S.C. Medicaid EHR Incentive Program
State Level Repository User Guide for Eligible Professionals

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Disclaimer

The pages that follow in this State Level Repository Guide for Eligible Professionals are intended to provide information to assist with completion of an Eligible Professional attestation to the S.C. Medicaid EHR Incentive Program; however, it is important to note that this SLR Guide is not, nor is it intended to be, the full source of information about the requirements of the Medicaid EHR Incentive Program. It is the responsibility of the provider who is attesting to the S.C. Medicaid EHR Incentive Program to be acquainted with the requirements of the Medicare and Medicaid EHR Incentive Programs Final Rules and the State Medicaid HIT Plan (SMHP).
The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Record (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade (AIU) to certified EHR technology and use it in a meaningful manner.

The Centers for Medicare and Medicaid Services (CMS) published a final rule in October 2015, the Electronic Health Record Incentive Program – Stage 3 and Modifications to MU in 2015 through 2017, that addresses criteria for Stage 3 and Modifications to Meaningful Use (MU) in 2015-2017 for the Electronic Health Records (EHR) Incentive Programs. Additionally, in October of 2016 the Centers for Medicare & Medicaid Services (CMS) finalized the Medicare Quality Payment Program and in November of 2016, the Centers for Medicare & Medicaid Services (CMS) finalized updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2017 which included modifications to the EHR Medicaid Incentive program that impacted the reporting periods for program year 2016 eligible providers. The last year to begin participation in the Medicaid EHR incentive programs is Program Year 2016.

The intent of this user guide is to describe changes to program year 2016 Meaningful Use attestations in response to this final rule S.C. Medicaid program changes and S.C. State Level Repository (SLR) attestation screen changes for Program Years (PY) 2016.

The CMS’ official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at http://www.cms.gov/EHRIncentivePrograms/. The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.
**Eligible Professional Types**

There are 5 types of providers who are considered Eligible Professionals (EPs) for the Medicaid EHR Incentive Program:

1. Physician*
2. Dentist
3. Nurse Practitioner
4. Certified Nurse Midwife
5. Physician Assistant (PA) practicing in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a PA:
   a. The PA is the primary provider in a clinic (e.g., a clinic with a part-time physician and full-time PA); or
   b. The PA is a clinical or medical director at a clinical site of practice; or
   c. The PA is the owner of an RHC.

*In South Carolina, this includes MDs, DOs, and Optometrists.

**Conditions that Exclude a Provider from Participating**

1. If the EP has any state or federal exclusions that would prevent the EP from receiving federal funding, the EP is not eligible to participate in the S.C. Medicaid EHR Incentive Program.

2. If the EP is a hospital-based provider, the EP is not eligible to participate in the S.C. Medicaid EHR Incentive Program. For purposes of this Program, a hospital-based provider is defined as a provider who furnishes 90% or more of their services in the following two places of service codes for HIPAA standard transactions: 21 – Inpatient Hospital, or 23 – Emergency Room.

For purposes of the S.C. Medicaid EHR Incentive Program, SCDHHS will make the determination about whether or not an EP is hospital-based by analyzing the EP's Medicaid paid claims data; or, in the case of EPs who deliver care via Medicaid managed care programs, by analyzing encounter data. Where there is not claims data specific to the provider (for example, as in the case where the provider may bill under a supervising provider) SCDHHS will request additional information from the provider to make the determination. For purposes of making this determination, SCDHHS will analyze data from the calendar year that precedes the participation year. The statutory definition of hospital-based EP provides that to be considered a hospital-based EP, the EP must provide “substantially all” of his or her covered professional services in a hospital setting.
Additional Program Participation Requirements
Once an EP meets the basic eligibility requirements for the S.C. Medicaid EHR Incentive Program, there are program participation requirements to meet in order to qualify for an incentive payment.

An EP must:

- Meet applicable patient volume threshold. (This is discussed further in Patient Volume.)

AND

- Adopt, implement, or upgrade to certified Electronic Health Record (EHR) technology, or demonstrate meaningful use of the certified EHR technology, in the provider’s first program year. After the first program year, the provider must successfully demonstrate meaningful use for all other program years.

Incentive Payments
The payment year for an EP is based on the calendar year. EPs may receive Medicaid EHR incentive payments over 6 payment years up to a maximum of $63,750. Medicaid EHR incentive payments do not need to be consecutive until 2016. No EP may initiate the program after 2016, and no EP will receive a payment after the 2021 Participation Year.

- Payment Year 1: $21,250 ($14,167 for Pediatricians qualifying with reduced Medicaid volume)

- Payment Years 2-6: $8,500 per year ($5,667 for Pediatricians qualifying with reduced Medicaid volume)

The South Carolina Department of Health and Human Services’ State Medicaid Health Information Technology Plan (SMHP) is available at www.scdhhs.gov/hit to provide detailed information about the S.C. Medicaid EHR Incentive Program.
Registration with the CMS Registration & Attestation System

EPs who wish to participate in either the Medicare or Medicaid EHR Incentive Program must first register with the Centers for Medicare and Medicaid Services (CMS) Registration and Attestation System. The last year an EP may begin participation is the 2016 Participation Year. The last year the EP may participate is the 2021 Participation Year.

Users working on behalf of an EP for registration and attestation must have a CMS Identity and Access Management System (I&A) Web user account (User ID/Password), and be associated to the provider’s NPI. In absence of a CMS I&A account, an individual may not act as a surrogate user on behalf of the EP. To establish an I&A account, visit the CMS Registration and Attestation System.

For assistance, please call the CMS EHR Information Center: (888) 734-6433.

Medicaid EPs use the CMS Web site to:

- Provide basic demographic information
- Select the state incentive program in which they will participate
- If applicable, switch their participation between the Medicaid and Medicare EHR Incentive Programs; or between state Medicaid EHR Incentive Programs.
  - EPs are allowed a one-time switch between the Medicaid and the Medicare EHR Incentive Programs once an incentive has been paid. The switch must occur before the 2015 Participation Year.
  - EPs may switch multiple times between state Medicaid EHR Incentive Programs.

EPs must provide the name, NPI, business address, phone number, and tax payer ID number (TIN) of the entity receiving the payment (i.e., the “Payee”). An EP may choose to receive the incentive, or may reassign it to a clinic or group with which he or she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive is required when registering with the CMS Registration and Attestation System. Upon successful completion of registration at the CMS level, the provider will receive an email confirmation from CMS that includes the provider’s individual CMS Registration ID.

The CMS system will transmit basic registration data to the S.C. Medicaid State Level Repository (SLR) of a provider’s choice to attest to the S.C. Medicaid EHR Incentive Program. SCDHHS will check the provider’s eligibility to participate in the program and will respond to CMS to either accept the registration, or to notify CMS that the provider has been found ineligible to participate. The CMS system will send an email to the EP of the registration acceptance or of the finding of ineligibility; SCDHHS will also email the EP of the next steps to begin the attestation process.
The CMS EHR Information Center is available to assist with provider inquiries: 1-888-734-6433, 6:30 a.m. until 5:30 p.m. (Eastern Time), Monday through Friday, except federal holidays.

Providers must revisit the CMS Registration and Attestation System to make any changes to their registration information and/or choices, such as changing the program from which they wish to receive their incentive payment, contact email address or their Payee information. After the initial registration, the provider does not need to return to the CMS Registration and Attestation System unless information provided in that system needs to be updated.
The S.C. Medicaid EHR Incentive Program is administered by S.C.’s Medicaid agency, the South Carolina Department Health & Human Services (SCDHHS), Division of Health Information Technology (HIT). Within 24-48 hours of successfully registering at CMS, the EP may access the S.C. Medicaid State Level Repository (SLR) to complete the attestation. The SLR is available at www.scdhhs.gov/slr.

To login, the EP must provide his or her NPI and CMS Registration ID (that was generated after successfully registering with the CMS Registration and Attestation System). If the CMS Registration ID is not known, the EP must return to his or her CMS registration to retrieve that ID. The CMS EHR Information Center is available to assist with questions about the CMS registration: (888) 734-6433.

During attestation, the EP will first have the opportunity to review basic registration information provided at the CMS Registration and Attestation System (displayed in the SLR’s “CMS Registration/SC Medicaid Data” screen). Then, the EP will progress through attestation screens to enter data to attest to meeting requirements of AIU (option for only the first program year) or MU first year or MU (all other program years). Attestations for meaningful use require that providers attest to meeting measures for the meaningful use objectives, and enter information pertaining to selected Clinical Quality Measures that have been generated by the certified EHR technology.

A final Attestation screen will provide the EP the opportunity to review a summary of their attestation data, and will require the EP (or the EP’s authorized designee) to agree to an attestation statement and that their attestation is true, accurate and complete prior to submitting the attestation for review by SCDHHS.
Logging into the SLR

SLR Log In Screen

Enter your NPI and CMS Registration ID
If an EP enters an incorrect NPI and CMS Registration ID combination 5 consecutive times for the same NPI, the SLR will display the following error message:

- “Your log-in screen to the SLR has been locked due to too many failed login attempts. Please contact (803) 898-2996, or email HITSC@scdhhs.gov, to request this screen be unlocked. If you do not know your CMS Registration ID, please contact the CMS EHR Information Center at (888) 734-6433.”
Red Asterisks
Required fields are denoted with a red asterisk.

Error Messages
Error messages are designed to alert the EP to an issue with the attestation so that the EP may submit a complete attestation. If the screen has errors (for example, a required field has not been completed), it will display an error message when the EP attempts to save the screen. In many screens, the EP will not be able to save the information (or progress to the next attestation screen) until the error has been corrected. Some screens will allow progression to the next attestation screen even after an error message has displayed; however, when the EP attempts to complete the final Attestation screen to submit the attestation, the SLR will not allow submission unless errors have been addressed and resolved.

Save, Next, and Previous Buttons
Upon completion of any screen, select the Save button to save the data; then, upon logout, the SLR will retain the information. When ready to proceed to the next screen of the attestation, select the Next button at the bottom of the screen. (Selecting “Next” will also result in saving the information on the screen.) The EP may always return to a previous screen by selecting the Previous button at the bottom of the screen.

Left Navigation Links
These navigation links remain available throughout the attestation process.
• **CMS Registration/SC Medicaid Data**: Returns the EP to the CMS Registration/SC Medicaid Data Screen (beginning of the attestation).

• **View All Payment Years**: Displays a view of payments received by payment year.

• **Alternate Contact Info**: Allows the EP to designate alternate contacts for the SCDHHS HIT Division should there be questions related to the attestation. The Alternate Contact link is functional even if the attestation is in a submitted status.

• **Issues/Concerns**: Allows submission of an issue or question within the attestation to the SCDHHS HIT Division.

• **Document Upload**: Navigates the EP to a screen to browse and upload files essential to the attestation or its review by the SCDHHS.

• **Additional Resources**: Expands to provide links to the S.C. Medicaid HIT site, the CMS EHR site, and the ONC CHPL site.

• **SLR Provider Guides**: Navigates to SLR Guides specific to Eligible Professionals and to Eligible Hospitals.

• **Send e-mail to HIT Division**: Allows the EP to send an email to the HITSC@scdhhs.gov e-mail box.
The SLR Home screen provides a “home page” for the EP to view messages from the SCDHHS HIT Division, payment information, and current status. It also displays a grid for the EP to access a view of past Paid attestations or to begin/modify a new attestation. The name of the EP will display in the screen header.

**Messages and Announcements**
Information from the SCDHHS HIT Division will display. This time-limited information may be general (for example, applicable to all EPs), or may be specific to the EP.

**Provider Information**
In the information displayed under Provider Information, the provider’s current status will display with one of the following messages:

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PreCheck inProcess</td>
<td>SCDHHS is checking provider eligibility to participate</td>
</tr>
<tr>
<td>PreCheck_Completed</td>
<td>Eligibility check is complete and the provider may begin attestation</td>
</tr>
<tr>
<td>Attest inProcess</td>
<td>Provider has begun the attestation, but has not yet submitted</td>
</tr>
<tr>
<td>Attest_Completed</td>
<td>Provider has submitted the attestation to the SLR</td>
</tr>
<tr>
<td>DHHSCheck inProcess</td>
<td>SCDHHS is checking the provider attestation against requirements</td>
</tr>
<tr>
<td>DHHSCheck_Completed</td>
<td>SCDHHS has completed the requirements check</td>
</tr>
<tr>
<td>NLRDupCheck inProcess</td>
<td>SCDHHS has sent CMS their intent to pay the incentives</td>
</tr>
<tr>
<td>NLRDupCheck_Completed</td>
<td>CMS has responded to SCDHHS’ request</td>
</tr>
<tr>
<td>MMISPayment inProcess</td>
<td>SCDHHS is processing payment</td>
</tr>
<tr>
<td>Paid</td>
<td>SCDHHS has disbursed the incentive</td>
</tr>
<tr>
<td>Ineligible</td>
<td>SCDHHS has found the provider to be ineligible for the incentives</td>
</tr>
<tr>
<td>Ineligible-CMS</td>
<td>CMS has found the provider to be ineligible for the incentive</td>
</tr>
</tbody>
</table>

**EHR Incentive Payment Details**
The SLR Home screen displays information about all attestation payments or adjustments in one summary table.
Program Year Selection Table
The Program Year (PY) Selection Table provides a view of past paid attestations, and also the means to begin or modify a new attestation.

The PY Selection table will not display a Program Year (PY) for selection for attestation until the date for selection should be available.

- The EP may attest during the current participation year; or for a two-month period following the participation year (the “attestation tail period”). So, although the participation year for an EP is the calendar year (January-December), the attestation tail period extends the attestation submission period through the February that follows the participation year. There are situations where CMS approves an extended tail period. This information is available on the HIT website, www.scdhhs.gov.

- The SLR does not allow the EP to begin a PY for which the deadline to submit an initial attestation has expired. Should the EP attempt to select a PY after the attestation submission deadline, the following message will display: “This Program Year is not available for attestation.” Note: Should the attestation be submitted by the PY deadline, and later be re-opened by SCDHHS for provider correction, the SLR will allow the EP to re-submit the attestation even after the PY deadline.

- The SLR does not allow the EP to begin a PY attestation when a prior year attestation is in progress, under review, or pending payment.
To view a Paid attestation, select the View link associated with the desired Program Year/Payment Year.

To begin or modify an attestation, select from the program year(s) currently available.
The CMS Registration/SC Medicaid Data screen allows the EP to review information sent to SCDHHS from the CMS registration, and to verify the Payee information for the incentive payments. EPs have the option of reassigning their incentive payments to their employer or an entity with which the EP has a contractual arrangement. EPs must designate their Payee NPI and Payee TIN when registering with the CMS Registration and Attestation System. The S.C. Medicaid EHR Incentive Program requires the Payee to be actively enrolled as a S.C. Medicaid provider. Once a payment is disbursed, the SCDHHS will notify CMS of the payment.

**CMS Registration Data Review**
The top portion of the CMS Registration/SC Medicaid Data screen displays information about the provider from the CMS Registration and Attestation System. Corrections to this information may only be made by the provider by returning to the CMS system to modify registration data.

**Note:** Do not return to the CMS registration unless a change is needed to the CMS registration information. If the EP does return to the CMS account, the EP must be sure to re-submit the registration at the CMS Registration and Attestation System, even if no changes are made. If the registration is not re-submitted, the account status with CMS will change to **In Progress** or **Registration Started/Modified** and will remain so until it is re-submitted. If the CMS account status shows **In Progress** or **Registration Started/Modified**, SCDHHS will not be able to exchange the transactions with CMS that are necessary to work the attestation. A status of **Pending State Validation** or **Registration Sent to State** in the CMS registration will indicate a successful submission.

Review the information the State has received from the EP’s registration at the CMS Registration & Attestation System.
S.C. Medicaid Data Review
The State Level Repository (SLR) system searches a download of provider data from the S.C. Medicaid Management Information System (MMIS) to display the Medicaid Provider ID(s) associated with the Payee NPI and Payee TIN provided by the EP during the CMS registration. Only actively enrolled Medicaid ID will display.

- Where there is only one active Payee Medicaid ID associated with the Payee information, it will display in the field for Payee Medicaid ID; the Mailing Address for the Payee will display also. (Note: Any changes noted for the Mailing Address must be made by the provider by contacting the S.C. Medicaid Provider Service Center: 888-289-0709.)

- Where there are multiple active Medicaid IDs associated with the Payee information, the Payee Medicaid ID field will display **Search**. Clicking **Search** will display the active Medicaid IDs; select the one to which the incentive payment will be made. Once the selection is made, the Mailing Address will display also. (Note: Any changes noted for the Mailing Address must be made by the provider by contacting the S.C. Medicaid Provider Service Center: 888-289-0709.) If the EP does not select a Payee Medicaid ID, the SLR will display an error message: **This is a required field. Please select the Payee Medicaid ID from the list.**

- If no information is displayed in the Payee Medicaid ID field, either the Payee TIN/Payee NPI is not associated in the MMIS with an active S.C. Medicaid ID, or there is an issue with
the SLR search of the MMIS data. Please contact the SCDHHS HIT Division at 803-898-2996, or by email at HITSC@scdhhs.gov, for assistance.

After reviewing information on the CMS Registration/S.C. Medicaid Data Screen, select the **Save** button to save your work; or, to proceed to the next screen, select the **Next** button.

**Note:** Communications from the SCDHHS HIT Division related to the provider attestation will be emailed to the email address associated with the CMS registration. Please ensure that this information is kept current.
EPs must enter two categories of data to complete the Provider Eligibility Details screen: Patient Volume data, and EHR Details. Patient volume reflects encounters from any representative continuous 90-day period from the calendar year preceding the participation year; or, as an additional option beginning with the 2013 Participation Year, from any representative continuous 90-day period from the 12-month period prior to attestation submission. The table below identifies 3 decision points for determining the patient volume calculation methodology.

|-------------------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| Medicaid Patient Volume: An EP must have a minimum 30% patient volume attributable to Medicaid patients. | An EP may qualify based on patient volume calculated on the individual EP’s patient encounters; OR Clinics and group practices may calculate the clinic/group practice Medicaid patient volume (or Needy Individual patient volume, as applicable), and its EPs may attest to the volume as a proxy for their own. | The S.C. Medicaid EHR Incentive Program offers the EP two options from which to choose to calculate patient volume: (1) The Encounter methodology

\[
\text{Total Medicaid patient encounters in any representative continuous 90-day period} \\
\geq \text{in the preceding year} \\
\geq 100
\]

Total patient encounters in that same 90-day period

OR

(2) The Panel methodology: Note: An EP must not count an assigned patient who was also an encounter more than once.

\[
\text{[Total Medicaid patients assigned to the provider in any representative continuous 90-day period]} \\
\geq \text{in the preceding calendar year with at least one encounter in the} \\
\geq 24 months preceding the start of the 90-day period} + [\text{Unduplicated Medicaid encounters in that same 90-day period}] \\
\geq 100
\]

\[
\text{[Total patients assigned to the provider in the same 90-day period with at least one encounter in the} \\
\geq 24 months preceding the start of the 90-day period} + [\text{All unduplicated encounters in that same 90-day period}] \\
\geq 100
\]

*or, the EP may opt to select the 90-day patient volume period from the 12-month period that precedes attestation submission.

*Pediatricians with reduced Medicaid patient volume may qualify for a reduced incentive with a minimum 20% patient volume.

A Medicaid encounter includes services rendered to an individual on any one day where the individual was enrolled in Medicaid at the time of service.

OR

“Needy Individual” Patient Volume: An EP who practices predominantly in an FQHC or RHC may meet a minimum 30% patient volume attributable to needy individuals.

Practicing predominantly: More than 50% of the EP’s encounters over 6 months in the calendar year prior to the PY occurred at FQHC or RHC.

A Needy Individual encounter means services rendered to an individual on any one day where the individual was enrolled in Medicaid at the time of service; or the services were furnished at no cost, and calculated consistent with $495.310; or the services were paid for at a reduced cost based on a sliding scale determined by the individual’s ability to pay.

For purposes of the S.C. Medicaid EHR Incentive Program, a group/clinic is defined as a group of healthcare practitioners organized as one legal entity under one Tax Identification Number (TIN).

There are conditions for group/clinic proxy: (1) The clinic or practice’s patient volume is appropriate as a patient volume calculation for the EP; (2) There is an auditable data source to support the clinic or practice’s patient volume determination; (3) The clinic or practice and EPs decide to use one methodology in each year, and (4) The group or clinic uses the entire group or clinic’s patient volume and does not limit it in any way.

If an EP works inside and outside of the clinic or practice, the group/clinic proxy patient volume calculation includes only those encounters associated with the clinic or group practice. (The EP’s outside encounters are not included.)

In order for an EP to utilize group patient volume as a proxy, it must be appropriate as a patient volume methodology calculation for the EP; i.e., the EP must be able and available to see Medicaid patients.
The EP will provide information in these fields on the Provider Eligibility Details Screen:

**Patient Volume**

Enter data into the following fields, as applicable:

- **Line 1:** Please indicate if you are using a clinic or group’s patient volume as a proxy for your own.
  For purposes of the S.C. Medicaid EHR Incentive Program, a group/clinic is defined as “A group of healthcare practitioners organized as one legal entity under one TIN.” All encounters for that TIN (even across multiple sites) must be used in the calculation of the group/clinic patient volume. If the EP is using group patient volume as a proxy for the EP’s own, answer Yes to Line 1 and also complete 2.A. and 2.B. If the answer is No to Line 1, Line 2.A and 2.B are not required (they do not allow data entry).

- **Line 2.A.:** If using clinic/group patient volume, indicate the TIN of the one legal entity.

- **Line 2.B.:** So that the TIN may be verified, the EP is asked to indicate one NPI that is associated with the TIN.
  If the NPI that is entered is not a valid NPI for the TIN, an error message will display as an alert that the TIN entered is not correct. (“The NPI and TIN does not match in MMIS. Please verify your info.”)

- **Line 3:** (If attesting to Needy Individual patient volume) Do you practice predominantly in an FQHC or RHC?
  In order to base an attestation on Needy Individual patient encounters, the EP must individually meet the requirement of practicing predominantly in an FQHC or RHC. “Practices predominantly” is based on the EP’s activity over 6 months in the most recent calendar year (e.g., 2015 for a 2016PY attestation). If attesting to Medicaid patient volume, and not Needy Individual patient volume, do not check the box for Line 3.

- **Line 4:** Select the option that indicates the time period from which the 90-day patient volume period is derived:
  Select one of the options that displays in the drop-down: prior calendar year; or, 12 months prior to attestation.

- **Line 5:** Enter the starting date of the 90-day period used to calculate patient volume percentage.
  Patient volume reflects encounters from any continuous 90-day period in the preceding calendar year; or, from any continuous 90-day period from the 12 months prior to attestation. If the starting date entered does not allow for a full 90-day period in the time period selected from the drop-down on Line 4, an error message will display.

- **Line 6:** Medicaid (or Needy Individual, as applicable) patient encounters during this period.
• Line 7. Total patient encounters during this period.

If the EP confuses data entry for the patient volume, and enters the Medicaid encounters in the total encounters field, and vice versa, an error message will display.

• Line 8. (If using the Panel Methodology) Total number of Medicaid (or Needy Individual) patients assigned to your panel with whom you did not have an encounter in the 90-day patient volume period but you did have an encounter in the 24 months prior. (If n/a, enter “0”).

If the EP has not used the Panel methodology to calculate patient volume, please enter a “0” in line 8. For more information on Panel methodology, please see the Final Rule, or the SCDHHS State Medicaid HIT Plan.

• Line 9. (If using the Panel Methodology) Total number of patients assigned to your panel from any Plan with whom you did not have an encounter in this 90-day period but you did have an encounter in the 24 months prior. (If n/a, enter “0”).

If the EP has not used the Panel methodology to calculate patient volume, please enter a “0” in line 9. For more information on Panel methodology, please see the Final Rule, or the SCDHHS State Medicaid HIT Plan.

Enter data into fields 1-9; then, select the Calculate button.

Line 10 will display the Medicaid or Needy Individual patient volume percentage calculated from the attestation.

**EHR Details**

• Line 11: Indicate the status of your EHR: Adopt, Implement, Upgrade (option only for first Program Year); Meaningful Use (first year), Meaningful Use (all other Program Years)

Upon completion of the Provider Eligibility Details Screen, select the Save button to save the data. The SLR will retain the information on the page.

To proceed to the next screen of the attestation, please select the Next button. To return to the previous screen, please select the Previous button.
If the EP is NOT attesting to using the Panel methodology to calculate patient volume, enter “0” in Fields 8 & 9.

Only select the checkbox for Line 3 if attesting to Needy Individual patient volume.

Please note: Providers attesting in consecutive years will not be allowed to use any part of the patient volume period from a previous attestation.
If the EP is attesting to Needy Individual patient volume (selected the checkbox to line 3 to attest to “practicing predominantly”), the next screen that will display is the Needy Individual Patient Volume screen. In order to attest to meeting patient volume requirements based on Needy Individual patient volume, an EP must individually meet the definition of “practicing predominantly” in an FQHC or RHC. The Final Rule defines an EP who "practices predominantly" as "an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of six months in the most recent calendar year occurs at an FQHC or RHC." In other words, the six-month period used for this determination must be from the calendar year preceding the participation year.

In this screen, the EP will identify the FQHC/RHC location(s) for the attestation of practicing predominantly by completing an FQHC/RHC table. Note: If the EP has not selected the checkbox in line 3 to attest to “practicing predominantly,” and is attesting to Medicaid patient volume, this screen will not display. Instead, the next screen that will display will be the Provider Locations screen.

When the screen first displays, the FQHC/RHC table is empty awaiting attestation. Select the FQHC/RHC(s) from the options; the choices will populate the table. Once the FQHC/RHC table is complete, select Next to proceed to the next attestation screen.
Enter part of the name in the search field, and select Find. In this example, the provider is searching by “Little.”

In this example, the EP has selected two locations. The EP may 'Delete' a choice from the table.

Click the Next button to save your information and proceed.
Beginning with the 2013 Participation Year, a new requirement was established (42 CFR 495.304) that states at least one clinical location used in the calculation of patient volume must have certified EHR technology (CEHRT) during the program year for which the eligible professional attests to having adopted, implemented or upgraded to CEHRT, or attests they are meaningful EHR user.

The Provider Locations screen collects information from the EP regarding all outpatient locations at which the EP renders services.

The screenshot below provides an example of how the screen will display prior to information being entered.

Once the EP enters information for the first provider location, and selects Add, the display will change to a more linear display. Information about additional locations must be typed into the fields under the column headings; then, select the Add button.
In the screenshot below, the provider has indicated 2 practice locations, and has entered data related to 1 of the 2 locations. Note that each row of the table includes a **Delete** button, and a **Modify** button, to either delete or modify the information in that row.

The EP must enter data for each practice location; for example, where the EP has indicated 2 locations, there must be 2 rows completed in the provider locations table. Should information be entered that is inconsistent (for example, only 1 description where the provider has indicated multiple locations), the SLR will display the following error message when the provider attempts to select **Next** to progress:

- "The number of locations in which you provide services must equal the number of location descriptions entered below."

Enter the number of locations at which the EP provides outpatient services; then complete the provider locations table, indicating for each location if the location was used for patient volume data, and if the location currently has certified EHR technology.

Upon completion of the Provider Locations screen, select the **Save** button to save the data. The SLR will retain the information on the page.

To proceed to the next screen of the attestation, please select the **Next** button. To return to the previous screen, please select the **Previous** button.
Certified EHR Technology is technology certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to the Office of the National Coordinator (ONC). The ONC has established new standards to define CEHRT that addresses new and revised objectives and measures for Modifications to Meaningful Use in 2015 Through 2017 (Modified Stage 2). Learn more about the Standards and Certification Criteria for Electronic Health Record Technology 2014 Edition Final Rule at: https://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-25595.pdf.

All 2016PY Modified Stage 2 Meaningful Use attestations must be based upon CEHRT that is certified to 2014 Edition certification standards.

On the CEHRT details screen, the EP will enter information to provide the EP’s attestation to the certified EHR technology (CEHRT). If the EP is attesting to Adopt, Implement, or Upgrade (option only for first program year), the EP will attest to the CEHRT that has been adopted, implemented, or upgraded at the time of the attestation.

If the EP is attesting to Meaningful Use, the EP will attest to the CEHRT(s) that was used for the Meaningful Use EHR Reporting period.

The ONC Certified Health IT Product List (CHPL) serves as the official listing of certified products: http://onc-chpl.force.com/ehrcert. This Web site is the single authority to obtain the CHPL/ONC Product Number(s) and the 15-character alphanumeric CMS EHR Certification ID for the certified EHR technology products(s). Please note: the left navigation link, “Additional Resources,” will expand when clicked to display a link to the ONC CHPL Website.

**Step 1: Enter the CMS EHR Certification ID of your certified EHR Technology.**

The CMS EHR Certification ID is a 15-character alphanumeric ID. Clicking the What Is This link located next to the field will enable the EP to view the ONC CHPL Web site. For more information on steps to take to determine the CMS EHR Certification ID for the certified EHR technology, click the link under the ‘Using the CHPL Application’ to Learn More.

- If the EP provided the CMS Certification ID of the certified EHR technology during the registration with the CMS Registration and Attestation System (optional), this field will pre-populate that information. **If the field is pre-populated, please review the information to be sure that it still accurately reflects the certified EHR technology in place at the time of the attestation submission (for AIU attestations), or the CEHRT used during the MU EHR reporting period (for MU attestations).**
- If there is no information displayed in the CMS Certification ID field, please enter information into this field.
Step 2: Complete the My Certified Health IT Product List.

Certified EHR technology must be a complete product, or combination of multiple products, that offers 100% of the criteria required by the Medicare and Medicaid EHR Incentive Programs.

Enter information into the tables listed for the certified EHR technology product(s) by completing the fields for **Product Name and Version #**, **Vendor Name (Developer)**, and **CHPL Product Number**. Select **Click Here to Add Product to My CHPL** to populate the information into the CHPL product table.

Failure to select “Click Here to Add Product,” will result in the following error message: “There cannot be any empty Certified Health IT Product List field. Please complete the Certified Health IT Product table.”
Step 3: Complete the Certified EHR Technology Description.

Note: Instructions for an AIU attestation differ than that for a MU attestation.

EHR Details Screen:  Adopt, Implement, Upgrade Attestation
Enter a description of the EP’s legal or financial commitment to the certified EHR technology at the time of attestation in this required text box. Include the full name and version of the technology, and relevant dates.

Examples are as follows:

- **Adopt:** “I purchased [name and version of product] on [date] and have a receipt for that purchase.”

- **Implement:** “My practice purchased [name and version of product] on [date] and is in the process of implementation; we have retained a receipt for that purchase.”

- **Upgrade:** “XYZ Medical Group signed its first contract with [vendor name] on [date]; we committed to an upgrade to certified EHR technology [name and version of product], as demonstrated by a legally binding contract dated [date]. The current contractual commitment is for three years ending [date].”

The EP must retain documentation for a minimum of six years that demonstrates a legal or financial commitment to the acquisition, purchase, or access to certified EHR technology prior to the incentive. This documentation would serve to differentiate between activities that may not result in AIU (for example, researching EHRs, interviewing EHR vendors, contract proposals) and an actual commitment to AIU. The documentation must show a legal or financial commitment to the adoption, implementation, or upgrade to certified EHR technology, naming the product(s) and version(s). Such documentation may include but is not limited to: an invoice and receipt for payment; purchase agreement; license agreement; binding contract (signed by both parties). Should the documentation not specify the certified EHR technology product (product name and version), a letter from the certified EHR technology vendor that clarifies the product name and version may be retained with the documentation as a supplement; however, such information will not be regarded as sufficient for stand-alone evidence.

EHR Details Screen:  Meaningful Use Attestation
The CMS EHR Certification ID and the CHPL table should reflect information for the certified EHR technology relative to the attestation to meaningful use (the CEHRT(s) used in the EHR reporting period). If the EHR details have changed from the previous year’s attestation, please enter details of the certified EHR technology that was in place during the EHR/Meaningful Use reporting period.
The SLR will run a check against the ONC CHPL site to validate that the CMS Certification ID that was entered is a valid CMS Certification ID. There may be slight delay as the system runs this check. If the CMS Certification ID supplied is not valid, the following error message will display: “Not a valid CMS certification ID.”

To continue to the next attestation screen, select the Next button at the bottom of the screen.
Meaningful Use Questionnaire Screen

Enter the MU/EHR Reporting Period Start and End Dates; then select whether the CQM entries are derived from the same reporting period as the EHR/MU Data. If the reporting periods differ, please enter the appropriate date ranges for the CQM reporting period.

Meaningful Use Menu Screen
The Meaningful Use Menu Screen allows the EP to view the three sections of the Meaningful Use attestation: MU Measures 1-9, Public Health Measures 10, and Clinical Quality Measures.

The Meaningful Use Specification Sheets for Program Year 2016 requirements are located on the CMS Program Website: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016_EPTableOfContents.pdf

Please refer to the CMS Specification Sheets for program year 2016 when completing the meaningful use objective questions. CMS provides tip sheets, fact sheets on public health reporting, and additional resources found on this website: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2016ProgramRequirements.html
Providers attesting to meaningful use must upload documentation to support the attestation for selected public health menu objective(s) measures and/or exclusions. The SCDHHS Division of Health Information Technology (Division of HIT) may also contact a provider to request documentation to support or clarify an attestation. The Document Upload screen provides the means for providers to attach PDF, Word, or Excel files to the provider attestation. Please note eligible providers should not upload to the attestation information that contains protected health information (PHI).

To upload a document, select the **Browse** button and locate the desired information. Then, select the **Upload** button.

If the upload is successful, the SLR will display a message:

‘You have successfully uploaded: [File Name].’

The EP may review the uploaded document by selecting the **View** button. To delete the file, select the **Delete** button. Once the attestation is submitted, uploaded documents may not be deleted.

*Please note for each program year attestation, eligible providers must upload documentation related to meeting the measures for objective 10: Public Health Reporting.*

To contact public health registries in the State of South Carolina please use the following contact information, or contact [HITSC@SCDHHS.GOV](mailto:HITSC@SCDHHS.GOV) with questions. Please contact DHEC for the latest and most comprehensive list of public health registries available at the time of attestation.

Public Health Agency (S.C. DHEC): [muhelpdesk@dhec.sc.gov](mailto:muhelpdesk@dhec.sc.gov)

- S.C. DHEC Immunization Registry: [sciregistry@dhec.sc.gov](mailto:sciregistry@dhec.sc.gov)
- S.C. DHEC Cancer Registry: [CancerRegistryMU@dhec.sc.gov](mailto:CancerRegistryMU@dhec.sc.gov)
- S.C. DHEC Electronic Reportable Labs and Syndromic Surveillance Registries: [muhelpdesk@dhec.sc.gov](mailto:muhelpdesk@dhec.sc.gov)

State Health Information Exchange (HIE): [SCHIEx.org](http://SCHIEx.org)
The Attestation screen displays a summary of information from the provider attestation; to also view the information from the provider attestation for the meaningful use objectives, the provider may select the **Pre-Attestation Measure Summary** navigation link located at the top left of the screen. If while reviewing the information the provider decides to revise information, he or she may return to the data entry field to modify information before submitting the attestation. Please note, however, that once the **Submit** button is selected, the attestation will be locked. In the screenshot that follows, a partial display of the Attestation Screen provides an example of the summary of information; note, too, that the link to the Pre-Attestation Measure Summary link is also shown.

Before submitting the attestation, read the Attestation Statement that is included on the Attestation Screen. To submit the attestation, enter the initials, the NPI, and select **Submit**.

Note: If the attestation to the meaningful use objectives has met the requirements, the Submit button will be displayed as active and will allow selection. If the attestation to the meaningful use objectives has not met the requirements, the Submit button will be grayed out, and the following error message will display: “Your MU attestation cannot be accepted. One or more of the measures did not meet MU requirements. Please select the navigation link to the Pre-Attestation Measure Summary to view all measures and the corresponding attestation data.”

Once an attestation is successfully submitted for meaningful use, the EP may select the **Post-Attestation Measure Summary** to view all measures and the corresponding calculations.
The following message appears in RED on the attestation screen if MU criteria are not met:

"Your MU attestation cannot be accepted. One or more of the measures did not meet MU requirements. Please select the navigation link to the Pre-Attestation Measure Summary to view all measures and the corresponding attestation data."

The submit button is also greyed out.

Once a provider has successfully submitted an attestation, the following screen will display:

Any provider attesting to receive an EHR incentive payment potentially can be subject to audit. ALL relative supporting documentation (in either paper or electronic format) used in the completion of the attestation responses must be retained and easily retrievable for a minimum of six years from the last year of participation in the Program.
Once the attestation is submitted, the SCDHHS Division of Health Information Technology (HIT) will review it to determine if it meets the requirements of the S.C. Medicaid EHR Incentive Program. Should the HIT Division staff have any questions concerning the attestation, they will contact the EP using the e-mail address provided by the EP to CMS during registration and, if necessary, alternate contact information provided by the EP in the SLR.

Approved incentives are incorporated into the SCDHHS’ weekly claims payment cycle and paid as **credit** adjustments to the individual or entity designated by the EP as the Payee. If the EP has reassigned the incentive, the EP should forward this important information to the Payee.

**Payment Notification**
Providers will be notified by e-mail of payments. The payment e-mail will provide information to identify provider-specific information on the remittance advice (RA).

- Payee Name
- Eligible Provider Who Earned the Incentive
- Payment Date
- Incentive Amount
- Provider Own Reference Number

**Remittance Advice**
Information about each EP’s incentive will be displayed as a separate line item in the Adjustments section. The names of the individuals for whom incentives are being issued will not be detailed on the RA; however, each line item will display information in columns labeled Provider Own Reference Number, Claim Reference Number, Action, and Debit/Credit Amount.

**An example of a remittance advice with information about 3 separate incentive credits follows on the next page.**
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<tr>
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<td>DEPT OF HEALTH AND HUMAN SERVICES</td>
<td></td>
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<tr>
<td>SOUTH CAROLINA MEDICAID PROGRAM</td>
<td></td>
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<tr>
<td>PAYMENT DATE</td>
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</table>

### Table: Provider Claim Information

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<th>RECIPIENT NAME</th>
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<th>ACTION</th>
<th>DEBIT / CREDIT AMOUNT</th>
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<td>INCENTIVE</td>
<td>21250.00</td>
<td>-</td>
</tr>
</tbody>
</table>

**PAGE TOTAL:** 63750.00

**MEDICAID TOTAL TO BE REFUNDED IN THE FUTURE:**

**CERTIFIED AMT:**

**ADJUSTMENTS**

**DEBIT BALANCE:**

**TO BE REFUNDED:**

**IN THE FUTURE:**

### Provider Information

**Provider Name:**

**Street Address:**

**City, State Zip Code:**

*FUNDS AUTOMATICALLY DEPOSITED TO:

**BANK NAME:** SECURITY FEDERAL SAVINGS ACCOUNT B: XXXXXXXXXX

**NOTIFY MEDICAID PROVIDER ENROLLMENT BEFORE CLOSING OR CHANGING YOUR BANK ACCOUNT.*

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2016 MU Participation Year SLR Guide for EP 34
The following resources are available to assist providers with questions about the Medicaid EHR Incentive Program:

- Official CMS Medicare and Medicaid EHR Incentive Programs Web site: http://www.cms.gov/EHRIncentivePrograms
- SCDHHS HIT Web site: http://www.scdhhs.gov/hit
- Dedicated SC e-mail address for questions concerning the S.C. Medicaid EHR Incentive Program: hitsc@scdhhs.gov

PROGRAM REGULATION

This section contains materials pertaining to the rulemaking for the Medicare and Medicaid EHR Incentive Programs. Click on any of the links below to learn more.

- Proposed Rule: The Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for CY 2017 (July 2016)
- Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Corrections and Correcting Amendment (CMS 3310 & 3311-F3) (June 2016)
- Electronic Health Record Initiative Program Stage 3 and Modifications to MU in 2015 through 2017; Corrections and Correcting Amendment (CMS 3310 & 3311-F2) (March 2016)
- CMS Stage 3 and Modifications to Meaningful Use in 2015 through 2017 Final Rule (October 2015)
- CMS Stage 3 NPRM (March 2015)
- CMS 2014 CEHRT Flexibility Final Rule (September 2014)
- CMS 2014 CEHRT flexibility NPRM (May 2014)
- CMS Stage 2 Final Rule (September 2012)
- CMS Stage 1 Final Rule (July 2010)
- ONC Health Information Technology Initial Set of Standards (Stage 1, 2011 Edition) Final Rule (July 2010)
- CMS Correcting Amendment (December 2010)
- Agency Information Collection Notice (October 22, 2010)
- ONC Establishment of the Permanent Certification Program for Health Information Technology Final Rule (January 2011)
• ONC Revisions to Health Information Technology Initial Set of Standards [Final Rule](#) (October 2010)
• ONC Establishment of the Temporary Certification Body [Final Rule](#) (June 2010)
• CMS [Stage 1](#) Proposed Rule (January 2010)