



# **KANSAS MEDICAID EHR INCENTIVE PROGRAM**

## **ELIGIBLE HOSPITAL PROVIDER MANUAL**

**UPDATED: NOVEMBER 2015**



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## Revision History

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## Useful Acronym List and Glossary

<b>ARRA</b>	<b>American Recovery and Reinvestment Act of 2009</b>
<b>CCHIT</b>	<b>Certification Commission for Health Information Technology</b>
<b>CCN</b>	<b>CMS Certification Number</b>
<b>CHPL</b>	<b>Certified Health IT Product List</b> A list of certified electronic health record systems supplied by ONC.
<b>CMSO</b>	<b>Center for Medicaid and State Operations</b>
<b>CMS</b>	<b>Centers for Medicare &amp; Medicaid Services</b>
<b>DHCF</b>	<b>Division of Health Care Finance</b> Visit the <a href="#">DHCF</a> page on the KDHE website for additional information.
<b>EHR</b>	<b>electronic health record</b> An electronic record of patient health information gathered from one or more encounters in any care delivery setting that includes patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. An EHR is created by linking health information between providers that is then available through a HIE. The EHR has the ability to provide a complete record of a clinical patient encounter, as well as supporting care-related activities directly or indirectly via interface, including evidence-based decision support, quality management, and outcomes reporting.
<b>EMR</b>	<b>electronic medical record</b> An EMR takes paper medical records and puts them onto an electronic file that is maintained in a secure database. An EMR is specific to each patient; contains all health-related information for that patient; and is created, managed, and consulted by authorized clinicians and staff within one healthcare organization.

<b>FQHC</b>	<b>Federally Qualified Health Center</b> All organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC look-alikes (such as an organization meeting all of the eligibility requirements of one that receives a PHS Section 330 grant but does not receive grant funding). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.
<b>HIE</b>	<b>health information exchange</b> The sharing of clinical and administrative data across healthcare institutions and providers.
<b>HIT</b>	<b>health information technology</b> HIT allows comprehensive management of medical information and its secure exchange between healthcare consumers and providers.
<b>KDHE</b>	<b>Kansas Department of Health and Environment</b> Visit the <a href="#">KDHE</a> website for additional information.
<b>KMAP</b>	<b>Kansas Medical Assistance Program</b>
<b>MAPIR</b>	<b>Medicaid Provider Incentive Repository</b> Visit the <a href="#">KMAP</a> website for additional information.
<b>MU</b>	<b>meaningful use</b>
<b>ONC</b>	<b>Office of the National Coordinator for Health Information Technology</b> The agency responsible for administering the CHPL.
<b>R&amp;A</b>	<b>CMS Medicare &amp; Medicaid EHR Incentive Program Registration and Attestation System</b>
<b>RHC</b>	<b>Rural Health Clinic</b> A public, private, or non-profit organization. The main advantage of RHC status is enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must be located in rural, underserved areas and must use one or more physician assistants or nurse practitioners.
<b>SMHP</b>	<b>State Medicaid HIT Plan</b>
<b>TIN</b>	<b>tax identification number</b>

# **Part I: Kansas Medicaid Electronic Health Record Incentive Program Background**

## **1 Introduction**

Kansas is committed to investing in health information technology and health information exchanges as a primary initiative to improve health care quality, efficiency, and effectiveness of patient-centric health care for all Kansans. Health information technology (HIT) and exchanges are also central to federal efforts under the [Affordable Care Act](#) to improve the quality and effectiveness of health care services.

HIT refers to electronic systems that make it possible for health care providers to better manage patient care through secure use and sharing of health information. HIT includes the use of electronic health records (EHRs) instead of paper medical records to maintain people's health information.

**HIT** refers to the electronic movement of health-related data and information among organizations according to agreed standards, protocols, and other criteria.

The American Recovery and Reinvestment Act (ARRA) of 2009 established a program to provide incentive payments to eligible providers who adopt, implement, upgrade, or meaningfully use federally-certified EHR systems. Under ARRA, states are responsible for identifying professionals and hospitals that are eligible for these Medicaid EHR incentive payments, making payments, and monitoring payments. The incentive payments are not a reimbursement but are intended to encourage adoption and meaningful use of EHRs.

The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing the provisions of the Medicare and Medicaid EHR incentive programs. CMS issued the [Final Rule](#) on the Medicaid EHR Incentive Program on July 28, 2010.

For more information on CMS EHR requirements, refer to the [CMS FAQs](#).

CMS requires states requesting federal funds for the EHR Incentive Program to submit a **State Medicaid HIT Plan (SMHP)**. The Kansas Department of Health and Environment (KDHE) submitted their SMHP to CMS for approval on October 27, 2011. Review a copy of the [Kansas SMHP](#) on the KDHE website.

## **Kansas Department of Health and Environment Programs (KDHE)**

KDHE is the lead agency in charge of coordinating state efforts to secure federal HIT and HIE funding for Kansas. To facilitate that process, the Kansas Department of Health Care Finance (DHCF) will work with stakeholder groups and other interested parties to help set priorities and develop specific proposals for the implementation of HIT and HIE in Kansas and to ensure they are implemented in the Kansas Medicaid program.

This mission is the result of almost a decade of effort by multiple stakeholders to define HIT and HIE in Kansas. Current HIT and HIE efforts are both promising and challenging due to the rural nature of the State, rural health professional shortages, limited financial and technical resources, and incomplete geographic access to internet connectivity and broadband.

Grant funding under ARRA from the Office of the National Coordinator for Health Information Technology (ONC) helped to reinvigorate HIT efforts in Kansas. KDHE coordinated meetings with stakeholders to review prior efforts and then established collaborative efforts around the creation and implementation of HIE governance, state policy, and technical infrastructure that will enable standards-based HIE and further development of an already high performing health care system. Medicaid HIT project staff actively participated in these meetings and collaborative efforts.

### **Kansas HIT Initiatives**

**Mission:** *Transform health care in Kansas through the deployment, coordination, and use of health information technology, and health information exchange.*

**Goals:** The overarching HIT goal for Kansas is to promote and achieve widespread adoption and meaningful use of HIT. This goal places emphasis on the use of technology to exchange health information, improve health care delivery, and implement a medical home for all Medicaid beneficiaries.

- Goal 1
  - Use HIE to measure meaningful use.
- Goal 2
  - Use HIE to gather data needed to document and measure qualification for Medicaid incentive payments.
- Goal 3
  - Use HIE as needed to gather data and fill gaps in order to compute quality measures and to help manage and coordinate care to ensure meaningful use for Medicaid beneficiaries- regardless of their connection to a primary care medical home.
- Goal 4
  - Improve access to medical information for the immediate needs of providers in caring for their patients.
- Goal 5
  - Use HIE to facilitate a medical home and patient-centered care for each individual.
- Goal 6
  - Explore opportunities to maximize care coordination through financial and nonfinancial incentives.
- Goal 7
  - Identify state agencies' investments that might be leveraged including Medicaid eligibility system, MMIS, and others in addition to Medicaid.
- Goal 8
  - Help physicians, researchers, and others better evaluate health care outcomes, measure and monitor quality, and determine best practices and clinical protocols. Achieving these goals will benefit individual patients and the community as a whole.

## **2 Purpose of the Eligible Hospital Provider Manual**

The *Kansas Medicaid EHR Incentive Program Eligible Hospital Provider Manual* is a resource for healthcare professionals who want to learn more about the Kansas Medicaid EHR Incentive Program including detailed information and resources on eligibility and attestation criteria as well as instructions on how to apply for incentive payments. This provider manual also provides information on how to apply to the program through the Medicaid Provider Incentive Repository (MAPIR), which is the KDHE web-based EHR Incentive Program application system.

The best way for a new user to orient themselves to the EHR Incentive Program requirements and processes is to read through each section of this provider manual in its entirety prior to starting the application process.

In the event this provider manual does not answer your questions or you are unable to navigate MAPIR or complete the registration, application, and validation process, you should contact EHR Provider Support.

- Phone: 1-800-933-6593, select option 7
- Email: [Kansas EHR Provider Support@groups.ext.hpe.com](mailto:Kansas_EHR_Provider_Support@groups.ext.hpe.com)

### **Other Resources**

Additional resources can be found on the [EHR](#) page of the KDHE website. These include webinars describing various aspects of the application and attestation process, frequently asked questions, and a patient volume calculator.

### 3 Who Is Eligible?

The CMS Final Rule outlines the following mandatory criteria for an eligible hospital (EH) to be considered for the Kansas Medicaid EHR Incentive Program.

KDHE also requires that EHs be enrolled as a Medicaid provider without sanctions or exclusions. Hospitals not currently enrolled will need to enroll with Medicaid prior to applying for KDHE’s EHR Incentive Program. Hospitals must meet program requirements, including meeting Medicaid patient volume thresholds.

EHs for the Medicaid program in Kansas include acute care, critical access, and children’s hospitals. Hospitals are eligible for both Medicaid and Medicare incentive payments, except for children’s hospitals and cancer hospitals which are only eligible for Medicaid incentive payments. There are specific sets of CMS Certification Numbers (CCNs) that correspond to EHs which are listed in **Figure 1** below.

**Figure 1: Hospital Eligibility Requirements per the CMS Final Rule**

Provider Type	Eligible Hospital Requirements	Medicaid Volume Threshold*
<b>Acute Care including CAH</b>	Acute care: CCNs between 0001 – 0879 Critical access hospitals: CCNs between 1300 – 1399	10%
<b>Children’s Hospital</b>	CCNs between 3300 – 3399	No patient volume requirement

\*Measured by Medicaid discharges over total discharges

Please note that a hospital is eligible for an incentive payment based on its CCN. Multiple hospitals within a health system may be rolled up into one CCN for the purposes of the Medicaid EHR Incentive Program.

#### 4 Overview of the EHR Incentive Program Application Process

The following steps describe the Kansas Medicaid EHR Incentive Program application process:

- Applicants must register with CMS at the [CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System](#) (also known as R&A) website. Applicants will need to provide information such as:
  - Payee's National Provider Identifier (NPI) and tax identification number (TIN)
  - CMS Certification Number (CCN)
  - Selection of incentive program option: Medicare or Kansas Medicaid
  - EHR Certification ID
  - Email contact information
- Once successfully registered with R&A, eligible applicants will receive a notification that they can register in MAPIR, which is accessed through the KMAP secure website. This may take up to 45 business days following successful registration with R&A. MAPIR is KDHE's web-based system that will track and act as a repository for information related to applications, attestations, payments, appeals, oversight functions, and interface with R&A.
- The applicant will use a user ID and password to log into the KMAP secure website. If an eligible hospital type, then the MAPIR application link will be displayed. By clicking on the link, the MAPIR application will search for a registration record received from R&A. Once a match is found, the application process can begin. If an application is not found within three days after an applicant registered at the R&A website, the applicant should contact EHR Provider Support.
  - Phone: 1-800-933-6593, select option 7
  - Email: [Kansas\\_EHR\\_Provider\\_Support@groups.ext.hpe.com](mailto:Kansas_EHR_Provider_Support@groups.ext.hpe.com)

- Applicants will need to verify the information displayed in MAPIR and will also need to enter additional required data elements and make attestations about the accuracy of the data elements entered in MAPIR. Applicants will need to demonstrate all of the following:
  - They meet Medicaid patient volume thresholds.
  - They are adopting, implementing, upgrading, or meaningfully using federally-certified EHR systems.
  - They meet all other federal program requirements.
- Applicants can use the patient volume calculator on the [KDHE](#) website prior to entering MAPIR to estimate eligibility based on patient volume for a continuous 90-day period.
- KDHE will use its own information (such as Medicaid claims data) and information in MAPIR to review applications and make approval decisions. KDHE will inform all applicants whether they have been approved or denied. All approvals and denials are based on federal rules about the EHR Incentive Program.
- Payments will be issued through the standard MMIS payments that process once a week, and hospitals will see their payments on their remittance advices and their annual 1099s.
- KDHE or EHR Provider Support may need to contact applicants during the application process before a decision can be made to approve or deny an application.
- Applicants have appeal rights available to them if, for example, an applicant is denied an EHR incentive payment. KDHE will convey information on the appeals process to all applicants denied. Appeals will be processed by KDHE's Bureau of Hearings and Appeals.

Applicants can contact EHR Provider Support for more assistance with the application process.

- Phone: 1-800-933-6593, select option 7
- Email: [Kansas EHR Provider Support@groups.ext.hpe.com](mailto:Kansas_EHR_Provider_Support@groups.ext.hpe.com)

## Application Readiness for Hospitals

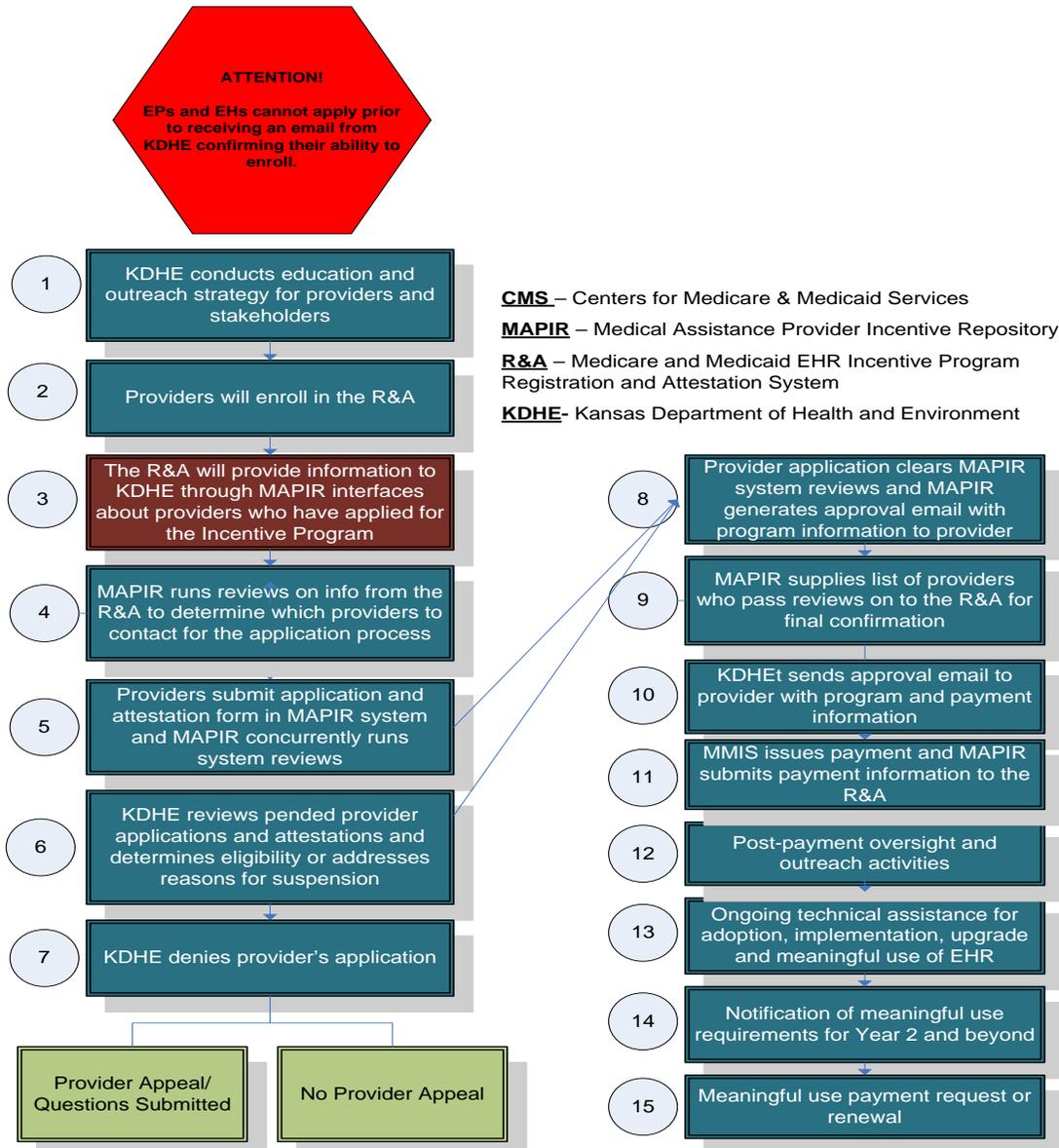
Applicants can take a number of steps to facilitate the processing of their applications:

- The applicant must provide a valid email address during the R&A process so KDHE can inform the applicant by email that the registration has been received from CMS and the MAPIR application process can begin.
- The applicant must obtain a user name and password for the KMAP secure website, if one has not already been obtained. If a user name and password are needed for the KMAP secure website or a password needs to be reset, call 1-800-933-6593 and select option 7.
- The NPI, CCN, and TIN provided to CMS must match the NPI and TIN information within MMIS. This combination should be the same NPI and TIN combination that you use for Medicaid claim payment purposes.
- KDHE will calculate hospital payments based on auditable sources of information such as hospital cost reports. However, KDHE may need to contact applicants to clarify the information entered. For CMS Cost Report 2552-96 or 2552-10: Worksheets S-3 for all attestation years and Worksheets – C and S-10 may be required. Payments can be estimated using the hospital payment calculator available on the [KDHE](#) website.

## Year One Process Flow: Medicaid EHR Incentive Program

Figure 2 below describes the overall application, registration, attestation, and monitoring process for the EHR Incentive Program.

Figure 2: Year One Process Flow - Medicaid EHR Incentive Program



\* Providers include Eligible Professionals and Eligible Hospitals as defined by the EHR Incentive Program rules.

## 5 Patient Volume Calculation

In order to be eligible for the Kansas Medicaid EHR Incentive Program, EHs must meet eligible patient volume thresholds, with the exception of children’s hospitals. The general rule is that EHs must have at least 10% of patient volume attributable to patient discharges and emergency department encounters for beneficiaries receiving Medicaid. Calculation of the patient threshold eligibility for an EH is determined by the equation below.

$$\begin{array}{ccc}
 \begin{array}{c} \text{Total Medicaid} \\ \text{encounters in any} \\ \text{representative,} \\ \text{continuous 90-day} \\ \text{period in the preceding} \\ \text{hospital fiscal year} \end{array} & \div & \begin{array}{c} \text{Total encounters in} \\ \text{the same 90-day} \\ \text{period} \end{array} = \begin{array}{c} \% \text{ Medicaid} \\ \text{patient volume} \end{array}
 \end{array}$$

Medicaid encounters are based on discharges, which include inpatient discharges and emergency department visits. Medicaid patient volume is measured over a continuous 90-day period in the previous hospital fiscal year or previous 12 months preceding attestation date for all hospital locations. Hospitals only enter the start date and MAPIR will calculate the end date.

Fiscal year example: If requesting an EHR incentive payment and your hospital fiscal year is between July 1 – June 30, the start of your continuous 90-day period must start and end between July 1, 2010 and June 30, 2011.

Previous 12-month example: If requesting an EHR incentive payment and the previous 12- month period is between May 1 – April 30, the start of your continuous 90-day period must start and end between May 1, 2012 and April 30, 2013.

Patient volume calculations can include managed care encounters and Kansas Medicaid encounters as part of the Kansas Medicaid patient volume calculations. If a provider is counting encounters not submitted to Medicaid, the burden lies on the provider to provide proof of eligibility at the time of the application.

The patient volume calculation will now include zero paid claims. The definition of a zero paid claim is any encounter with a Medicaid-eligible person on the date of service, regardless of whether the claim was actually submitted to or denied by Medicaid. The State of Kansas CHIP is not a Medicaid-expansion program. CHIP encounters from Kansas cannot be included in the patient volume calculation. Out-of-state CHIP encounters from Medicaid expansion programs can be included in the patient volume calculation.

Total encounter data includes all patient visits during the 90-day period. Encounters are defined as Medicaid, all private insurance, and self-pay patients.

A patient volume calculator to help estimate patient volume before applying in MAPIR is available on the [KDHE](#) website.

## 6 Hospital Incentive Payments

The federal rules also set forth the methodology that states must use to calculate EHR incentive payments. KDHE will calculate patient volume and payments for all eligible hospitals using the information submitted by the hospital upon application. KDHE is responsible for using auditable data sources to calculate EHR hospital incentive amounts and will use Medicaid and Medicare cost reports as well as other departmental data to validate the self-reported information. KDHE will make payments to eligible hospitals over a three-year time period: 50% in the first year, 30% in the second year, and 20% in the third year. CMS rules allow KDHE to audit and validate the three-year calculation as cost report data is received. Payments will be issued through the standard financial cycle that runs once a week, and hospitals will see their payments on their remittance advices.

As set forth in the federal rule, the formula for calculating Medicaid hospital EHR incentive payments is defined as seen below.

- The initial amount which is the sum of a \$2 million base amount and the product of a per discharge amount (of \$200) and the number of discharges (for discharges between 1,150 and 23,000 discharges). A more detailed breakdown can be seen below.

**Overall EHR Amount =**

{Sum over 4 year of [(Base Amount (\$2 million) + Discharge Related Amount Applicable for Each Year) \* Transition Factor Applicable for Each Year]}

**Multiplied By ( \* )**

**Medicaid Share =**

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

- The Medicare share is set at one for each year.
- The transition factor which phases down the incentive payments over the four-year period is described in the table below.

**Transition Factors**

Consecutive Payment Year	Transition Factor
Year 1	1
Year 2	0.75
Year 3	0.50
Year 4	0.25

KDHE will assume that discharges for an individual hospital have increased by the average annual growth rate for an individual hospital over the most recent four 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 four-year period, it will be applied as such.

Please note that nursery bed days or discharges cannot be included as part of your hospital payment calculation.

Accordingly, the following tables outline the payment calculation process that will take place based on the required information provided by a hospital.

Hospitals can also estimate their payments using the hospital payment calculator available on the [KDHE](#) website.

**Step 1: Enter the end date of the last full facility fiscal year.**

Hospital Fiscal Year	
	Entered fiscal year
	Entered minus 1 - calculated
	Entered minus 2 - calculated
	Entered minus 3 - calculated

*Calculation 1: The previous three hospital fiscal years will be filled in.*

Fiscal Year	Total Discharges	Total # IP MCD Bed Days	Total IP Days	Total Charges - All Discharges	Total Charity Care - All Discharges

**Step 2: Fill in the overall facility discharges to cover each of these time periods.**

Hospital Fiscal Year	Total Discharges
9/30/2009	115,000
9/30/2008	112,000
9/30/2007	116,000
9/30/2006	111,000

**Calculation 2a:** *These figures will be used to determine the facility growth rate year over year.*

Hospital Fiscal Year	Total Discharges	Yearly Growth Rate
9/30/2009	115,000	2.7%
9/30/2008	112,000	-3.4%
9/30/2007	116,000	4.5%*
9/30/2006	111,000	

\*4.5% is the difference from FY 2006 to FY 2007

**Calculation 2b:** *The average of the yearly growth rate is the overall facility growth rate.*

	Yearly Growth Rate
	2.7%
	-3.4%
	4.5%
<b>AVERAGE</b>	1.2%

*\*Please note that a negative growth rate will also be applied to the facility.*

**Step 3: Apply growth rate to the base number of discharges. Kansas will be paying over three years.**

Reporting Year	Reported Discharges	Growth Rate	Calculated Discharges
Base Year	115,000		115,000
Year 2		1.2%	116,432
Year 3		1.2%	117,881
Year 4		1.2%	119,349

\*116,432 is 1.24% times the self-reported 115,000 discharges.

**Calculation 3:** *As noted above, the initial discharge amount was increased by 1.2% each year.*

**Step 4: Determine eligible discharges. Only discharges between 1,149 and 23,000 are to be used in the equation.**

Reporting Year	Reported Discharges	Growth Rate	Calculated Discharges	Eligible Discharges
Base Year	115,000		115,000	21,851
Year 2		1.2%	116,380	21,851
Year 3		1.2%	117,777	21,851
Year 4		1.2%	119,190	21,851

*\* 21,851 is the discharges between 1,149 and 23,000.*

*Calculation 4: Any volume below 1,149 is not included and any volume over 23,000 is also not included.*

**Step 5: Multiply the eligible discharges by \$200.**

Reporting Year	Reported Discharges	Growth Rate	Calculated Discharges	Eligible Discharges	Eligible Discharge Payment
Base Year	115,000		115,000	21,851	\$4,370,200
Year 2		1.2%	116,380	21,851	\$4,370,200
Year 3		1.2%	117,777	21,851	\$4,370,200
Year 4		1.2%	119,190	21,851	\$4,370,200

**Step 6: Add the base year amount per payment year: \$2,000,000.**

Reporting Year	Reported Discharges	Growth Rate	Calculated Discharges	Eligible Discharges	Eligible Discharge Payment + Base Amount (\$2,000,000)
Base Year	115,000		115,000	21,851	\$6,370,200
Year 2		1.2%	116,380	21,851	\$6,370,200
Year 3		1.2%	117,777	21,851	\$6,370,200
Year 4		1.2%	119,190	21,851	\$6,370,200

*Calculation 6: Add the base amount of \$2,000,000 to each payment year.*

**Step 7: Use eligible discharge payment and Medicaid transition factor to create overall EHR amount.**

Reporting Year	Eligible Discharge Payment	Medicaid Transition Factor **	Overall EHR Amount
Base Year	\$ 6,370,200	1	\$6,370,200
Year 2	\$ 6,370,200	0.75	\$4,777,650
Year 3	\$ 6,370,200	0.5	\$3,185,100
Year 4	\$ 6,370,200	0.25	\$1,592,550

*\*As defined by federal regulations*

*Calculation 7: Multiply the eligible discharge payment by the Medicaid transition factor per payment year.*

**Step 8: Input the remaining self-reported information.**

Total # IP MCD Bed Days	Total IP Days	Total Charges - All Discharges	Total Charity Care - All Discharges
47,469	189,985	\$ 1,188,756,696	\$ 56,452,000

*Calculation 8: N/A - self-reported data entry step.*

**Step 9: Calculate the Medicaid share. This is used to weight Medicaid's impact on total bed days. It is considered a better metric than discharges since Medicaid patients generally have a higher illness burden.**

*Calculation 9a: Calculate the noncharity care ratio by subtracting charity care from total charges and dividing by total charges.*

Reporting Year	Total Charges - All Discharges	Total Charity Care - All Discharges	Noncharity Care Ratio
Base Year	\$ 1,188,756,696	\$ 56,452,000	95.3%
Year 2	\$ 1,188,756,696	\$ 56,452,000	95.3%
Year 3	\$ 1,188,756,696	\$ 56,452,000	95.3%
Year 4	\$ 1,188,756,696	\$ 56,452,000	95.3%

*Calculation 9b: Calculate the Medicaid bed days share ratio.*

Reporting Year	Total # IP MCD Bed Days	Total IP Days	Medicaid Bed Days Ratio
Base Year	47,469	189,985	25.0%
Year 2	47,469	189,985	25.0%
Year 3	47,469	189,985	25.0%
Year 4	47,469	189,985	25.0%

*Calculation 9c: Divide the Medicaid bed days ratio by the noncharity care ratio.*

Reporting Year	Noncharity Care Ratio	Medicaid Bed Days Ratio	Medicaid Share
Base Year	95.3%	25.0%	26.2%
Year 2	95.3%	25.0%	26.2%
Year 3	95.3%	25.0%	26.2%
Year 4	95.3%	25.0%	26.2%

**Step 10: Multiply the overall EHR amount by the Medicaid share.**

*Calculation 10: Multiply the overall EHR amount by the Medicaid share.*

Reporting Year	Overall EHR Amount	Medicaid Share	MCD Aggregate EHR Incentive
Base Year	\$ 6,370,200	26.2%	\$1,670,988.67
Year 2	\$ 4,777,650	26.2%	\$1,253,241.50
Year 3	\$ 3,185,100	26.2%	\$835,494.33
Year 4	\$ 1,592,550	26.2%	\$417,747.17

**Calculation 10b: Sum the MCD aggregate EHR incentive.**

<b>MCD Aggregate EHR Incentive</b>
\$1,670,988.67
\$1,253,241.50
\$835,494.33
\$417,747.17
<b>\$4,177,471.67*</b>

*\*This represents the total amount that the facility is eligible to receive based upon self-reported information.*

**Step 11: Apply distribution schedule for total MCD aggregate EHR amount over the three-year period (Kansas specific).**

<b>Reporting Year</b>	<b>Payment Percentage</b>	<b>Payment per Year</b>
Base Year	50%	\$2,088,735.84
Year 2	30%	\$1,253,241.50
Year 3	20%	\$835,494.33

## 7 *Adopt, Implement, or Upgrade (AIU) and Meaningful Use (MU)*

The goal of the Kansas Medicaid EHR Incentive Program is to promote the adoption, implementation, upgrade, and meaningful use of certified EHRs. Hospitals are required to attest to the status of their current certified EHR adoption phase.

- **Adopted** – acquired, purchased, or secured access to certified EHR technology.
- **Implemented** – installed or commenced utilization of certified EHR technology capable of meeting meaningful use requirements.
- **Upgraded** – expanded 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 a federally certified EHR technology.
- **Meaningful user** – eligible hospitals can attest to meeting Stage 1 meaningful use requirements as set forth by CMS. **Only hospitals that are dually eligible for both the Medicare and Medicaid EHR Incentive Programs and attest to meaningful use under Medicare in 2011 should attest to meaningful use (MU) in MAPIR. If you do not meet both of these requirements, select adopt, implement, or upgrade.**

The CMS Final Rule describes multiple stages for determining MU, each with its own separate measurements and criteria. The stages represent a graduated approach to achieving the full potential of MU. Only Stage 1 was described in detail in the Final Rule.

**Stage 1 criteria** will be implemented in 2011 for Medicare and 2012 for the Kansas Medicaid program except as described above. Stage 1 requires providers to capture health information in a structured format, using the information to track key clinical conditions (for care coordination purposes), implementing clinical decision support tools to facilitate disease and medication management, and using EHRs to engage patients and families and reporting clinical quality measures and public health information.

The criteria for Stages 2, 3, and beyond will be described in future rulemaking. Stage 1 includes a series of core and menu measures. For more information on MU criteria, visit the [CMS](#) website.

KDHE recommends submission of the following documentation for attestation of adopt, implement, or upgrade criteria:

- **Adopt**
  - KDHE recommends that hospitals provide one of the following documents to show the system number that was used for certification at the ONC, along with the model and serial numbers of the system:
    - Receipt, lease, legal document, vendor contract, cancelled checks, or user or license agreements
  - Model and serial numbers of EHR systems must match proofs of purchase, contracts, or lease documents. If this documentation is not provided at the time of application, KDHE may request it at a later date.
  
- **Implement**
  - KDHE recommends that hospitals provide one of the following documents to show the system number that was used for certification at the ONC, along with the model and serial numbers of the system:
    - Receipt, lease, legal document, vendor contract, cancelled checks, or user or license agreements.
  - Model and serial numbers of EHR systems must match proofs of purchase, contracts, or lease documents. If this documentation is not provided at the time of application, KDHE may request it at a later date.
  - KDHE recommends that hospitals provide applicable input and output examples from the EHR system to show how the system has been implemented.
    - Input example: user interfaces that mirror the once used hard file/paper forms
    - Output example: patient record templates, sample test results, decision-support alerts
  - If training sessions on the system took place, provide descriptions of the sessions such as the subjects, dates, times, and level of participation.

- **Upgrade**
  - KDHE recommends that hospitals provide one of the following documents to show the system number that was used for certification at the ONC, along with the model and serial numbers of the system:
    - Receipt, lease, legal document, vendor contract, cancelled checks, or user or license agreements.
  - Model and serial numbers of EHR systems must match proofs of purchase, contracts, or lease documents. If this documentation is not provided at the time of application, KDHE may request it at a later date.

## 8 *Attestations and Audits*

CMS requires states to ensure that payments are being made to the right hospital, at the right time, for the right reason. In order to receive an incentive payment, eligible hospitals will be attesting to, among other things, whether they are using a certified EHR; demonstrating adopting, implementing, or upgrading (AIU)-certified EHR technology; and demonstrating meaningful use.

States will be required to “look behind” eligible hospital attestations which will require audits both pre- and post-payment. CMS believes a combination of pre- and post-payment reviews will result in accurate payments and timely identification of overpayments.

All information submitted in the MAPIR application is subject to review. Applicants have the option to submit additional information. Acceptable types of supporting documents include:

- Copies of receipts
- Contracts
- Other documentation related to adopt, implement, and upgrade

CMS will review all meaningful use attestations for hospitals, both for hospitals that are participating in the Medicaid EHR Incentive Program only and hospitals participating in the Medicare and Medicaid EHR Incentive Programs.

### **MAPIR Attestations**

Eligible hospitals will need to verify the information displayed in MAPIR and will also need to enter additional required data elements and make attestations about the accuracy of data elements entered in MAPIR. For example, applicants will need to demonstrate that they meet patient volume thresholds; that they are adopting, implementing, or upgrading federally certified EHR systems; and that they meet all other federal program requirements.

The MAPIR system design is based on the CMS Final Rule for the EHR Incentive Program and Kansas-specific eligibility criteria. A series of reviews will identify applicants who do not appear to be eligible, for example:

- Applicants who do not meet patient volume thresholds
- Ineligible hospital types
- Providers with sanctions

These MAPIR system reviews will help to identify potential overpayments before they occur.

In addition to the MAPIR system reviews, all eligible hospitals will be reviewed prior to payment. KDHE will verify the information submitted in the application and determine payment amounts.

### **Postpayment Reviews**

KDHE will use a random sampling methodology to review EH applications, attestations, and payments. All elements of the application are subject to review. However, KDHE will also identify high-risk areas and review these applications and payments, for example, Kansas Medicaid patient volume percentages close to the required threshold or significant out-of-state Medicaid patient volume.

If fraud or abuse is suspected in the Medicaid EHR Incentive Program, the Kansas Attorney General's Office Medicaid Fraud and Abuse Unit will be notified to conduct further review and take appropriate action.



## 9 *Overpayments*

MAPIR is used to store and track records of incentive payments for all participating hospitals. KDHE will regularly monitor payments to ensure overpayments are not made. Once an overpayment is identified, MAPIR will be used to determine the amount of payments that have been made and must be returned by the hospital.

When overpayments are identified, KDHE will initiate the payment recoupment process and communicate with CMS on repayments. KDHE will recover any overpayments from instances of abuse; however, overpayments identified as a result of a fraud conviction are handled in conjunction with the Medicaid Fraud and Abuse Unit.



## 10 Appeals

Eligible hospitals will have the right to appeal certain Department decisions related to the Kansas Medicaid EHR Incentive Program. Examples of appeal reasons include, but are not limited to, any of the following:

- Applicant is determined ineligible for the EHR Incentive Program.
- Applicant has received an overpayment for the EHR Incentive Program.

KDHE will handle such appeals the same way it currently addresses provider appeals on other matters. Refer to Section 5300 (*Appeals Process*) of the *General Billing Fee-for-Service Provider Manual* on the [Provider Manuals](#) page of the KMAP website.

If an appeal is upheld, KDHE will re-review the application with reapplication by the provider if necessary. If an appeal is denied, the application process ends but the provider may reapply.

If the completed application is not denied, the provider will be notified and the process will continue from MAPIR to R&A.

## **Part II: Application Assistance**

## 11 *MAPIR Overview*

Users can apply for incentive payments through MAPIR. MAPIR is the state-level information system for the EHR Incentive Program that will both track and act as a repository for information related to payment, applications, attestations, oversight functions, and interface with R&A.

MAPIR is intended to streamline and simplify the hospital enrollment process by interfacing with other systems to verify data. Hospitals enter data into MAPIR and attest to the validity of data, thus improving the accuracy and quality of the data.

The MAPIR system is used to process provider applications, including:

- Interfacing between KDHE and R&A to:
  - Receive initial hospital registration information
  - Report eligibility decisions to CMS
  - Report payment on information (such as payment date and transaction number) to CMS
- Verify information submitted by applicant
- Determine hospital eligibility
- Allow hospitals to submit:
  - Attestations
  - Payee information
  - Submission confirmation/digital signature
- Communicate payment determination

In addition, MAPIR contains a series of validation checks used during the hospital application process (such as confirmation of R&A information, patient volume, and attestations) to confirm a hospital's eligibility for the program.

To begin in the MAPIR application process, hospitals must:

- Be enrolled at R&A
- Be enrolled as a Medicaid provider or have requested and been granted access with a secure user name and password to the KMAP website.
- Be free of sanctions or exclusions

**Note:** In some cases, hospitals will be redirected to R&A to correct discrepant data. In other cases, hospitals will be deemed ineligible for participation in the Kansas Medicaid EHR Incentive Program. KDHE will provide an email notification to applicants in these instances.

## **12 Kansas Provider Portal**

Hospitals can access MAPIR through the KMAP [secure](#) website.

To access the KMAP secure website, the user must have a secure user name and password.

To enroll as a Medicaid provider, applicants must complete the Medicaid enrollment process. Applications can be accessed on the [Provider Enrollment Applications](#) page of the KMAP website.

Providers who are not enrolled in KMAP can request a secure user name and password by completing the application at [Request KMAP Access](#).

Upon receipt of notification (by email) from KDHE, the user will then be able to access MAPIR from the KMAP secure website using the appropriate user name and password.

For assistance, contact EHR Provider Support.

- Phone: 1-800-933-6593, select option 7
- Email: [Kansas EHR Provider Support@groups.ext.hpe.com](mailto:Kansas EHR Provider Support@groups.ext.hpe.com)

### *13 Completing the MAPIR Application*

The following tips apply to specific areas of the MAPIR application. The appropriate *MAPIR tab* is followed by **the title** that appears on the screen. There are not comments for all MAPIR screens. Should you need screen prints of these processes, they may be obtained on the [Electronic Health Information Records](#) page of the KMAP website. Alternatively, you can call 1-800-933-6593 and select option 7 or email [Kansas\\_EHR\\_Provider\\_Support@groups.ext.hpe.com](mailto:Kansas_EHR_Provider_Support@groups.ext.hpe.com).

**Note:** You are required to use the same computer and user name throughout the entire application process. You will not be able to complete the application process at a different computer or with a different user name.

#### *Get Started*

**Get Started Guidance:** If you elect to leave the previous year's data in place, make sure that you are updating all the dates and data to reflect the year you are working on.

#### *R&A/Contact Info*

**R&A Verification:** Any errors on this page need to be corrected on the [CMS R&A](#) website.

**Contact Information:** The information provided on this screen needs to be the direct phone number and email address of the person who is completing the MAPIR application. This is the person who the EHR support team will contact if there are any questions or problems with the application. It is vital that the correct person is reached in timely manner.

#### *Eligibility*

**Eligibility Questions** (Part 2 of 2): A CMS EHR Certification ID can be obtained from the [ONC Certified Health IT Product List \(CHPL\)](#) website.

## *Patient Volumes*

**Patient Volume 90 Day Period** (Part 1 of 3): This needs to be a 90-day period from the year prior to the program year you are attesting to. This needs to coincide with the time frame used for your previous year's cost report. For example, if you are attesting for program year 2012 and your facility is on a federal fiscal year (FFY), your 90-day period for claims volume needs to be between 10/1/2010 through 9/30/2011.

**Patient Volume Cost Data** (Part 3 of 3): This date needs to match the date on your previous year's cost report. For example, if you are attesting to program year 2012 and your facility is on a FFY, the start date would be 10/1/2010. If your facility does not use a FFY, the start date needs to be the start date your facility reported on your 2011 cost report.

### **Documentation required for cost report data entered:**

- S-3 for the base year and four previous years
- Worksheet C for base year only
- S-10 for base year only
- Any additional documentation to support uncompensated care
- Any additional documentation to show why numbers are not matching exactly what is from the cost report

## *Review*

If all the information is correct, click **Continue**. Next, click **Submit** to begin the submit section.

## *Submit*

### **Application Submission** (Part 1 of 2)

### **Documentation required for cost report data entered:**

- S-3 for the base year and four previous years
- Worksheet C for base year only
- S-10 for base year only
- Any additional documentation to support uncompensated care
- Any additional documentation to show why numbers are not matching exactly what is from the cost report

**Documentation required for Attestation Phase:** Refer to page 29 in this manual for a list of required documentation for AIU attestation. If you are attesting as a meaningful user, no additional documentation is required.

## 14 Appendix

### Definitions per Final Rule and/or Kansas State Medicaid

**Acquisition** means to acquire 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 with one of the following:

- The average length of patient stay is 25 days or fewer
- A CMS certification number (previously known as the Medicare provider number) with the last four digits in the series 0001–0879

It can also be a critical access hospital with the last four digits in the series 1300–1399.

**Adopt, implement, or upgrade (AIU)** means one of the following:

- Acquire, purchase, or secure access to certified EHR technology (proof of purchase or signed contract is an acceptable indicator)
- Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
- Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training
- 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-a-hospital, that both:

- Has a CMS certification number (previously known as the Medicare provider number) that has the last 4 digits in the series 3300–3399
- Predominantly treats individuals less than 21 years of age

***Hospital-based*** indicates EPs who furnish 90% or more of their services in places of service classified under place of service codes 21 (inpatient hospital) or 23 (emergency room).

***Meaningful EHR user*** means EP, EH, or CAH that, for an EHR reporting period of a payment year, demonstrates meaningful use of certified EHR technology by meeting the applicable objectives and associated measures in the CMS Final Rule.

***Medicaid encounter for an EP*** means services rendered to a Medicaid beneficiary on any one day where the claim was zero.

***Medicaid encounter for an EH*** means services rendered to a Medicaid beneficiary per inpatient discharge and services rendered in an emergency room on any one day where a date of service resulted in a zero paid claim, regardless of whether the claim was actually submitted to or denied by Medicaid. Total encounter data includes all patient visits during the 90-day period. Encounters are defined as Medicaid, all private insurance, and self-pay patients.

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

**Needy individual** - Individual who meets one of following:

- Were furnished Medicaid paid for by Title XIX of the Social Security Act, Medicaid, or Title XXI of the Social Security Act, the CHIP funding including out-of-state Medicaid programs, or a Medicaid or CHIP demonstration project approved under Section 1115 of the Act
- Were furnished uncompensated care by the provider
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay

**Patient volume** is estimated through a numerator and denominator as defined in the SMHP for Kansas.

**Practices predominantly** means an EP for whom more than 50% of total patient encounters occur at a FQHC or RHC. 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.

## **Resources**

- [Kansas Department of Health and Environment Medicaid Electronic Health Record \(EHR\) Incentive Program](#)
- [Kansas State Medicaid Health Information Technology Plan \(SMHP\)](#)
- [KMAP public website](#)
- [42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Records Final Rule](#)
- [Medicare and Medicaid EHR Incentive Program basics](#)
- [Office of the National Coordinator for Health Information Technology](#)

## **MU Criteria: Core, Menu, and Clinical Quality Measures**

To demonstrate MU, EHs must use their EHR technology in meaningful ways. CMS has defined MU criteria, grouping these into core, menu, and clinical quality measures (CQM). Refer to these measures and their specifications on the [CMS](#) website.

*Core Measures* are required for meeting meaningful use. CMS has defined 14 core measures for EHs.

*Menu Measures* allow flexibility for EHs to choose measures that are more applicable to their service area or for which they can more readily report. EHs must choose five objectives from the ten menu measures defined for Stage 1. Providers must select at least one population and one public health measure for the menu to meet the MU criteria.

*Clinical Quality Measures (CQMs)* provide information on the outcomes from a health population. CMS has further classified the CQMs as core, alternate core, and additional.

**EHs have a separate list of 15 CQMs and must report on ALL.**

Providers must demonstrate data collection and MU for a consecutive period of time for patients they see where EHRs are available. CMS will provide additional criteria for Stages 2 and 3 with Stage 2 expected to be implemented in 2013. The HIT Policy Committee has released a [draft](#) of Stages 2 and 3 meaningful use criteria for comment..