

Eligible Professionals User Manual Electronic Health Records Incentive Program

Idaho Department of Health and Welfare
Division of Medicaid



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PART I: PROGRAM OVERVIEW

Purpose

The purpose of this manual is to provide eligible professionals (EPs) with an overview of the Idaho Medicaid Electronic Health Records (EHR) Incentive Program, information about what needs to be done to receive payments, and step-by-step instructions about how to enroll and attest.

Introduction

Through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), the Centers for Medicare & Medicaid Services (CMS) has implemented incentive payments to EPs that are participating in Medicare and Medicaid programs and are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are intended to encourage EPs 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 (ONC) for Health Information Technology has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://www.healthit.hhs.gov>.

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines; and 4) enable data sharing using the state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce the costs of health care nationwide. Idaho Medicaid staff will work closely with federal and state partners to ensure the Idaho Medicaid EHR Incentive Program fits into the overall strategic plan for the Idaho HIE, thereby advancing Idaho and national goals for HIE.

Eligibility

A provider's eligibility to receive EHR incentive payments is based on the provider type and specialty, patient volume, state of licensure and good standing, and verification that a qualifying EHR system is in place.

Provider Type and Specialty

The first tier of provider eligibility for the Idaho Medicaid EHR Incentive Program is based on provider type and specialty. At this time, CMS has determined that the following providers are potentially eligible to enroll in the Idaho Medicaid EHR Incentive Program:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioners
- Certified nurse-midwives
- Dentists
- Physician assistants who furnish services in a federally qualified health center (FQHC) or rural health clinic (RHC) that is led by a physician assistant

The EHR incentive payments will only be made to Idaho Medicaid providers (EPs with an Idaho Medicaid Provider Agreement), unless the provider predominantly practices in an RHC or FQHC.

Patient Volume

Patient volume thresholds must be established every year a provider applies for an incentive payment. To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must not be hospital-based (hospital-based means an EP who furnishes 90 percent or more of covered professional services in a hospital, inpatient, or emergency room setting in the year preceding the payment year) and must meet one of the following patient volume criteria:

- Have a minimum of 30 percent Medicaid patient volume attributable to individuals receiving Medicaid funded services.
- Have a minimum of 20 percent patient volume attributable to individuals receiving Medicaid funded services **and** be a pediatrician.
- *Practice predominantly* in an FQHC or RHC **and** have a minimum of 30 percent patient volume attributable to *needy individuals*.
 - To *practice predominantly* means an EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of six months in the most recent calendar year occurs at an FQHC or RHC. In Idaho, the most recent calendar year is defined as the previous completed calendar year. This is a statutory requirement that is not subject to the interpretation of the state. If an FQHC or RHC must use non-Medicaid encounters to reach the minimum 30 percent threshold, an EP hired in the current calendar year should have the appropriate track record for a six month period in the previous calendar year. This attestation will be subject to post-payment audit. Examples of non-eligible professionals include:
 - A doctor who is on staff at the FQHC but who was on sabbatical last year and didn't practice at all.
 - A new EP whose last job in the previous calendar year was at a university medical center.
 - A staff EP who performed only 1-49 percent of his or her encounters at an FQHC last year.
 - Services attributable to *needy individuals* are defined as those that meet one of the following:
 - Services rendered to an individual who is receiving assistance under Title XIX, who is receiving assistance under Title XXI, who is furnished uncompensated care by the provider, or for whom charges are reduced by the provider on a sliding scale based on the individual's ability to pay.
 - Services rendered on any one day to an individual where Medicaid or the Children's Health Insurance Program (CHIP) or a Medicaid or CHIP demonstration project under section 1115 of the Social Security Act paid all or part of their premiums, co-payments, or cost sharing.
 - Services rendered to an individual on any one day that were on a sliding scale or that were charity care.

CHIP Encounters for Patient Volume and Payment Calculation

Encounters with Medicaid participants receiving services funded by Title XXI **cannot** be included in the patient volume calculation unless the EP practices predominantly in an FQHC or RHC **and** is basing the patient volume on needy patient encounters. Because EPs can't always distinguish between funding sources, Idaho Medicaid has received permission from CMS to use a "CHIP patient volume average" strategy to help EPs determine their Medicaid patient volume.

Idaho's payment system differentiates the paying source using detailed codes for eligibility that are traceable to the claim. Using this information, Idaho Medicaid has identified a statewide average proportion for CHIP encounters for professionals. The CHIP patient volume average is currently seven percent. This is based on an analysis of three years of claims history. This percent gives the statewide average of CHIP-to-total Medicaid encounters. Eligible professionals must identify their total number of Medicaid encounters and reduce that by the CHIP patient volume average percent when applying for incentives.

Using this method will benefit some providers whose actual CHIP patient encounters are higher than the statewide average, and may disadvantage those whose CHIP volume is lower than average. Idaho Medicaid wants to work with EPs to ensure that they are not falsely denied eligibility based on this strategy. Providers can request the state provide them with the **actual** number of Medicaid and CHIP encounters for the 90-day period of their choosing **if** they are unable to meet the patient volume threshold with the CHIP patient volume average reduction and believe that they could meet it otherwise. Medicaid staff will give the number to the provider making the request. Professionals can contact the Idaho Medicaid EHR Incentive Program Help Desk staff at (208) 332-7989 for more information about this process.

Eligible Professionals Patient Volume Calculator

To calculate Medicaid patient volume, EPs who are not practicing predominantly in an FQHC or RHC must divide:

- The total Medicaid patient encounters in any representative, continuous 90-day calendar period in the preceding calendar year reduced by the seven percent CHIP average; by
- The total patient encounters in the same 90-day period.

To calculate Medicaid patient volume, EPs practicing predominantly in an FQHC or RHC and basing patient volume on needy encounters 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.

Medicaid will count only claims where Medicaid has paid \$.01 or more. If there is a \$0 paid claim, it will not be counted as an eligible encounter. If an EP believes the omission of \$0 paid claims for participants whose premiums were paid by Medicaid will push them under the 30 percent threshold, Idaho Medicaid staff can run a unique report that includes the amount of \$0 paid claims for the 90 days where Medicaid paid the premium. Medicaid will also include any claim for a Medicare dual eligible when Medicaid paid at least \$.01.

Statewide Average for CHIP and Impact on Auditing

For EPs that are audited and have used the CHIP patient volume average, the auditor will assess whether the total Idaho Medicaid encounters were accurately represented and will not attempt to evaluate an EP's actual Medicaid-only encounters. There would be no penalty for EPs who have an actual CHIP patient volume higher than the statewide patient volume average. For EPs who request their specific data, the audit will assess whether the Medicaid-only encounters were accurately represented, given the information provided by the state.

Group Proxy Calculation

The Idaho Medicaid EHR Incentive Program has developed a group proxy calculation worksheet to help facilitate consistent attestation of patient volumes by eligible professionals and to streamline patient volume verification. It is important for EPs to remember that:

- The entity responsible for the group must complete a group proxy calculation worksheet and make it available to all eligible professionals.
- Every eligible professional must attach a copy of the group proxy calculation worksheet and its supporting patient encounter report during the application/attestation process for the Idaho Incentive Management System (IIMS).
Note: The 90-day patient encounter report of needy/total patient encounters is required to support the proxy calculation.
- A **new** group proxy calculation worksheet must be completed every year the group's EPs apply for a Medicaid incentive if using the group proxy calculation approach that year.

The group proxy calculation can be set at the organizational level or the clinic level. If using an organizational level proxy calculation, the clinics that are included cannot be an arbitrary group of clinics to maximize patient volumes. An organizational level proxy must include all of the organization's clinics that are within the state of Idaho. **No out-of-state clinics will be allowed to be included in the proxy.**

After the group proxy calculation worksheet is completed, it needs to be converted to a PDF format and submitted during application/attestation in the IIMS.

Institutional License and Good Standing

All participating EPs must have a current institutional license (provisional licenses will be accepted) and must be free of both state- and federal-level sanctions and exclusions to be eligible for incentive payments.

Adopt, Implement, or Upgrade

All EPs must verify that they have adopted, implemented, or upgraded to a certified EHR system. Below are the criteria for each:

- **Adopt:** "acquire, purchase, or secure access to certified EHR technology."
There is evidence that an EP demonstrated actual installation prior to the incentive, rather than "efforts" to install. This evidence serves to differentiate between activities that may not result in installation (for example, researching EHRs or interviewing EHR vendors) and actual purchase/acquisition or installation.

- **Implement:** “install or commence utilization of certified EHR technology.”
The EP has installed certified EHR technology and has started using the certified EHR technology in his or her clinical practice. Implementation activities would include staff training in the certified EHR technology, the data entry of their patients’ demographic data into the EHR, or establishing data exchange agreements and relationships between the EP’s certified EHR technology and other EPs, such as laboratories and pharmacies.
- **Upgrade:** “expand the available functionality of certified EHR technology.”
The EP has added clinical decision support, electronic prescribing functionality, or other enhancements that facilitate the meaningful use of certified EHR technology. An example of upgrading that would qualify for the EHR incentive payment would be upgrading from an existing EHR to a newer version that is certified per the EHR certification criteria promulgated by the ONC related to meaningful use. Upgrading may also mean expanding the functionality of an EHR in order to render it certifiable per the ONC’s EHR certification criteria (<http://onc-chpl.force.com/ehrcert>).

Please see the “Preparing the Documentation Required for Attestation” section of this handbook for details about what documentation will meet verification needs.

Getting Your EHR Certification

The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology. Standards, implementation specifications, and certification criteria for EHR technology have been adopted by the Secretary of the Department of Health and Human Services. The EHR technology in use by the EP must be tested and certified by an ONC Authorized Testing and Certification Body (ATCB) in order for that EP to qualify for EHR incentive payments. Once certified, the product is listed on the ONC’s website, often referred to as the Certified Health IT Product List (CHPL), where an EP may obtain a unique CMS EHR Certification ID Number. This certification number must be provided as part of the attestation process for either the Medicare or Medicaid incentive program.

Eligible professionals can obtain the CMS EHR Certification ID Number for their EHR product by following these steps:

1. Go to the ONC CHPL website: <http://healthit.hhs.gov/chpl>.
2. Select the practice type by selecting either the “Ambulatory” or “Inpatient” button.
3. Search for EHR products by browsing all products, searching by product name, or searching by criteria.
4. Add products to your cart to determine if they meet 100 percent of the CMS required criteria.
5. Request a CMS EHR Certification ID Number for CMS attestation (this number should contain 15 alphanumeric characters).

Note: The "Get CMS EHR Certification ID" button will not be activated until the products in your cart meet 100 percent of the CMS required criteria. If the EHR products don’t meet 100 percent of the CMS required criteria to demonstrate meaningful use, a CMS EHR Certification ID Number will not be issued.

Important Clarifications

- The ONC CHPL Product Number issued to your vendor for each certified technology is different than the CMS EHR Certification ID Number issued to a professional for attestation purposes. Only a CMS EHR Certification ID Number (also obtained from the CHPL site) that is unique to the practice will be accepted at attestation.

- It is not enough for a provider’s EHR product to be certified by the Certification Commission for Health Information Technology (more commonly known as CCHIT certification). The product must be certified by an ONC-ATCB specifically for the Medicare and Medicaid EHR Incentive Programs and listed on the ONC’s website.
- An EP doesn’t need to have a certified EHR technology in place to register with CMS for the Medicare and Medicaid EHR Incentive Programs. However, the professional must adopt, implement, or upgrade to a certified EHR system under the Medicaid EHR Incentive Program or successfully demonstrate meaningful use of certified EHR technology under the Medicare EHR Incentive Program before the professional can receive an EHR incentive payment.

The ONC’s website of certified products has the final rules related to certification standards, fact sheets, frequently asked questions, a list of ONC-ATCBs, and a wealth of information about certified products and obtaining certification.

Special Eligibility Issues for FQHCs and RHCs

EPs that practice at FQHCs and RHCs encounter special eligibility issues other EPs do not.

Physician Assistants

Unlike other eligible provider types, physician assistants (PAs) can apply for an EHR incentive only if they are practicing at an FQHC or RHC. In addition, the FQHC or RHC where they practice must be led by a PA. The definition of PA leadership is the key to PA eligibility.

In the Federal Register (volume 75, number 144, page 44483, 7/28/2010: 42 CFR 495.302), CMS interprets the statutory language regarding “PA-led” as follows:

“We believe a PA would be leading an FQHC or RHC under any of the following circumstances:

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

We agree that FQHCs and RHCs that have PAs in these leadership roles can be considered PA-led. Furthermore, since RHCs can be practitioner owned (FQHCs cannot), we will allow ownership to be considered PA-led.”

Circumstances (2) and (3) above can usually be validated with internal data, public documents, and even clinic websites. Circumstance (1), in which a PA is the primary provider, is more difficult and cumbersome to authenticate, especially given the simplicity of the CMS example. In some cases - for instance, when full-time PAs outnumber full-time physicians, or a small rural clinic has only a single EP - primary providership may be easily established. To avoid making improper payments in cases that are less clear, the state will request dated, documented evidence from FQHCs and RHCs from which one or more PAs apply. Documentation might include position descriptions, work schedules, appointment calendars, emails, meeting minutes, and other organizational documents that yield conclusive indications of clinical leadership.

CMS has offered the following guidance to FQHCs and RHCs as they evaluate if the clinic is PA-led when a PA does not have the title of Medical Director. Consider if the PA:

- Sets the amount of clinical time and administrative time for the other EPs.
- Reviews and signs the policies and procedures for clinical practices.
- Sets the schedule for the other EPs.
- Leads the EP meetings.
- Sets quality goals for the clinic.
- Completes performance evaluations for the other EPs.

Provider Roster

Many EPs may not be enrolled as individual Idaho Medicaid EPs, but likely are identified as rendering providers for FQHCs or RHCs. It's difficult to verify if EPs are currently active or if they are one of the eligible provider types when they're not fully enrolled in the Medicaid system. The Idaho Medicaid EHR Incentive Program plans to leverage EP rosters completed by the FQHCs and RHCs as the initial point of reference for verification.

The Idaho EHR Incentive Program has developed a *Provider Roster Workbook* with two tabs. The first tab is the provider roster template for FQHCs and RHCs to complete to document their active providers. The second tab is a sample of a completed provider roster template. Clinic staff must decide who will complete and submit the provider roster, as only one is needed from each clinic. This should be done before clinic providers register for an incentive payment. The provider roster should list all **eligible professionals** at that clinic location, **not all practitioners**. This reflects a change in policy by Idaho Medicaid effective June 1, 2012. Professionals can contact the Idaho Medicaid EHR Incentive Program Helpdesk at (208) 332-7989 with questions.

After the provider roster is completed, please email it to the Idaho Medicaid EHR Incentive Program (please see the directions included with the provider roster template).

The provider roster will serve as a key initial reference that will facilitate preliminary verification that an EP is active and is the correct eligible provider type. It's important to remember that:

- FQHCs, RHCs, and Tribal clinics will be required to complete an EP provider roster and send it to the Idaho Medicaid EHR Incentive Program. The program will use the EP provider roster as a reference to perform initial verification of EPs from these clinics.
- Idaho Medicaid will ask for an updated provider roster every calendar quarter in order to have it as a handy reference when an eligible provider represented in the roster applies for an incentive payment.

The EP provider roster template and instructions are posted on the Idaho Medicaid EHR Incentive Program website at www.MedicaidEHR.dhw.idaho.gov. This *Provider Roster Workbook* contains the template, a guide about how to complete the template, an example of a completed form, and information about how to submit the form to Idaho Medicaid staff.

Payments

How to Become a Vendor With the State

Idaho Medicaid is using the state fiscal system to set up financial transactions for incentive payments. This fiscal system is not the same payment system that is used to process Medicaid payments to current EPs. Providers will need to ensure they are enrolled as a vendor in this system in order to receive payments. If EPs are unsure of prior vendor enrollment, they can call the Idaho Medicaid EHR Incentive Program Help Desk at (208) 332-7989 to see if they have previously enrolled.

- To enroll as a vendor who receives paper warrants and paper remittance advices (RAs), the EP must complete a W-9 form (<http://www.irs.gov/pub/irs-pdf/fw9.pdf>) and submit it to the Idaho Medicaid EHR Incentive Program using one of three methods:

Mail: EHR Incentive Payments
 Division of Medicaid
 PO Box 83720
 Boise, ID 83720-0009

Fax: (208) 334-6515

Email: EHRIncentives@dhw.idaho.gov

- To enroll as a vendor who receives direct deposits (EFT), the EP must complete the [Combined Substitute W-9/EFT Direct Deposit Authorization Form](#) (on the Idaho Office of the State Controller’s website). This form must be **mailed** along with a voided check (originals only, copies/faxes/scanned documents will not be accepted) to:

EHR Incentive Payments
 Division of Medicaid
 PO Box 83720
 Boise, ID 83720-0009

Processing of the completed EFT form includes verifying the vendor’s tax identification number (TIN) and name with the IRS to make sure they match, and verifying the vendor’s financial institution. This process usually takes a few weeks. Once the submitted EFT paperwork and voided check have been processed, the controller’s office sends the EP a letter or email with their logon information, password, and instructions for accessing the state controller’s vendor website so the EP can view the RAs.

Note: EPs who sign up for EFT will not receive paper warrants or paper RAs. If an EP is reassigning payment, the clinic or group to whom the payment is reassigned must be enrolled as a vendor with the state of Idaho and follow the instructions above to receive a paper warrant or EFT.

Understanding Payment Timelines

The maximum incentive payment an EP could receive from Idaho Medicaid equals \$63,750 over a period of six years, or \$42,500 for pediatricians with a 20-29 percent CMS patient volume as shown below.

Provider	EP: Patient Volume 30 Percent	EP-Pediatrician (Medicaid): 20-29 Percent
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	\$63,750	\$42,500

Pediatricians may qualify to receive the full incentive if they can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements. In Idaho, a pediatrician will be considered any physician whose National Provider Identifier (NPI) is associated with a pediatric taxonomy code, including specialties, all of which begin with 2080. In addition, any physician who predominantly treats individuals under 21 years of age and believes the above definition will negatively impact potential eligibility can contact the program eligibility specialist to discuss verification for pediatric focus.

Note: EPs must reapply to Medicaid each year they wish to receive a payment.

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than calendar year 2016. EPs can choose to receive the EHR payment **or** choose to re-assign the payment to a Medicaid contracted clinic or group to which the EP is associated. This decision must be made when the EP registers with the CMS EHR Registration and Attestation (R&A) website. The TIN of the individual or entity receiving the incentive payment is required when registering with CMS and must be associated to a TIN linked to the individual EP in the IIMS. All EPs who assign payment to themselves (and not a group or clinic) will be required to provide Idaho Medicaid with updated information.

Note: If Idaho Medicaid determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS.

Out-of-State Providers

The EHR incentive payments will only be made to Idaho Medicaid providers (EPs with an Idaho Medicaid Provider Agreement), unless they predominantly practice in an RHC or FQHC.

Program Integrity and Audit

Idaho Medicaid will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint, or incorporation into reviews selected for other objectives. EPs should be sure to keep their supporting documentation for six years after each payment is received.

Administrative Appeals

EPs can choose to appeal the determination made by the Idaho Medicaid EHR Incentive Program about the incentive payment application. All contested cases are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings".

Provider Attestation Process and Validation

It is the policy of Idaho Medicaid that EPs may permit a designated representative to complete the Idaho application/attestation forms on their behalf. The following is a description of information that will have to be reported or attested to during the process:

- After registering for the incentive program on the CMS EHR R&A website at <http://www.cms.gov/EHRIncentivePrograms/>, Idaho Medicaid will receive notification of registration from CMS. Idaho Medicaid will do some pre-verification and then contact the EP using the contact information provided to CMS. The EP will be given the link to the IIMS where the EP can log in to begin the application/attestation process. To log into the IIMS, the EP will need the CMS EHR Registration ID Number, NPI, and CMS-assigned Registration ID Number.

- The EP will then be asked to view the information that will be displayed with the pre-populated data received from the CMS EHR R&A process.
- EPs will then be asked to enter the patient volume characteristics and EHR details.

The EP will be asked to attest to:

- Assigning the incentive payment to a specific TIN, if applicable (the name of the EP and the TIN to which the payment was assigned will be displayed).
- Not working as a hospital-based professional (this will be verified by Idaho Medicaid through claims analysis).
- Not applying for an incentive payment from another state or Medicare.
- Not applying for an incentive payment under another Idaho Medicaid ID Number.
- Adopting, implementing, or upgrading the certified EHR technology.

Note: For EPs that are ready to demonstrate meaningful use in year 1, the EP will attest to this fact. In subsequent years, Idaho Medicaid will work with the Idaho HIE to provide a mechanism for EPs to submit meaningful use data to Idaho Medicaid.

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

The attestation itself will be electronic and will require the EP to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All EPs will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the IIMS.

During the first year of the program, EPs will only be able to attest to adopting, implementing, or upgrading to certified EHR technology for the Idaho Medicaid EHR Program. Documentation dated any time before the attestation is acceptable if the system and version of EHR technology has been certified by the ONC (the Certified Health IT Product List is on the ONC's website at www.healthit.hhs.gov).

Preparing the Documentation Required for Attestation

The following is a description of the documentation that an EP will have to upload to the IIMS (<https://IIMS.dhw.idaho.gov>) during attestation:

- Proof of adopting, implementing, or upgrading to certified EHR technology – this must be a document showing a binding agreement between the EP and the vendor, such as a contract between entities. Idaho Medicaid only needs the most current documents for proof, not all historical documents relating to the EHR system.
- An invoice showing payment for the certified EHR system (actual numbers may be blacked out).
- A purchase order.

Note: A vendor letter is not acceptable unless submitted with additional binding documentation. The documentation submitted must include the exact name of the EHR system including the software version number.

- A provider roster and PA-led documentation (if applicable).
- A patient volume encounter report - in the Idaho Medicaid EHR Incentive Program, all EPs are required to submit a 90-day patient volume report to support their attestation for Medicaid or needy patient encounters. The report must be from an auditable source and system generated from the practice's administrative or clinic care system. The content of the report is intended to provide the state sufficient information to validate patient encounters reported. The particular format of the report is not as important as the content; however, it will be important to make the content clear on the report by using headings and labels. The following are definitions of the content we require on the report:
 - **Date:** The date the report was generated.
 - **90-Day Period:** The start and end date of the 90 calendar days used to determine patient volume. Please use the most recent completed calendar year (12 month period: January-December) prior to the year you are completing the application/attestation. We will allow you to use an additional two months after the calendar year, called the "tail period," if you need to use this time frame to meet patient volume requirements.
 - **Name of EP:** The name of the individual EP or, if an EP is using a clinic/group proxy calculation, the name of the clinic/group.
 - **Provider NPI:** The NPI for all of the **eligible providers** included in the report. Every encounter must have an NPI if it is a service provided by an EP. If the report is to support a group proxy patient volume calculation, the report will list all encounters of all practitioners. Medicaid understands that some non-eligible practitioners may not have an NPI.
 - **Clinic NPI:** The NPI for the clinic that is connected to this EP or group of EPs, if using the group proxy approach for establishing patient volume.
 - **Total Medicaid or Needy Encounters:** The total number of Medicaid or needy encounters attributable to the EP or, if using a group proxy calculation, all practitioners at the clinic/group practice. The report could show daily, weekly, or monthly sub-totals if the EP desires. If the report includes out-of-state Medicaid/needy encounters, they must be identified and included in both the numerator and the denominator for the patient volume calculation.
 - **Total Patient Encounters:** The total number of patient encounters attributable to the EP or, if using a group proxy calculation, all practitioners at the clinic/group practice. If the report includes out-of-state Medicaid/needy encounters, they must be identified and included in both the numerator and the denominator for the patient volume calculation. Claims that are billed as a global service are counted as one encounter in the numerator and denominator for all payer sources.

Note: If providers have out-of-state encounters for the period, they may include them in their encounters only if this is needed to meet the patient volume threshold. When using out-of-state encounters, include these numbers in both the "Total Medicaid" or "Needy Encounters" and the "Total Patient Encounters". Identify the state and total encounters separately in these totals to provide visibility to these numbers.

PART II: STEP-BY-STEP STATE INSTRUCTIONS

Overview

Idaho has implemented a web-based interface, called the Idaho Incentive Management System (IIMS), for providers to apply and attest at the Idaho state level. To successfully use the IIMS to apply and attest, you must:

- Be successfully registered on the Centers for Medicare and Medicaid Services (CMS) website for the Incentive Management Program.
- Have the following information available:
 - The National Provider Identifier (NPI) you used to register at the CMS website.
 - The CMS Registration Identification Number that is associated with your NPI (provided by CMS during registration).
 - Supporting documentation on patient volume, EHR details, and PA-led clinics (if applicable).

Steps to complete your application/attestation in the IIMS include:

1. Log into the IIMS.
2. Review the CMS registration data.
3. Enter the eligibility details.
4. Review the incentive payment calculation.
5. Upload supporting documentation.
6. Submit the application/attestation.

The log-in process and step-by-step instructions for application, attestation, and information verification are discussed on the following pages.

Logging Into the IIMS

Begin the Idaho Medicaid EHR Incentive Program application and attestation process by accessing the IIMS at <https://IIMS.dhw.idaho.gov>. Once there, the following page is displayed:



ID Medicaid EHR Incentive Program

[Hospital User Manual](#)
[EP User Manual](#)
[CMS EHR Site](#)
[ID Medicaid EHR Site](#)
[Send E-mail](#)

In order to receive EHR incentive payments from Idaho Medicaid, you must first register at the [CMS Web Site](#). After your registration is complete, Idaho Medicaid will send you an email confirming that you can log in.

Please enter your NPI

Please enter the CMS Assigned Registration Identifier

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When this page appears:

1. Enter the NPI used when registering at the CMS EHR Incentive Program site and the CMS-assigned Registration ID Number. If the data entered here does not match the NPI or the CMS-assigned Registration ID Number on file, the message “Invalid NPI/Registration ID combination” will be displayed.
2. If you do not remember your CMS-assigned Registration Identification Number, you must return to the [CMS EHR Incentive Program Registration and Attestation System](#) to reference it.
3. Select “Submit” to log in and proceed to the CMS Registration Information page.

CMS Registration Information (Step 1 of 5)

Upon correct validation of the log in, the following CMS Registration Information page is displayed:

CMS Registration Information (Step 1 of 5) Logout

CMS Registration Information
Eligibility Details
Payments
Issue/Concern
Appeals
Hospital User Manual
EP User Manual
CMS EHR Site
ID Medicaid EHR Site
Send E-mail

You are currently enrolled in Idaho Medicaid's EHR Incentive Management System

The current status of your application for the first year payment is 'AWAITING PROVIDER ATTESTATION'

Applicant National Provider Index (NPI):	1100000000	Name:	Jane Nimble
Applicant TIN:	511111111	Address 1:	1234 West Staywell Ave
Payee National Provider Index (NPI):	9200000000	Address 2:	
Payee TIN:	522222222	City/State:	Boise / ID
Program Option:	MEDICAID	Zip Code:	83702 -1111
Medicaid State:	ID	Phone Number:	(208) 555-1212
Provider Type:	Physician	Email:	wheatonj@dhw.idaho.gov
Participation Year:	1	Specialty:	FAMILY PRACTICE
Federal Exclusions:		State Rejection Reason:	
Have you worked with the Washington and Idaho Regional Extension Center (WIREC)?	<input type="radio"/> No <input checked="" type="radio"/> Yes	State licensed in if not in Idaho:	<input type="text"/>
		Other State License #:	<input type="text"/>

*** If any of the above information is incorrect, please correct on the CMS EHR Incentive Registration and Attestation System web site.

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Some of the information on this page is for review only, but some information you'll need to provide. When this page appears:

1. Review this information carefully. This information is populated directly from your CMS registration information. You cannot update the existing information on this page. If you need to make updates to the existing information, return to the CMS website and make your changes. Once you have completed your update on the CMS website, your information will again be sent to Idaho and this page will be updated.
Important Note: As you make your changes at the CMS website, make sure you go through the screens, selecting "Save" and "Continue", until you get to the "Verify Registration" page and select "Submit". **Unless you select "Submit", your updated data will not be sent to Idaho and your payment will be delayed.**
2. Type either "yes" or "no" to answer the question, "Have you worked with WIREC?"
Note: An answer is required.
3. If you're licensed in Idaho, skip to step #4; if you are **not** licensed in Idaho:
 - a) Type the name of the state where you are licensed in the "State licensed in if not in Idaho" field (if you're not licensed in the state of Idaho, an answer is required).
 - b) Type the license number in the "Other State License" field (if you're not licensed in Idaho, an answer is required).
4. Select "Next" to proceed to the Provider Eligibility Details page.

Provider Eligibility Details (Step 2 of 5)

A graphic of the Provider Eligibility Details page is shown below. Use the step-by-step instructions below to complete this page.



Provider Eligibility Details (Step 2 of 5) Logout

[CMS Registration Information](#)
[Eligibility Details](#)
[Payments](#)
[Issue/Concern](#)
[Appeals](#)
[Hospital User Manual](#)
[EP User Manual](#)
[CMS EHR Site](#)
[ID Medicaid EHR Site](#)
[Send E-mail](#)

All * fields are required fields.

Patient Volume:

1. Is your patient volume calculated using the proxy method?
2. If yes, please enter the NPI of the proxy entity:
3. Select the starting date of the 90-day period to calculate Medicaid/needy patient encounter volume percentage: * (mm/dd/yy)
4. Medicaid/needy patient encounters during this period: *
Note: If using patient volume based only on Medicaid encounters, exclude 7% for CHIP encounters.
5. Total patient encounters during this period: *
6. Is your patient volume based on needy? * [What is this?](#) This is a required field.
Note: only FQHCs or RHCs can be based on needy; others must use Medicaid.
- 6b. I am not hospital based (less than 90% of my patient encounters are at the ED or in an inpatient setting). *
7. Medicaid/needy patient encounter volume percentage:

EHR Details:

8. Enter the CMS EHR Certification ID of your EHR: * [What is this?](#)
9. Indicate the status of your EHR: * Adopt Implement Upgrade

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Patient Volume:

1. Select “yes” or “no” from the drop down menu to indicate if your patient volume was calculated using the group proxy method.
2. If you answered “yes”, enter the NPI of the proxy entity (Idaho Medicaid will verify the NPI). If you entered “no”, skip to question #3.
3. Select the starting date of the 90-day period to calculate the Medicaid/needy patient encounter volume percentage.
Note: The date must be a valid date within the previous calendar year being attested to (January 1 - October 2). Dates from October 3 or later will not cover a 90-day period in the previous calendar year.
4. Enter the Medicaid/needy patient encounters during this period.
Note: If using patient volume based only on Medicaid encounters, exclude seven percent for CHIP encounters. If you are basing patient volume on needy, disregard the exclusion of CHIP encounters. The following is an example for excluding CHIP encounters for patient volumes based on Medicaid:
 - Total Medicaid encounters = 120
 - Calculated CHIP amount based on seven percent state average: 8.4 and round to the nearest whole number 8
 - Net Medicaid encounters: 120 - 8 = 112
 - Result: use 112 for the Medicaid patient encounters

5. Enter the number of total patient encounters during this period.
6. If you are basing your patient volume on needy encounters, select “yes” from the drop down menu and answer question 6a when it appears (see graphic below). **Only FQHCs or RHCs can be based on needy; others must use Medicaid.**
 - a. Select “yes” or “no” from the drop down menu to indicate if you practice predominantly at an FQHC or RHC (see graphic below). If you don’t practice predominantly in an FQHC or RHC, your payment will be \$0.



Logout

Provider Eligibility Details (Step 2 of 5)

All * fields are required fields.

CMS Registration Information

Eligibility Details

Payments

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ID Medicaid EHR Site

[Send E-mail](#)

Patient Volume:

1. Is your patient volume calculated using the proxy method?

2. If yes, please enter the NPI of the proxy entity: *

3. Select the starting date of the 90-day period to calculate Medicaid/needy patient encounter volume percentage: * (mm/dd/yy)

4. Medicaid/needy patient encounters during this period: *
Note: If using patient volume based only on Medicaid encounters, exclude 7% for CHIP encounters.

5. Total patient encounters during this period: *

6. Is your patient volume based on needy? * [What is this?](#)
Note: only FQHCs or RHCs can be based on needy; others must use Medicaid.

6a. Do you practice predominantly in an FQHC / RHC? *

7. Medicaid/needy patient encounter volume percentage: 33.33%

EHR Details:

8. Enter the CMS EHR Certification ID of your EHR: * [What is this?](#)

9. Indicate the status of your EHR: * Adopt Implement Upgrade

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If you are not basing your patient volume on needy encounters, select “no” from the drop down menu and answer question 6b (see graphic below) when it appears.

- b. Use the drop down menu to indicate if you are **not** hospital based (see graphic below). If you are hospital based, your payment will be \$0.



Logout

Provider Eligibility Details (Step 2 of 5)

All * fields are required fields.

CMS Registration Information

Eligibility Details

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Patient Volume:

1. Is your patient volume calculated using the proxy method?

2. If yes, please enter the NPI of the proxy entity: *

3. Select the starting date of the 90-day period to calculate Medicaid/needy patient encounter volume percentage: * (mm/dd/yy)

4. Medicaid/needy patient encounters during this period: *
Note: If using patient volume based only on Medicaid encounters, exclude 7% for CHIP encounters.

5. Total patient encounters during this period: *

6. Is your patient volume based on needy? * [What is this?](#)
Note: only FQHCs or RHCs can be based on needy; others must use Medicaid.

6b. I am not hospital based (less than 90% of my patient encounters are at the ED or in an inpatient setting): *

7. Medicaid/needy patient encounter volume percentage: 33.33%

EHR Details:

8. Enter the CMS EHR Certification ID of your EHR: * [What is this?](#)

9. Indicate the status of your EHR: * Adopt Implement Upgrade

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7. Medicaid/needied patient volume percentage (calculated).

Note: When items #4 and #5 are entered and the cursor is moved to the next entry, the patient volume percentage is displayed.

The following edits with messages apply:

- If the provider specialty is pediatrics and patient volume is based on Medicaid volumes but is below the 20 percent patient volume threshold, this message will be displayed: "x.xx% - you must meet the threshold of 20% to get an EHR Incentive Payment".
- For other provider specialties (regardless of how patient volume is based) and those below the 30 percent patient volume threshold, this message will be displayed: "x.xx% - you must meet the threshold of 30% to get an EHR Incentive Payment".

EHR Details:

8. This is your CMS EHR Certification ID, which will be auto-populated from your CMS registration information, if it was provided there. If not, the EHR Certification ID must be input here.
9. Select the status of your EHR – “Adopt”, “Implement”, or “Upgrade”.

After entering your data, you must select one of the following buttons from the bottom of the screen:

- “Previous” - If you have not saved your entries, this will cancel your entries and take you to the previous page.
- “Next” - Will save your entries and take you to the Incentive Payment Calculations page.
- “Save” - Will save your current entries on the page and you will remain on that page.
- “Cancel” - Will replace any changes you made with data retrieved from the last time you saved your information. For example, if you never entered anything into the page before selecting “Cancel”, you will see blank fields.

Incentive Payment Calculations (Step 3 of 5)



Incentive Payment Calculations (Step 3 of 5) Logout

CMS Registration Information Eligibility Details Payments Issue/Concern Appeals Hospital User Manual EP User Manual CMS EHR Site ID Medicaid EHR Site Send E-mail	Estimated Amount of Medicaid EHR Incentive Payment:		\$21,250.00
	Previous	Next	

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When this page appears:

- Review the incentive payment amount and contact the Idaho Medicaid EHR Incentive Program Help Desk if you have questions.
- If you see a \$0 payment, you may not have met eligibility requirements; click on the “Previous” button, which will take you back to the Provider Eligibility Details page, and check the calculated patient volume thresholds and your answer to question #6, “Is your patient volume based on needy?” **If you are not working at an FQHC or RHC, you must use Medicaid patient encounters, which is not needy.**
- If your payment amount looks correct, select “Next” to go to the Document Upload page.

Document Upload (Step 4 of 5)



Logout

Document Upload (Step 4 of 5)

[CMS Registration Information](#)
[Eligibility Details](#)
[Payments](#)
[Issue/Concern](#)
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[EP User Manual](#)
[CMS EHR Site](#)
[ID Medicaid EHR Site](#)
[Send E-mail](#)

It is required that you attach appropriate support documentation.

Click here for information on what supporting documentation is required.

Payment Year	File Name	Description
No uploaded document found.		

Upload a new PDF document:

Please select the documentation type:

- AIU
- Patient Encounters
- Proxy Calculation
- Physician Assistant Led Doc
- Miscellaneous

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When this page appears:

- You may not have to do anything. Medicaid should have all the pertinent information to support your attestation; however, you may be instructed to upload additional documentation.
Note: Only PDF files can be uploaded.
- You will still be able to upload files even after you have completed your attestation.
- Selecting “Next” will take you to the Attestation page of the IIMS.

Attestation (Step 5 of 5)



- [CMS Registration Information](#)
- [Eligibility Details](#)
- [Payments](#)
- [Issues/Concern](#)
- [Appeals](#)
- [Hospital User Manual](#)
- [EP User Manual](#)
- [CMS EHR SAs](#)
- [ID Medicaid EHR Site](#)
- [Need Email](#)

Please verify the following information:

CMS:

Applicant National Provider Index (NPI):	1100000000	Name:	Jane Nimble
Applicant TIN:	911111111	Address 1:	1234 West Staywell Ave
Payee National Provider Index (NPI):	9200000000	Address 2:	
Payee TIN:	922222222	City/State:	Boise / ID
Program Option:	MEDICAID	Zip Code:	83702 -1111
Medicaid State:	ID	Phone Number:	(208) 555-1212
Payment Year:	1	Email:	wheatonj@dhw.idaho.gov
Eligible Professional Type:	Physician	Specialty:	FAMILY PRACTICE

Eligible Details:

Patient Volume:	1. Is your patient volume calculated using the proxy method:	Yes
	2. If yes, please enter the NPI of the clinic or group:	1212121212
	3. The starting date of the 90-day period to calculate Medicaid encounter volume percentage:	7/1/2011 (mm/dd/yy)
	4. Medicaid patient encounters during this period:	500
	5. Total patient encounters during this period:	1500
	6. Is your patient volume based on need?:	No
	6a. I am not hospital based (less than 90% of my patient encounters are at the ED or in an inpatient setting):	Yes
	7. Medicaid/needed patient encounter volume percentage:	33.33%
EHR Details:	8. Enter the CMS EHR Certification ID of your EHR:	Q0000000ECGMAAQ
	9. Indicate the status of your EHR:	Adopt

ATTESTATION FOR PARTICIPATION IN THE IDAHO EHR INCENTIVE PROGRAM

This attestation is required for participation in the Idaho Medicaid Electronic Health Record (EHR) Incentive Payment Program to eligible professionals (EPs) and eligible hospitals who adopt, implement, upgrade (AU) or meaningfully use (MU) certified EHR technology. Participation must be in accordance with the requirements under United States Department of Health and Human Services, Centers for Medicare & Medicaid Services Final Rule regulations 42 CFR 495. Standards for the Electronic Health Record Incentive Program, revised July 28, 2010. These regulations implement the HITECH Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5). To comply with the above cited regulations, the Idaho Department of Health and Welfare (Department) requires that eligible professionals (EPs) and eligible hospitals submit this Attestation.

- This attestation certifies the following is known and understood:
- EPs are prohibited from seeking payment from another state or from the Medicare EHR incentive program in this payment year (applicable to EP only).
 - The Department can review, verify and/or audit all information provided by the EP or eligible hospital, both prior to and after payment has been made.
 - The Department can request AU and/or MU supporting information either at the time of attestation or after, and can review, verify and/or audit both prior to and after payment has been made.
 - The EP or eligible hospital is required to retain the documentation that verifies patient volume calculations, AU, MU, and any other information that validates the appropriateness of the EHR incentive payments received, and do so for 6 years from the date of payment.
 - The submission of any false information in this agreement or this process may result in the EP or eligible hospital being declared ineligible to participate in the Idaho Medicaid EHR Incentive Program.
 - Any incentive payments paid to the EP or eligible hospital, later found to have been made based on fraudulent or inaccurate information or attestation may be recouped by the Department or other appropriate state or federal agency.
 - The EHR incentive payments will be treated like all other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment.

- This Attestation also certifies that the following is true and accurate:
- With awareness and informed consent, this EP or eligible hospital is voluntarily participating in the Idaho Medicaid EHR Incentive Program.
 - The EHR certification number provided is the correct number, and accurately represents the certified EHR system or combination of certified EHR modules adopted and/or in use by this EP, group practice, or eligible hospital.
 - Any assignment of an EHR incentive payment is made voluntarily, which assumes informed consent, has been given by the EP, who understands that the party so designated—not the EP—will receive the payment (applicable to EPs only).
 - The person completing this electronic attestation is the EP, or the assigned representative of the EP, group practice or eligible hospital, who has been duly authorized to commit the EP or eligible hospital to the statements set forth in this attestation (applicable to EPs only).
 - If patient volume threshold is derived using encounter data from multiple practice locations, at least one of those locations must have a certified EHR (applicable to EPs only).
 - If the EP is a physician assistant, they are practicing in a physician assistant led FQHC or RHC.

I CERTIFY THAT the information provided in this Attestation and during the registration process, as well as in the documents submitted in support of registration, are true, accurate and complete. I hereby agree to retain such records for six years from the date of payment as are necessary to demonstrate I meet the program requirements, and to furnish those records to the Idaho Department of Health and Welfare, Division of Medicaid or contractor acting on their behalf, upon request before and/or after payment. I have read and understood this entire Attestation. I understand that any Medicaid EHR incentive payment made, in part, or wholly as a result of this Attestation will be from federal funds, and that falsification or concealment of material facts may be prosecuted under federal and state laws.

Initials: *	<input type="text"/>	Preparer:	<input type="text"/>
		Name:	What is this?
NPI: *	<input type="text"/>	Preparer:	<input type="text"/>
		Email:	<input type="text"/>
		Eligible Professional:	<input type="text"/>
		Email:	<input type="text"/>

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

Required:

- Enter your initials or name and the provider's NPI at the bottom of the screen.
 - This will serve as your electronic signature.
 - By entering this information, you attest to the validity of all data submitted for consideration by the Idaho Medicaid EHR Incentive Program.
- Select "Submit".

Important: After you select "Submit", **YOU CANNOT GO BACK AND MAKE ANY CHANGES.**

 - Once you select "Submit", it will take you to the first page of your attestation, "CMS Registration Information (Step 1 of 5)", to review. You can select "Previous" and "Next" to view the attestation pages in a review mode only.
 - Selecting "Submit" will notify Idaho Medicaid that the provider's attestation is ready for final eligibility review.

The attestation text is shown here:

ATTESTATION
FOR PARTICIPATION IN THE
IDAHO MEDICAID EHR INCENTIVE PROGRAM

This Attestation is required for participation in the Idaho Medicaid Electronic Health Record (EHR) Incentive Payment Program to eligible professionals (EPs) and eligible hospitals who adopt, implement, upgrade (AIU), or meaningfully use (MU) certified EHR technology. Participation must be in accordance with the requirements under United States Department of Health and Human Services, Centers for Medicare & Medicaid Services Final Rule regulations 42 CFR 495, "Standards for the Electronic Health Record Incentive Program", revised July 28, 2010. These regulations implement the HITECH Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5). To comply with the above cited regulations, the Idaho Department of Health and Welfare (Department) requires that EPs and eligible hospitals submit this Attestation.

This Attestation certifies the following is known and understood:

1. EPs are prohibited from seeking payment from another state or from the Medicare EHR incentive program in this payment year (applicable to EP only).
2. The Department can review, verify, and/or audit all information provided by the EP or eligible hospital, both prior to and after payment has been made.
3. The Department can request AIU and/or MU supporting information either at the time of attestation or after, and can review, verify, and/or audit both prior to and after payment has been made.
4. The EP or eligible hospital is required to retain the documentation that verifies patient volume calculations, AIU, MU, and any other information that validates the appropriateness of the EHR incentive payments received, and do so for six years from the date of payment.
5. The submission of any false information in this agreement or this process may result in the EP or eligible hospital being declared ineligible to participate in the Idaho Medicaid EHR Incentive Program.
6. Any incentive payments paid to the EP or eligible hospital that are later found to have been made based on fraudulent or inaccurate information or attestation may be recouped by the Department or other appropriate state or federal agency.
7. The EHR incentive payments will be treated like all other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment.

This Attestation also certifies that the following is true and accurate:

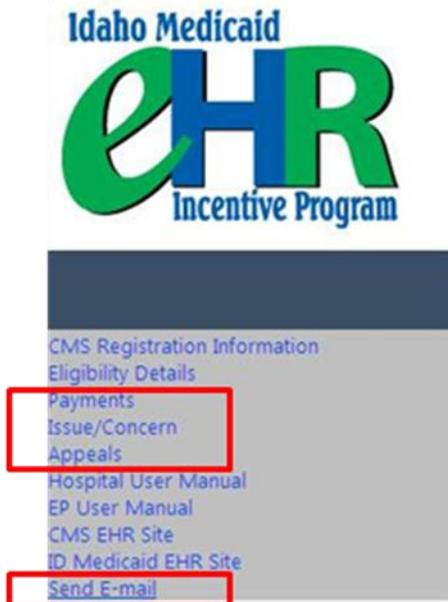
1. With awareness and informed consent, this EP or eligible hospital is voluntarily participating in the Idaho Medicaid EHR Incentive Program.
2. The EHR certification number provided is the correct number and accurately represents the certified EHR system or combination of certified EHR modules adopted and/or in use by this EP, group practice, or eligible hospital.
3. Any reassignment of an EHR incentive payment is made voluntarily, which assumes informed consent has been given by the EP, who understands that the party so designated—not the EP—will receive the payment (applicable to EPs only).
4. The person completing this electronic attestation is the EP or the assigned representative of the EP, group practice, or eligible hospital who has been duly authorized to commit the EP or eligible hospital to the statements set forth in this attestation (applicable to EPs only).
5. If patient volume threshold is derived using encounter data from multiple practice locations, at least one of those locations must have a certified EHR (applicable to EPs only).
6. If the EP is a physician assistant, he or she is practicing in a physician assistant led FQHC or RHC.

I CERTIFY THAT the information provided in this Attestation and during the registration process, as well as in the documents submitted in support of registration, are true, accurate, and complete. I hereby agree to retain such records for six years from the date of payment as are necessary to demonstrate I meet the program requirements, and to furnish those records to the Idaho Department of Health and Welfare, Division of Medicaid, or contractor acting on their behalf, upon request, before and/or after payment. I have read and understood this entire Attestation. I understand that any Medicaid EHR incentive payment made, in part or wholly as a result of this Attestation, will be from federal funds and that falsification or concealment of material facts may be prosecuted under federal and state laws.

Other Supporting Pages

The following pages are additional resources the provider may find useful when interacting with the Idaho Medicaid EHR Incentive Program.

The provider must be logged into the IIMS to see the left side menu items as shown below. The highlighted links will be described in the following pages.



Payments

To access this page, select "Payments" from the left side menu. After payment has been disbursed, the provider may review payments and any payment adjustments.



Payments Logout

CMS Registration Information
Eligibility Details
Payments
Issue/Concern
Appeals
Hospital User Manual
EP User Manual
CMS EHR Site
ID Medicaid EHR Site
[Send E-mail](#)

Payments Details:

Payment Year	Payment Amount	Payment Date	Payment Type
No payments found			

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Issue/Concern



Issues/Concerns Logout

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[EP User Manual](#)
[CMS EHR Site](#)
[ID Medicaid EHR Site](#)
[Send E-mail](#)

If you have any issue with the determination of your incentive payment application including but not limited to Eligibility, Patient volume or Payment Amount, you can notify us using the form below. Please be further advised that you also have access to a formal appeal process.

View Issue	Date Entered	Issue/Concern Status	Issue/Concern Description	Issue Category
No issues found				

Enter the issue/Concern below:

Issue Category:

Description:

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To access this page:

1. Select "Issue/Concern" from the left side menu. You can open an issue/concern to the Idaho Medicaid EHR Incentive Program Help Desk where they will be regularly monitored.
2. Select one of the following issue categories from the drop down menu in the center of the page:
 - Patient Volume
 - Payment Amount
 - Eligibility
 - Other
3. Enter a description with your contact information.
4. Select "Submit". Your issue/concern will be monitored by our Idaho Medicaid EHR Incentive Program Help Desk for follow up.

Appeals



Logout

Appeals

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Department of Health and Welfare Rules, IDAPA 16, Title 5, Chapter 3, Section 300, specifies your right to request an administrative review of any reimbursement calculation. The aforementioned procedures must be followed in order to preserve your appeal rights. The first step in that process is to request a review by the Administrator of the Division of Medicaid. Such a request should be addressed as follows:

Administrator
Division of Medicaid, Attn: Appeals
Idaho Department of Health and Welfare
P.O. Box 83720
Boise, Idaho 83720-0009

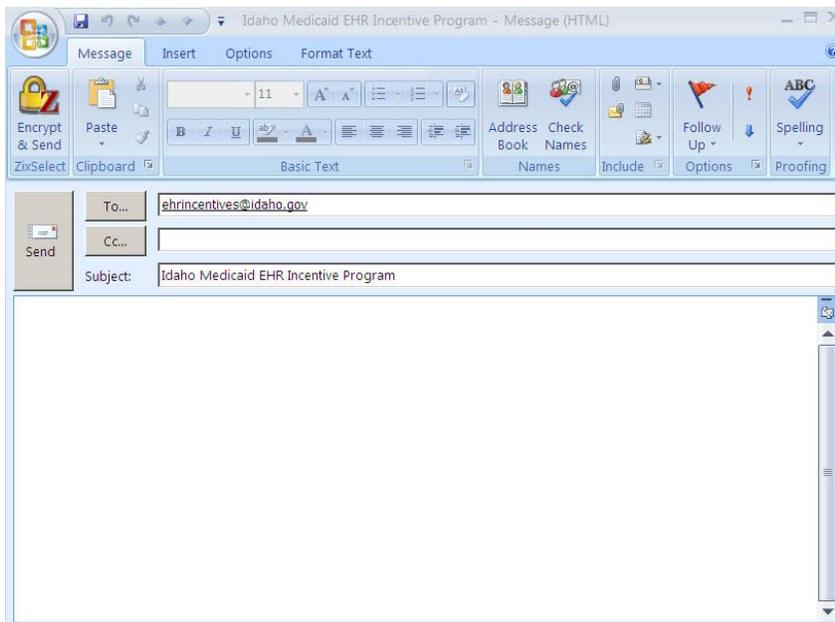
Your written request must be received by this office within twenty-eight (28) days of your receipt of a denial letter to be considered. If you have additional participant documentation that was available and relevant at the time of the request but not previously provided that you would like the Department to consider, please enclose it with your request for administrative review.

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To access this page:

1. Select "Appeals" from the left side menu.
2. Review the information to ensure any appeals you would like to file are sent to the correct location.
Note: A provider can only submit appeals in writing.

Send E-mail



To access this page:

1. Select "Send E-mail" from the left side menu to initiate the e-mail application on the provider's computer.
Note: This is the same as clicking on the "Send email to: EHrincentives@dhw.idaho.gov" on the Idaho Medicaid EHR Incentive Program website.
2. Enter the message and send the email.
Note: If you have problems with your email system, please contact your local office's IT support for assistance before contacting the Idaho Medicaid EHR Incentive Program Help Desk.

APPENDIX

Resources

Final Rule

The Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>.

Eligible Professional and Eligible Hospital Attestation Portal

Idaho Incentive Management System (IIMS) located at <http://www.MedicaidEHR.dhw.idaho.gov>.

Medicare and Medicaid Electronic Health Records (EHR) Incentive Program

The CMS website about EHR located at <http://www.cms.gov/EHRIncentivePrograms/>, which requires you to create a login and password to access.

Office of the National Coordinator for Health Information Technology (ONC)

Additional information about health information technology is located at http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov_home/.

Regional Extension Centers (RECs)

The Washington Idaho Regional Extension Center (WIREC) is designated to provide technical assistance to Idaho's eligible professionals. WIREC provides a full range of assistance related to EHR selection and training.

Qualis Health
PO Box 33400
Seattle, WA 98133-0400
Phone: (206) 364-9700
Toll-free: (800) 949-7536
Fax: (206) 366-3370
<http://www.wirecqh.org/>

Peggy Evans, PhD, CPHIT
WIREC Director
peggye@qualishealth.org
(206) 288-2471

Kristin Johnson
WIREC Project Coordinator
kristinj@qualishealth.org
(206) 288-2357

Frequently Asked Questions About Using a Provider Roster

Is using a proxy required?

The Medicaid EHR Incentive Program does not require an EP to use one method of patient volume calculation over the other. All EPs are free to use an individual patient volume calculation or a group proxy calculation. All EPs are encouraged to talk with their clinic's or organization's administration as they may have a preference.

What's the best way to establish a group approach?

All EPs enrolling in the Medicaid EHR Incentive Program from a clinic/organization must use the same approach for any given calendar year to meet patient volume requirements. The first provider approved for payment will set the approach for the clinic/organization. For example:

- If the first provider enrolling from a clinic/organization attests to individual patient volumes (and is approved for payment), all providers subsequently enrolling for that calendar year from that clinic/organization will be required to attest to individual patient volumes and are not allowed to use a proxy at either the organization or clinic level.
- If the first provider enrolling from a clinic/organization attests to the group proxy calculation for the clinic/organization, subsequent providers associated with that clinic/organization will be required to attest to the same overall patient volumes using the same group proxy worksheet. They will not be given the opportunity to use individual patient volumes.

Is there an example of a group proxy calculation?

The following excerpt from the CMS FAQ# 10362 illustrates how the group proxy calculation is to be applied:

If an eligible professional in the Medicaid EHR Incentive Program wants to leverage a clinic or group practice's patient volume as a proxy for the individual eligible professional (EP), how should a clinic or group practice account for EPs practicing with us part-time and/or applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?

EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2. There is an auditable data source to support the clinic's patient volume determination; and
3. So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data).

The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice. In order to provide examples of this answer, please refer to Clinics A and B, and assume that these clinics are legally separate entities.

If Clinic A uses the clinic's patient volume as a proxy for all eligible professionals practicing in Clinic A, this would not preclude the part-time eligible professional from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an eligible professional would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the group proxy calculation patient volume. However, such eligible professional's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the eligible professional could not use his or her patient encounters from clinic A in calculating his or her individual patient volume. The intent of the flexibility for the proxy volume (requiring all eligible professionals in the group practice or clinic to use the same methodology for the payment year) was to ensure against eligible professionals within the same clinic/group practice measuring patient volume from that same clinic/group practice in different ways. The intent of these conditions was to prevent high Medicaid volume eligible professionals from applying using their individual patient volume, where the lower Medicaid patient volume eligible professionals then use the clinic volume, which would of course be inflated for these lower-volume eligible professionals.

CLINIC A (with a fictional eligible professional and provider type)

- EP #1 (physician): individually had 40 percent Medicaid encounters (80/200 encounters)
- EP #2 (nurse practitioner): individually had 50 percent Medicaid encounters (50/100 encounters)
- Practitioner at the clinic, but not an EP (registered nurse): individually had 75 percent Medicaid encounters (150/200)
- Practitioner at the clinic, but not an EP (pharmacist): individually had 80 percent Medicaid encounters (80/100)
- EP #3 (physician): individually had 10 percent Medicaid encounters (30/300)
- EP #4 (dentist): individually had 5 percent Medicaid encounters (5/100)
- EP #5 (dentist): individually had 10 percent Medicaid encounters (20/200)

In this scenario, there are 1200 encounters in the selected 90-day period for Clinic A. There are 415 encounters attributable to Medicaid, which is 35 percent of the clinic's volume. This means that five of the seven professionals would meet the Medicaid patient volume criteria under the rules for the EHR Incentive Program (two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included). The purpose of these rules is to prevent duplication of encounters. For example, if the two highest volume Medicaid EPs in this clinic (EPs #1 and #2) were to apply on their own (they have enough Medicaid patients to do that), the clinic's 35 percent Medicaid patient volume is no longer an appropriate proxy for the low-volume providers (e.g., EPs #4 and #5). If EP #2 is practicing part-time at both Clinic A, and another clinic, Clinic B, and both Clinics are using the clinic level proxy option, each such clinic would use the encounters associated with the respective clinics when developing a proxy value for the entire clinic. EP #2 could then apply for an incentive using data from one clinic or the other.

Similarly, if EP #4 is practicing both at Clinic A, and has her own practice, EP #4 could choose to use the proxy level Clinic A patient volume data, or the patient volume associated with her individual practice. She could not, however, include the Clinic A patient encounters in determining her individual practice's Medicaid patient volume. In addition, her Clinic A patient encounters would be included in determining such clinic's overall Medicaid patient volume.

Related Frequently Asked Questions From CMS's Website Regarding Getting EHR Certification

How do I know if my EHR system is certified? How can I get my EHR system certified?

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The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology, as established by a new set of standards and certification criteria. Existing EHR technology needs to be certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) to meet these new criteria in order to qualify for the incentive payments. The Certified Health IT Product List (CHPL) is available at <http://www.healthit.hhs.gov/CHPL>. This is a list of complete EHRs and EHR modules that have been certified for the purposes of this program.

Through the temporary certification program, new certification bodies have been established to test and certify EHR technology. Vendors can submit their EHR products to the certifying bodies to be tested and certified. Hospitals and practices who have developed their own EHR systems or products can also seek to have their existing systems or products tested and certified. Complete EHRs may be certified as well as EHR modules that meet at least one of the certification criteria. Once a product is certified, the name of the product will be published on the ONC's website at <http://www.healthit.hhs.gov/CHPL>. For more information, please visit the ONC's website at healthit.hhs.gov/certification.

Must providers have their EHR technology certified prior to beginning the EHR reporting period in order to demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs?

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EPs may begin the EHR reporting period for demonstrating meaningful use before their EHR technology is certified. Certification need only be obtained prior to the end of the EHR reporting period. However, meaningful use must be completed using the capabilities and standards outlined in the ONC Standards and Certification Regulation for certified EHR technology. Any changes to the EHR technology after the beginning of the EHR reporting period that are made in order to get the EHR technology certified would be evidence the EP was not using the capabilities and standards necessary to accomplish meaningful use because those capabilities and standards would not have been available, and thus, any such change (even minimal) would disqualify the EP from being a meaningful EHR user. If EPs begin the EHR reporting period prior to certification of their EHR technology, they are taking the risk that their EHR technology will not require any changes for certification. Any changes made to gain certification must be done prior to beginning the EHR reporting period during which meaningful use will be demonstrated. This does not apply to changes made to EHR technology that were not necessary for certification.

My EHR system is CCHIT certified, does that mean it is certified for the EHR Incentive Programs?

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No. All EHR systems and technology must be certified specifically for this program. The Certified Health IT Product List is available at <http://www.healthit.hhs.gov/CHPL>. This is a list of all complete EHRs and EHR modules that have been certified for the purposes of this program.

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If a provider purchases a certified complete EHR or has a combination of certified EHR modules that collectively satisfy the definition of certified EHR technology, but opts to use a different, uncertified EHR technology to meet certain meaningful use core or menu set objectives and measures, will that provider be able to successfully demonstrate meaningful use under the Medicare and Medicaid EHR Incentive Programs?

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No, the EP would not be able to successfully demonstrate meaningful use. To successfully demonstrate meaningful use, a provider must do three things:

1. Have certified EHR technology capable of demonstrating meaningful use, either through a complete certified EHR or a combination of certified EHR modules;
2. Meet the measures or exclusions for 20 meaningful use objectives (19 objectives for eligible hospitals and Critical Access Hospitals (CAHs)); and
3. Meet those measures using the capabilities and standards that were certified to accomplish each objective.

An EP using uncertified EHR technology to meet one or more of the core or menu set measures would not be using the capabilities and standards that were certified to accomplish each objective. Please note that this does not apply to the use of uncertified EHR technology and/or paper-based records for purposes of reporting on certain meaningful use measures (i.e., measures other than clinical quality measures), which is addressed in FAQ #10589.

Additional Information

If you have questions or issues concerning the Idaho Medicaid EHR Incentive Program, please visit www.MedicaidEHR.dhw.idaho.gov. There you will find an "Ask the Program" feature that will allow you to send questions to program staff. You can also e-mail questions to EHRincentives@dhw.idaho.gov or call (208) 332-7989.