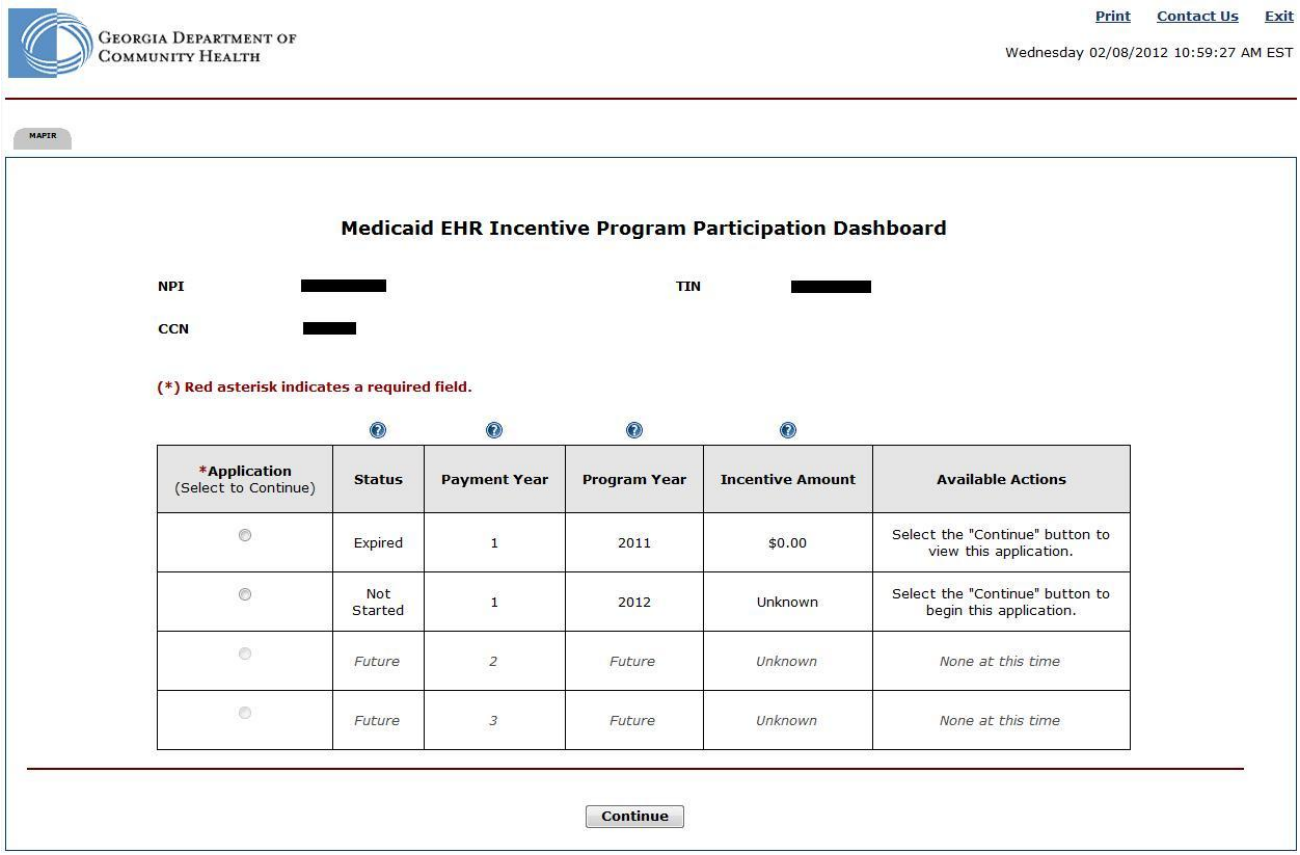
This screen displays your incentive applications. Only the incentive applications that you are eligible to apply for are enabled.

The **Status** will vary, depending on your progress with the incentive application. The first time you access the system the status should be **Not Started**.

From this screen you can choose to edit and view incentive applications in an Incomplete or Not Started status. You can only view incentive applications that are in a Completed, Denied, or Expired status. Also from this screen, you can choose to abort an incentive application that is in an Incomplete status. When you click **Abort** on an incentive application, all progress will be eliminated for the incentive application.

When an incentive application has completed the payment process, the status will change to **Completed**.

Select an application and click **Continue**.



Note: Georgia allows for a grace period which extends the specific Payment Year for a specific length of time. If two applications are showing for the same Payment Year, but different Program Years, one of your incentive applications is in the grace period. In this situation, the following message will display at the bottom of the screen.

> *You are in the grace period for program year <Year> which began on <Date> and ends on <Date>. The grace period extends the amount of time to submit an application for the previous program year. You have the option to choose the previous program year or the current program year.*

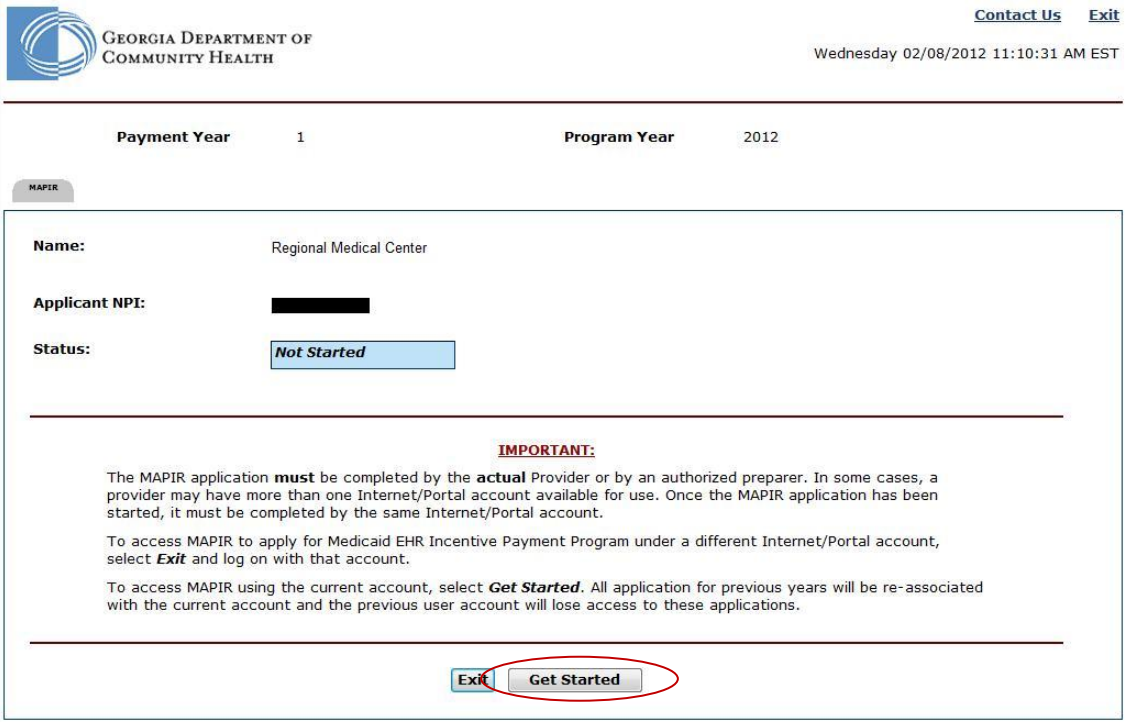
You may only submit an application for one Program Year so once you select the application, the row for the application for the other Program Year will no longer display. If the incentive application is not completed by the end of the grace period, the status of the application will change to Expired and you will no longer have the option to submit the incentive application for that Program Year.

This screen will display with the information for the incentive application you selected. A status of *Not Registered at R&A* indicates that you have not completed the federal level registration at the R&A, or the information provided during the R&A registration process does not match that on file with the Georgia Medicaid Program. If you feel this status is not correct you can click the Contact Us link in the upper right for information on contacting the Georgia Department of Community Health. A status of *Not Started* indicates that the R&A and Georgia MMIS information have been matched and you can begin the application process.

The **Status** will vary, depending on your progress with the application. The first time you access the system the status should be **Not Started**.

For more information on statuses, refer to Appendix E in this guide.

Click **Get Started** to access the **Get Started** screen or **Exit** to close the program.

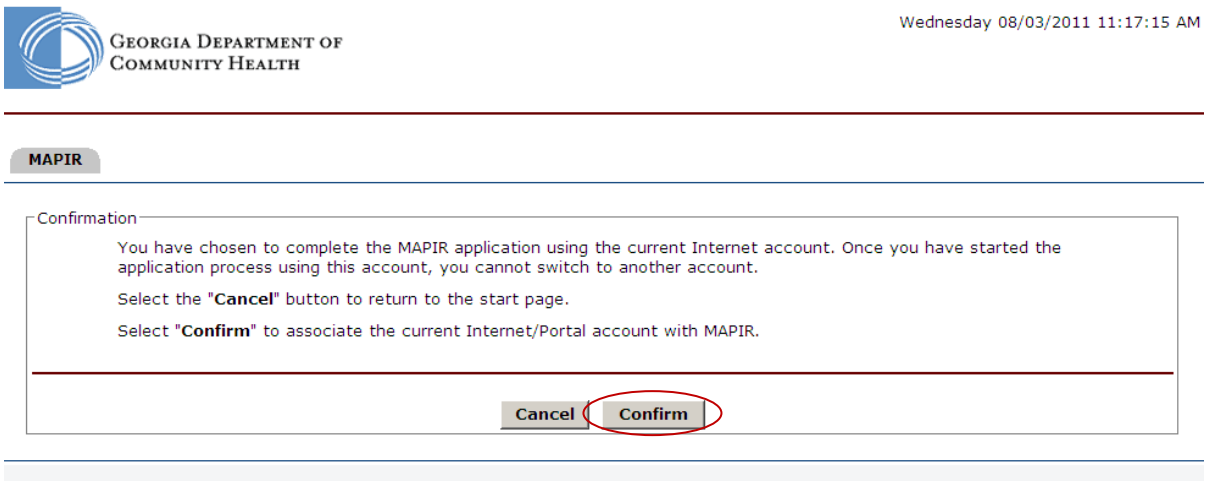


If you elect to start over, MAPIR will display a Confirmation Screen asking you to confirm your decision. If you selected an incentive application that you are not associated with, you will receive a message indicating that a different Internet/Portal account has already started the Medicaid EHR Incentive Payment Program application process and that the same Internet/Portal account must be used to access the application for this Provider ID. If

you are the new user for the provider and want to access the previous applications, you will need to contact the Georgia Department of Community Health for assistance.

If the confirmation screen appears, you can either:

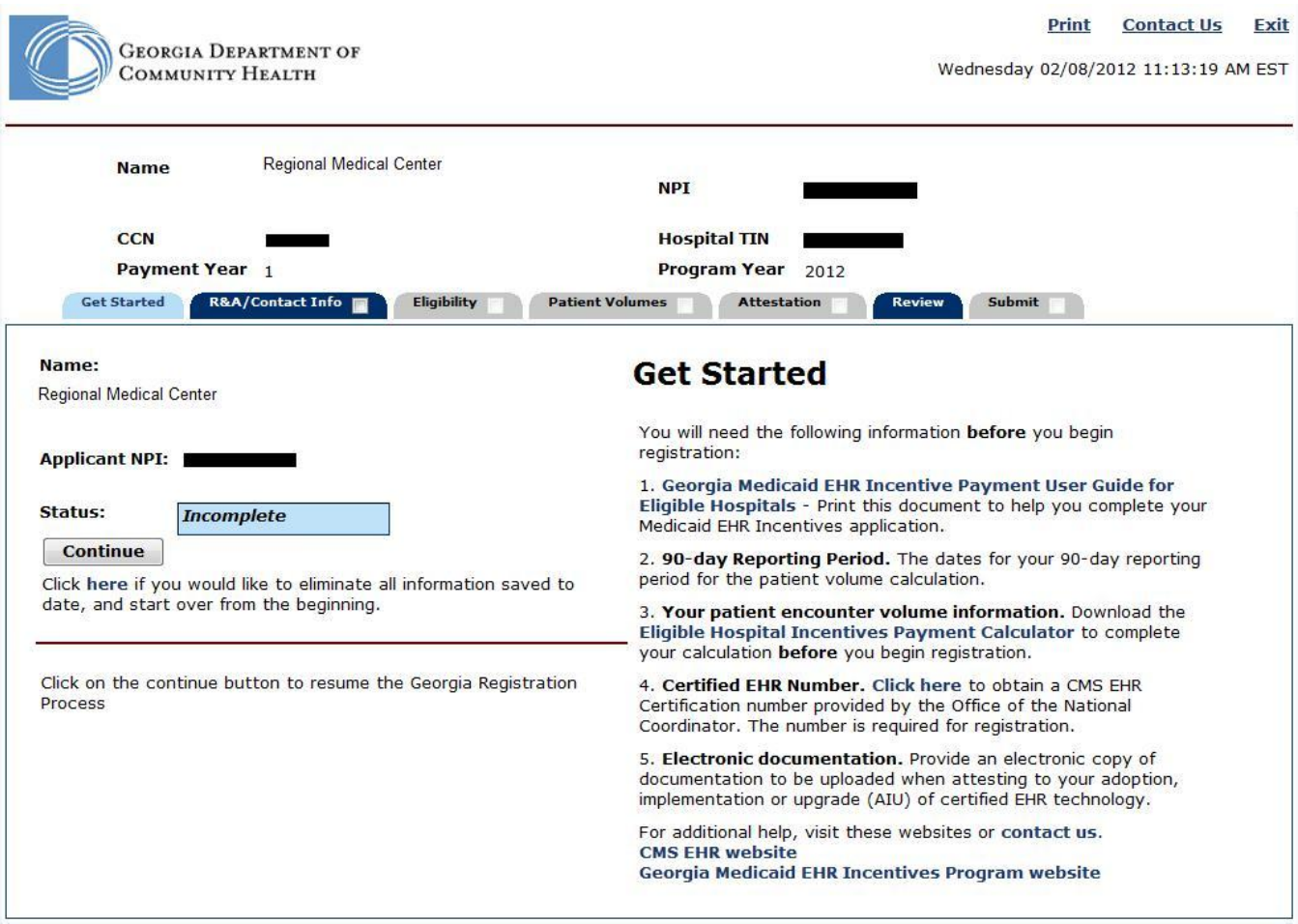
- Select **Cancel** and return to the ***Get Started*** screen; OR
- Select **Confirm**, to associate the current Internet/portal account with this incentive application and you will be prompted to initiate the application from the beginning.



The **Get Started** screen contains information that includes your facility **Name, Applicant NPI, CCN, and Hospital TIN**. Also included is the current status of your application.

Click **Continue** to proceed to the **R&A/Contact Info** section.

Please note: The header, which displays your provider, TIN, CCN, payment and program year information, will remain the same as you navigate throughout the MAPIR application.


Georgia Department of Community Health
Print
Contact Us
Exit
Wednesday 02/08/2012 11:13:19 AM EST
Name
Regional Medical Center
NPI
[redacted]
CCN
[redacted]
Hospital TIN
[redacted]
Payment Year 1
Program Year 2012
Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Name:
Regional Medical Center
Applicant NPI: [redacted]
Status: Incomplete
Continue
Click here if you would like to eliminate all information saved to date, and start over from the beginning.
Click on the continue button to resume the Georgia Registration Process
Get Started
You will need the following information before you begin registration:
1. Georgia Medicaid EHR Incentive Payment User Guide for Eligible Hospitals - Print this document to help you complete your Medicaid EHR Incentives application.
2. 90-day Reporting Period. The dates for your 90-day reporting period for the patient volume calculation.
3. Your patient encounter volume information. Download the Eligible Hospital Incentives Payment Calculator to complete your calculation before you begin registration.
4. Certified EHR Number. Click here to obtain a CMS EHR Certification number provided by the Office of the National Coordinator. The number is required for registration.
5. Electronic documentation. Provide an electronic copy of documentation to be uploaded when attesting to your adoption, implementation or upgrade (AIU) of certified EHR technology.
For additional help, visit these websites or contact us.
CMS EHR website
Georgia Medicaid EHR Incentives Program website

Step 2 – Confirm R&A and Contact Info

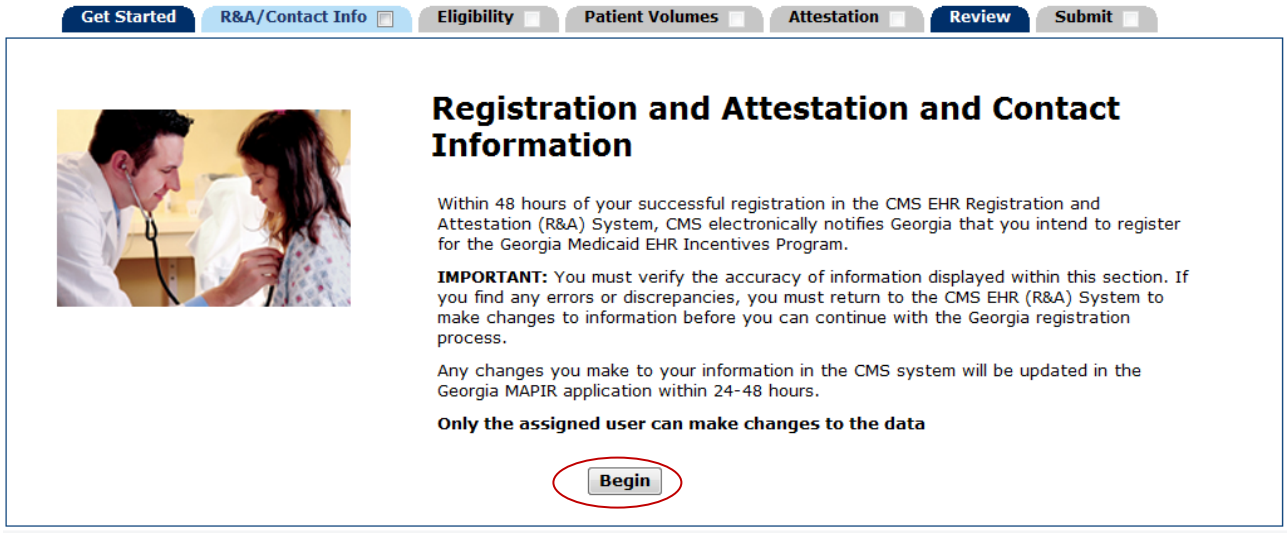
You will need to verify the accuracy of the information transferred from the R&A to MAPIR. If there are any errors in the information, you must return to the R&A to make these updates prior to moving forward with your MAPIR application.

Changes made in the R&A are not immediate and will not be displayed in MAPIR for at least two business days. You cannot continue with the MAPIR application process until the updated information is available in MAPIR.

The following link will direct you to the R&A to make updates or correct any errors: https://ehrincentives.cms.gov/hitech/login.action.

Please note that in this section, you will be required to enter a contact name and phone number, along with an email address. All email correspondence regarding your incentive payment application will be sent to this email address and also to the email address entered at the R&A.

Click **Begin** to access the **R&A/Contact Info** screen to confirm information and to enter your contact information.



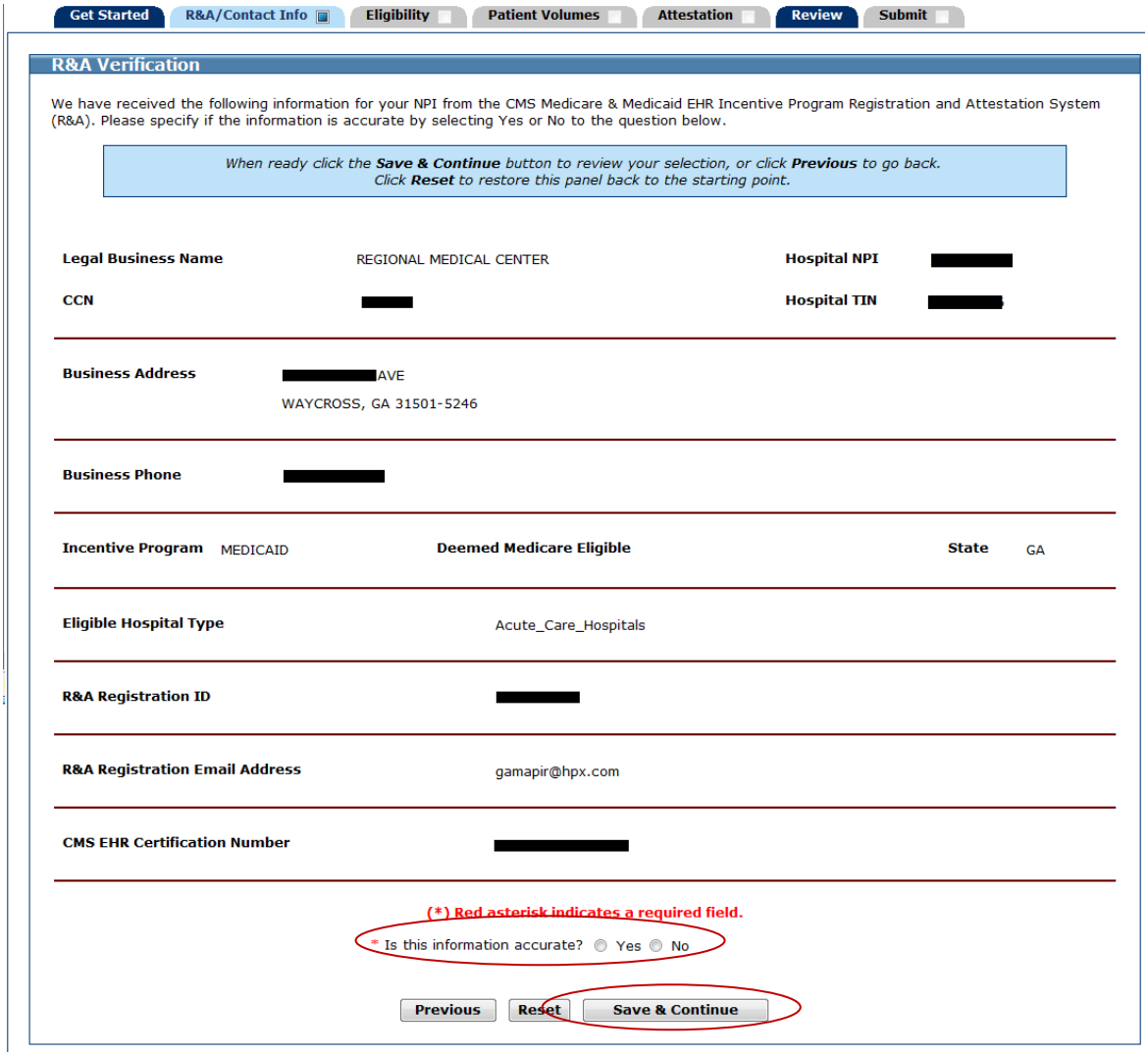
Check your information carefully to ensure that it is accurate.

Compare the R&A Registration ID you received when you registered with the R&A with the **R&A Registration ID** that is displayed.

After reviewing the information click **Yes** or **No**.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to clear all unsaved data.

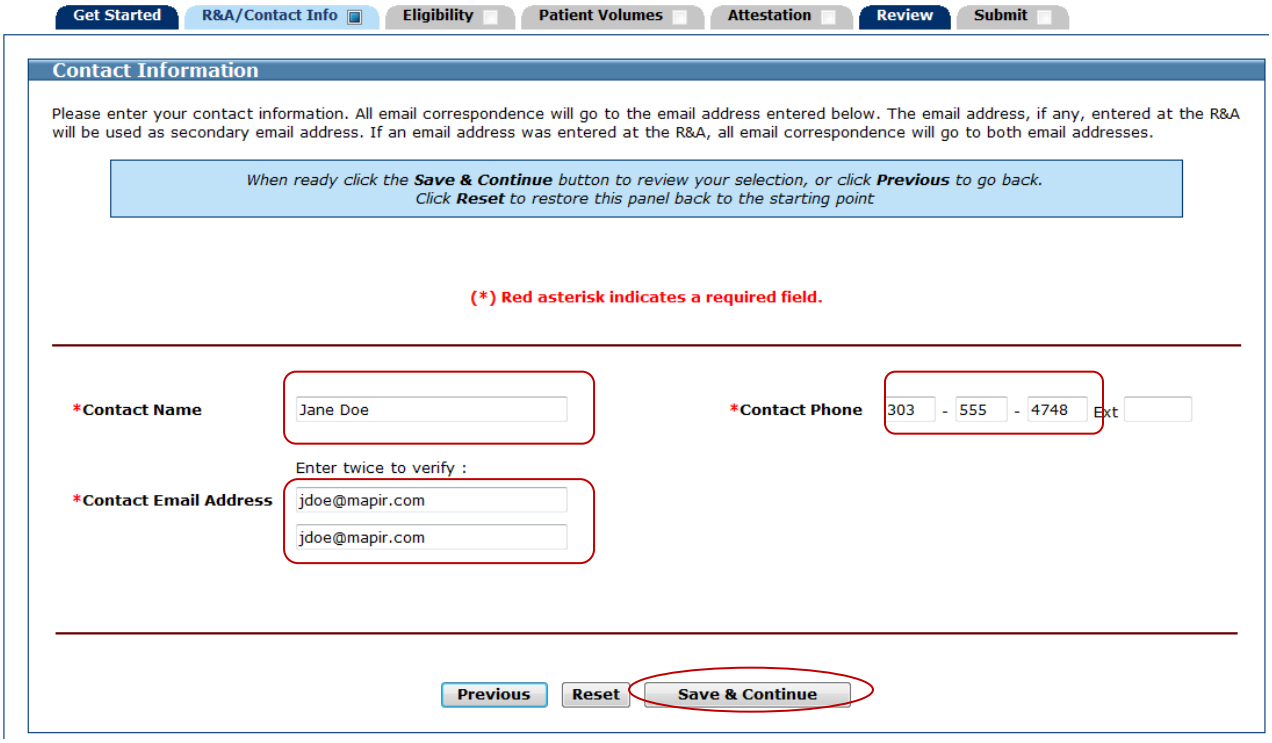
Any discrepancies must be updated directly in the R&A before you can proceed with your MAPIR application.



Enter a **Contact Name** and **Contact Phone number**.

Enter a **Contact Email Address** twice for verification. **All email communications from DCH will be sent to this email address and also to the email address entered in the R&A.**

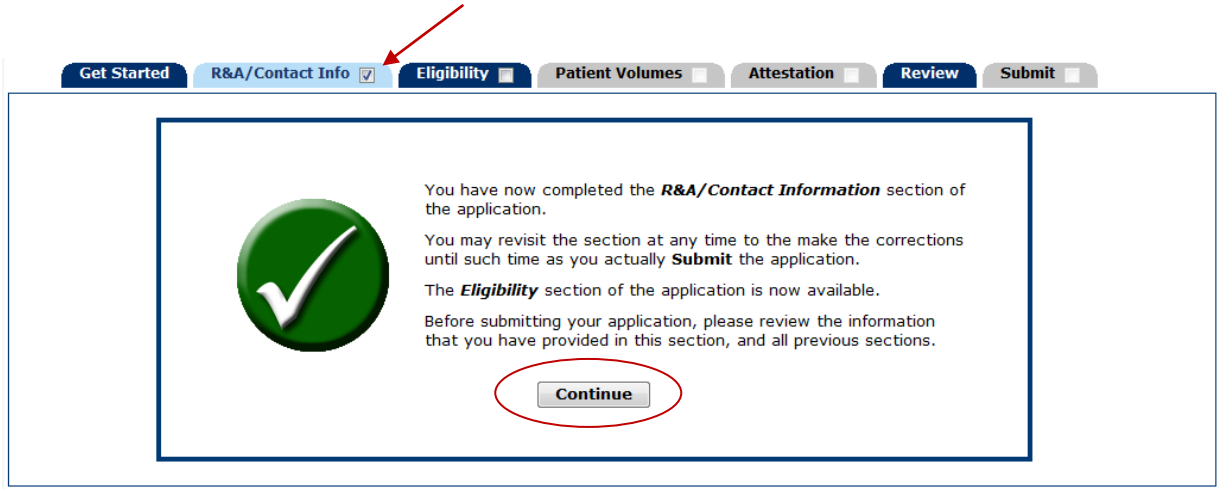
Click **Save & Continue** to proceed, **Previous** to return, or **Reset** to clear all unsaved data.



This page confirms you successfully completed the **R&A/Contact Info** section.

Note the check box located in the **R&A/Contact Info** tab. You can return to this section to update the Contact Information at any time prior to submitting your application.

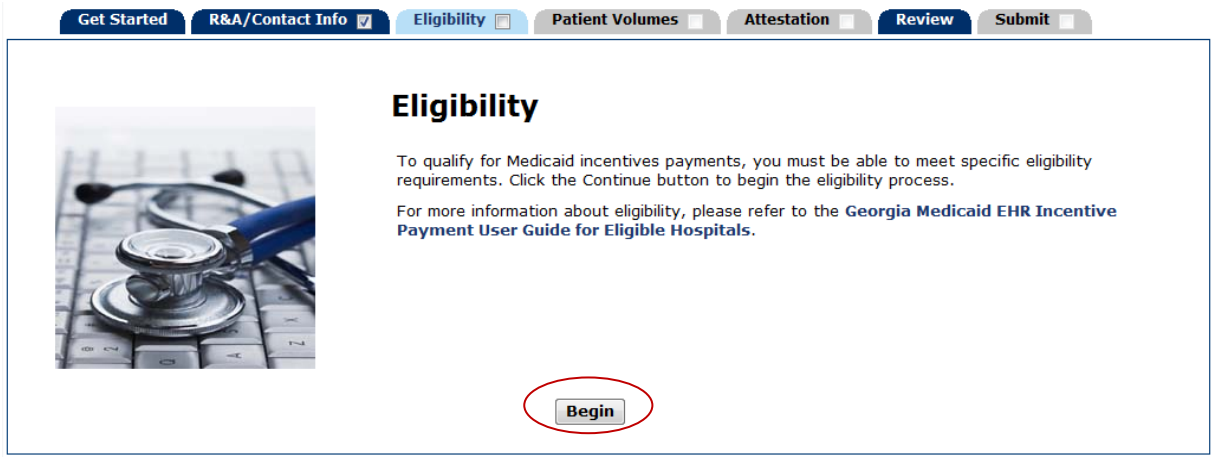
Click **Continue** to proceed to the **Eligibility** section.



Step 3 – Eligibility

The Eligibility section will ask questions to allow the Georgia Medicaid EHR Incentive Program to make a determination regarding your eligibility for a Medicaid EHR incentive payment. You will also enter your required CMS EHR Certification ID for your certified EHR technology.

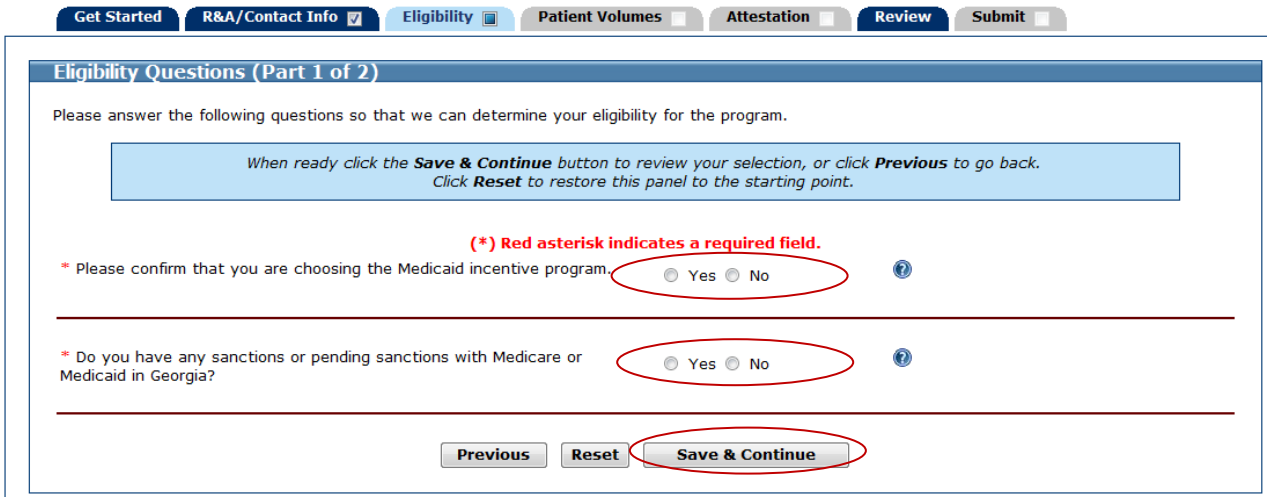
Click **Begin** to proceed to the **Eligibility Questions (Part 1 of 2)**.



The questions on this screen are required fields that must be answered.

Answer **Yes** or **No** to the eligibility questions.

Click **Save & Continue** to proceed, **Previous** to return, or **Reset** to clear all unsaved data.



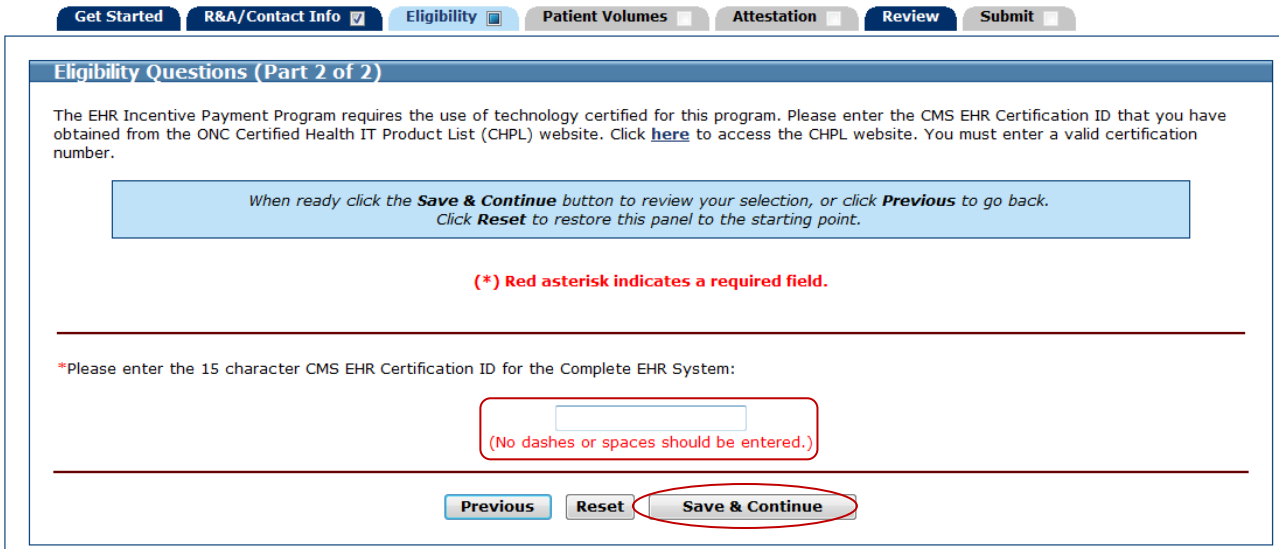
The **Eligibility** screen asks for information about your **CMS EHR Certification ID**.

The requested information on this screen is required and must be completed.

Enter the 15-character **CMS EHR Certification ID** without spaces or dashes.

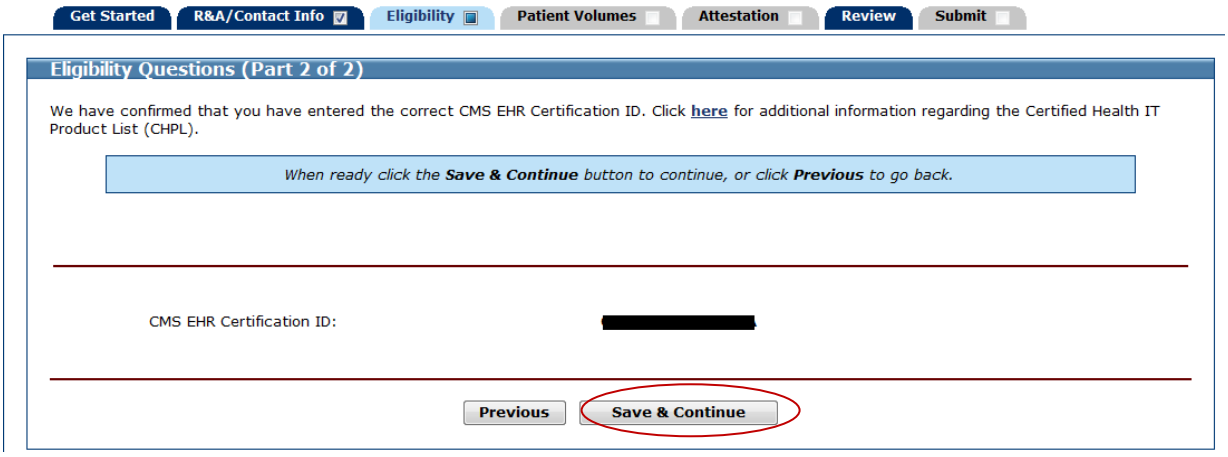
Click **Save & Continue** to proceed, **Previous** to return, or **Reset** to clear all unsaved data.
MAPIR will perform an online validation of the number you entered.

A CMS EHR Certification ID can be obtained from the ONC Certified Health IT Product List (CHPL) website (http://onc-chpl.force.com/ehrcert)



This screen confirms you successfully entered your **CMS EHR Certification ID**.

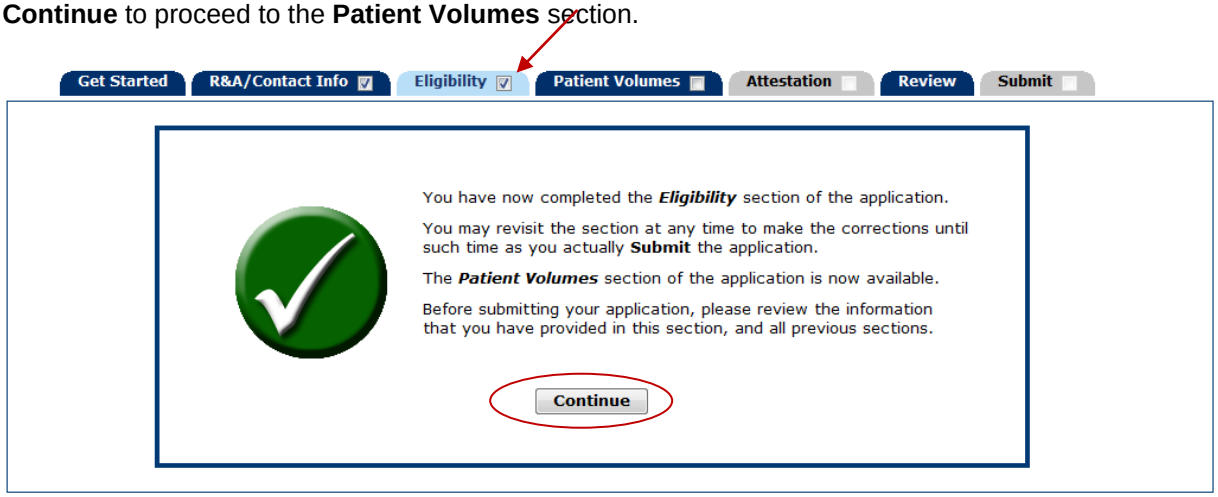
Click **Save & Continue** to proceed or **Previous** to return.



This screen confirms you successfully completed the **Eligibility** section.

Note the check box in the **Eligibility** tab.

Click **Continue** to proceed to the **Patient Volumes** section.



Step 4 - Patient Volumes

The **Patient Volumes** section gathers information about your facility location(s), the 90-day period you intend to use for meeting the Medicaid patient volume requirement, and your facility's patient volumes and cost data. Additionally, you will be asked about how you utilize your certified EHR technology.

Important:

This change affecting the **Medicaid patient volume calculation** is applicable to all eligible providers, regardless of the stage of the Medicaid EHR Incentive Program they are participating in. Billable services provided by an eligible provider to a patient enrolled in Medicaid would count toward meeting the minimum Medicaid patient volume thresholds. Examples of Medicaid encounters under this expanded definition that could be newly eligible might include: behavioral health services, HIV/AIDS treatment, or other services that might not be billed to Medicaid/managed care for privacy reasons, but where the provider has a mechanism to verify eligibility. Also, services to a Medicaid-enrolled patient that might not have been reimbursed by Medicaid (or a Medicaid managed care organization) may now be included in the Medicaid patient volume calculation (e.g., oral health services, immunization, vaccination and women's health services, telemedicine/telehealth, etc.).

In some instances, it may now be appropriate to include services denied by Medicaid in calculating patient volume. If Medicaid denied the service for timely filing or because another payer's payment exceeded the potential Medicaid payment, it would be appropriate to include that encounter in the calculation. If Medicaid denied payment for the service because the beneficiary has exceeded service limits established by the Medicaid program, it would be appropriate to include that encounter in the calculation.

If Medicaid denied the service because the patient was **ineligible** for Medicaid at the time of service, it would not be appropriate to include that encounter in the calculation.

There are three parts to the Patient Volumes section:

In this section, your continuous 90-day reporting period, Medicaid patient volume and patient volume cost data should match the data and calculations from your Eligible Hospital Patient Volume and Incentive Payment Calculator, which you must upload as part of the attestation phase.

Part 1 of 3 establishes the continuous 90-day period for reporting patient volumes.

Part 2 of 3 contains screens to enter locations for reporting **Medicaid Patient Volumes** and at least one location for **Utilizing Certified EHR Technology**, adding locations, and entering patient volumes for the chosen reporting period. If an Eligible Hospital serves Medicaid patients from bordering states (i.e., a state contiguous to Georgia) within 50-miles of the Georgia state line, the Eligible Hospital may include the Medicaid patient volume from that state *if those encounters would aid you in meeting the minimum patient volume threshold*.

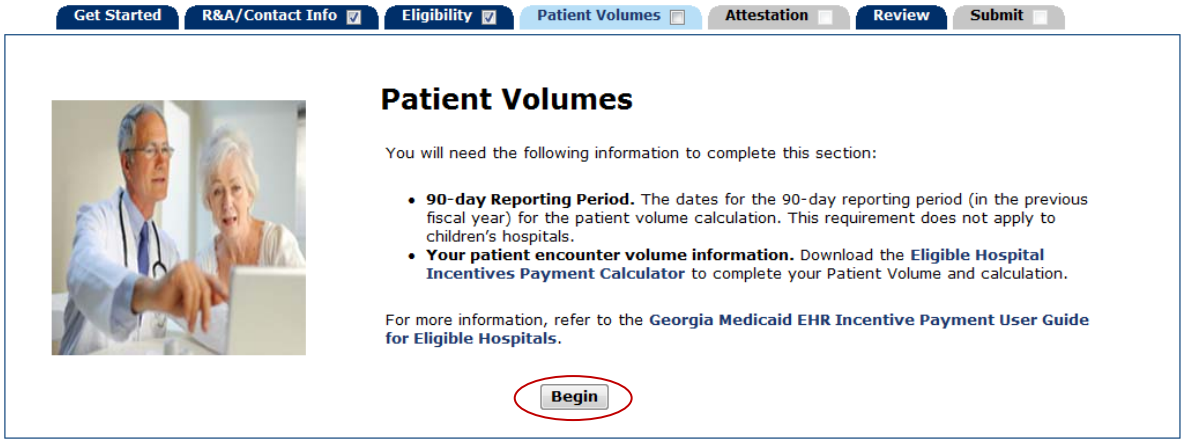
Part 3 of 3 contains pages to enter your hospital **Patient Volume Cost Data** information. This information will be used to calculate your potential hospital incentive payment amount.

Children's hospitals (children's hospitals with CCNs in the 3300 – 3399 range) are not required to meet the 10% Medicaid patient volume requirement. MAPIR will bypass these patient volume screens.

The initial **Patient Volumes** screen contains information about this section.

If you represent a Children's hospital, click **Begin** to go to the **Patient Volume Cost Data (Part 3 of 3)**, to bypass entering patient volumes and adding locations.

If you represent an Acute Care or Critical Access Hospital, click **Begin** to proceed to the **Patient Volume 90-Day Period (Part 1 of 3)** page.


Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Patient Volumes
You will need the following information to complete this section:
90-day Reporting Period. The dates for the 90-day reporting period (in the previous fiscal year) for the patient volume calculation. This requirement does not apply to children's hospitals.
Your patient encounter volume information. Download the Eligible Hospital Incentives Payment Calculator to complete your Patient Volume and calculation.
For more information, refer to the Georgia Medicaid EHR Incentive Payment User Guide for Eligible Hospitals.
Begin

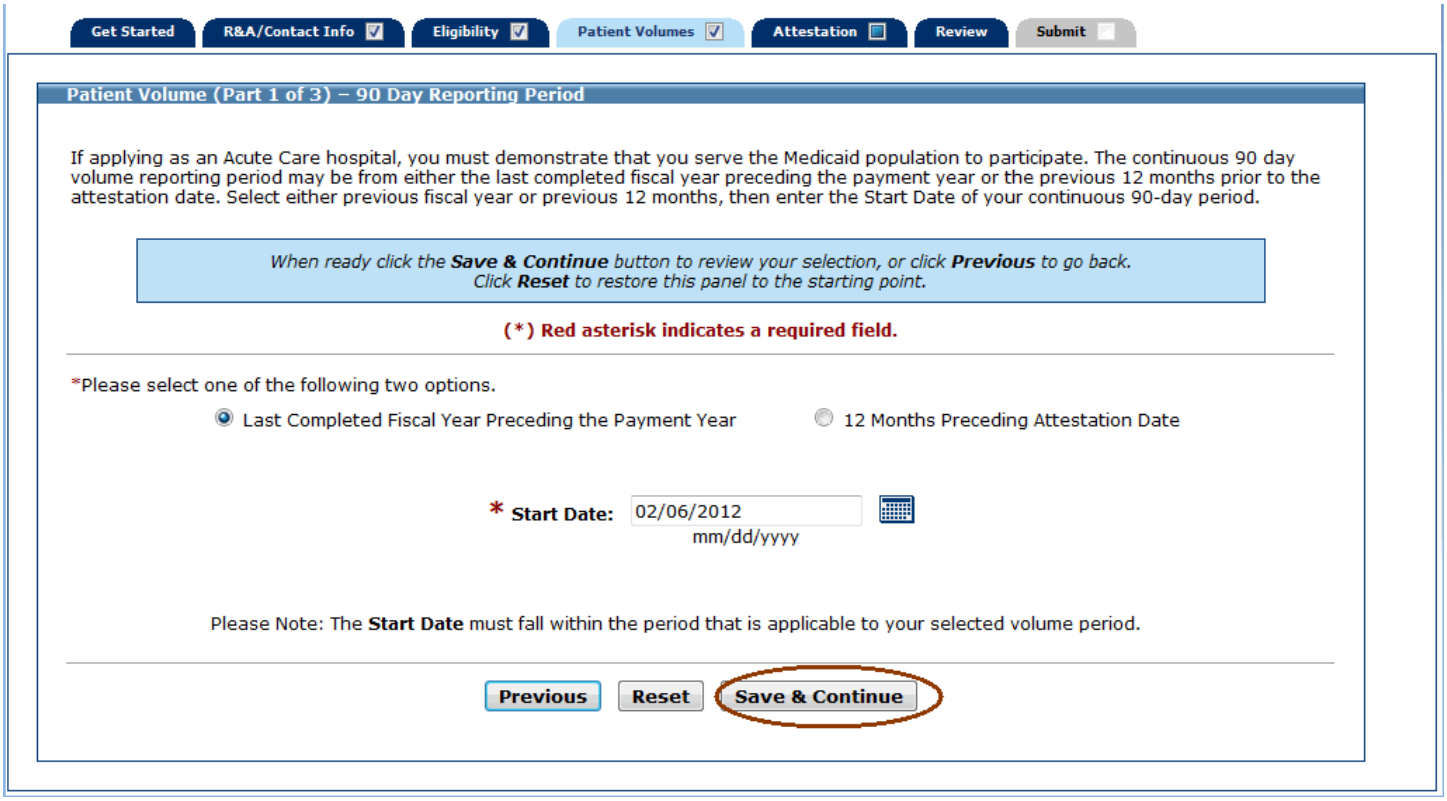
Part 1 of 3 - Patient Volume 90-Day Period

The Patient Volume (Part 1 of 3) - 90 Day Reporting Period section collects information about the Medicaid Patient Volume reporting period. Enter the start date for the 90 day reporting period in which you will demonstrate the required Medicaid patient volume participation level.

Select if you would like your 90 day reporting period to be from either the **Last Completed Fiscal Year Preceding the Payment Year** or the **12 Months Preceding Attestation Date**.

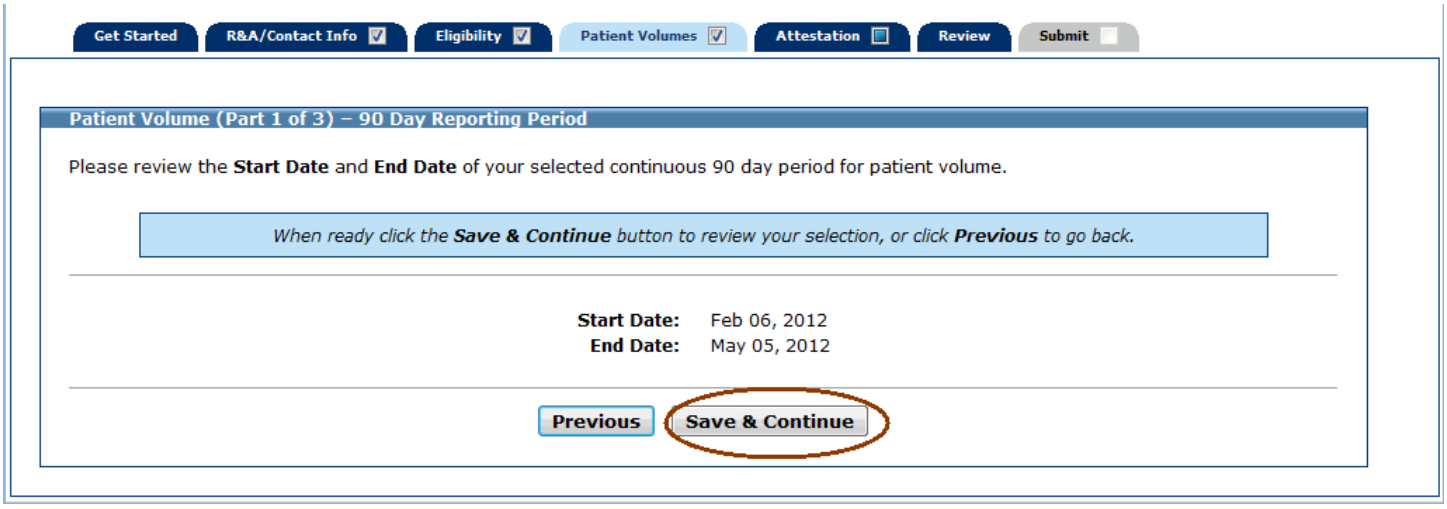
Enter a **Start Date** or select one from the calendar icon located to the right of the **Start Date** field.

Click **Save & Continue** to proceed, **Previous** to return, or **Reset** to clear all unsaved data.



Review the **Start Date** and **End Date** information. The 90 Day **End Date** has been calculated for you.

Click **Save & Continue** to review your selection, or click **Previous** to go back.



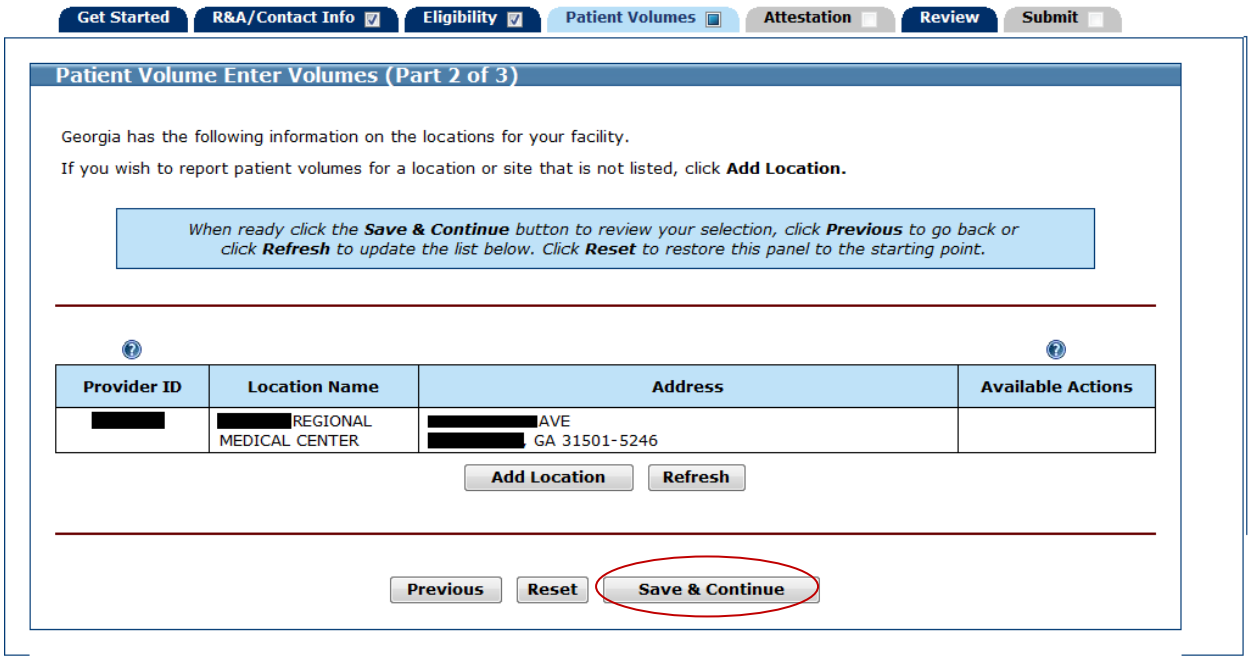
Part 2 of 3 – Patient Volumes

In order to meet the requirements of the Medicaid EHR Incentive Program, you must provide information about your facility. The information will be used to determine your eligibility for the Medicaid EHR Incentive Program.

Facility locations – MAPIR will present a list of locations that the Georgia Medicaid program has on record. If you have additional locations you will be given the opportunity to add them. Once all locations are added, you will enter the required Patient Volume information.

Review the listed locations. Add new locations by clicking **Add Location**.

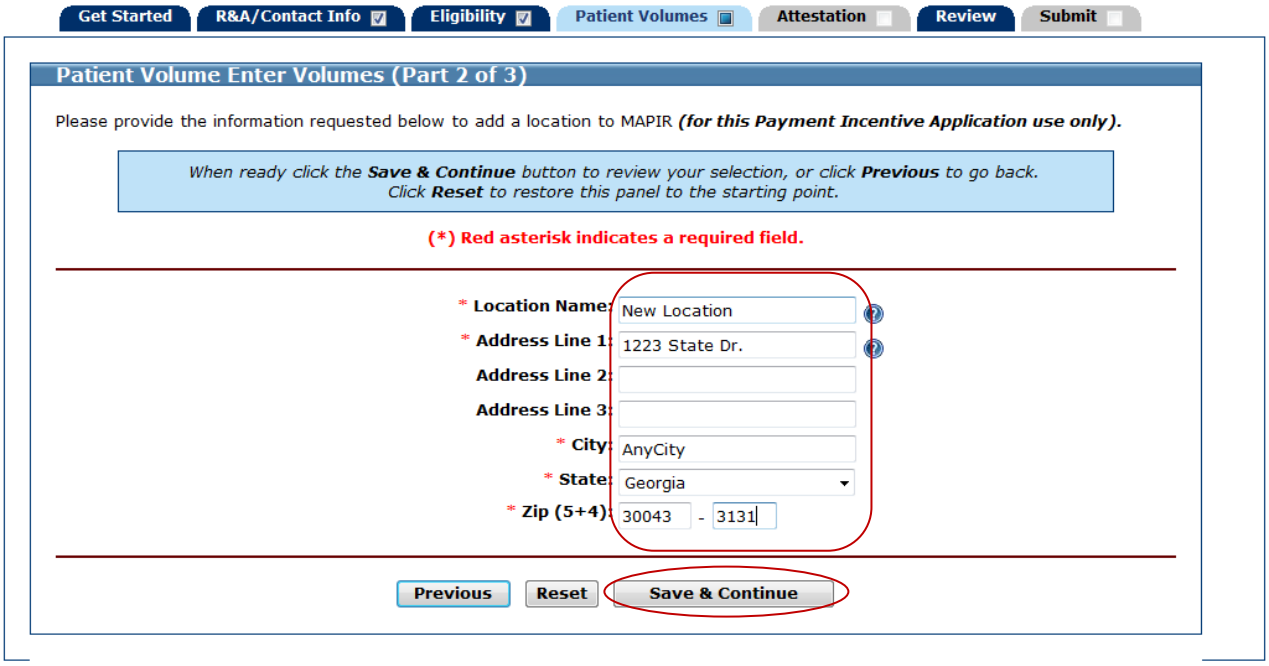
Note: Adding a location in the MAPIR application will not update or add a new location in the Georgia Medicaid MMIS. Please contact DCH Provider Enrollment for information regarding adding a new Medicaid location.



If you clicked **Add Location** on the previous screen, you will see the following screen.

Enter the requested information for your new location.

Click **Save & Continue** to proceed, **Previous** to return, or **Reset** to clear all unsaved data.

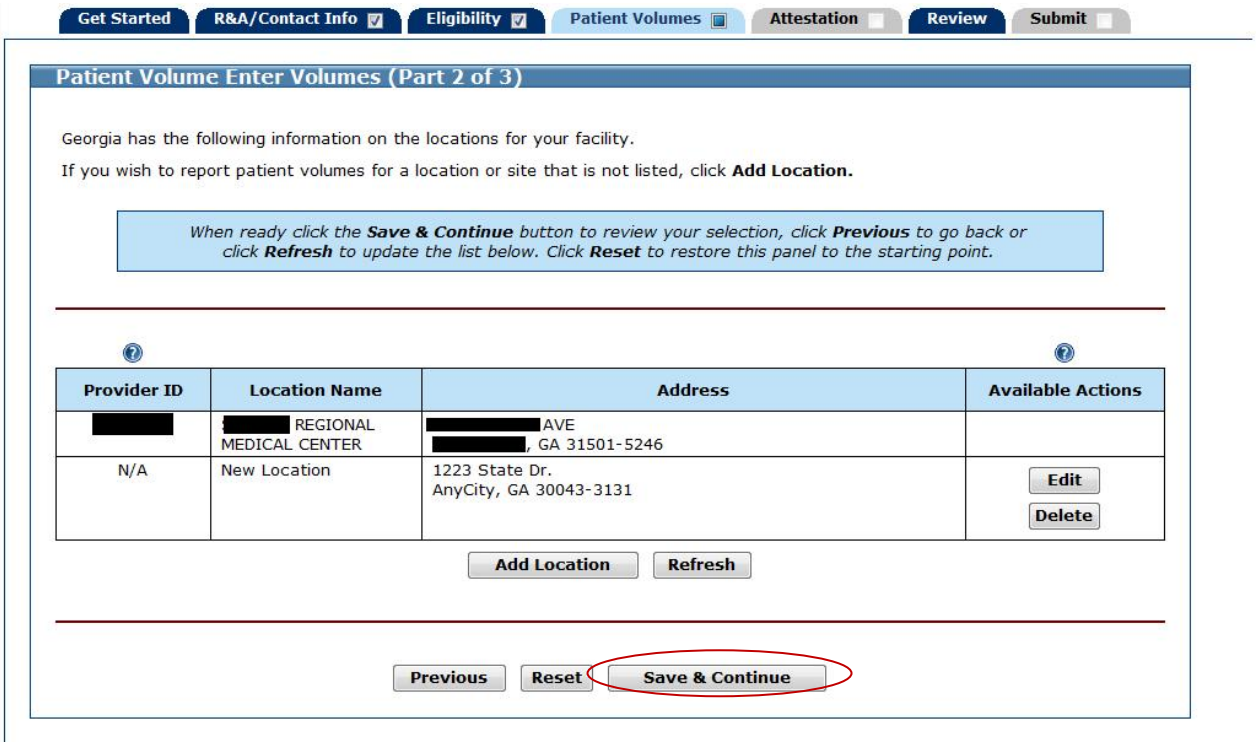


This screen shows one location on file and one added location.

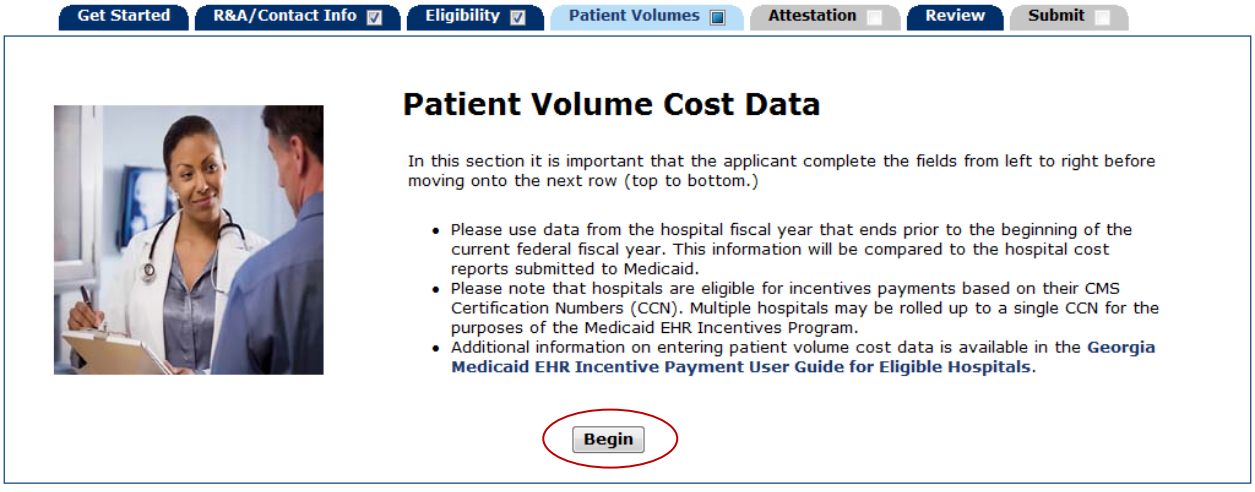
Click **Edit** to make changes to the added location or **Delete** to remove it from the list.

*Note: The **Edit** and **Delete** options are not available for locations already on file.*

Click **Save & Continue** to proceed, **Previous** to return, or **Reset** to clear all unsaved data.



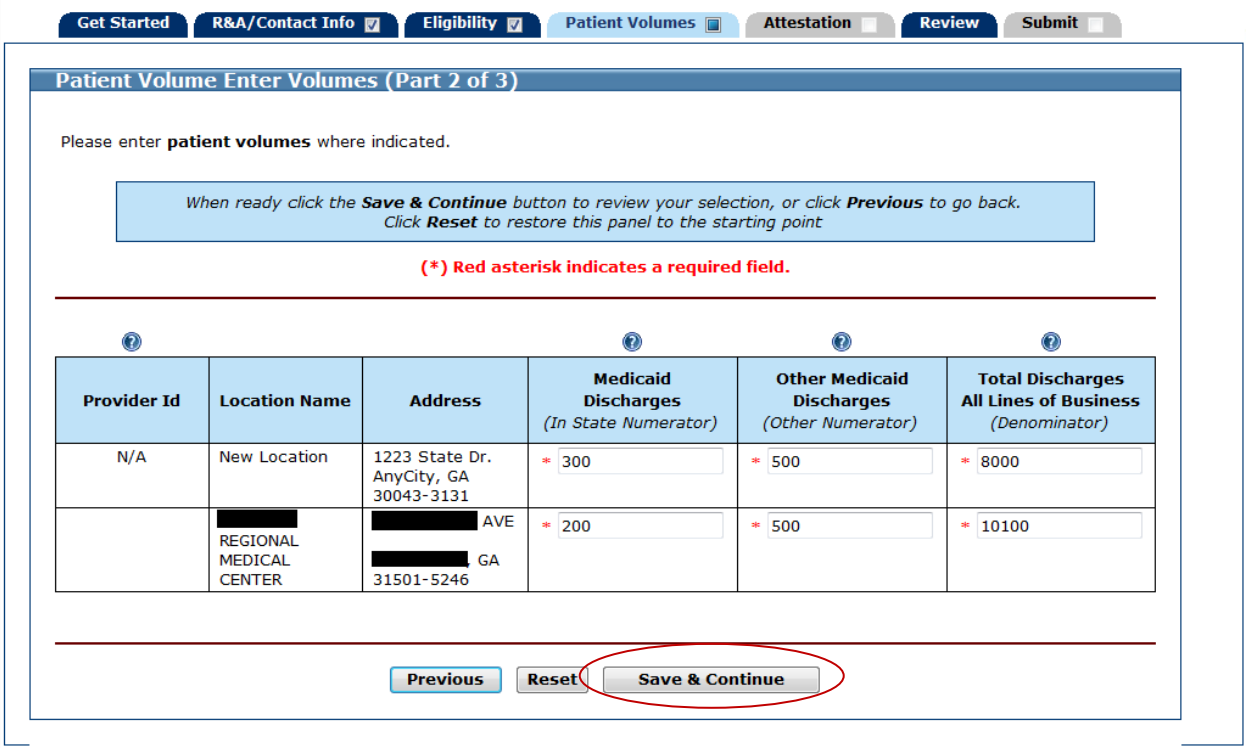
Click **Begin** to proceed to the pages where you will enter **Medicaid Patient Volumes**.



Enter **Patient Volumes** for each of the locations listed on the page.

Note: Patient volume and Patient cost data entered here will come from the previously completed Eligible Hospital Patient Volume and Incentive Payment Calculator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



This screen displays the patient volumes you entered, all values summarized, and the Medicaid Patient Volume Percentage.

The Medicaid Patient Volume Percentage Formula is:

(**Medicaid Discharges** + **Other Medicaid Discharges**)

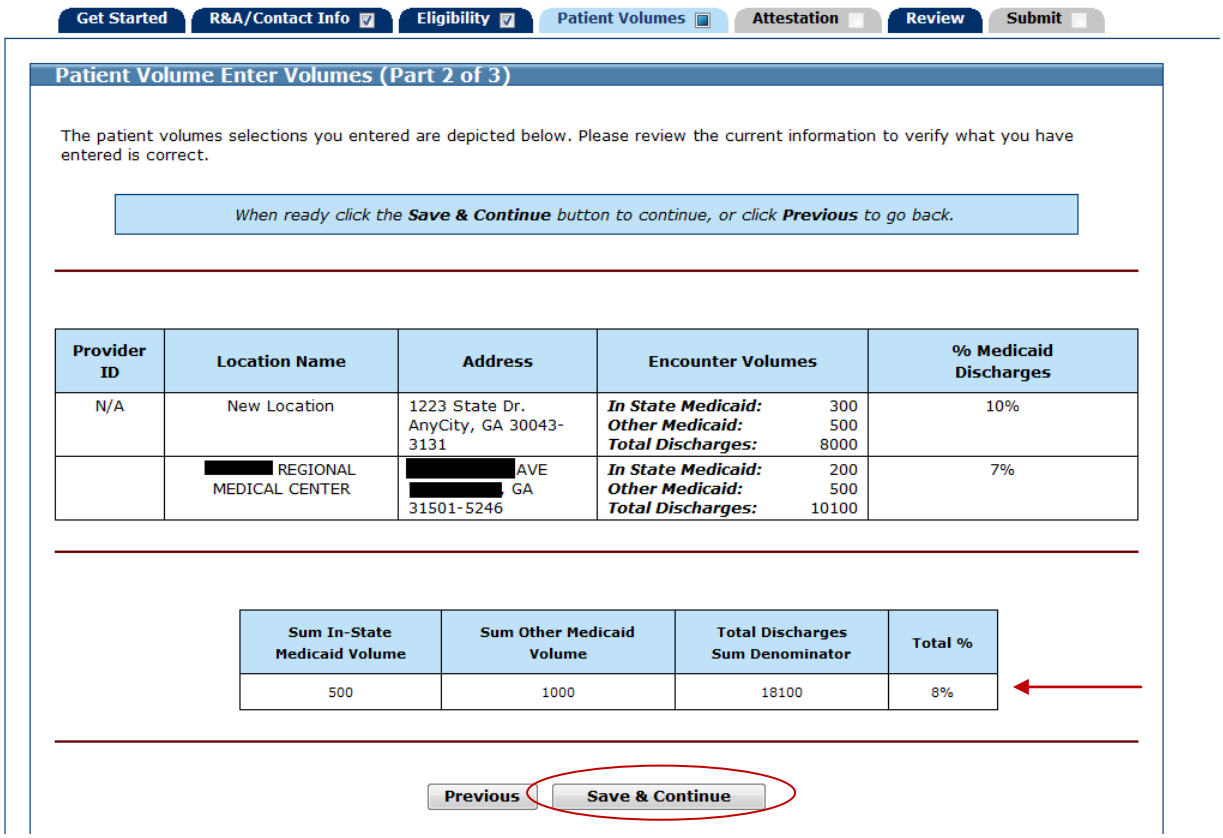
Divided by

Total Discharges All Lines of Business

Note: The **Total %** patient volume field. This percentage must be greater than or equal to 10% to meet the Medicaid patient volume requirement.

Note: **Patient Volume** entered on this page must come from the your completed Eligible Hospital Patient Volume and Incentive Payment calculator.

Click **Save & Continue** to proceed, or **Previous** to go back.



Part 3 of 3 - Patient Volume Cost Data

The following pages will request **Patient Volume Cost Data**. This information will be used to calculate your hospital incentive payment amount. The total hospital incentive payment is calculated in your first payment year and distributed over a three year period:

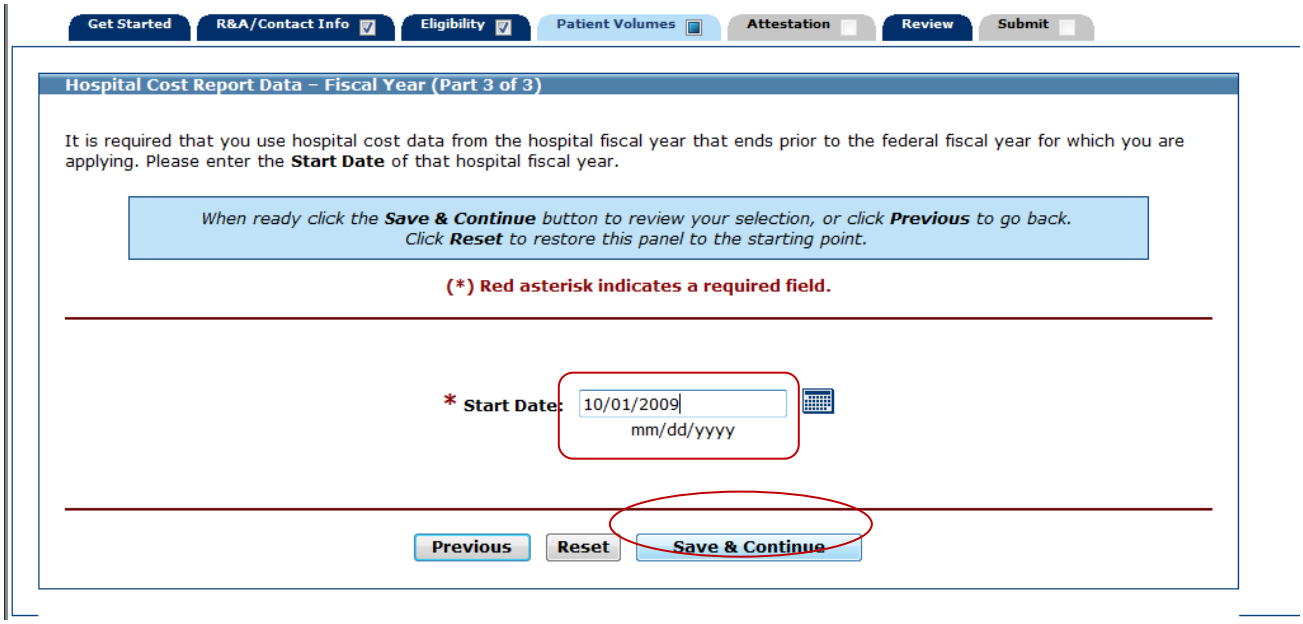
- Payment year – 40%
- Payment year – 40%
- Payment year – 20%

To receive subsequent year payments you must attest to the eligibility requirements, patient volume requirements (except Children's hospitals), and meaningful use each year.

Enter the **Start Date** of the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the first payment year, or select one from the calendar icon located to the right of the **Start Date** field.

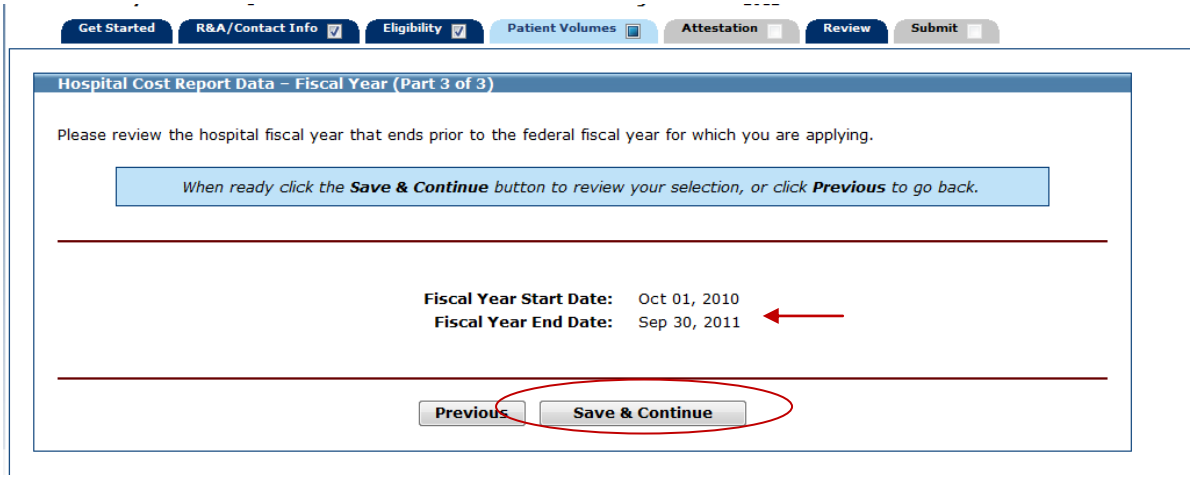
Note: **Patient Volume** entered here will come from your previously completed Eligible Hospital Patient Volume and Incentive Payment calculator.

Click **Save & Continue** to proceed, **Previous** to return, or **Reset** to clear all unsaved data.



This page displays your **Fiscal Year Start Date** and the **Fiscal Year End Date.**

If the Fiscal Year Start and End Dates are correct, click **Save & Continue** to proceed, or **Previous** to go back.



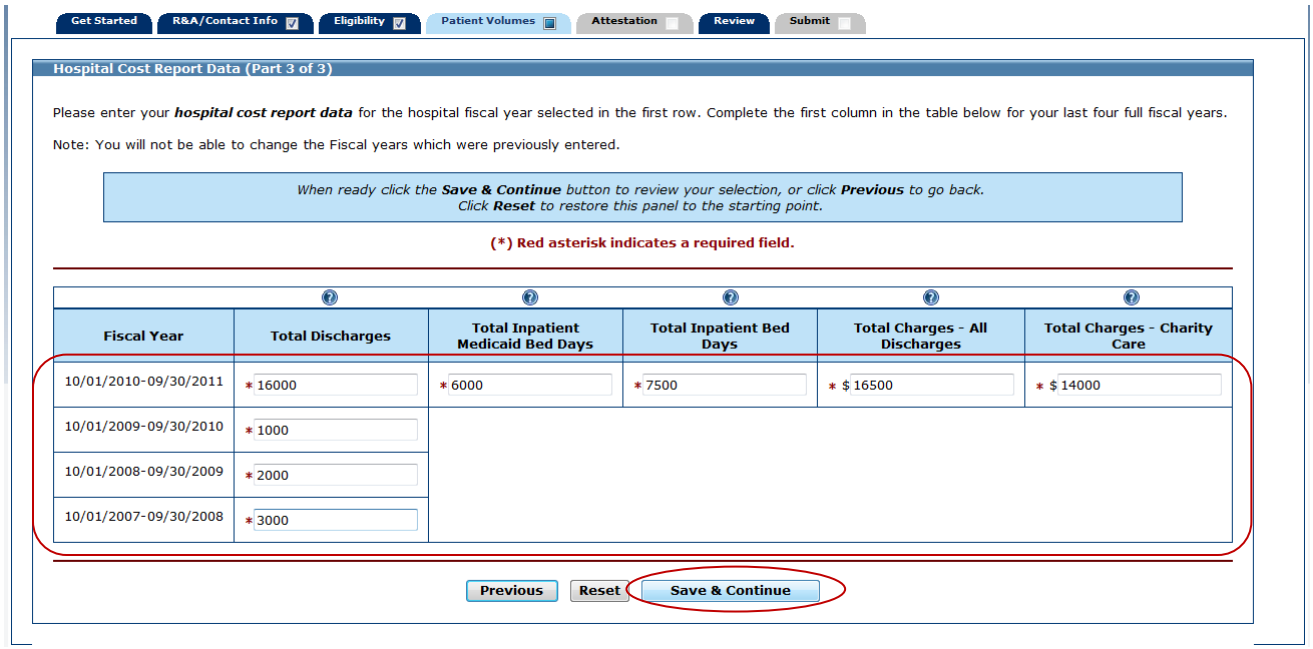
On this screen you will enter the data required to calculate your Medicaid EHR incentive payment. In the first column enter **Total Discharges** for the **Fiscal Years** displayed to the left. Enter the **Total Inpatient Medicaid Bed Days**, **Total Inpatient Bed Days**, **and Total Charges – All Discharges**, and **Total Charges – Charity Care**.

Click **Save & Continue** to proceed, **Previous** to return, or **Reset** to clear all unsaved data.

Note: **Patient Volume Cost Data** entered below, must come from your previously completed Eligible Hospital Patient Volume and Incentive Payment calculator. It is important that the applicant complete the fields from left to right before moving onto the next row (top to bottom).

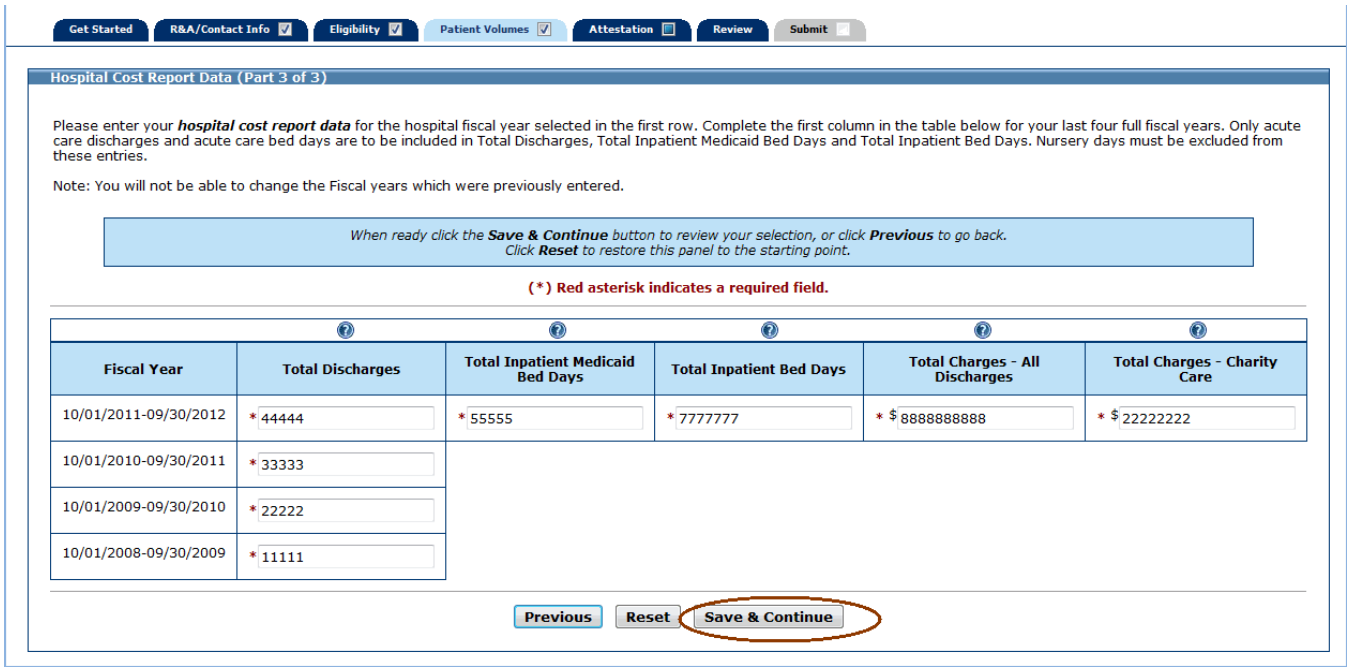
If you are in Payment Year 2 or subsequent payment years, this screen will display the hospital cost report data from the previous paid application. If you would like to change the hospital cost report data, refer to the Change Hospital Cost Report Data section of this manual. If you would like to proceed using the existing hospital cost report data from the previous paid application, click **Save & Continue**.

If you are accessing MAPIR for the first time and received one or more incentive payments from another state, the Patient Volume Cost Data screen will display zeroes. You will not be able to enter data. After submitting your application, contact the Georgia Department of Community Health.



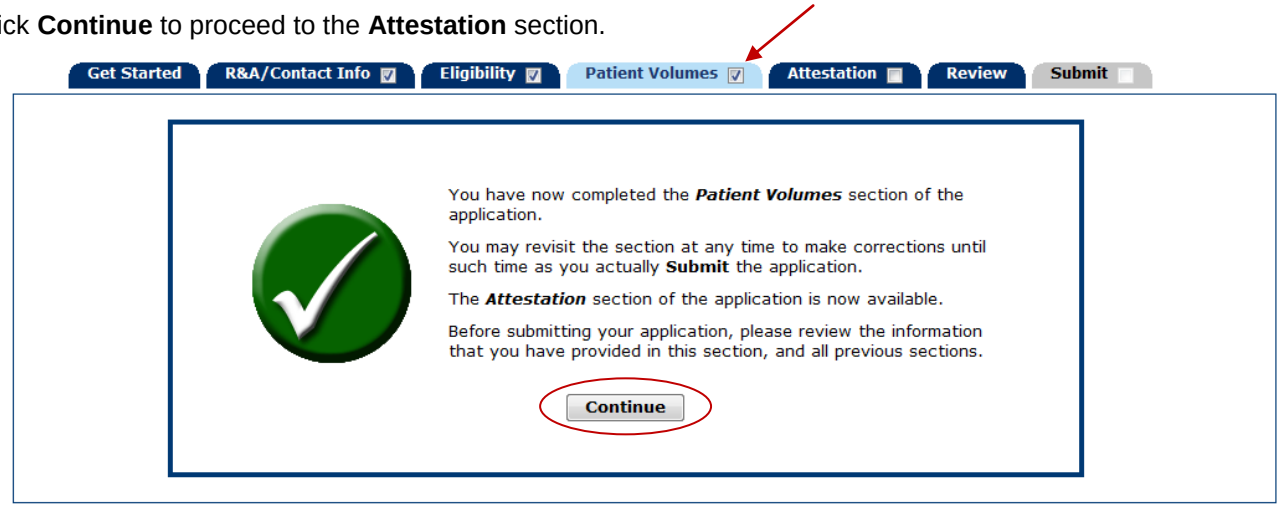
Please review the data that you entered on the previous page.

Click **Save & Continue** to proceed, or click **Previous** to go back.



This page confirms you successfully completed **Patient Volumes** section.

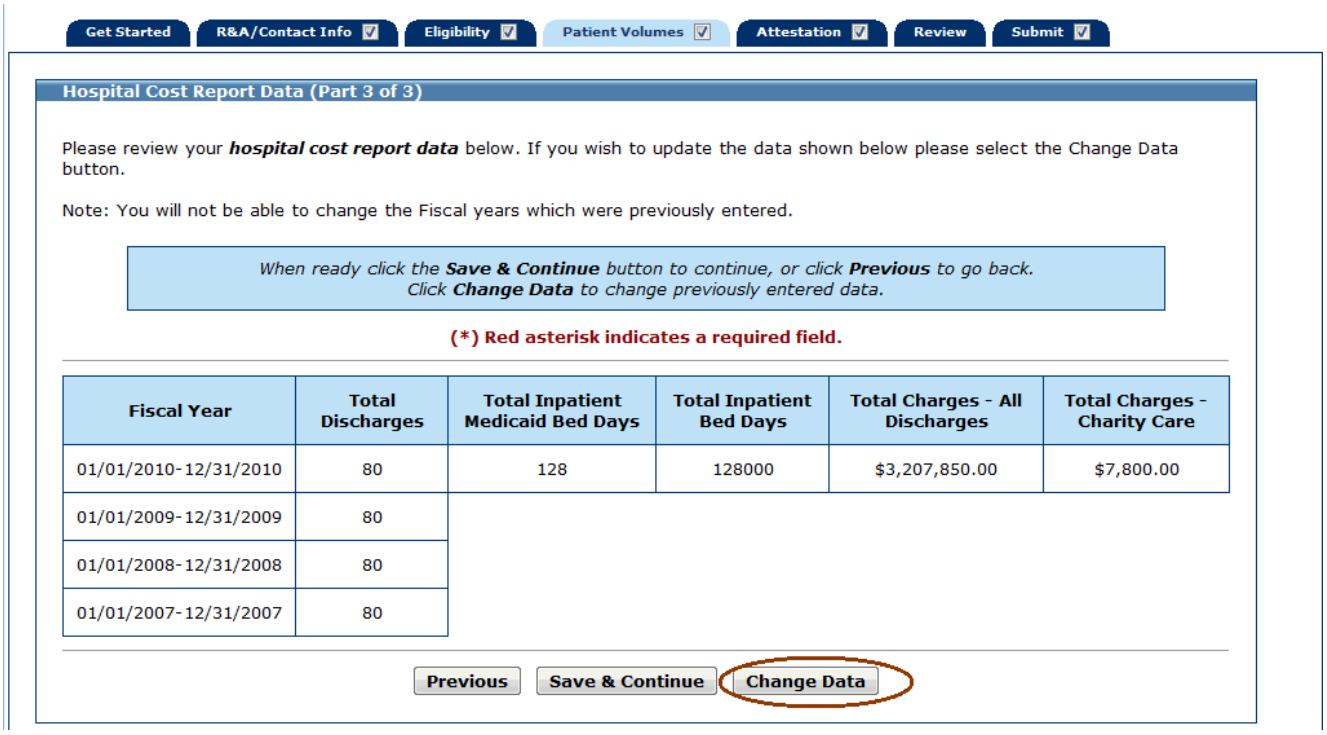
Click **Continue** to proceed to the **Attestation** section.



Change Hospital Cost Report Data

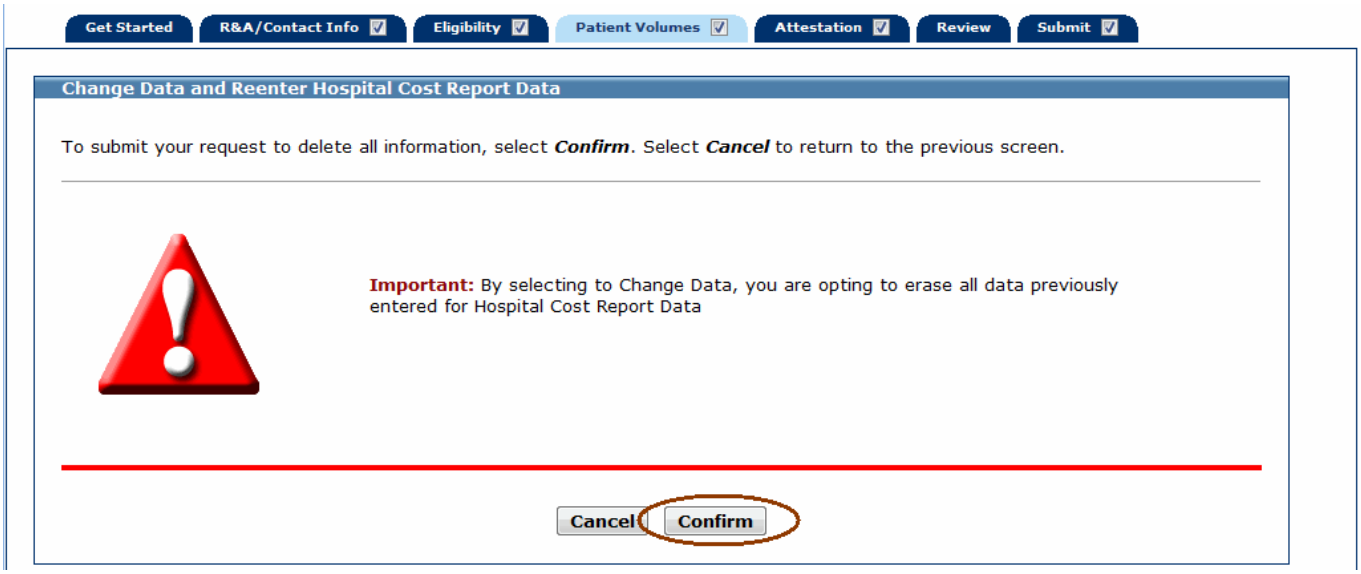
When you have applied since the start of the program in the same state and your payment year is 2 or higher, MAPIR allows you to revise previously entered hospital cost report data. The Hospital Cost Report Data screen will display the data from the previously paid application. The revised hospital cost report data that you enter will be referenced when MAPIR calculates your total EHR incentive amount, overriding any amount for previous years. When viewing any previous applications, MAPIR will continue to display the cost report data that was entered originally for reference purposes only. The fiscal years entered on the payment year 1 application cannot be changed.

From the Hospital Cost Report Data screen, click **Change Data**.



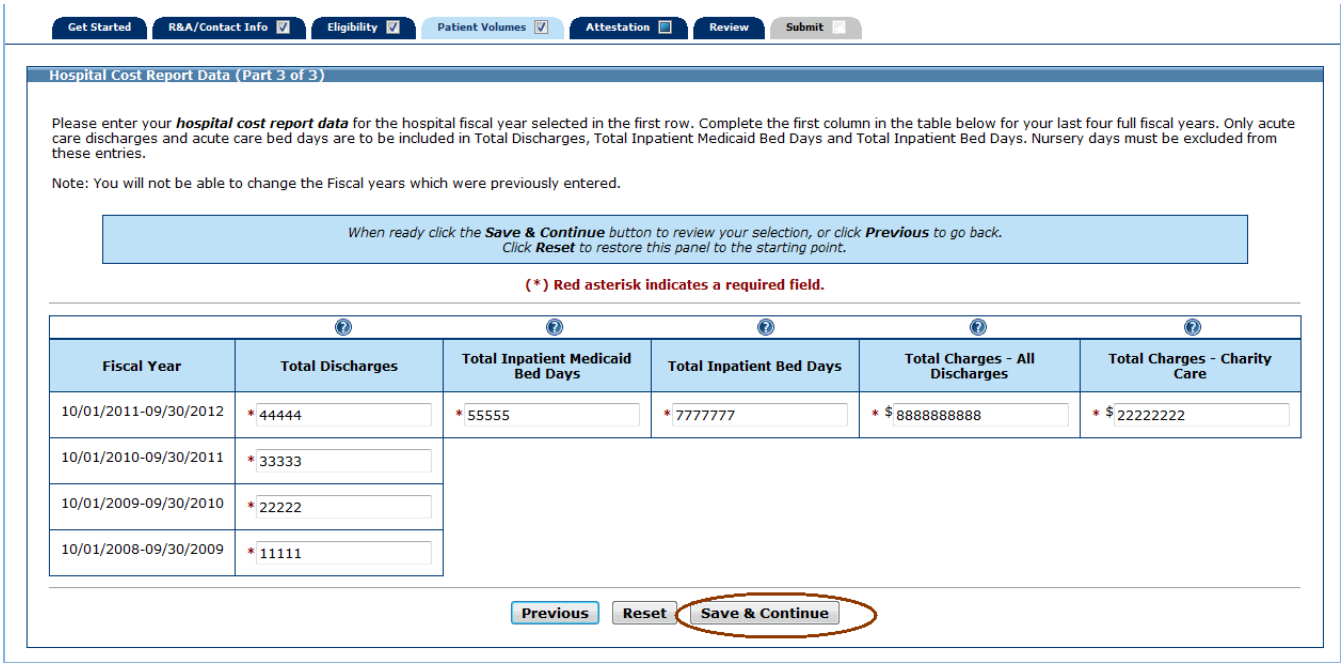
Confirm if you want to proceed to change the hospital cost report data. Be advised that if you elect to proceed the data that was previously entered for hospital cost report data will be erased.

Click **Confirm** to proceed. Click **Cancel** to return to the previous screen.



On this screen you will re-enter the hospital cost report data required to calculate your incentive payment. In the first column enter **Total Discharges** for the **Fiscal Years** displayed to the left. Enter the **Total Inpatient Medicaid Bed Days**, **Total Inpatient Bed Days**, **Total Charges – All Discharges**, and **Total Charges – Charity Care**.

Click **Save & Continue** to review your selection, or click **Previous** to go back to the existing hospital cost report data. Click **Reset** to restore this panel to the starting point.

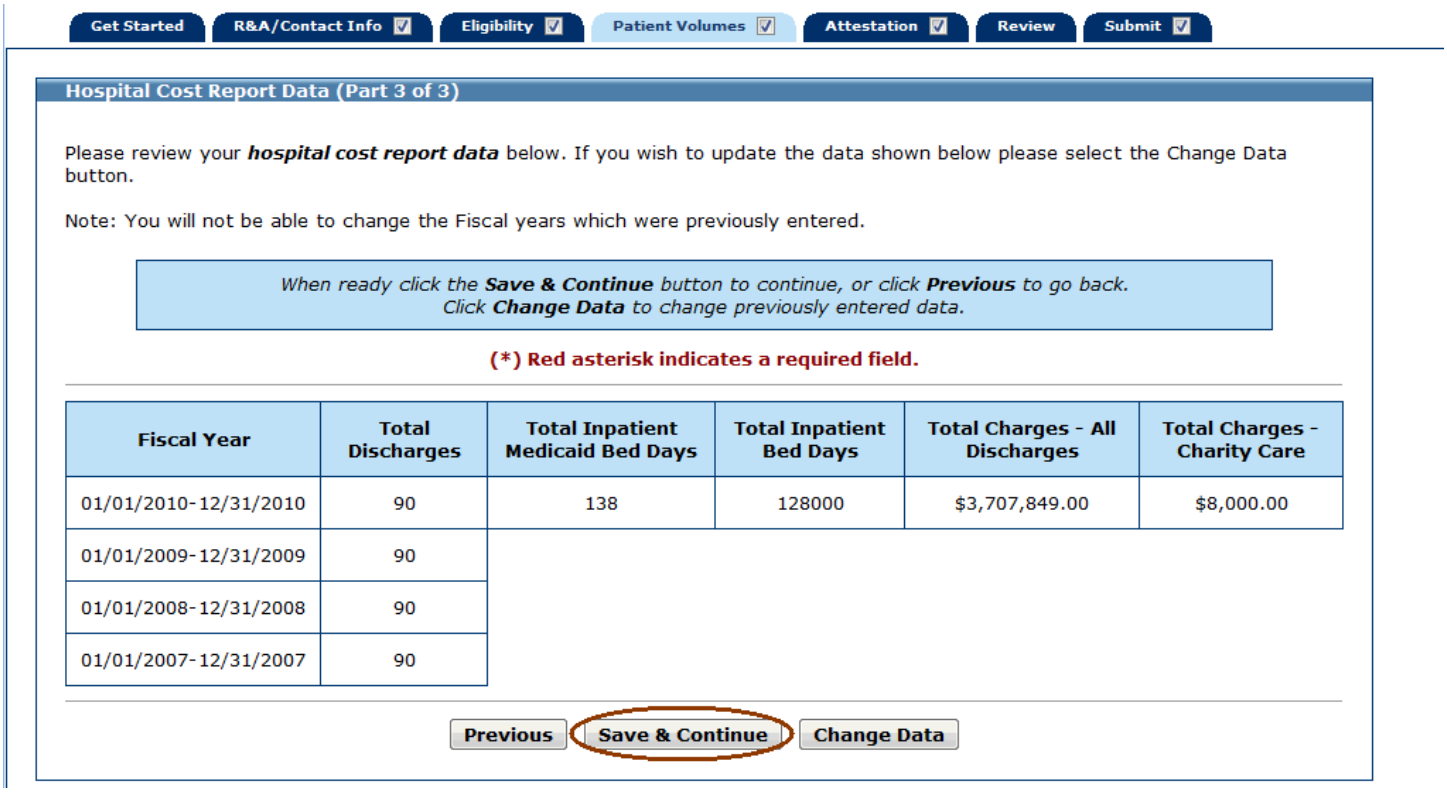


If you re-enter the hospital cost report data and the values match the existing hospital cost report data on file, you will receive an error message. The re-entered data cannot match the existing data on file.

Review your revised hospital cost report data.

Once you save the revised hospital cost report data you cannot revert to the hospital cost report data on file. At this point, if you decide you do not want to revise the existing hospital cost data on file, abort the current application and start over again.

Click **Save & Continue** to continue with new amounts, click **Previous** to go back to the first Hospital Cost Report Data screen, or click **Change Data** to change the data again.

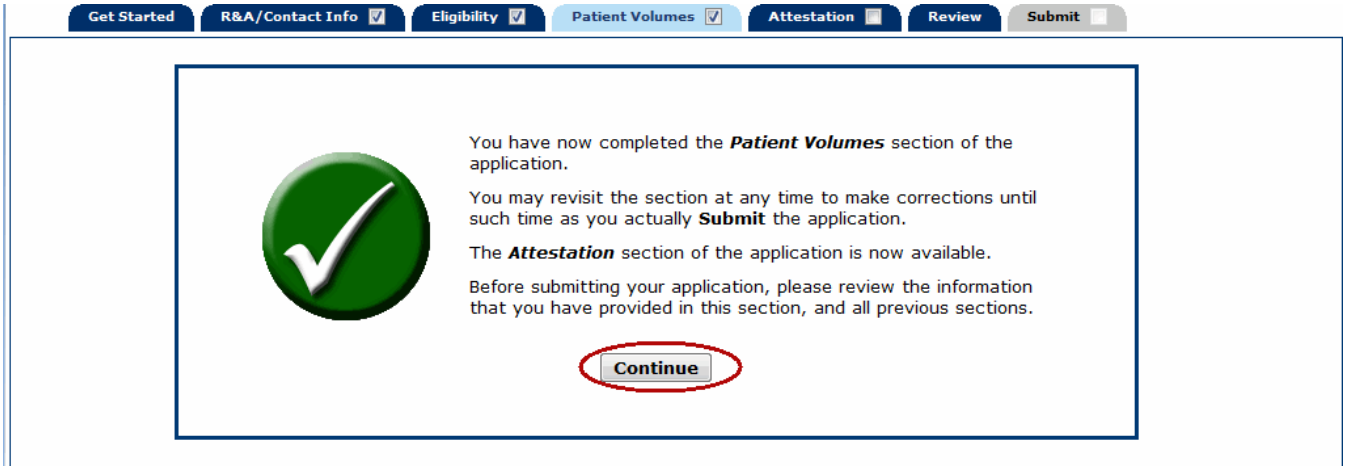


Once you have submitted the application, MAPIR recalculates the incentive payment for that year based on the revised hospital cost data as well as the remaining payments. If the new calculation results in a revised payment for the current year, you will receive a payment for the revised amount.

This screen confirms you successfully completed the **Patient Volumes** section.

Note the check box in the **Patient Volumes** tab.

Click **Continue** to proceed to the **Attestation** section.



Step 5 – Attestation

This section will ask you to provide information about your certified EHR System Adoption Phase. Adoption phases include **Adoption**, **Implementation**, **Upgrade**, and **Meaningful Use**. Based on the adoption phase you select, you may be asked to complete additional information about activities related to that phase.

For the first year of participation in the Medicaid EHR Incentive Program, Eligible Hospitals will have the option to attest to **Adoption**, **Implementation**, **Upgrade,** or **Meaningful Use**. After the first year of participation, the Eligible Hospitals are required to attest to **Meaningful Use.**

IMPORTANT: *You should only select meaningful use in MAPIR if you are 1) dually eligible for the Medicare and Medicaid EHR incentive programs and 2) attesting to meaningful use under Medicare in 2011.*

If you are a Dually Eligible Hospital, but have not been approved for Meaningful Use Attestation during the current Program Year at the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A), you will not be permitted to proceed with the MAPIR application process until you have completed this process at the R&A.

Click **Exit** to exit the MAPIR application or select any of the previously completed tabs

Adoption means acquired, purchased on secured access to certified EHR Technology capable of meeting meaningful use requirements.

Implemented means installed or commenced initialization of certified EHR Technology capable of meeting meaningful use requirements.

Upgraded means expanded the available functionality of certified EHR Technology capable of meeting meaningful use requirements.

This initial Attestation screen provides information about this section.

Click **Begin** to continue to the **Attestation** section.

Attestation Phase (Part 1 of 3)

The Attestation Phase (Part 1 of 3) screen asks for the **EHR Technology Status**.

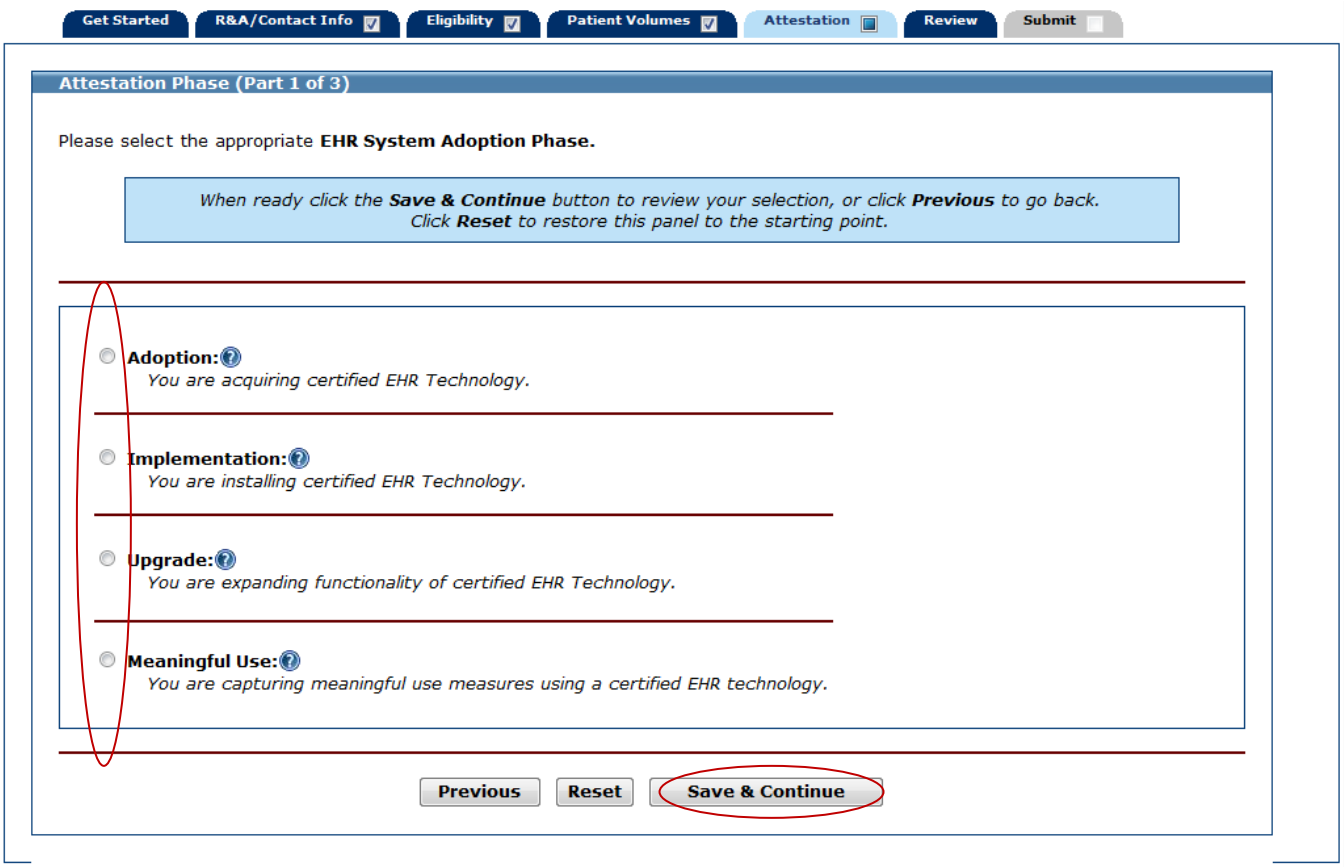
The screen shown below is the Attestation Phase (Part 1 of 3) screen you will see if it is your first year participating (Payment Year 1).

If it is not your first year participating (Payment Year 2 or beyond), turn to page 53 of this guide.

If you have registered at the R&A as a Dually Eligible hospital and are Deemed Eligible, you will bypass the Attestation Phase (Part 1 of 3). Proceed to page 1279 of this guide.

After making your selection, the next screen you see will depend on the status you selected.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



Adoption Phase

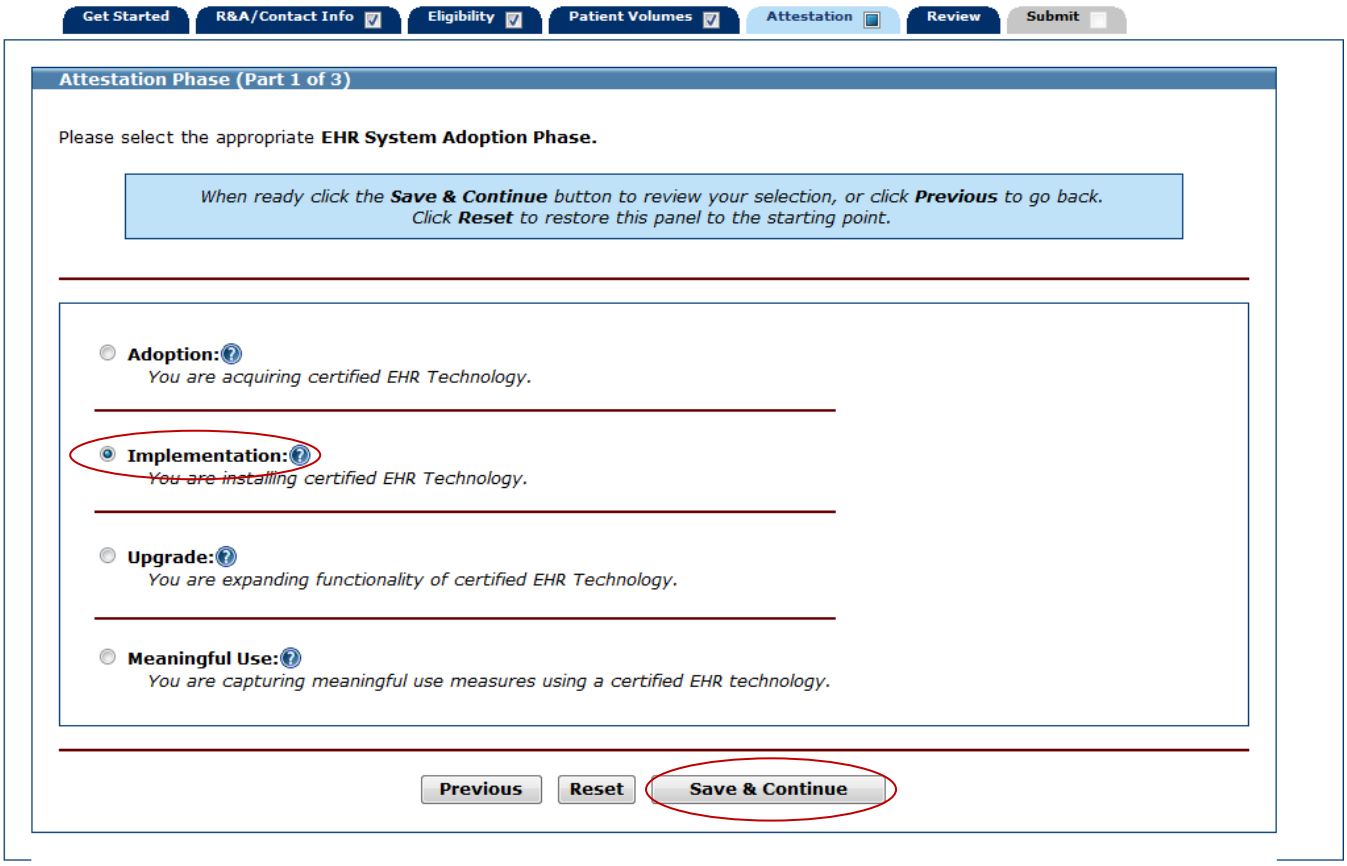
For **Adoption** select the Adoption button. Click **Save & Continue** to review your selection, Previous to return, or **Reset** to clear all unsaved data.

Proceed to page 127 of this guide.

Implementation Phase (Part 2 of 3)

For **Implementation** select the Implementation button.

Click **Save & Continue** to review your selection, **Previous** to go back, or **Reset** to clear all unsaved data.

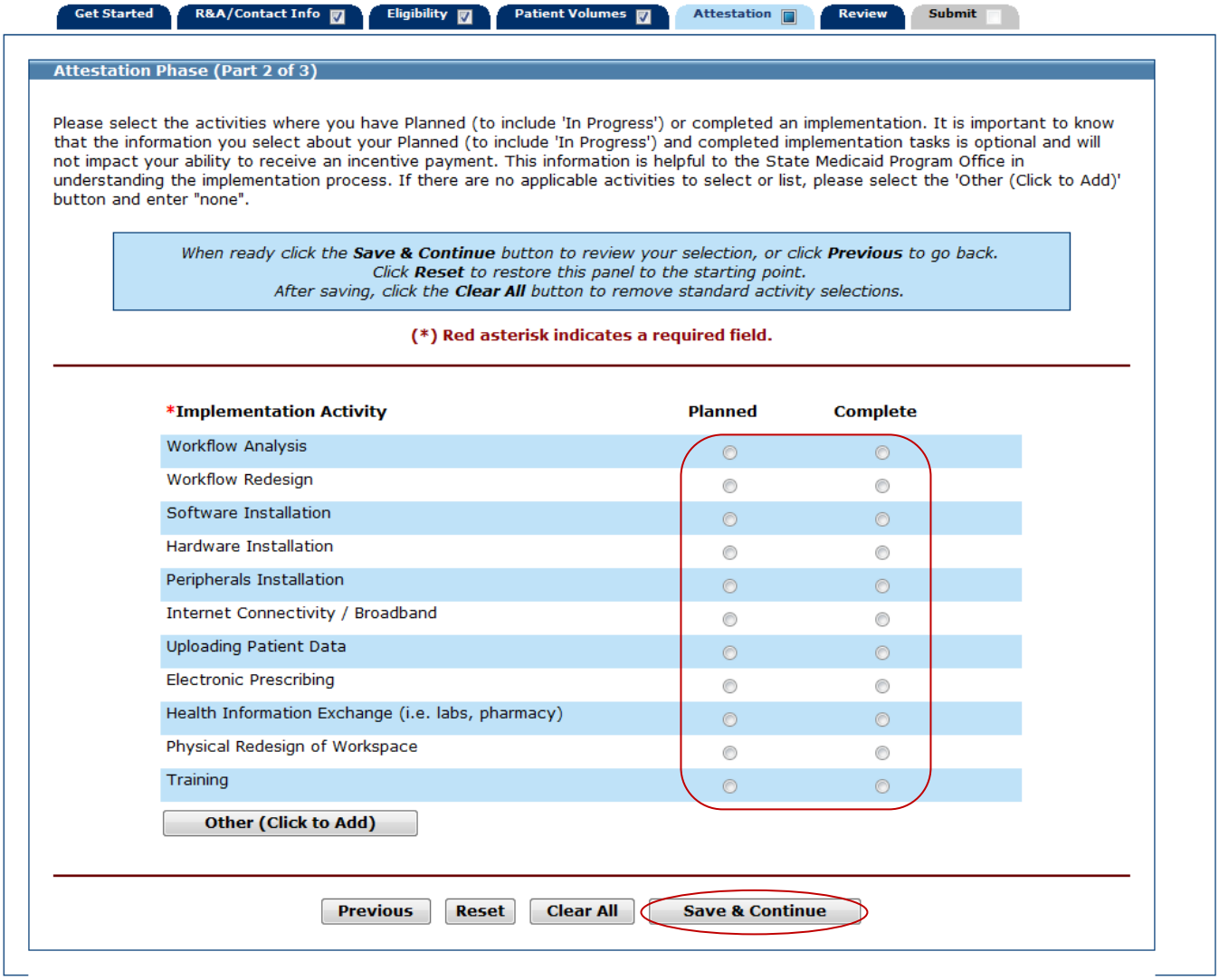


Select your **Implementation Activity** by selecting the **Planned** or **Complete** button**.**

At least one activity must be selected to proceed.

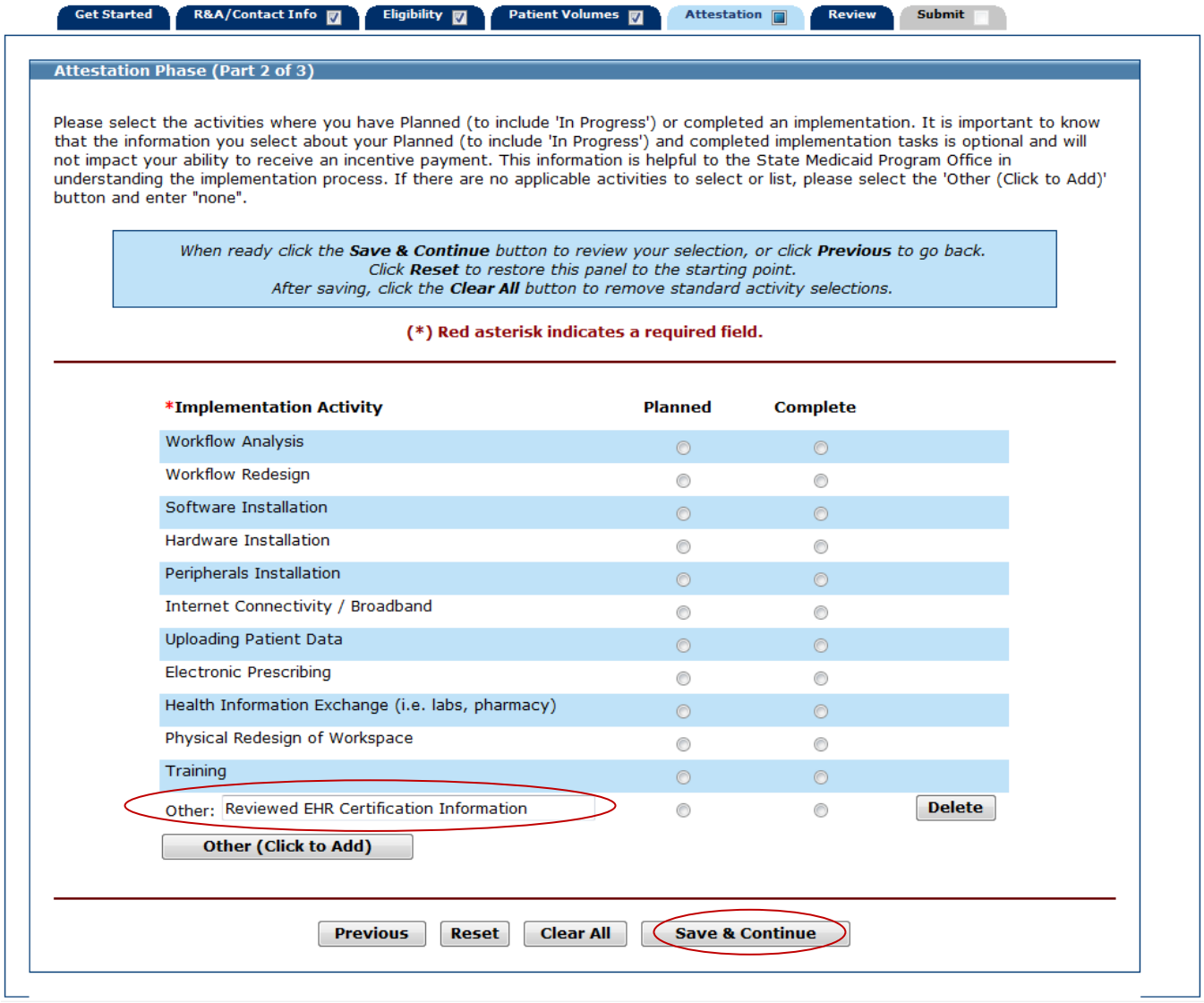
Click **other** to add any additional **Implementation Activities** you would like to supply.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data. After saving, click **Clear All** to remove standard activity selections.



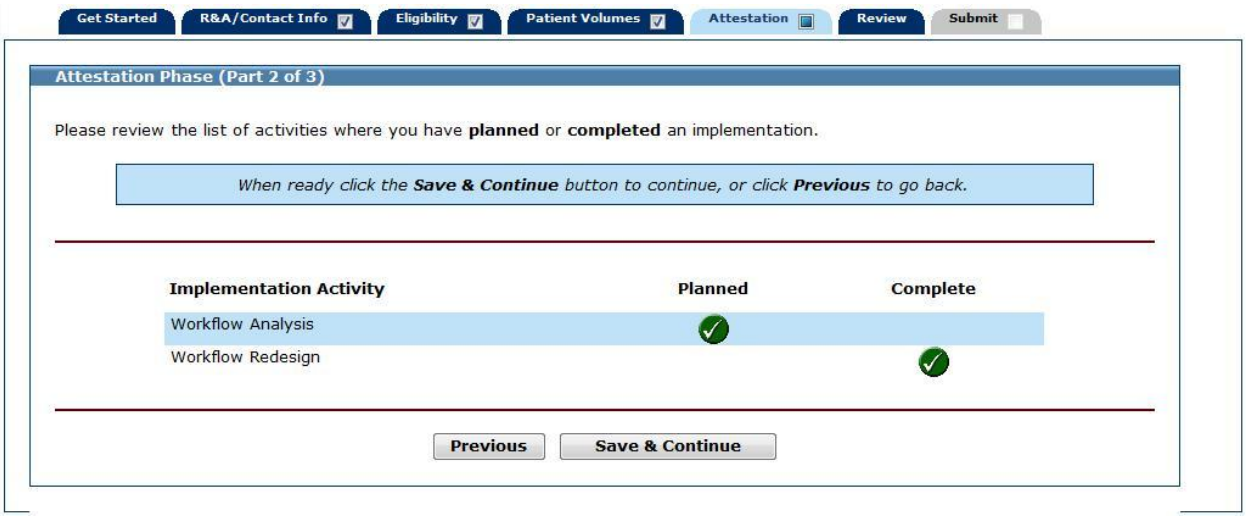
This screen shows an example of entering activities other than what was in the **Implementation Activity** listing.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



Review the **Implementation Activity** you selected.

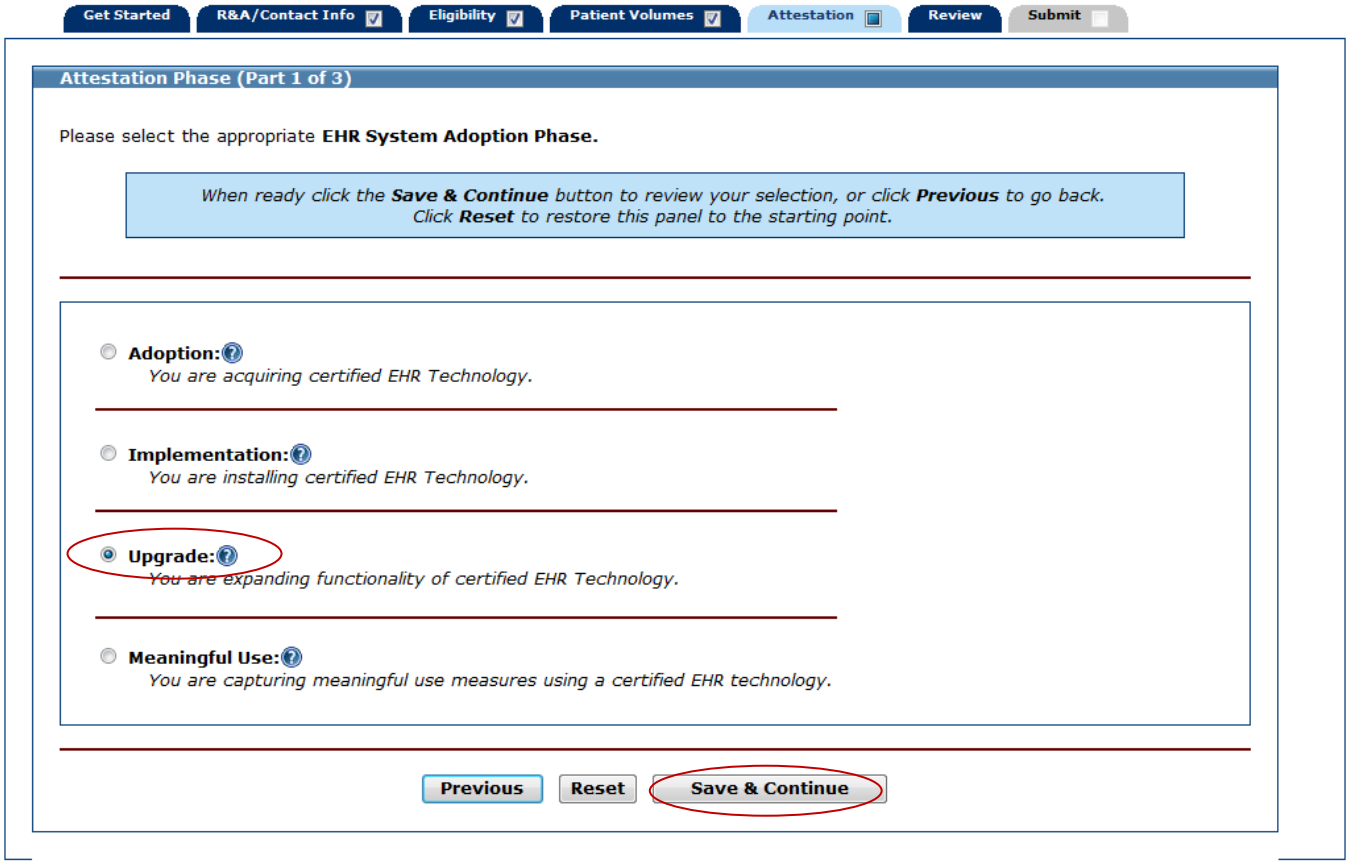
Click **Save & Continue** to continue, or click **Previous** to go back.


Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Phase (Part 2 of 3)
Please review the list of activities where you have planned or completed an implementation.
When ready click the Save & Continue button to continue, or click Previous to go back.
Implementation Activity
Planned
Complete
Workflow Analysis
Workflow Redesign
Previous
Save & Continue

Upgrade Phase (Part 2 of 3)

For **Upgrade** select the Upgrade button.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

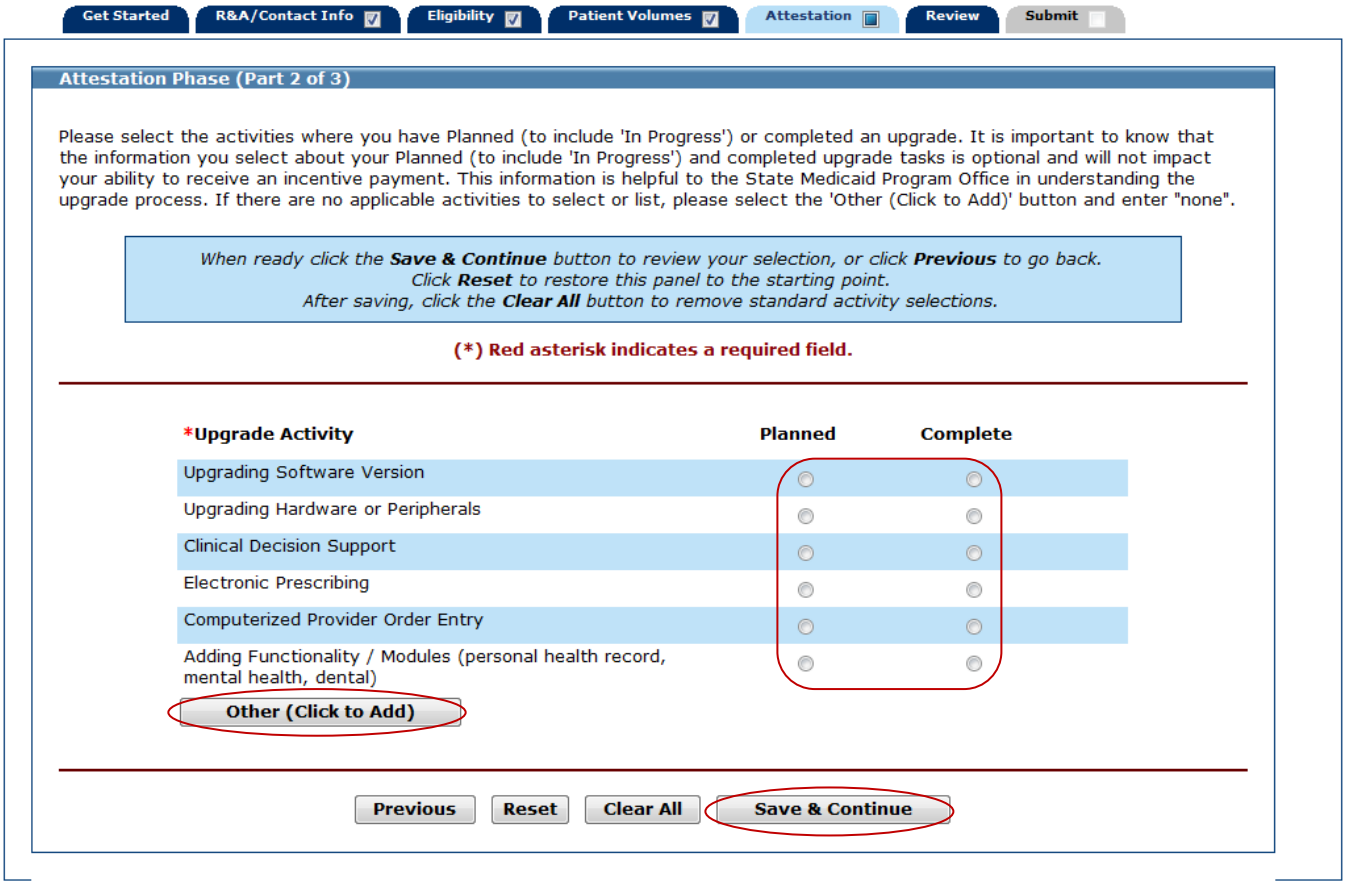


Select your **Upgrade Activities** by selecting the **Planned** or **Complete** button for each activity.

At least one activity must be selected to proceed.

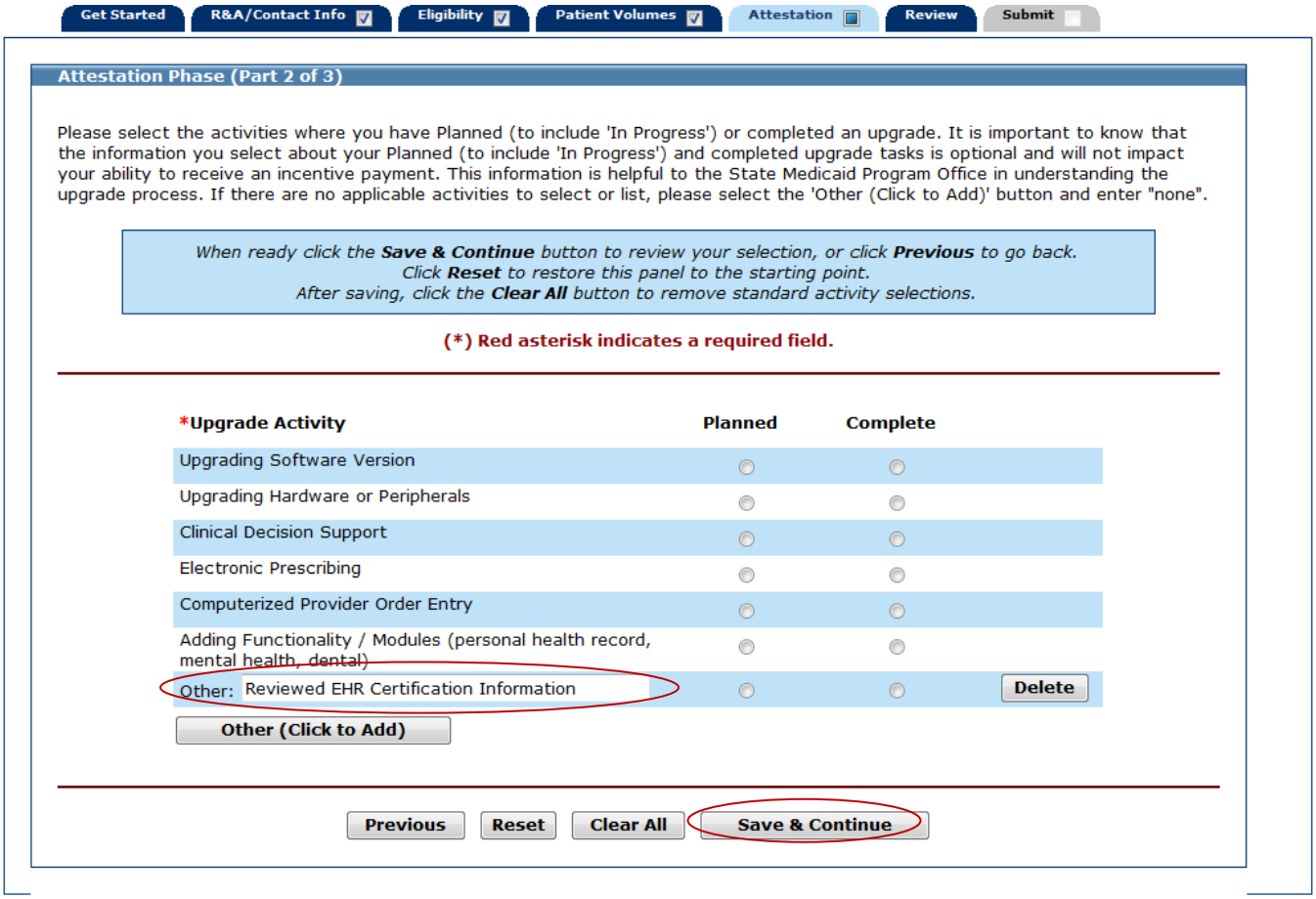
Click **other** to add any additional **Upgrade Activities** you would like to supply.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data. After saving, click **Clear All** to remove standard activity selections.



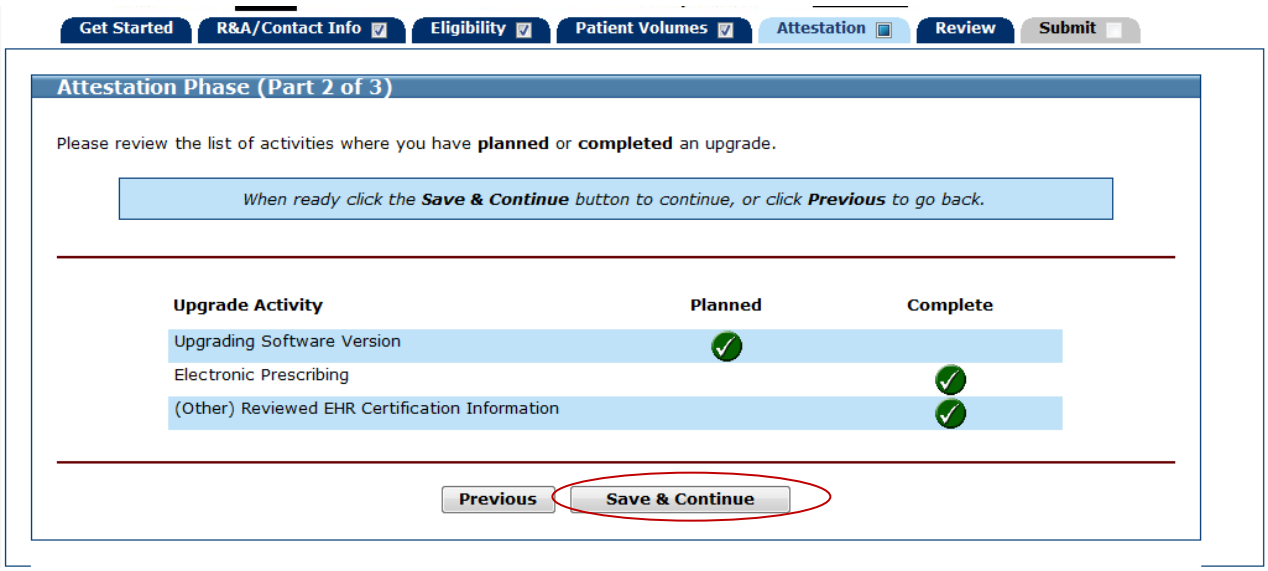
This page shows an example of entering an activity in the **Other** field.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data. After saving, click **Clear All** to remove standard activity selections.



Review the **Upgrade Activities** you selected.

Click **Save & Continue** to proceed or **Previous** to return.

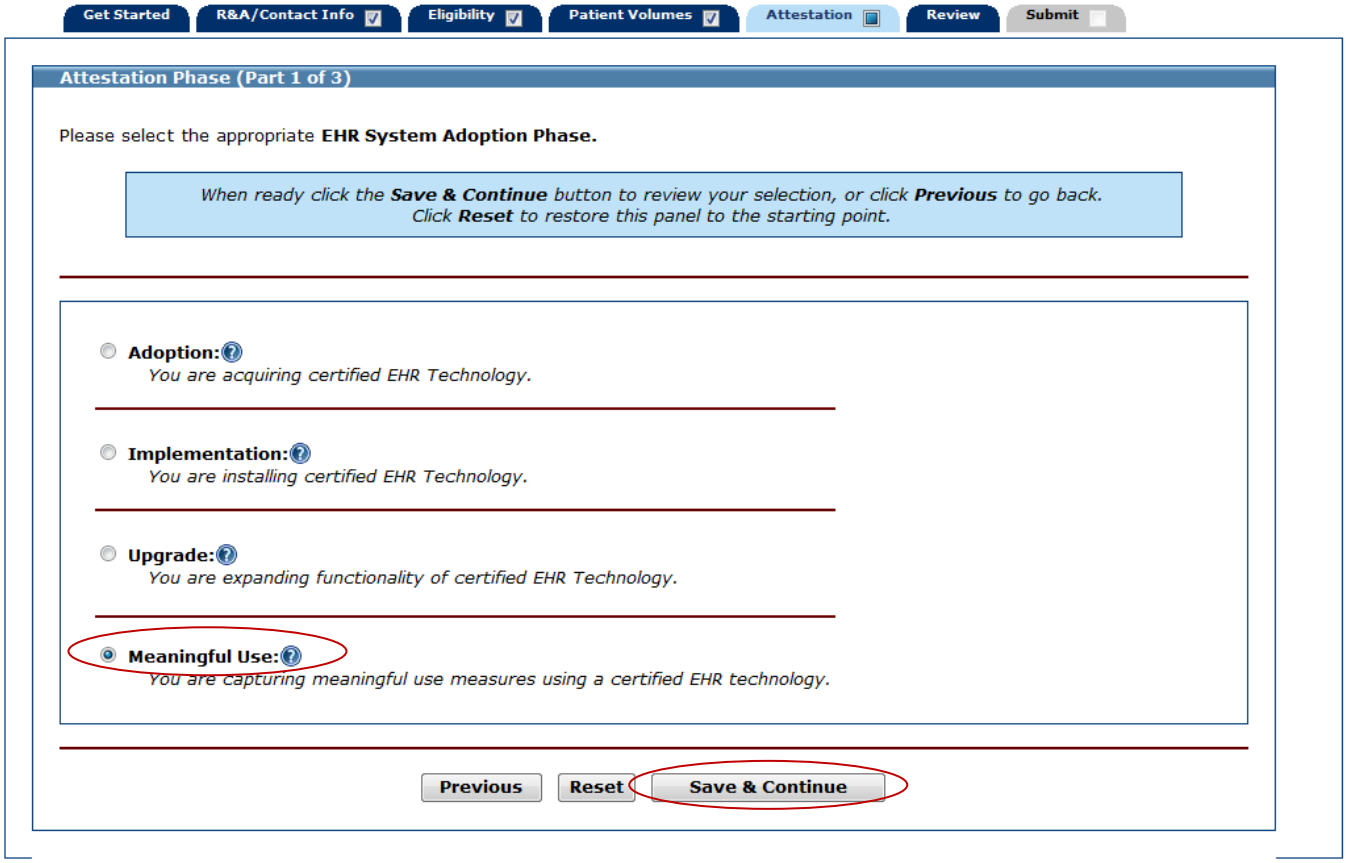


Meaningful Use

For **Meaningful Use** select the Meaningful Use button.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

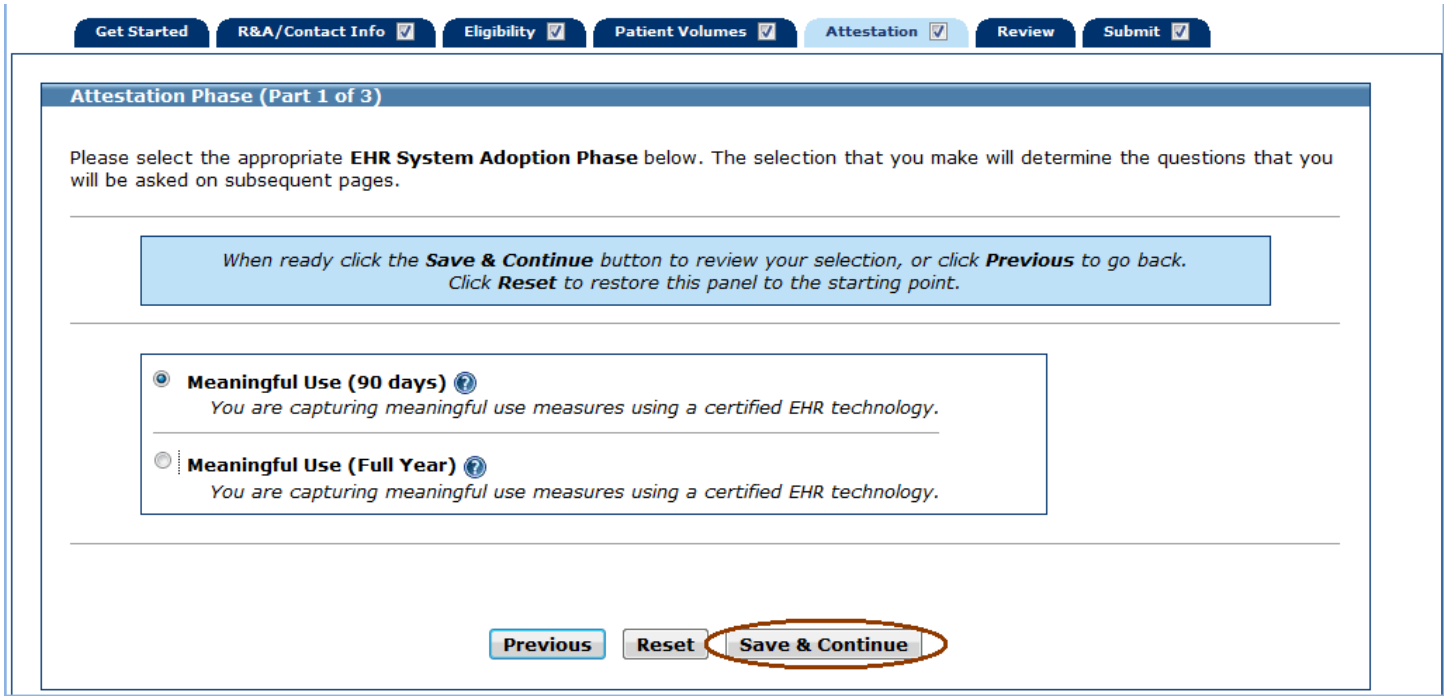
IMPORTANT *You should only select meaningful use if you are a 1) dually eligible hospital for the Medicare and Medicaid EHR Incentive Programs and 2) attesting to meaningful use under Medicare in 2011. After the first year of participation, the Eligible Hospitals are required to attest to* ***Meaningful Use.***



Select a 90-day period or a full year period for reporting **Meaningful Use of certified EHR technology.**

If you selected Meaningful Use in the Attestation Phase for Payment Year 1, your only option on this screen for Payment Year 2 and beyond will be the Meaningful Use (Full Year).

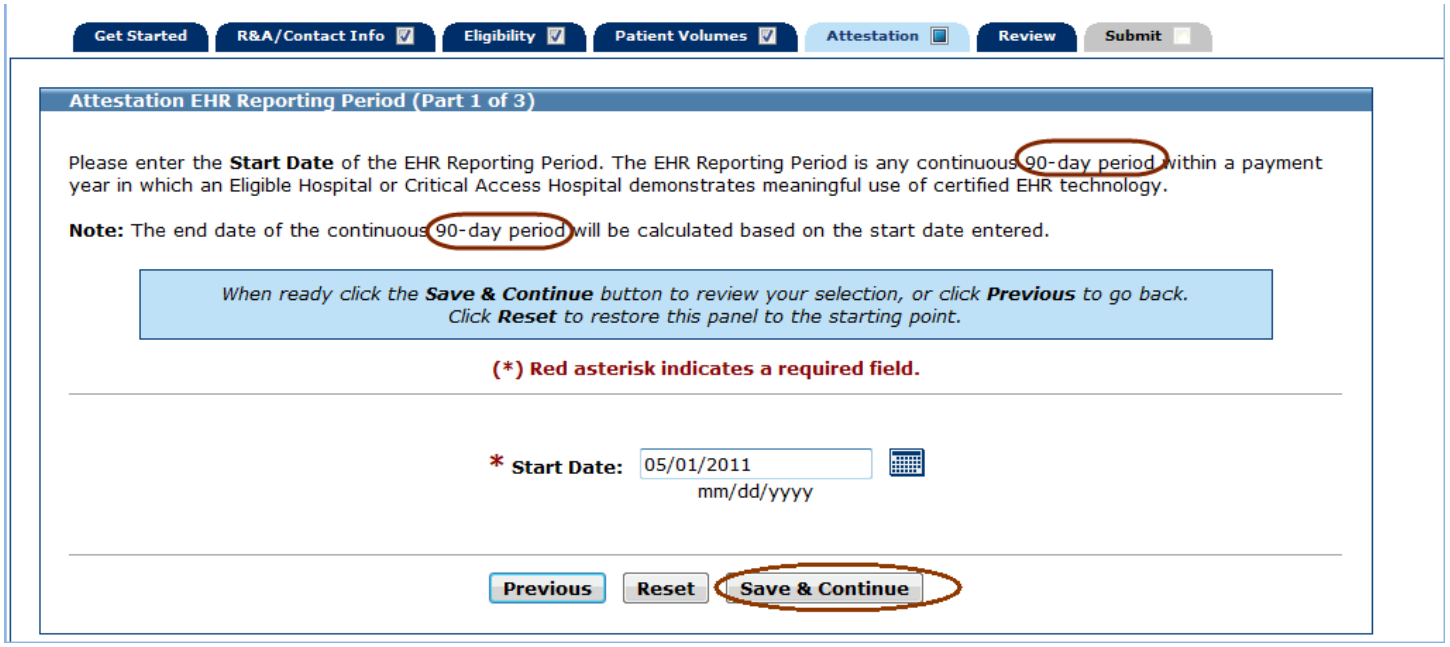
Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



Depending on the selection made on the previous screen, the Attestation EHR Reporting Period (Part 1 of 3) screen will display with the 90-day period or the full year period. The example below displays the 90-day period.

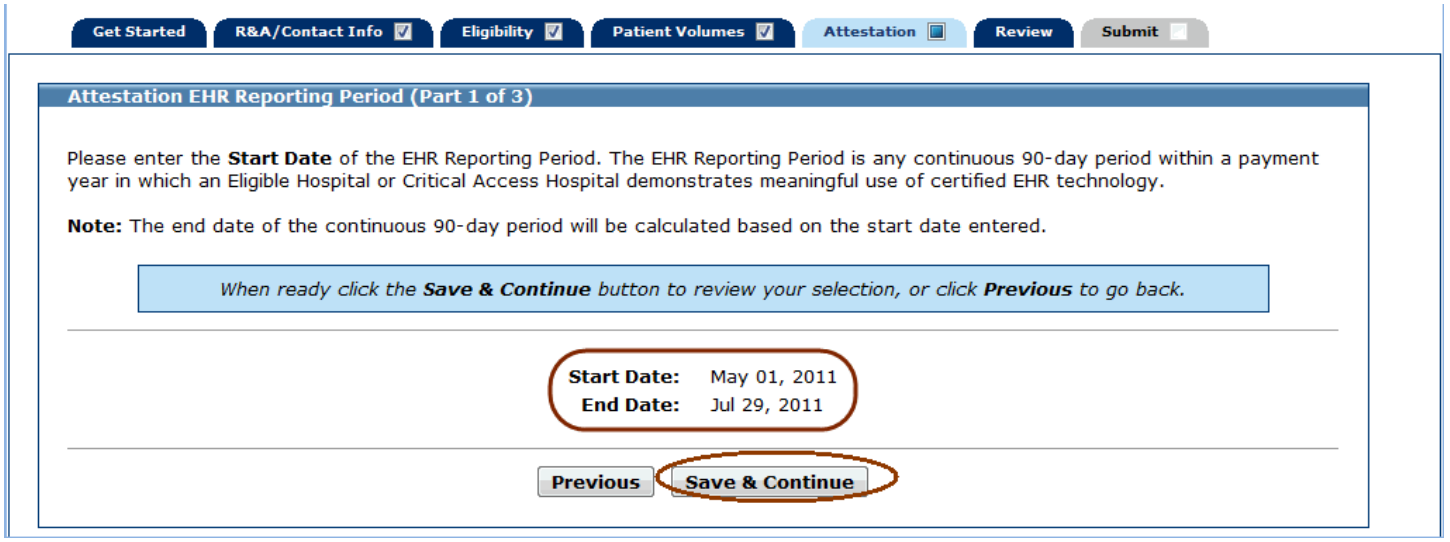
Enter a **Start Date** or use the calendar located to the right of the Start Date field.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.



This screen shows an example of a **Start Date** of May 1, 2011 and a system-calculated **End Date** of July 29, 2011.

Click **Save & Continue** to review your selection, or click **Previous** to go back.

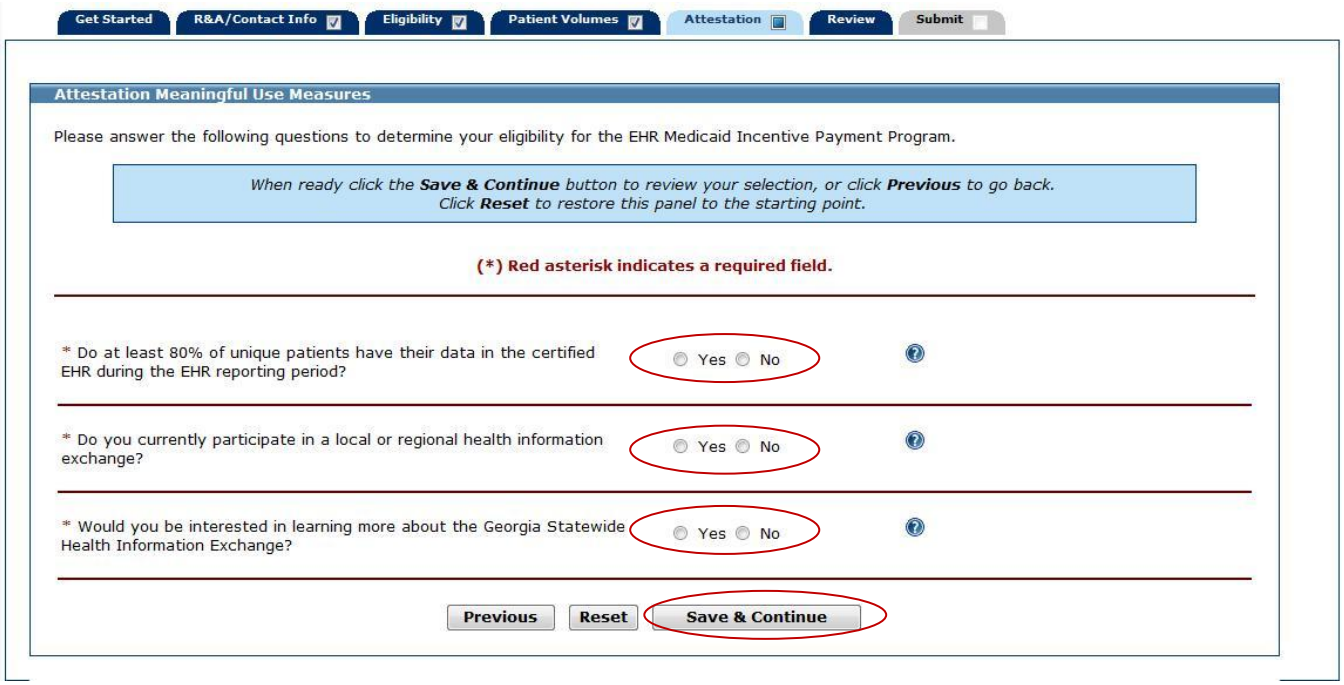


Attestation Meaningful Use Measures

This screen starts a series of screens related to the Meaningful Use Measure.

Click **Yes** or **No** to the first question.

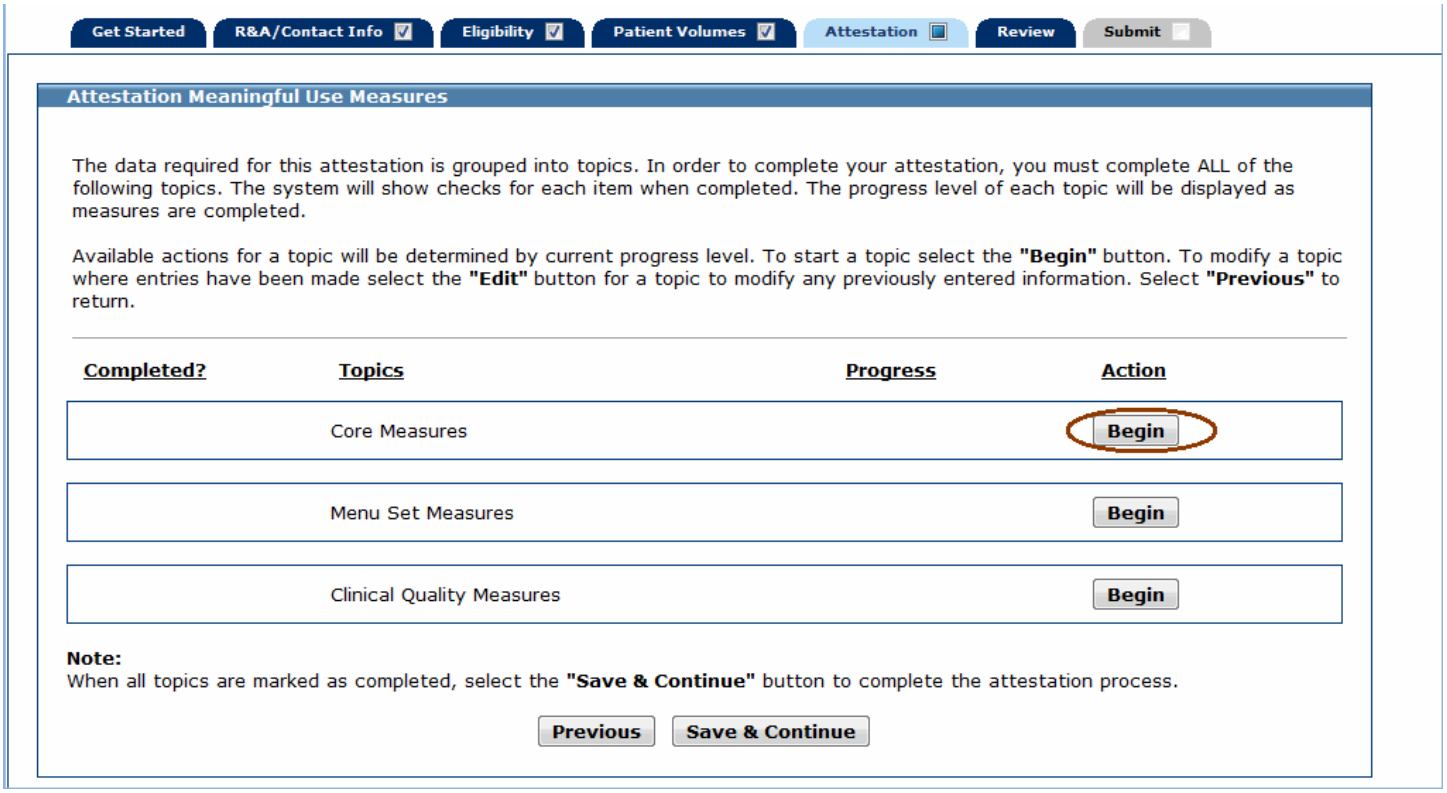
Click **Save & Continue** to proceed to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.



The screen below displays the Measures Topic List. The Attestation Meaningful Use Measures are divided into three distinct topics: Core Measures, Menu Set Measures, and Clinical Quality Measures.

You may select any of the three topics and complete them in any order. All three topics must be completed.

Click **Begin** to start a topic.



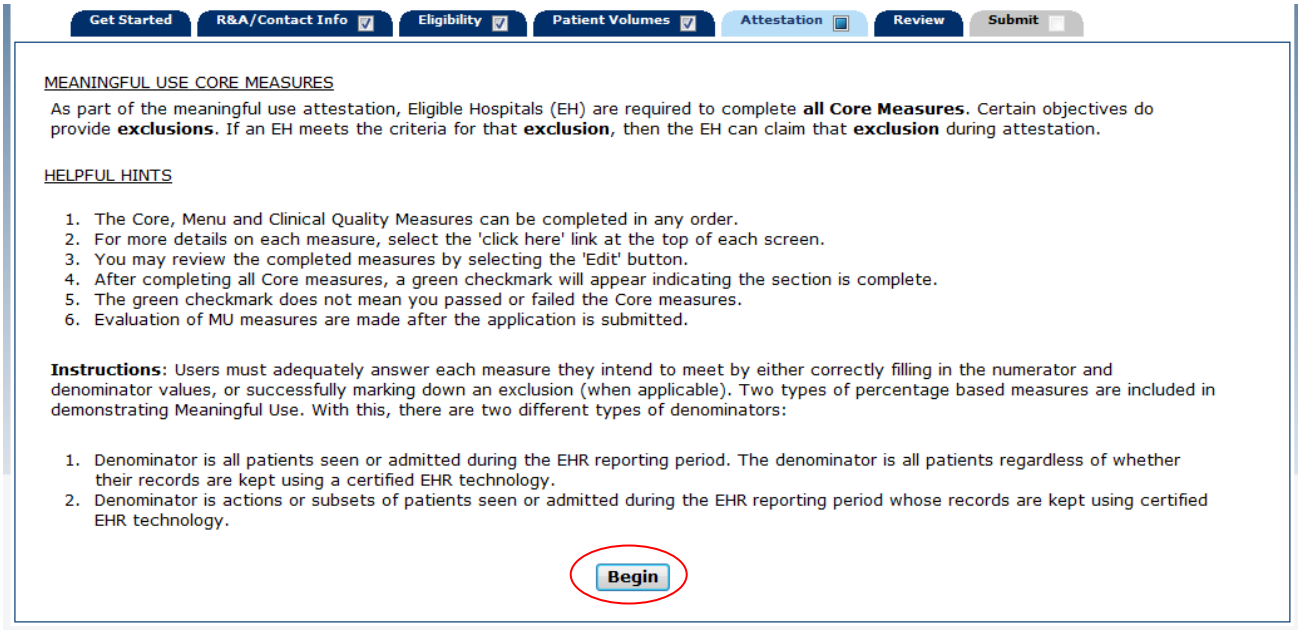
Meaningful Use Core Measures

While it is not required that you begin each topic in the order shown on the screen, this user guide will follow the order in which the topics are listed.

This screen provides information about the Meaningful Use Core Measures.

Please note that per the Stage 2 Final Rule, Meaningful Use Core Measures 9 and 13 are no longer available for attestation.

Click **Begin** to continue to the Meaningful Use Core Measure List Table.

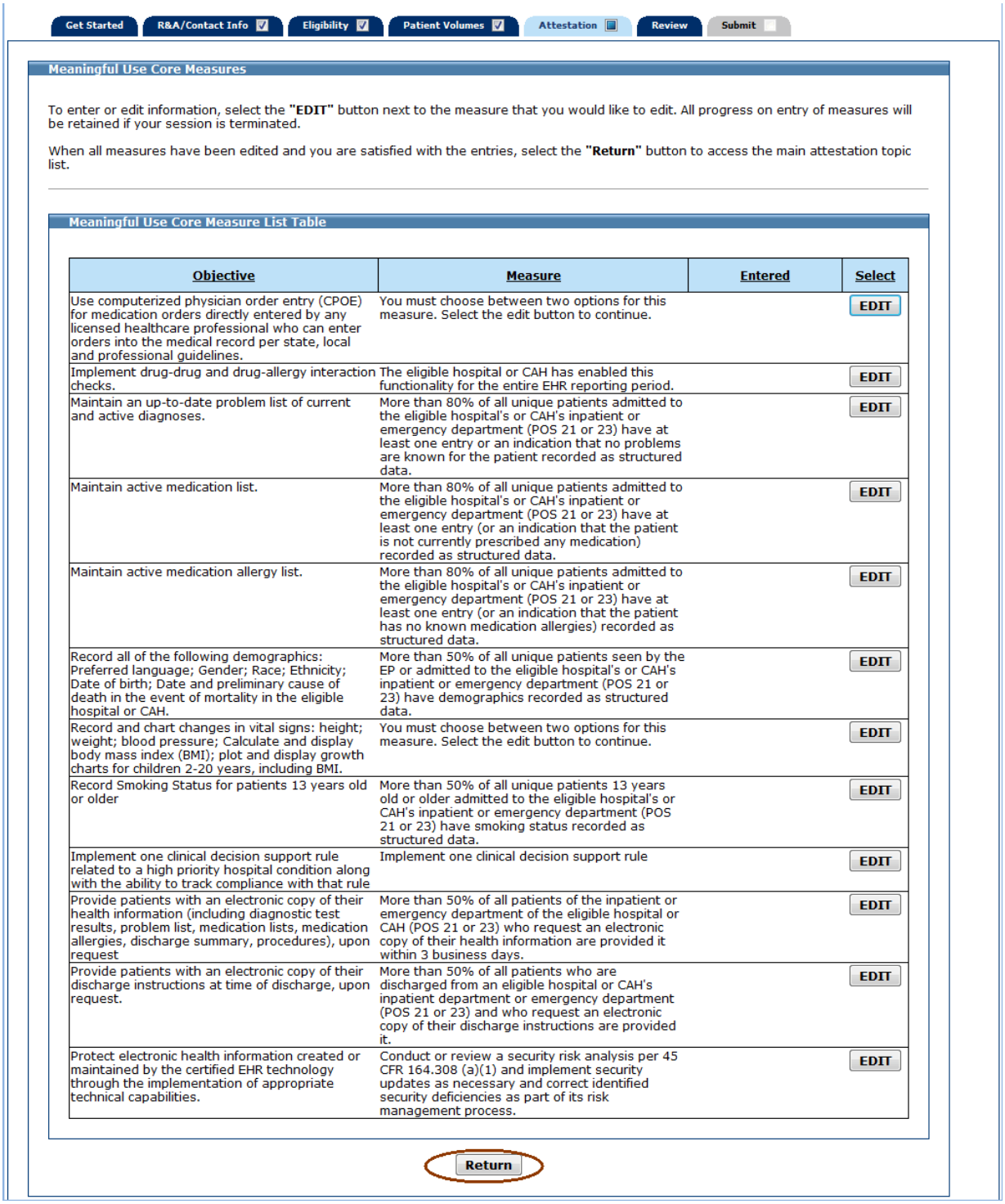


The screen on the following page displays the Meaningful Use Core Measure List Table.

The first time a topic is accessed you will see an **Edit** option for each measure.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

Click **Edit** to enter or edit information for a measure or click **Return** to return to the Measures Topic List.



Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Meaningful Use Core Measures

To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return"** button to access the main attestation topic list.

Meaningful Use Core Measure List Table

Objective	Measure	Entered	Select
Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	You must choose between two options for this measure. Select the edit button to continue.		EDIT
Implement drug-drug and drug-allergy interaction checks.	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.		EDIT
Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.		EDIT
Maintain active medication list.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.		EDIT
Maintain active medication allergy list.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.		EDIT
Record all of the following demographics: Preferred language; Gender; Race; Ethnicity; Date of birth; Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.		EDIT
Record and chart changes in vital signs: height; weight; blood pressure; Calculate and display body mass index (BMI); plot and display growth charts for children 2-20 years, including BMI.	You must choose between two options for this measure. Select the edit button to continue.		EDIT
Record Smoking Status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.		EDIT
Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule		EDIT
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	More than 50% of all patients of the inpatient or emergency department of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.		EDIT
Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.		EDIT
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.		EDIT

Return

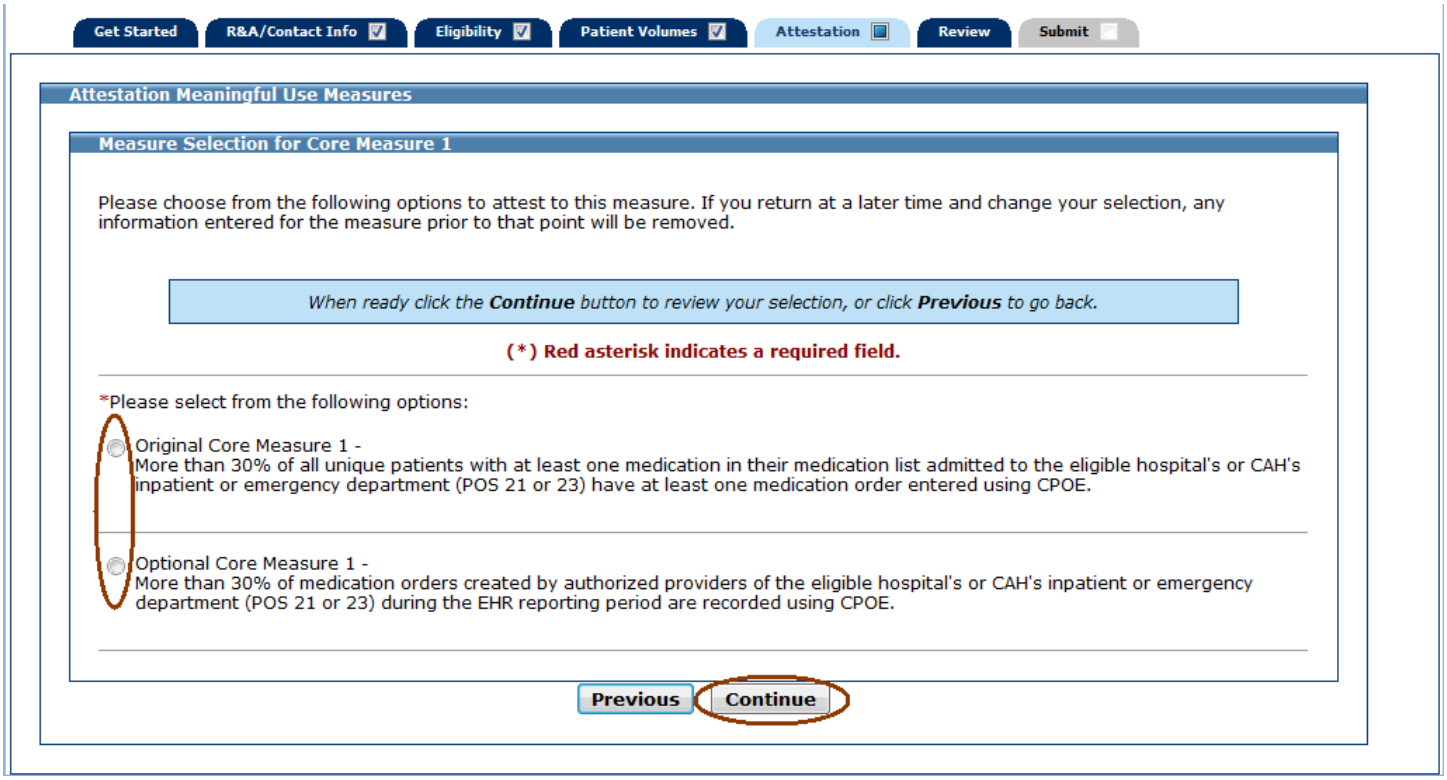
Measure Selection for Core Measure 1 (Measure Code EHCMU01)

Choose if you would like to attest to the **Original Core Measure 1** or the **Optional Core Measure 1**. If you return at a later time and change your selection, any information entered for the measure prior to that point will be removed.

Click **Save & Continue** to proceed to the appropriate core measure screen for the option you selected or click **Previous** to go back.

If you selected the Original Core Measure 1, continue to the next page.

If you selected the Optional Core Measure 1, continue to page 61.

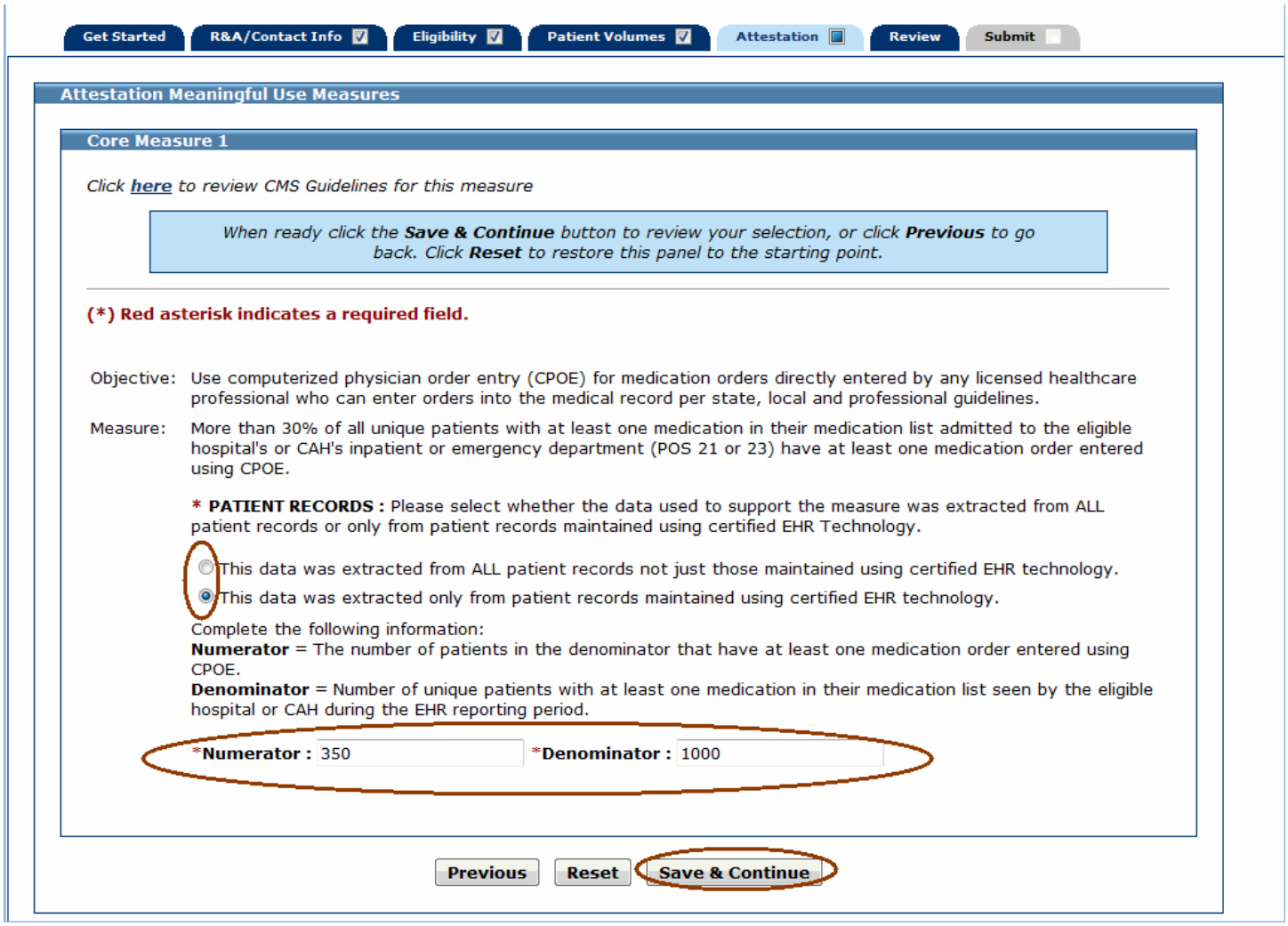


Original Core Measure 1 (Measure Code EHCMU01)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator entered.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

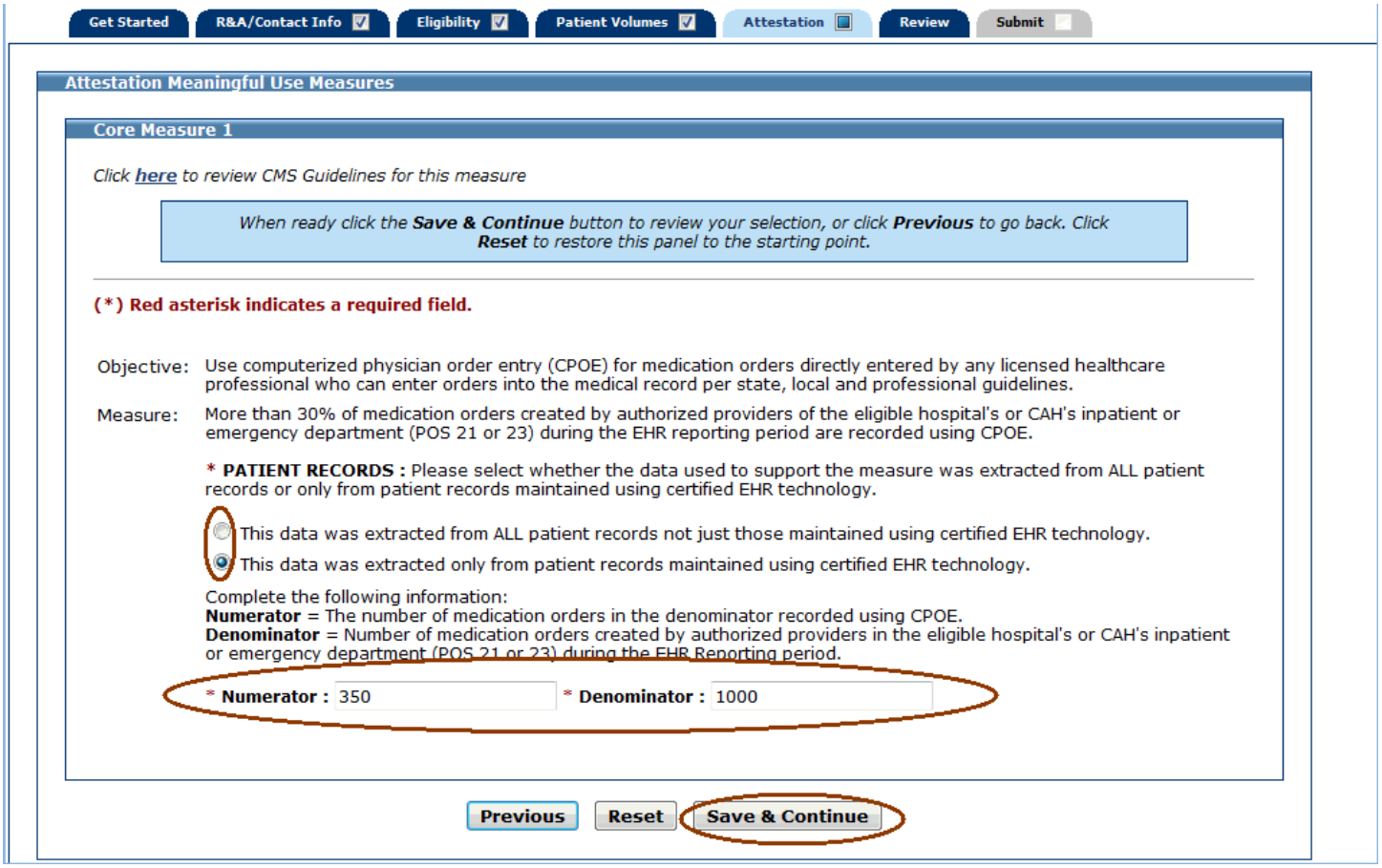


Optional Core Measure 1 (Measure Code EHCMU01)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator entered.

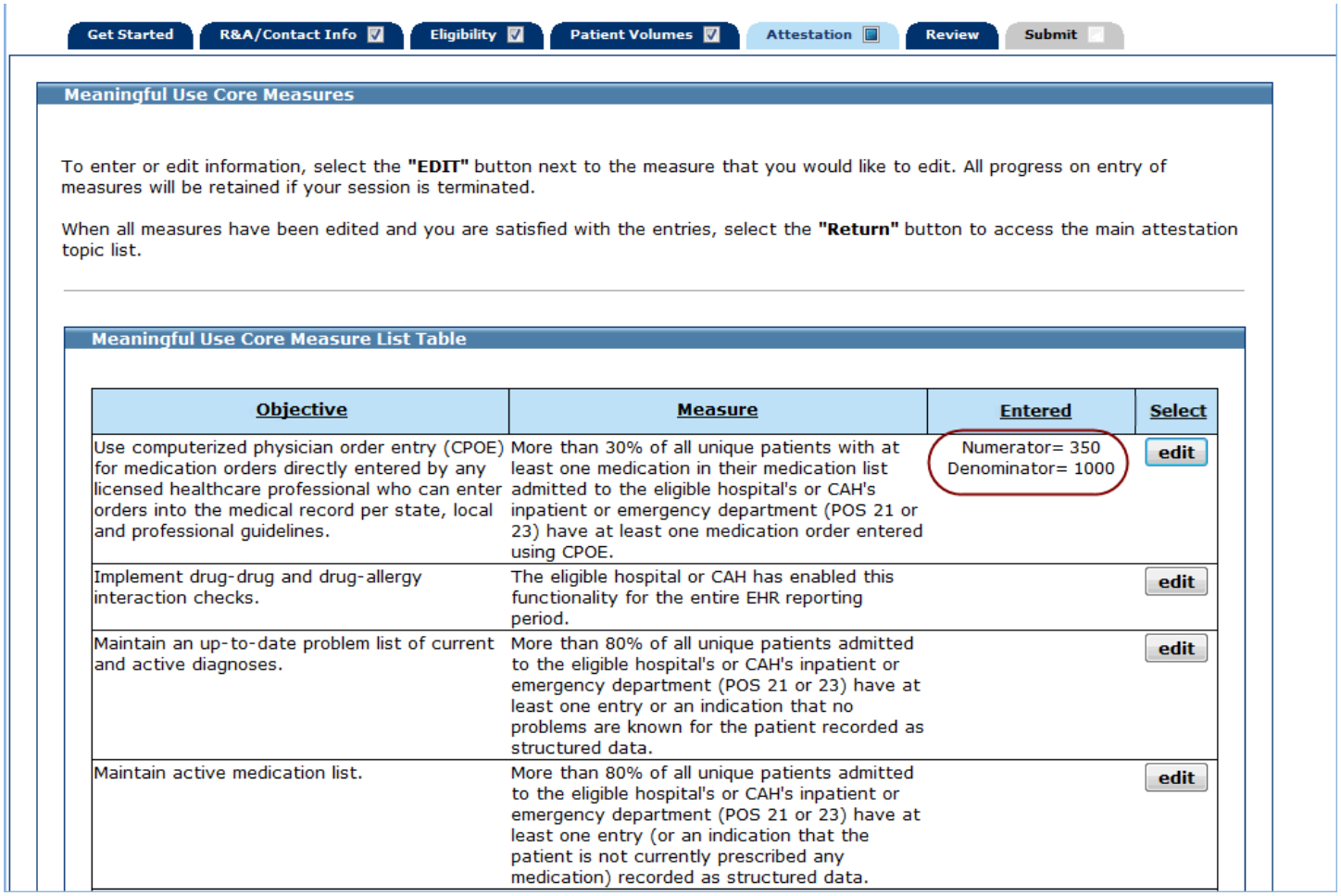
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.



After you enter information for a measure click the **Save & Continue**, you will be returned to the Meaningful Use Core Measure List Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below (please note that the entire screen is not displayed in this example).

You can continue to edit the measures at any point prior to submitting the application.

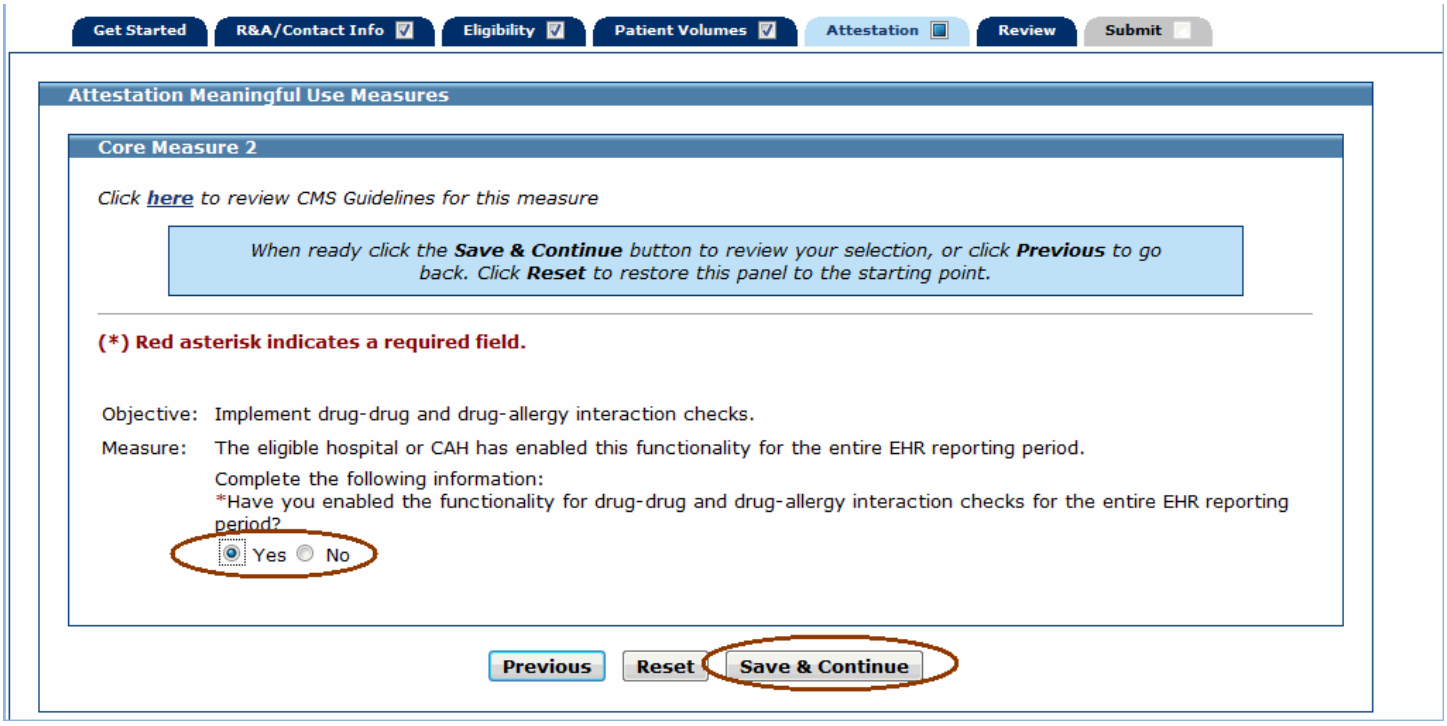
Click **Edit** for the next measure.



Core Measure 2 (Measure Code EHCMU02)

Enter information in all required fields.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

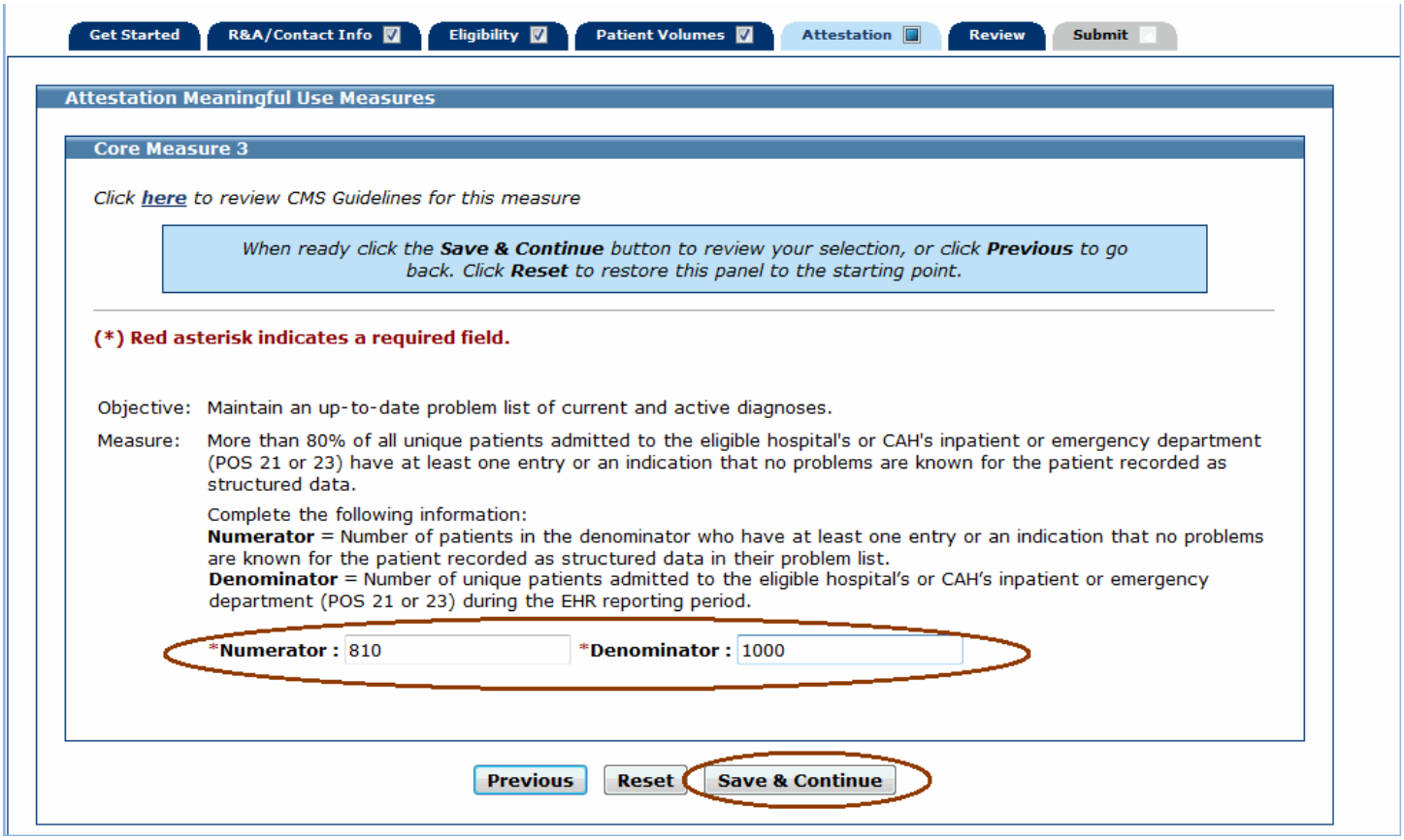


Core Measure 3 (Measure Code EHCMU03)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

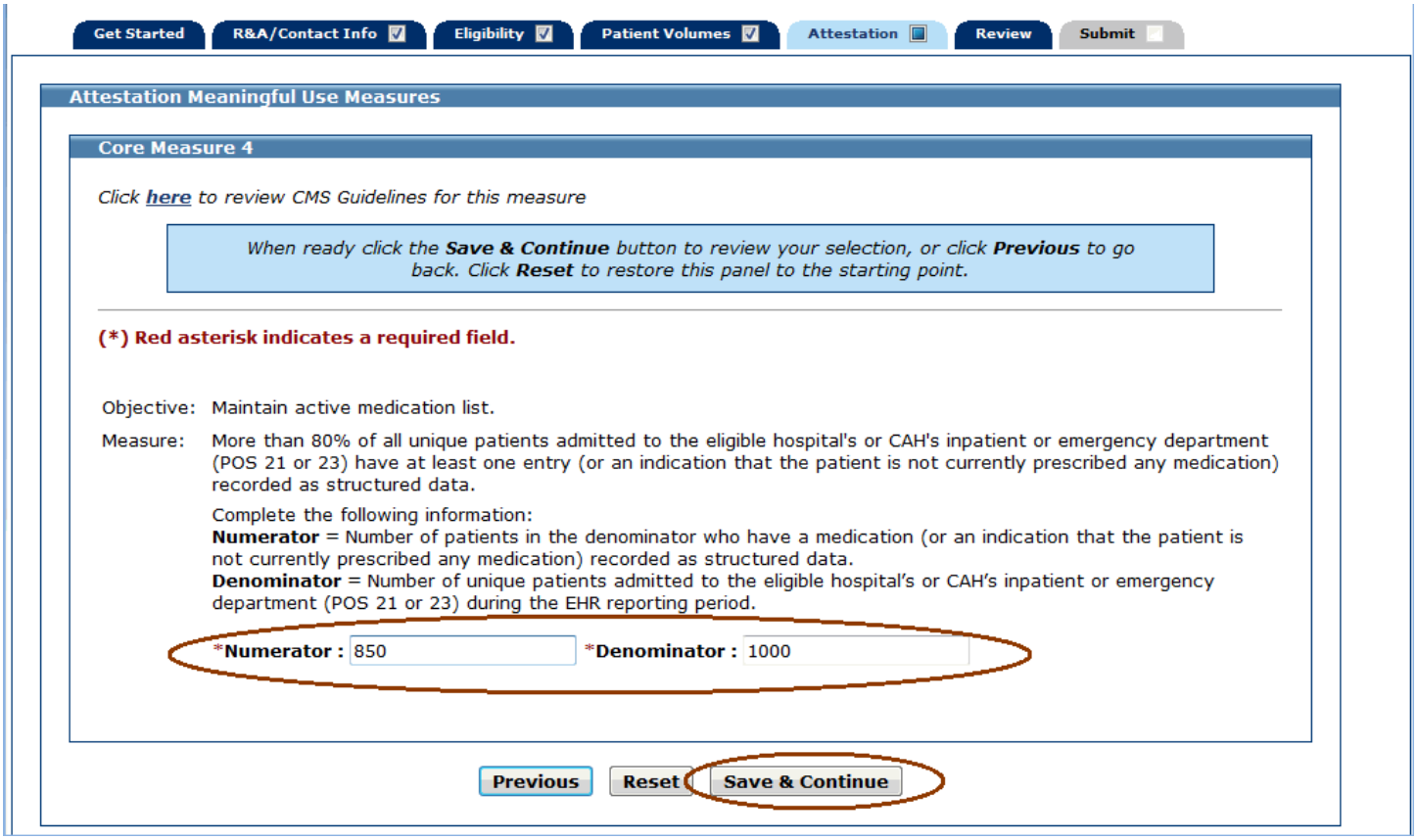


Core Measure 4 (Measure Code EHCMU04)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

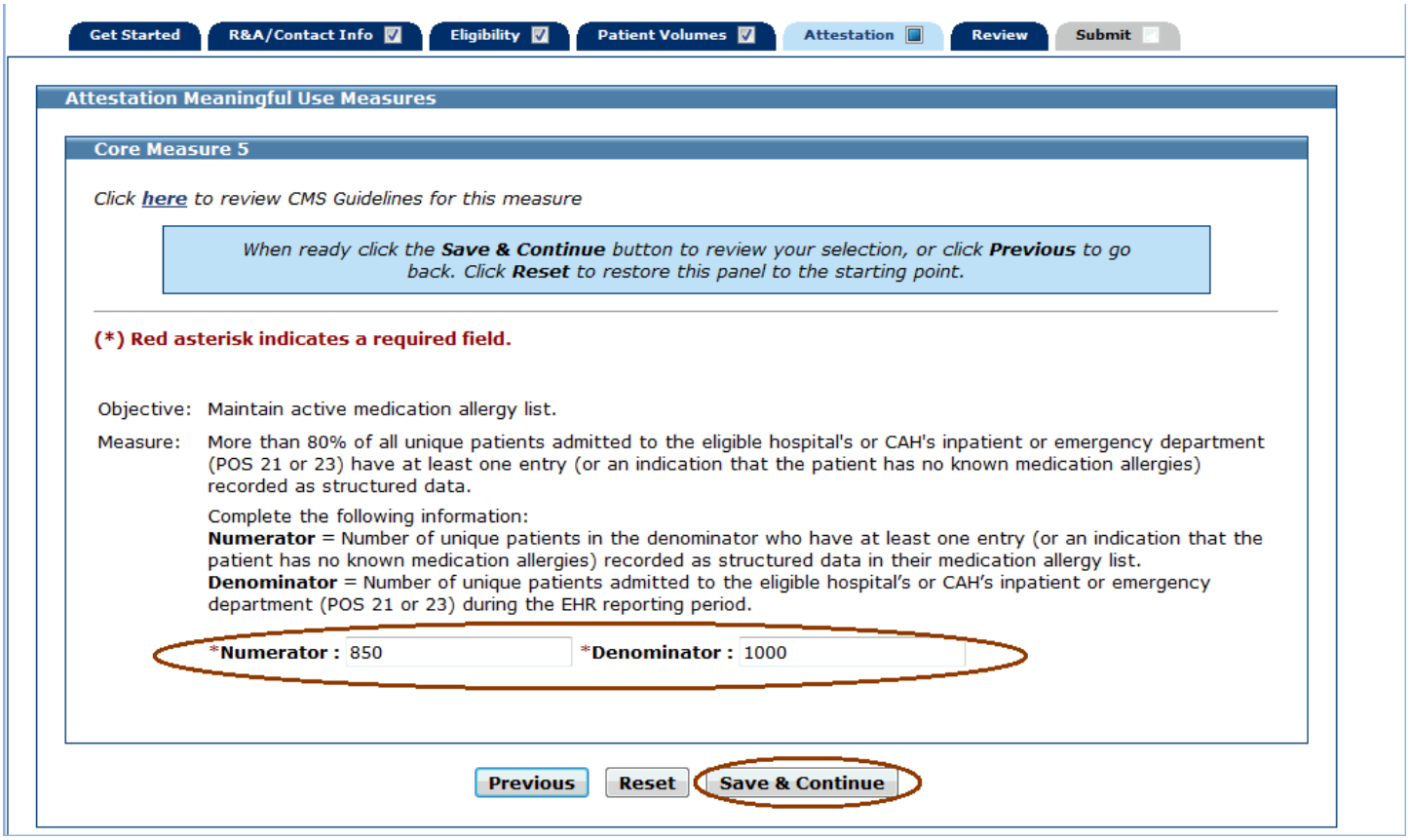


Core Measure 5 (Measure Code EHCMU05)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

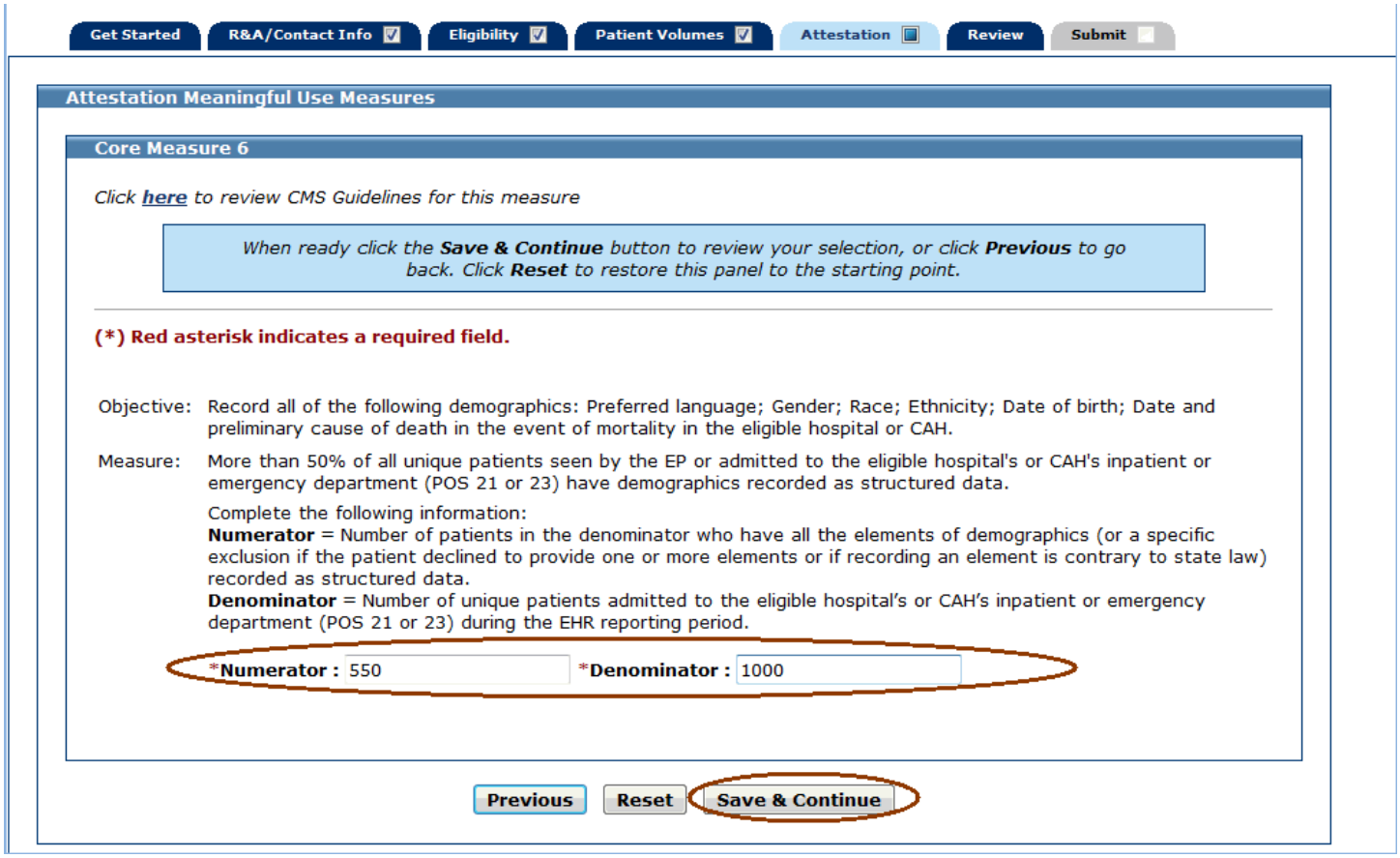


Core Measure 6 (Measure Code EHCMU06)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



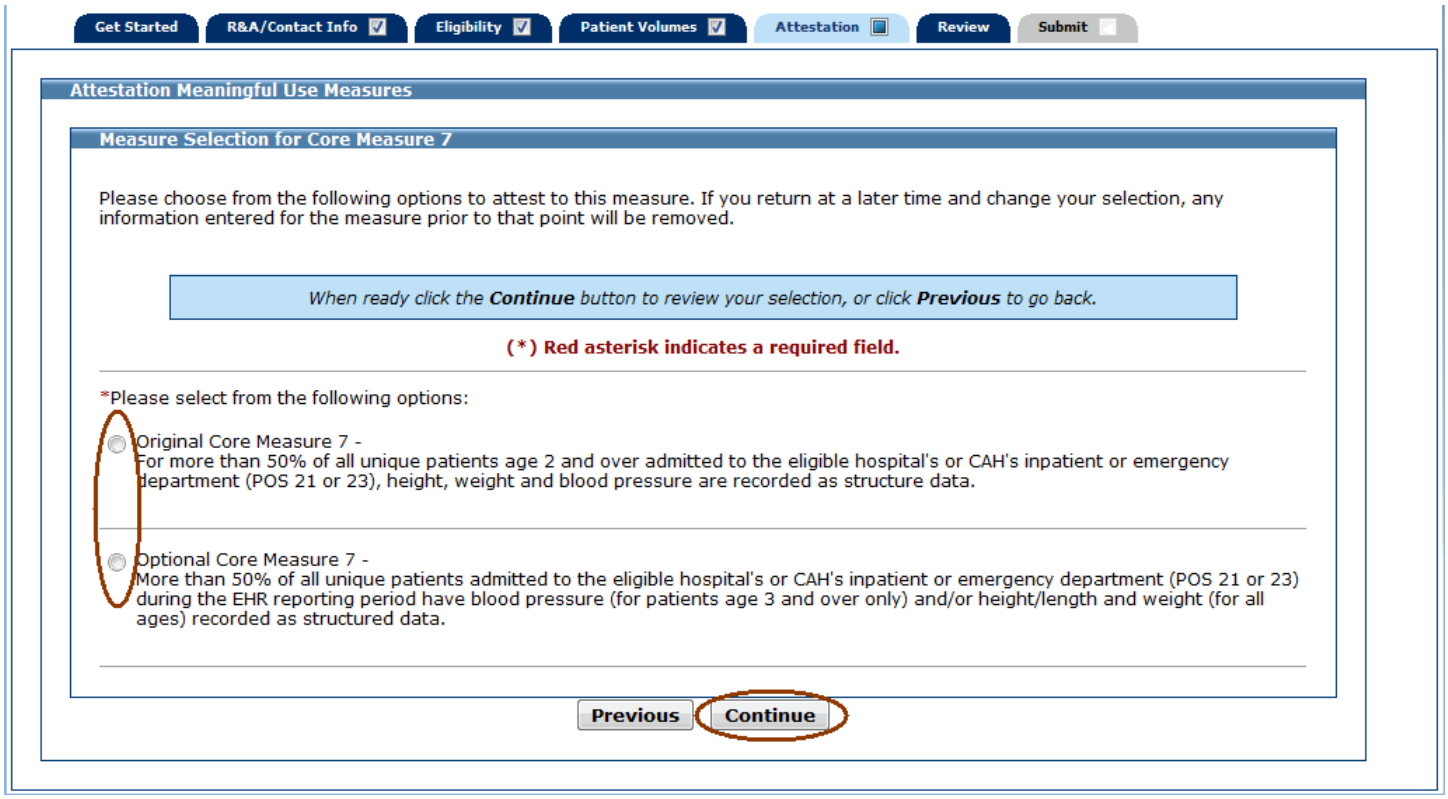
Measure Selection for Core Measure 7 (Measure Code EHCMU07)

Choose if you would like to attest to the **Original Core Measure 7** or the **Optional Core Measure 7**. If you return at a later time and change your selection, any information entered for the measure prior to that point will be removed.

Click **Save & Continue** to proceed to the appropriate core measure screen for option you selected or click **Previous** to go back.

If you selected the Original Core Measure 7, continue to the next page.

If you selected the Optional Core Measure 7, continue to page 70.

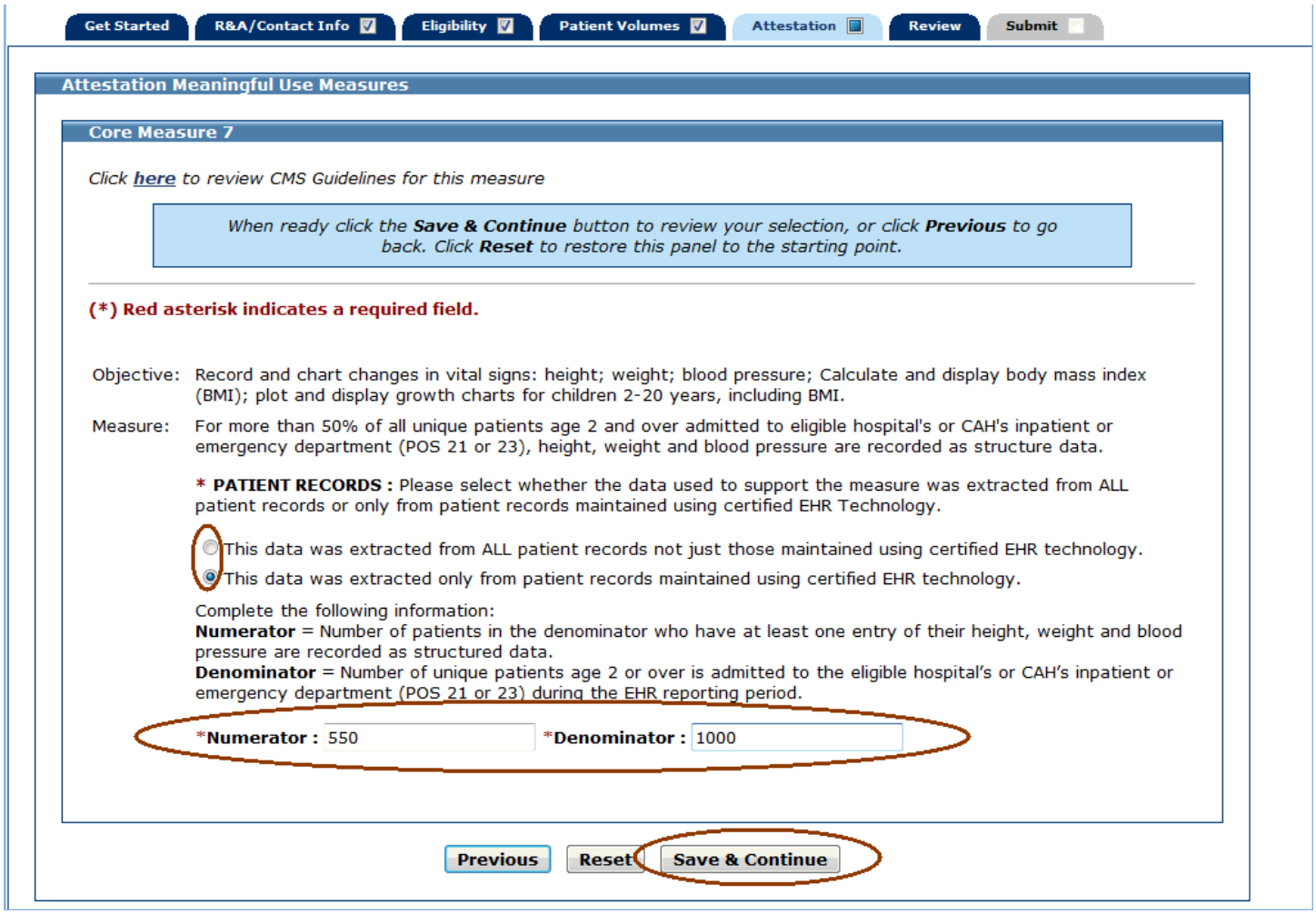


Original Core Measure 7 (Measure Code EHCMU07)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

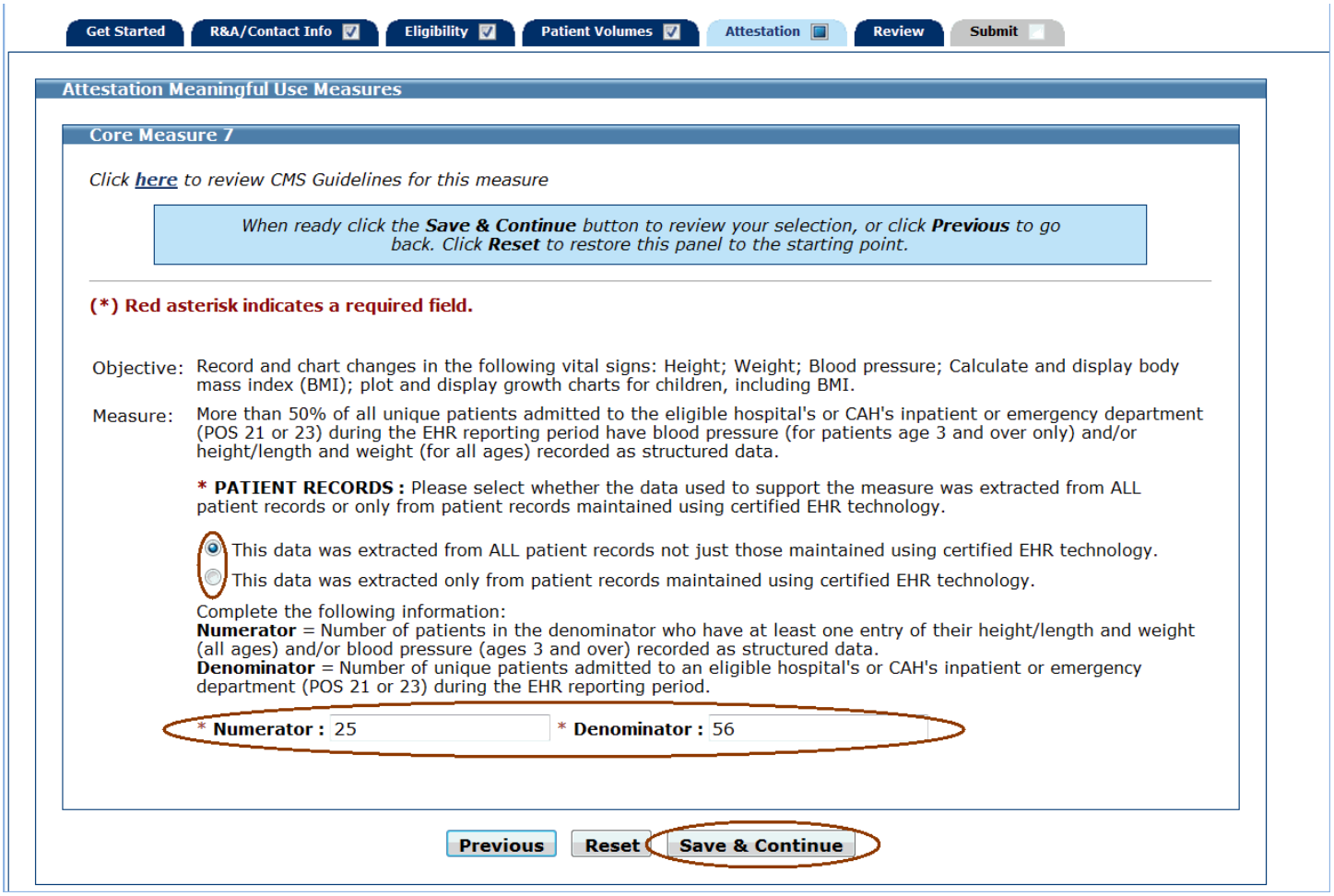


Optional Core Measure 7 (Measure Code EHCMU07)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.



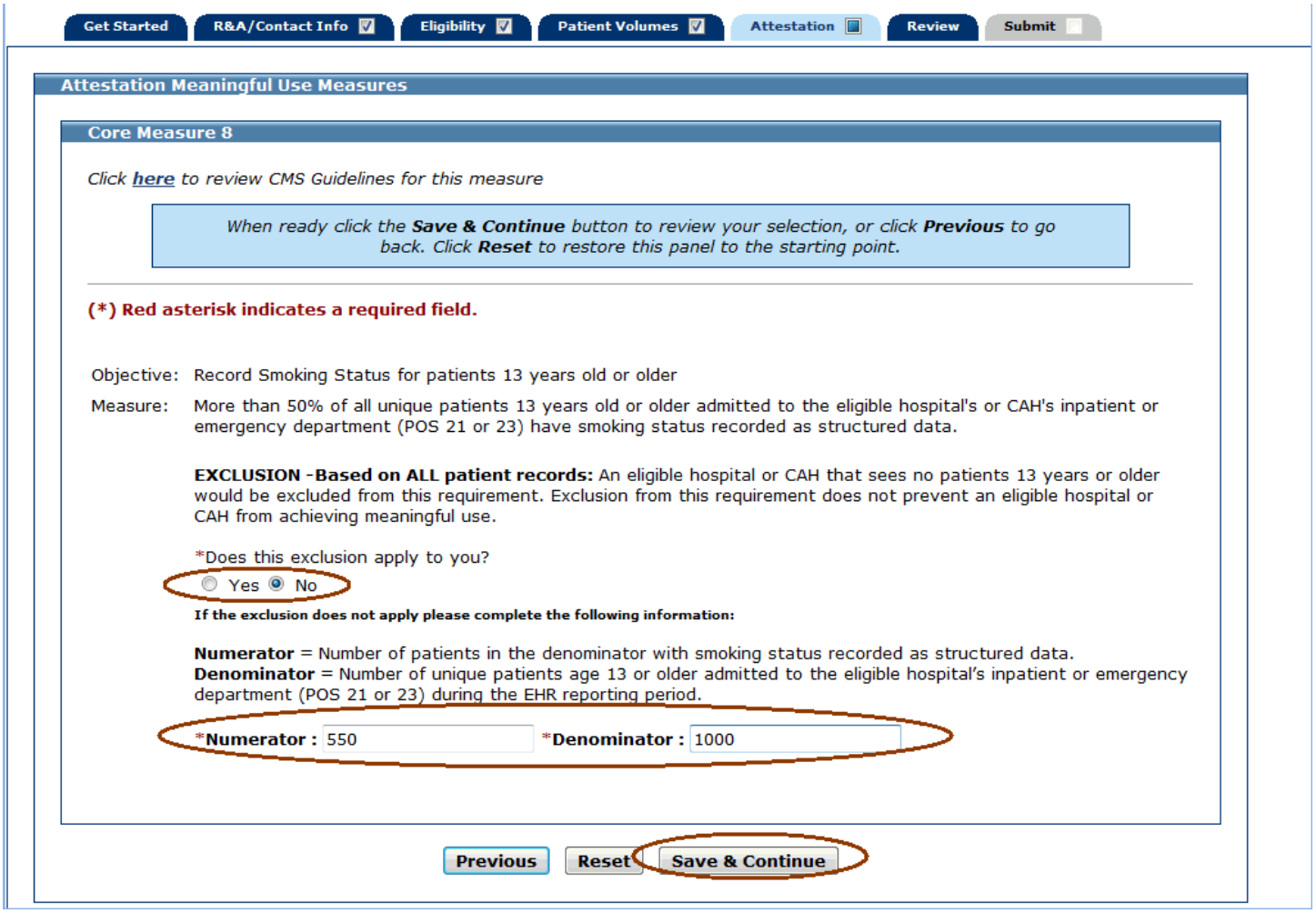
Core Measure 8 (Measure Code EHCMU08)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the next page.

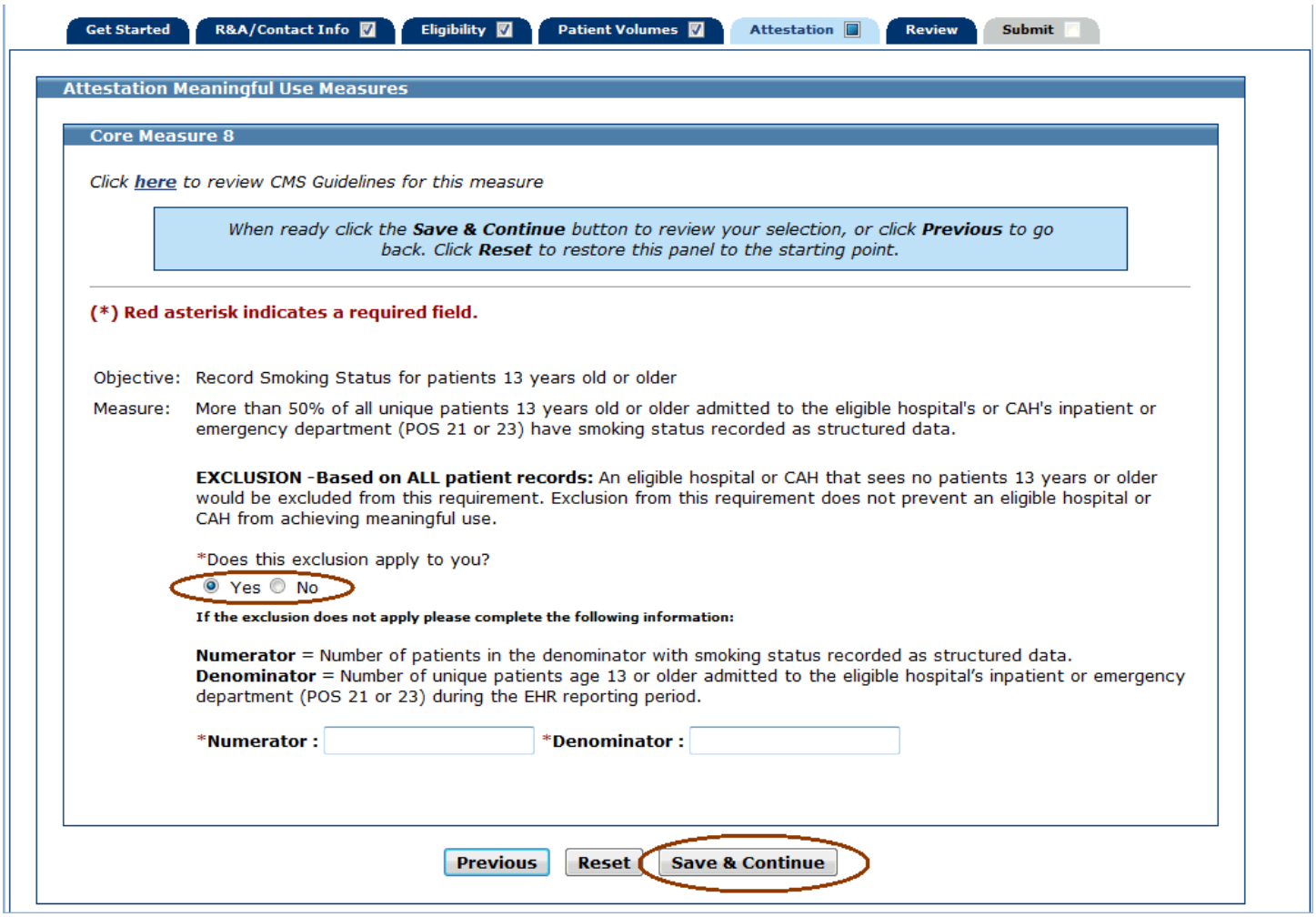
If the exclusion does not apply to you, select **No** to the exclusion and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



If the exclusion applies to you, select **Yes** to the exclusion and do not enter a numerator and denominator.

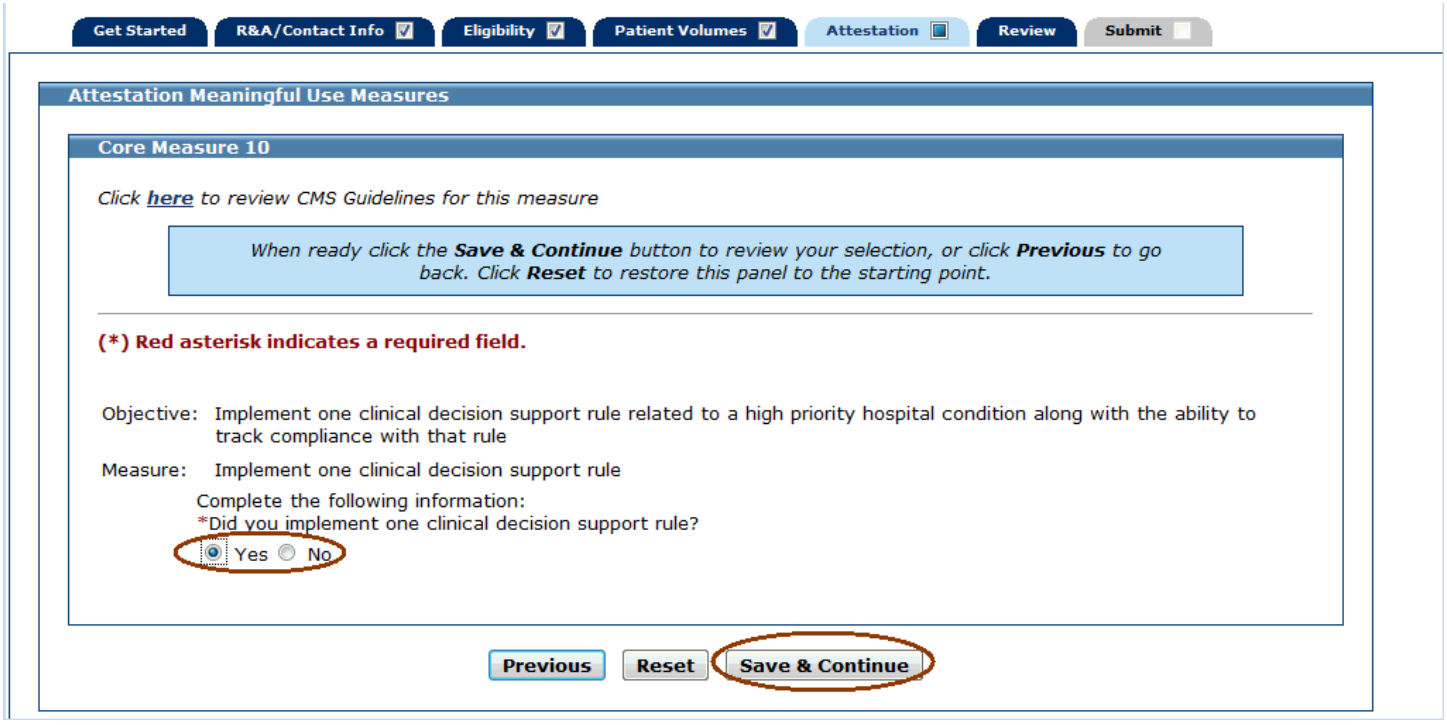
Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.


Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Core Measure 8
Click here to review CMS Guidelines for this measure
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Record Smoking Status for patients 13 years old or older
Measure: More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.
EXCLUSION -Based on ALL patient records: An eligible hospital or CAH that sees no patients 13 years or older would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
If the exclusion does not apply please complete the following information:
Numerator = Number of patients in the denominator with smoking status recorded as structured data.
Denominator = Number of unique patients age 13 or older admitted to the eligible hospital's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.
*Numerator :
*Denominator :
Previous
Reset
Save & Continue

Core Measure 10 (Measure Code EHCMU10)

Enter information in all required fields.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



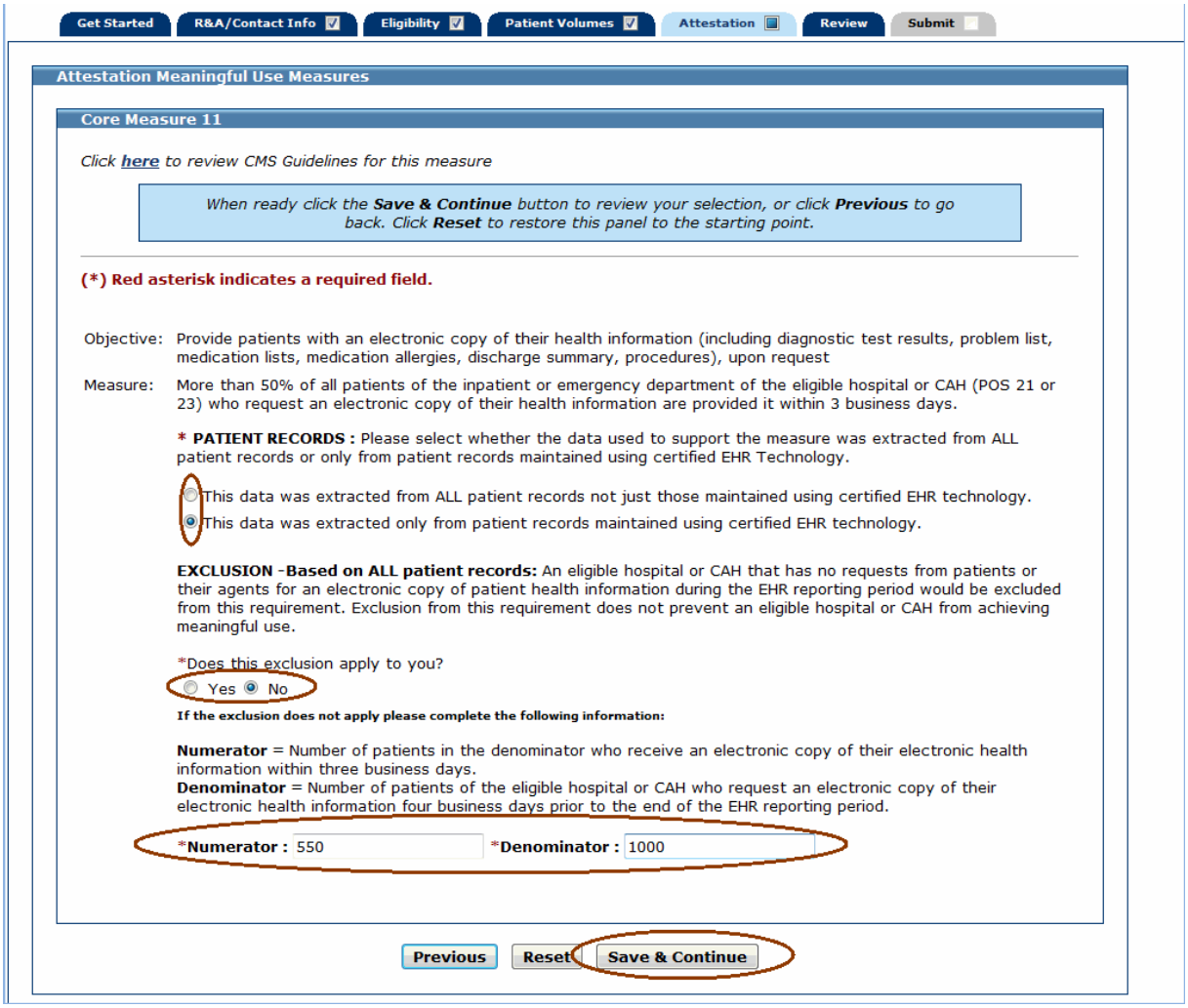
Core Measure 11 (Measure Code EHCMU11)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the following page.

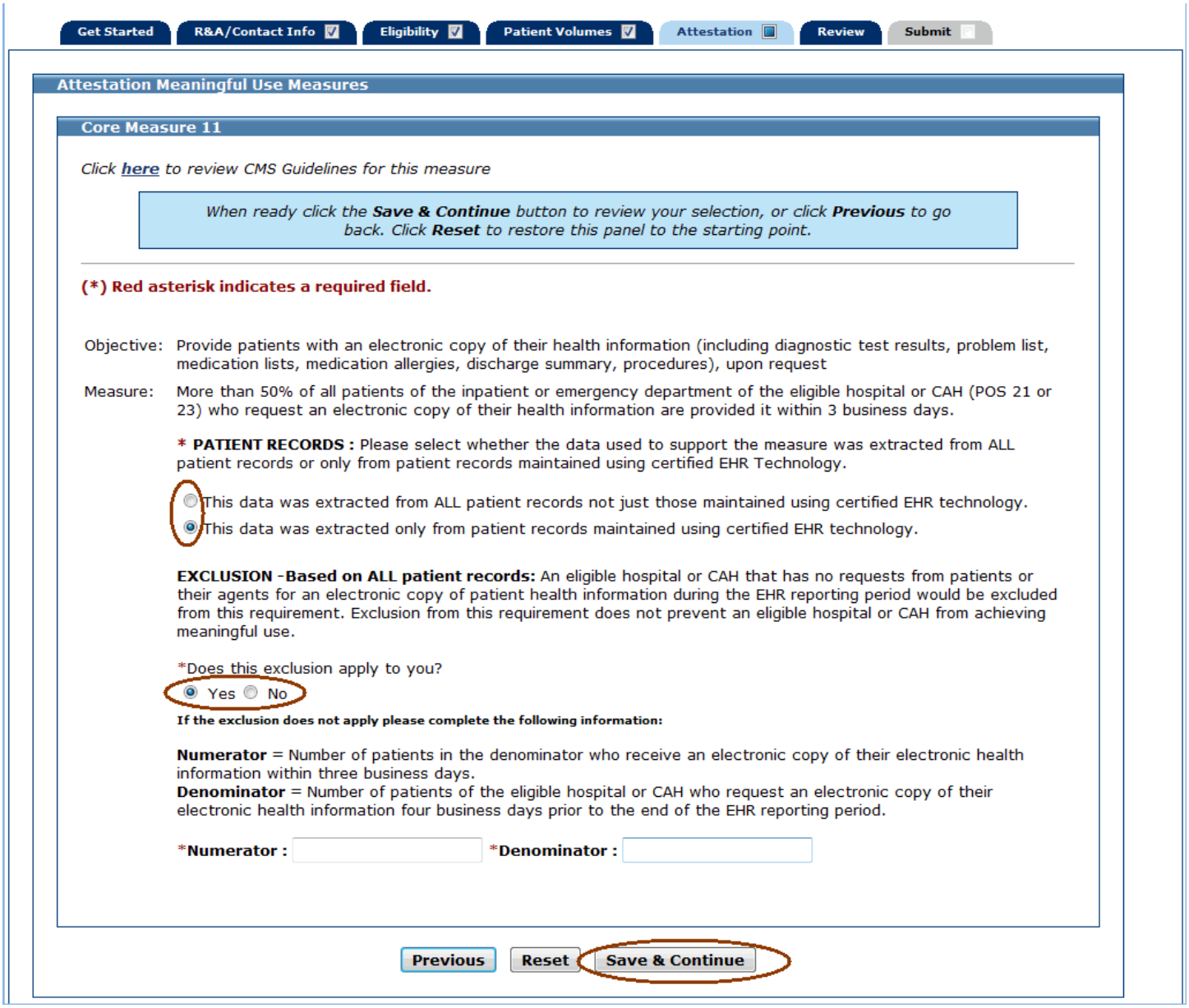
If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



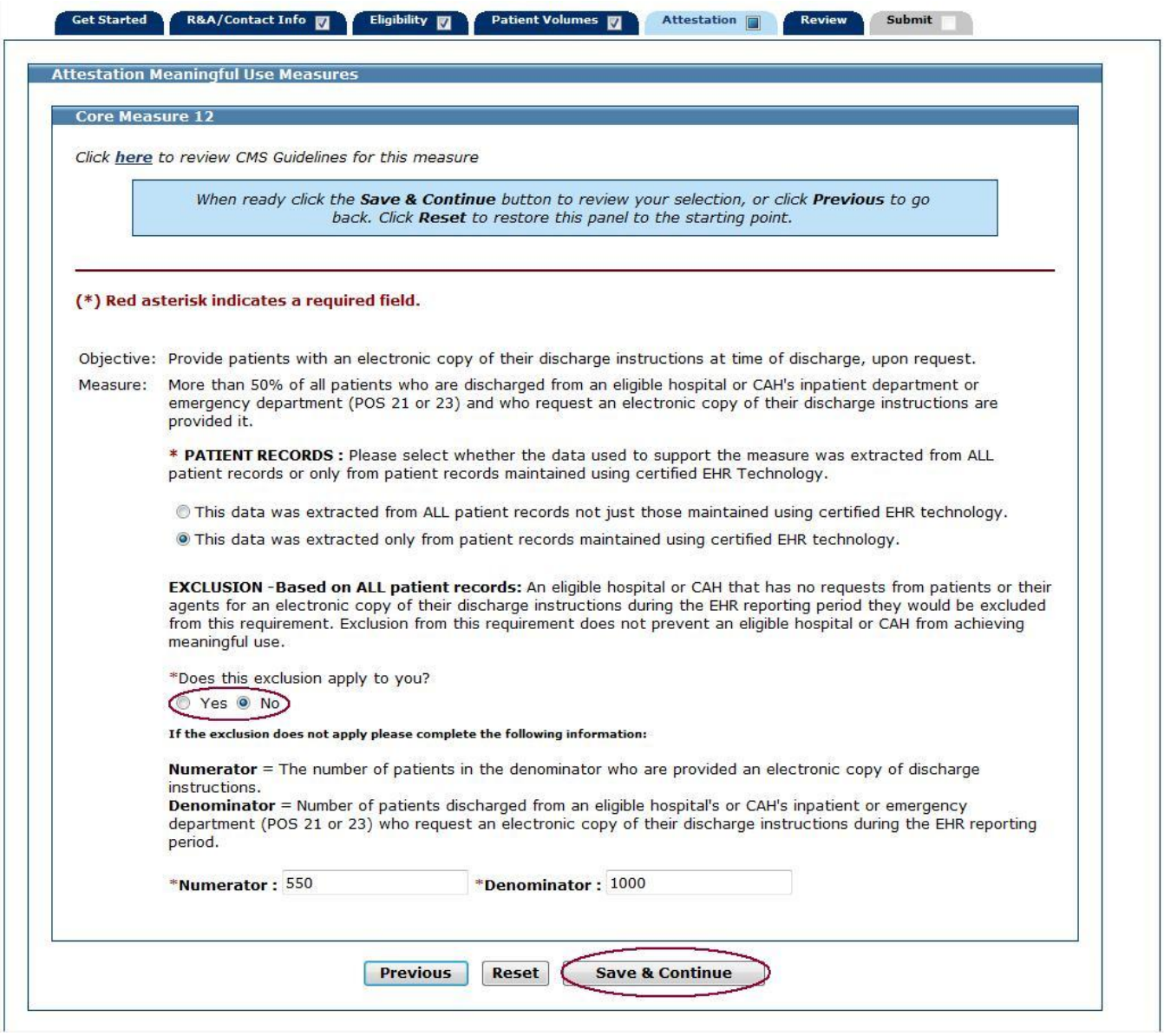
Core Measure 12 (Measure Code EHCMU12)

Enter information in all required fields.

If the exclusion applies to you, refer to the screen on the following page.

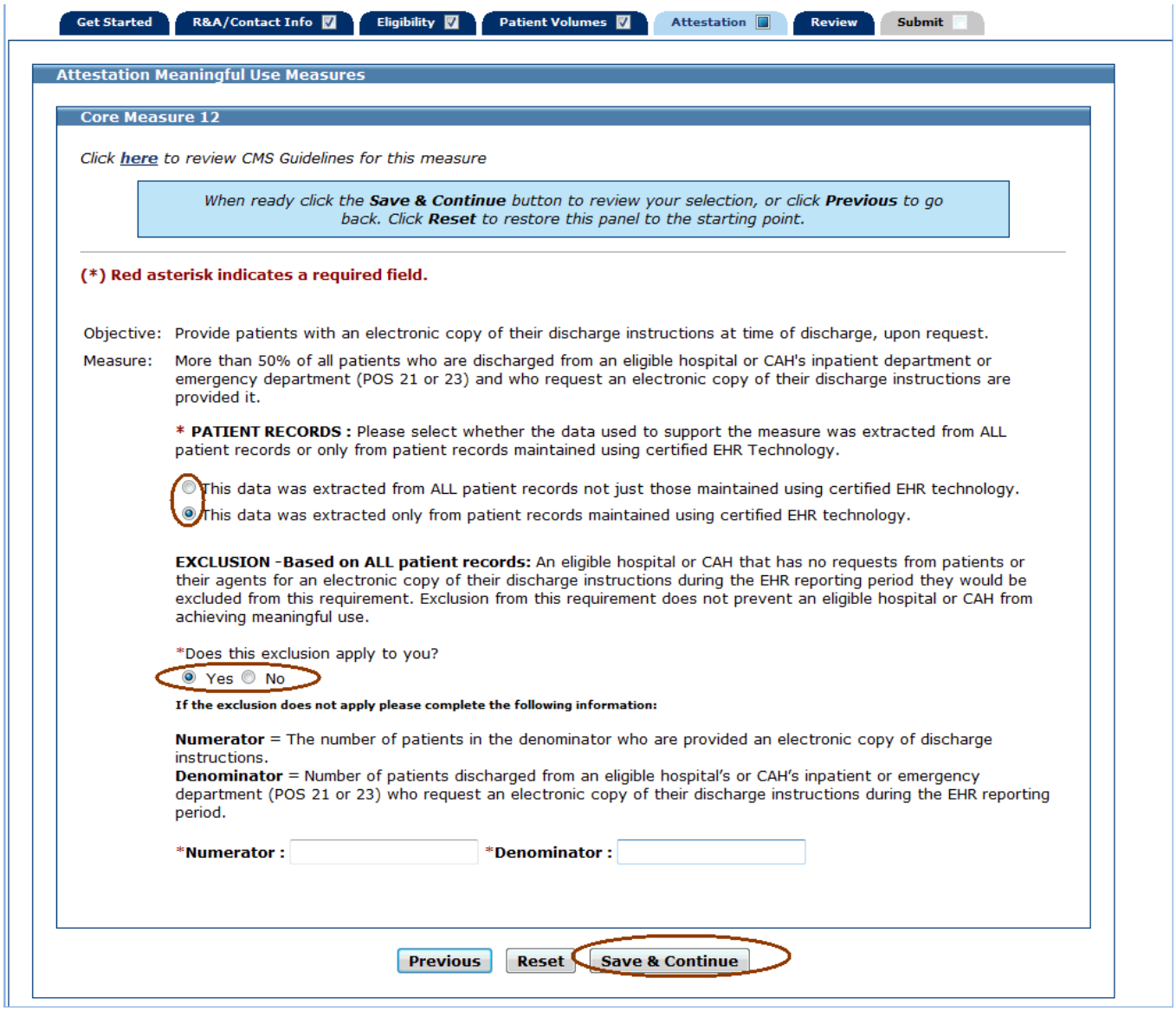
If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

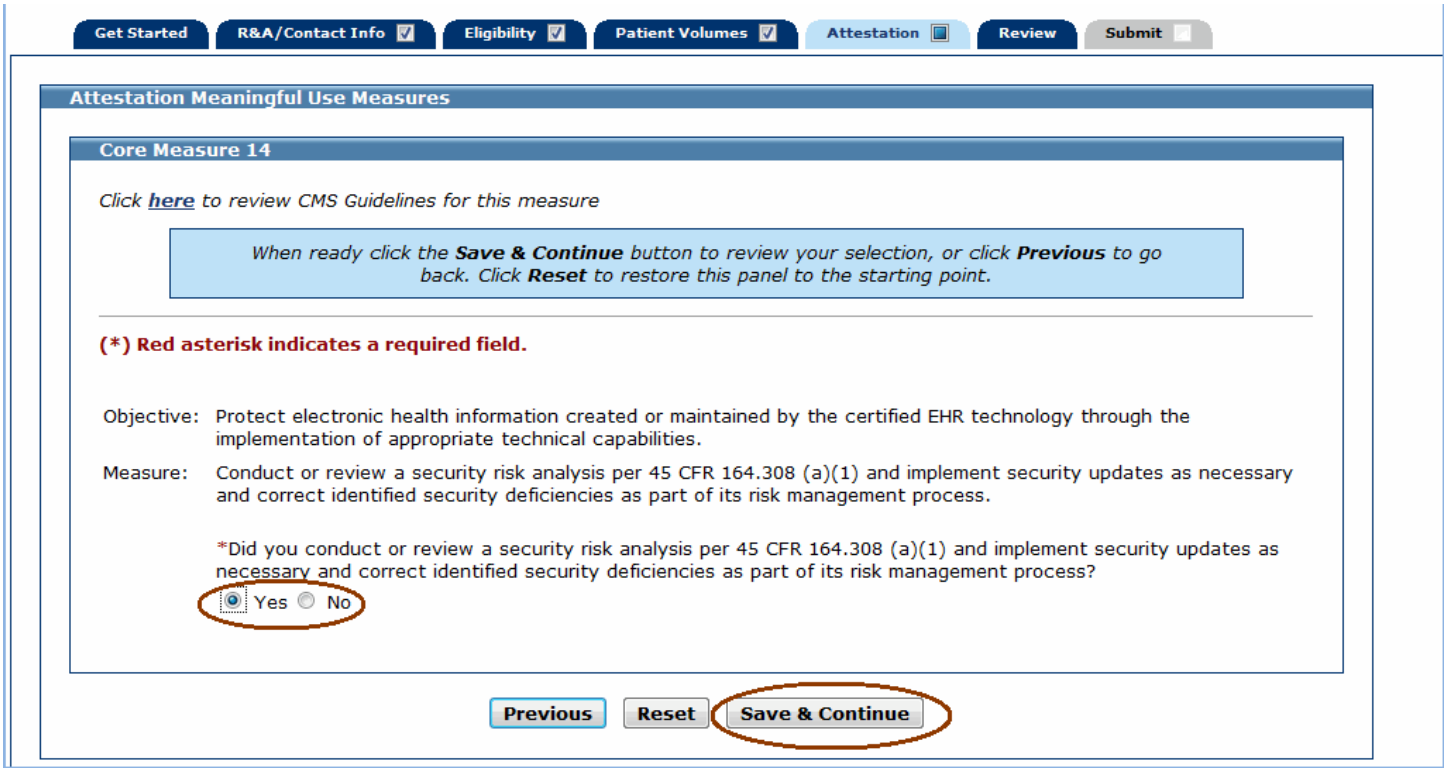
Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



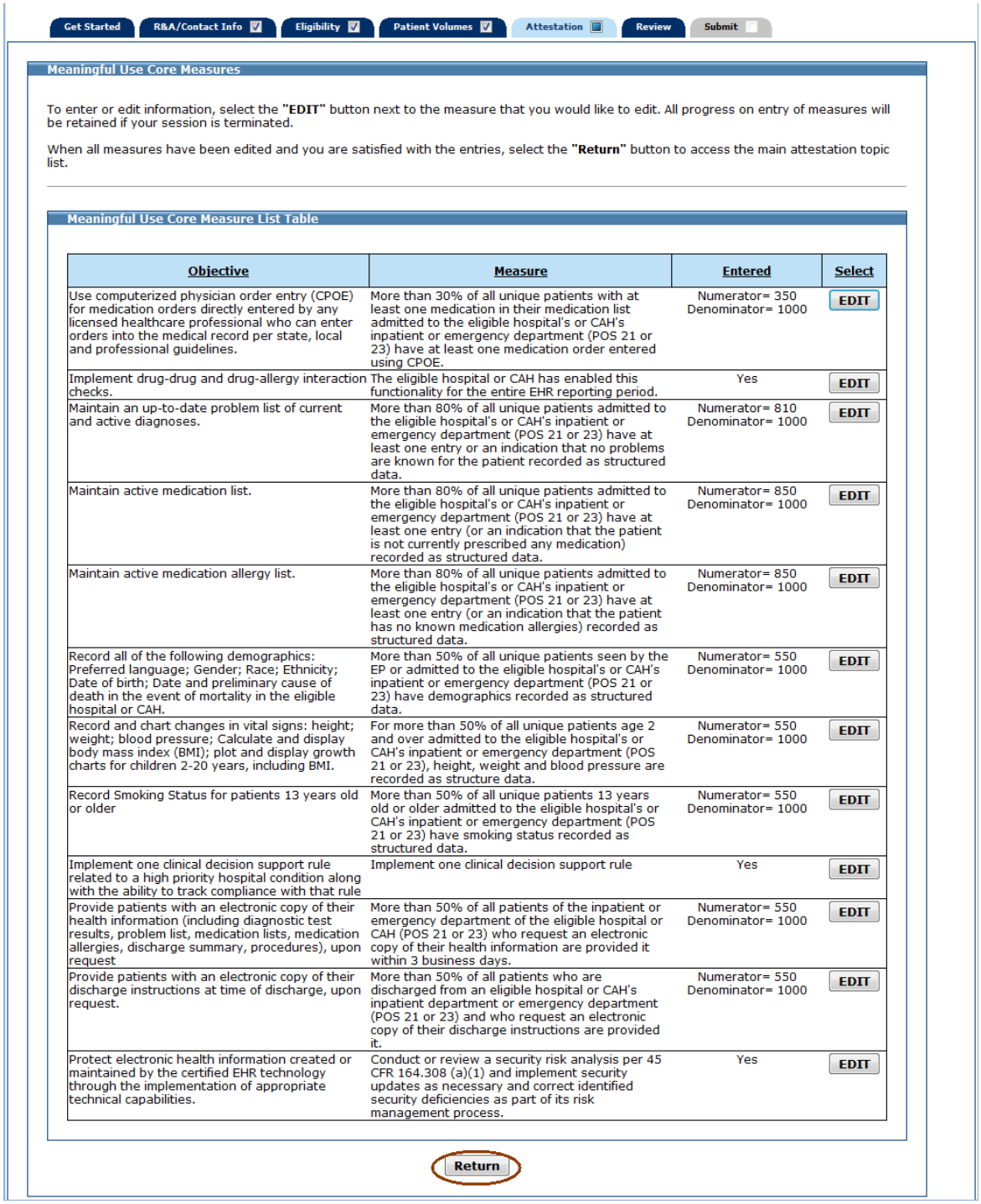
Core Measure 14 (Measure Code EHCMU14)

Enter information in all required fields.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



Once you attested to all the measures for this topic, click **Return** to return to the Measures Topic List.



Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Meaningful Use Core Measures

To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return"** button to access the main attestation topic list.

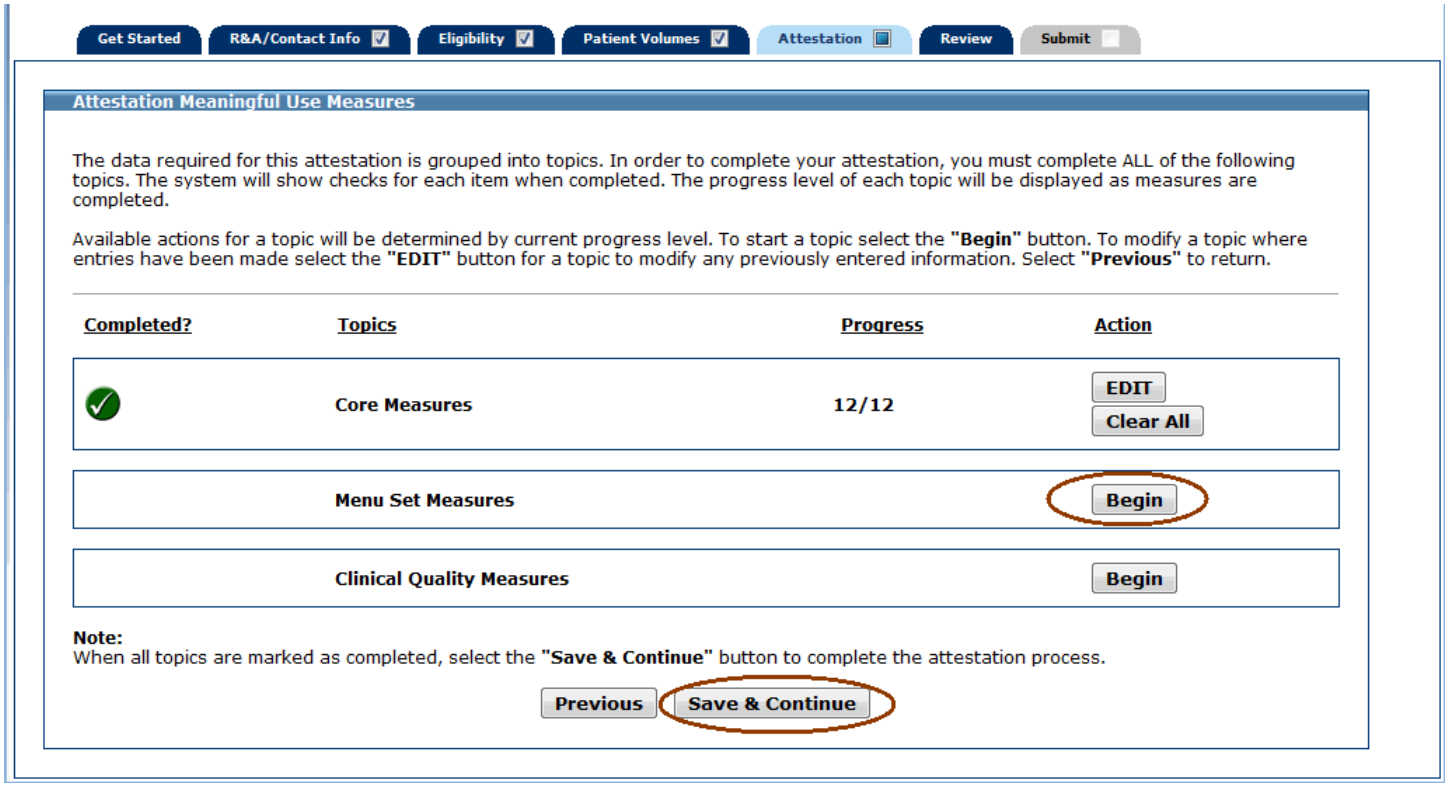
Meaningful Use Core Measure List Table

Objective	Measure	Entered	Select
Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE.	Numerator= 350 Denominator= 1000	EDIT
Implement drug-drug and drug-allergy interaction checks.	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.	Yes	EDIT
Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Numerator= 810 Denominator= 1000	EDIT
Maintain active medication list.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Numerator= 850 Denominator= 1000	EDIT
Maintain active medication allergy list.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Numerator= 850 Denominator= 1000	EDIT
Record all of the following demographics: Preferred language; Gender; Race; Ethnicity; Date of birth; Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	Numerator= 550 Denominator= 1000	EDIT
Record and chart changes in vital signs: height; weight; blood pressure; Calculate and display body mass index (BMI); plot and display growth charts for children 2-20 years, including BMI.	For more than 50% of all unique patients age 2 and over admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structure data.	Numerator= 550 Denominator= 1000	EDIT
Record Smoking Status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.	Numerator= 550 Denominator= 1000	EDIT
Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule	Yes	EDIT
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	More than 50% of all patients of the inpatient or emergency department of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.	Numerator= 550 Denominator= 1000	EDIT
Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.	Numerator= 550 Denominator= 1000	EDIT
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes	EDIT

Return

If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure after it has been marked complete.

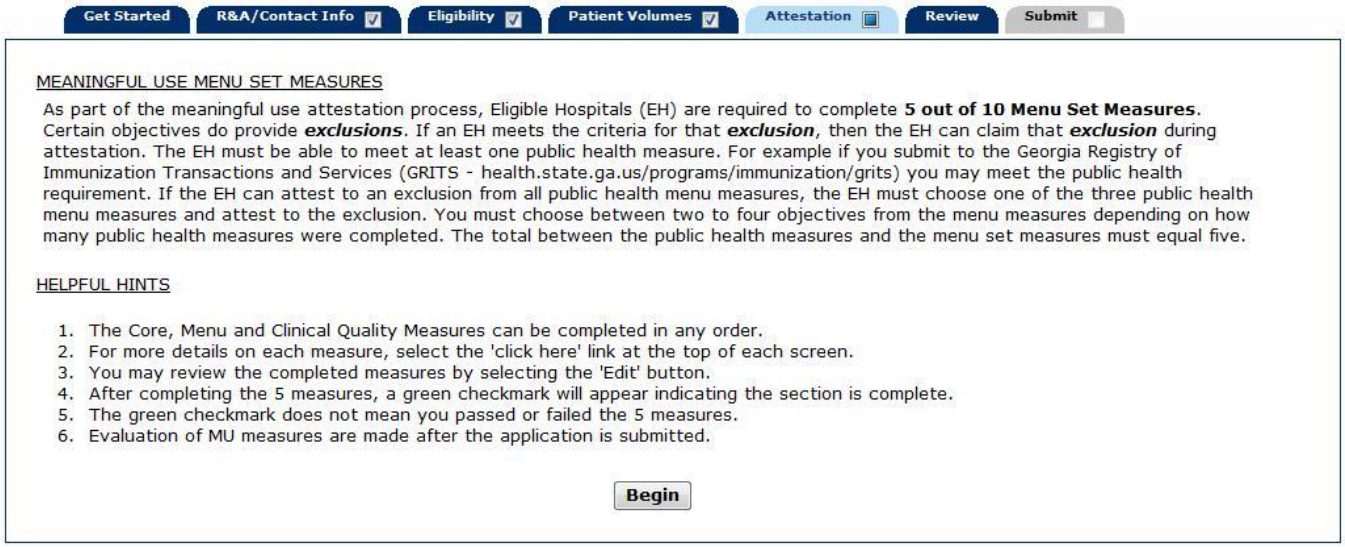
Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.



Meaningful Use Menu Set Measures

This initial screen provides information about the Menu Set Measures.

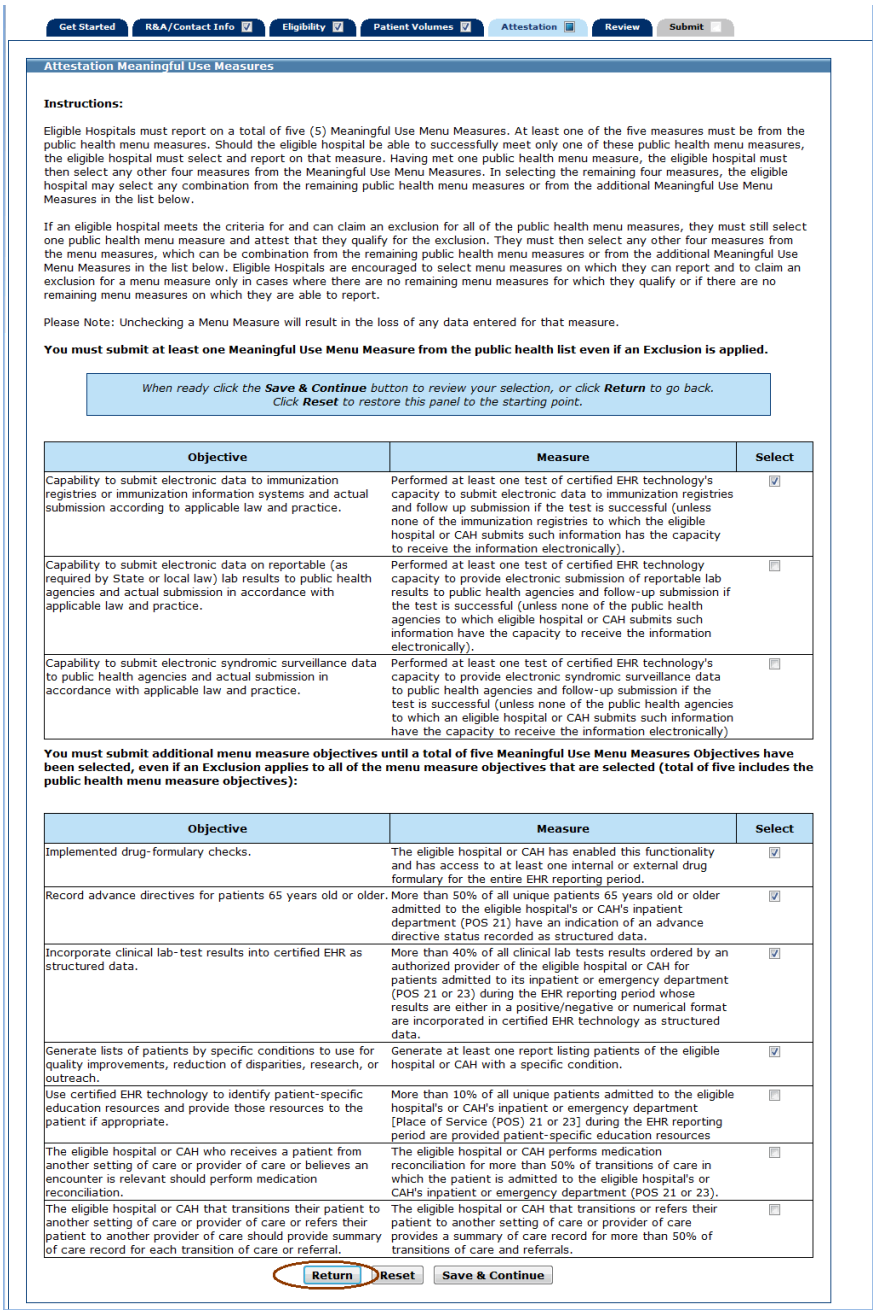
Click **Begin** to continue to the Menu Set Measures section.



From the screen on the following page, choose five Meaningful Use Menu Measures to attest to. One measure must be from the public health list (first three measures listed on the top half of the screen). The remainder of the measures can be any combination from the remaining public health list measures or from the additional Meaningful Use Menu Measures listed. In the example shown on the following page, one public health measure and four measures from the additional Meaningful Use Measures listed are selected.

If a measure is selected and information is entered for that measure, unselecting the measure will clear all information previously entered.

Click **Save & Continue** to proceed, or click **Return** to go back. Click **Reset** to restore this panel to the starting point.



Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Attestation Meaningful Use Measures

Instructions:

Eligible Hospitals must report on a total of five (5) Meaningful Use Menu Measures. At least one of the five measures must be from the public health menu measures. Should the eligible hospital be able to successfully meet only one of these public health menu measures, the eligible hospital must select and report on that measure. Having met one public health menu measure, the eligible hospital must then select any other four measures from the Meaningful Use Menu Measures. In selecting the remaining four measures, the eligible hospital may select any combination from the remaining public health menu measures or from the additional Meaningful Use Menu Measures in the list below.

If an eligible hospital meets the criteria for and can claim an exclusion for all of the public health menu measures, they must still select one public health menu measure and attest that they qualify for the exclusion. They must then select any other four measures from the menu measures, which can be combination from the remaining public health menu measures or from the additional Meaningful Use Menu Measures in the list below. Eligible Hospitals are encouraged to select menu measures on which they can report and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they qualify or if there are no remaining menu measures on which they are able to report.

Please Note: Unchecking a Menu Measure will result in the loss of any data entered for that measure.

You must submit at least one Meaningful Use Menu Measure from the public health list even if an Exclusion is applied.

*When ready click the **Save & Continue** button to review your selection, or click **Return** to go back.*
*Click **Reset** to restore this panel to the starting point.*

Objective	Measure	Select
Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).	☑
Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically).	☐
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive the information electronically)	☐

You must submit additional menu measure objectives until a total of five Meaningful Use Menu Measures Objectives have been selected, even if an Exclusion applies to all of the menu measure objectives that are selected (total of five includes the public health menu measure objectives):

Objective	Measure	Select
Implemented drug-formulary checks.	The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	☑
Record advance directives for patients 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded as structured data.	☑
Incorporate clinical lab-test results into certified EHR as structured data.	More than 40% of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	☑
Generate lists of patients by specific conditions to use for quality improvements, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.	☑
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department [Place of Service (POS) 21 or 23] during the EHR reporting period are provided patient-specific education resources	☐
The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	☐
The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	☐

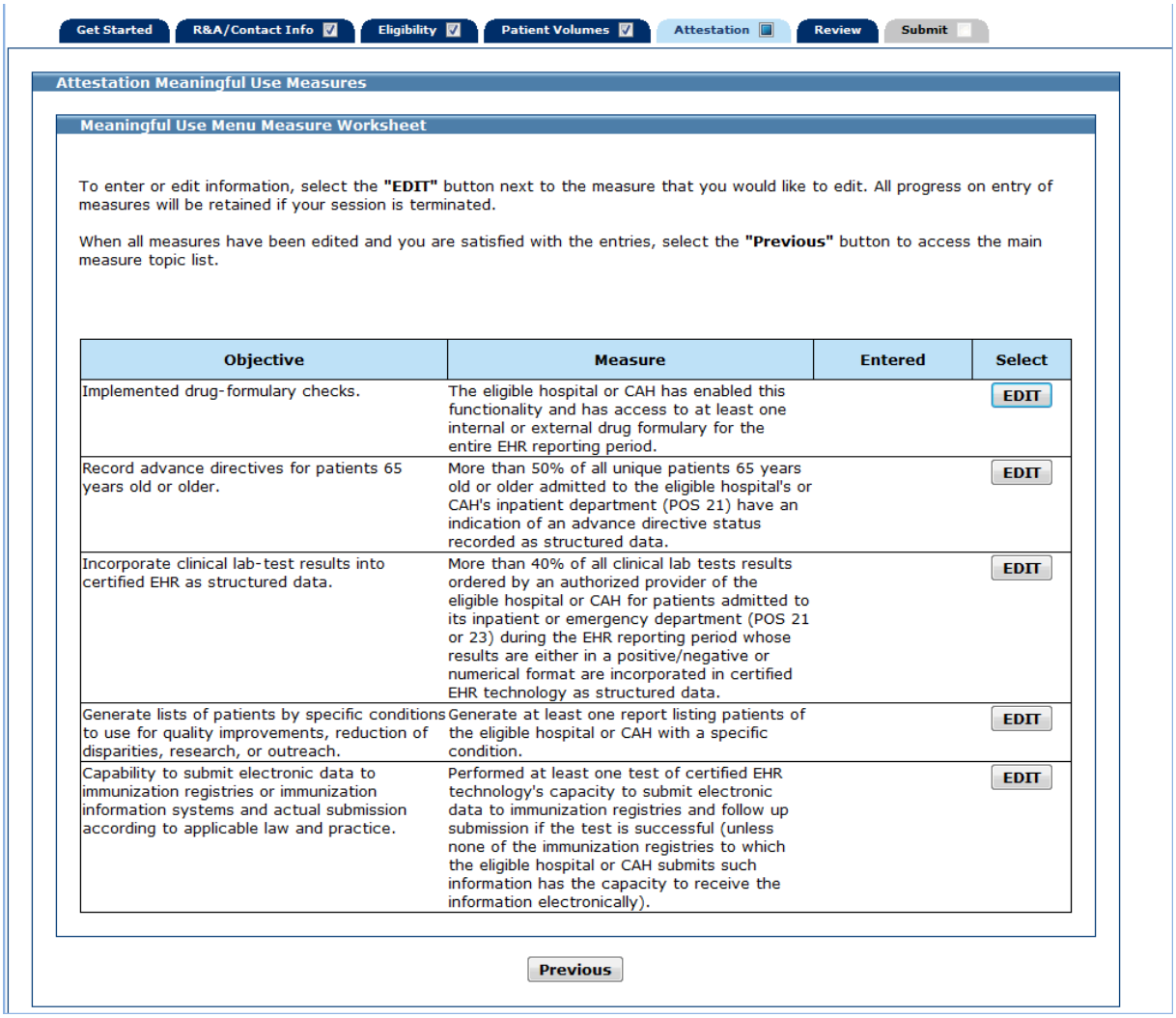
Return | Reset | Save & Continue

The five measures you selected to attest to will display on the Meaningful Use Menu Measure Worksheet. The example below displays the five measures selected on the previous screen example.

You must complete all measures.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.

Click **Edit** to enter or edit information for a measure or click **Previous** to return to the Measures Topic List.

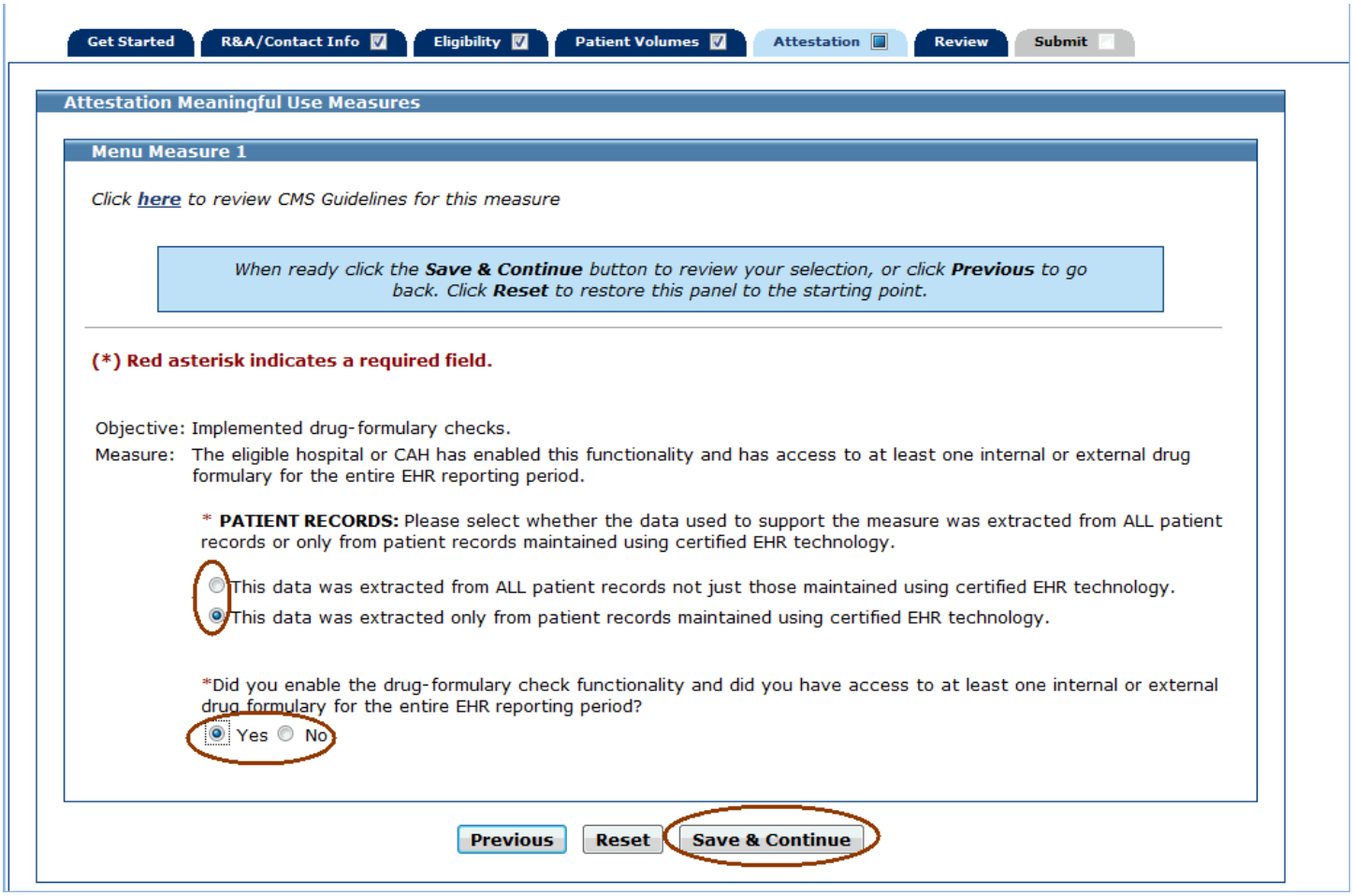


The 10 available Meaningful Use Menu Measures are described in this user guide. Only those that you selected will apply to you.

Menu Measure 1 (Measure Code EHMMU01)

Enter information in all required fields.

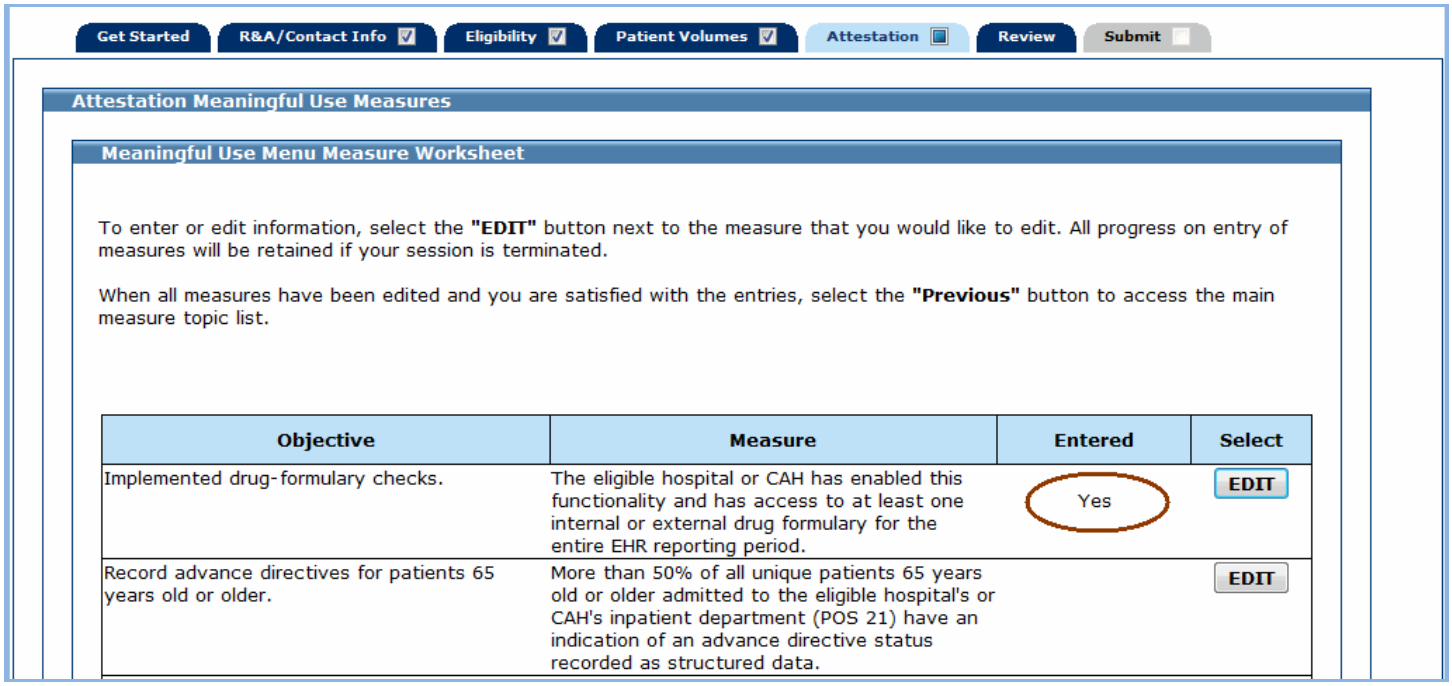
Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



After you enter information for a measure and click the **Save & Continue**, you will return to the Meaningful Use Core Menu Measure Worksheet. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below (please note that the entire screen is not displayed in this example).

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.



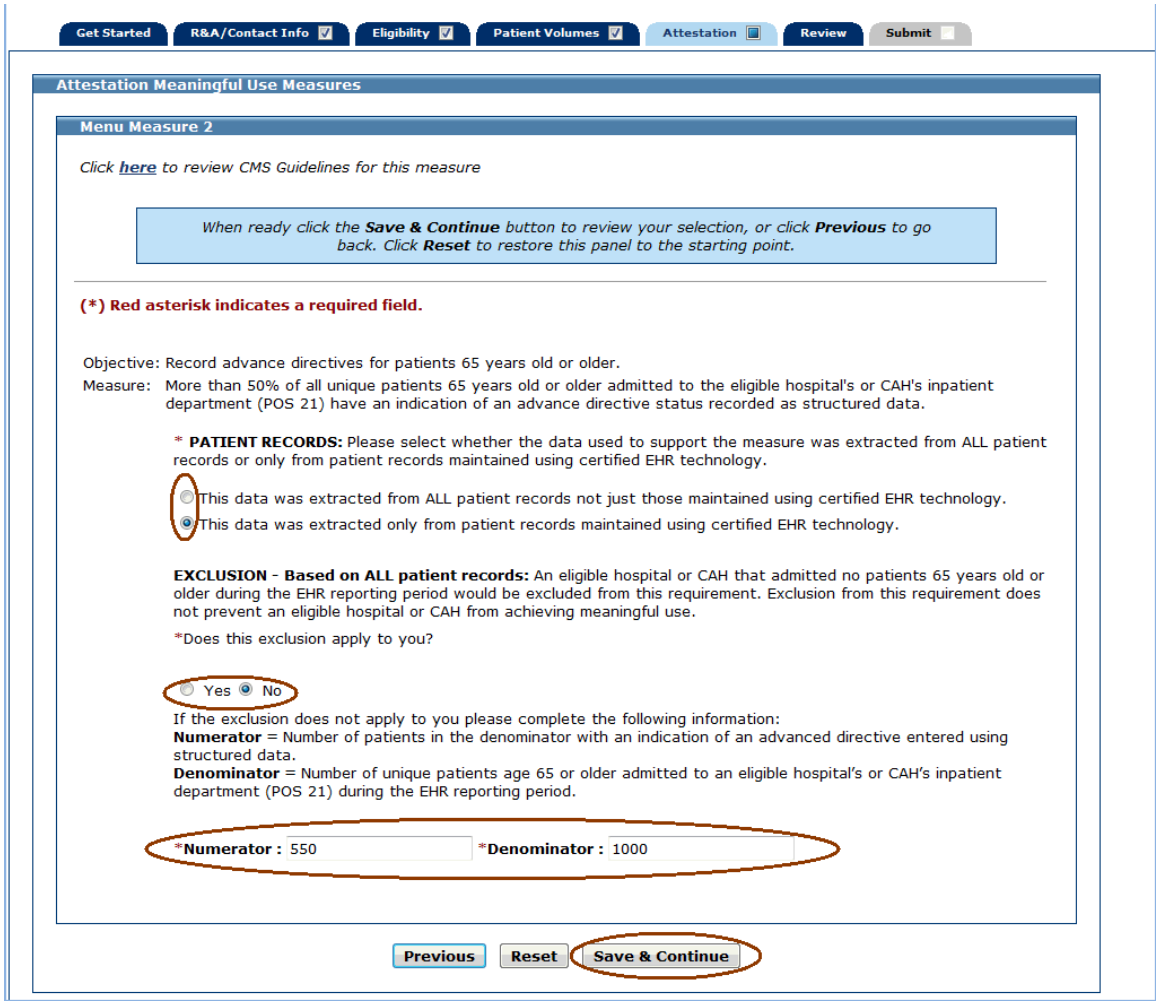
Menu Measure 2 (Measure Code EHMMU02)

Enter information in all required fields.

If the exclusion applies to you, see the screen on the following page.

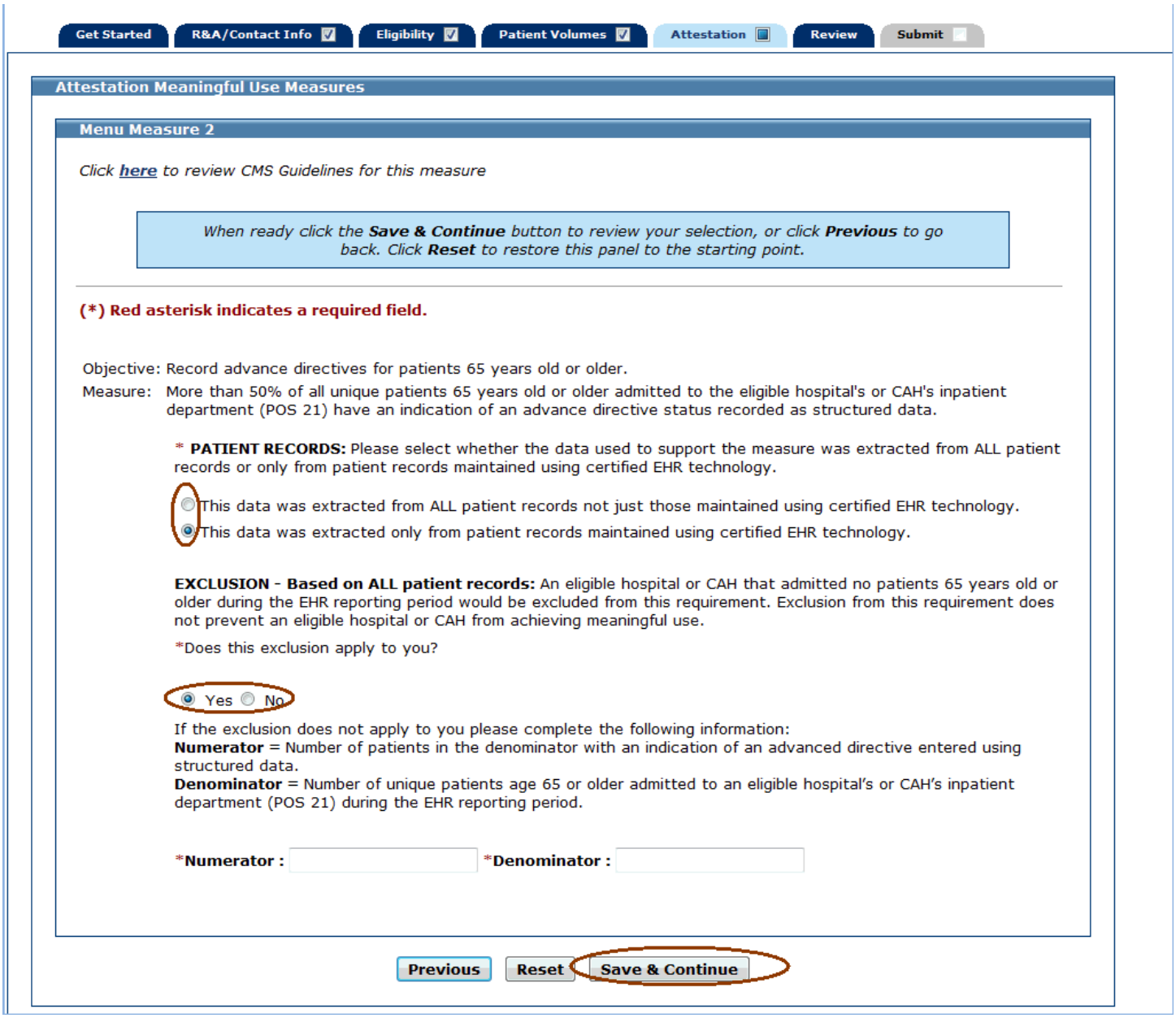
If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion and do not enter a numerator and denominator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

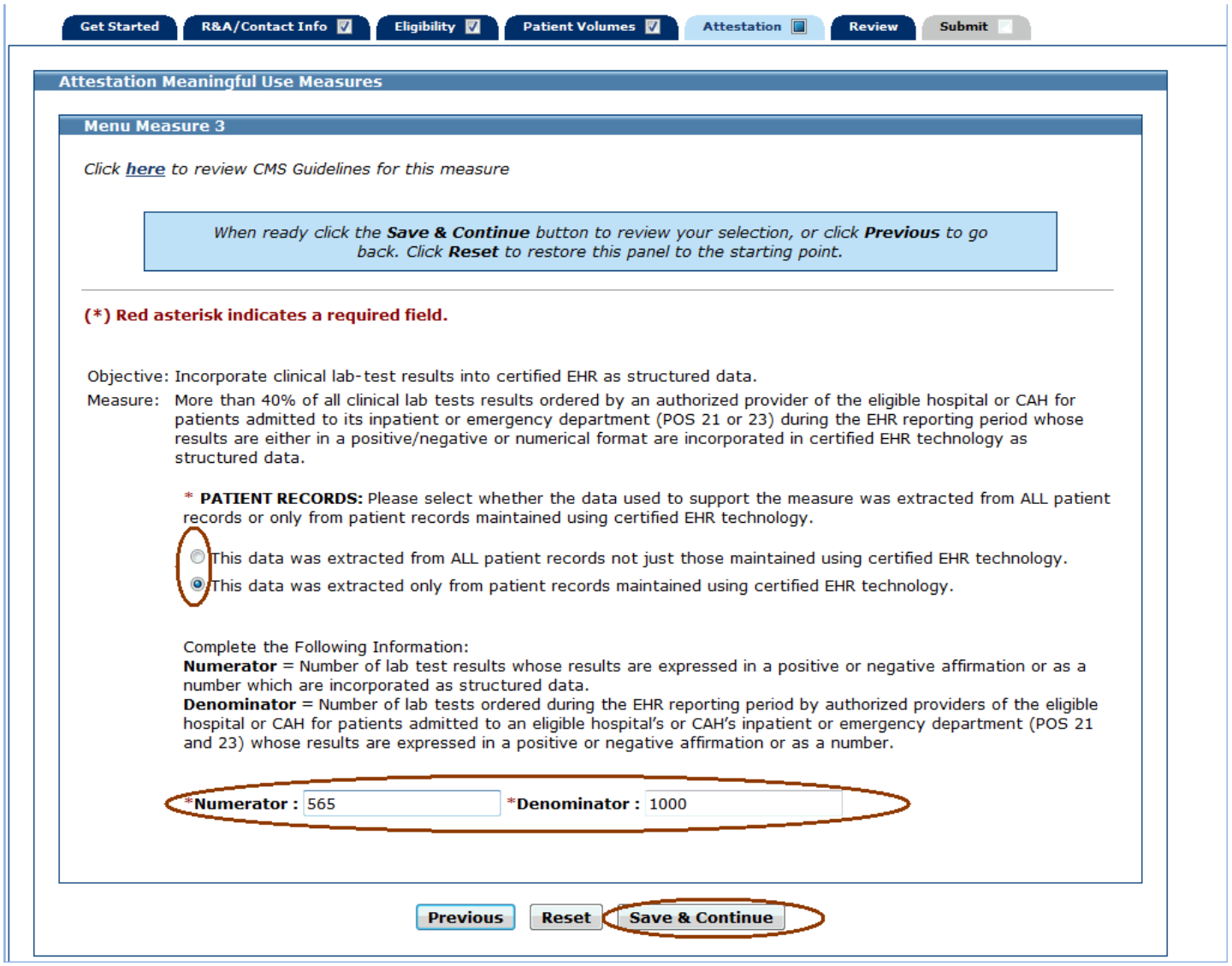


Menu Measure 3 (Measure Code EHMMU03)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

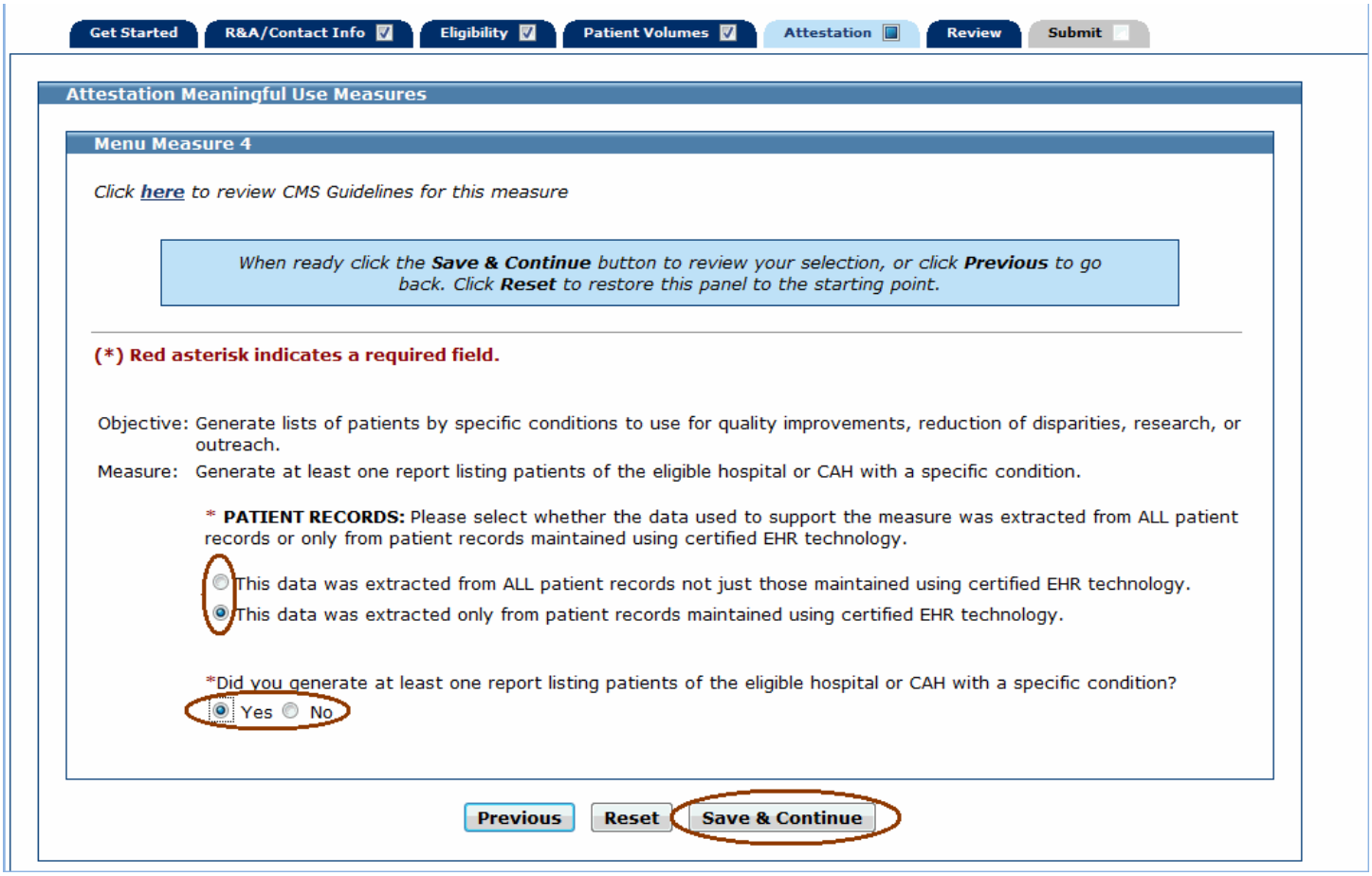
Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



Menu Measure 4 (Measure Code EHMMU04)

Enter information in all required fields.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

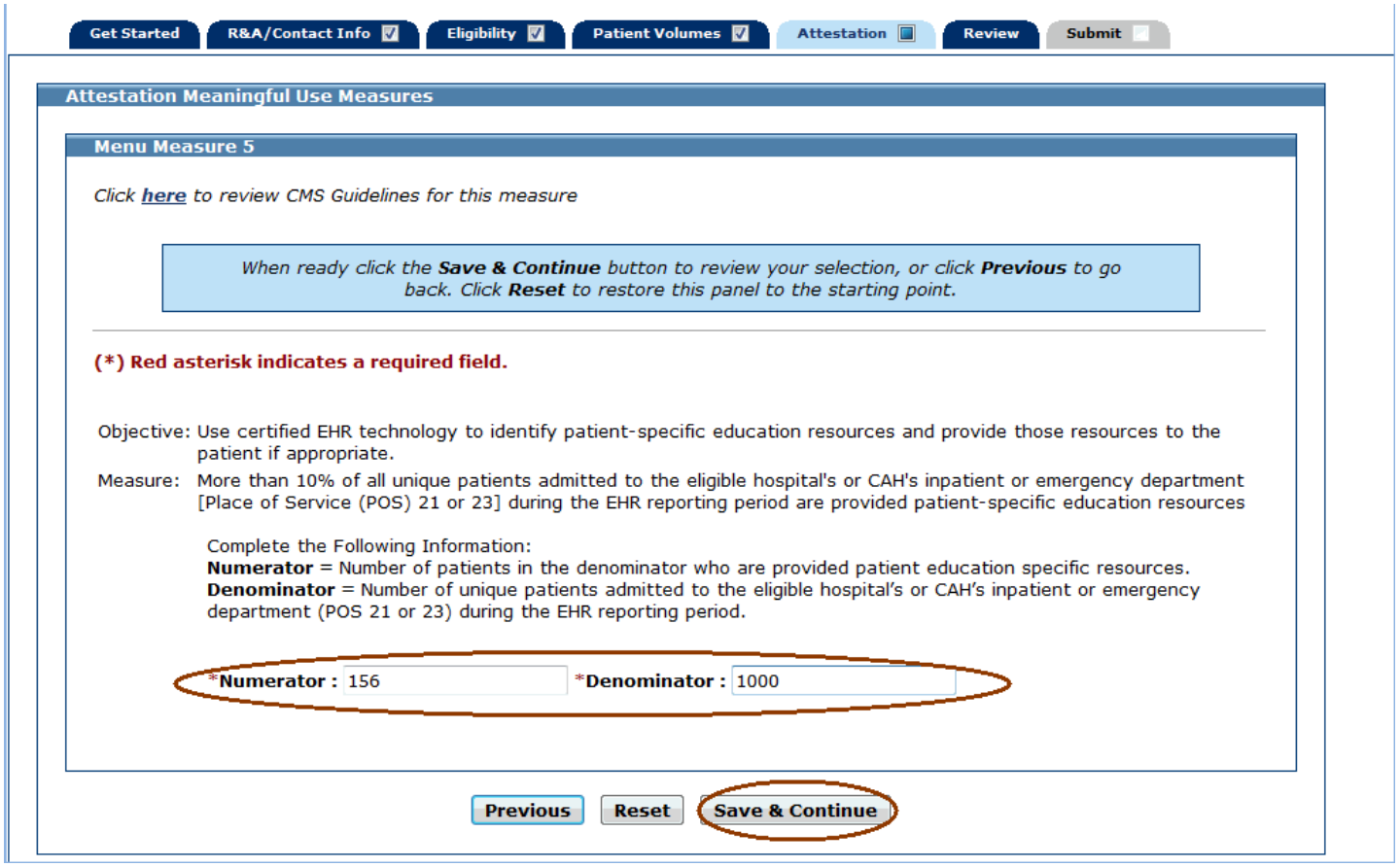


Menu Measure 5 (Measure Code EHMMU05)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

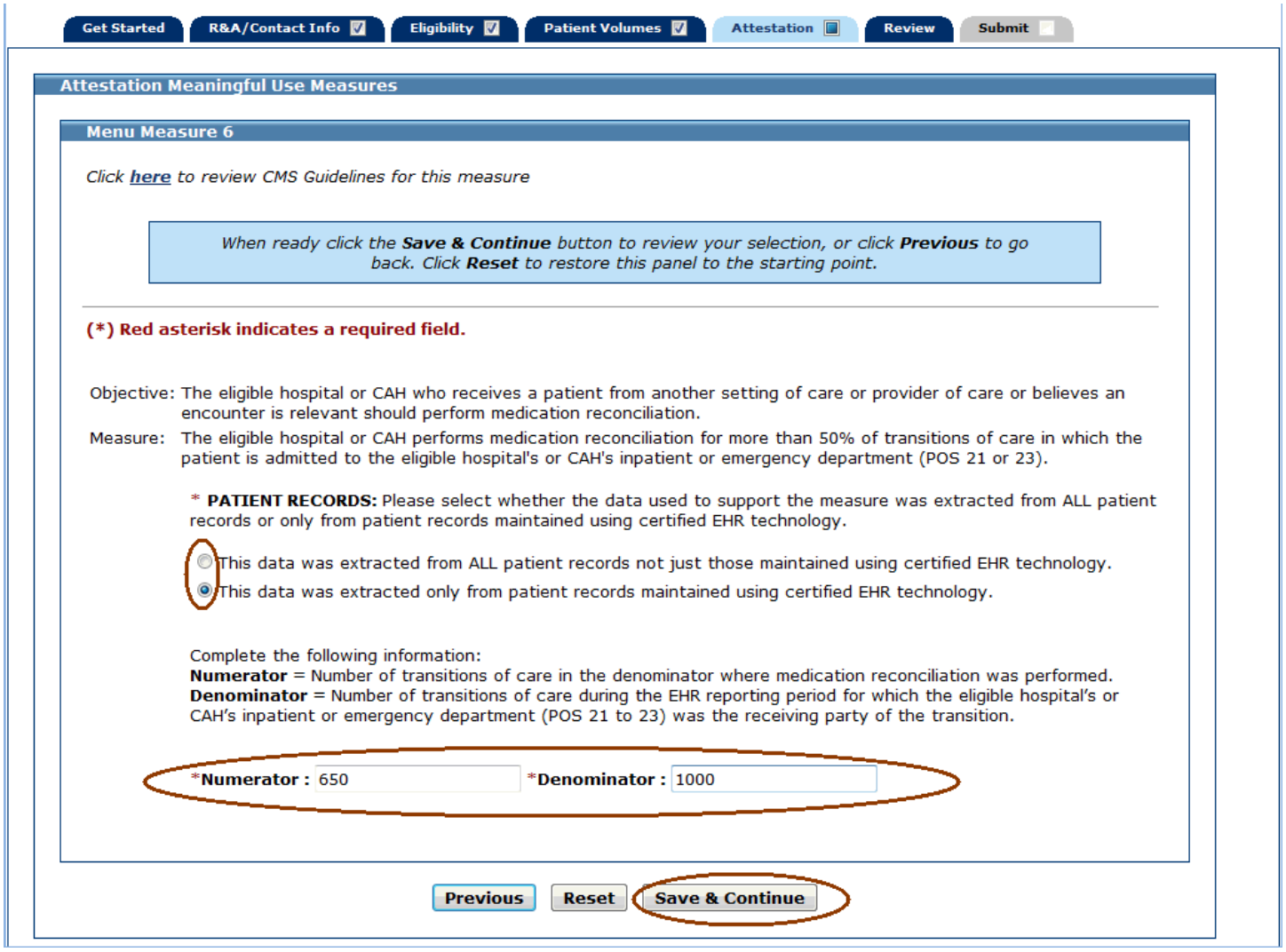


Menu Measure 6 (Measure Code EHMMU06)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

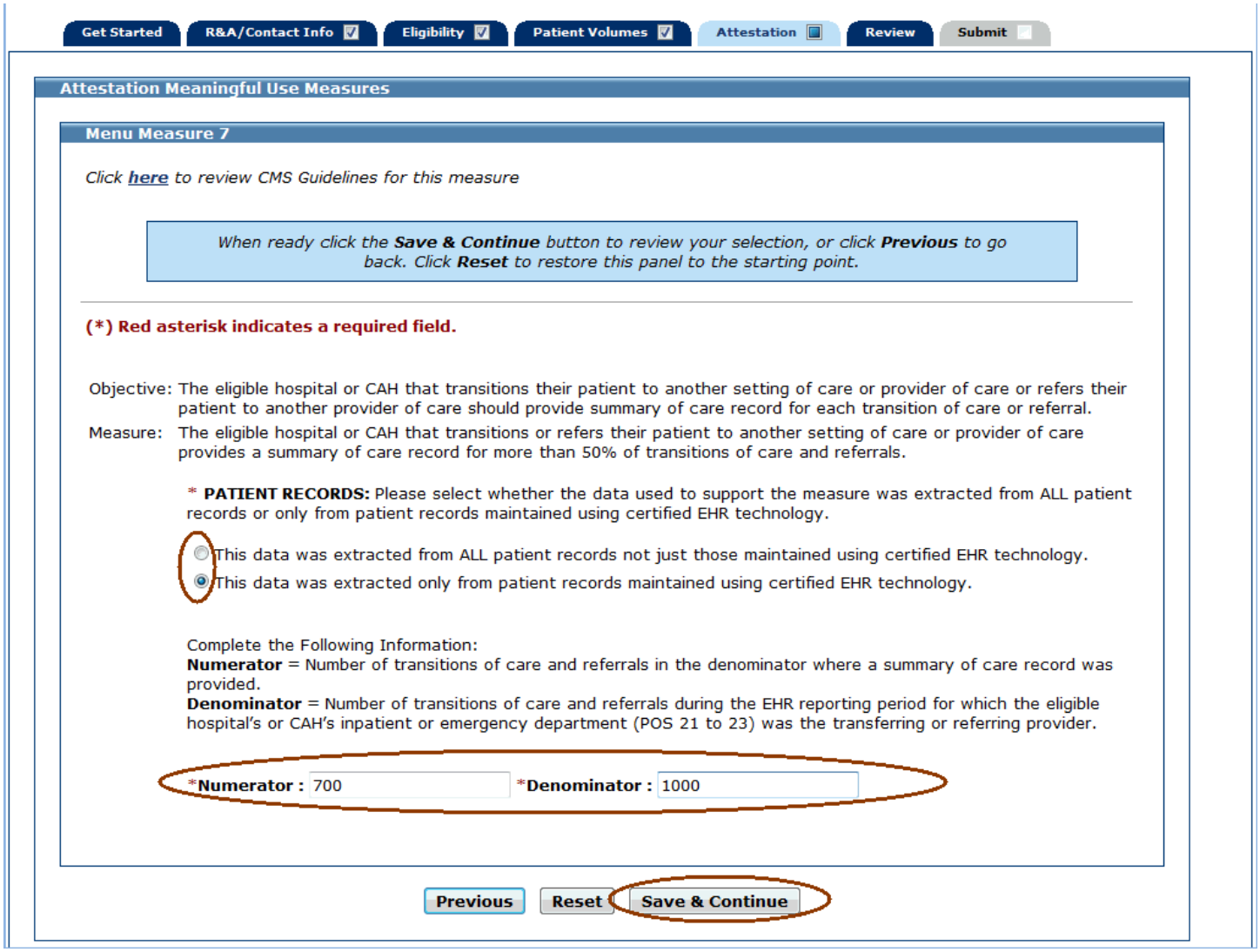


Menu Measure 7 (Measure Code EHMMU07)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



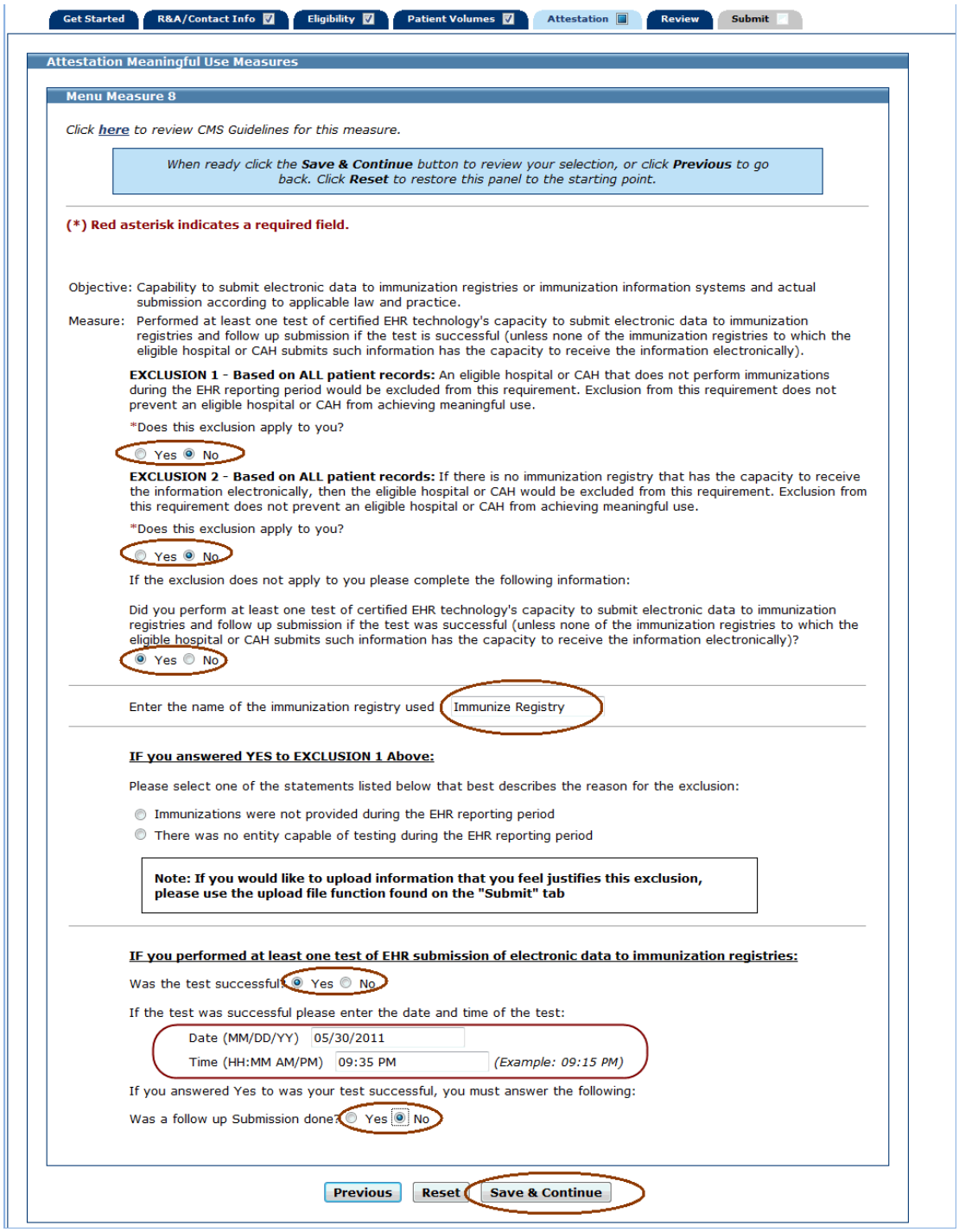
Menu Measure 8 (Measure Code EHMMU08)

Enter information in all required fields.

If Exclusion 1 and/or Exclusion 2 apply to you, refer to the screen on the following page.

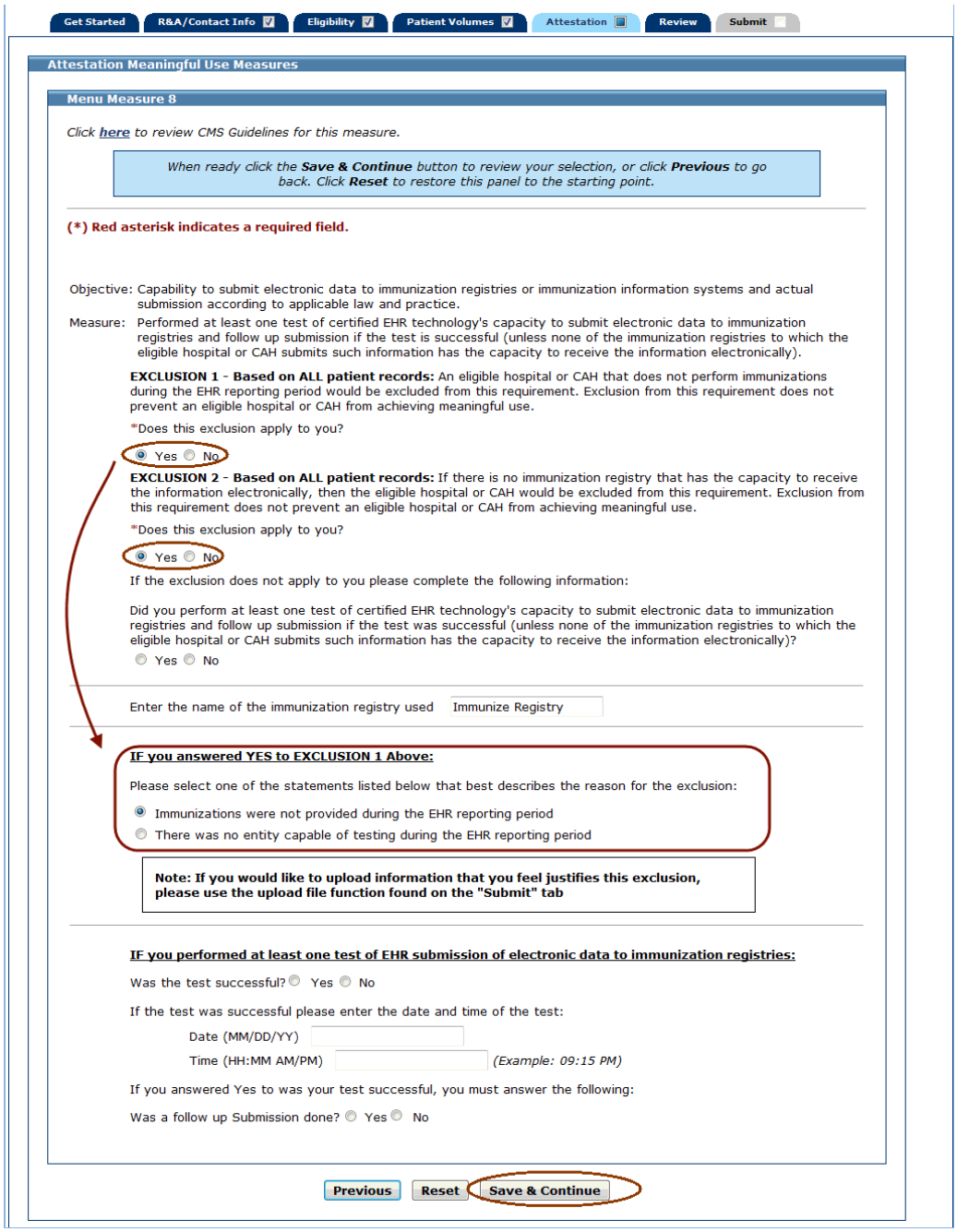
If Exclusion 1 and 2 do not apply to you, select **No** to the exclusions and do not answer the reason for exclusion question. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



If Exclusion 1 and/or Exclusion 2 apply to you select **Yes**. If you selected yes to Exclusion 1, select one of the statements listed that best describes the reason for the exclusion.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

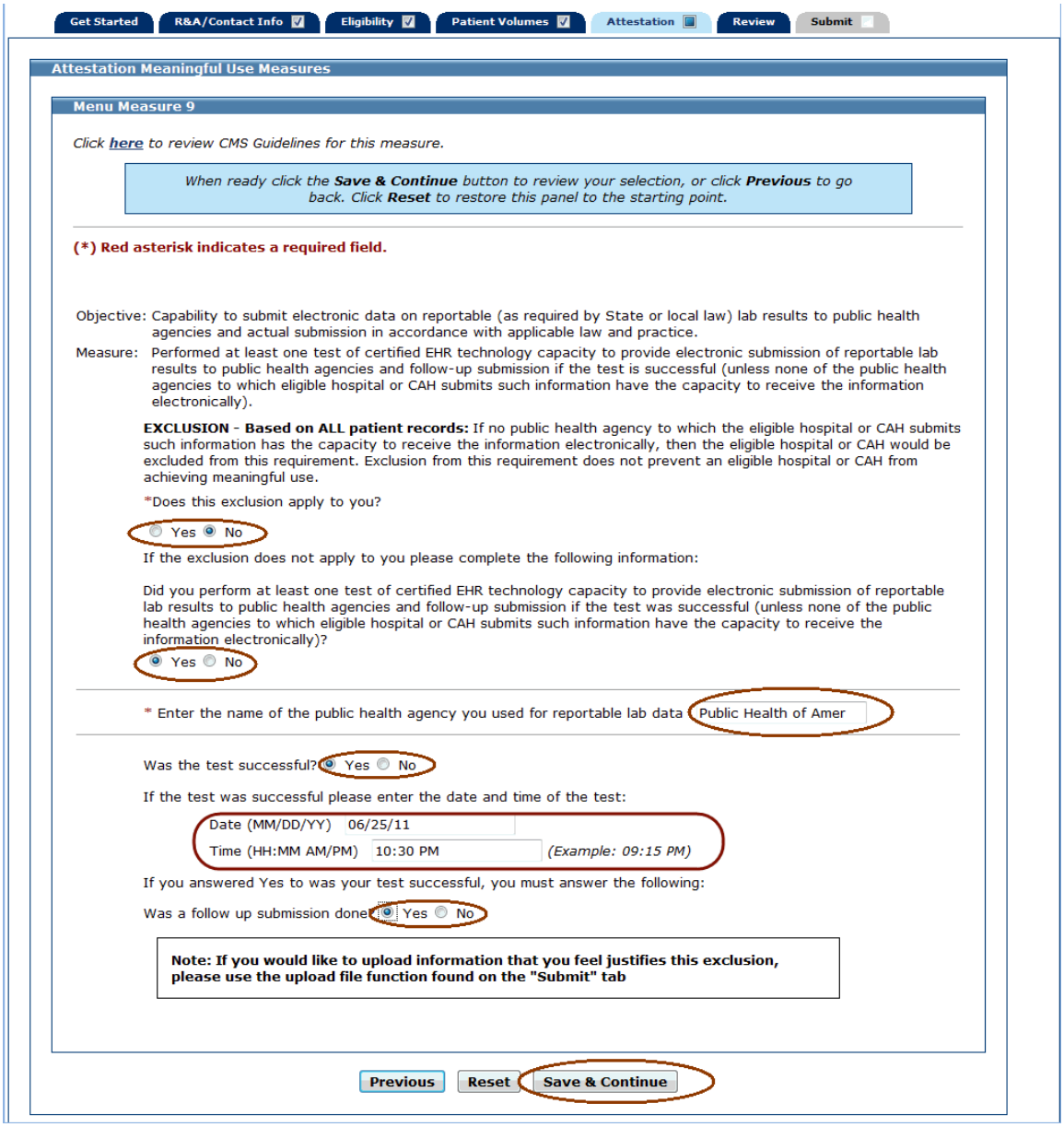


Menu Measure 9 (Measure Code EHMMU09)

Enter information in all required fields.

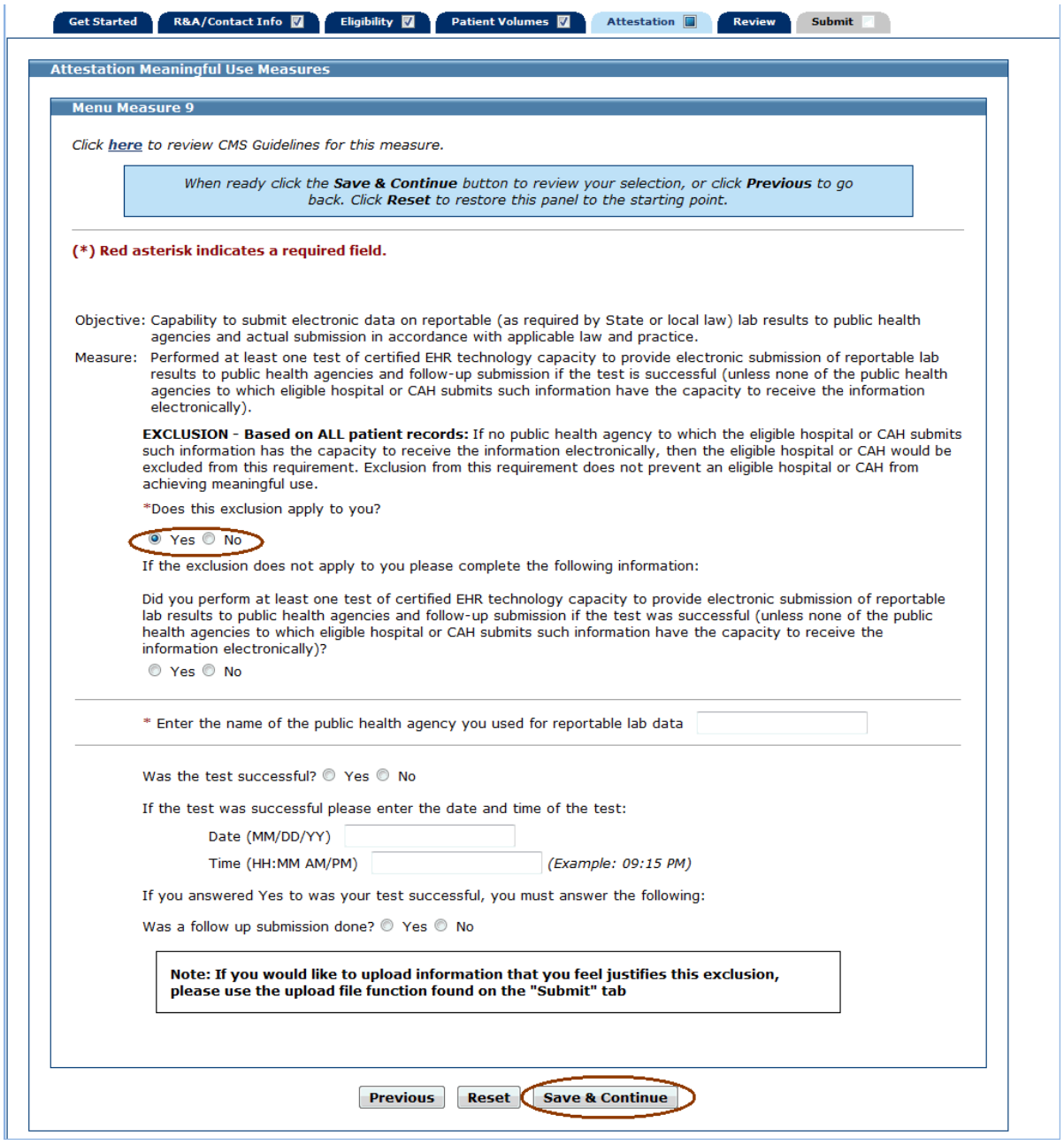
If the exclusion applies to you, refer to the screen on the following page. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



If the exclusion applies to you, select **Yes** to the exclusion.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

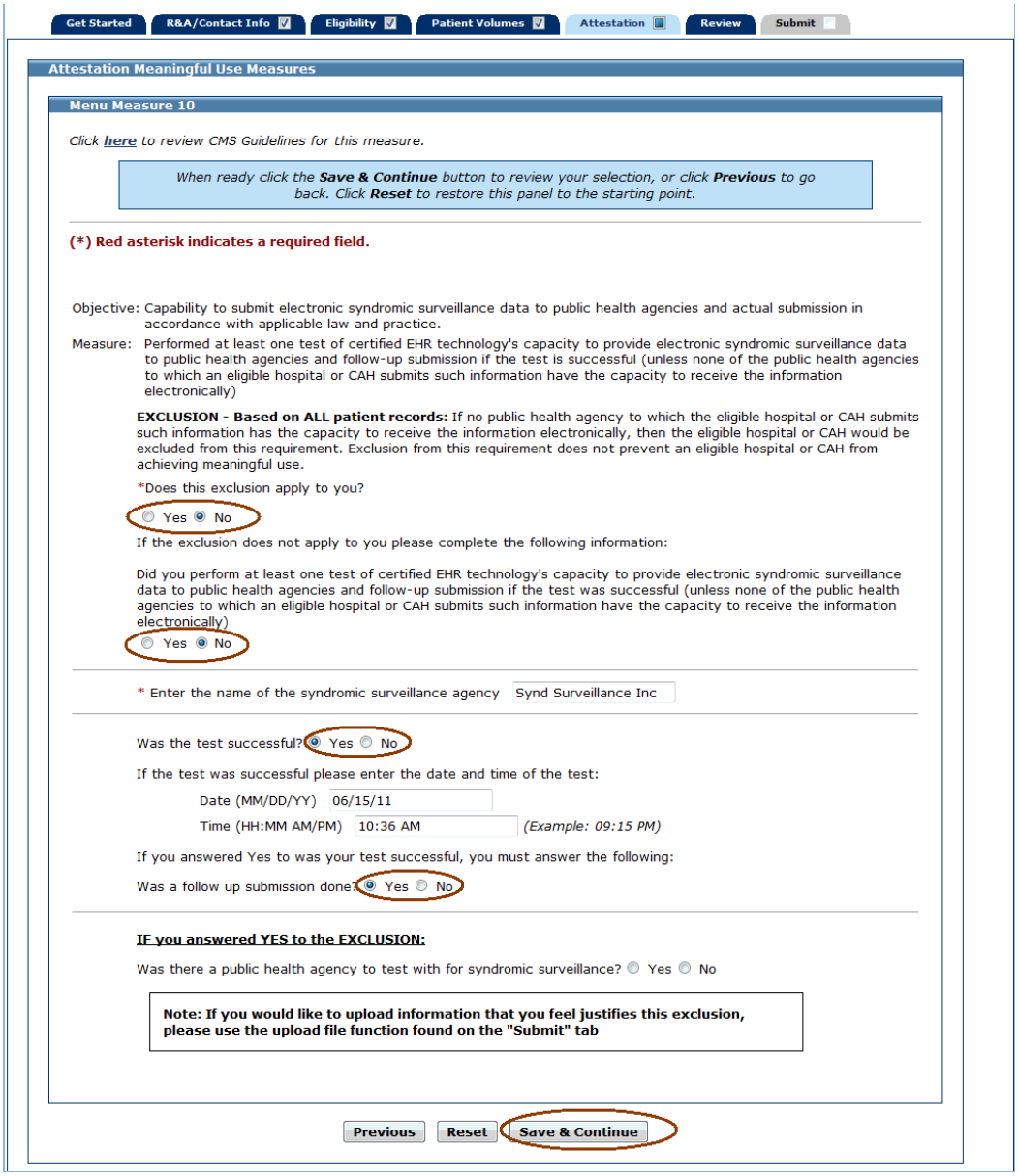

Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Menu Measure 9
Click here to review CMS Guidelines for this measure.
When ready click the Save & Continue button to review your selection, or click Previous to go back. Click Reset to restore this panel to the starting point.
(*) Red asterisk indicates a required field.
Objective: Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.
Measure: Performed at least one test of certified EHR technology capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically).
EXCLUSION - Based on ALL patient records: If no public health agency to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically, then the eligible hospital or CAH would be excluded from this requirement. Exclusion from this requirement does not prevent an eligible hospital or CAH from achieving meaningful use.
*Does this exclusion apply to you?
Yes No
If the exclusion does not apply to you please complete the following information:
Did you perform at least one test of certified EHR technology capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test was successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically)?
Yes No
* Enter the name of the public health agency you used for reportable lab data
Was the test successful? Yes No
If the test was successful please enter the date and time of the test:
Date (MM/DD/YY)
Time (HH:MM AM/PM) (Example: 09:15 PM)
If you answered Yes to was your test successful, you must answer the following:
Was a follow up submission done? Yes No
Note: If you would like to upload information that you feel justifies this exclusion, please use the upload file function found on the "Submit" tab
Previous
Reset
Save & Continue

Menu Measure 10 (Measure Code EHMMU10)

Enter information in all required fields.

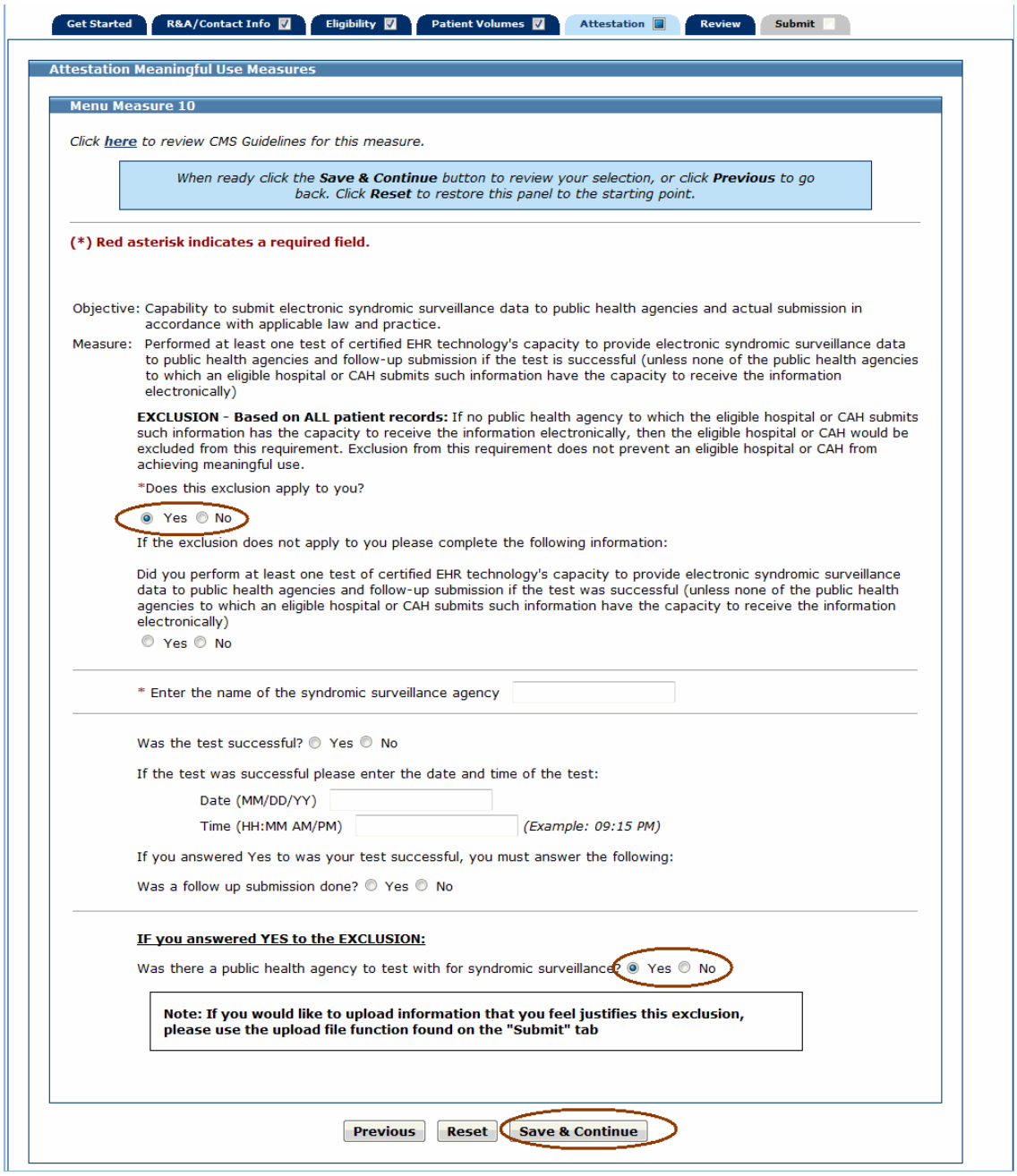
If the exclusion applies to you, refer to the screen on the following page. If the exclusion does not apply to you, select **No** to the exclusion and do not answer the exclusion question. In the example below, the exclusion does not apply.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

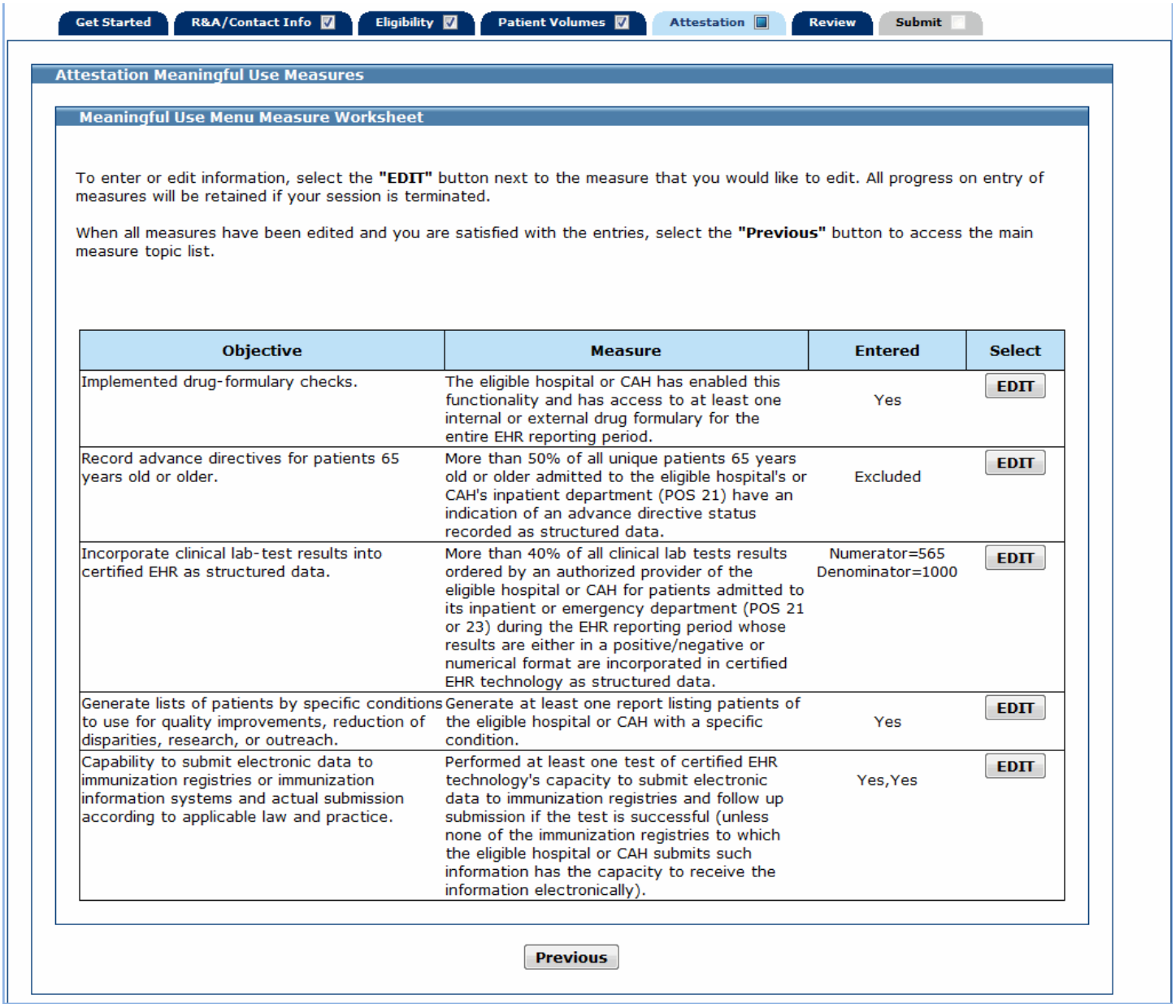


If the exclusion applies to you, select **Yes** to the exclusion and answer the exclusion question.

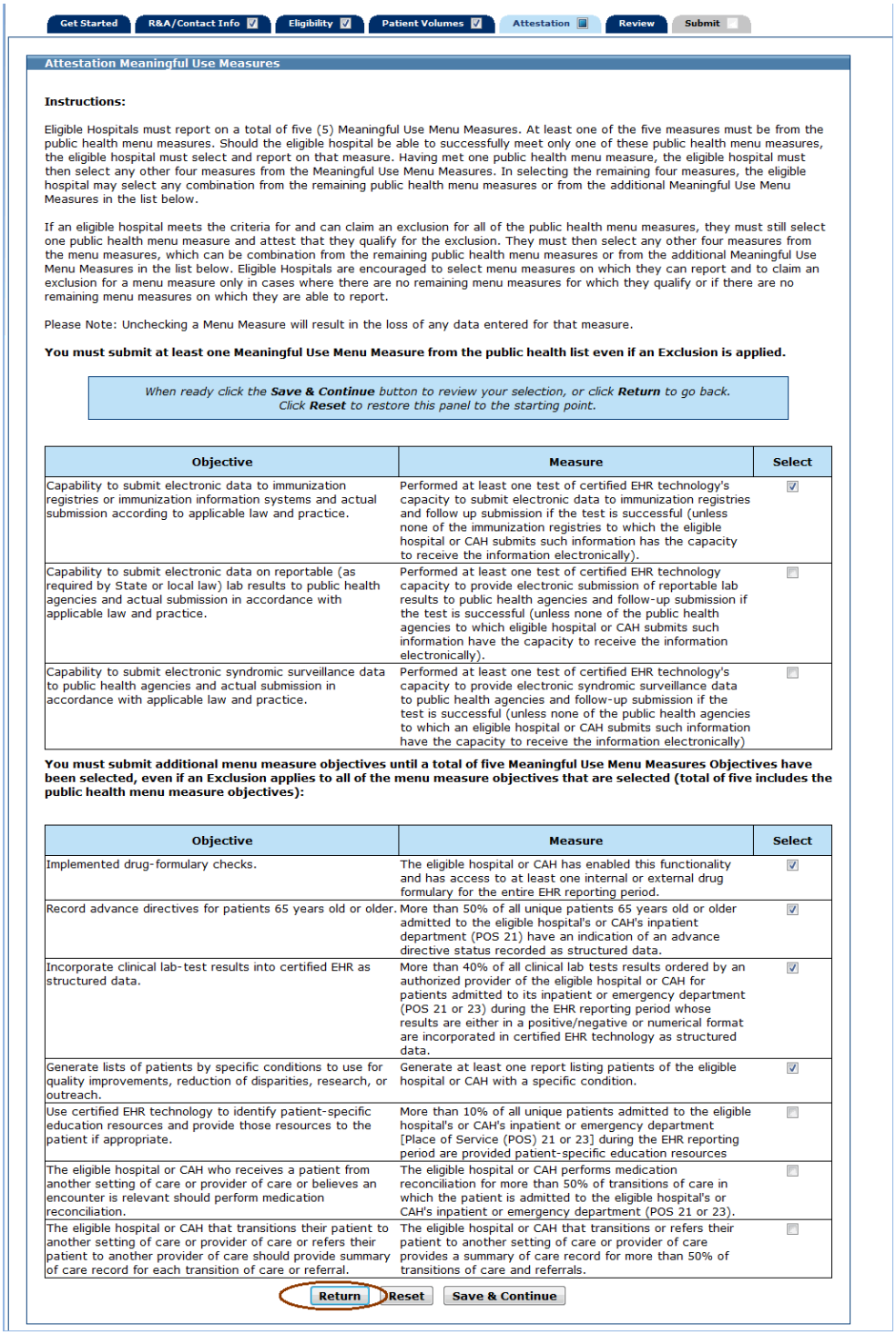
Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



Once you attested to all the measures for this topic, click **Previous** to return to the Attestation Meaningful Use Measures screen.



Click **Return** to return to the Measure Topic List.



Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Attestation Meaningful Use Measures

Instructions:

Eligible Hospitals must report on a total of five (5) Meaningful Use Menu Measures. At least one of the five measures must be from the public health menu measures. Should the eligible hospital be able to successfully meet only one of these public health menu measures, the eligible hospital must select and report on that measure. Having met one public health menu measure, the eligible hospital must then select any other four measures from the Meaningful Use Menu Measures. In selecting the remaining four measures, the eligible hospital may select any combination from the remaining public health menu measures or from the additional Meaningful Use Menu Measures in the list below.

If an eligible hospital meets the criteria for and can claim an exclusion for all of the public health menu measures, they must still select one public health menu measure and attest that they qualify for the exclusion. They must then select any other four measures from the menu measures, which can be combination from the remaining public health menu measures or from the additional Meaningful Use Menu Measures in the list below. Eligible Hospitals are encouraged to select menu measures on which they can report and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they qualify or if there are no remaining menu measures on which they are able to report.

Please Note: Unchecking a Menu Measure will result in the loss of any data entered for that measure.

You must submit at least one Meaningful Use Menu Measure from the public health list even if an Exclusion is applied.

*When ready click the **Save & Continue** button to review your selection, or click **Return** to go back.*
*Click **Reset** to restore this panel to the starting point.*

Objective	Measure	Select
Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).	☑
Capability to submit electronic data on reportable (as required by State or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically).	☐
Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an eligible hospital or CAH submits such information have the capacity to receive the information electronically)	☐

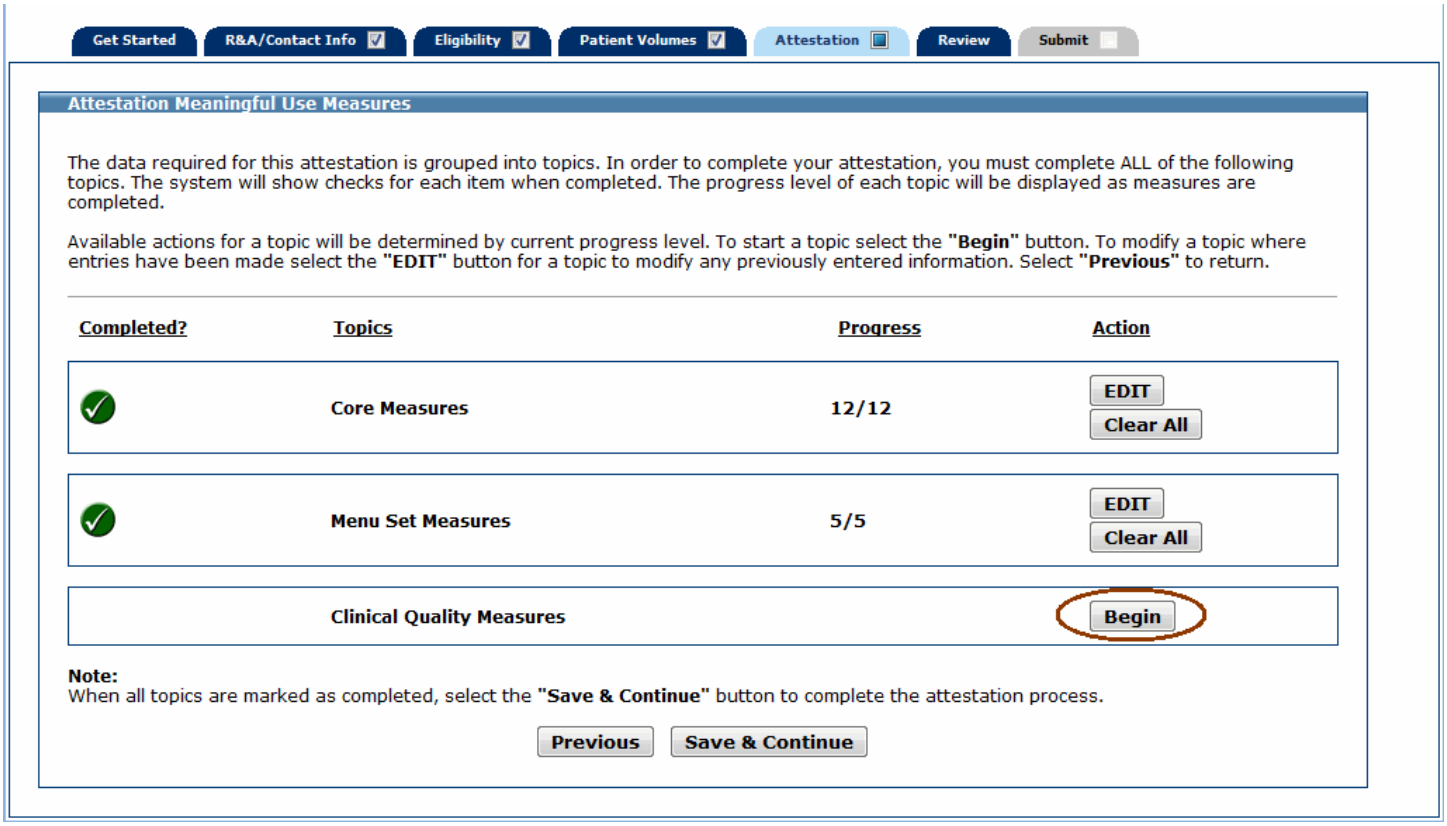
You must submit additional menu measure objectives until a total of five Meaningful Use Menu Measures Objectives have been selected, even if an Exclusion applies to all of the menu measure objectives that are selected (total of five includes the public health menu measure objectives):

Objective	Measure	Select
Implemented drug-formulary checks.	The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	☑
Record advance directives for patients 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded as structured data.	☑
Incorporate clinical lab-test results into certified EHR as structured data.	More than 40% of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	☑
Generate lists of patients by specific conditions to use for quality improvements, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.	☑
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	More than 10% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department [Place of Service (POS) 21 or 23] during the EHR reporting period are provided patient-specific education resources	☐
The eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	☐
The eligible hospital or CAH that transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral.	The eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals.	☐

Return | Reset | Save & Continue

If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure after it has been marked complete.

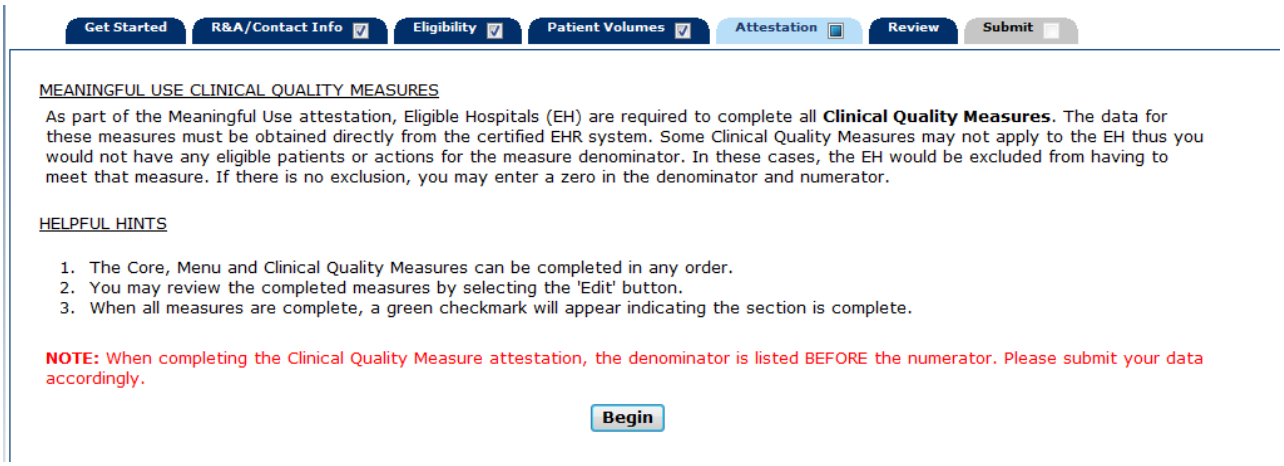
Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.


Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics. The system will show checks for each item when completed. The progress level of each topic will be displayed as measures are completed.
Available actions for a topic will be determined by current progress level. To start a topic select the "Begin" button. To modify a topic where entries have been made select the "EDIT" button for a topic to modify any previously entered information. Select "Previous" to return.
Completed?
Topics
Progress
Action
Core Measures
12/12
EDIT
Clear All
Menu Set Measures
5/5
EDIT
Clear All
Clinical Quality Measures
Begin
Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.
Previous
Save & Continue

Meaningful Use Clinical Quality Measures

This initial screen provides information about the Clinical Quality Measures.

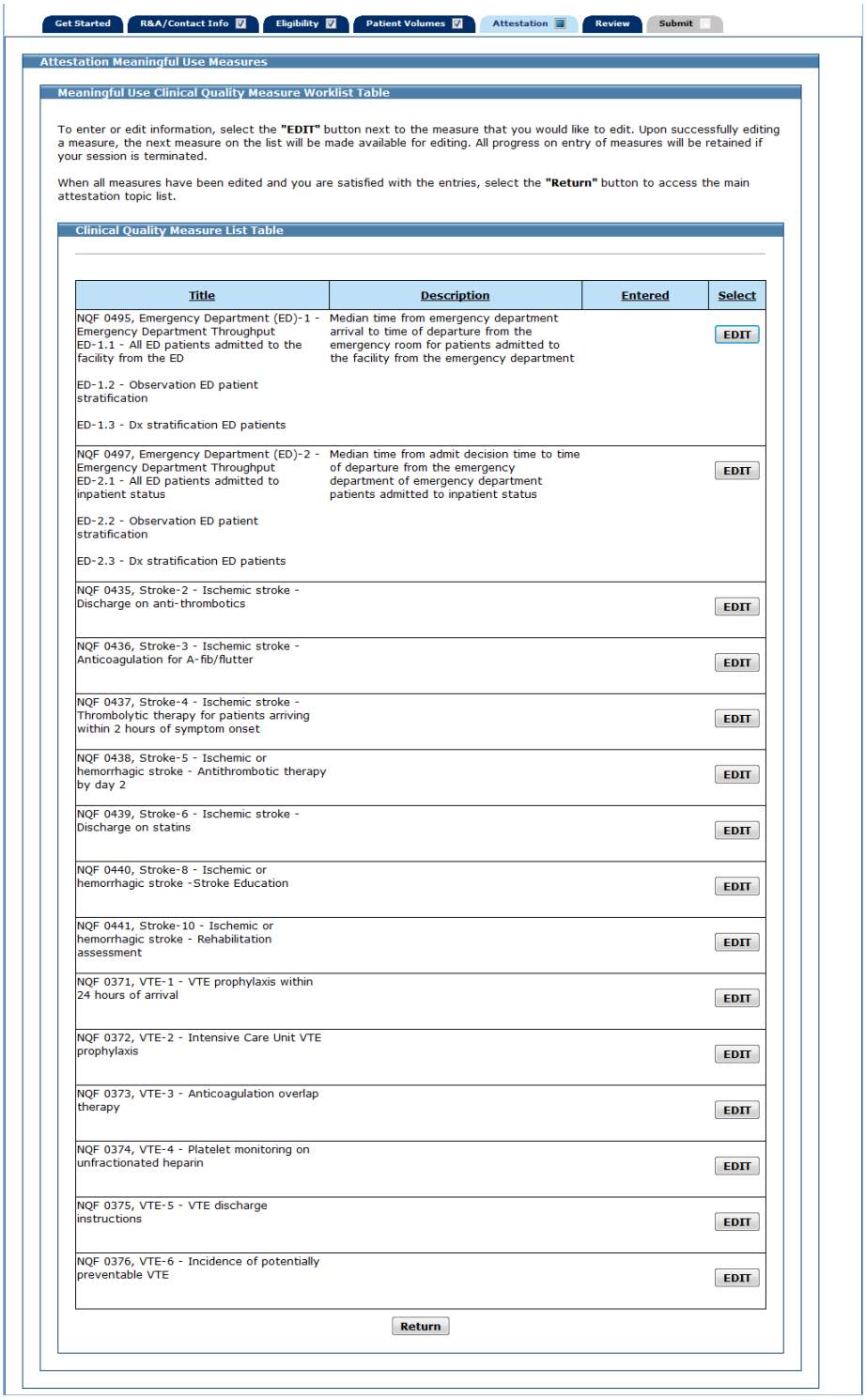
Click **Begin** to continue to the Meaningful Use Clinical Quality Measure Worklist Table.



The screen on the following page displays the Meaningful Use Clinical Quality Measure Worklist Table. You must complete all measures.

Once information is successfully entered and saved for a measure it will be displayed in the **Entered** column on this screen.

Click **Edit** to enter or edit information for the measure or click **Return** to return to the Measures Topic List.

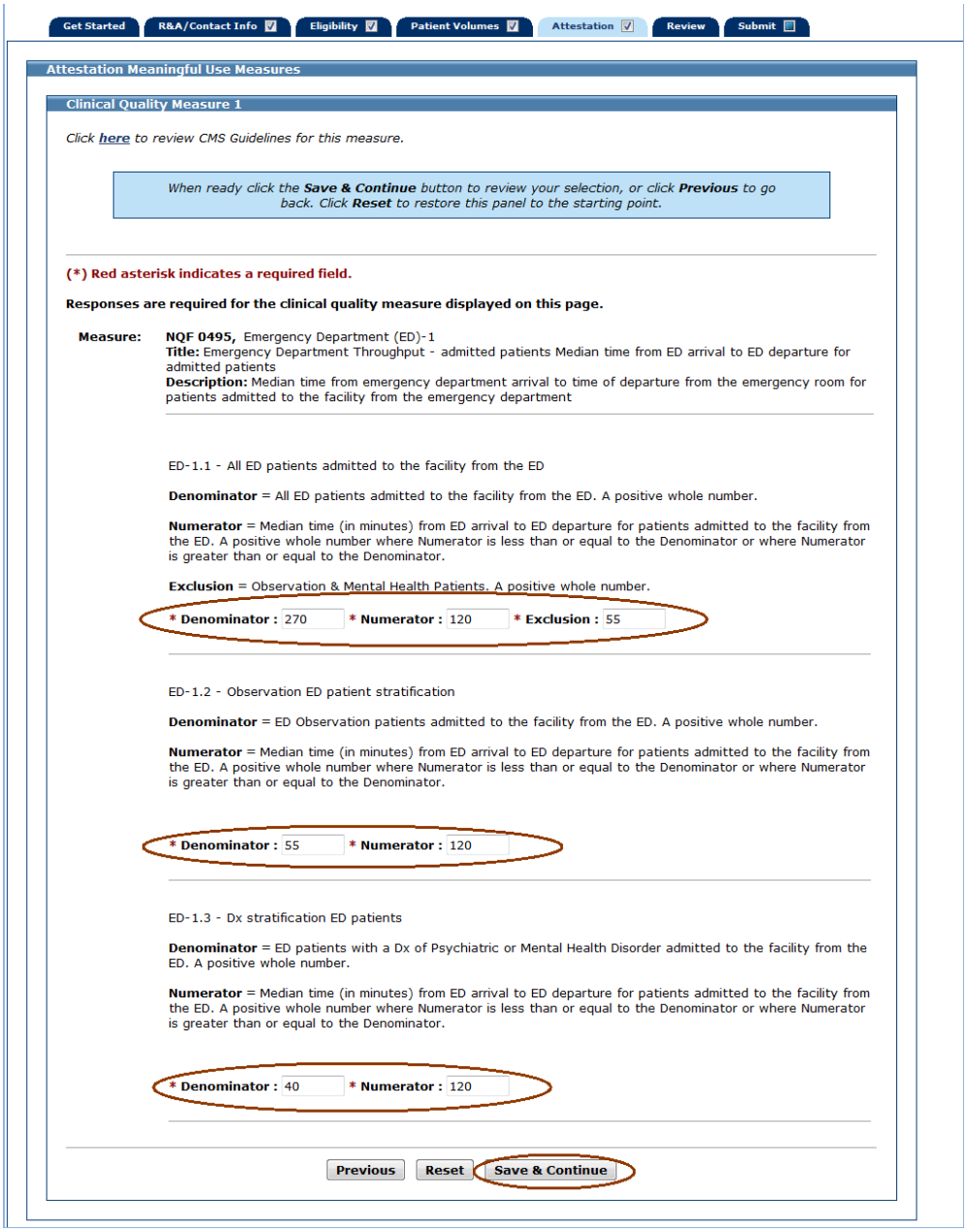


Clinical Quality Measure 1 (Measure Code NQF 0495)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

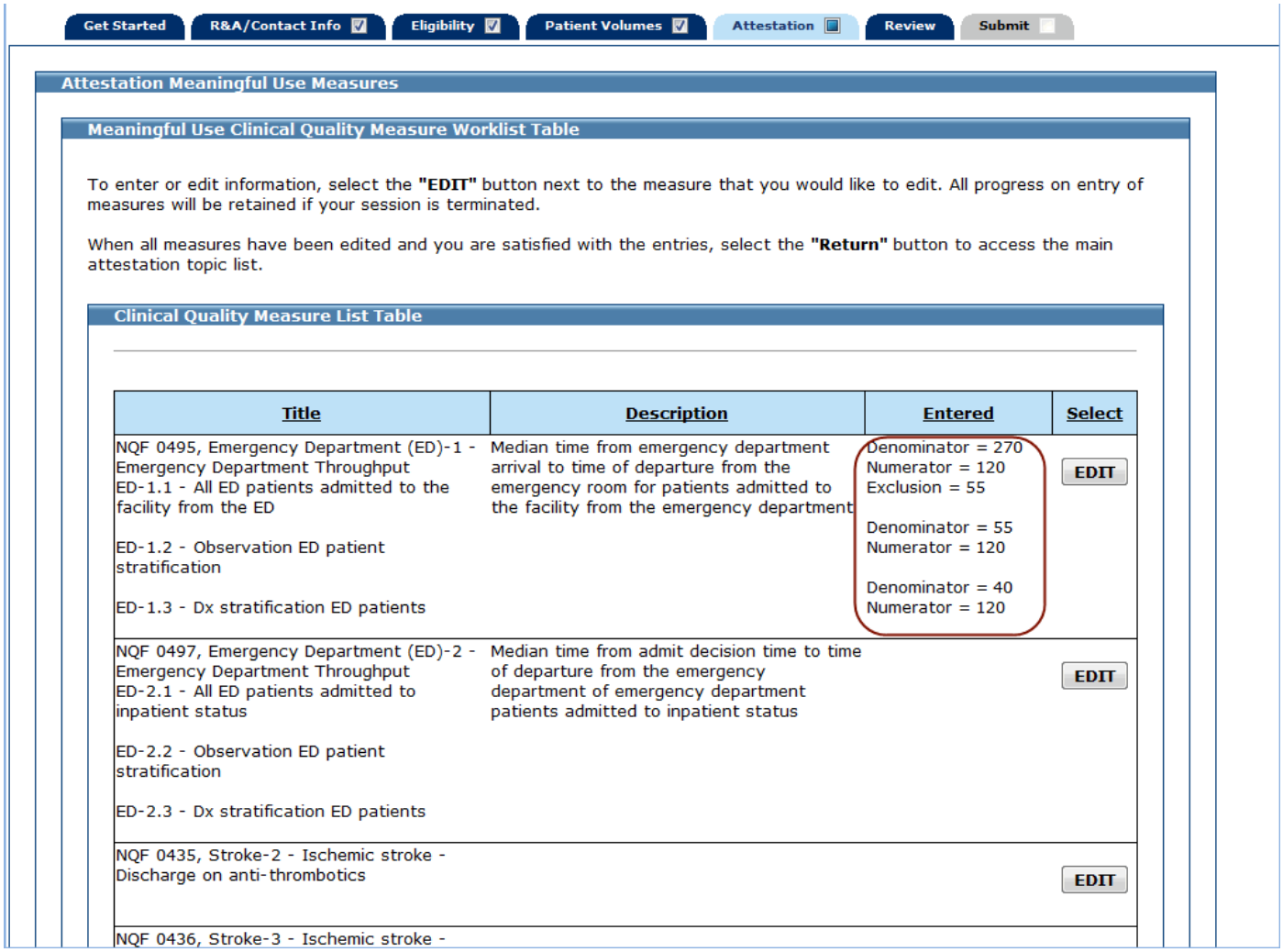
Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



After you enter information for a measure and click **Save & Continue**, you will be returned to the Clinical Quality Measure List Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below (please note that the entire screen is not displayed in this example).

You can continue to edit the measures at any point prior to submitting the application.

Click the **Edit** button for the next measure.

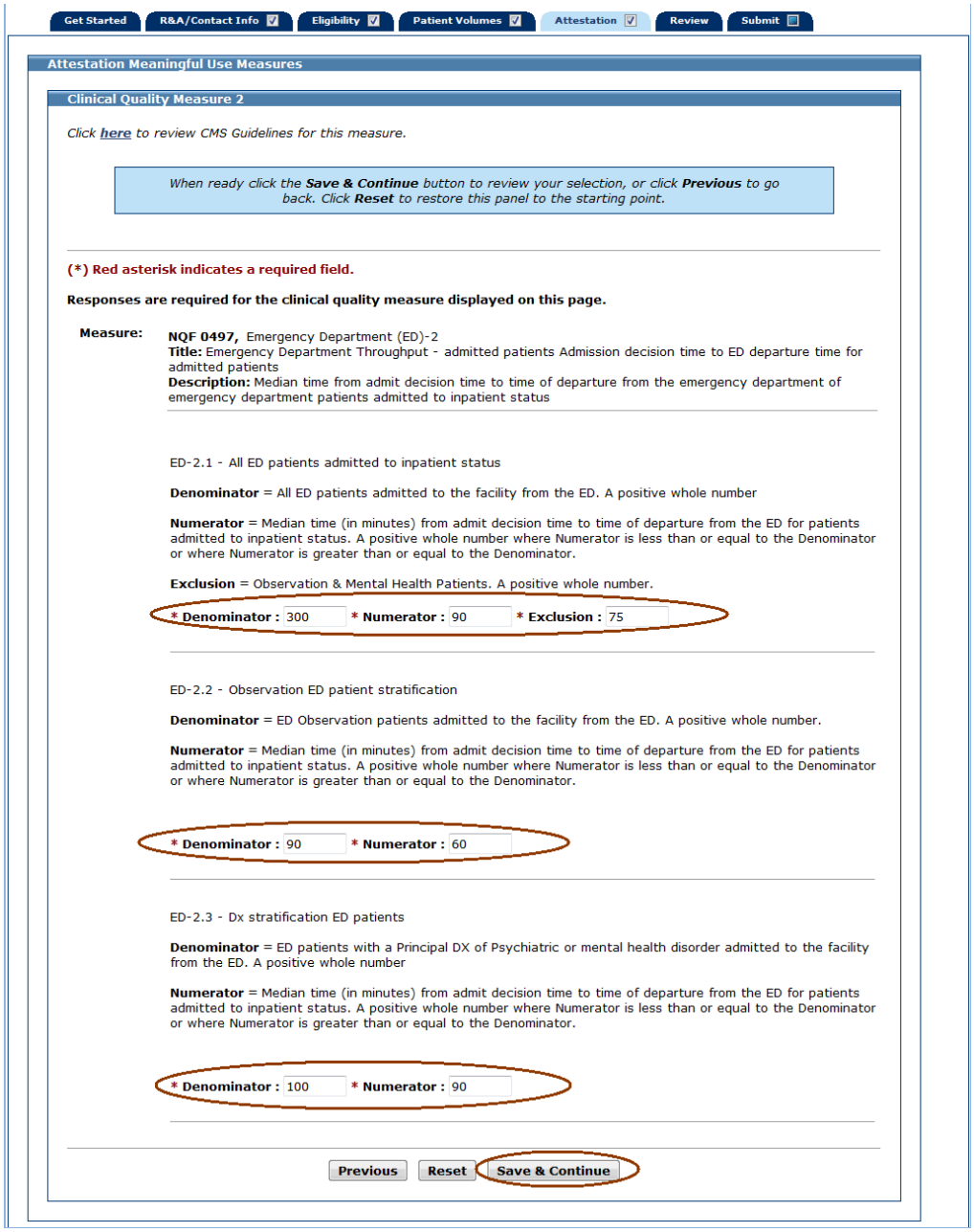

Get Started
R&A/Contact Info
Eligibility
Patient Volumes
Attestation
Review
Submit
Attestation Meaningful Use Measures
Meaningful Use Clinical Quality Measure Worklist Table
To enter or edit information, select the "EDIT" button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.
When all measures have been edited and you are satisfied with the entries, select the "Return" button to access the main attestation topic list.
Clinical Quality Measure List Table
Title
Description
Entered
Select
NQF 0495, Emergency Department (ED)-1 - Emergency Department Throughput
ED-1.1 - All ED patients admitted to the facility from the ED
ED-1.2 - Observation ED patient stratification
ED-1.3 - Dx stratification ED patients
Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department
Denominator = 270
Numerator = 120
Exclusion = 55
Denominator = 55
Numerator = 120
Denominator = 40
Numerator = 120
EDIT
NQF 0497, Emergency Department (ED)-2 - Emergency Department Throughput
ED-2.1 - All ED patients admitted to inpatient status
ED-2.2 - Observation ED patient stratification
ED-2.3 - Dx stratification ED patients
Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status
EDIT
NQF 0435, Stroke-2 - Ischemic stroke - Discharge on anti-thrombotics
EDIT
NQF 0436, Stroke-3 - Ischemic stroke -

Clinical Quality Measure 2 (Measure Code NQF 0497)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

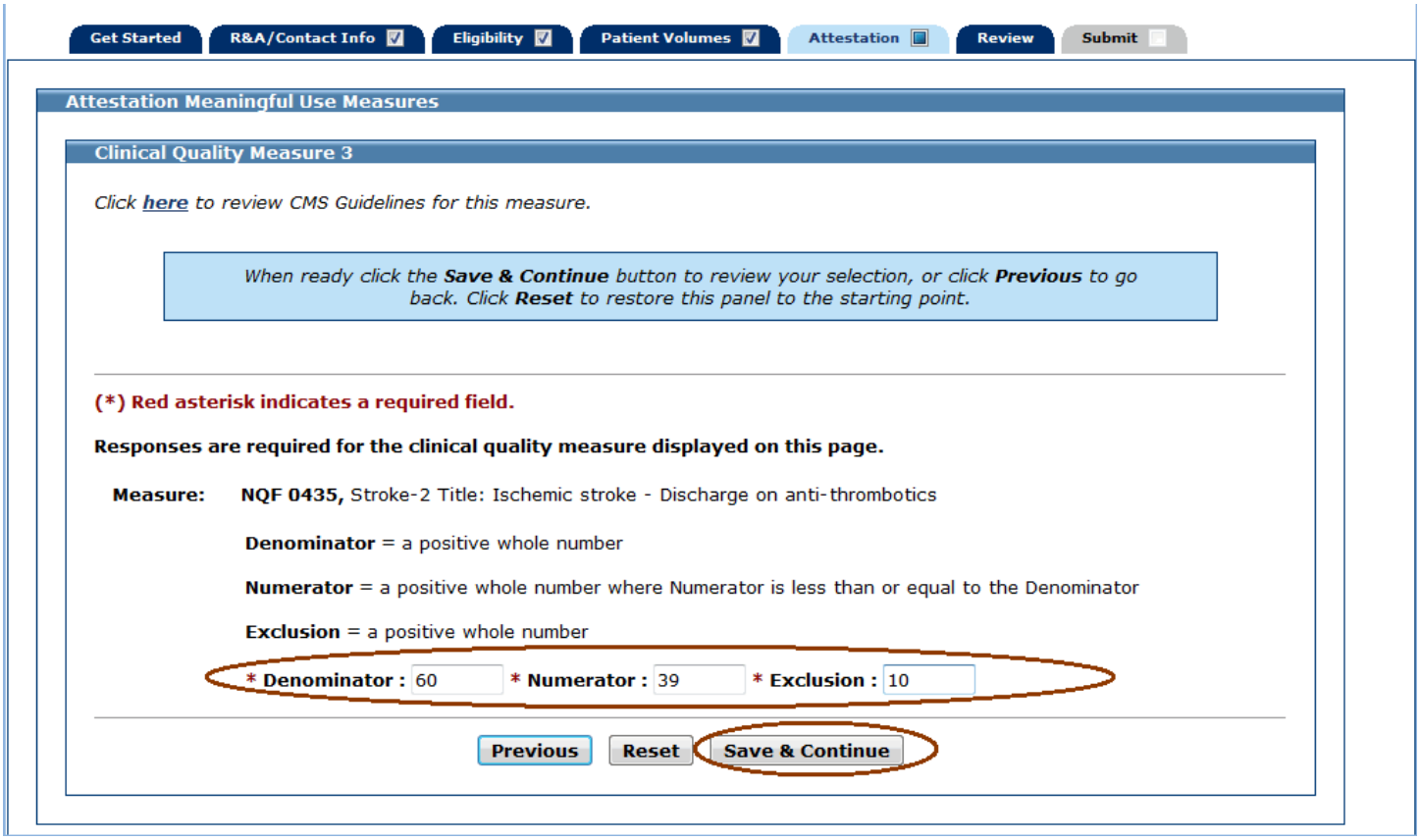


Clinical Quality Measure 3 (Measure Code NQF 0435)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

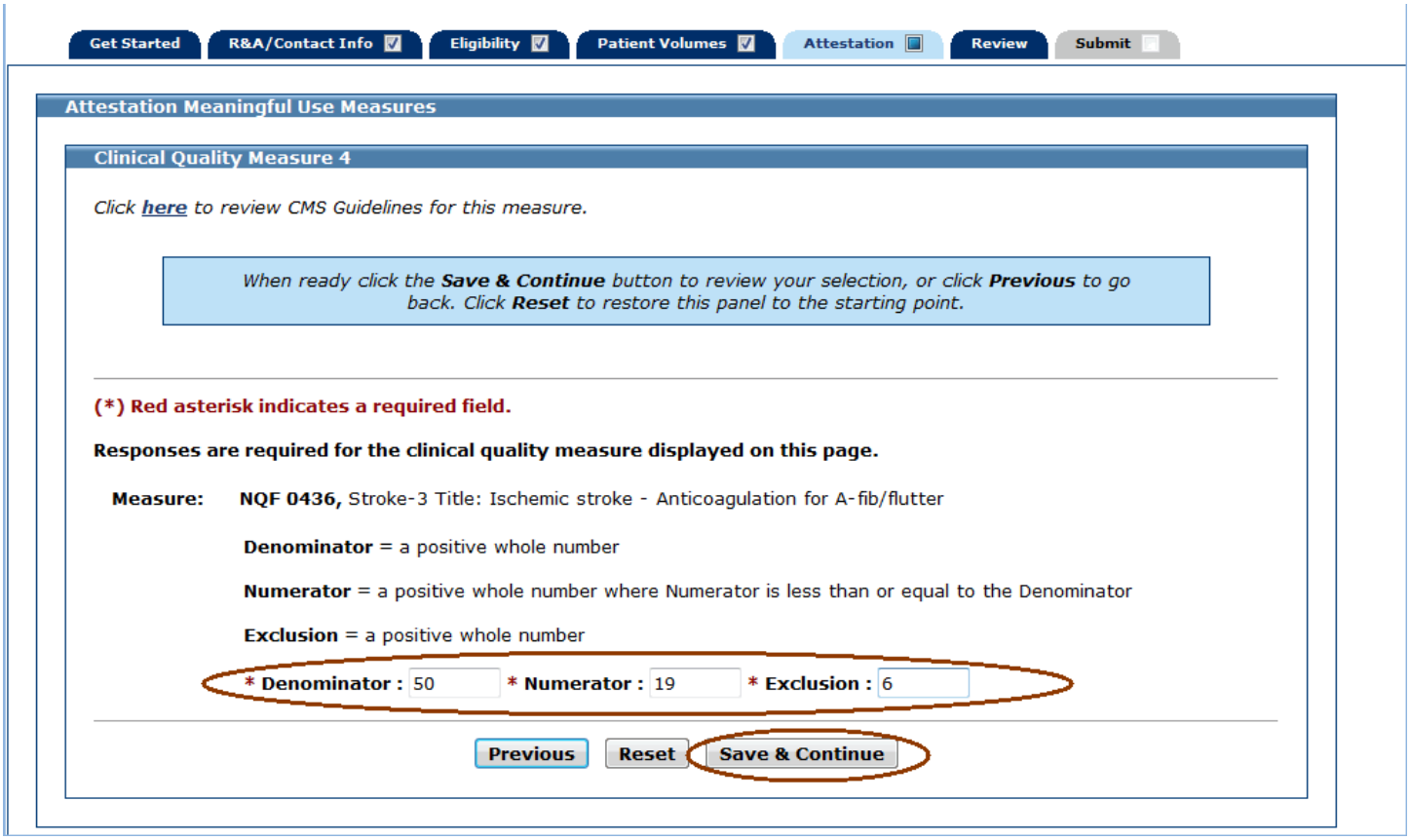


Clinical Quality Measure 4 (Measure Code NQF 0436)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

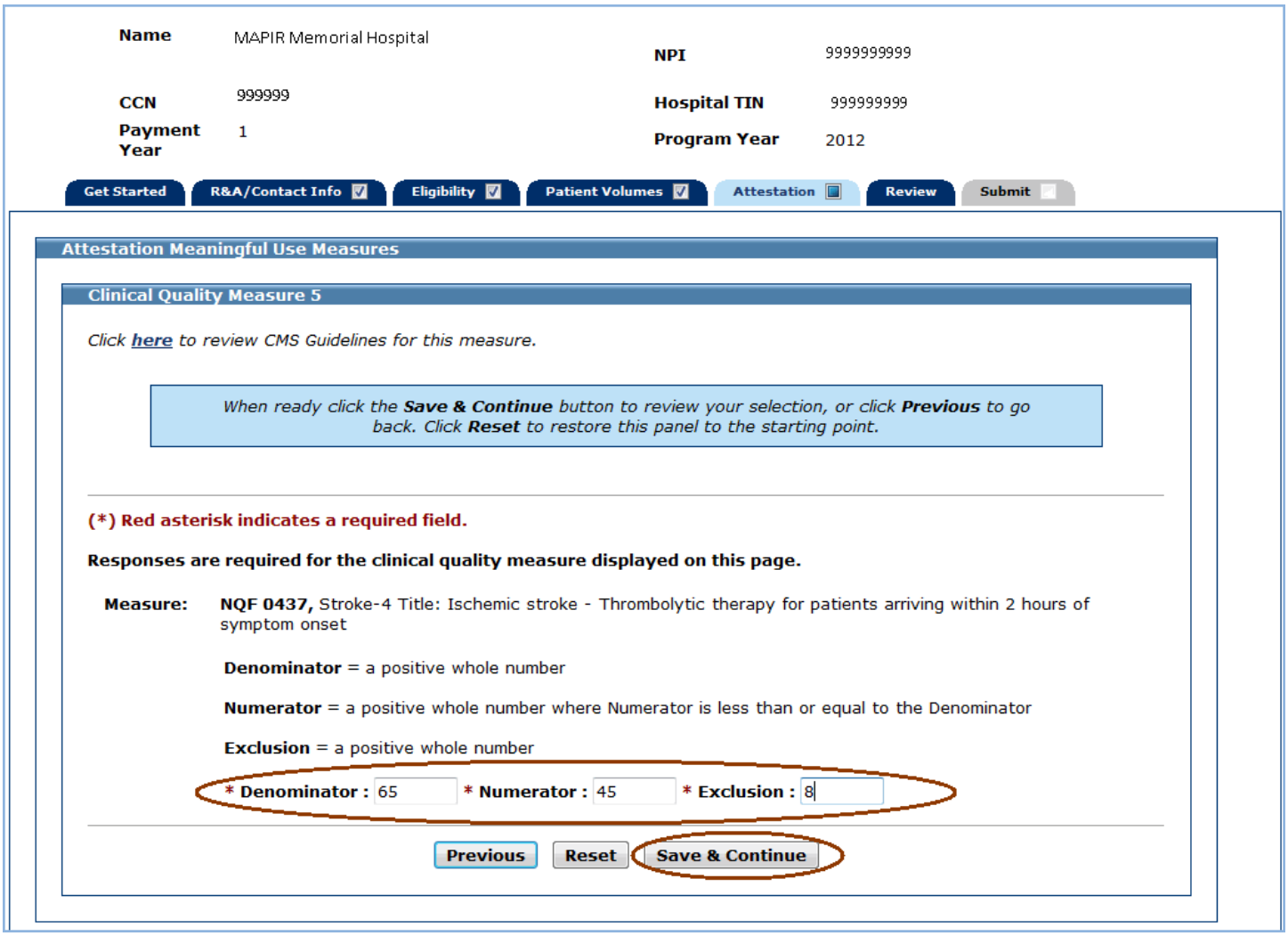


Clinical Quality Measure 5 (Measure Code NQF 0437)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

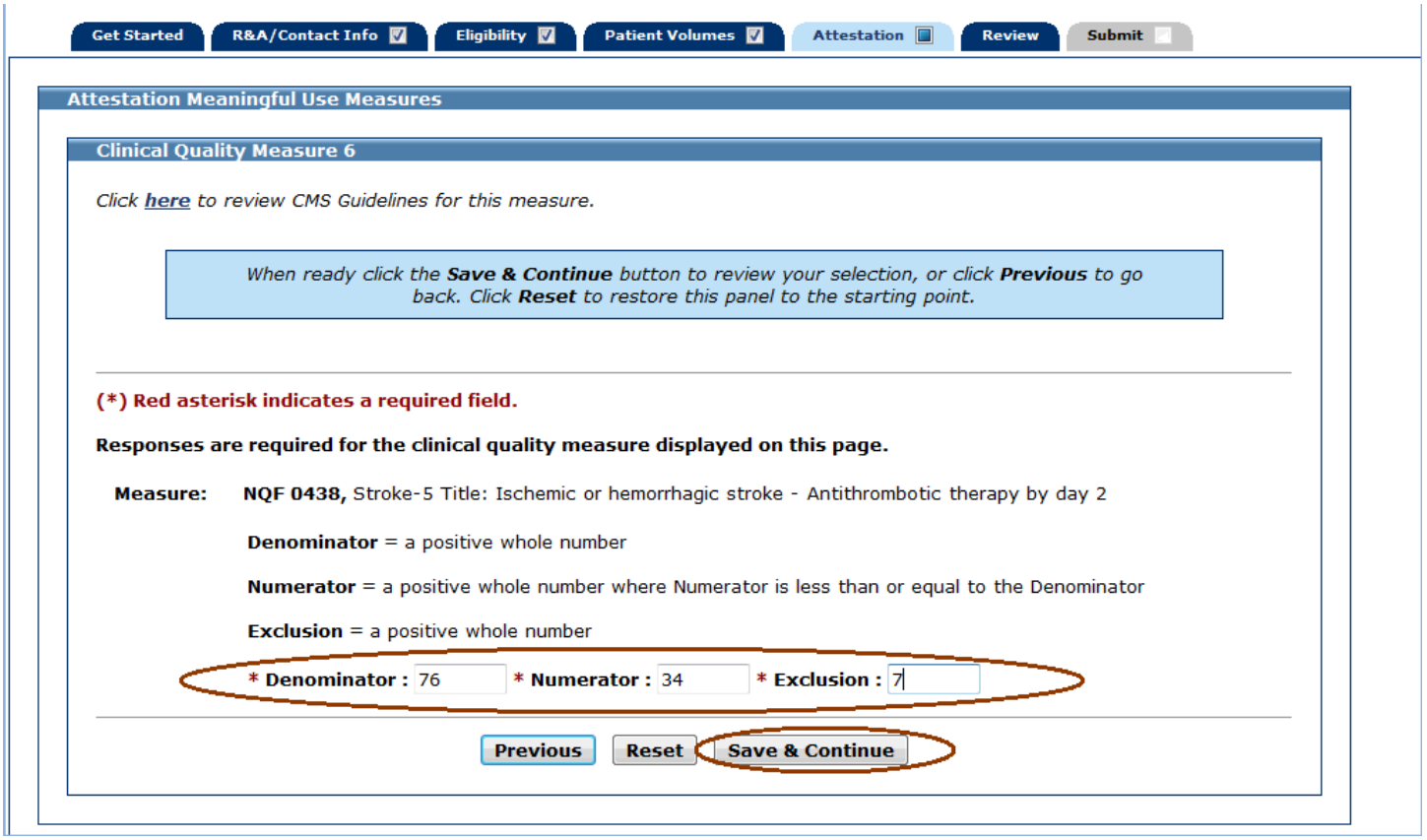


Clinical Quality Measure 6 (Measure Code NQF 0438)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

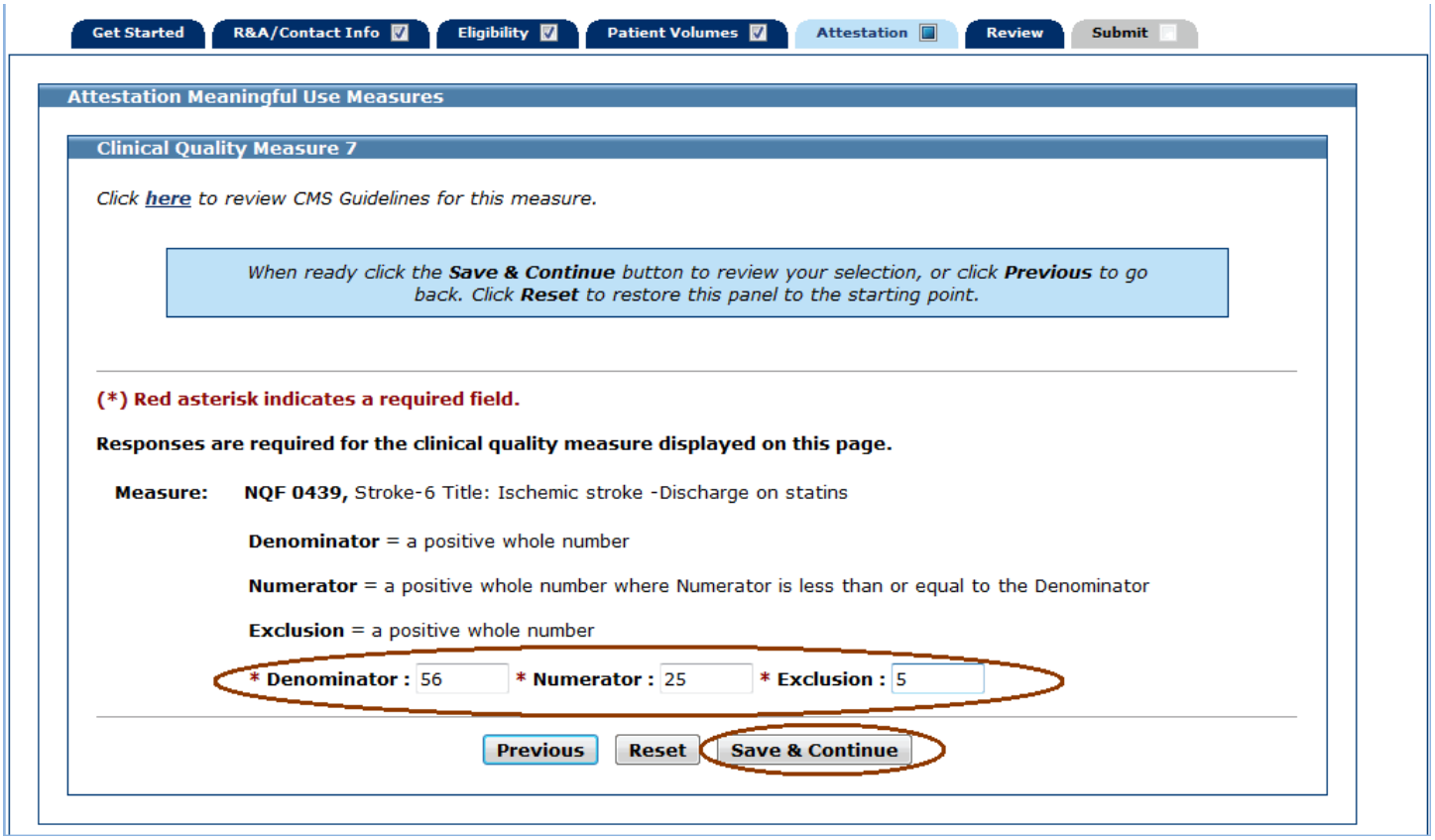


Clinical Quality Measure 7 (Measure Code NQF 0439)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

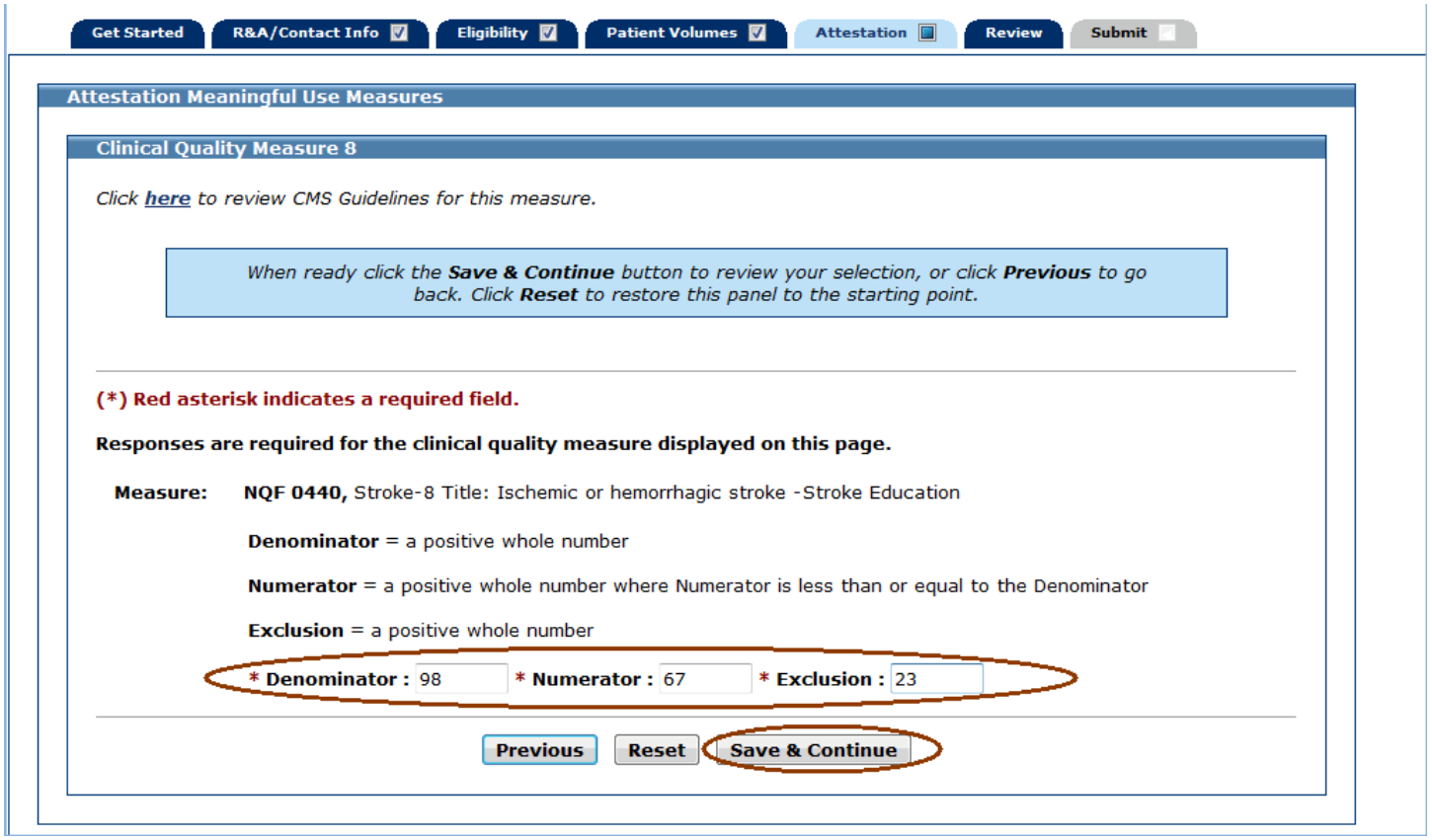


Clinical Quality Measure 8 (Measure Code NQF 0440)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

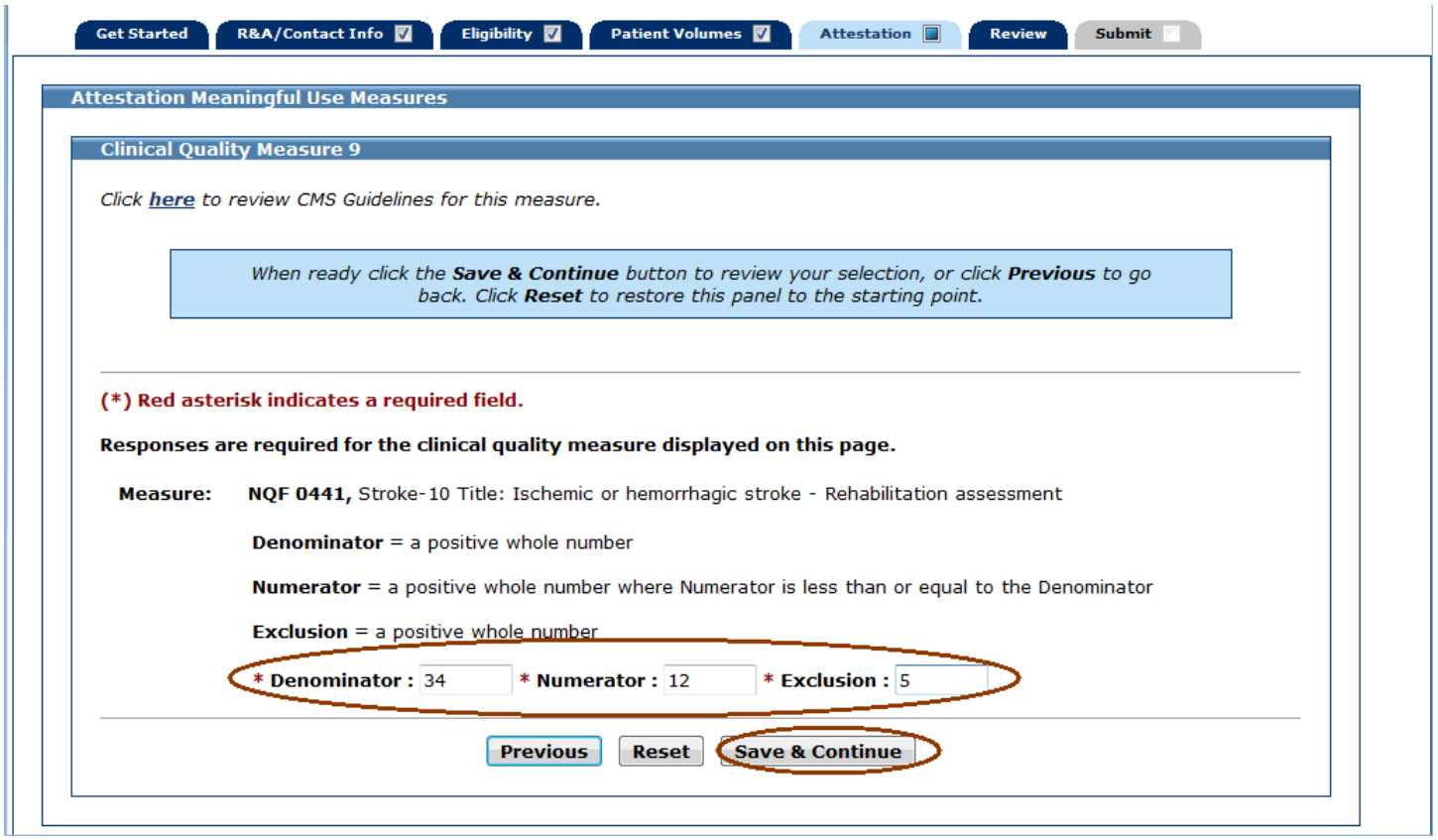


Clinical Quality Measure 9 (Measure Code NQF 0441)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

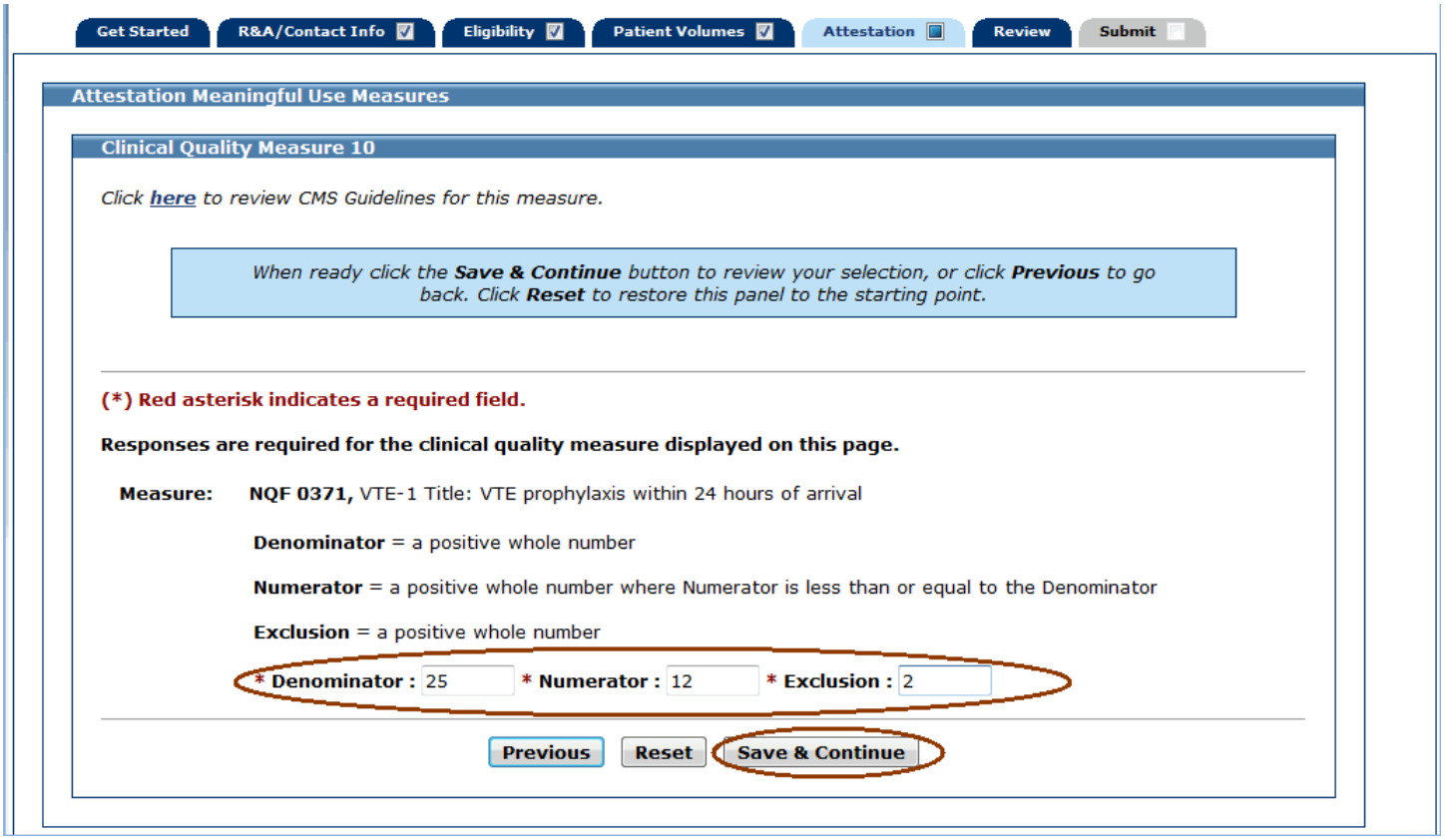


Clinical Quality Measure 10 (Measure Code NQF 0371)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

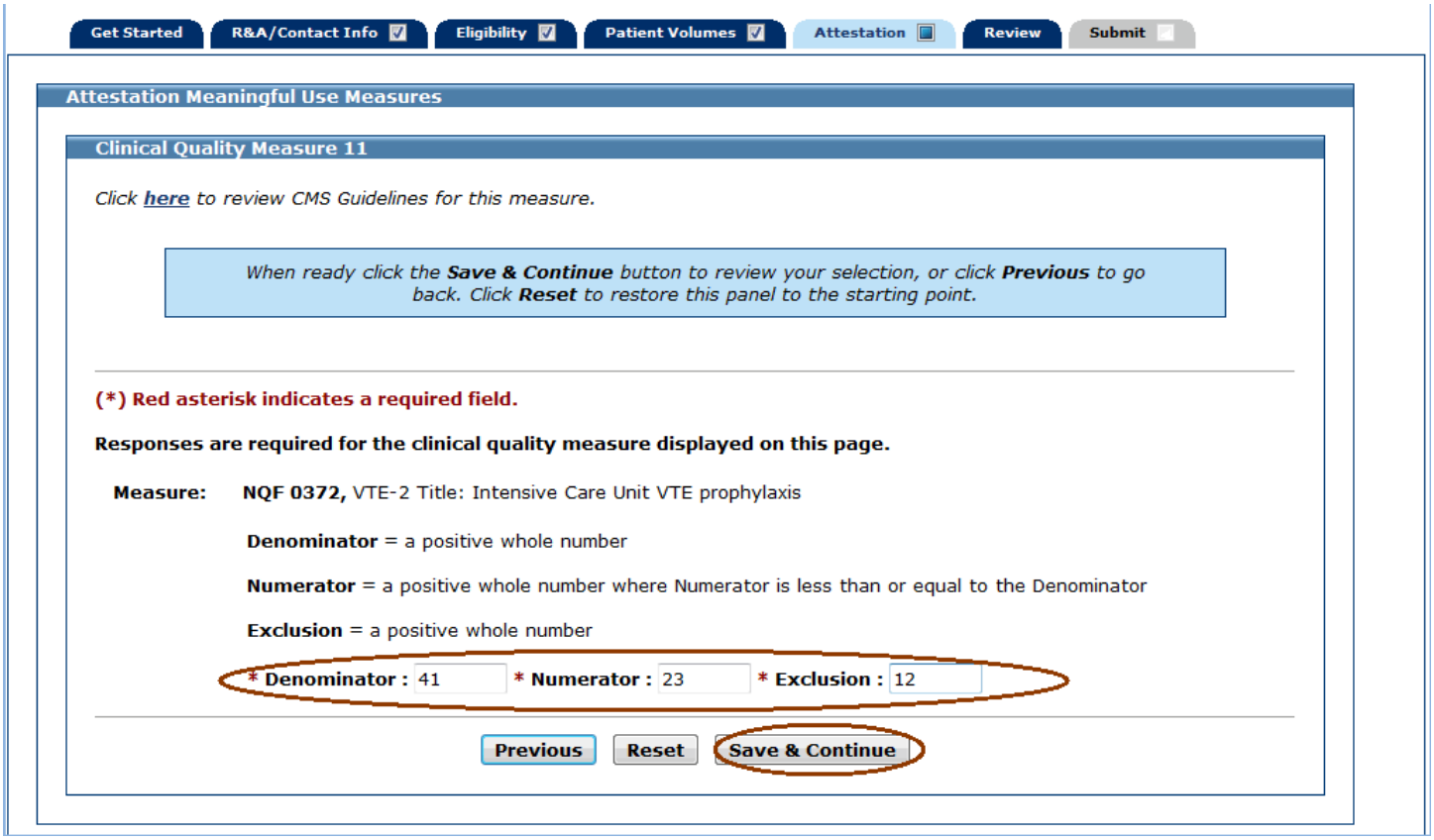


Clinical Quality Measure 11 (Measure Code NQF 0372)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

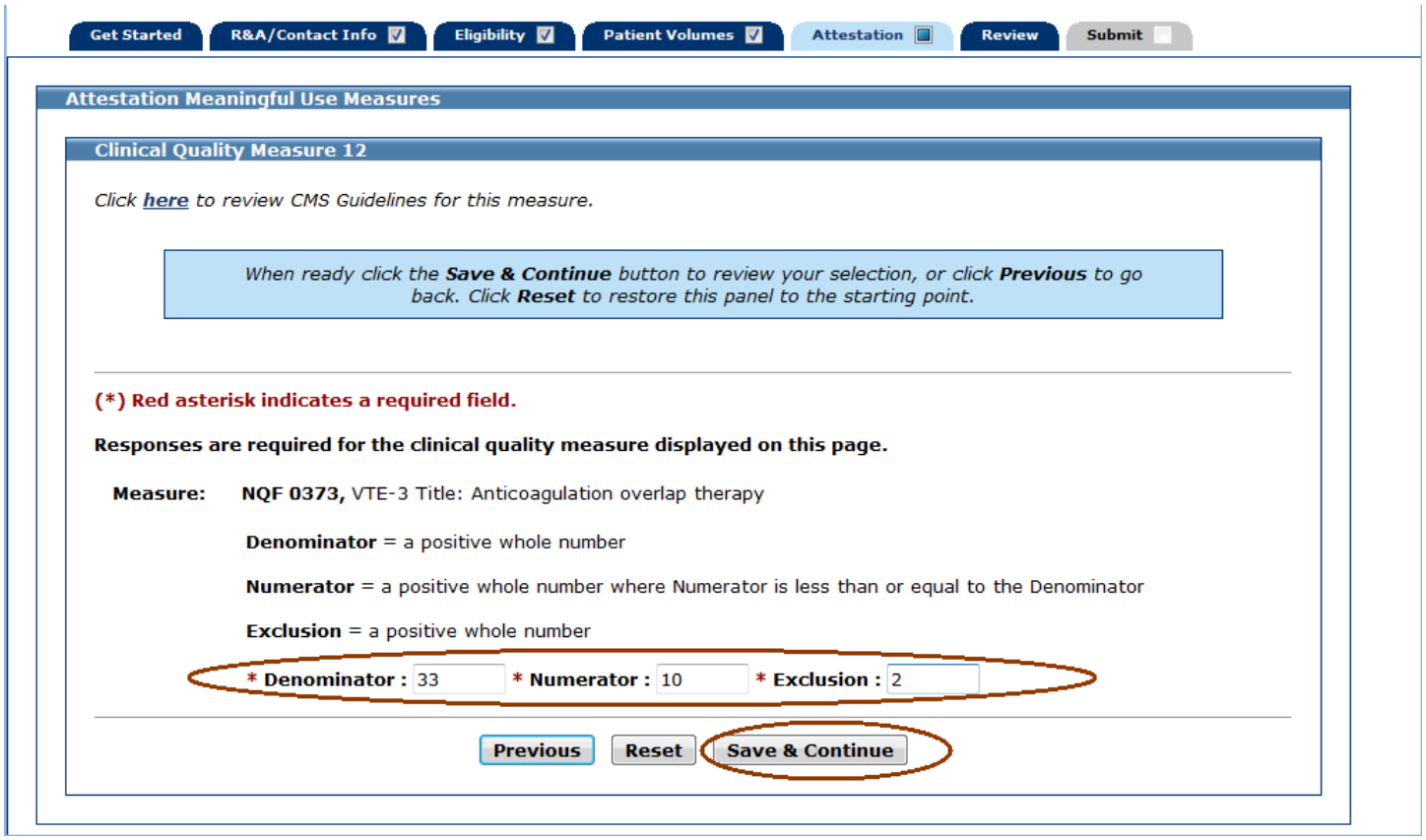


Clinical Quality Measure 12 (Measure Code NQF 0373)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

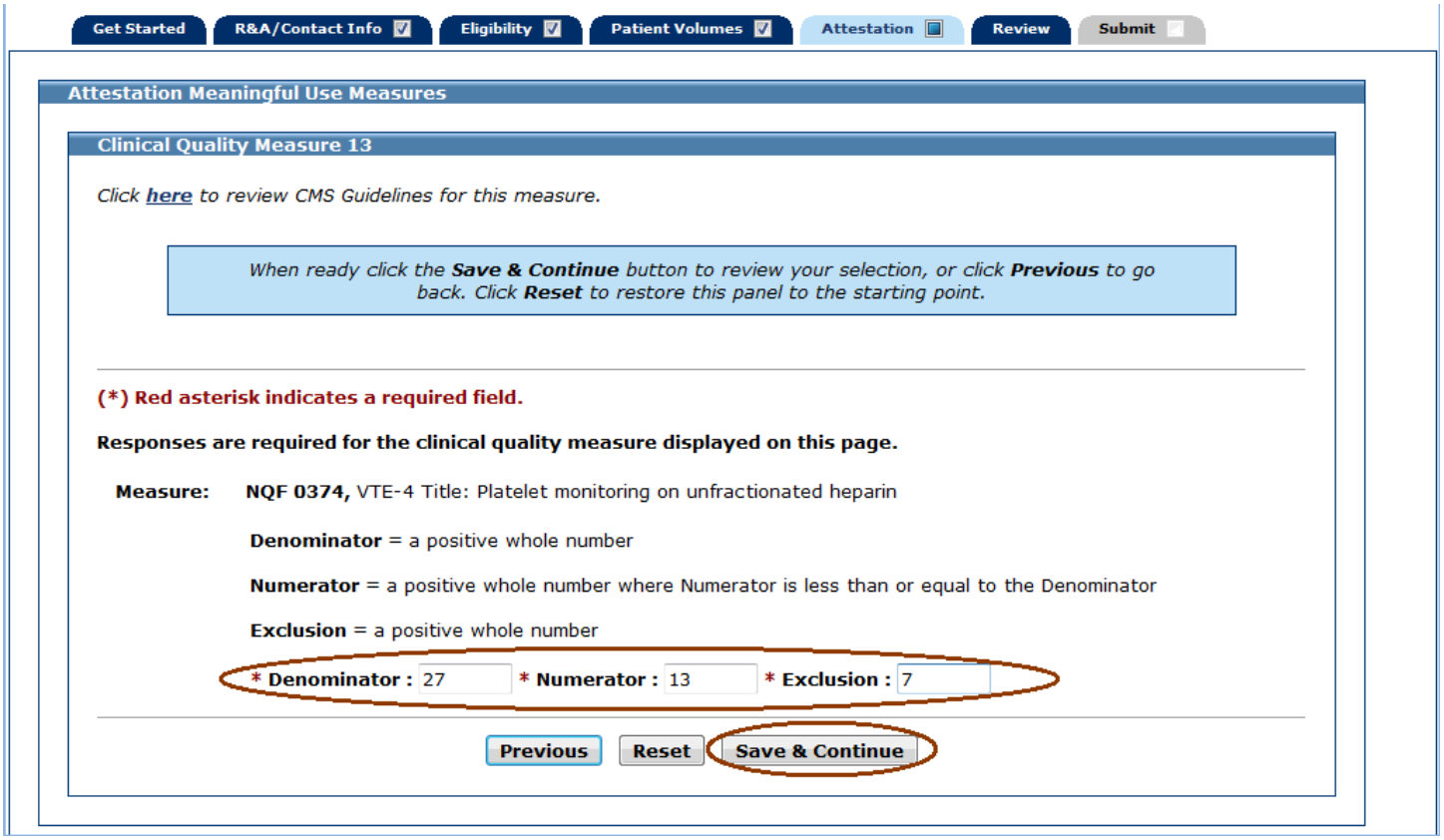


Clinical Quality Measure 13 (Measure Code NQF 0374)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

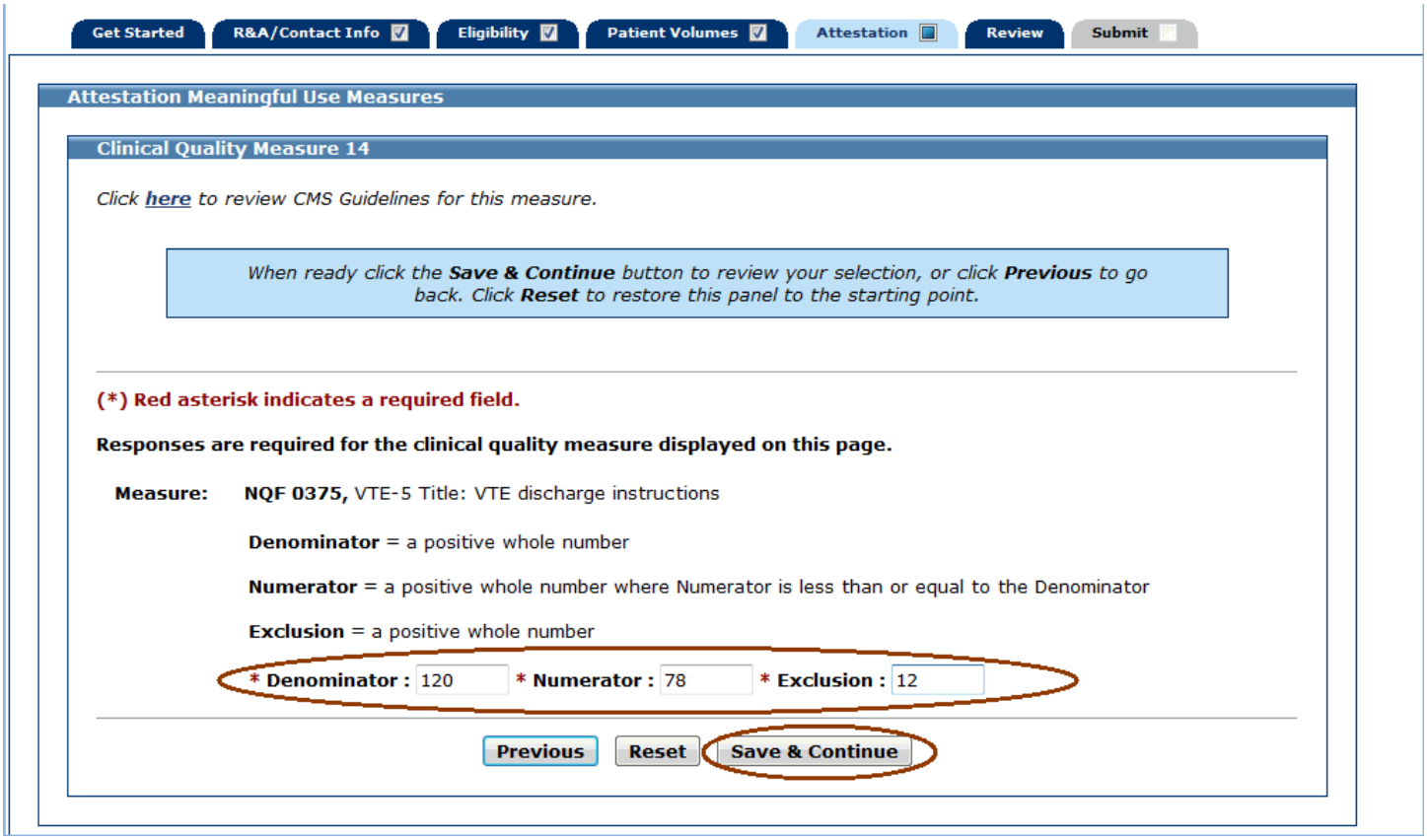


Clinical Quality Measure 14 (Measure Code NQF 0375)

Enter information in all required fields.

The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

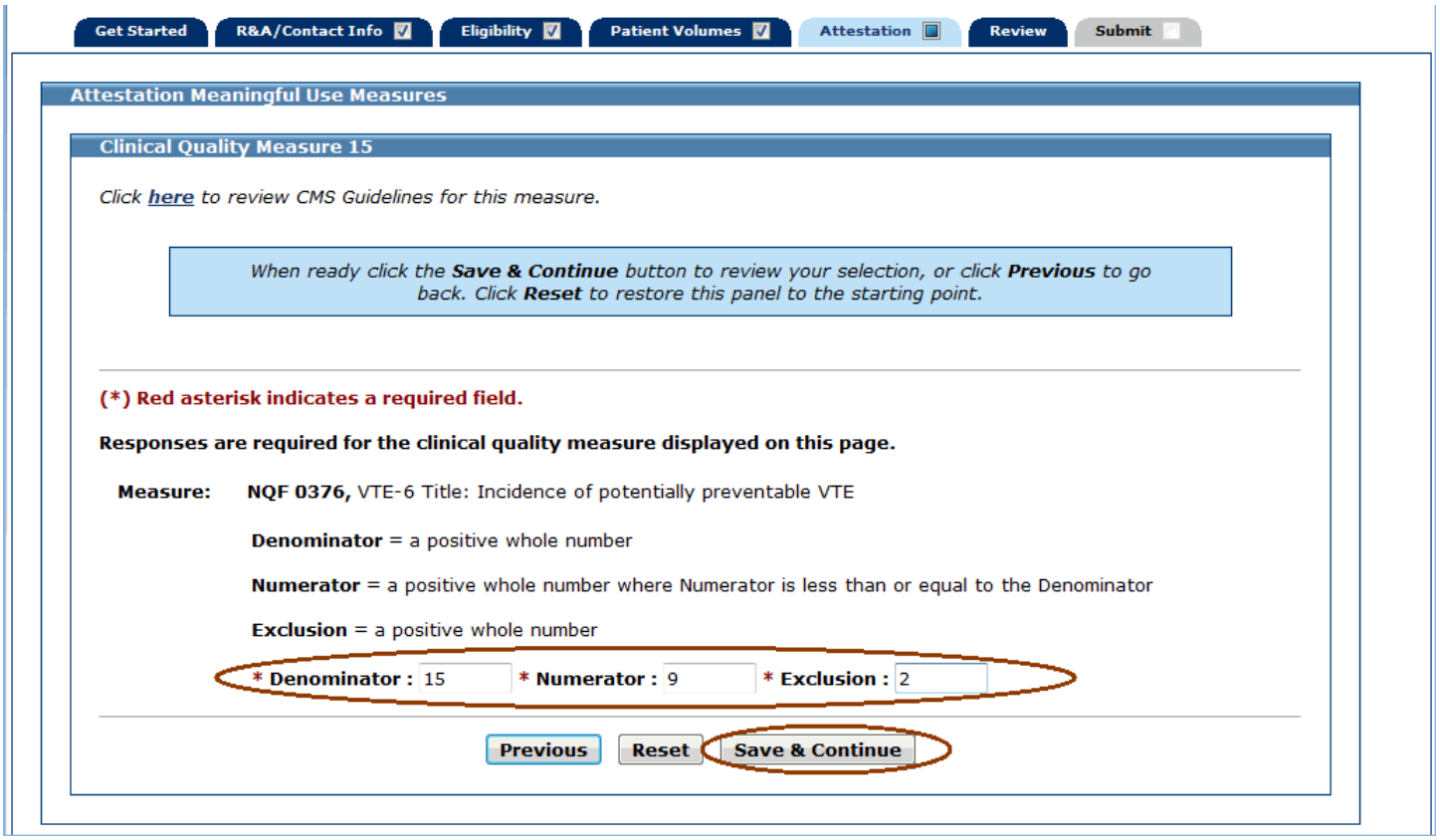


Clinical Quality Measure 15 (Measure Code NQF 0376)

Enter information in all required fields.

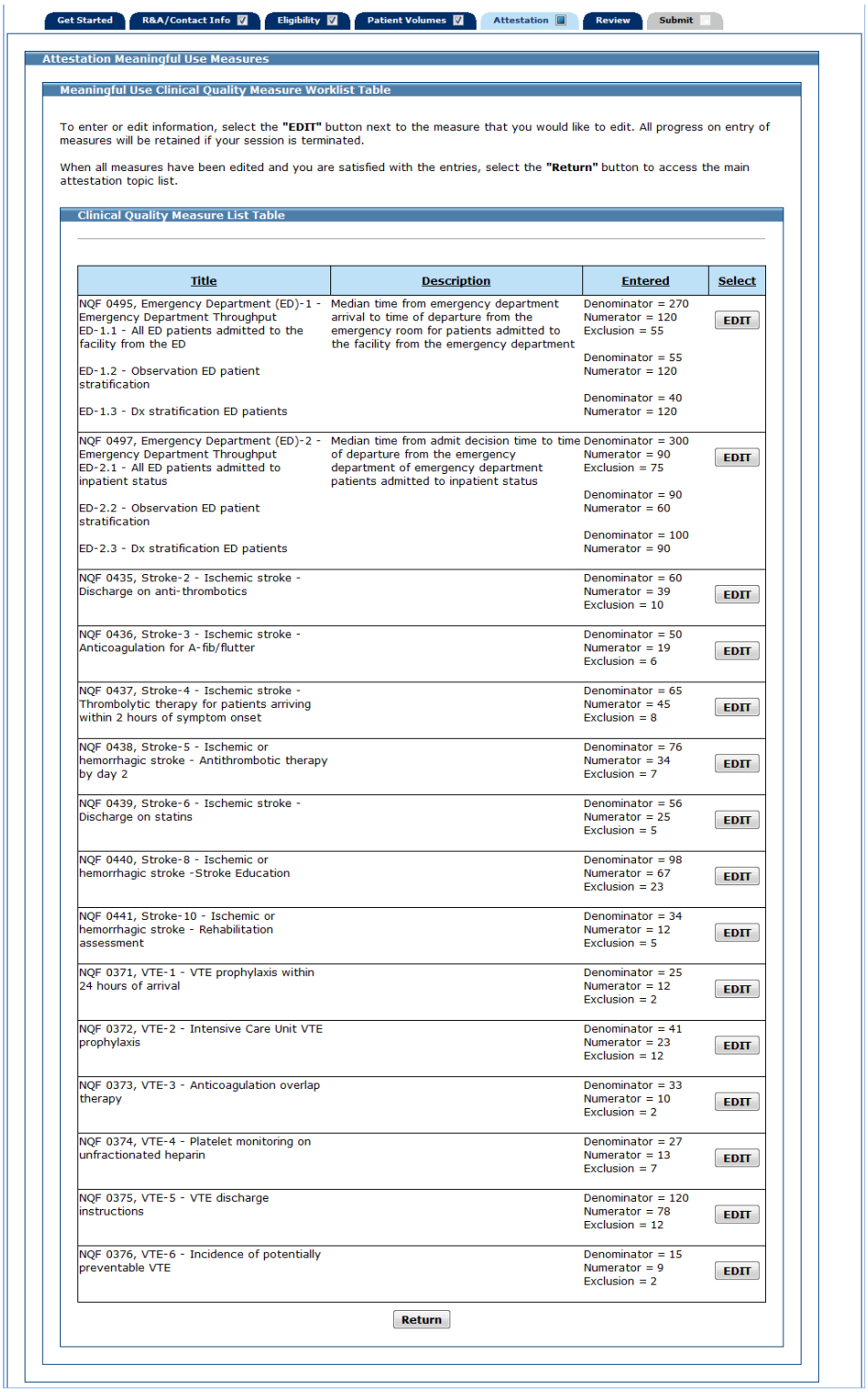
The denominator, numerator, and exclusion entries must be positive whole numbers.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



The screen on the following page displays Meaningful Use Quality Measures Worklist Table with data entered for every measure.

Click **Return** to return to the Measures Topic List.



Get Started | R&A/Contact Info | Eligibility | Patient Volumes | Attestation | Review | Submit

Attestation Meaningful Use Measures

Meaningful Use Clinical Quality Measure Worklist Table

To enter or edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

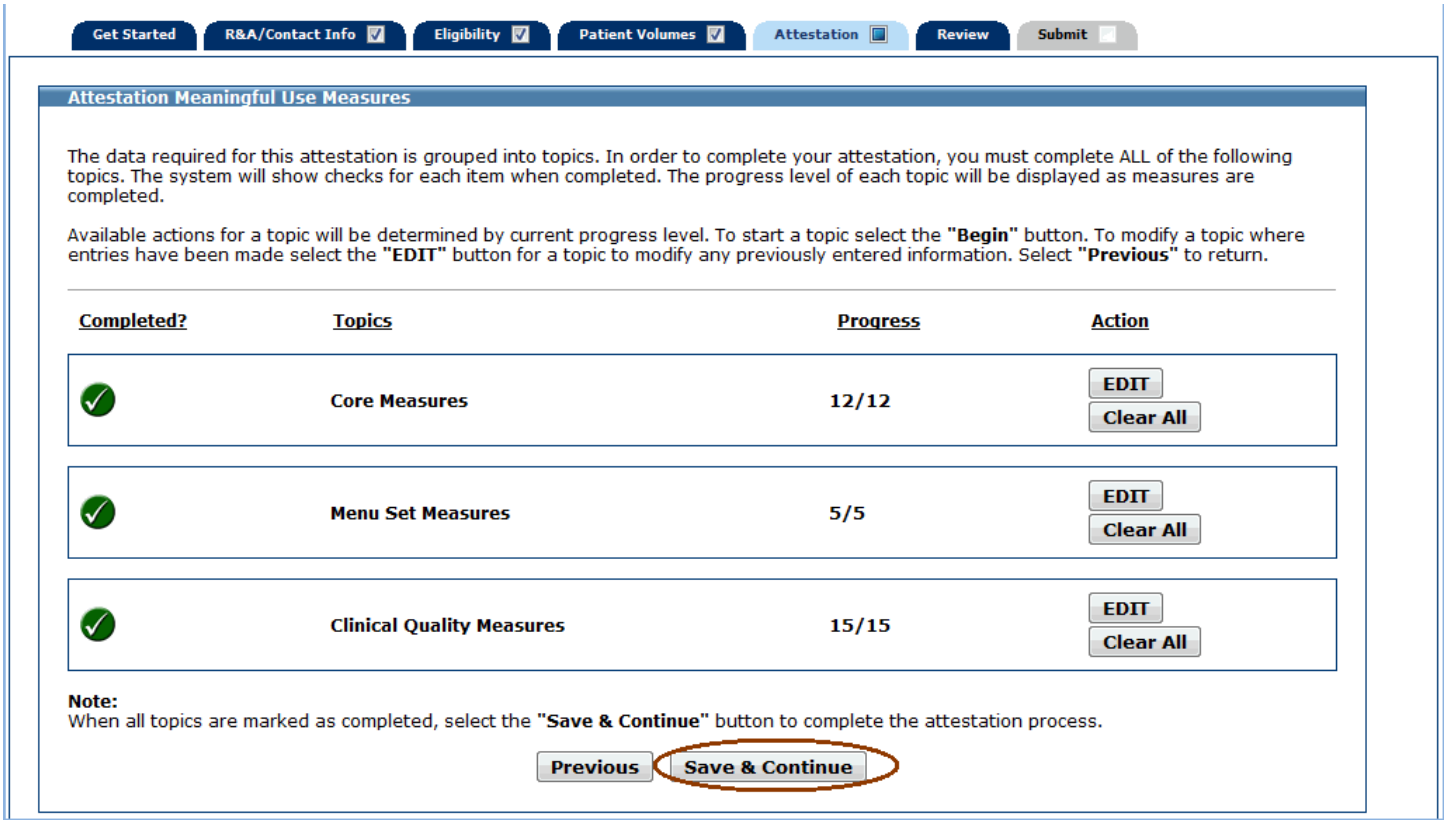
When all measures have been edited and you are satisfied with the entries, select the **"Return"** button to access the main attestation topic list.

Clinical Quality Measure List Table

Title	Description	Entered	Select
NQF 0495, Emergency Department (ED)-1 - Emergency Department Throughput ED-1.1 - All ED patients admitted to the facility from the ED ED-1.2 - Observation ED patient stratification ED-1.3 - Dx stratification ED patients	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department	Denominator = 270 Numerator = 120 Exclusion = 55 Denominator = 55 Numerator = 120 Denominator = 40 Numerator = 120	EDIT
NQF 0497, Emergency Department (ED)-2 - Emergency Department Throughput ED-2.1 - All ED patients admitted to inpatient status ED-2.2 - Observation ED patient stratification ED-2.3 - Dx stratification ED patients	Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status	Denominator = 300 Numerator = 90 Exclusion = 75 Denominator = 90 Numerator = 60 Denominator = 100 Numerator = 90	EDIT
NQF 0435, Stroke-2 - Ischemic stroke - Discharge on anti-thrombotics		Denominator = 60 Numerator = 39 Exclusion = 10	EDIT
NQF 0436, Stroke-3 - Ischemic stroke - Anticoagulation for A-fib/flutter		Denominator = 50 Numerator = 19 Exclusion = 6	EDIT
NQF 0437, Stroke-4 - Ischemic stroke - Thrombolytic therapy for patients arriving within 2 hours of symptom onset		Denominator = 65 Numerator = 45 Exclusion = 8	EDIT
NQF 0438, Stroke-5 - Ischemic or hemorrhagic stroke - Antithrombotic therapy by day 2		Denominator = 76 Numerator = 34 Exclusion = 7	EDIT
NQF 0439, Stroke-6 - Ischemic stroke - Discharge on statins		Denominator = 56 Numerator = 25 Exclusion = 5	EDIT
NQF 0440, Stroke-8 - Ischemic or hemorrhagic stroke -Stroke Education		Denominator = 98 Numerator = 67 Exclusion = 23	EDIT
NQF 0441, Stroke-10 - Ischemic or hemorrhagic stroke - Rehabilitation assessment		Denominator = 34 Numerator = 12 Exclusion = 5	EDIT
NQF 0371, VTE-1 - VTE prophylaxis within 24 hours of arrival		Denominator = 25 Numerator = 12 Exclusion = 2	EDIT
NQF 0372, VTE-2 - Intensive Care Unit VTE prophylaxis		Denominator = 41 Numerator = 23 Exclusion = 12	EDIT
NQF 0373, VTE-3 - Anticoagulation overlap therapy		Denominator = 33 Numerator = 10 Exclusion = 2	EDIT
NQF 0374, VTE-4 - Platelet monitoring on unfractionated heparin		Denominator = 27 Numerator = 13 Exclusion = 7	EDIT
NQF 0375, VTE-5 - VTE discharge instructions		Denominator = 120 Numerator = 78 Exclusion = 12	EDIT
NQF 0376, VTE-6 - Incidence of potentially preventable VTE		Denominator = 15 Numerator = 9 Exclusion = 2	EDIT

Return

This screen displays the Measures Topic List with all three meaningful use measure topics marked complete. Click **Save & Continue** to view a summary of the Meaningful Use Measures you attested to.

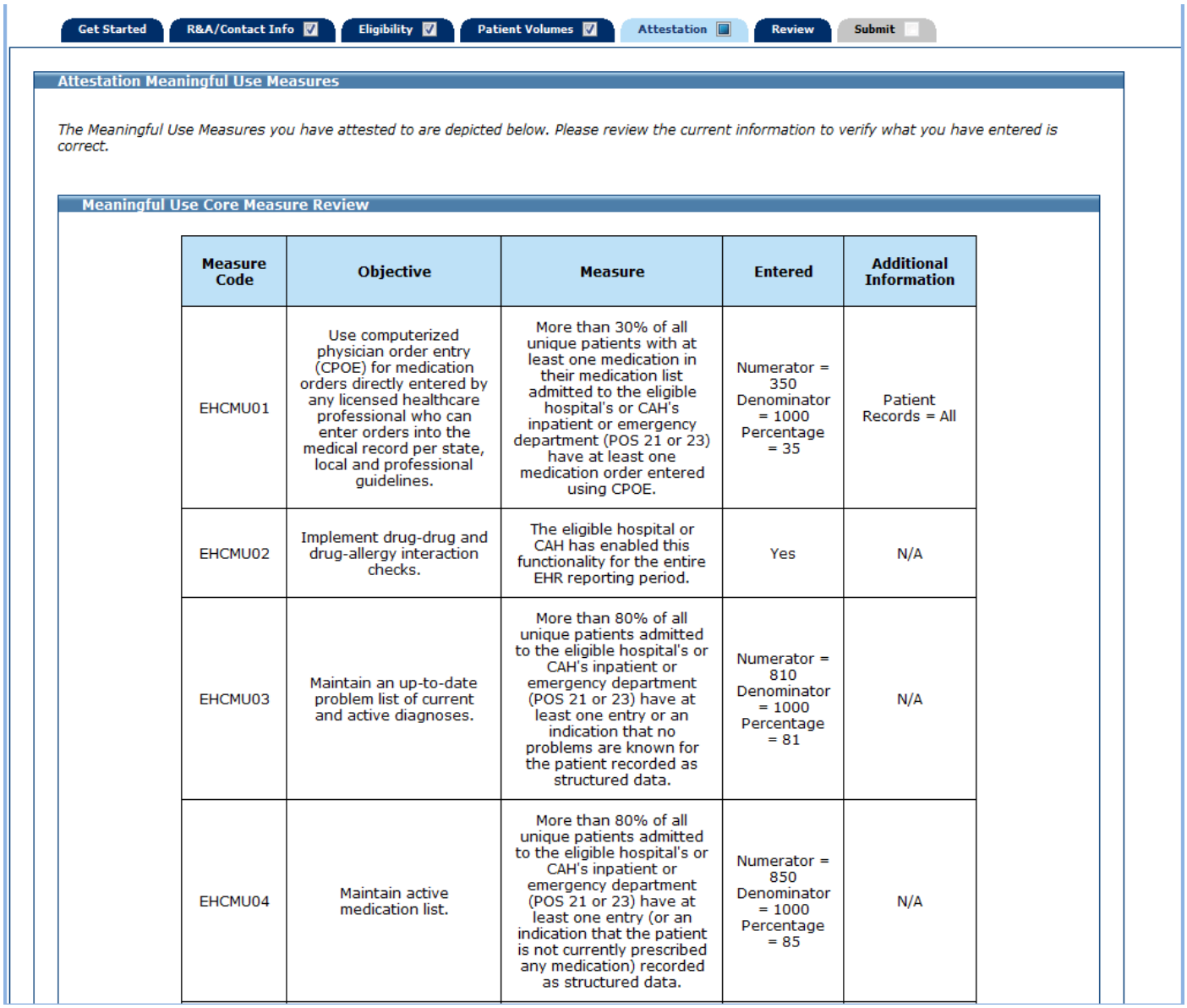


Meaningful Use Measures Summary

This screen displays a summary of all entered meaningful use attestation information.

Review the information for each measure. If further edits are necessary, click **Previous** to return to the Measures Topic List where you can choose a topic to edit.

If the information on the summary is correct, click **Save & Continue** to proceed to Part 3 of 3 of the Attestation Phase.

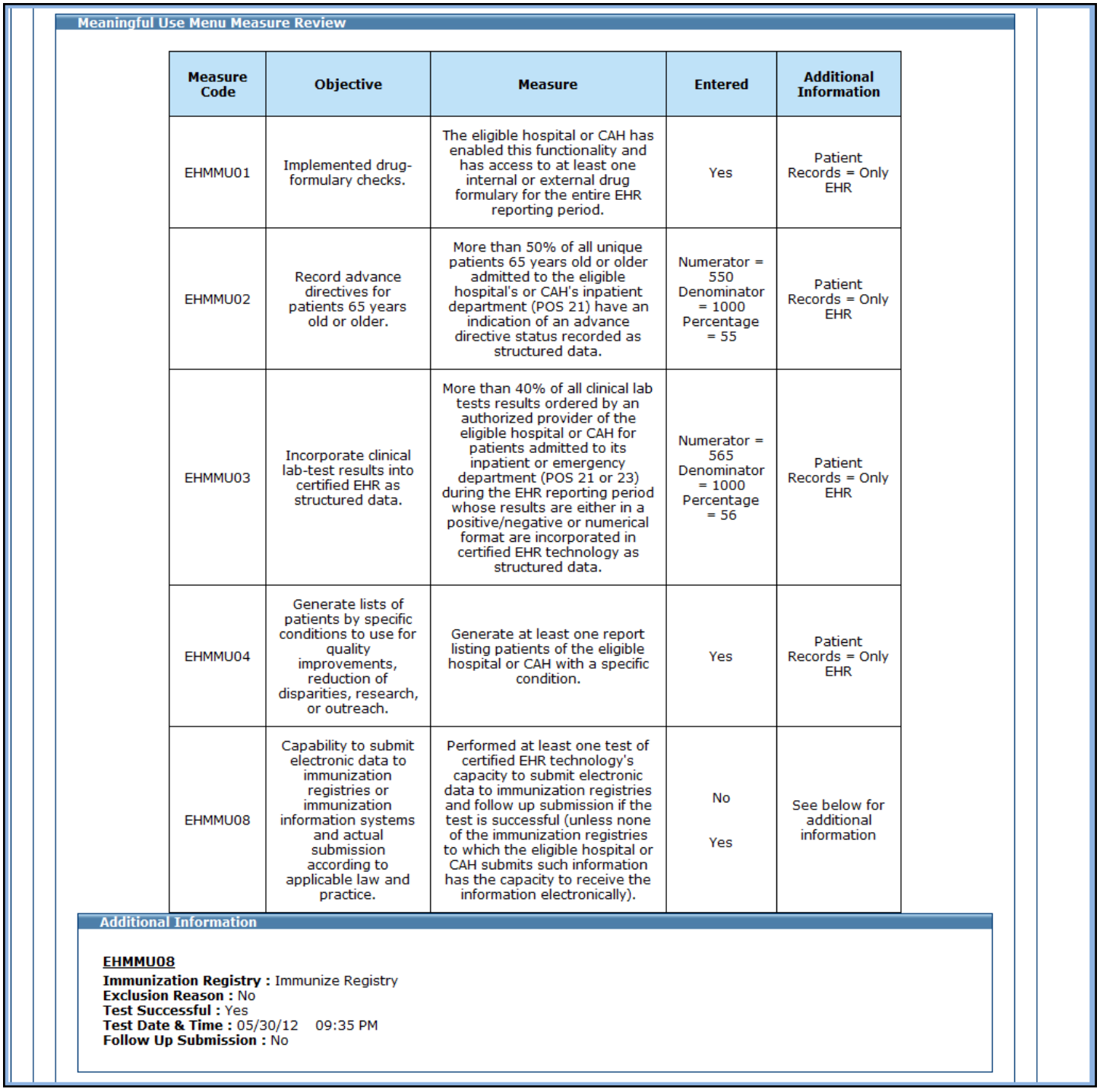


Measure Code	Objective	Measure	Entered	Additional Information
EHCMU01	Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	More than 30% of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE.	Numerator = 350 Denominator = 1000 Percentage = 35	Patient Records = All
EHCMU02	Implement drug-drug and drug-allergy interaction checks.	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.	Yes	N/A
EHCMU03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data.	Numerator = 810 Denominator = 1000 Percentage = 81	N/A
EHCMU04	Maintain active medication list.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.	Numerator = 850 Denominator = 1000 Percentage = 85	N/A

This is screen 2 of 5 of the Meaningful Use Measures Summary.

EHCMU05	Maintain active medication allergy list.	More than 80% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.	Numerator = 850 Denominator = 1000 Percentage = 85	N/A
EHCMU06	Record all of the following demographics: Preferred language; Gender; Race; Ethnicity; Date of birth; Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH.	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	Numerator = 550 Denominator = 1000 Percentage = 55	N/A
EHCMU07	Record and chart changes in vital signs: height; weight; blood pressure; Calculate and display body mass index (BMI); plot and display growth charts for children 2-20 years, including BMI.	For more than 50% of all unique patients age 2 and over admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structure data.	Numerator = 550 Denominator = 1000 Percentage = 55	Patient Records = All
EHCMU08	Record Smoking Status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data.	Numerator = 550 Denominator = 1000 Percentage = 55	N/A
EHCMU10	Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule	Implement one clinical decision support rule	Yes	N/A
EHCMU11	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request	More than 50% of all patients of the inpatient or emergency department of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days.	Numerator = 550 Denominator = 1000 Percentage = 55	Patient Records = All
EHCMU12	Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.	More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.	Numerator = 550 Denominator = 1000 Percentage = 55	Patient Records = All
EHCMU14	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes	N/A

This is screen 3 of 5 of the Meaningful Use Measures Summary.



Meaningful Use Menu Measure Review

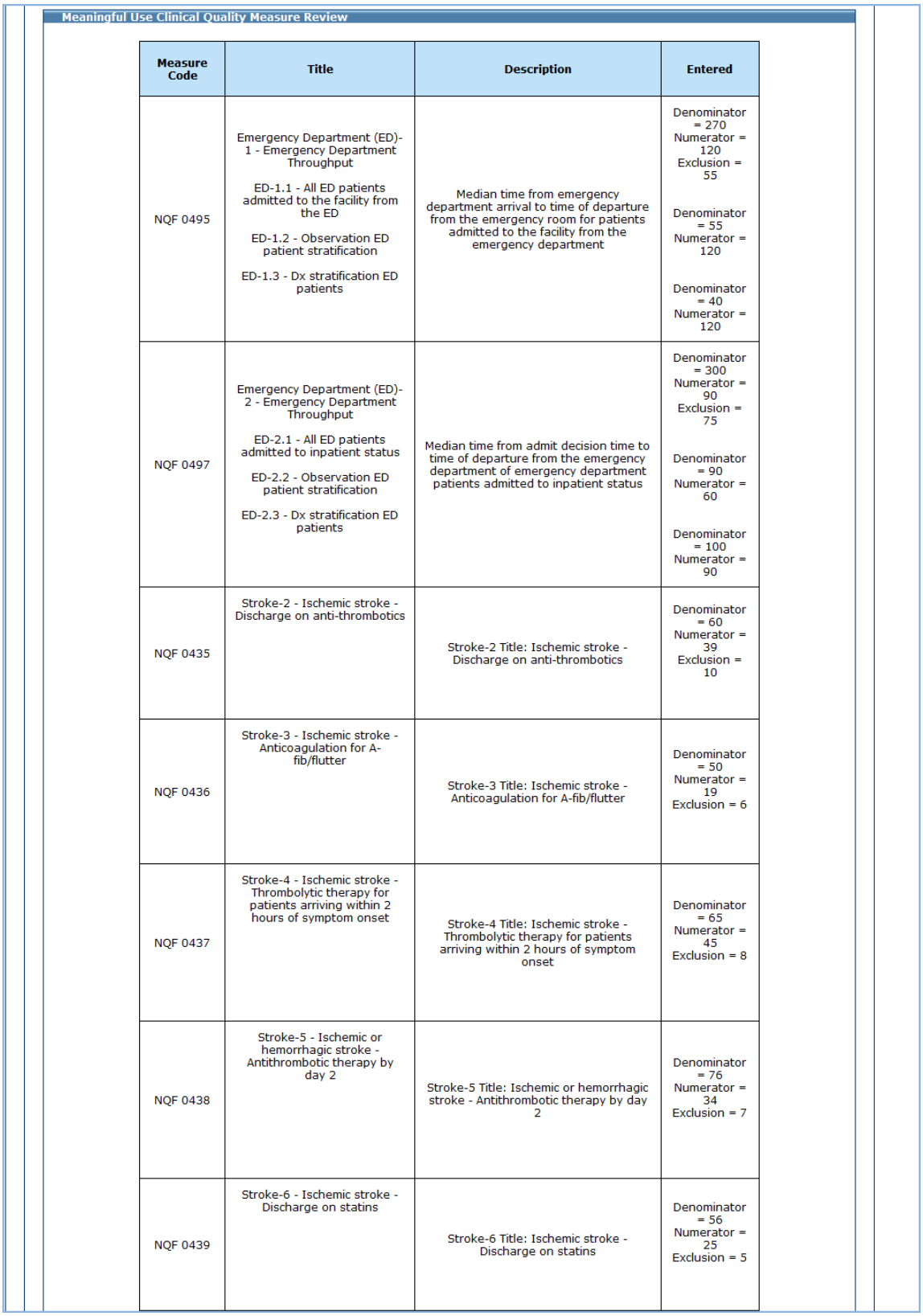
Measure Code	Objective	Measure	Entered	Additional Information
EHMMU01	Implemented drug-formulary checks.	The eligible hospital or CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	Yes	Patient Records = Only EHR
EHMMU02	Record advance directives for patients 65 years old or older.	More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded as structured data.	Numerator = 550 Denominator = 1000 Percentage = 55	Patient Records = Only EHR
EHMMU03	Incorporate clinical lab-test results into certified EHR as structured data.	More than 40% of all clinical lab tests results ordered by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	Numerator = 565 Denominator = 1000 Percentage = 56	Patient Records = Only EHR
EHMMU04	Generate lists of patients by specific conditions to use for quality improvements, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.	Yes	Patient Records = Only EHR
EHMMU08	Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).	No Yes	See below for additional information

Additional Information

EHMMU08

Immunization Registry : Immunize Registry
Exclusion Reason : No
Test Successful : Yes
Test Date & Time : 05/30/12 09:35 PM
Follow Up Submission : No

This is screen 4 of 5 of the Meaningful Use Measures Summary.



Meaningful Use Clinical Quality Measure Review

Measure Code	Title	Description	Entered
NQF 0495	Emergency Department (ED)-1 - Emergency Department Throughput ED-1.1 - All ED patients admitted to the facility from the ED ED-1.2 - Observation ED patient stratification ED-1.3 - Dx stratification ED patients	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department	Denominator = 270 Numerator = 120 Exclusion = 55 Denominator = 55 Numerator = 120 Denominator = 40 Numerator = 120
NQF 0497	Emergency Department (ED)-2 - Emergency Department Throughput ED-2.1 - All ED patients admitted to inpatient status ED-2.2 - Observation ED patient stratification ED-2.3 - Dx stratification ED patients	Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status	Denominator = 300 Numerator = 90 Exclusion = 75 Denominator = 90 Numerator = 60 Denominator = 100 Numerator = 90
NQF 0435	Stroke-2 - Ischemic stroke - Discharge on anti-thrombotics	Stroke-2 Title: Ischemic stroke - Discharge on anti-thrombotics	Denominator = 60 Numerator = 39 Exclusion = 10
NQF 0436	Stroke-3 - Ischemic stroke - Anticoagulation for A-fib/flutter	Stroke-3 Title: Ischemic stroke - Anticoagulation for A-fib/flutter	Denominator = 50 Numerator = 19 Exclusion = 6
NQF 0437	Stroke-4 - Ischemic stroke - Thrombolytic therapy for patients arriving within 2 hours of symptom onset	Stroke-4 Title: Ischemic stroke - Thrombolytic therapy for patients arriving within 2 hours of symptom onset	Denominator = 65 Numerator = 45 Exclusion = 8
NQF 0438	Stroke-5 - Ischemic or hemorrhagic stroke - Antithrombotic therapy by day 2	Stroke-5 Title: Ischemic or hemorrhagic stroke - Antithrombotic therapy by day 2	Denominator = 76 Numerator = 34 Exclusion = 7
NQF 0439	Stroke-6 - Ischemic stroke - Discharge on statins	Stroke-6 Title: Ischemic stroke - Discharge on statins	Denominator = 56 Numerator = 25 Exclusion = 5

This is screen 5 of 5 of the Meaningful Use Measures Summary.

NQF 0440	Stroke-8 - Ischemic or hemorrhagic stroke -Stroke Education	Stroke-8 Title: Ischemic or hemorrhagic stroke -Stroke Education	Denominator = 98 Numerator = 67 Exclusion = 23
NQF 0441	Stroke-10 - Ischemic or hemorrhagic stroke - Rehabilitation assessment	Stroke-10 Title: Ischemic or hemorrhagic stroke - Rehabilitation assessment	Denominator = 34 Numerator = 12 Exclusion = 5
NQF 0371	VTE-1 - VTE prophylaxis within 24 hours of arrival	VTE-1 Title: VTE prophylaxis within 24 hours of arrival	Denominator = 25 Numerator = 12 Exclusion = 2
NQF 0372	VTE-2 - Intensive Care Unit VTE prophylaxis	VTE-2 Title: Intensive Care Unit VTE prophylaxis	Denominator = 41 Numerator = 23 Exclusion = 12
NQF 0373	VTE-3 - Anticoagulation overlap therapy	VTE-3 Title: Anticoagulation overlap therapy	Denominator = 33 Numerator = 10 Exclusion = 2
NQF 0374	VTE-4 - Platelet monitoring on unfractionated heparin	VTE-4 Title: Platelet monitoring on unfractionated heparin	Denominator = 27 Numerator = 13 Exclusion = 7
NQF 0375	VTE-5 - VTE discharge instructions	VTE-5 Title: VTE discharge instructions	Denominator = 120 Numerator = 78 Exclusion = 12
NQF 0376	VTE-6 - Incidence of potentially preventable VTE	VTE-6 Title: Incidence of potentially preventable VTE	Denominator = 15 Numerator = 9 Exclusion = 2

Previous Save & Continue

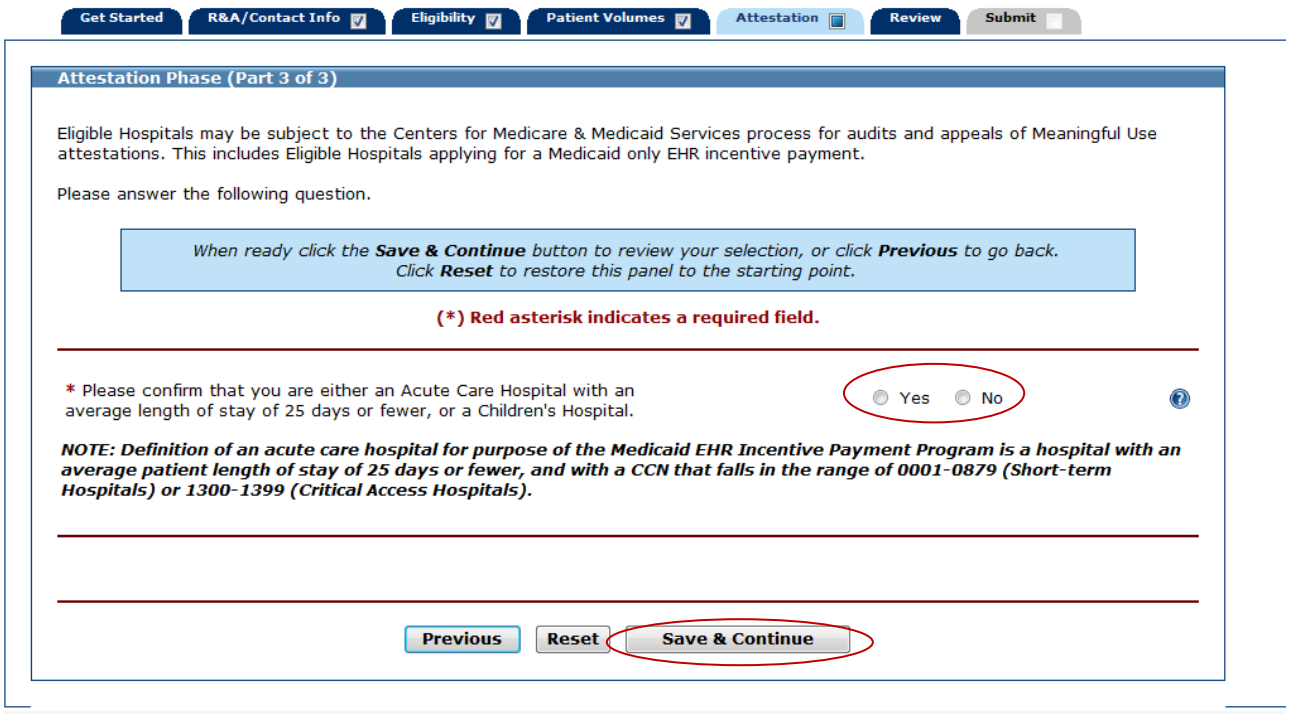
Attestation Phase (Part 3 of 3)

Part 3 of 3 of the **Attestation Phase** asks you to identify whether or not you are an Acute Care Hospital with an average length of stay of 25 days or fewer, or a Children's hospital.

Additionally, you are asked which address you would like to have your incentive payment sent to, contingent on approval for payment.

Click **Yes** to confirm you are either an Acute Care Hospital (Including Critical Access Hospital) with an average length of stay of 25 days or fewer, or a Children's hospital.

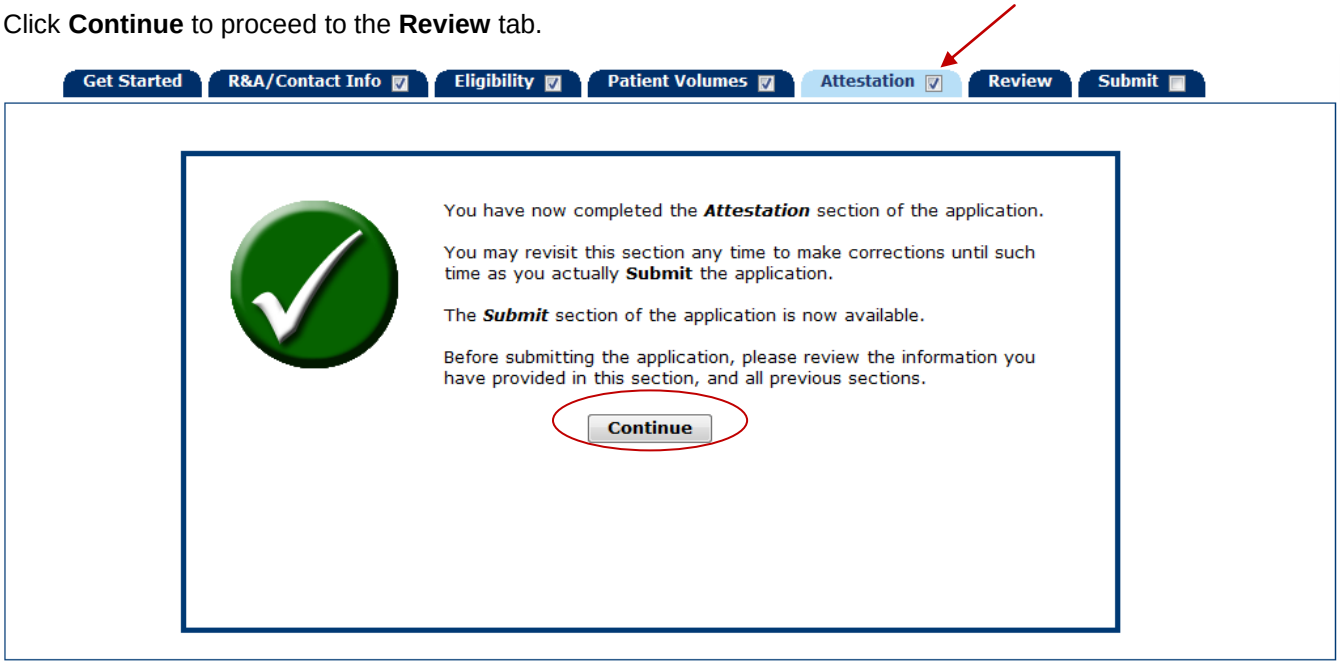
Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



This screen confirms you successfully completed the **Attestation** section.

Note the check box in the Attestation tab.

Click **Continue** to proceed to the **Review** tab.



Step 6 – Review Application

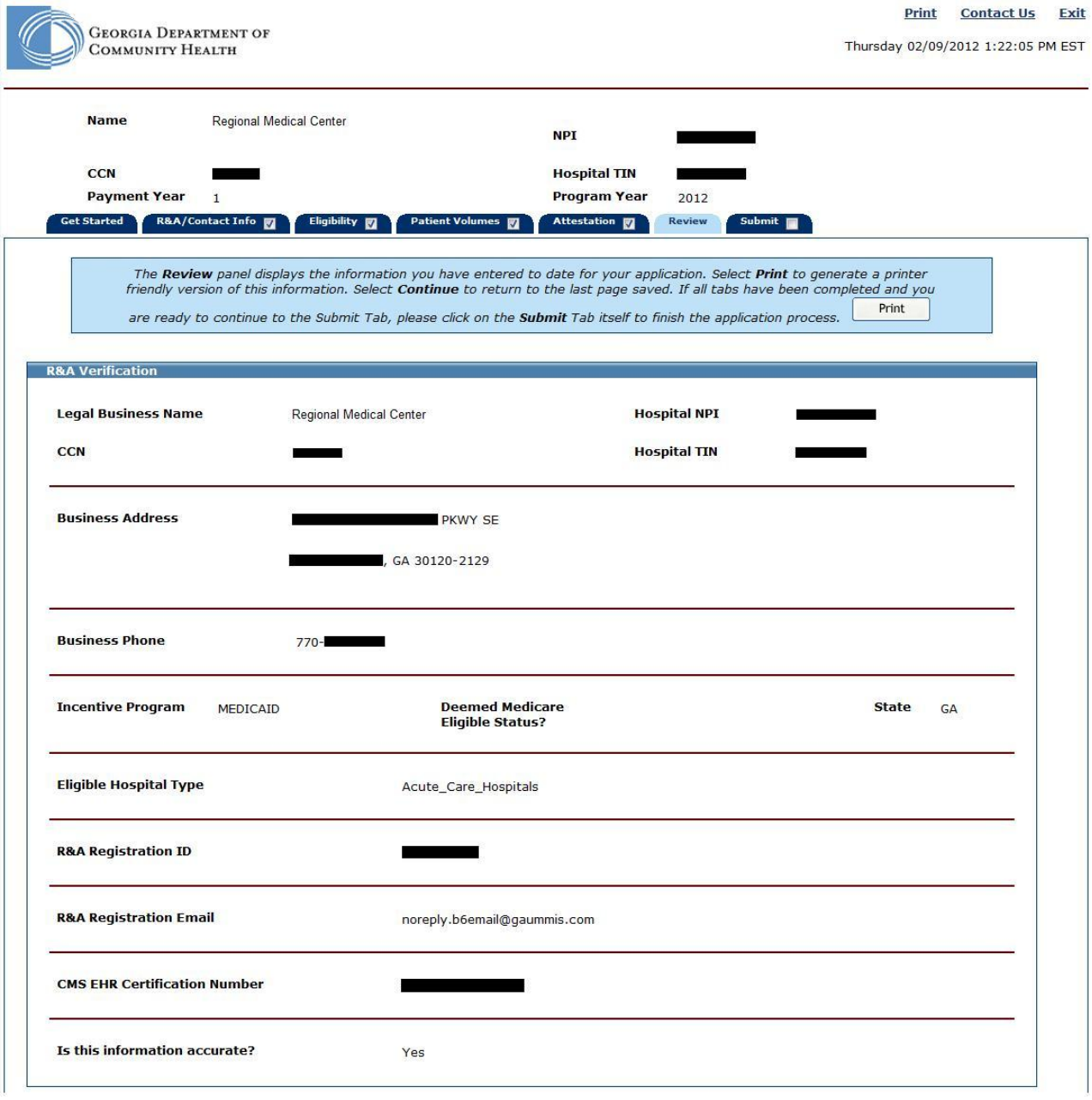
The **Review** tab displays all the information associated with your application.

Carefully review all of the information to ensure it is accurate.

Once you have reviewed all information click the **Submit** tab to proceed.

Click **Print** to generate a printer-friendly version of this information.

This is page 1 of 3 of the **Review** tab display.



This is page 2 of 3 of the **Review** tab display.

Contact Information

Contact Name Jane Doe
Contact Phone 303 - 555 - 4748 Ext
Contact Email Address jdoe@mapir.com

Eligibility Questions (Part 1 of 2)

Please confirm that you are choosing the Medicaid incentive program. **Yes**

Do you have any sanctions or pending sanctions with Medicare or Medicaid in Georgia? **Yes**

Eligibility Questions (Part 2 of 2)

CMS EHR Certification ID: [redacted]

Patient Volume 90 Day Period (Part 1 of 3)

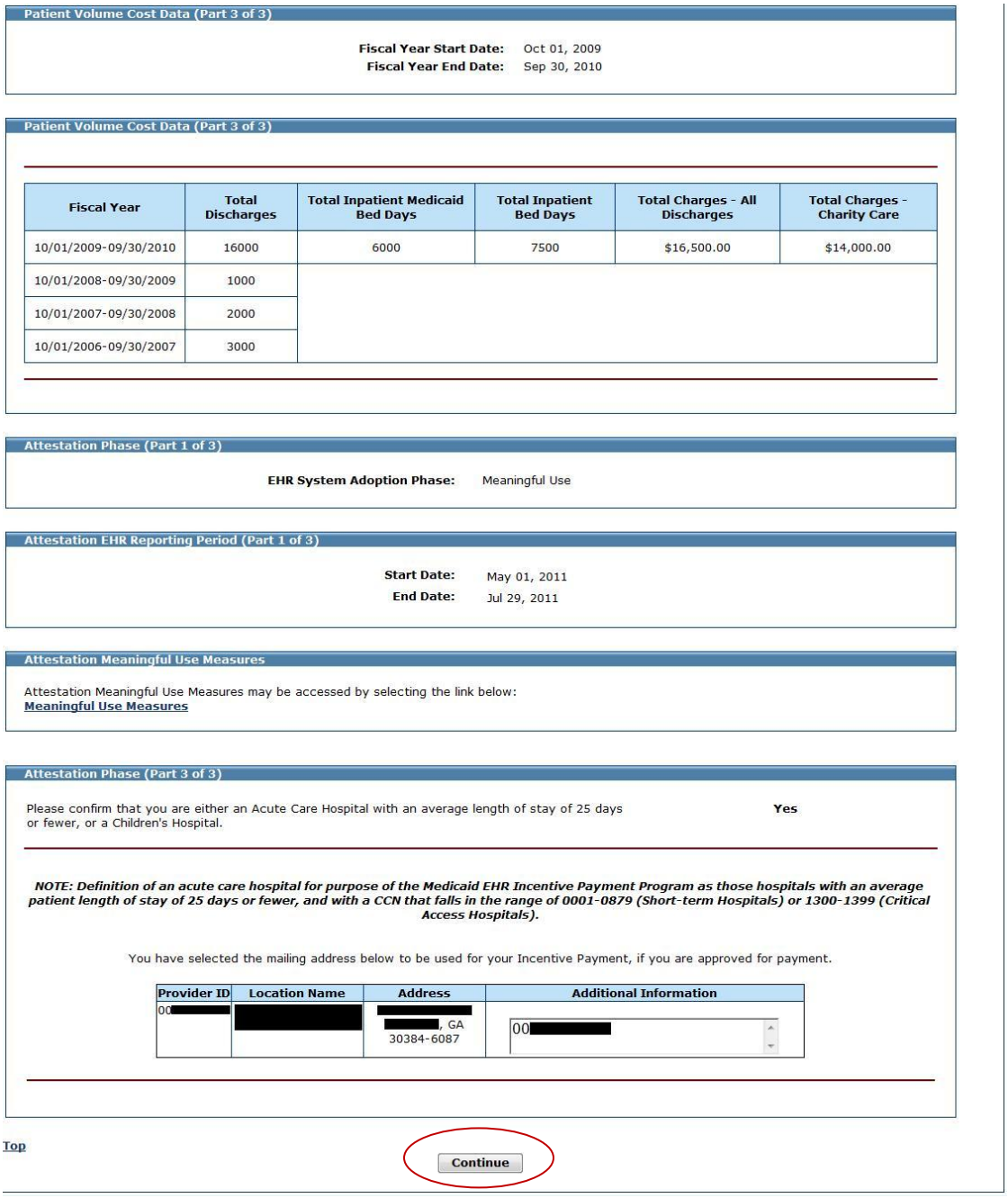
Start Date: Jan 01, 2010
End Date: Mar 31, 2010

Enter Patient Volumes (Part 2 of 3)

Provider ID	Location Name	Address	Encounter Volumes		% Medicaid Discharges
N/A	New Location	1223 State Dr. AnyCity, GA 30043-3131	***In State Medicaid:*** ***Other Medicaid:*** ***Total Discharges:***	300 500 8000	10%
	[redacted]REGIONAL MEDICAL CENTER	[redacted]AVE [redacted], GA 31501-5246	***In State Medicaid:*** ***Other Medicaid:*** ***Total Discharges:***	200 500 10100	7%

Sum In-State Medicaid Volume	Sum Other Medicaid Volume	Total Discharges Sum Denominator	Total %
500	1000	18100	8%

This is page 3 of 3 of the **Review** tab display.



Patient Volume Cost Data (Part 3 of 3)

Fiscal Year Start Date: Oct 01, 2009
Fiscal Year End Date: Sep 30, 2010

Patient Volume Cost Data (Part 3 of 3)

Fiscal Year	Total Discharges	Total Inpatient Medicaid Bed Days	Total Inpatient Bed Days	Total Charges - All Discharges	Total Charges - Charity Care
10/01/2009-09/30/2010	16000	6000	7500	$16,500.00	$14,000.00
10/01/2008-09/30/2009	1000				
10/01/2007-09/30/2008	2000				
10/01/2006-09/30/2007	3000				

Attestation Phase (Part 1 of 3)

EHR System Adoption Phase: Meaningful Use

Attestation EHR Reporting Period (Part 1 of 3)

Start Date: May 01, 2011
End Date: Jul 29, 2011

Attestation Meaningful Use Measures

Attestation Meaningful Use Measures may be accessed by selecting the link below:
Meaningful Use Measures

Attestation Phase (Part 3 of 3)

Please confirm that you are either an Acute Care Hospital with an average length of stay of 25 days or fewer, or a Children's Hospital. **Yes**

NOTE: Definition of an acute care hospital for purpose of the Medicaid EHR Incentive Payment Program as those hospitals with an average patient length of stay of 25 days or fewer, and with a CCN that falls in the range of 0001-0879 (Short-term Hospitals) or 1300-1399 (Critical Access Hospitals).

You have selected the mailing address below to be used for your Incentive Payment, if you are approved for payment.

Provider ID	Location Name	Address	Additional Information
00[redacted]	[redacted]	[redacted], GA 30384-6087	00[redacted]

Top

Continue

Step 7 – Submit Your Application

The final submission of your application involves the following steps:

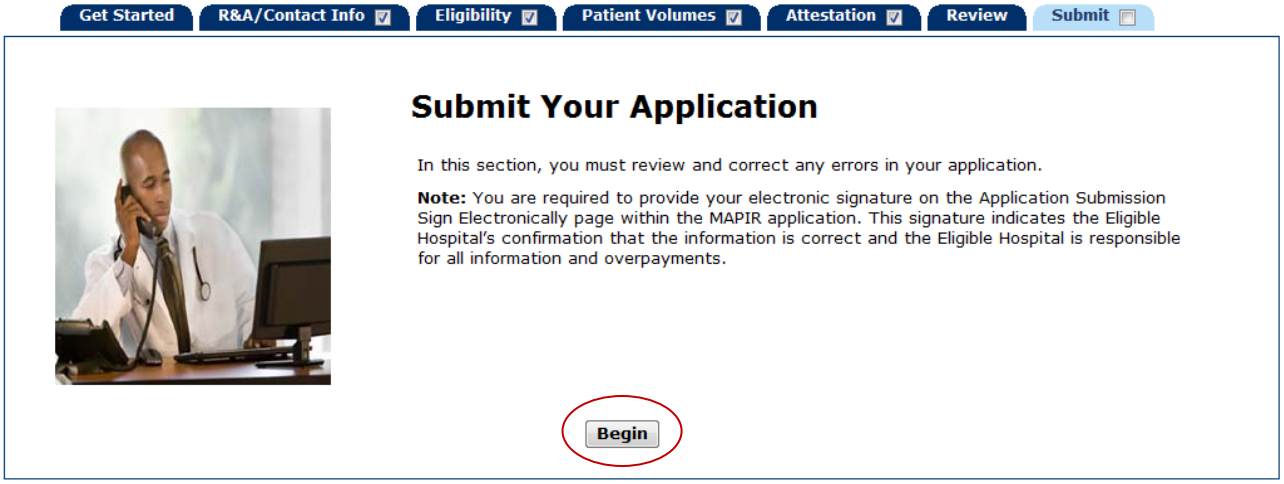
Review and Check Errors – MAPIR will check your application for errors. If errors are present you will have the opportunity to go back to the section where the error occurred and correct it. If you do not want to correct the errors you can still submit your application; however, *the errors may affect your eligibility and payment amount.*

Optional Questions – You may be asked a series of optional questions that do not affect your application. The answers will provide information to the Georgia Medicaid program about your Medicaid EHR Incentive Progam participation.

File Upload – You will be **required** to upload documentation supporting your application. This will include your Eligible Hospital Patient Volume and Incentive Payment Calculator and your AIU documentation.

The initial **Submit** screen contains information about this section.

Click **Begin** to continue to the submission process.



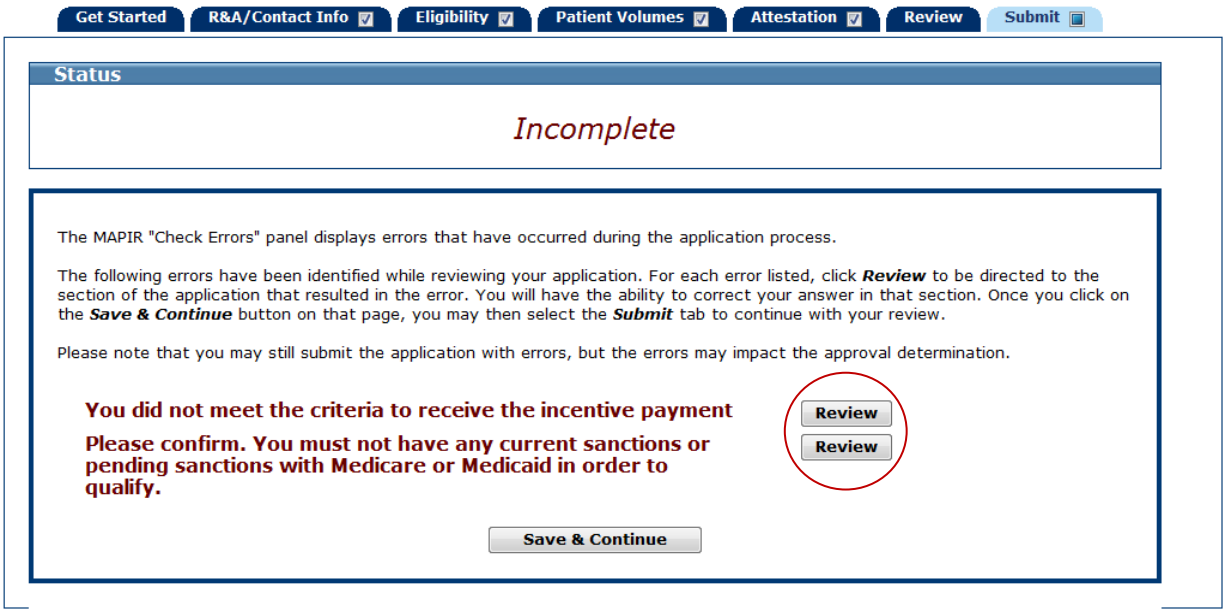
This page lists the current status of your application and any error messages that occurred during the application process.

You can submit this application without making any changes; however the validation messages identified may impact your eligibility and incentive payment amount.

To review error messages:

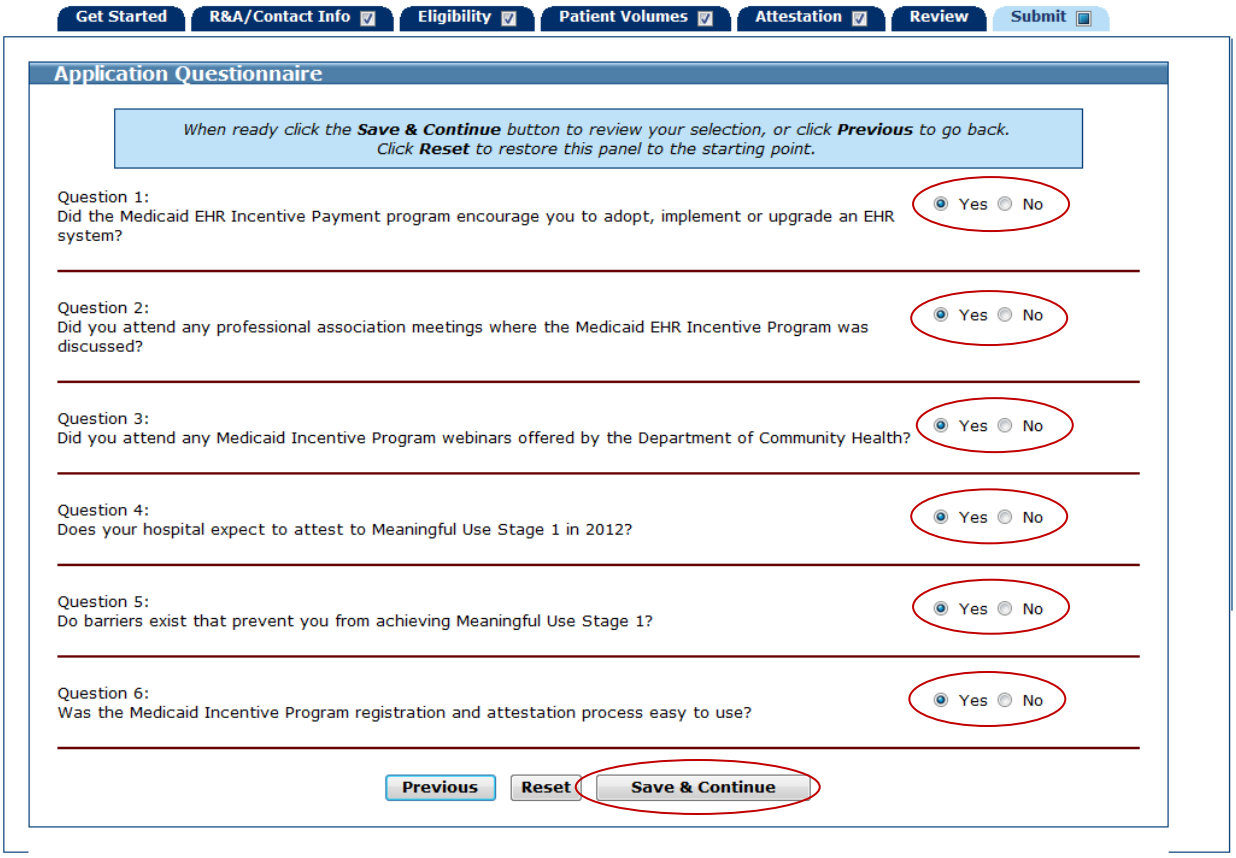
Click **Review** to be taken to the specific section identified and make any appropriate changes to the entered information. To return to this section at any time click the **Submit** tab.

Click **Save & Continue** to continue with Click **Save & Continue** to continue with the application submission.



A **Questionnaire** is included in this section. Please take a few moments to complete this and provide us with your feedback.

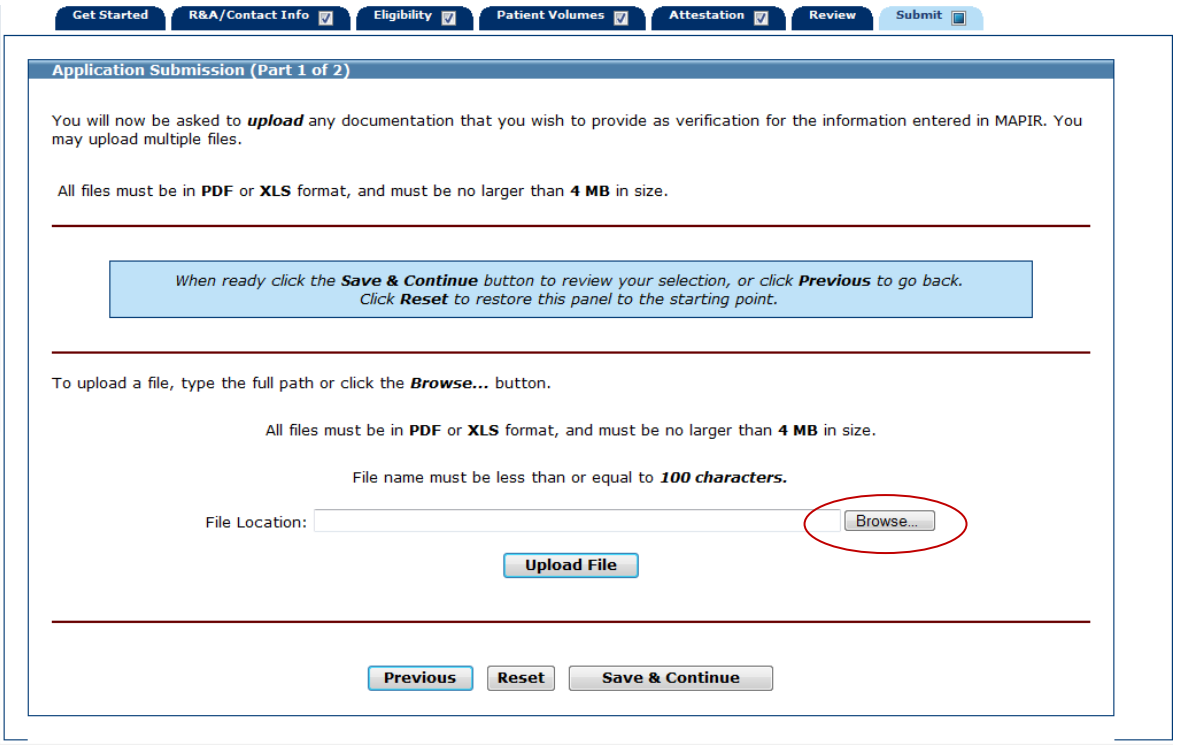
Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.



Remember - You are **required** to upload documentation supporting your application. This will include your Eligible Hospital Patient Volume and Incentive Payment Calculator and the supporting AIU documentation. **The documents listed in Appendix A are acceptable for verifying AIU.**

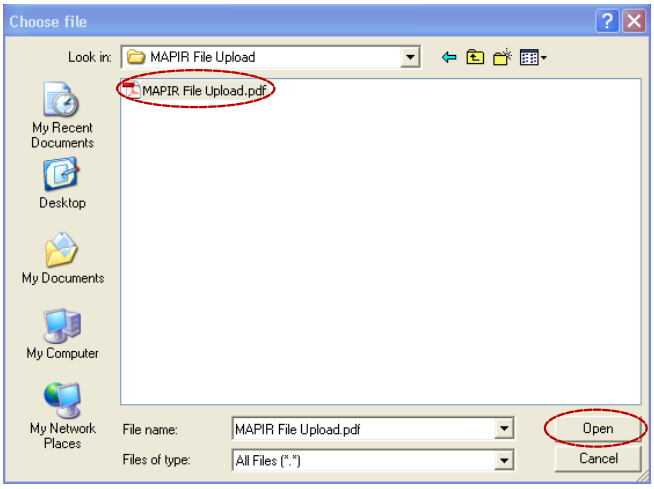
To upload files click **Browse** then select the file(s) you wish to upload from your computer.

Note: *Only files that are in portable data (.pdf) or excel (.xls or .xlsx) format and a maximum of 4 (MB) megabytes each in size may be uploaded.*



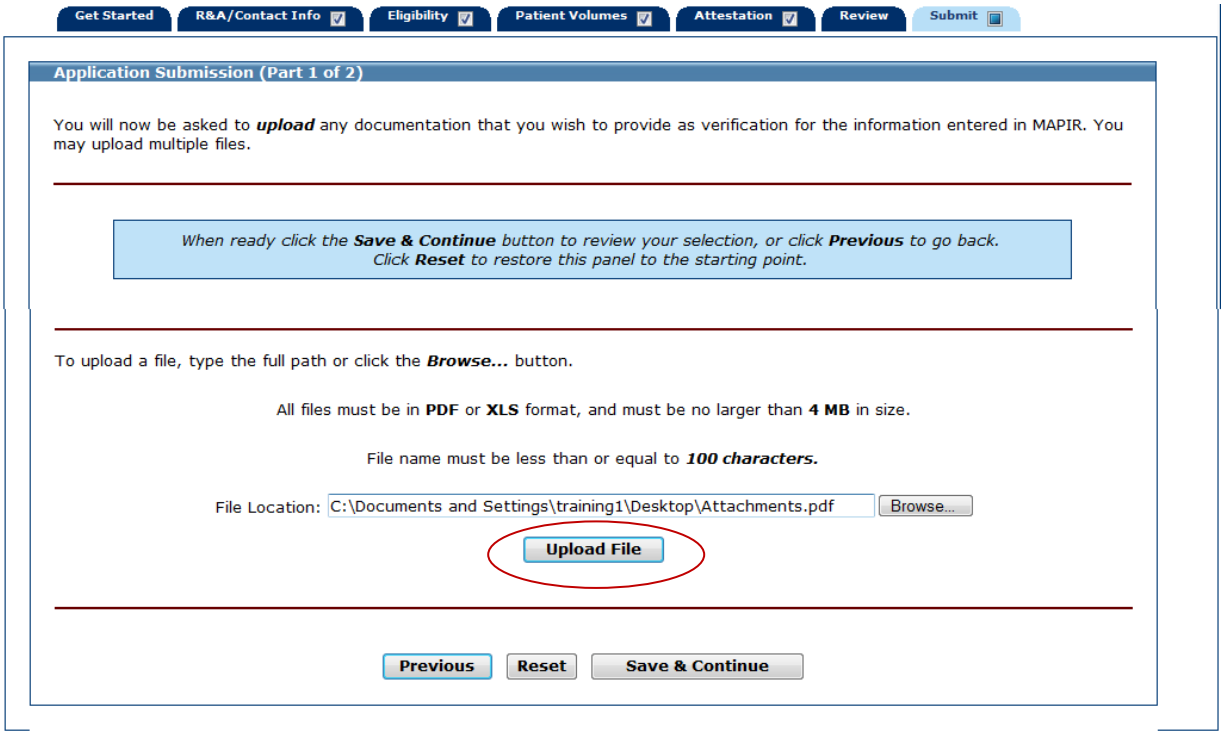
The **Choose file** dialog box will display.

Navigate to the file you want to upload and select **Open**.


Choose file
Look in:
MAPIR File Upload
MAPIR File Upload.pdf
My Recent Documents
Desktop
My Documents
My Computer
My Network Places
File name:
MAPIR File Upload.pdf
Files of type:
All Files (*.*)
Open
Cancel

Check the file name in the file name box.

Click **Upload File** to begin the file upload process.



Note the *"File has been successfully uploaded"* message.

Review the uploaded file list in the Uploaded Files box.

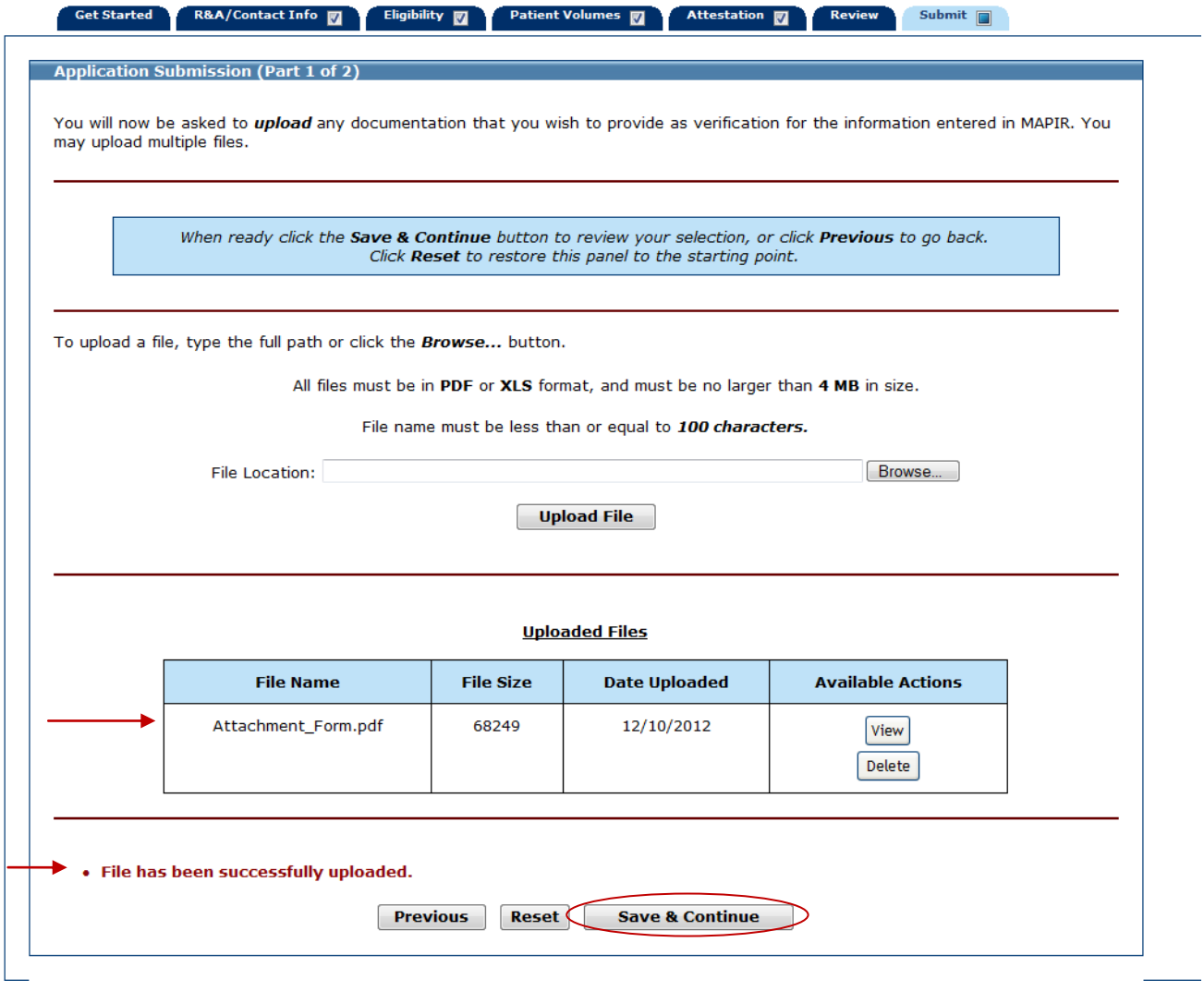
If you have more than one file to upload, repeat the steps to select and upload a file as many times as necessary.

All of the files you uploaded will be listed in the **Uploaded Files** section of the screen.

To delete an uploaded file click the **Delete** button in the Available Actions column.

Click **Save & Continue** to review your selection, **Previous** to return, or **Reset** to clear all unsaved data.

Failure to upload Patient Volume and Incentive Payment Calculator and supporting AIU documentation will result in denial of the application.



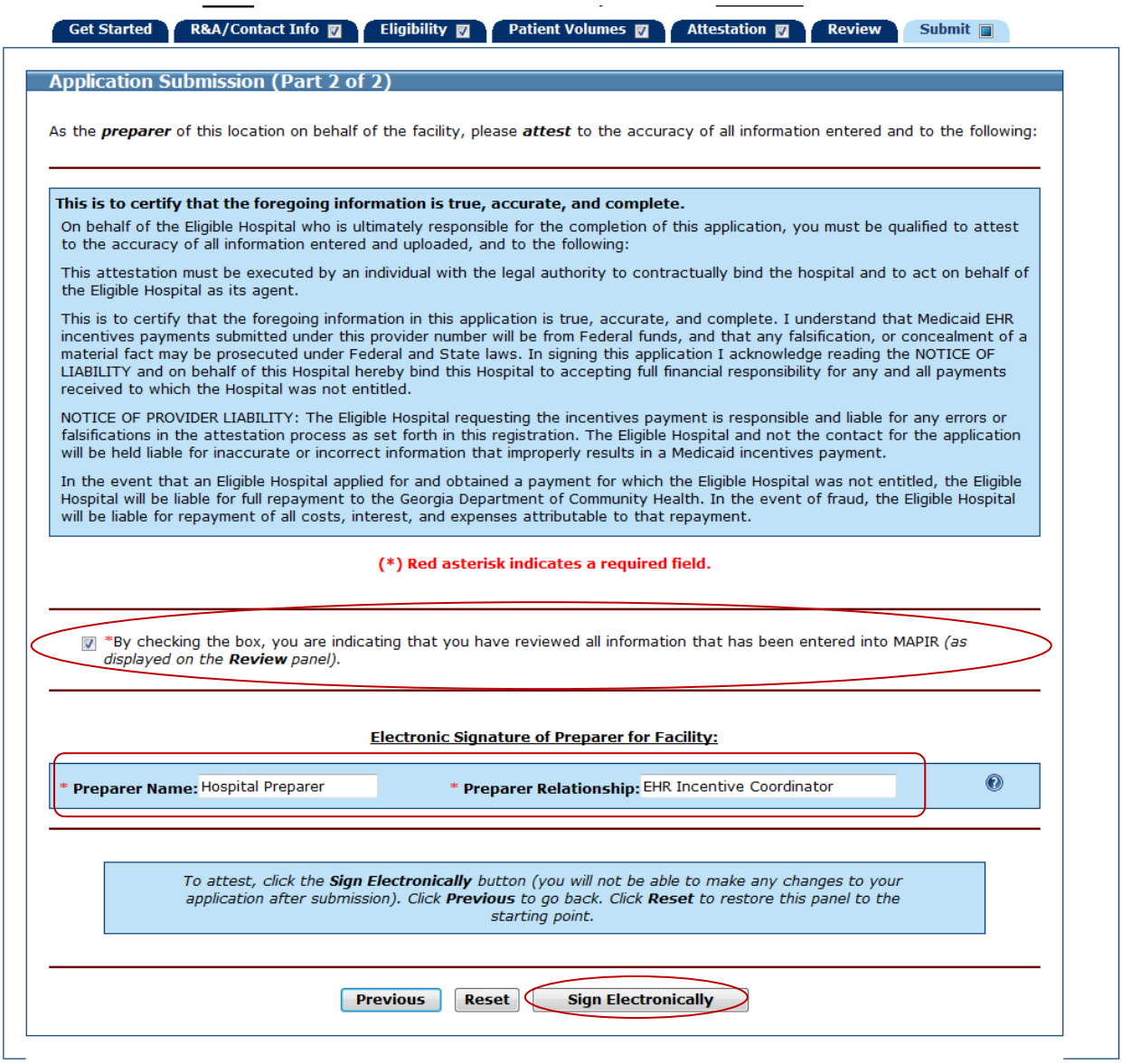
This screen depicts the Preparer signature screen.

Click the check box to indicate you have reviewed all information.

Enter your **Preparer Name** and **Preparer Relationship.**

Click **Sign Electronically** to proceed.

Click **Previous** to go back. Click **Reset** to clear all unsaved data.



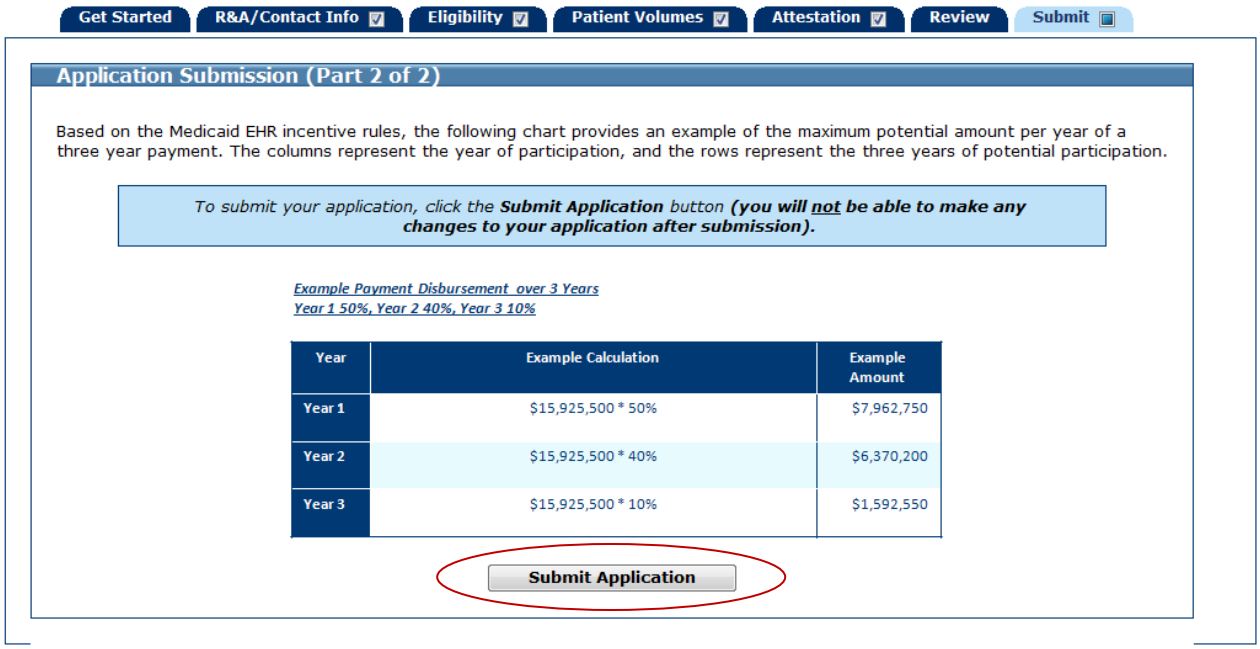
Your actual incentive payment will be calculated and verified by DCH. This screen shows **that** Georgia has opted to disburse the total incentive payment over a three year period:

- Payment Year One – 40%
- Payment Year Two – 40%
- Payment Year Three – 20%

No information is required on this screen.

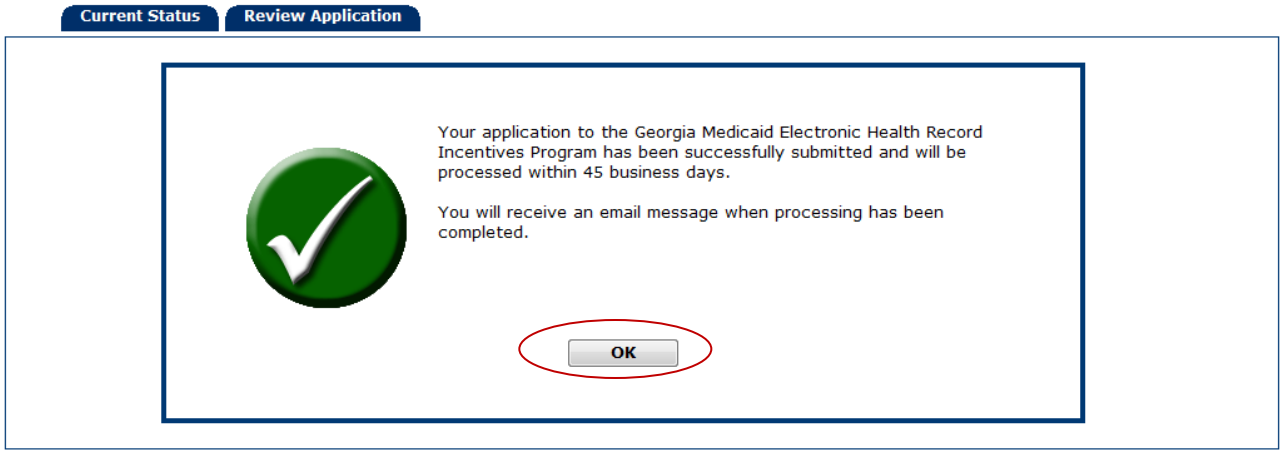
*Note: This is the final step of the Submission process. You will not be able to make any changes to your application after clicking the **Submit Application** button. If you do not want to submit your application at this time you can click Exit, and return at any time to complete the submission process.*

To submit your application, click **Submit Application** at the bottom of this screen.



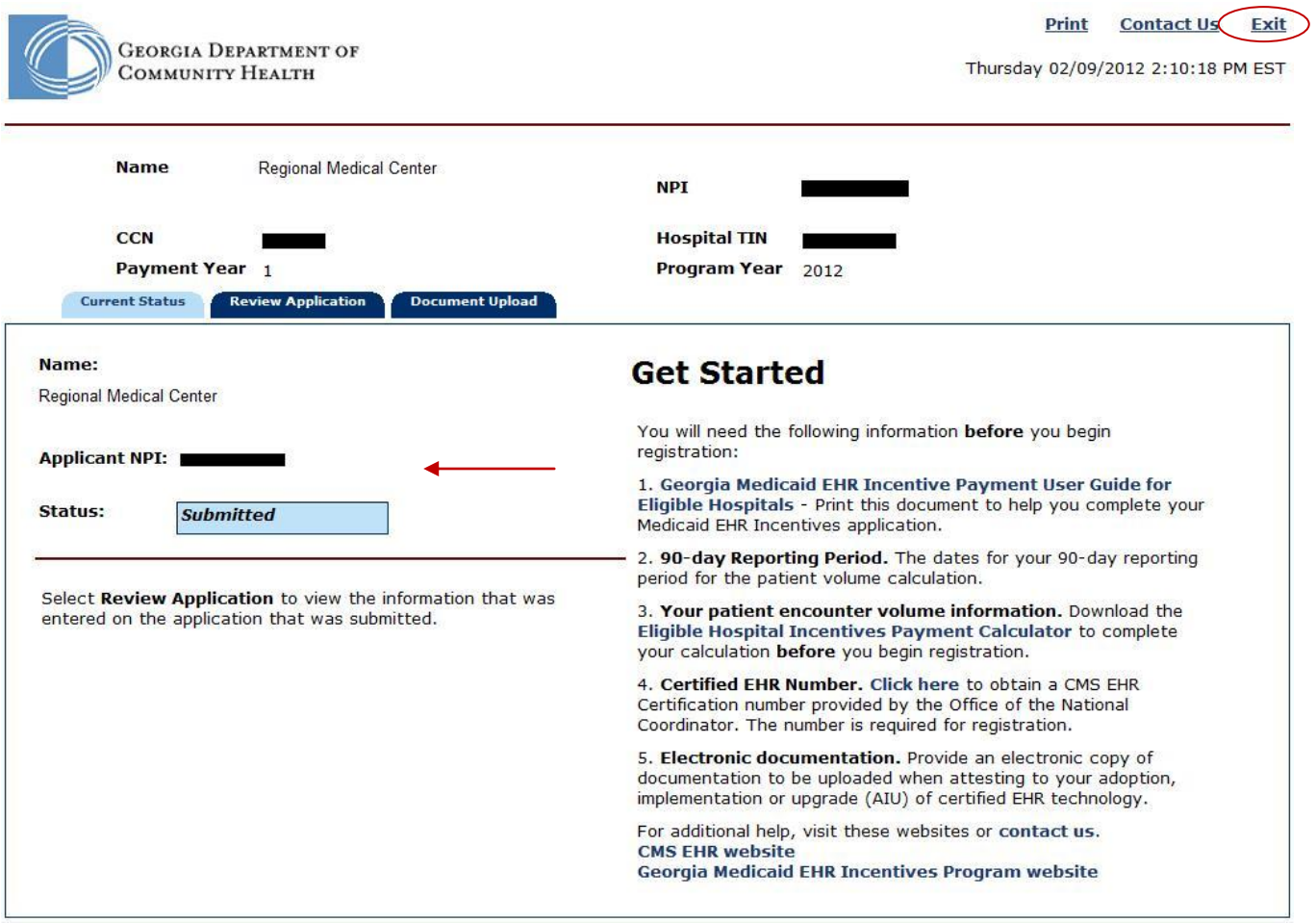
The check indicates your application has been successfully submitted.

Click **OK**.

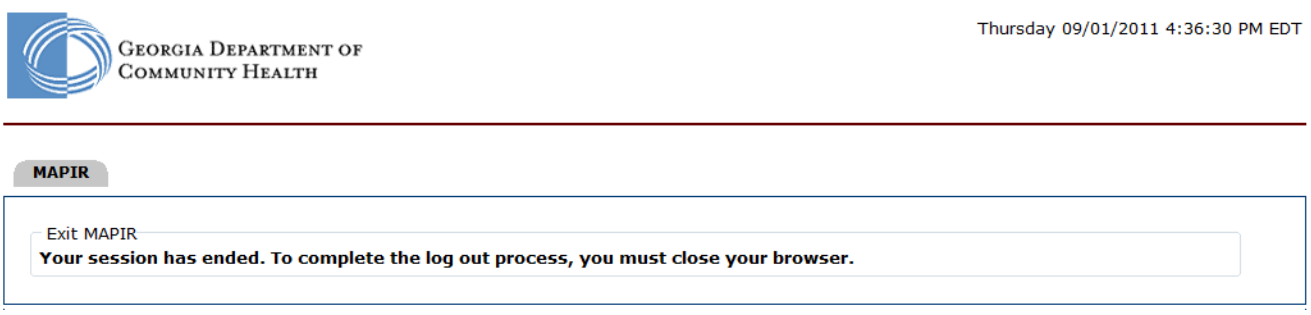


When your application has been successfully submitted, you will see the application status will change to **Submitted**.

Click **Exit** to exit MAPIR.



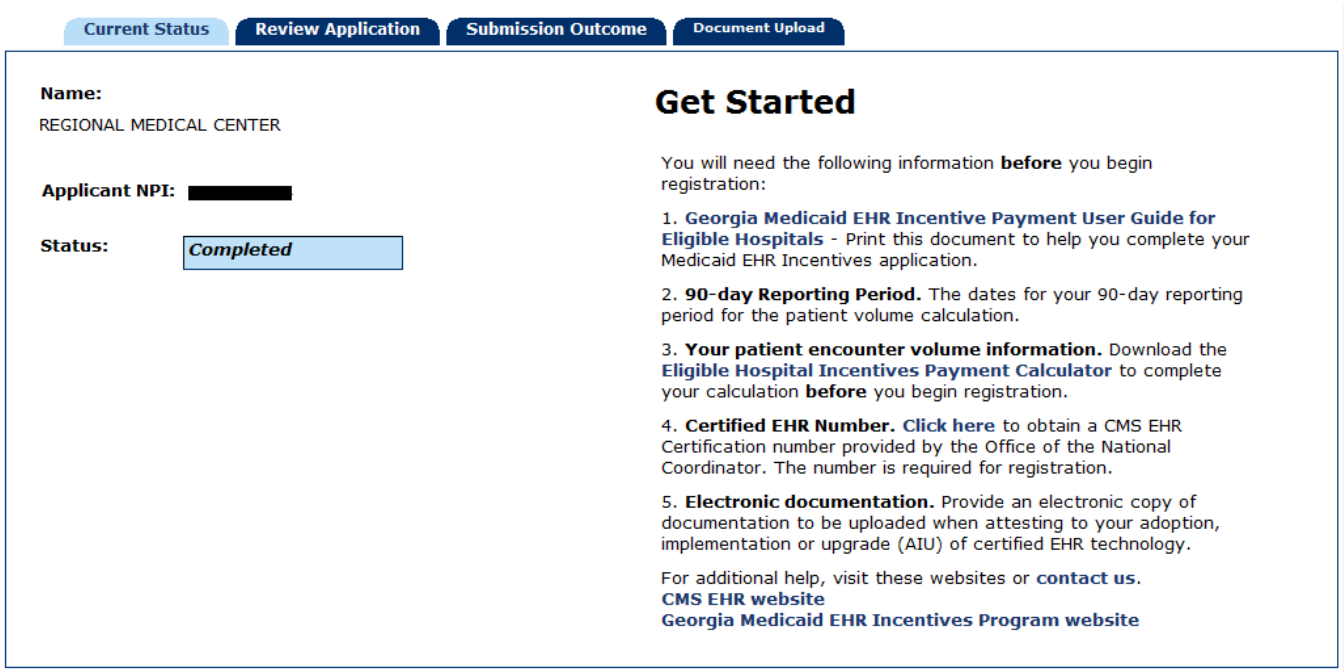
This screen shows that your MAPIR session has ended. You should now close your browser window.



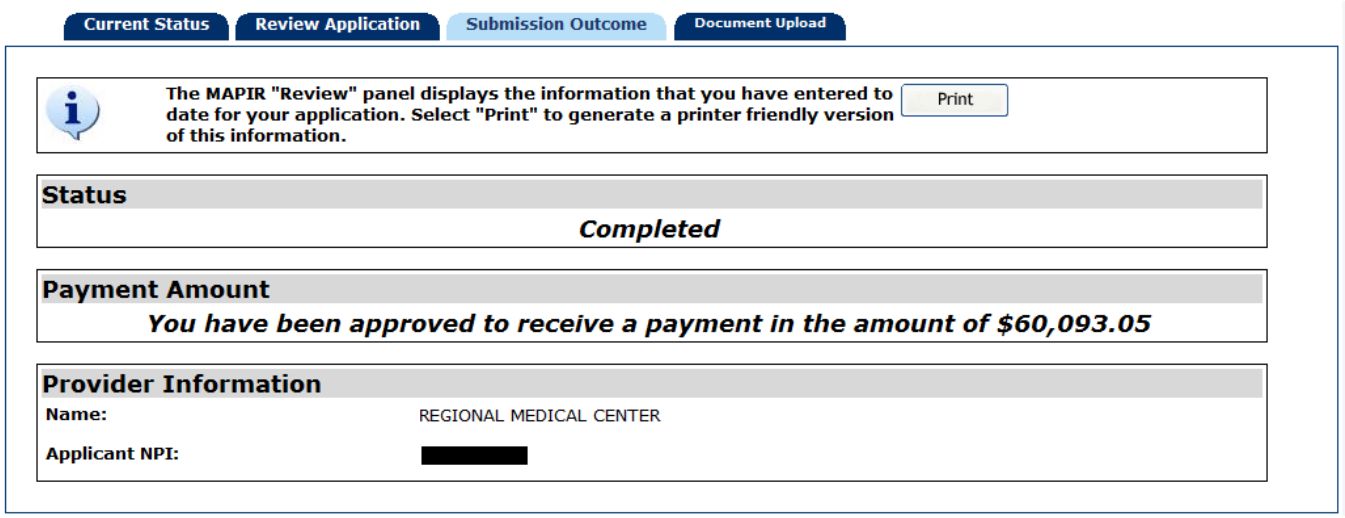
Post Submission Activities

When you have successfully completed the application submission process you will receive an email confirming your submission has been received by DCH. This section contains information about post-application submission activities. At any time you can check the status of your application by accessing MAPIR through the Georgia Web portal. You may also receive email updates from DCH as your application is processed. The screen below shows an application in a status of Completed. You can click the **Review Application** tab to review your application; however, you will not be able to make changes.

If your application is in a Submitted, Pended for Review, or a Completed status, you will have the option to upload additional documentation on the Document Upload tab; however, if your application is not in one of the statuses previously mentioned, the Document Upload tab will not display.



Once your application has been processed by DCH, you can click the **Submission Outcome** tab to view the status of your application.



AIU Document Requirements

Appendix A

Adoption, Implementation and Upgrade (AIU) Documentation Requirements for Eligible Hospitals

Eligible Professionals and Eligible Hospitals are required, as part of the state level registration and attestation process, to furnish evidence that verifies the adoption, implementation or upgrade (AIU) of certified Electronic Health Record (EHR) technology by uploading documents supporting AIU. The following is a list of documentation that will be acceptable for verifying AIU.

Adoption

The provider must furnish clearly dated documentation demonstrating the acquisition of or the intent to acquire *certified EHR technology*. Eligible Professionals and Eligible Hospitals must submit any of the following documents relating to the certified EHR technology to satisfy this requirement:

- Receipts from EHR software vendors
- Executed sales contract for software and/or hardware
- Purchase order
- Software licensing agreement
- Service performance agreement

In addition, documentation must be provided to show the CMS EHR certification ID provided during state level attestation. This certification ID will be validated against the Office of the National Coordinator (ONC) Certified HIT Product List (CHPL).

Implementation

The provider must furnish proof of adoption with one of the acceptable documents listed above *plus* evidence of costs associated with the implementation of *certified* EHR technology. Costs associated with the implementation of certified EHR can be incurred through various activities. The provider must submit documentation supporting any of the following implementation activities to satisfy this requirement:

- Evidence of adoption of certified EHR technology (see requirements above) **and** one of the following:
- Evidence of costs for installation of certified EHR technology
- Data use agreements pertaining to the certified EHR technology
- Evidence of costs associated with staff training support or staff support to implement certified EHR technology, including a contract if applicable
- Documented costs associated with workstation or physical plant re-design for the implementation of certified EHR technology
- For Eligible Hospitals (EHs), cost reports reflecting implementation expenses relating to the certified EHR technology. EHs must indicate in which Cost Center(s) on Worksheet A the implementation costs are included.

Upgrade

The provider must furnish clearly dated documentation for upgrading currently certified technology **or** upgrading from non-certified to *certified EHR technology*.

Eligible Professionals and Eligible Hospitals must submit any of the following documents relating to certified EHR technology to satisfy this requirement:

- Receipts from EHR software vendors
- Executed sales contract for software and/or hardware
- Purchase order
- Software licensing agreement
- Service performance agreement

Documentation must be provided to show the CMS EHR certification ID provided during state level attestation. This certification ID will be validated against the Office of the National Coordinator (ONC) Certified HIT Product List (CHPL).

In addition, other reasonable substantiating documents that reflect expenses incurred for AIU of certified EHR technology may also be acceptable.

Retention of AIU Documentation

Documentation submitted is considered auditable and must be retained by providers for auditing purposes. All Eligible Professionals and Eligible Hospitals must retain all such documentation for a minimum period of six (6) years from the date of an approved application that resulted in a Medicaid EHR incentive payment. With respect to applications for incentive payments submitted in subsequent program years, all providers must retain their supporting documentation for a minimum period of six (6) years from the date of an approved application that resulted in a Medicaid EHR incentive payment.

Any provider's failure to retain requisite documentation for review by the Department of Community Health or independent auditors for the six (6) year period may result in an adverse action against a provider, including, but not limited to, recoupment of incentive payments and sanctions.

Acronyms and Terms for Eligible Hospitals

Appendix B

Acute Care Hospital - means a health care facility including Critical Access Hospitals:
- Where the average length of patient stay is 25 days or fewer; and
- With a CMS Certification Number (previously known as the Medicare provider number) that has the last four digits in the series 0001–0879 or 1300–1399

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

CCN – CMS Certification Number.

Children's Hospital - means a separately certified children's hospital, either freestanding or hospital-within hospital that:

- Has a CMS Certification Number, (previously known as the Medicare provider number), that has the last 4 digits in the series 3300–3399; and
- Predominantly treats individuals less than 21 years of age.

CHIP – Children's Health Insurance Program

CHPL –Certified Health IT Product List maintained by the ONC.

CMS – Centers for Medicare and Medicaid Services

EHR – Electronic Health Record as defined by the Health Information Technology for Economic and Clinical Health Act (HITECH ACT)

MAPIR – The Medical Assistance Provider Incentive Repository is a software tool for processing Georgia's Medicaid EHR Incentive applications submitted by Eligible Professionals and Eligible Hospitals.

Medicaid Encounter for an Eligible Hospital – means services rendered to an individual per patient discharge or services rendered to an individual in an emergency room on any one day where:
- Medicaid paid for part or all of the service; or
- Medicaid paid all or part of the individual's premiums, copayments, and cost-sharing.

MMIS - Medicaid Management Information System is the electronic Medicaid claims payment system.

MMIS Web Portal - is the Web Portal solution that provides communication, data exchange, and self-service tools to the provider community. The web portal consists of both public and secure areas. Access to the secure area of the web requires a username and password. The secure area offers access to the state level registration tool, known as MAPIR.

NPI – National Provider Identifier is a ten digit number unique to each health care provider.

ONC – Office of the National Coordinator for Health Information Technology

R&A –Medicare and Medicaid EHR Incentive Program Registration and Attestation System maintained and controlled by CMS.

TIN – Tax Identification Number

Appeals Process

Appendix C

Georgia Medicaid Electronic Health Record (EHR) Incentive Program

I. *Appeals Generally*

The Commissioner of the Department of Community Health (DCH) shall appoint the Administrative Hearing Officer(s) for the Medicaid EHR Incentive Program appeal process. The appeals shall generally conform to and be comparable with the process and procedures for Georgia Medicaid provider appeals as set forth in O.C.G.A. § 49-4-153 (b) (3), O.C.G.A. § 50-13-19 and in accordance with 42 C.F.R. § 495.370 and 42 C.F.R. § 447.253 (e). A provider's failure to comply with the requirements set forth in the appeal process below will result in the provider's waiver of appellate rights.

II. *Initial Administrative Review*

1. (a) A provider shall file a Request for Initial Administrative Review of the decision to deny eligibility for an incentive payment, the decision as to the amount of an incentive payment, or suspension or termination from the program within thirty (30) calendar days from the date of such decision by submitting a written Request for Initial Administrative Review to the following address:

   Georgia Department of Community Health
   DCH Medicaid EHR Incentive Program
   Request for Initial Administrative Review
   2 Peachtree Street, N.W., 32nd Floor
   Atlanta, Georgia 30303

   (b) Any appeal of an action for recoupment of Medicaid incentive funds initiated by the Office of Inspector General will be handled in accordance with the procedures set out in Part 1, Policies and Procedures for Medicaid/PeachCare for Kids™, Chapter 500.

2. After review by Medicaid EHR Incentive Program staff of the Request for Initial Administrative Review, DCH will issue an Initial Administrative Review Determination in writing within thirty (30) calendar days from the date of receipt of the Request for Initial Administrative Review. In the rare event that DCH needs an extension of time before issuing this determination, DCH is authorized an additional period of time not to exceed thirty (30) calendar days. In addition, if Medicaid Incentive EHR Program staff requests additional information from the provider, then the time for issuing the Initial Administrative Review Determination shall be extended thirty (30) calendar days after receipt of the complete additional information so requested. The failure of the Medicaid EHR Incentive Program staff to issue an Initial Administrative Review Determination within the time period allowed shall constitute an automatic affirmance of the original decision. Thereafter, the provider may file a Request for Hearing.

III. *Review by an Administrative Hearing Officer*

1. A provider who is dissatisfied with the Initial Administrative Review Determination shall have thirty (30) calendar days from the date of the Initial Administrative Review Determination to file a Request for Hearing. The hearing will be conducted by an Administrative Hearing Officer in Atlanta at the headquarters of DCH. The issues for appeal of the Initial Administrative Review Determination regarding the Medicaid EHR Incentive Program include the following:

   a. Denial of incentive payments
   b. Incentive payment amounts
   c. Provider eligibility determinations

d. The demonstration of adopting, implementing, upgrading certified EHRs, and meaningful use eligibility for incentive payments under this program
e. The sufficiency of the documentation submitted with the application for payment
f. Other adverse actions including, but not limited to, termination or suspension

2. The provider's Request for Hearing shall be filed with the Commissioner at the following address:

Georgia Department of Community Health
Office of the Commissioner
Medicaid EHR Incentive Program Hearing Request
2 Peachtree Street, N.W., 40th Floor
Atlanta, Georgia 30303

3. An Appeal Hearing shall be scheduled within thirty (30) calendar days from the date upon which the Commissioner receives the Request for Hearing. The Request for Hearing filed by the provider must include all issues and justification for reversing the Initial Administrative Review Determination. The provider (whether an individual or an entity) shall have an opportunity to challenge the determination of the DCH Medicaid EHR Incentive Program by submitting documents or data or both to support the provider's claim(s) when filing a Request for Hearing. The provider shall also include an explanation of each and every claim including a statement explaining why the provider believes that the Initial Administrative Review Determination is wrong and a concise statement of the relief sought. If, in the opinion of the Administrative Hearing Officer, the Request for Hearing is not accompanied by the required supporting documentation, data, or proper explanation of the claim(s), the Administrative Hearing Officer will afford the provider ten (10) additional calendar days to provide the incomplete information. The provider's failure to timely submit the information requested by the Administrative Hearing Officer shall result in dismissal of the Request for Hearing and shall terminate any further review.

4. In cases involving an audit of a provider, any documentation submitted with either a Request for Initial Administrative Review or Request for Hearing may, at DCH's sole discretion, toll the time frame set out herein, to allow adequate time to re-audit the provider or for a referral to the Program Integrity Unit for the purpose of consideration of the newly submitted documentation. Such determination shall be made by the Initial Reviewer or the Administrative Hearing Officer in writing.

5. Failure to comply with the procedural requirements of the Initial Administrative Review and/or a Request for Hearing set out herein, including the requirement to timely submit necessary documentation, data or proper explanation shall constitute a waiver of any and all further appeal rights, including the right to an administrative hearing and/or judicial review.

6. The Initial Administrative Review process must be completed in order for a provider to be entitled to file a Request for Hearing.

7. The Administrative Hearing Officer shall render the written Final Administrative Decision of DCH as soon as practical after the completion of the hearing and the close of the record. Failure of the Administrative Hearing Officer to issue a Final Administrative Decision within ninety (90) calendar days of the close of the record shall constitute an affirmance of the Initial Administrative Review Decision. If the Administrative Hearing Officer requests additional information from the provider then the time for issuing the Final Administrative Decision shall be extended to be thirty (30) calendar days after receipt of the complete information so requested. Thereafter, the provider may seek judicial review as authorized by law.

IV. *Judicial Review*

Any provider who has exhausted all administrative remedies within DCH as set forth above and who is aggrieved by the Final Administrative Decision may seek judicial review in accordance with the provisions of O.C.G.A. § 50-13-19.

Getting Help

Appendix D

Where can an Eligible Hospital get technical assistance?

For smaller and rural hospitals, the Georgia Health Information Technology Extension Center (GA-HITEC) provides education, outreach and technical assistance in selecting, implementing and using health information technology to improve the quality and value of health care. For more information, visit the GA-HITEC website at http://ga-hitec.org or call toll free: 1-877-658-1990.

The CMS Electronic Health Record (EHR) Information Center is now open to assist the Provider Community with inquiries. Hours of Operation are from 8:30 a.m. – 7:30 p.m. (ET), Monday through Friday, except federal holidays. The main telephone number is 1-888-734-6433 or 1-888-734-6563 for TTY callers.

What if our hospital has additional questions not covered here?

- For more information about the Medicare and Medicaid EHR Incentive Programs, please visit http://www.cms.gov/EHRIncentivePrograms
- http://www.dch.georgia.gov/ehr

Can't find the answer to your question? Email us at hp.mapir.outreach@hp.com

Application Status

Appendix E

The following table lists some of the statuses your application may go through.

Status	Definition
Not Registered at R&A	MAPIR has not received a matching registration from both the R&A and the state MMIS.
Incomplete	The application is in a working status but has not been submitted and may still be updated by the provider.
Submitted	The application has been submitted. The application is locked to prevent editing and no further changes can be made.
Payment Approved	A determination has been made that the application has been approved for payment.
Payment Disbursed	The financial payment data has been received by MAPIR and will appear on your remittance advice.
Partial Recoupment Received	An adjustment has been requested and the total amount has not been recouped.
Partial Remittance Received	An adjustment has been processed and a partial recoupment has been made and will appear on your remittance advice.
Aborted	When in this status, all progress has been eliminated for the incentive application and the application can no longer be modified or submitted.
Appeal Initiated	An appeal has been lodged with the proper state authority by the provider.
Appeal Approved	The appeal has been approved.
Appeal Denied	The appeal has been denied.
Denied	A determination has been made that the provider does not qualify for an incentive payment based on one or more of the eligibility rules.
Completed	The application has run a full standard process and completed successfully with a payment to the provider.
Cancelled	An application has been set to “Cancelled” status only when R&A communicates a registration cancellation to MAPIR. MAPIR cancels both the registration and any associated application.
Future	This is a status that will be displayed against any application to indicate the number of future applications that the provider can apply for within the EHR Incentive Program.
Not Eligible	This is a status that will be displayed against any application whenever the provider has exceeded the limits of the program timeframe.
Not Started	This is a status that will be displayed against any application whenever the provider has not started an application but MAPIR received an R&A registration and has been matched to an MMIS provider.
Expired	An application is set to an “Expired” status when an application in an “Incomplete” status has not been submitted within the allowable grace period for a program year or when an authorized admin user changes an application to this status after the end of the grace period. Once an application is in an Expired status, the status cannot be changed and it is only viewable to the provider.