



Frequently Asked Questions

Florida Medicaid Promoting Interoperability Program

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Version 9

**For additional assistance, please contact the Florida EHR
Incentive Program Call Center at
(855) 231-5472 or email MedicaidHIT@ahca.myflorida.com.**

**For questions about Eligible Hospital participation, please contact Jaime Bustos at
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Disclaimer: The Agency for Health Care Administration is providing this material as an informational reference for participants in the EHR Incentive Program. Although every reasonable effort has been made to assure the accuracy of the information at the time of posting, the EHR Incentive program is constantly changing, and it is the responsibility of participants to remain abreast of EHR Incentive program requirements.

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Part 1: OVERVIEW

1. What is the Florida Medicaid Electronic Health Record (EHR) Incentive Program?

The Florida Medicaid EHR Incentive Program provides incentive payments to Eligible Professionals (EPs) and Eligible Hospitals (EHs) as they Adopt, Implement, or Upgrade (AIU), and demonstrate Meaningful Use (MU) of Certified Electronic Health Record Technology (CEHRT). EPs can participate in the program for up to six years and EHs have three years of participation. EPs are not required to participate in consecutive years and there is no Medicaid financial penalty for providers that choose not to complete the entirety of the program. The program was launched on September 5, 2011 and is scheduled to continue through 2021.

Beginning with the 2016 program year, EHs with participation years remaining must receive an incentive payment for the 2016 program year and must receive payment in consecutive years as applicable.

In Florida, the Agency for Health Care Administration (Agency) is administering the Medicaid EHR Incentive Program in accordance with the federal government guidelines. The program is funded through the provisions in the American Recovery and Reinvestment Act (ARRA), in a section known as the Health Information Technology for Economic and Clinical Health (HITECH) Act. Provider payments are funded 100 percent by federal funds.

The goal of the program is to promote the adoption and meaningful use of CEHRT by providers. This activity is a building block to the larger vision of Health Information Technology (Health IT) as a platform that serves to improve communication between patient and provider, empower patients to be more involved in their healthcare choices, improve quality and safety by a reduction in errors, and promote cost-containment through improved coordination.

The last year for EPs and EHs to begin participating in the EHR Incentive Program was 2016.

2. What is the Promoting Interoperability Program and how does it affect the Florida Medicaid EHR Incentive Program? Updated

The Centers for Medicare and Medicaid Services (CMS) renamed the Medicare and Medicaid EHR Incentive Programs to the Medicare and Medicaid Promoting Interoperability (PI) Program for eligible hospitals, critical access hospitals, and Medicaid providers.

CMS also renamed the Merit-based Incentive Payment System (MIPS) Advancing Care information performance category to the Promoting Interoperability performance category for MIPS-eligible clinicians. This rebranding does not merge or combine the EHR Incentive Programs and MIPS.

The goal of these changes is to continue the CMS focus on improving patients' access to health information and reducing the time and cost required of providers to comply with program requirements.

The Promoting Interoperability Program is the same as the Medicaid EHR Incentive Program.

3. What do the timeframe terms mean?

- **Payment Year** refers to the year of EP or EH program participation (e.g. Year 1).
- **Program Year** refers to the calendar year of program participation (e.g. 2018, 2019, etc.).
- **Volume Reporting Period** refers to the consecutive, 90-day period used to meet Medicaid patient volume requirements.

- **EHR Reporting Period** (also known as the MU reporting period) refers to the period of time that the EP or EH is documenting actual use of CEHRT and meeting specified measures and thresholds.

4. What are the Stages of Meaningful Use (MU)?

For Program Year 2018, all providers have a minimum 90-day EHR reporting period and will continue to have the option to attest to the Modified Stage 2 objectives and measures or Stage 3 objectives and measures dependent on their system technology. Note: For Program Year 2018, the CQM reporting period is a full year (365 days) for all EPs except for EPs attesting to MU for the first time.

For Program Years 2019 and 2020, the EHR reporting period will also be a minimum 90-day reporting period. The CQM reporting periods will not change.

[Part Four](#) of this document contains details on Meaningful Use requirements, measures, and thresholds.

5. Can someone attest on my behalf?

Providers and hospitals that allow someone to attest on their behalf must establish the relationship on the Centers for Medicare and Medicaid Services (CMS) registration and attestation system ([EHR Incentive Program Registration site](#)). The creation of the federal-level relationship will allow a user to access and manage the registration on behalf of a provider or hospital.

The state application is available via the provider's individual Medicaid provider portal. A provider must authorize a user to be their Account Administrator within the Medicaid provider portal. To establish this relationship, contact the EHR Incentive Program Call Center at (855) 231-5472. The preparer should indicate their relationship with the provider on MAPIR (the online state application) under the *Submit* tab.

6. How long should I keep records supporting my EHR program applications?

All documentation supporting the application should be kept for a period of six years from the date of the incentive payment. This includes back-up information submitted with the application. Providers are encouraged to keep extensive documentation to support measures, including numerical data and support for yes/no measures. For example, a screenshot of a patient which triggered a drug-drug interaction can document compliance with this measure. Summaries as well as detailed information on patient counts should be included in maintained documentation. It is further recommended that documentation be maintained in a central location that is accessible by more than one staff person to alleviate issues with access at the time of audit.

Documentation recommendations include:

- Detailed volume reports with patient name, date of birth, date of service, rendering provider, and payer. It is recommended that volume documentation be maintained in an EXCEL format.
- Paper or electronic copies of all reports.
- Screen shots supporting all measures, with dates.
 - It is recommended that screen shots are taken throughout the EHR reporting period to satisfy the requirement that the functionality is in effect during the entire reporting period.
- Details on the Security Risk Assessment (SRA) or review including an asset inventory— any documentation that may not be part of the final report.
- If you rely on an FAQ interpreting how you met a meaningful use measure, keep a copy of the FAQ with the effective date of the FAQ or the date you referenced the FAQ.

- Detailed reasoning for claiming an exclusion.

7. What, if any, types of audits will be conducted on incentive payments received?

The Agency is required to perform provider audits to ensure that incentive payments were made to EPs that met all program requirements. The Agency has contracted with KPMG LLP (KPMG), a public accounting and auditing firm, to conduct these post-payment audits. Providers will initially be notified by the Agency of their selection for audit. Within one week, KPMG will contact the provider directly with a list of requested documentation and information on how to submit documentation.

The documentation requested will vary based on the type of the audit. If the payment was received for adopt, implement, or upgrade (AIU), documentation requested may include detailed patient-level volume reports, the employment contract (if payment was assigned to a group), and additional supporting documentation of the certified EHR system. MU audits will focus more on the actual measures, but will also include volume, employment status, and system capabilities.

If selected for an audit, providers must respond within the time periods specified. Failure to provide documentation by the deadline will result in notification from the Agency that if documents are not provided in 30 days, it will be assumed that the provider does not qualify for the payment and Medicaid Program Integrity will be notified to begin recoupment.

Subsequent incentive program applications from the provider, and/or any member of the group with whom the provider is associated, will be held until audit disposition is complete with no findings requiring recoupment of the payment.

In addition to audits conducted on behalf of the Agency, the Florida Auditor General, the Centers for Medicare and Medicaid Services (CMS), and the Federal Office of the Inspector General (OIG) may conduct audits of EHR incentive payments.

8. What documentation should be included with my application?

The documents listed below must be uploaded as part of the application process. Providers should maintain complete documentation of any reports, screen shots, and policy clarifications used to support the application.

- Uploaded documents must be in PDF format and can be uploaded while the application is in either *Incomplete* or *Submitted* status.
- Large and/or numerous documents can also be “zipped” and uploaded.
- If the application is submitted without any documentation attached, an error message will appear reminding you that documents must be attached. The error message just validates that documentation has not been attached. There is no validation on the type of documents.

Documents should be clearly labeled so a processor will know what it contains. For example, do not use doc 1, doc 2, etc. Titles should be specific such as volume report, security risk analysis, etc.

Required Documentation

- Copy of the Practice Management Report supporting your volume.
- Copy of the encounter report supporting the denominator (total encounters) for General Requirement 1 (50% of all encounters during the EHR reporting period were at locations with CEHRT).
- Documentation from your EHR vendor stating the date you installed the 2014 or 2015 edition CEHRT.

- MU Measure Report for the EHR reporting period including all measures and Clinical Quality Measure (CQM) information.
- Documentation from Florida SHOTS, if not excluding because you provided no immunizations.
- If attesting to active engagement with a Specialized Registry, documentation from the registry regarding status.
 - If excluding from a Specialized Registry, a signed letter from the provider supporting that they meet the exclusion criteria.
- Copy of completed Security Risk Assessment (SRA) or review.

Note: If MU information is pulled from different systems for the EHR reporting period, then reports from all systems used must be uploaded.

AS APPLICABLE

- Additional Documentation Form if practicing at multiple locations.
- Physician Assistant (PA) Led Attestation Form.
- Advanced Registered Nurse Practitioners (ARNPs) or PAs billing under a supervising physician must include a copy of a medical record supporting your provision of a Medicaid service.

9. What will be the grace period for Program Year 2018 applications?

For Program Year 18 the CMS approved grace period extends through April 1, 2019. The grace period is only for attestations. Applicants must have completed program requirements by the end of the program year.

10. Are extensions to the CMS-approved 90-day grace period available?

There are no additional extensions available. The purpose of the CMS-approved, 90-day grace period following the end of the program year is to allow Eligible Professionals and Hospitals time to gather their meaningful use documentation and resolve any issues that may affect their ability to participate. This includes issues with Medicaid IDs, Medicaid Web Portal access, etc.

We always advise that Eligible Professionals and Hospitals submit their applications as soon as possible and not wait until the deadline to submit their applications. This allows sufficient time for any issues to be addressed.

11. I cannot access my Medicaid provider portal account – what should I do?

It is recommended that web portals be accessed routinely. All web portal accounts not logged into for 120 days or more will be locked due to inactivity. Agent accounts (those that can access the Medicaid provider portal on behalf of the provider) which have been locked for more than 120 days will be terminated resulting in the deletion of that account. A deleted account cannot be restored so a new account will have to be created and associated to any pre-existing applications.

If you have issues logging into your Medicaid provider portal account, please contact Provider Services at (800) 289-7799. It may take a few weeks for you to regain access.

The instructions below detail the steps you need to follow to complete reactivation of a locked account. Reactivation procedures include:

1. Enter the username in the Username field on the login page of the secure portal (<http://home.flmmis.com>).

2. Click on "Forgot your password?"
3. Re-enter the "username" and "email" associated with the account. You must use the email account that was used to register for your account or you will receive an error message.
4. A "PASSWORD RESET" email will be sent.
5. Click on the link and answer the security question that was created when the account was initially established.
6. Once the security question is successfully answered, you can create a new password and access your secure portal account.

If a different person will be completing the state online application (MAPIR) than in previous program years, the User ID attached to the MAPIR application may need to be changed. After the preparer gains access to the secure Medicaid Portal, if the EHR Incentive link is not present, a Username Reassignment may need to be completed. Please contact the EHR Program Call Center at (855) 231-5472 for assistance with updating the User ID.

12. Can I participate in both the Medicaid Meaningful Use program and the Quality Payment Program?

Yes. In order to participate, you do have to report to each program individually.

Part 2: ELIGIBILITY – Eligible Professionals (EPs)

1. Who is eligible for the Medicaid Electronic Health Record (EHR) Incentive Program?

- Non-hospital-based physicians
- Dentists
- Advanced Registered Nurse Practitioners (ARNP)
- Certified nurse midwives
- Physician assistants – must be working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) and that clinic is led by a physician assistant.

In order to participate, a provider must have had at least one EHR incentive payment for, or prior to, Program Year 2016.

2. How is “hospital based” status determined?

- Hospital based is defined as 90 percent or more of encounters occurring in an inpatient or emergency room setting (place of service 21 or 23).
- Processing staff validate non-hospital based using Medicaid encounters from the calendar year prior to the program year. If 90 percent or more of the provider’s Medicaid encounters were at place of service 21 or 23, the previous federal and state fiscal years are reviewed, in an attempt to qualify the provider.
- If 90 percent or more of the EP’s Medicaid encounters are hospital based, but their total encounters are less than 90 percent in hospital or emergency room locations, the provider can meet this requirement by uploading documentation from the practice management system of encounters by place of service. The time period for the report should be the calendar year prior to the program year.

PATIENT VOLUME

1. What is the Medicaid patient volume requirement?

| Eligible Professionals* | Medicaid Patient Volume Over 90-Day Period |
|---|--|
| Physician (MD, DO) | 30% Medicaid |
| Dentist | 30% Medicaid |
| Certified Nurse Midwife | 30% Medicaid |
| Nurse Practitioner | 30% Medicaid |
| Physician Assistant (PA) in a RHC or FQHC led by PA | 30% Medicaid |
| Pediatrician** | 20% Medicaid |

**Eligible professionals practicing at least 50 percent of the time in a rural health clinic (RHC) or federally qualified health center (FQHC) can count “needy individuals” when determining patient volume.*

*** Pediatricians who qualify with a 20 percent Medicaid patient volume receive two-thirds of the maximum incentive payment, totaling \$42,500.*

Providers must meet the volume requirement for each payment year. Volume percentages can be rounded up based on standard rounding, e.g. 29.6 percent could be rounded up to 30 percent.

2. What can I use to determine my Medicaid volume?

Patient volume is based on encounters. An encounter is defined as services provided to an individual on a single day. A patient should not be counted more than once per day; however, the patient should be counted more than once if the additional encounter(s) occurred on a different date of service within the volume period. The denominator is total encounters (Medicaid, commercial, or self-pay), regardless of whether the encounter is billed or paid.

- Medicaid encounters are defined as services rendered on any one day to an individual enrolled in a Medicaid program. It is not required that the encounter be paid in order to include it in Medicaid volume determination. This includes:
 - Services to Medicare/Medicaid dually eligible individuals;
 - Services to Medicaid recipients with primary third-party payers such as workers' compensation, travel insurance, etc.;
 - Services rendered to a Medicaid patient but not billed;
 - Services denied, unless the denial reason is that the individual was not enrolled in Medicaid on the date of service; and
 - Persons enrolled in Medicaid managed care plans e.g. Amerigroup, Humana, etc., and Medicaid Provider Service Networks.
- Volume is calculated by dividing Medicaid encounters by the total number of encounters.
- Services rendered to an individual should only be counted once per day to meet the CMS definition of an "encounter." *This can be done by removing duplicates based on patient ID and date of service.*
- At least one clinical location used in the calculation of patient volume must have Certified EHR Technology (CEHRT).
- Providers have the option to determine volume based on a continuous 90-day period in the calendar year prior to the program year or a continuous 90-day period in the 12 months prior to the application submit date. The 90-day period can span calendar years when using a 90-day period in the 12 months prior to the application submit date. The option for the 12 months prior to the application date is a rolling period of time that changes each day.

3. How is volume determined – individually or based on my group?

If you are an individual practitioner, you calculate the percentage of total individual Medicaid encounters over total individual practice encounters.

$$\frac{\text{Total Individual Medicaid Encounters}}{\text{Total Individual Practice Encounters}}$$

If you are a member of a group practice, you have two options:

Option One: All members of the group will use group Medicaid volume – this is also known as group proxy.

$$\frac{\text{Total Group Medicaid Encounters}}{\text{Total Group Encounters}}$$

Option Two: All members of the group will use their individual Medicaid encounters from the group (use individual formula).

Pediatricians can choose to qualify with 20 – 29 percent Medicaid volume in any of these examples, but will only receive two-thirds of the maximum payment.

4. How is volume validated?

EPs are required to upload a copy of their Practice Management System (PMS) or other billing system report that indicates the number of encounters by payer as well as totals for all payers. This report should delineate the individual provider of service if using individual volume. The reported volume, as well as the information from the PMS report, is validated against data in the Medicaid system.

Please note that the PMS or billing system is often a separate system from the EHR and that is acceptable. Also, if a practice does not have a billing system that can generate the volume numbers, this documentation can be provided through the manual creation of a report. If you have a question about how these numbers are obtained for your practice, please contact the EHR Call Center at (855) 231-5472 for further clarification.

5. What is meant by “needy volume” and can I include these individuals in my volume?

Only providers practicing in a Federally Qualified Health Center (FQHC) or federally designated Rural Health Clinic (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 project 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 individuals' ability to pay

6. Can Healthy Kids or MediKids be included in patient volume?

Healthy Kids and MediKids are eligibility groups under the Child Health Insurance Program (CHIP). Unless the provider is practicing predominantly in an FQHC or RHC and can include needy individuals, encounters for Healthy Kids or MediKids do not qualify as Medicaid encounters. CHIP is funded under Title XXI, not Medicaid Title XIX. Although claims for MediKids are billed to Medicaid for adjudication, they are not paid for by Medicaid funds.

7. Can I use the same volume period for different Program Year applications?

No. Each program year requires meeting the volume using a completely different period of time. MAPIR has been programmed to prevent a provider from selecting volume dates that overlap a volume period the same provider previously used.

GROUP PRACTICE/VOLUME

1. What is the definition of a group?

A basic definition of group is “how the provider bills Medicaid for services”. In most instances, this will be the Medicaid Group ID. This definition is not intended to be limiting; therefore, providers will have the option of requesting an exception to define their group within the following parameters:

- There must be an established relationship to the group within the Florida Medicaid Management Information System (FMMIS) (provider file);
- The documentation of the parameters of the group must be auditable; and
- The Medicaid IDs that comprise the group must have a common Tax ID; or common National Provider Identification (NPI); or common seven-digit base Medicaid ID.

2. What encounters should be included in the group volume calculation?

All encounters during the 90-day volume-reporting period should be included in your group calculation, including encounters for providers who are no longer associated with the group, providers who will not be applying for a Medicaid incentive payment, and encounters that occurred at locations other than the office. Group volume (also known as group proxy) is determined by how you bill for Medicaid services. For example:

Scenario A: All providers and locations associated with the Group bill for Medicaid services under ONE Medicaid number.

Group Volume: All encounters across all locations and among all providers would be included.

Scenario B: The group has more than one location and each location has its own Tax ID number. All providers within a location bill for Medicaid services under a Medicaid number that is specific to that location.

Group Volume: Only encounters associated with that location would be included. This is true even if the individual locations pay to one group NPI.

Scenario C: The group has more than one location. Each location has the same Tax ID. Each location has a different Medicaid ID, group NPI, and seven-digit base Medicaid ID.

Group Volume: Options include:

- Each location is considered a group OR
- The group is defined as all locations together

If one provider in the group uses group volume, all providers in the group are required to use the group volume UNLESS an individual provider is applying using their volume from a different location *not* affiliated with the group. In this case, the individual provider would not be able to use encounters associated with the group.

3. What conditions must be met to use group volume?

To use group volume, the group must meet the following conditions:

- 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 group's patient volume determination;
- The EP in the group decide to use one methodology in each payment year (in other words, groups could not have some of the EPs using their individual patient volume for patients seen with the group, while others use the group-level data);
- The group must use the entire practice's patient volume and not limit it in any way;
- The EP using group volume must have had at least one Medicaid encounter between the start of the 90-day volume period and the date of attestation; it is no longer required that the encounter be paid;
- The group must be recognized as a group within the Medicaid system and must be following group billing practices during the volume-reporting period; and
- All providers applying must be a member of at least one of the group Medicaid IDs used for volume.

PROVIDER TYPES

1. How does Florida define *pediatrician* for purposes of the EHR Incentive Program?

Pediatricians are physicians with a specialty in pediatrics. Physicians declare their specialty when they enroll in the Florida Medicaid program. Pediatricians may be eligible for incentive payments if their Medicaid volume is between 20 and 29 percent of their total volume. Pediatricians attesting with 30 percent Medicaid receive the full payment.

To be eligible for an incentive payment as a pediatrician with Medicaid volume between 20 and 29 percent, physicians must have the Specialty Code "035", which specifies "Pediatrics", on their Medicaid provider file. A physician may also have other specialty codes. Attestation to the specialty type must be submitted to the Medicaid fiscal agent *before* the EP applies to participate in the EHR Incentive Program.

Please note, if you are a pediatrician attesting to 20 to 29 percent Medicaid volume, make sure you select pediatrician for your provider type in MAPIR. Selecting physician and reporting volume under 30 percent will cause your application to be auto-denied.

2. Can a pediatric nurse practitioner or physician assistant qualify for the program with 20-29 percent Medicaid volume?

No. Only physician providers with a pediatric specialty can qualify with the lower volume.

3. As an ARNP, the majority of my services are billed using the supervising physician's billing information. Can I apply for a payment?

Yes, ARNPs are defined as EPs for the EHR Incentive Program and can receive an incentive payment. ARNPs can apply using group volume, their individual Medicaid volume from the group, or their supervising physician's individual volume from the group for services the ARNP rendered.

USING INDIVIDUAL VOLUME:

The application must contain the practice management system (PMS) or billing report indicating the volume attributable to the applicant ARNP.

USING GROUP VOLUME:

When an ARNP is using group volume, there must be at least one encounter with a Medicaid eligible recipient between the start of the 90-day volume reporting period and date of attestation/application.

USING SUPERVISING PHYSICIAN VOLUME:

- A. The volume reporting period for the ARNP must be distinctly different from the volume reporting period for the supervising physician when using individual volume as well as any other ARNP that may be using the supervising physician volume. For example, if a physician supervises ARNP A and ARNP B, there must be a distinct 90-day period for the physician, a distinct 90-day period for ARNP A, and a distinct 90-day period for ARNP B.
- B. The PMS or billing report must include encounters for the applicant ARNP, the supervising physician, and all other ARNPs under that physician's supervision.
- C. The application must also contain documentation of one Medicaid encounter as evidenced by a medical record. The medical record must contain: name and Medicaid number of the recipient; the date of service; the services rendered; the location of the services being rendered; and the signature of both the ARNP and supervising physician.

4. 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:

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

PAs completing applications will be asked to complete the “Attestation for Physician Assistant Led” form available on the EHR Incentive Program Website. This form will delineate how the PA meets the definition of practicing in a PA-led clinic. The form can be found at [PA Led Attestation Form](#).

As part of the prepayment validation process, claims history is reviewed as well as information contained on the Medicaid provider file. In order to be considered PA led, the number of encounters with the PA as the rendering provider should greatly exceed the number of encounters with the physician and any other providers as the rendering provider.

5. Are Optometrists eligible to participate?

No. The federal rule for the Medicaid EHR Incentive Program limits payments to doctors of medicine and osteopathy. Optometric services are not considered physician services under Florida statute or in the Florida Medicaid state plan; therefore, this provider type is not eligible for the program. Doctors of Optometry can qualify for participation in the Medicare Incentive Program.

6. Are residents eligible to participate in the Medicaid 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 Florida Medicaid provider.

7. What does it mean to be a “fully enrolled” Medicaid provider?

“Fully enrolled” is a term used for providers who participate in Medicaid either as a fee-for-service provider or member of a fee-for-service group. If Medicaid has paid you directly for a fee-for-service claim, you are fully enrolled. If you are part of a Medicaid health plan network, you may be registered with Medicaid as a treating provider, but not fully enrolled in Medicaid. With the move to managed care, providers and practices may not have any fee-for-service encounters. You must be fully enrolled in the Florida Medicaid program to participate in the Medicaid Promoting Interoperability Program. If your Medicaid provider number is terminated for not re-enrolling, you will have to reapply and have the new Medicaid number activated, or you won’t be able to access the MAPIR application.

Providers can fully enroll in the Florida Medicaid program using the online Enrollment Wizard, downloading the Provider Enrollment Application from the Internet, or requesting an application using the phone number provided below. Once submitted, the completed application and all applicable forms will be reviewed for accuracy. Upon completion of the enrollment process, approved providers are issued a nine-digit Medicaid provider number and a PIN. Please see *“Guide for Completing a Medicaid Provider Enrollment Application”* located at <http://www.mymedicaid-florida.com> under Public Information for Providers, select Enrollment, or call (800) 289-7799, Option 4, for a complete list of required enrollment documentation.

Part 3: ELECTRONIC HEALTH RECORD (EHR) SYSTEMS

1. How can it be determined whether an EHR is certified?

Providers must have access to or be using Certified Electronic Health Record Technology (CEHRT) as one condition of eligibility for the EHR Incentive Program. The Office of the National Coordinator (ONC) has established an Authorized Testing and Certification Body (ONC-ATCB) to review and certify systems. The Certified Health IT Product List is available at [Certified Health IT Product List \(CHPL\)](#).

The certification number from the CHPL is required for the online application. For Program Year 2018, providers must be using 2014 CEHRT or a combo of 2014 and 2015 CEHRT. Providers that have technology certified to a combination of the 2015 Edition and 2014 Edition may attest to the Stage 3 requirements if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. However, a provider who has technology certified to the 2014 Edition only may not attest to Stage 3.

2. Can an eligible professional (EP) use EHR technology certified for an inpatient setting to meet a meaningful use (MU) objective and measure?

Yes. For objectives and measures where the capabilities and standards of EHR technology designed and certified for an inpatient setting are equivalent to or require more information than EHR technology designed and certified for an ambulatory setting, an EP can use the EHR technology designed and certified for an inpatient setting to meet an objective and measure.

3. Does a provider such as a dentist who has access to a certified EHR system qualify?

As long as the provider has access to a certified EHR system that is capable of meeting MU objectives, they may qualify. In the case of dentists, many have a dental system that is interfaced with a certified EHR system; the provider would need access to all parts of the certified EHR system to qualify.

4. Can a provider still qualify when using a “free” EHR system? ^{Updated}

A provider can qualify when using a free EHR system. Documentation providing proof that the practice/provider has access to the certified EHR must include the dates the provider had access to the 2014 or 2015 certified technology.

Part 4: MEANINGFUL USE

1. What is Meaningful Use (MU)?

Meaningful Use (MU) describes the activities an eligible professional or hospital engages in to use electronic health records in a way that improves care and service to their patients. The Center for Medicare and Medicaid Services (CMS) established the rule for MU that includes a set of standards, implementation specifications, and certification criteria for electronic health record (EHR) technology. Complete information on the Meaningful Use program, can be found [here](#).

Providers are encouraged to review the CMS Specification Sheets published for each program year which can be found at the link above. CMS routinely updates specifications and provides additional information on meaningful use requirements through the specification sheets.

2. Do specialty providers have to meet all of the MU objectives for the incentive program, or can they ignore the objectives that are not relevant to their scope of practice?

EPs who participate in the Medicaid EHR Incentive Programs must meet all of the MU objectives and measures. However, certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation. Failure to meet the measure of an objective, or to qualify for an exclusion for the objective, will prevent an EP from successfully demonstrating MU and receiving an incentive payment.

3. Can I use group numbers in proving MU?

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

4. What are the general requirements for MU?

EPs must meet patient volume requirements, have Certified EHR Technology (CEHRT), meet MU objectives, submit the required number of Clinical Quality Measures (CQMs), and meet the following general MU requirements:

- a. Fifty (50) percent of all encounters must occur in locations equipped with CEHRT.
 - i. To demonstrate that a provider meets this requirement, encounters across all practice locations (excluding inpatient and emergency room settings) must be reported.
 - ii. An encounter is defined as medical, diagnostic, or consultation services. If multiple services are provided on the same day to the patient, then it counts as one encounter.
- b. Eighty (80) percent of unique patients seen at locations with CEHRT must have their records in a certified EHR system.

Providers should note that MU is not limited to just Medicaid encounters and patients but is reflective of all encounters and patients.

5. What if I change systems or use different systems during the EHR reporting period?

If a provider changes EHR systems or practices at multiple practices, information from all systems utilized during the reporting period must be used.

CHANGING SYSTEMS: If the information from the old system is transitioned into the new system, and the new system can report data from the entire reporting period, then only report data and include documentation from the new system. If the data is not transferred, then the information from both systems should be combined and documentation from both systems uploaded.

MULTIPLE LOCATIONS: Information from each location for the reporting period must be uploaded. The numerators and denominators for each measure should be combined and entered into the application.

If a provider is practicing at multiple practices utilizing different systems, and different Clinical Quality Measures (CQMs) have been selected at the varying locations, the provider should choose one set to report. Any CQMs that are the same for all practices should also be added together. Providers should upload reports for all objectives from both systems as well as a document explaining which CQMs they are choosing to report. Documentation should be maintained supporting the choice of CQMs. For more information on practicing at multiple locations, please see this [Fact Sheet](#) published by CMS.

It is recommended that before changing systems, screen shots be taken to support all MU objectives and back-up reports run and stored in case of a post-payment audit.

6. How will the online application system handle percentages in terms of MU measures? For example, the MU Measure report states 29.8 percent for a measure – will the system round that up to 30 percent?

The online state application (MAPIR) only rounds down to the whole number for MU measures. In this example, MAPIR would calculate that as 29 percent. Additionally, providers should be cautioned that the rule requires that measures be met at “more than” the specified threshold. Therefore, in this example, if the measure requires more than 30 percent, your percentage must be at least 30.01 to meet the measure. MAPIR will display the percentage at 30 percent but will pass the measure. If your percentage is 29.8 percent, MAPIR will display 29 percent and the measure will fail.

7. What is the purpose of the Additional Documentation Form (AD Form)?

The AD Form is required for those providers practicing at multiple locations utilizing different EHR systems or locations without CEHRT.

Information about each location at which the provider practices should be included with the exception of inpatient and emergency room settings. The current AD Form can be found at: <http://www.ahca.myflorida.com/Medicaid/EHR/resources/index.shtml>.

8. How can I determine whether I qualify for an exclusion due to lack of broadband availability?

For certain Modified Stage 2 Objectives, EPs can claim an exclusion if the EP conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability on the first day of the EHR reporting period, according to the latest information from the Federal Communications Commission (FCC).

CMS posted a tip sheet explaining [Broadband Access Exclusions](#). To assist providers in efficiently finding

information pertaining to the broadband download speed in their respective county, the tip sheet provides the states and associated counties which do not have the 4 Mbps of Broadband download speed, and therefore qualify for the broadband access exclusion. No county in Florida is listed as not having access to the required 4 Mbps of Broadband download speed, therefore, Providers practicing in Florida do not qualify for this exclusion.

9. What are the “Information Blocking” questions within MAPIR under Meaningful Use Objective 0?

As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Quality Payment Program final rule there were requirements that participants in both the Medicare and Medicaid EHR Incentive Programs show that they have not knowingly and willfully limited or restricted the compatibility or interoperability of their certified electronic health record (EHR) technology. These questions are required for providers to show they are meeting this requirement by attesting to three statements about how they implement and use certified EHR technology (CEHRT). Together, these three statements are referred to as the “Prevention of Information Blocking Attestation.” Providers should carefully read each question and answer appropriately. For more information on the questions, refer to the CMS Prevention of Information Blocking Attestation [Fact Sheet](#).

MODIFIED STAGE 2 MEANINGFUL USE

1. How does the Modified Stage 2 rule change MU reporting?

Starting with Program Year 2015, all providers were required to attest to a single set of objectives and measures known as Modified Stage 2. Providers will have the option in Program Year 2018 to attest to Stage 3 measures if they have upgraded to 2015 CEHRT or a combination of technologies. Complete information on Program Year 2018 MU requirements can be found [here](#).

2. What is required to meet the Electronic Reporting of Public Health Data objective for Modified Stage 2?

The Public Health Reporting objective has three measure options: Immunization Registry Reporting, Syndromic Surveillance Reporting, and Specialized Registry Reporting.

For Program Year 2018, providers must meet at least two of the three measure options, or meet only one and exclude from the rest. An exclusion for a measure does not count toward the total of two measures. Instead to meet this objective, a provider would need to meet two of the total number of measures available to them. If the provider qualifies for multiple exclusions and the remaining number of measures available to the provider is less than two, the provider can meet the objective by meeting the one remaining measure available to them and claiming the exclusions. If no measures remain available, the provider can meet the objective by claiming applicable exclusions for all three measures. A provider may report to more than one specialized registry and may count specialized registry reporting twice to meet the required number of measures.

Providers who did not register with the Public Health Agency or Specialized Registry in a previous program year must register within 60 days after the start of the EHR reporting period if the provider is attesting to registration as their level of active engagement as explained below.

Providers must be in “active engagement” with the Public Health Agency or Specialized Registry defined as:

- Completed Registration to Submit Data
 - EP has registered to submit data. Registration was completed within 60 days after the start of

the EHR reporting period and the provider is awaiting an invitation to begin testing and validation.

- Testing and Validation
 - EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the sponsor of the registry within 30 days; failure to respond twice within an EHR reporting period would result in the EP not meeting the measure.
- Production
 - EP has completed testing and validation of the electronic submission and is electronically submitting production data.

For complete information on this objective including exclusions, refer to the Modified Stage 2 CMS Specification Sheet for [Public Health Reporting](#).

3. How do I know what specialized registries are available?

Providers are required to look two places to see if there is a specialized registry that can accept electronic data: the Public Health entity in their jurisdiction (county or state) and with any specialty society of which the provider is a member.

Currently there are two known Public Health registries that qualify as specialized registries:

- The Florida Cancer Data System (FCDS) is Florida's Cancer Registry. The FCDS is a joint project of the Florida Department of Health and the University of Miami Miller School of Medicine. FCDS has been accepting electronic submission of cancer data since 2013. Please visit their website at <http://fcds.med.miami.edu/> to register for electronic submission of cancer data.
- The Florida Prescription Drug Monitoring Program, known as E-FORCSE® (Electronic-Florida Online Reporting of Controlled Substance Evaluation Program), was created by the 2009 Florida Legislature in an initiative to encourage safer prescribing of controlled substances and to reduce drug abuse and diversion within the State of Florida. E-FORCSE declared itself a specialized registry January 1, 2016. For more information, visit their [website](#).

Providers should check with any specialty society of which they are a member to determine if there is a specialized registry. Specialty societies with specialized registries can dictate the method in which they receive the data.

4. Is there a central place to research specialized registries?

CMS has developed a [centralized repository](#) for public health agency and clinical data registry reporting to provide an additional, centralized source of information for eligible professionals, eligible hospitals, and critical access hospitals looking for public health, clinical data, or specialized registry electronic reporting options. The CMS [Centralized Repository](#) is not the authoritative source of all reporting options currently available.

For purposes of reporting meaningful use, the absence of an entry on the CMS Centralized Repository is not sufficient documentation for claiming an exclusion and does not prevent a provider from attesting to reporting to a registry. Providers must still check with jurisdictional public health agencies or specialty societies to which they belong and document that information to satisfy Medicare or Medicaid reporting. For more information on steps providers have to take to determine if there is a specialized registry available for them, or if they could instead claim an exclusion, please review the [CMS Specific Sheet for Public Health Reporting](#).

5. What is required if I am using E-FORCSE for my specialized registry?

There must be at least one patient query during the EHR reporting period. The Rx Search Request History report (example below) should be used as documentation for the application. More information on E-FORCSE can be found [here](#). It is recommended that the Rx Search History report be run monthly throughout the program year and at the end of the EHR reporting period.



4052 Bald Cypress Way
Bin C-16
Tallahassee, FL 32399
(877) 719-3120

Report Prepared: 06/20/2018

Rx Search Request History

Date Range: 06/11/2018 – 06/20/2018

| Rx Search Requests | | | | | | |
|--------------------|-----------|----------------|---------------|-------------|----------|------------|
| First Name | Last Name | Requestor | Requested For | Report Type | Status | Created At |
| ■ | ■ | Erika Marshall | | AWARxE | complete | 06/11/2018 |

6. What documentation is required to claim an exclusion for specialized registries?

Providers who claim an exclusion for the specialized registry measure must upload a signed letter on their letterhead documenting that the following conditions apply:

- Does not treat or diagnose cancer;
- Does not prescribe controlled substances to patients 16 years of age or older; and
- Not a member of a specialty society that has a registry.

The provider must meet all of the conditions above in order to exclude. Providers must maintain documentation to support the exclusion.

7. Can a provider assign a designee on the E-FORCSE secure web portal to query on their behalf in terms of using E-FORCSE to meet the specialized registry measure?

Yes, the provider may assign a designee to query E-FORCSE on their behalf. Please be sure to follow the E-FORCSE instructions for linking a designee. In order for the transaction to properly display on the E-FORCSE Rx Search Request History report for the provider, the designee must be linked properly. At least one query is required during the provider's EHR reporting period. For more information on how to assign a designee, please contact [E-FORCSE](#).

8. How can I meet the Modified Stage 2 Health Information Exchange (HIE) objective?

This objective has two components: The EP must use CEHRT to create a summary of care record and must electronically transmit the summary of care record for more than 10 percent of the referrals and transitions of care. The measure no longer dictates the method of transmitting the summary of care record. Any secure, HIPAA-compliant electronic transmission can count as long as the provider has reasonable certainty that the record was received.

Providers who are using a system outside their EHR for transmission of the summary of care records, should maintain documentation to support their compliance with this objective since the numbers will not be reflected on the system generated meaningful use report. It is recommended that providers implement a workflow at the beginning of their EHR Incentive reporting period so that adequate documentation can be gathered and maintained.

9. What is required to meet the Patient Specific Education objective?

The Modified Stage 2 objective and measure states: Patient-specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.

- Denominator: Number of unique patients with office visits seen by the EP during the EHR reporting period.
- Numerator: Number of patients in the denominator who were provided patient-specific education resources identified by the CEHRT.
- Threshold: The resulting percentage must be more than 10 percent in order for an EP to meet this measure.
- Exclusion: Any EP who has no office visits during the EHR reporting period.

It is not required that the certified technology actually generate the educational material but it is required that the material provided be suggested by the CEHRT. Certified electronic health records use the patient's problem list, medication list, or laboratory results to identify clinically relevant education resources for a specific patient. Additional information within the record may also be used. The EP can then provide these educational resources to patients in a useful format for the patient such as electronic copy, printed copy, electronic link to source materials, or through a patient portal or PHR. The education resources or materials do not have to be stored in the CEHRT or generated by the CEHRT but they do have to be identified by the CEHRT to count in the numerator.

Audits have found that although providers may have a MU report showing that the measure is met, they are unable to demonstrate that their system actually suggested educational resources. Providers are encouraged to work with their vendor to understand how the system generates educational resource suggestions, how the MU report is generated, and what documentation is available to support meeting this requirement.

10. What is the process for electronically submitting immunization data to Florida SHOTS?

Florida SHOTS is the immunization-reporting registry for Florida and has established a process by which providers, including hospitals, can satisfy meaningful use requirements. The first step is to complete a registration form. Complete information on the process can be found at www.flshots.com.

Registration will be linked to your FLshots.com logon. If you are not participating in Florida SHOTS, you will need to contact Florida SHOTS to establish an account. Please use this website to enroll if you do not have a log in for Florida SHOTS.

Providers are encouraged to fully and accurately complete the registration with as much information as possible to expedite processing. A couple of key points:

- The contact name and email will be used for all subsequent correspondence.
- The form is dynamic, meaning that depending on the answers given, additional questions may appear.
- Use Internet Explorer as your web browser when accessing Florida SHOTS. Other browsers will not allow the site to operate properly.
- Registrants will be sent instructions to contact an implementation specialist if they are not already uploading.

- Registrants who are already uploading will be provided confirmation documentation via an automated monthly email from Florida SHOTS as well as an automated year-end summary of electronic transmissions.

If a provider does not give any type of immunizations OR has not provided any immunizations within the EHR reporting period, an exclusion may be claimed. It is not necessary to register with Florida SHOTS if excluding from this measure because no immunizations were provided.

Questions about testing with Florida SHOTS or the Immunization Registry should be directed to Florida SHOTS by email at flshotsMU@flhealth.gov. Providers are encouraged to start the process of testing with Florida SHOTS prior to or early in the EHR reporting period.

NOTE: Manually entering data into the Florida SHOTS web portal or a fixed file transfer does not meet meaningful use requirements – it must be an electronic exchange of information.

11. What is required to meet the Protect Patient Health Information objective?

This objective and measure requires that the provider conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process. A key component of the Security Risk Analysis (SRA) is an asset inventory which identifies where protected electronic health information (ePHI) is stored, how it is accessed, and how it is exchanged. The asset inventory should identify devices that are used to create, receive, access, store, and/or transmit ePHI (software, hardware, network, or computing components such as computers, laptops, fax machines, copiers, servers, etc.). Identifying the assets used to create, receive, access, store, and/or transmit ePHI is the first step in ensuring that ePHI is protected. The Security Risk Analysis documentation should include any recommendations for further action.

It is the responsibility of the provider to determine if they have met these requirements. Any security updates and deficiencies that are identified in the review should be included in the provider's risk management process and implemented or corrected as dictated by that process. Post-payment audits will require documentation that identified security updates and deficiencies were (or are) being addressed. Several audits have failed because of an inadequate SRA. A review must address any recommendations from the previous SRA.

An SRA or review must be conducted for each Program Year. The scope of the analysis or review must include the full EHR reporting period and must be conducted within the program year. The same SRA or review cannot be used for two program years.

Additional information and resources can be found on the [CMS Specification Sheet](#). You may also wish to review the [tip sheet](#) produced by CMS on the Security Risk Analysis requirement.

12. Am I required to upload a copy of my Security Risk Assessment with my application?

Yes. A copy of the SRA or review is required with the application. The SRA or review must include the cover page (with name and title of the person that completed), asset inventory, and final report.

13. For the Modified Stage 2 CPOE measure, what is meant by “credentialed” medical assistant? Are there minimal requirements that must be met?

This measure does not set standards for credentialing or certifying medical assistants rather the intent is to expand and specify the scope of the individuals that can be recognized in meeting the measure. Florida law specifies that medical assistants may be certified by the American Association of Medical Assistants or as a registered medical assistant by the American Medical Technologists (Florida Statutes 458.3485).

It is the responsibility of the provider attesting to the measure that if a credentialed medical assistant is used to enter CPOE for the purpose of this measure, documentation of the requisite credentialing is obtained, maintained, and that state, local and professional guidelines are being met.

Please note that [CMS FAQ 9058](#) states that the credentialing cannot come from the employing organization. Additionally, this FAQ specifies that anyone within the practice, regardless of job title that has received medical assistant credentialing can enter orders and be included in this measure.

STAGE 3 MEANINGFUL USE

1. When will I be required to attest to Stage 3 meaningful use measures?

For Program Year 2018, providers have the option to attest to Stage 3 as long as their certified EHR technology supports the objectives and measures to which they attest. Systems will need to be certified to the 2015 Edition or combination of 2014 Edition and 2015 Edition.

Stage 3 Specification Sheets for Program Year 2018 can be found [here](#).

For Program Year 2019, Stage 3 is required for all providers participating in the program and the certified EHR technology must be certified to the 2015 Edition.

CLINICAL QUALITY MEASURES

1. What is required for reporting Clinical Quality Measures (CQMs)? Updated

Eligible Professionals (EPs) are required to report on six out of 53 clinical quality measures. There is not a threshold that has to be met when reporting CQMs. For more information on CQMs, refer to [Clinical Quality Measures](#).

2. What should I do if there are no CQMs that apply to my practice?

EPs must still report CQMs even if the numerators and denominators are zero. It is understood that the CQMs available to report may be determined by your vendor’s certification and may not be reflective of the provider’s practice.

3. What are the reporting periods for CQMs for Program Year 2018?

EPs in their second or subsequent years of MU must use a full-year (365 days) reporting period for CQMs in Program Year 2018. Only EPs attesting to MU for the first time will be allowed to use a 90-day reporting period for CQMs in Program Year 2018.

Part 5: FEDERAL REGISTRATION and STATE APPLICATION PROCESS

1. Can I attest as a group?

No. Each individual Eligible Professional (EP) must complete the application and attestation process. A group administrator or other designated proxy may complete the application process on behalf of the EP. Refer to [Part One](#) for additional information.

2. Where is the link to the State Application?

The link to the state application is on your Medicaid provider portal. Upon signing into the Medicaid provider portal, a link should be present in the top, right hand corner under "Quick Links." Clicking on the EHR Incentive Payment link will take you to the Medicaid EHR Incentive Program Participation Dashboard. The Dashboard displays information on any previous Florida Medicaid application and any program year application that is available for completion.

3. Can I change the information at the federal registration and attestation site (CMS R&A)?

Yes, in fact certain changes must occur at the federal CMS R&A system, such as payee changes. It is important to note that when making a change at the R&A site, you must hit the resubmit button. Even if you do not make a change to the information, you must hit resubmit. If you do not resubmit, your R&A information is considered pending and will affect your ability to complete an application and receive a payment.

Part 6: PAYMENTS

1. Can I assign my payment?

Eligible Professionals (EPs) can decide to receive the payment or assign it to a group with which they have an employment or contractual relationship that allows the group to apply and receive payment for their covered services. The payment assignment relationship must be established in the Florida Medicaid Managed Information System (FMMIS) prior to attestation. In addition, the EP must be a member of the group at the time of every attestation. When an application is returned to incomplete status for corrections, resubmission requires a new attestation. If an EP left a group after the initial attestation and the application needs no corrections that require a new attestation, the group can receive the payment. If an EP leaves a group after attestation and the application is returned to *Incomplete* for corrections, the provider cannot assign the payment to the group. Each new attestation requires attesting to all the information in the application including the payment assignment.

Payment assignment is made as part of the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Registration and Attestation process (R&A). Any reassignment of the payment is made voluntarily, which assumes informed consent has been given by the EP. This means that the EP understands that the party so designated, not the EP, will receive the payment.

There are three options for payment assignment at the CMS R&A. It is important to pick the correct option or payments will be delayed. The data for the individual provider and the payee must match Medicaid provider files.

- Social Security Number (SSN): This option uses the provider's individual National Provider Identification (NPI) and SSN for the payment.
- Employer Identification Number (EIN): This option uses the provider's individual NPI and allows entry of an EIN.
- Group re-assignment: This option allows the provider to enter a group NPI and Tax ID.
 - The system validates that the NPI/TIN combination is on file with Provider Enrollment and the Chain and Ownership System (PECOS).

It is strongly recommended that practices discuss incentive payments with EPs prior to attesting. It is also recommended, but not required, that groups execute a signed agreement outlining the payment relationship prior to attesting. If the State is notified that an EP did not agree to have the payment assigned to the group who received it and the group has no documentation of the agreement, then recoupment action will be taken.

2. How is payment assignment validated?

As part of the prepayment validation process, the State will verify that the EP is a member of the group to whom payment has been assigned based on the information contained in FMMIS. If that relationship has not been established in FMMIS, the payment will not be approved. If it is found that the EP was not truly a member of the group at the time of attestation (e.g. left and FMMIS not updated), then payment will be recouped.

3. Where is the payment directed?

The registration with the CMS R&A establishes the NPI and Tax ID for the payment. MAPIR will display the Medicaid IDs associated with that NPI/TIN combination in the online application. The EP selects the Medicaid ID for the payment. If MAPIR does not display the Medicaid ID you were expecting to see, it is necessary to

update the registration.

A common registration error is selecting the payee TIN option of My Billing TIN. This option prepopulates the individual provider's NPI and allows entry of the group EIN.

Once a payee Medicaid ID is selected and the application is approved, the payment is made as part of the normal financial cycle and can be found on the remittance advice under non-specified claim payments with a disposition code of 8401. Payments are made based on the existing information contained in FMMIS including EFT information. *If you plan on receiving the payment yourself, please contact the EHR Call Center to verify that your Medicaid file contains your correct address and electronic funds transfer (EFT) information. The EHR Call Center number is (855) 231-5472.*

4. Is the incentive payment subject to federal income tax?

Incentive payments should be treated like any other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment. Providers should consult with a tax advisor or the Internal Revenue Service regarding how to properly report this income on their filings. The incentive payment will be included in 1099 reporting.

5. Can organizations request payments on behalf of their EPs, including attesting to required information?

EPs must legally attest that they meet the requirements in order to receive payments. Organizations are not allowed to apply for incentive payments without the knowledge and consent of their employees.

Part 7: ACRONYMS

| Acronym | Definition |
|----------------|---|
| AD | Additional Documentation Form |
| AGENCY | Agency for Health Care Administration (AHCA) |
| AIU | Adopt, Implement, Upgrade |
| ARNP | Advanced Registered Nurse Practitioner |
| CEHRT | Certified Electronic Health Record Technology |
| CQMs | Clinical Quality Measures |
| CY | Calendar Year |
| EH | Eligible Hospital |
| EHR | Electronic Health Record |
| EP | Eligible Professional |
| FMMIS | Florida Medicaid Management Information System |
| FQHC | Federally Qualified Health Center |
| HIE | Health Information Exchange |
| HIT | Health Information Technology |
| HITECH | Health Information Technology for Economic and Clinical Health Act Technical Assistance |
| HRSA | Health Resource and Services Administrations |
| HMO | Health Maintenance Organization |
| MACRA | Medicare Access and CHIP Reauthorization Act of 2015 |
| MAPIR | Medical Assistance Providers Incentive Repository (online application) |
| MIPS | Merit-Based Incentive Payments |
| MU | Meaningful Use |
| ONC | Office of the National Coordinator for Health Information Technology |
| PA | Physician Assistant |
| PMS | Practice Management System |
| PV | Patient Volume |
| RHC | Rural Health Center |