



Frequently Asked Questions

Florida Medicaid Promoting Interoperability (PI) Program

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Disclaimer: The Agency for Health Care Administration is providing this material as an informational reference for participants in the PI Program. Although every reasonable effort has been made to assure the accuracy of the information at the time of posting, the PI program is constantly changing, and it is the responsibility of participants to remain abreast of PI program requirements.

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Part 1: OVERVIEW

1. What is the Florida Medicaid Electronic Health Record (EHR) Incentive/Promoting Interoperability Program?

The Promoting Interoperability Program has been operational since 2011 and is currently providing incentive payments to Eligible Professionals (EPs) for demonstrating meaningful use. Historically, the program provided incentive payments to both Eligible Hospitals (EHs) and Eligible Professionals (EPs) as they either adopted, implemented, or upgraded (AIU) certified technology or met meaningful use requirements. For Florida, the program was launched on September 5, 2011 and is scheduled to continue through 2021 per legislative policy.

In Florida, the Agency for Health Care Administration (Agency) is administering the Medicaid Promoting Interoperability Program in accordance with the federal government regulations. The program is funded through the provisions in the American Recovery and Reinvestment Act (ARRA), in a section known as the Health Information Technology for Economic and Clinical Health (HITECH) Act. Provider payments are funded 100 percent by federal funds.

The continuing goal of the program is to promote use of Certified Electronic Health Record Technology (CEHRT) by providers not to just meet meaningful use but to also realize the benefits from the investments made in adopting CEHRT. This activity is a building block to the larger vision of Health Information Technology (Health IT) as a platform that serves to improve communication between patient and provider, empower patients to be more involved in their healthcare choices, improve and support quality and safety initiatives, and promote more efficient use of healthcare resources.

2. How do I access the application?

The link to the state application is on your Medicaid provider portal. Upon signing into the Medicaid provider portal, a link should be present in the top, right hand corner under "Quick Links." Clicking on the EHR Incentive Payment link will take you to the Program Participation Dashboard. The Dashboard displays information on any previous Florida Medicaid application and any program year application that is available for completion.

3. I cannot access my Medicaid provider portal account – what should I do?

It is recommended that web portals be accessed routinely. All web portal accounts not logged into for 120 days or more will be locked due to inactivity. Agent accounts (those that can access the Medicaid provider portal on behalf of the provider) which have been locked for more than 120 days will be terminated resulting in the deletion of that account. A deleted account cannot be restored so a new account will have to be created and associated to any pre-existing applications.

If you have issues logging into your Medicaid provider portal account, please contact Provider Services at (800) 289-7799. It may take a few weeks for you to regain access.

The instructions below detail the steps you need to follow to complete reactivation of a locked account.

Reactivation procedures include:

1. Enter the username in the Username field on the login page of the secure portal (<http://home.flmmis.com>).
2. Click on "Forgot your password?"
3. Re-enter the "username" and "email" associated with the account. You must use the email account that was used to register for your account, or you will receive an error message.
4. A "PASSWORD RESET" email will be sent.

5. Click on the link and answer the security question that was created when the account was initially established.
6. Once the security question is successfully answered, you can create a new password and access your secure portal account.

If a different person will be completing the state online application (MAPIR) than in previous program years, the User ID attached to the MAPIR application may need to be changed. After the preparer gains access to the secure Medicaid Portal, if the EHR Incentive link is not present or the system indicates that an application was already started by another user, a “Username Reassignment” may need to be completed. Please contact the MedicaidHIT@ahca.myflorida.com for assistance with updating the User ID.

4. Can someone attest on my behalf?

Providers and hospitals that allow someone to attest on their behalf must establish the relationship on the Centers for Medicare and Medicaid Services (CMS) registration and attestation system (The creation of the federal-level relationship will allow a user to access and manage the registration on behalf of a provider or hospital.

For the State application, a provider must authorize a user to be their Account Administrator within the Medicaid provider portal. To establish this relationship, contact MedicaidHIT@ahca.myflorida.com. The preparer should indicate their relationship with the provider on MAPIR (the online state application) under the *Submit* tab.

5. Can I attest as a group?

No. Each individual Eligible Professional (EP) must complete the application and attestation process. A group administrator or other designated proxy may complete the application process on behalf of the EP.

6. Can I change the information at the federal registration and attestation site (CMS R&A)?

Yes, in fact certain changes must occur at the federal CMS R&A system, such as payee changes. It is important to note that when making a change at the R&A site, you must hit the resubmit button. Even if you do not make a change to the information, you must hit resubmit. If you do not resubmit, your R&A information is considered pending and will affect your ability to complete an application and receive a payment.

7. What documentation should be included with my application? Updated

The documents listed below must be uploaded as part of the application process. Providers should maintain complete documentation of any reports, screen shots, and policy clarifications used to support the application.

- Uploaded documents must be in PDF format and can be uploaded while the application is in either *Incomplete* or *Submitted* status.
- Large and/or numerous documents can also be “zipped” and uploaded.
- If the application is submitted without any documentation attached, an error message will appear reminding you that documents must be attached. The error message just validates that documentation has not been attached. There is no validation on the type of documents.

Documents should be clearly labeled so the processing staff member will know what it contains. For example, do not use doc 1, doc 2, etc. Titles should be specific such as volume report, security risk analysis, etc.

Required Application Documentation

- Copy of the Practice Management Report supporting your volume.
- Copy of the encounter report supporting the calculation of the denominator (total encounters) for General Requirement 1 which is 50% of all encounters during the EHR reporting period were at locations with CEHRT.
- Documentation from your EHR vendor stating the date you installed the 2015 Edition CEHRT.
- MU Measure Report for the EHR reporting period including all measures and Clinical Quality Measure (CQM) information. If MU information is pulled from different systems for the EHR reporting period, then reports from all systems used must be uploaded.
- Documentation from Florida SHOTS, if not excluding, supporting the level of engagement attested to within the application
- Documentation from a Public Health Registry and/or Clinical Data Registry supporting the level of engagement attested to within the application
 - If excluding from a Public Health Registry and/or Clinical Data Registry, a signed letter from the provider supporting that they meet the exclusion criteria. Refer to Part 4 for details on Meaningful Use.
- Copy of completed Security Risk Assessment (SRA) or review including asset inventory, final report with risks identified, and cover page with date completed, practice name, and name and title of the person that completed the assessment. For Program Year 2021, providers who have not completed their SRA at time of attestation may acknowledge the SRA requirement in MAPIR and move forward without uploading a copy of their SRA with the application. Refer to Part 4, Meaningful Use, for further information.

AS APPLICABLE

- Additional Documentation Form if practicing at multiple locations.
- Physician Assistant (PA) Led Attestation Form.
- Advanced Registered Nurse Practitioners (ARNPs) or PAs billing under a supervising physician must include a copy of a medical record supporting your provision of a Medicaid service.

8. How long should I keep records supporting my EHR program applications?

All documentation supporting the application should be kept for a period of six years from the date of the incentive payment. This includes all supporting documentation and any relevant information regarding system changes and/or upgrades.

Documentation recommendations include:

- Detailed volume reports with patient name, date of birth, date of service, rendering provider, and payer. It is recommended that volume documentation be maintained in an EXCEL format.
- Paper or electronic copies of all reports.
- Screen shots supporting all measures, with dates.
 - It is recommended that screen shots are taken throughout the EHR reporting period to satisfy the requirement that the functionality is in effect during the entire reporting period.
 - For yes/no measures, screenshots of the requirement such as drug/drug interaction check.
- Details on the Security Risk Assessment (SRA) or review including an asset inventory– any documentation that may not be part of the final report.
- If you rely on an FAQ interpreting how you met a meaningful use measure, keep a copy of the FAQ with the effective date of the FAQ or the date you referenced the FAQ.
- Detailed reasoning for claiming an exclusion.

It is further recommended that documentation be maintained in a central location that is accessible by more than one staff person to alleviate issues with access at the time of audit. Providers should also be aware that not only are state audits a required program activity but that federal audits may be conducted as well. Refer to Part 1, Question 9 for audit details.

9. What, if any, types of audits will be conducted on incentive payments received?

The Agency is required to perform provider audits to ensure that incentive payments were made to EPs that met all program requirements. The Agency has contracted with KPMG LLP (KPMG), a public accounting and auditing firm, to conduct these post-payment audits. Providers will initially be notified by the Agency of their selection for audit. KPMG will then contact the provider directly with a list of requested documentation and information on how to submit documentation. KPMG, in conjunction with Agency staff, will conduct an auditee webinar further explaining the audit process including viewed request documentation.

If selected for an audit, providers must respond within the time periods specified. Failure to provide documentation by the deadline will result in notification from the Agency that if documents are not provided in 30 days, it will be assumed that the provider does not qualify for the payment and Medicaid Program Integrity will be notified to begin recoupment.

Subsequent incentive program applications from the provider, and/or any member of the group with whom the provider is associated, will be held until audit disposition is complete with no findings requiring recoupment of the payment.

In addition to audits conducted on behalf of the Agency, the Florida Auditor General, the Centers for Medicare and Medicaid Services (CMS), and the Federal Office of the Inspector General (OIG) may conduct audits of EHR incentive payments.

10. What do the timeframe terms mean?

- **Payment Year** refers to the year of EP or EH program participation (e.g. Year 1).
- **Program Year** refers to the calendar year of program participation (e.g. 2019, 2020, etc.).
- **Volume Reporting Period** refers to the consecutive, 90-day period used to meet Medicaid patient volume requirements.
- **EHR Reporting Period** (also known as the MU reporting period) refers to the period of time that the EP is documenting actual use of CEHRT and meeting specified measures and thresholds.

11. Can telehealth visits be counted under the definition of an office visits for purposes of the Promoting Interoperability Program?

Yes, the CMS definition of an office visit under Promoting Interoperability/ Meaningful Use includes telehealth visits.

12. Can telehealth visits be counted in meeting Meaningful Use thresholds?

Yes, if the EP performs and documents the actions related to Meaningful Use objectives and measures for telehealth visits in certified EHR technology (CEHRT). Providers should verify with their vendor on how telehealth visits are included in reporting.

13. When will the system be open for Program Year 2021 applications? New

For Program Year 2021, the system will be open from early Summer 2021 (anticipated June 1st) to July 30, 2021.

There will not be a grace period for Program Year 2021. .

14. What are the reporting options requirements for Program Year 2021? New

All providers have a 90-day reporting period for the meaningful use objectives and measures, as well as the Clinical Quality Measures (CQMs). The reporting period must end prior to the deadline to submit a Program Year 2021 application, which is scheduled for July 30, 2021. This shortened reporting attestation timeframe is due to the CMS final rule requirement that all incentive payment applications must be processed and paid by the end of calendar year 2021.

Part 2: ELIGIBILITY – Eligible Professionals (EPs)

1. Who is eligible for the Medicaid Promoting Interoperability (PI) Program/Electronic Health Record (EHR) Incentive Program?

- Non-hospital-based physicians
- Dentists
- Advanced Registered Nurse Practitioners (ARNP)
- Certified nurse midwives
- Physician assistants – must be working in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) and that clinic is led by a physician assistant.

In order to participate, a provider must have had at least one EHR incentive payment for, or prior to, Program Year 2016.

2. How is “hospital based” status determined?

- Hospital based is defined as 90 percent or more of encounters occurring in an inpatient or emergency room setting (place of service 21 or 23).
- Processing staff validate non-hospital based using Medicaid encounters from the calendar year prior to the program year. If 90 percent or more of the provider’s Medicaid encounters were at place of service 21 or 23, the previous federal and state fiscal years are reviewed, in an attempt to qualify the provider.
- If 90 percent or more of the EP’s Medicaid encounters are hospital based, but their total encounters are less than 90 percent in hospital or emergency room locations, the provider can meet this requirement by uploading documentation from the practice management system of encounters by place of service. The time period for the report should be the calendar year prior to the program year.

PATIENT VOLUME

1. What is the Medicaid patient volume requirement?

Eligible Professionals*	Medicaid Patient Volume Over 90-Day Period
Physician (MD, DO)	30% Medicaid
Dentist	30% Medicaid
Certified Nurse Midwife	30% Medicaid
Nurse Practitioner	30% Medicaid
Physician Assistant (PA) in a RHC or FQHC led by PA	30% Medicaid
Pediatrician**	20% Medicaid

**Eligible professionals practicing at least 50 percent of the time in a rural health clinic (RHC) or federally qualified health center (FQHC) can count “needy individuals” when determining patient volume.*

*** Pediatricians who qualify with a 20 percent Medicaid patient volume receive two-thirds of the maximum incentive payment, totaling \$42,500.*

Providers must meet the volume requirement for each payment year. Volume percentages can be rounded up based on standard rounding, e.g. 29.6 percent could be rounded up to 30 percent.

2. What can I use to determine my Medicaid volume?

Patient volume is based on encounters. An encounter is defined as services provided to an individual on a single day. A patient should not be counted more than once per day; however, the patient should be counted more than once if the additional encounter(s) occurred on a different date of service within the volume period. The denominator is total encounters (Medicaid, commercial, or self-pay), regardless of whether the encounter is billed or paid.

- Medicaid encounters are defined as services rendered on any one day to an individual enrolled in a Medicaid program. It is not required that the encounter be paid in order to include it in Medicaid volume determination. This includes:
 - Services to Medicare/Medicaid dually eligible individuals;
 - Services to Medicaid recipients with primary third-party payers such as workers' compensation, travel insurance, etc.;
 - Services rendered to a Medicaid patient but not billed;
 - Services denied, unless the denial reason is that the individual was not enrolled in Medicaid on the date of service; and
 - Persons enrolled in Medicaid managed care plans e.g. Amerigroup, Humana, etc., and Medicaid Provider Service Networks.
- Volume is calculated by dividing Medicaid encounters by the total number of encounters.
- Services rendered to an individual should only be counted once per day to meet the CMS definition of an "encounter." *This can be done by removing duplicates based on patient ID and date of service.*
- At least one clinical location used in the calculation of patient volume must have Certified EHR Technology (CEHRT).
- Providers have the option to determine volume based on a continuous 90-day period in the calendar year prior to the program year or a continuous 90-day period in the 12 months prior to the application submit date. The 90-day period can span calendar years when using a 90-day period in the 12 months prior to the application submit date. The option for the 12 months prior to the application date is a rolling period of time that changes each day.

3. How is volume determined – individually or based on my group?

If you are an individual practitioner, you calculate the percentage of total individual Medicaid encounters over total individual practice encounters.

$$\frac{\text{Total Individual Medicaid Encounters}}{\text{Total Individual Practice Encounters}}$$

If you are a member of a group practice, you have two options:

Option One: All members of the group will use group Medicaid volume – this is also known as group proxy.

$$\frac{\text{Total Group Medicaid Encounters}}{\text{Total Group Encounters}}$$

Option Two: All members of the group will use their individual Medicaid encounters from the group (use individual formula).

Pediatricians can choose to qualify with 20 – 29 percent Medicaid volume in any of these examples but will only receive two-thirds of the maximum payment.

4. How is volume validated?

EPs are required to upload a copy of their Practice Management System (PMS) or other billing system report that indicates the number of encounters by payer as well as totals for all payers. This report should delineate the individual provider of service if using individual volume. The reported volume, as well as the information from the PMS report, is validated against data in the Medicaid system.

Please note that the PMS or billing system is often a separate system from the EHR and that is acceptable. Also, if a practice does not have a billing system that can generate the volume numbers, this documentation can be provided through the manual creation of a report. If you have a question about how these numbers are obtained for your practice, please contact MedicaidHIT@ahca.myflorida.com for further clarification.

5. What is meant by “needy volume” and can I include these individuals in my volume?

Only providers practicing in a Federally Qualified Health Center (FQHC) or federally designated Rural Health Clinic (RHC) at least 50% of the time can include needy individuals in their volume calculation. Needy individuals are defined as those that:

- Received medical assistance from Medicaid or the Children's Health Insurance Program (CHIP), (or a Medicaid or CHIP demonstration project approved under section 1115 of the Act)
- Were furnished uncompensated care by the provider
- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay

6. Can Healthy Kids or MediKids be included in patient volume?

Healthy Kids and MediKids are eligibility groups under the Children’s Health Insurance Program (CHIP). Unless the provider is practicing predominantly in an FQHC or RHC and can include needy individuals, encounters for Healthy Kids or MediKids do not qualify as Medicaid encounters. CHIP is funded under Title XXI, not Medicaid Title XIX. Although claims for MediKids are billed to Medicaid for adjudication, they are not paid for by Medicaid funds.

7. Can I use the same volume period for different Program Year applications?

No. Each program year requires meeting the volume using a completely different period of time. MAPIR has been programmed to prevent a provider from selecting volume dates that overlap a volume period the same provider previously used.

8. When calculating patient volume, can telehealth visits be included?

Yes, telehealth visits can be included as part of the 30% (20-29% for pediatricians) Medicaid patient volume threshold if the patient is an active Medicaid enrollee.

GROUP PRACTICE/VOLUME

1. What is the definition of a group?

A basic definition of group is “how the provider bills Medicaid for services”. In most instances, this will be the Medicaid Group ID. This definition is not intended to be limiting; therefore, providers will have the option of requesting an exception to define their group within the following parameters:

- There must be an established relationship to the group within the Florida Medicaid Management Information System (FMMIS) (provider file);
- The documentation of the parameters of the group must be auditable; and
- The Medicaid IDs that comprise the group must have a common Tax ID; or common National Provider Identification (NPI); or common seven-digit base Medicaid ID.

2. What encounters should be included in the group volume calculation?

All encounters during the 90-day volume-reporting period should be included in your group calculation, including encounters for providers who are no longer associated with the group, providers who will not be applying for a Medicaid incentive payment, and encounters that occurred at locations other than the office. Group volume (also known as group proxy) is determined by how you bill for Medicaid services. For example:

Scenario A: All providers and locations associated with the Group bill for Medicaid services under ONE Medicaid number.

Group Volume: All encounters across all locations and among all providers would be included.

Scenario B: The group has more than one location and each location has its own Tax ID number. All providers within a location bill for Medicaid services under a Medicaid number that is specific to that location.

Group Volume: Only encounters associated with that location would be included. This is true even if the individual locations pay to one group NPI.

Scenario C: The group has more than one location. Each location has the same Tax ID. Each location has a different Medicaid ID, group NPI, and seven-digit base Medicaid ID.

Group Volume: Options include:

- Each location is considered a group OR
- The group is defined as all locations together

If one provider in the group uses group volume, all providers in the group are required to use the group volume UNLESS an individual provider is applying using their volume from a different location *not* affiliated with the group. In this case, the individual provider would not be able to use encounters associated with the group.

3. What conditions must be met to use group volume?

To use group volume, the group must meet the following conditions:

- 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 group's patient volume determination;
- The EP in the group decide to use one methodology in each payment year (in other words, groups could not have some of the EPs using their individual patient volume for patients seen with the group, while

others use the group-level data);

- The group must use the entire practice's patient volume and not limit it in any way;
- The EP using group volume must have had at least one Medicaid encounter between the start of the 90-day volume period and the date of attestation; it is no longer required that the encounter be paid;
- The group must be recognized as a group within the Medicaid system and must be following group billing practices during the volume-reporting period; and
- All providers applying must be a member of at least one of the group Medicaid IDs used for volume.

PROVIDER TYPES

1. How does Florida define *pediatrician* for purposes of the Promoting Interoperability Program?

Pediatricians are physicians with a specialty in pediatrics. Physicians declare their specialty when they enroll in the Florida Medicaid program. Pediatricians may be eligible for incentive payments if their Medicaid volume is between 20 and 29 percent of their total volume. Pediatricians attesting with 30 percent Medicaid receive the full payment.

To be eligible for an incentive payment as a pediatrician with Medicaid volume between 20 and 29 percent, physicians must have the Specialty Code "035", which specifies "Pediatrics", on their Medicaid provider file. A physician may also have other specialty codes. Attestation to the specialty type must be submitted to the Medicaid fiscal agent *before* the EP applies to participate in the EHR Incentive Program. Please note, if you are a pediatrician attesting to 20 to 29 percent Medicaid volume, make sure you select pediatrician for your provider type in MAPIR. Selecting physician and reporting volume under 30 percent will cause your application to be auto-denied.

2. Can a pediatric nurse practitioner or physician assistant qualify for the program with 20-29 percent Medicaid volume?

No. Only physician providers with a pediatric specialty can qualify with the lower volume.

3. As an ARNP, the majority of my services are billed using the supervising physician's billing information. Can I apply for a payment?

Yes, ARNPs are defined as EPs for the Promoting Interoperability Program and can receive an incentive payment. ARNPs can apply using group volume, their individual Medicaid volume from the group, or their supervising physician's individual volume from the group for services the ARNP rendered.

USING INDIVIDUAL VOLUME:

The application must contain the practice management system (PMS) or billing report indicating the volume attributable to the applicant ARNP.

USING GROUP VOLUME:

When an ARNP is using group volume, there must be at least one encounter with a Medicaid eligible recipient between the start of the 90-day volume reporting period and date of attestation/application.

USING SUPERVISING PHYSICIAN VOLUME:

- A. The volume reporting period for the ARNP must be distinctly different from the volume reporting period for the supervising physician when using individual volume as well as any other ARNP that may be using the supervising physician volume. For example, if a physician supervises ARNP A and ARNP B, there must

be a distinct 90-day period for the physician, a distinct 90-day period for ARNP A, and a distinct 90-day period for ARNP B.

- B. The PMS or billing report must include encounters for the applicant ARNP, the supervising physician, and all other ARNPs under that physician's supervision.
- C. The application must also contain documentation of one Medicaid encounter as evidenced by a medical record. The medical record must contain name and Medicaid number of the recipient; the date of service; the services rendered; the location of the services being rendered; and the signature of both the ARNP and supervising physician.

4. What is meant by a PA-led clinic?

A Physician Assistant (PA) would be leading an FQHC or RHC under any of the following circumstances:

- When a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, the PA would be considered the primary provider);
- When a PA is a clinical or medical director at a clinical site of practice; or
- When a PA is an owner of an RHC.

PAs completing applications will be asked to complete the "Attestation for Physician Assistant Led" form available on the Promoting Interoperability Program Website. This form will delineate how the PA meets the definition of practicing in a PA-led clinic. The form can be found at [PA LED ATTESTATION FORM](#). As part of the prepayment validation process, claims history is reviewed as well as information contained on the Medicaid provider file. In order to be considered PA led, the number of encounters with the PA as the rendering provider should greatly exceed the number of encounters with the physician and any other providers as the rendering provider.

5. Are Optometrists eligible to participate?

No. The federal rule for the Medicaid PI Program limits payments to Doctors of Medicine and osteopathy. Optometric services are not considered physician services under Florida statute or in the Florida Medicaid state plan; therefore, this provider type is not eligible for the program. Doctors of Optometry can qualify for participation in the Medicare Incentive Program.

6. Are residents eligible to participate in the Medicaid EHR Incentive Program?

Yes, if the resident is a fully enrolled Medicaid provider. Only residents that have been issued a full license are eligible to enroll as a Florida Medicaid provider.

7. What does it mean to be a "fully enrolled" Medicaid provider?

"Fully enrolled" is a term used for providers who participate in Medicaid either as a fee-for-service provider or member of a fee-for-service group. If Medicaid has paid you directly for a fee-for-service claim, you are fully enrolled. If you are part of a Medicaid health plan network, you may be registered with Medicaid as a treating provider, but not fully enrolled in Medicaid.

Providers can fully enroll in the Florida Medicaid program using the online Enrollment Wizard. Once submitted, the completed application and all applicable forms will be reviewed for accuracy. Upon completion of the enrollment process, approved providers are issued a nine-digit Medicaid provider number and a PIN. Please see Chapter 2 of the "Provider General Handbook" located at [HERE](#) under Provider Services (select Enrollment) or call (800) 289-7799, Option 4, for a complete list of required enrollment documentation.

Part 3: ELECTRONIC HEALTH RECORD (EHR) SYSTEMS

1. How can it be determined whether an EHR is certified?

Beginning with Program Year 2019, providers must attest utilizing 2015 Edition CEHRT. The Certified Health IT Product List is available at [CERTIFIED HEALTH IT PRODUCT LIST \(CHPL\)](#).

2. Can an eligible professional (EP) use EHR technology certified for an inpatient setting to meet a meaningful use (MU) objective and measure?

Yes. For objectives and measures where the capabilities and standards of EHR technology designed and certified for an inpatient setting are equivalent to or require more information than EHR technology designed and certified for an ambulatory setting, an EP can use the EHR technology designed and certified for an inpatient setting to meet an objective and measure.

3. Does a provider such as a dentist who has access to a certified EHR system qualify?

As long as the provider has access to a certified EHR system that is capable of meeting MU objectives, they may qualify. In the case of dentists, many have a dental system that is interfaced with a certified EHR system; the provider would need access to all parts of the certified EHR system to qualify.

4. Can a provider still qualify when using a “free” EHR system?

A provider can qualify when using a free EHR system. Documentation providing proof that the practice/provider has access to the certified EHR must include the dates the provider had access to the 2015 Edition CEHRT.

Part 4: MEANINGFUL USE

1. What is Meaningful Use (MU)?

Meaningful Use (MU) describes the activities an eligible professional engages in to use electronic health records in a way that improves care and service to their patients. The Center for Medicare and Medicaid Services (CMS) established the rule for MU that includes a set of standards, implementation specifications, and certification criteria for electronic health record (EHR) technology. Complete information on the Meaningful Use program, can be found [HERE](#).

Providers are encouraged to review the CMS Specification Sheets published for each program year which can be found at the link above. CMS routinely updates specifications and provides additional information on meaningful use requirements through the specification sheets.

2. Can providers meet just those MU objectives that are specific to their scope of practice?

EPs must meet all of the MU objectives and measures or qualify for the stated exclusion. Failure to meet the measure of an objective, or to qualify for an exclusion for the objective, will prevent an EP from successfully demonstrating MU and receiving an incentive payment.

3. Can I use group numbers in proving MU?

No. MU is based on the individual EP. It is important that each practitioner access the certified EHR under their own login information so that the system can capture the necessary information for demonstrating MU for each EP. Group measure information or measure information specific to another practitioner is NOT ACCEPTABLE in attesting to MU.

4. What are the general requirements for attesting to MU?

In addition to meeting MU and reporting Clinical Quality Measures (CQMs), EPs must meet the following general requirements:

- a. Fifty (50) percent of all encounters must occur in locations equipped with CEHRT.
 - i. To demonstrate that a provider meets this requirement, encounters across all practice locations (excluding inpatient and emergency room settings) must be reported.
 - ii. An encounter is defined as medical, diagnostic, or consultation services. If multiple services are provided on the same day to the patient, then it counts as one encounter.
- b. Eighty (80) percent of unique patients seen at locations with CEHRT must have their records in a certified EHR system.

5. What if I change systems or use different systems during the EHR reporting period?

If a provider changes EHR systems or practices at multiple practices, information from all systems utilized during the reporting period must be used.

CHANGING SYSTEMS: If the information from the old system is transitioned into the new system, and the new system can report data from the entire reporting period, then only report data and include documentation from the new system. If the data is not transferred, then the information from both systems should be combined and documentation from both systems uploaded.

MULTIPLE LOCATIONS: Information from each location for the reporting period must be uploaded. The numerators and denominators for each measure should be combined and entered into the application.

If a provider is practicing at multiple practices utilizing different systems, and different Clinical Quality Measures (CQMs) have been selected at the varying locations, the provider should choose one set to report. Any CQMs that are the same for all practices should also be added together. Providers should upload reports for all objectives from both systems as well as a document explaining which CQMs they are choosing to report. Documentation should be maintained supporting the choice of CQMs. For more information on practicing at multiple locations, please see this [FACT SHEET](#) published by CMS.

It is recommended that before changing systems, screen shots be taken to support all MU objectives and back-up reports run and stored in case of a post-payment audit.

6. How will the online application system handle percentages in terms of MU measures? For example, the MU Measure report states 29.8 percent for a measure – will the system round that up to 30 percent?

The online state application (MAPIR) only rounds down to the whole number for MU measures. In this example, MAPIR would calculate that as 29 percent. Additionally, providers should be cautioned that the rule requires that measures be met at “more than” the specified threshold. Therefore, in this example, if the measure requires more than 30 percent, your percentage must be at least 30.01 to meet the measure. MAPIR will display the percentage at 30 percent but will pass the measure. If your percentage is 29.8 percent, MAPIR will display 29 percent and the measure will fail.

7. What is the purpose of the Additional Documentation Form (AD Form)?

The AD Form is required for those providers practicing at multiple locations utilizing different EHR systems or locations without CEHRT.

Information about each location at which the provider practices should be included with the exception of inpatient and emergency room settings. The current AD Form can be found [HERE](#).

8. How can I determine whether I qualify for an exclusion due to lack of broadband availability?

CMS has not designated any county in Florida as not having access to the required 4 Mbps of Broadband download speed which qualifies providers for taking this exclusion. Therefore, providers practicing in Florida do not qualify for this exclusion.

9. What are the “Information Blocking” questions within MAPIR under Meaningful Use Objective 0?

As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the Quality Payment Program final rule there were requirements that participants in both the Medicare and Medicaid EHR Incentive Programs show that they have not knowingly and willfully limited or restricted the compatibility or interoperability of their certified electronic health record (EHR) technology. These questions are required for providers to show they are meeting this requirement by attesting to statements about how they implement and use certified EHR technology (CEHRT). These statements are referred to as the “Prevention of Information Blocking Attestation.” Providers should carefully read each question and answer appropriately. For more information on the questions, refer to the CMS Prevention of Information Blocking Attestation [FACT SHEET](#).

STAGE 3 MEANINGFUL USE

1. Am I required to attest to Stage 3 objectives? ^{Updated}

For Program Year 2021, all providers must attest to the Stage 3 Meaningful Use objectives. There are eight overall objectives some with multiple measures. The Stage 3 objectives are:

1. Protect Electronic Protected Health Information (ePHI)
2. Electronic Prescribing
3. Clinical Decision Support (CDS)
4. Computerized Provider Order Entry (CPOE)
5. Patient Electronic Access to Health Information
6. Coordination of Care through Patient Engagement
7. Health Information Exchange
8. Public Health and Clinical Data Registry Reporting

For complete information on the Stage 3 objectives for Program Year 2021, please refer to the CMS Specification Sheets found [HERE](#).

2. What is required to meet the Protect Patient Health Information objective?

The parameters of the security risk analysis are defined 45 CFR 164.308(a)(1), which was created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule. The PI Program does not impose new or expanded requirements on the HIPAA Security Rule nor does it require specific use of every certification and standard that is included in certification of EHR technology. More information on the HIPAA Security Rule can be found at <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/>.

The security risk analysis requirement under 45 CFR 164.308(a)(1) must assess the potential risks and vulnerabilities to the confidentiality, availability, and integrity of all ePHI that an organization creates, receives, maintains, or transmits. This includes ePHI in all forms of electronic media, such as hard drives, floppy disks, CDs, DVDs, smart cards or other storage devices, personal digital assistants, transmission media, or portable electronic media. At minimum, EPs should be able to show a plan for correcting or mitigating deficiencies and that steps are being taken to implement that plan. Key components of the Security Risk Analysis (SRA) are encryption and identification of an asset inventory which identifies where protected electronic health information (ePHI) is stored, how it is accessed, and how it is exchanged. The Security Risk Analysis documentation should include any recommendations for further action which can also be known as a risk mitigation plan.

An analysis must be done upon installation or upgrade to a new system and a review must be conducted covering each EHR reporting period. Any security updates and deficiencies that are identified should be included in the EP's risk management process and implemented or corrected as dictated by that process. The same SRA or review cannot be used for two program years.

Additional information and resources can be found on the Program Year 2020/2021 [CMS SPECIFICATION SHEET](#). Additional resources are available through the Office of the National Coordinator for Health IT, which can be found [HERE](#).

A copy of the SRA must be uploaded with the application and include the date completed, practice name, and name and title of the person that completed the assessment), asset inventory, and final report.

3. What are the SRA requirements for Program Year 2021? New

A Security Risk Assessment (SRA) must be conducted or reviewed during the program year. If the SRA requirement has not been completed at the time of attestation, the MAPIR application system will allow providers to acknowledge the SRA requirement and move forward without providing specific SRA details. However, providers that do not provide their SRA information for Program Year 2021 at the time of attestation will be required to provide this documentation during post-payment audit. Providers who complete their SRAs prior to attesting follow the same process in MAPIR as previous program years including uploading a copy of the SRA.

4. Can you explain what is meant by API access as required by Objective 5, Patient Access to Electronic Health and Objective 6, Coordination of Care through Patient Engagement?

An Application Program Interface (API) is a set of programming protocols established for multiple purposes. APIs may be enabled by a provider or provider organization to provide the patient with access to their health information through a third-party application. Simply stated, APIs to connect user-facing front ends with all-important back end functionality and data. For purposes of the MU program, API functionality has to be enabled so that patients can access their health information not just through the provider's patient portal but through other applications as well.

EPs should work with their vendor to ensure that API functionality is present and what processes are in place for other applications that may want to access patient information. Per the [CMS SPECIFICATION SHEET FOR OBJECTIVE 5](#) that to implement an API, an EP needs to fully enable the API functionality, such that any application chosen by a patient would enable the patient to gain access to their individual health information, provided that the application is configured to meet the technical specifications of the API. EPs may not prohibit patients from using any application, including third-party applications, which meet the technical specifications of the API, including the security requirements of the API. Additionally, EPs are expected to provide patients with detailed instructions on how to authenticate their access through the API and provide the patient with supplemental information on available applications that leverage the API.

5. How do I determine whether I qualify for an exclusion for Objective 7, Health Information Exchange?

There are three measures within the Health Information Exchange Objective:

- Measure 1: Creation of and electronic exchange of summary of care records transitioning outside the provider's practice.
- Measure 2: Incorporation of an electronic summary of care record for patients transitioning into the provider's practice.
- Measure 3: Clinical reconciliation of medication, medication allergy, and current problem list.

For Measure One, an EP can claim an exclusion if they transfer a patient to another setting or refers a patient to another provider fewer than 100 times during the EHR reporting period. For Measures Two and Three, the exclusion is based on the EPs receiving fewer than 100 transitions of care during the EHR reporting period.

An EP must attest to all three measures and meet the threshold for at least two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective. For complete details on the exclusion criteria, review the [CMS SPECIFICATION SHEET FOR OBJECTIVE 7](#).

PUBLIC HEALTH REPORTING

1. What is required for Public Health Reporting in Stage 3?

The EP must be in active engagement with a Public Health Agency (PHA) or Clinical Data Registry (CDR) to submit electronic public health data in a meaningful way using certified electronic health record technology (CEHRT), except where prohibited, and in accordance with applicable law and practice. Providers must be in active engagement status with **at least two** registries. If less than two, the EP must meet the exclusion criteria for all remaining measures. The five Public Health and Clinical Data Registry Reporting measures are:

- Measure 1: Immunization Registry Reporting
- Measure 2: Syndromic Surveillance Reporting
- Measure 3: Electronic Case Reporting
- Measure 4: Public Health Registry Reporting
- Measure 5: Clinical Data Registry (CDR) Reporting

2. What is meant by “active engagement” to submit Public Health data?

Providers must be in “active engagement” with the Public Health Agency or Specialized Registry defined as:

- Completed Registration to Submit Data
 - EP has registered to submit data. Registration was completed within 60 days after the start of the EHR reporting period and the provider is awaiting an invitation to begin testing and validation.
- Testing and Validation
 - EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the sponsor of the registry within 30 days; failure to respond twice within an EHR reporting period would result in the EP not meeting the measure.
- Production
 - EP has completed testing and validation of the electronic submission and is electronically submitting production data.

For complete information on this objective including exclusions, refer to the Stage 3 CMS Specification Sheet for [PUBLIC HEALTH REPORTING](#).

3. What documentation is required to claim exclusions for the Public Health and Clinical Data Registry Reporting measures?

Providers must be in active engagement status with **at least two** registries. If less than two, the provider must meet the exclusion criteria for all remaining measures and upload a signed letter documenting the necessary criteria has been met. The letter must document that the following conditions apply:

- Does not give immunizations [*do not include this item if attesting to Florida SHOTS*];
- Does not treat or diagnose cancer [*do not include this item if attesting to Florida Cancer Registry*];
- Does not prescribe controlled substances to patients 16 years of age or older or has not previously received an incentive payment using E-FORCSE as a registry option [*do not include this item if attesting to E-FORCSE*]; and
- Has researched registry options and does not diagnose or directly treat any disease or condition associated with a public health registry/clinical data registry in their jurisdiction or practices in a jurisdiction where no public health registry/clinical data registry has declared a readiness to receive electronic registry transactions as of six month prior to the start of the EHR reporting period.

Providers are strongly encouraged to keep all documentation relative to attempts to connect with registries, research conducted to locate potential registries, and other documentation supporting the exclusion criteria above. Additional documentation may be requested if the provider is selected for post-payment audit.

4. What is required to use Florida SHOTS as a registry option for Stage 3?

The CMS specifications for Stage 3 Immunization Registry Reporting (Objective 8, Measure 1) require a bi-directional connection, which means the certified EHR technology must be able to receive and display a consolidated immunization history and forecast in addition to sending the immunization record. Therefore, providers must specifically register for Meaningful Use Stage 3 with Florida SHOTS and upload documentation supporting their active engagement status during the EHR reporting period. Florida SHOTS Stage 3 registration information can be found [HERE](#).

Providers are ultimately responsible for ensuring their EHR vendor is responsive to requests from Florida SHOTS to establish the Stage 3 connection. Failure to respond will likely impact the provider's active engagement status. Providers who are experiencing technical difficulties connecting to Florida SHOTS should consider participating with another registry instead.

5. Is there a Syndromic Surveillance (Measure 2) registry available in Florida?

No. Within Florida, syndromic surveillance is only available to hospitals and EPs working in urgent care centers.

6. Is there an Electronic Case Reporting (Measure 3) registry available in Florida?

Yes. The Florida Department of Health has implemented an e-Case Reporting registry. More information can be found [HERE](#).

7. Is a specialized registry still a Public Health reporting option for Stage 3?

No. Specialized registries were an option for Stage 2 Public Health Reporting but are no longer a registry option for Stage 3. However, providers may want to contact these registries to see if they were reclassified as Clinical Data Registries for Stage 3.

8. Are EPs able to use the E-FORCSE Prescription Drug Monitoring Program (PDMP) as a registry option for Stage 3?

An EP may count E-FORCSE as a Public Health Registry (Objective 8, Measure 4) ONLY if the EP previously received an incentive payment in a previous program year using E-FORCSE as a registry option. If the EP meets the requirements to use E-FORCSE as a registry option for Stage 3, the EP must upload a copy of the "Rx Search History Request" report with their MAPIR application to document that patient queries were conducted by the EP in the E-FORCSE PDMP during his or her EHR reporting period (see example below).

Rx Search Requests						
First Name	Last Name	Requestor	Requested For	Report Type	Status	Created At
█	█	Erika Marshall		AWARxE	complete	06/11/2018

9. Can a provider assign a designee on the E-FORCSE secure web portal to query on their behalf in terms of using E-FORCSE to meet the specialized registry measure?

Yes. If the provider meets the requirements to use E-FORCSE as a registry in Stage 3, they may assign a designee to query E-FORCSE on their behalf. Please be sure to follow the E-FORCSE instructions for linking a designee. In order for the transaction to properly display on the E-FORCSE Rx Search Request History report for the provider, the designee must be linked properly. At least one query is required during the provider’s EHR reporting period. For more information on how to assign a designee, please contact [E-FORCSE](#).

10. Is Florida aware of any other Public Health Reporting (Objective 8, Measure 4) registries besides E-FORCSE and the Florida Cancer Registry?

The Centers for Disease Control and Prevention (CDC) has registries that are classified as Public Health Reporting (Measure 4) registries for Stage 3 including the [NATIONAL HEALTHCARE SAFETY NETWORK \(NHSN\)](#) and [NATIONAL HEALTH CARE SURVEYS](#).

The Florida Cancer Data System, classified as a Public Health Registry (Objective 8, Measure 4) for Stage 3 is a joint project of the Florida Department of Health and the University of Miami Miller School of Medicine. FCDS has been accepting electronic submission of cancer data since 2013. Please visit their [WEBSITE](#) to register for electronic submission of cancer data.

Providers are required to take appropriate actions to find available registries. Please see the Additional Information section of the [CMS SPECIFICATION SHEET FOR OBJECTIVE 8](#) for more information.

11. Is Florida aware of any other Clinical Data Registries (Objective 8, Measure 5)?

Florida is aware of the following Clinical Data Registries used by EPs for Stage 3:

- DARTNet Institute Clinical Data Registry
- The Diabetes Collaborative Registry
- PINNACLE Registry

In addition to these registries, there may be other Clinical Data Registries that are available for Stage 3.

12. Am I able to use more than one registry within certain Public Health and Clinical Data Registry reporting options?

EPs may choose to report more than one Public Health Registry (Measure 4) to meet the number of measures required to meet the objective. EPs may also choose more than one Clinical Data Registry (Measure 5) to meet the number of measures required to meet the objective.

CLINICAL QUALITY MEASURES

1. What is required for reporting Clinical Quality Measures (CQMs)? ^{Updated}

Clinical Quality Measures (CQMs) must be reported for a 90-day reporting period and EPs must report at six CQMs including at least one outcome measure. If no outcome measures are relevant to that EP, they must report on at least one high-priority measure. If there are no outcome or high-priority measures relevant to an EP's scope of practice, they must report on any six relevant measures.

Program Year 2021 – Outcome CQMs

Measure Title	CMS eCQM ID
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	CMS122v9
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	CMS133v9
Depression Remission at Twelve Months	CMS159v9
Controlling High Blood Pressure	CMS165v9
Children Who Have Dental Decay or Cavities	CMS75v9
Urinary Symptom Score Change 6-12 Months After Diagnosis of Benign Prostatic Hyperplasia	CMS 771v2

Program Year 2021 – High-Priority CQMs

Measure Title	CMS eCQM ID
Breast Cancer Screening	CMS125v9
Anti-Depressant Medication Management	CMS128v9
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	CMS129v10
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	CMS136v10
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	CMS137v9
Falls: Screening for Future Fall Risk	CMS139v9
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	CMS142v9
Appropriate Testing for Children with Pharyngitis	CMS146v9
Chlamydia Screening for Women	CMS153v9
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	CMS154v9
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	CMS155v9
Use of High-Risk Medications in the Elderly	CMS156v9
Oncology: Medical and Radiation – Pain Intensity Quantified	CMS157v9
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	CMS177v9

Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture	CMS249v3
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	CMS2v10
Closing the Referral Loop: Receipt of Specialist Report	CMS50v9
Functional Status Assessment for Total Hip Replacement	CMS56v9
Functional Status Assessment for Total Knee Replacement	CMS66v9
Documentation of Current Medications in the Medical Record	CMS68v10
Functional Status Assessments for Congestive Heart Failure	CMS90v10

Program Year 2021 – Other CQMs

Measure Title	CMS eCQM ID
Childhood Immunization Status	CMS117v9
Cervical Cancer Screening	CMS124v9
Pneumococcal Vaccination Status for Older Adults	CMS127v9
Colorectal Cancer Screening	CMS130v9
Diabetes: Eye Exam	CMS131v9
Diabetes: Medical Attention for Nephropathy	CMS134v9
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	CMS135v9
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS138v9
Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	CMS143v9
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	CMS144v9
Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	CMS145v9
Preventive Care and Screening: Influenza Immunization	CMS147v10
Dementia: Cognitive Assessment	CMS149v9
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	CMS161v9
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	CMS22v9
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CMS347v4
HIV Screening	CMS349v3
Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy	CMS645v4
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS69v9
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists	CMS74v10

There is not a threshold that has to be met when reporting CQMs. For more information on CQMs, refer to [CLINICAL QUALITY MEASURES](#).

2. What should I do if there are no CQMs that apply to my practice?

EPs must still report CQMs even if the numerators and denominators are zero. It is understood that the CQMs available to report may be determined by your vendor's certification and may not be reflective of the provider's practice.

Part 5: PAYMENTS

1. Can I assign my payment?

Eligible Professionals (EPs) can decide to receive the payment or assign it to a group with which they have an employment or contractual relationship that allows the group to apply and receive payment for their covered services. The payment assignment relationship must be established in the Florida Medicaid Managed Information System (FMMIS) prior to attestation. In addition, the EP must be a member of the group at the time of every attestation. When an application is returned to incomplete status for corrections, resubmission requires a new attestation. If an EP left a group after the initial attestation and the application needs no corrections that require a new attestation, the group can receive the payment. If an EP leaves a group after attestation and the application is returned to *Incomplete* for corrections, the provider cannot assign the payment to the group. Each new attestation requires attesting to all the information in the application including the payment assignment.

Payment assignment is made as part of the Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Registration and Attestation process (R&A). Any reassignment of the payment is made voluntarily, which assumes informed consent has been given by the EP. This means that the EP understands that the party so designated, not the EP, will receive the payment.

There are three options for payment assignment at the CMS R&A. It is important to pick the correct option or payments will be delayed. The data for the individual provider and the payee must match Medicaid provider files.

- Social Security Number (SSN): This option uses the provider's individual National Provider Identification (NPI) and SSN for the payment.
- Employer Identification Number (EIN): This option uses the provider's individual NPI and allows entry of an EIN.
- Group re-assignment: This option allows the provider to enter a group NPI and Tax ID.
 - The system validates that the NPI/TIN combination is on file with Provider Enrollment and the Chain and Ownership System (PECOS).

It is strongly recommended that practices discuss incentive payments with EPs prior to attesting. It is also recommended, but not required, that groups execute a signed agreement outlining the payment relationship prior to attesting. If the State is notified that an EP did not agree to have the payment assigned to the group who received it and the group has no documentation of the agreement, then recoupment action will be taken.

2. How is payment assignment validated?

As part of the prepayment validation process, the State will verify that the EP is a member of the group to whom payment has been assigned based on the information contained in FMMIS. If that relationship has not been established in FMMIS, the payment will not be approved. If it is found that the EP was not truly a member of the group at the time of attestation (e.g. left and FMMIS not updated), then payment will be recouped.

3. Where is the payment directed?

The registration with the CMS R&A establishes the NPI and Tax ID for the payment. MAPIR will display the Medicaid IDs associated with that NPI/TIN combination in the online application. The EP selects the Medicaid ID for the payment. If MAPIR does not display the Medicaid ID you were expecting to see, it is necessary to update the registration.

A common registration error is selecting the payee TIN option of My Billing TIN. This option prepopulates the individual provider's NPI and allows entry of the group EIN.

Once a payee Medicaid ID is selected and the application is approved, the payment is made as part of the normal financial cycle and can be found on the remittance advice under non-specified claim payments with a disposition code of 8401. Payments are made based on the existing information contained in FMMIS including EFT information. *If you plan on receiving the payment yourself, please contact MedicaidHIT@ahca.myflorida.com to verify that your Medicaid file contains your correct address and electronic funds transfer (EFT) information.*

4. Is the incentive payment subject to federal income tax?

Incentive payments should be treated like any other income and are subject to federal and state laws regarding income tax, wage garnishment, and debt recoupment. Providers should consult with a tax advisor or the Internal Revenue Service regarding how to properly report this income on their filings. The incentive payment will be included in 1099 reporting.

5. Can organizations request payments on behalf of their EPs, including attesting to required information?

EPs must legally attest that they meet the requirements in order to receive payments. Organizations are not allowed to apply for incentive payments without the knowledge and consent of their employees.

Part 6: ACRONYMS

Acronym	Definition
AD	Additional Documentation Form
AGENCY	Agency for Health Care Administration (AHCA)
AIU	Adopt, Implement, Upgrade
ARNP	Advanced Registered Nurse Practitioner
CEHRT	Certified Electronic Health Record Technology
CQMs	Clinical Quality Measures
CMS R&A	CMS Registration and Attestation System also known as the National Level Repository (NLR)
CY	Calendar Year
EH	Eligible Hospital
EHR	Electronic Health Record
EP	Eligible Professional
FMMIS	Florida Medicaid Management Information System
FQHC	Federally Qualified Health Center
HIE	Health Information Exchange
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act Technical Assistance
HRSA	Health Resource and Services Administrations
HMO	Health Maintenance Organization
MAPIR	Medical Assistance Providers Incentive Repository (online application)
MU	Meaningful Use
NLR	National Level Repository also known as CMS Registration and Attestation System
ONC	Office of the National Coordinator for Health Information Technology
PA	Physician Assistant
PI	Promoting Interoperability Program (EHR Incentive Program)
PMS	Practice Management System
PV	Patient Volume
RHC	Rural Health Center
SLR	State Level Repository
SRA	Security Risk Assessment