ELIGIBILITY

EP1. Can specialists participate in the incentive program?

Yes, if they meet program criteria and if they are an eligible provider type:

- Physician
- Dentist
- Nurse Practitioner
- Certified Nurse Midwife
- Physician Assistant (PA) in federally qualified health centers (FQHCs) or rural health clinics (RHCs) that are led by a PA

EP2. Can physicians at rural health clinics (RHCs) qualify for incentive payments?

Yes. Physicians that work at an RHC or FQHC are eligible and can receive incentives if they meet volume, meaningful use, and all other requirements associated with an FQHC or RHC.

See the Prerequisite Document for steps to take and information needed in order to participate in the incentive program.

EP3. Why are PA’s and NP’s treated differently? Who determined the difference?

Provider types were specified in the legislation.

EP4. How do you define “clinical director” of an FQHC or RHC? If a PA is a clinical director of QI (Quality Improvement), would the PA qualify for the EHR incentive?

PAs in FQHCs and RHCs are eligible for the incentive program if that FQHC or RHC is led by a PA who serves as one of the following:

- Clinical or medical director,
- Owner, or
- Primary provider at that location.

EP5. We have 9 Adolescent Primary care and Mental health Clinics in Galveston County, Texas. They don't operate under UTMB Hospital Systems but the Community Based Mental Health Department of UTMB. Would we be eligible and what would we need to produce?

Yes. The providers in these clinics may be eligible under the eligible professional (EP) program if they meet all the program requirements.

See the Prerequisite Document for steps to take and information needed in order to participate in the incentive program.
EP6. *I am an optometrist. Am I considered a physician in Medicaid to apply for EHR incentives?*
Yes. An Optometrist is considered an eligible provider type.

EP7. **How is hospital-based defined?**
Any provider who furnishes more than 90% of their services in the following place of service (POS) codes:
- Inpatient Hospital (POS 21) – a facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians, to patients admitted for a variety of medical conditions.
- Emergency Room (POS 23) – a portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
The determination of whether or not an EP is hospital-based is determined individually for each EP.

EP8. **Is an orthodontist the same as a dentist for purposes of the EHR incentive program?**
Yes. An orthodontist is considered a dental provider and is eligible for the incentive program if s/he is a DDS.

EP9. **I am a dentist and am part owner of three separate dental offices, which are set up as a PA type of corporation. I am a Medicaid performing provider in each of the three group dental offices. Can I apply three times, one for each business?**
You can only apply once because the NPI is tracked to the individual EP.

**SWITCHING PROGRAMS**

EP10. **If you qualify for the Medicaid Incentive Program the first year, but not the second, can you switch to the Medicare Incentive Program in year two and beyond?**
Yes, you can switch to Medicaid or Medicare once during the life of the program. However, after you have switched, you will not be able to change programs again. Furthermore, for Medicare, you will have to attest to the more robust meaningful use criteria for that program calendar year.

**OUT OF STATE**

EP11. **Can we count out-of-state Medicaid patient encounters in the patient volume calculation?**
Out-of-state Medicaid volumes can be counted; however if you include them in the numerator, they must be added in the denominator. You may be asked to produce reports to substantiate out-of-state encounters for patient volumes.
PATIENT VOLUME

EP12. What claims / encounters should I count in my patient volume?
All services paid in full or part by Medicaid – including fee-for-service, PCCM, and Managed Care – can be included in patient volume calculations. The denominator includes all encounters.

If you work in an FQHC / RHC, your patient volume threshold is 30%. You can include Needy Individuals (Medicaid, CHIP, uncompensated care, and no cost / reduced cost based on a sliding scale) in the numerator and the denominator.

See the Prerequisite Document for steps to take and information needed in order to participate in the incentive program.

EP13. Does Medicaid secondary apply to determine the 30% (20% for pediatricians) Medicaid patient volume?
Yes. As long as Medicaid pays a portion of each encounter.

EP14. To determine patient volume percentage, can we choose the option we’ll base our calculations upon? What is the difference between my MCO Assigned and the Total MCO Assigned?
Yes you can choose from the panel or encounter calculation.

The MCO Assigned will be added in to the numerator and the Total MCO Assigned will be the denominator.

See the Prerequisite Document for steps to take and information needed in order to participate in the incentive program.

EP15. Are we counting visits or patients in the patient volume calculation?
This depends on the methodology chosen to calculate patient volumes:
- **Encounter Option**: All Medicaid patient encounters over three full consecutive months (as a percentage of total patient encounters).
- **Panel Option**: All Medicaid encounters (using the Encounter Option above) plus any Medicaid patients in your panel not already included in the Medicaid encounter number with a visit in the last 12 months (as a percentage of total)

See the Prerequisite Document for steps to take and information needed in order to participate in the incentive program.

EP16. Can I start with any month and report the three consecutive months? So I can start March and report March, April, May, or can I start April and report April, May, and June??
Yes. The EP can choose which three consecutive months s/he reports in the previous calendar year. The reporting must start with the 1st day of the first month and end the last day of the 3rd month.
EP17. **What if an EP does not have three consecutive months in the previous year (i.e., new provider)?**

Beginning in 2013, providers can use a consecutive 3-month/90 day volume reporting period from the previous calendar year or the most recent 12 month period prior to the date of attestation.

EP18. **Can you tell me if WHP (Women’s Health) patients qualify as “Medicaid Patients”?**

Yes, as long as Medicaid pays part or all of the service.

**GROUP PATIENT VOLUME**

EP19. **How do you calculate the Medicaid patient encounters when reporting as a group? Do you use the number of encounters for the group or each provider?**

See the [Prerequisite Document](#) for steps to take and information needed in order to participate in the incentive program.

EP20. **On the ENROLLMENT tab, Step 1: Do you use the group practice’s TAX ID?**

If you will be using a group patient volume as a proxy for your individual patient volume, then select Group and enter the Group TPI.

See the [Prerequisite Document](#) for steps to take and information needed in order to participate in the incentive program.

EP21. **Does the EHR incentive program apply to individual providers or only to a group provider (per office)?**

The Medicaid Incentive Program applies to individuals, but those individuals may be eligible based on their individual volumes or that of a group (if they belong to one). Individuals who belong to a group will decide with their group if they will be participating individually or as a group.

See the [Prerequisite Document](#) for steps to take and information needed in order to participate in the incentive program.

EP22. **I have a group practice. How will I register and enroll the physicians in the group?**

When setting up a group, all participating members must agree to attest to patient volume as a group. All eligible providers that are to be part of the group must be registered with CMS for the EHR Incentive program.

To be eligible to receive the incentive, all eligible practitioners in the group / clinic must have some Medicaid client encounters during the period of time being attested to.

When calculating both the numerator and denominator, all Medicaid encounters are considered for every practitioner in the group / clinic regardless of whether the practitioner is eligible for the incentive program.

If an eligible professional (EP) chooses not to participate in the group / clinic, the encounters generated by that EP are still used in the calculation for that particular group / clinic. The EP cannot use those encounters for calculating volumes for another practice or individually.
See the Prerequisite Document for steps to take and information needed in order to participate in the incentive program.

**EP23. If we are a group practice and over 30% of our patients have Medicaid, can we register all of our physicians for the EHR Incentive Program, or should each one of them meet the requirement of at least 30% (20% for pediatricians) Medicaid patient volume?**

You may want to consider both options to determine which approach is most beneficial.

See the Prerequisite Document for steps to take and information needed in order to participate in the incentive program.

**EP24. At our institution, we have family medicine, pediatrics, OG/GYN, Internal Medicine and Surgery. We intend to attest using group volumes. Have I interpreted 'group' appropriately?**

Yes, as long as all eligible participating providers attest as a group. See also EP23.

See the Prerequisite Document for steps to take and information needed in order to participate in the incentive program.

**EP25. How is payment assigned (regarding groups)?**

Each individual provider is able to assign payment to a valid TPI payee of their choice.

**EP26. We are a group and have a PA as part of the group. She is enrolled with CMS as a performing provider. Can we include the PA’s encounters with the MD, when looking at volume?**

If your group will be using the group patient volume methodology as a proxy for the EPs in the group, all Medicaid encounters can be used, even encounters with non-eligible providers.

However, PAs are restricted to certain criteria. They must work at an FQHC or RHC to be eligible to participate. Also, the facility must be “so led” by a PA: the primary provider for the clinic, a clinical or medical director at the clinic, or an owner of an RHC.

**EP27. If some of the providers in our group joined in December 2010, how do we pick the three month period from the previous year?**

If the providers in your group will be using group patient volume as a proxy for individual patient volumes, then the three month period selected must include some Medicaid volume from all the group’s practitioners.

Please also see EP23.

**EP28. If payments are assigned over to a medical group, what happens when physicians transfer in or out of the practice during the reporting period?**

Every year, each individual provider must log into the Texas enrollment portal to attest and assign payment. They can change payment assignment designations each year if they wish.
EP29. *If the physicians apply as a group, does each individual physician need a “my account” sign on for TMHP?*

Yes. Each EP needs a login account with TMHP in order to attest to the group’s volumes and assign payment. Contact TMHP if you require a login.

EP30. *Is there any way to log in and enroll on behalf of providers in a group practice? Can the lead enroller be a non-provider?*

A group’s lead enroller can be a non-provider and can enroll all members in the group. However, it is then up to the individual members of the group to annually log in, attest to the volume and other information supplied by the lead enroller, as well as confirm payment assignment.

EP31. *Am I correct that in a group practice with physician employees, the incentive payments go to the physicians even though the practice paid all costs for the certified EHR?*

The Medicaid Incentive Program applies to individuals, but those individuals have the opportunity to designate who receives the incentive payment. This Payment Assignment designation is done in the enrollment portal and can be updated each year.

See the [Prerequisite Document](#) for steps to take and information needed in order to participate in the incentive program.

EP32. *What if we hire a provider in mid 2011 and this provider got payment via another practice in 2011? Can we apply for this new (for us) provider in 2011 and get paid again? How do we ensure that the previous practice does not get the $ in 2012?*

The new provider would not be able to receive another payment in 2011. Each eligible provider may be eligible to receive an incentive payment once per year for the duration of the program. The individual provider may retain the payment or assign the payment to the group.

Once the new provider starts working at a new practice, they would need to update information at CMS to reflect the new practice prior to application for 2012 participation. Every year, individual providers are required to validate and attest to program criteria.

The funds will be tracked by the NPI # to ensure duplicate payments aren’t made.

EP33. *We bill everyone via the group. Will the check be sent to the lead provider, or to each provider?*

The payment is on an individual basis, not a group. This is how providers are designated at the CMS level. Payment can be assigned to the group or individuals can retain the payment. Each individual will have the opportunity to select during enrollment how they want to designate their payment.

EP34. *One of the doctors in our practice is listed as a group but she is the ONLY provider in the "group". She has a group TPI and an individual TPI...does she enroll with her group or individual TPI?*

The provider may register with either TPI; however, she should ensure that her NPI is associated with whichever TPI she uses to enroll at the Texas portal level.
The provider should also consider that when registering for the incentive program at CMS, if she assigned payment to a Type I (individual or sole proprietor) NPI, she must use the social security number (SSN). Ensure that TMHP has your SSN on file; contact Support@tmhp-mi.com.

If she assigned payment to a Type II (corporation) NPI, then she must use the organization's Employer Identification Number (EIN). The EIN information must match what is in the CMS NPPES system.

**DOCUMENTATION**

**EP35. What supporting documentation will I need to provide in order to prove AIU?**

The only documentation required for uploading is related to AIU (Adopt / Implement / Upgrade) in Year 1 of participation – the purchase order, contract signature page, or subscription for a certified EHR.

**EP36. Do providers that are currently enrolled with TX Medicaid need to submit their licensure information for the State-level registration? What documentation/information would providers need to have on hand during registration? Attestation?**

If the EP is an enrolled Medicaid provider in good standing, there is no need to submit licensure information.

See the [Prerequisite Document](#) for steps to take and information needed in order to participate in the incentive program.

**EP37. Can all supporting documents be uploaded electronically to the provider portal?**

All supporting documents should be electronically uploaded where noted in the Texas Medicaid EHR Incentive Program portal.

**EP38. Are providers required to prove patient volume with documentation?**

While providers are not required to upload patient volume documentation during the enrollment and attestation process, the State will be verifying volumes and may request documentation at a later date. Providers must retain documentation from auditable sources for six years.

**PROCESS**

**EP39. How do I begin the process?**

See the [Prerequisite Document](#) for steps to take and information needed in order to participate in the incentive program.

**EP40. Once providers register nationally with CMS, what happens next?**

You will receive a communication from the State notifying you that you can start the enrollment and attestation process.

See the [Prerequisite Document](#) for steps to take and information needed in order to participate in the incentive program.
EP41. Where can I find the Medicaid EHR Incentive Program on TMHP.com (sign on for the portal, FAQs, program information, etc.)?

Once at TMHP.com, the provider can click on “Providers” and proceed to “Log Into My Account”. Once logged in using the user ID/password given by NPPES, the provider can then confirm their eligibility, click continue, and proceed to enroll.

See the Prerequisite Document for steps to take and information needed in order to participate in the incentive program.

ADOPT / IMPLEMENT / UPGRADE (AIU)

EP42. If you upgrade in 2011, do you need to report in 2011?

You can start the program anytime between 2011 and 2016. Medicaid providers can receive their first year’s incentive payment for adopting, implementing, or upgrading certified EHR technology, but must demonstrate meaningful use in subsequent years in order to qualify for additional payments.

EP43. We already have an EHR, so will we be adopting, implementing, or upgrading?

Providers can receive the first year of incentives by:

- “Adopting” – Purchasing a certified EHR;
- “Implementing” – Beginning implementation of a previously purchased certified EHR; or
- “Upgrading” – Purchasing or implementing a new and/or upgraded version of a certified EHR.

You must attest to having a certified EHR in order to receive the first year of payment.

EP44. Are early adopters required to demonstrate meaningful use in year 1? If so, how?

Medicaid providers, including early adopters, can receive their first year’s incentive payment for adopting, implementing, or upgrading certified EHR technology, but must demonstrate meaningful use in subsequent years in order to qualify for additional payments.

EP45. When will I need to prove meaningful use?

Meaningful use will need to be demonstrated the second and subsequent years of participation. During a provider’s first year of participation (anytime between 20011 and 2016), they only need to meet the AIU requirement.

RURAL HEALTH CLINICS (RHC)

EP46. RHC has only 1 PA practicing with a physician coming once a month. State and federal regulations for the RHC require a physician Medical Director; can the clinic be determined as PA-led with the PA as the Clinical Director and a physician as the Medical Director to meet the RHC regulations?

Yes. As long as the PA leads the RHC by being one of the following: 1) primary provider in the clinic; 2) a clinical or medical director at the clinic; or 3) an owner of the RHC.
REGIONAL EXTENSION CENTERS (RECs)

EP47. How actively will the four Texas RECs be engaged in enrolling Medicaid-eligible providers in your program? Are we required to register with a REC to get the incentive money?

RECs will provide assistance with EHR selection and implementation. They can be reached at www.txrecs.org. However, it is up to the individual EP to enroll with the REC.

You are not required but encouraged to work with the RECs with technical assistance, meeting meaningful use, etc.

EP48. Enrollment in your Regional Extension Center costs $300 per EP—is that right?

Yes, the cost is $300 for most eligible professionals (EPs). Please contact the REC in your area (www.txrecs.org) to find out more information on services and fees. Pricing may vary based on your specialty.

INCENTIVE PAYMENT

EP49. What can the money be used for? Can we use the money for staff training and paying off debt that we may have incurred in purchasing the system?

The incentive payment can be used at the EP’s discretion.

EP50. How will payments be issued? What PayTo detail will be used? Do providers have the opportunity to confirm their PayTo information during registration/attestation on the Provider Verification page?

An EP can retain payment or assign to a group. This choice is verified each year at the time of enrollment.

During CMS registration, providers will designate payment.

EP51. To help track/distinguish this payment from other Medicaid payments, what Remit Code or Reason Code would be associated with either the ERA/EFT/EOB that may come with the payment? Will such explanation of payment accompany the payment?

This will need to be researched and clarified at a later date.

EP52. Will payment for Year 1 be a lump sum of $21,250? Or will it be in installments? If installments, what may the varying amounts be across what timeframe?

If the EP is eligible for the incentive payment, the first payment will be a lump sum of $21,250.

EP53. Must we spend the money for the electronic health system in the SAME year we receive incentives? Can we purchase system in 2011 and receive incentive in 2012?

The incentive payment is yours to spend as and when you wish as long as you meet the requirements for the payment. Yes, you can purchase a system in 2011 and receive a payment in 2012.
EP54. **What is the payment amount? How is it processed?**

The first year payment amount is $21,250. It is paid out in one lump sum.

**CMS REGISTRATION**

EP55. **Can we begin the national enrolment process while we are still choosing an EHR?**

Yes, you can complete registration at the national level while you are still choosing an EHR. However, during the state enrollment process, you must have, at a minimum, purchased the certified EHR so that you can enter the certified product number and submit necessary documentation.

EP56. **Do I have to register with CMS before I can enroll with Medicaid?**

Yes, everyone needs to register with CMS first and select the state from which they wish to receive their Medicaid incentive payment. EPs can select to participate in either Medicaid or Medicare, not both.

**EMAIL NOTIFICATIONS**

EP57. **Can providers designate that communications be sent to a central person, i.e. the business administrator?**

Providers will have the opportunity to provide a corresponding email at CMS registration; however, only one can be given.

**CERTIFIED EHR SOFTWARE**

EP58. **My EHR software has not been certified. Do I understand correctly that I am unable to enroll or attest with CMS or HHSC until my EHR has been certified? When is the deadline to enroll or attest in order to receive the incentive for 2011?**

You won’t be eligible for the incentive program until the EHR software has been certified. 2016 is the last year of initial enrollment. Continue to encourage your software provider to become certified.

EP59. **Are any of the dental software companies currently used by dental offices EHR-certified? I am particularly asking about Dentrix software and Eagle Software. If not, what do we need to do to still use our current management software and comply with all the EHR requirements?**

Check the ONC website link for a list of certified products. Also, contact your software company with direct questions about their certification status. You must be using a certified EHR software solution to qualify for the incentive program.
AUDIT

EP60. Can you provide more information regarding the HIPAA audit? Does CMS perform this audit, or do we hire a third party to perform the audit and submit the documentation to CMS?

More information concerning audits will be communicated at a later date. It is imperative that EPs enrolling in the Medicaid incentive program provide auditable information.