Frequently Asked Questions

**Florida Medicaid Electronic
Health Record Incentive Program**

February 1, 2016
Version 5.0

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

**For questions about Eligible Hospital participation, please contact Jaime Bustos at
Jaime.bustos@ahca.myflorida.com.**

Due to changes finalized by the Stage 2 Modification Rule, the FAQs have been
revamped and reformatted to remove older program information. A copy of the March
2015 FAQs can be found under Archives.

Table of Contents

Part 1: OVERVIEW

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

The Florida Medicaid EHR Incentive Program provides incentive payments to eligible professionals (EP) and eligible hospitals (EH) as they adopt, implement, 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 and EHs 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.

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 Act (HITECH) Act. Provider payments are funded 100% 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 is 2016. EPs and EHs participating for the first time in program year 2016 must meet all requirements by December 31, 2016, and submit their application by the end of the grace period for program year 2016.

2. What do the timeframe terms mean?

- **Payment year** refers to the year of EP or EH program participation e.g. year one.
- **Program year** refers to the calendar year of program participation (e.g. 2015, 2016, etc.).
- **Volume reporting period** refers to the consecutive, 90-day period used to meet Medicaid patient volume requirements. During the volume reporting period, a provider does not have to be using certified technology.
- **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.

3. What are the differences in requirements between Adopt, Implement, and Upgrade (AIU) and Meaningful Use (MU)?

Through the Medicaid EHR Incentive Program, providers have the option of applying for their first year incentive payment by demonstrating that they have adopted, implemented, or upgraded (AIU) to CEHRT. Providers are not required to have actually implemented or be using CEHRT to qualify for AIU payment, but they must have possession of the CEHRT. It cannot be a "planned" upgrade or procurement. Providers may also choose to skip AIU attestation and move straight to MU attestation.

In order to qualify for MU payments, providers must demonstrate that they have been using CEHRT in a meaningful way by meeting specific MU measures and objectives. MU measures and objectives, including the thresholds for compliance, are set forth in federal legislation.

4. What are the Stages of Meaningful Use (MU)? ^{Updated}

Prior to the Stage 2 Modification Rule effective date of December 15, 2015, the MU program was divided into Stage 1, Stage 2, and planned Stage 3. Providers could attest to two years of each MU stage, even if the payment (participation) years were not consecutive. The Stage 2 Modification Rule sets forth a single set of objectives and measures including

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 3
February 1, 2016
Version 5.0

lower thresholds and alternate exclusions for providers in their first or second reporting year in Program Year 2015 and for certain measures in Program Year 2016.

Beginning in Program Year 2017, all providers will attest to the Modified Stage 2 objectives and measures. Those providers who have upgraded their systems to the 2015 certification standards will have the option of attesting to the Stage 3 objectives and measures.

Effective Program Year 2018, all providers will be required to attest to Stage 3 objectives and measures.

Part Six 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 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 work on their behalf 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 screen shot 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.

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 – ensure that you have a written account of the findings as well as any action taken to mitigate findings. Ensure that any review of the SRA is documented including the areas reviewed and all actions taken and planned.
  - A copy of the SRA or review must be included with the application.
- 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.

Audits will be conducted on AIU and MU attestations. The documentation requested will vary based on the type of the audit. 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 are encouraged to respond within the time periods specified. 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? Updated

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 does not validate the type of documents, rather just that documentation has not been attached.

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, SRA, etc.

ADOPT, IMPLEMENT, or UPGRADE (AIU)
- Copy of the Practice Management Report supporting your volume
- Documentation that supports the adoption, implementation or upgrade of the 2014 certified technology such as an invoice or contract

MEANINGFUL USE (MU)
- Copy of the Practice Management Report supporting your volume
- Documentation from your EHR vendor stating the date you installed the 2014 edition certified technology
- MU Measure report for the EHR reporting period including all measures and clinical quality measure (CQM) information
- Additional Documentation Form
- 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
- 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
- Volume Workbook recommended if using unpaid, denied or never billed Medicaid encounters
- 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

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 5
February 1, 2016
Version 5.0

9. Will there be always be a grace period for each Program Year?

Yes. The Program Year for EPs and EHs is the calendar year. The grace period for EPs typically extends through March 31st following the end of each program year. The grace period is only applicable for applicants that have completed program requirements by the end of the program year.

There is an exception for the 2015 program year. The grace period for EPs attesting to AIU for Program Year 2015 will extend through March 31, 2016. The end grace period for EPs attesting to meaningful use for Program Year 2015 will be August 31, 2016.

10. Have there been changes that affect access to Medicaid provider portal accounts?

Yes, security changes to Medicaid provider portal have been implemented. All 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. It may take several weeks to create and associate a new Medicaid provider portal account.

If you have issues logging into your Medicaid provider portal account, please contact Provider Services at 1-800-289-7799. 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 log in 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 on-line 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 preparer does not see the EHR Incentive link, the User ID may need to be updated. Please contact the EHR call center at 1-855-231-5472 for assistance with updating the User ID.

11. What are the payment adjustments for not meeting MU? ^{Updated}

Providers that are eligible for the Medicare EHR Incentive Program but have not successfully attested to MU can be subject to an adjustment on their Medicare payments. The payment adjustments only apply to Medicare, not to Medicaid. A provider can, however, report MU under the Medicaid EHR incentive program and avoid the Medicare payment adjustments.

Providers can avoid the payment adjustment by applying for a hardship exemption through CMS. For the most up to date information, please refer to Payment Adjustments and Hardship Exemptions.

Please note, there is no Medicaid payment adjustment.

12. How can a Medicare provider avoid the Medicare payment adjustment? ^{New}

Providers who are defined as eligible professionals under the Medicare EHR Incentive Program are subject to the Medicare payment adjustment if they do not attest to meaningful use. To avoid the adjustment, a provider can

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 6
February 1, 2016
Version 5.0

demonstrate meaningful use with either the Medicare or Medicaid Incentive Program or apply for and be approved for a hardship exemption.

13.   The CMS deadline for attesting to meaningful use and avoid the payment adjustment is March 11, 2016, but MAPIR won't be ready for attestations. What do providers need to do? New

EPs who successfully attested for the 2014 program year are exempt from the Medicare payment adjustment for 2016. Successfully attesting for the 2015 program year exempts these providers from the 2017 payment adjustment, even if the attestation is with the Medicaid Incentive Program and after the March 11, 2016 Medicare attestation deadline.

Every quarter, states provide a file to CMS of the providers who have attested to meaningful use. The data is used to exempt the Medicare providers from the payment adjustment.

EPs whose first year of demonstrating meaningful use will be program year 2015: These providers may already be receiving a payment adjustment for 2016 unless they were approved for a hardship exception in 2015 (these were due July 1 of 2015). The payment adjustment for 2016 will be removed and the provider's Medicare claims will be reprocessed if they successfully attest for meaningful use in either Medicare or Medicaid for an EHR reporting period in 2015.

14.   My group of Medicare providers is unable to meet the measure to provide summaries of care electronically because our referral sources cannot receive the CCDA electronically. Are the providers going to have their Medicare payment adjusted? New

EHR Certification/Vendor Issues (CEHRT Issues) is one of the categories for which Medicare providers can attest to as a reason for applying for the Medicare hardship exemption, category 2.2.d.

Medicare providers who are failing measures for the 2015 program year due to issues with the CEHRT should apply for a hardship exemption and select option 2.2d.   Failing the second measure of the Health Information Exchange objective, electronically sending the CCDA, due to a lack of referral partners being able to receive the CCDA electronically fits the criteria for 2.2d. This is the same category for which providers could apply in 2014 if they faced an issue of having CEHRT implemented but no viable means for exchanging a CCDA. In 2015, CMS expanded the transport options which should help many providers for the 2016 program year, but the timing of the guidance may mean that some providers were still unable to succeed for a reporting period for the 2015 program year and so they may use 2.2d to apply for a hardship exception.

15.   If an EP is failing measures, should the EP attest anyway? New

Medicare providers who are failing measures should not attest to the failed measures with either Medicare or Medicaid. Failed attestations are not linked to applications for hardship exemptions.

16.   I have been participating in the Medicaid program but no longer meet volume requirements. Can I still attest to avoid the penalty? New

CMS's Medicare attestation system now allows providers to attest solely for the purpose of avoiding the Medicare payment adjustment. This "non-payment" track can be used by Medicare providers registered with Medicaid who are not going to be able to successfully attest with the Medicaid program. For example, a provider who is passing the objectives and measures but whose Medicaid enrollment was terminated or whose Medicaid volume is under the required threshold cannot successfully attest with the Medicaid program. These providers can use the Medicare attestation to avoid the Medicare payment adjustment. Attestations must be submitted by the Medicare attestation deadline.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 7
February 1, 2016
Version 5.0

Medicare providers registered with Medicaid who are passing measures and plan to attest with Medicaid for the 2015 program year do not need to use the alternative attestation method with Medicare. The state provides attestation data to CMS that is used to identify Medicare providers who should be exempted from the payment adjustment for demonstrating meaningful use.

17. What is the deadline to apply for a hardship exemption? New

The deadline for EPs to apply for a hardship exemption is March 15, 2016.

The deadline for EHs and CAHs is April 1, 2016.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 8
February 1, 2016
Version 5.0

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 led by a physician assistant.

2. How is "hospital based" status determined?

- Hospital based is defined as 90% 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% 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% or more of the EP's Medicaid encounters are hospital based, but their total encounters are less than 90% 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% of the time in an rural health clinic (RHC) or federally qualified health center (FQHC) can count "needy individuals" when determining patient volume.

** *Pediatricians who qualify with a 20% 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% could be rounded up to 30%.

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

Patient volume is based on encounters. Encounters are defined as services provided to a single patient on a single day. The denominator is all patient encounters, regardless of whether the encounter is billed or paid. Each date of service is only counted once.

- 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;

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 9
February 1, 2016
Version 5.0

- o services to those with primary third party payers;
- o services rendered to a Medicaid patient but not billed; and
- o services denied, unless the denial reason is that the individual was not enrolled in Medicaid on the date of service.
- o 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 patient encounters.

- Each date of services rendered to an individual patient should only be counted once.

- At least one clinical location used in the calculation of patient volume must have certified EHR technology (CEHRT). If you are adopting CEHRT, it is not required that the technology be in use.

- 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 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.

Total *Individual* Medicaid Encounters
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.

Total *Group* Medicaid Encounters
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% Medicaid volume in any of these examples, but will only receive 2/3 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 1 (855) 231-5472 for further clarification.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 10
February 1, 2016
Version 5.0

Providers still have the option of basing volume solely on Medicaid paid claims. If including denied or never billed claims for patient volume, providers are encouraged to utilize the Volume Workbook. The use of this worksheet will expedite the pre-payment validation process since it will direct staff on how the numbers were calculated. The worksheet is available via the website under Volume Workbook.

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

Only providers practicing 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 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? ^{Updated}

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 (provider file); and
- The documentation of the parameters of the group must be auditable;
- 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.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 11
February 1, 2016
Version 5.0

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 EP using their individual patient volume for patients seen at through the group, while others use the group level data); and
- 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.
- 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% of their total volume.   Pediatricians attesting with 30% Medicaid receive the full payment.

To be eligible for an incentive payment as a pediatrician with Medicaid volume between 20% and 29%, 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% Medicaid volume, make sure you select pediatrician for your provider type in MAPIR. Selecting physician and reporting volume under 30% will cause your application to be denied.

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

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

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 12
February 1, 2016
Version 5.0

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 pre-payment 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 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.

6. 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 statue 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.

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. Providers and practices must update their Medicaid provider files with any address and contact changes to ensure that requests to re-enroll are received. You must be fully enrolled in the Florida Medicaid program to participate in the Medicaid EHR Incentive 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 1-800-289-7799, Option 4, for a complete list of required enrollment documentation.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 14
February 1, 2016
Version 5.0

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. Beginning with Program Year 2015, all providers must be using 2014 CEHRT or have acquired 2014 CEHRT for AIU to participate in the incentive program.

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. **Will the Agency need to verify the "installation" or "a signed contract" for adopting, implementing, or upgrading a certified EHR system?**

Yes. As part of the application process for first year payments, a letter is needed from the vendor indicating the provider's name or practice name, the name and version of the system, certification number, and date acquired. It cannot be a "planned" upgrade or procurement.

5. **Can a provider still qualify when using a "free" EHR system?**

Yes. If documentation of a licensing arrangement cannot be obtained from the vendor, the following documentation should be included as proof that the provider/practice has access to the system:

- A copy of page one of the license agreement
- A screenshot from the EHR system indicating the software's name and version
- A copy of the EHR system's screen that displays, at minimum, the provider's name and the name of the free software (usually a header at the top of each screen)

In addition, if access to the EHR system is through an arrangement with another individual or organization, a copy of the agreement between the owner of the system and the applicant that indicates the name and version of the software must be included.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 15
February 1, 2016
Version 5.0

Part 4: MEANINGFUL USE

1. **What is Meaningful Use (MU)?**^{Updated}

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. For complete information on the Meaningful Use program, visit https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms.

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. 50% 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. 80% 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 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.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 16
February 1, 2016
Version 5.0

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 handle percentages? For example, the MU Measure report states 29.8% for a measure – will the system round that up to 30%?

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

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

The AD Form provides information to support the data entered into the attestation/application for pre-payment validation and post-payment review activities. One important function is the capturing of location specific information supporting the provider's attestation to meeting general requirements. It should be noted that additional documentation may still be requested to support oversight activities. If the AD form is not uploaded as part of the application, the application will not be processed.

In Section A of the form, information about each location at which the provider practices should be included with the exception of inpatient and emergency room settings. Section B auto calculates based on the information in Section A. *NOTE: If a provider practices at various locations but all locations utilize the same technology and all patients are included in the certified technology, Section A does not need to be completed.*

Section C provides for details on certain meaningful use objectives. If any of the questions are not applicable, please indicate N/A. If a provider is practicing at multiple locations with CEHRT, it may be necessary to complete Section C for each of those locations since the answers may vary dependent on the location. EPs should use the AD form that is specific to the program year. Click here for AD Forms.

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

For certain Modified Stage 2 Objectives, EPs can claim an exemption if the EP conducts 50 percent or more of his or her patient encounters in a county that does not have 50% 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 on 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 on the list, therefore no EP in Florida qualifies for that exclusion.

MODIFIED STAGE 2 MEANINGFUL USE

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 17
February 1, 2016
Version 5.0

1. **How does the Modified Stage 2 rule change MU reporting?** ^{New}

Starting with Program Year 2015, all providers will be required to attest to a single set of objectives and measures known as Modified Stage 2. For providers scheduled to be in their first or second meaningful use reporting period in Program Years 2015 and 2016, there are alternate exclusions and specifications within individual objectives.

Providers will have the option in Program Year 2017 to attest to Stage 3 measures if they have upgraded to 2015 CEHRT. Stage 3 objectives will be required for all providers in Program Year 2018. For complete information on Modified Stage 2 visit https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms.

2. **What is meant by alternate exclusions and specifications?** ^{New}

There are several alternate exclusions and specifications for certain measures that are intended to help providers that may not otherwise be able to meet the criteria in 2015 and 2016 because they require the implementation of certified EHR technology beyond the functions that were required for Stage 1.
These provisions only apply to providers who are in their first or second reporting year:
*   For 2015, use a lower threshold for certain measures.
*   For 2015, exclude from measures for which there is no Stage 1 equivalent.
*   For 2015, exclude where a previous menu measure is now a requirement.
*   For 2016, claim an alternate exclusion for the CPOE objective measure 2 (laboratory orders) and measure 3 (radiology orders).

3. **What is required to meet the Electronic Reporting of Public Health Data objective?** ^{New}

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

Providers in their first or second reporting period of MU, must meet one of the measure options or be able to exclude from all three. Providers in their third or later reporting period of MU, must meet two of the three measure options or meet fewer and exclude from the rest. NOTE: 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 must be in "active engagement" with the Public Health Agency or Clinical Data 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 to 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 CMS Specification Sheet at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2015EP_10PublicHealthObjective.pdf.

4. **How do I know what specialized registries are available?** ^{New}

Providers are required to look two places to see if there is a specialized registry that can accept electronic data: the

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 18
February 1, 2016
Version 5.0

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 is accepting electronic submission of cancer data. 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. For more information, visit their website at www.e-forsce.com.

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.

- For example, the EHR vendor charges a fee to connect to the specialized registry. The specialized registry accepts data via a secure email. If the provider can send data through a secure email, they can get the data out of their EHR and follow the registry's instructions on securely emailing it.

- If the provider is a member of a specialty society with a specialized registry and the only way to electronically report to the registry is to pay an EHR vendor for a connection, the provider cannot take an exclusion because there is a registry available for their reporting.

5. **What documentation is required to claim an exclusion for specialized registries?** New

Providers who claim an exclusion will be required to complete the Additional Documentation form with information on why they are excluding.

6. **How can I meet the Health Information Exchange objective?** New

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% 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.

7. **What is required to meet the Patient Specific Education objective?** Updated

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

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 19
February 1, 2016
Version 5.0

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.

8. **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 by clicking here.

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 Florida SHOTS log in. http://www.flshots.com/enrollment/.

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 after their designated reporting period.

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.

9. **What is required to meet the Protect Patient Health Information objective?** New

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 is stored, how it is accessed and how it is exchanged.

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

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 20
February 1, 2016
Version 5.0

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.

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. The same SRA or review cannot be used for two program years. The SRA or review may take place before the start of the EHR reporting period or after but must be completed prior to attesting. CMS produced FAQ 13649 regarding the SRA.

Additional information and resources can be found on the CMS Specification Sheet at
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2015EP_1ProtectPatientHealthInfoObjective.pdf.

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

Yes. A copy of the SRA or review is required with the application. Information on the identification of the person completing the assessment and the date completed is also required on the Additional Documentation (AD) Form.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 21
February 1, 2016
Version 5.0

CLINICAL QUALITY MEASURES

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

Providers are required to report on 9 out of 64 clinical quality measures. These 9 measures must cross at least three of the 6 quality reporting domains. Providers do not have to meet a threshold for any of the 9 reported measures.

To facilitate provider reporting, CMS has a recommended set of Adult CQMs and Child CQMs. These are:

Adult		Child
Controlling High Blood Pressure		Appropriate Testing for Children with Pharyngitis
Use of High Risk Medications in the Elderly		Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		Chlamydia Screening for Women
Use of Imaging Studies for Low Back Pain		Use of Appropriate Medications for Asthma
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan		Childhood Immunization Status
Documentation of Current Medications in the Medical Record		Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up		ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
Closing the referral loop: receipt of specialist report		Preventive Care and Screening: Screening for Clinical Depression and Follow-Up
Functional status assessment for complex chronic conditions		Children who have dental decay or cavities

For more information on CQMs, refer to Clinical Quality Measures

2.   What are the six quality domains for CQMs?

- ✓   Patient and Family Engagement
- ✓   Patient Safety
- ✓   Care Coordination
- ✓   Population and Public Health
- ✓   Efficient Use of Healthcare Resources
- ✓   Clinical Processes/Effectiveness

3. What should I do if there are no Clinical Quality Measures (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 2014 certification and may not be reflective of the provider's practice.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 22
February 1, 2016
Version 5.0

Part 5: FEDERAL REGISTRATION and STATE APPLICATION PROCESS

1.   Can I register 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.   What should be done if a provider has an active Florida Medicaid Provider number but cannot access the State application?

Before you can apply for a Florida Medicaid Electronic Health Record (EHR) Incentive Payment, you have to complete the registration process at the Centers for Medicare and Medicaid Services (CMS) EHR Registration and Attestation site (R&A). If the information from the R&A matches the information contained in your Florida Medicaid provider file, then you should receive an email directing you to the state application (MAPIR) link. If you don't receive an e-mail (check your junk mail) from the state's registry, FL-EHRIncentivePgm@hp.com, within 3 days of completing your registration you may call the EHR Contact Center toll-free at 1-855-231-5472 for further information**.**

3.   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.

If you have successfully registered with the R&A, and your information matches the Medicaid's provider file (National Provider Identification (NPI) and Tax Identification Number (TIN)), your application status will say *Not Started.*

- If your R&A registration did not match your provider file, you will see an error message *Not Registered at R&A.*
- If you have not registered with the R&A, you will see an error message *Not Registered at R&A.*

If you do not have a Medicaid provider portal sign on, or cannot remember your sign on credentials, contact 1-800-289-7799, option 5. Please wait 3 days after registering with CMS at the R&A site before trying to access your state application. If you receive the *Not Registered at R&A status,* please contact the EHR Call Center at 1 (855) 231-5472 for further assistance.

4.   I have registered with the CMS Registration and Attestation (R&A) but cannot access the state application. What should I do?

If the state application link is not present, please contact the EHR Call Center at 1(855) 231-5472 for further assistance.

If the R&A registration information does not match your Florida Medicaid provider file, you are placed on a "mismatch" report. You will not be able to complete your state application until the matching issue is resolved. Common reasons for mismatching are:
- *You are not an eligible provider type*. Eligible provider types are: MDs and DOs; Dentists; Nurse Practitioners; and Physician Assistants (PA) working in PA-led federal qualified health centers (FQHCs) and rural health clinics;
- *Your Florida Medicaid enrollment is inactive;*
- *The applicant's NPI entered as part of the federal registration process is not contained in your Florida Medicaid provider file;*
- *You are not a fully enrolled Medicaid provider (this would apply to those providers that mainly participate in Managed Care programs;*

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 23
February 1, 2016
Version 5.0

- *There is a typographical error in the applicant's NPI or Social Security Number (SSN);*
- *The applicant's SSN is not in your Florida Medicaid provider file; or*
- *The payee's NPI and/or TIN received from the R&A conflicts with the information in the Florida Medicaid system.*

Please contact the EHR Call Center at (855) 231-5472 for assistance in resolving mismatch issues. If you are not an eligible provider type for the Medicaid incentives but qualify for the Medicare Incentive Program, you can change your registration at the federal level selecting the Medicare program. If you do not qualify for the Medicare program, then you should cancel your registration.

5.   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 switching between the Medicare and Medicaid program, payee changes, and state participation. 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?

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 (FLMMIS) 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 a provider 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 a provider 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 federal 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
- My Billing Tax Identification Number (TIN): This option uses the provider's individual NPI and allows entry of a TIN
- 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 PECOS.

It is strongly recommended that practices discuss the EHR payment 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 pre-payment 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 on line 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 pre-populates 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 1-855-231-5472.*

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 25
February 1, 2016
Version 5.0

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.

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 26
February 1, 2016
Version 5.0

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
MAPIR	Medical Assistance Providers Incentive Repository (online application)
MU	Meaningful Use
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician Assistant
PMS	Practice Management System
PV	Patient Volume
REC	Regional Extension Center
RHC	Rural Health Center

Funding for the EHR Incentive Program is subject to availability and budgetary approval by the Florida Legislature.

Page 27
February 1, 2016
Version 5.0