



Medicaid EHR Incentive Program

Provider User Manual

January 18, 2011
Version 1.4

Table of Contents

Contents

Introduction	2
Resources:.....	2
Revisions	2
Background	3
Eligibility	4
Additional requirements for the EH	5
Qualifying Providers by Type and Patient Volume	5
Out-of-State Providers	5
Establishing Patient Volume	6
Patient Encounters Methodology	6
Eligible Professionals.....	6
Eligible Hospitals:.....	7
Payment Methodology for EPs	7
Payments for Eligible Professionals	8
Payment Methodology for Eligible Hospitals	9
Provider Registration	10
Provider Attestation Process and Validation	11
Eligible Professional.....	11
Eligible Hospital	12
Incentive Payments	12
Administrative Appeals	13
Registration (Eligible Providers)	14
Eligible Provider Sign-in Screen.....	14
Provider Eligibility Details Screen	15
Provider Calculations Screen.....	16
Document Upload Screen	16
Registration (Eligible Hospitals)	18
Eligible Hospital Sign-in Screen:	18
Eligible Hospital CMS/NLR Screen	18
Hospital Eligibility Details Screen.....	19
Eligibility Hospital Cost Calculations Screen	20
Document Upload Screen	20
Attestation Screen.....	21
Meaningful Use	22

Introduction

The Kentucky Medicaid EHR Incentive Program will provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Registration began January 3, 2011. Participate early to get the maximum incentive payments!

Background information and registration procedures follow, **but if you are ready to start your EHR registration, please see Page 14 Registration for Eligible Providers and Page 18 Registration for Eligible Hospitals.**

Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>
- Kentucky State Medicaid HIT Plan (SMHP) Version 1.0 located at <http://chfs.ky.gov/dms/EHR.htm>
- Kentucky Medicaid HER Application Portal located at <https://apps4.chfs.ky.gov/kyslr/>
- Medicare and Medicaid Electronic Health records (HER) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>
- Office of the National Coordinator for Health Information Technology located at http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/1204

Two Regional Extension Centers (RECs) have been designated to provide technical assistance to Kentucky EPs, and I have copied both. The RECs provide a full range of assistance related to EHR selection and training and are listed below

:

- **Northern/Northeastern Kentucky – Tri-State REC**
Website: <http://www.healthbridge.org/rec/>
Phone: 513-469-7222 x4 or 513-469-7230
E-mail: info@healthbridge.org
- **Rest of Kentucky – Kentucky REC**
Website: <http://www.ky-rec.org/>
Phone: 888-KY-REC-EHR or 859-323-3090
E-mail: kyrec@uky.edu

Revisions

- Original 12/29/2010
- Version 1.1, Revised 1/3/2011
- Version 1.2, Revised 1/6/2011
- Version 1.3, Revised 1/14/2011
- Version 1.4 Revised 1/18/2011

Background

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 Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://www.healthit.hhs.gov>

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Kentucky Department for Medicaid Services (DMS) will work closely with federal and state partners to ensure the Kentucky Medicaid EHR Incentive Program fits into the overall strategic plan for the Kentucky Health Information Exchange (KHIE), thereby advancing national and Kentucky goals for HIE.

Eligible professionals and eligible hospitals must register in order to participate in the Medicare and Medicaid EHR incentive programs. They can do so, starting January 3, 2011, at a registration site maintained by CMS 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.

Eligibility

While EPs can begin the program in Calendar Year (CY) 2011, they must begin the program no later than CY 2016 and EHs must begin by Federal Fiscal year (FFY) 2016.

The first tier of provider eligibility for the Kentucky Medicaid EHR Incentive Program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the KY MMIS provider data store does not correspond to the provider types and specialties approved for participation in the Kentucky Medicaid EHR Incentive Program, the provider will receive an error message with a disqualification statement.

At this time, CHFS DMS has determined that the following providers and hospitals are potentially eligible to enroll in the Kentucky Medicaid EHR Incentive Program:

- Physicians = Any provider who has a Provider Type 64 and Specialty other than 345 (Pediatrics)
- Physician Assistant (practicing in a FQHC [Provider Type 31 and Specialty 80] or RHC [Provider Type 35] led by a Physician Assistant) = Any provider with a Provider Type 95 and Specialty other than 959 (PA Group). An FQHC or RHC is considered to be PA led in the following instances:
 - The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
 - The PA is the clinical or medical director at a clinical site of the practice
 - The PA is the owner of the RHC
- Pediatrician = Any provider with a Provider Type 64 and Specialty 345
- Nurse Practitioner = Any provider with a Provider Type 78 and not Specialty 095 (CNM) or 789 (Nurse Practitioner Group)
- CNM = Any provider with a Provider Type 78 and Specialty 095
- Dentist = Any provider with a Provider Type 60 (Individual)
- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children's Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

Additional requirements for the EP - to qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must not be hospital-based and must:

1. Meet one of the following patient volume criteria:
 - a. Have a minimum of 30 percent patient volume attributable to individuals receiving TXIX Medicaid funded services; or
 - b. Have a minimum 20 percent patient volume attributable to individuals receiving TXIX Medicaid funded services, **and** be a pediatrician; or
 - c. Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals.
2. Have no sanctions and/or exclusions.

An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the National Level Registry (NLR) and must match a TIN linked to the individual provider in DMS's system. This means the system will not be available to a provider for attestation from the time the contract is submitted for renewal until it has been approved by DMS.

Additional requirements for the EH - to qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

1. An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment and
2. A children’s hospital (exempt from meeting a patient volume threshold).

Hospital-based providers are not eligible for the EHR incentive program.

Note also that some provider types eligible for the Medicare program, such as podiatrists, chiropractors and optometrists, are not currently eligible for the Kentucky Medicaid EHR Incentive Program. CHFS DMS does not include optometrists because they do not meet the Kentucky State Plan for Medicaid Services definition of Physician Services (“Physician services include physicians, certified pediatric and family nurse practitioners, nurse midwives, FQHCs, RHCs and physician assistants.”) Optometrists are also excluded from the definition of “Physician” in the Social Security Act.

Qualifying Providers by Type and Patient Volume

Program Entity	Percent Patient Volume over Minimum 90-days	
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC -30% “needy individual” patient volume threshold
Pediatricians	20%	
Dentists	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	
Children’s Hospital	Exception	

Out-of-State Providers

The Kentucky Medicaid EHR Incentive Program welcomes any out-of-state provider to participate in this advantageous program as long as they have at least one physical location in Kentucky. Kentucky must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Kentucky DMS program or CMS. Records must be maintained as applicable by law in the state of practice or Kentucky, whichever is deemed longer.

Establishing Patient Volume

A DMS provider must annually meet patient volume requirements of Kentucky's Medicaid EHR Incentive Program as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). Patients' funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) - CHIP. All EPs (except EPs predominantly practicing in an FQHC/RHC) will calculate patient volume based on TXIX Medicaid and out-of-state Medicaid patients. The EHR statute allow for an EP practicing predominantly in an FQHC or RHC to consider CHIP patients under the needy individual patient volume requirements.

Patient Encounters Methodology

Eligible Professionals:

- EPs (except those practicing predominantly in an FQHC/RHC) – to calculate TXIX Medicaid patient volume, an EP must divide:
 - The total TXIX Medicaid or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
 - The total patient encounters in the same 90-day period.
- EPs Practicing Predominantly in an FQHC/RHC - to calculate needy individual patient volume, an EP must divide:
 - The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
 - The total patient encounters in the same 90-day period.

Definition of an Eligible Professional DMS Encounter

For purposes of calculating EP patient volume, a DMS encounter is defined as services rendered on any one day to an individual where TXIX DMS or another State's Medicaid program paid for

- Part or all of the service; or
- Part or all of their premiums, co-payments, and/or cost-sharing.

Definition of a Needy Individual Encounter

For purposes of calculating patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Paid for by TXIX Medicaid or TXXI Children's Health Insurance Program funding including DMS, out-of-state Medicaid programs or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- Furnished by the provider as uncompensated care; or
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Group practices - Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP;

- There is an auditable data source to support the clinic’s or group practice’s patient volume determination;
- All EPs in the group practice or clinic must use the same methodology for the payment year;
- The clinic or group practice uses the entire practice or clinic’s patient volume and does not limit patient volume in any way; and
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP’s outside encounters.

Eligible Hospitals:

To calculate TXIX DMS patient volume, an EH must divide:

- The total TXIX DMS and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year by:
- The total encounters in the same 90-day period.
 - Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period.
 - An emergency department must be part of the hospital.

Eligible Hospital DMS Encounter:

For purposes of calculating eligible hospital patient volume, a DMS encounter is defined as services rendered to an individual 1) per inpatient discharge, or 2) on any one day in the emergency room where TXIX DMS or another state’s Medicaid program paid for:

- Part or all of the service;
- Part or all of their premiums, co-payments, and/or cost-sharing;

Exception - a children’s hospital is not required to meet Medicaid patient volume requirements.

Payment Methodology for EPs

Payment for EPs equals 85 percent of “net average allowable costs,” or NAAC, which are capped by statute at \$25,000 in the first year, and \$10,000 for each of five subsequent years. NAAC for pediatricians with DMS patient volume between 20-29 percent are capped at two thirds of those amounts respectively. The maximum incentive payment an EP could receive from Kentucky Medicaid equals \$63,750, over a period of six years, or \$42,500 for pediatricians with a 20-29 percent DMS patient volume.

Provider	EP	EP-Pediatrician
Patient Volume	30 Percent	20-29 Percent
Year 1	\$21,250	\$14,167
Year 2	8,500	5,667
Year 3	8,500	5,667
Year 4	8,500	5,667
Year 5	8,500	5,667
Total Incentive Payment	\$63,750	\$42,500

Since pediatricians are qualified to participate in the Kentucky Medicaid EHR incentive program as physicians, and therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

Payments for Eligible Professionals

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation National Level Repository (NLR). The TIN must be associated in the Kentucky MMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated. EPs who assign payment to themselves (and not a group or clinic) will be required to provide DMS with updated information. Each EP must have a current DMS contract and be contracted for at least 90 days.

The Kentucky Medicaid EHR Incentive program does **not** include a future reimbursement rate reduction for non-participating Medicaid providers. (Medicare requires providers to implement and meaningfully using certified EHR technology by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that he/she was a meaningful user of EHR technology during that year. Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021

Currently, all providers are required to submit a valid NPI as a condition of DMS provider enrollment. Each EP or EH will be enrolled as a DMS provider and will therefore, without any change in process or system modification, meet the requirement to receive an NPI. DMS performs a manual NPPES search to validate NPIs during the enrollment process.

In the event DMS determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS.

The timeline for receiving incentive payments is illustrated below:

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	\$21,250					
CY 2012	\$8,500	\$21,250				
CY 2013	\$8,500	\$8,500	\$21,250			
CY 2014	\$8,500	\$8,500	\$8,500	\$21,250		
CY 2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
CY 2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
CY 2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
CY 2018			\$8,500	\$8,500	\$8,500	\$8,500
CY 2019				\$8,500	\$8,500	\$8,500
CY 2020					\$8,500	\$8,500
CY 2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Payment Methodology for Eligible Hospitals

Statutory parameters placed on Kentucky Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Children's hospitals and acute care hospitals may be paid up to 100 percent of an aggregate EHR hospital incentive amount provided over a three-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Kentucky is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Kentucky Medicaid incentive payments to those providers. Auditable data sources include:

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Kentucky MMIS (or other automated claims processing systems or information retrieval systems); and
- Hospital financial statements and hospital accounting records.

The Kentucky Medicaid EHR Incentive Program hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

Where:

Overall EHR Amount = {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}

Medicaid Share = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

Kentucky intends to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Kentucky Medicaid payments. The reason for this approach is that most of Kentucky's numerous rural hospitals operate on a very thin margin and need the money as soon as possible to offset their EHR system costs.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH.

Kentucky has worked with CMS on ways to effectively calculate costs. For example, charity care costs are not included on Kentucky's cost report. Kentucky has received approval from CMS to use the Kentucky Medical Assistance Program (KMAP) disproportionate share form

data in lieu of cost reports for this data. A standard questionnaire is used to determine the disproportionate share.

To the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients, the statute directs that such figure is deemed to equal 0. Likewise, if there is simply not sufficient data for the state to estimate the percentage of inpatient bed days that are not charity care (that is, [estimated total charges—charity care charges]/estimated total charges), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

Provider Registration

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. Providers must provide their name, NPI, business address, phone number, tax payer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN. EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong.

EPs must select between Medicare or Medicaid's incentive program (a provider may switch from one to the other once during the incentive program prior to 2015). If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments unless information needs to be updated. EHs seeking payment from both Medicare and Medicaid will be required to visit the NLR annually to attest to meaningful use before returning to the KYSLR system to attest for Kentucky's Medicaid EHR Incentive Program. DMS will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The NLR will assign the provider a CMS Registration Number and electronically notify DMS of a provider's choice to access Kentucky's Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the KYSLR system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a provider with the Kentucky DMS. If either of these conditions is not met, a message will be automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted. Once payment is disbursed to the eligible TIN, NLR will be notified by DMS that a payment has been made.

Provider Attestation Process and Validation

DMS will utilize the secure KYSLR system to house the attestation system. The attestation site is currently in development and should be available by January 3, 2011. Due to the short timeframe between release of the final rule and the start date of the program, all documentation may not be available in an electronic format. The system will be revised to upgrade features in subsequent versions of the attestation.

The link will only be visible to providers whose type in the MMIS system matches an EHR incentive eligible provider category. If an eligible provider registers at the NLR and does not receive the link to the attestation system within two business days, assistance will be available by contacting DMS Provider Enrollment Call Center Operations. Calls will be received and responded to using the existing standards MITA Manage Provider Communications business process.

Following is a description by eligible provider type of the information that a provider will have to report or attest to during the process.

Eligible Professional

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) (at <http://www.cms.gov/EHRIncentivePrograms/>), the EP will be asked to provide their NPI and CMS-assigned Registration Identifier.
2. The EP will then be asked to view the information that will be displayed with the pre-populated data received from the NLR (if the provider entry does not match, an error message with instructions will be returned).
3. EPs will then enter two categories of data to complete the Eligibility Provider Details screen including 1) patient volume characteristics and 2) EHR details.
4. The EP will be asked to attest to:
 - Assigning the incentive payment to a specific TIN (only asked if applicable); provider and TIN to which the payment was assigned at the NLR will be displayed;
 - Not working as a hospital based professional (this will be verified by DMS through claims analysis);
 - Not applying for an incentive payment from another state or Medicare;
 - Not applying for an incentive payment under another DMS ID; and
 - Adoption, implementation or upgrade of certified EHR technology.
5. The EP will be asked to electronically sign the amendment.
 - The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify).
 - The person filling out the form should enter his or her name.

Note: For providers that are ready to demonstrate Meaningful Use in year 1, the provider will attest to this fact. In subsequent years, DMS will work with the KHIE to provide a mechanism for providers to submit Meaningful Use data to DMS.

Eligible Hospital

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the EH will be asked provide:
 - Completed patient volume information on the KYSLR Web site;
 - Completed Hospital EHR Incentive Payment Worksheet;
 - Certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules); and
2. The EH will be asked to attest to:
 - Adoption, implementation or upgrade of certified EHR technology or meaningful use;
 - Not receiving a Medicaid incentive payment from another state; and
3. The EH will be asked to electronically sign the amendment;
 - The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify); and
 - The person filling out the form should enter his or her name.

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, DMS will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the EP or EH to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All providers will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

During the first year of the program, EPs will only be able to attest to adopting, implementing or upgrading to certified EHR technology. It should be noted that the documentation for AIU of certified EHR technology for EPs or EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (the Certified Health IT Product List can be located at ONC's website at www.healthit.hhs.gov). EHs can attest to either AIU or meaningful use as appropriate.

All providers will be required to attest to meeting meaningful use to receive incentive payments after the first year.

Incentive Payments

DMS plans to use the Supplemental Payment functionality in the Kentucky MMIS to set up financial transactions for incentive payments. To accomplish this, the Expenditure Panels will need be modified, and CHFS DMS will ensure this functionality is added. This will enable staff to query payments by originator. Specific accounting codes will also be required for the transactions to enable DMS to report the funds in the CMS-64 report. Different codes will be needed for each payment year.

Kentucky will ensure all reporting requirements and modifications to the MMIS are made to correctly report expenditures, attestation information, and approval information. This will include the creation of a new Management and Administrative Reporting (MAR) category of service for state and federal reporting. DMS will also make the necessary changes to the

CMS-64 reporting process to add the additional line item payment and administrative information, and, if required by CMS, the Medicaid Statistical Information System (MSIS) file will be modified to accommodate the incentive payment program.

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and validation by DMS, an incentive payment can be approved.

Program Integrity

DMS will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers should be sure to keep their supporting documentation.

Administrative Appeals

You may appeal the determination made by the Kentucky Department for Medicaid services on your incentive payment application. Please send a Formal Letter of Appeal to the address below, within 30 days of the determination date of notification. This formal written notification must include a detailed explanation of why the EP or EH deems a wrong determination made by the Kentucky Medicaid EHR Incentive Program. Any supporting documentation to the appeal should be included with the Letter of Appeal.

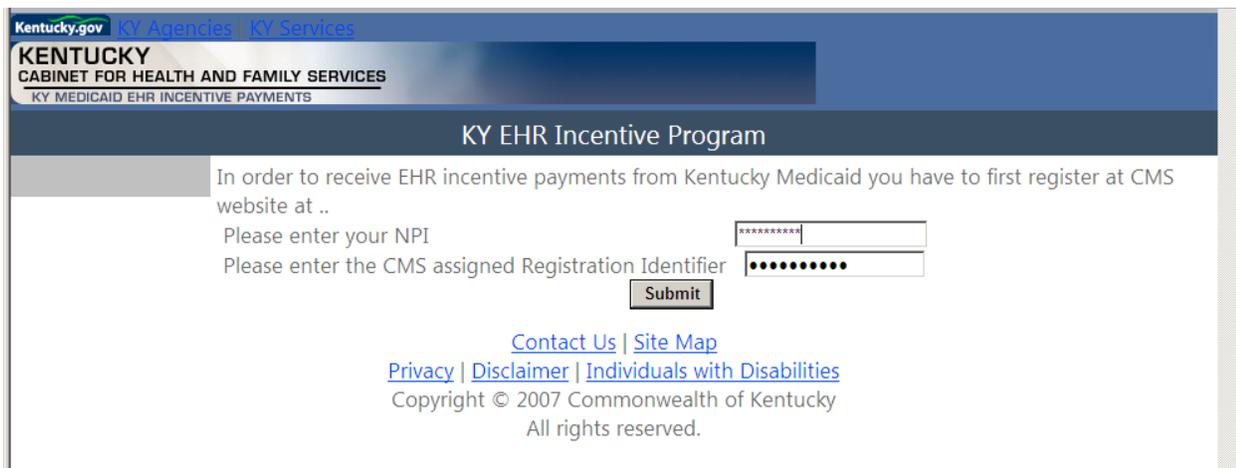
Division of Program Integrity
Department for Medicaid Services
275 E. Main Street, 6E-A
Frankfort, KY 40621

Registration (Eligible Providers)

Eligible providers will be required to provide details including patient volume characteristics, EHR details, upload requested documentation and electronically sign the attestation (more details follow in this manual).

After registering with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the provider then begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system (sign-in screen shown below).

Eligible Provider Sign-in Screen



The provider will enter the NPI registered on the NLR and the CMS-assigned Registration Identifier that was returned by the NLR. If the data submitted by the provider matches the data received from the NLR, the CMS/NLR Provider Demographics Screen will display with the pre-populated data received from the NLR. If the provider entry does not match, an error message with instructions will be returned.

An example of the CMS/NLR Provider Demographics screen is illustrated in the screen below.

Eligible Provider CMS/NLR Screen



Applicant National Provider Index (NPI):	1234567890	Name:	Demo User
Applicant TIN:	123456789	Address 1:	123 Any Street
Payee National Provider Index (NPI):	1234567890	Address 2:	
Payee TIN:	123456789	City/State:	Anytown / KY
Program Option:	MEDICAID	Zip Code:	40000
Medicaid State:	KY	Phone Number:	(502) 123-4567
Provider Type:	Physician	Email:	demo.user@demo.org
Participation Year:	1	Specialty:	
Federal Exclusions:	<input type="checkbox"/>		
State Rejection Reason:			

*** If any of this information is incorrect, please correct on the NLR

EPs must enter two categories of data to complete the Eligibility Provider Details screen including patient volume characteristics and EHR details. Providers will enter the following data on the screen:

- **Patient Volume**

- Patient volume was calculated at a clinic or practice level for all eligible professionals (Yes/No)
- (If yes to above) NPI of the clinic or group
- Starting date of the 90-day period to calculate Medicaid encounter volume percentage (select from calendar)
- Medicaid patient encounters during this period
- Total patient encounters during this period
- Total number of Medicaid patients on KenPAC or Passport roster/panel with whom you did not have an encounter in this 90-day period, but you did have an encounter in the last 12 months
- Medicaid patient volume percentage (calculated)

- **EHR Details**

- EHR certification number of your EHR
- Status of your EHR – Choices: A/I/U/Meaningful User

Upon entering the data for the Eligibility Provider Details screen, navigation will take EPs to a screen to enter data regarding their practice location details.

Provider Eligibility Details Screen

The screenshot shows the 'Provider Eligibility Details (Step 2 of 5)' screen. The header includes the Kentucky Cabinet for Health and Family Services logo and a 'Logout' button. The left sidebar contains navigation links: CMS/NLR, Eligibility Details, Payments, Issue/Concern, and Appeals. The main content area is titled 'Patient Volumes' and contains 10 numbered questions:

1. Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals:
2. If yes, please enter the NPI of the clinic or group: *
3. Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage: * (mm/dd/yy)
4. Medicaid patient encounters during this period: *
5. Total patient encounters during this period: *
6. Total number of Medicaid patients on your KenPAC or Passport roster/panel with whom you did not have an encounter in this 90-day period but you did have an encounter in the last 12 months: *
7. Total number of patients on your roster/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 last 12 months: *
8. Medicaid patient volume percentage: 17% - you should meet the threshold of 30% to get an EHR Incentive Payment.
9. Enter the EHR certification number of your EHR: *
10. Indicate the status of your EHR: * Adopt Implement Upgrade Meaningful User

At the bottom of the form are buttons for 'Previous', 'Next', 'Save', and 'Cancel'. A red message in the top right corner states: 'All * fields are required fields.'

All EPs and most hospitals have patient volume thresholds to meet to be eligible for incentive payments. (Note: The only exception to this rule is for children’s hospitals. There are no freestanding children’s hospitals in Kentucky). Claims data from the Kentucky MMIS DW will be used to verify the reasonableness of patient volume attested to by EPs.

EPs are required to have a minimum of 30 percent Medicaid for all patient encounters over any continuous 90-day period within the most recent calendar year prior to registering. There are two exceptions:

1. Pediatricians qualify if they have at least 20 percent Medicaid patient volume for all patient encounters over any continuous 90-day period within the most recent calendar year prior to registering
2. EPs practicing predominantly in an FQHC or RHC must have a minimum of 30 percent patient volume attributable to “needy individuals” for all patient encounters over any continuous 90-day period within the most recent calendar year prior to registering.

Needy individuals are defined as those:

- Receiving Medical assistance from Medicaid or CHIP
- Furnished uncompensated care by the provider
- Furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay

Acute care hospitals are required to have a minimum of 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment. Acute care hospitals will be asked to enter their Medicaid and total discharges for the prior federal fiscal year. Acute care and children’s hospitals’ Medicaid and total discharges are listed on the hospitals’ cost reports. CHFS DMS will take these numbers from the cost reports in order to verify the information entered by the hospitals.

Kentucky Medicaid defines “encounter” as a service provided to one patient by one provider on one day. For KenPAC and Passport EPs, the total number of Medicaid patients assigned to the provider’s roster/panel are counted if at least one encounter took place with the Medicaid patients in the year prior to the 90-day period.

Volume thresholds are calculated using as the numerator the hospital or the EP’s total number of *Medicaid* member encounters for the 90-day period and the denominator is *all* patient encounters for the same EP or hospital over the same 90-day period.

Provider Calculations Screen

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
 TRY MEDICAID THE INCENTIVE PAYMENTS

Provider Eligibility Calculations (Step 3 of 5) Logout

Medicaid EHR Average Allowable Cost:	\$54,000.00
Threshold of outside contributions as determined by CMS:	\$29,000.00
Maximum Net Average Allowable Cost:	\$25,000.00
Estimated Amount of Medicaid EHR Incentive Payment:	

[Previous](#) [Next](#)

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Document Upload Screen

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
 TRY MEDICAID THE INCENTIVE PAYMENTS

Document Upload (Step 4 of 5) Logout

Uploading documents (such as contracts with EHR vendors, patient volume calculations) is not required, but will help expedite your application.

Payment Year	File Name	Description	Delete
1	MIJ_Stage1_ReqSummary.pdf		Delete
1	MIJ_Stage1_ReqSummary.pdf	Invoice	Delete
1	MIJ_Stage1_ReqSummary.pdf		Delete

Upload a new PDF document:

Please select the documentation type:

[Previous](#) [Next](#)

Provider Attestation Screen:

Kentucky
KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
BY MEDICAID EHR INCENTIVE PAYMENTS

Attestation (Step 5 of 5) Logout

DMS/HLR
Eligibility Details
Payments
Issue/Concern
Appeals
User Manual
Additional Resource
Send E-mail

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

Initials: *

NPI: *

Note: Once you press the submit button below, you will not be able to change your information.

Previous Submit

The provider enters his/her initials and NPI on the bottom of the Attestation Screen to complete the Kentucky Medicaid EHR Incentive Program Attestation process. By completing this step of the registration process, the provider will have attested to the validity of all data submitted for consideration by the Kentucky Medicaid EHR Incentive Program. Once the provider submits this data on the screen, the registration process is completed, and the provider may logout of the application.

Note: For providers that are ready to demonstrate Meaningful Use in year 1, the provider will attest to this fact. In subsequent years, Kentucky Medicaid will work with the KHIE to provide a mechanism for providers to submit Meaningful Use data to Medicaid.

Registration (Eligible Hospitals)

Hospitals will be required to provide details including patient volume characteristics, EHR details, growth rate and Medicaid. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual). They will first register with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>.

The hospital provider then begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system (sign-in screen shown below) and entering the NPI and CMS assigned registration identifier that was received from CMS.

Eligible Hospital Sign-in Screen:

The screenshot shows the 'KY EHR Incentive Program' sign-in page. At the top, it says 'KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES' and 'KY MEDICAID EHR INCENTIVE PAYMENTS'. The main heading is 'KY EHR Incentive Program'. Below this, a message reads: 'In order to receive EHR incentive payments from Kentucky Medicaid you have to first register at CMS website at ...'. There are two input fields: 'Please enter your NPI' and 'Please enter the CMS assigned Registration Identifier', both with masked characters. A 'Submit' button is located to the right of the second field.

Eligible Hospital CMS/NLR Screen:

The screenshot shows the 'CMS/NLR (Step 1 of 4)' registration screen. The header includes 'KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES' and 'KY MEDICAID EHR INCENTIVE PAYMENTS'. A 'Logout' button is in the top right. A left sidebar contains links for 'CMS/NLR', 'Eligibility Details', 'Payments', 'Issue/Concern', and 'Appeals'. The main content area displays registration details for 'RUSSELL CO HOSPITAL' in two columns:

Applicant National Provider Index (NPI):	1013954437	Name:	RUSSELL CO HOSPITAL
Applicant TIN:	610965365	Address 1:	153 DOWELL RD
Payee National Provider Index (NPI):		Address 2:	
Payee TIN:	610965365	City/State:	RUSSELL SPRINGS / KY
Program Option:	DUALLY_ELIGIBLE	Zip Code:	42642 -0000
Medicaid State:	KY	Phone Number:	(270)866-4141
Provider Type:	Acute_Care_Hospitals	Email:	
Participation Year:	1	Specialty:	
Federal Exclusions:	None	State Rejection Reason:	None

Below the table, a red message states: '*** If any of this information is incorrect, please correct on the NLR'. A status message reads: 'You are currently enrolled in KY's EHR Incentive Program. The current status of your application for the first year payment is 'AWAITING PROVIDER ATTESTATION''. A 'Next' button is at the bottom left.

Hospital Eligibility Details Screen

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
BY MEDICAID EHR INQUIRY AGREEMENT

Hospital Eligibility Details (Step 2 of 4) Logout

CMS/NLR
Eligibility Details
Payments
Issue/Concern
Appeals

All * fields are required fields.

<u>Patient Volume:</u>	1. Select the starting date (in 2010) of the 90-day * <input type="text" value="3/3/2010"/> (mm/dd/yy) period to calculate Medicaid patient volume percentage:
	2. Total Medicaid patient discharges during this period: * <input type="text" value="120"/>
	3. Total patient discharges during this period: * <input type="text" value="300"/>
	4. Medicaid patient volume percentage: * 40%
<u>EHR Details:</u>	5. Enter the EHR certification number of your EHR: * <input type="text" value="111"/>
	6. Indicate the status of your EHR: * <input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User
<u>Growth Rate:</u>	7. Select the end date of your last full hospital fiscal year that ended prior to September 30, 2010: * <input type="text" value="1/1/2010"/> (mm/dd/yy)
	8. Total number of discharges that fiscal year: * <input type="text" value="670"/>
	9. Total number of discharges one year prior: * <input type="text" value="540"/>
	10. Total number of discharges two years prior: * <input type="text" value="480"/>
	11. Total number of discharges three years prior: * <input type="text" value="530"/>
<u>Medicaid Share:</u>	12. Total Medicaid inpatient bed days: * <input type="text" value="1200"/> (w/s 5-3 part I, col.5, line 12)
	13. Total Medicaid HMO inpatient bed days: * <input type="text" value="110"/> (w/s 5-3 part I, col.5, line 2)
	14. Total inpatient bed days: * <input type="text" value="2900"/> (w/s 5-3 part I, col.6, line 12)
	15. Total hospital charges: * <input type="text" value="800 00"/> (w/s c part I, col.8, line 103)
	16. Total uncompensated care charges: * <input type="text" value="200 00"/> (KMAP-4, line 4)

As shown above, hospitals must enter four categories of data to complete the Eligibility Details screen including patient volume characteristics, EHR details, growth rate, and Medicaid share. Providers will enter the following data on the screen:

- **Patient volume**
 - Starting date of the 90-day period to calculate Medicaid patient volume percentage (select from calendar)
 - Total Medicaid patient discharges during this period
 - Total patient discharges during the period
 - Medicaid patient volume percentage (calculated)
- **EHR details**
 - EHR certification number of EHR
 - Status of your EHR – Choices: A/I/U/Meaningful User
- **Growth rate**
 - Date of last full hospital fiscal year that ended prior to September 30, 2010 (select from calendar)
 - Total number of discharges that fiscal year
 - Total number of discharges one year prior
 - Total number of discharges two years prior
 - Total number of discharges three years prior
 - Average annual growth rate (calculated)
- **Medicaid share**
 - Total Medicaid inpatient bed days
 - Total Medicaid Health Maintenance Organization (HMO) inpatient bed days
 - Total inpatient bed days
 - Total hospital charges
 - Total uncompensated care charges
 - Estimated total payment (calculated)

Eligibility Hospital Cost Calculations Screen

Eligibility Hospital Cost Calculations
Logout

[CMS/NLR](#)
[Eligibility Details](#)
[Payments](#)
[Issue/Concern](#)
[Appeals](#)

Patient Volume Calculations

Medicaid Patient Volume Percentage: 40.00% * should be greater than 10% to qualify

Rate of growth prior year: 24.074%

Rate of growth 2 years prior: 12.500%

Rate of growth 3 years prior: -9.434%

Average rate of growth: 9.047% * use this growth rate to project number of discharges for year 2 through year 4 below

EHR Amount Calculations

	<u>Year Discharges</u>	<u>Allowable Discharges</u>	<u>Discharge Related Amount</u>	<u>Base Amount</u>	<u>Aggregate EHR amount</u>	<u>Transition Factor</u>	<u>EHR Amount</u>
First year	670	0	\$0.00	\$2,000,000	\$2,000,000.00	1.00	\$2,000,000.00
Second Year	731	0	\$0.00	\$2,000,000	\$2,000,000.00	.75	\$1,500,000.00
Third Year	797	0	\$0.00	\$2,000,000	\$2,000,000.00	.50	\$1,000,000.00
Fourth Year	869	0	\$0.00	\$2,000,000	\$2,000,000.00	.25	\$500,000.00
Total Amount							\$5,000,000.00

Medicaid Share Calculations

Total Medicaid and Passport Inpatient Bed Days: 1310

Total Bed Days: 2300

Percentage of total charges which are non-charity: ((total charges - uncompensated charges)/ total charges) 75.00%

Total Beds that should be considered non-charity: 1725

Total Medicaid Percentage: 75.94203%

Total Medicaid Aggregate EHR Incentive Payment: \$3,797,101.45

Total Estimated Medicaid Aggregate EHR Incentive Payment First Year (50%): **\$1,898,550.72**

Previous
Next

Document Upload Screen

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
BY MEDICAID EHR INCENTIVE PAYMENTS
Document Upload (Step 3 of 4)
Logout

[CMS/NLR](#)
[Eligibility Details](#)
[Payments](#)
[Issue/Concern](#)
[Appeals](#)

Uploading documents (such as contracts with EHR vendors, patient volume calculations) is not required, but will help expedite your application.

Payment Year	File Name	Description
You do not have any uploaded documents.		

Upload a new PDF document:

Please select the documentation type:

Previous
Next

After EPs and EHs have completed the Eligibility Details screens and press “Next,” navigation will take them to the Attestation screen below.

Attestation Screen

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
KY MEDICAID EHR INCENTIVE PAYMENTS

Attestation (Step 4 of 4)

Logout

[CMS/NLR](#)
[Eligibility Details](#)
[Payments](#)
[Issue/Concern](#)
[Appeals](#)

Please verify the following information:

CMS/NLR:			
Applicant National Provider Index (NPI):	1013954437	Name:	RUSSELL CO HOSPITAL
Applicant TIN:	610965365	Address 1:	153 DOWELL RD
Payee National Provider Index (NPI):		Address 2:	
Payee TIN:	610965365	City/State:	RUSSELL SPRINGS / KY
Program Option:	DUALY_ELIGIBLE	Zip Code:	42642 -0000
Medicaid State:	KY	Phone Number:	(270)866-4141
Provider Type:	Acute_Care_Hospitals	Specialty:	<input type="text"/>

	prior to September 30, 2010:	
	Total number of discharges that fiscal year:	670
	Total number of discharges one year prior:	540
	Total number of discharges two years prior:	480
	Total number of discharges three years prior:	530
Medicaid share:	Total Medicaid inpatient bed days:	1200 (w/s S-3 part I, col.5, line 12)
	Total Medicaid HMO inpatient bed days:	110 (w/s S-3 part I, col.5, line 2)
	Total inpatient bed days:	2300 (w/s S-3 part I, col.6, line 12)
	Total hospital charges:	800.00 (w/s c part I, col.8, line 103)
	Total uncompensated care charges:	200.00 (KMAP-4, line 4)

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and state laws.

All * fields are required fields.

Initials: *

NPI: *

Note: Once you press the submit button below, you will not be able to change your information.

Previous
Submit

After submitting the initials and NPI, your attestation is complete.

Issues/Concerns Screen:

The screenshot shows the 'Issues/Concerns' screen. At the top, there is a header for 'KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES' and 'KY MEDICAID EHR INCENTIVE PAYMENTS'. The page title is 'Issues/Concerns' and there is a 'Logout' button. On the left, there is a navigation menu with links for 'CMS/NLR', 'Eligibility Details', 'Payments', 'Issue/Concern', and 'Appeals'. The main content area contains a paragraph explaining that users can report issues with their incentive payment applications. Below this is a table with columns: 'View Issue', 'Date Entered', 'Issue/Concern Status', 'Issue/Concern Description', 'Issue Category', and 'Delete'. Under the table, there is a form with an 'Issue Category' dropdown menu set to 'Patient Volume' and a 'Description' text area. A 'Submit' button is located below the text area.

Appeals Screen:

The screenshot shows the 'Appeals' screen. At the top, there is a header for 'KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES' and 'KY MEDICAID EHR INCENTIVE PAYMENTS'. The page title is 'Appeals' and there is a 'Logout' button. On the left, there is a navigation menu with links for 'CMS/NLR', 'Eligibility Details', 'Payments', 'Issue/Concern', and 'Appeals'. The main content area contains a paragraph explaining that users can appeal a determination made by the Kentucky Department for Medicaid services. Below this, there is contact information for the Division of Program Integrity, Department for Medicaid Services, located at 275 E. Main Street, 6E-A, Frankfort, KY 40621. At the bottom, there are links for 'Contact Us', 'Site Map', 'Privacy', 'Disclaimer', and 'Individuals with Disabilities', along with a copyright notice for 2007 Commonwealth of Kentucky.

Meaningful Use

Please see the following CMS Web site for information on the Meaningful Use Core and Menu Sets: <https://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC-Core-and-MenuSet-Objectives.pdf>