KANSAS MEDICAID EHR INCENTIVE PROGRAM

ELIGIBLE PROFESSIONAL PROVIDER MANUAL

UPDATED: NOVEMBER 2015
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## Revision History

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<tr>
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<td>Original Eligible Professional Manual</td>
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| 2.01           | 08/05/2013 | Christina Rondash              | Updated Patient Volume Calculation  
                                                     | Edited for consistency & clarity                   |
| 3.0            | 11/02/2015 | HPE                            | HPE updates                                               |
### Useful Acronym List and Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ARRA</td>
<td>American Recovery and Reinvestment Act of 2009</td>
</tr>
<tr>
<td>CCHIT</td>
<td>Certification Commission for Health Information Technology</td>
</tr>
</tbody>
</table>
| CHIP    | Children’s Health Insurance Program  
*Synonymous with Title 21 (TXXI).* |
| CHPL    | Certified Health IT Product List  
A list of certified electronic health record systems supplied by ONC. |
| CMSO    | Center for Medicaid and State Operations |
| CMS     | Centers for Medicare & Medicaid Services |
| DHCF    | Division of Health Care Finance  
Visit the [DHCF](#) page on the KDHE website for additional information. |
| EHR     | Electronic health record  
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. |
| EMR     | Electronic medical record  
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. |
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
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<td></td>
<td>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.</td>
</tr>
<tr>
<td>HIE</td>
<td>health information exchange</td>
</tr>
<tr>
<td></td>
<td>The sharing of clinical and administrative data across healthcare institutions and providers.</td>
</tr>
<tr>
<td>HIT</td>
<td>health information technology</td>
</tr>
<tr>
<td></td>
<td>HIT allows comprehensive management of medical information and its secure exchange between healthcare consumers and providers.</td>
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<tr>
<td>KDHE</td>
<td>Kansas Department of Health and Environment</td>
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<td></td>
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</tr>
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<td>KMAP</td>
<td>Kansas Medical Assistance Program</td>
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<tr>
<td>MAPIR</td>
<td>Medicaid Provider Incentive Repository</td>
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<td></td>
<td>Visit the <a href="#">KMAP</a> website for additional information.</td>
</tr>
<tr>
<td>MU</td>
<td>meaningful use</td>
</tr>
<tr>
<td>ONC</td>
<td>Office of the National Coordinator for Health Information Technology</td>
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<td></td>
<td>The agency responsible for administering the CHPL.</td>
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<td>R&amp;A</td>
<td>CMS Medicare &amp; Medicaid EHR Incentive Program Registration and Attestation System</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Clinic</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>SMHP</td>
<td>State Medicaid HIT Plan</td>
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<tr>
<td>TIN</td>
<td>tax identification number</td>
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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 of 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 Programs 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 (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 Professional Provider Manual

The Kansas Medicaid EHR Incentive Program Eligible Professional Provider Manual is a resource for healthcare professionals who wish 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 new users 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, contact EHR Provider Support.

- Phone: 1-800-933-6593, select option 7
- Email: 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.
Who is Eligible?

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

1. EPs must be licensed physicians (MD or DO), dentists, certified registered nurse practitioners, certified nurse midwives, or physician assistants enrolled in the Kansas Medicaid program.

   a. While physician assistants are not eligible to be compensated for services provided to Kansas Medicaid beneficiaries, physician assistants who practice in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is “so led” by a physician assistant may be eligible for Kansas Medicaid EHR incentive payments. However, physician assistants who are eligible for incentive payments will be required to login to the KMAP secure website. See additional instructions below.

   b. For the purposes of this program, KDHE defines a pediatrician as a physician with the pediatric board certification. The certification is valid for seven years, and physician certification must be current.

2. EPs cannot be hospital-based. This means the EPs do not provide “substantially all” of their professional services in a hospital setting. “Substantially all” is defined to mean EPs who conduct more than 90% of their covered professional services in either an inpatient hospital (place of service code: 21) or hospital emergency department (place of service code: 23).

3. An EP must be without sanctions or exclusions and have been granted access to the KMAP website. Non-KMAP providers may request a secure user name and password by completing the application at Request KMAP Access.
INSTRUCTIONS FOR PHYSICIAN ASSISTANTS

Physician assistants applying for the incentive payment must meet the CMS-defined criteria of practicing at an FQHC or RHC that is “so led” by a physician assistant. “So led” is defined by CMS to mean the one of the following:

- When a physician assistant is the primary provider in an FQHC or RHC
- When a physician assistant is a clinical or medical director at a clinical site of practice at an FQHC or RHC
- When a physician assistant is an owner of an FQHC or RHC

Physician assistants applying for the incentive payment will be required to provide supporting documentation to validate the above criteria. Supporting documentation for enrolling with KDHE may include, but is not limited to, ownership documents, employment records, job description, information submitted formally to HRSA or CMS, board meeting minutes indicating that a physician assistant is leading the site, and/or a signed CEO or CFO attestation.

Physician assistants who are predominately practicing in an FQHC or RHC which is “so led” by a physician assistant and who think they may be eligible for Medicaid EHR Incentive Program payments should contact EHR Provider Support.

- Phone: 1-800-933-6593, select option 7
- Email: Kansas_EHR_Provider_Support@groups.ext.hpe.com
INSTRUCTIONS FOR PEDIATRICIANS

For the purposes of the Kansas Medicaid EHR Incentive Program, pediatricians are defined as physicians who are board-certified as pediatricians. A pediatrician applying for an incentive payment must be able to provide supporting documentation to demonstrate that he or she meets CMS and Department criteria for the EHR Incentive Program. KDHE may audit and validate pediatricians to verify that they meet the criteria for receiving incentive payments.

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)
  - Selection of incentive program option: Medicare or Kansas Medicaid
  - CMS Certification Number (CCN)
  - 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 name and password to log into the KMAP secure website. If an eligible provider 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 R&A, the applicant should contact EHR Provider Support.
  o Phone: 1-800-933-6593, select option 7
  o Email: 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:
  o They meet Medicaid patient volume thresholds.
  o They are adopting, implementing, upgrading, or meaningfully using federally-certified EHR systems.
  o They meet all other federal program requirements.

• 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.

• 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.

• Applicants are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the covered professional services.

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

- Phone: 1-800-933-6593, select option 7
- Email: Kansas_EHR_Provider_Support@groups.ext.hpe.com

Application Readiness for Providers

Applicants can take a number of steps to expedite 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 reset, call 1-800-933-6593 and select option 7. Applicants may request access to the KMAP secure website at Request KMAP Access.

• The NPI 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.
Year One Process Flow: Medicaid EHR Incentive Program

Figure 1 below describes the overall application, registration, attestation, and monitoring process for the EHR Incentive Program.

**Figure 1: Year One Process Flow - Medicaid EHR Incentive Program**

1. KDHE conducts education and outreach strategy for providers and stakeholders
2. Providers will enroll in the R&A
3. The R&A will provide information to KDHE through MAPIR interfaces about providers who have applied for the Incentive Program
4. MAPIR runs reviews on info from the R&A to determine which providers to contact for the application process
5. Providers submit application and attestation form in MAPIR system and MAPIR concurrently runs system reviews
6. KDHE reviews pended provider applications and attestations and determines eligibility or addresses reasons for suspension
7. KDHE denies provider’s application
8. Provider application clears MAPIR system reviews and MAPIR generates approval email with program information to provider
9. MAPIR supplies list of providers who pass reviews on to the R&A for final confirmation
10. KDHE sends approval email to provider with program and payment information
11. MMIS issues payment and MAPIR submits payment information to the R&A
12. Post-payment oversight and outreach activities
13. Ongoing technical assistance for adoption, implementation, upgrade and meaningful use of EHR
14. Notification of meaningful use requirements for Year 2 and beyond
15. Meaningful use payment request or renewal

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* ATTENTION!
EPs and EHs cannot apply prior to receiving an email from KDHE confirming their ability to enroll.

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* 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, EPs must meet eligible patient volume thresholds.

**DEFINITION OF ENCOUNTER**

The patient volume calculation includes Medicaid paid and 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 Children’s Health Insurance Program (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.

The basic formula for calculating the Medicaid patient volume is illustrated below.

\[
\frac{\text{Medicaid patient encounters} \ (\text{includes Medicaid encounters in and out of Kansas})}{\text{Total patient encounter volume in and out of Kansas}} = \text{\% Medicaid patient volume}
\]
Medicaid patient encounters include:

- Kansas Medicaid encounters
- Kansas managed care encounters
- Out-of-state Medicaid encounters
- Needy individuals (FQHC and RHC providers only – see below)
- Any encounter with a Medicaid-eligible person

Only Medicaid encounters, not including CHIP, are applicable for this program. If the provider cannot distinguish between CHIP and Medicaid encounters, then Medicaid encounters must be reduced by a “CHIP proxy” of 2.4%.

Total patient encounter volume includes:

- Medicaid patient encounters (described above)
- Private or commercial insurance patient encounters
- Self-pay patient encounters
MINIMUM VOLUME REQUIREMENTS

EPs must meet annual patient volume thresholds. The general rule is that EPs must meet the Medicaid patient volume thresholds, which is typically a minimum of 30% and 20% or higher for pediatricians.

There is not a minimum number for patient encounters.

Medicaid patient volume is measured over a continuous 90-day period in the previous calendar year or previous 12 months preceding attestation date for all service locations. Note: Providers only enter the start date and MAPIR will calculate the end date.

NEEDY INDIVIDUAL VOLUMES – FQHC and RHC Providers Only

For purposes of calculating needy individual patient volume, a needy patient encounter means services performed where:

- Medicaid or CHIP paid for all or part of the service or the individual’s premiums, copayments, or cost-sharing.
- The services were furnished at no cost.
- The services were paid for at a reduced cost based on a sliding scale determined by the individual’s ability to pay.

Note: If a provider is attesting to needy individual volumes, the following information is required: patient’s name or account number, date of service, and CPT or HCPC.

Exceptions

EPs that “practice predominantly” at a FQHC or RHC have different criteria. (See Figure 2 below for additional details.)

Pediatricians have special rules and are allowed to participate with a reduced eligible patient volume threshold (20% instead of 30%). If pediatricians have greater than 20% but less than 30% eligible patient volume, their annual incentive cap is reduced to two-thirds. Pediatricians who achieve 30% eligible patient volume are eligible to receive the full incentive amount for which they qualify.
### Figure 2: Patient Volume Thresholds per the CMS Final Rule

<table>
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<tr>
<th>Provider Type</th>
<th>Requirements</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Professionals</strong></td>
<td></td>
<td></td>
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<tr>
<td>EPs applying as individuals</td>
<td>Can include encounters from multiple locations. MAPIR will provide listing per Medicaid claims or provider enrollment data. Not all locations used for patient volume will require MU reporting.</td>
<td>30%</td>
</tr>
<tr>
<td>EPs applying as a group</td>
<td>Numerator: Includes totals for an entire group of providers and requires use of the group NPI(s) for verification. The group volume is then applied to all the providers in the group. The payments are for the individual providers, thus when the group volume calculation is used, it must be applied to all individual EPs in the group.</td>
<td>30%</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>Physicians must be board-certified in pediatrics. CRNPs and other EPs in pediatric offices must meet the 30% threshold. The 20% threshold applies only to pediatricians.</td>
<td>20%</td>
</tr>
<tr>
<td>EPs practicing predominantly in an FQHC or RHC</td>
<td>Numerator: Professionals who practice predominantly in an FQHC or RHC more than 50% of their time over a six-month period can also include “needy” individuals in the numerator totals. “Needy” is defined as those who receive services paid by Medicaid, CHIP, or some other auditable-reduced payment scale.</td>
<td>30%</td>
</tr>
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</table>
Group Volume Calculation

Incentive payments are for individual providers. However, individual providers practicing in clinics and group practices (including FQHCs and RHCs) are allowed to use the practice or clinic Medicaid patient volume (or needy population patient volume, insofar as it applies) for their patient volume.

Note: The group NPI must define the “group” and all members of the group must apply in an identical manner. EPs should enter the group NPI(s) in the Group Practice Provider ID field. The following conditions apply to group practice calculations:

1. There must be an auditable data source to support the group’s patient volume determination.

2. The group methodology is not appropriate for EPs who see commercial, Medicare, or self-pay exclusively.

3. EPs have the capability to enter four group NPIs. If there are more than four group NPIs, indicate by checking the Additional Group Practice Provider IDs box in MAPIR. Email all additional group NPI numbers and provider names to Kansas_EHR_Provider_Support@groups.ext.hpe.com.

4. If you are an EP in a group that practices predominantly in a FQHC or RHC, then you can include needy population encounters as a part of your patient volume.
6 Provider Incentive Payments

The federal rules also set forth the EP EHR incentive payments. EPs may receive up to $63,750 in six incentive payments by participating for six program years over the life of the incentive program. It is not necessary for EPs to participate for six consecutive years to receive the full incentive payment of $63,750, unless joining the program in 2016. (See Figure 3 below.)

Figure 3: Maximum Incentive Payments for Kansas Medicaid

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Eligible pediatricians who reach 20% of their total patient volume but not 30% may receive up to $42,500 through six incentive payments over the life of the program. The pediatrician incentive payments table provides an overview of incentive payments over the life of the Kansas Medicaid EHR Incentive Program. (See Figure 4 below.)

**Figure 4: Pediatrician Kansas Medicaid EHR Incentive Payments (Between 20 – 29%)**

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<td>CY 2011</td>
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<td>CY 2012</td>
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<td>CY 2021</td>
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<td>TOTAL</td>
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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. Professionals 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 federally certified EHR technology.

- **Meaningful User** – can attest to meeting Stage 1 meaningful use requirements as set forth by CMS.

*Note: Only EPs who are attesting to a 90-day or one-year period of meaningful use can attest as a meaningful user. If you do not meet either of these requirements, select adopt, implement, or upgrade.*

All providers will fall into one of the four groups listed above. You are only allowed to attest to AIU for your first payment year. All subsequent years you must meet MU requirements.

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 meaningful use. 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. 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, upgrade, or MU criteria:

- **Adopt**
  - KDHE recommends applicants 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 applicants 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 applicants 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 subjects, dates, times, and participation level.
• **Upgrade**
  - KDHE recommends applicants 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.

• **Meaningful Use**
  - At the time of submission, you are not required to attach any additional documentation; however, all reports generated and used from your EHR system to complete the MU section in MAPIR need to be readily available if requested for audit purposes.
  - We strongly recommend these reports be printed and stored at the time of submission in case of an audit.
CMS requires states to ensure that payments are being made to the right person, at the right time, for the right reason. In order to receive an incentive payment, EPs will be attesting to, among other things, whether they are using a certified EHR, demonstrating AIU-certified EHR technology, and demonstrating meaningful use.

States will be required to “look behind” eligible professional 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:

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

**MAPIR Attestations**

EPs 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 Medicaid 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:

- Hospital-based providers
- Applicants who do not meet patient volume thresholds
- Ineligible provider type
- Providers with sanctions

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

**Postpayment Reviews**

KDHE will use a random sampling methodology to review 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, such as Kansas Medicaid patient volume percentages close to the required threshold or significant out-of-state Medicaid patient volume. We strongly recommend MU reports are printed and stored at the time of submission in case of a postpayment review.

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 providers. 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 provider.

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

EPs 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.
- There is an appeal of the incentive payment amount (such as a pediatrician payment).

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 provider enrollment process by interfacing with other systems to verify data. EPs enter data into MAPIR and attest to the validity of data, thus improving accuracy and quality.

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

- Interfacing between KDHE and R&A to:
  - Receive initial registration information from professionals
  - Report eligibility decisions to CMS
  - Report payment information (such as payment date and transaction number) to CMS

- Verify information submitted by applicant

- Determine eligibility of professionals

- Allow professionals to submit:
  - Attestations
  - Payee information
  - Submission confirmation/digital signature

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

To begin in the MAPIR application process, professionals must:

1. Be enrolled at R&A

2. Be enrolled as a Medicaid provider or have requested and been granted access with a secure user name and password to the KMAP website

3. Be free of sanctions or exclusions

Note: In some cases, professionals will be redirected to R&A to correct discrepant data. In other cases, providers 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

Professionals can access MAPIR through the KMAP secure website.

To access the KMAP secure website, the user must have a KMAP provider number or 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
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.

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. Your user name is specific to the individual provider you represent. You cannot use the group user name associated with the provider. If the user is a clerk, the clerk must be granted access.

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 Provider Support Team will contact if there are any questions or problems with the application. It is vital that the correct person can be 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 Practice Type (Part 1 of 3): If you are attesting to patient volume as an individual practitioner and are a member of a group, ALL active members of that group MUST attest as individual practitioners as well if they are attesting with Kansas Medicaid.

If you are attesting to patient volumes as a group or clinic, ALL active members of your group MUST attest with Kansas Medicaid using the same patient volume numbers. If an individual practitioner is a member of multiple groups and chooses not to attest as a member of your group, you cannot attest as a group or clinic; all members must attest as individual practitioners.

If you have further questions, refer to page 22 in this manual.

Attestation

Attestation Phase (Part 1 of 3): If you attested and received your Year 1 payment under AIU, you must apply for Year 2 under meaningful use.

Attestation Meaningful Use Measures: If you have questions while completing the MU measures, use the help links embedded within the measures.

In Core Clinical Quality Measures, Alternate Core Clinical Quality Measures, and Additional Clinical Quality Measures, you must have the measure reference number to locate the appropriate help card. At this time, the measures are displayed as PDF files within a WinZip folder. This folder becomes available once you agree to the terms provided by CMS.

Review

If all the information is correct, click Continue. Next, click Submit to begin the submit section.
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 (ACH)** 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
- 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, eligible hospital, 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 an individual on any one day (in a doctor’s office or emergency room) or per patient discharge where the claim was zero.

**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, 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.
Pediatrician means a physician who is either board-certified as a pediatrician or has received 12 months of training with children under 21 years of age.

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, EPs 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 15 core measures for EPs.

**Menu measures** allow flexibility for EPs to choose measures that are more applicable to their service area or for which they can more readily report. EPs must choose five objectives from the 10 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.

**EPs must report on six measures.**
Three of the six measures for EPs must come from the Core or Alternate Core CQM measures. EPs then have the option to choose from the alternate list of 38 CQMs to meet the criteria for reporting on CQMs.

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.