E-Prescribing Incentive Program
How to earn an incentive in 2011 and avoid a penalty in 2012

Presented via Webinar
January 11, 2011

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Shaifali Ray
Objectives for Today’s Call

• Review e-prescribing program changes for individuals and groups
• Understand the reporting criteria for 2011-2013
• Review the details on how incentives and penalties will work
• Learn how UHC-AAMC Faculty Practice Solutions Center data can be used to track reporting and prepare for the future
Poll: Tell Us About Your Experience

Answer the following questions on the right-hand side of your WebEx viewer:

Question 1:
Does your organization have a qualified e-prescribing system?

Question 2:
Did your organization report e-prescribing in 2010?
E-Prescribing Incentive Program

Separate from, and in addition to, PQRS incentive

• 2011 and 2012: 1%
• 2013: 0.5%

Penalty:

• 2012: 1%
• 2013: 1.5%
• 2014: 2%

MUST REPORT IN FIRST HALF OF 2011 TO AVOID 2012 PENALTIES
eRx v. Medicare EHR Incentives

If Medicare EHR meaningful user –
• Not eligible for eRx incentives

BUT

• Will face 1% penalty in 2012 if you don’t report through claims to the eRx program in first half of 2011

TAKE AWAY.......
Multiple sets of criteria – why?

2011 Incentives
- Lump sum payment in 2012
- Can use data for entire CY2011

2012 Penalty
- Reduction at time the claim is processed
- Need to know by 1/1/2012 who is subject to penalty
- Use claims data from first half of 2011

2013 Penalty
- Use entire CY 2011 to determine who is subject to penalties
- May consider additional reporting periods
# Criteria for individual eligible professionals (EPs)

<table>
<thead>
<tr>
<th></th>
<th>Receive 1.0% Incentive Payment in 2011</th>
<th>AVOID 1.0% Payment Reduction in 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting mechanism</td>
<td>Claims, EHR, Registry</td>
<td>Claims only</td>
</tr>
<tr>
<td>“Successful e-prescriber”</td>
<td>Report 25 occurrences</td>
<td>Report 10 occurrences</td>
</tr>
</tbody>
</table>
### Criteria for individuals - cont

<table>
<thead>
<tr>
<th>Receive 1.0% Incentive Payment in 2011</th>
<th>AVOID 1.0% Payment Reduction in 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must meet all of the following:</td>
<td>All EPs are subject to the penalty unless one of the following apply:</td>
</tr>
<tr>
<td>1. Meet EP definition</td>
<td>1. Not a physician, NP, or PA on 6/30/11</td>
</tr>
<tr>
<td>2. Use a qualified system</td>
<td>2. No rx privileges*</td>
</tr>
<tr>
<td>3. Be “successful e-prescriber”</td>
<td>3. &lt; 100 encounters listed in the denominator</td>
</tr>
<tr>
<td>- 25 reporting events</td>
<td>4. Encounters listed in denominator &lt;10% of allowed charges</td>
</tr>
<tr>
<td>4. Encounters listed in denominator</td>
<td>5. Significant hardship*</td>
</tr>
<tr>
<td>&gt;10% of Medicare Part B allowed charges</td>
<td>6. Be “successful e-prescriber” - 10 reporting events</td>
</tr>
<tr>
<td>5. No Medicare EHR Incentives in 2011</td>
<td></td>
</tr>
</tbody>
</table>

*Must report G-code to indicate exception applies*
eRx Incentives – Step 1

Eligible Professionals

• Physicians, physical/occupational therapists, qualified speech-language pathologists, nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dietician, nutrition professionals, and qualified audiologists.

• Professionals must be authorized to prescribe in their state.
eRx Incentives - Step 2
Qualified System

“A qualified eRx system is one that is capable of ALL of the following:

• Generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs) if available

• Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts (defined below)

• Provide information related to lower cost, therapeutically appropriate alternatives (if any).

• Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan (if available)

The system must employ, for the capabilities listed, the eRx standards adopted by the Secretary for Part D by virtue of the 2003 Medicare Modernization Act (MMA).”

Source: 2011 E-prescribing measure specification
eRx Incentives – Step 3 Reporting

Numerator

G8553: At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

Denominator

CPT/HCPCS codes - 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

For claims reporting, must report G-code (with zero or one cent charge) on same claim as denominator encounter code.
eRx Incentives – Step 4
Calculating 10% threshold

At least 10% of allowed charges come from codes in the denominator.

\[
\frac{\text{Total Part B allowed charges for codes in denominator}}{\text{Total Part B allowed charges for covered PFS services}} \geq 10\%
\]

WARNING: Many Part B services, such as drug and lab services, are not covered under the physician fee schedule and therefore will not be in the denominator of this calculation.
eRx Incentives – Step 5

EPs that have received MEDICARE EHR incentives for meaningful use in 2011 are not eligible to receive the eRx Incentive – but may be subject to penalties.
Use FPSC Data to Estimate Eligibility, Project Incentives and Track eRx Reporting

The FPSC Procedure Summary report allows users to:

- Estimate eRx eligibility by time period, provider and payer category and project incentive
- Understand level of involvement if currently reporting via claims and track participation moving forward
Default View of the Procedure Summary Report

A. **Dimension Bar** – Select specific time periods, departments/divisions, CPT codes, payer categories, sites of service and locations

B. **Frequency/Units** – Number of units billed during given time period

C. **Total RVUs and Work RVUs** – Number of total or work RVUs generated during given time period

D. **Billings** – Charges entered during given time period

E. **Report Tool Bar Menu** – Create graphs, calculations and export files using the various icons

F. **Save As** – Save reports you create in your own folder or in your organization’s shared folder so other FPSC users can access the templates

Note: Procedure Summary report data is based on charge entry date
Steps to Determine Which Providers Are Eligible to Participate

A. Calculate each provider’s total Medicare FFS charges

B. Determine Medicare FFS charges for eligible visits (denominator)

C. Calculate eligible visits as a percent of total Medicare FFS charges
Identify A Group to Perform Analysis On

From the Dimension Bar:
1. Select desired time period
2. Select Medicare – Traditional/Fee for Service as the payer category
3. Select desired department/division. The data will drill down to the individual provider-level detail
(A) Calculate Each Provider’s Total Medicare Charges

4. Click Custom Subset icon
5. Title subset “Total Medicare (excl HCPCS and Path & Lab)”
6. Select “All CPT Ranges/Codes” from dimension drop-down menu
7. Click “Next”
8. Add all CPT families except for Path and Lab into the results set. Then open the HCPCS folder and range and add G0101, G0108 and G10109 into the results set
9. Click “Finish”
10. Report refreshes with summary for all eligible Medicare FFS visits
Calculate Each Provider’s Total Medicare Charges

11. Delete CPT family column to determine total Medicare volumes
12. Select the Billings measure
13. Export the results to Excel
14. Re-open the browser with the FPSC report

Tip: In the exported file, rename title of Billings column to “Total Medicare FFS Charges”
(B) Determine Charge Volume for Eligible Visits

1. Create a custom subset
2. Title subset “Eligible Visits”
3. Select “All CPT Ranges/ Codes” from dimension drop-down menu
4. Click “Next”
5. Add all applicable CPT codes (from slide 10) into result set
6. Click “Finish”
7. Report refreshes with summary of billings for all eligible Medicare FFS visits
8. Export the results to Excel
(C) Calculate Eligible Visits as a Percent of Total Medicare FFS Charges

<table>
<thead>
<tr>
<th>Provider</th>
<th>Total Medicare FFS Charges</th>
<th>Medicare FFS Charges for Eligible Visits</th>
<th>Eligible Visits as % of Total Charges</th>
<th>Qualify?</th>
</tr>
</thead>
<tbody>
<tr>
<td>3013</td>
<td>$135,739</td>
<td>$63,900</td>
<td>47.1%</td>
<td>Yes</td>
</tr>
<tr>
<td>3026</td>
<td>$216,583</td>
<td>$70,580</td>
<td>32.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>3022</td>
<td>$329,231</td>
<td>$86,800</td>
<td>26.4%</td>
<td>Yes</td>
</tr>
<tr>
<td>20064</td>
<td>$186,434</td>
<td>$42,945</td>
<td>23.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>3519</td>
<td>$106,022</td>
<td>$24,340</td>
<td>23.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>3518</td>
<td>$201,080</td>
<td>$39,320</td>
<td>19.6%</td>
<td>Yes</td>
</tr>
<tr>
<td>3023</td>
<td>$640,344</td>
<td>$119,935</td>
<td>18.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>3025</td>
<td>$346,661</td>
<td>$63,280</td>
<td>18.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>3000</td>
<td>$186,949</td>
<td>$24,810</td>
<td>13.3%</td>
<td>Yes</td>
</tr>
<tr>
<td>3501</td>
<td>$194,307</td>
<td>$24,825</td>
<td>12.8%</td>
<td>Yes</td>
</tr>
<tr>
<td>3027</td>
<td>$372,604</td>
<td>$39,740</td>
<td>10.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>3521</td>
<td>$21,675</td>
<td>$2,310</td>
<td>10.7%</td>
<td>Yes</td>
</tr>
<tr>
<td>3003</td>
<td>$349,757</td>
<td>$29,015</td>
<td>8.3%</td>
<td>No</td>
</tr>
<tr>
<td>3011</td>
<td>$371,004</td>
<td>$30,615</td>
<td>8.3%</td>
<td>No</td>
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<tr>
<td>3020</td>
<td>$292,174</td>
<td>$18,935</td>
<td>6.5%</td>
<td>No</td>
</tr>
<tr>
<td>3048</td>
<td>$208,236</td>
<td>$11,550</td>
<td>5.5%</td>
<td>No</td>
</tr>
<tr>
<td>95040</td>
<td>$319,998</td>
<td>$16,025</td>
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<tr>
<td>3073</td>
<td>$188,551</td>
<td>$9,300</td>
<td>4.9%</td>
<td>No</td>
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<tr>
<td>3520</td>
<td>$550,808</td>
<td>$25,390</td>
<td>4.6%</td>
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</tr>
<tr>
<td>3037</td>
<td>$366,510</td>
<td>$16,305</td>
<td>4.4%</td>
<td>No</td>
</tr>
</tbody>
</table>

16. Merge data from 2 exported Excel files together

17. Calculate Eligible Visits as % of Total Charges = Charges from Eligible Visits / Total Medicare FFS Charges

18. Identify if the values are greater than 10% to determine if each provider qualifies

Note:
FPSC charge data may not exactly match CMS data. This variance occurs because FPSC reports only include primary payer and reports are based on posting date rather than service date.
Take It a Step Further and Determine Projected eRx Incentive

Use this drop-down to change time period or division/specialty.

**Report is based on 2010 criteria for Eligible Visits**

<table>
<thead>
<tr>
<th>MEASURES as values</th>
<th>Total Medicare Charges (incl HCPCS &amp; Path and Lab)</th>
<th>Medicare Charges for Eligible Visits</th>
<th>Eligible Visits as a % of Total</th>
<th>Estimated Medicare Allowable at 30% GCR</th>
<th>Projected eRx Incentive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billings</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3264</td>
<td>$40,635</td>
<td>$24,135</td>
<td>59.44%</td>
<td>$12,190.80</td>
<td>$243.02</td>
</tr>
<tr>
<td>3089</td>
<td>$7,280</td>
<td>$5,080</td>
<td>83.52%</td>
<td>$2,184.00</td>
<td>$43.68</td>
</tr>
<tr>
<td>3201</td>
<td>$55,795</td>
<td>$53,430</td>
<td>95.76%</td>
<td>$16,738.50</td>
<td>$394.77</td>
</tr>
<tr>
<td>3202</td>
<td>$80,410</td>
<td>$77,425</td>
<td>96.29%</td>
<td>$24,123.00</td>
<td>$482.46</td>
</tr>
<tr>
<td>95268</td>
<td>$59,330</td>
<td>$58,985</td>
<td>99.42%</td>
<td>$17,799.00</td>
<td>$355.98</td>
</tr>
<tr>
<td>3211</td>
<td>$138,380</td>
<td>$157,505</td>
<td>99.45%</td>
<td>$47,514.00</td>
<td>$950.28</td>
</tr>
<tr>
<td>3175</td>
<td>$29,813</td>
<td>$27,165</td>
<td>91.12%</td>
<td>$8,943.90</td>
<td>$178.88</td>
</tr>
<tr>
<td>3247</td>
<td>$11,395</td>
<td>$1,020</td>
<td>8.95%</td>
<td>$3,410.50</td>
<td>$68.27</td>
</tr>
<tr>
<td>3258</td>
<td>$25,265</td>
<td>$24,310</td>
<td>92.55%</td>
<td>$7,879.80</td>
<td>$157.60</td>
</tr>
<tr>
<td>3074</td>
<td>$28,811</td>
<td>$26,550</td>
<td>92.50%</td>
<td>$8,643.30</td>
<td>$172.87</td>
</tr>
<tr>
<td>3068</td>
<td>$11,030</td>
<td>$8,540</td>
<td>78.33%</td>
<td>$3,309.00</td>
<td>$66.18</td>
</tr>
<tr>
<td>3179</td>
<td>$30,670</td>
<td>$13,620</td>
<td>44.41%</td>
<td>$9,201.00</td>
<td>$184.02</td>
</tr>
<tr>
<td>3344</td>
<td>$12,355</td>
<td>$11,495</td>
<td>93.15%</td>
<td>$3,766.50</td>
<td>$75.33</td>
</tr>
<tr>
<td>3027</td>
<td>$8,841</td>
<td>$8,140</td>
<td>92.07%</td>
<td>$2,652.30</td>
<td>$53.05</td>
</tr>
<tr>
<td>3199</td>
<td>$41,895</td>
<td>$39,785</td>
<td>94.96%</td>
<td>$12,558.50</td>
<td>$251.37</td>
</tr>
<tr>
<td>3233</td>
<td>$7,111</td>
<td>$6,550</td>
<td>92.11%</td>
<td>$2,133.30</td>
<td>$42.67</td>
</tr>
<tr>
<td>3343</td>
<td>$14,335</td>
<td>$12,325</td>
<td>86.00%</td>
<td>$3,900.50</td>
<td>$86.01</td>
</tr>
<tr>
<td>3334</td>
<td>$102,621</td>
<td>$85,936</td>
<td>84.72%</td>
<td>$30,786.30</td>
<td>$615.73</td>
</tr>
<tr>
<td>3225</td>
<td>$66,659</td>
<td>$56,010</td>
<td>84.02%</td>
<td>$19,997.70</td>
<td>$399.95</td>
</tr>
</tbody>
</table>
FPSC eRx Incentive Eligibility Report Definitions

Eligible Visits as % of Total = \( \frac{\text{Medicare Charges for Eligible Visits}}{\text{Total Medicare Charges}} \)

Total Medicare Allowable = 30% of Total Medicare Charges (i.e., model assumes GCR of 30% on Medicare)

Projected eRx Incentive = 2% of Total Medicare Allowable (this figure is reported for all providers, regardless of their standing relative to the 10% threshold)

Report is designed for the user to view one division/specialty at a time using the drop-down menu to change specialties)

User can change the time period using the drop-down menu at far left of report

Save this report in your organization’s shared folder so other FPSC users at your organization can access the incentive estimates for their divisions – Learn how to save reports to your FPSC Newsbox

* Charges for HCPCS and Path & Lab CPTs are excluded from total Medicare charges calculation to ensure only Physician Fee Schedule charges are included in the calculation
E-Prescribing Penalties

• 2012 penalties based on claims-based e-prescribing reporting during the first six months of 2011 (January – June)

• 2013 penalties
  • Successful e-prescribers in 2011 will NOT be subject to 2013 penalties
  • CMS may consider additional reporting periods in 2012
Avoiding 2012 E-prescribing Penalties

• Individual EPs - penalties apply unless the following exceptions apply:
  1. The EP is not a physician, nurse practitioner, or physician assistant as of June 30, 2011
  2. The EP does not have prescribing privileges (must report through G-code G6844 once during reporting period)
Avoiding 2012 E-prescribing Penalties

- Individual EPs - penalties apply unless the following exceptions apply (cont):
  3. The EP does not have at least 100 cases containing an encounter code that falls within the denominator of the measure;
  4. The EP has less than 10 percent of their total allowed charges come from the encounter codes listed in the measure denominator;
  5. The EP meets the criteria for a “significant hardship” exemption;
Significant Hardship

- 2 significant hardship exemptions
  - Rural areas with limited high speed internet access (G6842)
  - Areas with limited available pharmacies for e-prescribing (G6843)
  - Practices must report a “G-code” once to indicate hardship.

**NOT HAVING A QUALIFIED eRx SYSTEM DOES NOT EXEMPT YOU FROM THE PENALTIES**
Avoiding 2012 E-prescribing Penalties

The last way to avoid penalties:

- Between January 1, 2011-June 30, 2011, the EP
  - Reports on at least 10 encounters that at least one prescription was e-prescribed.
  - Must report via CLAIMS (EHR, Registry reporting is not an option)
Participants Who Are Submitting eRx QDC in FPSC Data

- Clarian Health Partners Inc.
- Columbia Doctors
- Duke University Medical Center, PDC
- Indiana University Medical Group
- LifeBridge Health - Sinai Hospital of Baltimore
- LSU Healthcare Network
- Medical College of Wisconsin
- Mount Sinai Faculty Practice Associates
- Oregon Health & Science University, OHSU Medical Group
- Rush Medical College
- Saint Louis University - SLUCare
- State University of New York at Stony Brook, Clinical Practice Management Plan
- SUNY Upstate Medical University, University Medical Associates at Syracuse, Inc.
- Thomas Jefferson University, Jefferson University Physicians
- Tufts Medical Center Physicians Organization
- UCLA Faculty Practice Group
- UCSF Medical Group
- University of Colorado, University Physicians, Inc.
- University of Pennsylvania Health System
- University of Rochester School of Medicine
- Weill Cornell Physician Organization
FPSC Data Suggests Some Eligible Providers Are Not Submitting eRx QDC

FPP X - General Internal Medicine
Jan – June 2010 Medicare FFS Data

Charges for Eligible Visits as a % of Total Medicare FFS Charges

<table>
<thead>
<tr>
<th>Provider</th>
<th>% Eligible Visits</th>
<th>Volume of Units for CPT G8553</th>
</tr>
</thead>
<tbody>
<tr>
<td>FPP X - General Internal Medicine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Trend eRx QDCs in the FPSC Reports To Ensure You’re On Track With Meeting Reporting

If you have been submitting eRx data by claims, be sure you’re also sending this data to the FPSC.

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Units of CPT Code G8553</th>
</tr>
</thead>
<tbody>
<tr>
<td>3264</td>
<td>8</td>
</tr>
<tr>
<td>3089</td>
<td>0</td>
</tr>
<tr>
<td>3202</td>
<td>64</td>
</tr>
<tr>
<td>95268</td>
<td>14</td>
</tr>
<tr>
<td>3211</td>
<td>12</td>
</tr>
<tr>
<td>3175</td>
<td>6</td>
</tr>
<tr>
<td>3258</td>
<td>15</td>
</tr>
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<td>3074</td>
<td>9</td>
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</tr>
<tr>
<td>3179</td>
<td>1</td>
</tr>
<tr>
<td>3344</td>
<td>0</td>
</tr>
</tbody>
</table>
eRx Incentive - Groups

Group reporting available to PQRS group practices

• Groups determine if they want to report as individuals or as a group practice

• Reporting period: January – December 2011

• TIN must have at least 10 percent of Medicare Part B charges come from encounters listed in measure denominator

• Filter out charges for EPs who have received EHR incentive
eRx Incentive - Groups

Reporting criteria:

• GPRO I - report e-prescribing at least 2,500 times

• GPRO II –
  • 2-10 EPs = 75 times
  • 11-25 EPs = 225 times
  • 26-50 EPs = 475 times
  • 51-100 EPs = 925 times
  • 101-199 EPs = 1,875 times
2012 Penalties for Groups

• Must meet 2011 criteria for successful e-prescribing in first six months of the year
**Key Takeaways**

- Penalties for 2012 (and 2013) will be based on 2011 reporting
- 2011 incentive and 2012 penalty have different reporting time periods and criteria
- Medicare EHR incentive program is a different program with different specifications. EPs **must** report to eRx to avoid the penalties, even if they are working on “meaningful use”
Additional Resources

FPSC (https://www.facultypractice.org/)

AAMC (www.aamc.org/gfp)

CMS (http://www.cms.gov/ERXincentive/)
For More Information

Would you like to learn more about the eRx program?

Contact:
Mary Patton Wheatley, Senior Specialist
mwheatley@aamc.org
(202) 862-6297

Would you like to learn more about the FPSC reports and how they can help inform your group’s eRx participation?

Contact:
Shaifali Ray, Senior Manager
ray@uhc.edu
(630) 954-1792