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2014 Milestones

December 5, 2013

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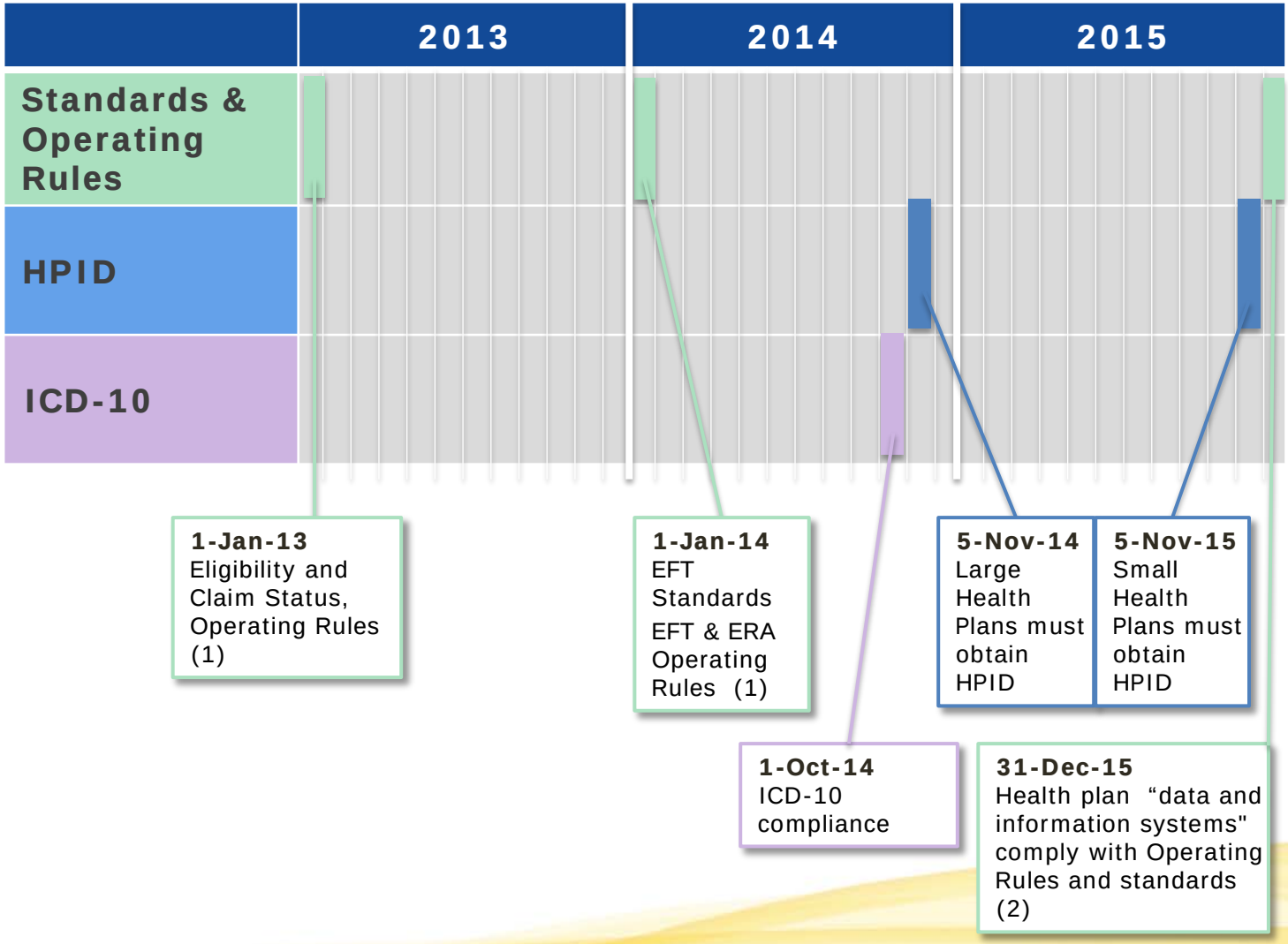
Administrative Simplification 2014 Milestones

Benefits of Administrative Simplification for Providers

- Reduces health care billing and payment costs by making it easier for providers and health plans to share administrative information electronically
- Less time on paperwork means more time for patients

Administrative Simplification Timeline



Eligibility Operating Rules

- Eligibility operating rules require health plans to respond to providers' eligibility questions with a patient's financial information, including the deductible and coverage information for specific service types. Health plans are also required to provide secure access to this information over the Internet.

Milestone:
January 1, 2013

Eligibility Operating Rules

Key Considerations for Providers

- **Data content**: Requirements for more robust 271 eligibility response (I and II), normalizing patient Last Name (II)
- **Connectivity:** Requires "safe harbor" connection via public internet (HTTP/S)
- **Companion Guide:** Standardized template
- **Response time:** 20 seconds or less (real time)
- **System availability:** Requires 86% availability per week
- Operating rules around **acknowledgements NOT** adopted

Claim Status Operating Rules

- Claim status operating rules require health plans to offer providers the ability to check on the status of the claim over the internet in real time.

Milestone:
January 1, 2013

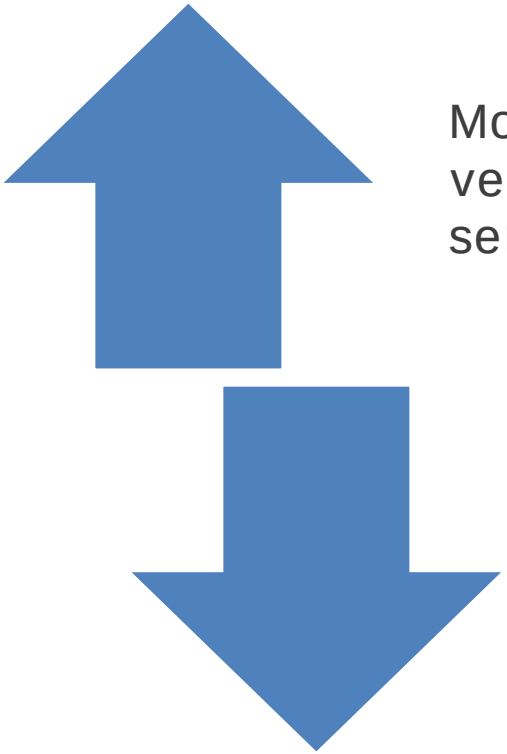
Claim Status Operating Rules

Key Considerations for Providers

- **No data content requirements**
- **Connectivity:** Requires “safe harbor” connection via public Internet (HTTP/S)
- **Companion Guide:** Standardized template
- **Response time:** 20 seconds or less (real time)
- **System availability:** Requires 86% availability per week
- Operating rules around **acknowledgements NOT** adopted

How Will Eligibility & Claim Status Operating Rules Affect Providers?

Eligibility and Claim Status



More accurate patient eligibility verification and improved point of service collections

Decrease in claim denials

EFT and ERA Standards and Operating Rules

Electronic Funds Transfer (EFT) standards are rules for the format and data content of the transmission a health plan sends to its bank to pay provider claims electronically (through an electronic funds transfer).

Electronic Remittance Advice (ERA) is a description of payment that health plans send to providers.

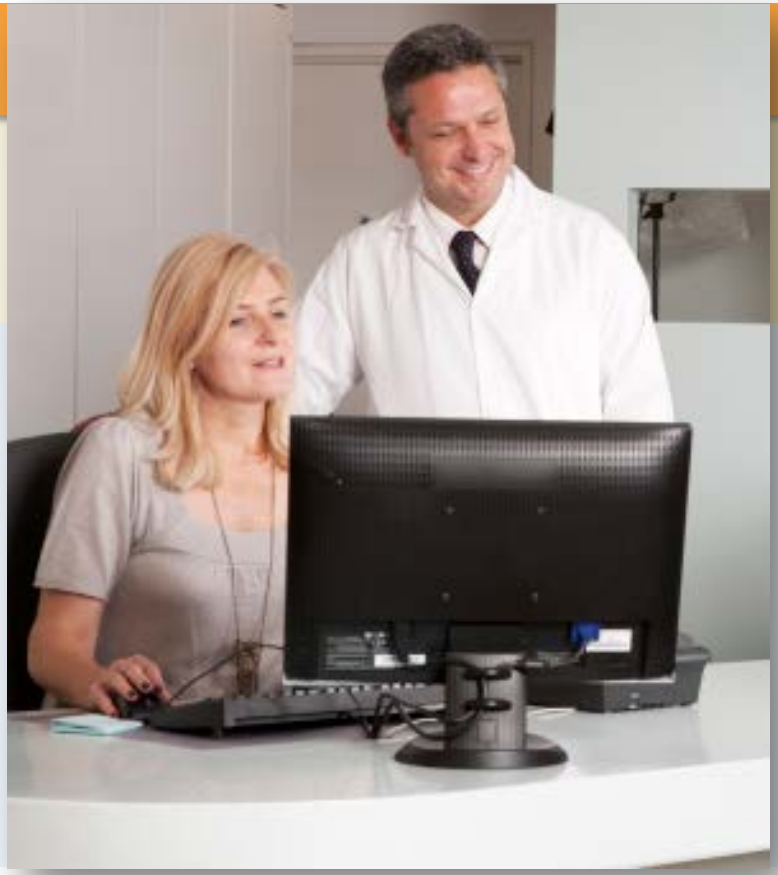
EFT and ERA Operating Rules are rules enabling providers to quickly and efficiently enroll and use EFT and ERA.

Milestone:
January 1, 2014

EFT and ERA Operating Rules

Key considerations:

- Simpler, standardized enrollment across different health plans
- Use of same trace number in both EFT and ERA allows for automated reassociation
- Standard use of code combinations (CARCS, RARCS, and Group Codes) across different health plans
- Talk with health plans, vendors, and your bank about the status of implementing operating rules



ICD-10

Key Considerations for Providers

- **ICD-10-CM:** Diagnosis coding for use in all U.S. health care settings.

- **ICD-10-PCS**: Inpatient procedure coding is for use in U.S. inpatient hospital settings only.

Milestone:
October 1, 2014

Why Transition to ICD-10?

ICD-9 Limitations

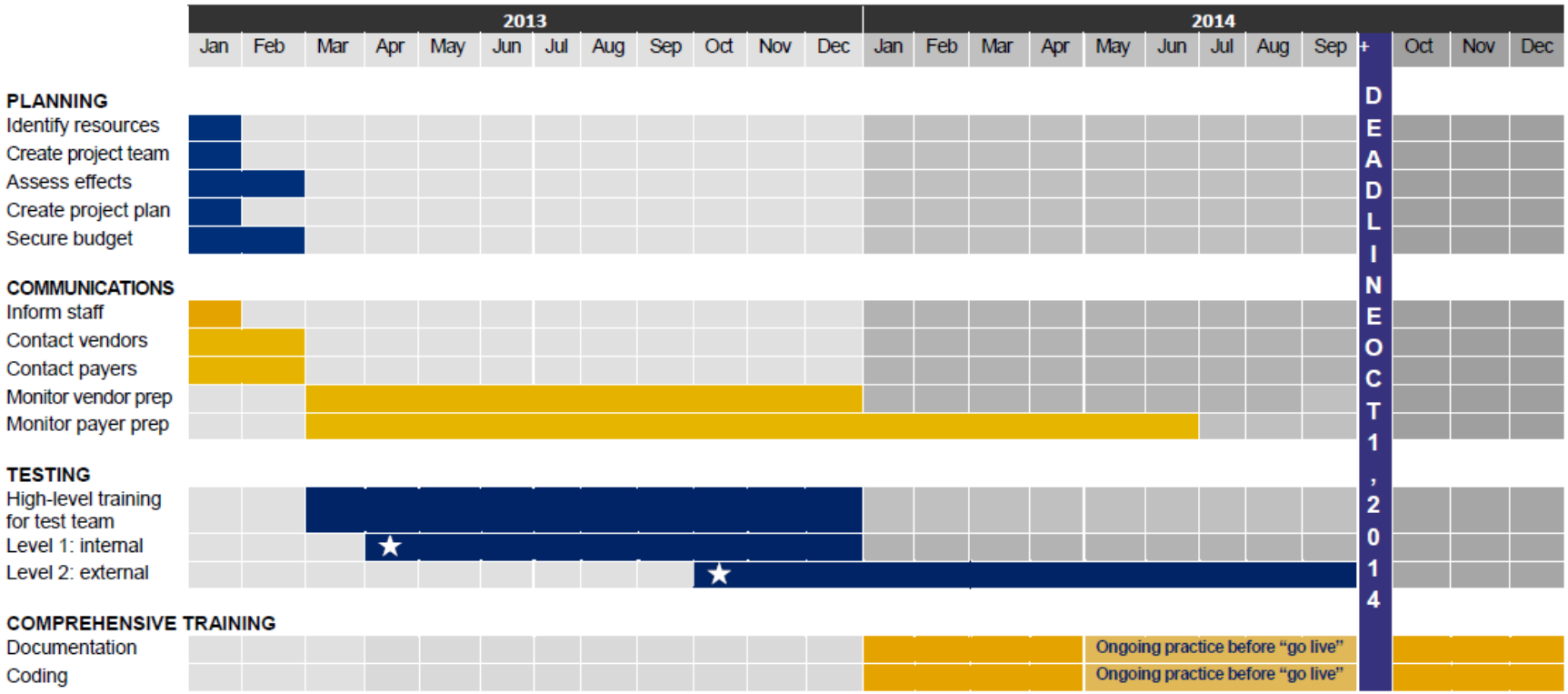
- ICD-9 limits operations, reporting, and analytic processes
- Follows a 1970s outdated medical coding system
- Lacks clinical specificity to inform claims processing and other critical processes
- Restricted to three to five characters, limiting the ability to account for complexity and severity
- Running out of capacity

ICD-10 Advantages

- ICD-10 limits operations, reporting, and analytic processes
- Detailed medical concepts
- Enhanced categorization models
- Granularity in severity, risk definitions, co-morbidities, complications, and anatomical location
- Greater forward flexibility and structure to support increased flexibility
- More consistent with the rest of the world

Transitioning to ICD-10

ICD-10 Timeline for Small-Medium Practices at a Glance



Prepare for ICD-10 Now

- **Identify** where you see ICD-9 codes used in your practice and become familiar with ICD-10 codes that you may use
- **Confirm** the readiness of your practice management and/or EHR system
- **Revisit** your action plan to make sure you are still on track




ICD-10 Resources

- ICD-10 Email Updates
- ICD-10 Fact Sheets
- Online ICD-10 Guide
- Medscape Modules
- Videos, Webinars, and Presentations
- Other organizations

Health Plan Identifier (HPID)

- Used to standardize how health plans are identified in transactions to avoid misrouting of transactions and incorrect rejections
- Required to be used by health plans and providers in standard transactions to identify a health plan that has an HPID
- Entities that meet the definition of controlling health plan, as defined in 45 CFR 162.103, will be required to obtain an HPID by November 5, 2014. This may include states.
- All covered entities will be required to use an HPID to identify a health plan in the HIPAA standard transactions by November 7, 2016.

Milestone:
November 5, 2014 —
Large health plans must obtain HPID

Questions?

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2014 Milestones: Physician Quality Reporting Program (PQRS)

Overview of Key Dates in 2014

Jan 1	2014 reporting year begins for eligible professionals (EPs) Last year participants can earn an incentive for satisfactorily reporting quality data to CMS
Jan 27	First day for groups to submit data through the group practice reporting option (GPRO) Web Interface
Jan 31	Last day to self-nominate to be a Qualified Clinical Data Registry (QCDR)
Feb 28	Last day to submit 2013 PQRS data through EHR reporting methods Last day to submit clinical quality measures (CQMs) for the PQRS-Medicare EHR Incentive Reporting Pilot Program Last day that 2013 claims will be processed to be counted for PQRS reporting to determine the 2013 incentive payment and the 2015 payment adjustment Last day that EPs who participated in the 2012 PQRS program can request an informal review of their 2012 PQRS results
Mar 21	Last day for groups to submit 2013 PQRS data through the GPRO Web Interface
Mar 31	Last day to submit PQRS data through registry reporting method Last day for Maintenance of Certification (MOC) Program entities to submit 2013 quality data Last day for QCDRs to submit measure information
Sep 30	Last day for groups to register to participate in GPRO for the 2014 PQRS program year via GPRO Web Interface, registry, EHR reporting, and CG CAHPS
Dec 31	2014 PQRS reporting ends for both group practices and individuals

January 1: Reporting Period Begins

Reporting period begins for EPs and group practices for calendar year 2014

- This is the last year participants can earn an **incentive for satisfactorily reporting quality data to CMS**
- By satisfactorily reporting, EPs and groups can **earn the 2014 incentive and avoid the 2016 payment adjustment**

January 27- March 21: 2013 Submission Period for GPRO Web Interface

- **Groups can submit 2013 data through the group practice reporting option** (GPRO) Web Interface between January 27 and March 21
- Review the GPRO Web Interface webpage on the PQRS website for more information: cms.gov/PQRS




January 31: QCDR Self-Nomination Deadline

Last day to self-nominate to be a Qualified Clinical Data Registry (QCDR)

- Learn more about qualifying to be a QCDR for PQRS on the Registry webpage of the PQRS website

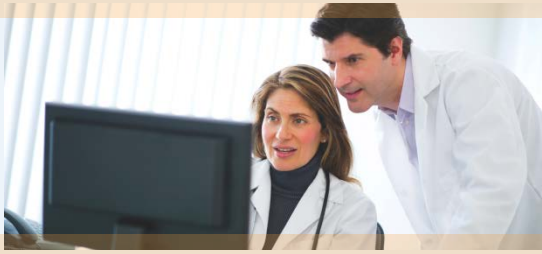
February 28: Multiple Deadlines

- **Last day to submit 2013 PQRS data** through EHR reporting methods
- **Last day to submit clinical quality measures (CQMs)** for the 2013 PQRS-Medicare EHR Incentive Reporting Pilot Program
- **Last day that 2013 claims will be processed to be counted for PQRS reporting** to determine the 2013 incentive payment and the 2015 payment adjustment
- **Last day 2012 PQRS program participants can request an informal review** of their 2012 PQRS results

March 31: 2013 MOC and Registry Deadline

- **Last day to submit 2013 PQRS data** through registry reporting method
- **Last day for Maintenance of Certification** (MOC) Program entities to submit 2013 quality data
  - Provides opportunity to earn PQRS incentive and an additional incentive of 0.5%



September 30: 2014 Group Registration Deadline

Groups can register to participate in GPRO for the 2014 PQRS program year via GPRO Web Interface, registry, EHR reporting, and CG CAHPS by September 30

- CMS created a new reporting mechanism, the certified survey vendor reporting mechanism:
  - Allows a group of 25 or more EPs to count reporting of Consumer Assessment of Healthcare Providers and Systems Clinician & Group (CG CAHPS) survey measures towards meeting criteria for satisfactory reporting for 2014 PQRS incentive and 2016 PQRS payment adjustment
- All registrants as of September 30 will be considered a 2014 PQRS GPRO participant and will be analyzed at the TIN level

December 31: 2014 Reporting Ends

- **2014 PQRS reporting ends for both group practices and individuals**
- EPs and groups can avoid the 2016 PQRS payment adjustment by **submitting one valid measure** (EPs can also submit one measure in a measures group)




Value Based Payment Modifier: Overview

- **1st Quarter 2014:** Complete submission of 2013 information for PQRS
- **Spring 2014-9/30/14:** Registration period
- **3rd Quarter 2014:** Retrieve 2013 Physician feedback reports(All Groups and Solo Practitioners)

More information on important Value-Based Payment Modifier dates can be found on the CMS website:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Milestone Resources

Learn more about CMS quality programs and important dates by reviewing these websites:

- **PQRS Program: http**://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
- **Value-Based Payment Modifier Program:** http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Questions?

- For questions or assistance with reporting contact the QualityNet Help Desk
- The QualityNet Help Desk is available **Monday–Friday**; **7:00 AM–7:00 PM CST** to assist with:
  - General CMS Physician Quality Reporting System information
  - Portal password issues
  - Feedback report availability and access
  - PQRI-IACS registration questions
  - PQRI-IACS login issue

  Phone: 1-866-288-8912
  TTY: 1-877-715-6222
  Email: Qnetsupport@sdps.org
- For questions related to participating in the PQRS-Medicare EHR Incentive Program Electronic Reporting Pilot contact the EHR Information Center
- The EHR Information Center is available **Monday–Friday**; **7:30 AM – 6:30 PM CST**.

  Phone: 1-888-734-6433
  TTY: 888-734-6563

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2014 Milestones for EPs: Medicare and Medicaid EHR Incentive Programs

Overview of Key Dates in 2014 for EPs

January 1	2014 reporting year begins Stage 2 begins
February 28	Last day to register and attest for 2013
July 1	Last day for EPs who have *not started* participation to begin their 90 days of meaningful use
October 1	Last day for Medicare EPs, *who are in their first year*, to attest to demonstrating meaningful use to receive an incentive payment and avoid the 2015 payment adjustment Last day for EPs, *who are not in their first year,* to begin 90-day reporting period for 2014
December 31	2014 reporting year ends

2014 Certification Criteria

- **All providers must adopt or upgrade** to the 2014 standards and criteria begin for EHR technology
- The new criteria will allow providers to meet both Stage 1 and Stage 2 requirements
- **Visit healthit.gov** for more information




January 1: Reporting Period Begins

- Reporting period begins for calendar year 2014
- All EPs, regardless of their stage, are only required to demonstrate meaningful use for a three-month, or 90-day, EHR reporting period
  - Medicare EPs in their first year of meaningful use may select any 90 day reporting period
  - Medicaid EPs can select any 90-day reporting period that falls within the 2014 calendar year

2014: Last Year for Medicare EPs to Start Participation

- 2014 is the last year Medicare EPs can begin program participation to receive an incentive payment
- Medicare EPs who have not yet started participation must begin their 90 days no later than July 1, and submit attestation by October 1
- The earlier reporting period allows CMS to review their data for Medicare EPs to avoid the payment adjustment




Avoiding the 2015 Medicare Payment Adjustments

Demonstrate meaningful use to CMS by:

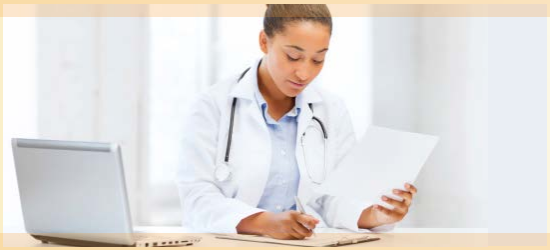
Meaningful EHR User in 2011, 2012 or 2013	Never been a Meaningful EHR User
End EHR reporting period by **December 31, 2013**	End EHR reporting period by **September 30, 2014**
Attest by **February 28, 2014**	Attest by **October 1, 2014**

Apply to CMS for a hardship exemption by:
July 1, 2014

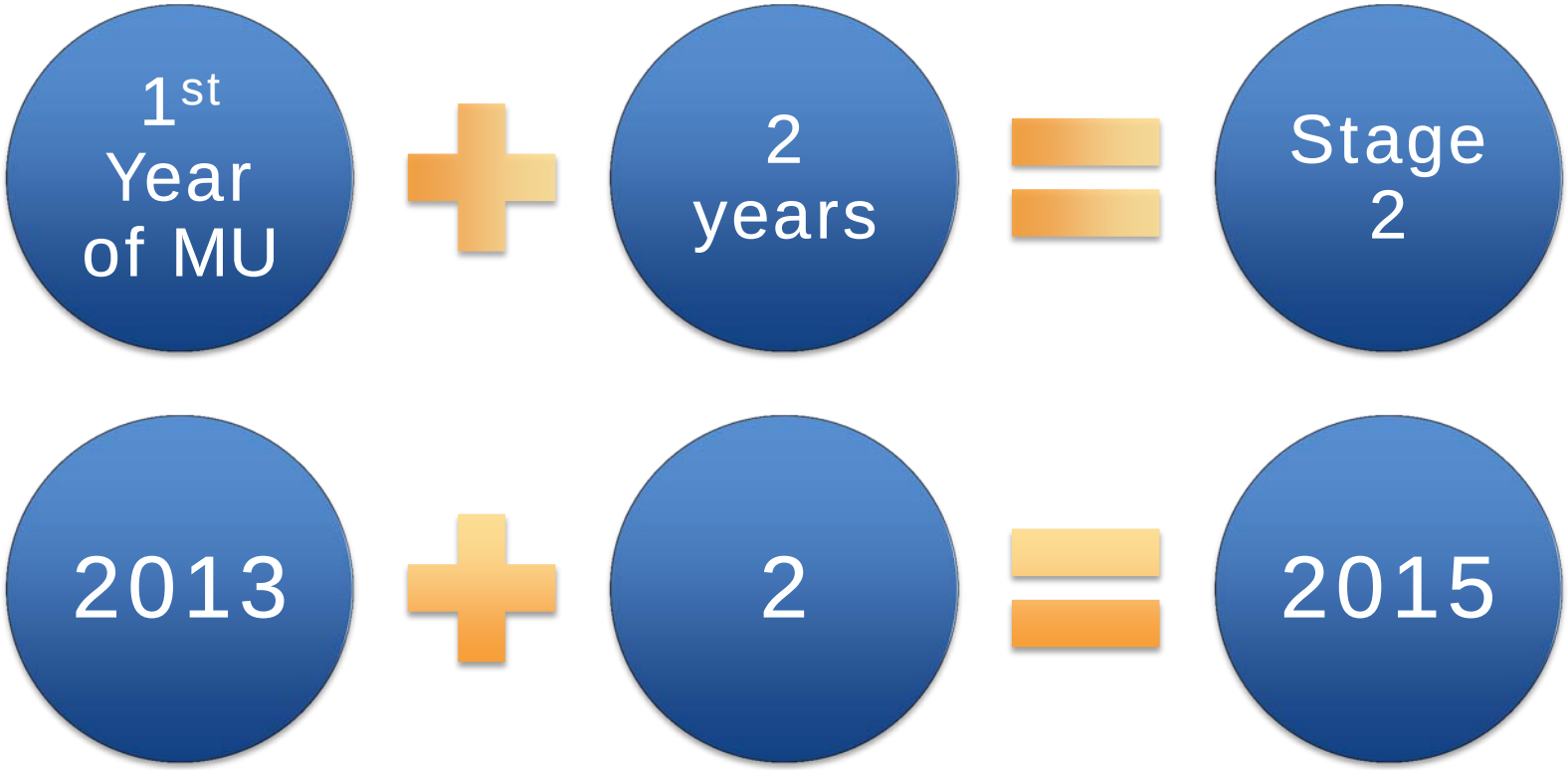
Note: *Medicaid EPs are not subject to payment adjustments. However, if you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you MUST demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.*

January 1: Stage 2 Begins for EPs

- January 1 is the start of Stage 2 for EPs who have completed ***at least two years*** of Stage 1
- **Stage 2 criteria will improve patient care** through better clinical decision support, care coordination, and patient engagement
- **All providers** begin participation in Stage 1 of meaningful use

When Do I Start Stage 2?

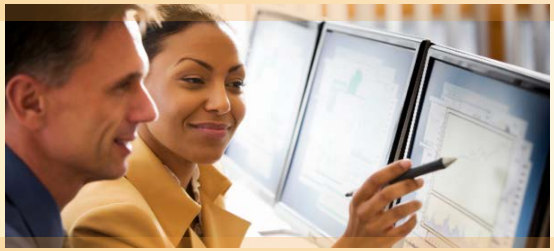


My EHR Participation Timeline

- EPs should refer to the CMS tool, ***My EHR Participation Timeline***, to determine what year they will meet Stage 1, Stage 2, and Stage 3 of meaningful use in the Medicare and Medicaid EHR Incentive Programs
- Tool is available on the CMS EHR website

Clinical Quality Measures (CQMs) in 2014

- Beginning in 2014, the reporting CQMs will change for everyone
- 2014 certified EHR technology will contain new CQM criteria
- **EPs will report using the new 2014 criteria** regardless of whether they are participating in Stage 1 or Stage 2 of the EHR Incentive Programs

Reporting CQMs in 2014

- **EPs have the option to electronically report their CQM data for the full calendar year of 2014** to receive credit for both PQRS and the Medicare EHR Incentive Program

- Providers who choose to submit electronically will:
  - Need to submit their CQM data as an electronic file between **January 1 and February 28, 2015**.
  - Receive their payment in Spring 2015
- Medicare EPs also have the option of submitting three months of CQM data online through the **CMS Registration & Attestation System**

Questions?