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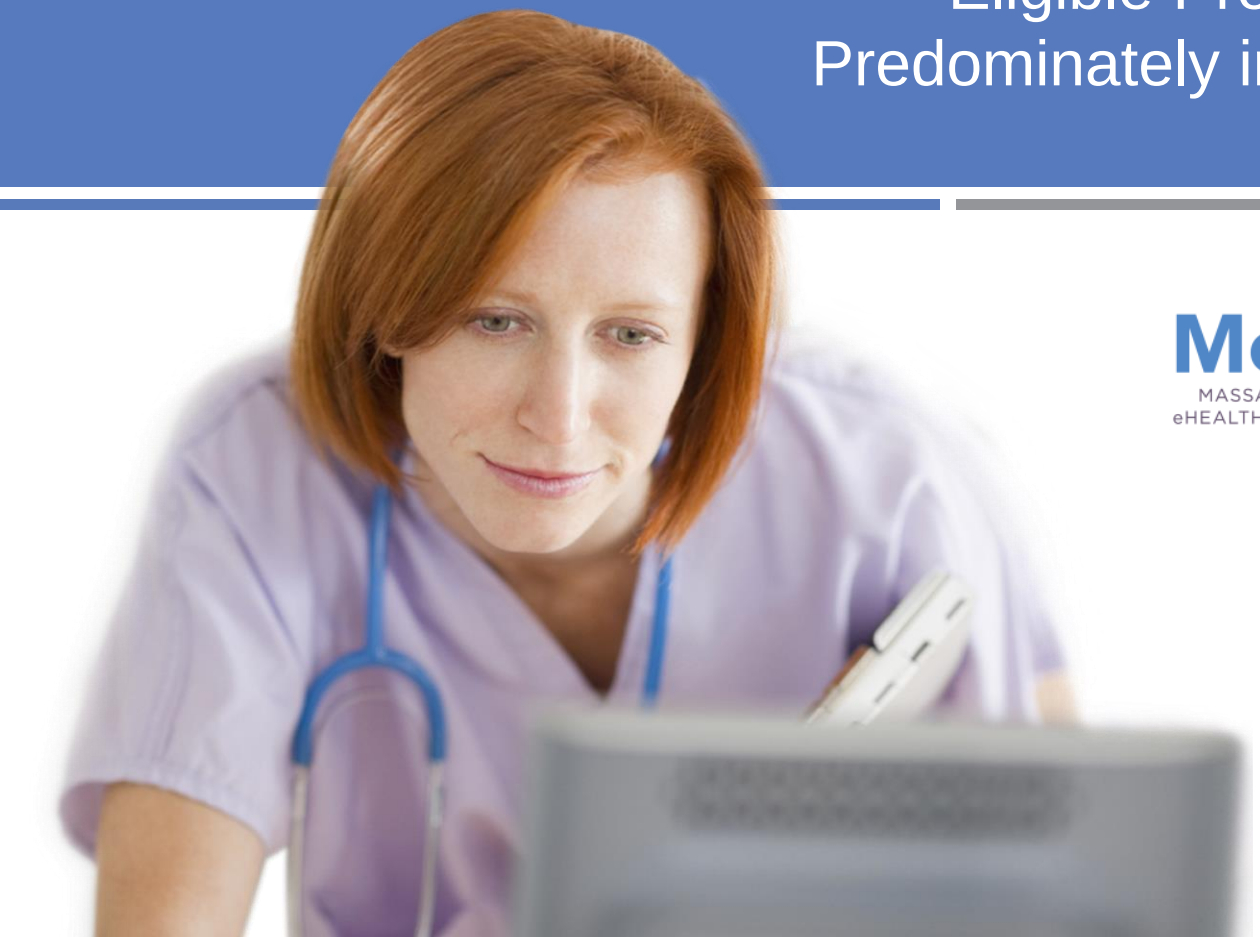
The Massachusetts eHealth Institute

Eligible Professionals Working Predominately in a Hospital Setting



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MeHI Overview

MeHI is a division of the Massachusetts Technology Collaborative, a public economic development agency

MeHI is designated state agency for:

- Coordinating health care innovation, technology and competitiveness
- Accelerating the adoption of health information technologies
- Promoting health IT to improve the safety, quality and efficiency of health care in Massachusetts
- Advancing the dissemination of electronic health records systems in all health care provider settings
- Connecting providers through the statewide HIE
- Managing HIE and REC grants from Office of National Coordinator

MeHI | How We Help

Regional Extension Center	Medicaid	Health Information Exchange
Support priority primary care providers implement and meaningfully use EHRs and engage in HIE	Partnership with EOHHS to support key operational components of the Medicaid Incentive Payment Program	Connects participants to, enables integration with, and maximizes adoption of the Mass HIway

MeHI - How We Help

Education	EHRs	HIway	Innovation
▪ MeHI Website ▪ MeHI Community	▪ REC IOO Program ▪ Medicaid Incentive Payment Program ▪ Health IT Adoption Program (2014)	▪ HIway Last Mile Adoption Program ▪ Vendors ▪ Technical Support ▪ Provider Communities ▪ Implementation Stories and Support	▪ eHealth Roundtable ▪ Identify and Promote Technology

Outreach - Communication

Hospital-Employed Eligible Professionals

Special Considerations for Hospital-Employed Eligible Professionals

- Must have access to and use an ambulatory certified EHR
- Must see less than 90% of their patients in POS 21 (inpatient) and POS 23 (emergency department) settings
- A hospital-employed EP who sees greater than 10% of their patients in an outpatient setting, including POS 22, may qualify
  - POS 22 is *a portion of a hospital, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization*
- Hospital employed specialists such as pathologists, radiologists, and anesthesiologists may meet the non-hospital based criteria and may qualify if they access and use ambulatory certified EHRs
- EPs at ambulatory clinics affiliated with the hospital may be eligible
  - an EP who sees greater than of their 10% patients in an ambulatory clinic and occasionally moonlights in the ED

Special Considerations for Hospital-Employed Eligible Professionals

- Since residents are now eligible, in some cases, they may be employees of a hospital and would have to demonstrate they practice less than 90% in the inpatient or ED settings
- Encounters occurring in POS 21 and POS 23 count towards meeting the patient volume threshold
- **Starting in 2013** and beyond, a hospital-based Eligible Professional who contributes funds to the acquisition, implementation and maintenance of certified EHR technology (CEHRT), including supporting hardware to meet meaningful use, without reimbursement from an eligible hospital, and uses the CEHRT in the inpatient or emergency department of a hospital may also be eligible to participate in the program

Registration & Attestation Requirements

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Registration & Attestation

Federal & State systems working together to support the Massachusetts Medicaid EHR Incentive Payment Program

CMS Identity & Access (I & A) and Registration & Attestation System (CMS R&A)

Medicaid Management Information System/ Provider Online Service Center (MMIS/POSC)

Medical Assistance Provider Incentive Repository (MAPIR)

How Do I Register?

STEP 1:
Confirm EP's NPPES, MMIS & licensure information is current

STEP 2:
Designee will create I&A Account if registering on behalf of an EP

STEP 3:
EP will log into NPPES to confirm designee may attest on their behalf

STEP 4:
EP or designee will complete CMS R&A application

STEP 5:
If the NPI/TIN match what's in MMIS - EP or designee will receive a welcome to MAPIR email

STEP 6:
EP or designee will complete MAPIR application and submit for review

Please note: *EPs completing their own application should complete step 1 and 4-6.*

CMS Registration Process
for Eligible Professionals

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CMS Registration Process Steps – EPs

Your NPI and NPPES Account

- Active NPI
- NPPES web user account
  - User ID and Password (update NPI/user information if not accurate)
- Login to NPPES - connects to PECOS
- Click link to view the NPPES website: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart
- If no NPPES web user account
  - Navigate to CMS I&A system to create account
- EP with NPPES account may work on behalf of organization
  - Login to NPPES to request work on behalf of other providers

CMS Registration Process
for Designees

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Register: First Step for Designees

Designee

First Step

Identity Access Management System

- I&A web user account required
  - Security front-end to PECOS
- Associated with NPI of the EP
  - NPIs of all EPs in Group Practice
  - EPs or authorized NPPES user must verify Designee & approve access
- If you do not have I&A account, create one
- Click Link to view the CMS I&A website: https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do

Register: Second Step for Designees

Designee

Second Step

Begin registering EPs/EHs with CMS

- I&A account links with PECOS
- PECOS allows any provider to enroll/register with CMS
  - Including EPs who accept Medicaid patients
- PECOS: basis for registration with CMS for EHR Incentive Payment Program
- Click link to view PECOS website: https://pecos.cms.hhs.gov/pecos/login.do

Designee: Add Information into CMS Registration System

Designee

Second Step (cont.)

Registering EPs into PECOS

- Designees enter EPs into CMS R&A System
- Following instructions, Designees add:
  - Name, address, telephone number
  - Incentive type
  - Payment information

CMS EHR Program R&A web-site

Click link to view the CMS R&A website:
https://ehrincentives.cms.gov/hitech/login.action

Designee: Tax Identifier Considerations for EPs

Designee

Second Step (cont.)

Tax Identifiers: TIN, EIN, SSN

- TIN issued by IRS
- Two types of Identification Numbers:
  1. EIN: used to identify a business entity
  2. SSN: issued by the Social Security Administration
     - TIN, in association with SSN, can also be issued by SSA

EHR Incentive Payments are taxed

- IMPORTANT that Designees correctly assign TINs
  - EPs/Group practices

Designee: Tax Identifiers for Individual EPs and Group Practices

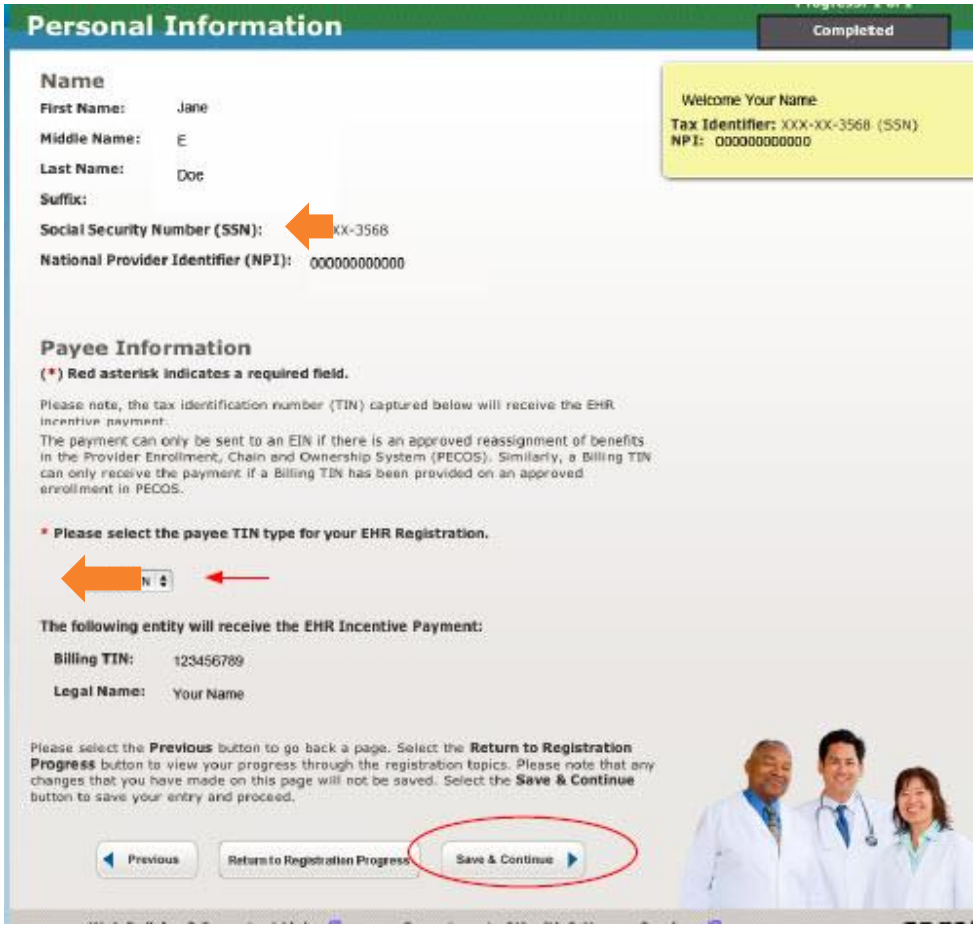
Second Step (cont.)

Billing TIN

- EP's SSN

Group Reassignment

- Group's NPI/EIN

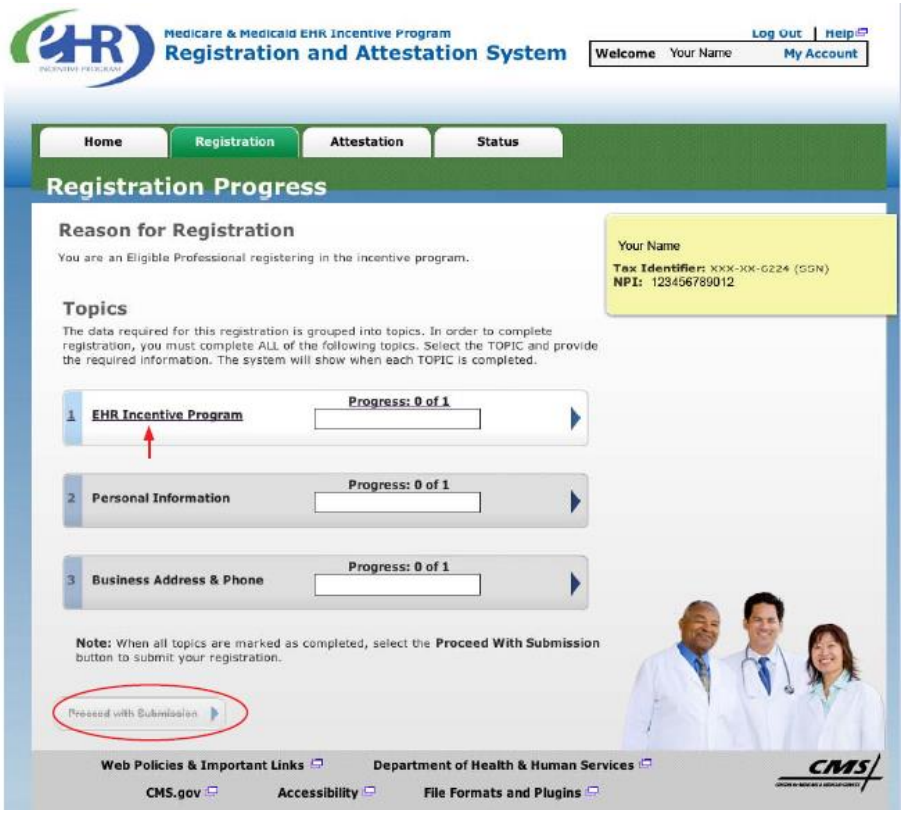


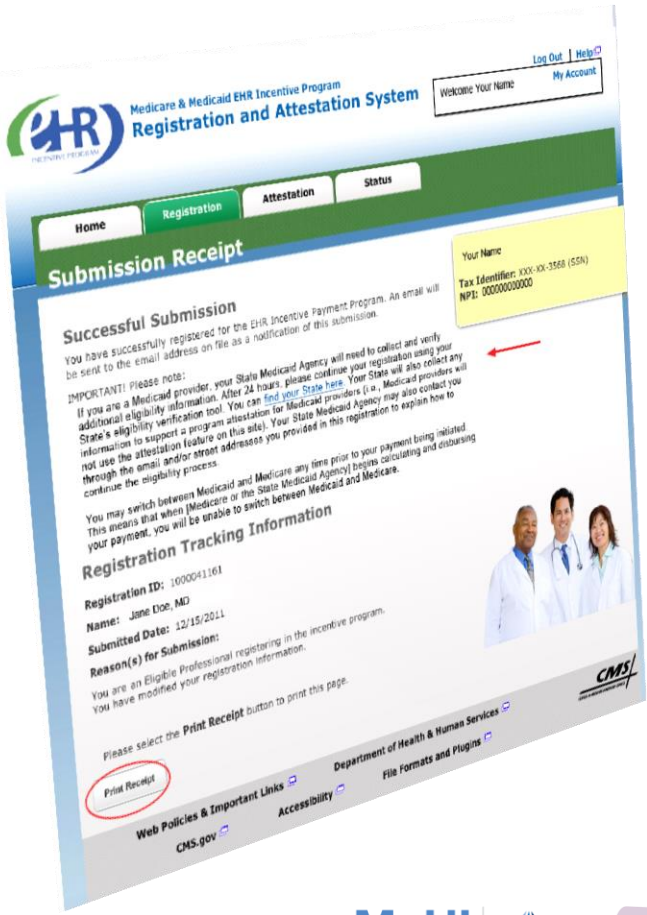
Registering in CMS R&A System: Verifying/Submitting Registration

Designee

Third Step

Verifying and Submitting Registration





CMS – Integration with The Executive Office of Health and Human Service (EOHHS) Systems

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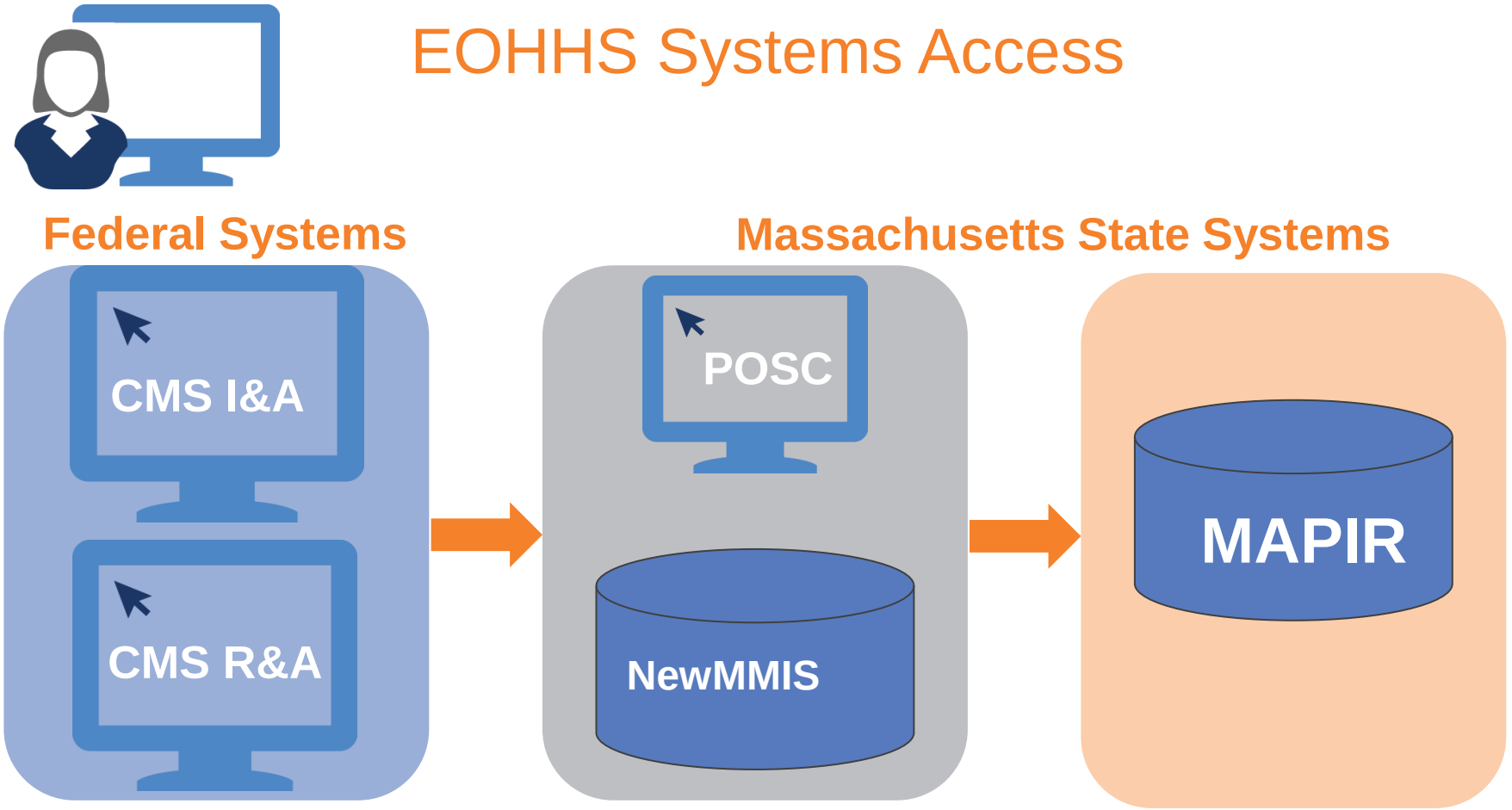
Register: Massachusetts Medicaid Systems Access

EOHHS Systems Access



- EH Admin, EP or Designee granted access to State systems
  - Receives “Welcome to MAPIR” e-mail
  - Link opens POSC

Provider Online Service Center – POSC

First Step

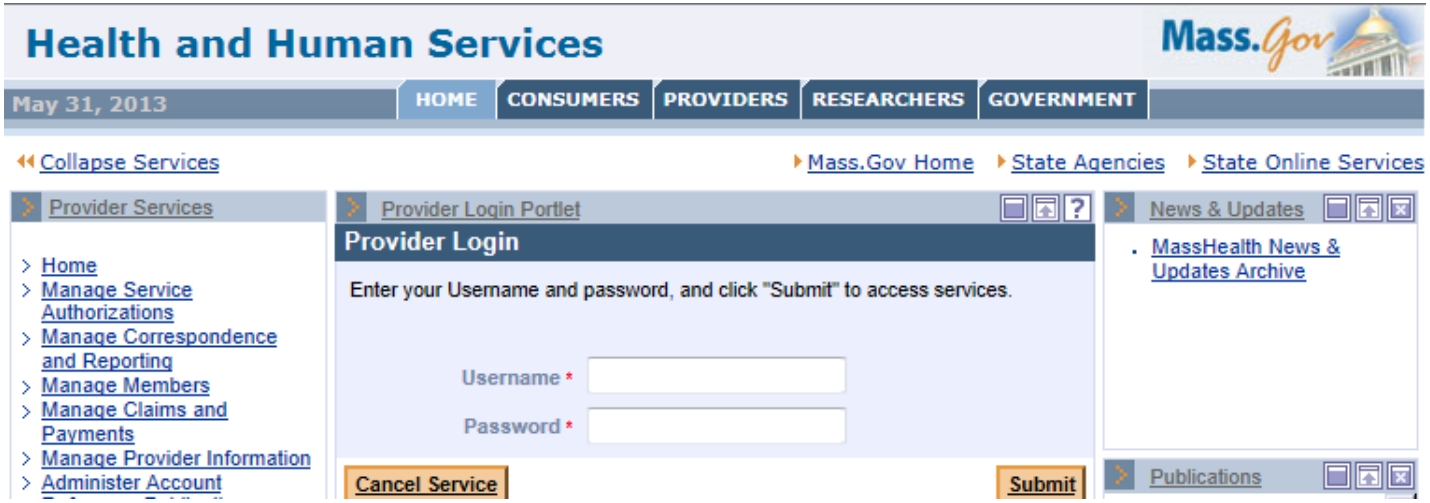
Massachusetts Medicaid Systems Access through POSC

Clicking this link brings users to the login screen

Click link to view the POSC website:
https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/appmanager/provider/desktop

Provider Online Service Center – POSC (Cont.)

Authorized users

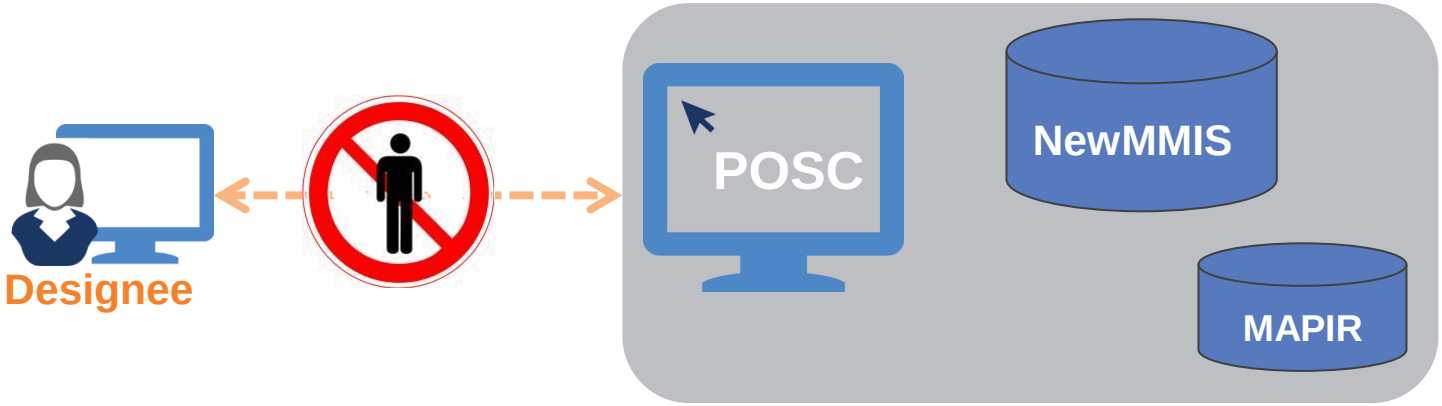


Notification users not authorized

Massachusetts Medicaid Systems Access: If Not Authorized

Second Step (cont.)

If Not Authorized



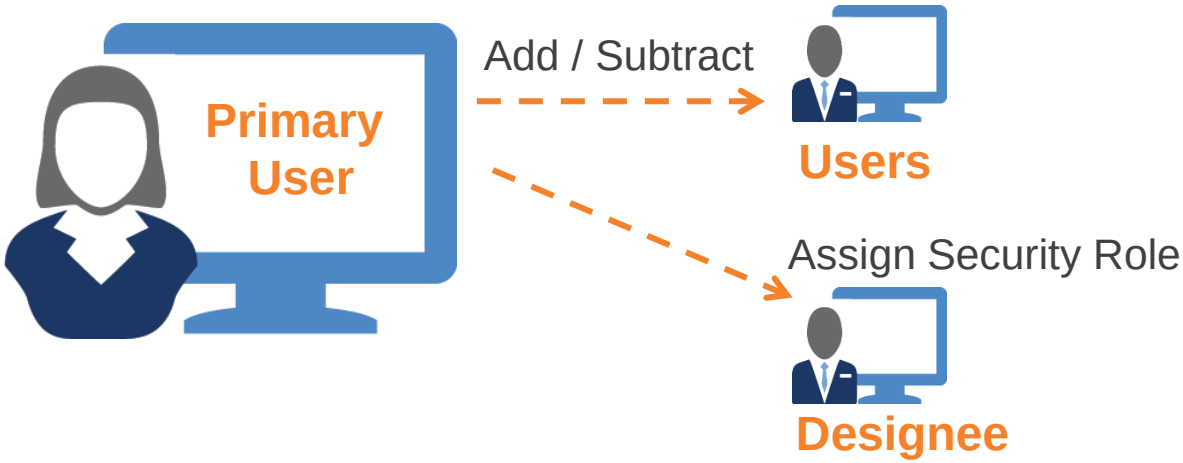
- Complete DCF
- Identify Primary User within Organization
- Roles of Designees and Primary Users

Who is the “Primary User” within the organization?

Massachusetts Medicaid Systems Access: Primary User

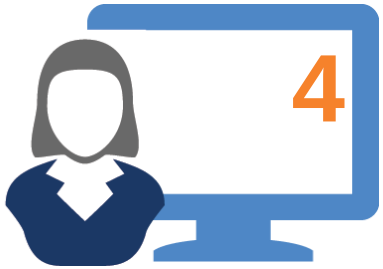
Third Step

Determining Primary User
to assign system privileges



- If EH Administrator, EP/Designee is <u>not</u> Primary User:
  - Contact Primary User (grants necessary privileges)
  - Virtual Gateway ⟶ Administer Account ⟶ Security Role
- If unaware who is Primary User:
  - Contact MassHealth Customer Service: **1-800-841-2900**

Massachusetts Medicaid Systems Access: DCF



Fourth Step

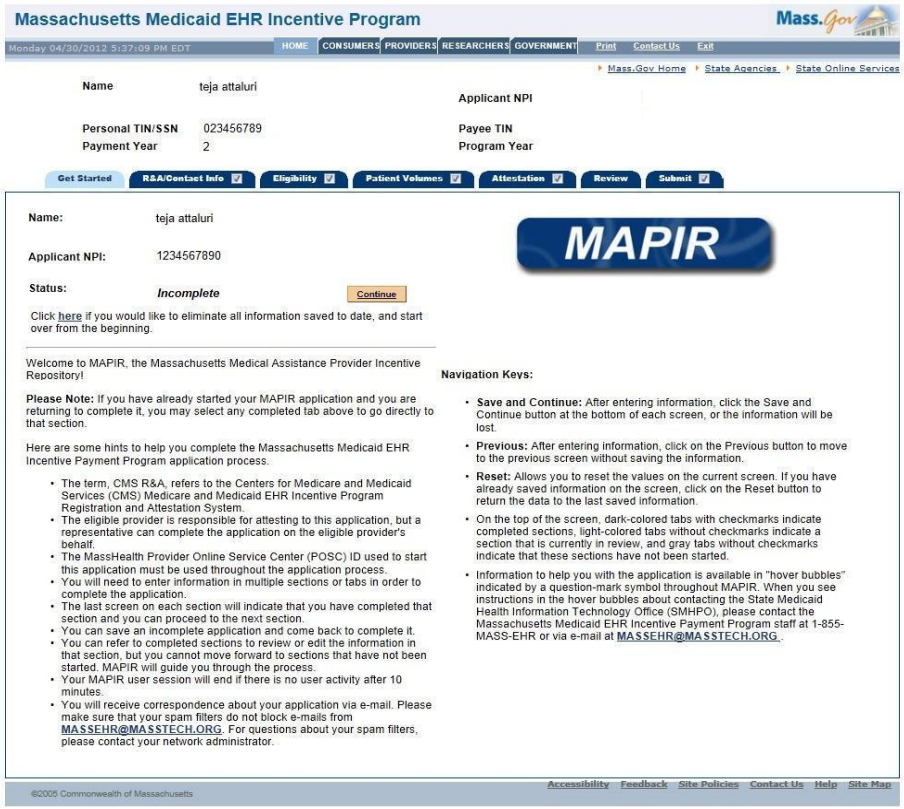
Data Collection Form (DCF)

- EH Administrators, EPs/Designees may need to complete a DCF (if access challenges)
  - Return DCF to MeHI
- When DCF approved:
  - EH Administrators, EPs/Designees granted access to systems
- Click link to view example - how to complete a DCF

Massachusetts Medicaid Systems Access: MAPIR

Fifth Step

MAPIR Access



Medicaid EHR Operations: 1-855-MassEHR (1-855-627-7347)

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Adopt, Implement, Upgrade (A/I/U)

Adopt, Implement, or Upgrade (A/I/U)

In the **first** year of participation, EPs must demonstrate one of the following:

- **ADOPT (A)**
  - Acquire, purchase, or secure CEHRT
- **IMPLEMENT (I)**
  - Install or initiate use of CEHRT
- **UPGRADE (U)**
  - Expand functionality of CEHRT
  - EPs will be required to provide supporting documentation showing that they have A/I/U to CEHRT

Examples of Acceptable EHR Supporting Documentation

- A copy of a Signed Data User Agreement; or
- Proof of Purchase; or
- Executed Licensed Vendor Contract; ***and***
- A letter from your CIO or IS department head stating the following:
  - EP(s) that are currently using or will be using the certified EHR technology
  - The EP(s) NPI Number
  - Date that the certified EHR technology was purchased
  - Location(s) where the certified EHR technology will be used
  - Certified EHR technology ONC Certified HIT Product List (CHPL) number and version
    - Visit: http://oncchpl.force.com/ehrcert?q=CHPL

Meaningful Use

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Key Healthcare Policy Domains

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/ Effectiveness

Meaningful Use Stages

THE CRITERIA FOR MEANINGFUL USE WILL BE STAGED IN THREE STEPS OVER THE NEXT FIVE YEARS:

STAGE 1 - Data capture and information sharing

- Sets baseline

STAGE 2 - Advanced Clinical Processes

- Final rules released on August 23, 2012.
- Guidelines build upon Stage 1

STAGE 3 – Improved Outcomes

- To be developed through future rule making.
- Expected to be implemented in 2015 (subject to change)

Focus of Stage 1 Meaningful Use Criteria

STAGE 1 | STAGE 2 | STAGE 3

- Electronically capturing health information in a structured format and using that information to track key clinical conditions
- Establishing the functionalities of certified EHR technology that will allow for continuous quality improvement and easy information exchange
- Communicating information for care coordination purposes (whether that information is structured or unstructured, but in a structured format whenever feasible)
- Implementing clinical decision support tools to facilitate disease and medication management
- Using EHRs to engage patients, their families, and reporting clinical quality measures and public health information

Focus of Stage 2 Meaningful Use Criteria

STAGE 1 | **STAGE 2** | STAGE 3

- Expand upon the Stage 1 criteria to encourage the use of health IT for continuous quality improvement at the point of care and the exchange of health information in the most structured format possible (e.g. electronic transmission of orders entered using computerized provider order entry (CPOE))
- More rigorous health information exchange (HIE)
- Increased requirements for e-prescribing and incorporating lab results
- Electronic transmission of patient care summaries across multiple settings
- More patient-controlled data

Focus of Stage 3 Meaningful Use Criteria

STAGE 1 → STAGE 2 → **STAGE 3**

- Improving quality, safety, and efficiency, leading to improved health outcomes
- Decision support for national high priority conditions
- Patient access to self-management tools
- Access to comprehensive patient data through patient-centered HIE
- Improving population health

Calculating Patient Volume Threshold

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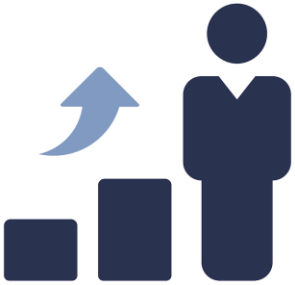
Medicaid Patient Volume Threshold – For Eligibility

Eligible Provider Type	Minimum Medicaid Patient Volume Threshold Requirement
Physicians (MDs & DOs)	30%
Pediatricians ****must be board certified****	20%
Dentists	30%
Nurse Practitioners	30%
Certified Nurse Midwives	30%

Medicaid/Medicaid 1115 Waiver Population Types



- When calculating Medicaid patient volume threshold for eligibility, EPs may include both Medicaid Fee-For-Service (FFS) and Medicaid Managed Care Organizations (MCO) encounters.
- **Some examples of populations that may be included are:**
  - BMC Healthnet Plan
  - Fallon Community Health Plan
  - Network Health
  - Neighborhood Health Plan
  - Health New England
  - Massachusetts Behavioral Health
  - Commonwealth Care Alliance
- Please reference the **Medicaid 1115 Waiver Population grid** for a complete list of which populations may be included when calculating Medicaid patient volume threshold.

Medicaid Patient Volume Threshold Definitions

…

MEDICAID PAID ENCOUNTER DEFINITION:

One service, per day, per patient, where Medicaid or a Medicaid 1115 Waiver population paid of all or part of the service or paid for all or part of the individual's premiums, copayments, or cost-sharing.

…

MEDICAID ENROLLEE DEFINITION:

One service, rendered any day to a Medicaid or Medicaid 1115 Waiver enrolled individual, regardless of payment liability. This includes zero pay encounters that may have been paid by Medicare or by another third party, and denied claims, excluding denied claims due to the provider or individual being ineligible on that date of service.

Patient Volume Threshold Calculation (Option 1)

MEDICAID PATIENT VOLUME THRESHOLD =

Medicaid Paid Patient Encounters
(over any continuous 90-day period either from the previous CY or in the 12 months preceding the provider's attestation)

Total Paid Patient Encounters
(over any continuous 90-day period either from the previous CY or in the 12 months preceding the provider's attestation)

Where a patient encounter is defined as: One service, per day, per patient, where Medicaid or a Medicaid 1115 Waiver Population ***paid*** for all or part of the service or ***paid*** for all or part of the individual's premiums, co-payments, or cost-sharing

- Medicaid patient volume threshold may be calculated using individual, group proxy, or practitioner panel data.
- A Children's Health Insurance Program (CHIP) reduction must be applied.

Patient Volume Threshold Calculation (Option 2)

MEDICAID PATIENT VOLUME THRESHOLD =

Medicaid Enrollee Patient Encounters
(over any continuous 90-day period either from the previous CY or in the 12 months preceding the provider's attestation)

Total Paid Patient Encounters
(over any continuous 90-day period either from the previous CY or in the 12 months preceding the provider's attestation)

Where a Medicaid Enrollee Encounter is defined as: One service, rendered any day to a Medicaid or Medicaid 1115 Waiver enrolled individual, regardless of payment liability. This includes zero-pay encounters that may have been paid by Medicare or by another third party, and denied claims, excluding denied claims due to the provider or individual being ineligible on that date of service.

- Medicaid Enrollee patient volume threshold may be calculated using individual, group proxy, or practitioner panel data.
- A Children's Health Insurance Program (CHIP) reduction must be applied.

Three Ways to Achieve Patient Volume Threshold

Individual, Group Proxy, or Practitioner Panel

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Individual Approach

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Paid Encounters vs. Medicaid Enrollee Approach

Example using an individual provider's encounters:

- Dr. Blue, Internal Medicine Provider
- Practices at one location where certified EHR technology is utilized

Paid Medicaid Encounters	All Medicaid Enrollee Encounters
Continuous 90-day reporting period: October 1, 2012 – December 30, 2012	Continuous 90-day reporting period: October 1, 2012 – December 30, 2012
Total encounters: 1280	Total encounters: 1280
Encounters where services were rendered and paid by an eligible Medicaid or an 1115 Waiver program: 309	All encounters where billable services were rendered to a Medicaid or an 1115 Waiver program enrollee: 421
309/1280 = .24 x 100 = 24%	421/1280 = .33 x 100 = 33%
Does not achieve the Medicaid patient volume threshold at this location	**Achieves the Medicaid patient volume threshold at this location**

Multiple Practice Locations

Example using PAID encounters*:

- Dr. Green, Internal Medicine Provider
- 2 practice locations. Both locations utilize certified EHR technology

*Same concept can be used for Medicaid Enrollee approach

East Medical Center	North Medical Center
Continuous 90-day reporting period: October 1, 2012 – December 30, 2012	Continuous 90-day reporting period: October 1, 2012 – December 30, 2012
Total paid encounters: 500	Total paid encounters: 85
Encounters where Medicaid or an 1115 Waiver population paid for all or part of the service, premium, copayment or cost-sharing: 95	Encounters where Medicaid or an 1115 Waiver population paid for all or part of the service, premium, copayment or cost-sharing: 35
95/500 = .19 x 100 = 19%	35/85 = .41 x 100 = 41%
Does not achieve the Medicaid patient volume threshold at this location	**Achieves the Medicaid patient volume threshold at this location**

Calculating Needy Individual Patient Volume Threshold For Federally Qualified Community Health Centers

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Needy Individual – Patient Volume Threshold: Two Options

- "Practice Predominately" at a Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) means 50% or more of an EP's patient encounters over a six-month period (in the current CY) occurred at an FQHC/RHC.

- EPs that practice predominately at an FQHC/RHC must meet a minimum needy individual patient volume:

  - 30% needy individual patient volume over a over any continuous 90-day period either from the preceding CY or in the 12 months preceding the Provider's attestation

"Needy Individual" is defined as a person receiving care from any of the following:

- Medicaid or Medicaid 1115 Waiver Population, CHIP, and those dually eligible for Medicare and Medicaid (includes MCO and FFS)
- Uncompensated care
- No cost or reduced cost services on a sliding scale based on individuals' ability to pay

Option 1

NEEDY INDIVIDUAL PATIENT VOLUME =

Needy Individual Paid Encounters
(over any continuous 90-day period either from the previous CY or in the 12 months preceding the provider's attestation)

Total Paid Patient Encounters
(over any continuous 90-day period either from the previous CY or in the 12 months preceding the provider's attestation)

Where a patient encounter is defined as:
One service, per day, per patient, where Medicaid (including Medicaid 1115 Waiver Population, CHIP, those dually eligible for both Medicare and Medicaid) ***paid*** for all or part of the service including an individual's premium, copayment, or cost sharing;

- Uncompensated care; or
- Services furnished at either no cost or reduced cost, based on a sliding scale

Needy individual patient volume threshold may be calculated using individual, group proxy, or practitioner panel data.

Option 2

NEEDY INDIVIDUAL PATIENT VOLUME =

Enrolled Needy Individual Encounters
(over any continuous 90-day period either from the previous CY or in the 12 months preceding the provider's attestation)

Total Patient Encounters
(over any continuous 90-day period either from the previous CY or in the 12 months preceding the provider's attestation)

- Threshold may be calculated using services rendered on any one day to a Medicaid-enrolled individual, ***regardless of payment liability***:
  - Based on MassHealth enrollment on date-of-service
  - Includes zero-pay claims and denied claims
    Does not include claims denied because either the provider or the member is ineligible on the date of service
- One service, per day, per patient, where the Patient is ***eligible*** for all or part of the service (including an individual's premium, copayment, or cost sharing) under
  - Medicaid (including Medicaid 1115 Waiver Population, CHIP, or is dually eligible for both Medicare and Medicaid);
  - Uncompensated care; or
  - Services furnished at either no cost or reduced cost, based on a sliding scale
- Needy individual patient volume can be calculated using individual, group proxy, or practitioner panel data.

Did you know?

- EPs that have practiced less than six months in the current CY at an FQHC/RHC are still eligible to receive an incentive payment as long as the following criteria are met:
  - The FQHC/RHC must use the group proxy method to calculate patient volume threshold.
  - The FQHC/RHC must calculate *Medicaid Patient Volume Threshold* rather than *Needy Individual Patient Volume Threshold*. Therefore, the following may not be included:
    - CHIP and those dually eligible (Medicare & Medicaid) - includes MCO & FFS
    - Uncompensated care
    - No cost or reduced cost services on a sliding scale based on individuals' ability to pay
  - A CHIP factor must be applied to the in-state number of paid Medicaid encounters.

Group Proxy Approach

Definition of Group Proxy

WHAT IS GROUP PROXY?

- A group is defined as two or more Eligible Professional's, who are practicing at the same site.
- The group proxy calculation is used by all of the group members to apply for the Medicaid EHR Incentive Payment Program. By doing this, an organization has the possibility of qualifying more EPs than if an EP applied individually.

WHY USE GROUP PROXY?

- Less administrative burden
- Most inclusive option for all EPs practicing at the same site
- Provides for quick validation and easy auditable data

Group Proxy Method (cont.)

WHO MAY USE A GROUP PROXY?

- EPs may use a clinic or group practice's patient volume as a proxy under these circumstances:
  - There is an auditable data source to support the patient volume determination.
  - EPs use one methodology in each year - the group cannot have some using individual patient volume and others using clinic-level data.
  - The clinic or practice must use the entire practice's patient volume and not limit it in any way.

Note:

- If your clinic or institution has unique billing practices and would like to use the group proxy method to calculate the Medicaid patient volume threshold, the Medicaid Operations Team will work with you and your organization to determine appropriate next steps.
- Hospitals that use the same NPI and Tax ID for all of their Ambulatory clinics will need to further breakdown their patient encounter data by Ambulatory Clinic and practice site location. For more information, please contact MeHI for guidance.

Group Proxy Reporting Example: Option 1

Example using PAID Medicaid encounters

- 5 Providers
- Same practice location
- Utilizing certified EHR technology

Continuous 90-day period either from the preceding CY or in the 12 months preceding the provider's attestation

Provider	Paid Medicaid Encounters (where Medicaid or Medicaid 1115 Waiver Population paid for all or part of the service, premium, copayment, or cost-sharing)	Total Paid Encounters
Physician 1	80	200
Physician 2	50	100
Nurse Practitioner	30	300
Nutritionist	150	200
Resident	0	0
Total	**310**	**800**

310/800 = .3875 x 100 = 38.75%

4 out of 5 professionals meet the Medicaid patient volume threshold requirement and would be eligible to participate.

Group Proxy Reporting Example: Option 2

Example using ALL encounters for Medicaid enrollees

- 5 Providers
- Same practice location
- Utilizing certified EHR technology

Continuous 90-day period either from the preceding CY or in the 12 months preceding the Provider's attestation

Provider	Medicaid-Enrolled Encounters (where eligible for Medicaid or Medicaid 1115 Waiver for all or part of the service, premium, copayment, or cost-sharing)	Total Encounters
Physician 1	120	200
Physician 2	100	100
Nurse Practitioner	45	300
Nutritionist	175	200
Resident	0	0
Total	**440**	**800**

440/800 = .5500 x 100 = 55.00%

4 out of 5 professionals meet the Medicaid patient volume threshold requirement and would be eligible to participate.

Practitioner Panel Method

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Definition of Practitioner Panel

- **PRACTITIONER PANEL** – A practitioner panel is for Eligible Professionals that practice in a ***managed care/medical home*** setting.

Practitioner Panel Example

90-day reporting period **(*continuous 90-day period from the preceding CY* or in the12 months preceding attestation)**	**1/1/12 – 3/31/12**
# of **Medicaid/Medicaid 1115 Waiver patients** assigned to the practitioner's panel during the chosen 90-day reporting period that had at least one encounter in the 24-month period prior to the start of the 90-day reporting period	250
Unduplicated encounters with **Medicaid/Medicaid 1115 Waiver patients** during the chosen 90-day reporting period	50
Total patients assigned to the practitioners panel during the same chosen 90-day reporting period that had at least one encounter in the 24-month period prior to the start of the 90-day reporting period	550
Total unduplicated encounters during 90-day reporting period in the preceding 24 months	100

Practitioner Panel Example (cont.)

250

(Patients assigned to Practitioner Panel with at least one Medicaid encounter in the 24 months prior to the beginning of the 90-day period)

+

50

(Medicaid unduplicated encounters)

550

(Total patients assigned to the Practitioner Panel with at least 1 encounter in the 24 months prior to the beginning of the 90-day period)

+

100

(all unduplicated encounters)

300/650 = .46 x 100

✓ **46% - Provider meets the Medicaid patient volume threshold requirements**

IMPORTANT

PLEASE NOTE:

- Meeting Patient Volume Threshold is **required**
  - For A/I/U and each stage of Meaningful Use
- Patient Threshold and EHR (MU) Reporting Period are two separate requirements
- Provider may not select a 12-month period that overlaps with a previously selected PV threshold 90-day reporting period
  - Required to select a different reporting period.

Patient Volume Threshold Supporting Documentation

- The MeHI Medicaid EHR Operations Staff are required to request supporting documentation when the following discrepancies are identified:
  - A variance of +/- 25% between what is reported as the Medicaid patient volume numerator in the Medical Assistance Provider Incentive Repository (MAPIR) and the MCO and FFS claim information extracted from the MassHealth Data Warehouse claim files

- Types of documentation we may request:
  - Claim remittance
  - Patient accounts management reports
  - Patient registration reports
  - Patient eligibility reports

Note: According to state guidelines, all EPs must keep their supporting documentation for a minimum of six years from attestation for auditing purposes

Medicare vs. Medicaid EHR Incentive Payment Programs

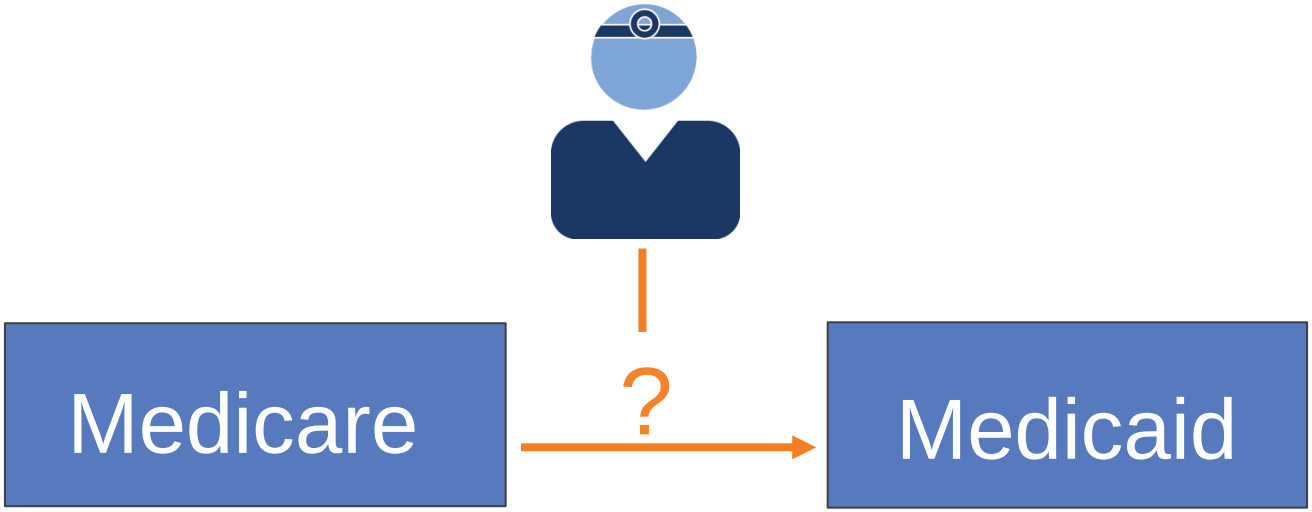
MeHI MASSACHUSETTS eHEALTH INSTITUTE at the MassTech Collaborative

MassHealth

Medicare vs. Medicaid EHR Incentive Payment Program

Medicare EHR Incentive Payment Program	Medicaid EHR Incentive Payment Program
Managed by CMS Attestation done at the federal level	State manages its own program Attestation done at the state level
Payment reductions begin in 2015 for providers who are eligible but choose not to participate	No Medicaid payment reductions if providers choose not to participate
In the first and all remaining years, providers have MU objectives and associated measures they must meet to get incentive payments	In the first year, providers can receive an incentive payment for adopting, implementing or upgrading a certified EHR. In remaining years, providers have the same MU objectives and associated measures as Medicare
EPs can receive a maximum incentive amount of $44,000 (over 5 successive years of program participation)	EPs can receive a maximum incentive amount of $63,750 (over 6 years of program participation)
As of 2013, Medicare EHR Incentive Payment amount annually reduced by 2% as part of the sequester	Medicaid EHR Incentive Payment amounts are exempted from sequester adjustments

Medicare vs. Medicaid



- May be financially advantageous for providers who qualify for both programs to switch
  - From Medicare EHR Incentive Program to Medicaid EHR Incentive Program
- On CMS website, indicate desire to apply for the Medicaid EHR Incentive Program instead of Medicare EHR Incentive Program
  - Website will guide you through the steps of applying

Medicare vs. Medicaid

- It is important to note:
  - Medicaid patient volume thresholds require that at least 30% of a provider's total encounters are with Medicaid patients
    - Requirement must be met each year of participation
    - Calculated using data from a continuous 90-day period, either from the previous calendar year or from the twelve months prior to attestation
      - Calculation may be done on an individual, group or patient panel basis
  - Providers may switch programs only once
    - May participate in only one program, not both, in a given year
    - Continue meeting MU measures where left off in previous program

Contact Us

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