



Medicare & Medicaid EHR Incentive Programs

Meaningful Use: Stage 1 and Stage 2
National Provider Call
January 16, 2013

Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

What is in the Rule

- ❑ Changes to Stage 1 of meaningful use
 - ❑ Stage 2 of meaningful use
 - ❑ New clinical quality measures
 - ❑ New clinical quality measure reporting mechanisms
 - ❑ Payment adjustments and hardships
 - ❑ Medicare Advantage program changes
 - ❑ Medicaid program changes
-

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.

Stage 2 Eligibility

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

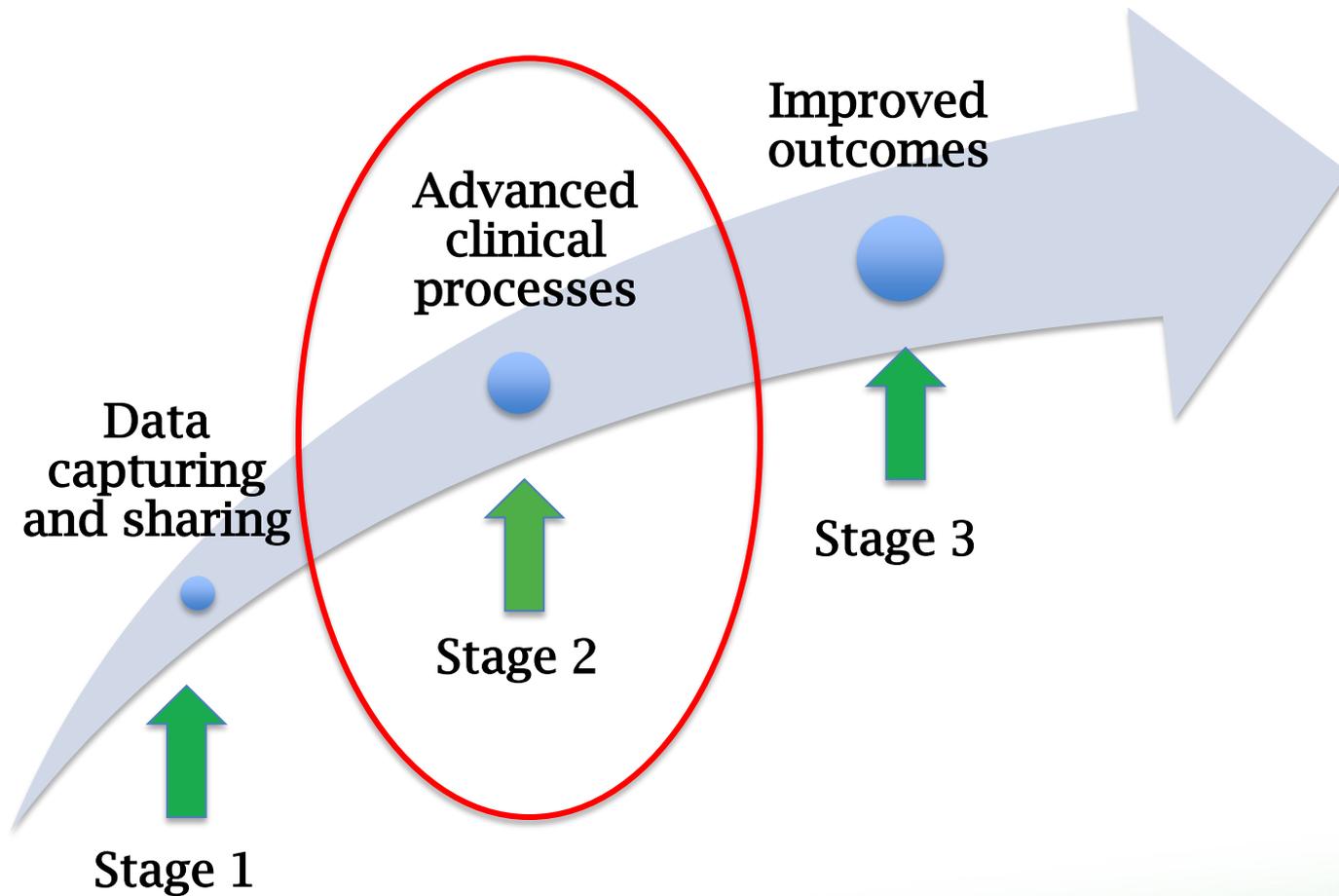
EPs can demonstrate that they fund the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for meaningful use without reimbursement from an eligible hospital or CAH — *in lieu of using the hospital's CEHRT* — can be determined non-hospital-based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



Determination will be made through an application process.

Stage 2 Meaningful Use

Stages of Meaningful Use



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?

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

Meaningful Use: Changes from Stage 1 to Stage 2

Stage 1

Eligible Professionals

15 core objectives

5 of 10 menu objectives

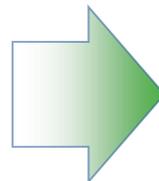
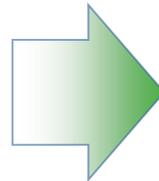
20 total objectives

Eligible Hospitals & CAHs

14 core objectives

5 of 10 menu objectives

19 total objectives



Stage 2

Eligible Professionals

17 core objectives

3 of 6 menu objectives

20 total objectives

Eligible Hospitals & CAHs

16 core objectives

3 of 6 menu objectives

19 total objectives

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.**

2014 Changes

1. **EHRs Meeting ONC 2014 Standards** – starting in 2014, all EHR Incentive Programs participants will have to adopt certified EHR technology that meets ONC’s Standards & Certification Criteria 2014 Final Rule
2. **Reporting Period Reduced to Three Months** – to allow providers time to adopt 2014 certified EHR technology and prepare for Stage 2, all participants will have a three-month reporting period in 2014.

Stage 2: 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.

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

- **EXCULSIONS** – 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.

Changes to Stage 1: CPOE

Current Stage 1 Measure

Denominator=

Unique patient
with at least one
medication in
their medication
list



New Stage 1 Option

Denominator=

Number of
orders during
the EHR
Reporting Period

This optional CPOE denominator is available in 2013 and beyond for Stage 1

Changes to Stage 1: Vital Signs

Current Stage 1 Measure

Age Limits= Age 2 for Blood Pressure & Height/ Weight

Exclusion= All three elements not relevant to scope of practice

New Stage 1 Measure

Age Limits= Age 3 for Blood Pressure, No age limit for Height/ Weight

Exclusion= Blood pressure to be separated from height /weight

The vital signs changes are optional in 2013, but required starting in 2014

Changes to Stage 1: Testing of HIE

Current Stage 1 Measure

One test of electronic transmission of key clinical information



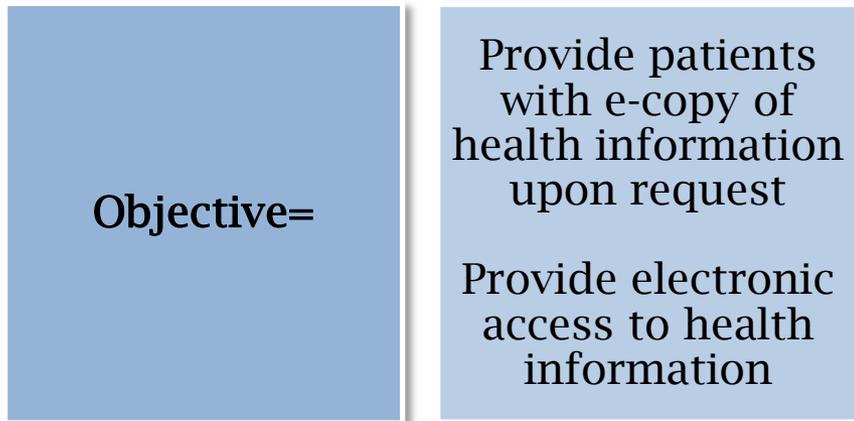
Stage 1 Measure Removed

Requirement removed effective 2013

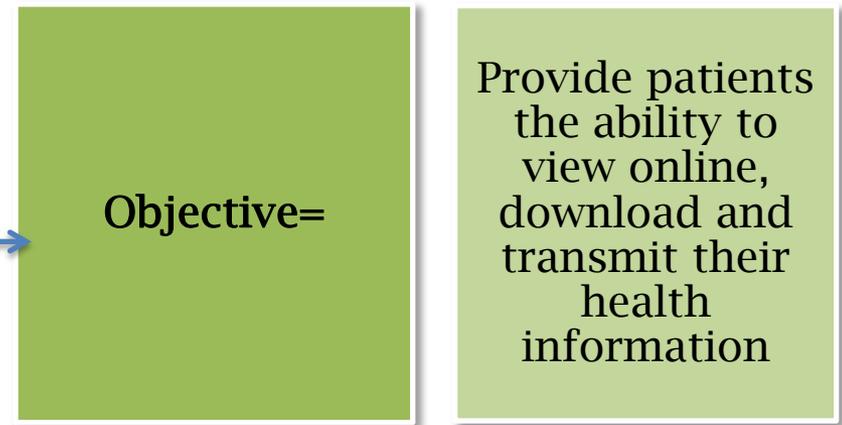
The removal of this measure is effective starting in 2013

Changes to Stage 1: E-Copy & Online Access

Current Stage 1 Objective



New Stage 1 Objective



- The measure of the new objective is 50% of patients have accessed their information; there is no requirement that 5% of patients do access their information for Stage 1.
- The change in objective takes effect in 2014 to coincide with the 2014 certification and standards criteria

Changes to Stage 1: Public Health Objectives

Current Stage 1 Objectives

Immunizations

Reportable Labs

Syndromic
Surveillance



New Stage 1 Addition

Addition of
“except where
prohibited” to all
three objectives

This addition is for clarity purposes and does not change the Stage 1 measure for these objectives.

Clinical Quality Measures

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 32 of the 44 CQMs finalized in the Stage 1 final rule
 - Excludes: NQF 0013, 0027, 0084, 0001, 0012, 0014, 0047, 0061, 0067, 0073, 0074, 0575
 - 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



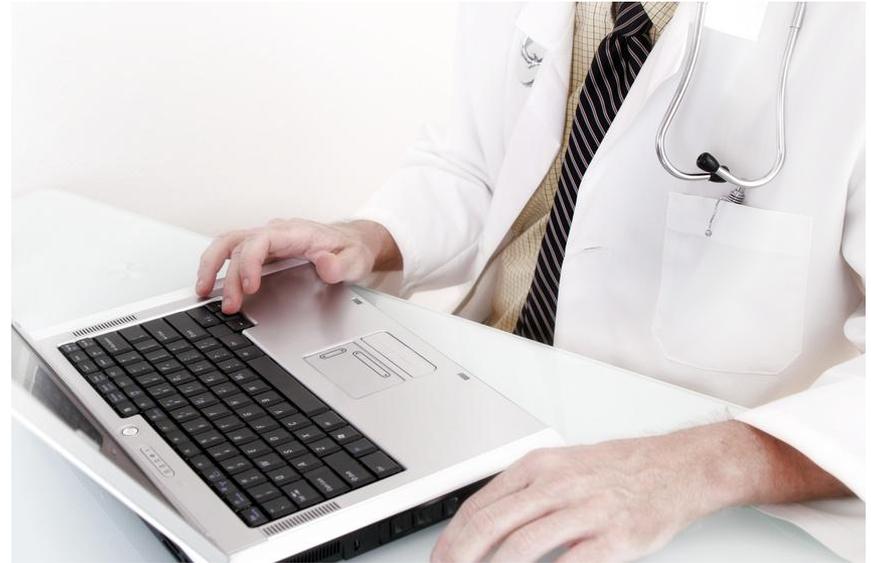
Aligning Reporting Mechanisms

- 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	<ul style="list-style-type: none"> • Option to submit once and get credit for the CQM requirement in two programs <ul style="list-style-type: none"> • Individual EPs <ul style="list-style-type: none"> • PQRS EHR reporting option • Group Practices <ul style="list-style-type: none"> • 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

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



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



The screenshot shows the CMS.gov website for EHR Incentive Programs. The header includes the CMS.gov logo and navigation links. The main content area features a large graphic with the EHR logo and a countdown timer for the 2012 Medicare Deadline, showing 43 days remaining. Below this, there is a section titled 'The Official Web Site for the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs' with introductory text and a list of links for registration, payment, and other program details.

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
-

Recommended Core CQMs for EPs(cont'd)

- 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

EPs

Report 6 out of 44 CQMs

- 3 core or alt. core
- 3 menu



Eligible Hospitals and CAHs

Report 15 out of 15 CQMs



Beginning in 2014

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 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 or Aggregate	Medicare +/- other payers	Electronic	Satisfy requirements of PQRS EHR Reporting Option using CEHRT NOTE: PQRS has the same reporting schema as Option 1
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 (GPRO Web Interface) or Aggregate (Registry)	Medicare +/- other payers	Electronic	Satisfy requirements of PQRS group reporting options using CEHRT NOTE: This includes the PQRS EHR group reporting option and the GPRO web interface

** Attestation is required for EPs in their 1st year of demonstrating MU because it is the only reporting method that would allow them to meet the submission deadline of October 1 to avoid a payment adjustment.*

***Groups with EPs in their 1st year of demonstrating MU can report as a group, however the individual EP(s) who are in their 1st year must attest to their CQM results by October 1 to avoid a payment adjustment.*

Hospital CQM Reporting Beginning in 2014 - Alignment with IQR

Eligible Hospitals reporting for the Medicare EHR Incentive Program

Category	Data Level	Payer Level	Submission Type	Reporting Schema
Eligible Hospitals/CAHs 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	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

** Attestation is required for Eligible Hospitals in their 1st year of demonstrating MU because it is the only reporting method that would allow them to meet the submission deadline of July 1 to avoid a payment adjustment.*

Hospital CQM Case Threshold Exemption

- Begins in FY2013 – all stages of meaningful use
- Must submit admin data for each reporting period to justify the exemption
- Threshold for exemption from reporting a CQM during the relevant EHR reporting period:
 - 1st year of demonstrating MU
 - 90-day EHR reporting period
 - 5 or fewer discharges
 - 2nd year or beyond of demonstrating MU
 - Full year EHR reporting period
 - 20 or fewer discharges
 - Defined by the CQM's denominator population
 - Applies on a CQM by CQM basis

Hospital CQM Case Threshold Exemption (cont'd)

- Invoking case threshold exemption in FY 2013:
 - All 15 of CQMs from Stage 1 final rule required
 - Reduce the # of CQMs required by the # of CQMs for which the hospital does not meet the case threshold of discharges
- Invoking case threshold exemption in FY 2014:
 - 16 CQMs covering at least 3 domains from a list of 29 CQMs required
 - Same process as in FY 2013, but in order to be exempted from reporting fewer than 16 CQMs, would need to qualify for case threshold exemption for more than 13 of the 29 CQMs.
 - If the CQMs for which the hospital can meet the case threshold of discharges do not cover at least 3 domains, the hospital would be exempt from the requirement to cover the remaining domains

CQM – Timing

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

Provider Type	Reporting Period for 1 st year of MU	Submission Period for 1 st year of MU (Attestation)	Reporting Period for Subsequent years of MU (2 nd year and beyond)	Submission Period for Subsequent years of MU (2 nd year and beyond) (Electronic)
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)

**In order to avoid payment adjustments, EPs must submit CQMs no later than October 1 and Eligible Hospitals must submit CQMs no later than July 1.*

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)

**In order to avoid payment adjustments, EPs must submit CQMs no later than October 1 and Eligible Hospitals must submit CQMs no later than July 1.*

Opportunities for Input

HIT Policy Committee RFC – Stage 3

- Request for comments regarding the Stage 3 definition of meaningful use of EHRs, including questions on CQMs
- Comment period closed 1/14/2013

CMS RFI – Hospital E-Reporting

- Request for information on hospital and vendor readiness for EHR HIQR data reporting
- Comment period closes 1/22/2013

CMS RFI – EP E-Reporting

- Request for information on the use of CQMs reported under the PQRS, EHR Incentive Program, and other reporting programs
- Includes questions based on *American Taxpayer Relief Act of 2012*
- Coming soon...

Payment Adjustments & Hardship Exceptions

Medicare Only

EPs, Subsection (d) Hospitals and CAHs

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	2019

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	2019

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	2019

**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	2019

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	2019

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	2019

**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

Medicaid-Specific Changes

Medicaid Eligibility Expansion

Patient Encounters:

The definition of what constitutes a Medicaid patient encounter has changed. The rule includes encounters for anyone enrolled in a Medicaid program, including Medicaid expansion encounters (except stand-alone Title 21), and those with zero-pay claims.

- The rule adds flexibility in the look-back period for overall patient volume.



Provider Eligibility: Patient Volume Calculation

Medicaid Encounters:

- Previously under Stage 1 rule:
 - Service rendered on any one day where Medicaid paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums
- Changed in Stage 2 rule (applicable to all stages):
 - Service rendered on any one day to a Medicaid-enrolled individual, *regardless* of payment liability
 - Includes zero-pay claims and encounters with patients in Title 21-funded Medicaid expansions (but not separate CHIPs)

Provider Eligibility: Patient Volume Calculation

Zero-pay claims include:

- Claim denied because the Medicaid beneficiary has maxed out the service limit
 - Claim denied because the service wasn't covered under the State's Medicaid program
 - Claim paid at \$0 because another payer's payment exceeded the Medicaid payment
 - Claim denied because claim wasn't submitted timely
-
- Such services can be included in provider's Medicaid patient volume calculation as long as the services were provided to a beneficiary who is enrolled in Medicaid

Provider Eligibility: Patient Volume Calculation

CHIP encounters to include in the patient volume calculation:

- Previously under Stage 1 rule:
 - Only CHIP encounters for patients in Title 19 Medicaid expansion programs
- Under Stage 2 rule (applicable to all stages):
 - CHIP encounters for patients in Title 19 and Title 21 Medicaid expansion programs
- As before, encounters with patients in stand-alone CHIP programs cannot be included in Medicaid patient volume calculation

Provider Eligibility: Patient Volume Calculation

90-day period for Medicaid patient volume calculation:

- Under Stage 1 rule, Medicaid patient volume for providers calculated across 90-day period in last calendar year (for EPs) or Federal fiscal year (for hospitals)
- Under Stage 2 rule (applicable to all stages), States also have option to allow providers to calculate Medicaid patient volume across 90-day period in last 12 months preceding provider's attestation
- Also applies to needy individual patient volume
- Applies to patient panel methodology, too
 - With at least one Medicaid encounter taking place in the 24 months prior to 90-day period (expanded from 12 months prior)

Children's Hospitals

Medicaid made approximately 12 additional children's hospitals eligible that have not been able to participate to date, despite meeting all other eligibility criteria, because they do not have a CMS Certification Number since they do not bill Medicare.



Children's Hospitals

Children's hospital:

- Not children's wings of larger hospital
- Previously under Stage 1 rule:
 - Separately certified hospital that has CMS Certification Number (CCN) with last 4 digits in the series 3300-3399
- Under Stage 2 rule (applicable to all stages):
 - Now also includes children's hospital that does not have CCN because they do not serve Medicare beneficiaries, but has received alternate number from CMS for Incentive Program participation

Hospital Incentive Calculation

Changes under Stage 2 rule for determining discharge-related amount:

- Hospitals that begin participating in FFY 2013 or later use discharge data from most recent continuous 12-month period for which data are available prior to payment year
- Hospitals that began participating before FFY 2013 use discharge data from hospital fiscal year that ends during FFY prior to hospital fiscal year that services as the first payment year

Clinical Quality Measures

2014 Pediatric Core Set:

- CMS146v1 - NQF 0002: Appropriate Testing for Children with Pharyngitis
- CMS155v1 - NQF 0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- CMS153v1 - NQF 0033: Chlamydia Screening for Women
- CMS126v1 - NQF 0036: Use of Appropriate Medications for Asthma
- CMS117v1 - NQF 0038: Childhood Immunization Status
- CMS154v1 - NQF 0069: Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- CMS136v2 - NQF 0108, ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
- CMS2v2 - NQF 0418: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- CMS75v1 - no NQF number: Children Who Have Dental Decay or Cavities

Additional Measures:

Behavioral Health

- CMS169v1 - NQF 0110, Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use
- CMS177v1 - NQF 1365, Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
- CMS82v1 - NQF 1401, Maternal Depression Screening

Oral Health

- CMS74v1 - no NQF number, Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists

Adopt, Implement, or Upgrade (AIU)

Starting in 2014:

- To align our polices with ONC EHR Certification Standards we modified our definition of Adopt, Implement or Upgrade.
- Providers can no longer attest to AIU with any Certified EHR Technology.
- Providers who attest to AIU in 2014 are required to secure Certified EHR Technology that can bring them to Meaningful Use in the subsequent years.

Stage 2 Resources

CMS Stage 2 Webpage:

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

Links to the Federal Register

Stage 2 Meaningful Use Specification Sheets

Tip Sheets:

- Stage 2 Overview
- 2014 Clinical Quality Measures
- Payment Adjustments & Hardship Exceptions (EPs & Hospitals)
- Stage 1 Changes
- Stage 1 vs. Stage 2 Tables (EPs & Hospitals)

Evaluate Your Experience with Today's National Provider Call

- To ensure that the National Provider Call (NPC) Program continues to be responsive to your needs, we are providing an opportunity for you to evaluate your experience with today's NPC. Evaluations are anonymous and strictly voluntary.
- To complete the evaluation, visit <http://npc.blhtech.com/> and select the title for today's call from the menu.
- All registrants will also receive a reminder email within two business days of the call. Please disregard this email if you have already completed the evaluation.
- We appreciate your feedback!

