

What you need to know about Attestation!

This is the next step in qualifying for the EHR Incentive Payment is finally here! Both Eligible Professionals (EPs) and Eligible Hospitals (EHs) must attest to the patient volume requirements and having a certified EHR system (or module(s)) to qualify for the EHR payment.

Briefly, an EP is a doctor (M.D. or D.O.), nurse practitioner, certified nurse-midwife, dentist, or a physician's assistant practicing in an FQHC or RHC so led by a physician's assistant. An EP must have a minimum 30% Medicaid patient volume, or if practicing predominately in an FQHC or RHC, a minimum 30% Needy Individual patient volume. A pediatrician may qualify for a lesser payment if he has a minimum 20%, but less than 30%, patient volume.

An EH must be either an acute care hospital (including a Critical Access Hospital) or a Children's Hospital. An acute care hospital must have an average length of stay of 25 days or less and a CCN that has the last four digits in the series 0001-0879 or 1300-1399. An acute care hospital must have a minimum Medicaid patient volume threshold of 10%. A Children's Hospital predominately treats individuals under 21 years of age, and has a CCN with the last four digits in the series 3300-3399. A Children's Hospital does not have a minimum Medicaid patient volume threshold requirement.

>> CHANGES

If you need to make any changes to the information you submitted through the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System, you must return to that web site to make those changes and/or corrections. (<https://ehrincentives.cms.gov/hitech/login.action>) You will need your registration number to re-enter the site to make the necessary changes. When making changes/corrections, you **must** go all the way through to the "Submit" button. Otherwise, your change may not be recorded and your profile corrected.

For example, if you want your EHR payment made to an NPI other than yours, such as a group NPI, you will need to make the change at the above web site. If you registered under the wrong provider type (and we have encountered that), you will need to go to the web site and make the correction.

Note: In some of our earlier presentations and communications, we have referred to the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System as the National Level Repository, or NLR for short. We have been informed by CMS that references to the NLR are incorrect. Therefore, all future references will be made to the CMS Medicare & Medicaid EHR Incentive Program Registration and Attestation System as the web site where EPs & EHs register and make changes or corrections to information as necessary.

>> ATTESTATION

EP Group Attestation

The paid encounters of all practitioners who are members of the group or clinic are to be included in the group's data regardless of whether they are even eligible to apply for the EHR incentive.

- For example, if a practitioner does not see any Medicaid recipients at all (only Medicare, commercial insurance, self-pay, etc), his paid encounters are to be included in the group's data. However, since he does not see any Medicaid recipients, he is not eligible to use the group data to apply for the EHR incentive payment.
- Or, a healthcare professional that is not enrolled by TennCare, such as a Registered Nurse (RN). The RN's paid Medicaid encounters (which were billed under a physician's Medicaid ID number) are to be included in the group's calculation, but the RN is not eligible for an EHR Incentive Payment.

When using group patient volume as a proxy to individual encounters, group practices/clinics only need to complete one Group Attestation of Patient Volume. However, a copy of that patient volume attestation **must be submitted with each EP's** attestation as a group member.

It is **not** mandatory that all EPs of a group submit their attestation to TennCare at the same time. Although it is helpful to TennCare's processing for payment to have as many of the group's attestations as possible at one time, it is **not** required that groups do so.

EH Attestation

Section 2 – Hospital Attestation of Medicaid Patient Volume and EHR Payment Calculation Data:

- Acute Care Hospitals (including Critical Access Hospitals) must complete **Part I – EHR Incentive Eligibility**. This provides us with information on the EH's patient volume and average length of stay.
- **All** hospitals, **including** children's hospitals, must complete **Part II – EHR Payment Calculation Data**. The information in this part is the basis for calculating the hospital's EHR incentive payment.

Additional Comments

Each EP, whether attesting as an individual practitioner or as a part of a group/clinic, **must submit** an Application and Attestation TennCare/Medicaid EHR Incentive Program packet found at this web site: <http://www.state.tn.us/tenncare/pipregistration.html>. **EHS** are to go to the same web site to access the Application and Attestation packet for Eligible Hospitals.

- TennCare has pre-populated certain fields with information received from the CMS Medicare & Medicaid Incentive Program Registration and Attestation System. If any of that information is incorrect, you must return to the CMS web site to make corrections.
- You will need the registration number you received from the CMS Medicare & Medicaid Incentive Program Registration and Attestation System when you registered and your NPI to access the attestation portal.
- Once you have told us how you are attesting – as an Individual, Group, or Hospital – we will generate the necessary attestation forms and email them to you within 24 – 48 hours.
- The two pages requiring signatures for attesting, the Substitute W-9 form, and the Automated Clearing House form, **all must be** printed, signed, and returned to the address via U.S. Mail that is on the cover page of the packet.

- For Group Practices or Clinic Attestations using group patient volume as a proxy: only one Section 4 – Attestation of Medicaid Patient Volume for Group Practice or Clinic, needs to be completed. However, **a copy** of that Section **must** accompany each EP's attestation.
- For those practicing predominately in an FQHC or RHC: References to "Medicaid Patient Volume" should be interpreted to mean "Needy Individual Patient Volume." The definition of "Needy Individual" is located on the first page of the section on attesting to patient volume. Such providers are to furnish the total of paid Medicaid encounters (Column B) and the total of all paid encounters for Needy Individuals (which includes Column B + other Needy Individual encounters).
- If you have not obtained the CMS Certification Number for your certified EHR system or module(s), go to <http://onc-chpl.force.com/ehrcert> and follow the instructions. The CMS Certification number **is not** the certification number the vendor received when its system/module was certified by CCHIT, Drummond, or InfoGard.
- At the bottom of the packet's cover page is a telephone number you can call if you have questions. You may also email your questions to: TennCare.EHRIncentive@tn.gov.

>>Critical access Hospitals (CAHs)

There has been some confusion lately about EHR Incentive Payments for CAHs and how they are calculated. CMS issued a Tip Sheet on the Medicare Learning Network entitled "EHR Incentive Program for Critical Access Hospitals" (ICN # 904627; November 2010). The following statements are found in that Tip Sheet: