

# eHealth Provider Webinar

## August 13, 2013



## Medicaid EHR Incentive Program: How Eligible Professionals Successfully Participate

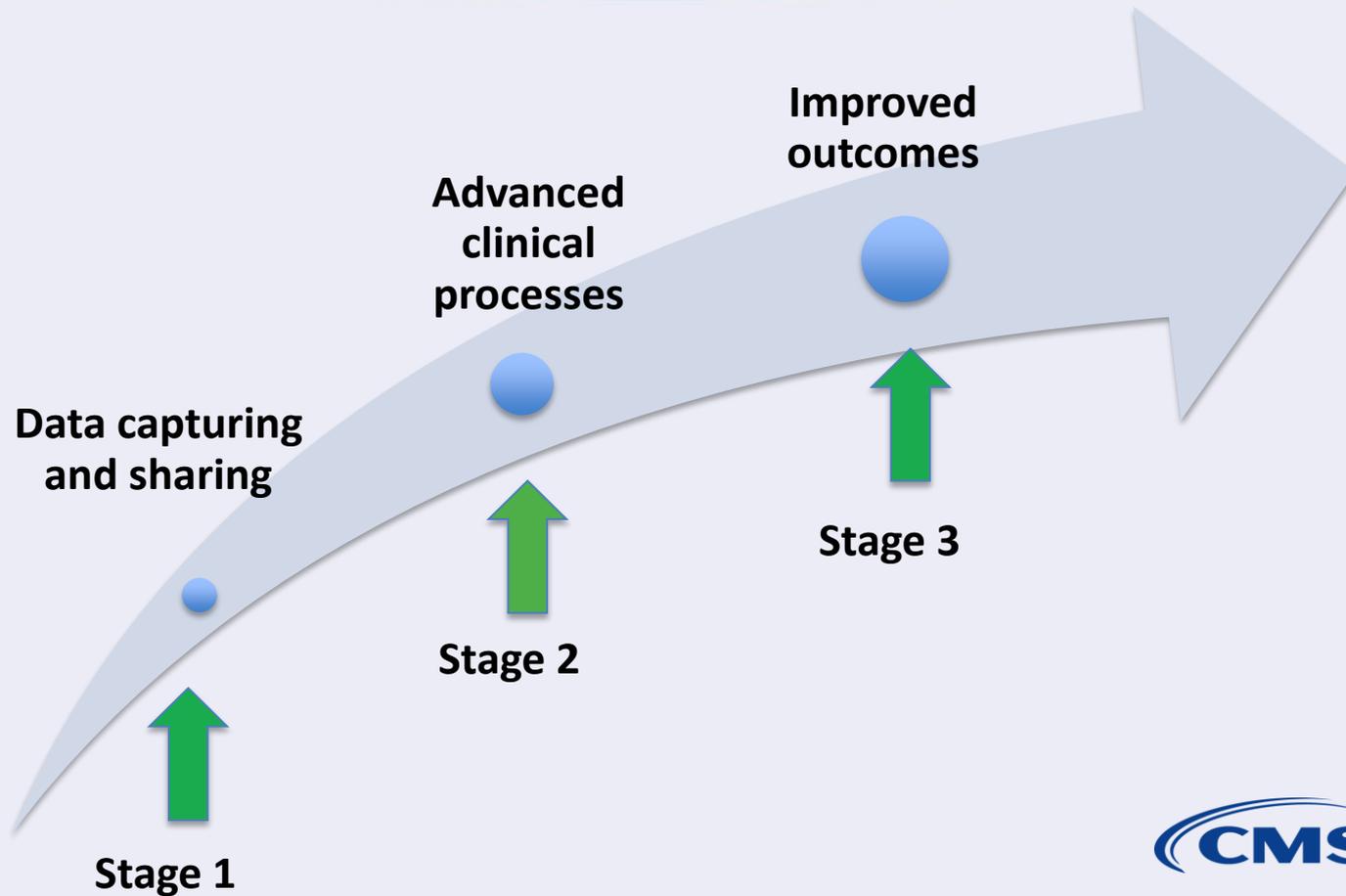
### Presentation Overview

1. Background
2. Eligibility & Patient Volume Calculations
3. Payments
4. Adopt, Implement, Upgrade and Meaningful Use
5. Clinical Quality Measures
6. Looking Ahead



# Background

# Stages of Meaningful Use



# Financial Oversight & Program Integrity

## States

- Required to seek recoupment of erroneous payments and have an appeals process

## CMS & States

- Must assure there is no duplication of payments to providers (between states and between states and Medicare)

## CMS/Medicaid

- Has oversight/auditing role including how states implement the EHR Incentive Program (90% FFP) and how they make correct payments to the right providers for the right criteria (100% FFP)

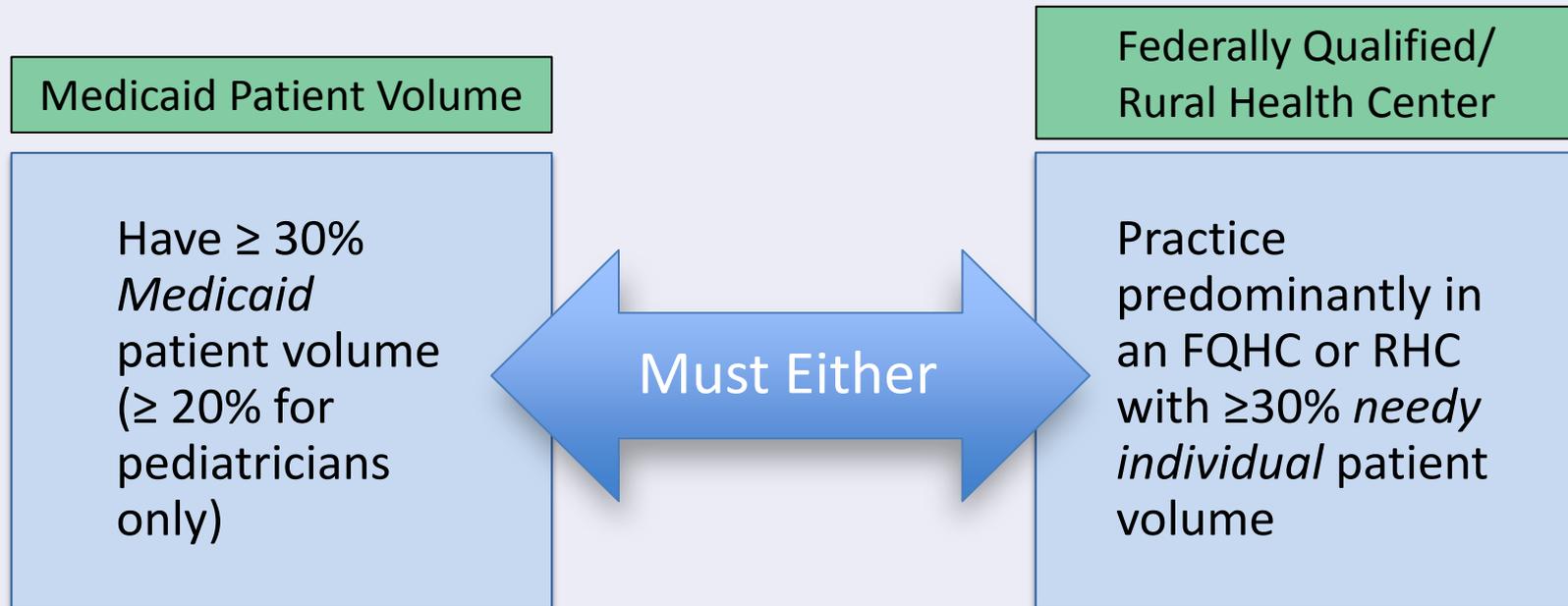
# Notable Differences Between the Medicare & Medicaid Programs



Category	Medicaid	Medicare
Participation	Voluntary for States to implement	Feds will implement
Payment Adjustments	No Medicaid payment adjustments	Medicare payment adjustments begin in 2015 for physicians who are not MUers
First Year Requirements	AIU option is for Medicaid first year only	Medicare must begin with MU in Y1
Total Payment	Max incentive for eligible professionals is \$63,750	Max incentive for eligible professionals is \$43,720
Meaningful Use	States can make adjustments to MU (common base definition)	MU will be common for Medicare
End of Program	Program sunsets in 2021; last year a provider may initiate program is 2016	Program sunsets in 2016; payment adjustments and market basket update begin in 2015
Who is Eligible	<ul style="list-style-type: none"> <li>•Physicians (primarily doctors of medicine and doctors of osteopathy)</li> <li>•Nurse practitioner</li> <li>•Certified nurse-midwife</li> <li>•Dentist</li> <li>•Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.</li> </ul>	<ul style="list-style-type: none"> <li>•Doctor of medicine or osteopathy</li> <li>•Doctor of dental surgery or dental medicine</li> <li>•Doctor of podiatry</li> <li>•Doctor of optometry</li> <li>•Chiropractor</li> </ul>

# Eligibility

# Eligibility: Professionals



- ✓ Licensed, credentialed
- ✓ No OIG exclusions, living
- ✓ Must not be hospital-based

# Medicaid Eligibility Expansion

**Patient Encounters:** The definition of what constitutes a Medicaid patient encounter has changed. The rule includes encounters for anyone enrolled in a Medicaid program (regardless of payment liability), including Medicaid expansion encounters (except stand-alone Title 21), and those with zero-pay claims.

- The rule also adds flexibility in the look-back period for overall patient volume



# Calculating Patient Volume

Two main options for calculating patient volume:

- Encounters
- Patient panel



Encounter defined for three scenarios:

- Fee-for-service
- Managed care and medical homes
- Hospitals

*State picks from these or proposes new method for review and approval. If CMS approves a method for one state, it may be considered an option for all states*

# Patient Encounters: Zero-Pay Claims

## Zero-pay claims include:

- Claim denied because the Medicaid beneficiary has exceeded the service limit
- Claim denied because the service wasn't covered under the State's Medicaid program
- Claim paid at \$0 because another payer's payment exceeded the Medicaid payment
- Claim denied because claim wasn't submitted timely

Such services can be included in provider's Medicaid patient volume calculation as long as the services were provided to a beneficiary who is enrolled in Medicaid

# Eligible Professional: Patient Volume Thresholds

Medicaid Eligible Professional Entity:	Minimum Patient Volume Threshold
Physicians	30%
- Pediatricians	20%*
Dentists	30%
CNMs	30%
PAs when practicing at an FQHC/RHC that is so led by a PA	30%
NPs	30%

**OR** the Medicaid eligible professional practices predominantly in an FQHC or RHC—30% needy individual patient volume threshold

*\*Pediatricians with a minimum of 20% patient volume, but less than 30% patient volume receive two-thirds of the maximum incentive payment*

# Eligibility: Practices Predominantly & Needy Individuals

- ❑ Eligible professional is also eligible when *practicing predominantly* in FQHC/RHC providing care to *needy individuals*
- ❑ *Practicing predominantly* is when Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) is the clinical location for over 50% of total encounters over a period of 6 months in the most recent calendar year/12-month period
- ❑ *Needy individuals* (specified in statute) include:
  - Medicaid or CHIP enrollees;
  - Patients furnished uncompensated care by the provider; or
  - Furnished services at either no cost or on a sliding scale

# Eligibility: Physician Assistants

- ❑ Physician assistants are eligible when working at an FQHC or RHC that is so led by a physician assistant
  
- ❑ “So led” is defined as:
  1. When a PA is the primary provider in a clinic;
  2. When a PA is a clinical or medical director at a clinical site of practice; **or**
  3. When a PA is an owner of an RHC

# CHIP: Patient Volume Calculation

## CHIP encounters to include in patient volume calculation:

- Under Stage 2 rule (applicable to all stages):
  - CHIP encounters for patients in Title 19 and Title 21 Medicaid expansion programs
- As before, encounters with patients in stand-alone CHIP programs cannot be included in Medicaid patient volume calculation

# Reporting Period for Patient Volume Calculation

## 90-day period for Medicaid patient volume calculation:

- Under Stage 2 rule, States also have option to allow providers to calculate Medicaid patient volume across 90-day period in last 12 months preceding provider's attestation
- Also applies to needy individual patient volume
- Applies to patient panel methodology, too
  - With at least one Medicaid encounter taking place in the 24 months prior to 90-day period (expanded from 12 months prior)

# Payments

# Payment Overview

- Timing, options
- Development of incentives for eligible professionals
- Payments to eligible professionals
- Registration
- State/federal systems for disbursement

# Payments: Eligible Professional Adoption Timeline

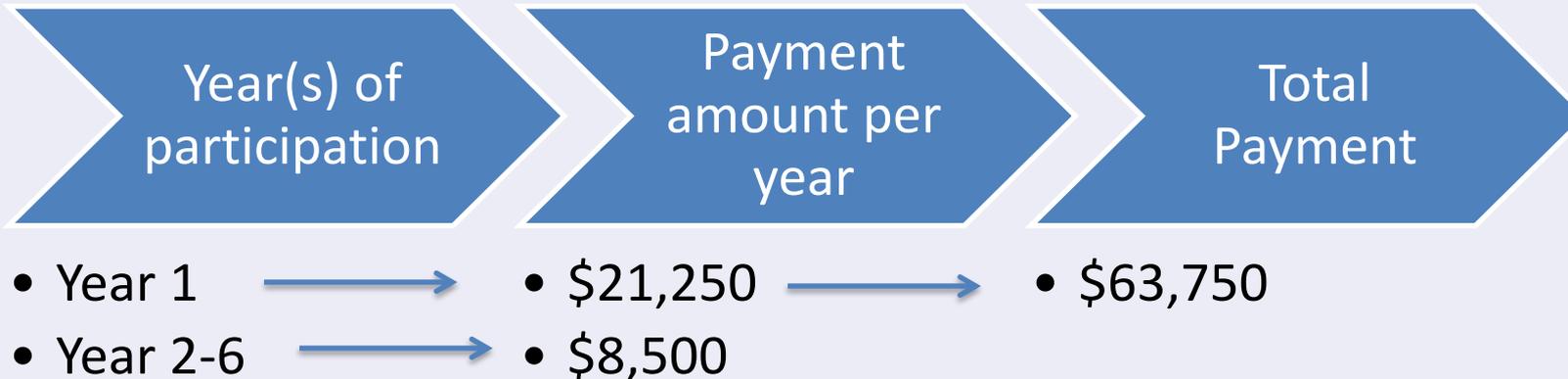
Annual Incentive Payment by Stage of Meaningful Use					
YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6
(AIU)	1	1	2	2	3
\$21,250	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500

- ✓ The maximum incentive amount is \$63,750. Payments are made over 6 years, and do not have to be consecutive
- ✓ 2016 is the last year that Medicaid eligible professionals can begin participation in the program

*A pediatrician under 30% Medicaid patient volume, but above 20%, would be eligible for 2/3 of these incentive amounts*

# Payments: Eligible Professional Incentives

## For most eligible professionals:



## For eligible pediatricians <30% PV:



# Payments: Registration

## States will:

- ✓ Connect to federal repository to continue provider registration at State
- ✓ Continue verification of eligibility
- ✓ Disburse payment after cross-checking for potential duplicative or inappropriate payments
- ✓ Disbursed payment to one eligible TIN
- ✓ Notify the national repository a payment was disbursed

# Adopt, Implement, Upgrade and Meaningful Use

# AIU & MU: Overview

- Adopt, implement, upgrade (AIU)
  - First participation year only
  - No EHR reporting period
- Meaningful use (MU)
  - Successive participation years; and
  - Early adopters
- Medicaid Providers' AIU/MU does not have to be over six consecutive years
- States may propose limited revisions to MU as it pertains to public health-related objectives to CMS for approval

## Under AIU



Medicaid eligible providers must be able to demonstrate a legal or financial commitment to a certified EHR (e.g., signed contract, purchase order, etc.)

Please consult with your State Medicaid Agencies for acceptable documentation to demonstrate AIU

Example: To demonstrate a legal commitment to a free, web-based certified EHR, an eligible provider could produce their signed, end-user license agreement

# AIU & MU: AIU

## Using Certified EHR Technology:

- ❑ Beginning in 2013, providers applying for AIU incentives only need to adopt, implement or upgrade to certified EHR technology sufficient to allow them to be meaningful users

For instance, starting in 2013:

- If a provider is exempt from an objective, his or her certified EHR technology does not need to have the functionality to perform that objective
  - A provider's certified EHR technology only needs to have the functionality to meet the menu measures that he or she chooses
- ❑ Providers who do not yet have certified EHR technology will need to purchase 2014 certified EHR technology to qualify for AIU or as a meaningful user
  - ❑ Providers who already have 2011 certified EHR technology will have to upgrade to 2014-certified EHR technology to qualify as a meaningful user

# MU: Applicability of Objectives and Measures

- ❑ Some MU objectives are not applicable to every provider's clinical practice, thus they would not have any eligible patients or actions for the measure denominator
- ❑ In these cases, the eligible professional would be excluded from having to meet that measure
  - E.g. Dentists who do not perform immunizations; Certified Nurse-Midwives do not e-prescribe
- ❑ Beginning 2014, qualifying for an exclusion from a menu objective will no longer reduce the number of menu objectives that an eligible professional

# Meaningful Use: Reporting Period

The *reporting period* is a continuous period where the provider successfully demonstrates meaningful use of certified EHR technology

- There is **no reporting period** for AIU
- There is a **90-day reporting period** in the provider's first year demonstrating MU under Stage 1
- There is a **90-day reporting period** in 2014, regardless of Stage 1 or 2
- Providers must demonstrate MU for **full annual period** for all other Stage 1 and Stage 2 years

# Meaningful Use: States' Flexibility to Revise MU

States can seek CMS prior approval to require 4 MU objectives be core for their Medicaid providers:

- Generate lists of patients by specific conditions for quality improvement, reduction of disparities, research or outreach (can specify particular conditions)
- Reporting to immunization registries, reportable lab results and syndromic surveillance (can specify for their providers how to test the data submission and to which specific destination)

# Meaningful Use: Changes from Stage 1 to Stage 2

## Stage 1

### Eligible Professionals

15 core objectives

5 of 10 menu objectives

20 total objectives



## Stage 2

### Eligible Professionals

17 core objectives

3 of 6 menu objectives

20 total objectives

# Changes to Meaningful Use

## Changes

- **Menu Objective Exclusion** – While you can continue to claim exclusions if applicable for menu objectives, starting in 2014 these exclusions will no longer count towards the number of menu objectives needed

## No Changes

- **Half of Outpatient Encounters** – at least 50% of eligible professional outpatient encounters must occur at locations equipped with certified EHR technology
- **Measure compliance = objective compliance**
- **Denominators based on outpatient locations equipped with CEHRT** and include all such encounters or only those for patients whose records are in CEHRT depending on the measure

# Changes to Stage 1: CPOE

## Current Stage 1 Measure

**Denominator=**

Unique patient with  
at least one  
medication in their  
medication list



## New Stage 1 Option

**Denominator=**

Number of orders  
during the EHR  
Reporting Period

**This optional CPOE denominator is available in 2013 and beyond for Stage 1**

# Changes to Stage 1: eRx

## Current Stage 1 Exclusion

**Exclusion=**

Any EP who writes fewer than 100 prescriptions during the EHR reporting period.



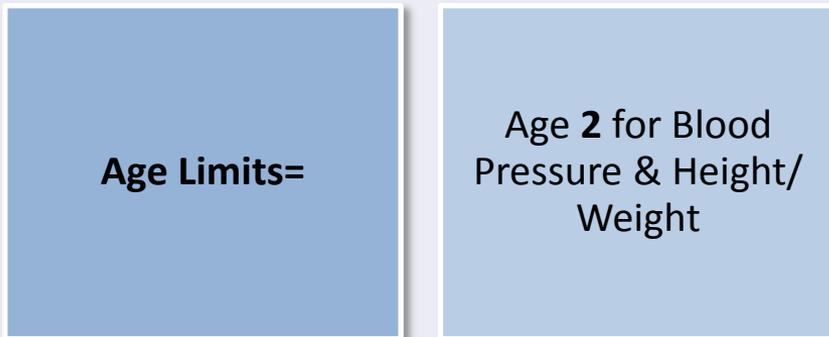
## Additional Exclusion

**Exclusion =**

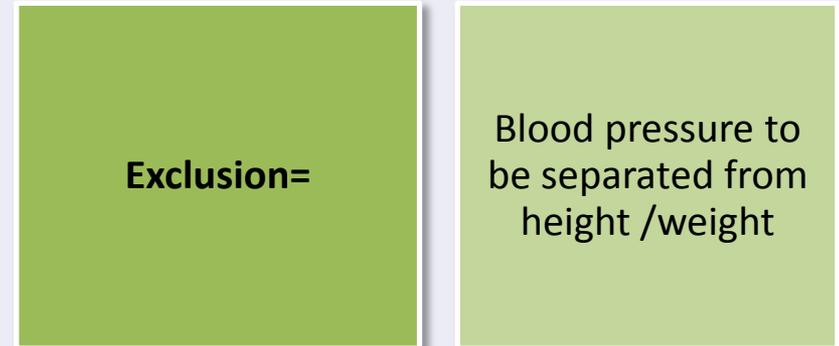
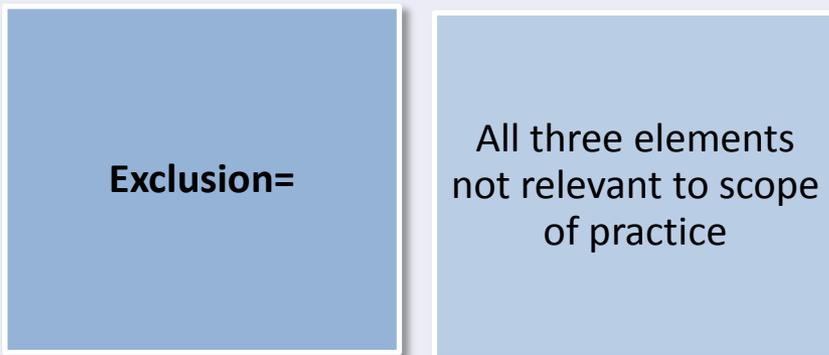
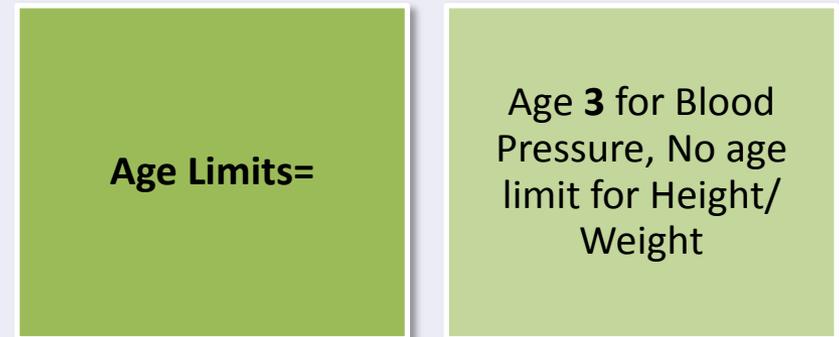
Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location

# Changes to Stage 1: Vital Signs

## Current Stage 1 Measure



## New Stage 1 Measure



The vital signs changes are optional in 2013, but required starting in 2014

# Changes to Stage 1: Testing of HIE

## Current Stage 1 Measure

One test of electronic transmission of key clinical information



## Stage 1 Measure Removed

Requirement removed effective 2013

The removal of this measure is effective starting in 2013

# Changes to Stage 1: E-Copy & Online Access

## Current Stage 1 Objective

**Objective=**

Provide patients with e-copy of health information upon request

Provide electronic access to health information



## New Stage 1 Objective

**Objective=**

Provide patients the ability to view online, download and transmit their health information

- The measure of the new objective is 50% of patients are provided access to their information; there is no requirement that 5% of patients do access their information for Stage 1.
- **The change in objective takes effect in 2014 to coincide with the 2014 certification and standards criteria**

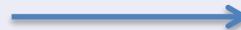
# Changes to Stage 1: Public Health Objectives

## Current Stage 1 Objectives

Immunizations

Reportable Labs

Syndromic  
Surveillance



## New Stage 1 Addition

Addition of “except  
where prohibited”  
to all three  
objectives

**This addition is for clarity purposes and does not  
change the Stage 1 measure for these objectives.**

# New Requirements for Stage 2

## Eligible Professionals

- Secure Messaging
- Family Health History
- Imaging Results
- Registry Reporting
- Progress Notes

## Hospital

- Online Patient Information
- Family Health History
- Imaging Results
- Registry Reporting
- Progress Notes
- E-Prescribing
- eMAR
- Electronic lab results

# Updated Requirements for Stage 2

Eligible Professionals	Hospital
<ul style="list-style-type: none"><li>• Lab Results</li><li>• Patient Lists</li><li>• Patient Education</li><li>• Summary of Care Records</li><li>• Medication Reconciliation</li><li>• Immunizations</li><li>• Patient Reminders</li><li>• Online Patient Information</li></ul>	<ul style="list-style-type: none"><li>• Lab Results</li><li>• Patient Lists</li><li>• Patient Education</li><li>• Summary of Care Records</li><li>• Medication Reconciliation</li><li>• Immunizations</li><li>• Public health lab results</li><li>• Syndromic surveillance</li></ul>

# 2014 Changes

- 1. EHRs Meeting ONC 2014 Standards** – starting in 2014, all EHR Incentive Programs participants will have to adopt certified EHR technology that meets ONC's Standards & Certification Criteria 2014 Final Rule
- 2. Reporting Period Reduced to Three Months** – to allow providers time to adopt 2014 certified EHR technology and prepare for Stage 2, all participants will have a three-month reporting period in 2014

# Clinical Quality Measures

# CQM Reporting in 2013

CQM reporting will remain the same through 2013:

- ❑ 44 eligible professional CQMs
  - 3 core or alternate core (if reporting zeroes in the core) plus 3 additional CQMs
  - Report minimum of 6 CQMs (up to 9 CQMs if any core CQMs were zeroes)

Medicaid providers submit CQMs according to their state-based submission requirements

# CQM Specifications in 2013

- ❑ Electronic specifications for the CQMs for reporting in 2013 **will not be updated.**
- ❑ Flexibility in implementing CEHRT certified to the 2014 Edition certification criteria in 2013
  - For eligible professionals, this includes 32 of the 44 CQMs finalized in the Stage 1 final rule
    - Excludes: NQF 0013, NQF 0027, NQF 0084
    - Since NQF 0013 is a core CQM in the Stage 1 final rule, an alternate core CQM must be reported instead since it will not be certified based on 2014 Edition certification criteria

# How do CQMs relate to the CMS EHR Incentive Programs?

All providers are required to report on CQMs in order to demonstrate meaningful use

Starting in 2014, although CQMs will no longer be a core objective of the EHR Incentive Programs, they must be submitted to successfully demonstrate meaningful use

# Changes to Eligible Professionals CQMs Reporting

Prior to  
2014

- Report 6 out of 44 CQMs
  - 3 core or alt. core
  - 3 menu

Beginning in  
2014

- Report 9 out of 64 CQMs
- Selected CQMs must cover at least 3 of the 6 NQS domains
- Recommended core CQMs:
  - 9 for adult populations
  - 9 for pediatric populations

# CQM Selection and HHS Priorities

All providers must select CQMs from at least 3 of the 6 HHS National Quality Strategy domains

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



# CQMs Beginning in 2014

- ❑ A complete list of CQMs required for reporting beginning in 2014 and their associated National Quality Strategy domains is posted on the CMS EHR Incentive Programs website

[www.cms.gov/EHRIncentivePrograms](http://www.cms.gov/EHRIncentivePrograms)

- ❑ CMS also posted a recommended core set of CQMs for eligible professionals that focus on high-priority health conditions and best-practices for care delivery on the site

- 9 for adult populations
- 9 for pediatric populations



The screenshot shows the CMS.gov website page for EHR Incentive Programs. The page features a navigation menu with categories like Medicare, Medicaid/CHIP, and Innovation Center. The main content area is titled "EHR Incentive Programs" and includes a "Medicare Deadline Get Paid for 2012" countdown timer showing 43 days remaining. Below the timer, there is a section titled "The Official Web Site for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs" with a list of links for registration, attestation, and program details.

# Recommended Core CQMs for Eligible Professionals

CMS selected the recommended core CQMs based on analysis of several factors:

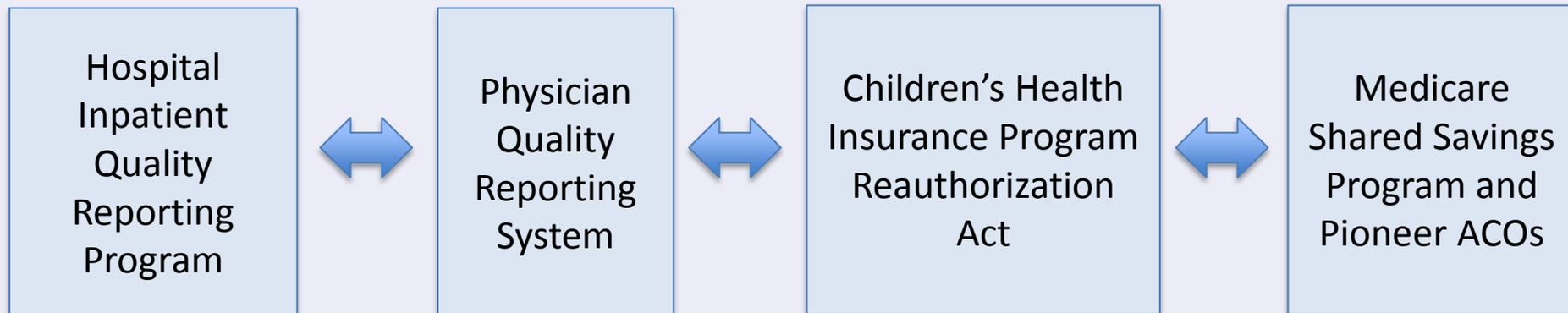
- Conditions that contribute to the morbidity and mortality of the most Medicare and Medicaid beneficiaries
- Conditions that represent national public/ population health priorities
- Conditions that are common to health disparities

# Recommended Core CQMs for Eligible Professionals (cont'd)

- Conditions that disproportionately drive healthcare costs and could improve with better quality measurement
- Measures that would enable CMS, States, and the provider community to measure quality of care in new dimensions, with a stronger focus on parsimonious measurement
- Measures that include patient and/or caregiver engagement

# Aligning CQMs Across Programs

- ❑ CMS's commitment to alignment includes finalizing the **same CQMs used in multiple quality reporting programs** for reporting beginning in 2014
- ❑ Other programs include Hospital IQR Program, PQRS, CHIPRA, and Medicare SSP and Pioneer ACOs



# Looking Ahead

# Other Federal Efforts in HIT

Department	Initiative
HHS, ONC	Grants under Recovery Act, HITECH section 3012 establishing Regional Extension Centers (RECs)
HHS, ONC	Grants under Recovery Act, HITECH section 3013 for State Health Information Exchange Cooperative Agreement Program
HHS, CMS & AHRQ	Pediatric and adult core measure sets through CHIPRA and ACA
HHS, CMS & AHRQ	Announcement of grant solicitation for pediatric EHR format, as specified from CHIPRA section 403
HHS, AHRQ	National Resource Center for HIT
HHS, IHS	Resource & Patient Management System (RPMS) EHR platform
FCC, USDA, Commerce	Rural Broadband Access Grants and coordination (National Rural Broadband Plan/ FCC) under Recovery Act, Title VI
VA	Veterans Health Information Systems and Technology Architecture (VistA) open-source EHR

# What's Next?

- ✓ CMS Outreach around Stage 2 final
- ✓ Continued State development of annual IAPDs, updated SMHPs, RFPs, and contracts
- ✓ States implementing audit strategies
- ✓ States collecting MU attestations and paying incentives for MU (rather than just AIU)
- ✓ States requesting 90% FFP to contribute to HIE development; exploring other approaches to fund HIE
- ✓ CMS/State joint workgroup for electronic CQM reporting
- ✓ Stage 3 regulation expected in 2014; providers to begin Stage 3 in 2016

# Stage 2 Resources

## CMS Stage 2 Webpage:

- ❑ [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage\\_2.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html)

## Tipsheets:

- Stage 2 Overview
- 2014 Clinical Quality Measures
- Payment Adjustments & Hardship Exceptions (Eligible Professionals & Hospitals)
- Stage 1 Changes
- Stage 1 vs. Stage 2 Tables (Eligible Professionals & Hospitals)

## 2014 CQM Webpage:

- ❑ <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014ClinicalQualityMeasures.html>

# Questions?



## Thank you!

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