The Medicare and Medicaid EHR Incentive Programs: What Medicare and Medicaid Providers Need to Know in 2014

Patrick Hamilton:
Hello, and welcome to the CMS Medicare and Medicaid EHR Incentive Programs: What Providers Need to Know in 2014 presentation. My name is Patrick Hamilton from the Centers for Medicare and Medicaid Services. The purpose of today's presentation is to give an overview of the requirements of the Medicare and Medicaid EHR Incentive Programs so that providers can participate to earn the incentives that are available in 2014 for successfully attesting the meaningful use objectives and clinical quality measures, as well as to avoid the payment adjustment in 2016 for not reporting this year. This MLN Connects video is part of the Medicare Learning Network.

2014 is a critical year in the EHR programs as it is the last year that providers can initiate their start in the program in order to earn those incentives and to avoid the first payment adjustments that are set to begin in 2015. CMS has been working vigorously with the Medicare/Medicaid provider communities to ensure that you have the most up-to-date knowledge and information available to guide you through our transition to electronic health records.

I'm joined today by Dr. Shari Ling, Deputy Chief Medical Officer for the Centers for Medicare and Medicaid Services and Medical Officer in the Center for Clinical Standards and Quality. She assists the CMS Chief Medical Officer in the agency's pursuit of higher quality healthcare, healthier populations, and lower costs through quality improvement. Dr. Ling's longstanding focus is on the achievement of meaningful health outcomes through delivery of high-quality, person-centered care across all care settings with special interest in the care of persons with dementia, multiple chronic conditions, functional limitations, and reducing health disparities. Dr. Ling represents the Clinical Services government work group and co-leads the long-term services work group for the national plan to address Alzheimer's disease. Thanks so much for joining us today, Dr. Ling.

Shari Ling:
It's my pleasure to be here.

Patrick Hamilton:
Dr. Ling, there has been much debate about the merits of CMS's EHR Incentive Programs specifically and about the conversion to electronic health records generally. How do you address the concerns that skeptics of electronic health record conversion have?

Shari Ling:
Well, health information and technology is a necessary part of healthcare transformation and we really are in the midst of it. It, in and of itself, is of course insufficient in that it must include a focus on quality and the ability to measure quality. There also must be alignment of incentives and provision of appropriate technical assistance, if you will. We must be able to assist providers who are having trouble. Nonetheless, we do have some good news to share in that electronic health records as a vehicle of reporting for the physician quality reporting system is actually the fastest together with registry-based reporting, the two fastest-growing vehicles for participation.

Patrick Hamilton:
For the past several years, CMS has been promoting what we've been calling our triple aim: better care for patients, better health for populations, and lowering per capita costs. How does the EHR Program help to realize those goals?

Shari Ling:
And thank you for that. I think EHRs, when meaningfully used, can reduce the burden of collecting information, sharing that information, and it can be used meaningfully to improve the care that is provided to our beneficiaries. What this might look like is clinical decision support can help improve the accuracy of medications that are prescribed, can also assist with decisions on whether or not to use potentially competing medications, particularly in populations with multiple chronic conditions or competing medical conditions.

EHRs can also be used to share information. That is, share information that must cross from provider to provider to create a well-synthesized implementation of a plan of care. And then, of course, as patients traverse from setting to setting, let's say from outpatient setting into the hospital, that information should be readily available to the receiving healthcare team and must be sent by the sending healthcare team. So, all of that can help support accomplishment and realization of the three-part aim, that is better care, higher quality care that is also safer that can result in healthier populations and resulting in also lower costs.

Patrick Hamilton:
And quality improvement and quality measurement are the main focus of the programs that you oversee. And this year, for the first time, CMS has made great strides in aligning the reporting requirements at the various quality programs including the Physician Quality Reporting System or PQRS, meaningful use, and the Medicare shared savings program. Can you explain how aligning these programs will help Medicare providers?

Shari Ling:
Certainly. So, measure alignment also means measure simplification. That is, taking a vast array of measures and actually consolidating around goals of the national quality strategy which has recently also been incorporated into the CMS quality strategy. So, alignment of measures

around those goals can really get all providers and physicians onto the same page as to what matters. And those goals are very important to patients as well. This means that what is sought is the attainment of care that is safer, care that is well-coordinated and effectively communicated that involves patients and families in their care, that can then translate into effective management based on the best-known evidence of chronic conditions and ideally also preventive strategies then can help mitigate the development of those chronic conditions which then also results in healthier populations and, of course, care that is safer as well as less expensive through quality improvement. So, I think there are benefits for physicians and providers and, by the way, the ideal scenario is to be able to report once and gain credit for multiple programs concurrently, but also that that measurement and use of the program and vehicles then translates into better care for our beneficiaries.

Patrick Hamilton:
Dr. Ling, thank you for joining us today. Today's presentation will include information on a variety of topics that are essential to the EHR Incentive Programs including: eligibility for the EHR Program, incentives available in 2014 and payment adjustments that could be assessed in 2016; the stages of meaningful use in determining what stage you are in this year; what your reporting period will be, and when Stage III will begin for you; certification and the requirements for your systems this year; the 2014 changes to meaningful use; the meaningful use objectives with the focus on patient engagement and information exchange; clinical quality measures; the new reporting requirements for all professionals in 2014; and opportunities to align with submission of quality measures with other programs; payment adjustments and hardship exemptions; and finally, audits and appeals.

We'll begin by talking about the eligibility requirements for the EHR Program. The turn on this slide shows the eligibility requirements for both the physician quality reporting system and the EHR Incentive Program, as well as how individual physicians and practitioners factor into the value modifier. Since we're talking about the EHR Incentive Program, we'll focus on that column. And as you can see for the Medicare Incentive Program, all Medicare physicians are eligible to participate. In terms of the Medicaid Incentive Programs, MDs, DOs, and dentists are eligible for the Medicaid program as well as physician assistants and nurse practitioners. However, it is only the Medicare physicians that would be subject to any type of payment adjustment as payment adjustments only pertain to Medicare reimbursement.

A few notes about eligibility. Eligible professionals are considered hospital-based and therefore ineligible to participate as an individual if 90 percent or more of their services took place in either the place of service code 21, which is the in-patient setting, or place of service code 23, which is the emergency department. So, if you are considered hospital-based for purposes of the EHR Incentive Program, you would not be eligible to participate nor would you be subject to payment adjustments in the payment adjustment year.

An important note about hospital-based status is the year in which we are looking at to determine hospital-based. For purposes of the 2014 program, we are looking at the fiscal year prior to the participation year. So, if you want to determine if you are considered hospital-based for 2014, CMS will look at your 2013 Fiscal Year data to determine whether or not you hit that 90 percent

threshold. So, if 90 percent or more of your claims took place in either the in-patient setting or the emergency department and again, we determine this by the place of service code, between the dates of October 1, 2012 and September 30, 2013, then you would be considered ineligible because you're hospital-based.

Medicare E.P.s may not receive EHR incentive payments under both the Medicare and the Medicaid program. As I mentioned, some physicians could be eligible to participate in both programs; however, you must select which program you're going to participate. CMS does allow a one-time change for physicians who want to change between Medicare and Medicaid after they've received one payment before the end of 2014.

In order to be eligible for the Medicaid Incentive Program, the E.P. must have a minimum of 30 percent Medicaid patient volume. Pediatricians, the minimum is 20 percent. Or they must practice predominantly in a federally qualified health center or in an RHC role health clinic with a minimum of a 30 percent patient volume attributable to needy individuals. This minimum patient volume only pertains to Medicaid. There is no minimum patient volume requirement on the Medicare side. As I mentioned, physicians' assistants are eligible for the Medicaid program but only if they furnish their service in a federally qualified health center or in a role health clinic that is led by a physician assistant.

If a provider is eligible for the Medicaid Incentive Program, in other words they meet that minimum patient requirement, but you have Medicare reimbursement in your practice, then you have to make sure that you are meeting the meaningful use deadlines that we're going to talk about in this presentation to avoid any payment adjustments to your Medicare reimbursement. The payment adjustments in the EHR Incentive Program only pertained to Medicare reimbursement. However, if you are opting to choose the Medicaid Incentive Program, again, you must meet the requirements and the timelines so that your Medicare reimbursement in your practice isn't adjusted for failure to meet the requisite timelines.

Finally, per the stage two final role doctors who have a certain designation of radiology, pathology, or anesthesiology will be automatically exempt from the EHR payment adjustment. We will go into more detail as to the specialty codes that are included in that automatic exception.

In 2014, we're giving groups and E.P.s in those groups the capability to report their clinical quality measures for the first time as a group in order to align with the PQRS program. However, it is very important to keep in mind that the incentive payments and the participation in the EHR program is still considered an individual participation in that all individual E.P.s must submit their core and menu measures on their own and the incentive payments are based on the activities of individual practitioners. If you are part of a practice, then each physician or each eligible professional in that practice may qualify for an incentive payment, but again they will each receive that incentive payment if they each separately report their core and menu measures. Each eligible professional is eligible for just one incentive payment per year; they are not split up. And it's regardless of how many different practice locations that that person is providing services. So, it's one part payment per MPI and where that payment is going to go will be determined by the information that you supply in the registration system. CMS will not split up

payments between different practices. It will be the determination of the provider to determine where the incentive payment goes.

We're now going to talk about the incentive payments that are available for your participation in 2014, as well as the payment adjustments that you may be assessed in 2016 for not participating. If you are an E.P. who is participating in both PQRS and in the EHR meaningful use program, you can receive incentive payments for participating in both programs. That was not the case with the e-prescribing initiative where, by law, we were forbidden to give incentive payments to providers who are doing both e-prescribing and meaningful use. But you can receive and will receive incentive payments for both PQRS and meaningful use if you successfully participate in both programs in 2014. The incentive payment for PQRS is a 0.5 percent of Medicare Part B allowed charges; 1 percent if the physician is doing a maintenance of certification. That's on the PQRS side.

In terms of the meaningful use incentive payments that are available in 2014, the amount that you can earn in 2014 will be based on when you first started meaningful use. When you start meaningful use, your first year you are put on a payment schedule. So, for example, if you were one of the early adopters and you started in 2011, then 2014 would be your fourth payment year, in which case, you can earn a $4,000 incentive and, again, this is per E.P. in your practice. If you started later in the program, you are earlier in the payment schedule so your payments will be a little bit more. In terms of the Medicaid meaningful use program, the incentive payments are generally set at $8,500 or $21,250 if this is the year that you are going to do your adopt implement or upgrade.

The charts on the next two slides are charts that we've developed to give providers and groups a birds-eye view of all of the incentives and the payment adjustments that pertain to the programs that we're talking about in 2014. For physicians, which are represented on this first chart, the PQRS incentive, again, in 0.5 percent of allowed charges on the B-side with a possible 1 percent total incentive if they're doing a maintenance of certification. The PQRS payment adjustment for 2016 for failure to participate this year is 2 percent. The value modifier could also come into play for physicians based on your group size. And then for the EHR Incentive Program, again based on when you started to participate in the program for the first time, your incentive payment could be anywhere from $4,000 to $12,000 this year and, again, if you are a Medicaid participant, it would be either $8,500 or $21,250. The 2016 payment adjustment for all E.P.s who are not meaningful users in 2014 is 2 percent.

So, the main takeaway from this graph is that if you are an E.P. who is eligible for these programs and you fail to comply, it would be a 2 percent payment adjustment for the meaningful use program, it would be 2 percent for PQRS, and then based on the size of your group, if you decide not to report on PQRS, it could be an additional 2 percent reduction for your value modifier. So the net result would be a maximum of a 6 percent reduction in your 2016 reimbursement for not participating in our programs this year.

The next slide focuses on non-physician practitioners and therapists. And as you can see with the exception of physician assistants, nurse practitioners, and certified nurse midwives, practitioners are generally not eligible for the meaningful use program, meaning they would not

be subject to any type of payment adjustments, however they will want to focus on PQRS in 2014.

We get a lot of questions from providers who are confused as to what stage they are in for 2014. So, to that end, we've developed a quick guide to help providers understand what stage they are in, how long their reporting period is for 2014, the amount of money that they can earn this year, and also what we'll be looking at in terms of avoiding the payment adjustment for 2016.

So, when you're determining what stage you are in this year, in 2014, the question you need to ask yourself is when did you first attest to meaningful use? If you were one of the early adopters and you tested in 2011, then for this year, you are in Stage 2. You're going to report for one calendar quarter. The maximum incentive that your E.P.s can receive is $4,000, and if you are successful this year, you will avoid the 2016 payment adjustment. If you started in 2012, it's basically the same thing. You are in Stage 2. You're reporting for one calendar quarter. Your incentive is $8,000 because you are in the third payment year and you will also avoid the payment adjustment for 2016.

If you are new to the program in 2013, then for 2014, you are going to be in your second year of Stage 1, so you will still have the Stage 1 criteria to meet. You are going to report your Stage 1 criteria for one calendar quarter. The incentive that you can earn is $12,000 which is the second payment for the payment schedule for those who began in 2013 and, if successful this year, you will also avoid the 2016 payment adjustment.

For those E.P.s who are opting to start the program this year in 2014, you obviously are going to begin in Stage 1. You are going to be able to choose any 90-day period. You will not be tied to the calendar quarter that we'll discuss in a moment. You can choose any 90 days to report. However, your reporting period can end no later than September 30th with your attestation submitted to CMS no later than October 1st. The first year incentive payment for those who begin in 2014 is $12,000 and so long as you are successful in reporting your menu, your core, and your clinical quality measures to CMS by October 1st of 2014, you'll avoid both the 2015 and the 2016 payment adjustments.

The next set of slides that we have developed are graphs that indicate based on when you started meaningful use, the length of the reporting period, the stage, the incentive money, and the performance year for the payment adjustment going through 2017 and beyond. So, this first slide will pertain to those who started the program in 2011, the early adopters. As you can see, you had three years at Stage 1 because we delayed the beginning of Stage 2 until 2014. You're also going to have three years at Stage 2 because we also delayed the beginning of Stage 3 until 2017. No one will begin Stage 3 until 2017.

In terms of the incentive -- or the payment adjustments, rather. If you look at the 2013 row, you'll see that there's an asterisk that will be looking at 2013 activity to determine your 2015 payment adjustment. Generally, the payment adjustment in 2015 is 1 percent. However, there is a caveat that stated that if an E.P. was subject to the 2014 e-prescribing payment adjustment and you're subject to the meaningful use payment adjustment next year in 2015, that payment adjustment jumps to 2 percent. And that only pertains to the 2015 payment adjustment.

After 2017, the Secretary has the authority to increase the payment adjustment to as high as 5 percent to all E.P.s who are not meaningful users. If the determination is made that 75 percent or more of all Medicare E.P.s have not become meaningful users by that time. Also, the incentives that are listed on these slides are subject to the congressionally-mandated 2 percent reduction due to sequestration. Currently, that is set to last through at least March of 2015. So, if you received your incentive payment and you see that there is a slight reduction, most likely it is due to the 2 percent congressionally-mandated reduction due to sequestration.

The next slide pertains to those E.P.s who demonstrated meaningful use for the first time in 2012. As you can see, they also will have three years at Stage 2. The next slide pertains to those E.P.s who demonstrated meaningful use in 2013 for the first time. They will have two years at Stage 1, two years at Stage 2, before moving into Stage 3 in 2017. And finally for those E.P.s who are starting the program in 2014, you see that this year you have 90 days, and that 90 days should start no later than July 1st so that you can meet that September 30th and October 1st deadline. You will be doing Stage 1 in 2014 and 2015, moving into Stage 2 in 2016 and 2017, and this group of E.P.s will not start Stage 3 until 2018 at the earliest. Also, keep in mind that 2014 is the final year that you can begin the program in order to earn incentive money. Starting in 2015, you will be participating in the program to avoid payment adjustments.

I want to briefly talk about certification and the new standards that have been implemented by the Office of National Coordinator. CMS has worked with ONC or the Office of National Coordinator to establish standards for the certification criteria, for structured data that all of your EHR systems must use in order to successfully capture and calculate the objectives for Stage 2 of meaningful use. These new standards and certification take place are to go into effect in 2014 and they are for all E.P.s, all hospitals, and all critical access hospitals regardless of what stage you're in.

So, we no longer -- we don't think of these certification requirements at Stage 1 or Stage 2 certification requirements. You must think of them as the 2014 certification requirements. So, if you are in Stage 1, you still have to have the 2014 certification requirements. And even if you already have a certified EHR, then you'll have to adopt or upgrade to the new certification in order to participate in the program in this year. In 2014. Again, regardless of what stage you're in.

If you are in a practice that has E.P.s that are -- some are in Stage 1, some are in Stage 2. The new certification standards allow for all of the docs in your practice to use that system and meet both the Stage 1 and the Stage 2 requirements for 2014. More information about the certification requirements can be found on the ONC website which is at healthIT.gov.

Now we'll talk about some of the changes to the meaningful use program that go into effect in 2014. We already touched upon this when we went through the charts, but we want to make sure that everyone understands their reporting periods that they're required to report in 2014. All E.P.s are going to demonstrate meaningful use for either a 3-month calendar quarter or a 90-day period, depending on where they are in the program. You're going to choose your reporting period based on your program and the participation year. So, for those who are in the Medicare

program and you've already started the meaningful use program, meaning 2014 is not your first year, then you're going to select a 3-month reporting period fixed to the quarter of the calendar year which means you can choose the period January 1st through March 31st or April 1st through June 30th or July 1st through September 30th or October 1st through December 31st. And again, that is for Medicare E.P.s that have already started the program before this year.

As I mentioned earlier, for those who are starting the program for the first time this year on the Medicare side, then you can select any 90-day period. You are not tied to the calendar quarter. But, again, you must begin no later than July 1st so that you can get your attestation by October 1st. For those of you participating in the Medicaid side, regardless of what stage you are in, you can select any 90-day period that falls within 2014.

We always emphasize that even though we tell you that July 1st is the drop-dead date or the last date that you can actually start to get a 90-day period in for the E.P.s who are starting for the first time in 2014. We strongly, strongly urge you not to wait until the last minute to begin reporting. In terms of changes to the meaningful use objectives, prior to 2014, CMS allowed E.P.s to choose menu objectives. Before, there were five of nine or 10 menu objectives from which you had to choose. And we allow providers to choose a menu objective, claim an exception, and that would be included or that would count for the choosing of a menu objective.

Starting in 2014, these exclusions will no longer count towards the number of menu objectives that are needed to become a meaningful user. The only menu objectives that can be chosen, for which an exclusion can be claimed, are ones that really do not pertain to your scope of practice and only if the remaining menu options -- the remaining menu objectives also do not pertain to your scope of practice. So, for example, when we look at the list of the six objectives, if two only apply to your scope of practice and you legitimately cannot report on the other four, you can choose the two that pertain to your scope of practice and then choose a third to claim an exception. But only if the remaining three that are still left on the table also do not pertain to your scope of practice.

We made some changes to the vital signs measure. There is no age limit on height or weight recording. We are requiring blood pressure for all patients who are three years of age or older. Also, for vital signs, you must calculate and display body mass index or BMI. Also, you must plot and display a growth chart for patients from birth through 20 years of age. The exclusion for vital signs, which was introduced in 2013 and is now mandatory in 2014. You can exclude the objection for vital signs if height, weight, and blood pressure -- if all three do not pertain, or you had the opportunity to split them out. So, if height and weight pertain to your patients but blood pressure does not, or vice versa, then you can exclude yourself from just one but not the other.

Also, we made an important distinction in saying that the clinical quality measures are no longer one of the core objectives. Prior to 2014 in Stage 1, if you looked at the old list of the core objectives, the reporting of the clinical quality measures was one of your core objectives. That's no longer considered a core objective. However it is still a critical piece in being deemed a meaningful user. We'll explain why this distinction is important a little bit later. Also, for all providers, starting in 2014, we're moving from providing electronic copies of records to more of

an online view, download, or transmit system. And, again, this is for providers of all stages starting in 2014 and we'll explain the difference in terms of the requirements for this objective.

Now we'll discuss the meaningful use objectives, and as you can see for Stage 2, we have maintained the basic structure of the meaningful use objectives that we had in Stage 1 since the beginning of the program. In Stage 1, eligible professionals are required to report 13 core and five of nine menu objectives for a total of 18. In Stage 2, the same setup of core and menu objectives is the same. Numbers are slightly different in Stage 2. It's a total of 17 core objectives and three of six menu objectives for a total of 20.

This chart shows the meaningful use core objectives for Stage 2. You'll notice that all the Stage 1 objectives, except for the ones that were removed from the beginning of the program, carry over, some have been consolidated, and all the menu objectives from Stage 1 with the exception of syndromic surveillance have now been incorporated into the core objectives. And again, there was some consolidation. We are going to be focusing our discussions in the next couple of slides on a couple of the objectives that are highlighted, mainly those that focus on patient engagement and electronic exchange.

So taking a closer look at the patient engagement objective, in moving from Stage 1 to Stage 2 and what CMS is trying to accomplish is we're moving from data collection, which is the focus of the beginning of the program in Stage 1 really to more data sharing in Stage 2, and to that end, patient engagement is critical. The patient engagement objective replaces the Stage 1 core objective that stated that E.P.s had to provide patients with an electronic copy of their health information, which included diagnostic test results, the problem list, medication list, and medication allergies upon request. And the Stage 1 menu objective for E.P.s requiring them to provide patients with timely electronic access to their health information, including lab results, problem list, medication list, and allergies within four business days of the information being available to the E.P.

So, the first patient objective that we are looking at deals with the requirement that 5 percent of patients must access their health information online. So not only will the provider have to make sure that that information is made available, but they also have to engage with their patients to make sure that they are actually going online to either view, download, or transmit the information themselves. This only applies to E.P.s who are in Stage 2 starting in 2014. And keep in mind that in meeting this requirement or in meeting this objective, this objective pertains to your entire population of patients, so the requirement is not that only your Medicare patients have to go and do the view, download, or transmit. But it's for all of your patients. We also reduced the proposal of a 10 percent threshold down to 5 percent based on the feedback that we got in the proposed rule for Stage 2 in 2012.

Unlike clinical summaries, the clinical summaries are an actual record of what happened during an office visit. Providing the patient electronic access to information is an on-going requirement. There's a separate requirement for timeliness as it relates to the clinical summaries after an office visit but when we're talking about electronic access to information, the requirement is on-going. If there's a specific data field that should be included in the information but it's not available to the E.P. at the time that the information is sent to the portal. That information does not have to

be made available online and the E.P. will not be penalized; they will still be able to meet the objective for patient access. However, as that new information becomes available to the doctor, those items should be updated and made available to the patient within four business days of the information being made available to the physician.

To that end, all the information that is available at the time that the information is sent to the portal must be made available to the patient online. However, CMS gives the discretion to the provider to withhold any information if the provider deems that disclosing that information could prove harmful to his or her patient. Fields specifically for the problem list, the medication list, and the medication allergy list must either contain the specific problems, medications, or allergies or a notation that the patient has none of them.

Moving onto the electronic exchange objective. Here we are talking about summary of care records as it refers to transitioning care from one provider to another or referral. Specifically, a transition of care is defined as the movement of a patient from one setting of care either in the hospital ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility, et cetera to another. The summary of care exchange should ensure providers who transitions the patient from one study of care to another, that the provider who is receiving that beneficiary has the most up-to-date information that is available to them. The information generally is limited to what is available to the E.P. at the time that the transition of care is developed and generated by the EHR technology.

There are three specific measures that are tied to the electronic exchange objective. For measure one of the summary of care objective, you would include the transitions of care in which a summary of care document was provided to the recipient of the transition or referral by any means. So, basically that means 50 percent or more of the instances where there is a transfer or a referral that an actual summary of care document has been created. Measure 2 goes a step further saying that the transition of care in which there is a care document is transmitted electronically to the recipient using a certified EHR system or via an exchange facilitated by an organization that is an eHealth Exchange participant.

So, what that means is that 10 percent of those documents that are created for your transitions or your referrals are transmitted electronically to the recipient of that care. However, you want to make sure that in order to meet this 10 percent objective that the recipient to whom you are sending the care document does not have the same access to the same patient information as you do. So, you want to make sure that you're including the electronic transmissions that are going to recipients, other providers who do not have access to your system.

For the third measure, finally, at least one summary of care document sent electronically must be sent to a recipient that has a completely different EHR vendor. So, what this means is that if Dr. Smith is referring a patient to Dr. Jones, theoretically Dr. Jones would have to have a completely different system than Dr. Smith because in this way, we are really testing the interoperability of information being exchanged between different systems. Now, in the case that Dr. Smith in our example would not be able to find a recipient or another provider who has a completely different system than Dr. Smith does then CMS and ONC have worked together to come up with what is called the EHR Randomizer. And basically a provider will register with the randomizer and they

will be matched up with the provider who has a different system. You can find more information on the EHR Randomizer on the CMS webpage.

For the summary of care records, unlike clinical summary for specific office visits or the on-going patient online access objectives, the E.P. must verify that the information was entered into the EHR for the problem list, the medication list, and the allergy list prior to generating the summary of care document. Those elements, the problem list, the medication list, and medication allergy list must either contain specific information or some notation that the patient has none of these particular items. If you leave the field blank for those particular data elements, you would not be able to meet the objective. If other data elements from the required list is not available in the EHR at the time that the summary of care record is generated, then that information does not have to be made available on the summary of care record and you would be able to meet the objective. However, the fields for problem list, medication list, and allergy list must either contain the problems, medications, and allergies or the notation that the patient does not have any of these items.

Here is a listing of the menu objectives that are new to Stage 2 starting in 2014 and as you can see with the exception of syndromic surveillance, these are new menu objectives. Now, when we talked about the menu objective exclusions, we noted that it could be possible that none of these objectives apply to your scope of practice. And if that is the case -- and if you qualify for the exclusions for each of the menu objectives, because each objective has specific criteria in order to meet the exclusion. But if you qualify for the exclusions for each of the menu objectives, then you still would select three menu objectives and claim the exclusion for each. The attestation will not let you move forward unless you select at least three menu objectives even if you are going to claim an exclusion. If you do not qualify for all of the exclusions to the menu objectives, meaning that they do somehow pertain to your scope of practice, then you must go back and select the menu objectives that you can report.

Now we're going to move onto the clinical quality measures and the changes of the clinical quality measure reporting requirements for 2014. As I mentioned earlier, starting this year, clinical quality measures are no longer considered one of the meaningful use core objectives. But, you still have to report these clinical quality measures in order to be deemed a meaningful user. In a few slides, we're going to talk about some of the time frames and you'll understand why it is critical to understand why the CQMs are no longer considered a core objective. Also, we are now talking about the 2014 CQM requirements. We no longer say that there are Stage 1 CQM requirements or Stage 2 CQM requirements, but there are 2014 CQM requirements that all E.P.s must meet regardless of what stage you are in. So they're no longer tied to your stage of meaningful use.

Also, regardless of the method that you're going to choose to report, and we'll go into detail about what those options are, all of your quality data must derive directly from the patient data that is located in your certified system. You'll see that the requirements in terms of the number of measures that you must report, the quality domains, and the measures themselves are aligned with the EHR reporting option of the PQRS system. And again, this is not by accident. This is a major way that CMS is attempting to align both reporting PQRS data with your CQM data for

meaningful use. For E.P.s that are going to participate in the Medicaid Incentive Program, you will continue to submit your CQM data to your state Medicaid agency.

The six quality domains that are listed on this slide are the same six quality domains that are part of the physician quality reporting system. For meaningful use, there are a total of 64 measures, 64 total CQMs from which you can choose nine so long as they come from three of these domains. We've listed here the number of measures that are contained within each domain and you'll notice that if you look at the PQRS measures list and you look at the column for the reporting option that the quality measures that have EHR reporting option are the same measures that are included with the CQMs for meaningful use.

For 2014 and beyond, the requirement -- and again, this is going to be reminiscent of the PQRS requirement -- is reporting nine total measures from at least three of the quality domains that were listed on the previous slide. No longer do we have the required core or the alternates to the core and the menu objectives that we had previously to 2014. However, CMS has published a list of preferred or recommended measures for both an adult population and for a pediatric population. And you can find those measures on the CMS website. Starting in 2014, there are also new reporting options, including for the first time the opportunity for groups to report quality measures together as a group reporting option.

We're now going to talk about the reporting options that individual E.P.s have to report their clinical quality measures. The first option is to generate a report through your certified EHR technology. In doing so, you will continue to use the attestation system to submit the data to CMS. For this reporting option, the quality measures will be submitted on an aggregate basis and will be reflective of all patients without regard to payer. So, again, you're not reporting on just your Medicare patients but to all the patients who are housed in your certified system. You would be submitting just three months of data, and again it's through the attestation system, and most likely it would be the same months for which you are reporting your core and your menu measures. However, if you are choosing this option, you would not be able to align the clinical quality measure reporting with the quality measures that you must report through PQRS because the reporting period for PQRS is one full calendar year. So, if you are going to generate a report from your system and you're going to use the attestation system. You may do so, you may report any time after your reporting period has ended, and you have until February 28th of 2015 to get that information into the attestation system.

The second option that you have to report your CQMs is to utilize the physician quality reporting system where PQRS, EHR reporting option, and this is how you align the programs in terms of your quality data reporting. So, you would submit and satisfactorily report PQRS CQMs under the PQRS EHR reporting option using your certified EHR technology. And basically you would be receiving credit for submitting for both programs. You would be submitting for a full year of data for both programs, so your clinical quality measures for meaningful use would be for the full year as they would be for PQRS. It's the same measures for the same reporting period.

You are required to use the June 2013 version of the ECQMs with the exception of the breast cancer measures, which is CMS 140, which can be reported using the December 2012 version CMS 140-V1.

In using the PQRS EHR reporting option, if your system happens to not contain patient data for at least nine of the measures covering the three domains, then the E.P. or the group practice will report the measures for which there is Medicare patient data. Again, keep in mind that you must report on at least one measure for which you have Medicare patient data. This is where it becomes important to understand the distinction as to why CQMs are no longer a core measure in terms of the objectives. If you are utilizing option two, then again your CQMs are going to be reported for the entire calendar year. However, you are still reporting your core and your menu objectives for one calendar quarter. So, in utilizing this option, it could be the case that you decide that you're going to, for example, use the April 1st through June 30th timeframe to report your core and menu objectives. And you can do that, and you can report your measures any time after June 30th and we'll hold that attestation of your measures until we receive the clinical quality measures because your clinical quality measures are going to encompass the entire year, not just the 90-day period. If you do attest to your core and your menu measures earlier in the year, we're going to hold that attestation. We're going to hold the payment until we receive your clinical quality measures. So, you are not deemed a meaningful user until your clinical quality measures have been successfully received by CMS.

2014 is the first year that CMS is giving the ability for groups to report their clinical measures together as a group. They can do so under two options. One is for E.P.s who are in an accountable care organization through the Medicare shared savings program. They have requirements to report clinical data as well. Second option are for the E.P.s who satisfy their requirements at the PQRS GPRO option. So, again, another way that we are aligning PQRS with meaningful use, and we want to give providers who are participating in the group practice reporting option the ability to align the programs, submit data, and receive credit for both. Again, the group must register with CMS to participate in the group practice reporting option no later than September 30th and all the E.P.s who are part of that GPRO -- again, it's going to be per their MPI -- will receive credits for their CQMs if the group as a whole entity is successful in the reporting of measures.

Keep in mind that this only pertains to the reporting of the clinical quality measures. All of the individual E.P.s in that group are still responsible for submitting their own core and menu measures. Please note that this option, the group reporting option, is only available to those E.P.s who are beyond their first year of meaningful use meaning E.P.s for whom 2014 is their first year, they cannot take advantage of this reporting option because they must meet that October 1st deadline that we talked about earlier. So, if you are in your first year of meaningful use in 2014 and that includes those who are part of a group practice that's participating in the PQRS group reporting, you are in an MNSP ACO or in a pioneer ACO. Again, you must report your CQMs for meaningful use via the attestation module by October 1st, 2014 so that you will not be assessed the payment adjustment in 2015.

We're now going to talk about the payment adjustments and also the hardship exceptions that are available to E.P.s this year. The payment adjustments which will go into effect starting in 2015 will be applied to the Medicare physician fee schedule amount for services furnished during the year so whenever there is a payment adjustment for the services furnished during that payment adjustment year, that is where the adjustment will be applied. Payment adjustment is 1 percent

starting in 2015 and increases to 2 percent in 2016 and 3 percent in 2017. And again, as I mentioned earlier, if you were subject to the e-prescribing payment adjustment in 2014 and you are subjected to the meaningful use payment adjustment in 2015, it will be a 2 percent payment adjustment.

Payment adjustment percentages are determined by the year and not by your participation in the timeline. So, for example, in this presentation we've been talking about the 2016 payment adjustment because it's based on your 2014 activity, the two-year look back. So, if you are assessed a payment adjustment in 2016, it will be 2 percent. Even if it's your first one. If you're assessed a payment adjustment in 2017 for the first time, that payment adjustment is 3 percent because that is the 2017 payment adjustment percentage amount. Payment adjustments are for one year only and those payment adjustments can go away if you subsequently are able to demonstrate meaningful use.

The next slide shows a number of tables that basically draw out the two-year look back period to determine if a payment adjustment will be assessed based on a participation year. And we do this according to when you started the program. So, if we look at the E.P.s who started meaningful use either in 2011 or 2012, you can see basically it's a one-for-one two-year look back period, so the 2015 payment adjustment is based on your 2013 reporting. For 2016, it's based on 2014 reporting. Even though you're reporting for just one calendar quarter, et cetera, et cetera. The same thing for E.P.s who demonstrated meaningful use for the first time in 2013. For those who demonstrated for the first time in 2013, even though it was just for a 90-day period, you still get full credit for the 2015 payment adjustment and moving forward it's the same schedule as above.

For E.P.s who are starting the program in 2014, you will see that your participation this year will give you credit not only for the 2015 payment adjustment, but also for the 2016 payment adjustment and that is so that we can get those providers on the same timeframe as those who started earlier in the program. Again, for those who are starting in 2014, your 90-day period can begin no later than July 1st. The reporting period ends no later than September 30th and your attestation must be in by October 1st, 2014 to avoid the 2015 payment adjustment.

The Stage 2 final rule listed a number of hardship exception categories that E.P.s can apply if they are meeting or if they are having difficulty in meeting meaningful use. Originally, the five categories included infrastructure, newly practicing E.P.s who did not have time to become meaningful users, unforeseen circumstances, E.P.s who lack face-to-face or telemedicine interaction with patients or lack follow-up meets with their patients, and E.P.s who practice at multiple locations who can demonstrate that they're unable to control the availability of certified EHR for more than 50 percent of their patient encounters.

In 2014, CMS added a sixth category which we are calling 2014 EHR Vendor Issues. And those basically have to deal with those instances in which EHR vendors were not able to obtain 2014 certification or if the E.P. was unable to implement meaningful use due to EHR certification delays on the part of their vendors. I mentioned earlier that there are some specialties that have automatic exceptions and those are anesthesiologists, radiologists, and pathologists. They are

granted automatic exceptions based on the fourth criteria which is lacking the face-to-face or telemedicine interaction or follow-up need with patients.

We look at the Medicare specialty codes that are listed on this slide and there are five. Diagnostic radiology, nuclear medicine, interventional radiology, anesthesiology, and pathology. It's those Medicare specialty codes in the pay codes system as of July 1st that will determine whether or not that E.P. and that specialty will get the automatic exception. So you always want to make sure that your pay codes record is accurate and up-to-date and we'll always be looking at the exceptions or we'll be looking at the information, the enrollment information as of July 1st prior to the year in which a payment adjustment would be assessed. So, for example, when talking about the 2015 payment adjustment, we'll be looking at these specialists per their Medicare specialty codes as of July 1st, 2014. These automatic exceptions are only for one year. So, if anything changes in the pay codes record and your specialty code changes, then that particular E.P. would either be on the hook to demonstrate meaningful use or to file a hardship exception application which we'll talk about now.

The hardship exception application process is now open. They are due to CMS no later than July 1st of 2014. If they are approved, the exception is valid for just one year. And future exceptions will require new applications. So, this is not a blanket exception for the remainder of the program. This is solely for the year for -- the single year for which you are filing the request.

Make sure that when you submit your application that you have a full explanation of the circumstances that are preventing you from becoming a meaningful user. And make sure that you have documentation to back that up because the determinations made by CMS regarding these applications are final and cannot be appealed. Also make sure that the email address of the staff person who is submitting the application is accurate because determinations will be returned to the email address that's provided on that application. This is how we communicate to the individual or to the practice for the applications. It will be based on the email address that's provided on the application.

We give you the email address and the fax number to which the application and any supporting documentation can be sent. And, of course, it is always a good idea to retain a copy of everything that is submitted to CMS for your records, including the return email that you'll get to verify that it was received.

We're going to briefly talk about audits and appeals as part of the EHR Program. Please keep in mind that any provider who participates in the EHR Program and who receives an EHR incentive payment for either of the programs, whether it's Medicare or Medicaid, could be subject to an audit. We are doing both random audits and risk-based audits. CMS is contracted with Figliozzi and Company to perform audits on Medicare and the duly-eligible Medicare and Medicaid providers on the hospital side. And for the Medicaid audits, they are being done by the states and their contractors. It is possible than an E.P. could be subject to audits in successive years and providers who are selected for pre- or post-payment audits will be required to submit documentation to validate that the data that they submitted via attestation was accurate. It is very important that if you get requests from the contractor, from the audit contractor that you follow the instructions in that letter.

In terms of the documentation, when you're participating in the EHR Program, it is very, very important that you maintain all of the documentation to support everything that you are putting into the attestation system. Documentation, again, should support what you've attested both for the core and the menu meaningful use objectives as well as your clinical quality measures. And it's a good practice to keep that information, that documentation on record for at least six years after you've attested. You should save any electronic or paper documentation that supports your attestation including documentation that supports the values that you entered into the module, the attestation module for your clinical quality measures. So, if you are still generating reports directly from your system, you want to make sure that you have all the paperwork, all the documentation to back up the numbers that you're putting into the system. Medicaid providers, you will be able to contact your state Medicaid agency for more information about how audits are being done on the EHR Program at the state level.

When talking about appeals in the meaningful use program, there are generally four bases for appeals. So, we were just talking about the audits and if you go through an audit and you found a meaningful use audit, then that would be your first basis of appeal or one of the bases for appeals. And that is we would allow an E.P. to demonstrate meaningful use by addressing each of the failed measures that resulted in that audit. The deadline would be 30 days from the date of the adverse audit determination letter. So, when you fail, if you fail an audit, you will receive a letter. It will be dated. You have 30 days to submit a request for an appeal for failing the audit.

If you have failed meaningful use, you submitted the information and some of the measures or one -- a couple of the measures you failed to meet the thresholds, then we allow the E.P. to show that the certified system was used to successfully demonstrate meaningful use but failed due to a reporting issue. So, if information was inadvertently put into the attestation system, for example, that would be the basis for a failure of reporting meaningful use audit.

There's also a CQM e-Reporting meaningful use audit whereby we will allow an E.P. to show that CQM e-reporting was successful in meeting meaningful use. The deadline to do so would be March 31st as the reporting deadline generally for the program is February 28th of the year following the participation year.

And finally, if you fail eligibility, we allow provider to show that all EHR incentive program requirements were met and the provider should have been able to participate in the program but could not because of circumstances that were outside of the provider's control. And again, the deadline for that type of appeal is also March 31st.

When you are filing your appeal, it is very important that all the documentation that you have to support your case must be submitted at the time that you are filing the request for the appeal. Anything additional that you try to submit after the appeal request goes through will not be accepted. So, any type of missing documentation or anything that's submitted in a format that's not recognizable or acceptable could result in a delay of a decision or for a denial. Again, we give you the email address and the fax number to which you can send your request for appeals. And also, again, good idea to keep a copy of everything that you submit to CMS for your records.

In closing, we want to give you some resources that you'll need in order to be successful in attesting to meaningful use. The EHR Incentive Program Information Center has been set up to help providers with registration, attestation, and all other types of mechanical issues as it relates to the program. The number to call is (888) 734-6433. If you're having any problems with the mechanics of the program, again such as registration, attestation, payment information, your first call should be to the EHR info center. They will triage the issue as appropriate. They will give you a remedy ticket number so that you can track and we can also track internally here at CMS the progress of the case that you have given to us. Also, all information for the Medicare-Medicaid EHR Incentive Programs can be found at the website that's listed below.

And with that, look at the resources that are available to you. That concludes our presentation. Thank you for viewing this MLN Connects video on the Medicare and Medicaid EHR Incentive Programs. This MLN Connects video is part of the Medicare Learning Network. The information in this presentation was correct as of the date it was recorded. This presentation is not a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.