



This is one of our largest issues EVER. There is a lot of good information (of course, we always say this), which we believe will assist you in the TennCare Medicaid EHR Incentive Program.

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📄 1099s 📄

The State of Tennessee has issued individual 1099s to providers receiving EHR Incentive Payments during 2013. Although Eligible Professionals do have the option to assign their EHR Incentive Payment to their Group Practice or Clinic, the Department of Finance and Administration believed that the proper interpretation of IRS guidelines require the issuance of individual 1099s irrespective of whom actually received the payment. The 1099 form is an informational return provided to the IRS. To determine if payments are taxable, you must consult your tax professional. In most cases, you will need to complete a “middleman 1099.” A “middleman 1099” transfers the income from your Social Security number and places such income in your employer’s tax ID number. You should have your employer’s tax ID number from the W-2 you were sent last year.

It is the responsibility of the eligible professional to assign his/her EHR Incentive Payment, either to his individual NPI or an organizational NPI (his employer or entity with whom he has a valid contractual relationship allowing the entity to bill for the EP’s services), in consideration of the program parameters and any agreements with his organization. The eligible professional is responsible for selecting the appropriate option in the CMS Registration and Attestation System, and

any payments will be made to the designated Payee NPI. The payment can be designated to different entities for each year of program participation but cannot be divided during a single year of program participation. CMS, the EHR Incentive Program, and the Bureau of TennCare are not responsible for decision-making or mediation regarding the assignment of incentive payments.

Again, we strongly encourage you to contact your tax professional on the proper handling of this matter. If you lose your 1099 or otherwise need a replacement, contact Donna Nicely at Donna.Nicely@tn.gov or (615) 253-5234. She will need your Tax ID number, name, and either an email address, fax number, or current mailing address where the replacement 1099 can be replaced.

2013 INCENTIVE YEAR 2014

The change of the calendar always creates some unusual situations. We are now in the *grace period* for Eligible Professionals (EPs) who are filing 2013 Incentive Year attestations. The grace period ends 11:59 PM March 31, 2014. After that date, we will no longer be accepting attestations using **2012 patient volume encounter data**. **Remember: the timeframe for patient encounter data is always a consecutive 90-day period from the previous calendar year. The timeframe for attesting to Meaningful Use of your CEHRT varies according to your stage of the attestation process.**

When completing the Provider Questions screen, question 7 asks, first, are you attesting as an individual or a group (this is based on how you are reporting your patient encounter data). The second part of question 7 asks for which year you are attesting – 2013 or 2014. This is a drop-down box for you to make a selection.

If you are attesting for **2013**:

- ◆ Your patient encounter data is coming from a 90-day period in calendar year 2012
- ◆ Your Meaningful Use (MU) data is coming from the appropriate timeframe in 2013 (either 90 days if this is your first MU attestation, or a full year if this is your second MU attestation)

If you are attesting for **2014**:

- ◆ Your patient encounter data comes from a 90-day period in calendar year 2013
- ◆ Your MU data comes from a 90-day period in 2014, regardless of stage.

In the September 4, 2012 *Final Rule*, CMS announced that, with all the changes being made for 2014, providers attesting for MU in 2014 are to use a 90-day period in 2014 rather than a full year, regardless of what stage of the program the provider is. This means, if you are doing a second or third year MU attestation, instead of 12 months of MU data, you only need 90 days of MU data. This also means that the earliest you can attest is April of 2014.

Upcoming Medicare Payment Reductions

EPs that see both Medicare and Medicaid patients should already be aware that Medicare has scheduled payment reductions beginning January 1, 2015 if you have not demonstrated MU in 2014. You can meet the MU requirement through the TennCare Medicaid EHR attestation process.

If you are attesting for your initial year in the EHR Incentive Program during 2014, there is a question 9 on the Provider Questions screen. It is a drop-down box where you can tell us if you are attesting for AIU (essentially that you have a CEHRT) or for MU (actually using your CEHRT in a meaningful way). To avoid the Medicare payment reductions, you must attest to meaningful use by September 30, 2014. Of course, you must meet all other criteria in order to receive your EHR incentive payment.

Please understand, if you are a Medicare/Medicaid provider it does not matter in which EHR Incentive Program you complete your attestation. The condition to avoiding the Medicare payment reduction is that you are a Meaningful User of your certified EHR system. If TennCare determines that you are a Meaningful User, that information will be passed along to CMS.

Eligible Hospitals (EHs) must also demonstrate MU in 2014. However, most all hospitals in Tennessee have reached the point where their attestations must be submitted to CMS before coming to TennCare for the TennCare Medicaid EHR Incentive Payment. To those EHs who have yet to attest, you must attest to Meaningful Use through CMS to avoid the Medicare Payment reductions scheduled January 1, 2015.

THERE ARE NO PAYMENT REDUCTIONS BEING MADE TO TennCare MEDICAID PAYMENTS AS RELATED TO THE EHR INCENTIVE PRORGAM. Medicaid-only EPs & EHs do not have to be concerned with the Medicare payment reductions.

Documentation

A reminder about documentation required for attesting in the TennCare Medicaid EHR Incentive Program. This **only** about the documentation required for an eligibility determination to participate in the Incentive Program. The documentation requirements discussed below are **ALL REQUIRED** each year in which you attest. However, the Signature Page is the only one that must be signed each year.

EHR DOCUMENTATION

Our EHR documentation requirements have been upgraded since the beginning of the program.

Providers are required to submit proof of a legal and/or financial obligation showing that they have adopted, implemented, or upgraded to certified EHR technology (CEHRT). Documentation must be submitted each year in which you attest for an incentive payment. The following list is acceptable documentation of a legal and/or financial obligation.

- The page of an executed contract or lease agreement clearly showing the CEHRT, vendor, and provider, and the executed dated signature page showing both the provider's and vendor's names and signatures
- If your current contract/lease requires the vendor to provide you with appropriate updates/upgrades to your system to qualify it as CEHRT, executed upgrade agreements for which a cost and timeframe are stated, and identified your CEHRT
- A copy of the vendor's invoice clearly identifying your CEHRT, and proof of payment
- A copy of your purchase order identifying the vendor and CEHRT being acquired, and proof of payment
- If using one of the free CEHRT, documentation requirements are a signed letter on the vendor's letterhead identifying the provider and CEHRT, and a copy of the User Agreement

NOT acceptable as documentation:

- A screenshot of CHPL showing the CMS certification number of your CEHRT
- A screenshot of your computer showing your CEHRT
- Requests for Proposals (RFPs) or vendor bids

Required Forms Screen

On the Required Forms screen are the forms that we must have **each year** in which you attest. These are the Substitute W-9, ACH (allows us to make electronic payments to you), Bank Information, and the Signature Page (the only one that must be signed each year). We are often asked why providers must submit the first three forms each year. Believe it or not, sometimes this information changes and providers forget to tell us. Oh, the MCOs are told since the majority of your TennCare payments come from them, but that information is not always passed to the Bureau. We have very strict requirements that the information you submit with your attestation must match up with what we have in your Provider Profile records.

There are two other forms listed on the Required Forms screen. These are the Nurse Practitioner Page and the Physician's Assistant page. These are specific to these two provider types.

- ⊕ Nurse Practitioner (NP) Page – Under TennCare Medicaid, NPs are allowed to submit claims under a doctor's or other proctor's NPI or that of the group practice or clinic. To make sure the NP is credited with all the encounters she is entitled to, we ask you complete the page as directed and upload it to the attestation.
- ⊕ Physician's Assistant (PA) Page – Under the EHR Incentive Program, PAs are only eligible to participate if they work in an FQHC or RHC that is led by a PA. They PA doesn't have to be the lead, but the clinic must be led by a PA. (See our FAQs for more information.) We get this information when the PA completes and submits this form with the attestation. This requirement about PA participation was established by federal regulation and not by the Bureau of TennCare.

Are You Ready for Stage 2 Meaningful Use?

Stage 2 Meaningful Use focuses on advanced clinical procedures including: measures focused on more rigorous health information exchange; additional requirements for e-prescribing and incorporating lab results; electronic transmission of patient care summaries across multiple settings; and increased patient and family engagement. To achieve Stage 2 Meaningful Use, EPs must meet 17 core objectives and 3 menu objectives, selected from a total list of 6 menu objectives. For EPs, that is a total of 20 objectives that must be met plus 9 Clinical Quality Measures that must be reported as part of Meaningful Use.

Stage 2 criteria place an emphasis on health information exchange between providers to improve care coordination for patients. One of the core objectives for EPs requires providers who transition or refer a patient to another care setting or provider of care to provide a summary of care record for more than 50% of those transitions of care and referrals. Additionally, there are new requirements for the electronic exchange of summary of care documents.

For more than 10% of transitions and referrals, EPs that transition or refer their patient to another care setting or provider of care must provide a summary of care record electronically. The EP that transitions or refers their patients to another care settings or providers of care must either a) conduct one or more successful electronic exchanges of a summary of care record with a recipient using technology that was designed by a different EHR developer than the sender's, or b) conduct one or more successful tests with the CMS- designated test EHR during the EHR reporting period.

There are also new Stage 2 menu objectives for EPs. Here is a short list of the new objectives:

- Record electronic notes in patient records
- Imaging results accessible through CEHRT
- Record patient family health history
- Identify and report cancer cases to a State cancer registry (for EPs only)
- Identify and report specific cases to a specialized registry (other than a cancer registry)

There are new Stage 2 measures for several objectives that require patients to use health information technology in order for providers to achieve meaningful use. CMS believes that EPs, eligible hospitals, and CAHs (Critical Access Hospital) are in the best position to encourage the use of health IT by patients to further their own health care.

- Under the Stage 2 core objectives - To provide patients the ability to view online, download and transmit their health information: An additional objective is for more than 5 percent of patients seen by the EP to view, download, or transmit to a third party their health information.
- Under the Stage 2 core objective - To use secure electronic messaging to communicate with patients on relevant health information: A secure message must be sent using the electronic messaging function of Certified EHR Technology by more than 5 percent of unique patients seen by an EP during the EHR reporting period.

Beginning in 2014, all providers regardless of their stage of meaningful use will report on CQMs in the same way. EPs must report on 9 out of 64 total CQMs. In addition, all providers must select CQMs from at least 3 of the 6 key health care policy domains recommended by the Department of Health and Human Services' National Quality Strategy. A complete listing of the new CQM measures can be found on the TennCare web site at http://www.tn.gov/tenncare/mu_cqm.shtml.

2014 Stage 1 Meaningful Use

Since the 2012 launch of the TennCare Provider EHR Incentive Payment Program, CMS has updated Stage 1 Meaningful Use objectives, measures and exclusions. The CMS Stage 1 Changes Tip Sheet can be found on the CMS website at <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage1ChangesTipsheet.pdf>. Below is a list of 2014 changes:

- (Optional in 2013) EPs must upgrade or implement CEHRT certified to the 2014 Edition certification criteria finalized by the Office of the National Coordinator for Health IT (ONC) for the 2014 EHR reporting period. Therefore, all reporting periods, regardless of stage or year are 90 days in 2014.
- (Optional in 2013) CMS added an alternate measure to the objective for computerized provider order entry (CPOE). The new alternate measure, now a requirement to be offered, is based upon the total number of medication orders created during the EHR reporting period, rather than the number of unique patients with a medication order in their medication lists, as required by the original objective. When submitting Stage 1 Meaningful Use Attestations, be sure to select the correct Option for Core 1.

- Core 8 measure is updated in 2014 to read, “For more than 50 percent of all unique patients seen by the EP during the EHR reporting period have blood pressure (for patients **age 3** and over only) and height and weight (for all ages) recorded as structured data”. Additional exclusions were also added. When you attest, carefully read the exclusions to assure you select the best reporting option for your practice.
- Core 13 and Menu 5 **objectives** are merged and changed to read, “**Provide patients the ability to view online, download and transmit** their health information within 4 business days of the information being available”. The **measure** will also change to read, “More than 50 percent of all unique patients seen by the EP during the reporting period are provided timely (within 4 business days after the information is available to the EP) online access to their health information subject to the EP’s discretion to withhold certain information.” Providing patients with an electronic copy of their health information will no longer meet the requirements for this measure.
- Beginning in 2014, EPs will no longer be permitted to count an exclusion toward the minimum of 5 menu objectives on which they must report **if** there are other menu objectives which they can select to report. EPs will not be penalized for selecting a menu objective and claiming the exclusion if they would also qualify for the exclusions for all the remaining menu objectives.
- Beginning in 2014, the reporting of clinical quality measures will change for all providers. EHR technology that has been certified to the 2014 standards and capabilities will contain new CQM criteria. EPs must report using the new 2014 criteria regardless of whether they are participating in Stage 1 or Stage 2 Meaningful Use. The new CQM criteria include 64 approved measures. CMS has recommended, but not required, EPs to select one of two core panels, one for the adult patient population and the other for the pediatric patient population. If an EP selects CQM singly, he/she must report 9 CQMs that cover at least 3 of 6 domains.



Web Site Updates



Our list of Acronyms and the Glossary has just been updated. So when we throw around all those funny terms and initials, you can look up to see what it is we are saying. Check it out [here](#).

We have mentioned this before, but we have PowerPoint presentations available to assist you through the attestation process. This can be viewed by going to this [link](#).

We do our best to keep our web site updated with the latest information about the TennCare Medicaid EHR Incentive Program. http://www.tn.gov/tenncare/ehr_intro.shtml If there is something you would like to see added to web site, let us know and we’ll consider it. In addition, if by chance you find an error, let us know that also so we can correct it.

Update Your Contact Email Address

Stay current with the latest news from the EHR Provider Incentive Program Plan. Keep communication lines open between your practice or hospital and TennCare Provider Services. Any time the email address for your primary EHR contact changes, **please update it in CMS Registration.**

Follow these instructions for making changes in CMS Registration:

- 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 new contact email address and help us keep you “in the loop” with Provider Services.

CMS HARDSHIP EXCEPTION

CMS has a ‘Hardship Exception’ process for providers who can show that demonstrating meaningful use would result in a significant hardship, for those facing the Medicare Payment reductions discussed earlier in this newsletter. NOTE: This is a CMS process, **NOT** a TennCare Medicaid process.

- ✓ EPs and EHs must complete a Hardship Exception application along with proof of the hardship.
- ✓ Hardship exceptions are only valid for 1 payment year. A new application must be submitted if the hardship continues for the following payment year.
- ✓ A provider may NOT be granted an exception for more than 5 years.

Application and all supporting documentation must be emailed to ehrhardship@provider-resources.com. For EPs without Internet connectivity, the information may be faxed to **814-464-0147**.

For more information, use this [link](#). TennCare Medicaid **does not** grant hardship exceptions. This is done **only** by CMS for those facing the Medicare payment reductions. There is a process to allow for the filing of a Hardship Exception for a group as opposed for having to apply individually.



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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