

State of Nebraska
Medicaid EHR Incentive Program (MIP)

User Manual

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Preface

This Nebraska Medicaid Electronic Health Record (EHR) Incentive Program portal user manual is intended to provide Eligible Professionals (EPs) and Eligible Hospitals (EHs) guidelines to successfully navigate the Nebraska Medicaid Electronic Health Record (EHR) Incentive Program user portal.

The NE Medicaid EHR Incentive Program is for providers who are eligible for the Medicaid EHR incentive payments outlined in the American Recovery and Reinvestment Act (ARRA) of 2009, and serve the NE Medicaid population as well as needy individuals in the State of Nebraska (if applicable). EPs and EHs will use this portal to attest to adoption, implementation or upgrading of a certified Electronic Health Record system and to attest and prove Meaningful Use.

NE MIP (Medicaid Incentive Program) is providing this material as a reference to providers. NE MIP will make every reasonable effort to ensure this material is accurate and up-to-date; however it is ultimately the responsibility of the providers to ensure they are submitting the required information in order to receive EHR incentive payments.

Complete definitions and rules can be found in the ARRA, Title XIX of the Social Security Act, the HITECH Act and 42 CFR Parts 412, 413, 422 and 495 Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule. This guide is not intended to be used in lieu of the Final Rule or any above mentioned Acts for guidelines in qualifying and obtaining the EHR incentive payments. Please refer to the above mentioned Acts and the Final Rule for clarifications.

If at any time you have a question, please contact the NE Medicaid EHR Incentive Program staff by sending an email to DHHS.EHRIncentives@nebraska.gov. A member of the staff will respond to your inquiry.

Acronyms/Definitions	
Term	Definition
AIU	Adoption, Implementation or Upgrade
CAH	Critical Access Hospital
CEHRT	Certified Electronic Health Record Technology
CHPL	Certified Health IT Product List – (used for EHR certification validation)
CMS	Centers for Medicare and Medicaid Services
CPOE	Computerized Physician Order Entry
CQM	Clinical Quality Measure
CY	Calendar Year
DHHS	State of Nebraska Department of Health and Human Services
EH	Eligible Hospital
EHR	Electronic Health Record

Acronyms/Definitions	
Term	Definition
EP	Eligible Professional
FQHC	Federally Qualified Health Center
FFY	Fiscal Year
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health
MIP	Medicaid Incentive Program
MMIS	Medicaid Management Information System
NLR	CMS National Level Repository
NPI	National Provider Identifier
ONC	Office of the National Coordinator
PA	Physician's Assistant
R&A	Registration and Attestation system for program registration with CMS
RHC	Rural Health Clinic
SMHP	State Medicaid Health Information Technology Plan
TIN	Taxpayer Identification Number

1. EP and EH Nebraska Registration

Prior to gaining access to the NE MIP portal, EHR registration must be completed at the CMS Registration and Attestation website. Once NE MIP has received a notice from CMS indicating a provider has successfully registered for a Medicaid incentive payment from Nebraska, providers will be sent an invitation to register with NE MIP using the NE MIP portal. The invitation will be sent to the email address used during CMS registration and will read as follows:

<Provider Name>
<NPI>

Nebraska Medicaid has received your EHR incentive enrollment information from the CMS Registration and Attestation System. Please go to the <PIPP portal> to establish your account and complete the attestation. You will be asked to create a User ID, a password, and provide responses to three security questions. Once you have completed this, you will be sent an activation email. After you activate your account, you will be ready to begin the attestation process. A user manual can be found here <help link>.

If you have any questions or problems completing your attestation, please contact 402-471-9147 to be directed to Medicaid EHR Incentive Program staff. Thank you for your interest and participation in the Nebraska Medicaid EHR Incentive Program.

NOTE: If you registered with CMS prior to 10/6/2014, you will not receive the invitation email. You may go directly to the portal to attest.

1.1. Access Provider Web Registration

Click on the 'Provider Web Registration' link on the left side of the screen.

1.1.1. Locate Provider Profile

Enter the required information to locate your provider profile. This information must match the individual or hospital data used to register with CMS R&A.

- CMS Registration Number
 - The number received after completing registration at the CMS Registration and Attestation web site. If you have forgotten or lost this number, please call the CMS Help Desk at 1-888-734-6433. NE MIP does not have this number.
- NPI
 - The NPI you used to register with CMS. If you are an Eligible Professional, this is your individual NPI.
- Tax ID
 - The last 4 digits of the Tax ID number you used to register with CMS. If you are an Eligible Professional, this is your individual Taxpayer Identification Number (TIN) or your Social Security Number (SSN).

Click 'Find'.

If your provider profile is located, the system displays a screen to create your user name and password.

If you receive an error after entering your information, the system is unable to match the data entered with any active registration data from CMS. Verify that you entered the data correctly. If the data is correct according to your records and the system is still unable to match your registration data, contact CMS at 1-888-734-6433 or return to the CMS R&A website to check your eligibility status and registration data.

1.1.2. Create New User Name and Password

Enter the required information to create a user name and password.

The following fields are pre-populated with the data received from CMS. You are responsible for verifying this data is accurate. If any of the pre-populated data is incorrect, you must return to the CMS R&A System website to make corrections. NE MIP cannot make corrections to this information for you.

- CMS Registration Number
- NPI
- Last four numbers of Tax ID
- First Name
- Last Name
- Email Address

NOTE: *ALL email correspondence is sent to the address listed on this screen.*

You must enter data in the remaining fields to complete registration. All fields on this screen are required.

Create New User Name

The User Name must have the following properties:

- Must be between 6 and 10 characters long
- May contain a combination of alphanumeric characters
- Must NOT contain non-alphanumeric characters
- User Name is not case sensitive

Create Password

The Password must have the following properties:

- Must be a minimum of 8 characters long
- Must contain at least one non-alphanumeric character
- Must contain at least one upper case character
- Must contain at least one lower case character

Confirm your password.

Answer Security Questions

Security questions are used in the event your user name and/or password needs to be recovered or reset.

A person creating multiple new user accounts for more than one provider must create a new user name and password for each provider. The passwords and security question answers can be the same but the user name must be unique to each individual provider.

1.1.3. Activate User Account

Once your account has been created, an activation email is sent to the email address registered with the CMS R&A system.

Click on the link provided in the email to activate your account. **You must click on the link to activate your account before attempting to login for the first time.**

1.2. Apply for Incentive

1.2.1. Log In

Using the link in the activation email opens the Log In page for the NE Medicaid EHR Incentive Program portal.

Enter the user name and password created during NE MIP Provider Web Registration.

If you enter the wrong password 3 times, the system automatically locks your account. If your account becomes locked, you need to contact the Nebraska Medicaid EHR Incentive Program unit to unlock your account.

1.2.2. Dashboard

The Dashboard displays communications sent to the email address associated with the user account as well as the status of your application, payment history (if applicable), and additional information to aid in completing your application.

The menu on the left of the screen contains the following options:

- My Profile
 - The user account contact name can be changed
 - This does not change the notification emails. They will continue to be sent to the email address that was used on the CMS registration.
 - The password can be changed
 - A security question must be successfully answered before any changes can be saved
- Log Out
 - Log out of the NE MIP portal
- Home
 - Displays the Dashboard
- Apply for Incentive
 - Link to the application pages
- CMS Registration Site
 - Link to <https://ehrincentives.cms.gov/hitech/login.action>
- Contact Us
 - Phone number and email address for NE EHR Incentive Program staff
- Quick Links

- Links that provide additional information about the EHR Incentive Program; helpful links from CMS, Nebraska specific information, and the portal user manual

2. Complete Application - EP

2.1. EP Application – General Information

Clicking on 'Apply for Incentive (Attest)' link from the Dashboard displays the Provider Attestation screen.

Current Case

The Current Case section displays provider information – most of this information is obtained from your registration with CMS.

First Column

- Provider – Provider name received from CMS registration
- Address – Address received from CMS registration
- City/State – City received from CMS registration
- Zip – Zip code received from the CMS registration
- Email – Email address received in the CMS registration – ALL EMAIL COMMUNICATION is sent to this email address.
- Status – Current status in NE Medicaid EHR Incentive Program processing (see table below)

Status	Description
CMS Received	The provider has successfully registered through the CMS portal and that information has been received in the MIP.
Application Pending	This status means one of three things: <ul style="list-style-type: none"> • You have completed at least one page of the application, but have not submitted the application to NE MIP. • If an EH, NE has received your MU information from CMS • NE has returned this application to you for additional information
Application Review	Your submitted application is in the first step of the NE review process
Application Review Secondary	Your submitted application is in the second step of the NE review process
Pending CMS Review	NE is waiting on final approval from CMS
C5 Pending	NE is waiting for your MU information from CMS (only for EHs)
C5 Review	NE has received your MU information from CMS and is reviewing the data (only for EHs)
Ready for Payment	CMS and NE have approved the application
Payment Pending	NE is processing the payment
Payment Complete	NE has issued the payment
Payment Rejected by CMS	CMS rejected the payment request by the state
Application Denied	NE has denied your application
Cancelled by CMS	CMS notified NE that your request to participate with NE has been cancelled

Second Column

- Provider Type – Provider type received from CMS registration
- NPI – Individual NPI received from CMS registration
- Payee NPI – EP’s Payee NPI received from CMS registration (payment assignment)
- Tax ID – Tax identification number received from CMS registration
- Payee Tax ID – Payee tax identification number received from CMS registration
- Status Date – The date the application moved into its current status
- Attestation Date – The original date of submission. This date is only populated when the application has been submitted. Otherwise it displays N/A.

Third Column

- Application ID – This is a system generated number assigned to each provider’s application. A provider will have a different Application ID each year.
- Imported Data – If previous year attestations existed in the old system used to process the Nebraska Medicaid EHR Incentive Program payments, this will display Y, otherwise this is always N.
- Program Year / Payment Year – The Program and Payment year for the current application
 - Professionals may participate for 6 years
 - Professionals follow the Calendar Year (CY) calendar for this program
- MU Stage – The Stage of Meaningful Use attestation – this is determined by previous participation and years of attestation

Proposed Stage of Meaningful Use Criteria by First Payment Year

First Payment Year	Stage of Meaningful Use (MU Year 1)										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2012		1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2013			1	1*	2	2	3	3	TBD	TBD	TBD
2014				1*	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3

* Continuous 90-day EHR reporting period (or 3 months at State option) for Medicaid EPs. All providers in their first year in 2014 use any continuous 90-day EHR reporting period.

First Payment Year	Stage of Meaningful Use (AIU Year 1)										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	AIU	1	1	1 or 2*	2	2	3	3	TBD	TBD	TBD
2012		AIU	1	1*	2	2	3	3	TBD	TBD	TBD
2013			AIU	1*	1	2	2	3	3	TBD	TBD
2014				AIU	1	1	2	2	3	3	TBD
2015					AIU	1	1	2	2	3	3
2016						AIU	1	1	2	2	3

Provider EHR Criteria

The 'Provider EHR Criteria' section displays the attestation question pages that must be completed. Begin your application by selecting the 'Attest' link next to Provider Questions. You must respond to all of the questions on each page. Once you have answered the questions on a page, click "OK". If no errors are received your data is saved and you are returned to the Provider Attestation main page to select another question page. If errors are displayed, you must correct any errors before your data is saved. You have the ability to change your answers on any page until your application is submitted for review.

Criteria Column: Lists the pages that must be completed in the current application

- Provider Questions – Information about the eligible professional (EP)
- EHR Questions – Information about the EP's certified EHR system/module(s); you will be asked to upload documentation that proves the EP owns or has access to a certified system/module
- Patient Volume – Submit information about the EP's total paid patient encounters and total paid Medicaid encounters. A patient encounter means inpatient discharges or services rendered in an emergency department on any one day. An enrolled Medicaid encounter is also defined as services rendered on any one day to an individual who is eligible for Medicaid regardless of payment by Medicaid. All Inpatient Discharges or services rendered in an emergency department on any one day count as one encounter
- Meaningful Use screens – See the section specific to EP MU attestation for details
 - These screens are only displayed if the provider is attesting to MU
 - Meaningful Use Core Set Questions
 - Meaningful Use Menu Set Questions
 - Meaningful Use Clinical Quality Measures

Status: Displays the status of each application page

- Pending – Answers have not been confirmed or saved
- Attested – Answers have been confirmed or saved
- Pass – Question page has been approved in one or more of the NE MIP review processes
- Fail – Question page has been denied/rejected in one or more of the NE MIP review processes

Received Date: Date of the latest change to the page

Denial Reason: Return and denial reasons are displayed in this column

Attested: "No" changes to "Yes" as each page is completed

2.2. EP Application – Eligibility Screens

This section includes guidelines for the application screens that determine your NE Medicaid EHR Incentive Program eligibility.

- These screens are required every year of attestation to determine eligibility
- These are the only screens required for providers attesting to AIU (Adopt, Implement, or Upgrade) in their first year of participation

If attesting to MU (Meaningful Use), see the guidelines in the section specific to MU attestations.

2.2.1. Provider Questions

- Are you currently enrolled as a Nebraska Medicaid provider?
 - Yes
 - No
- My professional license number is:
 - Enter your state issued license number
 - Enter your license state (defaults to NE)
- Do you have any sanctions?
 - Yes – A text box displays for a brief description of the sanction(s). The description is limited to 100 characters. Please upload any necessary supporting documentation or comments.
 - No
- Do you practice in multiple locations?
 - Yes – Click on 'Add' to enter the addresses of all locations where you provide services. You are required to enter at least two addresses.
 - Address
 - City
 - State
 - Zip
 - No
 - OK and Cancel Buttons
- EPs can choose to attest to AIU or MU in their first year of program participation without reducing their payments or years of eligibility. To what are you attesting?
 - Adopted
 - Implemented
 - Upgraded
 - Demonstrating Meaningful Use
- Upload supporting documentation
 - The system will prompt you if an upload is required

2.2.2. EHR Questions

- CMS EHR Certification number:
 - First Year:
 - If you included your EHR Certification number in your CMS registration, this field will be pre-populated with that number. Please verify this number is accurate and correct if needed.
 - If you did not include your EHR Certification number in your CMS registration you will need to enter that number here. A valid EHR Certification number is required on this page.
 - Supporting documentation is required
 - For Subsequent Years:
 - The CMS EHR Certification number used in previous years will not be displayed; you will need to enter your EHR Certification number.
 - A valid EHR Certification number must be entered

- If the EHR Certification number you enter does not match the EHR Certification number on record for previous years you will be required to upload supporting documentation for the new EHR technology
 - All Years:
 - Your EHR Certification number will be verified with the ONC CHPL – if the number is not valid according to their database, an error message will be displayed
- Name, version, and description of Certified EHR System:
 - Enter the name, version and a brief description of your Certified EHR technology in the text box provided. The text box is limited to 100 characters. If more space is needed please attach a document with additional details.
- Upload supporting documentation
 - The system will prompt you if an upload is required
 - If this is your first application with the state, or your number changed from the previous application, proof of your EHR system is required

Acceptable documentation for such proof:

- A page of the contract or lease showing the provider, vendor and name of the certified EHR technology and the dated signature page.
- If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology.
- A copy of your purchase order identifying the vendor and certified EHR technology being acquired and proof of payment

FOR 2014 ONLY –

The CMS EHR Certification Number indicates the version as follows:

If characters 3-5 =

- H13 = Hybrid 2011 and 2014 Edition
- 14E = 2014 Edition
- ≠ H13 **AND** ≠ 14E = 2011 Edition

For AIU - you must use a 2014 edition

For MU Stage 1 –

- If using a 2011 Edition:
 - You must attest that you were not able to fully implement a 2014 Edition of CEHRT due to delays in CEHRT availability
 - Your MU pages default to the 2013 Stage 1 Objectives and the 2013 CQMs
- If using a Hybrid 2011 and 2014 Edition – you must select an option:
 - 2013 Stage 1 Objectives and 2013 CQMs
 - You must attest that you were not able to fully implement a 2014 Edition of CEHRT due to delays in CEHRT availability
 - 2014 Stage 1 Objectives and 2014 CQMs
 - No additional messages will display; complete attestation page as described in this manual
- If using a 2014 Edition

- No additional messages will display; complete attestation page as described in this manual

For MU Stage 2 – at least your third or fourth year of participation in 2014 (you must have attested to two years of Meaningful Use before attesting to Stage 2 MU):

- If using a 2011 Edition:
 - You must attest that you were not able to fully implement a 2014 Edition of CEHRT due to delays in CEHRT availability
 - Your MU pages default to the 2013 Stage 1 Objectives and the 2013 CQMs
- If using a Hybrid 2011 and 2014 Edition – you must select an option:
 - 2013 Stage 1 Objectives and 2013 CQMs
 - You must attest that you were not able to fully implement a 2014 Edition of CEHRT due to delays in CEHRT availability
 - 2014 Stage 1 Objectives and 2014 CQMs
 - You must select an option:
 - Stage 1 = You must attest that you were not able to fully implement a 2014 Edition of CEHRT due to delays in CEHRT availability
 - Stage 2 = No additional messages displayed, complete the attestation page as described in this manual
- If using a 2014 version
 - You must select an option:
 - Stage 1 = You must attest that you were not able to fully implement a 2014 Edition of CEHRT due to delays in CEHRT availability
 - Stage 2 = No additional messages displayed, complete the attestation page as described in this manual

2.2.3. Patient Volume Questions

If you are applying during the 60 day period following the end of the program year, you will be required to identify the program year for which you are applying

- Select Incentive Year
 - This selection is displayed only during the attestation tail period (60 days after the end of the Calendar Year).
- Select the beginning date for the continuous 90-day period in the 12 months prior to the original submission of the attestation you are using for your patient volume period. The end date of the 90-day period is automatically calculated for you. Neither date can be a future date.
 - Begin Date – mm/dd/yyyy
 - End Date – mm/dd/yyyy (automatically calculated)
 - If the 90-day period is outside of the previous 12 months, an error message is displayed: The 90-day period must occur within the 12 months preceding the submission of this attestation.
- Is patient volume being submitted for an individual or group?
 - After the first provider has defined their group and submitted their attestation, all of the providers in the group, tied to the same Payee Tax ID, will be required to attest to group patient volume

- Individual
 - All providers tied to the same Payee Tax ID will be set to Individual as well
- Group
 - How is your group defined?
 - By Group Payee Tax ID
 - All providers tied to the same Payee Tax ID will be tied to the Payee Tax ID definition
 - By Group NPI
 - All providers tied to the same Payee Tax ID must select either an existing NPI on the screen, enter a new NPI, or select Location as their definition
 - By Group Physical Location
 - All providers tied to the same Payee Tax ID must select either an existing location, enter a new location, or select Payee NPI as their definition
- Are you claiming the Managed Care patient panel methodology?
 - Yes
 - Help Text displayed: If you are a Medicaid Managed Care Primary Care Physician (PCP) and submitting based on patient panel, please complete the following: (This is an optional method of reporting for managed care PCPs. This method requires the EP to maintain a record from the Managed Care plan which shows the number of patients assigned to them during the specified 90-day as well as proof of the encounters over the past year. Before using this method, it is suggested you e-mail Medicaid at DHHS.EHRIncentives@nebraska.gov to determine if this method is appropriate.)
 - No
- What is the total number of patient encounters within the selected 90-day period? (i.e. your denominator)
 - Enter the TOTAL patient encounter count for the selected 90-day period
 - Hover Over Help Text: Patient Encounter: Services rendered on any one day to an individual
 -
- What is the total number of Medicaid encounters within the selected 90-day period? (i.e. your numerator)
 - Enter the Medicaid encounter count for the 90-day period
 - Medicaid patient volume includes Nebraska Medicaid, out-of-state Medicaid as well as needy patient encounters, if applicable.
 - Hover Over Help Text: A Medicaid encounter means services rendered on any one day to an individual who is eligible for Medicaid regardless of payment by Medicaid. All services rendered on a single day to a single individual by a single Eligible Professional count as one encounter.
- Percentage of enrolled Medicaid encounters over the selected 90-day period:
 - This percentage is automatically calculated using the numerator and denominator entered above
- Hospital-based EPs are not eligible for the incentive payment. Are you a hospital-based provider?
 - Yes – You cannot be hospital-based and qualify for an EHR incentive payment unless you are an EP that practices predominantly in an FQHC or RHC. If you have at least 90 percent of your services furnished in a place of service code 21 (inpatient hospital) or 23 (emergency room) in the previous calendar year, you are considered hospital-based.
 - No

- Hover Over Help Text Displayed: Place of Service is Field 23B on CMS 1500 Claim form. Place of Service 21 is defined as Emergency Room – Hospital. If 90% or more of your professional services are in a hospital setting for the previous calendar year, you are not eligible for the EHR Incentive Payment. If you provide less than 90% of your professional services in the hospital setting hospital/emergency room encounters are included in your patient volume.
- Do you practice predominantly in an FQHC/RHC?
EPs that practice predominantly in an FQHC or RHC are not subject to being excluded as Hospital-Based EPs and are able to use the Needy Individual population to meet their Patient Volume threshold. Practicing Predominantly is defined as having over 50% of your encounters in an FQHC or RHC location in a six month period within the previous 12 months from the date of attestation.
 - FQHC
 - Follow up question displayed if provider is a Physician’s Assistant (PA): How is your clinic ‘so-led’ by a PA?
 - PA is the Director of the Clinic
 - PA is the Primary Provider
 - Supporting documentation is required
 - RHC
 - Follow up question displayed if provider is a Physician’s Assistant (PA): How is your clinic ‘so-led’ by a PA?
 - PA is the Director of the Clinic
 - PA is the Owner of the Clinic
 - PA is the Primary Provider
 - Supporting documentation is required
 - No
- Hover Over Help Text Displayed: Practicing predominantly is defined as having over 50% of your encounters in an FQHC or RHC location in a six month period within the previous 12 months from the date of attestation.
- Enter the dates you predominantly practiced at the FQHC or RHC:
 - Begin Date – mm/dd/yyyy
 - End Date – mm/dd/yyyy (An end date will be automatically calculated for six months after the begin date)
- Are any of your Medicaid patients covered by another state’s Medicaid program?
 - Yes – A table will be displayed to enter additional data. The state abbreviation and the encounter count for that state must be entered.
 - To ensure accurate multi-state reporting Nebraska Medicaid encounters must also be reported in this table. NE is the default for your first entry.
 - No
- Does your 30% include Needy Individuals?
 - This question will only be displayed if you indicated you practice predominantly in an FQHC or RHC on this page. If the Medicaid patient volume meets the minimum percentages, needy patient volume does not need to be entered.
 - Yes – Enter the following counts:
 - NE Medicaid
 - Uncompensated
 - No
- What is the auditable data source you are using to calculate patient volume?
 - EHR system
 - Billing system
 - Appointment Book
 - Other – provide a brief description of the ‘other’ source
- Enter your Nebraska Medicaid provider numbers that pertain to this attestation:

- 'Add' button to allow up to 30 Medicaid ID numbers
 - At least one entry is required
- Upload supporting documentation.
 - The system will prompt you if an upload is required

2.3. EP Application - Meaningful Use Screens

When attesting to Meaningful Use in Payment Years 1 through 6 you must complete the Meaningful Use Core, Menu, and Clinical Quality Measure (CQM) pages in addition to the eligibility question pages in the previous section; Provider Questions, EHR Questions, and Patient Volume Questions.

2.3.1. Layout for Meaningful Use Core and Menu Objectives

All Meaningful Use objectives are displayed in a similar fashion. Review the section below prior to beginning attestation to become familiar with the MU questions.

Due to the nature of the program the MU objectives and associated measures are not covered in this manual. The objective and measures may change annually and will change depending on the stage of MU you must attest to. Please refer to the final rule and www.healthit.gov and www.cms.hhs.gov/EHRincentiveprograms for detailed information on the Meaningful Use objectives and measures.

Objective

The top row displays the objective number and text from 42 CFR § 495 to allow you to easily locate the objective in the final rule for any clarifications you may need.

Answer

The second section of the question box contains the quick view of the required information in order to attest to meeting the measure requirements.

The answers may consist of numerators and denominators, radio buttons and free form text boxes.

Additional questions may appear below depending on your answer selection – see Additional Questions below

More link

The 'More' link expands the Answer box to provide detailed information on the measure for the objective. Details about the exclusion (if applicable) are displayed, as well as details for the numerator and denominator.

Collapse View

To collapse the expanded view, click on the Objective description.

WARNING: Expanding and collapsing the question field will clear your answers, please use the More link to get clarification prior to entering your answers.

Denominator Type

For objectives that require you to provide the type of denominator used to produce your MU data, an additional section is displayed for you to indicate the source of your denominator.

Additional Questions

Some objectives require you to provide additional information about your answer. These questions vary by objective and your answers. Please keep an eye out for these as you attest to MU. If the question is displayed an answer is required.

2.3.2. General Questions - Meaningful Use

The EHR reporting period for all providers in their first year of attesting for Meaningful Use is any continuous 90-day period within the application year (calendar year for EPs). For subsequent years the provider must use a full year for the EHR Reporting Period, except for 2014. CMS is permitting a one-time 90-day reporting period in 2014 to allow providers additional time to implement Certified EHR systems. This only applies to Calendar Year 2014 for EPs or Federal Fiscal Year 2014 for EHs.

GEN-1: Enter the begin date of the reporting period and the end date will be automatically calculated.

GEN-2: Did you have at least 50% of your encounters in a practice location that has a certified EHR system? (Yes or No).

GEN-3: At least 80% of unique patients must have their data in the certified EHR during the EHR reporting period. This is a general requirement that will help gauge if you will be able to successfully attest to Meaningful Use. (Numerator and Denominator for unique patients required).

GEN-4: What is the principal county in which you practice? (Dropdown list of all NE Counties).

GEN-5: Select the specialty that best describes your practice. (Dropdown list – Only displayed for Physicians).

2.3.3. EP Core Objectives

An EP must attest to all Core objectives. Attestation for most objectives is accomplished by entering a numerator, denominator, and exclusion information. Certain objectives do not require a numerator and denominator, but rather a Yes/No answer. Objectives that require the denominator type will display the types of denominators allowed. All questions require an answer unless otherwise specified.

As mentioned earlier in this guide, due to the nature of the program, the MU objectives and associated measures are not covered in this manual. The objective and measures may change annually and will change depending on the stage of MU you must attest to. Please refer to the final rule and www.healthit.gov and www.cms.hhs.gov/EHRincentiveprograms for detailed information on the Meaningful Use objectives and measures.

2.3.4. EP Menu Set Objectives

The Menu Set Objectives rules vary by Stage. Objective selection screens display instructions appropriate for your application based on your program participation history.

The selection screen displays grids that list the menu set objectives. The top portion of the grid contains the public health objectives; the bottom portion of the grid contains the additional menu objectives.

Please select carefully. Once you select your Menu Objectives the system displays a screen to enter your attestation data. You will not be able to save some of your objective/measure answers and return to the selection screen to change your objectives. You will be required to re-enter any previously completed questions if you reset your questions.

After your selection is made, the menu objectives are displayed in the same manner the core objectives. Refer to the earlier section specific to the MU question layout.

Please refer to the final rule and www.healthit.gov and www.cms.hhs.gov/EHRincentiveprograms for detailed information on the Meaningful Use objectives and measures.

2.3.5. Clinical Quality Measures Selection

The Clinical Quality Measure rules vary by year; the current version remains until the next version is published if not changed yearly. CQM selection screens display instructions appropriate for your application based on your program participation history.

Please select carefully. Once you select your CQMs the system displays a screen to enter your attestation data. You will not be able to save some of your objective/measure answers and return to the selection screen to change your measures. You will be required to re-enter any previously completed questions if you reset your questions.

3. Complete Application EH

3.1. EH Application – General Information

Clicking on 'Apply for Incentive (Attest)' link from the Dashboard displays the Provider Attestation screen.

Current Case

The Current Case section displays provider information – most of this information is obtained from your registration with CMS.

First Column

- Provider – Provider name received from CMS registration
- Address – Address received from CMS registration
- City/State – City received from CMS registration
- Zip – Zip code received from the CMS registration
- Email – Email address received in the CMS registration – ALL EMAIL COMMUNICATION will be sent to this email address.
- Status – Current status in NE Medicaid EHR Incentive Program processing (see table below)

Status	Description
CMS Received	The provider has successfully registered through the CMS portal and that information has been received in the MIP.
Application Pending	This status means one of three things: <ul style="list-style-type: none"> • You have completed at least one page of the application, but have not submitted the application to NE MIP. • If an EH, NE has received your MU information from CMS • NE has returned this application to you for additional information
Application Review	Your submitted application is in the first step of the NE review process
Application Review Secondary	Your submitted application is in the second step of the NE review process
Pending CMS Review	NE is waiting on final approval from CMS
C5 Pending	NE is waiting for your MU information from CMS
C5 Review	NE has received your MU information from CMS and is reviewing the data
Ready for Payment	CMS and NE have approved the application
Payment Pending	NE is processing the payment
Payment Complete	NE has issued the payment
Payment Rejected by CMS	CMS rejected the payment request by the state
Application Denied	NE has denied your application
Cancelled by CMS	CMS notified NE that your request to participate with NE has been cancelled

Second Column

- Provider Type – Provider type received from CMS registration
- NPI – Hospital NPI received from CMS registration

- Payee NPI – Hospital Payee NPI received from CMS registration
- Tax ID – Tax identification number received from CMS registration
- Payee Tax ID – Payee tax identification number received from CMS registration
- Status Date – The date the application moved into its current status
- Attestation Date – The original date of submission. This date is only populated when the application has been submitted. Otherwise it displays N/A.

Third Column

- Application ID – This is a system generated number assigned to each provider’s application. A provider will have a different Application ID each year.
- Imported Data – If previous year attestations existed in the old system used to process the Nebraska Medicaid EHR Incentive Program payments, this will display Y, otherwise this will always be N.
- Program Year / Payment Year – The Program and Payment year for the current application
 - Hospitals may participate for 3 years
 - Hospitals follow the Federal Fiscal Year (FFY) calendar for this program
- MU Stage – The Stage of Meaningful Use attestation – this is determined by previous participation and years of attestation
 - Schedule from *Federal Register / Vol. 77, No. 171 / Tuesday, September 4, 2012 / Rules and Regulations*

TABLE 3—STAGE OF MEANINGFUL USE CRITERIA BY FIRST PAYMENT YEAR

First payment year	Stage of meaningful use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	*2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	*2	2	3	3	TBD	TBD	TBD	TBD
2013			1	*1	2	2	3	3	TBD	TBD	TBD
2014				*1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

*3-month quarter EHR reporting period for Medicare and continuous 90-day EHR reporting period (or 3 months at state option) for Medicaid EPs. All providers in their first year in 2014 use any continuous 90-day EHR reporting period.

Provider EHR Criteria

The ‘Provider EHR Criteria’ section displays the attestation question pages that must be completed. Begin your application by selecting the ‘Attest’ link next to Provider Questions. You must respond to all of the questions on each page. Once you have answered the questions on a page, click “OK”. If no errors are received your data will be saved and you will be returned to the Provider Attestation main page to select another question page. If errors are displayed, you must correct any errors before your data is saved. You have the ability to change your answers on any page until your application is submitted for review.

Criteria Column: Lists the pages that must be completed in the current application

- Provider Questions – Information about the hospital

- EHR Questions – Information about the hospital’s certified EHR system/module(s); you will be asked to upload documentation that proves the hospital owns or has access to a certified system/module
- Patient Volume – Submit information about the hospital’s total paid patient encounters and total paid Medicaid encounters. A patient encounter means inpatient discharges or services rendered in an emergency department on any one day. An enrolled Medicaid encounter is also defined as services rendered on any one day to an individual who is eligible for Medicaid regardless of payment by Medicaid. All Inpatient Discharges or services rendered in an emergency department on any one day count as one encounter
- Payment Calculations – Requires information from the hospital’s Medicare Cost Report
- Meaningful Use screens – See the section specific to EH MU attestation for details
 - These screens are only displayed if the provider is attesting to MU
 - Meaningful Use Core Set Questions
 - Meaningful Use Menu Set Questions
 - Meaningful Use Clinical Quality Measures

Status: Displays the status of each application page

- Pending – Answers have not been confirmed or saved
- Attested – Answers have been confirmed or saved
- Pass – Question page has been approved in one or more of the NE MIP review processes
- Fail – Question page has been denied/rejected in one or more of the NE MIP review processes

Received Date: Date of the latest change to the page

Denial Reason: Return and denial reasons are displayed in this column

Attested: “No” changes to “Yes” as each page is completed

3.2. EH Application – Eligibility Screens

This section includes guidelines for the screens that determine eligibility for the Medicaid program.

- These screens will be required every year of attestation to determine eligibility
- These are the only screens required for providers attesting to AIU (Adopt, Implement, or Upgrade) in their first year of participation
- If attesting to MU (Meaningful Use), see the guidelines in the section specific to MU attestations

3.2.1. Provider Questions

- Type of hospital?
 - Acute Care Hospital/Critical Access Hospital (CAH)
 - Children's Hospital
- Does the hospital have any sanctions?
 - Yes - A text box will be displayed for a brief description of the sanction(s). The description is limited to 100 characters. Please upload any necessary supporting documentation or comments.
 - No
- Is your average length of patient stay less than 25 days?
 - Yes
 - No – Hospitals are not eligible if the average length of stay is greater than 25 days.
- What is the county where your hospital is located?
 - Select from a drop-down of the 93 counties in Nebraska
- EHs can choose to attest to AIU or MU in their first year of program participation without reducing their payments or years of eligibility. To what are you attesting?
****This question is only displayed in the first year of participation – AIU is no longer an option once MU has been attested to (Medicare MU or Medicaid MU)****
 - Adopted
 - Implemented
 - Upgraded
 - Demonstrated Meaningful Use
- Upload supporting documentation
 - The system will prompt you if an upload is required

3.2.2. EHR Questions

- CMS EHR Certification number:
 - First Year:
 - If you included your EHR Certification number in your CMS registration, this field will be pre-populated with that number. Please verify this number is accurate and correct if needed.
 - If you did not include your EHR Certification number in your CMS registration you will need to enter this number here. A valid EHR Certification number is required on this page.
 - Supporting documentation is required
 - For Subsequent Years:
 - The CMS EHR Certification number used in previous years will not be displayed; you will need to enter your EHR Certification number.
 - A valid EHR Certification number must be entered
 - If the EHR Certification number you enter does not match the EHR Certification number on record for previous years you will be required to upload supporting documentation for the new EHR technology
 - All Years:
 - Your EHR Certification number will be verified with the ONC CHPL – if the number is not valid according to their database, an error message will be displayed
- Name, version, and description of Certified EHR System:
 - Enter the name, version and a brief description of your Certified EHR technology in the text box provided. The text box is limited to 100 characters. If more space is needed please attach a document with additional details.

- Upload supporting documentation
 - The system will prompt you if an upload is required

Acceptable documentation for such proof:

- A page of the contract or lease showing the provider, vendor and name of the certified EHR technology and the dated signature page.
- If your current contract/lease agreement requires the vendor to provide you with appropriate updates/upgrades including certified EHR technology, a signed and dated copy of amendment/attachment showing the installation of certified EHR technology.
- A copy of your purchase order identifying the vendor and certified EHR technology being acquired and proof of payment

3.2.3. Patient Volume

If you apply during the 60-day period following the end of the program year, you will be required to identify the program year for which you are applying.

All eligible hospitals except Children's Hospitals must meet the Medicaid Patient Volume threshold of 10%. Children's Hospitals do not have a patient volume threshold requirement; therefore, they are not required to complete this section.

- Select Incentive Year
 - This selection is displayed only during the attestation tail period (60 days after the end of the Federal Fiscal Year).
- Select the beginning date for the continuous 90-day Patient Volume period in the 12 months preceding the beginning of the month in which the attestation is originally submitted. The end date is automatically calculated for you. Neither date can be a future date.
 - Begin Date – mm/dd/yyyy
 - End Date – mm/dd/yyyy (automatically calculated)
 - If the 90-day period is outside of the previous 12 months, an error message is displayed: The 90-day period must occur within the 12 months preceding the submission of this attestation.
- What is the total number of patient encounters within the selected 90-day period?
 - Enter the TOTAL patient encounter count for the selected 90-day qualifying period. This number is also referred to as the Patient Volume denominator.
 - For the purpose of calculating Patient Volume, the total patient encounters is the total population regardless of payment source where:
 - Services rendered to an individual per inpatient discharge; or
 - Services rendered to an individual in an emergency department on any one day
- What is the total number of Medicaid encounters within the selected 90-day period?
 - Enter the Medicaid encounter count for the 90-day qualifying period. This number is also referred to as the Patient Volume numerator.
 - For the purpose of calculating Patient Volume, the total Medicaid encounters are defined as:
 - Services rendered on any one day to an individual who is eligible for Medicaid regardless of payment by Medicaid

- Inpatient Discharges or services rendered in an emergency department on any one day count as one encounter
- Percentage of enrolled Medicaid encounters over the selected 90-day period:
 - This percentage is automatically calculated using the numerator and denominator information entered above.
- Are any of your Medicaid patients covered by another state's Medicaid program?
 - Yes – A table will be displayed to enter additional data. The state abbreviation and the encounter count for that state must be entered.
 - To ensure accurate multi-state reporting Nebraska Medicaid encounters must also be reported in this table. NE is the default for your first entry.
 - No
- What is the auditable data source you are using to calculate patient volume?
 - EHR system
 - Billing system
 - Appointment Book
 - Other – provide a brief description of the 'other' source
- Upload supporting documentation
 - They system will prompt you if an upload is required

3.2.4. Payment Calculation

Information entered in the first year will be used to calculate the total hospital incentive payment over the three year period. This is a one-time calculation

- Please indicate which data source you are using:
 - Medicare Cost Report
 - Other
- Overall EHR Amount
 - Current Year Discharges (hospital base year)
 - Prior Year 1 (Discharges)
 - Prior Year 2 (Discharges)
 - Prior Year 3 (Discharges)
 - Click 'COMPUTE'
- Medicaid Computation
 - Total Medicaid Days – Number of inpatient-bed-days attributable to Nebraska Medicaid and Medicaid Managed Care
 - Total Hospital Charges
 - Other Uncompensated Care Charges (aka Charity Care– Do not include bad debt charges)
 - Total Hospital Days
 - Click 'COMPUTE'
- Medicaid Payments
 - This section shows the schedule of anticipated payments for all three years of program participation

3.3. EH Application - Meaningful Use Screens

Dually Eligible Hospitals: If the hospital is eligible for Medicare and Medicaid incentive payments the attestation process differs from Medicaid-Only hospitals. Hospitals are allowed to attest to AIU with Medicaid for the first payment year, but must attest to Meaningful Use with Medicare for the first payment year. Medicare sends NE MIP your Meaningful Use data. If you attest to Meaningful Use for Medicare prior to attesting to AIU in your first year of Medicaid participation – you must attest to MU for all Medicaid participation years. AIU is only allowed in your first year, prior to attesting to Meaningful Use.

Providers must meet the Medicaid requirements every year to qualify for the Medicaid EHR incentive payment.

Medicaid Only Hospitals: Please contact Nebraska Medicaid for instructions prior to attesting.

The 'Provider Eligibility Criteria' section shows that the hospital has registered with CMS and the date the information was received by Nebraska.

The 'Provider EHR Criteria' section shows the Attestation questions that must be completed. You must respond to all of the questions on each page (click "Attest" in the first column). Once you have answered the questions on a page, click "OK" and you will return to this page. "Pend" will then appear in the first column. Up until you submit your information for review, you may go back and change your responses.

3.3.1. Layout for Meaningful Use Core and Menu Objectives

ONLY MEDICAID-ONLY HOSPITALS WILL COMPLETE MU USING THIS PORTAL

All Meaningful Use objectives are displayed in a similar fashion. Review the section below prior to beginning attestation to become familiar with the MU questions.

Due to the nature of the program the MU objectives and associated measures are not covered in this manual. The objective and measures may change annually and will change depending on the stage of MU you must attest to. Please refer to the final rule and www.healthit.gov and www.cms.hhs.gov/EHRincentiveprograms for detailed information on the Meaningful Use objectives and measures.

Objective

The top row displays the objective number and text from 42 CFR § 495 to allow you to easily locate the objective in the final rule for any clarifications you may need.

Answer

The second section of the question box contains the quick view of the required information in order to attest to meeting the measure requirements.

The answers may consist of numerators and denominators, radio buttons and free form text boxes.

Additional questions may appear below depending on your answer selection – see Additional Questions below

More link

The 'More' link expands the Answer box to provide detailed information on the measure for the objective. Details about the exclusion (if applicable) are displayed, as well as details for the numerator and denominator.

Collapse View

To collapse the expanded view, click on the Objective description.

WARNING: Expanding and collapsing the question field will clear your answers, please use the More link to get clarification prior to entering your answers.

Denominator Type

For objectives that require you to provide the type of denominator used to produce your MU data, an additional section is displayed for you to indicate the source of your denominator.

Additional Questions

Some objectives require you to provide additional information about your answer. These questions vary by objective and your answers. Please keep an eye out for these as you attest to MU. If the question is displayed an answer is required.

3.4. Submit Attestation for Review

Once all Attestation links have been completed, the 'Attested?' column on the far right will display 'Yes' for all rows.

A new button "Submit for Review" will be displayed. After clicking that button, a page is displayed requiring you to either agree or disagree with the affirmation statements listed in the box. Please read the text thoroughly and select the appropriate statement. If you click "I Do Not Agree," your attestation will not be submitted. Clicking on "I Agree" will confirm that you are agreeing to the terms and conditions listed, will electronically sign your application, and will submit it to Nebraska Medicaid for review.

Another pop-up box will appear indicating that your information has been successfully submitted. Click on "Log Out" (upper left hand side) and you are done! If you attested to MU, you will have the opportunity to print your MU answers. The link to print the MU information will also be available on your provider homepage.

If at any time you want to see the status of your attestation, return to the portal, log in, and the latest information will be available to you. You also have the ability to print your eligibility questions and answers on the Provider Attestation page.

Following submission, the first column will disappear (Attest link) preventing any changes to your application. If NE MIP discovers a problem or requires additional information, your application will be returned for you to make changes.

3.5. Appeals (EP and EH)

If your Nebraska Medicaid EHR incentive payment is denied, or you disagree with the incentive amount, you have the option to dispute the denial or payment amount by filing an appeal. An appeal must be submitted within 90 days of the denial date.

3.5.1. Access Appeals Page

Appeals for the Nebraska Medicaid EHR Incentive Program follow the existing NE appeal process. Please refer to http://dhhs.ne.gov/Pages/reg_t471.aspx for Nebraska DHHS appeal instructions.

A link to the electronic appeal form is provided for your convenience on the home page of the MIP portal.

3.6. Recover / Reset Log In Credentials (EP and EH)

In the event you need to recover your User Name or reset your Password, please follow these steps:

3.6.1. Recover User ID

- Click on “Recover User ID” link from the Log In page.
- Enter the following information:
 - CMS Registration Number (NLR#)
 - NPI
 - Last 4 Digits of your Tax ID Number
- An email with your User Name will be sent to the email address on file in the CMS R&A system.

3.6.2. Reset Password

- Click on “Reset Password” link from the Log In page.
- Enter:
 - User Name
 - Click Next
- Select a security question
 - You must provide a correct response to one of the three security questions answered when creating the user account
- Click Next
- The system displays a screen to create a new password
 - Enter the new password
 - Confirm the new password
 - The new password must be different from the passwords used in the last 12 months
 - The same password guidelines used during account set up apply in this screen:
 - Between 8 and 10 characters
 - Must contain at least one non-alphanumeric character (symbol)
 - Must contain at least one upper case character
 - Must contain at least one lower case character
- Click “Save”
- Log in to the system using your newly created password.

3.6.3. Change Password

Follow the steps below to change your password:

- Log in
- Click on “My Profile” on the left of the Dashboard
- Enter your old password

- Enter and Confirm your new password
- Answer a security question
- Click “Save”

3.7. Upload Supporting / Required Documentation (EP and EH)

All Attestation screens in the Nebraska MIP portal allow uploading of supporting documentation. Some screens require supporting documentation be uploaded. Please follow the steps below to upload your documentation wherever applicable.

****Do NOT include patient medical records as documentation.**

NOTE: For security purposes the uploaded documents are limited to the following file types:

- Excel - .xls, .xlsx
- Word - .doc, .docx, .rft
- Power Point - .ppt
- Text - .txt
- PDF - .pdf
- Images - .jpg, .jpeg, .gif, .png, .bmp, .tiff

3.7.1. Add Document

- Click “Add Document”
- Click on “Document Name” drop down box to select your document type
 - This drop down box contains suggestions for types of supporting documentation
 - Unless the system prompts you for an upload, these suggestions are just suggestions, you do not need to upload all of the document types listed
- Click “Upload Document”
 - Select file to be uploaded
- Once file is done uploading and the selected file name appears in the “Document File Name” field – Click “OK”
- You will be returned to the main screen of the selected Attestation

NOTE: *The current file size limit is 10MB.*

REMINDERS:

Do NOT include patient medical records as documentation.