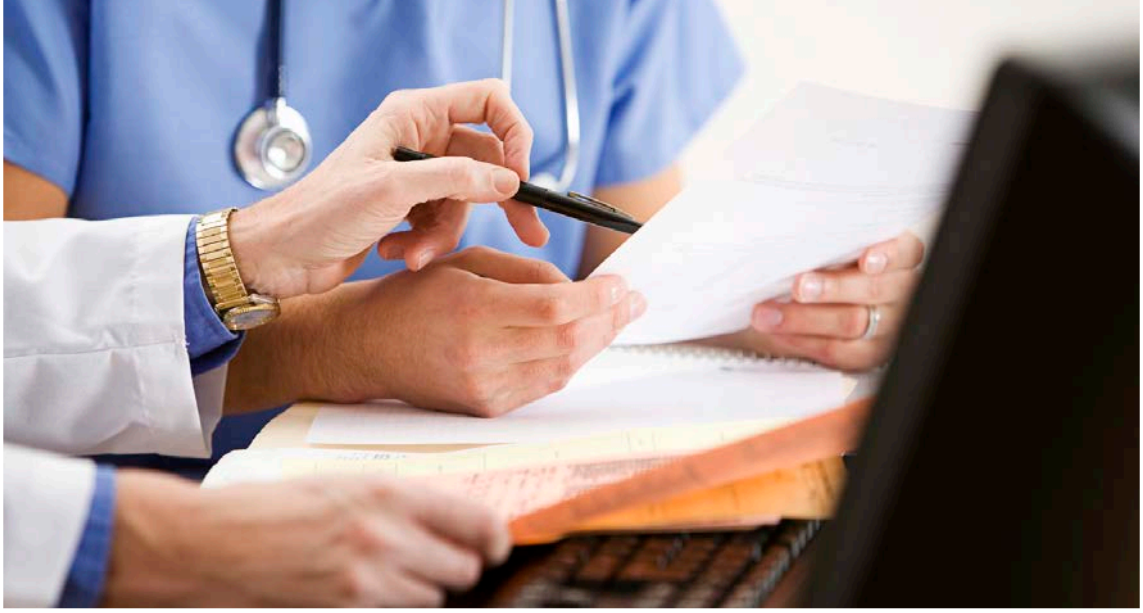


Medicaid Electronic Health Record Incentive Program

Eligible Professional Manual
Program year 2013

Oregon Health Authority
OHA SHARED SERVICES
Office of Health Information Technology
Medicaid Health IT Project

TABLE OF CONTENTS

INTRODUCTION **4**

THE MEDICAID EHR INCENTIVE PROGRAM APPLICATION PROCESS **4**

STEP-BY-STEP GUIDANCE ON REGISTRATION AND ATTESTATION **7**

PROGRAM OVERVIEW **10**

- **Participation guidelines** **10**
- **Eligibility** **11**
- **Calculating patient volume** **14**
- **Payments** **29**

USING MAPIR **31**

- **Step 1 — Getting started** **32**
- **Step 2 — Confirm R&A and contact info** **34**
- **Step 3 — Eligibility** **35**
- **Step 4 — Patient volumes** **37**
  - Patient volume practice type (Part 1 of 3) 37
  - Patient volume 90 day period (Part 2 of 3) 37
  - Patient volume (Part 3 of 3) 38
  - Patient volume — Individual 39
  - Patient volume — Group 41
  - Patient volume — Practitioner panel (Individual & Group) 43
- **Step 5 — Attestation** **46**
  - Attestation phase (Part 1 of 3) 46
  - Implementation phase (Part 2 of 3) 47
  - Upgrade phase (Part 2 of 3) 48
  - Meaningful use phase 49
  - Meaningful use menu measures 60
  - Meaningful use core clinical quality measures 70
  - Meaningful use alternate core clinical quality measures 72
  - Meaningful use additional clinical quality measures 76
  - Meaningful use measures summary 88
  - Attestation phase (Part 3 of 3) 90
- **Step 6 — Review application** **91**
- **Step 7 — Submit your application** **92**

POST SUBMISSION ACTIVITIES 98
ADDITIONAL USER INFORMATION 100
Hover bubble definitions 102
Resources and contacts 113
ACRONYMS AND TERMS 114

INTRODUCTION

The American Recovery and Reinvestment Act of 2009 was enacted on February 17, 2009. The Act provides for incentive payments to Eligible Professionals (EP) and Eligible Hospitals (EH) to promote the adoption and meaningful use of certified electronic health records (EHR).

Eligible health care providers who serve Oregon's most vulnerable individuals can access up to $63,750 over six years in federal incentive funds to help support the implementation and use of certified electronic health record systems in clinics and hospitals across the state.

The use of electronic health records improves the quality of care provided to patients by providing immediate access to patients' medical histories, reducing repetitive testing and preventing harmful drug or treatment interactions.

The Centers for Medicare and Medicaid Services (CMS) administers the Medicare EHR Incentive Programs, and the Oregon Health Authority's Division of Medical Assistance Programs administers the Medicaid EHR Incentive Program. Providers must choose between the Medicare and Medicaid incentives. Program requirements differ between the two programs, and Medicaid incentives are about $20,000 more than Medicare incentives per eligible provider.

THE MEDICAID EHR INCENTIVE PROGRAM APPLICATION PROCESS

This section of the manual provides information about:

- What to do to prepare for registration and application for the incentive program
- How to register and apply
- Participation and eligibility guidelines

It is suggested that someone on your staff reviews this entire manual before going back and following the specific steps in this section.

Some things to know before you start:

- You will need to register with the federal Centers for Medicare and Medicaid Services for this program first.
- You must be enrolled as an Oregon Health Plan provider and have access to the provider web portal before you can apply for an incentive payment. Allow at least 4-8 weeks for enrollment processing.

- To apply for the Oregon Medicaid incentive program, you will need to use the Medical Assistance Provider Incentive Repository (MAPIR), which is a Web-based program. This manual provides step-by-step instructions for using MAPIR.
- If you have additional questions that aren't answered in this manual, you can find more information on the incentive program's website at www.MedicaidEHRIncentives.oregon.gov and/or call the Oregon Health Authority-Division of Medical Assistance Programs help desk at 503-945-5898 for one-on-one assistance.

FOR ADDITIONAL INFORMATION ONLINE:

The Oregon Administrative Rules for the Medicaid EHR Incentive Program can be found at www.dhs.state.or.us/policy/healthplan/guides/mehri/main.html.

High-level information about the incentive program, including eligibility requirements and frequently asked questions, is included on the program website: www.MedicaidEHRIncentives.oregon.gov.

PREPARATION STEPS

Before an application can be completed, the following steps need to be taken.

- Adopt, implement, or upgrade to a certified EHR system. If you have not completed these steps, seek assistance with EHR systems as needed. (www.medicaidehrincentives.oregon.gov/OHA/mhit/ehr-support.shtml).
- Be an Oregon Health Plan provider. If you are not currently enrolled as an active Oregon Health Plan provider, enroll now (http://www.oregon.gov/OHA/healthplan/Pages/tools_prov/main.aspx)
- Register your National Provider Identifier (NPI) with the Division of Medical Assistance Programs (DMAP). If you have not registered your NPI with DMAP, contact them now (https://apps.state.or.us/Forms/Served/oe3113.pdf). If you do not have an NPI, apply for one with the National Plan and Provider Enumeration System (NPPES). (https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions).
- Be ready to receive your payment via direct deposit from DMAP. The Medicaid EHR Incentive Program will deposit incentive payments directly into your designated account. If you need to enroll in direct deposit, complete the direct deposit form. (http://www.oregon.gov/OHA/healthplan/Pages/tools_prov/main.aspx). If you are already enrolled in direct deposit, please make sure that the account that is setup is the same account where you want incentive payments to be deposited.

- Secure access to and/or update your information in the Web Portal (https://www.or-medicaid.gov/ProdPortal/Default.aspx). The online Medicaid EHR Incentive application, MAPIR, can only be accessed through the DMAP Provider Web Portal via the individual provider's web portal account. If a provider would like a representative to complete the incentive application on their behalf, the representative must be designated as the account administrator or as a clerk with access to the clerk role of "EHR Incentive." Please note, passwords expire every six months. Assistance for password reset or web portal access is available from the Provider Services Unit. They may be reached at 1-800-336-6016 or (www.oregon.gov/dhs/healthplan/webportal.shtml).
- Prepare for attestation by reviewing this Manual and using the Eligible Professionals Worksheet (www.medicaidehrincentives.oregon.gov/OHA/mhit/docs/EP-worksheet-v4.xls), an optional tool, to help organize your information for the attestation.

APPLICATION STEPS

- Register with CMS. The Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A; https://ehrincentives.cms.gov/hitech/login.action) serves as a federal repository to register providers and track payments for the Medicare and Medicaid EHR Incentive Programs. Registration is required for all providers seeking incentive payments. For more information on what you need to do to prepare for registration with CMS, see the Registration User Guide PDF (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHRMedicareEP_RegistrationUserGuide.pdf). CMS also has a video (www.youtube.com/watch?v=kL-d7zj44Fs&feature=relmfu) available to help explain the registration process.
- Complete an application with Oregon's Medicaid EHR Incentive Program. Providers can log on to the Provider Web Portal to access the Medicaid EHR Incentive Program application (https://www.or-medicaid.gov/ProdPortal/default.aspx).

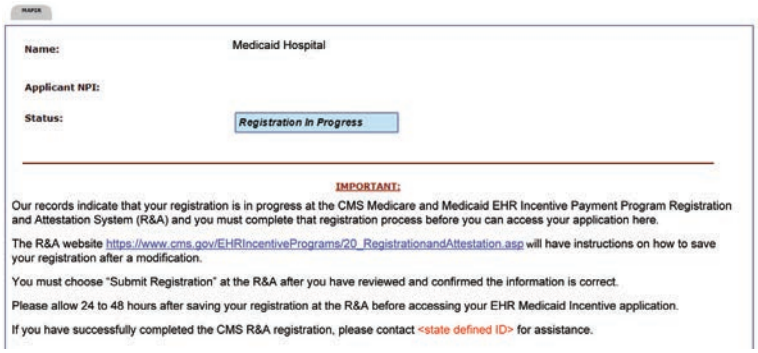
STEP-BY-STEP GUIDANCE ON REGISTRATION AND ATTESTATION

You must register at the R&A before accessing MAPIR. If you access MAPIR and have not completed this registration, you will receive the following screen:

COMPLETE YOUR R&A REGISTRATION.

You will not be able to start your MAPIR application process unless you have successfully completed this federal registration process (https://ehrincentives.cms.gov/hitech/login.action). When MAPIR has received and matched your provider information, you will receive an email to begin the MAPIR application process. Please allow at least two days from the time you complete your federal registration before accessing MAPIR due to the necessary exchange of data between these two systems.

NOTE: CHANGES TO YOUR R&A REGISTRATION



Please be aware that when accessing your R&A registration information, should any changes be initiated but not completed, the R&A may report your registration as "In Progress". This will result in your application being placed in a hold state within MAPIR until the R&A indicates that any pending changes have been finalized. You must complete your registration changes at the R&A prior to accessing MAPIR or certain capabilities will be unavailable. For example, it will not be possible to submit your application, create a new application, or abort an incomplete application. If you access MAPIR to perform the above activities and have not completed your registration changes, you will receive the following screen.

Should the R&A report your registration as "In Progress" and an application is incomplete or under review (following the application submission), MAPIR will send an email message to the email address entered in the R&A or in the incentive application in MAPIR. You will need to finalize your changes in the R&A and then allow at least two days from the time you complete your changes before accessing MAPIR due to the necessary exchange of data between these two systems.

IDENTIFY ONE INDIVIDUAL TO COMPLETE THE MAPIR APPLICATION.

MAPIR is accessed through Oregon's Provider Web Portal (www.oregon.gov/dhs/healthplan/webportal.shtml). Once an individual has started the MAPIR application process with their internet/portal account, they cannot switch to another account during that program year. MAPIR will allow the user to save the information entered and return later to complete an application; however, only the same individual's internet/portal account will be permitted access to the application once it has been started.

GATHER THE NECESSARY INFORMATION FOR THE ATTESTATION.

MAPIR will request specific information when you begin the application process. To facilitate the completion of the application, it is recommended that you review the manuals and worksheet to understand what information will be required. At a minimum, you should have the following information available:

- Information submitted to the R&A
- Medicaid Patient Volume and associated timeframes. A preformatted worksheet that includes Patient Volume and associated timeframes is available to assist providers (http://medicaidehrincentives.oregon.gov/OHA/mhit/docs/EH-worksheet-v4.xls)
- Medicaid Patient Volume and associated timeframes
- The CMS EHR Certification ID that you obtained from the Office of the National Coordinator (ONC) Certified Health IT Product List (CHPL) Web site (http://onc-chpl.force.com/ehrcert)
- If applying for a first year payment, documentation that supports the adoption, implementation, or upgrade to certified EHR technology. If applying for a second year payment and beyond, meaningful use reports that are generated by certified EHR technology.

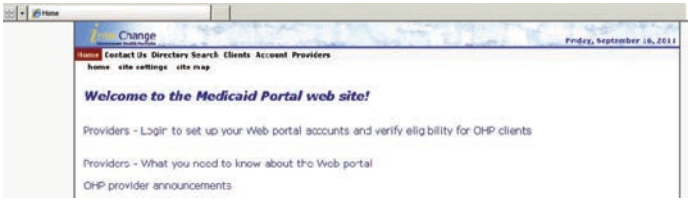
Note: All documentation that supports your attestation must be retained for seven years.

USE THE PROVIDER WEB PORTAL TO ACCESS MAPIR

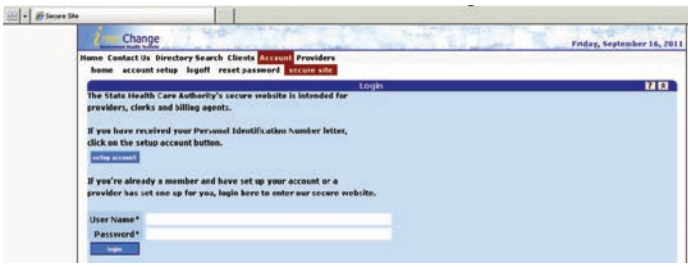
MAPIR is accessed through Oregon's Provider Web Portal (www.oregon.gov/dhs/healthplan/webportal.shtml).

Select the first hyperlink for Providers to log in or assign a clerk the role of EHR Incentives.

Click on **Providers** to log in.



Type in User Name and Password.
Select **Login** button.

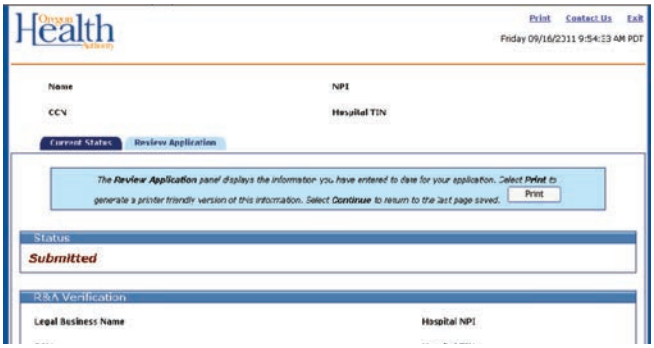


ACCESS THE EHR INCENTIVE (MAPIR) APPLICATION IN THE PROVIDER WEB PORTAL

A Medicaid Electronic Health Record (EHR) Incentive Application Status message will appear for types of providers that are eligible for the Medicaid EHR Incentive Program. This message shows the path to access MAPIR by selecting **EHR Incentive** from the **Providers** menu.

The provider, account administrator, or a designated clerk may complete the attestation. Clerks who have Provider Web Portal access rights to assign roles will be able to self-assign the appropriate role of **EHR Incentive**. If the clerk does not have access rights to assign roles, the administrator of the account will have to assign the role of **EHR Incentive**.

Once you select **Providers** in the menu along the top of the page and scroll to **EHR Incentive** from the dropdown list, or select **EHR Incentive** from the horizontal list across the second row of menu items, then the MAPIR application will open in a new window.



You are now logged into MAPIR and will see the Provider Name, Applicant NPI, and the current status of the MAPIR application. The identifying information that the provider entered at the CMS R&A system will be shown across the top. The **Review Application** tab will give providers an overview of the information they have entered in the MAPIR application.

PROGRAM OVERVIEW

PARTICIPATION GUIDELINES

LENGTH OF PARTICIPATION

The Medicaid EHR Incentive Program begins in 2011 and concludes in 2021. Providers may participate for up to six years and may skip participation years.

Providers can start the program in any year from 2011 to 2016. The payment year for eligible professionals is based on the calendar year (i.e., Jan. 1–Dec. 31). After the end of the payment year, providers have up to 90 days to apply for an incentive payment. For example, March 31, 2014 is the last day to apply for a 2013 payment.

ONE STATE

Providers may receive an incentive payment from only one state for a payment year.

ONE INCENTIVE PROGRAM

Providers must choose to participate in either the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program. They may not participate in both in any given payment year.

SWITCH BETWEEN MEDICARE AND MEDICAID

A one-time switch between the Medicare and Medicaid EHR Incentive Programs in either direction is allowed after receiving at least one incentive payment, and only for a payment year before 2015. If provider switches programs, in no case may payments to that provider exceed $63,750 in total incentive payments, which is the Medicaid limit.

ASSIGNMENT OF PAYMENT

Assignment of payment is permitted but must meet the following criteria:

- The assignment must be voluntary.
- The assignment may only be to the eligible professional's employer or an entity that has a contractual arrangement to bill and receive payment for the eligible professional's covered professional services.
- The decision on whether or not an incentive payment is to be assigned is an issue for the eligible professional and employer or contractual entity to decide. CMS and Oregon will not become involved to resolve disputes about assignment of payment. In the case of fraud, Oregon's Medicaid EHR Incentive Program staff will report the information to the appropriate law enforcement agency.
- The entire incentive payment amount must be assigned to one entity for any given payment year.

ELIGIBILITY

Note: Many program changes were enacted in program year 2013 and later by federal regulation. This manual does not address eligibility and program information effective in program years 2011 and 2012. Please contact the Medicaid EHR Incentive Program staff for any questions related to a 2011 or 2012 attestation.

PROVIDER TYPE

The following types of providers, or Medicaid Eligible Professionals (EPs), may be eligible for the Medicaid EHR Incentive Program if they meet all other requirements:

- Physicians (MD, DO) - Doctor of Medicine and Doctor of Osteopathy
- Pediatricians – a Physician who predominately treats individuals under 21 years of age (special eligibility and payment rules apply)
- Nurse Practitioners (NP), including Nurse Practitioner Nurse-Midwives
- Dentists

The eligible professional needs to meet and follow the scope of practice regulations, as applicable (as defined in 42 CFR Part 440). Licensing board and data in the Medicaid Management Information System (MMIS) will be used to verify provider types.

Pediatricians with Medicaid patient volume 20% or greater, but less than 30% need to select the Pediatrician type. Pediatricians with Medicaid patient volume of 30% or more should select the Physician type.

HOSPITAL-BASED PROVIDERS

Hospital-based providers are not eligible for the Medicare or Medicaid EHR Incentive Programs because hospitals can receive incentives directly. “Hospital-based” means 90% or more of “covered services” are provided in an inpatient or emergency department setting in the prior calendar year. Hospital-based is NOT based on or determined by certain occupations or employers. This rule does not apply to eligible professionals who practice predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC).

To determine whether a provider is hospital-based, the following calculation method should be used:

For all paid Medicaid encounters the prior calendar year, count all encounters that occurred in an inpatient or emergency department setting and divide by the total encounters in all settings

EXAMPLE

Doctor A is a cardiologist, works for a hospital-owned clinic, and worked in three settings in 2012. He is applying for a Medicaid EHR incentive payment for payment year 2013 but is concerned he may be hospital-based.

2012 MEDICAID ENCOUNTERS

Place of Service	Number of paid Medicaid Encounters
Inpatient	100
Emergency Room	50
Office	200
Total	350

EXAMPLE CALCULATION

In the entire calendar year 2012:

$$\frac{\text{Total count of all Medicaid encounters that occurred in an emergency department (Place of Service 23) or inpatient setting (Place of Service 21)}}{\text{Total count of all Medicaid encounters that occurred in all settings}}$$

$$\frac{150}{350}$$

EXAMPLE OUTCOME

Doctor A is not hospital based because less than 90% of the total covered services were rendered in an inpatient or emergency department setting.

How will the question be asked in Oregon's MAPIR application system?

Providers will be asked to answer "yes" or "no" as to whether they are hospital-based when they apply for an incentive payment.

PRACTICE PREDOMINANTLY IN AN FQHC OR RHC

Eligible professionals who practice predominantly in an FQHC or RHC may use "needy individuals" rather than strictly "Medicaid" in the patient volume calculation. Needy individuals include the following:

- Person who is receiving assistance under Title XIX (Medicaid);
- Person who is receiving assistance under Title XXI (CHIP);
- Person who is furnished uncompensated care by the provider;
- Person for whom charges are reduced by the provider on a sliding scale basis based on the individual's ability to pay

The term "practice predominantly" is defined as having over 50% of encounters be rendered within an FQHC or RHC setting during a six month period in either the prior calendar year or in the 12-month timeframe preceding the application date. This table illustrates how to calculate practice predominantly:

How to determine practice predominantly

Step	Example
A. Pick any 6 month period in either the prior calendar year or 12-month timeframe preceding the application date. For example, let's say today's date is 7/1/2013. You may pick a 6-month period in either 2012 or 7-1-2012 to 6/30/2013	July 1, 2012 – Dec 31, 2012
B. Calculate your FQHC/RHC Encounters by counting the encounters that occurred in the FQHC/RHC location during this timeframe	500
C. Calculate your total encounters by counting encounters that occurred in all locations during this timeframe	FQHC loc = 500 Location 2 = 250 Total = 750
D. Calculate your percentage of encounters by dividing the FQHC/RHC encounters by the total encounters	500/750 or 67%
E. If the amount is >50%, you meet the practice predominantly criterion	Yes

For more information about calculations for eligible professionals who practice predominantly in a FQHC or RHC, see the "Eligible Provider Manual for Federally Qualified Health Centers and Rural Health Centers."

How will the question be asked in Oregon's MAPIR application system?

Providers will be asked "yes" or "no" as to whether they practice predominantly in an FQHC or an RHC.

CALCULATING PATIENT VOLUME

Providers must meet at least 30% Medicaid patient volume (20% for pediatricians) calculated at the individual provider or the group/clinic level. There are multiple ways to calculate patient volume; "patient encounter" and the more complex, "patient panel." Most providers who will qualify for the Medicaid EHR Incentive Program will meet the minimum Medicaid patient volume threshold using the patient encounter method which is represented in most of the program documentation and guideline detail. However, for those providers who do not qualify using the patient encounter method, patient panel is an option.

Part of the application process for the Medicaid EHR Incentive Program requires the applicant to provide and attest to their patient volume data. We understand that this might be a challenge for some providers, particularly if they are still in the process of moving from paper to an EHR, but compiling that information is part of the application process. The Medicaid EHR Incentive Program staff is not able to provide patient data to providers to use in their applications. Data sources used to support patient volume attestations are required to be retained for seven years.

"Patient Encounter" Calculation

$$\frac{\text{Total Medicaid patient encounters*}}{\text{Total patient encounters}}$$

* In any representative 90-day period in either the prior calendar year or 12-month timeframe preceding the application date.

A Medicaid encounter means services rendered to an individual on any one day where the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under the Social Security Act section 1115) or Children's Health Insurance Program (CHIP) as part of a Medicaid expansion, at the time the billable service was provided.

Please note: Oregon's CHIP Program is NOT part of Medicaid Expansion so only Medicaid encounters are applicable to the Incentive Program. However, the Oregon Health Plan (OHP) includes funding for both Medicaid and the Children's Health Insurance Program (CHIP). Because providers can't differentiate between funding streams, providers must reduce all OHP encounters by 4.4%. This is Oregon's statewide rate of CHIP encounters (aka "CHIP proxy"). The CHIP proxy is calculated by taking the total OHP encounters for the selected 90-day period and multiplying that number by .956 as shown below.

$$\text{Total Medicaid encounters} = (\text{Total OHP encounters}) \times .956$$

Out of State Medicaid patients may be included in the patient volume.

TIPS AND NOTES:

- Use the date that the service was rendered rather than the date the claim was actually paid
- Do not use CPT codes for the calculation; only use encounters or visits as defined above
- The calculation is not a count of unique patients served. Services are counted on a per-day/per-provider basis. If a patient had two visits to the same doctor in one day, the encounter would be counted once. If a patient had two visits but saw a different doctor at each visit, the encounter would be counted twice. If a patient had two (or more) visits to the same doctor on different days in the 90 day timeframe, each visit would be counted.
- For total encounters, count all encounters (services rendered on any one day to an individual).

PATIENT VOLUME METHODOLOGIES

There are four different methods to calculate patient volume. Most eligible professionals will be able to calculate patient volume using the patient encounter methodology although the patient panel methodology may be used if it is the only way a provider may meet patient volume requirements.

PATIENT ENCOUNTER
- GROUP
- INDIVIDUAL

PATIENT PANEL
- GROUP
- INDIVIDUAL

PATIENT ENCOUNTER — INDIVIDUAL PROVIDER PATIENT VOLUME

Providers can choose to calculate their patient volume individually, selecting one or more clinic locations where they practiced in the prior calendar year, and reporting aggregate patient encounters for a continuous, representative 90-day period.

EXAMPLE

Doctor X is applying for a Medicaid EHR Incentive payment for payment year 2013. She has chosen a representative 90-day period to report patient volume in 2012 from January 15, 2012 to April 15, 2012

EXAMPLE ENCOUNTERS — JANUARY 15, 2012–APRIL 15, 2012

Payee	Number of rendered encounters
OHP	200
Medicaid (CHIP Proxy applied to OHP)	191 (200*.956)
All other sources, not including Medicaid	100
Total	300

EXAMPLE CALCULATION

$$\frac{\text{Medicaid}}{\text{Total patient encounters}}$$

$$\frac{191}{300}$$

EXAMPLE OUTCOME

Doctor X meets the patient volume threshold for payment year 2013. 63.7% of all encounters were rendered to Medicaid clients, making Doctor X potentially eligible for a Medicaid EHR incentive payment.

HOW WILL QUESTION BE ASKED IN OREGON'S INCENTIVE PAYMENT APPLICATION?

The application will calculate the percentage for patient volume.
Providers will enter their rendered encounters for the 90-day timeframe:

Which clinics?	Provider selects which clinic or clinics for which they will be reporting patient volume
90-day period	Enter start date and the 90-day period is calculated
In state numerator	Total OHP*.956
Total numerator	Add "in-state numerator" plus any out-of-state patient encounters
Denominator	Total encounters

PATIENT ENCOUNTER — GROUP/CLINIC PATIENT VOLUME

If you are part of a practice or clinic, the patient volume may be calculated on a group level, which means the encounters for all practitioners (eligible and non-eligible providers) in a group practice are used to determine patient volume. You will need to individually demonstrate meaningful use of certified EHR technology after your first year and will be eligible for one incentive payment each year, regardless of the number of practices or locations.

The group patient volume may not be appropriate in all circumstances and may only be used when all of the following apply:

I. The group's patient volume is appropriate* to use in the patient volume calculation for the eligible professional;

II. There is an auditable data source to support the group's patient volume data;

III. All eligible professionals in the group must use the same patient volume calculation method for the payment year;

IV. The group uses the entire practice or clinic's patient volume, including non-eligible providers, and does not limit patient volume in any way; and

V. If an eligible professional works inside and outside of the group, then the patient volume calculation includes only those encounters associated with the group, and not the eligible professional's outside encounters.

*"Appropriate" has been further refined to reflect that an eligible professional (EP) can use the group's patient volume when both:

- The provider is a part of the practice AND
- The provider served at least one Medicaid patient (where Medicaid paid at least part of the service).

All encounters for each provider in the group are added together to achieve the patient volume threshold. Notice in the representation below that "Physician A" only qualifies when using the group's patient volume.

Physician A

- 100 Medicaid patient encounters
- 400 Total patient encounters
- 25% Individual Medicaid volume (does not qualify)

Nurse Practitioner B

- 100 Medicaid patient encounters
- 200 Total patient encounters
- 50% Individual Medicaid volume

Registered Nurse C

- 100 Medicaid patient encounters
- 150 Total patient encounters
- 66.67% Individual Medicaid volume

Group

- 300 Medicaid encounters
- 750 Total encounters
- 40% Group patient volume
- Physician A and Nurse Practitioner B can apply for an incentive payment using the group patient volume

EXAMPLE — GROUP PATIENT VOLUME FOR A PROVIDER IN A NEW PRACTICE

In most of 2012 Doctor B was a part of Practice ABC. In January 2013, Doctor B moved to Practice XYZ. Doctor B saw Medicaid patients at Practice XYZ.

Practice XYZ adopted certified EHR technology in 2011 and the five eligible professionals in the clinic, which includes Doctor B, are applying for Medicaid EHR incentive payments. They will be using January 1 – March 30, 2012 as their 90-day patient volume period, and will apply using their group patient volume.

Even though Doctor B did not contribute to any of Practice XYZ's Medicaid encounters for the 90-day patient volume period, the doctor can still use Practice XYZ's group patient volume. The reason is that Doctor B is part of Practice XYZ and served at least one Medicaid client.

EXAMPLE CALCULATION

Payee	Number of billed encounters for the clinic
OHP	1000
Medicaid (CHIP Proxy applied to OHP)	956 (1000*.956)
All other sources, not including Medicaid	1700
Total	2700

$$\frac{\text{Medicaid}}{\text{Total patient encounters}}$$

$$\frac{956}{2700}$$

GROUP PATIENT VOLUME % = 35.4%

EXAMPLE OUTCOME

The five eligible professionals meet the patient volume threshold for payment year 2013. 35.4% of all encounters were rendered to Medicaid clients, making each eligible professional potentially eligible for a Medicaid EHR incentive payment.

HOW WILL THE QUESTION BE ASKED IN OREGON'S MAPIR APPLICATION SYSTEM?

The application will calculate the percentage for patient volume.
Providers will enter their groups billed encounters for the 90-day timeframe:

90-day period	Enter start date and the 90-day period is calculated
In-state numerator	Total OHP * .956
Total numerator	Add "in-state numerator" plus any out-of-state patient encounters
Denominator	Total encounters

PATIENT VOLUME: PATIENT PANEL — INDIVIDUAL

If providers cannot meet at least 30% Medicaid patient volume (20% for pediatricians) threshold using the patient encounter method, they may choose to calculate using the patient panel method by incorporating the patients assigned to the individual provider's panel. Panel is defined as: A managed care panel, medical or health home program panel, or similar provider structure with capitation or case assignment that assigns patients to providers. Providers can also use the patient panel method using a group patient panel calculation.

Providers select any representative 90-day period in either the prior calendar year or 12 month timeframe directly preceding the application date and apply it to the following formula:

$$\frac{\left(\text{Eligible professional's assigned** Medicaid patients*} + \text{Eligible professional's unduplicated*** Medicaid patient encounters*}\right)}{\left(\text{Eligible professional's total assigned** patients*} + \text{Eligible professional's total unduplicated*** Medicaid patient encounters*}\right)}$$

* Include encounters in any representative, continuous 90-day period either in the preceding calendar year or in the 12 month timeframe preceding the application date

** Include assigned patients who have had at least one encounter in the 24 months that occurred prior to the start date of the selected representative, continuous 90-day period.

*** Unduplicated: A patient should not be counted more than once in totaling assignments and encounters. In other words, if a patient is assigned to a panel for an eligible professional or a group, that patient should be counted only once in the calculation of the total assigned patients and the total unduplicated patient encounters.

Although some managed care providers may benefit from using this method, other managed care providers may not be able to use it if they do not have an auditable data source or the ability to determine which patients are on a panel.

EXAMPLE

Patient Panel Calculation				
Step	**Calculation Component**	**Action**	**Example Notes**	**Example formula input**
Step 1	Time frame	Pick a 90-day period in either the prior calendar year or in the 12 month timeframe directly preceding the application date		Jan 1,2012 – Mar 31, 2012
Step 2	Numerator 1	Count patients on your panel that had at least one Medicaid encounter during January 1, 2010 through December 31, 2011. This is the 24-months period that occurred prior to January 1, 2012, the start date of the selected 90-day period. If you are including out-of-state patients, be sure to add these in to your calculation.	Example - 300 OHP patients on a panel. Of those, 250 were seen at least once from January 1, 2010 through December 31, 2011. Apply .956 CHIP proxy to the 250 patients.	239
Step 3	Numerator 2	Count all other Medicaid patients not assigned to any panel in the clinic but who were seen in the selected 90-day period. If you are including out-of-state encounters, be sure to add these in to your calculation.	Example - 100 additional OHP patients were seen in the 90-day period who were not on any other providers' panel in the clinic. Apply .956 CHIP proxy to the 100 patients.	96
Step 4	Total Numerator	Add Step 1 and Step 2	239 + 96	335
Step 5	Denominator 1	Count patients on your panel that had at least one encounter during January 1, 2010 through December 31, 2011. This is the 24-months period that occurred prior to January 1, 2012, the start date of the selected 90-day period. If you are including out-of-state patients, be sure to add these in to your calculation.	Example - 500 total patients were on a panel during January 1, 2010 through December 31, 2011; of those, 450 were seen in this timeframe	450
Step 6	Denominator 2	Count all other patients not assigned to any panel in the clinic but who were seen in the selected 90-day period. If you are including out-of-state encounters, be sure to add these in to your calculation.	Example - 200 additional patients were seen who were not on any other providers' panel	200
Step 7	Total Denominator	Add step 5 and step 6	450 + 200	650
Step 8	Calculate Patient Volume	Divide results of Step 4 by results of Step 7	335/650	52%

HOW WILL THE QUESTION BE ASKED IN OREGON'S MAPIR APPLICATION SYSTEM?

The application will calculate the percentage for patient volume.
Providers will enter their panel figures for the 90 day timeframe:

90-day period	Enter start date and the 90-day period is calculated
Total Medicaid Patients on the Individual Practitioner Panel 1 (numerator)	Total (OHP *.956) + any out-of-state Medicaid patients on your panel that were seen at least once in the 24 months prior to the beginning of the 90-day period start date
Unduplicated Medicaid Only Encounter Volume 2 (numerator)	Total (OHP *.956) + any out-of-state Medicaid encounters for patients not on your panel who were seen in the 90-day selected timeframe
Total Patients on Practitioner Panel 3 –	Total patients on your panel that were seen at least once in the 24 months prior to the beginning of the 90-day period start date
Total Unduplicated Encounter Volume 4–	Total patients on your panel that were seen at least once in the 24 months prior to the beginning of the 90-day period start date

PATIENT VOLUME: PATIENT PANEL — GROUP

If providers cannot meet a threshold of at least 30% Medicaid patient volume (20% for pediatricians) using the patient encounter method, they may choose to calculate using the patient panel method incorporating the group's panel, or all patients assigned to all practitioners in the group. An auditable data source must be available should a group or clinic choose to calculate their patient volume in this manner.

Encounters and patients on a panel billed by the group are all included in the calculation. This includes both eligible provider types for the incentive program as well as all other provider types whose encounters contributed to the patient volume during the timeframe selected by the clinic. The group patient volume may not be appropriate in all circumstances and may only be used when all of the following apply:

I. The group's patient volume is appropriate* to use in the patient volume calculation for the eligible professional;

II. There is an auditable data source to support the group's patient volume data;

III. All eligible professionals in the group must use the same patient volume calculation method for the payment year;

IV. The group uses the entire practice or clinic's patient volume, including non-eligible providers, and does not limit patient volume in any way; and

V. If an eligible professional works inside and outside of the group, then the patient volume calculation includes only those encounters associated with the group, and not the eligible professional's outside encounters;

*Appropriate has been further refined to reflect that an eligible professional (EP) can use the group's patient volume when both:

- The provider is a part of the practice AND
- The provider served at least one Medicaid patient (where Medicaid paid at least part of the service).

Providers select any representative 90-day period in either the prior calendar year or 12 month timeframe directly preceding the application date and apply it to the following formula:

$$\frac{\left(\text{Group's assigned}^{**}\text{ Medicaid patients}^{*} + \text{Group's unduplicated}^{***}\text{ Medicaid patient encounters}^{*}\right)}{\left(\text{Eligible professional's total assigned}^{**}\text{ patients}^{*} + \text{Group's total unduplicated}^{***}\text{ Medicaid patient encounters}^{*}\right)}$$

* Include encounters in any representative, continuous 90-day period either in the preceding calendar year or in the 12 month timeframe preceding the application date

** Include assigned patients who have had at least one encounter in the 24 months that occurred prior to the start date of the selected representative, continuous 90-day period.

*** Unduplicated: A patient should not be counted more than once in totaling assignments and encounters. In other words, if a patient is assigned to a panel for an eligible professional or a group, that patient should be counted only once in the calculation of the total assigned patients and the total unduplicated patient encounters.

Although some managed care providers may benefit from using this method, other managed care providers may not be able to use it if they do not have an auditable data source or the ability to determine which patients are on a panel.

ADOPT, IMPLEMENT, OR UPGRADE (AIU) TO CERTIFIED EHR TECHNOLOGY

CERTIFIED EHR TECHNOLOGY

EHR technology must be tested and certified by an Authorized Testing and Certified Body (ATCB; http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3120) designated by the Office of the National Coordinator (ONC). EHR technologies that meet the certification requirements for the Medicare and Medicaid EHR Incentive Programs are listed on the ONC Certified HIT Product List (CHPL; http://onc-chpl.force.com/ehrcert) which has a complete up-to-date listing of certified EHR systems. A CMS EHR Certification ID must be obtained from the ONC Certified HIT Product List and be entered into the MAPIR application.

Certified EHR technology may be comprised of a complete EHR or a combination of EHR modules. The certified EHRs on the list are identified with the name of the certifying ATCB, the ONC certification number, vendor information, product information, and product version number. All modules used must be selected even if a complete certified EHR is used – e.g., a certified complete system is used with a separate data repository that is certified as a module.

ADOPT, IMPLEMENT, OR UPGRADE (AIU)

In the first year of participation, providers participating in the Medicaid EHR Incentive Program do not need to meet meaningful use reporting requirements. Rather, they will attest to the AIU of certified EHR technology:

- Adopt: Acquire, purchase, or secure access to certified EHR technology
- Implement: Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
- Upgrade: Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria

AIU is unique to the Medicaid EHR Incentive Program. Providers who participate in the Medicare EHR Incentive Program must report meaningful use in all years of participation. In addition, there is no reporting period for AIU, which means providers can adopt at any time prior to applying for an incentive payment.

MEANINGFUL USE

After the first year of participation, providers must attest to meaningful use. Meaningful use means providers need to show they are using certified EHR technology in ways that can be measured significantly in quality and in quantity. The criteria for meaningful use are staged in three steps over the course of the next five years.

- **Stage 1** sets the baseline for electronic data capture and information sharing.
- **Stage 2** (implemented in 2014) and Stage 3 (implemented later) will continue to expand on this baseline and be developed through future rule making.

The table below illustrates how AIU and the stages of meaningful use interact based on an initial participation year of 2011.

	Payment year				
First year of Participation	**2011**	**2012**	**2013**	**2014**	**2015**
2011	AIU	Stage 1	Stage 1	Stage 2	Stage 2
2012		AIU	Stage 1	Stage 1	Stage 2
2013			AIU	Stage 1	Stage 1
2014				AIU	Stage 1
2015					AIU

STAGE 1 MEANINGFUL USE

Stage 1 Meaningful use includes both a core set and a menu set of objectives that are specific to eligible professionals.

For eligible professionals, there are a total of 23 meaningful use objectives. To qualify for an incentive payment, 18 of these 23 objectives must be met. In addition, a set of clinical quality measures must also be reported.

- There are 13 required core objectives.
- The remaining 5 objectives may be chosen from the list of 10 menu set objectives. In Oregon, providers must select the immunizations public health measure from the menu.
- In addition, providers must report on six total clinical quality measures: three required core measures, substituting alternate core measures where necessary and three additional measures which are selected from a menu set of 38 clinical quality measures. For more information on CQMs, please visit CMS' web page at http://www.cms.gov/Regulations-and-Guidance/Legislation/ EHRIncentivePrograms/ClinicalQualityMeasures.html

These measures along with links to CMS specification sheets, are displayed in the meaningful use overview table. The CMS specification sheets explain each core or menu set objective in detail, including information on:

- Meeting the measure for each objective
- How to calculate the numerator and denominator for each objective
- How to qualify for an exclusion to an objective
- In-depth definitions of terms that clarify objective requirements
- Requirements for attesting to each measure

Click here for a list of all Stage 1 measures and specification sheets: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP-MU-TOC.PDF

EHR REPORTING PERIOD

The EHR reporting period is the timeframe used to capture and report meaningful use data. Providers do not report meaningful use in their first year of participation in the Medicaid EHR Incentive Program and do not have an EHR Reporting period. When providers **report meaningful use for the first time,** the EHR reporting period is a 90-day period in the payment year. In subsequent years, a 365-day period applies.

Year 1 — Adopt, Implement, or Upgrade

- No EHR Reporting period
- Applies only to the Medicaid EHR Incentive Program in a providers first year of participation

Year 2 — Meaningful use

- 90-day EHR reporting period
- Applies when a provider is reporting meaningful use for the first time.
- For example- If a provider applied for a 2011 AIU payment and is now applying for a 2012 payment, the EHR period is any 90-day period in 2012

Years 3 – 6 — Meaningful Use

- 365 day EHR reporting period
- For example - If a provider applied in 2011 for AIU, in 2012 for meaningful use, and is now applying for a 2013 payment, the EHR reporting period is the entire calendar year of January 1– December 31, 2013

FOR 2014 ONLY: All providers, regardless of their participation or stage in the program will have a 90-day EHR reporting period.

HOW WILL THE QUESTION BE ASKED IN OREGON'S MAPIR APPLICATION SYSTEM?

Certified EHR Technology: Providers will be asked to enter their 15-digit CMS EHR Certification ID from the ONC Certified HIT Product List website.

Documentation: At the end of the application, providers should upload documentation as proof of adopting, implementing, or upgrading to a certified EHR technology.

CMS is requiring that Oregon validate this eligibility criterion by verifying at least one of the four following types of documentation:

- copy of a software licensing agreement
- contract
- invoices
- receipt that validates your acquisition

Vendor letters and other documents may also be submitted as a supplement to the items on the documentation list above. However, these supplemental documents will not satisfy program eligibility requirements on their own.

Adopt, Implement, or Upgrade: Providers will select whether they have adopted, implemented or upgraded to certified EHR technology.

Meaningful Use: Providers will enter the start date of their EHR reporting period. Then, a meaningful use overview, or dashboard, of core and menu objectives as well as the clinical quality measures will display. Using the dashboard, providers will select measures to report. The dashboard will display meaningful use completion status.

ELIGIBLE PROFESSIONALS REPORTING PERIOD RELATIONSHIPS AND EXAMPLES

The following tables illustrate the relationships between the numerous reporting periods in the Medicaid EHR Incentive Program.

Professionals EHR Reporting Period Relationships Chart specific to the payment year

	Payment Year CY 2013 1/1/2013 – 12/31/2013	Payment Year CY 2014 1/1/2014 – 12/31/2014	Payment Year CY 2015 1/1/2015 – 12/31/2015	Payment Year CY 2016 1/1/2016 – 12/31/2016
Grace period (last date to apply)	90 days – 3/31/2014	90 days – 3/31/2015	90 days – 3/31/2016	90 days – 3/31/2017
EP Patient volume Period	Any 90-day period in CY 2012 or in a 12-month timeframe before the application date	Any 90-day period in CY 2013 or in a 12-month timeframe before the application date	Any 90-day period in CY 2014 or in a 12-month timeframe before the application date	Any 90-day period in CY 2015 or in a 12-month timeframe before the application date
Hospital-Based	CY 2012	CY 2013	CY 2014	CY 2015
Practice predominantly?	Any 6 month period in CY 2012 or within a 12-month timeframe before the application date	Any 6 month period in CY 2013 or within a 12-month timeframe before the application date	Any 6 month period in CY 2014 or within a 12-month timeframe before the application date	Any 6 month period in CY 2015 or within a 12-month timeframe before the application date

The following table shows an example of how the relationships may be applied for a provider participating in the Medicaid EHR Incentive Program.

Professionals EHR Reporting Period Relationships Chart – specific to provider's participation in the program

Provider's participation year	Payment Year CY 2013 1/1/2013 – 12/31/2013	Payment Year CY 2014 1/1/2014 – 12/31/2014	Payment Year CY 2015 1/1/2015 – 12/31/2015	Payment Year CY 2016 1/1/2016 – 12/31/2016
1st Year	**AIU** No EHR Reporting period Application period 1/1/2013 – 3/31/2014	**AIU** No EHR Reporting period Application period 1/1/2014 – 3/31/2015	**AIU** No EHR Reporting period Application period 1/1/2015 – 3/31/2016	**AIU** No EHR Reporting period Application period 1/1/2016 – 3/31/2017
2nd year	**MU – Stage 1** 90-day EHR Reporting period Application period 4/1/2013 – 3/31/2014	**MU – Stage 1** 90-day EHR Reporting period Application period 4/1/2014 – 3/31/2015	**MU – Stage 1** 90-day EHR Reporting period Application period 4/1/2015 – 3/31/2016	**MU – Stage 1** 90-day EHR Reporting period Application period 4/1/2016 – 3/31/2017
3rd Year	**MU – Stage 1** 365-day EHR Reporting period Application period 1/1/2013 – 3/31/2014	**MU – Stage 1** 90-day EHR Reporting period Application period 4/1/2014 – 3/31/2015	**MU – Stage 1** 365-day EHR Reporting period Application period 1/1/2016 – 3/31/2016	**MU – Stage 1** 365-day EHR Reporting period Application period 1/1/2017 – 3/31/2017
4th year		**MU – Stage 2** 90-day EHR Reporting period Application period 4/1/2014 – 3/31/2015	**MU – Stage 2** 365-day EHR Reporting period Application period 1/1/2016 – 3/31/2016	**MU – Stage 2** 365-day EHR Reporting period Application period 1/1/2017 – 3/31/2017
5th year			**MU – Stage 2** 365-day EHR Reporting period Application period 1/1/2016 – 3/31/2016	**MU – Stage 2** 365-day EHR Reporting period Application period 1/1/2017 – 3/31/2017
6th year				TBD

Description of terms

EHR Reporting period: The meaningful use reporting period within a payment year

Application period: The timeframe when a provider can attest (apply) for a Medicaid EHR Incentive Payment based on the EHR reporting period and payment year – Includes the grace period

OTHER ELIGIBILITY CRITERIA

Sanctions, HIPAA, Licensed in all states

Providers may not have any current or pending sanctions with Medicare or Medicaid in any state;

- Providers must be in compliance with all parts of the HIPAA regulations;
- Providers must be licensed in all states in which they practices.

HOW WILL THE QUESTION BE ASKED IN OREGON'S MAPIR APPLICATION SYSTEM?

Providers will be asked to answer "yes" or "no" to questions surrounding sanctions, licensing, and HIPAA.

PAYMENTS

MAXIMUM AMOUNT

An eligible professional can receive up to $63,750 over six years. Pediatricians who meet a 20% Medicaid patient volume but fall short of the 30% Medicaid patient volume can receive two-thirds of the incentive payment for up to $42,500 over six years.

YEARS OF PARTICIPATION

Payment years do not need to be consecutive (for example, if providers adopt a certified EHR but do not meet the meaningful use criteria in the next year, they may choose to skip payment years). Eligible Professionals (EP) must initiate participation no later than 2016.

PAYMENT STRUCTURE

In the first year of the program, EPs will receive $21,250. Providers are eligible for $8,500 for each of the subsequent five years of participation. The program ends with payment year 2021. Incentive payments for pediatricians who meet the 20% Medicaid patient volume but fall short of the 30% Medicaid patient volume are reduced to $14,167 in the first year and $5,667 in subsequent years.

Provider Incentive Payment Payout Examples

Payment year	EP participates in consecutive years, starting in 2011	EP participates in non-consecutive years	EP initiates payments in 2016
2011	$21,250	$0	$0
2012	$8,500	$21,250	$0
2013	$8,500	$0	$0
2014	$8,500	$8,500	$0
2015	$8,500	$8,500	$0
2016	$8,500	$8,500	$21,250
2017	$0	$0	$8,500
2018	$0	$0	$8,500
2019	$0	$8,500	$8,500
2020	$0	$8,500	$8,500
2021	$0	$0	$8,500
Total	$63,750	$63,750	$63,750

PROCESSING AND PAYMENTS

Most applications are requiring some additional clarification or documentation from applicants. Therefore, after you submit your application, you should anticipate getting a communication from program staff asking for some additional documentation.

Once your application has been completely reviewed, you have provided any necessary supplemental documentation, and your application is approved, you will then receive your payment within 45 days of approval.

Your payment will be processed as an Electronic Fund Transfer, and will be indicated on the Provider Remittance Advice (RA) as Systems Payouts – Non-claim specific.

USING MAPIR

MAPIR uses a tab arrangement to guide you through the application. You must complete the tabs in the order presented. You can return to previous tabs to review the information or make modifications until you submit the application. You cannot proceed without completing the current tab in the application progression, with the exception of the Get Started and Review tabs which you can access anytime.

Once you submit your application, you can no longer modify the data. It will only be viewable through the Review tab. Also, the tab arrangement will change after submission to allow you to view status information.

As you proceed through the application process, you will see your identifying information such as Name, National Provider Identifier (NPI), and Tax Identification Number (TIN) at the top of most screens. This is information provided by the R&A.

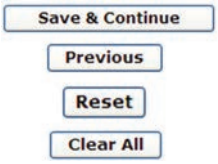
A **Print** link is displayed in the upper right-hand corner of most screens to allow you to print information entered. You can also use your internet browser print function to print screen shots at any time within the application.

There is a **Contact Us** link with contact instructions should you have questions regarding MAPIR or the Medicaid EHR Incentive Program.

Most MAPIR screens display an **Exit** link that closes the MAPIR application window. If you modify any data in MAPIR without saving, you will be asked to confirm if the application should be closed (as shown to the right).

You should use the **Save & Continue** button on the screen before exiting or data entered on that screen will be lost.

The **Previous** button always displays the previous MAPIR application window without saving any changes to the application.



The **Reset** button will restore all unsaved data entry fields to their original values.

The **Clear All** button will remove standard activity selections for the screen in which you are working.

A (*) red asterisk indicates a required field.

Note: Use the MAPIR Navigation buttons in MAPIR to move to the next and previous screens. Do not use the browser buttons as this could result in unexpected results.

As you complete your incentive application you may receive validation messages requiring you to correct the data you entered. These messages will appear above the navigation button. See the Additional User Information section for more information.

Many MAPIR screens contain help icons to give the provider additional details about the information being requested. Moving your cursor over the ? will reveal additional text providing more details.

STEP 1 — GETTING STARTED

1. Login to the Provider Web Portal and locate the EHR Incentive (MAPIR) selection. (www.oregon.gov/dhs/healthplan/webportal.shtml)
2. Click the link to access the EHR Incentive portal and locate the (MAPIR) screen.

The screen on the following page is the Medicaid EHR Incentive Program Participation Dashboard. This is the first screen you will access to begin the MAPIR application process.

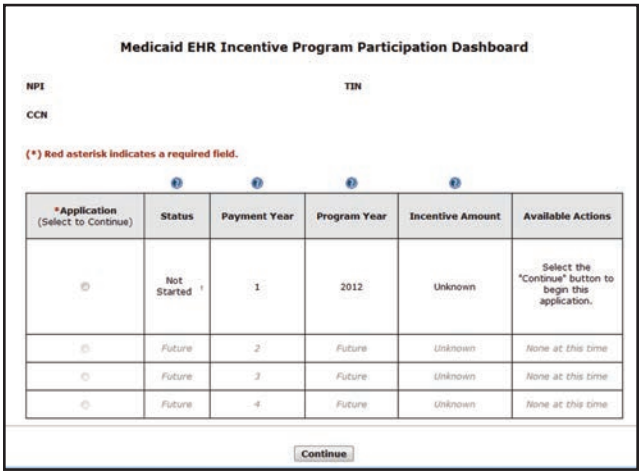
This screen displays your incentive applications. Incentive applications are listed for all 6 years. Only the incentive applications that you are eligible to apply for are enabled.

The Status will vary, depending on your progress with the incentive application. The first time you access the system the status should be Not Started. From this screen you can choose to edit and view incentive applications in an Incomplete or Not Started status. You can only view incentive applications that are in a Completed, Denied, or Expired status.

Also from this screen, you can choose to abort an incentive application that is in an Incomplete status. When you click Abort on an incentive application, all progress will be eliminated for the incentive application.

When an incentive application has completed the payment process, the status will change to Completed.

3. Select an application and click **Continue**.



Note: Oregon allows a 90-day grace period which allows providers to apply for a specific payment year up to 90-days after the program year has ended. If two applications are showing for the same Payment Year, but different Program Years, one of your incentive applications is in the grace period. In this situation, the following message will display at the bottom of the screen.

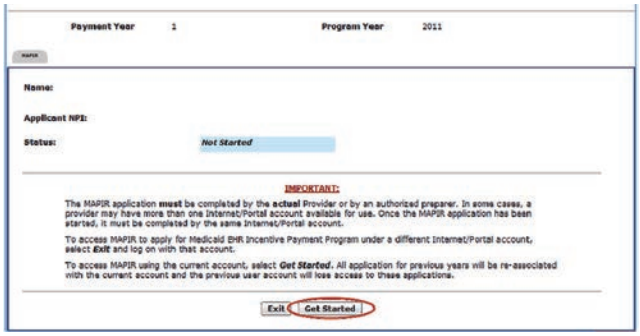
You are in the grace period for program year <Year> which began on <Date> and ends on <Date>. The grace period extends the amount of time to submit an application for the previous program year. You have the option to choose the previous program year or the current program year.

You may only submit an application for one Program Year so once you select the application, the row for the application for the other Program Year will no longer display. If the incentive application is not completed by the end of the grace period, the status of the application will change to Expired and you will no longer have the option to submit the incentive application for that Program Year.

The following screen will display with the information for the incentive application you selected. A status of *Not Registered at R&A* indicates that you have not registered at the R&A, or the information provided during the R&A registration process does not match that on file with the state Medicaid Program. A Status of *Registration In Progress* indicates that you have initiated but not completed R&A registration changes. If you feel this status is not correct you can click the **Contact Us** link in the upper right for information on contacting the state Medicaid program office. A status of *Not Started* indicates that the R&A and state MMIS information have been matched and you can begin the application process.

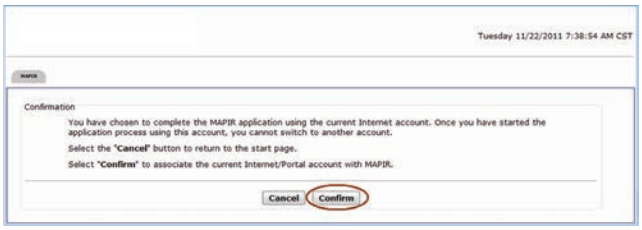
For more information on statuses, refer to the Additional User Information section later in this guide.

Click **Get Started** to access the Get Started screen or **Exit** to close the program.



If you selected an incentive application that you are not associated with, you will receive a message indicating a different internet/portal account has already started the Medicaid EHR Incentive Payment Program application process and that the same internet/portal account must be used to access the application for this Provider ID. If you are the new user for the provider and want to access the previous applications, you will need to contact Oregon's Medicaid EHR Incentive Program for assistance.

Click **Confirm** to associate the current internet/portal account with this incentive application.



The Get Started screen contains information that includes your Name and Applicant NPI. Also included is the current status of your application.

Click **Begin** to proceed to the R&A/Contact Info section.

STEP 2 — CONFIRM R&A AND CONTACT INFO

When you complete the R&A registration, your registration information is sent to Oregon's Medicaid EHR Incentive Program. This section will ask you to confirm the information sent by the R&A and matched with Oregon's program information. It is important to review this information carefully.

The R&A information can only be changed at the R&A or by contacting CMS directly at the EHR Information Center by calling 1-888-734-6433 (primary number) or 888-734-6563 (TTY number). Hours of operation are 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.

The initial R&A/Contact Info screen contains information about this section.

Click **Begin** to access the R&A/Contact Info screen to confirm information and to enter your contact information.

See the Using MAPIR section of this guide for information on using the Print, Contact Us, and Exit links.

Check your information carefully to ensure all of it is accurate.

Compare the R&A Registration ID you received when you registered with the R&A with the R&A Registration ID that is displayed.

After reviewing the information click **Yes** or **No**.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or last saved data. The Reset button will not reset R&A information. If the R&A information is not correct, you will need to return to the R&A to correct it.

Enter a Contact Name and Contact Phone.

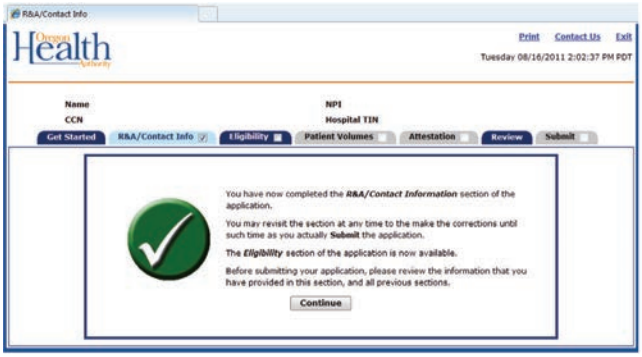
Enter a Contact Email Address twice for verification.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or last saved data.

This screen confirms you successfully completed the R&A/Contact Info section.

Note the check box located in the R&A/Contact Info tab. You can return to this section to update the Contact Information at any time prior to submitting your application.

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



STEP 3 — ELIGIBILITY

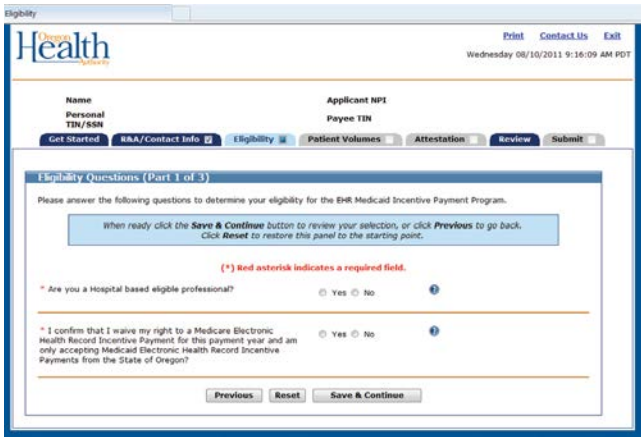
The Eligibility section will ask questions to allow the Medicaid EHR Incentive Program to make a determination regarding your eligibility for the Medicaid EHR incentive payment. You will also enter your required CMS EHR Certification ID.

The initial Eligibility screen contains information about this section.

Click **Begin** to proceed to the Eligibility Questions (Part 1 of 3).

Select **Yes** or **No** to the eligibility questions.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or the last saved data.



This screen will ask questions to determine your eligibility for the Medicaid EHR Medicaid Incentive Program. Please select your provider type from the list and answer the questions.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.

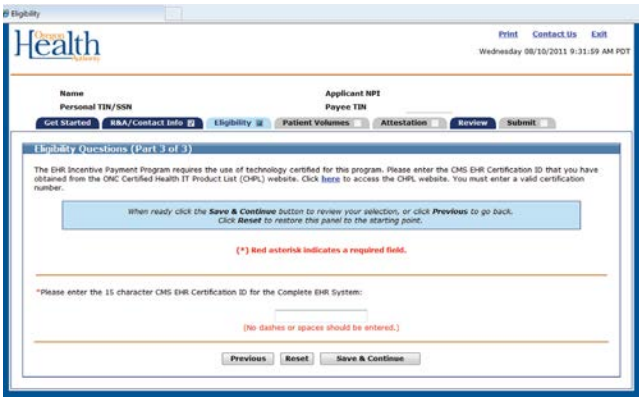
This Eligibility screen asks for information about your CMS EHR Certification ID.

Enter the 15-character CMS EHR Certification ID.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

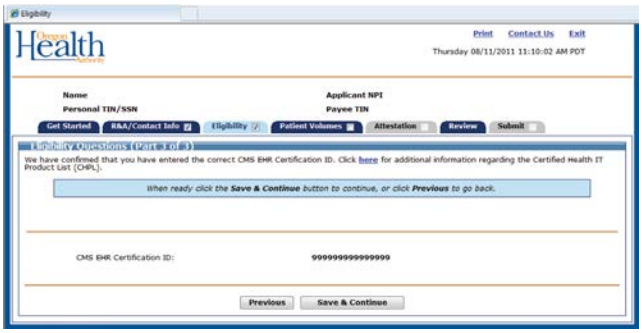
The system will perform an online validation of the CMS EHR Certification ID you entered.

A CMS EHR Certification ID can be obtained from the ONC Certified Health IT Product List (CHPL) website (http://onc-chpl.force.com/ehrcert)



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

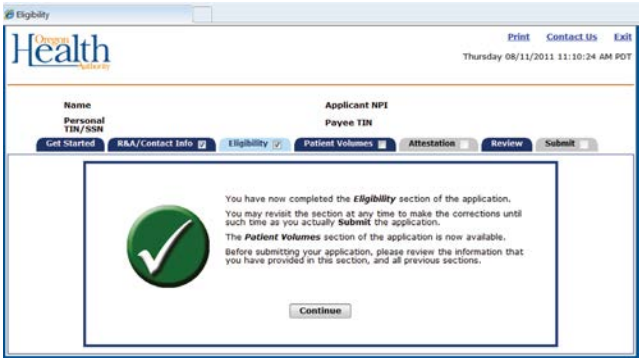
Click **Save & Continue** to proceed, **Previous** to go back.



This screen confirms you successfully completed the Eligibility section.

Note the check box in the Eligibility tab.

Click **Continue** to proceed to the Patient Volume section.



STEP 4 — PATIENT VOLUMES

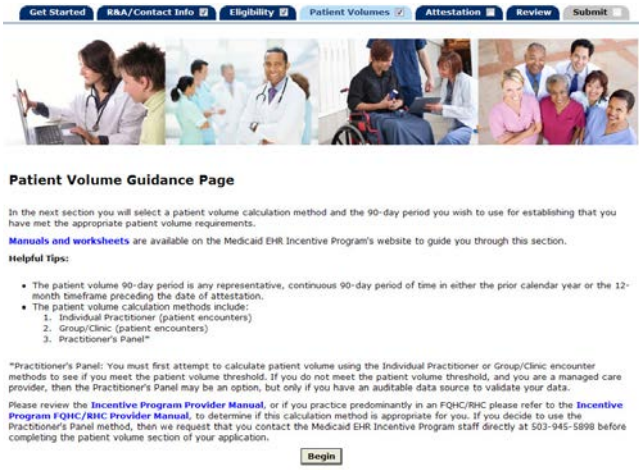
The Patient Volume section gathers information about your practice type, practice locations, the 90 day period you intend to use for reporting the patient volume, and the actual patient volume. Additionally, you will be asked about how you use your certified EHR technology.

There are three parts to Patient Volume:

- Part 1 of 3 contains two questions which will determine the method you use for entering patient volume in Part 3 of 3.
- Part 2 of 3 establishes the 90 day period for reporting patient volume.
- Part 3 of 3 contains screens to add new locations for reporting Medicaid Patient Volume, selecting at least one location for Utilizing Certified EHR Technology, and entering patient volume for the chosen reporting period.

The initial Patient Volume screen contains information about this section.

Click **Begin** to proceed to the Patient Volume Practice Type (Part 1 of 3) screen.

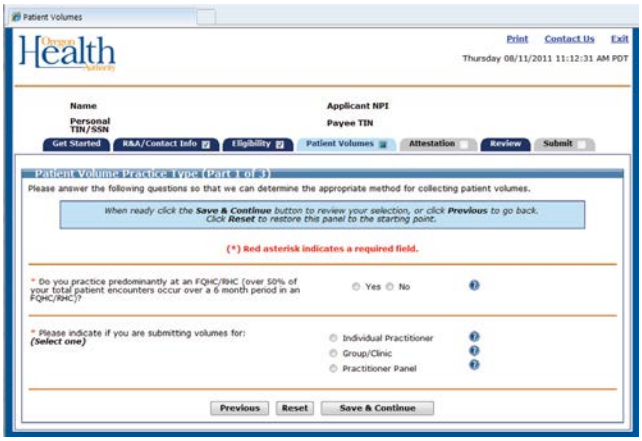


PATIENT VOLUME PRACTICE TYPE (PART 1 OF 3)

Patient Volume Practice Type (Part 1 of 3) contains two questions about your practice type to determine the appropriate method for collecting patient volume information.

Select the appropriate answers using the buttons. Move your cursor over the ? to access additional information.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.

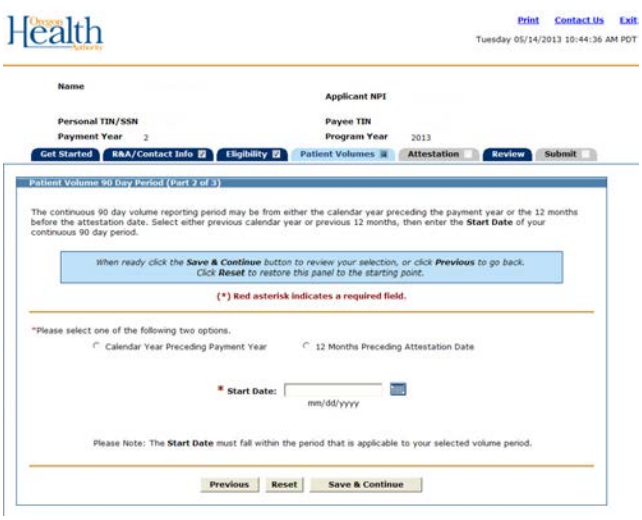


PATIENT VOLUME 90 DAY PERIOD (PART 2 OF 3)

For all practice types MAPIR will ask you to enter the start date of the 90 day patient volume reporting period in which you will demonstrate the required Medicaid patient volume participation level.

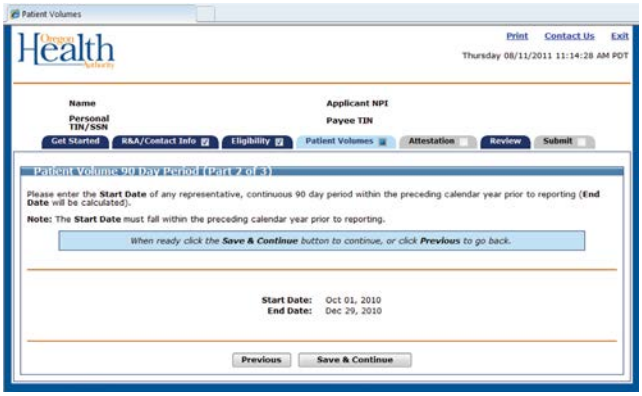
Enter a Start Date or select one from the calendar icon located to the right of the Start Date field.

Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.



Review the Start Date and End Date information. The 90 Day End Date has been calculated for you.

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



PATIENT VOLUME (PART 3 OF 3)

In order to meet the requirements of the Medicaid EHR Incentive Program you must provide information about your patient volume. The information will be used to determine your eligibility for the incentive program. The responses to the questions for Practice Type (Part 1 of 3) on the first Patient Volume screen determine the questions you will be asked to complete and the information required. The information is summarized below:

1. Practice locations — MAPIR will present a list of practice locations that Oregon has on record. If you have additional practice locations you have the option to add them. When all locations are added, you will enter the required information for all your practice locations.
2. Utilizing Certified EHR Technology — You must select the practice locations where you are using certified EHR technology. At least one practice location must be selected.
3. Patient volume — You are required to enter the information for the patient volume 90 day period you entered.

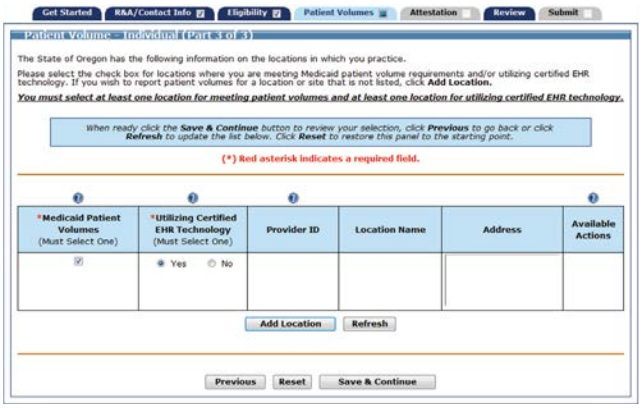
Depending on your practice type you will be asked for different information related to patient volume. Not all information you enter will be used in the patient volume percentage calculation. Information not used will be reviewed by the state Medicaid program to assist with determining your eligibility. The specific formula for each practice type percentage calculation is listed within the section for that practice type.

Part of the application process for the Medicaid EHR Incentive Program requires applicants to provide and attest to their patient volume data. We understand that this might be a challenge for some providers, particularly if they are still in the process of moving from paper to an EHR, but compiling that information is part of the application process. The Medicaid EHR Incentive Program staff is not able to provide patient data to providers to use in their applications. Data sources used to support patient volume attestations are required to be retained for seven years.

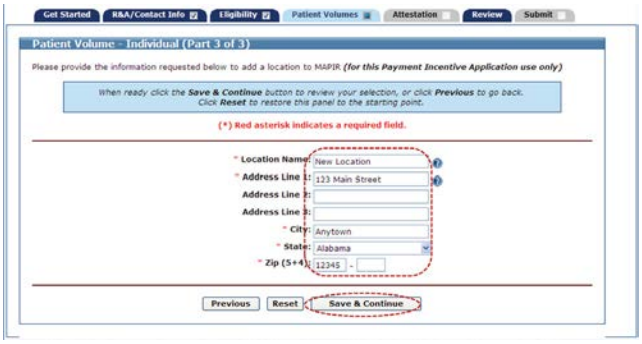
PATIENT VOLUME — INDIVIDUAL

The following pages will show you how to apply for the Medicaid EHR Incentive Program as an Individual provider. If you are not applying as an Individual provider please refer to the section on Patient Volume — Group.

- MAPIR will present a list of locations that Oregon has on record. Please contact the Medicaid EHR Incentive program if there are any issues with the information presented to you on this screen at 503-945-5898 or by emailing Medicaid.EHRIncentives@state.or.us.
- If you have additional locations, you can add them. Once all locations are added, you will enter the required Patient Volume information. Add new locations by clicking Add Location.

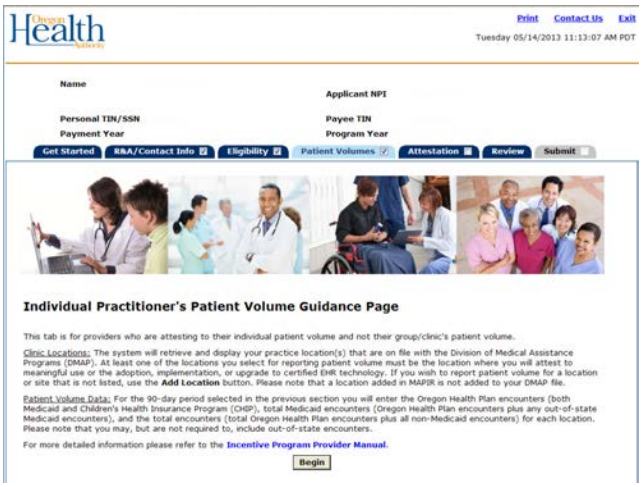


- If you clicked Add Location on the previous screen, you will see the following screen.
- Enter the requested practice location information.
- Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.



- For each location, check whether you will report Medicaid Patient Volume and whether you use Certified EHR Technology at that location. You must select at least one location for meeting patient requirements and at least one location for using certified EHR technology.
- If necessary, click **Edit** to make changes to an added location or Delete to remove it from the list. **Note:** The Edit and Delete options are not available for locations already on file.
- Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

Click **Begin** to proceed to the screens where you will enter patient volume.



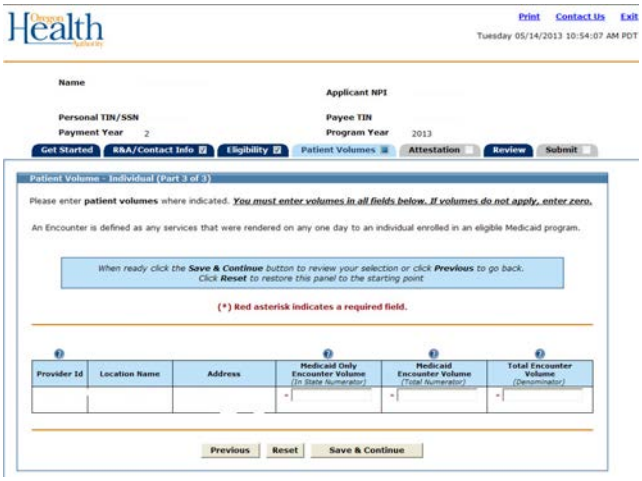
MEDICAID PATIENT VOLUME PERCENTAGE FORMULA — INDIVIDUAL

Individual Medicaid Encounter Volume

DIVIDED BY

Total Individual Encounter Volume

- Enter patient volume for each location listed on the screen.
- Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

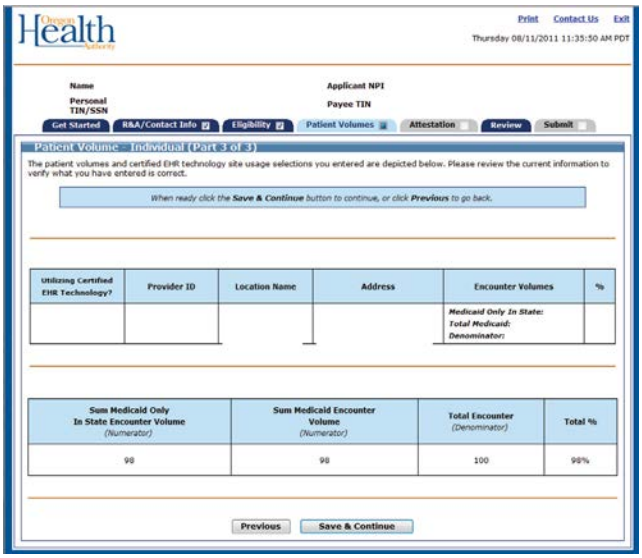


This screen displays the locations where you are using certified EHR technology, patient volume you entered, all values summarized, and the Medicaid Patient Volume Percentage.

- Review the information for accuracy.

Note the Total % patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For Pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement.

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

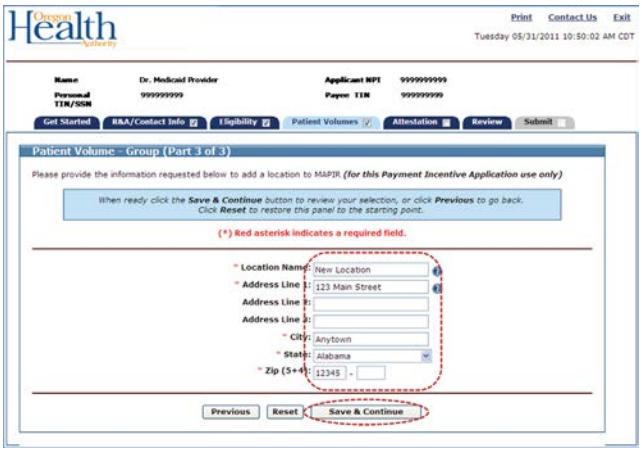


PATIENT VOLUME — GROUP

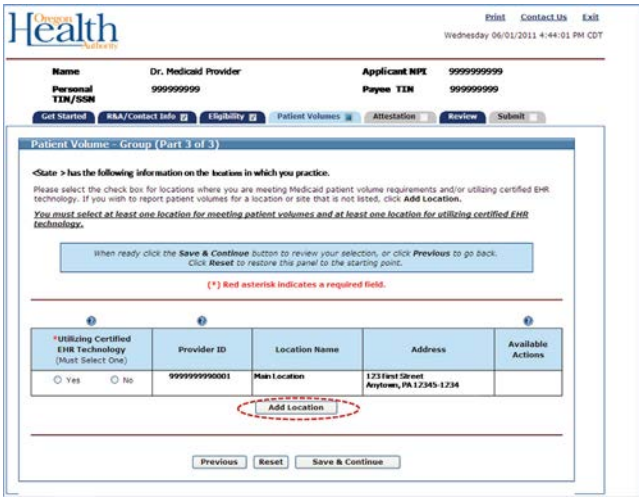
The following pages will show you how to apply for the EHR Incentive program as a Group provider. If you are not applying as a Group provider please refer to the section on Patient Volume — Individual.

- MAPIR will present a list of locations that Oregon has on record. Please contact the Medicaid EHR Incentive program if there are any issues with the information presented to you on this screen at 503-945-5898 or by emailing Medicaid.EHRIncentives@state.or.us.
- If you have additional locations, you can add them. Once all locations are added, you will enter the required Patient Volume information. Add new locations by clicking Add Location.

- If you clicked **Add Location** on the previous screen, you will see the following screen.
- Enter the requested practice location information.
- Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



- For each location, check whether you will report Medicaid Patient Volume and whether you use Certified EHR Technology at that location. You must select at least one location for meeting patient requirements and at least one location for using certified EHR technology.
- If necessary, click **Edit** to make changes to an added location or Delete to remove it from the list. **Note:** The Edit and Delete options are not available for locations already on file.
- Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



Click **Begin** to proceed to the screens where you will enter patient volume.

MEDICAID PATIENT VOLUME PERCENTAGE FORMULA — GROUP

Group Medicaid Encounter Volume

DIVIDED BY

Total Group Encounter Volume

It is important that you include all encounters for all practitioners in the clinic regardless of whether they can or will apply for an incentive payment.

- Enter Group Practice Provider IDs. These are the NPIs that you use to bill Medicaid.

If you listed four Group Practice Provider IDs and the patient volume numbers at the bottom reflect more than the four IDs you listed, please check the box directly below the provider IDs.

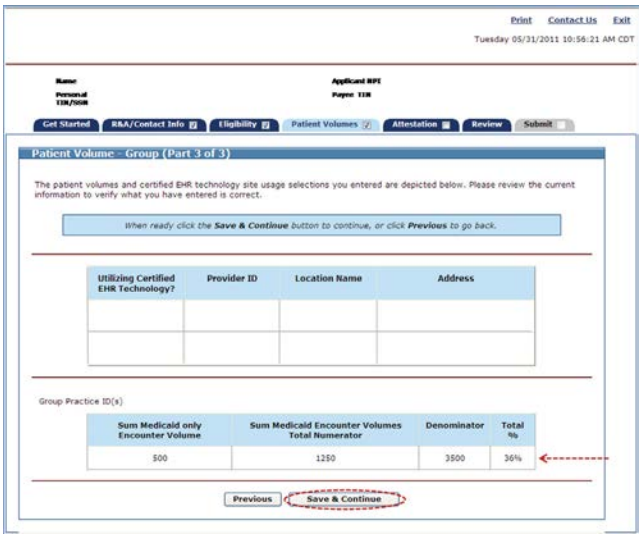
- Enter Patient Volume for the locations.
- Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point or last saved data.

This screen displays the locations where you are using certified EHR technology, patient volume you entered, all values summarized, and the Medicaid Patient Volume Percentage.

- Review the information for accuracy.

Note the Total % patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For Pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement.

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

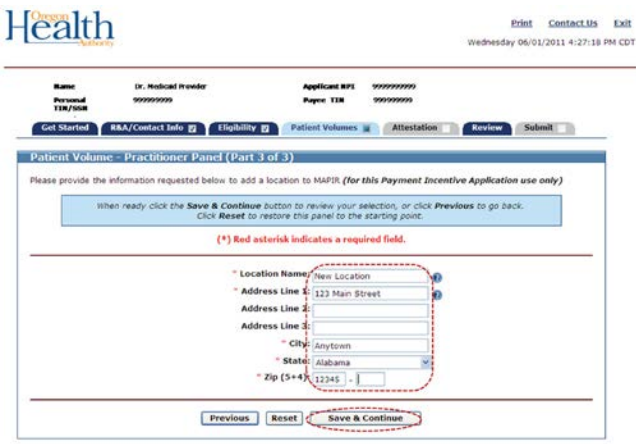


PATIENT VOLUME — PRACTITIONER PANEL (INDIVIDUAL & GROUP)

***** IF YOU ARE CONSIDERING USING THE PRACTITIONER PANEL, PLEASE CONTACT THE MEDICAID EHR INCENTIVE PROGRAM STAFF FIRST BEFORE PROCEEDING BY EMAILING MEDICAID.EHRINCENTIVES@STATE.OR.US. *****

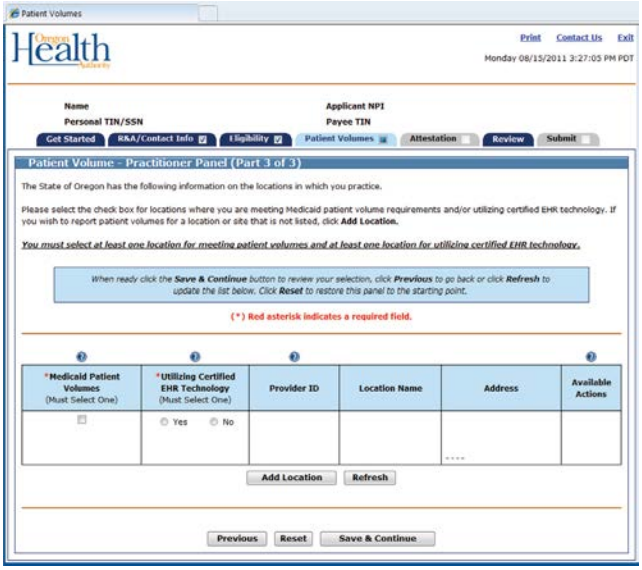
The following pages will show you how to apply for the EHR Incentive program as an Individual Practitioner Panel or Group Practitioner Panel provider.

- MAPIR will present a list of locations that Oregon has on record. Please contact the Medicaid EHR Incentive program if there are any issues with the information presented to you on this screen at 503-945-5898 or by emailing Medicaid.EHRIncentives@state.or.us.
- If you have additional locations, you can add them. Once all locations are added, you will enter the required Patient Volume information. Add new locations by clicking Add Location.
- If you clicked **Add Location** on the previous screen, you will see the following screen.
- Enter the requested practice location information.
- Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or the last saved data.



- For each location, check whether you will report Medicaid Patient Volume and whether you use Certified EHR Technology at that location. You must select at least one location for meeting patient requirements and at least one location for using certified EHR technology.

- If necessary, click **Edit** to make changes to an added location or Delete to remove it from the list. **Note:** The Edit and Delete options are not available for locations already on file.
- Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



- Click **Begin** to proceed to the screens where you will enter patient volume.

MEDICAID PATIENT VOLUME PERCENTAGE FORMULA — PRACTITIONER PANEL

(Total Medicaid Patients on the Individual Practitioner Panel + Individual's Unduplicated Medicaid Only Encounter Volume)

DIVIDED BY

(Individual's Total Patient Panel Encounters + Individual's Total Unduplicated Encounter Volume)

OR

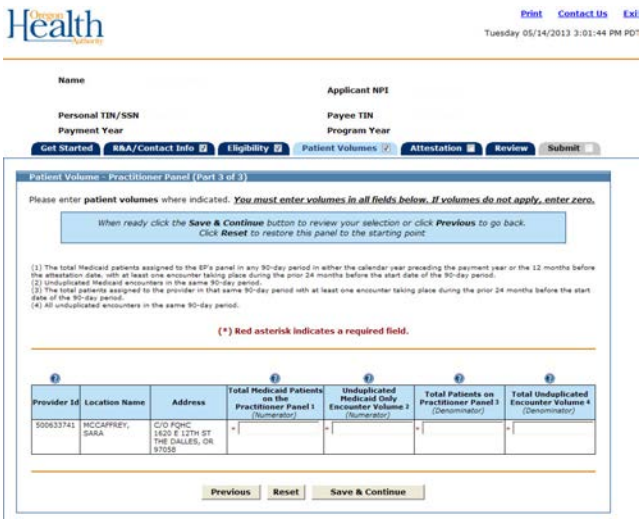
MEDICAID PATIENT VOLUME PERCENTAGE FORMULA — GROUP'S PRACTITIONER PANEL

(Total Medicaid Patients on the Group's Practitioner Panel + Group's Unduplicated Medicaid Only Encounter Volume)

DIVIDED BY

(Group's Total Patient Panel Encounters + Group's Total Unduplicated Encounter Volume)

- Enter patient volume for each location listed in the screen.
- Click **Save & Continue** to review your selection or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

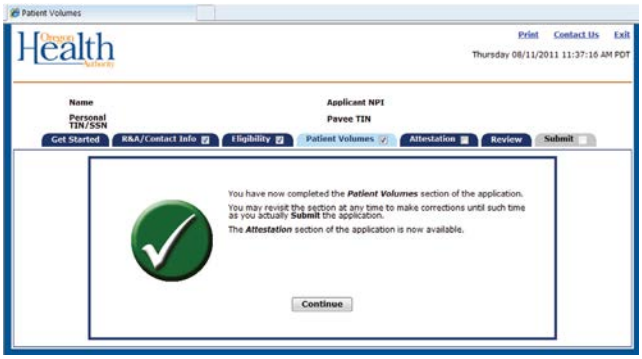


This screen displays the locations where you are using certified EHR technology, patient volume you entered, all values summarized, and the Medicaid Patient Volume Percentage.

- Review the information for accuracy.

Note the Total % patient volume field. This percentage must be greater than or equal to 30% to meet the Medicaid patient volume requirement. For Pediatricians the percentage must be greater than or equal to 20% to meet the Medicaid patient volume requirement.

- Click Save & Continue to proceed or Previous to go back.



STEP 5 — ATTESTATION

This section will ask you to provide information about your EHR System Adoption Phase. Adoption phases include Adoption, Implementation, Upgrade, and Meaningful Use. Based on the adoption phase you select, you may be asked to complete additional information about activities related to that phase.

For the first year of participation in the Medicaid EHR Incentive Program, Eligible Professionals will have the option to attest to Adoption, Implementation, or Upgrade. After the first year of participation, Eligible Professionals are required to attest to Meaningful Use.

This initial Attestation screen provides information about this section.

Click **Begin** to continue to the Attestation section.

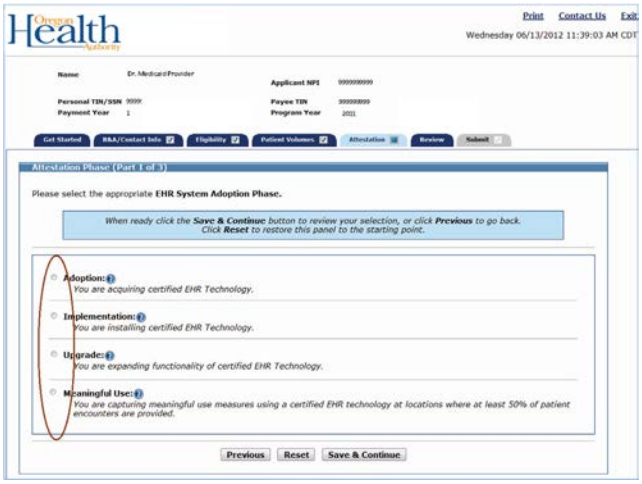
ATTESTATION PHASE (PART 1 OF 3)

The Attestation Phase (Part 1 of 3) screen asks for the EHR System Adoption Phase.

The screen shown below is the Attestation Phase (Part 1 of 3) screen you will see if it is your first year participating (Payment Year 1).

If it is not your first year participating (Payment Year 2 or beyond), turn to the meaningful use section in this guide. After making your selection, the next screen you see will depend on the phase you selected.

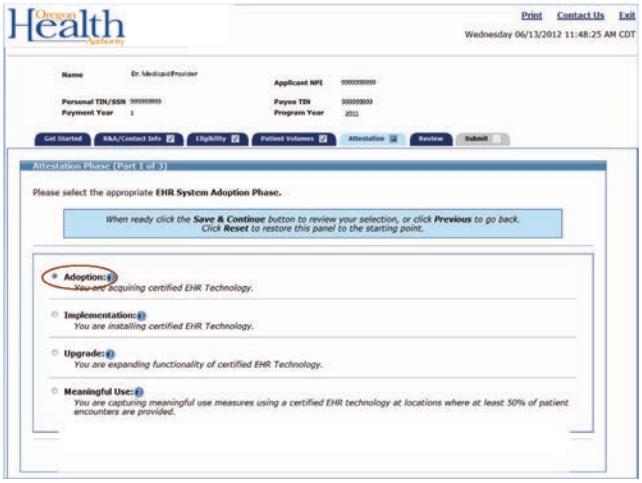
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



For Adoption continue to the next page of this guide.

ADOPTION PHASE

For Adoption select the Adoption button. Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



IMPLEMENTATION PHASE (PART 2 OF 3)

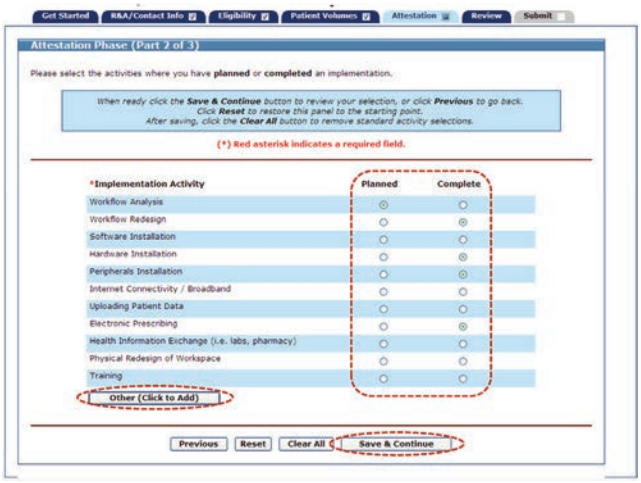
For Implementation select the Implementation button.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

Select your Implementation Activity by selecting the Planned or Complete button.

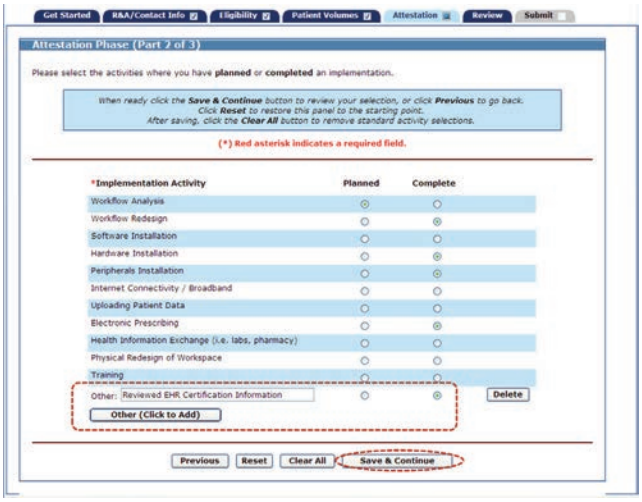
Click **Other** to add any additional Implementation Activities you would like to supply.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data. This is an example of a completed screen.



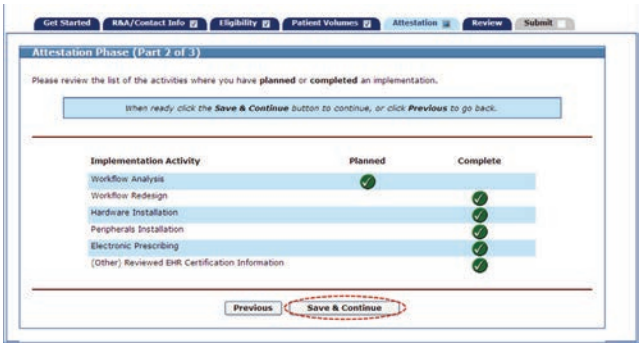
This screen shows an example of entering activities other than what was in the Implementation Activity listing.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data. After saving, click **Clear All** to remove standard activity selections.



Review the Implementation Activity you selected.

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



UPGRADE PHASE (PART 2 OF 3)

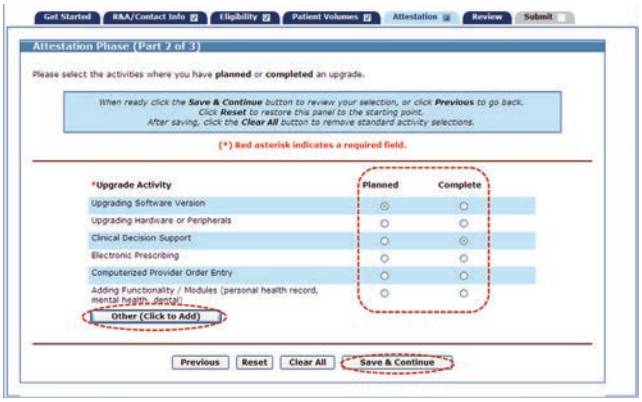
For Upgrade select the Upgrade button.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

Select your Upgrade Activities by selecting the Planned or Complete button for each activity.

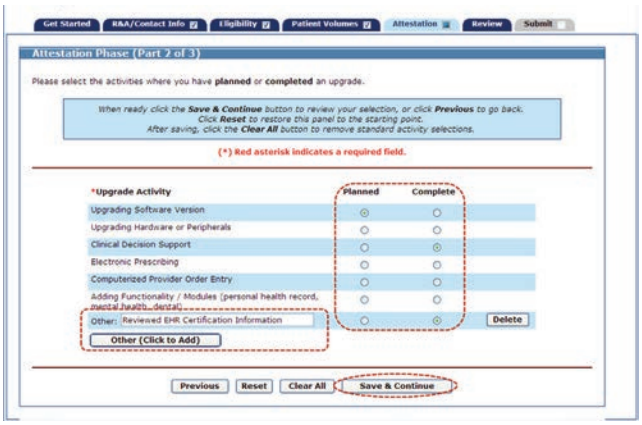
Click **Other** to add any additional Upgrade Activities you would like to supply.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data. After saving, click **Clear All** to remove standard activity selections.



This screen shows an example of entering activities other than what was in the Upgrade Activity listing.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data. After saving, click **Clear All** to remove standard activity selections.



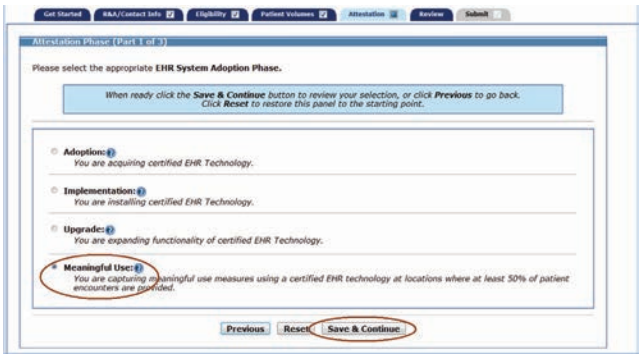
Review the Upgrade Activities you selected.

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

MEANINGFUL USE PHASE

For Meaningful Use select the Meaningful Use button.

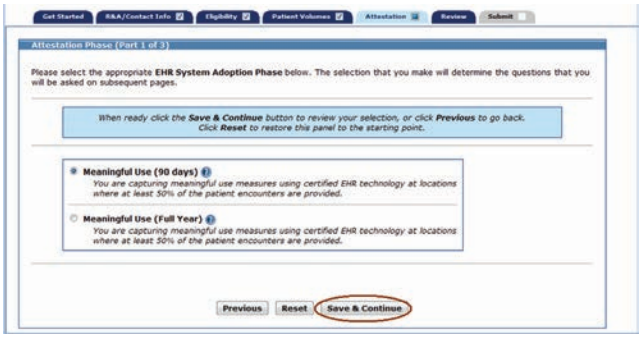
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



Select a 90-day period or a full year period for reporting Meaningful Use of certified EHR technology.

You may only select a 90-day reporting period in your first year of reporting meaningful use.

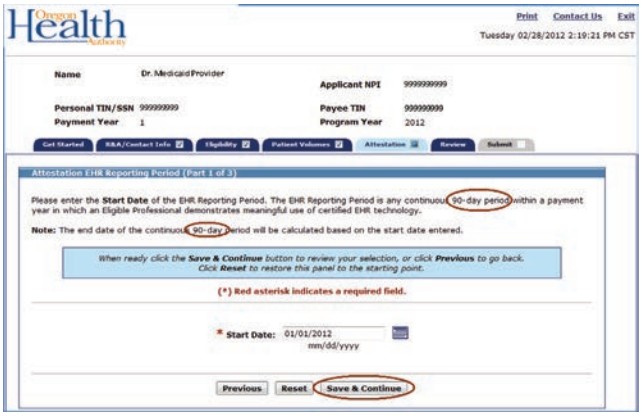
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.



Depending on the selection made on the previous screen, the Attestation EHR Reporting Period (Part 1 of 3) screen will display with the 90-day period or the full year period. The example below displays the 90-day period.

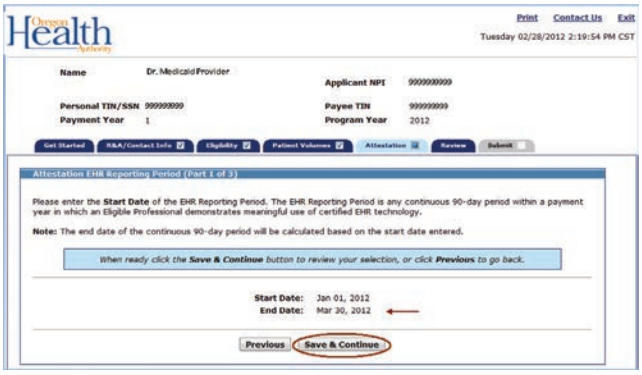
Enter a **Start Date** or use the **calendar** located to the right of the Start Date field.

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



This screen displays an example of a Start Date of January 1, 2012 and a system-calculated End Date of March 30, 2012.

Click **Save & Continue** to review your selection, or click **Previous** to go back.



ATTESTATION MEANINGFUL USE MEASURES

The screen on the following page displays the Measures Topic List. The Attestation Meaningful Use Measures are divided into six distinct topics: General Requirements, Core Measures, Menu Measures, Core Clinical Quality Measures, Alternate Core Clinical Quality Measures, and Additional Clinical Quality Measures.

You may select any of the six topics and complete them in any order. You are not required to complete any of the Alternate Core Clinical Quality Measures unless you have entered a zero denominator for one or more Core Clinical Quality Measures.

While it is not required that you begin each topic in the order shown on the screen, this user guide will follow the order in which the topics are listed.

Click **Begin** to start a topic.

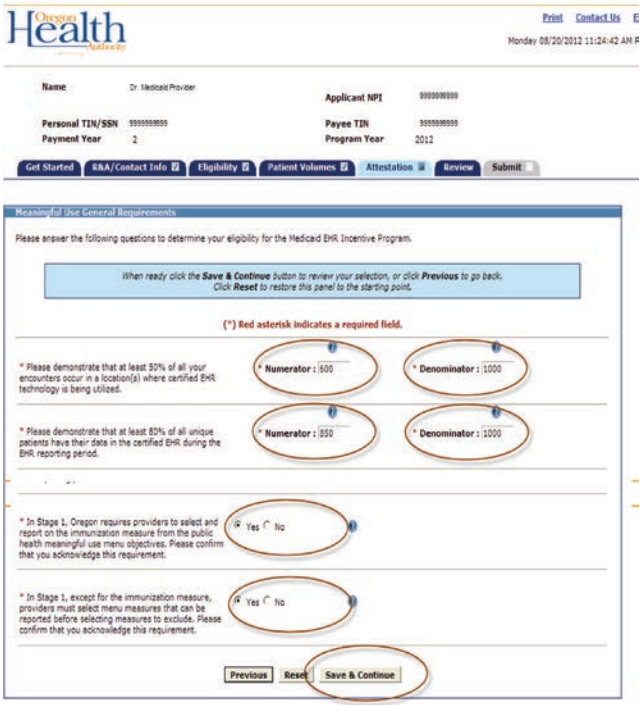
MEANINGFUL USE GENERAL REQUIREMENTS

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator entered. The numerator and denominator entries must be positive whole numbers.

Please also note the requirements surrounding the immunizations reporting in the menu set of measures.

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



If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure at any point prior to submitting the application.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.

MEANINGFUL USE CORE MEASURES

This screen provides information about the Meaningful Use Core Measures.

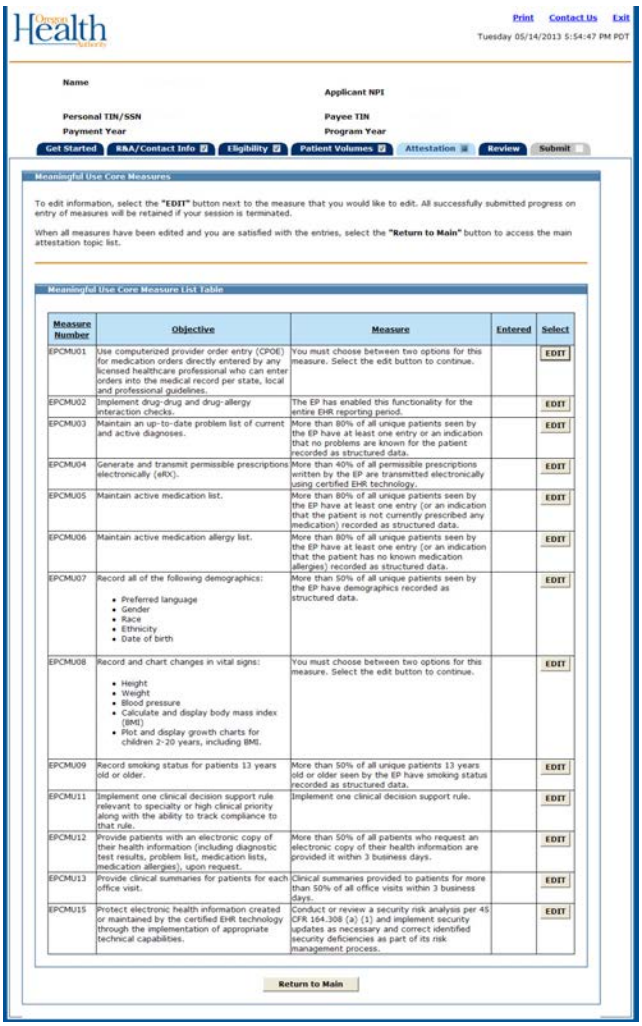
Click Begin to continue to the Meaningful Use Core Measure List Table.

The screen on the following page displays the Meaningful Use Core Measure List Table.

The first time a topic is accessed you will see an Edit option for each measure.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.

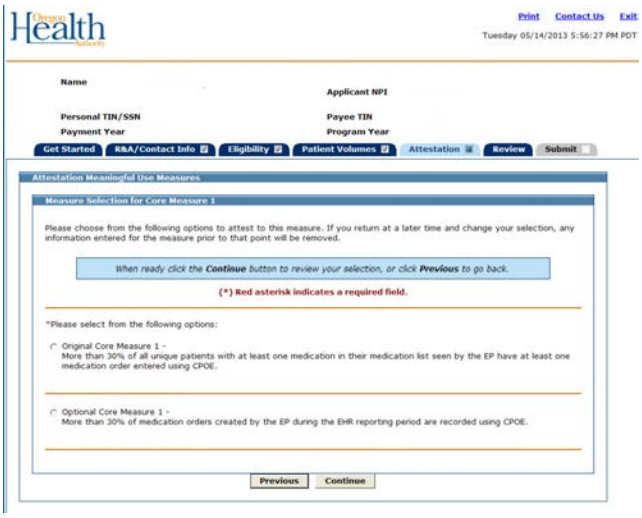
Click **Edit** to enter or edit information for a measure or click **Return** to Main to return to the Measures Topic List.



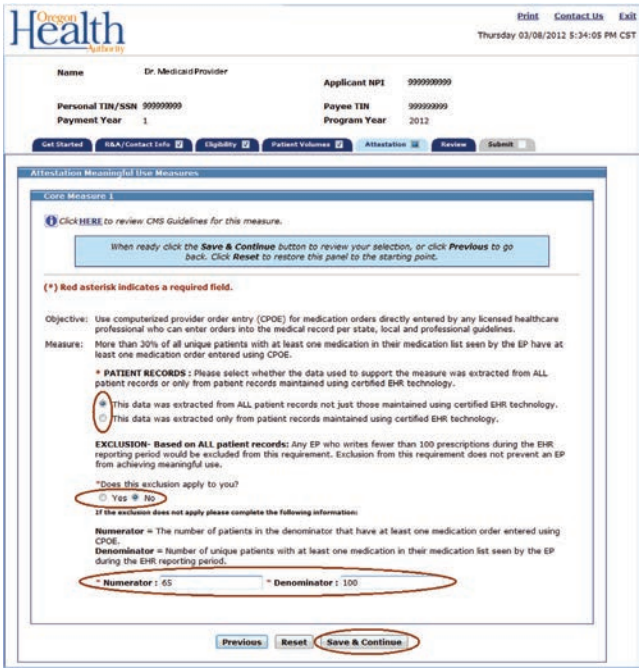
Measure Number	Objective	Measure	Entered	Select
EPCMU01	Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	You must choose between two options for this measure. Select the edit button to continue.		EDIT
EPCMU02	Implement drug-drug and drug-allergy interaction checks.	The EP has enabled this functionality for the entire EHR reporting period.		EDIT
EPCMU03	Maintain an up-to-date problem list of current and active diagnoses.	More than 80% of all unique patients seen by the EP have at least one entry or an indication that no problems are known for the patient recorded as structured data.		EDIT
EPCMU04	Generate and transmit permissible prescriptions electronically (eRX).	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.		EDIT
EPCMU05	Maintain active medication list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.		EDIT
EPCMU06	Maintain active medication allergy list.	More than 80% of all unique patients seen by the EP have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data.		EDIT
EPCMU07	Record all of the following demographics: • Preferred language • Gender • Race • Ethnicity • Date of birth	More than 50% of all unique patients seen by the EP have demographics recorded as structured data.		EDIT
EPCMU08	Record and chart changes in vital signs: • Height • Weight • Blood pressure • Calculate and display body mass index (BMI) • Plot and display growth charts for children 2-20 years, including BMI.	You must choose between two options for this measure. Select the edit button to continue.		EDIT
EPCMU09	Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.		EDIT
EPCMU11	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.	Implement one clinical decision support rule.		EDIT
EPCMU12	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.		EDIT
EPCMU13	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.		EDIT
EPCMU15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.		EDIT

Core Measure 1 (Measure Code EPCMU01)

There are two possible ways to calculate this measure. Select the method you will be using by clicking on one of the options below.



If you selected Original Core Measure 1, you will see the following screen.



If you selected Optional Core Measure 1, you will see the following screen.

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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

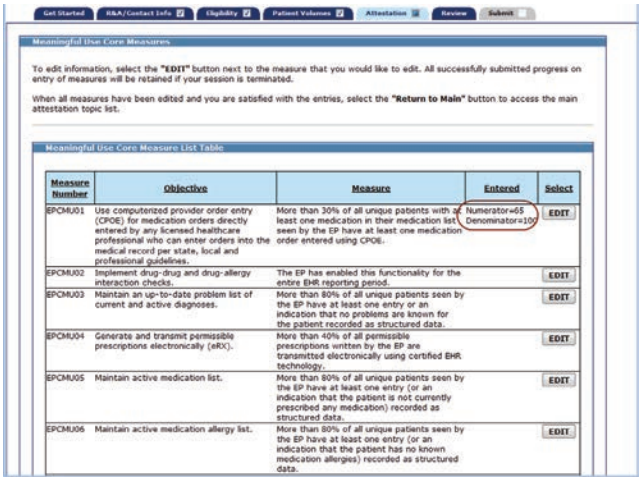
If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

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

After you enter information for a measure and click **Save & Continue**, you will be returned to the Meaningful Use Core Measure List Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below (please note that the entire screen is not displayed in this example).

You can continue to edit the measures at any point prior to submitting the application.

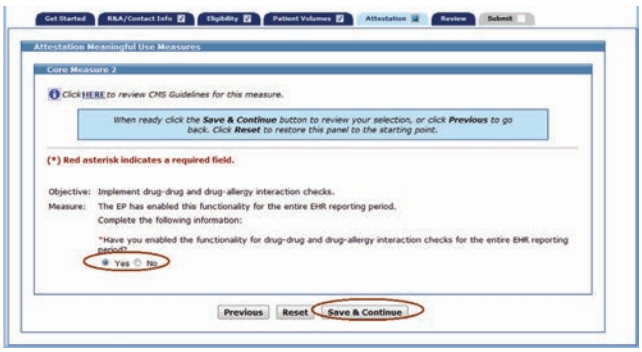
Click **Edit** for the next measure.



Core Measure 2 (Measure Code EPCMU02)

Enter information in all required fields.

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

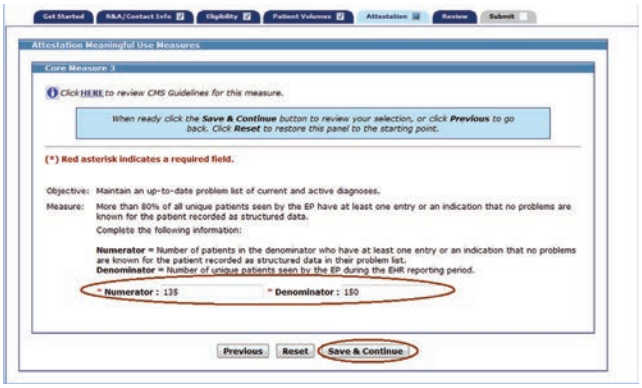


Core Measure 3 (Measure Code EPCMU03)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers.

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



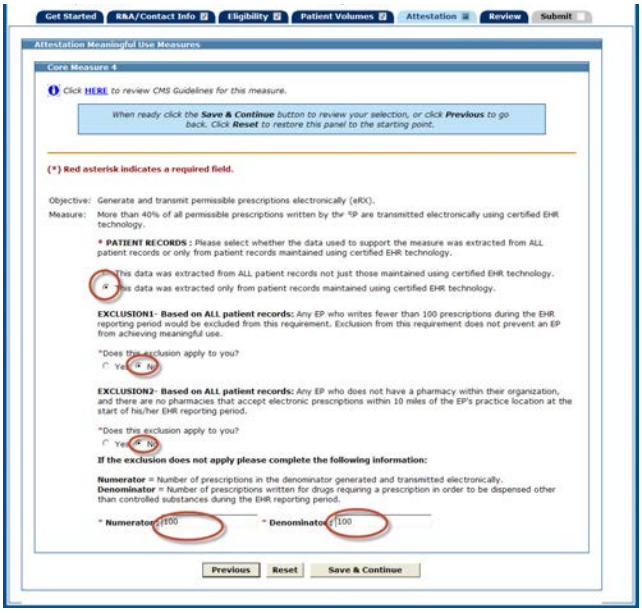
Core Measure 4 (Measure Code EPCMU04)

Enter information in all required fields.

If either exclusion applies to you, refer to the next example and screen.

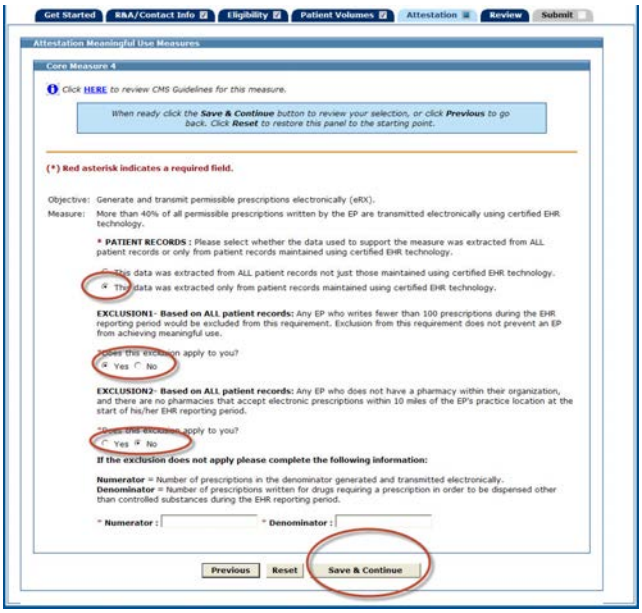
If the exclusions do not apply to you, answer the Patient Records question, select **No** to the exclusions, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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



If one or both of the exclusions applies to you, answer the Patient Records question, select **Yes** to the applicable exclusion(s), and do not enter a numerator and denominator.

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



Core Measure 5 (Measure Code EPCMU05)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers.

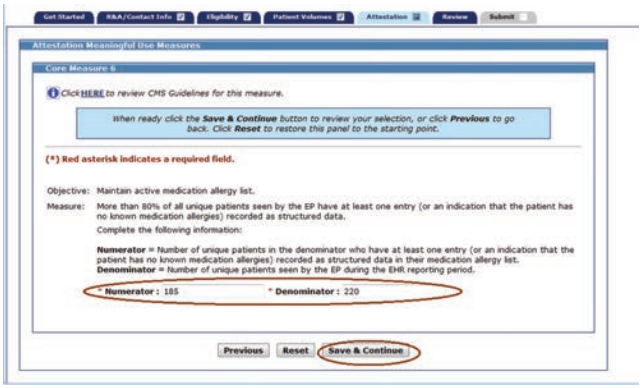
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.

Core Measure 6 (Measure Code EPCMU06)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers.

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

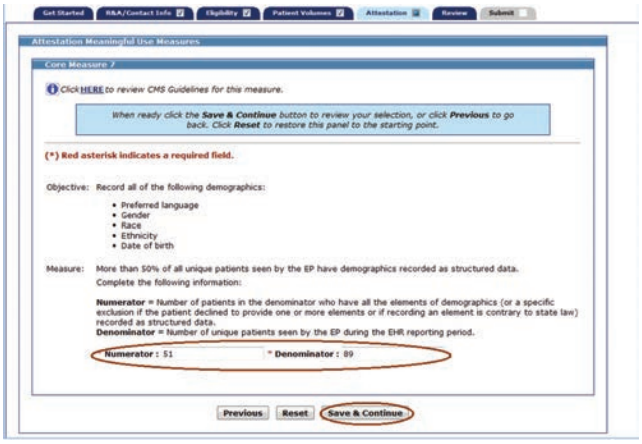


Core Measure 7 (Measure Code EPCMU07)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers.

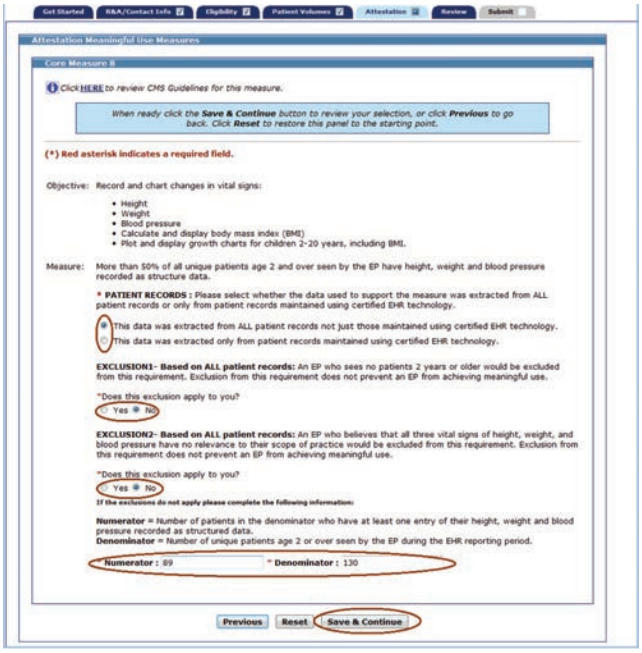
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.



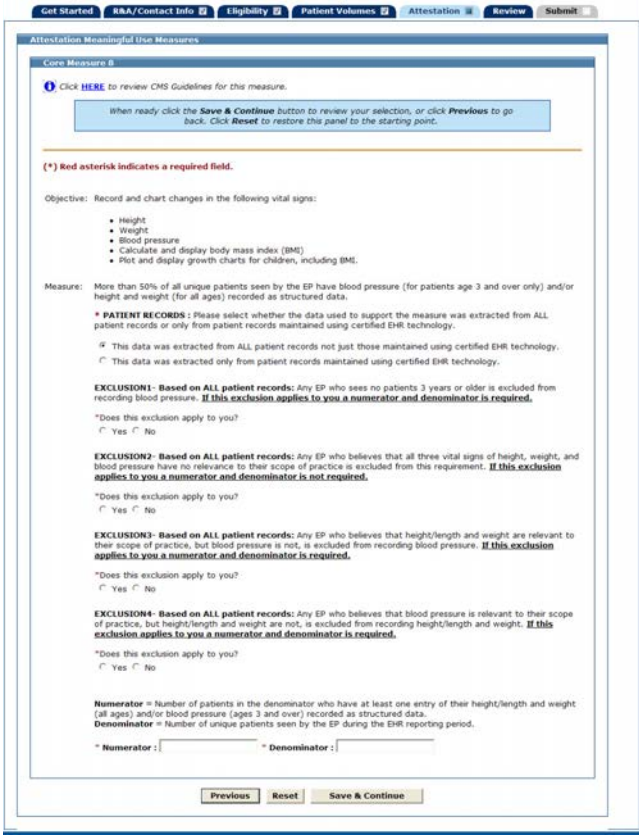
Core Measure 8 (Measure Code EPCMU08)

There are two possible ways to calculate this measure. Select the method you will be using by clicking on one of the options below:

If you selected Original Core Measure 8, you will see the following screen:



If you selected Optional Core Measure 8, you will see the following screen:



The first set of screen shots and instructions refers to Original Core Measure 8. If you selected the Optional Core Measure 8, skip to next section.

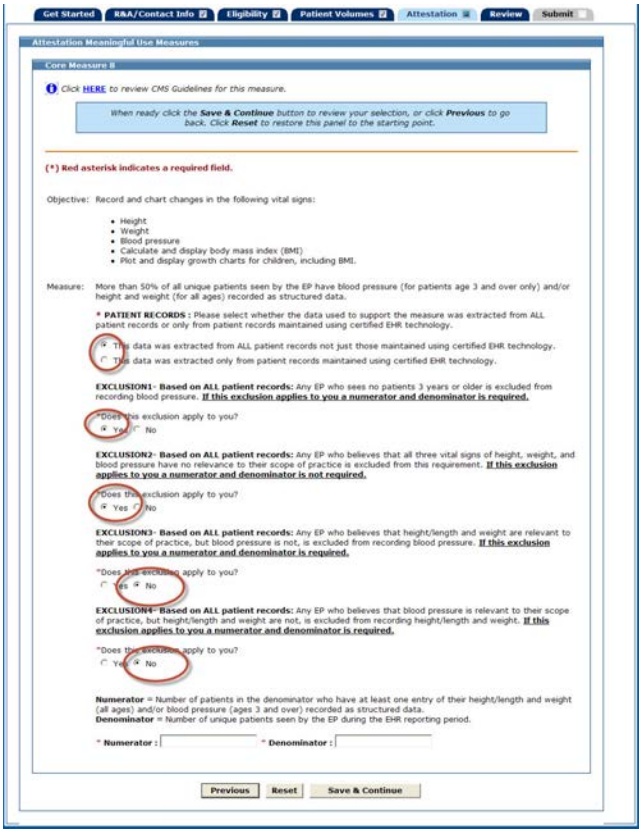
Enter information in all required fields

If any of the exclusions apply to you, refer to the next example and screen

If the exclusions do not apply to you, answer the Patient Records question, select **No** to each of the exclusions, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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

Optional Core Measure 8



If either of the exclusions applies to you, answer the Patient Records question, select **Yes** to the exclusion(s), and follow the instructions to determine whether you will need to enter a numerator and denominator.

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

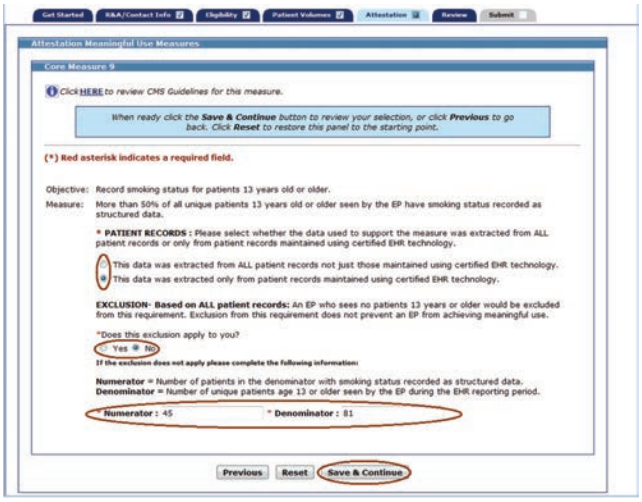
Core Measure 9 (Measure Code EPCMU09)

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

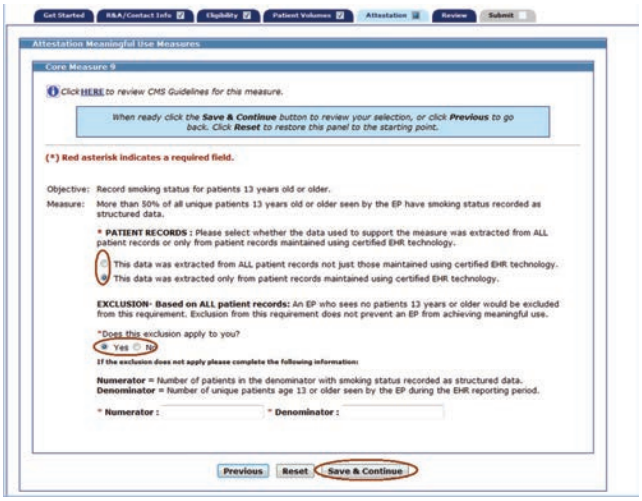
If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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



If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

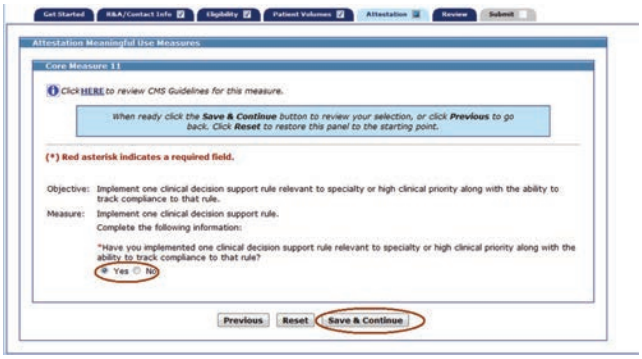
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.



Core Measure 11 (Measure Code EPCMU11)

Enter information in all required fields.

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



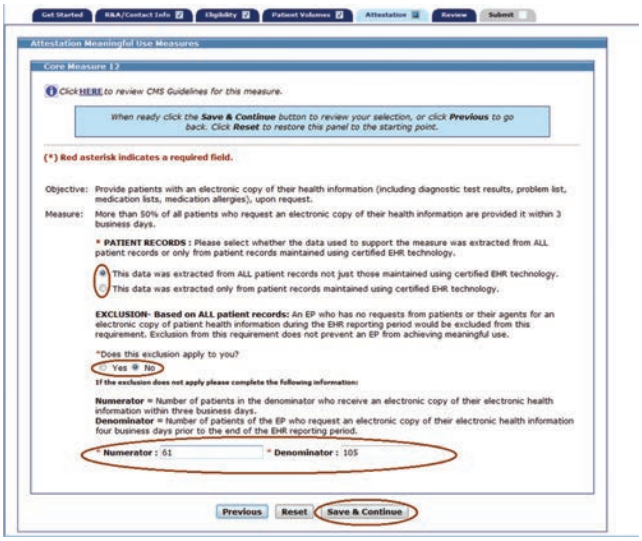
Core Measure 12 (Measure Code EPCMU12)

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

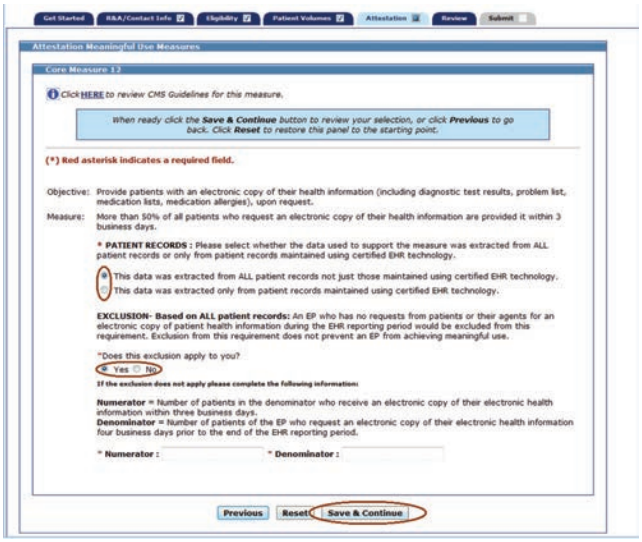
If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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



If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

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



Core Measure 13 (Measure Code EPCMU13)

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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

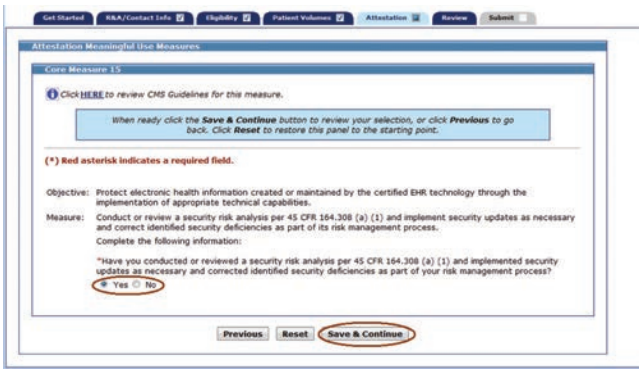
If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

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

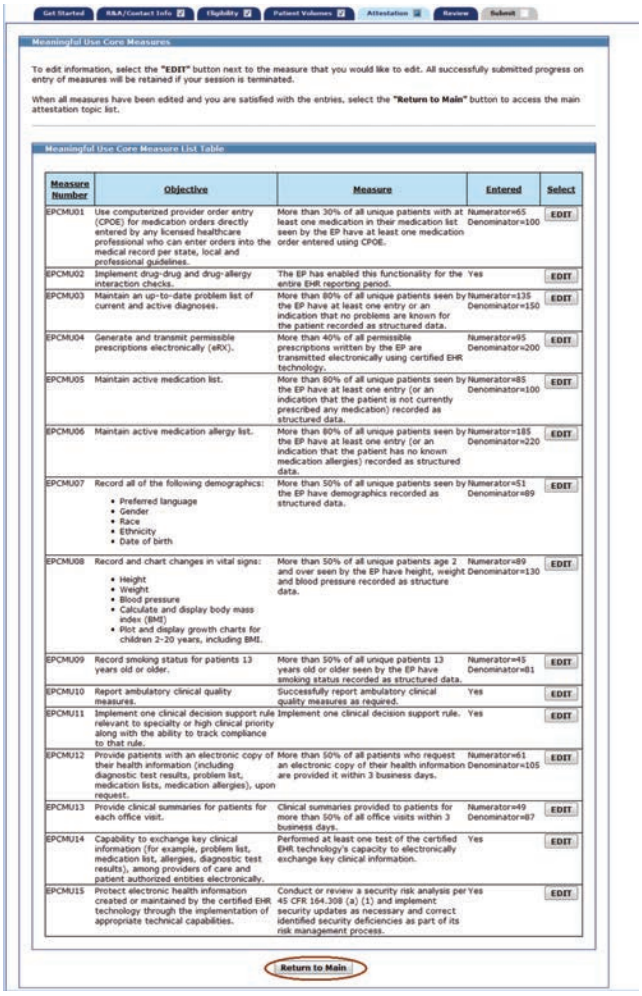
Core Measure 15 (Measure Code EPCMU15)

Enter information in all required fields.

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

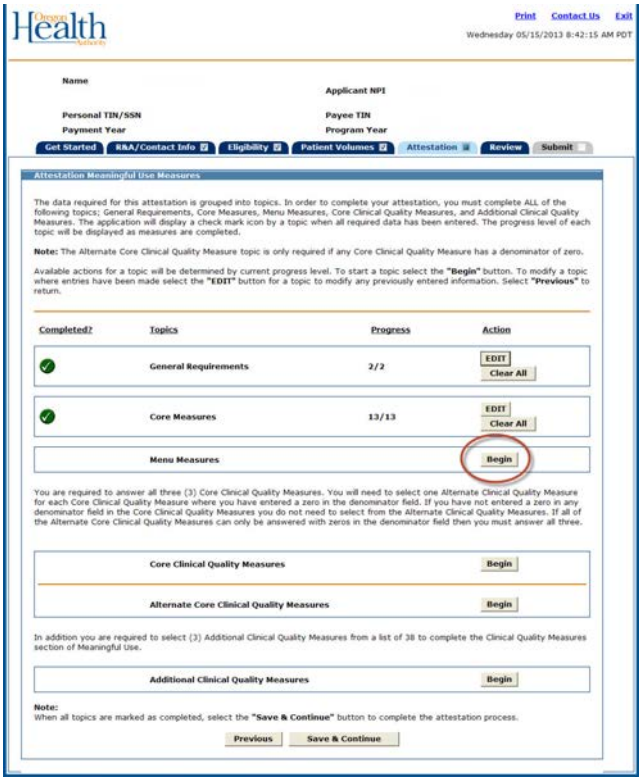


Once you attested to all the measures for this topic, click **Return to Main** to return to the Measures Topic List.



If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure at any point prior to submitting the application.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.



MEANINGFUL USE MENU MEASURES

This initial screen provides information about the Menu Measures.

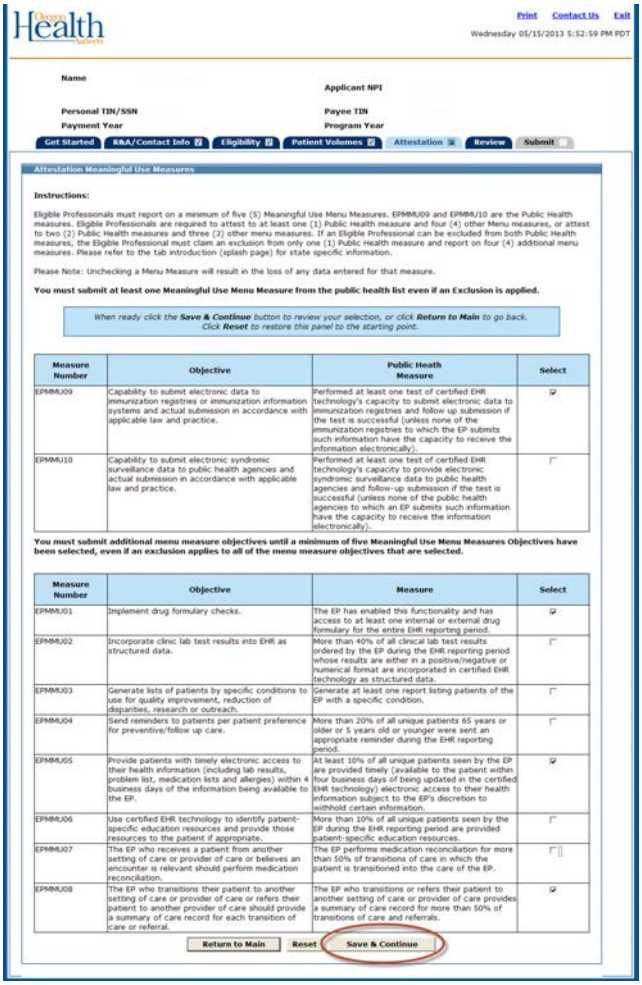
Click **Begin** to continue to the Meaningful Use Menu Measures Selection screen.

From the Meaningful Use Menu Measures Selection screen displayed on the following page, choose five Meaningful Use Menu Measures. Please note, **Oregon providers must select and report on the public health immunizations measure.**

In the example shown on the following page, one public health measure and four measures from the additional Meaningful Use Measures listed are selected.

If a measure is selected and information is entered for that measure, unselecting the measure will clear all information previously entered.

Click **Save & Continue** to proceed, or click **Return to Main** to go back. Click **Reset** to restore this panel to the starting point.



The five measures you selected to attest to will display on the Meaningful Use Menu Measure Worksheet. The example below displays the five measures selected on the previous screen example.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.

Click **Edit** to enter or edit information for a measure or click **Return** to Selection List to return to the Meaningful Use Menu Measures Selection screen.

The 10 available Meaningful Use Menu Measures are described in this user guide. Only those that you selected will apply to you.

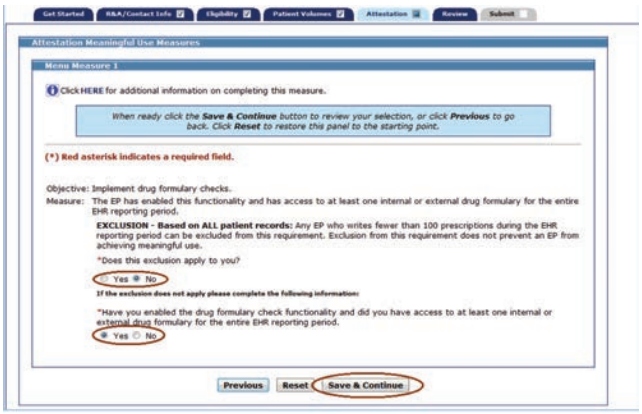
Menu Measure 1 (Measure Code EPMMU01)

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

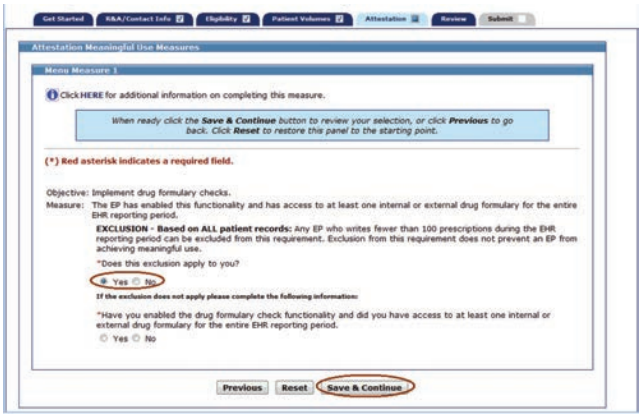
If the exclusion does not apply to you, select **No** to the exclusion and answer the question. In the example below, the exclusion does not apply.

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



If the exclusion applies to you, select **Yes** to the exclusion.

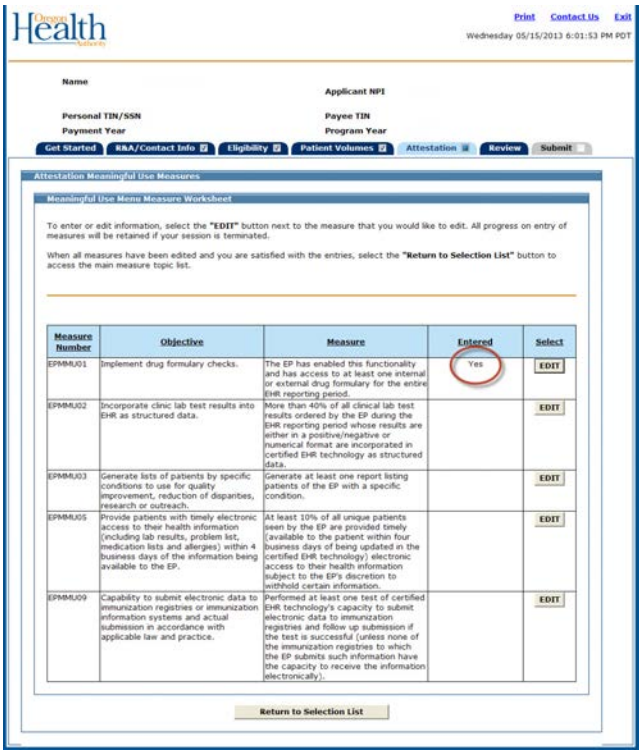
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.



After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Menu Measure Worksheet. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.



Menu Measure 2 (Measure Code EPMMU02)

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

If the exclusion does not apply to you, select **No** to the exclusion and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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

If the exclusion applies to you, select **Yes** to the exclusion and do not enter a numerator and denominator.

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

Menu Measure 3 (Measure Code EPMMU03)

Enter information in all required fields.

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

Menu Measure 4 (Measure Code EPMMU04)

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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

If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

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

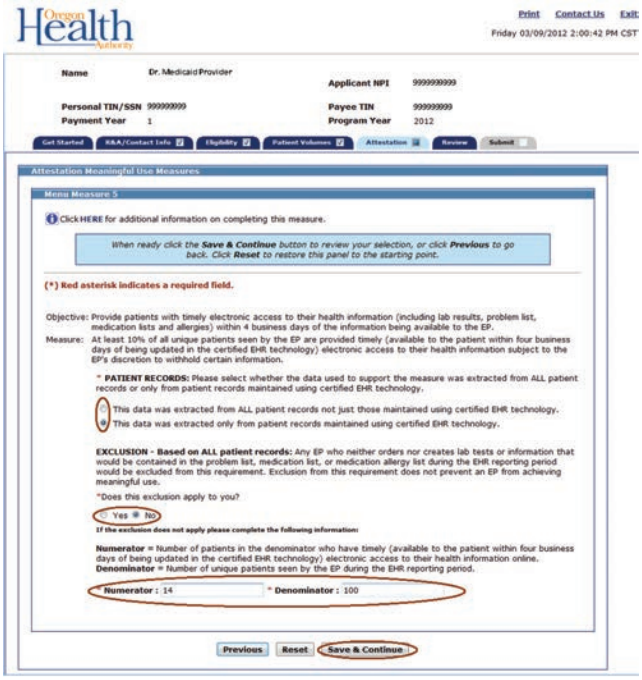
Menu Measure 5 (Measure Code EPMMU05)

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

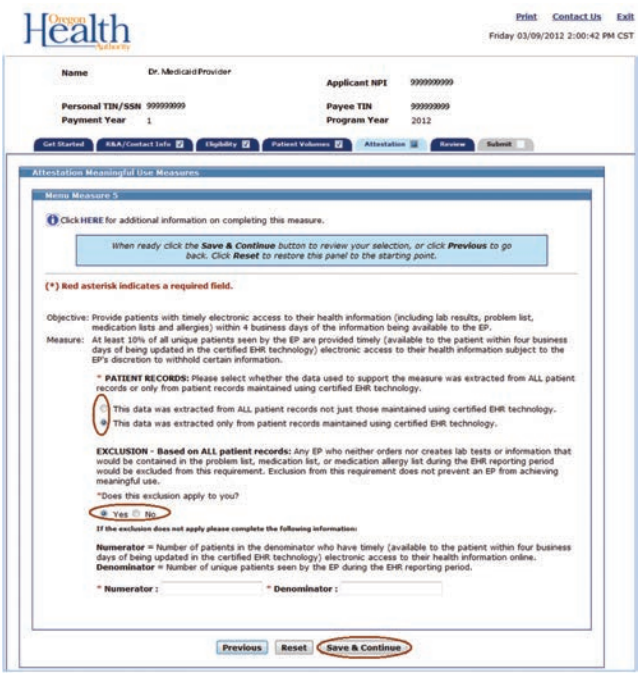
If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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



If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

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

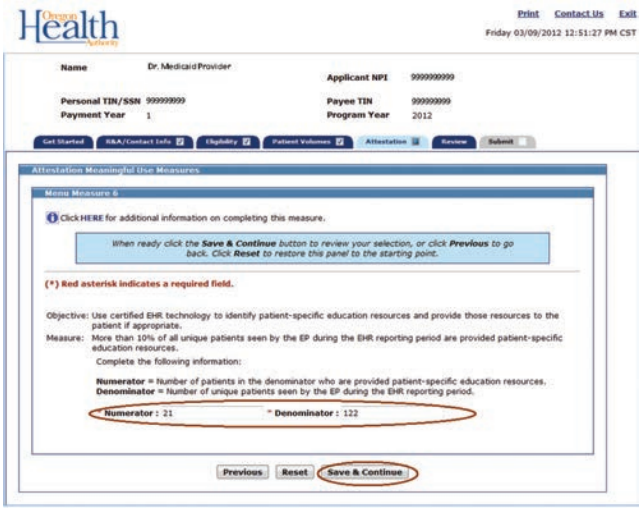


Menu Measure 6 (Measure Code EPMMU06)

Enter information in all required fields.

The denominator entered must be greater than or equal to the numerator. The numerator and denominator must be positive whole numbers.

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



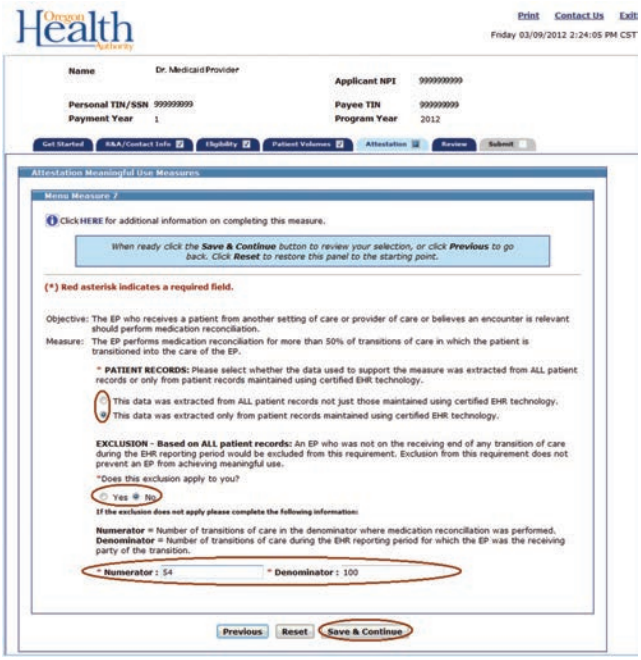
Menu Measure 7 (Measure Code EPMMU07)

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

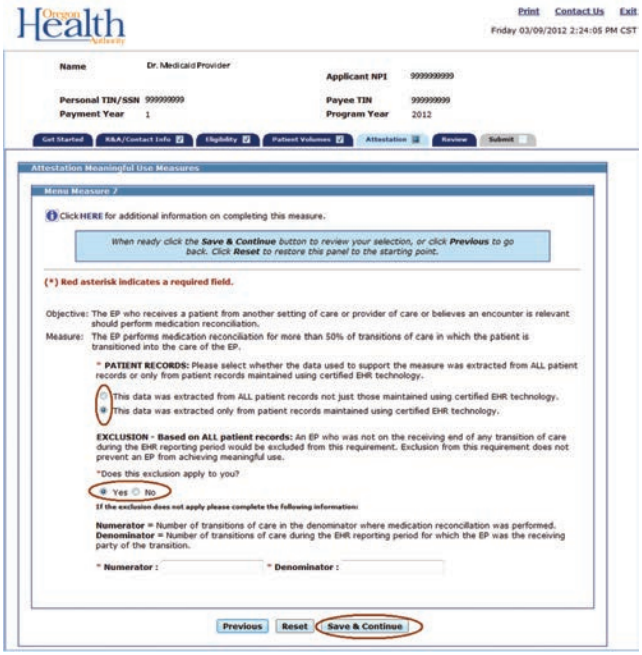
If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion, and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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



If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

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



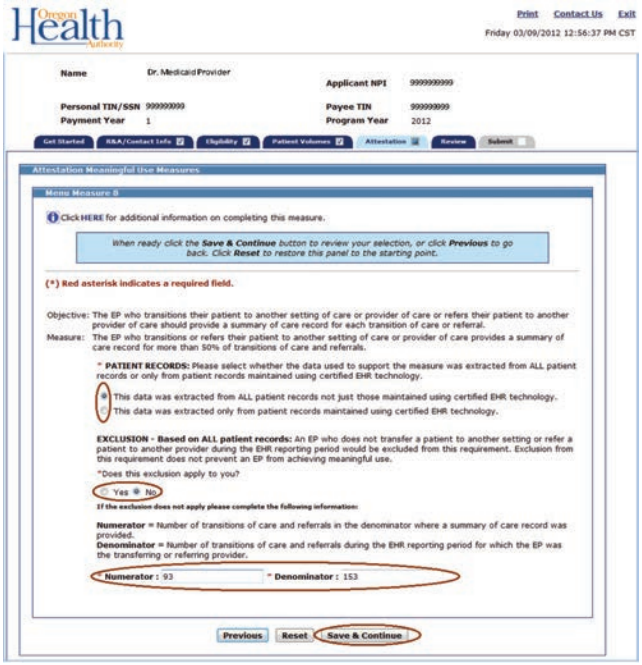
Menu Measure 8 (Measure Code EPMMU08)

Enter information in all required fields.

If the exclusion applies to you, refer to the next example and screen.

If the exclusion does not apply to you, answer the Patient Records question, select **No** to the exclusion and enter a numerator and denominator. The denominator entered must be greater than or equal to the numerator. The numerator and denominator entries must be positive whole numbers. In the example below, the exclusion does not apply.

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



If the exclusion applies to you, answer the Patient Records question, select **Yes** to the exclusion, and do not enter a numerator and denominator.

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

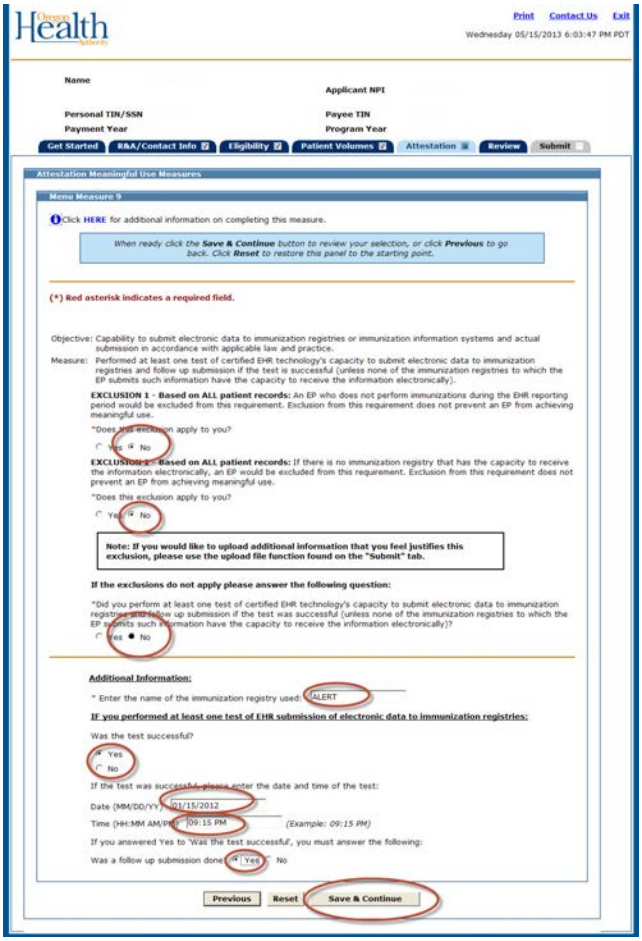
Menu Measure 9 (Measure Code EPMMU09)

Enter information in all required fields. Eligible professionals in Oregon must select and report data for this measure or that an exclusion applies.

If Exclusion 1 applies to you, refer to the second screen for this Menu Measure. Exclusion 2 does not apply to Oregon providers.

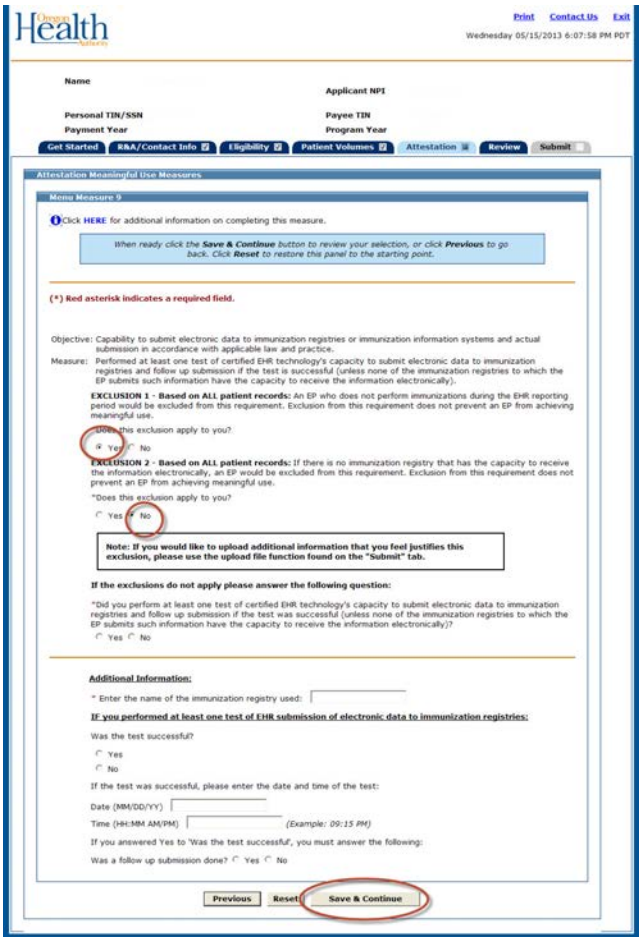
If Exclusion 1 and 2 do not apply to you, select **No** to the exclusions and answer the EHR technology question. If you answered yes to the EHR Technology question, complete the Additional Information section of the screen. In the example below, the exclusion does not apply.

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



If Exclusion 1 applies to you, select **Yes** and do not answer the EHR technology question.

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



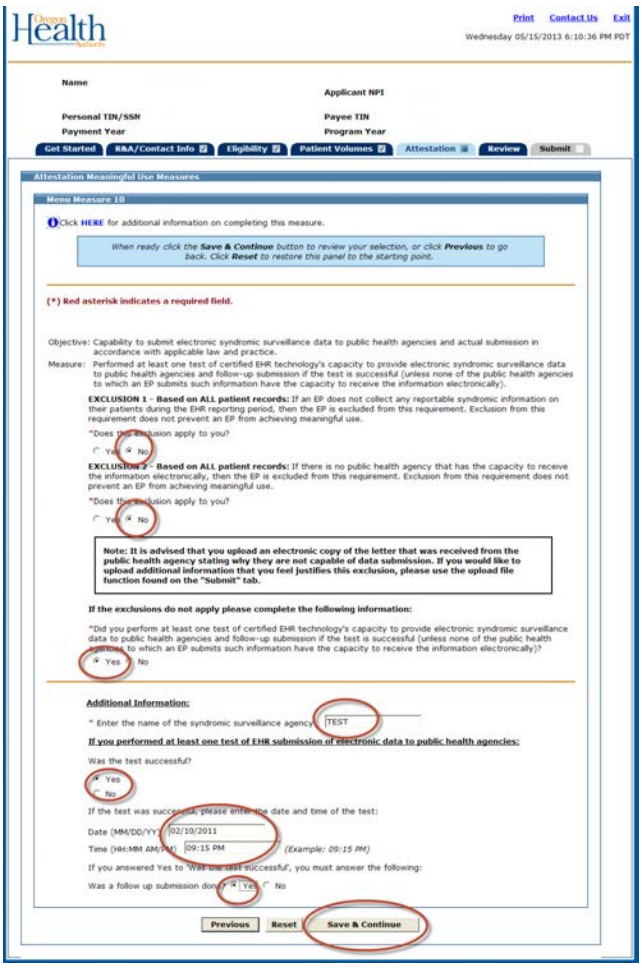
Menu Measure 10 (Measure Code EPMMU10)

Enter information in all required fields.

If Exclusion 1 and/or Exclusion 2 apply to you, refer to the next example and screen.

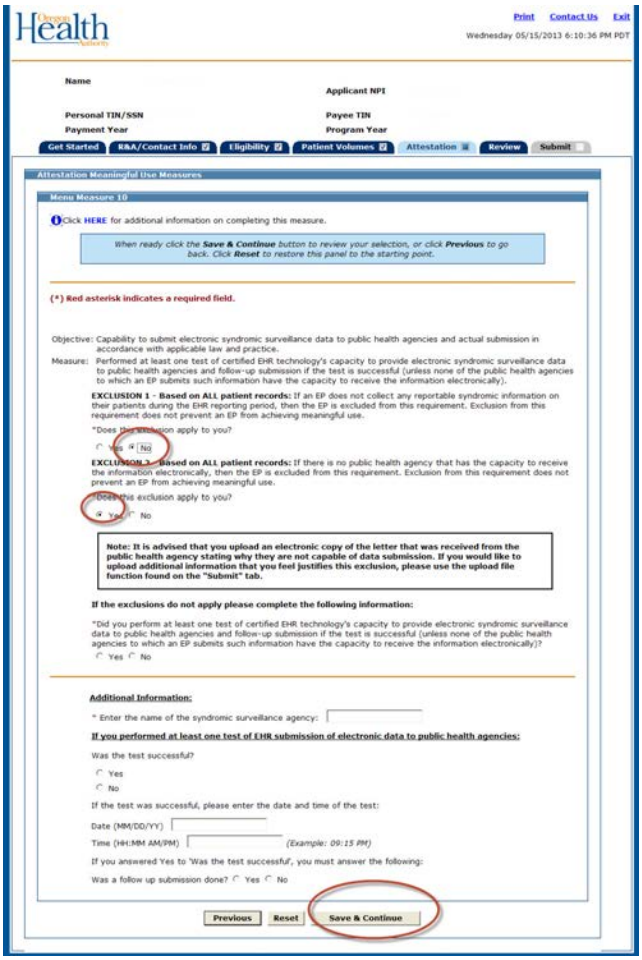
If Exclusion 1 and 2 do not apply to you, select **No** to the exclusions and answer the EHR technology question. If you answered yes to the EHR Technology question, complete the Additional Information section of the screen. In the example below, the exclusion does not apply.

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

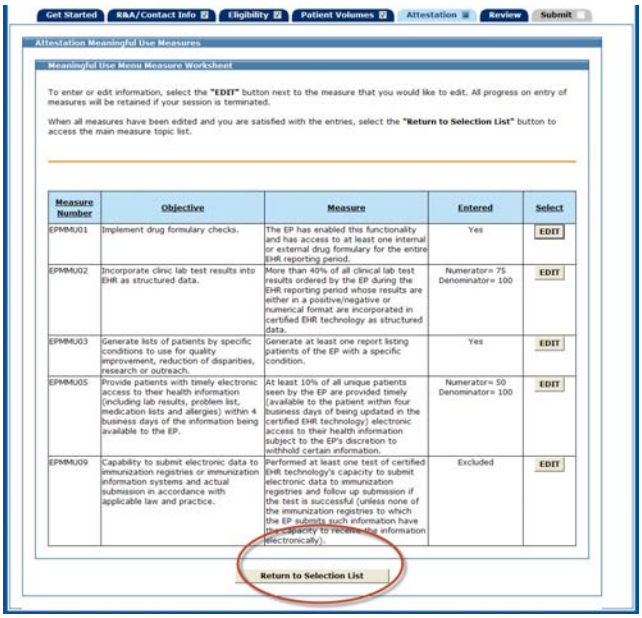


If Exclusion 1 and/or Exclusion 2 apply to you, select **Yes** and do not answer the EHR technology question.

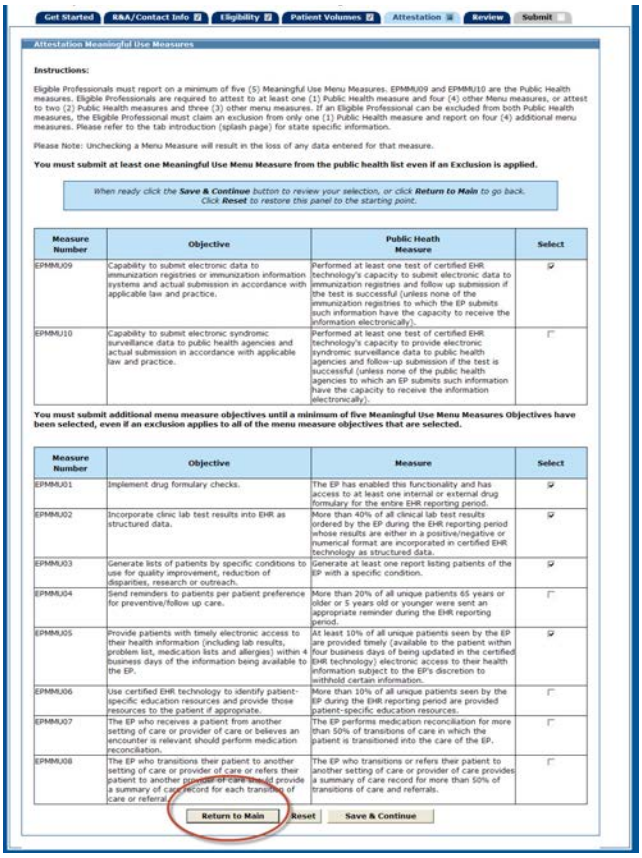
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore this panel to the starting point.



Once you attested to at least four measures for this topic, click **Return to Selection List** to return to the Meaningful Use Menu Measure Selection screen.

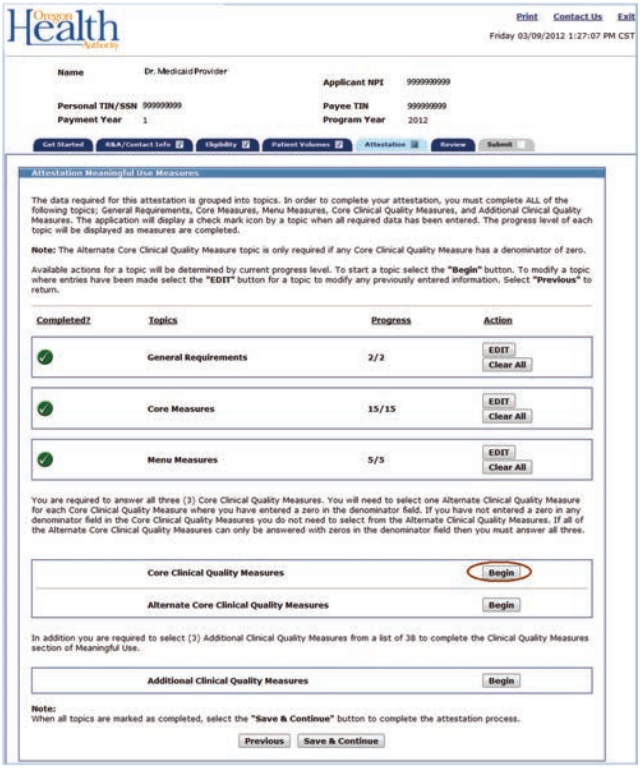


Click **Return to Main** to return to the Measure Topic List.



If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure at any point prior to submitting the application.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.



MEANINGFUL USE CORE CLINICAL QUALITY MEASURES

This initial screen provides information about the Meaningful Use Core Clinical Quality Measures.

Click **Begin** to continue to the Meaningful Use Core Clinical Quality Measure Worklist Table.

The following screen displays the Meaningful Use Core Clinical Quality Measure Worklist Table. You must complete all measures.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.

Click **Edit** to enter or edit information for the measure or click **Return to Main** to return to the Measures Topic List.

Core Clinical Quality Measure NQF 0013

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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

After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Core Clinical Quality Measure Worklist Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.

Core Clinical Quality Measure NQF 0028-PQRI 114

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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

Core Clinical Quality Measure NQF 0421-PQRI 128

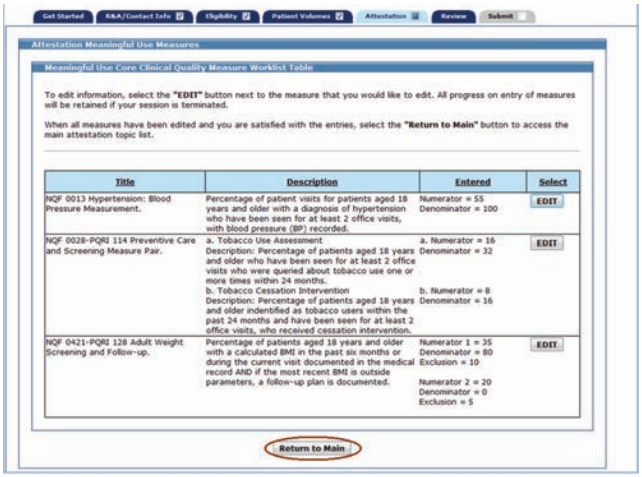
Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

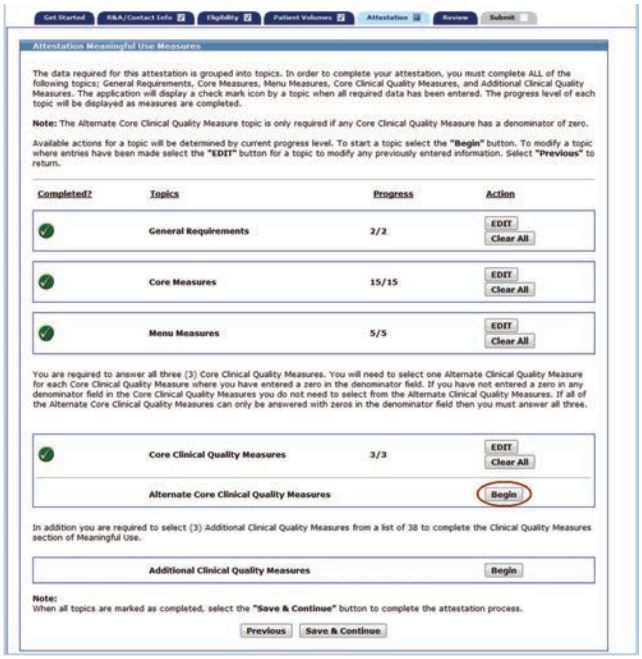
The following screen displays the Meaningful Use Core Clinical Quality Measures Worklist Table with data entered for every measure.

Click **Return to Main** to return to the Measures Topic List.



If all measures were entered and saved, a check mark will display under the Completed column for the topic as displayed in the example below. You can continue to edit the topic measure at any point prior to submitting the application

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click **Begin** to start the next topic.



MEANINGFUL USE ALTERNATE CORE CLINICAL QUALITY MEASURES

This initial screen provides information about the Alternate Core Clinical Quality Measures.

Click **Begin** to continue to the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

The following screen displays the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

You are only required to answer an Alternate Core Clinical Quality Measure if you entered a zero in a denominator field for a Core Clinical Quality Measure.

If you only enter zeros in the denominator fields for the Alternate Core Clinical Quality Measures, then you must attest to all three Alternate Core Clinical Quality measures to show that you were not able to attest to any of the Alternate Core Clinical Quality Measures with a value greater than zero in the denominator field.

Click on the **checkbox** next to the measure(s) you want to attest to. Click **Save & Continue** to proceed to the Meaningful Use Alternate

Core Clinical Quality Measure Worklist Table where you can review your selections. Click **Reset** to restore this panel to the starting point or last saved data. Click **Return to Main** to return to the Measures Topic List.

The 3 available Alternate Core Clinical Quality Measures are described in this user guide. Only those that you selected will apply to you.

The following screen displays the Meaningful Use Alternate Core Clinical Quality Measure Worklist Table which lists the measures you chose to attest to on the previous screen.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.

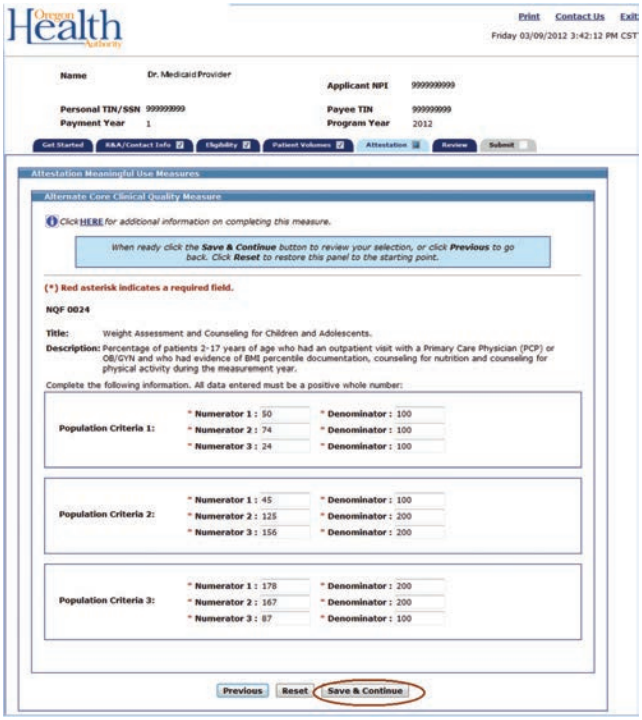
Click **Edit** to enter or edit information for the measure or click **Return to Selection List** to return to the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

Alternate Core Clinical Quality Measure NQF 0024

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

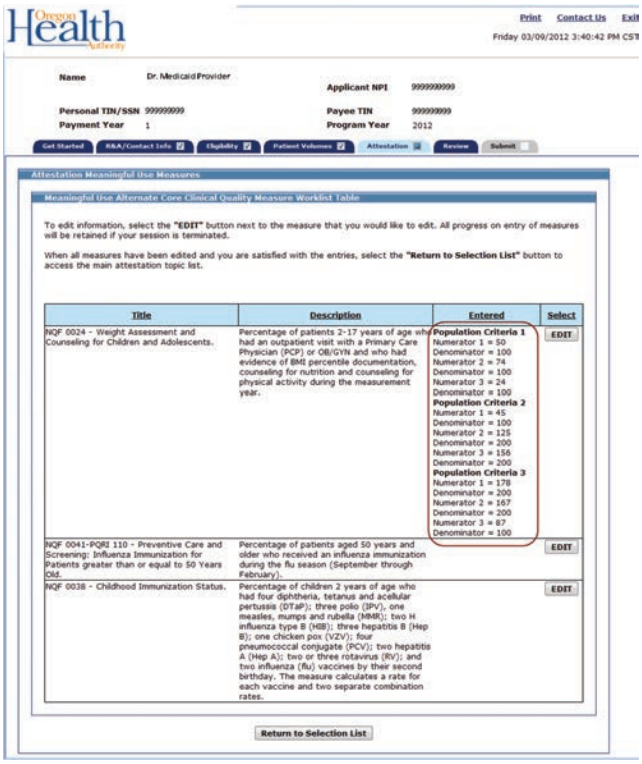
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.



After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Alternate Core Clinical Quality Measure Worklist Table. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.

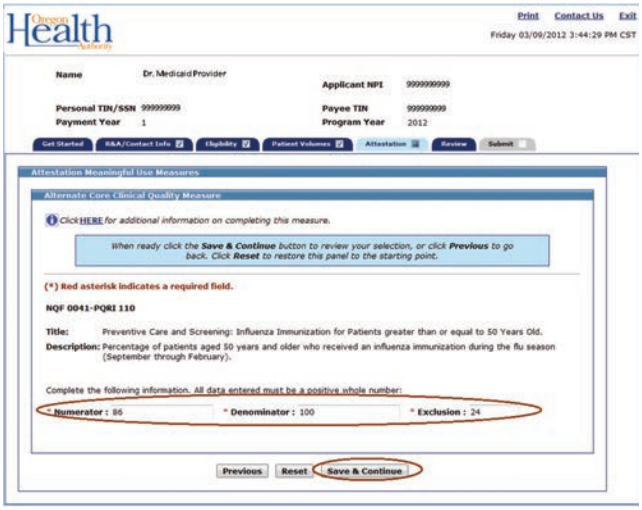


Alternate Core Clinical Quality Measure NQF 0041-PQRI 110

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

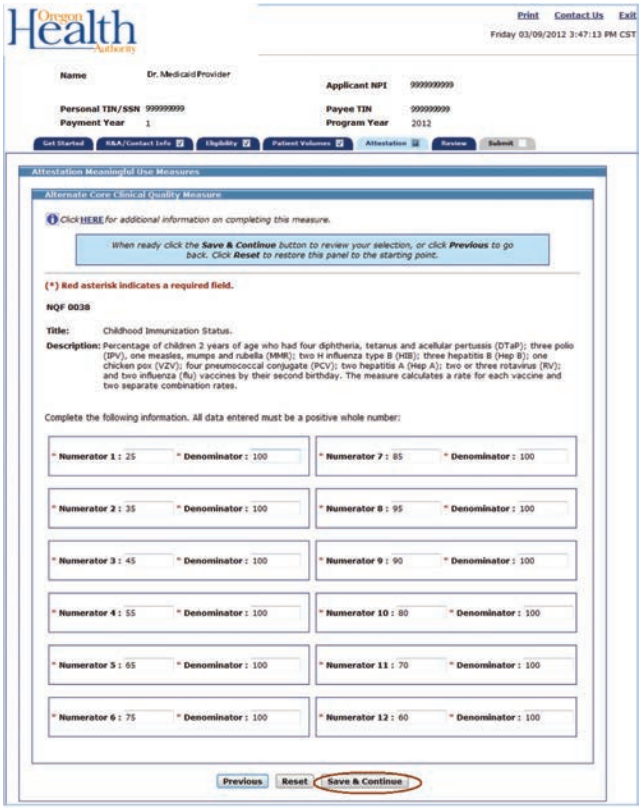


Alternate Core Clinical Quality Measure NQF 0038

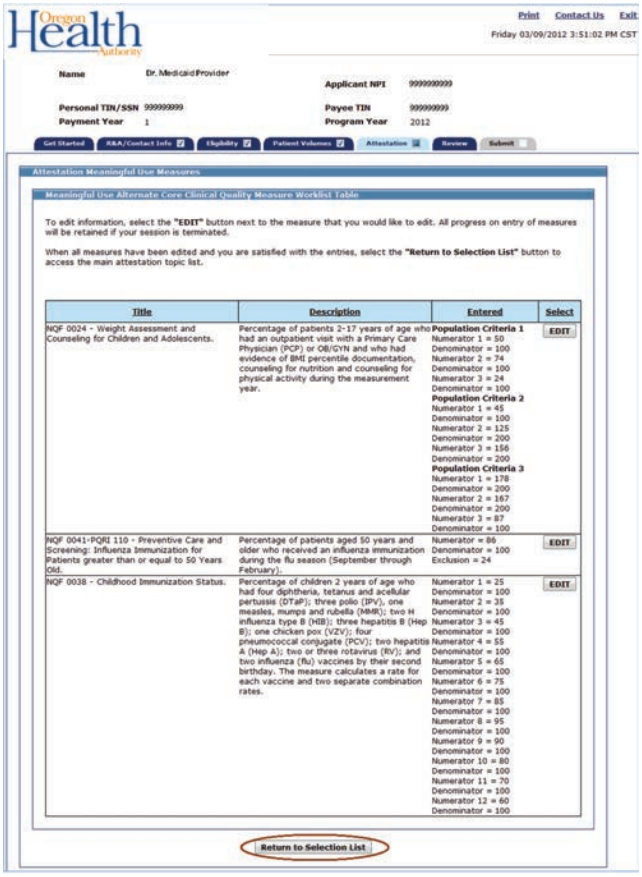
Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

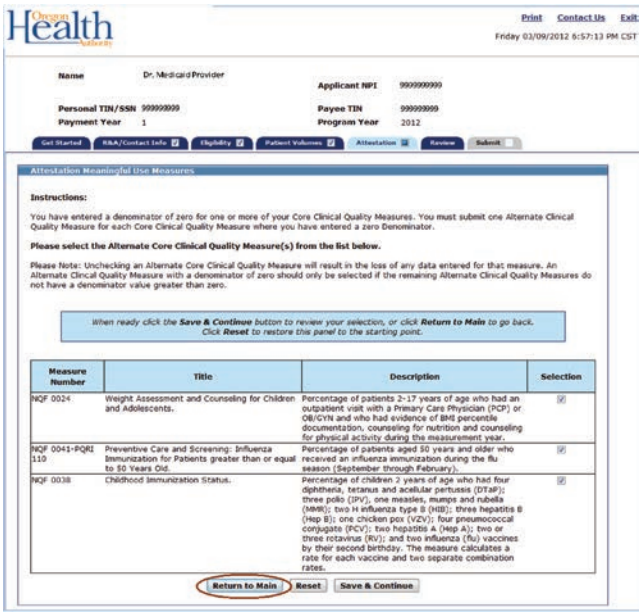
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.



Once you attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Alternate Core Clinical Quality Measures Selection screen.

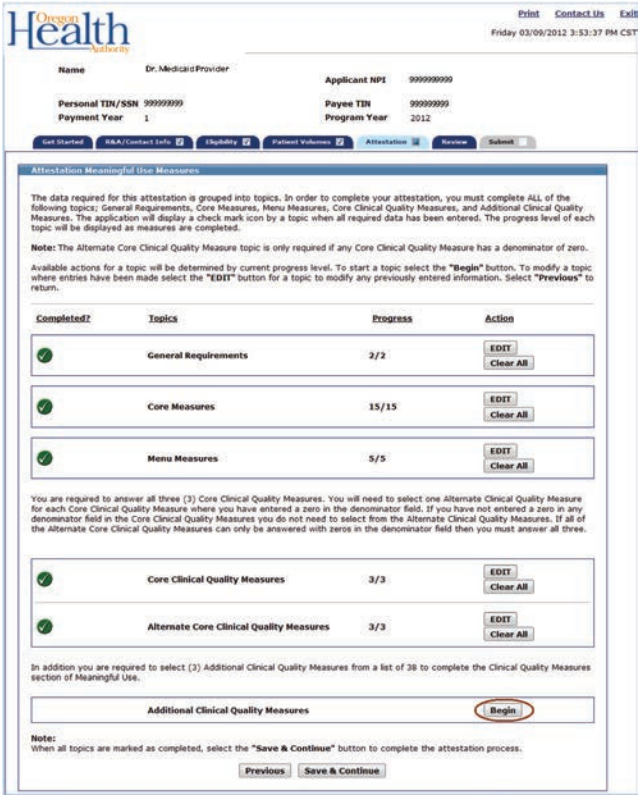


Click **Return to Main** to return to the Measure Topic List.



If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure at any point prior to submitting the application.

Click the **Edit** button to further edit the topic, click **Clear All** to clear all topic information you entered, or click Begin to start the next topic.



MEANINGFUL USE ADDITIONAL CLINICAL QUALITY MEASURES

This initial screen provides information about the Additional Clinical Quality Measures.

Click **Begin** to continue to the Meaningful Use Additional Clinical Quality Measures Selection screen.

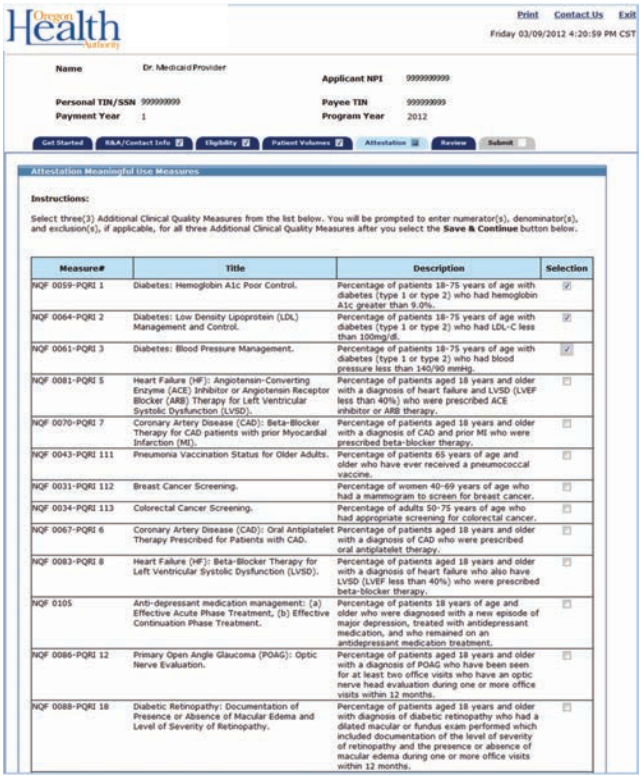
The screens on the following pages display the Meaningful Use Additional Clinical Quality Measures Selection screen.

You are required to answer three Additional Clinical Quality Measures. There are a total of 38 Additional Clinical Quality Measures to choose from.

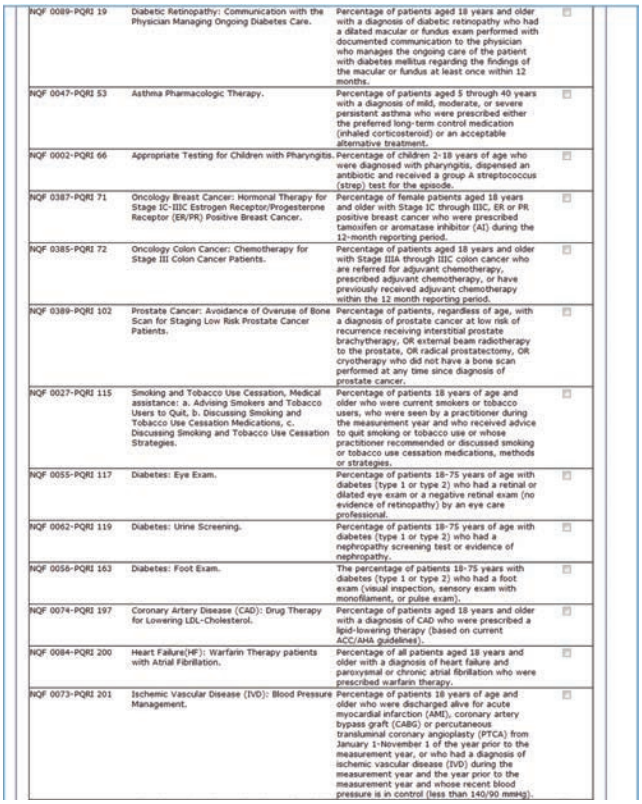
The 38 available Additional Core Clinical Quality Measures are described in this user guide. Only those that you selected will apply to you.

Click on the **checkbox** next to the measures you want to attest to, click **Save & Continue** to review your selections, or click **Reset** to restore this panel to the starting point or last saved data.

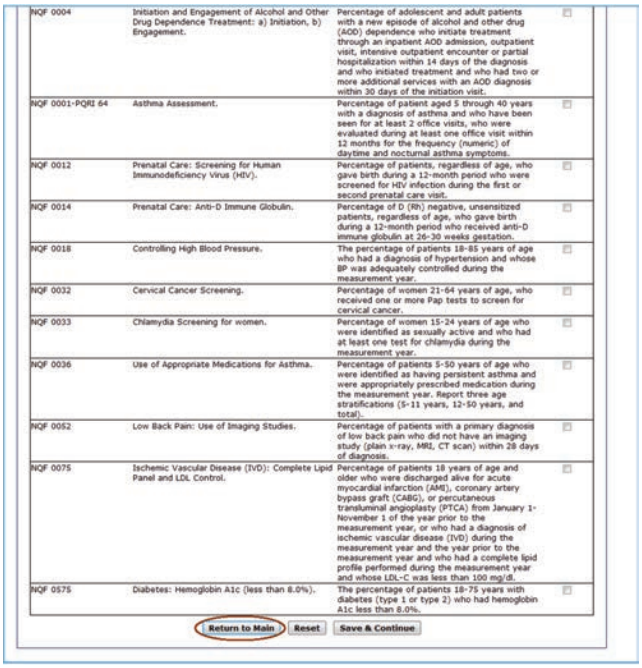
Meaningful Use Additional Clinical Quality Measures Selection screen (Part 1 of 3)



Meaningful Use Additional Clinical Quality Measures Selection screen (Part 2 of 3)



Meaningful Use Additional Clinical Quality Measures Selection screen (Part 3 of 3)



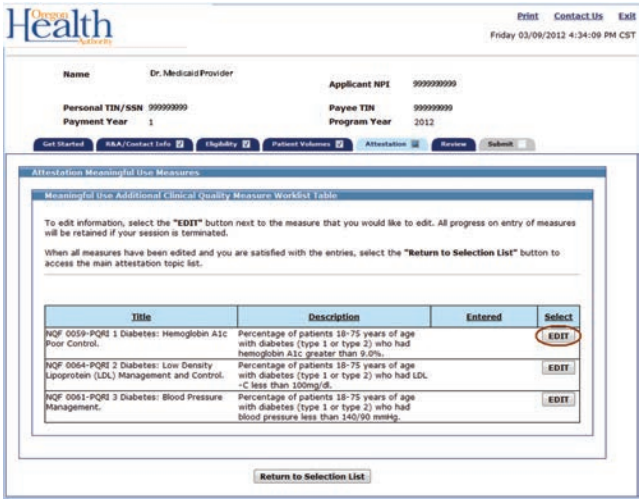
NQF 0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a) Initiation, b) Engagement.	Percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
NQF 0001-PQRI 64	Asthma Assessment.	Percentage of patient aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.
NQF 0012	Prenatal Care: Screening for Human Immunodeficiency Virus (HIV).	Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal care visit.
NQF 0014	Prenatal Care: Anti-D Immune Globulin.	Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.
NQF 0018	Controlling High Blood Pressure.	The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.
NQF 0032	Cervical Cancer Screening.	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.
NQF 0033	Chlamydia Screening for women.	Percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
NQF 0036	Use of Appropriate Medications for Asthma.	Percentage of patients 5-50 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).
NQF 0052	Low Back Pain: Use of Imaging Studies.	Percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of diagnosis.
NQF 0075	Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control.	Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was less than 100 mg/dl.
NQF 0575	Diabetes: Hemoglobin A1c (less than 8.0%).	The percentage of patients 18-75 years with diabetes (type 1 or type 2) who had hemoglobin A1c less than 8.0%.

Return to Main | Reset | Save & Continue

The following screen displays the Meaningful Use Additional Clinical Quality Measure Worklist Table with the Additional Clinical Quality Measures you selected to attest to.

Click **Edit** to enter or edit information for a measure or click **Return to Selection List** to return to the Meaningful Use Additional Clinical Quality Measures Selection screen.

Once information is successfully entered and saved for a measure it will be displayed in the Entered column on this screen.



Oregon Health Authority

Print | Contact Us | Exit

Friday 03/09/2012 4:34:09 PM CST

Name: Dr. Medicaid Provider

Applicant NPI: 999999999

Personal TIN/SSN: 999999999

Payee TIN: 999999999

Payment Year: 1

Program Year: 2012

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

Attestation Meaningful Use Measures

Meaningful Use Additional Clinical Quality Measure Worklist Table

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Selection List"** button to access the main attestation topic list.

Title	Description	Entered	Select
NQF 0059-PQRI 1 Diabetes: Hemoglobin A1c Poor Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.		EDIT
NQF 0064-PQRI 2 Diabetes: Low Density Lipoprotein (LDL) Management and Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL -C less than 100mg/dl.		EDIT
NQF 0061-PQRI 3 Diabetes: Blood Pressure Management.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.		EDIT

Return to Selection List

Additional Clinical Quality Measure NQF 0059-PQRI 1

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

Oregon Health Authority

Print | Contact Us | Exit

Friday 03/09/2012 4:37:14 PM CST

Name: Dr. Medicaid Provider

Applicant NPI: 999999999

Personal TIN/SSN: 999999999

Payee TIN: 999999999

Payment Year: 1

Program Year: 2012

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

Attestation Meaningful Use Measures

Additional Clinical Quality Measure

Click HERE for additional information on completing this measure.

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

(*) Red asterisk indicates a required field.

NQF 0059-PQRI 1

Title: Diabetes: Hemoglobin A1c Poor Control.

Description: Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.

Complete the following information. All data entered must be a positive whole number:

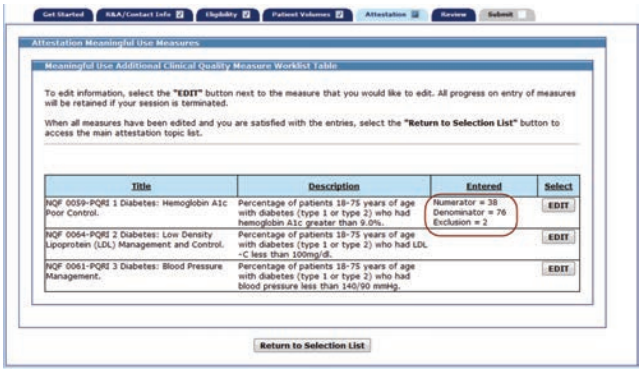
*** Numerator :** 38 *** Denominator :** 76 *** Exclusion :** 2

Previous | Reset | Save & Continue

After you enter information for a measure and click **Save & Continue**, you will return to the Meaningful Use Core Menu Measure Worksheet. The information you entered for that measure will be displayed in the Entered column of the table as shown in the example below.

You can continue to edit the measures at any point prior to submitting the application.

Click on the **Edit** button for the next measure.



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

Attestation Meaningful Use Measures

Meaningful Use Additional Clinical Quality Measure Worklist Table

To edit information, select the **"EDIT"** button next to the measure that you would like to edit. All progress on entry of measures will be retained if your session is terminated.

When all measures have been edited and you are satisfied with the entries, select the **"Return to Selection List"** button to access the main attestation topic list.

Title	Description	Entered	Select
NQF 0059-PQRI 1 Diabetes: Hemoglobin A1c Poor Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c greater than 9.0%.	Numerator = 38 Denominator = 76 Exclusion = 2	EDIT
NQF 0064-PQRI 2 Diabetes: Low Density Lipoprotein (LDL) Management and Control.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL -C less than 100mg/dl.		EDIT
NQF 0061-PQRI 3 Diabetes: Blood Pressure Management.	Percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mmHg.		EDIT

Return to Selection List

Additional Clinical Quality Measure NQF 0064-PQRI 2

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

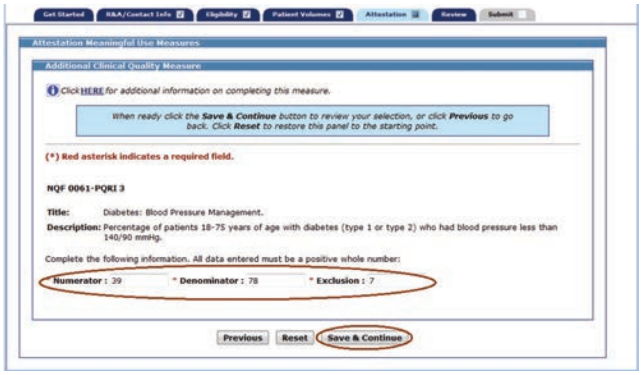
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0061-PQRI 3

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0081-PQRI 5

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

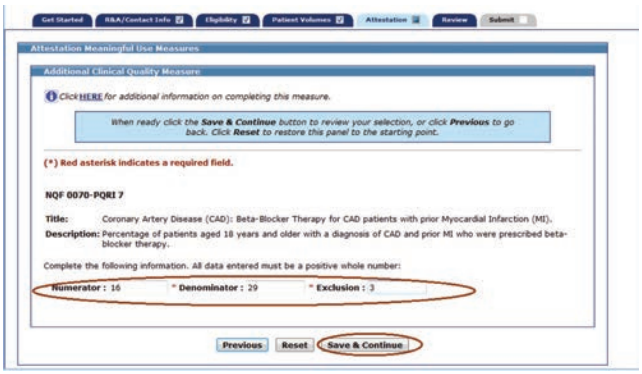
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0070-PQRI 7

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0043-PQRI 111

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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

Additional Clinical Quality Measure NQF 0034-PQRI 113

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

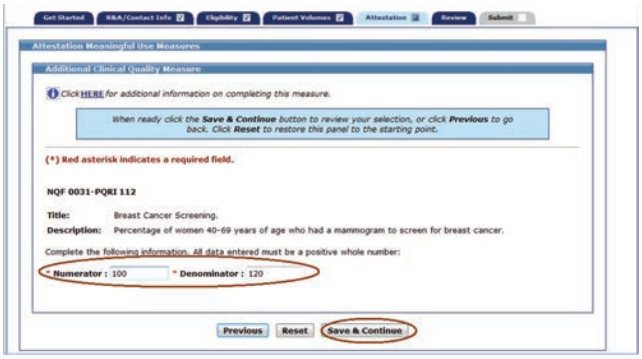
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0031-PQRI 112

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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

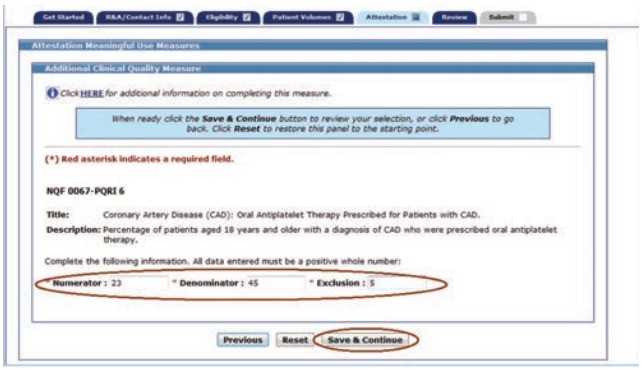


Additional Clinical Quality Measure NQF 0067-PQRI 6

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0083-PQRI 8

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

Additional Clinical Quality Measure NQF 0086-PQRI 12

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

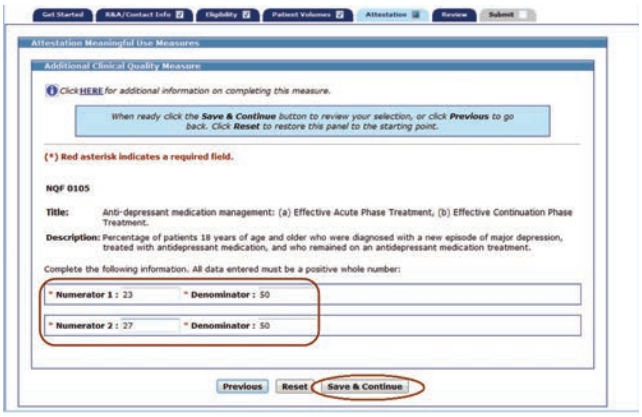
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0105

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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

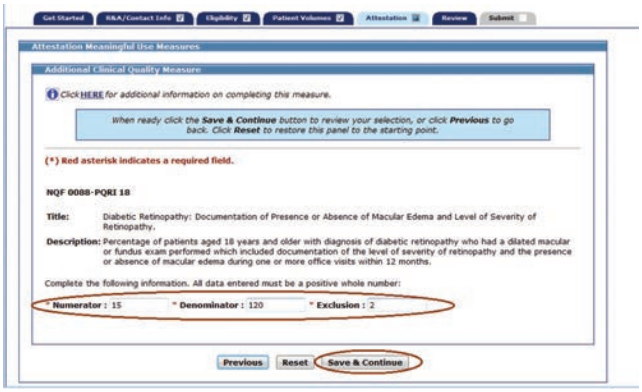


Additional Clinical Quality Measure NQF 0088-PQRI 18

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0089-PQRI 19

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

Additional Clinical Quality Measure NQF 0002-PQRI 66

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

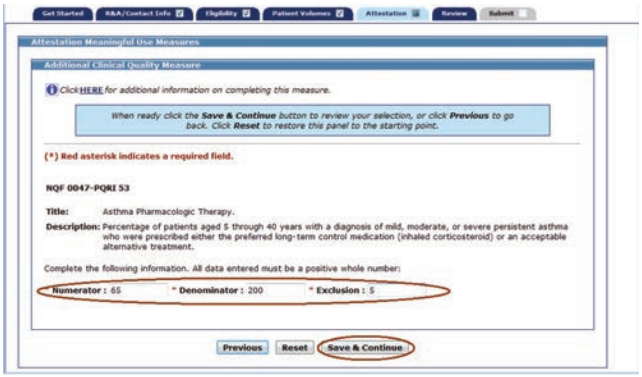
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0047-PQRI 53

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

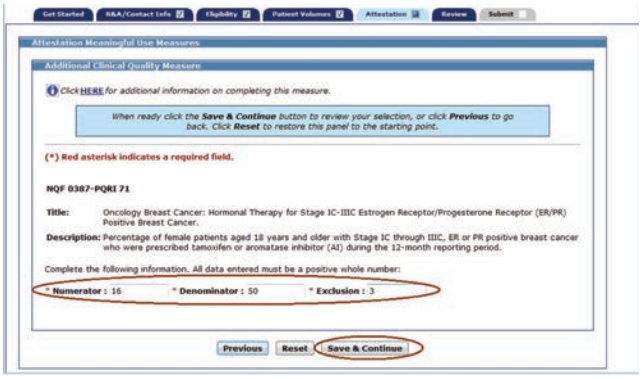


Additional Clinical Quality Measure NQF 0387-PQRI 71

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0385-PQRI 72

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

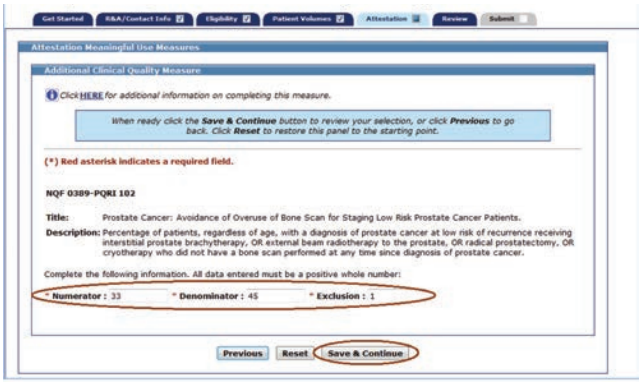
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0389-PQRI 102

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

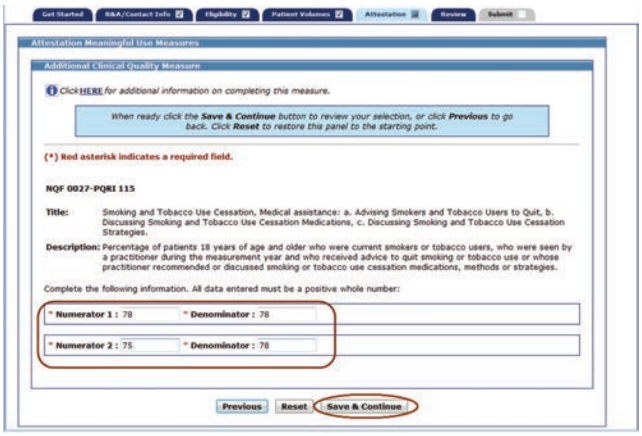


Additional Clinical Quality Measure NQF 0027-PQRI 115

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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

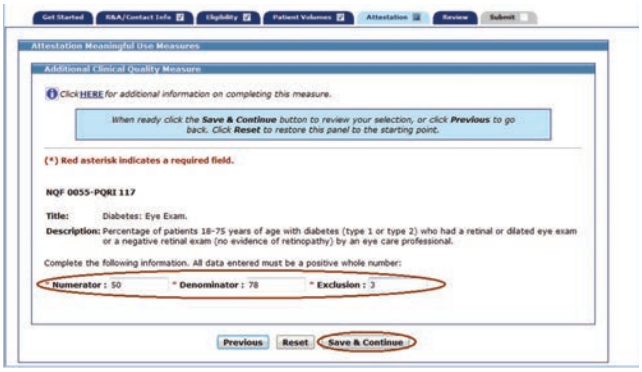


Additional Clinical Quality Measure NQF 0055-PQRI 117

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0062-PQRI 119

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

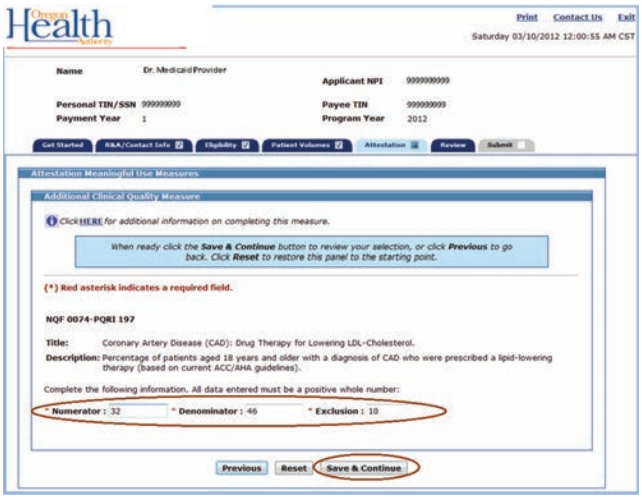
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0074-PQRI 197

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

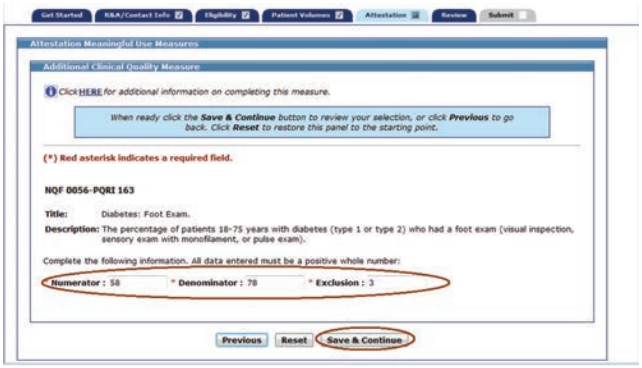


Additional Clinical Quality Measure NQF 0056-PQRI 163

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

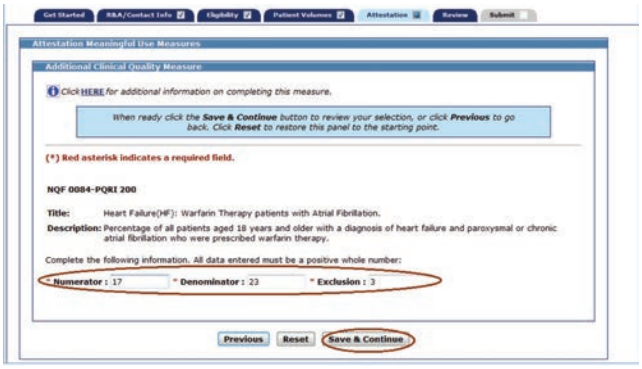


Additional Clinical Quality Measure NQF 0084-PQRI 200

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0073-PQRI 201

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

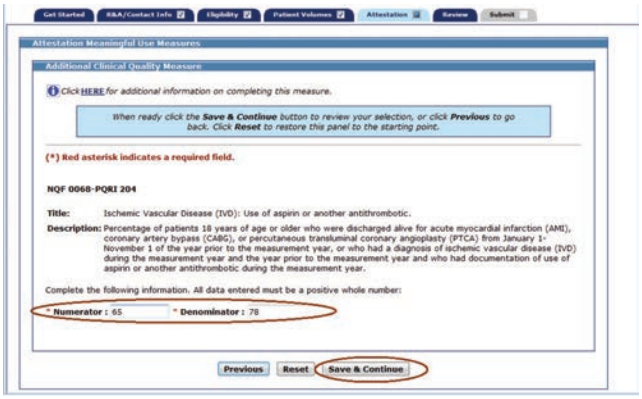
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0068-PQRI 204

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0004

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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

Additional Clinical Quality Measure NQF 0001-PQRI 64

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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

Additional Clinical Quality Measure NQF 0014

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

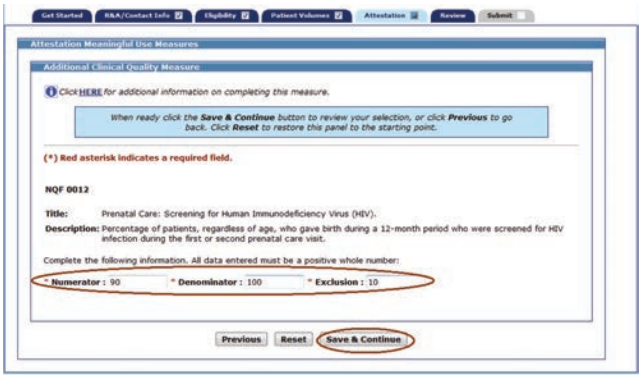
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0012

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

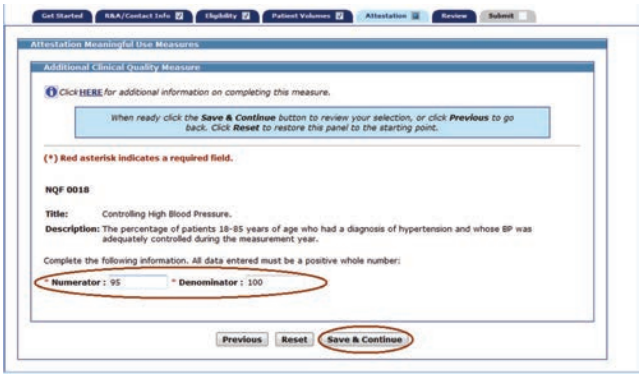


Additional Clinical Quality Measure NQF 0018

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0032

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

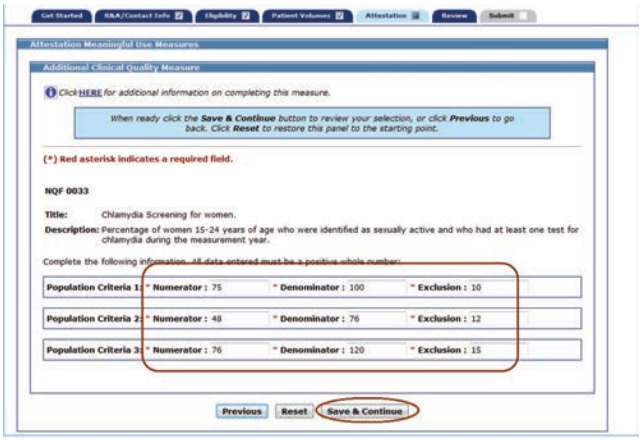
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0033

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0036

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

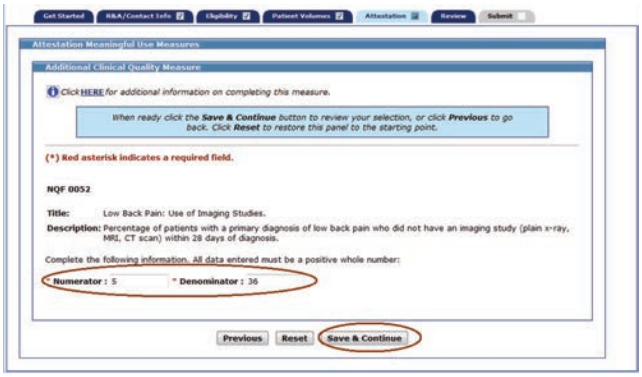
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0052

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

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



Additional Clinical Quality Measure NQF 0075

Enter information in all required fields.

The numerator and denominator entries must be positive whole numbers.

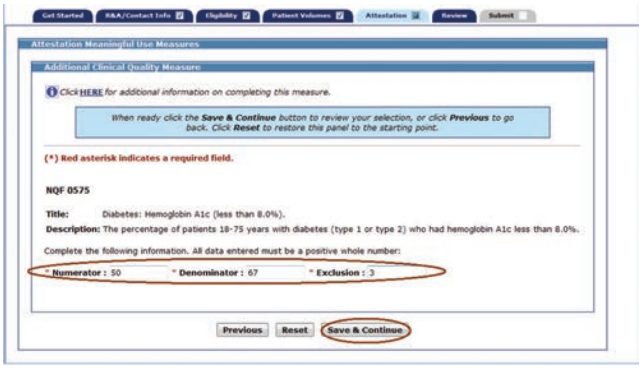
Click **Save & Continue** to review your selection, click **Previous** to go back, or click **Reset** to restore the panel to the starting point.

Additional Clinical Quality Measure NQF 0575

Enter information in all required fields.

The numerator, denominator, and exclusion entries must be positive whole numbers.

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

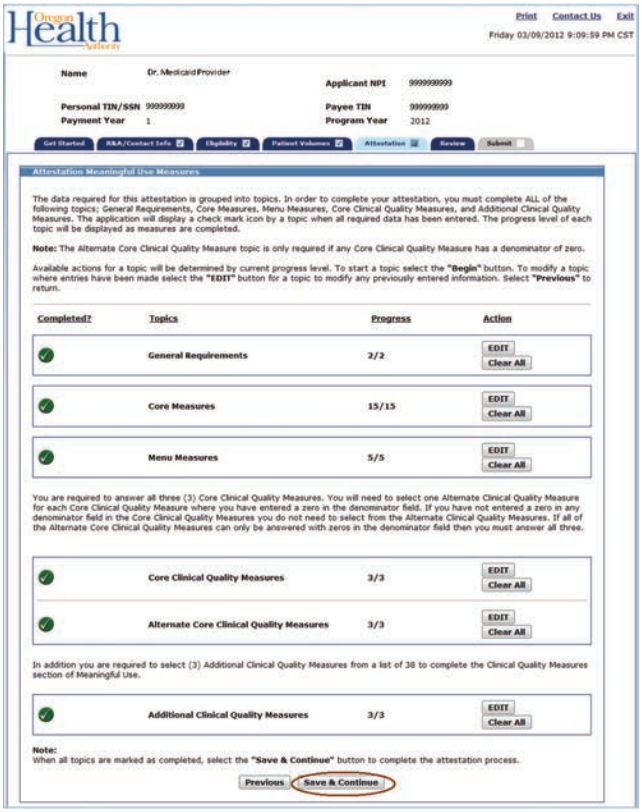


Once you attested to all the measures for this topic, click **Return to Selection List** to return to the Meaningful Use Additional Clinical Quality Measures Selection screen.

Click **Return to Main** to return to the Measure Topic List. (Only the top and bottom sections of the Meaningful Use Additional Clinical Quality Measures Selection screen are displayed below.)

If all measures were entered and saved, a check mark will display under the Completed column for the topic. You can continue to edit the topic measure at any point prior to submitting the application.

The screen on the following page displays the Measures Topic List with all six meaningful use measure topics marked complete. Click **Save & Continue** to view a summary of the Meaningful Use Measures you attested to.

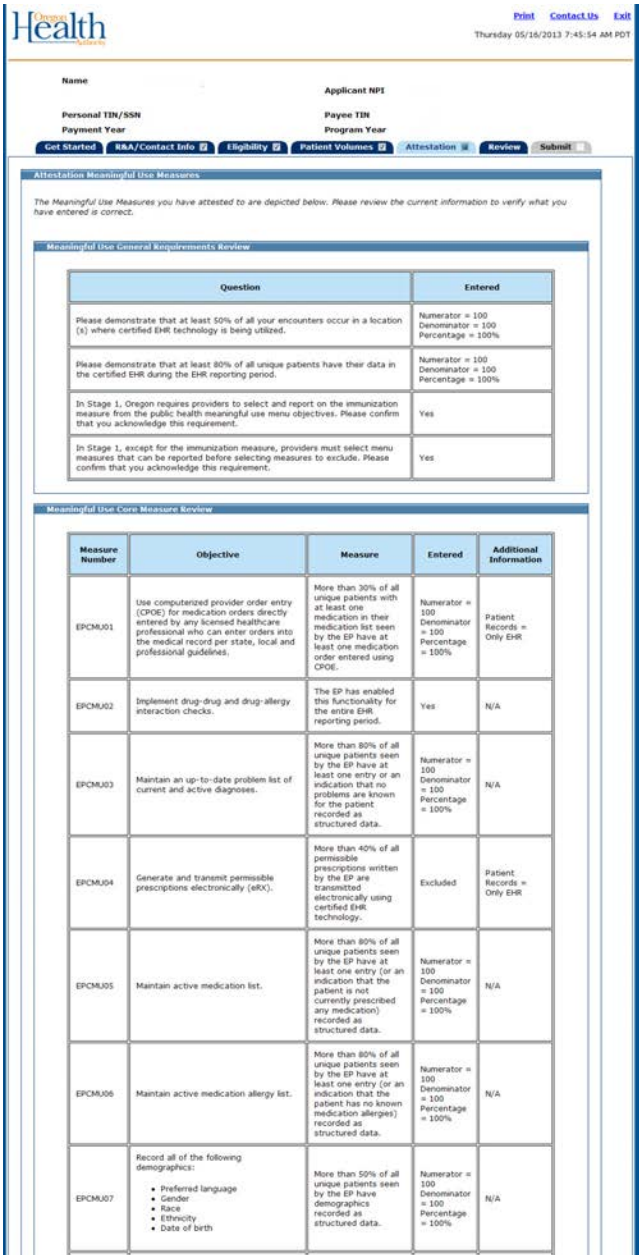


MEANINGFUL USE MEASURES SUMMARY

This screen displays a summary of all entered meaningful use attestation information.

Review the information for each measure. If further edits are necessary, click **Previous** to return to the Measures Topic List where you can choose a topic to edit.

If the information on the summary is correct, click **Save & Continue** to proceed to Part 3 of 3 of the Attestation Phase.



This is screen 2 of 3 of the Meaningful Use Measures Summary.

EPCMU08	Record and chart changes in the following vital signs: • Height • Weight • Blood pressure • Calculate and display body mass index (BMI) • Plot and display growth charts for children, including BMI.	More than 50% of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.	Excluded	Patient Records = All
EPCMU09	Record smoking status for patients 13 years old or older.	More than 50% of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.	Excluded	Patient Records = Only EHR
EPCMU11	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance to that rule.	Implement one clinical decision support rule.	Yes	N/A
EPCMU12	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	More than 50% of all patients who request an electronic copy of their health information are provided it within 3 business days.	Excluded	Patient Records = Only EHR
EPCMU13	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days.	Excluded	Patient Records = Only EHR
EPCMU15	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis per 45 CFR 164.308 (a) (1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.	Yes	N/A

Meaningful Use Menu Measure Review

Measure Number	Objective	Measure	Entered	Additional Information
EPMMU01	Implement drug formulary checks.	The EP has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.	Yes	N/A
EPMMU02	Incorporate clinic lab test results into EHR as structured data.	More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.	Numerator = 75 Denominator = 100 Percentage = 75%	N/A
EPMMU03	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach.	Generate at least one report listing patients of the EP with a specific condition.	Yes	Patient Records = Only EHR
EPMMU05	Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists and allergies) within 4 business days of the information being available to the EP.	At least 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.	Numerator = 50 Denominator = 100 Percentage = 50%	Patient Records = All
EPMMU09	Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information have the capacity to receive the information electronically).	Excluded (Reason 1) No	See below for additional information

Additional Information

EPMMU09
Immunization Registry :
Test Successful :
Test Date & Time :
Follow Up Submission :

This is screen 3 of 3 of the Meaningful Use Measures Summary.

Meaningful Use Core Clinical Quality Measure Review

Measure Number	Title	Description	Entered
NQF 0013	Hypertension: Blood Pressure Measurement.	Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.	Numerator = 10 Denominator = 15
NQF 0028-PQRI 114	Preventive Care and Screening Measure Pair.	a. Tobacco Use Assessment Description: Percentage of patients aged 18 years and older who have been seen for at least 2 office visits who were queried about tobacco use one or more times within 24 months. b. Tobacco Cessation Intervention Description: Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.	a.Numerator = 0 Denominator = 0 b.Numerator = 0 Denominator = 0
NQF 0421-PQRI 128	Adult Weight Screening and Follow-up.	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.	**Population Criteria 1** Numerator = 15 Denominator = 20 Exclusion = 1 **Population Criteria 2** Numerator = 16 Denominator = 25 Exclusion = 2

Meaningful Use Alternate Clinical Quality Measure Review

Measure Number	Title	Description	Entered
NQF 0041-PQRI 110	Preventive Care and Screening: Influenza Immunization for Patients greater than or equal to 50 Years Old.	Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	Numerator = 10 Denominator = 15 Exclusion = 1

Meaningful Use Additional Clinical Quality Measure Review

Measure Number	Title	Description	Entered
NQF 0031-PQRI 112	Breast Cancer Screening.	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	Numerator = 25 Denominator = 30
NQF 0034-PQRI 113	Colorectal Cancer Screening.	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Numerator = 25 Denominator = 30 Exclusion = 0
NQF 0067-PQRI 6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD.	Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.	Numerator = 10 Denominator = 15 Exclusion = 0

Previous | Save & Continue

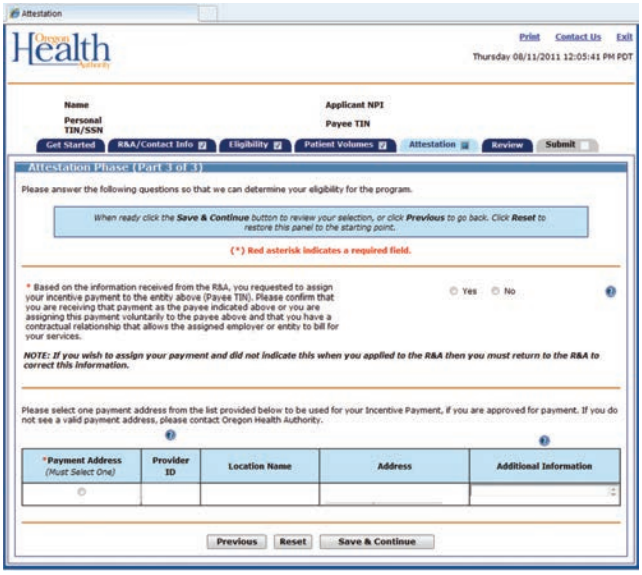
ATTESTATION PHASE (PART 3 OF 3)

Part 3 of 3 of the Attestation Phase contains a question regarding assignment of your incentive payment and confirmation of the address to which the incentive payment will be sent.

Click **Yes** to confirm you are receiving this payment as the payee indicated or you are assigning this payment voluntarily to the payee and that you have a contractual relationship that allows the assigned employer or entity to bill for your services.

Click the **Payment Address** from the list below to be used for your Incentive Payment.

Click **Save & Continue** to review your selections, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



This screen confirms you successfully completed the Attestation section.

Note the check box in the Attestation tab.

Click **Continue** to proceed to the Review tab.

STEP 6 — REVIEW APPLICATION

The Review section allows you to review all information you entered into your application. If you find errors you can click the associated tab and proceed to correct the information. Once you have corrected the information you can click the Review tab to return to this section. From this screen you can print a printer-friendly copy of your application for review.

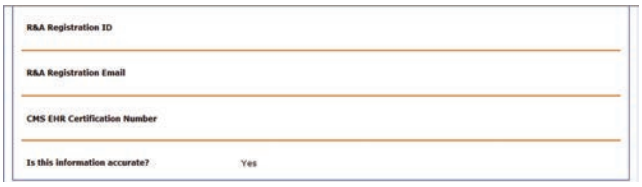
Please review all information carefully before proceeding to the Submit section. After you have submitted your application you will not have the opportunity to change it.

Click **Print** to generate a printer-friendly version of this information.

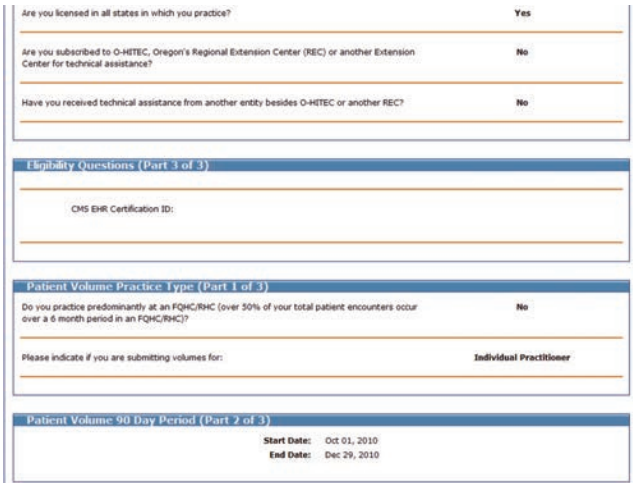
When you have reviewed all information click the **Submit** tab to proceed.

This is screen 1 of 4 of the Review tab display.

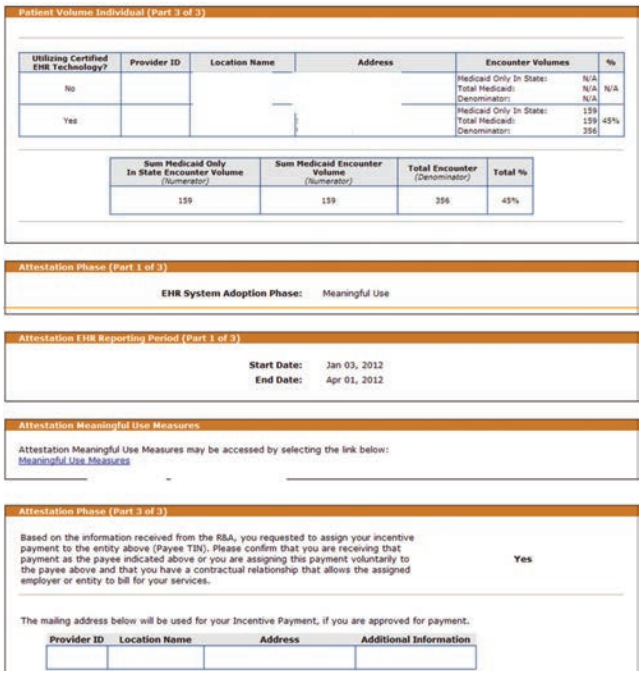
This is screen 2 of 4 of the Review tab display.



This is screen 3 of 4 of the Review tab display.



This is screen 4 of 4 of the Review tab display.



STEP 7 — SUBMIT YOUR APPLICATION

The final submission of your application involves the following steps:

Review and Check Errors — The system will check your application for errors. If errors are present you will have the opportunity to go back to the tab where the error occurred and correct it. If you do not want to correct the errors you can still submit your application; however, the errors may affect your eligibility and payment amount.

Questions — You will be asked a series of questions that do not affect your application.

The answers will provide information to Oregon's Medicaid EHR Incentive Program about program participation.

File Upload — You will have the opportunity to upload PDF files with documentation supporting your application. This information could include additional information on patient volume, locations, or your certified EHR system.

If you are attesting for the first time and are not reporting meaningful use, CMS is requiring that Oregon validate the eligibility criterion for Adopt/Implement/ Upgrade by verifying at least one of the four following types of documentation:

- copy of a software licensing agreement
- contract
- invoices
- receipt that validates your acquisition

Vendor letters and other documents may also be submitted as a supplement to the items on the documentation list above. However, these supplemental documents will not satisfy program eligibility requirements on their own.

If you are attesting for the first time for meaningful use Stage 1, staff will be asking for a supplemental questionnaire to be completed. You may also complete that questionnaire and upload it into this attestation. The link to the questionnaire is: https://www.surveymonkey.com/s/JKXGDL7

Preparer Information — Providers attesting to the Medicaid EHR Incentive Program have two options for completing the electronic signature portion of the application. The provider can perform the submission process, or the provider can designate a preparer to complete the application. If a preparer is completing the application they will navigate through screens to collect the additional required information from the preparer. The provider associated with this application is still responsible for the accuracy of the information provided and attested to.

The initial Submit screen contains information about this section.

Click **Begin** to continue to the submission process.

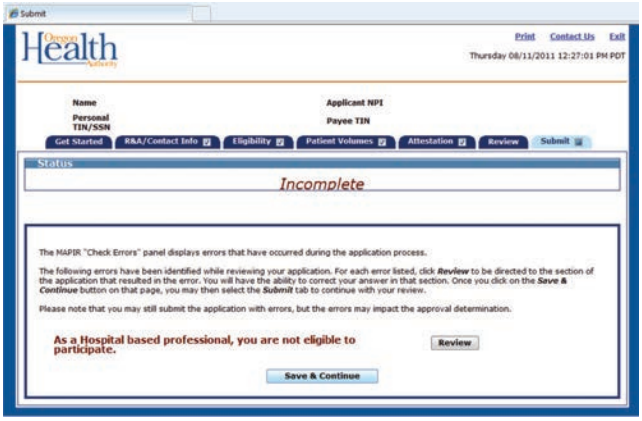
This screen lists the current status of your application and any error messages identified by the system.

You can correct these errors or leave them as is. You can submit this application with errors; however, errors may impact your eligibility and incentive payment amount.

To correct errors:

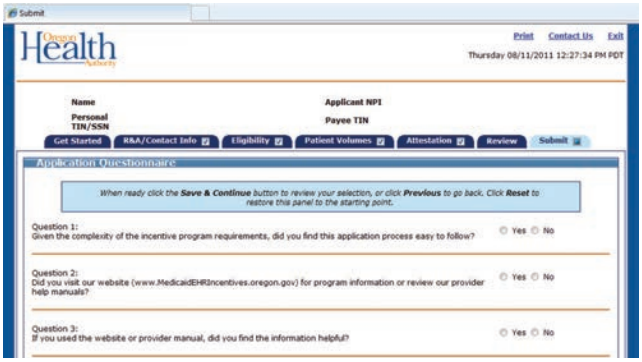
Click **Review** to be taken to the section in error and correct the information. To return to this section at any time click the **Submit** tab.

Click **Save & Continue** to continue with the application submission.



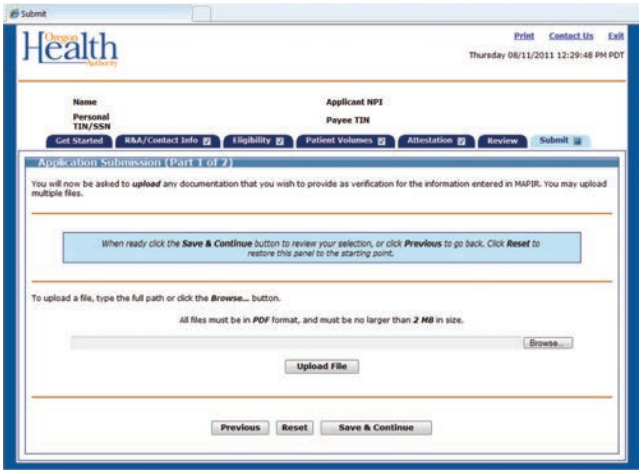
The Application Questionnaire screen includes optional questions. Answer the optional questions by selecting **Yes** or **No**.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



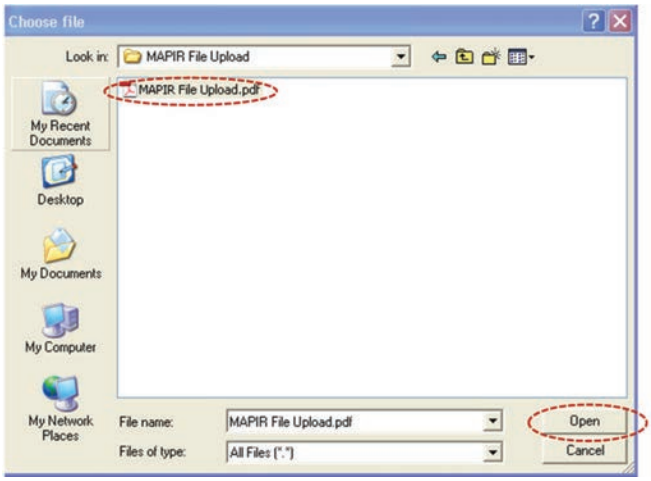
To upload files click **Browse** to navigate to the file you wish to upload.

Note: Only files that are in portable data format (PDF) and a maximum of 2 megabytes (MB) in size are acceptable documentation to upload.



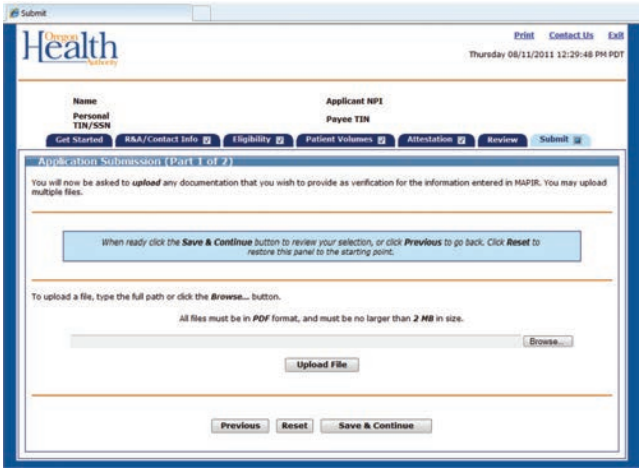
The Choose file dialog box will display.

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



Check the file name in the file name box.

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



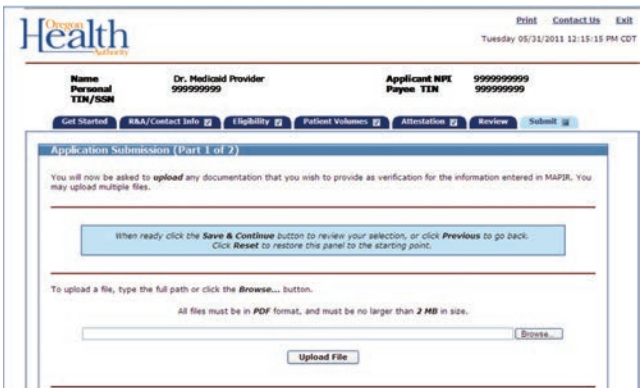
Note the "File has been successfully uploaded." message. Review the uploaded file list in the Uploaded Files box.

If you have more than one file to upload, repeat the steps to select and upload a file as many times as necessary.

All of the files you uploaded will be listed in the Uploaded Files section of the screen.

To delete an uploaded file click **Delete** in the Available Actions column.

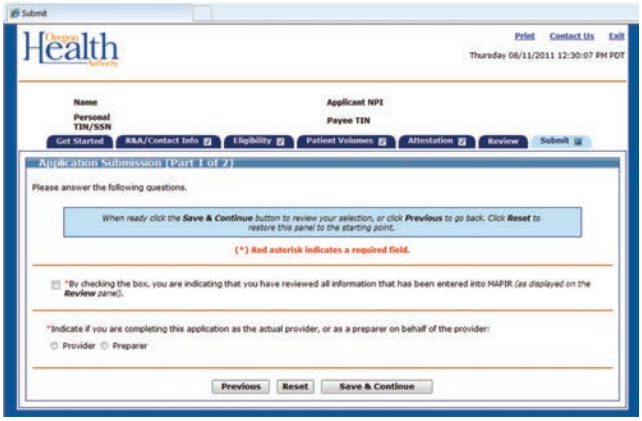
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data.



Select the check box to acknowledge that you have reviewed all of your information.

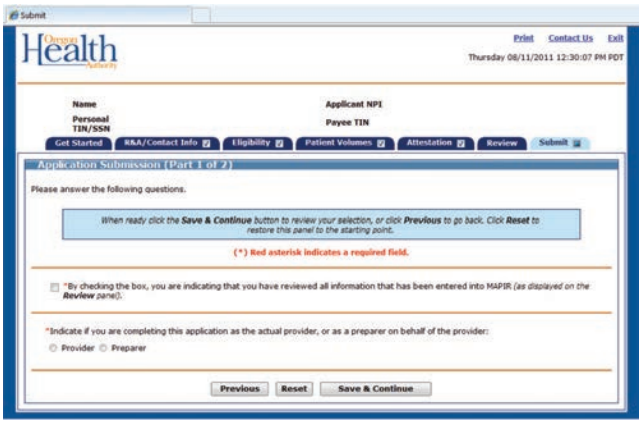
Select the **Provider** or **Preparer** button, as appropriate.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data.



This screen depicts Provider selection.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point or last saved data.



This screen depicts the Provider signature screen.

Enter your **Provider Initials**, **NPI**, and **Personal TIN**.

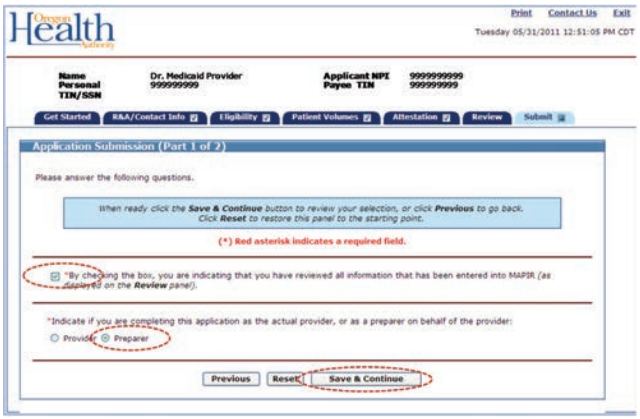
Click **Sign Electronically** to proceed.

Click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.

This screen depicts the signature screen for a Preparer on behalf of the provider.

As the preparer of this application on behalf of the provider, please attest to the accuracy of all information entered.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point or last saved data.



As the preparer of this application on behalf of the provider, please attest to the accuracy of all information entered.

Enter your **Preparer Name** and **Preparer Relationship** to the provider.

Click **Sign Electronically** to review your selection, or click **Previous** to return. Click **Reset** to restore this panel to the starting point or last saved data.

After electronically signing the application, MAPIR determines if the Meaningful Use attestation data you attested to is accepted or rejected. If your Meaningful Use attestation data is rejected, the following screen will display.

If your Meaningful Use attestation data is accepted, this screen will not display. Proceed to the following page.

Click on the **Meaningful Use Measures** link to review the Meaningful Use attestation data that you entered as well as the acceptance or rejection outcome for each measure. Click on the **Attestation** tab to return to the Meaningful Use Attestation where you can revise the Meaningful Use attestation data.

Please note that you may be subject to an audit after frequent attempts at correcting failed measures.

Also note that while you have the option to continue with your submission by clicking **Save & Continue**, if you do not meet the mandatory requirements, you will not receive an incentive payment.

Click **Previous** to go back, click the **Save & Continue** to proceed with the submission of your application.

This is an example of an incentive payment chart for a non Pediatric Professional.

No information is required on this screen.

The incentive payment chart example for Pediatricians is shown on the next page.

Note: *This is the final step of the Submit process. You will not be able to make any changes to your application after submission. If you do not want to submit your application at this time you can click* ***Exit****, and return at any time to complete the submission process.*

Click **Submit Application** to continue.

This is an example of an incentive payment chart for a Pediatric Professional.

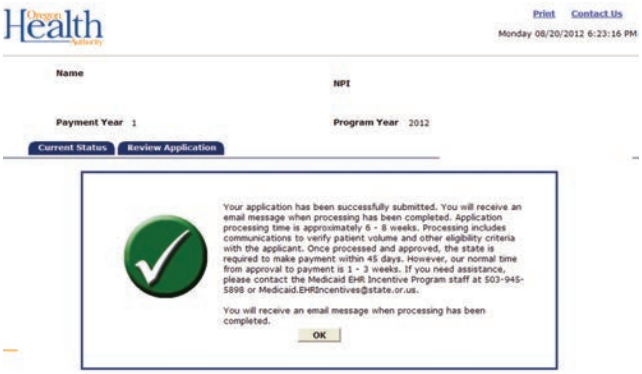
No information is required on this screen.

Note: *This is the final step of the Submit process. You will not be able to make any changes to your application after submission. If you do not want to submit your application at this time you can click* ***Exit****, and return at any time to complete the submission process.*

Click **Submit Application**.

The check indicates your application has been successfully submitted.

Click **OK**.



When your application has been successfully submitted, you will see the application status of Submitted.

Click **Exit** to exit MAPIR.

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

POST SUBMISSION ACTIVITIES

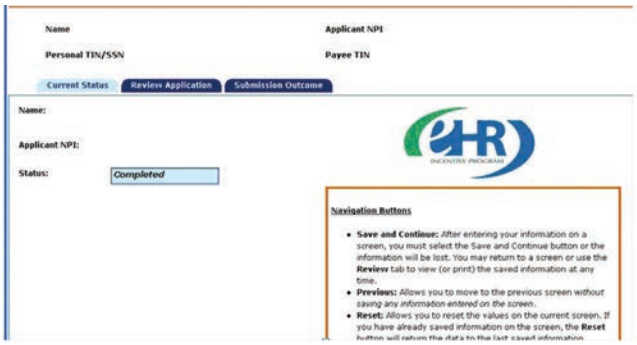
This section contains information about post application submission activities. At any time you can check the status of your application by logging into the Provider Web Portal. Once you have successfully completed the application submission process you will receive an email confirming your submission has been received. You may also receive email updates as your application is processed.

Most applications are requiring some additional clarification or documentation from applicants. Therefore, after you submit your application, you should anticipate getting a communication from program staff asking for some additional documentation.

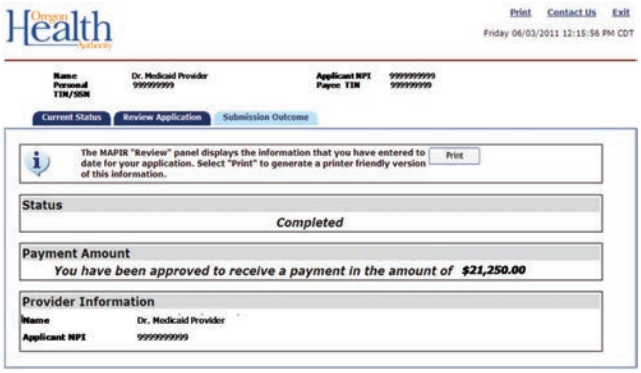
Once your application has been completely reviewed, you have provided any necessary supplemental documentation, and your application is approved, you will then receive your payment within 45 days of approval.

Your payment will be processed as an Electronic Fund Transfer, and will be indicated on the Provider Remittance Advice (RA) as Systems Payouts – Non-claim specific.

The screen below shows an application in a status of Submitted. You can click the **Review Application** tab to review your application; however, you will not be able to make changes.



You can click the **Submission Outcome** tab to view the results of submitting your application.



The following table lists some of the statuses your application may go through.

Status	Definition
Submitted	The provider has completed attestation and clicked Submit. The application is locked to prevent editing and no further changes can be made.
Pended for Review	The application is ready for a manual review by the Medicaid EHR Incentive Program staff before proceeding to the payment process.
Review Complete	The Medicaid EHR Incentive Program staff reviews the "Pended for Review" applications and determines that the provider is eligible for the incentive payment pending a final CMS check.
Payment Approved	A determination has been made that the application has been approved for payment.
Payment Requested	A payment request transaction has been sent to the MMIS to generate a financial remittance to the provider.
Payment Disbursed	The remittance advice data has been received by MAPIR.
Appeal Initiated – Review	An appeal has been lodged with the proper state authority by the provider and Medicaid EHR Incentive Program staff has been notified of the action.
Appeal Approved – Adjustment	The adjustment appeal has been approved and Medicaid EHR Incentive Program staff has been notified of the action and provided with the amount to process the adjustment.
Appeal Denied	The appeal has been denied and Medicaid EHR Incentive Program staff has been notified of the action.
Denied	A determination has been made that the provider does not qualify for an incentive payment based on one or more of the eligibility rules.
Completed	The application has run a full standard process and completed successfully with a payment to the provider.
Canceled	MAPIR has received an INACTIVE notification from the R&A. No further activity is allowed.

ADDITIONAL USER INFORMATION

This section contains an explanation of informational messages, system error messages, and validation messages you may receive.

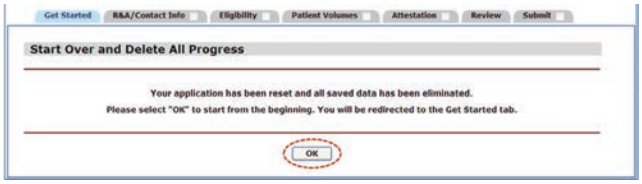
START OVER AND DELETE ALL PROGRESS

If you would like to start your application over from the beginning you can click the Get Started tab. Click the **here** link on the screen to start over from the beginning. This process can only be done prior to submitting your application. Once your application is submitted, you will not be able to start over.

This screen will confirm your selection to start the application over and delete all information saved to date. This process can only be done prior to submitting your application. Once your application is submitted, you will not be able to start over.

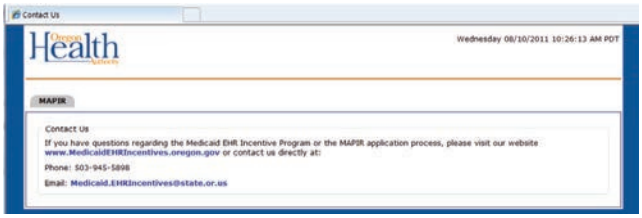
Click **Confirm** to Start Over and Delete All Progress.

If you clicked **Confirm** you will receive the following confirmation message. To continue, click **OK**.



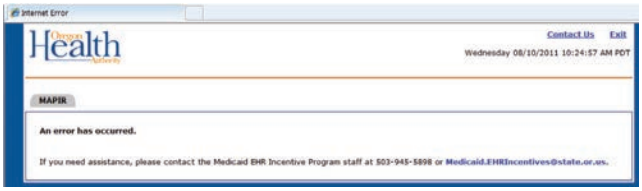
CONTACT US

Clicking on the **Contact Us** link in the upper right corner of most screens within MAPIR will display the following Medicaid EHR Incentive Program contact information.



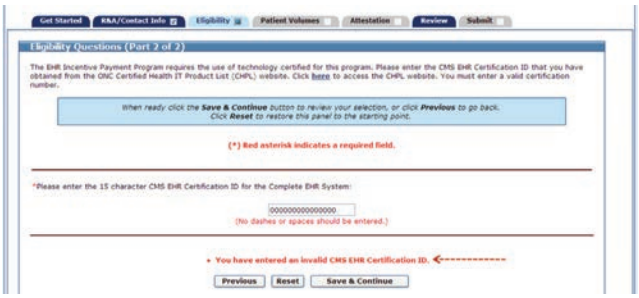
MAPIR ERROR MESSAGE

This screen will appear when a MAPIR error has occurred. Follow all instructions on the screen. Click **Exit** to exit MAPIR.



VALIDATION MESSAGES

The following is an example of the validation message – **You have entered an invalid CMS EHR Certification ID**. Check and reenter your CMS EHR Certification ID. The Validation Messages Table lists validation messages you may receive while using MAPIR.



VALIDATION MESSAGES TABLE

- Please enter all required information.
- You must provide all required information in order to proceed.
- Please correct the information at the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A).
- The date that you have specified is invalid, or occurs prior to the program eligibility.
- The date that you have specified is invalid.
- The phone number that you entered is invalid.
- The phone number must be numeric.
- The email that you entered is invalid.
- As a Hospital based physician, you are not eligible to participate.
- You must participate in the Medicaid incentive program in order to qualify.
- You must select at least one type of provider.
- You must select at least one location in order to proceed.
- The ZIP Code that you entered is invalid.
- You must select at least one activity in order to proceed.
- You must define all added 'Other' activities.
- Amount must be numeric.
- You must indicate whether you are completing this application as the actual provider or a preparer.
- You must verify that you have reviewed all information entered into MAPIR.
- Please confirm. You must not have any current sanctions or pending sanctions with Medicare or Medicaid in order to qualify.
- You did not meet the criteria to receive the incentive payment.
- All data must be numeric.
- You must enter all requested information in order to submit the application.
- The email address you have entered does not match.
- You have entered an invalid CMS EHR Certification ID.
- You must be licensed in the state(s) in which you practice.
- You must select Yes or No to utilizing certified EHR technology in this location.
- You have entered a duplicate Group Practice Provider ID.
- You must select a Payment Address in order to proceed.
- You must enter the email address a second time.
- You must be in compliance with HIPAA regulations.
- All amounts must be between 0 and 999,999,999,999,999.
- You must answer Yes to utilizing certified EHR technology in at least one location in order to proceed.
- The amounts entered are invalid.

HOVER BUBBLE DEFINITIONS

The following is a list the hover bubbles in MAPIR.

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
Eligibility Questions (Part 1 of 3)	Are you a Hospital based physician?	Yes/No	A Hospital based Eligible Professional (EP) such as a pathologist, anesthesiologist, or emergency physician, who furnishes 90 percent or more of his or her covered professional services in a hospital setting (Inpatient - Place of Service 21 or Emergency Room - Place of Service 23).
Eligibility Questions (Part 1 of 3)	I confirm I waive my right to a Medicare Electronic Health Record Incentive Payment for this payment year and am only accepting Medicaid Electronic Health Record Incentive Payments from <state>.	Yes/No	An Eligible Professional may only receive payment from either Medicare or Medicaid in a payment year, but not both. The state will validate Medicaid selection with CMS prior to payment issuance.
Eligibility Questions (Part 2 of 3)	What type of Provider are you? (Select One)	Radio Button	Eligibility for the Medicaid EHR Incentive Program is based on your provider type and specialty on file with the State's MMIS.
Eligibility Questions (Part 2 of 3)	Do you have any current sanctions or pending sanctions with Medicare or Medicaid in <state>?	Yes/No	The temporary or permanent barring of a person or other entity from participation in the Medicare or State Medicaid health care program and that services furnished or ordered by that person are not paid for under either program. See 42 CFR Ch. IV § 402.3 Definitions in the current edition.
Eligibility Questions (Part 2 of 3)	Are you currently in compliance with all parts HIPAA regulations?	Yes/No	All providers must be in compliance with the current Health Information Portability and Accountability Act (HIPAA) regulations. Current regulations can be reviewed at http://www.hhs.gov
Eligibility Questions (Part 2 of 3)	Are you licensed in all states in which you practice?	Yes/No	Eligible Professionals must meet the state law licensure requirements of the state that is issuing the EHR incentive payment.

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
Patient Volume Practice Type (Part 1 of 3)	Do you practice predominantly at an FQHC/RHC (over 50% of your patient encounters occur over a 6 month period in an FQHC/RHC)?	Yes/No	Practices predominantly means an EP for whom the clinical location(s) for over 50 percent of his or her total patient encounters over a period of 6 months in the most recent (prior) calendar year or the most recent 12 months occurs at a federally qualified health center or rural health clinic.
Patient Volume Practice Type (Part 1 of 3)	Please indicate if you are submitting volumes for: (Select one) --- Individual Practitioner	Radio Button	Individual Practitioners count his or her own Medicaid and non-Medicaid patient encounters only.
Patient Volume Practice Type (Part 1 of 3)	Please indicate if you are submitting volumes for: (Select one) --- Group/Clinic	Radio Button	Group/Clinic selection requires all Eligible Professionals to use the entire group practice or clinic's Medicaid and non-Medicaid patient encounters.
Patient Volume Practice Type (Part 1 of 3)	Please indicate if you are submitting volumes for: (Select one) --- Individual Practitioner's Panel	Radio Button	A Practitioner's Panel is calculated on and consists of Medicaid enrollees assigned to the Eligible Professional through a Medicaid panel plus any unduplicated Medicaid encounters.
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Medicaid Patient Volume (Must Select at Least One)	Check Box	Medicaid patient volume consists of encounters for individuals enrolled in Medicaid (Title XIX) including Medicaid Managed Care that paid for part or all of the service, part or all of the premiums, copayments, and/or cost-sharing for the continuous 90-day period selected.
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Utilizing Certified EHR Technology? (Must Select at Least One)	Yes/No	Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at http://healthit.hhs.gov/chpl
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Provider ID	Display Field	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations.
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Provider ID	Enterable	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations.

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Location Name	Enterable	Enter the legal entity name for the location being added
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Address Line 1	Enterable	Enter the location's street address. Example: 55 Main Street This cannot be a Post Office Box number.
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Available Actions	Buttons	Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Provider ID	Display Field	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations.
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Medicaid & CHIP Encounter Volume (Numerator)	Enterable	For the continuous 90-day period, for each location listed, the number of encounters where any services were rendered on any one day to an individual enrolled in CHIP (Title XXI) and Medicaid (Title XIX) programs.
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Other Needy Individual Encounter Volume (Numerator)	Enterable	Enter the number of encounters for the continuous 90-day period selected for each location below where the services furnished at either no cost or reduced cost based on a sliding scale as determined by the individual's ability to pay or furnished as uncompensated care.
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Total Needy Encounter Volume (Total Numerator)	Enterable	Enter the sum of the Medicaid & CHIP Encounter Volume plus the Other Needy Individual Encounter Volume.
Patient Volume - FQHC/RHC Individual (Part 3 of 3)	Total Encounter Volume (Denominator)	Enterable	Enter the total number of encounters (all States) for all patients regardless of health insurance coverage for the selected continuous 90-day period for each location selected.

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
Patient Volume - Individual (Part 3 of 3)	Medicaid Patient Volume (Must Select at Least One)	Checkbox	For the continuous 90-day period, the number of encounters where any services were rendered on any one day to an individual enrolled in an eligible Medicaid program
Patient Volume - Individual (Part 3 of 3)	Utilizing Certified EHR Technology? (Must Select at Least One)	Yes/No	Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at http://healthit.hhs.gov/chpl
Patient Volume - Individual (Part 3 of 3)	Provider ID	Display Field	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations.
Patient Volume - Individual (Part 3 of 3)	Provider ID	Enterable	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations.
Patient Volume - Individual (Part 3 of 3)	Location Name	Enterable	Enter the legal entity name for the location being added.
Patient Volume - Individual (Part 3 of 3)	Address Line 1	Enterable	Enter the service location's street address. Example: 55 Main Street. This cannot be a Post Office Box number.
Patient Volume - Individual (Part 3 of 3)	Available Actions	Buttons	Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.
Patient Volume - Individual (Part 3 of 3)	Provider ID	Display Field	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
Patient Volume - Individual (Part 3 of 3)	Medicaid Only Encounter Volumes (In State Numerator)	Enterable	For the continuous 90-day period, the number of encounters where any services were rendered on any one day to an individual enrolled in an eligible Medicaid program. In-state means the state to which you are applying for an incentive payment.
Patient Volume - Individual (Part 3 of 3)	Medicaid Encounter Volumes (Total Numerator)	Enterable	For the continuous 90-day period, the number of encounters where any services were rendered on any one day to an individual enrolled in an eligible Medicaid program.
Patient Volume - Individual (Part 3 of 3)	Total Encounter Volume (Denominator)	Enterable	Enter the total number of encounters for all patients regardless of health insurance coverage for the selected continuous 90-day period for each location selected.
Patent Volume - Individual Practitioner's Panel (Part 3 of 3)	Medicaid Patient Volume (Must Select at Least One)	Checkbox	Select the checkbox(es) for the location(s) where the Eligible Professional is reporting Medicaid patient volume for the continuous 90-day period selected.
Patent Volume - Individual Practitioner's Panel (Part 3 of 3)	Utilizing Certified EHR Technology? (Must Select at Least One)	Yes/No	Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at http://healthit.hhs.gov/chpl
Patent Volume - Individual Practitioner's Panel (Part 3 of 3)	Provider ID	Display Field	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations
Patent Volume - Individual Practitioner's Panel (Part 3 of 3)	Available Actions	Buttons	Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.
Patent Volume - Individual Practitioner's Panel (Part 3 of 3)	Provider ID	Display Field	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
Patent Volume - Individual Practitioner's Panel (Part 3 of 3)	Total Medicaid Patients on the Individual Practitioners Panel (Numerator)	Enterable	See Instructions for #1 (above). If you are an Eligible Provider practicing in an FQHC, RHC, or Group Practice and wish to calculate your Patient Volume based on a Panel methodology, please contact the Medicaid EHR Incentive Program.
Patent Volume - Individual Practitioner Panel (Part 3 of 3)	Unduplicated Medicaid Only Encounter Volume (Numerator)	Enterable	See Instructions for #2 (above). If you are an Eligible Provider practicing in an FQHC, RHC, or Group Practice and wish to calculate your Patient Volume based on a Panel methodology, please contact the Medicaid EHR Incentive Program.
Patent Volume - Individual Practitioner Panel (Part 3 of 3)	Total Patient Panel Encounters (Denominator)	Enterable	See Instructions for #3 (above). If you are an Eligible Provider practicing in an FQHC, RHC, or Group Practice and wish to calculate your Patient Volume based on a Panel methodology, please contact the Medicaid EHR Incentive Program.
Patent Volume - Individual Practitioner Panel (Part 3 of 3)	Total Unduplicated Encounter Volume (Denominator)	Enterable	See Instructions for #4 (above). If you are an Eligible Provider practicing in an FQHC, RHC, or Group Practice and wish to calculate your Patient Volume based on a Panel methodology, please contact the Medicaid EHR Incentive Program.
Patient Volume - FQHC/RHC Group (Part 3 of 3)	Utilizing Certified EHR Technology? (Must Select at Least One)	Yes/No	Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at http://healthit.hhs.gov/chpl
Patient Volume - FQHC/RHC Group (Part 3 of 3)	Provider ID	Display Field	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations
Patient Volume - FQHC/RHC Group (Part 3 of 3)	Medicaid & CHIP Encounter Volume (Numerator)	Enterable	For the continuous 90-day period, for each location listed, the number of encounters where any services were rendered on any one day to an individual enrolled in CHIP (Title XXI) and Medicaid (Title XIX) programs.

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
Patient Volume - FQHC/RHC Group (Part 3 of 3)	Other Needy Individual Encounter Volume (Numerator)	Enterable	Enter the number of encounters provided over the continuous 90-day period selected for each location where the services furnished at either no cost or reduced cost based on a sliding scale as determined by the individual's ability to pay, or furnished as uncompensated care.
Patient Volume - FQHC/RHC Group (Part 3 of 3)	Total Needy Encounter Volume (Numerator)	Enterable	Enter the sum of the Medicaid & CHIP Encounter Volume plus the Other Needy Individual Encounter Volume
Patient Volume - FQHC/RHC Group (Part 3 of 3)	Total Encounter Volume (Denominator)	Enterable	Enter the total number of encounters (all States) for all patients regardless of health insurance coverage for the selected continuous 90-day period for each location selected.
Patient Volume - Group (Part 3 of 3)	Utilizing Certified EHR Technology? (Must Select at Least One)	Yes/No	Certified EHR Technology means a complete EHR system or combination of EHR modules that meets the requirements of CMS. CMS requirements can be found at http://healthit.hhs.gov/chpl
Patient Volume - Group (Part 3 of 3)	Provider ID	Display Field	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations
Patient Volume - Group (Part 3 of 3)	Medicaid Only Encounter Volumes (In State Numerator)	Enterable	For the continuous 90-day period, the number of encounters where any services were rendered on any one day to an individual enrolled in an eligible Medicaid program. In-state means the state to which you are applying for an incentive payment.
Patient Volume - Group (Part 3 of 3)	Medicaid Encounter Volumes (Total Numerator)	Enterable	For the continuous 90-day period, the number of encounters where any services were rendered on any one day to an individual enrolled in an eligible Medicaid program.
Patient Volume - Group (Part 3 of 3)	Total Encounter Volume (Denominator)	Enterable	Enter the total number of encounters for all patients regardless of health insurance coverage for the selected continuous 90-day period for each location selected.

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
Attestation Phase (Part 1 of 3)	Adoption:	Radio Button	Eligible Professional has financial and/ or legal commitment to certified EHR technology capable of meeting Meaningful Use.
Attestation Phase (Part 1 of 3)	Implementation:	Radio Button	Eligible Professional is in the process of installing certified EHR technology capable of meeting Meaningful Use.
Attestation Phase (Part 1 of 3)	Upgrade:	Radio Button	Eligible Professional is expanding the functionality of certified EHR technology capable of meeting Meaningful Use.
Attestation Phase (Part 1 of 3)	Meaningful Use:	Radio Button	EPs will have the option to attest to 90 days from the current calendar year or a full year of Meaningful Use. The reporting period for the full year attestation will be the entire calendar year
Attestation Phase (Part 3 of 3)	Based on the information received from the R&A you requested to assign your incentive payment to the entity above (Payee TIN). Please confirm that you are assigning this payment voluntarily and that you have a contractual relationship that allows the assigned employer or entity to bill for your services.	Yes/No	EPs may reassign their incentive payment to an entity with which they have a valid contractual arrangement; this includes the ability to bill for the EP's services or a standard employment contract. The EP will select one TIN to receive any applicable Medicaid EHR incentive payment through the R&A.
Application Submission (Part 2 of 2)	Preparer Relationship:	Enterable	Enter the relationship the Preparer has with the Eligible Professional.
FQHC/RHC Group (Part 3 of 3)	FQHC/RHC Group Practice Provider ID	Enterable	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations
Attestation Phase (Part 3 of 3)	Additional Information	Display	

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
Patient Volume – FQHC/RHC Group (Part 3 of 3)	Available Actions	Buttons	Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/ Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.
Patient Volume – Group (Part 3 of 3)	Available Actions	Buttons	Edit/Delete actions are only presented when rows have been added. Review the information for the Provider ID/Location/ Address entered. Validate what was entered is accurate. Click Edit to modify the information. Click Delete to have the Provider ID/Location/Address removed from the list.
Patient Volume – Group (Part 3 of 3)	Please indicate in the box(es) provided, the Group Practice Provider ID(s) you will use to report patient volume requirements.	Enterable	This is the NPI number of the group practices used to report patient volume.
Patient Volume – Group (Part 3 of 3)	Medicaid Only Encounter Volumes (In State Numerator)	Enterable	
Attestation Phase (Part 3 of 3)	Provider ID	Display	The unique identifier used to retrieve the locations on file with the Division of Medical Assistance Programs (DMAP). You will attest to patient volume data at these locations
MAPIR Dashboard	Status	Display	Status of the incentive application.
MAPIR Dashboard	Payment Year	Display	The payment year is designated as a sequential number starting with payment year 1 up to the maximum number of payments for the program.
MAPIR Dashboard	Program Year	Display	The 4 digit year within which a provider attests to data for eligibility for a payment. For an EP this is the Calendar year (January thru December). For an EH it is the Federal Fiscal Year (October thru September). Valid Program Years are 2011-2021.

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
MAPIR Dashboard	Payment Amount	Display	The incentive amount that was paid for a particular application for the specified program and payment year. This includes initial and all adjustment amounts.
Attestation Phase (Part 1 of 3)	Meaningful Use – 90 Days	Radio Button	You may apply using the Meaningful Use 90 day if you have been utilizing EHR technology for a continuous 90 day period within the current Federal Fiscal year, and if you have not attested to 90 days of Meaningful Use in a previous program year.
Attestation Phase (Part 1 of 3)	Meaningful Use – Full Year	Radio Button	You must apply using the Meaningful Use Full Year if you have attested to 90 days of Meaningful Use in the previous program year, and you must be utilizing EHR technology for the entire current Federal Fiscal year.
Attestation Phase (Part 1 of 3)	Meaningful Use – Full Year	Radio Button	For EPs demonstrating they are meaningful EHR users for the first time after receiving a payment for A, I or U, you will utilize a continuous 90-day period within the calendar year for MU attestation.
Attestation Meaningful Use Measures	Meaningful Use – Full Year	Radio Button	For EPs demonstrating they are meaningful EHR users after attesting to 90 days MU for the previous payment, the EHR reporting period is the full calendar year.
EP MU General Requirements	Encounter Volumes	Enterable	Numerator – Enter only patient encounters where a medical treatment is provided and/or evaluation and management services are provided in location(s) with federally certified EHRs.
EP MU General Requirements	Encounter Volumes	Enterable	Denominator – Enter all patient encounters where a medical treatment is provided and/ or evaluation and management services are provided in location(s) with or without federally certified EHRs.

Screen/Panel Name	Item Name/Verbiage	Response	Mouse Over/Hover Bubble Verbiage
EP MU General Requirements	Unique Patients	Enterable	Numerator – Enter the number of unique patients during the reporting period seen by an EP that have their data in a certified EHR. If a patient is seen by an EP more than once during the reporting period, they can only be counted once.
EP MU General Requirements	Unique Patients	Enterable	Denominator – Enter all unique patients seen by an EP during the reporting period. If a patient is seen by an EP more than once during the reporting period, they can only be counted once.

RESOURCES AND CONTACTS

Thank you for your interest and participation in the Medicaid EHR Incentive Program!

FOR MORE INFORMATION:

Oregon Health Authority
Division of Medical Assistance Programs
500 Summer Street NE
Salem, Oregon 97301

Email: Medicaid.EHRIncentives@state.or.us

Website: www.MedicaidEHRIncentives.oregon.gov

Phone: 503-945-5898

Fax: 503-378-6705

ACRONYMS AND TERMS

CHIP — Children's Health Insurance Program

CHPL — ONC Certified Healthcare IT Product List

CMS — Centers for Medicare and Medicaid Services

EH — Eligible Hospital

EHR — Electronic Health Record

EP — Eligible Professional

FQHC/RHC — Federally Qualified Health Center/Rural Health Clinic

MAPIR — Medical Assistance Provider Incentive Repository

NPI — National Provider Identifier

ONC — Office of the National Coordinator for Health Information Technology

R&A — CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System

TIN — Taxpayer Identification Number

Oregon Health Authority
OHA SHARED SERVICES
Office of Health Information Technology
Medicaid Health IT Project

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact the Office of Health Information Technology at 503-945-5898, or email EHRIncentives@state.or.us.

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