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DEPARTMENT OF HUMAN SERVICES

PA Department of Human Services

Frequently Asked Questions

Medical Assistance Promoting Interoperability Program

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DEPARTMENT OF HUMAN SERVICES

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General

1. **Where are the webinar presentations posted?**
   The webinar presentations are posted on the Pennsylvania Department of Human Services (referred to as the Department throughout FAQs) Department's website.

2. **Can we switch from the Medicare EHR Incentive program to the Medical Assistance EHR Incentive program?**
   I. After a payment has been made, Eligible Professionals (EPs) can make a one-time switch between the Medicaid and Medicare EHR Incentive programs prior to 2015. Here are a couple of things to keep in mind:

      a. If you receive an incentive payment in 2012, that's when your program cycle begins. So, if you receive a Medicaid payment in 2012, then skip 2013, then receive a Medicaid payment in 2014 but switch to Medicare in 2015, you will be in your 4th payment year with Medicare even though you would be in your 3rd payment year if you stayed with Medicaid. Since Medicare does not allow providers to skip years, they would still include 2013 as a payment year even though no payment was received. On the other hand, if you first payment is in 2012 for Medicare and you skip program year 2013 and then switch to Medicaid in 2014, you would, that would be considered your second payment since the Medicaid program does allow you to skip years.

      b. If you receive an incentive payment from Medicare for 90 days meaningful use (MU) attestation and then switch to Medicaid, you would have to attest to 365 days of MU. Once you've received a payment for 90 days of MU, you cannot receive another payment for 90 days of MU (except in Program Year 2014 when everyone attests to 90 days of Meaningful Use).

EHR

1. **Where is the listing of the certified EHR systems?**
   I. The Certified Health IT Product List (CHPL) of certified EHR systems is found on the Office of the National Coordinator for Health Information Technology (ONC) website here.

2. **Are we eligible for an EHR Incentive payment if our current EHR system is not certified? Do we have to be using a certified EHR System to receive a payment this year?**
   I. In order to receive a Medical Assistance EHR Incentive payment, an eligible provider must have adopted, be in the process of implementing or upgrading or

meaningfully using a certified EHR system. An eligible provider would need to obtain the CMS EHR Certification ID number that corresponds to their EHR system at the ONC CHPL. Starting in 2014, the EHR systems must be 2014 certified in order to participate in the program.

3. **Do we have to stay on the same EHR system throughout the Incentive program?**
   I. You are not required to stay with the same certified EHR system for the duration of the program. However, every year you apply for an incentive payment you are required to have a certified EHR system and you will be asked to present documentation validating that you have a certified EHR system.

4. **After adopting, implementing or upgrading (AIU) an EHR system, what is required for subsequent years?**
   I. In your 2nd participation year, attestation to 90 days of Meaningful Use criteria is required in order to qualify for the next incentive payment. In your third participation year, attestation to 365 days of meaningful use is required in order to receive the 3rd incentive payment. Participation years do not need to be consecutive.

> **NOTE:** For program year 2014, all EPs and EHs will be attesting to 90 days of Meaningful Use (MU) regardless of what MU participation year they are participating. EPs and EHs will complete 2 years at Stage 1 MU (AIU is not considered Stage 1) before attesting to two years of Stage 2 MU requirements.

5. **What documentation is required for adopting, implementing, or upgrading (AIU)?**
   I. Adopting, Implementing or Upgrading: Please provide one of the following: signed contract or user agreement between you and the vendor; signed lease between you and the vendor; or receipt of purchase or paid invoice and (in addition to one of these documents) a signed vendor letter with the CSMS EHR system Certification ID number. A sample vendor letter can be viewed on our website.
   II. Model and serial numbers of EHR systems must match proofs of purchase, contracts or lease documents. If there are changes/upgrades to your EHR system, then we will need updated documentation. We will be asking for this information for Meaningful Use applications as well.

6. **What documentation is required for Medical Assistance patient volume justification?**
   I. **Volume:** Please provide total patient encounter volume and Medical Assistance encounter volume from the 90-day period that was chosen for the MA patient volume portion of the application. Supporting documentation must come from a

verifiable data sources such as a billing or practice management system. Here is a sample report to review.

II. As the sample indicates supporting documentation for patient volume must include a listing of all patients, identification of Medical Assistance patients seen during the 90 day period attested to with service dates, Patient ID, date of service, provider name, insurance carrier, payer ID, Medical Assistance in-state or out-of-state.

7. What if the incentive payment does not pay for the EHR System?

I. The EHR incentive program provides incentive payments for the adoption and the meaningful use of certified EHR technology and was not established to reimburse providers for the cost of certified EHR technology. Federal rules define maximum payments that the Department cannot change.

Eligibility

1. Who is eligible for the Medical Assistance EHR Incentive Program?

I. Eligible professionals (EPs) for the Medical Assistance program in Pennsylvania are physicians (doctors of medicine, doctors of osteopathy and pediatricians), dentists, certified registered nurse practitioners (CRNPs), certified nurse midwives and physician assistants (PA) who are participating in a FQHC or RHC that is so led by a physician assistant (see Question #3 for more information). Eligible professionals (such as Psychiatrists and CRNPs) that practice in behavioral health settings could be eligible for incentive payments as well.

2. What types of facilities qualify for the Medical Assistance EHR incentive program?

I. Eligible hospitals for the Medical Assistance program in Pennsylvania include acute care, critical access, and children's hospitals. Hospitals are eligible for both Medical Assistance and Medicare EHR incentive payments except for children's hospitals and cancer hospitals which are only eligible for Medical Assistance incentive payments. There are specific sets of CMS Certification Numbers (CCN) that correspond to eligible hospitals:

a. CCNs with the 0001 – 0879 (acute care), 1300-1399 (critical access hospitals), or 3300-3399 (children's hospitals) as the last four digits in the series. Additionally, Children's hospitals that predominately treat individuals under 21 years of age but do not have a CMS certification number (CCN), because they do not serve any Medicare beneficiaries, will be provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program.

3. Do Physician Assistants qualify?

I. Only physician assistants who practice predominately in a FQHC or RHC that is "so led" by a physician assistant may be eligible for Pennsylvania Medical Assistance EHR incentive payments. Physician assistants who meet the criteria will be required to enroll in PROMISe™.

II. Physician assistants applying for the incentive payment must 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 as one of the following:
   a. When a PA is the primary provider in an FQHC/RHC

III. When a PA is a clinical or medical director at a clinical site of practice at an FQHC/RHC; or

IV. When a PA is an owner of an FQHC/RHC.

V. Physician assistants must provide supporting documentation to validate they meet the above criteria prior to applying for the incentive payment for each year that they participate. Supporting documentation for enrolling with the Department will include a signed attestation as well as possibly including ownership documents or employment records.

4. Do Psychiatrists attached to outpatient facilities qualify?

I. A Psychiatrist would be considered an Eligible Professional for the Medicaid EHR incentive program as a physician. So long as the EP is not considered Hospital based the setting in which a professional practice is generally irrelevant to determining eligibility for the Medical Assistance EHR Incentive Program.

5. Are eligible professionals that work in behavior health settings eligible for an incentive payment?

I. Eligible Professionals are defined by provider type so for example, physicians or CRNPs that are practicing in psychiatric hospitals may be eligible. However, providers cannot be inpatient-based hospital providers. A Medical Assistance Eligible Professional is considered hospital-based if 90 percent or more of the Eligible Professional's services are performed in a hospital inpatient or emergency department setting.

6. Must an Eligible Professional be participating and enrolled in Medical Assistance?

I. In order to participate in the Pennsylvania Medical Assistance EHR incentive program, the Eligible Professional (EP) must be enrolled through Medical Assistance and the Pennsylvania PROMISe™ System.

7. **Are Eligible Professionals who spend a lot of time in the hospital eligible for the EHR Incentive program?**

   I. Eligible Professionals (such as Orthopedic Surgeons) who furnish 90 percent or more of their covered Medicaid professional services in a hospital setting (place of service code 21 or 23) in the year preceding the payment year would be considered hospital-based and not eligible for the program.

8. **How is a pediatrician defined for Pennsylvania's EHR incentive program?**

   I. 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.

9. **Do CRNPs in pediatrician offices qualify if they have Medical Assistance patient volumes greater than 20 percent but lower than 30 percent?**

   I. No. Only pediatricians can qualify for the EHR Incentive Program with a Medical Assistance patient volume less than 30 percent but greater than 20 percent. CRNPs in a pediatric office need to meet the 30% Medical Assistance Patient volume threshold in order to qualify.

10. **Do doctors/psychiatrists qualify for the incentive program if they are contracted or part-time, rather than employed?**

    I. Eligible Professionals (EPs) employment status does not dictate eligibility for an incentive payment. So long as a professional is one of the designated eligible professional provider types and meets other program (for example adoption, implementation or upgrade standards) requirements, he/she could be eligible for an incentive.

11. **Are non-Eligible Professionals (like RNs) required to apply?**

    I. Non-Eligible Professionals are not able to apply for an incentive. However, if you are using the group methodology in calculating Medical Assistance patient volume, non-Eligible Professional encounters would be included.

12. **If CRNPs are not currently enrolled with Medical Assistance are they eligible to apply for the EHR Incentive or will they have to wait until they are enrolled with Medical Assistance?**

    I. In order to participate, the Eligible Professional (EP) must be enrolled in Medical Assistance and have an individual PROMISe™ account. Enrolling in Medical Assistance and setting up a PROMISe™ does take time. Here is the link to the enrollment website.

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Application Process

1. **What information is needed to apply for the Medical Assistance EHR Incentive Program at the CMS Registration & Attestation website?**

   I. The Centers for Medicare & Medicaid Services (CMS) Registration & Attestation System will require that Medicare and Medical Assistance eligible professionals and hospitals register with CMS to submit the following information:
      i. **NPI:** National Provider Identifier (NPI) where the source system is NPPES (National Plan and Provider Enumeration System). An NPI for the applicant and payee will be required.
      ii. **Payee TIN:** Tax Identification Number (TIN) that is used for payment. NOTE: The TIN is used when payment is being assigned to a group. When paying to the individual provider, you must use the provider's Social Security Number.
      iii. **Personal TIN:** Personal Taxpayer Identification Number
      iv. **Program Option:** Choice of program to use for incentives; valid values include Medicare or Medical Assistance
      v. **State:** The selected State for Medical Assistance participation
      vi. **Provider Type:** Differentiates types of providers as listed in HITECH legislation
      vii. Provider's email address that is used to submit information to the CMS R&A (although this information is not required at the CMS R&A, it is highly suggested if the office needs to contact the provider.)
   II. Indication of whether the provider will assign the incentive payments (and, if so, to whom they wish to assign their incentive payments)
   III. If there are changes in the CMS R&A information requirements, it will be communicated on the CMS and Department websites.
   IV. More guidance on the Pennsylvania's Medical Assistance EHR incentive program process will be posted to our website.

2. **What attestations are required? When do providers make attestations?**

   I. Eligible Professionals and eligible hospitals will attest to all information collected as part of the application in MAPIR. For example, Eligible Professionals will attest to the following:
      a. Patient volume calculations
      b. Documentation of adopt, implement, or upgrade of EHR (in the first participation year)
      c. Meaningful Use of certified EHR system in second and subsequent participation years
      d. Assignment of payment is voluntary (if applicable)
      e. If the Eligible Professional practices predominantly in an FQHC or RHC

f. The Eligible Professional type including if the applicant meets the definition of a pediatrician
g. Hospital-Based status
h. For example, Eligible Hospitals will attest to:
    i. Patient Discharge volume
    ii. Documentation of adopt, implement, or upgrade of EHR (in the first participation year)
    iii. Meaningful Use of certified EHR system in second participation year
    iv. Cost Data for incentive payment

3. What documentation is required to validate status of certified EHR technology prior to final approval for an EHR incentive payment?

I. To receive an incentive payment through the MA EHR Incentive Program, Eligible Professionals (EPs) and Eligible Hospitals (EHs) are required to be in the process of adopting, implementing, upgrading or meaningfully using a certified EHR system.

a. In order to complete the MAPIR application process, the EP or EH will be required to provide documentation verifying the provider has adopted, implemented, upgraded to or is meaningfully using the certified EHR system that was attested to in the MAPIR application.
b. Validation documentation must have the CMS EHR system certification number that the eligible professional received from the Office of National Coordinator (ONC) Certified Health Produce List (ONC CHPL) prior to applying for an incentive payment.
c. If the CMS EHR system certification number is not identified on one of these documents, the EP or EH may provide a signed letter identifying the CMS EHR system certification number in addition to another supporting document. A signed vendor letter will not independently be enough for documentation.
d. Below is a list of documents we will accept to verify EHR certification attestation is enough. The Department will determine if the validation of the attestation is met after review of the documentation(s):
    i. Signed contract or user agreement between you and the vendor
    ii. Signed lease between you and the vendor
    iii. Receipt of purchase or paid invoice

e. **AND** (in addition to one of the above documents)
    II. A signed vendor letter **with** the CMS EHR system Certification ID number

A sample vendor letter can be viewed on our website.

> **NOTE:** We cannot accept a screen print of the ONC website that shows the CMS Certification ID number **OR** handwritten CMS Certification ID numbers on any above documentation. These documents can be uploaded during the MAPIR application process or they can be emailed to RA-mahealthit@pa.gov.

4. **Do I need to enter a CMS EHR Certification number when attesting for an EHR incentive payment?**
    I. Yes, you will need to enter r a certification number in the MAPIR system or you will not be able to proceed with your attestation until you enter a valid certification number.
5. **Are Eligible Professionals submitting an electronic signature when they apply in MAPIR?**
    I. Yes. Eligible Professionals will sign their application and attestation electronically in MAPIR.
6. **If the professional needs to demonstrate they have at least 50 percent of their encounters in a FQHC/RHC over a 6-month period, what time frame is used and what basis would we use to verify this?**
    I. The EP could either use 6 months from the previous calendar year or the preceding 12-month period from the date of attestation. For documentation, we would be able to utilize information out of your practice management system to verifythe 50 percent over a 6-month period requirement.
7. **How will providers enter volume threshold information?**
    I. Eligible Professionals and Hospitals will enter the numerator and denominator as part of the MAPIR application process, maintain supporting documentation, and make the supporting documentation available at the Department's request for review. The Department recommends that you upload supporting documentation to your application at the time of attestation.
8. **How do hospitals apply with the EHR Incentive program?**
    I. The process to register would be the same as an Eligible Professional but the hospital must be in one of these categories**:**
        a. Eligible Hospitals for the Medical Assistance program in Pennsylvania include acute care, critical access, cancer and children's hospitals. Hospitals are eligible

for both Medical Assistance and Medicare EHR incentive payments except for children's hospitals and cancer hospitals which are only eligible for Medical Assistance incentive payments. There are specific sets of CMS Certification Numbers (CCN) that correspond to eligible hospitals: CCNs with the 0001 – 0879 (acute care), 1300-1399 (critical access hospitals), or 3300-3399 (children's hospitals) as the last four digits in the series.

b. Additionally, Children's hospitals that predominately treat individuals under 21 years of age but do not have a CMS certification number (CCN), because they do not serve any Medicare beneficiaries, will be provided an alternative number by CMS for purposes of enrollment in the Medicaid EHR Incentive Program.

9. **Is participation in both the Medical Assistance and Medicare EHR Incentive Programs allowed?**

I. EPs are not allowed to participate in both programs during the same program year. However, the option to switch once between programs is allowed if the switch is made before 2015.

II. Acute Care Hospitals including Critical Access Hospitals can participate with and receive payments from the Medicare and Medical Assistance EHR Incentive Programs.

III. Children's and Cancer Hospitals are only able to participate with the Medical Assistance EHR Incentive Program.

10. **Do individual eligible professionals apply as an individual even when working under a group practice?**

I. Yes, all Eligible Professionals apply for incentive payments individually but can attest to Medical Assistance patient volume using either the individual or group Medical Assistance patient volume methodology.

11. **If our practice retains a new Eligible Professional, how will we know where they are in Medical Assistance EHR Incentive process with their previous practice and what incentive money would be available to them?**

I. Since Eligible Professionals are responsible for information contained in their application, they should be able to inform their employer of their status. A listing of all EPs is maintained at CMS. (click on the link near the bottom of the page entitled EP Recipients of Medicare EHR Incentive Program Payments).

12. **Can a third party apply on behalf of the professionals instead of the professionals needing to do this themselves?**

I. Someone may apply on behalf of the Eligible Professional in MAPIR, Pennsylvania's system for EHR incentive program applications. However,

anyone other than the professional associated with the NPI will need to be established as an alternate in the PROMISe™ provider portal.

II. The eligible professional must still legally attest they meet requirements for receiving payments. CMS may have different criteria for a third party registering at the R&A on behalf of the professionals. Please visit Promoting Interoperability Programs | CMS or call 1-888-734-6433 for more information.

III. If a third party (preparer) applies on behalf of the provider, the preparer must understand that by signing this attestation, the signatory hereby certifies that the foregoing information is true, accurate, and complete.

IV. If the signatory is a preparer and not the provider identified by the NPI noted above, the signatory acknowledges that as the preparer, he or she attests to the accuracy of the information on behalf of the provider and that the provider designated the preparer to complete this action.

V. The signatory also understands that Medicaid EHR incentive payment submitted under this NPI will be from Federal funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

VI. The signatory, either provider or preparer, further understands and agrees that the Department may ask for additional information which, in the Department's estimation, may be necessary to determine or validate EHR Program eligibility and payment amounts.

13. How will Eligible Professionals know that CMS R&A registration is complete?

I. When the CMS R&A registration status is “Pending State Validation” and a welcome email has been received, Eligible Professionals will be able to start their MAPIR application (accessed from the provider’s individual PROMISe account).

II. Once the status reads “Pending State Validation,” it will not change, and no further edits will be needed at the CMS R&A. If the CMS R&A registration is opened and the status changes, the provider’s application will be halted until the CMS R&A registration status is once again “Pending State Validation.”

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Eligible Hospital Application Process

1. Can you please define the term "acute care"?

I. Generally, acute care is a term used for immediate short-term treatment or stabilization of a disease, injury, or disorder. Acute care is generally provided in settings such as emergency, intensive care, coronary care, and cardiology departments. In contrast, sub-acute care is provided in units and facilities such as long-term care, skilled nursing, and rehabilitation.

II. The Medicaid EHR Incentive Program provides incentives only to acute care facilities and children's hospitals. Even within an eligible acute care or children's hospital, there are some units that are not considered acute care and are not counted in the calculations for determining eligibility or calculating the incentive payment. The following types of services are considered sub-acute and should be excluded from all calculations:

a. Nursery care, although neonatal intensive care services are acute care and should be counted
b. Skilled nursing or long-term care
c. Rehabilitation
d. Psychiatric services

2. What cost report data elements are used in the EHR incentive payment calculation for Medicaid Hospitals?

I. The current Medicaid cost report will be used to validate eligible hospitals' incentive payment. The Medicaid cost report data elements are as follows:

a. Total Discharges
   i. Worksheet S-2, Column 8, Line 9
   ii. Remove nursery days, non-acute swing days, rehabilitation days, psychiatry days and any other non-acute
b. Medicaid Inpatient Days
   i. Worksheet S-2, Column 8, Line 4
   ii. Worksheet S-5, Column 13, Line 1
   iii. Worksheet S-2A, Column 1, Line 1 (MCO Days)
   iv. Remove nursery days, non-acute swing days, rehabilitation days, psychiatry days and any other non-acute days
c. Total Inpatient Days
   i. Worksheet S-2, Column 8, Line 3
   ii. Remove nursery days, non-acute swing days, rehabilitation days, psychiatry days and any other non-acute
d. Total Charges
   i. Worksheet S-6, Line 8
   ii. Sum inpatient and outpatient

e. Charity Care Charges
   i. Worksheet S-6, Line 7
   ii. Sum inpatient and outpatient
   iii. Charity Care is not considered bad debt

3. **Do we need to reflect only discharges for claims paid by the Department through weekly remittance advices or can we use internal hospital systems to determine our total Medical Assistance discharges?**

   I. Documented/verifiable internal records are an acceptable source; the Department will perform an initial validation based on claim and encounter data.

4. **Will the hospital at some point have to provide documentation on how the numbers submitted were determined?**

   I. The hospital could be audited by the Department and would have to produce documentation supporting the information they reported in MAPIR.

5. **Does the definition of total discharges include Medical Assistance MCO plans or is this incentive program based on Medical Assistance FFS (fee-for-service) discharges only?**

   I. For purposes of the Medical Assistance EHR Incentive Program, you should include both FFS Medical Assistance patients and MCO Medical Assistance patients.

6. **In the MAPIR application, it is requesting total discharges, bed days and total charges for all discharges and total charges for charity care. Is this just inpatient total charges and inpatient charges for charity care?**

   I. No for total charges and charity care you should include inpatient and outpatient charges. These figures are used in calculating the Medical Assistance share for the EHR Incentive Program payment. Bad debt should not be included in charity care.

7. **If hospital outpatient ED visits can be included, would outpatient ED charges and outpatient ED charity care be included in the amounts?**

   I. Outpatient ED charges and outpatient ED charity care are included in Total Charges and Charity Care.

8. **If a patient is dually eligible for both Medicare and Medicaid, can they be counted twice by hospitals in their calculations if they are applying for electronic health record (EHR) incentive payments through both the Medicare and Medicaid EHR Incentive Programs?**

   I. For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share. Thus, in this respect the inpatient bed day of a dually eligible patient

could not be counted in the Medicaid share numerator. (See 1903(t)(5)(C), stating that the numerator of the Medicaid share does not include individuals "described in section 1886(n)(2)(D)(i).") In other respects; however, the patient would count twice. For example, in both cases, the individual would count in the total discharges of the hospital.

9. How are hospital payments calculated under the Medical Assistance EHR Incentive Program?

I. The Department will calculate hospital payment amounts for eligible hospitals using the following data elements:
   a. Base amount of $2 million
   b. Annual average growth rate
   c. Medical Assistance discharges
   d. Medical Assistance transition factor
   e. Inpatient bed days
   f. Total charges
   g. Total charity care
   h. There is a hospital payment estimator calculator available here.

Patient Volume Calculation

1. What are the Medical Assistance patient volume requirements?

I. All Eligible Professionals and many hospitals (the exception is for children's hospitals who do not need to meet volume requirements) must meet Medical Assistance patient volume thresholds to be eligible for incentive payments. In general, Medical Assistance patient volume is calculated by dividing the number of Medical Assistance encounters by the total number of encounters over a continuous 90-day period in the previous year (Eligible Professionals: calendar year; Eligible Hospitals: facility fiscal year) OR over a continuous 90-day period in the preceding 12 month period from the date of attestation.

II. For Medical Assistance Eligible Professionals, the general rule is that the Eligible Professionals must have at least 30 percent patient volume attributable to those who are receiving Medical Assistance to be eligible for incentive payments.

III. Pediatricians must have at least 20 percent Medical Assistance patient volume.

IV. Medical Assistance Eligible Professionals practicing predominantly (over 50 percent of his or her total patient encounters over a period of 6 months) in a Federally Qualified Health Center or Rural Health Clinic must have a minimum of 30 percent patient volume attributable to ''needy individuals.'' EPs will have the option to use a six-month period within the prior calendar year or the preceding 12-month period from the date of attestation for the definition of practicing predominantly (more than 50% of the encounters) in a FQHC or RHC. NOTE:

Pediatricians that practice predominately must meet 30% needy population threshold.

V. Eligible hospitals under the acute care category (including critical access hospitals) must have 10 percent Medical Assistance patient volume and there are no Medical Assistance patient volume requirements for children's hospitals.

VI. Upon application in MAPIR, Eligible Professionals and hospitals will be prompted to enter the information necessary to calculate Medical Assistance patient volume. The Department has developed resources that will help to guide providers through the application process. These resources will help providers calculate Medical Assistance patient volumes and answer other eligibility questions.

2. How is the term "needy individual" defined?

I. The term "needy" individual is defined under the Recovery Act. For the purposes of calculating Medical Assistance patient volume, Eligible Professionals practicing predominantly (more than 50 percent of their encounters) in a Federally Qualified Health Center or Rural Health Clinic setting may include "needy individuals" as part of their Medical Assistance patient volume calculations. "Needy individual" is defined as an individual who is receiving assistance under:

a. Medical Assistance
b. The Children's Health Insurance Program
c. Furnished uncompensated care by the professional
d. Charges are reduced by the professional on a sliding scale basis based on the individual's ability to pay

3. How is an encounter defined for purposes of determining patient volume?

I. Federal rules allow the services below to be considered Medical Assistance encounters for calculating patient volume.

a. **For Eligible Professionals:** Services rendered on any one day to an individual where the recipient is/was eligible for Medical Assistance.

b. **For Hospitals:** Services rendered to an individual per inpatient discharges where the recipient is/was eligible for Medical Assistance.

II. Services rendered to an individual in an emergency department on any one day where the recipient is/was eligible for Medical Assistance.

4. Can pediatricians with less than 30 percent Medical Assistance patient volume participate in the incentive program?

I. A pediatrician must have at least 20 percent patient volume attributable to Medical Assistance encounters. For pediatricians with under 30 percent Medical Assistance patient volume, the net allowable costs are capped at two-thirds of full amount (i.e., they may receive up to $42,500 over a six-

year period). Pediatricians who practice predominantly in a RHC/FQHC must meet the 30 percent patient volume using needy encounters.

5. **Can Eligible Professionals include patients who are enrolled in Medical Assistance managed care organizations (MCOs) when calculating patient volume?**

   I. Yes, the encounters from individuals enrolled in Medical Assistance MCOs are included in determining Medical Assistance patient volume.

6. **Do dual-eligible (Medical Assistance & Medicare) patients count towards the Medical Assistance volume?**

   I. Yes, if the encounter with the dual-eligible patient meets the definition of an encounter. For purposes of calculating Eligible Professionals' (medical assistance encounters) and hospitals' (ED visits and discharges) patient volume, a Medical Assistance encounter/discharge and ED visit means services rendered to an individual on any one day where the recipient is/was eligible for Medical Assistance.

7. **Can Eligible Professionals and hospitals include out-of-state Medical Assistance encounters in their Medical Assistance patient volume calculations?**

   I. Yes. Out-of-state encounters are included in Medical Assistance patient volume calculations; however, like all volume information provided on the application, providers must be prepared to submit supporting information should they be audited. Out of state Medical Assistance encounters will be reported separately from in-state Medical Assistance encounters. You would also need to include all your out-of-state encounters in the denominator when calculating patient volume.

8. **Are there a minimum number of encounters required?**

   I. No, there is no minimum number of encounters required. However, professionals and hospitals should be prepared to provide supporting documentation if requested.

9. **How do we calculate patient volume for Part-Time Eligible Professionals?**

   I. You would calculate the patient volume for a Part-Time Eligible Professional the same as a Full-Time Eligible Professional. You would take the Part-Time Eligible Professional's Medical Assistance patient encounters over a consecutive 90-day period in the previous calendar year or in the 12 months preceding attestation and divide that by his/her total number of encounters for that same 90-day time period. This will provide the percent of Medical Assistance patients and then will help determine if he/she meets the volume requirements.

10. Sometimes the CRNP bills 'Incident To' a physician, do these encounters count toward the CRNP orthe Physician?

I. Incident-to services could be counted as encounters for a mid-level eligible professional such as CRNP if the encounters can be validated that they meet the definition of Medical Assistance encounter and can be attributed to the mid-level eligible professionals.

11. For a general acute care hospital to qualify for Pennsylvania Medical Assistance EHR Incentive Program payments they must meet a ten percent (10%) volume threshold. How is this volume threshold calculated?

I. For purposes of calculating hospital patient volume, the Department can consider Medical Assistance fee-for- service and managed care inpatient discharges and services rendered to an individual in an emergency department (ED) on any one day. The volume threshold is calculated by dividing Medical Assistance inpatient discharges and Medical Assistance ED visits by total inpatient discharges and ED visits for any 90 continuous days during the hospital's prior fiscal year.

12. Does a hospital have to include emergency department (ED) visits in the volume calculation?

I. CMS has provided additional guidance regarding the hospital volume calculation and has indicated that hospitals do need to include ED visits when attesting to Medicaid patient volume percentage. Therefore, hospitals are instructed to include both inpatient discharges and ED visits when calculating their Medicaid volume percentage.

13. Are CHIP encounters included in the volume calculations?

I. For the purposes of calculating Medical Assistance patient volume, only Eligible Professionals practicing predominantly (more than 50 percent of their encounters over six months) in a FQHC or RHC setting may include, needy individuals as part of their Medical Assistance patient volume calculations. Needy individual is defined as ''an individual" who is receiving assistance under:
   a. Medical Assistance
   b. The Children's Health Insurance Program (CHIP)
   c. Furnished uncompensated care by the professional
   d. Charges are reduced by the professional on a sliding scale basis based on the individual's ability to pay

14. How is hospital-based status determined for an EP?

I. 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 to be hospital-based and are therefore not eligible for incentive payments under the Medicare and Medical Assistance EHR Incentive Programs. Data from the prior calendar year is utilized to determine hospital-based status.

15. What is the acceptable source of information to support Medical Assistance discharges and out of state Medical Assistance discharges entered in MAPIR?

I. Documented/verifiable internal records such as records from billing or patient management systems are an acceptable source.

16. Since ED visits are allowed in this equation, is it presumable to say only outpatient Medical Assistance ED patients that are not admitted?

I. For volume purposes, per CMS, if a patient is admitted to the hospital from the ED, the ED discharge and the hospital discharge are both allowed for the volume calculation.

17. Are volume calculations based on a 3-month period?

I. The encounters you use to determine Medical Assistance volume percent is based on a continuous 90 day period from the previous calendar year for Eligible Professionals and the previous Hospital Fiscal Year for Eligible Hospitals OR over a continuous 90-day period in the preceding 12 month period from the date of attestation.

II. So, for Eligible Professionals, if you are applying for program year 2014, you would use a continuous 90-day period from 2013 **OR** a continuous 90-day period in the preceding 12-month period from the date of attestation. If you are using the group calculation, you would enter all encounters from the same 90-day period for providers (even those not eligible for the program) that define the group NPI(s).

18. How do the incentives and payments work for professionals who bill Behavioral Health Managed Care Organizations like CBH in Philadelphia?

I. Eligible Professionals that bill either behavioral health or physical health MCOs can include these encounters toward their patient volume thresholds. For purposes of calculating Eligible Professional patient volume, a Medical Assistance encounter means services rendered to an individual on any one day where the recipient is/was eligible for Medical Assistance.

19. We have a new Eligible Professional, but he has no encounter history with our practice, can he apply using the encounters from the practice where he previously saw patients?

I. Eligibility for a professional is not based on being with one practice or another but whether the EP meets the standards for patient volume. The standards include requirements such as submitting volume from the previous calendar year for a continuous 90-day period OR over a continuous 90-day period in the preceding 12-month period from the date of attestation, as well as the requirements related to using group volume. EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

   a. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation)

   b. There is a verifiable data source to support the clinic's patient volume determination

   c. 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.

20. Can group practices aggregate their patient volume?

I. Incentive payments are for individual professionals, however, clinics and group practices (including FQHCs and RHCs) are allowed to use the practice or clinic Medical Assistance patient volume (or needy individual patient volume, insofar as it applies) and apply the practice or clinic volume calculation to all Eligible Professionals in their practice under three conditions:

   a. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the Eligible Professional

      i. **Example of Eligible Professional using group patient volume:** *Medical Assistance Patient Encounters (includes Medical Assistance patient encounters in and out of Commonwealth of PA across the entire group)/Total Encounter Volume in and out of Commonwealth of PA = %*

Medical Assistance Patient Volume (must be 30 percent Medical Assistance patient volume, at least 20 percent for pediatricians)

ii. There is a verifiable data source to support the clinic's patient volume determination

iii. The practice and Eligible Professionals use one methodology in each year (in other words, clinics could not have some Eligible Professionals using 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.

II. Eligible Professionals may attest to patient volume under the individual calculation or the clinic/practice group practice calculation in any participation year. Furthermore, if the Eligible Professional works in both the clinic and outside the clinic (or within and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

21. Is the percent Medical Assistance patient volume based on the group or the Eligible Professional?

I. Eligible Professionals (EPs) have the option of calculating patient volume by either using the individual methodology or by combining the volumes for all the professionals in the group in order to reach the minimum Medical Assistance patient volume threshold. If the group methodology is used and the minimum threshold is met, then each of the Eligible Professionals can use that patient volume calculation to qualify for an EHR Incentive payment.

22. Can I include Part-Time professional's volumes when utilizing the Group volume calculations? Also, we have multiple locations under one Tax ID, how do we calculate patient volume with multiple locations?

I. In using the group calculation, the practice and Eligible Professionals must decide to use one methodology in each year (in other words, clinics could not have some of the Eligible Professionals 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 (including part-time professionals) and not limit it in any way. Multiple locations may be used, but they need to be associated with the group NPI(s) that is defining the group.

23. We have multiple NPIs with a variety of specialists, but we all use the same Tax ID, can we include everyone in the group volume calculation?

I. When the Eligible Professional completes the application, they will have the option to include all NPI's associated with them. Information will be collected based on the Group NPI(s) number and not the Tax ID.

24. Can PAs and CRNPs in RHCs or non-Eligible Professional's patient volumes be used to qualify the supervising physician using either the individual or group methodology?

I. A supervising physician is permitted to use encounters from those they supervise but the encounters must be included in both their numerator and denominator. If group methodology is being used to calculate patient volume, then all the Medical Assistance encounters and all of the total encounters in the practice (including PAs and CRNPs) would be used regardless of who the professional was for that encounter. Encounters are defined as services rendered on any one day to an individual who is/was eligible for Medical Assistance.

> **NOTE:** PAs are not eligible professionals unless they practice predominately in an FQHC or RHC that is so-led by a PA (see Question #3 under Eligibility FAQs)

25. Are the patient volume calculations specific to the group or the site?

I. If you are using the group volume calculations, the group is defined by group NPI(s). If you are using the individual volume calculation, the encounters included must come from a location or locations that have certified EHR technology.

26. When calculating patient volume, do we use patient encounters from all locations where we see patients?

I. You may use multiple locations and they would need to represent the group NPI(s) number used to define the group for the volume calculation. If only one location is used for the patient volume calculation it must be from a location that has certified EHR technology. In using the group calculation the practice and Eligible Professionals must decide to use one methodology in each year (in other words, clinics could not have some of the Eligible Professionals 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 (including part-time providers and non-Eligible Professionals) and not limit it in any way. If using the group methodology when calculating Medical Assistance patient volume, you would utilize the group NPI(s) number. If this NPI number encompasses multiple locations, then you would include those locations.

27. If using the Group volume calculation and one of the Eligible Professionals from the time frame (90-day period) is no longer employed with the group or site, are his/her encounters still included?

I. Yes, you would include that Eligible Professional's Medical Assistance encounter and overall encounters when calculating the volume if you are using the group methodology to calculate your Medical Assistance patient volume.

Payments

1. Who receives the Medical Assistance incentive payments?

I. With the Medical Assistance EHR Incentive Program, each Eligible Professional (EP) would receive an incentive payment. Medical Assistance Eligible Professionals can reassign their incentive payments to one entity such as his or her employer or an entity with which they have a valid employment agreement or valid contractual arrangement that allows the entity to bill for the Eligible Professional's services. Applicants will attest to this relationship and that the assignment is voluntary during the application process. Eligible Professionals must have a current Medical Assistance fee assignment agreement in place with the entity they are re-assigning payment to (see question #1 under Error Message FAQs).

2. How and when are payments made?

I. If your Medical Assistance payments are normally sent to you via electronic funds transfer, your EHR Incentive will come to you via electronic funds transfer. If your Medical Assistance payments are normally sent to you via mail, your Incentive payment will be sent to you by mail. Payment will be made through our weekly transmittals. The payment is a lump sum payment that will be reflected as an add-on to the patient detail and properly identified as an EHR incentive payment. The payment is made 8 to 9 days after the date seen on remittance advice.

3. If patient volume is calculated as a group, is payment made to the group or to the individual provider?

I. Eligible Professionals (EPs) must enroll individually and can either be the recipient of the incentive payment or they can designate the payments to the clinic/group. The clinic/group practice volume methodology provides a way to attest that they meet the volume threshold; however, it does not determine who receives the payment. Eligible Professionals can reassign the payment (see question #1 under Payments FAQs).

4. Do Eligible Professionals have to participate in the Medical Assistance EHR incentive program in consecutive years to qualify for incentive payments?

I. Eligible Professionals do not have to participate consecutive years to qualify for the maximum Medical Assistance incentive payments, however they must start by 2016 in order to participate. The last payment year for Medical Assistance is 2021. Although the Medicaid program permits providers to skip years and still receive the maximum allowable payments providers that do not meet the meaningful use requirements each year of the program might be subject to the Medicare Payment adjustments.

5. What is the maximum incentive an Eligible Professional (EP) can receive under the Medical Assistance EHR Incentive Program?

I. Eligible Professionals who adopt, implement, upgrade and meaningfully use EHRs can receive a maximum of $63,750 in incentive payments for a total of six payment years. Special eligibility and payment rules apply for pediatricians.

II. Pediatricians who meet provider requirements and have a patient volume threshold of at least 30 percent can receive the maximum of $63,750 in incentive payments for a total of six payment years. Pediatricians who do not predominantly practice in an FQHC or RHC have a Medical Assistance patient volume threshold above 20 percent but below 30 percent may receive a maximum of $42,500 in incentive payments over a six-year payment period.

6. Can Eligible Professionals and Hospitals receive EHR incentive payments from both the Medicare and Medical Assistance programs?

I. Acute care hospitals are eligible to receive EHR incentive payments under both Medicare and Medical Assistance but not children's hospitals or cancer hospitals which can only receive Medical Assistance EHR incentive payments. Eligible Professionals who meet requirements of both programs must choose one program from which they will receive an EHR incentive payment.

7. If an Eligible Professional's EHR system costs much more than the incentive, may additional funds be requested?

I. The EHR incentive program provides incentive payments for the adoption and meaningful use of certified EHR technology and was not established to reimburse providers for the cost of certified EHR technology. Federal rules define maximum payments that the Department cannot change. Please refer to payment schedule here.

8. **Can an Eligible Professional change his or her incentive payment assignment?**

    I. Eligible Professionals will be able to assign payment to one entity each year they apply for the Medical Assistance EHR incentive program.

9. **Can Eligible Professionals receive incentive payments for Adoption, Implementation, or Upgrade (AIU) if they have already implemented an EHR system?**

    I. Yes. However, the system must meet certification requirements issued by the Office of the National Coordinator (ONC). For example, providers can receive an incentive payment for upgrades to a Federally certified system.

10. **Are the Medical Assistance EHR incentive payments taxable?**

    I. We note that nothing in the Act excludes such payments from taxation or as tax-free income. Therefore, it is our belief that incentive payments would be treated like any other income. Providers should consult with a tax advisor or the Internal Revenue Service regarding how to properly report this income on their filings.

11. **If using the group methodology to meet the 30 percent Medical Assistance patient volume, is the payment to each physician in the group? Ex. Year 1 with 6 physicians in the group - $21,250 each?**

    I. Yes, even though individual Eligible Professionals (EPs) can use the group Medical Assistance patient volume methodology to qualify for the EHR Incentive Program, payments are associated with an individual Eligible Professionals. If these Eligible Professionals qualify under the group calculation, then each would receive or be able to reassign the incentive payment.

Meaningful Use

1. **For what period-of-time do meaningful use criteria need to be met?**

    I. Eligible Professionals, will have the option to attest to adopting, implementing or upgrading in their first participation year. In the second participation year EPs must attest to meeting the meaningful use criteria for any continuous 90-day period within the same payment year (calendar year). After meeting the MU requirements for 90 days EPs will need to attest that they meet the MU requirements for a full program year during their subsequent payment years (calendar years).

    II. For Eligible Hospitals, they have the option to attest to adopting, implementing or upgrading in their first participation year. To receive their first payment associated with MU Eligible Hospitals must attest that they meet the MU requirements for 90 days within their payment year (Federal Fiscal Year). For subsequent payments for

MU Eligible Hospitals must meet the MU requirements for a full program year (Federal Fiscal Years).

> **NOTE:** In Program Year 2014 only, EPs and EHs will have to report on a 90-day reporting period regardless of their current participation year or stage of meaningful use.

2. Can I attest to meaningful use in the first payment year rather than for adoption, implementation, and upgrade?

I. Eligible Professionals (EPs) and Eligible Hospitals (EHs) can attest to Adopting, Implementing or Upgrading (AIU) to a certified EHR System or Meaningful Use in their first participation year. In subsequent participation years, EPs and EHs will need to attest to meeting the required meaningful use criteria. Hospitals that are dually eligible for both the Medicare and Medical Assistance EHR incentive programs must attest to the MU requirements through the CMS Registration and Attestation System.

3. Since my EHR system is Federally certified, can I receive an incentive payment for adoption, implementation, upgrade and an incentive payment for meeting meaningful use in the same participation year?

I. No. Eligible Professionals and Eligible Hospitals may only receive one payment per participation year.

4. Where can Meaningful Use standards be found?

I. Medical Assistance Meaningful Use requirements are the same as Medicare therefore visit the CMS website:
   a. **Eligible Professionals Stage 1:** http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf
   b. **Eligible Professionals Stage 2:** http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf
   c. **Eligible Hospitals Stage 1:** http://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf
   d. Eligible Hospitals Stage 2: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_M

eaningfulUseSpecSheet_TableContents_Eligible Hospitals_CAHs.pdf

5. **When eligible professionals work at more than one clinical site of practice, are they required to usedata from all sites of practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?**

I. CMS considers these two separate, but related issues.

a. **Meaningful use:** All eligible professional demonstrating meaningful use must have at least 50% of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with Certified EHR technology capable of meeting all the meaningful use objectives. Therefore, the Department of Human Services will collectinformation from all locations the provider practices that are equipped with Certified EHR technology to validate this requirement in an audit.

b. **Patient volume:** Eligible professionals may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all an eligible professional's sites of practice. However, at least one of the locations where the eligible professional is adopting or meaningfully using certified EHR technology should be included in the patient volume. In other words, if an eligible professional practice in two locations, one with certified EHR technologyand one without, the eligible professional should include the patient volume at least at the site that includes the certified EHR technology. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), a professional may calculate across all practice sites, or just at the one site.

6. **If an eligible professional (EP) is unable to meet the measure of a Meaningful Use objective because itis outside of the scope of his or her practice, will the EP be excluded from meeting the measure of thatobjective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?**

I. Some Meaningful Use objectives provide exclusions and others do not. Exclusions are available only when our regulations specifically provide for an exclusion. EPs may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet a Core Meaningful Use objective for which no exclusion is available, then that EP would not be able to successfully demonstrate Meaningful Use and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs. For Menu Meaningful Use objectives, providers must select one they can meet

and if they cannot meet the requirement then they can select an exclusion.

7. **Do specialty providers have to meet all the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs, or can they ignore the objectives that are not relevant to their scope of practice?**

   I. All eligible professionals (EPs) are required to attest to the minimum meaningful use (MU) measure requirements. Some MU measures do offer exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation. We encourage providers to review the CMS meaningful use specification sheets to determine which exclusions they may meet. Here is the link to the main CMS EHR Incentive program website.

8. **My practice does not typically collect information on any of the clinical quality measures (CQMs) listed in the Final Rule on the Medicaid Electronic Health Record (EHR) Incentive Program. Do I need to report on CQMs for which I do not have any data?**

   I. EPs are not excluded from reporting clinical quality measures, but zero is an acceptable value for the CQM denominator. If there were no patients who met the denominator population for a CQM, then the EP would report a zero for the denominator and a zero for the numerator. EPs are required to complete nine (9) of the 64 approved clinical quality measures and they must be from three (3) of the six (6) available National Quality Strategy (NQS) domains.

   II. Link to Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf

   III. Link to Final Rule published in September 2012: http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf

9. **For general requirement 1, "please demonstrate that at least 50% of all your encounters occur in a location(s) where certified EHR technology is being utilized," what information needs to be entered?**

   I. Any eligible professional demonstrating meaningful use must have at least 50% of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting all the meaningful use objectives.

   II. Numerator = number of encounters during the Meaningful Use (MU) reporting period that were at locations with CEHRT. Denominator = total number of encounters during the MU period from all service locations.

a. For example, if an EP has a total of 200 encounters between two locations and 98 of the encounters are at a location with a certified system and 102 encounters are with a non-certified system, then the numerator would be 98 and the denominator would be 200 which is only 49% so the EP would not meet the required 50% rule. However, if the EP had 102 encounters at a location with a certified system and 98 encounters with a non-certified system then the numerator would be 102, the denominator would still be 200, which is 51%, so the EP would meet this requirement.

10. For general requirement 2, "please demonstrate that at least 80% of all unique patients have their data in the certified EHR during the EHR reporting period," what information needs to be entered?

I. Pennsylvania's MA EHR incentive program gathers information about the percentage of unique patients having their data in the certified EHR during the EHR reporting period, to determine if the EP has reached an 80% threshold. This information helps the program understand more about the EP's MU attestation.

a. **Numerator** - unique patients during the reporting period seen by an EP that have their data in a certified EHR. If a patient is seen by an EP more than once during the reporting period, they can only be counted once.

b. **Denominator** - all unique patients seen by an EP during the reporting period (everyone, including paper record patients). If a patient is seen by an EP more than once during the reporting period, they can only be counted once.

i. For example, if an EP saw a total of 100 unique patients, 80 of those patients must have their data recorded in the certified EHR during the EHR reporting period.

c. This calculation is distinct from the 50% general requirement. This focuses on unique patients, their structured data entry and is related only to sites with CEHRT.

11. In Pennsylvania, how can eligible professionals and eligible hospitals meet the public health meaningful use requirements?

I. On our website, we have a spreadsheet that provides details about the various Department of Health registries. You can view this spreadsheet here.

II. Please take a look at CMS's FAQ.

12. If my certified EHR technology only includes the capability to submit information to an immunization registry using the HL7 2.3.1 standard but the immunization registry only accepts information formatted in the HL7 2.5.1 or some other standard, will I qualify for an exclusion because the immunization registry does not have the capacity to receive the information electronically? What if the immunization registry has a waiting list or is unable to test for other reasons but can accept information formatted in HL7 2.3.1, is that still a valid exclusion?

I. If the immunization registry does not accept information in the standard to which your EHR technology has been certified-that is, if your EHR is certified to the HL7 2.3.1 standard and the immunization registry only accepts HL7 2.5.1, or vice versa-and if the immunization registry is the only immunization registry to which you can submit such information, then you can claim an exclusion to this Meaningful Use objective because the immunization registry does not have the capacity to receive the information electronically. The capacity of the immunization registry is determined by the ability of the immunization registry to test with an individual EP or eligible hospital. An immunization registry may have the capacity to accept immunization data from another EP or hospital, but if for any reason (e.g. waiting list, on-boarding process, other requirements, etc.) the registry cannot test with a specific EP or hospital, that EP or hospital can exclude the objective. It is the responsibility of the EP or hospital to document the justification for their exclusion (including making clear that the immunization registry in question is the only one it can submit information to). If the immunization registry, due to State law or policy, would not accept immunization data from you (e.g., not a lifespan registry, etc.), you can also claim the exclusion for this objective. Please note, this FAQ applies in principle to all the Stage 1 public health meaningful use measures (syndromic surveillance and reportable lab conditions).

13. In Pennsylvania what versions of HL7 are the registries using?

I. On our website, we have a spreadsheet that provides details about the various registries and their requirements. You can view this spreadsheet here.

14. Are there restrictions on who can do CPOE based on State guidelines?

I. No there are not. An example as a reason why would be that CPOE is not only prescription writing, meaning it could be as simple as a nurse entering required data – i.e. medication to correct a patient problem. CPOE has a wide range of options and does not limit provider types in Pennsylvania.

pennsylvania
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Audit

1. How will Eligible Providers know if they are chosen for an audit?

I. If chosen for audit, Eligible Providers will receive an email from our audit team, RA-MAPIRaudit@pa.gov. The email will contain an explanation for the audit and instructions to follow.

2. How do you decide who will be audited?

I. When providers apply for the EHR incentive payment, their application is compared to other provider applications. Compiling results of all applications allows for a standard response to be benchmarked. Providers who are selected for audit are chosen when the provider has pieces of their application that fall outside of the attestation standards. Captured standard responses change from audit to audit, but program threshold minimums and provider types are always kept in mind when the applications are being reviewed.

3. What do Eligible Providers need to have available if audited?

I. If you are chosen for an audit, you will be notified, and additional details will be provided to you. As indicated at the time you received your incentive payment, we require you to keep all supporting documentation for 6 years. To ensure a smooth audit process, we recommend having dedicated staff members who have the knowledge and access to all supporting documents. This would include all login credentials as well as the knowledge of where in the system to access this information. The Audit Team has developed a Best Practices for Retaining Audit Documents guide to help in the case you are chosen for a post-payment audit.

4. What are the most common areas where EP's have difficulty supporting their attestations?

I. The three biggest are Core Measure 14 (eExchange), Core Measure 15 (Security Risk Assessment) and Menu Measure 9 and 10 (related). With Core Measure 14 and Menu Measures 9/10 be sure to include evidence that the recipient received the communication. A screenshot showing how the EHR initiates the exchange of data is not enough. (Insert links to examples).

II. It is suggested that providers keep an electronic copy of any tools/information/reports used to complete the MAPIR application in the event the provider is asked to support their attestation. This saves time and ensures accurate reports can be provided. Attaching reports and screenshots to the MAPIR Application (pdf only) at the time the application is submitted is encouraged.

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Error Messages in PROMISe™

1. MAPIR link cannot be seen in PROMISe™ account.

If you have registered at the R&A and you cannot see a link to MAPIR, then this could why:

I. Logged into PROMISe™ with the wrong Medical Assistance Identification Number. Must login into the individual provider's PROMISe™ account and not the group PROMISe™ account.
   a. The log on ID and password are linked to the providers 13 digit MAID number. The last 4 digits of the MAID number reference the service location. The fee assignment is linked to the service location; if you are logging in using the wrong service location you will not see the MAPIR link. Please note there is a separate login ID and password for each service location (service location is identified by the last 4 digits of the provider's Medical Assistance ID Number).

II. The provider's NPI number is not on file in PROMISe™.

III. The provider is enrolled in PROMISe™ under their FEIN instead of their SSN. In order to participate in the EHR incentive program in Pennsylvania, providers must enroll in Medical Assistance under their SSN.

IV. The provider is not an eligible provider type (i.e. chiropractors, optometrists, social workers, podiatrists, etc.).

V. If you need to create a PROMISe™ account for the provider, click here and select 'Register Now' in the box in the top left corner of the screen. If you try the first part of this response and you still do not see the link, please contact us via email, ra-mahealthit@pa.gov; be sure to include provider name, provider NPI and provider MAID.

2. "The designated payee for your HIT incentive payment is invalid in PROMISe™. For further information, please contact the Medical Assistance HIT Initiative Support Center."

I. This error is a result of information that is incorrectly matching up. The NPI and TIN used for the application at the CMS R&A are not properly linked and registered with the state. If you are receiving the message "The designated payee for your HIT incentive payment is invalid in PROMISe™" when attempting to access MAPIR, it could be due to one of the following scenarios:
   a. Information enter at the CMS R&A was incorrectly entered
   b. The payee is not enrolled in PROMISe™ at all (or has been end dated) and must complete an enrollment application in order to participate.
   c. The payee record in PROMISe™ does not have an NPI on file.
   d. Payee NPI and Payee TIN indicated at the CMS R&A Registration site does not match the provider's NPI and TIN (if payment is being assigned to the individual).

II. There is no fee assignment between the applicant and the designated payee in PROMISe™. It will be necessary to complete a fee assignment form with the professional's signature.

III. In order to pay to another entity (Group), a provider must have a contractual relationship with that entity and the provider must have an active service location that is linked to an active service location for that entity. In PROMISe™" this link is made via a fee assignment. There must be a fee assignment relationship between the EHR incentive applicant and the designated payee in PROMISe. If assigning payment to a group, the designated payee NPI must correspond to the Group NPI number for the Group MAID number in PROMISe to which the provider is fee assigned. To resolve this error, please contact us via email, ra-mahealthit@pa.gov; be sure to include provider name, provider NPI, provider MAID, payee NPI, payee MAID and that you are received the designated payee error.

3. When registering at the CMS R&A, a payee TIN Type needs to be selected and the options are as follows:

I. My Billing EIN
   a. **DO NOT** select this option. If the Option for My Billing EIN is selected, an error will occur when logging into the PROMISe Portal and you will have to log back into the CMS R&A change to Social Security Number or Group Fee Assignment.

II. SSN
   a. If paying to self, the SSN Option should be selected. The payee NPI must be the provider's NPI and the TIN should be the provider's social security number.

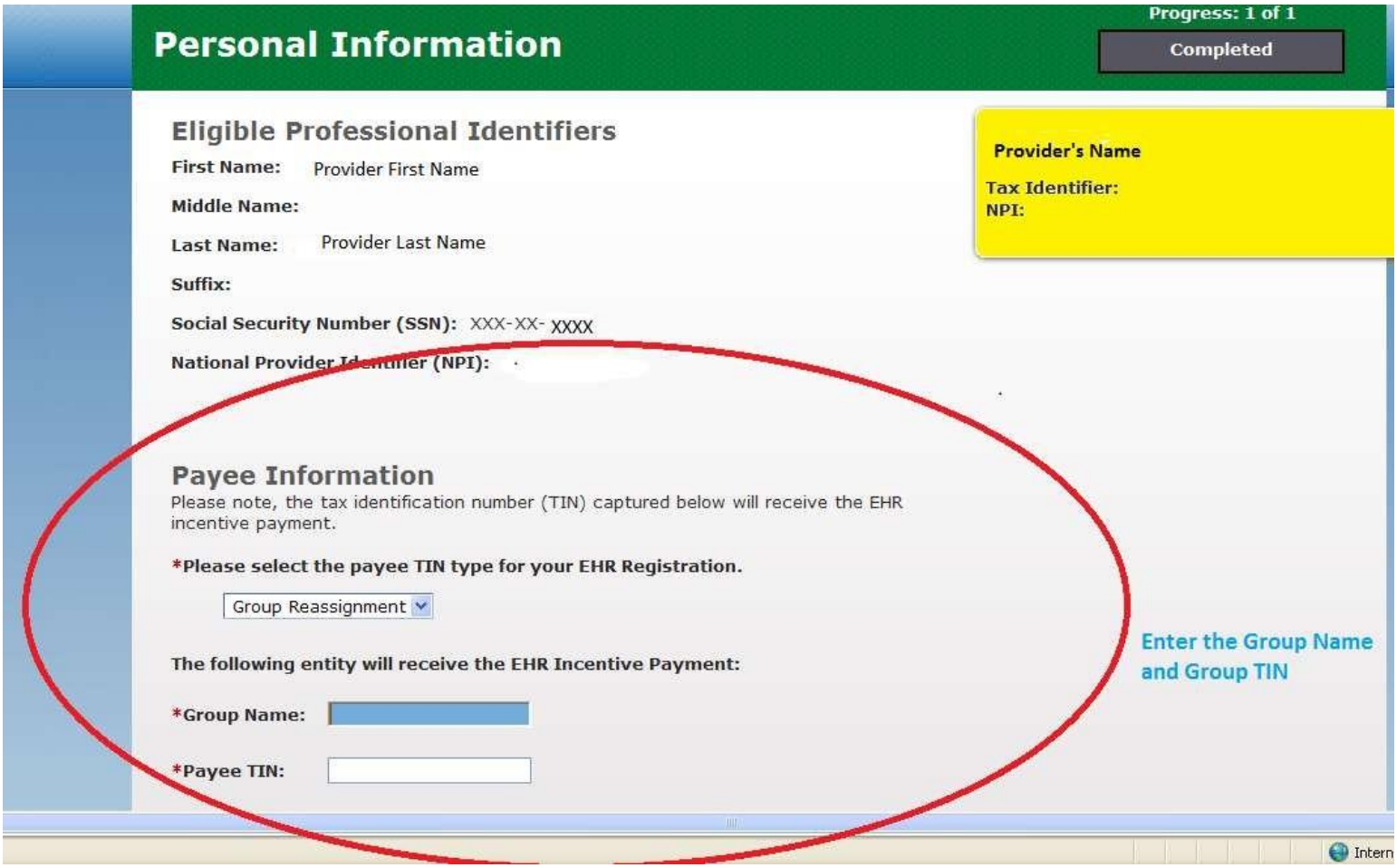
III. Group Reassignment
   a. If payment is being reassigned to another entity, the Group Reassignment option should be selected. You will need to enter the group NPI and the group EIN in the payee sections.

4. What is the process for an Eligible Professional (EP) to elect to have their incentive payment paid to another entity?

I. Go to Centers for Medicare and Medicaid Services (CMS) Registration and Attestation (R&A) website.

II. Log in to CMS and under the Registration tab choose to modify existing registration (as seen below). The reason for modifying the registration should be EHR Incentive Program.

III. Within the Payee Information screen under the Registration tab where it says Please select the payee TIN type foryour registration, select group reassignment (as shown below):



d. Enter the group's name in the Group Name field, the group's Tax Identification Number (TIN) in the Payee TIN field
and the group's NPI number in the Payee NPI field.
e. Save and submit the registration.
f. Wait 24 – 48 hours (after 10 AM) to try to login to the MAPIR application to ensure our system has received the
update. If you are still receiving the error, contact our support team at RA-mahealthit@pa.gov.

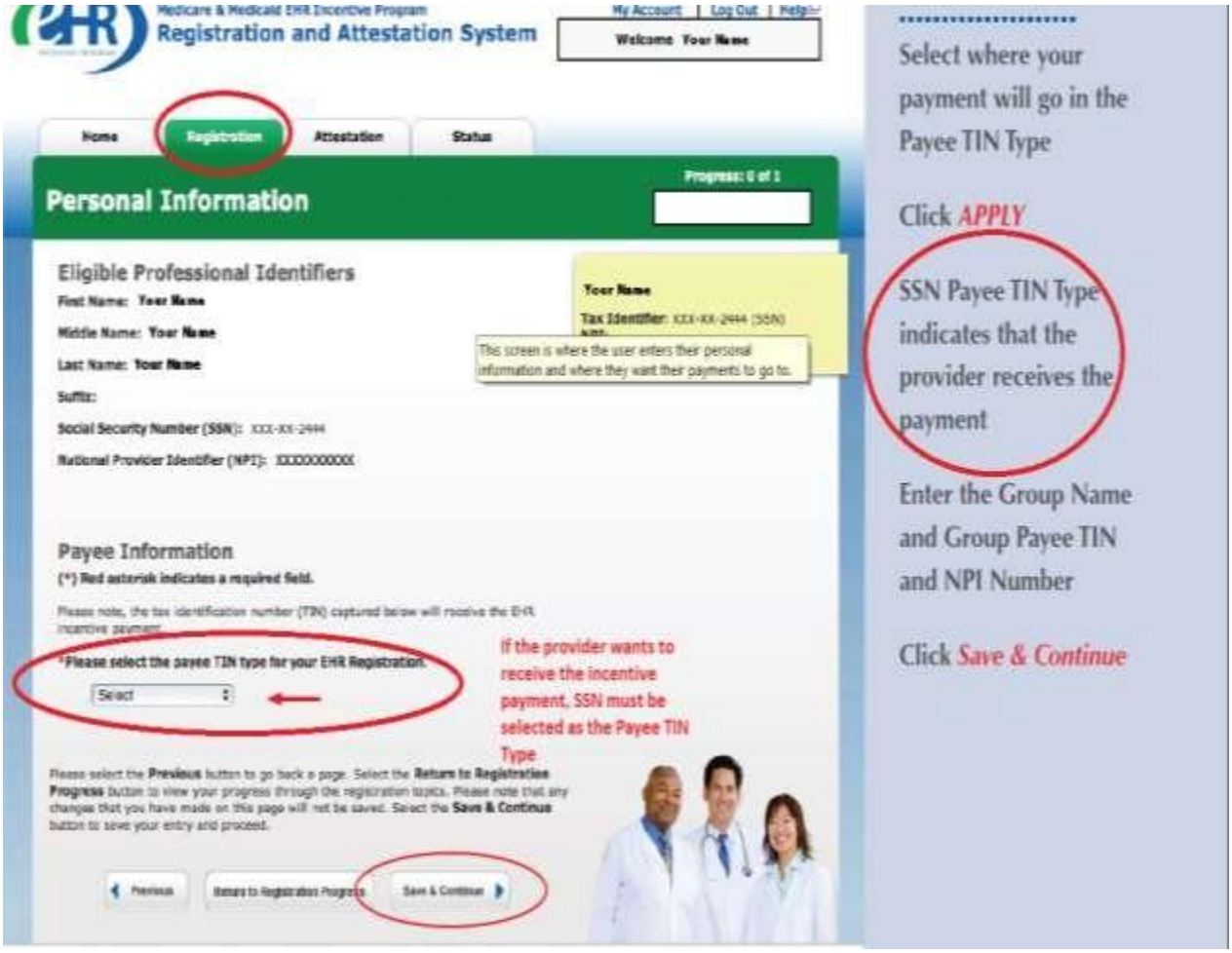
5. What is the process for an Eligible Professional (EP) to elect to have their incentive payment paid tothemselves?

I. When registering at the CMS R&A website, EPs need to select Social Security Number (SSN) as the payee type within the Payee Information screen under the Registration tab. If the EP enters his or her personal Tax Identification Number (TIN) instead of his or her SSN it will result in an error when trying to access the Medical Assistance Provider Incentive Repository

(MAPIR) application and the provider will not be able to complete the application. The EP will need to return to the CMS R&A website and change the payee information to his or her personal SSN in order to proceed with the MAPIR application.

II. Go to Centers for Medicare and Medicaid Services (CMS) Registration and Attestation (R&A) website.
    a. Log in to CMS and under the Registration tab choose to modify existing registration (as seen below). The reason formodifying the registration should be EHR Incentive Program:

Then under the registration tab under the Payee Information section where it says Please select the payee TIN type for your registration, you need to select SSN as the payee TIN type as seen below:



Save and submit the registration.

Wait 24 – 48 hours (after 10 AM) to try to login to the MAPIR application to ensure our system has received theupdate. If you are still receiving the error, contact our support team at RA-mahealthit@pa.gov.