U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

HRSA Health Information Technology and Quality Webinar

"Overview of Meaningful Use Stage 2 NPRM for Safety Net Providers"

Date: 3/30/2012

US Department of Health and Human Services
Health Resources and Services Administration

Office of Health Information Technology and Quality

Additional HRSA Health IT and Quality Toolboxes and Resources including past webinars can be found at:

http://www.hrsa.gov/healthit

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- **US Department of Health and Human Services**
- **Health Resources and Services Administration**

HRSA

Upcoming HRSA Health IT and Quality Announcements

- **HIMSS Jobmine for Safety Net Providers** (Free Job Postings for HRSA Grantees and Safety Net Providers). Email hfigge@himss.org for more information.
- **Competency Exam for Health IT Professionals ,** vouchers available for free exams, email healthit@hrsa.gov
- **Next HRSA Health IT and Quality Webinar** “"Using Health IT to Support Continuity of Care and Resiliency During Unforeseen Events” April 20th 2PM (ET)
- HRSA’s March/April Health IT and Quality Newsletter Available Next Week
- New HRSA “Network Guide” is now available on the HRSA Health IT website
- New State Medicaid Contacts Resources Available on CMS’s EHR Incentive Program Website

Introduction

Presenters:

- Jessica Kahn-Centers for Medicare & Medicaid Services
- Travis Broome-Centers for Medicare & Medicaid Services

Medicare & Medicaid EHR Incentive Programs

Stage 2 Proposed Rule

Travis Broome and Jessica Kahn

HRSA Webinar

March 30, 2012

Proposed Rule

Everything discussed in this presentation is part of a notice of proposed rulemaking (NPRM).

We encourage anyone interested in Stage 2 of meaningful use to review the NPRM for Stage 2 of meaningful use and the NPRM for the 2014 certification of EHR technology at

CMS Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4443.pdf

ONC Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-03-07/pdf/2012-4430.pdf

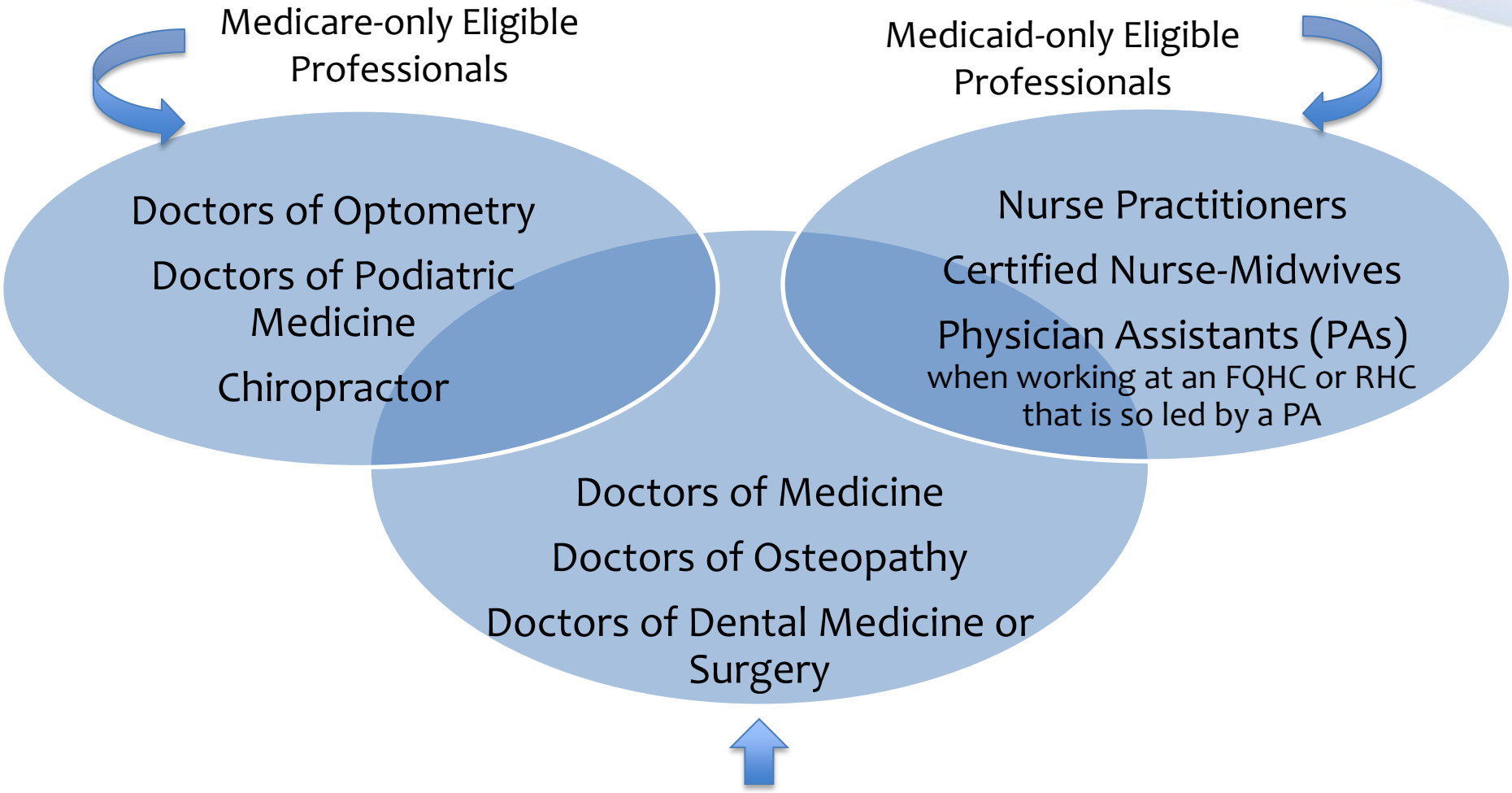
Comments can be made starting March 7 through May 7 at www.regulations.gov

What is in the Proposed Rule

- Minor changes to Stage 1 of meaningful use
- Stage 2 of meaningful use
- New clinical quality measures
- New clinical quality measure reporting mechanisms
- Appeals
- Details on the Medicare payment adjustments
- Minor Medicare Advantage program changes
- Minor Medicaid program changes

Eligibility

- Eligibility in general is determined by the HITECH Act and there have been no changes to the HITECH Act
- Therefore the only eligibility changes are those within our regulatory purview under the Medicaid EHR Incentive Program


Medicare-only Eligible Professionals
Medicaid-only Eligible Professionals
Doctors of Optometry
Doctors of Podiatric Medicine
Chiropractor
Nurse Practitioners
Certified Nurse-Midwives
Physician Assistants (PAs)
when working at an FQHC or RHC that is so led by a PA
Doctors of Medicine
Doctors of Osteopathy
Doctors of Dental Medicine or Surgery
Could be eligible for both Medicare & Medicaid

Medicare Eligible Professionals

- Must be a physician (defined as MD, DO, DDM/DDS, optometrist, podiatrist, chiropractor)
- Must have Part B Medicare allowed charges
- Must not be hospital-based
- Must be enrolled in Provider Enrollment, Chain and Ownership System (PECOS) and in an 'approved status' , living

Medicaid Eligible Professionals

Must either:

- Have ≥ 30% *Medicaid* patient volume (≥ 20% for pediatricians only); or
- Practice predominantly in an FQHC or RHC with ≥30% *needy individual* patient volume

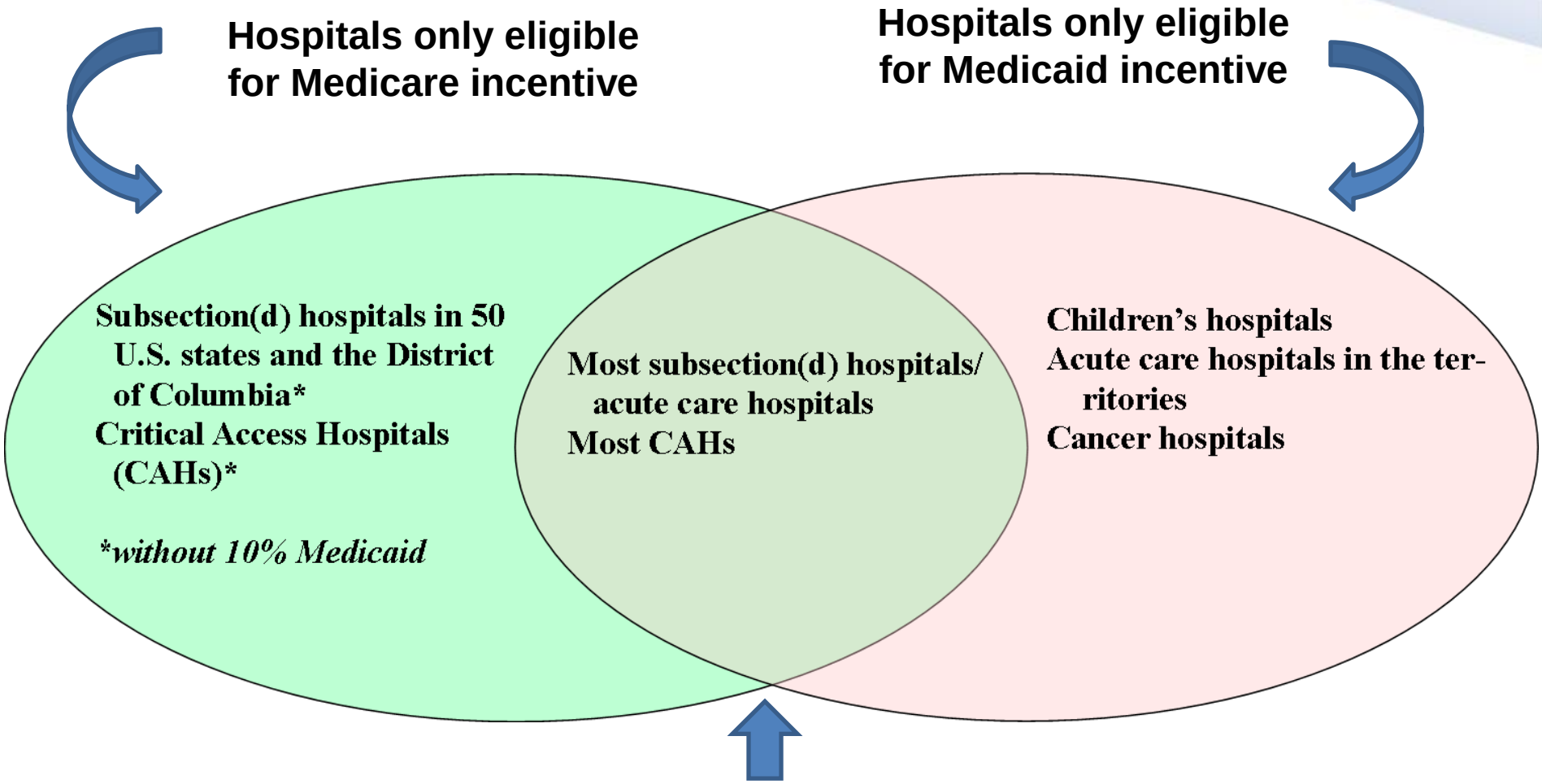
Licensed, credentialed

No OIG exclusions, living

Must not be hospital-based

Hospital Based Eligible Professionals

There are no proposed changes to the hospital based eligible professional definition. Although we do discuss and ask for comment on situations where an EP who is classified as hospital-based might still be providing their own Certified EHR Technology.


Hospitals only eligible for Medicare incentive
Hospitals only eligible for Medicaid incentive
Subsection(d) hospitals in 50 U.S. states and the District of Columbia*
Critical Access Hospitals (CAHs)*
*without 10% Medicaid
Most subsection(d) hospitals/ acute care hospitals
Most CAHs
Children's hospitals
Acute care hospitals in the territories
Cancer hospitals
Could be eligible for both Medicare & Medicaid (most hospitals)

Hospital Eligibility

Medicare

- Title XVIII subsection(d) qualified
  - Must be in 50 United States or D.C.
- Critical Access Hospitals (CAHs)
- Medicare Advantage (MA-Affiliated) Hospitals

Medicaid

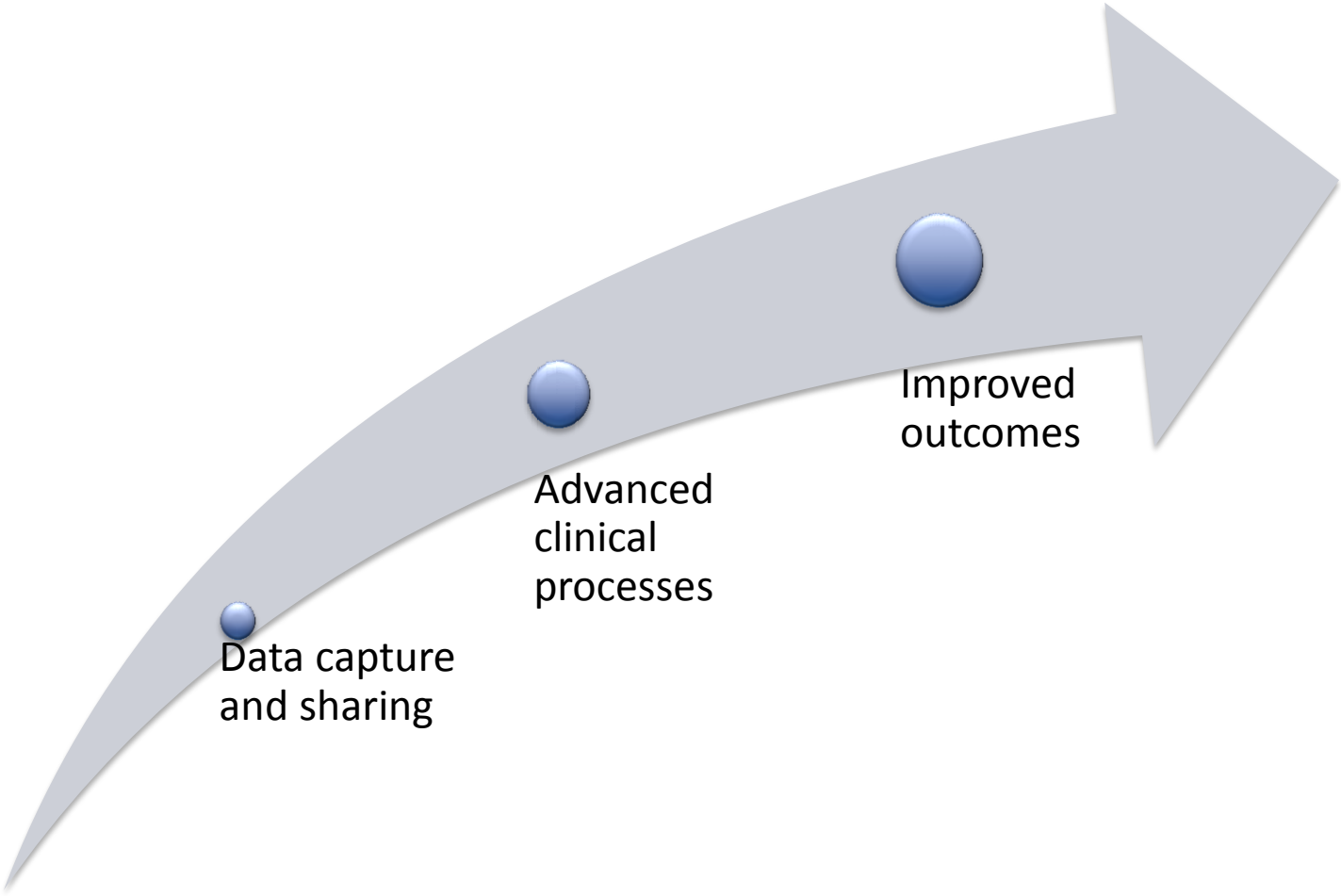
- Acute care hospital with at least 10% Medicaid patient volume
  - General, short-term stay
  - Cancer
  - Critical Access Hospitals
- Children's hospitals

What is Meaningful Use?

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

http://www.cms.gov/EHRIncentivePrograms/

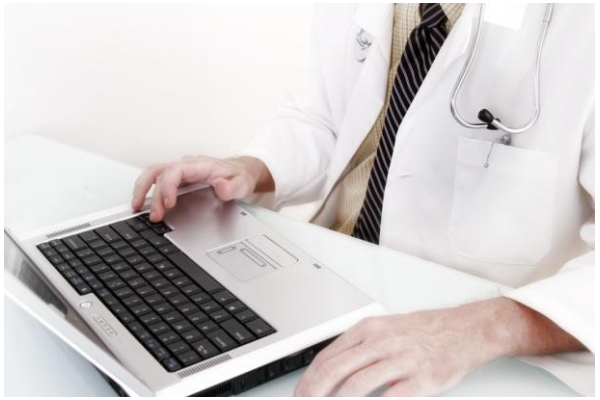
A Conceptual Approach to Meaningful Use



http://www.cms.gov/EHRIncentivePrograms/

MU and Implementation

- Put each objective in the context of the goal

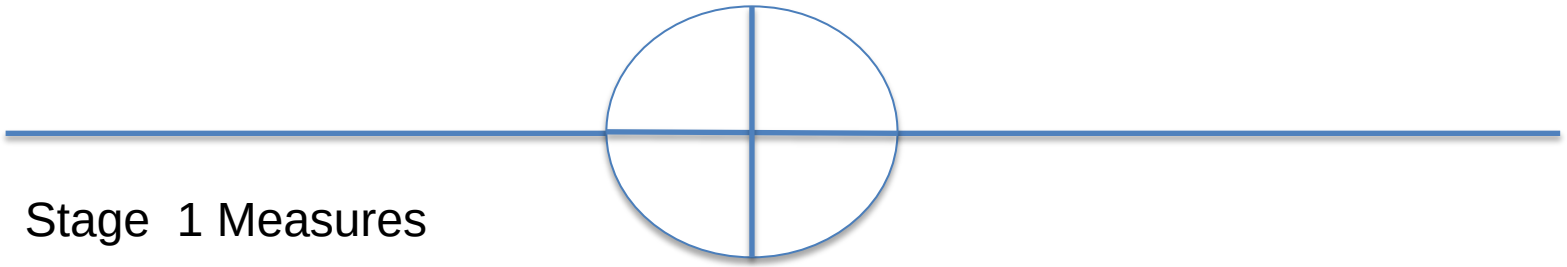


Why does CPOE improve quality, safety and efficiency?

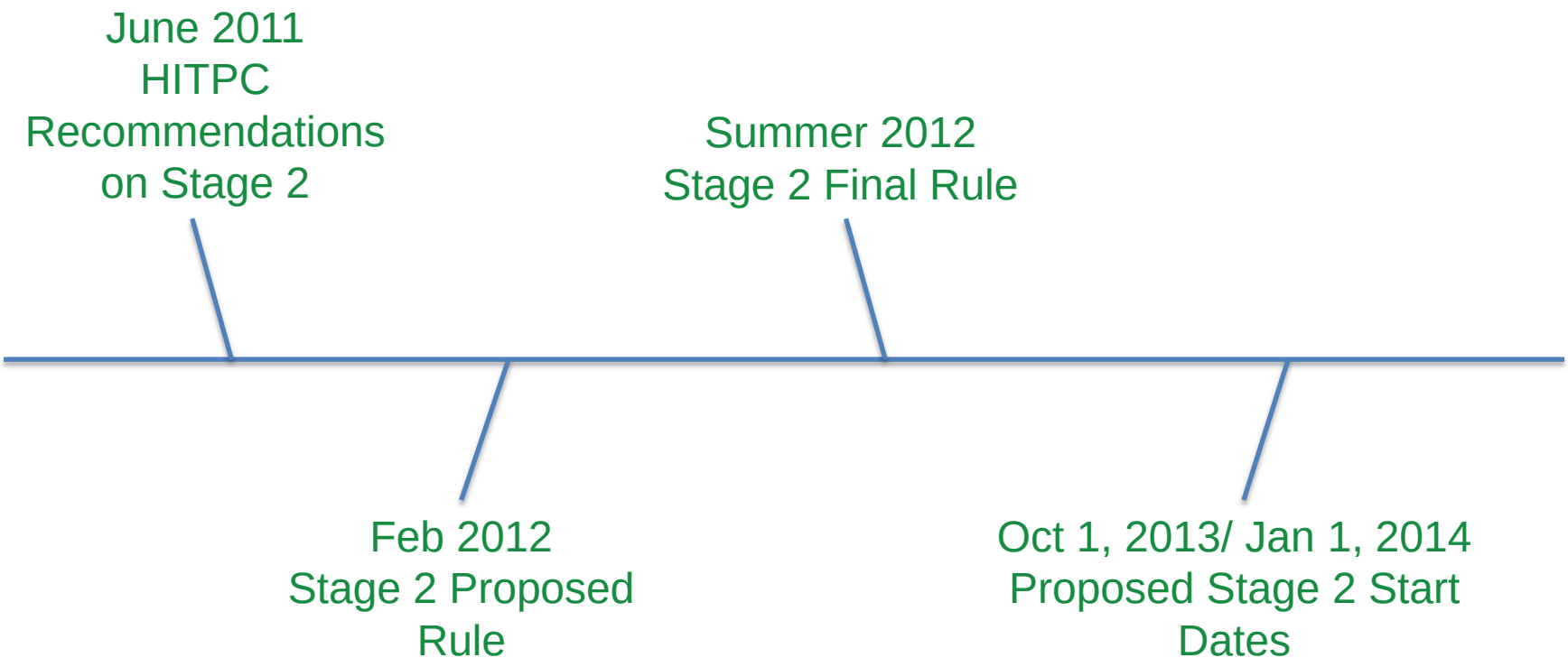
- Is it measurable?
- How can usability and workflow be better?

Meaningful Use Risks

- Can't measure, Can't Share
- Aiming too low



Stage 2 Timeline



http://www.cms.gov/EHRIncentivePrograms/

Stages of Meaningful Use

1st Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	3	3	TBD	TBD	TBD	TBD
2012		1	1	2	2	3	3	TBD	TBD	TBD	TBD
2013			1	1	2	2	3	3	TBD	TBD	TBD
2014				1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

http://www.cms.gov/EHRIncentivePrograms/

Stage 1 to Stage 2 Meaningful Use

Eligible Professionals

15 core objectives

5 of 10 menu objectives

20 total objectives

Eligible Professionals

17 core objectives

3 of 5 menu objectives

20 total objectives

Eligible Hospitals & CAHs

14 core objectives

5 of 10 menu objectives

19 total objectives

Eligible Hospitals & CAHs

16 core objectives

2 of 4 menu objectives

18 total objectives

http://www.cms.gov/EHRIncentivePrograms/

Meaningful Use Concepts

Changes

- Exclusions no longer count to meeting one of the menu objectives
- All denominators include all patient encounters at outpatient locations equipped with certified EHR technology

No Changes

- No change in 50% of EP outpatient encounters must occur at locations equipped with certified EHR technology
- Measure compliance = objective compliance

Stage 2 EP Core Objectives

1. Use CPOE for more than **60%** of medication, **laboratory and radiology** orders
2. E-Rx for more than **65%**
3. Record demographics for more than **80%**
4. Record vital signs for more than **80%**
5. Record smoking status for more than **80%**
6. Implement **5** clinical decision support interventions + drug/drug and drug/allergy
7. Incorporate lab results for more than **55%**

http://www.cms.gov/EHRIncentivePrograms/

Stage 2 EP Core Objectives

8. Generate patient list by specific condition
9. Use EHR to identify and provide more than 10% with reminders for preventive/follow-up
10. Provide **online access** to health information for more than 50% with more than **10% actually accessing**
11. Provide office visit summaries in **24 hours**
12. Use EHR to identify and provide education resources more than 10%

http://www.cms.gov/EHRIncentivePrograms/

Stage 2 EP Core Objectives

13. **More than 10% of patients send secure messages to their EP**
14. Medication reconciliation at more than **65%** of transitions of care
15. Provide summary of care document for more than **65%** of transitions of care and referrals with **10% sent electronically**
16. **Successful ongoing** transmission of immunization data
17. Conduct or review security analysis and incorporate in risk management process

Stage 2 EP Menu Objectives

1. **More than 40% of imaging results are accessible through Certified EHR Technology**
2. **Record family health history for more than 20%**
3. **Successful ongoing** transmission of syndromic surveillance data
4. **Successful ongoing transmission of cancer case information**
5. **Successful ongoing transmission of data to a specialized registry**

Stage 2 Hospital Core Objectives

1. Use CPOE for more than **60%** of medication, **laboratory and radiology** orders
2. Record demographics for more than **80%**
3. Record vital signs for more than **80%**
4. Record smoking status for more than **80%**
5. Implement **5** clinical decision support interventions + drug/drug and drug/allergy
6. Incorporate lab results for more than **55%**

http://www.cms.gov/EHRIncentivePrograms/

Stage 2 Hospital Core Objectives

7. Generate patient list by specific condition
8. **EMAR is implemented and used for more than 10% of medication orders**
9. Provide **online access** to health information for more than 50% with more than **10% actually accessing**
10. Use EHR to identify and provide education resources more than 10%
11. Medication reconciliation at more than **65%** of transitions of care

http://www.cms.gov/EHRIncentivePrograms/

Stage 2 Hospital Core Objectives

12. Provide summary of care document for more than **65%** of transitions of care and referrals with **10% sent electronically**
13. **Successful ongoing** transmission of immunization data
14. **Successful ongoing** submission of reportable laboratory results
15. **Successful ongoing** submission of electronic syndromic surveillance data
16. Conduct or review security analysis and incorporate in risk management process

http://www.cms.gov/EHRIncentivePrograms/

Stage 2 Hospital Menu Objectives

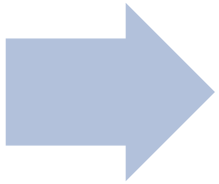
1. Record indication of advanced directive for more than 50%
2. **More than 40% of imaging results are accessible through Certified EHR Technology**
3. **Record family health history for more than 20%**
4. **E-Rx for more than 10% of discharge prescriptions**

http://www.cms.gov/EHRIncentivePrograms/

Changes to Stage 1

CPOE

Denominator: Unique Patient with at least one medication in their med list

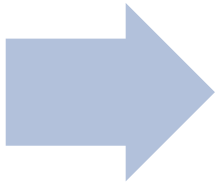


Denominator: Number of Orders during the EHR Reporting Period

Optional in 2013 Required in 2014+

Vital Signs

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



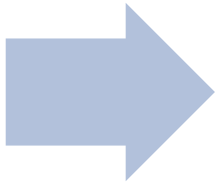
Age Limits: Age 3 for Blood Pressure, No age limit for Height/Weight

Optional in 2013 Required in 2014+

Changes to Stage 1

Vital Signs

Exclusion: All three elements not relevant to scope of practice

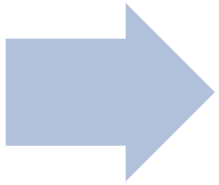


Exclusion: Allows BP to be separated from height/weight

Optional in 2013 Required in 2014+

Test of Health Information Exchange

One test of electronic transmission of key clinical information



Requirement removed effective 2013

Effective 2013

Changes to Stage 1

E-Copy and Online Access

Objective: Provide patients with e-copy of health information upon request

Objective: Provide electronic access to health information

→

Replacement Objective:

Provide patients the ability to view online, download and transmit their health information

Required in 2014+

Public Health Objectives

Immunizations

Reportable Labs

Syndromic Surveillance

→

Addition of "except where prohibited" to all three

Effective 2013

http://www.cms.gov/EHRIncentivePrograms/

CLINICAL QUALITY MEASURES

Clinical Quality Measures

Change from Stage 1 to Stage 2:

CQMs are no longer a meaningful use core objective, but reporting CQMs is still a requirement for meaningful use.

CQM – Timing

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

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

http://www.cms.gov/EHRIncentivePrograms/

CQM – Criteria for Selection

- Statutory requirements
- Implemented within the capacity of CMS infrastructure
- Alignment of Quality Measurement Programs

CQM – Criteria for Selection (cont'd)

- Measures that address known gaps in quality of care
- Measures that address areas of care for different types of eligible professionals
- Support CMS and HHS priorities for improved quality of care based on the National Quality Strategy and HITPC recommendations.

Alignment Among Programs

- CMS is committed to aligning quality measurement and reporting among programs
- Alignment efforts on several fronts:
  - Choosing the same measures for different program measure sets
  - Coordinating quality measurement stakeholder involvement efforts and opportunities for public input
  - Identifying ways to minimize multiple submission requirements and mechanisms

Alignment Among Programs (cont'd)

- Lessen provider burden
- Harmonize with data exchange priorities
- Support primary goal of all CMS quality measurement programs
  - Transforming our health care system to provide:
    - Higher quality care
    - Better health outcomes
    - Lower cost through improvement

CQM Priorities

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.

CQM Priorities (cont'd)

- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

CQM - Domains

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

CQM – Changes from July 28, 2010 Final Rule

Through 2013

Eligible Professionals

3 core OR 3 alt. core CQMs

plus

3 menu CQMs

6 total CQMs

Eligible Hospitals & CAHs

15 total CQMs

Align with ONC's 2011 Edition Certification

Beginning in 2014

Eligible Professionals

1a) 12 CQMs (≥1 per domain)

1b) 11 core + 1 menu CQMs

2) PQRS

Group Reporting

12 total CQMs

Eligible Hospitals & CAHs

24 CQMs (≥1 per domain)

24 total CQMs

Align with ONC's 2014 Edition Certification

http://www.cms.gov/EHRIncentivePrograms/

CQM Reporting in 2013 EPs & Hospitals

- CQMs will remain the same through 2013
  - As published in the July 28, 2010 Final Rule
- Electronic specifications for the CQMs are expected to be updated
- Reporting Methods:
  1) Attestation
  2) 2012 Electronic Reporting Pilots extended to 2013
  3) Medicaid – State-based e-submission

CQM Reporting for EPs Beginning in CY2014

- EHR Incentive Program Only
  - Option 1a: 12 CQMs, ≥1 from each domain
  - Option 1b: 11 “core” CQMs + 1 “menu” CQM
  - Aggregate XML-based format specified by CMS
  - Medicaid – State based e-submission
- EHR Incentive Program + PQRS (Medicare)
  - Option 2: Submit and satisfactorily report CQMs under PQRS EHR Reporting option using CEHRT
  - Requirements for PQRS are in CY 2012 Medicare Physician Fee Schedule Final Rule (76 FR 73314)

CQM Reporting for EPs Beginning in CY2014

- Group Reporting (3 options – Medicare only):

(1) ≥ 2 EPs, each with a unique NPI under one TIN	Submit 12 CQMs from EP measures table, ≥1 from each domain
(2) EPs in an ACO (Medicare Shared Savings Program)	Satisfy requirements of Medicare Shared Savings Program using Certified EHR Technology
(3) EPs satisfactorily reporting via PQRS GPRO option	Satisfy requirements of PQRS GPRO option using Certified EHR Technology

Core CQMs for EPs

CMS selected the CQMs for the proposed core set 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

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

CQM Reporting for Hospitals Beginning in FY2014

- 24 CQMs, ≥1 from each domain
  - Includes 15 CQMs from July 28, 2010 Final Rule
  - Considering instituting a case number threshold exemption for some hospitals
- Reporting Methods
  1) Aggregate XML-based format specified by CMS
  2) Manner similar to 2012 Medicare EHR Incentive Program Electronic Reporting Pilot
     - Requirements for pilot in CY 2012 Outpatient Prospective Payment System Final Rule (76 FR 74122)
  3) Medicaid – State-based e-submission

Medicare Only

EPs, Subsection (d) Hospitals and CAHs

PAYMENT ADJUSTMENTS

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
- As adopt, implement and upgrade does not constitute meaningful use, a provider receiving a Medicaid incentive for AIU would still be subject to the Medicare payment adjustment.

EP Payment Adjustments

% ADJUSTMENT ASSUMING LESS THAN 75 PERCENT OF EPs ARE MEANINGFUL EHR 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 ASSUMING MORE THAN 75 PERCENT OF EPs ARE MEANINGFUL EHR 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%

http://www.cms.gov/EHRIncentivePrograms/

EP EHR Reporting Period

EP who has demonstrated meaningful use in 2011 or 2012

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

EP who demonstrates meaningful use in 2013 for the first time

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

http://www.cms.gov/EHRIncentivePrograms/

EP EHR Reporting Period

EP who demonstrates meaningful use in 2014 for the first time

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

*In order to avoid the 2015 payment adjustment the EP must attest no later than Oct 1, 2014 which means they must begin their 90 day EHR reporting period no later than July 2, 2014

EP Hardship Exemption

Proposed Exemptions on an application basis

- Insufficient internet access two years prior to the payment adjustment year
- Newly practicing EPs for two years
- Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.

Applications need to be submitted no later than July 1 of year before the payment adjustment year; however, we encourage earlier submission

EP Hardship Exemption

Other Possible Exemption Discussed in NPRM

- Concerned that the combination of 3 barriers would constitute a significant hardship
  - Lack of direct interaction with patients
  - Lack of need for follow-up care for patients
  - Lack of control over the availability of Certified EHR Technology
- We do not believe any one of these barriers taken independently constitutes a significant hardship
- In our discussion we consider whether any specialty may nearly uniformly face all 3 barriers

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%

For 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

Subsection (d) Hospital EHR Reporting Period

Hospital who has demonstrated meaningful use in 2011 or 2012 (fiscal years)

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

Hospital who demonstrates meaningful use in 2013 for the first time

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

Subsection (d) Hospital EHR Reporting Period

Hospital who demonstrates meaningful use in 2014 for the first time

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

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

Subsection (d) Hospital Hardship Exemption

Proposed Exemptions on an application basis

- Insufficient internet access two years prior to the payment adjustment year
- New hospitals for at least 1 full year cost reporting period
- Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.

Applications need to be submitted no later than April 1 of year before the payment adjustment year; however, we encourage earlier submission

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%

CAH EHR Reporting Period

CAH who has demonstrated meaningful use prior to 2015 (fiscal years)

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

CAH who demonstrates meaningful use in 2015 for the first time

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

http://www.cms.gov/EHRIncentivePrograms/

CAH Hardship Exemption

Proposed Exemptions on an application basis

- Insufficient internet access for the payment adjustment year
- New CAHs for one year after they accept their first patient
- Extreme circumstances such as unexpected closures, natural disaster, EHR vendor going out of business, etc.

Medicare

APPEALS

Appeals - Types

- Eligibility Appeals (Medicare)
  - Provider has met all the program requirements and should have received an incentive but could not because of a circumstance outside the provider's control.
- Meaningful Use Appeals (Medicare/Medicaid)
  - Provider has shown that he or she used certified EHR technology and met the meaningful use objectives and associated measures.
- Incentive Payment Appeals (Medicare EPs only)
  - Provider has shown that he or she provided claims data not used in determining the incentive payment amount.

Appeals – Filing Requirements

- Deadlines
  - Eligibility – 30 days after the 2 month period following the payment year
  - Meaningful Use - 30 days from the date of the demand letter or other finding that could result in the recoupment of an EHR incentive payment
  - Incentive Payment - 60 days from the date the incentive payment was issued or 60 days from any Federal determination that the incentive payment calculation was incorrect

Appeals - Process

- Provider must present all relevant issues at the time of the initial filing of an appeal.
- An appeal is considered inchoate or premature if CMS still has an opportunity to resolve the issue. A provider is still permitted to file the same appeal again if the issue is not resolved by the program deadlines.
- Appeals have two levels: (1) an informal review that is completed within 90 days from the date of filing, and (2) a reconsideration can be requested if the provider does not prevail in the informal review.
- Providers dissatisfied can file a request for reconsideration with comments and documentation supporting the reconsideration within 15 days of the informal review decision.

Appeals References & Contacts

- For any Appeals-related questions, contact:
- Appeals Support Contractor
  - Email: OCSQAppeals@provider-resources.com
  - Toll-free: 855-796-1515
- CMS
  - Douglas Brown (douglas.brown@cms.hhs.gov)
  - Lawrence Clark (lawrence.clark@cms.hhs.gov)
- Website: https://www.cms.gov/QualityMeasures/05_EHRIncentiveProgramAppeals.asp

MEDICAID-SPECIFIC CHANGES

Medicaid- Specific Changes

- Proposed an expanded definition of a Medicaid encounter:
  - To include any encounter with an individual receiving medical assistance under 1905(b), including Medicaid expansion populations
  - To permit inclusion of patients on panels seen within 24 months instead of just 12
  - To permit patient volume (Medicaid and needy individual) to be calculated from the most recent 12 months, or on the CY for both EPs and EHs
  - To include zero-pay Medicaid claims

Medicaid-Specific Changes Continued

- Proposed that at least one site used for patient volume calculations have certified EHR technology
- Proposed that hospitals that switch States would not exceed the aggregate EHR incentive payment amount as calculated by the initial State
- Proposed that CMS would audit meaningful use for Medicaid-only hospitals and handle related appeals

Medicaid-Specific Changes Continued

- Proposed the inclusion of additional children's hospitals that do not have a CMS Certification Number (CCN)
- Proposed to extend States' flexibility with the definition of meaningful use to Stage 2

REGISTRATION & ATTESTATION

Register and Attest for the EHR Incentive Programs

- Visit the CMS EHR Incentive Programs website to,
  - Register for the EHR Incentive Programs
  - Attest for the *Medicare* EHR Incentive Programs

https://www.cms.gov/EHRIncentivePrograms/

Office of Health Information Technology and Quality

Additional HRSA Health IT and Quality Toolboxes and Resources including past webinars can be found at:

http://www.hrsa.gov/healthit

http://www.hrsa.gov/quality

Additional questions can sent to the following e-mail address:

HealthIT@hrsa.gov

- **US Department of Health and Human Services**
- **Health Resources and Services Administration**

HRSA