

Alaska Medicaid Program



ALASKA ELECTRONIC HEALTH RECORDS

Incentive Program

**Updated
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Provider Manual

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1. Background

The Centers for Medicare and Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA) enacted on February 17, 2009, incentive payments to Eligible Professionals (EP) and Eligible Hospitals (EH), including Critical Access Hospitals (CAH), participating in Medicare and Medicaid programs who Adopt, Implement, Upgrade (AIU), or meaningfully use certified Electronic Health Records (EHR) technology (CEHRT). Under ARRA, states are responsible for identifying professionals and hospitals that are eligible for these Medicaid EHR incentive payments, making payments, and monitoring use of the payments. The incentive payments are not a reimbursement but are intended to encourage EPs and EHs to adopt and meaningfully use CEHRT.

Use of certified EHR systems is required to qualify for incentive payments. The use of EHRs improves the quality of care provided to Alaska's most vulnerable individuals by providing immediate access to patients' medical histories therefor reducing repetitive testing and preventing harmful drug or treatment interactions. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <https://www.healthit.gov/>.

Goals for the national EHR program include:

- Enhance care coordination and patient safety;
- Reduce paperwork and improve efficiencies;
- Facilitate electronic information sharing across providers, payers, and state lines; and
- Enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN).





Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of healthcare nationwide.

EPs and EHs, including CAHs, must first register with the [CMS EHR Incentive Program Registration and Attestation \(R&A\) System](#) to apply for the Medicaid EHR Incentive Payment Program. Once registered, EPs/EHs can apply and attest online in Alaska using the [State Level Registry](#). For more information on applying in Alaska, see the [Alaska Department of Health and Social Services Medicaid EHR Incentive Program Frequently Asked Questions](#).

This manual provides eligibility and qualification requirements as well as instructions for registration for EPs/EHs including CAHs.

Additional resources:

- [7 AAC 165 - Alaska Medicaid Electronic Health Records Incentive Program](#)
- [42 CFR Parts 412, 413, 422, et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule](#)
- [Alaska State Medicaid HIT Plan \(SMHP\)](#)

- [CMS information on the Promoting Interoperability \(EHR\) Program](#) 
- [Office of the National Coordinator for Health Information Technology](#) 

List of Acronyms

The following is a list of common acronyms and meanings used throughout this manual.

Acronym	Meaning
ABP	American Board of Pediatrics
ACC	Alaska Administrative Code
AIU	Adopt, Implement, Upgrade
AOBP	American Osteopathic Board of Pediatrics
API	Application Programming Interface
ARRA	American Recovery and Reinvestment Act of 2009
CAH	Critical Access Hospital
CDR	Clinical Data Registry
CDS	Clinical Decision Support
CEHRT	Certified Electronic Health Record Technology
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CNN	CMS Certification Number
CPOE	Computerized Physician Order Entry
CQM	Clinical Quality Measure
CY	Calendar Year
EH	Eligible Hospital
EHR	Electronic Health Record
EP	Eligible Professional
ePHI	Electronic Protected Health Information
FCC	Federal Communications Commission
FFY	Federal Fiscal Year
FQHC	Federal Qualified Health Center
FY	Fiscal Year
HIE	Health Information Exchange
HIT	Health Information Technology
IHS	Indian Health Services
IIS	Immunization Information System
IRS	Internal Revenue Service
IT	Information Technology
MMIS	Medicaid Management Information System
NAAC	Net Average Allowable Cost
NHIN	National Health Information Network

Acronym	Meaning
NLR	National Level Registry
NPI	National Provider Identifier
ONC	Office of the National Coordinator for Health Information Technology
PECOS	Provider Enrollment, Chain, and Ownership System
PHA	Public Health Agency
PI	Promoting Interoperability
PQRI	Physician Quality Reporting Initiative
RHC	Rural Health Clinic
SLR	State Level Registry
SMHP	State Medicaid Health Information Technology Plan
SSN	Social Security Number
TIN	Tax Identifier Number

Definitions for the EHR Incentive Program

Acceptable documentation:

Satisfactorily completed written evidence of an approved phase of work or contract and acceptance of the evidence thereof by Alaska Medicaid. Acceptable documentation will refer to the CEHRT by name and will include financial and/or contractual commitment. Document date does not have to be within the preceding fiscal year, if the reported version of the EHR technology was certified after the document date. See examples below:

- Copy of contract
- Copy of invoice
- Copy of receipt
- Copy of purchase agreement
- Copy of user license agreement

Acute care hospital:

Healthcare facility

- (1) Where the average length of patient stay is 25 days or fewer; and
- (2) With a CMS certification number (previously known as the Medicare provider number) that has the last four digits in the series 0001–0879 or 1300–1399; or
- (3) Critical Access Hospitals.

Adopt, implement, or upgrade (AIU):

- (1) Acquire, purchase, or secure access to CEHRT (proof of purchase or signed contract will be an acceptable indicator);
- (2) Install or commence utilization of CEHRT capable of meeting meaningful use requirements; or
- (3) Expand the available functionality of CEHRT 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.

Children's hospital:

A separately certified children's hospital, either freestanding or hospital within hospital, that

- (1) Has a CMS certification number, (previously known as the Medicare provider number), that has the last four digits in the series 3300–3399; and
- (2) Predominantly treats individuals less than 21 years of age.

Hospital-based:

A professional furnishes 90 percent or more of their Alaska Medicaid-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or emergency room, using the facilities and equipment of the hospital, verified by MMIS claims analysis.

Meaningful use:

Using CEHRT to:

- Improve quality, safety, efficiency, and reduce health disparities;
- Engage patients and family; and
- Improve care coordination and population and public health.

Medicaid encounter (for an EH):

For purposes of calculating EH patient volume, a Medicaid encounter is defined as services rendered to an individual

- (1) per inpatient discharge, or
- (2) (2) on any one day in the emergency room to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims. Zero pay claims include:
 - Claims denied because the Medicaid beneficiary has maxed out the service limit;
 - Claims denied because the service was not covered under the State’s Medicaid Program;
 - Claim paid at \$0 because another payer’s payment exceeded the Medicaid payment; or
 - Claim denied because the claim was not submitted timely.

Medicaid encounter (for an EP):

Services rendered to an individual on any one day where:

- Medicaid paid for part or all the service or
- Medicaid paid all or part of the individual’s premiums, copayments, and cost-sharing.
- Claims denied because the Medicaid beneficiary has maxed out the service limit, or
- Claims denied because the service was not covered under the State’s Medicaid Program, or
- Claim paid at \$0 because another payer’s payment exceeded the Medicaid payment, or
- Claim denied, because the claim was not submitted timely.

Medicaid Management Information System (MMIS):

Medicaid claims payment system

Needy individuals:

Individuals that meet one of following conditions:

- Were furnished medical assistance paid for by Title XIX Medicaid or Title XXI Children’s Health Insurance Program (CHIP) funding including Alaska Medicaid, out-of-state Medicaid programs, or a Medicaid or CHIP demonstration project approved under section 1115 of the Act;
- Were furnished uncompensated care by the provider; or

- Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individuals' ability to pay.

Patient volume:

The proportions of an EPs or EHs patient encounters that qualify as a Medicaid encounter. This figure is estimated through a numerator and denominator and is defined as:

- [Total (Medicaid) patient encounters in any representative continuous 90-day or greater period in the preceding calendar year or in the 12 months immediately preceding the attestation date/Total patient encounters in that same 90-day or greater period] times 100
- A pediatrician must (1) hold a valid, unrestricted medical license, and (2) hold a board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP).
- The calculation for practices is based on a period of 6 months in the most recent calendar year.

Pediatrician:

Medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children.

Practices:

Predominantly means an EP for whom more than 50 percent of total patient encounters occur at a federally qualified health center or rural health clinic.

State Medicaid HIT Plan (SMHP):

Document that describes the state's current and future HIT activities.



2. How to use this Manual



The Alaska EHR Incentive Program Provider Manual is a resource for healthcare professionals and hospitals who wish to learn more about the Alaska Medicaid EHR Incentive Program including detailed information and resources on eligibility and attestation criteria. This manual provides details on how to apply for program incentive payments via the Alaska Medicaid State Level Registry (SLR) which is the Department's web-based EHR Incentive Program Attestation System.

The best way for a new user to orient themselves to the EHR Incentive Program requirements and processes is to read through each section of this manual in its entirety prior to starting the application process.

This manual is organized by EHR Incentive Program eligibility requirements, patient volume methodology, program payment methodology, meaningful use quality measures, and program registration requirements for both EPs and EOs, information on Stage 1, Modified Stage 2, and Stage 3 Meaningful Use, along with the SLR application process.



3. Additional Help

If you have any questions or problems, please contact the Health Information Technology – EHR Incentive Program Office. The EHR Incentive Program Office is the central point-of-contact to aid providers in enrolling in the Alaska Medicaid EHR Incentive Program and providing education and outreach to all Alaska Medical Assistance enrolled providers.

Address: 3601 C Street, Suite 902, Anchorage, AK 99503

Email Address: hss.hitinfo@alaska.gov

There are several resources available to assist providers with the Alaska Medicaid EHR Incentive Program application process. These resources can be found on our [Provider Outreach Page](#).

Alaska Medicaid State Level Registry for Provider Incentive Payments

Provider Outreach Home | FAQ | Contact Us

Welcome to the Alaska State Level Registry (SLR) — Provider Outreach Page

As the healthcare landscape continues to modernize, recent legislation was passed to encourage the adoption of Electronic Healthcare Record (EHR) technology in documenting patient care. As a result of the American Recovery and Reinvestment Act of 2009, beginning in 2011, eligible Medicaid providers are offered financial incentives for the implementation and meaningful use of Health Information Technology (HIT) in the management of patient populations.

To streamline the process in applying for the incentive and provide supportive resources throughout your HIT transition, this web portal centralizes the national, state and regional links for additional program information. It also serves as the portal to access Alaska's Medical Assistance program State Level Registry (SLR). In support of the Department of Health and Social Services (DHSS) vision to improve access to health care and quality of health care for Alaskans, this site also offers the following:

- A centralized "one-stop" launching pad of available tools for managing your EHR Incentive Program information
- Organized information offering real-time feeds of current HIT news and updates from other federal organizations such as CMS Educate yourself today on the benefits of HIT and be a part of transforming the quality, efficiency and safety of healthcare delivery.

Important Web Resources (all links open in new window)

- [CMS EHR Incentive Program Educational Resource Page](#)
- [Public Health Meaningful Use – Intent To Register Information](#)
- [CMS EHR Incentive Program Registration site](#)
- [Centers for Medicare & Medicaid Services \(CMS\)](#)
- [Office of the National Coordinator for Health Information Technology \(ONC\) Certified Health IT Product List](#)
- [State of Alaska — Health Information Technologies](#)
- [Healthconnect Alaska](#)

Want to get a jump start?
Click Here!

[Click here to view information that will give you a jump start on getting your ARRA incentive payment.](#)

Important Dates to Remember

Program Year 2016 was the last year an EP can begin participation in the Medicaid EHR Incentive Program.

For EPs - The SLR for Program Year 2018 will be open January 07, 2019 closing March 07, 2019. This will allow for those who have 365 days MU reporting periods.

For EHs - Alaska paid our last incentive payment to Eligible Hospitals (EHs) in Program Year 2017. The SLR will not be accepting any Hospital attestation for Program Year 2018 and beyond.

EP and EH Provider Manuals and Tip Sheets

(all links open in new window)

[EP/EH Provider Manual](#)

[Alaska EHR FAQ's](#)

[Documentation to Save for Audits](#)

[CMS's EHR Participation Time Line](#)

Need to create an SLR account?

Need an SLR account?

Click here to [create an SLR account](#) for accessing the Medicaid Provider Incentive Program site.

Already have an SLR account?

Already have an SLR account?

Click here to go [directly to the State Level Registry for Provider Incentive Payments](#) site.

To complete the registration process the provider will need to submit the attestation.

Interoperability Training Courses

The Office of the National Coordinator (ONC) has developed training modules around the Stage 2 Meaningful Use (MU) Rule to train Eligible Professionals (EPs) and Critical Access Hospitals (CAHs) on how to implement new standards to support - Transitions of Care, Lab Exchange, Patient Engagement, and Public Health Measures. Please click on the link to go to the training courses [Interoperability Training Courses](#).

Meaningful Use Education Module: Transitions of Care

This meaningful use educational module covers "transitions of care" from both a meaningful use and EHR technology certification perspective. It walks you through the requirements for the meaningful use "transitions of care" objective and measures as well as their relationship to EHR technology certification. Please click on the link to go to the training courses [Transitions of Care Module](#).

Are You Eligible?

Are you eligible for the Medicare & Medicaid EHR Incentive Program?

Run the [CMS Eligibility Wizard](#) and quickly see if you may qualify for incentive payments.

Frequently Asked Questions

Have a question? Click here to [view a list of frequently asked questions](#).

Improving Quality, Reducing Costs

4. Eligible Provider Types

EPs and EHs must begin participation in the program no later than calendar year (CY) 2016. The following Alaska medical assistance providers and out-of-state providers who are enrolled in the Alaska Medicaid Program are eligible to participate in the Alaska Medicaid EHR Incentive Program.

Eligible Professionals

- Physician (MD and DO)
- Dentist
- Certified Nurse Midwife
- Nurse Practitioner
- Physician Assistant (PA) practicing in a Federally Qualified Health Center (FQHC) led by a PA or a Rural Health Clinic (RHC) that is led by a PA

For the purposes of the EHR Incentive Program, a Tribal Clinic is considered an FQHC. A PA practicing in a Tribal Clinic must meet the same requirements of a PA practicing in an FQHC. Any other provider that practices in a Tribal Clinic follows the same rules as an FQHC.

A PA-led FQHC or RHC means a PA is:

- The primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider);
- A clinical or medical director at a clinical site of practice; or
- An owner of an RHC.

Eligible Hospitals

Alaska paid our last incentive payment to EHs in Program Year 2017. There will be no Eligible Hospital for Program Year 2018 and beyond. Information provided as a reference only.

- Acute care hospitals including critical access hospitals (CAH)
- Children's hospitals



5. Enrollment Requirements

Requirements for an Eligible Professional

To qualify for an EHR incentive payment, for each year the EP seeks the incentive payment, the EP must meet the following criteria:

- Meet one of the following patient volume criteria:
 - Have a minimum of 30 percent patient volume attributable to services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability (specific criteria apply);
 - Have a minimum 20 percent patient volume attributable to services rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability (specific criteria apply), and be a pediatrician¹; or
 - Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals
- Have a valid contract with Alaska Medical Assistance²;
- Have no sanctions and/or exclusions;
- Hospital-based providers may be eligible if they purchase and use their own EHR program (hospital-based is defined as 90% or more of services are performed in a hospital inpatient or emergency room setting)

Providers and hospitals currently ineligible for the Alaska Medicaid EHR Incentive Program include behavioral health (substance abuse and mental health) providers and facilities and long-term care providers and facilities.

Note: Some provider types eligible for the Medicare program, such as chiropractors, are not eligible for the Alaska Medicaid EHR Incentive Program per Federal regulations.

Requirements for an Eligible Hospital

To qualify for an EHR incentive payment, for each year the EH seeks the incentive payment, the EH must meet the following criteria:

- An acute care hospital including CAHs
 - Acute care and CAHs must have:
 - Medicaid discharges of at least 10% for the Medicaid patient volume,
 - An average Length of Stay (LOS) of 25 days or less, and
 - A CMS Certification Number (CCN) that ends in 0001–0879 or 1300–1399 to be eligible to receive an incentive payment.
- A children's hospital

¹ For the purposes of this program, the Department defines pediatricians as a practitioner who is board certified through the American Board of Pediatrics website or through the American Osteopathic Board of Pediatrics.

² A valid contract means the provider is currently enrolled with Alaska Medicaid Program to provide services. An individual EP may choose to receive the incentive him/herself or assign it to a Medicaid contracted clinic or group to which he/she is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the CMS EHR Incentive Program Registration and Attestation System. The TIN of the individual or entity receiving the incentive payment must match a TIN linked to the individual provider in the Medicaid Management Information System (MMIS). For entities that do not link providers to their MMIS enrollment, the provider must be in contractual arrangement with the group or clinic to which they assign their payment.

- Children’s hospitals without a CCN, because they do not serve Medicare beneficiaries, but have received alternate numbers from CMS for Incentive Program participation are eligible. They do not have to meet the patient volume threshold.

Qualifying Providers by Provider Type and Patient Volume


Provider Types	Patient Volume over 90-day Period
Eligible Hospital	
Acute Care Hospital (includes CAHs)	<ul style="list-style-type: none"> • 10% Medicaid-related encounters
Children’s Hospital	<ul style="list-style-type: none"> • No Medicaid volume requirement
Eligible Professional	
Physicians (MD, DO)	<ul style="list-style-type: none"> • 30% Medicaid-related encounters • For Eps practicing in a FQHC/RHC – 30% Needy Individuals
Dentists	
Certified Nurse Midwives	
Nurse Practitioners	
PAs when practicing at an FQHC/RHC that is led by a PA	
Pediatrician	<ul style="list-style-type: none"> • 30% Medicaid-related encounters • If Pediatrician patient volume = 20-29%, the provider may qualify for 2/3 of incentive payment

Out-of-State Providers

The Alaska Medicaid EHR Incentive Program allows out-of-state providers to participate in this advantageous program. Out-of-state providers have the same eligibility requirements as in-state providers. Alaska must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Alaska Department of Health and Social Services (DHSS) or CMS. Records must be maintained as applicable by law in the state of practice or Alaska, whichever is deemed longer. The out-of-state provider must be enrolled with Alaska Medicaid Program in order to participate in the Alaska Medicaid EHR Incentive Program.



6. Patient Volume Methodology

A Medicaid provider must annually meet patient volume requirements for the Alaska Medicaid EHR Incentive Program as established through the [State's CMS approved SMHP](#). 

Eligible Professional Patient Encounter Calculation

EP patient volume for those not practicing predominantly in a FQHC, RHC, or Tribal Clinic will be calculated based on Medicaid and out-of-state Medicaid patients. For EPs practicing predominantly in a FQHC or RHC, the patient volume is calculated using the needy individual patient volume requirements. Practicing predominantly is defined as an EP practicing at an FQHC or an RHC clinical location for over 50 percent of his/her total patient encounters over a period of 6 months.

The EP Medicaid patient volume or needy individual patient volume is calculated based on unique patient encounters per day for the 90-day period in the previous calendar year or in the 12 months preceding the providers' attestation date.

Eligible Professional Medicaid Encounter

For purposes of calculating the EP patient volume, a Medicaid encounter is defined as services rendered on any one day to a Medicaid enrolled individual, regardless of payment liability. This includes zero-pay claims and encounters. Zero-pay claims include:

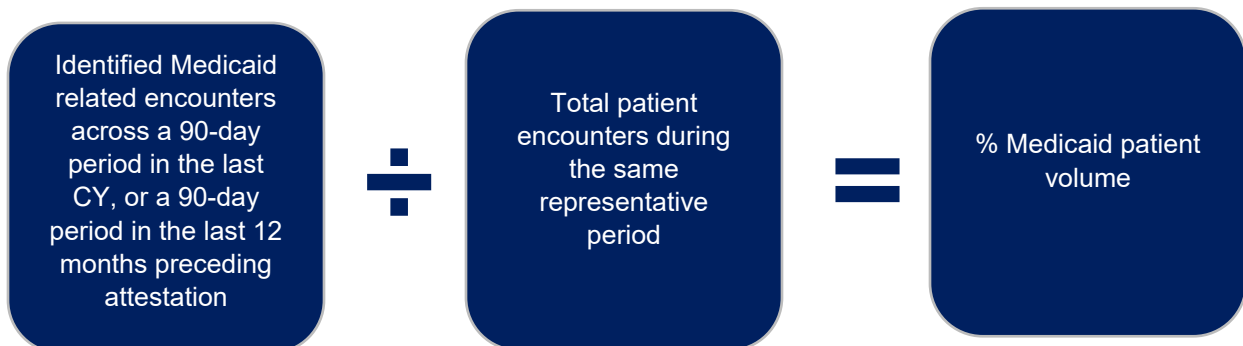
- Claims denied because the Medicaid beneficiary has maxed out the service limit.
- Claims denied because the service was not covered under the State's Medicaid Program.
- Claims paid at \$0 because another payer's payment exceeded the Medicaid payment.
- Claims denied because the claim was not submitted timely.

To calculate Medicaid patient volume, an EP must divide:

- The total identified Medicaid or out-of-state Medicaid related patient encounters:
 - a. in any representative 90-day period in the preceding calendar year, or
 - b. in any 3-month period in the preceding year that is 90-days or greater, or
 - c. the full preceding calendar year, or
 - d. in any 90-day period in the last 12 months preceding the provider's attestation;

by

- The total patient encounters in the same time period.



Eligible Professional Needy Individual Encounter

For purposes of calculating the patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- The identified Eligible Professional Medicaid Encounter definition listed on the prior page.
- Furnished by the provider as uncompensated care, or
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Note: For providers practicing in a Tribal Clinic, uncompensated care is a calculated figure, using charity care and bad debt to determine the number of encounters that are considered uncompensated care. Indian Health Services (IHS) has defined uncompensated care as:

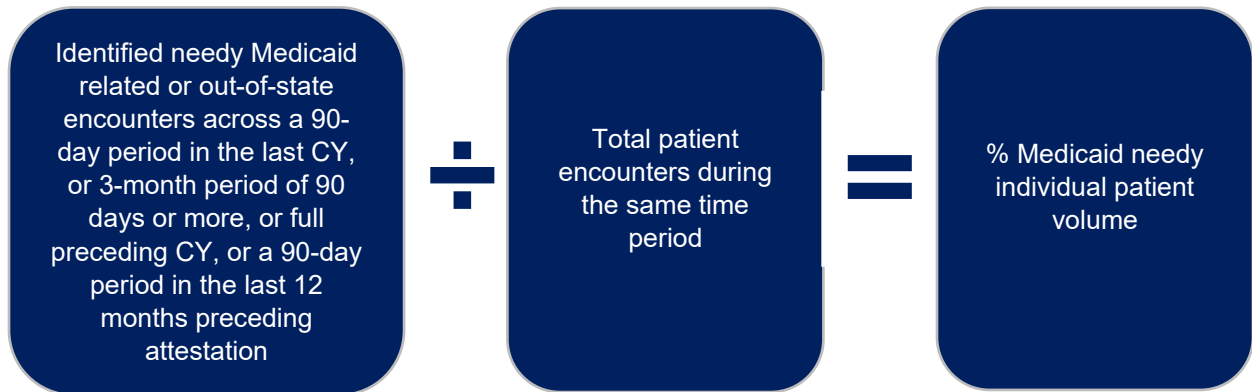
- Total visits – (minus) paid visits (regardless of payer)³ - (minus) charity care [special fund that people qualify for (this is zero for Tribes/Urban)] – (minus) bad debt = uncompensated care.

To calculate needy individual patient volume, an EP must divide:

1. The total identified needy individual Medicaid or out-of-state Medicaid related patient encounters
 - a. in any representative 90-day period in the preceding calendar year, or
 - b. in any 3-month period in the preceding year that is 90-days or greater, or
 - c. the full preceding calendar year, or
 - d. in any 90-day period in the last 12 months preceding the provider's attestation;

by

2. The total patient encounters in the same time period.



³ Under the paid visits figure, IHS is not considered a payer.

Group Practice Patient Encounter Calculation

Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level but only in accordance with all the following limitations:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP;
- There is an auditable data source to support the clinic or group practice's patient volume determination;
- All EPs in the group practice or clinic must use the same methodology for the payment year;
- The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice and not the EPs outside encounters.

Group encounters can be totaled in one of two different ways:

- The entire clinic/group practice's Medicaid encounter total, or
- Only those providers in the group that are considered eligible professionals for the Medicaid Incentive Payment Program whether or not they are attesting for the program in that year encounter total.

The group patient volume for a non-FQHC, RHC, or Tribal Clinic will be calculated based on eligible Medicaid encounters and out-of-state Medicaid patients. The group patient volume for a FQHC, RHC, or Tribal Clinic is calculated using the needy individual patient volume requirements if the providers within the group practiced predominantly in the FQHC, RHC, or Tribal Clinic in the previous calendar year.



Group Needy Individual Encounters

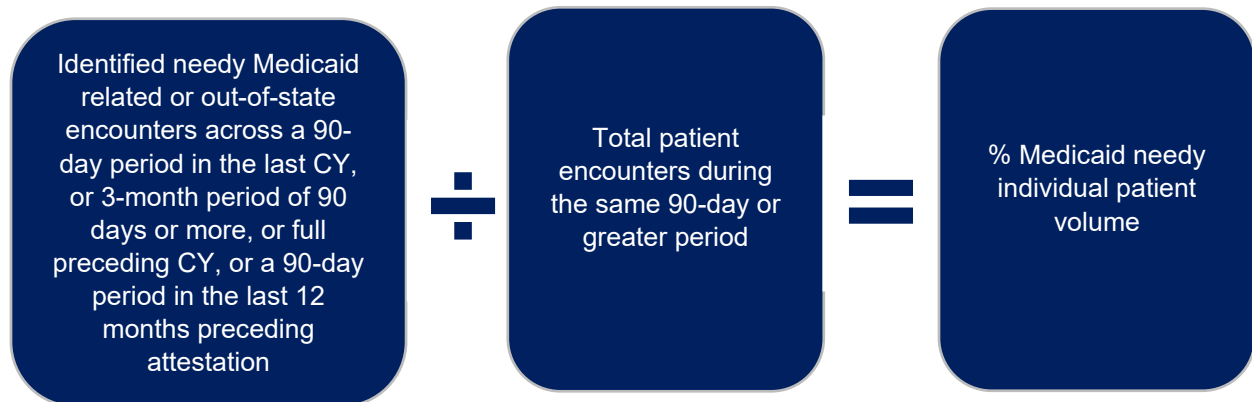
For providers to use the group needy individual patient volume, all providers within the group must have practiced predominantly in the FQHC, RHC, or Tribal Clinic for 50% of their encounters over a 6-month time period in the previous calendar year or in the 12 months preceding the attestation.

To calculate the group needy individual patient volume, a group must divide:

1. The group's total identified needy individual Medicaid or out-of-state Medicaid related patient encounters
 - a. in any representative 90-day period in the preceding calendar year, or
 - b. in any 3-month period in the preceding year that is 90-days or greater, or
 - c. the full preceding calendar year, or
 - d. in any 90-day period in the last 12 months preceding the provider's attestation;

by

2. The total patient encounters in the same 90-day or greater period.



Eligible Hospital Patient Encounter Calculation

For purposes of calculating EH patient volume, a Medicaid encounter is defined as services rendered to an individual (1) per inpatient discharge, or (2) on any one day in the emergency room to a Medicaid-enrolled individual regardless of payment liability. This includes zero-pay claims. Zero pay claims include:

- Claims denied because the Medicaid beneficiary has maxed out the service limit.
- Claims denied because the service was not covered under the State's Medicaid Program.
- Claims paid at \$0 because another payer's payment exceeded the Medicaid payment.
- Claims denied because the claim was not submitted timely.

For emergency room encounters to count towards the patient volume, the emergency department must be part of the hospital.

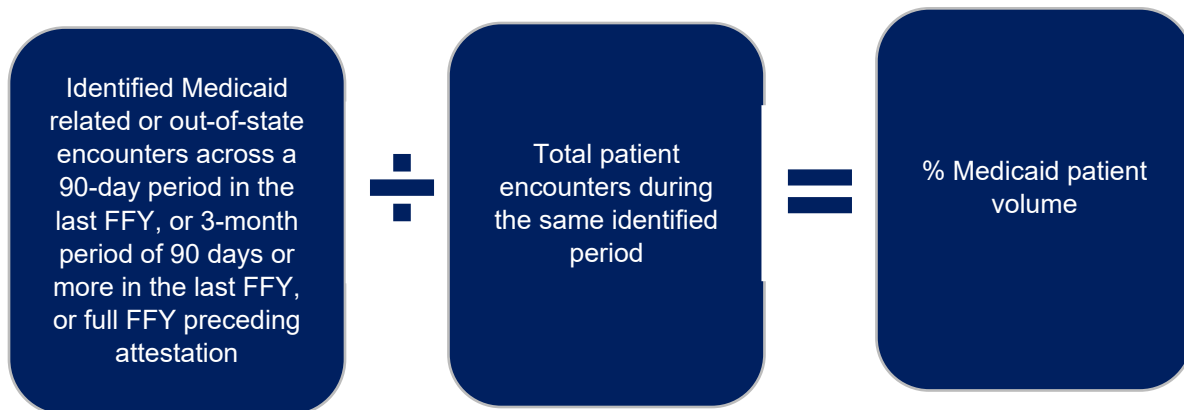
Exception - A children's hospital is not required to meet Medicaid patient volume requirements.

To calculate Medicaid patient volume, an EH must divide:

1. The total identified Medicaid or out-of-state Medicaid related patient encounters
 - a. in any representative 90-day period in the preceding federal fiscal year, or
 - b. in any 3-month period in the preceding federal fiscal year that is 90-days or greater, or
 - c. the full preceding federal fiscal year;

by

2. The total encounters in the same identified period.
 - a. Total number of inpatient discharges for the selected period; the encounters also include discharges within the 90 days in which the patient was admitted prior to the start of the selected period, plus could include the total number of emergency department visits in the same identified period.



7. Electronic Health Record Functions

Please note: Program Year 2016 was the LAST year a provider could enroll in the Medicaid EHR Incentive Program.

Adopt, Implement, or Upgrade (AIU)

Federal regulations allow EPs/EHs who participate in the Alaska Medicaid EHR Incentive Program to receive incentive payments if they adopt, implement, or upgrade to a certified EHR technology in the first year of participation. (This option is not available through the Medicare Incentive Program in which all providers must meet meaningful use in the first year.) At the time of attestation, the EP/EH will be required to provide documentation supporting the claim of AIU such as a contract or paid invoice.

What does Adopt, Implement, or Upgrade Mean?	
Adopt	Acquire, purchase, or secure access to CEHRT
Implement	Install or commence utilization of CEHRT capable of meeting meaningful use requirements
Upgrade	Expand the available functionality of CEHRT 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

Meaningful Use (MU)

The Medicare and Medicaid EHR Incentive Program provides financial incentives for the meaningful use of CEHRT to improve patient care. To receive an EHR incentive payment, providers must show they are meaningfully using their EHRs by meeting thresholds for several objectives. CMS has established the objectives for meaningful use that EPs, EHs, and CAHs must meet in order to receive an incentive payment.

Adopt, Implement, Upgrade in Year 1

EPs that adopt, implement, or upgrade in their first year of participation do not have to report meaningful use during the first payment year. In the second year of participation, EPs must display meaningful use for a selected 90-day reporting period.

In Program Year 2019, all providers will once again be attesting to a minimum 90-day EHR reporting period for the meaningful use objectives and measures.

EHR Incentive Payment Timelines

	1st Payment Received in 2011	1st Payment Received in 2012	1st Payment Received in 2013	1st Payment Received in 2014	1st Payment Received in 2015	1st Payment Received in 2016
2011 Payment Amount	\$21,250.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2012 Payment Amount	\$8,500.00	\$21,250.00	\$0.00	\$0.00	\$0.00	\$0.00
2013 Payment Amount	\$8,500.00	\$8,500.00	\$21,250.00	\$0.00	\$0.00	\$0.00
2014 Payment Amount	\$8,500.00	\$8,500.00	\$8,500.00	\$21,250.00	\$0.00	\$0.00

	1st Payment Received in 2011	1st Payment Received in 2012	1st Payment Received in 2013	1st Payment Received in 2014	1st Payment Received in 2015	1st Payment Received in 2016
2015 Payment Amount	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00	\$21,250.00	\$0.00
2016 Payment Amount	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00	\$21,250.00
2017 Payment Amount	\$0.00	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00
2018 Payment Amount	\$0.00	\$0.00	\$8,500.00	\$8,500.00	\$8,500.00	\$8,500.00
2019 Payment Amount	\$0.00	\$0.00	\$0.00	\$8,500.00	\$8,500.00	\$8,500.00
2020 Payment Amount	\$0.00	\$0.00	\$0.00	\$0.00	\$8,500.00	\$8,500.00
2021 Payment Amount	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$8,500.00
Total Payments	\$63,750.00	\$63,750.00	\$63,750.00	\$63,750.00	\$63,750.00	\$63,750.00

2020 Program Requirements

2015 Edition Certified EHR Technology (CEHRT) Required



You **MUST** be using a 2015 edition certified EHR technology system. The EHR system 2015 Edition CEHRT identification will contain “15E” in the third through fifth digits. Consult your EHR vendor if you are unsure of the certification standard of your system.

For your MU (Promoting Interoperability) reporting period, you must be using a 2015 Edition CEHRT for the entire 90-day reporting period. The 2015 Edition CEHRT **did not** have to be implemented on January 1, 2020. The functionality must be in place by the first day of the EHR reporting period and the product must be certified to the 2015 Edition criteria by the last day of the EHR reporting period.

EHR Reporting Period

For 2020, the EHR reporting period for Medicaid EPs and EHs is a minimum of any continuous 90-day period within calendar (CY) 2020.

Objectives and Measures



- View the [2020 Specification Sheets for Meaningful Use Stage 3 EPs \(PDF\)](#)  and hospitals.
- In 2020, all providers must attest to objectives and measures using EHR technology certified to the 2015 edition: [2015 EDITION CEHRT Fact Sheet](#) 
- The MU reporting period is 90 days in 2020 for all providers.
- The CQM reporting period is 90 days for all providers in 2020.


MU Stage 3 Objective and Measures

Meaningful Use Stage 3 requirements have been reorganized into eight objectives with a total of 20 measures. [The CMS Specification Sheets](#) for the 2020 Medicaid Promoting Interoperability/ EHR Incentive Program are posted at the [CMS Program Year 2020 webpage](#)

Objectives for 2020	Measures for Providers in 2020	Exclusions and/or Specifications for Certain Providers
<p>Objective 1: Protect Patient Health Information</p>	<p>Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (including encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary and correct identified security deficiencies as part of the provider’s risk management process.</p>	<p>NONE</p>
<p>Objective 2: Electronic Prescribing</p>	<p>Measure 1: More than 60 percent of all permissible prescriptions written by the eligible professional (EP) are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).</p>	<p>Exclusion: An EP may take an exclusion if any of the following apply: (1) Writes fewer than 100 permissible prescriptions during the Promoting Interoperability (PI) reporting period; or (2) Does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP’s practice location at the start of his or her EHR reporting period.</p>
<p>Objective 3: Clinical Decision Support</p>	<p>An EP must satisfy both measures for this objective through a combination of meeting the thresholds and exclusions.</p> <p>Measure 1: Implement five CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire EHR reporting period. Absent four CQMs related to an EPs scope of practice or patient population, the CDS interventions must be related to high-priority health conditions.</p> <p>Measure 2: Enable and implement the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p>	<p>Exclusion: Measure 2: An EP who writes fewer than 100 medication orders during the EHR reporting period may take an exclusion.</p>

Objectives for 2020	Measures for Providers in 2020	Exclusions and/or Specifications for Certain Providers
<p>Objective 4: Computerized Provider Order Entry (CPOE)</p>	<p>An EP must satisfy all three measures for this objective through a combination of meeting the thresholds and exclusions.</p> <p>Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p> <p>Measure 2: More than 60 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p> <p>Measure 3: More than 60 percent of diagnostic imaging orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p>	<p>Exclusions:</p> <p>Measure 1: Any EP who writes fewer than 100 medication orders during the EHR reporting period.</p> <p>Measure 2: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.</p> <p>Measure 3: Any EP who writes fewer than 100 diagnostic imaging orders during the EHR reporting period.</p>
<p>Objective 5: Patient Electronic Access to Health Information</p>	<p>An EP must satisfy both measures for this objective through a combination of meeting the thresholds and exclusions:</p> <p>Measure 1: For more than 80 percent of all unique patients seen by the EP:</p> <p>(1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and</p> <p>(2) The provider ensures the patient’s health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the Application Programming Interface (API) in the provider’s certified electronic health record technology (CEHRT).</p> <p>Measure 2: The EP must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide electronic access to those materials to more than 35 percent of unique patients seen by the EP during the EHR reporting period.</p>	<p>Exclusions:</p> <p>Measure 1 and 2: An EP may take an exclusion for either measure, or both, if either of the following apply:</p> <p>(i) He or she has no office visits during the EHR reporting period.</p> <p>(ii) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period.</p>

Objectives for 2020	Measures for Providers in 2020	Exclusions and/or Specifications for Certain Providers
<p>Objective 6: Coordination of Care through Patient Engagement </p>	<p>An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.</p> <p>Measure 1: More than 5 percent of all unique patients (or their authorized representatives) seen by the eligible professional (EP) actively engage with the EHR made accessible by the EP and either:</p> <p>(1) View, download, or transmit to a third party their health information; or</p> <p>(2) Access their health information using an Application Programming Interface (API) that can be used by applications chosen by the patient and configured to the API in the EP’s CEHRT; or</p> <p>(3) A combination of (1) and (2)</p> <p>Measure 2: For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient or their authorized representative.</p> <p>Measure 3: Patient generated health data or data from a non-clinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.</p>	<p>Exclusion:</p> <p>Measure 1, 2, and 3: An EP may take an exclusion for any or all measures if either of the following apply:</p> <p>(i) He or she has no office visits during the EHR reporting period, or;</p> <p>(ii) He or she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period.</p>
<p>Objective 7: Health Information Exchange </p>	<p>An EP must attest to all three measures and meet the threshold for two measures for this objective. If the EP meets the criteria for exclusion from two measures, they must meet the threshold for the one remaining measure. If they meet the criteria for exclusion from all three measures, they may be excluded from meeting this objective.</p> <p>Measure 1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care:</p> <p>(1) Creates a summary of care record using CEHRT; and</p>	<p>Exclusion:</p> <p>Measure 1: An EP may take an exclusion if either or both of the following apply:</p> <p>(1) He/she transfers a patient to another setting or refers a patient to another provider fewer than 100 times during the EHR reporting period.</p> <p>(2) He/she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information</p>

Objectives for 2020	Measures for Providers in 2020	Exclusions and/or Specifications for Certain Providers
	<p>(2) Electronically exchanges the summary of care record.</p> <p>Measure 2: For more than 40 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she incorporates into the patient’s EHR an electronic summary of care document.</p> <p>Measure 3: For more than 80 percent of transitions or referrals received and patient encounters in which the EP has never before encountered the patient, he/she performs a clinical information reconciliation. The EP must implement clinical information reconciliation for the following three clinical information sets:</p> <p>(1) Medication. Review of the patient’s medication, including the name, dosage, frequency, and route of each medication.</p> <p>(2) Medication allergy. Review of the patient’s known medication allergies.</p> <p>(3) Current Problem list. Review of the patient’s current and active diagnoses.</p>	<p>available from the Federal Communications Commission (FCC) on the first day of the EHR reporting period.</p> <p>Measure 2: An EP may take an exclusion if either or both of the following apply:</p> <p>(1) The total transitions or referrals received and patient encounters in which he/she has never before encountered the patient, is fewer than 100 during the EHR reporting period.</p> <p>(2) He/she conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.</p> <p>Measure 3: An EP may take an exclusion if the total transitions or referrals received and patient encounters in which he/she has never before encountered the patient, is fewer than 100 during the EHR reporting period.</p>
<p>Objective 8: Public Health and Clinical Data Registry Reporting </p>	<p>An EP must satisfy two measures for this objective. If the EP cannot satisfy at least two measures, they may take exclusions from all measures they cannot meet.</p> <p>Measure 1: Immunization Registry Reporting: The EP is in active engagement with a Public Health Agency (PHA) to submit immunization data and receive immunization forecasts and histories from the public health immunization registry/immunization information system (IIS).</p> <p>Measure 2: Syndromic Surveillance Reporting: The EP is in active engagement with a PHA to submit syndromic surveillance data.</p> <p>Measure 3: Electronic Case Reporting: The EP is in active engagement with a PHA to submit case reporting of reportable conditions.</p> <p>Measure 4: Public Health Registry Reporting: The EP is in active engagement with a PHA to submit data to public health registries.</p> <p>Measure 5: Clinical Data Registry (CDR) Reporting: The EP is in active engagement to submit data to a CDR.</p>	<p>Exclusion:</p> <p>Measure 1: An EP may take an exclusion if any of the following apply:</p> <p>(1) He/she does not administer immunizations to any of the populations for which data is collected by their jurisdiction’s immunization registry or IIS during the EHR reporting period;</p> <p>(2) He/she practices in a jurisdiction for which no immunization registry or IIS can accept the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</p> <p>(3) He/she practices in a jurisdiction where no immunization registry or IIS has declared readiness to receive immunization data as of six months prior to the start of the EHR reporting period.</p>

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Objectives for 2020	Measures for Providers in 2020	Exclusions and/or Specifications for Certain Providers
		<p>Measure 2: An EP may take an exclusion if any of the following apply:</p> <ul style="list-style-type: none"> (1) He/she is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system; (2) He/she practices in a jurisdiction for which no PHA can receive electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) He/she practices in a jurisdiction where no PHA has declared readiness to receive syndromic surveillance data from EPs as of six months prior to the start of the EHR reporting period. <p>Measure 3: An EP may take an exclusion if any of the following apply:</p> <ul style="list-style-type: none"> (1) He/she does not diagnose or directly treat any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the EHR reporting period; (2) He/she practices in a jurisdiction for which no PHA can receive electronic case reporting data in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or (3) He/she practices in a jurisdiction where no PHA has declared readiness to receive electronic case reporting data as of six months prior to the start of the EHR reporting period. <p>Measure 4: An EP may take an exclusion if any of the following apply:</p> <ul style="list-style-type: none"> (1) He or she does not diagnose or directly treat any disease or condition associated with a public health registry in their jurisdiction during the EHR reporting period; (2) He or she practices in a jurisdiction for which no PHA can


Objectives for 2020	Measures for Providers in 2020	Exclusions and/or Specifications for Certain Providers
		<p>accept electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</p> <p>(3) He or she practices in a jurisdiction where no PHA for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.</p> <p>Measure 5: An EP may take an exclusion if any of the following apply:</p> <p>(1) He or she does not diagnose or directly treat any disease or condition associated with a CDR in their jurisdiction during the EHR reporting period;</p> <p>(2) He or she practices in a jurisdiction for which no CDR can accept electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or</p> <p>(3) He or she practices in a jurisdiction where no CDR for which the EP is eligible to submit data has declared readiness to receive electronic registry transactions as of six months prior to the start of the EHR reporting period.</p>

Meaningful Use CQMs for EPs in 2020

EPs are required to report only six CQMs related to their scope of practice from the set of 47 available:

- CQM reporting period is any continuous 90-day period within CY 2020.
- EPs must report on at least one outcome measure. If no outcome measure is relevant to his/her scope of practice, the EP must report on one high-priority measure. If no high-priority measures are relevant to his/her scope of practice, the EP may report on any six relevant measures.

Stage 3 Meaningful Use Criteria

For more information on Stage 3 program requirements specific to EPs and EAs attesting to their state’s Medicaid EHR Incentive Program, [click here](#). 

EHR reporting period:

- In Program Year 2020, the EHR reporting period for EPs is a minimum of any continuous 90-day period.
- In PY 2020, all participants in the Medicaid Promoting Interoperability Program are **required** to use 2015 edition CEHRT.

Objectives and measures:

- All providers are required to attest to a single set of objectives and measures.
- For EPs there are eight objectives.
- View the Stage 3 Specification Sheets:
 - [EPs](#)

NOTE: To meet Stage 3 requirements, all participants in the Medicaid Promoting Interoperability Program are required to use 2015 edition CEHRT.



8. Payment Methodology

Payment Methodology for Eligible Professionals

Payment for EPs equals 85 percent of net average allowable costs (NAAC). NAAC are capped by statute at \$25,000 in the first year, and \$10,000 for each of five subsequent years. NAAC for pediatricians with Alaska Medicaid patient volume between 20-29 percent are capped at two-thirds of those amounts respectively. Thus, the maximum incentive payment an EP could receive from Alaska Medicaid equals \$63,750 over a period of six years, or \$42,500 for pediatricians with a 20-29 percent Medicaid patient volume.

Provider	EP	EP – Pediatrician
Patient Volume	30%	20-29%
Year 1	\$21,250	\$14,167
Year 2	\$8,500	\$5,667
Year 3	\$8,500	\$5,667
Year 4	\$8,500	\$5,667
Year 5	\$8,500	\$5,666
Year 6	\$8,500	\$5,666
Total Incentive Payment	\$63,750	\$42,500

Pediatricians may qualify to receive the full incentive, if the pediatrician can demonstrate they meet the minimum 30 percent Medicaid patient volume requirements.

Payments for Medicaid Eligible Professionals

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a Tax Identifier Number (TIN) in the CMS EHR Incentive Program Registration and Attestation System. The TIN must be associated with either the EP directly or a group or clinic with which the EP has a contractual relationship. State of Alaska policy requires a State of Alaska Substitute Form W9 for each payee. If all EPs within a group/clinic assign their payment to the clinic, only one Substitute W9 is required; if the payment is directed to each EP, one Substitute W9 for each EP is needed.

The [State of Alaska Substitute W-9](#) may be found [here](#). 

The Alaska Medicaid EHR Incentive Program does not include a future reimbursement rate reduction for non-participating Medicaid providers. (Medicare requires providers to implement and meaningfully use CEHRT by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that he/she was a meaningful user of EHR technology during that year, except in year one in which the provider may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Medicaid EPs are not required to participate on a consecutive annual basis, however, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021.

Maximum Incentive Payments for EPs

Payment Amount for Year	First Year Medicaid EP qualifies to receive Payment 2011	First Year Medicaid EP qualifies to receive Payment 2012	First Year Medicaid EP qualifies to receive Payment 2013	First Year Medicaid EP qualifies to receive Payment 2014	First Year Medicaid EP qualifies to receive Payment 2015	First Year Medicaid EP qualifies to receive Payment 2016
2011	\$21,250					
2012	\$8,500	\$21,250				
2013	\$8,500	\$8,500	\$21,250			
2014	\$8,500	\$8,500	\$8,500	\$21,250		
2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
2018			\$8,500	\$8,500	\$8,500	\$8,500
2019				\$8,500	\$8,500	\$8,500
2020					\$8,500	\$8,500
2021						\$8,500
Total Possible Incentive Payments	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

If the Department of Health and Social Services determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. Providers may refund the money to the State of Alaska in a lump sum, or an accounts receivable account will be created. The existing practice allows the Department of Health and Social Services to work out an acceptable repayment period.

Payment Methodology for Eligible Hospitals

Calculating the overall incentive payment is a multi-step process and utilizes hospital data on total discharges (excluding nursery discharges) to compute a growth rate which is used to determine projected eligible discharges. A base amount of \$2,000,000 is added to the eligible discharge amount, and a transition factor is applied to arrive at the overall EHR amount. The overall EHR amount needs to be adjusted for charity care before Medicaid’s share can be calculated. The aggregate EHR hospital incentive payment is calculated as the product of the overall EHR amount times the Medicaid share.

Calculating the overall EHR amount is a multi-step process, hospitals are required to provide and attest to the following information for the incentive payment to be calculated:

- Total inpatient discharges for the most recent four fiscal years
- Total number of Medicaid inpatient bed days
- Total number of inpatient bed days
- Total hospital charges
- Total charges for charity care

The following is an example of the steps that will be followed to calculate incentive payments to EHs. This is only an example.

Step 1: Calculating the average annual growth rate:

To calculate the average annual growth rate, the hospital reports the total discharges for the four most recent hospital fiscal year cost reports. Total discharges are the sum of all inpatient discharges (excluding nursery discharges).

Fiscal Year	Total Discharges	Calculating Annual Growth Rate	Average Annual Growth Rate
2007	23,500	$2008 - 2007 \div 2007 = \text{Growth Rate}$	5.11
2008	24,700	$24,700 - 23,500 \div 23,500 = 5.11\%$	+ 4.45
2009	25,800	$25,800 - 24,700 \div 24,700 = 4.45\%$	+ 4.26
2010	26,900	$26,900 - 25,800 \div 2,5800 = 4.26\%$	13.82 \div 3 = Average Annual Growth Rate 4.61%

Step 2: Applying the average annual growth rate to the base number of discharges:

The number of discharges for the base year of fiscal year 2010 is multiplied by the average annual growth rate of 4.61% (0.0461) to project the number of discharges over the next three years:

Projected Inpatient Discharge			
Fiscal Year 2010	Fiscal Year 2011	Fiscal Year 2012	Fiscal Year 2013
26,900			
x 1.0461	28,140		
	x 1.0461	29,437	
		x 1.0461	30,794

Step 3: Determining the number of eligible discharges and multiply by the discharge payment amount:

1. For the first through the 1,149th discharge, \$0
2. For the 1,150th through the 23,000th discharge, \$200 per discharge
3. For any discharge greater than the 23,000th, \$0

In this example, discharges for each year were greater than both 1,149 and 23,000, so the maximum number of discharges that can be counted are 21,851 (23,000 – 1,149) which then gets multiplied by the \$200 per discharge.

Fiscal Year	Calculated Discharges	Eligible Discharges	@ \$200 per Discharge	Eligible Discharge Payments
2010	26,900 (max 23,000 - 1,149)	21,851	x \$200	\$4,370,200
2011	28,140	21,851	x \$200	\$4,370,200
2012	29,437	21,851	x \$200	\$4,370,200
2013	30,749	21,851	x \$200	\$4,370,200

Step 4: Adding the base year amount of \$2,000,000 per payment year to the eligible

discharge payments:

and

Step 5: Multiplying the Medicaid Transition Factor to the eligible payment to arrive at the overall EHR amount:

The transition factor equals one for year 1, three-fourths for year 2, one-half for year 3, and one-fourth for year 4. All four years are then added together.

Step 4					Step 5				
Fiscal Year	Base Year Amount		Eligible Discharge Payments		Total Eligible Discharge Payments		Transition Factor		Overall EHR Amount
2010	\$2,000,000	+	\$4,370,200	=	\$6,370,200	x	1	=	\$6,370,200
2011	\$2,000,000	+	\$4,370,200	=	\$6,370,200	x	.75	=	\$4,777,650
2012	\$2,000,000	+	\$4,370,200	=	\$6,370,200	x	.50	=	\$3,185,100
2013	\$2,000,000	+	\$4,370,200	=	\$6,370,200	x	.25	=	\$1,592,550
									Total EHR Amount \$15,925,500

Step 6: Calculating the Medicaid share:

The next step requires the Medicaid share be applied to the total EHR amount. The Medicaid share is the percentage of Medicaid inpatient bed days divided by the estimated total inpatient bed days adjusted for charity care.

Note: All inpatient bed day totals should exclude nursery care.

To calculate the Medicaid share, the hospital will need to provide the following information from the most recently filed cost report. The most recently filed cost report is defined as the hospital costs report ending prior to the start of the current federal fiscal year.

Total of Medicaid Inpatient Bed Days	Total Inpatient Days	Total Hospital Charges	Total Charity Care Charges
7,251	21,250	\$135,500,000	\$12,300,000

The Medicaid share, against which the overall EHR amount is multiplied, is the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients. More specifically, the Medicaid share is a fraction:

- Medicaid Inpatient Bed Days ÷ Total Inpatient Days x (Total Hospital Charges - Charity Care Charges)
- (Total Hospital Charges - Charity Care Charges) ÷ Total Hospital Charges = Charity Care Adjustment

Total Hospital Charges - Charity Care Charges		Total Charges Less Charity Care Charges		Total Hospital Charges		Charity Care Adjustment
\$135,500,000 - \$12,300,000	=	\$123,200,000	÷	\$135,500,000	=	.909

- Total Inpatient Days x Charity Care Adjustment

Total Inpatient Days		Charity Care Adjustment		Adjusted Inpatient Days by Charity Care
21,250	x	.909	=	19,316

- Medicaid Inpatient Bed Days ÷ Adjusted Inpatient Days

Total Medicaid Inpatient Bed Days		Adjusted Inpatient Days		Medicaid Share
7,251	÷	19,316	=	.3754
Medicaid Share Percentage = 37.54%				

Step 7: Calculating the aggregate incentive payment amount:

To arrive at the aggregate incentive amount, multiply the overall EHR amount of \$15,925,500 by the Medicaid share of 37.54%.

- 15,925,500 x .3754 = \$5,978,433

Total Incentive Payment Amount	\$5,978,433
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Step 8: Distributing over three incentive payments:

The Department will issue hospital incentive payments in three incentive payment amounts. The following illustrates an example of how the payments will be issued in three payment years at 50, 40, and 10% respectively. The hospital would need to continue to meet the eligibility requirements and meaningful use criteria in all incentive payment years. Participate does not have to be in consecutive years until 2016.

Incentive Payment Timeline	Payment Amounts
Year 1 – 50%	\$2,989,216.50
Year 2 – 40%	\$2,391,373.20
Year 3 – 10%	\$597,843.30

Payments for Medicaid Eligible Hospitals

EH payments will be made in alignment with the calendar year and an EH must begin receiving incentive payments no later than Federal Fiscal Year (FFY) 2016. EHs will assign the incentive payments to a TIN in the CMS EHR Incentive Program Registration and Attestation System. The hospital in which the payment will be issued will be required to provide Alaska Medical Assistance with a State of Alaska Substitute Form W-9 to which the payment will be issued.

The [State of Alaska Substitute W-9](#) may be found here. 

For each year a hospital wishes to receive a Medicaid incentive payment, a determination must be made that the hospital was a meaningful user of EHR technology during that year, except in year one in which the hospital may be eligible to receive an incentive payment for adopting, implementing or upgrading to a certified EHR technology. Alaska Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program. Medicaid EHs are not required to participate on a consecutive annual basis, however, the last year a hospital may begin receiving payments is 2016, and the last year the hospital can receive payments is 2021.

Alaska medical assistance currently requires all hospitals to submit a valid NPI as a condition of Alaska Medicaid provider enrollment. Each hospital will be enrolled as an Alaska medical assistance provider and will therefore meet the requirement to receive an NPI.

In the event the Department of Health and Social Services determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS. Providers may refund the money to the State of Alaska in a lump sum, or an accounts receivable account will be created. The existing practice allows the Department of Health and Social Services to work out an acceptable repayment period.



9. Enrollment Process

To meet the qualifications for the Alaska Medicaid EHR Incentive Program, providers are required to attest the information submitted in their application is true and accurate.

For an EP/EH to qualify for an incentive payment in a particular calendar year, they must have completed their attestation in the SLR within 60 days of the close of the calendar year or alternatively identified attestation period to count towards that payment year (calendar year).

Before Applying

Before applying, an EP/EH must complete the following:

- Adopt, implement, or upgrade to a certified EHR technology system. To verify your EHR is certified, see the [List from ONC](#).
- Be a State of Alaska eligible provider or eligible hospital with an active medical license number and Medicaid ID. EPs must locate your active medical license number and Medicaid ID.
- Locate your NPI and TIN.
- Locate a copy of your signed contract or invoice with a vendor for the purchase, implementation, or upgrade of a certified EHR system. This contract or invoice needs to identify the current vendor and version of your EHR.
- EHs must locate the most recent four years of cost report data.
- Determine your Medicaid patient volume to be reported for the selected 90 days or greater period. See [Patient Volume Methodology](#).
- Determine method of CEHRT you will be attesting to - meaningful use.
- Complete the Eligibility Workbook and Adopt/Implement/Upgrade Attestation Workbook on the [Let's get started! screen](#).
- Identify one individual to complete the SLR application.

Medicare and Medicaid Registration and Attestation System

The Medicare Attestation Worksheets allow providers to log their meaningful use measures on a document to use as a reference when attesting for the Medicare EHR Incentive Program in CMS' R&A system.

Note: Medicare EP's will attest to the Advancing Care Information performance category under MIPs. To access the Quality Payment Program and requirements for Medicare eligible clinicians visit the official website.

EPs registering in the Medicaid EHR Incentive Program must enter their National Plan and Provider Enumeration System (NPPES) web user account user ID and password to log into the registration system.

EPs may choose to receive the incentive payment themselves or assign them to a clinic or group to which they belong. The EP must select where their payments will go in the payee TIN type. EPs must provide the SSN payee TIN type to indicate that the provider receives the payment. The EIN payee TIN type indicates the group receives the incentive payment. Providers will have to enter the group name, group payee TIN, and the group National Provider Identifier (NPI) for the provider to issue the payment to the group in which they are associated. For the group or

clinic to receive the incentive payments from Alaska, the EP must have a billing provider contract to which the payment is being assigned.






EPs must select between the Medicare and Medicaid incentive programs. If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the CMS R&A System to make any changes to their information and/or choices such as changing the program from which they want to receive their incentive payment.

Hospital representatives must enter their identification and authentication user ID and password to log into the CMS EHR Incentive Program R&A System. Hospitals must provide their CCN and the NPI for the hospital. The hospital must select the Medicaid state and the hospital type in which they will participate.



EHRs seeking payment from both Medicare and Medicaid will be required to visit the Medicare and Medicaid EHR Incentive Program Registration and Attestation System annually to attest to meaningful use before returning to SLR website to complete the attestation for Alaska's Medicaid EHR Incentive Program. Alaska Medicaid will assume meaningful use is met for hospitals deemed so for payment from the Medicare EHR Incentive Program.

The Medicare and Medicaid EHR Incentive Program Registration and Attestation System will electronically notify the Alaska Medicaid SLR of a provider's choice to enroll in the Alaska Medicaid EHR Incentive Program. The information completed by the provider at the national website is sent to the SLR electronically within 24-48 hours.

Below are user guides for Medicaid and Medicare EPs and EHRs:

- [Medicaid EHR Incentive Program EP User Guide](#) 
- [Medicare QualityNet Secure Portal Enrollment and Login User Guide](#) 
- [Medicare and Medicaid EHR Incentive Program EH User Guide](#) 
- [Enterprise Identity Data Management \(EIDM\) User Guide](#) 
- [2020 Medicare Promoting Interoperability Program Scoring Methodology Fact Sheet](#) 
-

Program Attestation Registration

1. Register with CMS at the [Medicare and Medicaid EHR Incentive Program Registration and Attestation System](#).  The Registration and Attestation (R&A) System serves as a federal repository to register providers and hospitals and track payments for the Medicare and Medicaid EHR Incentive Programs. Registration is required for all providers and hospitals seeking incentive payments. For more information, see the [CMS website](#). 
 - You will not be able to start the SLR application unless you have successfully completed the R&A process.

Note: Please be aware that if you initiate any changes to your R&A registration information and those changes have not been completed when you start your SLR application, the R&A may report your registration as "In Progress." You must complete any registration changes before applying to the SLR.

Welcome to the Promoting Interoperability Programs Registration System

About This Site

The Promoting Interoperability Programs (previously known as The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs) will provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. These interoperability programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care.

This web system is for the Promoting Interoperability Programs. Those wanting to take part in the program will use this system to register and participate in the program.

Additional Resources: For User Guides to Registration that will show you how to complete these modules, a list of EHR technology that is certified for this program, specification sheets with additional information on each Meaningful Use objective, and other general resources that will help you complete registration, please visit [CMS website](#).

Eligible to Participate - There are two types of groups who can participate in the programs. For detailed information, visit [CMS website](#).

Overview of Eligible Professional (EP) and Eligible Hospital Types

Eligible Professionals (EPs)

Medicaid EPs include:

- Physicians
- Nurse Practitioners
- Certified Nurse - Midwife
- Dentists
- Physicians Assistants who practice in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) that is led by a Physician Assistant.
- Doctors of Optometry

Further, Medicaid EPs must also:

- Have a minimum of 30% Medicaid patient volume (20% minimum for pediatricians), OR
- Practice predominantly in a FQHC or RHC and have at least 30% patient volume to needy individuals.

Eligible Hospitals

Medicaid Eligible Hospitals include:

- Acute Care Hospitals with at least 10% Medicaid patient volume. May include CAHs and cancer hospitals.

Alaska Medicaid State Level Registry

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation is provided, the Alaska Medicaid EHR Incentive Program Office will conduct a review to validate the EP or EH meets the qualifications of the program and will verify supporting documentation.

The attestation itself will require the EP or EH to attest to meeting all requirements defined in the federal regulations. All providers will be required to mail the originally signed attestation to the Alaska Medicaid EHR Incentive Program Office. To support specific elements of the attestation, some required documentation may be needed.

For example: Providers who attest to AIU of CEHRT will be required to submit a copy of a signed contract or paid invoice.

During the first year of the program, EPs/EHs will be able to attest to adopting, implementing or upgrading to certified EHR technology or attest to meaningful use.

Note: The documentation for AIU of CEHRT for EPs/EHs does not have to be dated in the year of reporting. Documentation dated any time prior to the attestation is acceptable if the system and version of EHR technology has been certified by ONC (click here for the [Certified Health IT Product List](#)).

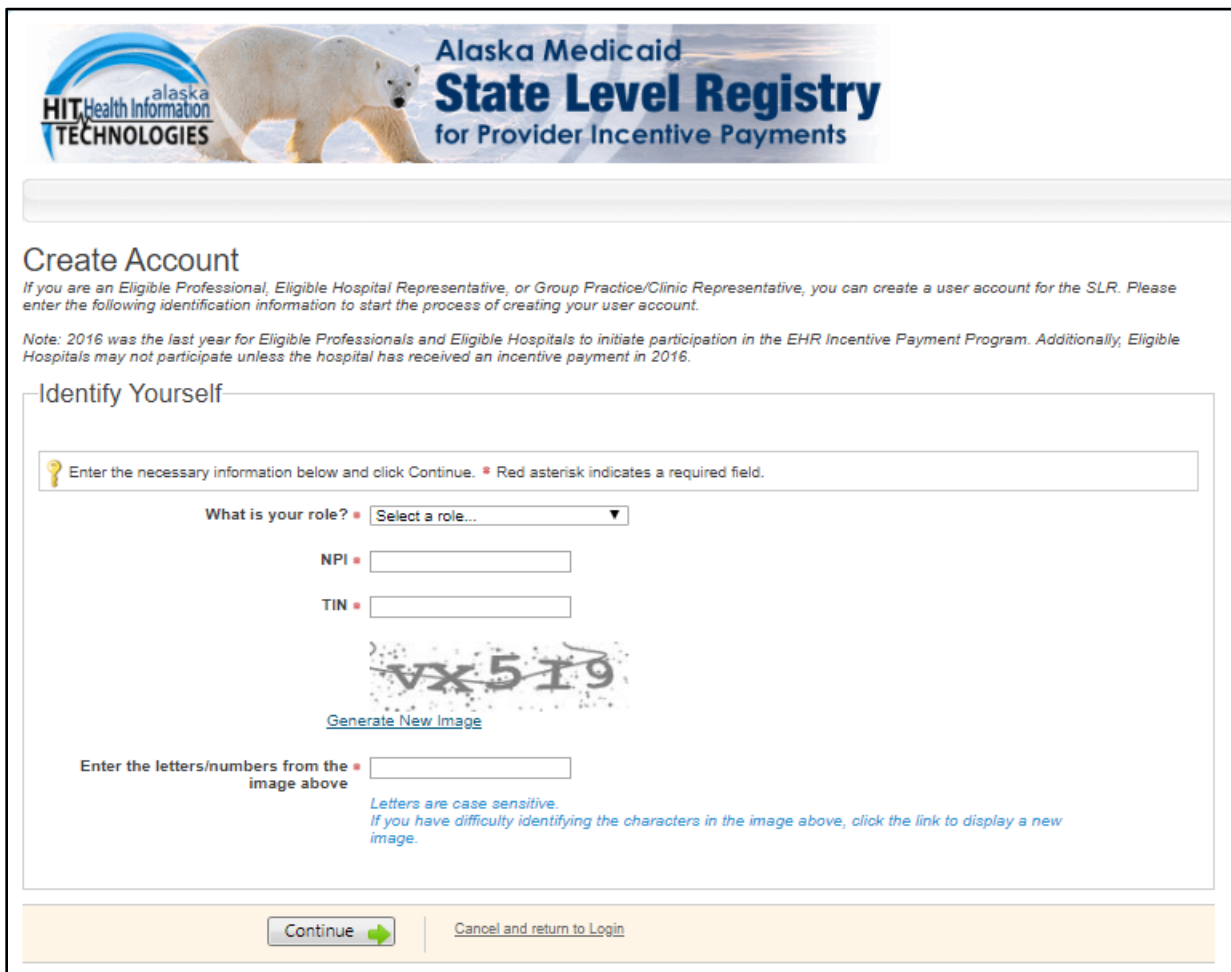
All providers will be required to attest to meeting meaningful use to receive incentive payments after the first year.

Create an Alaska SLR Account

1. Create an [Alaska SLR account here](#).
 - o You must register in the Registration and Attestation System before accessing the SLR.



The Create Account screen displays.



Alaska Medicaid State Level Registry
for Provider Incentive Payments

Create Account

If you are an Eligible Professional, Eligible Hospital Representative, or Group Practice/Clinic Representative, you can create a user account for the SLR. Please enter the following identification information to start the process of creating your user account.

Note: 2016 was the last year for Eligible Professionals and Eligible Hospitals to initiate participation in the EHR Incentive Payment Program. Additionally, Eligible Hospitals may not participate unless the hospital has received an incentive payment in 2016.


Identify Yourself

Enter the necessary information below and click Continue. * Red asterisk indicates a required field.

What is your role? *

NPI *

TIN *



[Generate New Image](#)

Enter the letters/numbers from the image above *

Letters are case sensitive.
If you have difficulty identifying the characters in the image above, click the link to display a new image.

[Cancel and return to Login](#)

2. Select your **Role**. Your choices are:
 - Individual/Eligible Provider
 - Eligible Hospital Representative
 - Group Representative
3. Enter your **NPI**.
Note: Your NPI must match the NPI on file with CMS and the Alaska Medical Assistance Program.
4. Enter your **TIN**.
Note: Your TIN must match the TIN on file with CMS and the Alaska Medical Assistance Program.
5. Enter the **CAPTCHA** displayed in the **Enter the letters/numbers from the image above** field.
 - Letters are case sensitive and must be entered exactly as they are displayed in the image.
 - If you have difficulty identifying the characters in the CAPTCHA image, select the **New Image?** link to display a new image.
6. Select the **Continue** button.

Create Account

Is This You?

Name

Address

Create Login

Enter the necessary information below and click Create Account. * Red asterisk indicates a required field.

User ID *

Password *

Confirm Password *

Select a Challenge Question *
Select Challenge Question...

Your Answer to the Challenge Question *

Phone *

E-mail address *

Confirm E-mail address *

In the **Is This You?** section, the name and address registered with CMS will display. If this information is incorrect, please contact the Alaska Medicaid EHR Incentive Program Office.

7. If the information displayed in the **Is This You?** section is correct, proceed to create your **User ID**. This is required.
 - Your User ID must be between 8-20 characters. Special characters are allowed. No spaces.
8. Create your **Password**. This is required.
 - Passwords must be between 8-20 characters, have at least one upper and one lower case letter, one number, and one special character (@ or # or !).
 - Passwords cannot contain your User ID.
 - You cannot reuse old passwords.
9. Retype your password exactly in the **Confirm Password** field. This is required.
10. Select a **Challenge Question** from the dropdown list. This field is required. This question will be asked if you ever forget your User ID or password.
11. Enter **Your Answer** to the Challenge Question. This is required. When you are asked the challenge question, you must enter the answer exactly as it is entered here.
12. Enter your **Phone** number. This field is required.
 - Number only beginning with area code.
 - No spaces, dashes, or parentheses.
13. Enter your **E-mail Address**. This is required.
14. Select the **Create Account** button to save your information.

Test	Result	Units	Reference Range
Urea and Electrolytes	139	mmol/L	(110 - 145)
Sodium	4.8	mmol/L	(3.5 - 5.3)
Potassium	101	mmol/L	(95 - 108)
Chloride	26	mmol/L	(22 - 29)
CO2	3.9	mmol/L	(2.5 - 7.8)
Urea	91	umol/L	(40 - 110)
Creatinine	>60	mLs/min	eGFR equation assumes Caucasian ethnicity.
eGFR	0.9	mg/L	(1)
C-reactive Protein	4	umol/L	
Urea Nitrogen	28	umol/L	

10. State Level Registry Provider Registration

Once the CMS registration information is received in the SLR, the provider may complete the registration process in the SLR web portal. The Alaska Medicaid EHR Incentive Program will utilize the secure Alaska Medicaid SLR to house the attestation system.

Step-by-Step Instructions

1. Navigate to the SLR Provider Home Page: [Alaska SLR Provider Home Page](#).

The screenshot shows the Alaska Medicaid State Level Registry website. The header includes the Alaska HIT logo and a polar bear. The main content area is divided into several sections:

- Important Dates to Remember:** Program Year 2016 was the last year an EP can begin participation in the Medicaid EHR Incentive Program. For EPs - The SLR for Program Year 2018 will be open January 07, 2019 closing March 07, 2019. For EHS - Alaska paid our last incentive payment to Eligible Hospitals (EHS) in Program Year 2017.
- Welcome to the Alaska State Level Registry (SLR) — Provider Outreach Page:** As the healthcare landscape continues to modernize, recent legislation was passed to encourage the adoption of Electronic Healthcare Record (EHR) technology in documenting patient care. To streamline the process in applying for the incentive and provide supportive resources throughout your HIT transition, this web portal centralizes the national, state and regional links for additional program information.
- Interoperability Training Courses:** The Office of the National Coordinator (ONC) has developed training modules around the Stage 2 Meaningful Use (MU) Rule to train Eligible Professionals (EPs) and Critical Access Hospitals (CAHs) on how to implement new standards to support - Transitions of Care, Lab Exchange, Patient Engagement, and Public Health Measures.
- Meaningful Use Education Module: Transitions of Care:** This meaningful use educational module covers "transitions of care" from both a meaningful use and EHR technology certification perspective.
- Are You Eligible?:** Run the CMS Eligibility Wizard and quickly see if you may qualify for incentive payments.
- Frequently Asked Questions:** Have a question? Click here to view a list of frequently asked questions.

A central graphic features a doctor and a computer monitor with the text: "Want to get a jump start? Click Here!" and a link: "Click here to view information that will give you a jump start on getting your ARRA incentive payment."

Select **Want to get a jump start? Click Here** to receive step-by-step instructions on how to complete the registration and attestation process by role.

2. If you have previously created your account on the SLR, [select here to logon to the State Level Registry](#).

The **Let's Get Started** screen displays.

Let's get started!

Please select your role. Select... [more info...](#)

Please Note: This information is provided for *Medicaid* practitioners interested in applying for the *Medicaid EHR Incentive Program*. If you are a Medicare practitioner looking for information on the Medicare EHR Incentive Program, please visit www.cms.gov/EHRIncentivePrograms for more information.

3. Select your **Role**. Your choices are:
- Individual Eligible Professional (EP)
 - Eligible Hospital (EH)
 - Group Administrative (Group)

Let's get started!

Please select your role. Individual Eligible Professional (EP) [more info...](#)

Below are the step by step instructions on how to complete the registration process. [Click here to print this list.](#)

- Locate the National Provider Identified (NPI) and Tax Identification Number (TIN) you'll need to register at CMS's EHR Incentive Program Registration site. You'll also need this to create an SLR account.
[If you don't have an NPI, visit CMS's site to apply for one. Need a TIN? Visit IRS.gov.](#)
- [Register at CMS's EHR Incentive Program Registration site.](#)
- You must have an active Alaska Medicaid Provider Number. To enroll or check the status of your enrollment, [visit the enrollment site.](#)
- Create or locate an electronic copy of your signed contract with a vendor for the purchase, implementation or upgrade of a [certified EHR system.](#)
- Locate information related to your medical license such as your license number and effective dates.
- Identify an individual who will be the contact for your application - you'll need their name, phone and email.
- [Determine the Medicaid Patient volume you'll be reporting.](#)
- Determine which method of Certified EHR technology for which you will be attesting.
- Certified EHR info — [verify that your system is on the list from ONC.](#)
- [Create an SLR account](#) to register for the Alaska Medicaid EHR Incentive Program.
- Ensure that you have access to a scanner or electronic faxing technology such as RightFax™.
- [Contact the Alaska Medicaid EHR Incentive Program Office](#) if you have questions or would like to set up a meeting to discuss the Alaska Medicaid EHR Incentive Program registration and attestation process.

The following workbooks are designed to help you in gathering the necessary attestation information:

- [Eligibility workbook](#)
- [Adopt / Implement / Upgrade Attestation workbook](#)
- [EP Meaningful Use Workbook](#)

4. Follow the step-by-step instructions displayed for your role to complete the registration process. These vary by role.
- You can print this list by selecting the provided link.
 - Select the link to the **Eligibility Workbook** to assist in gathering the necessary attestation information.
 - Select the link to the **Adopt/Implement/Upgrade Attestation Workbook** to assist in gathering the necessary attestation information.
 - Select the link to the **Meaningful Use Workbook**.

11. State Level Registry Provider Attestation

EP and EH Provider SLR Attestation

The attestation is an amendment and becomes part of the provider's contract. The following steps contain the information that a provider needs to enter into the SLR and attest to upon completion of the application.

1. Login to the SLR.

alaska HIT Health Information TECHNOLOGIES

Alaska Medicaid
State Level Registry
for Provider Incentive Payments

Contact Us

Existing Users

Enter the User ID and password you created to login to the SLR. If you have not already created a User ID, please select the Create Account option to create a new User ID. * Indicates required fields.

User ID *

Password *

[Forgot User ID?](#)

[Forgot Password?](#)

Need to Create an Account?

If you are an Eligible Professional, Eligible Hospital Representative, or Group Practice/Clinic Representative, you can create a user account for the SLR. If you have not already created a User ID, please select the Create Account button below to create a new User ID.

Privacy Terms of Use Accessibility

2. Enter your **User ID** and Password created from your SLR registration process.
3. Select the **Log In** button.

You are taken to the End User License Agreement and Terms of Use Agreement screen.

Electronic Health Records Incentive Program
Web Portal
End User License Agreement and Terms of Use
ACCEPTANCE OF USE

Indicate your acceptance of the End User License Agreement below. * Red asterisk indicates a required field.

THE SERVICES THAT PROVIDES TO THE PROVIDER ARE SUBJECT TO THE TERMS AND CONDITIONS OF THIS END USER LICENSE AGREEMENT AND TERMS OF USE ("AGREEMENT"). THIS AGREEMENT GOVERNS THE USE OF ALL DATA AND SOFTWARE AVAILABLE AT THIS SITE ("SITE"). PLEASE READ THIS AGREEMENT CAREFULLY. THE PROVIDER CAN ACCESS THIS AGREEMENT AT ANY TIME BY CLICKING ON TERMS OF USE AT THE BOTTOM OF EVERY PAGE ON THIS SITE. CLICKING ON THE "I AGREE" BUTTON AT THE END OF THIS AGREEMENT AND ACCESSING OF THIS SITE BY THE PROVIDER WILL CONSTITUTE THE PROVIDER'S ACCEPTANCE OF THIS AGREEMENT. CONTINUED ACCESSING OF THIS SITE BY THE PROVIDER WILL CONSTITUTE THE PROVIDER'S ACCEPTANCE OF ANY AMENDMENTS TO THIS AGREEMENT. THE PROVIDER'S FAILURE TO FOLLOW THE TERMS AND CONDITIONS FOR USE OF THIS SITE, WHETHER LISTED BELOW OR IN BULLETINS POSTED AT VARIOUS POINTS IN THIS SITE, MAY RESULT IN SUSPENSION OR TERMINATION OF THE PROVIDER'S ACCESS TO THIS SITE, WITHOUT NOTICE, IN ADDITION TO OTHER REMEDIES AVAILABLE TO ACS. IF THE PROVIDER DOES NOT ACCEPT THIS AGREEMENT, THE PROVIDER'S ACCESS TO ANY OTHER PAGES OF THIS SITE WILL BE DENIED.

1. DEFINITIONS

IN ADDITION TO THE TERMS DEFINED ELSEWHERE IN THIS AGREEMENT, FOR PURPOSES OF THIS AGREEMENT THE FOLLOWING TERMS ARE

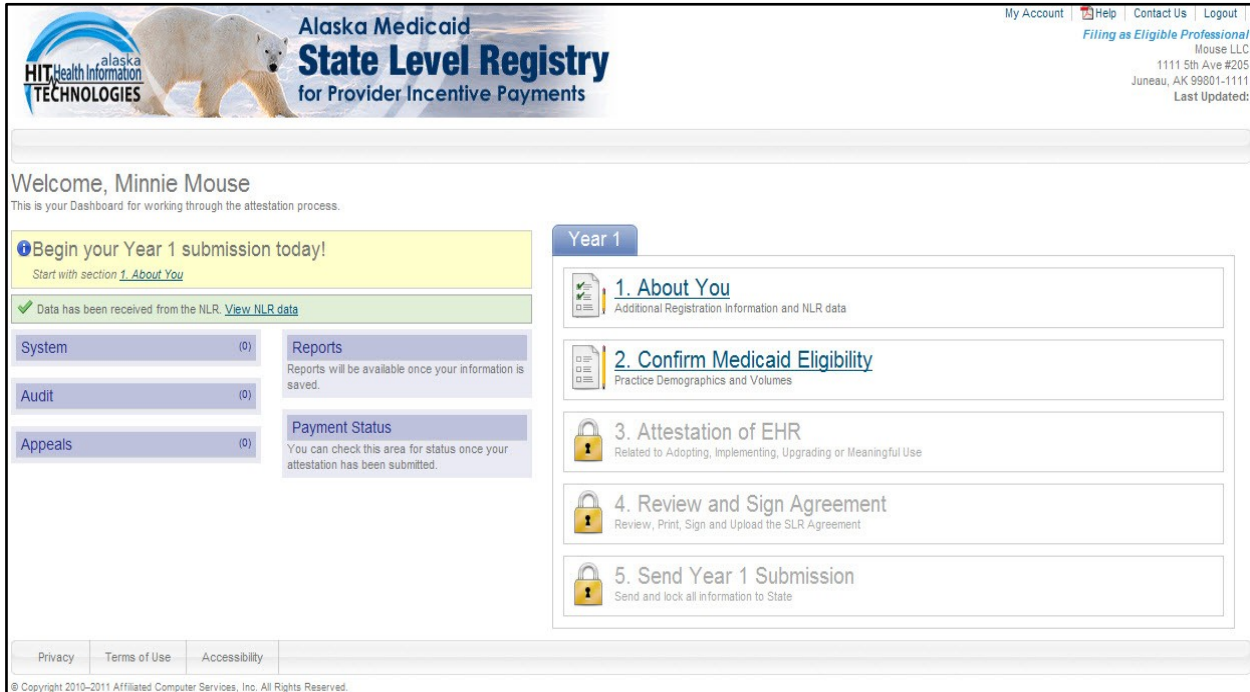
I Agree with the End User License Agreement. [Print EULA](#)

[Cancel and Return to Login](#)

Privacy Terms Of Use Accessibility

4. Read the **End User License Agreement and Terms of Use Acceptance of Terms**.
 - If you agree, accept the terms of agreement by selecting the **checkbox** next to the **I Agree** statement.
5. Select the **Continue** button.

The SLR Home Page screen displays.



The SLR Home Page is known as the Dashboard which displays basic system and account management information, provider reports, and identifies the steps for attestation. On the Dashboard:

- View any announcements under the welcome message.
- Open the **Help Guide** (select the Help link on the top right of the screen) which provides detailed instructions on how to complete the SLR application.
- The steps to complete the attestation workflow will be listed on the right of the screen.
 - You can only select the steps that show links in blue.

Step 1 – (EP) About You

1. Select the **About You** link.

The About You screen displays.

1. About You

In addition to the registration information you provided to NLR, the State of Alaska requires that you provide additional information to be used to help in determining your eligibility to participate in the Medicaid Incentive Program.

CMS National Level Repository (NLR) Record

✔ Data has been received from the NLR [View NLR data](#) | [Visit NLR website](#) #

Attestations

I attest that I DO NOT perform 90% or more of my services in an inpatient hospital or emergency room setting. [Why is this important?](#)

I attest that I am a pediatrician and am eligible for a reduced incentive payment if I achieve 20% Medicaid eligibility.

I attest that I am a Physician Assistant that practices predominantly in a PA led FQHC or RHC.

License Information

✔ Your license information is complete

Medicaid Number * Required field

Do you practice in a Tribal * Yes No
Health Program or other federal clinic without an Alaska license?

Alaska Professional License * Required field
Number

Licensing Board Name *

The **CMS National Level Repository (NLR) Record** section identifies if your CMS registration data has been received.

2. In the **Attestations** section, select the applicable **checkbox(es)**.
 - Eligible professionals may not be hospital based to qualify for the program. Eligible professionals are considered hospital based if 90% or more of their services are rendered in an inpatient or emergency room setting. If they are not hospital based, providers must attest they DO NOT perform 90% or more of their services in an inpatient hospital or emergency room setting by selecting the **checkbox**. This is required of eligible professionals.
 - A pediatrician who is qualifying for the program at the minimum 20% Medicaid patient volume must attest they are a pediatrician and are eligible to receive a reduced incentive payment amount if they achieve 20% Medicaid eligibility by selecting the **checkbox**. Doctors who qualify as pediatricians may receive a reduced incentive payment if they achieve between 20%-29% Medicaid patient volume.
 - Physician assistants may only qualify for the Medicaid EHR Incentive Program if they practice in a FQHC or RHC that is led by a physician assistant. They must attest they are a physician assistant that practices predominantly in a physician assistant-led FQHC or RHC and attached auditable documentation to who the EP meets the definition of a physician assistant in a physician assistant-led facility by selecting the **checkbox**.

3. In the **License Information** section, enter your **Alaska Medicaid Provider Number**.

License Information

✓ Your License Information is complete

Alaska Medicaid # ✓

Do you practice primarily in a Tribal Health Program or other Federal Clinic without an Alaska License? Yes No ✓

Alaska Professional License Number ✓

Licensing Board Name ✓

4. You must identify if you practice in an IHS clinic without an Alaska license.
- If you select **Yes** and practice in an IHS/Tribal Clinic and do not have an Alaska professional license, select **Other** from the **Licensing Board Name** drop-down. Enter the **Other License Number** and select the **Other License State** from the drop-down list.
 - If you answered **No** to the Tribal Health Program question, enter your **Alaska Professional License Number**. This is required.

5. Select your **Licensing Board Name** from the drop-down list. This is required.

Note: If you receive a message stating, “Professional License Number not found” or “Alaska Medicaid # does not match the Medicaid # on file”, you may still proceed to the next step of the application. Your professional license number will be validated at the payment approval step.

1. About You

In addition to the registration information you provided to NLR, the State of Alaska requires that you provide additional information to be used to help in determining your eligibility to participate in the Medicaid Incentive Program.

Professional License Number not found.

Alaska Medicaid # does not match the Medicaid # on file.

6. Move to the **Contact Person** section.

EPs may identify another contact person’s name, phone number, and email address. This person may be contacted if there are any issues with the attestation in addition to the contact information entered under the My Account screen. The information entered here does not change the contact information under the My Account or provided to CMS during the registration process.

Contact Person

Changing the contact information here does not change the contact information set up under the My Account page or the contact information provided to CMS in the registration process. SLR generated messages will be sent to all email accounts recorded for this provider.

✔ Your contact information is complete

Name *

Title

Phone Number *
9999999999 (no spaces, dashes, parens)

Email Address *
name@domain.com

Attach Documentation

File(s) Attached - {0}

[Cancel and lose About You changes](#)

7. Enter the **Name** of the contact person. This is required.
8. Optionally, enter the contact person’s **Title**.
9. Enter the **Phone Number** of the contact person. This is required.
10. You must enter the contact person’s **Email Address**. This is required. SLR generated messages will be sent to all email accounts recorded for this provider.
11. You may attach documentation by selecting the **Manage Files** button and selecting the file(s) from your computer’s file explorer.
12. After all the required fields have been completed, select the **Save About You** button to save the information entered.

Note: You are returned to the Dashboard. The About You tab has been completed and is highlighted green.

Step 1 – (EH) About You

1. Select the **About You** link.

The About You screen displays.

1. About You

In addition to the registration information you provided to NLR, the State of Alaska requires that you provide additional information to be used to help determine eligibility to participate in the Medicaid Incentive Program.

CMS National Level Repository (NLR) Record

✔ Data has been received from the NLR. [View NLR data](#) | [Visit NLR website](#)

Contact Person

Changing the contact information here does not change the contact information set up under the My Account page or the contact information provided to CMS in the registration process. SLR generated messages will be sent to all email accounts recorded for this provider.

Enter your contact information below. * indicates required fields.

Name *

Phone Number *
9999999999 (no spaces, dashes, parens)

Email Address *
name@domain.com

EHs may identify another contact person's name, phone number, and email address. This person may be contacted if there are any issues with the attestation in addition to the contact information entered under the My Account screen. The information entered here does not change the contact information under the My Account or provided to CMS during the registration process

2. Enter the **Name** of the contact person. This is required.
3. Enter the **Phone Number** of the contact person. This is required.

You must enter the contact person's **Email Address**. This is required. SLR generated messages will be sent to all email accounts recorded for this provider.

4. After all the required fields have been completed, select the **Save About You** button to save the information entered.

Note: You are returned to the Dashboard. The About You tab has been completed and is highlighted green.

Step 2 – (EP) Confirm Medicaid Eligibility

1. Select the **Confirm Medicaid Eligibility** link.

The Confirm Medicaid Eligibility screen displays.

Practice Eligibility Details

Enter your eligibility information below. * Red asterisk indicates a required field.

To qualify, Eligible Professionals (EPs) must achieve at least 30% Medicaid patient volumes, though Pediatricians who achieve a 20% volume may qualify to receive a reduced incentive payment amount. However Pediatricians who practice predominantly in a FQHC/RHC must achieve at least 30%.

Enter Representative Period * 90-day period ✓

Year 1 Start Date * 5/1/2010 ✓

Year 1 End Date * 7/29/2010 ✓

Total Encounters * 700 ✓
Please enter your total patient encounters for the selected reporting period.

Total Medicaid Encounters * 312 ✓
Please enter your total Medicaid Patient Encounters for the selected reporting period.

Do you have Medicaid Patients * from more than one State? Yes No ✓

Do you practice predominately in a Federally Qualified Health Care Center (FQHC) or Rural Health Center (RHC)? FQHC RHC None ✓
Predominately is defined by CMS as greater than 50%.

Eligibility Formula * 44.57% ✓

Calculate

(Total Medicaid Encounters/Total Encounters or, if predominant practice is selected, then Other Needy Individuals' Patient Encounters + Medicaid Encounters/ Total Patient Encounters)

Meets Eligibility Requirements?
 Yes

2. In the **Practice Eligibility Details** section, select the **Enter Representative Period** from the drop-down list. This is the start date of your 90-day of greater period. This is required. **Note:** You must select from the calendar the start date for the 90 days or greater representative period use to enter the patient volume data. The choices are:
 - 90-day period in previous calendar year
 - You must select the start date of the selected 90-day period from the preceding calendar year and the SLR will calculate the end date.
 - Full calendar year period
 - You must enter the start date of January 1st of the previous calendar year and the SLR will calculate the end date.
 - Consecutive 3-month period
 - 90 days
 - 90-day Period in 12 months preceding the attestation
3. Enter the **Total Encounters**
 - This is the total number of encounters for the selected representative period. This is required.

4. Enter the **Total Medicaid Encounters**.
 - This is the total number of unique Medicaid encounters for the same representative period. This is required.
5. Select the correct answer to the **Do you have Medicaid patients from more than one state?** question. The EP must identify if they practice in more than state. This is required.
 - If you do not practice in more than one state, you may proceed to the next question.
 - If you select **Yes**, you will have the option of using the Medicaid patient volume from the other state, although you are not required to use the out-of-state Medicaid patient volume.

Do you practice in more than ***** Yes No
one state?

Do you want your volumes for ***** Yes No
all states to be used to
determine eligibility?

State	Total Encounters	Total Medicaid Encounters	Remove
Alaska	150	30	<input type="checkbox"/>
Washington	100	15	<input type="checkbox"/>

The sum of each State's Total Encounters must match the Total Encounters entered above.
The sum of each State's Total Medicaid Encounters must match the Total Medicaid Encounters entered above.

- If you identify that you practice in more than one state, you must identify if you wish to use the Medicaid and total encounters from that state. Select the desired answer to **Do you want your volumes for all states to be used to determine eligibility?**
 - If you select **No**, continue to the next question
 - If you select **Yes**, you will be asked to enter the **State**, the **Total Encounters** from that state, and the **Total Medicaid Encounters** for that state. You can enter more than one by selecting the **Add a State** button.

Note: If you use the other state's encounter volume, you are required to enter the number of Medicaid encounters and total encounters for each of the states in which you practice, including Alaska, in these date fields. The total encounters and total Medicaid encounters entered in these fields must match the total encounters and total Medicaid encounters entered in the initial patient volume data entry.

6. Select the correct answer to **Do you practice predominantly in a Federally Qualified Health Care Center (FQHC) or Rural Health Center (RHC)? Predominately is defined by CMS as greater than 50%.** This is required. An EP practices predominantly in a FQHC or RHC when the clinical location is over 50% of the EP's total patient encounters over a 6-month time period.
 - If you select FQHC or RHC, you must enter your **Other Needy Individuals Patient Encounters**. The number entered should include the total number of needy individual encounters that are not included in the total Medicaid encounter volume entered in the initial patient volume data entry.
7. To determine if you meet the patient volume criteria, select the **Calculate** button for Eligibility Formula.

8. Attach any optional documentation by selecting the **Manage Files** button, and then selecting the appropriate files to attach.
9. Select the **Save** button to ensure all the information entered has been saved.

Note: You are returned to the Dashboard. The Confirm Medicaid Eligibility tab has been completed and is highlighted green. Step 3 has been unlocked to allow you to continue.



Step 2 – (EH) Confirm Medicaid Eligibility

1. Select the **Confirm Medicaid Eligibility** link.

The Confirm Medicaid Eligibility screen displays.

2. Confirm Medicaid Eligibility

For purposes of calculating hospital patient volume, the following are considered Medicaid services:

1. Services rendered to an individual per inpatient discharges where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service;
2. Services rendered to an individual per inpatient discharge where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost-sharing;
3. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act either paid for part or all of the service; or
4. Services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, co-payments, and/or cost sharing.
5. [more info](#)

Medicaid Volume

Enter your Medicaid Volume information below. * indicates required fields.

Enter Representative Period * Other 05/01/2010 09/30/2010

Total Discharges for Representative Period *

Medicaid Discharges for Representative Period *

Do you have Medicaid patients from more than one state? Yes No

Average Length of Stay, in days, for the hospital fiscal year that ends during the prior federal fiscal year. Excluding Swing and Nursery Bed days. [more info...](#)

Medicaid Volume 21.95%

(Medicaid discharges for representative period/Total discharges for representative period)

Meets Medicaid Eligibility Requirements?

Yes! Meets Medicaid Eligibility Requirements.

2. Select the **Enter Representative Period** from the drop-down list. This is the start date of your 90-day of greater period. This is required.

Note: You must select from the calendar the start date for the 90 days or greater representative period use to enter the patient volume data. The choices are:

- 90-day period in previous calendar year
 - You must select the start date of the selected 90-day period from the preceding calendar year and the SLR will calculate the end date.
 - Full calendar year period
 - You must enter the start date of January 1st of the previous calendar year and the SLR will calculate the end date.
 - Consecutive 3-month period
 - 90 days
 - 90-day Period in 12 months preceding the attestation
3. Enter the **Total Discharges for Representative Period**
 - Enter the total discharges over the selected representative period.
 4. Enter the **Medicaid Discharges for Representative Period**
 - Enter the Medicaid inpatient discharges and emergency room discharges over the selected representative period.
 5. Answer **Do you have Medicaid patients from more than one state?**
 - Identify if the hospital has Medicaid patients outside the State of Alaska by selecting **Yes** or **No**.
 6. Enter the **Average Length of Stay**

- Enter the average length of stay for the hospital fiscal year that ends in the prior federal fiscal year
 - The average length of stay calculation is calculated by the total inpatient bed days divided by total discharges
7. Select the **Medicaid Volume Calculate** button to determine if the hospital meets the minimum patient volume.
 8. In the Hospital Demographics Information section, enter the **Current Cost Report Year**. This will adjust the field labels for question 1.
 - This information is obtained from the hospital cost report that has ended in the previous federal fiscal year.
 9. **Enter the Discharges for the last four years of available data from your CMS Cost Reports.**
 - This is the total discharges for the acute care portion of the hospital for the previous four most recent years of hospital cost report discharge data. This excludes nursery discharges.
 10. Enter the Total Discharges.
 - This is the total discharges for the acute care portion of the hospital from the cost report ending in the federal fiscal year prior to the payment year. This excludes nursery discharges.

Note: Payments years are based on the federal fiscal year for hospitals.

Example: if a hospital is applying for an incentive payment in federal fiscal year 2011 (October 1, 2010-September 30, 2011), and the hospital fiscal year runs from July 1-June 30, the hospital cost report data to be used would be collected from the hospital cost report ending on June 30, 2010.

11. Enter the **Total Medicaid Inpatient Bed Days** from the hospital cost report ending in the federal fiscal year prior to the payment year. This excludes nursery days.

4. Enter the Total Medicaid Managed Care Inpatient Bed Days from the 2010 cost report . [more info...](#)

Total Medicaid Managed Care Inpatient Bed Days

Nursery and Swing Beds should be excluded from the Total Medicaid Managed Care Inpatient Bed Days.

5. Enter the Total Inpatient Bed Days from the 2010 cost report . [more info...](#)

Total Inpatient Bed Days

Nursery and Swing Beds should be excluded from the Total Inpatient Bed Days.

6. Enter the Total hospital charges from the 2010 cost report. [more info...](#)

Total Hospital Charges

7. Enter the Total charges attributable to Charity Care from the 2010 cost report. [more info...](#)

Hospital Charity Care Charges

If neither charity care nor uncompensated care charges are identifiable on the cost report, enter 1. The charity care ratio will be set to 1 for the incentive calculation.

Attach Documentation

File(s) Attached - {0}

Note: If a patient is dually eligible for both Medicare and Medicaid inpatient bed days: if Medicare inpatient bed days would count for the purpose of calculating the Medicare share, they cannot be counted in the numerator for the Medicaid share.

12. Enter the **Total Medicaid Managed Care Inpatient Bed Days**

Note: The Alaska Medical Assistance Program does not have a Medicaid Managed Care program. Hospitals may enter “0” in this field.

13. Enter the **Total Inpatient Bed Days** for the acute care portion of the hospital from the hospital cost report ending in the federal fiscal prior to the payment year. This excludes nursery days.

14. Enter the **Total Hospital Charges** from the hospital cost report ending in the federal fiscal year prior to the payment year.

15. Enter the **Hospital Charity Care Charges** from the hospital cost report ending in the federal fiscal year prior to the payment year.

16. Attach any documentation by selecting the **Manage Files** button, and then selecting the appropriate files to attach.

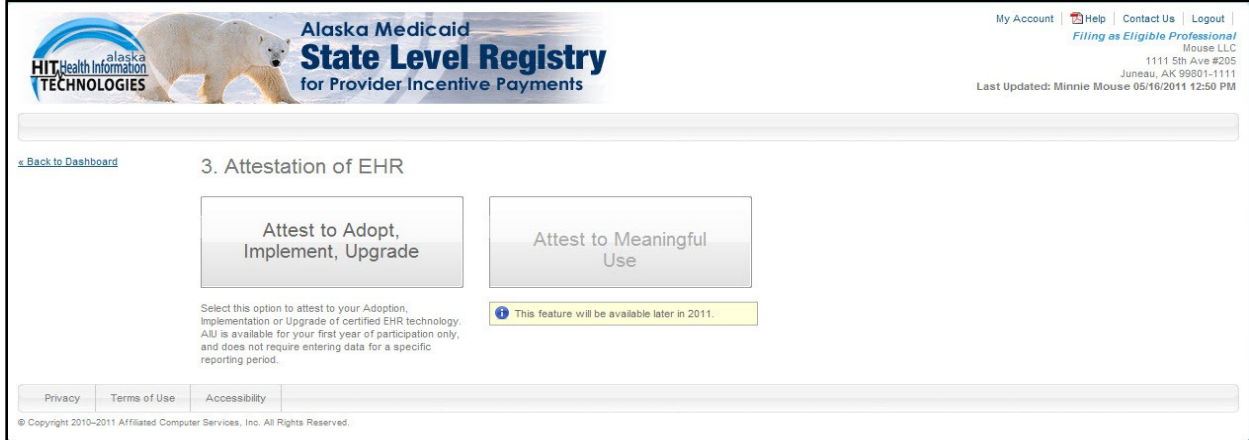
17. Select the **Save Eligibility** button to ensure all the information entered has been saved.

Note: You are returned to the Dashboard. The Confirm Medicaid Eligibility tab has been completed and is highlighted green. Step 3 has been unlocked to allow you to continue.

Step 3 – (EP/EH) Attestation of EHR

1. Select the **Attestation of EHR** link.

The Attestation of EHR screen displays.

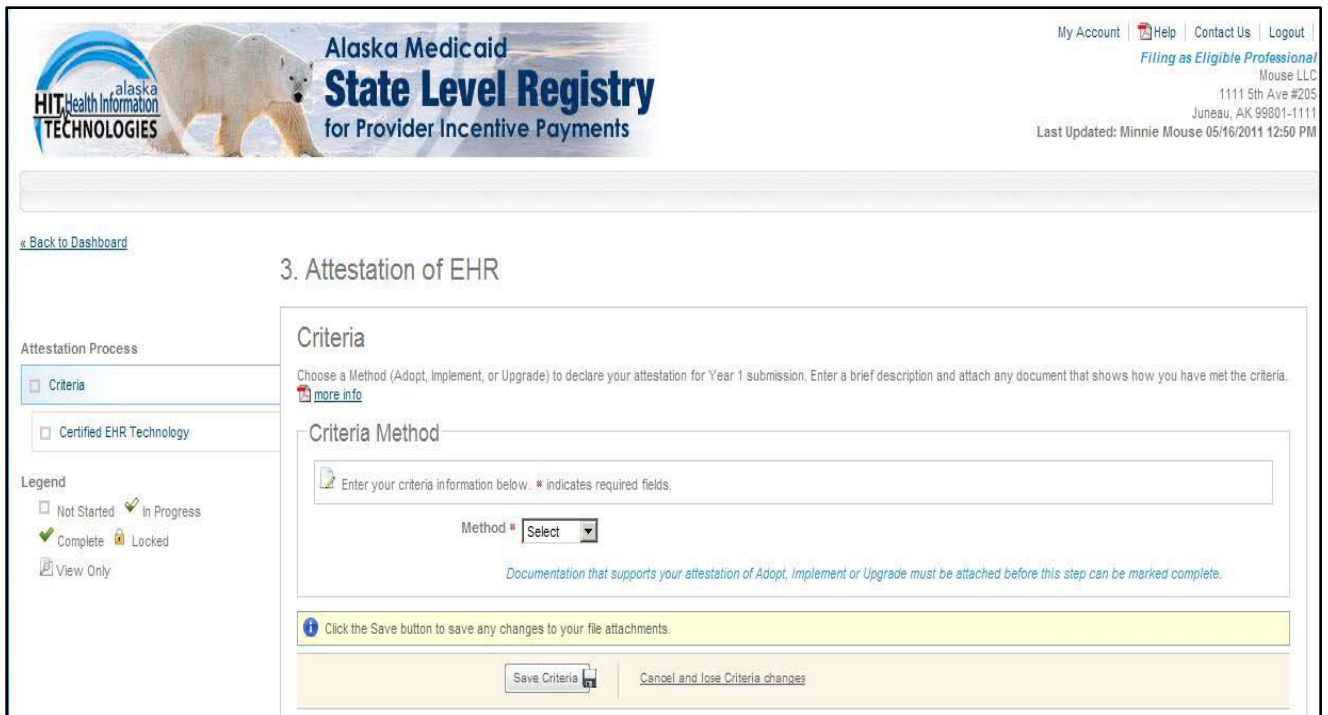


2. Select **Attest to Adopt, Implement, Upgrade** or **Attest to Meaningful Use**.

- o Adopt, Implement, Upgrade is only available for the first year of participation. In the first year of participation in the Medicaid EHR Incentive Program, EPs and EHs have the option to attest to Adopt, Implement, Upgrade to a certified EHR technology or to meaningful use.
- o In the second year of participation, EPs/EHs must attest to meaningful use.

Attest to Adopt, Implement, Upgrade

If Attestation to Adopt, Implement, Upgrade is selected, the AIU screen displays.



3. EPs/EHs must select the **Method** of attestation from the drop-down list. This is required. The choices are:
 - Adopt
 - Implement
 - Upgrade

4. You are required to **describe briefly how you meet the criteria for Adoption of EHR Technology**. Enter the description of how you meet the criteria of adopt, implement, or upgrade.

Note: You may enter up to 1,000 characters.

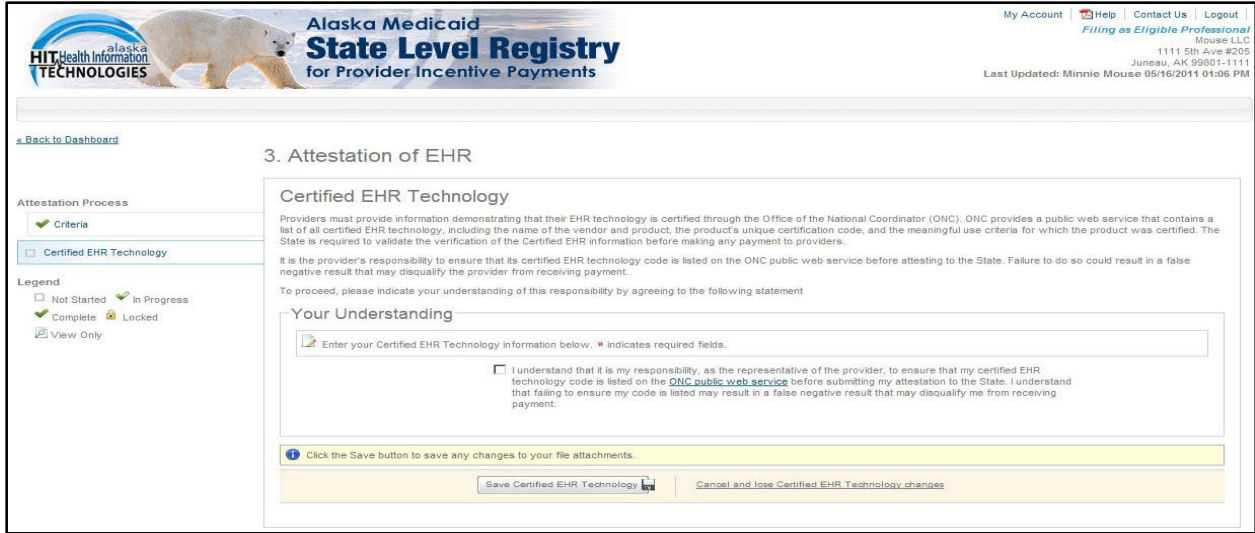
5. Select the **Manage Files** button. You must upload a file that supports the criteria for adopt, implement, or upgrade. At a minimum, you are required to upload a document in the subject of **Contract**. Other acceptable documents include a work plan, action plan, or staffing work plan.

6. When you add a file, you must select the subject of the file from the **Subject** drop-down list.

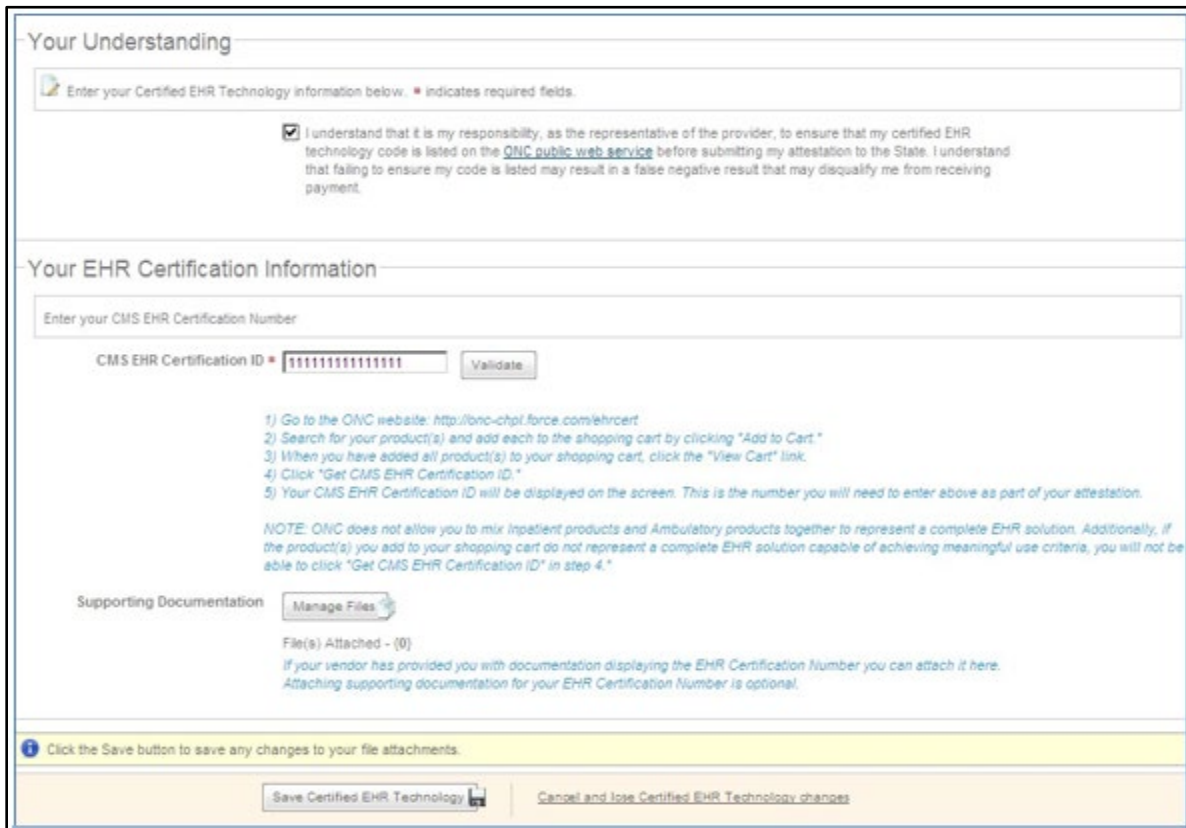
Note: A letter of agreement that has been signed by both the provider/group and the EHR vendor is an acceptable document to upload under the subject **Contract**.

7. Select **Save Files**.

The Certified EHR Technology screen displays.



8. Under the Your Understanding section, you must select the **checkbox** stating you agree to the following: “I understand that it is my responsibility, as the representative of the provider, to ensure that my certified EHR technology code is listed on the ONC public web service before submitting my attestation to the State. I understand that failing to ensure my code is listed may result in a false negative result that may disqualify me from receiving payment.”
 - o Once you agree, additional steps will appear requiring EHR certification information to be entered.



9. You must enter the **CMS EHR Certification ID** for your product. If you do not know your product's CMS EHR Certification ID complete the following steps:
 - a. Go to the ONC website: <http://onc-chpl.force.com/ehrcert>
 - b. Search for your product(s) and add each to the shopping cart by clicking **Add to Cart**.
 - c. When you have added all product(s) to your shopping cart, click the **View Cart** link.
 - d. Click **Get CMS EHR Certification ID**.
 - e. Your CMS EHR Certification ID will display on the screen. This is the number you will need to enter as part of your attestation.

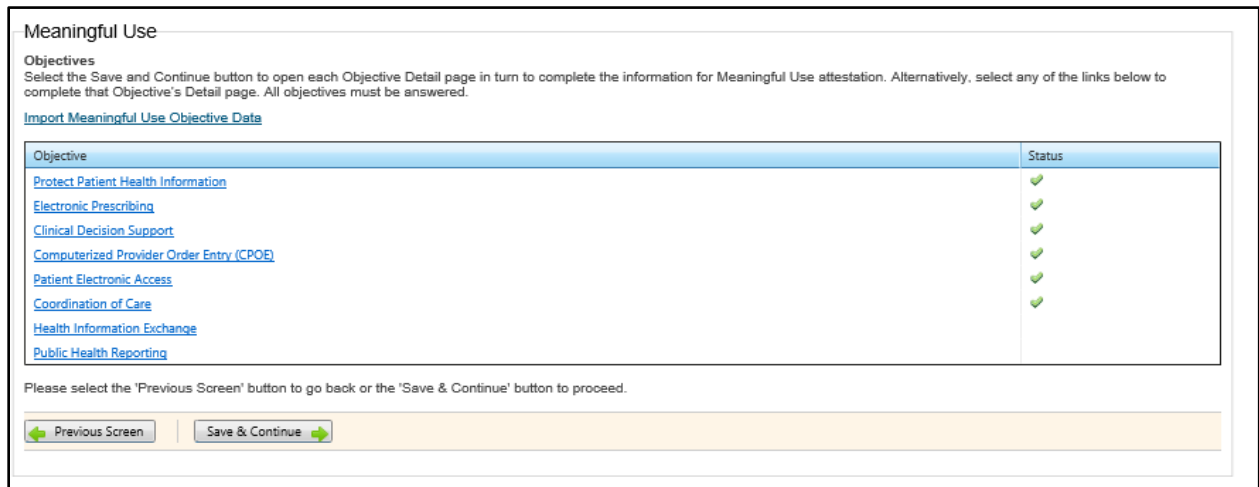
Note: ONC does not allow you to mix inpatient and ambulatory products together to represent a complete EHR solution. Additionally, if the product(s) you add to your shopping cart do not represent a complete EHR solution capable of achieving meaningful use criteria, you will not be able to click "Get CMS EHR Certification ID" in step d."

10. To attach Supporting Documentation, select the **Manage Files** button.:
 - o This is proof of the version of the EHR you have identified as your CEHRT. If your CEHRT is for Allscripts V11.4.1, please provide proof that you are using this version. This could be a vendor letter or an invoice with the version listed on it.
11. Select the **Save Certified EHR Technology** button to ensure all the information entered has been saved.

Note: You are returned to the Dashboard. The Attestation of EHR tab has been completed and is highlighted green. Step 4 has been unlocked to allow you to continue.

Attest to Meaningful Use (second year or participation)

If **Attest to Meaningful Use** is selected, the Meaningful Use screen displays.



3. Select the **Save & Continue** button to open each objective detail screen and complete the information. All objectives must be answered.

The Protect Patient Data Health Information screen displays.

Protect Patient Health Information

Red asterisk indicates a required field.

Objective: Protect electronic protected health information (ePHI) created or maintained by the CEHRT through the implementation of appropriate technical, administrative, and physical safeguards.
[Click here to view the CMS Stage 3 Meaningful Use Medicaid Eligible Professional specification sheets](#)

Measure: Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of data created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the EP's risk management process.
HHS Office of Civil Rights (OCR) has issued guidance on conducting a security risk analysis.
[Click here to view their guidance:](#)
[Click here for a Security Risk Assessment \(SRA\) Tool developed by ONC and OCR:](#)

Complete the following information:

- Have you conducted or reviewed a security risk analysis in accordance with the requirements?
 - Yes No
- Date within the current Program Year the security risk analysis was completed
 - Please enter the date your security risk analysis was completed.

Attach Files

The following attachment is required: The following attachments are optional:

- Security Risk Analysis
- Other

File Name	Subject	Remove
No records to display.		

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

1. Review the Objective by selecting the link.
2. You must select an answer to: **Have you conducted or reviewed a security risk analysis in accordance with the requirements?**
 - o Select either **Yes** or **No**.
3. Select the **Date within the current Program Year the security risk analysis was completed.**
4. You are required to attach a copy of the Security Risk Analysis by selecting the **Add Files** button and selecting the file from your computer.
5. Select the **Save & Continue** button.

The Electronic Prescribing screen displays.

Electronic Prescribing

* Red asterisk indicates a required field.

Objective: Generate and transmit permissible prescriptions electronically (eRx).
[Click here to view the CMS Stage 3 Meaningful Use Medicaid Eligible Professional specification sheets](#)

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you write **fewer than** 100 permissible prescriptions during the EHR reporting period? No Yes
[What if I still want to report on the measure?](#)

Do you have a pharmacy within your organization or one that accepts electronic prescriptions within 10 miles of your practice location at the start of his or her EHR reporting period? No Yes

Measure: More than 60% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

***PATIENT RECORDS:** Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.
 This data was extracted only from patient records maintained using certified EHR technology.
 Please make a selection for Patient Records.

Complete the following information:

* **Numerator** = The number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.
 Please enter a numerator.

* **Denominator** = Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period, or number of prescriptions written for drugs requiring a prescription in order to be dispensed during the EHR reporting period.
 Please enter a denominator.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen Save & Continue

1. Review the Objective by selecting the link.
2. Answer the questions under Exclusion Criteria by selecting **Yes** or **No**.
 - o Your answer will determine the need for more information on this screen.
3. Enter any required information for the **Measure**, if applicable.
4. Optionally, attach applicable files by selecting the **Add Files** button.
5. When finished, select the **Save & Continue** button.

The Clinical Decision Support screen displays.

Clinical Decision Support

Red asterisk indicates a required field.

Objective: Implement clinical decision support (CDS) interventions focused on improving performance on high-priority health conditions.
[Click here to view the CMS Stage 3 Meaningful Use Medicaid Eligible Professional specification sheets](#)

Exclusion Criteria Did you write **fewer than 100** of the following orders during the EHR reporting period? Writing **fewer than 100** orders qualifies for the exclusion for Measure #2 only. No Yes

Measure #1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to the EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions.
 Complete the following information:
 *Have you implemented five clinical decision support interventions related to four or more clinical quality measures or high-priority health conditions at a relevant point in patient care for the entire EHR reporting period?
 No Yes

* List the five clinical decision support interventions you have implemented

1	
2	
3	
4	
5	

* These clinical decision support interventions are related to
 4 or more clinical quality measures 4 or more high priority health conditions

* Select CQMs

A cross reference listing of the Clinical Quality Measures is located in the User Guide to assist you with identifying the applicable CQM numbers, if needed.

Measure #2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
 Complete the following information:
 *Have you enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period?
 No Yes
Required Field

Attach Files

The following attachments are optional:

- Other
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen Save & Continue

1. Review the Objective by selecting the link.
2. Answer the Exclusion Criteria question by selecting **Yes** or **No**.
 - o Your answer will determine the need for more information on this screen.
3. Enter any required information for **Measure #1**, if applicable.
4. Enter any required information for **Measure #2**, if applicable.

5. Optionally, attach applicable files by selecting the **Add Files** button.
6. When finished, select the **Save & Continue** button.

The Computerized Provider Order Entry (CPOE) screen displays.

Computerized Provider Order Entry (CPOE)

Red asterisk indicates a required field.

Objective: Use computerized provider order entry (CPOE) for medication, laboratory, and diagnostic imaging orders directly entered by any licensed healthcare professional, credentialed medical assistant, or a medical staff member credentialed to and performing the equivalent duties of a credentialed medical assistant, who can enter orders into the medical record per state, local, and professional guidelines.

[Click here](#) to view the CMS Stage 3 Meaningful Use Medicaid Eligible Professional specification sheets

Exclusion Criteria: Did you write fewer than 100 of the following orders during the EHR reporting period? Writing fewer than 100 orders qualifies for the exclusion for the associated measure.

Medication Orders (Measure #1) No Yes

Laboratory Orders (Measure #2) No Yes

Diagnostic Imaging Orders (Measure #3) No Yes

Measure #1: More than 60% of medication orders created by the EP during the EHR Reporting period are recorded using CPOE.

*PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

- * Numerator = The number of orders in the denominator recorded using CPOE.
Please enter a numerator.
- * Denominator = Number of medication orders created by the EP during the EHR reporting period.
Please enter a denominator.

Measure #2: More than 60% of laboratory orders created by the EP during the EHR Reporting period are recorded using CPOE.

*PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

- * Numerator = The number of orders in the denominator recorded using CPOE.
Please enter a numerator.
- * Denominator = Number of laboratory orders created by the EP during the EHR reporting period.
Please enter a denominator.

Measure #3: More than 60% of diagnostic imaging orders created by the EP during the EHR Reporting period are recorded using CPOE.

*PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

Please make a selection for Patient Records.

Complete the following information:

- * Numerator = The number of orders in the denominator recorded using CPOE.
Please enter a numerator.
- * Denominator = Number of diagnostic orders created by the EP during the EHR reporting period.
Please enter a denominator.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Please select the Previous Screen button to go back or the Save & Continue button to proceed.

1. Review the Objective by selecting the link.
2. Answer the questions under Exclusion Criteria by selecting **Yes** or **No**.
 - Your answers will determine the need for more information on this screen.
3. Enter any required information for **Measure #1**, if applicable.
4. Enter any required information for **Measure #2**, if applicable.
5. Enter any required information for **Measure #3**, if applicable.
6. Optionally, attach applicable files by selecting the **Add Files** button.
7. When finished, select the **Save & Continue** button.

The Patient Electronic Access screen displays.

Patient Electronic Access

Red asterisk indicates a required field.

Objective: Provide patients (or patient-authorized representative) with timely electronic access to their health information and patient-specific education
 Click [here](#) to view the CMS Stage 3 Meaningful Use Medicaid Eligible Professional specification sheets

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for both measures.

Did you have any office visits during the EHR reporting period? No Yes

Did you conduct 50% or more of your encounters in a county/area that does not have more than 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? No Yes

Measure#1: More than 80% of all unique patients seen by the EP during the EHR reporting period are 1) provided timely access to view online, download, and transmit his or her health information; and 2) the EP ensures the patient's health information is available for the patient (or patient-authorized representative) to access using any application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.

Complete the following information:

* **Numerator** = The number of patients in the denominator (or patient authorized representative) who are provided timely access to health information to view online, download, and transmit to a third party and to access using an application of their choice that is configured to meet the technical specifications of the API in the provider's CEHRT.
 Please enter a numerator.

* **Denominator** = Number of unique patients seen by the EP during the EHR reporting period.
 Please enter a denominator.

Measure#2: The provider must use clinically relevant information from CEHRT to identify patient-specific education resources and provide electronic access to those materials to more than 35% of unique patients seen by the EP during the EHR reporting period.

Complete the following information:

* **Numerator** = The number of patients in the denominator who were provided electronic access to patient-specific educational resources using clinically relevant information identified from CEHRT during the EHR reporting period.
 Please enter a numerator.

* **Denominator** = Number of unique patients seen by the EP during the EHR reporting period.
 Please enter a denominator.

Attach Files

The following attachments are optional:

- Other
- De-identified report from certified EHR technology to support numerator and denominator
- Written proof exclusion applies to EP, could be a report from certified EHR technology

File Name	Subject	Remove
No records to display.		

Add Files Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Previous Screen | Save & Continue

Coordination of Care

Red asterisk indicates a required field.

Objective: Use CEHRT to engage with patients or their authorized representatives about the patient's care (providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective).
[Click here](#) to view the CMS Stage 3 Meaningful Use Medicaid Eligible Professional specification sheets

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you have any office visits during the EHR reporting period? No Yes

Did you conduct 50% or more of your encounters in a county/area that does not have more than 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? No Yes

Measure#1: During the EHR reporting period, more than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).

Complete the following information:

= Numerator = The number of patients (or patient authorized representative) in the denominator who have viewed online, downloaded, or transmitted to a third party the patient's health information during the EHR reporting period and the number of unique patients (or patient authorized representative) in the denominator who have accessed their health information through the use of an API during the EHR reporting period.
 Please enter a numerator.

= Denominator = Number of unique patients seen by the EP during the EHR reporting period.
 Please enter a denominator.

Measure#2: For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

Complete the following information:

= Numerator = The number of patients in the denominator for whom a secure electronic message is sent to the patient (or patient-authorized representative) or in response to a secure message sent by the patient (or patient-authorized representative), during the EHR reporting period.
 Please enter a numerator.

= Denominator = The number of unique patients seen by the EP during the EHR reporting period.
 Please enter a denominator.

Measure#3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.

Complete the following information:

= Numerator = The number of patients in the denominator for whom data from non-clinical settings, which may include patient-generated health data, is captured through the CEHRT into the patient record during the EHR reporting period.
 Please enter a numerator.

= Denominator = The number of unique patients seen by the EP during the EHR reporting period.
 Please enter a denominator.

Attach Files

The following attachments are optional:

- Other

File Name	Subject	Remove
No records to display.		

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

Review the Objective by selecting the link.

1. Answer the questions under Exclusion Criteria by selecting **Yes** or **No**.
 - o Your answers will determine the need for more information on this screen.
2. Enter any required information for **Measure #1**, if applicable.
3. Enter any required information for **Measure #2**, if applicable.

4. Optionally, attach applicable files by selecting the **Add Files** button.
5. When finished, select the **Save & Continue** button.

The Coordination of Care screen displays.

Coordination of Care

Red asterisk indicates a required field.

Objective: Use CEHRT to engage with patients or their authorized representatives about the patient's care (providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective).
[Click here to view the CMS Stage 3 specification sheet for EPs.](#)

Exclusion Criteria: Meeting either of the following criteria qualifies for the exclusion for this measure.

Did you have any office visits during the EHR reporting period? No Yes

Did you conduct 50% or more of your encounters in a county/area that does not have more than 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? No Yes

Measure#1: During the EHR reporting period, more than 5 percent of all unique patients (or their authorized representatives) seen by the EP actively engage with the electronic health record made accessible by the provider and either: (1) View, download or transmit to a third party their health information; or (2) access their health information through the use of an API that can be used by applications chosen by the patient and configured to the API in the provider's CEHRT; or (3) a combination of (1) and (2).

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#2: For more than 5 percent of all unique patients seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient authorized representative), or in response to a secure message sent by the patient or their authorized representative.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Measure#3: Patient generated health data or data from a nonclinical setting is incorporated into the CEHRT for more than 5 percent of all unique patients seen by the EP during the EHR reporting period.

You meet the requirement for exclusion from this measure. Exclusion from the requirement does not prevent an EP from achieving Meaningful Use.

Attach Files

The following attachments are optional:

- Other

File Name	Subject	Remove
No records to display.		

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

1. Review the Objective by selecting the link.
2. Answer the questions under Exclusion Criteria by selecting **Yes** or **No**.
 - o Your answers will determine the need for more information on this screen.
3. Enter any required information for **Measure #1**, if applicable.
4. Enter any required information for **Measure #2**, if applicable.
5. Enter any required information for **Measure #3**, if applicable.
6. Optionally, attach applicable files by selecting the **Add Files** button.

7. When finished, select the **Save & Continue** button.

The Health Information Exchange screen displays.

Health Information Exchange

Red asterisk indicates a required field.

Objective: The EP provides a summary of care or record when transitioning or referring their patient to another setting of care, receives or retrieves a summary of care record upon receipt of a transition or referral or upon the first patient encounter with a new patient, and incorporates summary of care information from other providers into their EHR using the functions of CEHRT (providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective).

[Click here](#) to view the CMS Stage 3 Meaningful Use Medicaid Eligible Professional specification sheets

Exclusion Criteria : Meeting the following criteria qualifies for the exclusion for the relevant measures.

Did you transfer a patient to another setting or refer a patient to another provider **less than 100** times during the EHR reporting period? **(Measure #1)** No Yes

Did you conduct 50% or **more** of your encounters in a county/area that does not have **more than 50%** or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? **(Measure #1)** No Yes

Were transitions or referrals received and patient encounters in which the provider has never before encountered the patient **fewer than 100** during the EHR reporting period? **(Measure #2)** No Yes

Did you conduct 50% or more of your encounters in a county/area that does not have **more than 50%** or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period? **(Measure #2)** No Yes

Were transitions or referrals received and patient encounters in which the provider has never before encountered the patient **fewer than 100** during the EHR reporting period? **(Measure #3)** No Yes

[What if I still want to report on the measure?](#)

Measure #1: For more than 50 percent of transitions of care and referrals, the EP that transitions or refers their patient to another setting of care or provider of care: (1) Creates a summary of care record using CEHRT; and (2) electronically exchanges the summary of care record.

Measure #2: For more than 40 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP incorporates into the patient's EHR an electronic summary of care document.

Measure #3: For more than 80 percent of transitions or referrals received and patient encounters in which the provider has never before encountered the patient, the EP performs clinical information reconciliation. The provider must implement clinical information reconciliation for the following three clinical information sets: (1) Medication. Review of the patient's medication, including the name, dosage, frequency, and route of each medication. (2) Medication allergy. Review of the patient's known medication allergies.(3) Current Problem list. Review of the patient's current and active diagnoses.

Attach Files

The following attachment is required: *The following attachments are optional:*

- HIE Participation Agreement, or proof the EP met this measure, or written proof the exclusion applies to the EP
- Other

File Name	Subject	Remove
No records to display.		

Add Files Remove Selected

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

1. Review the Objective by selecting the link.
2. Answer the questions under Exclusion Criteria by selecting **Yes** or **No**.
 - o Your answers will determine the need for more information on this screen.
3. Enter any required information for **Measure #1**, if applicable.
4. Enter any required information for **Measure #2**, if applicable.
5. Enter any required information for **Measure #3**, if applicable.

6. Attach the required file and any other applicable files by selecting the **Add Files** button.
7. When finished, select the **Save & Continue** button.

The Public Health Reporting screen displays.










Public Health Reporting

Objective: The EP is in active engagement with a Public Health Agency (PHA) or clinical data registry (CDR) to submit electronic public health data in a meaningful way using certified EHR technology, except where prohibited, and in accordance with applicable law and practice.


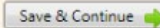
[Click here to view the CMS Stage 3 Meaningful Use Medicaid Eligible Professional specification sheets](#)

In order to meet this objective, EPs must meet two of the total number of measures available to them. Reporting an exclusion for a measure does not qualify towards meeting the objective unless the EP can report on fewer than 2 measures. If an EP can report on fewer than 2 measures, the EP must report on any possible measures and claim the exclusion for the remaining measures. If no measures remain available, the EP can meet the objective by claiming applicable exclusions for all measures.

For Measure 4, EPs may choose to report to more than one public health registry to meet the number of measures required to meet the objective. For Measure 5, EPs may choose to report to more than one clinical data registry to meet the number of measures required to meet the objective. Select "I will report on this measure" to report for the specific measure. Select "I will claim exclusion for this measure to claim exclusion for the specific measure."

Measure		I will report on this measure	I will claim exclusion for this measure
Measure 1 – Immunization Registry Reporting		<input type="checkbox"/>	<input type="checkbox"/>
Measure 2 – Syndromic Surveillance Reporting		<input type="checkbox"/>	<input type="checkbox"/>
Measure 3 – Electronic Case Reporting (not required until 2019)		<input type="checkbox"/>	<input type="checkbox"/>
Measure 4 – Public Health Registry Reporting (Registry #1)		<input type="checkbox"/>	<input type="checkbox"/>
Measure 4 – Public Health Registry Reporting (Registry #2)		<input type="checkbox"/>	<input type="checkbox"/>
Measure 4 – Public Health Registry Reporting (Registry #3)		<input type="checkbox"/>	<input type="checkbox"/>
Measure 5 – Clinical Data Registry Reporting (Registry #1)		<input type="checkbox"/>	<input type="checkbox"/>
Measure 5 – Clinical Data Registry Reporting (Registry #2)		<input type="checkbox"/>	<input type="checkbox"/>
Measure 5 – Clinical Data Registry Reporting (Registry #3)		<input type="checkbox"/>	<input type="checkbox"/>

Please select the 'Previous Screen' button to go back or the 'Save & Continue' button to proceed.

1. Review the Objective by selecting the link.
2. Select the Measures you wish to report on and the Measures you will claim exclusion for.
 - o Your answers will determine the need for more information on this screen.
3. When finished, select the **Save & Continue** button.
4. You will be taken to the first Measure you will report on. Enter the required information for the Measure and then select **Save & Continue** to move to the next Measure. When you have entered all the information required for the Measures you chose to report on, you are returned to the Meaningful Use screen.
5. Select **Save & Continue** to return to your SLR Dashboard.

Note: You are returned to the Dashboard. The Attestation of EHR tab has been completed and is highlighted green. Step 4 has been unlocked to allow you to continue.

Step 4 – (EP/EH) Review and Sign Agreement

Select the **Review and Sign Agreement** link.

The Review, Sign, and Attach Attestation screen displays.

4. Review, Sign, and Attach Attestation

Review and attach your signed attestation below. * Indicates required fields.

Step 1: Print to Sign Attestation
The information you entered in support of your attestation is displayed below. Please carefully review the entire document and all attachments before signing.

Alaska Medicaid Electronic Health Record Incentive Program Attestation Agreement

State of Alaska

Department of Health and Social Services

This Attestation Agreement is required for participation in the Electronic Health Record (EHR) incentive payment program to individual providers who adopt, implement, upgrade (AIU) or meaningfully use (MU) certified EHR technology in accordance with requirements under **United States Department of Health and Human Services, Centers for Medicare & Medicaid Services Final Rule regulations 42 CFR 495, Standards for the Electronic Health Record Incentive Program, revised July 28, 2010 which implements the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub.L. 111-5)**. As part of the cited regulations, the State of Alaska requires that all applicants for EHR payments submit a signed Attestation Agreement.

By signing this agreement, I attest that the following information entered below is true, accurate and complete:

1. I am authorized to seek one payment from the Alaska Medicaid EHR Incentive program and I have not, nor will I seek a payment from another state or Medicare EHR incentive program in this payment year.
2. I am seeking payment to Adopt/Implement/Upgrade for Year 1 of the program. I meet the requirements for Adopt as specified in the Medicare and Medicaid EHR Incentive Program rules and by the State of Alaska EHR Incentive Program rules.

Step 2: Scan and Upload Signed Attestation
After you have signed your attestation, please attach the signed copy for submission to the State and click the Save button below. If you have a problem attaching your document, please contact our Help Desk at (866) 879-0109 for assistance.

Locate Signed Attestation *

1. Select the **Print Attestation** button to print the attestation displayed on the screen.
2. Carefully read and then sign the attestation.
3. Upload the signed agreement to the SLR by selecting the **Browse** button.
 - Your file explorer window will display. Select the file with the signed attestation and then select open.
 - The file name will display in the **Locate Signed Attestation** field.
 - Select **Save Signed Attestation** button to ensure all entered information is saved.

Note: You are returned to the Dashboard. The Review and Sign Agreement tab has been completed and is highlighted green. Step 5 has been unlocked to allow you to continue.

Step 5 – (EP/EH) Send Year 1 Submission

Select the **Send Year 1 Submission** link.

The Send Attestation to State screen appears.

Send Attestation to State ✕

You have successfully submitted your attestation for Year 1 to the State of Alaska. Your attestation will be validated by the State to determine your eligibility to receive the incentive payment. Once the State has completed the validation process, your information will be submitted to CMS to verify you are eligible to receive Federal funds. Upon receiving confirmation from CMS that you are eligible to receive payment, the State will initiate the payment process. The validation process may take up to 17 – 33 business days to complete.

PLEASE NOTE: The State may elect to audit any and all information submitted as part of your attestation prior to or after approving your payment.

Please periodically check the State Level Registry Dashboard message area for information about the status of your attestation and payment.

Send Attestation
Cancel and do not send attestation

1. Select the **Send Attestation** button.
 - Once your attestation has been sent, the SLR will display a message confirming the attestation was sent.

Sent Attestation Confirmation ✕

✔ Attestation Submitted

You have successfully submitted your attestation for Year 1 to the State of Alaska. Your attestation will be validated by the State to determine your eligibility to receive the incentive payment. Once the State has completed the validation process, your information will be submitted to CMS to verify you are eligible to receive Federal funds. Upon receiving confirmation from CMS that you are eligible to receive payment, the State will initiate the payment process. The validation process may take up to 17 – 33 business days to complete.

PLEASE NOTE: The State may elect to audit any and all information submitted as part of your attestation prior to or after approving your payment.

Please periodically check the State Level Registry Dashboard message area for information about the status of your attestation and payment.

Note: You are returned to the Dashboard. The Send Year 1 Submission has been completed and all steps are now locked.

12. Validation and Approval Process

Requesting Payment

Once the attestation process is complete, the Alaska Medicaid EHR Incentive Program Office will validate the provider meets all qualifications for the program.

If additional information is needed to support the attestation, the Alaska Medicaid EHR Incentive Program Office may request any missing or additional information from the provider. If missing or additional information is required, the Program Office will notify the provider by electronic mail of the specific information needed. A provider must submit the additional information to the Program Office no later than 30 days after the date of the electronic mail notice. If the provider fails to submit the required information during that period, the Department will determine the registration incomplete, although the Program Office will work with the Provider Office to complete the application.

Before determining the provider meets the requirements of the program, the EHR Incentive Program Office will evaluate the facts to which the provider has attested and may request additional information from sources other than the provider to validate the provider's attestation submitted.

Upon completion of the attestation process, the EHR Incentive Program Office will review and validate the attestation. If all criteria are met and passed, an incentive payment will be approved. The State of Alaska will issue the payment to the TIN identified in the CMS EHR Incentive Program Registration and Attestation System. The same payee information must be input on the Substitute W9 form.

If the EHR Incentive Program Office determines the provider does not meet the requirements of the program, the provider will be notified by letter with the reason for denial. The provider will be notified of their right to request an appeal. If a change occurs in the information the Department used to deny participation or that previously resulted in a failure to receive CMS validation, the provider may submit a new or updated attestation at any time during that payment year.

Administrative Appeals

Administrative appeals of decisions related to the Alaska EHR Incentive Payment Program will be handled under the procedures described in the Alaska Medicaid EHR Incentive Program Regulations.

A provider may appeal the Department's decision to do any of the following:

- Deny participation in the Alaska Medicaid EHR Incentive Program under 7 AAC 165.030;
- Suspend an incentive payment under 7 AAC 165.050;
- Require repayment of all or a portion of an incentive payment under 7 AAC 165.050;
- Terminate participation in the Alaska Medicaid EHR Incentive Program under 7 AAC 165.050; and/or
- Terminate or suspend participation in the Medicaid program in this State under 7 AAC 165.050.

To appeal a decision of the Program Office, a provider must submit a written request for a first-level appeal to the EHR Incentive Program Office no later than 30 days after the date of the EHR Incentive Program Office letter denying participation. The request for a first-level appeal must

specify the basis upon which the Department's decision is challenged and include any supporting documentation. A first-level appeal will be conducted by the State Health Information Technology Coordinator.

Upon receipt of a request for a first-level appeal, if the Department has suspended an incentive payment, the Department may continue suspending the payment until a final determination is made regarding the appropriateness of the suspension. The Department will notify the provider in writing of the Department's first-level appeal decision.

The first-level appeal may be sent to:

Department of Health & Social Services Health Information Technology Office
Attn: State Health Information Technology Coordinator
3601 C Street, Suite 902
Anchorage, AK 99503

A provider who is not satisfied with the first-level appeal decision may request a second-level appeal by submitting a written request to the Department of Health and Social Services Commissioner no later than 30 days after the date of the first-level appeal decision.

The request for second-level appeal must include:

- A copy of the Department's first-level appeal decision;
- A description of the basis upon which the decision is being appealed;
- A copy of the first-level appeal submitted by the provider; and
- Any additional supporting documentation that supports the basis upon which the provider is making the appeal.

The Commissioner's review of the original appeal record, decision, and any additional material submitted by the provider and the Department constitutes the second-level appeal. A decision by the Commissioner under this subsection is the final administrative decision of the Department. The Department will notify the provider of the provider's right to appeal to the superior court under the Alaska Rules of Appellate Procedure.

This request must be submitted to:

Office of the Commissioner
Department of Health and Social Services
Attn: Alaska Medicaid EHR Incentive Program Appeals
P.O. Box 110601
Juneau, Alaska 99811-0601

Program Integrity

The Department will conduct regular reviews of attestations and incentive payments. These reviews will be selected as part of our current audit selection process including risk assessment, receipt of a complaint, or incorporation into reviews selected for other objectives. Be sure to retain supporting documentation for information reported for the incentive program for the standard Internal Revenue Service (IRS) business retention (approximately 7 years).

Payment recoupment

In the event of a recoupment, the provider will be notified by letter of the request for recoupment, along with the provider's right to appeal the decision. When an erroneous payment occurs resulting in an overpayment, repayment options will be discussed with the provider. A provider

has an option to refund the full payment in one payment or in multiple segments; the final decision is made by the Department. The refund will be made to the State of Alaska.

The provider can send payment in full to:

State of Alaska Program Integrity Unit

PO Box 240249

Anchorage, AK 99524