CONDUENT

Conduent State Level Registry for Provider Incentive Payments

SLR State Dashboard User Manual

Version 5.0

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1. Introduction

The State Level Registry (SLR) is a web application used by providers to submit information and documents to the State, offering proof that they qualify for the CMS Provider Incentive Payment program. The Dashboard offers several tools to manage the attestation process, and is used by State representatives to manage the providers and the attestation process.

Application Availability

This user manual is intended for State users needing to organize and manage the attestation review process.

Problem Reporting

For general Help, all SLR web pages have a **Help** Link that opens up a copy of this User Manual. **Help** link on the *Dashboard* page opens the Dashboard User Manual, while other pages open the Eligible Hospital, Group Administrator, or Eligible Professional SLR Manuals. For SLR Web application assistance, you may contact the Conduent Help Desk designated to support the SLR.

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

2. Overview

As the healthcare landscape continues to modernize, recent legislation was passed to encourage the adoption of Electronic Healthcare Record (EHR) technology in documenting patient care. Because of the American Recovery and Reinvestment Act (ARRA) of 2009, beginning in 2011, eligible Medicaid providers are being offered financial incentives for the implementation and meaningful use of Health Information Technology (HIT) in the management of their patient populations. In support of this initiative, Conduent has developed the EHR Provider Incentive Portal (State Level Registry) application.

The State Level Registry (SLR) application gives providers access to a streamlined application for federally funded HIT incentives through an easy-to-use website. The Dashboard provides the tools that State representatives need to manage provider information and the attestation process..

Application Features

- In future iterations of the SLR Dashboard, more and more functionality will be implemented. Currently the following functionality is available:
- Manage Providers: allows you to search for, view, and review the progress of providers' EHR Incentive submissions.
- Audit Providers: allows you to perform Eligibility, Financial, and either Adopt, Implement, or Upgrade (AIU) or Meaningful Use audits on attestations. These audits are performed after the payment is sent to the providers.
- Audit Queries: several queries are available that will display audited providers.
- Manage Attestations: allows you to take action on or record information about a provider's attestation. Users can approve or reject attestations, view attachments, audit a completed attestation, take action on validation exceptions generated during an attestation, etc.
- View Eligibility Queries: allows you to identify providers that are eligible, not eligible, or whether any providers had soft or hard stops on any of the attestation pages. For example, if required criteria documents were not attached, the attestation application would be ineligible.
- Verify Attestations: allows you to verify each provider's attestation application.
- Manage Verifications: allows you to create and manage Verification Sets that guide the review of the State's provider attestations.
- Manage State Users: create, update, and remove State Users and manage their passwords.
- View Opt-Out Queries: allows you to identify those providers who have opted out of using Group volumes.
- Approve, Reject, or Append Attestations: allows you to approve attestations for payment, reject them, or pend them to unlock them and help the Provider resolve any issues.
- Select Providers for Transmission: allows you to select providers that have no exceptions to be included in B7 or D16 data exchanges.

- Adjust Financial Information: allows you to view and recoup or adjust payment information for providers.
- Import MU data: allows you to import a file of MU information in either the PQRI and QRDA XML formats.
- Run Reports: allows you to generate several reports to help to management of the project, such as NLR Applications Waiting on SLR, Providers with Volumes from Multiple States, Active Registrations Not Meeting Eligibility Threshold, etc.
- Request for Modifications: is a function of the multi-client SharePoint site that allows State users to request reports, suggest changes and new features, and report bugs and other issues.
- Adjustments and Recoupments: document these changes in the amounts paid to providers in SLR, including sending updates to CMS.
- Appeals: document and manage Appeals using three levels, and communicate changes and results to CMS.

Application Architecture

The SLR Web application features the following:

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

Configuration

The functionality of the Dashboard for all States and Territories is essentially identical, though the payment component will have one of three methods: integration with a Medicaid Medical Information System (MMIS), the use of a Payment Form, or the use of an invoicing system. Each State will use one of these three payment systems after an attestation is approved by a State representative. The system will either generate an invoice, export a Payment Form, or will export the provider's information to the State's MMIS.

Each State's Dashboard will have the State logo and look and feel defined by the State, as well as restrict access rights to approved State users. Each State will also define the Verifications they use to verify the information on each provider's attestation.

Materials and Preparations

Materials the user will need to use the software:

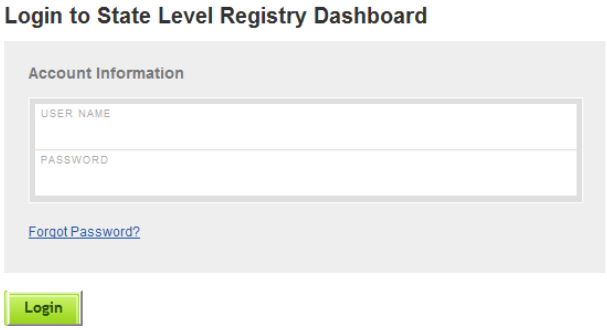
- Computers with access to the web browser.
- Software – **Adobe Acrobat Reader –** installed on your machine to view PDF files.
- Pop-up Blocker browser feature should be set to **Off** to receive the Pop-up window features.
- Manuals and/or FAQ's that are available for distribution.

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

3. Method

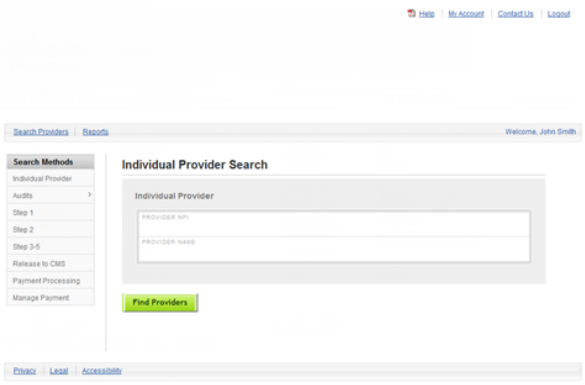
Login-Accessing the SLR

The SLR is a web-based application accessible from the internet directly from a login URL.



1. Open Microsoft Internet Explorer to access the Web.
2. Type the State's URL in the address field and press the Enter key on your keyboard.
   https://xx.arraincentive.com/Dashboard.

3. Enter your information into the **Username** and **Password** fields. The *Dashboard* will open.

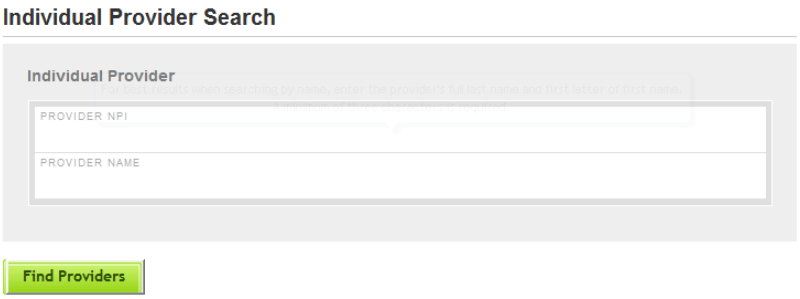


Dashboard Sections

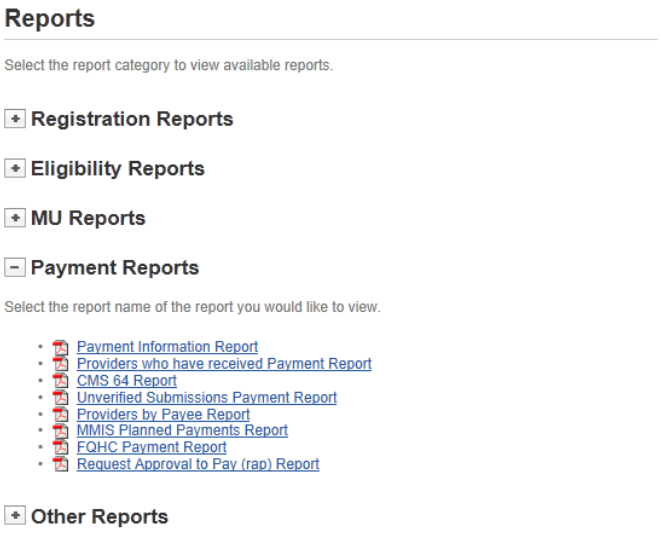
The header located at the top of the page is a banner that displays the following items on every page of the SLR application:

- State's logo.
- A motto for the organization or the name of the application.
- The Conduent logo.
- **Help** link: opens this user manual. Other user types – such as Eligible Professional and Eligible Hospital users – will access the standard user manual for their user type.

- **My Account** link: opens the *My Account* page, allowing each user to update their contact information or change their password.
- **Contact Us** link: opens a pop-up page displaying contact information including the Conduent Help Desk phone number and email address.
- **Login** or **Logout** link: once you are logged in, this link changes to the **Logout** link. When the **Logout** link is clicked, the session ends and the user is logged out.
- Footer section. Located at the bottom of the page, the footer displays the following items:
    - **Privacy** link: opens a new window with the SLR's Privacy Policy displayed.
    - **Legal** link: opens a new window with all legal policies displayed, including the application's Terms of Use and any legal documents.
    - **Accessibility** link: opens a new window with the website's Accessibility policy displayed.
    - **Conduent Copyright.** This is Conduent's copyright symbol and text.
- Navigation Bar. Located immediately below the logo, this section contains links to the different sections of the Dashboard.
- **Search Providers** link: opens the *Individual Provider Search* page.



- **Reports** link: opens the *Reports* page. Only those reports available to the State will appear in the list. MMIS reports for example will appear only for those States that have SLR integrated with their Medicaid Management Information System. Reports are now organized into five categories to make them easier to access.



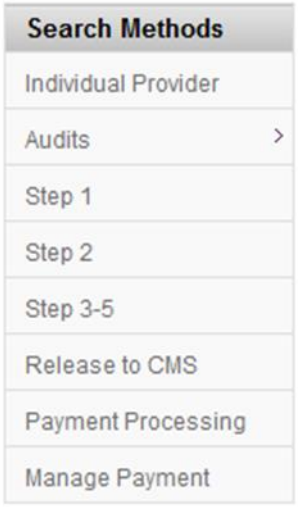
- **Admin** link: opens the *Admin* page, which is accessible to the administrators of the site.
- "Welcome, [Username]" message: this displays the name of the user currently logged on to the system.
- *Navigation Menu*. Located immediately below the logo on the left side of the page, this section allows you to access the various search methods of the *Dashboard*. Clicking on the **Audits** cell will open the *Audit General Search* page, while hovering the mouse pointer over it will cause a submenu to appear.

Search Methods

This navigation device provides access to the audits and queries in the system.

- **Individual Provider** link: opens the *Individual Provider Search* page, which is open by default when a user first logs into the system.
- **Audits** link: this opens a submenu that provides access to all the different types of Audits the system supports, including general audit searches, post payment audit searches, and those dedicated to eligible professionals, eligible hospitals, and groups.
- **Step 1** link: opens the *Registration Checks Search* page, which offers standard queries related to provider registration issues to State users.
- **Step 2** link: opens the *Eligibility Checks Search* page, which offers standard queries related to provider Eligibility issues.
- **Step 3-5** links: opens the *Attestation Checks Search* page, which offers standard queries related to provider attestation issues.
- **Release to CMS** link: opens the *Release to CMS Search* page, which offers queries related to B7 and D16 notification issues – providing a quick way to view attestation applications that need a transmission sent to CMS.
- **Payment Processing** link: opens the *Payment Processing Search* page, which allows State users to release the payment, either to the invoicing process or to the State's financial interface.
- **Manage Payment** link: opens the *Manage Payment Search* page.

Note: DC and HI users will use the State Payment Form until their MMIS is fully integrated with SLR, and then the Manage Payment components will be used.



Individual Provider Search

This page will appear when the State user first logs in to SLR. Users can search for providers by NPI number or by the name of the provider. Only those providers that are associated with the State will appear.

- **Provider NPI** text field: this is an exact match search field – ten characters are required to begin the search.
- **Provider Name** text field: enter a whole or part of a name, either last or first, into this field. The system will return all matches it finds. A minimum of three characters must be used for a name search.

- **Find Providers** button: searches the database for the search string entered into either of the search fields, and opens the *Provider List*.

Searches

Most of these are pre-configured searches that were recommended by CMS to help States review and manage SLR applications. The other options in the menu, **Payment Processing** or **Release to CMS**, are preconfigured searches that open attestation submissions with the associated statuses and conditions.

Audit General Search

The page is opened by selecting the **General** option in the **Audits** submenu, and has several active search functions.

- **Provider type equals** pull-down menu: allows you to select Certified Nurse Midwife, Dentist, Hospital, Nurse Practitioner, Physician, Physician Assistant, and display a list of all the providers of that Provider Type.
- **Attestation status equals** pull-down menu: allows you to select one of the following options and view all providers that match that status:
    - New: providers for whom a B6 Add transaction has been received from CMS, but the corresponding user account in SLR has not yet been created.
    - Submission Not Started: providers that have not yet entered any information into the system.

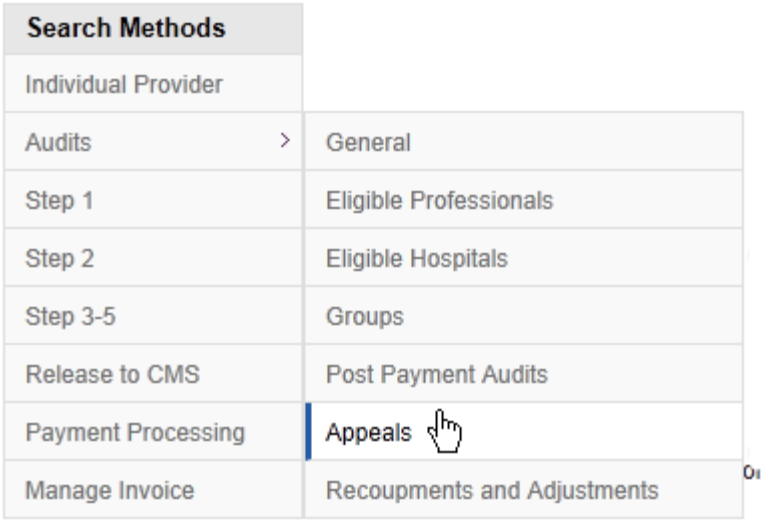
- Step 1 Complete (Registration): providers that have completed the required fields on the *About You* page.
- Step 2 Complete (Eligibility): providers that have completed the required fields on the *Confirm Eligibility* page.
- Step 3 Complete (Attestation): providers that have completed the required fields on either the attestation of EHR Criteria, Attestation of EHR, and Certified EHR Technology pages; or on the Meaningful Use pages.
- Step 4 Complete (Agreement Signed): providers that have uploaded signed copies of the Registration and Attestation form to the SLR.
- Submission Unverified (Step 5 Complete): providers that have clicked the **Send Attestation** button on the *Send Attestation to State* page.
- Submission Rejected: providers with attestation submissions that have been reviewed and rejected by the State.
- Submission Approved: providers with attestation submissions that have been reviewed and approved by the State.
- Ineligible B7 Submitted: providers with attestation submissions that have been reviewed and rejected by a State representative, and the submissions have also been released to CMS. The B7 Ineligible transmission has been queued for transmission to CMS.
- Ineligible B7 Sent to CMS: providers that have had B7 Ineligible transmissions sent to CMS.
- CMS Error Processing Registration Confirmation (B7): providers for which B7 transmissions have been sent to CMS, but an error occurred on those messages. These must be resent using the *Release to CMS* page.
- Duplicate Payment Check (D16) Submitted: providers with attestation submissions that have been approved and had their D16 transmissions queued for transmission to CMS.
- Duplicate Payment Check (D16) Sent: providers with attestation submissions that have been approved and had their D16 transmissions sent to CMS.
- CMS Error Processing Duplicate Payment Check (D16): providers for which D16 transmissions have been sent to CMS, but an error occurred on those messages. These must be resent using the *Release to CMS* page.
- CMS Approved (D16): confirmation has been received from CMS that the provider has no duplicate payments or exclusions.
- CMS Rejected (D16): confirmation has been received from CMS that the provider has a State or Federal exclusion or a duplicate payment registered from CMS.
- Released for Payment: providers for which a D16 Response has been received.
- Invoice Generated: providers for which an invoice was generated by SLR.
- Invoice Preprocessed: providers with attestation submissions for which an invoice was generated, and the invoice was updated and saved in the system.
- Invoice Printed: providers for which an invoice was printed.
- Invoice Processed: providers for which an invoice was reprinted after being updated or corrected.

- Invoice Complete: providers for which an invoice was printed and the information updated after payment. Both the EFT or check number and the Disbursement Date are entered.
- MMIS File Submitted: providers with attestation submissions that have been approved by both SLR and CMS, and the payment information file queued for transmission sent to the MMIS system.
- MMIS File Sent: providers with attestation submissions that have been approved by both SLR and CMS, and the payment information file sent to the MMIS system.
- Error Processing MMIS File: providers for which MMIS transmissions have been sent, but an error occurred on those messages.
- MMIS File Received: providers for which MMIS transmissions have been sent and confirmations received.
- Incentive Payment (D18) Submitted: providers that have had their D18 transmissions sent to CMS.
- Payment Complete: a check or MMIS payment has been delivered to the provider, and the invoice updated if necessary.
- CMS Error Processing Incentive Payment (D18): providers that have had their D18 transmissions sent to CMS, but an error occurred on those messages.
- Submission Locked: provider is locked in the system.
- Cancelled – B-6 Inactive: providers for whom a B6 Inactivate transaction has been received from the CMS.
- Cancelled – Expired: providers that did not submit their attestations prior to the grace period end date for a given program year.
- Cancelled – Recouped: providers that have had at least one payment recouped by the State.

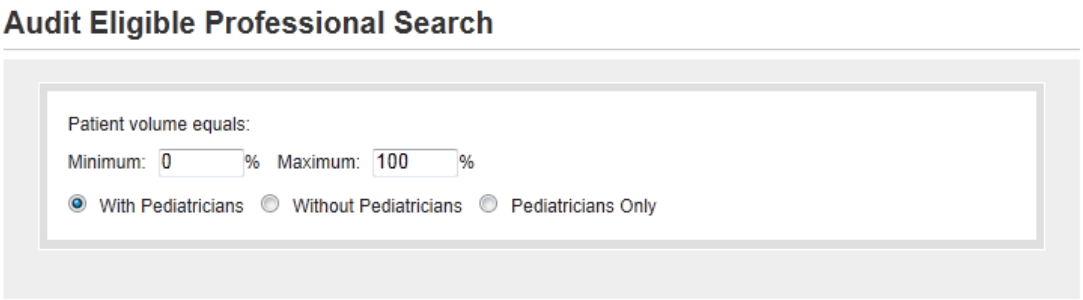
- **Attestation has exceptions** pull-down menu: allows you to select Show All, Show Only Eligible Professionals, or Show Only Eligible Hospitals, and return providers of the selected type that have exceptions or State rejections.
- **Pended Providers** pull-down menu: allows you to select Eligible Professionals or Eligible Hospitals or Show All to reveal all pended providers of that Provider Type.
- **Encounters ending in "00" for both Medicaid and total encounters** pull-down menu: allows you to list all or only Eligible Professionals that have encounter numbers that end in two zeroes. The "00" is a red flag for auditors.
- **Random Sample** pull-down menu: this feature has not yet been implemented. This menu has Show All, Show Only Eligible Professionals, or Show Only Eligible Hospitals options. Click the **Update Total** button to show the number of attestations that have been completed and passed all validations and have not been previously selected for audit. Enter a percentage in the **% to Select** text field and click the **Find Providers** button.
- **Providers who have assigned their payment to another NPI/TIN** pull-down menu: allows you to select Eligible Professionals or Eligible Hospitals or Show All to reveal all providers of the selected Provider Type that have declared a Payee other than themselves.
- **Find Providers** button: clicking this button will open the *Provider List* page, which lists all the providers in the system that fulfills the criteria selected from one of the pull-down menus.

Audit Eligible Professionals

This page is opened by clicking the **Eligible Professionals** submenu option revealed when the user points at the **Audits** option in the Navigation Menu. The page contains fields that allow a user to find providers with specified Medicaid patient volumes.



- *Patient Volume Equals* section: this section has a **Minimum** and a **Maximum** field. The user enters numbers in order to specify a range and return all providers that have a Medicaid patient volume percentage within that range. Entering 10 in the **Minimum** field and 29 in the **Maximum** field and selecting the **Find Providers** button would return all providers with patient Medicaid volumes of between 10% and 29%.



Pediatricians can qualify for a Medicaid Incentive Payment at a 20% Medicaid patient volume rather than the normal 30%, so users try to track this provider type more closely. These three radio buttons allow the user to view Pediatrician providers in three ways.

- **With Pediatricians** radio button: with this selected, the page will list all providers that fall in the specified range in the search results.
- **Without Pediatricians** radio button: with this selected, the page will list all providers except for Pediatricians that fall in the specified range in the search results.
- **Pediatricians Only** radio button: with this selected, the page will list only Pediatricians that fall in the specified range in the search results.

Audit Eligible Hospitals

This page is opened by clicking the **Eligible Hospitals** submenu option revealed when the user points at the **Audits** option in the *Navigation Menu*. The page contains two pre-configured queries.

- **Hospitals that entered Medicaid Managed Care Inpatient Bed Days** radio button: selecting this and then the **Find Providers** button returns a list of hospitals that entered Managed Care Bed Days.
- **Hospitals whose payment is greater than $2 million for the payment year** radio button: selecting this and then the **Find Providers** button returns reveals those Hospitals receiving large payments.

Audit Groups

Note: This feature is not yet available.

This page is opened by clicking the **Groups** submenu option revealed when the user points at the **Audits** option in the Navigation Menu. The page contains one pre-configured query.

- **Groups that have more than 14 providers** radio button: selecting this and then the **Find Providers** button returns a list of groups with at least 15 providers.

Post Payment Audits

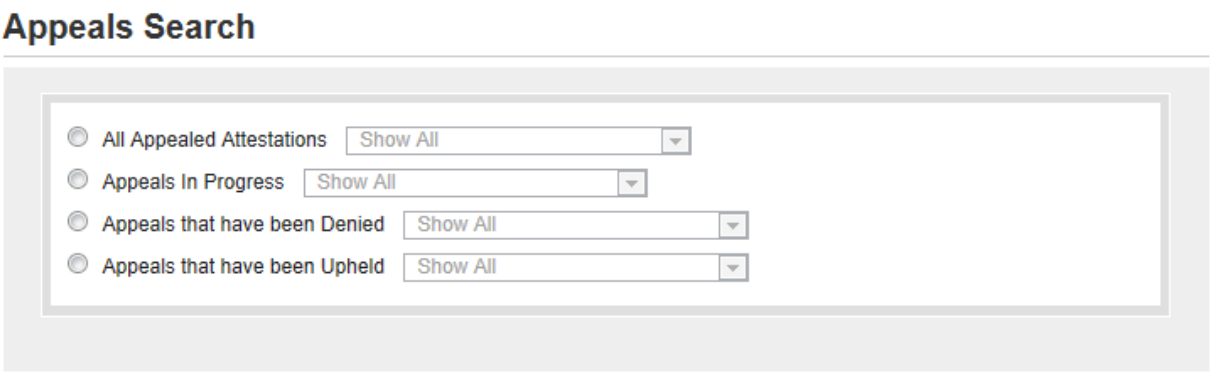
This navigation option opens the *Audit Search* page, which provides searches to find providers that have been audited in SLR.

- **Providers who have been selected for audit** radio button: lists those providers who have been Marked for Audit by a State Dashboard user.
- **Providers selected for** radio button: selecting this will enable the pull-down menu from which the user which select the Audit Type from four options.
    - Financial
    - Eligibility
    - Meaningful Use
    - Adopt, Implement, Upgrade

- Those providers that have had the selected audit initiated will be listed in the Provider List. **Note:** a provider who is simply Marked for Audit may not have had an audit initiated for them as yet. Those selected for audit will still have to have an audit started for them to appear in this list.
- **Providers with multiple audits** radio button: lists those providers who have had multiple Audit Types initiated in a single Payment Year.
- **Providers with audit results =** radio button:
    - Adverse Finding – Incentive Payment Modification: the Audit uncovered a problem and the payment will be recouped or adjusted.
    - Failed to show AIU of Certified EHR: the providers did not provide adequate evidence that they had adopted, implemented, or upgraded approved EHR Software
    - Did not use Certified EHR to meet MU: the provider did not use EHR software certified by the ONC, and is therefore not eligible for the incentive payment.
    - Did not meet Patient Volume: the provider did not meet Eligibility numbers in order to qualify for the incentive payment this year.
    - Did not meet MU Objectives and Measures: the provider did not meet the measures required for Meaningful Use, and therefore did not qualify for an incentive payment.
    - Did not meet MU Objectives and Exclusions: the provider did not meet the Objective and Exclusion requirements for Meaningful Use, and therefore did not qualify for an incentive payment.
    - Did not meet CQM: the provider did not meet the requirements for Clinical Quality Measure requirements for Meaningful Use, and therefore did not qualify for an incentive payment.
    - Was not Medicaid Provider: the provider did not qualify as a officially licensed medical provider.
    - No Adverse Finding: the audit did not uncover a problem with the attestation, and the payment will not be modified.

Appeals

This navigation option opens the *Appeal Search* page, which provides searches to find providers that have made Appeals to their State.



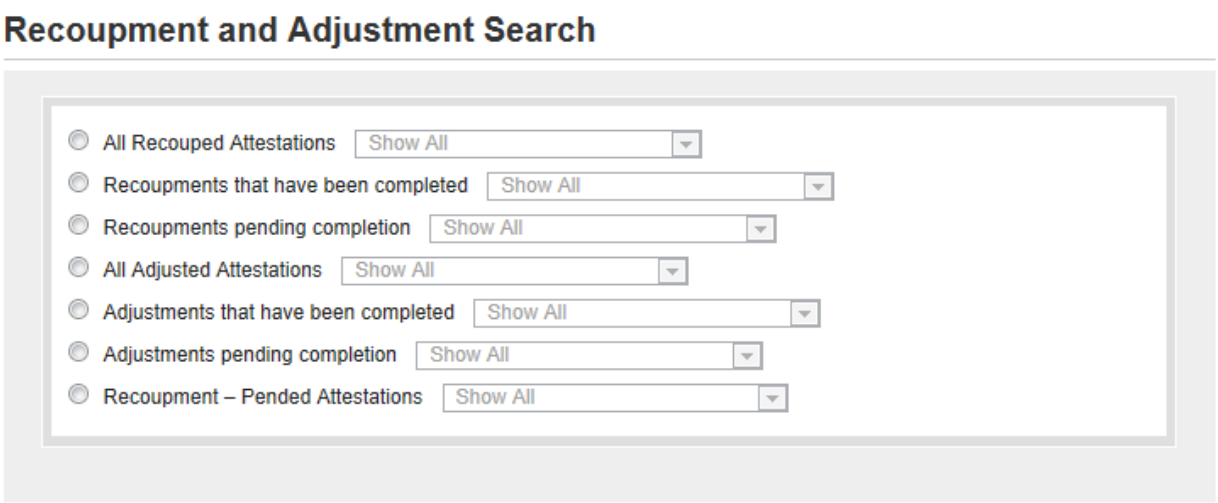
- **All Appealed Attestations** radio button: lists all providers and their Attestations for which an Appeal has been filed.
- **Appeals in Progress** radio button: lists all providers and their Attestations for which an Appeal has been started, but has not been finished. Appeals are finished when an Appeal Status has been assigned.
- **Appeals that have been Denied** radio button: lists all provider Attestations that have Appeals with the Denied status.
- **Appeals that have been Upheld** radio button: lists all provider Attestations that have Appeals with the Upheld status.

When the user selects the Find Providers button and no results are found a message is displayed, No results matching your criteria are found.

Recoupments and Adjustments

This navigation option opens the *Recoupment and Adjustment Search* page, which provides searches on attestations in the system. All of the search menus on this page have three options:

- Show All
- Show Only Eligible Professionals
- Show Only Eligible Hospitals



The page contains seven searches that are currently available:

- **All Recouped Attestations** radio button: lists all Attestations that have had a Recoupment initiated.
- **Recoupments that have been completed** radio button: displays Attestations with completed Recoupments.
- **Recoupments pending completion** radio button: displays Attestations with Recoupments that are currently active, meaning that they haven't been canceled or submitted.
- **All Adjusted Attestations** radio button: lists all Attestations that have had an Adjustment initiated.
- **Adjustments that have been completed** radio button: displays Attestations with completed Adjustments.

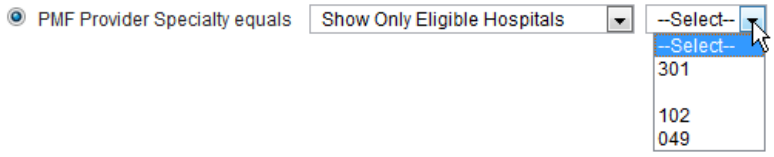
- **Adjustments pending completion** radio button: displays Attestations with Adjustments that are currently active, meaning that they haven't been canceled or submitted.
- **Recoupment – Pended Attestations** radio button: list those Attestation that have been pended as a result of a Recoupment.

Step 1

This navigation option opens the *Registration Checks Search* page, which provides searches on the Provider Master File (PMF) provided by the State. The SLR combines information from the Federal level through CMS and its NLR registration, and from the State level through the State's PMF and other data sources.

The page contains five searches that are currently available:

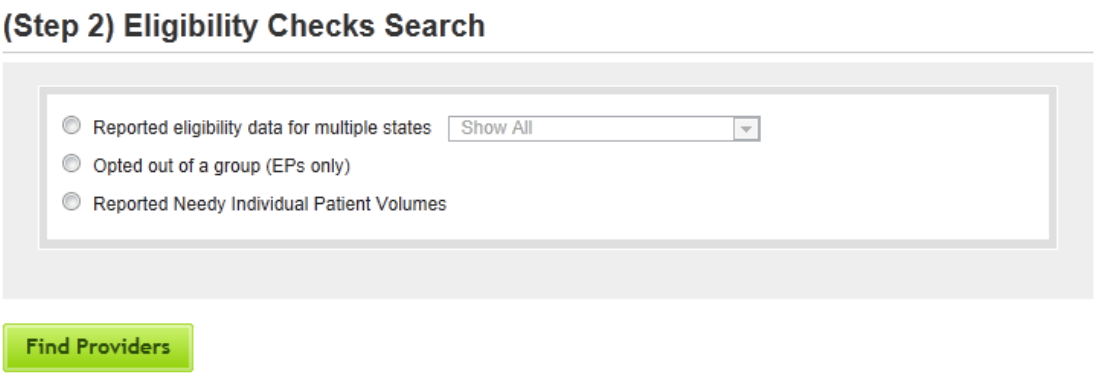
- **Providers that attest to being a Physician Assistant** radio button: selecting this will list only the PA providers.
- **Providers that attest to being a Pediatrician** radio button: select Show All, Show Only Eligible Hospitals, or Show Only Eligible Professionals from the pull-down menu.
- **PMF Provider Type** radio button: select Certified Nurse Midwife, Dentist, Hospital, Nurse Practitioner, Physician, or Physician Assistant, and display a list of all the providers of that type.
- **PMF Provider Taxonomy equals** radio button: select Show All, Show Only Eligible Hospitals, or Show Only Eligible Professionals from the pull-down menu, then select an applicable Taxonomy Code.
- **PMF Provider Specialty equals** radio button: select Show All, Show Only Eligible Hospitals, or Show Only Eligible Professionals from the pull-down menu, then select a Specialty Code.



Select a search option and click the **Find Providers** button. The page will refresh and the providers that match the selected search options will be displayed in a list. Only Specialty and Taxonomy Codes used by the State will be included in the second pull-down menu.

Step 2

This navigation option opens the *Eligibility Checks Search* page, which provides searches on SLR and NLR provider data. The SLR combines information from the Federal level through CMS and its NLR registration, and from the State level through the State's PMF.



The page contains preconfigured searches:

- **Reported eligibility data for multiple States** radio button: selecting this button will activate the pull-down menu, which enables the user to select a State. This will list providers with claims from the selected State.
- **Opted out of a group (EPs only)** radio button: selecting this will list providers that have been added by a Group Administrator, but elected to use their own Medicaid patient encounter numbers on their attestation submission.
- **Reported Needy Individual Patient Volumes** radio button: selecting this button will list those providers that see patients classified as Needy Individuals.

Select a search option and click the **Find Providers** button. The page will refresh and the providers that match the selected search options will be displayed in a list.

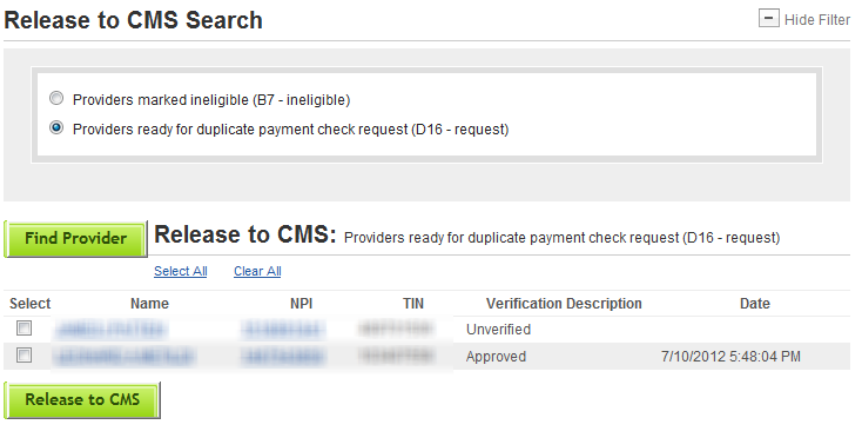
Step 3-5

Note: These searches are not yet available.

Release to CMS

This navigation option opens the *Release to CMS* page, which provides searches to find providers that are ready for one of two transactions sent to CMS. The page contains two preconfigured searches:

- **Providers marked ineligible (B7 – ineligible)** radio button: selecting this will list providers that were found to be ineligible for the EHR Incentive payment during the SLR process.
- **Providers ready for duplicate payment check request (D16 – request)** radio button: selecting this will list providers that were found to be eligible for the EHR Incentive payment during the SLR process, and are ready for the D16.



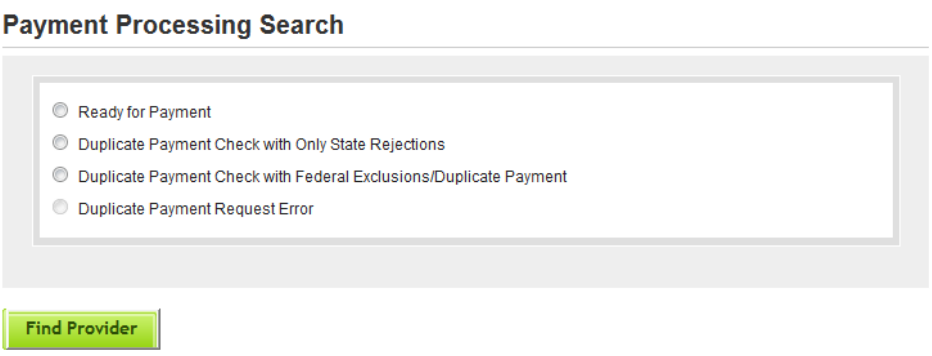
Select a search option and click the **Find Provider** button. The page will refresh and the providers that match the selected search options will be displayed in a list. Only participants who have been approved (for D16) or Rejected (for B7) during the verification process will appear on these searches. This list will have six columns:

- **Select** column: allows the provider to select the provider to send their associated attestation information to CMS.
- **Name** column: the name of the provider. The names in this column open the *Provider Information* page displaying the attestation submission associated with the selected provider.
- **NPI** column: the National Provider Identifier number assigned to the provider.
- **TIN** column: the Tax Identification number assigned to the provider.
- **Verification Description** column: the stage or state of the attestation. For providers marked ineligible, this column is titled the **Rejection Description** column.
- **Date** column: the date the attestation submission was denied. For providers marked ineligible, this column is titled the **Rejection Date** column.

Select one or more providers and click the release to **CMS** button. The *Release to CMS Search* page will reappear, and the selected provider's attestation will be added to the Release to CMS queue.

Payment Processing

These navigation options open the *Payment Processing* page, which provides queries to find providers that have either fulfilled all requirements and are ready to receive EHR Incentive payments from the State, or have an exclusion. The page contains four preconfigured searches:



- **Ready for Payment** radio button: selecting this will list providers that have no duplicate payments, federal exclusions, or State rejection reasons. These participants can be selected and released for payment from the list.
- **Duplicate Payment Check with Only State Rejections** radio button: selecting this will list providers that have a Duplicate Payment Check response from CMS that has one or more State Reject Reasons. These participants will be displayed with both the **Release for Payment** and the **Reject** button enabled. The State user has the option to select participants to be rejected or released for payment.
    - If the provider is rejected, the provider's SLR status will be updated to "Rejected by CMS" and a Not Eligible B7 will be sent to CMS.
    - If the Release for Payment button is selected, the Attestation is assigned a status of "Invoice Generated" for Invoice States, or "MMIS Files Sent" for MMIS States
- **Duplicate Payment Check with Federal Exclusions/Duplicate Payment** radio button: selecting this will list providers that have either a Duplicate Payment or another Federal exclusion on the Duplicate Payment Check Request Response from CMS.
- **Duplicate Payment Request Error** radio button: selecting this will list providers for which there was an error in the transmission. This provides only the list, and is an informational display only. **Note:** this query is not yet available.

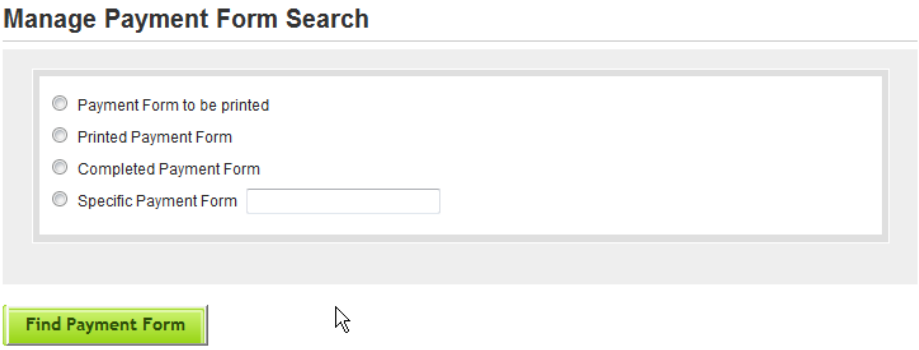
Select a search option and click the **Find Provider** button. The page will refresh and the providers that match the selected search options will be displayed in a list. Only participants who have been approved for payment during the verification process will appear on these searches.

Manage Payment Forms

This control appears for States using State Payment Forms to communicate payment information to financial departments within their State. The navigation option opens the *Manage Payment Form Search* page, which provides several searches to find forms that have been or need to be produced by the State in order to provide payments. The page contains four preconfigured searches:

- **Payment Form to be Printed** radio button: selecting this will list providers that have been released for payment, but their patient information has not been transferred to the State's financial office.
- **Printed Payment Form** radio button: selecting this will list forms that have already been generated. State users will update the **Check** or **EFT Number**, **Disbursed Date**, and **Total Disbursed Amount** fields for these forms to complete the provider's information. This will initiate the D18 transmission to CMS.
- **Completed Payment Form** radio button: selecting this will list forms that have already been updated and the D18 sent to CMS.
- **Specific Payment Form** radio button: selecting this will activate the search field. Entering a number in this field and clicking the **Find Payment Form** button will list all forms matching the search string.

Select a search option and click the **Find Payment Form** button. The page will refresh and the providers that match the selected search options will be displayed in a list.



List Pages

When the **Find Provider** or **Find Payment Form** buttons are selected, those pages will refresh and display the results of the associated search in list form on the page. Each *List* page shares the common features listed below.

- **Showing [n] – [n] of [n]** label: displays the number of providers listed on the Provider List at the current moment, and the total number of Providers that matched the search criteria. Only 20 providers will be listed at any one time. A Next >> link will appear if more than 20 providers matched the search criteria.
- **Next >>** link: clicking this link will display the next 20 providers that matched the search criteria.
- **<< Previous** link: this link will appear when the providers beyond the first 20 on the list are displayed, and clicking the link will display the previous 20 providers that matched the search criteria.
- **Show Filter** icon: clicking this will display the search controls you used to display the Provider List. This allows you to alter the search query and re-populate the Provider List if needed.

Payment Form List

The *Payment Form List* displays the State Payment Forms that matched the search query in a series of columns.

Note: DC users will use the State Payment Form until their MMIS is fully integrated with SLR, and then the Manage Payment components will be used.

- **Select** column: allows the user to select the form in order to view it by cells in an online spreadsheet.
- **Payment Form Number** column: the unique number assigned to the form by the system. The numbers in this column also serve as links to the Payment Form Details page, which displays the information about the provider and their EHR Incentive payment. This page allows a State user to update the provider information with payment details such as the **Disbursement Date**.
- **Payee NPI** column: the National Provider Identifier number assigned to the provider the form is associated with.

- **Payee Name** column: the name is listed last name first.
- **Number of Providers** column: in some cases, an SPF will be prepared for a group. This column displays the number of providers in that group.
- **Payment Amount** column: the amount paid to the provider and documented by this form.

Payment Form Details Page

This page contains two sections, the *Payment Information* section and a list section on the bottom. All fields in the *Payment Information* section can be updated by a State user.

- **Payee**: the name of the payee – this may be different from the name of the provider who has been approved for the Incentive Payment.
- **Payment Form Number**: the unique number assigned to the form by the system.
- **Payee TIN**: the Tax Identification number used by the payee.
- **Reason for Payment**: this will always display “EHR Incentive Payment”.
- **Total Payment Amount**: the amount of the Incentive Payment.
- **Payment Method**: **EFT** for Electronic Funds Transfer or **Check** – the method used by the State to pay the payee.
- **Number**: the number of the Check or EFT transaction.
- **Disbursed Date**: the date the check was produced by the State’s financial system, or the date the funds were transferred to the payee’s account by EFT.
- **Total Disbursed Amount**: the amount sent to the provider.

The information in the table below the *Payment Information* section is display-only.

- **CMS Confirmation Number** column: a unique number assign to a provider, and identifying a unique NPI and TIN combination.
- **Provider NPI column**: the National Provider Identifier number assigned to the provider.
- **Provider TIN** column: the Tax Identification number assigned to the provider.
- **Provider Name** column: the name of the payee – this may be different from the name of the provider who has been approved for the Incentive Payment.
- **Type** column: the type of provider.
- **Total Disbursed Amount** column: the amount determined by the SLR system to be owed the provider if approved for an incentive payment.

Clicking the **Save** button will preserve any changes in the database. Clicking the **Cancel** link will open the *Manage Payment Form Search* page and abandon any changes made to the fields.

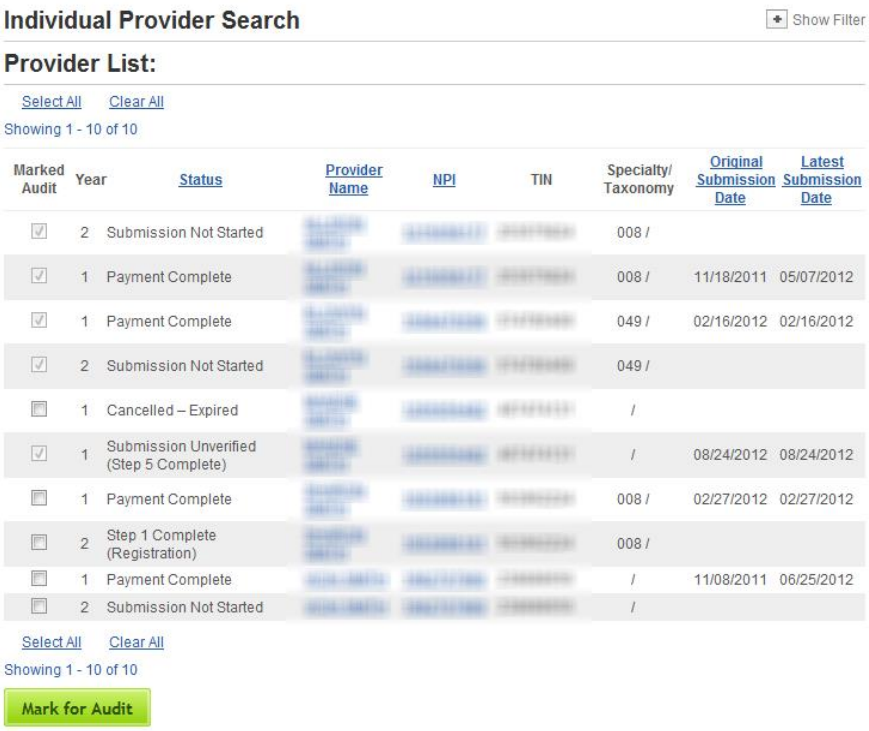
State Payment Form

This page contains the *State Payment Form (SPF).* All the fields on this page are display-only.

Provider List

The *Provider List* displays the providers that matched the search query in a series of columns. Clicking on the **Status**, **Provider Name**, or **NPI** columns will order the columns, first in ascending and then in descending order.

- **Marked Audit** column: displays either an icon that indicates that a provider has been marked for audit  , or a checkbox  that can be selected. If the checkbox is selected and the **Mark for Audit** button is clicked, that provider will be selected for an audit. Each Audit is begun on the *Audit* page.
- **Year** column: displays the Payment Year the provider is attesting. The first time the providers attest is reflected by a Year of 1.
- **Status** column: indicates the last step the provider has completed.
- **Provider Name** column: the name is listed last name first. The names in this column also serve as links to the *Provider Information* page, which displays comprehensive information about the provider and their EHR Incentive attestation.
- **NPI** column: the National Provider Identifier number assigned to the provider. The numbers in this column also serve as a link to the *Provider Information* page.
- **TIN** column: the Employer Identification Number or Social Security Number that the provider is using to confirm their identity.
- **Specialty/Taxonomy** column: any relevant professional codes in the database, if these are available.
- **Original Submission Date** column: displays the first time during the associated Payment Year that the provider submitted their attestation.
- **Latest Submission Date** column: displays the most recent time during the associated Payment Year that the provider submitted their attestation.



- **Show Filter** icon: clicking this will display the search controls you used to display the Provider List. This allows you to alter the search query and re-populate the *Provider List* if needed.
- **Showing [n] – [n] of [n]** label: displays the number of providers listed on the *Provider List* at the current moment, and the total number of Providers that matched the search criteria. Only 20 providers will be listed at any one time. A **Next >>** link will appear if more than 20 providers matched the search criteria.
- **Next >>** link: clicking this link will display the next 20 providers that matched the search criteria.
- **<< Previous** link: this link will appear when the any providers beyond the first 20 on the list are displayed, and clicking the link will display the previous 20 providers that matched the search criteria.
- **Select All** command: selects all checkboxes on the current page of results. Once the **Mark for Audit** button is selected, the associated providers will all be marked for audit. Notification emails can be sent to the providers if the State wishes to turn on this feature.
- **Clear All** command: All the checkboxes on the current page of results will be cleared of any recent selections.

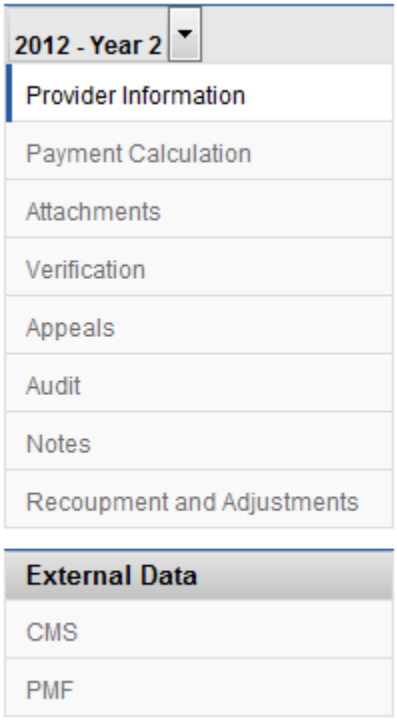
Provider Information Section

This component is opened from the *Provider List*, and displays all the information about a provider and his or her EHR Incentive attestation. The first page is the *Provider Information* page.

Navigation Menu

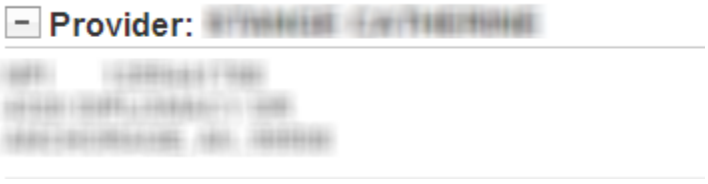
The *Provider Information* page opens by default when a provider is selected from the *Provider List*.

- **Year** pull-down menu: this menu will contain only the years that are applicable to the selected provider. If the provider has participated for only one year, the only option will be Year 1. Each link of the *Navigation Menu* will open pages relating to the year selected in the **Year** menu.



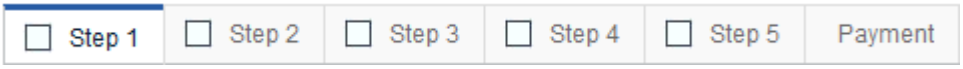
- **Provider Information** link: opens the *Provider Information* page, the first page of the *Provider Information* section.
- **Payment Calculation** link: opens the *Payment Amount* page for Eligible Professionals, or the *Payment Calculation* page for Eligible Hospitals.
- **Attachments** link: opens a page listing all the attachments added to a Provider's attestation for the selected Year.
- **Verification** link: opens a page that displays all the verifications established for the State's providers, and the progress that State users have made verifying the selected provider's information.
- **Appeals** link: opens a page that allows users to document and manage any Appeals associated with the attestation.
- **Audit** link: in a future iteration of the SLR, this will open the *Audit* page.
- **Notes** link: this section allows State users to add notes the any provider's attestation.
- **Recoupments & Adjustments** link: opens the *Recoupment and Adjustment* page, allowing the user to complete or initiate a Recoupment or Adjustment.
- **CMS** link: opens the *CMS Data for Provider* report, which displays all the data that the Centers for Medicare and Medicaid Services' system has on the selected provider.
- **PMF** link: opens the *PMF Data for Provider* report, which displays all the data that the Provider Master File provided by the State has on the selected provider.

All pages within the *Provider Information* section have an icon  that, when clicked, will reveal the provider's NPI number and address.



Provider Information Page

Navigation tabs: indicate the progress of the Provider in the SLR system.



A blue line on the tab indicates the tab you are currently viewing, and each tab will display an icon that represents the status of that step for the selected provider:

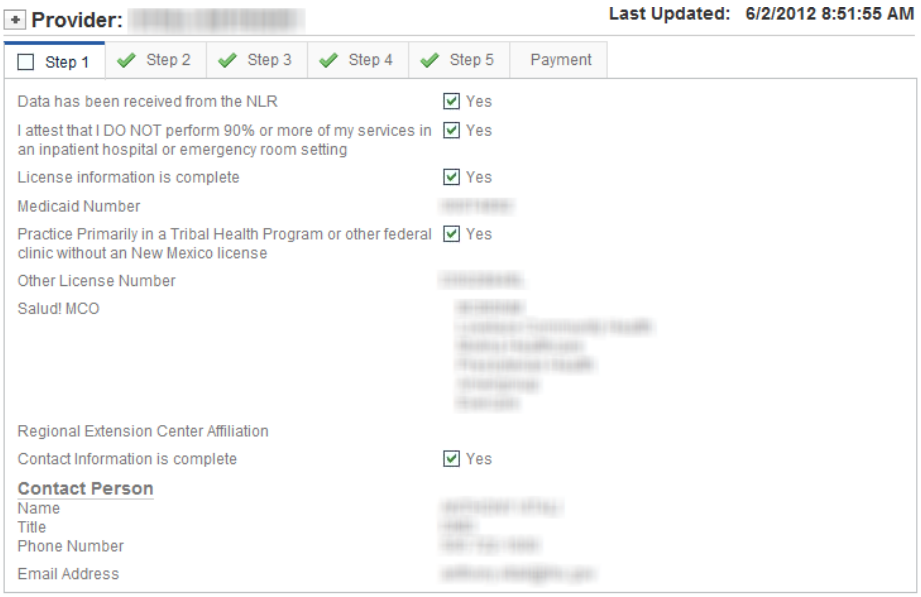
: Completed steps are indicated by a checkmark icon.

: Tabs representing steps that have not been started contains this icon.

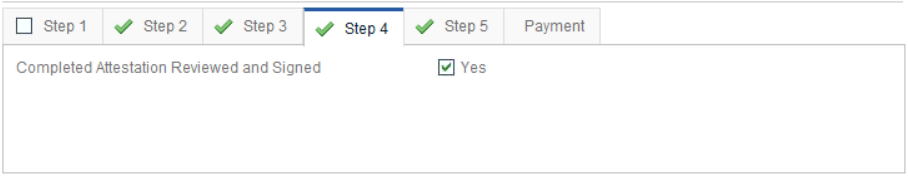
: Steps that have been started but not completed display this icon.

The tabs below show that all the steps of the selected provider's attestation have been completed.

Pages: each page opened by one of the *Provider Information* navigation tabs will present data entered by the provider on the corresponding page in the SLR system. Below is the page displaying an Eligible Provider's Step 1 information.



During *Step 4* of the SLR process, the provider prints and signs the *Attestation Agreement*. This page simply has a checkbox that indicates whether the provider completed the step or not, though the tab provides this information as well.



Some providers will be demonstrating meaningful use of the EHR software they have implemented, and the tabs and data contained on these pages will be different. Hospitals and Professionals have different fields within a step of the SLR workflow, and their *Provider Information* pages reflect those differences.

Step 1 Complete (Registration): EH

<< Return to Search Results

Provider: [redacted] Last Updated: 10/22/2012 2:44:48 PM

Step 1 | Step 2 | Step 3 | Step 4 | Step 5 | Payment

Data has been received from the NLR	Yes
Contact Information is complete	Yes

Contact Person

Name	EASTERN NM MEDICAL CENTER
Title	
Phone Number	[redacted]
Email Address	[redacted]

Step 1 Complete (Registration): EP

Provider: [redacted] Last Updated: 6/2/2012 8:51:55 AM

Step 1 | Step 2 | Step 3 | Step 4 | Step 5 | Payment

Data has been received from the NLR	Yes
I attest that I DO NOT perform 90% or more of my services in an inpatient hospital or emergency room setting	Yes
License information is complete	Yes
Medicaid Number	[redacted]
Practice Primarily in a Tribal Health Program or other federal clinic without an New Mexico license	Yes
Other License Number	[redacted]
Salud! MCO	[redacted]
Regional Extension Center Affiliation	
Contact Information is complete	Yes

Contact Person

Name	[redacted]
Title	[redacted]
Phone Number	[redacted]
Email Address	[redacted]

The fields are specific to the State in which the provider is registered.

Step 2 Complete (Eligibility): EH

Step 1 | Step 2 | Step 3 | Step 4 | Step 5 | Payment

Click to View Hospital Demographics Information

Meets Medicaid Eligibility Requirements	Yes
Representative Period	Other
Start Date	3/1/2010
End Date	5/31/2010
Total Discharges	1341
Medicaid Discharges for representative Period	150
Medicaid Volume	11.19 %
Average Length of Stay in days	4.00

Step 1 | Step 2 | Step 3 | Step 4 | Step 5 | Payment

Click to View Medicaid Volume

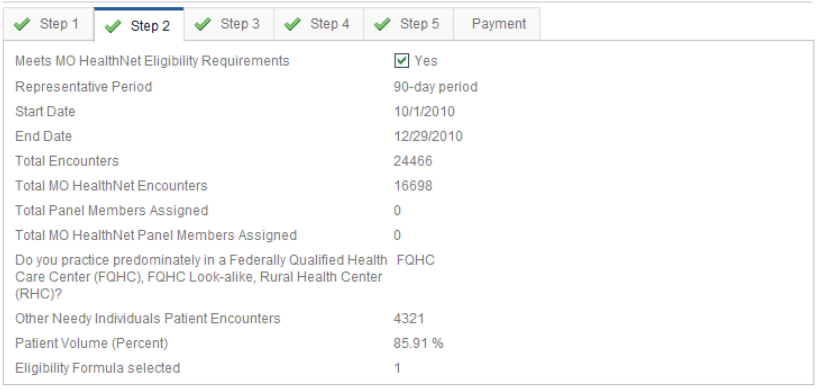
Current Cost Report Year	2010			
Discharges for the last four years of available data from CMS Cost Reports	Year 4	Year 3	Year 2	Year 1
	7165	5365	4648	5225

Data from the Year 1 cost report

Total Discharges	5225
Total Medicaid Inpatient Bed Days	5372
Total Medicaid Managed Care Inpatient Bed Days	0
Total Inpatient Bed Days	23447
Total Hospital Charges	$392,196,275.00
Hospital Charity Care Charges	$17,186,665.00

EHs have two pages of information for Step 2: the *Hospital Demographics* page and the *Medicaid Volume* page. Click the link at the top of the page to toggle between the two pages.

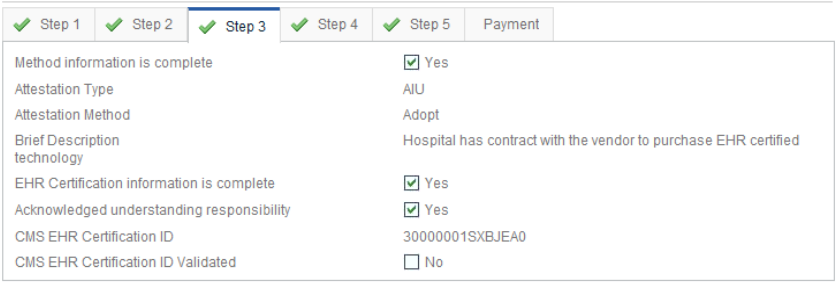
Step 2 Complete (Eligibility): EP



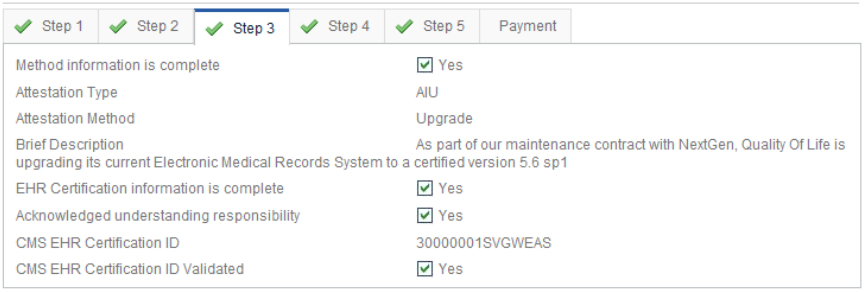
Step 3 Complete

This page can display either Adopt, Implementation, Upgrade or Meaningful Use information.

Step 3 Complete (Attestation): EH AIU



Step 3 Complete (Attestation): EP AIU



Step 3 Complete (Attestation): EP MU

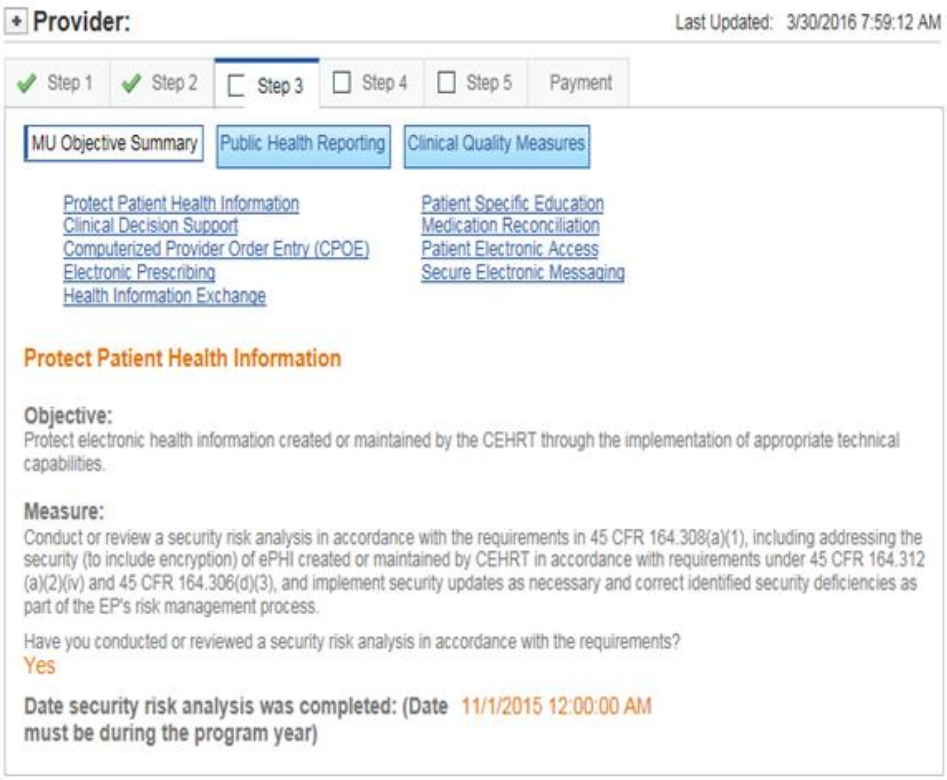
The initial page displays general information that is specific to Step 3, such as the EHR Certification Number and Reporting Period. The **Source of MU Data** field displays Manual Entry if the MU information was typed into the SLR interface. If the information was populated by a C5 file or from an import file created by the EHR Software, the message will display the source of the information.

C5 Files are received from CMS for every Dually Eligible hospital in the State. Dually Eligible Hospitals will have already submitted MU information into the CMS system to qualify for the Medicare payment. The C5 file populates the SLR database with all the previously entered MU information, and automatically completes this step for the Hospital.

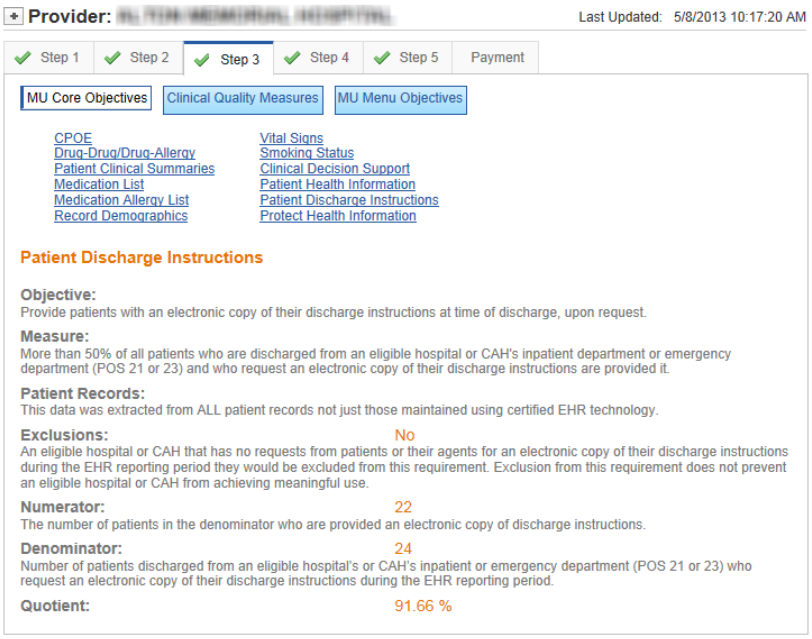
Select one of the Measures links (such as the **MU Objective Summary** link) to view the data from that set of Meaningful Use measures. All of the data captured by SLR will be revealed on the data pages within the **Step 3** tab.

Once a Measures button is selected, the titles of the specific measures in that group will be displayed on the page as a series of links. Click a link to view a measure's information.

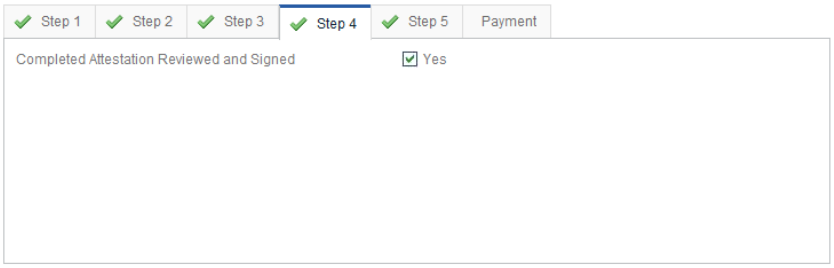
Orange text (not including the title) represents the answers that the provider entered into the system. Black text displays the question that was answered so that the context of the information is clear.



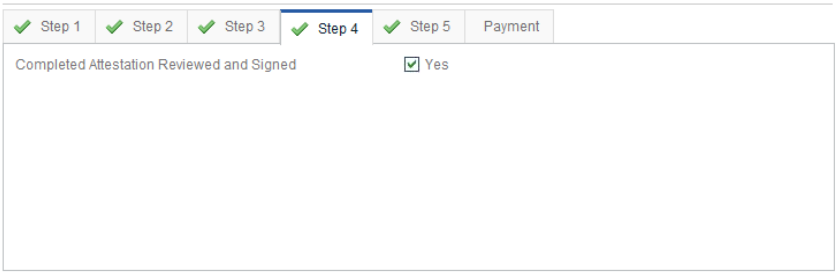
Step 3 Complete (Attestation): EH MU



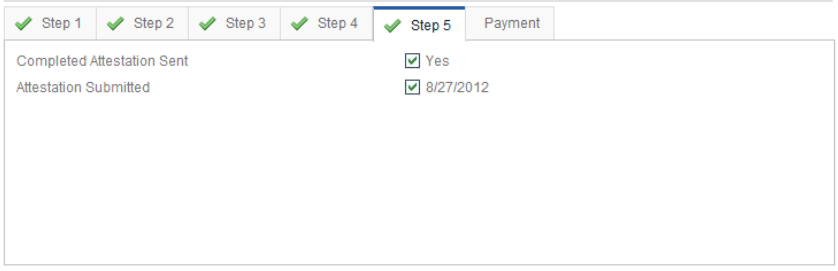
Step 4 Complete (Agreement Signed): EH



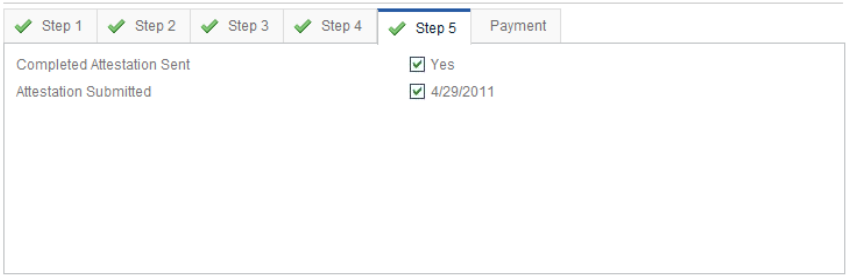
Step 4 Complete (Agreement Signed): EP



Step 5 (Submission Sent): EH

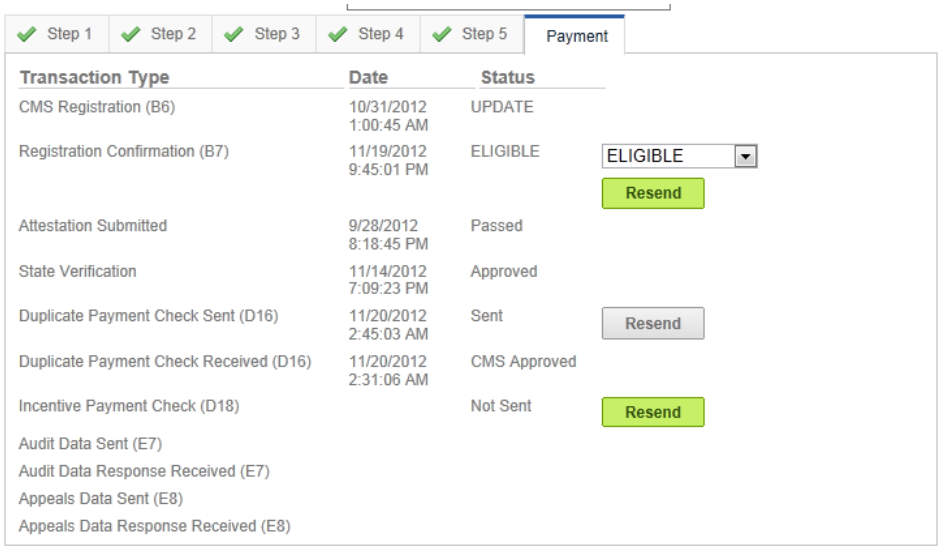


Step 5 (Submission Sent): EP



Payment: EP and EH

Unlike the other pages of the section, which simply display the information entered into the SLR pages, the *Payment* tab provides the history of the actions, payments, and CMS transactions that impact the selected year. It will also be the page where State users with sufficient permissions will resend the D16, D18, and the B7 transactions.

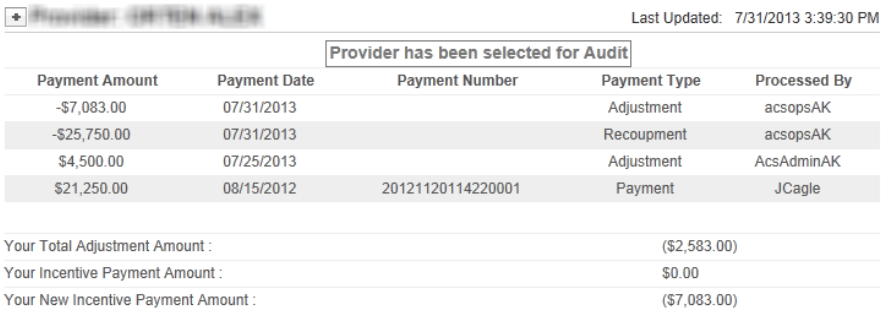


- **CMS Registration (B6):** the date that the provider was last added or updated in the CMS EHR Incentive
- **Registration Confirmation (B7):** this transaction can be resent as either an eligible or an ineligible B7. If the status is Not Eligible, a reject reason will be required.
- **Attestation Submitted:** the provider completed and submitted the Attestation on this date.
- **State Verification:** State users completed all Verification Items for the Attestation.
- **Duplicate Payment Check Sent (D16):** this transaction can only be resent if the participant has passed all required verifications and been approved by the State. It also must be over 48 hours since an original D16 was sent and there is no corresponding D16 response in SLR's database tables.
- **Duplicate Payment Check Received (D16):** a confirmation that the batch transaction was received.
- **Incentive Payment Check (D18):** this transaction can only be resent if the attestation application has a status that indicates payment has been made by the State, and only if SLR gets no response from CMS.

- **Audit Data Sent (E7):** the E7 batch transmission is sent any time there is a change in the status of an Audit being performed on the provider.
- **Audit Data Response Received (E7):** a response from CMS will be received.
- **Appeals Data Sent (E8):** the E8 transmission is sent any time there is a change in the status of an Appeal being conducted on the provider's behalf.
- **Appeals Data Response Received (E8):** a response from CMS will be received.

Payment Calculation

For Eligible Professionals, the determination of the payment is very straightforward. The *Payment Calculation* page displays the payment amount and any Adjustment or Recoupment that has occurred. For the first year, the payment for an Eligible Professional has been established by CMS at $21,250. Pediatricians can qualify for a reduced payment at a lower eligibility threshold, and this is the only variance.



Last Updated: 7/31/2013 3:39:30 PM

Provider has been selected for Audit

Payment Amount	Payment Date	Payment Number	Payment Type	Processed By
-$7,083.00	07/31/2013		Adjustment	acsopsAK
-$25,750.00	07/31/2013		Recoupment	acsopsAK
$4,500.00	07/25/2013		Adjustment	AcsAdminAK
$21,250.00	08/15/2012	20121120114220001	Payment	JCagle

Your Total Adjustment Amount :	($2,583.00)
Your Incentive Payment Amount :	$0.00
Your New Incentive Payment Amount :	($7,083.00)

In this example, the provider has been selected for Audit. The message will appear on all *Provider Information* pages if the provider has been selected for Audit, including the *Provider Information* pages for other Payment Years.

Hospital payment calculations are complex, and the page displays year-to-year growth rates, discharges, amounts, bed days, the Medicaid share of patient encounters, and all other pertinent information. If a Recoupment or Adjustment affected the payment, that will be reflected here as well.

Last Updated: 3/2/2012 4:0

Growth Rate

	Year 4	Year 3	Year 2	Year 1	
Discharges	9,246	9,147	8,595	8,861	
Total Discharges	8,861				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Average Annual Growth Rate**
Growth Rate	N/A	-1.07 %	-6.03 %	3.09 %	-1.34 %

Initial Amount

	Year 1	Year 2	Year 3	Year 4
Annual Discharges w/growth factor	8,861	8,742	8,625	8,509
Disallowed Discharges	1,149	1,149	1,149	1,149
Allowable Discharges	7,712	7,593	7,476	7,360
Per Discharge Amount	$200	$200	$200	$200
Discharge Related Amount	$1,542,400	$1,518,600	$1,495,200	$1,472,000
Base Amount	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Growth Amount	$3,542,400	$3,518,600	$3,495,200	$3,472,000
Transition Factor	1.00	0.75	0.50	0.25
Annual EHR Amount	$3,542,400	$2,638,950	$1,747,600	$868,000
Overall EHR Amount	$8,796,950			

Medicaid Share

Medicaid Inpatient Bed Days	2,318
Medicaid Managed Care Inpatient Bed Days	0
Numerator	2318
Total Inpatient Bed Days	33,317
Total Hospital Charges	$441,081,546
Total Charity Care Charges	$14,423,705.00
Denominator	32227.50
Medicaid Share	7.19
Aggregate EHR Incentive Amount	$632,500.71
Payment Amount	$316,250.36

Attachments

The *Attachments* page allows State users to access all the files that were attached to a selected provider's attestation. Beneath the provider's name and information, the attachments are listed in a table with four columns:

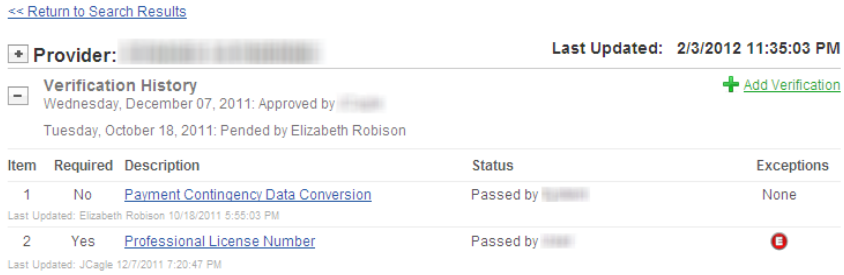
- **Section** column: indicates the page or step in SLR where the file was attached.
- **Subject** column: displays the subject selected on the *Manage Files* component to identify the document. This subject was selected by the user who uploaded the file.
- **Description** column: displays the description.
- **Date Added** column: the date the file was uploaded into SLR.
- **Filename** column: the name of the file. The filename also serves as a link to open and view each file in a separate window.

Section	Subject	Date Added	Filename
Eligibility Documentation	Practice Management Report	8/8/2011	SARHA EHR REPORT.pdf
Attestation Of EHR Adopt Documentation	Vendor Letter	8/8/2011	BS.pdf
Attestation Of EHR Adopt Documentation	Vendor Letter	8/8/2011	BS.pdf
Signed Attestation	Signed Attestation Agreement	8/8/2011	[redacted] attestation.pdf

Verifications

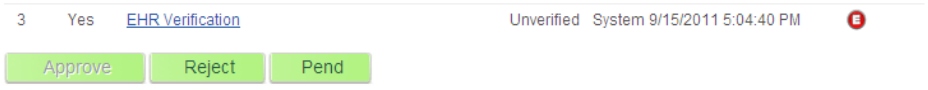
This section allows State users to review and approve attestations submitted to the State. The Verification option will not appear in the Navigation Menu until an application has completed Step 2 of the attestation process. When approving an attestation, a State user will view each Verification Item that the State has established, add a note to each, and then approve, pend, or reject the item. The State will also decide whether to make each item required.

The items in the list are configurable by the State, and a State user can add to the Verification Items at any time. This way a necessary item will not have to wait for a new SLR system deployment and can be added right away.



Verification Item List page: this opens when the **Verification** link in the *Navigation Menu* is selected. It contains six columns:

- **Item:** the number of the item.
- **Required:** indicates whether the item is required to be passed before the attestation can be approved by the State.
- **Description:** the title of the Verification item. Clicking on the link in this column will open the *Verification Detail* page.
- **Status:** shows the status of the Verification item, which will generally be Unverified or Passed by User.
- **Exceptions:** some of the verification items are associated with an exception check, such as a soft stop. If a soft stop or other exception occurred on a page of that provider's attestation, an icon is displayed, and a special Verification Item to deal with that exception will appear.



The page also has six controls:

- **Add Verification** link: opens the *Verification Admin* page, allowing you to add another Verification item.

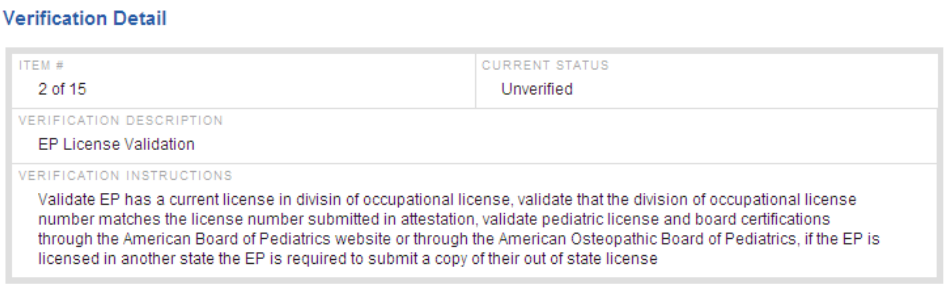
- **Provider Detail** icon: the attestation will have an icon next to the provider's name. This section will always display the latest item in the attestation's history. Clicking the icon will display the NPI, CCN, and location information of the provider.
- **Verification History** icon: this section will have a an icon allowing the user to display the history of the Verification of the attestation, including the date and user that passed or failed a Verification Item.
- **Approve** button: clicking this button designates the attestation as approved for payment by the State. The button will activate only when all Verifications are passed.
- **Reject** button: designates the attestation as rejected for payment by the State. In the future, this will send messages through the SLR messaging system to interested parties and initiate any appeals process that the State has established.
- **Pend** button: pends the attestation, which unlocks the application at Step 1, allowing the provider to correct or revise some information and resubmit it for approval.

Verification Admin page: opens when the user clicks the **Add Verification** link on the *Verification List* page. This page allows a State user to add a new verification item. The item will not be required by the system. The page has two fields and two controls:

- **Verification Description** text field: the title of the verification item.
- **Verification Instructions** text field: allows the user to enter instructions for State employees to review before passing or failing the verification item.
- **Save** button: saves the new verification in the system and opens the *Verification Detail* page, allowing the user to pass or fail the new item.
- **Cancel** link: cancels the operation and opens the *Verification Item List* page.

Verification Detail page: this page opens when a Verification Item is selected on the *Verification Item List* page, or when a new Verification Item is created on the *Verification Admin* page. The top of the page is a read-only section that displays information about the selected Verification Item.

- **Item #** display field: the number of the item on the *Verification Item List*, and the total number of items.
- **Current Status** display field: displays whether the item has been Passed, Failed, Unverified, etc. this field will also display the State user who engaged the status.
- **Verification Description** display field: contains the title of the Verification Item.
- **Verification Instructions** text field: displays instructions for State employees to review before passing or failing the Verification Item.



SLR Data table: if a Verification Item relates directly to data contained in the SLR system, that information and the relationship will be displayed in the *SLR Data* table.

- **Step** column: contains the Step in the SLR workflow where the information is collected or verified. In this case, the provider's Enrollment Status was not found in SLR, which means that the provider did not register with CMS.
- **Section** column: the section that the data element can be found. For example, the Enrollment Status code is checked against data received from CMS during Step 1.
- **Field** column: the field name of the data element.
- **Value** column: the value of the data element. In this case, the provider has not registered with CMS, so the field is unpopulated.
- **Exception** column: a description of the exception.

The lower half of the page has three tabs and three controls.

- **Notes** tab: contains a list of the notes that have been previously added to the Verification Item, including the time and date it was added, the user who added the note, and its text. Clicking the **Add Notes** link will open a component allowing you to apply a new note to the Verification Item:
    - **Date** display field: displays the date stamp that will be associated with the Note.
    - **User** display field: displays the user who adding the associated note.
    - **Note** text field: provides a text field to capture the text of the note added by the user.
    - **Save Note** button: adds the new note and displays it in the list on this tab.
    - **Cancel** link: removes the *Add Note* component without making any changes.
- **Attachments** tab: contains a list of files that were attached to support or document the Verification Item. The page displays the date and time the file was added, the user who added it, and the subject of the file. Clicking the subject will open the file. Clicking the **Add Attachments** link will open a component allowing you to add a document:
    - **Subject** text field: allows the user to select or enter a short description or title for the document
    - **Add Attachment** section: clicking the **Browse** button in this section will cause a *Choose File* window to appear, allowing you to browse to and select the correct file.
    - **Upload File** button: clicking this button adds the selected file to the list of Attachments. The **Notes** tab will open when the button is selected.
    - **Close** link: closes the *Add Attachment* component.

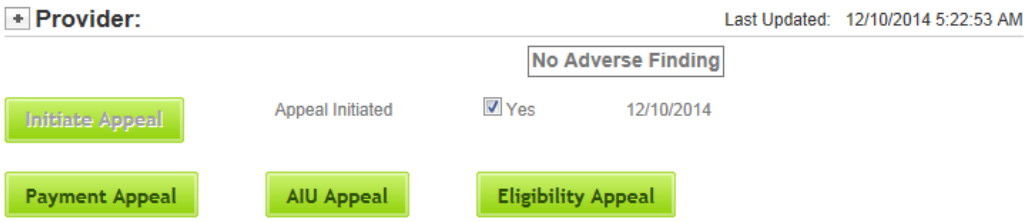
    - **Pass** button: saves the status of the Verification Item as Passed. A note must be added to the Verification Item in order to pass or fail the item.
    - **Fail** button: saves the status of the Verification Item as Failed. The **Pass** and **Fail** buttons can be clicked while viewing any of the tabs.
    - **Verification History** tab: displays the time, date, and user for each change in status made to the Verification Item.
- **Return to Verifications List** link: re-opens the *Verification Items List* page.
- **Approve** button: located on the *Verification Item List* page, the **Approve** button will activate when all the verifications on a single attestation submission have been passed by a State user. It will remain inactive if the provider has already been paid, or the verification process has not yet been completed for the provider. Once this is selected, the attestation will have a status of Submission Approved. After that, the State user will release the submission to CMS so that CMS will be notified and the payment process will begin.
- **Reject** button: this will reject the attestation. At this point, the account is locked. The State user will release the submission to CMS, at which point a transmission is sent to CMS's EHR Incentive Payment system identifying the provider as not eligible for payment, including the rejection reason and code.
- **Pend** button: selecting this button will pend the application, allowing the State employee to work with the provider to correct information or resolve any problems with the attestation. The Verification Items are locked, though the history of each is retained. The attestation form is deleted and will have to be re-submitted by the provider, and the attestation itself is restarted at Step 1 (*About You*) of the process. All data the user entered will still populate the attestation.

Appeals

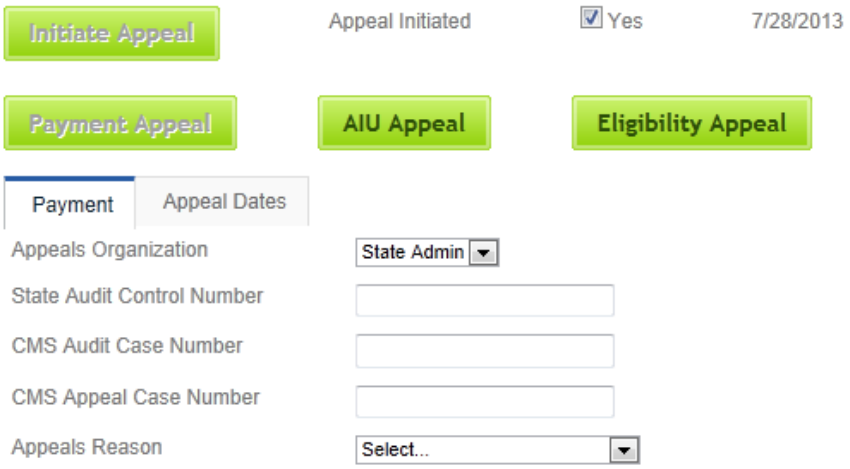
An appeal is a petition by a provider to change a decision made by a State user or Auditor. The rules and details follow guidelines established by CMS and are enforced at the State level. Some of the Attestations submitted through the SLR system will be found to be below the minimum threshold for payment and will be rejected. State users can document up to three levels of appeals in the SLR Dashboard. The details of the Appeal process, including the names of the three levels of Appeals, are determined by each State.

Note: All clients currently have automatic notifications to providers turned off, so all communications with providers are handled by the state. this is true of Appeals, Recoupments, and Adjustments.

When a provider is denied an EHR incentive payment , they will be notified of their right to appeal. After selecting a provider, click the **Appeals** button on the Navigation Bar. Clicking the **Initiate Appeals** button on the *Appeals* page will reveal three Appeal Types: **Payment**, either **AIU** or **MU**, and **Eligibility**. Clicking one of these buttons will start the appeal.



Depending on which option the provider is using on the Attestation, either an **AIU** or an **MU** button will appear on the page. Once initiated, the **Appeal Initiated** date field will appear on the page. The user can change this date or the Appeal Completed date after the Appeal is selected. This is to ensure that the Appeals process followed by the state is accurately documented in SLR.

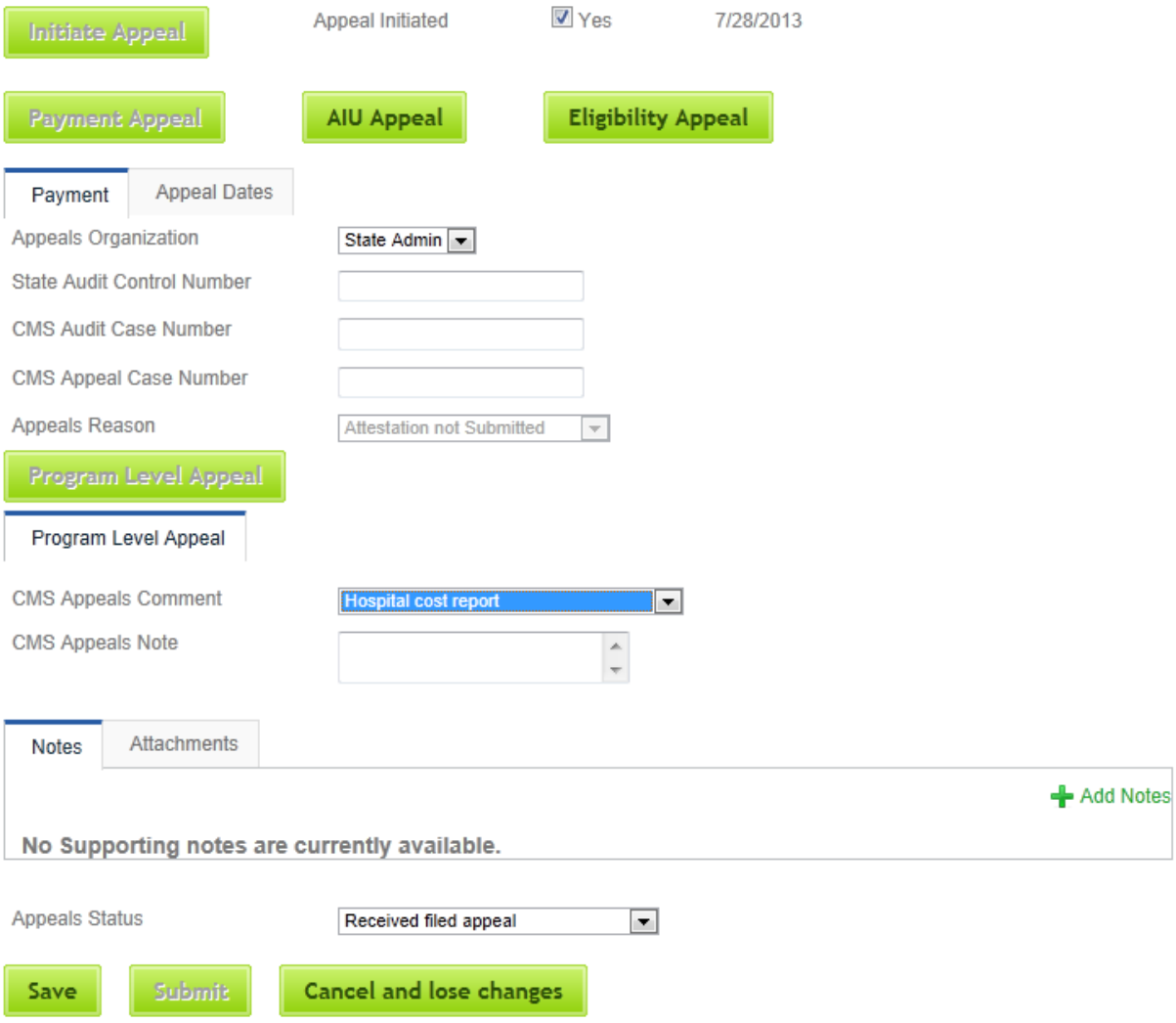


The Appeal Types all have the same fields and controls. Once an Appeal type is selected, the following fields will appear:

- **Appeals Organization** pull-down menu: this will default to the *State Admin*, option, and the choices are determined by the State.
- **State Audit Control Number** display field: this will display the Audit Control Number assigned to the Attestation if the State has initiated an audit and assigned a number. The field will be blank if an audit has not been initiated.
- – blank and read only if the provider has not had an audit initiated and an audit control number recorded through the dashboard audit functionality
- **CMS Appeal Case Number** display field: this is populated when the CMS E8 interface file is sent for the provider.
- **CMS Audit Case Number** display field: this will display the Audit Case Number assigned to the Attestation by CMS, and received by SLR through the E7 interface.
- **Appeals Reason** pull-down menu: allows the State user to select the reason for the Appeal.

- Attestation Not Submitted
- Attestation Rejected by State
- Payment was Recouped
- Payment was Adjusted

Once the **Appeals Reason** menu is populated, the user can initiate the Appeal Level. The names of the Appeal Levels are determined by the State. By default, these are Informal Review, Judiciary Review, and Final Determination. Click the **Appeal Level button**, and the Level-specific fields will be displayed. These are the same across the three Levels of Appeals.



- **CMS Appeals Comment** pull-down menu: allows the user to select the point or stage that the Appeal is currently at. Each selection will be recorded in the system so that the various stages are documented.
  - <Select>

- Additional Documentation Requested
- Additional Documentation Received
- Additional Documentation Not Received
- Amendment Filed
- Deadline Missed
- Inchoate
- Hospital Cost Report
- Precluded by Statute
- Non Permissible
- Extension Requested
- Extension Granted
- Extension Denied
- Ability to Re-file
- No Ability to Re-file

- **CMS Appeals Note** text field: allows a user to record appeal notes for transmission to CMS in the E8 interface. Up to 100 characters can be entered in this field.
- **Notes** and **Attachments** Tabs: Appeals have a component that allows State users add Notes and Attachments to the respective pages. These will be associated with the specific Appeal Level selected. The component works the same as other Notes and Attachments components used on other pages in the Dashboard, such as the Audit and Verification pages.
- **Appeals Status** pull-down menu: allows a user to finalize the Appeal.
    - Received filed appeal: this will keep the Appeal Level and all its fields active.
    - Appeal dismissed with prejudice: this status indicates that the provider may not re-file the appeal as it has been found to be without merit.
    - Appeal dismissed without prejudice: this this will keep the Appeal Level and all its fields active, as the provider could refile the paperwork.
    - Appeal denied: This status indicates that the provider may re-file the appeal with the next level in the defined appeals process. If this is selected from the third Appeal Level, no more Appeals are allowed.
    - Appeal upheld: disables the Appeal Level and all its fields, and grants the provider the Appeal. This may initiate an adjustment.

Initiating Adjustments

Once an Appeal is completed, an Adjustment may be created automatically. If Appeal Upheld is selected from the Appeal Status pull-down menu, and "Payment was recouped was selected from the **Appeals Reason** pull-down menu, the adjustment is created to offset the Recoupment.

Save, Submit, or Cancel

Only one Appeal can be active at one time. It is considered “active” if the Appeal has been initiated, but has not yet been submitted or cancelled.

- **Submit** button: this will open the *Confirm Appeal* window, enabling a State user to designate the Appeal completed for this Appeal Level of the Payment Year.
- **Save** button: This allows the user to start the Appeal and finish it during another session.
- **Cancel and lose changes** button: this will open a confirmation pop-up allowing the State user to cancel the Appeal. Once cancelled, the **Initiate Appeal** button is reactivated.

Audits

Audits are designated on attestations by State users, and a single attestation could undergo several simultaneous or consecutive audits.

- **Risk Profile** pull-down menu: this is applicable to all audits in general, and is specified for the provider.
- **Mark for Audit** button: this allows a State user to designate the attestation for audit. The audit is not initiated at this point. It is put into the queue of attestations that will potentially be audited. Attestations can be designated as marked for audit using this button or by using the Mark for Audit feature on the Provider List. The **Initiate Audit** buttons will appear after an Attestation is marked for audit.
    - **Initiate Financial Audit** button: initiates a financial audit.
    - **Initiate Eligibility Audit** button: initiates an audit of patient volume and other eligibility information, such as the licensure of the provider.
    - **Initiate MU Audit** button: either this button or the Initiate AIU Audit button will appear, depending on which one was used by the provider as their Attestation Type. The Meaningful Use audit will investigate the Objective and Clinical Quality Measures that the provider reported.
    - **Initiate AIU Audit** button: there are four types of audits, though there will only be three types available to assign to a provider. The AIU audit is available to assign to a provider only in the first Payment Year, and only if the provider chose AIU as their Attestation Type. After the first payment, only the MU audit will be available, as the provider will not have the option for AIU in his or her second year.

Selecting an **Initiate [x] Audit** button will reveal a tab corresponding to that choice. The **Audit Dates** tab will accompany any or all other Audit Type tabs. Once initiated, the Audit can be cancelled, but cannot be restarted. If users wish to perform another audit of the same Audit Type, then they will use the second Audit Method. A user can initiate an Audit only once per Audit Type. After a cancellation, the auditor will use an additional Audit Method used.

Audit Type Fields

Fields common to all Audit Types include the following:

- **Audit Organization** pull-down menu: currently this contains only one option, State Auditor, but the field is fully configurable.
- **State Audit Control Number** text field: allows an auditor to enter the audit number provided by the State to the attestation.
- **CMS Audit Case Number** display field: in a future release, this will be returned by CMS and is a tracking number used by CMS to catalog the audit.
- **Reason for Audit** pull-down menu: contains a number of options that are specific to each State.
- **Audit Note** text field: when Audits are initiated, the reason that the audit is being begun should be recorded as a note. Audit Notes are 250 characters in length.

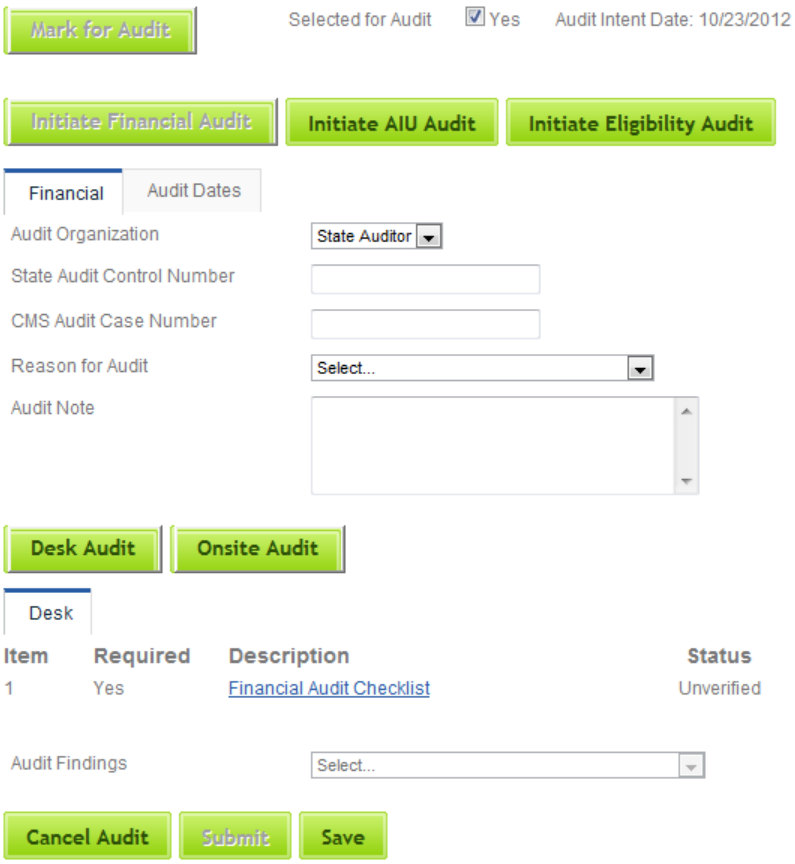
The Audit cannot proceed without an Audit Method being selected, as this determines which Audit Checklist items need to be completed in order to finish the audit.

Audit Dates Tab

This tab will appear whenever any audit is initiated and it's method is selected. It will display the date the attestation was first marked for audit, and give the initiated, completed, and/or cancelled date of each audit performed on the attestation.

Audit Methods

Each State will determine the number of Audit methods available for each Audit Type. For most States, there are two methods: Desk Audit and Onsite Audit. Each Audit Method button will add a tab containing the Audit Checklist items associated with the selected Payment Year/Provider Type/Audit Type/Audit Method combination.



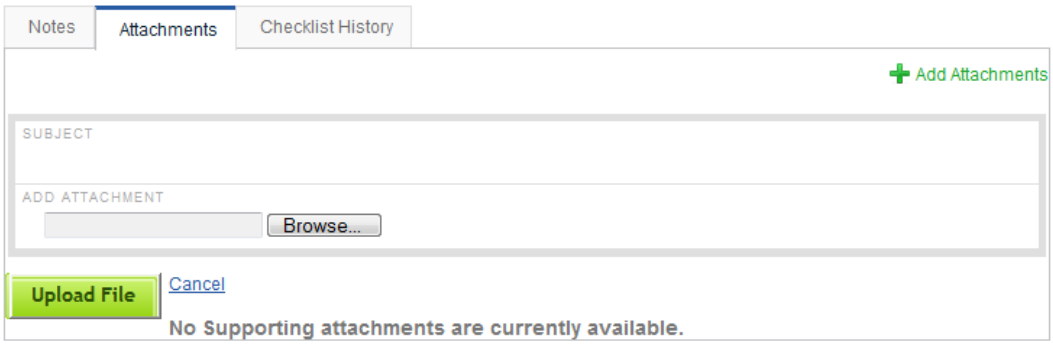
Audit Checklist Items

An audit is officially begun when one of the **Initiate [x] Audit** buttons is clicked, though an Audit Method must be selected as well. Once the method is selected, a tab will appear beneath the **Desk** and **Onsite** buttons. The audit is completed by completing the items listed here. These items will operate in basically the same way as Verification Items.

Click an item in the **Description** column to open an individual Audit Checklist item. The *Audit Checklist Detail* page will appear. This page contains the instructions that tell the auditor what is needed to perform this step of the audit. As with Verification Items, the State user must add a note and then select one of the buttons at the bottom of the page to complete the Audit Checklist item.

- **Pass** button: passes the Audit Checklist item.
- **Fail** button: indicates that the attestation has failed to pass the item.
- **N/A** button: indicates that the item is not applicable to the provider or the specific attestation.
- **Need More Info** button: this is a temporary status that indicates that more information is needed. If this status is selected, the audit cannot be completed until it is changed to another status.

The **Notes**, **Attachments**, and **History** tabs operate in the same manner as their Verification counterparts. Remember that a note must be added to pass or fail an Audit Checklist item.



Audit Method Tab

Each Audit Checklist item is specific to an Audit Type, Audit Method, Payment Year, and Provider Type combination. They will be listed on its row in a table, and operate in the same manner as a Verification Item. If all items are completed (given a status of Passed, Failed, or Not Applicable), the **Audit Findings** pull-down menu will activate.

- **Audit Findings** pull-down menu: records the finding of the Auditor for the selected Audit Method and Audit type. This can be a No Adverse Finding, which means the Audit passes the criteria established for the Audit, and at least according to this specific audit, the Attestation was valid and deserving of an incentive payment.

Or the result can be an adverse finding (such as Adverse Finding – Incentive Payment Modification), in which case the audit will prompt an adjustment or recoupment to the payment. Each Audit Type will have its group of Audit Findings. If an Adverse Finding is selected, two radio buttons will appear:

  - **Adjustment Required** radio button: this will initiate a Payment Adjustment on the provider for the selected Payment Year. Only one Adjustment can be current at one time, so an error message will appear if the **Submit** button is clicked and an adjustment has not yet been completed.
  - **Recoupment Required** radio button: this will initiate a Recoupment on the provider for the selected Payment Year, meaning all of the money sent to the provider for the Payment Year must be returned.

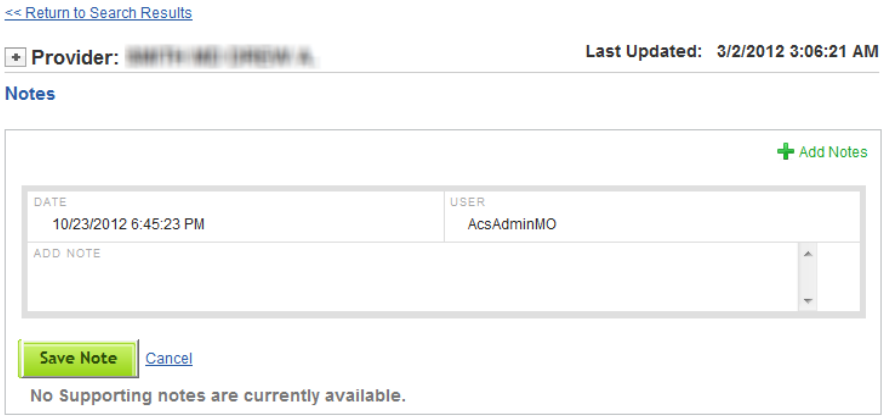
- **Cancel** Audit button: an audit is a combination of Audit Type and Audit Method, and can be cancelled at any time. If cancelled, the audit cannot be re-initiated. The Audit Cancelled Date on the **Audit Dates** tab will be populated for the cancelled audit. The user can start the other Audit Method of the selected Type if needed.
- **Submit** button: this button activates when all the Audit Checklist Items have been completed, all the required fields on the *Audit* page have been filled, an Audit Finding has been selected from the *Audit Findings* pull-down menu, and one of the **Adjustment** or **Recoupment** radio buttons has been selected if need be. This will complete the Audit.
- **Save** button: the information on the *Audit* page can be saved at any time so that a State user can come back and complete it another time.

Notes

Just as notes can be associated with individual Audit Checklist or Verification items, Notes can also be added to the attestation of a provider. The page will contain a list of the notes that have been previously added to Attestation, including the time and date it was added, the user who added the

note, and its text. Clicking the **Add Notes** link will open a component allowing you to apply a new note to the Audit Checklist Item:

- **Date** display field: displays the date stamp that will be associated with the Note.
- **User** display field: displays the user who adding the associated note.
- **Add Note** text field: provides a text field to capture the text of the note added by the user.
- **Save Note** button: adds the new note and displays it in the list on this tab.
- **Cancel** link: removes the *Add Note* component without making any changes.



Recoupment and Adjustments

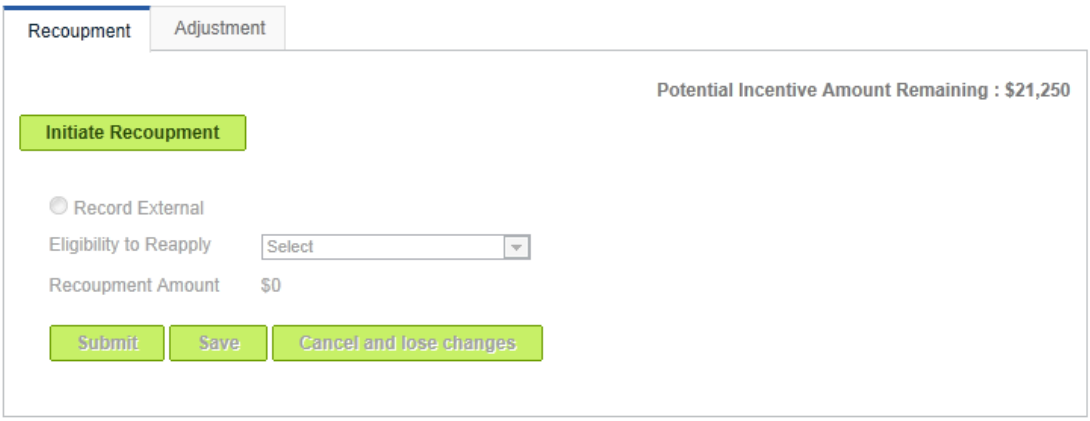
The Recoupments and Adjustments component in SLR allows State Users to reverse or adjust payments made by their State to providers in the EHR Incentive Program. Currently, Recoupments and Adjustments are recorded in SLR but are assumed to be executed outside the system, using the State's financial system. SLR will update CMS on the Recoupments and Adjustments made on an Attestation using the E8 interface.

An Adjustment in SLR is an official change in the payment amount of a provider's EHR Incentive payment. It can be positive or negative, depending on the results of a post-payment audit. A Recoupment is a return to the State of the full amount paid to the provider.

The Recoupment and Adjustment pages are be accessed after a provider is selected and the Recoupments and Adjustments option on the navigation bar is clicked. The two processes are separate and only one Adjustment or Recoupment can be active at one time. If an Adjustment has already been initiated, the *Adjustment* page will display, and the **Initiate Adjustment** button will be disabled. Otherwise the *Recoupment* page opens by default.

Recoupments and Adjustments have a component that allows State users add Notes and Attachments to the respective pages. These will be associated with the Payment Year selected. The component works the same as other Notes and Attachments components used on other pages in the Dashboard, such as the Audit and Verification pages.

Note: If a State user has approved an Attestation, it is treated as if the Attestation was already paid, even if the payment has not yet been processed. The Approval of an Attestation is the point of no return. After an Attestation's approval, it must be adjusted as it can't be withdrawn.



Recoupments Tab

A Recoupment is the return of all money from the provider to the State for a selected Program Year if an EHR Incentive payment was incorrectly awarded. For example, a Recoupment will be made if the patient volume numbers were incorrect on the Attestation and the provider did not actually have to necessary 30% Medicaid patient volume needed to receive the payment.

The State user will indicate on the *Recoupment* page whether the provider is eligible to reapply. If the provider is eligible to reapply for the Incentive payment, the recoupment negates the Payment Year. For example, if the provider's first year is recouped, the provider can apply the next year for their first Payment Year as if the first attestation never happened.

Additionally, the stage that the provider is at will be re-determined if one of their years is recouped. For example, an EP has submitted three years of attestations and was approved and paid for each one. A State auditor then audited the Year 2 attestations from that state and found a mistake in the provider's Attestation which dropped the provider below the 30% needed to qualify for a payment.

The provider's Year 2 attestation is recouped by the state and the provider is now considered to have completed two years and not three. The provider would have gone to Stage 2 of Meaningful Use reporting at her next Attestation, but since she was recouped, her next attestation will be another Stage 1 of MU.

Initiating a Recoupment

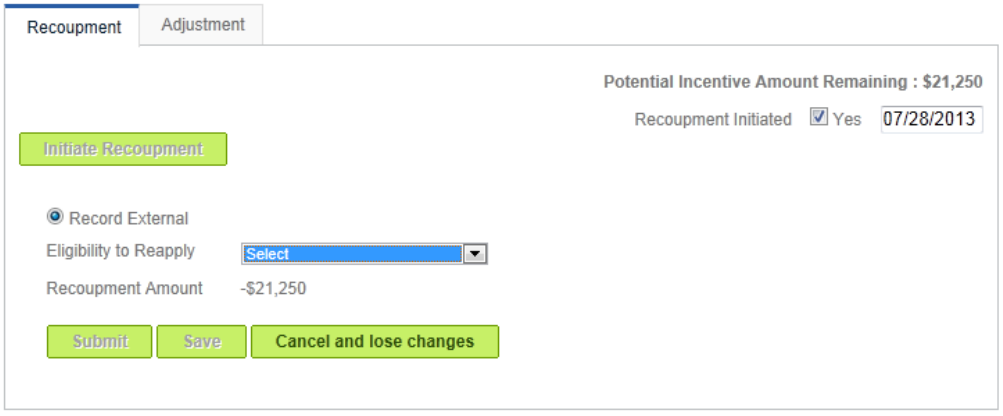
The **Initiate Recoupment** button is enabled only if the attestation has a status of Payment Complete. Once started, the Recoupment can be saved, submitted to the system, or cancelled, but only one Recoupment or Adjustment can be active at one time.

Once the **Initiate Recoupment** button is selected, a message indicating the date the recoupment was started is displayed. If the recoupment was initiated by selecting the **Recoupment Required** radio button on one of the audit tabs, the associated button on this page will already be selected. The **Recoupment Initiated** date field is editable so that it can be synchronized with your state's financial system.

Potential Incentive Amount Remaining display field will display the amount of money still owed to the provider under the EHR Incentive Program. This is the total overall amount of the Incentive Payment subtracted by any amount already paid. Recoupments and negative adjustments will restore some of the amount. The field should reduce errors over time, as this field combined with the Payment Year gives a state user a method of knowing the ballpark figure owed to the provider.

SLR communicates Recoupments and Adjustment information to CMS through the E8 interface. When a Recoupment or Adjustment is initiated, edited, or cancelled, completed, CMS will be notified of the change to the associated provider.

The **Recoupment Amount** field shows the entire payment amount for the selected Program Year, and is display only. Click the **Record External** radio button to enable the **Eligibility to Reapply** pull-down menu. "record External in this case means that adjustment was made and processed externally to SLR, and the state user is recording it for the purpose of reporting the adjustment in the D18 sent to CMS.



Program and Payment Years

The recoupment amount will be processed by the state as a negative amount by their payment process, and will be documented in both SLR and at CMS. By the definition of a Recoupment, the full amount of the payment for a particular year will be collected from the Provider. If the

Recoupment is completed, the **Initiate Recoupment** button will not be re-enabled for the same Program Year, as the money can be collected only once.

A following calendar year will replace the recouped year. The system ensures that when a Recoupment is made, any Payment Year change will be applied to the next year. If a provider had their Year 1 recouped, the provider can choose to do AIU again, provided their next Attestation has not already been approved. If one attestation is recouped, and the next Payment Year has already been approved, the provider will not be able to change their AIU or MU method

Most EPs Year 3 (or more) payment will be equal to the Year 2 payment, so if the Year 2 is recouped, the Year 3 will simply be assigned to be Year 2 in the process. For Pediatricians, the Year 3 (or more) payment might be different from the recouped payment, and an Adjustment will be created.

Recoupments Can Initiate Adjustments

For EPs, the yearly payments are all the same after Year 1, so no Adjustment is needed when moving from Year 2 to Year 3. An Adjustment for Year 2 will be needed when Year 1 is recouped. The Adjustment is the delta between what the Payment should be and what was actually paid.

For EHs, a recoupment is more complicated because it will change the Allocations established for the Payment Years of a provider, so the following yearly amounts will have to be increased. The Payment Year will be reset and the Payment Amount for each year will be recalculated based on the year of Attestation, which will create adjustments for future years. If an EH recoupment is initiated for Year 1 and a new Attestation has been created, submitted, and paid, a new Payment Amount will be recalculated, and an Adjustment will be initiated for the second attestation's payment.

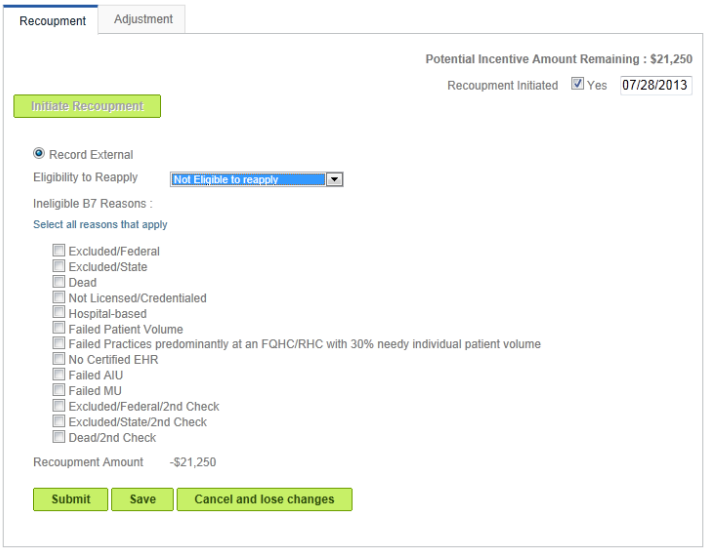
Eligible to Reapply

Once the **Record External** radio button is clicked, the **Eligibility to Reapply** pull-down menu will activate, and the field is required. This has two options, and determines whether the provider can continue in the EHR program or not. Once an option is selected in the menu other than <Select>, the **Submit** button will activate.

- Not Eligible to reapply means the provider is ineligible for the EHR Incentive program. If this option is selected, the provider will be prevented from creating an account in SLR in all years. A D18 will be sent to CMS.
- Eligible to reapply means the provider can continue in the program and will be restored to eligibility. For example, a provider was paid for three program years, and the last was recouped. This provider would begin in Payment Year 3.

Once an option is selected, a series of checkboxes will appear. These are the Ineligible B7 Reasons and there is a difference between “Ineligible” and “Not Eligible”. “Ineligible” refers to the reason why a provider was found to be ineligible for a particular year and was recouped for that year. “Not Eligible to Reapply” means a permanent ban from the EHR Incentive program. Eligible to Reapply means a provider is eligible to submit future years attestations.

Example: A provider who attested as AIU was paid an payment of $21,250 in 2011 and the State later determined provider should not have been paid, but is eligible to reapply. Payment needs to be recouped for 2011 and the 2012 attestation needs to allow the provider to apply for AIU and receive the full $21,250 amount. This works like the Canceled-Expired process that shuts down an open attestation when the grace period ends and re-enables the same Payment Year for the next attestation.



State users may select as many **Ineligible B7 Reasons** checkboxes from the list as they wish. Valid values for the pick list are all defined CMS values that are valid for the appropriate Provider Type.

Pending an Attestation

If an Attestation is recouped and the Payment Year following the recouped year has already been submitted by the provider, the Attestation is pended so that the demographic data can be re-entered. This is especially important for EHs. New yearly reports will have been generated since the recouped Attestation was first calculated, so a new set of numbers will contribute to the new calculation.

System Notes

If the user clicks the **Submit** button and a Payment Year was reset, the system will create a note in the **Notes** tab at the Attestation level added to the attestation for which the Recoupment was created. The note will read: “One or more of the provider’s Payment Years was changed due to the recoupment.” The user will be the user who initiated the recoupment, and the date/time will be captured as well.

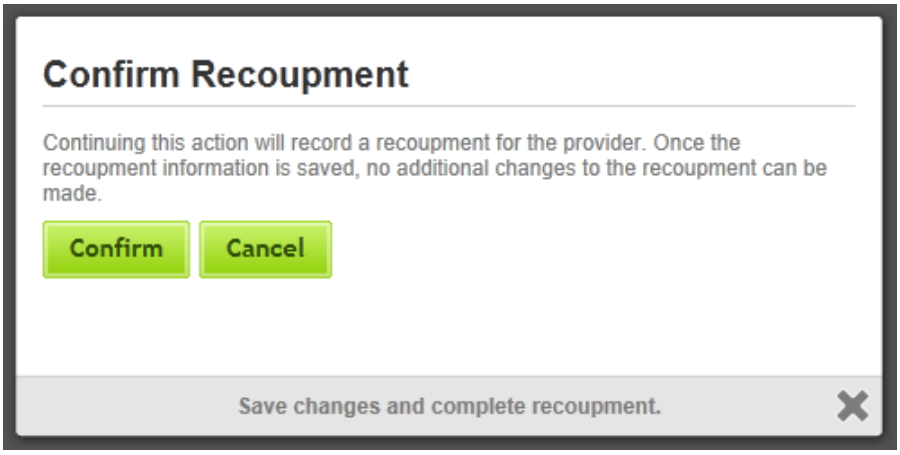
If the user clicks the **Submit** button and a Pend is initiated, the system will create a note in the **Notes** tab at the Attestation level that communicated the reason for the Pend was a Recoupment. The note will read: “The Provider’s Incentive Payment was recouped for the previous Payment Year, and this caused the attestation for this Payment Year to be pended.” The user will be the user who initiated the recoupment, and the date/time will be captured as well.

The Recoupment will be documented at the bottom of the *Recoupment* page and on the *Payment Calculation* page. This will include the date, amount, and user that completed the Recoupment.

Save, Submit, or Cancel

Only one Recoupment or Adjustment can be active at one time. It is considered “active” if the Recoupment or Adjustment has been initiated, but has not yet been submitted or cancelled.

- **Submit** button: this will open the *Confirm Recoupment* window, enabling a State user to designate a recoupment for this provider and Program Year. Only one recoupment can be initiated per program year.
- **Save** button: this will activate when a selection is made in the **Eligibility to Reapply** pull-down menu. This allows the user to start the recoupment and finish it during another session.
- **Cancel and lose changes** button: this will open a confirmation pop-up allowing the State user to cancel the Recoupment. Once cancelled, the **Initiate Recoupment** button is reactivated.



Note: When the **Submit** button is selected, an error will be displayed if the Recoupment would create an Adjustment for the provider in the same Payment Year an Adjustment was already initiated. The previous Adjustment must be submitted or cancelled before a new one can be initiated.

Adjustment Tab

An Adjustment is a change in the amount of the Payment for a given Payment Year. If the patient volume for an EP rises because the user entered the information incorrectly, a Pediatrician might qualify for a higher payment, or might qualify for a payment but receive a lower amount. Different Medicaid demographic numbers for Hospitals will cause the payment to be recalculated. When this is recalculated, the payments made during all Payment Years will be recalculated. Payments made in previous years will be adjusted up or down, but unlike Recoupments, the Payment Year will stay the same for adjusted years.

Adjustments are not connected to an Audit or the Appeal, but could be initiated by a user as a result of the Appeal, Audit, or other action. There is no connection between a recoupment and an appeal that we are tracking other than a note if a user leaves one on the Attestation when creating the Adjustment. Adjustments independent of Audits or Appeals could be used by State users for error correction.

Initiating the Adjustment

Submitting an audit with a selection of Adjustment Required will initiate the adjustment, but it is up to the user to complete it. The **Initiate Adjustment** button is displayed only if the attestation has a status of Payment Complete. Once Started, a message indicating the date the adjustment was started is displayed. If the adjustment was initiated by selecting the **Recoupment Required** or **Adjustment Required** radio buttons on one of the audit tabs, the associated button on this page will already be selected. An adjustment can be initiated at any time.

Once initiated, the user will select the **Record External** radio button, which in this case means that adjustment was made and processed externally to SLR, and the State user is recording it for the purpose of reporting the adjustment in the D18 sent to CMS. Adjustments do not require a D16.

The **Adjustment Initiated** date field is editable so that if the Adjustment was created prior to the date entered in the Dashboard, it can be changed. Once the Adjustment has been initiated, the **Initiate Recoupment** button is disabled. If the Adjustment is canceled or completed, the **Initiate Adjustment** button is re-enabled. Any number of Adjustments can be completed on a single Attestation, but an Adjustment must be completed before another one is started for the same year. If users have already submitted the Adjustment and then find out that there are changes that need to be made, they will initiate a new adjustment.

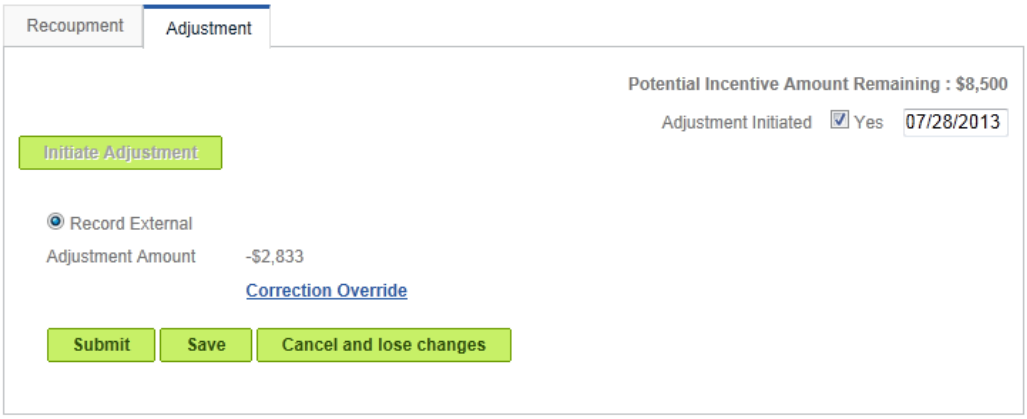
EPs

Adjustments for EPs and EHs are very different. Adjustments are likely more prevalent among EHs, but there are five scenarios that are likely to occur among a State's EPs, four of them involving Pediatricians:

- A pediatrician is found to have a 20% volume instead of a 30% volume in Year 1, which results in a decrease from a full payment to a Pediatrician payment
- A pediatrician is found to have a 20% volume instead of a 30% volume in Year 2.
- A pediatrician is found to have a 30% volume instead of a 20% volume in Year 1, which results in an increase from a Pediatrician payment to a full payment.
- A pediatrician is found to have a 30% volume instead of a 20% volume in Year 2.
- Full payment amount (as a result of a Recoupment that is successfully appealed.

Any EP payment year can be adjusted independently of any other year. The **Adjustment Amount** field will prepopulate with the calculated amount of the adjustment between the full incentive payment amount and the reduced amount for pediatricians as a read-only value.

- Year 1 (+/-) $7,083
- Years 2 – 6 (+/-) $2833



A **Correction Override** control will appear below the **Adjustment Amount** field. This will allow a user to override the auto-calculation of the adjustment amount. When the **Correction Override** button is clicked, the **Adjustment Amount** display field is replaced by an **Adjustment Amount** dollar field. The user can enter any amount they wish in the Adjustment Amount dollar field, and indicate if the amount be positive or negative.

The **Correction Override** control may not appear for all users, as only a few will have Permission to use it. It is used to correct a mistake or to reverse a Recoupment, which may be done after a successful Appeal.

EH

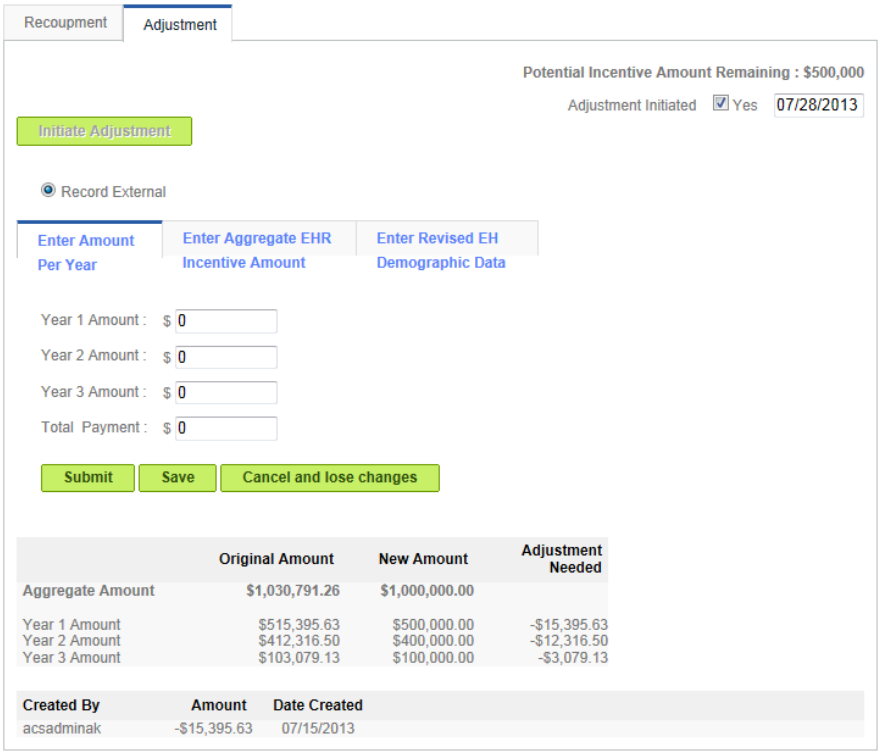
When the Record External radio button is selected, three tabs will appear:

- **Enter Amount per Year**
- **Enter Aggregate EHR Incentive Amount**
- **Enter Revised EH Demographic Data**

Each of the tabs has an associated permission. The number of Payment Year fields may be different for different States. For example, some States distribute EHR Payments over three years, and others over four years.

Enter Amount per Year

This page contains three or four **Year [x] Amount** dollar fields, and a **Total Amount** display field. The state user will simply enter the positive or negative amount of the payment that will be made to the EH for each year, and multiple adjustments will be created when the Submit button is clicked.



After entering a dollar amount into each **Year [x] Amount** field, click the **Save** button. The Incentive Program's **Total Incentive Amount** will be shown in the field, and the differences will be shown in the table beneath the buttons. The amounts in the Adjustment column are calculated by the system, and show the change between the original amount and the newly entered amount for each year.

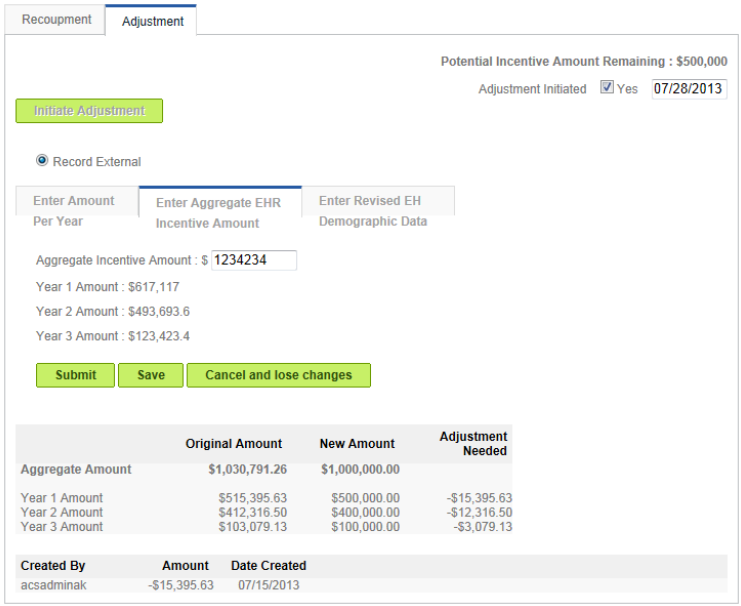
There are statutory rules that are enforced on the fields when the Adjustment is submitted. If an EH attestation is on Payment Year 1, then the payment for any one year can't be greater than 50% of the total. If the attestation is on Payment Year 2, then the payment for 2 years can't be more than 90% of the total. For most States the Allocation Percentage is 50-40-10 across three Payment Years. Montana currently has a 50-30-10-10 distribution, and will have one more Year field than the other states. Alabama currently has allocation percentages of 50-30-20.

Enter Aggregate Amount

The **Aggregate EHR Incentive Amount** tab is the reverse of the previous tab. The user enters the total amount that will be paid to the hospital through the EHR Incentive Program in the **Aggregate Incentive Amount** field. SLR will allocate the correct percentage to each year based on that state's allocation percentages.

After entering a dollar amount into the **Aggregate Incentive Amount** field, click the **Save** button. The amount allocated to each Payment Year will be shown in the display fields, and the table

beneath the buttons will show the Adjustments that will be created when the **Submit** button is clicked.



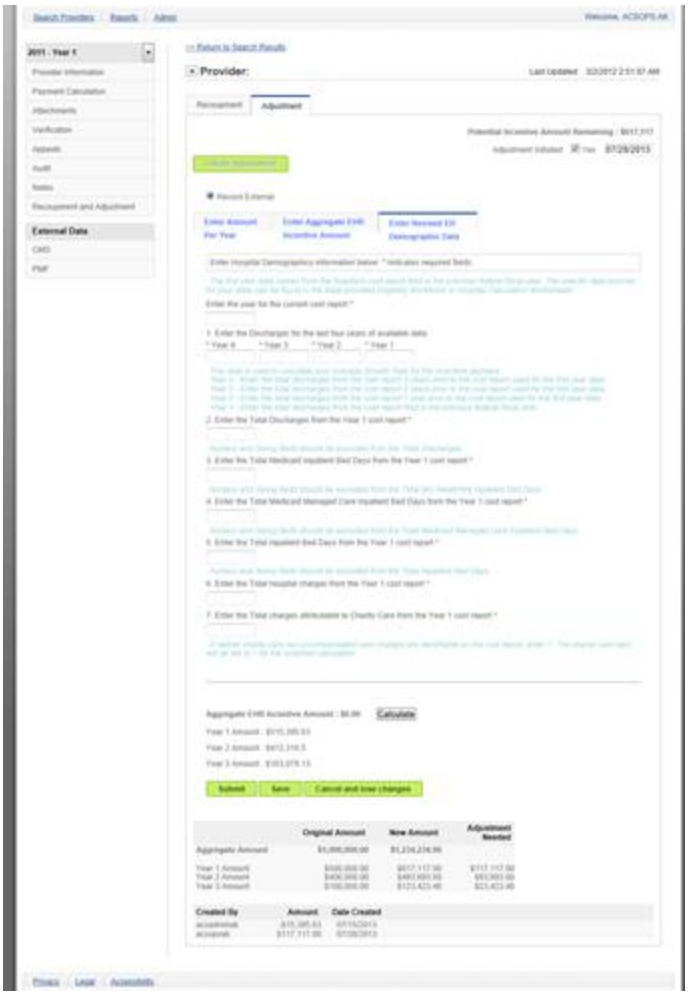
The same statutory rules enforced on the *Enter Amount per Year* page is submitted are enforced for this page as well.

Enter Revised EH Demographic Data

This page contains all the demographic fields that are on the Step 2 page that EH providers use in SLR. It allows a State user to re-enter the data for a Hospital, which then recalculates the yearly payments made to the Hospital and the Adjustments needed as a result of the change in Total Incentive Payment.

For example, a 2012 Cost Report establishes the payment that will be made to a Hospital. The 2013 Cost Report causes the provider to submit revised data, and this changes the overall payment amount.

Clicking the **Calculate** button will refresh the page and the amount allocated to each Payment Year will be shown in the table beneath the buttons. The table will also show the Adjustments that will be created when the **Submit** button is clicked.



System Notes

The Adjustment will be documented at the bottom of the *Adjustment* page. This will include the date, amount, and user that completed the Adjustment. The most recently entered adjustment will be displayed at the top, with the next earliest adjustment beneath it. Each adjustment will also appear on the Payment Calculation page.

Save, Submit, or Cancel

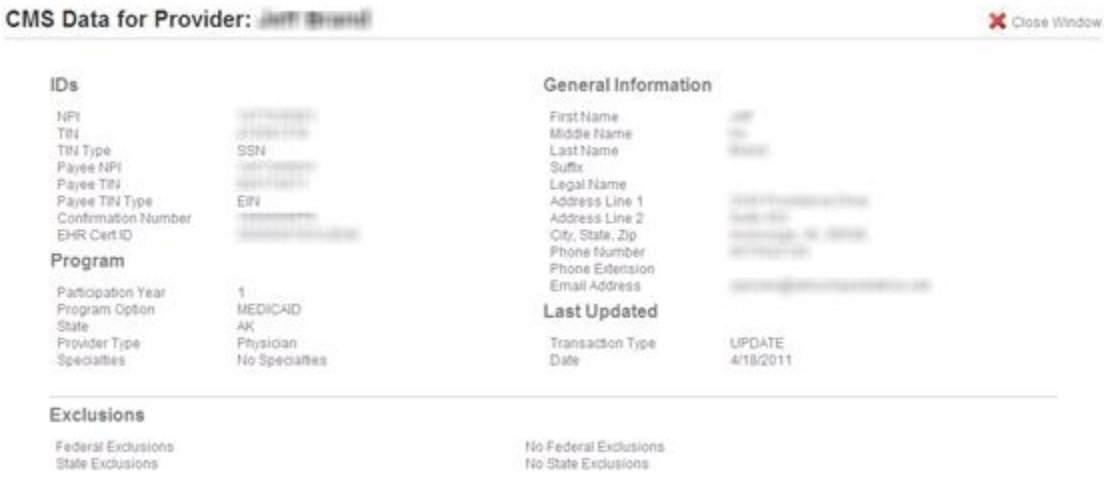
Only one Recoupment or Adjustment can be active at one time. It is considered “active” if the Recoupment or Adjustment has been initiated, but has not yet been submitted or cancelled.

- **Submit** button: this will open the *Confirm Adjustment* window, enabling a State user to designate an Adjustment for this provider and Program Year.
- **Save** button: this will activate when a tab is selected for an EH provider, or will be available by default. Saving will save the information in the fields so that a State user can complete the Adjustment during a future session. The **Initiate Adjustment** button will reactivate, as multiple adjustments are available for each Attestation.
- **Cancel and lose changes** button: this will open a confirmation pop-up allowing the State user to cancel the Recoupment. Once cancelled, the **Initiate Recoupment** button is reactivated.

Note: Once an Adjustment is initiated, it must be completed or cancelled before another can be started.

External Data

CMS link: this option displays information in SLR that has been received from CMS. Data is received from CMS at least twice for each provider: when provider first registers with SLR and then again after attestation. Updates are also sent from CMS on a regular basis.



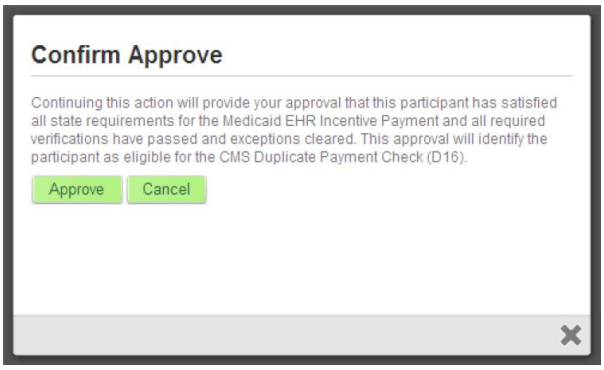
PMF link: this option displays the information contained in SLR that was provided by the State's Provider Master File. This information is sent to SLR from the State and is updated on a weekly schedule.

Approve, Reject, and Pend

State users will approve, reject, or pend EHR Incentive Payment submissions on the *Verification* page of a selected provider's attestation.

Approve

This action designates the attestation submission as approved. A State user will still have to release the information to CMS using the *Release to CMS Search* page to ensure there are no duplicate payments or State or Federal exclusions. When the **Approve** button is selected a confirmation pop-up will appear.



Select the **Approve** button to designate the attestation as approved. At this point, the attestation will have a status of Submission Approved. Select the **Cancel** button to return to the *Verification* page. At this time no messages will be sent through the system's messaging component.

Reject

This action designates the attestation as rejected by the State. A State user will still have to release the information to CMS using the *Release to CMS Search* page, to inform CMS of the State's decision. When the **Reject** button is selected a confirmation pop-up will appear.

Select the **Reject** button to designate the attestation submission as rejected. At this point, the attestation submission will have a status of Submission Rejected and the reject code will be State Rejected. Select the **Cancel** button to return to the Verification page. At this time no messages will be sent through the system's messaging component.

Pend

This action is used when a State user wishes to help the provider clarify or update information in their attestation submission. When the **Pend** button is selected a confirmation pop-up will appear.

When a State Representative selects the **Pend** button on the confirmation pop-up, the provider's submission is reopened at Step 1 of the SLR Process. The user will go through each step, review the information, and resubmit each page. All the information the provider previously entered is still in the database, but the attestation documents are deleted. The user will also need to resubmit their attestation documents. Clicking **Cancel** on the confirmation pop-up closes it, returning the user to the *Verification* page.

Suspending a Provider

When a provider is suspended, they will be prevented from making changes to any of their attestations in the SLR system. A suspension is begun by submitting a Request for Modification from a State User is received by SLR and a script is deployed to the Production environment. State users will also be prevented from performing certain functions on any attestations, such as releasing them for payment. Other functions that are disabled when a provider is suspended include:

- The **Approve** button on the *Verifications* page will be disabled while the provider is suspended. The button is re-enabled when the suspension ends.
- The checkbox in the **Select** column on the *Payment Processing List* page for those providers that are currently suspended will be disabled while the provider is suspended. The checkbox is re-enabled when the suspension ends.
- The checkbox in the **Select** column on the *Release to CMS* page for those providers that are currently suspended will be disabled while the provider is suspended. The checkbox is re-enabled when the suspension ends.

Report Section

The number of reports will increase over time; States will request new reports as the attestation process matures. Occasionally, a report may be replaced by one that improves on its information. The number of reports can vary from State to State

State Dashboard Reports

Dashboard reports are divided into five categories to make them easier to find and access. Descriptions of each of the reports available in each section are below. Recently added reports are identified by asterisks (**).

Registration Reports

- **NLR Applications waiting on SLR activity:** displays provider requests that have been entered in the CMS site but have no corresponding SLR registration started.
- **SLR Applications waiting on NLR registration:** displays attestation applications that have been entered into the SLR but cannot proceed because NLR (B6) information has not been received.
- **Provider Account and Registration Detail Report:** displays NPI, TIN, name, and full contact and payee information for all providers associated with the State.
- **Active Registration Applications with State:** displays providers who have submitted their applications for the EHR incentive payment through the SLR system, but have not yet received payment from the State.
- **All Registration Applications with the State:** displays EHR Certification Numbers, and statuses for the provider, the attestation, and the payment for all the State's providers.
- **CMS B6 Registration Report:** for each provider, displays the last B6 file update, which consists of information from the CMS EHR Incentive Program site, including whether the file was an update or the original provider add.
- **Provider with Inactive Status at NLR:** displays those providers listed as inactive at the national level.
- **NLR Data Detail Report:** user selects to list either hospitals or eligible professionals and view all the information on the provider that was sent to SLR from the CMS EHR Incentive Program site, including exclusion information.
- **NLR Application Status Report:** lists providers by NPI and name and identifying the major milestones each provider has passed in the system.
- **Providers with PMF Mismatch Information:** lists providers that are crosschecked between the State's Provider Master File and information recorded at the CMS EHR Incentive payment site, identifying any mismatches.
- **Providers with CMS in Progress Status Report:** lists providers with a states of IN_PROGRESS at the CMS level. The report includes name, NPI, and TIN, Submission Date, and address.

Eligibility Reports

- **Active Registrations not meeting Eligibility Threshold:** displays attestation applications that have entered Eligibility information in Step 2, but that currently do not meet the CMS eligibility threshold.
- **Providers with Volumes from Multiple States:** displays providers and Groups with patient encounters from multiple States. The report lists the name, NPI, and TIN of each provider along with all States that originated patients and the patient encounters and Medicaid claims from each of those States.
- **EH Average Length of Stay Comparison Report:** for each hospital of the State, this report compares the Average Length of Stay (ALOS) that a Hospital enters on their *Confirm Eligibility* page to the length of stay calculated by dividing the Total Patient Days by the Number of Discharges.
- **EH Volumes and Average Length of Stay:** for a selected eligible hospital, displays patient volume, discharge, and average length of stay numbers.

MU Reports Stage 2

- **Meaningful Use Measures by Individual Provider:** MU measure thresholds and numbers by selected Providers.
- **Percentage of Providers Submitting Specific Measure:** state users will select a Program, Provider Type, an Objective Type (Core, Menu, or CQM), and the specific objective to view the number and percentage of providers that completed that objective, and the total number of providers attesting to MU in your state.
- **Actual Percentage Performance of Specific Measure:** the number of providers and totals of all reported numbers for a selected MU measure.
- **Actual Percentage Performance of Specific Measure by Provider Type:** the percentage results of a selected MU measures by a selected provider Type, Specialty, and Taxonomy Code.
- **Actual Percentage Performance of Specific Measure by Denominator Size:** the percentage of the results of a selected MU measures by a range of size (for example 2000 to 2500).
- **Actual Percentage Performance of Specific Measure by County:** the results of a selected MU measure for a selected county.
- **Percentage of Providers Meeting Minimal Threshold of a Specific Measure:** lists those providers that achieved the minimum threshold for a select MU measure, and includes those providers with an excluded from the measure.
- **Actual Percentage Performance of Specific Measure by Zip Code:** displays a selected MU measure for a selected zip code and program year.
- **EP Measure Analysis:** lists Meaningful use objectives by provider, including numerator, denominator, the percentage value, and other information.
- **MU Objective Audit Report**: lists Meaningful use objectives by program year, objective type and provider.

Payment Reports

- **EH Payment Information Report:** also called the Payment Calculation Report, this displays detailed information on the discharges and payment amount that compromise each hospital's payment amount.
- **Providers Who Received Payment Report:** displays providers who have received payments as a result of the EHR Incentive Program.
- **CMS 64 Report:** displays information that will help State personnel to complete the CMS-64 Form, listing providers that received incentive payments during a specified date range, including the date and amount.
- **Unverified Submissions Payment Report:** provides a list of those attestations that have been submitted to the SLR system, but have not yet been verified by State personnel.
- **Providers by Payee Report:** a list of the State's designated payees for the EHR Incentive Payment program.
- **MMIS Planned Payment Report:** available for MMIS States, this lists providers for whom payments are planned to be released to the MMIS through the automated SLR interface.
- **FQHC Payment Report:** this refers to a Federally Qualified Health Center, and lists those providers affiliated with an FQHC. The report includes detailed information on the provider, and the Payee's name and location, and now includes Payment Status and Payment Year columns.
- **REC Payment Report:** lists providers associated with a Regional Extension Center in the state.
- **Request Approval to Pay (RAP) Report:** lists comprehensive provider, financial, and attestation status information and was created specifically for the payment process.

Other Reports

- **Incomplete Applications Report:** displays provider information, the status, and the date started of all incomplete applications in the SLR. This report will primarily be used to track attestation applications that have been started but not yet submitted.
- **Completed Applications Report:** displays the provider information for completed attestation applications that have been fully executed for the current benefit year. Completion status can be categorized as Applications submitted through SLR, applications submitted to CMS, and applications that have Payments Process Complete.
- **Active Applications Attached to a Group:** displays the NPI and name of each Group, along with the NPI and the name of each member, for all Groups with active EP's in the SLR.
- **Inactive Attestation Applications Currently Pending:** displays the attestation applications that have experienced a hardstop in the SLR workflow, including when the last update took place and the reason for the hard stop.
- **Providers with Federal or State Sanctions:** displays providers that have State or Federal sanctions in their NLR or D16 data. The report includes the sanction type (State or Federal), the reason code, and a description of each sanction.

- **Login History Report:** a listing of the usernames of providers by Provider Name, and NPI, and including the date and page of their last action in SLR.
- **Hospitals Who Have received C5**: provides a list of Hospitals that have received a C5.
- **Program Year Submission:** lists providers in order of last name, displaying the date their attestation was submitted and the Program Year to which the attestation was applied.
- **Pended Provider Comments:** lists all the providers that currently have a Pended status, and the comments added when that status was assigned.
- **Providers Reporting Participation in MCO:** lists providers by name and by Managed Care Organization to which they belong.
- **Providers by Specialty Code Report:** users selects to view detailed information for or simply the number of providers of a selected Specialty Code.
- **EHR Certification:** contains EHR Certification information.
- **Report of all CMS Interactions:** lists relevant information for each CMS transaction for a specific provider. This will include Transaction Numbers, Confirmation Numbers, relevant dates, and other information. (**)
- **EHR Certification Full list for Export:** lists the EHR Certification Number, Product Names, Product Versions, and other information for each provider in the system. (**)

Report Interface

Report links: click a link in the section to open the corresponding report.

Provider Account and Registration Detail Report

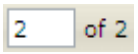
A framework will open that provides controls and features for the selected report.

Report Header: The title of the report will appear at the top, along with a logo.

Toolbar: The row of icons across the top of the report works the same on all reports. Each icon or control has a tool tip that should help you to identify the feature – hovering over the icon will reveal the tip.

First Page icon: displays the first page of the report.

Previous Page icon: displays the page prior to the one you are viewing.

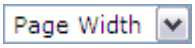


Page Indicator field: displays the page number of the report you are currently viewing. Typing a number in the entry field and pressing the **Enter** key will display that page within the report.

Next Page icon: displays the next page in the report.

Last Page icon: displays the last page in the report.

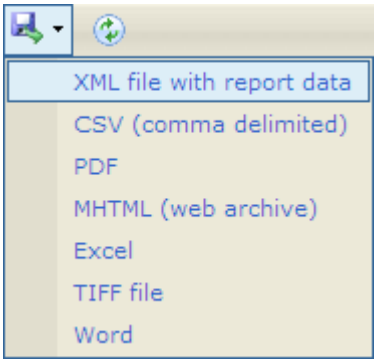
Go back to the parent report icon: some reports will be accessed from within other reports. This icon returns you to the original report if a second report was opened from within it.

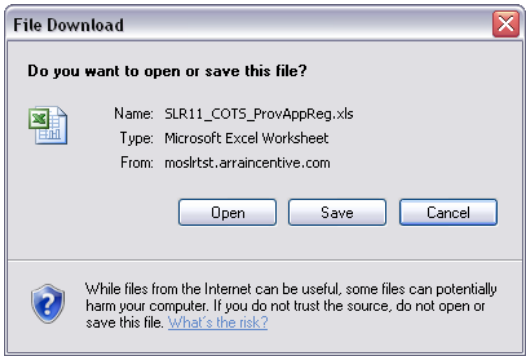


Zoom pull-down menu: allows you to specify a viewing preference.

Find feature: the **Find** and **Next** links work with the text field to search the report for text strings entered into the field. Adding text to the field and clicking the **Find** button will begin the search from the first page of the document. Clicking the **Next** button will find the next instance of the letters or numbers entered in the **Find** text field.

Export icon: opens a menu that allows you to select a different file format to export the data contained in the report. Selecting one of the file types will opens a *File Download* window.



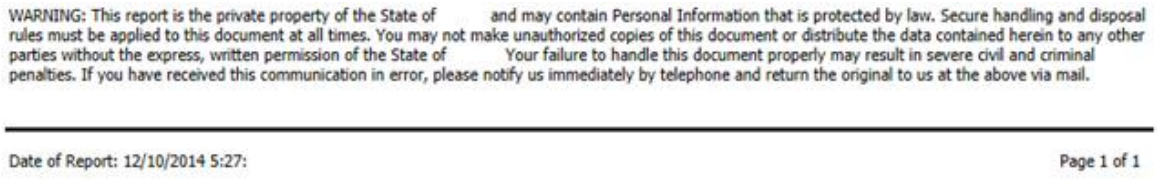


Clicking the **Open** button will open the newly created file in the appropriate application on your PC. The **Save** button allows you to save the file, and the **Cancel** button will simply remove the window.

Refresh icon: will reopen the report, incorporating any additional database changes that may have occurred since the last time you opened the report.

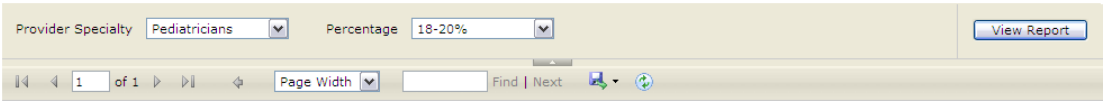
Print icon: opens a *Print* window allowing you to select options and print to a local printer.

- Copyright Statement: each report will have State-specific copyright content, and the page numbers will appear when the report is printed.



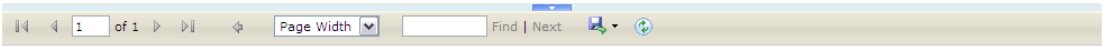
- **Date of Report** field: this field in the bottom left corner captures the data and time the report was generated. The report is displayed with the latest information from SLR, though there will be some delays for data originating at the NLR level.
- Parameter bar: Besides the Toolbar that is displayed with every report, there will sometimes be an additional bar called the Parameter bar. This Parameter bar will contain menus and other controls.

In the example below, the user would select a Provider Type from the **Provider** Specialty pull-down menu. The range options in the Percentage pull-down menu would update depending on the choice made in the Provider Specialty pull-down menu.



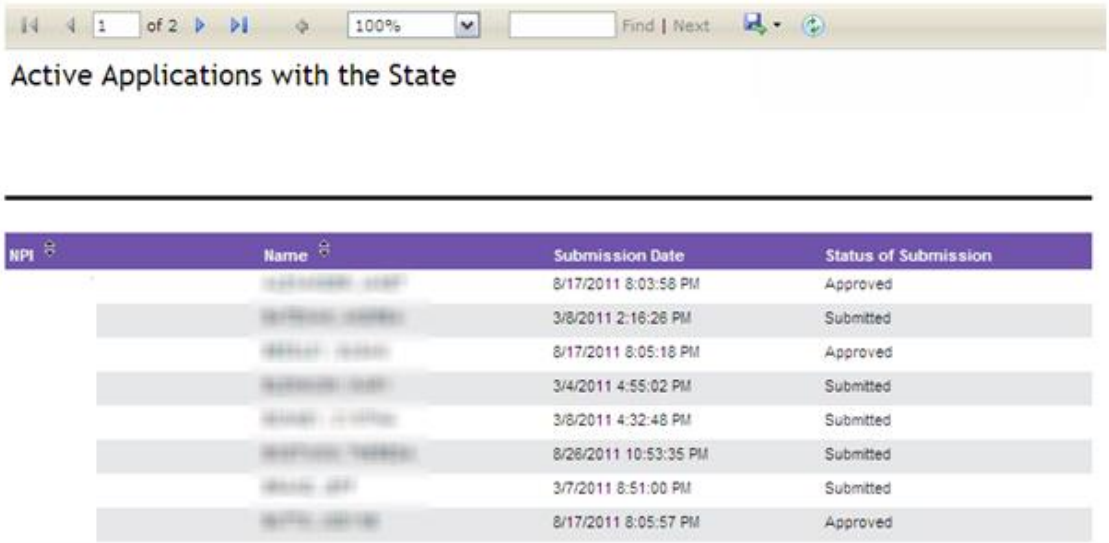
When options such as pull-down menus appear on a report, it will not be generated until the **View Report** button is selected

 Show/Hide button: clicking this button will hide the Parameter Bar (if the arrow is pointing up), or reveal the parameter bar (if the button is blue and the arrow is pointing down).



Active Registration not meeting Eligibility Threshold

Some reports will have icons in the column titles so that users can sort the report by more parameters. The *Active Applications with the State* report contains two columns with sort icons.



Sort icons: clicking this icon will refresh the report, this time organizing the information by the selected column in ascending order. A different icon will appear in the column title to indicate the direction of the sort: . Clicking the icon again will refresh the report again, this time organizing the information in the column in descending order.

Passwords and User Information

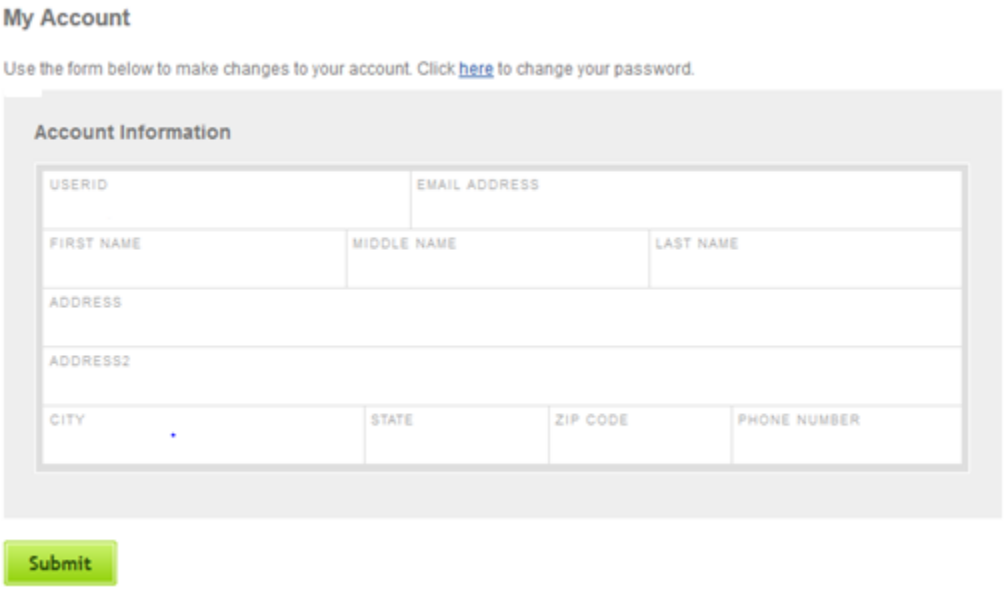
Forgot Password

State users that have misplaced their passwords will use the **Forgot Password** link to reset passwords.

- *Login to S*tate Level Registry Dashboard page: beneath the Username and Password fields is a **Forgot Password** link. Clicking this link will open the *Forgot your Password* page.
- *Forgot Your Password* page: type your Username into the **USER NAME** field and click the **Submit** button. The system will email a temporary password. When you next log in, the system will prompt you to reset the password.

User Information

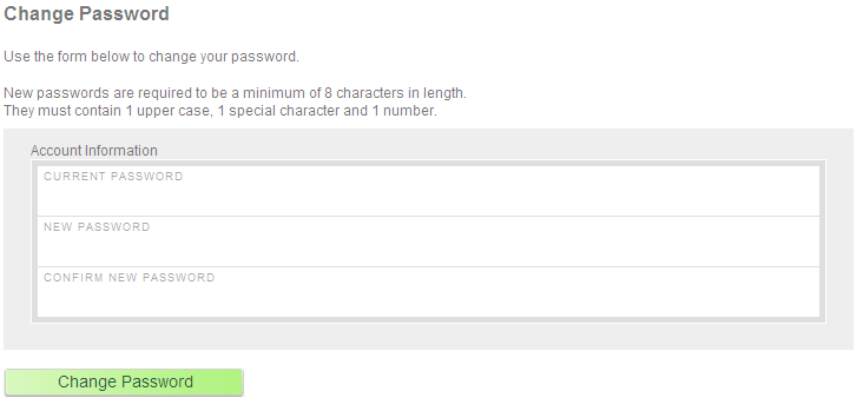
To update your personal and contact information, click the **My Account** link in the header of the Dashboard. The *My Account* page will open. Users can edit their name, address, phone number, and email address.



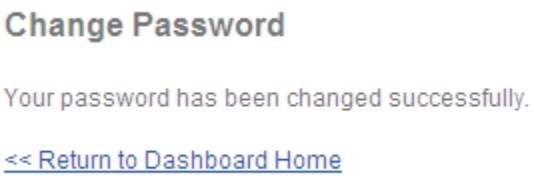
Click the **here** link to open the *Change Password* page. Enter changes into any field and click the **Submit** button to preserve those changes in the database.

Change Password

The *Change Password* page is accessed from the *My Account* page, which itself is accessed by the **My Account** link in the header of each page in the Dashboard.



Enter the current password into the first field, and then the new password into the **NEW PASSWORD** and **CONFIRM NEW PASSWORD** fields. Passwords for the Dashboard must be at least eight characters in length and contain an uppercase letter, a special character, and a number. Click the **Change Password** button.

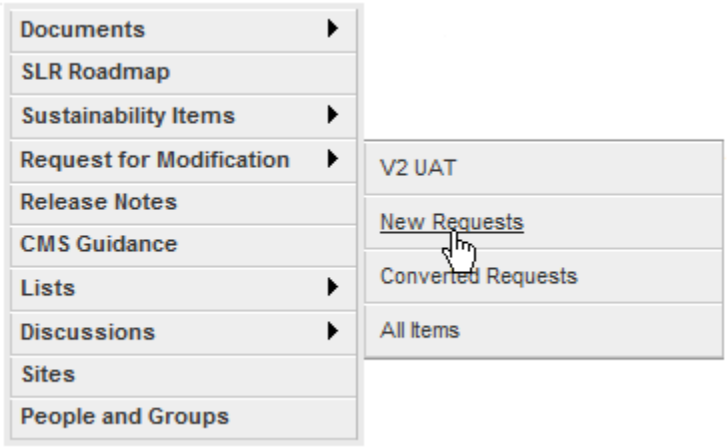


A confirmation message will appear containing a link to return to the *Individual Provider Search* page.

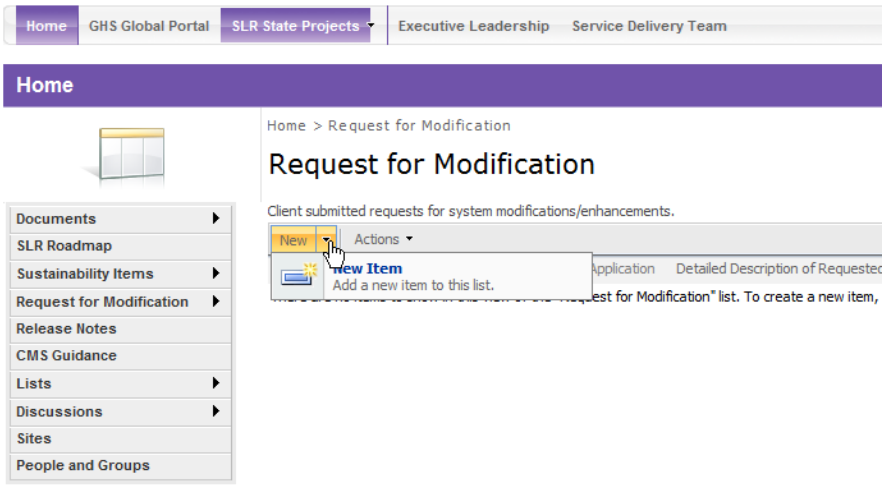
4. Request for Modifications

State users will use a SharePoint site to submit requests for new functionality or report bugs. These are captured by a form submitted to the SLR Product Team so that they can be converted into TFS tickets and prioritized by the User Group. To access the Request for Modification form,

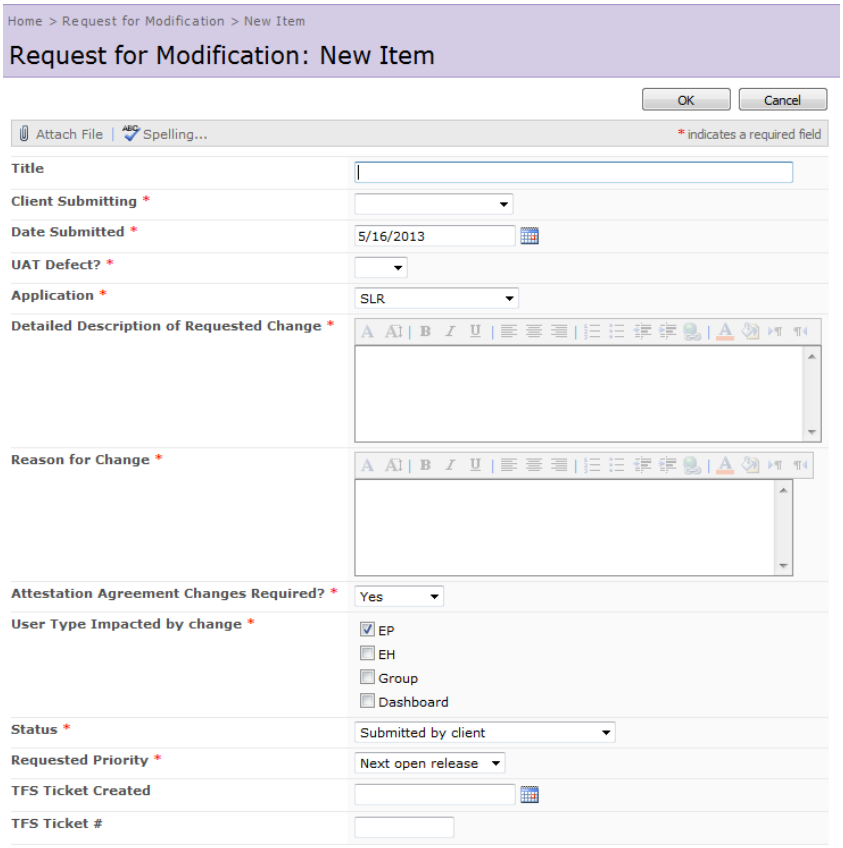
1. Open the *SLR Client SharePoint* site at https://sp.acs-inc.com/ghs/sites/HIESLR/default.aspx
2. Move the mouse pointer over the **Request for Modification** item in the left-hand navigation bar.
3. Click the **New Request** option from submenu that appears.



4. Click the **New** button underneath the Request for Modification title. The Request for modification: new item page will appear.

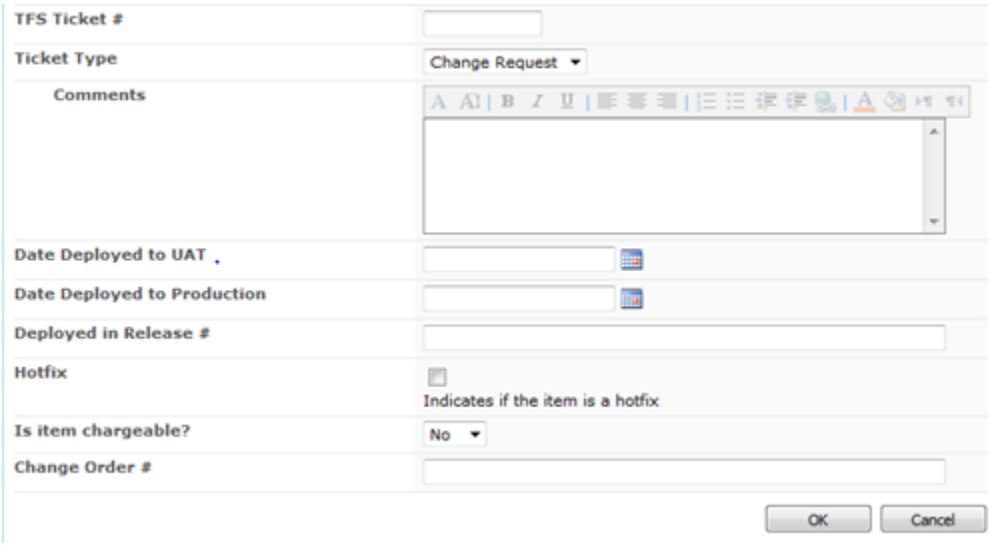


Fill the form out with as much information as possible, particularly if you are reporting a bug. Include where you found the bug, the username, and all related activity.

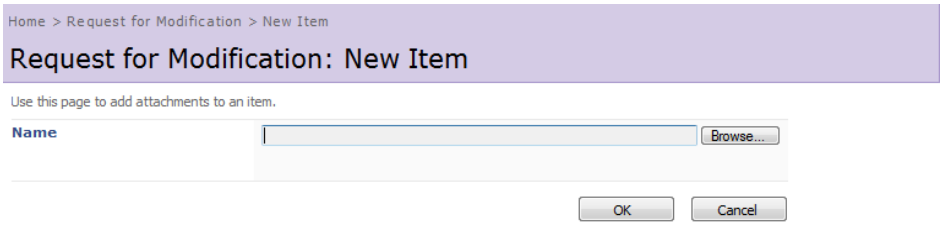


- **Title** text field: this field is not required, but a clear and descriptive Title would help our Product Team to more quickly identify and correct the problem.
- **Client Submitting** pull-down menu: select your state or territory from this menu.
- **Date Submitted** date field: enter the date or click the Calendar icon to select the date. This is the date the form is being submitted to the SLR team.
- **UAT Defect?** pull-down menu: select the Yes or No option.
- **Application** pull-down menu: Select the part of the system that is affected or in need of correction:
    - SLR: the five-step application used by Eligible Professional, Eligible Hospitals, and groups user to enter information and submit attestations.
    - Dashboard: the application used by State personnel to manage providers and their attestations.
    - Outreach Page: better known as the POP or Provider Outreach Page.
    - SharePoint: upgrades or changes to the Shared Client SharePoint site can be requested.
    - Call Center: select this to request changes to the Call Center or Operations Resources.
    - Report Development: select this to request the creation of a new report, or a change in an existing report.
    - V2 Sandbox: this option was used primarily when the Meaningful Use section was being constructed.

- **Detailed Description of Requested Change** text field:
- **Reason for Change** text field:
- Attestation Agreement Changes Required? pull-down menu: Yes No Unknown
- **User Type Impacted by Change** checkboxes: EP, EH, Group, Dashboard
- **Status** pull-down menu:
    - Submitted by client
    - Under review by Product Team
    - Converted to Active Ticket
    - Duplicate of existing CR or Defect
    - Rejected
    - Not an Issue
    - Deferred to Parking Lot
    - Resolved - Deployed to UAT
    - Fixed - pending deployment to UAT
    - Unable to reproduce - please retest
    - Completed
- **Requested Priority** pull-down menu:
    - Next open release:
    - Next three months:
    - Next six months:
    - No priority:
    - Immediate:
- **TFS Ticket Created Date** date field: an SLR Product Team member will add the date that he or she created a TFS ticket.



- **TFS Ticket #** text field: when an SLR Product Team member creates a TFS ticket to govern the work associated with the Request that was received from a State, it will be entered into this field.
- Ticket Type pull-down menu: this will default to a Change Request, but Defect can also be selected.
- **Comments** text field: the SLR team member will add comments to communicate back to the State, or say why the Request was resolved or declined. For example, there may have already been a ticket in the system addressing the change requested or the problem reported.
- **Date Deployed to UAT Date** field: when a new SLR component or report is deployed into UAT, or scheduled for UAT, the date will be entered here.
- **Date Deployed to Production Date** field: when a new SLR component is deployed to Production, meaning that it will be available for use with live provider data, or scheduled for Production, the date will be entered here.
- **Deployed in Release #** text field: SLR is deployed in a series of releases, each incorporating new components, changes, and fixes from the last release.
- **Hotfix** checkbox: this is selected to indicate that the item is a hotfix
- **Is item chargeable?** pull-down menu: this indicates that the contract permits the item to be charged to the State.
- **Change Order #** text field: if the change is related to a Change order, this field can be used to store that number.
- **Attach File** command item: opens a component that allows the user to attach a file, such as an example for the report you are requesting, or a screenshot of an error.



- **Spelling** command item: a component will open that identifies items that are potentially misspelled.

5. 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 Conduent 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 patient's medical history, that is maintained by the Provider over time, and may include all of the key administrative clinical data relevant to that persons care under a particular Provider, including demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports.[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.

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]

[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.

[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
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]
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]
Recoupment	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 Conduent 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]