

# District of Columbia State Level Registry for Provider Incentive Payments Eligible Hospital User Manual



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# Table of Contents

<b>Introduction</b>	<b>7</b>
Who can benefit from the User Manual?	7
DC-SLR Application Availability	7
Problem Reporting	7
<b>Overview</b>	<b>8</b>
Dates	8
Application Architecture	9
Materials and Preparations	9
<b>Method</b>	<b>10</b>
Login – Accessing the DC-SLR	10
Error Messages	10
DC-SLR login from the Provider Outreach Web Portal	11
DC-SLR login directly from the DC-SLR login URL	15
Error Messages	16
Creating a New DC-SLR Account for Eligible Hospitals	17
Error Messages	22
Accepting the End User License Agreement (EULA)	24
Error Messages	24
Changing Your Password	25
Error Messages	26
Navigating SLR	27
Hard and Soft Stops	27
Save and Continue	28
Navigation Bar	28
Applying for the incentive as an Eligible Hospital (EH)	29
Home Page	29
Workflow Section Details	33
Step 1: About You Section	34
Error Messages	36
Step 2: Confirm Medicaid Eligibility Details	37
Error Messages	42
Step 3: Attestation of EHR Details	44
AIU Method Page	45
Error Messages	46
EHR Certification Page	47

Error Messages	48
Meaningful Use Section	50
Error Messages	55
Step 4: Review and Sign Agreement Details	58
Error Messages	59
Step 5: Send Year X Attestation Details	59
Error Messages	60
Accessing Reports	62
Reports for Eligible Hospitals	62
View Payment Information	63
Payment Calculations for Eligible Hospitals	63
Attaching Files	67
The Attach Documentation Section	67
Error Messages	69
Timing Out	70
Accessing Help	71
Help Text Displays	71
<b>Definitions</b>	<b>73</b>

# Introduction

The overall goal of the User Manual is to help guide hospital administrators through the process of completing their application for the Centers for Medicare & Medicaid Management's (CMS's) EHR Incentive Payment. This application is submitted through the District of Columbia (DC)'s State Level Registry (DC-SLR), a web tool designed to capture all information needed for the approval of the EHR payment, and to submit the application to the district.

## Who can benefit from the User Manual?

This manual is for administrators of Eligible Hospitals to use as a guide to the DC-SLR web application.

## DC-SLR Application Availability

The application is available 24 hours a day, 7 days a week, and is accessible from the internet.

## Problem Reporting

For general Help, all DC-SLR web pages have a **Help** Link that opens up a copy of this User Manual. For DC-SLR Web application assistance, you may contact the Xerox Help Desk designated to support the DC-SLR at (866)-879-0109. Select option 0 for assistance with:

- System Issues
- Directions for completing the Attestation Agreement
- Assistance with using the application
- Other questions related to the SLR application

You may also email the SLR Help Desk at: [SLRHelpdesk@xerox.com](mailto:SLRHelpdesk@xerox.com). For questions specific to the DC Medicaid EHR Incentive program, visit the DC EHR Incentive Program Provider Outreach Page at

<http://dc.arryaincentive.com>. For policy questions regarding the DC Medicaid EHR Incentive program, you may email [dcslr@dc.gov](mailto:dcslr@dc.gov).

## Overview

As the healthcare landscape continues to modernize, legislation was passed to encourage the adoption of Electronic Health Record (EHR) technology in documenting patient care. Because of the American Recovery and Reinvestment Act (ARRA) of 2009, eligible Medicaid Providers are being offered financial incentives for the implementation and meaningful use of Health Information Technology (HIT) in the management of patient populations. In support of this initiative, Xerox has developed the EHR Provider Incentive Portal application, called the State Level Registry (DC-SLR).

By using DC-SLR, you have access to a streamlined application for federally funded HIT incentives through an easy-to-use website. With self-service flexibility, you can move through registration, eligibility and attestation at your own pace while the DC-SLR application stores your information in an organized manner. This application provides the most direct path to your incentive payment.

## Dates

An EH applying for the 2013 program year must have Medicaid eligibility dates between 10/1/11 – 9/30/12. For SLR clients that are allowing additional periods, the Hospital fiscal year that ends in prior Federal fiscal year must have an end date that ends between 10/1/10 – 9/30/11. EHs starting their applications after January 1, 2013 will be in the 2013 program year.

Each State has a designated Grace Period in the beginning of the new fiscal year during which users that have not submitted an Attestation Agreement can elect the year for which they are Attesting. Users may select the current year and submit Eligibility numbers for the previous fiscal year, or select the previous year as their Program Year and enter numbers from the year before that.

Select Attestation Program Year

Program Year \*



## Application Architecture

The DC-SLR Web application features the following:

- Compliance with Section 508 accessibility guidelines.
- Accessibility from the internet: Xerox has made every effort to make this site accessible to people with disabilities. In the event you experience difficulty accessing this site with assistive devices, please contact our Help Desk at (866) 879-0109 for assistance in obtaining the information you need.
- Secure protected page access.

## Materials and Preparations

Materials the user will need to use the software:

- Computers with access to the web browser.
- Software – **Adobe Acrobat Reader** – installed on your machine to view PDF files.
- The Pop-up Blocker feature of your browser should be set to **Off** to enable pop-up window features.
- Manuals and/or FAQ's that are available for distribution.

Also note that this application is approved for use with Microsoft Internet Explorer versions 7.0 and 8.0 and not certified for use with other browsers or versions..

# Method

## Login – Accessing the DC-SLR

The DC-SLR is a web-based application. It is accessible from the internet via the Provider Outreach Web portal or directly from a login URL.

1. Open Microsoft Internet Explorer to access the Web.
2. Type your State’s URL in the address field and press the **Enter** key on your keyboard.

<https://dc.ara incentive.com>

### Error Messages

<p>You are not eligible to participate in the Medicaid EHR Incentive Program in the District of Columbia. Please contact DHCF at <a href="http://dcslr.dc.gov">dcslr.dc.gov</a> if you believe this is an error or you have questions.</p>	<p>The provider must contact a District representative to solve this issue with DC’s Medicaid agency.</p>
<p>The State Level Registry (SLR) for Provider Incentive Payments and related web sites (such as the SLR Provider Outreach page) require a minimum screen resolution of 1024x768. The SLR and related web sites are best viewed with Internet Explorer version 7 and above. Using Compatibility Mode/ Compatibility View in Internet Explorer may result in the application displaying incorrectly.</p>	<p>A message for the provider to ensure the correct browser and a minimum standard for the monitor.</p>

# DC-SLR login from the Provider Outreach Web Portal

You can access the DC-SLR Web application from the Provider Outreach Web portal. This webpage features provider education resources related to the American Reinvestment and Recovery Act (ARRA) and the Health Information Technology for Economic and Clinical Health (HITECH) act, and also provides a link to the DC-SLR application login page.

The *Provider Outreach* page displays the following:

1. Located at the top of the page is a banner that displays the following items that are visible on every page of the DC-SLR application:
  - a. The District's logo.
  - b. The heading "State Level Registry (SLR)". This is the name of the application.
  - c. **Provider Outreach Home** link: on other pages in the Provider Outreach site, this links to the home page.
  - d. **Contact Us** link: opens a pop-up page displaying contact information including the Xerox Help Desk phone number and email.
2. DC-SLR Dates, Account Creation/Entry, News, and FAQs sections. Located to the left and right of the page, these columns display the following sections:
  - a. *Important Dates to Remember* section: Gives the date DC will begin to accept registration in the SLR and attestations completed within SLR.
  - b. *Need to create an SLR account?* section: accesses the Medicaid Provider Incentive Program site directly, allowing providers to register for the program.
  - c. *Already have an DC-SLR account?* section: directs you to the *Login* page of SLR.
  - d. *Frequently Asked Questions* section: the view our list of most frequently asked questions link directs you to CMS' frequently asked questions website related to electronic health record (EHR) technologies and the incentive program.

- e. *Are You Eligible?* section: clicking this link or graphic opens the CMS Eligibility Wizard, which asks a series of questions to see if a Provider would likely be eligible for an incentive payment.
  - f. *Healthcare IT News* section: a link in this section opens up a new tab or window and displays an article related to Healthcare IT news.
  - g. *Centers for Medicare & Medicaid Services (CMS)* section: links in this section open up a new tab or window and displays CMS news.
  - h. *EMR and HIPAA* section: links in this section open up a new tab or window and display news related to Electronic Medical Records (EMR) and the Health Insurance Portability and Accountability Act (HIPAA).
3. Located in the middle of the page, the primary page content entails the following sections:
- a. Welcome text. This is an overview of the Medicaid EHR Incentive Program (MEIP) portal.
  - b. Click the EH process (Eligible Hospital) link to open detailed instruction for your user type.
  - c. *Important Web Resources* section. A link in this section opens up a new window and displays the appropriate website. Standard links provided by Xerox include links to CMS and the ONC.
    - i. **CMS EHR Incentive Programs Registration site** link: opens up a new window and displays the Medicare & Medicaid EHR Incentive Program Registration and Attestation System.
    - ii. **Centers for Medicaid and Medicaid Services** link: opens the CMS site.
    - iii. **Office of the National Coordinator for Health Information Technology (ONC) Certified Health IT Product List** link: opens up a new tab or window and displays the Certified Health IT Product List.
  - d. *Regional Extension Centers (REC)* section. Clicking the **eHealthDC** link in this section opens up a new tab or window and displays the REC website.
  - e. *Additional Resources* section. Clicking the link in this section opens up a new tab or window and displays the associated website. These include:

**i. The District of Columbia - Health Information Exchange Site**

4. Footer section. Located at the bottom of the page, the footer displays the following items:
  - a. **Privacy** link: opens a new window with a Privacy policy displayed.
  - b. **Terms of Use** link: opens a new tab or window with the Terms of Use policy displayed.
  - c. **Accessibility** link: opens a new tab or window with the website's Accessibility policy displayed.
  - d. **Xerox Copyright**. This is Xerox's copyright symbol and text.

**Important Dates to Remember**

The District of Columbia State Level Registry (DC SLR) will begin accepting registration and attestations on August 1, 2013. You must register at the CMS EHR Registration and Attestation System prior to registering with the DC SLR, and you may do so on or after August 1, 2013.

**Need to create an SLR account?**

Click here to [leave this site and create an SLR account](#) for accessing the Medicaid Provider Incentive Program site.

**Already have an SLR account?**

Click here to [go directly to the State Level Registry for Provider Incentive Payments](#) site.

**Frequently Asked Questions**

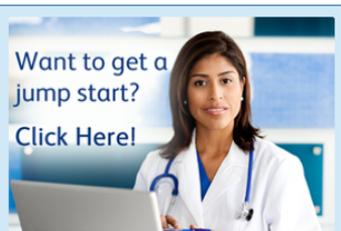
Have a question? Click here to [view the CMS list of frequently asked questions](#).

**Medicaid EHR Incentive Program (MEIP)**

The MEIP was established under the provisions of the HITECH Act and provides for incentive payments to certain health care professionals and hospitals that meet specific eligibility requirements when they adopt, implement, upgrade and meaningfully use certified EHR technology.

Department of Health Care Finance (DHCF) is responsible for the MEIP in the District of Columbia and anticipates being able to accept online enrollments and attestations for the MEIP by July 2013.

Note: Eligible Hospitals that register for both Medicare and Medicaid may pre-register for MEIP before the District launches its online attestation portal in July, but your hospital will be placed in a "pending state validation" status for eligibility in MEIP. To prepare for the MEIP, health care professionals and hospitals must adopt, implement or upgrade to a CMS-certified EHR system, (use the Certified Health IT Product List available at <http://onccplp.force.com/ehrcert> to verify the certification status of your EHR system); register on the CMS EHR registration website available at the [CMS EHR registration website](#).



Click here to view information that will give you a jump start on getting your ARRA incentive payment.

- [Eligible Professionals](#)
- [Eligible Hospitals](#)
- [Group Administrators](#)

To begin now,

1. Register at CMS.gov for Medicare and Medicaid EHR Incentive Program.
2. Verify approved EMR version for Adopt, Implement, and Upgrade (AIU).
3. Please select and download the documents below to learn more about the Medicaid and Medicare Incentive program, eligibility, and registration process.

- [EP process \(Eligible Professional\)](#)
- [EH process \(Eligible Hospital\)](#)

Feel free to also use this Step by Step process by selecting the link below to learn more about Meaningful Use and Attestation: <http://www.healthit.gov/providers-professionals/ehr-implementation-steps/step-1-assess-your-practice-readiness>

For more information, including payment tables, visit the web address listed below and return to this web site, frequently, for future updates regarding our [Registration and Attestation portal](#).

- MEIP will continue to pay incentives through 2021. Eligible professionals can participate for 6 years, and participation years do not have to be consecutive. The last year that an eligible professional can begin participation in the MEIP is 2016.
- Incentive payments for eligible professionals under the MEIP are higher than the Medicare Incentive Program — up to \$63,750 over six years.

**What are the categories of eligible professionals that may qualify for the MEIP?**

- Physicians
- Nurse practitioners
- Certified Nurse – Midwife
- Dentists
- Physician Assistants (PA) who practice in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) that is led by a PA.

**Important Web Resources** (all links open in new window)

- [CMS EHR Incentive Program Registration site](#)
- [Centers for Medicare & Medicaid Services \(CMS\)](#)
- [Office of the National Coordinator for Health Information Technology \(ONC\) Certified Health IT Product List](#)

**Regional Extension Centers (REC)** (all links open in new window)

- [eHealthDC](#)

**Additional Resources** (all links open in new window)

- [DC HIE](#)

**Are You Eligible?**

Run the CMS Eligibility Wizard and quickly see if you may qualify for incentive payments.

**Centers for Medicare & Medicaid Services (CMS)**

Beginning January 3, 2011, the Electronic Health Record (EHR) Information Center will be open to assist the EHR Provider Community with both program and system inquiries from 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays, at 1-888-734-6433 (primary number) or 888-734-6563 (TTY number). [more info...](#)

(all links open in new window)

May 07, 2013  
[Administration offers consumers unprecedented look at hospital charges](#)

Apr 30, 2013  
[CMS announces single streamlined Marketplace application](#)

Apr 09, 2013  
[Navigator Grants announced to help inform consumers in the new Health Insurance Marketplace](#)

**Healthcare IT News**

(all links open in new window)

Apr 15, 2013  
[The road ahead for health IT... and for EHRWatch](#)

Apr 12, 2013  
[ONC budget includes proposed vendor fee](#)

Apr 11, 2013  
[Genomics data just the first in long line of hurdles](#)

**EMR and HIPAA**

(all links open in new window)

Jun 13, 2013  
[A Primer On HIPAA Compliance For BYOD](#)

Jun 12, 2013  
[4500 Patient Records Found During Drug Bust](#)

Jun 11, 2013  
[EHR's EHR Code of Conduct – Will Anything Change?](#)

To get to the login page from the *Provider Outreach* page, click on the **go directly to the State Level Registry for Provider Incentive Payments** link located on the left side of the *Provider Outreach* webpage.



## DC-SLR login directly from the DC-SLR login URL

If you have already created an account, you may also get to the SLR's *Login* page by entering the URL into your browser:

<https://dc.rraincentive.com/>

Type the State Level Registry URL in the address field and press the **Enter** key on your keyboard.

From here, you will reach the DC-SLR Web application *Login* page. You'll have three chances to enter in the correct login information before the system locks your account. If that happens, call the Help Desk for assistance.

Throughout the DC-SLR application, red asterisks (\*) display on various fields. This symbol indicates that this field is required to be completed in order to continue through the application.

The Login page displays the following:

1. **User ID** field: enter your User ID.
2. **Password** field: enter your password.
3. **Login** button: verifies the User ID and password you entered and opens the End User License Agreement (EULA).
4. **Forgot User ID?** link: selecting this will open a *Forgot User ID* pop-up asking you for your National Provider Identifier (NPI) and Tax

Identification Number (TIN) as well as the answer to the Challenge Question you selected when you first created the account. Once you have entered those correctly, the system will email the User ID to the email address entered when you created your account.

### Forgot User ID

**Identify Yourself**

Select the user role for which you registered, then enter the appropriate IDs and click Continue \*  
Red asterisk indicates required fields.

What is your role? \*

NPI \*

TIN \*

5. **Forgot Password?** link: select when you have forgotten your password. The system will ask you for your User ID as well as the answer to the Challenge Question you picked when creating your account. Once you have entered those correctly, the system will email you a link to reset your password to the email address you entered when you created your account.
6. **Create Account** button: select this if you need to create a new DC-SLR account.

**Existing Users**

Enter the User ID and password you created to login to the SLR. If you have not already created a User ID, please select the Create Account option to create a new User ID. \* Red asterisk indicates a required field.

User ID \*

Password \*

*The State Level Registry (SLR) for Provider Incentive Payments and related web sites (such as the SLR Provider Outreach page) require a minimum screen resolution of 1024x768. The SLR and related web sites are best viewed with Internet Explorer version 7 and above.*

[Forgot User ID?](#)

[Forgot Password?](#)

**Need to Create an Account?**

If you are an Eligible Professional, Eligible Hospital Representative, or Group Practice/Clinic Representative, you can create a user account for the SLR. If you have not already created a User ID, please select the Create Account button below to create a new User ID.

## Error Messages

<p>Your login attempt was not successful. Please try again. Call the Help Desk at 866-879-0109 if you</p>	<p>This may appear at login. Carefully type the password.</p>
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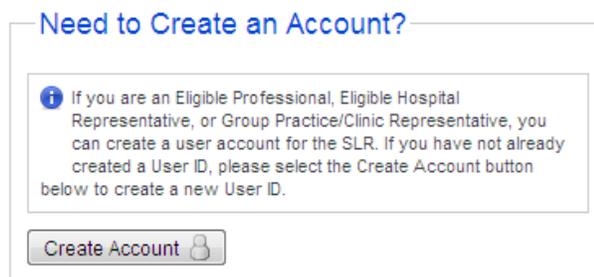
need assistance.	
Your account is currently locked out; please contact the Help Desk at 866-879-0109	This message will appear for accounts that have been locked out or expired.
Required Field	This warning will appear next to each required data item that is unpopulated. The page will not save until the field is populated.
If you do not click Continue, you will be logged out of the system in 30 seconds and lose any unsaved data.  To remain logged into the SLR application, click Continue	As a security feature, SLR will time out after 10 minutes of inactivity. This warning will appear before the user is logged out.

## Creating a New DC-SLR Account for Eligible Hospitals

To create a new account from the *Provider Outreach* page, select the **leave this site and create an DC-SLR account** link located on the left side of the *Provider Outreach Jumpstart* page.



To create a new account from the *Login* page, select the **Create Account** button.



The *Create Account* page displays the following:

1. **What is your role?** pull-down menu: identify your Provider Type by selecting an option from the menu. As a hospital administrator, select [Individual Eligible Hospital](#).
2. **NPI** text field: enter your National Provider Identifier (NPI) number. If you have more than one NPI, use the one that you used while registering with the CMS Medicaid EHR Incentive Program Registration Site. If the number entered is not recognized, an error message will appear, and you will not be able to proceed.
3. **TIN** text field: enter your Taxpayer Identification Number (TIN), which is either your Employer Identification Number (EIN) or your Social Security Number (SSN).
4. **CAPTCHA** image: a computer-generated image.
5. **Generate New Image?** link: refreshes the image above if you are unsure of what numbers and letters are being displayed.

6. **Enter the letters/numbers from the image above** text field: enter the letters and/or numbers you see in the **CAPTCHA** image. This is a security feature.
7. **Continue** button: select this button to the open the SLR. You will confirm your name and the address associated with your NPI and TIN.
8. **Cancel and return to Login** link: opens the *Login* page.

## Create Account

If you are an Eligible Professional, Eligible Hospital Representative, or Group Practice/Clinic Representative, you can create a user account for the SLR. Please enter the following identification information to start the process of creating your user account.

### Identify Yourself

Enter the necessary information below and click Continue. \* Red asterisk indicates a required field.

What is your role? \*

NPI \*

TIN \*



Generate New Image

Enter the letters/numbers from the \*

Letters are case sensitive.  
If you have difficulty identifying the characters in the image above, click the link to display a new image.

Continue 
Cancel and return to Login

Clicking the **Continue** button opens the next page where you will confirm that the information the system has retrieved up is accurate.

The *Create Account Confirmation* page displays the following:

1. **NPI** display field: the NPI you entered on the *Identify Yourself* page.
2. **TIN** display field: the TIN entered on the *Identify Yourself* page.
3. **Medicaid ID** display field: the Medicaid ID associated with the NPI and TIN you entered.
4. **Name** display field: the name associated with the NPI and TIN you entered.

5. **Address** display field: the address associated with the NPI and TIN you entered.
6. **Active** display field: will display true if the NPI / TIN is active with the District's Medicaid program and false if it is inactive.
7. **No, Go back** button: returns to the previous page.
8. **Yes, Continue** button: opens the next page to continue creating your account.

Create Account

Is This You?

	NPI	TIN	Medicaid ID	Name	Address	Active
<input checked="" type="checkbox"/>	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX	XXXXXXXXXX, XXXXX, XXXXX	True

Select the provider record you wish to use to create your user account.

All records that match the NPI or TIN will be displayed, including any records with an inactive status. Only those records with an active status can be used to create an account.

If the information is not correct, select the **No, Go back** button to return to the previous page. From there, you may either retry entering your NPI and TIN or call the Help Desk for assistance.

If the information is correct and you click the **Yes, Continue** button, the following additional section will appear on the page:

1. **User ID** text field: enter a User ID Number. This must be at least 8 letters and/or numbers long, but not more than 20 letters and numbers.
2. **Password** text field: enter a password. Your password also needs to be at least 8 letters and numbers long and must be less than 20 letters/numbers. When you are choosing a password, you also need to make sure to include the following:
  - At least one capital letter
  - At least one lower case letter
  - At least one number
  - At least one of the following special characters: @ or # or !

Your password cannot be your User ID or your User ID spelled backwards.

3. **Confirm Password** text field: enter the password you entered above to confirm it.
4. **Select a Challenge Question** pull-down menu: select an option from the pull-down menu as a Challenge Question to answer.

5. **Your answer to the Question** text field: enter an answer for the Challenge Question that you selected above. You'll need this information if ever forget your User ID or password.
6. **Phone Number** text field: enter your phone number as a ten-digit number, with no spaces, dashes, or parentheses.
7. **Email Address** text field: enter your email address.
8. **Confirm Email Address** text field: enter your email address again to ensure it wasn't misspelled.
9. **Create Account** button: select this button to save your account. If you have left a required field blank or entered information incorrectly, you will receive an error message.
10. **Cancel and return to Login** link: select this button to cancel all the changes and return to the *Login* page.

Create Account

Is This You?

Name

Address

Create Login

Enter the necessary information below and click Create Account. \* Red asterisk indicates a required field.

User ID \*

Password \*

Confirm Password \*

Select a Challenge Question \*

Select Challenge Question...

Your Answer to the Challenge Question \*

Phone \*

E-mail address \*

Confirm E-mail address \*

Create Account

[Cancel and return to Login](#)

Once you click the **Create Account** button, you will be routed to the final page for creating an account.

The final *Create Account* page displays the following:

1. **Account successfully created.** This is a message signifies that you have successfully created your DC-SLR account.
2. **Continue to Login** button: opens the *Login* page.

## Error Messages

<p>The User ID must be between 8 – 20 characters. No spaces or special characters are allowed. Please try again.</p>	<p>The information in the other fields will not be lost. The system also stops entry of characters past 20.</p>
<p>User ID exists. Please enter a different User ID.</p>	<p>The user must select a username that is unique among all users of the site.</p>
<p>Password must have a minimum of 8 characters and a maximum of 20. Your password must include at least 1 upper and 1 lower case letter, 1 number, 1 special character (the “at” symbol “@” ; pound “#” ; exclamation “!”), not your login name and not an old password.</p>	<p>The user must select a password that fulfills all the requirements.</p>
<p>Confirm Password</p>	<p>The page will not submit until the <b>Confirm Password</b> field is populated.</p>
<p>The Confirm New Password must match the Password entry</p>	<p>The page will not submit until the password is duplicated in the <b>Confirm Password</b> field.</p>
<p>Invalid phone format</p>	<p>The user must enter a number in requested format. If the number was copied from another document or web page and pasted in the field, the formatting will likely need to be corrected.</p>

<p>Confirm E-Mail Address must match the E-mail address</p>	<p>The page will not submit until the email address is duplicated in the <b>Confirm E-Mail Address</b> field.</p>
<p>The characters you entered didn't match the word verification. Please try again</p>	<p>If the provider mistypes the CAPTCHA field, the field will refresh for another try. No other values are changed on the screen except for the CAPTCHA field.</p>
<p>There is already an account registered with the NPI and TIN entered. Please contact the help desk at 866-879-0109.</p>	<p>This message will display if the TIN or the NPI entered into the fields is already associated with a User ID. The provider will need to contact the Help Desk to solve the issue.</p>
<p>The NPI and TIN entered does not match an enrolled provider with DC Medicaid. Please contact the help desk at (866) 879-0109, select option 0 for assistance.</p>	<p>This pop-up message appears when system checks the PMF data and does not find the record. This produces a Hard Stop. All pop up messages have a <b>Cancel</b> and an <b>X</b> button that may be used to close the message.</p>
<p>The NPI and TIN entered does not match provider registration data received from CMS. If it has been more than 24 hours since you submitted registration to CMS, please contact the help desk at (866) 879-0109, select option 0 for assistance.</p>	<p>This message appears if the system checks the CMS R&amp;A data and does not find the record. If a provider registers with CMS, they should wait until the next day before registering with SLR, and the data is transferred overnight.</p>
<p>The provider is registered as an Eligible Professional at CMS. Please check the role that you have selected at SLR and proceed with creating your account. Please contact the help desk at 866-879-0109 for assistance.</p>	<p>The system checks the CMS R&amp;A data and found a match with an Eligible Professional. The provider must select Eligible Professional Hospital as their user type.</p>

<p>The characters you entered didn't match the word verification. Please try again</p>	<p>If the provider mistypes the CAPTCHA field, the field will refresh for another try. No other values are changed on the screen except for the CAPTCHA field.</p>
--	--

## Accepting the End User License Agreement (EULA)

After your first login to the system, you will be presented with the End User License Agreement (EULA). You must agree with the EULA in order to continue.

The *End User License Agreement* page displays the following:

1. **I Agree with the End User License Agreement** checkbox: selecting this checkbox indicates that you agree with the associated statement.
2. **Print EULA** button: clicking this will open a *Print EULA* window with the EULA formatted for printing, and open a *Print* window so that the content may be printed to a local printer.
3. **Continue** button: opens the SLR home page.
4. **Cancel and return to Log in** link: returns you to the *Login* page.

## Error Messages

<p>Please agree to the End User License Agreement.</p>	<p>The user must check the box in order to proceed.</p>
--	---

# Changing Your Password

Your password will be good for 45 days. When you login and 45 days have passed since you created the password, a *Reset Password* page will appear. You may change your password on this page.

1. After 45 days, the Reset Password page displays:
  - a. **New Password** text field: enter a new password.
  - b. **Confirm New Password** text field: enter the password again.
  - c. **Save** button: selecting this button saves your new password.
  - d. **Cancel** button: clears entries made into the two text fields above, and no change is made to your password.

2. Voluntary Password Change:

To change your password before the 45 days have passed, select the **My Account** link in the top right-hand corner of the DC-SLR home page. In addition to changing your password, you may also update contact information or change your Challenge Question and answer on this page.

The *My Account* page displays the following:

- a. **User ID** text field: displays your current User ID and allows you to change it.
- b. **Password** link: select the **Click Here to Change** link to open the *Change Password* page.
  1. **Current Password** text field: enter your current password in this field.
  2. **New Password** text field: enter a new password.
  3. **Confirm New Password** text field: enter the new password to confirm it in this field.
  4. **Change Password** button: click this to change the password and open the *My Account* page.
  5. **Cancel and return to My Account** link: opens the *My Account* page without making a change.
- c. **Select a Challenge Question** pull-down menu: select a new Challenge Question.
- d. **Your Answer to the Challenge Question** text field: if you select a new Challenge Question, enter a new answer to the Question.
- e. **Phone** text field: displays your current phone number and allows you to change it.

- f. **Email Address** text field: displays your current email address and allows you to change it.
- g. **Save My Account** button: saves any updated information you entered on this page.
- h. **Cancel and lose My Account changes** link: clears the information you have entered.

### My Account

Make changes to your account below.

Changing the contact information here does not change the contact information set up under the About You page or the contact information provided to CMS in the registration process. SLR generated messages will be sent to all email accounts recorded for this provider.

User ID

Password [Click Here to Change](#)

Select a Challenge Question

Your Answer to the Challenge Question

Phone

E-mail address   
[name@domain.com](#)

[Cancel and lose My Account changes](#)

## Error Messages

The password section will have similar error messages as the Account Creation pages to enforce password standards.

Invalid Password. Please try again.	The system will verify the password.
There was an error saving your password. Please contact the Help Desk at 866-879-0109	When changing a password, some errors will need to provider to contact the Help Desk. This will generally be account lockouts.
You cannot use a password that you have already used in the past.	SLR will saves all passwords, and an older password cannot be used.
The Confirm New Password must	The page will not submit the

match the Password entry.	<b>Confirm Password</b> field duplicates the password.
Password must have a minimum of 8 characters and a maximum of 20. Your password must include at least 1 upper and 1 lower case letter, 1 number, 1 special character (the 'at' symbol '@' ; pound '#' ; exclamation '!'), not your login name and not an old password.	The user must select a password that fulfills all the requirements.
Invalid phone format is displayed.	The indicated phone format must be followed.
Please enter a valid Email address.	The email address must be valid.

## Navigating SLR

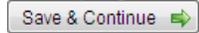
### Hard and Soft Stops

Certain fields are required to be populated, like the **Contact Person Name** field on the *Step 1. About You* page. Other fields are both required to be populated and checked against another system to ensure they are correct, such as the **EHR Certification Number** field on the *EHR Certification* page. The District's Medicaid specialists have decided whether required fields are hard or soft stops.

- **Hard Stop:** the system will not allow the user to proceed to the next step without populating the field, and having it validated correctly if necessary. The information on the page cannot be saved until the field is populated correctly.
- **Soft Stop:** the user may proceed and enter other information in the system, though the field is still required and must be completed before the user can proceed to *Step 4*. A warning message will be displayed on the page and an icon will be visible in the Navigation Menu. At *Step 4*, the Attestation Agreement is produced, and at this point all required fields must be completed before it can be generated.

## Save and Continue

SLR pages that require data entry have a **Save & Continue** button



. When this is selected, measures entered onto certain pages are validated. For example, the **Enter Representative Period** field on the *Confirm Medicaid Eligibility* page is verified to be in the previous federal fiscal year.

Enter Representative Period \* 90-day period ▼

Year 1 Start Date \* 5/1/2011 

Year 1 End Date \* 7/29/2011 

 Representative Period must be in the previous federal fiscal year.

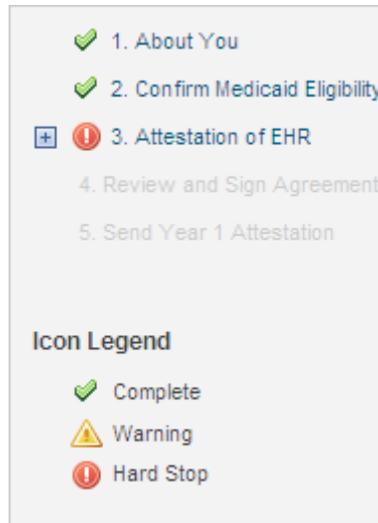
Only the **Save & Continue** button will validate that the information in required fields is correct and save the results to the database. Using any other kind of navigation – the **Back** button  on your browser or links in the *Navigation Menu*, for example – will abandon the page and the entries will not be saved.

## Navigation Bar

In DC- SLR, moving through the site is assisted by the use of a *Navigation Menu* on SLR pages, though it does not appear on the *Home* page. Only links to pages that are available to be accessed will be active in the *Navigation Menu*. Inactive links appear light gray in color, while active links are blue.

Icons appear next to the page links that indicate the status of each page and section in SLR – whether it is complete () , has generated an error notice () , or a required field or task was left undone (). Click the expand icon to  view all the submenu items. Click the collapse icon  to hide the submenu items.

If the user elects to attest to the Meaningful Use of their EHR Technology solution, the MU Objectives and CQM (Clinical Quality Measures) page links will appear in the *Navigation Menu*. If the user attests to the Adoption, Implementation, or Upgrade (AIU) of the EHR Technology solution, the *AIU Method* and *EHR Certification* page links will appear.



In the example above, the provider has completed Steps 1 and 2 and is now at Step 3. A required field has not been completed. A hard stop will prevent the page from being saved.

## Applying for the incentive as an Eligible Hospital (EH)

After you log in as an Eligible Hospital (EH) user and accept the EULA, the EH *Home* page will open. The home page serves as a dashboard and navigation tool for the DC-SLR application.

### Home Page

The DC-SLR home page for EH displays the following:

1. DC-SLR Banner section. Located at the top of the page, the banner displays the following items that are visible on every page of the DC-SLR application:
  - a. The District's logo.
  - b. **State Level Registry:** the name of the application.
  - c. **My Account** link: opens the *My Account* page.
  - d. **Help** link: displays a PDF copy of this User Manual.

- e. **Contact Us** link: a pop-up page displaying contact information, including the Xerox Help Desk phone number and email address.
  - f. **Logout** link: allows you to log out of the DC-SLR Web application.
  - a. **Filing as Eligible Hospital Representative** message: designates your Provider Type.
  - g. Hospital Name display field: the name of your Hospital.
  - h. Hospital Street Address display field: your Hospital's street address.
  - i. Hospital City, State and Zip Code display fields: the City, State and Zip Code of your Hospital.
  - j. **Last Updated**: display field: displays the last person who updated your account and the date it was updated.
2. *Next Steps* section. Located to the left of the page, the Next Steps section displays messages an:
- a. **Begin/Continue/Complete your Year X submission!** message: displays the year of attestation you are currently completing.
  - b. **Section link**: communicates the next page in the process that must be completed.
  - c. CMS Message display field: this will display "Data has/has not been received from the CMS Medicaid EHR Incentive Program Registration site", which indicates whether the DC-SLR application has received data from CMS.
    - i. **View CMS Medicaid EHR Incentive Program Registration Data** link: opens a pop-up window that

displays your CMS record.

The data on this screen was provided by the CMS Medicaid EHR Incentive Program Registration site and contains the information that you provided to the CMS Medicaid EHR Incentive Program Registration. If any of the information displayed is incorrect, please update your registration information in the CMS Medicaid EHR Incentive Program Registration site. Updates to the CMS Medicaid EHR Incentive Program Registration data may take two to three days before they can be viewed here.

General Information	Last Updated
First Name	Date 9/2/2011
Middle Name	
Last Name	
Suffix	
Address Line 1	
Address Line 2	
City	
State	
Zip	
Phone Number	
Phone Extension	
E-Mail Address	

IDs
Personal NPI
Personal TII
Personal TII Type
Payee NPI
Payee TII
Payee TII Type
Confirmation Number
EHR Cert ID 300000020KUREAA

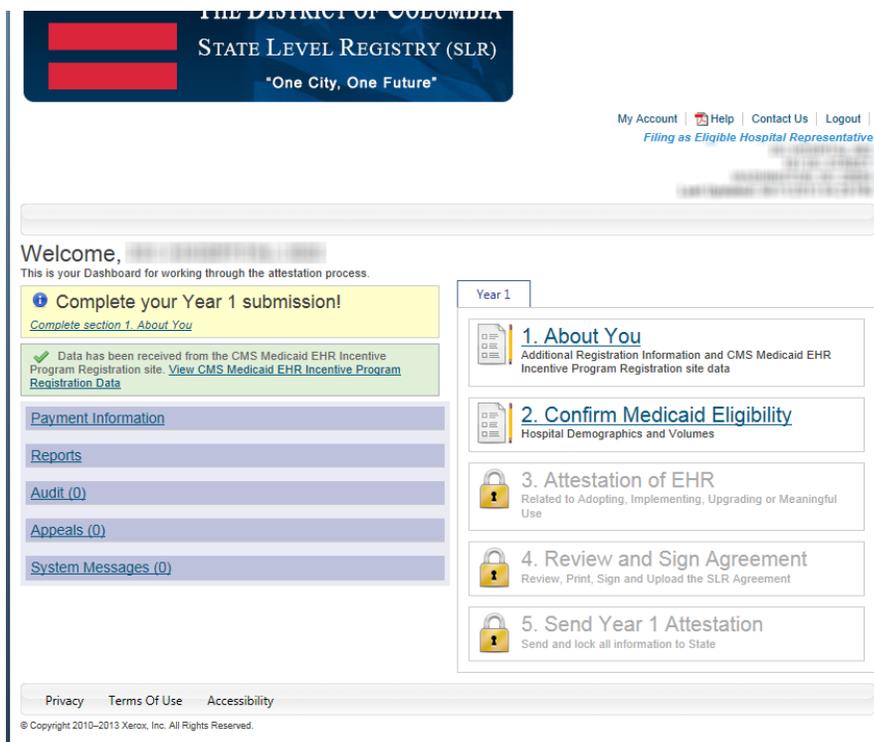
Exclusions	Program
Federal Exclusions	Participation Year 1
No Federal Exclusions	Program Option MEDICAID
State Rejection Reasons	State US
	State ID US
	Provider Type Nurse_Practitioner
	Provider Speciality

3. *Payment Information* section: located on the left of the home page, the *Payment Information* section displays the following items that are visible on the home page:
  - a. **How your payment is calculated** message: opens a pop-up window that explains how your payment is going to be calculated.
  - b. **Payment Status** message: allows you to check on the status of your payment once your attestation has been submitted.
4. *Reports* section: Located to the left of the home page, the *Reports* section displays the following items:
  - a. **Reports** message: you will see the following message when you don't have any data in the system to run a report on: "Reports will be available once your information is saved."
  - b. Report Titles: the titles of available reports will appear here. For example, the **Registration and Attestation Summary Report** link will appear after you have saved at least some information in the DC-SLR Web application. Clicking this link opens a pop-up window displaying the report.
5. Messages sections. Located to the left side of the home page, the Messages sections displays the following items:
  - a. *Audit* section: provides access to Audit messages.
    - i. **#** display field: indicates the number of unread messages that you have.

- b. *System Messages* section: provides access to System messages.
    - i. **#** display field: indicates the number of unread messages that you have.
  - c. *Appeals* section: provides access to Appeals messages.
    - i. **#** display field: indicates the number of unread messages that you have.
  - d. Individual messages. Clicking on one of the individual message links will reveal a message.
    - i. The first line indicates the window title.
    - ii. **Subject** display field:
    - iii. **Date Received** display field: the date the message was sent.
    - iv. **From** display field: the sender the message.
    - v. Message Text section: the message text.
6. *Workflow* section (Detailed further below): located to the right of the page, the *Workflow* section displays the following items that are visible on the home page:
- a. **Year [x]** tabs: each tab represents a year in which you have completed an attestation. The most current year's tab will always be the one visible when you log in. Click other tabs to view previous year information.
  - b. Sections: each section has a Status icon ( , , ,  ) that indicates whether the each page has been started, whether the page has been completed, or whether it is still locked. A locked page cannot be accessed until the previous page has been completed. Each section will also have a description. The title of each section provides a link to that section.
    - i. **About You.**
    - ii. **Confirm Medicaid Eligibility.**
    - iii. **Attestation of EHR.** This link will not be active until you've already completed your registration and eligibility.
    - iv. **Review and Sign Agreement.** This link will not be active until you've completed your attestation of EHR.
    - v. **Send Year X Attestation.** This link will not be active until you've reviewed, signed and uploaded your signed

attestation agreement. Once you submit the attestation, all of the other sections will be locked for editing and will display your information as view-only.

7. Footer section - Located at the bottom of the page, the footer displays the following items:
  - a. **Privacy** link: clicking this link opens a new window with a Privacy Statement displayed.
  - b. **Terms of Use** link: clicking this link opens a new window with a Legal Statement displayed.
  - c. **Accessibility** link: clicking this link opens a new window with the website's Accessibility policy displayed.
  - a. **Xerox Copyright**: Xerox's copyright symbol and text.



## Workflow Section Details

This section describes in more detail the specific steps to take when applying for the Provider incentive. This begins with Step 1, the *About You* section, where you will enter your registration and contact information.

## Step 1: About You Section

Clicking the **About You** link on the EH *Home* page directs you to the *1. About You* page, allowing you to enter your registration information.

The *About You* page displays the following:

1. **< Back to Dashboard** link: returns you to the *Home* page.
2. *CMS Medicaid EHR Incentive Program Registration Record* section

Please note that it may take up to three days for the DC-SLR to receive data from CMS.

- a. “Data has not been received from the CMS Medicaid EHR Incentive Program Registration site.” message: this message appears if your data has not been received by the DC-SLR.
  - b. “Data has been received from the CMS Medicaid EHR Incentive Program Registration site.” message: this message appears if the DC-SLR has received your CMS data.
  - c. **View CMS Medicaid EHR Incentive Program Registration Data** link: this link is visible if your CMS data has been received. Clicking the link opens a pop-up window that displays the CMS data. If you need to make a change to your CMS data, you must make updates on the CMS site. You cannot make changes to your CMS data through DC-SLR, and it takes between two and three days for changes at the CMS level to be applied to DC-SLR.
  - d. **Visit CMS website** link: opens the CMS website. The link is visible whether or not your data has been received.
3. *Contact Person* This section allows you to enter an additional contact besides the one listed as the Eligible Hospital User.
    - i. **Contact Person Name** text field: enter the name of the contact.
    - ii. **Title text** field: enter the title of the individual.
    - iii. **Phone Number** text field: enter the phone number as ten digits, with no spaces, dashes, or parentheses.
    - iv. **Email Address** text field: enter the contact’s email address. Initially this defaults to the address that was entered when the User Account was first created.

### Contact Person

Changing the contact information here does not change the contact information set up under the My Account page or the contact information provided to CMS in the registration process. SLR generated messages will be sent to all email accounts recorded for this provider.

Enter your contact information below.

Contact Person Name \*

Title

Phone Number \*   
Enter phone number without dashes.

Email Address \*   
name@domain.com

4. **Save & Continue** button: saves the information you entered. If you have left a required field blank or entered information incorrectly, an error message will appear. Once all required fields are completed, this section will be marked as complete. The 2. *Confirm Medicaid Eligibility* page will open.
5. **Cancel and lose About You changes** link: clears the page of any information you have just entered and returns you to the *Home* page.

After completing this information, you may proceed to your eligibility information by selecting the **Save & Continue** button. The status icon on your home page will change to indicate that your registration section is complete. The green background of the first section and the icon indicate that this section has been completed.

After completing this information, you may proceed to completing your eligibility information by returning to the dashboard and selecting the next step. The status icon on your home page will change to indicate that your registration section is complete.

Year 1



**1. About You**  
Additional Registration Information and CMS Medicaid EHR Incentive Program Registration site data



**2. Confirm Medicaid Eligibility**  
Practice Demographics and Volumes



**3. Attestation of EHR**  
Related to Adopting, Implementing, Upgrading or Meaningful Use



**4. Review and Sign Agreement**  
Review, Print, Sign and Upload the SLR Agreement



**5. Send Year 1 Attestation**  
Send and lock all information to State

## Error Messages

<p>The Medicaid ID number entered does not match the Medicaid ID number on file for DC Medicaid. You may submit your attestation. However, additional review may be required to confirm your program eligibility.</p>	<p>A check is made against the Provider Master File provided by the DC Medicaid program. If the Medicaid number entered in the field does not match the number provided by DC, a soft stop occurs.</p>
<p>Your enrollment status with the DC Department of Health Care Finance is Temporarily Suspended. You may not continue with your application. Please contact the help desk at (866) 879-0109, select option 0 for assistance.</p>	<p>This is a Hard Stop.</p>
<p>Your enrollment status with the DC Department of Health Care Finance is Permanently Suspended . You may not continue with your application. Please contact the help desk at (866) 879-0109, select option 0 for assistance.</p>	<p>This is a Hard Stop.</p>

<p>Your enrollment status with the DC Department of Health Care Finance is Inactive. You may not continue with your application. Please contact the help desk at (866) 879-0109, select option 0 for assistance.</p>	<p>This is a Hard Stop.</p>
<p>CMS has reported a federal exclusion for your NPI indicating that you are not eligible to receive federal funds. You may not continue with your attestation and no incentive funds will be paid.</p>	<p>This is a Hard Stop.</p>
<p>CMS has reported that a state has reported exclusion data for the EHR Incentive Program for your NPI. You may submit your attestation. However, additional review may be required to confirm your program eligibility.</p>	<p>A State exclusion is a Soft Stop.</p>

## Step 2: Confirm Medicaid Eligibility Details

Clicking the **Confirm Medicaid Eligibility** link on the EH home page opens the *Confirm Medicaid Eligibility* page, which allows you to enter your Hospital's eligibility information.

### 2. Confirm Medicaid Eligibility

For purposes of calculating hospital patient volume, the following are considered Medicaid services: 1.Services rendered to an individual per inpatient discharges where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service; 2.Services rendered to an individual per inpatient discharge where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing; 3.Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act either paid for part or all of the service; or 4.Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost sharing.

The *Confirm Medicaid Eligibility* page displays the following:

1. **< Back to Dashboard** link: clicking this link will return you to the *Home* page.
2. **Print Registration Attestation** link: opens a PDF document containing all the information you have entered for the Hospital so far in the SLR process.
3. *Medicaid Volume* section.
  - a. **Eligibility Completion status** icon: indicates whether your eligibility information is complete or if there is still some missing information on the page.
  - b. **Enter Representative Period** pull-down menu: select the appropriate period for patient volumes used in determining the eligibility of the Hospital. The District has two options: [90-day period in previous calendar year](#), and [90-day period in the 12 months preceding the attestation](#).

**Year {x} Start Date** field: enter the date of the first day of your representative period. The system will automatically display the end date.

Calendar icon: opens a Calendar Utility from which you may click on a date to select it.

## Medicaid Volume

 Enter your eligibility information below. \* Red asterisk indicates a required field.

*Acute Care and Critical Access Hospitals (CAH) must have Medicaid discharges of at least 10%, an average Length of Stay (LOS) of 25 days or less, and a CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment. Please note that Children's Hospitals are automatically eligible to participate in the program, regardless of if the data entered below for discharges and average length of stay meets the minimum criteria.*

Enter Representative Period \* 90-day period in previous calendar year ▼

Year 1 Start Date \*  

Year 1 End Date \*  

Total Discharges for Representative Period \*

Medicaid Discharges for Representative Period \*

Total Discharges for a full Fiscal year

Total Patient Bed Days for a full Fiscal year

Average Length of Stay \* 99.9 [more info...](#)



*Average Length of Stay in days. Calculation used is Total Patient Bed Days/Total Discharges for the full Calendar/Fiscal year.*

Medicaid Volume: \* 99.99%



*(Total Medicaid Discharges/Total Discharges)*

- c. **Year {x} End Date** display field: the end date of the 90-day representative period based on the start date you entered. If you select **Other Period** from the **Enter Representative Period** pull-down menu, the end date will be editable.
- d. **Total Discharges for Representative Period** field: enter your total Discharges for the representative period you noted above.
- e. **Medicaid Discharges for Representative Period** field: enter your Medicaid Discharges for the representative period you noted above.
- j. **Total Discharges for a full Fiscal year** field: enter total patient discharges for the previous fiscal year.
- k. **Total Patient Bed Days for a full Fiscal year** field: enter total number of bed days for all patients in the previous fiscal year.
- l. **Average Length of Stay** display field: the Average Length of Stay for the year of the hospital cost report. The District of

Columbia has designated that the Average Length of Stay should be determined based on hospital fiscal year.

- i. **Calculate** button: calculates the results of Medicaid Volume. The calculated results will be displayed.
  - ii. **Display field.** This is where the calculated result is displayed.
- m. **Medicaid Volume** section: this formula uses the Total Discharges and Medicaid Discharges to calculate your result.
- i. **Calculate** button: calculates the results of Medicaid Volume. The calculated results will be displayed.
  - ii. **Display field.** This is where the calculated result is displayed.
- n. **Meets Medicaid Eligibility Requirements** message: appears if the Calculate button next to the Medicaid Volume display field is selected. It indicates whether you have met the requirements for eligibility.
- i. “Yes! Meets Medicaid Eligibility Requirements.” will display if your hospital meets the following criteria:
    - Your hospital is a Children’s Hospital
    - Your hospital’s Medicaid volume is greater than 10% with an average length of stay less than or equal to 25 days and the last four digits of your CCN are between 00001 through 0879 or 1300 through 1399
  - ii. “No - you may wish to adjust your representative period...” This message displays when the information entered does not meet the minimum criteria for hospital eligibility. Acute Care and Critical Access Hospitals (CAH) must have Medicaid discharges of at least 10%, an average Length of Stay (LOS) of 25 days or less, and a CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment. Children’s Hospitals with a CCN that ends in 3300 – 3399 are automatically eligible.

#### 4. *Hospital Demographics Information* section.

Each of the following fields (or group of fields) has explanatory help text in blue beneath the field, and a **more info** link to help identify what the field is capturing. The first year data comes from the hospital’s cost report filed in the previous federal fiscal year. The specific data sources for your state can be found in the state provided Eligibility

Workbook. The workbook is designed to help you collect information needed to complete the Eligibility components of the SLR. It is designed to gather detailed information regarding your practice and create summarized data for entry into the SLR. You may also use the workbook to estimate your Medicaid eligibility based on your patient volumes.

- **Enter the year for the current cost report field.**
  - **Enter the Discharges for the last four years of available data fields:** enter discharges for the last four years in the **Year {x-4}** through **Year {x}** fields.
  - **Enter the Total Discharges from the Year {x} cost report field.**
  - **Enter the Total Medicaid Inpatient Bed Days from the Year {x} cost report field.**
  - **Enter the Total Medicaid Managed Care Inpatient Bed Days from the Year {x} cost report field.**
  - **Enter the Total Inpatient Bed Days from the Year {x} cost report field.**
  - **Enter the Total hospital charges from the Year {x} cost report field.**
  - **Enter the Total charges attributable to Charity Care from the Year {x} cost report field.** Enter total estimated Charges attributable to Charity Care for the hospital fiscal year that ends during the prior Federal Fiscal Year. A number is required in this field, and you may not enter a zero. You may use hospital financial reports to determine uncompensated care amounts, but may not count bad debt as part of your uncompensated care. If you are unable to identify your uncompensated care amount, enter 1.
5. *Attach Documentation* section. The District requires an Eligibility Workbook, the hospital's most recent Cost Report, and Cost Reports for the previous three years.
  6. **Save & Continue** button: saves the information you have just entered and opens the next page in the SLR process. If you have left a required field blank or entered information incorrectly, you will receive an error message.
  7. **Cancel and lose Medicaid Eligibility changes** link: opens the EH *Home* page, saving none of the changes made to fields on the confirm *Medicaid Eligibility* page.

## Hospital Demographics

 Enter your Hospital Demographics information below. \* indicates required fields.

*The first year data comes from the hospital's cost report filed in the previous federal fiscal year. The specific data sources for your state can be found in the state provided Eligibility Workbook or Hospital Calculation Worksheets. [more info...](#)*

Enter the year for the current cost report.

\*

1. Enter the Discharges for the last four years of available data: [more info...](#)

2009	2010	2011	2012
<input type="text" value="1"/>	<input type="text" value="2"/>	<input type="text" value="3"/>	<input type="text" value="4"/>

*This data is used to calculate your Average Growth Rate for the incentive payment.*

*2009 – Enter the total discharges from the cost report 3 years prior to the cost report used for the first year data.*

*2010 – Enter the total discharges from the cost report 2 years prior to the cost report used for the first year data.*

*2011 – Enter the total discharges from the cost report 1 year prior to the cost report used for the first year data.*

*2012 – Enter the total discharges from the cost report filed in the previous federal fiscal year.*

2. Enter the Total Discharges from the 2012 cost report. [more info...](#)

✓  
*Nursery and Swing Beds should be excluded from the Total Discharges.*

3. Enter the Total Medicaid Inpatient Bed Days from the 2012 cost report. [more info...](#)

✓  
*Nursery and Swing Beds should be excluded from the Total MO HealthNet Inpatient Bed Days.*

4. Enter the Total Medicaid Managed Care Inpatient Bed Days from the 2012 cost report. [more info...](#)

✓  
*Nursery and Swing Beds should be excluded from the Total Medicaid Managed Care Inpatient Bed Days.*

5. Enter the Total Inpatient Bed Days from the 2012 cost report. [more info...](#)

✓  
*Nursery and Swing Beds should be excluded from the Total Inpatient Bed Days.*

6. Enter the Total hospital charges from the 2012 cost report. [more info...](#)

✓

7. Enter the Total charges attributable to Charity Care from the 2012 cost report. [more info...](#)

✓  
*If neither charity care nor uncompensated care charges are identifiable on the cost report, enter 1. The charity care ratio will be set to 1 for the incentive calculation.*

## Error Messages

Representative Period must in be the previous federal fiscal year ending on September 30th.

For Hospitals, the Attestation period is within the federal fiscal year.

Representative Period must be in the last 12 months.	For Hospitals, the Attestation period must also take place within one year.
NOTE: Reporting period must be greater than Year {X} Start Date + 89 days and less than a calendar year.	This is not an error message, but simply a warning.
Total Discharges for reporting period must be greater than the Medicaid Discharges.	The 'Total' fields are there to provide a double-check on the numbers entered into the other fields, ensuring they add up correctly.
No - you may wish to adjust your representative period. Acute Care and Critical Access Hospitals (CAH) must have Medicaid discharges of at least 10%, an average Length of Stay (LOS) of 25 days or less, and a CCN that ends in 0001 – 0879 or 1300 – 1399 to be eligible to receive an incentive payment. Children's Hospitals with a CCN that ends in 3300 – 3399 are automatically eligible.	This appears in response to the check to ensure the provider meets Eligibility requirements after the <b>Calculate</b> button is clicked.
NOTE: There is not data populated in the Total Discharges for a full Hospital Fiscal Year and Total Patient Bed Days for a full Hospital Fiscal Year	All the patient volume Eligibility fields are required to be filled in.
A number other than Zero must be entered in the Total Discharges for the calculation to run.	The 'Total' fields are there to provide a double-check on the numbers entered into the other fields, ensuring they add up correctly.
Medicaid Inpatient Bed Days cannot be greater than total Inpatient Days.	The 'Total' fields are there to provide a double-check on the numbers entered into the other fields, ensuring

	they add up correctly.
Sum of Medicaid Inpatient Bed Days and Medicaid Managed Care Inpatient Bed Days cannot be greater than total Inpatient Bed Days	The 'Total' fields are there to provide a double-check on the numbers entered into the other fields, ensuring they add up correctly.
You do not meet the patient volume requirements for the selected 90-day period. You may choose a different 90-day period that meets the requirements.	This is a Hard Stop.
Please attach your supporting document. Please attach your required documentation.	This is a Hard Stop – a document must be attached, and it must have the subject that has been required by the District.
CMS has reported a federal exclusion for your NPI indicating that you are not eligible to receive federal funds. You may not continue with your attestation and no incentive funds will be paid.	This is a Hard Stop.
CMS has reported that a state has reported exclusion data for the EHR Incentive Program for your NPI. You may submit your attestation. However, additional review may be required to confirm your program eligibility.	This is a Soft Stop. The provider may continue to work on the Attestation, but will have to resolve this with the District before Payment can be approved. The page is saved and the provider is advanced to Step 3. Attestation of EHR.

### Step 3: Attestation of EHR Details

EHRs may either attest that they have adopted, implemented, or upgraded EHR software, or that they are actively using it in meaningful ways. AIU may only be selected in the first year and is a much easier attestation. Clicking the

**Attestation of EHR** link on the *EH Home* page directs you to the **3. Attestation of EHR** page. This lets you select Adopt, Implement, Upgrade (AIU) or Meaningful Use (MU) for your Attestation Type. Once you have selected the Attestation Type, you will then be able to upload documents related to your EHR Software, enter its certification number, and enter other information.

**3: Attestation of EHR.** The first step of completing this section is to choose the type of attestation. You will be able to access this section once the *About You* and *Confirm Medicaid Eligibility* pages are completed. This page displays the following:

1. **Attest to Adopt, Implement, Upgrade** button: opens the AIU workflow. This option is available only in your first year of participating. This section contains three pages: the *AIU Method* page and the *EHR Certification* page in addition to the *Attestation of EHR* page.
2. **More info** link: opens the Attestation of AIU information pop-up.
3. **Attest to Meaningful Use** button: opens the MU workflow. This section contains three sections: *Core Objectives*, *Menu Objectives*, and *Clinical Quality Measures*. Each of these sections contains between 10 and 15 pages, though not all of the Menu Objectives are required.

### 3. Attestation of EHR

The screenshot shows a web interface for EHR attestation. It features two main buttons: 'Attest to Adopt, Implement, Upgrade' and 'Attest to Meaningful Use'. Below the first button, text explains that this option is for the first year of participation and does not require data entry. Below the second button, text explains that this option is for demonstrating meaningful use, followed by a numbered list of three requirements: 1. Use of certified EHR technology in a meaningful manner, such as e-prescribing; 2. That the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improved the quality of care; and 3. Using certified EHR technology to submit information on clinical quality measures and other such measures of Meaningful Use. A 'more info...' link is visible at the bottom left of the content area.

**Note:** if the user has already completed their first year, they must enter MU data.

## AIU Method Page

Once the **Attest to Adopt, Implement, Upgrade** button is selected, two new navigation options appear in the Navigation Menu: *AIU Method* and *EHR Certification*. The *AIU Method* page is opened.

This page allows you to choose the method of your AIU attestation and provide any supporting details for that choice.

1. **More info** link: opens a PDF document titled “Attestation of AIU” that explains how documentation would be attached for the selected attestation method.
2. **AIU Method** pull-down menu: select [Adopt](#), [Implement](#), or [Upgrade](#) from the menu to best describe your EHR Technology use at this point.
3. **more info** link: opens a pop-up window explaining the type of documentation that needs to be attached for the selected attestation method.
4. **Please describe briefly how you meet...** text area: allows you to describe how you meet the criteria for the AIU method selected.
5. *Attach Documentation* section: the District requires a fully executed contract with a EHR Vendor and a vendor letter to be attached to the page. An Invoice, Receipt, or Vendor Letter may also be added.
6. **Save & Continue** button: selecting this will open the *EHR Certification* page after SLR ensures that all fields on this page are populated.

## Error Messages

<p>CMS has reported a federal exclusion for your NPI indicating that you are not eligible to receive federal funds. You may not continue with your attestation and no incentive funds will be paid.</p>	<p>This is a Hard Stop error and must be cleared by the District..</p>
<p>CMS has reported that a state has reported exclusion data for the EHR Incentive Program for your NPI You may submit your attestation. However, additional review may be required to confirm your program eligibility.</p>	<p>This is a Soft Stop. The provider may continue to work on the Attestation, but will have to resolve this with the District before Payment can be approved. The page is saved and the provider is advanced to Step 3. Attestation of EHR.</p>

## EHR Certification Page

This page allows you to identify your EHR Technology and attach supporting documentation. It appears for both AIU and MU

1. **Understanding** checkbox: signifies that you agree with the statement of understanding next to the checkbox. When you check this box, additional fields display. If you do not check this box, the system will not allow you to continue.
  - a. "I understand that it is my responsibility, as the provider, to ensure..." This is a statement of understanding as to your responsibility to demonstrate that your EHR technology is certified through the ONC. When you check the box before this statement, you will be required to complete the other field on the page. If you do not check the box before this statement, the system will not allow you to continue.

### EHR Certification

Providers must provide information demonstrating that their EHR technology is certified through the Office of the National Coordinator (ONC). The ONC Certified HIT Product List (CHPL) contains the list of all certified EHR technology products and is used by the providers to generate the unique EHR Certification ID that represents the system or combination of modules that is capable of meeting Meaningful Use. The State is required to validate the verification of the Certified EHR information before making any payment to providers.

It is the provider's responsibility to generate an EHR Certification ID that accurately reflects the complete EHR or combination of modules representing a complete EHR used by the provider before attesting to the State. Failure to do so could result in a false negative result that may disqualify the provider from receiving payment.

To proceed, please indicate your understanding of this responsibility by agreeing to the following statement:  
[more info...](#)

I understand that it is my responsibility, as the provider, to ensure that my certified EHR technology code is listed on the [ONC public web service](#) before submitting my attestation to the State. I understand that failing to ensure my code is listed may result in a false negative result that may disqualify me from receiving payment. ✓

### Your EHR Certification Information

EHR Certification Number  ✓

- 1) Go to the ONC website: <http://onc-chpl.force.com/ehrcert>
- 2) Search for your product(s) and add each to the shopping cart by clicking "Add to Cart"
- 3) When you have added all product(s) to your shopping cart, click the "View Cart" link
- 4) Click "Get CMS EHR Certification ID"
- 5) Your CMS EHR Certification ID will be displayed on the screen. This is the number you will need to enter above as a part of your attestation.

NOTE: ONC does not allow you to mix inpatient products and Ambulatory products together to represent a complete EHR solution. Additionally, if the product(s) you add to your shopping cart do not represent a complete EHR solution capable of achieving meaningful use criteria, you will not be able to click "Get CMS EHR Certification ID" in step 4.

- b. **ONC public web service** link: opens the Office of the National Coordinator for Health Information Technology's *Certified Health IT Product List* site. The page also includes instructions to access the ONC website, find software, and retrieve an EHR Certification Number (<http://onc-chpl.force.com/ehrcert>). Once this number is entered into the **EHR Certification Number** field

and the **Save & Continue** button is clicked, SLR will validate that the number represents approved software.



The Certified HIT Product List (CHPL) provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC). Each Complete EHR and EHR Module listed below has been certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to ONC. Only the product versions that are included on the CHPL are certified under the ONC Temporary Certification Program.

Please send suggestions and comments regarding the Certified Health IT Product List (CHPL) to [ONC.certification@hhs.gov](mailto:ONC.certification@hhs.gov), with "CHPL" in the subject line.

Vendors or developers with questions about their product's listing should contact the ONC-Authorized Testing and Certification Body (ONC-ATCB) that certified their product.

#### USING THE CHPL WEBSITE

To browse the CHPL and review the comprehensive listing of certified products, follow the steps outlined below:

1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Select the "Browse" button to view the list of CHPL products

To obtain a CMS EHR Certification ID, follow the steps outlined below:

1. Select your practice type by selecting the Ambulatory or Inpatient buttons below

2. *Your EHR Certification Information* section. When you select the EHR Certification option in the *Navigation Menu*, the **CMS EHR Certification ID** field may already be populated, containing a certification number entered for the previous year's Attestation. Otherwise you will have to enter the correct number. If your hospital has changed its software since that time, look up and enter the correct number.
3. *Attach Documentation* section. The District requires the user attach a screenshot from the ONC CHPL showing the certification number and listing the EHR components that are included with the certification number.
4. **Save & Continue** button: saves the information you have just entered. If you have left a required field blank or entered information incorrectly, you will receive an error message.

Once you have successfully saved the information on all pages within the AIU Attestation of EHR, the status icon on your home page will change to indicate that your Attestation of EHR section is complete. The system will now allow you move onto Step 4.

## Error Messages

Certification number is not found.	A Hard Stop occurs and the page is not saved. The certification number of the EHR software the provider is using must be found and entered into
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	the field.
Certification Number is not found. There was an error connecting to the ONC CHPL Web Service used for certification validation. Please try again.	A Hard Stop occurs. If the ONC service is down, the provider might want to return to the Attestation after an hour or so if repeated tries are unsuccessful.
The payee NPI and TIN entered does not match an enrolled provider with DC Medicaid. Please contact the help desk at (866) 879-0109, select option 0 for assistance.	A Hard Stop occurs.
CMS has reported a federal exclusion for your NPI indicating that you are not eligible to receive federal funds. You may not continue with your attestation and no incentive funds will be paid.	A Hard Stop occurs.

**Year 1**

- 
**1. About You**  
 Additional Registration Information and NLR data
- 
**2. Confirm Medicaid Eligibility**  
 Practice Demographics and Volumes
- 
**3. Attestation of EHR**  
 Related to Adopting, Implementing, Upgrading or Meaningful Use
- 
**4. Review and Sign Agreement**  
 Review, Print, Sign and Upload the SLR Agreement
- 
**5. Send Year 1 Submission**  
 Send and lock all information to State

## Meaningful Use Section

To attest for Meaningful Use (MU), Hospitals will enter data that has been captured by their EHR Software. A report within your EHR system should be available to help you enter the correct information in the MU fields. In the provider's second participation year, clicking the **3. Attestation of EHR** link shall open the *EHR Certification* page directly, as the user has the option to adopt, implement, or upgrade their software in the first year of participation only.

Providers may elect to enter Meaningful Use data during their first year of Attestation, but are required to enter MU information during each year after their first year. The first year of MU is Stage 1, and fields are grouped into a series of Objectives and Clinical Quality Measures. Stage 2 of the Meaningful Use program will begin in 2014 and this will require more fields to be populated and data to be captured. When providers attest for MU, they will enter the data captured by their software for a specified time period – 90 days for their first MU year, and a full year of data thereafter.

**Note:** In order to qualify for the EHR Incentive payment, 80% of patients must have records in the EHR solution.

In addition to pages that capture Meaningful Use information, there are two pages that capture information that is fundamental to Meaningful Use and to Attestation for the EHR Incentive payment.

1. *EHR Certification* page. The *EHR Certification* page in the *Meaningful Use* section is identical to the *EHR Certification* page in the *AIU* section except that it also contains a *Supporting Documentation* section. This allows the user to attach a file if needed. Select the **Provider Understands Responsibility** checkbox to accept responsibility for finding and entering the correct EHR Certification Number into the previous page. A link to the Office of the National Coordinator for Health IT (ONC) website is provided.
2. *EHR Reporting Period* page. This page contains a checkbox and **EHR Reporting Period** fields. For the first year, only data captured during a 90-day period is required, though a full year is required after that. An EH applying for the 2012 program year must have Medicaid eligibility dates between 10/1/10 and 9/30/11. An EH applying for the 2013 Program Year must have Medicaid eligibility dates between 10/1/11 and 9/30/12.

Reporting Period	AIU is First Year	MU is First Year
<b>EH</b>		
Year 1	--None	--90 days (MU) Stage 1
Year 2	--90 days (Stage 1 MU)	--Federal Fiscal Year (Stage 1 MU)
Year 3	--Federal Fiscal Year (MU) Stage 1	--Federal Fiscal Year (Stage 1 MU) if year is 2013, --otherwise Stage 2
Year 4	--90 days if Year 4 is 2014, otherwise, -- Federal Fiscal Year (Stage 2MU)	--90 days if Year 4 is 2014, otherwise, -- Federal Fiscal Year (MU) Stage 2
Year 5	-- Federal Fiscal Year (Stage 2 MU)	-- Federal Fiscal Year (MU)
Year 6	-- Federal Fiscal Year (MU)	-- Federal Fiscal Year (MU)

The **Start Date** field and **End Date** fields have an icon  that will open a Calendar Utility that allows a user to select a date rather than enter it into the field.

3. *Meaningful Use Import.* This page allows providers to import Core and Menu objective data. Data imported in this manner will display on the individual Core and Menu Objective detail pages as read only data. All validations performed on individual Core and Menu pages will be enforced and the appropriate visual indicators will be displayed in the navigation tree. Click the **MU Import Control Document** link to open technical specifications for the Import file.

*Note:* the import function will import all records in the file or none of the records if an error occurs with the import. If all required data is not populated for the Core and Menu objectives then you will be required to manually enter and save.

## Meaningful Use Import

Instructions: Use the MU Import functionality to import your Core and Menu objective data. The import function will import all records in the file or none of the records if an error occurs with the import. The data imported will display on the individual Core and Menu Objective detail pages as read only data. All validations performed on the individual Core and Menu Objective Detail pages shall apply and shall be used to display the appropriate visual indicators in the navigation tree. If all required data is not populated for the Core and Menu objective then you will be required to manually enter and save.

The MU import specification control document defines the format required to import Core and MU objective data.

 [MU Import Specification Control Document](#)

### File Import

File \*



Please select the 'Previous Screen' button to go back or the 'Continue' button to proceed.



4. *Navigation Menu.* The left-hand Navigation Menu will contain page titles that serve as links associated with the MU pages that must be completed. The majority of MU pages are collected in three groups. Clicking the name of a subgroup or clicking the expand icon  will reveal all the pages in the subgroup, all of which must be completed by the user. Once all the pages in a navigation group have been completed, and all have passed their validation criteria, then the group will receive a completed icon . Clicking the collapse icon  will hide the title of the individual pages in a subgroup.

- ✔ 1. About You
- ⚠ 2. Confirm Medicaid Eligibility
- ☰ 3. Attestation of EHR
  - ✔ EHR Certification
  - ✔ EHR Reporting Period
  - MU - Import
  - + MU Core Objectives
  - MU Menu Objectives
  - CQM - Import
  - + CQM - Core
  - CQM - Additional
- 4. Review and Sign Agreement
- 5. Send Year 1 Attestation

**Icon Legend**

- ✔ Complete
- ⚠ Warning
- ! Hard Stop

5. *Selection Pages and Detail Pages.* Each group of measures includes a *Selection* page, which provides a place for the user to select or at least access the measures. The *Menu Objective Selection* page allows a user to select Objective measures, since a user must select only five of the ten measures. Users cannot select a measure on the *Core CQM* or *Core Objective Selection* pages, since all core measures are required.

### 3. Attestation of EHR

#### Meaningful Use

**Core Objectives**  
 Select the Continue button to open each Core Objective Detail page in turn to complete the information for Meaningful Use attestation. Alternatively, select any of the links below to complete that Objective's Detail page. All objectives must be answered.

	Objective	Measure	Status
<a href="#">View</a>	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.	
<a href="#">View</a>	Implement drug-drug and drug-allergy interaction checks.	The eligible hospital or CAH has enabled this functionality for the entire EHR reporting period.	
<a href="#">View</a>	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.	
<a href="#">View</a>	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.	
<a href="#">View</a>	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.	
<a href="#">View</a>	Record all of the following demographics:	More than 50% of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.	

Each measure within a group also includes a *Detail* page where users will record the applicable data. Select the **Save & Continue** button on each measure *Detail* page to save the data and move to the next measure requiring input, or to the next *Selection* page. All *Detail* pages include an *Attach Documentation* section so that users may associate a document that is relevant to the measure.

6. *Exclusions*. Sometimes the measure will not apply to your particular practice. Children's Hospitals, for example, will have no patients over 65 years old. To account for this, measures of this nature include Exclusion **Yes** and **No** radio buttons. The measure's data field will appear if the Exclusion does not apply.
7. *Core Objectives*. Core Objectives measure how much of a provider's patient population has been entered into the EHR software. If the user selects the **Save & Continue** button with all fields completed on a page and the result fails the criteria set, a failed icon will appear. If even one Core Objective fails to meet its minimum criteria, the Attestation will fail.

Providers must enter all Core Objectives and these are listed in the *Navigation Menu* when the MU Attestation Type is selected. Core Objectives generally consist of an acknowledgement that you have met the obligations, or a Numerator and a Denominator.

For example, for the objective *Maintain Active Medication List*, the user would enter the number of unique patients seen by the hospital during the EHR reporting period as a **Denominator**. In the **Numerator** field, the user would enter the number of patients in the denominator who have a medication recorded as structured data, plus the number of patients that are not currently prescribed any medication.

Objectives also have a measure validation: if the result of the **Numerator** divided by the **Denominator** and rendered as a percentage does not exceed the percentage stated in the **Measure** field on each *Detail* page, the measure is failed. For example, *Maintain Active Medication List* has a **Measure** of "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."

*Menu Objectives*. Users must select at least one of the three Public Health Objectives on the *Menu Selection* page, and select a minimum of five of the Menu Objectives in general. When Menu Objectives are selected from the *Menu Selection* page, the selections will appear as options in the *Navigation Menu* when the **Save & Continue** button is selected on the page.

Other than being selected, Menu Objectives are similar in structure and content to the Core Objectives.

4. *Core Clinical Quality Measures Import*. This page allows providers to import CQM data in the same way the associated page allowed the import of Core and Menu objective data. Data imported in this manner will display on the individual CQM Detail pages as read only data. Validation performed on individual pages will be enforced and the appropriate visual indicators will be displayed in the navigation tree.

### Clinical Quality Measures Import

Instructions: Use the CQM Import functionality to import your Core and Menu Objective data. The import function will import all records in the file or none of the records in the file if an error occurs with the import. The data imported will display on the individual CQM pages as read-only. All validations performed on the CQM pages shall apply and shall be used to display the appropriate visual indicators in the navigation tree. If all required data is not populated for the CQM data, then you will be required to manually enter and save. Select the appropriate format used to import your Clinical Quality Measure data.

**File Import**

CQM Import File Format \*

File \*

Please select the 'Previous Screen' button to go back or the 'Continue' button to proceed.

8. *Core Clinical Quality Measures*. Clinical Quality Measures, or CQMs, capture information about patient treatments and diagnoses instead of information about the number of patients in the EHR. There are no passing percentages, as these pages are simply intended to capture information about patients.

Core CQMs are all required. If the participating hospital has seen no patients to which one of these CQMs would apply, you will enter 0 in the **Denominator** field of that page's *Detail* page. For example, the *Core CQM 1* has 3 lines of Population Criteria, each line having a **Numerator**, **Denominator**, and **Exclusion** field.

## Clinical Quality Measures

### Questionnaire (1 of 15)

 \* Red asterisk indicates a required field.

Responses are required for the clinical quality measures 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

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 NxD or NxD.

Denominator = All ED patients admitted to the facility from the ED. A positive whole number.

Exclusion = Observation & Mental Health Patients. A positive whole number.

\*Numerator:  \*Denominator:  \*Exclusion:

For example, if the participating hospital did not have an Emergency Department, the user would enter **0** in the **ED-1.1 Denominator** field.

9. *Dually Eligible Hospitals.* Some Hospitals, called Dually Eligible Hospitals, qualify for both Medicare and Medicaid incentive payments. Those hospitals that have already submitted and passed Meaningful Use measurements for Medicare automatically meet Meaningful Use obligations for the Medicaid program.

CMS will send the SLR system a file called the C5, which will contain data that will automatically populate the SLR with the data entered into the Medicare EHR Incentive Program Registration and Attestation System. All pages will then be read-only for the SLR EH user.

10. *Attach Documentation* section: allows you to add a Fully Executed Contract, a Fully executed agreement demonstrating binding legal or financial commitment to EHR (invoice, receipt, service agreement), or another type of document.

The year 2014 will see more changes in Meaningful Use measures, as Stage 2 of the program take effect. Providers will then meet more core measures for EHR usage, and also choose three from a menu of six additional measures. A third and final stage of Meaningful Use is scheduled to begin in 2016.

## Error Messages

The reporting period end date must end before the current date.	This appears on the <i>Step 3 EHR Reporting</i>
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	page.
"The Start Date will display [x]/[x]/2012. The End Date field shall be automatically populated with a date calculated as 365 or 366 days from the Start Date for subsequent years. (Start Date +364 days for a standard year, Start Date + 365 days for a leap year).	If a full year is selected, this message will display.
Please attach your supporting document. Please attach your required documentation.	An attachment is required for some AIU pages, and may be required for some MU pages.
You do not meet the requirements for meeting Meaningful Use for this reporting period. If you are using a 90-day EHR reporting period, please choose a different 90-day reporting period that meets the requirements. You may not continue with your attestation for the currently selected reporting period.	This is a Hard Stop. The attestation of Meaningful Use has certain requirements, such as the percentage of patients that have been transferred to EHR records.
CMS has reported a federal exclusion for your NPI indicating that you are not eligible to receive federal funds. You may not continue with your attestation and no incentive funds will be paid.	This indicates a Soft Stop has occurred. The provider may continue to work on the Attestation, but will need to resolve the issue with CMS before submitting.
CMS has reported that a state has reported exclusion data for the EHR Incentive Program for your NPI. You may submit your attestation. However, additional review may be required to confirm your program eligibility.	This indicates a Soft Stop has occurred. The provider may continue to work on the Attestation, but will need to resolve the issue with CMS before submitting.
Your file did not import correctly.	This message will appear during the

<p>Please confirm that you have selected the correct format for importing and try again.</p>	<p>file import if the file was not able to load/. If it loaded correctly, another message will display: "If the import passes the default message is displayed, "Your MU data has been imported. Please review your MU data."</p>
<p>Please make a selection for Patient Records.</p>	<p>Many Objectives will have an exclusion, which indicates that the measure will not apply to your particular practice. There may also be more than one Exclusion per Measure.</p>
<p>Numerator - Please enter a numerator Denominator - Please enter a denominator</p>	<p>Unless the provider is excluded from a measure, the Numerator and Denominator fields will be required.</p>
<p>At least one Public Health Objective must be selected.</p>	<p>The provider must select one of the Public Health the Menu Objectives, and may select more. These are hard stop errors.</p>
<p>Please select a total of five (5) Meaningful Use Menu Measure Objectives, including at least one Objective from the Public Health section.</p>	<p>The provider may choose which five Menu Measures are the best fit for their practice.</p>
<p>If you deselect an item from the table, all information recorded about that Measure shall be lost. Ensure the item is selected in order to keep any changes you made to the item's Detail page.</p>	<p>If a provider enters information on one of the Measure pages and then returns to the Selection page, and changes his or her selections, this error will appear.</p>
<p>Your file did not import correctly. Please confirm that you have</p>	<p>If the CQM data Import fails, the provider should check to ensure the</p>

<p>selected the correct format for importing and try again.</p>	<p>format is correct. If the import is successful, another message will appear: "Your CQM data has been imported. Please review your CQM data."</p>
<p>Required Field</p>	<p>This error message will appear beside all Population Criteria, Numerator, Denominator and Exclusion fields.</p>

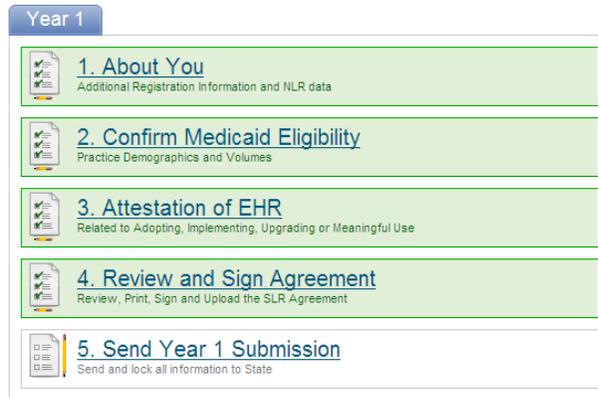
## Step 4: Review and Sign Agreement Details

Clicking the **Review and Sign Agreement** link on the EH *Home* page directs you to *the 4. Review and Sign Agreement* page. This is where you will review the attestation agreement. Once you have had a chance to review it, you must print it out in order to sign it. Once signed, the agreement must be scanned and then uploaded into the DC-SLR.

The *Review and Sign Attestation* page displays the following:

1. The *Step 1: Print to Sign Attestation* section contains the **Print to Sign** button. When selected, this will open a file Download window, allowing you to open or save the Attestation Agreement and print a copy of the document.
2. The *Step 2: Scan and Upload Signed Attestation* section contains an *Attach Documentation* component that will allow you to upload the Attestation Agreement. You have the ability to remove and attach different files until you submit your final attestation. The District requires a Direct Deposit Form in addition to the Attestation.
3. **Save & Continue** button: saves the information you have entered on this page and opens the *Home* page.
4. **Cancel and lose changes** link: clears the page of any information you have just entered and opens the *Home* page.

Once you have successfully saved the signed attestation, the status icon on your home page will change to indicate that Step 4 is complete. The system will now let you move onto Step 5.



## Error Messages

The majority of the error messages for Step 4 are the same as found in previous steps, including:

<p>CMS has reported a federal exclusion for your NPI indicating that you are not eligible to receive federal funds. You may not continue with your attestation and no incentive funds will be paid.</p>	<p>Federal exclusions are checked on this page as well, and this is a Hard Stop.</p>
<p>CMS has reported that a state has reported exclusion data for the EHR Incentive Program for your NPI. You may submit your attestation. However, additional review may be required to confirm your program eligibility.</p>	<p>State exclusions are Soft Stops.</p>

## Step 5: Send Year X Attestation Details

Clicking the **Send Year X Attestation** link opens a pop-up window allowing you to send your Hospital's attestation agreement to the State, with X being the Program Year of the Hospital's participation in the incentive program..

The *Send Attestation to State* window displays the following:

1. **Send Attestation** button: clicking this will submit your attestation agreement to the State. All steps in the workflow section of your home page will be locked down after this is done. You will not be able to make any more changes to the section, but may still view the information you entered on a report. The *Send Attestation to State* window will appear displaying the expected time period for payment and other payment-related information.
2. **Cancel and Do No Send** link: returns you to the *Home* page.

After sending the Attestation Agreement, a System Message will arrive that designates the time and date.

System Messages (1)		
Subject	Date Received	From
Your attestation has been submitted	11/30/2011 4:45:21 PM	

## Error Messages

Step 5 includes all the final checks that are made before the Attestation is submitted. Many of these are also seen on other Steps. They are performed again because a significant amount of time could pass between the start of an Attestation and its submission. After the Attestation is submitted, the fields become read-only, but changes may be made to the Attestation by the District's reviewers.

<p>You do not meet the patient volume requirements for the selected 90-day period. You may choose a different 90-day period that meets the requirements. The pop up message has a Cancel and X button. Hard stop indicator is displayed in the left navigation.</p>	<p>This is a Hard Stop and must be changed before the Attestation can be saved.</p>
<p>You do not meet the patient volume requirements for the selected 90-day period. You may choose a different 90-day period that meets the requirements.</p>	<p>This is a Hard Stop.</p>

<p>The payee NPI and TIN entered does not match an enrolled provider with DC Medicaid. Please contact the help desk at (866) 879-0109, select option 0 for assistance.</p>	<p>This is a Hard Stop.</p>
<p>Your CMS Medicaid EHR Incentive Program Registration record for the DC Department of Health Care Finance indicates that you are no longer eligible to receive payment through the District Medicaid incentive program. Please update your registration with CMS' Medicaid EHR Incentive Program Registration and Attestation site</p>	<p>This is a Hard Stop.</p>
<p>Your enrollment status with the DC Department of Health Care Finance is Inactive. You may not continue with your application. Please contact the help desk at (866) 879-0109, select option 0 for assistance.</p>	<p>This is a Hard Stop.</p>
<p>Your enrollment status with the DC Department of Health Care Finance is Temporarily Suspended. You may not continue with your application. Please contact the help desk at (866) 879-0109, select option 0 for assistance.</p>	<p>This is a Hard Stop.</p>
<p>Your status with the DC Department of Health Care Finance is Permanently Suspended. You may not continue with the application process as providers with this status are not eligible to participate in the EHR Incentive Program. If you believe this is in error, please contact the DC Department of Health Care</p>	<p>This is a Hard Stop.</p>

Finance.	
CMS has reported a federal exclusion for your NPI indicating that you are not eligible to receive federal funds. You may not continue with your attestation and no incentive funds will be paid. The pop up message has a Cancel and X button. Hard stop icon is displayed in the left navigation.	This is a Hard Stop.
CMS has reported that a state has reported exclusion data for the EHR Incentive Program for your NPI. You may submit your attestation. However, additional review may be required to confirm your program eligibility.	This is a Soft Stop.

## Accessing Reports

### Reports for Eligible Hospitals

Located to the left of the page, the *Reports* section displays the following items:

1. **Reports message:** the following message appears if you don't have any data in the system to run a report: "Reports will be available once your information is saved."
2. **Registration and Attestation Summary Report link:** once some information has been saved to the DC-SLR web application, this link appears. Clicking this link opens a pop-up window with the **Registration and Attestation Summary** report results. This report prints all of the Attestation information that you have already entered.

The **Registration and Attestation Summary** report displays the following:

- a. *Identifying Information* section: displays the information entered when the DC-SLR account was created, including NPI, TIN, Phone Number, and Address.
- b. *Filing Information* section: displays the EHR Incentive application information, such as user type, program year, and payment year.
- c. *Contact Person* section: the name, phone number, and email of the EH's contact.
- d. *Confirmation of Eligibility* section: displays the information saved when you completed the *Confirmation of Eligibility* section.
- e. *Summary of Meaningful Use* sections: These three sections list your Hospital's Objective and Clinical Quality Measure data.

You can print this report after you have saved any of your information in the DC-SLR Web application. If you print the report before all of the areas have been completed, only those sections with saved information will print on the report. You can also filter the report by year.

## View Payment Information

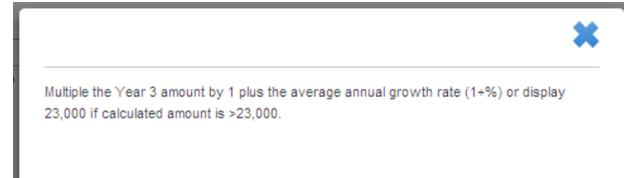
### Payment Calculations for Eligible Hospitals

Located to the left of the page, the *Payment Information* section displays the following items that are visible on the home page:

1. **How your payment is calculated** link: opens a window that explains in detail how your payment is going to be calculated, including the per-discharge amount and the patient volumes entered for your Hospital.
  - a. **< Back to Dashboard** link: returns you to the home page.
  - b. *How Your Payment is Calculated* page.
  - c. "States may pay hospitals up to 100 percent..." a detailed explanation as to how your payment will be paid.
  - d. Information icons: click one of the small "i" icon to open a pop-up window containing information or instructions on the associated field.

Initial Amount	Year 1	Year 2	Year 3	Year 4
Annual discharges w/ growth factor	10,000	10,195	10,394	10,597

Clicking the information icon beneath the Year 4 cell opens this help window:



e. *Initial Amount* section.

- i. **Annual discharges w/growth factor** row: displays the discharges with growth factors applied to Year 2 through 4.
  1. Year 1: total discharges up to 23,000.
  2. Year 2: Year 1 amount plus the average annual growth rate (+1%) up to 23,000.
  3. Year 3: Year 2 amount plus the average annual growth rate (+1%) up to 23,000.
  4. Year 4: Year 3 amount plus the average annual growth rate (+1%) up to 23,000.
- ii. **Disallowed discharges** row: displays the discharges that are not allowed as part of the calculation.
  1. Metric: the per discharge amount is calculated based on the 1150<sup>th</sup> – 23,000<sup>th</sup> discharge.
  2. Year 1: the disallowed discharges for year 1.
  3. Year 2: the disallowed discharges for year 2.
  4. Year 3: the disallowed discharges for year 3.
  5. Year 4: the disallowed discharges for year 4.
- iii. **Allowable discharges** row: displays discharges that are allowed as part of the calculation.
  1. Metric: Year {X} Annual Discharges with growth factor – 1149, with a maximum of 23,000 allowable.
  2. Year 1: the allowed discharges for year 1.
  3. Year 2: the allowed discharges for year 2.
  4. Year 3: the allowed discharges for year 3.

5. Year 4: the allowed discharges for year 4.
- iv. **Per Discharge Amount** row: displays the amounts per discharge, currently \$200 for all hospitals.
  1. Metric: the per discharge amount is \$200 for all hospitals.
  2. Year 1: \$200.
  3. Year 2: \$200.
  4. Year 3: \$200.
  5. Year 4: \$200.
- v. **Discharge Related Amount** row: displays the amounts calculated on the allowable discharges.
  1. Metric: Year {X} Allowable Discharges X Per Discharge, which is \$200.
  2. Year 1: the sum of allowed discharges for year 1 multiplied by \$200.
  3. Year 2: the sum of allowed discharges for year 2 multiplied by \$200.
  4. Year 3: the sum of allowed discharges for year 3 multiplied by \$200.
  5. Year 4: the sum of allowed discharges for year 4 multiplied by \$200.
- vi. **Base Amount** row: displays the base amount for all hospitals, which is \$2,000,000.
  1. Metric: the base amount is \$2,000,000 for all hospitals.
  2. Year 1: \$2,000,000.
  3. Year 2: \$2,000,000.
  4. Year 3: \$2,000,000.
  5. Year 4: \$2,000,000.
- vii. **Gross Amount** row: displays the sum of the base amount for all hospitals plus the discharge related amount.
  1. Metric: Year {X} Discharge Related Amount plus Base Amount of \$2,000,000.
  2. Year 1: the gross amount for year 1.

3. Year 2: the gross amount for year 2.
  4. Year 3: the gross amount for year 3.
  5. Year 4: the gross amount for year 4.
- viii. **Transition Factor** row: displays the transition factor applied for each year.
1. Metric: the transition factor is reduced each year.
  2. Year 1: Displays the transition factor of 1.
  3. Year 2: Displays the transition factor of 0.75.
  4. Year 3: Displays the transition factor of 0.50.
  5. Year 4: Displays the transition factor of 0.25.
- ix. **Annual EHR Amount** row: displays the sum of the year's gross amount multiplied by the transition factor.
1. Metric: Year {X} Gross Amount X Transition Factor
  2. Year 1: the annual EHR amount for year 1.
  3. Year 2: the annual EHR amount for year 2.
  4. Year 3: the annual EHR amount for year 3.
  5. Year 4: the annual EHR amount for year 4.
- x. **Overall EHR Amount** row: displays the sum your EHR amounts for all four years.
- f. *Medicaid Share* section.
- i. **Medicaid Inpatient Bed Days** field: displays the Medicaid inpatient bed days that you entered on the *Confirm Eligibility* page.
  - ii. **Medicaid Managed Care Inpatient Bed Days** field: displays the Medicaid Managed Care inpatient bed days that you entered on the *Confirm Eligibility* page.
  - iii. **Numerator** field: displays the sum of the two previous fields: *Medicaid Inpatient Bed Days + Medicaid Managed Care Inpatient Days*.
  - iv. **Total Inpatient Bed Days** field: displays the inpatient bed days that you entered on the *Confirm Eligibility* page.
  - v. **Total Charges** field: displays the total charges you entered on the *Confirm Eligibility* page.

- vi. **Total Charity Care Charges** field: displays the total charges that you attributed to charity care on the *Confirm Eligibility* page.
  - vii. **Denominator** field: displays the results of *Total Inpatient Bed Days x ((Total Charges - Total Charity Care Charges) / Total Charges)*.
  - viii. **Medicaid Share** field: displays the results of *(Medicaid Inpatient Bed Days + Medicaid Managed Care Inpatient Bed Days) / (Total Inpatient Bed Days x ((Total Charges - Total Charity Care Charges) / Total Charges))*.
- g. *Aggregate EHR Amount* section.
- i. The Aggregate EHR amount is the Overall EHR Amount x Medicaid Share.

## Attaching Files

### The Attach Documentation Section

*Attach Documentation* sections are available in several pages of the SLR. These identify documents that must be attached – like a Cost Report, a fully executed software sales contract, a vendor letter, and the Attestation Agreement itself – and identify documents that are optional.

#### Attach Documentation

*The following attachments are required: At least one of the following are required:*

- Eligibility Workbook
- Cost Report - Current Year
- Cost Report - Prior Year 1
- Cost Report - Prior Year 2
- Cost Report - Prior Year 3
- Other

File Name	Subject	Remove
<a href="#">blank.docx</a>	Eligibility Workbook	<input type="checkbox"/>

Add Files 
Remove Selected

A table lists those attachments that have already been added to the section in three columns:

1. **Filename** column: the name of the uploaded file. Selecting the filename will open the file for viewing, provided your PC has an application that can open the file.
2. **Subject** column: the subject of the uploaded file selected by the user when the file was attached.
3. Selecting a checkbox in the unnamed column and clicking the **Remove Selected** button will remove the file from the list and delete the file from SLR.

Attach Documentation

The following attachments are optional: ✓

- Eligibility Workbook
- Practice Management Report
- Other - Please Describe

File Name	Subject	Remove
<a href="#">blank.doc.docx</a>	Practice Management Report	<input type="checkbox"/>

Add Files  Remove Selected 

Clicking the **Add Files** button opens the *Add Files* pop-up window.

1. Close icon: clicking the blue X in the upper right-hand corner closes the *Add Files* window without attaching a file.
2. **Subject** pull-down menu: select an option to identify what type of document or documents you are attaching. These will be restricted to subjects that are appropriate for the section of SLR you are viewing.
3. **File(s) Subject** display field: this displays the default subject. This is populated when a document is selected.
4. **Description** text field: if the **Other – Please Describe** option is selected from the **Subject** pull-down menu, this field will appear. It requires the user to enter a brief description of the document being attached.
5. **File Name** text field: the file name will display once it is selected.
6. **Select** button: allows you to select the file you would like to attach from a local drive.
7. **Add** button: adds another **File** field and **Select** button to allow the user to attach another file. The file will be added under the same subject as the file above it.
8. **Remove** icon: clicking this removes file reference from the window. It will not be imported.

9. **Attach** button: adds the document or documents that were selected.
10. **File(s) Attached – {X}** message allows you to know the number of files currently attached for this specific page.
11. **Cancel and lose file changes** button: this will close the window, discarding any changes.

Up to 10 files of up to 10 MB apiece may be added to the *Attach Documentation* component of each section.

### Add Files ✕

You may attach files with multiple subjects using this function.

- Select the subject for the first attachment from the drop down list
- Use the Select function to choose your file
- Click the Add button to add another file
- Select the subject for the second attachment from the drop down list
- Use the Select function to choose your file

When all documents are attached, click the Attach button.

Allowed File Types: .bmp, .pdf, .jpeg, .jpg, .gif, .png, .doc, .docx, .xls, .xlsx

Subject \* Eligibility Workbook ▾

File(s) \* Subject:

Filename: \*  Select ✕ Remove

Add

📎 Attach
✕ Cancel and lose file changes

## Error Messages

<p>Please attach your document using Adobe PDF, GIF, BMP, PNG, JPEG, MS Word or MS Excel file type.</p>	<p>SLR will accept the following file types:</p> <ul style="list-style-type: none"> <li>- Adobe PDF</li> <li>- GIF</li> <li>- JPEG</li> <li>- BMP</li> <li>- PNG</li> <li>- JPG</li> <li>- XLS</li> <li>- XLSX</li> <li>- DOC</li> <li>- DOCX</li> </ul>
<p>Attached documents must be 10MB</p>	<p>If a document is longer than this, the</p>

or smaller.	provider may split it into multiple files of allowable length.
Please attach your supporting document. Please attach your required documentation.	If a document is required, it might engage a Hard Stop.

## Timing Out

SLR pages have a session timeout occur at 9 minutes and 30 seconds. If no field has been modified or a page accessed during that time, a pop-up window shall appear asking if you wish to log out or continue to use SLR. The pop-up window itself will disappear in 30 seconds if no action is taken.

# Troubleshooting

## Accessing Help

For general Help, all DC-SLR web pages have a **Help** Link that opens up a copy of this User Manual. For DC-SLR Web application assistance, you may contact the Xerox Help Desk designated to support the DC-SLR at (866)-879-0109. Select option 0 for assistance with:

- System Issues
- Directions for completing the Attestation Agreement
- Assistance with using the application
- Other questions related to the SLR application

You may also email the SLR Help Desk at: SLRHelpdesk@xerox.com. For questions specific to the DC Medicaid EHR Incentive program, visit the DC EHR Incentive Program Provider Outreach Page at <http://dc.arraincentive.com>. For policy questions regarding the DC Medicaid EHR Incentive program, you may email [dclsr@dc.gov](mailto:dclsr@dc.gov).

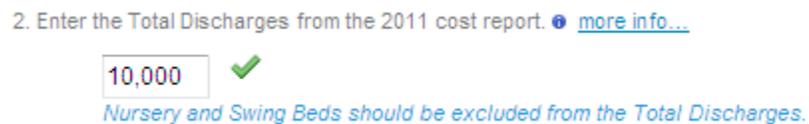
## Help Text Displays

Located throughout the DC-SLR Web application, there are tool tips, help text, and **more info** links that should help to complete the pages.

1. Tool Tips: A tool tip is text that displays when you hover your mouse over an area on the page.



2. The **more info** link of this field opens the following help window:





---

This is your total discharges for all payers, including Medicaid, for the first year of data for all states you are using to determine eligibility. You must enter an amount in this field.

3. Help Text. Help text is text that displays on the page. Help text instructs you on how to respond to a particular field or, it provides some additional information about the field or the page. The blue text from the below example, “Enter phone number without dashes.” This is help text.

Contact Person Name \*  ✓

Title  ✓

Phone Number \*  ✓  
*Enter phone number without dashes.*

Email Address \*  ✓  
*name@domain.com*

# Definitions

This section lists any glossary terms specifically applicable to this document.

Term/Acronym	Explanation/Expansion
Active Medication List	A list of medications that a given patient is currently taking.
Admitted to the Emergency Department	There are two methods for calculating ED admissions for the denominators for measures associated with Stage 1 of Meaningful Use objectives. Eligible hospitals and CAHs must select one of the methods below for calculating ED admissions to be applied consistently to all denominators for the measures. That is, eligible hospitals and CAHs must choose either the “Observation Services method” or the “All ED Visits method” to be used with all measures. Providers cannot calculate the denominator of some measures using the “Observation Services method,” while using the “All ED Visits method” for the denominator of other measures. Before attesting, eligible hospitals and CAHs will have to indicate which method they used in the calculation of denominators. <sup>3</sup>
All ED Visits Method	An alternate method for computing admissions to the ED is to include all ED visits (POS 23 only) in the denominator for all measures requiring inclusion of ED admissions. All actions taken in the inpatient or emergency departments (POS 21 and 23) of the hospital would count for purposes of determining meaningful use. <sup>3</sup>
Allergy	An exaggerated immune response or reaction to substances that are generally not harmful. Unique Patient – If a patient is seen by a provider more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period. <sup>3</sup>
American Reinvestment and Recovery Act of 2009 (ARRA)	The American Reinvestment and Recovery Act of 2009 is an economic stimulus package enacted by the 111th United States Congress in February 2009 <sup>1</sup> . Part of the act included money for health information technology (HIT) investments and payments.

<sup>1</sup> “American Recovery and Reinvestment Act of 2009.” *Wikipedia: The Free Encyclopedia* Wikimedia Foundation, Inc. Last modified: November 18, 2010. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Appropriate Technical Capabilities	A technical capability would be appropriate if it protected the electronic health information created or maintained by the certified EHR technology. All of these capabilities could be part of the certified EHR technology or outside systems and programs that support the privacy and security of certified EHR technology. <sup>3</sup>
Business Days	Business days are defined as Monday through Friday excluding Federal or State holidays on which the EH or their respective administrative staffs are unavailable. <sup>3</sup>
Centers for Medicare and Medicaid Services (CMS)	The Centers for Medicare and Medicaid Services (CMS) is a United States Federal Agency which administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). <sup>2</sup>
Clinical Decision Support	HIT functionality that builds upon the foundation of an EHR to provide persons involved in care decisions with general and person-specific information, intelligently filtered and organized, at point of care, to enhance health and health care. <sup>3</sup>
Clinical Summary	An after-visit summary that provides a patient with relevant and actionable information and instructions containing the patient name, provider's office contact information, date and location of visit, an updated medication list, updated vitals, reason(s) for visit, procedures and other instructions based on clinical discussions that took place during the office visit, any updates to a problem list, immunizations or medications administered during visit, summary of topics covered/considered during visit, time and location of next appointment/testing if scheduled, or a recommended appointment time if not scheduled, list of other appointments and tests that the patient needs to schedule with contact information, recommended patient decision aids, laboratory and other diagnostic test orders, test/laboratory results (if received before 24 hours after visit), and symptoms. <sup>3</sup>
CMS Certification Number (CCN)	A number assigned to hospitals by the Centers of Medicare and Medicaid Services, the CMS Certification Number (CCN) is the hospital's identification number that is link to its Medicare provider agreement. The CCN is used for CMS certification and also for submitted and reviewing the hospital's cost reports. <sup>4</sup>

<sup>2</sup> "Centers for Medicare & Medicaid Services." *CMS: Centers for Medicare & Medicaid services*. United States Department of Health & Human Services. Date accessed: November 22, 2010.

<sup>3</sup> "HITECH Attestation Mockups EP" and "HITECH Attestation Mockups EH Version 9". CMS: Centers for Medicare & Medicaid services. United States Department of Health & Human Services. Date published: 3/8/2011.

<sup>4</sup> "Frequently Asked Questions about Accrediting Hospitals in Accordance with their CMS' Certification Number (CCN)." *The Joint Commission*. Article date: July 15, 2010. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
CMS Medicaid EHR Incentive Program Registration site	The national <a href="#">site</a> that supports the administration and incentive payment disbursements of Medicare and Medicaid programs to medical professionals, hospitals and other organizations. <sup>5</sup>
Computerized Physician Order Entry (CPOE)	Computerized Physician Order Entry (CPOE) refers to any system in which clinicians directly enter medication orders and/or tests and procedures into a computer system, which then transmits the order directly to the pharmacy. <sup>6</sup>
Computerized Provider Order Entry (CPOE)	CPOE entails the provider's use of computer assistance to directly enter medication orders from a computer or mobile device. The order is also documented or captured in a digital, structured, and computable format for use in improving safety and organization. <sup>3</sup>
CPOE	See Computerized Provider Order Entry. <sup>3</sup>
Diagnostic Test Results	All data needed to diagnose and treat disease. Examples include, but are not limited to, blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, and pulmonary function tests. <sup>3</sup>
Different Legal Entities	A separate legal entity is an entity that has its own separate legal existence. Indications that two entities are legally separate would include (1) they are each separately incorporated; (2) they have separate Boards of Directors; and (3) neither entity is owned or controlled by the other. <sup>3</sup>
Discharge Instructions	Any directions that the patient must follow after discharge to attend to any residual conditions that need to be addressed personally by the patient, home care attendants, and other clinicians on an outpatient basis. <sup>3</sup>
Distinct Certified EHR Technology	Each instance of certified EHR technology must be able to be certified and operate independently from all the others in order to be distinct. Separate instances of certified EHR technology that must link to a common database in order to gain certification would not be considered distinct. However, instances of certified EHR technology that link to a common, uncertified system or component would be considered distinct. Instances of certified EHR technology can be from the same vendor and still be considered distinct. <sup>3</sup>
EHR Provider Incentive Portal (SLR)	The EHR Provider Incentive Portal (SLR) is a Xerox application created for the capture and maintenance of state mandated information related to the payment of Provider incentive payments provided for under the ARRA.

<sup>5</sup> "Grumman nets \$34M CMS' data repository project." *CMIO Contracts and Installations*. TriMed Media Group, Inc. Article date: May 17, 2010. Data accessed: November 22, 2010.

<sup>6</sup> "Computerized Provider Order Entry." AHRQ: Agency for Healthcare Research and Quality. United States Department of Health & Human Services. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Electronic Health Record (EHR)	An Electronic Health Record (EHR) is an electronic version of a patient's medical history, that is maintained by the Provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular Provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. <sup>7</sup>
Electronic Medical Record (EMR)	An electronic medical record (EMR) is a computerized <a href="#">medical record</a> created in an organization that delivers care, such as a hospital and doctor's surgery. <sup>8</sup>
Eligible Hospital (EH)	<p>For the purposes of the Medicaid EHR Incentive Program and SLR applications documentation, an eligible hospital (EH) is defined as the following:</p> <p>Acute care hospitals (including Critical Access Hospitals and cancer hospitals) with at least 10% Medicaid patient volume.</p> <p>Children's hospitals (no Medicaid patient volume requirements).<sup>9</sup></p>
Eligible Professional (EP)	<p>For the purposes of the Medicaid EHR Incentive Program and SLR application documentation, an eligible professional (EP) is defined as the following:</p> <p>Physicians (primarily doctors of medicine and doctors of osteopathy).</p> <p>Nurse practitioner.</p> <p>Certified nurse-midwife.</p> <p>Dentist.</p> <p>Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.</p> <p>To qualify for an incentive payment under the Medicaid EHR Incentive Program, an EP must meet one of the following criteria:</p> <p>Have a minimum 30% Medicaid patient volume*.</p> <p>Have a minimum 20% Medicaid patient volume, and is a pediatrician*.</p> <p>Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals.</p> <p>*Children's Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria.<sup>10</sup></p>

<sup>7</sup> "Electronic Health Records Overview." *CMS: Centers for Medicare & Medicaid services*. United States Department of Health & Human Services. Date accessed: November 22, 2010.

<sup>8</sup> "Electronic medical record." *Wikipedia: The Free Encyclopedia* Wikimedia Foundation, Inc. Last modified: November 5, 2010. Date accessed: November 22, 2010.

<sup>9</sup> "EHR Incentive Programs: Eligibility – Eligible Hospitals." *CMS: Centers for Medicare & Medicaid services*. United States Department of Health & Human Services. Date accessed: November 22, 2010.

<sup>10</sup> "EHR Incentive Programs: Eligibility – Eligible Professionals." *United States Department of Health & Human Services*. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
End User License Agreement (EULA)	The End User License Agreement (EULA) details how the software can and cannot be used. <sup>11</sup>
Exchange	Clinical information must be sent between different legal entities with distinct certified EHR technology and not between organizations that share a certified EHR technology. Distinct certified EHR technologies are those that can achieve certification and operate independently of other certified EHR technologies. The exchange of information requires that the provider must use the standards of certified EHR technology as specified by the Office of the National Coordinator for Health IT, not the capabilities of uncertified or other vendor-specific alternative methods for exchanging clinical information. Electronic Exchange of Clinical Information. <sup>3</sup>
Federally Qualified Health Center (FQHC)	A type of provider that includes all organizations receiving grants under Section 330 of the Public Health Service Act. Advantages include grant funding, enhanced Medicare and Medicaid reimbursement, medical malpractice coverage through the Federal Tort Claims Act, reduced cost for medications for outpatients, etc.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	The purpose of the Health Insurance Portability and Accountability Act is “to improve...the Medicaid program...and the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information.” <sup>12</sup>
Health Information Technology (HIT)	Health Information Technology (HIT) refers to the use of technology in managing health information. For example, the use of electronic health records instead of paper medical records.
Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH)	The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) amends the Public Health Service Act by adding a number of funding opportunities to advance health information technology. <sup>13</sup>
Medication Reconciliation	The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. <sup>3</sup>

<sup>11</sup> “EULA.” *Webopedia*. QuinStreet Inc. Date accessed: November 22, 2010.

<sup>12</sup> “Health Insurance Portability and Accountability Act of 1996.” *CMS: Centers for Medicare & Medicaid services*. Public Law 104-191. 104<sup>th</sup> Congress. Date accessed: November 22, 2010.

<sup>13</sup> “HITECH and Funding Opportunities.” *The Office of the National Coordinator for Health Information Technology*. United States Department of Health & Human Services. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
National Provider Identifier (NPI)	The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care Providers. <sup>14</sup>
Observation Services Method	<p>"The denominator should include the following visits to the ED:</p> <ul style="list-style-type: none"> <li>• The patient is admitted to the inpatient setting (place of service (POS) 21) through the ED. In this situation, the orders entered in the ED using certified EHR technology would count for purposes of determining the computerized provider order entry (CPOE) Meaningful Use measure. Similarly, other actions taken within the ED would count for purposes of determining Meaningful Use</li> <li>• The patient initially presented to the ED and is treated in the ED's observation unit or otherwise receives observation services. Patients who receive observation services under both POS 22 and POS 23 should be included in the denominator."<sup>3</sup></li> </ul>
Office of the National Coordinator (ONC) for Health Information Technology	The Office of the National Coordinator for Health Information Technology (ONC) is the principal Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. <sup>15</sup>
Office Visit	Office visits include separate, billable encounters that result from evaluation and management services provided to the patient and include: (1) Concurrent care or transfer of care visits, (2) Consultant visits, or (3) Prolonged Physician Service without Direct (Face-To-Face) Patient Contact (tele-health). A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider. <sup>3</sup>
Patient Authorized Entities	Any individual or organization to which the patient has granted access to their clinical information. Examples would include an insurance company that covers the patient, an entity facilitating health information exchange among providers, or a personal health record vendor identified by the patient. A patient would have to affirmatively grant access to these entities. <sup>3</sup>
Patient-Specific Education Resources	Resources identified through logic built into certified EHR technology which evaluates information about the patient and suggests education resources that would be of value to the patient. <sup>3</sup>

<sup>14</sup> "National Provider Identifier Standard (NPI): Overview." *CMS: Centers for Medicare & Medicaid services*. United States Department of Health & Human Services. Date accessed: November 22, 2010.

<sup>15</sup> "The Office of the National Coordinator for Health Information Technology (ONC)." *The Office of the National Coordinator for Health Information Technology*. United States Department of Health & Human Services. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Permissible Prescriptions	The concept of only permissible prescriptions refers to the current restrictions established by the Department of Justice on electronic prescribing for controlled substances in Schedule II-V. (The substances in Schedule II-V can be found at <a href="http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf">http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf</a> ). Any prescription not subject to these restrictions would be permissible. <sup>3</sup>
Preferred Language	The language by which the patient prefers to communicate. <sup>3</sup>
Prescription	The authorization by a provider to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization. <sup>3</sup>
Problem List	A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient. <sup>3</sup>
Provider	For the purposes of the EHR Provider Incentive Portal (SLR) application documentation, a Provider refers to both EPs and EHS.
Public Health Agency	An entity under the jurisdiction of the U.S. Department of Health and Human Services, tribal organization, State level and/or city/county level administration that serves a public health function. <sup>3</sup>
Relevant Encounter	An encounter during which the provider performs a medication reconciliation due to new medication or long gaps in time between patient encounters or for other reasons determined appropriate by the provider . Essentially an encounter is relevant if the provider judges it to be so. (Note: Relevant encounters are not included in the numerator and denominator of the measure for this objective.) <sup>3</sup>
Rural Health Clinic (RHC)	RHCs must be located in rural, underserved areas and must use one or more physician assistants or nurse practitioners. RHCs can be public, private, or non-profit, and are intended to increase primary care services for Medicaid and Medicare patients in rural communities. An advantage of RHC status is enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas.
Specific Conditions	Those conditions listed in the active patient problem list. <sup>3</sup>
State Level Registry (SLR)	The State Level Registry (SLR) is a Xerox application created for the capture and maintenance of state mandated information related to the payment of provider incentive payments provided for under the ARRA.
Taxpayer Identification Number (TIN)	A Taxpayer Identification Number (TIN) is an identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. <sup>16</sup>
Transition of Care	The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another. <sup>3</sup>

<sup>16</sup> "Taxpayer Identification Numbers (TIN)." IRS.gov. Internal Revenue Service. Last modified: August 20, 2010. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Uniform Resource Locator (URL)	In <a href="#">computing</a> , a Uniform Resource Locator (URL) is a <a href="#">Uniform Resource Identifier</a> (URI) that specifies where an identified resource is available and the mechanism for retrieving it. <sup>17</sup>
Unique Patient	If a patient is seen by a provider more than once during the EHR reporting period, then for purposes of measurement that patient is only counted once in the denominator for the measure. All the measures relying on the term “unique patient” relate to what is contained in the patient’s medical record. Not all of this information will need to be updated or even be needed by the provider at every patient encounter. This is especially true for patients whose encounter frequency is such that they would see the same provider multiple times in the same EHR reporting period. <sup>3</sup>
Up-to-date	The term “up-to-date” means the list is populated with the most recent diagnosis known by the provider . This knowledge could be ascertained from previous records, transfer of information from other providers, diagnosis by the provider, or querying the patient. <sup>3</sup>

<sup>17</sup> “Uniform Resource Locator.” *Wikipedia: The Free Encyclopedia* Wikimedia Foundation, Inc. Last modified: November 22, 2010. Date accessed: November 22, 2010.