



pennsylvania

DEPARTMENT OF PUBLIC WELFARE

Electronic Health Record (EHR) Incentive Program

Meaningful Use Frequently Asked Questions Webinar

Agenda

- **Program Update**
- **Meaningful Use Frequently Asked Questions**
- **Meaningful Use Challenges**
- **Meaningful Use Best Practices**
- **Questions**

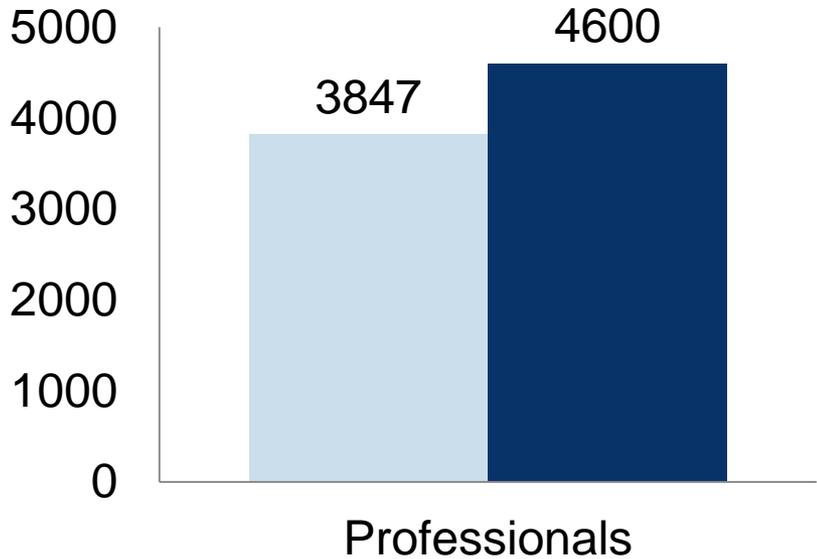
Program Update: National Payments



	State	Medicaid Payment Total		State	# of Paid Provider
1	Texas	\$ 447,142,281	1	California	6,400
2	California	\$ 430,758,473	2	Texas	6,072
3	Florida	\$ 289,951,108	3	Florida	4,311
4	New York	\$ 268,568,266	4	Ohio	4,139
5	Ohio	\$ 190,096,831	5	Pennsylvania	4,068
6	Pennsylvania	\$ 163,404,177	6	New York	3,937
7	Illinois	\$ 152,708,459	7	Massachusetts	3,251
8	Louisiana	\$ 150,610,005	8	Washington	3,132
9	Washington	\$ 134,739,641	9	Tennessee	2,475
10	Massachusetts	\$ 126,311,858	10	Wisconsin	2,285

Totals above are through December 2012 and source is CMS EHR incentive program

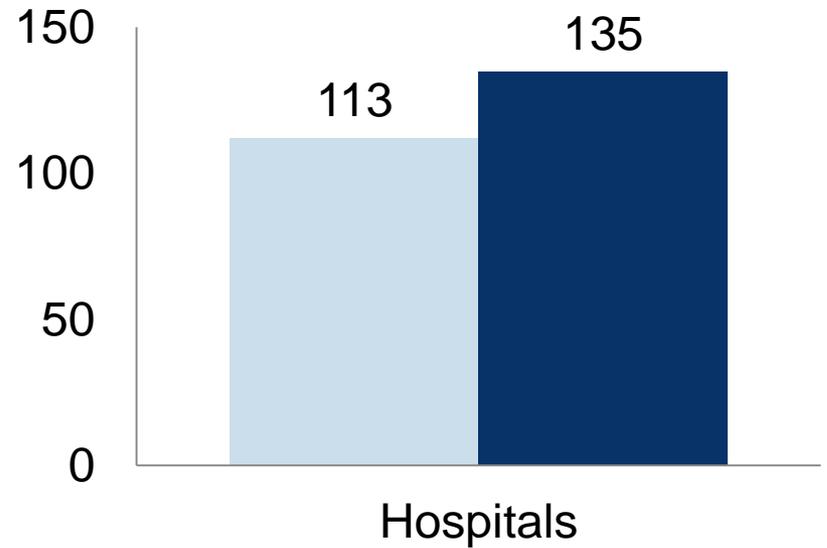
Program Update: Payments



■ Received 1st Payment ■ Estimate

Professional: 84%

Total Professional Payments*:
\$ 85,862,856



■ Received 1st Payment ■ Estimate

Hospital: 84%

Total Hospital Payments*:
\$100,904,866

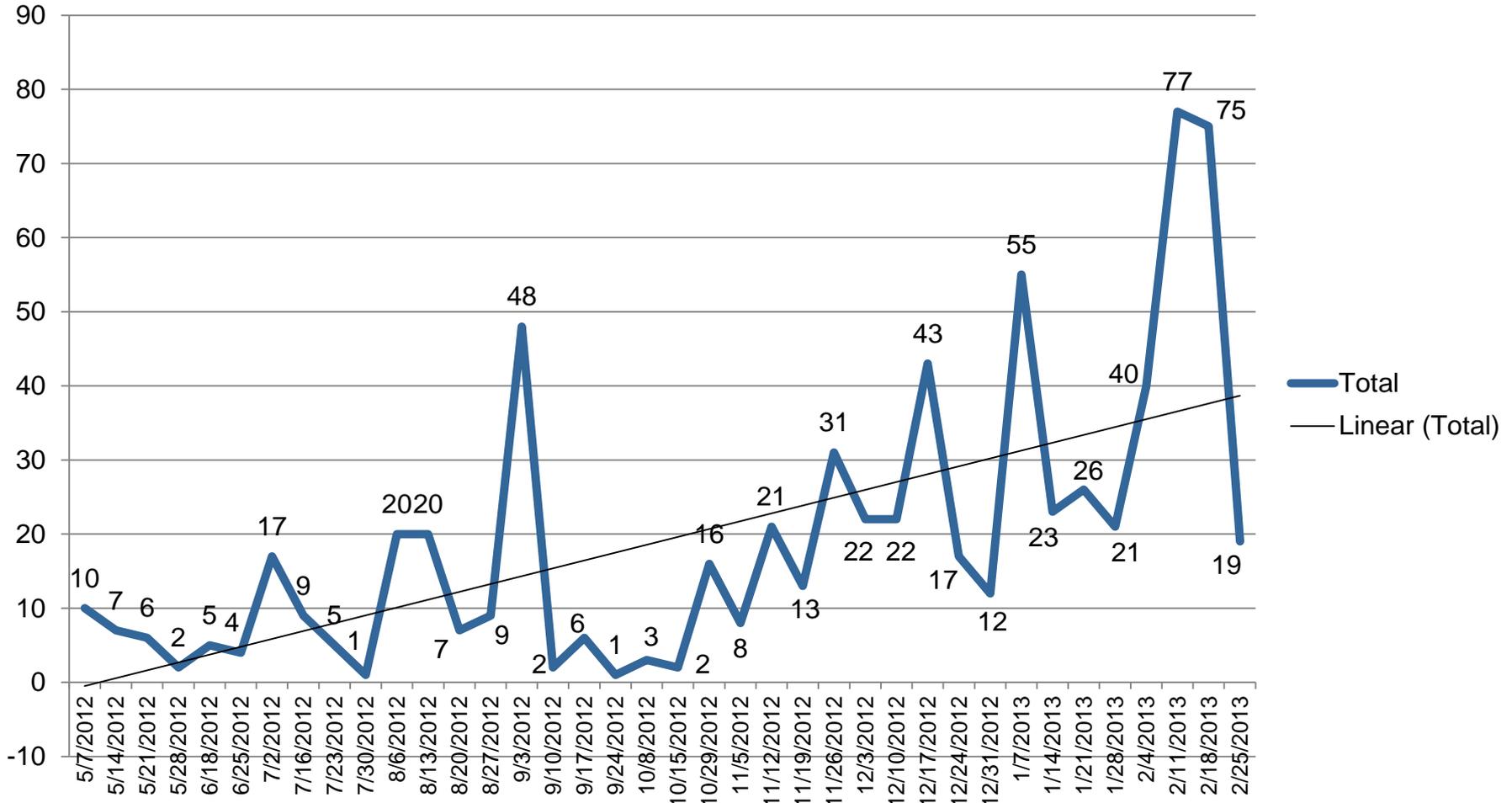
Total Payments* - \$ 186,767,722

* Payments through Feb. 25, 2012 for first (EP- 3847, EH-113) and second (EP - 711, EH - 42) payments

Program Update: MU Participation



Total EP MU Payments





Updated Final Rule – The EP updates for Program Year 2013 is on target for April 2013. We will host a webinar on April 4th to display changes in MAPIR

Developing Program 2014 system requirements – Requesting CMS feedback on certain points



What is the deadline for EPs to attest to the Medical Assistance EHR incentive for program year 2012?

March 30, 2013 is the last day EPs can apply for program year 2012 for the MA program. The deadline for Medicare is tomorrow (February 28th)



Can I attest to meaningful use in the first payment year rather than for adoption, implementation, and upgrade?

Eligible Professionals (EPs) and Eligible Hospitals (EHs) can attest to Adopting, Implementing or Upgrading (AIU) to a certified EHR System or Meaningful Use in their first participation year. In subsequent participation years, EPs and EHs will need to attest to meeting the required meaningful use criteria. Hospitals that are dually eligible for both the Medicare and Medical Assistance EHR incentive programs must attest to the MU requirements through the CMS Registration and Attestation System.



When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program?

CMS considers these two separate, but related issues.

Meaningful use: All eligible professional demonstrating meaningful use must have at least 50% of their of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with Certified EHR technology capable of meeting all of the meaningful use objectives. Therefore, the Department of Public Welfare will collect information from all locations the provider practices that are equipped with Certified EHR technology to validate this requirement in an audit.



When eligible professionals work at more than one clinical site of practice, are they required to use data from all sites of practice to support their demonstration of meaningful use and the minimum patient volume thresholds for the Medicaid EHR Incentive Program? (cont.)

Patient volume: EPs may choose one (or more) clinical sites of practice in order to calculate their patient volume. This calculation does not need to be across all of an eligible professional's sites of practice. However, at least one of the locations where the eligible professional is adopting or meaningfully using certified EHR technology should be included in the patient volume. In other words, if an EP practices in two locations, one with certified EHR technology and one without, the EP should include the patient volume at least at the site that includes the certified EHR technology. When making an individual patient volume calculation (i.e., not using the group/clinic proxy option), an EP may calculate across all practice sites, or just at the one site.

If an eligible professional (EP) is unable to meet the measure of a Meaningful Use objective because it is outside of the scope of his or her practice, will the EP be excluded from meeting the measure of that objective under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs?

Some Meaningful Use (MU) objectives provide exclusions and others do not. Exclusions are available only when our regulations specifically provide for an exclusion. EPs may be excluded from meeting an objective if they meet the circumstances of the exclusion. If an EP is unable to meet a Core MU objective for which no exclusion is available, then that EP would not be able to successfully demonstrate Meaningful Use and would not receive incentive payments under the Medicare and Medicaid EHR Incentive Programs. For Menu MU objectives, providers must select one they can meet and if they cannot meet the requirement then they are allowed to select an exclusion.



Do specialty providers have to meet all of the meaningful use objectives for the Medicare and Medicaid EHR Incentive Programs, or can they ignore the objectives that are not relevant to their scope of practice?

There are a total of 25 meaningful use objectives. To qualify for an incentive payment, 20 of these 25 objectives must be met. There are 15 required core objectives. The remaining 5 objectives may be chosen from the list of 10 menu set objectives. Certain objectives do provide exclusions. If an EP meets the criteria for that exclusion, then the EP can claim that exclusion during attestation. However, if an exclusion is not provided for a core measure, or if the EP does not meet the criteria for an existing exclusion for a core measure, then the EP must meet the measure of the objective in order to successfully demonstrate meaningful use and receive an EHR incentive payment. If an EP cannot meet a menu measure or qualify for the menu measure's exclusion then the EP can choose another menu measure to use. Failure to meet the measure of an objective or to qualify for an exclusion for the objective will prevent an EP from successfully demonstrating meaningful use and receiving an incentive payment.

For general requirement 1, “please demonstrate that at least 50% of all your encounters occur in a location(s) where certified EHR technology is being utilized,” what information needs to be entered?

Any eligible professional demonstrating meaningful use must have at least 50% of their of their patient encounters during the EHR reporting period at a practice/location or practices/locations equipped with certified EHR technology capable of meeting all of the meaningful use objectives.

Numerator = number of encounters during the Meaningful Use (MU) reporting period that were at locations with CEHRT.

Denominator = total number of encounters during the MU period from all service locations.

For general requirement 2, “please demonstrate that at least 80% of all unique patients have their data in the certified EHR during the EHR reporting period,” what information needs to be entered?

Pennsylvania’s MA EHR incentive program gathers information about the percentage of unique patients having their data in the certified EHR during the EHR reporting period, to determine if the EP has reached an 80% threshold. This information helps the program understand more about the EP’s MU attestation.

Numerator = unique patients during the reporting period seen by an EP that have their data in a certified EHR. If a patient is seen by an EP more than once during the reporting period, they can only be counted once.

Denominator = all unique patients seen by an EP during the reporting period (everyone, including paper record patients). If a patient is seen by an EP more than once during the reporting period, they can only be counted once.

What is the new definition for an Encounter and when can we start using this new definition?

The new definition of an encounter is:

Eligible Professionals: Services rendered on any one day to an individual where the recipient is/was eligible for Medical Assistance.

Hospitals: Services rendered to an individual per inpatient discharges where the recipient is/was eligible for Medical Assistance.

This new definition is effective starting with the Program Year 2013 applications.



What dates are used to calculate Medical Assistance patient volume?

Starting in Program Year 2013 the encounters you use to determine Medical Assistance volume percent is based on a continuous 90 day period from the previous calendar year for Eligible Professionals and the previous Hospital Fiscal Year for Eligible Hospitals OR over a continuous 90-day period in the preceding 12 month period from the date of attestation.

Does PA DPW have a process in place to amend Medicaid MU attestations? If so, what is the process and the timeframes?

Only providers can amend their MU attestations. If the attestation is still able to be re-opened providers could amend at that point. If there is a need to amend after the attestation has been reviewed the program would work with individuals to address the attestation changes.

Is batch filing required in 2014? Is batch filing for all MU attestation data or just clinical quality measures?

The Medical Assistance incentive program will not accept batch filing in 2014.

For 2014, do we report clinical quality measures for a 90 day time period, for a quarter or for the entire year?

For 2014 specifically, all MU measures (Core, Menu & CQM) will be a 90 day reporting period. If you report 90 days in 2014, then in 2015 you would report for a full year.

Where can Meaningful Use standards be found?

Medical Assistance Meaningful Use requirements are the same as Medicare therefore visit the CMS website:

- **Eligible Professionals Stage 1:**

<http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf>

- **Eligible Professionals Stage 2:** http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf

- **Eligible Hospitals Stage 1:**

http://www.cms.gov/EHRIncentivePrograms/Downloads/Hosp_CA_H_MU-TOC.pdf

- **Eligible Hospitals Stage 2:** http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EligibleHospitals_CA_Hs.pdf

How are other providers dealing with attesting for meaningful use (MU) for dental providers?

FQHC – We are in the process of transitioning dental providers to EMR but still working on workflows and form modifications before going live with the new system.

Dentists are encouraged to review all the specifications related to the MU requirements to evaluate if they could address by modifying workflow as well as appropriately claim an exclusion.

For Core Measure 6 (Medication Allergy List) how is this information collected from your EHR system?

This data is discreet and identifiable in our EHR. Our EHR prompts the EP with an alert to tell them a patient does not have med allergies documented.

The system should have lists of known allergies. For each patient there should be a point of data indicating that an allergy or 'NO ALLERGIES' have been documented

For Core Measure 7 (Record Demographics) why is some data collected and some not?

Our demographic data is interfaced into our EHR from our registration system. The demographic information is required information for our registrars. If a field is missed (race ethnicity or language), there is a MU alert indicating a piece is missing (just not what piece)

We ask these questions during registration for the patient and have a series of discrete required fields that we can query against.

For Core Measure 8 (Record Vital Signs) we were told that if a vital hasn't changed and isn't updated, the EHR system shows this as not meeting this measure. Is that true for your system?

The vital signs objective states that we must record and chart 'changes' to vitals. CMS spec sheet states that they need to have at least one entry for the vitals but does not specify that the entry needed to be captured during the reporting period.

“Alert Fatigue”

Due to volume of data conditions that will trigger an alert, the EPs experience ‘Alert Fatigue.’ Our system can’t differentiate between MU-related alerts and general alerts. Our leadership monitors MU status’s closely and if numbers drop off for this objective, intervention needs to occur with staff and the EP.

Lack of Pediatric CQMs

As a pediatric group, the lack of pediatric CQMs for 2012 stage 1 proved to be a large obstacle, as we found ourselves having to build clinical guidelines in our EHR for services that are not relevant to a pediatric population just to demonstrate that we do not have any patients that meet those measures.

Smoking Status/ Privacy Challenge

Pediatricians are hesitant to capture smoking status in front of a parent/guardian due to privacy concerns.

Smoking Status/ Privacy Challenge

Once smoking status is captured, it appears in the social history which then appears in the Clinical Summary that the parent of the minor receives

Smoking Status/ Privacy Challenge

The pediatricians chose to use Smoking current status unknown and then documented the true smoking status as text in the note.

Best Practice Idea – Record Demographics

Currently, our MU measurements for demographics are very high because we implemented an intensive training effort early on with our registrars to capture this data.

Workflows need to be established for patients who refuse to provide some information so the refusal is recorded as well. The minimum requirements can be made 'hard stops.'

Best Practice Idea – One Thing That Helps

Do your best to go out to practices to observe current state workflows, especially with Specialty groups. Some workflows don't align with the standard policy. Sometimes information is entered into the EHR in a way that you might not expect it to be entered. Make sure your Meaningful Use effort includes perspectives from different viewpoints, particularly areas outside of the EHR & clinical domains: Legal, Audit, Privacy. Physician Billing, Provider Enrollment and others have played key roles in our project.

Best Practice Idea – Suggestions

Now that the EHR vendors have more experience under their belts with MU, do your best to leverage your relationship with them for lessons learned.

Best Practice Idea – Suggestions

Take time to understand the specifics of each measure (in spec sheets), and how your EHR measures each objective before you develop your workflows.

Best Practice Idea – Suggestions

Build a plan to make Meaningful Use ‘Meaningful’ to your clinical practice. Adding workflows that can capture all this data creates a great resource for studying areas of your practice and care delivery. By mining some of this data you can engage clinical staff that questions the relevance of some of the measures.

Best Practice Idea – Suggestions

Make sure your Providers are clear on the uses of MU payments. If they are going to be kept by the practices, have them sign over the payments so you have a record of their agreement to do so.

Best Practice Idea – Suggestions

Make sure you develop a multi-year tracking model so you can handle new hires, people in different stages and to support auditing.

Best Practice Idea – Suggestions

Connect Meaningful Use to
organizational strategy,
individual annual performance
goals, etc.

Best Practices Group

Group of Pennsylvania professionals and hospitals who will present their best practices for meaningfully using their certified EHR systems.

Discussion to focus on challenges, suggestions and is also an opportunity to get Final Rule clarification.

Information gathered from group will be made available to others so that they could determine if the best practices identified would apply to their settings.

Stage 2 Resources

CMS Stage 2 Information

- **Tip Sheets**
- **Stage 1 vs. Stage 2 Comparisons**
- **FAQs**
- **Final Rule**

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

Program Update: PA / CMS DIRECT Project



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