

EHR Incentive Program

Provider User Manual

March 1, 2013

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Introduction

The Illinois Medicaid EHR Incentive Program will provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Background information and registration procedures follow:

Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://edocket.access.gpo.gov/2010/pdf/2010-17207.pdf>
- Illinois Medicaid EHR Application Portal located at: <https://secure.myhfs.illinois.gov/login/AuthenticateUserRoamingEPF.html>
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>
- Office of the National Coordinator for Health Information Technology located at http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204

Two Regional Extension Centers (RECs) have been designated to provide technical assistance to Illinois providers. The RECs provide a full range of assistance related to EHR selection and training and are listed below:

IL-HITREC

www.ilhitrec.org

P.O. Box 755, Sycamore, IL 60178

Phone: 815-753-1136

Fax: 815-753-2460

Email: info@ILHITREC.org

CHITREC

750 N. Lake Shore Drive, 9th Floor

Chicago, Illinois 60611

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Revisions

- Original 3/1/2013

Background

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to eligible professionals (EP) and eligible hospitals (EH), including critical access hospitals (CAHs), participating in Medicare and Medicaid programs that are meaningful users of certified Electronic Health Records (EHR) technology. The incentive payments are not a reimbursement, but are intended to encourage EPs and EHs to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://www.healthit.hhs.gov>

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Illinois Department of Healthcare and Family Services (HFS) will work closely with federal and state partners to ensure the Illinois Medicaid EHR Incentive Program fits into the overall strategic plan for the Illinois Health Information Exchange (HIE), thereby advancing national and Illinois goals for HIE.

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. The site provides general and detailed information on the programs, including tabs on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

Eligibility

EPs must begin the program no later than CY 2016 and EHs must begin by Federal Fiscal Year (FFY) 2016.

The first tier of provider eligibility for the Illinois Medicaid EHR Incentive Program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the IL MMIS provider data base does not correspond to the provider types and specialties approved for participation in the Illinois Medicaid EHR Incentive Program, the provider will be notified of disqualification.

At this time, IL HFS has determined that the following providers and hospitals are potentially eligible to enroll in the Illinois Medicaid EHR Incentive Program:

- Physicians = Any provider who has a Provider Type 010
- Physician Assistant (practicing in a FQHC [Provider Type 040] or RHC [Provider Type 048] led by a Physician Assistant) = Any provider with a Provider Type 089. An FQHC or RHC is considered to be PA led in the following instances:
 - The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
 - The PA is the clinical or medical director at a clinical site of the practice
 - The PA is the owner of the RHC
- Pediatrician = Any provider with a Provider Type 010 and is Board Certified as a Pediatrician or the percentage of Medicaid Recipients Under the Age of 21 is 90% or more.
- Nurse Practitioner = Any provider with a Provider Type 016
- CNM = Any provider with a Provider Type 016
- Dentist = Any provider with a Provider Type 011 (Individual)
- Optometrist = Any provider with a Provider Type 012
- Acute Care Hospital = Any provider with a Provider Type 030 and Specialty Code 001
- Children's Hospital = Any provider with a Provider Type 030 and Specialty Code 004, CCN in the range of 3300-3399
- Critical Access Hospital = Any provider with a Provider Type 030 and Specialty Code CAH, CCN in the range of 1300-3399

Additional requirements for the EP

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must:

1. Meet one of the following patient volume criteria from previous Calendar Year (CY):
 - a. Have a minimum of 30 percent patient volume attributable to individuals receiving Title XIX Medicaid funded services (NOTE: changes were made for Attestion Year 2013 to allow the use of Title XXI CHIP funded encounters. Those changes have not yet been incorporated in this manual) ; or
 - b. Have a minimum 20 percent patient volume attributable to individuals receiving TXIX Medicaid funded services, **and** be a pediatrician NOTE: changes were made for Attestion Year 2013 to allow the use of Title XXI CHIP funded encoutners. Those changes have not yet been incorporated in this manual); or
 - c. Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals.
2. Have no sanctions and/or exclusions.
3. Not Deceased.
4. Not have more than 90% of the EPs Medicaid encounters take place in a hospital setting.
5. Enrolled and in good standing with IL Medicaid.

An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the National Level Registry (NLR) and must match a TIN linked to the individual provider in the Department of Healthcare and Family Services (HFS) provider database. This means the system will not be available to a provider for attestation from the time the contract is submitted for renewal until it has been approved by HFS.

Additional requirements for the EH

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

1. An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume in the previous Federal Fiscal Year (FFY) for each year the hospital seeks an EHR incentive payment; or (NOTE: changes were made for Attestion Year 2013 to address the use of Title XXI CHIP funded encounters. Those changes have not yet been incorporated in this manual) and
2. A children’s hospital (exempt from meeting a patient volume threshold).

Hospital-based providers are not eligible for the EHR incentive program.

Note: Some provider types who are eligible for the Medicare program, such as podiatrists and chiropractors, are not currently eligible for the Illinois Medicaid EHR Incentive Program.

Qualifying Providers by Type and Patient Volume

Program Entity	Minimum Percent Patient Volume (90-day period)	
Physicians	30%	

Pediatricians	20%	Or the Medicaid EP practices predominantly in a FQHC or RHC -30% "needy individual" patient volume threshold
Dentists	30%	
Optometrist	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	
Acute care hospital	10%	
Children's Hospital	No minimum	

Out-of-State Providers

The Illinois Medicaid EHR Incentive Program welcomes any out-of-state provider to participate in this program as long as they are enrolled in Illinois Medicaid. Illinois must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit. Records must be maintained as applicable by law in the state of practice or Illinois, whichever is deemed longer.

Establishing Patient Volume

An Illinois Medicaid provider must annually meet patient volume requirements. The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP. All EPs (except EPs predominantly practicing in an FQHC/RHC) will calculate patient volume based on TXIX Medicaid and out-of-state Medicaid patients. The EHR statute allows for an EP practicing predominantly in a FQHC or RHC to consider CHIP patients under the needy individual patient volume requirements.

Patient Encounter Methodology

Eligible Professionals:

- EPs (except those practicing predominantly in a FQHC/RHC) – to calculate TXIX Medicaid patient volume, an EP must divide:
 - The total TXIX Medicaid or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
 - The total patient encounters in the same 90-day period.
- EPs Practicing Predominantly in a FQHC/RHC – to calculate needy individual patient volume, an EP must divide:
 - The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year; by
 - The total patient encounters in the same 90-day period.

Definition of an Eligible Professional Medicaid Encounter

For purposes of calculating EP patient volume, a Medicaid encounter is defined as services rendered on any one day to an

individual where TXIX HFS or another State's Medicaid program paid for

- Part or all of the service; or
- Part or all of their premiums, co-payments, and/or cost-sharing.

Definition of a Needy Individual Encounter

For purposes of calculating patient volume for an EP practicing predominantly in a FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Paid for by TXIX Medicaid or TXXI Children's Health Insurance Program funding including HFS, out-of-state Medicaid programs or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- Furnished by the provider as uncompensated care; or
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Group practices – Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP;
- There is an auditable data source to support the clinic's or group practice's patient volume determination;
- All EPs in the group practice or clinic must use the same methodology for the payment year;
- The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

Eligible Hospitals

To calculate TXIX patient volume, an EH must divide:

- The total TXIX and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year by:
- The total encounters in the same 90-day period.
 - Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period. (*Please note per CMS FAQ nursery days are excluded from inpatient bed days*)
 - An emergency department must be part of the hospital.

Eligible Hospital Medicaid Encounter

For purposes of calculating eligible hospital patient volume, a Medicaid encounter is defined as services rendered to an individual 1) per inpatient discharge, or 2) on any one day in the emergency room where TXIX Medicaid program paid for:

- Part or all of the service;

- Part or all of their premiums, co-payments, and/or cost-sharing;

Exception – a children’s hospital is not required to meet Medicaid patient volume requirements.

Payment Methodology for EPs

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

Provider	EP	EP-Pediatrician
Patient Volume	30 Percent	20-29 Percent
Year 1	\$21,250	\$14,166.67
Year 2	8,500	5,666.67
Year 3	8,500	5,666.67
Year 4	8,500	5,666.67
Year 5	8,500	5,666.67
Year 6	8,500	5,666.65
Total Incentive Payment	\$63,750	\$42,500

Since pediatricians are qualified to participate in the Illinois Medicaid EHR incentive program as physicians, and therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirement.

Payments for Eligible Professionals

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation National Level Repository (NLR). The TIN must be associated to the provider in the Illinois MMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated.

The timeline for receiving incentive payments is illustrated below:

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	\$21,250					
CY 2012	\$8,500	\$21,250				
CY 2013	\$8,500	\$8,500	\$21,250			
CY 2014	\$8,500	\$8,500	\$8,500	\$21,250		
CY 2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
CY 2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
CY 2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
CY 2018			\$8,500	\$8,500	\$8,500	\$8,500
CY 2019				\$8,500	\$8,500	\$8,500
CY 2020					\$8,500	\$8,500
CY 2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

Note: Pediatricians receive 2/3 of the incentive payments above. For any given year that a pediatrician attests to 30% or more Medicaid encounters, the pediatrician shall receive the full incentive above.

Payment Methodology for Eligible Hospitals

Statutory parameters placed on Illinois Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

The last year that a hospital may begin to receive the Medicaid incentive payments is FY 2016. States must make payments over a minimum of three years. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

The PIP amount for each EH is calculated one time. The hospital aggregate incentive amount calculation is made using the equation outlined in the Final Rule, as follows:

(Overall EHR Amount) times (Medicaid Share) where Overall EHR Amount Equals {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]} times Medicaid Share Equals {(Medicaid inpatient-bed-days plus 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)]}

HFS plans to disburse EH incentive payments on the following payment schedule:

- Year 1: 25% of the aggregate payment amount
- Year 2: 25% of the aggregate payment amount
- Year 3: 20% of the aggregate payment amount
- Year 4: 15% of the aggregate payment amount
- Year 5: 15% of the aggregate payment amount

As outlined below, hospitals may qualify for an expedited schedule.

Historically, the Illinois Medicaid program has relied upon a fragmented, provider-driven delivery system. Looking ahead to the promise of national health reform and the expansion of the Medicaid program in 2014, Illinois is taking steps to move the Medicaid program toward a delivery system that integrates care, shares information across healthcare providers, and is focused on health outcomes—better health outcomes—for our enrollees.

The Illinois General Assembly recently enacted substantial and comprehensive Medicaid reform legislation (*Public Act 096-1501*) for Illinois. The *Act*, among other things, directs HFS to greatly expand participation in integrated and coordinated care programs to improve the quality and cost-effectiveness of care provided to Illinois Medicaid beneficiaries (see SMHP Section 2.4.9 for more information on *Public Act 096-1501*). These objectives are consistent with those of the federal HIT initiatives and the development of EHRs.

Illinois Medicaid presently offers a voluntary managed care option to family plan (children and caretaker relatives) enrollees in selected parts of the state. Beginning later this spring, in the suburban Chicago metropolitan area, non-Medicare aged or disabled beneficiaries will be enrolled with integrated care plans. That, however, is only the beginning. Illinois fully intends to develop a variety of accountable care organizations and other forms of coordinated care that will support healthcare reform.

Effective integrated and coordinated care relies on sharing and use of information. EHR is critical to both. The PIP initiative encourages the adoption of EHR technology and initiates MU of certified EHR technology. Hospital participation in the care integration and coordination initiatives of the Illinois Medicaid program will accelerate actual and MU of EHR. Participation by hospitals in these coordinated care initiatives will further the development of *HITECH* envisioned federal legislation and supported by State policy.

The EH PIP schedule is designed to support the economic and efficient administration of the Illinois Medicaid program through providing an incentive to hospitals to participate in care integration and coordination initiatives of the Illinois Medicaid program. That incentive takes the form of more expeditious payment of the total incentive amount to EHs that cooperate with HFS to further coordination of care provided to Medicaid enrollees.

Definitions:

“Coordinated care participating hospital” means a hospital that is located in a geographic area of the state in which HFS mandates some or all of the beneficiaries of the Medical Assistance Program residing in the area to enroll in a care coordination program, as defined in 305 *Illinois Compiled Statutes (ILCS) 5/5-30*, that is one of the following:

- (i) Has entered into a contract to provide hospital services to enrollees of the care coordination program.
- (ii) Has not been offered a contract by a care coordination plan that pays no less than HFS would have paid on a fee-for-service (FFS) basis, but excluding disproportionate share hospital adjustment payments or any other supplemental payment that HFS pays directly.
- (iii) Is not licensed to serve the population mandated to enroll in the care coordination program.

“Medicaid Managed Care Entity (MMCE) participating hospital” means a hospital that is located in a geographic area of the state in which HFS offers enrollment with a MMCE as a voluntary option to beneficiaries of the Medical Assistance Program and that has entered into a contract to provide hospital services to enrollees of an MMCE.

PIP schedule for EHS:

Table 1: Hospital Incentive Payment Schedule

Percentage of the overall EHR amount to be paid, by payment schedule and year					
Payment schedule	Year				
	(1)	(2)	(3)	(4)	(5)
A	25%	25%	20%	15%	15%
B	40%	30%	20%	10%	0%
E	50%	40%	10%	0%	0%

Group A is comprised of hospitals that do not qualify for groups B or E—those in coordinated care areas that have not yet availed themselves of the opportunity to participate in efforts to improve the coordination of care of Medicaid enrollees.

Hospitals qualifying for PIP will be paid under schedule (A) unless qualifying for an expedited schedule (B or E)—i.e., the schedule applicable to the first class description into which the hospital falls.

Table 2: Hospital Payment Schedule by Hospital Class

Hospital class	Payment schedule
Pediatric specialty hospitals.	E
CAHs.	E
Hospitals operated by the Cook County Health and Hospitals System.	E
Hospitals operated by the University of Illinois at Chicago.	E
Hospitals that are both a coordinated care participating hospitals and an MMCE participating hospital.	E
Coordinated care participating hospitals that are in an area in which:	
—Both an MMCE and a mandatory coordinated care program operate.	B
—Only a mandatory coordinated care program operates.	E
MMCE participating hospitals that are in an area in which:	
—Both an MMCE and a mandatory coordinated care program operate.	B
—Only a voluntary coordinated care program operates.	E
Hospitals located outside of Illinois that are either a coordinated care participating hospitals or an MMCE participating hospital.	E
Hospitals in areas where neither an MMCE nor a mandatory coordinated care program operate.	B

Hospital class	Payment schedule
All other hospitals.	A

An applicant hospital will be notified of its eligibility for, and the amount of, the PIP. In that same notice, the hospital will be informed if it qualifies for an expedited payment schedule.

All EHs will receive all of the incentive payments to which they are entitled. This 5-year period is allowed in federal law. (42 CFR 495.310(f)(1) The payment is provided over a minimum of a 3-year period and maximum of a 6-year period.) Illinois' proposed disbursement schedule is fully in compliance with the regulation.

Note that June 15, 2011, of the 223 acute care hospitals with which we do business and that may potentially qualify for payments (the 10 percent test notwithstanding), only 22 of them fall into group A. Moving from group A to another group is entirely within the control of a hospital.

Hospitals that during the five-year payment period, qualify for a different payment schedule will, to the extent permissible under federal regulation, have their remaining payments adjusted to line up with the new schedule.

Provider Registration

Both EPs and EHs are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. Providers must provide their name, NPI, business address, phone number, tax payer ID number (TIN) of the entity receiving the payment and hospitals must provide their CCN. EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong.

EPs must select the Medicare or Medicaid's incentive program (a provider may switch from one to the other once during the incentive program prior to 2015). If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the program from which they want to receive their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments unless information needs to be updated. EHs seeking payment from both Medicare and Medicaid will be required to visit the NLR annually to attest to meaningful use before returning to the Illinois EHR Incentive system to attest for Illinois' Medicaid EHR Incentive Program. HFS will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The NLR will assign the provider a CMS Registration Number and electronically notify HFS of a provider's choice to access Illinois' Medicaid EHR Incentive Program for payment. The CMS Registration Number will be needed to complete the attestation in the Illinois MEDI system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the Illinois Medicaid Management Information System, and 2) validate the EP is an active provider with Illinois Medicaid. If either condition is not met, a message will be automatically generated to the CMS NLR indicating the EP is not eligible. EPs may check back at the NLR level to determine if the registration has been accepted.

Once payment is disbursed to the eligible TIN, NLR will be notified by Illinois Medicaid that a payment has been made.

Provider Attestation Process and Validation

Illinois Medicaid will utilize the secure MEDI system to house the attestation system. The link will only be visible to EPs whose Provider Type (PT) in the MMIS system matches an EHR incentive eligible provider category. If an EP registers at the NLR and does not receive the link to the attestation system within two business days, assistance will be available by contacting the HFS Provider Enrollment Unit.

Following is a description by eligible provider type of the information that an EP will have to report or attest to during the process.

Eligible Professional

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) (at <http://www.cms.gov/EHRIncentivePrograms/>), the EP will be asked to provide their NPI and CMS-assigned Registration Identifier.
2. The EP will then be asked to view the information that will be displayed with the pre-populated data received from the NLR (if the provider entry does not match, an error message with instructions will be returned).
3. EPs will then enter two categories of data to complete the Eligibility Provider Details screen including 1) patient volume characteristics and 2) EHR details.
4. The EP will be asked to attest to:
 - Assigning the incentive payment to a specific TIN (only asked if applicable); provider and TIN to which the payment was assigned at the NLR will be displayed;
 - Not working as a hospital based professional (this will be verified by HFS through claims analysis);
 - Not applying for an incentive payment under another DMS ID; and
 - Adoption, implementation or upgrade of certified EHR technology.
5. The EP will be asked to electronically sign the amendment.

Note: For EPs ready to demonstrate Meaningful Use in year 1, the provider will attest to this fact. In subsequent years, HFS will work with the HIE to provide a mechanism for providers to submit Meaningful Use data to HFS.

Eligible Hospital

1. After registering for the incentive program with the CMS EHR Registration and Attestation National Level Repository (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the EH will be asked to provide:
 - Completed patient volume information;
 - Completed Hospital EHR Incentive Payment Worksheet;
 - Certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules); and
2. The EH will be asked to attest to:
 - Adoption, implementation or upgrade of certified EHR technology or meaningful use;
 - Not receiving a Medicaid incentive payment from another state; and
3. The EH will be asked to electronically sign the amendment;
 - The provider enters his/her initials and NPI on the Attestation Screen.

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

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

During the first year of the program, EPs will only be able to attest to adopting, implementing or upgrading (AIU) to certified EHR technology. During attestation you are required to upload documents in support of AIU of certified EHR technology for EPs or EHs. The documentation does not have to be dated in the same year of attestation. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (the Certified Health IT Product List can be located at ONC's website at <http://www.healthit.hhs.gov>).

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

Incentive Payments

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and validation by DMS, an incentive payment can be approved and issued by the Office of the State Comptroller.

Program Integrity

HFS will be conducting regular reviews of attestations and incentive payments. These reviews will be selected as part of the current audit selection process, including risk assessment, receipt of a complaint or incorporation into reviews selected for other objectives. Providers should be sure to keep their supporting documentation.

Administrative Appeals

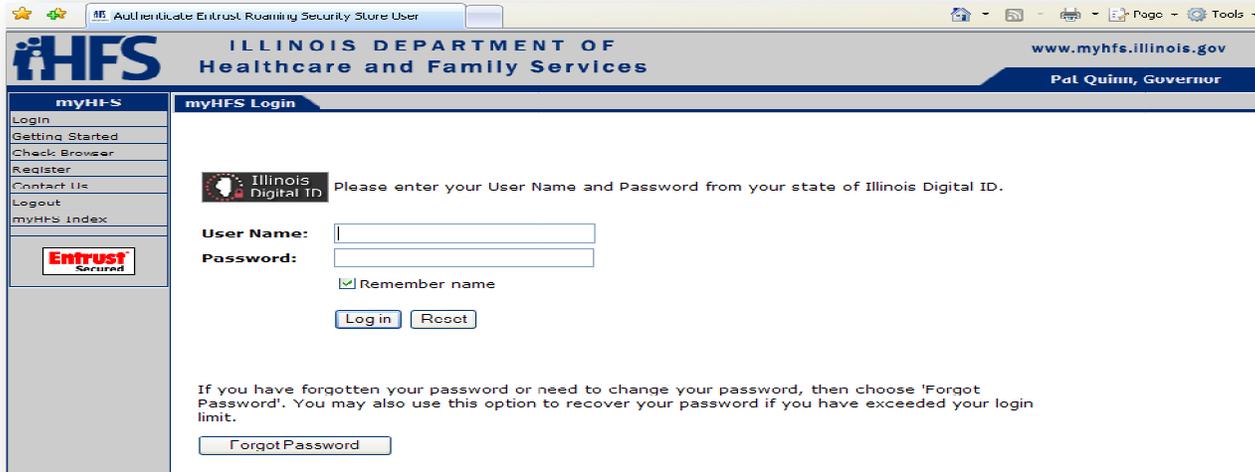
Providers who feel they have received this denial in error may request a hearing within thirty (30) calendar days after the date of this notice. The request must be in writing and must contain a brief statement of the basis upon which the department's action is being challenged. If such a request is not received within ten (30) calendar days, or is received, but later withdrawn, the department's decision shall be a final and binding administrative determination. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

Registration (Eligible Providers)

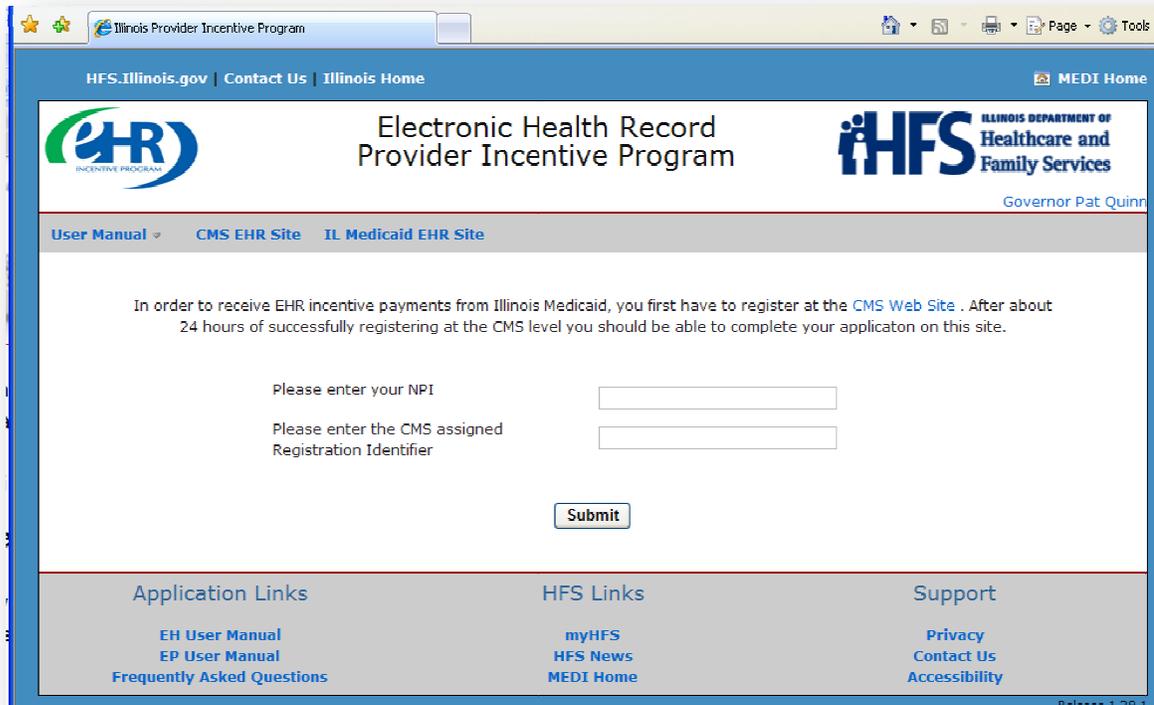
Eligible providers will be required to provide details including patient volume characteristics, EHR details, upload requested documentation and electronically sign the attestation (more details follow in this manual).

After registering with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the provider then begins the Illinois Medicaid EHR Incentive Program registration process by accessing the Medical Electronic Data Interchange (MEDI) portal at: <http://www.myhfs.illinois.gov>

Eligible Provider Sign-in Screen



The provider will enter the NPI registered on the NLR and the CMS-assigned Registration Identifier that was returned by the NLR. If the data submitted by the provider matches the data received from the CMS Registration Module, the Home page for the Illinois EHR Incentive Program will be displayed. If the provider entry does not match, an error message with instructions will be returned.



Eligible Provider Home Screen

The Home screen will give the EP data about their current Illinois Attestation as well as provide navigation for the EP to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment.

The screenshot shows the 'Eligible Provider Home Screen' for the 'Electronic Health Record Provider Incentive Program'. The page is titled 'Home (Year 1 Attestation)' and features several sections:

- Announcements And Messages:** No Announcements and Messages !
- Issues/Concerns:** Clicking the below link will redirect you to the Issues/Concerns page, where you will be able to submit any issues and view the responses received from HFS. [Click Here](#)
- Provider Information:** You are currently enrolled in Illinois' EHR Incentive Program. Payment Year '1' is your current year attestation. **The current status of your application for the year 1 payment is 'AWAITING PROVIDER ATTESTATION'.**
- Provider Status Flow:** A diagram showing the flow from 'CMS Registration' to 'Preliminary Verification', which is marked as 'Completed'.
- Provider Attestations:** A table listing the provider's attestations.

Payment Year	Status	AttestationID	Action
1	PreCheck_Completed	-	Begin/Modify Attestation

There are 5 sections to the Home page listed below:

1. **Messages and Announcements** – This will be the first section on the page if a message or announcement exists for the provider.
2. **Issues/Concerns** – This will be the second section on the page. The Issues / Concerns will provide a link for the provider to redirect to the Issues / Concerns page if he would like to submit a new issue or view a response to an issue.
3. **Provider Information** – This is the third section of the home page. The provider information will give the high level status for the provider, the current payment year and the current status for the payment year.
4. **Provider Status Flow** – this is the fourth section of the home page. The Provider Status Flow will give a diagram showing the provider where he is in the current year's attestation. If the provider has been found not eligible for any reason, he will also find the specific reasons for that finding in this section.
5. **Provider Attestations** – this is the fifth section of the home page. The Provider Attestation table will list the providers

attestations by payment year and list the navigation actions he has available for each.

Eligible Provider CMS/NLR Screen

The screenshot shows the 'Electronic Health Record Provider Incentive Program' interface. The header includes the HFS logo and the text 'ILLINOIS DEPARTMENT OF Healthcare and Family Services'. The main content area is titled 'Provider CMS Registration Data' and contains a table of registration information. A warning message at the top states: '*** If any of this information is incorrect, please correct on the CMS Registration Module'. The table lists fields such as Applicant National Provider Index (NPI), Applicant TIN, Payee National Provider Index (NPI), Payee TIN, Program Option, Medicaid State, Provider Type, Participation Year, Federal Exclusions, Name, Address 1, Address 2, City/State, Zip Code, Phone Number, Email, Specialty, and State Rejection Reason. At the bottom, there are buttons for 'Previous', 'Next', 'Save', and 'Cancel'.

Field	Value
Applicant National Provider Index (NPI):	1231231231
Applicant TIN:	131313131
Payee National Provider Index(NPI):	1414141414
Payee TIN:	151515151
Program Option:	MEDICAID
Medicaid State:	IL
Provider Type:	Physician
Participation Year:	1
Federal Exclusions:	None
Name:	Jane Doe
Address 1:	123 OAK STREET
Address 2:	
City/State:	CHICAGO / IL
Zip Code:	60030 -2289
Phone Number:	(312) 904-9494
Email:	JDOE@GMAIL.COM
Specialty:	INTERNAL MEDICINE
State Rejection Reason:	None
Medicaid Provider Type:	-- Select --

Please review the information in the 'Provider CMS Registration Data' section for accuracy. The data provided by the CMS Registration Module is view only. If any of this data is incorrect then the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected in the screen above. The fields that are from the CMS registration are listed below:

- **Applicant National Provider Index (NPI)** – This is the eligible provider’s individual NPI. The NPI registered at CMS should be the same individual NPI that is enrolled in IL Medicaid.
- **Applicant TIN** – This is the Tax Identification Number that was listed in the CMS registration. This TIN should be a TIN that is listed as a valid payee for the provider in the HFS Medicaid enrollment system.
- **Payee National Provider Index (NPI)** – This is the eligible providers payee NPI given during the CMS registration. The Payee NPI given during registration should be enrolled in IL Medicaid and also a payee NPI that IL Medicaid has listed as a payee with whom is registered with HFS.
- **Payee TIN** – The Tax Identification Number associated with the payee NPI. This was the tax id given during registration which will have the tax liability of the incentive payment. The Payee TIN should be a payee that is listed as a certified payee for the provider in HFS Medicaid enrollment systems.
- **Program Option** – This is the program option that was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.

- **Medicaid State** – This is the State that was selected during the provider’s registration.
- **Provider Type** – This is the provider type that was given during the registration at CMS. This type will be validated with your type of license.
- **Participation Year** – This is the provider’s participation year with the EHR Incentive Program
- **Federal Exclusion** – This will list any federal exclusion found on the provider if any during registration with CMS.
- **Name** – The Provider’s name listed on the CMS Registration
- **Address 1** – The provider’s street address listed on the CMS registration
- **Address 2** – The provider’s street address listed on the CMS registration
- **City/State** – The provider’s city/state listed on the CMS registration
- **Zip Code** – The provider’s zip code listed on the CMS registration
- **Phone Number** – The provider’s phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.
- **Email** – The provider’s email given during the CMS registration. This email address is used for system generated emails on updates for the provider’s attestation and communication from the EHR review staff.
- **Specialty** – The provider’s specialty listed in the CMS registration.
- **State Rejection Reason** – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

Provider Eligibility Details Screen

Patient Volume:	1.	For which program year are you applying?	*	2012	▼
	2.	Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals:		No	▼
	3.	If yes, please enter the NPI of the clinic or group:			0
	4.	Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage:	*	04/01/2011	(mm/dd/yy)
	<p>Note: Due to transparency initiatives, providers cannot determine the difference between encounters billed for Title 19 Medicaid and Title 21 programs. The numerator [below] must consist of all encounters billed to HFS as (Title 19 + 21). HFS will be deducting encounters billed for state only funded programs from the numerator and denominator during adjudication except for providers practicing predominantly in an FQHC/RHC in order to verify eligibility pursuant to legislation.</p>				
	5.	Medicaid patient encounters during this period:	*	100	
	6.	Do you practice predominantly (50% of patient encounters in 6 months) in an FQHC/RHC:	**	<input type="checkbox"/> Yes	
	7.	How many of the Medicaid patient encounters listed above are Total Needy Individual patient encounters (for the 90 day period):			
	8.	Total patient encounters during this period:	*	300	
	9.	Estimated Medicaid patient volume percentage:			
EHR Details:	10.	If you are a pediatrician, please select one:		Average Age of Patient Volume < 21	▼
	11.	Enter the CMS EHR Certification ID of your EHR:	*	30000005A8V4EAJ	What is this?
	12.	Indicate the status of your EHR:	*	<input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User	

EPs must enter two categories of data to complete the Eligibility Provider Details screen including patient volume characteristics and EHR details. The Provider will also have the option to change their mailing address for EHR payments. Providers will see the following data on the screen:

▪ **Patient Volume**

- Select the program year for which you are applying. EP's are allowed a 90 day extension past the end of the incentive year to attest. Example: 2012 attestations may be submitted between Jan 1, 2012 and March 31, 2013
- Please indicate if your patient volume was calculated at a clinic or practice level for all eligible professionals
- If yes, please enter the NPI of the clinic or group.
- Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage. This should be from the year prior to the program year selected.
- Medicaid patient encounters during this period
 - Due to transparency initiatives, providers cannot determine the difference between encounters billed for Title 19 Medicaid and Title 21 programs. The numerator must consist of all encounters billed to HFS as (Title 19 + 21). HFS will be deducting encounters billed for state only funded programs from the numerator and denominator during adjudication except for providers practicing predominantly in an FQHC/RHC in order to verify eligibility pursuant to legislation.

- Designate by selecting yes if the provider practiced predominantly (50% of patient encounters in 6 months) in an FQHC/RHC in previous year

- If yes above, Enter how many of the Medicaid patient encounters listed above are Total Needy Individual patient encounters (for the 90 day period) (“Needy individuals” are defined as those receiving medical assistance from Medicaid or the Children’s Health Insurance Program, individuals furnished uncompensated care by the health care provider, or individuals furnished services at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay.)
- Total patient encounters during this period
- Medicaid patient volume percentage (calculated)

▪ **EHR Details**

- Enter the CMS EHR Certification ID of your EHR
- Indicate the Status of your EHR – Choices:
 - (A) Adopt - Acquire, purchase, or secure access to certified EHR technology
 - (I) Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
 - (U) Upgrade - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria
 - Meaningful User – An Eligible Professional for an EHR reporting period for a payment year, demonstrates the meaningful use of a certified EHR technology by meeting the applicable objectives and measures under 42 CFR 495.6.

Provider Calculations Screen



This screen displays the estimated payment for the Eligible Professional based upon the payment year and the volume calculated.

Document Upload Screen

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MEDI Home | Welcome, Jane.Doe | Logout

Electronic Health Record Provider Incentive Program

Home View All Payment Years Issues/Concerns Appeals Additional Resources User Manual

Document Upload (Year 1 Attestation)

Documentation needed to process your application may be attached below. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc. If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation. **Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.**

Payment Year	File Name	Description
No uploaded document found.		

Upload a new PDF document:

Please select the documentation type:

--Select the type of a document--

--Select the type of a document--

Receipt

Purchase Order

Invoice

License

License

Cust Reports

Patient Volume

Miscellaneous

Please upload the following files:

1. Proof of Certified Electronic Health Record Adoption, Implementation or Upgrade or Meaningful Use
 - Contract
 - Software license
 - Receipt or proof of acquisition
 - Purchase order
 - Receipt for Training – evidence of cost or contract
 - Hiring of staff to assist with the implementation – payroll records for the staff hired
2. (Required only if you are attesting to Meaningful Use) Proof of compliance with the Public Health measure “Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice”
 - Public Health iCare registry email stating that the provider has attempted a test of the EHR capabilities

This screen allows the Eligible Professional to attach supporting documentation for their attestation. PDFs up to 100MB may be uploaded.

Documentation needed to process your application may be attached using the screen above. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide the following:

1. Proof of Certified Electronic Health Record Adoption, Implementation or Upgrade or Meaningful Use

- Contract
- Software license
- Receipt or proof of acquisition
- Purchase order
- Receipt for Training – evidence of cost or contract
- Hiring of staff to assist with the implementation – payroll records for the staff hired

2. (Required only if you are attesting to Meaningful Use) Proof of compliance with the Public Health measure “Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice”

- Public Health iCare registry email stating that the provider has attempted a test of the EHR capabilities

Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider should be kept for 6 years.

Provider Attestation Screen



Electronic Health Record
Provider Incentive Program



Governor Pat Quinn

[Home](#) | [View All Payment Years](#) | [Issues/Concerns](#) | [Appeals](#) | [Additional Resources](#) | [User Manual](#)

Attestation (Year 1 Attestation)

Please verify the following information:

CMS/NIR:

Applicant National Provider Index (NPI):	1231231231	Name:	Jane Doe
Applicant TIN:	131313131	Address 1:	123 OAK STREET
Payee National Provider Index (NPI):	1414141414	Address 2:	
Payee TIN:	151515151	City/State:	CHICAGO / IL
Program Option:	MEDICAID	Zip Code:	60030 -2289
Medicaid State:	IL	Phone Number:	(312) 904-9494
Payment Year:	1	Email:	JDOE@GMAIL.COM
Provider Type:	Physician	Specialty:	<input type="text" value="INTERNAL MEDICINE"/>

Medicaid Provider Data

Mailing Address:

Address 1:	Medicaid Provider Type:	<input type="text" value="Physician"/>
Address 2:		
City / State:		
Zip code:	Please give the name of the person who assisted you:	

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Illinois Medicaid Program for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

All * fields are required fields.

Initials: *

NPI: *

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

The provider enters his/her initials and NPI on the bottom of the Attestation Screen to complete the Illinois Medicaid EHR Incentive Program Attestation process. By completing this step of the registration process, the provider will have attested to the validity of all data submitted for consideration by the Illinois Medicaid EHR Incentive Program. Once the provider submits this data on the screen, the registration process is completed, and the provider may logout of the application.

Registration (Eligible Hospitals)

Hospitals will be required to provide details including patient volume characteristics, EHR details, growth rate and Medicaid. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual). They will first register with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>.

The hospital provider then begins the Illinois Medicaid EHR Incentive Program registration process by accessing the MEDI system at <https://secure.myhfs.illinois.gov/login/AuthenticateUserRoamingEPF.html>

Eligible Hospital Sign-in Screen

Providers will need to click on the EHR / Provider Incentive Payment Program Link and enter the NPI registered on the CMS Registration Module and the CMS-assigned Registration Identifier that was returned by the CMS registration. If the data submitted by the provider matches the data received from the CMS Registration Module, the Home page for the Illinois EHR Incentive Program will be displayed. If the provider entry does not match, an error message with instructions will be returned.

Eligible Provider Home Screen

The Home screen will give the EH data about their current IL Attestation as well as provide navigation for the EH to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment.

Electronic Health Record
Provider Incentive Program

Home (Year 1 Attestation)

Announcements And Messages
No Announcements and Messages !

Issues/Concerns
Clicking the below link will redirect you to the Issues/Concerns page, where you will be able to submit any issues and view the responses received from HFS.
[Click Here](#)

Provider Information
You are currently enrolled in Illinois' EHR Incentive Program.
Payment Year '1' is your current year attestation.
The current status of your application for the year 1 payment is 'AWAITING PROVIDER ATTESTATION'.

Provider Status Flow

```

    graph LR
      A[CMS Registration] --> B[Preliminary Verification]
      B --- C[Completed]
  
```

Provider Attestations

Payment Year	Status	AttestationID	Action
1	PreCheck_Completed	-	Begin/Modify Attestation

There are 5 sections to the Home page listed below:

1. **Messages and Announcements** – This will be the first section on the page if a message or announcement exists for the provider.
2. **Issues/Concerns** – This will be the second section on the page. The Issues / Concerns will provide a link for the provider to redirect to the Issues / Concerns page if he would like to submit a new issue or view a response to an issue.
3. **Provider Information** – This is the third section of the home page. The provider information will give the high level status for the provider, the current payment year and the current status for the payment year.
4. **Provider Status Flow** – this is the fourth section of the home page. The Provider Status Flow will give a diagram showing the provider where he is in the current year's attestation. If the provider has been found not eligible for any reason, he will also find the specific reasons for that finding in this section.
5. **Provider Attestations** – this is the fifth section of the home page. The Provider Attestation table will list the providers attestations by payment year and list the navigation actions he has available for each.

Eligible Hospital CMS/NLR Screen

Provider CMS Registration Data	
*** If any of this information is incorrect, please correct on the CMS Registration Module	
Applicant National Provider Index (NPI): 777777777	Name: TEST CLINIC HOSPITAL
Applicant TIN: 777777777	Address 1: 3 BOO Ave.
Payee National Provider Index(NPI):	Address 2:
Payee TIN:	City/State: Owenton / KY
Program Option: DUALY_ELIGIBLE	Zip Code: 40359 -1502
Medicaid State: KY	Phone Number: 5025640105
Provider Type: Acute_Care_Hospitals	Email: amy.sanders@ky.gov
Participation Year: 2	Specialty: CRITICAL ACCESS HOSPITAL
Federal Exclusions: None	State Rejection Reason: None

Along with the pre-populated data from the CMS Registration Module there are additional fields that can be updated by the provider.

The data provided by the CMS Registration Module is view only. If any of this data is incorrect then the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected in the screen above. The fields that are from the CMS registration are listed below:

- **Applicant National Provider Index (NPI)** – This is the eligible hospital or CAH’s registering NPI. The NPI registered at CMS should be the same NPI that is enrolled in IL Medicaid.
- **Applicant TIN** – This is the Tax Identification Number that was listed in the CMS registration. This TIN should be the same TIN that is listed for the provider under IL Medicaid.
- **Payee National Provider Index (NPI)** – This is the payee NPI given during the CMS registration.
- **Payee TIN** – The Tax Identification Number associated with the payee NPI.
- **Program Option** – This is the program option that was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.
- **Medicaid State** – This is the State that was selected during the provider’s registration.
- **Provider Type** – This is the provider type that was given during the registration at CMS.
- **Participation Year** – This is the provider’s participation year with the EHR Incentive Program
- **Federal Exclusion** – This will list any federal exclusion found on the provider if any during registration with CMS.
- **Name** – The Provider’s name listed on the CMS Registration
- **Address 1** – The provider’s street address listed on the CMS registration
- **Address 2** – The provider’s street address listed on the CMS registration
- **City/State** – The provider’s city/state listed on the CMS registration
- **Zip Code** – The provider’s zip code listed on the CMS registration
- **Phone Number** – The provider’s phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.

- **Email** – The provider’s email given during the CMS registration. This email address is used for system generated emails on updates for the provider’s attestation and communication from the EHR review staff.
- **Specialty** – The provider’s specialty listed in the CMS registration.
- **State Rejection Reason** – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

Hospital Eligibility Details Screen

Hospital Eligibility Details (Year 1 Attestation)

All * fields are required fields.

Patient Volume:	1. For which program year are you applying?	*	2012	
	2. Select the starting date of the 90-day period(in the prior FFY) to calculate Medicaid patient volume percentage:	*	5/5/2011 (mm/dd/yy)	
	3.(i) Medicaid Inpatient Discharges during this period:	*	5	
	(ii) Medicaid ER/other Discharges (requires attestation):	*	5	
	(iii) Total Medicaid patient discharges during this period:	*	10	
	4. Total patient discharges during this period:	*	11	
	5. Medicaid patient volume percentage:		90.91%	
EHR Details:	6. Enter the CMS EHR Certification ID of your EHR:	*		What is this?
	7. Indicate the status of your EHR:	*	<input type="radio"/> Adopt <input checked="" type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User	
Growth Rate:	8. Select the end date of the hospital's most recently filed 12-month cost reporting period:	*	5/5/2011 (mm/dd/yy)	
	9. Total number of discharges that fiscal year:	*	10	(w/s S-3, part I, col. 15, line 14)
	10. Total number of discharges one year prior:	*	20	
	11. Total number of discharges two years prior:	*	30	
	12. Total number of discharges three years prior:	*	10	
Medicaid Share:	13. Total Medicaid inpatient bed days (Exclude Nursery beds):	*	15	(w/s S-3, part I, col. 7, line 14)
	14. Total Medicaid HMO inpatient bed days (Exclude Nursery beds):	*	18	(w/s S-3, part I, col. 7, line 2)
	15. Total inpatient bed days:	*	50	(w/s S-3, part I, col. 8, line 14)

As shown above, hospitals must enter four categories of data to complete the Eligibility Details screen including patient volume characteristics, EHR details, growth rate, and Medicaid share. Providers will enter the following data on the screen:

- **Patient volume**
 - Select the program year for which you are applying. An EH may attest for a given program year until the December 31st following the end of that Federal Fiscal Year(10/1 – 9/30).
 - Starting date of the 90-day period to calculate Medicaid patient volume percentage. This should be a 90 day period that is within the Federal Fiscal year prior to the one selected as the program year.
 - Total Medicaid Inpatient Discharges during this period
 - Total Medicaid ER/Other Discharges during this period
 - Total Medicaid patient discharges during this period – Automatically calculated by adding the 2 entries above.
 - Total patient discharges during the period
 - Medicaid patient volume percentage (calculated)
- **EHR details**

- EHR certification ID of EHR
 - Status of your EHR – Choices:
 - **(A) Adopt** - Acquire, purchase, or secure access to certified EHR technology
 - **(I) Implement** - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
 - **(U) Upgrade** - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria
- Meaningful User** – An Eligible Hospital or CAH, for an EHR reporting period for a payment year, demonstrates the meaningful use of a certified EHR technology by meeting the applicable objectives and measures under 42 CFR 495.6.

▪ **Growth rate**

- End date of the hospital’s most recently filed 12-month cost reporting period (must be within FFY preceding the incentive program year)
- Total number of discharges that fiscal year
 - CMS 2552-96 (Worksheet S-3 Part 1, Column 15, Line 12); or
 - CMS 2552-10 (Worksheet S-3 Part 1, Column 15, Line 14)
- Total number of discharges one year prior
 - CMS 2552-96 (Worksheet S-3 Part 1, Column 15, Line 12); or
 - CMS 2552-10 (Worksheet S-3 Part 1, Column 15, Line 14)
- Total number of discharges two years prior
 - CMS 2552-96 (Worksheet S-3 Part 1, Column 15, Line 12); or
 - CMS 2552-10 (Worksheet S-3 Part 1, Column 15, Line 14)
- Total number of discharges three years prior
 - CMS 2552-96 (Worksheet S-3 Part 1, Column 15, Line 12); or
 - CMS 2552-10 (Worksheet S-3 Part 1, Column 15, Line 14)
- Average annual growth rate (calculated)

▪ **Medicaid share**

- Total Medicaid inpatient bed days excluding Nursery Bed days
 - CMS 2552-96 (Worksheet S-3, Part I, Column 5, Line 1 + Lines 6-10); or
 - CMS 2552-10 (Worksheet S-3, Part I, Column 7, Line 1 + Lines 8-12)
- Total Medicaid Health Maintenance Organization (HMO) inpatient bed days excluding Nursery Bed days
 - CMS 2552-96 (Worksheet S-3, Part I, Column 7, Line 1 + Lines 8-12); or
 - CMS 2552-10 (Worksheet S-3, Part I, Column 7, Line 2)
- Total inpatient bed days (Please note per CMS FAQ nursery days are excluded from inpatient bed days)
 - CMS 2552-96 (Worksheet S-3 Part 1, Column 6, Line 1, 2 + Lines 6 -10); or
 - CMS 2552-10 (Worksheet S-3 Part 1, Column 8, Line 1, 2 + Lines 8 – 12)
- Total hospital charges
 - CMS 2552-96 (Worksheet C Part 1, Column 8, Line 101); or
 - CMS 2552-10 (Worksheet C Part 1, Column 8, Line 200)
- Total uncompensated care charges
 - CMS 2552-96 (Worksheet S-10, Column 1, Line 30); or
 - CMS 2552-10 (Worksheet S-10, Column 3, Line 20)
- Estimated total payment (calculated)

Document Upload Screen

HFS.Illinois.gov | Contact Us | Illinois Home MEDI Home | Welcome, Jane.Doe | Logout

EHR INCENTIVE PROGRAM **Electronic Health Record Provider Incentive Program** **iHFS ILLINOIS DEPARTMENT OF Healthcare and Family Services**

Governor Pat Quinn

[Home](#) [View All Payment Years](#) [Issues/Concerns](#) [Appeals](#) [Additional Resources](#) [User Manual](#)

Document Upload (Year 1 Attestation)

Documentation needed to process your application may be attached below. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc. If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation. **Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.**

Payment Year	File Name	Description
No uploaded document found.		

Upload a new PDF document:

Please select the documentation type:

--Select the type of a document--
--Select the type of a document--
Receipt
Purchase Order
Invoice
Lease
License
Cost Reports
Patient Volume
Miscellaneous

Please upload the following files:

1. Proof of Certified Electronic Health Record Adoption, Implementation, or Maintenance
 - Contract
 - Software license
 - Receipt or proof of acquisition
 - Purchase order
 - Receipt for Training – evidence of cost or contract
 - Hiring of staff to assist with the implementation – payroll records for the staff hired
2. (Required only if you are attesting to Meaningful Use) Proof of compliance with the Public Health measure "Capability to submit electronic data to immunization registries or immunization information systems and actual submission according to applicable law and practice"
 - Public Health iCare registry email stating that the provider has attempted a test of the EHR capabilities

This screen allows the Eligible Hospitals to attach supporting documentation for their attestation. PDFs up to 100MB may be uploaded.

Documentation needed to process your application may be attached using the screen above. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance. Please provide proof of certified technology being attested for your practice or facility. This can be a contract, invoice, purchase order, etc. If you are attesting to Meaningful Use Measures, please provide documentation on your testing with other entities as well as documentation supporting your Public Health Measure response. Patient Volume documentation is not required but if you are using Medicaid patients from multiple states you could be requested to provide additional documentation. **Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.**

After EPs and EHs have completed the Eligibility Details screens and press “Next,” navigation will take them to the Attestation screen below.

Attestation Screen

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Illinois Medicaid Program for this year.

This is to certify that the foregoing information is true, accurate, and complete. I understand the Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

All * fields are required fields.

Initials: *

NPI: *

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

After submitting the initials and NPI, your attestation is complete.

Issues/Concerns Screen

HFS.Illinois.gov | Contact Us | Illinois Home MEDI Home | Welcome, Jane.Doe | Logout



Electronic Health Record Provider Incentive Program

Governor Pat Quinn

[Home](#) [View All Payment Years](#) [Issues/Concerns](#) [Appeals](#) [Additional Resources](#) [User Manual](#)

Issues/Concerns (Year 1 Attestation)

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

View Issue	Date Entered	Issue/Concern Status	Issue/Concern Description	Issue Category
<input type="button" value="Select"/>	2/28/2013 1:33:13 PM	Open	How do i calculate	Patient Volume <input type="button" value="Delete"/>

Enter the issue/Concern below:

Issue Category:

-
-
-
-
-

Description:

Meaningful Use

Please see the Meaningful Use manuals for EP and EH for information specific to attesting for Meaningful Use. The Links for these manuals are listed below. You may also find additional information on Core and Menu Measure details at the CMS sites listed below:

- Eligible Hospital Meaningful Use Manual – **Coming** Soon
- Eligible Professional Meaningful Use Manual - **Coming** Soon
- **EP Core and Menu Meaningful Use Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet Meaningful Use measure per Measure. Provides Definitions and FAQs per measure. - <http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf>
- **EH/CAH Core and Menu Meaningful Use Measure Specifications** – Provides additional detailed data to assist the provider in understanding how to meet Meaningful Use measure per Measure. Provides Definitions and FAQs per measure. - http://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CAH_MU-TOC.pdf