



## 📢 ATTENTION ELIGIBLE PROFESSIONALS ⌚

The deadline for submitting 2013 Incentive Year attestations (using 2012 Patient Encounters and 2013 MU data) is Monday, March 31<sup>st</sup>, 11:59 PM. (You are answering Question 7 on the Provider Questions screen by choosing incentive year 2013.)

The FIRST day you can do a MU attestation using 2014 MU data is April 1<sup>st</sup>. That means you have been using your EHR system in a meaningful way since at least January 1, 2014. In 2014, CMS is permitting all providers, regardless of stage of attestation, to use a 90-day MU data period rather than a full year of data.

## 2015 MediCARE Payment Reductions

The following is from a newsletter issued by CMS on February 2, 2014. We want to re-emphasize: The scheduled payment reductions for January 2015 affect MediCARE payments **ONLY**. The decision to reduce provider payments is determined by CMS. You can attest to Meaningful Use through the TennCare EHR Incentive Program and we will inform CMS of your status.

*There are no reductions in TennCare Medicaid payments for failing to meet MU requirements.*

---

### Important Payment Adjustment Information for Medicare EPs

Eligible professionals (EPs) participating in the Medicare EHR Incentive Program may be subject to payment adjustments beginning on **January 1, 2015**. CMS will determine the payment adjustment based on meaningful use data submitted prior to the 2015 calendar year. EPs must demonstrate meaningful use prior to 2015 to avoid payment adjustments.

Determine how your EHR Incentive Program participation start year will affect the 2015 payment adjustments:

**If you began in 2011 or 2012...**

If you first demonstrated meaningful use in 2011 or 2012, you must demonstrate meaningful use for a full year in 2013 to avoid the payment adjustment in 2015.

**If you began in 2013...**

If you first demonstrate meaningful use in 2013, you must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid the payment adjustment in 2015.

**If you plan to begin in 2014...**

If you first demonstrate meaningful use in 2014, you must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid the payment adjustment in 2015. This reporting period must occur in the first 9 months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, to avoid the payment adjustment.

**Avoiding Payment Adjustments in the Future**

You must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you **MUST** demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.

If you are only eligible to participate in the Medicaid EHR Incentive Program, you are not subject to these payment adjustments.

**Helpful Resources**

For more information on EP payment adjustments, view the [Payment Adjustments and Hardship Exceptions Tipsheet](#) for EPs.

---

**We highly recommend that you do not wait until the last minute to attest for 2014. CMS is allowing all providers, regardless of what stage of attestation they are in, to use a 90-day period in 2014 to demonstrate Meaningful Use. That means that the earliest you can attest to MU in 2014 is April 1<sup>st</sup>. As we need to report to CMS that you passed MU during the 4<sup>th</sup> quarter of 2014, the sooner you attest after April 1, the better it is for you.**

**See Link: [What Medicare Providers Need to Know](#)**

## ➔ Medicare Acute Care Hospitals Take Note!

Payment adjustments for not achieving Meaningful Use will be applied on Medicare billing beginning October 1, 2014 for Medicare eligible hospitals. Medicaid eligible hospitals that also treat Medicare patients will have a payment adjustment to Medicare reimbursements starting in 2015 if they do not successfully demonstrate meaningful use. Payment adjustments for Critical Access Hospitals will also be applied beginning with the cost-reporting period for fiscal year 2015, which starts October 1, 2014. Below is an illustration of the way the adjustment could potentially affect reimbursement. Adjustments are applied to the rate increase in the inpatient prospective payment system (IPPS).

| Year         | Annual Medicare Revenue | IPPS Payment Rate Increase | Expected Increase in Medicare Revenue | CMS MU Penalty (% Decrease in IPPS) | Adjusted Increase in Revenue | Penalty Amount     |
|--------------|-------------------------|----------------------------|---------------------------------------|-------------------------------------|------------------------------|--------------------|
| 2015         | \$48,000,000            | 2%                         | \$960,000                             | 25%                                 | \$720,000                    | \$240,000          |
| 2016         | \$49,200,000            | 2%                         | \$984,000                             | 50%                                 | \$492,000                    | \$492,000          |
| 2017         | \$50,430,000            | 2%                         | \$1,008,600                           | 75%                                 | \$252,150                    | \$756,450          |
| 2018         | \$51,690,750            | 2%                         | \$1,033,815                           | 75%                                 | \$258,454                    | \$775,361          |
| <b>TOTAL</b> |                         |                            |                                       |                                     |                              | <b>\$2,263,811</b> |

## 2014 EHR CERTIFICATION REQUIREMENTS

The September 4, 2012 *Final Rule* made a change in the requirements for certified EHR systems and modules approved for use in the EHR Incentive Program. (See 42 CFR § 495.4; 45 CFR § 170.102; 45 CFR § 170.314) From 45 CFR § 170.102 *Definitions*: Complete EHR, 2014 Edition means EHR technology that meets the Base EHR definition and has been developed to meet, at a minimum, all mandatory 2014 Edition EHR certification criteria for either an ambulatory setting or inpatient setting.

**Example** of a 2014 CMS Certification Number: A0**14E**01CFES9EAB

For providers, this means that when attesting for the 2014 Incentive Year (**NOT** a 2013 attestation being done in 2014) you must have an EHR system that meets the 2014 EHR Certification requirements. To meet these requirements means that you either have purchased a new 2014-certified system, or have obtained modules that bring your current EHR system up to the 2014 standards. In further conversations with CMS, they have emphasized that any attestation – AIU or MU – done for Incentive Year 2014 must be done using a 2014-Certified EHR system.

How do you know if you are attesting to Incentive Year 2014? Question 7 on the Provider Questions screen asks if you are attesting to Individual or Group Patient Volume, and then asks for what year you are attesting. At this moment, the only providers who can do a 2014 Incentive Year attestation are those who are attesting to AIU.

### **Program Year 2014 Adopt, Implement, or Upgrade Attestations**

There is no delay for providers wishing to submit a 2014 application attesting to adopting, implementing, or upgrading to certified technology as long as the EHR system has received 2014 certification. Providers are encouraged to check with their EHR vendor for 2014 certification status. When entering application information, please ensure that you are using the 2014 certification number otherwise your application will be returned.

## **Meaningful Use Clinical Quality Measures 2014**

Clinical Quality Measures, or CQMs, are tools that help measure and track the quality of healthcare services provided by eligible professionals (EPs) within our health care system. These measures use a wide variety of data that are associated with a provider's ability to deliver high-quality care or relate to long-term goals for health care quality. CQMs measure many aspects of patient care including: health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagement, population and public health, and clinical guidelines.

**Continuously measuring and reporting these measures helps to ensure that our health care system can deliver effective, safe, efficient, patient-centered, equitable, and timely care.**

Beginning in 2014, the reporting of CQMs will change for all providers participating in the EHR Incentive Program demonstrating MU. All providers, regardless of whether they are in MU Stage 1 or Stage 2, will be required to report on the 2014 CQMs finalized in the Stage 2 Rule. At this time, TennCare is not accepting electronic CQM. EHR technology that has been certified to the 2014 Edition standards and certification criteria will have the enhanced CQM related capabilities. EPs must report on 9 of the 64 approved CQMs. The 9 selected CQMs for EPs in 2014 must cover at least 3 of the National Quality Strategy domains below:

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

CMS has created and encourages EPs to report one of two panels, 9 CQMs for the adult population or 9 CQMs for the pediatric population. If EPs choose not to report the recommended panels, measures related to health disparities, national public health priorities, significant morbidity and mortality should be included in their CQM reporting. NQF 0018 (Hypertension: Blood Pressure Measurement) is also strongly encouraged since controlling blood pressure is a high priority goal for many national health initiatives, including the Million Hearts campaign (The Million Hearts campaign is a national initiative to prevent 1 million heart attacks and strokes by 2017). You can find more information about the new 2014 CQM measures on the TennCare web site at [http://www.tn.gov/tenncare/mu\\_cgm.shtml](http://www.tn.gov/tenncare/mu_cgm.shtml).

## **A Primer on Patient Volume**

We receive many questions on meeting the patient volume threshold requirement, especially after we return an attestation for insufficient patient volume. We thought it would be a good idea to do a quick review of this requirement, especially how we determine that a provider falls short of the percentage required to pass. Data collection periods for patient encounters and Meaningful Use (MU) data are two distinct and different timeframes. What we are discussing here is the data that is reported on the Patient Volume screen ONLY.

- ❖ Patient Volume (PV) data always, always comes from the previous calendar year (for Eligible Hospitals (EHs), it's the previous fiscal year). If you are doing a 2013 Incentive Year attestation, you use PV data from a 90-day period in 2012. For Incentive Year 2014, PV data comes from 2013.
- ❖ All Eligible Professionals (EPs) must have at least 30% or greater Medicaid to Total Encounters ratio to qualify for an EHR Incentive Payment, **except** pediatricians. Pediatricians can qualify for a reduced EHR Incentive Payment if they have at least 20% Medicaid encounters but less than 30%. A pediatrician can receive the full EHR Incentive Payment if he has 30% or more Medicaid encounters. EHs must have at least 10% Medicaid encounters to qualify.

- ❖ Individual PV vs. Using Group PV as a Proxy: If you are a member of a group practice or clinic, CMS allows you a choice. Either you can attest using your own patient encounter data, **OR** you may combine the encounter data of ALL members of the group and use that number as a proxy for individual data. What's the difference?

Let's say you have a group of five EPs. Three of those EPs have Medicaid percentages of 32%, 38%, & 50%. The other two EPs have Medicaid percentages of 5% and 15%. Obviously if each EP attested based on his individual PV encounter data, three will qualify and two will not. Now, if you combine the Medicaid encounters and the Total encounters for all five EPs, and that percentage is equal to or greater than 30%, then all five will receive an EHR Incentive Payment.

- ❖ Effective in 2013, CMS allowed the inclusion of denied claims in addition to paid claims. However, the claim must have been denied for some reason other than the patient not being enrolled in a state Medicaid program on the date the billable service was performed, or the provider was not enrolled in a state Medicaid program on the date the billable service was performed.
- ❖ Out-of-State Medicaid encounters and Medicare-Medicaid crossovers are includable in your totals.
- ❖ So the \$21,250/\$8,500 Question – How do we verify patient encounters when providers submit attestations? (EHs – of course your payments are a little bit higher!) We take the Medicaid encounter data that each provider submits and compare that number to what the TennCare MCCs (MCOs and DBM) report to TennCare (when using group data, we look at the group). If those numbers are not within acceptable ranges, that is when your attestation is returned to you for not meeting the PV threshold requirement. However, before we return an attestation we have the numbers re-run outside the PIPP portal to determine if the problem is on our end.

So, what do you do? First, go back and double-check your calculations. Don't forget denied claims and Medicare-Medicaid crossovers. Second, check with your contracted MCOs or the DBM and verify that they are reporting your claims to TennCare accurately. If you are still failing to meet the PV threshold, you can email us at the address below and we'll see if we can help further.

- ❖ **Notes to OB/GYNs & Pediatricians** OB/GYNs – encounters involving pregnancies are billed under a global procedure code are counted differently. See our FAQs for more information. Pediatricians – If you have more than 20% Medicaid encounters and believe you'll reach 30% or more, don't stop counting and think that we'll find them. We base our evaluation of your attestation on what **YOU** report on your attestation.

Please see our FAQs [Section IV](#) for more information about Patient Volume.

## CMS Registration Status - In Progress

Some of you have received emails from TennCare with the above as the subject. A few more of you have received this email multiple times.

CMS does not inform us as to why they have put providers in this status. They have told us it means that you have gone back to the CMS Registration & Attestation web site to do one of two things. You have either gone back to view the information you previously entered without making any changes, or you have gone back to make a change. Either way, unless you follow the instructions below (which are included in the email we send), we cannot process your attestation until this is cleared up.

- Go to the CMS Registration & Attestation System web site
- Enter the CMS Registration Number you were originally given
- Click on "Modify"
- On **EACH** page, click "Save & Continue"
- On the appropriate page(s), make the needed change(s), click "Save & Continue"
- On the last page, click "Submit"

CMS sends us updates daily, so that once you have corrected the problem, we can proceed with the processing of your attestation.



## Contact Information

As always, anytime you have a question or need assistance, please feel free to contact us. We will get back to you as quickly as possible.

**Please be sure to include the provider's name and NPI when contacting us.**

- ◆ For questions relating to **Meaningful Use (MU)**, send an email to [EHRMeaningfuluse.TennCare@tn.gov](mailto:EHRMeaningfuluse.TennCare@tn.gov)
- ◆ For **all other questions**, send an email to [TennCare.EHRIncentive@tn.gov](mailto:TennCare.EHRIncentive@tn.gov)
- ◆ The **CMS Help Desk** can be reached at 1-888-734-6433.
- ◆ **TennCare Medicaid EHR Incentive Program web site:** [http://www.tn.gov/tenncare/ehr\\_intro.shtml](http://www.tn.gov/tenncare/ehr_intro.shtml)
- ◆ **PowerPoint Presentations** on different subject areas are available here:  
[http://www.tn.gov/tenncare/ehr\\_page6.shtml](http://www.tn.gov/tenncare/ehr_page6.shtml)

**TennCare E-Newsletters:**

If you choose to unsubscribe from this list at any time, you may do so by sending a message to:

[listserv@listserv.tn.gov](mailto:listserv@listserv.tn.gov),

(no subject) and **unsubscribe MedicaidHIT**

You will receive an email confirming your removal.

**To view previous** TennCare E-Newsletters, go to [http://www.tn.gov/tenncare/ehr\\_newsletters.shtml](http://www.tn.gov/tenncare/ehr_newsletters.shtml)