Psychiatric Clinical Nurse Specialists

How to Get Your Medicaid EHR Incentive for 2016

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Agenda

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- Adopt, Implement, Upgrade
- Sneak Peek: Meaningful Use
- Common Issues
- What's the Bottom Line?
- Questions

Massachusetts Medicaid EHR Incentive Program

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What is the MA Medicaid EHR Incentive Program?

The Health Information Technology for Economic and Clinical Health (HITECH) Act introduced financial incentives, offered through Medicare or Medicaid, for Eligible Professionals (EPs) who demonstrate Meaningful Use (MU) of Certified EHR Technology (CEHRT)

- The MA Executive Office of Health and Human Services oversees the program
  - contracts with MeHI to administer key components of the program
- EPs can receive a total incentive payment of $63,750 over six years
  - $21,250 in the first payment year; $8,500 in subsequent payment years
- In their first year, Medicaid EPs have the option to Adopt, Implement, or Upgrade (AIU); in subsequent years, they must demonstrate Meaningful Use (MU)

Medicaid EHR Incentive Program – Payment Schedule

Year	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

New Eligible Professional: Psychiatric Clinical Nurse Specialist

The Centers for Medicare and Medicaid Services (CMS) recently approved Psychiatric Clinical Nurse Specialists (PCNS) as a new category of EPs

- Program Year 2016 is the last year for all EPs (including PCNS) to initiate program participation
- We encourage all PCNS to register with CMS as soon as possible and complete Special Enrollment paperwork (if needed) by

December 5, 2016

- The deadline for Program Year 2016 incentive applications is

March 31, 2017

Why EHRs?

Why EHRs?

What's the big picture?	
Payment reform	▪ All payers: Medicare, Medicaid, private insurance • Medicare Quality Payment Program (QPP) ▪ Movement away from fee-for-service payments toward performance-based reimbursement ▪ Tracking of performance metrics and submission of data
Benefits	▪ Organized and searchable data ▪ ePrescribing, med reconciliation, drug interaction checks ▪ Referrals ▪ Modernization of healthcare industry – don't get left behind!
Challenges	▪ Transition issues – paper to electronic ▪ EHR functionality that aligns more with Primary Care ▪ Integration of Behavioral Health & Primary Care ▪ Reporting to state agencies
Tips	▪ Avoid simply replicating what you're already doing on paper ▪ Look for ways to streamline processes where feasible

EHR Selection

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EHR Selection: Things to Consider

- Goals: what do you hope to accomplish by implementing an EHR?
- Compatibility with Practice Management or Billing System(s)
- Certification – necessary if you wish to receive incentive payments
- Security
- Customization options
- Cost, functionality, and vendor support
  - free, web-based systems may not have certain functionality/features and may not offer vendor training or support
- Timing
  - to be eligible for Medicaid incentives, must sign contract by December 31, 2016
- Contact us to discuss your specific situation and needs

Program Eligibility

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Program Eligibility

Program Eligibility Criteria:

- **Provider Type** – must be an Eligible Professional (EP)
- **Patient Population** – must be serving the target population and actively seeing Medicaid patients at the time of attestation
- **Patient Volume Threshold (PVT)** – must meet a minimum Medicaid PVT of 30%
  - Based on a 90-day period from either the previous calendar year or the 12-month period preceding attestation
  - Please reference the Medicaid 1115 Waiver Population Grid for a complete list of programs and payers that may be included when calculating PVT
- **EHR Type** – must have 2014 Edition (or higher) CEHRT
- **Hospital-Based Status** – must be Non-Hospital-Based

Program Eligibility

What does it mean to be Non-Hospital-Based?

- CMS guidelines define “hospital-based” as providers who render 90% or more of their services in either Place of Service 21 (Inpatient) or Place of Service 23 (Emergency Department)
- To participate in the Medicaid EHR Incentive Program, providers must be Non-Hospital-Based
  - In other words, they must have rendered at least 11% of their services in an outpatient setting of care *during the previous calendar year*
  - Outpatient settings include any POS code other than POS 21 or POS 23

- Providers who have no billing data in MMIS, or whose office is located at a hospital site, must submit a letter confirming their non-hospital-based status

- Contact us with questions about your unique situation

Registration Process

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Registration Process

Federal & State systems work together to support the MA Medicaid EHR Incentive 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)

The MAPIR system is where EPs or their designees complete their attestation for the Medicaid EHR Incentive Program.

Registration Process

How the registration process ideally works	
1	Visit CMS I&A to set up an I&A account if you do not already have one. *Note: EPs who wish to use a designee must give permission for that designee to attest on their behalf*
2	Register the EP on the CMS R&A site.
3	The CMS registration system finds the EP's information in MMIS, and you receive a "Welcome to MAPIR" email. Follow the instructions in the email to begin the MAPIR attestation process.

Registration Process

How the process will work for some PCNS	
1	Visit CMS I&A to set up an I&A account if you do not already have one. *Note: EPs who wish to use a designee must give permission for that designee to attest on their behalf*
2	Register the EP on the CMS R&A site.
3	Since some PCNS do not bill MassHealth directly, the CMS registration system will **not** be able to pull up a match in MMIS. MeHI staff will receive notice of the discrepancy and contact you to complete a Special Enrollment.
4	Once the Special Enrollment documents are processed, you will be able to access MAPIR and begin the attestation process.

Special Enrollment

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Special Enrollment

- EPs who are not enrolled with MassHealth or who have an “inactive” status in MMIS
- MeHI staff will contact you if a Special Enrollment is required
- Required documents for all Special Enrollments:
  - **Data Collection Form (DCF)** – this form identifies the primary user in your organization and establishes their User ID and password. The primary user will have access to MAPIR via the Provider Online Service Center (POSC)
  - **Limited Provider Agreement (LPA)** – this form enrolls the EP with MassHealth for the purposes of participating in the Medicaid EHR Incentive Program
  - **Copy of EP’s License** – a copy of the EP’s current (unexpired) medical license
- Required only if the EP wishes to receive payments directly (not reassign payments to their organization):
  - **W9 Form**
  - **Electronic Funds Transfer (EFT)**

Patient Volume Threshold (PVT) Requirements and Options

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Patient Volume Threshold Requirements

- To be eligible for the Medicaid EHR Incentive Program, providers must meet a minimum Medicaid Patient Volume Threshold (PVT) of **30%**
  - At least 30% of encounters are with Medicaid patients
  - Providers may include Medicaid Fee-For-Service (FFS) and Medicaid Managed Care Organization (MCO)/CarePlus Program encounters
  - Please reference the Medicaid 1115 Waiver Population Grid for a complete list of programs and payers that may be included when calculating PVT
- Medicaid PVT is calculated using a 90-day reporting period from either the previous calendar year, or the 12-month period preceding attestation
- Medicaid PVT requirements must be met for each year of program participation. EPs must select a new PVT reporting period each year.

Medicaid 1115 Waiver Population Grid

Medicaid Fee For Service Plans
MassHealth Standard
MassHealth Breast and Cervical Cancer Treatment Program
MassHealth CommonHealth
MassHealth Family Assistance
MassHealth Limited
New Program - MassHealth CarePlus
New Program - MassHealth Small Business Employee Premium Assistance

Medicaid Contracted Payors
Boston Medical Center HealthNet Plan (BMCHP)
CeltiCare Health
Fallon Community Health Plan (FCHP) (Fallon Health)
Health New England (HNE)
Neighborhood Health Plan (NHP)
Tufts Health Plan
Boston Medical Center Senior Care Options
Commonwealth Care Alliance
Navicare (Fallon Community Health Plan)
Senior Whole Health
Tufts Medicaid Managed Care Product
United Health Care Medicaid Managed Care Product

Payor
Beacon Health Options – Boston Medical Center HealthNet Plan
Beacon Health Options – Fallon Health
Beacon Health Options – Neighborhood Health Plan
Cenpatico – CeltiCare Health
Massachusetts Behavioral Health Partnership – Health New England
Massachusetts Behavioral Health Partnership – PCC Plan
Tufts Health Plan
DentaQuest
Commonwealth Care Alliance
Tufts Health Plan

Patient Volume Threshold Options

Medicaid Patient Volume Threshold Options
90-day Reporting Period
▪ Previous calendar year or 12-month period preceding attestation
Methodology
▪ Individual or Group Proxy
Encounter Definition
▪ Paid Claims or Enrollees

Methodology: Individual vs. Group Proxy

Methodology: Individual vs. Group Proxy

To determine their Medicaid PVT, EPs may use either individual data or Group Proxy Methodology.

- Individual data: each EP uses only his/her own patient encounters to determine Medicaid PVT
- Group Proxy Methodology: all providers in the practice (including those not eligible for the Medicaid EHR Incentive Program) aggregate their data to determine the group's Medicaid PVT
  - A group is defined as two or more EPs practicing at the same site

Methodology: Individual vs. Group Proxy

- In any given year, all EPs must use the same methodology; an organization cannot have some EPs using individual data and others using Group Proxy
- If using Group Proxy Methodology, the organization must use the entire practice's patient volume and not limit it in any way
- Group Proxy Methodology usually involves less administrative burden and often allows more EPs to participate

Dr. Green	25%
Dr. Brown	35%
Dr. Smith	35%
Dr. Jones	35%
Dr. Johnson	35%
Group Total	**33%**

- Example: using individual data, Dr. Green would not qualify; aggregating the group's data allows all five EPs to participate

- If your organization has unique billing practices and would like to use Group Proxy Methodology, MeHI will work with you to provide guidance and determine appropriate next steps

Encounter Definition: Paid Claims vs. Enrollees

Paid Claims vs. Enrollees

To determine their PVT, EPs may use either Medicaid paid claims or Medicaid enrollees.

- For EPs using paid claims, a patient encounter is defined as:

> One service, per patient, per day, where Medicaid or a Medicaid 1115 Waiver Population paid for all or part of the service rendered, or paid for all or part of the individual's premiums, co-payments, or cost-sharing

- For EPs using the enrollee approach, a patient encounter is defined as:

> One service rendered to a Medicaid or Medicaid 1115 Waiver enrolled patient, regardless of payment liability. This includes zero-pay encounters and denied claims (excluding denied claims due to the provider or patient being ineligible on the date of service)

Calculating Patient Volume Threshold

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Calculating Medicaid Patient Volume Threshold

Medicaid Patient Volume Threshold =

$$\frac{\text{Medicaid Patient Encounters}}{\text{Total Patient Encounters}}$$

(over any continuous 90-day period from the preceding calendar year or the 12 months preceding the provider's attestation)

(over the same 90-day period)

Numerator: Medicaid Patient Encounters
Denominator: Total Patient Encounters

Calculating Medicaid Patient Volume Threshold

- The Children's Health Insurance Program (CHIP) factor is a percentage reduction that must be applied to the in-state numerator
- The CHIP factor varies depending on the PVT reporting period chosen
- Please see the CHIP Factor Grid on our website to determine the appropriate CHIP factor to apply to your in-state numerator

PVT Data Entry and Supporting Documentation

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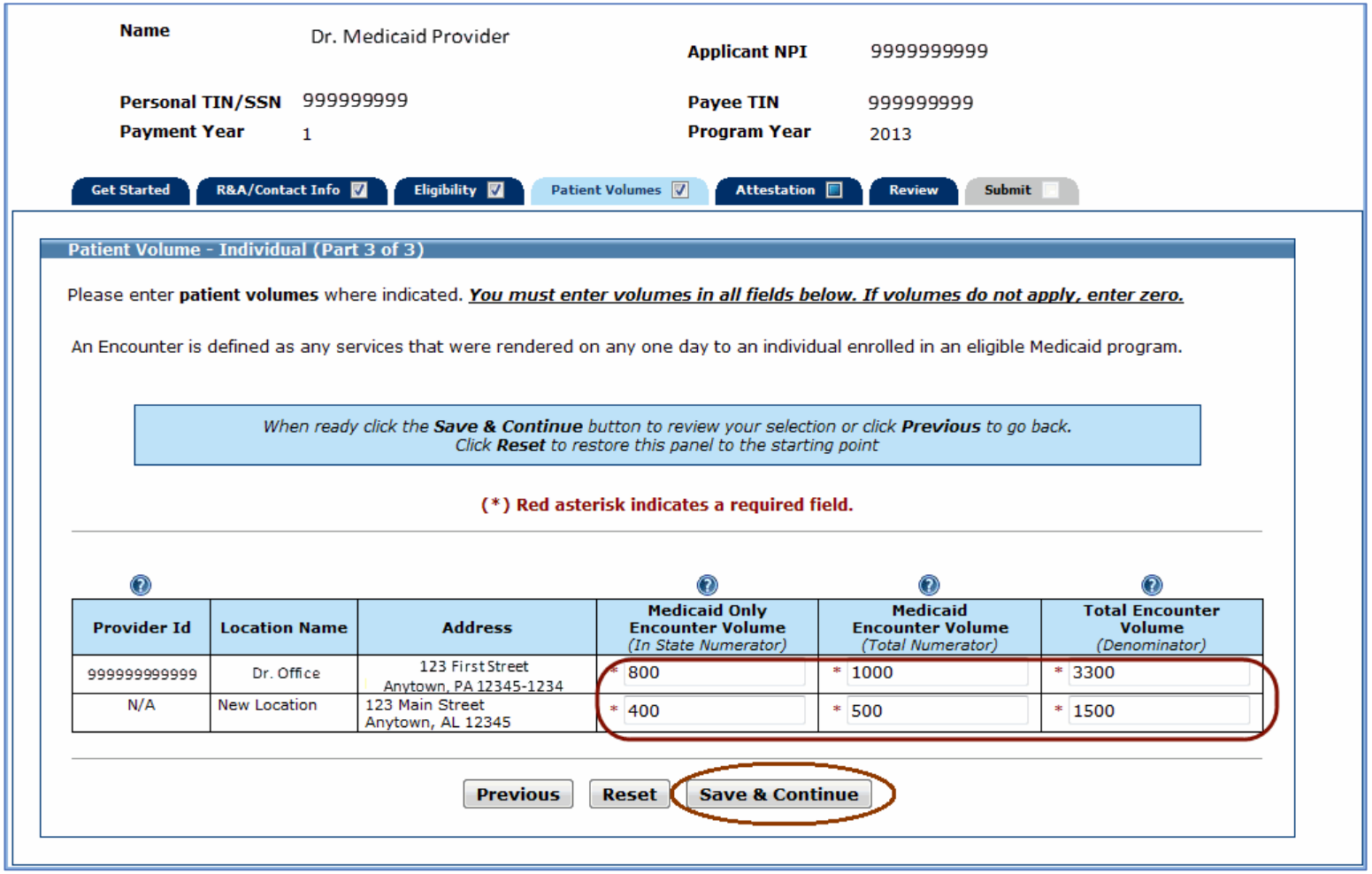
PVT Data Entry

- When preparing PVT data to be entered into MAPIR, ensure that you have all the data elements shown below:

90-Day PVT Data Preparation for Entering into MAPIR

Total In-State Medicaid Encounters		3,071	
CHIP Reduction	-3.20%	-98	
Reduced Total In-State Medicaid Encounters		2,973	MAPIR field #1
Out-of-State Encounters		2	
Reduced Total In-State Medicaid plus Out-of-State Encounters		2,975	MAPIR field #2
All Encounters from All Payors		9,706	MAPIR field #3
% Medicaid		30.63%	

MAPIR Data Entry – Individual Patient Volume



Name Dr. Medicaid Provider

Applicant NPI 9999999999

Personal TIN/SSN 999999999

Payee TIN 999999999

Payment Year 1

Program Year 2013

Get Started | R&A/Contact Info ☑ | Eligibility ☑ | Patient Volumes ☑ | Attestation ☐ | Review | Submit ☐

Patient Volume - Individual (Part 3 of 3)

Please enter **patient volumes** where indicated. ***You must enter volumes in all fields below. If volumes do not apply, enter zero.***

An Encounter is defined as any services that were rendered on any one day to an individual enrolled in an eligible Medicaid program.

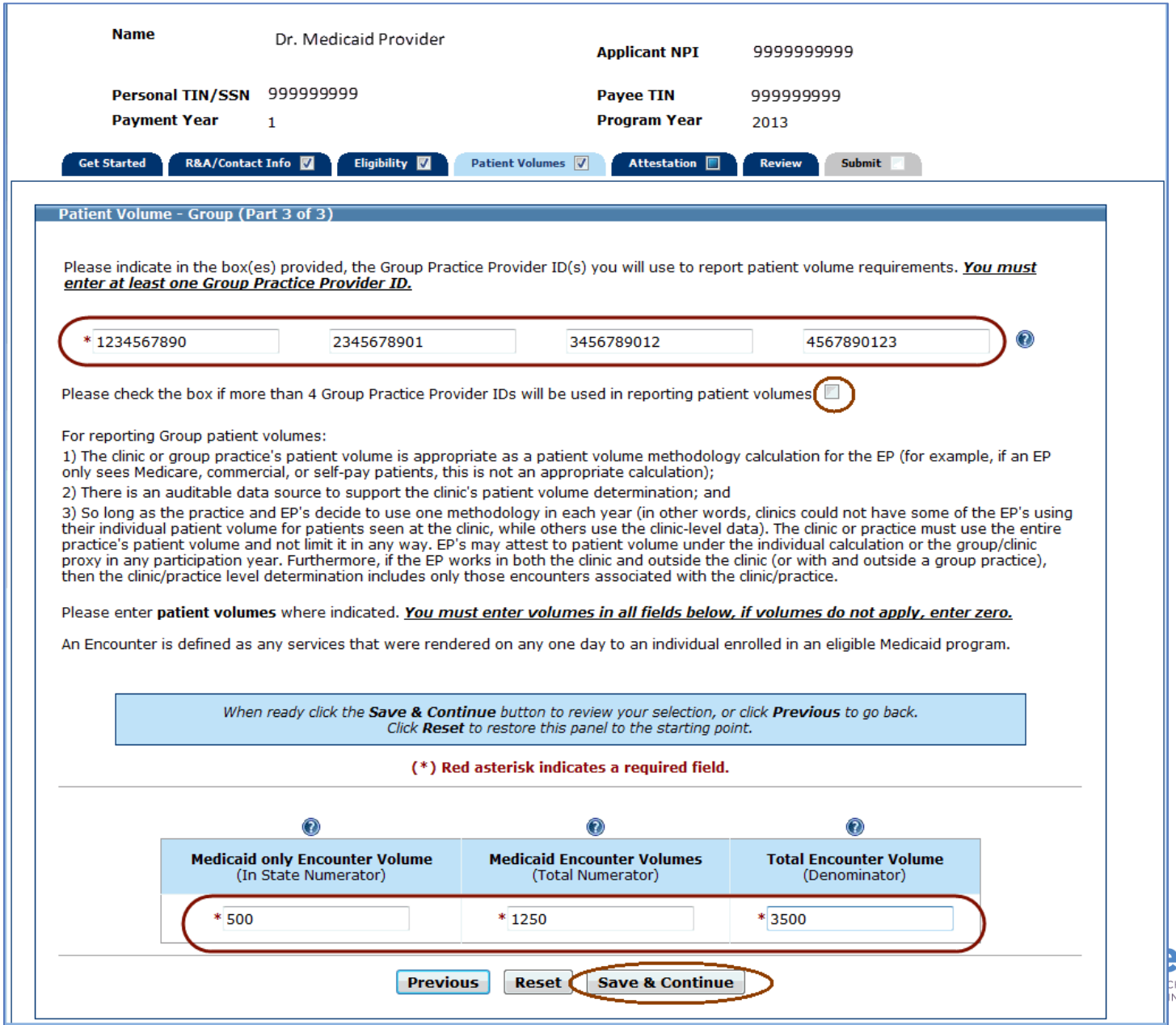
*When ready click the **Save & Continue** button to review your selection or click **Previous** to go back.*
*Click **Reset** to restore this panel to the starting point*

(*) Red asterisk indicates a required field.

Provider Id	Location Name	Address	Medicaid Only Encounter Volume *(In State Numerator)*	Medicaid Encounter Volume *(Total Numerator)*	Total Encounter Volume *(Denominator)*
999999999999	Dr. Office	123 First Street Anytown, PA 12345-1234	* 800	* 1000	* 3300
N/A	New Location	123 Main Street Anytown, AL 12345	* 400	* 500	* 1500

Previous | Reset | Save & Continue

MAPIR Data Entry – Group Proxy Patient Volume



PVT Supporting Documentation

- EPs are required to submit PVT supporting documentation **only upon request**
  - Supporting documentation is requested when the claims information extracted from the MassHealth Data Warehouse (MDW) shows a Medicaid PVT of less than 30% or whenever there is a variance of +/- 25% or greater between the PVT reported in the EP's MAPIR application and MDW data
- PVT documentation must be provided in a searchable format (i.e. Excel)
- PVT supporting documentation must contain all data elements listed in the Sample Patient Volume Templates on our website. Required data elements include:
  - Organization Name and NPI
  - Location(s)
  - 2 Unique Patient IDs (MRN and DOB)
  - Date of Service
  - Primary Payer and Total Amount Paid
  - Secondary Payer and Total Amount Paid
  - Claim Status and Denial Reason (if including Zero Pay and Denied claims)

Adopt, Implement, Upgrade

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Adopt, Implement, Upgrade

- In their first year of participation, EPs have the option to either:
  1. Adopt, Implement, Upgrade (AIU) to Certified EHR Technology (CEHRT)

     or
  2. Attest to Meaningful Use (MU)

- No matter which option an EP chooses, the first year payment remains the same ($21,250)

- EPs must utilize 2014 Edition (or higher) CEHRT

AIU Supporting Documentation

All EPs attesting to AIU are required to upload the following items:

1. Letter on letterhead signed by your CIO or IS Department Head. The letter must state the following:
   - List of providers(s)with NPI number(s)who are currently using or will be using the federally-certified EHR technology, and location(s) the federally-certified EHR technology will be used
   - EHR Vendor, product name, and version
   - CMS Certification Number and Certified Health IT Product List (CHPL) Product Number
2. One of the following: Signed copy of License Agreement, Proof of Purchase, or Signed Vendor Contract (must be signed by practice and vendor)
3. I**If requested**, Medicaid Patient Volume Threshold information and Hospital-Based Information

Please see the 2016 Supporting Documentation Guide for more information.

Sneak Peek: Meaningful Use

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Sneak Peek: Meaningful Use

- Program Year 2016:
  - Attest to Adopt, Implement, Upgrade (AIU)
    - Note: Program Year 2016 is the last year to initiate participation in the Medicaid EHR Incentive Program
- For Program Year 2017:
  - Attest to Modified Stage 2 Meaningful Use using a Meaningful Use (MU) reporting period of any continuous 90-day period within calendar year 2017
    - Note: The Patient Volume Threshold (PVT) reporting period is different from the MU reporting period; PVT is based on a 90-day period from either the previous calendar year or the 12-month period preceding attestation
- For Program Year 2018:
  - Attest to Stage 3 Meaningful Use using 2015 Edition CEHRT and an MU reporting period of the full calendar year
    - Note: There is an attestation grace period (usually January-March) following each Program Year to allow providers to attest using a full calendar year MU reporting period

Sneak Peek: Meaningful Use

- Meaningful Use Objectives – Modified Stage 2

1. Protect Patient Health Information (Security Risk Analysis)
2. Clinical Decision Support (CDS)
3. Computerized Provider Order Entry (CPOE)
4. Electronic Prescribing (eRx)
5. Health Information Exchange (HIE) – *previously known as "Summary of Care"*
6. Patient-Specific Education
7. Medication Reconciliation
8. Patient Electronic Access (Patient Portal)
9. Secure Electronic Messaging
10. Public Health Reporting
    a. Immunization Registry Reporting
    b. Syndromic Surveillance Reporting
    c. Specialized Registry Reporting

Common Issues

Common Issues - Registration

- Entering the wrong Payee NPI or Payee TIN when registering with CMS
  - For EPs who wish to reassign payment to their organization, you must enter the *organization's* NPI and TIN
  - Also be sure to select "Group Reassignment" (only select "My Billing TIN" if the EP wishes to assign payment to themselves)
- Failing to update CMS registration if there is a change in demographic info
- Sending Special Enrollment documents without a request from MeHI
  - The first step is to register the EP at the CMS R&A website
  - MeHI staff will contact you if a Special Enrollment is needed
- Other MAPIR access issues

Common Issues – Patient Volume Threshold

- Excluding legitimate MassHealth payers
- Confusion over what constitutes a group
- When using patient volume data from the 12 months prior to attestation, reporting period is a moving target
  - For example, if you attest in January 2017, you may use data from January 2016 onward. However, if you wait and attest in March 2017, January 2016 and February 2016 are out – only data from March 2016 onward may be used
- Data does not cover a 90-day period exactly (calendar quarters)
- Difficulty in extracting data from billing system
- Forgetting to apply the CHIP factor to the in-state numerator
- Difficulty understanding what numbers correspond to the PVT fields in MAPIR
- Patients not identified in two ways on supporting documentation
- Failing to remove duplicates

What's the Bottom Line?

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What's the Bottom Line?

Questions

Questions?

Contact Us

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Helpful Links

- CMS I&A
- CMS R&A
- MeHI Medicaid EHR Incentive Program page
- MeHI MU Toolkit for Eligible Professionals
- 2016 Supporting Documentation Guide
- Special Enrollment Checklist
- Medicaid 1115 Waiver Population Grid
- Calculating Patient Volume
- CHIP Factor Grid
- Group Proxy Guide
- MeHI EHR Toolkit
- MeHI EHR Tools and Resources
- Office of the National Coordinator for Health IT (ONC) Certified Health IT Product List (CHPL)