The Massachusetts Medicaid EHR Incentive Payment Program

Regional Meeting Series
Presentation Overview

• How We Got Here & Massachusetts eHealth Institute (MeHI) Overview
  • Regional Extension Center (REC) Update
  • Statewide Health Information Exchange Update

• Massachusetts Medicaid Electronic Health Record (EHR) Program Goals & Objectives

• Eligible Professional (EP) Participation Requirements
  • Adopt, Implement, or Upgrade (A/I/U) Overview
  • Stage 1 Meaningful Use (MU) Overview

• Staying Connected: Important Health Information Technology Updates
  • Changes to Stage 1 Meaningful Use
  • Stage 2 Meaningful Use Requirements
  • Massachusetts Immunization Information System (MIIS)

• Questions
The Massachusetts Medicaid EHR Incentive Payment Program
How We Got Here
How We Got Here – The HITECH Act

- The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 was passed as part of the American Recovery and Reinvestment Act (ARRA)

- Created financial incentives through Medicare and Medicaid for providers and hospitals that demonstrate they are “meaningful users” of certified EHR systems

- The Massachusetts Office of Medicaid (MassHealth) plans, oversees and directs the Massachusetts Medicaid EHR Incentive Program. MassHealth contracted with the MeHI to administer key components of the Medicaid EHR Incentive Payment Program
The Massachusetts eHealth Institute
Who We Are
Massachusetts eHealth Institute Overview

• A Division of the Massachusetts Technology Collaborative, a public economic development agency

• The state's entity for health care innovation, technology and competitiveness

• Working to accelerate the adoption of eHealth technologies
  • Supporting the safety, quality and efficiency of health care in Massachusetts
  • Advancing the dissemination of health information technology throughout Massachusetts, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange

• Chapter 305 created MeHI, which is overseen by the Health Information Technology Council
Massachusetts eHealth Institute Programs

• **Regional Extension Center:** Offers services designed to help providers implement and meaningfully use EHRs and engage in electronic health information exchange

• **Health Information Exchange:** Works in collaboration with other state entities and its private partners to deploy a secure statewide health information exchange. MeHI is responsible for supporting the Last Mile Initiative: connection, education and optimization

• **Massachusetts Medicaid EHR Incentive Payment Program:** MassHealth has partnered with MeHI to support key operational components of the Massachusetts Medicaid EHR Incentive Payment Program with the goal of reaching 7,251 providers and 64 hospitals that are eligible to participate in the program
Massachusetts eHealth Institute
Regional Extension Center (REC) and
Statewide Health Information Exchange (HIE) Update

Presented By: Jim Brennan
What is a Regional Extension Center?

- Part of a national network of organizations that help providers transition to a practice that meaningfully uses electronic health records
- Supported by funding made available through the Office of the National Coordinator for Health Information Technology (ONC)
- Provides funding for services to help reduce providers’ costs of EHR adoption
- Assists providers in achieving Meaningful Use to qualify for maximum Medicare/Medicaid EHR Incentive Payments
- National goal of supporting 100,000 providers by 2014
- MeHI was first REC in nation to reach its enrollment goal (2500 PPCPs)

62 Federally–Designated Regional Extension Centers
Current Services and Support for Providers

• Direct Assistance Program
  • Pre-negotiated contracts and discounted pricing with Implementation and Optimization Organizations (IOOs) and EHR vendors

• Oversight of project implementations
• Experienced Clinical Relationship Managers (CRMs) assigned to each practice as a resource
• HIT Community – web base Community of Practice
• Stage 2 and 3 Education on Meaningful Use
• Regional Meetings and Educational Summits
## Direct Assistance Program

<table>
<thead>
<tr>
<th>Milestones</th>
<th>Basic Services 1 (No EHR)</th>
<th>Basic Services 2 (EHR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Execution of IOO Contract</td>
<td>$1000</td>
<td>$1000</td>
</tr>
<tr>
<td>EHR Go-Live</td>
<td>$2000</td>
<td>------</td>
</tr>
<tr>
<td>Meaningful Use</td>
<td>$1500</td>
<td>$1500</td>
</tr>
<tr>
<td>Total:</td>
<td>$4500</td>
<td>$2500</td>
</tr>
</tbody>
</table>

### Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Primary Care Provider (PPCP)</td>
<td>From MeHI to IOO</td>
</tr>
<tr>
<td>Specialist</td>
<td>From Specialist to IOO</td>
</tr>
</tbody>
</table>
Role of MeHI

Partnering With Executive Office of Health and Human Services (EOHHS)

- The Executive Office of Health and Human Services and more specifically, MassHealth, the Commonwealth’s Medicaid Agency, will implement and deploy the HIE services and procurements.

- MeHI will focus on the end-user integration and development of the “Last Mile” solution that will maximize connectivity to the operational HIE by as many providers as possible.
Massachusetts has formally adopted a three-stage approach to the development of its HIE infrastructure:

- **Stage One**: incorporates the standards of Direct exchange, where one provider can send or push health information to another.
- **Stage Two**: development of registries and analytical repositories.
- **Stage Three**: fully functional bi-directional exchange
MeHI Last Mile Program

• Program Goal
  Stimulate adoption and use of State Health Information Exchange (HIE) to improve coordination of care and clinical outcomes and reduce costs.

• Program Components
  • Education
  • Connection
  • Optimization
Providers

- Thought leadership on health information exchange, Meaningful Use, continuity of care, etc.
- Education materials: available online and distributed to practices
- MeHI Regional meetings and training sessions

Consumers/Patients

- Patient materials, such as patient tool kit available in the provider practice and online

EHR Vendors

- Information on Last Mile Program
- Vendor technical assistance with Direct integration
3 methods of accessing HIE services

User types

- Physician practice
- Hospital
- Long-term care
- Other providers
- Public health
- Health plans
- Labs and imaging centers

HIE Services

- Provider directory
- Certificate repository
- Direct gateway
- Web portal mailbox

EHR connects directly

EHR connects through LAND (Local Application for Network Distribution)

Browser access to webmail inbox
• Support for ambulatory and hospital settings through the Last Mile Direct Assistance Program

• Workflow optimization services
  • Designed to enhance efficiency and effectiveness
  • Available to all healthcare providers
  • Grants available for qualified providers
Massachusetts Medicaid EHR Incentive Payment Program
Massachusetts Medicaid EHR Program Goals & Objectives

Presented By: Timothy Whitaker
Vision and Goal

**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 Medicaid EPs and 64 EHs across the Commonwealth
## Massachusetts Medicaid EHR Incentive Performance Metrics

### Total Incentive Amount Distributed as of 8/31/12

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total EHs Approved for Payment FY2011</td>
<td>$41,663,846.00</td>
</tr>
<tr>
<td>Total EHs Approved for Payment FY2012</td>
<td>$11,339,147.16</td>
</tr>
<tr>
<td>Total EPs Approved for Payment CY2011</td>
<td>$38,731,700.00</td>
</tr>
<tr>
<td>Total EPs Approved for Payment CY2012</td>
<td>$26,728,684.41</td>
</tr>
</tbody>
</table>

### Total Incentive Amount

$118,460,000
Who’s Up For the Challenge?

• Centers for Medicare and Medicaid Services (CMS) goal is to accelerate the number of EPs achieving MU. They have issued a challenge to all states: help 100,000 providers achieve MU by the end of Calendar Year (CY) 2012

• Massachusetts has set the statewide goal of having 3,200 EPs and 50 eligible hospitals (EHs) receive a Medicaid EHR Incentive Payment (for A/I/U or MU) by December 31, 2012
  • Massachusetts has achieved 90% of it’s goal.
Massachusetts Medicaid EHR Incentive Payment Program
General Program Overview
### Medicare vs. Medicaid EHR Incentive Payment Program

<table>
<thead>
<tr>
<th>Medicare EHR Incentive Payment Program</th>
<th>Medicaid EHR Incentive Payment Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed by CMS</td>
<td>State manages its own program</td>
</tr>
<tr>
<td>Incentive payments for eligible hospitals are based on a number of factors, beginning with a $2 million base payment</td>
<td>Incentive payments for eligible hospitals are based on a number of factors, beginning with a $2 million base payment</td>
</tr>
<tr>
<td>Payment reductions begin in 2015 for providers who are eligible but choose not to participate</td>
<td>No Medicaid payment reductions if providers choose not to participate</td>
</tr>
<tr>
<td>In the first year and all remaining years, providers have MU objectives and associated measures they must meet to get incentive payments</td>
<td>In the first year, providers can receive an incentive payment for adopting, implementing or upgrading a certified EHR.</td>
</tr>
<tr>
<td>EPs can receive a maximum incentive amount of $44,000 (over 5 successive years of program participation)</td>
<td>EPs can receive a maximum incentive amount of $63,750 (over 6 years of program participation)</td>
</tr>
</tbody>
</table>
Pediatricians that meet the 20% Medicaid patient volume threshold may receive up to $42,500 over a six year period: $14,167 in the first year of participation and up to $5,667 in subsequent years. Pediatricians that meet or exceed the 30% Medicaid patient volume threshold will receive the full incentive amount.
## Stages of the Medicaid EHR Incentive Payment Program

<table>
<thead>
<tr>
<th>Stages</th>
<th>Medicaid Patient Threshold</th>
<th>EHR Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>A/I/U</td>
<td>90 days</td>
<td>N/A</td>
</tr>
<tr>
<td>Stage 1 Meaningful Use</td>
<td>90 days</td>
<td>90 days</td>
</tr>
<tr>
<td>Stage 1 Meaningful Use</td>
<td>90 days</td>
<td>365 days</td>
</tr>
<tr>
<td>Stage 2 Meaningful Use</td>
<td>90 days</td>
<td>365 days</td>
</tr>
<tr>
<td>Stage 3 Meaningful Use</td>
<td>90 days</td>
<td>365 days</td>
</tr>
</tbody>
</table>

- **Preceding Calendar Year (CY)**
- **Current Calendar Year (CY)**
Massachusetts Medicaid EHR Incentive Payment Program
Eligible Professional Participation Requirements
Who Is Eligible to Participate?

- Physicians (Doctors of Medicine (MD) and Doctors of Osteopathy (DO))
  - Residents (if proposal was received and approved by the Massachusetts Medicaid EHR Incentive Payment Program)

- Dentists
  - Limited Licensed Dentists

- Certified Nurse-Midwives

- Nurse Practitioners

- Please Note: If 90% or more of an EP’s encounters occur in an inpatient (POS 21) or emergency room (POS 23) setting, they are not eligible to participate
The Massachusetts Medicaid EHR Incentive Payment Program
Adopt, Implement, Upgrade
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
Certified Health IT Product List

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

Vendors or developers with questions about their product’s listing should contact the ONC-Authorized Testing and Certification Body (ONC-ATCB) that certified their product.

USING THE CHPL WEBSITE

To browse the CHPL and review the comprehensive listing of certified products, follow the steps outlined below:

1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Select the “Browse” button to view the list of CHPL products

To obtain a CMS EHR Certification ID, follow the steps outlined below:

1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Search for EHR Products by browsing all products, searching by product name or searching by criteria met
3. Add product(s) to your cart to determine if your product(s) meet 100% of the required criteria
4. Request a CMS EHR Certification ID for CMS registration or attestation from your cart page

STEP 1: SELECT YOUR PRACTICE TYPE

Ambulatory Practice Type

http://oncchpl.force.com/ehrcert?q=CHPL
Certified Health IT Product List (cont.)

http://oncchpl.force.com/ehrcert?q=CHPL
The Massachusetts Medicaid EHR Incentive Payment Program
3 Ways to Calculate Medicaid Patient Volume Threshold
Individual, Group Proxy or Practitioner Panel
## Medicaid Patient Volume Threshold

<table>
<thead>
<tr>
<th>Eligible Professional</th>
<th>Minimum 90-day Medicaid Patient Volume Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (MD’s &amp; DO’s)</td>
<td>30%</td>
</tr>
<tr>
<td>Residents</td>
<td>30%</td>
</tr>
<tr>
<td><em>Pediatricians</em></td>
<td>20%</td>
</tr>
<tr>
<td>Dentists</td>
<td>30%</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>30%</td>
</tr>
<tr>
<td>Certified Nurse Midwives</td>
<td>30%</td>
</tr>
</tbody>
</table>
When calculating Medicaid patient volume threshold, EPs may include both Medicaid Fee-For-Service (FFS) and Medicaid Managed Care Organizations (MCO) paid 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.
For the purposes of participating in the Massachusetts Medicaid EHR Incentive Payment Program, 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 Medicaid or a Medicaid 1115 Waiver Population paid for all or part of the individual’s premiums, co-payments or cost-sharing

**Medicaid Patient Volume Threshold =**

\[
\frac{\text{Medicaid Patient Encounters}}{\text{Total Patient Encounters}} \text{ (over a continuous 90 day period from the preceding CY)}
\]

\[
\text{Total Patient Encounters} \text{ (during the same continuous 90 day period from the preceding CY)}
\]

- Medicaid patient volume threshold may be calculated using individual, group proxy or practitioner panel data

- A Children’s Health Insurance Program (CHIP) reduction of 3.13% must be applied to reduce the CY2011 MassHealth encounters
Massachusetts Medicaid EHR Incentive Payment Program
Calculating Needy Individual Patient Volume Threshold
For Federally Qualified Community Health Centers
“Practice Predominately” at an 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 continuous 90 day period from preceding CY

“Needy Individual” is defined as a person receiving care from any of the following:
- Medicaid or Medicaid1115 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
Needy Individual Patient Volume Threshold

• For the purposes of participating in the Massachusetts Medicaid EHR Incentive Payment Program, 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

\[
\text{Needy Individual Patient Volume} = \frac{\text{Needy Individual Encounters (90 day continuous period; preceding CY)}}{\text{Total Patient Encounters (same 90 day continuous period; preceding CY)}}
\]

• Needy individual patient volume can be calculated using individual, group proxy or practitioner panel data
• EPs that have practiced less than 6 months in the current CY at an FQHC/RHC are still eligible to receive an incentive payment as long as the following criteria is met:

  • The EP must pass hospital-based test (if 90% or more of an EP’s encounters occur in an inpatient or ER setting, then they are considered hospital-based)

  • 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 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

  • A CHIP Factor of 3.13% must be applied to the in-state number of paid Medicaid encounters
The Massachusetts Medicaid EHR Incentive Payment Program
Achieving Medicaid Threshold Using *Individual* Paid Claim Encounters
Definition of an Individual Provider

- Individual – A qualifying individual provider is defined as an MD, DO, Dentist, Certified Nurse Midwife, or Nurse Practitioner who can achieve a 30% (Pediatricians minimum of 20%) Medicaid patient volume threshold throughout the program
Individual Reporting Example: Multiple Practice Locations

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

<table>
<thead>
<tr>
<th>East Medical Center</th>
<th>North Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous 90 day reporting period:</td>
<td>Continuous 90 day reporting period:</td>
</tr>
<tr>
<td>Total paid encounters: 500</td>
<td>Total paid encounters: 85</td>
</tr>
<tr>
<td>Encounters where Medicaid or an 1115 Waiver population</td>
<td>Encounters where Medicaid or an 1115 Waiver population</td>
</tr>
<tr>
<td>paid for all or part of the service, premium,</td>
<td>paid for all or part of the service, premium,</td>
</tr>
<tr>
<td>copayment or cost-sharing:</td>
<td>copayment or cost-sharing:</td>
</tr>
<tr>
<td>95</td>
<td>35</td>
</tr>
<tr>
<td>95/500 = .19 x 100 = 19%</td>
<td>35/85 = .41 x 100 = 41%</td>
</tr>
<tr>
<td>× Does not achieve the Medicaid patient volume</td>
<td>✓ Achieves the Medicaid patient volume</td>
</tr>
<tr>
<td>threshold at this location</td>
<td>threshold at this location</td>
</tr>
</tbody>
</table>

- Does not achieve the Medicaid patient volume threshold at this location
- Achieves the Medicaid patient volume threshold at this location
The Massachusetts Medicaid EHR Incentive Payment Program
Achieving Medicaid Threshold Using *Group* Paid Claim Encounters
Definition of 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 a Group Proxy?
• Less administrative burden
• Most inclusive option for all EPs practicing at the same site
• Provides for quick validation and easy auditable data
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
Group Proxy Reporting Example

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

Continuous 90 day reporting period (preceding CY): 1/1/11 – 3/31/11

<table>
<thead>
<tr>
<th>Provider</th>
<th>Paid Medicaid Encounters</th>
<th>Total Paid Encounters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician 1</td>
<td>80</td>
<td>200</td>
</tr>
<tr>
<td>Physician 2</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>30</td>
<td>300</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>150</td>
<td>200</td>
</tr>
<tr>
<td>Resident</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>310</strong></td>
<td><strong>800</strong></td>
</tr>
</tbody>
</table>

\[
\frac{310}{800} = 0.3875 \times 100 = 38.75\%
\]

✓ 4 out of 5 professionals meet the Medicaid patient volume threshold requirement and would be eligible to participate.
The Massachusetts Medicaid EHR Incentive Payment Program
Achieving Medicaid Threshold Using Practitioner Panel Method
Definition of Practitioner Panel

- Practitioner Panel – A practitioner panel is for those providers that practice in a managed care/medical home setting
# Practitioner Panel Example

<table>
<thead>
<tr>
<th>90 day reporting period (preceding CY)</th>
<th>1/1/11 – 3/31/11</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Medicaid patients assigned to the practitioner’s panel during chosen 90 day reporting period from the preceding CY</td>
<td>400</td>
</tr>
<tr>
<td># of Medicaid patients assigned to the practitioner’s panel during the chosen 90 day reporting period that had at least one encounter in the CY prior to the start of the 90 day reporting period (Jan 10 – Dec 10)</td>
<td>250</td>
</tr>
<tr>
<td>Unduplicated encounters where Medicaid or the Medicaid 1115 Waiver population paid for all or part of the service during the chosen 90 day reporting period</td>
<td>50</td>
</tr>
<tr>
<td>Total patients assigned to the practitioners panel during the same chosen 90 day reporting period that had at least one encounter in the CY prior to the start of the 90 day reporting period (Jan 10 – Dec 10)</td>
<td>550</td>
</tr>
<tr>
<td>Total unduplicated encounters during 90 day reporting period in the preceding CY</td>
<td>100</td>
</tr>
</tbody>
</table>
Practitioner Panel Example (cont.)

250
(Patients assigned to Practitioner Panel with at least 1 paid Medicaid encounter from the CY preceding the reporting period) +
50
(paid Medicaid unduplicated encounters)
(chosen continuous 90 day period from the preceding CY)

550
(Total patients assigned to the Practitioner Panel with at least 1 encounter from the CY preceding the reporting period) +
100
(all unduplicated encounters)
(during the same chosen continuous 90 day period from the preceding CY)

300/650 = .46 x 100

✓ 46% - Provider meets the Medicaid patient volume threshold requirements
Massachusetts Medicaid EHR Incentive Payment Program

When Is Supporting Documentation Requested?
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.

- According to state guidelines, all EPs must keep their supporting documentation for six years for auditing purposes.
Massachusetts Medicaid EHR Incentive Payment Program
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
Massachusetts Medicaid EHR Incentive Payment Program
Entering Medicaid Patient Volume into the Medical Assistance Provider Incentive Repository (MAPIR)
Entering Individual Patient Volume in MAPIR

Massachusetts Medicaid EHR Incentive Program

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

Encounters are defined as:

1) Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid for part or all of the service, or
2) Services rendered on any one day to an individual for whom Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, copayments, and/or cost-sharing.

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

**Apply CHIP Factor of 3.13% to Medicaid Only Encounters**

<table>
<thead>
<tr>
<th>Provider Id</th>
<th>Location Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>2720308161, 110007280A</td>
<td>DENTIST, PRAVEEN</td>
<td>129 FEDERAL ST, BOSTON, MA 02110</td>
</tr>
</tbody>
</table>
Entering Group Level Patient Volume in MAPIR

[Image of a screenshot from the Massachusetts Medicaid EHR Incentive Program website]

**Patient Volume - Group (Part 3 of 3)**

Please indicate in the box(es) provided, the Group Practice Provider ID(s) you will use to report patient volume requirements. **You must enter at least one Group Practice Provider ID.**

Please check the box if more than 4 Group Practice Provider IDs will be used in reporting patient volumes. [ ]

For reporting Group patient volumes:
1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2. There is an auditable data source to support the clinic's patient volume determination, and
3. So long as the practice and EP's decide to use one methodology in each year (in other words, clinics could not have some of the EP's using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EP's may attest to patient volume under the individual calculation for the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic practice level determination includes only those encounters associated with the clinic practice.

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

Encounters are defined as:
1. Services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under section 1115 of the Act paid for part or all of the service, or
2. Services rendered on any one day to an individual for which Medicaid or a Medicaid demonstration project under section 1115 of the Act paid all or part of their premiums, copayments, and/or cost-sharing.

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.
**Patient Volume - FQHC/RHC 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.**

Needy Encounters are defined as:

1. Services rendered on any one day to an individual where Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid for part or all of the service.
2. Services rendered on any one day to an individual for whom Medicaid or CHIP or a Medicaid or CHIP demonstration project under section 1115 of the Act paid all or part of their premiums, copayments, and/or cost-sharing.
3. Services rendered to an individual on any one day on a sliding scale or that were uncompensated.

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.

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Location Name</th>
<th>Address</th>
<th>Medicaid and CHIP Encounter Volume (Numerator)</th>
<th>Other Needy Individual Encounter Volume (Numerator)</th>
<th>Total Needy Encounter Volume (Total Numerator)</th>
<th>Total Encounter Volume (Denominator)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2720308161, 110087280A</td>
<td>DENTIST, PRAVEEN</td>
<td>123 FEDERAL ST, BOSTON, MA 021</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Entering Group Level Patient Volume in MAPIR – FQHC/RHC

Massachusetts Medicaid EHR Incentive Program

Getting Started

Name: Praveen, Dentist
Applicant NPI: 2720308161
Payee TIN: 043564371

Personal TIN/SSN: 123402004

Patient Volumes

Enter Group NPI Number(s)

Group Practice Provider ID(s)

Patient Volume - FQHC/RHC Group (Part 3 of 3)

Please indicate in the box(es) provided, the Group Provider ID(s) you will use to report patient volume requirements. You must enter at least one Group Practice Provider ID.

You must enter at least one Group Practice Provider ID.

Please check the box if more than 4 Group Practice Provider IDs will be used in reporting patient volumes.

For reporting Group practice volumes:
1) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation).
2) There is an auditable data source to support the clinic's patient volume determination, and
3) So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic, or with and outside a group practice, then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

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

Medicaid & CHIP Encounter Volume (Numerator)
Other Needy Individual Encounter Volume (Numerator)
Total Needy Encounter Volume (Numerator)
Total Encounter Volume (Denominator)

(*) Red asterisk indicates a required field.

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.
Massachusetts Medicaid EHR Incentive Payment Program
Program Year 1 vs. Program Year 2
Program Year 1 and Program Year 2 Participation Checklist

**Adopt, Implement, Upgrade Program Year 1**

- Ensure the EP practices less than 90% in an inpatient or ER setting
- Confirm EP can meet Medicaid patient volume threshold requirements during a chosen 90 day reporting period from the preceding CY
- Determine if you’re adopting, implementing or upgrading to certified EHR technology
- Collect Supporting Documentation

**Stage 1 Meaningful Use Program Year 2**

- Ensure the EP practices less than 90% in an inpatient or ER setting
- Confirm EP can meet Medicaid patient volume threshold requirements during a chosen 90 day reporting period from the preceding CY
- Meet 2 MU general requirements
- Collect MU measure data: 90 day reporting period, current CY
Massachusetts Medicaid EHR Incentive Payment Program
Meaningful Use Overview

Presented By: Al Wroblewski
5 Pillars of Meaningful Use

• Meaningful Use (MU) is using certified EHR technology to:
  • Improve quality, safety, efficiency, and reduce health disparities
  • Engage patients and families in their health care
  • Improve care coordination
  • Improve population and public health
  • Maintaining privacy and security
Meaningful Use Stages

• CMS and key stakeholders felt a phased approach to meaningful use would be the best method

• The criteria for meaningful use will be staged in three steps over the course of the next five years
  
  • Stage sets the baseline for electronic data capture and information sharing
  
  • Stage 2 guidelines will build upon Stage 1. Stage 2 final rules were released on August 23, 2012
  
  • Stage 3 will be developed through future rule making and is expected to be implemented in 2015 (subject to change)
Focus of Stage 1 Meaningful Use Criteria

**STAGE 1**

- Electronically capturing health information in a structured format using 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

- 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

- 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
Massachusetts Medicaid EHR Incentive Payment Program
Meaningful Use: Stage 1 Requirements
Meaningful Use: Stage 1

- Stage 1 MU requires a 90 day reporting period in the current CY for EPs and current FFY for EHs.
  - e.g. if attesting to stage 1 meaningful use in CY2012, the earliest an EP may attest is April 2012, with a reporting period of January-March

**EP:**
- 15 Core Measures
- 5 of 10 from Menu Set
- 6 CQMs
- 26 Objectives

**EH:**
- 14 Core Measures
- 5 of 10 from Menu Set
- 15 CQMs
- 34 Objectives
Meaningful Use Supporting Documentation

- EPs or designees will be required to submit the following when completing attestation for meaningful use stage 1:
  - Menu Measure 9: Acknowledgement (ACK) that the EP’s EHR system has the capability to submit electronic immunization data to immunization registries or information systems according to applicable law and practice.

- If a discrepancy is found, an EP or designee may be asked to submit additional documentation.

- Examples of documentation that may be requested:
  - Core Measure 11: Description of clinical decision support rule that was implemented.
  - Core Measure 15: Provide a copy of the security risk analysis report.
Stage 1 Meaningful Use General Requirements

- 50% of an EP’s encounters must occur at the location or location(s) that utilize CEHRT

- At least 80% of unique patients must have their data in a CEHRT during the chosen 90 day reporting period

Example:

<table>
<thead>
<tr>
<th>Dr. Jones – Practices at 1 Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Location: 180 Lyman St.</td>
</tr>
<tr>
<td>90 Day Reporting Period (Current CY): 6/1/12 – 8/31/12</td>
</tr>
<tr>
<td>✔ CEHRT</td>
</tr>
<tr>
<td>✔ 100% encounters occur at 180 Lyman St.</td>
</tr>
<tr>
<td>✔ 80 unique patients</td>
</tr>
<tr>
<td>• 70 in CEHRT,</td>
</tr>
<tr>
<td>• 70/80 x 100 = 87%</td>
</tr>
<tr>
<td>✔ Provider meets Meaningful Use general requirements</td>
</tr>
</tbody>
</table>
### Dr. Lyman– Practices at 1 Location

90 Day Reporting Period (Current CY): 6/1/12 – 8/31/12

Practice Location: 75 North Dr.

<table>
<thead>
<tr>
<th>✔</th>
<th>CEHRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔</td>
<td>100% encounters occur at 75 North Dr.</td>
</tr>
</tbody>
</table>
| ✗ | • 70 unique patients  
  • 15 in CEHRT  
  • 15/70 x 100 = 21% |

**✗ Provider does not meet Meaningful Use general requirements**
Dr. Horst Practices at 2 locations:

<table>
<thead>
<tr>
<th>90 Day Reporting Period (Current CY): 6/1/12 – 8/31/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Location 1: 123 Main St.</td>
</tr>
<tr>
<td>Practice Location 2: 150 Boston St.</td>
</tr>
</tbody>
</table>

- **CEHRT**
  - **Practice Location 1:**
    - 85 encounters
    - 85/100 x 100 = 85%
  - **Practice Location 2:**
    - No CEHRT

- **90 unique patients**
  - **Practice Location 1:**
    - 80 unique patients
    - 80 in CEHRT
    - 80/90 x 100 = 88%
  - **Practice Location 2:**
    - 10 unique patients
    - 10 are not in a CEHRT
    - 10/90 x 100 = 12%

- **Provider meets meaningful use general requirements**
### Dr. North Practices at 2 Locations

<table>
<thead>
<tr>
<th>90 Day Reporting Period (Current CY): 6/1/12 – 8/31/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Location 1: 150 Broad St.</td>
</tr>
<tr>
<td>Practice Location 2: 175 Hanover St.</td>
</tr>
<tr>
<td>✓ CEHRT</td>
</tr>
<tr>
<td>× No CEHRT</td>
</tr>
</tbody>
</table>

#### 200 total encounters

- **Practice Location 1: 150 Broad St.**
  - 25 encounters
  - 25/200 \times 100 = 25%

- **Practice Location 2: 175 Hanover St.**
  - 150 encounters
  - 150/200 \times 100 = 75%

#### 40 unique patients total

- **Practice Location 1: 150 Broad St.**
  - 10 unique patients
  - 10 in CEHRT
  - 10/40 \times 100 = 25%

- **Practice Location 2: 175 Hanover St.**
  - 30 unique patients
  - 30 are not in a CEHRT
  - 30/40 \times 100 = 75%

**× Provider does not meet meaningful use general requirements**
### Meaningful Use Specification Sheets

**Eligible Professional Meaningful Use Table of Contents**

**Core and Menu Set Objectives**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.</td>
</tr>
<tr>
<td>(2)</td>
<td>Implement drug-drug and drug-allergy interaction checks</td>
</tr>
<tr>
<td>(3)</td>
<td>Maintain an up-to-date problem list of current and active diagnoses</td>
</tr>
<tr>
<td>(4)</td>
<td>Generate and transmit notification of prescription electronically (eRx)</td>
</tr>
<tr>
<td>(5)</td>
<td>Maintain active medication list</td>
</tr>
<tr>
<td>(6)</td>
<td>Maintain active medication allergy list</td>
</tr>
</tbody>
</table>
| (7) | Record all of the following demographics: 
- Preferred language 
- Gender 
- Race 
- Ethnicity 
- Date of birth | AVAILABLE |
| (8) | Record and chart changes in the following vital signs: 
- Weight 
- Blood pressure 
- Calculate and display body mass index (BMI) 
- Plot and display growth charts for children 2-20 years, including BMI | AVAILABLE |
| (9) | Record smoking status for patients 13 years old or older | AVAILABLE |
| (10) | Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EFs, the states | AVAILABLE |
| (11) | Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule | AVAILABLE |
| (12) | Provide patients with an electronic copy of their health information (including diagnostics test results, problem list, medication lists, medication allergies) upon request | AVAILABLE |
| (13) | Provide clinical summaries for patients for each office visit | AVAILABLE |

- **Detail EP Core & Menu objectives**
- **Requirements to meet measure for each objective**
- **Calculation of numerator & denominator**
- **Qualify for an exclusion**
- **Definition of terms**
- **Attestation requirements for each measure**

**Specification Sheets may be found by visiting the meaningful use section of the [https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage](https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage).**
Exceptions/Exclusions

- Some Core and Menu objectives are not applicable to every provider’s clinical practice (e.g., dentists do not perform immunizations)

- Some CQMs cannot be met during the reporting period chosen by the provider

- Reporting “zeros” is acceptable for CQMs if that is what has been calculated by your certified EHR technology
Massachusetts Medicaid EHR Incentive Payment Program
Entering Meaningful Use Measures into the Medical Assistance Provider Incentive Repository (MAPIR)
Example - Entering Meaningful Use Core Measures

Attestation Meaningful Use Measures

Core Measure 1

Click HERE to review CMS Guidelines for this measure.

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.

Objective: Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Measure: More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE.

* PATIENT RECORDS: Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

☐ This data was extracted from ALL patient records not just those maintained using certified EHR technology.
☐ This data was extracted only from patient records maintained using certified EHR technology.

EXCLUSION: Based on ALL patient records: Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

*Does this exclusion apply to you?

☐ Yes ☐ No

If the exclusion does not apply please complete the following information:

Numerator = The number of patients in the denominator that have at least one medication order entered using CPOE.
Denominator = Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.

* Numerator: 65  * Denominator: 100
Example - Entering Meaningful Use Menu Set Measures

Attestation Meaningful Use Measures

Menu Measure 2

Click HERE for additional information on completing this measure.

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.

Objective: Incorporate clinical lab test results into EHR as structured data.
Measure: More than 40% of all clinical lab test results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

EXCLUSION - Based on ALL patient records. Any EP who orders no lab test whose results are either in a positive/negative or numeric format during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

*Does this exclusion apply to you?

- Yes  
- No

If the exclusion does not apply please complete the following information:

Numerator = Number of lab test results whose results are expressed in a positive or negative affiliation or as a number which are incorporated as structured data.
Denominator = Number of lab tests ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affiliation or as a number.

* Numerator: 40  
* Denominator: 63

Previous  Reset  Save & Continue
Massachusetts Medicaid EHR Incentive Payment Program
Example: 2 or More Eligible Professionals Participating from the Same Organization
Example: 2 or More Eligible Professionals Participating from the Same Organization

<table>
<thead>
<tr>
<th>Practice Location: 495 Main Street</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Noble – 1st Year of participation – CY11</td>
</tr>
<tr>
<td>90 Day reporting period: 1/1/10 – 3/31/10</td>
</tr>
<tr>
<td>Passes &lt; 90% inpatient test</td>
</tr>
<tr>
<td>Individual Medicaid Patient Volume: 35%</td>
</tr>
<tr>
<td>Adopted certified EHR technology</td>
</tr>
<tr>
<td>✓ Dr. Noble meets participation requirements</td>
</tr>
</tbody>
</table>
Example: 2 or More Eligible Professionals Participating from the Same Organization (cont.)

<table>
<thead>
<tr>
<th>Practice Location: 495 Main Street</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Noble – 2nd Year of participation – CY12 Stage 1 MU</td>
</tr>
<tr>
<td>Passes &lt; 90% inpatient test</td>
</tr>
<tr>
<td>Group Proxy Medicaid Patient Volume: 35%</td>
</tr>
<tr>
<td>Attested to stage 1 MU – 90 day reporting period – current CY 4/1/12 – 6/30/12</td>
</tr>
</tbody>
</table>

✓ Dr. Noble meets participation requirements × Dr. Jackson does not meet MU requirements - skips a year ✓ Dr. Klein meets participation requirements
Massachusetts Medicaid EHR Incentive Payment Program
Staying Connected: Important Health Information
Technology Updates
The State is currently reviewing the stage 1 proposed changes and stage 2 Meaningful Use guidelines and fully intends to adopt all modifications.

Prior to implementing these changes, Massachusetts must update its State Medicaid Health Information Technology Plan (SMHP) and receive approval from CMS regarding said revisions.

- The State must also operationally accommodate these changes (i.e. updating MAPIR, etc.).

Further information regarding changes to stage 1 and stage 2 Meaningful Use guidelines will be available via the MeHI website and our e-newsletter.
Changes to Stage 1 Meaningful Use Requirements

**Changes to Medicaid Patient Volume Reporting Period**

**Current:**
Medicaid & Needy Individual Patient Volume Threshold must be calculated using a continuous 90-day period from the previous CY or previous FFY for EHs.

**Pending:**
For EPs & EHs attesting for the program in 2013 and subsequent years, the Medicaid & Needy Individual Patient Volume Threshold may be calculated using any continuous 90-day period in the 12 months preceding the EPs or EH’s attestation.

**Changes to Medicaid Patient Volume Threshold Requirements**

**Current:**
One service, per day, per patient, where Medicaid or a Medicaid 1115 Waiver Population paid for all or part of the service; or Medicaid or a Medicaid 1115 Waiver Population paid for all or part of the individual’s premiums, co-payments or cost-sharing.

**Pending:**
For EPs & EHs attesting for the program in 2013 and subsequent years, the definition of an encounter is any billable service rendered on any one day to an individual enrolled in a Medicaid program. This includes encounters for patients who are Title XIX eligible & who meet the definition of “optional targeted low income children”.
Changes to Stage 1 Meaningful Use Requirements

**CPOE**

Measure for CPOE is based on the number of unique patients with a medication in their medication list that was entered using CPOE.

Alternate Measure for CPOE is based on the number of medication orders created during the EHR reporting period.

*Optional in 2013, Required 2014 +*

**Record & Chart Changes in Vital Signs**

Vital signs must be recorded for more than 50% of all unique patients ages 2 and over.

Blood pressure must be recorded for all patients *ages 3 and over* and height and weight for patients of *all ages*.

*Optional in 2013, Required 2014 +*
Changes to Stage 1 Meaningful Use Requirements

Record & Chart Changes in Vital Signs

EP may claim an exclusion if:
1. The EP sees no patients over 3 years or older (would not need to record blood pressure)
2. If all 3 vital signs are not relevant to the EP’s scope of practice (no vital signs)
3. Height & Weight are not relevant to EP’s scope of practice (blood pressure is still recorded)
4. Blood Pressure is not relevant to the EP’s scope of practice (height & weight is still recorded)

Optional 2013, Required 2014 +

Exchange Key Clinical Information

Perform at least one test of certified EHR technology’s capacity to electronically exchange key clinical information.

Objective removed from Stage 1 requirements.
Effective 2013+
## Changes to Stage 1 Meaningful Use Requirements

### Generate & Transmit Permissible Prescriptions Electronically

| E-prescribing: Generate and transmit permissible prescriptions electronically. |
| Current Exclusion: An EP who writes fewer than 100 prescriptions during the EHR reporting period |
| Additional Exclusion Added: 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 at the start of his/her EHR reporting period. |

*Effective 2013 +*

### Public Health Measures

| Immunizations |
| Reporting Labs |
| Syndromic Surveillance |

| Addition of "except where prohibited" to the objective regulation text for the public health objectives. |

*Effective 2013 +*
Changes to Stage 1 Meaningful Use Requirements

Clinical Quality Measures

Report Clinical Quality Measures to CMS or State.

Objective is incorporated directly into the definition of a meaningful EHR user and eliminated as an objective. Effective 2013 +

View Online, Download and Transmit

**EP & Hospital**: provide patients with an electronic copy of health information upon request

**EP**: Provide patients with timely access to their health information within 4 days.

**EH**: Provide patients with an electronic copy of their discharge instructions at time of discharge

Replace with the following objectives:

**EP**: Provide patients the ability to view online, download & transmit their health information within 4 business days of the information being available

**EH**: Provide Patients with the ability to view online, download and transmit information about a hospital admission. Effective 2014+
Massachusetts Medicaid EHR Incentive Payment Program
Overview: Stage 2 Meaningful Use Requirements
Meaningful Use Timeline

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AIU</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>AIU</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>AIU</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>AIU</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>AIU</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

- In 2014, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month EHR reporting period.

- CMS is permitting this one-time three-month reporting period in 2014 only so that all providers who must upgrade to 2014 certified EHR technology will have adequate time to implement their new certified EHR systems.
Stage 1 vs. Stage 2 Measures

Eligible Professionals

Stage 1:
15 Core Measures
5 of 10 from Menu Set
20 Objectives

Stage 2:
17 Core Measures
3 of 6 from Menu Set
20 Objectives

Eligible Hospitals

Stage 1:
14 Core Measures
5 of 10 from Menu Set
19 Objectives

Stage 2:
16 Core Measures
3 of 6 from Menu Set
19 Objectives
17 EP Core Objectives

1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders
2. Generate and transmit permissible prescriptions electronically (eRx)
3. Record demographic information
4. Record and chart changes in vital signs
5. Record smoking status for patients 13 years old or older
6. Use clinical decision support to improve performance on high-priority health conditions
7. **Provide patients the ability to view online, download and transmit their health information***
8. Provide clinical summaries for patients for each office visit
9. Protect electronic health information created or maintained by the Certified EHR Technology
10. Incorporate clinical lab-test results into Certified EHR Technology
11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
12. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care
13. Use certified EHR technology to identify patient-specific education resources
14. Perform medication reconciliation
15. Provide summary of care record for each transition of care or referral
16. Submit electronic data to immunization registries
17. **Use secure electronic messaging to communicate with patients on relevant health information** *

* Signifies newly added stage 2 core objective
1. Submit electronic syndromic surveillance data to public health agencies
2. *Record electronic notes in patient records*
3. *Imaging results accessible through CEHRT*
4. *Record patient family health history*
5. *Identify and report cancer cases to a State cancer registry*
6. *Identify and report specific cases to a specialized registry (other than a cancer registry)*

*Signifies newly added stage 2 menu objective*
16 EH Core Objectives

1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders
2. Record demographic information
3. Record and chart changes in vital signs
4. Record smoking status for patients 13 years old or older
5. Use clinical decision support to improve performance on high-priority health conditions
6. **Provide patients the ability to view online, download and transmit their health information within 36 hours after discharge.**
7. Protect electronic health information created or maintained by the Certified EHR Technology
8. Incorporate clinical lab-test results into Certified EHR Technology
9. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
10. Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate
11. Perform medication reconciliation
12. Provide summary of care record for each transition of care or referral
13. Submit electronic data to immunization registries
14. Submit electronic data on reportable lab results to public health agencies
15. Submit electronic syndromic surveillance data to public health agencies
16. **Automatically track medications with an electronic medication administration record (eMAR)**

*Signifies newly added stage 2 core objective*
1. Record whether a patient 65 years old or older has an advance directive
2. Record electronic notes in patient records*
3. Imaging results accessible through CEHRT*
4. Record patient family health history*
5. Generate and transmit permissible discharge prescriptions electronically (eRx)*
6. Provide structured electronic lab results to ambulatory providers*

*Signifies newly added stage 2 menu objective
Clinical Quality Measures (CQM’s)

• Beginning in 2014, all providers regardless of their stage of meaningful use will report on CQMs in the same way.
  • EPs must report on 9 out of 64 total CQMs.
  • Eligible hospitals must report on 16 out of 29 total CQMs.

• Providers must select CQMs from at least 3 of the 6 key health care policy domains recommended by the Department of Health and Human Services’ National Quality Strategy:
  • Patient and Family Engagement
  • Patient Safety
  • Care Coordination
  • Population and Public Health
  • Efficient Use of Healthcare Resources
  • Clinical Processes/Effectiveness

• EHs and EPs eligible for only the Medicaid EHR Incentive Payment Program will report their CQM data directly to the State.
Programmatic Updates

• Residents and Limited Licensed Dentists
  • Eligible to participate in the program
  • Due to the various residency program models, each Massachusetts Teaching Hospital, Health Care Organization and Community Health Center is required to develop and submit a proposal stating how they will meet the programmatic eligibility requirement as set forth in the EHR Incentive Program Final Rules.
Overview of the MIIS

- Secure, confidential, web-based system with capabilities for HL7 data exchange or GUI data entry
- Lifespan registry that supports a complete set of immunization-related functions
  - Helps identify pockets of unimmunized and under-immunized children and adults
  - Assists providers with clinical decision making through forecasting tool
  - Provides practice management tools for providers such as reminder/recall for patients due or overdue for vaccines, immunization coverage and vaccine usage reports
- Future version of the system will allow for on-line vaccine ordering, replacing current fax method
MIIS EHR Roll-Out

- Started EHR Pilot in Fall 2011
  - 38 sites currently in production
  - Daily newborn demographic and birth data from the Registry of Vital Records and Statistics (RVRS)
- Meeting provider MU Stage 1 needs
- Conducting testing of HL7 messages for Production
Meaningful Use Test Messages

If your EHR system can generate HL7 2.5.1 and transport using Soap UI:

- Have your EHR Technical Support staff review the HL7 Transfer Specifications, accessible on the link below:
  - [https://www.contactmiis.info/ehrIntegration.asp](https://www.contactmiis.info/ehrIntegration.asp)
- Please send an email to the MIIS Help Desk at MIISHelpdesk@stata.ma.us with your contact name and the names of your associated practice(s).
- MDPH will provide generic credentials for the Soap WSDL.
- The MIIS provides an HL7 Acknowledgment messages via the Virtual Gateway.
Weekly IT Technical Discussion

If your EHR system can transmit HL7 2.5.1 and you have questions on our Transfer Specifications or Soap message requirements:

- When: Occurs every Thursday from 10:00 AM to 11:00 AM EST
  - Web: https://www3.gotomeeting.com/join/312380934
  - Phone: Dial +1 (312) 878-3081; Access Code: 312-380-934
Steps for Production Readiness

- **Technical Readiness**
  - Providers send HL7 messages to QA environment
  - Sender provides Test Script so that IT can search GUI
  - Test names, CVX, MVX, Site, Route and location
  - Data is de-identified by sender due to VG constraints
  - If message content does not persist to GUI, IT reviews HL7 Logs for errors and works with Provider to adjust format.

- **Clinical Readiness**
  - Gain an understanding for Clinical Integration and the duty to inform patients and their right to limit data sharing.
  - Sites register to use the MIIS via the ContactMIIS Resource Center
    - [www.contactmiis.info](http://www.contactmiis.info)
    - Training, Clinical Integration and IT resources can be found on the ContactMIIS
Questions?

Please contact the MIIS Help Desk at:

- miishelpdesk@state.ma.us
- 617-983-4335
Massachusetts Medicaid EHR Incentive Payment Program:
P: 1-855-MassEHR (1-855-627-7347)
E: massehr@masstech.org
F: 508-439-5690

Key Contacts:

Tarsha Weaver, MSM
Director, Medicaid EHR Operations
P: 508-768-0050 x652
E: weaver@masstech.org

Nafisa Osman, MPA
Manager, Provider Enrollment and Verification
P: 508-768-0050 x380
E: osman@masstech.org

Kelsey O’Toole
Medicaid Incentive Communications Specialist
P: 508-768-0050 x657
E: o'toole@masstech.org
Helpful Links

Massachusetts eHealth Institute:
http://maehi.org/content/medicaid-ehr-incentive-payment-program

Executive Office of Health & Human Services:
http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/electronic-records/

Centers for Medicare and Medicaid EHR Incentive Programs:

Office of the National Coordinator for Health Information Technology:
http://healthit.hhs.gov

Health IT.gov:
http://www.healthit.gov/

Massachusetts Immunization Information System (MIIS):
http://www.mass.gov/dph/miis

Provider Online Service Center (POSC):
https://newmmis-portal.ehs.state.ma.us/EHSPortal/appmanager/provider/desktop
QUESTIONS?