

Medicaid EHR Incentive Program

**Eligible Hospital
Meaningful Use Attestation
Manual**

**April 1, 2013
Version 1.2**

Table of Contents

- 1 Introduction 1**
- Resources:..... 1
- 2 Background 1**
- 3 Eligibility 2**
- 3.1 Additional requirements for the EH 2
- 3.1.1 Out-of-State Providers..... 2
- 4 Establishing Patient Volume 3**
- 4.1 Eligible Hospitals..... 3
- 4.1.1 Eligible Hospital SMA Encounter 3
- 5 Payment Methodology for Eligible Hospitals 4**
- 6 Provider Registration 6**
- 7 Provider Attestation Process and Validation 7**
- 8 Incentive Payments 8**
- 9 Program Integrity 8**
- 10 Administrative Appeals 8**
- 11 Registration (Eligible Hospitals)..... 9**
- 11.1 Eligible Hospital Sign-in Screen 9
- 11.2 Eligible Provider Home Screen..... 10
- 11.3 Eligible Hospital CMS/NLR Screen 11
- 11.4 Hospital Eligibility Details Screen 13
- 11.5 Meaningful Use Questionnaire Screen..... 15
- 11.6 Eligibility Incentive Payment Calculations Screen 17
- 11.7 Document Upload Screen 17
- 11.8 Attestation Screen 18
- 11.9 Issues/Concerns Screen..... 19
- 11.10 Appeals Screen 19
- 11.11 Meaningful Use 19

1 INTRODUCTION

The Guam Medicaid EHR Incentive Program will provide incentive payments to Eligible Hospitals (EH) and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>
- Office of the National Coordinator for Health Information Technology located at http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

2 BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://www.healthit.hhs.gov>.

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

3 ELIGIBILITY

While EHs can begin the program in Calendar Year (CY) 2011, they must begin the program no later than Federal Fiscal year (FFY) 2016.

The first tier of provider eligibility for the Guam Medicaid EHR Incentive Program is based on provider type and specialty.

At this time, Guam SMA has determined that the following hospitals are potentially eligible to enroll in the Guam Medicaid EHR Incentive Program:

- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children's Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

3.1 Additional requirements for the EH

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

1. An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment or
2. A children's hospital (exempt from meeting a patient volume threshold).

Hospital-based providers are not eligible for the EHR incentive program.

Qualifying Providers by Type and Patient Volume

Program Entity	Percent Patient Volume over Minimum 90-days
Acute care hospital	10%
Children's Hospital	Exception

3.1.1 Out-of-State Providers

The Guam Medicaid EHR Incentive Program welcomes any out-of-state provider to participate in this program as long as they have at least one physical location in Guam. Guam must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Guam SMA program or CMS. Records must be maintained as applicable by law in the state of practice or Guam, whichever is deemed longer.

4 ESTABLISHING PATIENT VOLUME

A SMA provider must annually meet patient volume requirements of Guam's Medicaid EHR Incentive Program as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP.

4.1 Eligible Hospitals

To calculate TXIX patient volume, an EH must divide:

- The total TXIX and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year by:
- The total encounters in the same 90-day period.
 - Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period. *(Please note per CMS FAQ nursery days are excluded from inpatient bed days)*
 - An emergency department must be part of the hospital.

4.1.1 Eligible Hospital SMA Encounter

For purposes of calculating eligible hospital patient volume, a SMA encounter is defined as services rendered to an individual 1) per inpatient discharge, or 2) on any one day in the emergency room where TXIX SMA or another state's Medicaid program paid for:

- Part or all of the service;
- Part or all of their premiums, co-payments, and/or cost-sharing;

Exception – a children's hospital is not required to meet Medicaid patient volume requirements.

5 PAYMENT METHODOLOGY FOR ELIGIBLE HOSPITALS

Statutory parameters placed on Guam Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Children's hospitals and acute care hospitals may be paid up to 100 percent of an aggregate EHR hospital incentive amount provided over a three-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Guam is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Guam Medicaid incentive payments to those providers. Auditable data sources include:

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Guam Medicaid electronic systems; and
- Hospital financial statements and hospital accounting records.

The Guam Medicaid EHR Incentive Program hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

$$\text{EH Payment} = \text{Overall EHR Amount} \times \text{Medicaid Share}$$

Where:

Overall EHR Amount = {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}

Medicaid Share = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH.

Guam has worked with CMS on ways to effectively calculate costs. For example, charity care costs are not included on Guam's cost report.

To the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients, the statute directs that such figure is deemed to equal 0. Likewise, if there is simply not sufficient data for the state to estimate the percentage of inpatient bed days that are not charity care (that is, [estimated total charges— charity care charges]/estimated total charges), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful

demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

6 PROVIDER REGISTRATION

EHRs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. Providers must provide their name, NPI, business address, phone number, tax payer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN.

Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments unless information needs to be updated. EHRs seeking payment from both Medicare and Medicaid will be required to visit the NLR annually to attest to meaningful use before returning to the GuamSLR system to attest for Guam's Medicaid EHR Incentive Program. SMA will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The NLR will assign the provider a CMS Registration Number and electronically notify SMA of a provider's choice to access Guam's Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the GuamSLR system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a provider with the Guam SMA. If either of these conditions is not met, a message will be automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted.

Once payment is disbursed to the eligible TIN, NLR will be notified by SMA that a payment has been made.

7 PROVIDER ATTESTATION PROCESS AND VALIDATION

SMA will utilize the secure GuamSLR system to house the attestation system.

Following is a description of the information that a provider will have to report or attest to during the process.

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the EH will be asked to provide:
 - Completed patient volume information on the GuamSLR Web site;
 - Completed Hospital EHR Incentive Payment Worksheet;
 - Certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules); and
2. The EH will be asked to attest to:
 - Adoption, implementation or upgrade of certified EHR technology or meaningful user;
 - Not receiving a Medicaid incentive payment from another state; and
3. The EH will be asked to electronically sign the amendment;
 - The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify); and
 - The person filling out the form should enter his or her name.

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, SMA will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the EH to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All providers will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

During the first year of the program is the only time an EH will be allowed to attest to adopting, implementing or upgrading to certified EHR technology. It should be noted that the documentation for AIU of certified EHR technology for EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (the Certified Health IT Product List can be located at ONC's website at <http://www.healthit.hhs.gov>). EHs can attest to either AIU or meaningful use as appropriate.

All providers will be required to attest to meeting meaningful use to receive incentive payments after the first year.

8 INCENTIVE PAYMENTS

SMA will make the necessary changes to the CMS-64 reporting process to add the additional line item payment and administrative information, and, if required by CMS, the Medicaid Statistical Information System (MSIS) file will be modified to accommodate the incentive payment program.

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and validation by SMA, an incentive payment can be approved.

9 PROGRAM INTEGRITY

SMA will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers should be sure to keep their supporting documentation.

10 ADMINISTRATIVE APPEALS

You may appeal the determination made by the Guam State Medicaid Agency on your incentive payment application. Please send a Formal Letter of Appeal to the address below, within 30 days of the determination date of notification. This formal written notification must include a detailed explanation of why the EP or EH deems a wrong determination made by the Guam Medicaid EHR Incentive Program. Any supporting documentation to the appeal should be included with the Letter of Appeal.

Bureau of Health Care Financing
Attn: EHR Incentive Program Appeals
123 Chalen Kareta Route 10
Mangilao, GU 96913

11 REGISTRATION (ELIGIBLE HOSPITALS)

Hospitals will be required to provide details including patient volume characteristics, EHR details, growth rate and Medicaid. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual). They will first register with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>. This registration is only needed once, if this is your second year of the EHR Incentive Program then you may go directly to the GuamSLR sight shown below.

The hospital provider then begins the Guam Medicaid EHR Incentive Program registration process by accessing the GuamSLR system at <http://ehrincentives.guam.gov> (sign-in screen shown below) and entering the NPI and CMS-assigned registration identifier that was received from CMS.

11.1 Eligible Hospital Sign-in Screen

The provider will enter the NPI registered on the NLR and the CMS-assigned Registration Identifier that was returned by the NLR. Please allow 48 hours from registration to log into the GuamSLR. The EH will only need to register once, if you are a returning provider you will be able to log in at any time.

If the data submitted by the provider matches the data received from the NLR, the CMS/NLR Provider Demographics Screen will display with the pre-populated data received from the NLR. If the provider entry does not match, an error message with instructions will be returned.

11.2 Eligible Provider Home Screen

The Home screen will give the EH data about their current Guam Attestation as well as provide navigation for the EH to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment.

The screenshot displays the Home page for an Eligible Provider. The page is titled "Home" and includes a "Logout" button in the top right corner. A navigation menu on the left lists: Home, View All Payment Years, Issues/Concerns, Appeals, Additional Resources, User Manual, and Send E-mail. The main content area is organized into five sections:

- Issues/Concerns:** A text box stating, "Clicking the below link will redirect you to the Issues/Concerns page, where you will be able to submit any issues and view the responses received from the DMS." with a "Click Here" link.
- Provider Information:** Text indicating the provider is enrolled in the EHR Incentive Program, with Payment Year '2' as the current year. The status of the year 2 application is "AWAITING PROVIDER ATTESTATION".
- Provider Status Flow:** A flowchart showing the process: CMS Registration (Completed) → Preliminary Verification (Completed) → Provider Attestation (In Process).
- Provider Attestations:** A table listing attestations by payment year.

Payment Year	Status	AttestationID	Action
1	Paid	KY0000184	View
2	Attest_inProcess	-	Begin/Modify Attestation

There are 5 sections to the Home page listed below:

1. **Messages and Announcements** – This will be the first section on the page if a message or announcement exists for the provider.
2. **Issues/Concerns** – This will be the second section on the page. The Issues / Concerns will provide a link for the provider to redirect to the Issues / Concerns page if he would like to submit a new issue or view a response to an issue.
3. **Provider Information** – This is the third section of the home page. The provider information will give the high level status for the provider, the current payment year and the current status for the payment year.
4. **Provider Status Flow** – this is the fourth section of the home page. The Provider Status Flow will give a diagram showing the provider where he is in the current year's attestation. If the provider has been found not eligible for any reason, he will also find the specific reasons for that finding in this section.
5. **Provider Attestations** – this is the fifth section of the home page. The Provider Attestation table will list the providers attestations by payment year and list the navigation actions he has available for each.

11.3 Eligible Hospital CMS/NLR Screen

Along with the pre-populated data from the CMS Registration Module there are additional fields that can be updated by the provider.

The data provided by the CMS Registration Module is view only. If any of this data is incorrect then the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected in the screen above. The fields that are from the CMS registration are listed below:

- **Applicant National Provider Index (NPI)** – This is the eligible hospital or CAH’s registering NPI. The NPI registered at CMS should be the same NPI that is enrolled in Guam Medicaid.
- **Applicant TIN** – This is the Tax Identification Number that was listed in the CMS registration. This TIN should be the same TIN that is listed for the provider under Guam Medicaid.
- **Payee National Provider Index (NPI)** – This is the payee NPI given during the CMS registration.
- **Payee TIN** – The tax identification number associated with the payee NPI.
- **Program Option** – This is the program option that was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.
- **Medicaid State** – This is the State that was selected during the provider’s registration.
- **Provider Type** – This is the provider type that was given during the registration at CMS.
- **Participation year** – This is the provider’s participation year with the EHR Incentive Program
- **Federal Exclusion** – This will list any federal exclusion found on the provider if any during registration with CMS.

- **Name** – The Provider’s name listed on the CMS Registration
- **Address 1** – The provider’s street address listed on the CMS registration
- **Address 2** – The provider’s street address listed on the CMS registration
- **City/State** – The provider’s city/state listed on the CMS registration
- **Zip Code** – The provider’s zip code listed on the CMS registration
- **Phone Number** – The provider’s phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.
- **Email** – The provider’s email given during the CMS registration. This email address is used for system generated emails on updates for the provider’s attestation and communication from the EHR review staff.
- **Specialty** – The provider’s specialty listed in the CMS registration.
- **State Rejection Reason** – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

The data listed under the section **Provider Medicaid Attestation Data** is updatable by the provider during attestation. Once the attestation is submitted by the provider the data will become view only. Those data fields are described below:

- **Medicaid ID**
 - This field only displays if you have multiple Guam Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Guam Medicaid Numbers. This Medicaid Number will be used to for your incentive payments.
- **Mailing Address**
 - The mailing address can be updated if the provider would like to give an alternate address from the one listed from CMS for correspondence.
 - Indicating a new address in these fields will change the Payee address for the Provider’s EHR incentive payment.
- **Were you assisted by the Hawaii Pacific Regional Extension Center:**
 - Response to this question is required.
 - If the response is yes, then please type the name of the person who assisted you during the attestation process.

11.4 Hospital Eligibility Details Screen

Hospital Eligibility Details (Year 2 Attestation)	
All * fields are required fields.	
Patient Volume:	1. For which program year are you applying? * 2012
	2. Select the starting date of the 90-day period(in the prior FFY) to calculate Medicaid patient volume percentage: * 1/3/2011 (mm/dd/yy)
	3.(i) Medicaid Inpatient Discharges during this period: * 500
	(ii) Medicaid ER/other Discharges (requires attestation): * 50
	(iii) Total Medicaid patient discharges during this period: * 550
	4. Total patient discharges during this period: * 1000
	5. Medicaid patient volume percentage: 55.00%
EHR Details:	6. Enter the CMS EHR Certification ID of your EHR: * 30000004HOWLEAS What is this?
	7. Indicate the status of your EHR: * <input checked="" type="radio"/> Meaningful User
Due to special circumstances does your Cost report information need to be adjusted? * <input type="radio"/> Yes <input checked="" type="radio"/> No	
Growth Rate:	8. Select the end date of the hospital's most recently filed 12-month cost reporting period: * 3/4/2010 (mm/dd/yy)
	9. Total number of discharges that fiscal year: * 234 (w/s S-3, part I, col. 15, line 14)
	10. Total number of discharges one year prior: * 333
	11. Total number of discharges two years prior: * 345
	12. Total number of discharges three years prior: * 4555
Medicaid Share:	13. Total Medicaid inpatient bed days (Exclude Nursery beds): * 9000 (w/s S-3, part I, col. 7, line 14)
	14. Total Medicaid HMO inpatient bed days (Exclude Nursery beds): * 9388 (w/s S-3, part I, col. 7, line 2)
	15. Total inpatient bed days: * 155000 (w/s S-3, part I, col. 8, line 14)
	16. Total hospital charges: * 209.00 (w/s c part I, col. 8, line 202)
	17. Total uncompensated care charges: * 32.00 (KMAP-4, line 4)
<input type="button" value="Previous"/> <input type="button" value="Next"/> <input type="button" value="Save"/> <input type="button" value="Cancel"/>	

As shown above, hospitals must enter four categories of data to complete the Eligibility Details screen including patient volume characteristics, EHR details, growth rate, and Medicaid share. Providers will enter the following data on the screen:

Patient volume

- Select the program year you wish to attest.
 - This should be either the current year or it can be the prior Federal Fiscal year if the current date is between 10/1 – 12/31.
- Starting date of the 90-day period to calculate Medicaid patient volume percentage
 - This date should be a 90 day period within the Federal Fiscal Year prior to the program year selected above.
- Medicaid Inpatient discharges during this period
- Medicaid ER/other discharges during this period
- Total patient discharges during the period – automatically calculated from the two responses above
- Medicaid patient volume percentage (calculated)

EHR details

- EHR certification ID of EHR
- Status of your EHR – Choices:
 - (A) Adopt - Acquire, purchase, or secure access to certified EHR technology
 - (I) Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
 - (U) Upgrade - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria
 - Meaningful User - currently meaningfully using certified EHR technology and are prepared to attest to Meaningful Use and Clinical Quality Measures.

Growth rate

- Due to special circumstances does your cost report information need to be adjusted – This should only be yes if the data used to calculate your original payment included nursery or swing bed days or you have been working with the Hospital Division due to another issue and requested that you update this information.
- End date of the hospital's most recently filed 12-month cost reporting period
- Total number of discharges that fiscal year
 - On the cost report documents this will be w/s S-3 part I, col. 15, line 14
- Total number of discharges one year prior
- Total number of discharges two years prior
- Total number of discharges three years prior
- Average annual growth rate (calculated)

Medicaid share

- Total Medicaid inpatient bed days
 - On the cost report documents this will be w/s S-3 part I, col. 7, line 14 and should not include nursery/swing bed days
- Total Medicaid Health Maintenance Organization (HMO) inpatient bed days
 - On the cost report documents this will be w/s S-3 part I, col. 7, line 2 and should not include nursery/swing bed days
- Total inpatient bed days (Please note per CMS FAQ nursery/swing days are excluded from inpatient bed days)
 - On the cost report documents this will be w/s S-3 part I, col. 8, line 14 and should not include nursery/swing bed days
- Total hospital charges
 - On the cost report documents this will be w/s c part I, col. 8 line 202 and should not include nursery/swing bed days Total uncompensated care charges
- Total uncompensated care charges

11.5 Meaningful Use Questionnaire Screen

After entering the provider eligibility details, EHs who have selected Meaningful Use will be directed to the Meaningful Use Questionnaire screen and will need to enter some additional data prior to entering data for their measures.

****Please note, if you are registered as a dual eligible hospital you must complete your MU attestation with Medicare prior to entering your attestation with Medicaid.**

EHR Reporting Period

The EHR reporting period is the timeframe that was used for the Meaningful Use Measure data and Clinical Quality Measures data that are being submitted during the attestation. This reporting period should be within the current program year that is being attested.

For the first year of reporting Meaningful Use EHs are required to report on a continuous 90 day period within the program year being attested. For the second year of reporting Meaningful Use an entire year of reporting will be required.

EH/ CAHs who are registered as dual eligibles will only have one year of 90 day reporting for Meaningful Use despite which program was attested. Their will never be two consecutive years of 90 day Meaningful Use reporting. Therefore if an EH/CAH has attested 90 days of MU to Medicare in one year they will either report the same 90 days in Medicaid during the same program/payment year or they will go directly to full year MU reporting with Medicaid during a later program/payment year.

Meaningful Use Questionnaire (Year 2 Attestation)

Meaningful Use Questionnaire

Please provide the EHR reporting period associated with this attestation:

- EHR Reporting Period Start Date: (mm/dd/yy)
- EHR Reporting Period End Date: (mm/dd/yy)
- Enter the percentage of unique patients who have structured data recorded your certified EHR technology as of the reporting period above:

***Emergency Department (ED) Admissions:** An eligible hospital must choose one of the two methods to designate how patients admitted to the Emergency Department (ED) will be included in the denominators of certain Meaningful Use Core and Menu Measures. Please select the method that will be used for ALL Meaningful Use Core and Menu Measures:

Observation Services Method

All ED Visits Method

The following fields are required to continue with the attestation:

- **EHR Reporting Period Start Date** – This is the starting date for the period of time you are reporting your Meaningful Use Measure data.
 - **If you are attesting as a dual eligible hospital then this date should be the same date as the one that was attested for your Medicare Meaningful Use attestation. The system will locate the file from Medicare from this date and you will not be requested to re-enter those measures already submitted to Medicare**
- **EHR Reporting Period End Date** – This is the end date for the period of time you are reporting your Meaningful Use Measure data.

- **If you are attesting as a dual eligible hospital then this date should be the same date as the one that was attested for your Medicare Meaningful Use attestation. The system will locate the file from Medicare from this date and you will not be requested to re-enter those measures already submitted to Medicare**

- Enter the percentage of unique patients who have structured data recorded in your certified EHR technology as of the reporting period above
 - This should be the percentage of all the patients you have seen total who have data recorded in your EHR. The amount of patients with structured data stored in your EHR should be at least 80%

- **Emergency Department (ED) Admissions**
 - Indicate the method that designates how patients admitted to the ED will be included in the denominators of certain Meaningful Use Core and Menu Measures.

11.6 Eligibility Incentive Payment Calculations Screen

Logout

Incentive Payment Calculations

CMS/NLR
Eligibility Details
Payments
Issues/Concern
Appeals
User Manual
Additional Resources
Send E-mail

Patient Volume Calculations

Medicaid Patient Volume Percentage: 50.00% * should be greater than 10% to qualify

Rate of growth prior year: 1.324%

Rate of growth 2 years prior: 1.816%

Rate of growth 3 years prior: 4.677%

Average rate of growth: 2.606% * use this growth rate to project number of discharges for year 2 through year 4 below

EHR Amount Calculations

	Year	Discharges	Allowable Discharges	Discharge Related Amount	Base Amount	Aggregate EHR amount	Transition Factor	EHR Amount
First year		25330	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	1.00	\$6,370,200.00
Second Year		25990	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.75	\$4,777,650.00
Third Year		26667	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.50	\$3,185,100.00
Fourth Year		27362	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.25	\$1,792,550.00
Total Amount								\$15,925,500.00

Medicaid Share Calculations

Total Medicaid and Passport Inpatient Bed Days: 6231

Total Bed Days: 132145

Percentage of total charges which are non-charity: (total charges - uncompensated charges) / total charges: 99.66%

Total Beds that should be considered non charity: 131696

Total Medicaid Percentage: 4.73135%

Total Medicaid Aggregate EHR Incentive Payment: \$753,491.30

Total Estimated Medicaid Aggregate EHR Incentive Payment First Year (50%): **\$376,745.65**

Previous Next

The screen lists the estimated payment for the EH or CAH for the current attestation.

11.7 Document Upload Screen

Logout

Document Upload (Year 2 Attestation)

CMS/NLR
Meaningful Use Questionnaire
Meaningful Use Menu Options
Meaningful Use Core Measures
Meaningful Use Menu Summary
Clinical Quality Measures
Pre-Attestation Measure Summary
View All Payment Years
Issues/Concerns
Appeals
Additional Resources
User Manual
Send E-mail

Documentation needed to process your application may be attached below. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc. If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation. Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.

	Payment Year	File Name	Description	
View	2	EP MU Spec sheet.pdf		Delete

Upload a new PDF document:

Please select the documentation type:
--Select the type of a document--

You have successfully uploaded: EP MU Spec sheet.pdf

This page will allow the EH to attach documentation with their current year attestation.

- Clicking on the Browse button will allow the EH to search and select the documents they would like to attach
- Clicking on the upload button will attach and save the document relating to the current attestation payment year.
- Only PDFs up to 100MB can be uploaded

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.

After the EH has completed the Eligibility Details screens and press "Next," navigation will take them to the Attestation screen below.

11.8 Attestation Screen

Attestation (Step 4 of 4) Logout

[CMS/NLR](#)
[Eligibility Details](#)
[Payments](#)
[Issue/Concern](#)
[Appeals](#)
[User Manual](#)
[Additional Resources](#) ▶
[Send E-mail](#)

CMS/NLR:

Applicant National Provider Index (NPI):	0123456789	Name:	Demo Hospital
Applicant TIN:	012345678	Address 1:	123 Any Street
Payee National Provider Index (NPI):	0123456789	Address 2:	
Payee TIN:	012345678	City/State:	Anytown / NY
Program Option:	DUALY_ELIGBLE	Zip Code:	40000 -
Medicaid State:	NY	Phone Number:	(800) 323-8867
Payment Year:	1	Email:	demo.hospital@demo.org
Provider Type:	Acute_Care_Hospitals	Specialty:	

Hospital Eligibility Details:

Patient Volume:	1.	Select the starting date (in 2010) of the 90-day period to calculate Medicaid patient volume percentage:	5/6/2010 (mm/dd/yyyy)
	2.	Total Medicaid patient discharges during this period:	100
	3.	Total patient discharges during this period:	200
EHR Details:	4.	Enter the EHR certification number of your EHR:	300000015WU6EAK
	5.	Indicate the status of your EHR:	<input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User
Growth Rate:	6.	Select the end date of your last full hospital fiscal year that ended prior to September 30, 2010:	8/6/2010 (mm/dd/yyyy)
	7.	Total number of discharges that fiscal year:	25320 (w/5 S-2 part 1, col.5, line 12)
	8.	Total number of discharges one year prior:	24099
	9.	Total number of discharges two years prior:	24553
	10.	Total number of discharges three years prior:	23456
Medicaid Share:	11.	Total Medicaid inpatient bed days (Exclude Nursery beds):	6231
	12.	Total Medicaid HMO inpatient bed days (Exclude Nursery beds):	0
	13.	Total inpatient bed days:	132145
	14.	Total hospital charges:	919293949.00 (w/5 c part 1, col.8, line 103)
	15.	Total uncompensated care charges:	3124555.00 (RMAP-4, line 4)

I understand that I must have and retain documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

Initials:

NPI:

Note: Once you press the submit button below, you will not be able to change your information.

Previous
Submit

After submitting the initials and NPI, your attestation is complete.

11.9 Issues/Concerns Screen

The Issues / Concerns screen will work as it does today. The EH may submit an issue or concern by selecting an issue category and typing in the details of their issue or concern. It will be saved upon them clicking the submit button.

11.10 Appeals Screen

The Appeals screen is a read only screen that inform the EH of how to initiate an appeal and provides contact information for the appeal.

11.11 Meaningful Use

If you are a EH / CAH who is not registered as dually eligible and are only attesting for the Medicaid Incentive Payments then you will be required to go through the measure screens and enter the EH/CAH Measure data. Currently there are no hospitals in Guam who are not dually eligible therefore the Measures must be submitted to Medicare prior to attesting for Medicaid. Please allow at least 3 days after your Medicare attestation to ensure the data has been sent to the State prior to your Guam Attestation.

If you would like more information on the measures required for Meaningful Use please see the site below:

http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage