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Medicare & Medicaid EHR Incentive Programs: Stage 2, Payment Adjustments & Audits

January 14, 2014

CMS
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DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Presentation Objective

Help Eligible Professionals prepare for:

1. Stage 2
2. Clinical Quality Measures
3. 2014 EHR Certification Changes
4. Payment Adjustments & Hardship Exceptions
5. Audits

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Stage 2

When Do I Start Stage 2?

Everyone Starts in Stage 1
No One Starts Stage 2 Before 2014

Changes to Meaningful Use

Changes

- **Menu Objective Exclusion**– While you can continue to claim exclusions if applicable for menu objectives, starting in 2014 these exclusions will no longer count towards the number of menu objectives needed to successfully demonstrate meaningful use.

No Changes

- **Half of Outpatient Encounters**– at least 50% of EP outpatient encounters must occur at locations equipped with certified EHR technology.
- **Measure compliance = objective compliance**
- **Denominators based on outpatient locations equipped with CEHRT** and include all such encounters or only those for patients whose records are in CEHRT depending on the measure.

Impact of Certification

Q: What Certified EHR Technology do I need in 2014?

A: EHR Technology certified to the 2014 Criteria covering the "base" EHR plus all objectives I intend to attest for in 2014.

Q: Does it matter if I am in Stage 1 or 2?

A: No

Note: *Providers beyond their first year of participation may electronically report their CQMs for the full calendar year of 2014. This means providers will submit their CQM data between January 1 and February 28, 2015.*

Meaningful Use:
Changes from Stage 1 to Stage 2

Stage 1

Eligible Professionals
13 core objectives
5 of 9 menu objectives
18 total objectives

Stage 2

Eligible Professionals
17 core objectives
3 of 6 menu objectives
20 total objectives

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Changes for Stage 2

New Requirements

- Secure Messaging
- Family Health History
- Imaging Results
- Registry Reporting
- Progress Notes

Updated Requirements

- Lab Results
- Patient Lists
- Patient Education
- Summary of Care Records
- Medication Reconciliation
- Immunizations
- Patient Reminders
- Online Patient Information

Refer to the Stage 2 Specification Sheets on the Educational Resources page for a full list of measures.

Closer Look at Stage 2: Patient Engagement

Patient engagement – engagement is an important focus of Stage 2.

Requirements for Patient Action:

- More than 5% of patients must send secure messages to their EP
- More than 5% of patients must access their health information online

EXCLUSIONS – CMS is introducing exclusions based on broadband availability in the provider's county.

Closer Look at Stage 2: Electronic Exchange

Stage 2 focuses on actual use cases of electronic information exchange:

- Stage 2 requires that a provider send a summary of care record for more than 50% of transitions of care and referrals.
- The rule also requires that a provider electronically transmit a summary of care for more than 10% of transitions of care and referrals.
- At least one summary of care document sent electronically to recipient with different EHR vendor or to CMS test EHR.

Special Reporting Periods in 2014

Demonstrate meaningful use for a **3-month, or 90-day**, reporting period, regardless if you are demonstrating Stage 1 or Stage 2 of meaningful use.

- Choose your reporting period based on your program and participation year:
  - **Medicare EPs beyond first year of meaningful use:** Select a three-month reporting period fixed to the quarter of the calendar year.
  - **Medicare EPs in first year of meaningful use**: Select any 90-day reporting period. *To avoid the 2015 payment adjustment, begin reporting by July 1 and attest by October 1.*
  - **Medicaid EPs:** Select any 90-day reporting period that falls within the 2014 calendar year.

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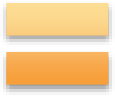
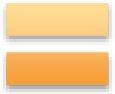
Clinical Quality Measures

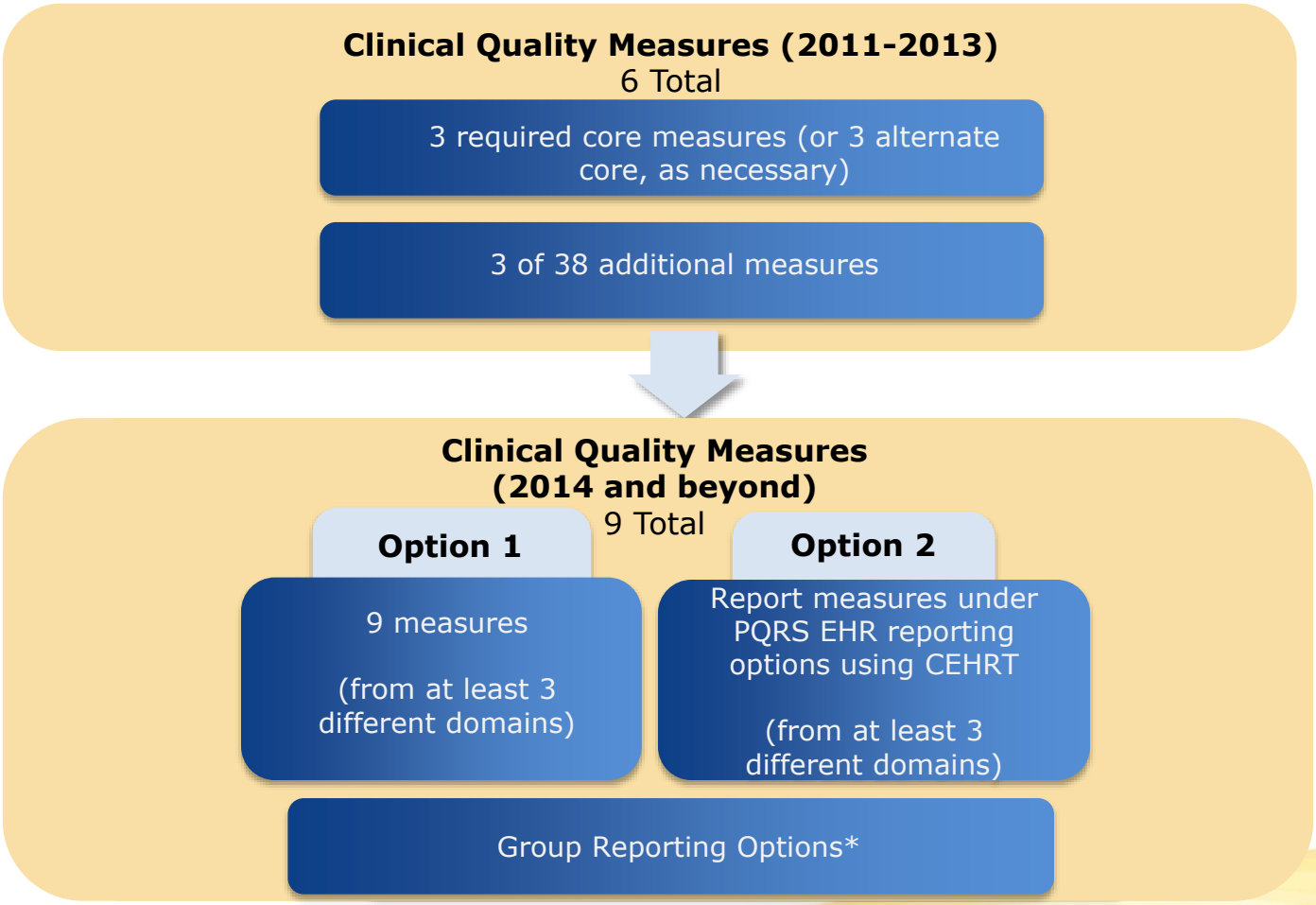
Clinical Quality Measures

CQM Requirements  **Stage of Meaningful Use**

CQM Requirements  **Current year**

CQM Requirements  **Output of current Certified EHR**

CQM Requirements



* Discussed further in subsequent slides

2014 CQM Domains

CQM Domains:

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population/Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Process/Effectiveness

Clinical Quality Measures 2014 and Beyond

9 Total Measures
- Choose from at least 3 different domains
- No required core set, though CMS **suggests** a core set of CQMs for both adults and children

2014 eCQM Reporting Options

- **Option 1:** Report through Certified EHR Technology
  - For this reporting option, CQMs will be submitted on an aggregate basis reflective of all patients without regard to payer
  - Submit three months of data through the EHR Registration & Attestation System

2014 eCQM Reporting Options (continued)

- **Option 2:** Utilize the Physician Quality Reporting System (PQRS)* EHR Reporting Option
  - Submit and satisfactorily report PQRS CQMs under the PQRS EHR Reporting option using Certified EHR Technology
  - Submit a full year (January through December) of data electronically to receive credit for EHR Incentive Program and the Physician Quality Reporting System.

*For more information on the requirements of the PQRS, refer to 42 CFR 414.90 and the CY 2014 Medicare PFS proposed rule (78 FR 43356 through 43479)

2014 eCQM Reporting Options (continued)

- Group Reporting
  - Option A: EPs in an ACO who satisfy requirements of Medicare Shared Savings Program or Pioneer ACO model using Certified EHR Technology
  - Option B: EPs who satisfy requirements of PQRS GPRO option using Certified EHR Technology

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2014 EHR Certification Changes

General Points to Remember

- There are 3 ways to meet the CEHRT definition
  1. **Complete EHR**
     - Generally provides overall assurance
     - EPs would still need EHR technology certified to cancer registry certification criteria if they seek to meet that MU objective
  2. **Combination of EHR Modules**
  3. **Single EHR Module**

In the case of EHR Modules, it is now possible for an eligible provider to have just enough EHR technology certified to the 2014 Edition EHR certification criteria to meet the CEHRT definition

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Payment Adjustments & Hardship Exceptions

Medicare Only

EPs, Subsection (d) Hospitals and CAHs

Avoiding the 2015 Payment Adjustments

Demonstrate meaningful use to CMS or your State by:

Meaningful EHR User in 2011 or 2012	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 exception by:

July 1,2014

Hospital Subtract 3 Months

How Payment Adjustments Affect You

- A payment adjustment will be applied to the Medicare physician fee schedule amount for services furnished during the year
- The payment adjustment is 1% per year and is cumulative for every year meaningful use is not met
  - Eligible professionals who are subject to the eRx payment adjustment in 2014 will receive 2% in 2015
- Payment adjustment percentages are determined by year, not by your participation timeline
  - Example: If you successfully participate in 2014, but do not participate in 2015, you would incur a 3% payment adjustment in 2017

Refer to the Payment Adjustment Tipsheet for EPs on the Educational Resources page.

Payment Adjustments for Providers Eligible for Both Programs

Eligible for both programs?

If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you **MUST** demonstrate meaningful use according to the timelines in the previous slides to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.

Note: *Congress mandated that an EP must be a meaningful user in order to avoid the payment adjustment; therefore receiving a Medicaid EHR incentive payment for adopting, implementing, or upgrading your certified EHR Technology would not exempt you from the payment adjustments.*

EP Hardship Exceptions

EPs can apply for hardship exceptions in the following categories:

1. **Infrastructure**
   EPs are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
2. **New EPs**
   Newly practicing EPs who would not have had time to become meaningful users.
3. **Unforeseen Circumstances**
   Examples may include a natural disaster or other unforeseeable barrier.
4. **EPs meet the following criteria:**
   - » Lack of face-to-face or telemedicine interaction with patients
   - » Lack of follow-up need with patients
5. **EPs who practice at multiple locations must demonstrate that they:**

Are unable to control the availability of CEHRT for more than 50% of patient encounters

EP Hardship Exceptions

EPs whose primary specialties are anesthesiology, radiology or pathology:

As of July 1st of the year preceding the payment adjustment year, EPs in these specialties will receive a hardship exception based on the 4th criteria for EPs

EPs must demonstrate that they meet the following criteria:

- Lack of face-to-face or telemedicine interaction with patients
- Lack of follow-up need with patients

Applying for Hardship Exceptions

- **Applying:** EPs must apply for hardship exceptions to avoid the payment adjustments.
- **Granting Exceptions:** Hardship exceptions will be granted only if CMS determines that providers have demonstrated that those circumstances pose a significant barrier to their achieving meaningful use.
- **Deadlines:** Applications need to be submitted **no later than July 1 for EPs** of the year before the payment adjustment year; however, CMS encourages earlier submission

For More Info: Details on how to apply for a hardship exception will be posted on the CMS EHR Incentive Programs website in the future: **www.cms.gov/EHRIncentivePrograms**

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Audits

EPs, Subsection (d) Hospitals and CAHs

Audit Basics

- Any provider that receives an EHR incentive payment for either EHR Incentive Program may be subject to an audit
- CMS, and its contractor, Figliozzi and Company, will perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers who are participating in the EHR Incentive Programs
- States, and their contractor, will perform audits on Medicaid providers participating in the Medicaid EHR Incentive Program

Audit Timing

- Post-payment audits began in July 2012, and will take place during the course of the EHR Incentive Programs
- CMS began pre-payment audits this year, starting with attestations submitted during and after January 2013
  - Pre-payment audits are in addition to the pre-payment edit checks that have been built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment
- Providers selected for pre or post-payment audits will be required to submit supporting documentation to validate their submitted attestation data

Medicare Audits

- Medicare EPs and Dual-Eligible Hospitals
- 5-10% of providers subject to pre/post-payment audits
- Random audits and risk profile of suspicious/anomalous data
- If a provider continues to exhibit suspicious/anomalous data, could be subject to successive audits
- In order to ensure robust oversight, CMS will not be making the risk profile public

What CMS Cannot Do

- Discuss issues or circumstances related to specific audits of actual providers (e.g., One of my providers failed the audit and shouldn't have...)
- Provide information regarding protocols used by audit contractor (e.g., What raises a "red flag" for auditors?, What information will auditors ask for? ,etc.)
- Resolve issues related to specific audits—Providers must use the appeals process if they believe they received an incorrect adverse audit finding.

Medicare Documentation

- It is the provider's responsibility to maintain documentation.
- Documentation to support attestation data for meaningful use objectives and clinical quality measures should be retained for **six years** post-attestation.
- Save any electronic or paper documentation that supports attestation, including documentation that supports values you entered in the Attestation Module for clinical quality measures.
- Hospitals should also maintain documentation that supports their payment calculations.

Medicaid providers can contact their State Medicaid Agency for more information about audits for Medicaid EHR Incentive Program payments.

Primary Source Documentation

- Primary source document is usually the report generated by the provider's certified EHR technology
- Report should contain the following elements:
  - Numerators and denominators for the measures
  - Time period the report covers
  - Evidence to support that it was generated for that provider (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc.)
- Snapshot vs. rolling reports

Additional Documentation

Example:

Meaningful Use Objective	• Drug-Drug/Drug-Allergy Interaction Checks
Audit Validation	• Functionality is available, enabled, and active in the system for the durations of the EHR reporting period
Suggested Documentation	• One or more screenshots from the certified EHR system that are dated during the EHR reporting period selected for attestation

**Review the "Supporting Documentation for Audits" fact sheet on the EHR website for more guidance on audit documentation*

Audit Resources

CMS EHR Incentive Programs Webpage:

- Supporting Documentation for Audits
- Sample Audit Letter for EPs
- Sample Audit Letter for Eligible Hospitals & CAHs
- Audit Overview Fact Sheet

EHR Resources

1. CMS Stage 2 Webpage:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

- Stage 2 Overview
- 2014 Clinical Quality Measures
- Payment Adjustments & Hardship Exceptions (EPs & Hospitals)

2. 2014 CQM Webpage: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2014_ClinicalQualityMeasures.html

3. Audits: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/EducationalMaterials.html

4. Payment Adjustments & Hardship Exceptions: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

Additional Information

- For more information on the EHR Incentive Programs, contact the EHR Information Center at 1-888-734-6433 or 1-888-734-6563 (TTY).

- To learn more about CMS' eHealth initiatives, visit: http://cms.gov/eHealth.