



pennsylvania

DEPARTMENT OF HUMAN SERVICES

Medical Assistance Promoting Interoperability Program

ELIGIBLE PROFESSIONAL PROVIDER MANUAL

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Part I: Pennsylvania Medical Assistance Promoting Interoperability (PI) Program

1 Introduction

Pennsylvania, like other states, recognizes the value of having real-time medical information when providers care for their patients. The use of health information technology (HIT) including electronic health records (EHR) to make this information available at the point-of-care has the potential to improve patient outcomes and the efficiency of the healthcare system.

The American Recovery and Reinvestment Act of 2009 ([ARRA](#)) established a program to provide incentive payments to eligible providers who adopt, implement, upgrade, or meaningfully use federally certified EHR systems. Under ARRA, states are responsible for identifying professionals and hospitals that are eligible for Medicaid Promoting Interoperability Program (PIP) incentive payments, making payments, and monitoring payments. The Pennsylvania Medical Assistance Health Information Technology Initiative (MAHITI) oversees the Medical Assistance PIP in Pennsylvania. The incentive payments are not a reimbursement but are intended to encourage adoption and meaningful use (MU) of EHRs.

The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing the provisions of the Medicare and Medicaid PIP, formerly known as the Medicare and Medicaid Electronic Health Record Incentive Program. CMS issued the [Final Rule](#) on the MA Promoting Interoperability Program on July 28, 2010. CMS has issued additional Final Rules since the original rule, if you would like to review those rules please, [click here](#).



Pennsylvania Department of Human Services Office of Medical Assistance Programs (OMAP)

For many years, Pennsylvania has been a national leader in healthcare, pursuing a variety of strategies to improve access to affordable quality care. Pennsylvania’s Medical Assistance has implemented a long list of initiatives to improve the quality of care delivered to Pennsylvania Medical Assistance consumers. The Department of Human Services Office of Medical Assistance Programs OMAP, Pennsylvania’s Medical Assistance agency, has recognized health information technologies (HIT) as essential tools for achieving long-term transformation of the healthcare delivery system.

The Medical Assistance PIP administers the project that provides funding to eligible professionals for the MU of EHR systems. When the project began as the Medical Assistance Electronic Health Record Incentive Program in 2011, DHS made payments to EPs that sought to Adopt, Implement, and/or Upgrade Electronic Health Record systems. As of February 21, 2019, the state’s healthcare provider has received over \$257 million dollars for this effort and more than 19,500 payments have been made. Program Year 2016 was the last year that Pennsylvania’s providers could participate in the program for the very first time.

Pennsylvania’s HIT Initiatives

Vision: To improve the quality and coordination of care by connecting providers to patient information at the point of care through the MU of EHRs.

Goals: Pennsylvania Medical Assistance will achieve this vision by actively encouraging the adoption of HIT through a variety of means, including the PIP. Our HIT goals for the Pennsylvania Medical Assistance program center on:

- **Increased Awareness** → Education enables providers and consumers to understand the benefits of HIT adoption.
- **Increased Quality** → Better information to support clinical decisions by providers increases quality for consumers while reducing costs.
- **Increased Coordination** → Eliminating duplicative services and identifying gaps in care increases administrative efficiencies and results in better care coordination.

- **System Redesign** → Data capture and analysis provides opportunities to enhance and improve current quality initiatives for both providers and consumers.

2 Purpose of the Eligible Professional Provider Manual

The Pennsylvania Medical Assistance PIP Eligible Professional Provider Manual is a resource that includes detailed information about eligibility and attestation criteria, and instructions on how to apply for incentive payments. This Manual also explains how to apply to the program using the Medical Assistance Provider Incentive Repository (MAPIR), which is the Department's web-based PIP application system.

We suggest that you read the manual (in its entirety) prior to starting the application process. Each year program requirements change, and as a result, the MAPIR system has changed to keep pace. The manual is best viewed through the website and due to the length, you may not want to print the entire document. If you still have questions or you are unable to navigate the MAPIR system or complete the registration and application process, please contact the Department by email at RA-mahealthit@pa.gov.

Other Resources

The Pennsylvania Medical Assistance PI Program maintains a host of resources on our website at: [Medical Assistance Provider Incentive Repository \(MAPIR\) Resources](#). For example, there is a tip sheet to assist in the attestation process, frequently asked questions, and a patient volume calculator. There is also a list of additional resources at the end of this [manual](#).

3 Who is Eligible?

The Centers for Medicare and Medicaid Services (CMS) and the Department of Human Services issue regulations and guidance that govern program eligibility for EPs. To be considered for the Pennsylvania Medical Assistance PIP:

1. EPs must be licensed physicians, dentists, pediatricians, certified registered nursepractitioners, certified nurse midwives, and physician assistants enrolled in the Pennsylvania Medical Assistance Program.
 - a. **Note:** While physician assistants are not eligible to be compensated for services provided to Pennsylvania Medical Assistance recipients, physician assistants who practice in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is “so led” by a physician assistant may be eligible for Pennsylvania Medical Assistance PIP incentive payments. However, physician assistants who are eligible for incentive payments will be required to enroll in Pennsylvania’s MMIS provider internet portal, PROMISe™. See additional instructions below.
 - b. For the purposes of this Program, the Department defines a pediatrician as a physician who is either board-certified as a pediatrician or has received 12 months of training with children under the age of 21 years old.
2. EPs cannot be hospital-based. Hospital-based is determined by the site where the service was delivered. Physicians who furnish substantially all, defined as 90 percent or more, of their covered professional services in either an inpatient (POS 21) or emergency department (POS 23) of a hospital are considered hospital-based and, therefore, are not eligible for incentive payments under the Medicare and Medical Assistance PIP. The program uses data from the prior calendar year to determine hospital-based status.
3. EPs must be enrolled as a Pennsylvania Medical Assistance provider without sanctions or exclusions. Providers who are not enrolled will need to enroll with Pennsylvania Medical Assistance prior to applying for the Pennsylvania Medical Assistance PIP. Providers must maintain an active PROMISe™ account throughout the entire application/payment process.

INSTRUCTIONS FOR PHYSICIAN ASSISTANTS WHO ARE RE-APPLYING

Physician Assistants re-applying for the incentive payment must continue meet the CMS-defined criteria of practicing at an FQHC/RHC that is “so led” by a Physician Assistant. “So led” is defined by CMS to mean the following:

- When a Physician Assistant is the primary provider in an FQHC/RHC.
- When a Physician Assistant is a clinical or medical director at a clinical site of practice at an FQHC/RHC; or,
- When a Physician Assistant is an owner of an FQHC/RHC.

Physician Assistants re-applying for the incentive payment are required to provide a signed FQHC/RHC Attestation Form as one source of supporting documentation to validate the above criteria. The FQHC/RHC Attestation Form must be completed and signed by either the chief executive officer, president, vice president or other senior organizational lead. Additionally, the Physician Assistant will be asked to provide other supporting documentation such as an organizational chart to complement the FQHC/RHC Attestation Form. Physician Assistants will be asked to provide the supporting documentation for meeting the above criteria for each year they participate in the Medical Assistance PIP. This information will be reviewed and approved prior to an incentive payment being issued.

A FQHC/RHC Attestation Form is available on our [website](#).

The Department will help you determine if you meet the criteria for the Medical Assistance PIP. If the Department determines you are eligible to participate with the PIP as a Physician Assistant, you will be directed to complete the [PROMISe™ application](#).

INSTRUCTIONS FOR PEDIATRICIANS

For the purposes of the Pennsylvania Medical Assistance PIP, pediatricians are defined as physicians who are either board-certified as pediatricians, or who have received 12 months of training with children under the age of 21 years old. Pediatricians applying for an incentive payment must be able to provide supporting documentation to demonstrate that they meet CMS and Department criteria as a pediatrician for the PIP. The Department may audit and validate pediatricians to verify that they meet the criteria for receiving an incentive payment. Supporting documentation may include but is not limited to a copy of the board certification, or verification of 12 months of training or practice in pediatrics. Pediatricians must have 20

percent Medicaid patient volume when they do not practice predominantly in a FQHC or RHC and must have 30 percent Medical Assistance and needy patient volume when they do practice predominantly in a FQHC or RHC.

If you would like to submit this documentation so that it is on file with the Department, please send your information by email or fax to the contacts below:

To submit via email: RA-mahealthit@pa.gov

Note: Please include your name and NPI number on all correspondence.

4 Overview of the Promoting Interoperability Program (PIP) Application Process

The following steps describe the Pennsylvania Medical Assistance PIP application process; please forego the CMS R&A steps unless you need to modify your registration at the CMS R&A):

- Applicants must be registered with the Centers for Medicare & Medicaid Services (CMS) at the CMS Medicare and Medicaid PIP Registration and Attestation System (also known as the R&A) website.
- **After the first participation year, applicants can go directly into the MAPIR system to begin the to begin the application process.** As of Program Year 2016, Eligible Professionals can no longer apply to the PIP for the first time. If you do go back to the CMS R&A website to make an update or review the information, you must 'submit' the application before exiting. Failure to re-submit will result in a delay of the processing of your application. For the CMS R&A registration, applicants will need to provide information such as:
 - Individual and Payee NPI and Tax Identification Numbers (TIN); – **Note:** if reassigning payment to another entity the applicant must make sure they have the necessary fee assignment in place. This information can be

confirmed by logging into the providers PROMISe™ account and then selecting the ePEAP button

- Incentive Program option of Medicare or Pennsylvania Medical Assistance (referred to as Medicaid in the R&A),
Note: If Medicaid, indicate the state for which you are applying.
 - CMS EHR Certification Number
 - Email contact information. All correspondence will be sent via email.
- Once successfully registered with the R&A, eligible applicants will receive a notification that they can register in MAPIR, which is accessed through the Pennsylvania MMIS provider internet portal. This may take up to two business days following successful registration with the R&A. MAPIR is the Department's web-based system that will track and act as a repository for information related to applications, attestations, payments, appeals, oversight functions, and interface with the CMS R&A.
 - Applicants will use their individual PROMISe™ Internet Portal User ID and password to log into the Pennsylvania MMIS provider internet portal. If they are an eligible professional type, then a MAPIR application link will be displayed. By clicking on the link, the MAPIR application will search for a registration record received from the R&A. Once a match is found, the application process can begin. If an application is not found within three days after an applicant registered with the R&A, the applicant should contact the Department for assistance by email at RA-mahealthit@pa.gov.
 - Applicants will need to verify the information displayed in MAPIR, enter additional required data elements, and make attestations about the accuracy of data elements entered in MAPIR.

Applicants will need to demonstrate they meet:

Medicaid patient volume thresholds

- 30% for Physicians, Dentists, CRNPs and Mid-wives
- 20% for Pediatricians

The Department may request a Patient Volume Report which must be in Excel format and sent by using one of the following methods:

- **DIRECT Messaging Account** (if you have a DIRECT account):
PADPW-OMAP-MAHEALTHIT@directaddress.net
- **Password Protect**: You may password protect your Excel document to ensure its security. If you choose this method, please send us a separate email to RA-mahealthit@pa.gov providing us with the password to open your Excel document. If you are unsure how to password protect an Excel file, you can find instructions [here](#).
- **Email**: RA-mahealthit@pa.gov by using **secure/encrypted email**. Due to your document containing PHI, it **must** be sent securely. If you are unable to send a secure/encrypted email from your location, please email us and we will be happy to send you a secure email that you may reply to by attaching your Excel document in a secure format.

The following required MU Supporting Documentation must be uploaded into the MAPIR application:

- Signed contract or user agreement between you and your EHR vendor
- Signed lease between you and your EHR vendor
- Receipt of purchase or paid invoice AND (in addition to one of the above documents)
- A signed vendor letter **with** the CMS EHR system Certification ID number
 - **NOTE**: We cannot accept a screen print of the ONC website that shows the CMS Certification ID number. Handwritten CMS Certification ID number on any above documentation is also not accepted.

A sample vendor letter can be viewed [here](#).

- **Security Risk Analysis** - A completed copy of the annually conducted or reviewed security risk analysis and correction action plan (if negative findings are identified) that ensures that you are protecting private health information. Report should be dated within the calendar year for your MU reporting period. A list of EPs names and NPI numbers for which this analysis applies should accompany the report.
- **Clinical Decision Support**
 - **Measure 1**: Screenshots of at least five clinical decision support rules that were implemented during the entire MU reporting period.
 - **Measure 2**: Dashboard or screenshot showing when the drug-drug and drug-allergy interaction checks occurred during the reporting period. A list of EPs names and NPI numbers for which this analysis applies should accompany the report.
 - **Dashboard or report** - generated from the EHR system or from an external data source supporting the numerators and denominators you enter for each MU and CQM objective and measure.
 - **Public Health Options** - If you exclude any of the Public Health Options, you must provide supporting documentation to support each exclusion.
- Applicants may use the patient volume calculator on the Department's website [Medical Assistance Provider Incentive Repository \(MAPIR\) Resources](#) webpage prior to entering MAPIR to estimate eligibility based on patient volume for a continuous 90-day period within the previous calendar year or 90-days within the 12 months preceding the application attestation date.
- Applicants may refer to MU requirements on our webpage [Medical Assistance Provider Incentive Resources Repository \(MAPIR\) Resources](#) prior to entering MAPIR to attest to MU. All MU data is done at the individual EP level and cannot be done at the group level like patient volume. In the second participation year EPs must attest to meeting the MU criteria for any continuous 90-day period within the same payment year (calendar year).

- The Department will review applications submitted in MAPIR and make approval decisions. The Department will inform all applicants whether they have been approved or denied via email. All approvals and denials are based on PIP rules set forth by CMS. You may review all current program year MU Spec Sheets on the CMS website: [CMS Promoting Interoperability \(PI\) Program](#)
- Due to the volume of applications submitted to the Department the review and approval time varies. Payments will be issued via the standard PROMISe™ system that runs once a week. Applicants will see approved payments on their remittance advices and their annual 1099s.
- It is possible the Department may need to contact applicants during the application process before a decision can be made to approve or deny an application. Applicants are encouraged to contact the Department if they have questions about the process, by email at: RA-mahealthit@pa.gov.
- Applicants have appeal rights available to them, if an applicant is denied an incentive payment or if a provider is prohibited from participating in the MA PIP. The Department will convey information on the appeals process to all applicants wishing to begin an appeal. Appeal will be processed by the Department's Bureau of Hearings and Appeals.
- Applicants are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the applicant's covered professional services. This contractual arrangement is validated by active fee assignments within the PROMISe™ system.

Applicants should feel free to contact the Department for more assistance with the application process. Applicants can contact the Department by email at RA-mahealthit@pa.gov. Please include your name and NPI number on all correspondence.

Application Readiness for Providers

Applicants can take several steps to expedite the processing of their applications:

- Applicant's must obtain a PROMISe™ Internet Portal User ID and password for the PROMISe™ provider portal if they do not already have one. For registration information, please click here.

- The NPI and TIN provided to CMS must match the NPI and Payee TIN information within the PROMISe™ system. This combination should be the same NPI/TIN combination that is used for Medical Assistance claim payment purposes. If it does not match when starting an application, you will not be able to access the MAPIR link. If you have already started your MAPIR application and there is a mismatch with PROMISe™ you will receive an error message.
- A fee assignment relationship needs to be established in the PROMISe™ between the individual provider and the group they are assigning payment to. The provider needs to be fee assigned to the payee NPI and TIN they are registering at CMS.
- Applicants should provide all required supporting documentation with their application submission by uploading the documents into MAPIR.

Years Two through Six Process Flow: Medicaid Promoting Interoperability Program

(PIP) The following figure describes the overall application, registration, attestation, and monitoring process for the MA PIP years two through six (see **Figure 1** below). Year One Process Flow is no longer included since Program Year 2016 was the last year for first year participation.

<p>Year 2-6: Once an EP is registered at the CMS R&A site--- it is not necessary to re-register <u>UNLESS</u> the NPI or payee assignment information has changed or if EP switches State participation.</p> <p>NOTE: If NPI or Payee Assignment is changed at the CMS R&A and does not match PROMISe™ or an already submitted MAPIR application this will result in an issue with your application.</p>	
<p>When EPs are ready to apply for Payment Year 2 and subsequent years, go directly into the application through the MAPIR system and complete the required fields and submit.</p>	
<p>When all information is obtained from the EP, the Department will make a payment determination. If requested information is not received within 60 days, the application will not be processed. This determination is either to approve or deny the application.</p>	
<p>The Department reviews the EPs application and attestations to determine eligibility for payment. Failure to provide all supporting documentation will result in delayed payment.</p>	
<p>Approval: MAPIR generates an email notifying the EP of approval.</p>	<p>Denial: EPs are notified of the reason for the denial prior to the denial being processed. The Department will work with the EP to make necessary corrections and/or provide required documentation. If the application is denied providers will be provided with formal instructions on the appeal process.</p>

5 Patient Volume Calculation

To be eligible for the Pennsylvania Medical Assistance PIP, EPs must meet patient volume thresholds. The basic formula for calculating the **Medicaid Patient Volume** is illustrated below:

$$\begin{array}{ccc}
 \begin{array}{c} \textit{Medical Assistance} \\ \textit{Patient Encounters} \\ \textit{(includes Medicaid} \\ \textit{encounters in and out} \\ \textit{of Commonwealth of} \\ \textit{Pennsylvania)} \end{array} & \div & \begin{array}{c} \textit{Total Patient} \\ \textit{Encounter} \\ \textit{Volume in and} \\ \textit{out of} \\ \textit{Commonwealth of} \\ \textit{Pennsylvania} \end{array} & = & \begin{array}{c} \textit{\% Medicaid} \\ \textit{Patient} \\ \textit{Volume} \end{array}
 \end{array}$$

EPs must meet patient volume thresholds each year they participate in the Medical Assistance PIP. The general rule is that EPs must meet the Medicaid patient volume thresholds which is a minimum of 30 percent but can be 20 percent or higher for pediatricians.

Medicaid patient volume numerator calculations are based on services rendered on any one day where the recipient is/was eligible for Medical Assistance and the denominator includes services rendered during the 90-day period for all patients. Medicaid patient volume is measured over a continuous 90-day period in the previous calendar year or a 90-day period within the 12 months preceding the application submission date. For example, if the application submission date is 9/1/2015, the volume must be achieved and reported for a continuous 90-day period in 2014 or a continuous 90-day period between 9/1/2014 and 8/31/2015. You may be asked to provide us with a patient volume report to support your attestation. To help expedite the process, documentation must be in spreadsheet format using Microsoft Excel. MAPIR cannot accept Excel documents, therefore please submit your Patient Volume Report using one of the following secure methods:

- DIRECT Messaging Account (if you have a DIRECT account): PADPW-OMAP-MAHEALTHIT@directaddress.net
- Password Protect: You may password protect your Excel document to ensure its security. If you choose this method, please send us a separate email to RA-mahealthit@pa.gov. us with the password to open your Excel document. If you are unsure how to password protect an Excel file, you can find instructions [here](#).

- Email: RAmahealthit@pa.gov by using secure/encrypted email. Due to your document containing PHI, it must be sent securely. If you are unable to send a secure/encrypted email from your location, please email us and we will be happy to send you a secure email that you may reply to by attaching your Excel document in a secure format.

A sample volume report can be found [here](#).

DEFINITION OF ENCOUNTER

For purposes of calculating EP patient volume, a Medicaid encounter means services rendered on any one day where the recipient is/was eligible for Medical Assistance. Patient volume calculations can include managed care/HealthChoices encounters and dual Medicaid/Medicare eligible encounters so long as the Medicaid recipient was eligible the day the service was rendered.

FQHC/RHC and Pediatrician Requirements:

EP's that "practice predominantly" at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) have different criteria, (see **Figure 2** below for additional details).

Pediatricians not practicing in a FQHC or RHC have special rules and can participate with a reduced eligible patient volume threshold (20 percent instead of 30 percent). If pediatricians have greater than 20 percent but less than a 30 percent eligible patient volume, their annual incentive cap is reduced to 2/3 of the standard incentive amount. Pediatricians who achieve 30 percent eligible patient volume are eligible to receive the full incentive amount for which they qualify.

Figure 2: Patient Volume Thresholds per the CMS Final Rule

Provider Type	Requirements	Threshold
Eligible Professionals		
EPs Applying as Individuals	Can use encounters from multiple locations. MAPIR will provide information for each location with Medicaid claims or provider enrollment data. The EP can manually add locations into the MAPIR application as well. Also, must be actively seeing at least one Medicaid patient.	30%
EPs Applying as a group	EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions: (1) 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) (2) there is an auditable data source to support the clinic's patient volume determination; and (3) so long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not 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. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice. (4) Must be actively seeing at least (1) Medicaid Patient	30%
Pediatrician	Must be a physician who is either board-certified as a pediatrician or has received 12 months of training with children under the age of 21 years old. Other EPs who are not Pediatricians but work in a pediatric group must meet the 30% threshold. Please note that pediatricians practicing predominantly in FQHC/RHCs must meet the 30% Medicaid patient volume threshold (including Medical Assistance and Needy patient encounters).	20% (30% FQHC/ RHC)
EP's Practicing Predominantly in an FQHC/RHC	Eligible Professionals (EPs) may participate in the Medical PI Program if: 1) They practice predominantly in an FQHC or RHC and have 30% needy individual patient volume. FQHCs and RHCs are not eligible to receive payment under the program. Please contact your State Medicaid agency for more information on which types of encounters qualify as Medicaid/needy individual patient volume.	30%

Needy Patient Volume – Applies only to EPs Who Practice Predominantly in an FQHC/RHC

“Needy population encounter” means services performed where:

- The individual is/was eligible for Medical Assistance or the Children’s Health Insurance Program (CHIP) at the time of the encounter.
- The services were furnished at no cost; or,
- The services were paid for at a reduced cost based on a sliding scale determined by the individual’s ability to pay.

“Practices predominantly” means that more than 50 percent of your patient encounters occur at a federally qualified health center or rural health clinic. The calculation is based on a period of 6 months in the most recent calendar year or a 6-month period from the 12 months preceding the application attestation date.

Group Volume Calculation

Incentive payments are for individual providers, however, individual providers practicing in clinics and group practices (including FQHCs and RHCs) can use the practice or clinic Medicaid patient volume (or needy population patient volume, insofar as it applies) for their patient volume.

Note The group NPI must define the “group” and all members of the group must apply in an identical manner in other words certain EPs in the group cannot use an individual volume methodology if other EPs in the group are using the group volume calculation. EPs should enter the group NPIs in the group practice provider ID field. The following conditions apply to group practice calculations:

1. There must be an auditable data source to support the group’s patient volume determination. Providers are encouraged to email their Patient Volume **securely** to ra-mahealthit@pa.gov and include the subject line “MA patient volume report.” There are additional secure methods you may utilize listed on page 14-15. A sample volume report can be found [here](#).
2. The group methodology is not appropriate for eligible professionals who see commercial, Medicare, or self-pay exclusively. The Pennsylvania Medical Assistance PIP will verify that EPs are currently and actively seeing medical assistance (or needy individuals if the EP practices predominately in a FQHC or RHC) by reviewing claims history for the EP.

3. EPs have the capability to enter four (4) group NPIs. If there are more than four (4) group NPIs please indicate by checking the box in MAPIR described as “*additional group practice provider IDs.*” Please send all additional group NPI numbers and provider names by email to: RA-mahealthit@pa.gov.
4. If you are an eligible professional in a group that practices predominantly in an FQHC or RHC then you can include needy population encounters as part of your patient volume.

A patient volume calculator to help estimate EP patient volume before applying in MAPIR is [available](#) on the department’s website.

For FQHC/RHC clinics, you may send us a report matching the MAPIR application information in a slightly different format as outlined below:

- Column 1: Medicaid & CHIP Encounter Volume – This is all Pennsylvania Medicaid and Pennsylvania CHIP encounters
- Column 2: Other Needy Individual Encounter Volume – This is Pennsylvania sliding scale and Pennsylvania uncompensated encounters
- Column 3: Total Needy Encounter Volume – This is 1 plus 2 plus out of state Medicaid, sliding and uncompensated
- Column 4: Total Encounter Volume – This is all encounters regardless of payer and regardless of state (this should always be larger than 3)

This report would still include 90-day consecutive period the data represents. However, it **WILL** need to be signed and dated by an authorized official (CEO, CFO, COO) of the health center.

6 *Provider Incentive Payments*

EPs may receive up to \$63,750 in six incentive payments by participating in 6 program years over the life of the incentive program. It is not necessary for EPs to participate in 6 consecutive years, unless joining the program in 2016, to receive the full incentive payment of \$63,750, (see **Figure 3** below).

Eligible pediatricians that reach the 20 percent of their total patient volume but not 30 percent may receive up to \$42,500 through six incentive payments over the life of the program. The pediatrician incentive payments table, (see **Figure 4** below), provides an overview of incentive payments over the life of the Pennsylvania Medical Assistance PIP.

Note: Pediatricians who receive the lower incentive payment in year one still have the opportunity to receive the higher incentive payment in subsequent years if their MA patient volume increases to over 30%.

Figure 3: Maximum Incentive Payments for Pennsylvania Medical Assistance

	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

Figure 4: Pediatrician Pennsylvania MA Promoting Interoperability Program (PIP) Payments (Between 20 – 29 Percent)

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	\$14,167					
CY 2012	\$5,667	\$14,167				
CY 2013	\$5,667	\$5,667	\$14,167			
CY 2014	\$5,667	\$5,667	\$5,667	\$14,167		
CY 2015	\$5,667	\$5,667	\$5,667	\$5,667	\$14,167	
CY 2016	\$5,665	\$5,667	\$5,667	\$5,667	\$5,667	\$14,167
CY 2017		\$5,665	\$5,667	\$5,667	\$5,667	\$5,667
CY 2018			\$5,665	\$5,667	\$5,667	\$5,667
CY 2019				\$5,665	\$5,667	\$5,667
CY 2020					\$5,665	\$5,667
CY 2021						\$5,665
TOTAL	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500	\$42,500

7 Adopt, Implement or Upgrade (AIU) and Meaningful Use

The goal of the Pennsylvania Medical Assistance PIP is to promote the adoption, implementation, upgrade, and MU of certified EHRs. In their first payment year, professionals were to be able to attest to and demonstrate that they have:

- **Adopted:** Acquired, purchased, or secured access to certified EHR technology.
- **Implemented:** Installed or commenced utilization of certified EHR technology capable of meeting MU requirements.
- **Upgraded:** Expanded the available functionality of certified EHR technology capable of meeting MU requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to a federally-certified EHR system.

As of Program Year 2016, EPs can no longer attest to AIU and must attest as a meaningfulUser.

- **Meaningfully User:** Utilized a certified EHR technology to obtain meaningful use measures for a minimum of 90 continuous days within the calendar year the application is being attested. So, for a program year 2018 application, the 90 continuous days would be from 2018.

The CMS Final Rule describes multiple stages for determining MU each with its own separate measurements and criteria. The stages represent a graduated approach to arriving at the end goal.

AIU, Stage 1, Modified Stage 2, and Stage 3

You may visit CMS Promoting Interoperability (PI) Program Website at the link below: [CMS Promoting Interoperability Program](#) to review the various program stage details. Program Year 2016 was the final year for EPs to attest to AIU; Program Year 2018 is the last year for providers to attest to Modified Stage 2; beginning in Program Year 2019 all providers must attest to Stage 3 requirements for the remaining years of the program.

8 Attestations and Audits

CMS requires states to ensure that payments are being made to the right person, at the right time, for the right reason. To receive an incentive payment, eligible professionals will be attesting that they are using a certified EHR, meeting meaningful use requirements and providing all required supporting documentation at the time of application submission.

States will be required to “look behind” provider attestations which will require audits both pre- and post-payment. CMS believes a combination of pre-payment and post-payment reviews will result in accurate payments and timely identification of overpayments. Therefore, all EPs are required to provide all MU supporting documentation at the time of application submission for pre-payment purposes. In addition, we ask that you keep all supporting documentation at least 6 years following participation in the program for post-payment audit purposes.

With MU, the Department will use pre- and post-audit opportunities to combat fraud and abuse, encourage MU of certified EHR systems, and assist with promoting HIT initiatives to increase affordable access to quality healthcare. The Department will confirm that EHR incentive payments were appropriately disbursed by ensuring that MU eligibility requirements are met and reflect their attestations in the MAPIR application. Along with fraud and abuse detection practices, the Department will facilitate providers with MU of Certified EHR systems, which will ultimately assist with patients and medical professional’s decision making. The Department will also determine how eligible provider’s Certified EHR systems will increase the likelihood that the systems can align with other HIT initiatives that support the exchange of information, care coordination, improved quality of care, safety, efficiency, and reduction in health disparities.

All information submitted in the MAPIR application is subject to review. Applicants are required to submit all supporting MU documentation at the time of application submission. Failure to do so will result in a delay of your incentive payment. We request that you upload all MU documentation directly into the MAPIR application with exception to your Patient Volume Report. Patient Volume reports must be in Excel format and can be sent using of the below secure methods:

- **DIRECT Messaging Account** (if you have a DIRECT account): PADPW-OMAP-MAHEALTHIT@directaddress.net

- **Password Protect:** You may password protect your Excel document to ensure its security. If you choose this method, please send us a separate email to RA-mahealthit@pa.gov providing us with the password to open your Excel document. If you are unsure how to password protect an Excel file, you can find instructions [here](#).
- **Email:** RAmahealthit@pa.gov by using **secure/encrypted email**. Due to your document containing PHI, it **must** be sent securely. If you are unable to send a secure/encrypted email from your location, please email us and we will be happy to send you a secure email that you may reply to by attaching your Excel document in a secure format.

MAPIR Attestations

Professionals will need to verify the information displayed in MAPIR and will also need to enter additional required data elements and make attestations about the accuracy of data elements entered in MAPIR. For example, applicants will need to demonstrate that they meet Medicaid patient volume thresholds, that they are meaningfully using federally certified EHR systems, and that they meet all other federal program requirements. If additional documentation is requested, the EP has 60 days from the time of the request to submit the documentation to validate the attestation requirements.

The MAPIR system design is based on the CMS Final Rule for the PI Program and Pennsylvania's specific eligibility criteria. A series of reviews will identify applicants who do not appear to be eligible, for example:

- Hospital-based providers
- Providers who do not meet patient volume thresholds
- Those who are ineligible provider types
- Providers with current sanctions
- Validation of MU attestations via supporting documentation

These MAPIR system reviews help ensure providers meet all requirements of the program and reduce incorrect payments and overpayments.



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Pre-Payment and Post-Payment (Audit) Reviews

MAHITI and the MAPIR Operations team members will refer issues related to fraud with program requirements to BPI and work directly with BPI to resolve the issue.

In the case of abuse, MAHITI and the Operations team will reach-out to the applicant to correct the issue, (this is performed during the application process as part of the pre-payment audit). In the case where abuse is identified after the payment is processed, MAHITI and the Operations team will refer the issue to BPI. Abuse is characteristically an innocent mistake, while fraud consists of an event that was knowingly and willingly incorrect, and that was purposely executed to obtain a benefit.

The Department will perform a multitude of different post-payment audit strategies. The department has categorized higher risk type applications for potential fraud or abuse for review such as professionals that had Medicaid sanctions in the past.

In the case of MU auditing, the Department will use pre- and post-payment audit opportunities to combat fraud and abuse. MAPIR will have system checks to ensure that providers are meeting MU standards. Along with these system checks, manual reviews will be used to look behind the attestations. Risk categories developed by the Department or by CMS, along with sampling techniques can be used for audit selection. These manual reviews can take place by means of primary and secondary data analysis and comparison, ultimately leading to desk and field audits to ensure proper access and use of EHRs.

According to the Final Rule, a state must comply with federal requirements to ensure the program qualifications of the provider, detect improper payments, and refer suspected cases of fraud and abuse to the Medicaid Fraud Control Unit for that state.

The Bureau of Program Integrity will refer all cases of suspected provider fraud to the Medicaid Fraud Control Section (MFCS) found in the Pennsylvania Attorney General's Office.

Medical Assistance Promoting Interoperability Program Post-Payment Audit Request Policy

The Program gives the provider sixty (60) business days to submit the required documentation that was requested. The auditor can authorize a fifteen (15) business day extension if requested,

and appropriately justified, by the provider. If the provider needs more than seventy-five (75) business days to produce the documents, approval from the HIT Coordinator is required.

9 Overpayments

MAPIR will be used to store and track records of incentive payments for all participating EPs. The Department will regularly monitor payments to ensure overpayments are not made. Once an overpayment is identified, MAPIR will be used to determine the amount of payments that have been made and that must be returned by EPs.

When overpayments are identified, the Department will initiate the payment recoupment process and communicate with CMS on repayments. The Department will recover any overpayments from instances of abuse; however, overpayments identified because of a fraud conviction are handled in conjunction with the Medicaid Fraud Control Unit.

The Department will request that providers submit overpayments by check. If a provider fails to submit a payment by check within 90 calendar days of the notice to return the overpayment, the Department will take other measures to recoup the overpayment. Federal law requires the Department to return overpayments within one (1) year of identification.

Program Year 2016 was the last year for EPs to begin participation in the program. (Payment Year 1). Therefore, if an EP subsequently fails an audit for PY2016 and has participated in additional program years, all incentive payments received will result in recoupment.

Example:

EP participates and receives incentive payment for Program Years 2016, 2017, and 2018. Payment Year 1 application fails audit. This would result in recoupment of all three incentive payments received because of failing their first participation year in 2016.

10 Appeals

EPs will have the right to appeal certain Department decisions related to the Medical Assistance PIP. Appeals are not related to disputes between providers and practices. Examples of appeal reasons include, but are not limited to, the following:

- Applicant is determined ineligible for the PIP.
- Applicant has received an overpayment for the PIP; or,
- Appeal of incentive payment amount, (e.g., pediatrician payment).

You will receive a notice of denial via email and a follow-up denial letter with specific instructions on how to submit an appeal.

Appeals related to this program will be processed like all other provider appeal issues. Providers should submit appeals to the Department's Bureau of Hearings and Appeals copying the Bureau of Program Integrity and the Office of Medical Assistance HIT Coordinator.

11 MAPIR Overview

This section of the Pennsylvania Medical Assistance PIP. Eligible Professional Provider Manual describes how users apply for incentive payments through the Medical Assistance Provider Incentive Repository (MAPIR). MAPIR is the state-level information system for the MA PIP that will both track and act as a repository for information related to payment, applications, attestations, oversight functions, and interface with the Medicare and Medicaid Promoting Interoperability Program Registration and Attestation System (R&A).

MAPIR is intended to streamline and simplify the provider enrollment process by interfacing with other systems to verify data. EPs will enter data into MAPIR and attest to the validity of data thus improving the accuracy and quality of the data.

The MAPIR system is used to process provider applications, in addition to:

- Interfacing between the Department and the R&A to:
 - Receive initial registration information from professionals
 - Report eligibility decisions to CMS
 - Report payment information (payment date, transaction number, etc.) to CMS
- Verify information submitted by applicant
- Determine eligibility of professionals
- Allow professionals to submit:
 - Attestations
 - Payee information
 - Submission confirmation/digital signature
- Communicate Payment Determination

In addition, MAPIR contains a series of validation checks that is used during the application process (e.g., confirmation of R&A information, patient volume, and attestations) to confirm a professional's eligibility for the program.

To begin in the MAPIR application process, professionals must:

1. Enroll at the CMS R&A (first year only or if there have been changes since your first payment year, i.e. changing payee assignment);
2. Be enrolled in Medical Assistance; and,
3. Be free of sanctions or exclusions.

Note: In some cases, professionals will be re-directed to the R&A to correct discrepant data. In other cases, providers will be deemed ineligible for participation in the Pennsylvania Medical Assistance PI Program. The Department will provide an email notification to applicants in these instances.

12 MU Criteria: Meaningful Use Objectives and Clinical Quality Measures

To demonstrate meaningful use (MU), EHs must use their EHR technology in meaningful ways. CMS has defined MU criteria, grouping these into core objectives and clinical quality measures (CQM). These measures and their specifications can be viewed at: (*Listed by Program Year*) [CMS Promoting Interoperability Program Requirements](#)

Objectives Providers are required to complete the measures within the Objectives.

- EPs must report on ten (10) Objectives for Modified Stage 2 in 2018
- EPs must report on eight (8) Objectives for Stage 3 in 2018 and beyond

Clinical Quality Measures (CQMs) provide information on the outcomes from a health population.

- EP's must report on six (6) CQMs

Outcome and High Priority Clinical Quality Measures

- Beginning in Program Year 2019, CMS has specified certain CQMs as Outcome or High Priority. In MAPIR, you will see these categories separated as CMS would like EPs to select **at least** one (1) Outcome CQM. If none of the Outcome CQMs pertain to your scope of practice you must select **at least** one (1) High Priority CQM. If none of the High Priority CQMs pertain to your scope of practice you must select six (6) CQMs from the Other category.

Please see below the list of **Outcome** CQMs for PY 2019:

	CMS CQM number	Description
1	CMS 75	Children who have Dental Decay or Cavities
2	CMS 122	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)
3	CMS 132	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
4	CMS 133	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
5	CMS 159	Depression Remission at Twelve Months
6	CMS 165	Controlling High Blood Pressure

Please see below the list of **High Priority** CQMs for PY 2019:

	CMS CQM number	Description
1	CMS 2	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
2	CMS 50	Closing the Referral Loop: Receipt of Specialist Report
3	CMS 56	Functional Status Assessment for Total Hip Replacement
4	CMS 66	Functional Status Assessment for Total Knee Replacement
5	CMS 68	Documentation of Current Medications in the Medical Record
6	CMS 90	Functional Status Assessments for Congestive Heart Failure
7	CMS 125	Breast Cancer Screening
8	CMS 128	Antidepressant Medication Management
9	CMS 129	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
10	CMS 136	Follow-Up Care for Children Prescribed ADHD Medication (ADD)
11	CMS 137	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
12	CMS 139	Falls: Screening for Future Fall Risk
13	CMS 142	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
14	CMS 146	Appropriate Testing for Children with Pharyngitis
15	CMS 153	Chlamydia Screening for Women
16	CMS 154	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
17	CMS 155	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
18	CMS 156	Use of High-Risk Medications in the Elderly
19	CMS 157	Oncology: Medical and Radiation - Pain Intensity Quantified
20	CMS 177	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
21	CMS 249	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture

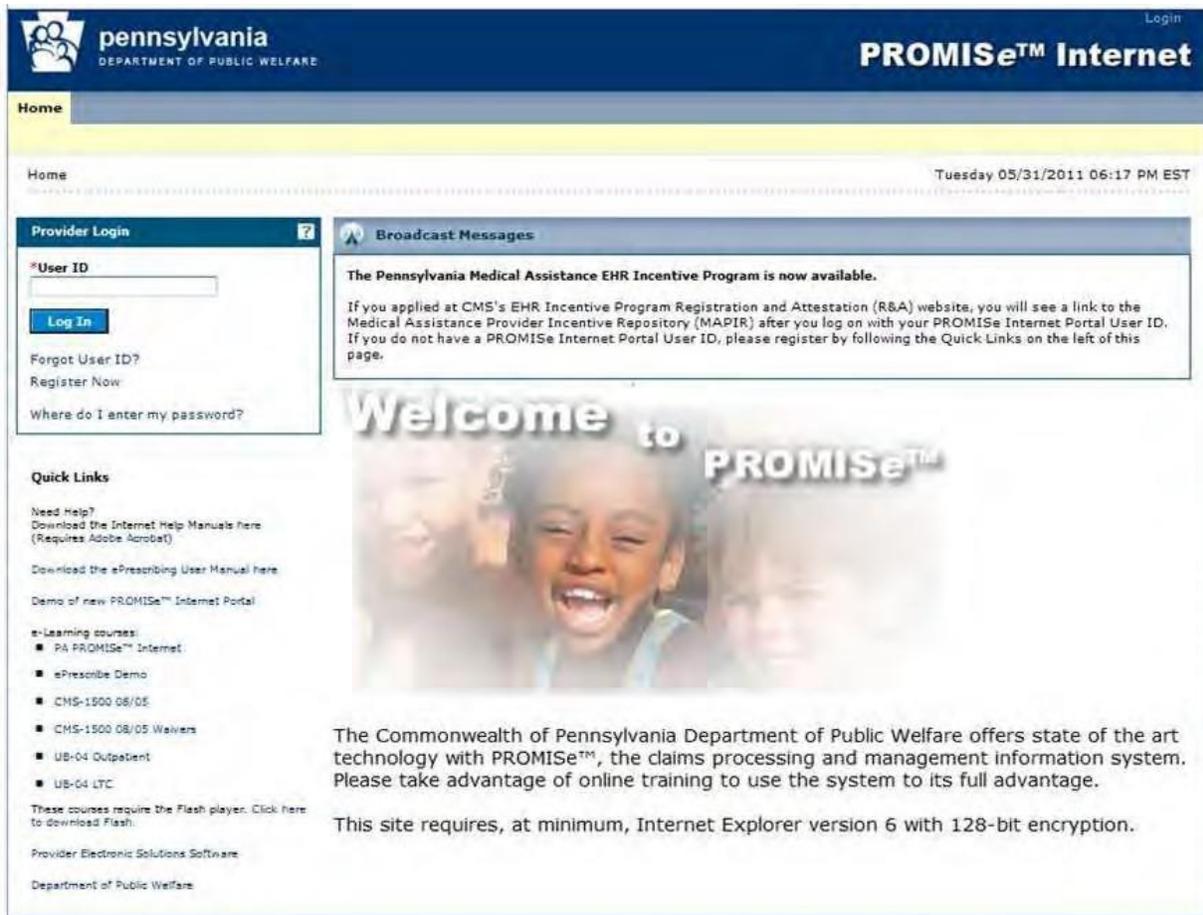
Please see below the list of **“Other” CQMs** not categorized as Outcome or High Priority:

	CMS CQM number	Description
1.	22	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
2.	52	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
3.	69	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
4.	74	Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists
5.	82	Maternal Depression Screening
6.	117	Childhood Immunization Status
7.	124	Cervical Cancer Screening
8.	127	Pneumococcal Vaccination Status for Older Adults
9.	130	Colorectal Cancer Screening
10.	131	Diabetes: Eye Exam
11.	134	Diabetes: Medical Attention for Nephropathy
12.	135	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
13.	138	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
14.	143	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
15.	144	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
16.	145	Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
17.	147	Preventive Care and Screening: Influenza Immunization
18.	149	Dementia: Cognitive Assessment
19.	160	Depression Utilization of the PHQ-9 Tool
20.	161	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
21.	347	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
22.	349	HIV Screening
23.	645	Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy

The Pennsylvania HIT website has a [Meaningful Use Resource page](#) on the website if you would like more details about meaningful Use.

13 Pennsylvania's PROMISe™ Provider Portal

Providers can access MAPIR through Pennsylvania's MMIS provider Internet portal, available [here](#).



The screenshot shows the Pennsylvania PROMISe™ Internet Provider Portal. The header includes the Pennsylvania Department of Public Welfare logo and the text "PROMISe™ Internet". The main content area features a "Provider Login" section with a "User ID" input field, a "Log In" button, and links for "Forgot User ID?", "Register Now", and "Where do I enter my password?". To the right, a "Broadcast Messages" section contains a message about the Pennsylvania Medical Assistance EHR Incentive Program. Below this is a "Welcome to PROMISe™" banner with a photo of a smiling child. A "Quick Links" section on the left lists various resources like "Need Help?", "Download the Internet Help Manuals here", "Download the e-Prescribing User Manual here", "Demo of new PROMISe™ Internet Portal", and "e-Learning courses". At the bottom, there is a footer with "Provider Electronic Solutions Software" and "Department of Public Welfare".

To access PROMISe™, the user must first be an enrolled Medical Assistance provider. To enroll as a Medical Assistance provider, applicants must complete the Medical Assistance enrollment process as defined in our [online information](#).

It is important to note that there are no specific applications for Physician Assistants or Pediatricians. Instead, they should use the application for individual practitioners (PT31). To review the individual practitioners PT31 application, please [click here](#).

Upon receipt of notification (via email) from the Department, applicants will be able to access MAPIR from the PROMISe™ provider portal using their PROMISe™ Internet Portal User ID.

To apply for the MA Promoting Interoperability incentive payment via MAPIR, the individual provider who registered at the R&A must have a PROMISe™ applicant has elected someone else to enroll for them. A group practice internet account ID will not display the MAPIR link. If the EP does not already have an individual PROMISe™ Internet account ID, you may register for one [here](#).

If you need assistance, you may access the [PROMISe™ Internet eLearning course](#) or call the Provider Assistance Center at 1-800-248-2152.

NOTE: You must use the same PROMISe™ Internet Portal User ID throughout the application process including if you start and then must restart the application. The same PROMISe™ Internet Portal User ID will need to be used in subsequent years as well. If you need to change that User ID, please contact the Department at RA-mahealthit@pa.gov.

14 Appendix

Definitions per Final Rule and/or Pennsylvania State Medical Assistance

Acquisition means to acquire health information technology (HIT) equipment or services for implementation and administration under this part from commercial sources or from State or local government resources.

Acute Care Hospital means a healthcare facility:

- Where the average length of patient stay is 25 days or fewer: and,
- With a CMS certification number (previously known as the Medicare provider number) that has the last four digits in the series 0001–0879 or,
- Critical Access Hospitals that have the last four digits in the series 1300–1399.

Adopt, Implement, or Upgrade (AIU) means:

- Acquire, purchase, or secure access to certified EHR technology (proof of purchase or signed contract will be an acceptable indicator).
- Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or

- 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.

Children’s Hospital means a separately certified children’s hospital, either freestanding or hospital-within hospital that:

- Has a CMS certification number, (previously known as the Medicare provider number), that has the last 4 digits in the series 3300–3399; and,
- Predominantly treats individuals less than 21 years of age.

Hospital-based indicates EPs who furnish 90% or more of their services in places of service classified under place of service codes 21 (Inpatient Hospital) or 23 (Emergency Room).

Meaningful EHR User means EP, eligible hospital or CAH that, for an EHR reporting period for a payment year, demonstrates meaningful use of certified EHR technology by meeting the applicable objectives and associated measures in the CMS Final Rule.

Medical Assistance Encounter for an EP means services rendered on any one day where the recipient is/was eligible for Medical Assistance.

Medical Assistance Encounter for an EH means services rendered on any one day where the recipient is/was eligible for Medical Assistance

Medicaid Management Information System (MMIS) means the electronic Medical Assistance claims payment system.

Needy Individuals mean individuals that meet one of following:

- Were furnished medical assistance paid for by Title XIX of the Social Security Act, Medicaid or Title XXI of the Social Security Act, The Children’s Health Insurance Program funding including out-of-state Medical Assistance programs, or a Medical Assistance or CHIP demonstration project approved under section 1115 of the Act;
- Were furnished uncompensated care by the provider; or
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay.

Patient Volume means the proportion of an EP’s or EH’s patient encounters that qualify as a Pennsylvania Medical Assistance encounter. This figure is estimated through a numerator and denominator as defined in the State Medicaid HIT Plan (SMHP) for Pennsylvania.

Pediatrician a physician who is either board-certified as a pediatrician or has received 12 months of training with children under the age of 21 years old.

Practices Predominantly means an EP for whom more than 50 percent of total patient encounters occur at a FQHC or RHC. The calculation is based on a period of 6 months in the most recent calendar year or a period of 6 months in the year preceding the application attestation date.

Useful Acronym List

ARRA	American Recovery and Reinvestment Act of 2009
CCHIT	Certification Commission for Health Information Technology
CHPL	Certified Healthcare Product List: list of certified electronic health record systems supplied by ONC
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic Health Record: an electronic record of patient health information gathered from one or more encounters in any care delivery setting that includes patient demographics, progress notes, problems, medication, vital signs, past medical history, immunizations, laboratory data and radiology reports. An EHR is created by linking health information between providers that is then available through a health information exchange (HIE). The EHR has the ability to provide a complete record of a clinical patient encounter, as well as supporting other care-related activities directly or indirectly via interface, including evidence-based decision support, quality management and outcomes reporting.
EMR	Electronic Medical Record: an EMR takes paper medical records and puts them onto an electronic file that is maintained in a secure database. An EMR is specific to each patient, contains all health-related information for that patient and is created, managed, and consulted by authorized clinicians and staff within one healthcare organization.
FQHC	Federally Qualified Health Center: Includes all organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes (i.e., an organization that meets all of the eligibility requirements of an organization that receives a PHS Section 330 grant, but does not receive grant funding). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an

underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

HIE	Health Information Exchange: the sharing of clinical and administrative data across healthcare institutions and providers.
HIT	Health Information Technology: HIT allows comprehensive management of medical information and its secure exchange between healthcare consumers and providers.
MAAC	Medical Assistance Advisory Committee
MAHITI	Medical Assistance Health Information Technology Initiative
MAPIR	Medical Assistance Provider Incentive Repository
MU	Meaningful Use
OMAP	Pennsylvania Office of Medical Assistance Programs
ONC	[The] Office of the National Coordinator for Health Information Technology: responsible for administering the CHPL.
PI	Promoting Interoperability Program
R&A	Medicare & Medicaid Promoting Interoperability Program Registration and Attestation System
RHC	Rural Health Clinic: can be public, private, or non-profit. The main advantage of RHC status is enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must be in rural, underserved areas and must use one or more physician assistants or nurse practitioners.



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Resources

- Pennsylvania Department of Human Services (DHS) [Medical Assistance Promoting Interoperability Program](#)
- Pennsylvania PROMISe™ internet [provider portal](#).
- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Records [Final Rule](#).
- Medicare and Medicaid Promoting Interoperability [Program](#).
- Office of the National Coordinator for Health Information Technology – [About the IT Health IT Certification Program](#).
- Enrollment: Medical Assistance [Enrollment forms](#).
- FQHC/RHC Attestation [Form](#)