eHealth Provider Webinar
June 20, 2013

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

Presentation Objectives

Assist EPs prepare for:

1. Stage 2 and 2014 CQMs
2. 2014 certification of EHR systems
3. Payment adjustments
4. Audits

What is Meaningful Use?

- Meaningful Use is using certified EHR technology to
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and families in their health care
  - Improve care coordination
  - Improve population and public health
  - All the while maintaining privacy and security
- Meaningful Use mandated in law to receive incentives

Data

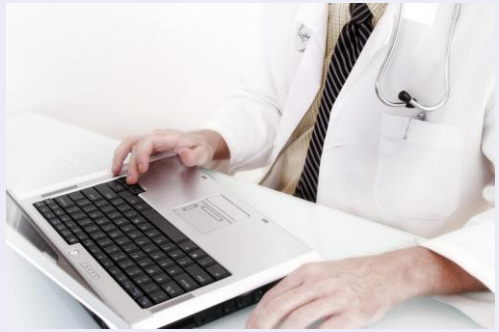
Information

Health Information Technology is the only feasible way to capture all the data

HIT can also turn data into information

MU and Implementation

- Put each objective in the context of the goal



Why does CPOE improve quality, safety and efficiency?

- Implement to the goal
- Is it measurable?
- How can usability and workflow be better?

Turning Data into Information

Clinician involvement is a must in deciding whether this a clinician function or HIT function for a given data element.

Factors:

- Is it a clinical decision?
- Does x always lead to y?
- Is the HIT information a suggestion or a hard stop?

Stage 2

What Stage 2 Means to You

- **New Criteria** – Starting in 2014, providers participating in the EHR Incentive Programs who have met Stage 1 for two or three years will need to meet meaningful use
  Stage 2 criteria.

- **Improving Patient Care** – Stage 2 includes new objectives to improve patient care through better clinical decision support, care coordination and patient engagement.

- **Saving Money, Time, Lives** – With this next stage, EHRs will further save our health care system money, save time for doctors and hospitals, and save lives.

EHR Incentive Program Eligibility

1. In general, eligibility is determined by the HITECH Act

2. There have been no changes to the HITECH Act

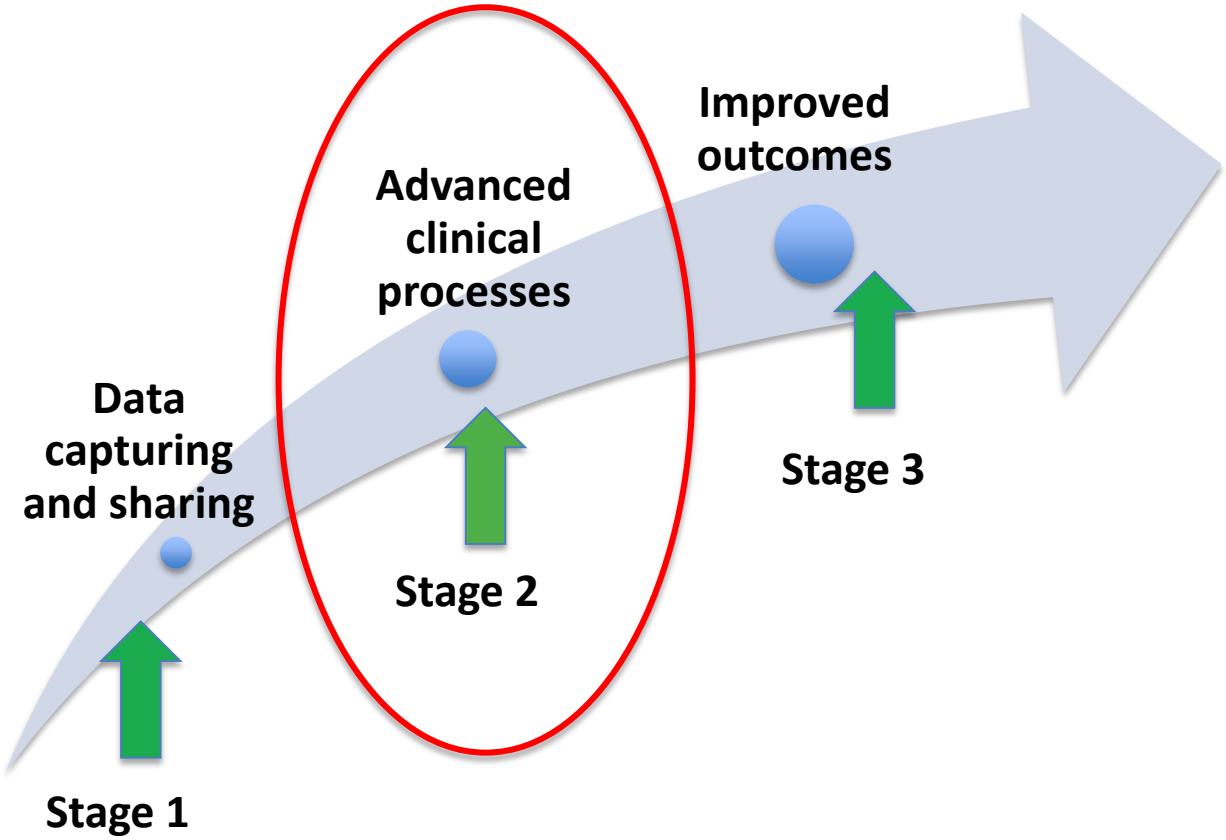
3. Therefore the only eligibility changes are those within our regulatory purview under the Medicaid EHR Incentive Program

Stage 2 Change: Hospital-Based EP Definition

EPs who can demonstrate that they fund the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH — *in lieu of using the hospital's CEHRT* — can be determined non-hospital-based and potentially receive an incentive payment.

Determination will be made through an application process.

Stages of Meaningful Use

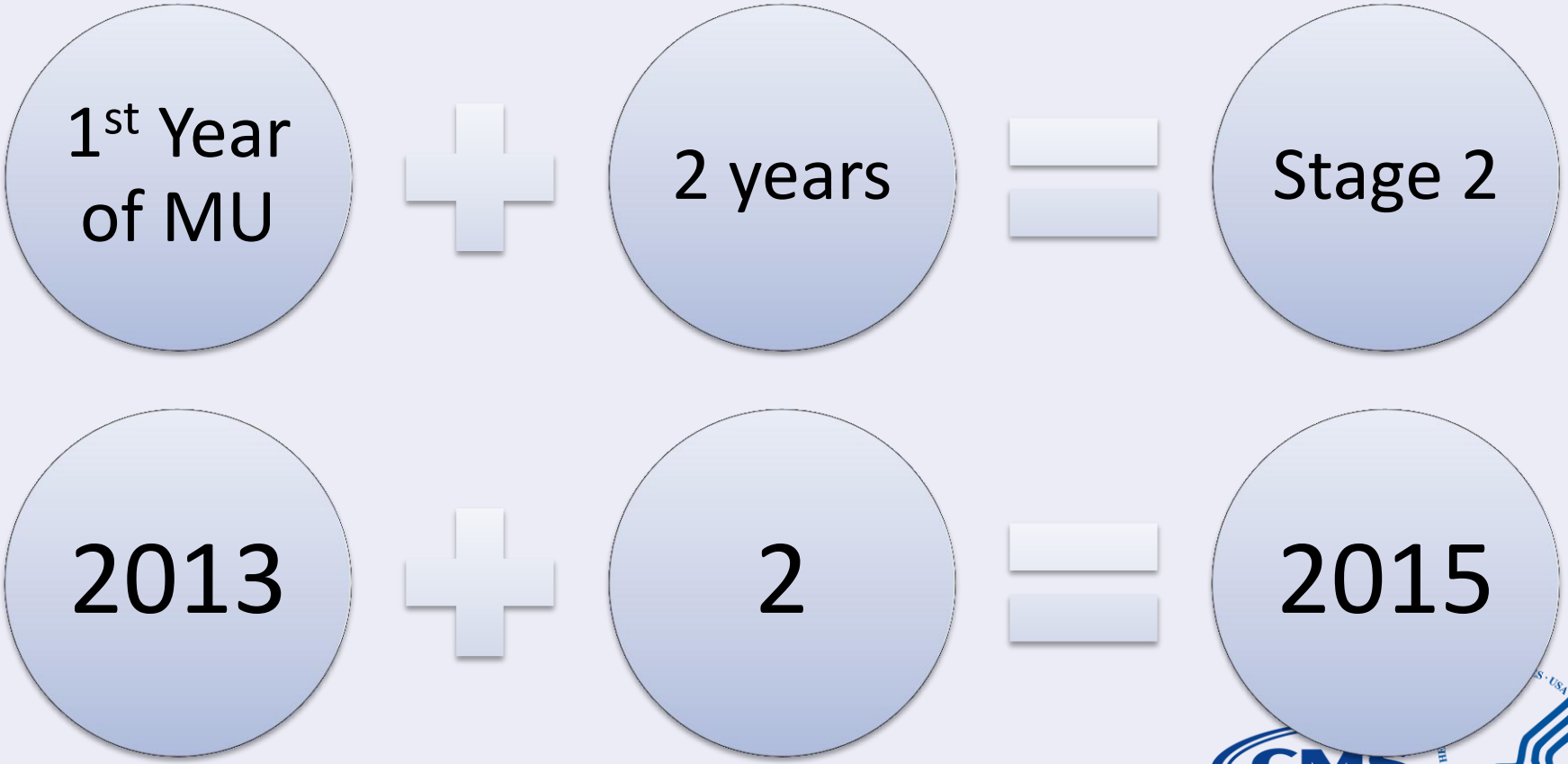


When Do I Start Stage 2?

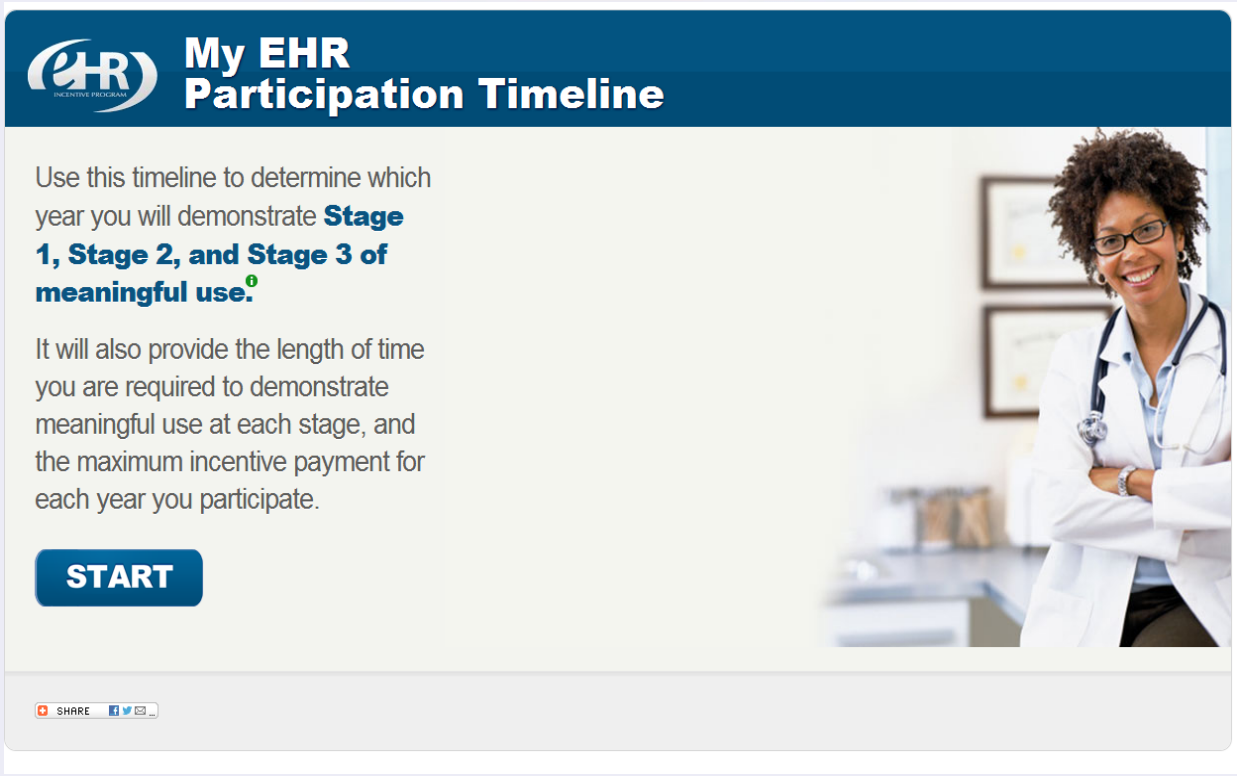
Everyone starts in Stage 1

No one starts Stage 2 before 2014

When Do I Start Stage 2?



When Do I Start Stage 2?



http://cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Participation-Timeline.html

What is Your Meaningful Use Path?

For Medicare EPs:

Maximum Payment by Start Year	Annual Incentive Payment by Stage of Meaningful Use					
	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
$44,000	$18,000	$12,000	$8,000	$4,000	$2,000	
2012		1	1	2	2	3
$44,000		$18,000	$12,000	$8,000	$4,000	$2,000
2013			1	1	2	2
$39,000			$15,000	$12,000	$8,000	$4,000
2014				1	1	2
$24,000				$12,000	$8,000	$4,000

What is Your Meaningful Use Path?

eHealth
CENTERS FOR MEDICARE & MEDICAID SERVICES

For Medicare Hospitals:

First Year of Participation	Stages of Meaningful Use for Eligible Hospitals (Fiscal Year)					
	2011	2012	2013	2014	2015	2016
2011	1	1	1	2	2	3
2012		1	1	2	2	3
2013			1	1	2	2
2014				1*	1	2

*Payments will decrease for hospitals that start receiving payments in 2014 and later

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What is Your Meaningful Use Path?

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For Medicaid EPs:

Annual Incentive Payment by Stage of Meaningful Use					
YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6
(AIU)	1	1	2	2	3
$21,250	$8,500	$8,500	$8,500	$8,500	$8,500

Maximum incentive amount is $63,750. Payments are made over 6 years and do not have to be consecutive.

*2016 is the last year that Medicaid EPs can begin participation in the program.

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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.

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

Q: Can I use 2014 Certified EHR Technology to satisfy Stage 1 in 2013?

A: Yes

Note: *Providers beyond their first year of participation will need to 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.*

Stage 2: Batch Reporting

Stage 2 rule allows for batch reporting.

Stage 2 rule allows for batch reporting.

What does that mean?

Starting in 2014, **groups** will be allowed to submit attestation information for **all of their individual EPs** in one file for upload to the Attestation System, rather than having each EP individually enter data.

Meaningful Use: Changes from Stage 1 to Stage 2

Stage 1	Stage 2
Eligible Professionals 14 core objectives 5 of 10 menu objectives 19 total objectives	**Eligible Professionals** **17** core objectives **3 of 6** menu objectives 20 total objectives
Eligible Hospitals & CAHs 13 core objectives 5 of 10 menu objectives 18 total objectives	**Eligible Hospitals & CAHs** **16** core objectives **3 of 6** menu objectives 19 total objectives

New Requirements for Stage 2

EP	Hospital
• Secure Messaging • Family Health History • Imaging Results • Registry Reporting • Progress Notes	• Online Patient Information • Family Health History • Imaging Results • Registry Reporting • Progress Notes • E-Prescribing • eMAR • Electronic lab results

Updated Requirements for Stage 2

EP	Hospital
• Lab Results • Patient Lists • Patient Education • Summary of Care Records • Medication Reconciliation • Immunizations • Patient Reminders • Online Patient Information	• Lab Results • Patient Lists • Patient Education • Summary of Care Records • Medication Reconciliation • Immunizations • Public health lab results • Syndromic surveillance

Stage 2 EP Core Objectives

EPs must meet all 17 core objectives:

Core Objective	Measure
1. CPOE	Use CPOE for more than **60%** of medication, **30%** of laboratory, and **30%** of radiology
2. E-Rx	E-Rx for more than **50%**
3. Demographics	Record demographics for **more than 80%**
4. Vital Signs	Record vital signs for **more than 80%**
5. Smoking Status	Record smoking status for **more than 80%**
6. Interventions	Implement **5** clinical decision support interventions + drug/drug and drug/allergy
7. Labs	Incorporate lab results for **more than 55%**
8. Patient List	Generate patient list **by specific condition**
9. Preventive Reminders	Use EHR to identify and provide reminders for preventive/follow-up care for **more than 10%** of patients with two or more office visits in the last 2 years

Stage 2 EP Core Objectives

EPs must meet all 17 core objectives:

Core Objective	Measure
10. Patient Access	Provide online access to health information for **more than 50%** with **more than 5%** actually accessing
11. Visit Summaries	Provide office visit summaries for **more than 50%** of office visits
12. Education Resources	Use EHR to identify and provide education resources **more than 10%**
13. Secure Messages	**More than 5%** of patients send secure messages to their EP
14. Rx Reconciliation	Medication reconciliation at **more than 50%** of transitions of care
15. Summary of Care	Provide summary of care document for **more than 50%** of transitions of care and referrals **with 10% sent electronically** and **at least one sent to a recipient with a different EHR vendor or successfully testing with CMS test EHR**
16. Immunizations	Successful ongoing transmission of immunization data
17. Security Analysis	Conduct or review security analysis and incorporate in risk management process

Stage 2 EP Menu Objectives

EPs must select 3 out of the 6:

Menu Objective	Measure
1. Imaging Results	More than **10%** of imaging results are accessible through Certified EHR Technology
2. Family History	Record family health history for more than **20%**
3. Syndromic Surveillance	Successful ongoing transmission of syndromic surveillance data
4. Cancer	Successful ongoing transmission of cancer case information
5. Specialized Registry	Successful ongoing transmission of data to a specialized registry
6. Progress Notes	Enter an electronic progress note for **more than 30%** of unique patients

Stage 2 Hospital Core Objectives

Eligible hospitals must meet all 16 core objectives:

Core Objective	Measure
1. CPOE	Use CPOE for **more than 60%** of medication, **30%** of laboratory, and **30%** of radiology
2. Demographics	Record demographics for **more than 80%**
3. Vital Signs	Record vital signs for **more than 80%**
4. Smoking Status	Record smoking status for **more than 80%**
5. Interventions	Implement **5** clinical decision support interventions + drug/drug and drug/allergy
6. Labs	Incorporate lab results for **more than 55%**
7. Patient List	Generate patient list by specific condition
8. eMAR	eMAR is implemented and used for more than **10%** of medication orders

Stage 2 Hospital Core Objectives

Eligible hospitals must meet all 16 core objectives:

Core Objective	Measure
9. Patient Access	Provide online access to health information for more than **50%** with more than **5%** actually accessing
10. Education Resources	Use EHR to identify and provide education resources more than **10%**
11. Rx Reconciliation	Medication reconciliation at more than **50%** of transitions of care
12. Summary of Care	Provide summary of care document for **more than 50%** of transitions of care and referrals **with 10% sent electronically** and **at least one sent to a recipient with a different EHR vendor or successfully testing with CMS test EHR**
13. Immunizations	Successful ongoing transmission of immunization data
14. Labs	Successful ongoing submission of reportable laboratory results
15. Syndromic Surveillance	Successful ongoing submission of electronic syndromic surveillance data
16. Security Analysis	Conduct or review security analysis and incorporate in risk management process

Stage 2 Hospital Menu Objectives

Eligible Hospitals must select 3 out of the 6:

Menu Objective	Measure
1. Progress Notes	Enter an electronic progress note for **more than 30%** of unique patients
2. E-Rx	**More than 10%** electronic prescribing (eRx) of discharge medication orders
3. Imaging Results	**More than 10%** of imaging results are accessible through Certified EHR Technology
4. Family History	Record family health history for **more than 20%**
5. Advanced Directives	Record advanced directives for **more than 50%** of patients 65 years or older
6. Labs	Provide structured electronic lab results to EPs for **more than 20%**

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.**

Clinical Quality Measures

Clinical Quality Measures

CQM Requirements ≠ Stage of Meaningful Use

CQM Requirements = Current year

CQM Requirements = Output of current Certified EHR

CQM Reporting in 2013

- CQM reporting will **remain the same** through 2013.
  - 44 EP CQMs
    - 3 core or alternate core (if reporting zeroes in the core) plus 3 additional CQMs
    - Report minimum of 6 CQMs (up to 9 CQMs if any core CQMs were zeroes)
  - 15 Eligible Hospital and CAH CQMs
    - Report all 15 CQMs
- In 2012 and continued in 2013, there are **two reporting methods** available for reporting the Stage 1 measures:
  - Attestation
  - eReporting pilots
    - Physician Quality Reporting System EHR Incentive Program Pilot for EPs
    - eReporting Pilot for eligible hospitals and CAHs
- Medicaid providers submit CQMs according to their **state-based submission requirements**.

CQM Specifications in 2013

- Electronic specifications for the CQMs for reporting in 2013 **will not be updated**.
- Flexibility in implementing CEHRT certified to the 2014 Edition certification criteria in 2013
  - Providers could report via attestation CQMs finalized in both Stage 1 and Stage 2 final rules
  - For EPs, this includes 32of the 44 CQMs finalized in the Stage 1 final rule
    - Excludes: NQF 0013, NQF 0027, NQF 0084
    - Since NQF 0013 is a core CQM in the Stage 1 final rule, an alternate core CQM must be reported instead since it will not be certified based on 2014 Edition certification criteria.
  - For Eligible Hospitals and CAHs, this includes all 15 of the CQMs finalized in the Stage 1 final rule

How do CQMs relate to the CMS EHR Incentive Programs?

CQMs are no longer a core objective of the EHR Incentive Programs beginning in 2014, but all providers are **required to report on CQMs** in order to demonstrate meaningful use.

CQM Selection and HHS Priorities

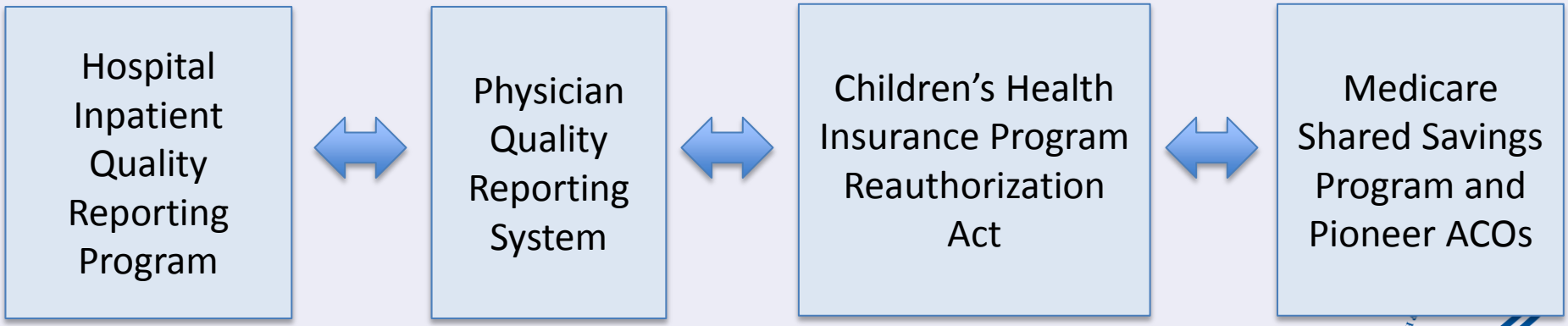
All providers must select CQMs from **at least 3 of the 6** HHS National Quality Strategy domains:

- ❑ Patient and Family Engagement
- ❑ Patient Safety
- ❑ Care Coordination
- ❑ Population and Public Health
- ❑ Efficient Use of Healthcare Resources
- ❑ Clinical Processes/Effectiveness

Aligning CQMs Across Programs

- CMS's commitment to alignment includes finalizing the **same CQMs used in multiple quality reporting programs** for reporting beginning in 2014

- Other programs include Hospital IQR Program, PQRS, CHIPRA, and Medicare SSP and Pioneer ACOs



Aligning Reporting Mechanisms

Identifying ways to minimize multiple submission requirements and mechanisms

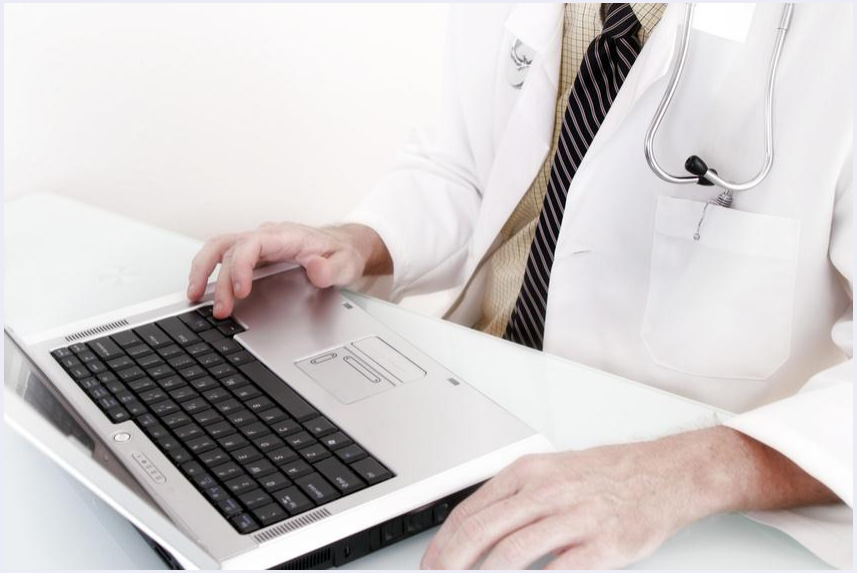
Provider	Requirements	Mechanisms

EPs	CY 2013 Medicare Physician Fee Schedule (MPFS) NPRM includes proposals for aligning reporting requirements	Option to submit once and get credit for the CQM requirement in two programs
		• Individual Eps
		  • PQRS EHR reporting option
		• Group Practices
		  • PQRS GPRO options
		  • Medicare SSP or Pioneer ACOs

Eligible Hospitals and CAHs	FY 2012 and FY 2013 Inpatient Prospective Payment Schedule (IPPS) final rules include target for electronic reporting in Hospital IQR Program	eReporting pilot will be the possible basis for the electronic reporting mechanism in hospital reporting programs, beginning with the Hospital IQR Program

Electronic Submission of CQMs Beginning in 2014

- All Medicare-eligible providers in their second year and beyond of demonstrating meaningful use **must electronically report** their 2014 CQM data to CMS.
- Medicaid providers will report their CQM data to their state, which may include electronic reporting.



CQM and Meaningful Use Reporting Periods in 2014

2014 CQM Reporting = Full Year for Providers Beyond 1st Year

- As mentioned earlier, providers beyond their first year of participation will need to electronically report their CQMs for the **full calendar year of 2014** (January 1, 2014 to December 31, 2014). This means providers will submit their CQM data between January 1 and February 28, 2015.

2014 Meaningful Use Reporting = Three Months for all Providers

- All Medicare eligible professionals in both Stage 1 and Stage 2 will select a **three-month reporting period** fixed to the quarter of the calendar year for the reporting of their meaningful use objectives.

Payment Status

- EPs will submit their meaningful use data following the end of their reporting period, but no later than **February 28, 2015 at 12 a.m. ET.** EPs who complete their attestation prior to January 1, 2015 will be placed in a pending status until their 2014 CQM data has been received.

CQMs Beginning in 2014

- A complete list of CQMs required for reporting beginning in 2014 and their associated National Quality Strategy domains will be posted on the CMS EHR Incentive Programs website (www.cms.gov/EHRIncentivePrograms) in the future.

- CMS will include a recommended core set of CQMs for EPs that focus on high-priority health conditions and best-practices for care delivery.
  - 9 for adult populations
  - 9 for pediatric populations

Recommended Core CQMs for EPs

CMS selected the recommended core CQMs based on analysis of several factors:

- Conditions that contribute to the morbidity and mortality of the most Medicare and Medicaid beneficiaries
- Conditions that represent national public/ population health priorities
- Conditions that are common to health disparities
- Conditions that disproportionately drive healthcare costs and could improve with better quality measurement
- Measures that would enable CMS, States, and the provider community to measure quality of care in new dimensions, with a stronger focus on parsimonious measurement
- Measures that include patient and/or caregiver engagement

Changes to CQMs Reporting

Prior to 2014		Beginning in 2014	
EPs	Report 6 out of 44 CQMs - 3 core or alt. core - 3 menu	**EPs**	Report 9 out of 64 CQMs Selected CQMs must cover at least 3 of the 6 NQS domains Recommended core CQMs: - 9 for adult populations - 9 for pediatric populations
Eligible Hospitals and CAHs	Report 15 out of 15 CQMs	**Eligible Hospitals and CAHs**	Report 16 out of 29 CQMs Selected CQMs must cover at least 3 of the 6 NQS domains

EP CQM Reporting Beginning in 2014

Eligible Professionals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
EPs in 1st Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
EPs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 9 CQMs from EP measures table (includes adult and pediatric recommended core CQMs), covering at least 3 domains
Option 2	Patient	Medicare	Electronic	Satisfy requirements of PQRS EHR Reporting Option using CEHRT
Group Reporting (only EPs Beyond the 1st Year of Demonstrating Meaningful Use)**				
EPs in an ACO (Medicare Shared Savings Program or Pioneer ACOs)	Patient	Medicare	Electronic	Satisfy requirements of Medicare Shared Savings Program of Pioneer ACOs using CEHRT
EPs satisfactorily reporting via PQRS group reporting options	Patient	Medicare	Electronic	Satisfy requirements of PQRS group reporting options using CEHRT

Hospital CQM Reporting Beginning in 2014

Eligible Hospitals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
Eligible Hospitals in 1st Year of Demonstrating MU*	Aggregate	All payer	Attestation	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains
Eligible Hospitals/CAHs Beyond the 1st Year of Demonstrating Meaningful Use				
Option 1	Aggregate	All payer	Electronic	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains
Option 2	Patient	All payer (sample)	Electronic	Submit 16 CQMs from Eligible Hospital/CAH measures table, covering at least 3 domains ➢ Manner similar to the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot

CQM – Timing

Time periods for reporting CQMs – **NO CHANGE** from Stage 1 to Stage 2

Provider Type	Reporting Period for 1st year of MU	Submission Period for 1st year of MU	Reporting Period for Subsequent years of MU (2nd year and beyond)	Submission Period for Subsequent years of MU (2nd year and beyond)
EP	90 consecutive days within the calendar year	Anytime immediately following the end of the 90-day reporting period, but no later than February 28 of the following calendar year*	1 calendar year (January 1 – December 31)	2 months following the end of the EHR reporting period (January 1 – February 28)
Eligible Hospital/ CAH	90 consecutive days within the fiscal year	Anytime immediately following the end of the 90-day reporting period, but no later than November 30 of the following fiscal year*	1 fiscal year (October 1 – September 30)	2 months following the end of the EHR reporting period (October 1 – November 30)

2014 CQM Quarterly Reporting

For Medicare providers, the 2014 3-month reporting period is fixed to the quarter of either the fiscal (for eligible hospitals and CAHs) or calendar (for EPs) year in order to align with existing CMS quality reporting programs.

In subsequent years, the reporting period for CQMs would be the entire calendar year (for EPs) or fiscal year (for eligible hospitals and CAHs) for providers beyond the 1st year of MU.

Provider Type	Optional Reporting Period in 2014*	Reporting Period for Subsequent Years of Meaningful Use	Submission Period for Subsequent Years of Meaningful Use
EP	Calendar year quarter: January 1 – March 31 April 1 – June 30 July 1 – September 30 October 1 – December 31	1 calendar year (January 1 - December 31)	2 months following the end of the reporting period (January 1 - February 28)
Eligible Hospital/CAH	Fiscal year quarter: October 1 – December 31 January 1 – March 31 April 1 – June 30 July 1 – September 30	1 fiscal year (October 1 - September 30)	2 months following the end of the reporting period (October 1 - November 30)

2014 EHR Certification Changes

Revised Certified EHR Technology (CEHRT) Definition

July 2010 Final Rule Policy
Static Definition
Driven by Certification Criteria

August 2012 Final Rule Policy
Dynamic Definition
Driven by Meaningful Use

General Points to Remember

- Two types of certifications can be issued:
  1. "Complete EHR" (i.e., EHR tech certified to all mandatory cert. criteria)
  2. "EHR Module" (i.e., EHR tech certified to less than all mandatory cert. criteria)
- The scope of a certification issued to EHR technology represents only the capabilities for which the certification was sought/granted
- EHR technology developers get to choose the type of certification sought for EHR technology and its scope

Ways to Meet CEHRT Definition

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

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 13, 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

Hospitals Subtract 3 Months

Payment Adjustments

- The HITECH Act stipulates that for Medicare EP, subsection (d) hospitals and CAHs **a payment adjustment applies if they are not a meaningful EHR user.**
- An EP, subsection (d) hospital or CAH becomes a meaningful EHR user **when they successfully attest to meaningful use under either the Medicare or Medicaid EHR Incentive Program**

Adopt, implement and upgrade ≠ meaningful use

A provider receiving a Medicaid incentive for AIU **would still be subject to the Medicare payment adjustment.**

EP Payment Adjustments

% Adjustment shown below assumes **less than 75%** of EPs are meaningful users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	**99%**	**98%**	**97%**	**96%**	**95%**	**95%**
EP is subject to the payment adjustment for e-Rx in 2014	**98%**	**98%**	**97%**	**96%**	**95%**	**95%**

% Adjustment shown below assumes **more than 75%** of EPs are meaningful users for CY 2018 and subsequent years

	2015	2016	2017	2018	2019	2020+
EP is not subject to the payment adjustment for e-Rx in 2014	**99%**	**98%**	**97%**	**97%**	**97%**	**97%**
EP is subject to the payment adjustment for e-Rx in 2014	**98%**	**98%**	**97%**	**97%**	**97%**	**97%**

EP EHR Reporting Period

Payment adjustments are based on prior years' reporting periods. The length of the reporting period depends upon the first year of participation.

For an EP who has demonstrated meaningful use in **2011** or **2012**:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on Full Year EHR Reporting Period	2013	2014*	2015	2016	2017	2018

* Special 3 month EHR reporting period

To Avoid Payment Adjustments:
EPs **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

EP EHR Reporting Period

For an EP who demonstrates meaningful use in **2013** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2013					
Based on Full Year EHR Reporting Period		2014*	2015	2016	2017	2018

* Special 3 month EHR reporting period

To Avoid Payment Adjustments:
EPs **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

EP EHR Reporting Period

EP who demonstrates meaningful use in **2014** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2014*	2014				
Based on Full Year EHR Reporting Period			2015	2016	2017	2018

In order to avoid the 2015 payment adjustment the EP must attest no later than October 1, 2014, which means they must begin their 90 day EHR reporting period no later than July 1, 2014.

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.*

Subsection (d) Hospital Payment Adjustments

% Decrease in the Percentage Increase to the IPPS* Payment Rate that the hospital would otherwise receive for that year:

	2015	2016	2017	2018	2019	2020+
% Decrease	**25%**	**50%**	**75%**	**75%**	**75%**	**75%**

Example:
If the increase to IPPS for 2015 was 2%, than a hospital subject to the payment adjustment would only receive a 1.5% increase

2% increase X 25% = .5% payment adjustment **OR** 1.5% increase total

**Inpatient Prospective Payment System (IPPS)*

Subsection (d) Hospital EHR Reporting Period

Payment adjustments are based on prior years' reporting periods. The length of the reporting period depends upon the first year of participation.

For a hospital that has demonstrated meaningful use in **2011** or **2012** (fiscal years):

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on Full Year EHR Reporting Period	2013	2014*	2015	2016	2017	2018

For a hospital that demonstrates meaningful use in **2013** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2013					
Based on Full Year EHR Reporting Period		2014*	2015	2016	2017	2018

*Special 3 month EHR reporting period

To Avoid Payment Adjustments:
Eligible hospitals **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

Subsection (d) Hospital EHR Reporting Period

For a hospital that demonstrates meaningful use in **2014** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2014*	2014				
Based on Full Year EHR Reporting Period			2015	2016	2017	2018

In order to avoid the 2015 payment adjustment the hospital must attest no later than July 1, 2014 which means they must begin their 90 day EHR reporting period no later than April 1, 2014

Critical Access Hospital (CAH) Payment Adjustments

Applicable % of reasonable costs reimbursement which absent payment adjustments is 101%:

	2015	2016	2017	2018	2019	2020+
% of reasonable costs	100.66%	100.33%	100%	100%	100%	100%

Example:
If a CAH has not demonstrated meaningful use for an applicable reporting period, then for a cost reporting period that begins in FY 2015, its reimbursement would be reduced from 101 percent of its reasonable costs to 100.66 percent.

CAH EHR Reporting Period

Payment adjustments for CAHs are also based on prior years' reporting periods. The length of the reporting period depends upon the first year of participation.

For a CAH who has demonstrated meaningful use **prior to 2015** (fiscal years):

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on Full Year EHR Reporting Period	2015	2016	2017	2018	2019	2020

For a CAH who demonstrates meaningful use in **2015** for the first time:

Payment Adjustment Year	2015	2016	2017	2018	2019	2020
Based on 90 day EHR Reporting Period	2015					
Based on Full Year EHR Reporting Period		2016	2017	2018	2019	2020

To Avoid Payment Adjustments:
CAHs **must** continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

EP Hardship Exceptions

EPs can apply for hardship exceptions in the following categories:

1. **Infrastructure**
   EPs must demonstrate that they 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 can apply for a 2-year limited exception to payment adjustments.

3. **Unforeseen Circumstances**
   Examples may include a natural disaster or other unforeseeable barrier.

4. **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

5. **EPs who practice at multiple locations must demonstrate that they:**

Lack of control over 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

Eligible Hospital and CAH Hardship Exceptions

Eligible hospitals and CAHs can apply for hardship exceptions in the following categories

1. **Infrastructure**
   Eligible hospitals and CAHs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
2. **New Eligible Hospitals or CAHs**
   New eligible hospitals and CAHs with new CMS Certification Numbers (CCNs) that would not have had time to become meaningful users can apply for a limited exception to payment adjustments.
   - For CAHs the hardship exception is limited to one full year after the CAH accepts its first patient.
   - For eligible hospitals the hardship exception is limited to one full-year cost reporting period.
3. **Unforeseen Circumstances**
   Examples may include a natural disaster or other unforeseeable barrier.

Applying for Hardship Exceptions

- **Applying:** EPs, eligible hospitals, and CAHs 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 April 1 for hospitals**, and **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**

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

Documentation for Audits

EPs, eligible hospitals, and CAHs should retain all relevant supporting documentation—in either paper or electronic format—used to complete the Attestation Module as follows:

- ✓Documentation to support attestation data for meaningful use objectives and clinical quality measures should be retained for six years post-attestation

- ✓Documentation to support payment calculations (such as cost report data) should follow the current documentation retention processes

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

Audit Process Overview

1. Initial request letters sent to providers selected for an audit

2. Initial review process conducted using info provided in response to request letter
   - Additional info may be needed during or after initial review process
3. On-site review at provider's location may follow
   - A demonstration of EHR system may be required

4. Figliozzi and Company will use secure communication process to assist provider in sending sensitive info

5. Questions pertaining to info requested should be directed to Figliozzi and Company

6. If found ineligible for payment, provider's payment will be recouped/ will not be distributed

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:** https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/EducationalMaterials.html
   - Supporting Documentation for Audits
   - Sample Audit Letter for EPs
   - Sample Audit Letter for Eligible Hospitals & CAHs
   - Audit Overview Fact Sheet