Texas Medicaid
Electronic Health Record (EHR)
Incentive Program:
*Federally Qualified Health Centers (FQHCs)*

Julia Alejandre, Medicaid / CHIP Health IT
Jason Phipps, Medicaid / CHIP Health IT

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EHR Incentive Program Overview

• Payment is an incentive for using certified electronic health records (EHR) in a meaningful way.
  • Not a reimbursement and not intended to penalize early adopters.
• First year payment can be received in 2011 through 2016.
• Final payment can be received up to 2021.
• Eligible professionals (EP) must meet certain criteria:
  • Eligible provider type.
  • Medicaid patient volume thresholds.
  • Meaningful use (MU) of certified EHRs for at least 50 percent of patient encounters during the reporting period.
Eligibility for Participation

- Eligible professionals (EPs) include:
  - Physicians
  - Dentists
  - Nurse Practitioners
  - Certified Nurse Midwives
  - Physician Assistants (PA) in federal qualified health centers (FQHC) and rural health clinics (RHC) led by a PA

- Must adopt, implement, or upgrade to certified EHR technology in the first year of participation, and demonstrate meaningful use in up to 5 subsequent participation years.

- Incentives are based on the individual, not the clinic.

- Hospital-based physicians are not eligible for incentives (unless an FQHC or RHC provider).
Dentists are eligible for the Texas Medicaid EHR Incentive Program.

- They must meet program criteria (patient volume thresholds, meaningful use, and certified EHR system)

For AIU:

- Attest to AIU if you have adopted, implemented, or upgraded to a certified EHR

For Meaningful Use Stage 1:

- Additional requirements must be met (discussed later in the presentation)
## Eligibility: Patient Volume

<table>
<thead>
<tr>
<th>Provider</th>
<th>Minimum Medicaid Patient Volume Threshold</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>30%</td>
<td>if the Medicaid EP <em>practices predominantly</em> in a Federal Qualified Health Center (FQHC) — 30% <em>needy individual</em> patient volume threshold</td>
</tr>
<tr>
<td>- Pediatrists</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Certified Nurse Midwives</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Physician Assistants (PAs) when practicing at an FQHC/RHC that is led by a PA</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospitals (includes critical access hospitals)</td>
<td>10%</td>
<td>Not an option for hospitals</td>
</tr>
<tr>
<td>Children's Hospitals</td>
<td>No requirement</td>
<td></td>
</tr>
</tbody>
</table>
### Incentive Payments for Eligible Professionals

<table>
<thead>
<tr>
<th>Payment Year by EP Type</th>
<th>Incentive Amount</th>
<th>Maximum cumulative incentive over 6 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 for <strong>most EPs</strong></td>
<td>$21,250</td>
<td>$63,750</td>
</tr>
<tr>
<td><strong>Years 2-6 for most EPs</strong></td>
<td>$8,500</td>
<td></td>
</tr>
<tr>
<td><strong>Year 1 for pediatricians with a minimum 20% patient volume, but less than 30% patient volume, Medicaid patients</strong></td>
<td>$14,167</td>
<td>$42,500</td>
</tr>
<tr>
<td><strong>Years 2-6 for pediatricians with a minimum 20% patient volume, but less than 30% patient volume, Medicaid patients</strong></td>
<td>$5,667</td>
<td></td>
</tr>
</tbody>
</table>
Skipping Years in the Program

- Skipping years is permissible in the Medicaid incentive program.
  - You may skip one or more years.
  - For example, a provider might enter the program in 2011 with AIU and then skip two years. They would re-enter the program in 2014 with Stage 1 (other providers might be in Stage 2 at that point).

- Keep in mind that the program ends in 2021, so if you start in 2016 (the last year you can begin the program), you would need to participate in consecutive years if you want all 6 payments. Skipping is still allowed, but you wouldn’t receive all 6 payments.
There are two reporting periods that apply for the Medicaid EHR Incentive Program:

• For patient volume, an eligible professional (EP) should use any continuous, representative 90-day period in the prior calendar year.

• For demonstrating meaningful use, EPs should use the EHR reporting period associated with that payment year:
  - First payment year that an EP is demonstrating meaningful use, the reporting period is a continuous 90-day period within the calendar year.
  - Subsequent years, the period is the full calendar year.
FQHC

Specific Requirements

- **Practices Predominantly**: An EP needs to work in an FQHC for over 50 percent of total encounters for a six-month period in the most recent calendar year.

- Physician Assistants (PA) at an FQHC "so led" by a PA is defined as when a PA is:
  - the primary provider in the clinic; or
  - a clinical or medical director at the clinic.

- If the FQHC is led by a PA, all PAs at that clinic may qualify for the EHR incentive.
Needy Patient Volume Calculation for FQHCs

The methodology for calculating patient volume for FQHCs is the “Needy Patient” volume calculation. It is based on patient encounters over three full consecutive months that includes:

- Medicaid clients.
- CHIP clients.
- Client services provided as uncompensated care.
- Client services provided at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay.

\[
\frac{\text{Medicaid + CHIP + Other Allowable Patient Encounters}}{\text{Total Patient Encounters}} \times 100
\]
National Level Activities
Steps to Participate: National Level

1. Determine which incentive program – Medicare or Medicaid.

2. Collect required information:
   - National Provider Identifier (NPI). To confirm that you have an active NPI go to https://nppes.cms.hhs.gov/NPPES/.
   - Tax Identification Number (TIN).
   - CMS EHR Certification Number (optional for CMS registration; required at Texas incentive program portal).

3. Register at CMS. Go to www.cms.gov/EHRIncentivePrograms, then click on “Registration”.
   - Payment assignment to:
     o Clinic: Select Employer Identification Number (EIN) as the payee TIN type, and then enter the organization’s TIN.
     o Self: Select SSN as payee TIN type. Ensure that your SSN is on file with TMHP and linked to your TPI.
ONC Certified Health IT Product List

http://onc-chpl.force.com/ehrcert

The Certified HIT Product List (CHPL) provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC). Each Complete EHR and EHR Module listed below has been certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to ONC. Only the product versions that are included on the CHPL are certified under the ONC Temporary Certification Program. Please note that the CHPL is a “snapshot” of the current list of certified products. The CHPL is updated frequently as newly certified products are reported to ONC.

Please send suggestions and comments regarding the Certified Health IT Product List (CHPL) to ONC.certification@hhs.gov, with “CHPL” in the subject line.

USING THE CHPL

To determine if an EHR product or a bundle of EHR products meets meaningful use requirements, or to request a CMS reporting ID:

1. Select your practice type using the two buttons below
2. Search for EHR Products and add them to your cart
3. Check your cart to see if the product or products meet 100% of the required criteria
4. Request a CMS EHR Certification ID using the button on the Certification Cart page

Search Ambulatory Products

Search Inpatient Products

If you do not wish to request a CMS EHR Certification ID, and only want to view a complete list of Certified EHR products that includes both Ambulatory and Inpatient products, please use the ‘View list of all Certified Products’ button.

View List of all Certified Products
Registration

Registration for the Medicare EHR Incentive Program is now open. Visit the Attestation page for more information.

Registration for the Medicare and Medicaid EHR Incentive Programs is now open. We encourage providers to register for the Medicare and/or Medicaid EHR Incentive Program(s) as soon as possible to avoid payment delays. Please note that not all states have launched a Medicaid EHR Incentive Program yet, and you should check your state’s status.

You can register before you have a certified EHR. Register even if you do not have an enrollment record in PECOS (which is required for all hospitals and Medicare eligible professionals).

Although the Medicaid EHR Incentive Programs opened in January 2011, some states are not ready to participate. Information on when registration will be available for Medicaid EHR Incentive Programs in specific states is posted at Medicaid State Information. Eligible Professionals will not be able to register for a Medicaid EHR Incentive Program until their state’s program has launched and that state’s site has opened.

Note for hospitals that register for "Both Medicare & Medicaid": You may pre-register for the Medicaid EHR Incentive Program before your state launches, but you will be placed in a “pending state validation” status for eligibility in the Medicaid Incentive Program.

Register for the Medicare and/or Medicaid EHR Incentive Programs

Below are step-by-step guides to help you register for EHR Incentive Programs. Choose the guide that fits your needs:

- Registration User Guide for Eligible Professionals – Medicare Electronic Health Record (EHR) Incentive Program.
- Registration User Guide for Eligible Professionals – Medicaid Electronic Health Record (EHR) Incentive Program.
- Registration User Guide for Eligible Hospitals – Medicare and Medicaid Electronic Health Record (EHR) Incentive Program.
Welcome to the Medicare & Medicaid EHR Incentive Program Registration & Attestation System

About This Site
The Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs will provide incentive payments to eligible professionals and eligible hospitals as they demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology. These incentive programs are designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation to improve the quality, safety, and efficiency of patient health care.

This web system is for the Medicare and Medicaid EHR Incentive Programs. Those wanting to take part in the program will use this system to register and participate in the program.

Overview of Eligible Professional (EP) and Eligible Hospital Types

Eligible Professionals (EPs)
- Medicare EPs include:
  - Doctors of Medicine or Osteopathy
  - Doctors of Dental Surgery or Dental Medicine
  - Doctors of Podiatric Medicine
  - Doctors of Optometry
  - Chiropractors

- Medicaid EPs include:
  - Physicians
  - Nurse Practitioners
  - Certified Nurse - Midwife
  - Dentists
  - Physicians Assistants who practice in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) that is led by a Physician Assistant.

Medicare Advantage Organization (MAO) EPs - A qualifying MAO may receive an incentive payment for their

Additional Resources: For User Guides to Registration and Attestation that will show you how to complete these modules, a list of EHR technology that is certified for this program, specification sheets with additional information on each Meaningful Use objective, and other general resources that will help you complete registration and attestation, please visit CMS website.

Eligible to Participate - There are two types of groups who can participate in the programs. For detailed information, visit CMS website.
Texas Enrollment and Attestation
Steps to Participate: Texas

1. Enroll in Texas Medicaid – limited or full enrollment.
2. Set up or confirm TMHP account, log-in, and PIN number.
3. Obtain CMS EHR Certification number for the certified EHR.
4. Obtain documentation for your certified EHR (contract, subscription, or purchase order, for example).
5. Determine patient volume.
6. Verify payee assignment. If you want to change payee assignment, this must be done at the CMS level.
7. Go to the Texas Medicaid EHR Incentive Program portal and enroll:
   • Go to the TMHP provider website and log in.
   • Scroll to “Manage Provider Account”
   • Click on the “Texas Medicaid EHR Incentive Program” link.
8. Attest each year to continue to receive payments.
Providers NOT Currently Enrolled in Texas Medicaid

• If you are an individual provider practicing in an FQHC, and you will be assigning the incentive payment to your clinic, please use the limited enrollment application: [http://www.tmhp.com/Provider_Forms/Health%20IT/EHR%20Deeming%20Form.pdf](http://www.tmhp.com/Provider_Forms/Health%20IT/EHR%20Deeming%20Form.pdf).
  • A TPI will be issued and a notice submitted to the billing provider or administrator.

• If you are retaining the payment, full enrollment in Medicaid is required. Use this form: [http://www.tmhp.com/Provider_Forms/Provider%20Enrollment/Texas%20Medicaid%20Provider%20Enrollment%20Application.pdf](http://www.tmhp.com/Provider_Forms/Provider%20Enrollment/Texas%20Medicaid%20Provider%20Enrollment%20Application.pdf).
Providers with a TPI

• If your TPI is current and represents your current work location, no action is needed.
• You will need an active TPI to participate in the program. TPIs from a previous employer will still work in the program – just update your work address with TMHP.
• If you have questions about your TPI, contact 1-800-925-9126 option 4.
Recent Questions

• New providers can participate using clinic volume if they meet program criteria and they have at least one filed or billed service or encounter at any time during the calendar year of the patient volume reporting period up until the day of attestation.

  • **Example:** If you began work on July 18, 2012 and attest the next day, you only need one (or more) patient encounter(s) to participate, which can come from the current or previous clinic / group anytime from January 1, 2011 to July 19, 2012.

• Eligible professionals (EPs) must still be working in order to attest (if someone has retired or quit, they are not eligible).

• The program is annual – EPs can receive at most one payment per year.
Who Do I Call For Help Or Additional Information?

- Review the e-learning tool at [www.texasehrincentives.com](http://www.texasehrincentives.com).
- Providers can call toll free at 800-925-9126, option 4. This option will take you directly to Help Desk employees that specialize in this program.
- Sign up for e-mail updates by visiting the TMHP website at [www.tmhp.com/Pages/HealthIT/HIT_Home.aspx](http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx) and click on “Sign up for email updates” in the “Want To Know More?” box.
- Submit questions by visiting the TMHP website; go to “Contact Us” at [www.tmhp.com/Pages/Medicaid/medicaid_contacts.aspx](http://www.tmhp.com/Pages/Medicaid/medicaid_contacts.aspx).
Medicaid EHR Incentive Program

Questions?
Stage 1 and 2 Meaningful Use
Stage 1 Meaningful Use

- Attestation began April 1, 2012 because Jan 1 – March 31 was the earliest 90-day Meaningful Use reporting period.
- Volume calculation is determined from the previous calendar year.
- Must attest to AIU before attesting to Stage 1.
- One attestation per year.
- 15 core (required) measures; pick 5 more from “menu set” of 10 measures.
- One of the core measures contains the CQM reporting.
Clinical Quality Measures (CQMs)

- 44 measures published by CMS.
- Must report 6 measures.
- 3 core (required) measures (or alternate core) + 3 electives.
- Core 1 – blood pressure recorded.
- Core 2 – tobacco use assessment and intervention.
- Core 3 – adult weight screening and follow-up.
Stage 1 Core Measures

- The following measures are automatically achieved by using a certified EHR or are simpler to implement:
  - Recording demographics, vitals, medications, and medication orders electronically.
  - Maintain a problem list.
  - E-Prescribing.
  - Drug interaction checks.
  - Ability to supply patients with an electronic copy of their health record.
  - Provide clinical summaries at end of encounter.
  - Implement one clinical decision support (CDS) rule.
Stage 1 Core Measures – CDS Rule

- Adult / pediatric immunization schedules.
- Cervical cancer screenings.
- Each EHR will have its own list of available CDS rules.
Stage 1 Core Measures – The Harder Ones

- Allergy lists.
- Smoking status.
- CMS Clinical Quality Measures (CQMs).
- Privacy and Security – for example, security risk analysis.
- Exchange Key Clinical Data – generate a Continuity of Care Document (CCD) and transmit it via secure email (this measure may be removed in 2013).
• Drug formulary checks.
• Medication reconciliation.
• Patient lists – for example, by condition (ICD code).
• Patient portal for self-service record retrieval.
• Provider portal for manual HIE.
Stage 1 Menu Set

- Send patient reminders to > 20% of patients.
- Provide patient-specific education to > 10%.
- Public health measure – immunization data test.
- Public health measure – lab data test.
- Public health measure – syndromic surveillance.
Stage 1 Exclusions

- Available for both core and menu sets.
- It is up to the provider to decide which exclusions are applicable to their practice.

CMS has issued the following statement about exclusions:

“We encourage EPs to select menu objectives that are relevant to their scope of practice, and claim an exclusion for a menu objective only in cases where there are no remaining menu objectives for which they qualify or if there are no remaining menu objectives that are relevant to their scope of practice. For example, we hope that EPs will report on 5 measures, if there are 5 measures that are relevant to their scope of practice and for which they can report data, even if they qualify for exclusions in the other objectives.”
Stage 1 Exclusions

• Immunization reporting - “EP who administers no immunizations during the reporting period or where no immunization registry has the capacity to receive the information electronically”.

• Relevant vs. Uncommon – the vitals measure example.

• It is uncommon to check BP in a dentist’s office. However, BP is relevant. So dentists should not exclude themselves from this measure.
Stage 1 Exclusions

- CMS and ADA are collaborating on guidance for dentists.
PROPOSED Big Changes to Stage 1

- Final rule for stage 2 may contain modifications.
- Blood pressure can be separated from weight and height vitals requirements where this makes sense (like dentistry).
- The Health Information Exchange (HIE) requirement is deleted as of 2013.
- Look for these when the final rule is published in late summer 2012.
PROPOSED Stage 2 Meaningful Use

• NPRM published in March 2012.
• Comments taken until May.
• Final Rule to be published at end of summer.
• Will contain stage 2 requirements, changes to stage 1, new CQMs.
June 2011
HITPC
Recommendations
on Stage 2

Summer 2012
Stage 2 Final Rule

Feb 2012
Stage 2 Proposed
Rule

Oct 1, 2013/ Jan 1, 2014
Proposed Stage 2 Start
Dates
PROPOSED Stage 2 Meaningful Use

- Structure of requirements has changed.
- 17 core measures (required).
- 5 “menu set” measures (pick 3).
- No more exclusions for menu set measures.
- Most stage 1 measures still present, but with increased compliance percentage.
PROPOSED Stage 2 Meaningful Use - Core

• Smoking status recorded – 50% to 80%.
• Record vital signs – 50% to 80%.
• Receive electronic lab results – 40% to 55%.
• E-Prescribing – 40% to 50%.

• Computerized Physician Order Entry (CPOE) goes from 30% to 65% AND will include labs and radiology.
PROPOSED Stage 2
Meaningful Use - Core

- Increase to 5 CDS rule implementations.
- Patient reminders now required on core set.
- Provide online access to health info (patient portal) with > 10% of patients accessing it.
- Patient education moved to core set.
- More than 10% of patients sent a secure message to a provider.
- > 10% of referrals and transitions of care have summary of care sent electronically.
PROPOSED Stage 2 Meaningful Use - Core

- Successful, ongoing transmission of immunization data.
- Conduct security analysis and incorporate into risk management process.
PROPOSED Stage 2
Meaningful Use – Menu Set

- Syndromic surveillance reporting (not just a test).
- Ability to access imaging results, > 40% of results.
- Reporting to cancer registry.
- Reporting to a second registry of choice.
- Record family history.
PROPOSED Stage 2 CQM Reporting

• Not an MU measure anymore, but a separate part of attestation, like volume.
• Options- 12 provider-selected CQMs or participation in PQRS, formerly PQRI (electronic reporting capability for PQRS is required of EHR vendors by 2014).
• 125 proposed CQMs.
• Starting in stage 2, CQM reporting period is full calendar year.
Stage 1 and 2 Meaningful Use

Questions?