



Wisconsin Medicaid Electronic Health Record Incentive Program Frequently Asked Questions Eligible Professionals



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1 OVERVIEW

The following sections include the most frequently asked questions (FAQs) posed to the Wisconsin eHealth Team concerning the Wisconsin Medicaid Electronic Health Record (EHR) Incentive Program. If you have questions beyond the scope of this document, you can call Provider Services at 800-947-9627 or email the Wisconsin EHR Incentive Program at dhsehrincentiveprogram@wisconsin.gov.

2 ELIGIBILITY

2.1 Who qualifies as an Eligible Professional?

In order to qualify for the Wisconsin Medicaid EHR Incentive Program, a provider must:

1. Be licensed to practice in Wisconsin and be Medicaid-enrolled.
2. Have no current or pending sanctions.
3. Be one of the following provider types:

Eligible Professionals
Physicians (provider type 31)
Pediatricians
Dentists (provider type 27)
Certified nurse midwives (provider type 16)
Nurse practitioners (provider type 09)
Advanced practice nurse prescribers with a psychiatric specialty (provider type 11)
Physician assistants practicing predominantly* in a federally qualified health center (FQHC) or rural health clinic (RHC) so led by a physician assistant (Provider Type 10)

**"Practicing predominantly" is defined as providing 50 percent or more of services in an FQHC or RHC during a six-month period in the previous calendar year or during the 12 months preceding the attestation date.*

4. Have less than 90 percent of services occurring in an inpatient (place of service code 21) or emergency department (place of service code 23) setting.
5. Meet patient volume requirements. Read [Section 4: Patient Volume](#) for more information.

Read the following FAQs for details on how some hospital-based Eligible Professionals may qualify for the Wisconsin Medicaid EHR Incentive Program.



2.2 What does it mean to be an enrolled Medicaid provider?

To be eligible for an incentive payment, a provider must be enrolled in Wisconsin Medicaid as a billing/rendering provider on the date his or her Wisconsin Medicaid EHR Incentive application is submitted and on the date the incentive payment is issued. If the provider's Medicaid enrollment has lapsed or terminated, he or she cannot receive the incentive payment.

2.3 How do I determine if I am a hospital-based Eligible Professional?

Hospital-based Eligible Professionals are defined as providers who render 90 percent or more of their covered professional services in either the inpatient (place of service code 21) or emergency department (place of service code 23) of a hospital.

2.4 If I am a hospital-based Eligible Professional, how do I determine if I qualify for the Wisconsin Medicaid EHR Incentive Program?

Hospital-based Eligible Professionals will only qualify for the Wisconsin Medicaid EHR Incentive Program if they can demonstrate that they have funded the acquisition, implementation, and maintenance of CEHRT they are using without reimbursement from an Eligible Hospital.

As part of the application process, hospital-based Eligible Professionals are required to upload documentation detailing their acquisition of CEHRT (e.g., receipt, proof of purchase, contract or lease), including the vendor, product, and version number.

2.5 Can Wisconsin Medicaid run a report for me to determine if an Eligible Professional is hospital-based?

No. Wisconsin Medicaid does not have the resources to run individualized reports.

2.6 Can I continue to participate if I have joined a new practice?

Yes. Payment schedules are tied to an individual Eligible Professional, not a practice. Therefore, if an Eligible Professional joins a new practice, the Eligible Professional may still participate provided eligibility criteria are still met. This also applies to all Eligible Professionals who are transferring over state lines.

2.7 Can I take a year off from participating in the Wisconsin Medicaid EHR Incentive Program?

After the first payment year, Eligible Professionals can choose the years in which they would like to participate without penalty (for example, losing a year of eligibility). Eligible Professionals do not need to take any steps, such as notifying the Wisconsin Medicaid EHR Incentive Program, when choosing not to participate in the program for a year.



2.8 Can I enroll in both the Wisconsin Medicaid EHR Incentive Program and the Medicare EHR Incentive Program?

No. Eligible Professionals may not participate in both programs in the same payment year. Eligible Professionals must select either the Medicare or Medicaid EHR Incentive Program when registering through the [Centers for Medicare and Medicaid Services \(CMS\) Registration and Attestation System](#).

3 INCENTIVE PAYMENTS

3.1 What is the maximum incentive amount I can receive as an Eligible Professional participating in the Wisconsin Medicaid EHR Incentive Program?

Eligible Professionals who adopt, implement, upgrade, or demonstrate the Meaningful Use of certified EHR technology can receive up to \$63,750 over the six years that they choose to participate in the program – receiving \$21,250 the first year and \$8,500 each following year.

Pediatricians have special rules and are allowed to participate with a reduced patient volume threshold (20 percent instead of 30 percent). If pediatricians participate and have a patient volume less than 30 percent of total encounters, they receive incentive payments reduced to two-thirds of the regular payment levels. Pediatricians receive \$42,500 total over their six years participating in the program – receiving \$14,167 the first year and \$5,666 each following year. Eligible Professionals must begin receiving incentive payments by calendar year 2016.

3.2 Over how many years will an Eligible Professional receive payments?

Eligible Professionals may participate for a total of six years.

3.3 When is the last year an Eligible Professional can begin receiving payments from the Wisconsin Medicaid EHR Incentive Program?

The last year an Eligible Professional may begin receiving payments is calendar year 2016, and the last year an Eligible Professional can receive payments is calendar year 2021.

3.4 Can I reassign my Wisconsin Medicaid EHR Incentive Program payment to the practice where I work?

Yes. Eligible Professionals may reassign their full incentive payments to the entity that is associated with their taxpayer identification number on file with Wisconsin Medicaid. Eligible Professionals are responsible for maintaining their Wisconsin Medicaid provider file, including their financial address information. Eligible Professionals can maintain their provider file information by using the



[Demographic Maintenance Tool](#) available through their secure [ForwardHealth Provider Portal](#) account.

Providers are encouraged to confirm that the information in their provider file matches the registration information provided in the [CMS Registration and Attestation System](#).

4 PATIENT VOLUME

4.1 What are the patient volume requirements?

Eligible Professionals must meet a 30 percent Medicaid (Title XIX) member encounter threshold during a 90-day reporting period in either the calendar year preceding the payment year or during the 12 months directly preceding the attestation date.

If the Eligible Professional practices predominately in an FQHC or RHC, they must meet a 30 percent “needy individual” encounter threshold [“needy individuals” include Medicaid (Title XIX), Children’s Health Insurance Program (CHIP or Title XXI), uncompensated care, and encounters remunerated on a sliding fee scale based on an individual’s ability to pay].

Pediatricians may also qualify with a 20 percent Medicaid (Title XIX) member encounter threshold; however, if they qualify with a Medicaid patient volume under 30 percent, they will see a reduction in total incentive payments.

More information on patient volume requirements can be found in the [Introduction to Eligible Professional Patient Volume Webinar](#).

4.2 How is an eligible Medicaid encounter defined?

For the purposes of calculating Eligible Professional patient volume, a Medicaid encounter is defined as services rendered on any one day to a member enrolled in a Medicaid program (regardless of the Medicaid reimbursement amount). Unpaid encounters for services rendered on any one day to a member enrolled in a Medicaid program may be counted as eligible Medicaid encounters. Only one encounter can be counted for a member per day per provider regardless of the number of services provided to the member in a single day by the provider.

Claims denied because the individual was not Medicaid eligible at the time of service cannot be counted as Medicaid encounters.



4.3 How do I calculate patient volume?

$$\text{Patient Volume} = \frac{\text{Eligible Member Encounters} \times (1 - \text{Standard Deduction})}{\text{All Encounters}} \times 100$$

As it is not possible for providers to distinguish between Medicaid (Title XIX) and CHIP (Title XXI) encounters through claims records, Wisconsin Medicaid has developed a standard deduction that must be applied to adjust volume eligibility numerators to reflect just Title XIX encounters. Eligible Professionals must use the standard deduction to remove their CHIP volume when calculating Medicaid patient volume encounters.

The Wisconsin Medicaid EHR Incentive Program will calculate and publish the standard deduction annually through a *ForwardHealth Update*. Each Program Year's standard deduction is also published in the Announcements section of the [EHR website](#) homepage.

4.4 Can I use patient volume based on a group practice's volume data?

Yes. A group practice is defined by how each group of providers is organized under the billing provider's National Provider Identifier (NPI) number. When using group practice patient volume, all encounters for that group practice must be considered when determining both numerators and denominators. Even if a provider in the practice is not eligible for the program, his or her patient encounters must be included in both the numerator [Medicaid (Title XIX) patient encounters] and denominator (total patient encounters regardless of payer) and not limited in anyway.

In order to use the group practice patient volume calculation, an Eligible Professional is required to have at least one encounter with an eligible Medicaid member during the patient volume reporting period at the current group practice or another group practice/clinic where the Eligible Professional practices. This encounter does not need to be reimbursed by Wisconsin Medicaid. If the Eligible Professional is new to practicing medicine (e.g., a recent graduate of an appropriate training program), he or she does not need to provide proof of an encounter with a Medicaid member.

4.5 What is a "needy individual"?

Eligible Professionals practicing predominantly in an RHC or FQHC can qualify for incentive payments with a 30 percent "needy individuals" patient volume threshold. Eligible Professionals are considered to be practicing predominantly at an FQHC or RHC when they have at least 50 percent of total patient encounters over a period of six months occur in the most recent calendar year or 12-month period at the FQHC or RHC clinical location.



“Needy individuals” are those receiving medical assistance from Medicaid (Title XIX) or CHIP (Title XXI), individuals who are furnished uncompensated care by the provider, or individuals furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

4.6 Can Wisconsin Medicaid run a report for me to determine patient volume?

No. Wisconsin Medicaid does not have the resources to run individualized reports.

4.7 Is there a minimum denominator for patient volume?

No. There is no minimum denominator; only the percent of qualifying patient encounters is counted.

4.8 Am I required to submit documentation to support my patient volume attestation?

Yes. Beginning in Program Year 2015, Eligible Professionals must submit documentation to support their attestation in addition to the information entered directly into the ForwardHealth application (regardless of their year of participation in the program). See the details of this requirement on the [Eligible Professionals – Required Documentation](#) page.

5 REGISTRATION

5.1 How do I register for Wisconsin Medicaid EHR incentive payments?

Eligible Professionals must register through the [CMS Registration and Attestation System](#). Refer to these two useful registration resources: [CMS Registration and Attestation User Guide](#) and [EHR Incentive Programs Registration Checklist](#).

After an Eligible Professional has registered successfully with CMS, applicants for Wisconsin Medicaid EHR incentive payments must complete their attestation through the ForwardHealth Portal. Eligible Professionals can refer to our [Eligible Professional Application Process Guide](#) for an overview of the process of registering and applying for a Wisconsin Medicaid EHR Incentive Program application.

5.2 Why do I have to wait two business days after entering my payee information to complete the Wisconsin Medicaid EHR Incentive Program application?

The Wisconsin Medicaid EHR Incentive Program requires 48 hours to validate that the payee combination is appropriate for the rendering provider.



5.3 Do I need an electronic fund transfer account before registering for the program?

If you are applying as an Eligible Professional and plan on designating yourself as the recipient of the program's incentive payments, you do not need an electronic fund transfer (EFT) account. You can opt to receive a paper check.

However, if you are an organization or are an Eligible Professional applying and planning on designating an organization or clinic as the recipient of the program's incentive payments, that organization must have an EFT account, and it must be included in the provider's Wisconsin Medicaid provider file.

6 ATTESTATION

6.1 How do I attest to the Wisconsin Medicaid EHR Incentive Program?

After an Eligible Professional has registered successfully with CMS, applicants for Wisconsin Medicaid EHR incentive payments must complete their attestation through the [ForwardHealth Portal](#). Please allow two business days after registration at the CMS Registration and Attestation System before attempting to begin your application at the ForwardHealth Portal.

Eligible Professionals may refer to our [Eligible Professional Application Process Guide](#) (P-01151) for an overview of the process of registering and applying for a Wisconsin Medicaid EHR Incentive Program application. This is an abbreviated version of the user guide for Eligible Professionals.

For additional details on the application process, refer to the step-by-step user guide: [Wisconsin Medicaid EHR Incentive Program for Eligible Professionals](#).

6.2 What information do I need to begin my attestation?

Eligible Professionals should have the following information available when beginning the Wisconsin Medicaid EHR Incentive Program Application:

- Information submitted to the CMS Registration and Attestation System. Eligible Professionals will need to confirm all of this information during the initial application phases.
 - Providers are encouraged to confirm information in their ForwardHealth provider file before beginning an application. Providers will be required to update any differences between the provider file and the registration information provided in the CMS Registration and Attestation System.
- Contact name, telephone number, and email address of the preparer of the Eligible Professional's application if not the Eligible Professional.



- Before beginning the Wisconsin Medicaid EHR Incentive Program Application, the EHR incentive clerk role must be assigned to the clerk completing the application. For more information on obtaining a Provider Portal account or assigning a clerk role, refer to the [ForwardHealth Provider Portal Account User Guide](#) on the Portal User Guides page of the Provider Portal.
- Whether or not the Eligible Professional applying to the Wisconsin Medicaid EHR Incentive Program has any sanctions or pending sanctions with the Medicare or Medicaid programs and is licensed to practice in all states in which services are rendered.
- The CMS EHR Certification Identification (ID) for the CEHRT that has been or is contractually obligated to be acquired.
 - For more information on approved EHR technology, Eligible Professionals should refer to the Office of the National Coordinator for Health Information Technology (ONC) Certified Health IT Product List (CHPL) website at <http://onc-chpl.force.com/ehrcert/>.
 - If you need assistance obtaining your CMS EHR Certification ID, use this [walk-through document](#) to understand how to generate a CMS EHR Certification ID using the ONC Certified Health IT Product List.
- The [required patient volume documentation](#), the start date of the 90-day patient volume reporting period, and required patient volume data.
 - The total in-state eligible member-only patient volume during the previously determined continuous 90-day reporting period.
 - The total eligible member patient volume during the previously determined continuous 90-day reporting period.
 - The total patient volume during the previously determined continuous 90-day reporting period.

6.3 How do EHRs become certified?

The Medicare and Medicaid EHR Incentive Programs require the use of CEHRT as identified by the ONC [Certified Health IT Product List](#). For information on certification please visit the CMS website page on [Certified EHR Technology](#).

Before an Eligible Professional may attest to meeting Medicare and Medicaid EHR Incentive Program requirements, he or she must acquire or have access to CEHRT.

- In Program Year 2015, all Eligible Professionals are required to use technology certified to the 2014 Edition.
- In Program Years 2016 and 2017, Eligible Professionals can choose to use technology certified to the 2014 Edition, the 2015 Edition, or a combination of the two editions.
- In Program Year 2018 and subsequent Program Years, all Eligible Professionals are required to use technology certified to the 2015 Edition.



6.4 Where can I find a list of CEHRT?

A list of CEHRT is available through the ONC [Certified Health IT Product List](#).

Once you find your EHR system, you will need the CMS EHR Certification ID for your CEHRT when registering at the CMS Registration and Attestation System. If you need assistance obtaining your CMS EHR Certification ID, use this [walk-through document](#) to understand how to generate a CMS EHR Certification ID using the ONC Certified Health IT Product List.

6.5 Am I required to submit documentation to support my acquisition of CEHRT?

Yes. Beginning in Program Year 2015, Eligible Professionals must submit documentation to support their attestation in addition to the information entered directly into the ForwardHealth application (regardless of their year of participation in the program). See the details of this requirement on the [Eligible Professionals – Required Documentation](#) page.

6.6 How do I know what stage of Meaningful Use I will attest to?

The table below indicates what stage of Meaningful Use must be reported based on the first year an Eligible Professional began participation in the Wisconsin Medicaid EHR Incentive Program. It is assumed that an Eligible Professional's first year of participation is the adopt, implement, upgrade (AIU) phase and that his or her participation occurs in consecutive years; however, Eligible Professionals may participate in nonconsecutive Program Years and may attest to meaningful use criteria the first year of participation.

First year of participation (AIU)	Stage of Meaningful Use			
	2015	2016	2017	2018+
2011	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3
2012	Modified Stage 2	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3
2013	Modified Stage 2*	Modified Stage 2	Modified Stage 2 or Stage 3	Stage 3
2014	Modified Stage 2*	Modified Stage 2*	Modified Stage 2 or Stage 3	Stage 3
2015	AIU	Modified Stage 2*	Modified Stage 2 or Stage 3	Stage 3
2016	N/A	AIU	Modified Stage 2 or Stage 3	Stage 3

***In 2015 and 2016, Modified Stage 2 includes alternate exclusions and specifications for certain objectives and measures for Eligible Professionals scheduled to demonstrate Stage 1 of Meaningful Use. (Eligible Professionals who successfully attest to any stage of Meaningful Use in two prior years of participation are scheduled to demonstrate Stage 2 and may not use alternate exclusions and specifications in 2015 and 2016, with the exception of the public health reporting alternate exclusions available in 2015 and 2016.) Alternate exclusion reporting continues in 2016 for Computerized Provider Order Entry (CPOE) and public health only.*



EHR Reporting Period for Meaningful Use

The following are the EHR reporting periods for Meaningful Use:

- In Program Year 2016, the EHR reporting period for Eligible Professionals is a minimum of 90 days between January 1, 2016, and December 31, 2016.
- In Program Year 2017, the EHR reporting period for Eligible Professionals is any continuous 90 days between January 1, 2017, and December 31, 2017.
- In Program Year 2018 and subsequent Program Years, all Eligible Professionals, except new meaningful users, will be allowed to select any continuous 90-day period from January 1, 2018, through December 31, 2018.

Note: Eligible Professionals are not required to attest in consecutive years and may attest to the AIU phase and then a 90-day EHR reporting period in a subsequent year of participation.

6.7 What are the Meaningful Use requirements for Modified Stage 2?

The requirements for Modified Stage 2 contain 10 objectives for Eligible Professionals, including one consolidated public health reporting objective. Each objective has one or more measures to which Eligible Professionals are required to attest. Since the changes in the final rule occurred after some Eligible Professionals had already started to work toward Meaningful Use in 2015, there are alternate exclusions and specifications within individual objectives for Eligible Professionals in Program Years 2015 and 2016.

For more information on the Eligible Professional Modified Stage 2 requirements for Program Year 2015, review the [Eligible Professional 2015 Meaningful Use Specification Sheets](#).

For more information on the Eligible Professional Modified Stage 2 requirements for Program Year 2016, review the [Eligible Professional 2016 Meaningful Use Specification Sheets](#).

6.8 What are the Meaningful Use requirements for Stage 3?

The requirements for Stage 3 contain eight objectives for Eligible Professionals, including one consolidated public health reporting objective.

For information about the objectives and measures for Stage 3, Eligible Professionals should refer to the [Federal Register](#).

Additional information on the Eligible Professional Stage 3 requirements is forthcoming. The CMS [Medicare and Medicaid EHR Incentive Program website](#) will be updated to include new information and resources reflecting the latest requirements for participation in Stage 3.



6.9 What are my available CQMs?

All Eligible Professionals, regardless of the stage of Meaningful Use, are required to report on nine of the 64 [clinical quality measures \(CQMs\) finalized in 2014](#). The CQMs selected must cover at least three of the six available National Quality Strategy (NQS) domains, which represent the Department of Health and Human Services' NQS priorities for health care quality improvement. The six NQS domains are:

1. Patient and family engagement
2. Patient safety
3. Care coordination
4. Population/public health
5. Efficient use of health care resources
6. Clinical process/effectiveness

6.10 Is zero an acceptable value for a CQM?

Yes. Zero is an acceptable value for the CQM denominator, numerator, and exclusion fields and will not prevent you from demonstrating Meaningful Use or receiving an incentive payment. Eligible Professional can meet the CQM requirements even if one or more CQM has "0" in the denominator provided that this value was produced by CEHRT.

7 MEDICARE PAYMENT ADJUSTMENTS

7.1 What is a Medicare payment adjustment?

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to Medicare Eligible Professionals who are not meaningful users of CEHRT under the EHR Incentive Program.

If a provider is eligible to participate in the Medicare EHR Incentive Program, he or she must demonstrate Meaningful Use in either the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program to avoid a payment adjustment. Medicaid Eligible Professionals who can only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.

For more information, visit the CMS [Payment Adjustments and Hardship Information](#) page and the CMS [2017 Medicare Electronic Health Record \(EHR\) Incentive Program Payment Adjustment Fact Sheet for Hospitals](#).



7.2 Can I avoid a Medicare payment adjustment by successfully attesting to Meaningful Use during the Wisconsin Medicaid EHR Incentive Program's attestation timeline?

Eligible Professionals can avoid the Medicare payment adjustment by successfully demonstrating Meaningful Use for the Medicaid EHR Incentive Program, even if it occurs after the Medicare attestation period closes, as long as the attestation is accepted.

For more information, visit the CMS [Payment Adjustments and Hardship Information](#) page and the CMS [2017 Medicare Electronic Health Record \(EHR\) Incentive Program Payment Adjustment Fact Sheet for Hospitals](#).

7.3 Can Eligible Professionals who fail to meet the eligibility requirements for the Medicaid EHR Incentive Program still attest to Meaningful Use to avoid a payment adjustment?

Yes. In the [final rule](#) for the Medicare and Medicaid EHR Incentive Programs, CMS finalized the proposal to allow certain Medicaid Eligible Professionals to use an *alternate attestation method* in order to avoid a [Medicare payment adjustment](#). This alternate method allows Eligible Professionals who are registered for the Medicaid EHR Incentive Program, but do not meet the eligibility criteria, to demonstrate meaningful use in order to avoid a Medicare payment adjustment.

This is considered an alternate method because a provider who would normally demonstrate meaningful use using the Wisconsin attestation system (i.e., ForwardHealth Portal) will alternatively demonstrate meaningful use using the CMS method for attestation – the CMS Registration and Attestation System.

7.4 How do I avoid a Medicare payment adjustment using the alternate attestation method?

To use the alternate method of demonstrating Meaningful Use, Eligible Professionals that are registered to attest to the Wisconsin Medicaid EHR Incentive Program will attest to Meaningful Use for no payment through the [CMS EHR Incentive Program Registration and Attestation System](#). **Eligible Professionals must resubmit their registration information if it has not been updated in the last 12 months.** Please note, Eligible Professionals must resubmit their registration information through the CMS Registration and Attestation System even if it has remained unchanged. If this action is not performed, Eligible Professionals will be blocked from accessing the alternate attestation portion of the CMS Registration and Attestation System.



The following is additional information on using the alternate method of demonstrating Meaningful Use:

- Medicaid Eligible Professionals seeking to exercise this option must attest in the CMS Registration and Attestation System and in accordance with the requirements for the Medicare EHR Incentive Program in order to successfully demonstrate Meaningful Use and avoid the Medicare payment adjustment.
- Eligible Professionals may use this alternate method for attesting to Meaningful Use in the CMS Registration and Attestation System to avoid a payment adjustment in conjunction with an attestation for an incentive payment in the Medicaid EHR Incentive Program in the same program year.
- In Program Year 2017, an Eligible Professional using this alternate method who is attesting to Meaningful Use criteria for the first time may not attest to Stage 3 requirements in the CMS Registration and Attestation System and MUST attest prior to 10/1/2017 to avoid the 2018 payment adjustment.
- Use of the alternate attestation method will NOT result in a Medicare or Medicaid incentive payment, is solely for the purpose of avoiding a payment adjustment, and does NOT constitute a switch from the Medicaid EHR Incentive Program to the Medicare EHR Incentive Program.
- An Eligible Professional's payment year schedule and associated EHR reporting period for the Wisconsin Medicaid EHR Incentive Program is not impacted by an alternate attestation through the CMS Registration and Attestation System. For example, if an Eligible Professional attested through the Wisconsin Medicaid EHR Incentive Program to AIU for Payment Year 1 in Program Year 2016 and then attested through the CMS Registration and Attestation System solely to avoid the Medicare payment adjustment in Program Year 2017, the provider would be able to attest through the Wisconsin Medicaid EHR Incentive Program to Stage 3 for a 90-day EHR reporting period for Payment Year 2 in Program Year 2018.

More information is available in the [final rule](#) (80 FR 62900 through 62901).

8 PUBLIC HEALTH

8.1 How do I register for the Public Health Meaningful Use Objectives?

Eligible Professionals are required to register with the Wisconsin Division of Public Health (DPH) to initiate an onboarding process for any of the public health measures. For more information, visit the [Public Health Meaningful Use](#).



9 CONTACTS

9.1 What resources are available to answer questions about the Wisconsin Medicaid EHR Incentive Program?

If you have any questions regarding the Wisconsin Medicaid EHR Incentive Program or are having difficulty with the application process, the following resources are available to assist you.

Available Resources	Contact Information	Service Area
Wisconsin Provider Services Help Desk	800-947-9627	Technical difficulties
Wisconsin EHR Incentive Program Mailbox	dhsehrincentiveprogram@wi.gov	EHR Incentive Program policy and application requirements

9.2 What resources are available for technical assistance?

The Wisconsin Medicaid Health IT Extension Program offers free expert assistance to Medicaid-enrolled health care providers as they adopt, implement, upgrade, and meaningfully use CEHRT.

The Health IT Extension Program has a team of experienced local professionals with extensive knowledge of the Wisconsin medical community and a deep understanding of Meaningful Use requirements.

Free services provided include:

- Vendor-neutral EHR selection and implementation guidance.
- Meaningful Use education and consulting, including readiness assessments, audit preparation, and more.
- Public health objective assistance.
- Health Insurance Portability and Accountability Act of 2009 (HIPPA) security risk assessments.
- Workflow optimization.

For more information or to sign up for assistance, email info@metastar.com.

9.3 What resources are available for health information exchange?

The Wisconsin Statewide Health Information Network (WISHIN) is leading the way to enable health information exchange in Wisconsin. As the state-designated entity for health information exchange, WISHIN has been working to create a network that will give health care providers a secure system to access medical information where they need it, when they need it.

As an independent not-for-profit organization, WISHIN is dedicated to bringing the benefits of widespread, secure, interoperable health information technology to patients and caregivers throughout the state.



WISHIN's statewide health information network connects physicians, clinics, hospitals, pharmacies, and clinical laboratories across Wisconsin in order to promote and improve the health of individuals and communities. WISHIN provides information-sharing services that facilitate electronic delivery of the right health information at the right place and right time to the right individuals.

Statewide health information exchange offers the promise of timely, relevant information that can lead to better clinical decisions, less duplication, more effective transitions of care, and reduced administrative costs.

To learn more about WISHIN and about the benefits of health information exchange, go the www.wishin.org.