WHAT’S NEW ON THE EHR FRONT?

TODAY’S AGENDA

• 2015 EHR Proposed Rule / Proposed Stage III regulations
• Latest EHR Statistics
• EHR Tentative Settlement Letters
• HITECH Payment Audits
• Texas Medicaid EHR Audits / Questionnaire
• Pre Post Payment EHR Audit Medicaid reviews
• Meaningful Use Audits / New SRA guidance / “Flexibility” Rule
• Best practices to attain / maintain MU measures
• Roadmaps
2015 EHR PROPOSED RULE

• This proposed rule was published for public comment on March 20th and is based on:
  • Elevating patient-centered care
  • Improving health outcomes
  • Supporting the providers who care for patients

This rule is completely separate from the proposed rule for Stage III Meaningful Use that was also published for public comment on the same day.

2015 EHR PROPOSED RULE

• Expected changes in the Proposed Rule:
  • **Shortening the 2015 reporting period to 90 days** to address provider concerns about their ability to fully deploy 2014 Edition software
  
  • **Realigning hospital reporting periods to the calendar year** to allow eligible hospitals more time to incorporate 2014 Edition software into their workflows and to better align with other quality programs
  
  • **Modifying other aspects of the programs** to match long-term goals, reduce complexity, and lessen providers’ reporting burden
PROPOSED STAGE III REGULATIONS

- Snippets from the Stage III public notice:
  - “Stage 3 will focus on improving health care outcomes and further advance interoperability.”
  - CMS plans to “propose changes to the reporting period, timelines, and structure of the [EHR Incentive Program], including providing a single definition of meaningful use”
  - CMS intends to “provide a flexible, yet, clearer framework to ensure future sustainability of the EHR program and reduce confusion stemming from multiple stage requirements.”

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### TABLE 3--PROPOSED STAGE OF MEANINGFUL USE CRITERIA BY FIRST PAYMENT YEAR

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<tr>
<td>2011</td>
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<td>1 or 2*</td>
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<td>2017</td>
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</tbody>
</table>

*3-month quarter EHR reporting period for Medicare and continuous 90-day EHR reporting period (or 3 months at State option) for Medicaid EPs. All providers in their first year in 2014 use any continuous 90-day EHR reporting period.

### TABLE 3: STAGE OF MEANINGFUL USE CRITERIA BY FIRST YEAR

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<td>2 or 3</td>
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<td>1</td>
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<td>2</td>
<td>2 or 3</td>
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<td>3</td>
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<tr>
<td>2018 and future years</td>
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</table>

*Please note, a provider scheduled to participate in Stage 2 in 2014, who instead elected to demonstrate stage 1 because of delays in availability of EHR technology certified to the 2014 Edition, is still considered a stage 2 provider in 2014 despite the alternate demonstration of meaningful use. In 2015, all such providers are considered to be participating in their second year of Stage 2 of meaningful use.
WHAT DOES THE LATEST INFORMATION TELL US?

• Through September 2014 - 149 CAHs had received no EHR payments of any kind – these hospitals may not be aware of the relaxing of the qualifications for the Medicaid EHR programs.

• Through September 2014 - 348 CAHs had received Medicare EHR payments but no Medicaid EHR payments– these hospitals may not be aware of the relaxing of the qualifications for the Medicaid EHR programs.

• Any hospital not already in the Medicaid EHR program should re-evaluate its potential qualification before the end of Program Year 2016

WHAT DOES THE LATEST INFORMATION TELL US?

• Through January 1, 2015:
  • 1,814 Eligible Hospitals (EHs) had successfully attested to Stage II for Program Year 2014 (out of approximately 5,000 EHs nationwide)
  • 16,359 Eligible Professionals (EPs) had successfully attested to Stage II for Program Year 2014 (out of approximately 500,000 EPs nationwide)
  • Approximately 257,000 EPs are under penalty as of January 1, 2015 for failing to meet Meaningful Use
WHAT DOES THE LATEST INFORMATION TELL US?

- The Medicare EP attestation deadline for Program Year 2014 was extended to March 20, 2015.

- The Medicare EP attestation deadline pushback does not affect an individual State’s Medicaid EP deadline which could be before or after March 20, 2015.

- The EHR reporting option for PQRS was also extended until March 20, 2015.

% ADJUSTMENT ASSUMING LESS THAN 75 PERCENT OF ELIGIBLE PROFESSIONALS ARE MEANINGFUL USERS

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<td>Eligible professional is not</td>
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<td>98%</td>
<td>97%</td>
<td>96%</td>
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<td>subject to the payment</td>
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<td>adjustment for the e-Rx in 2014</td>
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<td>Eligible professional is</td>
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<td>adjustment for the e-Rx in 2014</td>
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</table>
PQRS & VALUE BASED MODIFIER PENALTIES

- PQRS Penalty:
  - Didn’t meet PQRS in 2013 – 1.5% Medicare Fee Schedule penalty in 2015
  - Didn’t meet PQRS in 2014 – 2.0% Medicare Fee Schedule penalty in 2016
  - Didn’t meet PQRS in 2015 – 2.0% Medicare Fee Schedule penalty in 2017

<table>
<thead>
<tr>
<th>% ADJUSTMENT ASSUMING MORE THAN 75 PERCENT OF ELIGIBLE PROFESSIONALS ARE MEANINGFUL USERS</th>
</tr>
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<tbody>
<tr>
<td>Eligible Professional is not subject to the payment adjustment for the e-Rx in 2014</td>
</tr>
<tr>
<td>Eligible Professional is subject to the payment adjustment for the e-Rx in 2014</td>
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</table>
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):

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on Full Year EHR Reporting Period</td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2019</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on 90 day EHR Reporting Period</td>
<td>2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on Full Year EHR Reporting Period</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2019</td>
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To Avoid Payment Adjustments:
Eligible hospitals must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.
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):

<table>
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<tr>
<th>Payment Adjustment Year</th>
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<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on Full Year EHR Reporting Period</td>
<td>2015</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
<td>2020</td>
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For a CAH who demonstrates meaningful use in 2015 for the first time:

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
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<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on 90 day EHR Reporting Period</td>
<td>2015</td>
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<td></td>
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<tr>
<td>Based on Full Year EHR Reporting Period</td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
<td>2020</td>
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</table>

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

EHR TENTATIVE SETTLEMENTS

- Letters appear not credible
- Usually letters do not contain dates, program year, or reasons for the payback; only that it is related to an EHR Payback.
- Be sure to ask for and review supporting workpapers
First and Final Request for Repayment
March 25, 2014

RE: HITECH Incentive Payment
Provider Name:
Provider NPI:
Outstanding Balance: $185,802.52
HITECH Transaction Number:

Dear Sir/Madam,

The purpose of this letter is to inform you that your final cost report filing created a HITECH incentive overpayment in the amount of $185,802.52 for which you must repay. The registrant is responsible for any changes in your HITECH incentive payment as a result of filing a final cost report. Adjustment or changes in the cost report created the overpayment that is owed.

Please return in full the overpaid amount to us by 04/24/2014 and no interest charge will be assessed. Make the check payable to EHR HITECH Incentive Payment and send it with a copy of this letter to:

EHR HITECH Incentive Payment Center
P.O. Box 809338
Chicago, IL 60680-9338

If you do not return full within 30 days: In accordance with 42 CFR 405.378 simple interest at the rate of 10.25% will be charged on the unpaid balance of the overpayment beginning on the 31st day. If your debt reaches 61 days delinquent your debt will be referred to the Department of Treasury’s Debt Collection Center (DCC) for Cross Servicing and Offset of Federal Payments. Your debt will be referred under provisions of federal law, title 31 of the United States Code, Section 3720A and the authority of the Debt Collection Improvement Act of 1996.
The Debt Collection Center will use various tools to collect the debt, including offset, demand letters, phone calls, referral to a private collection agency and referral to the Department of Justice for litigation. Other collection tools available, which may be used, include Federal salary offset and administrative wage garnishment. If the debt is discharged, it may be reported to the IRS as potential taxable income. During the collection process, interest will continue to accrue on the debt and you will remain legally responsible for any amount not satisfied through the collection efforts.

For Individual Debtors Filing a Joint Federal Income Tax Return
The Treasury Offset Program automatically refers debts to the IRS for offset. Your Federal income tax refund is subject to offset under this program. If you file a joint income tax return, you should contact the IRS before filing your tax return to determine the steps to be taken to protect the share of the refund which may be payable to the non-debtor spouse.

Federal Salary Offset
If the facility ownership is either a sole proprietorship or partnership, your individual salary(s) may be offset if you are or become a federal employee.

Due Process
You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing to the address listed below. You have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise this right, this office must receive a copy of the evidence to support your position, along with a copy of this letter. You must submit any evidence that the debt is not owed or legally enforceable within 60 days of the date of this letter. If, after sixty days from the date of this letter, we have not received such evidence, your debt, if it is still outstanding and eligible for referral, will be referred to the Department of Treasury or its designated Debt Collection Center for cross servicing/offset.

Please contact the EHR HITECH Incentive Payment Center immediately at 1-855-223-1343 if:

- You are unable to make full payment at this time and are requesting approval for an extended repayment plan. To determine eligibility for a repayment plan. (Refer to Financial Management Manual 100-06, Chapter 4, Section 50.2; Subsection 401.607(c) of Title 42 CFR for details.)
- You disagree with this overpayment decision and wish to file an appeal (Refer to Medicare Claims Processing Manual 100-04; Chapter 29; Sections 220, 230 and 240; Section 1870 (b)(c) of the Social Security Act; Subsections 405.350-405.359 of Title 42 CFR, Subsections 404.506-404.509, 404.510a and 404.512 of Title 20 of the United States Code of Federal Regulations and 20 CFR for details)
- You have filed a bankruptcy petition or are involved in a bankruptcy proceeding. Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Sincerely,

EHR HITECH Incentive Payment Center
HITECH PAYMENT AUDITS (MAC)

- For every Medicare EHR incentive payment, every facility that receives an EHR incentive payment will have one of three audits on their cost report:
  - Desk review
  - In-House Audit
  - On-Site Audit

HITECH PAYMENT AUDITS (MAC)

- Positive Adjustment Opportunities
  - Part C Days
  - Total Days
  - Charity Care
    - Presumptive Charity Care
    - Policy Review
From: [email redacted]  [mailto:support@myhospital.org]
Sent: Wednesday, January 21, 2015 10:32 AM
To: [email redacted]
Cc: [email redacted]
Subject: Texas Medicaid EHR Incentive Program

YYYYY Texas Hospital
NPI 9999999999

As a part of the Pre-Payment Review of the enrollment for Hospital NPI 9999999999 in the Texas Medicaid Electronic Health Record (EHR) Incentive Program, please review and complete the following questionnaire based on the Medicare Cost Report data supplied for calculation of your EHR incentive payments. The questionnaire applies to all discharges, inpatient days, total charges and charity care data from Cost Reports and/or internal documents supplied for calculation of the hospital’s EHR incentive payments. We have attached a copy of the hospital calculation worksheet to help identify the Cost Report data elements described below.

Growth Rate Calculation
Initial Year Discharges - [2011]
Three previous years - [2010, 2009, 2008]
1. Hospitals must remove all Non-Acute discharges from the Medicare Cost Report line item for reporting discharges. Do the Medicare Cost Report discharge amounts that were entered during attestation include any discharges in the following areas?
   a. Nursery Days
   b. Psychiatric Days
   c. Rehab Days
   d. Skilled Nursing Facility (SNF) Days

2. Did the hospital’s Medicare Cost Report include all allowable discharges in the payment calculation? The following discharges should be included in the growth rate calculation, even if they were not included in the specific Cost Report discharge line items.
   a. Labor & Delivery discharges
   b. Neonatal Intensive Care Unit (NICU) discharges
   c. Intensive Care Unit (ICU) discharges

Bed Days Calculation
Medicaid Fee-For-Service (FFS) Inpatient-bed-days - [2011]
Medicaid Managed Care (MCO) Inpatient-bed-days - [2011]
Total Inpatient-bed-days - [2011]

1. Hospitals must remove unpaid bed days from Medicaid FFS, MCO, and Total Inpatient Bed days. Did the hospital remove dually-eligible inpatient bed days from the calculation?

2. Dually-Eligible days should be deducted from Medicaid FFS inpatient bed days and Medicaid MCO inpatient bed days. For dually-eligible hospitals, hospitals may not include acute inpatient bed days in the numerator for patients where Medicare Part A or Medicare Advantage under Part C was the primary payer [i.e. Medicare with Medicaid as secondary payer]. Did the hospital remove dually-eligible inpatient bed days from the calculation?

3. Did the hospital’s Medicare Cost Report include all allowable inpatient bed days in the payment calculation? The following inpatient bed days should be included in Medicaid FFS, MCO, and Total Inpatient Bed days:
   a. Labor & Delivery
   b. NICU
   c. ICU

Total Charges
Charity Care - [2010]

1. CMS does not allow the inclusion of bad debt in the calculation of Charity Care. Did the hospital remove bad debt from the Charity Care calculation?
PRE POST PAYMENT EHR AUDIT MEDICAID REVIEWS

- OIG has these EHR post-payment audits as a high priority through 2018
- Positive Adjustment Opportunities
  - Potential missing Medicaid days
  - Incorrect reporting period used for payment calculation
  - Total Days (including hospice days, employee days, Part B days, etc.)
- Be alerted to potential overpayments for things like unpaid days and bad debts being included with Charity care

EHR MEANINGFUL USE AUDITS (FIGLIOZZI)

- Worked on program years 2011, 2012 and 2013
- 2014 and/or Stage II audits have yet to begin
- The audit protocol for Stage II audits has yet to be released
- Still auditing a minimum of 5% of the nations Meaningful Users
- **ALL or NOTHING** penalty
  - Including Medicare & Medicaid incentive payments
“FLEXIBILITY” FINAL RULE

- Allowed facilities to attest to a lower level of criteria than the facility was scheduled to attest for Program Year 2014

- No upfront checking of qualifications for appropriate use of the rule

- Check the radial button, put in an ONC certification number consistent with the lower level of criteria, and click a button saying you will maintain documentation supporting the facility’s use of the Flexibility Rule for at least 6 years – that’s all that’s required...

- Documentation, Documentation, Documentation is the key

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**Table 2: Proposed CEHRT Systems Available for Use in 2014**

<table>
<thead>
<tr>
<th>If you were scheduled to demonstrate:</th>
<th>You would be able to attest for Meaningful Use:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Using 2011 Edition CEHRT to do:</td>
</tr>
<tr>
<td></td>
<td>Using 2011 &amp; 2014 Edition CEHRT to do:</td>
</tr>
<tr>
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<td>Using 2014 Edition CEHRT to do:</td>
</tr>
<tr>
<td>Stage 1 in 2014</td>
<td>2013 Stage 1 objectives and measures*</td>
</tr>
<tr>
<td></td>
<td>2013 Stage 1 objectives and measures* -OR-</td>
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<td></td>
<td>2014 Stage 1 objectives and measures*</td>
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<td>2014 Stage 1 objectives and measures</td>
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<tr>
<td>Stage 2 in 2014</td>
<td>2013 Stage 1 objectives and measures*</td>
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<td>2013 Stage 1 objectives and measures* -OR-</td>
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<tr>
<td></td>
<td>2014 Stage 1 objectives and measures* -OR-</td>
</tr>
<tr>
<td></td>
<td>Stage 2 objectives and measures*</td>
</tr>
</tbody>
</table>

*Only providers that could not fully implement 2014 Edition CEHRT for the reporting period in 2014 due to delays in 2014 Edition CEHRT availability.*
EHR MEANINGFUL USE AUDITS (FIGLIOZZI)

- Working with Figliozzi is easier than with CMS if facility fails.

- Can appeal Figliozzi failure with CMS
  - One Bite at the Apple
  - Submit only NEW evidence

NEW GUIDANCE ON SECURITY RISK ANALYSES

- Please note that a security risk analysis or review needs to be conducted during each EHR reporting year for Stage 1 and Stage 2 of meaningful use to ensure the privacy and security of their patients’ protected health information. (CMS FAQ 10754 – last updated 11.05.2014)

- Texas interpretation: The security risk analysis requirements must be met for each program’s year. It is not acceptable to use the same security risk analysis (a new security risk analysis or a review) for more than one program year.

- Figliozzi has not previously enforced a new SRA requirement each year in previous audits but Stage II audit protocol is not yet available.
BEST PRACTICES FOR MEANINGFUL USE MEASURES

- The two biggest issues we typically see in achieving Stage II Meaning Use are the 50% View, Download, Transmit (VDT) requirement and the 5% actual use of the patient portal. Some best practices include:
  - Be creative – discharge planners setting up and going into patient portal prior to discharge
  - Giveaways for setting up and utilizing patient portal (Boxes of diapers, gift cards, etc.)

EHR “ROADMAP”

- So much bad information
- Documenting future events
- Customized specific for your facility
- Protects against losing “Black Box” knowledge
EHR “ROADMAP”

What could be included on a ROADMAP?

- Timelines
- Penalties
- Payments
- Stages of MU
- Reporting Periods
- Attestations
- Guidance
- Confidence
- Outlook
- Deadlines

KEY “TAKE AWAYS” FROM THIS PRESENTATION

- Best practices including meeting Patient Portal Requirement and others
- Use of the “Flexibility” Final Rule needs to be DOCUMENTED
- MU Audit penalty is very REAL and the key is your documentation
- Every participant that receives an interim payment will experience a HITECH audit
THANK YOU

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