



Happy New Year!

Under the heading it's always better to be late than never, we at the TennCare EHR Incentive Program hope you had a good holiday season. A lot of things happened at the end of the year with the Incentive Program; we're hoping that 2015 won't be quite so hectic.

Contents

Deadline Reminders

1099s

Medicaid Encounter Data: Individual vs. Group Proxy

Meaningful Use Challenges for 2015

Security Risk Analysis

Updated Signature Page Now Available

Information from CMS

Contact Information

Deadline Reminders

As the 2014 attestation deadline for Eligible Hospitals is imminent (Jan. 31, 2015), and is fast approaching for Eligible Providers (March 31, 2015), here is a checklist of reminders for those who have yet to submit:

- CMS is allowing all providers to use a 90-day attestation period for 2014 regardless of where you are in the EHR Provider Incentive Program.
- All 2014 attestations will reflect patient encounters from a 90-day period in 2013 (patient encounters always come from the previous calendar year). For those applying for Meaningful Use, MU data must come from a 90-day period in 2014.
- The attestation period for Eligible Hospitals is based on the federal fiscal year. Also, EHs MUST attest through Medicare first.
- EPs should note that 2014 is the year they MUST be approved as a meaningful user of a certified EHR system in order to avoid the 2015 MediCARE reimbursement reductions. These reductions go into effect Jan. 1, 2015.
- First time users may choose to attest for MU in order to avoid the 2015 MediCARE reimbursement reductions (Medicare payment reductions do not apply to providers whose services are not normally covered by Medicare).
- Eligible Providers who can attest that they were unable to fully implement a 2014 Certified Electronic Health Technology (CEHRT) system due to an availability delay, may choose to claim one of the flexibility options permitted under the CMS Final Rule, 79 52910 September 4, 2014 (aka, The Flex Rule). Under the rule,

providers are able to use 2011 Edition CEHRT, and have the option to attest to the 2013 Stage 1 meaningful use objectives and the 2013 definition CQMs.

- Eligible Providers can use these CMS-developed resources to help them determine which Flex Rule option to choose:

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

[2014 CEHRT Flexibility Chart](#) – chart provides a visual overview of CEHRT participation options for 2014.

[2014 CEHRT Rule Quick Guide](#) – guide provides corresponding resources based on the option a provider chooses to participate in the EHR Incentive Programs in 2014.

- New users attesting to either AIU or MU cannot claim the Flexibility Rule, they may attest only with a 2014 CHERT.
- Complete information on attesting using the Flex Rule is found [on our web site](#).



The State of Tennessee will issue individual 1099s to providers receiving EHR Incentive Payments during 2014. This mailing will occur on or shortly after January 31, 2015. Although Eligible Professionals do have the option to assign their EHR Incentive Payment to their Group Practice or Clinic, the Department of Finance and Administration believed that the proper interpretation of IRS guidelines requires the issuance of individual 1099s irrespective of who actually received the payment. The 1099 form is an informational return provided to the IRS. To determine if payments are taxable, you must consult your tax professional. In most cases, you and your organization will need to complete a “middleman 1099.” A “middleman 1099” transfers the income from your Social Security number and places such income in your employer’s tax ID number. You should have your employer’s tax ID number from the W-2 you were sent last year.

It is the responsibility of the eligible professional to assign his/her EHR Incentive Payment, either to his individual NPI or an organizational NPI (his employer or entity with whom he has a valid contractual relationship allowing the entity to bill for the EP’s services), in consideration of the program parameters and any agreements with his organization. The eligible professional is responsible for selecting the appropriate option in the CMS Registration and Attestation System, and any payments will be made to the designated Payee NPI. The payment can be designated to different entities for each year of program participation but cannot be divided during a single year of program participation.

CMS, the EHR Incentive Program, and the Bureau of TennCare are not responsible for decision-making or mediation regarding the assignment of incentive payments.

Again, we strongly encourage you to contact your tax professional on the proper handling of this matter. If you lose your 1099 or otherwise need a replacement, contact Donna Nicely at Donna.Nicely@tn.gov or (615) 253-5234. She will need your Tax ID number, name, and either an email address, fax number, or current mailing address where the replacement 1099 can be replaced. Any questions about the EHR Incentive Program should be sent to one of the email addresses at the end of the newsletter. Donna will **NOT** be able to help you with those.

Medicaid Encounter Data: Individual versus Group Proxy

Note: This discussion is only about Medicaid Encounter Data, which can be reported in one of two ways. Meaningful Use Data is always reported individually. Additionally, this discussion applies to Eligible Professionals (EPs) and not Eligible Hospitals (EHs).

Providers attesting in the TennCare Medicaid EHR Provider Payment Incentive Program (PIPP) must meet a minimum patient volume requirement. Most EPs must have a minimum of 30% Medicaid encounters as a step towards qualifying for the incentive payment. Pediatricians may qualify for a reduced incentive payment amount if their Medicaid encounter ratio is between 20% and 29%. (If a pediatrician has a Medicaid ratio of 30% or more, he qualifies for the full incentive amount.)

Patient Volume encounters, both Medicaid and Total, are tabulated from a consecutive 90-day period in the **previous** calendar year. In other words, if you are attesting for the **2015** Program Year, your Patient Volume data will come from a **90-day period in 2014**. This 90-day period can begin on any day of the month and is not necessarily a calendar quarter. It cannot span years; it must be totally within the previous calendar year.

Our previous newsletter discussed what a Medicaid encounter is and the fact that denied claims, under certain circumstances, can also be counted. Go [here](#) to see that newsletter if you don't have it. In that discussion, we did not cover the definition of Needy Individual encounters for those practicing primarily in an FQHC or RHC.

Needy Individual Encounter (applies to services provided in an FQHC or RHC only): A Needy Individual encounter occurs when services are rendered to an individual on any one day and either

- Medicaid (TennCare) or CHIP (CoverKids) paid for part or all of the service
- Medicaid (TennCare) or CHIP paid all or part of the individual's cost sharing
- The individual was enrolled in a Medicaid program (TennCare or the Medicaid program of another state) at the time the billable services were provided
- The services were furnished at no cost consistent with 42 CFR § 495.310(h)
- The services were paid at a reduced rate based on a sliding scale determined by the individual's ability to pay. (42 CFR § 495.306(e)(3))

The inclusion of Needy Individuals in the threshold calculation applies **only** to meeting the patient volume requirements for EPs practicing predominately in FQHCs or RHCs. All services rendered on a single day to a single individual by a single EP counts as one encounter. If the individual receives services from another EP practicing in the same FQHC or RHC on the same day, this counts as an encounter for each EP. Again, denied Medicaid claims, under certain circumstances, can also be counted.

So, how do we determine the Medicaid encounter ratio?

$$\frac{\text{Total Medicaid Encounters}}{\text{Total Encounters}} \quad \text{for FQHCs:} \quad \frac{\text{Total Needy Individual Encounters}}{\text{Total Encounters}}$$

Total encounters are defined as ALL encounters during the 90-day period, regardless of who the payer was; such as private pay, commercial insurance, Medicaid, Medicare, non-paid, whomever.

Individual Encounter Data versus Group Encounter Data

So, back to our original topic. EPs that are a part of a group or clinic have the option to report encounter data in one of two ways – either the EP’s individual encounters, or by using the group’s encounter data.

There are three conditions when using the group proxy is appropriate.

- The group/clinic’s patient volume (PV) is appropriate as a PV methodology calculation for the EP (if, for example, an EP sees only Medicare, commercial insurance, or self-pay patients, this is not an appropriate calculation);
- There is an auditable data source to support the group/clinic’s PV determination; and
- The group/clinic and the EPs must elect to use one methodology each year of attestation. In other words, all members of a group/clinic must report using the same encounter method. You can, however, change reporting methods from year to year (i.e., individual reporting one year and group reporting the next). The first EP who attests sets the reporting requirement for the group as a whole. The group/clinic must use the entire practice’s PV and not limit it in any way, when using the group PV method,

What does this mean? What’s the difference?

EPs who are a part of group who are reporting encounters using the individual method, are reporting only the patient encounters of patients they themselves see. If you individually have a Medicaid ratio of at least 30% (20% for pediatricians), then you will qualify for the EHR Incentive Payment (assuming all other criteria are met). If you don’t meet the patient volume requirement, then you don’t qualify for the incentive payment.

When using the group reporting method, you are using the patient encounters of all medical personnel in the group, regardless of whether they participate in TennCare Medicaid, or are not eligible for the TennCare Medicaid PIPP. For example, you may have an RN who sees patients, including Medicaid patients. TennCare does not cover the services of an RN, however, the RN’s encounters would be included. The clinic may include a pharmacy. Although TennCare does cover prescriptions, the pharmacist is not eligible for a PIPP payment, but the encounters would be included in the clinic’s totals. So, how does this help EPs meet the patient volume requirement?

Let’s say you have a group of 5 EPs who have Medicaid encounter ratios of A – 32%, B – 28%, C -15%, D – 38%, and E – 45%, attesting individually. In this situation, EPs A, D, & E would qualify for the PIPP payment (a total of \$63,750), while B & C would not. In fact, the PIPP system would not even allow EPs B & C to submit their attestations. Now let’s say that you take those same 5 EPs as a group, add their Medicaid and Total encounters together and come up with a Medicaid encounter ratio of 31%. Then all 5 EPs would have met the patient encounter requirement and be eligible for the PIPP payment (\$106,250). We are assuming in both examples that all other program criteria are met.

An example that includes the counting of RNs’ and pharmacists’ encounters can be found on our web site in the [FAQs – QIV-4](#). The FAQs also covers the definitions discussed here and others.

While we cannot advise you on how to attest, individually or as a member of a group, we generally find that it is to both the individual’s and group’s benefit to attest using the group patient encounters as a proxy for the individual’s encounters.

Meaningful Use Challenges for 2015

Providers attesting to Stage 1 or Stage 2 meaningful use in 2015 must meet the **patient electronic access** objective, which gives patients access to their health information in a timely manner. The EHR Incentive Program encourages patient involvement in health care. Online access to health information allows patients to make informed decisions about their care and allows them to share their most recent clinical information with other health care providers. Providers in Stage 1 must meet the threshold for providing access only. Access is defined as when the patient possesses all of the necessary information needed to view, download or transmit their health information. Per CMS guidelines patients who do not wish to receive electronic access or “opt out” of receiving their health information electronically cannot be removed from the denominator for this measure.

However, if they have been given all of the information necessary for them to opt back in without requiring any follow up action from the provider, they can be counted in the numerator. In addition to meeting the Stage 1 requirement for patient electronic access, providers in Stage 2 must meet a second threshold related to the percentage of their unique patients who actually go online to view, download or transmit their health information. In meeting the Stage 2 requirement, many practices have begun to sit down with patients or their representatives before they leave their office and help them access their information for the first time in their office. When they access their information online, those patients can be counted in the additional Stage 2 measure numerator.

Providers attesting to Stage 1 or Stage 2 meaningful use in 2015 should take notice of the changes to the **vital signs measure**. It is much more flexible to allow providers the ability to report this measure aligning with the scope of their practice. The measure requires providers to record blood pressure for patients 3 and over, and height and weight for patients of all ages. What provides this new flexibility? The addition of two new exclusions which allows providers to report only height and weight recordings or only blood pressure recordings make it now possible for providers to align more closely their attestation with their scope of practice. Providers have always been able to exclude this measure when they see no patients age 3 or over or when they believe all three vital signs of height, weight and blood pressure have no relevance to their scope of practice. When attesting to meaningful use, **read the exclusion criteria carefully** and if you select an exclusion, make sure you have selected the correct exclusion for your scope of practice.

Beginning in 2014, providers will no longer be permitted to count exclusions toward the required number of **menu measures** to be reported. In other words, a provider cannot select a menu objective and claim an exclusion for it if there are other menu objectives they can meet.

Security Risk Analysis

The Security Risk Analysis or Stage 1 Core 15 or Stage 2 Core 9 has been the most frequent adverse audit finding during post payment meaningful use audits nationwide for the EHR Incentive Program. As a result, there is a change in the TennCare PIPP. When EPs now access the PIPP portal, on the left side of their screen they will have access to Security Risk Analysis Guidance link. When you click on the link, you can access links to several Security Risk Analysis tools, guidance documents and websites. The Security Risk Analysis is not evaluated during the prepayment verification process performed by Quality Oversight. Your Security Risk Analysis will be assessed during the post payment audit process, if you are randomly selected for this audit. Do not risk losing your

meaningful use EHR payment, please **use this resource to assure you understand and are meeting the Security Risk Analysis measure**. These resource links have also been added to the TennCare meaningful use web site at http://www.tn.gov/tenncare/mu_cm15.shtml.

[Home](#)

(This will take you back to the Home Page from anywhere else in the portal)

[Apply for Incentive \(Attest\)](#)

(This is the starting point for attesting)

[Appeals](#)

(Use this link if you wish to appeal a denial or payment amount)

[CMS Registration site](#)

(Takes you to the CMS Registration & Attestation System web site)

[Required Forms](#)

(Certain forms required when attesting)

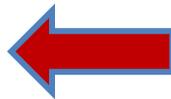
[Help/User Manual](#)

(Contains information to assist providers when attesting)

[Additional Information](#)

(Links to previous TennCare EHR Newsletters, containing additional information)

[Security Risk Analysis Guidance](#)



UPDATED SIGNATURE PAGE NOW AVAILABLE

An updated version of the EHR Incentive Program attestation Signature Page is now available for you to download from the Required Forms page in PIPP. All attestations which are being currently submitted must include this [newest version](#).

When you submit your attestation and supporting documents, TennCare requires you to include a Signature Page bearing your signature and the sign date, within 30 days of the attestation date. With this Signature Page, you attest, or certify, that you are treating Medicaid patients, that you understand and agree to all provisions of the program, and that the information you provide is true, accurate, and complete.

Occasional changes to the program's provisions often affect the verbiage that must appear on the Signature Page, creating the need for an update. For example, this new version includes a statement for attestors using one of the Certified Electronic Health Technology (CEHRT) flexibility options allowed under the CMS Final Rule, 79 FR 52910, September 4, 2014 (aka, The Flex Rule). Because of such changes, attestors must always use the current version of the document available for download from the PIPP Required Forms page.

If an attestation is submitted without the correct version, the attestation will be returned with a request for the current Signature Page.

Always remember, after you upload a corrected Signature Page or any other document to a returned attestation, open **EACH** page of your attestation, click “OK”, and then “submit.” Failure to follow this step will result in your attestation not being returned to us for processing. It will remain in a pended status until resubmitted.



Hospitals Must Start MediCARE EHR Participation in 2015 to Earn Incentives

Not participating in the Medicare EHR Incentive Program yet? 2015 is the **last year** for eligible hospitals to begin and still earn incentive payments.

To earn a 2015 incentive payment and avoid a 2016 payment adjustment, first-time participants should:

- Begin their 90-day reporting period no later than **April 1, 2015**
- Attest by **July 1, 2015**

Eligible hospitals that miss this deadline can still earn a 2015 incentive payment—and avoid the 2017 payment adjustment—if they begin their reporting period by July 1 and attest by November 30. However, they will be **subject to the 2016 payment adjustment** unless they apply and qualify for a [hardship exception](#).

Hospitals that successfully attest in 2015 will also be eligible to earn a 2016 incentive if they continue to participate.

Eligible hospitals that begin participating after 2015 will **not** be able to earn incentive payments. They will also be subject to payment adjustments in 2016 and 2017.

Additional Resources

The [EHR Incentive Programs](#) website offers tools and resources to help eligible hospitals to successfully participate:

- [Tip Sheet for Medicare Eligible Hospitals](#)
- [Eligible Hospital 2014 Definition Spec Sheets](#)
- [Stage 1 Eligible Hospital and CAH Attestation Worksheet \(2014 Definition\)](#)
- [Stage 1 Attestation User Guide for Eligible Hospitals and CAHs](#)
- [Payment Adjustment Form Hardship Exception Tip Sheet for Hospitals](#)



Contact Information

As always, anytime you have a question or need assistance, please feel free to contact us. We will get back to you as quickly as possible.

 **Please be sure to include the provider's name and NPI when contacting us.** 

- ◆ For questions relating to **Meaningful Use (MU)**, send an email to EHRMeaningfuluse.TennCare@tn.gov
- ◆ For **all other questions**, send an email to TennCare.EHRIncentive@tn.gov
- ◆ The **CMS Help Desk** can be reached at 1-888-734-6433.
- ◆ **TennCare Medicaid EHR Incentive Program web site:** http://www.tn.gov/tenncare/ehr_intro.shtml
- ◆ **PowerPoint Presentations** on different subject areas are available here:
http://www.tn.gov/tenncare/ehr_page6.shtml

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