Alabama Stage 1 Meaningful Use Attestation Submission Guidelines For Eligible Hospitals

On April 1, 2012, Alabama launched the ability for providers to submit attestations through the State Level Registry (SLR) for Stage 1 Meaningful Use of Electronic Health Records (MU). Eligible Hospitals (EH) will find some differences in the requirements for Year 2 from what was required in Year 1.

What's the same?

Step 1 (About You), Step 4 (Attestation) and Step 5 (Attestation Submitted) of the SLR capture essentially the same information as before.

- ***Step 1*** is identifying data for the provider. The information may be updated if there are changes.
- ***Step 4*** involves reviewing, signing and uploading the Attestation Agreement.
- ***Step 5*** is the submission of the data being reported and the Attestation Agreement to the State Level Registry.

What's different?

In ***Step 2***, Confirm Medicaid Eligibility, you will only need to enter data necessary to establish Medicaid eligibility. This requires identifying the representative period for the numbers used to determine your 10%-minimum Medicaid patient volume. This is significantly less data than what was required for the first year of program participation.

In ***Step 3***, Meaningful Use, all EHs will again be required to identify the certified EHR technology at the hospital. In addition, they will be required to establish that they are using that certified EHR technology by attesting to a number of specified MU measures. This will include specifying how many patients have data captured in the EHR system, identifying what patient data is recorded, whether the data is being used in specified ways, and whether the system has specified capabilities. *How this step is completed will differ for EHs that are Medicaid-only program participants than for those EHs that are dual eligible Medicare-Medicaid program participants.*

Important Note: EHs must note that Step 3 also requires identifying the "Reporting Period" for their MU measures. The Reporting Period is NOT the same as the "representative period" which is used for establishing eligibility. The Reporting Period must be within the EHs program year for which the incentive payment is being sought and is the period when the MU measures were taken.

What Must Be Submitted For Year 2?

Establishing Medicaid Eligibility and the Amount of the Incentive Payment

All EHs must establish Medicaid eligibility each year they apply for an incentive payment. Each year of program participation the EH must establish that it is an EH that has a minimum 10% Medicaid patient volume and an average length of stay of not more than 25 days for all patients. Although the EH must report certain demographic data each year to establish eligibility, the newly reported data *does not* alter the amount of the incentive payment because the ***total amount of the incentive payment is established in the EH's Year 1*****.** The incentive payment is paid in three installments with

- 50% of the total amount paid in Year 1,
- 30% in Year 2, and
- 20% in Year 3.

However, the total amount of an EH's incentive payment could change under one of the following situations:

1. The EH did not have four years of cost report data to report in Year 1, or
2. Errors in the Year 1 data were noted and must be corrected, or
3. Other adjustments are warranted resulting from audits

What documentation is required to submit attestations?

SLR Step 2 – Confirm Medicaid Eligibility

1. Required Data: EHs must again provide demographic data to establish Medicaid eligibility. This will include establishing the minimum 10% Medicaid patient volume based on the number of discharges in the representative period. The EH will also need to determine the average length of stay from the number of inpatient days and discharges. The EH Workbook for Year 2 will assist the EH in reporting this information.

2. Required Documentation: The EH will be required to submit a copy of:

    a. The completed **EH Workbook for Year 2**,
    b. A copy of the page(s) from the appropriate **Cost Report (CR).** The Cost Report must cover the *representative period*, which is:

- any continuous 90-day period *or* the entire one-year CR period during the federal fiscal year (FFY) *PRIOR* to the payment year for which the application is being made.
- Using the entire CR period is the preferred, fastest and easiest for the State to review.
- If an EH finds it advantageous to use a 90-day period, documentation in addition to the CR will be mandatory to support the numbers being reported.
- When using a 90-day representative period, the entire 90-days must be within the prior FFY. When using the one-year CR period, the period must *END* at any time during the prior FFY. For example, an EH applying for its Year 2 payment in FFY 2012, the representative period must be in the 2011 FFY, which is October 2010 through September 2011.

c. **Supplemental Information -** when the CR discharge numbers alone are insufficient to establish 10% Medicaid patients, emergency room encounters may also be counted. The emergency room encounters must be supported with documentation in addition to the CR (if not clearly identified in the CR). The supplemental documentation may include a copy of the page(s) from some other hospital report or census. This supplemental data must also be from a specifically identified auditable data source.

Medicare-Medicaid Hospitals

EHs attesting to both Medicare and Medicaid have application requirements different from EHs that attest only to Medicaid. The very first difference is that these dual-eligible EHs must attest to Medicare **BEFORE** attesting to Medicaid. In doing so, Medicare will automatically transfer the EH's MU data to Medicaid and the transferred data will automatically populate the required MU data fields in the Alabama SLR for Step 3.

SLR Step 3: Certified EHR Systems

PLEASE REFER TO THE FOLLOWING CMS SITES FOR INFORMATION REGARDING THE CEHRT FLEXIBILITY RULE AND OPTIONS FOR ATTESTATION IN 2014.

- **CEHRT Flexibility Decision Tool**
- **2014 CEHRT Flexibility Chart**
- **2014 CEHRT Rule: Quick Guide**

As a dual-eligible EH that has already attested to Medicare, your EHR certification information will have been received from Medicare and automatically populated the appropriate fields in this step. Therefore, ***all you need to do is visually confirm the data is present and you must not alter anything***.

SLR Step 3: Meaningful Use Measures

As a dual-eligible EH that has already attested to Medicare, all of your Meaningful Use data will have been received from Medicare and automatically populated the appropriate fields in this step. Therefore, ***all you need to do is visually confirm the fields have been populated and you must not alter anything***.

Medicaid-Only Hospitals

Hospitals that attest only to Medicaid must physically enter the appropriate data into the SLR in order to complete Step 3. The EH should call Medicaid if assistance is needed to complete this step.

More Information:

The Specification Sheets defining and describing all Meaningful Use measures as well as the validation methods can be found on the CMS Incentive Payment website at the following URL:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

For Program Questions and Assistance:

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