# Medicare & Medicaid EHR Incentive Programs

Stage 2 Final Rule
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# Stage 2 Final Rule

**Everything discussed in this presentation is part of the final rule.**

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

**CMS Rule:**
**http://www.ofr.gov/(X(1)S(uzclbwrx5fwqm2w2mipkysrh))/OFRUpload/OFRData/2012-21050_PI.pdf**

**ONC Rule:**
**http://www.ofr.gov/(X(1)S(uzclbwrx5fwqm2w2mipkysrh))/OFRUpload/OFRData/2012-20982_PI.pdf**

# What is in the Rule

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

# Stage 2 Eligibility

# EHR Incentive Program Eligibility

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

2. There have been no changes to the HITECH Act.

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

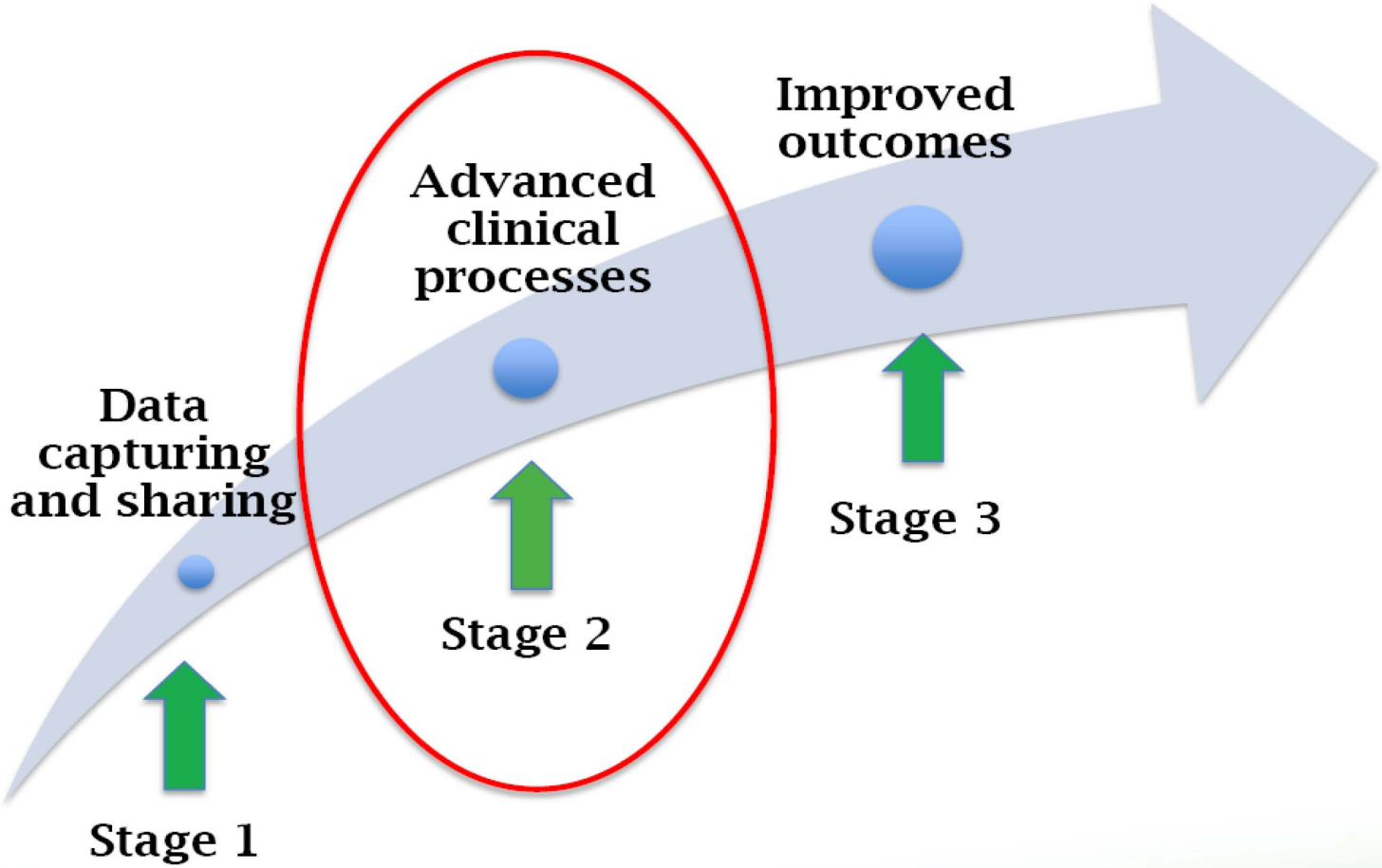
# Stage 2 Change: Hospital-Based EP Definition

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

**Determination will be made through an application process.**

# Stage 2 Meaningful Use

# Stages of Meaningful Use



# What is Your Meaningful Use Path?

## For Medicare EPs:

| First Year of Participation | Stages of Meaningful Use for Eligible Hospitals (Fiscal Year) | | | | | |
|---|---|---|---|---|---|---|
| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
| **2011** | 1 | 1 | 1 | 2 | 2 | 3 |
| $44,000 | $18,000 | $12,000 | $8,000 | $4,000 | $2,000 | |
| **2012** | | 1 | 1 | 2 | 2 | 3 |
| $44,000 | | $18,000 | $12,000 | $8,000 | $4,000 | $2,000 |
| **2013** | | | 1 | 1 | 2 | 2 |
| $39,000 | | | $15,000 | $12,000 | $8,000 | $4,000 |
| **2014** | | | | 1 | 1 | 2 |
| $24,000 | | | | $12,000 | $8,000 | $4,000 |

# What is Your Meaningful Use Path?

## For Medicare Hospitals:

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

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

# 2014 Changes

1. **EHRs Meeting ONC 2014 Standards** – starting in 2014, all EHR Incentive Programs participants will have to adopt certified EHR technology that meets ONC's Standards & Certification Criteria 2014 Final Rule

2. **Reporting Period Reduced to Three Months** – to allow providers time to adopt 2014 certified EHR technology and prepare for Stage 2, all participants will have a three-month reporting period in 2014.

# Changes to Meaningful Use

## Changes

- **Menu Objective Exclusion**– While you can continue to claim exclusions if applicable for menu objectives, starting in 2014 these exclusions will no longer count towards the number of menu objectives needed.

## No Changes

- **Half of Outpatient Encounters**– at least 50% of EP outpatient encounters must occur at locations equipped with certified EHR technology.
- **Measure compliance = objective compliance**
- **Denominators based on outpatient locations equipped with CEHRT** and include all such encounters or only those for patients whose records are in CEHRT depending on the measure.

# Stage 2: Batch Reporting

**Stage 2 rule allows for batch reporting.**

***What does that mean?***

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

# Meaningful Use: Changes from Stage 1 to Stage 2

## Stage 1

### Eligible Professionals

15 core objectives

5 of 10 menu objectives

20 total objectives

### Eligible Hospitals & CAHs

14 core objectives

5 of 10 menu objectives

19 total objectives

## Stage 2

### Eligible Professionals

**17** core objectives

**3 of 6** menu objectives

20 total objectives

### Eligible Hospitals & CAHs

**16** core objectives

**3 of 6** menu objectives

19 total objectives

# Closer Look at Stage 2: Patient Engagement

- **Patient engagement** – engagement is an important focus of Stage 2.

**Requirements for Patient Action:**

- **More than 5% of patients must send secure messages to their EP**
- **More than 5% of patients must access their health information online**

- **EXCULSIONS** – CMS is introducing exclusions based on broadband availability in the provider's county.

# Closer Look at Stage 2: Electronic Exchange

Stage 2 focuses on actual use cases of electronic information exchange:

- **Stage 2 requires that a provider send a summary of care record for more than 50% of transitions of care and referrals.**
- **The rule also requires that a provider electronically transmit a summary of care for more than 10% of transitions of care and referrals.**
- **At least one summary of care document sent electronically to recipient with different EHR vendor or to CMS test EHR.**

# Stage 2 EP Core Objectives

## EPs must meet all 17 core objectives:

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

# Stage 2 EP Core Objectives

## EPs must meet all 17 core objectives:

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

# Stage 2 EP Menu Objectives

## EPs must select 3 out of the 6:

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

# Stage 2 Hospital Core Objectives

## Eligible hospitals must meet all 16 core objectives:

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

# Stage 2 Hospital Core Objectives

## Eligible hospitals must meet all 16 core objectives:

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

# Stage 2 Hospital Menu Objectives

## Eligible Hospitals must select 3 out of the 6:

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

# Changes to Stage 1: CPOE

**Current Stage 1 Measure**

**Denominator=**

Unique patient with at least one medication in their medication list

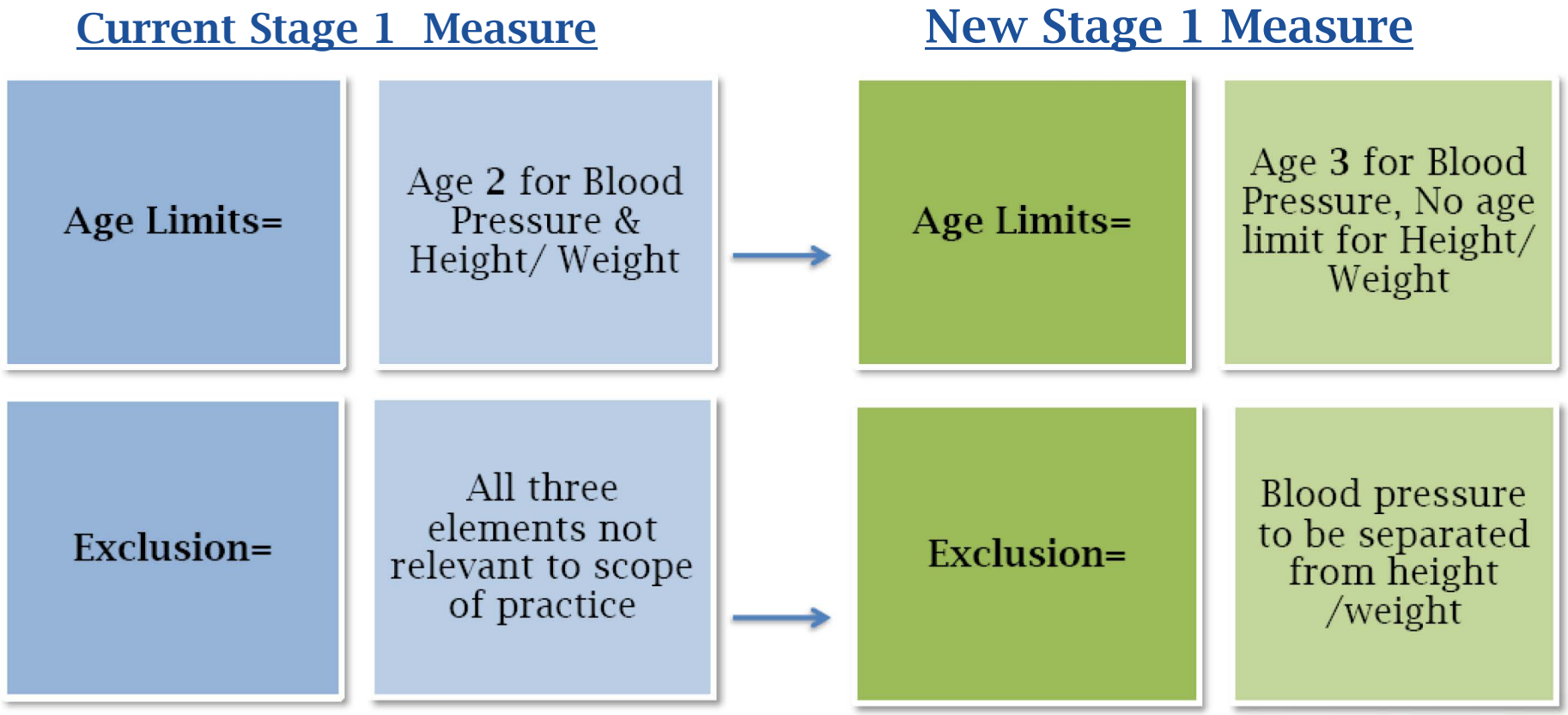
**New Stage 1 Option**

**Denominator=**

Number of orders during the EHR Reporting Period

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

# Changes to Stage 1: Vital Signs



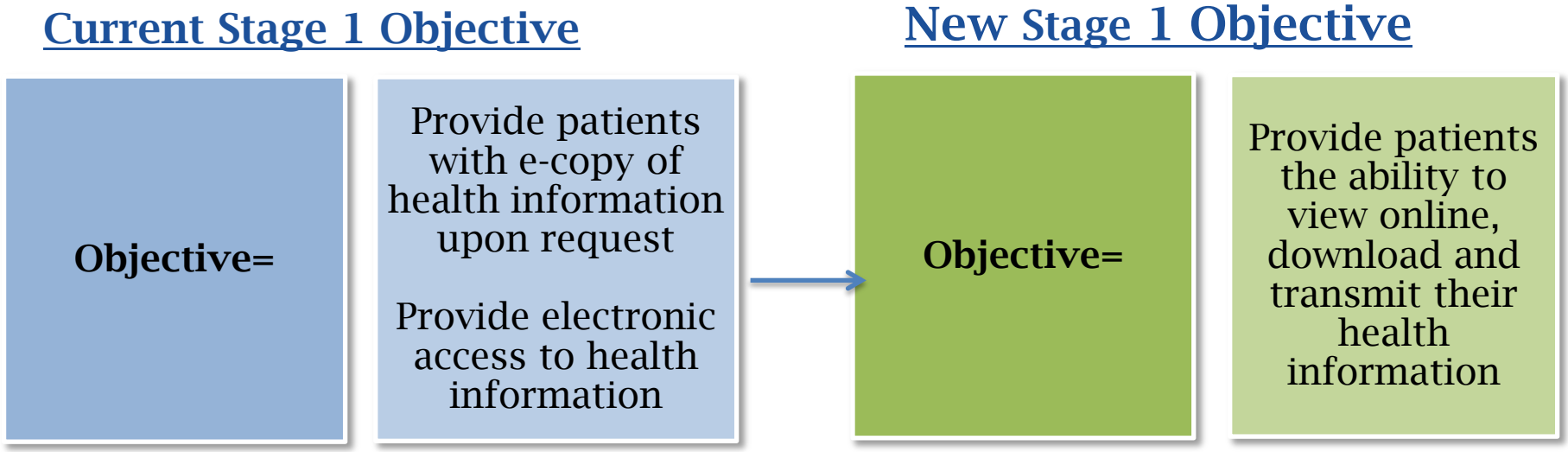

**The vital signs changes are optional in 2013, but required starting in 2014**

# Changes to Stage 1: Testing of HIE

| Current Stage 1 Measure | | Stage 1 Measure Removed |
|---|---|---|
| One test of electronic transmission of key clinical information | → | Requirement removed effective 2013 |

The removal of this measure is effective starting in 2013

# Changes to Stage 1: E-Copy & Online Access




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

# Changes to Stage 1: Public Health Objectives

**Current Stage 1 Objectives**

- Immunizations
- Reportable Labs
- Syndromic Surveillance

**New Stage 1 Addition**

Addition of "except where prohibited" to all three objectives

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

# Clinical Quality Measures

# CQM Reporting in 2013

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

# CQM Specifications in 2013

- Electronic specifications for the CQMs for reporting in 2013 **will not be updated**.
- Flexibility in implementing CEHRT certified to the 2014 Edition certification criteria in 2013
  - Providers could report via attestation CQMs finalized in both Stage 1 and Stage 2 final rules
  - For EPs, this includes 41 of the 44 CQMs finalized in the Stage 1 final rule
    - Excludes: NQF 0013, NQF 0027, NQF 0084
    - Since NQF 0013 is a core CQM in the Stage 1 final rule, an alternate core CQM must be reported instead since it will not be certified based on 2014 Edition certification criteria.
  - For Eligible Hospitals and CAHs, this includes all 15 of the CQMs finalized in the Stage 1 final rule

# How do CQMs relate to the CMS EHR Incentive Programs?

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

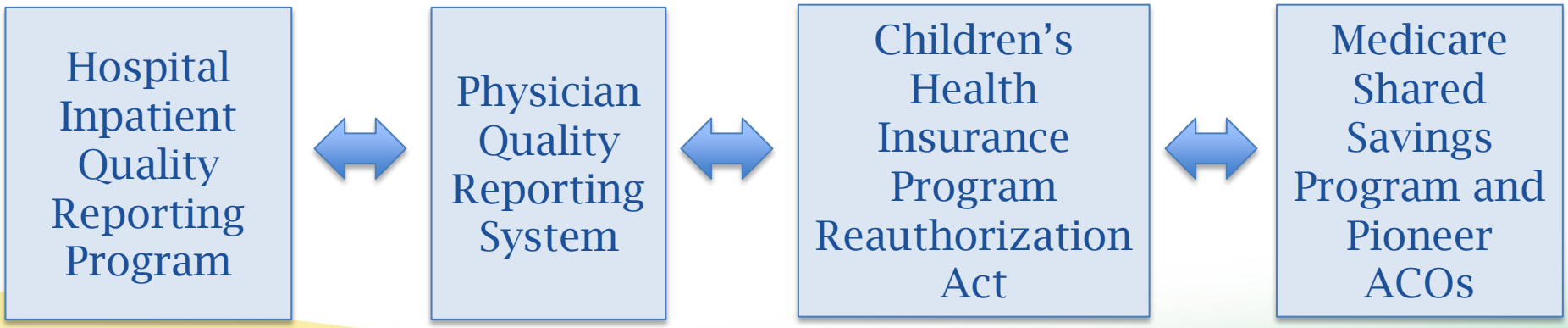
# CQM Selection and HHS Priorities

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

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

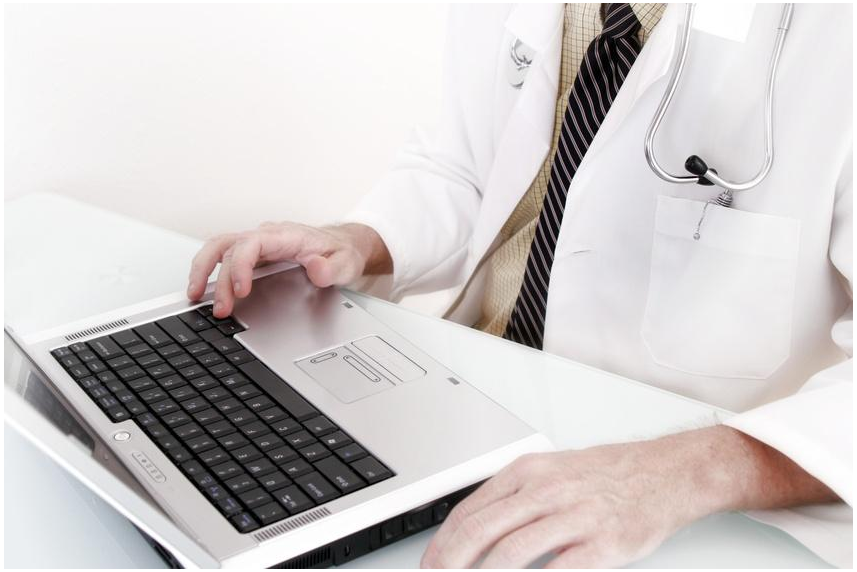
# Aligning CQMs Across Programs

- CMS's commitment to alignment includes finalizing the **same CQMs used in multiple quality reporting programs** for reporting beginning in 2014
- Other programs include Hospital IQR Program, PQRS, CHIPRA, and Medicare SSP and Pioneer ACOs



# Electronic Submission of CQMs Beginning in 2014

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



# CQMs Beginning in 2014

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


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

# Changes to CQMs Reporting

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

# EP CQM Reporting Beginning in 2014

## Eligible Professionals reporting for the Medicare EHR Incentive Program

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

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

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

# Hospital CQM Reporting Beginning in 2014

## Eligible Hospitals reporting for the Medicare EHR Incentive Program

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

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

# CQM – Timing

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

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

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

# 2014 CQM Quarterly Reporting

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

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

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

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

# Payment Adjustments & Hardship Exceptions

**Medicare Only**

EPs, Subsection (d) Hospitals and CAHs

# Payment Adjustments

- The HITECH Act stipulates that for Medicare EP, subsection (d) hospitals and CAHs **a payment adjustment applies if they are not a meaningful EHR user.**

- An EP, subsection (d) hospital or CAH becomes a meaningful EHR user **when they successfully attest to meaningful use under either the Medicare or Medicaid EHR Incentive Program**

Adopt, implement and upgrade ≠ meaningful use

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

# EP EHR Reporting Period

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

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

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

* Special 3 month EHR reporting period

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

# EP EHR Reporting Period

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

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

* Special 3 month EHR reporting period

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

# EP EHR Reporting Period

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

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

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

# Subsection (d) Hospital EHR Reporting Period

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

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

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

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

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

*Special 3 month EHR reporting period

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

# Subsection (d) Hospital EHR Reporting Period

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

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

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

# CAH EHR Reporting Period

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

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

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

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

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

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

# Hardship Exceptions

1. **Infrastructure**
   EPs must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
2. **New EPs**
   Newly practicing EPs who would not have had time to become meaningful users can apply for a 2-year limited exception to payment adjustments.
3. **Unforeseen Circumstances**
   Examples may include a natural disaster or other unforeseeable barrier.
4. **EPs must demonstrate that they meet the following criteria:**
   - Lack of face-to-face or telemedicine interaction with patients
   - Lack of follow-up need with patients
5. **EPs who practice at multiple locations must demonstrate that they:**
   - Lack of control over availability of CEHRT for more than 50% of patient encounters

CMS

EHR INCENTIVE PROGRAM

# EP Hardship Exceptions

**EPs whose primary specialties are anesthesiology, radiology or pathology:**

As of July 1st of the year preceding the payment adjustment year, EPs in these specialties will receive a hardship exception based on the 4th criteria for EPs

**EPs must demonstrate that they meet the following criteria:**

- Lack of face-to-face or telemedicine interaction with patients
- Lack of follow-up need with patients

# Medicaid-Specific Changes

# Medicaid Eligibility Expansion

**Patient Encounters:**

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

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

# Children's Hospitals

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

# Stage 2 Resources

CMS Stage 2 Webpage:

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

Links to the Federal Register

Tipsheets:

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