Medicaid EHR Incentive Program

Focus on Stage 2

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# Understanding Participation

## Program Year

- January 1\textsuperscript{st} - December 31\textsuperscript{st}.
- Year in which you met program requirements.
- Program years through 2021.

## Payment Year

- Simple count.
- Medicaid: One - Six.
  - Payment Year One: $21,250
  - Payment Years Two - Six: $8,500
- Medicare: One - Five.
  - Payments vary based on when participation began and program year participation
Program Updates

• Program Year 2014 applications must have proof of 2014 certified technology on vendor letterhead:
  – Provider or practice name
  – 2014 Certification number
  – Name and version of the system
  – Date of implementation

• Medicare Payment Adjustments:
  – Only applies to those provider types that can participate in the Medicare EHR incentive program
  – Can receive a payment and an adjustment in the same Program year
  – CMS reopened the Hardship Exemption Application Process for providers who have been unable to:
    • Attest by October 1, 2014 using the flexibility options provided in the CMS 2014 CEHRT Flexibility Rule.
Meaningful Use Stages

Adopt, Implement, Upgrade
• Not actually using system
• Must be more than a “planned” implementation

2014 Stage 1
• 13 core measures
• 5 out of 9 menu measures
• 9 out of 64 Clinical Quality Measures (CQMs)

2014 Stage 2
• 17 core measures
• 3 out of 6 menu measures
• 9 out of 64 CQMs

Stage 3
• Begins January 1, 2017 for Eligible Professionals (EPs)
Meaningful Use Basics

• Meaningful use reporting is based on all patients/encounters.

• 50% of encounters must be at locations equipped with certified EHR technology.

• 80% of unique patients seen at locations with certified EHR technology must have their records in a certified EHR system.
Meaningful Use Documentation

- Screenshots
- Dashboard
- Summary report

Documents must contain numeric measures
- Core measures
- Menu measures
- CQMs

If reporting from multiple systems – have documentation from the systems
- Add numerators/denominators for application

Additional Documentation (AD) Form – specific to stage
- Sections A and B not required if only practicing at one location or using same system at different locations
- Section C is based on location
2014 Stage 1 Core Measures

Met at More Than:

1. Computerized order entry for medication orders - 30% of unique patients.
2. Implement drug-drug, drug-allergy checks - Yes/No.
3. Maintain an up-to-date problem list - 80% of unique patients.
4. Generate and transmit permissible prescriptions electronically - 40%.
5. Maintain active medication list - 80% of unique patients.
6. Maintain active medication allergy list - 80% of unique patients.
7. Record demographics - 50% of unique patients.
2014 Stage 1 Core Measures

Met at More Than:

8. Record and chart changes in vital signs - 50% of unique patients.

9. Record smoking status for patients 13 and older - 50% of unique patients.

10. Implement one clinical decision support rule - Yes/No.

11. Provide patients with the ability to view online, download, and transmit their health information - **New for 2014** 50% of unique patients.

12. Provide clinical summaries for each office visit - 50% of unique patients.

13. Protect electronic health information (privacy & security) - Yes/No.
2014 Stage 1 Menu Measures

Met at More Than:

1. Implement drug-formulary checks - Yes/No
2. Incorporate clinical lab-test results into certified EHR as structured data - 40% of clinical lab results
3. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach - Yes/No
4. Send reminders to patients per patient preference for preventive/follow-up - 20% of all patients 65 or older and 5 years and younger
5. Use certified EHR to identify patient-specific education resources and provide to patient if appropriate - 10% of unique patients
2014 Stage 1 Menu Measures

Met at More Than:


7. Provide summary care record for transitions in care or referrals - 50% of transitions of care.

8. Capability to submit electronic data to immunization registries and actual submission - Public Health Measure.

9. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission - Public Health Measure.
Stage 2 Requirements

- Eligible Professional.
- Progress to Stage 2 after two reporting periods of Stage 1.
Stage 2 Core Measures for EPs

- CPOE for medication; lab and radiology orders.
- eRx.
- Record demographics.
- Record vital signs.
- Record smoking status.
- 5 CDSI rules AND drug-drug and drug-allergy interaction checks.
- Provide online access to health info (View, download, and transmit).
- Provide clinical visit summaries.
- Conduct security risk analysis.
- Incorporate structured lab results.
- Generate patient list by condition.
- Reminders for preventative/follow-up.
- Provide patient education resources.
- Medication reconciliation.
- Provide summary of care document.
- Transmission of immunization data.
- Secure messaging with patients.
Stage 2 Menu Measures for EPs

1. Capability to submit electronic syndromic surveillance data.
2. Record electronic notes in patient records.
3. Imaging results accessible through CEHRT.
4. Record patient family history as structured data.
5. Identify and report cancer cases to a public health central cancer registry.
6. Identify and report cases to a specialized registry (other than a cancer registry).
Computerized Order Entry

Objective
• Use computerized order entry (CPOE) for medication, laboratory and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Measure
• More than: 60% of medication orders, 30% of radiology orders, and 30% of laboratory orders.

Exclusion
• Writes fewer than 100 medication, radiology or laboratory orders during the EHR reporting period.

Change from Stage 1
• Increased threshold for meds from 30% to 60%.
• Adds lab and imaging.

Tips
• CPOE used to create the first record of the order so it becomes part of the medical record and action can be taken on it.
• Any licensed healthcare professionals and credentialed medical assistants can enter orders. Comply with state, local and professional guidelines and MAs must be credentialed by an organization other than the employing organization.
• Denominator is specific to orders created by the EP or authorized providers.
E-Prescribing

Objective
• Generate and transmit permissible prescriptions electronically (e-Rx).

Measure
• More than 50% of permissible prescriptions are queried for a drug formulary and transmitted electronically using certified electronic health record technology.

Exclusions
• Writes fewer than 100 permissible prescriptions.
• Does not have a pharmacy within their organization and there is not a pharmacy that accepts electronic prescriptions within 10 miles.

Change from Stage 1
• Increased threshold from 40%.
• Consolidates drug-formulary check from Stage 1.

Tips
• A prescription is defined as the authorization by an EP to a pharmacist to dispense a drug that the pharmacist would not dispense to the patient without such authorization.
• Providers can use intermediary networks that convert information from the certified EHR into a computer-based fax as long as the EP generates the e-Rx and transmits it to the intermediary.
Record Demographics

Objective
• Record the following demographics: preferred language, sex, race, ethnicity, and date of birth.

Measure
• More than 80% of all unique patients seen by the EP have demographics recorded as structured data.

Exclusion
• None.

Change from Stage 1
• Increased threshold from 50%.
• The term gender is replaced with the term sex.

Tips
• If a patient declines to provide demographic information, or if capturing a patient’s ethnicity or race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure.
Record Vital Signs

Objective
• Record and chart changes in the following vital signs: Height, Weight, Blood Pressure; calculate and display body mass index (BMI); and plot and display growth charts for children 2–20 years, including BMI.

Measure
• More than 80% 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.

Exclusions
• Sees no patients three years or older is excluded from recording blood pressure.
• Believes three vital signs have no relevance to their practice.
• Believes height and weight are relevant, but blood pressure is not, is excluded from recording blood pressure.
• Believes blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.

Tips
• Change from Stage 1 - Increased threshold from 50%.
Record Smoking Status

Objective
• Record smoking status for patients 13 years old and older.

Measure
• More than 80% of all unique patients 13 years or older seen by the EP have smoking status recorded as structured data.

Exclusion
• EPs who see no patients 13 years or older.

Change from Stage 1
• Increased threshold from 50%.

Tips
• This is a check of the medical record for patients 13 years old or older.
• If this information is already in the medical record available through certified EHR technology, an inquiry does not need to be made every time a provider sees a patient 13 years old or older.
• The frequency of updating this information is left to the provider and guidance is provided already from several sources in the medical community.
Clinical Decision Support Interventions

Objective
• Use clinical decision support (CDSI) to improve performance on high-priority health conditions.

Measure
• One: Implement five CDS interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent clinical quality measures – CDS interventions must be related to high-priority, health conditions
• Two: Enabled functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period

Exclusion
• Measure two – EPs who write fewer than 100 prescriptions during the EHR reporting period.

Change from Stage 1
• Increased from one CDSI to five.
• Drug-drug; drug-allergy consolidated into this measure.
• 1 CDSI suggested to be related to efficiency.

Tips
• Drug-drug and drug-allergy interaction alerts are separate from the 5 CDSIs.
• Full scope of CDSI – not just pop-up alerts.
• Can be supportive of quality initiatives within the practice.
Patients View, Download, and Transmit

Objective
• Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP. Specific information required.

Measure
• One: More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely (Four business days after the information is available to the EP) online access.
• Two: More than 5% of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download or transmit to a third party their health information.

Exclusion
• Neither orders or creates health information may exclude both measures.
• Conducts 50% or more of patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability.

Tips
• Access: when a patient possesses all the necessary information to view, download, and transmit their information.
• Encourage patient use of the portal and know how your system calculates patient use/access.
Patients View, Download, and Transmit

- The following information must be made available online as health information requirements:
  - Patient name
  - Provider's name and office contact information
  - Current and past problem list
  - Procedures
  - Laboratory test results
  - Current medication list and medication history
  - Current medication allergy list and medication allergy history
  - Vital signs (height, weight, blood pressure, BMI, growth charts)
  - Smoking status
  - Demographic information (preferred language, sex, race, ethnicity, date of birth)
  - Care plan field(s), including goals and instructions
  - Any known care team members including the primary care provider (PCP) of record

- Not required if:
  - The information is not available in certified EHR technology (CEHRT); or
  - Is restricted from disclosure due to any federal, state or local law regarding the privacy of a person’s health information, including variations due to the age of the patient; or
  - The provider believes that substantial harm may arise from disclosing particular health information in this manner.
Clinical Summaries

Objective
• Provide clinical summaries for patients for each office visit.

Measure
• Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50% of office visits.

Exclusion
• EPs who have no office visits during the EHR reporting period.

Change from Stage 1
• Shortens timeframe from three days to one business day.
• Additional required fields including care plan.

Tips
• Can be provided through a PHR, patient portal on the web, secure email, or electronic media.
• If specified information not available – indication can be made to satisfy this measure.
• If an EP believes that substantial harm may arise from the disclosure of particular information, an EP may choose to withhold that particular information from the clinical summary.
• Know how your system calculates.
Clinical Summary Information

- Patient name
- Provider's name and office contact information
- Date and location of the visit
- Reason for the office visit
- Current problem list
- Current medication list
- Current medication allergy list.
- Procedures performed during the visit
- Immunizations or medications administered during the visit.
- Vital signs taken during the visit (or other recent vital signs)
- Laboratory test results

- List of diagnostic tests pending
- Clinical instructions
- Future appointments
- Referrals to other providers
- Future scheduled tests
- Demographic information maintained within certified electronic health record technology (sex, race, ethnicity, date of birth, preferred language)
- Smoking status
- Care plan field(s), including goals and instructions
- Recommended patient decision aids (if applicable to the visit)
Protect Electronic Health Information

Objective
• Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

Measure
• Conduct or review a security risk analysis in accordance with 45 CFR 164.308(a)(1) including addressing the encryption/security of data stored in accordance with 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3) and implement security updates as necessary and correct identified deficiencies as part of the provider’s risk management process.

Exclusion
• None.

Change from Stage 1
• Emphasis on data encryption.

Tips
• If previously done and meets the requirements specified – only a review is required. Documentation is critical.
• Meaningful use does not impose new or expanded requirements on the HIPAA security rule.
• Be sure you understand the requirements.
Incorporate Lab Results

Objective
• Incorporate clinical lab test results into EHR as structured data.

Measure
• More than 55% of all clinical lab test results ordered by the EP during the EHR reporting period who results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data.

Exclusion
• EP who order no lab tests whose results are either in a positive/negative or numerical format during the EHR reporting period.

Change from Stage 1
• Previously a menu measure.

Tips
• The EP is not limited to only counting structured data received via electronic exchange, but may count in the numerator all structured data entered through manual entry through typing, option selecting, scanning, or other means.
Patient Lists

Objective
• Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities; research or outreach

Measure
• Generate at least one report listing patients of the EP with a specific condition

Exclusion
• None.

Change from Stage 1
• Was a menu measure.

Tips
• Each EHR reporting period must have its own report.
• Maintenance of problem lists and medication lists will need to be a workflow priority.
Reminders for Preventive Care

Objective
• Use clinically relevant information to identify patients who should receive reminders for preventative/follow-up care and send these patients the reminders, per patient preference.

Measure
• More than 10% of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.

Exclusion
• EPs who have had no office visits in the 24 months before the EHR reporting period.

Change from Stage 1
• Was a menu measure.
• Requirements broadened but threshold reduced.

Tips
• To count, the patient must not already be scheduled for preventive/follow-up care.
• Reminders to engage in certain activities is also included in this measure.
Patient Specific Education Resources

Objective
• Use clinically relevant information from certified EHR technology to identify patient-specific education resources and provide those resources to the patient.

Measure
• Education resources are provided to more than 10% of all unique patients with office visits during the EHR reporting period.

Exclusion
• EPs who have no office visits during the EHR reporting period.

Change from Stage 1
• Was a menu measure.

Tips
• Unique patient calculation.
• Certified technology uses the patient’s problem list, medication list or laboratory test results to identify patient-specific educational resources.
• Materials do not have to be stored within the certified technology.
Medication Reconciliation

Objective
• The EP who receives a patient from another setting of care OR provider of OR believes an encounter is relevant should perform medication reconciliation.

Measure
• The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.

Exclusion
• EPs who were not the recipient of any transitions of care during the EHR reporting period.

Change from Stage 1
• Was a menu measure.

Tips
• Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.
• The measure of this objective does not dictate what information must be included in medication reconciliation.
• Will need the ability to indicate that the visit is a transition of care visit.
Summary of Care

Objective
• The EP who transitions their patient to another setting of care OR provider of care OR refers their patient to another provider of care should provide summary care record for each transition of care or referral.

Measure
• One: Summary of care record or more than 50% of transitions and referrals.
• Two: More than 10% of transitions or referrals are either (a) electronically transmitted using certified technology or (b) where the recipient receives the summary of care record via exchange facilitated by an NwHIN participant or in a manner consistent with the governance mechanism established for NwHIN.
• Three: Conducts one or more successful electronic exchanges of a summary of care record (counted in measure 2) to a different EHR platform OR conducts one or more successful tests with the CMS designated test entity.

Exclusion
• Less than 100 transitions of care or referrals during the EHR reporting period.

Change from Stage 1
• Was a menu measure.
Immunization Registry Submission

Objective
• Capability to submit electronic data to immunization registries except where prohibited and in accordance with applicable law and practice.

Measure
• Achieved ongoing submission in prior EHR reporting period and continuing to submit.
• Registered with FL SHOTS by deadline (60 days within start of EHR reporting period) and ongoing submission was achieved.
• Registered with FL SHOTS by deadline and currently engaged in testing.
• Registered with FL SHOTS by deadline and waiting to begin testing.

Exclusion
• Four exclusions, one is applicable for Florida:
  – Does not administer immunizations during the EHR reporting period.

Change from Stage 1
• Was a menu measure.

Tips
• Testing no longer meets this measure.
• http://flshotsusers.com/resources/meaningful-use-verification/
Secure Messaging

Objective
• Use secure electronic messaging to communicate with patients on relevant health information.

Measure
• A secure message was sent using the electronic messaging function of certified EHR technology by more than 5% of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

Exclusion
• No office visits during the EHR reporting period.
• Conducts 50% or more of patient encounters in a county that does not have 50% or more of its housing units with 3Mbps broadband availability.

Tips
• Not an expectation that the EP personally respond to messages.
• A phone call or office visit may be more appropriate to address the concerns raised in the message.
• Requires patient action which may need to be encouraged by the EP.
Stage 2 Menu Measures

1. Capability to submit electronic syndromic surveillance data - urgent care providers in Florida.
2. Record electronic notes in patient records.
3. Imaging results accessible through CEHRT.
4. Record patient family history as structured data.
5. Identify and report cancer cases to a public health central cancer registry.
6. Identify and report cases to a specialized registry (other than a cancer registry).
Syndromic Surveillance

Objective
• Capability to submit syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.

Measure
• Successful ongoing submission of electronic syndromic surveillance data from the certified EHR technology to a public health agency for the entire EHR reporting period.

Exclusion
• Four exclusions, two apply in Florida:
  – Not in a category of providers that collects ambulatory syndromic surveillance information.
  – No public health agency capable of receiving data in the specific standards required by the certified EHR technology at the start of their EHR reporting period.

Tips
• Florida DOH is only accepting syndromic surveillance data from urgent care EPs.
• https://www.epicomfl.net/MerlinCaseReporting/Meaningfuluse/Meaningful_Registration_dtl.aspx
Record Electronic Notes

Objective
• Record electronic notes in patient records.

Measure
• Enter at least one electronic progress note created, edited and signed by an EP for more than 30% of unique patients with at least one office visit during the EHR reporting period. Text must be searchable and may contain drawings and other content.

Exclusion
• None.

Tips
• CMS will rely on providers own determination and guidelines defining when progress notes are necessary to communicate individual patient circumstances and for coordination with previous documentation of patient observations, treatments and/or results in the electronic health record.
• Non-searchable notes do not qualify – but the entire note does not have to be text.
Imaging Results

Objective
- Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through the certified EHR technology.

Measure
- More than 10% of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through the certified EHR technology.

Exclusion
- EPs who order less than 100 tests whose result is an image during the EHR reporting period.
- EPs who have no access to electronic imaging results at the start of their EHR reporting period.

Tips
- Radiologic services as any imaging services that uses electronic product radiation.
- Images and imaging results that are scanned may be counted in the numerator.
Family Health History

Objective
• Record patient family health history as structured data.

Measure
• More than 20% of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.

Exclusion
• No office visits during the EHR reporting period.

Tips
• First Degree Relative: a family member who shares about 50% of their genes with a particular individual in a family.
• First degree relatives include parents, offspring and siblings.
• This measure is a minimum and not a limitation on the health history that can be recorded.
• Recording of “unknown” as structured data can be used to count in the numerator.
Cancer Registry Reporting

Objective
• Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited and in accordance with applicable law and practice.

Measure
• Successful ongoing submission of cancer case information from the certified EHR technology for the entire EHR reporting period.

Exclusion
• Four exclusions, one applies in Florida:
  – Not in a category of providers that diagnosis or treat cancer

Tips
• [http://fcds.med.miami.edu/inc/MU2FLCancerReporting.shtml](http://fcds.med.miami.edu/inc/MU2FLCancerReporting.shtml)
Specialized Registry Reporting

Objective

• Capability to identify and report specific cases to a specialized registry (other than a cancer registry) except where prohibited and in accordance with applicable law and practice.

Measure

• Successful ongoing submission of specific case information from the certified EHR technology for the entire EHR reporting period.

Exclusion

• Four exclusions – three that may apply:
  – Not in a category of providers that diagnosis or treat any disease associated with a specialized registry sponsored by a national specialty society for which the EP is eligible or the public health agencies in their jurisdiction.
  – No specialized registry capable of receiving data in the specific standards required by the certified EHR technology at the start of their EHR reporting period.
  – No public health registry in Florida
Summary of Care Record

• Summary of Care for Transitions of Care (TOC).
  – Three measures, two require electronic transmission of the summary of care

• Know how your vendor plans on meeting this requirement.
  – When will they be ready?
  – What forms of exchange will they support?
  – Will the system allow for exchange with a sufficient number of providers?
  – Connections with HIEs

• Know your denominator.

• Know your referral base.
Patient Engagement Requirements

Patient Access to Health Information

- Requires more than 5% of unique patients seen during reporting period view, download, or transmit their health information to a third party.

Secure Messaging

- Requires more than 5% of unique patients seen during reporting period or their authorized representatives send a secure message using the electronic messaging function of the certified EHR.
Preparing for Stage 2

- Many of the measures are what you are doing.
- Know what is expected and incorporate now.
- Focus on patient engagement.
- Know Problem Areas.
2014 Clinical Quality Measures

- Regardless of Stage.
- EPs - 9 out of 64.
- Cover at least three of the National Quality Strategy Domains.
- Core Sets for Adult and Children.
- Choices may be driven by what vendor is offering.
- No threshold that must be met.

CQM Reporting
- Dually eligible hospitals beyond 1st year of Meaningful Use must electronically report CQM data.
- Medicaid only providers will report to the state through the on-line application.
Certification Flexibility Rule

• Rule effective October 1, 2014

• The rule grants flexibility to providers who are unable to fully implement 2014 Edition Certified Electronic Health Record Technology (CEHRT) for an EHR reporting period in 2014 due to delays in 2014 CEHRT availability.

Implementation…a provider’s ability to fully implement the functionality may be limited by the availability and timing of product installation, deployment of new processes and workflows, and employee training.

• Providers may now use EHRs that have been certified under the 2011 Edition, a combination of the 2011 and 2014 Editions, or the 2014 Edition for 2014 participation.
## Attestation Options

### Certification Flexibility Rule Attestation Options

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Unable To Fully Implement Due To

- Software development delays.
- Missing or delayed software updates.
- Being able to implement 2014 CEHRT for only part of the reporting period not the full reporting period.
- Unable to train staff, test the updated system, or put new work flows in place because of delays associated with installation of 2014 CEHRT.
- Unable to meet Stage 2 summary of care measures due to recipient of transmittals impacted by 2014 CEHRT issues.
Not Allowable Reasons

- Financial issues.
- Inability to meet one or more measures.
- Staff turnover and changes.
- Provider waited too long to engage a vendor.
- Refusal to purchase the requisite software updates.
Additional Considerations

CQM reporting will be tied to the reporting option chosen. For example, providers will not be allowed to attest to 2014 Stage 1 measures and 2013 CQMs.

Additional attestation documents will be required documenting why a 2014 CEHRT could not be fully implemented.

Changes to MAPIR allowing a provider to attest using a previous edition of CEHRT are expected to be completed Spring 2015.

Certification Number entered will determine reporting options.
Immunization Measure Details

Attesting under a Flexibility Option:
• No new test is required.
• Use 2013 program year documentation.

Attesting Using 2014 edition CEHRT
• Stage 1
  – First year of Stage 1 – must perform the test.
  – Second year of Stage 1 - must perform a test unless they have achieved ongoing submission or have documentation from Florida Shots advising not to perform the test.
  – Documentation from Florida Shots regarding status at the end of the EHR reporting period.
• Stage 2
  – Register by the deadline of no later than 60 days after the start of their EHR reporting period.
  – Work with Florida Shots toward ongoing submission if it was not already achieved.
  – Stage 2 registration will not allow for entry of an EHR reporting period end date in the past.
  – Providers who achieved ongoing submission prior to their 2014 EHR reporting period and did not register by the deadline, must register and enter a date the form will accept.
What Does This Mean?

• Providers are encouraged to talk to their vendor about their options in accessing 2013 Meaningful Use reports as this ability may no longer be available once you begin installing 2014 CEHRT.

• Providers must have 2014 CEHRT for Program Year 2015.

• Program Year 2015 will require a full year reporting period if not your first meaningful use period.

• Medicare Hardship Exemption applications reopened.
  – Request due by November 30, 2014 and are only for reasons specified
Audits

Prepare reports and screenshots from your EHR before completing your application.

Review your attestation to help ensure you have attested to menu measures you have qualified for.

Read CMS guidelines regarding each measure’s rule and objective. – [http://www.cms.gov](http://www.cms.gov)

Correspond with auditors and provide requested documentation in timely manner.

Ask questions you have regarding the audit and the requested documentation.

If you are selected for audit, any future program year payments will be held until the audit is completed.
Additional Contacts and Resources

**EHR Incentive Program Call Center:**
(855) 231-5472

*MedicaidHIT@AHCA.MyFlorida.com*

*Kim.davis@ahca.myflorida.com*

**Florida HIE Help Desk:**
850-412-3752

*FLHII@ahca.myflorida.com*

**www.ahca.myflorida.com/medicaid/ehr**

**www.Florida-HIE.net**