

State of Oklahoma
Oklahoma Health Care Authority



Oklahoma Electronic Health Records
Incentive Program
Provider Manual

Summer 2017



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Background:

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at www.healthit.gov

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines; and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of health care nationwide.

Resources:

- OAC 317: 30-3-28 – Electronic Health Records Incentive Program
- OAC 317: 2-1-2 (b) – Administrative Appeals
- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule
- Oklahoma State Medicaid HIT Plan (SMHP) Version 1.0
- www.okhca.org/ehr-incentive
- www.cms.gov/EHRIncentivePrograms
- www.HealthIT.gov
- OHCA Health Information Technology Program Education Team 405-522-7EHR(7347)
- Forms can be found at www.okhca.org in the Provider Section

Disclaimer: The Oklahoma Health Care Authority (OHCA) is providing this material as an informational reference for physicians and non-physician practitioners-providers. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of posting, the Oklahoma EHR Incentive program is constantly changing, and it is the responsibility of each physician, non-physician practitioner, supplier or provider to remain abreast of the Oklahoma EHR Incentive program requirements.

Definitions per Final Rule and/or Oklahoma State Medicaid:

****Acceptable Documentation:*** documentation that meets the requirement needs for your attestation. (Examples below)

- Vendor Letter - The EHR vendor on vendor letterhead or an email with vendor logo. A sample can be found on the OHCA web site and will contain:
 - Provider name and point of contact
 - Vendor name and point of contact
 - Certified system name, version and ONC certification number
 - CMS EHR certification ID
 - *Note this is not considered a valid auditable data source. A copy of the legal or binding agreement must be presented at the time of an audit

Or

- Legal or Binding Agreement between the provider and EHR Vendor.

And each of the following (where applicable):

- Patient Volume Report – Report showing SoonerCare encounters being reported for the 90 day period selected and will contain:
 - Provider Name
 - SoonerCare Provider ID
 - Member/Patient Name
 - SoonerCare Member ID
 - Date of Service of encounter
 - Primary Diagnosis (upon request)
- Meaningful Use Report – Report showing the meaningful use and CQM findings for the reporting period.
- Board Certified Pediatrician – Copy of the certification from the board.

Acquisition: acquire health information technology (HIT) equipment and/or services from commercial sources or from State or local government resources for the purpose of implementation and administration of EHR.

Acute Care Hospital: health care facility;

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

Adopt, Implement, or Upgrade (AIU): (Ended 3-31-2017)

- (1) Acquire, purchase, or secure access to certified EHR technology (proof of purchase or signed contract will be an acceptable indicator);
- (2) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or
- (3) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.

CEHRT: Certified Electronic Health Record Technology

Children's Hospital: separately certified children's hospital, either freestanding or hospital-within hospital that:
(1) Has a CMS certification number, (previously known as the Medicare provider number), that has the last 4 digits in the series 3300–3399; and
(2) Predominantly treats individuals less than 21 years of age.

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

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

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

Medicaid Non-Billed Encounter for an EP: services rendered to an enrolled Medicaid patient on any one day where the encounter was never submitted for reimbursement.

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

Medicaid Non-Billed Encounter for an EH: services rendered to an enrolled Medicaid patient on any one day where the encounter was never submitted for reimbursement.

Medicaid Management Information System (MMIS): electronic Medicaid claims payment system.

Needy Individuals: individuals that meet one of the following;

- (1) Were furnished medical assistance paid for by TXIX Medicaid or TXXI Children's Health Insurance Program funding including SoonerCare, out-of-state Medicaid programs, or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- (2) Were furnished uncompensated care by the provider; or
- (3) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay.

Physician Assistant (PA) led Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC):

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

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

Pediatrician: a Medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must: (1) hold a four-year undergraduate college degree; (2) hold a four-year Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) degree; (3) have at least three (3) years of residency training; (4) hold a valid, unrestricted medical license, **and** (5) hold a board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American State of Oklahoma Osteopathic Board of Pediatrics (AOBP).

Practices Predominantly: More than 50 percent of a provider's total patient encounters occur at a federally qualified health center or rural health clinic. The calculation is based on a period of six (6) months in the most recent calendar year.

Problem List: contains an up-to-date list of current and active diagnoses which may include both chronic and acute diagnoses.

State Medicaid HIT Plan (SMHP): a document that describes the State's current and future HIT activities.

Useful Acronyms:

ABP	American Board of Pediatrics
AIU	Adopt, Implement, or Upgrade (of certified EHR technology)
AOBP	American Osteopathic Board of Pediatrics
AR	Accounts Receivable
ARRA	American Recovery and Reinvestment Act of 2009
CAH	Critical Access Hospital
CCN	CMS Certification Number
CEHRT	Certified EHR Technology
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CPOE	Computerized Physician Order Entry
CQM	Clinical Quality Measures
CY	Calendar Year (January through December)
EH	Eligible Hospital
EHR	Electronic Health Record
EP	Eligible Professional
FFY	Federal Fiscal Year (October through September)
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
MMIS	Medicaid Management Information System
MU	Meaningful Use
NHIN	National Health Information Network
NPI	National Provider Identifier
NPES	National Plan and Provider Enumeration System
OAC	Oklahoma Administrative Code
OHCA	Oklahoma Health Care Authority
ONC	Office of the National Coordinator (preferred abbreviation for ONCHIT)
PA	Physician Assistant
RHC	Rural Health Clinic
SMHP	State Medicaid Health Information Technology Plan
TIN	Taxpayer Identification Number

Eligibility:

Per federal rule, EPs must begin the program no later than CY 2016 and EHs must begin by FFY 2016. The following SoonerCare and out-of-state Medicaid providers are eligible to participate in the Oklahoma incentives program:

- A physician (MD and DO)
- A dentist
- A certified nurse-midwife
- A nurse practitioner
- A physician assistant practicing in a Federally Qualified Health Center (FQHC) led by a physician assistant or a rural health clinic (RHC), that is so led by a physician assistant (see definition on page 5).
- Acute care hospitals
- Children's hospitals

Additional requirements for the EP: To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must not be hospital-based and must meet the following criteria:

1. Meet one of the following patient volume criteria:
 - a. Have a minimum of 30 percent patient volume attributable to individuals receiving Medicaid funded services**; or
 - b. Have a minimum 20 percent patient volume attributable to individuals receiving Medicaid funded services, and be a pediatrician**; or
 - c. Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals.
2. Have a valid contract with OHCA*;
3. Have no sanctions and/or exclusions;

* A valid contract means that the provider is currently contracted with OHCA to provide services at the time of attestation. An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he/she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the Medicare & Medicaid EHR Incentive Program Registration and Attestation System and must match a TIN linked to the individual provider in OHCA's system. Also, the banking information for the individual or entity receiving the payment must be on file with OHCA. Finally, providers may not enter into the Oklahoma EHR Incentive system while their contract is under review by OHCA for renewal. This means the system will not be available to a provider for attestation from the time the contract is submitted for renewal until it has been approved by OHCA.

** The Centers for Medicare and Medicaid Services allow rounding 29.5% and higher to 30% for purposes of determining patient volume. Similarly, pediatric patient volume may be rounded from 19.5% and higher to 20%. Finally, acute care hospitals are required to demonstrate a patient volume of at least 10% Medicaid patients over a 90-day period in the fiscal year preceding the hospital's payment year or in the 12 months before attestation. Hospitals' patient volume may be rounded from 9.5% and higher to 10%.

Additional requirement for the EH: To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

- An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment.
- A children's hospital (exempt from meeting a patient volume threshold).

Hospital-based providers are not eligible for the EHR incentive program unless they can demonstrate that they have funded the acquisition, implementation, and maintenance of Certified EHR Technology, including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an eligible hospital or CAH; and uses such Certified EHR Technology in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT). Other providers and hospitals that are currently ineligible for the Oklahoma EHR Incentive Program include behavioral health (substance abuse and mental health) providers and facilities, and long-term care providers and facilities. Note that some provider types eligible for the Medicare program, such as chiropractors, are not eligible for the Oklahoma EHR Incentive Program per federal regulations.

Qualifying Providers by Type and Patient Volume:

EH Type	Patient Volume over 90-day Period
Acute Care Hospital	10%
Children's Hospital	No percentage requirement
EP Type	Patient Volume over 90-day Period
Physicians (M.D., D.O.)	<ul style="list-style-type: none"> ○ 30% SoonerCare ○ For Medicaid EPs in FQHC/RHC - 30% Needy Individuals
Dentists	
Certified Nurse Midwives	
Nurse Practitioners	
PAAs in FQHC/RHC led by a Physician Assistant (PA)	
Pediatricians	<ul style="list-style-type: none"> ○ 30% SoonerCare ○ If Pediatrician patient volume = 20-29%, the provider may qualify for 2/3 of incentive payment

Out-of-State Providers:

The Oklahoma EHR Incentive Program welcomes any out-of-state provider to participate in this advantageous program. Out-of-state providers have the same eligibility requirements as in-state providers. Oklahoma must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Oklahoma Medicaid program or CMS. Records must be maintained as applicable by law in the state of practice or Oklahoma, whichever is deemed longer.

Provider Registration:

Both EPs and EHs are required to begin by registering at the national level with the Medicare & Medicaid EHR Incentive Program Registration and Attestation System. Providers must provide their name, NPI, business address, phone number, tax payer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN. EPs may choose to receive the incentive payment themselves or assign their incentive payment to a clinic or group to which they belong (Provider will use a group TIN if they desire allocation of payment to the group instead of self). In order to receive the incentive payments from Oklahoma, the EP of a group must update their SoonerCare contract to a "yes biller" in order to receive a direct payment to them versus the group, otherwise if the group TIN is used the payment will be submitted to the group.

While not necessary to register, both EPs and EHs must enter the current CMS Certification Number for their ONC Certified EHR technology prior to attestation. As versions of your system are updated, it is possible that your CMS Certification Number may need updating. It is important that the system you have in your facility matches the CMS Certification Number on file for audit purposes. Remember to submit all changes or updates on the Medicare & Medicaid EHR Incentive Program Registration and Attestation System so update files can be transferred to OHCA.

Providers must revisit the Medicare & Medicaid EHR Incentive Program Registration and Attestation System to make any changes to their information. EHs seeking payment from both Medicare and Medicaid will be required to visit the Medicare & Medicaid EHR Incentive Program Registration and Attestation System annually to attest to meaningful use before returning to OHCA's website to attest for Oklahoma's Medicaid EHR Incentive Program.

The Medicare & Medicaid EHR Incentive Program Registration and Attestation System will assign the provider a CMS Registration Number and electronically notify OHCA of a provider's choice to access Oklahoma's Medicaid Incentive Program for payment. The information completed by the provider is sent to OHCA electronically overnight so there will be a delay between the time a provider registers at the federal level and the time that OHCA's system receives the information. One to two business days will be required for the transaction to be received by OHCA and the validation process (described below) to be performed before the provider can obtain access to the attestation system.

On receipt of Medicare & Medicaid EHR Incentive Program Registration and Attestation System Registration transactions from CMS, two (2) basic validations take place at the state level: 1) validate the NPI and the transaction is on file in OHCA's MMIS Provider database, and 2) validate the provider is currently contracted with OHCA (specific contracting requirements can be found on the OHCA public web site at www.okhca.org). If either of these conditions is not met, a 'provider not eligible' status will be automatically sent back to the Medicare & Medicaid EHR Incentive Program Registration and Attestation System. Providers may check back at the Medicare & Medicaid EHR Incentive Program Registration and Attestation System level to determine if the registration has been accepted.

Once payment is disbursed to the eligible TIN, OHCA will notify the Medicare & Medicaid EHR Incentive Program Registration and Attestation System that a payment has been made.

Establishing Patient Volume:

A Medicaid provider must annually meet patient volume requirements of Oklahoma's EHR incentive program as established through the State's CMS approved SMHP. Patients' funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) - CHIP. All EPs (except EPs predominantly practicing in an FQHC/RHC) will calculate patient volume based on TXIX SoonerCare and out-of-state Medicaid patients. The EHR statute allows for an EP practicing predominantly in an FQHC or RHC to consider CHIP patients under the needy individual patient volume requirements.

Patient Encounters Methodology:

ELIGIBLE PROFESSIONALS

(A) EPs (except those practicing predominantly in an FQHC/RHC) –

To calculate TXIX SoonerCare patient volume, an EP must divide:

- The total TXIX SoonerCare or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
- The total patient encounters in the same 90-day period.

(B) EPs Practicing Predominantly in an FQHC/RHC -

To calculate needy individual patient volume, an EP must divide:

- The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
- The total patient encounters in the same 90-day period.

Definition of an Eligible Professional SoonerCare Encounter:

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

A provider should have at least one (1) Medicaid encounter during the patient volume (PV) begin date or beginning of the program year (whichever is earlier) and the date the attestation was submitted in order to qualify for the program.

Definition of a Needy Individual Encounter:

For purposes of calculating patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

1. Paid for by TXIX Medicaid or TXXI Children's Health Insurance Program funding including SoonerCare, out-of-state Medicaid programs or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
2. Furnished by the provider as uncompensated care, or
3. Furnished at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay.

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

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

ELIGIBLE HOSPITALS

To calculate TXIX SoonerCare patient volume, an EH must divide:

- The total TXIX SoonerCare and out-of-state Medicaid paid encounters in any representative 90-day period in the preceding federal fiscal year; by
- The total encounters in the same 90-day period.
 - Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period.
 - An emergency department must be part of the hospital.

Eligible Hospital SoonerCare Encounter:

For purposes of calculating eligible hospital patient volume, a SoonerCare encounter is defined as services rendered to a Medicaid-enrolled individual per inpatient bed days to include the discharge day and services rendered to an individual in an emergency room on any one day at the time of the billable or non-billable service.

Exception - A children’s hospital is not required to meet Medicaid patient volume requirements.

Payment Methodology for EPs:

The maximum incentive payment an EP could receive from Oklahoma Medicaid equals \$63,750, over a period of six (6) years, or \$42,500 for pediatricians with a 20-29 percent SoonerCare patient volume.

<u>Provider</u>	<u>EP</u>	<u>EP-Pediatrician</u>
Patient Volume	30%	20-29%
Year 1	\$21,250	\$14,167
Year 2	8,500	5,667
Year 3	8,500	5,667
Year 4	8,500	5,666
Year 5	8,500	5,666
Year 6	<u>8,500</u>	<u>5,666</u>
Total Incentive Payment	<u>\$63,750</u>	<u>\$42,500</u>

Since pediatricians are qualified to participate in the Oklahoma Medicaid EHR incentive program as physicians, and therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

Payments for SoonerCare Eligible Professionals:

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the Medicare & Medicaid EHR Incentive Program Registration and Attestation System. The TIN must be associated in the Oklahoma SoonerCare MMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated. EPs who assign payment to themselves (and not a group or clinic) will be required to provide OHCA with updated EFT information for payments. Each EP must have a current SoonerCare contract with OHCA at the time of attestation.

The Oklahoma Medicaid EHR Incentive program does **not** include a future reimbursement rate reduction for non-participating Medicaid providers. (Medicare requires providers to implement and meaningfully using certified EHR technology by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that he/she was a meaningful user of EHR technology during that year. Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021.

Maximum Incentive Payments for EPs:

Calendar Year	Medicaid EPs who begin meaningful use of certified EHR technology in--					
	2011	2012	2013	2014	2015	2016
2011	\$21,250	-----	-----	-----	-----	-----
2012	\$8,500	\$21,250	-----	-----	-----	-----
2013	\$8,500	\$8,500	\$21,250	-----	-----	-----
2014	\$8,500	\$8,500	\$8,500	\$21,250	-----	-----
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	-----
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017	-----	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018	-----	-----	\$8,500	\$8,500	\$8,500	\$8,500
2019	-----	-----	-----	\$8,500	\$8,500	\$8,500
2020	-----	-----	-----	-----	\$8,500	\$8,500
2021	-----	-----	-----	-----	-----	\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

OHCA currently requires that all providers submit a valid NPI as a condition of SoonerCare provider enrollment. Each EP or EH will be enrolled as an OHCA SoonerCare provider and will therefore, without any change in process or system modification, meet the requirement to receive an NPI. OHCA performs a manual NPPES search to validate NPIs during the enrollment process.

In the event OHCA determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. Providers may refund the money to OHCA in a lump sum, or an AR account will be set up for the provider and the overpayment recouped through future payments. The existing practice allows OHCA to work out an acceptable repayment period dependent upon the provider circumstances.

Payment Methodology for Eligible Hospitals:

The Medicaid EHR Incentive Program hospital calculation is a onetime calculation of a total incentive payment, which is distributed by States over a minimum of three (3) years and a maximum of six (6) years. The calculation consists of two (2) main components:

- 1. The Overall EHR Amount**
- 2. The Medicaid share**

The Overall EHR Amount

Generally stated, the overall EHR amount is a dollar amount calculated based on a hospital's total number of inpatient acute care discharges over a theoretical 4-year period.*

To calculate the overall EHR amount, a State must determine a "discharge-related amount" that is based on a hospital's total number of inpatient acute care discharges and then increase (or decrease) that discharge figure by an average annual rate of growth. Hospitals that begin participation in 2013 and later will use the most recent continuous 12 month period for which data are available, prior to the payment year when determining the discharge-related amount. Hospitals that began participation in the program prior to program year 2013 will not have to adjust previous calculations. Hospitals that initiated participation in 2011 and 2012 must have used data on hospital discharges from the hospital fiscal year that ends during the federal fiscal year prior to the hospital fiscal year that serves as the first payment year.

Because only the first year uses actual discharge data, there is a need to estimate a hospital's future discharges. In order to do this, an average annual growth rate is applied.

****It is a "theoretical" 4-year period, because the overall EHR amount is not determined on an annual basis; rather, it is calculated once, based on how much a hospital might be paid over four (4) years.***

The Overall EHR amount is determined by calculating for each of the theoretical four (4) years of payment the following amount, and then adding all four (4) years together for the overall amount:

Initial amount * Transition Factor

The Initial Amount

Initial Amount = a base amount of \$2,000,000 + a discharge-related amount for each year.

Table 1 (below) provides three (3) examples of the initial amount calculation, based on discharges.

The Discharge-Related Amount

The discharge-related amount provides an additional \$200 for discharges between 1,150 and 23,000 for each of the four (4) years. No payment is made for discharges less than 1,150, or for discharges greater than 23,000.

Computing the Average Annual Growth Rate

The average annual growth rate is calculated by averaging the annual percentage change in discharges over the most recent three (3) years of available data. This average is then applied to the first year's discharges to either increase or decrease the total discharges in theoretical years 2 through 4. Note that if a hospital's average annual rate of growth is negative over the 3 year period, it is applied as such.

Table 1: Initial Amount Calculation

Type of Hospital	Hospitals with 1,149 or fewer discharges during the payment year	Hospitals with at least 1,150 but no more than 23,000 discharges during the payment year	Hospitals with 23,000 or more discharges during the payment year
Base Amount	\$2,000,000	\$2,000,000	\$2,000,000
Discharge-Related Amount	\$0	\$200 x (n - 1,149) (n is the number of discharges (see above discussion of the discharge related amount for additional information))	\$200 x (23,000 - 1,149)
Total Initial Amount	\$2,000,000	Between \$2,000,000 and \$6,370,200 depending on the number of discharges	Limited by law to \$6,370,200

Transition Factor

The transition factor is applied to the initial amount, so that the initial amount diminishes by 25 percent for each year.

Table 2: Transition Factor by Year

Transition Factor	
Year 1	1.00
Year 2	0.75
Year 3	0.50
Year 4	0.25

Once the transition factor is applied, all four (4) years are totaled to determine the Overall EHR Amount.

The Medicaid Share

The formula for the Medicaid Share is as follows:

$$\frac{\# \text{ of Medicaid Acute Inpatient Days} + \# \text{ of Acute Inpatient Managed Care days} *}{\text{Total Acute Inpatient Hospital Days} \times \left[\frac{\text{Total Charges} - \text{Charges attributable to Charity Care}}{\text{Total Charges}} \right]}$$

The numerator of the Medicaid Share is the sum of:

1. The estimated number of Medicaid acute inpatient-bed-days, and
2. The estimated number of Medicaid managed care* acute inpatient-bed-days.

*Managed Care includes individuals who are enrolled in a managed care organization, a pre-paid inpatient plan, or a pre-paid ambulatory health plan.

The denominator of the Medicaid Share is the product of:

1. The estimated total number of acute inpatient-bed-days for the eligible hospital during that period; multiplied by
2. The Non-charity percentage:
 - o The estimated total amount of the eligible hospital's charges during that period, not including any charges that are attributable to charity care* divided by the estimated total amount of the hospital's charges during that period.

***The removal of charges attributable to charity care in the formula, in effect, increases the Medicaid Share resulting in higher incentive payments for hospitals that provide a greater proportion of charity care.**

Acute Inpatient: Both discharges and inpatient bed-days are limited to those from the acute care portion of a hospital (see "Additional Notes" below for information on acute inpatient).

Dual Eligible: The numerator of the Medicaid Share calculation must exclude Medicaid dual eligible acute inpatient-bed-days. In computing inpatient-bed-days, a State may not include estimated acute inpatient-bed-days attributable to individuals with respect to whom payment may be made under Medicare Part A, or acute inpatient-bed-days attributable to individuals who are enrolled with a Medicare Advantage organization under Medicare Part C. The denominator may include Medicaid Dual eligible acute inpatient-bed-days.

The Medicaid Aggregate EHR Incentive Payment Amount:

The Medicaid Aggregate EHR amount is the Overall EHR Amount multiplied by the Medicaid Share.

Additional Notes:

Data Sources

Auditable data sources for the Medicaid EHR hospital payment calculation include but are not limited to:

1. Providers' Medicare cost reports;
2. State-specific Medicaid cost reports;
3. Payment and utilization information from the State's MMIS (or other automated claims processing systems or information retrieval systems); and
4. Hospital financial statements and hospital accounting records.

Acute Inpatient Care

Page 44450 and page 44453 of the Medicare portion of the preamble in the final rule state that statutory language clearly restricts discharges and inpatient bed-days for the hospital calculation to discharges and inpatient bed-days related to the acute care portion of a hospital, because of the definition of "eligible hospital" in section 1886(n)(6)(B) of the Social Security Act (the Act).

Page 44497 of the final rule explains that statutory parameters placed on Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. Therefore, as Medicaid is held to the same parameters as Medicare, the same statutory definition of total discharges applies to Medicaid EHR incentive program hospital calculations.

For a more simple view of the EH payment calculation CMS has broken it down into four (4) steps:

- **EH Payment Calculation Step 1:**

Add:

- Base Amount (per statute) = \$2,000,000, *plus*
- Discharge related amount =
 - Year 1: \$200 per discharge for 1,150th – 23,000th discharge
 - Year 2-4: *multiplied by* the hospitals growth rate over the previous three (3) years' data

= Subtotal

- **EH Payment Calculation Step 2:**

Compute:

- **Subtotal** from previous calculation *multiplied by*...
- Transition Factor =
 - Year 1: 1
 - Year 2: $\frac{3}{4}$
 - Year 3: $\frac{1}{2}$
 - Year 4: $\frac{1}{4}$

= Overall EHR Amount

- **EH Payment Calculation Step 3:**

Compute:

- **Overall EHR Amount** *multiplied by*....
 - Medicaid Share:
 - Estimated Medicaid paid inpatient-bed-days *divided by*...
 - The results of:
 - Estimated total inpatient-bed-days *multiplied by*...
 - Estimated total charges minus charity care charges divided by estimated total charges

= Aggregate EHR Hospital Incentive Amount for the reporting year

- **EH Payment Calculation Step 4:**

Compute:

- **Aggregate EHR Hospital Incentive Amount for the reporting year** *multiplied by*....
 - Year 1: 50%
 - Year 2: 40%
 - Year 3: 10%

= Total EH Annual Incentive

Adopt, Implement or Upgrade (AIU) and Meaningful Use (MU): (Ended 3-31-2017)

Adopt, Implement or Upgrade (AIU). For AIU, a provider does not have to have installed certified EHR technology. The definition of AIU in 42 CFR 495.302 allows the provider to demonstrate AIU through any of the following: (a) acquiring, purchasing or securing access to certified EHR technology; (b) installing or commencing utilization of certified EHR technology capable of meeting meaningful use requirements; or (c) expanding the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the EHR certification criteria published by the Office of the National Coordinator of Health Information Technology (ONC). Thus, a signed contract indicating that the provider has adopted or upgraded would be sufficient. (This option is not available through the Medicare Incentive Program in which all providers must meet meaningful use in the first year.) At the time of attestation, the EP or EH will be required to provide either a copy of the entire signed and dated contract, a vendor letter on letterhead or an email with vendor logo printed out and submitted with attestation. Please note the vendor letter will not suffice as an auditable data source during an audit; your contract will be necessary as proof during an audit.

Meaningful Use (MU) Meaningful use of EHR technology is a major goal of this program. CMS has determined that MU will be rolled out in three (3) stages. The first year of Stage 1 will consist of an attestation for a 90 day period, and each subsequent year will consist of an attestation for a 365 day period (with the exception of 2014, 2015, 2016, 2017 where all attestations will be for a 90 day period) which will encompass two (2) participation years per stage.- For all returning providers, the EHR reporting period will be a full calendar year from January 1 to December 31.

The current rule will provide specific information on all stages which focuses heavily on establishing the functionalities in certified EHR technology that will allow for continuous quality improvement and ease of information exchange. They include:

- Electronically capturing health information in a structured format;
- Using that information to track key clinical conditions and communicating that information for care coordination purposes (whether that information is structured or unstructured, but in structured format whenever feasible);
- Implementing clinical decision support tools to facilitate disease and medication management; using EHRs to engage patients and families; and
- Reporting clinical quality measures and public health information.

Though some functionalities may be optional in various stages, all of the functionalities are considered crucial to maximize the value to the health care system provided by certified EHR technology. CMS encourages all EPs, EHs and CAHs to be proactive in implementing all of the functionalities of each stage in order to prepare for later stages of meaningful use, particularly functionalities that improve patient care, the efficiency of the health care system and public health. Current federal regulations indicate that providers practicing in multiple locations must provide meaningful use data only for locations that utilize certified EHR technology.

To meet each stage of meaningful use criteria, EPs and EHs must meet all objectives and measures. A particular objective may be excluded if the following criteria are met:

EPs only:

1. The federal regulations indicate the objective includes the option to attest that the objective is not applicable;

EPs and EHs:

2. Meets the criteria in the applicable objective that would permit the attestation.

Clinical Quality Measures:

Clinical quality measures, or CQMs, are tools that assist us with measuring and tracking the quality of healthcare services provided by our providers. These measures use a wide variety of data that are associated with a provider's ability to deliver quality care or relate to long term goals for health care quality. Many aspects of CQMs include: health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagements, population and public health, and clinical guidelines. As the EHR Incentive Program continues, CQMs may be updated or different per stages. For more information on CQMs you may visit the [National Library of Medicine Value Set Authority Center \(VSAC\)](#).

To demonstrate meaningful use successfully prior to 2014, eligible professionals, eligible hospitals and CAHs are required also to report clinical quality measures specific to eligible professionals or eligible hospitals and CAHs.

- Eligible professionals must report on six (6) total clinical quality measures: three (3) required core measures (substituting alternate core measures where necessary) and three (3) additional measures (selected from a set of 38 clinical quality measures).
- Eligible hospitals and CAHs must report on all 15 of their clinical quality measures.

To demonstrate meaningful use successfully 2014 and beyond, eligible professionals, eligible hospitals and CAHs are required to report:

- Eligible professionals must report on nine (9) of 64 approved CQMs. There are nine (9) CQMs recommended for adult populations, and nine (9) CQMs recommended for pediatric populations; however it is not mandatory to select these.
- Eligible hospitals and CAHs must report on 16 of the 29 approved CQMs. The selected CQMs must cover at least three (3) of the National Quality Strategy domains.

Provider Attestation Process and Validation:

OHCA will utilize the secure provider website to house the attestation system in the existing Online Enrollment section.

Once the registration information for an EP/EH has been validated, the provider should see a link to the attestation system once they select the "Update Provider File" link. *The link will only be visible to providers whose type in the MMIS system matches an EHR incentive eligible provider category.* If an eligible provider registers at the Medicare & Medicaid EHR Incentive Program Registration and Attestation System and does not receive the link to the attestation system within two (2) business days after registration, assistance is available by contacting the OHCA Health Information Technology Program Education Team 405-522-7EHR(7347).

The attestation is an amendment and becomes part of the provider's contract. Attestation must be completed within 90 days after the closing of the attestation participation year (calendar year for EPs and fiscal year for EHs.) Following is a description by eligible provider type of the information that a provider will have to report or attest to during the process.

Eligible Professional:

1. The EP will be asked to verify:
 - a. The CMS Registration Number on file;
 - b. The CMS Certification Number on file;
 - c. The Payee information on file; and
 - d. The provider information provided by CMS.
2. The EP will be asked to attest to:
 - a. Assigning the incentive payment to a specific TIN (only asked if applicable; provider and TIN to which the payment was assigned at the Medicare & Medicaid EHR Incentive Program Registration and Attestation System will be displayed;

- b. Not working as a hospital based professional (this will be verified by OHCA through claims analysis) unless proof exists the EHR system is purchased, owned, and used by the professional;
 - c. Not applying for an incentive payment from another state or Medicare;
 - d. Not applying for an incentive payment under another SoonerCare ID;
 - e. Adoption, implementation or upgrade of certified EHR technology; and
 - f. Meet the required thresholds for meaningful use in years 2-6.
3. EP will be asked to electronically sign the attestation.
 4. Upon completion of the electronic attestation EP will upload or fax the following:
 - a. Fax coversheet ,required when faxing;
 - b. Vendor Letter or entire signed and dated contract;
 - c. Patient Volume Report to include:
 - i. Provider Name
 - ii. SoonerCare Provider ID
 - iii. Member/Patient Name
 - iv. SoonerCare Member ID
 - v. Date of Service
 - vi. Primary Diagnosis for encounter
 - d. Meaningful Use Report;
 - e. Copy of board certificate for Pediatricians.

Eligible Hospital:

1. The EH will be asked to verify:
 - a. The CMS Registration Number on file;
 - b. The CMS Certification Number on file;
 - c. The CCN number on file;
 - d. The Payee information on file; and
 - e. The provider information provided by CMS.
2. The EH will be asked to attest to:
 - a. Adoption, implementation or upgrade of certified EHR technology or meaningful use;
 - b. Any dual reporting EHs will only be required to attest for MU at the CMS level;
 - c. Not receiving a Medicaid incentive payment from another state.
3. EH will be asked to electronically sign the attestation.
4. Upon completion of the electronic attestation EH will upload or fax the following:
 - a. Fax coversheet, when faxing;
 - b. Completed Hospital Calculation Worksheet (First Participation Year Only)
 - c. Vendor Letter or entire signed and dated contract
 - d. Patient Volume Report to include:
 - i. Provider Name
 - ii. SoonerCare Provider ID
 - iii. Member/Patient Name
 - iv. SoonerCare Member ID
 - v. Date of Service
 - vi. Primary Diagnosis for encounter

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, OHCA will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation. Upon receiving all necessary documentation, allow up to 30 days for review and processing. Processing time does not begin until all correct documentation has been received by OHCA.

The attestation itself will be electronic and will require the EP or EH to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All professionals and hospitals who attest to AIU/MU of certified EHR technology will be required to submit either: a vendor letter on vendor letterhead, a printed copy of a vendor email with vendor logo, or a complete signed and dated contract, a copy of the patient volume report and a copy of the meaningful use report. More information on documentation will be provided on the attestation website.

Three (3) automated notifications to the contact email address submitted in the EHR Attestation will be sent. It is important to utilize a regularly-monitored email to assure that you receive all messages. The messages are as follows:

- **Awaiting Documents** - The EHR attestation will systematically deny if supporting documents are not received (via upload or by fax) within 30 days the Attestation submission date.
- **Corrections Needed** - If you do not submit corrections to the EHR Attestation within 30 days of the initial request, the EHR Attestation will systematically deny.
- **Additional Documents Needed** - The EHR attestation will systematically deny if additional documents required are not received (via upload or by fax) within 30 days of the initial request

It is important to enter a regularly-monitored email address in the attestation to ensure that you receive all messages.

Requesting Payment:

By submitting your attestation you are notifying OHCA that you are requesting payment. Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and review and acceptance by OHCA, an incentive payment will be approved. Incentive payments will be electronically deposited based on EFT information on file for the provider or his assignee. Your payment will be reflected upon the correct weekly remittance advice as a “non-claim specific payout to provider”. In the event the payment is made to the group, and there are multiple payments, you may review a list of paid NPIs on our website www.okhca.org/ehr-incentive. The list will be broken out by payment date.

Program Integrity:

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

CMS will be responsible for conducting reviews on Eligible Hospitals for meaningful use (MU). OHCA will be responsible for conducting reviews on reported patient volume and AIU requirements. Should CMS deem it necessary to recoup payments made for MU, it will be necessary for OHCA to recoup payments made for MU as well.

Payment Recoupment:

When an erroneous payment occurs which results in an overpayment, repayment options will be discussed with the provider. A provider may choose to refund the payment in full in a lump sum, or an automatic recoupment will be set up to deduct the refund from future claim payments. The provider can send payment in full to:

OHCA
Attention: Finance Division
PO Box 18299
Oklahoma City, OK 73154

Administrative Appeals:

Administrative appeals of decisions related to the Oklahoma EHR Incentive Payment program will be handled under the procedures described in OAC 317:2-1-2(b). See below for the provider process overview:

- All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).
- The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)
- If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.
- The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.
- A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.
- The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.