



Frequently Asked Questions & Answers



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I – Provider Eligibility for EHR Incentive Payments

Q I-1: Who is **eligible to participate** in the TennCare Medicaid EHR Provider Incentive Program?

A I-1: An **Eligible Professional (EP)** is a

- Physician (Medical or Osteopathic)
- Dentist
- Nurse Practitioner
- Certified Nurse Midwife
- Physician’s Assistant (PA) who practices in an FQHC led by a PA, or in an RHC so led by a PA.

An **Eligible Hospital (EH)** is

- An Acute Care Hospital
- A Critical Access Hospital (CAH)
- A Children’s Hospital

Q I-2: What is a **Hospital-Based Eligible Professional**?

A I-2: An EP is considered “hospital-based” when he provides substantially all of his professional services in a hospital setting. “Substantially all” is defined as 90% or more of the EP’s professional services are performed in a hospital setting (patients seen as an inpatient (POS 21) or emergency department (POS 23)).

Q I-3: What does it mean to **Practice Predominately in an FQHC/RHC**?

A I-3: An EP is considered to “practice predominately in an FQHC/RHC” when over 50% of his total encounters over a period of six (6) months in the most recent calendar year are provided in an FQHC or RHC.

Q I-4: A Physician’s Assistant (PA) is only eligible to participate in the EHR Incentive Program if he works in an FQHC that is led by a PA or an RHC **so led** by a PA. What does “**so led**” mean?

A I-4: An FQHC/RHC is “so led” by a PA when:

- A PA is the primary provider in the clinic (for example, when there is a part-time physician and full-time PA, CMS considers the PA as the primary provider); or
- A PA is a clinical or medical director at a clinical site of practice (being the director of a department **within** the FQHC/RHC does not qualify the PA as being the lead); or
- A PA is the owner is an RHC.

Q I-5: I am a **pediatrician**, but my Medicaid patient volume is 35%. Am I eligible for the full incentive payment or will I still receive only the reduced incentive amount?

A I-5: Any EP, including pediatricians, whose Medicaid patient volume is equal to or exceeds 30% is eligible for the full EHR incentive payment. Pediatricians whose patient volume is equal to or greater than 20%, **but less than 30%** are eligible for a reduced incentive payment equal to two-thirds of the full incentive payment.

Q I-6: What if I choose **not to** participate in the EHR Incentive Program? Will my TennCare Medicaid reimbursements be reduced?

A I-6: If an EP chooses not to participate in the EHR Incentive Program, his **TennCare Medicaid** reimbursements **will not** be reduced. However, EPs who are **Medicare** providers and choose not to acquire and use certified EHR technology **will** see their **Medicare** reimbursements reduced beginning in 2015.

II – Determination of EHR Incentive Payments

Q II-1: Can an EP receive both the **TennCare Medicaid EHR Incentive Payment** and the **Medicare EHR Incentive Payment**? What about an EH?

A6: No, EPs may receive an EHR Incentive Payment from either TennCare Medicaid or Medicare, but not both in the same year. EPs can switch between the TennCare Medicaid and Medicare incentive programs one time. The last year for making an incentive program switch is calendar year 2014.

Payments are tracked by CMS to ensure that duplicate payments are not made.

EHS **can** receive EHR incentive payments from both the Medicare and the Medicaid EHR Incentive Programs, **IF** the hospital enrolled **initially** as a dually eligible hospital on the CMS Registration & Attestation System web site.

Q II-2: I participate in the TennCare Medicaid program and the **Medicaid program of another state**. Can I receive an EHR Incentive Payment from both states?

A II-2: No, providers (EPs & EHs) can only receive an EHR Incentive Payment from one state in a program year. A provider can switch between the state programs in which he chooses to participate.

QII-3: What is a **payment year for hospitals**?

A II-3: Hospital payment years are based on the federal fiscal year (FFY). The Federal Fiscal Year runs October 1 to September 30 of the next year. The patient volume qualifying period for an EH must be a 90-day period in the previous FFY.

Q II-4: How is an EHR Incentive **payment assigned** (regarding groups)?

A II-4: For EPs, the EHR Incentive is based on individual EPs. However, during enrollment at the CMS Registration & Attestation System web site, the provider has the ability to direct where the payment is to be made. It can be made directly to the provider or to the group practice or clinic in which he is a member.

Q II-5: What if our group/clinic hires a provider in mid-2011, and this provider has already received an EHR Incentive payment through his previous group? Can we apply for this new (to us) provider in 2011 and still receive an incentive payment for this provider? How do we ensure that the previous group does not get the incentive payment for this provider in 2012?

A II-5: This new provider to your practice cannot receive an additional incentive payment in 2011. Each EP may be eligible to receive an incentive payment once per year for the duration of the program. An EP may retain the payment or assign the incentive payment to the group.

Once the new provider starts working at a new practice, he would need to update this information at the CMS Registration & Attestation System web site to reflect the new practice prior to the 2012 attestation. Every year, EPs are required to validate and attest to EHR program criteria.

Payments are tracked by CMS to ensure that duplicate payments are not made.

III – Understanding Adopt, Implement, and Upgrade, and Meaningful Use

Q III-1: I hear the term **Adopt, Implement, and Upgrade** in reference to a certified EHR system. What does that mean to me?

A III-1: EPs and EHs who meet minimum patient thresholds qualify for the first year TennCare Medicaid incentive payment by demonstrating they have adopted, implemented, or upgraded (AIU) to certified EHR technology – either a complete system and/or module(s).

- **Adopt** – means the provider has acquired and installed EHR technology (must show evidence of acquisition & installation)
- **Implement** – a provider has commenced utilization of certified EHR technology (staff training, data entry of patient data, data use agreements, etc.)
- **Upgrade** – A provider has expanded the functionality of a current system (with certified modules; Version 2.0, etc.)

Q III-2: What **documentation or proof of AIU** must I show?

A III-2: EPs & EHs are required to submit proof that they have adopted, implemented, or upgraded (AIU) to certified EHR technology. The following is acceptable documentation for such proof.

- A copy of the page of a contract or lease showing the provider, vendor, and name of the certified EHR technology **and** a copy of the dated signature page. **Do not send the entire contract or lease.**
- If your contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of the EHR technology being acquired and proof of payment.
- A signed and dated letter on the vendor's letterhead showing the provider and the name of the certified EHR technology provided, including version, if appropriate.
- If using a free on-line certified EHR system, the provider must provide a vendor letter proving agreement to use the system.

TennCare does not accept documentation of a previously purchased/leased electronic system as proof of AIU. Providers must submit documentation that such a system has been **upgraded** to a certified EHR system. [For example, proof of a system purchased in 2005 is not proof of AIU. What is required is proof (receipt, invoice, proof of payment, vendor letter, etc.) that this system was upgraded to a certified EHR system in 2010 or after.] Additionally, bids or proposals are not acceptable as documentation.

A screenshot of CHPL showing a certified EHR system and/or module(s) **is not** sufficient documentation of proof of AIU. If you have a question about what is acceptable documentation, please contact the TennCare/Medicare EHR Program staff at TennCare.EHRIncentive@tn.gov.

Q III-3: What is **Meaningful Use**?

A III-3: "Meaningful Use" (MU) of certified EHR technology is that which attains specific procedural and clinical benchmarks. For the first year of an EP's or EH's participation in the TennCare Medicaid EHR Provider Incentive program, attesting to MU is **not** required. EPs and EHs are only required to demonstrate AIU (see above). Beginning in the second payment year of an EP's/EH's participation, demonstration of MU is required. Visit the [Meaningful Use Overview](#) to learn more about the MU criteria and access resources to plan years of successful attestation.

IV – Calculating Patient Volume

Q IV-1: What defines a **Paid Medicaid Encounter** for EPs when determining patient volume?

A IV-1: A "paid Medicaid encounter," for determining EP patient volume, means services rendered on any one day to an individual where TennCare Medicaid paid for part or all of the services, or TennCare Medicaid paid part or all of the individual's cost sharing. All services rendered on a single day to a single

individual by a single EP counts as one encounter. If the individual receives services from another EP who is a part of the same group, each EP can count his services provided as a separate encounter.

Individuals receiving assistance from CHIP (CoverKids) **do not** count toward the Medicaid patient volume.

Q IV-2: How is a Paid Medicaid Hospital Encounter defined?

A IV-2: When calculating hospital patient volume (acute care and critical access hospitals [CAH]), paid TennCare Medicaid hospital encounters are defined as

- Services rendered to an individual per inpatient discharge where Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act [TennCare]) paid for part or all of the service; or
- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act [TennCare]) paid all or part of the individual's cost-sharing; and
- Services rendered to an individual in an emergency department on any one day where Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act [TennCare]) paid for part or all of the service; or
- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Act [TennCare]) paid all or part of the individual's cost sharing.

Children enrolled in CHIP (CoverKids) **do not** count toward the Medicaid patient volume criteria.

Q IV-3: Can Medicaid be the secondary insurer when determining total Medicaid patient encounters?

A IV-3: When calculating an EP's or EH's Medicaid patient encounter, TennCare Medicaid must pay for all or part of the services or pay all or part of the individual's cost sharing. When the primary insurer (commercial insurance, Medicare, etc.) pays as much or more than TennCare Medicaid would, TennCare Medicaid pays the claim at zero dollars (the claim is considered paid by TennCare). If TennCare Medicaid denies the claim, then the encounter **cannot** be counted in the Medicaid encounter.

When calculating the EP's patient volume at an FQHC/RHC, TennCare Medicaid must pay for all or part of the service rendered to the Needy Individual (see below), or all or part of the Needy Individual's cost sharing, **unless** the service is offered to an individual at no cost or at a reduced cost based on a sliding scale determined by the individual's ability to pay.

Q IV-4: If an EP wants to **leverage a clinic's or group practice's patient volume as a proxy** for the individual EP's patient volume, how should a clinic or group practice account for EPs practicing part-time and/or applying for the incentive through a different location? (That is, where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics.)

A IV-4: EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:

- (1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- (2) There is an auditable data source to support the clinic's patient volume determination; and
- (3) As long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while other use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such an EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from Clinic A in calculating his or her individual patient volume.

CLINIC A (with a fictional EP and provider type)

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

Totals:

- ✓ 1,200 encounters in the selected 90-day period for Clinic A
- ✓ 415 encounters attributable to Medicaid – 35% of the clinic's volume

This means that five (5) of the seven (7) professionals would meet the Medicaid patient volume under the rules of the EHR Incentive Program. Two (2) of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included. (The Registered Nurse and Pharmacist are not EPs for the EHR Incentive Program as defined by CMS.)

Q IV-5: Can I count **out-of-state Medicaid patient encounters in the patient volume threshold?**

A IV-5: Out-of-State Medicaid encounters can be counted; however, if you include them in the numerator, they must be included in the denominator. In the attestation process, you are asked if you are including out-of-state Medicaid encounters in your calculation. If so, we ask that you give us the state, number of encounters, and your Medicaid ID number for that state. This applies to both EPs and EHs.

Q IV-6: Who is considered as a **Needy Individual?**

A IV-6: A Needy Individual is an individual who meets **any** of the following three criteria:

- One who is receiving medical assistance from TennCare Medicaid or CHIP (CoverKids); or
- One who is furnished uncompensated care by the provider; or
- One who is furnished services either at no cost or at a reduced cost based on a sliding scale determined by the individual's ability to pay.

The inclusion of Needy Individuals in the threshold calculation applies **only** to meeting the patient volume requirements for EPs practicing predominately in FQHCs or RHCs. All services rendered on a single day to a single individual by a single EP counts as one encounter. If the individual receives services from another EP practicing in the same FQHC or RHC on the same day counts as an encounter for each EP.

Q IV-7: What makes up the **numerator and **denominator** used to determine the patient volume ratio?**

A IV-7: EPs must have a Medicaid patient volume of 30% or more (20% for pediatricians) in the qualifying period of 90 consecutive days in the previous calendar year to qualify for an EHR incentive payment.

EHs must have a Medicaid patient volume of 10% or more in the qualifying period of 90 consecutive days in the previous federal fiscal year. Children's hospitals **do not** have a minimum patient volume requirement.

The **numerator** = total number of paid Medicaid encounters in the qualifying period.

The **denominator** = total number of all paid encounters regardless of payer in the qualifying period.

V – Audit Information

Q V-1: Are EHR incentive payments subject to audit after the payment has been received?

A V-1: Yes. The Division of Audit & Investigations within the Bureau of TennCare is responsible for performing audits of payments made to providers who have qualified for the EHR incentive payment.

All payments are potentially subject to audit.

Q V-2: Who is subject to EHR incentive payment audits?

A V-2: Any Eligible Provider (EP) or Eligible Hospital (EH) that has received an EHR incentive payment is subject to being audited.

Q V-3: How will I know if I am being audited?

A V-3: You will receive a Notification of Onsite Audit from the Bureau of TennCare Division of Audit & Investigations in the form of an email or a letter. You or a representative will be asked to respond within two weeks of the date of the notification with a time that is convenient for you or a representative to meet with the auditor(s).

Q V-4: Where will the audits take place?

A V-4: The audits will be conducted on-site where the EHR system of the Eligible Provider (EP) or Eligible Hospital (EH) is located.

Q V-5: What will be reviewed during an audit?

A V-5: You or a representative will be required to supply the documentation used to complete your application for Adopt, Implement, Upgrade (AIU) and/or Meaningful Use (MU) payment(s). Types of documentation to support your patient volume data may include an appointment book, EHR system report(s), etc. Audit will also physically inspect your certified EHR system and/or vendor contract.

Q V-6: If I am audited in one year, am I automatically subject to being audited for another payment year?

A V-6: No. However, all payments made to providers are potentially subject to audit each year a payment is received. An audit in one year does not automatically subject a provider to audit in future payment years.

Q V-7: What happens after an on-site audit is conducted?

A V-7: You will receive a notification regarding the results of the audit. In the event of a finding, the notification will have contact information and instructions for the next steps in the process.

Q V-8: If I disagree with the audit findings, what should I do and whom should I contact?

A V-8: The notification you receive will provide instructions and contact information regarding disputes with audit findings.

Q V-9: If I am being audited for Adopt, Implement, or Upgrade (AIU), will this affect my ability to attest to Meaningful Use (MU) criteria?

A V-9: No. If you are being audited for your AIU payment, you may still attest to MU.