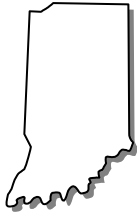
HP Provider Enrollment EHR Unit



INDIANA HEALTH COVERAGE PROGRAMS

# Indiana Electronic Health Records Incentive Program

POLICIES AND PROCEDURES AS OF NOVEMBER 1, 2011
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# Revision History

| Version | Date | Reason for Revision | Completed By |
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| 1.0 | May 17, 2011 | Initial Creation | HP Provider Relations and Provider Enrollment Units |
| 1.1 | Policies and Procedures as of November 1, 2011<br>Published: January 24, 2012 | Semiannual review | HP Provider Enrollment and Publications Units |

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# Section 1: Overview

## Electronic Health Records 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 (EPs) and eligible hospitals (EHs), 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 healthit.hhs.gov

Goals for the national program include:

- Enhance care coordination and patient safety
- Reduce paperwork and improve efficiencies
- Facilitate electronic information sharing across providers, payers, and state lines
- Enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals improves health outcomes, facilitates access, simplifies care, and reduces costs of healthcare nationwide.

Indiana works closely with federal and state partners to ensure the Indiana EHR Incentive Program fits into the overall strategic plan for the Indiana Health Information Exchange (INHIE), thereby advancing national and Indiana goals for HIE.

## EHR Resources

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule
- cms.gov/EHRIncentivePrograms
- healthit.hhs.gov
- Provider Services
  **Local Telephone: (317) 488-5145**
  **Toll Free Telephone: 1-855-856-9563**
  **Toll Free Fax: 1-866-293-7606**

## Definitions Per Final Rule (Federal) and/or Indiana State Medicaid Directives

**Acceptable documentation** means satisfactorily completed written evidence of an approved phase of work or contract and acceptance of the evidence thereof by the Indiana Provider Enrollment EHR

registration team. Acceptable documentation refers to the certified EHR technology by name and certification number and includes financial and/or contractual commitment. Document date does not have to be within the preceding fiscal year, if the reported version of the EHR technology was certified after the document date. See the following examples:

- Copy of invoice
- Copy of receipt
- Copy of contract

**Acquisition** means to 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** means a healthcare 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)** means—

1. Acquire, purchase, or secure access to certified EHR technology (proof of purchase or signed contract is an acceptable indicator).
2. Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements.
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.

**Children's hospital** means a 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 four digits in the series 3300–3399.
2. Predominantly treats individuals less than 21 years of age.

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

**Medicaid Encounter for an EP** means services rendered to an individual on any one day where:

- Medicaid paid for part or all of the service; or
- Medicaid paid all or part of the individual's premiums, copayments, and cost-sharing.

**Medicaid Encounter for an EH** means services rendered to an individual per patient discharge or services rendered to an individual in an emergency room on any one day where:

- Medicaid paid for part or all of the service; or
- Medicaid paid all or part of the individual's premiums, copayments, and cost-sharing.

**Medicaid Management Information System (MMIS)** means the electronic Medicaid claims payment system.

**Needy individuals** as defined by *Section 1903(t)(3)(F)* of the Act, defines needy individuals as individuals meeting any of the following three criteria:

1. They are receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP).
2. They are furnished uncompensated care by the provider.
3. They are furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

**Patient volume** means 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 Indiana.

**Pediatrician** means a medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children. A pediatrician must:

- Hold a four-year undergraduate college degree.
- Hold a four-year Doctor of Medicine (MD) or Doctor of Osteopathy (DO) degree.
- Have at least three years of residency training.
- Hold a valid, unrestricted medical license.

**Practices predominantly** means an EP for whom more than 50% of his or her total patient encounters occur at a federally qualified health center or rural health clinic. The calculation is based on a period of six months in the most recent calendar year.

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

# Section 2: Program Information

## Provider Eligibility

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

- A physician (MD and DO)
- A dentist
- A certified nurse-midwife
- A nurse practitioner (advanced practice nurse)
- Physician assistants (PAs) when practicing at an FQHC/RHC that is so led by a PA
- Acute care hospitals
- Critical access 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% patient volume attributable to individuals receiving TXIX Medicaid funded services.
    b. Have a minimum 20% patient volume attributable to individuals receiving TXIX Medicaid funded services, and be a pediatrician.
    c. Practice predominantly in a FQHC or RHC and have a minimum 30% patient volume attributable to needy individuals.
2. Have a valid agreement with Indiana Medicaid*.
3. Have no sanctions and/or exclusions.
4. Have valid license or certification.

* A valid agreement means that the provider is currently actively enrolled with Indiana Medicaid to provide services and has been enrolled for at least 90 days. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the National Level Registry (NLR) and must match a TIN linked to the individual provider in the Indiana Medicaid's provider enrollment system. Rendering providers cannot receive payment from Indiana Medicaid. Rendering providers must choose a billing provider TIN to receive payment on their behalf, which must be made when registering with the CMS NLR.

### *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% 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. Other providers and hospitals that are currently ineligible for the Indiana 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 EHR Incentive Program per federal regulations.

## Out-of-State Providers

The Indiana 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. Indiana must be the only state a provider is 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 Indiana Medicaid program or the CMS. Records must be maintained as applicable by law in the state of practice or Indiana, whichever is deemed longer.

# Section 3: Registering using Web interChange

## Web interChange EP and EH Registration Portal

Eligible EPs and EHs use Web interChange to initiate the EHR Incentive Payment Program registration process in Indiana. To access the Web interChange EH and EP Registration tool, you must have provider profile inquiry access. Log on to the secure server with your assigned Web interChange ID and password. If you are a rendering provider registering for the Electronic Health Record (EHR) Incentive Program, you need to obtain access to Web interChange to use the EHR Registration tool. Complete the interChange *Administrator Request Form* located under “How To Obtain An ID” on the Web interChange website at https://interchange.indianamedicaid.com/Administrative/logon.aspx Submit the request form and a letter of acknowledgement to the address on the form, or fax to HP EDI Solutions at (866) 293-7606. To complete the EHR registration process, all rendering providers need their own access to Web interChange. Groups are not able to access the EHR Incentive Program registration site on Web interChange.

### *Provider Registration*

EPs and EHs must 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, telephone number, taxpayer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN. EPs may choose to receive the incentive payment themselves, if they are enrolled as a billing provider, but must assign their incentive payment to a clinic or group to which they belong. If an EP provider is a rendering provider, they must submit the group’s TIN to Medicare & Medicaid EHR Incentive Program Registration and Attestation System to allocate the payment to the group instead of self.

EPs must select between Medicare and Medicaid’s incentive program. A provider may switch from one to the other once during the incentive program prior to 2015. If Medicaid is selected, the provider must choose only one state. EPs may switch states annually. Providers must revisit the Medicare & Medicaid EHR Incentive Program Registration and Attestation System 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 Medicare & Medicaid EHR Incentive Program Registration and Attestation System before seeking annual payments, unless information needs to be updated. EHs seeking payment from Medicare and Medicaid are required to visit the Medicare & Medicaid EHR Incentive Program Registration and Attestation System annually to attest to meaningful use before returning to Indiana Medicaid’s website to attest for Indiana’s Medicaid EHR Incentive Program. Indiana Medicaid assumes meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The Medicare & Medicaid EHR Incentive Program Registration and Attestation System assigns the provider a CMS Registration Number and electronically notifies Indiana Medicaid of a provider’s choice to access Indiana’s EHR Incentive Program for payment. The CMS Registration Number is validated when the provider completes the EHR Application and Attestation registration process at Indiana Medicaid’s enrollment and attestation website on Web interChange. The information completed by the provider is sent to Indiana Medicaid electronically overnight so there is a delay between the time a provider registers at the federal level and the time that Indiana Medicaid’s system receives the information. One to two business days are required for the transaction to be received by Indiana Medicaid and the following validation process to be performed before the provider can obtain access to the attestation system.

On receipt of the Medicare & Medicaid EHR Incentive Program Registration and Attestation System Registration transactions from the CMS, two basic validations take place at the state level:

- Validate the NPI in the transaction is in the Indiana Medicaid's MMIS Provider database.
- Validate the provider is currently enrolled with the Indiana Medicaid (for more than 90 days).

If either of these conditions is not met, a "provider not eligible" status is automatically returned 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 to determine if the registration has been accepted. If the validation check was good, then the provider may access the Indiana Web interChange EHR Registration tool by entering the CMS Registration number given when you registered with the Medicare & Medicaid EHR Incentive Program Registration and Attestation System. You must have security access to provider profile inquiry on Web interChange before being able to view or access the EHR Incentive Program registration link. There are system edits in place to verify the user is eligible to register and attest in the state of Indiana. Table 3.1 lists the errors that trigger error messages when the system validates and verifies data being entered by a user once the CMS registration number is entered on the tool's launch page. Error messages explain the error encountered.

Table 3.1 – Error and Error Message List

| Error | Error Message |
|---|---|
| User registering for the first time, and the participation year is after 2016. | Our records indicate this is your first participation year. EHR Incentive program participation may not begin after 2016. |
| User enters the CMS registration number and they do not have security access in Web interChange for the NPI reported on the B6. | You are not permitted to submit an EHR Incentive application because your Web interChange user ID is not linked to the NPI we received from the CMS. |
| User's NPI not on file with Indiana Medicaid. | Your NPI on file does not match the NPI we received from the CMS. Please contact Indiana Medicaid Provider Enrollment, EHR registration team for help. |
| User enters the CMS# and the search of the B6 does not find the CMS# as participating in IN. | Our records indicate you have switched your Medicaid EHR Incentive Program participation to another state (as reported to HP from the CMS). If you wish to participate in the Indiana EHR Incentive Program, change your preference in the CMS EHR Registration system. |
| User accessing has not been enrolled for the past 90 days. | Our records indicate you have not been actively enrolled for the required 90 day period prior to entry date within the preceding reporting year. |
| The user's CMS# is not associated with a TIN or NPI on the B6 file. | Our records indicated that either the payee TIN or the payee NPI is not associated with the CMS# entered. Please add or correct your payee TIN and payee NPI on the CMS EHR Registration system. |
| User enters a Payee TIN that is not associated with a billing provider number. | The Payee TIN you have assigned your EHR Incentive Payment is designated as a Rendering (nonbilling) provider in our system. Please submit a Billing provider TIN in the CMS EHR Registration system. |
| User enters a CMS# that is associated with a participation year that is >3 years for hospitals or >6 | Our records show that your CMS EHR Registration has expired. EH participation cannot be greater than 3 |

| Error | Error Message |
|---|---|
| years for professionals. | years and EP participation cannot be greater than 6 years. |
| User's type/specialty associated with the LPI/NPI registered with Indiana Medicaid is not valid. | Users LPI/NPI must have a primary type registered with Indiana Medicaid from the following list of eligible EHR provider type:<br>• 01=Hospital<br>• 31=Physician<br>• 09=Advanced Practice Nurses (includes both the NPs and the Nurse Midwife)<br>• 10=Mid-Level Practitioners (Physician Assistants)<br>• 27=Dentist |
| User enters a CMS# that has already been entered on Indiana Medicaid EHR registration tool. | Our records indicate you have already registered using this site. |
| Users TIN not on file with Indiana Medicaid | Your Tax ID Number on file does not match the Tax ID Number we received from the CMS. Please contact Indiana Medicaid Provider Enrollment, EHR Registration team for help. |
| User is an EH without a CCN listed on the B6 file | Your provider type on file with Indiana Medicaid indicates your provider type is hospital; however, we did not receive a CCN from the CMS. |
| Users CCN not on file with Indiana Medicaid | Your CCN on file with Indiana Medicaid does not match the CCN we received from the CMS. Please update your CCN information with Indiana Medicaid. |
| User is an EP with a CCN listed on B6 | Your provider type on file with Indiana Medicaid indicates you are not a hospital; however, we received a CCN from the CMS. Please verify that you are enrolled correctly with Indiana Medicaid. |
| Payee TIN submitted on the B6 is not associated with Payee NPI registered with Indiana Medicaid. | The Payee TIN to which you have assigned your EHR Incentive is not associated with this NPI Number in Indiana. In order to make proper payment, please verify the correct Payee TIN has been submitted to the CMS, or that the correct Payee TIN is on file with Indiana Medicaid. |
| Provider not associated with Payee NPI registered with Indiana Medicaid. | The Payee NPI to which you have assigned your EHR Incentive is not associated with this provider in Indiana. In order to make proper payment, please verify the correct Payee NPI has been submitted to the CMS, or that the correct Payee NPI is on file with Indiana Medicaid. |
| User times out before printing the Fax Cover Sheet. | Print function has timed out and you will not be able to print the fax cover sheet needed to complete the registration process. Please contact HP EHR Customer Service for assistance in completing the Indiana EHR registration. Call (317) 488-5137 if you are local to Indianapolis, or call 1-855-856-9563 toll free. |

User should follow instructions given on the error message to resolve issues with registering. If assistance is needed, user may contact HP EHR Customer Service at (317) 488-5137 or toll free at 1-855-856-9563.

## Provider Attestation Process and Validation

Indiana utilizes the secure provider profile website on Web interChange to house the EHR Application and Attestation registration tool. Providers need provider profile inquiry access to view and access the EHR Registration system. The steps and information needed to begin the registration process with Indiana are described below and are broken down between professionals and hospitals.

### *Eligible Professional*

1. The EP is asked to provide their CMS Registration Number.
2. The EP is asked to provide:
   a. A completed patient volume form (link on the web page);
   b. The certification number for the CMS certified EHR system (or numbers if obtained in modules); and
   c. Number of full-time employee jobs created by implementing a certified product.
3. The EP is asked to:
   a. Assign the incentive payment to a specific TIN (only asked if applicable; provider and TIN to which the payment was assigned at the NLR are displayed).
   b. Attest to not working as a hospital based professional (this is verified by Indiana Medicaid through claims analysis)
   c. Attest to not applying for an incentive payment from another state or Medicare
   d. Attest to not applying for an incentive payment under another Indiana Medicaid ID
   e. Attest to the adoption, implementation or upgrade of certified EHR technology.
   f. Certify that they have read the attestation's legal verbiage.
   g. Select their relationship to Provider (Provider, or member of provider's staff or an agent of provider).
   h. The person filling out the form should enter his or her name.
4. EP must print fax cover sheet containing the ATN (It is highly recommended that the Acknowledgment page with the ATN number be saved to the user's desktop or that the user record the ATN somewhere for future reference)
   a. EP must fax the required documents (patient volume worksheet, completed application and signed attestation form, and copy of receipt, invoice, or purchase order for EHR system) to the Indiana PE EHR registration team to complete the registration process.
   b. The registration packet must have the fax cover sheet with the ATN printed on the top for tracking purposes.
   c. From the acknowledgement page there is an "I want to" box with the following tasks listed, user must print i, ii, and iii, and it is highly recommended that user also print iv to use when corresponding with the Indiana EHR team about your application:
      i. Print fax cover sheet
      ii. Print Patient Volume Information worksheet
      iii. Print *EP Application and Attestation* form
      iv. Save and print copy of this screen

### Eligible Hospital

1. The EH is asked to provide their CMS Registration Number.
2. The EH is asked to provide:
   a. A completed patient volume form (link on the webpage)
   b. A completed Hospital IN EH Incentive Payment Worksheet
   c. The certification number for the CMS certified EHR system (or numbers if obtained in modules)
   d. Number of full-time employee jobs created by implementing a certified product
3. The EH is asked to attest to:
   a. Adoption, implementation, or upgrade of certified EHR technology or meaningful use
   b. Not receiving a Medicaid incentive payment from another state
4. The EH is asked to certify that they have read the attestation legal verbiage.
5. The EH is asked to enter the following information:
   a. Enter whether the submitter is an agent or a staff member of the hospital.
   b. Enter name of person (should be name of person with authority to submit application on behalf of the hospital).
6. EH must print fax cover sheet containing the ATN
   a. EH must fax required documents (patient volume worksheet; completed application and signed attestation form; the IN EH Hospital Calculation worksheet; and a copy of receipt, invoice, or purchase order for EHR system) to the Indiana PE EHR team.
   b. The registration packet must have the fax cover sheet with the ATN for tracking purposes.
   c. From the acknowledgement page there is an "I want to" box with the following tasks listed, user must print i, ii, iii, and iv, and it is highly recommended that user also print v to use when corresponding with the Indiana EHR team about your application:
      i. Print fax cover sheet
      ii. Print Patient Volume Information worksheet
      iii. Print *EP Application and Attestation* form
      iv. Print IN EH Incentive Payment worksheet
      v. Save and print copy of this screen

## Web interChange Screen shots

The following screen shots are the EHR Registration tool windows showing the information that the user needs to enter when starting the registration process for the Indiana EHR Incentive Program.

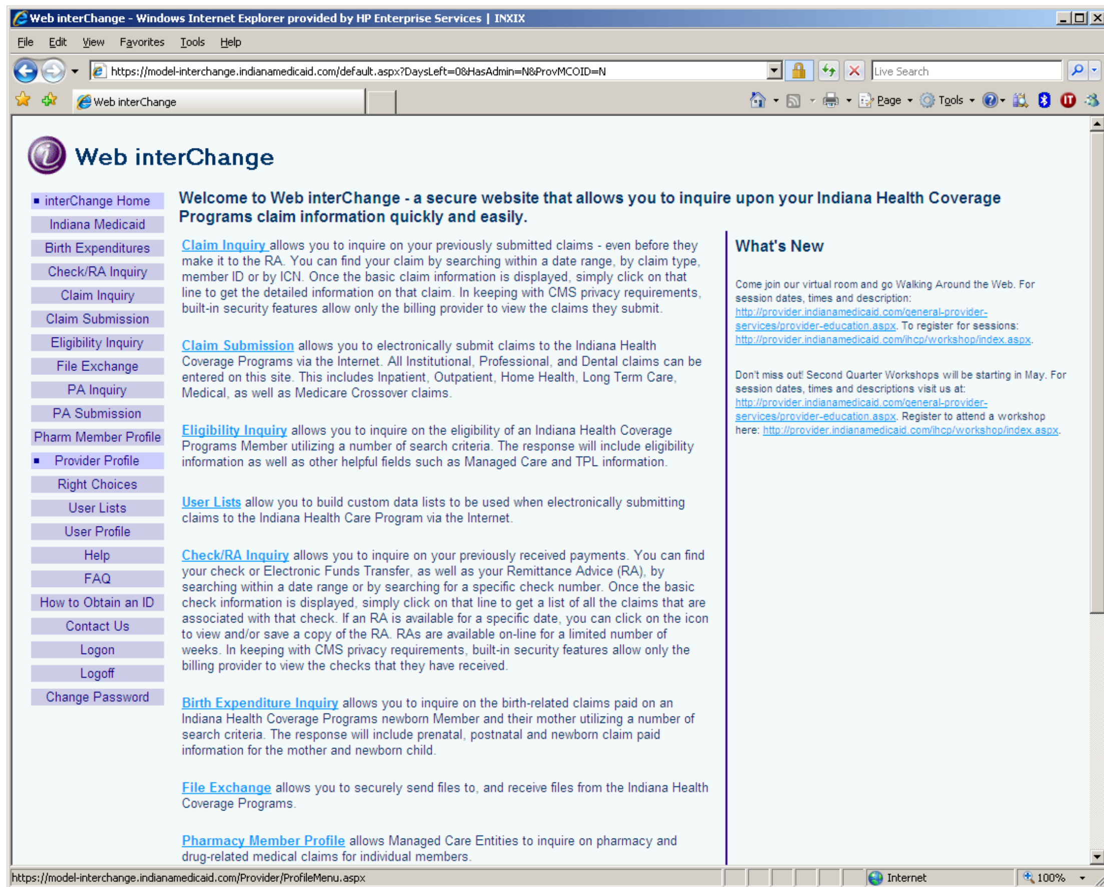


Figure 3.1 - Provider Profile Page in Web interChange

Provider view is dependent on security access. To choose the Provider Profile link, you must have valid security access. More information is available on the Web interChange website at [interchange.indianamedicaid.com](interchange.indianamedicaid.com)

## Provider Steps

1. Choose **Provider Profile** from menu on left.

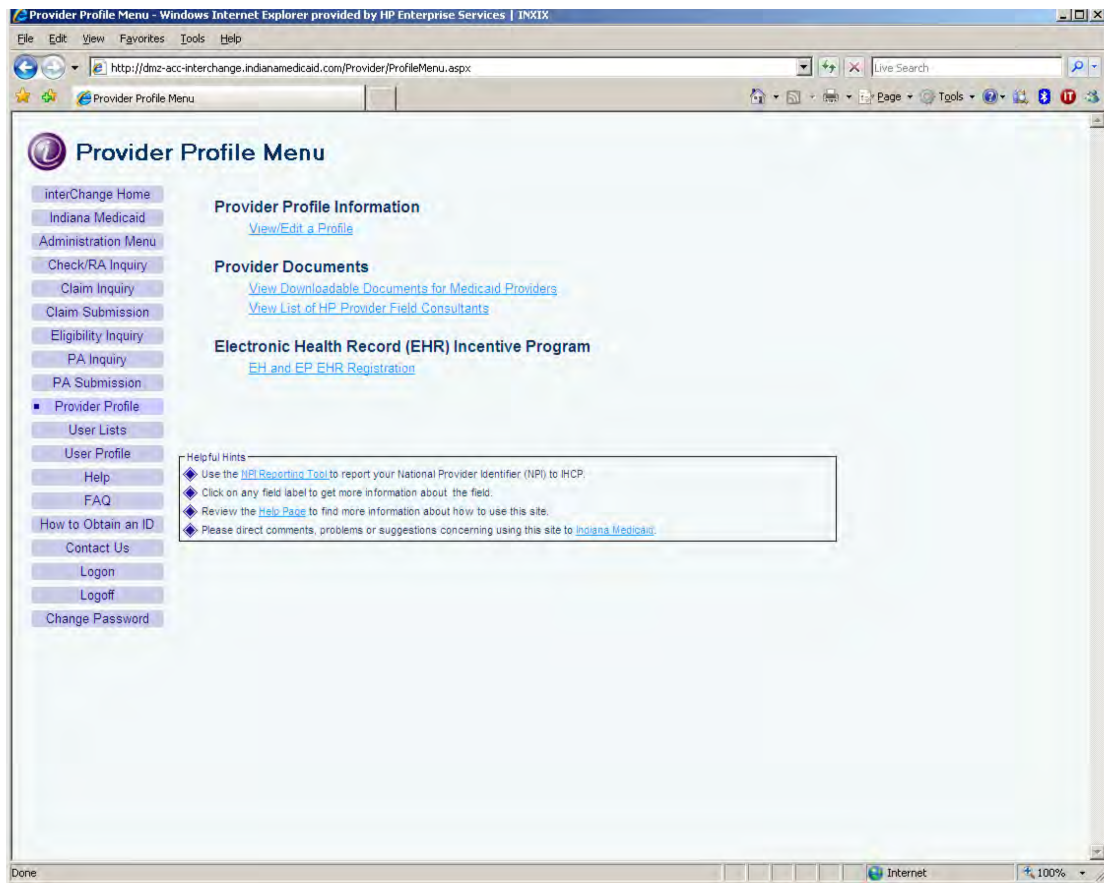


Figure 3.2 – Web interChange Provider Profile

| Note: | *Your view of this window may not be the same, but you must see the Electronic Health Record (EHR) Incentive Program with the EH and EP EHR Registration link to continue.* |
|---|---|

## Provider Steps

1. Choose **EH and EP EHR Registration** link under Electronic Health Record (EHR) Incentive Program heading.

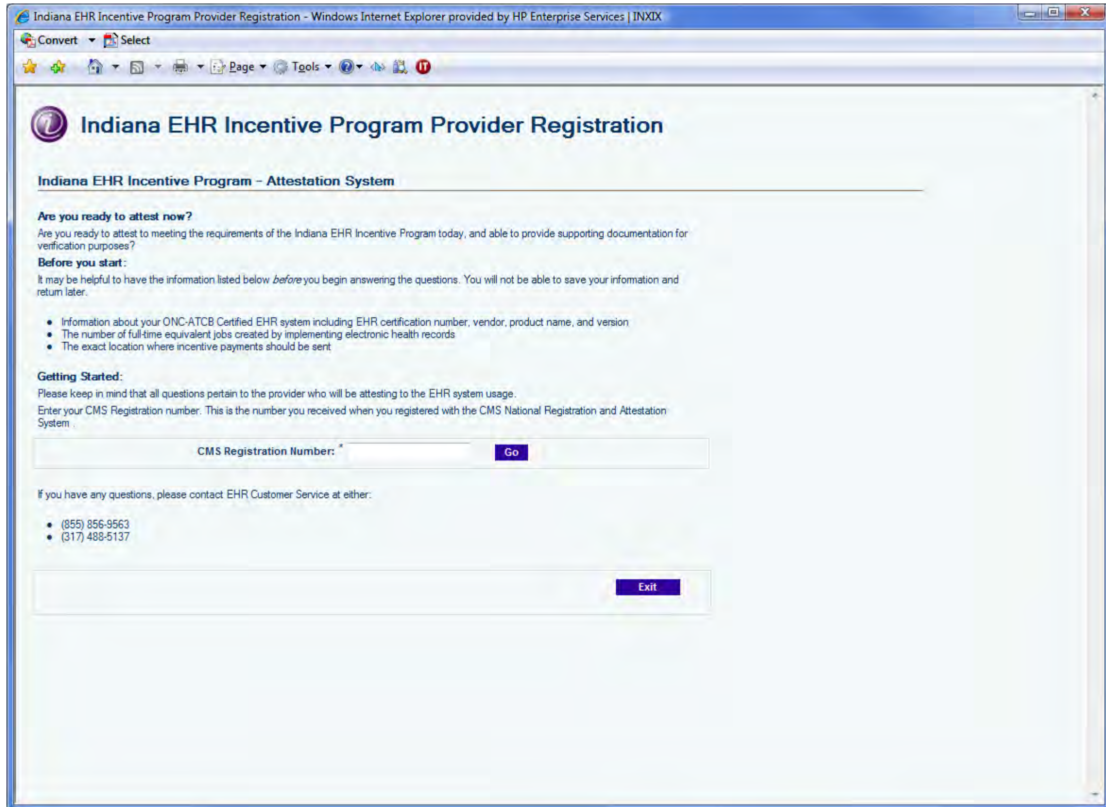


Figure 3.3 - Web interChange Indiana EHR Incentive Program – Registration & Attestation System

## Provider Steps

1. Enter the CMS Registration Number you received when you registered with the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System.

Indiana EHR Incentive Program Provider Registration - Windows Internet Explorer provided by HP Enterprise Services | INXIX

**Indiana EHR Incentive Program Provider Registration**

**Indiana EHR Incentive Program - Attestation System**

**Are you ready to attest now?**

Are you ready to attest to meeting the requirements of the Indiana EHR Incentive Program today, and able to provide supporting documentation for verification purposes?

**Before you start:**

It may be helpful to have the information listed below *before* you begin answering the questions. You will not be able to save your information and return later.

- Information about your ONC-ATCB Certified EHR system including EHR certification number, vendor, product name, and version
- The number of full-time equivalent jobs created by implementing electronic health records
- The exact location where incentive payments should be sent

**Getting Started:**

Please keep in mind that all questions pertain to the provider who will be attesting to the EHR system usage.

Enter your CMS Registration number. This is the number you received when you registered with the CMS National Registration and Attestation System .

CMS Registration Number: * 0000000000 Go

**The service locations that match the Payee information entered with your CMS number are displayed below.**
**Please select the Payee location that should receive payment (NPI / TIN / Name / Service Location Address) ***

**Steps to follow**

1. Answer a few questions about your EHR system.
2. Complete a worksheet documenting your patient volume and fax it to HP.
3. Complete and sign your application and attestation form and fax copies of requested documentation to the HP Provider Enrollment unit.

**Documents to Fax**

- Patient Volume Information worksheet
- EP Application and Attestation Form
- Proof of Adopting/ Implementing/ Upgrading a certified EHR system

If you have any questions, please contact EHR Customer Service at either:

- (855) 856-9563
- (317) 488-5137

Continue Exit

Figure 3.4 – Web interChange EHR Registration, after entering valid CMS number (EP view)

A service location window appears and the EP requesting payment needs to identify the service location for the payee.

> *Note: The payment is delivered based on current payment policy (EFT if established for the identified payee, or check sent to the "Pay To" address associated with the Payee service location identified on the EHR Registration tool*

## Provider Steps

1. Choose the **Payee** service location radio button in the Service Location box.

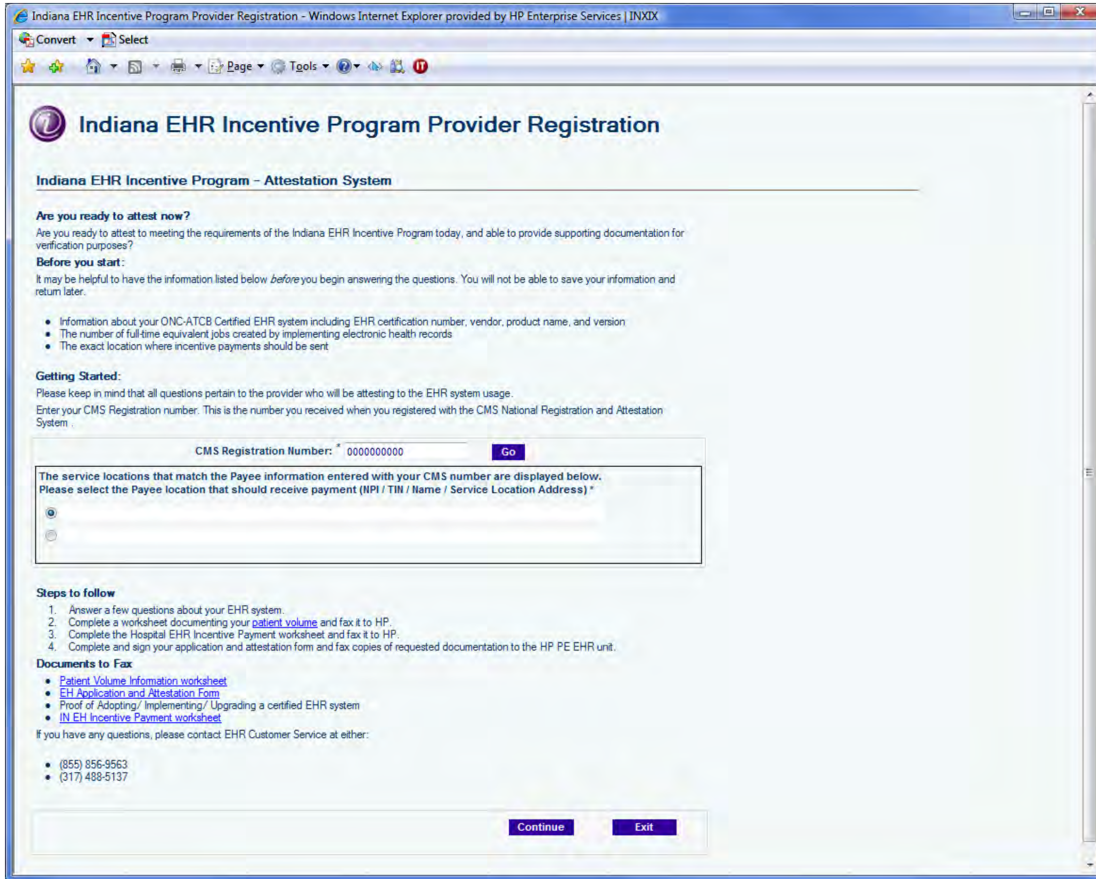


Figure 3.5 - Web interChange EHR Registration, after entering valid CMS number (EH view)

## Provider Steps

1. Choose the **Payee** service location radio button in the service location box.

Indiana EHR Incentive Program Provider Registration

Indiana EHR Incentive Program - EHR System

Use the Previous button at the bottom of the page in place of the browser back button.

**Please answer the following questions about the EHR system you are, or plan on, using, and the number of jobs created by using an EHR system.**

When you have finished, select "**Next**" to continue.

Required fields are marked with an asterisk (*).

EHR System

The Certified HIT Product List (CHPL) provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC). Please enter the EHR System identification information about the EHR system you have adopted, upgraded, or installed in the fields below:

CMS EHR Certification Number: *

Vendor: *

Product Name: *

Version Number: *

Job Creation

Under the American Recovery & Reinvestment Act (ARRA) of 2009 regulations, we must report any jobs created using ARRA stimulus funds. The Indiana EHR Incentive Program uses ARRA stimulus funds.

Enter the number of full time equivalent jobs created by implementing electronic health records. If you belong to a group, be sure these jobs are entered by only one provider in the group, to avoid over-reporting.

Number of jobs created: *

Use decimals to represent half-time equivalents, for example 0.25, 1.5

Previous Next

Figure 3.6 – Web interChange EHR System Information page

## Provider Steps:

1. Enter the CMS EHR Certification Number, the Vendor Name, the Product Name, the Version Number, of the EHR product you are attesting to having.
2. Enter the Number of jobs created by using EHR before going to the next page.

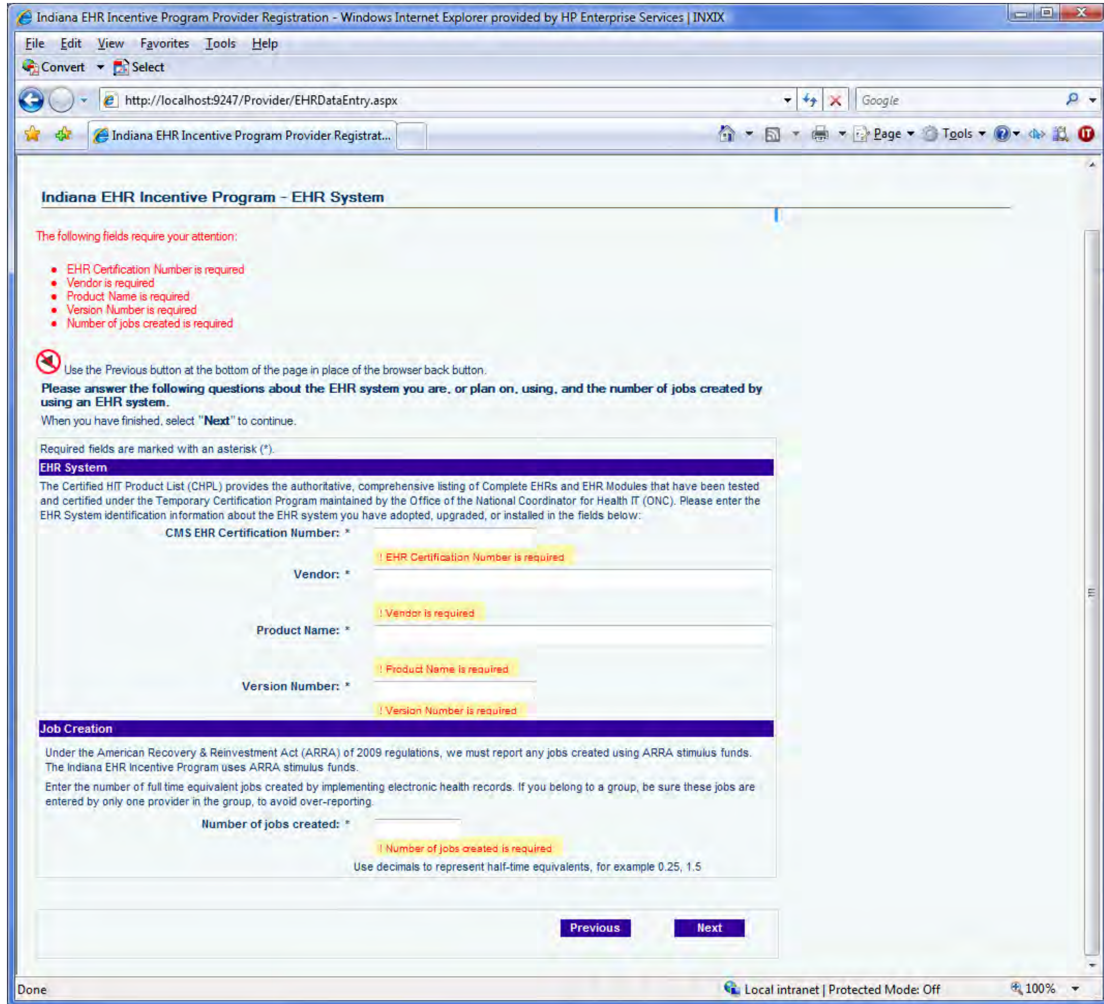


Figure 3.7 – Web interChange EHR System information window with error message displayed

Error message user sees if information is not supplied before choosing the **Next** button.

> *Note: Number of jobs created is limited to entry of a number between 1 and 999.99 with two-decimal point limit.*

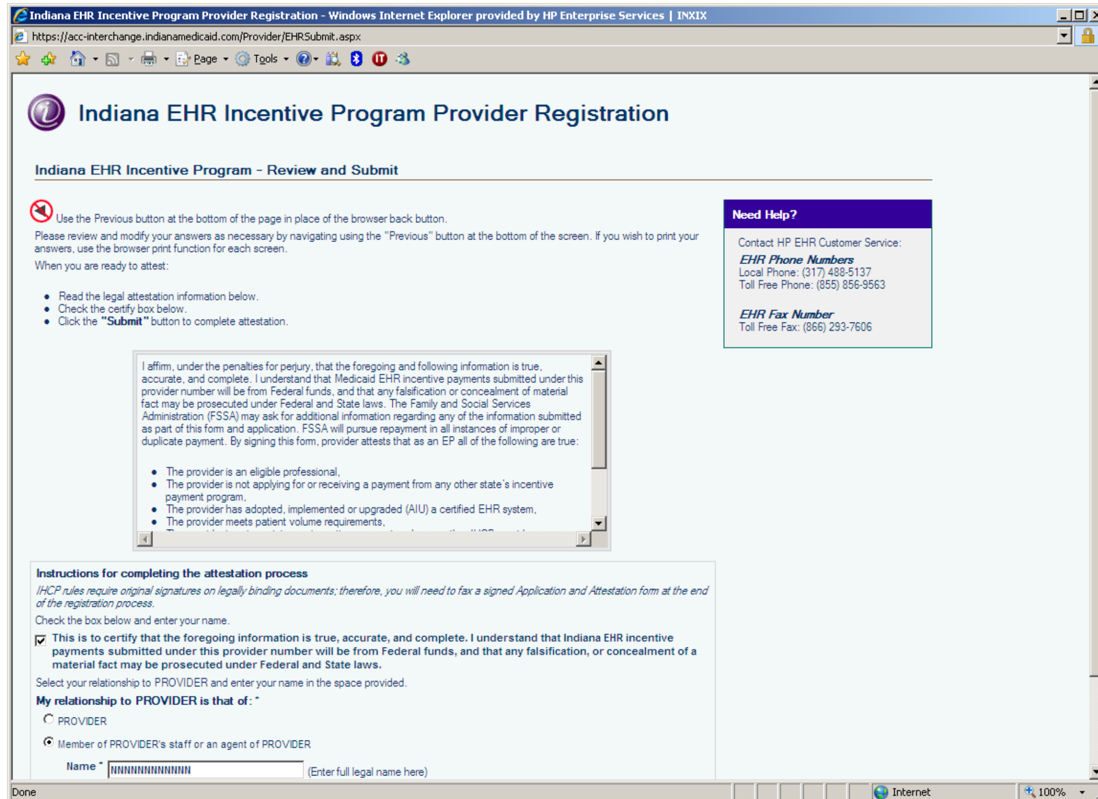


Figure 3.8 – Web interChange EHR Registration Review and Submit page (EP view)

User must read the legal verbiage in the box and then must check the box next to “This is to certify that the forgoing information is true...” and then choose the relationship of the user to the provider, which is the provider or a member of the provider’s staff, or an agent of the provider. Once the relationship is chosen a name box appears and the user must enter his or her name in the box.

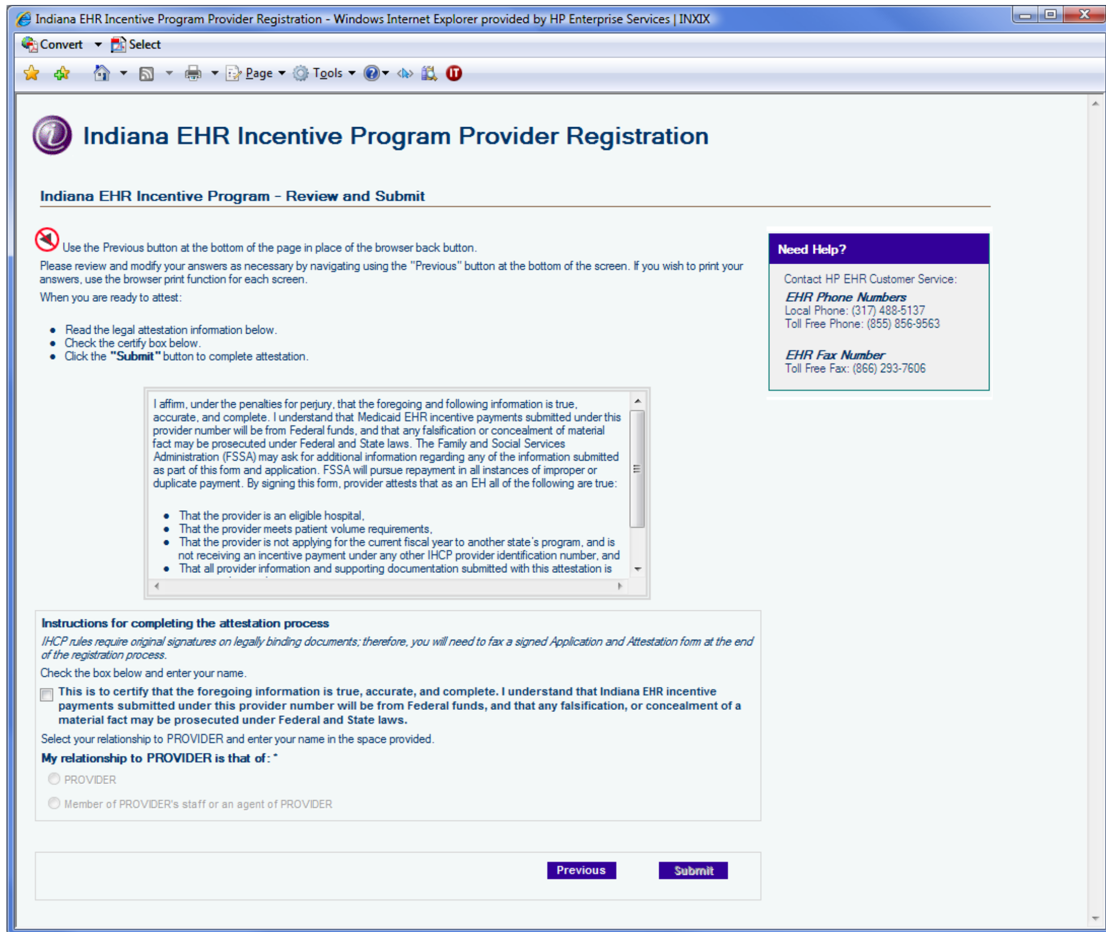


Figure 3.9 - Web interChange EHR Registration Review and Submit page (EH view)

Figure 3.10 – Web interChange Review and Submit page (EP view)

The view of this page changes dependent on whether the provider is an EH or an EP. The legal attestation verbiage is different for an eligible hospital than it is for an eligible professional, see Figure 3.9.

## Provider Steps

1. Check the box before the “This is to certify that the foregoing information is true...” to begin the attestation process.
2. Choose **PROVIDER** radio button or **Member of PROVIDER’s staff or an agent of PROVIDER** radio button.
3. Enter full legal name in the name box.

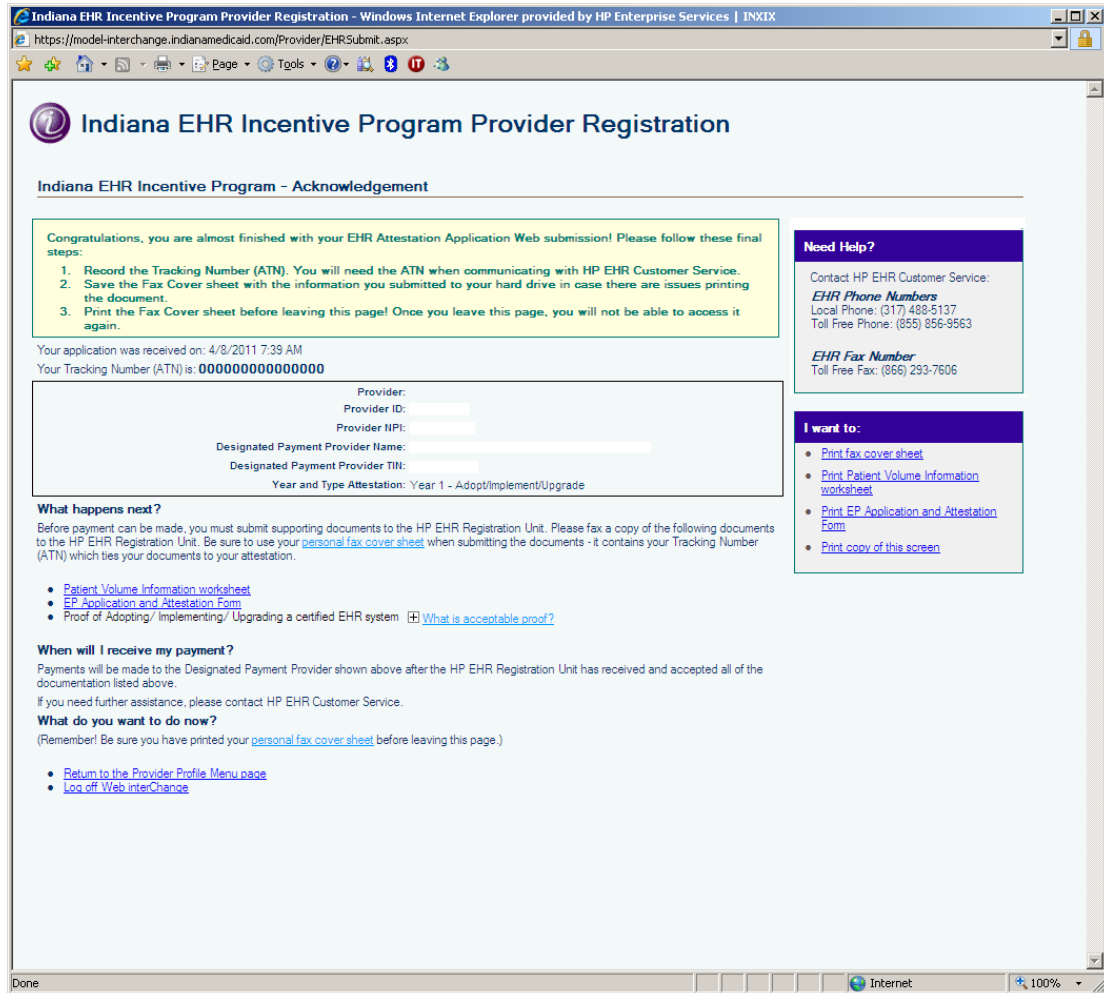


Figure 3.11 – Web interChange EHR Incentive Program Acknowledgement page (EP view)

EPs and EHs see a different acknowledgement page.

## Provider Steps

1. Write down your tracking number (the ATN) for future use.
2. Print the *Patient Volume Information* worksheet.
3. Print the *EP Application and Attestation* form.
4. Print the fax cover sheet.

Indiana EHR Incentive Program Provider Registration - Windows Internet Explorer provided by HP Enterprise Services | INXIX

https://model-interchange.indianamedicaid.com/Provider/EHRSubmit.aspx

Indiana EHR Incentive Program Provider Registration

Indiana EHR Incentive Program - Acknowledgement

Congratulations, you are almost finished with your EHR Attestation Application Web submission! Please follow these final steps:

1. Record the Tracking Number (ATN). You will need the ATN when communicating with HP EHR Customer Service.
2. Save the Fax Cover sheet with the information you submitted to your hard drive in case there are issues printing the document.
3. Print the Fax Cover sheet before leaving this page! Once you leave this page, you will not be able to access it again.

Your application was received on: 4/8/2011 11:34 AM

Your Tracking Number (ATN) is: 000000000000000

Provider:

Provider ID:

Provider NPI:

Designated Payment Provider Name:

Designated Payment Provider TIN:

Year and Type Attestation: Year 1 - Adopt/Implement/Upgrade

What happens next?

Before payment can be made, you must submit supporting documents to the HP EHR Registration Unit. Please fax a copy of the following documents to the HP EHR Registration Unit. Be sure to use your personal fax cover sheet when submitting the documents - it contains your Tracking Number (ATN) which ties your documents to your attestation.

- Patient Volume Information worksheet
- EH Application and Attestation Form
- IN EH Incentive Payment worksheet
- Proof of Adopting/ Implementing/ Upgrading a certified EHR system What is acceptable proof?

When will I receive my payment?

Payments will be made to the Designated Payment Provider shown above after the HP EHR Registration Unit has received and accepted all of the documentation listed above.

If you need further assistance, please contact HP EHR Customer Service.

What do you want to do now?

(Remember! Be sure you have printed your personal fax cover sheet before leaving this page.)

- Return to the Provider Profile Menu page
- Log off Web interChange

Need Help?

Contact HP EHR Customer Service:

EHR Phone Numbers

Local Phone: (317) 488-5137

Toll Free Phone: (855) 856-9563

EHR Fax Number

Toll Free Fax: (866) 293-7606

I want to:

- Print fax cover sheet
- Print Patient Volume Information worksheet
- Print EH Application and Attestation Form
- Print IN EH Incentive Payment worksheet
- Print copy of this screen

Done Internet 100%

Figure 3.12 - Web interChange EHR Incentive Program Acknowledgement page (EH view)

EH have an additional worksheet for calculating the incentive payment that needs to be completed. The EH view contains an additional link to this worksheet (IN EH Incentive Payment worksheet).

## Provider Steps

1. Write down your tracking number (the ATN) for future use.
2. Print the Patient Volume Information worksheet.
3. Print the *IN EH Incentive Payment* worksheet.
4. Print the *EH Application and Attestation* form.
5. Print the fax cover sheet.

## Important Web interChange User Notes

It is important to understand that this tool has the following limitations:

- You cannot save your entered data and return at a different time; you must complete the submission in one setting.
- If you have not submitted and printed your fax cover sheet, returning to Provider Profile Menu page results in the loss of all data that has been entered. You must print your fax cover sheet to complete the registration process. The fax cover sheet has the ATN, which is a tracking number that has been assigned to your specific registration. It is suggested that you write down the ATN number as soon as you reach the Acknowledgement page.
- The system times out after 20 minutes on the Acknowledgement page. If you do not print your fax cover sheet within 20 minutes of landing on the Acknowledgement page, you will not be able to print the cover sheet and you receive the following message (Figure 3.13).

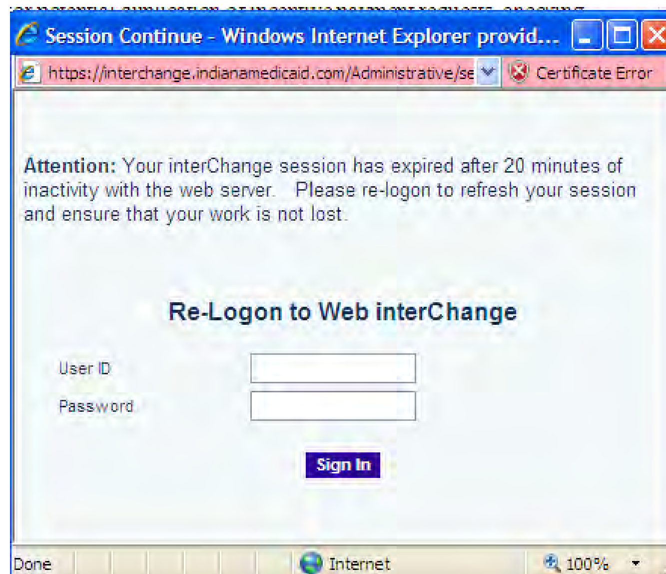


Figure 3.13 – Session Time out for interChange

> *Note: You will not be able to print the fax cover sheet if you receive the time out message. You need the ATN from your session to complete the registration process. Contact HP EHR Customer Service to request assistance.*

- You cannot save your entered data and return at a different time. You must complete the EHR Registration submission in one setting.
- Not all pages have a **Previous** button.
- You cannot leave a web page during a submission session and return using the URL from that page, if you try to enter the EHR Registration system using a URL instead of accessing the EHR Registration tool through Web interChange you receive the following message (Figure 3.14):

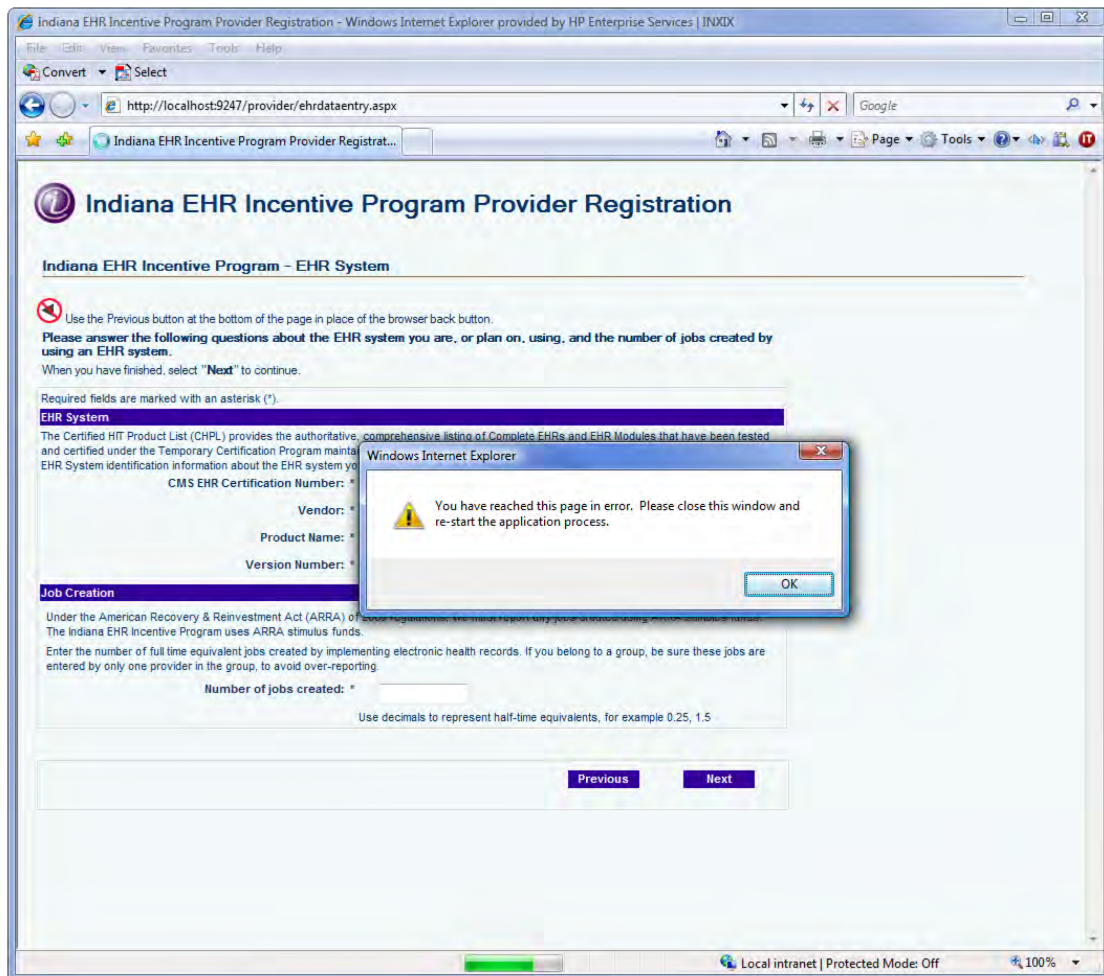


Figure 3.14 – URL Use Error message

## Completing the Registration Process

EPs and EHs must print the fax cover sheet, the Patient Volume Worksheet, and the EP or EH Application and Attestation form from the Indiana Web interChange EHR Registration portal. EH also must complete and submit the EH Incentive Payment worksheet. All these documents, along with a copy of proof of purchase, order, or payment of the EHR system must be faxed to the HP EHR Registration team toll free 866-293-7606. Once the faxed registration packet (signed attestation, patient volume worksheet, IN EH Incentive Worksheet-hospitals only, proof of EHR AIU, and completed and signed application and attestation form) is submitted by a qualifying provider, Indiana Medicaid conducts an evaluation and review for approval or rejection. The evaluation and review includes cross-checking for potential duplication of incentive payment requests, checking provider exclusion lists, license verification, checking for Indiana Medicaid participation of 90 days or more, along with verification and proof of AIU.

During the first year of registration into the program, EPs and EHs only be able to attest to adopting, implementing or upgrading to certified EHR technology. This allows Indiana to implement a data warehouse for meaningful use information. Note that the documentation for AIU of certified EHR technology for EPs or 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 healthit.hhs.gov.

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

## Contact Information

For assistance, contact the Provider Enrollment EHR Customer Service team.

**Local Telephone: (317) 488-5145**
**Toll-Free Telephone: 1-855-856-9563**
**Toll-Free Fax: 1-866-293-7606**

# Section 4: Incentive Payments

## Payment Expectations

Upon completion of the Indiana attestation and registration process, including submission of the EHR Attestation registration on Web interChange, receipt of required documentation, and review and approval by the PE EHR registration team, an incentive payment request (expenditure request) is submitted to the OMPP. If the application is rejected, the provider is contacted by telephone and informed of the reason for the rejection.

Once the application is approved, and the request for incentive payment is approved and returned by OMPP the payment is made to the provider or his assignee. The payment is included on the Provider Remittance Advice, on the Financial Transactions Page, under the nonclaims specific payout section with the payout amount in Field 27, and in Field 32 the Expenditure Code of 8374 (system EHR payment) or 8375 (manual EHR payment) is listed. A FIN ARC code is also listed as EP (EHR Payment).

The Finance Unit at HP is responsible for payment amount determination based on the CMS guidelines. The Finance Unit determines payment calculation based on the following scenarios:

- EP Year One (physician, dentist, advanced practice nurse, physician assistants) is $21,250, with the following exceptions: Pediatrician with Patient Volume 30% or more receives $21,250 Pediatrician with Patient Volume 20% – 29% receives $14,167
- EH Year One is based on calculations submitted on the IN EH Incentive Worksheet submitted by the hospital.

## Appeals Process

If you disagree with this action and wish to appeal the agency's decision, you must file an appeal request within 15 calendar days of your notification. The appeal request must state that you are the party to whom the order is specifically addressed, that you are adversely affected by the order, and that you are entitled to review under the law. The appeal must be mailed to the following address. Appeal proceedings are conducted by an IFSSA-appointed administrative law judge.

Such appeal must be delivered to:

**Michael Gargano, Secretary**
**Indiana Family and Social Services Administration**
**c/o Gwen Killmer, OMPP**
**402 West Washington Street, Room W382**
**Indianapolis, IN 46204**

If you elect to appeal this determination, you must also file a statement of issues within 45 calendar days after receipt of this letter or at the time your appeal is filed, whichever is later. [*405 IAC 1-1.5-2(d)*]. The statement of issues should be sent to the same address as the appeal request. The statement of issues should conform to *405 IAC 1-1.5-2 (d)* and *IC 4-21.5-3*.

Failure to file an appeal request within 15 calendar days from receiving notification results in the waiver of any right to appeal this determination.

# Program Integrity

Indiana is conducting regular reviews of attestations and incentive payments. These reviews are 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 for information you report for the incentive program.

# Establishing Patient Volume

A Medicaid provider must annually meet patient volume requirements of Indiana'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 Indiana and out-of-state Medicaid patients.

# Eligible Professionals Patient Encounters Methodology

## *EPs (except those practicing predominantly in an FQHC/RHC)*

To calculate Title XIX Indiana patient volume, an EP must divide:

- The total Title XIX Indiana 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.

## *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 Indiana Encounter*

For purposes of calculating EP patient volume, an Indiana encounter is defined as services rendered on any one day to an individual where Title XIX Indiana or another State's Medicaid program paid for

1. Part or all of the service
2. Part or all of their premiums, copayments, and/or cost-sharing

## *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 defined by *Section 1903(t)(3)(F)* of the Act as needy. *Section 1903(t)(3)(F)* of the Act defines needy individuals as individuals meeting any of the following three criteria:

1. They are receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP).
2. They are furnished uncompensated care by the provider.
3. They are furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

### *Group practices*

Clinics or group practices are 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.
- If an EP works inside and outside the clinic or practice, the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

## Eligible Hospitals Patient Encounters Methodology

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

- The total Title XIX Indiana and out-of-state Medicaid 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 Indiana Encounter*

For purposes of calculating eligible hospital patient volume, an Indiana encounter is defined as services rendered to an individual in one of these ways:

- Per inpatient discharge
- On any one day in the emergency room where Title XIX Indiana or another State's Medicaid program paid for:
  - Part or all of the service
  - Part or all of their premiums, copayments, and/or cost-sharing

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

## Payment Methodology for Indiana EPs

Payment for EPs equals 85% of ‘‘net average allowable costs,’’ or NAAC. NAAC are capped by statute at $25,000 in the first year, and $10,000 for each of five subsequent years. NAAC for pediatricians with Indiana patient volume between 20-29% are capped at two-thirds of those amounts respectively. Thus, the maximum incentive payment an EP could receive from Indiana Medicaid equals $63,750, over a period of six years, or $42,500 for pediatricians with a 20-29% Indiana Medicaid patient volume.

Table 4.1 – Payment Methodology

| Provider | EP | EP-Pediatrician |
|---|---|---|
| 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 | $5,667 |
| Year 5 | $8,500 | $5,667 |
| Year 6 | $8,500 | $5,667 |
| **Total Incentive Payment** | **$63,750** | **$42,500** |

Because pediatricians are qualified to participate in the Indiana 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% Medicaid patient volume requirements.

Table 4.2 – EP AIU or MU Payments

| | **Effective** | | | | |
|---|---|---|---|---|---|
| | **PY 2011** | **PY 2012** | **PY 2013** | **PY 2014** | **PY 2015** |
| **CY 2011** | AIU Stage 1 | MU Stage 1 | MU Stage 2 | MU Stage 2 | TBD |
| **CY 2012** | | AIU/MU Stage 1 | MU Stage 1 | MU Stage 2 | TBD |
| **CY 2013** | | | AIU/MU Stage 1 | MU Stage 1 | TBD |
| **CY 2014** | | | | AIU/MU Stage 1 | TBD |

## Payments for Indiana Eligible Professionals

EP payments are made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation national level repository (NLR). The TIN must be associated in the Indiana MMIS system with the EP him/herself or a group or clinic with whom the EP is affiliated. Each EP must have a current Indiana Medicaid provider agreement, and have been enrolled for at least 90 days.

The Indiana EHR Incentive program does *not* include a future reimbursement rate reduction for nonparticipating Medicaid providers. (Medicare requires providers to implement and meaningfully use 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.

Table 4.3 – Maximum Incentive Payments for EPs

| | **Medicaid EPs who begin meaningful use of certified EHR technology in--** | | | | | |
|---|---|---|---|---|---|---|
| **Calendar Year** | **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** | **$63,700** | **$63,700** | **$63,700** | **$63,700** | **$63,700** | **$63,700** |

Indiana currently requires that all providers submit a valid NPI as a condition of Indiana Medicaid provider enrollment. Each EP or EH is enrolled as an Indiana Medicaid provider and therefore, without any change in process or system modification, meet the requirement to receive an NPI. The HP Provider Enrollment Unit for the Indiana Medicaid performs a manual NPPES search to validate NPIs during the enrollment process.

In the event Indiana Medicaid determines monies have been paid inappropriately, incentive funds are recouped and refunded to the CMS. Providers may refund the money to Indiana Medicaid in a lump sum, or an accounts receivable (A/R) account is set up for the provider and the overpayment recouped through future payments. The existing practice allows Indiana Medicaid to work out an acceptable repayment period dependent upon the provider's circumstances.

## Payment Methodology for Eligible Hospitals

Parameters placed on Indiana 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 hospitals' aggregate EHR hospital incentive amounts on the federal fiscal year (FFY) to align with hospitals participating in the Medicare EHR incentive program.

Indiana may pay children's hospitals and acute care hospitals up to 100% of an aggregate EHR hospital incentive amount provided over a 3-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. Prior to 2016, Medicaid incentive payments to hospitals can be made on a nonconsecutive, annual basis. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Indiana is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Indiana 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 Indiana MMIS (or other automated claims processing systems or information retrieval systems)
- Hospital financial statements and hospital accounting records

For purposes of the Indiana Medicaid EHR hospital incentive program, the overall EHR amount is equal to the sum over four years of (I)(a) the base amount (defined by statute as $2,000,000); plus (b) the discharge related amount defined as $200 for the 1,150$^{th}$ – 23,000$^{th}$ discharge for the first year (for subsequent years, the CMS assumes discharges increase by the provider's average annual rate of growth for the most recent 3 years for which data are available per year): multiplied by (II) the transition factor for each year equals 1 in year 1, ¾ in year 2, 1⁄2 in year 3, and ¼ in year 4.

The statute specifies that the payment year is determined based on a Federal fiscal year. *Section 1886(n)(2)(C)* of the Act provides the Secretary with authority to determine the discharge related amount on the basis of discharge data from a relevant hospital cost reporting period, for use in determining the incentive payment during a Federal fiscal year.

Federal fiscal years begin on October 1 of each calendar year, and end on September 30 of the subsequent calendar year. For purposes of administrative simplicity and timeliness, Indiana uses data on the hospital discharges from the hospital fiscal year that ends during the federal fiscal year which serves as the first payment year.

The discharge-related amount is $200 per discharge for discharges 1,150 through 23,000. To determine the discharge-related amount for the three subsequent years that are included in determining the overall EHR amount, Indiana assumes discharges for an individual hospital have increased by the average annual growth rate for an individual hospital over the most recent three years of available data from an auditable data source. Per federal regulations, if a hospital's average annual rate of growth is negative over the three-year period, it is applied as such.

The overall hospital EHR amount requires that a transition factor be applied to each year. This transition factor equals 1 for year 1, ¾ for year 2, ½ for year 3, and ¼ for year 4, as provided for in sections *1886(n)(2)(A)* and *1886(n)(2)(E)* of the Act, and as incorporated through section *1902(t)(5)(B)* of the Act.

The ''Medicaid Share,'' against which the overall EHR amount is multiplied, is essentially the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients. More specifically, the Medicaid share is a fraction expressed:

Estimated Medicaid inpatient-bed days plus estimated Medicaid managed care inpatient-bed-days;

Divided by;

Estimated total inpatient-bed days multiplied by {(estimated total charges minus charity care charges) divided by (estimated total charges)}.

As indicated in the previous formula, the Medicaid share includes Medicaid inpatient-bed-days and Medicaid managed care inpatient-bed-days. This is in keeping with section *1903(t)(5)(C)* of the Act, which provides that in computing inpatient-bed-days, the Secretary shall take into account inpatient-bed-days that are paid for individuals enrolled in a Medicaid managed care plan under sections *1903(m) or 1932* of the Act.

In addition, because the formula for calculating the Medicaid share requires a determination of charity care charges, Indiana uses the revised Medicare 2552–10, Worksheet S–10 or another auditable data source to determine the charity care portion of the formula. In the absence of sufficient charity care data to complete the calculation, section 1886(n)(2)(D) of the Act, requires the use of uncompensated care data to derive an appropriate estimate of charity care, including a downward adjustment for bad debts. CMS interpreted bad debt to be consistent with the Medicare definition of bad debt as promulgated at § 413.89(b)(1).

Finally, per section 1886(n)(2)(D) of the Act, 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% of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90% of the aggregate incentive.

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

1. EH Payment Calculation Step 1:
   - Add: Base Amount (per statue) = $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 years' data
   - = Subtotal
2. EH Payment Calculation Step 2:
   - Subtotal from previous calculation *multiplied by….*
   - Transition Factor =
     - Year 1: 1
     - Year 2: ¾
     - Year 3: ½
     - Year 4: ¼
   - = Overall EHR Amount

3. EH Payment Calculation Step 3:
   - Overall EHR Amount *multiplied by…..*
     - Medicaid Share:
       - Estimated Medicaid 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
4. EH Payment Calculation Step 4:
   - = Aggregate EHR Hospital Incentive Amount for the reporting year *multiplied by….*
     - Year 1: 50%
     - Year 2: 40%
     - Year 3: 10%

= Total EH Annual Incentive

Table 4.4 – EH AIU or MU Payments

| | **Effective** | | | | |
|---|---|---|---|---|---|
| | **PY 2011** | **PY 2012** | **PY 2013** | **PY 2014** | **PY 2015** |
| **FFY 2011** | AIU/MU Stage 1 | MU Stage 1 | MU Stage 2 | MU Stage 2 | TBD |
| **FFY 2012** | | AIU/MU Stage 1 | MU Stage 1 | MU Stage 2 | TBD |
| **FFY 2013** | | | AIU/MU Stage 1 | MU Stage 1 | TBD |
| **FFY 2014** | | | | AIU/MU Stage 1 | TBD |

# Section 5: Meaningful Use

## What is AIU and MU?

### Adopt, Implement, or Upgrade (AIU)

The federal regulations allow EPs and EHs in the Medicaid EHR Incentive Program to receive incentive payments for year one if they adopt (acquire and install), implement (train staff, deploy tools, exchange data) or upgrade (expand functionality or interoperability) of their certified EHR systems technology. (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 is required to provide documentation supporting the claim of AIU, such as a contract or paid invoice.

### Meaningful Use (MU)

Meaningful use of EHR technology is a major goal of this program. The CMS has determined that MU will be rolled out in three stages. The current rule provides specific information on Stage 1, which focuses heavily on establishing the functionalities in certified EHR technology that allows 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
- Reporting clinical quality measures and public health information

Though some functionalities are optional in Stage 1, as outlined in discussions later in this manual, all of the functionalities are considered crucial to maximize the value to the healthcare system provided by certified EHR technology. The CMS encourages all EPs, eligible hospitals and CAHs to be proactive in implementing all of the functionalities of Stage 1 to prepare for later stages of meaningful use, particularly functionalities that improve patient care, the efficiency of the healthcare 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.

### Eligible Professionals – 15 Stage 1 Core Objectives

> *Note: Objectives with exclusion permitted for qualified EPs are indicated with a ^; check federal regulations for explanatory information regarding specific exclusions.*

- Use Computerized Physician Order Entry (CPOE)
- Generate and transmit E-Prescribing (eRx)
- Report ambulatory clinical quality measures to CMS/State
- Implement one clinical decision support rule

- Provide patients with an electronic copy of their health information, upon request
- Provide clinical summaries for patients for each office visit
- Implement drug-drug and drug-allergy interaction checks
- Record demographics
- Maintain an up-to-date problem list of current and active diagnoses
- Maintain active medication list
- Maintain active medication allergy list
- Record and chart changes in vital signs
- Record smoking status for patients 13 years or older
- Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
- Protect electronic health information

## Eligible Professionals – 10 Stage 1 Menu Set

> *Note: Must choose five including at least one public health objective*; objectives with exclusion permitted for qualified EPs are indicated with a ^; check federal regulations for explanatory information regarding specific exclusions.*

- Drug-formulary checks
- Incorporate clinical lab test results as structured data
- Generate lists of patients by specific conditions
- Send reminders to patients per patient preference for preventive/follow up care
- Provide patients with timely electronic access to their health information
- Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
- Medication reconciliation
- Summary of care record for each transition of care/referrals
- *Capability to submit electronic data to immunization registries/systems
- *Capability to provide electronic syndromic surveillance data

## Eligible Hospitals – 14 Stage 1 Core Objectives

- Use CPOE
- Implement drug-drug and drug-allergy interaction checks
- Record demographics
- Implement one clinical decision support rule
- Maintain up-to-date problem list of current and active diagnoses
- Maintain active medication list

- Maintain active medication allergy list
- Record and chart changes in vital signs
- Record smoking status for patients 13 years or older
- Report hospital clinical quality measures to CMS or State
- Provide patients with an electronic copy of their health information, upon request
- Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request
- Capability to exchange key clinical information among providers of care and patient-authorized entities electronically
- Protect electronic health information

## Eligible Hospitals – 10 Stage 1 Menu Set Objects

*Note: Must choose five including at least one public health objective* must be selected.*

- Implement drug-formulary checks
- Record advanced directives for patients 65 years or older
- Incorporate clinical lab test results as structured data
- Generate lists of patients by specific conditions
- Use certified EHR technology to identify patient-specific education resources and provide to patient, if appropriate
- Perform medication reconciliation
- Provide summary of care record for each transition of care/referrals
- *Capability to submit electronic data to immunization registries/systems
- *Capability to provide electronic submission of reportable lab results to public health agencies
- *Capability to provide electronic syndromic surveillance data to public health agencies

*Stage 2:* The goals for the Stage 2 meaningful use criteria, consistent with other provisions of Medicare and Medicaid law, expand upon the Stage 1 criteria to encourage the use of HIT for continuous quality improvement at the point of care and the exchange of information in the most structured format possible, such as the electronic transmission of orders entered using CPOE and the electronic transmission of diagnostic test results (such as blood tests, microbiology, urinalysis, pathology tests, radiology, cardiac imaging, nuclear medicine tests, pulmonary function tests, genetic tests, genomic tests and other such data needed to diagnose and treat disease).

It is expected that Stage 2 meaningful use requirements include rigorous expectations for health information exchange, including more demanding requirements for e-Prescribing and incorporating structured laboratory results and the expectation that providers electronically transmit patient care summaries to support transitions in care across unaffiliated providers, settings and EHR systems. Increasingly robust expectations for health information exchange in Stage 2 and Stage 3 support and make real the goal that information follows the patient.

The CMS has indicated that more information about Stage 2 MU will be released at a later date.

*Stage 3:* The goals for the Stage 3 meaningful use criteria are:

- Consistent with other provisions of Medicare and Medicaid law
- Focus on promoting improvements in quality
- Provide safety
- Efficiency leading to improved health outcomes
- Focus on decision support for national high priority conditions
- Provide patient access to self management tools
- Access to comprehensive patient data through robust
- Provide patient-centered health information exchange
- Improve population health

The CMS has indicated that more information about Stage 3 MU will be released at a later date.

To meet Stage 1 meaningful use criteria, EPs and EHs must meet all core objectives and five from the menu set of objectives, with at least one being a public health objective (denoted by the asterisk). 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:

1. Meets the criteria in the applicable objective that would permit the attestation.
2. Attests. An exclusion reduces the number of objectives that otherwise apply. For instance, an EP that qualifies for the exclusion of an objective from the menu set are required to select only four from the menu set. The EP must still report at least one of the public health objectives.

> *Note: Table 5.1 through Table 5.9 were created based on* 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program*; published July 28, 2010. These tables were accurate at the time of publication but more recent information may have been published. See the following website for the most current information: cms.gov/EHRIncentivePrograms.*

Table 5.1 – Provider Eligibility at a Glance – EP

| **Qualifying Eligible Professionals (EP)** | | |
|---|---|---|
| 1 | Current Indiana Medicaid Provider Agreement | |
| 2 | Hospital based EPs are NOT eligible | 90% or more of services are performed in a hospital inpatient or emergency room setting. |
| 3 | Provider Type | Physicians (MD, DO)<br>Pediatricians |
| | | Dentists |
| | | Certified Nurse Midwives |

| | | |
|---|---|---|
| | | Nurse Practitioners |
| | | Physician Assistants (PA) practicing at a FQHC/RHC so led by a PA |
| 4 | Patient Volume over a 90-day period | 30% Indiana Medicaid |
| | | 20-29% Indiana Medicaid – Pediatricians – 2/3 of inventive payment |
| | | 30% Needy individuals Medical EPs practicing predominantly in FQHC or RHC |

Table 5.2 – Provider Eligibility at a Glance – EH

| **Qualifying Eligible Hospitals (EH)** | | | |
|---|---|---|---|
| 1 | Current Indiana Medicaid Provider Agreement | | |
| 2 | Hospital Types | Acute Care Hospital (includes (CAHs & cancer hospitals) | Avg. length of stay ≤ 25 days |
| | | | CCN* last 4 of 0001 – 0879; 1300 – 1399 |
| | | Children's Hospital | CCN* last 4 of 3300 – 3399 |
| | | | Not applicable to children's wings of larger hospitals |
| 3 | Patient Volume over a 90-day period | Acute Care Hospital | 10% Indiana Medicaid |
| | | Children's Hospitals | No Requirement |

## Attestation Chart – EP

Table 5.3 – Attestation Chart – EP

| During EHR Year 1 reporting periods, the EP attests: | During EHR Years 2 through 6 reporting period, the EP attests: |
|---|---|
| The EP is a board certified pediatrician, if applicable | The EP is a board certified Pediatrician, if applicable |
| The physician assistant attests that he or she is working in an FQHC or RHC so led by one of the following:<br>(a) A PA as the primary provider in the clinic<br>(b) A PA as the clinical or medical director at a site of practice<br>(c) A PA as an owner of an RHC | The physician assistant attest that he or she is working in an FQHC or RHC so led by one of the following:<br>(a) A PA as the primary provider in the clinic<br>(b) A PA as the clinical or medical director at a site of practice<br>(c) A PA as an owner of an RHC |
| The EP attests that he or she practices predominantly in an FQHC or RHC, if applicable | The EP attests that he or she practices predominantly in an FQHC or RHC, if applicable |
| The EP is not hospital-based professional who furnishes 90% or more of his or her professional services in an inpatient hospital or emergency room setting, if he or she does not practice predominately | The EP is not hospital based professional who furnishes 90% or more of his or her professional services in an inpatient hospital or emergency room setting, if he or she does not practice predominately |

| During EHR Year 1 reporting periods, the EP attests: | During EHR Years 2 through 6 reporting period, the EP attests: |
|---|---|
| in an FQHC or RHC | in an FQHC or RHC |
| The EP is not concurrently receiving an incentive payment from another state or under another Indiana Medicaid LPI or Medicare Program | The EP is not concurrently receiving an incentive payment from another state or under another Indiana Medicaid LPI or Medicare Program |
| The EP has adopted, implemented or upgraded (A/I/U) a certified EHR | The EP used certified EHR technology |
| The EHR product used is certified and EP entered a product certification number | The EHR product used is certified and EP entered a product certification number |
| The EP has reported the number of full-time equivalent (FTE) jobs created by implementing this certified EHR product | The EP has reported the number of FTE jobs created by implementing this certified EHR product |
| The EP has reported the amount of cash payments made directly attributable to him or her for the certified EHR (not including payments from state or local governments, in-kind contributions, and so forth) | The EP has reported the amount of cash payments made directly attributable to him or her for the certified EHR (not including payments from state or local governments, in-kind contributions, and so forth) |
| The EP has confirmed that at least $3,750 of the EHR technology is the responsibility of him or her or his or her employer, group, clinic, hospital affiliation, or in-kind contributions or grants | The EP has confirmed that at least $1,500 of the EHR technology is the responsibility of him or her or his or her employer, group, clinic, hospital affiliation, or in-kind contributions or grants |
| The EP has confirmed assignment of his or her payment to another TIN and agrees to this assignment, if applicable | The EP has confirmed assignment of his or her payment to another TIN and agrees to this assignment, if applicable |
| The EP's percentage of Medicaid encounters or Needy Individual (for EP's practicing predominantly in an FQHC/RHC) patient volume is equal to or greater than the allowed percentage of their specialty. | The EP's percentage of Medicaid encounters or Needy Individual (for EP's practicing predominantly in an FQHC/RHC) patient volume is equal to or greater than the allowed percentage of their specialty. |
| The EP has specified the patient volume date range of at least 90 days | The EP has specified the patient volume date range of at least 90 days |
| N/A | The EP has specified the EHR reporting period and provided the result of each applicable measure for all patients seen during the EHR reporting period for which a selected measure is applicable |
| N/A | The EP has satisfied the required objectives and associated measures under § 495.6(e), except § 495.6 (d)(10) "Report ambulatory clinical quality measures to the State" |
| N/A | The EP attests to meeting the meaningful use criteria associated with his or her year of participation and applicable stage per the rule |

| During EHR Year 1 reporting periods, the EP attests: | During EHR Years 2 through 6 reporting period, the EP attests: |
|---|---|
| N/A | If applicable, the EP attests that the clinical quality measures not reported do not apply to any patients treated by the EP |
| The EP attests that all information is true and accurate per wording in the rule | The EP attests that all information is true and accurate per wording in the rule |

## Attestation Chart – EH

Table 5.4 – Attestation Chart – EH

| Eligible Hospitals or CAHs eligible only for the Indiana Medicaid EHR Incentive Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that: | During 2011 reporting period, the eligible hospitals or CAHs attesting to Meaningful Use attests that: | During 2010 and subsequent reporting periods, the eligible hospitals or CAHs attesting to Meaningful Use attests that" |
|---|---|---|
| The EH or CAH adopted, implemented, or upgraded (A/I/U) a certified her | The EH or CAH used certified EHR technology | The EH or CAH used certified EHR technology |
| N/A | The EHR product used is certified and EH or CAH entered product certification number, vendor, product, and version | The EHR product used is certified and EH or CAH entered product certification number, vendor, product, and version |
| The EH or CAH has reported the number of FTE jobs created by implementing this certified EHR product | The EH or CAH has reported the number of FTE jobs created by implementing this certified EHR product | The EH or CAH has reported the number of FTE jobs created by implementing this certified EHR product |
| N/A | The EH or CAH satisfied the required objectives and associated measures under §495.6(f) and §495.6(g). | The EH or CAH satisfied the required objectives and associated measures under §495.6(f) and §495.6(g), except § 495.6(f)(9) "Report hospital clinical quality measures to the State" |
| N/A | N/A | The EH or CAH attests that the information submitted with respect to clinical quality measures was generated as output from an identified certified EHR technology |
| N/A | N/A | The EH or CAH attests that the information was submitted to the knowledge and belief of the official submitting on behalf of the eligible hospital or CAH |
| N/A | N/A | The EH or CAH attests that the information submitted includes information on all patients to whom the measure applies |
| N/A | N/A | For EHs or CAHs that do not report one or more measures, the EH or CAH attests that the clinical quality measures not reported do not apply to any patients treated by the EH or CAH during the |

| Eligible Hospitals or CAHs eligible only for the Indiana Medicaid EHR Incentive Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that: | During 2011 reporting period, the eligible hospitals or CAHs attesting to Meaningful Use attests that: | During 2010 and subsequent reporting periods, the eligible hospitals or CAHs attesting to Meaningful Use attests that" |
|---|---|---|
| | | reporting period |
| N/A | N/A | The EH or CAH attest numerators, denominators, and exclusions for each clinical quality measure result reported, providing separate information for each clinical quality measure including the numerators, denominators, and exclusions for all patients irrespective of third party payer or lack thereof; for Medicaid patients |
| N/A | N/A | The EH or CAH attests the beginning and end dates for which the numerators, denominators, and exclusions apply |
| N/A | The EH or CAH specified the EHR reporting period and provided the result of each applicable measure for all patients admitted to the inpatient or emergency department (POS 21 or 23) of the hospital during the EHR reporting period for which a selected measure is applicable | The EH or CAH specified the EHR reporting period and provided the result of each applicable measure for all patients admitted to the inpatient or emergency department (POS 21 or 23) of the hospital during the EHR reporting period for which a selected measure is applicable |
| The EH or CAH attests that all information is true and accurate per wording in the rule | The EH or CAH attests that all information is true and accurate per wording in the rule | The EH or CAH attests that all information is true and accurate per wording in the rule |
| The EH or CAH electronic signature on the attestation is valid for the Indiana EHR incentive Program payment request | The EH or CAH electronic signature on the attestation is valid for the Indiana EHR Incentive Program payment request | The EH or CAH electronic signature on the attestation is valid for the Indiana EHR Incentive Program payment request |

## Meaningful Use Core Sets

Table 5.5 – Meaningful Use Core Sets

| Meaningful Use Core Sets | | | |
|---|---|---|---|
| **Health Outcomes Policy Priority** | **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| Improving quality, safety, efficiency, and reducing health disparities | Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines. | Use CPOE for medical orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines | More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE |
| N/A | Implement drug-drug and drug-allergy interaction checks | Implement drug-drug and drug-allergy interaction checks | The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period |
| N/A | Generate and transmit permissible prescriptions electronically (eRx) | N/A | More than 40% of all permissible prescriptions by the EP are transmitted electronically using certified EHR technology. |
| N/A | Record demographics:<br>• Preferred language<br>• Gender<br>• Race<br>• Ethnicity<br>• Date of birth | Record demographics:<br>• Preferred language<br>• Gender<br>• Race<br>• Ethnicity<br>• Date of birth<br><br>Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH | More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS21 or 23) have demographics recorded as structured data |
| N/A | Maintain an up-to-date problem list of current and active diagnoses | Maintain an up-to-date problem list of current and active diagnoses | More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at |

| Meaningful Use Core Sets | | | |
|---|---|---|---|
| **Health Outcomes Policy Priority** | **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| | | | least one entry or an indication that no problems are known for the patient recorded as structured data |
| N/A | Maintain active medication list | Maintain active medication list | More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data |
| N/A | Maintain active medication allergy list | Maintain active medication allergy list | More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data |
| N/A | Record and chart changes in vital signs:<br>• Height<br>• Weight<br>• Blood Pressure<br>• Calculate and display BMI<br>• Plot and display growth charts for children 2-2- years, including BMI | Record and chart changes in vital signs:<br>• Height<br>• Weight<br>• Blood Pressure<br>• Calculate and display BMI<br>• Plot and display growth charts for children 2-2- years, including BMI | For more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight, and blood pressure are recorded as structured data |

| Meaningful Use Core Sets | | | |
|---|---|---|---|
| **Health Outcomes Policy Priority** | **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| N/A | Record smoking status for patients 13 years old or older | Record smoking status for patients 13 years old or older | More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data |
| N/A | Implement on clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule | Implement one clinical decision support rule related to a high priority hospital condition along with the ability to track compliance with that rule | Implement one clinical decision support rule |
| N/A | Report ambulatory clinical quality measures to the CMS or the State | Report hospital clinical quality measures to the CMS or the State | For 2011, provide aggregate numerator, denominator, and exclusions through attestation as discussed in section II(A)(3) of the final rule |
| N/A | N/A | N/A | For 2012, electronically submit clinical quality measures as discussed in section II(A)(3) of the final rule |
| Engage patients and families in their health care | Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request | Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures), upon request | More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within three business days |
| N/A | N/A | Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request | More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their discharge instructions are provided it within three business days |

| Meaningful Use Core Sets | | | |
|---|---|---|---|
| **Health Outcomes Policy Priority** | **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| N/A | Provide clinical summaries for patients for each office visit | N/A | Clinical summaries provided to patients for more than 50% of all office visits within three business days |
| Improve care coordination | Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically | Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically | Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information |
| Ensure adequate privacy and security protections for personal health information | Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities | Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities | Conduct or review a security risk analysis per *45 CFR 164.308 (a)(1)* and implement security updates as necessary and correct indentified security deficiencies as part of its risk management process |

## Meaningful Use Menu Set

Table 5.6 – Meaningful Use Menu Sets

| Meaningful Use Menu Set | | | |
|---|---|---|---|
| **Health Outcomes Policy Priority** | **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| Improving quality, safety, efficiency, and reducing health disparities | Implement drug-formulary checks | Implement drug-formulary checks | The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period |
| N/A | N/A | Record advance directives for patients 65 years old or older | More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient department (POS 21) have an indication of an advance directive status |

| Meaningful Use Menu Set | | | |
|---|---|---|---|
| **Health Outcomes Policy Priority** | **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| | | | recorded |
| N/A | Incorporate clinical lab test results into certified EHR technology as structured data | Incorporate clinical lab test results into certified EHR technology as structured data | More than 40% of all clinical lab tests results ordered by the EP or by an authorized provided of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data |
| N/A | Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach | Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach | Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition |
| N/A | Send reminders to patients per patient preference for preventive/follow up care | N/A | More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period |
| Engage patients and families in their health care | Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP | N/A | More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information |

| Meaningful Use Menu Set | | | |
|---|---|---|---|
| **Health Outcomes Policy Priority** | **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| N/A | Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate | Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate | More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources |
| Improve care coordination | The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation | The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation | The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) |
| N/A | The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral | The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral | The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals |
| Improve population and public health | Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice | Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice | Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically) |

| Meaningful Use Menu Set | | | |
|---|---|---|---|
| **Health Outcomes Policy Priority** | **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| N/A | N/A | Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice | Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information electronically) |
| N/A | Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice | Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice | Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submissions if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically) |
| N/A | Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate | Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate | More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources |

## Meaningful Use Measure Calculation

Table 5.7 – Meaningful Use Measure Calculation – Denominator Based on Unique Patients

| **Measures with a Denominator of Unique Patients Regardless of Whether the Patient's Records Are Maintained Using Certified EHR Technology** | | |
|---|---|---|
| **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| Maintain an up-to-date problem list of current and active diagnoses | Maintain an up-to-date problem list of current and active diagnoses | More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data |
| Maintain active medication list | Maintain active medication list | More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data |
| Record demographics:<br>• Preferred language<br>• Gender<br>• Race<br>• Ethnicity<br>• Date of birth | Record demographics:<br>• Preferred language<br>• Gender<br>• Race<br>• Ethnicity<br>• Date of birth<br>• Date and preliminary cause of death in the event of mortality in the eligible hospital or CAH | More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data |
| Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP | N/A | More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information |

| **Measures with a Denominator of Unique Patients Regardless of Whether the Patient's Records Are Maintained Using Certified EHR Technology** | | |
|---|---|---|
| **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate | Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate | More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources |

Table 5.8 – Meaningful Use Measure Calculation – Denominator Based on Counting Actions

| **Measures with a Denominator of Based on Counting Actions for Patients who Records are Maintained using Certified EHR Technology** | | |
|---|---|---|
| **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines | Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines | More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE |
| Generate and transmit permissible prescriptions electronically (eRx) | | More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology |
| Record and chart changes in vital signs:<br>• Height<br>• Weight<br>• Blood pressure<br>• Calculate and display BMI<br>• Plot and display growth charts for children 2-20 years, including BMI | Record and chart changes in vital signs:<br>• Height<br>• Weight<br>• Blood pressure<br>• Calculate and display BMI<br>• Plot and display growth charts for children 2-20 years, including BMI | For more than 50% of all unique patients age 2 and over seen by the EP or admitted to eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23), height, weight, and blood pressure are recorded as structured data |
| Record smoking status for patients 13 years old or older | Record smoking status for patients 13 years old or older | More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data |

| Measures with a Denominator of Based on Counting Actions for Patients who Records are Maintained using Certified EHR Technology | | |
|---|---|---|
| **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| N/A | Record advance directives for patients 65 years old or older | More than 50% of all unique patients 65 years old or older admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data |
| Incorporate clinical lab-test results into certified EHR technology as structured data | Incorporate clinical lab-test results into certified EHR technology as structured data | More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data |
| Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request | Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, discharge summary, procedures) upon request | More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within three business days |
| | Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request | More than 50% of all patients who are discharged from an eligible hospital or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it |
| Provide clinical summaries for patients for each office visit | N/A | Clinical summaries provided to patients for more than 50% of all office visits within three business days |
| Send reminders to patients per patient preference for preventive/follow up care | | More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period |
| The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation | The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation | The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency |

| **Measures with a Denominator of Based on Counting Actions for Patients who Records are Maintained using Certified EHR Technology** | | |
|---|---|---|
| **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| | | department (POS 21 or 23) |
| The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral | The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral | The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals. |

Table 5.9 – Meaningful Use Measure Calculation – Measures Requiring Only a Yes/No Attestation

| **Measures Requiring Only a Yes/No Attestation** | | |
|---|---|---|
| **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| Implement drug-drug and drug-allergy interaction checks | Implement drug-drug and drug-allergy interaction checks | The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period |
| Implement drug-formulary checks | Implement drug-formulary checks | The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period |
| Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach | Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach | Generate at least one report listing patients of the EP, eligible hospital, or CAH with a specific condition |
| Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule | Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule | Implement one clinical decision support rule |
| Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically | Capability to exchange key clinical information (for example, discharge summary, procedures, problem list, medication list, medication allergies, diagnostic test results), among providers of care and patient authorized entities electronically | Performed at least one test of certified EHR technology's capacity to electronically exchange key clinical information |
| Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice | Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice | Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically) |
| N/A | Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice | Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies and follow up submission if the test is successful (unless none of the public health agencies to which eligible hospital or CAH submits such information have the capacity to receive the information |

| Measures Requiring Only a Yes/No Attestation | | |
|---|---|---|
| **Eligible Professionals** | **Eligible Hospitals and CAHs** | **Stage 1 Measures** |
| | | electronically) |
| Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice | Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice | Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically) |
| Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities | Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities | Conduct or review a security risk analysis per *45 CRF 164.308(a)(1)* and implement security updates a necessary and correct identified security deficiencies as part of its risk management process |

# Appendix A: Acronyms

Table A.1 – EHR Acronyms

| Acronym | Definition |
|---|---|
| ARRA | American Recovery and Reinvestment Act of 2009 |
| AAC | Average Allowable Cost (of certified EHR technology) |
| AIU | Adopt, Implement, Upgrade (certified EHR technology) |
| ATCB | Authorized Testing and Certification Body |
| CAH | Critical Access Hospital |
| CAHPS | Consumer Assessment of Healthcare Providers and Systems |
| CCN | CMS Certification Number |
| CFR | Code of Federal Regulations |
| CHIP | Children’s Health Insurance Program |
| CHIPRA | Children’s Health Insurance Program Reauthorization Act of 2009 |
| CMS | Centers for Medicare & Medicaid Services |
| CPOE | Computerized Physician Order Entry |
| CY | Calendar Year (January through December) |
| EHR | Electronic Health Record |
| EH | Eligible Hospital |
| EP | Eligible Professional |
| EPE | Electronic Provider Enrollment |
| EPO | Exclusive Provider Organization |
| FACA | Federal Advisory Committee Act |
| FFP | Federal Financial Participation |
| FFY | Federal Fiscal Year (October through September) |
| FFS | Fee-For-Service |
| FQHC | Federally Qualified Health Center |
| FTE | Full-Time Equivalent |
| FY | Fiscal Year |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HHS | Department of Health and Human Services |
| HIE | Health Information Exchange |
| HIT | Health Information Technology |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| HITECH | Health Information Technology for Economic and Clinical Health Act |
| HMO | Health Maintenance Organization |
| HOS | Health Outcomes Survey |
| HPSA | Health Professional Shortage Area |
| HRSA | Health Resource and Services Administration |

Table A.1 – EHR Acronyms

| | |
|---|---|
| IAPD | Implementation Advance Planning Document |
| ICR | Information Collection Requirement |
| IHCP | Indiana Health Coverage Programs (Indiana Medicaid) |
| IHS | Indian Health Service |
| IPA | Independent Practice Association |
| IT | Information Technology |
| MA | Medicare Advantage |
| MAC | Medicare Administrative Contractor |
| MAO | Medicare Advantage Organization |
| MCO | Managed Care Organization |
| MITA | Medicaid Information Technology Architecture |
| MMIS | Medicaid Management Information Systems |
| MSA | Medical Savings Account |
| NAAC | Net Average Allowable Cost (of certified EHR technology) |
| NCQA | National Committee for Quality Assurance |
| NCVHS | National Committee on Vital and Health Statistics |
| NLR | National Level Repository |
| NPI | National Provider Identifier |
| NPRM | Notice of Proposed Rulemaking |
| ONC | Office of the National Coordinator for Health Information Technology |
| PAHP | Prepaid Ambulatory Health Plan |
| PAPD | Planning Advance Planning Document |
| PE | Provider Enrollment |
| PFFS | Private Fee-For-Service |
| PHO | Physician Hospital Organization |
| PHS | Public Health Service |
| PHSA | Public Health Service Act |
| PIHP | Prepaid Inpatient Health Plan |
| POS | Place of Service |
| PPO | Preferred Provider Organization |
| PQRI | Physician Quality Reporting Initiative |
| PSO | Provider Sponsored Organization |
| RHC | Rural Health Clinic |
| RHQDAPU | Reporting Hospital Quality Data for Annual Payment Update |
| RPPO | Regional Preferred Provider Organization |
| SMHP | State Medicaid Health Information Technology Plan |
| TIN | Tax Identification Number |

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