What individual provider types are eligible for the Oklahoma EHR incentive program?

Eligible professionals under the Medicaid EHR Incentive Program include:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioner
- Certified nurse-midwife
- Dentist
- A physician assistant practicing in a Federally Qualified Health Center (FQHC) or a rural health clinic (RHC), that is so led by a physician assistant.

How does OHCA define "Pediatrics"?

Pediatrician means a Medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must (1) hold a four-year undergraduate college degree, (2) hold a four-year Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree, (3) have at least three years of residency training, (4) hold a valid, unrestricted medical license, ***and*** (4) hold a board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American State of Oklahoma Osteopathic Board of Pediatrics (AOBP).

What is meant by a PA-led clinic?

A Physician Assistant (PA) would be leading an FQHC or RHC under any of the following circumstances:

- A PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider);
- A PA is a clinical or medical director at a clinical site of practice; or
- A PA is an owner of an RHC.

Are residents eligible to participate in the EHR Incentive Program?

Yes, if the resident is a fully enrolled Medicaid provider. Only residents that have been issued a full license are eligible to enroll as a Oklahoma Medicaid provider.

How is hospital-based defined?

Hospital-Based means a professional furnishes ninety percent (90%) or more of their SoonerCare-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or Emergency Room, through the use of the facilities and equipment of the hospital; verified by MMIS claims analysis.

What if 90% or more of my professional services are in a hospital setting, but I am using my own EHR technology and not the hospital?

New for 2013 and beyond: EPs who can demonstrate that they have funded the acquisition, implementation, and maintenance of Certified EHR Technology, including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an eligible hospital or CAH; and uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT) may be eligible for the EHR Incentive Program.

Where can I find a list of certified EHR systems? What information do I need to have about my EHR system?

A list of certified EHR systems is available through Office of the National Coordinator for Health Information Technology at: http://onc-chpl.force.com/ehrcert

Once you select a certified EHR system, you will need the following to attest to OHCA:

- CMS Certification number
- Vendor name
- Product name
- Version

How do I register at the CMS EHR Incentive Registration and Attestation System? What information do I need to do so?

To register with the Center for Medicaid and Medicare Services (CMS) EHR Incentive Registration and Attestation System, visit the CMS EHR Incentive Program website: http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp#BOOKMARK1

In order to register you will be required to input name, individual NPI, contact information and the Tax Identification Number (TIN) of who will receive the incentive payment. Select Medicaid and then select Oklahoma as the state from which you wish to receive payment. Be sure to record your CMS registration number at the end of the national registration process. **Wait two business** days then return to this site to find rules and requirements to fill out your on-line attestation with Oklahoma.

Note: If you wish the payment to go to yourself, and your claims payments are paid to your group, please call the OHCA Provider Contracting Unit to verify we have your banking information on file. (800) 522-0114, option #5.

Who receives the 1099?

1) The recipients must include the incentive payments in gross income unless they receive the payments as a conduit or an agent of another and are thus unable to keep the payments.

(2) CMS/OHCA has a reporting requirement under section 6041 of the Internal Revenue Code with respect to the eligible providers.

(3) In the event of an assignment by the eligible providers to a third party, CMS/OHCA would be obligated to report a payment to the eligible provider, even if the payment is assigned to a third party. The eligible provider would then likely bear a reporting obligation with respect to the

assignment to a third party. CMS/OHCA would not have a reporting obligation with respect to the third-party assignee unless CMS/OHCA exercised managerial oversight with respect to, or had a significant economic interest in, the assignment.

How do I get my CMS registration number?

Once you have registered at the CMS EHR Incentive Program website above, at the end of this process you will be given a CMS registration number which will be required as part of the Oklahoma attestation.

Why do I have to enter my CMS certification number at the CMS registration site if it states that field is optional?

While it is true that at the CMS registration site it is optional to enter the CMS certification number, it is mandatory in order to complete the attestation process at the state level. Verification of the correct certification number will be part of the audit review.

How often do I need to go to the Medicare & Medicaid EHR Incentive Program Registration and Attestation System?

After initial sign up, you will only need to visit this site if you are:

- Updating your CMS certification number
- Updating your payee information
- Switching between the Medicaid/Medicare program (may only do this once)
- Switching your participating state

How can I obtain a forgotten user ID and PIN for the OHCA Secure Site?

You can contact 800-522-0114, option 2, then option 1 for the Internet Helpdesk and they should be able to assist you.

What are the patient volume requirements for this program?

To qualify for an incentive payment under the Medicaid EHR Incentive Program, an eligible professional must meet **one** of the following criteria:

- Have a minimum 30% Medicaid patient volume
- Have a minimum 20% Medicaid patient volume, and is a board-certified pediatrician
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals

What time period do I select for patient volume?

- Preceding Calendar Year
    - Must be a continuous 90 day period
- Preceding year from attestation MU period
    - Can’t use same dates as MU
    - Must be a continuous 90 day period

Can OHCA run a report for me to determine patient volume?

Unfortunately, OHCA does not have the resources to run individualized reports. An alternative is to use the OHCA Secure Site to meet your needs. By using the Claim Inquiry screen, you can select your 90-day period, your claim status and claim type to run a query. You will need to count the number of claims on each screen to come up with your total. Please note this is not an exact count, as it queries all and does not remove duplicates, adjusted or recouped claims.

What is the definition of an encounter?

A SoonerCare encounter is now defined as any service rendered to a Medicaid patient on any one day regardless of payment liability (I.E. paid, denied, non-covered, etc. For audit purposes, you must prove an encounter occurred.)

What is meant by needy volume and can I include these individuals in my volume?

Only providers participating in an FQHC or RHC at least 50% of the time can include needy individuals in their volume calculation. Needy individuals are defined as those that:

- Received medical assistance from Medicaid or the Children's Health Insurance Program (CHIP) (or a Medicaid or CHIP demonstration projected approved under section 1115 of the Act).
- Were furnished uncompensated care by the provider.
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual' ability to pay.

Can I use my group's patient volume?

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

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

What is an acceptable form of verification of adopting/implementing/upgrading to a certified EHR system?

- A letter on vendor letterhead or an email with vendor log to include the following:
    - Provider name and point of contact
    - Vendor name and point of contact

- Certified system name, version and ONC certification number
- CMS EHR Certification ID

(Please note a vendor letter does not constitute a legal or financial obligation to an EHR vendor, but will provide the sufficient information needed to proceed with A/I/U. In the event a vendor letter cannot be provided, EPs/EHs will be required to submit a document supporting a legal or financial obligation with an EHR vendor providing a certified EHR system along with the information requested in the vendor letter.)

Is there a deadline to participate?

Yes/No, while you are not required to start your attestation consecutively until year 2016, you will need to complete it consecutively starting with 2016 in order to obtain the complete incentive, as the program sunsets in 2021.

Is there a deadline for the reporting attestation year?

Yes, there is a deadline closing period for each calendar year. You must have started your attestation for the reporting year no later than 90 days following the calendar year. (Example: For calendar year 2013, you have until March 31st 2014 to complete your attestation. Remember your patient volume will always be prior to your attestation reporting period.)

Will I be penalized for not participating in the Medicaid incentive program?

No, participation is voluntary. Medicaid reimbursements will not be affected if you choose not to participate.

Will I be penalized for not participating in the Medicare incentive program?

You may participate in either the Medicaid or Medicare incentive programs and must demonstrate meaningful use prior to 2015 in order to avoid a reduction in Medicare reimbursement. For detailed information on how the penalty will be determined and applied, visit http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html .

Can I switch between the Medicare and Medicaid incentive programs?

Yes, but you are limited to one change and for a payment year before 2015. The switch is only counted if it occurs AFTER an initial payment from either program. If you are SWITCHING from participating in the Medicare Program to the Medicaid Incentive Program, you must attest to the full calendar year of meaningful use for your initial Medicaid program payment. Once a provider has attested to 90 days of Meaningful Use (as was required for the initial Medicare payment), the next required reporting period will be 365 days regardless of the program in which you are participating. The only exception is for Program Year 2014 during which time all providers, regardless of stage will only be required to have a 90-day reporting period.

The total amount of payments you could receive from a combination of programs will not exceed the Medicaid program maximum amount of $63,750.

Is there a deadline for the reporting attestation year?

Yes, there is a deadline closing period for each calendar year. You must have started your attestation for the reporting year no later than 90 days following the calendar year. (Example: For calendar year 2013, you have until March 31st 2014 to complete your attestation. Remember your patient volume will always be prior to your attestation reporting period.)

Can I use group numbers in proving Meaningful Use?

No, Meaningful Use is based on the individual provider. It is important that each practitioner access the certified EHR under their own log-in information so that the EHR system can capture the necessary information for demonstrating Meaningful Use for each individual provider. Group measure information or measure information specific to another practitioner is NOT ACCEPTABLE in attesting to Meaningful Use.

I have a new Professional in my group, how can I find out if they are participating in this program?

- Log into the Medicare & Medicaid EHR Incentive Program Registration and Attestation System to verify registration; OR
- Log into the OHCA Secure site to view EHR history

My new Professional's Payee information belongs to their old group, where do I update this information?

- Log into the Medicare & Medicaid EHR Incentive Program Registration and Attestation System to verify registration
- Update any necessary information, including Payee and CMS certification number
- Submit the changes to CMS; wait 2 business days for information to be update at OHCA.

How do I find my payment?

The EHR Incentive payment will be reflected in your weekly remittance advice. You may locate this payment at the end of the remittance advice as a non-claim specific payout to provider.

Are there any changes to Stage 1 Meaningful Use with the 2013 updates?

Yes. Changes to the Stage 1 Meaningful Use Measures are as follows:

- CPOE Entered by CMAs: A credentialed medical assistant (CMA) is now considered a "licensed health care professional" for purposes of computerized provider order entry (CPOE). The CMA must still adhere to State, local and professional guidelines for order entry. The CMA's credentialing must have been obtained from an organization other than the "employing organization."
- Alternative Measure for CPOE: More than 30% of the medication orders created by the provider during the EHR period are recorded using CPOE.
- New exclusion for Generate & Transmit eRX: If no pharmacy within organization and no pharmacy within 10 miles who accept electronic submissions.

- Alternative Measure for Vital Signs: More than 50% of all unique patients seen by the provider during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data.
- New Exclusion for Vital Signs: Any provider who (1) sees no patients 3 years or older is excluded from recording blood pressure; (2) Believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them; (3) Believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure; (4) Believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.
- Removal of electronic transmission of key clinical information requirement.
- The reporting of Clinical Quality Measures is no longer a Core measure, but is now part of the definition of Meaningful Use.

What will be required to provide if I am selected for an audit?

OHCA will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of our current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Be sure to keep supporting documentation as an auditable data source for any reports used for the incentive program. (317:30-3-15 Record Retention) It is encouraged to keep a file for each provider that contains a printed form all supporting documentation.

How long should I keep records supporting my EHR program attestation?

All documentation supporting the program should kept in accordance with OHCA policy 317:30-3-15. This will include any back up information compiled as well as copies of any documentation actually supplied with the program itself. Providers are encouraged to keep documentation supporting all numbers reported and for each specific measure, including yes/no measures. It is important to also maintain documentation supporting your patient volume calculation.

What is recommended to prove that my office has complied with Core Measure – Privacy and Security Assessment?

It is the responsibility of the provider to determine if they have met the requirements of 45 CFR 164.308 (a)(1) and correctly identified security deficiencies as part of its risk management process. OHCA requests that you provide the identification of the person completing the assessment and the date complete. The assessment has to be completed and identified deficiencies corrected (or a plan of correction in progress) prior to the end of the EHR reporting period. The assessment could have occurred prior to the beginning of the reporting period; however, a new review will have to be conducted for each subsequent reporting period.