

Centers for Medicare & Medicaid Services
National Provider Call on Medicare and Medicaid EHR Incentive Program Basics for
Eligible Professionals
Moderator: Diane Maupai
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Welcome

Operator: Welcome to the National Provider Call on Medicare and Medicaid EHR Incentive Program Basics for Eligible Professionals. All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for participating in today's call.

I will now turn the conference over to Diane Maupai. Ma'am, you may begin.

Diane Maupai: Thank you and good afternoon, everyone. This is Diane Maupai with the Provider Communications Group at CMS in Baltimore. Thanks for joining us today.

I want to remind everybody that the presentation for today's call is on our website, which is www.cms.gov/EHRIncentivePrograms. It's on the Spotlight Page, the first link under Presentations. Now, if you were an early bird and downloaded the presentation early yesterday or the day before, it did not have page numbers, which would really be handy to have today. But if you downloaded yesterday afternoon or this morning like I would, you're good to go. Otherwise, you may want to pencil in some numbers or print another set.

Well, since the program opened in January, the program's really come a long way. As of June 30th, over \$273 million has been paid in Medicare and Medicaid EHR incentive payments. There are over 68,000 active registrations of both eligible professionals and eligible hospitals for both of those incentive programs. Twenty-one States have launched Medicaid EHR Incentive Programs and 14 of those States have issued incentive payments. We had four more States join us on Independence Day.

I'd also like to give you a heads-up to mark your calendars for our next two National EHR calls. There'll be a call on Meaningful Use on August the 18th, at this same time, 1:30 Eastern Standard. This is a live repeat of the call we had in May. We'll also be having a call on September the 9th, for EP Registration and Attestation. And I'll remind you of those dates again at the end of the call. Registration will probably be opening for the August 18th call in the next week or so. So be on the alert for more messages.

We have two speakers sharing our session today, Rob Anthony from the Office of E-Health Standards and Services and Michelle Mills, who's the Technical Director in the Center for Medicaid, CHIP, and Survey & Certification. And I think, Michelle, you're going to start us off today?

Slides 1 thru 12

Michelle Mills: Yes, sure am. Thanks, Diane. Hi, everyone. We're excited to talk to you today about some Medicare and Medicaid EHR Incentive Programs basics. We've included a lot of slides for your reference today. It's kind of a primer for this session, but we're really only going to hit on the basics.

As Diane mentioned, we've got a call coming up on August 18th that will cover Meaningful Use much more in depth, and then one covering Registration Attestation also in September. That will cover these topics in more detail as well. So we're going to cover kind of the fundamentals of the program today and then refer you to some of the resources on our website to help get you ready for those other calls in August and September.

So with that, I'm going to start the slide deck. Today we're going to cover eligibility and payments for eligible professionals. I'm going to turn it over to Rob and he's going to cover some Meaningful Use high level topics. He's going to come back to me. I'm going to cover some registration at high level again; and then Rob's going to close it out covering some high level attestation topics just to give you a sense of where the program's going and what you need to do.

So with that, I'm going to start on slide three where we talk about who is eligible to participate for this program. One of the key features is that eligible professionals cannot participate in this program if they're considered hospital-based. Hospital-based determinations are based on Place of Service codes 21, and 23, which are inpatient and emergency departments of a hospital.

The reason is that hospitals are also eligible for these incentives. Therefore, the eligible professionals that provide the majority of their services in hospitals would be working towards meeting the hospitals' requirements for

their incentives. Eligible professionals outside of the hospitals, we believe that they need the incentive money in order to offset the costs associated with their adoption of their EHR whereas folks in the hospital are probably using the hospital's EHR.

This is derived from statute, which means that this is a decision that Congress made. CMS doesn't have any flexibility on letting hospital-based eligible professionals in or out of the program.

Next slide, slide four. This is a Venn diagram that shows you who can participate in the program, and whether they're eligible for Medicare, Medicaid or both. If you are eligible for both Medicare and Medicaid incentives, you may only participate in one program in each year, which we'll cover that in a little bit as well.

As you can see here in the blue oval on the left, doctors of optometry and podiatrists, and chiropractors are only eligible for the Medicare incentives, whereas on the far right, you can see on the yellow circle, nurse practitioners, certified nurse midwives and certain physician assistants are only eligible for the Medicaid incentives.

The folks in the middle, the dentists, the Doctors of Medicine and Doctors of Osteopathy or DOs, they're eligible for either program. So what they would do is they'd want to look at their options under both Medicare and Medicaid and see which program makes more sense for them. We'll talk about the incentives in a little bit, but you do receive more money under the Medicaid program. So if those folks there in the middle circle qualify for Medicaid, they should probably look closely at the Medicaid incentive.

Next slide, slide five, shows you the hospitals that are eligible for the programs as well. We're going to skip the hospital-based slides today. Those are really in the deck for your reference.

So slide six talks about basics of Medicaid eligibility for this program. As we showed you on the Venn diagram, you need to be one of five types of eligible professionals in order to participate in the Medicaid incentives. That includes

Doctors of Medicine or Osteopathy, dentists, certified nurse midwives, nurse practitioners or physician assistants under certain circumstances.

Secondly, there's another bar that Medicaid providers have to jump over to show that they are Medicaid providers and providing a large proportion of care to Medicaid beneficiaries. It's binary, so the first is that they have to either have at least 30 percent of their patient volume derived from Medicaid, or they would practice predominantly in a Federally Qualified Health Center or a Rural Health Clinic and have at least 30 percent of their patient volume derived from needy individuals.

There's lots of loaded terms in what I just said there. So Medicaid patient volume is just generally the number of patients that folks see. We have some optional definitions for States to consider in administering their programs. So States may be looking at your total number of encounters, your encounters plus your patient panels if you provide care in a managed care coordinated care type setting, or States can propose an alternative to us to look at that.

Practicing predominantly is when over 50 percent of your clinical encounters within a six-month period are within an FQHC or an RHC, and needy individuals include folks on Medicaid, CHIP, uncompensated care or folks who are provided free or sliding scale services based on their ability to pay. Folks practicing predominantly in FQHCs will have no trouble meeting that threshold. RHCs are a little bit different and folks may have trouble meeting that.

For questions specific to how your State is calculating Medicaid patient volume, we can refer you to our website where you can find your State's website to get more information on that. Or frankly you can Google your State's program and probably find that faster.

Additionally, like the Medicare program, providers have to be licensed and credentialed appropriately to participate. We do check that there aren't any exclusions prohibiting the individual from participating in a Federal program, that they're living so we check the Social Security Death Master File to make

sure the provider's alive. And just like Medicare, the providers can't be hospital-based.

On slide seven, we cover hospitals. Again, we're going to skip, that's just in there for your reference.

Slide eight shows the Medicare basics. So again, you must be a physician, which under the Medicare program, physician is defined as an MD, a DO, a dentist, an optometrist, a podiatrist or a chiropractor. They must have Part B Medicare allowed charges in order to get an incentive in this program. And like Medicaid, they must not be hospital-based, and they must be living and must not also have sanctions from the Office of the Inspector General for HHS that prohibits them from receiving Federal funds under this program.

And the difference here with Medicare that is notable is that they must also have an active enrollment in our Provider Enrollment, Chain and Ownership System known as PECOS, a system that enrolls and pays Medicare providers. We have a link to our PECOS site on our website so you can check to see if you have an active enrollment.

And skipping slide nine because that covers hospitals, again for your reference. So folks, you might want to know how much I'm going to get paid under this program which is a very important question. The payments are very different under Medicare and Medicaid. We'll go over the Medicaid payments in the next slide, but generally, under Medicare you can get \$44,000 over a five year period if you begin your participation this year or next year. You can get \$18,000 in your first year from Medicare if you participate again this year and next year. There's a tiered approach to payments after that.

The incentive payments for Medicare are based on the Part B Fee-For-Service allowed charges up to \$25,000. So what we're looking at is a cap of \$25,000 of allowed charges and then the incentive is based on a percentage of that up to \$18,000.

There's another notable point on here as well, so it explains things like you have to start participating by 2014, and the last payment year is 2016. One other notable point is that for professionals practicing in Health Professional

Shortage Areas, which are designated also by CMS, there's an extra 10 percent of the incentives that folks can get if they are practicing in those areas.

Next slide, slide 11, we cover Medicaid incentive payments. Again, Medicaid payments are more. Over a six year period folks can get almost \$64,000 and the first year's payment is \$21,250. A difference we'll talk about here a little bit more in the next couple of slides is that under Medicaid, you also don't have to meaningfully use the certified EHR technology in your first year. You can adopt, implement or upgrade to certified EHR technology in order to get your incentive of \$21,250, and we hope that this will help offset the cost of providers with adopting or implementing to certified EHR technology.

Medicaid eligible professionals are not eligible for the Health Professional Shortage Area bonus that we talked about in the previous slide. But like Medicare, they must participate by 2016 in order to receive incentive payments. The difference is that for Medicare, that's the last year they can receive incentive payments, but for Medicaid, it's the last year they can begin receiving incentive payments. Medicaid Incentive Program goes through 2021.

Next as I just mentioned Medicaid eligible professionals can adopt, implement or upgrade certified EHR technology in their first year. So we're going to spend a lot of time talking about Meaningful Use today. Rob's going to cover that at a high level, but it's a fairly complex topic in terms of getting incentive money for Meaningful Use.

Adopt, Implement, Upgrade is pretty easy for providers comparatively. We explain here what we mean by each of those terms. And because new certification standards just came out in the Fall, what we mean by certified EHR technology, we think all providers in the program will have adopted, implemented or upgraded their technology in order to have certified EHR technology. So this shouldn't be hard for folks that are planning to participate in the Meaningful Use part of the program.

The general principle here is that you don't have to have it installed. You don't have to have purchased it. We're not looking at the boxes and wires.

We want you to be legally obligated to pay for it. So some people are leasing it or they purchased it on some sort of an installment plan where they sign a purchase order now and then the installation begins later this year for example. And so, folks like that are eligible for the incentive now so long as there is documentation legally binding them to pay for this software at the time that they registered and attest for the program.

With that I'm going to turn it over to Rob so he can talk about the Meaningful Use slides.

Slides 13 thru 23

Robert Anthony: Thanks, Michelle. As Michelle said, we're going to go over and we're going to do sort of a top-line summary of Meaningful Use. There is a lot of detail to this program and we won't be able to delve into all of it here. But I really do encourage people to visit our website; that's here on a later slide. There is a Meaningful Use Tab. There are fair amounts of educational materials that you'll be able to print off and take a look at. That will walk you through the different aspects of Meaningful Use, and especially our Meaningful Use Specification Sheets that cover each of the objectives that you have to achieve in detail. So please do visit the website.

Starting on page 14, this is an illustration of the approach to Meaningful Use that we're taking. We've divided Meaningful Use into three stages. The first stage, which is the stage that we're in right now, really focuses all of the objectives on data capture and sharing. It's sort of getting the technology in place and getting people to using it so that we can eventually lead up to what these future stages are.

So we'll be looking at advanced clinical processes as we move forward. And then ultimately, the goal of the program is to improve outcomes and capture efficiencies within the system. So right now we're where that circle is on data capturing and sharing.

Looking at slide 15, just a very basic overview of what Meaningful Use is for Stage 1. For Medicare participants the first year participation is a reporting period of 90 days. In other words, you'll have to have your certified EHR

technology in place, and then you'll have to be achieving these Meaningful Use Objectives over a period of 90 days and that's what you'll end up reporting data on to us.

In subsequent years, you're going to report for the entire Calendar Year as an eligible professional. Now for Medicare – I'm sorry, for Medicaid as Michelle explained, the first year is an Adopt, Implement, Upgrade year and your second year would be 90 Days Stage 1 Meaningful Use.

The reporting to us is going to happen through attestation and we often get questioned what attestation is. The attestation is actually an online process. I'll retrieve some of those screenshots after this. But you'll actually go there and you'll enter yes, no's, numerators, denominators, indications for exclusions, all of those things for the objectives. There are objectives in Clinical Quality Measures that you have to complete in order to qualify for an incentive payment and we'll review those really quickly here.

And as I said, you're going to see that some of those objectives are a yes/no, and some of them are numerator/denominator. What that really means is that some of them require you to have a certain functionality enabled and you will simply attest that you have enabled that functionality for the duration of your reporting period whereas some of them have a particular threshold that you have to hit and there are defined numerators and denominators for what goes into that threshold.

It is important to keep in mind that for some of these objectives and measures that have thresholds, there is an 80 percent threshold that there isn't an exclusion for. So in other words, at a minimum you're going to need to have 80 percent of patients that you see during that reporting period have to have records in the certified EHR technology. So keep that in mind as you go through.

As we look at slide 16, I just want to cover sort of the broad outline of what eligible professionals will have to do. We also have hospitals here for your information. But for Stage 1, there are 15 core Meaningful Use Objectives, and that means that there are 15 objectives that every eligible professional is

going to have to report on or they're going to have to qualify for an exclusion for.

There's also a menu set of objectives. And 10 of those are provided out of which you have to report on five. So in other words, there will be a total of 20 objectives that you will either report on or indicate that you have been excluded from in order to attest for Meaningful Use.

In addition, there are the Clinical Quality Measures. EPs are going to end up reporting on six total Clinical Quality Measures. We'll go into a little bit more detail about it, but essentially, it's three core and three from a menu set, and I'll detail that a little bit more. Hospitals have slightly different objectives. You can see at the bottom there is a lot of crossover, but we're going to concentrate on EPs here.

On slide 17, as I said, some of these objectives as we move forward are not going to be applicable to everyone's scope of practice. You may not have any eligible patients for a particular objective. You may not have any eligible action for those measures. An example might include the objective for E-prescribing. There is an exclusion provided if you write fewer than 100 prescriptions during the reporting period that you can exclude yourself from having to report on the E-prescribing measure. When you can claim those exclusions, those do not count against you, you will still be able to achieve Meaningful Use. But you'll see later on in the screenshots how you would indicate that.

It's important to keep in mind for scope of practice, we've often been asked if something isn't relevant to my scope of practice but there's not an exclusion provided, do I have to report on it. And the fact is that if there is not an exclusion provided, you are required to report on it. You are required to meet that objective in order to achieve Meaningful Use. So you have to meet the measures of those particular exclusions in order to exclude from them.

On page 18, just to give you an idea that on the measures that there are numerators and denominators where there are particular thresholds, there's often a choice on these as to how you calculate the denominator. You can

sometimes elect to include all patients that you have seen or admitted during the EHR reporting period. There are other times that you can restrict that denominator to particular actions that you have performed or subsets of patients that you've seen during that EHR reporting period whose records are maintained within the certified EHR technology. You'll see that on each of those objectives, you will indicate how you accomplished that particular, how you calculated that particular denominator.

On slide 19, there is a provision within the regulation that States can seek approval to require four Meaningful Use objectives to be core for their Medicaid providers and those are listed here. It is important to note that to date no State has sought or been approved for that option but it is a possibility that States can seek that.

And then, finally, on 20, we often get the question from people about what if they're working in multiple locations, and some of those locations have a certified EHR product and some of them do not. There is a provision for this in the regulation and it does state that you need to have 50 percent of your total patient encounters at locations where the certified EHR technology is available.

And then essentially, what you will do is you'll base all of your Meaningful Use Measures on that 50 percent. So in other words, if a particular measure has a bar of 80 percent, a threshold of 80 percent, it will end up being 80 percent of that 50 percent, where you have actually certified EHR available.

On Slide 21, a little bit more detail about the Clinical Quality Measures. As we said there are six total that you're going to report on. Three of those, they are a core set. If you're not able to – if you don't have a population for a particular CQM in the core set, in other words, if you reported a denominator of zero for one of those core sets, there is an alternate core set from which you'll choose.

And then, you'll choose an additional three from a menu set of 38. So there will be six total. Currently, you're going to report those through attestation on

our website and we'll show an example of what the Clinical Quality Measures look like in some of the attestation screenshots.

There is a provision in the regulation for 2012 reporting those Clinical Quality Measures electronically. Right now in the physician fee schedule NPRM, there is a proposal for actually using the Physician Quality Reporting System to report electronically on Clinical Quality Measures. It is not a requirement but it is an option for electronic reporting. That's out for comment now and I encourage people to take a look at that and enter any comments that they have, and hopefully, we'll be solidifying that once we publish the final rule.

Slide 22 is really here for your information. It's just a contrast between the Medicare and Medicaid programs, comparing incentive dollars, the difference between Meaningful Use and the A/I/U in the first year.

And then on slide 23, again, this is our website. I really do encourage people to take advantage of the resources that are available on the website. We have a wealth of FAQs, Meaningful Use Specification Sheets, Registration and Attestation User Guides that will walk you through each of those processes, and a lot of other educational resources. There's also a link here to the ONC website where you can learn about certified EHR technology, which products have been certified for the program, what you can use and some more FAQs specifically about certified EHR technology; so really, a lot of great resources that we put out there that I hope people will take advantage of.

And I'm going to turn it over to Michelle here to talk a little bit about the registration system on our website where you would first go to initiate into the program.

Slides 24 thru 42

Michelle Mills: Thanks, Rob. So we're going to go through the next two modules that cover registration and attestation pretty quickly. It's probably the most boring part of the presentation today, but we feel that it's important in understanding the larger program framework. And you know, you have to go through these steps to register and attest for our program in order to get the money. So it's a good idea to have a sense of what's going on.

Like Diane said in the beginning of the call, there will be a more detailed session covering these topics on September 9th. And Rob just pointed you to a slide that's so great, we included it twice in this deck and it will be at the end again. And it covers all of the various resources that we have, not just directly related to registration and attestation, but general program materials.

One of the things on our website under the Registration Tab is a user guide for both registration and attestation which cover in detail all of these various screenshots that we're going to show you in the next few slides, but also detailed instructions for how to get through each of those different steps.

So with that, I'm going to cover registration at a high level. The first thing that folks should know is that to register for this program, everyone needs to have a National Provider Identifier or an NPI and a web-based user account for that. You'll use your login and password for the National Provider Identifier System, what we call NPPIES. It's the National Plan and Provider Enumeration System. You'll use your same web-based user ID and login in order to get into our system as well.

Next, if you're a Medicare beneficiary, I'm sorry, a Medicare provider, you need to also have as I mentioned earlier an active enrollment record in our PECOS system. That's the Provider Enrollment, Chain and Ownership System, where we – how we pay and enroll Medicare providers. It's not required for Medicaid eligible professionals to have a PECOS enrollment and we wouldn't expect you to, some might but you don't have to have for this program.

And the last sort of tidbit of administrative information is that in order – if someone's going to register and attest on your behalf, you also have to be in the CMS Identity and Access Management System, what you may hear is called the I&A system which allows you to essentially defer your ability to register and attest for this program to, you know, an office manager or someone else that may register a number of folks on their behalf so that the providers don't actually have to do it themselves.

There is more information on our website also about the CMS Identity and Access management and what you need to do in order to leverage that for this program. Again, we call that the I&A system or I&A management.

So with that, I'm on slide 25. One of the important things to know about this program when you're registering are the differences between Medicare and Medicaid. So if you're a Medicare provider and wanting incentives under the Medicare program, you'll do everything at the CMS Registration and Attestation system. Because Congress gave States the flexibility to administer their own programs, 56 States and territories have different programs. Some of them are up and running as Diane said at the beginning of the call; some are coming online later this year and some even early next year.

If you're registering for Medicaid incentives, there are activities that you need to do both at the Federal level and at the State level. And we tried to make it as easy as possible for providers. We needed to make sure that providers were only getting one incentive. In other words, they weren't trying to participate in both Medicare and Medicaid, so we had to have a central repository for how we're managing that. And then the States needed to also be able to administer their program and leverage the flexibilities that are accorded to them under the statute and regulations for this program.

So with that said, we're going to walk you through some screenshots and show you at a high-level how you would register for the program and then the different paths you may take if you're a Medicare or a Medicaid EP.

I'm on slide 26 which is the first screenshot of the registration system. And I'm going to cruise through and tell you which slide I'm on when there's something that's relevant to this discussion to pay attention to. Again, we're going to get into more detail on September 9th, and there's a lot of information on our website too.

Slide 27 shows you use your NPES or NPI user name and password to log into the system. And then on slide 31, this shows you where you would pick between Medicare and Medicaid. You can only receive, as I said, the incentive payment from one program in each year, and you're allowed to

switch between the program tracks once before 2015. So you could participate in the Medicare program this year and then decide, say, next year I meet the Medicaid patient volume requirement and I get more money under Medicaid, and then you can finish off the program under Medicaid, but you couldn't go back to Medicare again.

Also notable on this slide is that we ask if you have certified EHR technology. At the time you're registering for the program, you don't have to have this in place. We encourage folks to register before they even have the certified EHR technology just so that you can work through any of the kinks. Like, for example, you may get to a screen where you don't know how to answer the questions or you don't have the information being requested. And that way, you can save your work. You can go back and collect the information that you need and then finish the registration process later.

So when you get to this screen, if you say no, it doesn't prohibit you from registering for the program. It does however prohibit you from receiving payments. You won't be able to complete the attestation process either with the State or with Medicare until you have that information.

And so, we ask you for the number there. The number is not the same number that you'll get from your vendor. Everyone has to have a number from the Office of the National Coordinator's website for certified EHR technology, and there's a link there that tells you a little bit more about that process. If you work for, say, a large physician practice or a large group, that would be information that your office administrator or someone who's leading the charge in this effort can help you get and that would be the same information for everyone at that practice using that same suite of services.

Moving to slide 34, this is just largely our legalese that you are agreeing that you are submitting correct information to our program under penalty of all of the things that CMS can do to you and what not, and then you're agreeing in order to proceed with the program.

If you receive, I'm on slide 35 now, if you receive a failed submission, there will be information there about what you need to do to fix your file. There

may be no match for you in the PECOS system if you're a Medicare provider. You might be erroneously or not on the Death Master File that's run by Social Security. And so, there will be specific steps you need to take in order to correct your registration.

If you don't agree with that information or you have trouble, you're always welcome to call our help desk to have them get specific information for you or to tell you what next steps you need to take. You will need this registration ID that's here halfway through the page when you call the help desk so that they can help you more efficiently.

It's also important to note that when you get this page, whether it's failed submission or successful submission, it's not like Amazon where you get an e-mail confirmation sent to you. I think – I know I rely on those when I go to websites and I don't actually print these kinds of things when they say to print them because usually you get an e-mail alert. We at this time are not able to send out e-mail alerts to folks verifying this information. So you do want to take either an electronic screen grab and save that on your computer or you want to go ahead and print that. You'll need that information later.

I'm skipping to slide 39 which shows a successful submission. It also notes that if you're a Medicaid provider, you're not done yet. You need to go to the State's system to complete additional information for the State. There's a link there that shows you how you can find your State's website. You're also welcome to contact our help desk again if you have any questions about that. They have the same information.

And so, I'm on slide 40 which shows – actually 40, 41 and 42 show screen grabs from the State of Michigan Medicaid provider attestation portal, and it shows you how a provider attests in the Medicaid program – there'll be a number of fields that are pre-populated from what you just completed with the Fed, and then, the State used to verify additional information, what we talked about earlier.

So things like are you considered hospital-based and therefore ineligible to participate; did you meet your Medicaid patient volume requirement; things

like that. So they will collect some additional information for you that can't be collected Federally because of the differences between the States. And then the State is actually the one that pays Medicaid eligible professionals. So after they go through some processes to validate the information that you've given them, they will issue you a payment.

OK. And with that, we're on slide 43 and I'm going to turn it back to Rob to finish this out with the attestation overview.

Slides 43 thru 58

Robert Anthony: Thanks, Michelle. I just want to run through a couple of example slides. Most of these are here for folks because we've received the feedback that people want to be able to walk away and see what it is they're actually going to be completing when they're doing their attestation.

So this is where you actually enter your data for Meaningful Use. If you are a Medicare EP, you will come back to that same online module, you will log in with the same NPI, NPPES user account that Michelle had referred to for registration. And then you'll see looking at slide 44 at the top of the page, there are a number of tabs. You'll click on the Attestation Tab. This slide just shows you the topics that the Attestation Module is going to walk you through for the core measures, the menu measures and then the Critical Quality Measures.

If you look at slide 45, at the bottom of that slide, this is an example of an exclusion. When you take a look at a particular measure, you'll see the objective, you'll see the measure, and then at the bottom, if there's a particular exclusion, it will define what that exclusion is and you'll attest if that does apply to you or not and indicate yes or no.

Slide 46 is an indication of one of those objectives that I talked about, with the yes/no objective. It just tells you, you know, have you enabled that functionality for the entire reporting period. So here you are, yes or no.

And then slide 47 shows you what a numerator/denominator is going to look like on the screen. You'll see the objective; you'll see the measure; and you'll

see the exact definition of the numerators and denominators for that particular measure. You can also see this exact language ahead of time on our website. If you go and take a look at the Meaningful Use Specification Sheets, each of those provide the exact language, a definition of some terms that may help you and any other point that may help you with meeting that.

Some folks have asked about Slide 48 the menu measures. You are again selecting five out of a list of 10. One of them has to be what we call a public health objective which is submitting data to immunization registry or submitting syndromic surveillance data to a public health agency. You'll actually see this on one very long screen. It continues on slide 49. And what you'll do is in the check boxes on the right under the select column, you'll actually put a check in the box and indicate which of these you want to report on, and then the system is going to bring up one right after the other so that you can report on exactly the one, the measures that you want to report on.

There's some other examples of the menu measures just so you could see the menu measures look like the core measures, the same format. And then we have some examples of what the Clinical Quality Measures are going to look like. If you look at slide 51, here is an example of a Clinical Quality Measure. I do want to highlight here that when you look in the attestation system at the core and menu measures, you're always going to see the numerator and then the denominator whereas the reverse is true with Clinical Quality Measures.

The denominator will be the first field; the numerator will be the second field. Just make sure you say no to that when you're printing out reports and you're getting ready to put that information in for attestation.

There are some additional fields here that show you what the other Clinical Quality Measures are going to look like. I encourage everybody to take a look at that. But on Slide 55, we've had a number of people who have asked if they are going to see what the system calculated for their performance. And after you submit your attestation for Meaningful Use, there's actually a place where you will be able to click through and look at your core measures, your menu measures and your Clinical Quality Measures and see how it did.

As you can see on slide 55, it will show you where you were accepted and rejected. In this case, for example, maintaining an up-to-date problem list was rejected. It will give you the reason why you were rejected and it will give you what your measure was based on the numerator and denominator that you entered or it will indicate the yes or no that you entered. This is a great place if you have to go back and edit your attestation and resubmit it later to find out where it is that your objectives fell short of the measures.

On slide 56 you see that there's similar space for Clinical Quality Measures after you've submitted. It will show you where you've been accepted and rejected and tell you the reason for it.

And then slide 57 is really for hospitals included as a reference for how Emergency Department is included. There's no need to cover it now. On slide 58 the thing I really want to call attention to here, we talked a number of times about these different resources. But you'll see we do have our EHR Information Center number. The EHR Information Center is there to help you through the registration and attestation process. So if you have system questions, they're an excellent resource for that. They're also a good resource if you have specific program questions that you don't find or are not answered by our FAQs or our program materials on our website. So direct your questions to them and they'll be able to get back to you with an answer if they don't have one right away.

So thank you, everybody, for tuning in for this. And I think we've got a good amount of time for some questions from folks. So I'm going to pass it back to Diane.

Questions and Answers

Diane Maupai: Thank you. Melissa, if you could open the line for questions?

Operator: We will now open the lines for a question and answer session. To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key.

Please state your name and organization prior to asking a question. And pick up your handset before asking a question to ensure clarity. Please note your line will remain open during the time you're asking a question, so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Debbie Vernon. Your line is now open.

Debbie Vernon: Yes. My name is Debbie Vernon with Renaissance Billing Services. I think back on page 12 you were talking about paying for the program and you had to show that you were paying for the program at some time at some way. And many providers are starting to make use of the free EHRs that are out there. Does this disqualify them from the program?

Michelle Mills: That's a really great question. So just to again say that for folks, she's referring to the Adopt, Implement, Upgrade provisions which are applicable only to eligible professionals participating in the Medicaid Incentive Program.

And no, the free software would not prohibit individuals participating in the program. We're not looking at just the software for these provisions. We're looking at anything that they would spend money on relative to adopting, implementing or upgrading. So this may include practice management changes, redesign. It may include Internet access. There are myriad topics related to what this could impact cost-wise for providers. So even if the software is free, we know that there's training and other things associated with cost for this program as well.

Debbie Vernon: And you said there's a list of the accepted software on your website somewhere?

Michelle Mills: There's a list of which vendors have been certified under this program on the Office of the National Coordinator's website. The site is Certified Health IT Products List; the CHPL. Many people call it the chapel. And you can find a link on the Office of the National Coordinator's website which is also on our list of resources here - healthit.hhs.gov.

Debbie Vernon: OK. Thank you.

Operator: Your next question comes from the line of Celine Young. Your line is now open.

Celine Young: Yes. I would like to know if ...

Operator: Celine, if you could just re-queue and we will reopen your line? In the meantime, your next question comes from the line of Cassie Veralight. Your line is now open.

Cassie Veralight: Yes. We were wondering – we're on the actual page and we're not finding the link under presentation to print the whole presentation out.

Diane Maupai: This is Diane. You're on the Spotlight and Upcoming Events page?

Cassie Veralight: Yes.

Diane Maupai: If you scroll down almost, you'll see – there's a section called Presentations; it's underlined. It's the first link under those, there are about five presentations listed. It says EP Basics July 14th call.

Cassie Veralight: No. It's not there.

Diane Maupai: It's before you get to the Download section. There's another section that says Presentations right above the Download section.

Cassie Veralight: How interesting. OK. We don't see it at all.

Diane Maupai: Listen, why don't you call the information center and they'll route your question to me and I can send you the deck? And their number is 1-888-734-6433.

Cassie Veralight: Wonderful. Thank you.

Diane Maupai: Sure.

Cassie Veralight: OK. Hello?

Diane Maupai: I think we're ready for the next question.

Operator: Your next question comes from the line of Stefano Miller. Your line is now open.

Stefano Miller: Hi. On slide 25, last bullet reads "States will pay no later than 5 months after you register; most sooner." I want to make sure I'm interpreting that correctly. Is it actually the word "register" or should that be "attest"?

Michelle Mills: That's a great question. So for States, they have a phased launch program similar to have Medicare and States were able to start their programs in January this year. Medicare began accepting attestations in April and then making payments in May.

So what we told States is that you can launch your program and you have to be able to accept attestations within three months from launching. So during those three months, some States are just launching and accepting ...

(AUDIO GAP)

Stefano Miller: We've lost you.

Robert Anthony: Michelle, have we lost you?

Operator: Ms. Mills, your line is still open.

Robert Anthony: I'm sorry. Hopefully, we can get Michelle back on the line. It looks like we've had a technical difficulty that's cut her off. I'm sure she's trying to call back in. But hopefully, she'll be able to finish off the answer about that question when she returns.

Stefano Miller: It does have very different meanings. If I read that correctly as five months after you register, that implies that you really need to delay your registration until you're really close to being ready to attest. Otherwise, if you register too soon, then you could miss a window. And I don't think that's the intent. I don't think that's what I heard in the past, but as I read that, it made me nervous.

Robert Anthony: Yes. I don't think that's the intent either and I think that Michelle's going to address exactly that when she's able to get back on.

Diane Maupai: Maybe we can move to the next question in the meantime.

Operator: Your next question comes from the line of Sandy Primavatera. Your line is now open.

Sandy Primavatera: Hi. My question is for all of the quality measures, you know, for all of the percentages that we have to meet. Is that just – can we do that specifically for our Medicare patients? We really have a big practice. If we switch all our Medicare patients to the EMR, is that what we're going to have to submit? Or are we going to have to submit information for all patients?

Robert Anthony: That's a good question. And actually, it's for all patients - it is not simply for Medicare or Medicaid patients. It is applicable to all patients. We discussed a little bit of this in the final rule and ultimately decided after a lot of public feedback that it would actually impose a pretty serious burden on a lot of practices to have to separate those patients out.

Sandy Primavatera: OK. Thank you.

Operator: Your next question comes from the line of Marie Voltaire. Your line is now open.

Marie Voltaire: Hi. It's Marie Voltaire from Row General Hospital. My question is about the radiologist doctors. Are they eligible for the program? And if yes, how do they register using the hospital EHR?

Robert Anthony: So the answer to that is most radiologists are eligible because they are Doctors of Medicine and they are not considered hospital-based; in other words, they do not bill in the Emergency Department or inpatient of a hospital. 90 percent or more of their services are not in an inpatient or an Emergency Department of a hospital, so they wouldn't be considered hospital-based.

An ambulatory physician, in other words, an eligible professional like a radiologist cannot qualify for the program using an inpatient EHR. So in fact,

to earn the incentive you would have to have a product, an EHR product that is certified specifically for an ambulatory setting.

Marie Voltaire: Thank you.

Michelle Mills: I would also add that that goes for any specialists that are MDs or DOs or any other specialists that are able to participate in this program.

Operator: Your next question comes from the line of Beth Kolchak. Your line is now open.

Beth Kolchak: Yes. On the last slide, I think it's slide 58 or 59 where you have your attestation information slide, the EHR certification numbers, is that my EHR certification number for my software or the one my providers themselves will receive?

Robert Anthony: That's a great question. So what you will do with this certification number, you have to get it from the Office of the National Coordinator's Certified Health IT Products List and that's that healthit.hhs.gov address that you can get to that from.

Beth Kolchak: So it's the software certification number.

Robert Anthony: It is the software number but it is not the number that the vendor has for certification. You have to take that software vendor number, put that into what we call the chapel and that will give you the certification number that you then insert in the attestation module.

Beth Kolchak: OK, that I have that number. Thank you.

Michelle Mills: Just so folks don't think we're being cute with how they have to get that number, what the system does is that it may collect a variety of modules. You may have one EHR that's a complete package that's been certified and that's fantastic. But a lot of folks have modules that they're cobbling together in order to meet the certification standards for this program. So they may have a number of different products numbers that have been certified and then this

website will spit out a number that we know all of these things together are certified.

Beth Kolchak: All right. Thank you very, very much.

Operator: Your next question comes from the line of Barbara Rugos. Your line is now open.

Barbara Rugos: Yes. Thank you very much. I work with MSN and we bill and do process management for over 680 radiologists, all of whom practice in a hospital setting, so their professional services are ancillary to the hospital technical component. They don't typically see patients. Their patients belong to the referring or the ordering physicians and they're registered through the hospital. But because more than 10 percent of their services are in the hospital outpatient place, Place of Service 22, they qualify. And I'd venture to say that a very tiny, tiny percentage of hospital-based specialists practice 90% or more inpatient and ERs.

So they really have no way of complying because they rely solely on the hospital risks, the packs, the HIS and now the EHR technology. Do you know if this issue is being addressed for these specialists who have no practical way of complying?

Robert Anthony: All I can tell you right now is that we're aware of it. We talked to a number of specialist societies who expressed some concerns on behalf of some of their members. There is not anything that I can tell you that is on the table right now, just that we're aware that the issue is there and hope to address that in the future.

Barbara Rugos: Great. Thank you very much.

Operator: Your next question comes from the line of Dr. Arnold Revistova. Your line is now open.

Arnold Revistova: Yes. Hi. Thank you very much. I have a couple of questions. First question I have is, you know, when you were talking about upgrading, is it something that we do at the time of attestation?

The second question is we are already participating and doing electronic prescription and PQRI measures. Now, is that part of the EHR incentive payment?

Michelle Mills: So let me make sure. I want to tease out because it sounds like you're asking about a few different things here. Are you interested in the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program?

Arnold Revistova: No, Medicare, Medicare, Medicare.

Michelle Mills: Medicare. OK. So the Adopt, Implement, Upgrade provision is only for Medicaid eligible professionals in their first year. It's not related to the Medicare program. With that I'm going to turn it back over to the other folks to talk, to answer your other questions.

Arnold Revistova: Thank you.

Robert Anthony: Yes. I think it's important to keep in mind that there are a number of different incentive programs here at CMS. They don't necessarily have the same requirements for things, but there may be some overlaps in some of it. I'm going to ask Patrice, are you on the line? Can you talk a little bit about PQRS?

Patrice Holtz: Sure. I believe we have all the information regarding program participation for this on the website and I would certainly encourage you to go to either the PQRS website directly or the HITECH –correction electronic specification - website where the Clinical Quality Measures are which also contains the link.

Arnold Revistova: Right.

Patrice Holtz: And I think your question was can you participate in both? Is that what you're saying, or is it considered both because they're two separate programs.

Arnold Revistova: Correct.

Patrice Holtz: So each program has its own requirements.

Arnold Revistova: The question is, actually, the question is currently, right now, you know, we are doing PQRI in our group. And you know, we are also participating in the Electronic Prescription Program. Now, with this EHR technology, I understand your PQRS is already built into some of the measures.

Is that going to be a separate payment because it's supposed to be for the PQRI or will, you know, DPRO, whatever you want to call it, these things actually I thought it's a separate payment of one percent from Medicare.

Patrice Holtz: OK. So if we are talking about the current 2011 attestation year for the Medicare EHR Incentive Program, if you participated in that program, that's a separate incentive from the PQRS Reporting Program.

Arnold Revistova: OK.

Patrice Holtz: So these are not ...

Arnold Revistova: Thank you.

Patrice Holtz: They're totally separate as of right now.

Arnold Revistova: I see. I have one more question real quick. The question I have is the attestation, so it is a process where you do once you have all your information and that is your final step. You register in the beginning and once you attest, that means you do already have all the information that is necessary. And that's the last step. Correct?

Robert Anthony: That's correct. You're going to go through after you've done your reporting period and you've collected your data about the actions you've taken, and then you will attest to that data of having taken those actions. So it would happen after you've completed what we are calling Meaningful Use of your certified EHR technology.

Arnold Revistova: Thank you very much.

Michelle Mills: I'd just add that's, again, that's just for Medicare in the first year. For Medicaid, States will have a similar process in years two through six for collecting Meaningful Use information from the providers that are getting

payments. But in the first year, the Medicaid EPs don't have to go through that.

Operator: Your next question comes from the line of Stefano Miller. Your line is now open.

Stefano Miller: Yes. We're going to try this again. Michelle, you dropped off when you were trying to answer our question before about the ...

Michelle Mills: Payments.

Robert Anthony: Excellent.

Stefano Miller: Question on slide 25.

Michelle Mills: Yes. Thanks for queuing back up; sorry about that.

Stefano Miller: No problem.

Michelle Mills: So what I was saying was that after a provider attests to the State's or the Medicaid program, in other words, they said they've met patient volume and some of these other things, once the State is capable of making payments, they have a 45-day period maximum in order to get you your incentive money.

So it's not like you go in and give your information for patient volume and so on, and then they'd give you a payment six months later. They have to turn it right back around pretty quickly. The actual period of time depends on the State and their normal payment cycle. In some States they're doing it weekly or bi-weekly or monthly, for example. But 45 days is the maximum once they are capable of making payments.

Stefano Miller: OK.

Michelle Mills: And we have 14 States right now making payments.

Stefano Miller: So that bullet should actually read attestation as opposed to register.

Michelle Mills. No, because after you register, which means the program is launched, the State has five months to begin making payments to initiate their payment process. After the payment process is initiated, then they have 45 days.

Stefano Miller: Let me ask a corollary question there then. So if we believe that we're still a year away from being able to attest, is there any reason we could not go ahead and register now? I don't want to miss a window because we registered too early.

Michelle Mills. No. That's a great question and I'm glad you asked. There's no penalty for registering for this program in either Medicare or Medicaid and then not completing the process. We encourage anyone who's interested in this program to go register now. If you don't finish it this year, that's OK. You could come back next year as well.

But in terms of – I think when you were referring to attestation for Medicaid, I just want to be clear, what you're attesting to in Medicaid isn't the Meaningful Use requirement. You're attesting that you either adopted, implemented or upgraded certified EHR technology and you're also attesting to the other program requirements like that you met patient volume and so and so forth.

Stefano Miller: OK. Thank you.

Michelle Mills: You bet.

Questions and Answers Continued

Operator: Your next question comes from the line of Stacey Parks. Your line is now open.

Stacey Parks: Yes. I'm calling about an EP who sees some people in the hospital but also sees many in nursing homes. Will the nursing homes count towards the Meaningful Use percentage and since it's not hospital-based?

Robert Anthony: They potentially could if there is certified EHR technology in place in those areas. And that's what we referred to when we talked about providers who work in multiple practices. You have to make sure that that provider has at

least 50 % of their patient encounters in scenarios where certified EHR technology is available.

Stacey Parks: OK. So I just want to make sure I understand: this EP carries his own electronic medical record stuff with him? Is that – I mean everything he does is on there?

Robert Anthony: If that EHR technology is certified specifically for this program, that very well could count.

Stacey Parks: OK. So EHR certified – and that's what you were saying earlier is that we have to be on the CHPL to see if the software he's using is approved.

Robert Anthony: Yes. So I encourage everybody to check out the Office of the National Coordinators website. That's the healthit.hhs.gov website where you can find that list of all of the software that's been certified specifically for the EHR incentive program.

Stacey Parks: OK. Thank you.

Michelle Mills: It's helpful to note also that there are a number of differences in the program requirements between things like Meaningful Use, hospital-based, patient volume and so on. The reason is not that we wanted to make the program complicated as possible, which may end up being the result, but rather that we were afforded flexibilities in different cases when we were developing this program and we wanted to make it as flexible on providers as possible so that we can have the highest number of folks qualifying for this program.

So we encourage – if you have questions that you think of later, things that sounded alike but you thought might have differences, definitely call our help desk or check the website too.

Stacey Parks: OK. And then I have one last question. Is Kentucky one of the States that's already paying?

Michelle Mills: Yes. Kentucky was one of our first States that launched as soon as the program, as soon as they were able to launch on January 3rd.

Stacey Parks: OK. All right. Great. Thank you.

Operator: Your next question comes from the line of Harry Purcell. Your line is now open.

Harry Purcell: Good afternoon and thank you so much. It sounds like there's a lot of radiology groups on the line. I, too, represent a number of hospital-based radiologists that provide greater than 10 percent of their services in an ambulatory setting.

My first question is some groups that I work with have asked to have their practice administrator register for them. And although it seems pretty simple for the doctors themselves, it seems to be more difficult as an administrator there's an actual paper process, where you have to mail some forms in.

And also, it looks like there's some personal information that the administrator has to submit including your Social Security number, you know, representing all of the information that's true and there may be some action taken against them and I find some of the practice administrators being apprehensive in completing it. Could you speak to that? And I have a couple of questions that follow.

Robert Anthony: Yes. I think, you know, there is a way to indicate that third-party or proxy access for people and it's through what we call our Identity and Access Management system or I&A system. I do know that there are requirements for registering somebody in that system to allow them to, in this case, register or legally attest on your behalf as an EP. So that's sort of been established.

If the process that is often used, people who work in hospitals may be familiar with this because that I&A system is used pretty widely to access CMS systems with hospitals. But in this case, there is a form that you're going to have to fill out in order to identify as a person who can register and legally attest in an EP's stead.

Harry Purcell: OK.

Michelle Mills: And one of the key things that Rob just said was legally attest. And so, again, we're not trying to make this as difficult as possible on folks. We're trying to make sure that there's a legal chain of accountability for information that's entered into the system so that we're responsibly handling these public funds that are being expended to providers.

Harry Purcell: Sure ...

Michelle Mills: But there are detailed instructions on our website under the Registration Tab under what he was calling the I&A system, the Identity and Account Management System, that talks about what you need to do and there's links to the forms.

Harry Purcell: OK. And thank you for that. Again, the apprehension I found with some of those administrators is "Hey, wait a minute; this is asking for my personal Social Security number. If someone submits some information, I've got, you know, 17 radiologists. When someone does something wrong here or they're going to come after me." I guess that's been their question, you know. And it appears the answer would be yes.

Michelle Mills: Well, if they're doing it on behalf of someone else, then the accountability is on them ultimately to make sure that the information is accurate. If the information is being entered by someone else, then they wouldn't be linked to that account.

Harry Purcell: OK.

Michelle Mills: You know the Federal government has folks' Social Security numbers, I understand there's some apprehension with providing that, but that's data that we have. We are a sister agency with the Social Security Administration.

Harry Purcell: OK. With regard to the measures that these radiologists may be reporting and one of my colleagues asked a similar question earlier in terms of data being available to hospital-based radiologists, if they have a fully certified EHR system and there's only a few of them out there for radiologists and they are hospital-based, would it be acceptable to report a zero numerator and

denominator while they are working with the hospital to extract that information from their system?

Rob Anthony: I'm sorry. I just want to clarify and make sure that I'm understanding this correctly. So you're saying if there were no patients that they saw during the reporting period, would they report a zero numerator and denominator? Or are you asking would it be OK to report a zero numerator and denominator while they are transferring information from another system?

Harry Purcell: Would it be acceptable to report a zero numerator/denominator if the information was not currently being captured by the hospital or made available to the radiologist? So some measures, they may be able to report successfully where they're able to extract that from the hospitals, other measures where they are not able to successfully extract it, could they report a zero/zero?

Rob Anthony: So in this case for eligible professionals, it's up to the eligible professional to make sure that the data that is indicated for these particular measures that is appropriate is captured within their own system. So simply because a hospital system isn't capturing that information, they can't defer reporting that information. It is the responsibility of the EP to capture that information in the way that it is indicated by the Meaningful Use objectives.

And again, I just want to say we have heard from radiologists, we have heard from some other specialists that there are some folks who may not be hospital-based according to the definition of this program, but certainly are practicing within a hospital setting that this poses some challenges for. At this point, we don't have a particular solution to address that, but it is something we are aware of.

Harry Purcell: Understood. Thank you so much. Final question, actually a two part question, but it is my understanding that you must report successfully for 90 days within the Calendar Year you would like to begin receiving the incentive and so by default, would that mean by at the latest October 2011, you would then report for that three month period before submitting your attestation for

2011. And as I understand it, you would not complete attestation until that 90 day period was complete.

Rob Anthony: Yes. So your 90 day period has to be within the Calendar Year. So in this case, the final 90 days that you could do for 2011, would be October to the end of the year and you would not report – in other words, you would not actually attest until you had completed your reporting period because the attestation is going to be providing data from that completed reporting period.

Harry Purcell: OK. And it's – in this case, if you complete your attestation in 2012, but did complete the reporting for that 90 day period within 2011, would you still qualify for the 2011 ...

Rob Anthony: Yes. That's actually – that's an excellent question and it's a really good point. You will have 60 days after the close of the Calendar Year to actually get your attestation in to us and that's specifically for folks who are reporting that October through December, 90 day period and then of course later as you participate in Medicare, that period is going to be the entire reporting year, so the entire Calendar Year. So it will come to a point where everybody is sort of reporting in January/February of the following year for attesting to the previous year.

Harry Purcell: Excellent. Thank you so much for your time.

Rob Anthony: Sure.

Operator: Your next question comes from the line of Jennifer Hennessy. Your line is now open.

Jennifer Hennessy: Hi. I have a question. I am a specialist, actually an ENT specialist and I am having some difficulty as far as the menu option for the additional three things that have to be followed and measured. As an ENT, there are not three that pertain to my practice and there aren't three that we measure. I don't deal with heart failure and diabetes and high blood pressure directly. Do you have any recommendations for what a specialist does if they don't have those – if they can't find three additional menu options to follow and what kind of options do we have?

Patrice Holtz: So are you referring to the Clinical Quality Measure objectives?

Jennifer Hennessy: Yes.

Patrice Holtz: OK. So what you want to do is, you definitely want to produce a report from your electronic health record that demonstrates the information for the first three core measures. And for each one of those measures, if you don't see that patient population, then the denominator for the measure will most likely be a zero.

Jennifer Hennessy: OK.

Patrice Holtz: For each core measure that you get a zero result, you then go to the alternative core measures and you select them in whatever order you want. If you want to do the first one because that applies to your population, fine and you get something other than a zero for the denominator population and that's all you needed, then that replaces one of the core. If by chance all of the three core measures result in zero denominators, meaning you have no patients in your practice, then you would do all three alternate core measures. If by chance you also result in three zeros for each one of those measures, then you still select three menu measures and report on those. So it is possible that an attestation could be zero/zero six times.

Jennifer Hennessy: OK.

Patrice Holtz: And that's acceptable.

Jennifer Hennessy: My – OK. My understanding the additional menu options, those were additional alternate menu measures? Or they're in addition to having one of the three core measures?

Patrice Holtz: OK. So ...

Jennifer Hennessy: So the core measures, there's three that I can follow and that's not the issue, but ...

Patrice Holtz: OK. So that's fine. If you have three measures in the core, in that first three set and you're going to produce results other than zero for those first three, then your next step is to go the additional 38 measures and select three from there.

Jennifer Hennessy: And if there are not three that apply, what do I – just do a zero ...

Patrice Holtz: Then you would select – for your system, if you have all 38, you would continue to select each one until you exhausted them. I don't know whether your EHR has all or a – it's a module which would have less than the 38. Whatever your system has, you have to exhaust.

Jennifer Hennessy: OK. OK.

Patrice Holtz: OK.

Jennifer Hennessy: (Inaudible) zero denominator. OK. Sounds great.

Patrice Holtz: Yes and if it's a zero – if all 38 resulted in a zero denominator, that's what you attest to.

Jennifer Hennessy: OK. Fantastic.

Patrice Holtz: OK. All right.

Operator: Your next question comes from the line of Kelly Davis. Your line is now open.

Kelly Davis: I think my question got answered about the radiology system. We're basically saying that an ambulatory EHR product is the only way a radiologist could be certified or excuse me could achieve Meaningful Use through this program and that they have to have greater than 10 percent of their services, we have to make sure that they can report the quality measures and the data has to be captured. My only question is, I heard someone speaking about having information extracted from a hospital EHR system into an ambulatory system. So is that still qualifying them if they were using an ambulatory system?

Rob Anthony: So just to clarify, yes, if you're an eligible professional and you are not considered hospital-based, then you have to use a certified EHR product that is specifically certified for the ambulatory setting in order to achieve Meaningful Use. And the reason you have to do that is because inpatient products are certified for hospital requirements and hospital requirements are slightly different from the EP requirements. So you wouldn't be able to complete all of the fields that you would have to in attestation as an EP using the hospital product.

As far as your question about how the information gets into the system, there are a variety of ways that information can make its way into the system and for most of the Meaningful Use Measures, in fact for all of the Meaningful Use Measures except for computerized provider order entry, we don't specify how information gets into the system. So it is possible to have an interface from a hospital unit that would move information like demographic information or vital signs or so on into that EHR. It's incredibly possible to have it come from other systems. The only objective for which we actually specify how information must be entered and at what point and by whom is for the computerized provider order entry objective.

Kelly Davis: All right. Thank you.

Rob Anthony: No problem.

Operator: Your next question comes from the line of Jason Scall. Your line is now open.

Jason Scall: Hi, thank you. Jason Scall with the Infectious Diseases Society of America. I have two hopefully quick questions about hospital-based eligible professionals. Early on in the presentation, I believe that I heard that CMS had no flexibility in this definition. So let me start out by saying it's been a while since I've read the HITECH Act, so I could be wrong about what I am about to say. But my understanding is that while HITECH did define hospital-based EPs as those who furnish substantially all of their services in a hospital setting, it didn't define what that meant. That was actually defined, I think, in the Stage 1 Rule as the – with the 90 percent threshold.

Michelle Mills: Sorry. What I was indicating was that it was statutory that we exclude individuals who are considered hospital-based. The CMS did have some, although very little, discretion as to how we define that in regulation. We tried to be as flexible as possible and we think the 90 percent threshold does reflect substantially all of...

Jason Scall: Right. Right and I understand – you know I understand that CMS had to put that threshold somewhere, although it is impacting ID physicians who provide specifically lots of outpatient infusions to their patients, but whom other than that, probably have mostly hospital-based services. So my next question really relates to that, so what happens if an – let's say an ID physician is determined to be hospital-based, let's say for 2011, 2012, and 2013 because I think you're going to have to do this every year, but then in 2014, they perform just enough outpatient services to try to become a meaningful user. Will they then be subject to payment penalties beginning in 2015, if they fail to become a meaningful user even though they only qualify for an incentive payment for one year?

Rob Anthony: I know a lot of people have this question about what happens if you become available specifically in this situation, with hospital-based, would you be subject to penalties? And I think it's important to say right now that we haven't addressed the penalty phase of the regulation. That's going to be addressed in the upcoming Stage 2 regulation, of which the notice of proposed rulemaking for that is going to go out in January of 2012. There will be a public comment period. And that's really where we hope to detail how penalties are going to affect providers in different situations.

Jason Scall: Fair enough. Thank you very much.

Michelle Mills: And just to make sure folks are clear, the penalties specified under statute only impact Medicare eligible professionals and hospitals, not Medicaid.

Questions and Answers Concluded

Operator: Your next question comes from the line of Rachel Samariffa. Your line is now open.

Rachel Samariffa: Good afternoon. Thanks for hearing my call. I just wanted to echo the words for the other – in regards to radiology and pathology. We would like to have some guidance and my doctors are very anxious, they don't want to wait until the last minute and they, of course, don't want to miss out on the full incentive if they should have to. I would recommend maybe excluding Place of Service 22 as well. But my main question is, what about new professionals that are just getting out of school and opening a practice, but they don't have a patient volume yet? Do they need to wait a year before they can consider attesting for the incentive plan for Medicare?

Michelle Mills: So the patient volume requirements are relative only to the Medicaid eligible professionals, not Medicare. But your question may still be relevant to other folks on the call, so I will answer it. The requirements for patient volume are that the individual select a 90 day period from the previous Calendar Year and so if there is a new person or somebody that was just licensed, let's say is an MD for example, this year and they don't have patient volume from last year, in those cases that would prohibit them from receiving Medicaid incentive payment. There are a couple of exceptions that we didn't talk about today, for example we let groups in clinics use the proxy value and that could apply to new professionals as well. If you fall into that bucket, since it doesn't impact probably too many people on today's call, I encourage you to work with your State on that to see how you could qualify.

Rachel Samariffa: OK. Great. Thank you.

Operator: Your next question comes from the line of Jackie Chandler. Your line is now open. Jackie Chandler, your line is now open.

Jackie Chandler: Hello? Can you hear me?

Rob Anthony: Yes.

Jackie Chandler: Hello. Oh, OK. I'm with Medical Data Technology and my question is – I have two questions. One is, the State that you're in or that you're working with doctors is not able to do transmitting data as one of the core measures says and see its one of the 15 that you have a transfer, what do you do about that?

Rob Anthony: I'm sorry. Are you asking specifically about one of the public health objectives like immunization registry or syndromic surveillance?

Jackie Chandler: Right. And the State's not keeping up with that, so how (inaudible) ...

Rob Anthony: But there is an exclusion for both of the public health objectives. If your State is unable to receive electronically either the immunization or the syndromic data, then you are able to exclude.

Jackie Chandler: OK. And then the other question is, if one of the doctors is a podiatrist and they take all of the clinical information that you're requiring for attestation, can they still attest?

Rob Anthony: I'm sorry.

Jackie Chandler: They are MDs.

Rob Anthony: If they're a podiatrist who is taking the information and what?

Jackie Chandler: A physiatrist, physical medicine, and they do take all of the information that you're requiring for Meaningful Use and they are MDs. Can they still attest?

Rob Anthony: Under Medicare, if you're a medical doctor, you would qualify. It's just a question of whether you have part B allowed charges.

Jackie Chandler: OK.

Rob Anthony: Because you're not hospital-based.

Jackie Chandler: Right. No, not hospital-based. OK. Good. Thank you.

Operator: Your next question comes from the line of Carol Carpenter. Your line is now open.

Carol Carpenter: Thank you. I have some questions regarding reporting. If a doctor starts his 90 days for attestation on September 1st and that runs through the end of

November, does he start his next reporting on December 1st? Or does he have to wait until January of next year to start the next reporting period?

Rob Anthony: That's a good question. Your reporting period in the first year is any 90 days that are continuous within that Calendar Year. So in other words, your September to November would qualify as the 90 days. For the next year, for Medicare, it's going to be the entire Calendar Year. So it will actually start at January 1st, and run through December 31st.

Carol Carpenter: OK. Then in another scenario, he could probably then not start the beginning of November and do 90 days, which would run through the end of January of 2012?

Rob Anthony: No, it does have to be 90 continuous days within the Calendar Year. So you can't overlap Calendar Years.

Carol Carpenter: OK. He can't split it. OK. And I had another question about reporting. If he doesn't start reporting until 2013, is the first reporting after 90 days the same way it is now? Or will there be different parameters?

Rob Anthony: Currently Stage 1 really only details the 2011, and 2012 years. The upcoming Stage 2 NPRM is going to have more detail about what happens in 2013 and beyond.

Carol Carpenter: OK. OK. And just one more question. One of the slides addressed Health Professional Shortage Areas. How can we find that information? Where can we go to find what doctors in our area are in Health Professional Shortage Areas and what would they need to do to register for additional incentives?

Diane Maupai: I'm thinking – this is Diane. I'm thinking you could Google HPSA, but I believe that it's HRSA, the health services resources – Health Resource Services Administration that is responsible for designating the HPSA areas.

Michelle Mills: It's also on the CMS website as Diane mentioned if you just Google Health Professional Shortage Areas in Medicare, it will come up. It's the first hit.

Diane Maupai: This is Diane. I'm afraid we're out of time for today. Thank you all for joining and thank you, Rob and Michelle for speaking. I want to remind you about our upcoming calls, August the 18th, Meaningful Use and September the 9th, EP registration and attestation and don't forget our resources for more information, which is, slide 58. EHR Information Center, 1-888-734-6433. Thanks and have a great day.

Operator: And this does conclude today's conference call. You may now disconnect.

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