



Medicaid EHR Incentive Program

Eligible Hospital Meaningful Use Attestation Manual

February 15, 2012
Version 1.1



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1 INTRODUCTION

The Kentucky Medicaid EHR Incentive Program will provide incentive payments to Eligible Hospitals (EH) and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>
- Kentucky State Medicaid HIT Plan (SMHP) Version 1.0 located at <http://chfs.ky.gov/dms/EHR.htm>
- Kentucky Medicaid EHR Application Portal located at <https://apps4.chfs.ky.gov/kyslr/>
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>
- Office of the National Coordinator for Health Information Technology located at http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

Revisions

- Original 12/18/2011
- Revised 2/15/2012 (1.20 application release)

2 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 <http://www.healthit.hhs.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.

The Kentucky Department for Medicaid Services (DMS) will work closely with federal and state partners to ensure the Kentucky Medicaid EHR Incentive Program fits into the overall strategic plan for the Kentucky Health Information Exchange (KHIE), thereby advancing national and Kentucky goals for HIE.

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

3 ELIGIBILITY

While EHs can begin the program in Calendar Year (CY) 2011, they must begin the program no later than Federal Fiscal year (FFY) 2016.

The first tier of provider eligibility for the Kentucky Medicaid EHR Incentive Program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the KY MMIS provider data store does not correspond to the provider types and specialties approved for participation in the Kentucky Medicaid EHR Incentive Program, the provider will receive an error message with a disqualification statement.

At this time, CHFS DMS has determined that the following hospitals are potentially eligible to enroll in the Kentucky Medicaid EHR Incentive Program:

- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children's Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

3.1 Additional requirements 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:

1. 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 or
2. A children's hospital (exempt from meeting a patient volume threshold).

Hospital-based providers are not eligible for the EHR incentive program.

Qualifying Providers by Type and Patient Volume

Program Entity	Percent Patient Volume over Minimum 90-days
Acute care hospital	10%
Children's Hospital	Exception

3.1.1 Out-of-State Providers

The Kentucky Medicaid EHR Incentive Program welcomes any out-of-state provider to participate in this program as long as they have at least one physical location in Kentucky. Kentucky 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 Kentucky DMS program or CMS. Records must be maintained as applicable by law in the state of practice or Kentucky, whichever is deemed longer.

4 ESTABLISHING PATIENT VOLUME

A DMS provider must annually meet patient volume requirements of Kentucky's Medicaid EHR Incentive Program as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP.

4.1 Eligible Hospitals

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

- The total TXIX DMS and out-of-state Medicaid encounters in any representative 90-day period in the preceding 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. (*Please note per CMS FAQ nursery days are excluded from inpatient bed days*)
 - An emergency department must be part of the hospital.

4.1.1 Eligible Hospital DMS Encounter

For purposes of calculating eligible hospital patient volume, a DMS encounter is defined as services rendered to an individual 1) per inpatient discharge, or 2) on any one day in the emergency room where TXIX DMS or another state's Medicaid program paid for:

- Part or all of the service;
- Part or all of their premiums, co-payments, and/or cost-sharing;

Exception – a children's hospital is not required to meet Medicaid patient volume requirements.

5 PAYMENT METHODOLOGY FOR ELIGIBLE HOSPITALS

Statutory parameters placed on Kentucky Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Children's hospitals and acute care hospitals may be paid up to 100 percent of an aggregate EHR hospital incentive amount provided over a three-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Kentucky is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Kentucky Medicaid incentive payments to those providers. Auditable data sources include:

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

The Kentucky Medicaid EHR Incentive Program hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

Where:

Overall EHR Amount = {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}

Medicaid Share = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

Kentucky intends to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Kentucky Medicaid payments. The reason for this approach is that most of Kentucky's numerous rural hospitals operate on a very thin margin and need the money as soon as possible to offset their EHR system costs.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH.

Kentucky has worked with CMS on ways to effectively calculate costs. For example, charity care costs are not included on Kentucky's cost report. Kentucky has received approval from CMS to use the Kentucky Medical Assistance Program (KMAP) disproportionate share form data in lieu of cost

reports for this data. A standard questionnaire is used to determine the disproportionate share.

To the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients, the statute directs that such figure is deemed to equal 0. Likewise, if there is simply not sufficient data for the state to estimate the percentage of inpatient bed days that are not charity care (that is, [estimated total charges— charity care charges]/estimated total charges), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid, contingent on successful demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

6 PROVIDER REGISTRATION

EHRs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. 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.

Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments unless information needs to be updated. EHRs seeking payment from both Medicare and Medicaid will be required to visit the NLR annually to attest to meaningful use before returning to the KYSLR system to attest for Kentucky's Medicaid EHR Incentive Program. DMS will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The NLR will assign the provider a CMS Registration Number and electronically notify DMS of a provider's choice to access Kentucky's Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the KYSLR system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a provider with the Kentucky DMS. If either of these conditions is not met, a message will be automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted.

Once payment is disbursed to the eligible TIN, NLR will be notified by DMS that a payment has been made.

7 PROVIDER ATTESTATION PROCESS AND VALIDATION

DMS will utilize the secure KYSLR system to house the attestation system. 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 NLR and does not receive the link to the attestation system within two business days, assistance will be available by contacting the DMS Provider Enrollment Call Center Operations.

Following is a description of the information that a provider will have to report or attest to during the process.

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the EH will be asked provide:
 - Completed patient volume information on the KYSLR Web site;
 - Completed Hospital EHR Incentive Payment Worksheet;
 - Certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules); and
2. The EH will be asked to attest to:
 - Adoption, implementation or upgrade of certified EHR technology or meaningful user;
 - Not receiving a Medicaid incentive payment from another state; and
3. The EH will be asked to electronically sign the amendment;
 - The provider enters his/her initials and NPI on the Attestation Screen (there is a place for an agent or staff member of the provider to so identify); and
 - The person filling out the form should enter his or her name.

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, DMS will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the 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 providers will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

During the first year of the program is the only time an EH will be allowed to attest to adopting, implementing or upgrading to certified EHR technology. It should be noted that the documentation for AIU of certified EHR technology for EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (the Certified Health IT Product List can be located at ONC's website at <http://www.healthit.hhs.gov>). EHs can attest to either AIU or meaningful use as appropriate.

All providers will be required to attest to meeting meaningful use to receive incentive payments after the first year.

8 INCENTIVE PAYMENTS

DMS plans to use the Supplemental Payment functionality in the Kentucky MMIS to set up financial transactions for incentive payments. To accomplish this, the Expenditure Panels will need be modified, and CHFS DMS will ensure this functionality is added. This will enable staff to query payments by originator. Specific accounting codes will also be required for the transactions to enable DMS to report the funds in the CMS-64 report. Different codes will be needed for each payment year.

Kentucky will ensure all reporting requirements and modifications to the MMIS are made to correctly report expenditures, attestation information, and approval information. This will include the creation of a new Management and Administrative Reporting (MAR) category of service for state and federal reporting. DMS will also make the necessary changes to the CMS-64 reporting process to add the additional line item payment and administrative information, and, if required by CMS, the Medicaid Statistical Information System (MSIS) file will be modified to accommodate the incentive payment program.

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and validation by DMS, an incentive payment can be approved.

9 PROGRAM INTEGRITY

DMS will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers should be sure to keep their supporting documentation.

10 ADMINISTRATIVE APPEALS

You may appeal the determination made by the Kentucky Department for Medicaid Services on your incentive payment application. Please send a Formal Letter of Appeal to the address below, within 30 days of the determination date of notification. This formal written notification must include a detailed explanation of why the EP or EH deems a wrong determination made by the Kentucky Medicaid EHR Incentive Program. Any supporting documentation to the appeal should be included with the Letter of Appeal.

Division of Program Integrity
Department for Medicaid Services
275 E. Main Street, 6E-A
Frankfort, KY 40621

11 REGISTRATION (ELIGIBLE HOSPITALS)

Hospitals will be required to provide details including patient volume characteristics, EHR details, growth rate and Medicaid. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual). They will first register with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>. This registration is only needed once, if this is your second year of the EHR Incentive Program then you may go directly to the KYSLR sight shown below.

The hospital provider then begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system at <http://chfs.ky.gov/dms/ehr.htm> (sign-in screen shown below) and entering the NPI and CMS-assigned registration identifier that was received from CMS.

11.1 Eligible Hospital Sign-in Screen



The provider will enter the NPI registered on the NLR and the CMS-assigned Registration Identifier that was returned by the NLR. Please allow 48 hours from registration to log into the KYSLR. The EH will only need to register once, if you are a returning provider you will be able to log in at any time.

If the data submitted by the provider matches the data received from the NLR, the CMS/NLR Provider Demographics Screen will display with the pre-populated data received from the NLR. If the provider entry does not match, an error message with instructions will be returned.

11.2 Eligible Hospital CMS/NLR Screen

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
 KY MEDICARE EHR INCENTIVE PAYMENTS

Release 1.10
 KY Agency: KY Services
 TEST EHR HOSPITAL

CMS/NLR (Year 2 Attestation) [Logout](#)

CMS/NLR
[View All Payment Years](#)
[Issues/Concerns](#)
[Appeals](#)
[Additional Resources](#)
[User Manual](#)
[Send E-Mail](#)

You are currently enrolled in KY's EHR Incentive Program
 The current status of your application for the second year payment is 'AWAITING PROVIDER ATTESTATION'

Applicant National Provider Index (NPI): 777777777
 Applicant TIN: 777777777
 Payee National Provider Index (NPI):
 Payee TIN:
 Program Option: DUALY_ELIGBLE
 Medicaid State: KY
 Provider Type: Acute_Care_Hospitals
 Participation Year: 2
 Federal Exclusions:

Name: TEST EHR HOSPITAL
 Address 1: 3 800 Ave.
 Address 2:
 City/State: Owenton / KY
 Zip Code: 40359-1502
 Phone Number:
 Email: amy.sanders@ky.gov
 Speciality: CRITICAL ACCESS HOSPITAL
 State Rejection Reason:

*** If any of this information is incorrect, please correct on the [CMS Registration Module](#)
 *** If you want to change the mailing address, please modify it here

Mailing Address
 Address 1: 3 800 Ave.
 Address 2:
 City/State: Owenton KY
 Zip Code : 40359 1502 [Save](#)

Please select one of the following options:

Payment Year	Status	Action
1	Paid	View
2	Attest_inProcess	Begin/Modify Attestation

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The CMS/NLR screen lists information provided in your registration at the CMS Registration Module. In addition to that information you may update the following data directly from this screen:

- Mailing Address – This address is the address that you would like your incentive payment to be mailed.

Once you have completed the information required on the CMS/NLR screen click on the 'Save' button. You will click next if this is your first year applying or Begin/Modify Attestation next to the year that you are wishing to attest.

If any other data on this screen requires a change then you would need to go to the CMS Registration module (link provided on this screen) and update that information.

11.3 Hospital Eligibility Details Screen

Hospital Eligibility Details (Year 2 Attestation)

All * fields are required fields.

Patient Volume:	1. For which program year are you applying?	*	2012
	2. Select the starting date of the 90-day period(in the prior FFY) to calculate Medicaid patient volume percentage:	*	1/3/2011 (mm/dd/yy)
	3.(i) Medicaid Inpatient Discharges during this period:	*	500
	(ii) Medicaid ER/other Discharges (requires attestation):	*	50
	(iii) Total Medicaid patient discharges during this period:	*	550
	4. Total patient discharges during this period:	*	1000
	5. Medicaid patient volume percentage:		55.00%
EHR Details:	6. Enter the CMS EHR Certification ID of your EHR:	*	30000004HOWLEAS What is this?
	7. Indicate the status of your EHR:	*	<input checked="" type="radio"/> Meaningful User
Due to special circumstances does your Cost report information need to be adjusted?		*	<input type="radio"/> Yes <input checked="" type="radio"/> No
Growth Rate:	8. Select the end date of the hospital's most recently filed 12-month cost reporting period:	*	3/4/2010 (mm/dd/yy)
	9. Total number of discharges that fiscal year:	*	234 (w/s S-3, part I, col. 15, line 14)
	10. Total number of discharges one year prior:	*	333
	11. Total number of discharges two years prior:	*	345
	12. Total number of discharges three years prior:	*	4555
Medicaid Share:	13. Total Medicaid inpatient bed days (Exclude Nursery beds):	*	9000 (w/s S-3, part I, col. 7, line 14)
	14. Total Medicaid HMO inpatient bed days (Exclude Nursery beds):	*	9388 (w/s S-3, part I, col. 7, line 2)
	15. Total inpatient bed days:	*	155000 (w/s S-3, part I, col. 8, line 14)
	16. Total hospital charges:	*	209.00 (w/s c part I, col. 8, line 202)
	17. Total uncompensated care charges:	*	32.00 (KMAP-4, line 4)

As shown above, hospitals must enter four categories of data to complete the Eligibility Details screen including patient volume characteristics, EHR details, growth rate, and Medicaid share. Providers will enter the following data on the screen:

Patient volume

- Select the program year you wish to attest.
 - This should be either the current year or it can be the prior Federal Fiscal year if the current date is between 10/1 – 12/31.
- Starting date of the 90-day period to calculate Medicaid patient volume percentage
 - This date should be a 90 day period within the Federal Fiscal Year prior to the program year selected above.
- Medicaid Inpatient discharges during this period
- Medicaid ER/other discharges during this period
- Total patient discharges during the period – automatically calculated from the two responses above
- Medicaid patient volume percentage (calculated)

EHR details

- EHR certification ID of EHR
- Status of your EHR – Choices:

- (A) Adopt - Acquire, purchase, or secure access to certified EHR technology
- (I) Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
- (U) Upgrade - 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
- Meaningful User - currently meaningfully using certified EHR technology and are prepared to attest to Meaningful Use and Clinical Quality Measures.

Growth rate

- Due to special circumstances does your cost report information need to be adjusted – This should only be yes if the data used to calculate your original payment included nursery or swing bed days or you have been working with the Hospital Division due to another issue and requested that you update this information.
- End date of the hospital's most recently filed 12-month cost reporting period
- Total number of discharges that fiscal year
 - On the cost report documents this will be w/s S-3 part I, col. 15, line 14
- Total number of discharges one year prior
- Total number of discharges two years prior
- Total number of discharges three years prior
- Average annual growth rate (calculated)

Medicaid share

- Total Medicaid inpatient bed days
 - On the cost report documents this will be w/s S-3 part I, col. 7, line 14 and should not include nursery/swing bed days
- Total Medicaid Health Maintenance Organization (HMO) inpatient bed days
 - On the cost report documents this will be w/s S-3 part I, col. 7, line 2 and should not include nursery/swing bed days
- Total inpatient bed days (Please note per CMS FAQ nursery/swing days are excluded from inpatient bed days)
 - On the cost report documents this will be w/s S-3 part I, col. 8, line 14 and should not include nursery/swing bed days
- Total hospital charges
 - On the cost report documents this will be w/s c part I, col. 8 line 202 and should not include nursery/swing bed days Total uncompensated care charges
- Total uncompensated care charges

11.4 Meaningful Use Questionnaire Screen

After entering the provider eligibility details, EHs who have selected Meaningful Use will be directed to the Meaningful Use Questionnaire screen and will need to enter some additional data prior to entering data for their measures.

****Please note, if you are registered as a dual eligible hospital you must complete your MU attestation with Medicare prior to entering your attestation with Medicaid.**

EHR Reporting Period

The EHR reporting period is the timeframe that was used for the Meaningful Use Measure data and Clinical Quality Measures data that are being submitted during the attestation. This reporting period should be within the current program year that is being attested.

For the first year of reporting Meaningful Use EHs are required to report on a continuous 90 day period within the program year being attested. For the second year of reporting Meaningful Use an entire year of reporting will be required.

EH/ CAHs who are registered as dual eligibles will only have one year of 90 day reporting for Meaningful Use despite which program was attested. Their will never be two consecutive years of 90 day Meaningful Use reporting. Therefore if an EH/CAH has attested 90 days of MU to Medicare in one year they will either report the same 90 days in Medicaid during the same program/payment year or they will go directly to full year MU reporting with Medicaid during a later program/payment year.

Meaningful Use Questionnaire (Year 2 Attestation)

Meaningful Use Questionnaire

Please provide the EHR reporting period associated with this attestation:

- EHR Reporting Period Start Date: (mm/dd/yy)
- EHR Reporting Period End Date: (mm/dd/yy)
- Enter the percentage of unique patients who have structured data recorded your certified EHR technology as of the reporting period above:

*Emergency Department (ED) Admissions: An eligible hospital must choose one of the two methods to designate how patients admitted to the Emergency Department (ED) will be included in the denominators of certain Meaningful Use Core and Menu Measures. Please select the method that will be used for ALL Meaningful Use Core and Menu Measures:

Observation Services Method

All ED Visits Method

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The following fields are required to continue with the attestation:

- **EHR Reporting Period Start Date** – This is the starting date for the period of time you are reporting your Meaningful Use Measure data.
 - **If you are attesting as a dual eligible hospital then this date should be the same date as the one that was attested for your Medicare Meaningful Use attestation. The system will locate the file from Medicare from this date and you will not be requested to re-enter those measures already submitted to Medicare**
- **EHR Reporting Period End Date** – This is the end date for the period of time you are reporting your Meaningful Use Measure data.

- **If you are attesting as a dual eligible hospital then this date should be the same date as the one that was attested for your Medicare Meaningful Use attestation. The system will locate the file from Medicare from this date and you will not be requested to re-enter those measures already submitted to Medicare**

- Enter the percentage of unique patients who have structured data recorded in your certified EHR technology as of the reporting period above
 - This should be the percentage of all the patients you have seen total who have data recorded in your EHR. The amount of patients with structured data stored in your EHR should be at least 80%

- **Emergency Department (ED) Admissions**
 - Indicate the method that designates how patients admitted to the ED will be included in the denominators of certain Meaningful Use Core and Menu Measures.

11.5 Eligibility Incentive Payment Calculations Screen

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
KY MEDICAID EHR INCENTIVE PAYMENTS

Incentive Payment Calculations Logout

Patient Volume Calculations

Medicaid Patient Volume Percentage: 50.00% * should be greater than 10% to qualify
 Rate of growth prior year: 1.324%
 Rate of growth 2 years prior: 1.816%
 Rate of growth 3 years prior: 4.677%
 Average rate of growth: 2.606% * use this growth rate to project number of discharges for year 2 through year 4 below

EHR Amount Calculations

Year	Discharges	Allowable Discharges	Discharge Related Amount	Base Amount	Aggregate EHR amount	Transition Factor	EHR Amount
First year	25330	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	1.00	\$6,370,200.00
Second Year	25990	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.75	\$4,777,650.00
Third Year	26667	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.50	\$3,185,100.00
Fourth Year	27362	21851	\$4,370,200.00	\$2,000,000	\$6,370,200.00	.25	\$1,592,550.00
Total Amount							\$15,925,500.00

Medicaid Share Calculations

Total Medicaid and Passport Inpatient Bed Days: 6231
 Total Bed Days: 132145
 Percentage of total charges which are non-charity: (total charges - uncompensated charges)/total charges: 99.66%
 Total Beds that should be considered non charity: 131696
 Total Medicaid Percentage: 4.73135%
 Total Medicaid Aggregate EHR Incentive Payment: \$753,491.30
 Total Estimated Medicaid Aggregate EHR Incentive Payment First Year (50%): **\$376,745.65**

Previous Next

The screen lists the estimated payment for the EH or CAH for the current attestation.

11.6 Document Upload Screen

KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
KY MEDICAID EHR INCENTIVE PAYMENTS

Document Upload (Year 2 Attestation) Logout

Documentation needed to process your application may be attached below. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc. If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation. Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.

View	Payment Year	File Name	Description	Delete
<input type="button" value="View"/>	2	EP MU Spec sheet.pdf		<input type="button" value="Delete"/>

Upload a new PDF document:

Please select the documentation type:
 --Select the type of a document--

You have successfully uploaded: "EP MU Spec sheet.pdf"

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This page will allow the EH to attach documentation with their current year attestation.

- Clicking on the Browse button will allow the EH to search and select the documents they would like to attach
- Clicking on the upload button will attach and save the document relating to the current attestation payment year.
- Only PDFs up to 100MB can be uploaded

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.

After the EH has completed the Eligibility Details screens and press "Next," navigation will take them to the Attestation screen below.

11.7 Attestation Screen

KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
KEY MEDICAID EHR INCENTIVE PAYMENTS
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CMS/NLR:

Applicant National Provider Index (NPI):	0123456789	Name:	Demo Hospital
Applicant TIN:	012345678	Address 1:	123 Any Street
Payee National Provider Index (NPI):	0123456789	Address 2:	
Payee TIN:	012345678	City/State:	Anytown / KY
Program Option:	DUALLY_ELIGIBLE	Zip Code:	40000
Medicaid State:	KY	Phone Number:	(502) 123-4567
Payment Year:	1	Email:	demo.hospital@demo.org
Provider Type:	Acute_Care_Hospitals	Specialty:	

Hospital Eligibility Details:

Patient Volume:	1.	Select the starting date (in 2010) of the 90-day period to calculate Medicaid patient volume percentage:	5/6/2010 (mm/dd/yy)
	2.	Total Medicaid patient discharges during this period:	100
	3.	Total patient discharges during this period:	200
EHR Details:	4.	Enter the EHR certification number of your EHR:	300000015WU6EAK
	5.	Indicate the status of your EHR:	<input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User
Growth Rate:	6.	Select the end date of your last full hospital fiscal year that ended prior to September 30, 2010:	8/6/2010 (mm/dd/yy)
	7.	Total number of discharges that fiscal year:	25330 (w/s 5-3 part 1, col.5, line 12)
	8.	Total number of discharges one year prior:	24999
	9.	Total number of discharges two years prior:	24553
	10.	Total number of discharges three years prior:	23456
Medicaid Share:	11.	Total Medicaid inpatient bed days (Exclude Nursery beds):	6231
	12.	Total Medicaid HMO inpatient bed days (Exclude Nursery beds):	0
	13.	Total inpatient bed days:	132145
	14.	Total hospital charges:	919293949.00 (w/s c part 1, col.8, line 103)
	15.	Total uncompensated care charges:	3124555.00 (BMAP-4, line 4)

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

Initials:
 NPI:

Note: Once you press the submit button below, you will not be able to change your information.

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After submitting the initials and NPI, your attestation is complete.

11.8 Issues/Concerns Screen

The Issues / Concerns screen will work as it does today. The EH may submit an issue or concern by selecting an issue category and typing in the details of their issue or concern. It will be saved upon them clicking the submit button.

11.9 Appeals Screen

The Appeals screen is a read only screen that inform the EH of how to initiate an appeal and provides contact information for the appeal.

11.10 Meaningful Use

If you are a EH / CAH who is not registered as dually eligible and are only attesting for the Medicaid Incentive Payments then you will be required to go through the measure screens and enter the EH/CAH Measure data. Currently there are no hospitals in KY who are not dually eligible therefore the Measures must be submitted to Medicare prior to attesting for Medicaid. Please allow at least 3 days after your Medicare attestation to ensure the data has been sent to the State prior to your KY Attestation.

If you would like more information on the measures required for Meaningful Use please see the site below:

http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage