

OCTOBER
2016



Incentive News

TENNCARE EHR PROVIDER INCENTIVE PAYMENT PROGRAM

ACCEPTING FOR 2016:

- ◆ **AIU and first-year MU attestations.**
- ◆ **MU attestations (requiring a full year of MU data) beginning Jan. 1, 2017.**

SEE YOU AT THESE FALL EVENTS:

Joint Amerigroup- UnitedHealthcare Provider Expos:

Nov 2 | Memphis
Nov 3 | Jackson
Nov 8 | Nashville
Nov 16 | Johnson City
Nov 17 | Knoxville
Nov 18 | Chattanooga

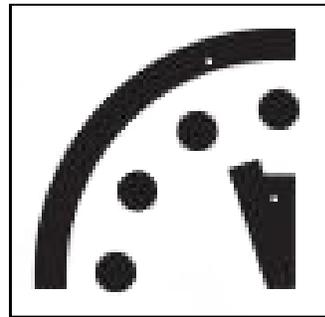
Dec. 31: Final Day to Register to Enter TennCare's EHR Incentive Program

Incentive Year 2016 is the final year to enroll in and attest for the first time to TennCare's EHR Incentive Program. **To participate, you must register to enter the program by Dec. 31, 2016 and attest for 2016 by March 31, 2017.**

The financial incentive for providers who successfully adopt and use Certified EHR Technology is that they can earn incentive payments totaling \$63,750 over six years. (Pediatricians can earn a lower incentive payment by meeting a lower patient volume requirement.) Plus the benefits of using a CEHRT continues to be an important and necessary part of today's health care system.

After 2016 anyone not already enrolled in PIPP will not be able to participate. The following providers are eligible to participate: physicians (both medical and osteopathic), nurse practitioners, dentists, nurse mid-wives, and physician assistants under certain conditions.

If there are providers you know in or outside your group who are not yet participating in this program, we encourage you to tell them to visit the [TennCare EHR](#)



The clock is ticking! EHR Incentive Program registration ends Dec. 31!

[Incentive website](#) and the [CMS EHR Incentive website](#). You would not want them to pass up this opportunity!

If an unenrolled provider tells you they checked into the program once before and decided they did not meet the Medicaid Patient Volume requirement, tell them they might want to revisit their calculation.

They may now meet the requirement without realizing it, as situations do change over time.

Newcomers might be particularly interested in the TennCare website's [PowerPoint Presentations](#). The presentations take viewers step-by-step through enrollment and the first year attestation process.

Questions may be addressed to our EHR Provider Incentive Unit at TennCare.EHRIncentive@tn.gov.

Questions specifically about the Meaningful Use (MU) portion of the program can be directed to EHRMeaningfuluse.TennCare@tn.gov.

A member of either staff will be happy to assist you.

Stage 3 MU: From Paper Reporting to Electronic Case Reporting

The Tennessee Department of Health (TDOH) is currently revising the Reportable Disease and Events form (PH-1600) used by providers to report cases of reportable diseases, conditions, or events to public health. The revisions will help maximize the information provided to public health to conduct timely investigations while balancing the burden on those reporting the cases.

For 2017, additional clinical and laboratory questions will be added to make the form more useful for reporting by providers and laboratories. TDOH will also allow providers the option to report cases of reportable

diseases, conditions, or events through a REDCap web entry form.

In 2017 TDOH will declare readiness to accept Electronic Case Reports from EPs, EHs, and CAHs under Stage 3 of the Medicaid Meaningful Use EHR Incentive Program. However, registration for this public health measure will not begin until January of 2018. These electronic initial case reports (eICRs) will allow healthcare providers the opportunity to report suspected cases to TDOH for further investigation instead of waiting on lab test results to confirm a suspected case.

Unlike the REDCap web entry form on

which reporters will still be required to manually enter data into an online electronic form, eICRs will be generated by capturing from CEHRT critical clinical and demographic patient data not otherwise included in laboratory reports. The eICR will be sent electronically to TDOH. Utilizing electronic initial case reporting will not only reduce paper-based and labor-intensive administrative processes associated with manual data entry, it will increase the quality and timeliness of case reporting to public health.

Any questions can be directed to CEDS.Informatics@tn.gov.

To Insure Payments, Keep Provider Information Updated

Three registration websites share information with the TennCare EHR Provider Incentive Payment Program (PIPP) attestation software. Prior to attesting, complete all information at these sites:

1. TennCare Provider Registration

<http://www.tn.gov/tenncare/topic/provider-registration>

If you are a contracted provider with one or more of TennCare's MCOs, you should be registered here already. If you were not added or have incomplete records, enter both your Individual Provider and your Group Provider information and establish a link between them.

Tip: Be sure the "Yes" button is selected near the top of the ACH Authorization page, as the incentive is only paid electronically. Help Desk: provider.registration@tn.gov

2. CMS EHR Registration

<https://ehrincentives.cms.gov/hitech/login.action>

Read through an overview of the program and begin entering the information necessary to enroll. Once you complete CMS Registration, you will receive an email message directing you to the TennCare PIPP Registration site.

Tip: Be sure to enter the CMS Certification ID for the CEHRT you will use when attesting. While this field is shown as optional, it is required for TennCare's EHR Incentive. CMS Help Desk: 888.734.6433

3. PIPP Registration

<https://pipp.tenncare.nash.tenn/login.aspx>

Set up your PIPP user account and begin attesting. Choose a user name, a password, and security questions you can remember.

Tip: Before you can submit, click "OK" at the bottom of each page to see a "Yes" in the "Attested" column of the User Dashboard. Help Desk: TennCare.EHRIncentive@tn.gov

An Overview of 2016 MU Objectives and Measures

Reference this table when planning your 2016 EHR Incentive attestation to Meaningful Use (MU).

<p style="text-align: center;">2016 Objectives and Measures EPs must attest to all 10 Meaningful Use Objectives & 9 Clinical Quality Measures covering at 3 National Quality Strategy domains</p>		
Objective	Measure	Exclusion
Objective 1: Protect Patient Health Information	Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained in CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the EP's risk management process.	none
Objective 2: Clinical Decision Support	<p>Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions.</p> <p>Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.</p> <p>Exclusion: For the second measure, any EP who writes fewer than 100 medication orders during the EHR reporting period.</p>	Measure 2 Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period.
Objective 3: Computerized Provider Order Entry	<p>Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p> <p>Exclusion for Measure 1: Any EP who writes fewer than 100 medication orders during the EHR reporting period.</p> <p>Measure 2: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p> <p>Exclusion for Measure 2: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.</p> <p>Alternate Exclusion for Measure 2: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.</p> <p>Measure 3: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry. Measure 3: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.</p>	<p>Measure 1 Exclusion: Any EP who writes fewer than 100 medication orders during the EHR reporting period.</p> <p>Measure 2 Exclusion: Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.</p> <p>Alternate Exclusion for Measure 2: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.</p> <p>Measure 3 Exclusion: Any EP who writes fewer than 100 radiology orders during the EHR reporting period.</p> <p>Alternate Exclusion for Measure 3: Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.</p>

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2016 Objectives and Measures

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Objective	Measure	Exclusion
Objective 4: Electronic Prescribing	Measure: More than 50 percent of permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.	Exclusion: Any EP who -Writes fewer than 100 permissible prescriptions during the EHR reporting period; or Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his or her EHR reporting period.
Objective 5: Health Information Exchange	Measure: The EP that transitions or refers their patient to another setting of care or provider of care must (1) use CEHRT to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.	Exclusion: Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.
Objective 6: Patient Specific Education	Measure: Patient specific education resources identified by CEHRT are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.	Exclusion: Any EP who has no office visits during the EHR reporting period.
Objective 7: Medication Reconciliation	Measure: The EP performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.	Exclusion: Any EP who was not the recipient of any transitions of care during the EHR reporting period.
Objective 8: Patient Electronic Access (VDT)	Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download, and transmit to a third party their health information subject to the EP's discretion to withhold certain information. Measure 2: For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.	Measure 2 Exclusion: Any EP who: Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information." or Conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.
Objective 9: Secure Messaging	Measure: For an EHR reporting period in 2016, for at least 1 patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or the patient-authorized representative), or in response to a secure message sent by the patient (or the patient-authorized representative) during the EHR reporting period.	Exclusion: Any EP who has no office visits during the EHR reporting period, or any EP who conducts 50 percent or more of his or her patient encounters in a county that does not have 50 percent or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

2016 Objectives and Measures

(Continued)

Objective 10: Public Health Report

EPs must attest to at least 2 public health measures
EPs may claim Alternate Exclusions for Measure 2 and Measure 3

Measure	Measure Specification	Exclusion
<p>Measure 1: Immunization Registry</p>	<p>The EP is in active engagement with a public health agency to submit immunization data.</p>	<p>Any EP meeting at least one of the following criteria may be excluded:</p> <ul style="list-style-type: none"> Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period
<p>Measure 2: Syndromic Surveillance</p>	<p>The EP is in active engagement with a public health agency to submit syndromic surveillance data.</p>	<p>Any EP meeting at least one of the following criteria may be excluded</p> <ul style="list-style-type: none"> Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period; or Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period
<p>Measure 3: Specialized Registry</p>	<p>The EP is in active engagement to submit data to a specialized registry.</p>	<p>Any EP meeting at least one of the following criteria may be excluded:</p> <ul style="list-style-type: none"> Does not diagnose or treat any disease or condition associated with, or collect relevant data that is collected by, a specialized registry in their jurisdiction during the EHR reporting period Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

How We Verify Your Reported Patient Volume

The Patient Volume Review

Fifth in a series of articles giving you an inside view of how TennCare reviews your EHR Incentive attestation.

Once your attestation is corrected and the Eligibility Review is passed, the attestation is forwarded for the Patient Volume Review. During this review, we verify the patient encounter numbers you entered for your chosen 90-day Patient Volume period.

Patient Volume is a count of Medicaid encounters seen by a provider or group within a 90-day period of time in the year prior to one for which you are attesting. That is, if you are attesting for 2014, you will count Medicaid encounters from 90 consecutive days in 2013.

A “Medicaid encounter” refers to services rendered to an individual on any one day where:

- Medicaid (or a Medicaid demonstration project – TennCare) paid for part or all of the service
- Medicaid (or a Medicaid demonstration project – TennCare) paid all or part of the individual’s cost sharing
- The individual is enrolled in a Medicaid program (or a Medicaid demonstration project – TennCare, or the Medicaid program of another state) at the time the billable service was provided. (42 CFR § 495.306(e)(1))

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 who is a part of the same group, each EP can count his services provided as a separate encounter.

If you provided a billable service to an individual who was enrolled in TennCare (or the Medicaid program of another state), that encounter is to be included in your patient volume data.

If your claim was denied because of untimely filing, services not covered by the Tennessee Medicaid State Plan (or that of another state in which the individual is enrolled), or the individual has exceeded benefit limits (TennCare’s or that of the state in which he is enrolled), the encounters may be counted.

You cannot count claims that were denied because the individual was not enrolled in any Medicaid program on the date of service.

When reviewing an attestation, we take the number of Medicaid encounters you report and compare it to what the MCOs report to us as your paid and denied claims. If the difference between those numbers fall outside an acceptable range, then we cannot approve the attestation. For providers who are dual Medicare/Medicaid providers, crossover claims are included in our count as well.

TIP: If your attestation is denied because your Patient Volume is not acceptable, contact the MCOs with which you are contracted, and verify that they are reporting with the correct NPIs to TennCare. You can always select a different 90-day period from which to draw your patient encounter data and re-attest.

Patient Volume always comes from a 90-day period in the year prior to the Incentive Year for which you are attesting.



Division of
Health Care
Finance & Administration

TennCare

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With EHR Incentive Program questions,
email TennCare.EHRIncentive@tn.gov

With Meaningful Use (MU) questions, email
EHRMeaningfuluse.TennCare@tn.gov
CMS Help Desk, 888.734.6433

TennCare Medicaid EHR Incentive Program
website: [www.tn.gov/tenncare/section/
electronic-health-record](http://www.tn.gov/tenncare/section/electronic-health-record)

How-to PowerPoint Presentations are
available at [www.tn.gov/tenncare/topic/
powerpoint-presentations](http://www.tn.gov/tenncare/topic/powerpoint-presentations)

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.

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www.tn.gov/tenncare/topic/e-blast-newsletters

TennCare Medicaid EHR Incentive Program Update

The TennCare Medicaid Electronic Health Record (EHR) Incentive Program provides financial incentives to eligible professionals and hospitals to promote the transition to EHRs. Providers who practice using EHRs are in the forefront of improving quality, reducing costs, and addressing health disparities. Since June 2011 *more than \$255 million* in incentive funds have been distributed *within 8,242* payments to Tennessee Medicaid providers.

8,242
Payments

\$255+
Million Paid

Are you
eligible?

For more information, visit the [TennCare Medicaid EHR Incentive Program](http://www.tn.gov/tenncare/topic/e-blast-newsletters) website.

How-to [PowerPoint Presentations](#) are also available.