



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Eligible Hospitals User Guide for the Georgia Medicaid EHR Incentive Program

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Document Control

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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.
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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 MAPIR 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.

The screenshot displays the Georgia Web Portal interface. At the top, it features the Georgia Department of Community Health logo on the left, the 'GEORGIA WEB PORTAL' text in the center, and the 'GEORGIA HEALTH PARTNERSHIP' logo on the right. A search bar is located in the top right corner. Below the header, a navigation menu includes links for Home, Contact Information, Member Information, Provider Information, Provider Enrollment, Nurse Aide, EDI, and Pharmacy. A blue banner indicates a session refresh and a 19-minute timeout. A date stamp shows Friday, August 26, 2011. A prominent alert message titled 'Scheduled Site Maintenance' is displayed, explaining that users may experience downtime and providing a table of maintenance windows. Below the alert, a 'User Information' section contains a 'Login/Manage Account' link and a 'Login' button, which is circled in red. The main content area is divided into several sections: 'Members' with links for 'Register for Secure Access' and 'Member Information'; 'Providers' with links for 'PIN Activation' and 'Provider Information'; 'Upcoming Events' with a notice about HP Enterprise Services as the new Fiscal Agent for Georgia Medicaid; 'Web Portal Overview' with a detailed description of the portal's public and secure areas; and 'Surveys' with a link to complete a survey about the automated phone system. At the bottom, there are links for 'English | Español | Accessibility | Privacy | AIAA & ADA Copyright', a 'REPORT FRAUD' logo, and a copyright notice for Hewlett-Packard Development Company, L.P.

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.

The screenshot shows the Georgia Department of Community Health Web Portal. At the top, there are logos for the Georgia Department of Community Health, Georgia Web Portal, and Georgia Health Partnerships. Below the logos, there is a welcome message and a search bar. The main navigation menu includes links for Home, Contact Information, Member Information, Provider Information, Provider Enrollment, Nurse Aide, EDI, and Pharmacy. A secondary menu includes Home, Secure Home, Demographic Maintenance, Procedure Search, EOB Search, and MAPIR Registration. The 'User Information - Provider' section is active. The 'Medical Assistance Provider Incentive Repository (MAPIR) Information' section contains instructions on how to access the MAPIR application. A red circle highlights the link 'Click here to access MAPIR' in the 'Access MAPIR' section. Below this, there are sections for 'PDF Reader Required' and 'File Download Issues'. At the bottom, there is a 'MAPIR Manuals (0 rows returned)' section with the message '*** No rows found ***'. The footer includes links for English, Español, Accessibility, Privacy, and AMA & ADA Copyright, along with a 'REPORT FRAUD' button and copyright information for Hewlett-Packard Development Company, L.P.

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

The screenshot shows a form for entering the R&A Application Confirmation Number. The form is titled 'Please enter your R&A Application Confirmation Number:' and features a text input field. A red circle highlights the input field. Below the input field is a 'Submit' button. The Georgia Department of Community Health logo is visible in the top left corner of the form area.

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**.



[Print](#) [Contact Us](#) [Exit](#)
 Wednesday 02/08/2012 10:59:27 AM EST

MAPIR

Medicaid EHR Incentive Program Participation Dashboard

NPI ██████████ TIN ██████████

CCN ██████████

(* Red asterisk indicates a required field.)

*Application (Select to Continue)	Status	Payment Year	Program Year	Incentive Amount	Available Actions
<input type="radio"/>	Expired	1	2011	\$0.00	Select the "Continue" button to view this application.
<input type="radio"/>	Not Started	1	2012	Unknown	Select the "Continue" button to begin this application.
<input type="radio"/>	Future	2	Future	Unknown	None at this time
<input type="radio"/>	Future	3	Future	Unknown	None at this time

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.

The screenshot shows the MAPIR application interface. At the top left is the Georgia Department of Community Health logo. At the top right are links for "Contact Us" and "Exit", and the date/time "Wednesday 02/08/2012 11:10:31 AM EST". Below this is a header with "Payment Year 1" and "Program Year 2012". A "MAPIR" tab is visible. The main content area displays the following information:

- Name:** Regional Medical Center
- Applicant NPI:** [Redacted]
- Status:** Not Started

Below the application details is an **IMPORTANT:** notice:

The MAPIR application **must** be completed by the **actual** Provider or by an authorized preparer. In some cases, a provider may have more than one Internet/Portal account available for use. Once the MAPIR application has been started, it must be completed by the same Internet/Portal account.

To access MAPIR to apply for Medicaid EHR Incentive Payment Program under a different Internet/Portal account, select **Exit** and log on with that account.

To access MAPIR using the current account, select **Get Started**. All application for previous years will be re-associated with the current account and the previous user account will lose access to these applications.

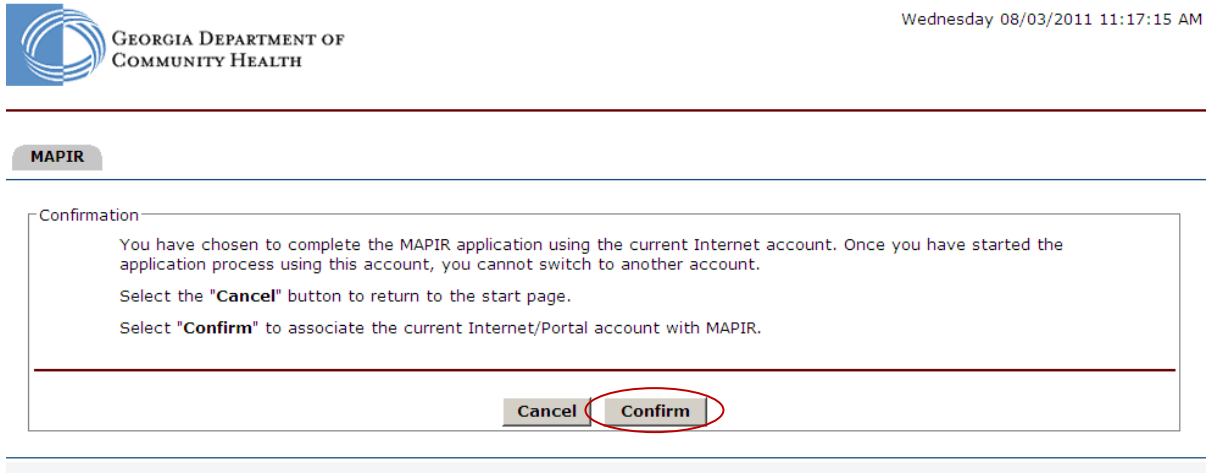
At the bottom of the screen, there are two buttons: "Exit" and "Get Started". The "Get Started" button is circled in red.

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.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Wednesday 08/03/2011 11:17:15 AM

MAPIR

Confirmation

You have chosen to complete the MAPIR application using the current Internet account. Once you have started the application process using this account, you cannot switch to another account.

Select the "**Cancel**" button to return to the start page.

Select "**Confirm**" to associate the current Internet/Portal account with MAPIR.

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.



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

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.

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



Registration and Attestation and Contact Information

Within 48 hours of your successful registration in the CMS EHR Registration and Attestation (R&A) System, CMS electronically notifies Georgia that you intend to register for the Georgia Medicaid EHR Incentives Program.

IMPORTANT: You must verify the accuracy of information displayed within this section. If you find any errors or discrepancies, you must return to the CMS EHR (R&A) System to make changes to information before you can continue with the Georgia registration process.

Any changes you make to your information in the CMS system will be updated in the Georgia MAPIR application within 24-48 hours.

Only the assigned user can make changes to the data

Begin

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.

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

R&A Verification

We have received the following information for your NPI from the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A). Please specify if the information is accurate by selecting Yes or No to the question below.

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

Legal Business Name	REGIONAL MEDICAL CENTER	Hospital NPI	██████████
CCN	██████████	Hospital TIN	██████████

Business Address ██████████ AVE
WAYCROSS, GA 31501-5246

Business Phone ██████████

Incentive Program	MEDICAID	Deemed Medicare Eligible	State	GA
-------------------	----------	--------------------------	-------	----

Eligible Hospital Type Acute_Care_Hospitals

R&A Registration ID ██████████

R&A Registration Email Address gamapir@hpx.com

CMS EHR Certification Number ██████████

(*) Red asterisk indicates a required field.

* Is this information accurate? Yes No

Previous **Reset** **Save & Continue**

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.**

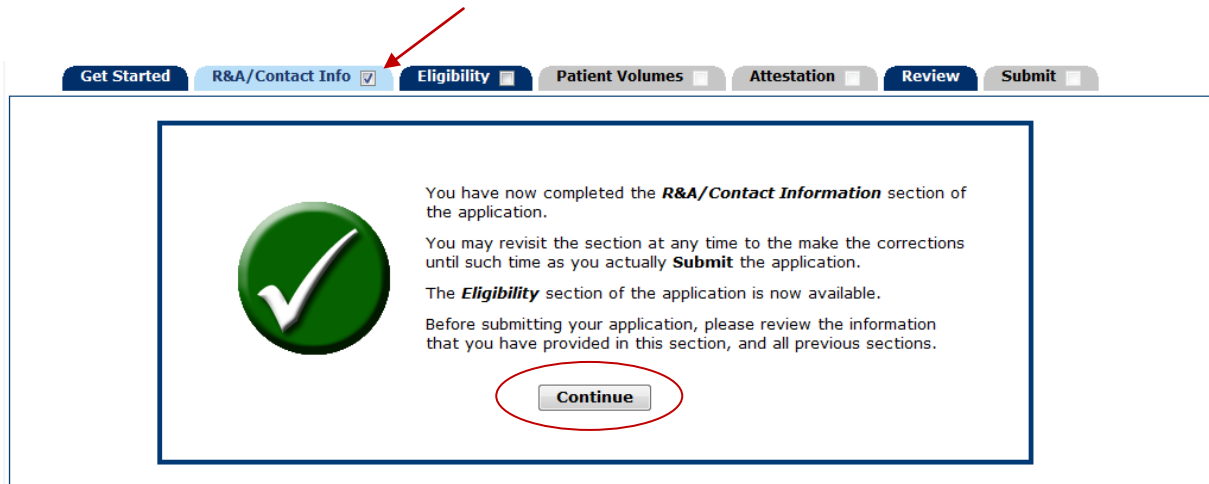
Click **Save & Continue** to proceed, **Previous** to return, or **Reset** to clear all unsaved data.

The screenshot shows a web application interface with a navigation bar at the top containing buttons for 'Get Started', 'R&A/Contact Info', 'Eligibility', 'Patient Volumes', 'Attestation', 'Review', and 'Submit'. The 'R&A/Contact Info' button is active. Below the navigation bar is a section titled 'Contact Information' with a blue header. The main content area contains the following text: 'Please enter your contact information. All email correspondence will go to the email address entered below. The email address, if any, entered at the R&A will be used as secondary email address. If an email address was entered at the R&A, all email correspondence will go to both email addresses.' Below this is a blue instruction box: 'When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point.' A red asterisk note states: '(*) Red asterisk indicates a required field.' The form fields are: '*Contact Name' with the value 'Jane Doe'; '*Contact Phone' with values '303', '555', and '4748' in separate boxes and an 'Ext' box; and '*Contact Email Address' with two identical boxes containing 'jdoe@mapir.com'. At the bottom of the form are three buttons: 'Previous', 'Reset', and 'Save & Continue', with the 'Save & Continue' button circled in red.

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.

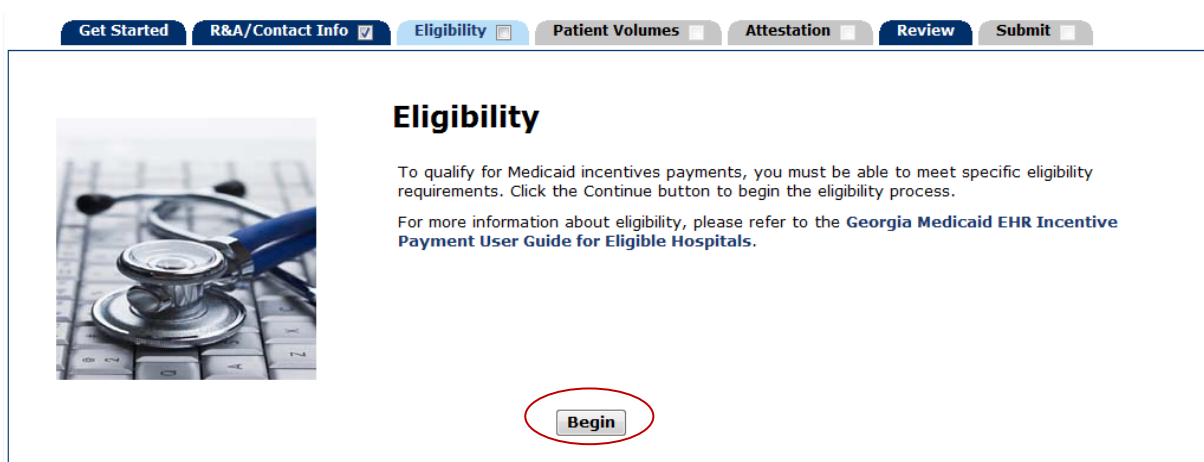
Click **Continue** to proceed to the **Eligibility** section.



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.

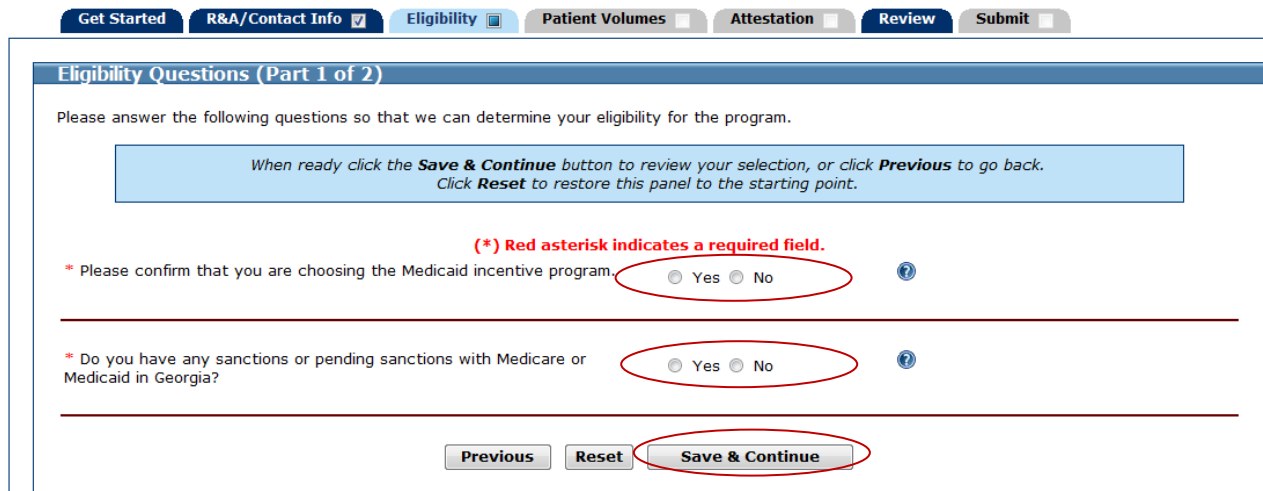
Click **Begin** to proceed to the **Eligibility Questions (Part 1 of 2)**.



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>)

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

Eligibility Questions (Part 2 of 2)

The EHR Incentive Payment Program requires the use of technology certified for this program. Please enter the CMS EHR Certification ID that you have obtained from the ONC Certified Health IT Product List (CHPL) website. Click [here](#) to access the CHPL website. You must enter a valid certification number.

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.

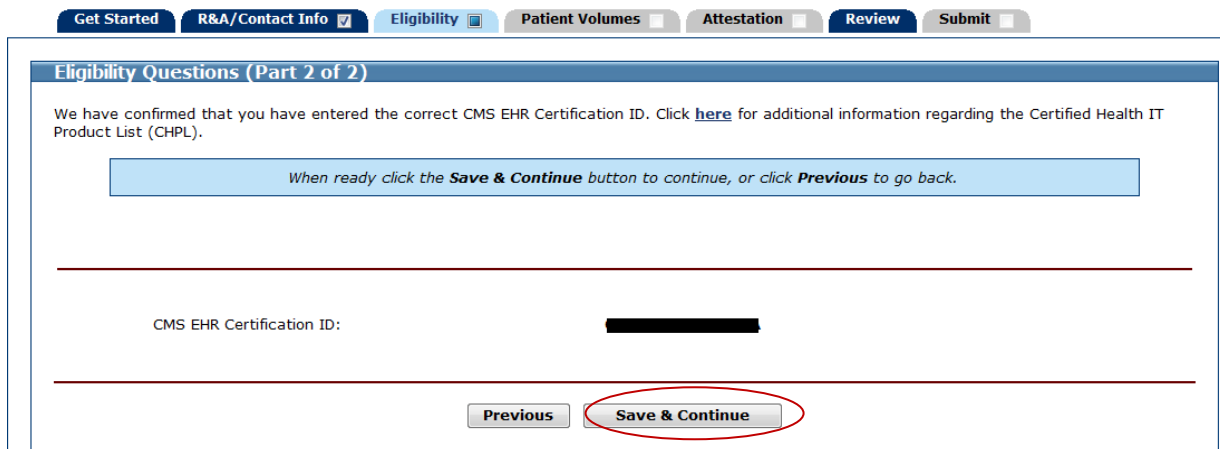
*Please enter the 15 character CMS EHR Certification ID for the Complete EHR System:

(No dashes or spaces should be entered.)

Previous Reset Save & Continue

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

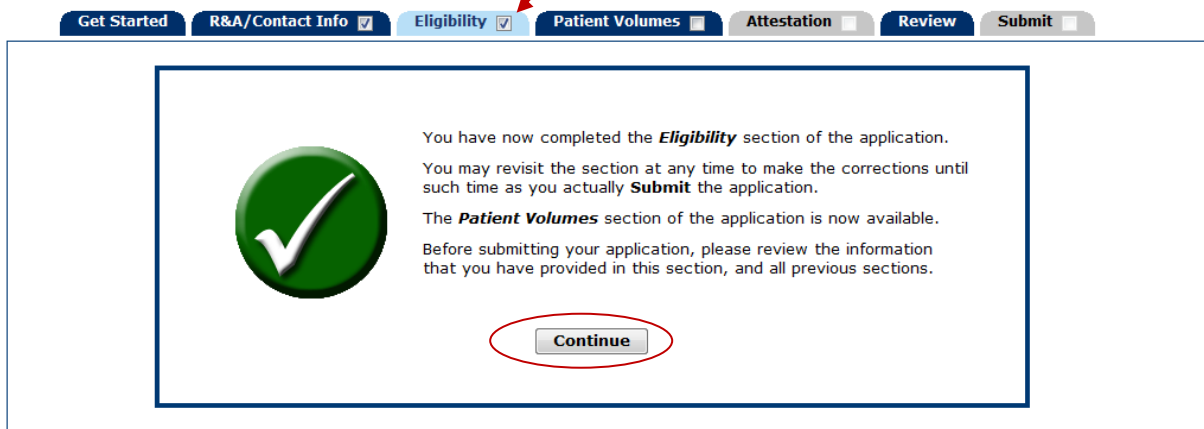
Click **Save & Continue** to proceed or **Previous** to return.



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.

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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.

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Patient Volume (Part 1 of 3) – 90 Day Reporting Period

If applying as an Acute Care hospital, you must demonstrate that you serve the Medicaid population to participate. The continuous 90 day volume reporting period may be from either the last completed fiscal year preceding the payment year or the previous 12 months prior to the attestation date. Select either previous fiscal year or previous 12 months, then enter the Start Date of your continuous 90-day period.

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.

*Please select one of the following two options.

Last Completed Fiscal Year Preceding the Payment Year 12 Months Preceding Attestation Date

* **Start Date:** mm/dd/yyyy

Please Note: The **Start Date** must fall within the period that is applicable to your selected volume period.

Previous **Reset** **Save & Continue**

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.

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Patient Volume (Part 1 of 3) – 90 Day Reporting Period

Please review the **Start Date** and **End Date** of your selected continuous 90 day period for patient volume.

When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back.

Start Date: Feb 06, 2012
End Date: May 05, 2012

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.

Georgia has the following information on the locations for your facility.
If you wish to report patient volumes for a location or site that is not listed, click **Add Location**.

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

Provider ID	Location Name	Address	Available Actions
██████████	██████████ REGIONAL MEDICAL CENTER	██████████ AVE ██████████ GA 31501-5246	

Add Location **Refresh**

Previous **Reset** **Save & Continue**

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.

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Patient Volume Enter Volumes (Part 2 of 3)

Please provide the information requested below to add a location to MAPIR *(for this Payment Incentive Application use only)*.

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.

* Location Name: New Location

* Address Line 1: 1223 State Dr.

Address Line 2:

Address Line 3:

* City: AnyCity

* State: Georgia

* Zip (5+4): 30043 - 3131

Previous Reset **Save & Continue**

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.

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Patient Volume Enter Volumes (Part 2 of 3)

Georgia has the following information on the locations for your facility.
 If you wish to report patient volumes for a location or site that is not listed, click **Add Location**.

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


Provider ID	Location Name	Address	Available Actions
██████████	██████████ REGIONAL MEDICAL CENTER	██████████ AVE ██████████, GA 31501-5246	
N/A	New Location	1223 State Dr. AnyCity, GA 30043-3131	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Add Location Refresh

Previous Reset **Save & Continue**

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

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Patient Volume Cost Data

In this section it is important that the applicant complete the fields from left to right before moving onto the next row (top to bottom.)

- Please use data from the hospital fiscal year that ends prior to the beginning of the current federal fiscal year. This information will be compared to the hospital cost reports submitted to Medicaid.
- Please note that hospitals are eligible for incentives payments based on their CMS Certification Numbers (CCN). Multiple hospitals may be rolled up to a single CCN for the purposes of the Medicaid EHR Incentives Program.
- Additional information on entering patient volume cost data is available in the **Georgia Medicaid EHR Incentive Payment User Guide for Eligible Hospitals**.

Begin

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.

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Patient Volume Enter Volumes (Part 2 of 3)

Please enter **patient volumes** where indicated.

*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.

Provider Id	Location Name	Address	Medicaid Discharges <i>(In State Numerator)</i>	Other Medicaid Discharges <i>(Other Numerator)</i>	Total Discharges All Lines of Business <i>(Denominator)</i>
N/A	New Location	1223 State Dr. AnyCity, GA 30043-3131	* 300	* 500	* 8000
	REGIONAL MEDICAL CENTER	██████ AVE ██████ GA 31501-5246	* 200	* 500	* 10100

Previous
Reset
Save & Continue

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

The Medicaid Patient Volume Percentage Formula is:

$$\text{(Medicaid Discharges + Other Medicaid Discharges)}$$

Divided by

$$\text{Total Discharges All Lines of Business}$$

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.

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Patient Volume Enter Volumes (Part 2 of 3)

The patient volumes selections you entered are depicted below. Please review the current information to verify what you have entered is correct.

When ready click the **Save & Continue** button to continue, or click **Previous** to go back.

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

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

Previous
Save & Continue

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.

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Hospital Cost Report Data – Fiscal Year (Part 3 of 3)

It is required that you use hospital cost data from the hospital fiscal year that ends prior to the federal fiscal year for which you are applying. Please enter the **Start Date** of that hospital fiscal year.

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.

* Start Date:
mm/dd/yyyy

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.

The screenshot shows a web application interface for entering hospital cost report data. At the top, there is a navigation bar with buttons for 'Get Started', 'R&A/Contact Info' (checked), 'Eligibility' (checked), 'Patient Volumes' (active), 'Attestation', 'Review', and 'Submit'. Below this is a header for 'Hospital Cost Report Data - Fiscal Year (Part 3 of 3)'. The main content area contains the instruction: 'Please review the hospital fiscal year that ends prior to the federal fiscal year for which you are applying.' Below this is a blue box with the text: 'When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back.' The form displays 'Fiscal Year Start Date: Oct 01, 2010' and 'Fiscal Year End Date: Sep 30, 2011'. A red arrow points to the end date. At the bottom, there are two buttons: 'Previous' and 'Save & Continue', with the latter circled in red.

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.

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Hospital Cost Report Data (Part 3 of 3)

Please enter your *hospital cost report data* for the hospital fiscal year selected in the first row. Complete the first column in the table below for your last four full fiscal years.
 Note: You will not be able to change the Fiscal years which were previously entered.

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.

Fiscal Year	Total Discharges	Total Inpatient Medicaid Bed Days	Total Inpatient Bed Days	Total Charges - All Discharges	Total Charges - Charity Care
10/01/2010-09/30/2011	* 16000	* 6000	* 7500	* \$ 16500	* \$ 14000
10/01/2009-09/30/2010	* 1000				
10/01/2008-09/30/2009	* 2000				
10/01/2007-09/30/2008	* 3000				

Previous
Reset
Save & Continue

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

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

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Hospital Cost Report Data (Part 3 of 3)

Please enter your **hospital cost report data** for the hospital fiscal year selected in the first row. Complete the first column in the table below for your last four full fiscal years. Only acute care discharges and acute care bed days are to be included in Total Discharges, Total Inpatient Medicaid Bed Days and Total Inpatient Bed Days. Nursery days must be excluded from these entries.

Note: You will not be able to change the Fiscal years which were previously entered.

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.


Fiscal Year	Total Discharges	Total Inpatient Medicaid Bed Days	Total Inpatient Bed Days	Total Charges - All Discharges	Total Charges - Charity Care
10/01/2011-09/30/2012	* 44444	* 55555	* 777777	* \$ 888888888	* \$ 2222222
10/01/2010-09/30/2011	* 33333				
10/01/2009-09/30/2010	* 22222				
10/01/2008-09/30/2009	* 11111				

Previous Reset **Save & Continue**

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

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

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



You have now completed the **Patient Volumes** section of the application.

You may revisit the section at any time to make corrections until such time as you actually **Submit** the application.

The **Attestation** section of the application is now available.

Before submitting your application, please review the information that you have provided in this section, and all previous sections.

Continue

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**.

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Hospital Cost Report Data (Part 3 of 3)

Please review your **hospital cost report data** below. If you wish to update the data shown below please select the Change Data button.

Note: You will not be able to change the Fiscal years which were previously entered.

When ready click the **Save & Continue** button to continue, or click **Previous** to go back.
Click **Change Data** to change previously entered data.

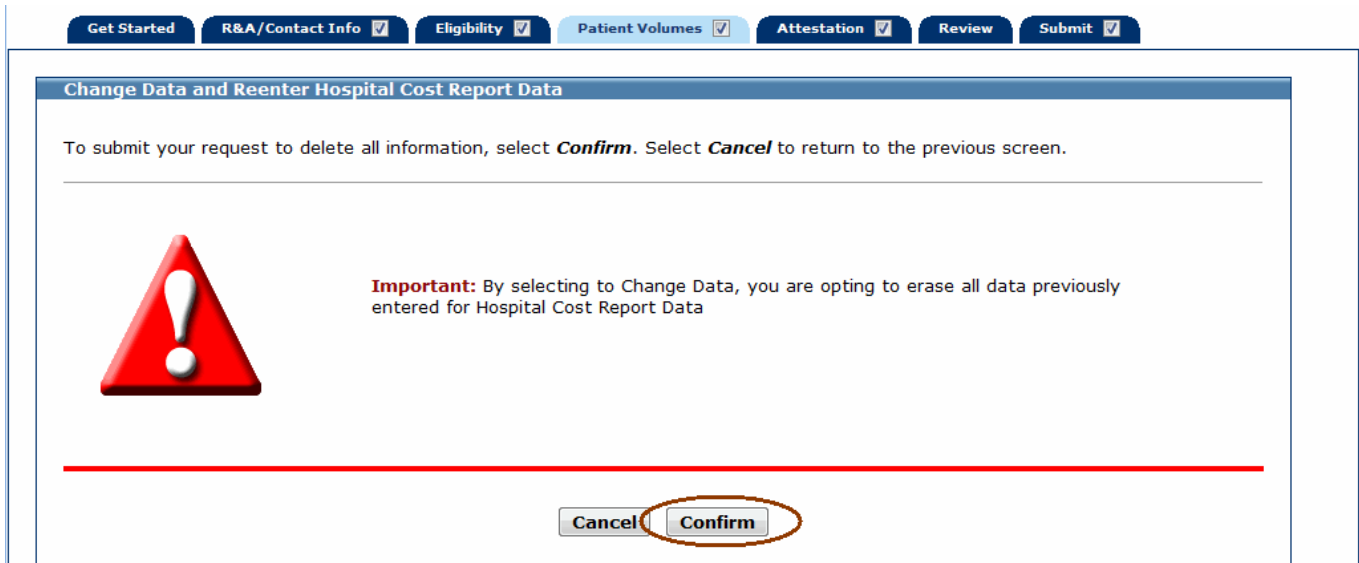
(*) Red asterisk indicates a required field.

Fiscal Year	Total Discharges	Total Inpatient Medicaid Bed Days	Total Inpatient Bed Days	Total Charges - All Discharges	Total Charges - Charity Care
01/01/2010-12/31/2010	80	128	128000	\$3,207,850.00	\$7,800.00
01/01/2009-12/31/2009	80				
01/01/2008-12/31/2008	80				
01/01/2007-12/31/2007	80				

Previous
Save & Continue
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.



The screenshot shows a web application interface with a navigation bar at the top containing buttons for 'Get Started', 'R&A/Contact Info', 'Eligibility', 'Patient Volumes', 'Attestation', 'Review', and 'Submit'. The 'Patient Volumes' button is highlighted. Below the navigation bar is a main content area with a blue header that reads 'Change Data and Reenter Hospital Cost Report Data'. The text below the header states: 'To submit your request to delete all information, select **Confirm**. Select **Cancel** to return to the previous screen.' A red warning triangle icon with a white exclamation mark is positioned to the left of the text. Below the text, a red horizontal line spans the width of the content area. At the bottom of the content area, there are two buttons: 'Cancel' and 'Confirm'. The 'Confirm' button is circled in orange.

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.

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Hospital Cost Report Data (Part 3 of 3)

Please enter your *hospital cost report data* for the hospital fiscal year selected in the first row. Complete the first column in the table below for your last four full fiscal years. Only acute care discharges and acute care bed days are to be included in Total Discharges, Total Inpatient Medicaid Bed Days and Total Inpatient Bed Days. Nursery days must be excluded from these entries.

Note: You will not be able to change the Fiscal years which were previously entered.

*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.

Fiscal Year	Total Discharges	Total Inpatient Medicaid Bed Days	Total Inpatient Bed Days	Total Charges - All Discharges	Total Charges - Charity Care
10/01/2011-09/30/2012	* 44444	* 55555	* 7777777	* \$ 8888888888	* \$ 22222222
10/01/2010-09/30/2011	* 33333				
10/01/2009-09/30/2010	* 22222				
10/01/2008-09/30/2009	* 11111				

Previous
Reset
Save & Continue

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.

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Hospital Cost Report Data (Part 3 of 3)

Please review your *hospital cost report data* below. If you wish to update the data shown below please select the Change Data button.

Note: You will not be able to change the Fiscal years which were previously entered.

When ready click the **Save & Continue** button to continue, or click **Previous** to go back.
Click **Change Data** to change previously entered data.

(*) Red asterisk indicates a required field.

Fiscal Year	Total Discharges	Total Inpatient Medicaid Bed Days	Total Inpatient Bed Days	Total Charges - All Discharges	Total Charges - Charity Care
01/01/2010-12/31/2010	90	138	128000	\$3,707,849.00	\$8,000.00
01/01/2009-12/31/2009	90				
01/01/2008-12/31/2008	90				
01/01/2007-12/31/2007	90				

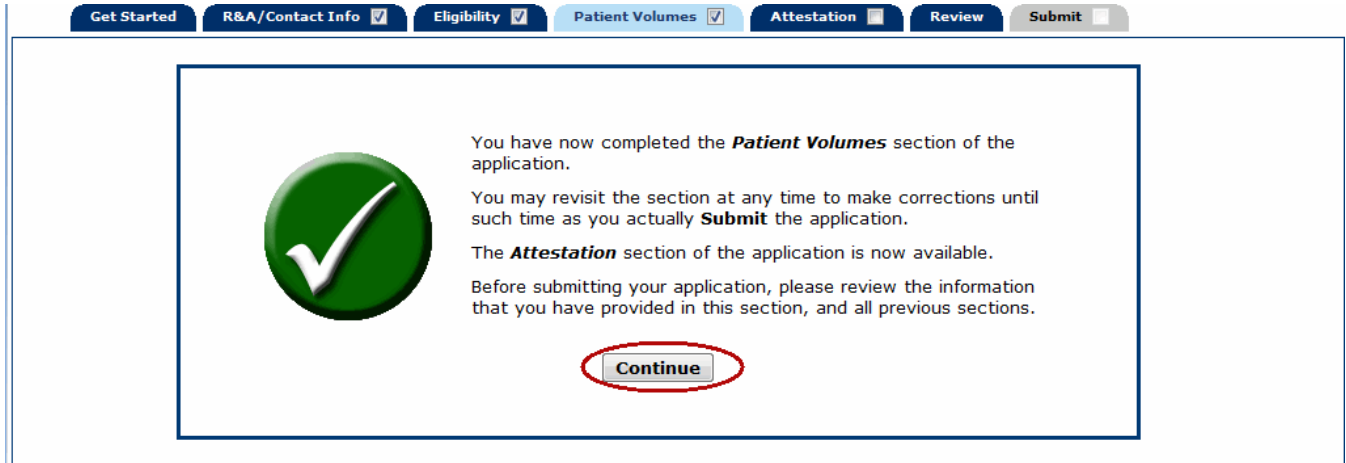
Previous
Save & Continue
Change Data

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.

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Attestation

In this section of your application, you must attest to Adoption, Implementation or Upgrade (AIU) of certified EHR technology and verify your payment designation.

Please refer to the **Georgia Medicaid EHR Incentive Payment User Guide for Eligible Hospitals** for the definition of Adoption, Implementation or Upgrade of certified EHR technology and additional information on AIU documentation that must be uploaded.

Definition of Meaningful Use for Hospitals: ONLY hospitals that are 1) dually eligible for both the Medicare and Medicaid EHR incentives programs and 2) attesting to Meaningful Use under the Medicare Incentives Program in 2011 should attest to Meaningful Use at the state level in MAPIR. If you do not meet both of these requirements, please select Adoption, Implementation or Upgrade for attestation.

NOTICE OF PROVIDER LIABILITY: The Eligible Hospital requesting the incentives payment is responsible and liable for any errors or falsifications in the attestation process as set forth in this registration. The Eligible Hospital and not the contact for the application will be held liable for inaccurate or incorrect information that improperly results in a Medicaid incentives payment.

In the event that an Eligible Hospital applied for and obtained a payment for which the Eligible Hospital was not entitled, the Eligible Hospital will be liable for full repayment to the Georgia Department of Community Health. In the event of fraud, the Eligible Hospital will be liable for repayment of all costs, interest, and expenses attributable to that repayment.

Begin

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.

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

Attestation Phase (Part 1 of 3)

Please select the appropriate **EHR System Adoption Phase**.

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.

Adoption: You are acquiring certified EHR Technology.

Implementation: You are installing certified EHR Technology.

Upgrade: You are expanding functionality of certified EHR Technology.

Meaningful Use: You are capturing meaningful use measures using a certified EHR technology.

Previous Reset Save & Continue

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.

The screenshot shows a web interface for the 'Attestation Phase (Part 1 of 3)'. At the top, there is a navigation bar with buttons: 'Get Started', 'R&A/Contact Info', 'Eligibility', 'Patient Volumes', 'Attestation', 'Review', and 'Submit'. The 'Attestation' button is highlighted. Below the navigation bar, the main content area is titled 'Attestation Phase (Part 1 of 3)'. It contains the instruction: 'Please select the appropriate EHR System Adoption Phase.' A light blue box provides guidance: '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.' Below this, there are four radio button options for EHR System Adoption Phases: 'Adoption', 'Implementation', 'Upgrade', and 'Meaningful Use'. The 'Implementation' option is selected and circled in red. At the bottom of the form, there are three buttons: 'Previous', 'Reset', and 'Save & Continue'. The 'Save & Continue' button is also circled in red.

Attestation Phase (Part 1 of 3)

Please select the appropriate **EHR System Adoption Phase**.

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.

Adoption: ?
You are acquiring certified EHR Technology.

Implementation: ?
You are installing certified EHR Technology.

Upgrade: ?
You are expanding functionality of certified EHR Technology.

Meaningful Use: ?
You are capturing meaningful use measures using a certified EHR technology.

Previous Reset Save & Continue

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.

Attestation Phase (Part 2 of 3)

Please select the activities where you have Planned (to include 'In Progress') or completed an implementation. It is important to know that the information you select about your Planned (to include 'In Progress') and completed implementation tasks is optional and will not impact your ability to receive an incentive payment. This information is helpful to the State Medicaid Program Office in understanding the implementation process. If there are no applicable activities to select or list, please select the 'Other (Click to Add)' button and enter "none".

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.
After saving, click the **Clear All** button to remove standard activity selections.

(*) Red asterisk indicates a required field.

*Implementation Activity	Planned	Complete
Workflow Analysis	<input type="radio"/>	<input type="radio"/>
Workflow Redesign	<input type="radio"/>	<input type="radio"/>
Software Installation	<input type="radio"/>	<input type="radio"/>
Hardware Installation	<input type="radio"/>	<input type="radio"/>
Peripherals Installation	<input type="radio"/>	<input type="radio"/>
Internet Connectivity / Broadband	<input type="radio"/>	<input type="radio"/>
Uploading Patient Data	<input type="radio"/>	<input type="radio"/>
Electronic Prescribing	<input type="radio"/>	<input type="radio"/>
Health Information Exchange (i.e. labs, pharmacy)	<input type="radio"/>	<input type="radio"/>
Physical Redesign of Workspace	<input type="radio"/>	<input type="radio"/>
Training	<input type="radio"/>	<input type="radio"/>

Other (Click to Add)

Previous **Reset** **Clear All** **Save & Continue**

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.

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Attestation Phase (Part 2 of 3)

Please select the activities where you have Planned (to include 'In Progress') or completed an implementation. It is important to know that the information you select about your Planned (to include 'In Progress') and completed implementation tasks is optional and will not impact your ability to receive an incentive payment. This information is helpful to the State Medicaid Program Office in understanding the implementation process. If there are no applicable activities to select or list, please select the 'Other (Click to Add)' button and enter "none".

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.
 After saving, click the **Clear All** button to remove standard activity selections.

(*) Red asterisk indicates a required field.

*Implementation Activity	Planned	Complete
Workflow Analysis	<input type="radio"/>	<input type="radio"/>
Workflow Redesign	<input type="radio"/>	<input type="radio"/>
Software Installation	<input type="radio"/>	<input type="radio"/>
Hardware Installation	<input type="radio"/>	<input type="radio"/>
Peripherals Installation	<input type="radio"/>	<input type="radio"/>
Internet Connectivity / Broadband	<input type="radio"/>	<input type="radio"/>
Uploading Patient Data	<input type="radio"/>	<input type="radio"/>
Electronic Prescribing	<input type="radio"/>	<input type="radio"/>
Health Information Exchange (i.e. labs, pharmacy)	<input type="radio"/>	<input type="radio"/>
Physical Redesign of Workspace	<input type="radio"/>	<input type="radio"/>
Training	<input type="radio"/>	<input type="radio"/>
Other: Reviewed EHR Certification Information	<input type="radio"/>	<input type="radio"/>

Other (Click to Add)

Previous
Reset
Clear All
Save & Continue

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.

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

Attestation Phase (Part 1 of 3)

Please select the appropriate **EHR System Adoption Phase**.

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.

Adoption: You are acquiring certified EHR Technology.

Implementation: You are installing certified EHR Technology.

Upgrade: You are expanding functionality of certified EHR Technology.

Meaningful Use: You are capturing meaningful use measures using a certified EHR technology.

Previous Reset **Save & Continue**

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.

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

Attestation Phase (Part 2 of 3)

Please select the activities where you have Planned (to include 'In Progress') or completed an upgrade. It is important to know that the information you select about your Planned (to include 'In Progress') and completed upgrade tasks is optional and will not impact your ability to receive an incentive payment. This information is helpful to the State Medicaid Program Office in understanding the upgrade process. If there are no applicable activities to select or list, please select the 'Other (Click to Add)' button and enter "none".

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.
After saving, click the **Clear All** button to remove standard activity selections.

(*) Red asterisk indicates a required field.

*Upgrade Activity	Planned	Complete
Upgrading Software Version	<input type="radio"/>	<input type="radio"/>
Upgrading Hardware or Peripherals	<input type="radio"/>	<input type="radio"/>
Clinical Decision Support	<input type="radio"/>	<input type="radio"/>
Electronic Prescribing	<input type="radio"/>	<input type="radio"/>
Computerized Provider Order Entry	<input type="radio"/>	<input type="radio"/>
Adding Functionality / Modules (personal health record, mental health, dental)	<input type="radio"/>	<input type="radio"/>

Other (Click to Add)

Previous Reset Clear All Save & Continue

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.

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

Attestation Phase (Part 2 of 3)

Please select the activities where you have Planned (to include 'In Progress') or completed an upgrade. It is important to know that the information you select about your Planned (to include 'In Progress') and completed upgrade tasks is optional and will not impact your ability to receive an incentive payment. This information is helpful to the State Medicaid Program Office in understanding the upgrade process. If there are no applicable activities to select or list, please select the 'Other (Click to Add)' button and enter "none".

*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.
After saving, click the **Clear All** button to remove standard activity selections.*

(*) Red asterisk indicates a required field.

*Upgrade Activity	Planned	Complete	
Upgrading Software Version	<input type="radio"/>	<input type="radio"/>	
Upgrading Hardware or Peripherals	<input type="radio"/>	<input type="radio"/>	
Clinical Decision Support	<input type="radio"/>	<input type="radio"/>	
Electronic Prescribing	<input type="radio"/>	<input type="radio"/>	
Computerized Provider Order Entry	<input type="radio"/>	<input type="radio"/>	
Adding Functionality / Modules (personal health record, mental health, dental)	<input type="radio"/>	<input type="radio"/>	
Other: Reviewed EHR Certification Information	<input type="radio"/>	<input type="radio"/>	Delete

Other (Click to Add)

Previous Reset Clear All Save & Continue

Review the **Upgrade Activities** you selected.

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

The screenshot shows a web interface for the 'Attestation Phase (Part 2 of 3)'. At the top, there is a navigation bar with buttons: 'Get Started', 'R&A/Contact Info', 'Eligibility', 'Patient Volumes', 'Attestation', 'Review', and 'Submit'. Below this, a blue header reads 'Attestation Phase (Part 2 of 3)'. The main content area contains the text: 'Please review the list of activities where you have **planned** or **completed** an upgrade.' Below this is a light blue box with the instruction: 'When ready click the **Save & Continue** button to continue, or click **Previous** to go back.' A table follows, listing upgrade activities and their status. The 'Save & Continue' button at the bottom is circled in red.

Upgrade Activity	Planned	Complete
Upgrading Software Version	✓	
Electronic Prescribing		✓
(Other) Reviewed EHR Certification Information		✓

Navigation buttons: **Previous** and **Save & Continue** (circled in red).

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**.

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

Attestation Phase (Part 1 of 3)

Please select the appropriate **EHR System Adoption Phase**.

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.

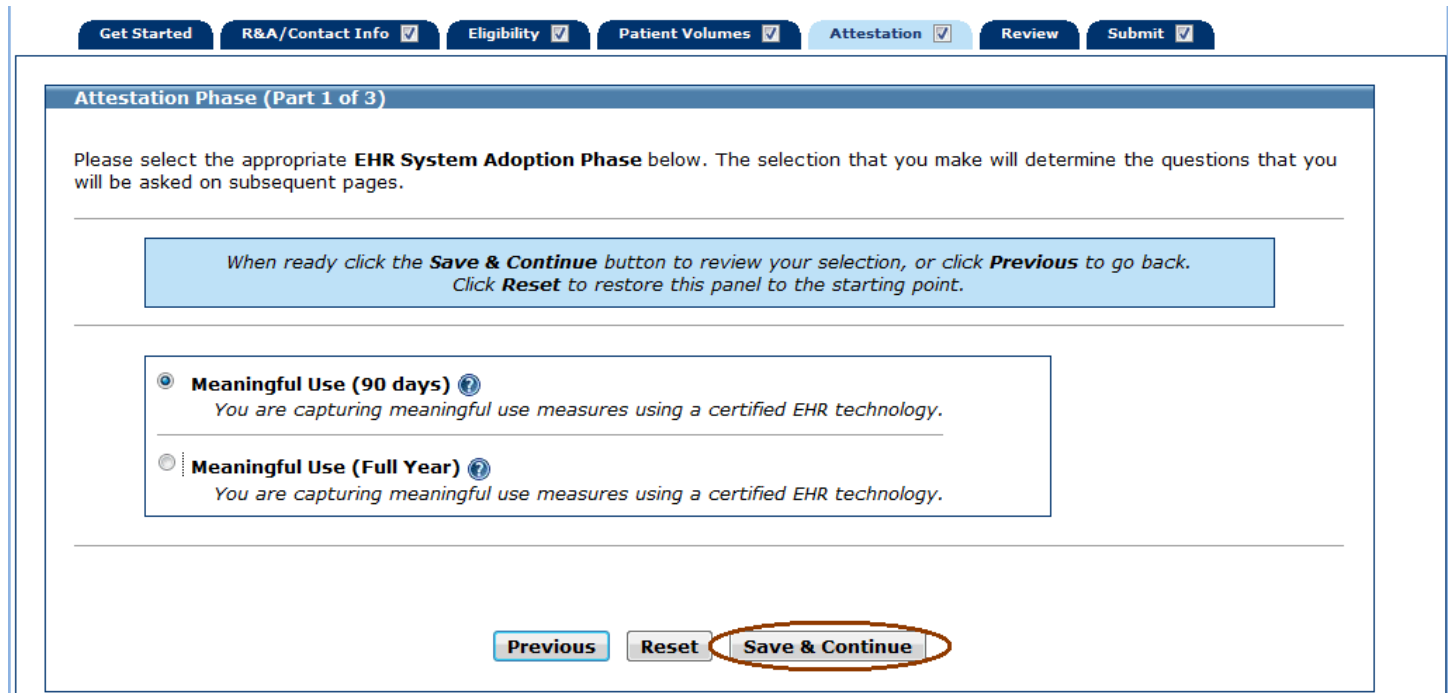
- Adoption:** You are acquiring certified EHR Technology.
- Implementation:** You are installing certified EHR Technology.
- Upgrade:** You are expanding functionality of certified EHR Technology.
- Meaningful Use:** You are capturing meaningful use measures using a certified EHR technology.

Previous Reset **Save & Continue**

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.





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

Attestation Phase (Part 1 of 3)

Please select the appropriate **EHR System Adoption Phase** below. The selection that you make will determine the questions that you will be asked on subsequent pages.

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.

Meaningful Use (90 days) 
You are capturing meaningful use measures using a certified EHR technology.

Meaningful Use (Full Year) 
You are capturing meaningful use measures using a certified EHR technology.

Previous **Reset** **Save & Continue**

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.

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Attestation Meaningful Use Measures

Please answer the following questions to determine your eligibility for the EHR Medicaid Incentive Payment Program.

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.

* Do at least 80% of unique patients have their data in the certified EHR during the EHR reporting period? Yes No ?

* Do you currently participate in a local or regional health information exchange? Yes No ?

* Would you be interested in learning more about the Georgia Statewide Health Information Exchange? Yes No ?

Previous Reset Save & Continue

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.

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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		Begin
	Menu Set Measures		Begin
	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

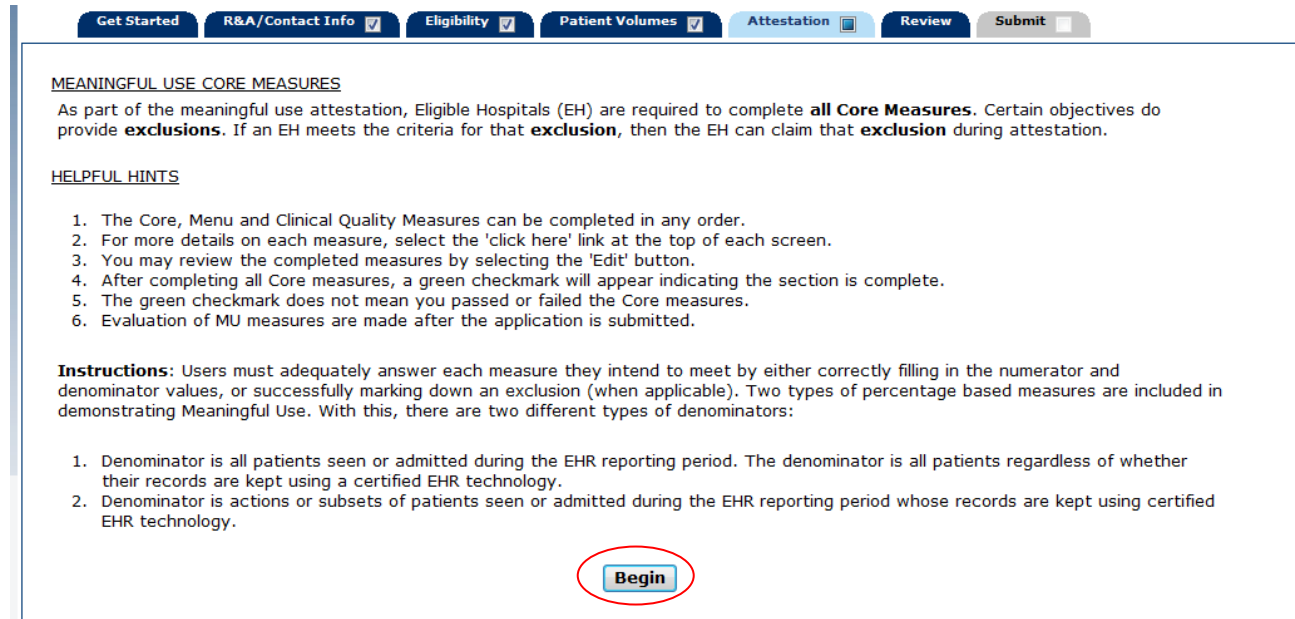
Meaningful Use Core Measures

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.



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MEANINGFUL USE CORE MEASURES

As part of the meaningful use attestation, Eligible Hospitals (EH) are required to complete **all Core Measures**. Certain objectives do provide **exclusions**. If an EH meets the criteria for that **exclusion**, then the EH can claim that **exclusion** during attestation.

HELPFUL HINTS

1. The Core, Menu and Clinical Quality Measures can be completed in any order.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. After completing all Core measures, a green checkmark will appear indicating the section is complete.
5. The green checkmark does not mean you passed or failed the Core measures.
6. Evaluation of MU measures are made after the application is submitted.

Instructions: Users must adequately answer each measure they intend to meet by either correctly filling in the numerator and denominator values, or successfully marking down an exclusion (when applicable). Two types of percentage based measures are included in demonstrating Meaningful Use. With this, there are two different types of denominators:

1. Denominator is all patients seen or admitted during the EHR reporting period. The denominator is all patients regardless of whether their records are kept using a certified EHR technology.
2. Denominator is actions or subsets of patients seen or admitted during the EHR reporting period whose records are kept using certified EHR technology.

Begin

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.

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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.

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Attestation Meaningful Use Measures

Measure Selection for Core Measure 1

Please choose from the following options to attest to this measure. If you return at a later time and change your selection, any information entered for the measure prior to that point will be removed.

When ready click the **Continue** button to review your selection, or click **Previous** to go back.

(*) Red asterisk indicates a required field.

*Please select from the following options:

- Original Core Measure 1 - 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.
- Optional Core Measure 1 - More than 30% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

Previous Continue

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.

Attestation Meaningful Use Measures

Core Measure 1

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: 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.

Measure: 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.

*** PATIENT RECORDS :** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR Technology.

- This data was extracted from ALL patient records not just those maintained using certified EHR technology.
- This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of patients in the denominator that have at least one medication order entered using CPOE.

Denominator = Number of unique patients with at least one medication in their medication list seen by the eligible hospital or CAH during the EHR reporting period.

*Numerator : 350 *Denominator : 1000

Previous **Reset** **Save & Continue**

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.

Attestation Meaningful Use Measures

Core Measure 1

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: 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.

Measure: More than 30% of medication orders created by authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.

*** PATIENT RECORDS** : Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = The number of medication orders in the denominator recorded using CPOE.

Denominator = Number of medication orders created by authorized providers in the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR Reporting period.

* Numerator : 350 * Denominator : 1000

Previous Reset **Save & Continue**

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.

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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	<input type="button" value="edit"/>
Implement drug-drug and drug-allergy interaction checks.	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.		<input type="button" value="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.		<input type="button" value="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.		<input type="button" value="edit"/>

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.

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Attestation Meaningful Use Measures

Core Measure 2

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: Implement drug-drug and drug-allergy interaction checks.

Measure: The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.

Complete the following information:

*Have you enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?

Yes No

Previous Reset Save & Continue

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.

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Core Measure 3

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: Maintain an up-to-date problem list of current and active diagnoses.

Measure: 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.

Complete the following information:

Numerator = Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.

Denominator = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator : 810 *Denominator : 1000

Previous Reset Save & Continue

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.

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Core Measure 4

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: Maintain active medication list.

Measure: 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.

Complete the following information:
Numerator = Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Denominator = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator : 850 *Denominator : 1000

Previous Reset Save & Continue

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.

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Core Measure 5

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: Maintain active medication allergy list.

Measure: 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.

Complete the following information:

Numerator = Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.

Denominator = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator : 850 *Denominator : 1000

Previous Reset Save & Continue

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.

Attestation Meaningful Use Measures

Core Measure 6

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 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.

Measure: 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.

Complete the following information:

Numerator = Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.

Denominator = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator : 550 *Denominator : 1000

Previous Reset Save & Continue

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.

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Attestation Meaningful Use Measures

Measure Selection for Core Measure 7

Please choose from the following options to attest to this measure. If you return at a later time and change your selection, any information entered for the measure prior to that point will be removed.

When ready click the **Continue** button to review your selection, or click **Previous** to go back.

(*) Red asterisk indicates a required field.

*Please select from the following options:

- Original Core Measure 7 -
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.
- Optional Core Measure 7 -
More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and/or height/length and weight (for all ages) recorded as structured data.

Previous Continue

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.

Attestation Meaningful Use Measures

Core Measure 7

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 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.

Measure: For more than 50% of all unique patients age 2 and over admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight and blood pressure are recorded as structure data.

*** PATIENT RECORDS** : Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR Technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of patients in the denominator who have at least one entry of their height, weight and blood pressure are recorded as structured data.

Denominator = Number of unique patients age 2 or over is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator : 550 *Denominator : 1000

Previous Reset Save & Continue

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.

Attestation Meaningful Use Measures

Core Measure 7

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 and chart changes in the following vital signs: Height; Weight; Blood pressure; Calculate and display body mass index (BMI); plot and display growth charts for children, including BMI.

Measure: More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and/or height/length and weight (for all ages) recorded as structured data.

*** PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:
Numerator = Number of patients in the denominator who have at least one entry of their height/length and weight (all ages) and/or blood pressure (ages 3 and over) recorded as structured data.
Denominator = Number of unique patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

* Numerator : 25 * Denominator : 56

Previous **Reset** **Save & Continue**

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.

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 : 550 *Denominator : 1000

Previous Reset Save & Continue

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.

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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.

The screenshot shows a web application interface for 'Attestation Meaningful Use Measures'. At the top, there is a navigation bar with buttons: 'Get Started', 'R&A/Contact Info' (checked), 'Eligibility' (checked), 'Patient Volumes' (checked), 'Attestation' (active), 'Review', and 'Submit'. Below this is a header for 'Attestation Meaningful Use Measures' and a sub-header for 'Core Measure 10'. A blue box contains instructions: 'Click [here](#) to review CMS Guidelines for this measure' and '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.' A red asterisk note states: '(*) Red asterisk indicates a required field.' The objective is 'Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule'. The measure is 'Implement one clinical decision support rule'. The instruction is 'Complete the following information: *Did you implement one clinical decision support rule?'. There are two radio buttons: 'Yes' (selected) and 'No'. At the bottom, there are three buttons: 'Previous', 'Reset', and 'Save & Continue' (circled in red).

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.

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Core Measure 11

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: 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

Measure: 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.

*** PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR Technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION - Based on ALL patient records: An eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period 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 who receive an electronic copy of their electronic health information within three business days.

Denominator = Number of patients of the eligible hospital or CAH who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

***Numerator :** 550 ***Denominator :** 1000

Previous Reset **Save & Continue**

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.

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Attestation Meaningful Use Measures

Core Measure 11

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: 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

Measure: 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.

*** PATIENT RECORDS :** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR Technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION -Based on ALL patient records: An eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period 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 who receive an electronic copy of their electronic health information within three business days.

Denominator = Number of patients of the eligible hospital or CAH who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.

***Numerator :** ***Denominator :**

Previous **Reset** **Save & Continue**

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.

Attestation Meaningful Use Measures

Core Measure 12

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: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.

Measure: 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.

*** PATIENT RECORDS :** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR Technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION -Based on ALL patient records: An eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of their discharge instructions during the EHR reporting period they 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 = The number of patients in the denominator who are provided an electronic copy of discharge instructions.

Denominator = Number of patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) who request an electronic copy of their discharge instructions during the EHR reporting period.

***Numerator :** ***Denominator :**

Previous **Reset** **Save & Continue**

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.

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Core Measure 12

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: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.

Measure: 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.

*** PATIENT RECORDS :** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR Technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION - Based on ALL patient records: An eligible hospital or CAH that has no requests from patients or their agents for an electronic copy of their discharge instructions during the EHR reporting period they 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 = The number of patients in the denominator who are provided an electronic copy of discharge instructions.

Denominator = Number of patients discharged from an eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) who request an electronic copy of their discharge instructions during the EHR reporting period.

***Numerator :** ***Denominator :**

Previous
Reset
Save & Continue

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.

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Core Measure 14

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: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

Measure: 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.

*Did you 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 No

Previous Reset Save & Continue

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

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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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="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	<input type="button" value="EDIT"/>

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.

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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	<input type="button" value="EDIT"/> <input type="button" value="Clear All"/>
	Menu Set Measures		<input type="button" value="Begin"/>
	Clinical Quality Measures		<input type="button" value="Begin"/>

Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.

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.

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MEANINGFUL USE MENU SET MEASURES

As part of the meaningful use attestation process, Eligible Hospitals (EH) are required to complete **5 out of 10 Menu Set Measures**. Certain objectives do provide **exclusions**. If an EH meets the criteria for that **exclusion**, then the EH can claim that **exclusion** during attestation. The EH must be able to meet at least one public health measure. For example if you submit to the Georgia Registry of Immunization Transactions and Services (GRITS - health.state.ga.us/programs/immunization/grits) you may meet the public health requirement. If the EH can attest to an exclusion from all public health menu measures, the EH must choose one of the three public health menu measures and attest to the exclusion. You must choose between two to four objectives from the menu measures depending on how many public health measures were completed. The total between the public health measures and the menu set measures must equal five.

HELPFUL HINTS

1. The Core, Menu and Clinical Quality Measures can be completed in any order.
2. For more details on each measure, select the 'click here' link at the top of each screen.
3. You may review the completed measures by selecting the 'Edit' button.
4. After completing the 5 measures, a green checkmark will appear indicating the section is complete.
5. The green checkmark does not mean you passed or failed the 5 measures.
6. Evaluation of MU measures are made after the application is submitted.

Begin

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.

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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 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).	<input checked="" type="checkbox"/>
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).	<input type="checkbox"/>
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).	<input type="checkbox"/>

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.	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>
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).	<input type="checkbox"/>
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.	<input type="checkbox"/>

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.

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Meaningful Use Menu Measure Worksheet

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 **"Previous"** button to access the main measure topic list.

Objective	Measure	Entered	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.		<input type="button" value="EDIT"/>
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.		<input type="button" value="EDIT"/>
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.		<input type="button" value="EDIT"/>
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.		<input type="button" value="EDIT"/>
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).		<input type="button" value="EDIT"/>

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.

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Attestation Meaningful Use Measures

Menu Measure 1

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: Implemented drug-formulary checks.
Measure: 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.

*** PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.
 This data was extracted only from patient records maintained using certified EHR technology.

***Did you enable the drug-formulary check functionality and did you have access to at least one internal or external drug formulary for the entire EHR reporting period?**

Yes No

Previous Reset **Save & Continue**

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.

The screenshot displays a web application interface for 'Attestation Meaningful Use Measures'. At the top, there is a navigation bar with buttons for 'Get Started', 'R&A/Contact Info', 'Eligibility', 'Patient Volumes', 'Attestation', 'Review', and 'Submit'. Below this is a header for 'Attestation Meaningful Use Measures' and a sub-header for 'Meaningful Use Menu Measure Worksheet'. A text block explains that users should click 'EDIT' to modify measures and that progress is saved. Below the text is a table with four columns: 'Objective', 'Measure', 'Entered', and 'Select'. The first row lists 'Implemented drug-formulary checks' with the measure description '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.' The 'Entered' column contains 'Yes', which is circled in orange, and the 'Select' column has an 'EDIT' button. The second row lists 'Record advance directives for patients 65 years old or older' with the measure description '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.' and an 'EDIT' button in the 'Select' column.

Objective	Measure	Entered	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.	Yes	EDIT
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.		EDIT

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.

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Menu Measure 2

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 advance directives for patients 65 years old or older.
 Measure: 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.

*** PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.
 This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION - Based on ALL patient records: An eligible hospital or CAH that admitted no patients 65 years old or older during the EHR reporting period 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:
Numerator = Number of patients in the denominator with an indication of an advanced directive entered using structured data.
Denominator = Number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.

*Numerator : 550 *Denominator : 1000

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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.

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Menu Measure 2

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 advance directives for patients 65 years old or older.
Measure: 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.

*** PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.
 This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION - Based on ALL patient records: An eligible hospital or CAH that admitted no patients 65 years old or older during the EHR reporting period 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:
Numerator = Number of patients in the denominator with an indication of an advanced directive entered using structured data.
Denominator = Number of unique patients age 65 or older admitted to an eligible hospital's or CAH's inpatient department (POS 21) during the EHR reporting period.

*Numerator : *Denominator :

Previous
Reset
Save & Continue

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.

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Menu Measure 3

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: Incorporate clinical lab-test results into certified EHR as structured data.
 Measure: 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.

*** PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.
 This data was extracted only from patient records maintained using certified EHR technology.

Complete the Following Information:
Numerator = Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which are incorporated as structured data.
Denominator = Number of lab tests ordered during the EHR reporting period by authorized providers of the eligible hospital or CAH for patients admitted to an eligible hospital's or CAH's inpatient or emergency department (POS 21 and 23) whose results are expressed in a positive or negative affirmation or as a number.

*Numerator : 565 *Denominator : 1000

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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.

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Menu Measure 4

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: Generate lists of patients by specific conditions to use for quality improvements, reduction of disparities, research, or outreach.

Measure: Generate at least one report listing patients of the eligible hospital or CAH with a specific condition.

*** PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

***Did you generate at least one report listing patients of the eligible hospital or CAH with a specific condition?**

Yes No

Previous Reset **Save & Continue**

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.

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Menu Measure 5

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: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.

Measure: 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

Complete the Following Information:
Numerator = Number of patients in the denominator who are provided patient education specific resources.
Denominator = Number of unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period.

*Numerator : 156 *Denominator : 1000

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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.

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Menu Measure 6

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: 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.

Measure: 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).

*** PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

Complete the following information:

Numerator = Number of transitions of care in the denominator where medication reconciliation was performed.

Denominator = Number of transitions of care during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 to 23) was the receiving party of the transition.

*Numerator : 650 *Denominator : 1000

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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.

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Menu Measure 7

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: 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.

Measure: 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.

*** PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

Complete the Following Information:
Numerator = Number of transitions of care and referrals in the denominator where a summary of care record was provided.
Denominator = Number of transitions of care and referrals during the EHR reporting period for which the eligible hospital's or CAH's inpatient or emergency department (POS 21 to 23) was the transferring or referring provider.

***Numerator :** 700 ***Denominator :** 1000

Previous **Reset** **Save & Continue**

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.

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Menu 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: Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).

EXCLUSION 1 - Based on ALL patient records: An eligible hospital or CAH that does not perform immunizations during the EHR reporting period 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

EXCLUSION 2 - Based on ALL patient records: If there is no immunization registry that 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's capacity to submit electronic data to immunization registries and follow up submission if the test was 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)?

Yes No

Enter the name of the immunization registry used:

IF you answered YES to EXCLUSION 1 Above:

Please select one of the statements listed below that best describes the reason for the exclusion:

Immunizations were not provided during the EHR reporting period

There was no entity capable of testing during the EHR reporting period

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

IF you performed at least one test of EHR submission of electronic data to immunization registries:

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

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.

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Menu 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: Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice.

Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the eligible hospital or CAH submits such information has the capacity to receive the information electronically).

EXCLUSION 1 - Based on ALL patient records: An eligible hospital or CAH that does not perform immunizations during the EHR reporting period 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

EXCLUSION 2 - Based on ALL patient records: If there is no immunization registry that 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's capacity to submit electronic data to immunization registries and follow up submission if the test was 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)?

Yes No

Enter the name of the immunization registry used

IF you answered YES to EXCLUSION 1 Above:

Please select one of the statements listed below that best describes the reason for the exclusion:

Immunizations were not provided during the EHR reporting period

There was no entity capable of testing during the EHR reporting period

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

IF you performed at least one test of EHR submission of electronic data to immunization registries:

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

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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.

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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/YYYY)

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

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.

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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

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.

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

Attestation Meaningful Use Measures

Menu Measure 10

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 syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.

Measure: 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)

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's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test was 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)

Yes No

* Enter the name of the syndromic surveillance agency

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

IF you answered YES to the EXCLUSION:

Was there a public health agency to test with for syndromic surveillance? 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

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.

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

Attestation Meaningful Use Measures

Menu Measure 10

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 syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.

Measure: 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)

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's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test was 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)

Yes No

* Enter the name of the syndromic surveillance agency

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

IF you answered YES to the EXCLUSION:

Was there a public health agency to test with for syndromic surveillance? 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**

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

Get Started
R&A/Contact Info
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Submit

Attestation Meaningful Use Measures

Meaningful Use Menu Measure Worksheet

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 **"Previous"** button to access the main measure topic list.

Objective	Measure	Entered	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.	Yes	<input type="button" value="EDIT"/>
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.	Excluded	<input type="button" value="EDIT"/>
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	<input type="button" value="EDIT"/>
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	<input type="button" value="EDIT"/>
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).	Yes, Yes	<input type="button" value="EDIT"/>

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).	<input checked="" type="checkbox"/>
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).	<input type="checkbox"/>
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).	<input type="checkbox"/>

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.	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>
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.	<input checked="" type="checkbox"/>
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	<input type="checkbox"/>
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).	<input type="checkbox"/>
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.	<input type="checkbox"/>

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
<input checked="" type="checkbox"/>	Core Measures	12/12	<input type="button" value="EDIT"/> <input type="button" value="Clear All"/>
<input checked="" type="checkbox"/>	Menu Set Measures	5/5	<input type="button" value="EDIT"/> <input type="button" value="Clear All"/>
	Clinical Quality Measures		<input type="button" value="Begin"/>

Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.

-
-

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.

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

MEANINGFUL USE CLINICAL QUALITY MEASURES

As part of the Meaningful Use attestation, Eligible Hospitals (EH) are required to complete all **Clinical Quality Measures**. The data for these measures must be obtained directly from the certified EHR system. Some Clinical Quality Measures may not apply to the EH thus you would not have any eligible patients or actions for the measure denominator. In these cases, the EH would be excluded from having to meet that measure. If there is no exclusion, you may enter a zero in the denominator and numerator.

HELPFUL HINTS

1. The Core, Menu and Clinical Quality Measures can be completed in any order.
2. You may review the completed measures by selecting the 'Edit' button.
3. When all measures are complete, a green checkmark will appear indicating the section is complete.

NOTE: When completing the Clinical Quality Measure attestation, the denominator is listed BEFORE the numerator. Please submit your data accordingly.

Begin

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.

Get Started | RBA/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. Upon successfully editing a measure, the next measure on the list will be made available for editing. 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	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department		<input type="button" value="EDIT"/>
ED-1.2 - Observation ED patient stratification			
ED-1.3 - Dx stratification ED patients			
NQF 0497, Emergency Department (ED)-2 - Emergency Department Throughput ED-2.1 - All ED patients admitted to inpatient status	Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status		<input type="button" value="EDIT"/>
ED-2.2 - Observation ED patient stratification			
ED-2.3 - Dx stratification ED patients			
NQF 0435, Stroke-2 - Ischemic stroke - Discharge on anti-thrombotics			<input type="button" value="EDIT"/>
NQF 0436, Stroke-3 - Ischemic stroke - Anticoagulation for A-fib/flutter			<input type="button" value="EDIT"/>
NQF 0437, Stroke-4 - Ischemic stroke - Thrombolytic therapy for patients arriving within 2 hours of symptom onset			<input type="button" value="EDIT"/>
NQF 0438, Stroke-5 - Ischemic or hemorrhagic stroke - Antithrombotic therapy by day 2			<input type="button" value="EDIT"/>
NQF 0439, Stroke-6 - Ischemic stroke - Discharge on statins			<input type="button" value="EDIT"/>
NQF 0440, Stroke-8 - Ischemic or hemorrhagic stroke - Stroke Education			<input type="button" value="EDIT"/>
NQF 0441, Stroke-10 - Ischemic or hemorrhagic stroke - Rehabilitation assessment			<input type="button" value="EDIT"/>
NQF 0371, VTE-1 - VTE prophylaxis within 24 hours of arrival			<input type="button" value="EDIT"/>
NQF 0372, VTE-2 - Intensive Care Unit VTE prophylaxis			<input type="button" value="EDIT"/>
NQF 0373, VTE-3 - Anticoagulation overlap therapy			<input type="button" value="EDIT"/>
NQF 0374, VTE-4 - Platelet monitoring on unfractionated heparin			<input type="button" value="EDIT"/>
NQF 0375, VTE-5 - VTE discharge instructions			<input type="button" value="EDIT"/>
NQF 0376, VTE-6 - Incidence of potentially preventable VTE			<input type="button" value="EDIT"/>

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.

Attestation Meaningful Use Measures

Clinical Quality Measure 1

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0495, Emergency Department (ED)-1
Title: Emergency Department Throughput - admitted patients Median time from ED arrival to ED departure for admitted patients
Description: Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department

ED-1.1 - All ED patients admitted to the facility from the ED
Denominator = All ED patients admitted to the facility from the ED. A positive whole number.
Numerator = Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED. A positive whole number where Numerator is less than or equal to the Denominator or where Numerator is greater than or equal to the Denominator.
Exclusion = Observation & Mental Health Patients. A positive whole number.
 * Denominator : 270 * Numerator : 120 * Exclusion : 55

ED-1.2 - Observation ED patient stratification
Denominator = ED Observation patients admitted to the facility from the ED. A positive whole number.
Numerator = Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED. A positive whole number where Numerator is less than or equal to the Denominator or where Numerator is greater than or equal to the Denominator.
 * Denominator : 55 * Numerator : 120

ED-1.3 - Dx stratification ED patients
Denominator = ED patients with a Dx of Psychiatric or Mental Health Disorder admitted to the facility from the ED. A positive whole number.
Numerator = Median time (in minutes) from ED arrival to ED departure for patients admitted to the facility from the ED. A positive whole number where Numerator is less than or equal to the Denominator or where Numerator is greater than or equal to the Denominator.
 * Denominator : 40 * Numerator : 120

Previous Reset **Save & Continue**

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	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	<input type="button" value="EDIT"/>
ED-1.2 - Observation ED patient stratification			
ED-1.3 - Dx stratification ED patients			
NQF 0497, Emergency Department (ED)-2 - Emergency Department Throughput ED-2.1 - All ED patients admitted to inpatient status	Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status		<input type="button" value="EDIT"/>
ED-2.2 - Observation ED patient stratification			
ED-2.3 - Dx stratification ED patients			
NQF 0435, Stroke-2 - Ischemic stroke - Discharge on anti-thrombotics			<input type="button" value="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.

Attestation Meaningful Use Measures

Clinical Quality Measure 2

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0497, Emergency Department (ED)-2
Title: Emergency Department Throughput - admitted patients Admission decision time to ED departure time for admitted patients
Description: Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status

ED-2.1 - All ED patients admitted to inpatient status
Denominator = All ED patients admitted to the facility from the ED. A positive whole number
Numerator = Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status. A positive whole number where Numerator is less than or equal to the Denominator or where Numerator is greater than or equal to the Denominator.
Exclusion = Observation & Mental Health Patients. A positive whole number.
* Denominator : 300 * Numerator : 90 * Exclusion : 75

ED-2.2 - Observation ED patient stratification
Denominator = ED Observation patients admitted to the facility from the ED. A positive whole number.
Numerator = Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status. A positive whole number where Numerator is less than or equal to the Denominator or where Numerator is greater than or equal to the Denominator.
* Denominator : 90 * Numerator : 60

ED-2.3 - Dx stratification ED patients
Denominator = ED patients with a Principal DX of Psychiatric or mental health disorder admitted to the facility from the ED. A positive whole number
Numerator = Median time (in minutes) from admit decision time to time of departure from the ED for patients admitted to inpatient status. A positive whole number where Numerator is less than or equal to the Denominator or where Numerator is greater than or equal to the Denominator.
* Denominator : 100 * Numerator : 90

Previous Reset Save & Continue

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.

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

Attestation Meaningful Use Measures

Clinical Quality Measure 3

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0435, Stroke-2 Title: Ischemic stroke - Discharge on anti-thrombotics

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 60 * Numerator : 39 * Exclusion : 10

Previous Reset Save & Continue

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.

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

Attestation Meaningful Use Measures

Clinical Quality Measure 4

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0436, Stroke-3 Title: Ischemic stroke - Anticoagulation for A-fib/flutter

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 50 * Numerator : 19 * Exclusion : 6

Previous Reset Save & Continue

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.

Name	MAPIR Memorial Hospital	NPI	999999999
CCN	999999	Hospital TIN	999999999
Payment Year	1	Program Year	2012

Attestation Meaningful Use Measures

Clinical Quality Measure 5

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0437, Stroke-4 Title: Ischemic stroke - Thrombolytic therapy for patients arriving within 2 hours of symptom onset

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 65 * Numerator : 45 * Exclusion : 8

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.

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

Attestation Meaningful Use Measures

Clinical Quality Measure 6

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0438, Stroke-5 Title: Ischemic or hemorrhagic stroke - Antithrombotic therapy by day 2

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 76 * Numerator : 34 * Exclusion : 7

Previous Reset Save & Continue

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.

Attestation Meaningful Use Measures

Clinical Quality Measure 7

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0439, Stroke-6 Title: Ischemic stroke -Discharge on statins

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 56 * Numerator : 25 * Exclusion : 5

Previous Reset Save & Continue

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.

Attestation Meaningful Use Measures

Clinical Quality 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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0440, Stroke-8 Title: Ischemic or hemorrhagic stroke -Stroke Education

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 98 * Numerator : 67 * Exclusion : 23

Previous Reset Save & Continue

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.

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

Attestation Meaningful Use Measures

Clinical Quality 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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0441, Stroke-10 Title: Ischemic or hemorrhagic stroke - Rehabilitation assessment

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 34 * Numerator : 12 * Exclusion : 5

Previous Reset **Save & Continue**

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.

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

Attestation Meaningful Use Measures

Clinical Quality Measure 10

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0371, VTE-1 Title: VTE prophylaxis within 24 hours of arrival

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 25 * Numerator : 12 * Exclusion : 2

Previous Reset Save & Continue

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.

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

Attestation Meaningful Use Measures

Clinical Quality Measure 11

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0372, VTE-2 Title: Intensive Care Unit VTE prophylaxis

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 41 * Numerator : 23 * Exclusion : 12

Previous Reset Save & Continue

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.

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

Attestation Meaningful Use Measures

Clinical Quality Measure 12

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0373, VTE-3 Title: Anticoagulation overlap therapy

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 33 * Numerator : 10 * Exclusion : 2

Previous Reset Save & Continue

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.

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

Attestation Meaningful Use Measures

Clinical Quality Measure 13

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0374, VTE-4 Title: Platelet monitoring on unfractionated heparin

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 27 * Numerator : 13 * Exclusion : 7

Previous Reset **Save & Continue**

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.

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

Attestation Meaningful Use Measures

Clinical Quality Measure 14

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0375, VTE-5 Title: VTE discharge instructions

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 120 * Numerator : 78 * Exclusion : 12

Previous Reset Save & Continue

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.

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

Attestation Meaningful Use Measures

Clinical Quality Measure 15

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.

Responses are required for the clinical quality measure displayed on this page.

Measure: NQF 0376, VTE-6 Title: Incidence of potentially preventable VTE

Denominator = a positive whole number

Numerator = a positive whole number where Numerator is less than or equal to the Denominator

Exclusion = a positive whole number

* Denominator : 15 * Numerator : 9 * Exclusion : 2

Previous Reset **Save & Continue**

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 RAA/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	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	EDIT
ED-1.2 - Observation ED patient stratification		Denominator = 55 Numerator = 120	
ED-1.3 - Dx stratification ED patients		Denominator = 40 Numerator = 120	
NQF 0497, Emergency Department (ED)-2 - Emergency Department Throughput ED-2.1 - All ED patients admitted to inpatient status	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	EDIT
ED-2.2 - Observation ED patient stratification		Denominator = 90 Numerator = 60	
ED-2.3 - Dx stratification ED patients		Denominator = 100 Numerator = 90	
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.

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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	<input type="button" value="EDIT"/> <input type="button" value="Clear All"/>
✓	Menu Set Measures	5/5	<input type="button" value="EDIT"/> <input type="button" value="Clear All"/>
✓	Clinical Quality Measures	15/15	<input type="button" value="EDIT"/> <input type="button" value="Clear All"/>

Note:
When all topics are marked as completed, select the "Save & Continue" button to complete the attestation process.

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.

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Attestation Meaningful Use Measures

The Meaningful Use Measures you have attested to are depicted below. Please review the current information to verify what you have entered is correct.

Meaningful Use Core Measure Review				
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 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
<p>EHMMU08 Immunization Registry : Immunize Registry Exclusion Reason : No Test Successful : Yes Test Date & Time : 05/30/12 09:35 PM Follow Up Submission : No</p>

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.

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

Attestation Phase (Part 3 of 3)

Eligible Hospitals may be subject to the Centers for Medicare & Medicaid Services process for audits and appeals of Meaningful Use attestations. This includes Eligible Hospitals applying for a Medicaid only EHR incentive payment.

Please answer the following question.

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.

* 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 No

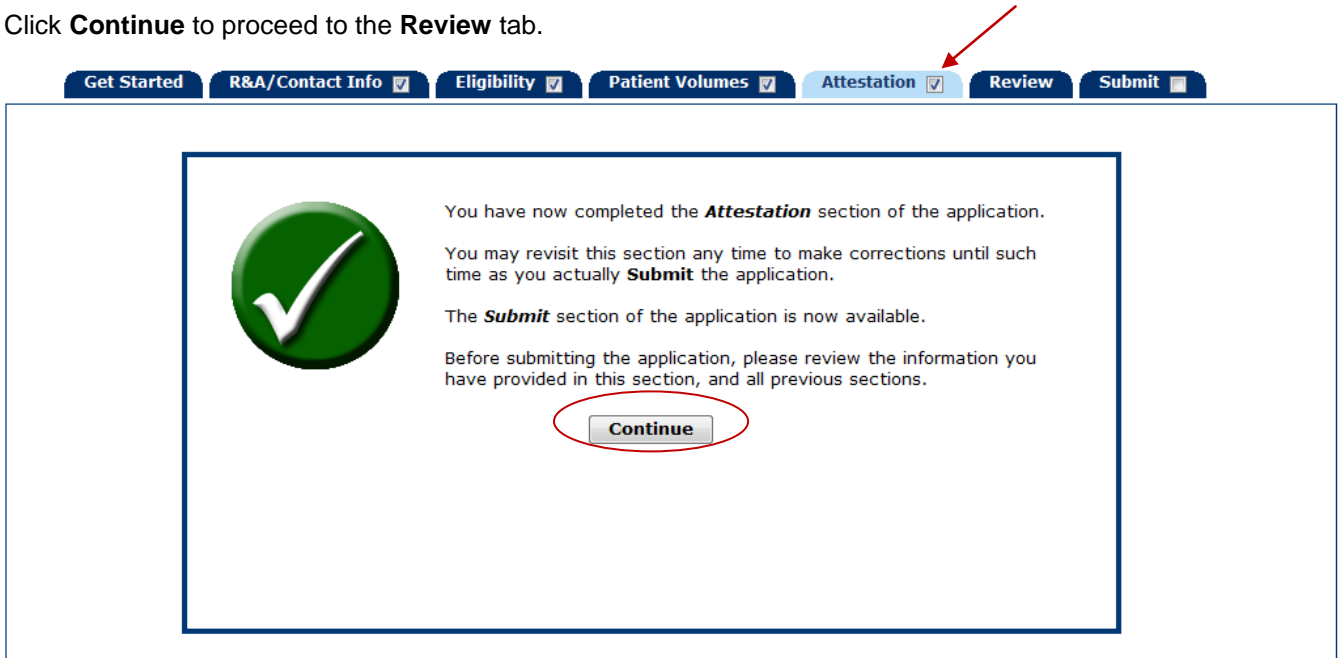
NOTE: Definition of an acute care hospital for purpose of the Medicaid EHR Incentive Payment Program is a hospital with an average patient length of stay of 25 days or fewer, and with a CCN that falls in the range of 0001-0879 (Short-term Hospitals) or 1300-1399 (Critical Access Hospitals).

Previous Reset Save & Continue

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.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

[Print](#) [Contact Us](#) [Exit](#)
Thursday 02/09/2012 1:22:05 PM 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

*The **Review** panel displays the information you have entered to date for your application. Select **Print** to generate a printer friendly version of this information. Select **Continue** to return to the last page saved. If all tabs have been completed and you are ready to continue to the Submit Tab, please click on the **Submit** Tab itself to finish the application process.*

R&A Verification

Legal Business Name	Regional Medical Center	Hospital NPI	[REDACTED]
CCN	[REDACTED]	Hospital TIN	[REDACTED]
<hr/>			
Business Address	[REDACTED] PKWY SE [REDACTED], GA 30120-2129		
<hr/>			
Business Phone	770-[REDACTED]		
<hr/>			
Incentive Program	MEDICAID	Deemed Medicare Eligible Status?	State GA
<hr/>			
Eligible Hospital Type	Acute_Care_Hospitals		
<hr/>			
R&A Registration ID	[REDACTED]		
<hr/>			
R&A Registration Email	noreply.b6email@gaummis.com		
<hr/>			
CMS EHR Certification Number	[REDACTED]		
<hr/>			
Is this information accurate?	Yes		

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	<i>In State Medicaid:</i> 300 <i>Other Medicaid:</i> 500 <i>Total Discharges:</i> 8000	10%
	[REDACTED] REGIONAL MEDICAL CENTER	[REDACTED] AVE [REDACTED], GA 31501-5246	<i>In State Medicaid:</i> 200 <i>Other Medicaid:</i> 500 <i>Total Discharges:</i> 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		. GA 30384-6087	00

[Top](#)



Step 7 – Submit Your Application

The final submission of your application involves the following steps:

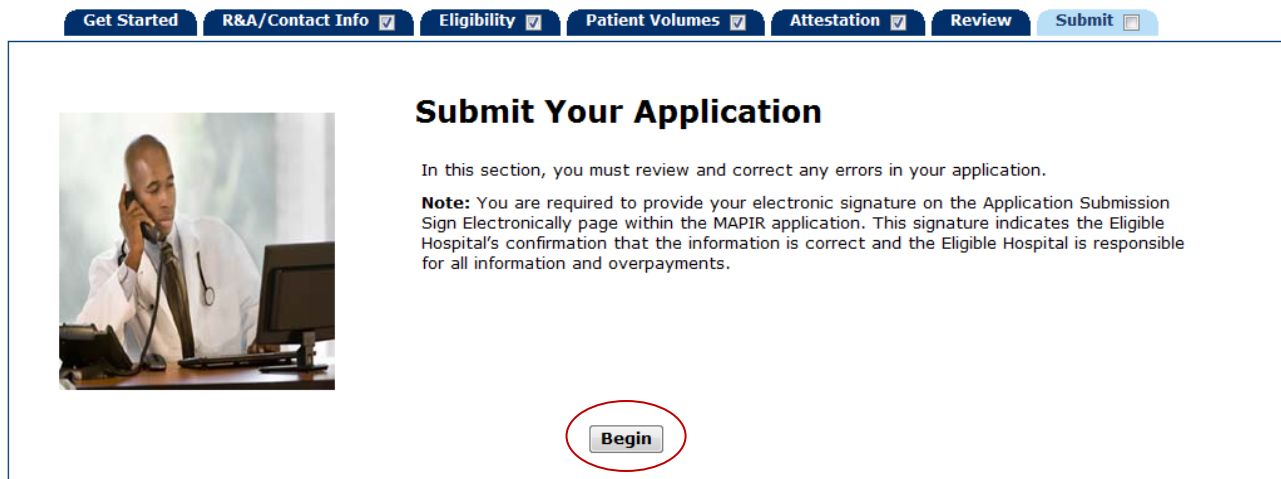
Review and Check Errors – MAPIR will check your application for errors. If errors are present you will have the opportunity to go back to the section where the error occurred and correct it. If you do not want to correct the errors you can still submit your application; however, *the errors may affect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



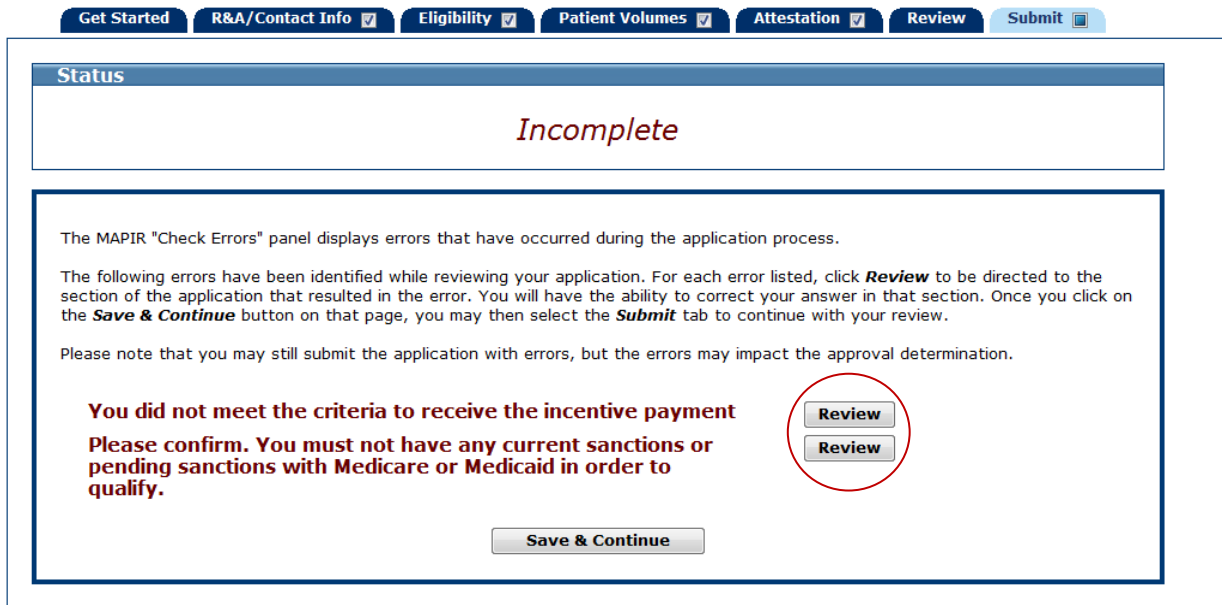
This page lists the current status of your application and any error messages that occurred during the application process.

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.

The screenshot displays the 'Application Questionnaire' interface. At the top, a navigation bar contains buttons for 'Get Started', 'R&A/Contact Info', 'Eligibility', 'Patient Volumes', 'Attestation', 'Review', and 'Submit'. Below this, a blue header reads 'Application Questionnaire'. A light blue instruction box states: '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.' The questionnaire consists of six questions, each with a 'Yes' or 'No' radio button option. The 'Save & Continue' button at the bottom is circled in red. The questions are:

- Question 1: Did the Medicaid EHR Incentive Payment program encourage you to adopt, implement or upgrade an EHR system? (Yes selected)
- Question 2: Did you attend any professional association meetings where the Medicaid EHR Incentive Program was discussed? (Yes selected)
- Question 3: Did you attend any Medicaid Incentive Program webinars offered by the Department of Community Health? (Yes selected)
- Question 4: Does your hospital expect to attest to Meaningful Use Stage 1 in 2012? (Yes selected)
- Question 5: Do barriers exist that prevent you from achieving Meaningful Use Stage 1? (Yes selected)
- Question 6: Was the Medicaid Incentive Program registration and attestation process easy to use? (Yes selected)

Navigation buttons at the bottom are 'Previous', 'Reset', and 'Save & Continue' (circled in red).

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.

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

Application Submission (Part 1 of 2)

You will now be asked to **upload** any documentation that you wish to provide as verification for the information entered in MAPIR. You may upload multiple files.

All files must be in **PDF** or **XLS** format, and must be no larger than **4 MB** in size.

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.

To upload a file, type the full path or click the **Browse...** button.

All files must be in **PDF** or **XLS** format, and must be no larger than **4 MB** in size.

File name must be less than or equal to **100 characters**.

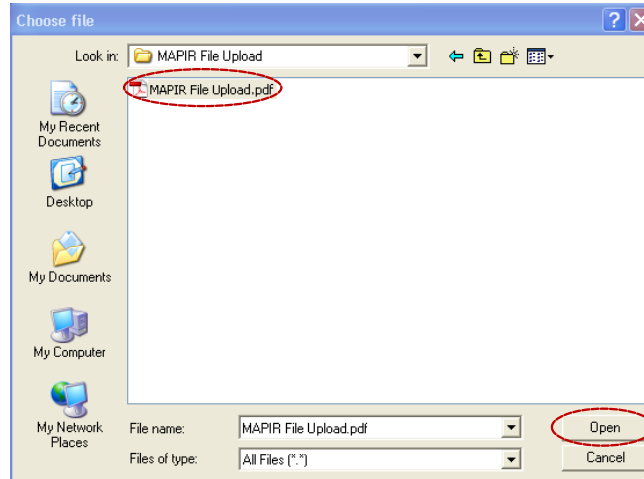
File Location: **Browse...**

Upload File

Previous **Reset** **Save & Continue**

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

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



Check the file name in the file name box.

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

The screenshot shows a web application interface for 'Application Submission (Part 1 of 2)'. At the top, there is a navigation bar with buttons: 'Get Started', 'R&A/Contact Info' (checked), 'Eligibility' (checked), 'Patient Volumes' (checked), 'Attestation' (checked), 'Review', and 'Submit'. The main content area has a blue header with the title 'Application Submission (Part 1 of 2)'. Below the header, there is a paragraph: 'You will now be asked to **upload** any documentation that you wish to provide as verification for the information entered in MAPIR. You may upload multiple files.' This is followed by a light blue instruction box: '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.' Below this, another paragraph states: 'To upload a file, type the full path or click the **Browse...** button. All files must be in **PDF** or **XLS** format, and must be no larger than **4 MB** in size. File name must be less than or equal to **100 characters**.' The 'File Location' field contains the text 'C:\Documents and Settings\training1\Desktop\Attachments.pdf' and a 'Browse...' button. Below the field is an 'Upload File' button, which is circled in red. At the bottom of the form, there are three buttons: 'Previous', 'Reset', and 'Save & Continue'.

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.

The screenshot shows the 'Application Submission (Part 1 of 2)' interface. At the top, there are navigation tabs: 'Get Started', 'R&A/Contact Info' (checked), 'Eligibility' (checked), 'Patient Volumes' (checked), 'Attestation' (checked), 'Review', and 'Submit'. The main content area has a blue header with the title 'Application Submission (Part 1 of 2)'. Below the header, there is a text block: 'You will now be asked to **upload** any documentation that you wish to provide as verification for the information entered in MAPIR. You may upload multiple files.' This is followed by a light blue instruction box: '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.' Below this, there is a text block: 'To upload a file, type the full path or click the **Browse...** button. All files must be in **PDF** or **XLS** format, and must be no larger than **4 MB** in size. File name must be less than or equal to **100 characters**.' There is a 'File Location:' input field with a 'Browse...' button and an 'Upload File' button. Below this is a section titled 'Uploaded Files' containing a table with the following data:

File Name	File Size	Date Uploaded	Available Actions
Attachment_Form.pdf	68249	12/10/2012	<input type="button" value="View"/> <input type="button" value="Delete"/>

Below the table, there is a message: '• File has been successfully uploaded.' At the bottom, there are three buttons: 'Previous', 'Reset', and 'Save & Continue' (which is circled in red).

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.

Application Submission (Part 2 of 2)

As the **preparer** of this location on behalf of the facility, please **attest** to the accuracy of all information entered and to the following:

This is to certify that the foregoing information is true, accurate, and complete.
 On behalf of the Eligible Hospital who is ultimately responsible for the completion of this application, you must be qualified to attest to the accuracy of all information entered and uploaded, and to the following:
 This attestation must be executed by an individual with the legal authority to contractually bind the hospital and to act on behalf of the Eligible Hospital as its agent.
 This is to certify that the foregoing information in this application is true, accurate, and complete. I understand that Medicaid EHR incentives payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws. In signing this application I acknowledge reading the NOTICE OF LIABILITY and on behalf of this Hospital hereby bind this Hospital to accepting full financial responsibility for any and all payments received to which the Hospital was not entitled.
 NOTICE OF PROVIDER LIABILITY: The Eligible Hospital requesting the incentives payment is responsible and liable for any errors or falsifications in the attestation process as set forth in this registration. The Eligible Hospital and not the contact for the application will be held liable for inaccurate or incorrect information that improperly results in a Medicaid incentives payment.
 In the event that an Eligible Hospital applied for and obtained a payment for which the Eligible Hospital was not entitled, the Eligible Hospital will be liable for repayment to the Georgia Department of Community Health. In the event of fraud, the Eligible Hospital will be liable for repayment of all costs, interest, and expenses attributable to that repayment.

(*) Red asterisk indicates a required field.

*By checking the box, you are indicating that you have reviewed all information that has been entered into MAPIR (as displayed on the **Review** panel).

Electronic Signature of Preparer for Facility:

* **Preparer Name:** Hospital Preparer * **Preparer Relationship:** EHR Incentive Coordinator

To attest, click the **Sign Electronically** button (you will not be able to make any changes to your application after submission). Click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

Previous **Reset** **Sign Electronically**

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.

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

Application Submission (Part 2 of 2)

Based on the Medicaid EHR incentive rules, the following chart provides an example of the maximum potential amount per year of a three year payment. The columns represent the year of participation, and the rows represent the three years of potential participation.

To submit your application, click the **Submit Application** button (**you will not be able to make any changes to your application after submission**).

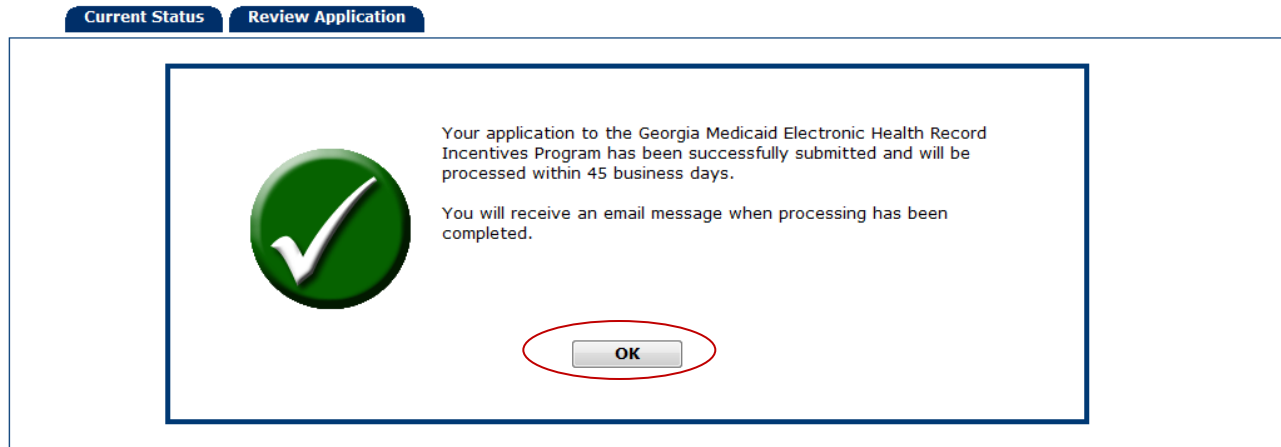
Example Payment Disbursement over 3 Years
Year 1 50%, Year 2 40%, Year 3 10%

Year	Example Calculation	Example Amount
Year 1	\$15,925,500 * 50%	\$7,962,750
Year 2	\$15,925,500 * 40%	\$6,370,200
Year 3	\$15,925,500 * 10%	\$1,592,550

Submit Application

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.



[Print](#) [Contact Us](#) [Exit](#)

Thursday 02/09/2012 2:10:18 PM EST

Name Regional Medical Center

NPI [Redacted]

CCN [Redacted]

Hospital TIN [Redacted]

Payment Year 1

Program Year 2012

[Current Status](#) [Review Application](#) [Document Upload](#)

Name:
Regional Medical Center

Applicant NPI: [Redacted]

Status: **Submitted**

Select **Review Application** to view the information that was entered on the application that was submitted.

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](#)

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



Thursday 09/01/2011 4:36:30 PM EDT

MAPIR

Exit MAPIR

Your session has ended. To complete the log out process, you must close your browser.

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.

The screenshot shows a web interface with four tabs: 'Current Status', 'Review Application', 'Submission Outcome', and 'Document Upload'. The 'Review Application' tab is active. On the left, the application details are listed: Name: REGIONAL MEDICAL CENTER, Applicant NPI: [REDACTED], and Status: Completed. On the right, a 'Get Started' section provides a list of five items needed for registration, including a user guide, reporting period information, patient encounter volume information, a certified EHR number, and electronic documentation. At the bottom of this section, it directs users to the CMS EHR website and the Georgia Medicaid EHR Incentives Program website for additional help.

Current Status **Review Application** **Submission Outcome** **Document Upload**

Name:
REGIONAL MEDICAL CENTER

Applicant NPI: [REDACTED]

Status: **Completed**

Get Started


You will need the following information **before** you begin registration:

- Georgia Medicaid EHR Incentive Payment User Guide for Eligible Hospitals** - Print this document to help you complete your Medicaid EHR Incentives application.
- 90-day Reporting Period.** The dates for your 90-day reporting period for the patient volume calculation.
- Your patient encounter volume information.** Download the **Eligible Hospital Incentives Payment Calculator** to complete your calculation **before** you begin registration.
- 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.
- 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](#)

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

Current Status **Review Application** **Submission Outcome** **Document Upload**

 The MAPIR "Review" panel displays the information that you have entered to date for your application. Select "Print" to generate a printer friendly version of this information.

Status
Completed

Payment Amount
You have been approved to receive a payment in the amount of \$60,093.05

Provider Information
Name: REGIONAL MEDICAL CENTER
Applicant NPI: ██████████

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](http://ga-hitec.org) 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.