Montana State Level Registry for Provider Incentive Payments

Group Administrator User Manual

State Level Registry for Provider Incentive Payments

April 2014
Version 3.1

Revision History

Version Number	Date	Description	Author
1.0	11/16/2010	Draft document	Annie Washington Madhuri Pamidipati David Morton
1.1	11/26/2010	Peer review edits	Annie Washington
1.2	1/16/2011	CMS rule changes	Annie Washington
1.3	3/1/2011	System changes during client UAT; split guide into EP, EH and Group versions	Annie Washington
1.4	9/12/2011	Montana specifications	Gwendolyn Carnes
2.0	2/17/2012	Revising to the V2 interface.	Will Graeter
2.0	2/27/2012	Added Xerox branding material	Will Graeter
2.1	6/11/2012	Added Account Creation – Is This You? and EHR Reporting Period – Add New Location instructions	Will Graeter
2.4	11/1/2012	2.4 updates, including Payee Medicaid ID.	Will Graeter
2.5	1/13/2013	Updates from the 2.5 release.	Will Graeter
2.6	8/8/2013	Updates from the 2.6 release, including Appeals, and expanded Recoupments and Adjustments.	Will Graeter
3.1	4/22/2014	New table of CQMs, MU content changes, and password period changes.	Will Graeter

Table of Contents

Introduction

The overall goal of the User Manual is to help guide medical professionals through the process of completing their State's application for the Centers for Medicare & Medicaid Management's (CMS's) EHR Incentive Payment. This application is submitted through the State Level Registry, a web tool designed to capture all information needed for the approval of the EHR payment, and to submit the application to your State. Users are called Eligible Professionals (EPs) because medical personnel other than physicians can also apply for the incentive payment. Nurse Practitioners are one example.

SLR Application Availability

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

Problem Reporting

For general Help, all SLR web pages have a **Help** Link that opens up a copy of this User Manual. For SLR technical support, you can contact the ACS Help Desk designated to support the SLR.

Phone: (866) 879-0109
Email: SLRHelpdesk@acs-inc.com

Fro questions about the Montana EHR incentive payment program, contact a Montana representative:

Email: MedicaidEHR@mt.gov
http://medicaidprovider.hhs.mt.gov/providerpages/ehrincentives.shtml

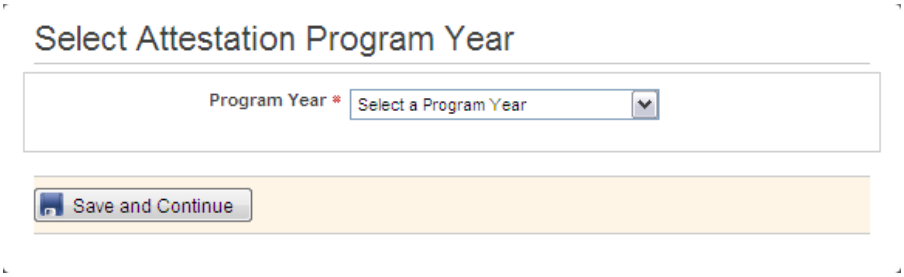
Overview

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, ACS has developed the EHR Provider Incentive Portal application, called the State Level Registry (SLR).

By using 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 SLR application stores your information in an organized manner. This application provides the most direct path to your incentive payment.

Dates

An EP applying for the 2014 program year will have had Medicaid eligibility dates between 1/1/14 and 12/31/14. Each State has a designated Grace Period in the beginning of the year during which users that have not submitted an Attestation Agreement can elect the year for which they are Attesting.



Application Architecture

The SLR Web application features the following:

- Compliance with Section 508 accessibility guidelines.
- Accessibility from the internet: ACS 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. State of Montana accessibility standards are available for review.
- 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.
- Pop-up Blocker browser feature should be set to **Off** to receive the Pop-up window features.
- Manuals and/or FAQ's that are available for distribution.

Also note that this application is compatible with Microsoft Internet Explorer V7.0 and above only.

Method

Login – Accessing the SLR

The SLR is a web-based application 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://mt.arraincentive.com

SLR login from the Provider Outreach Web portal.

You can access the 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 SLR application login page.

The *Provider Outreach* page displays the following:

1. Montana banner section. Located at the top of the page, the banner displays the following items that are visible on every page of the SLR application:
    a. Client logo and tagline. This is the Montana Department of Public Health and Human Services logo and with SLR tagline.
    b. SLR heading "Montana Medicaid State Level Registry for Provider Incentive Payments". This is the name of the application.
    c. **Provider Outreach Home** link: Clicking this link returns you to the *Provider Outreach (Home)* page.
    d. **Contact Us** link: Clicking this link opens a pop-up page displaying contact information consisting of the ACS Help Desk phone number and email.
2. SLR Account Creation/Entry, FAQs and RSS Feeds sections. Located to the left and right of the page, these columns display the following sections:
    a. *Deadlines for Calendar Year Montana Medicaid EHR Incentive Payment Applications* section: contains links to information for both eligible professionals and eligible hospitals.
    b. *Need to create an SLR account?* section: clicking the **leave this site and create an SLR account** link directs you to the *Create Account* page.
    c. *Already have an SLR account?* section: Clicking the **go directly to the State Level Registry for Provider Incentive Payments** link directs you to the *Login* page.
    d. *Centers for Medicare & Medicaid Services (CMS)* section: clicking a link in this section opens up a new window and displays an article related to CMS.

e. *EMR and HIPAA* section: clicking a link in this section opens up a new window and displays an article related to one of these healthcare topics.

f. *Are you Eligible?* section: clicking the **Run the CMS Eligibility Wizard** link directs you to a wizard designed by CMS to help you determine basic eligibility to the provider incentive program.

g. *Frequently Asked Questions* section: clicking 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.

h. *Healthcare IT News* section: clicking a link in this section opens up a new window and displays an article related to Healthcare IT news.

3. Primary Page Body Content section. Located in the middle of the page, the primary page content entails the following sections:

   a. Welcome text. This is an overview of the Provider Outreach Web portal.

   b. *Want to get a jump start? Click Here!* section: clicking this link opens up a new window and will guide you through the process of gathering information to complete the SLR, the link to create an account.

   c. *Regional Extension Centers (REC)* section: clicking a link in this section opens up a new window and displays the REC website.

4. *Important Web Resources* section: clicking a link in this section opens up a new window and displays the associated website.

5. Footer section. Located at the bottom of the page, the footer displays the following items:

   a. **Privacy** link: opens the approved Statewide Policy for Internet Privacy and Security in a new window.

   b. **Terms of Use** link: Clicking this link opens a new window with a Terms of Use policy displayed.

   c. **Accessibility** link: Clicking this link opens a new window with the website's Accessibility policy displayed.

   d. ACS/Xerox copyright: this is ACS's copyright symbol and text.

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** located on the upper left hand corner of the *Provider Outreach* webpage.

SLR login directly from the SLR login URL.

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

https://mt.arraincentive.com/

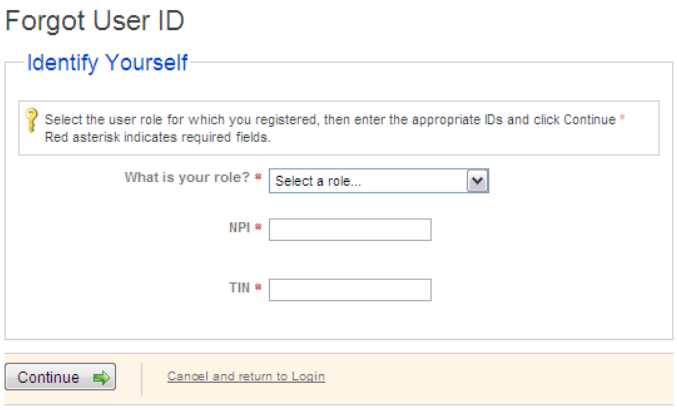
Type the Montana State Level Registry URL in the address field and press the **Enter** key on your keyboard.

From here, you will reach the 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.

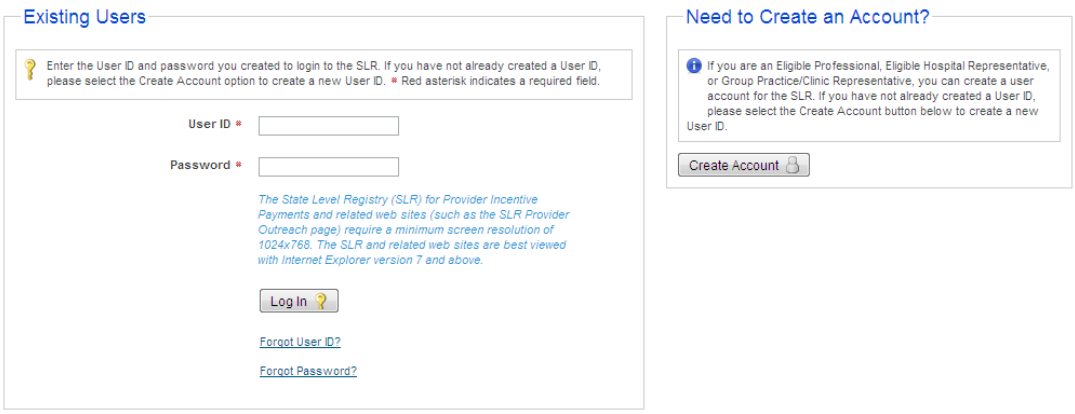
Throughout the SLR application, red asterisks (*) display on various fields. This symbol indicates that this field is required to be completed in order to continue through the application.

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.



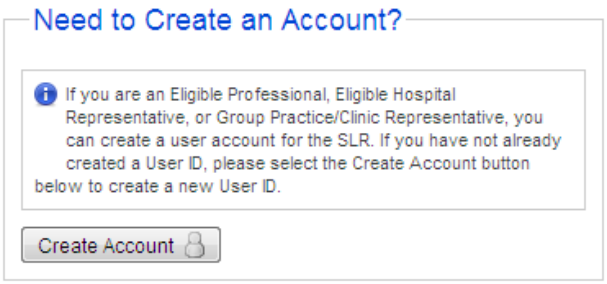
5. **Forgot Password?** link: select when you have forgotten your password. The system will ask you for your User ID as well as the answer to the Challenge Question you picked when creating your account. Once you have entered those correctly, the system will email a link to reset your password to the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



Creating a New SLR Account for Eligible Professionals and Group Representatives

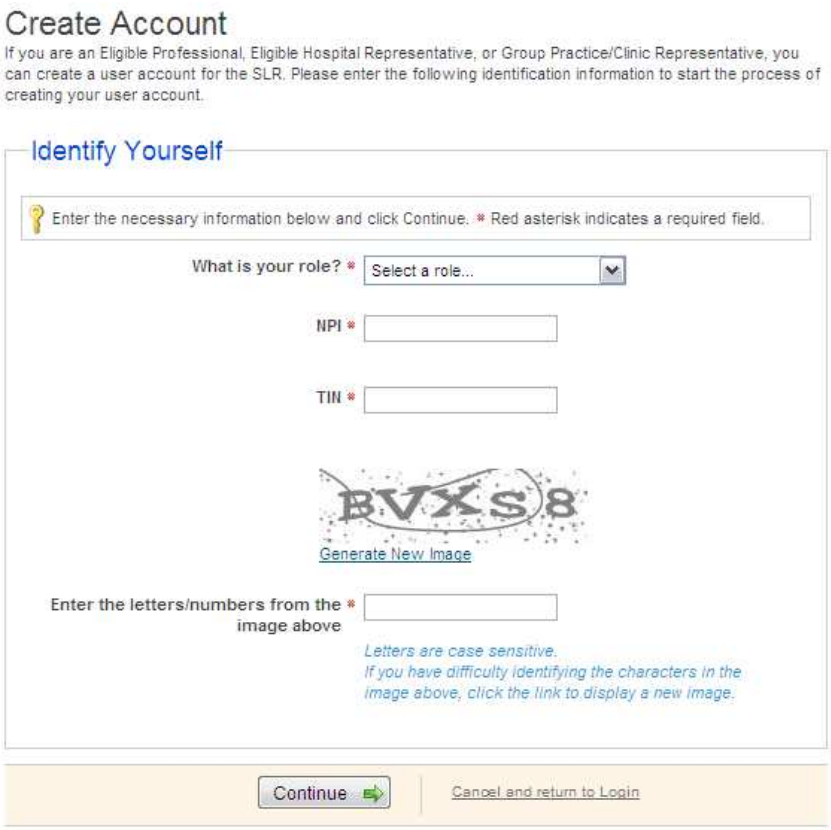
To create a new account from the *Provider Outreach* page, select the **leave this site and create an SLR account** link located on the left side of the *Provider Outreach Jumpstart* page.

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



The *Create Account* page displays the following:

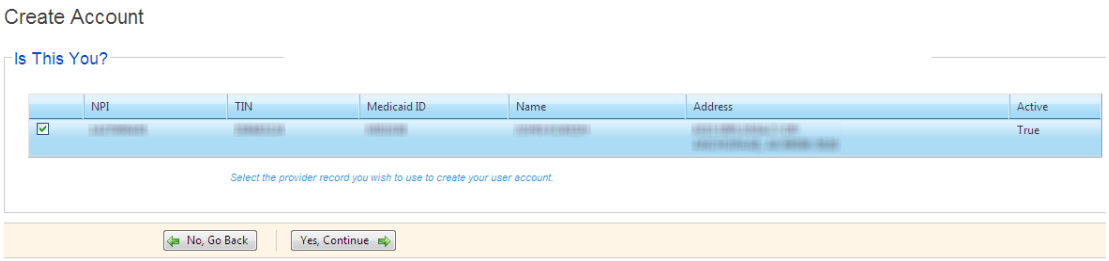
1. **What is your role?** pull-down menu: identify your Provider Type by selecting an option from the menu. As an individual physician or medical professional, select Individual Eligible Professional.
2. **NPI** text field: enter your National Provider Identifier (NPI) number. If you have more then one 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 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.



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 state 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.



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.

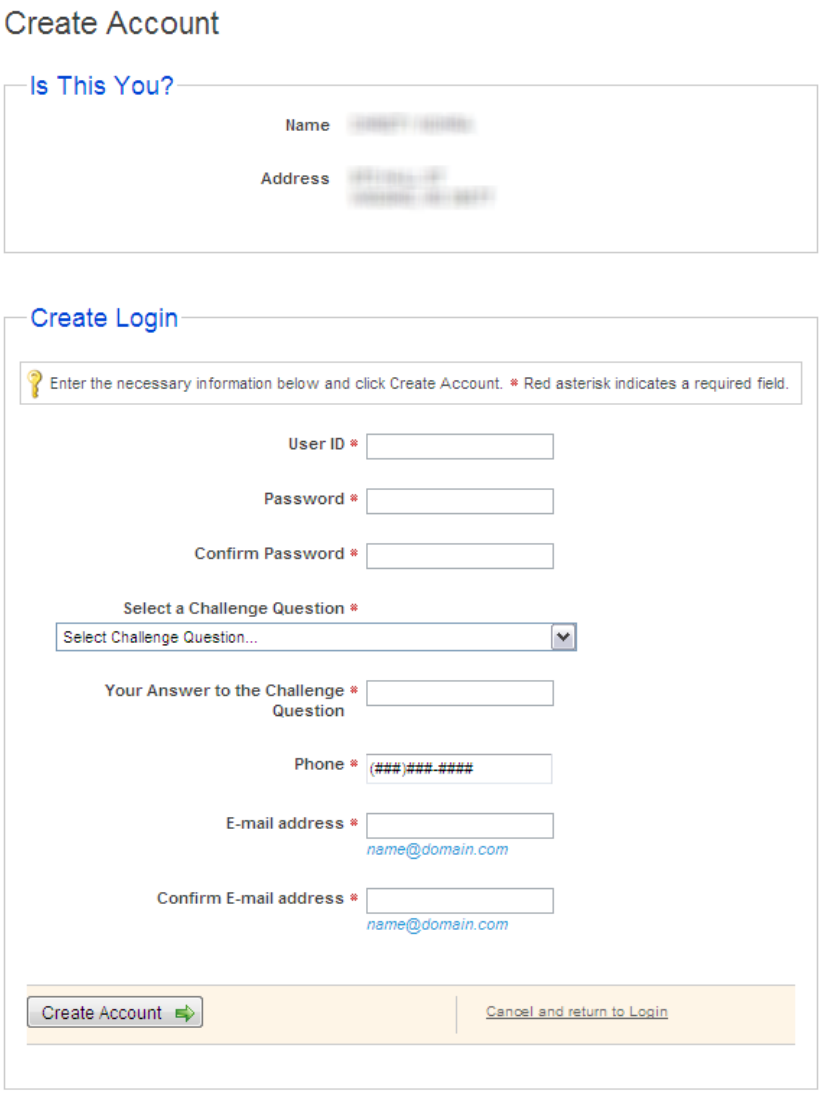
If the information is not correct, select the **No, Go Back** button to return to the previous page. From there, you can either retry entering your NPI and TIN or call the Help Desk for assistance.

If the information is correct and you click the **Yes, Continue** button. The following 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 was not misspelled.
9. **Create Account** button: select this button to save your account. If you 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.



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** display message: signifies that you have successfully created your SLR account.
2. **Continue to Login** button: opens the Login page.

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 read and 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** link: clicking this link will open a new window containing a printable version of the EULA. A *Print* window will also open.
3. **Continue** button: opens the SLR home page.
4. **Cancel and return to Log in** link: returns you to the *Login* page.

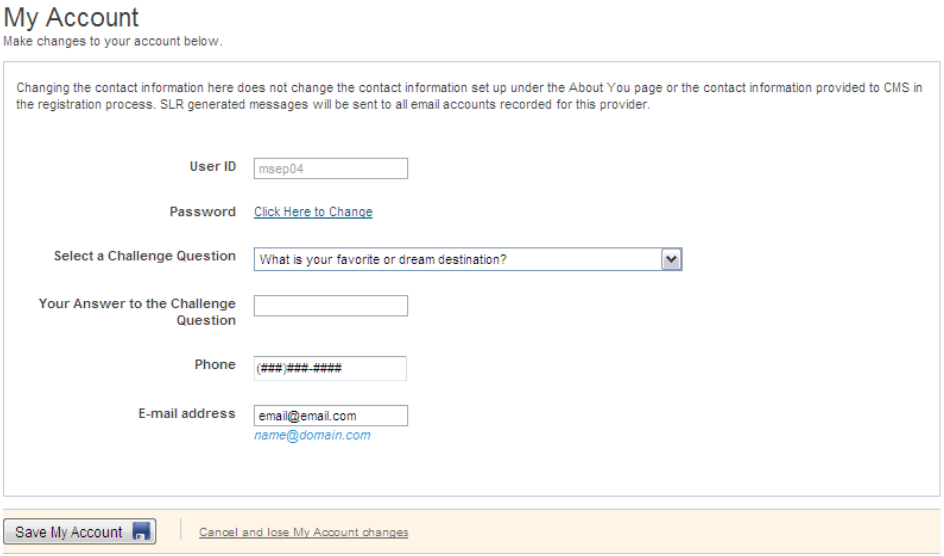
Changing Your Password

Your password will be effective for 60 days. When you log in and 60 days have passed since you created the previous password, a *Reset Password* page will appear. You can change your password on this page.

1. After 60 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 60 days have passed, select the **My Account** link in the top right-hand corner of the SLR *Home* page. In addition to changing your password, you can also update contact information or change your Challenge Question or 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
msep04
Password
Click Here to Change
Select a Challenge Question
What is your favorite or dream destination?
Your Answer to the Challenge Question
Phone
(###)###-####
E-mail address
email@email.com
name@domain.com
Save My Account
Cancel and lose My Account changes

Navigating SLR

Hard and Soft Stops

Certain fields are required to be populated, like the **Professional License Number** 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 Numbe**r field on the *EHR Certification* page. The State decides 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 **Total (Medicaid) Encounters** entry must be 30% of the **Total Encounters** entry on the *Confirm Eligibility* page.

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 Version 2 of SLR, moving through the site is assisted by the use of a *Navigation Menu* on the left-hand side of 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 expend 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 (MU) of their EHR Technology solution, MU Objective and CQM (Clinical Quality Measure) 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 Professional (EP)

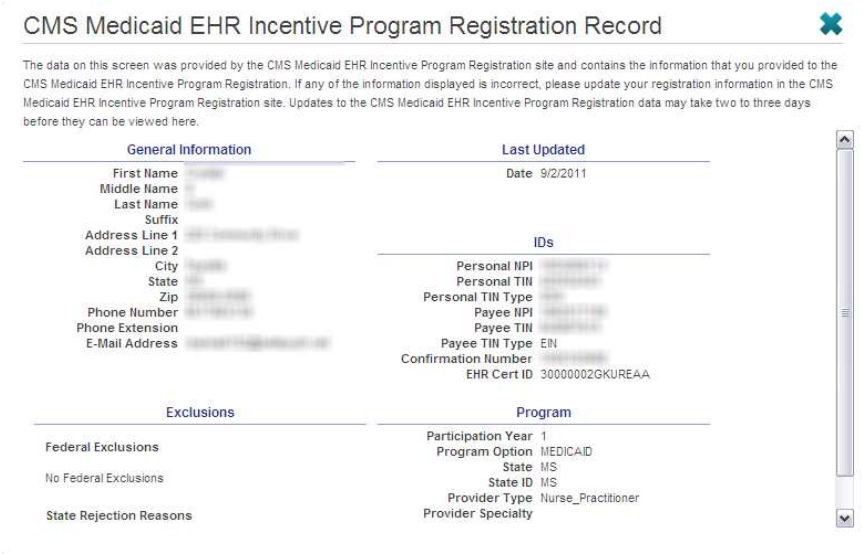
After you log in as an Eligible Professional (EP) user and accept the EULA, the EP home page will open. The home page serves as a dashboard and navigation tool for the SLR application.

Home Page

The SLR *Home* page for EPs displays the following:

1. Banner section. Located at the top of the page, the banner displays the following items that are visible on every page of the SLR application:
    a. Montana's Medicaid logo and tagline.
    b. SLR heading “Montana Medicaid State Level Registry for Provider Incentive Payments”. This is 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 ACS Help Desk phone number and email address.
    f. **Logout** link: allows you to log out of the SLR Web application.
    g. **Filing as Eligible Professional** message: designates your Provider Type.
    h. Practice Name display field: the name of your practice.
    i. Practice Street Address display field: your practice’s street address.
    j. Practice City, State and Zip Code display fields: the City, State and Zip Code of your practice.
    k. **Affiliated with Group Practice Name** display field: If you are affiliated with a Group practice, your Group’s name will appear.
    l. **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:
    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 SLR application has received data from the CMS.

i. **View CMS Medicaid EHR Incentive Program Registration Data** link: opens a pop-up window that displays your CMS record.



3. *Payment Information* section: located on the left of the home page, the *Payment* section will display the following items on the *Home* page:
    a. **How your payment is calculated** message: opens a pop-up window that shows your payment for the current year. This will appear after you enter information in the Confirm Eligibility section.
    b. **Payment Calculation** message: allows you to check on the status of your payment once your attestation has been submitted.
4. *Reports* section: Located on the left of the home page, the *Reports* section displays the following items when selected:
    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 SLR Web application. Clicking this link opens a pop-up window displaying the report in PDF format.
5. *Messages* sections. Located to the left side of the home page, the *Messages* section displays the following items:
    a. *Audit* section: provides access to Audit messages.
    b. *Appeals* section: provides access to Appeals messages.
    c. *System Messages* section: provides access to System messages.
    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 a previous year's information.

   b. Sections: each section has a Status icon () that indicates whether 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 pages have 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 have completed the Attestation of EHR section.

      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 Legal Statement for the site.

   c. **Accessibility** link: clicking this link opens a new window with the website's Accessibility policy displayed.

   d. **ACS/Xerox Copyright.** This is ACS'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 s*ection, where you will enter your registration and contact information.

Step 1: About You Section Details

Clicking the **About You** link on the EP *Home* page directs you to the *1. About You* page. This is where you enter your registration information.

The *About You* page displays the following:

1. *CMS Medicaid EHR Incentive Program Registration Record* section

   Please note that it can take up to three day for the SLR to receive your data from the 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 SLR.

   b. "Data has been received from the CMS Medicaid EHR Incentive Program Registration site." message: this message appears if the 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 SLR, and it takes between two and three days for changes at the CMS level to be applied to SLR.

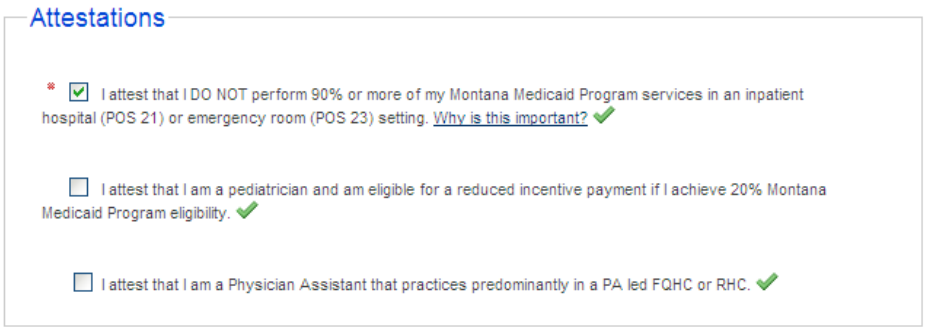
   d. **Visit CMS website** link: opens the CMS website. The link is visible whether or not your data has been received.

2. **Print Registration Information** link: opens a PDF that contains contact information, filing information, and license information.

3. *Attestation* section

   a. **"I attest…"** checkboxes: you must agree to one of three statements in order to be eligible to continue: the standard, or a Pediatrician or Physician Assistant statement. Agree by clicking the checkbox next to the appropriate statement.

   b. **Why is this important?** Link: clicking this opens a pop-up window explaining why you need to agree to this qualification.



4. *License Information* section

   Not all of the fields listed below will appear for all states.

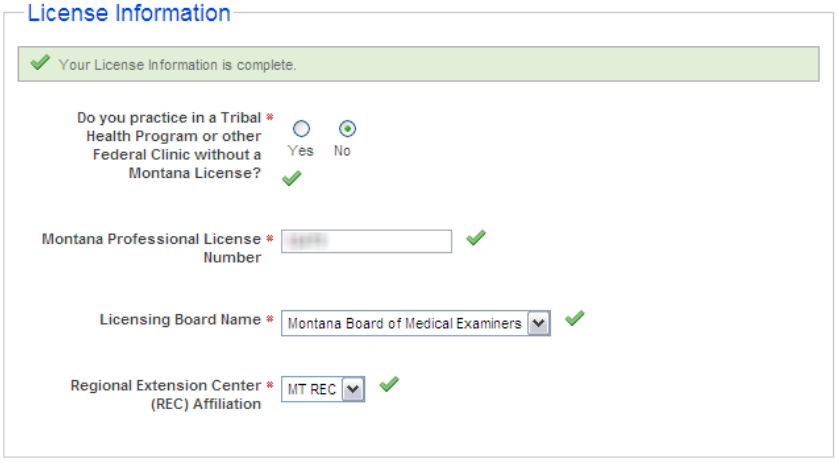
   a. **Do you practice primarily in a Tribal Health Clinic or other Federal clinic without a Montana license?** radio buttons: if you select the **Yes** radio button, the **Other License Number** and **Other License State** fields display.

      1. **Other License Number** text field: enter a professional license number from another state. If you are only licensed in Montana then enter your Montana **Professional License Number**.
      2. **Other License State** pull-down menu: This is where you choose the state that issued your other license number.

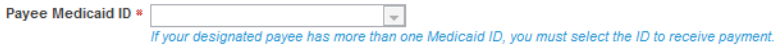
   b. **Montana Professional License Number** text field: enter the professional license number assigned by the Montana licensing board. This can be between 1 and 9 digits.

   c. **Licensing Board Name** pull-down menu: choose your licensing board from a drop down menu.

   d. **Regional Extension Center (REC) Affiliation** pull-down menu: select MT REC if you are affiliated with the REC.



   e. **Payee Medicaid ID** pull-down menu: if the user's designated payee (entered when registering with CNS) has more than one Medicaid ID, you must select the ID to receive payment.



5. *Contact Person* section

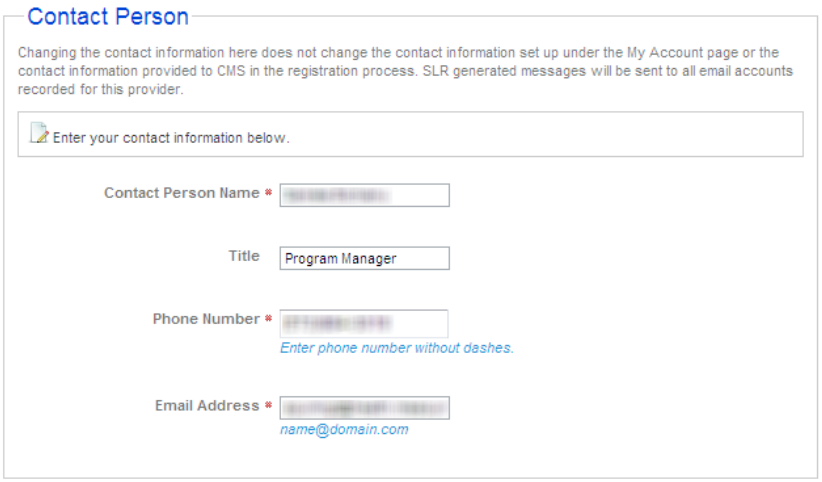
   This allows you to enter an additional contact besides the one listed as the Eligible Professional.

   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.



6. *Attach Documentation* section: if needed, you may attach documents such as a Board Certification using this component.

7. **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.

8. **Cancel and lose About You changes** link: clears the page of any information you have just entered and returns you to the *Home* page.

   a. After completing this information, you can 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.

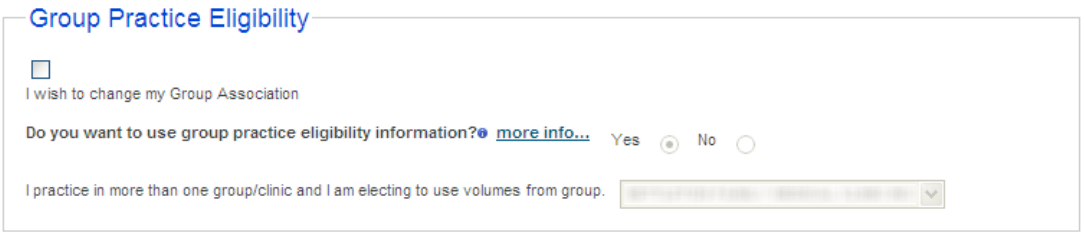
Now that you have entered your registration, you can move onto completing your eligibility information by returning to the dashboard and selecting the next step. Also, the status icon on your home page will change to indicate that your registration section is complete.

Step 2: Confirm Medicaid Eligibility Details

Clicking the **Confirm Eligibility** link on the EP *Home* page opens the *Confirm Medicaid Eligibility* page, which allows you to enter specific practice information. This information is then used in the calculation that determines your Medicaid eligibility for the Provider Incentive program.

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 that contains all the information captured by SLR so far in the process.
3. **More Info** link: opens a PDF file that provides more detailed information about entering your Medicaid eligibility for the provider incentive program.
4. *Group Practice Eligibility* section. This section will appear only if you have been added to a Group. Group members have a single point of contact for the SLR process, and have their Eligibility information added by a Group Administrator rather than entering it themselves.



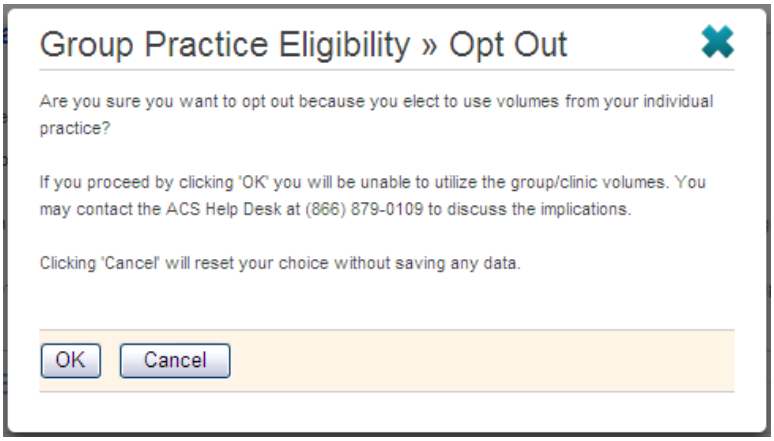
   a. **I wish to change my Group Association** checkbox: this allows you to select a different Group if you belong to more than one Group. Once you select a Group, that Group's eligibility numbers will populate this page. Select this checkbox and then select a different Group from the pull-down menu below to change your Group affiliation.

   b. **Do you want to use Group practice eligibility information?** radio buttons: select the **Yes** radio button to use the eligibility numbers of your Group or practice. Select the **No** radio button to use only your own patient encounter numbers.

   c. **More info** link: opens a pop-up explaining how Groups work in SLR. The most important thing to remember is this: CMS rules dictate that all professionals within a Group or clinic must use the same methodology for determining Medicaid eligibility. If you elect to opt out of using the Group volumes, all other professionals within your Group will be unable to use the Group volumes to determine their eligibility. All providers associated with that Group will have to use individual volumes.

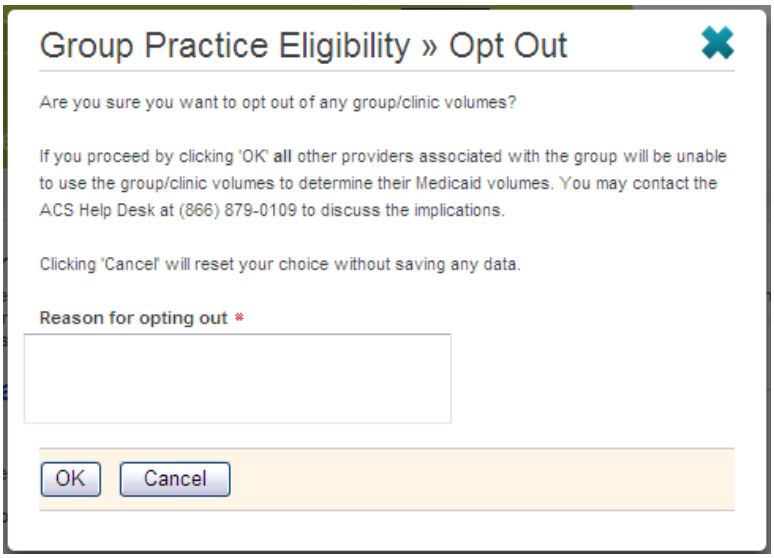
   d. **I practice in more than one Group/clinic and I am electing to use volumes from Group** pull-down menu: After clicking the checkbox, select the Group you wish to be associated with.

   e. **I practice in both a group/clinic and my own practice…** radio button: this field appears if the **No** radio button in the **Group Practice Eligibility Information** field is selected. Users select this button to use patient volumes in their own practice rather than the group to which they are affiliated. Clicking this radio button opens the *Group Practice Eligibility >> Opt Out* window.



f. **I am opting out of using any group/clinic volumes and am electing to use my individual patient volumes…** radio button: this field appears if the **No** radio button in the **Group Practice Eligibility Information** field is selected. Users select this button to use their patient volumes with the group practice rather than the patient numbers of the group to which they are affiliated. This will generally happen if overall the group does not qualify for an EHR Incentive payment by achieving the necessary 30%. But one or two members of the group may still qualify using their own volume. Clicking this radio button opens the *Group Practice Eligibility* >> *Opt Out* window.

1. **Reason for Opting Out** field: this time the window contains this field. Enter the reason you have decided not to use the group volume and then click the **OK** button.



5. *Practice Eligibility Details* section. This is the section title.

a. **Enter Representative Period** pull-down menu: select the appropriate period from which the patient volume numbers will be used.

b. **Year [n] Start Date** text field: enter the date of the first day of your representative period. The system will automatically display the end date based on the Representative Period.

    1. **Calendar icon.** Clicking this icon opens up a calendar from which you can click on a date to select it.

c. **Year [n] End Date** display field: the end date of the representative period based on the start date you entered.

d. **Total Encounters** text field: enter the total encounters for the period you noted above.

e. **Total Montana Medicaid Encounters** text field: enter your total Medicaid encounters for the period.

g. **Do you want your volumes for all states to be used to determine eligibility?** radio buttons: identify whether or not you want to use the other states' volumes to determine your eligibility. If you chose the **Yes** radio button, the *Add a State* component will appear.

h. Select the **Add a State**  button to add another row to the table

    a. **State** pull-down column: select a State to enter the encounter information for that State.

    b. **Total Encounters** column: enter the encounters for the State and selected time period.

    c. **Total Medicaid Encounters** column

    d. **Total Panel Members** column

    e. **Total Medicaid Panel Members** column

    f. **Insert** link: adds the numbers to the multi-State table.

    g. **Cancel** link: cancels the operation.

    h. **Remove** link. This will remove the associated row.

    Select the **Add a State**  button to add another row to the table.

f. **Total Montana Medicaid Panel Members Assigned** text field: enter your total assigned Panel Members. Panel Members are patients for whom you receive capitation payments.

g. **"Panel members are members seen in the calendar year…"** This is help text that defines panel members.

h. **Total Panel Members Seen** text field: enter the total number of Panel Members that you have seen during the period. Panel Members are patients for whom you receive payments on other than a fee for service basis.

i. **Do you practice predominately in a Federally Qualified...** radio buttons: select one of the buttons if you practice more than 50% of the time in one of these types of health center. This field is required for Physician's Assistants, who must practice in a FQHC, RHC, or IHS.

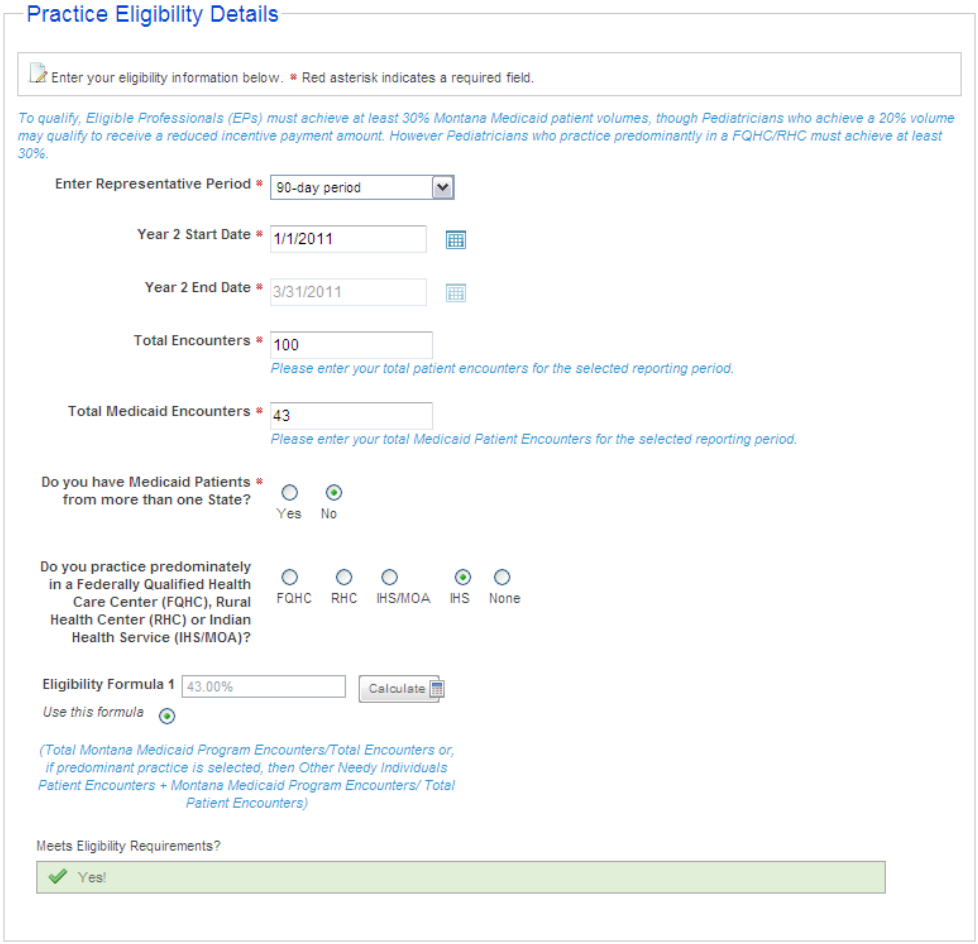
    i. If you select any option besides **None**, a **Medically Needy Individuals Patient Encounters** text field will appear. Enter your patient encounters for the medically needy patients you serve.

i. **More info…** link: opens a pop-up window that explains what CMS considers medically needy patients.

j. **Eligibility Formula 1** section: select this formula for your eligibility calculation to use total patient encounters and total Medicaid encounters as well as the medically needy patient encounters (if applicable) to calculate your result.

   i. **Use this formula** radio button: indicates you are using this formula.

   ii. **Calculate** button: calculates the results of Eligibility Formula 1. If the numbers qualify, a message will be displayed below the section.



s. **Meets Medicaid Eligibility Requirements?** section: messages will instruct you about whether you have met the requirements for eligibility.

   i. **Yes:** displays if the result of the formula you selected meets the following criteria:

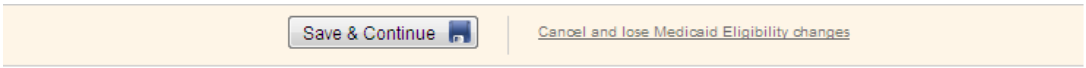
   - ≥ 20% for Pediatricians
   - ≥ 30% for all other Provider Types

ii. **No- you may wish to adjust your reporting period:** displays if the result of the formula you selected does not meet the criteria listed above.

t. *Attach Documentation* Section: documents such as a *Practice Management* report could be attached using this tool.

u. **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. If you do not meet the requirements, you will not be able to proceed.

v. **Cancel and lose Medicaid Eligibility changes** link: clears the page of any information you have just entered.



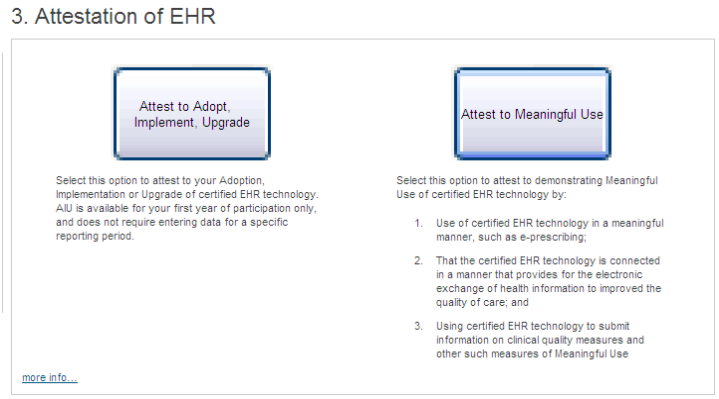
Once the *About You* and *Eligibility* pages are successfully saved, the system will move to *Step 3: Attestation of EHR*. The status icon on your home page will change to indicate that your eligibility information is complete.

Step 3: Attestation of EHR Details

EPs may either attest that they have adopted, implemented, or upgraded EHR software, or that they are actively using it in meaningful ways. AIU can only be selected in the first year and it is a much easier attestation. Clicking the **Attestation of EHR** link on the EP *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 you complete the *About You* and *Confirm Medicaid Eligibility* pages. 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. **Attest to Meaningful Use** button: opens the MU workflow. This section contains four to five different sections depending on your selections. Each of these sections contains three to 38 pages, though not all are required.
3. **More info** link: opens the Attestation of AIU information pop-up.



Note: if the user has already completed their first year, they must enter MU data and will receive the following message.

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: Missouri requires a fully executed contract with an EHR Vendor to be attached to the page. An Invoice, Receipt, or Vendor Letter can 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.

EHR Certification Page

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

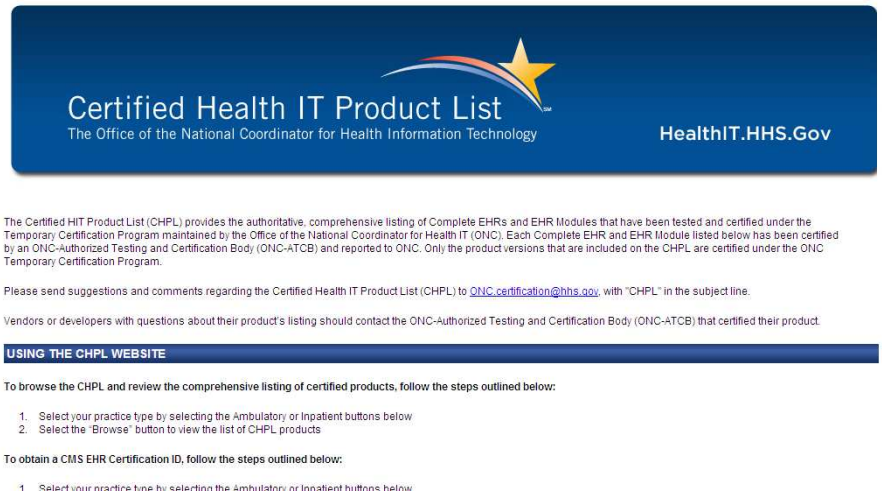
1. **Understanding** checkbox: signifies that you agree with the statement of understanding next to the checkbox. When you check this box, additional fields display. If you do not check this box, the system will not allow you to continue.

    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.

    b. **ONC public web service** link: opens the Office of the National Coordinator for Health Information Technology's *Certified Health IT Product List* site.

2. The *Your EHR Certification Information* section. When you select the EHR Certification option in the *Navigation Bar* and are a member of a Group, the **CMS EHR Certification ID** field may already be populated, containing a certification number entered by your Group's contact. Otherwise you will have to enter the correct number.

3. This section 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.



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.

Meaningful Use Section

The goal of Meaningful Use is to improve health care by providing better access to information and providing patient empowerment. In order for a healthcare provider to receive an incentive payment they must show “Meaningful Use” of their EHR by meeting thresholds for certain objectives as established by CMS. The following are the three primary components of Meaningful Use:

1. Use of certified EHR in a meaningful manner,
2. Use of certified EHR technology to enable the electronic exchange of health information to improve quality of healthcare,
3. Use of certified EHR technology to submit clinical quality measures into SLR.

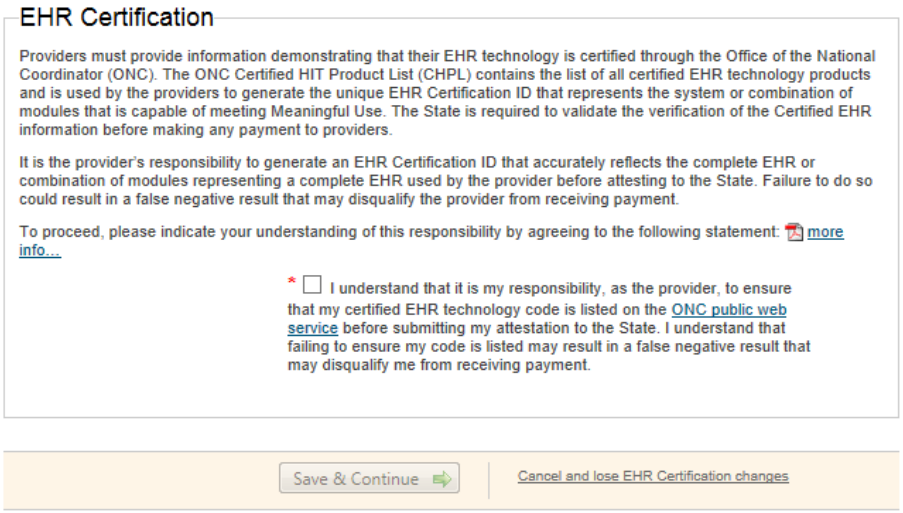
To attest for Meaningful Use (MU), providers will enter data that has been captured by their EHR Software. A report within your EHR system should be available to help you enter the correct information in the MU fields. In the provider’s second participation year, clicking the **3. Attestation of EHR**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

Providers may elect to enter Meaningful Use data during their first year of Attestation, but must enter MU information during each year after their first year. The first year of MU is called “Stage 1”, and fields are grouped into a series of Objectives and Clinical Quality Measures. Stage 2 of the Meaningful Use program begins 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 either 90 days or a full year of data.

The year 2014 has more changes in Meaningful Use measures, as Stage 1 question are modified slightly. Providers need to upgrade to 2014 Edition EHR technology regardless of the Meaningful Use stage they need to meet. A third and final stage of Meaningful Use is scheduled to begin in 2016.

Note: Meaningful Use measures are based solely on encounters that occurred at locations where the certified EHR solution is available. In order to qualify for the EHR Incentive payment, 80% of patients must have records in the EHR solution. Eligible Professionals who work at multiple locations but don’t have certified EHR technology available at all of their locations must have 50% of their total patient encounters at locations where the EHR technology is available.

1. *Certified EHR Technology*. 2014 edition EHR certification criteria support revised MU Stage 1 and new Stage 2 requirements, and include important updates that set new baselines for interoperability, electronic health information exchange, and patient engagement. EHR technology certified to the 2011 Edition will no longer be acceptable for the purposes of meeting the Certified EHR Technology definition. From a regulatory perspective 2011 Edition certifications will “expire” come the 2014 MU reporting period.
2. *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.

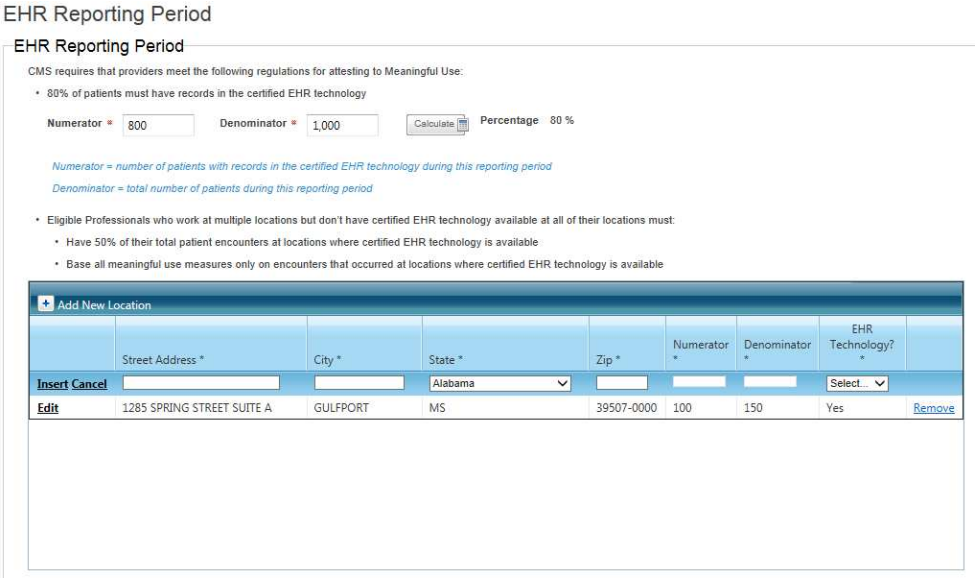


3. *EHR Reporting Period* page. CMS requires that providers meet specific regulations for attesting to Meaningful Use. This page contains checkboxes and **EHR Reporting Period** fields.

   a. **Numerator** text field: enter the number of patients with records in the certified EHR technology during the reporting period.

   b. **Denominator** text field: enter the total number of patients during the reporting period.

   c. **Calculate** button: at least 80% of patients must have records in the certified EHR technology. The Numerator will be divided by the Denominator, and the percentage is displayed on the page.



   d. **Add New Location** table: Eligible Professionals who work at multiple locations but do not have certified EHR technology available at all locations must:

      - Have 50% of their total patient encounters at locations where certified EHR technology is available

- Base all meaningful use measures only on encounters that occurred at locations where certified EHR technology is available

Select **Add New Location** button and the default address associated with the NPI/TIN will be displayed and may be changed if required. Any new locations added will require all data to be entered. There will be no default values displayed. The **Add New Location** table displays the following:

i. **Street** text field: enter the street.

ii. **City** text field: enter the city.

iii. **State** pull down list field: select a state from the available list.

iv. **Zip** text field: enter the zip code.

v. **Numerator** text field: enter the number of patient encounters entered into the EHR Software at the specified location during the reporting period.

vi. **Denominator** text field: enter the number of patient encounters at the specified location during the reporting period.

vii. **EHR Technology** pull down list: select yes if certified EHR technology was used at the specified location or no if it was not used.

viii. **Percentage:** the percentage of patients entered into the EHR software out of the entire population of patients.

ix. **Insert link:** adds the record to the *Add New Location* table.

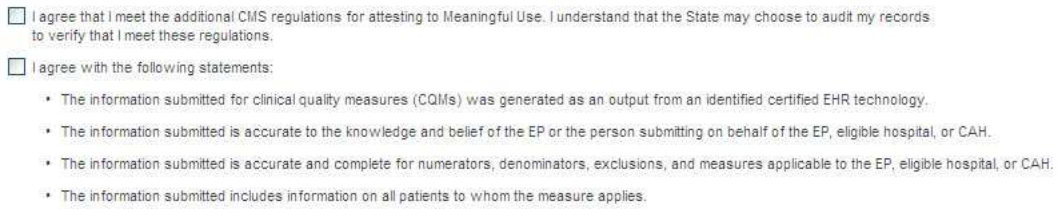
x. **Cancel link:** cancels the operation.

xi. **Remove link:** will remove the associated row.

xii. **Edit link:** enables fields for modifications in an inserted row to be modified.

Select the Add New Location button to add another row to the table.

e. Select the **Meet the Additional CMS Regulations** and **Following Statements** checkboxes to indicate that you agree with the associated statements.



f. For the first year, only data captured during a 90-day period is required, though a full year is required after that. The **Start Date** and **End Date** must fall within the current calendar year.

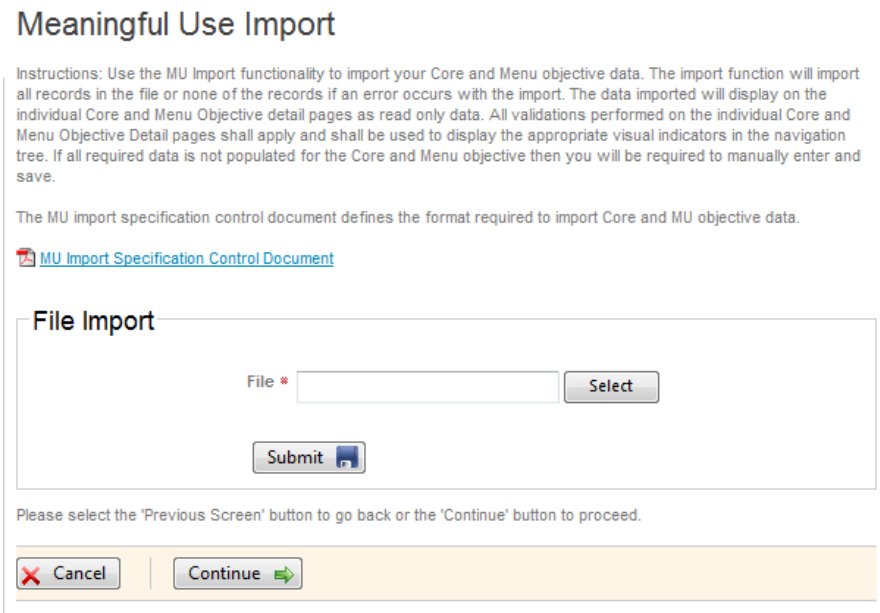
Reporting Period	AIU is First Year	MU is First Year
EP		
Year 1	- None	- 90 days (Stage 1 MU)
Year 2	- 90 days (Stage 1 MU)	- Calendar year (Stage 1 MU)
Year 3	- 90 days if Year 3 is 2014 - otherwise Calendar Year	- 90 days if the Year 3 is 2014, - Calendar year (Stage 1 MU) if

	(Stage 1 MU)	Year 3 is 2013, - otherwise Stage 2
Year 4	- 90 days if Year 4 is 2014, - otherwise Calendar year (MU) Stage 2	- 90 days if Year 4 is 2014, - otherwise Calendar year (MU) Stage 2
Year 5	- Calendar year (MU) Stage 2	- Calendar year (MU) Stage 3 (planned)
Year 6	- Calendar year (MU) Stage 3 (planned)	- Calendar year (MU) Stage 3 (planned)

The system itself will only allow choices to the providers that are appropriate for the year and their stage in the process. **Start Date** 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.

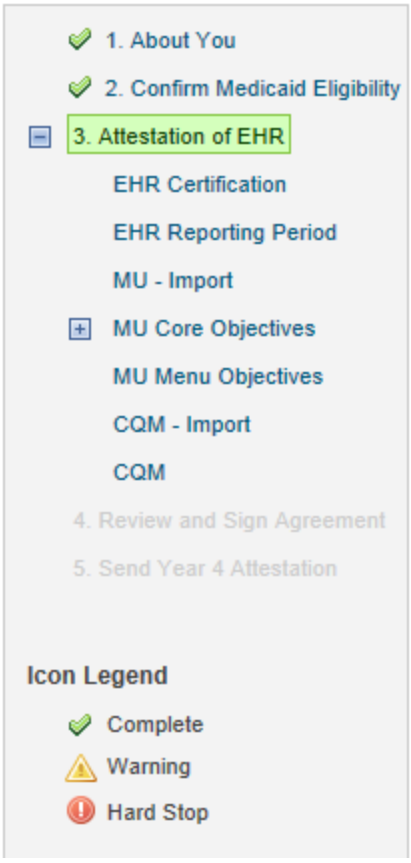
4. *Meaningful Use Import.* This page allows providers to import Core and Menu objective data. Data imported in this manner will display on the individual *Core* and *Menu Objective* detail pages as read only data. All validations performed on individual *Core* and *Menu* pages will be enforced, and 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 objective, you will be required to manually enter and save.



5. *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 four or five subgroups. Clicking the name of a subgroup or clicking the expand icon will reveal all the pages in the subgroup, all of which must

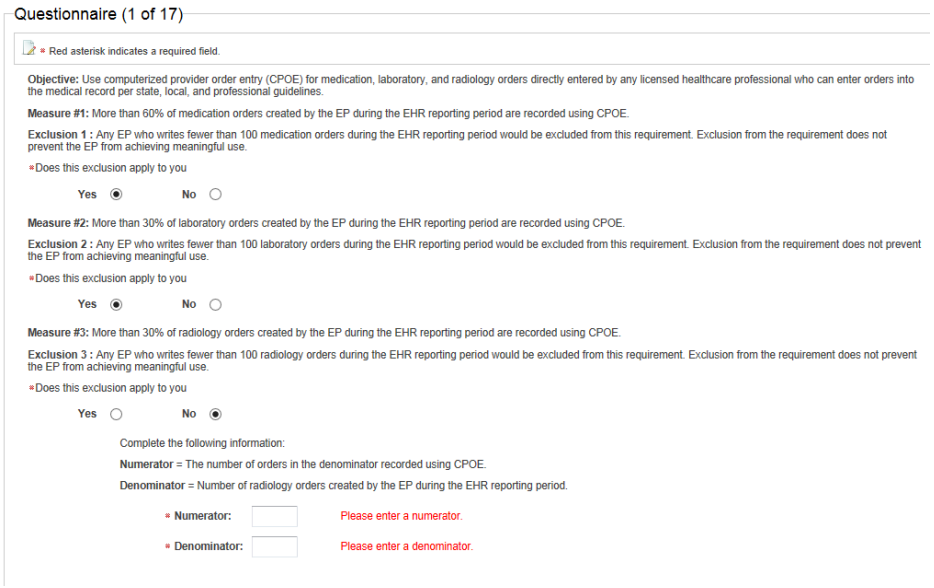
be completed by the user. Once all the pages in a navigation group have been completed, and all have passed their validation criteria, then the subgroup will receive a completed icon (✔). Clicking the collapse icon (−) will hide the title of the individual pages in a subgroup.



6. *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 some of the measures. Users cannot select a measure on the *Core CQM* or *Core Objective Selection* pages, since all core measures are required.

   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 move unto the next measure requiring input, or the next *Selection* page. *Detail* pages include an *Attach Documentation* section so that users can associate a document that is relevant to the measure.

7. *Exclusions*. Sometimes the measure will not apply to your particular practice. Pediatricians, for example, 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 fields will appear if the Exclusion does not apply. There can also be more than one Exclusion per Measure.



8. *Core Objectives*. Objectives measure how much of a provider's patient population has been entered into the EHR software for certain reasons. 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. There are different numbers of Core Objectives for the different stages of Meaningful Use.

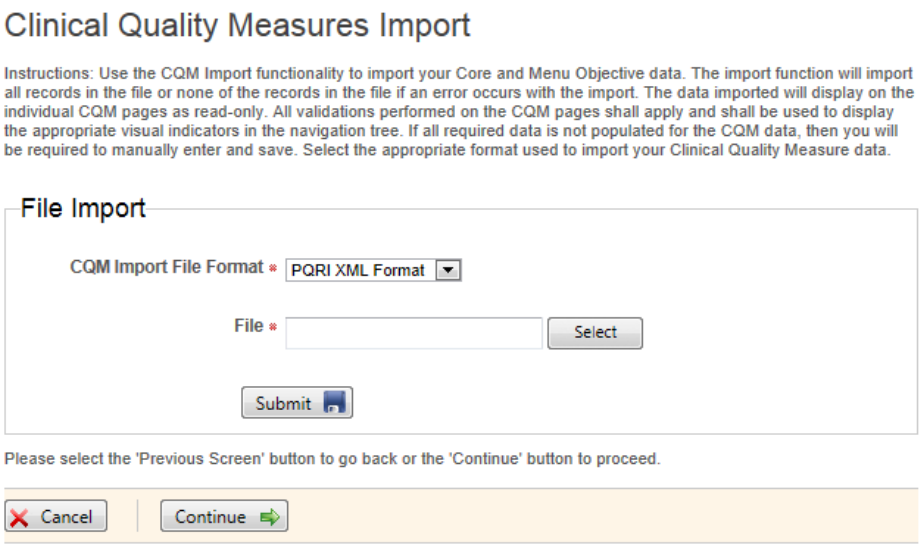
   For example, for the Objective *Maintain Active Medication List* the user would enter the number of unique patients seen by the EP during the EHR reporting period as a **Denominator**. In the **Numerator** field, the user would enter the number of patients in the denominator who have a medication recorded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

   Objectives also have a measure validation: if 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 seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data."

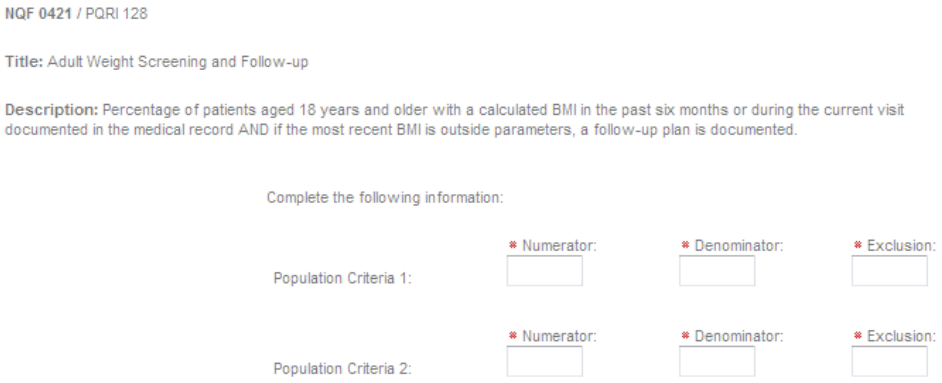
9. *Menu Objectives*. Users must select at least one of the Public Health Objectives on the *Menu Selection* page, and select a minimum of five of the Menu Objectives in general. When Menu Objectives are selected from the *Menu Selection* page, the selections will appear as options in the Navigation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

10. *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.



11. *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.
12. *Stage 1 CQMS.* Stage 1 Core CQMs are all required. If your practice 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, one CQM has 2 lines of Population Criteria, each line having a **Numerator**, **Denominator**, and **Exclusion** field.



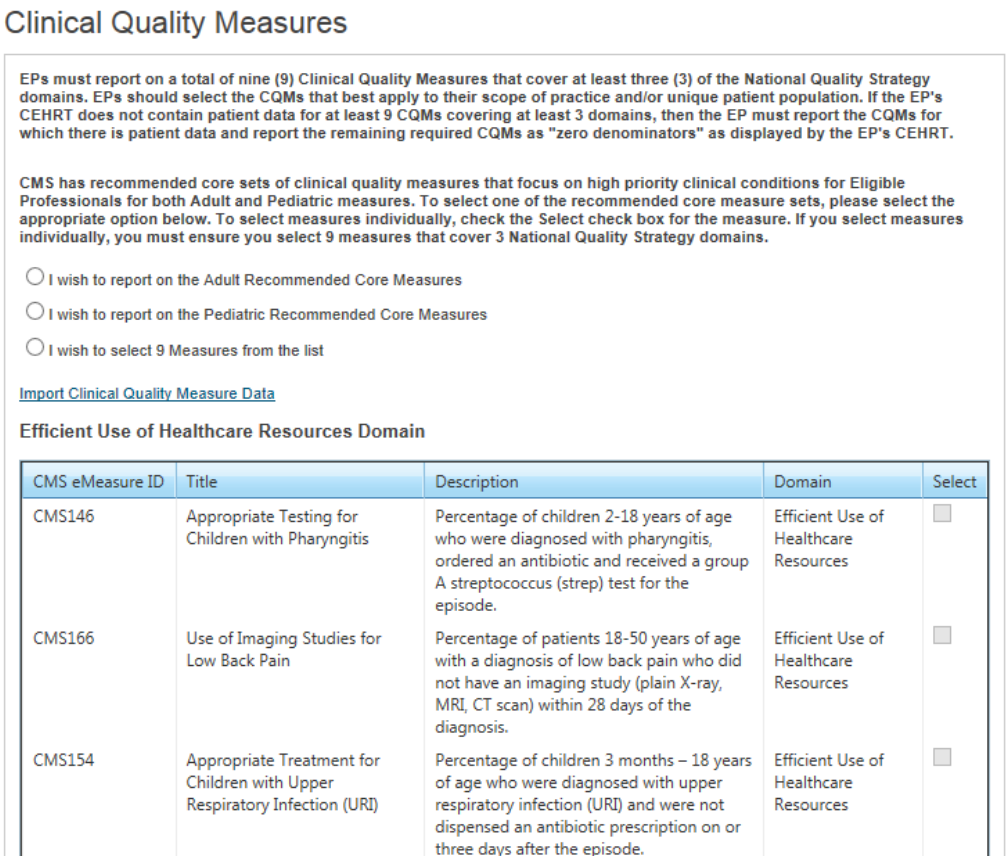
If the user entered a zero in either of these Denominators, the *Alternate CQM Selection* link will appear in the *Navigation Menu*, and one of the three Alternate CQMs is now required. If zero was entered into **Denominator** fields of three Core CQM pages, then all three Alternate CQMs would be required.

The *Alternate CQM Selection* page allows a user to select between one and three CQMs, depending on how many Core CQMs had a zero in a **Denominator** field. Clicking the **Save & Continue** button will open the *Detail* page entered of the first selected Alternate CQM.

Users are required to select three Additional CQMs from among the options on the Stage 1 *Additional CQM Selection* page. Clicking the **Save & Continue** button will open the *Detail* page of the first selected Additional CQM.

In 2014, certain Core and Menu objectives have been removed or combined and providers will no longer count measure exclusions toward meeting menu objectives. Stage 1 EPs, EHs, and CAHs now need to provide more than 50% of unique patients with the ability to access their health information online (to meet the new Stage 1 Core measure, the View, Download, Transmit to Third Party objective).

13. *Stage 2 CQM.* In 2014, CQMs will change to a new Stage 2 list. EPs must report on a total of nine measures that cover at least three of the National Quality Strategy Domains, and should select CQMs that best apply to their scope of practice and/or unique patient population. If the EP's certified EHR software does not contain patient data for at least 9 CQMs covering in at least 3 domains, then the EP must report the CQMs for which there is patient data. The EP would place a zero in the denominator of any of the remaining required CQMs.



Clinical Quality Measures have been renumbered, as the NQF references are no longer used. The list of CQMs for Eligible Hospitals is in the table below.

eMeasure ID	Title	Description	Domain

Adult Recommended Measures			
CMS165	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	Clinical Process/ Effective-ness
CMS156	Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	Patient Safety
CMS138	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Popula-tion/Public Health
CMS166	Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	Efficient Use of Healthcare Resources
CMS2	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.	Population /Public Health
CMS68	Documentation of Current Medications in the Medical Record	Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Patient Safety
CMS69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current reporting period documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current reporting period. Normal Parameters: • Age 65 years and older BMI ≥ 23 and < 30 • Age 18-64 years BMI ≥ 18.5 and <	Popula-tion/Public Health

		25	
CMS55	Closing the referral loop: receipt of specialist report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Care Coordina-tion
CMS90	Functional status assessment for complex chronic conditions	Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments.	Patient and Family Engage-ment
Pediatric Recommended Measures			
CMS146	Appropriate Testing for Children with Pharyngitis	Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	Efficient Use of Healthcare Resources
CMS155	Use of Imaging Studies for Low Back Pain	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	Efficient Use of Healthcare Resources
CMS153	Chlamydia Screening for Women	Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement period.	Population /Public Health
CMS126	Use of Appropriate Medications for Asthma	Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.	Clinical Process/ Effective-ness
CMS117	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Population /Public Health
CMS154	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	Efficient Use of Healthcare Resources
CMS136	ADHD: Follow-up Care for Children Prescribed Attention-Deficit/Hyperac tivity Disorder (ADHD) Medication	Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/ hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase.	Clinical Process/ Effective-ness

		b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	
CMS2	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.	Population /Public Health
CMS75	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Percentage of children 3 months – 18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	Efficient Use of Healthcare Resources
CMS129	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	Efficient Use of Healthcare Resources
Clinical Process/ Effectiveness			
CMS137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	Clinical Process/ Effective-ness
CMS125	Breast Cancer Screening	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	Clinical Process/ Effective-ness
CMS124	Cervical Cancer Screening	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	Clinical Process/ Effective-ness
CMS130	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Clinical Process/ Effective-ness
CMS126	Use of Appropriate	Percentage of patients 5-64 years of age who were identified as having persistent	Clinical Process/

	Medications for Asthma	asthma and were appropriately prescribed medication during the measurement period.	Effective-ness
CMS127	Pneumonia Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	Clinical Process/ Effective-ness
CMS131	Diabetes: Eye Exam	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	Clinical Process/ Effective-ness
CMS123	Diabetes: Foot Exam	Percentage of patients 18-75 years of age with diabetes who had a foot exam during the measurement period.	Clinical Process/ Effective-ness
CMS122	Diabetes: Hemoglobin A1c Poor Control	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Clinical Process/ Effective-ness
CMS148	Hemoglobin A1c Test for Pediatric Patients	Percentage of patients 5-17 years of age with an HbA1c test during the measurement period.	Clinical Process/ Effective-ness
CMS134	Diabetes: Urine Protein Screening	Percentage of patients 18-75 years of age with diabetes who had had a nephropathy screening test or evidence of nephropathy during the measurement period.	Clinical Process/ Effective-ness
CMS163	Diabetes: Low Density Lipoprotein (LDL) Management	Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.	Clinical Process/ Effective-ness
CMS164	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.	Clinical Process/ Effective-ness
CMS145	Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic	Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.	Clinical Process/ Effective-ness

	Dysfunction (LVEF <40%)		
CMS182	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100mg/dL).	Clinical Process/ Effective-ness
CMS135	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients 18 years of age and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	Clinical Process/ Effective-ness
CMS144	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Percentage of patients 18 years of age and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	Clinical Process/ Effective-ness
CMS143	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation	Percentage of patients aged 18 years and older with a diagnosis of POAG who have had an optic nerve head evaluation during one or more office visits within 12 months.	Clinical Process/ Effective-ness
CMS167	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and presence or absence of macular edema during one or more office visits within 12 months.	Clinical Process/ Effective-ness
CMS142	Diabetic Retinopathy: Communicatio n with the	Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication	Clinical Process/ Effective-ness

	Physician Managing Ongoing Diabetes Care	to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	
CMS161	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patients aged 18 years and older with a new diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Clinical Process/ Effective-ness
CMS128	Anti-depressant Medication Management	Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)	Clinical Process/ Effective-ness
CMS136	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperac tivity Disorder (ADHD) Medication	Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Clinical Process/ Effective-ness
CMS169	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Clinical Process/ Effective-ness
CMS141	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.	Clinical Process/ Effective-ness
CMS140	Breast Cancer: Hormonal Therapy for Stage IC-IIIC	Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor	Clinical Process/ Effective-ness

	Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	(AI) during the 12-month reporting period.	
CMS62	HIV/AIDS: Medical Visit	Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.	Clinical Process/ Effective-ness
CMS52	HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis	Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.	Clinical Process/ Effective-ness
CMS77	HIV/AIDS: RNA control for Patients with HIV	Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL.	Clinical Process/ Effective-ness
CMS133	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.	Clinical Process/ Effective-ness
CMS158	Pregnant women that had HBsAg testing	This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.	Clinical Process/ Effective-ness
CMS159	Depression Remission at Twelve Months	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	Clinical Process/ Effective-ness
CMS160	Depression Utilization of the PHQ-9 Tool	Adult patients age 18 and older with the diagnosis of major depression or dysthemia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit.	Clinical Process/ Effective-ness
CMS75	Children who have dental decay or cavities	Percentage of children ages 0-20 years, who have had tooth decay or cavities during the measurement period.	Clinical Process/ Effective-ness
CMS74	Primary Caries Prevention	Percentage of children, ages 0-20 years, who received a fluoride varnish application	Clinical Process/

	Intervention as Offered by Primary Care Providers, including Dentists	during the measurement period.	Effective-ness
CMS61	Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed	Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.	Clinical Process/ Effective-ness
CMS64	Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C)	Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.	Clinical Process/ Effective-ness
CMS149	Dementia: Cognitive Assessment	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.	Clinical Process/ Effective-ness
CMS65	Hypertension: Improvement in blood pressure	Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Clinical Process/ Effective-ness
Patient Safety Domain			
CMS156	Use of High-Risk Medications in the Elderly	Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	Patient Safety
CMS139	Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	Patient Safety
CMS68	Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the mediations' name, dosage, frequency	Patient Safety

		and route of administration.	
CMS132	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.	Patient Safety
CMS177	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Percentage of patient visits for those patents aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Patient Safety
CMS179	ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range	.....Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.	Patient Safety
Population/Public Health Domain			
CMS155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. • Percentage of patients with height, weight, and body mass index (BMI) percentile documentation • Percentage of patients with counseling for nutrition • Percentage of patients with counseling for physical activity.	Population /Public Health
CMS138	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Population /Public Health
CMS153	Chlamydia Screening for Women	Percentage of women 16 – 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	Population /Public Health
CMS117	Childhood Immunization Status	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H	Population /Public Health

		influenza type B (HiB); three hepatitis B (Hep B); one chick pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	
CMS147	Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Population /Public Health
CMS2	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.	Population /Public Health
CMS69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months AND when the BMI is outside of normal parameters, follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI >= 23 and <30 Age 18-64 years BMI >= 18.5 and <25	Population /Public Health
CMS82	Maternal Depression Screening	The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.	Population /Public Health
CMS22	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Population /Public Health
Patient and Family Engagement Domain			
CMS157	Oncology: Medical and Radiation – Pain Intensity Quantified	Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	Patient and Family Engagement
CMS66	Functional status assessment for knee replacement	Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patient and Family Engagement

CMS56	Functional status assessment for hip replacement	Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patient and Family Engagement
CMS90	Functional status assessment for complex chronic conditions	Percentage of patients aged 65 years and older with heart failure who completed baseline and follow-up patient-reported functional status assessments.	Patient and Family Engagement
Care Coordination Domain			
CMS50	Closing the referral loop: receipt of specialist report	Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Care Coordination

Step 4: Review and Sign Attestation

Clicking the **Review and Sign Agreement** link on the EP *Home* page directs you to *the 4. Review and Sign Agreement* page, 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 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.
3. **Save & Continue** button: saves the information you have entered on this page and opens the *Home* page.
4. **Cancel and lose Review 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.

Step 5: Send Year X Attestation Details

Clicking the **Send Year X Attestation** link opens a pop-up window allowing you to send your attestation to the State.

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

1. **Send Attestation** button: clicking this will submit your attestation application to the State. All steps in the workflow section of your home page will be locked down. You will not be able to make any more changes to the section, but can 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.

Applying for the Incentive as a Group Administrator

A Group is a practice or clinic that is comprised of multiple Eligible Professionals. All of these individual providers may decide to apply for the EHR Incentive Payment using the patient encounter numbers of the practice or clinic. A representative from your Group will serve as the Group Administrator and provide a single point of contact for the State Level Registration of the Medicaid EHR Incentive Payment process.

This individual will enter the volume information for the Group, and this information will appear on each Group member's *Confirm Medicaid Eligibility* page. Each member of the Group will still need to review and sign the Attestation form to ensure that the numbers are correct. Group administrators will select the "Group" user type when they first create a SLR account.

Group Home Page

The *SLR Home* page for Groups is similar to the home pages for EP and EH users. See the *EP Home* page section for more information about the parts of this page. The links in the *Header* and *Footer* sections, the *Reports* and *Messages* sections, and the **Year** tabs are all identical to the EP *Home* page, except the messages will now include Group messages. The only visible difference on the page for Group users is the *Workflow* section, though it will still have five steps. As with the EP *Home* page, each of these is a link to the page representing that Step in the SLR process, and each will have a completion icon that shows the status of the step. The user is able to move unto the next step only after completing the first.

1. *About Your Group* section: allows you to enter information about the Group's primary contact. By default this is populated with your user information.
2. *Confirm Group Eligibility* section: allows you to enter patient and Medicaid volume information.
3. *Group Certified EHR Information* section: allows you to enter Certified EHR technology information, in particular the EHR Certification Number of your Group's software. Each member of the Group will still have to attest to the technology they are using, but the information may be pre-populated for them.
4. *Manage Providers in Your Group* section: allows you to add members to your Group.
5. *Enter Data on Behalf of Your Providers* section: page provides access to the individual pages of each provider in your Group. In this way, you can add or edit the information for each of these providers.

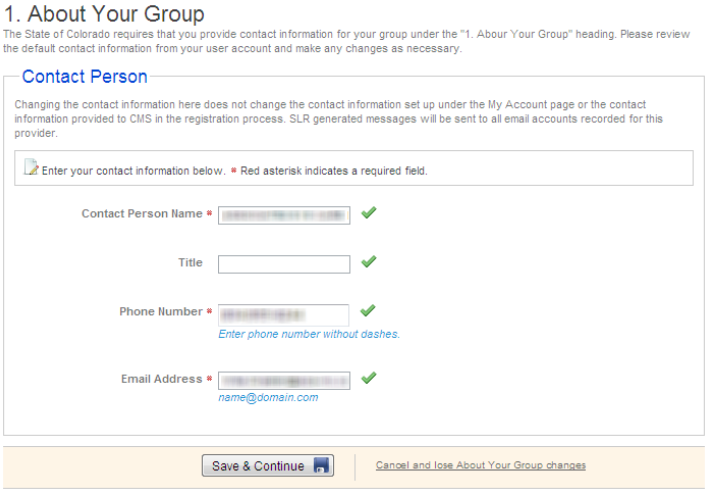
Workflow Section Details

This section describes in more detail the specific steps needed to set up a Group in the SLR system. Starting with Step 1, the *About Your Group* page, you will enter your registration and contact information. Like Eligible Professional users, Group Users will have a *Navigation*

Menu to both access pages and keep track of their progress. The five options correspond to the pages in the group component.

Step 1: About Your Group Section Details

Clicking the **About Your Group** link on the *Group Home* page opens the *About Your Group* page, allowing you to provide contact information. The contact information is especially important, as one of the primary reasons to have a Group user is to provide a single point of contact for the Group to State auditors that are reviewing the SLR submissions. By default, this information will be the same as the user registered in the system.



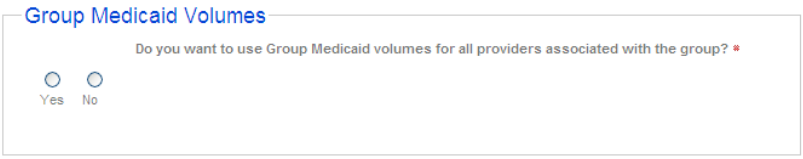
1. **Name** text field: enter your name.
2. **Phone Number** text field: enter your phone number. Initially it defaults to the phone number that you entered while creating your User Account.
    a. **9999999999** (no spaces, dashes, parentheses): shows you how the system would like you to enter your phone number.
3. **Email Address** text field: enter your email address. Initially it defaults to the email address that you entered while creating User Account.
    b. **name@domain.com**: displays the correct format for your email address.
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 a system message. Once all required fields are completed, this section will be marked as complete.

5. **Cancel and Lose About Your Group changes** link: clears the page of any information you have just entered.

Step 2: Confirm Group Medicaid Eligibility

The *Confirm Group Eligibility* page is identical to the associated page for EPs except that it has an additional section at the top, the *Group Medicaid Volumes* section.

1. See *Section 3.6.4 Step 2: Confirm Medicaid Eligibility* above for a complete description of the rest of the fields on this page.
2. The *Group Medicaid Volumes* section allows to user to select whether to use Group Medicaid volumes for the entire Group.

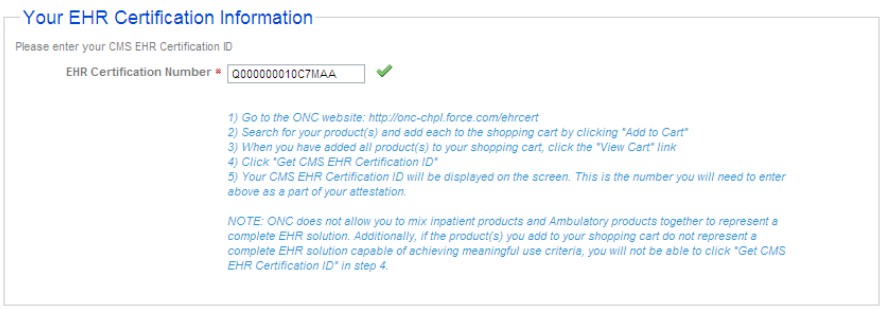


The system will move you onto *Step 3: Group Certified EHR* Information and the status icon on your home page will change to indicate that your eligibility information is complete.

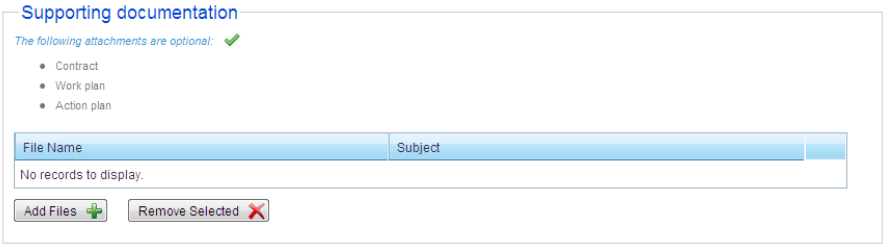
Step 3: Group Certified EHR Information

Clicking the **Group Certified EHR Information** link on the *Group Home* page directs you to Step 3 of the process. This page allows you to enter your practice's EHR technology information.

1. **Do you wish to use Group Certified EHR Technology information for all providers you are managing?** radio button: select the **Yes** radio button to apply the EHR Technology you enter on this page to all the members of the Group. The *Your Understanding* section will appear.
2. *Your Understanding* section: click the checkbox to affirm your responsibility. The *Your EHR Certification Information* section will appear.
3. *Your EHR Certification Information* section: contains a field and instructions for retrieving the correct EHR Certification Number from the ONC website.
    - EHR Certification Number text field: enter your group's EHR Software's Certification Number in the **EHR Certification Number** field. The field will be validated when the **Save Certified EHR Technology** button is selected.



4. *Supporting Documentation* section: use this component to add a contract, Work plan, Action plan, or other document associated with your practice's EHR software. A document is not required on this page.



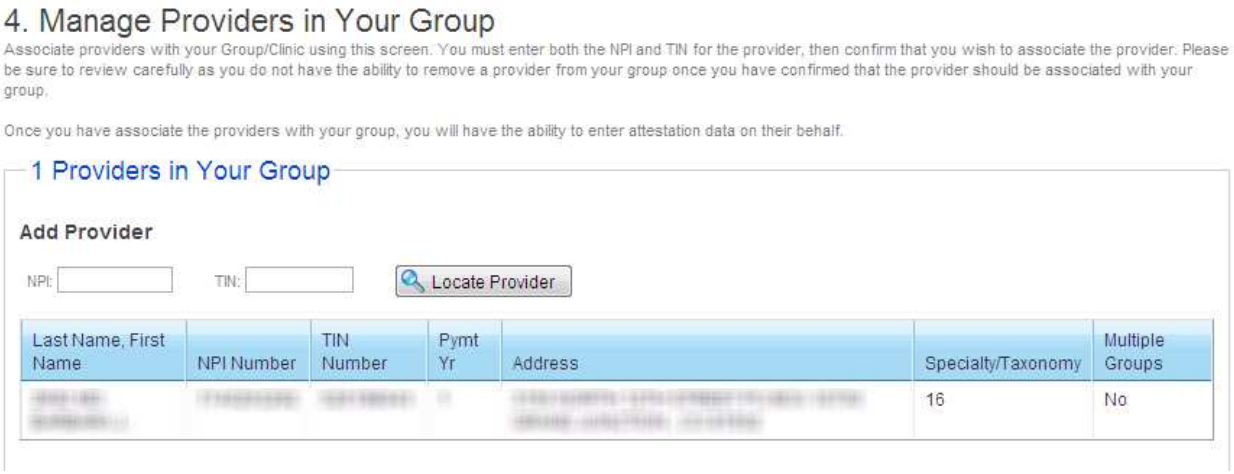
5. **Save Certified EHR Technology** button: saves the EHR system information.

6. **Cancel and lose certified EHR Technology changes** link: this will cancel any changes made to this page. The page will refresh, restoring the original values and files to the fields on the page.
7. **<< Back to Dashboard**. Select this link to return to the *Group Home* page.

Once you have successfully saved the information in the *Group Certified EHR Information* page, the status icon on your *Home* page will change to indicate that the *Group Certified EHR Information* section is complete. The system will move you to *Step 4*.

Step 4: Manage Providers in Your Group.

Clicking the **Manage Providers in Your Group** link on the *Group Home* page (or in the *Navigation Menu*) opens *Step 4* of the process. This page allows you to search for and add Eligible Professionals to your Group. They must exist in the SLR database before they can be added, so they must register with CMS before you perform this step.



1. *Providers in Your Group* section: enter the NPI and TIN of the professional you wish to add to the Group and click the **Locate Provider** button. An error message will appear if the professional was not found. A pop-up confirmation window will appear if the provider was found in the system.

2. *Is this the provider you want to add?* window: this displays the identification numbers, name, address, and Specialty Codes of the provider found using the query fields. This additional information helps you to identify the correct medical professional to add to your Group.

   Note: You can add providers to the Group, but cannot remove providers. Be very careful about those providers that you add.

3. **No, Go back** button: click this button to close the window. The professional will not be added to the Group.
4. **Yes, Add to Group** button: click this button to add the professional to the Group. If the provider is found but has opted to use his or her own volume numbers rather than those of a Group, the pop-up window displays a message that the provider has opted out from Groups.
5. *List of Providers* table: displays all the providers added your Group and is sorted alphabetically by last name. Each provider's name, identification numbers, address, and Specialty or Taxonomy codes are listed in the table. The table also indicates whether the provider has been added to more than one Group.

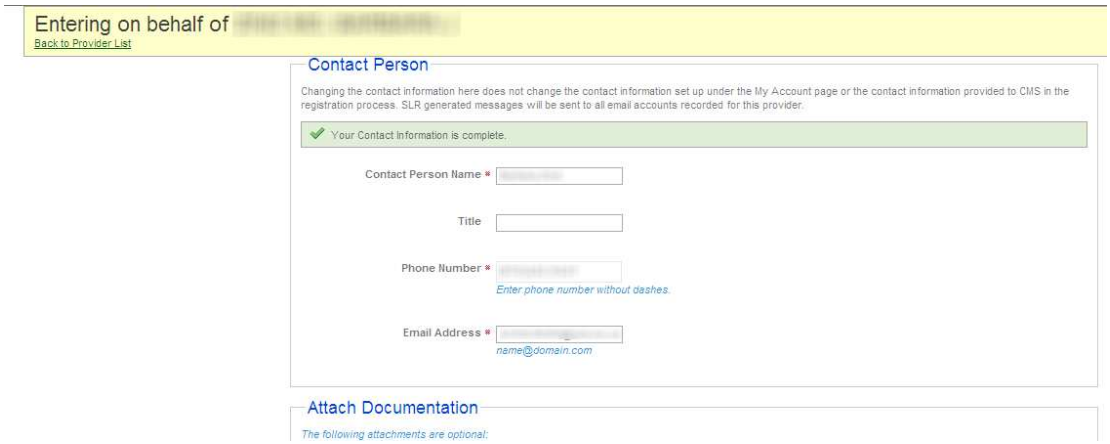
Step 5: Enter Data for Providers [Year]

Clicking the **Enter Data on Behalf of Your Providers** link on the *Group Home* page (or in the *Navigation Menu*) opens *Step 5* of the process. This page allows you to access the EP pages of the members of your Group, and view, add, or edit the data for them. Each provider that was added using the *Manage Providers in Your Group* page will appear in the table on this page.

1. **Manage Providers** button: clicking this will open the *Manage Providers in Your Group* page, which is used to add providers to your Group.
2. **Of [n] Providers: Not started=[n], In progress=[n], Completed=[n], Signed & Attached=[n], Submitted=[n]** message: next to the **Manage Providers** button is a

status line that provides a running count of the providers in your Group and their progress in each stage of the process.

3. *Provider Action List* table: displays all the members of the providers in the Group; each provider will have the following columns referencing their data:
    a. **Provider Name** column: displays the name of the provider.
    b. **NPI** column: the provider's NPI information.
    c. **TIN** column: the provider's TIN information.
    d. **Pymet Yr** column: the Payment Year to which the provider is attesting.
    e. **Elected** column: indicates whether the provider has joined your Group or not.
    f. **About You** column: contains a status icon that indicates whether this section for a provider is complete or not.
        ✔ indicates that the step is complete;
        ✔ indicates that the step has been started but not finished;
        ☐ indicates that the step has not been started.
    g. **Eligibility** column: contains a status icon.
    h. **Attestation** column: contains a status icon.
    i. **Signed & Attached** column: contains a status icon.
    j. **Submitted** column: contains a status icon.
    k. **Actions** pull-down menu: allows the user to open the associated page and enter data into SLR for that user. Select an option for the menu, such as About You, Eligibility, or Attestation), and the corresponding page of that user will open.



When opened, the SLR page of your Group's provider will be topped by a special header identifying the provider you are entering information for, such as in the example above. The header section also has a **< Back to Provider** list button, which returns you to the Group Administrator *Step 5* page.

Accessing Reports

Reports for Eligible Professionals

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. **Provider SLR Application Information** link: once some information has been saved to the SLR web application, this link appears. Clicking this link opens a pop-up window with the *Provider SLR Application Information* 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 you entered when you created your SLR account.

   b. *Filing Information:* displays the Program Year and status of the Attestation association.

   c. *About You* section: displays the information saved when you completed the *About You* section.

   d. *Confirmation of Eligibility* section: displays the information saved when you completed the *Confirm Medicaid Eligibility* section.

   e. *Summary of Meaningful Use Core Measures*: displays Core Objective measures if these were entered.

   f. *Summary of Meaningful Use Menu Measures.*

   g. *Summary of Core Clinical Quality Measures.*

   h. *Summary of Alternate Core Clinical Quality Measures.*

   i. *Summary of Additional Clinical Quality Measures.*

   You can print this report after you have saved any of your information in the 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.

Viewing Payment Status/Payment Calculations

Payment Information and Calculations for Eligible Professionals

Payment Information section: located on the left of the home page, the *Payment* section will display the following item on the *Home* page:

1. **How your payment is calculated** message: opens a pop-up window that shows your payment for the current year. Any Recoupment or Adjustment information is also displayed here.
2. **Payment Status** message: check on the status of your payment in this area.

Appeals, Adjustments and Recoupments

Appeals

Providers are able to appeal a rejection of their Attestation. The rules and details are specified by the State of Montana, and will follow guidelines established by CMS. All communications and the progression of each Appeal will be handled by State representatives.

Adjustments

An Adjustment in SLR is an official change in the payment amount of a provider's EHR Incentive payment. For EPs, an Adjustment is more likely for Pediatricians than other Provider Types because they can still qualify for an EHR Incentive payment at a 20% Medicaid volume. If a Pediatrician's percentage changes because of an change in claims, an entry mistake, or an Audit, this might mean a higher or lower payment. As with Appeals, State representatives will handle the communication with providers regarding all Adjustments.

Recoupments

A Recoupment is a return to the State of the full amount paid to the provider for a Payment Year. This will usually be the result of Audit showing a mistake in the Medicaid claims percentage. As with As with Appeals and Adjustments, State representatives will handle the communication with providers regarding all Recoupments.

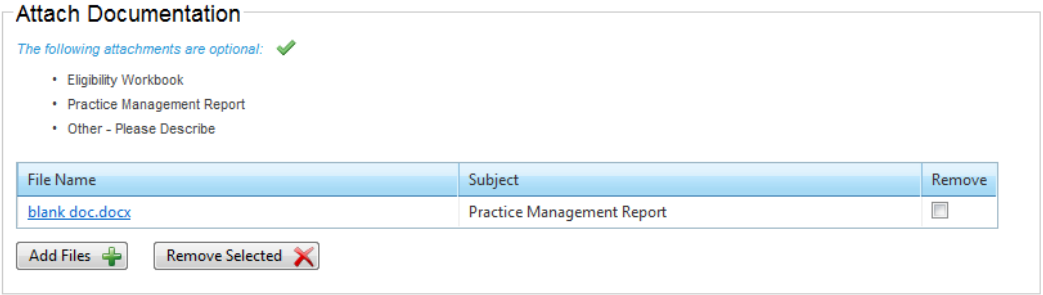
Attaching Files

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, Software Sales contract, and the Attestation Agreement itself – and identify documents that are optional.

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

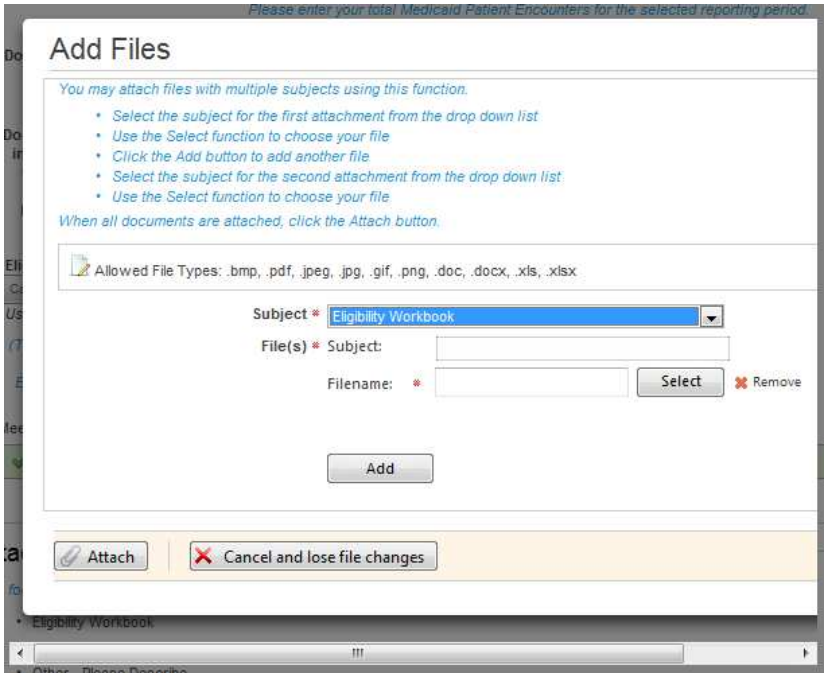
1. **File Name** column: the name of the uploaded file. Selecting the filename will open the file for viewing, provided your PC has an application that can open the file.
2. **Subject** column: the subject of the uploaded file selected by the user when the file was attached.
3. Selecting a checkbox in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



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. **Remove** icon: clicking this removes file reference from the window. It will not be imported.
8. **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.
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.



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

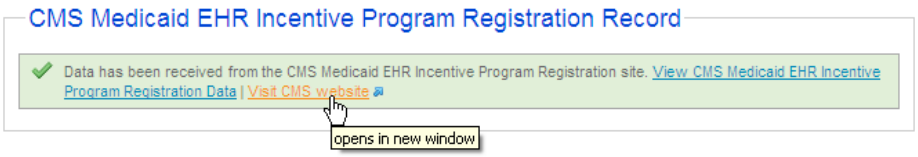
For general Help, all SLR web pages have a **Help** Link that opens up a copy of this User Manual. For SLR Web application assistance, you can contact the ACS Help Desk designated to support the SLR.

Phone: (866) 879-0109
Email: SLRHelpdesk@acs-inc.com

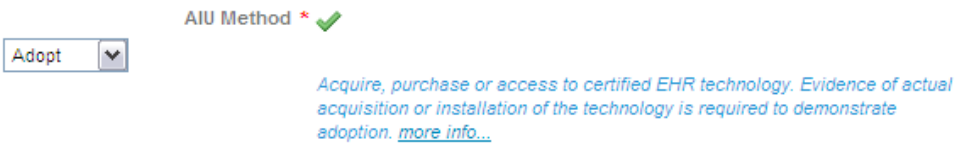
Help Text Displays

Located throughout the 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 will open a help window:



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.
Adjustment	An official change in the payment amount of a provider's EHR Incentive payment. This can be a positive or negative change.
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. [3]
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. [3]
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. [3]
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[1]. Part of the act included money for health information technology (HIT) investments and payments.

[1] "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
Appeal	A petition by a provider to change a decision made by a State user or Auditor. The rules and details follow guidelines established by CMS and are enforced at the State level.
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. [3]
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. [3]
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).[2]
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. [3]
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.[3]
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.[4]

[2] "Centers for Medicare & Medicaid Services." *CMS: Centers for Medicare & Medicaid services.* United States Department of Health & Human Services. Date accessed: November 22, 2010.
[3] "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.
[4] "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 d that supports the administration and incentive payment disbursements of Medicare and Medicaid programs to medical professionals, hospitals and other organizations.[5]
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.[6]
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. [3]
CPOE	See Computerized Provider Order Entry. [3]
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. [3]
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. [3]
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. [3]
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. [3]
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.

[5] "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.

[6] "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 patients 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.[7]
Electronic Medical Record (EMR)	An electronic medical record (EMR) is a computerized medical record created in an organization that delivers care, such as a hospital and doctor's surgery.[8]
Eligible Hospital (EH)	For the purposes of the Medicaid EHR Incentive Program and SLR applications documentation, an eligible hospital (EH) is defined as the following: Acute care hospitals (including Critical Access Hospitals and cancer hospitals) with at least 10% Medicaid patient volume. Children's hospitals (no Medicaid patient volume requirements).[9]
Eligible Professional (EP)	For the purposes of the Medicaid EHR Incentive Program and SLR application documentation, an eligible professional (EP) is defined as the following: Physicians (primarily doctors of medicine and doctors of osteopathy). Nurse practitioner. Certified nurse-midwife. Dentist. Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant. To qualify for an incentive payment under the Medicaid EHR Incentive Program, an EP must meet one of the following criteria: Have a minimum 30% Medicaid patient volume*. Have a minimum 20% Medicaid patient volume, and is a pediatrician*. Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals. *Children's Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria.[10]

[7] "Electronic Health Records Overview." *CMS: Centers for Medicare & Medicaid services.* United States Department of Health & Human Services. Date accessed: November 22, 2010.
[8] "Electronic medical record." *Wikipedia: The Free Encyclopedia* Wikimedia Foundation, Inc. Last modified: November 5, 2010. Date accessed: November 22, 2010.
[9] "EHR Incentive Programs: Eligibility – Eligible Hospitals." *CMS: Centers for Medicare & Medicaid services.* United States Department of Health & Human Services. Date accessed: November 22, 2010.
[10] "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.[11]
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. [3]
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."[12]
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.[13]
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. [3]
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.[14]

[11] "EULA." *Webopedia*. QuinStreet Inc. Date accessed: November 22, 2010.
[12] "Health Insurance Portability and Accountability Act of 1996." *CMS: Centers for Medicare & Medicaid services.* Public Law 104-191. 104th Congress. Date accessed: November 22, 2010.
[13] "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.
[14] "National Provider Identifier Standard (NPI): Overview." *CMS: Centers for Medicare & Medicaid services.* United States Department of Health & Human Services. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
Observation Services Method	"The denominator should include the following visits to the ED: • 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 • 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." [3]
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.[15]
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. [3]
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. [3]
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. [3]
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 http://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf). Any prescription not subject to these restrictions would be permissible. [3]
Preferred Language	The language by which the patient prefers to communicate. [3]
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. [3]

[15] "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
Problem List	A list of current and active diagnoses as well as past diagnoses relevant to the current care of the patient. [3]
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. [3]
Recoupments	A Recoupment is a return to the State of the full amount paid to the provider for a Payment Year.
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.) [3]
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. [3]
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.[16]
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. [3]
Uniform Resource Locator (URL)	In computing, a Uniform Resource Locator (URL) is a Uniform Resource Identifier (URI) that specifies where an identified resource is available and the mechanism for retrieving it.[17]

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

[17] "Uniform Resource Locator." *Wikipedia: The Free Encyclopedia* Wikimedia Foundation, Inc. Last modified: November 22, 2010. Date accessed: November 22, 2010.

Term/Acronym	Explanation/Expansion
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.[3]
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. [3]