Medicaid Electronic Health Record Incentive Program

Eligible Hospital Manual

OHA SHARED SERVICES
Office of Health Information Technology
Medicaid Health IT Project

Medicaid Electronic Health Record Incentive Program

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INTRODUCTION

The American Recovery and Reinvestment Act of 2009 was enacted on February 17, 2009. The Act provides for incentive payments to Eligible Professionals (EPs) and Eligible Hospitals (EHs) to promote the adoption and meaningful use of certified electronic health records (EHRs).

Hospitals and eligible health care providers who serve Oregon's most vulnerable individuals can access federal incentive funds to help support the implementation and use of certified electronic health record systems in clinics and hospitals across the state.

The use of electronic health records improves the quality of care provided to patients by providing immediate access to patients' medical histories, reducing repetitive testing and preventing harmful drug or treatment interactions.

The Centers for Medicare and Medicaid Services (CMS) administers the Medicare EHR Incentive Program, and the Oregon Health Authority's Division of Medical Assistance Programs administers the Medicaid EHR Incentive Program. Acute care hospitals (which include Critical Access Hospitals) that meet the eligibility criteria for both the Medicare and the Medicaid EHR Incentive Programs may receive payments from both programs.

The Medical Assistance Provider Incentive Repository (MAPIR) is a Web-based program administered by the Oregon Health Authority – Division of Medical Assistance Programs' Medicaid Electronic Health Record (EHR) Incentive Program that allows Eligible Professionals and Eligible Hospitals to apply for incentive payments to help defray the costs of a certified EHR system.

To apply for the Medicaid EHR Incentive Payment Program, Eligible Hospitals must first register with the CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System (R&A). Once registered, providers can submit an application and attest online in Oregon using MAPIR.

This manual provides step-by-step directions for using MAPIR and submitting an application to Oregon's Medicaid EHR Incentive Program.

The eligibility and qualification requirements are also included in this document.

Separately, the Hospital Worksheet, available online (http://www.medicaidehrincentives.oregon.gov/OHA/mhit/docs/EP-worksheet-v4.xls), helps organize your information to attest with Oregon. High-level information about the Medicaid EHR Incentive Program, including eligibility requirements and frequently asked questions, is included on the program website: www.MedicaidEHRIncentives.oregon.gov.

THE MEDICAID EHR INCENTIVE PROGRAM APPLICATION PROCESS

This section of the manual provides information about:

- What to do to prepare for registration and application for the incentive program
- How to register and apply
- Participation and eligibility guidelines

It is suggested that someone on your staff reviews this entire manual before going back and following the specific steps in this section.

Some things to know before you start:

- Your organization will need to register with the federal Centers for Medicare and Medicaid Services for this program first.
- To apply for the Oregon Medicaid incentive program, you will need to use the Medical Assistance Provider Incentive Repository (MAPIR), which is a Web-based program. This manual provides step-by-step instructions for using MAPIR.
- If you have additional questions that aren't answered in this manual, you can use the incentive program's website at www.MedicaidEHRIncentives.oregon.gov and/or call the Oregon Health Authority-Division of Medical Assistance Programs help desk at 503-945-5898 for one-on-one assistance.

FOR ADDITIONAL INFORMATION ONLINE:

The Oregon Administrative Rules for the Medicaid EHR Incentive Program can be found at www.dhs.state.or.us/policy/healthplan/guides/mehri/main.html.

High-level information about the incentive program, including eligibility requirements and frequently asked questions, is included on the program website: www.MedicaidEHRIncentives.oregon.gov.

PREPARATION STEPS

Before an application can be completed, the following steps need to be taken.

- Adopt, implement, or upgrade to a certified EHR system. If you have not completed these steps, seek assistance with EHR systems as needed. (www.medicaidehrincentives.oregon.gov/OHA/mhit/ehr-support.shtml).
- Be an Oregon Health Plan hospital. If you are not currently enrolled as an active Oregon Health Plan hospital, enroll now (www.oregon.gov/OHA/healthplan/tools_prov/providerenroll.shtml).

- Register the hospital's National Provider Identifier (NPI) with the Division of Medical Assistance Programs (DMAP). If you have not registered your hospital's NPI with DMAP, contact them now (http://dhsforms.hr.state.or.us/forms/served/oe1038.pdf). If you do not have an NPI, apply for one with the National Plan and Provider Enumeration System (NPPES). (https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions).
- Be ready to receive direct deposit from DMAP. The Medicaid EHR Incentive Program will deposit incentive payments directly into your designated account.
- Enroll in direct deposit (www.oregon.gov/OHA/healthplan/tools_prov/providerenroll.shtml). If you are already enrolled in direct deposit, please make sure that the account that is setup is the same account where you want incentive payments to be deposited.
- Secure access to and/or update your information in the Web Portal (https://www.or-medicaid.gov/ProdPortal/Default.aspx).
- The provider web portal will be used to access the software application that will be used for provider attestations. The person who completes the Medicaid EHR Incentive Program application must be assigned to the hospital's web portal account. DMAP enrolled providers who do not have access to the web portal will need to contact provider services to update or gain access to the web portal. The person with authority to assign roles for the hospital in the Provider Web Portal can assign a specific hospital representative to the role of "EHR Incentive" to complete the attestation (www.oregon.gov/dhs/healthplan/webportal.shtml).
- Be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS) (https://pecos.cms.hhs.gov/pecos/login.do). All eligible hospitals must be enrolled in PECOS to participate in either the Medicaid or Medicare EHR Incentive Programs. Obtain a CMS Identity & Access Management (I&A) User ID and Password. Additional hospital staff will need to request access to the EHR Incentive Programs application through Identity & Access Management and be approved by the Hospital's Authorized Official (https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do).
- Review this Manual to understand the program and prepare for attestation. Enter your data into the Eligible Hospitals Worksheet (www.medicaidehrincentives.oregon.gov/OHA/mhit/docs/EP-worksheet-v4.xls) to help organize your information to attest with Oregon.

APPLICATION STEPS

- Register with CMS. The Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A; https://ehrincentives.cms.gov/hitech/login.action) serves as a federal repository to register hospitals and track payments to hospitals for the Medicare and Medicaid EHR Incentive Programs. Registration is required for all providers seeking incentive payments. For more information on what you need to do to prepare for registration with CMS, see the Registration User Guide PDF (www.cms.gov/EHRIncentivePrograms/Downloads/EHRHospital_RegistrationUserGuide.pdf). CMS also has a video (www.youtube.com/user/

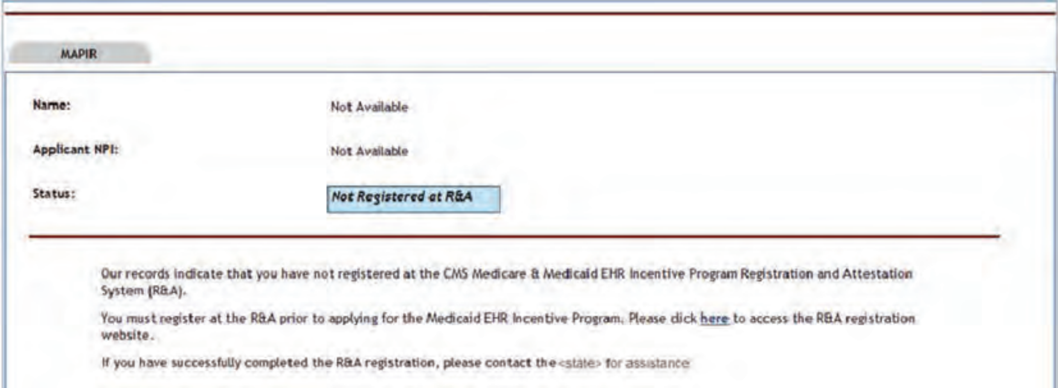
CMSHHSgov?feature=mhum#p/search/21/ExOQOaYwie4) available to help explain the registration process. Note: Hospitals are encouraged to register with CMS for both Medicaid and Medicare EHR Incentive Programs, whether eligible for one or both. There is no penalty if a hospital registers for both and is found eligible only for one, but it is more difficult to add a program once registration has begun.

- Complete an application with Oregon's Medicaid EHR Incentive Program. Hospitals can log on to the Provider Web Portal to access the Medicaid EHR Incentive Program application (https://www.or-medicaid.gov/ProdPortal/default.aspx).

STEP-BY-STEP GUIDANCE ON REGISTRATION AND APPLICATION

You must register at the R&A before accessing MAPIR. If you access MAPIR and have not completed this registration, you will receive the following screen:

Figure 1: R&A Registration Status



Please access the federal Web site below for instructions on how to do this or to register.

For general information regarding the Incentive Payment Program: www.cms.gov/EHRIncentivePrograms

To register: https://ehrincentives.cms.gov/hitech/login.action

CMS also has a video (www.youtube.com/user/CMSHHSgov?feature=mhum#p/search/21/ExOQOaYwie4) available to help explain the registration process.

COMPLETE YOUR R&A REGISTRATION.

You will not be able to start your MAPIR application process unless you have successfully completed this federal registration process. Once MAPIR has received and matched your provider information, you will receive an email to begin the MAPIR application process. Please allow at least two days from the time you complete your federal registration before accessing MAPIR due to the necessary exchange of data between these two systems.

IDENTIFY ONE INDIVIDUAL TO COMPLETE THE MAPIR APPLICATION.

MAPIR is accessed through Oregon's Provider Web Portal (www.oregon.gov/dhs/healthplan/webportal.shtml). Once an individual has started the MAPIR application process with his portal account, he cannot switch to another account during that payment year. MAPIR will allow the user to save the information entered and return later to complete an application; however, only the same individual's portal account will be permitted access to the application after it has been started.

GATHER THE NECESSARY INFORMATION TO FACILITATE THE COMPLETION OF THE REQUIRED DATA.

MAPIR will request specific information when you begin the application process. To facilitate the completion of the application, it is recommended that you review the manuals and worksheet to understand what information will be required. At a minimum, you should have the following information available:

- Information submitted to the R&A
- A completed worksheet that includes Patient Volume and associated timeframes (http://medicaidehrincentives.oregon.gov/OHA/mhit/docs/EH-worksheet-v4.xls)
- The CMS EHR Certification ID that you obtained from the ONC Certified Health IT Product List (CHPL) Web site (http://onc-chpl.force.com/ehrcert).

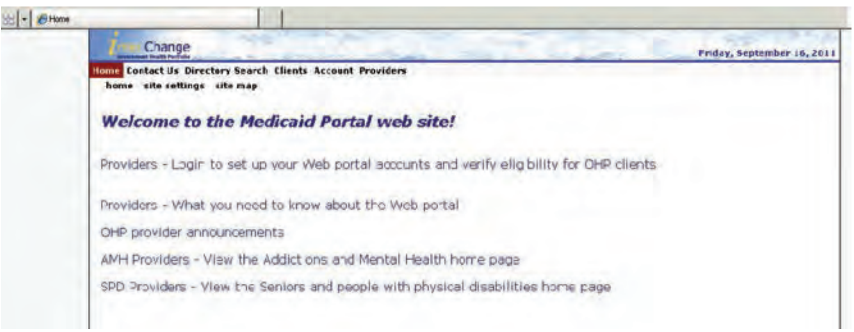
All documentation that supports your attestation must be retained for seven years.

USING THE PROVIDER WEB PORTAL TO ACCESS MAPIR

MAPIR is accessed through Oregon's Provider Web Portal (www.oregon.gov/dhs/healthplan/webportal.shtml). Once an individual has started the MAPIR application process with her portal login, she cannot use a different user login during that payment year. MAPIR will allow the user to save the information entered and return later to complete an application; however, only the same individual's portal account will be permitted access to the application after it has been started.

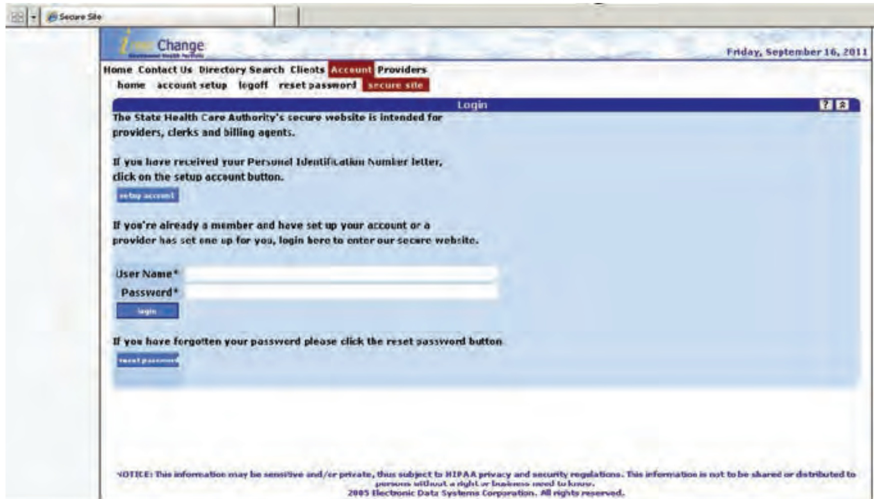
Select the first hyperlink for Providers to log in or assign a clerk the role of **EHR Incentives.**

Figure 2: Medicaid Portal welcome



Click on **Providers** to log in.

Figure 3: Portal Login



Type in User Name and Password. Select **Login** button.

ACCESSING THE EHR INCENTIVE (MAPIR) APPLICATION IN THE PROVIDER WEB PORTAL

For the hospital and provider types that are eligible for the Medicaid EHR Incentive Program you will see the Medicaid Electronic Health Record (EHR) Incentive Application Status message on the screen. This message shows the path to access MAPIR by selecting **EHR Incentive** from the **Providers** menu.

Clerks who have Provider Web Portal access rights to assign roles will be able to self-assign the appropriate role of **EHR Incentive.** If the clerk does not have access rights to assign roles, the administrator of the account will have to assign the role of **EHR Incentive.**

Once you select **Providers** in the menu along the top of the page and scroll to **EHR Incentive** from the dropdown list, or select **EHR Incentive** from the horizontal list across the second row of menu items, then the MAPIR application will open in a new window.

Figure 4: MAPIR application

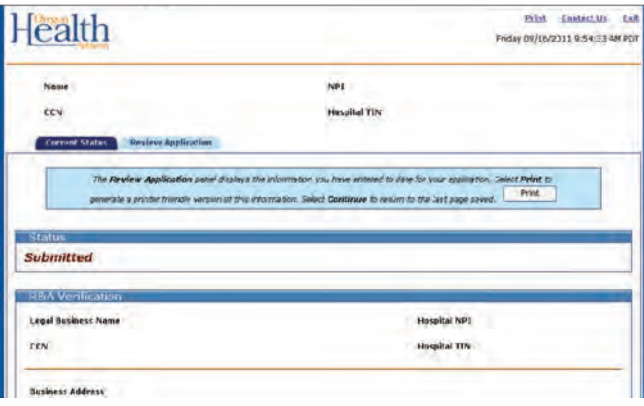


Figure 5: MAPIR confirmation

You are now logged into MAPIR and will see the Provider Name, Applicant NPI, and the current status of the MAPIR application. The identifying information that the provider entered at the CMS R&A system will be shown across the top. The **Review Application** tab will give providers an overview of the information they have entered in the MAPIR application.

BACKGROUND ON THE PROGRAM

PARTICIPATION GUIDELINES

LENGTH OF PARTICIPATION

The Medicaid EHR Incentive Program begins in 2011 and concludes in 2021.

YEARS OF PARTICIPATION

Medicaid eligible hospitals that adopt, implement, upgrade, or meaningfully use certified EHR technology may begin receiving incentive payments in any year from federal fiscal year (FFY) 2011 to FFY 2016. The last year for an eligible hospital to begin to receive payment is FFY 2016. In addition, after FFY 2016, payments must be consecutive; a hospital will not receive an incentive payment if it did not receive a payment in the prior fiscal year. A multi-site hospital with one CMS Certification Number (CCN) is considered one hospital for purposes of calculating payment.

ONE STATE

Hospitals may receive a Medicaid EHR incentive payment from only one state for a payment year.

DUAL ELIGIBLE FOR BOTH EHR INCENTIVE PROGRAMS

Hospitals may participate in both the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program in any given payment year.

IMPLEMENTATION YEAR

Eligible hospitals have 60 days after the end of the payment year to apply for an incentive payment. The payment year for eligible hospitals is based on the federal fiscal year (i.e., Oct. 1 – Sept. 30). For example, Nov. 30, 2011 was the last day to apply for a 2011 payment.

APPLICATION PROCESSING AND PAYMENT TIMING

Most applications are requiring some additional clarification or documentation from applicants. Therefore, after you submit your application, you should anticipate getting a communication from program staff asking for some additional documentation.

Once your application has been completely reviewed, you have provided any necessary supplemental documentation, and your application is approved, you will then receive your payment within 45 days of approval.

Your payment will be processed as an Electronic Fund Transfer, and will be indicated on the Provider Remittance Advice (RA) as Systems Payouts – Non-claim specific.

HOSPITAL TYPE

The two types of hospitals included in the Medicaid EHR Incentive Program are acute care and children's. Hospitals will be asked to select their hospital types in the CMS registration and attestation system and then confirm that information in their applications for Oregon Medicaid EHR incentive payments.

DEFINITIONS

Acute care hospital — A healthcare facility, including but not limited to a critical access hospital:

- with a CMS certification number (CCN) that ends in 0001-0879 or 1300-1399; and
- where the average length of patient stay is 25 days or fewer.

Children's hospital — A separately certified hospital, either freestanding or hospital-within-a-hospital that:

- has a CMS certification number that ends in 3300–3399; and
- predominantly treats individuals under 21 years of age.

A multi-site hospital with one CCN is considered one hospital for purposes of calculating payment.

OREGON-SPECIFIC INFORMATION

Indian Health Service-owned hospitals and cancer hospitals may be eligible if they meet the certification requirements to have a CCN in the required ranges. Because the eligibility criteria limit CCNs to those ending in 0001-0879 or 1300-1399, it is unlikely that any Indian Health Service-owned hospitals or cancer hospitals in Oregon will meet this definition.

Similarly, because the eligibility criteria limit children's hospitals to those with CCNs that end in 3300-3399, no children's hospitals in Oregon are expected to qualify. Existing Oregon children's hospitals all fall within larger hospital systems with CCNs that fall outside the specified range.

PATIENT VOLUME

An acute care hospital must meet at least 10% Medicaid patient volume; however, a children's hospital is exempt from meeting a patient volume threshold.

Patient volume is determined using encounters for a 90-day period, selected by the hospital, in the prior federal fiscal year which runs from October 1 to September 30.

A Medicaid encounter means:

- Services rendered to an individual per inpatient discharge (service code 21) where Medicaid paid for part or all of the service, premiums, copayments, or cost-sharing; or
- Services rendered in an emergency department (place of service code 23) on any one day where Medicaid paid for part or all of the service, premiums, copayments, and cost-sharing.

CHIP PROXY

The following information will help hospitals determine their patient volume, especially regarding the Children's Health Insurance Plan (CHIP). Because the Oregon Health Plan (OHP) includes both Medicaid and CHIP funding, hospitals do not have a way of knowing which funding streams cover their OHP patients. The federal rule around the Medicaid EHR Incentive Program does not allow encounters paid by CHIP to be counted as part of the Medicaid patient volume. To simplify calculations, Oregon determined a CHIP proxy of 4.4% (based on statewide averages) which has been approved by CMS for patient volume calculations. Hospitals applying for an Oregon Medicaid EHR incentive should calculate their patient volume by applying the CHIP proxy. Hospitals reduce their OHP encounters by 4.4% before submitting their patient volume using the following formula:

Oregon's "Patient Encounter" Calculation requirement using CHIP proxy

Figure 6: Patient encounter calculation

$$\frac{\text{Oregon Health Plan encounters* x 0.956\%}}{\text{Total patient encounters}}$$

*In any representative 90-day period in the prior federal fiscal year.

If you do not meet the patient volume threshold using the CHIP proxy, and believe you meet the patient volume threshold because you have reason to believe that your CHIP patient volume is lower than 4.4%, please contact the Incentive Program staff for assistance at the time of attestation to determine your actual Medicaid patient volume.

CLARIFICATIONS

Figure 7: Data for the patient volume calculation

Variable	Medicaid data for patient volume calculation
Unit	Discharges and Encounters
Patient Type	Inpatient and ED
Funding	Apply CHIP proxy to OHP to determine Medicaid
Dual Eligibles	Included
Healthy Newborns	Included (if in POS 21 or POS 23)
Time Period	90 Days
Time Frame	Previous Federal Fiscal Year

Nursery inpatient bed-days and discharges within Place of Service (POS) 21 or 23 may be included in the patient volume calculation. (Note: Nursery inpatient bed-days and discharge counts are not included when calculating the hospital incentive payment amount.)

Outpatient hospital visits (place of service code 22) do not count as encounters. The place of service code 22 is used for diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

ADOPT, IMPLEMENT, UPGRADE, OR DEMONSTRATE MEANINGFUL USE OF CERTIFIED EHR TECHNOLOGY

CERTIFIED EHR TECHNOLOGY

Complete EHRs and EHR modules are required to be certified through an Authorized Testing and Certified Body (ATCB; http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3120) designated by the Office of the National Coordinator (ONC). A complete, up-to-date list of certified products can be found on the ONC Certified HIT Product List (CHPL; http://onc-chpl.force.com/ehrcert). This same ONC website is also used to obtain the CMS certification ID which is required on the application for an incentive payment.

The certified EHRs on the list are identified with the name of the certifying ATCB, the ONC certification number, vendor information, product information, and product version number. Certified EHR technology may be a single complete system or comprised of multiple modules. When making selections on the website, all modules used must be selected even if a complete certified EHR is used – e.g., a certified complete system is used with a separate data repository that is certified as a module.

ADOPT, IMPLEMENT, UPGRADE, AND MEANINGFUL USE

In the first year of participation, hospitals that are applying only for a Medicaid EHR incentive payment do not need to meet meaningful use reporting requirements. For this reason many hospitals may attest to the adoption, implementation or upgrade (AIU) of certified EHR technology.

- Adopt: Acquire, purchase, or secure access to certified EHR technology
- Implement: Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements
- Upgrade: Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria

Adopt, Implement, or Upgrade is unique to the Medicaid EHR Incentive Program. Hospitals that participate in the Medicare EHR Incentive Program must report meaningful use in all years of participation. There is no reporting period for AIU, which means hospitals can adopt at any time prior to applying for an incentive payment.

If a hospital has already been deemed by the Medicare EHR Incentive Program to demonstrate meaningful use for the payment year, then that hospital will attest as a meaningful user for Oregon's Medicaid EHR Incentive Program. These meaningful use hospitals do not have to meet any meaningful use criteria in Oregon to qualify for the Medicaid EHR incentive payment for the same payment year. This includes the public health immunization criteria.

Figure 8

WHAT DOCUMENTATION IS NEEDED TO DEMONSTRATE AIU?

Providers will be asked to enter their 15-digit CMS EHR Certification ID from the ONC Certified HIT Product List website.

At the end of the application, providers should upload documentation as proof of adopting, implementing, or upgrading to a certified EHR technology.

CMS is requiring that Oregon validate this eligibility criterion by verifying at least one of the four following types of documentation:

- copy of a software licensing agreement
- contract
- invoices
- receipt that validates your acquisition

Vendor letters and other documents may also be submitted as a supplement to the items on the documentation list above. However, these supplemental documents will not satisfy program eligibility requirements on their own.

PAYMENTS

MEDICAID EHR INCENTIVE PAYMENT CALCULATION

The Medicaid EHR Incentive Program hospital calculation is a one-time calculation of a total incentive payment, which is distributed over three years in Oregon. The calculation consists of two main components:

1. The Overall EHR Amount
2. The Medicaid Share

PAYMENT STRUCTURE

Payments are disbursed to an eligible hospital on a rolling basis following verification of eligibility for the payment year. An eligible hospital is paid the aggregate incentive amount over three years of qualified participation in the Medicaid EHR Incentive Program. The Medicaid incentive payment amount is calculated once to determine the total amount a hospital could receive in incentive payments. In Oregon, incentives will be paid out over three years as follows:

- Payment Year 1: 50% Aggregate EHR Hospital Incentive Amount
- Payment Year 2: 40% Aggregate EHR Hospital Incentive Amount
- Payment Year 3: 10% Aggregate EHR Hospital Incentive Amount

DATA

The Medicaid EHR hospital incentive payment calculation data includes but are not limited to the hospital's Medicare cost report. Oregon is asking that Eligible Hospitals submit the Medicare cost reports supporting the information attested to for the payment calculation. This information is needed to assure expedient processing. All documentation that supports your attestation must be retained for seven years. CMS's FAQ on what information should be used in the payment calculation can be found at https://questions.cms.gov/ if you search text for 10771, which is the FAQ number. The following table lists the Medicare cost report data elements included in the hospital payment calculation:

Figure 9: Medicare cost report data elements

Component	2552-96 (Old)	2552-10 (New)
Medicaid IP Bed Days	Worksheet S-3, Part I, Column 5, Lines 1, 2 & 6-10	Worksheet S-3, Part I, Column 7, Lines 1, 2 & 8-12
Total IP Bed Days	Worksheet S-3, Part I, Column 6, Lines 1, 2 & 6-10	Worksheet S-3, Part I, Column 8, Lines 1, 2 & 8-12
Total Discharges	Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14
Total Charges	Worksheet C, Part I, Column 8, Line 101	Worksheet C, Part I, Column 8, Line 200
Charity Charges	* Worksheet S-10, Column 1, Line 30	Worksheet S-10, Column 3, Line 20

* CMS has provided clarification that Charity Charges must have uncompensated care removed from this line of the cost report for this program. If the hospital has included uncompensated care in this line, it must be subtracted out before being entered into the application.

Oregon requires that hospitals only report paid days in their calculation of inpatient bed days. If the hospital's cost report data contains unpaid days, the hospital will be expected to submit an auditable report along with the cost report that demonstrates the difference between the cost report data and the paid days that are attested to in MAPIR.

THE MEDICAID EHR INCENTIVE PAYMENT CALCULATION

Aggregate EHR Amount (product of the Overall EHR amount and Medicaid Share)

OVERALL EHR AMOUNT

The Overall EHR Amount is the product of an Initial Amount, the Medicare Share, and a Transition Factor calculated for each of four theoretical payment years and then summed.

Theoretical Year:	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Initial amount (also see table below to calculate discharge-related amount) =	(a base amount of $2,000,000) + (Year 1 discharge-related amount)	(a base amount of $2,000,000) + (Year 2 discharge-related amount)	(a base amount of $2,000,000) + (Year 3 discharge-related amount)	(a base amount of $2,000,000) + (Year 4 discharge-related amount)
Medicare share =	1	1	1	1
Transition factor =	1.00	0.75	0.50	0.25
Total Yearly EHR amount:	(Initial amount) x (Medicare share) x (Transition factor)	(Initial amount) x (Medicare share) x (Transition factor)	(Initial amount) x (Medicare share) x (Transition factor)	(Initial amount) x (Medicare share) x (Transition factor)
Overall EHR Amount =	Sum of the 4 Yearly EHR Amounts			

INITIAL AMOUNT (CALCULATED FOR EACH THEORETICAL PAYMENT YEAR)

The initial amount is the sum of a base amount and a discharge-related amount. The base amount is $2,000,000, and the discharge-related amount provides an additional $200 for estimated discharges between 1,150 and 23,000 discharges. No payment is made for discharges prior to the 1,150th discharge or for discharges after the 23,000th discharge. See table below.

	Hospitals with ≤ 1,149 discharges during the payment year	Hospitals with ≥ 1,150 ≤ 23,000 discharges during the payment year	Hospitals with ≥ 23,001 discharges during the payment year
Base Amount	$2,000,00	$2,000,000	$2,000,000
Discharge-Related Amount		$200 x (n – 1,149) (n is the number of discharges during the payment year)	$200 x (23,001 – 1,149)
Adjusted by average annual rate of growth	Average of most recent three years annual rate of growth in total discharges		

Continues on next page

Total Initial Amount	$2,000,000	Between $2,000,000 and $6,370,400 depending on the number of discharges	Limited by law to $6,370,400

Hospital discharge data are derived from discharges during the hospital fiscal year that ends during the federal fiscal year prior to the hospital fiscal year that serves as the first payment year. For example, a hospital wants to apply for an incentive payment for the first time in August 2012 and the hospital's fiscal year ends on Jun 30, 2010. The prior federal fiscal year ended on 9-30-2011. Therefore, the hospital would use discharges from their 2011 hospital fiscal year because the hospital fiscal year end 6-30-2011 falls within the federal fiscal year 10-01-2010 to 9-30-2011. See Figure 11 for more examples.

MEDICAID SHARE:

The Medicaid share incorporates the proportion of Medicaid bed days out of total bed days adjusted for charity care. See formula below:

Estimated # of inpatient-bed-days attributable to Medicaid*, including: fee-for-service, managed care, pre-paid inpatient health plan, or pre-paid ambulatory care plan

(÷)

Estimated total # of inpatient-bed-days for the eligible hospital during that period

(x)

Estimated total amount of the eligible hospital's charges during that period minus charity care

Estimated total amount of the eligible hospital's charges during that period including charity care

* Most hospitals will be eligible for both a Medicare and a Medicaid EHR incentive payment. For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share for a Medicare incentive payment. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator.

AVERAGE ANNUAL GROWTH RATE:

To calculate the average annual growth rate the hospital will report the total discharges from the four most recent hospital fiscal year cost reports. Total discharges are the sum of all inpatient discharges. The annual growth rate calculation for each year is: [(Total Discharges for the Year) – (Total Discharges for the Previous Year)] ÷ (Total Discharges for the Previous Year). See the following example:

Fiscal Year	Total Discharges	Calculating Annual Growth Rate	Annual Growth Rate
2010	*A*	*(A – B) ÷ B x 100*	*E%*
2009	*B*	*(B - C) ÷ C x 100*	*F%*
2008	*C*	*(C – D) ÷ D x 100*	*G%*
2007	*D*		
Average Annual Growth Rate		**(E + F + G) ÷ 3**	**X%**

Figure 11: Selecting the correct year for discharge

HOSPITAL FISCAL YEAR END	2012 PAYMENT YEAR
March	April 1, 2010 through March 31, 2011
April	May 1, 2010 through April 30, 2011
June	July 1, 2010 through June 30, 2011
July	August 1, 2010 through July 31, 2011
September	October 1, 2010 through September 30, 2011
December	January 1, 2010 through December 31, 2010

THE OVERALL EHR AMOUNT

The Overall EHR Amount is the base amount of $2,000,000 added to a discharge-related amount and then multiplied by a transition factor. This figure is calculated over four years beginning with the hospital fiscal year ending in the federal fiscal year that serves as the payment year. For example, to receive a payment for 2011, the first year is the hospital fiscal year that ends in federal fiscal year 2011 (October 1, 2010 through September 30, 2011). The discharge-related amount is projected for the three years following the first payment year by adjusting total discharges using the average annual rate of growth of the hospital's total discharges for the previous three years. To arrive at the discharge-related amount, the estimated total discharges for each year between 1,150 and 23,000 are multiplied by 200.

HOW IT IS DETERMINED

The Overall EHR Amount is determined by calculating, for each of the theoretical four years of payment: the initial amount multiplied by the transition factor, and then adding all four years together.

Figure 12: Overall EHR amount

OVERALL EHR INCENTIVE AMOUNT IS THE SUM OF

{ Year 1 amount = (2,000,000 + (200 * (Year 1 discharges up to 23,001 - 1,149))) * (Transition Factor = 1) }

\+

{ Year 2 amount = (2,000,000 + (200 * ((Year 1 discharges + (Year 1 discharges * Average Annual Growth Rate) up to 23,001) - 1,149))) * (Transition Factor = 0.75) }

\+

{ Year 3 amount = (2,000,000 + (200 * ((Year 2 discharges + (Year 2 discharges * Average Annual Growth Rate) up to 23,001) - 1,149))) * (Transition Factor = 0.5) }

\+

{ Year 4 amount = (2,000,000 + (200 * ((Year 3 discharges + (Year 3 discharges * Average Annual Growth Rate) up to 23,001) - 1,149))) * (Transition Factor = 0.25) }

THE INITIAL AMOUNT

Initial Amount = a base amount of $2,000,000 + a discharge-related amount for each year.

THE DISCHARGE-RELATED AMOUNT

The discharge-related amount provides an additional $200 for discharges between 1,150 and 23,000 for each of the four years. No discharge-related payment is made for discharges less than 1,150, or for discharges greater than 23,000.

AVERAGE ANNUAL GROWTH RATE

The average annual growth rate is calculated by determining the annual percentage change in total discharges from the payment year and the three most recent years for which data are available. Each year's percentage change is then averaged and that resulting percentage is the average annual growth rate. This average is then applied to the first year's total discharges to either increase or decrease the total discharges in theoretical years 2 through 4. Note that if a hospital's average annual rate of growth is negative over the three-year period, it is applied as such.

TRANSITION FACTOR

The transition factor is applied to the initial amount, so that the initial amount diminishes by 25% for each year.

THE MEDICAID SHARE

The Medicaid Share determines the Medicaid portion of the Overall EHR Amount. Charity care charges are removed from the formula to increase incentive payments for hospitals with a higher proportion of charity care. CMS has provided clarification that Charity Charges must have uncompensated care removed from this line of the cost report for this program. If the hospital has included uncompensated care in this line, it must be subtracted out before being entered into the application.

The formula for the Medicaid Share is as follows:

Figure 13: Medicaid Share

MEDICAID SHARE =

$$\frac{\left(\text{Estimated \# of inpatient-bed days attributable to Medicaid, managed care, pre-paid inpatient health plan, or pre-paid ambulatory health plan}\right)}{\text{Estimated total \# of inpatient-bed-days for the eligible hospital during that period} \times \frac{\left(\text{Estimated total amount of the eligible hospital's charges during that period minus charity care}\right)}{\left(\text{Estimated total amount of the eligible hospital's charges during that period including charity care}\right)}}$$

DUAL ELIGIBLE PATIENTS

The numerator of the Medicaid Share calculation must exclude inpatient-bed-days for patients who are eligible for both Medicaid and Medicare. Due to the fact that hospitals are eligible for both Medicare and Medicaid incentives, and hospitals are not to be paid twice for the same patient, these dual-eligible patients must be excluded from Medicaid. However, the denominator, total inpatient-bed-days, must include these dual eligibles.

PAYMENT YEAR

The Federal Fiscal Year (FFY) for which an eligible hospital is attesting to qualify for an incentive payment.

THE MEDICAID AGGREGATE EHR INCENTIVE PAYMENT AMOUNT

The Medicaid Aggregate EHR amount is the Overall EHR Amount multiplied by the Medicaid Share. An example of the payment calculation can be found on page 21-22. This is the amount that will be broken into three incentive payments and paid to hospitals for each of three qualified payment years. The lines from the Medicare cost report that correspond to each data element are identified on page 15-16.

CLARIFICATIONS

Figure 14: Differences between the patient volume and payment calculations

	Medicaid Threshold (10% patient volume calculation)	Medicaid Share (payment calculation)
Unit	Discharges and Encounters	Days
Patient Type	Inpatient and ED	Inpatient
Qualification	Medicaid paid	Medicaid paid
Dual Eligibles	Included	Excluded
Healthy Newborns	Included (if in POS 21/23)	Excluded
Time Period	90 Days	1 Year
Time Frame	Previous Federal Fiscal Year	Hospital Fiscal Year*
CHIP	Apply CHIP proxy	No CHIP proxy

* Hospital fiscal year, "ending in the Federal fiscal year before the hospital's fiscal year that serves as the first payment year." 42 CFR §495.310(g)

Oregon requires that hospitals report only paid days in their calculations of inpatient bed days. If the hospital's cost report data contains unpaid days, the hospital will be expected to submit an auditable report along with the cost report that demonstrates the difference between the cost report data and the paid days that are attested to in MAPIR.

The CHIP proxy will not be applied to the Medicaid inpatient bed days for the hospital payment calculation because Oregon hospitals are able to distinguish CHIP from Medicaid in the inpatient setting.

Nursery days and discharges are excluded from the payment calculation because they are not considered acute inpatient services.

EXAMPLE HOSPITAL PAYMENT CALCULATION

Figure 15: Example of Average Annual Growth Rate Calculation

Fiscal Year	Total Discharges	Calculating Annual Growth Rate	Annual Growth Rate
2010	2,000	(2,000 – 1,918) ÷ 1,918 x 100	4.3%
2009	1,918	(1,918 – 1,835) ÷ 1,835 x 100	4.5%
2008	1,835	(1,835 – 1,745) ÷ 1,745 x 100	5.2%
2007	1,745		
Average Annual Growth Rate		(4.4+4.5+5.2) ÷ 3	4.7%

Figure 16: Example of medicaid share calculation

Medicaid Share calculation	7,000 (÷) 21,000 x (8,700,000/10,000,000)	= 0.38

Figure 17: Example Aggregate EHR Incentive Amount Calculation

Aggregate EHR Incentive Amount							
	Initial amount			Transition factor	Yearly EHR amount (Initial x Transition)	Medicaid share	Aggregate EHR Incentive Amount (Yearly EHR Amount x Medicaid share)
	Base amount	Discharge related amount					
		Discharges (Years 2-4 adjusted by 4.7% average annual rate of growth)	Total discharge related amount				
Year 1	$2m	200 x (2000-1149)	170,200	1	$2,170,200		
Year 2	$2m	200 x (2094-1149)	189,000	0.75	$1,641,750		
Year 3	$2m	200 x (2192-1149)	208,600	0.5	$1,104,300		
Year 4	$2m	200 x (2295-1149)	229,200	0.25	$557,300		
Total					$5,473,550	0.38	$2,079,949

Figure 18: Example Fields

Fields to enter into MAPIR	Example hospital data
FY 2010 total discharges	2,000
FY 2009 total discharges	1,918
FY 2008 total discharges	1,835
FY 2007 total discharges	1,745
Medicaid inpatient bed days	7,000
Inpatient bed days	21,000
Total charges excluding charity care	$8,700,000
Total charges for the period	$10,000,000

Figure 19: Example Incentive Payment Disbursement

Payment Year	Aggregate Payment %	Payment Amount
Year 1	50%	$1,039,974.50
Year 2	40%	$831,979.60
Year 3	10%	$207,994.90
Total	100%	$2,079,949.00

USING MAPIR

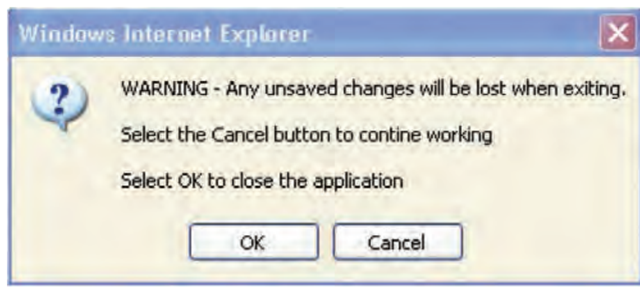
MAPIR uses a tab arrangement to guide you through the application. You must complete the tabs in the order presented. You can return to previous tabs to review the information or make modifications until you submit the application. You cannot proceed without completing the current tab in the application progression, with the exception of the Get Started and Review tabs which you can access anytime. Once you submit your application, you can no longer modify the data. It will only be viewable through the Review tab. Also, the tab arrangement will change after submission to allow you to view status information.

As you proceed through the application process, you will see your identifying information such as Name, National Provider Identifier (NPI), and Tax Identification Number (TIN) at the top of most screens. This is information provided by the R&A.

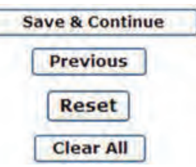
A **Print** link is displayed in the upper right-hand corner of most screens to allow you to print information entered. You can also use your Internet browser print function to print screen shots at any time within the application.

There is a **Contact Us** link with contact instructions should you have questions regarding MAPIR or the Medicaid EHR Incentive Program.

Most MAPIR screens display an **Exit** link that closes the MAPIR application window. If you modify any data in MAPIR without saving, you will be asked to confirm if the application should be closed (as shown to the right).



You should use the **Save & Continue** button on the screen before exiting or data entered on that screen will be lost.



The **Previous** button always displays the previous MAPIR application window without saving any changes to the application.

The **Reset** button will restore all unsaved data entry fields to their original values.

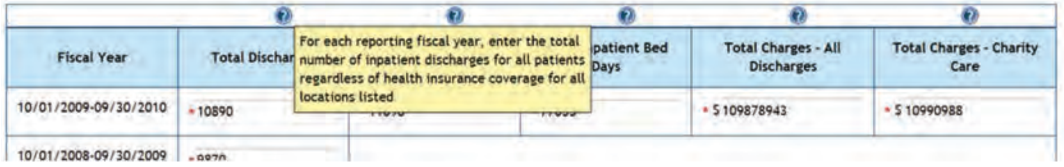
The **Clear All** button will remove standard activity selections for the screen in which you are working.

A red asterisk (*) indicates a required field. Help icons located next to certain fields display help content specific to the associated field when you hover the mouse over the icon.

Note: Use the MAPIR Navigation buttons in MAPIR to move to the next and previous screens. Do not use the browser buttons as this could result in unexpected results. As you complete your incentive application you may receive validation messages requiring you to correct the data you entered. These messages will appear above the navigation button. See the Additional User Information section for more information.

Many MAPIR screens contain help icons to give the provider additional details about the information being requested. Moving your cursor over the will reveal additional text providing more details.

Figure 20: Help icons



Fiscal Year	Total Dischar[ges]		[In]patient Bed Days	Total Charges - All Discharges	Total Charges - Charity Care
10/01/2009-09/30/2010	* 10890			* $ 109878943	* $ 10990988
10/01/2008-09/30/2009					

STEP 1 — GETTING STARTED

1. Log in to the state Medicaid portal (www.or-medicaid.gov/ProdPortal/Default.aspx) and locate the **MAPIR** link.
2. Click the link to access the **MAPIR** screen.

The screen below, the Medicaid EHR Incentive Program Participation Dashboard, is the first screen you will see when you begin the MAPIR application process.

This screen displays your incentive applications. Only the incentive applications that you are eligible to apply for are enabled.

The **Status** will vary, depending on your progress with the incentive application. The first time you access the system the status should be **Not Started.**

From this screen you can choose to edit and view incentive applications in an Incomplete or Not Started status. You can only view incentive applications that are in a Completed, Denied, or Expired status. Also from this screen, you can choose to abort an incentive application that is in an Incomplete status. When you click **Abort** on an incentive application, all progress will be eliminated for the incentive application.

When an incentive application has completed the payment process, the status will change to **Completed.**

3. Select an application and click **Continue.**

Figure 21: Dashboard

Medicaid EHR Incentive Program Participation Dashboard

NPI TIN

CCN

(*) Red asterisk indicates a required field.

*Application (Select to Continue)	Status	Payment Year	Program Year	Incentive Amount	Available Actions
	Not Started	1	2012	Unknown	Select the "Continue" button to begin this application.
	Future	2	Future	Unknown	None at this time
	Future	3	Future	Unknown	None at this time
	Future	4	Future	Unknown	None at this time

Continue

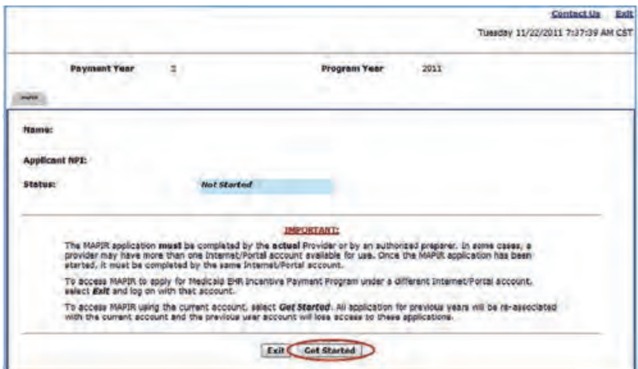
Note: Oregon allows a grace period which extends the time to apply in a Payment Year for 60 days. If two applications are showing for the same Payment Year, but different Program Years, one of your incentive applications is in the grace period. In this situation, the following message will display at the bottom of the screen.

You are in the grace period for program year <Year> which began on <Date> and ends on <Date>. The grace period extends the amount

of time to submit an application for the previous program year. You have the option to choose the previous program year or the current program year.

You may only submit an application for one Program Year so once you select the application, the row for the application for the other Program Year will no longer display. If the incentive application is not completed by the end of the grace period, the status of the application will change to Expired and you will no longer have the option to submit the incentive application for that Program Year.

Figure 22: Start screen



This screen will display with the information for the incentive application you selected. A status of *Not Registered at R&A* indicates that you have not registered at the R&A, or the information provided during the R&A registration process does not match that on file with the state Medicaid Program. If you feel this status is not correct you can click the Contact Us link in the upper right for information on contacting the state Medicaid program office. A status of *Not Started* indicates that the R&A and state MMIS information have been matched and you can begin the application process.

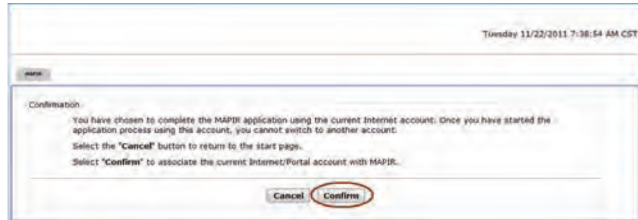
For more information on statuses, refer to the Additional User Information section later in this guide.

Click **Get Started** to access the **Get Started** screen or **Exit** to close the program.

If you selected an incentive application that you are not associated with, you will receive a message indicating that a different Internet/Portal account has already started the Medicaid EHR Incentive Payment Program application process and that the same Internet/Portal account must be used to access the application for this Provider ID. If you are the new user for the provider and want to access the previous applications, you will need to contact your *Oregon Medicaid EHR Incentive Program* for assistance.

Click **Confirm** to associate the current Internet/portal account with this incentive application.

Figure 23: Confirmation



Click **Begin** to proceed to the **R&A/Contact Info** section.

Figure 24: Guidance page

STEP 2 — CONFIRM R&A AND CONTACT INFO

When you complete the R&A registration, your registration information is sent to Oregon's Medicaid EHR Incentive Program. This section will ask you to confirm the information sent by the R&A and matched with Oregon's program information. It is important to review this information carefully.

The initial **R&A/Contact Info** screen contains information about this section.

Click **Begin** to access the **R&A/Contact Info** screen to confirm information and to enter your contact information.

Figure 25: R&A guidance

See the **Using MAPIR** section of this guide for information on using the **Print**, **Contact Us**, and **Exit** links.

1. Check your information carefully to ensure all of it is accurate.
2. Compare the R&A Registration ID you received when you registered with the R&A with the **R&A Registration ID** that is displayed. If you return to the R&A at any time after your original registration, please make certain that the submit button is selected before you leave the R&A website or else your application with Oregon may be delayed.
3. After reviewing the information click **Yes** or **No**.
4. Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point. The Reset button will not reset R&A information. If the R&A information is not correct you will need to return to the R&A to correct it.

   The R&A information can only be changed at the R&A or by contacting CMS directly at the EHR Information Center by calling 1-888-734-6433 (primary number) or 1-888-734-6563 (TTY number). Hours of operation are 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.

Figure 26: R&A verification

R&A Verification

We have received the following information for your NPI from the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A). Please specify if the information is accurate by selecting Yes or No to the question below.

*When ready click the **Save & Continue** button to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel back to the starting point.*

Legal Business Name
CCN
Hospital NPI
Hospital TIN
Business Address
Business Phone
Incentive Program
State
Eligible Hospital Type
R&A Registration ID
R&A Registration Email Address
CMS EHR Certification Number

(*) Red asterisk indicates a required field.

Enter a **Contact Name** and **Contact Phone**.

1. Enter a Contact Email Address twice for verification.
2. Click **Save & Continue** to review your selection, or click **Previous** to go back.

Click **Reset** to restore this panel back to the starting point.

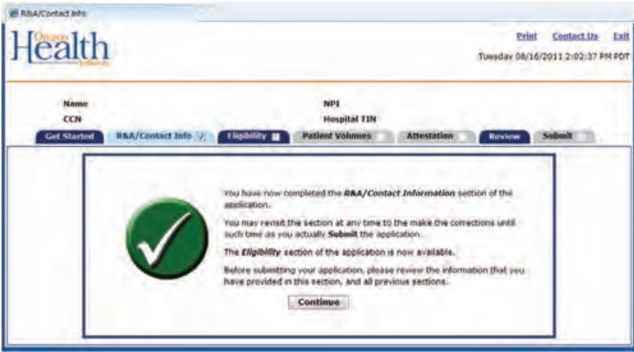
Figure 27: Contact information

This screen confirms you successfully completed the **R&A/Contact Info** section.

Note the check box located in the **R&A/ Contact Info** tab. You can return to this section to update the Contact Information at any time prior to submitting your application.

Click **Continue** to proceed to the **Eligibility** section.

Figure 28: Contact information confirmation



STEP 3 — ELIGIBILITY

The Eligibility section will ask questions to allow the Medicaid EHR Incentive Program to make a determination regarding your eligibility for a Medicaid EHR incentive payment. You will also enter your required CMS EHR Certification ID.

The initial **Eligibility** screen contains information about this section.

Click **Begin** to proceed to the **Eligibility Questions (Part 1 of 2)**.

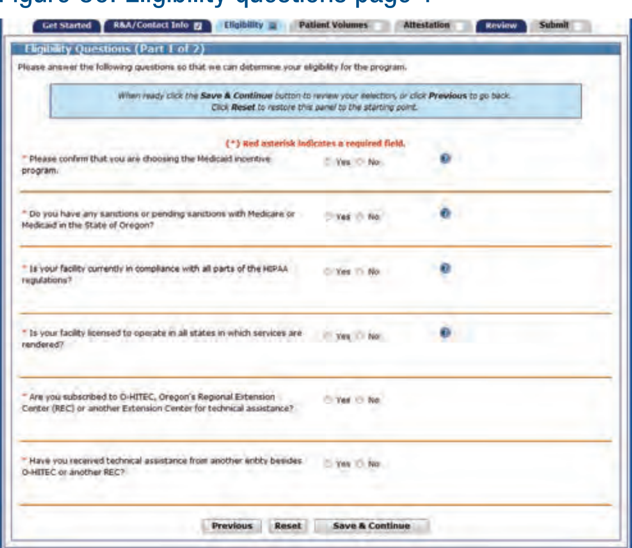
Figure 29: Eligibility guidance page

Select **Yes** or **No** to the eligibility questions.

Click **Save & Continue** to review your selection, or click **Previous** to go back.

Click **Reset** to restore this panel to the starting point.

Figure 30: Eligibility questions page 1



The **Eligibility Questions (Part 2 of 2)** screen asks for information about your CMS EHR **Certification ID**.

Enter the 15-character **CMS EHR Certification ID**.

Click **Save & Continue** to review your selection, or click **Previous** to go back.

Click **Reset** to restore this panel back to the starting point.

The system will perform an online validation of the CMS EHR Certification ID you entered. A CMS EHR Certification ID can be obtained from the Office of the National Coordinator (ONC) Certified Health IT Product List (CHPL) website (http://onc-chpl.force.com/ehrcert)

Figure 31: Eligibility questions page 2

This screen confirms you successfully entered your **CMS EHR Certification ID**.

Click **Save & Continue** to continue, or click **Previous** to go back.

Figure 32: Eligibility part 2

This screen confirms you successfully completed the **Eligibility** section.

Note the check box in the **Eligibility** tab.

Click **Continue** to proceed to the **Patient Volumes** section.

Figure 33: Eligibility confirmation

STEP 4 — PATIENT VOLUMES

The Patient Volumes section gathers information about your facility locations, the 90-day period you intend to use for reporting the Medicaid patient volume requirement, and the actual patient volumes. Additionally, you will be asked about how you utilize your certified EHR technology.

There are three parts to the Patient Volumes section:

- Part 1 of 3 establishes the 90-day period for reporting patient volumes.
- Part 2 of 3 contains screens to enter locations for reporting **Medicaid Patient Volume** and at least one location for **Utilizing Certified EHR Technology**, adding locations, and entering patient volume for the chosen reporting period.
- Part 3 of 3 contains screens to enter your hospital **Patient Volume Cost Data** information. This information will be used to calculate your hospital incentive payment amount.

Children's hospitals (separately certified children's hospitals with CCNs in the 3300 – 3399 range) are not required to meet the 10% Medicaid patient volume requirement. Based on a hospital's CCN, MAPIR will bypass these patient volume screens.

The initial **Patient Volumes** screen contains information about this section.

If you represent a Children's hospital, click **Begin** to go to the **Patient Volume Cost Data (Part 3 of 3)**, page 2 in this guide, to bypass entering patient volumes and adding locations.

If you represent an Acute Care or Critical Access Hospital, click **Begin** to proceed to the **Patient Volume 90 Day Period (Part 1 of 3)** screen.

Figure 34: Patient volume and locations guidance

PART 1 OF 3 — PATIENT VOLUME 90 DAY PERIOD

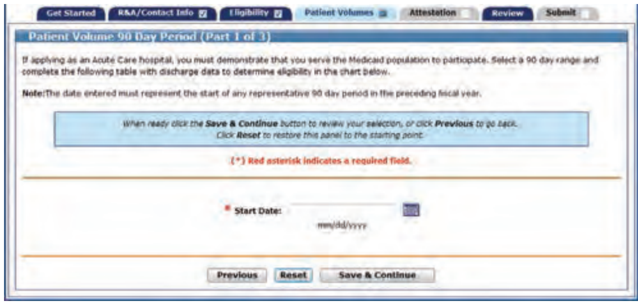
The Patient Volume 90 Day Period section collects information about the Medicaid Patient Volume reporting period. Enter the start date for the 90 day reporting period in which you will demonstrate the required Medicaid patient volume participation level.

Enter a **Start Date** or select one from the calendar icon located to the right of the Start Date field.

Click **Save & Continue** to review your selection, or click **Previous** to go back.

Click **Reset** to restore this panel back to the starting point or last saved values.

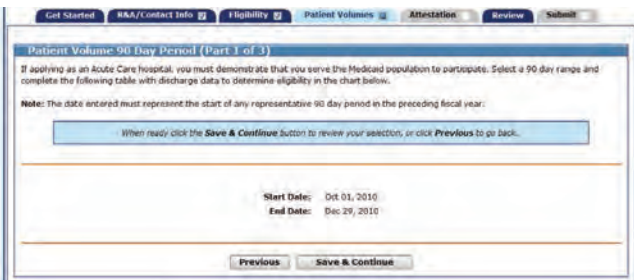
Figure 35: Patient volume 90-day period part 1



Review the **Start Date** and **End Date** information. The 90 Day End Date has been calculated for you.

Click **Save & Continue** to review your selection, or click **Previous** to go back.

Figure 36: Patient volume 90-day period part 1



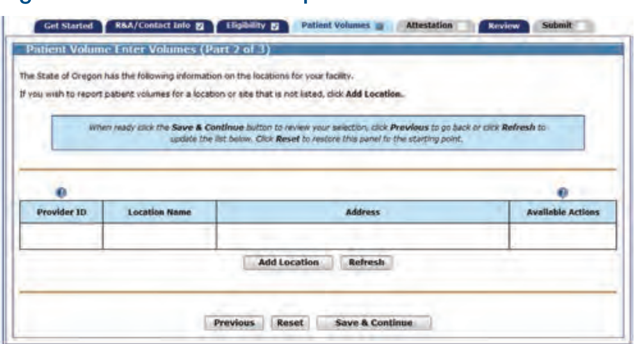
PART 2 OF 3 — PATIENT VOLUME ENTER VOLUMES

In order to meet the requirements of the Medicaid EHR Incentive Program, you must provide information about your facility. The information will be used to determine your eligibility for the incentive program.

Facility locations – MAPIR will present a list of locations that Oregon has on record. If you have additional locations you will be given the opportunity to add them. Once all locations are added, you will enter the required Patient Volume information.

Review the listed locations. Add new locations by clicking **Add Location**.

Figure 37: Patient volume part 2



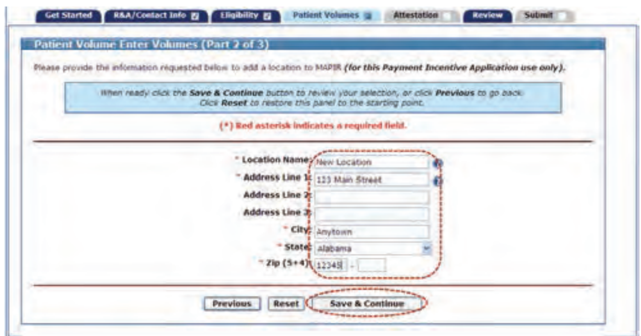
If you clicked **Add Location** on the previous screen, you will see the following screen.

Enter the requested information for your new location.

Click **Save & Continue** to review your selection, or click **Previous** to go back.

Click **Reset** to restore this panel to the starting point.

Figure 38: Patient volume part 2



This screen shows one location on file and one added location.

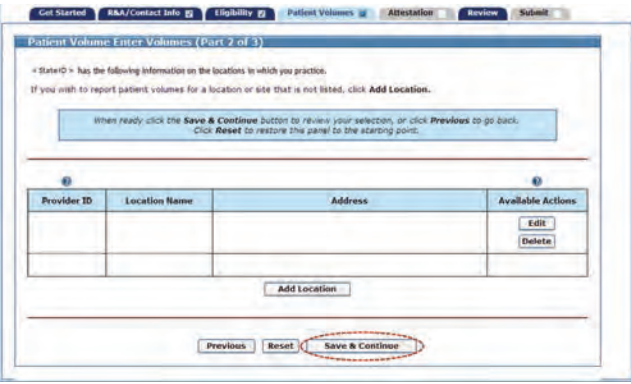
Click **Edit** to make changes to the added location or **Delete** to remove it from the list.

Note: The **Edit** and **Delete** options are not available for locations already on file.

Click **Save & Continue** to review your selection, or click **Previous** to go back.

Click **Reset** to restore this panel to the starting point.

Figure 39: Patient volume part 2



Click **Begin** to proceed to the screens where you will enter patient volumes.

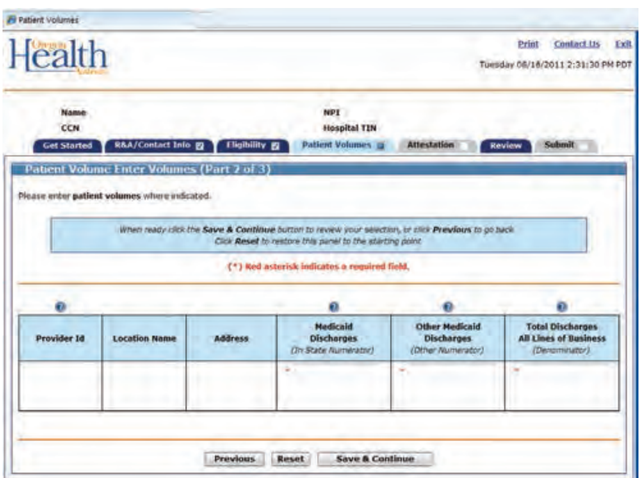
Figure 40: Patient volume and data guidance

Enter **Patient Volumes** for each of the locations listed on the screen.

Click **Save & Continue** to review your selection, or click **Previous** to go back.

Click **Reset** to restore this panel to the starting point.

Figure 41: Patient volume enter volumes part 2



*****PLEASE REFER TO THE HOSPITAL MANUAL AND HOSPITAL WORKSHEET TO COMPLETE THE SPECIFIC PATIENT VOLUME DATA FIELDS. FAILURE TO DO SO MAY SIGNIFICANTLY ALTER THE ACCURACY OF YOUR ATTESTATION*****

This screen displays the patient volumes you entered, all values summarized, and the Medicaid Patient Volume Percentage.

The Medicaid Patient Volume Percentage Formula is:

$$\frac{(\text{Medicaid Discharges} + \text{Other Medicaid Discharges})}{(\div)\ \text{Total Discharges All Lines of Business}}$$

Medicaid Patient volume is calculated as:

Medicaid patient encounters/Total patient encounters

(in any consecutive 90-day period of time in the prior federal fiscal year)

A Medicaid patient encounter is defined as:

- Services rendered on any one day to an individual where Medicaid paid for part or all of the service or,
- Services rendered on any one day to an individual where Medicaid paid for part or all of the premiums, co-payments, and/or cost-sharing.

A patient encounter is defined as:

Services rendered on any one day to an individual

Notes:

- You will use the date that the service was rendered rather than the date the claim was actually paid.
- Do not use CPT codes for the calculation; only use encounters or visits as defined above.
- The calculation is not a count of unique patients served. Services are counted on a per day basis.
- For Medicaid patient encounters only, do not count denied Medicaid encounters.

Note the **Total** % patient volume field. This percentage must be greater than or equal to 10% to meet the Medicaid patient volume requirement.

Click **Save & Continue** to continue, or **Previous** to go back.

Figure 42: Patient volume enter volumes part 2

PART 3 OF 3 — PATIENT VOLUME COST DATA

The following screens will request Patient Volume Cost Data. This information will be used to calculate your hospital incentive payment amount. The total hospital incentive payment is calculated in your first payment year and distributed over three years (Year 1: 50%, Year 2: 40%, Year 3: 10%) as defined by Oregon. To receive subsequent year payments you must attest to the eligibility requirements, patient volume requirements (except Children's hospitals), and meaningful use each year.

Enter the **Start Date** of the hospital fiscal year that ends during the Federal fiscal year prior to the fiscal year that serves as the first payment year, or select one from the calendar icon located to the right of the Start Date field.

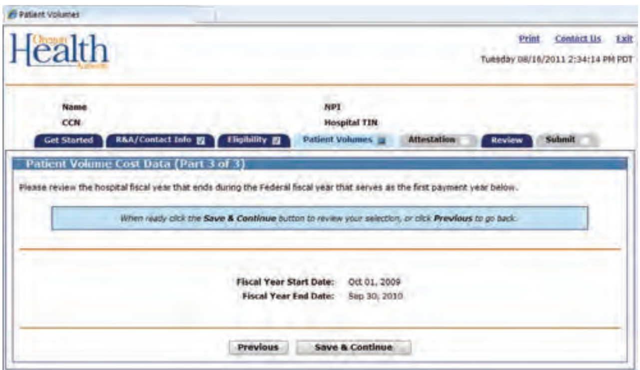
Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

Figure 43: Patient volume cost data

This screen displays your **Fiscal Year Start Date** and the **Fiscal Year End Date**.

If the Fiscal Year Start and End Dates are correct, click **Save & Continue** to review your selection, or click **Previous** to go back.

Figure 44: Patient volume cost data



On this screen you will enter the data required to calculate your incentive payment. In the first column enter **Total Discharges** for the **Fiscal Years** displayed to the left. Enter the **Total Inpatient Medicaid Bed Days, Total Inpatient Bed Days, Total Charges – All Discharges**, and **Total Charges – Charity Care**.

CMS's FAQ on what information should be used in the payment calculation can be found at https://questions.cms.gov/ if you search text for 10771, which is the FAQ number. The following table lists the Medicare cost report data elements included in the hospital payment calculation:

Figure 45: Medicare cost report data

Component	2552-96 (Old)	2552-10 (New)
Medicaid IP Bed Days	Worksheet S-3, Part I, Column 5, Lines 1, 2 & 6-10	Worksheet S-3, Part I, Column 7, Lines 1, 2 & 8-12
Total IP Bed Days	Worksheet S-3, Part I, Column 6, Lines 1, 2 & 6-10	Worksheet S-3, Part I, Column 8, Lines 1, 2 & 8-12
Total Discharges	Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14
Total Charges	Worksheet C, Part I, Column 8, Line 101	Worksheet C, Part I, Column 8, Line 200
Charity Charges	Worksheet S-10, Column 1, Line 30	Worksheet S-10, Column 3, Line 20

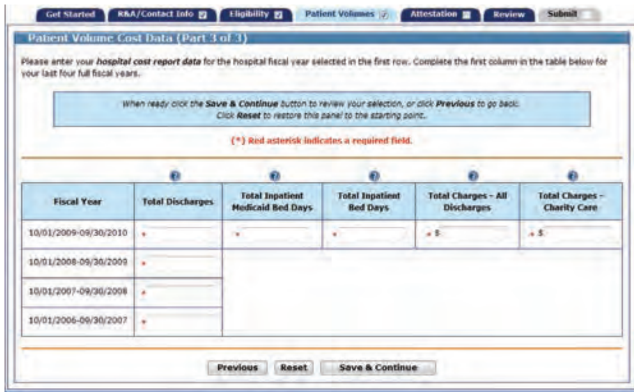
* CMS has provided clarification that Charity Charges must have uncompensated care removed from this line of the cost report for this program. If the hospital has included uncompensated care in this line, it must be subtracted out before being entered into the application.

Oregon requires that hospitals only report paid days in their calculation of inpatient bed days. If the hospital's cost report data contains unpaid days, then the hospital will be expected to submit an auditable report along with the cost report that demonstrates the difference between the cost report data and the paid days that are attested to in MAPIR.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

*****PLEASE REFER TO THE PROGRAM INFORMATION IN THIS MANUAL AND HOSPITAL WORKSHEET TO COMPLETE THE SPECIFIC COST DATA FIELDS. FAILURE TO DO SO MAY SIGNIFICANTLY ALTER THE ACCURACY OF YOUR ATTESTATION*****

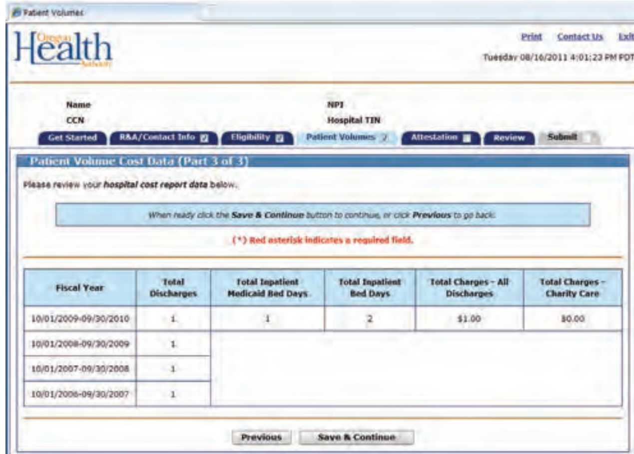
Figure 46: Patient volume cost data



Check the numbers you entered.

Click **Save & Continue** to continue, or click **Previous** to go back.

Figure 47: Patient volume cost data

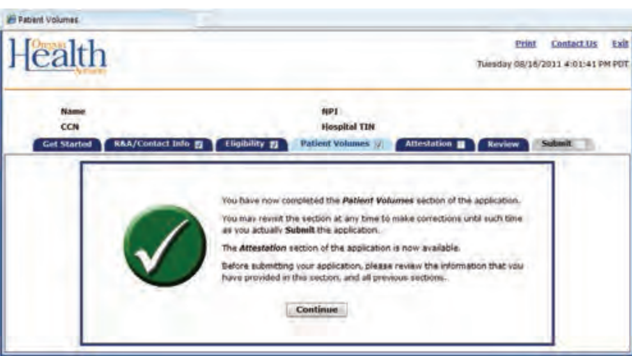


This screen confirms you successfully completed the **Patient Volumes** section.

Note the check box in the **Patient Volumes** tab.

Click **Continue** to proceed to the **Attestation** section.

Figure 48: Patient volumes confirmation



STEP 5 — ATTESTATION

This initial Attestation screen provides information about this section.

Click **Begin** to continue to the **Attestation** section.

Figure 49: Attestation guidance page

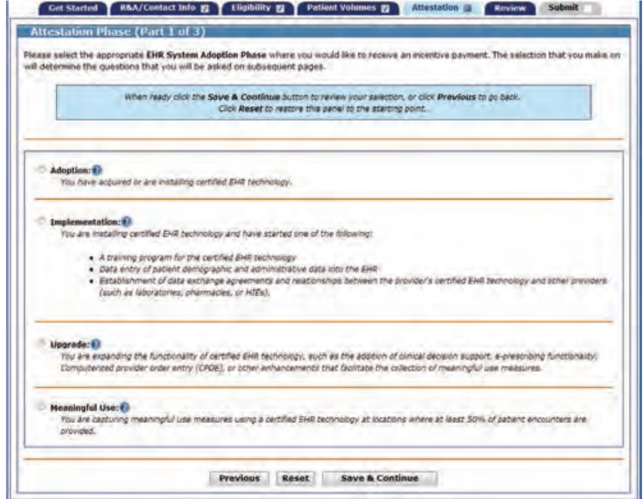
ATTESTATION PHASE (PART 1 OF 3)

The Attestation Phase (Part 1 of 3) screen asks for the **EHR System Adoption Phase**.

After making your selection, the next screen you see will depend on the phase you selected.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

Figure 50: Attestation phase part 1

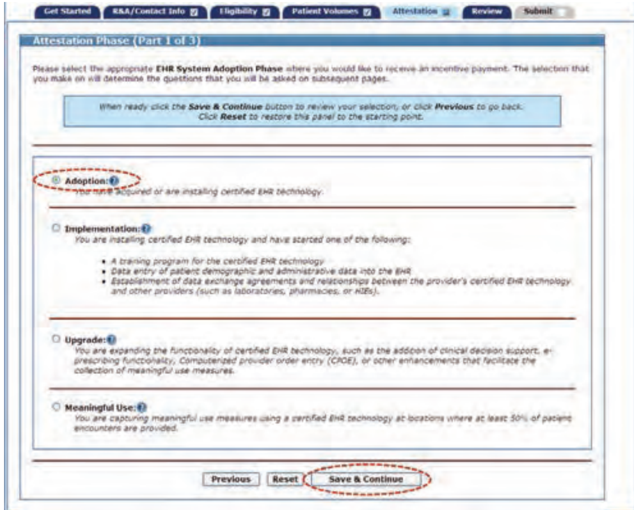


This section will ask you to provide information about your **EHR System Adoption Phase.** Adoption phases include **Adoption, Implementation, Upgrade,** and **Meaningful Use.** Based on the adoption phase you select, you may be asked to complete additional information about activities related to that phase. If your adoption phase is Meaningful Use, you will be required to provide information about the dates you were a **Meaningful User of Certified EHR Technology.** For the first year of participation in the Medicaid EHR Incentive program, Eligible Hospitals are only required to attest to **Adoption, Implementation,** or **Upgrade.**

ADOPTION PHASE

For **Adoption** select the Adoption button. **Click Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

Figure 51: Attestation phase part 1 adoption

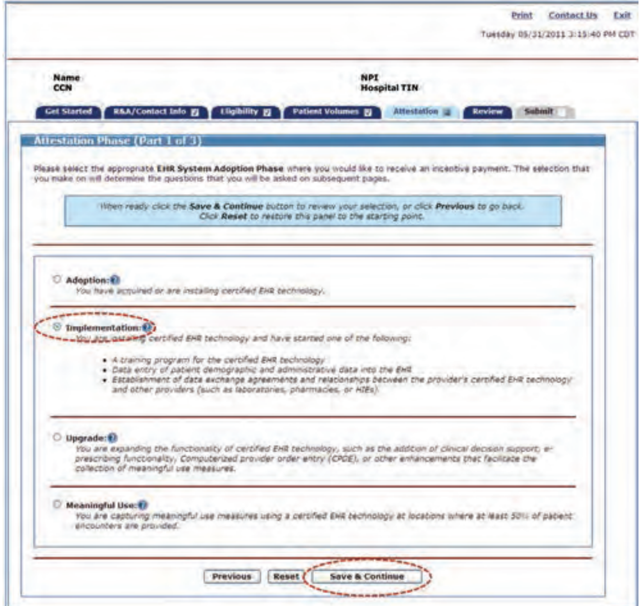


IMPLEMENTATION PHASE

For **Implementation** select the Implementation button.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

Figure 52: Attestation phase part 1 implementation

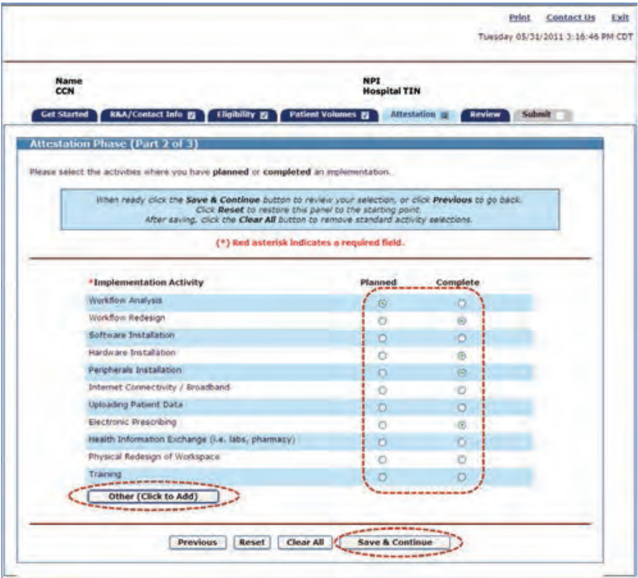


Select your **Implementation** Activity by selecting the **Planned** or **Complete** button.

Click **Other** to add any additional **Implementation Activities** you would like to supply.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point. After saving, click **Clear All** to remove standard activity selections.

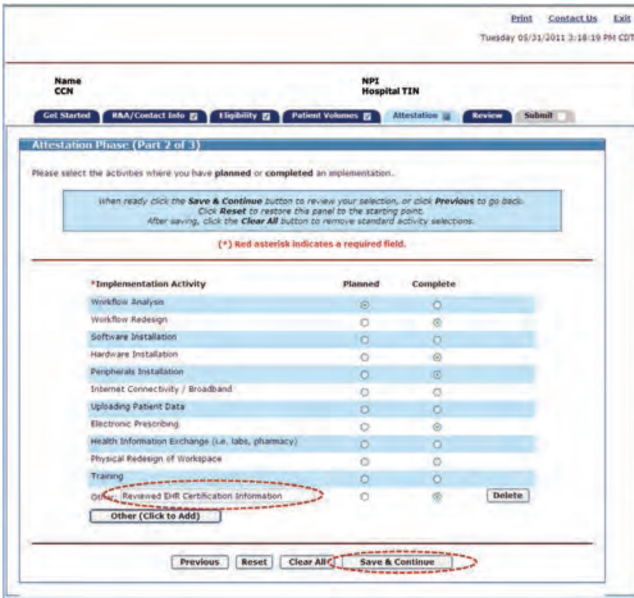
Figure 53: Attestation phase part 2



This screen shows an example of entering activities other than what was in the Implementation Activity listing.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point. After saving, click **Clear All** to remove standard activity selections.

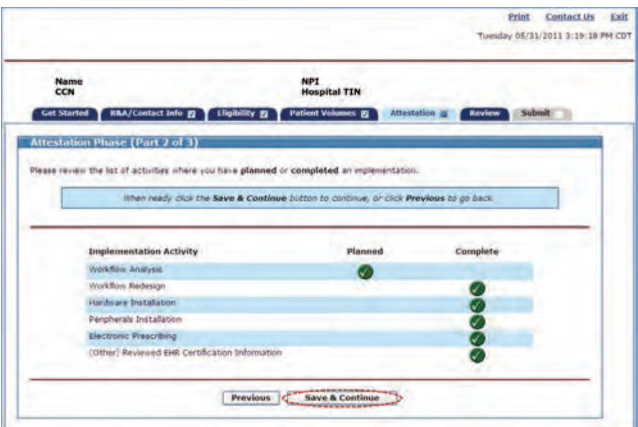
Figure 54: Attestation phase part 2



Review the **Implementation Activity** you selected.

Click **Save & Continue** to continue, or click **Previous** to go back.

Figure 55: Attestation phase part 2

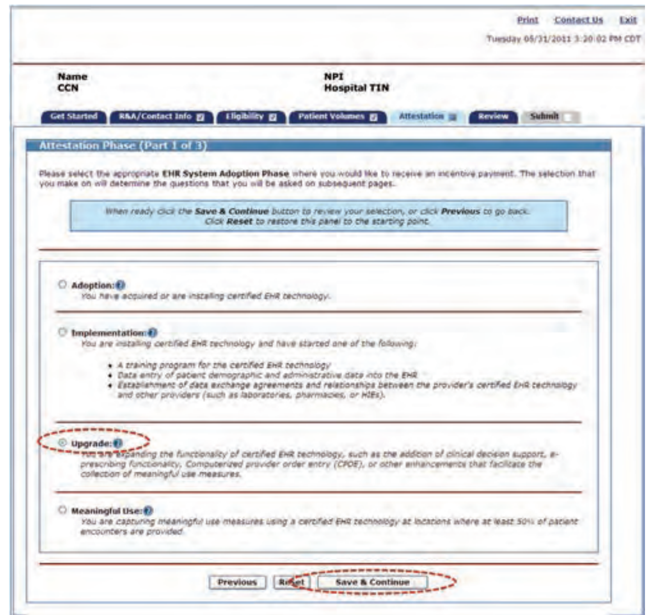


UPGRADE PHASE

For **Upgrade** select the Upgrade button.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

Figure 56: Attestation phase part 1 upgrade

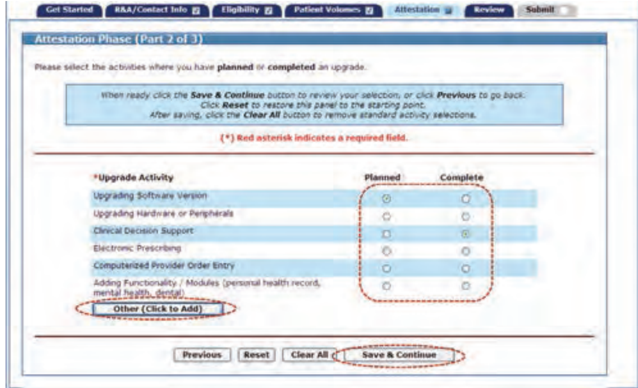


Select your **Upgrade** Activities by selecting the **Planned** or **Complete** button for each activity.

Click **Other** to add any additional **Upgrade Activities** you would like to supply.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point. After saving, click **Clear All** to remove standard activity selections.

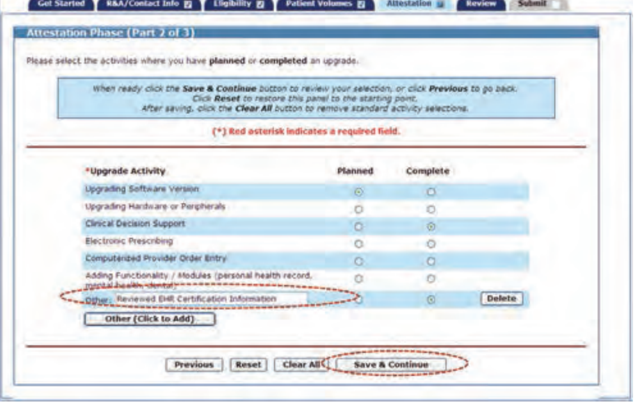
Figure 57: Attestation phase part 2



This screen shows an example of entering activities other than what was in the Upgrade Activity listing.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point. After saving, click **Clear All** to remove standard activity selections.

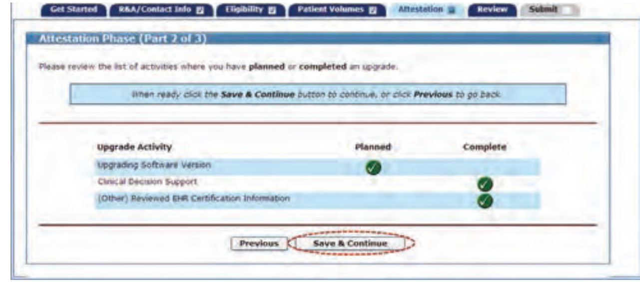
Figure 58: Attestation phase part 2



Review the **Upgrade Activities** you selected.

Click **Save & Continue** to proceed or **Previous** to return.

Figure 59: Attestation phase part 2



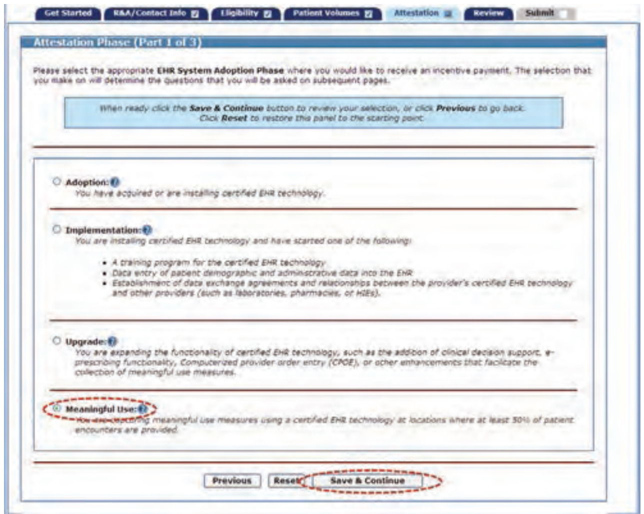
MEANINGFUL USE PHASE

For **Meaningful Use** select the Meaningful Use button. Hospitals may only select this option if they have been **Deemed a Meaningful User** by CMS Medicare EHR Incentive Program for the same payment year.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

Meaningful Use data for hospitals are reported to CMS through the Registration and Attestation system for Medicare. Hospitals that meet meaningful use requirements for Medicare are deemed meaningful users for Medicaid. This means the meaningful use objectives and measures will not be entered into MAPIR.

Figure 60: Attestation phase part 1 meaningful use



ATTESTATION PHASE

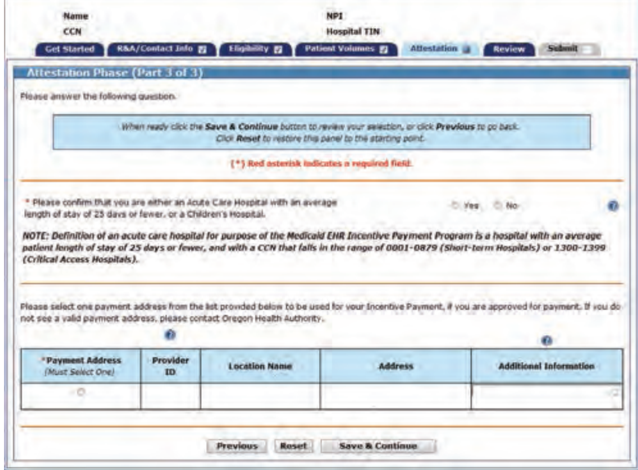
Part 3 of 3 of the Attestation Phase contains questions regarding the average length of stay for your facility and confirmation of the address to which the incentive payment will be sent.

Click **Yes** to confirm you are either an Acute Care Hospital with an average length of stay of 25 days or fewer, or a Children's Hospital.

Click the **Payment Address** from the list below to be used for your Incentive Payment.

Click Save & Continue to review your selection, or click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

Figure 61: Attestation phase part 3



This screen confirms you successfully completed the **Attestation** section.

Note the check box in the Attestation tab.

Click **Continue** to proceed to the **Review** tab.

Figure 62: Attestation phase completion

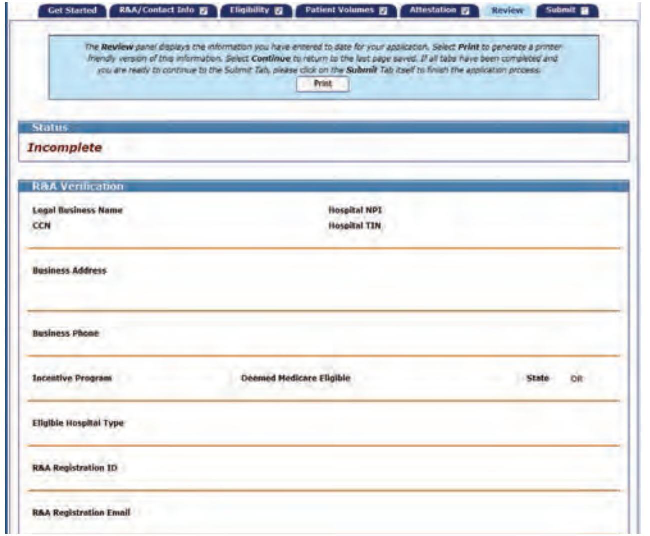
STEP 6 — REVIEW APPLICATION

The Review section allows you to review all information you entered into your application. If you find errors, you can click the associated tab and proceed to correct the information. When you have corrected the information you can click the **Review** tab to return to this section. From this screen you can print a printer-friendly copy of your application for review. Please review all information carefully before proceeding to the Submit section. Once your application is submitted you will not have the opportunity to change it.

Click **Print** to generate a printer-friendly version of this information.

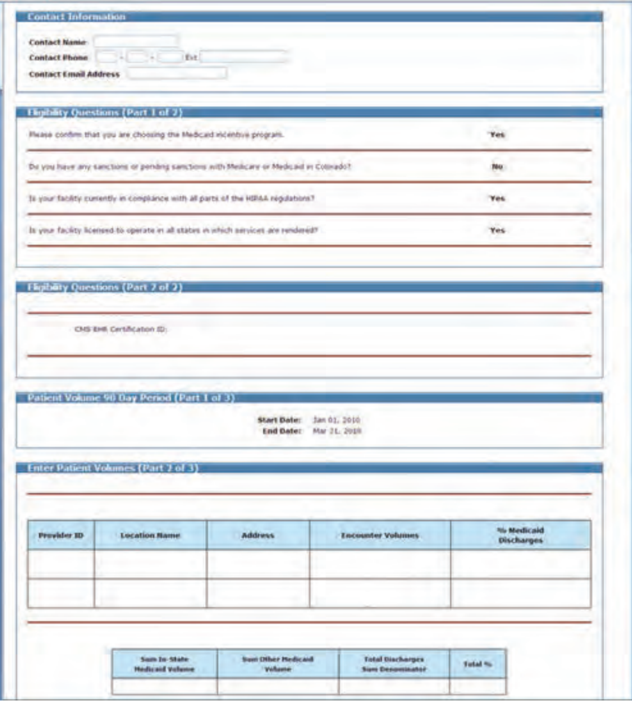
When you have finished reviewing all information click the **Submit** tab to proceed.

Figure 63: Review tab



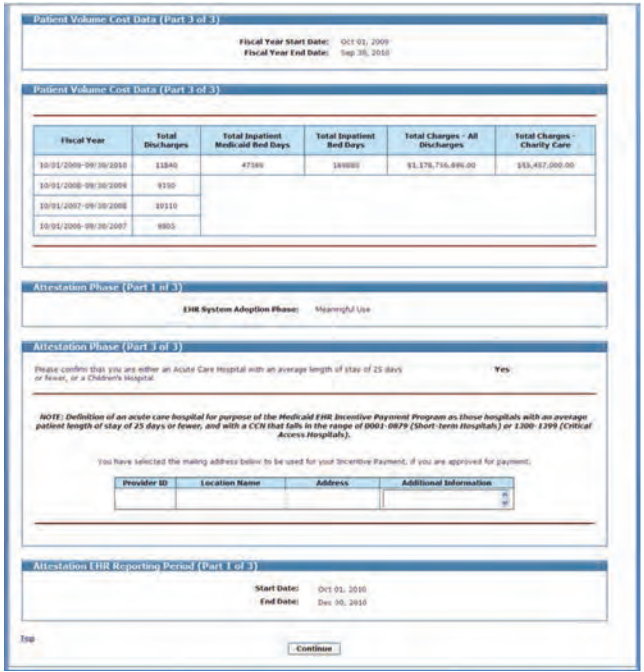
This is screen 2 of 3 of the Review tab display.

Figure 64: Review tab screen 2



This is screen 3 of 3 of the Review tab display.

Figure 65: Review tab screen 3



STEP 7 — SUBMIT YOUR APPLICATION

The final submission of your application involves the following steps:

- **Review and Check Errors**
  MAPIR will check your application for errors. If errors are present you will have the opportunity to go back to the section where the error occurred and correct it. If you do not want to correct the errors you can still submit your application; however, the errors may affect your eligibility and payment amount.
- **Questions**
  You will be asked a series of questions that do not affect your application. The answers will provide information to Oregon's Medicaid EHR Incentive Program about program participation.
- **File Upload**
  You will have the opportunity to upload PDF files with documentation supporting your application. This information could include additional information on patient volume, locations, or your certified EHR system.
  - CMS is requiring that Oregon validate the eligibility criterion for Adopt/Implement/Upgrade by verifying at least one of the four following types of documentation:
    - copy of a software licensing agreement
    - contract
    - invoices
    - receipt that validates your acquisition

  Vendor letters and other documents may also be submitted as a supplement to the items on the documentation list above. However, these supplemental documents will not satisfy program eligibility requirements on their own.
  - Oregon is also asking that Eligible Hospitals submit the Medicare cost reports supporting the information attested to for the payment calculation. This information is needed to ensure expedient processing.

The initial **Submit** screen contains information about this section.

Click **Begin** to continue to the submission process.

Figure 66: Submit guidance page

This screen lists the current status of your application and any error messages identified by the system.

You can correct these errors or leave them as is. You can submit this application with errors; however, errors may impact your eligibility and incentive payment amount.

To correct errors:

Click **Review** to be taken to the section in error and correct the information. To return to this section at any time click the **Submit** tab.

Click **Save & Continue** to continue with the application submission.

Figure 67: Errors page

The Application Questionnaire screen presents a series of questions. Answer the questions by selecting **Yes** or **No**.

Click **Save & Continue** to review your selection, or click **Previous** to go back.

Click **Reset** to restore this panel to the starting point.

Figure 68: Application questionnaire

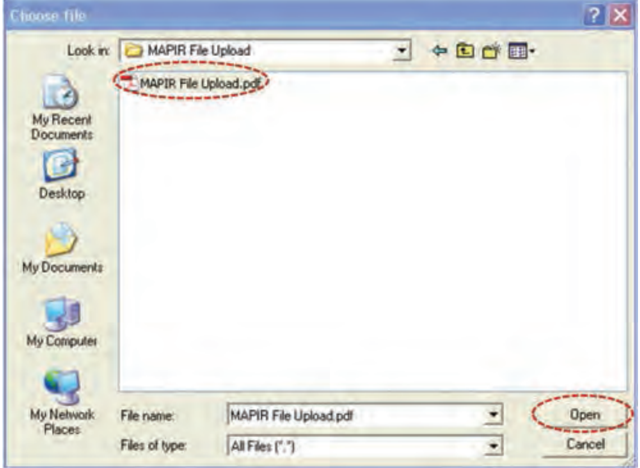
To upload files click **Browse** to navigate to the file you wish to upload.

Note: Only files that are in portable data format (PDF) and a maximum of 2 megabytes (MB) in size are acceptable documentation to upload.

Figure 69: Application submission part 1

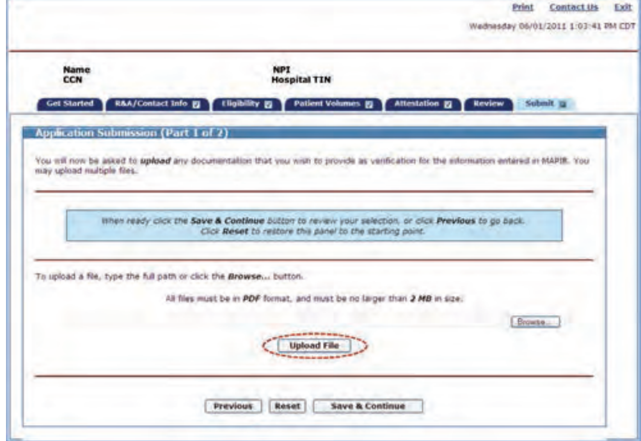
The **Choose file** dialog box will display. Navigate to the file you want to upload and select **Open**.

Figure 70: MAPIR file upload



Check the file name in the file name box. Click **Upload File** to begin the file upload process.

Figure 71: Upload file



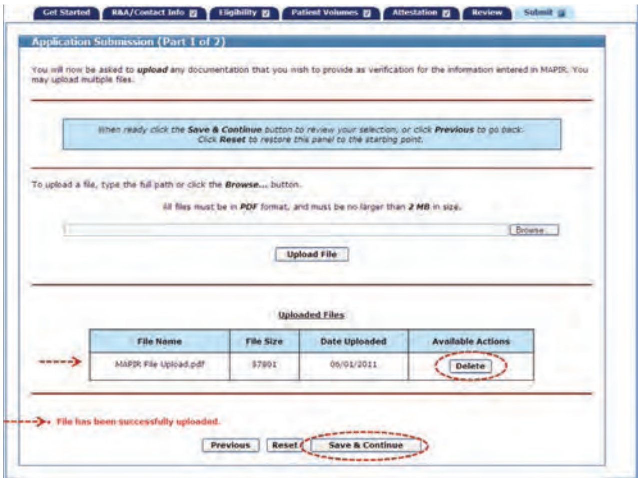
Note the "*File has been successfully uploaded*" message. Review the uploaded file list in the **Uploaded Files** box. If you have more than one file to upload, repeat the steps to select and upload a file as many times a necessary.

All of the files you uploaded will be listed in the **Uploaded Files** section of the screen.

To delete an uploaded file click the **Delete** button in the Available Actions column.

Click **Save & Continue** to review your selection, or click **Previous** to go back. Click **Reset** to restore the panel to the starting point.

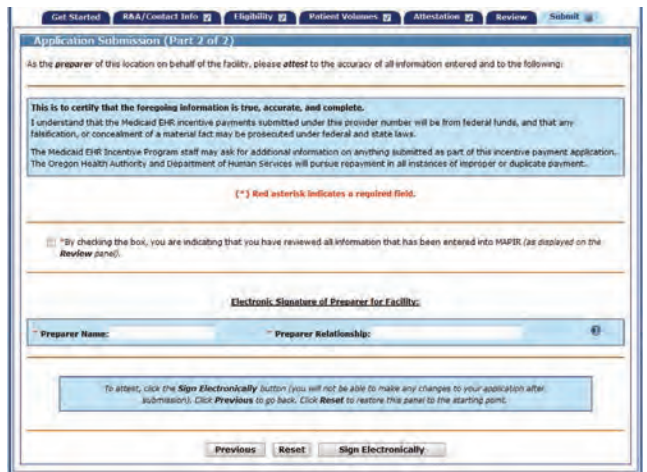
Figure 72: Upload file



This screen depicts the Preparer signature screen. Click the check box to indicate you have reviewed all information.

- Enter your **Preparer Name** and **Preparer Relationship**.
- Click Sign Electronically to proceed.
- Click **Previous** to go back. Click **Reset** to restore this panel to the starting point.

Figure 73: Application submission part 2



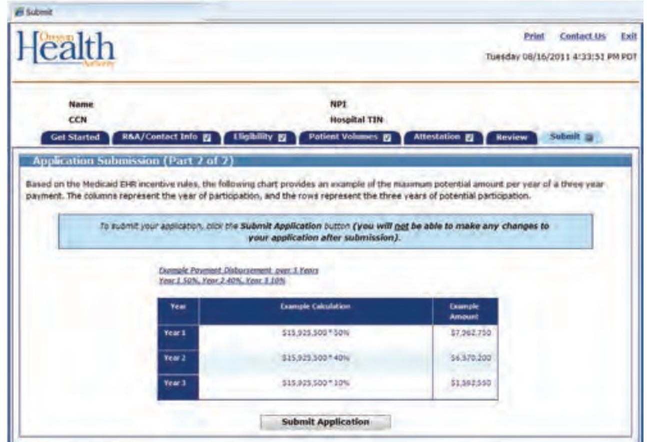
Your actual incentive payment will be calculated and verified by the Medicaid EHR Incentive Program staff. Oregon has chosen to disburse hospital incentive payments over three years of program qualification. This screen shows a **Payment Disbursement over 3 Years**.

No information is required on this screen.

Note: This is the final step of the Submit process. You will not be able to make any changes to your application after submission. If you do not want to submit your application at this time you can click Exit, and return at any time to complete the submission process.

To submit your application, click **Submit Application** at the bottom of this screen

Figure 74: Submit application



The check indicates your application has been successfully submitted.

Click **OK**.

Figure 75: Submission confirmation

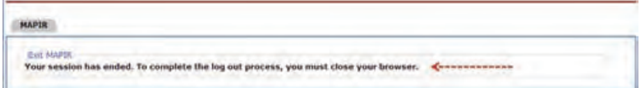
When your application has been successfully submitted, you will see the application status of Submitted.

Click **Exit** to exit MAPIR.

Figure 76: Exit MAPIR

This screen shows that your MAPIR session has ended. You should now close your browser window.

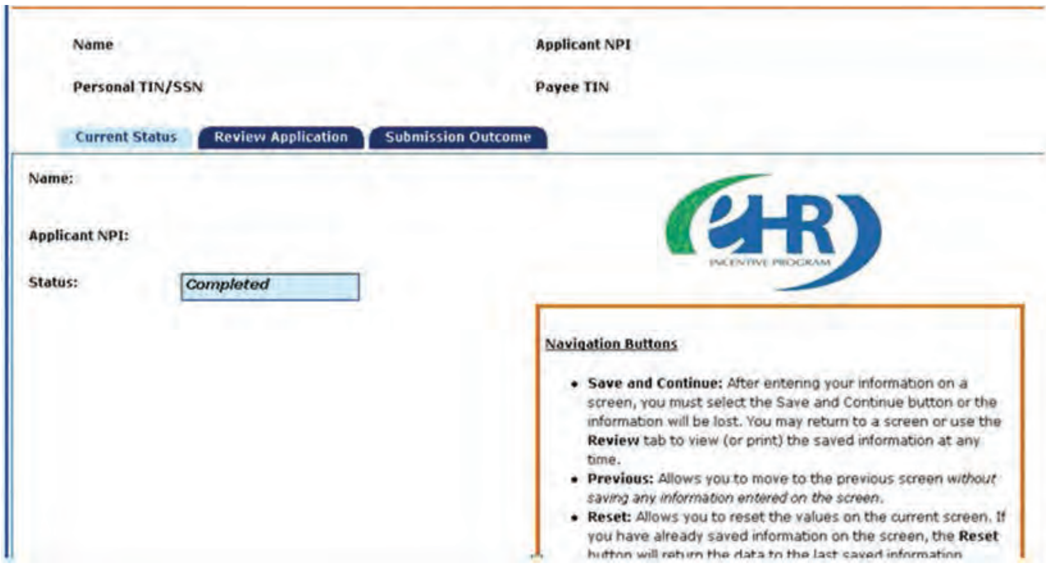
Figure 77: End MAPIR



POST SUBMISSION ACTIVITIES

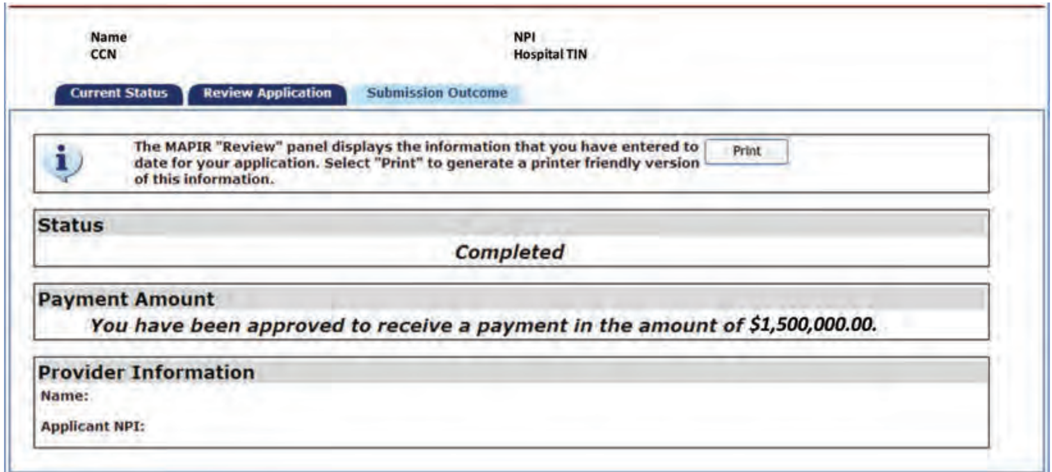
This section contains information about post application submission activities. At any time you can check the status of your application by logging into the Provider Web Portal. When you have successfully completed the application submission process you will receive an email confirming your submission has been received. You may also receive email updates as your application is processed. The screen below shows an application in a status of Completed. You can click the Review Application tab to review your application; however, you will not be able to make changes.

Figure 78: Completed application



Once your application has been processed by the Medicaid EHR Incentive Program staff, you can click the **Submission Outcome** tab to view the results of submitting your application.

Figure 79: Approval screen



APPLICATION STATUS TYPES

Figure 80

Status	Definition
Submitted	The provider has completed attestation and clicked Submit. The application is locked to prevent editing and no further changes can be made.
Pended for Review	The application is ready for a manual review by the Medicaid EHR Incentive Program staff before proceeding to the payment process.
Review Complete	Medicaid EHR Incentive Program staff reviews the "Pended for Review" applications and determines that the provider is eligible for the incentive payment pending a final CMS check.
Payment Approved	A determination has been made that the application has been approved for payment.
Payment Requested	A payment request transaction has been sent to the MMIS to generate a financial remittance to the provider.
Payment Disbursed	The remittance advice data has been received by MAPIR.
Appeal Initiated – Review	An appeal has been lodged with the proper state authority by the provider and Medicaid EHR Incentive Program staff has been notified of the action.
Appeal Approved – Adjustment	The adjustment appeal has been approved and Medicaid EHR Incentive Program staff has been notified of the action and provided with the amount to process the adjustment.
Appeal Denied	The appeal has been denied and Medicaid EHR Incentive Program staff has been notified of the action.
Denied	A determination has been made that the provider does not qualify for an incentive payment based on one or more of the eligibility rules.
Completed	The application has run a full standard process and completed successfully with a payment to the provider.

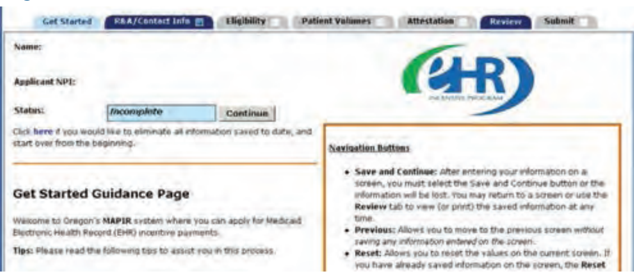
ADDITIONAL USER INFORMATION

This section contains an explanation of additional user information, system messages, and validation messages you may receive.

START OVER AND DELETE ALL PROGRESS

If you would like to start your application over from the beginning you can click the **Get Started** tab. Click the here link on the screen to start over from the beginning.

Figure 81: Start over screen



This screen asks you to confirm your selection to start the application over and delete all information saved to date. This process can only be done prior to submitting your application. Once your application is submitted, you will not be able to start over.

Click **Confirm** to Start Over and Delete All Progress.

Figure 82: Start over confirmation

If you clicked **Confirm** you will receive the following confirmation message: "To **continue** click **OK**."

Figure 83: Reset application

CONTACT US

Clicking on the Contact Us link in the upper right corner of most screens within MAPIR will display the following Medicaid EHR Incentive Program contact information.

Figure 84

MAPIR ERROR MESSAGE

This screen will appear when a MAPIR error has occurred. Follow all instructions on the screen. Click **Exit** to exit MAPIR.

Figure 85: MAPIR error

VALIDATION MESSAGES

The following is an example of the validation message – **You have entered an invalid CMS EHR Certification ID**. Check and reenter your CMS EHR Certification ID. The Validation Messages Table lists validation messages you may receive while using MAPIR.

Figure 86: Invalid ID screen

VALIDATION MESSAGES TABLE

- Please enter all required information.
- You must provide all required information in order to proceed.
- Please correct the information at the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A).
- The date that you have specified is invalid, or occurs prior to the program eligibility.
- The date that you have specified is invalid.
- The phone number that you entered is invalid.
- The phone number must be numeric.
- The email that you entered is invalid.
- You must participate in the Medicaid incentive program in order to qualify.
- You must select at least one location in order to proceed.
- The ZIP Code that you entered is invalid.
- You must select at least one activity in order to proceed.
- You must define all added ‘Other’ activities.
- Amount must be numeric.
- You must verify that you have reviewed all information entered into MAPIR.
- Please confirm. You must not have any current sanctions or pending sanctions with Medicare or Medicaid in order to qualify.
- You did not meet the criteria to receive the incentive payment.
- All data must be numeric.
- You must enter all requested information in order to submit the application.
- The email address you have entered does not match.
- You have entered an invalid CMS EHR Certification ID.
- You must be licensed in the state(s) in which you practice.
- You must select Yes or No to utilizing certified EHR technology in this location.
- You have entered a duplicate Group Practice Provider ID.
- You must select a Payment Address in order to proceed.
- You must enter the email address a second time.
- You must be in compliance with HIPAA regulations.
- You must be an Acute Care Hospital or a Children’s Hospital to be eligible to receive the EHR Medicare Program Payment.
- All amounts must be between 0 and 999,999,999,999,999.
- You must answer Yes to utilizing certified EHR technology in at least one location in order to proceed.
- The amounts entered are invalid.

RESOURCES AND CONTACTS

Thank you for your interest and participation in the Medicaid EHR Incentive Program!

FOR MORE INFORMATION:

Oregon Health Authority

Division of Medical Assistance Programs

500 Summer Street NE

Salem, Oregon 97301

Email: Medicaid.EHRIncentives@state.or.us

Website: www.MedicaidEHRIncentives.oregon.gov

Phone: 503-945-5898

Fax: 503-378-6705

ACRONYMS AND TERMS

CCN – CMS Certification Number

CHIP – Children's Health Insurance Program

CHPL – ONC Certified Health IT Product List

CMS – Center for Medicare and Medicaid Services

EH – Eligible Hospital

EHR – Electronic Health Record

EP – Eligible Professional

MAPIR – Medical Assistance Provider Incentive Repository

NPI – National Provider Identifier

ONC – Office of the National Coordinator for Health Information Technology

R&A – CMS Medicare and Medicaid EHR Incentive Program Registration and Attestation System

TIN – Taxpayer Identification Number

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact the Office of Health Information Technology at 503-945-5898, or email EHRIncentives@state.or.us.
(7/2012)

OHA SHARED SERVICES
Office of Health Information Technology
Medicaid Health IT Project