

Provider User Manual

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Introduction

The Guam 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.

Background information and registration procedures follow, but **if you are ready to start your EHR registration, please see 'Registration for Eligible Providers' on page13 and 'Registration for Eligible Hospitals' on page Error! Bookmark not defined..**

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>
- Office of the National Coordinator for Health Information Technology located at http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

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.

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/>. 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 Guam Medicaid EHR Incentive Program is based on provider type and specialty.

At this time, Guam SMA has determined that the following providers and hospitals are potentially eligible to enroll in the Guam 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)
- Optometrist = Any provider with a Provider Type 77
- 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 SMA'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 SMA.

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 who are eligible for the Medicare program, such as podiatrists and chiropractors, are not currently eligible for the Guam Medicaid EHR Incentive Program.

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%	
Optometrist	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 Guam Medicaid EHR Incentive Program welcomes any out-of-state provider to participate in this program as long as they have at least one physical location in Guam. Guam 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 Guam SMA program or CMS. Records must be maintained as applicable by law in the state of practice or Guam, whichever is deemed longer.

Establishing Patient Volume

A SMA provider must annually meet patient volume requirements of Guam's Medicaid EHR Incentive Program as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). The patient 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 allows 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 SMA Encounter

For purposes of calculating EP patient volume, a SMA encounter is defined as services rendered on any one day to an individual where TXIX SMA 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 SMA, 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 SMA patient volume, an EH must divide:

- The total TXIX SMA 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. (*Please note per CMS FAQ nursery days are excluded from inpatient bed days*)
 - An emergency department must be part of the hospital.

Eligible Hospital SMA Encounter

For purposes of calculating eligible hospital patient volume, a SMA 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 SMA 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

The maximum incentive payment an EP could receive from Guam Medicaid equals \$63,750, over a period of six years, or \$42,500 for pediatricians with a 20-29 percent SMA patient volume as shown below.

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
Year 6	8,500	5,665
Total Incentive Payment	\$63,750	\$42,500

Since pediatricians are qualified to participate in the Guam 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 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 SMA with updated information. Each EP must have a current SMA contract and be contracted for at least 90 days.

The Guam Medicaid EHR Incentive program does **not** include a future reimbursement rate reduction for non-participating Medicaid providers. (Medicare requires providers to implement and meaningfully use 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 SMA provider enrollment. Each EP or EH will be enrolled as a SMA provider and will therefore, without any change in process or system modification, meet the requirement to receive an NPI. SMA performs a manual NPPES search to validate NPIs during the enrollment process.

In the event SMA 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 Guam 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.

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

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports; and
- Hospital financial statements and hospital accounting records.

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

$$EH\ Payment = Overall\ EHR\ Amount \times Medicaid\ Share$$

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)]}

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.

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 the 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 Guam SLR system to attest for Guam's Medicaid EHR Incentive Program. SMA 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 SMA of a provider's choice to access Guam's Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the Guam SLR system.

On receipt of NLR Registration transactions from CMS, the SMA validates the provider is a provider with the Guam SMA. If this condition 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 SMA that a payment has been made.

Provider Attestation Process and Validation

SMA will utilize the secure Guam SLR system to house the attestation system. 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 the SMA Provider Enrollment Call Center Operations.

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 SMA through claims analysis);
 - Not applying for an incentive payment from another state or Medicare;
 - Not applying for an incentive payment under another SMA 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.

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 Guam SLR 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, SMA 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 <http://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

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

Program Integrity

SMA 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 Guam 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 Guam Medicaid EHR Incentive Program. Any supporting documentation to the appeal should be included with the Letter of

Appeal.

Bureau of Health Care Financing
Attn: EHR Incentive Program Appeals
123 Chalen Kareta Route 10
Mangilao, GU 96913

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 Guam Medicaid EHR Incentive Program registration process by accessing the Guam SLR system at <http://ehrincentives.guam.gov> (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. Along with the pre-populated data from the NLR there are additional fields that can be updated by the provider. They are detailed below:

- **Medicaid ID**
 - If you have multiple Guam Medicaid Provider Numbers that are linked to one NPI, you will need to select one of your Guam Medicaid Numbers. **This Number will be used to for your incentive payments.**
- **Mailing Address**
 - The mailing address can be updated if the provider would like to change the address that is indicated on the top right side of the screen.
 - Indicating a new address in these fields will change the Payee address for the Provider's EHR incentive payment
 - This address will no longer be updateable if the Provider has attested or has been found not eligible for the EHR program.

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

Eligible Provider CMS/NLR Screen



EPs must enter two categories of data to complete the Eligibility Provider Details screen including patient volume characteristics and EHR details. The Provider will also have the option to change their mailing address for EHR payments. Providers will see the following data on the screen:

- **Patient Volume**

- Please indicate if your patient volume was calculated at a clinic or practice level for all eligible professionals
- If yes, please enter the NPI of the clinic or group
- Select the 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
- Medicaid patient volume percentage (calculated)

- **EHR Details**

- Enter the CMS EHR Certification ID of your EHR
- Indicate the Status of your EHR – Choices:
 - (A) Adopt - Acquire, purchase, or secure access to certified EHR technology
 - (I) Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
 - (U) Upgrade - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria

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

Provider Eligibility Details (Step 2 of 5) Logout

Patient Volume:

- Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals: Yes No
- If yes, please enter the NPI of the clinic or group: *
- Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage: * 1/4/2010 (mm/dd/yy)
- Medicaid patient encounters during this period: * 150
- Total patient encounters during this period: * 1000
- 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: * 500
- 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: * 1020
- Medicaid patient volume percentage: **32.18%**

EHR Details:

- Enter the CMS EHR Certification ID of your EHR: * 30000001SWU6EAK [What is this?](#)
- Indicate the status of your EHR: *
 Adopt Implement Upgrade

Based on ProvType this screen is displayed. This is an EP screen

All EPs and most hospitals have patient volume thresholds to meet to be eligible for incentive payments.

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. Guam SMA will take these numbers from the cost reports in order to verify the information entered by the hospitals.

Guam 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

Calculation	Value
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:	\$21,250.00

Document Upload Screen

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
No uploaded document found.		

Upload a new PDF document:

Please select the documentation type:

Previous Next

Supporting documents will be displayed.

Provider Attestation Screen

CMS/NLR
 Eligibility Details
 Payments
 Issue/Concern
 Appeals
 User Manual
 Additional Resources ▶
 Send E-mail

Please verify the following information:

CMS/NLR:

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 / NY
Program Option:	MEDICAID	Zip Code:	40000 -
Medicaid State:	NY	Phone Number:	(800) 123-4567
Payment Year:	1	Email:	demo.user@demo.org
Provider Type:	Physician	Specialty:	

Eligible Details:

Patient Volume:	1.	Was patient volume calculated at a clinic or practice level for all Eligible professionals:	Yes
	2.	If yes, Please enter the NPI of the clinic or group:	0
	3.	I am not hospital based(less than 90% of my patient encounters are at the ER or in an inpatient setting)	Y
	4.	The starting date of the 90-day period to calculate Medicaid encounter volume percentage:	1/4/2010 (mm/dd/yy)
	5.	Medicaid patient encounters during this period:	150
	6.	Total patient encounters during this period:	1000
	7.	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:	500
	8.	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:	1020
EHR Details:	9.	Enter the CMS EHR Certification ID of your EHR:	30000001SWU6EAK
	10.	Indicate the status of your EHR:	<input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User

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

The provider enters his/her initials and NPI on the bottom of the Attestation Screen to complete the Guam 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 Guam 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.

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 Guam Medicaid EHR Incentive Program registration process by accessing the Guam SLR system at <http://ehrincentives.guam.gov> (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 'Medicaid EHR Incentive Program' sign-in page. It features a navigation menu on the left with links for 'User Manual', 'CMS EHR Site', 'Medicaid EHR Site', and 'Send E-mail'. The main content area contains a message: 'In order to receive EHR incentive payments from Medicaid, you first have to register at the CMS Web Site. After about 24 hours of successfully registering at the CMS level you should be able to complete your application on this site.' Below this message are two input fields: 'Please enter your NPI' with the value '0123456789' and 'Please enter the CMS assigned Registration Identifier' with a masked value '*****'. A 'Submit' button is located below the second field.

Eligible Hospital CMS/NLR Screen

The screenshot shows the 'CMS/NLR (Step 1 of 4)' registration screen. It includes a 'Logout' button in the top right corner. The main content area displays the user's current status: 'You are currently enrolled in the EHR Incentive Program' and 'The current status of your application for the first year payment is 'IN PROCESS AT DMS''. The screen is divided into two columns of information. The left column lists various identifiers and options: Applicant National Provider Index (NPI): 0123456789, Applicant TIN: 012345678, Payee National Provider Index (NPI): 0123456789, Payee TIN: 012345678, Program Option: DUALY_ELIGIBLE, Medicaid State: HI, Provider Type: Acute_Care_Hospitals, Participation Year: 1, and Federal Exclusions: . The right column lists contact and location information: Name: Demo Hospital, Address 1: 123 Any Street, Address 2: (empty), City/State: Anytown, HI, Zip Code: 40000, Phone Number: (808) 555-4321, Email: demo.hospital@demo.org, Speciality: (empty), and State Rejection Reason: (empty). A red warning message states: '*** If any of this information is incorrect, please correct on the NLR'. Below this is a 'Mailing Address' section with input fields for Address 1 (111 main st), Address 2 (empty), City/State (Louisville, Ky), and Zip Code (40242, 00). A 'Next' button is located at the bottom of the page.

Hospital Eligibility Details Screen

Hospital Eligibility Details (Step 2 of 4) Logout

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All * fields are required fields.

Patient Volume:	1. Select the starting date of the 90-day period(in the prior FFY) * <input type="text" value="1/1/2010"/> (mm/dd/yy)
	2. Total Medicaid patient discharges during this period: * <input type="text" value="100"/>
	3. Total patient discharges during this period: * <input type="text" value="200"/>
	4. Medicaid patient volume percentage: 50.00%
EHR Details:	5. Enter the CMS EHR Certification ID of your EHR: * <input type="text" value="30000001SWU6EAK"/> What is this?
	6. Indicate the status of your EHR: * <input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade
Growth Rate:	7. Select the end date of the hospital's most recently filed 12-month cost reporting period: * <input type="text" value="1/1/2010"/> (mm/dd/yy)
	8. Total number of discharges that fiscal year: * <input type="text" value="25330"/> (w/s S-3, part 1 col. 15, line 12)
	9. Total number of discharges one year prior: * <input type="text" value="24999"/>
	10. Total number of discharges two years prior: * <input type="text" value="24553"/>
	11. Total number of discharges three years prior: * <input type="text" value="23456"/>
Medicaid Share:	12. Total Medicaid inpatient bed days (Exclude Nursery beds): * <input type="text" value="6231"/>
	13. Total Medicaid HMO inpatient bed days (Exclude Nursery beds): * <input type="text" value="0"/>
	14. Total inpatient bed days: * <input type="text" value="132145"/>
	15. Total hospital charges: * <input type="text" value="919293949.00"/> (w/s c part 1 col.8, line 103)
	16. Total uncompensated care charges: * <input type="text" value="3124555.00"/> (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 ID of EHR
 - Status of your EHR – Choices:
 - (A) Adopt - Acquire, purchase, or secure access to certified EHR technology
 - (I) Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
 - (U) Upgrade - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria
- **Growth rate**
 - End date of the hospital's most recently filed 12-month cost reporting period (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 (*Please note per CMS FAQ nursery days are excluded from inpatient bed days*)
- Total hospital charges
- Total uncompensated care charges
- Estimated total payment (calculated)

Eligibility Incentive Payment Calculations Screen

Incentive Payment Calculations Logout

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Patient Volume Calculations	
Medicaid Patient Volume Percentage:	50.00% * should be greater than 10% to qualify
Rate of growth prior year:	1.324%
Rate of growth 2 years prior:	1.816%
Rate of growth 3 years prior:	4.677%
Average rate of growth:	2.606% * use this growth rate to project number of discharges for year 2 through year 4 below

EHR Amount Calculations								
	Year	Discharges	Allowable Discharges	Discharge Related Amount	Base Amount	Aggregate EHR amount	Transition Factor	EHR Amount
First year		25330	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	1.00	\$6,370,200.00
Second Year		25990	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.75	\$4,777,650.00
Third Year		26667	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.50	\$3,185,100.00
Fourth Year		27362	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.25	\$1,592,550.00
Total Amount								\$15,935,500.00

Medicaid Share Calculations	
Total Medicaid and Passport Inpatient Bed Days:	6231
Total Bed Days:	132145
Percentage of total charges which are non-charity: (total charges - uncompensated charges)/ total charges)	99.66%
Total Beds that should be considered non charity:	131696
Total Medicaid Percentage:	4.73135%
Total Medicaid Aggregate EHR Incentive Payment:	\$753,491.30
Total Estimated Medicaid Aggregate EHR Incentive Payment First Year (50%):	\$376,745.65

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Document Upload Screen

Document Upload (Step 3 of 4) Logout

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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
View	1	Copy of EHR Calc 8-25-10 (XLSX)	
View	1	BusinessRules Doc-KYSLR.docx	
View	1	Copy of EHR Calc 8-25-10 (XLSX)	
View	1	BusRule KYSLR.docx	Invoice
View	1	Copy of EHR Calc 8-25-10 (XLSX)	
View	1	Copy of EHR Calc 8-25-10 (XLSX)	
View	1	BusRule KYSLR.docx	
View	1	Business Rules Document.docx	
View	1	BusinessRules Doc-KYSLR.docx	

Upload a new PDF document:

Please select the documentation type:

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

Attestation Screen

Attestation (Step 4 of 4)
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[Send E-mail](#)

CMS/NLR:

Applicant National Provider Index (NPI):	0123456789	Name:	Demo Hospital
Applicant TIN:	012345678	Address 1:	123 Any Street
Payee National Provider Index (NPI):	0123456789	Address 2:	
Payee TIN:	012345678	City/State:	Anytown / ##
Program Option:	DUALLY_ELIGIBLE	Zip Code:	40000 -
Medicaid State:	##	Phone Number:	(###) ###-####
Payment Year:	1	Email:	demo.hospital@demo.org
Provider Type:	Acute_Care_Hospitals	Specialty:	

Hospital Eligibility Details:

Patient Volume:	1.	Select the starting date (in 2010) of the 90-day period to calculate Medicaid patient volume percentage:	5/6/2010 (mm/dd/yy)
	2.	Total Medicaid patient discharges during this period:	100
	3.	Total patient discharges during this period:	300
EHR Details:	4.	Enter the EHR certification number of your EHR:	300000015WU6EAK
	5.	Indicate the status of your EHR:	<input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User
Growth Rate:	6.	Select the end date of your last full hospital fiscal year that ended prior to September 30, 2010:	8/6/2010 (mm/dd/yy)
	7.	Total number of discharges that fiscal year:	25320 (w/s S-2 part 1, col.5, line 12)
	8.	Total number of discharges one year prior:	24999
	9.	Total number of discharges two years prior:	24553
	10.	Total number of discharges three years prior:	23456
Medicaid Share:	11.	Total Medicaid inpatient bed days (Exclude Nursery beds):	6231
	12.	Total Medicaid HMO inpatient bed days (Exclude Nursery beds):	0
	13.	Total inpatient bed days:	132145
	14.	Total hospital charges:	919293949.00 (w/s c part 1, col.8, line 103)
	15.	Total uncompensated care charges:	3124555.00 (ROMAP-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.

Initials:

NPI:

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

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Submit

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

Issues/Concerns Screen

Appeals Screen

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>.