Connecticut Medicaid EHR Incentive Program Flexibility
Checklist for Eligible Professionals for Meaningful Use

Last Revision: May 27, 2015

The Medicaid EHR Incentive Program provides incentive payments to eligible professionals (EPs) that are meaningful users of certified Electronic Health Record (EHR) technology (CEHRT). The use of certified EHR systems is required in order to qualify and receive incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems, which are listed here: http://oncchpl.force.com/ehrcert?q=CHP. EPs who would like to receive the incentive must choose to adopt and meaningfully use the certified technology in 3 stages for 6 non-consecutive years. Providers are given the option to skip a year but do not have to do so if they are able to attest to Meaningful Use (MU).

- Providers must have upgraded or purchased an EHR system that meets 2014 certification requirements.
- All EPs must begin the program no later than Program Year 2016 to be eligible to participate.
- Providers may begin with AIU and then attest for 2 years at each stage of MU.

MU occurs in three stages:

- Stage 1 (data capture and sharing)
- Stage 2 (advanced clinical processes) begins in 2014
- Stage 3 (improved outcomes) expected to begin in 2017

2014 Flexibility Option

On August 29, 2014, the Department of Health and Human Services (HHS) published a final rule that allows health care providers participating in the EHR Incentive Programs more flexibility in how they use CEHRT to meet meaningful use for an EHR Incentive Program reporting period for 2014. Specifically, EPs can use the 2011 Edition CEHRT or a combination of 2011 and 2014 Edition CEHRT for an EHR reporting period in 2014.

All EPs, EHs, and CAHs are required to use the 2014 Edition CEHRT in 2015.

http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-08-29.html

2014 Participation Options

Below are the participation options for Program Year 2014 based on the Edition of EHR certification the EP is currently using:

CEHRT SYSTEMS AVAILABLE FOR USE IN 2014

If you were scheduled to demonstrate:	You would be able to attest for Meaningful Use: Using 2011 Edition CEHRT to do:	Using 2011 & 2014 Edition CEHRT to do:	Using 2014 Edition CEHRT to do:
Stage 1 in 2014	2013 Stage 1 objectives and measures*	2013 Stage 1 objectives and measures* -OR- 2014 Stage 1 objectives and measures*	2014 Stage 1 objectives and measures
Stage 2 in 2014	2013 Stage 1 objectives and measures*	2013 Stage 1 objectives and measures* -OR- 2014 Stage 1 objectives and measures* -OR- Stage 2 objectives and measures*	2014 Stage 1 objectives and measures* -OR- Stage 2 objectives and measures

**Only providers that could not fully implement 2014 Edition CEHRT for the EHR reporting period in 2014 due to delays in 2014 Edition CEHRT availability.*

CEHRT Flexibility Resources

To help you understand the final rule's changes to 2014 participation, CMS has developed the following resources:

CEHRT Interactive Decision Tool – providers answer a few questions about your current stage of meaningful use and Edition of EHR certification, and the tool displays the corresponding 2014 options.

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CEHRT_Rule_DecisionTool.pdf

2014 CEHRT Flexibility Chart – chart provides a visual overview of CEHRT participation options for 2014

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CEHRT2014_FlexibilityChart.pdf

ELIGIBILITY FOR MEDICAID EHR INCENTIVES

To qualify for incentive payments, health care professionals must meet certain eligibility criteria:

- ❖ Be one of the permissible eligible professional (EP) types
- ❖ Meet patient volume requirements
- ❖ Adopt/ Implement/ Upgrade (AIU) to a certified EHR
- ❖ Show that you are meaningfully using the EHR system

Eligible Professionals:

The following providers are potentially eligible to enroll in the EHR Medicaid Incentive Payment Program:

- ☐ Physicians
- ☐ Pediatrician: Any provider who is Board Certified as a Pediatrician or has at least 90% of Medicaid Recipients Under the Age of 18
- ☐ Nurse Practitioners
- ☐ Certified Nurse Midwives
- ☐ Dentists
- ☐ Physician Assistant (PA) practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Center (RHC) which is led by a PA.

  ***** An FQHC or RHC is considered to be PA led in the following instances:

  - The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
  - The PA is the clinical or medical director at a clinical site of the practice
  - The PA is the owner of the RHC

Additional Eligible Professional Requirements:

- ☐ Must not be hospital-based. A hospital-based EP is defined as an EP who furnishes 90% or more of their covered professional services in either the inpatient or emergency department of a hospital and cannot claim allowed hospital exclusion under CFR495.5.
- ☐ Must be licensed to practice in the State of Connecticut.
- ☐ Must not have any current or pending sanctions with Medicare or State Medicaid programs.
- ☐ Must be a CT Medicaid-enrolled provider.

Qualifying for Patient Volume:

To be eligible to receive an incentive payment under the **Medicaid** EHR Incentive Program, an EP must meet **one** of the following **patient volume criteria** during a consecutive 90-day period in the preceding calendar year or the preceding 12 month period from date of attestation:

- ☐ Have 30% of your encounters with Medicaid patients (20% for pediatricians)
- ☐ Practice predominately in an FQHC or RHC with a 30% needy individual patient volume threshold. Needy patient volume is defined as patients who are enrolled in the Medicaid or Children's Health Insurance Program (CHIP), receive uncompensated care, or receive care on a reduced fee scale.
    - * *In Connecticut, Children's Health Insurance Program (CHIP) patients, also known as HUSKY B patients, do not count toward the Medicaid patient volume criteria.*
    - * Please note that at least one clinical location used in the calculation of patient volume must have CEHRT during the payment year for which the eligible professional attests to adopting, implementing or upgrading to CEHRT or meaningful use.

Included in Patient Volume:

- ❖ Medicaid Patients receiving services under HUSKY A, HUSKY C (previously known as Medicaid Fee for Service) and HUSKY D (previously known as Medicaid for Low Income Adults – MLIA) Programs.
- ❖ Providers have the option to include zero-pay claims in their patient volume calculation. If the provider chooses to include zero-pay claims in the calculation, they should be included in the total encounters number (denominator).

Calculation:

The patient volume for Medicaid is calculated by dividing Medicaid encounters for the EP during a consecutive 90-day period in the calendar year prior to the program year or a 12 month period preceding the date of attestation by the total encounters over the same 90 day period.

The **numerator** is the number of Medicaid encounters during the 90-day period selected. An encounter is defined as any services rendered on any one day to an individual enrolled in HUSKY A, HUSKY C or HUSKY D; regardless of payment liability, including zero-pay claims.

The **denominator** is all patient encounters for the same EP over the same 90-day period. For example, if the EP had 100 encounters and 30 were Medicaid encounters, they would have a 30% patient volume.

$$\frac{\text{Total Medicaid Encounters in any representative, continuous 90-day period in the preceding calendar year or twelve months prior to the attestation}}{\text{Total Patient Encounters in the same 90-day period}} = \text{Patient volume} * 100$$

Definition of an Eligible Professional Medicaid Encounter

For purposes of calculating EP patient volume, a Medicaid encounter is defined as any services rendered on any day to an individual enrolled in HUSKY A, HUSKY C or HUSKY D program.

Definition of a Needy Individual Encounter for FQHC/RHC

For purposes of calculating patient volume for an EP practicing predominantly in a FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Furnished by the provider as uncompensated care (charity care)
- Furnished at either no cost or reduced cost based on a sliding fee scale determined by the individual's ability to pay

To calculate needy individual patient volume, EPs practicing predominantly in a FQHC/RHC must divide:

- The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year or twelve months prior to the attestation date; by
- The total patient encounters in the same 90-day period.

Individual vs. Group Patient Volume:

Medicaid patient volume thresholds may be met at the individual level (by provider NPI) or at the group practice level. EPs may attest to patient volume under the individual calculation or the group/clinic calculation in any participation year. EPs may use a clinic or group practice's patient volume as their own under the following conditions:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP.
- There is an auditable data source to support the clinic or group practice's patient volume determination.
- All the EPs in the group practice or clinic must use the same methodology for the payment year
- The clinic or group practice must use the entire practice or clinic's patient volume and not limit it in any way.
- If the EP works both inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

For more information on eligibility, go to CMS EHR Incentive Program Eligibility page at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligibility.html

FAQ 2993

https://questions.cms.gov/faq.php?id=5005&faqId=2993

MEANINGFUL USE

In the first year of participation, providers must demonstrate meaningful use for a consecutive 90-day EHR reporting period within the calendar year. In subsequent years, the EHR reporting period must be the entire calendar year.

> ***For 2014 only:*** *Because all provider must upgrade or adopt newly certified EHRs in 2014, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a 90-day EHR reporting period in 2014. Medicaid EPs can select any 90-day reporting period that falls within the 2014 calendar year.*

Providers who participate in the Medicaid EHR Incentive Programs are not required to demonstrate meaningful use in consecutive years, but their progression through the stages of meaningful use would follow the same overall structure of two years meeting the criteria of each stage, with the first year of meaningful use participation consisting of a 90-day EHR reporting period.

Providers and hospitals must ensure that their Medicaid enrollment and certification and/or license are up current and valid. Providers will be unable to complete their EHR Incentive Program registration until this information is up to date within the MMIS system.

Information required for attestation of meaningful use measures varies based on the measure. It is highly recommended that providers familiarize themselves with the required objectives prior to beginning data entry. Some objectives will only be a yes/no question whereas others require entry of a numerator and denominator that meet a specified threshold.

The information on Core and Menu Meaningful Use Measures can be found at the following CMS websites:

- **General Stage 1 Information** – Provides general information about Stage 1 Meaningful Use.
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

- **Stage 1 EP Core and Menu Meaningful Use Measure Specifications** – Provides detailed information and definitions for each measure to assist the provider in understanding the requirements and how to meet Stage 1 Meaningful Use.
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_Attestation_Stage1Worksheet_2014Edition.pdf

- **General Stage 2 Information** – Provides general information about Stage 2 Meaningful Use.
  http://cms.hhs.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

- **Stage 2 EP Core and Menu Meaningful Use Measure Specifications** – Provides detailed information and definitions for each measure to assist the provider in understanding the requirements and how to meet Stage 2 Meaningful Use.
  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf

REPORTING PERIOD FOR DEMONSTRATING MEANINGFUL USE

The reporting periods for demonstrating MU for Medicaid are listed below. The 90-day reporting period begins AFTER the practice or organization has installed all versions/patches that will include the certified version of EHR technology in an ambulatory setting. Remember to use the same reporting period for all measures.

- AIU of certified EHR technology during the first calendar year – If the Medicaid EP attests to AIU in the first year of payment and demonstrates MU in the second year of payment, then the EHR reporting period in the second year of payment is a continuous 90-day period within the calendar year. In subsequent years of MU, the EHR reporting period must be the entire calendar year.
    - AIU in the first payment year
    - 90-day continuous reporting period for the second payment year
    - 1-year continuous reporting period for all subsequent payment years, except in 2014

Demonstrate Achievement of Stage 1 Meaningful Use for CT Medicaid

As stated under the section "Eligibility for Medicare and Medicaid Incentive Payments", EPs must demonstrate meaningful use to be eligible for an incentive payment. This section covers how to demonstrate MU, calculate the MU reporting period, and verify achievement of MU.

- In the first year of Stage 1, Adopt, Implement, or Upgrade (AIU) to a certified EHR.

  Note: EPs can attest to MU in the first payment year if they wish to do so.
- After the first year, demonstrate MU of a certified EHR.

Objectives for Stage 1 MU:

- Report on all **13 core objectives**
    - List of Stage 1 Core Objectives with identical denominators:
        - Problem List/Diagnosis
        - Medication List
        - Medication Allergy List
        - Demographics

- Report on **5 out of 9 Menu Set Objectives** (1 of which must be a public health measure)
    - Starting in 2014, exclusions will no longer count towards the 5 menu objectives needed to successfully demonstrate meaningful use. EPs cannot claim an exclusion for a menu objective if there are other menu objectives they can meet. EPs must meet 5 out of the 9 menu objectives unless the EP has an exclusion from five or more objectives, in which case the EP must meet all remaining objectives. ***Note:*** *CMS released guidance in March 2015 that allows EPs to count exclusion for one of the public health measures towards their 5 required menu measures. See https://questions.cms.gov/faq.php?faqId=2903*
    - You will have to report numerators, denominators and exclusions, if applicable. See EP MU Core and Menu Set Objectives found at: http://cms.hhs.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html

- Report on a total of **9 out of a possible 64 CQMs** covering at least 3 National Quality Strategy domains. ***Note****: For Stage 1 MU, there are no performance targets for CQMs.*

Demonstrate Achievement of Stage 2 Meaningful Use for CT Medicaid

Objectives for Stage 2 MU:

Stage 2 of the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs includes several objectives that require information to be shared with another party. Three of these objectives – Clinical Summary, Patient Electronic Access, and Summary of Care – outline specific data elements needed to meet the objective. While some of the data elements are common between these three objectives, other data elements are individual to each objective.

- Report on all **17 Core Objectives** – These are objectives that everyone who participates in Stage 2 must meet. Some of the core objectives have exclusions, but many do not.
    - List of Stage 2 Core Objectives with Identical Denominators:
        - Demographics
        - Vital Signs
        - Electronic Access to Patient Health Info
- **3 of 6 Menu Objectives** – You only have to report on 3 out of the 6 available menu objectives for Stage 2. You can choose objectives that make sense for your workflow or practice. Again, some of these objectives have exclusions.

Please see the following for guidance on Core Objective and Menu Objectives:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Guide_EPs_9_23_13.pdf

Many of the objectives in Stage 2 will be familiar to you from Stage 1. Some objectives that were in the menu set in Stage 1 have been moved to the core set for Stage 2 and are now required for all providers. Some objectives that were in the core set in Stage 1 now have higher thresholds that you must achieve in order to successfully demonstrate meaningful use of your EHR in Stage 2. There are also some new Stage 2 core and menu objectives.

- **EPs must report on 9 out of 64 total CQMs**

In addition, all 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.

VERIFY ACHIEVEMENT OF GENERAL MEANINGFUL USE AND CERTIFIED EHR TECHNOLOGY THRESHOLDS

You will be asked to provide numerators and denominators for each of these items and attest to their accuracy.

- ☐ At least 50% of all your encounters occur in a location(s) where certified EHR technology is being used.
- ☐ At least 80% of all unique patients have their data in the certified EHR during the EHR reporting period.

Verify Achievement of Meaningful Use

Your complete EHR typically provides reports or a dashboard to help you verify achievement of Meaningful Use (MU) requirements.

- ☐ Run or Review MU Report/Dashboard to verify achievement of Core and Menu measure requirements during the appropriate EHR reporting period
- ☐ Run Clinical Quality Measure Report to verify achievement of CQM measure requirements during the appropriate EHR reporting period
- ☐ Print and retain the above documentation (on paper and/or electronically) to support your attestation
- ☐ Upload this documentation into MAPIR to support your attestation. **All Supporting Documentation MUST CONTAIN the provider's name and/or NPI, EHR system, and show the EHR reporting period.**

Attest for Incentive Payments

Medicaid EPs will have to demonstrate meaningful use through Connecticut's web-based MAPIR System. Providers will enter numerators and denominators for the meaningful use objectives and clinical quality measures, indicate if they qualify for exclusions to specific objectives, and legally attest that they have successfully demonstrated meaningful use.

- ❖ A complete EHR system will typically provide a report with the numerators, denominators and other information for most measures.
- ❖ If any MU measure fails to meet the threshold, MAPIR will display a message and offer the EP an opportunity to make corrections during the submission process.
- ❖ Providers may qualify for a Medicaid EHR incentive payment upon completing a **successful** online submission through the MAPIR System.
- ❖ Applications will be reviewed by DSS staff prior to authorizing payments.

MAPIR Guide

Review the MAPIR User Guide for EPs at https://www.ctdssmap.com/CTPortal/portals/0/StaticContent/Publications/ehr%20ep%20user%20manual.pdf, which provides step-by-step instructions for login, completing the attestation, and uploading documents.

PLEASE VERIFY THAT YOU HAVE THE BELOW INFORMATION AVAILABLE FOR YOUR MEANINGFUL USE ATTESTATION:

Information from CMS EHR Incentive Program R&A System

Information submitted to the CMS Medicare and Medicaid EHR Incentive Program Registration & Attestation (R&A) system including:

☐ Payee NPI _____

☐ Payee TIN _____

☐ Email address _____

CMS EHR Certification ID

☐ CMS EHR 2014 Certification ID for attestation. This ID is available when you add your certified EHR product(s) to your cart at http://healthit.gov/chpl. Within the ID, the 3rd-5th position of the ID MUST READ 14E

CMS ID # _____

☐ Print and retain your CMS EHR Certification ID to enter into the MAPIR system and upload a copy of the Certification ID cart web page in PDF format.

Supporting documentation: AIU and MU

Must demonstrate a relationship to the eligible professional submitting the evidence of A/I/U and must demonstrate that the eligible professional has a financial and/or legally binding agreement with the EHR vendor. Please see examples of supporting documents below:

☐ Purchase Order/Invoice
☐ Contract/License Agreement (with 2 signatures)
☐ Maintenance agreements
☐ Upgrade documentation

Patient Volume Data

Select your Patient Volume Reporting Period.
The reporting period for calculating patient volume is any continuous 90-day period in the preceding calendar year (CY) or in the 12 months preceding attestation.

Start Date: _____

End Date: _____

Out-of-State Encounters

Were out-of-state encounters included in the eligible professional's patient volume calculation? (Yes or No)

If yes, from which states or territories?

Patient Volume Attestation

The following are considered Medicaid Encounters for eligible professionals:

- Services rendered to an individual on any one day where the individual was enrolled in a Medicaid program (HUSKY A, HUSKY C or HUSKY D)

During the 90-day reporting period, what was the eligible professional's total number of:

Medicaid patient encounters? _____

Total Patient encounters? _____

Eligible professionals will be asked to upload documentation supporting their patient volume calculation. This must be a list of all patient encounters for the 90 day period selected including the following information for each encounter:

- Provider's name and/or NPI
- Date of service
- Patient name
- Patient DOB
- Patient's Medicaid ID for Medicaid encounters
- Insurance (Medicaid or other insurance)

The number of Medicaid encounters and total encounters on this list must coincide with the EP's patient volume numerator and denominator entered into MAPIR. (Preference is for list to be in an excel format)

MEANINGFUL USE

To be a meaningful user, eligible professionals must identify their meaningful use reporting period, practice locations, EHR solution, unique patient encounters and meet meaningful use objectives.

Meaningful Use EHR Reporting Period

For the first year of meaningful use, eligible professionals will select any consecutive 90-day EHR reporting period within the payment year. For all subsequent years, eligible professionals will select a 12-month EHR reporting period, which must be the entire calendar year.

- **Please Note:** ONLY in Payment Year 2014, all eligible professionals, regardless of their stage of meaningful use, are only required to demonstrate meaningful use for a 90-day EHR reporting period.

Meaningful Use Reporting Period:

Start Date: _____

End Date: _____

Practice Locations

For each of the eligible professional's practice locations, he or she must provide the practice's address, phone number, and indicate if the practice is the eligible professional's primary practice location. Eligible professionals must also provide the following:

- ❖ Does the practice location include EHR technology (Yes or No): _____
- ❖ Number of the eligible professional's unique patients in the EHR: _____
- ❖ Number of the eligible professional's unique patients: _____
- ❖ Number of the eligible professional's patient encounters: _____
- ❖ CMS Certification ID: _____

Unique Patient(s): If a patient is seen by an eligible professional more than once during the EHR reporting period, then for purposes of meaningful use measurement, that patient is only counted once in the denominator for the measure. If a patient is seen at more than one of the eligible professionals practice locations, that patient should only be reported at one of the practice locations. The eligible professional's unique patients should not be duplicated across multiple practice locations.

Note: Data elements for this section should be based on unique patients seen by the eligible professional during the meaningful use reporting period.

Meaningful Use and Clinical Quality Measures: MAPIR Uploads (Required)

- ☐ Printouts or calculations documenting that you meet the general 50% and 80% rules or thresholds for using certified EHR technology
- ☐ Dashboard printouts, EHR-generated reports, or other documents and information that show the numerator, denominator, and exclusions for the Stage 1 (13 core and 5 menu set meaningful use objectives) OR Stage 2 (17 core and 3 or 6 menu set objectives) as shown in the certified EHR technology. All supporting documentation must include the provider's name and/or NPI and the EHR reporting period. *Note: EHR-generated reports are preferred*
- ☐ EHR-generated report containing provider's name and/or NPI, EHR reporting period, and the numerator, denominator and exclusions for the 9 out of 64 total CQMs while using at least 3 of the 6 key health care policy domains.
- ☐ Certificate of Public Health Meaningful Use Testing (MUST Portal Test):
    - EPs attesting to either Stage 1 or Stage 2 MU can use the MUST Portal to perform the technical test in order to meet the immunization registry menu measure. The MUST Portal test must be completed during the EHR reporting period. EPs must upload the MUST Portal Testing Certificate into their MAPIR attestation as supporting documentation for this measure. The option to perform repeat annual testing against the MUST Portal for Stage 2 MU will remain until such time the State is ready to accept ongoing electronic submissions to the immunization registry.
    - For EPs affiliated with a group/practice, the Department will accept a MUST Portal Testing Certificate with the group/practice's name and NPI. However, the individual EP must be registered under the group/practice in the MUST Portal.
    - For EPs attesting to MU in Program Year 2014 only, an exclusion for the immunization registry was approved for the entire program year. If an EP chooses to take the exclusion for the immunization registry menu measure, they are required to upload the DPH exclusion letter in lieu of the MUST Portal Testing Certificate.

☐ Security Risk Analysis (SRA) Checklist

- EPs are required to complete the SRA checklist and upload it into their MAPIR attestation. The checklist must contain the provider's name, NPI, and must be signed and dated by the EP or designee. If any items are unchecked, the EP must provide a proposed plan with summary and completion date of when this activity is planned to be completed. The SRA checklist is required for Program Year 2015 attestations and beyond. The checklist can be found on the CT Medicaid EHR Incentive Program website at the link below: