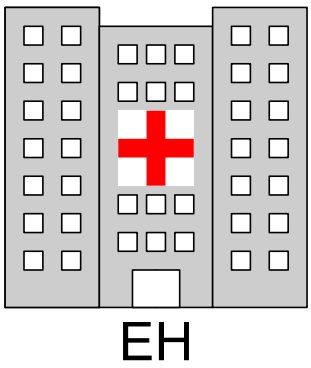
ARIZONA
MEDICAID EHR INCENTIVE PROGRAM

Reference Guide for Eligible Hospitals



Proposed Draft as of June 29, 2011
Subject to CMS Approval

REVISION HISTORY

Version Number	Date	Reviewer	Comments Proposed Draft *(subject to CMS Approval)*
1.0	04.20.2011	EHR Workgroup	Initial Distribution to Pilot Participants
2.0	05.13.2011 05.20.2011	EHR Workgroup	Streamlined document
3.0	06.29.2011	EHR Workgroup	

Description of Change	Page
Introduction	3
NIHB AI/AN REC	5
Patient Volume Elements	
►Summary	15
Payment Criteria (Text)	
►Transition Factor	20
►Overall EHR Amount	21
►Charity Care Charges	21
►Aggregate EHR Hospital Incentive	21
►Medicaid EHR IP Payment	21
►Definitions	22
Payment Rules (Text)	24
Data Elements	26
Acronyms	27, 28
Glossary – EH	30

EHR Incentive Program

Introduction

The American Recovery and Reinvestment Act of 2009 (ARRA or Recovery Act) provides for EHR Incentive Program payments to eligible professionals (EPs) and eligible hospitals (EHs) including critical access hospitals (CAH) participating in Medicare and Medicaid programs as they demonstrate adoption, implementation, upgrade or meaningful use of certified electronic health record (EHR) technology.

To facilitate the vision of transforming our nation's health care system to improve quality, safety and efficiency of care to EHR technology, the Health Information Technology for Economic and Clinical Health (HITECH) Act established programs under Medicare and Medicaid.

The Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator (ONC) have released final rules to guide and implement the provisions of the Recovery Act.

The Arizona Health Care Cost Containment System Administration (AHCCCS) is responsible for the implementation of Arizona's Medicaid EHR Incentive Program. Over the next 10 years, AHCCCS will disburse payments to providers who adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology in their first year of participation in the program and successfully demonstrate meaningful use in subsequent years.

These incentive programs are designed to support providers in this period of Health Information Technology (HIT) transition, accelerate the adoption of HIT and instill the use of qualified EHRs in meaningful ways to help our nation to improve the quality, safety and efficiency of patient health care.

Arizona's EHR Incentive Program

Two key components of the EHR Incentive Program are registration and attestation.

AHCCCS' Division of Health Care Management (DHCM) has fiduciary responsibility to ensure that Medicaid supplemental funds are disbursed accurately in compliance with federal and state regulations.

AHCCCS' EHR Electronic Provider Incentive Payment System (ePIP) facilitates the processing of EHR Incentive Program payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

Registration

The registration process allows the provider to participate in the EHR Incentive Program. Providers must complete a Federal and State level registration process.

Attestation

The attestation process allows the providers to attest to the EHR Incentive Program's eligibility criteria as they demonstrate adoption, implementation, upgrade or meaningful use of EHR technology.

Provider Outreach & Recruitment

Health-e Connection
Arizona Regional Extension Center
A collaboration of AzHeC, ASU-BMI, HSAG & PACeHR

The Arizona Regional Extension Center (REC) is one of 62 RECs nationwide designated to serve Arizona as an unbiased, trusted resource with national perspective and local expertise to assist healthcare providers with electronic health record (EHR) adoption, optimization and achievement of Meaningful Use. The program is a led by Arizona Health-e Connection (AzHeC) in collaboration with Arizona State University's Department of Biomedical Informatics (ASU-BMI) and Health Services Advisory Group (HSAG).

The REC serves as a neutral source for credible EHR and HIT information—something much needed as healthcare providers seek to navigate EHR options and select vendors who meet new federal Meaningful Use requirements.

The REC strives to fully identify and provide solutions to the challenges Arizona healthcare providers face in adopting EHR systems. Finally, and most important, the program provides critical, "hands-on" services for EHR adoption as outlined below.

Regional Extension Center Services	
General Assistance	Technical Assistance
▪ Outreach and education ▪ Workforce support ▪ Tools and resources in all aspects of electronic health record (EHR) and health information technology (HIT)	▪ Vendor selection and preferred pricing ▪ Project management ▪ Practice and workflow redesign ▪ System implementation ▪ Interoperability and health information exchange (HIE) ▪ Privacy and security

The REC has a unique national perspective and local expertise and is committed to building connection and collaboration among the state's healthcare community, ensuring that the individuals and organizations are connected to the right people, tools and resources to optimize success of EHRs and achievement of Meaningful Use of EHRs.

To take advantage of the REC services, please contact them directly at:

Arizona Regional Extension Center
3877 N. 7th Street, Suite 130
Phoenix, AZ 85014
602.688.7200
www.azhec.org

Provider Outreach & Recruitment for National Indian Health Board American Indian /Alaska Native Regional Extension Center

The National Indian Health Board (NIHB) views health information technology (IT) as a major development leading to improvements in the next generation of healthcare for our nation's American Indian and Alaska Native communities. As an organization, NIHB is poised to advocate for policy decisions that will produce optimal outcomes for deployment of health IT in Native communities. Through the initial collaborative efforts of NIHB staff working with Area Indian Health Boards and Regional Tribal Health Organizations, we are now placed with the collective responsibility and opportunity to establish and support a national HITECH Center to serve the health IT needs and interests of Native communities across the country.

In 2010, the Office of the National Coordinator for Health Information Technology (ONC) funded 62 HITECH Regional Extension Centers (RECs) in every geographic region of the U.S. NIHB received a cooperative agreement award to establish the American Indian/Alaska Native (AI/AN) Regional Extension Center (REC). While most RECs serve a single state, the NIHB AI/AN REC is the only national center serving tribes and urban Indian populations located in 37 states throughout the U.S. NIHB will need sustainable working partnerships with Tribes and Tribal Organizations, Urban Indian Organizations and the Indian Health Service (IHS) to make this project a success.

The support of the IHS, Area Indian Health Boards, Regional Tribal Health Organizations and urban Indian health organizations is necessary to ensure the success of the NIHB AI/AN REC.

IHS, Tribal and Urban Indian Organization Participation	
Milestones	
Milestone 1	To obtain signed agreements with Providers in the local service Area to work with and receive services of the NIHB AI/AN REC.
Milestone 2	To implement use of Electronic Health Records by Providers in the local service Area.
Milestone 3	To support Providers in the local service Area meet Meaningful Use standards in their use of Electronic Health Records.

Why Should IHS, Tribal and Urban Indian Health Organizations Support NIHB AI/AN REC Activities?

- Build local capacity to implement and manage health IT systems in Tribal communities.
- Support development of local plans to meet health IT needs.
- Develop local health IT workforce to serve future Tribal community needs.

One of the highest priorities of the NIHB AI/AN REC is to ensure direct health IT services are provided to Primary Care Providers serving their Tribal communities to:

- Support implementation and use of certified Electronic Health Records by Providers in Indian Health Service/Tribal/Urban Indian (I/T/U) health facilities.
- Support Providers in I/T/U health facilities to achieve Meaningful use of Electronic Health Records.

To take advantage of the NIHB AI/AN National REC services, please contact them directly at:

http://www.nihb.org/rec/rec.php

EHR Incentive Program
Federal Pre-Registration

Getting Ready for Federal Registration

Providers opting to receive EHR Incentive Program payments must first register with the CMS Registration & Attestation System. Before registering, you must have the proper enrollment records in the appropriate systems. Let's look at these pre-registration activities that will prepare you for registration!

Completing the Federal Pre-Registration is recommended before completing the Federal Registration.

Begin Here First!		
Pre-Registration Checklist	In order to register on the CMS Registration & Attestation System, you will need the following:	
	EHR IP	Eligible Hospitals can select Medicare EHR Incentive Program, Medicaid EHR Incentive Program or Both Medicare & Medicaid EHR Incentive Program. *(selection of both is recommended)*
	CCN	Unique hospital identifier assigned by CMS known as the CMS Certification Number
	I&A	CMS system that assigns the CMS Identity & Access Management User ID & Password
	NPI	Unique identification number assigned by CMS for covered health care providers known as the National Provider Identifier
	NPPES	CMS system that assigns the National Plan & Provider Enumeration System (NPPES) User ID & Password
	PECOS	CMS system that assigns the Provider Enrollment Chain and Ownership System Enrollment Record
	STATE	Medicaid EHR State *(You Decide if you will participate in the Medicaid EHR Incentive Program)*
	TIN	Unique identification number used by IRS in the administration of tax law known as the Taxpayer Identification Number

Tell Me More!	
NPI	The National Provider Identifier (NPI) is a *Health Insurance Portability and Accountability Act of 1996* (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. When covered health care providers, health plans, and health care clearinghouses submit claims/encounter data, they will use the NPI in the administrative and financial transactions adopted under HIPAA. To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have an active National Provider Identifier. If you do not have an NPI, navigate to the CMS National Plan and Provider Enumeration System website to apply. https://nppes.cms.hhs.gov/NPPES/Welcome.do
NPPES	The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. CMS has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have a National Plan & Provider Enumeration System (NPPES) web user account. If you do not have a NPPES, navigate to National Plan and Provider Enumeration System to apply. https://nppes.cms.hhs.gov/NPPES/Welcome.do
PECOS	The Provider Enrollment, Chain and Ownership System (PECOS) is the national repository of enrolled Medicare Fee For Service Providers and Suppliers. To participate in the EHR Incentive Program, All Eligible Hospitals must have an enrollment record in PECOS. If you do not have a PECOS enrollment record, navigate to the CMS PECOS website to apply. http://www.cms.gov/EHRIncentivePrograms/Downloads/Medicare_EP_PECOS_Notification_61110.pdf
I&A	The CMS Identity & Access Management (I&A) assigns NPPES & PECOS User IDs and passwords. If you are an EP and do not have a NPPES or PECOS or an EH without a PECOS, navigate to the I&A website to apply. https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do

EHR Incentive Program
CMS Registration & Attestation Systems
Federal Portal

Summary

The CMS Registration and Attestation System web portal is used for the facilitation of the Medicare and Medicaid EHR Incentive Programs.

To participate in the EHR Incentive Program, providers must first complete a Federal level registration process.

Completing the Federal Registration is a prerequisite for completing the State Registration.

CMS Registration & Attestation System	
CMS Registration	**Federal Registration** https://ehrincentives.cms.gov Providers must register with the CMS Registration & Attestation System to commence the EHR Incentive Program process. If seeking the Medicaid EHR Incentive Program payment, providers must complete the state level registration at the state's web portal.
	Successful Registrations Completed Federal Registrations are assigned a CMS Registration ID. You will need this to access the State Registration. Providers opting to receive Medicaid EHR Incentive Program payments from Arizona after successfully completing Federal Registration will be required to register with AHCCCS' Electronic Provider Incentive Payment (ePIP) website. After 24-48 hours, providers may initiate the state registration process. A hospital may be eligible for both the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program. Hospitals that register only for one of the programs will not be able to manually change their registration (i.e., change to "Both Medicare and Medicaid EHR Incentive Program" or from one program to the other) after a payment is initiated. It is our recommendation for the Eligible Hospital to select "Both Medicare and Medicaid" during the Federal Registration process even if planning to apply only for one of the programs.

EHR Incentive Program
State Pre-Registration

Getting Ready for State Registration

Providers opting to receive Medicaid EHR Incentive Program payments from Arizona must register with AHCCCS' EHR Electronic Provider Incentive Payment (ePIP) System. Before registering, you must have the proper identification numbers. Let's look at these pre-registration activities that will prepare you for registration!

Completing the State Pre-Registration is recommended before completing the State Registration.

Begin Here First!

Pre-Registration Checklist

In order to register and attest on the EHR Electronic Provider Incentive Payment System, you will need the following:

AHCCCS Provider Number	Unique identifier assigned by AHCCCS to an accepted provider for participating in Arizona's Medicaid Program
CCN	Unique hospital identifier assigned by CMS known as the CMS Certification Number
CMS Registration ID	Unique number assigned by CMS Registration & Attestation System after completing the Federal Registration
EHR Certification Number	Unique number assigned by ONC-Authorized Testing & Certification Board after an EHR system has been successfully certified
NPI	Unique identification number assigned by CMS for covered health care providers known as the National Provider Identifier
TIN	Unique identification number used by IRS in the administration of tax law known as the Taxpayer Identification Number

Tell Me More!

EHR CERTIFICATION NUMBER

The EHR Certification Number is assigned by Office of National Coordinator -Authorized Testing & Certification Board (ONC-ATCB) after an EHR system has been successfully certified.

To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have a CMS Certification Number for their EHR System.

If you do not have a EHR Certification Number, navigate to the Office of National Coordinator for Health Information Technology Certified Health IT Product List website.
http://onc-chpl.force.com/ehrcert

CMS REGISTRATION ID

The CMS Registration ID is assigned by the CMS Registration & Attestation System after successfully completing the Federal Registration. You need this number in order to register at the state level.

To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have a CMS Registration ID.

If you do not have a CMS Registration ID, navigate to the CMS Registration & Attestation System website.
https://ehrincentives.cms.gov/hitech/login.action

NPI

The National Provider Identifier (NPI) is a *Health Insurance Portability and Accountability Act of 1996* (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. When covered health care providers, health plans, and health care clearinghouses submit claims/encounter data, they will use the NPI in the administrative and financial transactions adopted under HIPAA.

To participate in the EHR Incentive Program, All Eligible Professionals and Eligible Hospitals must have an active National Provider Identifier.

If you do not have an NPI, navigate to the CMS National Plan and Provider Enumeration System website to apply.
https://nppes.cms.hhs.gov/NPPES/Welcome.do

Medicaid EHR Incentive Program
EHR Electronic Provider Incentive Payment System (ePIP)
State Portal

Summary

AHCCCS' EHR Electronic Provider Incentive Payment System (ePIP) web portal is used for the facilitation of the Medicaid EHR Incentive Program.

To participate in the Medicaid EHR Incentive Program, providers must complete a State level registration process after successfully completing the Federal level registration process.

Completing the State Registration is a prerequisite for completing the State Attestation.

EHR Electronic Provider Incentive Payment System (ePIP)	
Step 1 Register	Providers must register with the EHR Electronic Provider Incentive Payment System to initiate the Medicaid EHR Incentive Program.
Step 2 Attest	Providers must meet specific attestation requirements to qualify for the Medicaid EHR Incentive Program.
Step 3 Payment	Providers may sign on to the ePIP System at any time to get a status of their payment. Once the provider completes the registration process, the ePIP System starts to report the account status.

ePIP
Provider Registration
Eligible Hospitals
Step 1

Summary

Providers must register with the EHR Electronic Provider Incentive Payment System to initiate the Medicaid EHR Incentive Program.

Completing the State Registration is a prerequisite for completing the State Attestation.

ePIP State Level Registration	
Register	**State Registration** https://www.azepip.gov **Available July 2011** Use this Tab to perform the following functions: o Register in the Medicaid EHR Incentive Program o Terminate participation in the Medicaid EHR Incentive Program In order to complete registration, you must complete the following registration actions: ☑ User Agreement ☑ User Identification ☑ User Validation ☑ User Web Account

Begin Here First!	
Items From State Pre-Registration Checklist	In order to register on the EHR Electronic Provider Incentive Payment System, you will need the following: ☑ AHCCCS Provider Number ☑ CMS Certification Number (CCN) *(for Hospitals)* ☑ CMS Registration ID ☑ EHR Certification Number *(if known)* ☑ NPI ☑ TIN

Actions		
User Agreement	Eligible Providers are AHCCCS Medicaid Providers who agree to create an ePIP web account in order to participate in the Medicaid EHR Incentive Program. In addition, such providers and if applicable their payee must agree to have an electronic funds transfer record with AHCCCS in order to receive payments.	
User Identification	Eligible Providers are required to provide identifying security data to gain access to the system. *(i.e. CCN, NPI, TIN, CMS Registration ID & AHCCCS Provider Number)*	
User Verification	☑ Validate Pre-filled data feed from CMS Registration & Attestation System *(i.e. CCN, NPI, TIN, AHCCCS Provider Number, Name, Business Address, Email, Phone, EHR Certification Number $_{\text{if known}}$)* *If pre-filled data is incorrect, exit ePIP and navigate to the CMS Registration & Attestation Systems to perform corrective action.*	
User Web Account	☑ ePIP Login & Password	☑ System assigns ePIP User Name *(same as AHCCCS Provider Number)* ☑ Provider provides alternate contact name, phone & email (optional) ☑ Provider creates ePIP User Password

ePIP
State Level Attestation
Eligible Hospitals
Step 2

Summary

Providers must meet specific attestation requirements to qualify for the Medicaid EHR Incentive Program.

To participate in the Medicaid EHR Incentive Program, providers must complete a State level attestation process after successfully completing the State level registration process.

Re-attestation is required for each EHR Incentive Program payment year.

Completing the State Attestation is a prerequisite for determining the EHR Incentive Program payment.

ePIP State Level Attestation	
Attest	**State Attestation** https://www.azepip.gov **Available July 2011** Use this Tab to perform the following functions: o Attest for the Medicaid EHR Incentive Program o Modify Existing Attestation o View Attestation Summary In order to complete attestation, you must complete the following attestation actions: ☑ AIU Election Criteria ☑ Provider Type Criteria ☑ License & Sanctions Criteria ☑ Patient Volume Threshold Criteria ☑ Payment Criteria Additional Requirements are needed for CCN & Average Length of Patient Stay.
Begin Here First!	
Attestation Checklist	In order to attest on the EHR Electronic Provider Incentive Payment System, you will need the following: ☑ AIU Type ☑ CMS Certification Number (CCN) ☑ ePIP User Name & Password ☑ EHR Certification Number ☑ Hospital Medicare Cost Reporting Period *(A 12-month Period representative of the Hospital's Fiscal Year)* ☑ Hospital Medicare Cost Report Preparation Date ☑ Medicaid Inpatient Bed Days ☑ Medicaid Patient Encounters - Emergency Department Discharges (AZ & each Out-of-State) ☑ Medicaid Patient Encounters - Inpatient Hospital Discharges (AZ & each Out-of-State) ☑ Patient Volume Reporting Period *(A Continuous 90-day Period in the Prior Fiscal Year)* ☑ Provider Type ☑ Total Charity Care Charges ☑ Total Discharges *(filed reports for Current Year, Prior Year 1, Prior Year 2, Prior Year 3)* ☑ Total Hospital Charges or Hospital Cost for *IHS Facilities & 638 Tribally Operated Facilities* ☑ Total Inpatient Bed Days ☑ Total Patient Encounters - Emergency Department Discharges ☑ Total Patient Encounters - Inpatient Hospital Discharges

ePIP
Attest to AIU Election Criteria
Eligible Hospitals
Step 2a

Summary

Eligible Providers must obtain certified EHR technology and attest to Adoption, Implementation or Upgrade of their system in order to participate in the first year of the Medicaid EHR Incentive Program.

Criteria

Completing the State Attestation is a prerequisite for determining the EHR Incentive Program payment.

AIU Election			
	AIU Attestation Requirement		**AIU Documentation Requirement**
Select Adoption, Implementation or Upgrade (AIU)	**A**	Adoption of an EHR system requires that a provider acquired, purchased or secured access to certified EHR technology.	A copy of the vendor contract, paid invoice, purchase order or a document showing a legal contractual obligation verifying the provider acquired, purchased or secured access to certified EHR technology.
	I	Implementation of an EHR system requires that a provider installed or commenced utilization of certified EHR technology.	A copy of the vendor contract, paid invoice, purchase order or a document showing a legal contractual obligation verifying the provider installed certified EHR technology or basic production reports verifying the provider commenced utilization of certified EHR technology.
	U	Upgrade of an EHR system requires that a provider upgraded from existing EHR technology to certified EHR technology or expanded the functionality of existing certified EHR technology.	A copy of the vendor contract, paid invoice, purchase order or a document showing a legal contractual obligation verifying the provider upgraded to certified EHR technology or expanded functionality of the existing certified EHR technology.
	AIU Type:		Eligible Provider Selects one of the above AIU methods
	EHR Certification Number:		Eligible Provider Enters after obtaining from ONC-ATCB
Attestation Requirement	YES or NO	☑ Eligible Provider selects attestation method ☑ Eligible Provider provides EHR Certification Number ☑ Eligible Provider uploads proof of AIU compliance	
Exceptions	None		
Ineligible	Providers without proof of AIU are not eligible for the Medicaid EHR Incentive Program		

Definitions

Adoption, Implementation or Upgrade **(**AIU) attestation requires the provider to obtain certified EHR technology for the first year (AIU1) of participation.

Meaningful Use (MU) attestation requires the provider to provide quantitative measures to substantiate meaningful use for a contiguous reporting period of 90 days for the first Meaningful User year (MU1) and the entire year for subsequent MU years. Medicaid Meaningful Use attestations will not be available in 2011. Functionality is currently being developed for deployment in 2012.

ePIP
Attest to Provider Type Criteria
Eligible Hospitals
Step 2b

Summary

Providers must meet a specific Provider Type eligibility requirement to qualify for the EHR Incentive Program.

Criteria

Completing the State Attestation is a prerequisite for determining the EHR Incentive Program payment.

Provider Eligibility Criteria		
Select Type of Eligible Hospital (EH)	Eligible Hospitals (EHs) are: o Acute Care Hospitals (includes Critical Access Hospitals and Cancer Hospitals) o Children's Hospitals	
	Provider Type:	Provider's selection feeds from the CMS Registration & Attestation System
Attestation Requirement	YES or NO	EH attests to meeting one of the above provider types
Exceptions	None	
Ineligible	Provider Types not listed are not eligible for the Medicaid EHR Incentive Program	

For the purposes of the Medicare EHR Incentive Program, Eligible Hospitals are Acute Care Hospitals and Children's Hospitals.

Acute Care Hospitals are health care facilities where the average length of patient stay is 25 days or fewer and with a CMS Certification Number (CCN) that has the last four digits in the series 0001 – 0879 or 1300 – 1399. Acute Care Hospitals encompasses general short-term hospitals, cancer hospitals and critical access hospitals that meet the Medicaid patient volume criteria.

Children's Hospitals are a separately certified children's hospital, either freestanding or hospital-within hospital that predominantly treats individuals under 21 years of age and with a CMS Certification Number (CCN) that has the last 4 digits in the series 3300 – 3399.

ePIP
Attest to Provider Type Criteria
Eligible Hospitals
Step 2b$_1$

Additional Requirements – CCN Criteria

In addition to the above provider eligibility requirement, Hospitals must meet the below criteria to qualify to participate in the EHR Incentive Program.

Completing the State Attestation is a prerequisite for determining the EHR Incentive Program payment.

Provider Eligibility Criteria		
CMS Certification Number	Acute Care Hospitals are eligible if the last four digits of the CMS Certification Number (CCN) satisfy one of the following requirements: o 0001 – 0879 or o 1300 – 1399 Children's Hospitals are eligible if the last four digits of the CMS Certification Number (CCN) satisfy the following requirements: o 3300 – 3399	
	CMS Certification Number:	Provider's selection feeds from the CMS Registration & Attestation System
Attestation Requirement	YES or NO	EH attests to meeting above provider type CCN Criteria
Exceptions	None	
Ineligible	Hospitals with CCNs outside the above series are not eligible for the Medicaid EHR Incentive Program	

Definitions

CMS Certification Number (CCN) is a unique hospital identifier used to verify Medicare/Medicaid certification.

For purposes of determining Medicaid's EHR Incentive Program eligibility, a multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating the EHR Incentive Program payment.

ePIP
Attest to Provider Type Criteria
Eligible Hospitals
Step 2b$_2$

Additional Requirements – Average Length of Patient Stay

Acute Care Hospitals must meet an average length of patient stay eligibility requirement.

Criteria

Completing the State Attestation is a prerequisite for determining the EHR Incentive Program payment.

Provider Eligibility Criteria				
Average Length of Patient Stay	EH reports Total Inpatient Bed Days & Total Discharges from the most recently filed Hospital Medicare Cost Report (MCR) in Hospital Medicare Cost Reporting Period			
	Hospital Medicare Cost Reporting Period:			A 12-month period representative of the Hospital's accounting Fiscal Year
	Hospital Medicare Cost Report Preparation Date:			Preparation Date from the Current filed Hospital Medicare Cost Report
	A	**Numerator**	Total Inpatient Bed Days	Number of All Unique Inpatient Bed Days in Hospital Medicare Cost Reporting Period
	B	**Denominator**	Total Discharges	Number of All Unique Total Discharges in Hospital Medicare Cost Reporting Period
	C	**Average Length of Patient Stay**		☑ ePIP calculates: [Numerator / Denominator]
Attestation Requirement	YES or NO	EH attests to meeting the average length of patient stay criteria		
Exceptions	Children's Hospitals are not required to meet an Average Length of Patient Stay Criteria			
Ineligible	EH not meeting the provider type average length of patient stay of 25 days or less are not eligible for the Medicaid EHR Incentive Program			

Definitions

For purposes of determining Medicaid's EHR Incentive Program eligibility, an EH's Average Length of Patient Stay is the average number of days a patient is confined in the hospital facility measured by the ratio of inpatient bed days to discharges using statistical fiscal year data reported on the filed/audited CMS Hospital Medicare Cost Report.

- For Discharges & Inpatient Bed-days data used in the Average Length of Patient Stay calculation, nursery (excluding NICU), observation, labor & delivery are not included in the inpatient bed day or discharge counts because they are not considered to be acute inpatient services based on the level of care provided.

The Hospital Medicare Cost Reporting Period is the hospital's 12-month period of operations based upon the hospital's accounting fiscal year.

For purposes of determining Medicaid's EHR Incentive Program eligibility, Hospitals must select the appropriate report that ends within a specified range as indicated in the example below.

		Hospital Fiscal Year
		Current
FFY	Payment Year	MCR Ending
2011	Oct 2010 - Sept 2011	Oct 2009 - Sept 2010
2012	Oct 2011 - Sept 2012	Oct 2010 - Sept 2011

ePIP
Attest to License & Sanctions Criteria
Eligible Hospitals
Step 2c

Summary

Eligible Providers must have the proper licenses/certifications and not have active unresolved sanctions. AHCCCS will use existing operational protocols to validate licensure and sanctions.

Criteria

Completing the State Attestation is a prerequisite for determining the EHR Incentive Program payment.

Provider Eligibility Criteria		
License & Sanctions	Eligible Provider must be an active AHCCCS Provider and in good standing	
	License	☑ Eligible Provider has proper license/certification
	Sanctions	☑ Eligible Provider does not have current sanctions
Attestation Requirement	YES or NO	☑ Eligible Provider attests to possessing proper license/certification ☑ Eligible Provider attests to clearance of any sanctions
Exceptions	None	
Ineligible	Providers not licensed are not eligible for the Medicaid EHR Incentive Program Providers with sanctions are not eligible for the Medicaid EHR Incentive Program	

Definitions

Eligible Providers must meet licensure/certification requirements applicable to its provider type as required by the professional licensing and certification boards or entities and as specified by federal and state statutes and regulations.

Eligible Providers may be sanctioned by AHCCCS for violations of the terms of the AHCCCS Provider Agreement. Sanctions may be imposed due to fraudulent or abusive conduct on the part of the AHCCCS provider. Sanctions must be resolved before disbursement of the EHR Incentive Program payment.

ePIP
Attest to Patient Volume Criteria
Eligible Hospitals
Step 2d

Summary

Arizona's EHR Incentive Program has adopted CMS' Patient Encounter Methodology. Eligible Providers (excluding Children's Hospitals) are required to meet a specific patient volume threshold each payment year to be eligible for the EHR Incentive Program.

EH measurements are based on the Medicaid Patient Volume Type.

Criteria

Completing the State Attestation is a prerequisite for determining the EHR Incentive Program payment.

Provider Eligibility Criteria				
Patient Volume	EP reports Medicaid Patient Encounters & Total Patient Encounters in Patient Volume Reporting Period			
	Patient Volume Reporting Period:			A Continuous 90-day Reporting Period in the Prior Fiscal Year
	A	Medicaid Inpatient Hospital Discharges		Number of Unique Medicaid Title XIX Inpatient Hospital Discharges in numerator
	B	Medicaid Emergency Department Discharges		Number of Unique Medicaid Title XIX Emergency Department Discharges in numerator
	Medicaid Patient Encounters			☑ ePIP calculates: A + B
	C	Total Inpatient Hospital Discharges		Number of All Unique Total Inpatient Hospital Discharges in denominator
	D	Total Emergency Department Discharges		Number of All Unique Total Emergency Department Discharges in denominator
	Total Patient Encounters			☑ ePIP calculates: C + D
	E	**Numerator**	Medicaid Patient Encounters	Number of Unique Medicaid Patient Encounters in denominator
	F	**Denominator**	Total Patient Encounters	Number of All Unique Total Patient Encounters in Patient Volume Reporting Period
	Patient Volume Threshold Percentage			☑ ePIP calculates: [Numerator / Denominator] x 100
Attestation Requirement	YES or NO	EH attests to meeting the provider type patient volume threshold		
Exceptions	1. Children's Hospitals are not required to meet a Medicaid Patient Volume Threshold. 2. Eligible Providers have the option to include out-of-state patient encounters in their eligible patient volume threshold. If electing to do so, they must report each state's Medicaid encounters separately. This will trigger an eligibility verification audit and require AHCCCS to contact the other state(s) to confirm patient encounter data. This will delay payment until the data is properly validated.			
Ineligible	EHs not meeting the provider type patient volume threshold are not eligible for the EHR Incentive Program			

ePIP
Attest to Patient Volume Criteria
Eligible Hospitals
Step 2d Continue

Definitions

For purposes of calculating EH Patient Volume, Medicaid Encounters are:

- Services rendered to an individual per inpatient hospital discharges where Medicaid paid for part or all of the service, individual's premiums, co-payments, and/or cost-sharing;

- Services rendered to an individual in an emergency department on any one day where Medicaid paid for part or all of the service; premiums, co-payments, and/or cost-sharing. An emergency department must be part of the hospital under the qualifying CCN.

The Patient Volume Threshold percentage is defined as the total Medicaid patient encounters in any representative continuous 90-day period in the preceding year, divided by the total of all patient encounters in the same 90-day period multiplied by 100.

The qualifying patient volume thresholds for the Medicaid EHR Incentive Program are given in the following:

Entity	Minimum 90-day Medicaid Patient Volume Threshold
Acute care hospital	10%
Children's hospital	N/A

For purposes of the Medicaid EHR Incentive Program eligibility, Eligible Hospitals includes the above provider types who are legally authorized to operate under federal and state laws in the treatment of AHCCCS members under the Arizona Medicaid Program. The EH must be an AHCCCS Provider who meets the following requirements within the scope of their business rules:

- A Hospital classified as a health care institution that provides, through an organized medical staff, inpatient beds, medical services, and continuous nursing services for the diagnosis and treatment of patients, holds a current license and complies with applicable licensing statues and rules.
    - Acute Care Hospitals encompasses general short-term hospitals, cancer hospitals and critical access hospitals that meet the EHR Incentive Program requirements.
    - Children's Hospitals are a separately certified children's hospital, either freestanding or hospital-within hospital that predominantly treats individuals under 21 years of age that meet the EHR Incentive Program requirements.

ePIP
Attest to Payment Criteria
Eligible Hospitals
Step 2e

Summary

EHs may quality for both Medicare and Medicaid EHR Incentive Programs. The EH payment calculations requires data from the EH's filed CMS Hospital Medicare Cost Reports (MCR) and the hospital's financial statement.

Criteria

Arizona's EHR Incentive Program payments for EHs are determined based on a formula and disbursed over a 4-year period. The Aggregate EHR Hospital Incentive Amount is calculated as the product of the Overall EHR Amount and the Medicaid Share. For each payment year, the EHR Incentive Program payment is based on a percentage (defined by the State) of this Aggregate EHR Hospital Incentive Amount.

Completing the State Attestation is a prerequisite for determining the EHR Incentive Program payment.

Provider Payment Criteria			
Payment	Eligible Hospital reports Discharges, Medicaid Inpatient Bed Days, Total Inpatient Bed Days, Total Hospital Charges/Cost and Total Charity Care Charges in Hospital Medicare Cost Reporting Period		
	Hospital Medicare Cost Reporting Period:		A 12-month period representative of the Hospital's Accounting Fiscal Year
	Hospital Medicare Cost Report Preparation Date:		Preparation Date from the Current filed Hospital Medicare Cost Report
	Average Annual Growth Rate		
	A1	Total Discharges in Current Year	Number of All Unique Total Discharges in the Current Hospital Medicare Cost Reporting Period
	A2	Total Discharges in Prior Year 1 {PY1}	Number of All Unique Total Discharges in the Prior Year 1 Hospital Medicare Cost Reporting Period
	A3	Total Discharges in Prior Year 2 {PY2}	Number of All Unique Total Discharges in the Prior Year 2 Hospital Medicare Cost Reporting Period
	A4	Total Discharges in Prior Year 3 {PY3}	Number of All Unique Total Discharges in the Prior Year 3 Hospital Medicare Cost Reporting Period
	B1	Discharges Growth from Current → PY1	☑ ePIP calculates: A1 – A2
	B2	Discharges Growth from PY1→ PY2	☑ ePIP calculates: A2 – A3
	B3	Discharges Growth from PY2→ PY3	☑ ePIP calculates: A3 – A4
	C1	Discharges % Growth from Current → PY1	☑ ePIP calculates: (B1 / A2) * 100
	C2	Discharges % Growth from PY1→ PY2	☑ ePIP calculates: (B2 / A3) * 100
	C3	Discharges % Growth from PY2→ PY3	☑ ePIP calculates: (B3 / A4) * 100
	C	Cumulative Discharge Percent Growth Rate Over 3 Years	☑ ePIP calculates: C1 + C2 + C3
	D	**Average Annual Growth Rate Over 3 Years**	☑ ePIP calculates: C / 3

Discharge Related Amount				
E1	Projected Discharges in Payment Year 1			☑ ePIP user input: A1
E2	Projected Discharges in Payment Year 2			☑ ePIP calculates: E1 + (E1 * D)
E3	Projected Discharges in Payment Year 3			☑ ePIP calculates: E2 + (E2 * D)
E4	Projected Discharges in Payment Year 4			☑ ePIP calculates: E3 + (E3 * D)
	Projected Discharges	**Allowable Discharges**		Allowable Discharges are the number of projected discharges allowed in determining the Discharge Related Amount not to exceed 23,000 allowable discharges.
E5	1 - 1,149	Value of Projected Discharges		
E6	1,150 – 23,000	Value of Projected Discharges		
E7	> 23,000	23,000		
F1	Allowable Discharges in Payment Year 1			☑ ePIP calculates based on E5 or E6 or E7
F2	Allowable Discharges in Payment Year 2			☑ ePIP calculates based on E5 or E6 or E7
F3	Allowable Discharges in Payment Year 3			☑ ePIP calculates based on E5 or E6 or E7
F4	Allowable Discharges in Payment Year 4			☑ ePIP calculates based on E5 or E6 or E7
	Allowable Discharges	**Discharge Related Amount**		Discharge Related Amount is $0 for allowable discharges 1 to 1,149 and $200 per allowable discharge for allowable discharges from 1,150 to 23,000.
F5	1 - 1,149	$0		
F6	1,150 – 23,000	$200 * Allowable Discharges		
G1	Discharge Related Amount Payment Year 1			☑ ePIP calculates based on F5 or F6
G2	Discharge Related Amount Payment Year 2			☑ ePIP calculates based on F5 or F6
G3	Discharge Related Amount Payment Year 3			☑ ePIP calculates based on F5 or F6
G4	Discharge Related Amount Payment Year 4			☑ ePIP calculates based on F5 or F6
G	**Total Discharge Related Amount Over 4 Years**			☑ ePIP calculates: G1 + G2 + G3 + G4
Initial Amount				
H	Base Amount			☑ ePIP defaults to $2,000,000 (defined by Statue)
I1	**Initial Amount Payment Year 1**			☑ ePIP calculates Base Amount + G1
I2	**Initial Amount Payment Year 2**			☑ ePIP calculates Base Amount + G2
I3	**Initial Amount Payment Year 3**			☑ ePIP calculates Base Amount + G3
I4	**Initial Amount Payment Year 4**			☑ ePIP calculates Base Amount + G4
Transition Factor				
Transition Factor				Transition Factor phases down the EHR Incentive Program payments over a 4-year period. It is defined by the Statue based on Payment Year.
J1	Transition Factor Year 1	100%	1.00	☑ ePIP defaults based on Payment Year 1
J2	Transition Factor Year 2	75%	0.75	☑ ePIP defaults based on Payment Year 2
J3	Transition Factor Year 3	50%	0.50	☑ ePIP defaults based on Payment Year 3
J4	Transition Factor Year 4	25%	0.25	☑ ePIP defaults based on Payment Year 4

	Overall EHR Amount		
	K1	EHR Amount Payment Year 1	☑ ePIP calculates I1 * J1
	K2	EHR Amount Payment Year 2	☑ ePIP calculates I2 * J2
	K3	EHR Amount Payment Year 3	☑ ePIP calculates I3 * J3
	K4	EHR Amount Payment Year 4	☑ ePIP calculates I4 * J4
	K	**Overall EHR Amount Over 4 Years**	☑ ePIP calculates: K1 + K2 + K3 + K4
	Medicaid Share		
	L1	Medicaid Inpatient Bed Days	Number of Unique Medicaid Title XIX Inpatient Bed Days in denominator
	L2	Total Inpatient Bed Days	Number of All Unique Total Inpatient Bed Days in Hospital Medicare Cost Reporting Period
	L3	Total Hospital Charges or Hospital Cost*	Number of All Unique Total Hospital Charges / Hospital Cost* in Hospital Medicare Cost Reporting Period *Applies to IHS Facilities & 638 Tribally Operated Facilities
	L4	Total Charity Care Charges**	Number of All Unique Total Charity Care Charges in Hospital Medicare Cost Reporting Period **Charity Care Charges Report required
	L5	Adjusted Total Inpatient Bed Days	☑ ePIP calculates: L2 * [(L3 – L4) / L3]
	Numerator	Medicaid Inpatient Bed Days	☑ ePIP user input: L1
	Denominator	Adjusted Total Inpatient Bed Days	☑ ePIP calculates: L5
	L	**Medicaid Share**	☑ ePIP calculates: [L1 / L5] * 100
	Aggregate EHR Hospital Incentive Amount		
	M1	Overall EHR Amount Over 4 Years	☑ ePIP calculates: K
	M2	Medicaid Share	☑ ePIP calculates: L
	M	**Aggregate EHR Hospital Incentive Amount Over 4 Years**	☑ ePIP calculates: K * L
	Medicaid EHR Incentive Program Payment		
	N1	EHR Incentive Program Payment Year 1	☑ ePIP calculates M * 40% Disbursement Percentage Payment Year 1
	N2	EHR Incentive Program Payment Year 2	☑ ePIP calculates M * 30% Disbursement Percentage Payment Year 2
	N3	EHR Incentive Program Payment Year 3	☑ ePIP calculates M * 20% Disbursement Percentage Payment Year 3
	N4	EHR Incentive Program Payment Year 4	☑ ePIP calculates M * 10% Disbursement Percentage Payment Year 4
	N	**Medicaid EHR Incentive Program Payment Over 4 Years**	☑ ePIP calculates: N1 + N2 + N3 + N4
Attestation Requirement	YES or NO	EH attests to accuracy of data used in determining the EHR Incentive Program payment	
Exceptions	None		
Ineligible	EHs not meeting the data requirements are not eligible for the EHR Incentive Program Payment		

ePIP
Attest to Payment Criteria
Eligible Hospitals
Step 2e Continue

Definitions

For purposes of determining Medicaid's EHR Incentive Program payment, the following terms are defined:

Average Annual Growth Rate is the Hospital's growth rate measured by discharges averaged over the most recent 3 years using statistical fiscal year data reported on the filed/audited CMS Hospital Medicare Cost Report.

- For Discharges & Inpatient Bed-days data used in the Average Annual Growth Rate calculation, nursery (excluding NICU), observation, labor & delivery are not included in the inpatient bed-day or discharge counts because they are not considered to be acute inpatient services based on the level of care provided.

Projected Discharges are first determined for Payment Year 1 and then calculated for subsequent years by applying the average annual growth rate for each successive year. Projected discharges for Year 1 are based on the total discharges from the Current filed/audited CMS Hospital Medicare Cost Report. For subsequent years, it is based on the average annual growth rate multiplied by the projected discharges from the prior year.

Allowable Discharges are the number of projected discharges allowed in determining the Discharge Related Amount not to exceed 23,000 allowable discharges.

Discharge Related Amount is $0 for allowable discharges 1 to 1,149 and $200 per allowable discharge for allowable discharges from 1,150 to 23,000.

Initial Amount is the base amount of $2,000,000 (defined by the Statue) plus the discharge related amount.

Transition Factor phases down the EHR Incentive Program payments over a 4-year period. It is defined by the Statue based on Payment Year.

Overall EHR Amount is based on a theoretical 4-years of payment and is the product of the Initial Amount times the Transition Factor for each of the four payment years.

Medicaid Share is the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients measured using statistical fiscal year data reported on the filed/audited CMS Hospital Medicare Cost Report.

- For Discharges & Inpatient Bed-days data used in the Medicaid Share calculation, nursery (excluding NICU), observation, labor & delivery are not included in the inpatient bed-day or discharge counts because they are not considered to be acute inpatient services based on the level of care provided.
- For Hospital Charges & Hospital Cost data used in the Medicaid Share calculation, nursery (including NICU), observation, labor & delivery are included in the hospital charges or hospital cost counts because they reflect the total amount of the eligible hospital's charges.

Charity Care Charges are an initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria for care delivered for the entire facility as defined in the CMS Hospital Medicare Cost Report. The Hospital must upload the Charity Care Charges Report from the Hospital's financial records. This report must reflect the same reporting period used to determine the EHR Incentive Program payment.

The Aggregate EHR Hospital Incentive Amount is the EH's total EHR Incentive Amount over 4-years. It is product of the Overall EHR Amount over 4-years times the Medicaid Share.

Disbursement Percentage is the percentage of the Aggregate EHR Hospital Incentive Amount disbursed in each payment year as predefined by the State.

ePIP
Attest to Payment Criteria
Eligible Hospitals
Step 2e Continue

Definitions

Hospital Medicare Cost Reporting Period: Hospitals must select the appropriate Hospital Medicare Cost Report that ends within a specified range as indicated in the example below.

		Hospital Fiscal Year			
		Current	Prior 1	Prior 2	Prior 3
FFY	Base Payment Year	MCR Ending	MCR Ending	MCR Ending	MCR Ending
2011	Oct 2010 - Sept 2011	Oct 2009 - Sept 2010	Oct 2008 - Sept 2009	Oct 2007 - Sept 2008	Oct 2006 - Sept 2007
2012	Oct 2011 - Sept 2012	Oct 2010 - Sept 2011	Oct 2009 - Sept 2010	Oct 2008 - Sept 2009	Oct 2007 - Sept 2008
2013	Oct 2012 - Sept 2013	Oct 2011 - Sept 2012	Oct 2010 - Sept 2011	Oct 2009 - Sept 2010	Oct 2008 - Sept 2009
2014	Oct 2013 - Sept 2014	Oct 2012 - Sept 2013	Oct 2011 - Sept 2012	Oct 2010 - Sept 2011	Oct 2009 - Sept 2010
2015	Oct 2014 - Sept 2015	Oct 2013 - Sept 2014	Oct 2012 - Sept 2013	Oct 2011 - Sept 2012	Oct 2010 - Sept 2011
2016	Oct 2015 - Sept 2016	Oct 2014 - Sept 2015	Oct 2013 - Sept 2014	Oct 2012 - Sept 2013	Oct 2011 - Sept 2012
2017	Oct 2016 - Sept 2017	Oct 2015 - Sept 2016	Oct 2014 - Sept 2015	Oct 2013 - Sept 2014	Oct 2012 - Sept 2013
2018	Oct 2017 - Sept 2018	Oct 2016 - Sept 2017	Oct 2015 - Sept 2016	Oct 2014 - Sept 2015	Oct 2013 - Sept 2014
2019	Oct 2018 - Sept 2019	Oct 2017 - Sept 2018	Oct 2016 - Sept 2017	Oct 2015 - Sept 2016	Oct 2014 - Sept 2015

ePIP
Status
Eligible Hospitals
Step 3

Summary

Providers may sign on to the ePIP System at any time to get a status of their payment. Once the provider completes the registration process, the ePIP System starts to report the account status.

Completing the State Attestation is a prerequisite for determining the status of the EHR Incentive Program payment.

ePIP Status

Payment

State Payments
https://www.azepip.gov
Available July 2011

Use this Tab to perform the following functions:
- Status of Payment

In order to check your account status, you must complete the following action:

☑ Registration
☑ Attestation

Begin Here First!

Checklist

In order to check the status of your EHR EHR Incentive Program payment, you must log into the EHR Electronic Provider Incentive Payment (ePIP) System. You will need the following:

☑ ePIP User Name
☑ ePIP User Password

Actions

Check Status

The following milestones will be tracked:
- Attestation
- Payment

ePIP System Status Notification Indicators	
Status Indicators	**Status Descriptions**
In Progress	Action initiated but not yet completed
On Hold	Action on hold for additional information
Completed	ACCEPTED – Action Completed
	REJECTED – Action Completed

Medicaid EHR Incentive Program
Eligible Hospitals
Payment Rules

Summary

The Medicaid EHR Incentive Program payments will be made approximately 90-days after an Eligible Provider successfully meet the program's eligibility requirements. EH payments are disbursed on a rolling Federal fiscal year basis following verification of eligibility for the payment year.

Payments

Arizona's EHR Incentive Program payments for EHs are determined based on a formula and disbursed over a 4-year period. The Aggregate EHR Hospital Incentive Amount is calculated as the product of the Overall EHR Amount and the Medicaid Share. For each payment year, the EHR Incentive Program payment is based on a percentage (defined by the State) of this Aggregate EHR Hospital Incentive Amount.

Payment Limitations

1. EH payments are on a Federal Fiscal Year basis from October 1 – September 30.
2. EHs cannot receive more than the aggregate EHR incentive amount.
3. EHs may not begin receiving payments any later than Federal fiscal year 2016.
4. EHs may receive payments on a non-consecutive, annual basis prior to Federal fiscal year 2016.
5. A multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating the EHR Incentive Program payment.
6. No payments may be made after Federal fiscal year 2019 based on Arizona's 4-year incentive disbursement period.
7. EHs may be eligible for both the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program. Hospitals that register only for one of the programs will not be able to manually change their registration (i.e., change to "Both Medicare and Medicaid EHR Incentive Program" or from one program to the other) after a payment is initiated. It is our recommendation for the Eligible Hospital to select "Both Medicare and Medicaid" during the Federal Registration process even if planning to apply only for one of the programs.
8. EHs may receive an EHR Incentive Program payment from only one State in a payment year.
9. EHs must have an Electronic Funds Transfer (EFT) record with AHCCCS in order to receive payments.
10. There are no payment adjustments or penalties for Medicaid Eligible Providers.
11. Payments may be recouped in cases of fraud, abuse or if AHCCCS' audit determines the provider was ineligible for the EHR Incentive Program payment.

Medicaid EHR Incentive Program
Eligible Hospitals
System Access IDs

Summary

Eligible Providers will need their User IDs and passwords from various systems.

Eligible Hospital Data Elements				Provider Enters	
PROVIDER	**Provider Analysis Results**	EHR Incentive Program		Select One	Select 1 Medicaid EHR Incentive Program Medicare EHR Incentive Program Both EHR Incentive Program
	State	Medicaid State			Enter Medicaid State if selecting Medicaid EHR Incentive Program Or None (for Not Applicable)
	Tax Identification Number	TIN			Hospital verifies populated TIN
CMS	**CMS Certification Number**	CCN			Enter CCN
	CMS Identity and Access Management	I&A	User ID		Enter I&A ID
			Password		Enter I&A Password
	National Provider Identifier	NPI			Enter NPI
	National Plan & Provider Enumeration System	NPPES	User ID		Check NPPES ID
			Password		Check NPPES Password
	Provider Enrollment Chain & Ownership System	PECOS			Check PECOS to ensure EH has Active Enrollment Record
	CMS Registration & Attestation System	CMS Registration ID			Assigned from CMS Registration & Attestation System Enter in State's ePIP System
ONC	**ONC-Authorized Testing & Certification Board**	EHR Certification Number			Retrieve from ONC-ATCB website for your Certified EHR System
AHCCCS	**AHCCCS Provider Agreement**	AHCCCS Provider Number			Retrieve Your Current AHCCCS Provider Number
	Electronic Provider Incentive Payment	ePIP	User Name		Assigned from State EHR System (ePIP)
			Password		Provider Sets ePIP Password

Medicaid EHR Incentive Program
Eligible Hospitals
Patient Volume & Payment Data Elements

Summary

Eligible Providers must report components of their eligible patient volume. EHs must utilize their provider data, Hospital Medicare Cost Report and the hospital's financial statements.

Eligible Hospital Data Elements					Provider Enters
AIU Type		A	Adoption		Select One
		I	Implementation		
		U	Upgrade		
EHR Certified System		EHR Certification Number			
Provider Type		Acute Care Hospital Children's Hospital			Select One
CMS		CMS Certification Number (CCN)			
Hospital Medicare Cost Report *(12-month Hospital Medicare Cost Reporting Period)*		CMS Hospital Cost Report Form			Select One
		Hospital Medicare Cost Reporting Period			to
		Hospital Medicare Cost Report Preparation Date			
Average Length of Patient Stay *(12-month Hospital Medicare Cost Reporting Period)*		Total Inpatient Bed Days			
		Total Discharges {Current Year}			
PATIENT VOLUME *(90 day Reporting Period)*	**Patient Volume Reporting Period**	Patient Volume Reporting Period			to
	Patient Encounters	Medicaid Patient Encounters *(per state)*	Medicaid Inpatient Hospital Discharges		
			Medicaid Emergency Dept Discharges		
		Total Patient Encounters	Total Inpatient Hospital Discharges		
			Total Emergency Department Discharges		
PAYMENT *(12-month Hospital Medicare Cost Reporting Period)*	**Discharges**	Total Discharges {Current Year}			
		Total Discharges {Prior Year 1}			
		Total Discharges {Prior Year 2}			
		Total Discharges {Prior Year 3}			
	Medicaid Share	Medicaid Inpatient Bed Days			
		Total Inpatient Bed Days			
		Total Hospital Charges	OR	Total Hospital Cost {IHS Facilities} {638 Tribally Operated Facilities}	
		Total Charity Care Charges {EH uploads Report}			

Acronyms - General

The following acronyms are used in this document:

Acronym	Definition
AHCCCS	Arizona Health Care Cost Containment System
AI / AN	American Indian / Alaska Native
AIU / AIU1	Adoption, Implementation or Upgrade; AIU for first year
ARRA	American Recovery and Reinvestment Act
ASU-BMI	Arizona State University's Department of Biomedical Informatics
AzHeC	Arizona Health-e Connection
CMS	Centers for Medicare and Medicaid Services
DHCM	AHCCCS' Division of Health Care Management
EHR	Electronic Health Record
EHR IP	Electronic Health Record Incentive Program
EFT	Electronic Funds Transfer
ePIP	Electronic Provider Incentive Payment System
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HSAG	Health Services Advisory Group
MU / MU1	Meaningful Use; Meaningful Use for first year.
NIHB	National Indian Health Board
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
ONC	Office of the National Coordinator for Health Information Technology
ONC-ATCB	Office of National Coordinator -Authorized Testing & Certification Board
PMMIS	Prepaid Medicaid Management Information System
REC	Regional Extension Center
RPMS	Resource & Patient Management System

Acronyms - EH

The following acronyms are used in this document:

Acronym	Definition
CAH	Critical Access Hospital
CCN	CMS Certification Number (applies to hospitals only); previously know as the OSCAR Provider Number
DSH	Disproportionate Share Hospital Report
EH	Eligible Hospital
EIN	Employer Identification Number
FFY	Federal Fiscal Year (used by Eligible Hospitals in the EHR Incentive Program)
FY	Fiscal Year (used by Hospitals);
I&A	CMS Identity & Access Management
IHS	Indian Health Services
I/T/U	IHS, Tribal & Urban Indian Health Facilities (also referred to as IHS and 638 Tribally Operated Facilities)
MCR	Medicare Cost Report
TIN	Taxpayer Identification Number

Glossary - General

The following terms are used in this document.

Term	Definition
Adoption, Implementation or Upgrade	For Medicaid's EHR Incentive Program, the Adoption, Implementation or Upgrade (AIU) criteria requires the provider to obtain certified EHR technology for the first year (AIU1) of participation. This means that they must: o Acquire, purchase, or secure access to certified EHR technology; o Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or o Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.
AHCCCS	Arizona Health Care Cost Containment System is a state agency designated as Arizona's Medicaid Program.
AHCCCS Contractor	An organization, person or entity with a prepaid capitated contract with AHCCCS Administration to provide goods and services including health care services, to members either directly or through subcontractors with providers, in conformance with contractual requirements, AHCCCS statues & rules, and Federal law & regulation.
AHCCCS Member	Individual eligible for AHCCCS services based on their income and resources, citizenship, Arizona residency and/or medical condition who are enrolled with an AHCCCS Contractor or are Fee For Service.
AHCCCS Provider	A contracted/non-contracted provider who enters into a provider agreement with the AHCCCS Administration and meets licensing or certification requirements to provide AHCCCS covered services.
Attestation	Medicaid's EHR Incentive Program attestation process allows the providers to attest to the EHR Incentive Program's eligibility criteria as they demonstrate adoption, implementation, upgrade or meaningful use of EHR technology.
EHR Reporting Period	For demonstrating meaningful use of Electronic Health Records (EHRs), Eligible Providers must use the EHR reporting period associated with that payment year. For the first payment year (MU1) that an Eligible Provider is demonstrating meaningful use, the EHR Reporting Period is a continuous 90-day period within the payment year; for subsequent years, the EHR Reporting Period is the full payment year. For EPs, the payment year is on a Calendar Year basis. For EHs, the payment year is on a Federal Fiscal Year basis. There isn't an EHR Reporting Period associated with Adoption, Implementation, or Upgrade of certified EHR technology.
Eligible Providers	Eligible Professionals and Eligible Hospitals who have registered with the CMS Registration and Attestation System and request an EHR Incentive Program payment.
Meaningful Use	For Medicaid's EHR Incentive Program, the Meaningful Use criteria requires the provider to provide quantitative measures to substantiate meaningful use for a contiguous reporting period of 90 days for the first Meaningful User year (MU1) and the entire year for subsequent MU years. Medicaid Meaningful Use attestations will not be available in 2011. Functionality is currently being developed for deployment in 2012.
Patient Volume Reporting Period	A Continuous 90-day Period in the Prior Calendar Year for Eligible Professionals or Prior Fiscal Year for Eligible Hospitals.
Patient Volume Threshold	Total Medicaid/Needy Individual patient encounters in any representative continuous 90-day period in the preceding year, divided by the total of all patient encounters in the same 90-day period multiplied by 100.
Payee TIN	The Taxpayer Identification Number for a provider's payee.
Registration	Medicaid's EHR Incentive Program registration process allows the provider to participate in the EHR Incentive Program. Providers must complete a Federal and State level registration process.
TITLE XIX	The section of the Social Security Act which describes the Medicaid program's coverage for eligible persons, (i.e., medically indigent/needy).
TITLE XXI	The section (or Title) of the Social Security Act that authorizes the State Children's Health Insurance Program known as KidsCare in Arizona.

Glossary - EH

The following terms are used in this document.

Term	Definition
Allowable Discharges	Allowable Discharges are the number of projected discharges allowed in determining the Discharge Related Amount not to exceed 23,000 allowable discharges.
Average Annual Growth Rate	Hospital's growth rate measured by discharges averaged over the most recent 3 years using statistical fiscal year data reported on the filed/audited CMS Hospital Medicare Cost Report. Nursery (excluding NICU), observation, labor & delivery are not included in the inpatient bed-day or discharge counts because they are not considered to be acute inpatient services based on the level of care provided.
Average Length of Patient Stay	Average number of days a patient is confined in the hospital facility measured by the ratio of inpatient bed days to discharges using statistical fiscal year data reported on the filed/audited CMS Hospital Medicare Cost Report. Nursery (excluding NICU), observation, labor & delivery are not included in the inpatient bed-day or discharge counts because they are not considered to be acute inpatient services based on the level of care provided.
Charity Care Charges	Charity Care Charges are an initial payment obligation of patients who are given a full or partial discount based on the hospital's charity care criteria for care delivered for the entire facility as defined in the CMS Hospital Medicare Cost Report. The Hospital must upload the Charity Care Charges Report from the Hospital's financial records. This report must reflect the same reporting period used to determine the EHR Incentive Program payment.
CMS Certification Number	CMS Certification Number (CCN) is a unique hospital identifier used to verify Medicare/Medicaid certification. For purposes of determining the EHR Incentive Program eligibility, a multi-site hospital with one CMS Certification Number is considered one hospital for purposes of calculating the EHR Incentive Program payment.
Disbursement Percentage	Disbursement Percentage is the percentage of the Aggregate EHR Hospital Incentive Amount disbursed in each payment year as predefined by the State.
Discharge Related Amount	Discharge Related Amount is $0 for allowable discharges 1 to 1,149 and $200 per allowable discharge for allowable discharges from 1,150 to 23,000.
Eligible Hospitals	For purposes of determining Medicaid's EHR Incentive Program eligibility, Eligible Hospitals are: o Acute Care Hospitals are health care facilities where the average length of patient stay is 25 days or fewer and with a CMS Certification Number (CCN) that has the last four digits in the series 0001–0879 or 1300– 1399. o Children's Hospitals are a separately certified children's hospital, either freestanding or hospital-within hospital that predominantly treats individuals under 21 years of age and with a CMS Certification Number (CCN) that has the last 4 digits in the series 3300–3399.
Initial Amount	Base amount of $2,000,000 (defined by the Statue) plus the discharge related amount.
Medicaid Patient Encounter - EH	For purposes of calculating EH Patient Volume, Medicaid Encounters are: o Services rendered to an individual per inpatient hospital discharges where Medicaid paid for part or all of the service, individual's premiums, co-payments, and/or cost-sharing; o Services rendered to an individual in an emergency department on any one day where Medicaid paid for part or all of the service; premiums, co-payments, and/or cost-sharing. An emergency department must be part of the hospital under the qualifying CCN.
Medicaid Share	Percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients measured using statistical fiscal year data reported on the filed/audited CMS Hospital Medicare Cost Report. o For Discharges & Inpatient Bed-days data used in the Medicaid Share calculation, nursery (excluding NICU), observation, labor & delivery are not included in the inpatient bed-day or discharge counts because they are not considered to be acute inpatient services based on the level of care provided. o For Hospital Charges & Hospital Cost data used in the Medicaid Share calculation, nursery (including NICU), observation, labor & delivery are included in the hospital charges or hospital cost counts because they reflect the total amount of the eligible hospital's charges.
Overall EHR Amount	Amount is based on a theoretical 4-years of payment and is the product of the Initial Amount times the Transition Factor for each of the four payment years.
Projected Discharges	Discharges are first determined for Payment Year 1 and then calculated for subsequent years by applying the average annual growth rate for each successive year. Projected discharges for Year 1 are based on the total discharges from the Current filed Hospital Medicare Cost Report. For subsequent years, it is based on the average annual growth rate multiplied by the projected discharges from the prior year.
Transition Factor	Transition Factor phases down the EHR Incentive Program payments over a 4-year period. It is defined by the Statue based on Payment Year.

END OF DOCUMENT