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## RE M I N D E R S

The **DEADLINE** for **Eligible Professional** attestations for Program Year 2014 is **March 31, 2015 @ 11:59 PM**. Any attestations received after this time will be returned as untimely submissions.

CMS is changing the rules about Program Year 2015 attestations for both EPs and EHs. **However**, those changes are not effective until after the proposed rule is posted, the review & comment period is held, and CMS posts the final rule with an effective date. In the meantime, you should make every effort to get your 2014 Edition CEHRT System up and running as soon as possible.

## Meaningful Use 2014 Patient Electronic Access Update

Beginning with 2014 Stage 1 and Stage 2 meaningful use, the objective and measures for patient electronic access have changed from the 2013 Stage 1 version. CMS now requires that providers participating in both Stage 1 and Stage 2 of the EHR Incentive Programs must meet the Patient Electronic Access objective, which gives patients access to their health information in a timely manner. 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. The purpose of this change is to allow patients access to their health information to help them make informed decisions about their care and share most recent clinical information with other health care providers. However, *providers must have a patient portal, access to a personal health record on line or access to a health information exchange to fully satisfy this measure for Stage 1 or 2.*

Measure 1 is for both Stage 1 and Stage 2. The measure 1 requirement is to provide for more than 50% of all unique patients seen by the Eligible Professional (EP) during the EHR reporting period the ability to *view online*,

*download, and transmit* their health information within four (4) business days of the information becoming available to the EP. The denominator for this measure is now the number of unique patients seen by the EP during the EHR reporting period, or the unique patient denominator used in many other meaningful use measures. While there is Stage 1 exclusion available for this measure, not very many providers will be able to meet the exclusion criteria. The new exclusion is for any EP who neither orders nor creates any of the information listed for inclusion except for “Patient name” and “Provider’s name and office contact information”. The provider may withhold any clinical information from online disclosure if he or she believes providing such information may result in significant harm. Otherwise, as new information becomes available to the provider, that information must be updated and made available to the patient within four business days. The emphasis of this measure is on the access, which is defined by CMS as, “when a patient possess all of the necessary information needed to view, download, or transmit their health information.” This could include providing patients with instructions on how to access the website address, and providing a unique and registered username and password, instructions on how to create a login and any other instructions, tools or materials that a patient would need in order to view, download or transmit their personal health information. There is no requirement *in this measure* to report how many patients follow through and view, download or transmit their online health information. This measure replaces the old Stage 1 core, to provide patients with an electronic copy of their health information.

Measure 2, which applies only to Stage 2, assesses the patient follow through to actually create an online account and use it. To meet measure 2, more than 5% of the unique patients seen by the EP during the reporting period, or their authorized representatives must view online, download or transmit to a third party their health information. Providers participating in Stage 2 meaningful use must meet both measure 1 and 2. While the threshold for this measure is low, many EPs have found this to be a challenge. Some strategies EPs in Tennessee have used for this measure include providing patients the ability to create their login when they are in the office before they leave, helping patients create an email account to be able to create a login username or to provide a username and temporary password that will can be used for a specified amount of time. When a patient accesses their online health information, other EPs in the same practice can share the credit *if they saw the patient during their EHR reporting period* and count those patients in the numerator for measure 2. (See FAQ 9686: <https://questions.cms.gov/faq.php?faqId=9686>).

Related resource links

[Patient Electronic Access Tipsheet](#)  
[Stage 1 Changes 2014](#)

### *Important Immunization Measure Reminders*

- **Stage 1** Meaningful Use **Immunization Registry** testing with Tennessee Department of Health (TDOH) and/or validation must occur between **January 1<sup>st</sup> and the last day of your reporting period**. To satisfy this measure for Stage 1 year 1, a test must be created from your CEHRT, sent to TDOH, received by TDOH, and tested. In Stage 1 year 2, per CMS FAQ 8910, any EP who could demonstrate engagement with the immunization registry during year 2. The engagement could be communication with the registry showing

another test is not beneficial, working toward follow up submission or an update showing additional actions taken. It is not acceptable to use the test from year 1 to meet the Stage 1 year 2 measure.

- **Stage 2 registration of intent** with TDOH must occur **within the first 60 days of your reporting period** for Immunization or Cancer Registry. However, just registering your intent will not completely satisfy this measure. The purpose of this measure is for EPs to successfully begin or maintain submission of electronic immunization data from their CEHRT if they administer immunizations. There are two ways Stage 2 EPs can fail to meet MU requirements for the Immunization measure:
  - Failure to register their intent by the deadline; or
  - Failure to participate in the onboarding process as demonstrated by failure to respond to the Public Health written requests for action within 30 days on two separate occasions.

Related resource links:

[Public Health Registry Tipsheet](#)

<https://questions.cms.gov/faq.php?id=5005&faqId=8910>



## **EHR Documentation Must Show Legal/Financial Obligation to System**



### ***Vendor Letter Is Not Proof***

To comply with an on-site audit by CMS, the Bureau of TennCare in 2013 upgraded its EHR documentation requirements. The new rules adopted at that time require providers to show a legal/financial obligation to the certified EHR technology (CEHRT) they are attesting to use.

As understood, in order to prove an adoption, implementation, or upgrade of an EHR system, CMS was requesting to see more in the way of proof of payment (such as an invoice) or legal obligation (such as a contract). Requirements for those using a “free” CEHRT were also strengthened.

Most providers attesting for the TennCare EHR Incentive Program submit a contract or lease agreement as their EHR documentation. To be considered as valid documentation, a contract or lease agreement must be *executed*, as evidenced by the signatures of both parties in the contract or agreement. In order to show a legal/financial obligation, the document must be signed by a representative of your practice, as well as by a representative of the EHR technology vendor. Documents bearing the signature of only one party are not executed and therefore not valid.

Often a vendor’s proposal or order document is executable in that it may become a contract or lease agreement when it is appropriately signed by both parties. A vendor’s proposal or order form that is not executed or that is signed by only one party is not valid documentation.

When submitting an executed contract or lease agreement, providers may submit only the first page (that is not a cover page) and the signature page of the document. The first page must clearly show the names of the CEHRT, vendor, and provider. The contract signature page must be dated and executed, bearing the names and signatures of representatives of both the provider and vendor.

Alternatively, providers may submit a copy of their purchase order or a copy of the vendor's invoice. These documents must clearly identify the practice name, vendor, and CEHRT, and must be accompanied by proof of payment of the amount shown on the purchase order or invoice. Where regular and ongoing payments are made to an EHR vendor for the acquisition or lease of a CEHRT, a vendor's receipt for an automatic bank draft or credit/debit card payment may be submitted.

If a current contract or lease requires the vendor to provide appropriate updates/upgrades to your system to qualify it as CEHRT, executed upgrade agreements may be provided as acceptable documentation. Such agreements must state a cost and timeframe, and identify the CEHRT.

Attestations are often received with a letter from the CEHRT vendor attached. Such vendor letters are not acceptable as valid EHR documentation, except in the following circumstances:

- Providers using one of the free CEHRTs may submit a signed letter on the vendor's letterhead identifying the provider and CEHRT, and a copy of the User Agreement. The User Agreement must be complete (all pages) in order to be accepted.
- For incentive years in which CMS requires an upgrade (such as was the case for 2014 attestations), a signed letter on the vendor's letterhead identifying the provider and upgrade is acceptable as proof of upgrade, as long as it accompanies an executed contract, invoice, or other documentation as proof of a legal/financial obligation to the base EHR system.

Other unacceptable types of documentation include:

- 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

All submitted EHR documentation is subject to additional evaluation, as rules or interpretation of rules may change. Provider Services also retains the right to flag for audit any attestation for which special attention is needed.

Proper EHR documentation must be submitted with each attestation, regardless of whether or not the information was submitted previously.



## Has Your Meaningful Use Attestation Been Returned?

We all know the easiest & fastest way to reply to an email is to hit “Reply.” However, all emails sent from the TennCare EHR Incentive Program come from the TennCare EHR Incentive Program mailbox, including those returned where there is a problem with the MU portion of the attestation.

On those rare occasions (😊) when an attestation is returned due to an MU-related problem, the subject line of the email will read “Meaningful Use Attestation Return Notice.” The fastest way to get any questions you have about the return answered, is to use the return address contained within the email message. That address is [EHRMeaningfuluse.TennCare@tn.gov](mailto:EHRMeaningfuluse.TennCare@tn.gov). This will direct your email to the unit responsible for reviewing your MU data. If you click “Reply,” we will forward your email to that unit, so do not worry that you won’t get a response.

### From CMS:



### Medicare Eligible Hospitals: Take Action by April 1 to Avoid 2016 Payment Adjustment

Payment adjustments for eligible hospitals that did not successfully participate in the Medicare EHR Incentive Program in 2014 will begin on October 1, 2015. Medicare eligible hospitals can avoid the 2016 payment adjustment by taking action by April 1 and [applying](#) for a 2016 hardship exception.

The hardship exception [application](#) and [instructions](#) for Medicare eligible hospitals are available on the [EHR Incentive Programs website](#), and outline the specific types of circumstances that CMS considers to be barriers to achieving meaningful use, and how to apply.

To file a hardship exception, Medicare eligible hospitals must:

- Show proof of a circumstance beyond the hospital's control.
- Explicitly outline how the circumstance significantly impaired the hospital's ability to meet meaningful use.

Supporting documentation must also be provided. CMS will review applications to determine whether or not a hardship exception should be granted.

### Apply by April 1

As a reminder, the application must be submitted electronically or postmarked no later than **11:59 p.m. ET on April 1, 2015** to be considered.

If approved, the exception is valid for one year. If the hospital claims a hardship exception for the following payment year, a new application must be submitted.

### Want more information about the EHR Incentive Programs?

Be sure to visit the [Medicare and Medicaid EHR Incentive Programs website](#) for the latest news and updates on the EHR Incentive Programs.



## 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)

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