Washington State Health Care Authority

Washington State Medicaid EHR Incentive Program
Eligible Provider (EP) Application Worksheet

The application worksheet is the companion piece to the Washington State Medicaid EHR Incentive Program Web-based application (eMIPP) and should be prepared prior to completing and submitting your program application. Submission of this document in not necessary, but is to be used as a tool to determine if you meet eligibility standards. You will want to consult the eMIPP User Guide to ensure that the correct information is in the correct fields. Each eligible professional or their designee must complete the application and attestation process individually. A glossary of key terms is provided on page 5 of this document.

The provider must be contracted with Washington Medicaid in order to attest to our state.

STEP 1 – MAKE SURE YOU ARE REGISTERED WITH CMS FOR THE PROGRAM, AND ALL INFORMATION IS CORRECT.

Prior to starting in eMIPP, you must register with the Centers for Medicare and Medicaid Services. Use this link to access their EHR materials and processes:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/EducationalMaterials.html

There are some things to keep in mind when registering. CMS sends us basic information that will populate some of the fields in eMIPP. These cannot be changed in eMIPP so please be mindful of your information. If you find that this information needs to be changed it has to be changed in the CMS registration and re-submitted in order to update our system in 24 hours.

KEY POINTS:

Contact Information:

When applying/attesting on behalf of a provider in eMIPP, please make sure you are listed as the current contact person with CMS (and your email as the contact email). If you have a change in staff working with your EHR account, it is imperative that you also update your contact information with CMS. Our files are updated based on the information you provide CMS. If you are not listed as the contact person, we will not be able to discuss any information with you and you will not receive automated information about your attestation. This is an effort to protect and restrict unauthorized access to your account information. Sometimes using a "generic" email is beneficial. Only the email and phone number get transferred into our system.

Payee NPI:

An eligible provider who wants to reassign their payment to a clinic must have an active business relationship documented in the ProviderOne system. For the purposes of this program, this means an EP (Eligible Provider) must be listed as a servicing provider in ProviderOne under the exact NPI selected in the PAYEE NPI/PAYEE TIN section of the CMS registration. This relationship must be current at the time of attestation. If you have questions and would like to request a step-by-step "Getting Paid Correctly" document, http://www.hca.wa.gov/HealthIT/Documents/Business%20relationship%20required%20for%20payment%20reassignment.pdf

ONC Number:

The EHR number that identifies your EHR system. In 2015 you "must" have a 2014 certified edition of your EHR in order to attest. We will need a copy of your ONC Certificate when you attest. You will find the certificate on the ONC website: http://oncchpl.force.com/ehrcert/ehrproductsearch

STEP 2: Gathering Information for eMIPP:

Log-in Info:

Eligible Provider's Name: _____

Eligible Provider's NPI: _____

Eligible Provider's Domain:_____**User ID:**_____**Password:** _____

CMS Registration Number (NLR #): _____

STEP 3: Basic Eligibility Information

1. **Do you provide more than 90% of your services in an inpatient hospital or ER?** If so, you are not eligible to attest.

   (Hospital-Based means a professional furnishes ninety percent (90%) or more of their 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 claims analysis.)

2. **Are you a FQHC, RHC or Tribal Health Clinic?** If so, you have the option to use "Medically Needy Encounters" in order to qualify. If this is the case, the EP must have Practiced Predominantly in a FQHC/RHC.

   (Practices predominantly - an EP for whom more than fifty percent (50%) of his or her total patient encounters occur at a federally qualified health center (FQHC), rural health clinic (RHC) or Tribal Health Clinic.)

3. **Are you a Physician Assistant (PA) who practices in an FQHC or RHC which is led by a PA?** If so, you are eligible to attest. If you are not, then you are not eligible.

   Led by a Physician Assistant is defined as:
   A PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider;
   A PA is a clinical or medical director at a clinical site of practice;
   A PA is an owner of an RHC; or
   A PA works in a PA-Lead clinic

4. **What stage are you with regard to your certified electronic health record technology?**

   Adopted, Implemented, Upgraded or Meaningful Use Stage 1 or Stage 2

STEP 4: Patient Volumes

Eligible professionals must provide the following information regarding patient volume and indicate the 90-day period within the previous calendar year or previous 12 months from which your totals were obtained. This information should be based on Medicaid fee-for-service claims, managed care encounters, zero paid claims and/or denied claims (unless the claims was denied for lack of ineligibility). CHIP and "State Only" funded encounters are excluded.

What method are you using to calculate patient volume?
Group Proxy_____Individual _____

If using Group Proxy, which Organization NPI will you use?
Keep in mind that each EP has to have a business relationship in ProviderOne with that ORG NPI and be listed as a servicing provider. It does NOT mean they have to use the ORG NPI for billing claims.

What is the 90-day date span for encounters? _____
Total encounters (paid or unpaid): _____
Total Medicaid and Medicaid Managed Care encounters _____
(excluding CHIP and State Funded Only…see below ***)
Medically Needy Encounters Option (FQHC, RHC and Tribal only):

CHIP: _____
Sliding Fee Scale: _____
Charity Care: _____

Note: Sliding Fee and Charity Care is based on pre-documented financial criteria, signed by the patient. It does not include bad-debt write-offs.

Note: An encounter = 1 per visit. Ancillary charges do not count as separate encounters. Multiple visits on the same day, for a related reason, do not count as separate encounters.

***Short-cut to removing CHIP and State-Only Funded encounters:**

The state has simplified the approach to calculating patient volume by providing a single multiplier to calculate and adjust for CHIP and "State Only" encounters, eliminating the administrative burden associated with pulling and reconciling a detailed report for each individual or group.

Washington analyzed historical paid fee-for-service claims and managed care encounter data to determine an average proportion of the ineligible statewide CHIP and State Only encounters.

Category	CHIP	State Only	Total
Percentage of all paid encounters	.01	.04	.05

Washington will use a total multiplier of .95 for eligible professionals (.99 for State only and .96 for CHIP only if you have to separate them). FHQCs, RHCs and Tribal Clinics (if

using the Medically Needy Calculation) will only use the .99 multiplier to remove State Only since CHIP is recorded on a separate line.

STEP 5: GATHER DOCUMENTS TO UPLOAD:

Having your documentation ready to upload during the attestation process will save you time and increase your processing time to payment. **Please upload your documentation into your application by using the Upload Documentation Tab.**

Please see the "White Papers" about EHR Documentation and Encounter Reports on our website: www.hca.wa.gov/healthit

STEP 6: ATTESTATION AND AUDIT INFORMATION

Applicants will be required to electronically sign an attestation while submitting their online information. This Attestation certifies the following is known and understood. On the Attestation Tab, print a copy, have the EP sign it and save it.

1. EPs are prohibited from seeking payment from another state or from the Medicare EHR incentive program in this payment year.
2. The State can request supporting information not provided as part of the Washington Medicaid EHR registration, and can review, verify and/or audit both prior to and after payment has been made.
3. The EP is required to keep 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 6 years from the date of the final payment.
4. The submission of any false information in this agreement or this process may result in the EP being declared ineligible to participate in the Washington State Medicaid EHR Incentive Program.
5. Any incentive payments paid to the EP, later found to have been made based on fraudulent or inaccurate information may be recouped by the State.
6. 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.

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

1. With awareness and informed consent, this EP is voluntarily participating in the Washington State 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.
3. The person completing this electronic attestation is the assigned representative of the EP, who has been duly authorized to commit the hospital to the statements set forth in this Attestation.

For all other questions or for additional information please visit: www.hca.wa.gov/healthit or email us at HealthIT@dshs.wa.gov.

GLOSSARY

An unduplicated "Encounter": Services rendered to an individual on any one day where Medicaid paid for part or all of the service; or paid all or part of the individual's premiums, copayments and cost-sharing.

Group Proxy: The clinic or group practice uses the entire practice or clinic's patient volume; if the clinic or group practice meets the patient volume threshold, all EP's associated with the group qualify as long as they have a claim on file within the previous or current year.

CHIP and State Only "Multiplier": An average proportion of the statewide paid CHIP and State Only fee for service claims and managed care encounters

"Needy Individuals": Needy individuals are recognized when:

✓ State Only funds or CHIP paid for all or part of the service; or individual's premiums, copayments or cost-sharing in 2009; This method is only to be used for FQHCs and RHCs

✓ Services were furnished at no cost; or

✓ Services were paid for at reduced cost based on a sliding scale determined by an individual's ability to pay.

Patient Panel:

EPs who are primary care providers (PCP) that have Medicaid managed care or medical home patients assigned to them have the option to use a Managed Care Patient Panel method to calculate patient volume. The formula for determining eligible patient volume using patient panel assignments is:

[Total Medicaid patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the calendar year preceding the start of the 90-day period]

PLUS

[Unduplicated Medicaid encounters in that same 90-day period]

DIVIDED BY

[Total patients assigned to the provider (all payers) in the same 90-day with at least one encounter in the calendar year preceding the start of the 90-day period] -PLUS- [All unduplicated encounters in that same 90-day period.

For all other questions or for additional information please visit:
www.hrsa.dshs.wa.gov/HealthIT/ or email us at HealthIT@dshs.wa.gov

Name Change Disclaimer: CMS is renaming the EHR Incentive Programs to the Promoting Interoperability (PI) Programs. Washington does not plan on following the name change however, you will see reference to it in most of our documents. For more information please visit the CMS website.