HIMSS Meaningful Use Regional Meeting

Clinical Quality Measures

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Chief Medical Officer
CMS Region III
Eligibility for EHR Incentive Program

- Incentive payments for eligible professionals are based on individual practitioners.
- If you are part of a practice, each eligible professional may qualify for an incentive payment if each eligible professional successfully demonstrates meaningful use of certified EHR technology.
- Each eligible professional is only eligible for one incentive payment per year, regardless of how many practices or locations at which he or she provides services.
# 2014 Incentives and 2016 Payment Adjustments

<table>
<thead>
<tr>
<th>PQRS</th>
<th>Value Modifier</th>
<th>EHR Incentive Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10-99 EPs</td>
<td>100+ EPs</td>
</tr>
<tr>
<td></td>
<td>PQRS-Reporting</td>
<td>PQRS-Reporting (Up or Neutral Adj)</td>
</tr>
<tr>
<td></td>
<td>Non-PQRS Reporting</td>
<td>Non-PQRS Reporting (Down Adj)</td>
</tr>
<tr>
<td><strong>MD &amp; DO</strong></td>
<td><strong>Incentive</strong></td>
<td><strong>Pay Adj</strong></td>
</tr>
<tr>
<td></td>
<td>0.5% of MPFS</td>
<td>-2.0% of MPFS</td>
</tr>
<tr>
<td></td>
<td>(1.0% with MOC)</td>
<td>-2.0% of MPFS</td>
</tr>
</tbody>
</table>

**DDM**

**Oral Sur**

**Pod.**

**Opt.**

**Chiro.**

- 2.0% of MPFS

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- Medicare Inc.

- Medicaid Inc.

- Medicare Pay Adj

- N/A
What Stage Am I In for 2014??

When Did You First Attest to Meaningful Use?

2011
In 2014:
• Stage 2
• 1 Calendar Quarter
• $4,000 incentive
• Avoid the 2016 payment adjustment

2012
In 2014:
• Stage 2
• 1 Calendar Quarter
• $8,000 incentive
• Avoid the 2016 payment adjustment

2013
In 2014:
• Stage 1
• 1 Calendar Quarter
• $12,000 incentive
• Avoid the 2016 payment adjustment

2014
In 2014:
• Stage 1
• Any 90 days (attest no later than October 1, 2014)
• $12,000 incentive
• Avoid the 2015 & 2016 payment adjustment
Incentives and Payment Adjustments in 2014

- EPs who are eligible for both PQRS and the EHR meaningful use (MU) program may participate in both programs and earn incentives for both.

- Medicare EHR incentive payments for 2014 is based on when the individual EP first demonstrated MU:

<table>
<thead>
<tr>
<th>If first year of MU was:</th>
<th>2014 MU Incentive Is (per EP):</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$4,000</td>
</tr>
<tr>
<td>2012</td>
<td>$8,000</td>
</tr>
<tr>
<td>2013</td>
<td>$12,000</td>
</tr>
<tr>
<td>2014</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

- 2014 Incentive for EPs participating in the Medicaid MU program is either $21,250 or $8,500.
Certification

- CMS & ONC have established standards and certification criteria for structured data that EHRs must use in order to successfully capture and calculate objectives for Stage 2 of meaningful use.
- These new standards and certification criteria will take effect in 2014.
- Even if you already have a certified EHR, you will have to adopt or upgrade to the new certification in order to participate in the EHR Incentive Programs beginning in 2014.
- EHR technology that is certified to the 2014 standards and certification criteria will allow providers to meet both Stage 1 and Stage 2 meaningful use requirements.
Changes: 2014 Reporting Periods

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

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

- **Menu Objective Exclusion**— While you can continue to claim exclusions if applicable for menu objectives, starting in 2014 these exclusions will no longer count towards the number of menu objectives needed to successfully demonstrate meaningful use.
- Changes to vital signs measure become required
- Reporting of clinical quality measures removed as objective but still required
- Patient electronic access and electronic copy of health info objectives merge to become view online, download, and transmit (VDT) objective
Meaningful Use Objectives

- Stage 2 retains the same basic structure as Stage 1
- EPs must report on **17 core objectives** and **3 out of 6 possible menu objectives**

**Stage 1**

Eligible Professionals

- 13 core objectives
- 5 of 9 menu objectives
- 18 total objectives

**Stage 2**

Eligible Professionals

- 17 core objectives
- 3 of 6 menu objectives
- 20 total objectives
## Meaningful Use Core Objectives

<table>
<thead>
<tr>
<th>1. Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Generate and transmit permissible prescriptions electronically (eRx)</td>
</tr>
<tr>
<td>3. Record demographic information</td>
</tr>
<tr>
<td>4. Record and chart changes in vital signs</td>
</tr>
<tr>
<td>5. Record smoking status for patients 13 years or older</td>
</tr>
<tr>
<td>6. Use clinical decision support to improve performance on high-priority health conditions</td>
</tr>
<tr>
<td>7. Provide patients the ability to view online, download and transmit their health information (PATIENT ENGAGEMENT)</td>
</tr>
<tr>
<td>8. Provide clinical summaries for patients for each office visit</td>
</tr>
<tr>
<td>9. Protect electronic health information created or maintained by Certified EHR Technology</td>
</tr>
<tr>
<td>10. Incorporate clinical lab-test results into Certified EHR Technology</td>
</tr>
<tr>
<td>11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach</td>
</tr>
<tr>
<td>12. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care</td>
</tr>
<tr>
<td>13. Use certified EHR technology to identify patient-specific education resources</td>
</tr>
<tr>
<td>14. Perform medication reconciliation</td>
</tr>
<tr>
<td>15. Provide summary of care record for each transition of care or referral (ELECTRONIC EXCHANGE)</td>
</tr>
<tr>
<td>16. Submit electronic data to immunization registries</td>
</tr>
<tr>
<td>17. Use secure electronic messaging to communicate with patients on relevant health information (PATIENT ENGAGEMENT)</td>
</tr>
</tbody>
</table>
CHAPTER 2: WHAT ARE THE REQUIREMENTS UNDER STAGE 2 OF MEANINGFUL USE?

Core Objectives for Eligible Professionals

Provide summary care record for each transition of care or referral (continued)

| What that means for you | For over half of the patients you refer to another provider or transfer to another setting of care (e.g., nursing home), you have to send the next provider of care either an electronic or paper summary of care document that is generated by your certified EHR.

Of those summary of care documents you send, more than 10% must be sent electronically—either directly to a recipient or using the eHealth Exchange standards.

At least one of the summary of care documents that are sent electronically must be sent to someone who is using a completely different EHR vendor or to the CMS designated test EHR. |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Are you excluded from doing this?</td>
<td>You can be excluded from all three measures if you transfer a patient to another setting or refer a patient to another provider less than 100 times during the reporting period.</td>
</tr>
</tbody>
</table>
Closer Look at Stage 2: Electronic Exchange

• Summary of care exchange: Ensure provider who transitions a patient to someone else’s care gives receiving provider most up-to-date information available

• Information generally limited to what is available to EP and in certified EHR technology at time summary of care is generated

• 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
Measure Guidance: Summary of Care

• Unlike clinical summary and patient online access objectives, EP must verify that info was entered into EHR for problem list, medication list, and medication allergy list prior to generating summary of care.

• Problem list, medication list, and medication allergy list must either contain specific information or a notation that the patient has none of these items.
Measure Guidance: Summary of Care (con’t)

• Leaving field blank would not allow provider to meet objective
  o If other data elements from required list is not available in EHR at time summary of care is generated, that info does not have to be made available in summary of care

• Fields for problem list, medication list, and medication allergy list must either contain problems, medications, and medication allergies or a specific notation that patient has none of these items
New CMS and ONC Tool

- EHR “Randomizer” lets you exchange data with a test EHR in order to meet measure #3 of the Transition of Care requirement
- You must register with the EHR Randomizer
- Will pair your EHR technology with a different test EHR from a list of authorized systems
- Must send a Consolidated Clinical Document Architecture (CCDA) summary of care record to the test EHR
- Recommend that you send a document to the test EHR that does not contain actual patient data
- Test EHR will send an email within one day denoting success or failure
CHAPTER 2: WHAT ARE THE REQUIREMENTS UNDER STAGE 2 OF MEANINGFUL USE?
Core Objectives for Eligible Professionals

<table>
<thead>
<tr>
<th>Use secure electronic messaging to communicate with patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What this measure requires</strong></td>
</tr>
<tr>
<td>A secure message was sent using the electronic messaging function of CEHRT by more than 5% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.</td>
</tr>
<tr>
<td><strong>What that means for you</strong></td>
</tr>
<tr>
<td>Certified EHR technology will contain the capability to send secure messages between you and your patients. In order to meet this objective, you have to make sure that more than 5% of your patients actually use this capability by sending you a secure message.</td>
</tr>
<tr>
<td><strong>Are you excluded from doing this?</strong></td>
</tr>
<tr>
<td>You can be excluded if you have no office visits during the reporting period. You can also be excluded if you practice in an area with low broadband availability. For more information about qualifying for this exclusion, visit the <a href="http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/Stage2_EPCore_17UseSecureElectronicMessaging.pdf">Stage 2 Meaningful Use Specification Sheet for this objective</a>.</td>
</tr>
</tbody>
</table>
Closer Look at Stage 2: Patient Engagement

- Patient engagement is an important focus of stage 2
- Allows patients easy access to health info so they can make informed decisions regarding care and share most recent clinical info with other health care providers and personal givers

- More than 5% of patients must send secure messages to their EP
- More than 5% of patients must access their health information online
- EXCLUSIONS: Based on broadband availability in the provider’s community
Measure Guidance: Patient Access

• Unlike clinical summaries, which are tied to specific office visits, providing patient electronic access to info is an ongoing requirement.

• If a specific data field is not available to EP at time info is sent to patient portal, that info does not have to be made available online and EP can still meet the objective.

• As new info for specific items listed becomes available to provider, that info must be updated and made available to patient online within four (4) business days.
Measure Guidance: Patient Access

- All info available at time info is sent to patient portal must be made available to patient online

- EP may withhold any info from online disclosure if he or she believes providing such info may result in significant harm

- Fields for problem list, medication list, and medication allergy list must either contain problems, medications, and medication allergies, or a specific notation that patient has none
Clinical Quality Measures (CQMs)

• Starting in 2014, clinical quality measures are no longer a meaningful use objective, but reporting CQMs is part of the definition of a meaningful user.

• The requirements for CQMs are now tied to the current year of participation, not your stage of MU.

• CQMs must derive from patient data that is located in your CEHRT.

• Requirements, quality domains, and quality measures aligned with EHR Reporting option of the Physician Quality Reporting System (PQRS).

• Medicaid EPs must submit their CQM data to their State Medicaid Agency.
CQM 2014

- Beginning in 2014, all Medicare-eligible providers beyond their first year of demonstrating meaningful use must electronically report their CQM data to CMS.
- Physician Quality Reporting System (PQRS)—Electronic submission of samples of patient-level data in the Quality Reporting Data Architecture (QRDA) Category I format.
- EPs can also report as group using the PQRS GPRO tool. EPs who electronically report using this PQRS option will meet both their EHR Incentive Program and PQRS reporting requirements.
- CMS-designated transmission method—Electronic submission of aggregate-level data in QRDA Category III format.
Recommended Adult Measures

- Controlling High Blood Pressure (Clinical Process/Effectiveness)
- Use of High-Risk Medications in the Elderly (Patient Safety)
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Population/Public Health)
- Use of Imaging Studies for Low Back Pain (Efficient Use of Healthcare Resources)
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (Population/Public Health)
- Documentation of Current Medications in the Medical Record (Patient Safety)
- Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (Population/Public Health)
- Closing the referral loop: receipt of specialist report (Care Coordination)
- Functional status assessment for complex chronic conditions (Patient and Family Engagement)
Recommended Pediatric Measures

- Appropriate Testing for Children with Pharyngitis (Efficient Use of Healthcare Resources)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (Population/Public Health)
- Chlamydia Screening for Women (Population/Public Health)
- Use of Appropriate Medications for Asthma (Clinical Process/Effectiveness)
- Childhood Immunization Status (Population/Public Health)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI) (Efficient Use of Healthcare Resources)
- ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (Clinical Process/Effectiveness)
- Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (Population/Public Health)
- Children who have dental decay or cavities (Clinical Process/Effectiveness)
CMS selected the recommended core set of CQMs for EPs 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 health priorities
- Conditions that are common to health disparities
- Conditions that disproportionately drive healthcare costs and could improve with better quality measurement
- Measures that would enable CMS, States, and the provider community to measure quality of care in new dimensions, with a stronger focus on parsimonious measurement
- Measures that include patient and/or caregiver engagement
Clinical Quality Measures (CQMs)

• For 2014 and beyond, the requirement is to report **9 total measures from at least 3 of the quality domains**

• No more required core set of CQMs as in previous years
  - CMS has published a recommended set of measures for both adult and pediatric populations (see next slides)

• New options for reporting in 2014, including group reporting options
Clinical Quality Measures (CQMs)

National Quality Strategy (NQS) Domains

1. Patient and Family Engagement (4 measures)
2. Patient Safety (6 measures)
3. Care Coordination (1 measure)
4. Population/Public Health (9 measures)
5. Efficient Use of Healthcare Resources (4 measures)
6. Clinical Processes/Effectiveness (40 measures)
<table>
<thead>
<tr>
<th>CMS eMeasure ID</th>
<th>NQF #</th>
<th>Measure Title</th>
<th>Measure Description</th>
<th>Numerator Statement</th>
<th>Denominator Statement</th>
<th>Measure Steward</th>
<th>Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS138v1</td>
<td>0028</td>
<td>Preventive Care and Screening: Tobacco Use:</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user</td>
<td>Patients who were screened for tobacco use at least once within 24 months AND who</td>
<td>All patients aged 18 years and older</td>
<td>American Medical Association-convened Physician Consortium for Performance Improvement® (AMA-PCPI)</td>
<td>Population/Public Health</td>
</tr>
<tr>
<td>CMS138v1</td>
<td></td>
<td>Screening and Cessation Intervention</td>
<td></td>
<td>received tobacco cessation counseling intervention if identified as a tobacco user</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS125v1</td>
<td>0031</td>
<td>Breast Cancer Screening</td>
<td>Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.</td>
<td>Women with one or more mammograms during the measurement period or the year prior to</td>
<td>Women 42-69 years of age with a visit during the measurement period</td>
<td>National Committee for Quality Assurance</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS124v1</td>
<td>0032</td>
<td>Cervical Cancer Screening</td>
<td>Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.</td>
<td>Women with one or more Pap tests during the measurement period or the two years prior to the measurement period</td>
<td>Women 24–64 years of age with a visit during the measurement period</td>
<td>National Committee for Quality Assurance</td>
<td>Clinical Process/Effectiveness</td>
</tr>
<tr>
<td>CMS153v1</td>
<td>0033</td>
<td>Chlamydia Screening for Women</td>
<td>Percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.</td>
<td>Women with at least one chlamydia test during the measurement period</td>
<td>Women 16-24 years of age who are sexually active and who had a visit in the measurement period</td>
<td>National Committee for Quality Assurance</td>
<td>Population/Public Health</td>
</tr>
</tbody>
</table>
2014 eCQM Reporting Option 1:

Report through Certified EHR Technology

- For this reporting option, CQMs will be submitted on an aggregate basis reflective of all patients without regard to payer.
- Submit three months of data through the EHR Registration & Attestation System.
- Can align with the same three month-reporting period for MU objectives.
- This option will NOT enable you to align with quality data submission for PQRS.
2014 eCQM Reporting Option 2:

Utilize the Physician Quality Reporting System (PQRS) EHR Reporting Option

- Submit and satisfactorily report PQRS CQMs under the PQRS EHR Reporting option using Certified EHR Technology
- Submit a full year (January through December) of data electronically to receive credit for EHR Incentive Program and the Physician Quality Reporting System.
- Required to use the June 2013 version of the eCQMs with the exception of CMS140, which is to be reported using the December 2012 version (CMS 140v1)
2014 eCQM Reporting Option 2:

Utilize the Physician Quality Reporting System (PQRS) EHR Reporting Option (cont’d)

- If the system does not contain patient data for at least 9 measures covering at least 3 domains, then the EP or group practice must report the measures for which there is Medicare patient data.
  - An EP or group practice must report on at least 1 measure for which there is Medicare patient data

- EHR incentive payment will be held until quality data is submitted, regardless of the quarter in which MU objectives are submitted
2014 eCQM Reporting Option 2:

• Attestation for the Medicare EHR Incentive Program is not complete until you submit clinical quality measure data, so your EHR incentive payment will be held until your electronic submission is processed.

• Providers who choose to submit electronically will submit their CQM data as an electronic file between January 1 and February 28, 2015.

• Medicaid eligible professionals must submit their clinical quality measurement data to their State Medicaid Agency.
2014 eCQM Group Reporting Option

- Option A: EPs in an ACO who satisfy requirements of Medicare Shared Savings Program or Pioneer ACO model using Certified EHR Technology
- Option B: EPs who satisfy requirements of PQRS GPRO option using Certified EHR Technology
  - Group self-nominates to participate in GPRO by September 30, 2014
  - EPs included in GPRO (per individual NPI) receive credit for CQMs if group is successful in group reporting of measures
### 2014 eCQM Reporting Options Summary

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

*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.
What are Electronic Specifications?

• The e-specifications include the data elements, logic and definitions for that measure in an Health Level Seven (HL7) standard known as the Health Quality Measures Format (HQMF).

• QHMF represents a clinical quality measure as an electronic Extensible Markup Language (XML) document that can be captured or stored in the EHR so that the data can be sent or shared electronically.
Electronic Specifications for 2014 - CMS eCQM Library for 2014

Each eCQM can be described in 3 different ways depending on the intended use:

• **HTML** - This is a human readable format so that the user can understand both how the elements are defined and the underlying logic used to calculate the measure.

• **XML** – This is a computer readable format which enables the automated creation of queries against an EHR or other operational data store for quality reporting.

• **Value Sets** – Value sets are the specific codes used by developers to program the system to accurately capture patient data in the EHR system.
• A payment adjustment will be applied to the Medicare physician fee schedule amount for services furnished during the year.

• The payment adjustment is 1% per year and is cumulative for every year meaningful use is not met.
  o Eligible professionals who are subject to the eRx payment adjustment in 2014 will receive 2% in 2015.

• Payment adjustment percentages are determined by year, not by your participation timeline.
  o Example: If you successfully participate in 2014, but do not participate in 2015, you would incur a 3% payment adjustment in 2017.
Hardship Exceptions

EPs can apply for hardship exceptions in the following categories:

1. **Infrastructure**
   EPs are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).

2. **New EPs**
   Newly practicing EPs who would not have had time to become meaningful users.

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

4. **EPs meet the following criteria:**
   - Lack of face-to-face or telemedicine interaction with patients
   - Lack of follow-up need with patients

5. **EPs who practice at multiple locations must demonstrate that they:**
   Are unable to control the availability of CEHRT for more than 50% of patient encounters

6. **2014 EHR Vendor Issues:** EHR vendor was unable to obtain 2014 certification or the eligible professional was unable to implement meaningful use due to 2014 EHR certification delays.
Hardship Exceptions

• EPs whose primary specialties are anesthesiology, radiology or pathology will be granted an automatic exemption based on the fourth criteria

• Based on PECOS enrollment as of July 1 of the year preceding an adjustment year

• Medicare Specialty Codes:
  - diagnostic radiology (30)
  - nuclear medicine (36)
  - interventional radiology (94)
  - anesthesiology (05)
  - pathology (22)
Hardship Exceptions

• “Eligible Professional 2015 Hardship Exception Application” must be submitted no later than midnight EST on July 1, 2014
• If you successfully met meaningful use in 2013, you will be exempt from the 2015 payment adjustment and do not need to submit an application
• Circumstances must be beyond the control of the EP and the EP must explicitly outline how the circumstance significantly impaired EP’s ability to meet meaningful use
Hardship Exceptions

- If approved, exception is valid for **one year**
  - Future exceptions will require new applications
- Determinations made by CMS regarding hardship exceptions are final and cannot be appealed
- Determinations will be returned to the email address provided on the application
- Send application and supporting documentation to ehrhardship@provider-resources.com; or fax to 814-464-0147
- Retain a copy for your records
Audits

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

•
Audits

• Post-payment audits began in July 2012, and will take place during the course of the EHR Incentive Programs

• CMS began pre-payment audits this year, starting with attestations submitted during and after January 2013
  o Pre-payment audits are in addition to the pre-payment edit checks that have been built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment

• Providers selected for pre or post-payment audits will be required to submit supporting documentation to validate their submitted attestation data
Audits

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

- Can appeal on the basis of:
  - **Failed Audit Meaningful Use Audit**: Allows EP to demonstrate meaningful use by addressing each of the failed measures
    - **Deadline**: 30 days from the date of the adverse audit determination letter
  - **Failed Reporting Meaningful Use**: Allows EP to show that CEHRT was used to successfully demonstrate meaningful use but failed due to a reporting issue
    - **Deadline**: March 31\(^{st}\)
  - **CQM e-Reporting Meaningful Use**: Allows EP to show that CQM e-reporting was successful in meeting meaningful use
    - **Deadline**: March 31\(^{st}\)
  - **Eligibility**: Allows a provider to show that all EHR Incentive Program requirements were met and the provider should have been able to register and attest for the program but could not because of circumstances outside the provider’s control
    - **Deadline**: March 31\(^{st}\)
Appeals

• All documentation is required at the time of submission and additional documentation will not be accepted
  o Missing documentation or submissions in formats other than those acceptable (.pdf, .doc, .docx, .xls, .xlsx, WinZip) could result in delay or denial

• Completed requests should be sent to ehrappeals@provider-resources.com

• Can fax to 814-464-0147

• Retain a copy for your records
### CHAPTER 4: RESOURCES

#### Resources

<table>
<thead>
<tr>
<th>Topic</th>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified EHR Technology</td>
<td>CPHL Certified EHR List</td>
<td>Webpage maintained by ONC that provides a comprehensive listing of complete EHRs and EHR modules</td>
</tr>
<tr>
<td>Clinical Quality Measures (CQMs)</td>
<td>CQMs Homepage</td>
<td>Main CQM webpage of the EHR website, providing basic CQM information, links to other CQM pages, and resources</td>
</tr>
<tr>
<td>Clinical Quality Measures (CQMs)</td>
<td>CQMs Through 2013 Page</td>
<td>Webpage of the EHR website for information on reporting CQMs in 2013</td>
</tr>
<tr>
<td>Clinical Quality Measures (CQMs)</td>
<td>Electronic Specifications for CQMs Page</td>
<td>Webpage of the EHR website for information on electronic specifications for CQMs and information on how to submit CQMs electronically</td>
</tr>
<tr>
<td>Clinical Quality Measures (CQMs)</td>
<td>2014 CQMs Page</td>
<td>Webpage of the EHR website for information on the 2014 CQMs</td>
</tr>
<tr>
<td>Clinical Quality Measures (CQMs)</td>
<td>2014 CQMs Tipsheet</td>
<td>A PDF document that helps EPs meet CQM requirements in 2013 and 2014</td>
</tr>
<tr>
<td>Clinical Quality Measures (CQMs)</td>
<td>Guide to Clinical Quality Measures</td>
<td>A guide to help EPs understand clinical quality measures</td>
</tr>
<tr>
<td>Clinical Quality Measures (CQMs)</td>
<td>eCQM Library</td>
<td>Webpage that contains the CMS updates to the CQM specifications used in the EHR Incentive Programs; CMS updates the specifications frequently in order to ensure that specifications maintain alignment with current clinical guidelines and the CQMs remain relevant within the clinical care setting</td>
</tr>
</tbody>
</table>
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<tr>
<td>Other CMS Programs</td>
<td><strong>EHR Incentive Program, PQRS, and e-Prescribing Comparison Tip Sheet</strong></td>
<td>A PDF document that compares the three CMS incentive programs</td>
</tr>
<tr>
<td>Other CMS Programs</td>
<td><strong>Medicare Improvements for Patients and Providers Act (MIPPA) e-Prescribing Incentive Program Homepage</strong></td>
<td>CMS webpage that provides information on the MIPPA e-prescribing incentive program</td>
</tr>
<tr>
<td>Other CMS Programs</td>
<td><strong>Physician Quality Reporting System (PQRS) Homepage</strong></td>
<td>CMS webpage that provides information on the PQRS and how to participate in it</td>
</tr>
<tr>
<td>Stage 2</td>
<td><strong>Stage 2 Homepage</strong></td>
<td>Stage 2 webpage of the EHR website, providing basic Stage 2 information and resources</td>
</tr>
<tr>
<td>Stage 2</td>
<td><strong>Stage 2 Specification Sheets for EPs</strong></td>
<td>A PDF document that provides EPs with information for each Stage 2 objective</td>
</tr>
<tr>
<td>Stage 2</td>
<td><strong>Stage 2 Overview Tipsheet</strong></td>
<td>A PDF document that helps providers understand the Stage 2 final rule and its objectives</td>
</tr>
<tr>
<td>Stage 2</td>
<td><strong>Stage 1 vs. Stage 2 Comparison Table for EPs</strong></td>
<td>A PDF document that gives EPs a side-by-side look at Stage 1 versus Stage 2</td>
</tr>
<tr>
<td>Stage 2</td>
<td><strong>Payment Adjustments &amp; Hardship Exceptions Tipsheet for EPs</strong></td>
<td>A PDF document that helps EPs understand payment adjustments and hardship exceptions</td>
</tr>
</tbody>
</table>
Where to Call for Help

• QualityNet Help Desk:
  o Portal password issues
  o PQRS/eRx feedback report availability and access
  o IACS registration questions
  o IACS login issues
  o PQRS and eRx Incentive Program questions

  866-288-8912 (TTY 877-715-6222)
  7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@sdps.org
  You will be asked to provide basic information such as name, practice, address, phone, and e-mail

• Provider Contact Center:
  o Questions on status of 2012 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)

• EHR Incentive Program Information Center:
  888-734-6433 (TTY 888-734-6563)
System Dashboard

• Tool for tracking and providing feedback on 2014 electronic Clinical Quality Measures (CQMs). We encourage the EHR technology developer and user communities to provide feedback regarding the implementation, structure, intent, and data elements pertaining to CQMs.

• As the site progresses, it is intended to be a place where EHR technology developers and users can look for answers to questions, share suggestions and code, and provide real-time feedback to CMS, ONC, and federal agencies that develop and release quality standards.

http://oncprojecttracking.org/secure/Dashboard.jspa
QUESTIONS?

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Barbara.Connors@cms.hhs.gov