



ATTENTION EPs

As you know, CMS is scheduled to begin Medicare payment reductions on January 1, 2015.

- ❖ The payment reductions only apply to providers who treat Medicare patients.
- ❖ There are **NO** payment reductions to TennCare Medicaid payments, as it relates to the EHR Incentive Program. (**Note:** There are some TennCare Medicaid payment reductions which are due to budgetary considerations, **not** whether MU is met.)
- ❖ To avoid the Medicare payment reductions, you must be an approved Meaningful User of ONC-certified EHR technology.
- ❖ **From CMS:** Eligible professionals who first demonstrated meaningful use in 2011 or 2012 must demonstrate meaningful use for a full year in 2013 to avoid payment adjustments in 2015. They must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years. (Note: If you applied for and were granted an exemption by CMS, you will not be subject to the Medicare payment reductions.)

First-time meaningful users must successfully complete their attestation to meet all meaningful use requirements for payment year 2014 before October 1, 2014 in order to avoid MEDICARE payment adjustments for 2015.

The Bureau of TennCare is required to report to CMS those providers who meet the MU requirements on October 1, 2014, and quarterly thereafter. If you attested for **AIU** in 2013, you must attest to **MU** this year. In order to be sure there is enough time to correct any mistakes and for TennCare to report your status to CMS timely, we strongly recommend you attest **IMMEDIATELY** and certainly before September 15th. Likewise, if you are attesting for the first time in 2014 and you treat Medicare patients, you need to attest to MU **ASAP**.

▶▶ Remember in 2014, CMS is allowing ALL providers regardless of level of attestation, to use a consecutive 90-day period in 2014 for purposes of reporting MU data. (Your Medicaid patient encounter volume must come from a consecutive 90-day period in 2013.)

If you have questions about Meaningful Use, send an email to EHRMeaningfuluse.TennCare@tn.gov. That office will be happy to assist you with any questions you may have.

Please understand the Bureau of TennCare has no authority to extend deadlines or to make exceptions. The Medicare payment reductions are the sole responsibility of CMS.

Eligible Hospitals

The last 90-day MU period to be submitted to Medicare for 2014 Payment Year Hospital attestations ends September 30, 2014. EHs must use 90 days from the previous Fiscal Year to meet the 10% Medicaid percentage as required (acute care & CAHs only). EHs have until December 31, 2014 to submit the attestations in PIPP.

📄 PATIENT ELECTRONIC ACCESS IN 2014 📄

Starting in 2014, CMS requires that eligible providers and hospitals participating in both Stage 1 and Stage 2 of the EHR Incentive Programs must meet the Patient Electronic Access objective, which gives patients online access to their health information in a timely manner. To meet the new measure, providers must not only provide electronic access, but in addition, patients must have the ability to download and transmit their health information. Providers participating in Stage 1 are required to meet one patient electronic access measure, and providers participating in Stage 2 need to meet two measures.

Measure #1 for Stage 1 and Stage 2:

- Eligible Professionals: More than 50 percent of all unique patients seen during the reporting period are provided online access to their health information within 4 business days after the information is available to the eligible professional.
- Eligible Hospitals: More than 50 percent of all unique patients discharged from the inpatient or emergency departments during the reporting period have their information available online within 36 hours of discharge.

Measure #2 for Stage 2:

- Eligible Professionals: More than 5 percent of all unique patients (or their authorized representatives) seen during the reporting period view online, download, or transmit to a third party their health information.

- **Eligible Hospitals:** More than 5 percent of all unique patients (or their authorized representatives) who are discharged from the inpatient or emergency department view, download or transmit to a third party their information during the EHR reporting period.

QUESTIONS AND ANSWERS

Q: How does CMS define “access”?

A: Access is when the patient possesses all of the necessary information needed to view, download, or transmit their health information.

Q: What does “necessary information” include?

A: Necessary information could include website address, username and password, and, if needed, instructions on how to create a username and log on to the website.

Q: What health information must eligible professionals and eligible hospitals make available to patients?

A: All information available at the time the information is sent to the patient website must be made available to the patient online. However, the provider may withhold any information from online disclosure if he or she believes that providing such information may result in significant harm.

Q: If multiple eligible professionals or eligible hospitals contribute information to a shared portal or to a patient's online personal health record (PHR), how is it counted for meaningful use when the patient accesses the information on the portal or PHR?

A: If multiple eligible professionals or eligible hospitals contribute information to an online portal or PHR during the same EHR reporting period, all of the providers can count the patient to meet the measure if the patient accesses any of the information in the portal or PHR. In other words, a patient does not need to access the specific information an eligible professional or eligible hospital contributed, in order for each of the eligible professionals and hospitals to count the patient to meet his or her threshold.

Q: Can an eligible professional or eligible hospital charge patients a fee to have access to their health information?

A: CMS does not believe it would be appropriate for the eligible professional or hospital to charge the patient a fee to access certified EHR technology.

See the CMS Patient Electronic Access Tipsheet at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PatientElecAccTipsheet_06182014-.pdf for more detailed information.

≧ CHANGES IN THE MEANINGFUL USE ≦ ≧ VITAL SIGNS CORE OBJECTIVE IN 2014 ≦

Did you know that the vital signs objective is different in 2014? This year there was an increase in the patient age limit for recording blood pressure to age 3 and a removal of age limit requirement for height and weight for the Stage 1 objective. These changes mirror the requirements for the objective in Stage 2.

To meet the Stage 1 requirement, you will need to record more than 50% of all unique patients' blood pressures (for patients age 3 and over only) and height and weight (for all ages) as structured data using one numerator and denominator. When appropriate vital signs are taken and documented, the certified EHR will calculate BMI and the growth chart based upon age.

You are also not required to update height and weight and blood pressure for every visit by the patient. You can make the decision based on the patient's individual circumstances.

In both Stage 1 and Stage 2, you can be excluded from reporting this objective if you meet the specific exclusion criteria. What are the exclusion requirements and when are the exclusions applicable to you?

Exclusions available for this measure are:

1. If you do not see any patients 3 years of age or older, you are excluded from recording blood pressure.
2. If you believe that all three vital signs of height, weight and blood pressure have no relevance to your scope of practice, you are excluded from recording them.
3. If you believe that height and weight are relevant to your scope of practice, but blood pressure is not, you are excluded from recording blood pressure.
4. If you believe that blood pressure is relevant to your scope of practice, but height and weight are not, you are excluded from recording height and weight.

If you meet the criteria for either exclusion 3 or 4, you must attest to the exclusion and report the appropriate numerator and denominator for the remaining elements of the measure.

DIRECT MESSAGING AND EHR

The Tennessee Office of eHealth Initiatives has led other states in developing a directory for individuals in healthcare organizations who have a DIRECT secure messaging address. DIRECT is a technology developed by the Office of the National Coordinator for HIT in order to provide a means of securely exchanging health information between healthcare providers. The use of DIRECT is expected to grow in coming months since the technology to send and receive DIRECT messages is required to be included in EHR systems certified for the EHR incentive programs. DIRECT will allow the efficient and secure exchange of clinical summaries and other health information documents when patients are discharged from the hospital or when patients are referred to specialists.

Tennessee's directory of DIRECT addresses will become a valuable tool for providers to discover the DIRECT address of providers they exchange information with. If you already have a DIRECT address, take the opportunity to enter your address in Tennessee's DIRECT directory, so that other providers can find you when they need to exchange information about a mutual patient. Soon, you will be able to find other providers' DIRECT addresses when you need to send information about patients and they will be able to find your DIRECT address.

If you don't yet have a DIRECT address, here is the link to learn more about how DIRECT messaging will allow secure and efficient exchange of health information and improve the care of patients in Tennessee: <http://www.healthsharetn.com/directory.php>



All TennCare Medicaid EHR-Related communications are done through email. Whether it's the communication about establishing and activating your User Account to attestation returns due to problems found, everything is sent to the email address you entered when you enrolled in the EHR Incentive program at the CMS Registration & Attestation System web site.

If for any reason your email address changes, you **MUST** go back to the CMS Registration web site and change your email address there and CMS will forward it to us. We cannot make the change in our records or for you. To make the change, you must follow these instructions:

- 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”

This will save your information and cause CMS to re-send your information back to us for processing within 24 – 48 hours.

Even if you only go to the CMS web site to see what you have previously entered, you must complete the above steps. Anytime a provider accesses his EHR Incentive registration, CMS places the registration in a status called “In Progress.” We cannot process your attestation if it is in this status. Only by following the above instructions, even if you do not need to make a change, can you keep your registration ‘active.’



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
- ◆ For **all other questions**, send an email to 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
- ◆ **PowerPoint Presentations** on different subject areas are available here: http://www.tn.gov/tenncare/ehr_page6.shtml

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