

Frequently Asked Questions (FAQs) Alaska Electronic Health Record (EHR) Incentive Program

- 1. Scenario A for inpatient hospital: a contract is signed on September 1, 2011 making the inpatient hospital eligible right away for year one incentive payment; do we have to show meaningful use (MU) by September 30, 2012 to receive year two incentive payment?**

If the hospital enrolled in the EHR incentive program and submitted an Attestation Agreement on September 1, 2011, prior to the end of the Federal Fiscal Year (FFY), they would be eligible for payment after they have been validated and approved for payment (the time frame could be up to 45 days). If the hospital received the payment in FFY 2011, they then would be eligible for their second payment in FFY 2012 at the earliest. The second payment does not have to be in consecutive years following the year one payment until 2016. To be eligible for a second incentive payment the hospital must display MU during any 90 day reporting period in that FFY.

- 2. Scenario B for inpatient hospital: a contract is signed on October 1, 2011 in FFY 2012, is the hospital eligible right away for a year one incentive payment? Do we have until September 30, 2013 to show MU for the second incentive payment?**

In this scenario since the hospital enrolled and attested in FFY 2012, they would be eligible for payment after they have been validated and approved for payment. This would be a year one payment in FFY2012. Currently year one corresponds to the year that providers adopted, implemented or upgraded (AIU) to a certified EHR. The second payment does not have to be in consecutive years following the year one payment until 2016. To be eligible for a second incentive payment in FFY 2013 the hospital must display MU during any 90 day reporting period in FFY 2013 between October 1, 2012 - September 30, 2013.

- 3. The definition of Eligible Professional (EP) list five types of providers that are eligible for Medicaid incentive payments: physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in an Federally Qualified Health Care Center (FQHC) or Rural Health Center (RHC) that is led by a physician assistant. If the provider wanted to issue their payment to a community mental health clinic, group or clinic in which they practice how do they issue the payment to that organization?**

While the facilities including the community mental health clinic, group, or clinic would not be considered eligible to participate in these incentives, some of the EPs practicing at these facilities may be eligible. One example is that a psychiatrist (physician) or nurse practitioner is likely to treat individuals at a behavioral health facility. The EP must identify a Tax Identification Number (TIN) to which the incentive payment should be made. In accordance with 1903(t)(6)(A) of the Act, an EP could assign payment to a TIN associated with his or her employer or the facility in which the provider works. Any assignment of payment must be voluntary and the decision as to whether an EP does assign incentive payments to a specific TIN is an issue which EPs and these other parties should resolve. Any assignment of payment

must be consistent with applicable laws, rules, and regulations, including, without limitation, those related to fraud, waste and abuse.

4. How do I calculate my Medicaid patient volume to enroll in the program?

For a provider to determine their Medicaid patient volume for the EHR Incentive program a provider must identify and submit the total number of encounters paid by the Alaska Medical Assistance Program as the numerator and the total number of all encounters as the denominator. If the number of Medicaid encounters submitted is not consistent with the number of encounters identified by the Alaska Medicaid EHR Incentive Program Office, we will contact you to provide further assistance. If you have any further questions on how to determine your Medicaid patient volume you may contact us at hss.hitinfo@alask.gov.

5. How is adopt, implement or upgrade defined for year one participation in the EHR incentive program?

- **Adopt** = Acquire, purchase or secure access to certified EHR technology
 - There must be evidence that the provider has purchased or acquired the certified EHR and has a plan for how and when they will implement the EHR technology
- **Implement** = Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
 - The provider has installed the certified EHR and has started using the EHR in their clinical practice
 - Activities would include staff training, data entry of their patient demographics and administrative data in the EHR
 - Establish data exchange agreements and relationships between the providers certified EHR technology and other providers including laboratories, pharmacies and HIE.
- **Upgrade** = Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the Office of the National Coordinator (ONC) EHR certification criteria
 - Expand the functionality of the certified EHR could include the addition of clinical decision support, e-prescribing functionality, Computerized Physician Order Entry (CPOE) or other enhancements that facilitate the meaningful use of certified EHR technology

6. As an Eligible Professional (EP), can I use my group practice or clinic patient volume data to apply as a proxy to establish the Medicaid patient volume?

The group practices or clinics may use the group practice or clinic Medicaid patient volume (or needly individual patient volume, insofar as it applies) and apply it to all EPs in their practice under three conditions:

- a. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- b. There is an auditable data source to support the clinic's patient volume determination; and

- c. As long as the practice and all of the EPs decide to use one methodology in each year, clinics cannot have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data

The clinic or practice must use the entire practice’s patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/ clinic proxy in any participation year.

7. As a hospital or an Eligible Professional (EP), do I have to meet the Medicaid patient volume threshold each year of participation to receive an incentive payment?

Yes, in order for a hospital or EP to receive an incentive payment they must meet the Medicaid patient volume threshold each year they request an incentive payment.

8. What are the EHR reporting periods for eligible hospitals participating in both the Medicare and Medicaid EHR Incentive Programs?

There are two factors that determine the EHR reporting period for hospitals eligible for both the Medicare and Medicaid EHR Incentive Programs:

- Whether the hospital is attesting to Medicaid only; Medicaid first, then Medicare in the same fiscal year; or Medicare and Medicaid simultaneously/Medicare first, then Medicaid in a later fiscal year.
- The payment year for which the hospital is attesting (first, second third, etc.)

See the table below (where having adopted, implemented or upgraded to certified EHR technology for Medicaid is abbreviated as AIU and meaningful use as abbreviated as MU):

Payment Year	Hospital Participating In:		
	Medicaid Incentive Program Only	Medicaid 1 st , then Medicare in same FY	Medicare and Medicaid Simultaneously / Medicare 1 st , then Medicaid in a later FY
1 st payment year	AIU	AIU (Medicaid); MU, 90 day reporting period (Medicare)	MU, 90 day reporting period
2 nd payment year	MU, 90 day reporting period	MU, 12 month reporting period	MU, 12 month reporting period
3 rd payment year	MU, 12 month reporting period	MU, 12 month reporting period	MU, 12 month reporting period

Relevant points to remember regarding eligible hospitals:



- Hospitals that are eligible for EHR incentive payments under both Medicare and Medicaid should select "Both Medicare and Medicaid" during the registration process on the CMS EHR Incentive Payment Program registration, even if they initially plan to apply for an incentive under only one program.
- A hospital that is a meaningful EHR user under the Medicare EHR Incentive Program is deemed to be a meaningful user for Medicaid. CMS will audit hospitals eligible for both the Medicare and Medicaid EHR Incentive Programs for compliance with the meaningful use requirements under the Medicare program. The states are responsible for auditing AIU and other requirements for receiving an EHR incentive payment, such as patient volume.
- There will never be two consecutive years of 90-day reporting periods for meaningful use. The 90-day reporting period is always followed by a 12-month reporting period the following year, irrespective of when attestation occurred and whether to Medicare or Medicaid.
- The reporting period must begin and end in the Federal Fiscal year that constitutes the payment year.
- There is no reporting period for adopt/implement/upgrade.
- A hospital participating in the Medicaid EHR Incentive program must meet all Medicaid requirements, including patient volume requirements.

Note: Additional FAQs are available on the CMS website at <http://questions.cms.hhs.gov/app/answers/list/p/21,26,1058>