Commonwealth of Massachusetts
Executive Office of Health and Human Services

Meaningful Use Regional Meeting

Holiday Inn, Dedham, MA
Tuesday, November 17, 2015

Stacy A. Piszcz, Deputy Director
Medicaid EHR Incentive Program

Agenda

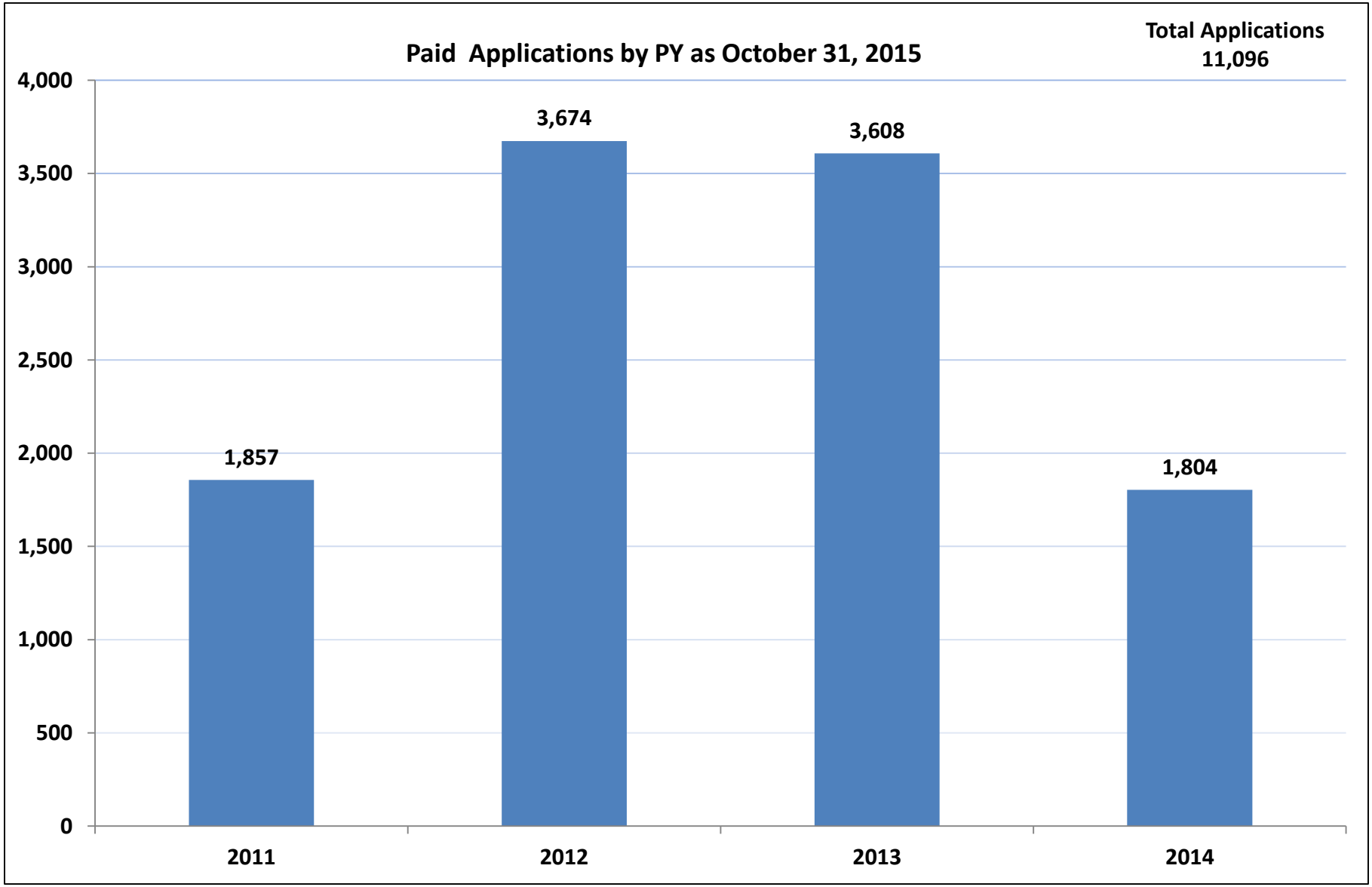
Meaningful Use

- Program Analysis
- Landscape

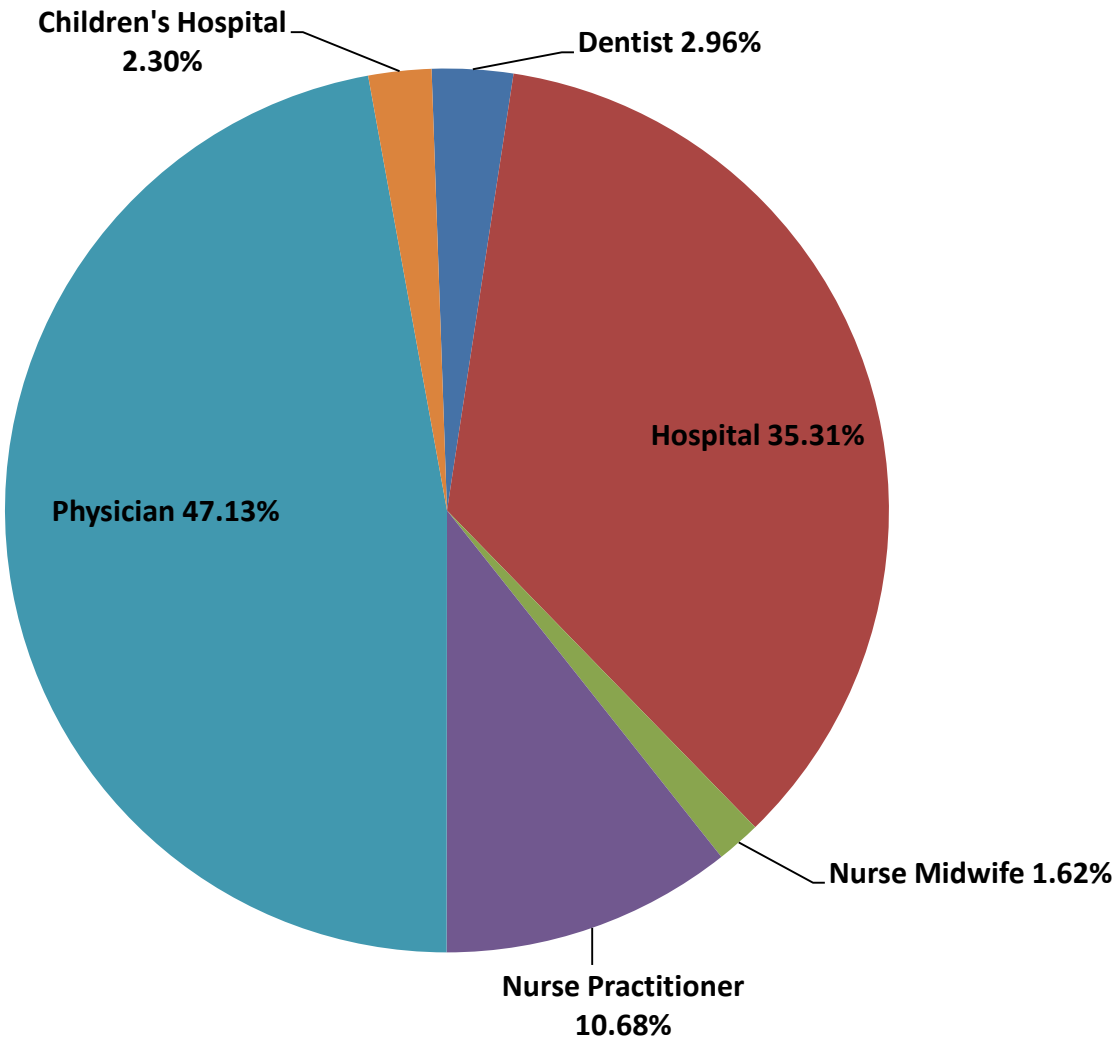
EHR Overview to Meaningful Use in 2015 - 2017 and Stage 3 Final Rule (Modified Stage 2)

Commonwealth Program Updates

EHR Incentive Program Participation Analysis



Payments by Provider Type as of October 31, 2015



Meaningful Use - Landscape

Continue moving forward at the federal level

- 2015 OIG work plan
  - Increased oversight as program matures
  - Security of certified electronic health record technology under meaningful use
- Simplification of EHR Incentive Program
  - Promulgated Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017 (2015-2017 Modified Final Rule)

2015 – 2017 Modified Final Rule

- Aligns EHR reporting period with full calendar year
- Changes EHR reporting period in 2015 to 90-day period to accommodate modifications
- Synchronizes on single stage and single reporting period beginning in 2018
- Streamlines program by removing redundant, duplicative and topped out measures

New Federal Participation Timeline

2015	Attest to modified criteria for 2015-2017 (Modified Stage 2) with accommodations for Stage 1 providers
2016	Attest to 2015-2017 (Modified Stage 2) criteria*
2017	Attest to either 2015-2017 (Modified Stage 2) criteria **Or** full version of Stage 3
2018	Attest to full version of Stage 3

Some alternate exclusions remain in 2016 for Stage 1 providers

2015 – 2017 Modified Final Rule Changes for EPs

Previous EP Stage 2 Objectives

- 17 core objectives including public health objectives
- 3 of 6 menu objectives

2015 – 2017 Modified Final Rule EP Objectives

- **10 objectives** (including one consolidated public health reporting objective with 3 measure options)

2015 – 2017 Modified Final Rule

10 core objectives (including one consolidated public health reporting objective with 3 measure options)

1. Protect Patient Health Information – Security Risk Analysis
2. Clinical Decision Support
3. CPOE
4. Electronic Prescribing (eRx)
5. Health Information Exchange – Transitions of Care
6. Patient Specific Education
7. Medication Reconciliation
8. Patient Electronic Access
9. Secure Messaging (EPs only)
10. Public Health and Clinical Data Registry Reporting

2015 – 2017 Modified Final Rule Changes for EHs

Previous EHs/CAHs Stage 2 Objectives

- 16 core objectives including public health objectives
- 3 of 6 menu objectives

EHs/CAHs Objectives for 2015 – 2017 Modified Final Rule

- **9 objectives** (including one consolidated public health reporting objective with 4 measure options)

Massachusetts EHR Program Updates

Program Update

- 2015 – 2017 Modified Final Rule
  - Effective December 15, 2015
  - Applications received prior to December 15, 2015 will be processed under previous rules
    - » PY 2015 AIU, and MU Stage I (90 days) can attest using previous rules
    - » MU Stage II – cannot attest until MAPIR is updated
  - MAPIR Collaborative is establishing timelines to support the 2015-2017 Modified Final Rule
  - Current thinking for 2015 program year applications
    - » EPs can attest early next year
    - » Dually-Eligible EHs can attest early next year
    - » Medicaid only EHs can attest later next year
- Continuing building out infrastructure
  - Processes, request attestation deadline extension, etc.

References

Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule:

- https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-25595.pdf

OIG 2015 Work plan is here:

- http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Work-Plan.pdf

Medicaid EHR Incentive Program Operations

Today's presenter:

Nicole Bennett, Provider Enrollment & Verification Manager

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Topics We'll Discuss

- Massachusetts eHealth Institute (MeHI)
- Medicaid EHR Incentive Landscape
- Eligible Provider Types
- Registration and Attestation
- Timelines
- Patient Volume Threshold
- 2015 Program Supporting Documentation Requirements
- Reconsideration & Appeals Process
- Payment Adjustments – Alternate MU Attestation
- Questions and Answers

Medicaid EHR Incentive Program

MeHI's role in administering components of the Program

- Assists with Program Planning and Administration
- Enrollment and Eligibility Verification
- Attestation and Pre-Payment Verification
- Verification and Payment Authorization
- Reconsideration, Denial & Appeals
- Assist with Program Reporting and Analysis to State and Federal Government

***Note**: The Medicaid Provider Enrollment & Verification Team pre-audits applications. Therefore, they do not provide direct EHR or MU Technical Assistance. Please contact MeHI's eHealth Services Technical Assistance Team.*

Medicaid EHR Incentive Overview

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Medicaid Program Overview

VISION

To improve the quality and coordination of care by connecting providers to patient information instantly through the use of certified EHR technology (CEHRT)

GOAL

To promote the adoption and Meaningful Use of interoperable CEHRT to 7,251 EPs and 64 EHs across the Commonwealth

Don’t miss the Opportunity to Receive an Incentive

Incentive payments are available for eligible Medicaid healthcare providers to adopt and use EHR technology in ways that can positively affect patient care.

- First year - adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology
- Subsequent years - must demonstrate meaningful use
- Higher incentive payments - up to $63,750 over 6 years

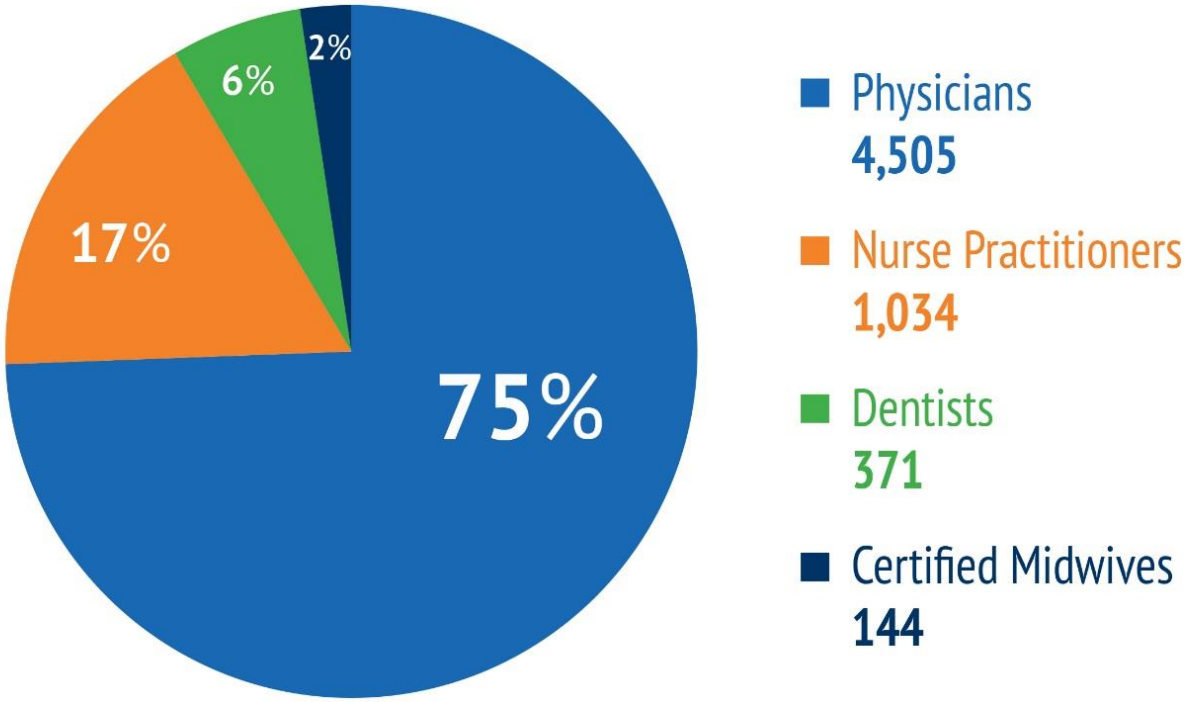
Eligible Provider Types

Eligible Provider Types

- Physicians
- Dentists
- Certified Nurse-Midwives
- Nurse Practitioners
- Physician Assistants (PA)
- Residents

Metrics of Participating Providers to date

Medicaid EHR Incentive Program Provider Types



Note: Meaningful use is established on a provider-specific basis – each provider within a practice that **sees** a given patient can count that patient toward his or her MU objectives.

Registration and Attestation

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Registration and Attestation

- To successfully register at the federal level, EPs need a:
  - National Provider Identifier (NPI)
  - National Plan and Provider Enumeration System (NPPES) Identity and Access Management (I&A) ID and Password
  - Payee Tax Identification Number (TIN)
  - Payee NPI EHR Certification Number

- To successfully register at the state level, EPs need to:
  - Be recognized in MassHealth's Medicaid Management System
  - Have a Primary User on file
  - Obtain a Virtual Gateway username & password

Important Program Deadlines

Documents	Program Deadline
Special Enrollments & Data Collection Forms	Must be submitted 75 days prior to the Program Year attestation deadline
Hospitals' Ambulatory Group Proxy Data – submitted on behalf of EPs	Must be submitted 60 days prior to the Program Year attestation deadline
Resident Proposals	Must be submitted 60 days prior to the Program Year attestation deadline

NOTE: Any forms or documents received after the Program Year attestation deadline will be processed for the next Program Year.

Group Proxy Options

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Medicaid Patient Volume Thresholds

MEDICAID PAID ENCOUNTER DEFINITION:

One service, per day, per patient, where Medicaid or a Medicaid 1115 Waiver population paid for all or part of the service including an 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.

Group Proxy

WHAT IS GROUP PROXY

- A group is defined as two or more EPs, 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
- Multiple options
- Provides for quick validation and easy auditable data

Group Proxy Options

A group of Eligible Professionals who…

Medical Group Practice or Health Center	work at the same practice site.
Physician Foundations that have separate NPIs or Tax IDs	are employed by a Hospital Physician Foundation, which is generally a not-for-profit, wholly owned subsidiary of a health system.
Hospital owned Outpatient Clinics	work within the same Outpatient Clinic (Ambulatory). Each Outpatient Clinic is defined as a separate group.
Stand-Alone Outpatient Facilities	work in different Outpatient (Ambulatory) Clinics within the same building that is owned and operated by a Health Care Organization.

Key Patient Volume Take-Aways

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Patient Volume – Facts to Remember

Important Reminders:

- If a discrepancy is identified with the EP's patient volume, supporting documentation will be requested. The EP will have 30 days from the date of notice to submit accurate/sufficient supporting documentation.
- Utilize the Patient Volume Sample Templates as a reference to ensure you have captured all appropriate data fields.
- Reference the Medicaid and 1115 Waiver Grid to ensure the EP has accurately included all Medicaid Insurance Products.
- Develop a formula to make certain all duplicate encounters or claims have been removed.
- Include an Insurance Payer Product Key.
- Contact MeHI to obtain Children's Health Insurance Program (CHIP) Factor prior to submitting your attestations.

2015 Program Year Supporting Documentation Requirements

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2015 Supporting Documentation Requirements

- The 2015 supporting documentation requirements are currently in development and will be posted to MeHI's website in 90 days.
- Per Program Regulations, each EP's application must stand on its own and corresponding documentation must be uploaded to their respective MAPIR application.
- EPs are required to keep auditable data sources for all components of the EHR incentive program for a minimum of six years for each year of participation.

Reconsideration & Appeal Process

Reconsideration & Appeals

The Reconsideration & Appeals Process will be fully operationalized the first or second quarter of 2016.

What does this mean?

All Program Participants:

- Are required to ensure the integrity of their EHR Incentive applications prior to attestation.
- Will receive Initial Determination Notices (IDN) if discrepancies have been identified with their EHR Incentive applications.
- Will have 30 days from the date of the letter to submit sufficient documentation to demonstrate compliance.
- A Final Determination Notice (FDN) will be issued if the Hospital or Provider:
  - Fails to meet program regulations
  - Fails to submit accurate and appropriate supporting documentation
  - Exceeds filing timeline
  - Self-Reports a denial

Reconsideration & Appeals Cont'd.

Rights to Appeals

- Program participants who have been denied participation will have 30 calendar days from the date the Final Determination Notice was issued to file a claim for an Adjudicatory Hearing.

NOTE: If a Hospitals or Provider's MAPIR attestation has been denied, it does not preclude them from participating in future years.

Payment Adjustments

Payment Adjustments

- Per EHR Regulations, the payment adjustment information is applicable to Medicaid EPs. While the payment adjustments are being imposed by Medicare and not Medicaid State Agencies, they impact EPs participating in the Medicaid EHR Incentive Program.
- Medicaid EPs who do not meet the eligibility criteria to attest to the Medicaid EHR Incentive Program and want to avoid the Medicare payment adjustment would have the option of attesting through the EHR Incentive Program Registration and Attestation system for the purpose of avoiding the Medicare payment adjustment.
- The alternate method would allow EPs who have previously received an incentive payment under the Medicaid EHR Incentive Program to demonstrate they are meaningful users of EHRs in situations where they fail to meet the eligibility criteria for the Medicaid EHR Incentive Program in a subsequent year.

Questions

Questions?

Contact Us

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